

**THE NUTS AND BOLTS OF
REIMBURSEMENT
AND
SUBROGATION
ISSUES**

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INTRODUCTION

Potentially any person or entity that has provided benefits to the client as a result of his injuries may be entitled to a share of the settlement. A hospital or physician may have a lien for their charges. Alternatively, Medicare, Medicaid or the client's own health insurer may seek to recover payments made for medical bills. In addition, the client may have received disability income benefits from Social Security or a private insurer, which may assert an interest in the settlement. Reimbursement also may be sought by a worker's compensation insurer, no-fault carrier, or other benefit provider.

The process of dealing with third-party claims is a minefield fraught with uncertain law, conflicting precedents, and potential conflicts of interest between attorney and client. Until recently, attorneys often were able to ignore potential third-party claims when a recovery was obtained, distributing the proceeds to the client with the hope that the third-party would never assert a claim. Increasingly, third-parties are aggressively seeking reimbursement, making it difficult for them to be ignored. While inaction may be appropriate in a particular case, an attorney should consider alternatives. For example, in many cases, claims can be settled at a significant discount.

Regardless of the approach taken, however, it is important for the client to be fully informed of the existence of any third-party claims and agree upon the approach. Prudence dictates that the client be informed in writing of any third-party claims that remain outstanding at

the time a recovery is distributed and that the client approve in writing the strategy for dealing with such claims.

This paper will first discuss the various types of third-party claims likely to be encountered in the handling of a personal injury case. It is intended to serve as an introduction to, not a treatise of, the law relating to third-party claims. The cases cited are merely a starting point for research and analysis.

A. Hospital and Physician Practice Liens

The Georgia statute for providing hospitals and nursing homes with a lien against personal injury recoveries was amended in 2004 to also include physician practices. O.C.G.A. §§ 44-14-470 - 476. Pursuant to the statute, a hospital, nursing home, “traumatic burn care medical practice,” and “physician practice” has a lien “upon any and all causes of action accruing to the person to whom the care was furnished or to the legal representative of such person on account of injuries giving rise to the causes of action and which necessitated the hospital, nursing home, physician practice, or provider of traumatic burn care medical practice care. . . .” O.C.G.A. § 44-14-470(b).

More notable than the inclusion of physician practices in Georgia’s personal injury lien statutes, however, is the Georgia General Assembly’s amendment of the procedure by which medical providers must perfect their liens. Paragraph (a)(1) of the previously enacted statute provided that medical providers had to provide written notice of the lien to all applicable persons and entities “within thirty days after the person has been discharged.” O.C.G.A. § 44-14-471(a)(1) (2003). Paragraph (a)(2) of the previously enacted statute then required the medical

provider to file the lien “no sooner than fifteen days after the date of the written notice provided for in this Code section.” O.C.G.A. § 44-14-471(a)(2) (2003).

By contrast, paragraph (a)(1) of the newly amended statute now provides that the medical provider must provide written notice of the lien to all applicable persons and entities “not less than 30 days prior to the date of filing the statement required under paragraph (2) of this subsection” O.C.G.A. § 44-14-471(a)(1) (2004). However, paragraph (a)(2) has only been amended to read that the medical provider must file the lien, “no sooner than 30 days after the date of the written notice provided for in this Code section” O.C.G.A. §44-14-471(a)(2) (2004). Because neither paragraph (a)(1) nor paragraph (a)(2) provide a definite means of determining a proper date to give notice of or file the lien, the new amendment unfortunately creates considerable ambiguity regarding when a medical provider must file a lien against a patient’s personal injury cause of action.

The lien is subject to any attorney's lien, ensuring that the attorney is paid before the physician, hospital or nursing home. Id.; Holland v. State Farm Mut. Auto. Ins. Co., 236 Ga. App. 832, 513 S.E.2d 48, 50 (1999); Ramsey v. Sumner, 211 Ga. App. 202, 438 S.E.2d 676 (1993).

These statutory liens are particularly onerous because they are not subject to the “complete compensation” requirement, Holland v. State Farm Mutual Auto. Ins. Co., 244 Ga.App. 583, 584, 536 S.E.2d 270 (2000), and a hospital or physician with a lien is not even required to pay a pro rata share of the attorneys fees incurred to achieve the recovery. Watts v. Promina Health Sys., Inc., 242 Ga. App. 377, 381, 530 S.E.2d 14 (2000). Although these liens are onerous, the Court of Appeals has recently held that such a lien only attaches to claims

brought by the patient or the patient's representative and does not attach to a wrongful death claim brought by the family of a deceased patient. Nash v. Allstate Ins. Co., 256 Ga. App. 143, 146, 567 S.E.2d 748 (2002). In a death case, therefore, the Plaintiff's attorney can defeat a lien by electing to file only a wrongful death claim and not filing a claim on behalf of the decedent's estate. Id.

Despite the seemingly strict requirements of the earlier statutory language, the Court of Appeals had held that the failure to file within the 30-day period does not prevent the hospital from enforcing the lien against a third-party having actual notice. Thomas v. McClure, 236 Ga. App. 622, 513 S.E.2d 43 (1999). According to Thomas, the hospital's lien attaches at the moment of treatment and nothing in the Lien Act specifically imposes any pre-conditions to obtaining a valid lien. Filing only is an issue with respect to those who have no knowledge of the lien. Id.; see also Macon-Bibb Hosp. Auth. v. National Union Fire Ins. Co., 793 F. Supp. 321 (M.D. Ga. 1992); Annot., "Construction, Operation and Effect of Statute Giving Hospital Lien Against Recovery from Tortfeasor Causing Patient's Injuries," 16 A.L.R.5th 262 (1996).

The lien statute does not give a provider a new right of action against the injured person. Hospital Auth. of Augusta v. Boyd, 96 Ga. App. 705, 101 S.E.2d 207 (1957). Similarly, the provider has no right of action against the tortfeasor directly. O.C.G.A. § 44-14-476; see also Integon Indemnity Corp. v. Henry Medical Ctr., 235 Ga. App. 97, 94, 508 S.E.2d 476 (1998) (holding lienholder could not bring an action against the liability insurer). The lien right created by the statute is analogous to the remedy provided to a creditor by the garnishment laws -- i.e.

the ability to recover amounts owing to the creditor from funds belonging to a debtor in the hands of a third person.

Nonetheless, the existence of a provider lien has ramifications for any plaintiff in a personal injury suit. That is because a settlement between the plaintiff and a tortfeasor is not binding on a lienholder, unless the provider joins in the release. O.C.G.A. § 44-14-473(a). Accordingly, if the patient and a tortfeasor enter into a settlement without the participation of a provider with a lien, the lienholder may enforce the lien by collecting from the tortfeasor. Id.; Dawson, 98 Ga. App. At 792, 106 S.E.2d at 807.

