

Unraveling the Lining of ERISA Health Insurer Pockets—A Vote for National Federal Common Law Adoption of the Make Whole Doctrine

I. INTRODUCTION

Imagine the following nightmare. On a typical Monday morning you are again driving on a congested freeway, hoping for a timely arrival at your underpaid workplace. Despite considerable vehicular obstacles, you eventually maneuver to the off-ramp and reach the surface streets that lead to your office. As you approach the last intersection before turning into your office parking lot, you experience the final seconds of the last typical Monday you will ever have because a split second later, the driver of a 1985 Dodge Ram Truck, while looking below his dashboard for a dropped cigarette, speeds through a mature red light at 50 mph directly into the driver's side of your car.

One life flight, four surgeries, and several weeks later, you realize, while lying in a hospital bed, that you are grateful to be alive. You muse to yourself that shortly before your accident you had griped to your spouse that paying car and health insurance premiums was like throwing money out the window, since you had never benefited from either. You do some quick calculations in your head. Since you have been paying your own premiums, for about ten years, you have paid nearly \$50,000 in car and health insurance premiums without receiving anything in return. Now, despite unfortunate circumstances, you have finally received your bittersweet payday. Your health insurance has already paid out over \$100,000 for your medical treatment. You have a year's worth of physical therapy staring you in the face, another potential surgery, and at least nine months of lost wages.

You also feel some justification in your inspired decision to increase your uninsured motorist coverage as the driver of the '85 Ram was uninsured, to go along with his lack of a valid driver's license. The \$100,000 car insurance policy will come in handy as you struggle to pay bills and make ends meet while you are unable to work. Between meeting your normal monthly obligations and funding your

newly acquired medical necessities, you figure that the insurance proceeds will sustain you for about a year while you literally get back on your feet.

Given the fact that your case has been conservatively valued at \$300,000, your car insurance company quickly settles for the \$100,000 policy limit on your uninsured motorist policy. Unfortunately, unbeknownst to you, your nightmare has just begun. Your health insurance carrier has filed a lien on the entire proceeds of the settlement. Initially you are puzzled—why have you been paying health insurance premiums if you have to pay the entire cost of your treatment anyway?

You hire an attorney who specializes in resolving dilemmas such as the one you are specifically facing. She explains that state law prescribes that until an injured party is “made whole,” or is compensated for the entirety of his damages, a health insurance company has no right to reimbursement for payment of medical treatments. There is, however, an important caveat. If a health plan qualifies as an ERISA (Employee Retirement Income Security Act) plan, it can preempt state law, including state law considerations of whether a victim has been made whole.

Your health insurance plan is unquestionably an ERISA plan. The legal counsel for your health insurer relies on the ERISA caveat and is unwilling to negotiate a settlement. Litigation ensues. Despite your attorney’s best efforts, the trial court finds that the subrogation clause in your health insurance contract is sufficient to provide your health insurer with first priority to your settlement monies. The entire \$100,000 from your auto policy settlement goes to your health insurer. Befuddled and dazed, and despite a decade’s worth of faithful insurance premium payments, you are left with physical and emotional scars and nothing from your auto policy settlement with which to pay your day-to-day expenses, your newly amassed attorney bill, your future medical treatment, and lost wages. Instead of being “made whole” through the security blanket of insurance, you have been callously and indifferently dumped into an insurance-“made hole” of financial despair. Congratulations, you have been properly initiated into the cruel world of insurance subrogation claims.

The foregoing and admittedly long-winded hypothetical situation provides an alarming, yet realistic, introduction to the legal Scylla and Charybdis between which personal injury victims all too often find themselves. The purpose of this note is to discuss the in-

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herent problems with ERISA subrogation claims, to analyze contrasting circuit court positions on the subject in light of the intent behind ERISA and insurance contracts in general, and to propose a new paradigm within which personal injury subrogation claims may be more equitably adjudicated.

Part II of this note purveys a brief history of insurance subrogation claims and of the applicability of ERISA, providing a context for the factual and analytical posture of the court in the recently decided federal district court case, *In re Paris*,¹ described in Part III. Part IV reveals the ideological, methodological, and legal shortcomings of the current circuits favoring ERISA subrogation over the “make whole doctrine” as exposed in *Paris*. It then proposes a new standard by which subrogation claims may be determined in light of legislative intent and simple principles of equity. Finally, Part V of this note concludes that the current circuits favoring subrogation do so without solid legal foundation and at the expense of equity. Rather focusing on making an injured party “whole” is not only in harmony with the fundamental principles underlying our legal system, but also in no way places an unfair legal burden upon would-be health insurance subrogee.

