

# **TRICKS OF THE TRADE**

## **Common “Tricks” of Insurers and Medical Providers**

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Darren began his career in 1994 as a trial lawyer for State Farm Mutual Automobile Insurance Company. He handled cases involving automobile accidents, premises liability, intentional torts, fire claims, theft claims, homeowner's claims, insurance bad faith, and coverage disputes. While at State Farm, Darren handled well over a hundred trials as lead counsel.

After leaving State Farm in 1997, Darren was a founding member of Penn & Pate LLP where he built a successful trial practice exclusively representing plaintiffs in a wide variety of personal injury and business tort trials. His extensive experience with the insurance industry was pivotal in the development of a highly successful practice, and, in 2000, Darren merged his practice into the firm that is now Scherffius, Ballard Still & Ayres LLP.

Darren received both his undergraduate and law degrees from the University of Georgia. He served as Executive Articles Editor of the *Georgia Journal of International and Comparative Law* and participated in the Moot Court. He is a member of the State Bar of Georgia, the Atlanta Bar Association, Georgia Trial Lawyers Association, Lawyers Club of Atlanta, American Trial Lawyers Association, American Bar Association, Southern Trial Lawyers Association, and AIEG. He is AV rated by Martindale-Hubbell and is a frequent speaker at CLE seminars on topics related to trial tactics, products liability, insurance and subrogation and liens.

## TRICKS OF THE TRADE

### Common “Tricks” of Insurers and Medical Providers

It is a common theme that is played out in nearly every case. We, as the representatives of those harmed by others, seek to maximize our client’s recovery to the fullest extent possible. Insurance companies and medical providers continually chip away at our ability to gain full recovery for our clients in a nonstop effort to maximize their own recoveries. This battle leads to some interesting tricks and tactics in tort cases that every plaintiff’s lawyer, before the case can be finally settled, must address. The failure to pay attention to these issues can lead to a less than satisfactory recovery when it is all said and done.

#### I. BALANCE BILLING

Your client was injured in an automobile accident that was not her fault and was admitted to the hospital because she sustained injuries. She tells the admissions personnel her injuries are the result of an auto accident and she has health insurance. She belongs to an HMO which has an agreement with that hospital to provide medical care at a discount. Your client’s HMO picks up the tab for the hospital bills and the hospital is supposed to consider payment from the HMO as full reimbursement. The hospital however, knowing your client was injured in an auto accident, files a lien against any auto insurance liability settlement for the difference between what the HMO paid and the billed amount. For instance, your client’s hospital bill is \$10,000 and her HMO’s preset agreement with the hospital allows it a discount of 40 percent. Your client’s HMO pays \$6,000 and the hospital files a lien for the remaining \$4,000.

When hospitals or other medical providers bill the health insurer or HMO *and* your client, it is a practice commonly known as “balance billing.” While the issue has not been squarely addressed in Georgia, several courts have ruled the practice illegal. Hospitals and other medical providers have every right to receive payment for services rendered and can come after your clients if they or their health insurers have not paid the bills. However, if the health insurer and health care provider agree on a payment schedule, even if those fees are at a discount, the health care provider should not seek reimbursement from your client once they have been paid by the health insurance plan. Some hospitals and other medical providers are ignoring the law.

In Watts v. Promina Gwinnett Health System, Inc. et. al., 242 Ga. App. 377 (2000), the plaintiff sued a hospital for balance billing. The hospital, despite a written agreement with the plaintiff’s HMO authorizing a flat fee for emergency services and prohibiting the hospital from pursuing collection of the bill from plan members, collected nearly twice as much as it was allowed by filing a lien against the plaintiff’s automobile accident claim. The plaintiff’s problem, however, was that she had *paid* the hospital’s lien before filing suit. Under the “voluntary payment doctrine” codified at O.C.G.A. § 13-1-13, the plaintiff was barred from suing the hospital for collecting more than it had agreed. Interestingly, the Georgia Court of Appeals reversed the trial court’s grant of a

declaratory judgment seemingly blessing the hospital's balance billing. Thus, the issue has yet to be fully addressed in Georgia.

