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ARTICLES

Subrogation on Medical Expense Claims: The "Double Recovery" Myth and the Feasibility of Anti-Subrogation Laws

Roger M. Baron*

> Subrogation is a windfall to the insurer. It plays no part in rate schedules . . . ."
>
> Edwin W. Patterson[1]

I. Introduction

Subrogation enables an insurer who has indemnified an insured to "stand in the shoes" of the insured on the insured's claim for compensation against a third party, usually a tortfeasor. Ideally, the insured enjoys the benefit of receiving prompt indemnification for loss with the risk of ultimate recovery from the tortfeasor falling upon the insurer, who has been subrogated to the rights of the insured.[2] The doctrine of subrogation is of equitable origin,[3] and rights of subrogation have been honored without substantial controversy in mat-

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1. EDWIN W. PATTERSON, ESSENTIALS OF INSURANCE LAW 151 (2d ed. 1957).
2. *See generally* ROBERT E. KEETON & ALAN I. WIDISS, INSURANCE LAW § 3.10 (1988).
3. *Id.*

ters regarding *property* insurance.[4] The insurer's opportunity to pursue a subrogation claim has historically been founded on the notion that the wrongdoing third party should not be unjustly enriched by the fact of insurance coverage.[5] An insurer's right of subrogation may be granted contractually through the policy ("conventional subrogation"), by statute, or by judicial creation ("legal subrogation").[6]

The successful collection of a subrogated claim results in a "windfall" to the insurer[7] in the following sense: In paying the loss, the insurer simply pays an anticipated loss on a risk that has been actuarially distributed over a pool of similarly-situated insureds. The initial setting of the insurance premium for the transfer of the risk from the insured to the insurer encompasses the insured's pro-rata share of total estimated losses for the pool, as well as the insured's pro-rata share of the insurer's profit to be realized from the insurance undertaking.[8] The prospect of a successful subrogation collection is not a factor in the insurer's rate determination. In fact, the conjectural and remote nature of subrogation militates against including it as a factor in premium rate setting.[9] Thus, when an insurer pays out on an insured risk, any recovery that the insurer is able to obtain through subsequent subrogation is a "windfall" to the insurer.[10]

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4. JOHN ALAN APPLEMAN & JEAN APPLEMAN, INSURANCE LAW AND PRACTICE § 1675 (1967).

5. "Subrogation, which developed as an equitable doctrine, facilitates an adjustment of rights to avoid unjust enrichment in many types of situations by substituting one person or entity in place of another in regard to some claim or right the second person or entity has against a third party." *Id.*

6. *See* KEETON & WIDISS, *supra* note 2, § 3.10(a)(1).

7. PATTERSON, *supra* note 1 and accompanying text.

8. KEETON & WIDISS, *supra* note 2, § 3.13(b)(2).

> The policyholder purchasing insurance for a venture pays an insurer a premium which is calculated by estimating a number of factors, including (1) the proportionate part of the total predicted cost of meeting specified types of losses in the ventures that have been grouped by the insured into a "pool of risks," (2) appropriate amounts for a reserve fund in the event the total risk was underestimated, (3) the administrative costs of the insurer, (4) other expenses of doing business (including fees for sales representatives such as agents and brokers), and (5) profits for companies engaging in insurance as a business enterprise.

KEETON & WIDISS, *supra* note 2, § 3.13(b)(2).

9. Of course, if it were possible to accurately factor successful subrogation into the rate making process, the total projected losses would be much lower and the premiums would also be lowered.

10. *See* PATTERSON, *supra* note 1 and accompanying text. The observation that subrogation is a "windfall" to the insurer is not appropriate for self-insurers or self-funded plans where the insured's contribution for the transference of the risk is directly affected by individual losses as they arise.

II. The Extension of Subrogation Beyond Property Damage Claims

The doctrine of subrogation has its genesis in *property* insurance, an area of the law of subrogation that has remained fairly stable. Over the past thirty years, insurers have continually sought the creation and enforcement of subrogation rights for payments on medical expenses and other non-property claims. During this period, subrogation clauses have been inserted in first party medical payments coverage in automobile policies, uninsured and underinsured motorist coverage, and medical and hospitalization coverage. Initially, this expansion was successfully resisted by the common law prohibitions against the assignment of personal injury claims[11] and against the splitting of causes of action involving personal injuries.[12] The continued efforts of the insurance industry, however, eventually led many jurisdictions to either allow subrogation directly[13] on medical expense claims or to permit the same result by upholding insurers' revised policy language purporting to give the insurer the right to reimbursement[14] as opposed to subrogation.[15]

A. The Majority View: Subrogation Permitted on Non-Property Damage Claims

A majority view soon developed that permitted the insurance industry to effectively subrogate medical expense claims.[16] The ma-

11. *E.g.*, Wrightsman v. Hardware Dealers Mut. Fire Ins. Co., 147 S.E.2d 860, 861 (Ga. Ct. App. 1966) (noting that subrogation provision of the contract amounted to no more than agreement to assign personal injury claim and held provision void and of no effect).