II. BACKGROUND

In order to fairly evaluate the interplay between subrogation and the make whole doctrine, this note will briefly address the historical background of subrogation. The general evolution of subrogation in insurance law and in ERISA qualified plans has set the stage for the current controversy between health insurers and personal injury victims.

A. The Roots of Subrogation

As it applies to personal injury and insurance law, subrogation is a principle whereby an insurer who has indemnified an insured may assume legal standing in place of the insured to sue a third-party tortfeasor on the insured’s claim for compensation.² Initially banned from application to personal injury claims by (1) the public policy disfavoring the assignment of personal injury claims and (2) judicial

1. 44 F. Supp. 2d 747 (D. Md. 1999).

2. *See generally* BLACK’S LAW DICTIONARY 995 (6th ed. 1991).

efficiency policy prohibiting the division of a cause of action, subrogation invidiously began to worm its way into insurance contracts in the 1960s.³ By couching policy language in the loophole terms of “reimbursement” instead of “subrogation,”⁴ insurers were able to make an end run around the letter of the law. However, the practical and economic effect of plan language often resulted in a conventional subrogation application.

This process was clearly borne out in *Lee v. State Farm Mutual Automobile Insurance Co.*,⁵ where a California state court upheld the following State Farm Insurance policy language:

[I]f requested in writing by the company . . . such [injured] *person* shall take, through any representative designated by the company, such action as may be necessary or appropriate to recover such payment as damages from such other person or organization, such action to be taken in the name of such person; in the event of a recovery, the company shall be reimbursed out of such recovery for expenses, costs and attorneys’ fees incurred by it in connection therewith⁶

In a “reluctant” concurring opinion, Justice Friedman conceded that the cases upon which the court relied “represent a creeping erosion of the anti-subrogation principle established at common law The successive amendments of State Farm’s ‘reimbursement’ clauses illustrate how eagerly and quickly the disingenuous draftsmen of insurance policies move into the gaps created by decisional erosion”⁷ Justice Friedman concluded by stating that “[t]he cumulative effect of the policy provisions is to create the economic reality of subrogation to the personal injury claim without its language.”⁸

3. See Roger M. Baron, *Subrogation: A Pandora’s Box Awaiting Closure*, 41 S.D. L. REV. 237, 239 (1996).

4. In basic terms, subrogation allows an insurer to step into the shoes of an insured and sue a third party tortfeasor for recovery of compensation, where the insured does not initiate such an action herself. With true reimbursement, however, an insurer relies on the injured insured to take action against the third party and can only recover out of whatever proceeds the insured is able to procure. For the purpose of this note, the distinction between the two concepts will not be further discussed.

5. 129 Cal. Rptr. 271, 274 (Cal. Ct. App. 1976).

6. *Id.* at 274.

7. *Id.* at 278.

8. *Id.*

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On a practical level, subrogation clauses have been justified by insurers in two ways. First, insurers posit that subrogation serves to reduce insurance rates. Second, insurers have piously promoted the argument that an insured should not “unduly benefit from a loss and thereby enjoy a ‘double recovery’ from both the insurer and the tortfeasor.”⁹ In short, insurers claim that “[s]ubrogation prevents an insured from obtaining one recovery from the insurer under its contractual obligations and a second recovery from the tortfeasor under general tort principles.”¹⁰

B. Subrogation in the ERISA Context

Despite a conspicuous absence of statutory language and legislative directive, subrogation has played a major role in cases involving ERISA health insurers. The following discussion will not attempt to unravel all of the convoluted complexities of ERISA applications in health benefit situations, but rather will provide a simple framework within which to understand ERISA subrogation cases.

1. Introduction

In terms of general legal foundation, insurers seek to bring subrogation claims under ERISA based on a theory of unjust enrichment. Even if states have embraced laws applying a make whole doctrine, ERISA, in certain circumstances, preempts state law that may be more favorable to the injured party.

