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The "Make-Whole" Doctrine

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INTRODUCTION

The make-whole doctrine is a common law rule that provides "that an insurer cannot enforce subrogation rights unless and until the insured has been made whole by any recovery."[1] In practice, the make-whole doctrine allows otherwise enforceable subrogation clauses to be defeated when an injured party has damages which exceed available compensation.

In order for the make-whole doctrine to apply, the subrogation and/or reimbursement provision contained within the insurance contract must be found to be ambiguous, inasmuch as the contract fails to specifically opt out of the make-whole rule.[2]

A great number of subrogation provisions have been found to be ambiguous, and thus subject to the make-whole doctrine. The make-whole doctrine was recognized by the Ohio Supreme Court in 1995 in the case of *Blue Cross Blue Shield v. Hrenko*[3], and adopted by the Sixth Circuit Court of Appeals in 1997 in the case of *Marshall v. Employers Health Ins. Co.*[4] For the past several years, arguments among benefit plans, auto insurance companies, and injured persons have abounded on the application of the doctrine. These arguments include whether the doctrine exists, whether it applies in certain situations, whether the injured person has been made whole, and what is the amount available for recovery.

This article will provide some background on the make-whole doctrine and its application to health insurance contracts, automobile medical payment provisions, and other statutory subrogation. It will also suggest a framework to use in analyzing whether or not a plaintiff has been made whole.

SUBROGATION DEFINED

In Ohio, there are three kinds of subrogation: legal, statutory, and conventional.[5] "Legal subrogation arises out of operation of law and applies when one person is subrogated to certain rights of another so that the person is substituted in the place of the other and succeeds to the rights of the other person."[6] Statutory subrogation exists only against the wrongdoer.[7] The right of conventional subrogation arises out of express or implied contractual obligations.[8]

The injured person in *Hrenko* challenged Blue Cross & Blue Shield's ("Blue Cross") reimbursement rights for health benefits paid pursuant to a health insurance policy which included a reimbursement provision. The Ohio Supreme Court, noting that the insurance policy contained an express contractual subrogation provision, determined that the policy validly subrogated the health insurer to the rights of its insured, once its insured was fully compensated.[9]

THE MAKE-WHOLE DOCTRINE DEFINED

Since *Hrenko*, the clear trend of courts in Ohio, both state and federal courts, has been in line with the make-whole doctrine. The Ohio Supreme Court in *Blue Cross Blue Shield v. Hrenko* held:

> Pursuant to the terms of an insurance contract, a health insurer that has paid medical benefits to its insured and has been subrogated to the rights of its insured may recover from the insured after the insured receives full compensation by way of a settlement with the insured's uninsured motorist carrier.[10]

Because the plaintiff had settled his injury claim with his uninsured motorist carrier well within the available coverage limits, it was not disputed that he received full compensation. Thus, in *Hrenko*, the Ohio Supreme Court held Blue Cross' subrogation rights were enforceable.

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Citing *Hrenko*, several Ohio appellate courts have applied the make-whole doctrine.[11] The first court to do so was the Fifth District Court of Appeals in *Central Reserve v. Hartzell,* which held that a health carrier was not able to enforce its subrogation rights against a $25,000 recovery from the tortfeasor, and a $70,000 recovery from the underinsurance carrier where an arbitration panel had assessed the injured person's damages at $140,000. The First, Second, and Sixth Districts soon followed with similar reasoning and holdings.[12] Likewise, citing *Marshall*, federal district courts throughout the Sixth Circuit have also applied the make-whole doctrine in numerous cases, thereby further defining and expanding the doctrine.[13]

A. When Does the Make-Whole Doctrine Apply?

The make-whole doctrine was first applied under state common law in Ohio.[14] It was argued, therefore, that because ERISA preempted state common law, the make whole doctrine was not applicable to ERISA plans.[15] The Sixth Circuit, however, following the lead of the Ninth and Eleventh Circuits, also adopted the common law make-whole doctrine in cases of conventional (contractual) subrogation claims.[16]

Some Plans then argued that there was a difference between *subrogation* provisions and *reimbursement* provisions, contending that the make-whole doctrine did not apply to the latter. This position has been rejected repeatedly by the Sixth Circuit.[17] Accordingly, the make-whole doctrine applies to ERISA plans, whether they contain subrogation provisions, reimbursement provisions, or both.[18]