12. *E.g.*, Nationwide Mut. Ins. Co. v. DeJane, 326 N.E.2d 701 (Ohio Ct. App. 1974). In *DeJane*, the court stated that, "We feel that by not permitting subrogation of medical expenses we are preserving the orderly nature of practice in this state by following the rule that one cannot split a cause of action, avoid multiplicity of suits and benefit the insured public and the public at large." *Id.* at 705. It should be noted that the court did recognize that subrogation on property damage claims was already an authorized exception to the prohibition against splitting a cause of action. *See id.* at 703-04.

13. *E.g.*, Smith v. Travelers Ins. Co., 362 N.E.2d 264 (Ohio 1977) (effectively overruling *DeJane*, 326 N.E.2d 701 (Ohio Ct. App. 1974)).

14. *E.g.*, Shook v. Pilot Life Ins. Co., 373 S.E.2d 813 (Ga. Ct. App. 1988). The court distinguished *Wrightsman*, 147 S.E.2d 860 (Ga. Ct. App. 1966), on the ground that the policy language in *Wrightsman* purported to create a right of subrogation, but actually constituted an assignment of the cause of action, while no such language was present in the *Shook* policy. Rather, the court reasoned that the *Shook* policy merely gave the insurer a right to be reimbursed for benefits paid on behalf of the insured to the extent of monies received by the insured from the tortfeasor "as a result of judgment, settlement or otherwise." *See Shook*, 373 S.E.2d at 814-15.

15. *But see* Lee v. State Farm Mut. Ins. Co., 129 Cal. Rptr. 271, 278 (Cal. Ct. App. 1976) (Friedman, J., concurring) (cumulative effect of policy provisions is to create economic reality of subrogation to personal injury claim without actually using language of subrogation).

16. Imel v. Travelers Indemnity Co., 281 N.E.2d 919, 921 (Ind. Ct. App. 1972) (The court "agree[d] with the majority of the jurisdictions which make a distinction between an assignment of a claim for personal injuries and subrogation of one's right arising from a per-

jority of courts reasoned that to disallow subrogation would enable the insured to have a "double recovery" for only one loss.[17] Thus, the "collateral source rule" that had traditionally permitted an injured plaintiff to collect from both the wrongdoing tortfeasor and the insurer was revised to avoid allowing the injured party an apparent "double recovery." The wrongdoing tortfeasor, who certainly should not benefit from the injured party's insurance, was still required to pay for the damages, but the tortfeasor's payment was channelled directly to the insurer by subrogation or indirectly through the hands of the insured by reimbursement.[18]

B. The Minority View: Anti-Subrogation on Non-Property Damage Claims

A small but solid minority of jurisdictions have rejected the insurance industry's attempt to expand subrogation beyond claims for property damage. Courts in Missouri[19] and Arizona[20] recognized that allowing subrogation on medical payment claims would be equivalent to "lifting the lid on a pandora's box crammed with both practical and legal problems."[21] The Missouri and Arizona courts have consistently kept the lid to "pandora's box" closed by refusing to honor tendered policy provisions that would accomplish the same result as subrogation by requiring repayment[22] or reimbursement[23] to the insurer from the proceeds of the insured's recovery from a third party. The Connecticut Supreme Court also endorsed the minority view in a case involving payment made for personal injuries on uninsured motorist coverage.[24] The court recognized that the allowance of subrogation would serve "to prejudice the ultimate ability

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sonal injury."). *See also* Schuldt v. State Farm Mut. Automobile Ins. Co., 238 N.W.2d 270, 271 (S.D. 1975) (noting that similar subrogation clauses have been upheld by the overwhelming majority of courts that have ruled on their validity).

17. *E.g.*, *Smith*, 362 N.E.2d at 266 (reasoning that to disallow subrogation would permit an injured plaintiff to recover twice for the same medical expenses).

18. *Lee*, 129 Cal. Rptr. at 275 (noting that "right given to the insurer according to the terms of the policy is not to the chose in action but is to the proceeds of settlement or judgment"). The court also discussed the collateral source rule. *See id.* at 274-75.