Subject to some exceptions, any state law relating to subrogation rights is preempted by ERISA if the subrogation rights are part of an employee benefit plan.¹¹ Hence, the first step in ERISA subrogation analysis is to determine whether a plan is an employee benefit plan. Even if such a plan is identified, certain state laws may yet be exempt from ERISA preemption under the “savings” clause (where certain laws are “saved” from preemption) if the state law “regulates insurance.”¹² In determining whether a state law regulates insurance, ERISA also includes a “deemer” clause,¹³ which prevents a court

9. Baron, *supra* note 3, at 241.

10. *Id.* at 241 n.30 (quoting Elaine M. Rinaldi, *Apportionment of Recovery Between Insured and Insurer in a Subrogation Case*, 29 TORT & INS. L.J. 803, 803 (1994)).

11. *See* 29 U.S.C. § 1144(a) (1994).

12. *See id.* § 1144(b)(2)(A).

13. *See id.* § 1144(b)(2)(B).

from “deeming” a plan to be an insurance company unless it truly fits the mold of such a company.¹⁴ Although it is beyond the scope of this note to conduct a detailed analysis of ERISA preemption, in order to provide proper background, the key elements will be briefly addressed below.

2. *Employee benefit plans*

Based on statutory language found within ERISA, an employee benefit plan is defined as follows:

The terms “employee welfare benefit plan” and “welfare plan” mean any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment¹⁵

Most challenges to the existence of an ERISA employee benefit plan focus on whether “(1) a plan was ‘established or maintained;’ (2) by an ‘employer’ or ‘employee organization;’ and whether (3) the plan covers ‘employees.’”¹⁶

a. *“Established or maintained.”* Federal courts generally recognize that an employee benefit plan has been established or maintained by objectively identifying intended benefits, class of beneficiaries, source of financing, and procedures for receiving benefits.¹⁷ In the Ninth Circuit, a plan meeting the foregoing qualifications can only be excluded from ERISA coverage if all of the following four qualifications are met:

- (1) The employer makes no contributions;
- (2) Employee participation in the program is completely voluntary;
- (3) The sole functions of the employer are to “permit the insurer

14. See generally 3 EMPLOYMENT COORDINATOR ¶¶ B-10,511-10,514 (Jennifer L. Howicz et al. eds., 1999).

15. 29 U.S.C. § 1002(1) (1994 & Supp. III 1997).

16. Karra J. Porter, Subrogation by Health Insurers Under ERISA 2 (Feb. 22, 1996) (unpublished manuscript) (on file with author).

17. See *id.*

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to publicize the program to employees or members, to collect premiums through payroll deductions or dues checkoffs and to remit them to the insurer;¹⁸ and

(4) The employer receives no consideration other than reasonable compensation for administrative services “actually rendered in connection with payroll deductions or dues checkoffs.”¹⁹

In practice, proof that a plan has been established almost always equates with the existence of an employee benefit plan because the showing of “employer” and “employee,” addressed below, is generally a foregone conclusion.

b. “Employer or employer organization” and “employee.” ERISA defines an employer as “any person acting directly as an employer, or indirectly in the interest of an employer, in relation to an employee benefit plan.”²⁰ Based on this broad language, this standard will easily be met in a majority of cases.²¹ Likewise, the standard for identifying an “employee” under ERISA requires only a minimal showing based on common law principles of agency.²²

3. The “savings” and “deemer” clauses

Once a court identifies the existence of an employee benefit plan, ERISA preempts state laws applying to the plan unless the savings clause removes them from the grasp of ERISA. In essence, the savings clause “saves” state laws which regulate insurance from ERISA preemption. The state law must do more than impact the insurance industry to meet this qualification; it must specifically address the insurance industry.²³

The ERISA deemer clause applies in this setting.²⁴ In essence, it is an exception to the savings clause exception. The deemer clause prohibits a court from simply deeming a plan to be an insurance company when it does not fit the traditional mold. Generally, deemer clause questions are easily resolved. If benefits are provided exclusively by a “traditional” insurance company, the plan passes

18. *PacifiCare Inc. v. Martin*, 34 F.3d 834, 837 (9th Cir. 1994) (citing *Kanne v. Connecticut Gen. Life Ins. Co.*, 867 F.2d 489, 492 (9th Cir. 1988)).

19. *Id.*

20. 29 U.S.C. § 1002(5).