The make-whole doctrine was also applied to an auto policy medical payment subrogation claim in *Johnson v. Progressive Insur. Co.*[19], albeit not entirely successfully for the insured. Similarly, the Tenth District entertained the application of the rule in the medical payment context, but found that the insured had been made whole by a $4,462 settlement with Allstate, the tortfeasor's insurance company.[20]

There also appears to be a logical extrapolation of the make-whole doctrine in the context of underinsurance and uninsurance subrogation, whether the subrogation claim arises in the conventional context (*i.e.*, contract), or if it arises in the equitable context.[21]

In perhaps the most expansive application of the make-whole doctrine yet, the First District in *Moellman v. Niehaus* applied the doctrine to a self-funded employer's statutory subrogation lien.[22] Subsequent to *Moellman*, the Ohio Supreme Court found the Workers' Compensation subrogation statute unconstitutional,[23] thus obviating the need to assert the make-whole doctrine in the Workers' Compensation context. Nevertheless, the *Moellman* case remains useful precedent in support of broad application of the make-whole doctrine in other statutory subrogation contexts.[24]

B. Is the Plan Ambiguous?

In order to avoid application of the make-whole doctrine, the subrogation provision must unambiguously so state:

> Such a rule is consistent with the equitable principle that [an] insurer does not have a right of subrogation until the insured has been fully compensated, unless the agreement itself provides to the contrary. Also, the make-whole rule is merely a default rule. If a plan sets out the extent of the subrogation right or states that the participant's right to be made whole is superseded by the plan's subrogation right[,] no silence or ambiguity exists.[25]

The ERISA Plan in *Copeland Oaks v. Haupt*[26] argued that the Plan Administrator could self-interpret the Plan's terms, thus requiring the court to defer to its conclusion that its Plan language expressly opted out of the make-whole doctrine. The Sixth Circuit disagreed, and, in rejecting this argument, further clarified the ambiguity requirement, stating:

> [W]e now hold that in order for plan language to conclusively disavow the default rule, it must be specific and clear in establishing *both* a priority to the funds recovered *and* a right to any full or partial recovery. In the absence of such clear and specific language rejecting the make-whole rule—with clarity and specificity ultimately determined by the reviewing court—it is arbitrary and capricious for a plan administrator not to apply the default.[27]

A good example of the kind of language courts find to be ambiguous is found in *Lamp v. Community Insurance Co.*[28] The plan in *Lamp* provided:

> If benefits are paid under the GM Program, and later it is determined that another party should have been responsible for the expenses, the GM Program is entitled to be reimbursed. In that way, financial liability remains where it belongs, with the party responsible incurring the expenses, and the GM Program costs are reduced.
>
> If you, or one of your covered dependants, is involved in such a situation, you are required to provide the GM carrier with whatever assistance necessary to recover payments made on behalf of the GM Program. If you, or your dependant, receive payment for medical expenses, you will be required to reimburse the GM Program.

In *Lamp*, the Northern District of Ohio, Eastern Division, found an ambiguity because the GM plan language did not explicitly override the make-whole rule, and did not claim priority over funds when there was a partial recovery by the insured.[29] Citing the Sixth Circuit's decision in *Copeland Oaks v. Haupt*, the *Lamp* court held that, to "conclusively disavow" the default make-whole rule, there must be specific and clear language in establishing both a priority to the funds recovered and a right to any full or partial recovery.[30] This language is typical of what courts have held to be ambiguous.[31] Not all plan language, however, has been held ambiguous.[32]

The ambiguity issue having been resolved with regard to subrogation rights, Plans then turned to their next argument, to wit: the make-whole doctrine does not apply to Reimbursement provisions. This argument was rejected by the Sixth Circuit.[33]

A note of caution though -- some courts have held that a failure on the

part of the injured person to protect the subrogation rights of the insurance company voids the make-whole doctrine.[34] Citing *James v. Michigan Mut. Ins. Co.*,[35] the Tenth District Court of Appeals held that when the insured settled a lawsuit without the approval of the medical payment insurer, he essentially violated the plain language of the make-whole doctrine. This, however, seems to be an overly-technical reading of the Ohio Supreme Court's holding in *James*. Be that as it may, it would be prudent to notify the subrogated party of the settlement prior to its conclusion, along with an assertion of the make-whole doctrine, to give the insurance company an opportunity to assert its rights directly.

