H.B. 1869: The Impact of the Subrogation Reform Bill Upon Third-Party Liability Claims

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The Texas legislature passed a law this session that will significantly impact the negotiation and settlement of automobile collision cases starting January 1, 2014. The new statute affects the subrogation interests of payors of health care benefits to injured claimants. Although the law does not take effect until next year, it will impact cases that are being asserted right now. This paper is a brief summary of the new law and its impact upon third-party liability carriers.

A. Background & Purpose of the Bill

H.B. 1869 stands to have a significant impact on settling all personal injury claims. The bill directly affects the subrogation rights of a health insurer or other "payor" of benefits to an injured party who asserts a third party liability claim.[1] The purpose of the bill is to insure that the injured party gets some portion of the recovery even if the medical bills exceed the total recovery. The statute sets a cap on the amount a health insurer can recover from the proceeds of a plaintiff's settlement with a third party defendant. However, the new law does not affect all health insurance plans, only certain types. As a personal injury practitioner, it will be essential to know and understand the implications of this new law. H.B. 1869 will be codified as Chapter 140 of the Texas Civil Practices & Remedies Code.

Interestingly, both TTLA and TADC came together in support of the Subrogation Reform Bill. TTLA's support grew from their legitimate interest in making sure that injured parties receive a fair portion of settlement proceeds. TADC's interest in the bill arose from its interest in fair, consistent, efficient resolution of claims.

A press release by the bill's author, Representative Four Price, summarizes the position of the proponents of the bill:

> *Currently, most health insurance companies are entitled to reimbursement for all such medical expenses paid, thereby often leaving an injured person with little or nothing from their recovery. There is little incentive for many cases to settle quickly or at all. House Bill 1869 provides an equitable legal framework for settling cases, which helps an injured person timely meet other expenses while providing certainty to health insurers.*

B. Exceptions to the Statute

Certain types of health insurance plans and payors will fall outside the purview of the new law. The following health insurance plans are NOT subject to H.B. 1869**:** Medicare plans, Medicaid plans, CHIPS, workers compensation plans, and self-funded ERISA plans. The types of health insurance plans that ARE subject to the limitations created by H.B. 1869 include ERS plans for state employees, self-funded plans of political subdivisions such as cities, counties and school districts, insured ERISA plans and any other non-ERISA self-funded plans.

[1] For ease of reference in this paper, the term "health insurer" will generally be used instead of the terms "payor of benefits" and "payor" as stated in the statute.

ERISA self-funded plans are not covered by H.B. 1869. These types of plans are governed by ERISA. ERISA effectively pre-empts state law, except those that expressly regulate insurance. Because self-funded plans are not insurance, they are exempt from state laws regulating insurance. ERISA plans, especially the self-funded plans, maintain that they are exempt from any form of state regulation.

Because there will be many plans that will fall outside the purview of the new statute, it will be important to learn the type of plan which insures the claimant at the time of settlement. Although the claimant may believe that she is fully insured by an insurance company such as Aetna, Blue Cross Blue Shield, United or other health insurer, a quick look at the benefits card may tell a different story. Many group health policies are self-funded by the employer and administered by the insurer. If the plan is fully insured, it falls under the purview of the new statute. If the plan is self-funded but administered by the insurer, the plan is not within the purview of the new statute. Primarily, the statute will apply to fully insured plans and plans for governmental workers.

C. The Statutory Division of the Settlement Proceeds

H.B. 1869 places a limit on the amount a health insurer and other payors can recover against a third party settlement.[2] If the plaintiff is represented by an attorney, the most the payors can take is one-third of the plaintiff's settlement. Essentially, the attorney, the plaintiff and the health insurer split the recovery three ways up to the amount of the lien. The provision works similarly to the worker's compensation scheme.

By the express terms of the statute, the health insurer can recover up to one-half of the plaintiff's recovery. However, the insurer must also pay a reasonable fee to the plaintiff's attorney. The fee is not to exceed one-third of the total recovery. Thus, the insurer pays 1/3 of its half to plaintiff's attorney and the plaintiff pays 1/3 of his half to the attorney resulting in 1/3 for each. Like the worker's compensation statute, the statute allows the health insurer the right to hire its own attorney and pay a proportionate share of the attorneys' fees to its own counsel.

Let's use an example. Plaintiff was injured in a car wreck and incurred $50,000.00 in medical bills. Those bills were paid by his health insurer, ABC, under a fully insured plan. Plaintiff and his lawyer agreed to settle the case for $90,000.00. ABC, Plaintiff and Plaintiff's attorney each recover $30,000.00 out of the settlement proceeds based upon the new statute. If Plaintiff had not been represented by counsel, ABC and Plaintiff would each recover $45,000.00 per the terms of the statute. Plaintiff is better off under the new law in that ABC insurer could have insisted on recovering its full $50,000.00 in medical bills under the old law. In that instance, after attorneys' fees Plaintiff would only have a $10,000.00 net recovery as opposed to the $30,000.00 recovery under the new law.