19. Travelers Indemnity Co. v. Chumbley, 394 S.W.2d 418 (Mo. Ct. App. 1965). This appears to be the leading case for the minority view, generating J.A. Bock's annotation, *Subrogation Rights of Insurer Under Medical Payment Provision of Automobile Insurance Policy*, 19 A.L.R.3d 1054 (1968).

20. State Farm Fire and Casualty Co. v. Knapp, 484 P.2d 130 (Ariz. 1971).

21. *Chumbley*, 394 S.W.2d at 425. *See also Knapp*, 484 P.2d at 181 (quoting *Chumbley*, 394 S.W.2d at 425).

22. Allstate Ins. Co. v. Druke, 576 P.2d 489 (Ariz. 1978).

23. Waye v. Bankers Multiple Line Ins. Co., 796 S.W.2d 660 (Mo. Ct. App. 1990).

24. Berlinski v. Ovellette, 325 A.2d 239 (Conn. 1973).

of the injured person to be compensated fully."[25]

The minority view has become increasingly popular. Recent decisions by the Nevada Supreme Court[26] and Montana Supreme Court[27] have fully endorsed the minority view. In both cases, the court noted its awareness of alignment with a distinct minority view,[28] but nevertheless held that public policy considerations dictated the result.[29] Pennsylvania follows the minority view by virtue of state statute.[30] The state of Oklahoma originally adopted the minority view,[31] then rejected it,[32] and, most recently, returned to the minority view as a result of legislative action.[33] Even jurisdictions following the majority view have not hesitated to apply the minority view of anti-subrogation when given the opportunity to do so through choice-of-law princples.[34]

III. It's Time to Reconsider the Minority View

The courts and legislatures of those states following the majority view should now reconsider the merits of the minority view and give a more in-depth analysis to public policy considerations. Reconsideration of the minority view is appropriate for three general reasons: (1) the recent recognition by the United States Supreme Court that even though anti-subrogation laws do not apply to self-funded ERISA plans, they do apply to regulated insurers insuring ERISA plans; (2) the idea that the insured injured party would enjoy a double recovery has been shown to be a myth; and (3) actual experience in those jurisdictions following the majority view demonstrates that the majority view prejudices the rights of the insured and en-

25. *Id.* at 242. Connecticut's subsequent statutory adoption of no-fault insurance has dramatically transformed the issue into one of reimbursement for reparations benefits. *See, e.g.*, Shelby Mut. Ins. Co. v. Ghelfa, 513 A.2d 52 (Conn. 1986).

26. Maxwell v. Allstate Ins. Co., 728 P.2d 812 (Nev. 1986).

27. Allstate Ins. Co. v. Reitler, 628 P.2d 667 (Mont. 1981).

28. *Maxwell*, 728 P.2d at 815 (court cognizant that it was adopting minority position). *See also Reitler*, 628 P.2d at 670.

29. *Maxwell*, 728 P.2d at 815 (holding that public policy rationales precluded insurer's subrogation of medical payments). *See also Reitler*, 628 P.2d at 670.

30. 75 PA. CONS. STAT. ANN. § 1720 (Supp. 1991).

31. Hardware Dealers Mut. Fire Ins. Co. v. Krueger, 486 P.2d 737 (Okla. 1971) (minority view adopted in case involving medical payments coverage in automobile policy).

32. Aetna Casualty and Surety Co. v. Associated Transports, Inc., 512 P.2d 137 (Okla. 1973) (specifically overruling *Krueger*, 486 P.2d 737 (Okla. 1971)).

33. Aetna Casualty and Surety Co. v. State Board for Property and Casualty Rates, 637 P.2d 1251 (Okla. 1981) (minority view re-adopted after legislative action). *See* PATTERSON, *supra* note 1; *see also supra* note 7 and accompanying text.

34. *E.g.*, State Farm v. Baker, 797 P.2d 168 (Kan. Ct. App. 1990) (upholding Missouri's anti-subrogation law in a case applying Missouri law to an accident that occurred in Kansas).

courages delay and non-payment of legitimate claims.