Alternatively, the attorney can request that the tortfeasor insurance company issue separate drafts – one for the undisputed amount to be payable to the attorney and the client, and one for the subrogated amount with the insurance company's name added. This alternative will allow the insurance company to waive its subrogation voluntarily under the make-whole doctrine; and, failing a voluntary waiver, it will allow a declaratory judgment action to proceed without the defense of interference-with-subrogation.

In any event, the battlefield now appears to have evolved to the next phrase to be defined – make-whole. The make-whole test is going to be the focus of many cases to come, and will no doubt inspire creative arguments on both sides.

C. What Does Make-Whole Mean?

Some cases present clear examples of a lack of full compensation. For instance, in *Quintero, supra*, the trial court found that the plaintiff had not been made whole because the net recovery after payment of legal fees, medicare liens, and litigation expenses, left the plaintiff with $35,444.32, which the court found would likely be consumed by nursing home expenses that were projected to be $73,344 over the remainder of his expected lifetime.

In *Hrenko*, the Supreme Court implicitly found that *Hrenko* had been made whole by his $42,000 settlement with his uninsurance carrier, whose limits evidently exceeded the settlement. Some courts have left their imprint on the definition by applying a default rule of three-times specials.[36] In *National City Corp. v. Miller*, the district court held that the injured parties had been made whole by their $300,000 recovery from available insurance where they failed to present evidence that "their physical injuries and the sequellae ... were so disproportionate to their medical bills [$65,841.86] as to justify an extreme departure from the usual 'rule of thumb' of tripling medical expenses to arrive at a fair settlement."[37]

Other cases are less clear. When determining whether or not a injured party has been made whole by their recovery, a review beyond merely the medical and wage damages is required. In fact, it has been held in make-whole cases that the court needs to consider not only the medical expenses involved in the case, but also the pain and suffering of the injured person.[38] In *Toledo Area Construction Workers v. Lewis*, for example, the United States District Court for the Northern District of Ohio, Western Division, held that "[u]nder the make-whole doctrine, [the insured is] entitled to recover for both medical expenses and pain and suffering from the accident."[39]

Also, the Ohio Jury Instructions require the trier of fact to consider a great deal more than just medical expenses in determining compensation. These measures of compensation should be employed even where a case has not been presented to a jury, because they accurately reflect damages which people are legally entitled to recover in the State of Ohio.[40] In the dispositive motions that are filed, attorneys for the injured party should argue, for instance:

> Had this case proceeded to a jury trial, the jury would have been instructed, in part, to consider the following elements of damages: the nature and extent of the injury; the effect upon physical health; the pain and suffering experienced; the ability or inability to perform usual activities; lost wages; the reasonable cost of necessary medical and hospital expenses incurred; interference with activities of daily living; future medical expenses; and pain and suffering; impairment of earning capacity; and permanency.[41]

To support the argument that the injured party has not been made whole, the reports that were gathered from doctors and vocational specialists should be converted into affidavits to attach to the dispositive motion. Also, affidavits may be obtained from an insurance adjuster, an attorney with experience evaluating injury cases, and lay witnesses that could have been called at trial.

Some courts have said that whether a person has been made whole creates a jury question, and thus an actual trial may need to be conducted.[42] In applying the make-whole rule in *Grine v. Payne, supra*, a bench trial was conducted to determine the extent of the injured person's damages, and the trial court made a specific monetary designation for medical bills ($53,395.42) and pain and suffering ($115,000), which put Grine's damages above the available total recovery of $100,000.[43] Thus, the Sixth District was able to sustain the trial court's finding that Grine had not been made whole.[44]

Although there is a clear consensus that all damages to which a person may be legally entitled to recover should be included in the make-whole analysis, **there does not appear to be a consensus among courts, as of yet, on the manner in which the make-whole analysis is to be conducted. Some have conducted the analysis through dispositive motions, while others have said the make-whole** analysis creates questions of fact.

D. Statutory Liens: Workers' Compensation, Medicaid, and Medicare:

As noted above, the make-whole doctrine has been applied to statutory liens in the workers' compensation context.[45] Pursuant to R.C. §4123.931, a workers' compensation claimant provided a "statutory subrogee" with a right of subrogation against a third party for past payments of compensation, medical benefits, future compensation, and future medical benefits.[46]