Because of the possibility of being forced to pay both the plaintiff and the provider, insurers routinely insist as part of any settlement that a plaintiff warrant there are no outstanding liens and promise to indemnify the insurer in the event such a lien exists and is pursued. As a result, there is considerable pressure on the plaintiff to ensure that the lien is satisfied by the time of the settlement.

Under the circumstances, it may be useful for the plaintiff's attorney to begin discussions with an unpaid physician practice, hospital or nursing home before a settlement is negotiated with the tortfeasor. Through an early approach, a plaintiff's attorney is in a better position to convince the provider to accept less than 100 percent of its lien, if a reduction in the amount of the lien is appropriate under the circumstances of the case. For example, the plaintiff's attorney can point out that if the provider insists on full payment it is possible that no settlement will be achieved, subjecting the provider to the risk that the plaintiff will lose the case and thus never be able to pay anything.

Before agreeing to pay a provider's bill, a plaintiff's attorney should examine it carefully. The client is only obligated to pay reasonable expenses for care attributable to his injury. Further, a hospital that has accepted Medicare payments is precluded from seeking to recover amounts exceeding what it billed the federal government, except for deductibles or coinsurance payments. Rybicki v. Hartley, 792 F.2d 260 (1st Cir. 1986) (Medicare); Holle v. Moline Public Hosp., 598 F. Supp. 1017 (C.D. Ill. 1984). That is because a hospital participating in the Medicare program must enter into a contract in which it promises "not to charge . . . any individual or other person for items or services for which such individual is entitled to have payment made under this subchapter . . ." 42 U.S.C. § 1395cc(a)(1)(A); 42 C.F.R. § 411.54(b). Similar rules also apply to hospitals accepting benefits from Medicaid. See Evanston Hosp. v. Hauck, 1 F.3d 540 (7th Cir. 1993).

A plaintiff, consequently, cannot be forced to pay the usual rates charged by a hospital to private patients if the hospital has decided to accept payment from Medicare or Medicaid. A plaintiff's attorney can save his client substantial sums by ensuring that a hospital receiving Medicare payments does not overreach. For example, in Rybicki, the hospital unsuccessfully tried to assert a lien for \$31,000 in charges even though it had already received a flat fee of \$9,000 from Medicare.

Attorneys should be aware that a hospital may decide to bill a patient for its usual charges rather than seek Medicare reimbursement even though the patient is eligible for a government benefits under the Medicare program. Such a situation might arise if the hospital is aware that the patient has entered or is about to enter into a settlement with a tortfeasor before a bill is sent

to the government. Under such circumstances, the hospital probably can recover its full charges from the patient rather than the amount it would have received had it billed Medicare. Oregon Assoc. of Hosp. v. Bowan, 708 F. Supp. 1135 (D. Ore. 1989). Having accepted Medicare reimbursement, however, a hospital cannot refund Medicare and then sue the injured person. See Evanston Hosp., 1 F.3d at 540.

Finally, a hospital lien does not apply to settlements that occurred prior to the plaintiff's hospitalization. Thus, for example, the existence of a hospital lien does not give the hospital a lien right for any future treatment rendered to the plaintiff, even if the treatment is a direct result of the actions of the tortfeasor giving rise to the original injuries.

B. Health and Disability Insurers

Health and disability policies (as well as other types of policies such as those providing med pay) frequently contain clauses giving the insurer certain rights in the event of a tort recovery by the insured. The law in Georgia is clear that traditional subrogation clauses -- i.e., those allowing the insurer to step into the shoes of the insured and pursue a claim for reimbursement directly from the tortfeasor -- are unenforceable. Government Employees Ins. Co. v. Hirsh, 211 Ga. App. 374, 439 S.E.2d (1993); Government Employees Ins. Co. v. Hardman, 212 Ga. App. 367, 444 S.E.2d 165 (1994); Southern General Ins. Co. v. Ezekiel, 213 Ga. App. 665, 445 S.E.2d 807 (1994). On the other hand, clauses permitting the insurer to be reimbursed from the insured's own recovery are valid if the insured has been **fully compensated**. See O.C.G.A. § 33-24-56.1; but see State Farm Mut. Auto. Ins. Co. v. Walker, 234 Ga. App. 101, 103, 505 S.E.2d 101 (1998) (complete compensation rule inapplicable to exclusion

provision in insurance contract). Absent a specific clause permitting reimbursement, it appears the insurer has no reimbursement right. See Department of Medical Assistance v. Hallman, 203 Ga. App. 615, 417 S.E.2d 218 (1992); Schultz v. Gotlund, 138 Ill.2d 171, 149 Ill. Dec. 282, 561 N.E.2d 652 (1990) (group health insurers do not have a common law right of subrogation); see generally Annot., “Right of ‘Blue Cross’ or ‘Blue Shield’ or Similar Hospital or Medical Service Organization, to be Subrogated to Certificate Holder’s Claims Against Tortfeasor”, 73 A.L.R.3d 1140 (1976).

The Georgia legislature has established a clear statutory scheme governing when various benefit providers are entitled to seek reimbursement of medical expenses or disability benefits in personal injury cases. See O.C.G.A. § 33-24-56.1. Under this statute, a benefit provider is entitled to “require reimbursement from the injured party of benefits it has paid on account of the injury” if two conditions are met: (1) the injured person receives complete compensation; and (2) the reimbursement claim is reduced by the pro rata amount of the attorneys’ fees and litigation expenses. O.C.G.A. § 33-24-56.1(b). The complete compensation language is particularly strong. It permits reimbursement only when “the amount of the recovery exceeds the sum of all economic and non-economic losses incurred as a result of the injury, exclusive of losses for which reimbursement may be sought under this Code Section.” O.C.G.A. § 33-24-56.1(1). A benefit provider is entitled to bring a declaratory judgment action to challenge a plaintiffs’ contention that the settlement does not provide complete compensation. In such a declaratory judgment action, “if the court determines said settlement does not fully and completely compensate the injured party, the benefit provider has no right of reimbursement.” O.C.G.A. §

33-24-56.1(c); see also Davis v. Kaiser Foundation Health Plan, 271 Ga. 508, 521 S.E.2d 815 (1999) (holding complete compensation doctrine applicable reimbursement claims made prior to enactment of statute).