A. FMC Corp. v. Holliday: *The United States Supreme Court Distinguishes Self-Insurers from Regulated Insurers Providing an Impetus for Reconsideration of the Minority View*

In *FMC Corp. v. Holliday*,[35] the Supreme Court addressed whether the anti-subrogation law of Pennsylvania would prohibit subrogation by an ERISA health care benefit provider.[36] The plan at issue contained a subrogation clause under which a plan member agreed to reimburse the plan for benefits if the member recovered on a claim in a liability action against a third party.[37] Even though the plan member's medical expenses exceeded $178,000 and the plan member had recovered only $49,000 from the tortfeasor's liability insurer,[38] the plan demanded reimbursement.[39]

The plan member relied on Pennsylvania's Motor Vehicle Responsibility Law which denied either subrogation or reimbursement on such medical expenses.[40] The Supreme Court held that since the plan was self-funded, the provision of ERISA stating that employee benefit plans shall not "be deemed to be an insurance company"[41] controlled the issue of reimbursement.[42] Therefore, the court held that ERISA preempted application of the Pennsylvania statute to the self-funded employee benefit plan.[43] The Court did note that a regulated insurance company insuring an employee benefit plan *would be subject to the anti-subrogation law of Pennsylvania.*[44] The message was clear in *FMC Corp.* that only self-funded plans enjoyed the exemption and that regulated insurers must follow both direct and indirect state regulation.[45]

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35. 111 S. Ct. 403 (1990).
36. *Id.* at 405.
37. *Id.* at 405-06.
38. FMC Corp. v. Holliday, 885 F.2d 79, 80 (3d Cir. 1989).
39. FMC Corp. v. Holliday, 111 S. Ct. 403, 406 (1990).
40. *Id.*
41. *See* 29 U.S.C. § 1144(b)(2)(B) (1988).
42. *FMC Corp.*, 111 S. Ct. at 409.
43. *Id.* at 411.
44. FMC Corp. v. Holliday, 111 S. Ct. 403, 409 (1990). The Court stated that:
> On the other hand, employee benefit plans that are insured are subject to indirect state insurance regulation. An insurance company that insures a plan remains an insurer for purposes of state laws "purporting to regulate insurance" after application of the deemer clause. The insurance company is therefore not relieved from state insurance regulation. The ERISA plan is consequently bound by state insurance regulations insofar as they apply to the plan's insurer.

Id.

45. *Id.* The dissenting opinion in *FMC Corp.* criticizes the distinction made by the majority and would hold *both* regulated insurers and self-funded plans subject to the state's anti-

Subrogation results in a windfall to regulated insurers because subrogation claims are not anticipated when insurers set rates.[46] Conversely, the "windfall" effect of subrogation is non-existent in the self-insurance context because the insureds' contributions are determined by actual losses and subrogated recoveries. The Supreme Court's line-drawing between self-insurers and regulated insurers should serve as impetus for reconsideration of anti-subrogation's merits. The "windfall" aspect of subrogation, as well as the myth of a "double recovery," deserve analysis and consideration by those jurisdictions adhering to the majority view.

B. The Rationale of Anti-Subrogation[47]

The traditional resistance to subrogation of medical expense claims can be traced to common law principles that forbade the assignment of personal injury claims as well as res judicata principles that forbade the splitting of a cause of action.[48] The modern rationale for the prohibition of medical claim subrogation is the simple acknowledgment that the allowance of subrogation would prevent insureds from being fully compensated and would in fact *prejudice* insureds in their ability to be compensated at all.[49]

1. Prohibiting Subrogation Does Not Result in a "Double Recovery" by the Insured.—According to the majority view, denial of subrogation results in a "double recovery" for the insured.[50] A neces-

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subrogation law. *See id.* at 411-15 (Stevens, J., dissenting).

46. *See supra* notes 7-10 and accompanying text.

47. The principle of subrogation is at odds with the "collateral source rule." It has been suggested that the insured's right to payment from her insurer under the collateral source rule is protected under Article I, § 10 of the United States Constitution which forbids a state from impairing the "Obligation of Contracts." The argument is that "the 'collateral source rule,' like the exclusionary rule in fourth amendment jurisprudence, may not have explicitly textual constitutional basis," but is nevertheless worthy of constitutional protection. *See* John Barrow, *The Contracts Clause and the Collateral Source Rule*, 24 TRIAL 33, 36 (July 1988).

48. *See supra* notes 11-15 and accompanying text.

49. Berlinski v. Ovellette, 325 A.2d 239, 242 (Conn. 1973). The *Berlinski* court observed that:

> The reasons underlying the rule have been variously stated: unscrupulous interlopers and litigious persons were to be discouraged from purchasing claims for pain and suffering and prosecuting them in court as assignees: actions for injuries that in the absence of statute did not survive the death of the victim were deemed too personal in nature to be assignable; a tortfeasor was not to be held liable to a party unharmed by him: and excessive litigation was thought to be reduced . . . . The more modern cases suggest that such an assignment directly or indirectly serves to prejudice the ultimate ability of the injured person to be compensated fully.