In *Moellman v. Niehaus, supra*, the First District held that an injured employee had priority to the tortfeasor's $12,500 liability limits over the self-funded employer who had paid $23,000 in workers' compensation medical treatment and lost wages.[47] The First District gave priority to the recovery to the employee until the employee was fully compensated.[48] Notably, the First District cited R.C. §4123.95, which provide that the workers' compensation statutes are to be "liberally construed" in favor of employees and the dependents of de-

ceased employees.[49] The First District also noted that R.C. §4123.931(D) gave an employee the option of obtaining a special verdict or jury interrogatories indicating that a jury award represents damages other than medical expenses and compensation.[50] Importantly, damages other than medical expenses and compensation are not subrogated under R.C. §4123.931(D).[51] Finally, the workers' compensation statute provided a right to attorney fees and costs of the action.[52]

The right to subrogation under the Medicaid statute is very similar to the workers' compensation statute.[53] Like the workers' compensation statute, when public assistance is provided under Medicaid, the Medicaid statute provides a right of subrogation for medical services and care "arising out of injury, disease, or disability of the public assistance recipient or participant."[54] The Department of Job and Family Services is subrogated to "the entire amount of any settlement or compromise of the action or claim, or any court award or judgment." Attorney fees and costs or other expenses incurred by the recipient are not subject to subrogation.[55]

Although the make-whole doctrine has yet to be applied in Ohio in the Medicaid context, a good argument can be made that the make-whole doctrine ought to apply to Medicaid benefits based upon the similarity in language in the Medicaid statute as compared with the workers' compensation statute and based on the holdings in *Hrenko, supra*, and *Moellman v. Niehaus, supra*. Also, if the tortfeasor qualifies for immunity under the law of governmental immunity, the right of subrogation is defeated by the immunity of the tortfeasor.[56] Finally, even though the Medicaid statute does provide for subrogation, there is no right of subrogation where the Ohio Department of Human Services fails to provide proof of the total amount of the medical payments, proof that the medical payments were proximately caused by the defendant, and proof that the subrogee was entitled to recover, thus, entitling ODHS to recover.[57]

As with workers' compensation and Medicaid, the federal government has reserved a right of subrogation.[58] Medicare issues a conditional payment in exchange for a right to reimbursement from other sources such as workers' compensation law, a plan of the United States or a State, an automobile or liability insurance policy or plan, or under no fault insurance.[59] The United States is subrogated "to the extent of payment made under" Medicare for "such an item or service."[60]

As with Medicaid, the make-whole doctrine has yet to be applied to Medicare in any reported decision. Pursuant to *Marshall v. Employers Health Ins. Co., supra*, and its progeny, however, a fair argument can be made that Medicare is not entitled to be reimbursed unless the Medicare statute is read to "conclusively disavow" the make-whole default rule and to require that priority to any and all funds be given to Medicare.

CONCLUSION

In order to apply the make-whole doctrine, there must be a multi-step analysis: 1) is there a right of subrogation being claimed; 2) has the insurance company failed to explicitly and unambiguously disavow the make-whole doctrine; 3) has the injured person exhausted all available sources of compensation; and 4) has the injured person received less than full compensation from all available sources. **If each of these components is answered in the affirmative, the insurance company has, in effect, no enforceable subrogation rights.**

1. *Hiney Printing Co. v. Brantner* (6th Cir. 2001) 243 F.3d 956 (quoting *Copeland Oaks v. Haupt* (6th Cir. 2000), 209 F.3d 811, 813).

2. *Id.*

3. (1995), 72 Ohio St.3d 120, 121, 647 N.E.2d 1358, 1359.

4. *Marshall v. Employers Health Ins. Co.* (6th Cir. 1997), No. 96-6063, 1997 WL 809997, unreported.

5. See *Hrenko, supra*, at 1359.

6. *Id.*

7. *Id.*

8. *Id.*

9. *Id.* at 1360.

10. *Id.* at 1359, syllabus, (emphasis added) (citing *James v. Michigan Mut. Ins. Co.* (1985), 18 Ohio St.3d 386, 481 N.E.2d 272).

11. See *Central Reserve v. Hartzell* (Nov. 30, 1995), 1995 WL 768553, Tuscarawas App. No. 94AP120094, unreported.

12. *Moellman v. Niehaus* (Feb 5, 1999), Hamilton App. No. C-971113, unreported (injured employee had priority to tortfeasor's $12,500 liability limits, over employer who had paid $23,000 in workers compensation medical treatment and lost wages); *Porter v. Tabern* (Sept. 17, 1999), Champaign App. No. 98-CA-26, unreported (health carrier not subrogated to $50,000 recovery from tortfeasor and $50,000 from underinsurance carrier where medical bills were over $60,000, and lost wages were $39,337.60); *Grine v. Payne* (March 23, 2001), Wood App. No. WD-00-044, unreported (health carrier not subrogated to $25,000 recovery from tortfeasor and $75,000 recovery from underinsurance carrier where medical bills totaled $53,395.24 and a finding through a bench trial that the Participant's damages for pain and suffering were $115,000).