Other courts have ruled "balance billing" is an illegal practice. In Satsky v. United States of America, 993 F. Supp. 1027 (D.C. Tex., 1998), the total hospital bill was a little over \$125,000 and the hospital was paid \$42,300 pursuant to the injured victim's health insurance. As is typical, the hospital and health insurer operated under an agreement that provided that the amount reimbursed by the health insurer would be considered *full* payment of the hospital's bills. The district court judge ruled that the agreement to accept the health insurer's payment of the bill negated the hospital lien filed pursuant to Texas law and the hospital could not collect more than it agreed.

In Dorr vs. Sacred Heart Hosp., 228 Wis.2d 425, 597 N.W.2d 462, the Wisconsin Court of Appeals hammered a hospital for its balance billing. The plaintiff was an automobile accident victim that was taken to the hospital for emergency care. Here again, the plaintiff had insurance through an HMO that had contracted with the hospital to render medical services to its subscribers at an agreed upon rate. Despite the contract, which included a "hold harmless" provision whereby the hospital agreed not to pursue additional payments from plan members, the hospital pursued payment in excess of the HMO's reimbursement by filing a lien on the plaintiff's claim against the tortfeasor. The court ruled that the HMO agreement operated to exclude any debt owed by the plaintiff to the hospital and, therefore, the hospital was without legal authority to seek payment from her. Accordingly, the Wisconsin court held that the plaintiff's claims for false representation, unfair debt collection, breach of contract, racketeering, and punitive damages should be tried to a jury and affirmed the trial court's grant of summary judgment on the plaintiff's claims of conversion and tortious interference with contract.

Another example of a court prohibiting balance billing is Nahom v. Scottsdale Mem. Hosp., 180 Ariz. 548, 885 P.2d 1113 (1994). In addition, Maryland's attorney general and the insurance commissioners in Arkansas, Florida and Massachusetts have specifically warned hospitals and other health care providers about the illegality of "balance billing."

## **II. ARE YOU SURE YOU HAVE ALL OF THE INSURANCE?**

O.C.G.A. § 33-3-28(a)(1) requires every insurer providing liability or casualty insurance coverage in this state and which *may* be liable to pay all or a part of any claim to provide, within 60 days of receiving a written request, a statement under oath stating with regard to *each known policy* of insurance issued by it, including excess or umbrella insurance, the name of the insurer, the name of each insured, and the limits of coverage. In the alternative, an insurer may satisfy the information requirement by providing a copy of the declaration page of each policy that may provide coverage. The request for information must provide the nature of the claim and be sent via certified mail or statutory overnight delivery.

If the insurer is not known, the request can be sent to the tortfeasor under subsection (a)(2) of the statute and they must disclose the name of each known insurer which may be liable to the claimant within 30 days of receiving the written request. Under subsection (d), there is a duty to amend the information provided to a claimant or his attorney with additional relevant information.

The duty to disclose insurers and insurance policies seems rather straightforward. One of the first letters plaintiff attorneys send after being retained is the letter requesting insurance information. Insurance companies routinely respond to these requests and often times do not even require the requests to be sent via certified mail. Do not be lulled to sleep by an insurer's seeming disclosure of insurance information. In practice, this is an area rife with potential abuse. You should pay particular attention to the method and manner of disclosure to ensure that you are indeed getting "full disclosure."

Have you ever really paid attention to the responses sent by the insurance companies providing insurance information other than to check out the policy limits? Sure they provide information on *a* policy of insurance, but are there other policies? Are there other insureds? Remember, there must be a proper disclosure for *each and every* policy of insurance that *may* be applicable to the claim. In every day practice, the most trouble comes from the failure to disclose business, homeowner's, other household policies, and umbrella policies.

