SITF, *"What Is It and How Does It Work?"*

Introduction

The Subsequent Injury Trust Fund is a state agency created by statute in 1977. The purpose of the Fund is to encourage employers to hire or to retain employees with certain physical handicaps by reimbursing these employers when such an employee suffers a work-related injury which is somehow made worse because of the preexisting condition. In order to obtain reimbursement from the Fund for amounts paid on the claim, the employer must be able to show that it was aware of the preexisting condition either at the time the employee was hired or at some point prior to the subsequent injury and that the employer considered the condition to be a hindrance or obstacle to employment. The employer must also be able to show that there has been a "merger" between the preexisting condition and the subsequent injury. The issue of merger will be dealt with more extensively later in this paper but, in general terms, merger means that there has been some type of interaction between the preexisting condition and the subsequent injury which operates to increase the employer's exposure on the workers' compensation claim.

Assuming these requirements have been met, there is a phased-in reimbursement for medical expenses after the first $5,000.00 of medical expense and there is reimbursement of indemnity benefits after 104 weeks of benefits have been paid. The Fund will also reimburse settlement proceeds under certain conditions.

Employer Knowledge

Perhaps the starting point of any potential claim to the SITF is establishing that the employer had advance knowledge of the preexisting impairment. See O.C.G.A. § 34-9-361. With the advent of the Americans with Disabilities Act, it has become somewhat more problematic to obtain this knowledge at the time of hire. An employer who is subject to the ADA is not allowed to inquire about physical impairment at the initial stage of the application process. It is only permissible for the employer to inquire about the employee's qualifications for the job. It is possible to ask in a very carefully crafted question whether the employee has any conditions which might affect his ability to perform the essential functions of the position for which he is applying either with or without reasonable accommodations. The employer must be very careful not to give the impression that it is screening applicants based on physical ability without regard to the reasonable accommodations which that employer might be able to make.

Assuming that the applicant is qualified for the position by virtue of previous experience, training, etc. and once a conditional offer of employment has been made, the employer is allowed to send the employee for a preemployment physical and, at that stage, the employee may be asked questions about his or her health history with a view towards identifying physical conditions which would

prevent the employee from being able to perform the essential functions of the job. Please also note that under the ADA, the employer's obligation does not end with simply identifying a physical inability to perform the essential functions of the job, the employer must also determine whether there are any reasonable accommodations which can be made to allow the employee to perform the essential functions of the position. A further discussion of this process is beyond the scope of this paper, but the employer is cautioned to be mindful of the requirements of the ADA anytime it attempts to determine information from the employee about his medical condition.

The employer's knowledge of the preexisting impairment may also be obtained after the employee is hired. The statute, O.C.G.A. § 34-9-361 merely requires that the employer gain this knowledge prior to occurrence of the subsequent injury.

It is important to note that the statute defines "permanent impairment" as:

"...any permanent condition due to previous injury, disease, or disorder which is, or is likely to be, a hindrance or obstacle to employment or to obtaining reemployment if the employee should become unemployed." O.C.G.A. § 34-9-351(2)

Thus, the permanent impairment does not necessarily have to result from some injury or condition which carries a rating pursuant to the A.M.A. Guides. Any previous condition which affects the employee's ability to perform his job might qualify.

The knowledge requirement is actually two-fold. In addition to simply being aware of the preexisting condition, the employer must also be able to satisfy the Fund that it considered the preexisting condition to be a hindrance or obstacle to employment. In practice, this means that the employer must be able to show how the preexisting condition limited the employee in the performance of his duties. Alternatively, the employer may meet this knowledge requirement by establishing that it knew that the preexisting condition increased the propensity for sustaining a reinjury or that the condition is a known complicating factor to any injury.