13. *Marshall v. Employers Health Ins. Co.* (6th Cir. 1997), No. 96-6063, 1997 WL 809997, unreported; *Copeland Oaks v. Haupt*. (2000 6th Cir.), 209 F.3d 811; *Hiney Printing Co. v. Branter* (6th Cir. 2001), 243 F3d 956 (applying making whole doctrine to reimbursement provision); *QualChoice, Inc. v. Williams* (March 13, 2000 6th Cir.), No. 1:99CV0701, 2000 U.S. Dist. LEXIS 7504, unreported; *Lamp v. Community Insurance Company*, No. 4:99 CV 1454, 2000 U.S. Dist. LEXIS 11426, unreported; *Community Ins. v. Ohayon* (N.D. Ohio 1999), 73 F.Supp.2d 862, 866; *Community Ins. v. Quintero* (October 19, 2001), N.D. Ohio U.S. Dist. W.D., No. 3:00 CV 766, unreported.

14. *Hrenko, supra.*

15. *Marshall, supra.* Non-ERISA plans would fall under *Hrenko*, thus, the state laws on subrogation would apply.

16. *Id.*

17. *Hiney Printing Co. v. Branter* (6th Cir. 2001), 243 F3d 956 (applying making whole doctrine to reimbursement provision); *QualChoice, Inc. v. Williams* (March 13, 2000 6th Cir.), No. 1:99CV0701, 2000 U.S. Dist. LEXIS 7504, unreported; *Community Ins. v. Quintero* (October 19, 2001), N.D. Ohio U.S. Dist. W.D., No. 3:00 CV 766, unreported.

18. *Id.*

19. *Johnson v. Progressive Insur. Co.* (Dec. 23, 1999), Lake App. No. 98-L-102, 1999 WL 1313672, unreported.

20. *Erie Ins. v. Kaltenbach* (1998), 130 Ohio App.3d 542, 720 N.E.2d 597.

21. *Nationwide Ins. Co. v. Rice* (Dec 28, 2000), Muskingum App. No. CT 2000-0020, 2000 WL 1902428, unreported (case remanded for clarification of summary judgment order – whether summary judgment in favor of auto insurer was based upon equitable subrogation or contractual subrogation); *Johnson, supra* ("If we assume Progressive has equitable subrogation rights, in granting summary judgment, the trial court erred in precluding Johnson from raising the issue of full compensation in this action.").

22. *Moellman v. Niehaus* (Feb 5, 1999), Hamilton App. No. C-9711113, 1999 WL 49370, unreported.

23. *Holeton v. Crouse Cartage Co.* (2001), 92 Ohio St.3d 115, 748 N.E.2d 1111 (finding R.C. 4123.931 to be unconstitutional).

24. See Part D, Statutory Liens: Worker's Compensation, Medicaid and Medicare, *infra*.

25. *Copeland Oaks, supra* (citing Marshall v. Employers Health Ins. Co. 1997 WL 809997 (6th Cir.1997).

26. (2000 6th Cir.) 209 F.3d 811.

27. *Id.*

28. *Lamp v. Community Insurance Co.*, No. 4:99 CV 1545, 2000 U.S. Dist. LEXIS 11426 at *7, unreported.

29. *Id.*

30. *Id.* at *7-8.

31. See also *Hiney Printing Co. v. Brantner* (6th Cir. 2001) 243 F.3d 956 where the plan language was held ambiguous that read:

Right of Subrogation: The Plan shall be subrogated to the extent of any payments under this Plan of health coverage to all of the Plan Member's right of recovery therefore irregardless [sic] of the entity or individual from who the recovery may be due...The Plan will have the right, at its discretion

and Plan Administrator's sole instigation, to take legal action on behalf of the insured or on behalf of the Plan itself. Any amounts so recovered, however designated, shall be apportioned as follows: this Plan shall be reimbursed to the extent of its payments under this plan of health coverage. If any balance then remains from such recovery, it shall be applied to reimburse the Plan Member and any other policy providing benefits to the Plan Member as their interest may appear.