21. *See Porter*, *supra* note 16, at 5.

22. *See id.*

23. *See id.* at 8.

24. 29 U.S.C. § 1144(b)(2)(B).

muster and is subject to savings clause analysis. If, however, benefits are provided by a self-insured sponsor, the deemer clause applies and no savings clause analysis is necessary.

4. *Subrogation provisions in ERISA plans*

Currently, once an insurer has successfully proved the preemptive power of ERISA, its odds of recovering vis-à-vis reimbursement or subrogation are good. Insurers will generally be able to seek reimbursement under ERISA § 502(a)(3), which states that “[a] civil action may be brought . . . (3) by a participant, beneficiary, or fiduciary . . . to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this title or the terms of the plan.”²⁵ The principle of equitable relief relating to subrogation claims is unjust enrichment. Generally, adequately worded reimbursement and subrogation provisions are enforced under ERISA.²⁶

5. *ERISA subrogation summary*

In sum, in a dispute between an insurer and an injured insured, the ability to bring an ERISA claim for subrogation is often the determinative factor in a successful recovery by the insurer. In many cases, however, despite acknowledging that a plan is an ERISA plan, the insured argues that the make whole doctrine, outside the parameters of state law, is an exception to ERISA preemption. That is the focus of this note. Thus, the pertinent issue is whether the make whole doctrine should prevail, even if ERISA applies, in circumstances where insurers seek subrogation of third-party settlements of insureds who, if required to reimburse their medical plan, will be left with less than adequate compensation for their injuries.

III. IN RE *PARIS*

The conflicting convergence of subrogation principles and the make whole doctrine was recently illustrated in a Maryland federal district court case, *In re Paris*.²⁷

25. *Id.* § 1132(a)(3).

26. *See* Porter, *supra* note 16, at 15.

27. 44 F. Supp. 2d 747 (D. Md. 1999).

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A. The Facts

In June 1996, Shawn Paris (“Paris”), then twenty-four years old, went for an afternoon motorcycle ride. His ride ended prematurely when he was struck by a negligent driver. Paris was severely injured, and his ensuing medical treatment totaled over \$100,000. The litigation arising from Paris’s accident resulted in a \$100,000 settlement with the third-party insurance carrier.²⁸ The language in Paris’s health insurance plan with Iron Workers’ Trust Fund (the “Fund”) reads as follows:

The Fund’s subrogation right is established by the Plan Once the Third Party’s liability is resolved, you will be required to reimburse the Fund up to the full amount of the recovery for the full amount of loss of time benefits and/or medical benefits received By accepting benefits from the Fund, the insured person agrees that any amounts recovered by the insured person by judgment, settlement or otherwise will be first applied to reimburse the fund.²⁹

Paris filed a petition in Maryland state court seeking a declaration that the make whole doctrine superceded the subrogation language and rights described in the excerpt of the plan above. The petition was removed to federal district court under the preemptive sweep of ERISA and was subsequently amended.³⁰

In pertinent part, the petition noted that even without losing the \$100,000 to subrogation, Paris would not be made whole and, therefore, should be spared from the grasp of the Fund’s subrogation language. The petition further stated that in light of the fact that Paris suffered permanent brain damage and qualified statutorily as a disabled, destitute adult, the \$100,000 settlement should be accessible to Paris’s mother (who, as a result of Paris’ injuries, became his legal guardian) to expense the fifty-one years of Paris’s determined remaining life expectancy.³¹

28. *See id.* at 748.

29. *Id.*

30. *See id.*

31. *See id.*

B. The Reasoning of the Court

In its memorandum opinion, the United States District Court for the District of Maryland prefaced its “reasoning” by definitively stating that “[n]o further briefing or oral argument is needed . . . as the motion raises only a legal issue that, albeit one of first impression in this District and Circuit, is clearly settled by weight of persuasive authority.”³² In less than one page of analysis, the court, after correctly recognizing that the issue at bar fell under the purview of ERISA, cited only one case in direct support of its proposition that “[t]he majority of Circuit Court cases that have dealt with the issue hold that even a ‘boilerplate’ subrogation clause can override the ‘make whole doctrine.’ ”³³

After acknowledging that the Eleventh Circuit had adopted case law to the contrary and that its own circuit (the Fourth Circuit) had not yet spoken to the issue, the court stated that it was “of the opinion that the plan language at issue [in the current case] absolutely rules out any application of the ‘make whole doctrine’ ” and therefore, “[b]ased on the clear and unequivocal language of the plan at issue [in the current case], there is absolutely no question that the petition in th[e] case must be denied.”³⁴

The practical result of the court’s decision was that the remainder of the \$100,000 settlement (after a legal contingency fee had been deducted) was to be paid to the Fund while Ms. Paris and her adult, destitute child were left with nothing other than the remainder of the Fund bill debt and years of future financial challenges.