The legislature recognized that certain types of preexisting conditions are so well known to create a hindrance or obstacle to employment or to so complicate the recovery from a subsequent injury that it established that the employer merely has to show knowledge of the condition and it is then presumed that the employer considered the condition to be a hindrance or obstacle to employment. These conditions are listed in O.C.G.A. § 34-9-361:

"It shall be incumbent upon the employer to establish that the employer had reached an informed conclusion prior to the occurrence of the subsequent injury or occupational disease that the preexisting impairment is permanent and is likely to be a hindrance or obstacle to employment or reemployment. Where, however, the employer establishes knowledge of the preexisting permanent impairment

prior to the subsequent injury, there shall be a presumption that the employer considered the condition to be permanent and to be, or likely to be, a hindrance or obstacle to employment where the condition is one of the following:

(1) Epilepsy;

(2) Diabetes;

(3) Arthritis which is an obstacle or hindrance to employment or reemployment;

(4) Amputated foot, leg, arm, or hand;

(5) Loss of sight of one or both eyes or a partial loss of uncorrected vision of more than 75 percent bilaterally;

(6) Residual disability from poliomyelitis;

(7) Cerebral palsy;

(8) Multiple sclerosis;

(9) Parkinson's disease;

(10) Cardiovascular disorders;

(11) Tuberculosis;

(12) Mental retardation, provided the employee's intelligence quotient is such that he falls within the lowest 2 percent of the general population; provided, however, that it shall not be necessary for the employer to know the employee's actual intelligence quotient or actual relative ranking in relation to the intelligence quotient of the general population;

(13) Psychoneurotic disability following confinement for treatment in a recognized medical or mental institution for a period in excess of six months;

(14) Hemophilia;

(15) Sickle cell anemia;

(16) Chronic osteomyelitis;

(17) Ankylosis of major weight-bearing joints;

(18) Hyperinsulism;

(19) Muscular dystrophy;

(20) Total occupational loss of hearing as defined in Code Section 34-9-264;

(21) Compressed air sequelae;

(22) Ruptured intervertebral disc; or

(23) Any permanent condition which, prior to the occurrence of the subsequent injury, constitutes a 20 percent impairment of a foot, leg, hand, or arm, or of the body as a whole."

Please note that the statute sets out a presumption that an employer who was aware of one of these conditions prior to the subsequent injury considered it to be a hindrance or obstacle to employment, but it is not a conclusive presumption. The Fund can, and sometimes will, challenge this presumption if it discovers evidence which tends to show that the condition was not, in fact, a hindrance or obstacle to employment.

Proof of the employer's knowledge is typically first established by having a representative of the employer complete an employer's knowledge affidavit on a form required by the Fund. The Fund is quite particular that the knowledge affidavit which is submitted be the most recent incarnation of the form and that the original of the affidavit must be submitted. The form requires the employer to state how it received knowledge of the prior impairment, why the employer considered the impairment to be permanent, and how the impairment created a hindrance or obstacle to employment. The Fund is increasingly likely these days to request documentation from the employer's file to back up this knowledge, such as an employment application or a preemployment physical which discloses the condition or group medical records or perhaps even records of a prior workers' compensation claim, if the condition arose in that fashion. The Fund will typically request a letter from the employer on its letterhead certifying that such records came from the employer's file.

Notice and Filing Requirements

The employer/insurer must notify the Fund of a potential claim within 78 calendar weeks of the date of the subsequent injury or before 78 weeks of income benefits have been paid, whichever occurs later. O.C.G.A. § 34-9-362. Thus, a notice of claim filed with the Fund could still be timely more than 78 weeks after the accident if less than 78 weeks of income benefits had been paid by that point. The notice of a potential claim should be filed using a "notice of claim" form supplied by the Fund. The notice needs to be filed with the administrator of the Fund. Filing a notice of claim with the Board and not with the Fund does not provide proper notice to the Fund and will not toll the 78-week statute of limitations.

The notice of claim form supplied by the Fund allows the employer/insurer to identify the particulars of their claim, but it is not required to simply toll the running of the 78-week statute of limitations. All that is required is that the

identifying information, such as the claimant's name, social security number, accident date, and addresses of the employer and insurer be completed. Note that there is a block that can be checked to indicate that you are simply filing to toll the statute of limitations. The remainder of the form can be left blank except for the signature lines. The employer should send the original of the form to the administrator of the Fund along with a copy and request that the Fund return a filed-stamped copy so that proof of filing can be shown at a later time, if necessary. Considering the ease with which the 78-week statute of limitations can be tolled, a notice of a potential claim should be filed whenever there is even a remote possibility of a claim.

When the Fund receives the notice of claim, they will assign a file number which should be referenced on all future communications with the Fund. They will also respond with a short letter indicating that the claim was being filed to simply toll the statute of limitations indicating that they assume that it will be pursued at a later time. If the file is not pursued, the Fund will put the file into an inactive stage, but the employer/insurer can request that the Fund reactivate the file at anytime.