Id.

50. *See supra* notes 16-18 and accompanying text.

sary predicate for this view is the notion that the insured's premium *only* guarantees the insured that the insured will be made whole from all sources. This notion alone may not be palatable. Arguably, the insured ought to be entitled to receive the insurance benefits for which she has paid a premium.[51] The insured made a conscious decision to purchase the insurance coverage and should receive the benefits of the investment.[52] Allowing the insurer subrogation results in a windfall to the insurer because the insurer retains a premium charged to cover an insured risk and, upon the occurrence of the risk, the insurer suffers no loss.[53]

Subrogation on non-property damage claims renders insurance coverage "illusory" because the insured receives nothing for the separate premium paid to the insurer when a tortfeasor is liable for damages.[54] The "illusory" nature of first party medical payments coverage in an automobile policy is even more apparent in those jurisdictions that statutorily require every driver of an automobile to be covered by liability insurance or other proof of financial responsibility. The innocent plaintiff would never collect on her own medical payments coverage because the third-party tortfeasor would always be financially responsible.

The insurer's "double recovery" argument would be more palatable if the prospect of subrogation had been initially factored into

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51. Allstate Ins. Co. v. Reitler, 628 P.2d 667, 670 (Mont. 1981). In *Reitler*, the court noted that "the insured has paid a premium for medical payments coverage . . . . The allegation that the insured will make a double recovery in the absence of medical payment subrogation is not persuasive for the insured has paid for that additional coverage." *Id.*

52. Allstate Ins. Co. v. Druke, 576 P.2d 489, 492 (Ariz. 1978) (reasoning that to require injured policyholder to return to insurer benefits for which premiums have been paid is to deny policyholder benefits of his thrift and foresight). *See also* Lee v. State Farm Mut. Ins. Co., 129 Cal. Rptr. 271, 278 (Cal. Ct. App. 1976) (Friedman, J. concurring). In *Lee*, the court stated that:

> The defendant insurance company argues that these clauses prevent double recovery . . . . In a free society an individual may go out and buy and keep all the merchandise he desires. The question is not whether the policyholder is recovering from two sources but whether the insurance company is supplying the merchandise for which it exacted a premium. The double recovery recovery argument is singularly unmoving.

Id.

53. Maxwell v. Allstate Ins. Cos., 728 P.2d 812, 815 (Nev. 1986) (allowing subrogation deprived insured of coverage for which insured had paid premium and resulted in windfall recovery for insurer).

54. Milbank Ins. Co. v. Henry, 441 N.W.2d 143, 149 (Neb. 1989) (Fahrnbruch, J., dissenting). Justice Fahrnbruch stated in dissent that:

> Subrogation clauses make medical pay clauses illusory. The policy owner receives nothing for paying a separate premium for medical expense coverage when a tortfeasor is liable for his damages . . . . Public policy requires that insurance companies deliver what has been paid for by the insured and that the insured receives more than illusory coverage.

Id.

the setting of the rates. However, more and more courts are recognizing that the allowance of subrogation results in a pure windfall to the insurer with no corresponding adjustment in the premium charged.[55] Even courts that do permit subrogation occasionally admit that subrogation results in a windfall gain to the insurer not reflected in the setting of rates.[56]

Denial of subrogation on non-property damage claims is unlikely to yield a "double recovery" to the insured for other reasons. In personal insurance contracts, such as medical payments coverage or health care coverage, the determination of the exact loss is difficult, if not impossible, to ascertain.[57] Mental anguish and physical pain are not insurable and are rarely fully recoverable from a third party. Agreed-upon settlements with third-party tortfeasors or their liability insurers frequently take into consideration that the injured parties' medical expenses have or will be paid by other sources, thereby lessening the amount of recovery. Additionally, the injured party frequently must compromise a claim against a third party because of numerous factors: (1) imposition of liability upon the third party may be subject to dispute; (2) the third-party tortfeasor may have limited assets or limited liability insurance coverage; (3) the applicable law may not provide for recovery to the injured party from the tortfeasor for certain losses; and (4) future losses of income and other future damages may be omitted from the recovery.[58]

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55. Travelers Indemnity Co. v Chumbley, 394 S.W.2d 418, 425 (Mo. Ct. App. 1965) (The court recognized that "automobile medical payments coverage is of comparatively recent origin. It was conceived and reared without benefit of subrogation . . . so 'conditioning' medical payments coverage does not, *in fact*, work a perceptible reduction in the premium charged for such coverage."). *See also* Allstate Ins. Co. v. Druke, 576 P.2d 489, 492 (Ariz. 1978). In *Druke*, the court stated that:

> [I]n terms of public policy, the only justification for allowing an insurance company to recoup the benefits it contracted to pay out in exchange for the receipt of premium payments which are presumably actuarially adequate would be the lowering of premium rates as a result of such recoupment. This is generally not the case . . . .