IV. ANALYSIS

A. Placing In re Paris in a Proper Legal Context—A View from Four Circuits

Despite what appears to be, on its face, a blatantly inequitable result in *Paris*, the Maryland federal court’s decision harmoniously blends in with existing circuit court holdings. Four circuits have recently addressed the issue of subrogation in personal injury cases to either the detriment or extinction of the make whole rule.

32. *Id.*

33. *Id.* (citing *Cutting v. Jerome Foods, Inc.*, 993 F.2d 1293, 1297 (7th Cir. 1993)).

34. *Id.* at 748-49.

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1. The Fifth Circuit—Sunbeam-Oster Co. Group Benefits Plan v. Whitehurst

In *Sunbeam*, Leonard Whitehurst Jr. was severely injured when an eighteen-wheel tractor/trailer negligently collided with his car.³⁵ Based upon health coverage provided by his wife's employee benefit plan (the "Plan"), under which Whitehurst was also covered, Whitehurst received \$137,000 in medical benefits. Whitehurst subsequently settled his tort claim against the vehicle owner for the vehicle owner's insurance policy limit of \$500,000.³⁶ After several unsuccessful attempts by the plan administrator to obtain reimbursement for the \$137,000 it had already paid for Whitehurst's medical bills, it filed suit against Whitehurst.³⁷

The district court held in favor of Whitehurst, reasoning that the Plan language did not address the circumstance where a beneficiary only partially recovers his damages from a third party.³⁸ The court, after officially adopting the make whole rule³⁹ as a matter of federal common law, found that Whitehurst had suffered damages of \$2 million, and his wife and child together had suffered an additional

35. See *Sunbeam-Oster Co. Group Benefits Plan v. Whitehurst*, 102 F.3d 1368, 1369-70 (5th Cir. 1996).

36. See *id.* at 1370.

37. See *id.* at 1372. The language upon which the Plan relied is as follows:

The Plan has subrogation and reimbursement provisions which allow the Plan to recover for benefits it pays which are duplicated from another source. The Plan provides an automatic lien on any funds subject to reimbursement or subrogation.

Reimbursement gives the Plan the right to collect from you money that you receive in a settlement or lawsuit that covers expenses that the Plan has already paid for

Reimbursement Example—You are injured and receive \$1,000 in covered expenses from the Plan. The person who caused your injury agrees to settle with you and pays you the \$1,000. The Sunbeam-Oster Plan has a legal right to reimbursement from you of the \$1,000.

Id. at 1371.

38. See *id.* at 1372.

39. See *id.* The district court specified that the make whole rule would apply as a default rule of plan language construction. See *id.* The Fifth Circuit described the make whole doctrine as follows:

In essence, the Make Whole rule is the diametric opposite of the Plan Priority rule: In the former, a plan gets no reimbursement until the beneficiary has been made whole; in the latter, the beneficiary retains nothing until he has reimbursed the plan (or the plan has recovered through subrogation) all funds expended on medical costs of the beneficiary, dollar for dollar.

Id.

\$500,000 in damages.⁴⁰

On appeal, the Fifth Circuit determined that the Plan language was unambiguous:

[I]n the absence of any expressly selected alternative standard (such as Pro-Rata or Make Whole) which deviates from the anticipated Plan Priority norm—such language vested the Plan with an unconditional and unequivocal Plan Priority right to reimbursement for the full amount of the medical benefits it paid on a participant's behalf⁴¹

Accordingly, the Fifth Circuit reversed the decision of the lower court, instructing it to enter a judgment directing Whitehurst to “reimburse the Plan, dollar for dollar, for all qualifying expenditures made on his behalf, as well as for all expenditures of such nature that the Plan might make in the future.”⁴²

In dicta, the Fifth Circuit felt obliged to specifically address the make whole issue spawned by the district court decision, describing the issue as its “most serious concern.”⁴³ In no uncertain terms, the Fifth Circuit gave a crushing blow to the future viability of the make whole doctrine, stating that “we have serious doubts whether we would ever approve or adopt the make whole rule as this circuit's default rule for the priority of recovery in reimbursement or subrogation between an ERISA plan and its participant or beneficiary under circumstances such as the ones we consider today.”⁴⁴

2. *The Seventh Circuit*—Cutting v. Jerome Foods, Inc.

