

CRS § 10-1-135 and the Changing Face of Subrogation Claims in Colorado

by Christopher P. Koupal

This article describes recent changes to Colorado law governing subrogation claims.

Before the recent passage of CRS § 10-1-135, claims for subrogation or reimbursement of medical benefits in personal injury cases were largely controlled by common law. This article discusses the new statute, which codifies many of the common law principles that previously governed the resolution of subrogation claims in Colorado.

Subrogation Claims Before CRS § 10-1-135

Before CRS § 10-1-135 became effective on August 11, 2010, subrogation claims in Colorado were loosely governed by a set of common law principles. From the mid-1970s through the repeal of the Colorado Auto Accident Reparations Act (No-Fault Act) in 2003, Colorado courts recognized the “make whole” doctrine in the context of subrogation claims for personal injury protection benefits brought by no-fault insurers. Cases analyzing the former No-Fault Act applied make whole principles to prohibit a no-fault insurer from recovering personal injury protection benefits in situations where the insured had not otherwise been fully compensated.¹

Courts that considered make whole arguments following repeal of the No-Fault Act in 2003 largely declined to apply make whole principles to subrogation or reimbursement claims in other contexts, including medical payment claims.² CRS § 10-1-135 revives many of the common law make whole principles and applies them to traditional subrogation claims. Indeed, the legislative purpose of the old No-Fault Act—“to avoid inadequate compensation to victims of automobile accidents”—is strikingly similar to the legislative intent stated in CRS § 10-1-135—“to ensure that each insured injured party recovers full compensation for bodily injury. . . .”³

The common fund doctrine has a long tradition of being applied to subrogation claims in Colorado. At common law, the common fund doctrine was an equitable principle arising from the

theory that “those who benefit from litigation ought to share in its cost.”⁴ So, where a plaintiff would undertake legal action at his or her own expense to recover medical expenses to which his or her health insurer claimed a right of reimbursement, the common fund doctrine would mandate that the health insurer pay its share of the expense associated with the recovery.⁵ In the early 1990s, both the Colorado Supreme Court and the Colorado Court of Appeals applied the common fund doctrine to require workers’ compensation and health insurers seeking to enforce subrogation rights to share in the costs incurred by an injured party in obtaining the recovery from a third party.⁶

Subrogation Claims After CRS § 10-1-135

CRS § 10-1-135 essentially codifies the common law principles of the make whole doctrine and the common fund doctrine. Although there has been some political debate over the substantive policy reflected in the statute, there is no question that the statute sets out a definitive framework for resolution of subrogation claims in Colorado.

Claims That Are Not Affected

Before discussing what the statute does, it is important to note what it does not do. The statute does not affect statutory lien rights given to hospitals under CRS § 38-27-101 or statutory liens under the Colorado Medical Assistance Act (Medicaid liens) under CRS § 25.5-4-301.⁷ The statute also does not modify subrogation and lien rights granted to workers’ compensation carriers or self-insured employers under CRS § 8-41-203.⁸

The statute does not modify traditional collateral source rule principles that have been developed under CRS § 13-21-111.6, in-

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cluding the admissibility at trial of collateral source payments.⁹ The statute confirms that:

the fact or amount of any collateral source payment or benefits shall not be admitted as evidence in any action against an alleged third-party tortfeasor or in an action to recover benefits.¹⁰

This issue was recently addressed by the Colorado Supreme Court in *Volunteers of Am. Colorado Branch v. Gardenswartz*.¹¹

Although not specifically mentioned in the statute, practitioners can safely assume that certain employee benefit plans that are subject to the Employee Retirement Income Security Act (ERISA) still will enjoy federal preemption from all state laws governing subrogation claims.¹² Similarly, subrogation claims involving Medicare and veterans benefits will continue to be governed by federal law and are not subject to the provisions of CRS § 10-1-135.¹³

Parties Affected by the Statute

The statute covers the three basic parties to any subrogation claim: (1) the injured party (the person making the recovery); (2) the payer of benefits (the entity seeking subrogation or reimbursement from the recovery); and (3) to a lesser extent, the third party from whom the injured party is making the recovery. These parties are broadly defined in the statute. The definition of “injured party” includes:

a person who has sustained bodily injury as the result of the act or omission of a third party, has pursued a personal injury or other similar claim against the third party or has made a claim

under his or her uninsured or underinsured motorist coverage, and has received benefits as a policyholder, participant, or beneficiary from the payer of benefits.¹⁴

Practitioners should note that the definition of injured party includes parties making claims against their uninsured/underinsured motorist coverage.

The statute defines “payer of benefits” as any insurer, health maintenance organization, health benefit plan, preferred provider organization, employee benefit plan, other insurance policy or plan, or any other payer of benefits.¹⁵

The definition of “benefits” includes “payment or reimbursement of health care expenses, health care services, disability payments, lost wage payments, or any other benefits of any kind. . . .”¹⁶

General Rules

The statute contains a set of ground rules for resolving subrogation claims in Colorado by and between an injured party and a payer of benefits. These general rules hinge largely on a determination of whether the injured party has been fully compensated by the recovery he or she has obtained.