It is important to note that a single cap applies to all health benefit payors. If there is a disability insurer and a health insurer, the maximum recovery for all payors

[2] Significantly, the statute also restricts subrogation from certain first-party coverage such as UM, PIP and Med Pay. However, a discussion of the statute's impact on first-party insurance is beyond the scope of this paper.

would be the statutory cap. The statute does not address how to allocate the recovery between multiple payors.

D. Practical Guide for C.P.R.C. Chapter 140

Both plaintiffs and defense attorneys need to be familiar with the application of the new statute and how it will impact future settlements. While plaintiffs' attorneys may think that they do not need to worry about the statute until next year, that is absolutely not true. Many cases that are being signed up today are going to potentially be governed by the new statute at the time of settlement. Because the applicability of the statute will significantly impact the division of the settlement proceeds, it is important to be paying attention to the ramifications of the statute right now.

Most importantly, when evaluating new personal injury cases, it is important to determine whether the injured party is covered by a fully insured plan, a self-funded non-ERISA plan, or an ERISA self-funded plan. The difference will greatly affect the health insurer's right of recovery. If the claimant has an ERISA self-funded plan, H.B. 1869 does not apply. The health insurer has no statutory cap on its right of recovery. Accordingly, plaintiff's attorneys will have to negotiate these liens in the traditional manner, and the health insurer is likely to expect more than one-third of the total recovery.

Thus, it is extremely important to determine the type of plan involved when signing up clients. The type of plan, unfortunately, may significantly impact the claimant's recovery which, in turn, affects the ability to settle the claim within a reasonable range. If the ERISA plan is self-funded but administered by the insurer, the plan is not within the purview of the new statute. It is important to know this information up front in order to evaluate the cost of eliminating the lien holders and subrogees.

From the defense perspective, it is anticipated that it will be easier to settle cases that fall within the purview of the statute. The statute should provide more certainty and more efficient resolution of claims. Instead of relying upon the claimant's counsel to negotiate a health insurer's interest, the third party insurance carrier can quickly and precisely calculate how much will be going to resolve the subrogation claim. In past experience, health insurers rarely agree to accept one-third of the settlement proceeds, and this will be a significant shift in the ability to settle these kinds of cases. The statute should be beneficial to parties on both sides of the personal injury bar in that it provides a smaller recovery for the health insurer as well as a definitive division of the proceeds.

APPENDIX A

H.B. No. 1869

AN ACT

relating to contractual subrogation and other recovery rights of certain insurers and benefit plan issuers.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:

SECTION 1. Title 6, Civil Practice and Remedies Code, is amended by adding Chapter 140 to read as follows:

CHAPTER 140. CONTRACTUAL SUBROGATION RIGHTS OF PAYORS OF CERTAIN BENEFITS

Sec. 140.001. DEFINITIONS. In this chapter:

(1) "Covered individual" means an individual entitled to benefits described by Section 140.002.

(2) "Payor of benefits" or "payor" means an issuer of a plan providing benefits described by Section 140.002 that:

(A) pays benefits to or on behalf of a covered individual as a result of personal injuries to the covered individual caused by the tortious conduct of a third party; and

(B) has a contractual right of subrogation described by Section 140.004.

Sec. 140.002. APPLICABILITY OF CHAPTER. (a) This chapter applies to an issuer of a health benefit plan that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, a disability benefit plan, or an employee welfare benefit plan, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a

group hospital service contract, or an individual or group evidence of coverage or similar coverage document, including:

(1) an insurance company;

(2) a group hospital service corporation operating under Chapter 842, Insurance Code;

(3) a fraternal benefit society operating under Chapter 885, Insurance Code;

(4) a stipulated premium insurance company operating under Chapter 884, Insurance Code;

(5) a reciprocal exchange operating under Chapter 942, Insurance Code;

(6) a health maintenance organization operating under Chapter 843, Insurance Code;

(7) a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846, Insurance Code; or

(8) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844, Insurance Code.

(b) Notwithstanding Section 172.014, Local Government Code, or any other law, this chapter applies to a risk pool providing health and accident coverage under Chapter 172, Local Government Code.

(c) Notwithstanding any other law, this chapter applies to an issuer of a plan or coverage under Chapter 1551, 1575, 1579, or 1601, Insurance Code.

(d) Notwithstanding any other law, this chapter applies to any self-funded issuer of a plan that provides a benefit described by Subsection (a).

(e) This chapter applies to any policy, evidence of coverage, or contract under which a benefit described by Subsection (a) is provided and:

(1) that is delivered, issued for delivery, or entered into in this state; or

(2) under which an individual or group in this state is entitled to benefits.

(f) This chapter does not apply to:

(1) a workers' compensation insurance policy or any other source of medical benefits under Title 5, Labor Code;

(2) Medicare;

(3) the Medicaid program under Chapter 32, Human Resources Code;

(4) a Medicaid managed care program operated under Chapter 533, Government Code;

(5) the state child health plan or any other program operated under Chapter 62 or 63, Health and Safety Code; or

(6) a self-funded plan that is subject to the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.).