In *Cutting*, Diane Cutting incurred \$90,000 in medical expenses after suffering serious injuries in an automobile accident.⁴⁵ After Cutting successfully brought a claim against an uninsured-motorist policy and a products liability claim, Cutting's ERISA benefit plan (the “Plan”) sought reimbursement for its payment of medical expenses.⁴⁶ Cutting, based on the make whole doctrine (she alleged

40. *See id.*

41. *Id.* at 1376.

42. *Id.* at 1379.

43. *Id.* at 1377.

44. *Id.* at 1378.

45. *See Cutting v. Jerome Foods, Inc.*, 993 F.2d 1293, 1294 (7th Cir. 1993).

46. *See id.* at 1294-95. The Plan language stated that “the Plan shall be subrogated to all claims, demands, actions and rights of recovery of the individual against any third party or

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that her recoveries still left her nearly \$400,000 from being made whole), refused to reimburse the Plan.⁴⁷ The Plan then successfully moved for summary judgment in its legal pursuit of the \$90,000.⁴⁸

On appeal, Judge Richard Posner, writing for the Seventh Circuit, focused the overwhelming majority of his opinion on the question of whether the court should “adopt a federal common law rule to the effect that rights of subrogation are enforceable only after the plan beneficiary has been made whole for the loss giving rise to the claim for benefits.”⁴⁹ In a lengthy description, comprising over half of his opinion, Judge Posner described subrogation as a “good thing,”⁵⁰ a principle, when practically applied, that serves to shift risk of recovery “from the individual to a specialist in bearing risk and enforcing claims—the insurance company.”⁵¹ According to Judge Posner, the result of controlled risk is that insureds save money on insurance policies while conceding only the opportunity to receive “double recovery.”⁵² Judge Posner further analogized subrogation to the assignment of an insured’s tort claim, which serves to shift “the insured’s tort rights to the insurance company, reduc[ing] the price of insurance and thus enabl[ing] the insured to obtain more coverage, in effect trading an uncertain bundle of tort rights for a larger certain right, which is just the sort of trade that people seek through insurance.”⁵³

After Judge Posner’s discourse on the merits of subrogation, he concluded by admitting that the “subrogation” versus “make whole controversy” did not need to be decided in the case at hand “[b]ecause, as the Cuttings concede, the make-whole rule is just a principle of interpretation, it can be overridden by clear language in the plan.”⁵⁴ In holding that the Plan language was clear, the Seventh

any insurer, including the Workers’ Compensation, to the extent of any and all payments made or to be made hereunder by the Plan.” *Id.* at 1295.

47. *See id.* at 1295.

48. *See id.* at 1294-95.

49. *Id.* at 1296.

50. *Id.* at 1298.

51. *Id.* at 1297.

52. *See id.* at 1297-98.

53. *Id.* at 1298.

54. *Id.* at 1298-99.

Circuit affirmed the summary judgment decision of the lower court, and Cutting was ordered to reimburse her health insurance plan.⁵⁵

3. *The Ninth Circuit*—Barnes v. Independent Automobile Dealers Association of California Health and Welfare Benefit Plan

A glimmer of hope for the make whole doctrine was conceived in *Barnes v. Independent Automobile Dealers Association of California Health and Welfare Benefit Plan*.⁵⁶ In *Barnes*, after being rear-ended by Catherine Clark in an automobile accident, Susan Barnes incurred medical bills of \$23,075.40.⁵⁷ In January 1991, Barnes filed suit against Clark for, *inter alia*, payment of Barnes's medical bills.⁵⁸ Shortly thereafter, Barnes submitted an accident claim form to her health plan (the "Plan") for payment of her medical bills.⁵⁹ The Plan, citing its subrogation clause in the benefit agreement, denied payment because of Barnes's pending litigation against Clark.⁶⁰ Barnes eventually recovered \$25,000 from Clark (the liability limit of Clark's insurance policy) and \$5,000 from Barnes's own automobile insurance policy.⁶¹

In August 1992, Barnes filed suit against the Plan for payment of her outstanding medical bills (\$18,075.40) plus interest.⁶² Despite an affidavit indicating that her claim was valued at a minimum of \$65,000, the federal district court granted the Plan's motion for summary judgment.⁶³

55. *See id.* at 1299.