While the statutory duty is to disclose information regarding all policies of insurance that may be applicable to a particular claim, insurers have a pattern of producing information related solely to the automobile or liability policy directly related to the incident causing your client's injuries. The certificate of coverage may state something like "automobile policy number . . . was in full force and effect on . . ." or "policy number . . . was in force and in effect for insured . . ." or "(tortfeasor's name) was insured under policy number . . . on . . ." Too often other policies exist yet the claims adjuster or tortfeasor make the independent decision that they do not apply. Worse, they may simply miss the other policies. Policies exist for different named insureds, vehicles, and types of coverage such as umbrella or excess coverage. In addition, many policies stack under certain rules. If you are not persistent you may be missing significant available insurance proceeds. If you do not pay attention to the wording of the disclosure and are not diligent in your search for insurance you may easily miss other policies and/or insureds.

Perhaps the most important case on this issue is Merritt v. State Farm &c. Ins. Co., 247 Ga. App. 442, 544 S.E.2d 180 (2000). The plaintiff sued State Farm for fraud, misrepresentation, false swearing, and RICO violations after State Farm failed to disclose the existence of a \$1,000,000 umbrella policy until after she had settled for the previously disclosed policy limits of \$250,000. The plaintiff's attorney sent the request pursuant to statute for disclosure of policy limits, and State Farm responded with a certificate indicating coverage for one automobile in the amount of \$250,000 maximum per person (250/500). Two days later, counsel for the plaintiff sent a letter specifically asking if there was an umbrella policy, and State Farm responded with a letter stating that all

policies had been disclosed. Plaintiff demanded the full policy limits "contingent upon your insured's policy limits with State Farm being \$250,000 and the accuracy of your representation that there is no other insurance applicable to this claim," and the case eventually settled for the \$250,000 "policy limits." Before finally executing the release, the plaintiff's attorney called defense counsel and again asked if there was an umbrella policy. To his surprise, he was told that there *was* one. State Farm told the plaintiff to keep the \$250,000 as a partial payment and keep negotiating. The plaintiff's attorney demanded \$1.25 million to release all claims against the insured and State Farm. State Farm countered with \$400,000 and suit was filed.

Of note, the application and umbrella policy were approved and entered into the computer before the settlement, but after the request for disclosure of limits. No one bothered to continue checking. It was only due to Bob Altman's, the plaintiff's attorney, persistence in continuing to ask that he ever found out. Note also that the insured in that case testified that he told the adjuster about the umbrella policy 4-6 times and that his agent jokingly said, "Don't tell anyone about the umbrella policy"!

The trial court granted summary judgment to State Farm after concluding that there was no valid settlement agreement since it was contingent on State Farm having disclosed all of the policy limits. This effectively meant that State Farm could void the whole settlement due to its own failure to disclose insurance. In reversing, the Georgia Court of Appeals first held that there was an enforceable settlement agreement and that State Farm should not be allowed to void the contract due to its own misrepresentation. Second, the plaintiff could affirm the settlement agreement and sue for fraud damages. Finally, the Georgia Supreme Court held that there were damages upon which to base the fraud. Namely, State Farm itself had valued the claim at \$500,000 and thus the plaintiff lost the use of that additional value while negotiating.

In Cross v. Tokio Marine & Fire Ins. Co., Ltd., 254 Ga. App. 739, 563 S.E.2d 437 (2002) the plaintiff and Tokio's insured were involved in motor vehicle accident. The plaintiff's attorney sent a proper letter requesting the name of each insurer and the policy limits. The claims adjuster responded by sending a copy of a declarations page indicating coverage under one policy for \$1 million. The plaintiff made a settlement demand of \$750,000 "based on the specials, nature of injuries and past, present and future pain and suffering." The specials included \$88,000 in medical bills and lost wages of \$15,000. The case did not settle and the plaintiff filed suit. A jury returned a verdict for \$1,204,000. The judgment was entered and not appealed despite the fact that after the judgment the plaintiff's counsel was informed that the total coverage was actually \$2,000,000 and this number was later revised to \$7,000,000.