The statute also contains procedural requirements the benefit provider must meet in order to preserve its claim for reimbursement. Ten days prior to the consummation of a settlement or commencement of a trial, the plaintiff must provide notice of the claim to any benefit provider the plaintiff has reason to believe has paid benefits relating to the injury at issue. O.C.G.A. § 33-24-56.1(a). If a plaintiff provides such notice to the benefit provider, the benefit provider loses its right to claim reimbursement if it does not provide actual notice to the injured person before the consummation of the settlement or commencement of the trial that it seeks reimbursement and provides a specific itemization of payments for which it seeks reimbursement. O.C.G.A. § 33-24-26.1(h). If a plaintiff fails to provide notice to a benefit provider of the existence of the claim, then a claim for reimbursement is enforceable provided it meets the requirements of complete compensation and reduction by a pro rata share of attorneys' fees and expenses. O.C.G.A. § 33-24-56.1(i).

The statute also provides some very favorable language that plaintiffs and defendants can use to help defeat a benefit provider's claim for reimbursement. The statute permits the benefit provider to recover "benefits it has paid on account of the injury, *up to the amount allocated to those categories of damages in the settlement documents or judgment.*" O.C.G.A. § 33-24-56.1(b) (emphasis added). As such, it would seem that a settlement document allocating

settlement payments to certain categories of damages would be binding on the benefit provider in its attempt to seek reimbursement.

C. Group Benefit Plans

1. Does ERISA pre-emption apply?

Health benefit plans provided by employers and unions frequently contain a right of subrogation allowing the plan to recover medical benefits given to an employee if the employee has received a personal injury recovery from a tortfeasor. Plans also frequently provide that if the employee's injuries were caused by a tortfeasor no medical benefits will be paid at all unless and until the employee agrees in writing to reimburse the plan from any recovery. Numerous other types of restrictions may be encountered in a plan. For example, some plans prohibit payment of medical expenses caused by injuries sustained in a motor vehicle accident. The list of possibilities is almost endless.

Oftentimes, these subrogation provisions and other restrictive clauses are inconsistent with state law, particularly with the common law doctrine that there can be no subrogation unless and until the injured person has been made whole. Plans argue that they are not subject to such inconsistent state laws and that as a result their subrogation claims should be enforced. These arguments are based on the Employee Retirement Income Security Act, 29 U.S.C. § 1001, et seq. ("ERISA"). ERISA is a comprehensive federal statute governing all "employee benefit plans", including plans sponsored by employers and unions that provide medical benefits to employees. 29 U.S.C. § 1002(1) and (3). With certain exceptions, ERISA preempts all state laws "relating to" employee benefit plans. 29 U.S.C. § 1144(a).

Initially, employees had some success countering these arguments by contending that ERISA's preemption provisions did not apply to subrogation claims. The federal appellate courts split on the issue. However, in 1990, the Supreme Court finally resolved the issue adversely to the employees' position in FMC Corp. v. Holliday, 498 U.S. 52 (1990). In that case, the Court interpreted ERISA's preemption provisions and held that group plans funded entirely by the employer are exempt from state laws restricting subrogation. Plans that are funded by insurance, however, remain subject to state laws. Thus, if a plan is funded through insurance purchased by the employer or union, it will be treated as any other group health insurer for purposes of determining whether a subrogation claim is enforceable. If the plan is self-insured, state laws generally are inapplicable.

Subsequent cases generally have followed the distinction established in the Supreme Court's decision. See, e.g., Blue Cross and Blue Shield of Alabama v. Lewis, 754 F. Supp. 849 (N.D. Ala. 1991) (holding that a group plan underwritten by Blue Cross was subject to state law allowing subrogation only if the injured person had been made whole); Provident Life and Accident Ins. Co. v. Linthicum, 930 F.2d 14 (8th Cir. 1991) (self-funded plan not subject to state restrictions on subrogation); Blue Cross and Blue Shield of Alabama v. Fondren, 966 F. Supp. 1093, 1097 (M.D. Ala. 1997) (same); Buchman v. Wayne Trace Local School District Bd. of Educ., 763 F. Supp 1405 (N.D. Ohio 1991) (provision requiring employee to execute a lien and reimbursement agreement as a condition to receiving benefits was enforceable under ERISA); Electro-Mechanical Corp. v. Ogan, 9 F.3d 445 (6th Cir. 1993).

In light of these precedents, a plaintiff's attorney faced with a subrogation or reimbursement claim by a group benefit plan must first determine whether the plan is self-funded and thus governed by ERISA or funded by insurance and thus governed by state law. The distinction is not always readily apparent. Several courts, for example, have held that a plan funded by the employer but having "stop loss" insurance to pay claims in excess of a specified amount is still considered to be self-funded for purposes of preemption under ERISA. See Thompson v. Talquin Building Products Co., 928 F.2d 649 (4th Cir. 1991). Whether a particular plan or arrangement is subject to ERISA can oftentimes be a difficult issue. Any detailed treatment is outside the scope of this paper.

2. Does the “made whole” doctrine apply?

Even if it is clear that ERISA governs, the attorney's job is not done. To say that a self-funded plan is exempt from state law does not necessarily mean that its subrogation provisions are enforceable. ERISA itself does not have any provisions dealing with the issue of subrogation. As a result, federal courts must develop a federal common law dealing with subrogation claims. See Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 110 (1989).

The Eleventh Circuit has held that an injured person must be made whole before a subrogation claim can be made unless the plan specifically rejects application of the made-whole doctrine. Cagle v. Bruner, 112 F.3d 1510, 1522, (11th Cir. 1997). In Cagle, the plan's language purported to reserve subrogation rights, but the court held that the language in the plan did not “demonstrate a specific rejection of the made-whole doctrine.” Id. The insufficient language gave the fund “the right to seek repayment from the other party of his insurance company, or in

the event you or your dependent recovers the amount of medical expense paid by the fund by suit, settlement or otherwise from any third person or his insurer, . . . the right to be reimbursed therefore through subrogation.” The Eleventh Circuit held that “an ERISA plan overrides the made whole doctrine only if it includes language specifically allowing the plan the right of first reimbursement out of any recovery the participant was able to obtain even if the participant were not made whole.” *Id.* at 1522. As such, it is essential to evaluate the plan language carefully.