Id. See also Maxwell v. Allstate Ins. Cos., 728 P.2d 812, 815 (Nev. 1986) (reasoning that only justification for allowing subrogation for medical payments would be lowering of premium rates as a result of recoupment and not that such lowering did not generally follow recoupment).

56. *E.g.*, DeCespedes v. Prudence Mut. Casualty Co., 193 So.2d 224, 227-28 (Fla. Dist. Ct. App. 1966) (court admitted that subrogation has been two-edged sword frequently resulting in source of windfall to insurers because anticipated recoveries under subrogation rights are generally not reflected in computation of premium rates), *aff'd*, 202 So.2d 561 (Fla. 1967).

57. Aetna Casualty and Surety Co. v. State Bd., 637 P.2d 1251, 1255 (Okla. 1981) (noting difficulty of ascertaining exact loss and reasoning that this militates against finding double recovery).

58. *See generally* Allstate Ins. Co. v. Druke, 576 P.2d 489, 492 (Ariz. 1978); Allstate Ins. Co. v. Reitler, 628 P.2d 667, 670 (Mont. 1981); Maxwell v. Allstate Ins. Cos., 728 P.2d 812, 815 (Nev. 1986).

In at least partial recognition of this reality, some jurisdictions have adhered to the rule that subrogation will not be allowed where the insured's total recovery from all sources is less than the insured's actual loss.[59] Although this rule is a step in the right direction, it has drawbacks: 1) it requires policing on a case-by-case basis; 2) it prejudices the rights of the injured party to recover from the third party;[60] and 3) it subjects the insured's claims to unnecessary posturing by the insurer and protracted litigation.[61] Even states professing to follow this rule do not truly make the insured whole. For example, Iowa only requires that the insured be made whole on the particularized loss for which subrogation is sought without regard to whether the insured has been made whole on permanent disability or pain and suffering.[62]

In addition, the insured must bear litigation expenses including attorney fees when pursuing the third-party tortfeasor. In many cases the litigation expenses that the insured must pay are taken out of the recovery from the third-party tortfeasor. As a result, the insured receives a net payment far below the gross recovery. The insured's attorney fee alone may be one-third of the gross recovery and may very well exceed the insured's medical expenses for which subrogation or reimbursement is sought. Some jurisdictions that permit subrogation or reimbursement attempt to compensate for this by assessing the insurer its pro-rata share of the attorney fees,[63] but even this approach falls short of making the insured whole.[64]

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59. Westendorf v. Stasson, 330 N.W.2d 699, 703 (Minn. 1983). The court stated that:

> Given its origins in equity and its restitutionary purpose of preventing unjust enrichment, the general rule is that subrogation, whether arising from equity or contract, will be denied prior to full recovery. That is, absent express contract terms to the contrary, subrogation will not be allowed where the insured's total recovery is less than the insured's actual loss.

Id.

60. For a discussion of prejudice, *see infra* text accompanying notes 63-71.

61. *E.g.*, Tierney v. American Group Benefit Services, Inc., 406 N.W.2d 579 (Minn. Ct. App. 1987) (insurer denied payment of medical expenses until insured signed subrogation agreement and then sought intervention in insured's personal injury action against third party).

62. *See* Ludwig v. Farm Bureau Mut. Ins. Co., 393 N.W.2d 143, 145 (Iowa 1986) (insured need not be paid in full for pain and suffering and liability before subrogation for medical expenses).

63. Lee v. State Farm Mut. Ins. Co., 129 Cal. Rptr. 271 (Cal. Ct. App. 1976).

64. Consider the following example extracted from Milbank Ins. Co. v. Henry, 441 N.W.2d 143, 148 (Neb. 1989) (Fahrnbruch, J. dissenting):

> Assume, for the purpose of argument, that a non-negligent injured person's automobile insurance policy includes medical coverage on the insured of $15,000. The insured incurs $31,675 in medical expenses and receives that $15,000 policy amount from his insurer. This non-negligent person then obtains a verdict for $25,000 and collects that amount from the tortfeasor's insurer. The tortfeasor is otherwise judgment-proof. From the $25,000, the injured person must pay his

The ultimate irony of the "double recovery" argument posed by the insurance industry to permit subrogation is that subrogation makes the insurer one hundred percent whole, regardless of whether or not the injured party fully recovers.[65] The wholeness attained by the insurer comes as a windfall recovery to it in addition to the premium paid by the insured for the transference of the insured risk to the insurer.