Merger

Perhaps the area most frequently litigated is the requirement that there be a merger between the preexisting permanent impairment and the subsequent injury. O.C.G.A. § 34-9-351 states that merger means,

(A) Had the preexisting permanent impairment not been present, the subsequent injury would not have occurred;

(B) The disability resulting from the subsequent injury in conjunction with the preexisting permanent impairment is materially, substantially, and cumulatively greater than that which would have resulted had the preexisting permanent impairment not been present, and the employer has been required to pay and has paid compensation or that greater disability; or

(C) Death would not have been accelerated had the preexisting permanent impairment not been present.

What this means is that merger can be proven in one of two different ways. The merger theory contained in O.C.G.A. § 34-9-351(1)(A) involves a direct causal connection between the preexisting permanent impairment and the subsequent injury. For example, an employee with a preexisting back injury who aggravates that condition. Under this scenario, it is typically fairly easy to establish that the subsequent injury, i.e. the aggravation, would not have occurred but for the fact that the employee's back was already injured. There would thus be a direct cause-and-effect relationship between the two conditions and merger would have occurred.

Note that this type of merger might also be shown in claims involving the so-called "fictional new injury" rule established by such cases as Zurich Ins. Co. v. Cheshire et al., 178 Ga. App. 539, 343 S.E.2d 753 (1986). The rule established in this line of cases is that where an employee is injured but continues to work and becomes disabled at a later date, the accident date is taken to be the date that he is forced to discontinue his employment. Thus, an employee who suffers a back injury but continues to work with no lost time, might have a qualifying pre-existing permanent impairment if the employer can show how the back injury created a hindrance or obstacle to employment. When he becomes disabled, the date of disability is the subsequent injury.

Expect the Fund to examine a "fictional new injury" case very closely. They may argue that the prior impairment and the subsequent injury are really the same condition and that there has been no true "subsequent injury." However, the Fund has lost a case at the Court of Appeals on facts very close to this. In Subsequent Injury Trust Fund v. Hanson Injustries et al., 211 Ga. App. 700, 440 S.E.2d 89 (1994), the employee suffered from a prior impairment identified as "venous insufficiency." Over several years, the employee had to be transferred to different positions to accommodate her condition. She subsequently contracted a bacterial infection which was facilitated and exacerbated by her poor circulation. The Board found that the employee's job duties aggravated her condition to the point that she became disabled. When the employer submitted a claim to the Fund, contending that there had been a subsequent injury, the Fund denied it. The Fund argued that the prior impairment and the subsequent injury were really one in the same and that there was therefore no "subsequent injury." The Court of Appeals rejected this argument finding very simply that the employee had a prior impairment, was later injured on the job, and that the employer was entitled to reimbursement. Thus, any slow developing condition such as the gradual onset of back problems, cumulative trauma disorders, etc. should be examined for the possibility of a claim to the Fund. At the very least, a notice of claim should be filed with the Fund to toll the statute so that it can be pursued later.

Direct cause-and-effect merger under O.C.G.A. § 34-9-351(1)(A) may also be proven even where there are two different body parts involved. For example, a direct cause-and-effect merger would occur where an employee with a preexisting knee injury falls as the result of his knee giving way and injures his back. The back injury would not have occurred but for the preexisting knee condition, and merger would be satisfied.

The second way in which merger can be proven is through what is commonly called a "combined effects" theory. This is the theory described in O.C.G.A. § 34-9-351(b). If the employer can establish that the employee's overall disability following the subsequent injury is "materially, substantially, and cumulatively greater" because of the combined effects of the prior impairment and the subsequent injury, then merger will also be proven. For example, merger may exist where an employee with a preexisting permanent back injury later sustains an injury to his knee such that he is effectively totally disabled because of the combined effects of the two conditions. Note that the resulting disability must be

"cumulatively" greater which means that the restrictions resulting from the two conditions must not overlap. For example, an employee with a preexisting permanent impairment to his knee who later sustains an injury to his foot on the same leg would probably not have a cumulatively greater disability, since he was already laboring under work restrictions involving the leg.