The Cagle court reached this decision by concluding that federal common law contains the made-whole doctrine. In the absence of a specific rejection of the made-whole doctrine in the plan, the made-whole doctrine serves as a default provision. Two other circuits have agreed with the Cagle decision. See Copeland Oaks v. Haupt, 209 F.3d 811, 813 (6th Cir. 2000); Barnes v. Independent Auto Dealers of California Health and Welfare Benefit Plan, 64 F.3d 1389, 1395 (9th Cir. 1995). The majority of federal circuits, however, reject the made-whole doctrine’s application in an ERISA plan. Harris v. Pilgrim Healthcare, 208 F.3d 274, 279 (1st Cir. 2000); Waller v. Hormel Foods Corp., 120 F.3d 138, 140 (8th Cir. 1997); Sunbeam-Oster Co. v. Whitehurst, 102 F.3d 1368, 1374-76 (5th Cir. 1996); Cutting v. Jerome Foods, Inc., 993 F.2d 1293, 1299 (7th Cir. 1993); Alves v. Silverado Foods, 6 Fed. App. 694 (10th Cir. 2001) (unpublished); In re Paris, 211 F.3d 1265 (4th Cir. 2000) (table); see also Yerby v. United Healthcare Ins. Co., 846 So.2d 179; 189 (Miss. 2002).

3. Knudson and its limitations on ERISA's efforts to seek reimbursement

In January of 2002, the United States Supreme Court issued its decision in Great-West Life & Annuity Insurance Co v. Knudson, 534 U.S. 204, 122 S.Ct. 708 (2002). This decision limits an ERISA plan's ability to seek reimbursement from tort plaintiffs, but has also created numerous confusing and sometimes contradictory decisions as lower courts attempt to interpret it. The basic holding in Knudson is that an ERISA plan fiduciary is limited to bringing civil actions for equitable relief only and cannot bring an action for legal relief. In Knudson, this limitation meant that an ERISA plan could not seek reimbursement from that particular tort plaintiff. Knudson, however, by no means prohibits an ERISA plan from enforcing reimbursement provisions. It only prohibits a plan from seeking an equitable remedy. The key issue post-Knudson, therefore, is whether the remedy the plan seeks is equitable or legal. Equitable remedies are prohibited, and legal remedies are allowed.

Janette Knudson was injured in a car wreck and her ERISA plan paid over \$400,000 of her medical expenses. The plan also contained a reimbursement provision requiring her to reimburse the plan if she achieved a recovery from a third party. Ms. Knudson filed an action against the automobile manufacturer and subsequently settled the case for \$650,000. The bulk of the plaintiffs' share of this settlement was placed in a special needs trust, and only \$13,828.70 was allocated in the settlement to reimburse the ERISA plan's medical expenses. The ERISA plan filed a separate action seeking to enforce the reimbursement provision and to require the

Knudsons to pay the plan over \$400,000 from any proceeds recovered from third parties. The Supreme Court accepted certiorari to determine whether this action was permitted under ERISA.

The Supreme Court concluded that this action was not permitted because the plan was limited to equitable relief only. The disputed funds were held in a special needs trust and were not in the plaintiff's possession, so the plan's claim was to impose personal liability on the tort plaintiff. "Here, [the plan] seeks, in essence, to impose personal liability on [the tort plaintiffs] for a contractual obligation to pay money – relief that was not typically available in equity." Id. at 713. The Court engaged in a detailed analysis of legal versus equitable remedies and concluded that the remedies sought by the plan were legal, not equitable. Importantly, the Supreme Court did not foreclose an ERISA plan's ability to obtain reimbursement:

We note, though it is not necessary to our decision that there may have been other means for petitioners to obtain the essentially legal relief that they seek. We express no opinion as to whether petitioners could have intervened in the State Court tort action brought by respondents or whether a direct action by petitioners against respondents asserting state law claims such as breach of contract would have been pre-empted by ERISA. Nor do we decide whether petitioners could have obtained equitable relief against respondents' attorney and the trustee of the Special Needs Trust

Id. at 719.

Knudson requires a detailed analysis of the arcane distinction between equitable and legal remedies, a discussion that exceeds the scope of this paper. Not surprisingly, lower courts attempting to interpret Knudson have taken a variety of approaches. Most courts have held that the dispositive factor is whether the insured is in possession of funds when the plan files the action. See, e.g., Bombardier Aerospace Employee Welfare Benefits Plan v. Ferrer, Poirot and

Wansbrough, 354 F.3d 348, 356 (5th Cir. 2003) (allowing action because funds were in attorney's trust account); Bauhaus USA, Inc. v. Copeland, 292 F.3d 439, 445 (5th Cir. 2002) (prohibiting action because funds not in plaintiff's possession); IBEW- NECA Southwestern Health & Benefit Fund v. Douthitt, 211 F. Supp.2d 812, 816 (N.D. Tex. 2002) (permitting action because funds held in plaintiff's attorney's trust account); Forsling v. J.J. Keller & Assoc., Inc., 241 F. Supp.2d 915, 917 (E.D.Wis. 2003) (permitting action for constructive trust because tort defendant's insurer retained possession of funds); Great-West Life & Annuity Ins. Co. v. Brown, 192 F. Supp.2d 1376, 1381 (N.D.Ga. 2002) (permitting action because funds in plaintiff's attorney's trust account).

Some courts even hold that the timing of the action can be dispositive. See Primax Recoveries, Inc. v. Goss, 240 F. Supp.2d 800, 803 (N.D. Ill. 2002) (prohibiting ERISA plan from seeking to impose a trust on potential proceeds); Primax Recoveries, Inc. v. Carey, 247 F. Supp. 2d 337 (S.D.N.Y. 2002) (barring plan's request for an equitable lien against future settlement); Primax Recoveries, Inc. v. Duffy, 204 F. Supp. 2d 1111, 1113 (N.D. Ill. 2002) (prohibiting plan fiduciary from recovering against funds already received but not prohibiting a lien on specific funds yet to be received). Other courts have held that the dispositive factor is whether the plaintiff controls the money. See, e.g., Wellmark, Inc. v. Deguara, 257 F. Supp. 2d 1209, 1216 (S.D. Iowa 2003) (permitting declaratory judgment action on reimbursement claim because the funds were in the insured's attorney's trust account); Administrative Committee of the Wal-Mart Stores, Inc. Associates' Health & Welfare Plan v. Varco, 338 F.3d 680, 687 (7th Cir. 2003) (permitting action because the tort plaintiff had established a separate account to hold the money

that was the subject of the plan's claim); but see Sealy, Inc. v. Nationwide Mutual Ins. Co., 286 F. Supp.2d 625 (M.D.N.C. Sept. 29, 2003) (action permitted when funds were deposited in the registry of the court). At least two circuits have held that Knudson severely restricts any effort by a plan to enforce the terms of a subrogation clause. Community Health Plan of Ohio v. Mosser, 347 F.3d 619, 624 (6th Cir. 2003); Westaff v. Arce, 298 F.3d 1164, 1167 (9th Cir. 2002).