Generally, CRS § 10-1-135 permits subrogation “only if the injured party has first been fully compensated for all damages arising out of the claim.”¹⁷ The statute does not specifically define what is meant by “fully compensated,” but it sets out a series of presumptions to help guide the parties in resolving the issue.

If the injured party recovers something less than the total amount of insurance coverage available, including any under-

insured or uninsured motorist coverage, there is a rebuttable presumption that the injured party has been fully compensated by the recovery.¹⁸ If the injured party recovers “an amount equal to the total amount of coverage available”—that is, a policy limits settlement—there is a rebuttable presumption that the injured party has not been fully compensated by that recovery.¹⁹

If the injured party obtains a judgment, the amount of the judgment is “presumed to be the amount necessary to fully compensate the injured party.”²⁰ Practitioners should note that, although the presumptions given to recoveries obtained by settlement are rebuttable, the plain language of the statute seems to indicate that an injured party who obtains a judgment will not be able to rebut the presumption that he or she has been fully compensated.

If the injured party has been fully compensated, the statute authorizes subrogation not to exceed the amount actually paid by the payer of benefits.²¹ For capitated payments (where a certain amount is paid to cover all services, such as with certain health maintenance organizations), the statute authorizes subrogation of eighty percent of the usual and customary charge for the same services by health care providers that provide health care services on a noncapitated basis in the geographic region in which the services are rendered.²²

Presumably, it will be up to the parties to develop what the usual and customary charges are for purposes of determining the amount of the subrogation claim.

If it is determined that the injured party has been fully compensated such that subrogation is appropriate, the statute requires that the payer of benefits accept a reduction in the claim that is proportionate to the attorney fees and expenses incurred by the injured party in making the recovery. This statutory requirement echoes traditional common fund doctrine principles.

Essentially, the attorney fees and litigation costs are added and then divided by the amount of the recovery to arrive at a percentage that has been referred to as the “procurement cost.”²³ The total amount of the subrogation claim then is reduced by the procurement cost. For example, if the recovery is \$100,000, the attorney is charging a 35 percent contingency fee, and the litigation costs are \$10,000, the procurement cost would be 45 percent, and the payer

of benefits would be required to accept a 45 percent reduction on its claim.

Disputes and Enforcement

In the event the parties are unable to reach an agreement as to whether the injured party has been fully compensated, the statute contains a framework for resolution of the issue. If an injured party intends to enforce the general rules set out in the statute, that party is required to give notice to the payer of benefits within sixty days of the receipt of each recovery.²⁴ The notice must include: (1) the total amount and source of the recovery; (2) the coverage limits applicable to any available insurance policy, contract, or benefit plan; and (3) the amount of any costs charged to the injured party.²⁵

The statute does not require formal service of the notice on the payer of benefits. In the event that the payer of benefits has retained a third-party company to handle its subrogation claims, practitioners would be well advised to put both the insurer and the third-party company on notice.

If the payer of benefits intends to dispute the injured party's contention that he or she has not been fully compensated, the payer of benefits has sixty days from the receipt of the injured party's notice to request arbitration of the dispute.²⁶ If the parties cannot agree on an arbiter, the individual arbiters chosen by both parties will select a third arbiter.²⁷

If the arbiter determines that the injured party was not fully compensated, the payer of benefits has no right to repayment, reimbursement, or subrogation.²⁸ Presumably, if the arbiter were to find that the injured party was fully compensated, the payer of benefits still would be required to accept a reduction in the claim that is proportionate to the attorney fees and expenses incurred by the injured party in making the recovery.

Restrictions on Direct Actions by Insurers

The statute also restricts an insurer's ability to bring a direct action for subrogation or reimbursement of benefits against a potentially liable third party.²⁹ Previously, a payer of benefits could bring a direct action against a third party to recover any benefits it paid. CRS § 10-1-135 now prohibits the payer of benefits from bringing

a direct action until sixty days prior to the date on which the statute of limitations expires.³⁰ Even if a payer of benefits brings a direct action within the sixty-day window allowed under the statute, an injured party can pursue the third party until the statute expires and, in that case, the payer of benefits' right to subrogation still would be limited as set out in the statute.³¹

Also under the statute, a third party (in most cases, a liability insurer) is prohibited from including a payer of benefits as a copayee on a check or draft issued as payment of a settlement or judgment on behalf of an injured party.³² This section is of great practical significance to plaintiffs' attorneys. Prior to the enactment of the statute, they often would find a client's settlement delayed or frustrated due to a liability insurer's concern over seeing that a subrogation claim is resolved.