The Fund can be particularly demanding in accepting this type of merger. The Fund will invariably argue that if the subsequent injury is the "principal factor" inhibiting the claimant's ability to return to work, then the resulting overall disability is not "materially, substantially, and cumulatively greater" and, thus, merger had not occurred. In support of this, the Fund relies upon the Georgia Court of Appeals case of JPS Carpets, et al. v. Troupe, 203 Ga. App. 602, 417 S.E.2d 333 (1992). In that case, the claimant had a preexisting knee injury; then tripped and fell, injuring her shoulder. The employer argued that the claimant fell because of her weak knee, but the ALJ was not convinced that there were sufficient facts to establish this and denied the cause-and-effect merger theory. The employer next argued that the claimant's overall disability, considering the effects of her prior knee injury and the subsequent shoulder injury, was "materially, substantially, and cumulatively greater" and, thus, that her employability was substantially worse because of the preexisting condition. The ALJ denied this theory as well and the decision was subsequently affirmed all the way through to the Court of Appeals. In affirming the decision of the ALJ, the court stated that,

". . . the focus of O.C.G.A. § 34-9-351(1)(B) is not merely the cumulative effect of the injuries but requires that the disability resulting from the subsequent and preexisting injuries be 'materially, substantially, and cumulatively greater than that which would have resulted had the preexisting permanent impairment not been present' [cites]. The Board considered the effect of the injuries on Troup's ability to maintain employment and determined that the principal factor inhibiting her ability to return to work was the impairment of her right arm [cites]; that her disability, within the meaning of the Workers' Compensation Act resulted primarily from the (subsequent injury); and, therefore, pursuant to O.C.G.A. § 34-9-351(1)(B), that the disability resulting from the two injuries was not greater than that which would have resulted had the preexisting injury not been present."

So what does all this mean? In cases of "combined effects" merger, you will have an employee with a preexisting impairment who has returned to work. It is, of course, the subsequent injury which immediately causes him to be disabled. The Fund will then argue that it is the subsequent injury alone which prompts the employee's disability, will cite JPS Carpets v. Troup, *supra* and will contend that merger has not occurred. If you stop to think about it, painting this scenario with such a broad brush would mean that "combined effects" merger could never occur, since it is, of course, the subsequent injury which always prompts the employee to become disabled.

But it is possible to avoid this logical trap. If, for example, the employer can establish that the employee was limited to a certain range of jobs because of the

prior impairment and that, because of the subsequent injury there are no other positions available to him, then combined effects merger can be proven. For example, consider the employee in JPS Carpets v. Troup. If the employer could have established that, with her bad knee, the employee was only able to operate a certain machine in the plant because it allowed her to sit and operate it exclusively with her arms but then, because of the injury to her shoulder, she could not operate that device nor could she be transferred to a device that required use of her legs, then it can be shown that the resulting disability is "materially, substantially and cumulatively" greater, i.e. that the subsequent shoulder injury is not the only reason that the employee could not return to some position in the plant. The employer could then truthfully say that there is nothing in its plant which someone with a bad knee and a bad shoulder could do, since every position involves operating equipment using the feet or with the arms.

While this may seem to be a somewhat esoteric distinction, the result can have substantial financial impact on the company. Proving a combined effects merger, while not entitling the employer to reimbursement of medical expenses as will be explained more fully below, will result in reimbursement of indemnity benefits over 104 weeks as well as reimbursement of settlement proceeds. This is undoubtedly a tremendous advantage to the employer.

Apportionment of Medical Expenses

The manner in which merger is proven also affects the type of reimbursement available from the Fund. If a direct cause and effect merger is shown, i.e. that the subsequent injury was caused in some way by the prior impairment, then the Fund will reimburse both medical and indemnity benefits, since the employer's exposure for medical and indemnity benefits has been increased by virtue of the prior impairment. If, however, merger is satisfied through a "combined effects" theory, then the Fund typically will not reimburse medical expenses, because it is the employer's exposure for disability benefits which is increased by the combination of the two conditions but not the medical expenses. For example, consider the situation where an employee with a preexisting knee injury suffers a subsequent back injury. Assuming that the prior knee injury did not cause the back injury and assuming that the employer can show a "combined effects" merger by establishing that the employee's overall disability is greater because of the two conditions, then it is the exposure for indemnity benefits which has been increased by virtue of the preexisting condition. The medical expenses associated with the subsequent injury, the back injury, are not increased at all because of the fact that the employee had a preexisting knee condition.