As evidence of the uncertainty that the Knudson decision has created, Sealy and Bauhaus are directly contradictory. Sealy permitted an action by an ERISA plan when the funds were deposited into the court because the funds were clearly traceable to the tortfeasor's insurance policy. Sealy, 286 F. Supp. 2d at 625. Bauhaus, on the other hand, refused to permit an action when the funds had been deposited into the court's registry specifically because the funds were not in the tort plaintiff's possession. Bauhaus, 292 F.3d at 445. It may take years, and perhaps another Supreme Court decision, to clarify this area of the law.

4. Other considerations

Regardless of what law applies to a plan governed by ERISA, an attorney representing an injured person must look closely at the terms of the plan itself. Obtaining a copy of the plan document -- to which every participant has a right of access under ERISA -- is essential. This is true even if the employee has signed a separate subrogation agreement at the plan's request as a pre-condition to receiving medical benefits. Such an agreement may be unenforceable, particularly where it exceeds the scope of the plan itself. See Kennedy v. Georgia-Pacific Corp., 31 F.3d 606, 610 (8th Cir. 1994).

The language of the plan document must be studied carefully once a copy of the plan is obtained. Notwithstanding that the plan administrator claims a right of subrogation, the plan document may provide otherwise or may restrict the scope of any subrogation right. See Western and Southern Life Ins. Co. v. Wall, 903 F. Supp. 1155 (E.D. Mich. 1995) (plan language did not permit employer to be reimbursed for medical expenses from a settlement that as a matter of state law did not include a recovery for medical expenses); U.S. Healthcare, Inc. v. O'Brien, 868 F. Supp. 607 (S.D.N.Y. 1994) (language of plan precluded subrogation from settlement for personal injury only); Kennedy, 31 F.3d at 606 (plan did not permit reimbursement from uninsured motorist coverage).

A plan, however, can be written to give broad subrogation rights and those rights may well be enforced by a federal court. Numerous courts for example have required injured persons to reimburse ERISA plans for medical benefits out of the proceeds of settlements in which the person did not recover medical expenses from the tortfeasor. E.g. Singleton v. Board of Trustees of IBEW Local 613, 830 F. Supp. 630 (N.D. Ga. 1993); McIntosh v. Pacific Holding Co., 992 F.2d 882 (8th Cir. 1993); Novak v. TRW, Inc., 822 F. Supp. 963 (E.D.N.Y. 1993) (disapproving of personal injury settlements that purport to be for pain and suffering only).

In addition to the plan itself, an attorney should also obtain and study the “summary plan description,” a document that ERISA requires be given to participants to notify them of their rights. Under prevailing federal law, any inconsistency between the plan document itself and the brochure that is relied upon by the employee is construed in the employee's favor. As a result, in Thompson v. Federal Express Corp., the court refused to allow subrogation of disability benefits

as provided in the plan because the brochure had led the employee to believe that subrogation was limited to medical benefits. And in Alco Standard Corp. v. Gilbert, 1992 WL 91939 (N.D. Ill. 1992), the court held that where the plan's right of subrogation was not disclosed in the summary plan description, the right could not be enforced. See also Germany v. Operating Engineers Trust Fund, 789 F. Supp. 1165 (D.D.C. 1992) (holding that terms of summary plan description controlled over separate subrogation agreement).

Even if the plan has a valid subrogation right, an employee may still have a defense. At least one case has held that a plan may waive its right of subrogation by not acting quickly enough to enforce the right. Health Cost Controls v. Wardlow, 825 F. Supp. 152, 156 (W.D. Ky. 1993).

It should also be emphasized that ERISA cannot be used to expand a plan's subrogation rights beyond those allowable by law. For example, in Liberty Corp. v. NCNB National Bank of South Carolina, 786 F. Supp. 552 (D.S.C. 1992), aff'd, 984 F.2d 1383 (4th Cir. 1993), the court held that a subrogation clause in an ERISA plan did not give the employer a right to be reimbursed for a decedent's medical expenses from a settlement in a wrongful death action brought by the administrator of the decedent's estate. According to the court, the subrogation clause could only be used to obtain reimbursement from claims belonging to the decedent. Since a wrongful death action does not belong to the decedent, the employer had no right of reimbursement. See also Kelleher v. Hood, 238 Ill. App.3d 842, 179 Ill. Dec. 4, 605 N.E.2d 1018 (1992) (ERISA plan's subrogation provision for medical expenses paid during minor's last illness could not reach personal injury settlement by minor's estate).

Lastly, any attorney handling third-party claims involving ERISA plans should be aware of the decision in Chapman v. Klemick, 750 F. Supp. 520 (S.D. Fla. 1990). In that case, the defendant was an attorney who represented a person injured in an auto wreck. The attorney's client received medical benefits of \$28,000 from an ERISA plan and signed a subrogation agreement calling for the plan to be reimbursed out of any amount recovered from the tortfeasor. The client's personal injury case arising out of the wreck was then settled for \$25,000. Over the objection of the ERISA plan, which claimed the entire settlement for itself, the attorney distributed the settlement proceeds to the client and himself. The ERISA plan immediately sued the attorney.

The district court found in favor of the plan, holding that the settlement monies were assets of the plan, that the attorney was a plan fiduciary within the meaning of ERISA and that he should not have distributed plan assets to his client. While Florida law imposed no obligation on an attorney to pay an insurer holding a subrogation claim from settlement funds in his possession, this law was preempted by ERISA, according to the court.

Obviously, if Chapman were widely followed, attorneys representing injured persons would be placed in an untenable conflict of interest between the ERISA plan and their clients. Fortunately, the district court's opinion was reversed on appeal and its analysis rejected. Chapman v. Klemick, 3 F.3d 1508 (1993), *cert. denied*, 114 S.Ct. 1191 (1994); *see also* Hotel Employees Union Welfare Fund v. Gentner, 815 F. Supp 1354 (D.Nev. 1993), *aff'd*, 50 F.3d 719 (9th Cir. 1995) (rejecting the district court's analysis). Nevertheless, Chapman suggests that

attorneys must be careful about dealing with ERISA plans. If a dispute cannot be resolved, interpleading the funds into court may be an attractive option.

D. Medicare

1. Medicare's Reimbursement Rules

Under the Medicare program, the federal government provides health care benefits to those over age 65 and certain disabled people who have contributed to the Social Security system for the required period of time. Benefits are not based on economic need. Eligible clients who are injured by a tortfeasor may have some or all of their medical expenses paid by Medicare. If so, Medicare has a right of subrogation covering any benefits paid by a client's own insurance and the proceeds of any settlement received in a personal injury lawsuit.