After learning of the misrepresentation, the plaintiffs filed suit against Tokio alleging violation of O.C.G.A. § 33-3-28(d), false swearing under O.C.G.A. § 16-10-71, fraud and misrepresentation, and RICO violations and sought pre-judgment interest under O.C.G.A. § 51-12-14(b). The plaintiffs claimed that because of Tokio's misrepresentation of the coverage limits, they recovered less than the full value of their claim. The Georgia Court of Appeals ruled that the plaintiffs could not prove the

elements of their claims because their case had been tried to a jury and a judgment entered and satisfied. Thus, the full value of their claims had been awarded and received. They simply could not prove any damage by the failure of Tokio to disclose additional policy limits. Further, they knew about the misrepresentation when they accepted the payment of the judgment and their initial settlement demand was for only \$750,000. Finally, they did not seek to set aside the judgment and this was fatal to their claims. You cannot attack the judgment without moving to set it aside or for a new trial.

In Parris v. State Farm Ins. Co., 229 Ga. App. 522, 494 S.E.2d 244 (1997), the plaintiffs sent State Farm a proper request for disclosure of insurance information and State Farm responded by stating that *the car* was insured by their insured's grandfather and the policy limits were \$25,000 per person, \$50,000 per accident (25/50). After settlement negotiations had begun, State Farm disclosed that that the insured's father had two policies of insurance that *may* provide coverage. Negotiations stalled, the plaintiffs filed suit and in response to interrogatories it was confirmed that the three policies provided coverage but the policy limits of the two additional policies were misrepresented to be 20/50 when they were actually 50/100 each. However, the responses were amended to reflect the proper policy limits before the two cases eventually settled.

Despite the settlements, the plaintiffs sued State Farm for failure to furnish coverage information, fraud and false swearing. The Georgia Court of Appeals affirmed the trial court's grant of summary judgment to State Farm. It is simple: No damages, no claim. In reality this was not an improper reporting case since the plaintiffs had all of the information before settling. State Farm initially responded incorrectly to a request for coverage information. There was simply no evidence showing that State Farm would have settled sooner had the company disclosed the correct limits initially, and no evidence that the outcome would have been different had they filed suit sooner.

Despite the fact that there were no damages in the Parris case, the Georgia Court of Appeals stated it best:

[I]t is not a universal truth in insurance disclosure matters that all is well that ends well. Improper insurance reporting may result in liability under a proper factual scenario." Id. at 526, 494 S.E.2d at 247.

### **III. "WE DON'T COVER YOU BECAUSE THERE IS LIABILITY COVERAGE FOR THE MEDICAL BILLS"**

You sign up a big case and are pretty happy about it. But is there going to be enough liability coverage to fully compensate your client? During the initial interview you are relieved to find out that she has health insurance that will cover the medical expenses. At least the medical expenses will be covered and not eat into the settlement if there is not enough liability coverage for the claim. Less than two hours after your meeting, however, your client calls to say that her health insurer told her that since her

injuries were caused in an automobile accident the tortfeasor's insurance will pay the bills. The representative from the insurer informed your client that they will not be paying the medical bills. How do you respond?

This boils down to a contractual issue. Historically, with the exception of misrepresentation in the application claims, insurers do not fair too well in refusal to pay cases based on terms of coverage. See, e.g. Beggs v. Pacific Mut. Life Ins. Co., 171 Ga. App. 204, 318 S.E.2d 836 (1984); Connell v. Guarantee Trust Life Ins. Co., 246 Ga. App. 467, 541 S.E.2d 403 (2000); Pilot Life Ins. Co. v. McCrary, 103 Ga. App. 549, 120 S.E.2d 134 (1961). See also, Aetna Health Plans of California, Inc. v. Yucaipa-Calimesa Joint Unified School District, 72 Cal. App.4th 1175, 85 Cal.Rptr.2d 672 (1999) (primary insurer failed to pay benefits leading to delay and death of insured).

Automobile liability insurance is not primary for medical expenses for the simple reason that it is contingent on a finding of liability and damages. If a health insurer rejects coverage when there is automobile insurance the insured may never be reimbursed for medical expenses. This is a clear breach of the health insurance contract. Do not allow your client to be led to believe that she has no health insurance if someone is at fault for her injuries. It is incumbent that the attorney fights to have the medical bills paid pursuant to the health insurance contract.