Reimbursement: If the Plan member recovers damages from any party or through any coverage named above, he must hold in trust for the Employer the proceeds of the recovery, and must reimburse us to the extent of payment made.

And also, the provision in *Qualchoice, Inc. v. Williams*, 2001 U.S. Dist. No. 00-3485 (6th Cir. 2001), unreported, read:

You agree to protect our lien rights if you are injured or become ill through the act of a third party. If you are due money from such third party for the cost of such Covered Services, we will have the right to bring suit against such third party in your name to the extent permitted b applicable state law. *If you receive payment, however designated, from a third party, you are obligated to reimburse us, less our pro rata share of the reasonable attorney's fees and costs you sustained in obtaining such recovery.*

32. *Community Health Insurance Plan of Ohio v. Mosser*, 1999 U.S. Dist. No. 99-CV-961, unreported. The U.S. District Court for the Southern District of Ohio held that the ERISA plan language stating that the ERISA plan "has a right of recovery against any person, firm, or organization..." was broad enough to establish the plan's priority to any funds recovered by the employee. The participant has appealed.

33. See *Hiney Printing, supra*, and *QualChoice, supra.*

34. *Erie Ins. v. Kaltenbach* (1998), 130 Ohio App.3d 542, 720 N.E.2d 597 ("We hold that ... Kaltenbach was fully compensated for his injury, and even if he was not, the full-compensation rule does not apply because of Kaltenbach's interference with Erie's recovery rights...."). In addition, some insurance companies have argued that any settlement equates to a finding of full compensation. See *Johnson v. Progressive, supra*. However, the Eleventh District reversed this finding, stating, "The trial court adopted the view that by settling his claims Johnson was necessarily fully compensated. This is erroneous." *Id.*

35. *James v. Michigan Mut. Ins. Co.* (1985), 18 Ohio St.3d 386, 387, 481 N.E.2d 272, 274 ("Where an insured has not interfered with an insurer's subrogation rights, the insurer may neither be reimbursed for payments nor seek setoff from the limits of its coverage until the insured has been fully compensated for his injuries.).

36. *National City Corp. v. Miller* (Jan. 22, 1998), N.D. U.S. Dist. W.D., No. 3:96 CV 7449, unreported.

37. *Id.*

38. See *Toledo Area Construction Workers Health & Welfare Plan v. Lewis*, 1997 U.S. Dist. LEXIS 21759 (N.D. Ohio Dec. 2, 1998), unreported.

39. *Id.* See also *Lamp, supra*, ("But there is nothing to indicate that the $12, 500 Autumn Lamp was paid from Leatherberry's insurance was for 'medical expenses' as opposed to any other type of compensation to which Lamp might have been entitled.").

40. See personal injury damage instructions, O.J.I., 23.01 *et seq.*.

41. *Id.*

42. *Johnson v. Progressive Ins. Co.* (Dec. 23, 1999), Lake App. No. 98-L-102, 1999 WL 131672, unreported ("whether or not he was fully compensated, and what he was compensated for, are questions of fact.... This review cannot be done in a summary judgment if there are disputed questions of fact.").

43. See *Grine* at footnote 11.

44. *Id.*

45. See *Moellman v. Niehaus* (Feb 5, 1999), Hamilton App. No. C-971113, unreported.

46. See R.C. §4123.93.

47. *Moellman*, at *2, ("We note that the trial court did not deny that Tru Green had a right of subrogation. It merely held that Moellman's claims had priority over Tru Green's claim until they were fully compensated.")

48. *Id.* (citing *Blue Cross Blue Shield v. Hrenko, supra*, and *Central Res. Life Ins. Co. v. Hartzell, supra).*

49. *Id.* at *3.

50. *Id.*

51. *Id.*

52. *Id.*

53. See R.C.§5101.58.

54. *Id.*

55. *Id.*

56. See *McCaslin v. Ohio Department of Human Services* (1995), 104 Ohio App.3d 495, 662 N.E.2d 835, 837 (Ohio Department of Human Services subrogation rights under the Medicaid statute were defeated due to the immunity of the tortfeasor.).

57. See *Isabell v. Kaiser Foundation Health Plan*, 85 Ohio App.3d 313, 619 N.E.2d 1055, 1058.

58. See 42 U.S.C. §1395(b)(2)(A).

59. See 42 U.S.C. §1395y(b)(2)(A)(i) to (b)(2)(B)(ii).

60. See 42 U.S.C. §1395y(b)(2)(B)(iii). OT