Medicare originally had no right to recover benefits paid to people injured by others. In 1980, however, Congress changed the law, mandating that Medicare benefits would be secondary to other insurance under certain circumstances. As a result, Medicare benefits now generally are not available to a person injured in an automobile wreck who has insurance providing medical coverage or who may be compensated in a tort action. 42 U.S.C. § 1395y(b)(2). Obviously, if Medicare never paid benefits it would have no need for a subrogation right. However, Medicare may conditionally pay the medical bills of an injured person in some cases, such as where there would otherwise be a substantial delay. 42 U.S.C. § 1395y(b)(2).

Pursuant to regulations adopted by the Health Care Financing Authority, a person who receives a conditional payment must reimburse Medicare within 60 days after the settlement of a personal injury claim. 42 C.F.R. § 411.25(h). The person also has 60 days to reimburse

Medicare after receiving payment from a no-fault or med-pay insurance. Id. There is no formal requirement that Medicare provide notice of its interest or notify the beneficiary of his obligation to repay conditional payments. See 42 C.F.R. § 411.21.

Medicare's subrogation right is not limited to recovering from the injured person. If the injured person does not reimburse Medicare after the settlement, then the tortfeasor's insurer must do so even though the insurer has already reimbursed the plaintiff. 42 C.F.R. § 411.25(I). Similarly, Medicare may pursue a no-fault or med-pay insurance carrier if the injured party does not make reimbursement. Id. Finally, attorneys should beware. Medicare has an express right to reimbursement from an attorney who has received a payment from the tortfeasor. 42 C.F.R. § 411.24(g) and § 411.26(a). Medicare takes the position that the six year statute of limitations in 28 U.S.C. § 2814(a) applies to claims for reimbursement.

Medicare does not insist upon receiving payment in full of all sums that it expended on the plaintiff's behalf. Rather, Medicare will subtract its proportionate share of the costs and attorney's fees incurred in obtaining the judgment. 42 C.F.R. § 411.37. The regulations set out the following method for computing the amount of reimbursement as follows:

- (1) Determine the ratio of the procurement costs to the total judgment or settlement payment.
- (2) Apply the ratio to the Medicare payment. The product is the Medicare share of procurement costs.
- (3) Subtract the Medicare share of procurement costs from the Medicare payments. The remainder is the Medicare recovery amount.

42 C.F.R. § 411.37(c). If the amount due Medicare equals or exceeds the recovery, Medicare demands the entire amount, less attorney's fees and costs. 42 C.F.R. § 411.37(d).

A plaintiff's attorney may ask Medicare to waive its subrogation right or to accept less than what it would otherwise be entitled to receive under its regulations. Medicare has the statutory authority to do so if it "determines that the waiver is in the best interests of the program." 42 U.S.C. § 1395y(b)(2) (B)(iv). By regulations, the Health Care Financing Authority (HCFA) states that it will waive recovery "if the probability of recovery, or the amount involved, does not warrant pursuit of the claim." 42 C.F.R. § 411.28. Further, the agency says that it will compromise a claim if the client does not have the ability to pay the full amount within a reasonable time, the client refuses to pay and the government is unable to collect within a reasonable time, there is "real doubt" that the government can prove its case in court, or the costs of collecting the claim are not justified. 42 C.F.R. § 405.374(d).

In 1996, Congress passed the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The Act was primarily known for increasing the portability of health insurance when Americans change employers, but it also enacted measures to ensure the solvency of the Medicare Program. One of these measures instructed HCFA to hire a Coordinator of Benefits (COB) Contractor to manage all of HCFA's claims, including Medicare reimbursement claims. The HCFA website is informative and provides good information about Medicare reimbursement claims.

Although your initial contact should be with the COB Contractor, the COB Contractor will then appoint another entity, called a "fiscal intermediary," to provide the actual handling of

your client's case. As such, administration of the Medicare program has largely been delegated to private organizations called "fiscal intermediaries" and "carriers", which determine the amounts of compensation due, make the actual payments, and enforce any rights of subrogation. 42 U.S.C. §§ 1395h, 1395u. The COB Contractor should establish this fiscal intermediary in your individual case.

After your initial contact with the COB Coordinator, communications regarding Medicare claims should be directed to the intermediary. The intermediary will then represent Medicare throughout your client's claim. The intermediary will initially send you a statement of Medicare's charges to which it claims reimbursement. In order for it to gather this information, it is imperative that the COB Contractor have received information about the type of injuries your client has suffered. When the intermediary sends you this claim, it will also send you various forms for you to use to request a waiver. There are two ways you can seek a reduction of Medicare's claim. First, you can request either a pre-settlement compromise or a post-settlement compromise. This avenue is usually the most productive. Although you are required to submit your request for a pre-settlement or post-settlement compromise to the intermediary, the intermediary will forward your request to the Center for Medicare and Medicaid Services (CMS) in Atlanta. CMS will issue a decision on your request for compromise within 60 days and often sooner. A request for compromise is the only avenue to negotiate with Medicare prior to entering into a settlement with the tortfeasor. There is no appeal from a denial of a compromise, but submitting a compromise request does not prevent you from also requesting a waiver, which is the second method of seeking a reduction.

A waiver is only available after your client has settled with the tortfeasor. A request for a waiver is submitted to the intermediary, and the intermediary makes a decision regarding the waiver within 120 days. You can appeal a negative decision, and this appeal will be conducted by the reconsideration department in the intermediary's office. If this appeal is denied, you can then request that the reconsideration department send your claim to an administrative law judge. The administrative law judge will typically hold a hearing within 30 days, but may not issue a decision for as long as two years.

Perhaps the reason requests for compromises tend to be more successful than requests for waivers is that CMS can compromise a claim if it believes it to be in the best interest of Medicare. On the other hand, the intermediary is limited to considering your client's circumstances, namely whether Medicare's claim would impose a financial hardship or would be contrary to equity and fairness. According to BCBS, it tends to be more restrictive than CMS in reducing the amount of Medicare's claim. As such, it would seem to be advantageous to request a pre-settlement compromise.

Medicare is not governed by the "made whole" doctrine and has the right to demand that your client fork over the entire settlement (less attorneys fees and expenses) if Medicare's claim equals or exceeds the settlement. As noted above, however, the regulations specifically permit a partial or full reduction. The primary reasons Medicare permits the reduction are if the waiver is in Medicare's best interest, 42 U.S.C. § 1395y(b)(2)(B)(iv), or if your client's circumstances warrant a waiver, 42 U.S.C. § 1395gg(c).