The support for this position is found in the statute at O.C.G.A. § 34-9-364 which states, "the administrator of the Fund may apportion or deny the employer or insurer reimbursement from the Fund for medical expense provided by O.C.G.A. § 34-9-360 where there are clear and unequivocal facts to establish that the subsequent injury to the permanently impaired employee was not caused by or in any way related to the employee's preexisting disability." Thus, the general rule of thumb is that proving a direct cause and effect merger results in

reimbursement of medical and indemnity benefits but proving combined effects merger results only in reimbursement of indemnity benefits.

Reimbursement

Assuming that the Fund accepts a case for full reimbursement, i.e. both medical and indemnity benefits, then it will reimburse indemnity benefits once the employer has paid 104 weeks of indemnity benefits. Medical expenses are phased in once the employer has paid the first $5,000.00. Between $5,000.00 and $10,000.00 of total medical expense on the claim, the Fund will reimburse 50%. Above $10,000.00 of total medical and rehabilitation expense on the file, the Fund will reimburse 100%. Thus, the Fund essentially reimburses all but $7,500.00 of medical and rehabilitation expense. See O.C.G.A. § 34-9-360.

The Fund will not, however, reimburse an employer/insurer for its defense costs nor will the Fund reimburse assessed attorney's fees. See O.C.G.A. § 34-9-367. Additionally, the Fund will not reimburse interest on sums due claiming parties such as the statutory interest which runs on awards appealed past the level of the Appellate Division. The Fund can be liable itself, however, for assessed attorney's fees if it fails to accept a claim without reasonable grounds. O.C.G.A. § 34-9-367.

Keep in mind, however, that the Fund is only liable for reimbursement of indemnity, medical, and rehabilitation expenses that the employer or insurer was legally obligated to pay to the claimant. O.C.G.A. § 34-9-361(f). Likewise, the Fund is not bound by any legal order or award of the Board to which it was not a party. Thus, the Fund can, and sometimes does, challenge the claims-handling decisions of the employer/insurer and will argue that it is not required to reimburse benefits paid as a result of poor claim handling. For example, the Fund, when reviewing a case for reimbursement, will look for the first light-duty release given to the claimant. The Fund will then take the position that it is only liable for temporary partial disability benefits beginning 52 weeks after that light-duty release, because the employer/insurer could have filed a WC-104 and reduced benefits pursuant to O.C.G.A. § 34-9-104 whether or not a WC-104 was actually filed. Under these circumstances, the Fund will also take the position that the temporary partial disability benefits are payable for a maximum of 350 weeks from the accident date (which, of course, is true) and thus, refuse to make further reimbursement.

The Fund might also decide that a claim should have been controverted based upon the occurrence of a new accident. The Fund has been known to request hearings in order to prove the occurrence of a new accident even where the employer/insurer investigated the possibility and concluded there was none. Likewise, the Fund has been known to contest medical treatment which the employer/insurer deemed authorized and then to refuse reimbursement.

Thus, whenever the Fund has accepted a claim for reimbursement, they should be kept in the loop concerning all critical claim decisions. This is particularly true

on such issues as whether to pursue a new accident defense or whether to authorize a questionable medical procedure for treatment. In cases in which the Fund has not yet accepted the claim for reimbursement, it is also sometimes prudent to discuss the case with the Fund, particularly if there is substantial exposure involved.

Litigation Against the Fund

In the event that the Fund denies reimbursement, then the employer/insurer has the right to file for a hearing at the Board. The hearing request must be filed with the Board within 90 days of the receipt of the formal denial from the Fund. O.C.G.A. § 34-9-363(c). Failure to timely request a hearing will constitute a bar to recover from the Fund.

The Fund will assign their defense to a special assistant attorney general. Typically, there are only two or three of these attorneys who handle cases for the Fund state-wide. The hearing against the Fund proceeds much like any other workers' compensation hearing. The employer/insurer has the burden of establishing all of the elements for reimbursement but, typically, the Fund is willing to stipulate to certain undisputed issues. Most frequently, it is the issue of merger which is litigated.

Sometimes the Fund is willing to enter into an agreement for partial reimbursement in a closely contested case. Think of this as a "settlement" of the reimbursement issue. For example, the Fund might agree to a 75% reimbursement of medical and indemnity benefits above the threshold amounts.