There may be one exception to the rule that health insurance is the primary coverage depending on the terms of the health insurance contract. Medical payments ("MPC") and other "no-fault" coverage afforded in some automobile insurance contracts could be construed as the "primary" medical expense coverage under some health insurance contracts. The best policy for any attorney is to discover *all* of the medical expense coverage available to your client and if your client has MPC coverage, use it. Use the health insurance coverage as well. Use all of it. The goal is to have your client's bills paid through all available medical coverage to avoid dipping into the available liability limits. If the insurance is there it should be used or your client may not recover as much as she is entitled under the law.

Most health insurance contracts contain "co-ordination of benefits" and "anti-duplication of benefits" clauses. There are even provisions for ignoring the benefits of other plans which themselves have co-ordination of benefits clauses and there commonly are provisions for determining which insurance is "primary" when there are other available insurance proceeds. O.C.G.A. § 33-24-56.1(f) allows for these types of clauses as well. Obtaining copies of the applicable contracts cannot be overly stressed.

The Georgia Court of Appeals in Barker v. Coastal States Life Ins. Co., 138 Ga. App. 164, 225 S.E.2d 924 (1976) held that co-ordination of benefits clauses are valid. There, the plaintiff's husband was covered by Blue Cross/Blue Shield through his employer. He was also covered through family provisions of his wife's group health policy through her employer. He became ill and died and the bulk of the claim was covered by Blue Cross. However, the wife filed a claim with her health insurance for *full payment of the bills*. Her insurer denied the full claim due to its "co-ordination of

benefits” clause, but agreed to cover the excess bills not covered by Blue Cross. The wife sued for full coverage under her insurance plan claiming that the premiums were paid and there should be coverage. The Georgia Court of appeals held that the co-ordination of benefits clause whereby the medical bills were paid proportionately by both plans was valid. The Court reasoned that allowing these clauses keeps premiums low and the insured is not able to “profit” from being ill. The insured is precluded from recovering more than will make them whole.

In Feagin v. Smith, 136 Ga. App. 21, 220 S.E.2d 41(1975), the Georgia Court of Appeals set forth the rule that our clients are duty and conscious bound to disclose all available health insurance. That would include other health plans as well as medical payments coverage or any kind of no-fault medical coverage. In Feagin, a wife incurred substantial medical expenses. The husband gave the hospital his health insurance plan and did not disclose health insurance purchased in his wife’s name. The husband’s policy had a co-ordination of benefits clause that allowed it to reduce the amount it paid to the excess of medical bills not covered by the primary insurance. The Court of Appeals held that the husband had a legal duty to disclose the coverage.

If there is a dispute, request the health insurance policy. Invariably, the response will be a faxed copy of a page containing subrogation or reimbursement language or some other paragraph from the policy. *Get the entire policy.* The general law in Georgia is that insurance coverage is construed in favor of the insured and against the insurer as the drafter of the contract. The benefit of interpretation goes to your client, the insured. If, after attempting to resolve the issue the health insurer continues to refuse to pay the medical bills, send a bad faith refusal to pay letter. Continue to push for your client’s rights until the bills are paid as called for by the contract or you are convinced that the health insurer is right. In my time as an attorney representing plaintiffs, however, I can assure you that I have never been convinced that a health insurer was correct in not paying my client’s medical expenses.

Though extremely rare, you may be forced file suit against the health insurer. If that is the case, be aware of *assignments of claims* to the hospital or other medical provider by your clients. It is becoming more and more common for a health care provider to obtain an assignment of the patient’s rights under their health insurance contracts in order to pay the bills. If there is an assignment, have the medical provider pursue the claim or you must get reassignment *before* suing or permission to pursue it. If the provider will not pursue it, there is a strong argument against the medical provider that your client assigned his rights, the bills are covered by the policy, and your client is no longer responsible for the bills.