Other Restrictions on Insurers

The statute imposes several other restrictions or requirements on insurers, all of which provide further and additional protections to injured parties. Under the statute, a health insurer is prohibited from denying, delaying, or withholding benefits in cases that may give rise to a personal injury claim, or in cases where "the obligation to pay benefits results from an act or omission for which a third party may be liable."³³ Also, the statute prohibits a health insurer from delaying or withholding benefits as a means to enforce a claim for reimbursement or subrogation.³⁴ Any benefits an insurer recovers also must be credited against any lifetime maximum benefit under the policy.³⁵ Finally, the statute declares as void and un-

enforceable any insurance policy or contract language that is contrary to the statute.³⁶

Conclusion

CRS § 10-1-135 provides a definitive framework for resolving subrogation claims in Colorado. Because the statute offers both injured parties and insurers opportunities to argue for their respective interests, it should not be seen as a substitute for meaningful and good faith negotiations between the parties. For example, a plaintiff's attorney might rebut the presumption that a client was made whole by a settlement that was for an amount less than policy limits by arguing that the settlement was discounted from policy limits only to save the cost of litigation and, thus, the client was not made whole. Similarly, where a plaintiff is availing himself or herself of the statutory presumption that he or she has not been made whole by a policy limits settlement, a lawyer representing a benefit plan might argue that the reasonable value of the case is at or close to limits of available insurance, such that the presumption should not apply or the reasonable value of the case actually is lower than the limits, albeit close enough to warrant settlement at that level. A good working knowledge of the statute, coupled with good negotiating skills, will go a long way toward helping clients successfully resolve any subrogation issues that arise.

Notes

1. See *Marquez v. Prudential Prop. & Cas. Ins. Co.*, 620 P.2d 29, 32 (Colo. 1980) (no-fault insurer had no right to recover, at expense of insured, personal injury protection benefits already paid by third-party tort-

feasor's insurer where insured had not been fully compensated for injuries he suffered).

2. *See DeHerrera v. Am. Family Mut. Ins. Co.*, 219 P.3d 346, 352 (Colo. App. 2009) *cert. denied*, No. 09SC325, 2009 WL 4021376 (Colo. Nov. 23, 2009) (declining to apply "make whole" principles in action seeking declaration that automobile insurer did not have an equitable subrogation right for reimbursement of medical expenses).

3. *Compare* CRS § 10-1-135(1)(c) *with* CRS § 10-4-702, repealed by Laws 1997, H.B.97-1209 § 8, eff. July 1, 2003.

4. *Kuhn v. State*, 924 P.2d 1053, 1058 (Colo. 1996).

5. *Castellari v. Partners Health Plan of Colo., Inc.*, 860 P.2d 593, 595 (Colo.App. 1993).

6. *See id.* (health insurer required to pay a proportionate share of attorney fees and costs incurred in litigation producing recovery from which claim was paid); *County Workers Compensation Pool v. Davis*, 817 P.2d 521, 526 (Colo. 1991) (workers' compensation carrier required to pay a reasonable share of attorney fees and court costs incurred in tort litigation producing settlement).

7. CRS § 10-1-135(10)(b).

8. CRS § 10-1-135(10)(c).

9. CRS § 10-1-135(10)(a).

10. *Id.*

11. *Volunteers of Am. Colorado Branch v. Gardenswartz*, No. 09SC20, 2010 WL 4595812 (Colo. Nov. 15, 2010) (holding that a successful tort plaintiff may recover damages for the full amount of medical expenses incurred).

12. *See* Employee Retirement Income Security Act (ERISA), 29 U.S.C. §§ 1001 *et seq.* ERISA is a federal statute governing employee benefit plans, including plans providing medical benefits for employees. 29 U.S.C. § 1002(1) and (3). With some exceptions, ERISA preempts all state laws relating to employee benefit plans. 29 U.S.C. § 1144(a). The law governing subrogation claims under ERISA is complex and beyond the scope of this

article. Generally speaking, self-funded plans are exempt from state insurance law, and plans that merely purchase insurance for their participants are not. 29 U.S.C. § 1144(b)(2)(A).

13. *See* 38 U.S.C. § 629(a)(1) (veterans benefits); 42 U.S.C. § 1395y(b)(2) (Medicare benefits).

14. CRS § 10-1-135(2)(b).

15. CRS § 10-1-135(2)(c)(I).

16. CRS § 10-1-135(2)(a).

17. CRS § 10-1-135(3)(a)(I).

18. CRS § 10-1-135(3)(d)(I).

19. *Id.*

20. CRS § 10-1-135(3)(d)(II).

21. CRS § 10-1-135(3)(b).

22. *Id.*

23. "Procurement cost" is a term of art that is most associated with Medicare subrogation claims. Much like CRS § 10-1-135, 42 C.F.R. § 411.37 requires that Medicare accept a discount in its subrogation claims that is proportionate to the attorney fees and litigation costs incurred by the injured party in making the recovery.

24. CRS § 10-1-135(4)(a)(II).

25. *Id.*

26. CRS § 10-1-135(4)(a)(III).

27. CRS § 10-1-135(4)(a)(IV)(A) to (C).

28. CRS § 10-1-135(4)(b).

29. CRS § 10-1-135(6)(a)(I).

30. CRS § 10-1-135(6)(a)(II).

31. *Id.*

32. CRS § 10-1-135(6)(b).

33. CRS § 10-1-135(5) and (7)(a)(I).

34. CRS § 10-1-135(7)(a)(II).

35. CRS § 10-1-135(8).

36. CRS § 10-1-135(9). ■