Sec. 140.003. CONFLICTS WITH OTHER LAW. In the event of a conflict between this chapter and another law, including a rule of procedure or evidence, this chapter controls to the extent of the conflict.

Sec. 140.004. CONTRACTUAL SUBROGATION RIGHTS AUTHORIZED. An issuer of a plan that provides benefits described by Section 140.002 under which the policy or plan issuer may be obligated to

make payments or provide medical or surgical benefits to or on behalf of a covered individual as a result of a personal injury to the individual caused by the tortious conduct of a third party may contract to be subrogated to and have a right of reimbursement for payments made or costs of benefits provided from the individual's recovery for that injury, subject to this chapter.

Sec. 140.005. PAYORS' RECOVERY LIMITED. (a) If an injured covered individual is entitled by law to seek a recovery from the third-party tortfeasor for benefits paid or provided by a subrogee as described by Section 140.004, then all payors are entitled to recover as provided by Subsection (b) or (c).

(b) This subsection applies when a covered individual is not represented by an attorney in obtaining a recovery. All payors' share under Subsection (a) of a covered individual's recovery is an amount that is equal to the lesser of:

(1) one-half of the covered individual's gross recovery; or

(2) the total cost of benefits paid, provided, or assumed by the payor as a direct result of the tortious conduct of the third party.

(c) This subsection applies when a covered individual is represented by an attorney in obtaining a recovery. All payors' share under Subsection (a) of a covered individual's recovery is an amount that is equal to the lesser of:

(1) one-half of the covered individual's gross recovery less attorney's fees and procurement costs as provided by Section 140.007; or

(2) the total cost of benefits paid, provided, or assumed by the payor as a direct result of the tortious conduct of the third party less attorney's fees and procurement costs as provided by Section 140.007.

(d) A common law doctrine that requires an injured party to be made whole before a subrogee makes a recovery does not apply to the recovery of a payor under this section.

Sec. 140.006. ATTORNEY'S FEES IN DECLARATORY JUDGMENT ACTION. Notwithstanding Section 37.009 or any other law, if a declaratory judgment action is brought under this chapter, the court may not award costs or attorney's fees to any party in the action.

Sec. 140.007. ATTORNEY'S FEES IN RECOVERY ACTION. (a) Except as provided by Subsection (c), a payor of benefits whose interest is not actively represented by an attorney in an action to recover for a personal injury to a covered individual shall pay to an attorney representing the covered individual a fee in an amount determined under an agreement entered into between the attorney and the payor plus a pro rata share of expenses incurred in connection with the recovery.

(b) Except as provided by Subsection (c), in the absence of an agreement described by Subsection (a), the court shall award to the attorney, payable out of the payor's share of the total gross recovery, a reasonable fee for recovery of the payor's share, not to exceed one-third of the payor's recovery.

(c) If an attorney representing the payor's interest actively participates in obtaining a recovery, the court shall

award and apportion between the covered individual's and the payor's attorneys a fee payable out of the payor's subrogation recovery. In apportioning the award, the court shall consider the benefit accruing to the payor as a result of each attorney's service. The total attorney's fees may not exceed one-third of the payor's recovery.

Sec. 140.008. FIRST-PARTY RECOVERY. (a) Except as provided by Subsection (b), a payor of benefits may not pursue a recovery against a covered individual's first-party recovery.

(b) A payor of benefits may pursue recovery against uninsured/underinsured motorist coverage or medical payments coverage only if the covered individual or the covered individual's immediate family did not pay the premiums for the coverage.

Sec. 140.009. CONSTRUCTION OF CHAPTER. This chapter does not create a cause of action. Nothing in this chapter shall be construed to prevent a payor of benefits from waiving, negotiating, or not pursuing any claim or recovery described by Section 140.004 or 140.005.

SECTION 2. Section 172.015, Local Government Code, is repealed.

SECTION 3. It is the intent of the legislature that if any provision, section, subsection, sentence, clause, phrase, or word of this Act or the application thereof to any person or circumstance is found to be unconstitutional, the provision, section, subsection, sentence, clause, phrase, or word is hereby declared to be severable and the balance of this Act remains effective notwithstanding such unconstitutionality. Moreover, the

legislature declares that it would have passed this Act, and each provision, section, subsection, sentence, clause, phrase, or word thereof, irrespective of the fact that any provision, section, subsection, sentence, clause, phrase, or word, or any of their applications, were to be declared unconstitutional.

SECTION 4. The change in law made by this Act applies only to a contractual right of subrogation in a cause of action that accrues on or after the effective date of this Act to assert a contractual right of subrogation or recovery described by Section 140.004, Civil Practice and Remedies Code, as added by this Act.

SECTION 5. This Act takes effect January 1, 2014.