In Blue Cross & Blue Shield of Georgia, Inc. v. Bennett, 223 Ga. App. 291, 477 S.E.2d 442 (1996), a patient attempted to sue her health insurer for bad faith refusal to pay and she had signed an assignment. The Georgia Court of Appeals held that the assignment divested her of the right to bring the action and that she had transferred the right to demand payment and bring an action for bad faith to the hospital. The assignment makes the medical provider the holder of the policy within the meaning of the

bad faith statute. See also, Allianz Life Ins. Co. of N. Am. v. Reidl, 264 Ga. 395, 444 S.E.2d 736 (1994) (assignment divested insured of right to bring action against insurer and provider, as assignee, was real party in interest and was entitled to opportunity to ratify or join action or to be substituted for insured).

#### **IV. “THERE IS AUTO (LIABILITY) INSURANCE SO WE ARE NOT GOING TO SUBMIT THE BILLS TO YOUR HEALTH INSURER”**

This is similar to section III. above. Usually, however, the call from the client comes from the medical provider’s office and goes something like, “You told me to give them my health insurance information and they are refusing to submit the bills because it is an automobile case.” With 92% of the insured population participating in some type of managed-care plan, most health-care providers feel pressured into joining up with an HMO to survive. *10 Things Your Health Insurer Won’t Tell You*, Smartmoney (2004). Most providers will accept the insurance. However, there are a few medical providers that would rather attempt to collect the full amount of their bills through the tort settlement rather than an HMO discount.

While there is very little law on this issue, if the health care provider has entered into a contract with your client’s insurer, they are contractually bound to submit the insurance. If they refuse, obtain a copy of the contract between the health insurer and the provider. There is a strong argument that your client is a third-party beneficiary to that contract.

If the provider does not have a contract, then, unfortunately, it is truly their call on whether to submit the bills for health insurance reimbursement. It gets tricky and you must stay on top of this because most health insurance policies have a 90 or 180 day cutoff date. If the bills are not submitted within that time period, your client will lose the insurance. The solution is to stay proactive and continue to seek reimbursement. One response is to have your client submit the bills to their health insurer. If they submit payment and the medical provider accepts, it is arguably estopped from claiming additional bills from your client (balance billing).

#### **V. “SIGN ON THE DOTTED LINE AND WE WILL PAY YOUR BILLS”**

Many times the health insurer refuses to pay the medical expenses unless your client, their insured, agrees to sign a document acknowledging their right to reimbursement. These documents are often referred to as “acknowledgment of lien/reimbursement/subrogation rights” or “reimbursement agreements.” When this issue is raised, the lawyer should reject all attempts to have the client sign these agreements and demand that the insurer cover the bills. Unless the plan is an ERISA plan a lawyer is in good stead to tell the health insurer to bug off and pay the bills. In light of the current case law surrounding ERISA, it is a good idea to resist even these agreements and demand coverage for as long as you can.

Under O.C.G.A. § 33-24-56.1, there is no reimbursement to the health insurer unless your client's recovery exceeds the sum of all economic and noneconomic losses incurred as a result of the injury and there is a pro rata reduction for the amount of attorney's fees and expenses of litigation incurred in bringing the claim. There can be no subrogation against the tortfeasor pursuant to subsection (e) and subsection (f) states that no health insurer is entitled to withhold or set off benefits as a means of enforcing reimbursement. Finally, subsection (j) provides that any policy or contract provisions for subrogation or reimbursement in conflict with the statute may not be enforced. Simply put, these reimbursement agreements are unenforceable under Georgia law and an insurer cannot force your client to sign them.