2. Subrogation on Non-Property Claims Actually Prejudices the Insured.—In those jurisdictions permitting subrogation or reimbursement, the mere opportunity for subrogation by the insurer prejudices the rights of the insured as against both the third-party tortfeasor and the insurer.

a. Prejudice as Against the Third-Party Tortfeasor.—When defending a personal injury claim in a jurisdiction permitting subrogation on medical expense claims, the defendant may be unable to completely settle the dispute through agreement with the injured plaintiff. A general release from the injured plaintiff has been held not to protect the defendant from subsequent subrogation claims brought by the plaintiff's own insurer.[66] If the plaintiff has both medical payment coverage and health care coverage, the defendant faces the prospect of multiple subrogation claims.[67] Disagreements between the plaintiff and the insurer or disagreements between the multiple subrogees tend to complicate the settlement process.[68] As a

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own attorney $8,325 (one-third contingent fee) and must also reimburse his own insurance company $15,000, leaving him with $1,675. Add back the $15,000 the insured received from his own medical pay policy, and the insured nets $16,675. When that amount is deducted from the amount of medical expenses, the insured still owes $15,000 in medical bills. Even if the medical pay insurer paid its share of the attorney fee involved, the insured would still owe $10,000. If we would hold that the reimbursement clause in the insured's medical pay policy is void, the injured insured would net $31,675 and would at least be fully compensated for his medical expenses.

Id.

65. "Yet under a subrogation clause the plaintiff's insurer is assured full reimbursement for its medical expenses regardless of whether the injured person's tort recovery fully covers his actual damages." Maxwell v. Allstate Ins. Cos., 728 P.2d 812, 815 (Nev. 1986). *See also* Allstate Ins. Co. v. Reitler, 628 P.2d 667, 670 (Mont. 1981).

66. Home Ins. Co. v. Hertz Corp., 375 N.E.2d 115 (Ill. 1978) (unlimited release by insured subrogor did not bar subrogee's action for subrogation on medical payments coverage of auto policy); Travelers Indemnity Co. v. Vaccari, 245 N.W.2d 844 (Minn. 1976) (general release did not bar subrogation claim on medical expenses portion of auto policy).

67. Travelers Indemnity Co. v. Chumbley, 394 S.W.2d 418, 425 (Mo. Ct. App. 1965) (nurturing of subrogation would give substance to unwelcome specter of *multiple* subrogation claims).

68. *Id.*

result, voluntary settlements are more difficult to negotiate with third-party tortfeasors.[69] Additionally, the insured confronts the possibility that the insured's own insurer may attempt to intervene in the lawsuit against the third-party tortfeasor, thereby subjecting the insured to protracted litigation.[70]

Discouraging protracted litigation and keeping the pathway to voluntary settlements unimpeded has always been a fundamental policy of the law. The allowance of subrogation violates this principle[71] and prejudices the insured in the prosecution of her claim against the third-party tortfeasor in the following respects: (1) it makes settlement more difficult and less attractive to the defendant; (2) it diminishes the control the insured has over the destiny of her claim against the third-party tortfeasor; and (3) it subjects the insured to protracted litigation and expense.

b. Prejudice As Against Insurer Seeking Right of Subrogation.—Allowing subrogation encourages a "wait and see" attitude by the insurer. Instead of promptly paying on a claim, the insurer may delay the processing of the claim, waiting for the insured to attain recovery from the third-party tortfeasor. Claims adjusters may actually encourage the insured to proceed against the third-party while the claim is being processed. The insurer may also demand an unqualified commitment in writing by the insured to guarantee reimbursement *prior to* approving the claim.[72]

In the event the insured does attain a recovery from the third-party tortfeasor prior to payment by the insurer, the insurer may, depending on the policy's terms, successfully deny any payment whatsoever. Many policies contain conditions relating to conduct by the insured that may be prejudicial to the insurer. A number of cases have held that a tortfeasor's general release by the insured bars an action by the insured against the insurer because the insurer's right of subrogation has been destroyed.[73] Policy language typically

69. *Id.*

70. *E.g.*, Hamerl v. Marshall, 518 N.E.2d 575 (Ohio Ct. App. 1986) (health insurer asserted an unqualified right to intervene); *see also* Tierny v. American Group Benefit Services, Inc., 407 N.W.2d 57 (Minn. Ct. App. 1987).