Congress permits Medicare to waive its subrogation claims to the extent it “determined that the waiver is in the best interest of the program,” and the agency itself acknowledges in regulations that it will waive recovery “if the probability of recovery or the amount involved does not warrant pursuit of the claim.” 42 C.F.R. § 411.28. These rules offer two potential avenues for negotiation. First, if there has been not settlement with the tortfeasor, you can request a pre-settlement compromise and take the position that your client will not accept a settlement with the tortfeasor if Medicare insists on collecting its full demand. This negotiating approach may prove particularly effective in cases where your client has suffered severe injuries, but due to liability questions the defendant is not offering a settlement that adequately compensates your client. Second, if Medicare’s subrogation interest is fairly small, and your client takes an aggressive approach, CMS may conclude that “the amount involved does not warrant pursuit of the claim.” 42 C.F.R. § 411.28.

The other primary avenue for waiver depends upon your client’s circumstances. If payment of the entire amount would cause either financial hardship or be “against equity and good conscience,” Medicare can waive some or all of its claim. See 42 U.S.C. § 1395gg(c). For a request based on financial hardship, the intermediary requires detailed financial information about your client and his family. A request based on the “equity and good conscience” basis would seem to be a prime opportunity to argue that your client has not been made whole by the settlement. According to BCBS, this argument is at times successful, but requires careful documentation of the basis for your claim that your client was not fully compensated.

2. The 2003 Amendments: Removing any Doubt About Medicare's Lien

The Fifth Circuit's initial decision in Thompson v. Goetzmann, 315 F.3d 457 (5th Cir. 2002) withdrawn and superseded by Thompson v. Goetzman, 337 F.3d 489 (5th Cir. 2003) sent shock waves through the legal community because it seemed to signal the end to Medicare's right to reimbursement. The Medicare statutes cited above state that Medicare is entitled to reimbursement if the primary payor could be "reasonably expected" to pay for the medical expenses "promptly." HCFA regulations defined "promptly" as a payment that occurs within 120 days of the date the claim is filed or the date the treatment occurs. Thompson held that "[g]iven the time delay inherent in strongly prosecuted and defended tort litigation, the Government cannot legitimately assert that a settlement arrived at in the heat of a hard fought adversarial engagement for alleged tort liability . . . is the type of insurance plan that the Government can reasonably expect to make prompt payment for medical care." Thompson, 315 F.3d at 467-68. This holding seemed to suggest that recoveries from tort lawsuits were not subject to Medicare's right to reimbursement. In a separate holding, Thompson held that the tort defendant, a product manufacturer, was not "self-insured" within the meaning of the statute. Negotiating a single settlement did not constitute a self-insured plan, which it defined as an entity that "creates or maintains a fund or source and establishes rules for making disbursements therefrom in covering the self-insurer's future risk" Id. at 464.

This decision dealt a severe blow to Medicare's reimbursement right, but the blow was short-lived. The Fifth Circuit panel withdrew its decision and issued a superseding opinion. The new opinion withdrew the holding that a tort settlement is not subject to reimbursement because

payment cannot reasonably be expected to occur “promptly.” Thompson, 337 F.3d at 492. (It affirmed the original result due to the holding that the manufacturer was not a self-insurance plan.) The Eleventh Circuit recently addressed the “prompt pay” issue and reached a different conclusion. U.S. v. Baxter International, 345 F.3d 866 (11th Cir. 2003); see also Brown v. Thompson, 374 F.3d 253, 260 (4th Cir. 2004) (holding “the fact that Medicare lacked an expectation of prompt payment from a primary plan, does not free [the plaintiff] from her obligation to reimburse Medicare once a primary plan has paid [the plaintiff]”).

In the recently-passed legislation adding a prescription drug benefit to Medicare, Congress has eliminated the issues raised in Thompson. The legislation contained amendments designed to address the prompt pay argument as well as the self-insured argument. The new amendments make clear that Medicare is entitled to recover from a tort settlement and eliminates the “prompt pay” requirement. 42 U.S.C. § 1395y(b)(2).

E. Medicaid

Medicaid is a joint federal/state program to provide medical benefits to the poor. Essentially, the federal government provides grants to establish "medical assistance plans," which are partially funded and administered by the states. See generally 42 U.S.C. § 1396 et seq. Georgia participates in the program through the Georgia Department of Medical Assistance. O.C.G.A. § 49-4-140, et seq.

The federal government requires that each state take reasonable measures to ascertain whether a third party may be liable for medical expenses paid by Medicaid to an injured person and to recover such expenses if liability is determined to exist. 42 U.S.C. § 1396a (25). The

Health Care Financing Authority has adopted lengthy regulations relating to such third party liability. 42 C.F.R. Subpart D, §§ 433.135, et. seq.

In accordance with the federal mandate, Georgia has enacted legislation governing efforts by the Department to recover medical benefits paid to injured persons for which tortfeasors are liable. O.C.G.A. §§ 49-4-148; 49-4-149. Pursuant to O.C.G.A. § 49-4-148, the Department is subrogated to the rights of the injured person, may recover directly from the tortfeasor, and for this purpose is entitled to use the liens available to private hospitals. Pursuant to O.C.G.A. § 49-4-149, the Department also has a lien "upon any moneys or other property accruing to the recipient . . . due to the liability of a third party" and may perfect and enforce this lien by following the procedures O.C.G.A. § 49-4-149(a). The Department has one year from the date of the last item of medical care to file a verified lien statement in the county where the recipient resides and in Fulton County. O.C.G.A. § 49-4-149(b).

The Georgia Court of Appeals has also addressed these provisions in Department of Medical Assistance v. Hallman, 203 Ga. App. 615, 417 S.E.2d 218 (1992). In that case, the Department filed a lien for over \$100,000 in medical care rendered to a quadriplegic injured in an auto wreck. The quadriplegic's lawsuit against the tortfeasor was subsequently settled and checks in the amount of the lien were issued by the insurer made payable to the quadriplegic, his lawyers and the Department. Over one year after the settlement was concluded, the injured person's lawyer filed a declaratory judgment action contending that the Department had waived its lien rights by failing to initiate legal action on the lien as required by O.C.G.A. § 44-14-473(a), which states that an action to enforce the lien "shall be

commenced against the person liable for the damages within one year after the date the liability is finally determined by a settlement."