This is not necessarily the case with an ERISA plan however. In Cagle v. Bruner, 112 F.3d 1510 (11<sup>th</sup> Cir. 1997) the 11<sup>th</sup> Circuit Court of Appeals held that an ERISA plan may require a plan participant to sign a subrogation agreement before paying claims submitted by that participant on behalf of a plan beneficiary. The plan may do so where the required subrogation agreement does not contain an arbitrary and capricious interpretation of the plan's subrogation rights. However, the 11<sup>th</sup> Circuit also held that the "made whole" doctrine applies as a default rule in ERISA reimbursement claims. So, the ERISA plan can force your client to sign the agreement, but it may still be subject to the made whole doctrine. See also, Wright v. Aetna Life Ins. Co., 110 F.3d 762 (11<sup>th</sup> Cir. 1997) (ERISA insured's reimbursement obligation was governed by reimbursement agreement that insured signed before receiving benefits from plan, not by reimbursement provision of summary plan document); Thompson v. Federal Express Corp., 809 F. Supp. 950 (M.D. Ga. 1992) (reimbursement agreement valid and enforceable after being ratified by insured and attorney).

## VI. MED PAY/UNINSURED MOTORIST SETOFFS

O.C.G.A. § 33-24-56.1(f) provides,

No benefit provider shall be entitled to reduce the amount for which it is liable under an insured party's coverage for liability, *uninsured motorist*, disability, *medical payments*, or other benefits as a setoff against any claim for reimbursement under subsection (b) of this Code section, nor shall any benefit provider be entitled to withhold or set off insurance benefits as a means of enforcing a claim for reimbursement. . .” (emphasis added).

Despite this language in the statute, automobile insurers continue to routinely seek setoffs under medical payments and uninsured motorist coverage. The question to keep in mind when the automobile insurer wants to setoff benefits is whether the client has been made whole. If not, there is no right to a setoff. A number of Georgia cases put this into perspective.

In Anderson v. Mullinax, 269 Ga. 369, 497 S.E.2d 796 (1998), the Georgia Supreme Court declared that there is no medical payments setoff on uninsured motorist coverage for medical payments paid by the tortfeasor's insurance. This setoff the insurer was seeking was not provided for in the language of the policy.

In Duncan v. Integon General Ins. Corp., 267 Ga. 646, 482 S.E.2d 325 (1997) the Georgia Supreme Court verified the application of the made whole doctrine in holding that an uninsured motorist carrier is not entitled to medical payments setoff if the plaintiff is not made whole in the settlement with the tortfeasor's insurance carrier.

Hudson v. Whited, 250 Ga. App. 451, 552 S.E.2d 447 (2001) dealt with a UM provision that provided for a reduction in the uninsured motorist coverage for the amount of coverage available for medical payments such as worker's compensation. The UM policy limit was \$15,000 and the worker's compensation carrier paid \$30,000. The plaintiff's damages were much higher. The trial court reduced the UM to zero by applying the clause in the contract. The Georgia Court of Appeals reversed this decision since the UM statute, O.C.G.A. 33-7-11(a)(1), provides that the purpose of UM is to pay the insured "all sums" they are legally entitled to within the limits of the policy. The Georgia Court of Appeals held that if the insured is entitled to more than what is available then the clause reducing coverage is invalid. In other words, if your client is not made whole then the clause allowing a setoff cannot be enforced.

Johnson v. State Farm Mut. Auto. Ins. Co., 216 Ga. App. 541, 455 S.E.2d 91 (1995) provides another illustration. There, the plaintiff was awarded over \$190,000 in damages by a jury. The plaintiff's UM carrier, with a coverage limit of \$300,000, sought to enforce a policy provision to reduce the verdict by \$21,643.10 for medical expenses the carrier paid under medical payments coverage. The Georgia Court of Appeals enforced the provision, reasoning that since the available coverage limit far exceeded the insured's actual losses, the insured was certain to receive "all sums" she was legally entitled to even with the reduction. However, the Georgia Court of Appeals warned that such a clause would not be enforceable when the actual damages are greater than the policy limits because such a result would violate the requirement that UM coverage pay the insured "all sums" which she is legally entitled to recover as damages.

What happens when a federal benefit program requires your client to reimburse the payment of medical expenses regardless of whether she is made whole?