Reimbursement Agreement

If the Fund accepts a claim for reimbursement, it will notify the employer/insurer by letter and then forward a reimbursement agreement. The agreement must be signed by a representative of the employer/insurer and returned to the Fund. It is then signed by the Administrator and sent to the Board for approval. The agreement does not take effect until approved by the Board.

Settlement

Once the Fund has accepted a claim for reimbursement, the employer/insurer must notify the Fund of a proposed settlement and must get advance authorization for the settlement from the Fund. O.C.G.A. § 34-9-363.1. If the employer/insurer settles a claim that has been accepted for reimbursement by the Fund without first obtaining the Fund's permission, the Fund has the right to request that the reimbursement agreement be rescinded and, under the statute, the Board has no recourse but to rescind the reimbursement agreement. Thus, once the reimbursement agreement has been rescinded, there will be no reimbursement of the settlement proceeds and, potentially, the Fund could ask for a return of any amounts already paid on the claim.

However, the employer/insurer is free to settle a claim without the prior consent of the Fund at any time before the Fund formally accepts the claim for reimbursement. But, since the Fund is not a party to the settlement agreement, they have no obligation to reimburse the full amount of the settlement. The Fund can, and sometimes does, take the position that the employer/insurer paid too much on the settlement and will only agree to reimburse a portion of the settlement.

To guard against this, if the employer/insurer is aware of a strong possibility of future reimbursement from the SITF, it should exercise great care in evaluating the case for settlement. As mentioned earlier, the Fund will review a file retroactively looking for the first opportunity that the employer/insurer could file a WC-104 and will only reimburse at the temporary partial disability rate beginning 52 weeks thereafter. The Fund will then sometimes take the position that the settlement value of the case is the present day value of the remaining 350 calendar-week entitlement to temporary partial disability benefits. The Fund also is unwilling to assume a future catastrophic designation, and so it rarely will reimburse a settlement in excess of the present day value of the balance of the 400-week maximum temporary total disability benefit entitlement. Because of these considerations, it may make better sense for the employer/insurer to delay settlement talks until after the Fund has accepted the claim for reimbursement.

The Fund will typically treat the settlement amount as indemnity benefits. Thus, in cases of combined effects merger where there is no reimbursement for medical expense, the Fund generally does not try to argue that a portion of the settlement amount constitutes foreclosure of future medical costs. Beware that the Fund might take a different approach if the language of the settlement agreement specifically sets out the amount attributed to settlement of the medical expense.

Subrogation and the Fund

An interesting situation is presented where there is a subrogation recovery on a claim which has been accepted for reimbursement by the Fund. Assume the employer/insurer has paid $150,000 to date on a claim. Once the Fund accepts the case for reimbursement, it essentially reimburses all medical expenses after the first $7,500 and all indemnity benefits after the first 104 weeks. At the current TTD rate, the threshold would be $36,400 for indemnity so the total threshold would be $43,900. The employer/insurer would therefore expect to receive $106,100 in reimbursement. The employer/insurer is then required to reduce its reserves to the threshold amounts. As additional medical and indemnity expense accrues, the employer/insurer may submit it for reimbursement.

Now assume that the accident was caused by the liability of a third party such that the employer/insurer has a subrogation lien pursuant to O.C.G.A. § 34-9-11.1. The employer/insurer has a lien against any recovery the employee makes to the extent of the indemnity and medical expenses paid. Let's say the employer/insurer recovers $75,000 on the lien. Who gets the money?

If the employer/insurer keeps it all, they actually make a profit of $31,100 since they have only paid out a total of $43,900 and have been reimbursed by the Fund for the rest. The employer/insurer is basically using the Fund's money to document their lien.

Should the employer be limited in its lien by the amount of un-reimbursed expenses? If so, that would mean that the employee gets a windfall.

What if the employer/insurer recovers on the lien before the Fund gets involved. Should the employer/insurer reduce the medical and indemnity expenses which it submits for reimbursement by the amount it recovered from the subro lien?

Maybe the employer/insurer and the Fund should split the money pro-rata based on the total amount each has paid on the claim. This might be the fairest approach but there is no statutory or case law on this point. As far as this author knows, there are no answers to these questions yet. The reader is cautioned to step carefully when dealing with the complex interaction between the SITF and our subrogation law.