The Department counterclaimed, asserting a right to be paid by the injured person who had received Medicaid benefits. Summary judgment was granted against the Department. The Court of Appeals affirmed. According to the court, the Department had no right to be reimbursed from the injured person, holding that the common law doctrine of money had and received was inapplicable. Further, the statute of limitations on enforcement of its lien right against the tortfeasor had expired and the Department had not pursued the tortfeasor directly under O.C.G.A. § 49-4-148, which gives the Department an independent right of subrogation. (Whether the subrogation right created by O.C.G.A. § 49-4-148 creates a right of reimbursement against the injured person arguably is left open in Hallman).

Following the decision in Hallman, the General Assembly amended O.C.G.A. § 9-2-21 to provide that an attorney representing an injured person who has received Medicaid benefits shall before filing against the tortfeasor notify the Department of Medical Assistance of the claim. The notice provision also applies before the attorney communicates with the tortfeasor about the claim. Notice to the Department, however, is not a condition precedent to the filing of a suit.

The Department has a great deal of discretion in connection with the recovery of medical expenses incurred on behalf of injured people. According to O.C.G.A. § 49-4-148, the Department "may compromise, settle, and execute a release of any such claim or waive, expressly, any such claim, in whole or in part, for [its] convenience." The Department's regulations do not specify the circumstances under which this power will be exercised.

A recent case, Richards v. Georgia Department of Community Health, addressed many of the open issues in Georgia law regarding Medicaid reimbursement. No. S04A0866, 2004 WL 2495011 (Ga. Nov. 8, 2004). In Richards, Medicaid recipients brought a class action lawsuit against Georgia Department of Community Health (GDCH), challenging O.C.G.A. § 49-4-149, the statute that provides the mechanism for the State to recoup money spent on Medicaid benefits for injuries due to third-party tortfeasors. Id. at *2. Plaintiffs argued that the lien could only be asserted against the portion of plaintiffs' recovery directly related to medical expenses. Id. The court reasoned that to adopt the plaintiffs' "preferred reading would allow a Medicaid recipient to negotiate a tort settlement structured in such a way so as to reflect no, or minimal, compensation for medical expenses, or to convince a jury to create such structures, and thereby gain a recovery that does not require any significant compensation to the taxpayers who funded his medical care." Id. at *3. Accordingly, the court held that "GDCH's lien is applied to all of the funds in a tort recovery." Id. The court also rejected the plaintiffs' argument that GDCH should pay a portion of plaintiffs' attorneys' fees. Id.

The Georgia Court of Appeals has also held that "the complete compensation rule applies only to the subrogation rights of an insurance carrier who has received payments from the injured party and does not apply to Medicaid liens. Padgett v. Toal, 261 Ga. App. 154, 157, 581 S.E.2d 744, 746-47 (2003).

F. Worker's Compensation

Subrogation under the state's worker's compensation statute has frequently been a subject of legislative attention. As originally enacted in 1920, the worker's compensation law did not

provide an employer with any subrogation rights. In 1922, such a right was provided. Workers' compensation subrogation, however, was abolished in 1972. Then, in 1992, the legislature once again provided employers and their insurers with a right of subrogation. O.C.G.A. § 34-9-11.1; see Maryland Casualty Ins. Co. v. Glomski, 210 Ga. App. 759, 437 S.E.2d 616 (1993)(describing the legislative history.)

The 1992 statute gives the employer and its insurer a "subrogation lien" for amounts paid to the injured employee and afforded a right to intervene in a personal injury action to protect the lien. In addition, the statute, somewhat strangely, provided that if the injured worker did not file suit against a wrongdoer within one year of the wrongful act, the right to sue the wrongdoer would be automatically assigned to the employer or insured. As a result, the statute seemingly had the effect of reducing to one year the statute of limitations applicable to the injured employee's claim. The employer thereafter had the exclusive right to bring suit.

This strange provision created a great deal of controversy and raised many questions on both sides of the bar. See Bennett v. Williams Electrical Construction Co., 215 Ga. App. 423, 450 S.E.2d 873 (1994) (holding that the employer could not reassign the claim to the employee after one year had expired). In the face of the controversy, the General Assembly revised the statute in 1995 to eliminate the automatic assignment from the employee to the employer.

The statute currently provides that beginning one year after the employee's injury the employer has a non-exclusive right to file suit in its own name or the name of the employee. See O.C.G.A. § 34-9-11.1(c). If the employer brings suit, notice must be provided to the employee,

who has an absolute right to intervene. An employee must notify the employer of any lawsuit only if the suit is filed more than one year after the injury. Id.

The employer retains the right to intervene in the employee's lawsuit to protect its subrogation interest. Canal Insurance Co. v. Liberty Mutual Ins. Co., 256 Ga. App. 866 (2002). However, in order to have standing before the court, the employer or its insurer must actually become a party. It is insufficient that the complaint was filed jointly by the attorneys for both the injured worker and his employer. Astin v. Callahan, 222 Ga. App. 226, 474 S.E.2d 81 (1996) (employer which was not actual party could not appeal.).

As provided in the 1992 statute, the employer's right of reimbursement extended only to disability benefits and medical expenses paid to the injured worker. There was no right of reimbursement for death benefits. Bankhead v. Lucas Aerospace, Ltd., 878 F. Supp. 221 (N.D.Ga. 1994); Wausau Ins. Co. v. McLeroy, 266 Ga. 794, 471 S.E.2d 504 (1996). The 1995 amendment, however, the legislature extended the employer's right of recovery to include death benefits. However, there still is no right of subrogation for other benefits paid under the act, such as rehabilitation benefits.

The subrogation right established by O.C.G.A. § 34-9-11.1 is subject to the "complete compensation" rule. The employer has no right of reimbursement unless the employee has been fully compensated for his injuries, including both economic and non-economic damages. "The trial court and not a jury must determine if the employee has been fully and completely compensated by workers' compensation benefits and by a recovery from a third-party tortfeasor." Canal Ins. Co., 256 Ga. App. at 870. Although the parties can agree to submit the

complete compensation issue to a jury, the “legal duty” to make that determination remains with the trial court “even if it uses a jury to advise it in reaching such a determination.” Id. at 871. In making the complete compensation determination, the trial court cannot consider affirmative defenses such as contributory negligence and assumption of the risk. Id. An insurer or employer must prove complete compensation in cases that settle. See Hartford v. Federal Express, 253 Ga. App. 520 (2002)(holding insurer failed to prove complete compensation).

CONCLUSION

An awareness of the law applicable to medical liens, insurance subrogation and other third-party claims is essential for the ethical and competent plaintiff's lawyer, whose job is not necessarily complete when a defendant's check is in hand. The manner in which the lawyer approaches third-party claims can make a significant difference to the client's future.