That question was answered in Thurman v. State Farm Mut. Auto. Ins. Co., 278 Ga. 162, 598 S.E.2d 448 (2004). A U.S. postal worker was injured in an automobile accident on the job. The liability limits were \$100,000 and the UM limits were \$75,000. Typically, the greater available liability limits would cancel out the UM coverage. The plaintiff settled with the tortfeasor for \$95,000 (policy limits minus damage to the postal truck). The plaintiff had received lost wages and medical bill payments through her worker's compensation (Federal Employee Compensation Act 5 U.S.C.A. § 8101 et seq.) and employer's group medical insurance (Federal Employees Health Benefits Act, 5 U.S.C.A. § 8901 et seq.). The plaintiff was required reimburse the federal government

out of the proceeds pursuant to 5 U.S.C.A. § 8132. The liability carrier issued three checks, one to the plaintiff and two with the plaintiff and lienholders as co-payees. The plaintiff ended up netting \$60,000 when all was said and done. The plaintiff then sought UM benefits because her net recovery was less than the available UM limits. The Georgia Supreme Court held that the tortfeasor was considered “underinsured” for the \$15,000 difference and she was entitled to pursue the claim because public policy strongly supports the complete compensation rule.

This is a great case to keep in mind when dealing with claims made by Medicare, Medicaid, ERISA and other federal programs whereby your client may be forced to reimburse despite no full and complete compensation.

## **VII. “WE MUST PUT THE CLAIMHOLDER ON THE CHECK”**

A variation of this is the claim that the adjuster will not send the check and release until there is written confirmation that the claim has been negotiated. Since the only true danger to the tortfeasor or liability carrier involves Medicare or Medicaid claims, this is usually just another delay tactic. There is simply no authority for an insurer to add a health insurer claiming reimbursement as a co-payee on a settlement draft. O.C.G.A. § 33-24-56.1(e) specifically provides that subrogation for medical expenses and disability payments by a benefit provider against a person at fault for injury is prohibited and no defendant or liability insurance carrier may include any insurer seeking reimbursement as a co-payee on a settlement check. It really is that simple, but adjusters are notorious for attempting this tactic.

What about Medicare, Medicaid, & ERISA claims? Most authoritative minds believe that reimbursement under ERISA may no longer exist in light of recent decisions such as Great-West Life & Annuity Ins. Co. v. Knudson, 534 U.S. 204 (2002). Besides, ERISA plans claim rights of reimbursement, not subrogation. Therefore, there is no reason to protect the tortfeasor and liability carrier.

Medicare, Medicaid and other federal benefits programs could be the subject of a seminar on their own with the myriad claims involved. The key with these programs is to have the time to negotiate with them. The offer of indemnification in the settlement agreement covers the tortfeasor and liability insurer and allows you to negotiate without prejudicing your client. The indemnification clause should not include attorney’s fees and costs of litigation.

## **VIII. OTHER TRICKS**

Minor Claims – The insurer convinces your eventual clients, the minor’s parents, that they will accept responsibility for the accident and that there is no need to rush things because the SOL does not expire until 2 years after the age of majority. They then deny the parents’ claims for medical expenses after expiration of 2 year statute.

Coverage claims – Most policies contain a 1 year contractual limitation for filing suit. In order to sue for bad faith, you must send a written demand via certified mail and give them 60 days to pay *before* filing suit. See O.C.G.A. § 33-4-6. The insurer simply does not make a decision, drags their feet, delays the insured, or will not give you the policy until literally forced to file suit. Suit is filed but the time there was not enough time to send the bad faith demand.

Notice of Claim/Suit – Insurance agent claims that there is no coverage under the policy. Later, it is discovered that the policy does provide coverage but the insurer attempts to deny coverage for a lack of notice of the claim or suit.

Medical Records/Testimony – Medical providers attempt to overcharge for copies of medical records, consultations with lawyers, and testimony. See O.C.G.A. § 31-33-3. Consider using medical narratives more often.

Releases – Insurance adjuster claims that general release covers loss of consortium or all claims instead of what you negotiated. You and your clients must decide how you want to deal with this scenario. A motion to enforce the settlement is a commonly used tactic. Others simply agree to release the loss of consortium claim.