71. *See Chumbley*, 394 S.W.2d at 425. In *Chumbley*, the court stated that "multiple subrogation claims inevitably would lead to conflicts and disputes between subrogation claimants, would complicate and make more difficult the negotiation of voluntary settlements with third-party tortfeasors, and would encourage and promote suits and interpleaders, all running counter to the policy of the law." *Id.*

72. *See, e.g.*, *Tierny*, 407 N.W.2d 57.

73. Ruby v. Midwestern Indemnity Co., 532 N.E.2d 730 (Ohio 1988) (claim under underinsured motorist coverage in the amount of $100,000 was denied because insured materially

requires that the insured "shall do nothing after loss to prejudice" the subrogation rights of the insurer.[74]

The allowance of subrogation on non-property claims directly encourages an insurer to delay payment. Eventual settlements between the insured and third-party tortfeasor will reward the insurer's patience through the enforcement of policy provisions that prohibit the insured from releasing the tortfeasor.

IV. Conclusion

The majority rule allows subrogation on non-property damage claims. Experience under the majority rule suggests that a reconsideration is appropriate. Despite initial contentions by the insurance industry, experience demonstrates that without subrogation an insured does not enjoy a "double recovery." Recoveries from third-party tortfeasors rarely, if ever, fully compensate the insured. The "gross" recovery from a third-party tortfeasor frequently falls far short of the insured's actual loss. The "net" recovery to the insured, after litigation costs including attorney fees are deducted, is even less. The allowance of subrogation not only lessens the ability of the insured to be fully compensated, but also prejudices the ability of the insured to proceed against either the third-party tortfeasor or the insurer.

Historically, the traditional resistance to subrogation was founded on common law principles relating to prohibitions against the assignment of personal injury claims and splitting a cause of action. This resistance was easily overcome by the majority view allowing subrogation. However, experience now demonstrates that the problems caused by subrogation are more sophisticated and were not drawn into issue in the early judicial decisions forming the basis for the majority view. A reconsideration of the minority view is in order.

The Supreme Court recently recognized in *FMC Corp. v. Holliday*[75] that while anti-subrogation laws (the adoption of which is urged by this Article) are pre-empted by ERISA in regard to self-funded employee benefit plans, anti-subrogation laws may indeed reach regulated insurers that provide similar coverage for employee

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breached her insurance contract by executing a release that precluded the insurer from exercising its subrogation rights); Hart v. State Farm, 248 N.W.2d 881 (S.D. 1977) (settlement of $4,242.39 with tortfeasor served to defeat insured's claim for the policy limit of $1000 on medical expenses because insurer's right of subrogation was destroyed).

74. Lee v. State Farm Mut. Ins. Co., 129 Cal. Rptr. 271, 273 (Cal. Ct. App. 1976); *Ruby*, 532 N.E.2d at 732; *Hart*, 248 N.W.2d at 883.

75. 111 S. Ct. 403 (1990).

benefit plans.[76] The distinction is critical. In self-funded plans that pool contributions of employees to provide medical care benefits for plan participants, subrogation inures directly to the benefit of all the insureds. The amount of contribution assessed against plan participants reflects the benefits of subrogation. In the case of a regulated insurer, subrogation results in a "windfall" to the insurer, and the insured does not benefit from reduced premium rates. The distinction made by the Supreme Court in *FMC Corp.* should serve as an impetus for a re-examination of the subrogation issue because insurers do not consider the issue of subrogation when setting premium rates.

In order to establish and protect the right of subrogation, insurers have argued that without subrogation the insured realizes a "double recovery." This argument has been proven to be a red herring. Accepting the insurers' argument results in perhaps the greatest irony of all, a true "windfall" to the insurer. The insured pays a premium to the insurer to transfer the risk of medical expense to the insurer. The premium includes the insured's pro-rata share of the total expected losses for the pool of all similarly-situated insureds in which the insured is included. The premium also includes a margin of profit for the insurer. However, the insurer does not lower the premium in anticipation of successful subrogation claims. When a loss occurs, an insurer must simply pay the cost of an actuarially anticipated loss for the pool. Which is fundamentally more just? To allow the insured to recover payment on the expense which the insured, in exchange for the consideration of premium dollars, transferred to the insurer or to allow the insurer a "windfall" recovery? The bogus issue of a "double recovery" to the insured should play no role in resolving this question.

76. *Id.* at 409.