56. 64 F.3d 1389 (9th Cir. 1995).

57. *See id.* at 1391.

58. *See id.*

59. *See id.*

60. *See id.* at 1392. The Plan language read as follows:

This plan may withhold payment of benefits when a party other than the employee or dependent may be liable for expenses until liability is legally determined. However, if this plan makes payment which the employee, dependent or any other party is or may be entitled to recover against any person or organization responsible for an accident or illness, this Plan is subrogated to all rights of recovery to the extent of its payment. The employee, dependent, or other person or organization receiving payment from this Plan shall execute and deliver instruments and papers and do whatever else is necessary to secure such rights to the Plan, and shall do nothing either before or after payment by the Plan to prejudice such rights.

Id. at 1393 (italics omitted).

61. *See id.* at 1392.

62. *See id.*

63. *See id.*

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On appeal, the Ninth Circuit reversed the district court's grant of summary judgment and remanded for an entry of judgment directing the Plan to pay for Barnes's outstanding medical expenses.⁶⁴ In reaching its conclusion, the federal appellate court noted that the make whole doctrine was "supported by substantial authority in existing insurance law, and it is consistent with ERISA's purpose of protecting participants in employee benefit plans."⁶⁵ The Ninth Circuit further stated: "We adopt as federal common law this generally accepted rule that, *in the absence of a clear contract provision to the contrary*, an insured must be made whole before an insurer can enforce its right to subrogation."⁶⁶ However, despite this apparently definitive stance taken by the Ninth Circuit, its potency was somewhat diluted by the court's ensuing analysis of the Plan's language. In response to the Plan's argument that the subrogation language of "all rights of recovery" barred application of the make whole rule, the Ninth Circuit differentiated the case from those that had found references to "any" or "all" rights in subrogation clauses sufficient to trump the make whole doctrine.⁶⁷ The court noted that those cases involved situations where an insurance company had already paid an insured's claim, or where a plan bestowed discretion upon its administrator to interpret plan provisions.⁶⁸

So, in short, what first appeared to be a major victory for proponents of the make whole doctrine turned out to be a much-less-than-definitive position by the Ninth Circuit. Based on the Ninth Circuit's holding in *Barnes*, subrogation clauses effectively demolish the make whole doctrine in circumstances where a plan has already paid an insured's medical bills or where a plan vests discretion in its administrator, both of which arguably constitute a healthy majority of subrogation disputes.

64. *See id.* at 1397.

65. *Id.* at 1394-95 (citing *Batchelor v. Oak Hill Med. Group*, 870 F.2d 1446, 1449 (9th Cir. 1989) and *Guy v. Southeastern Iron Workers' Welfare Fund*, 877 F.2d 37, 39-40 (11th Cir. 1989)).

66. *Id.* at 1395 (emphasis added).

67. *See id.* at 1396.

68. *See id.*

4. The Eleventh Circuit—Cagle v. Bruner

The most conclusive circuit court position on the make whole doctrine arose in *Cagle v. Bruner*.⁶⁹ In *Cagle*, Cobbie Bruner Jr. received emergency medical treatment after being involved in a car accident caused by a third party.⁷⁰ The Retail, Wholesale and Department Store International Union and Industry Health and Benefit Fund (the “Fund”), under coverage held by Cobbie’s mother, Nancy Bruner, paid an initial medical claim of \$296.00.⁷¹ However, the Fund refused to pay any additional claims in connection with Cobbie’s four-month hospitalization and subsequent four-month outpatient treatment until Nancy Bruner signed a standard subrogation form.⁷²

Bruner signed the form, but attached an addendum indicating that the signed agreement did not “in any way expand the subrogation rights” of the Fund.⁷³ The Fund rejected Bruner’s addendum and again sent an original copy of the agreement to Bruner who again returned it with an identical addendum.⁷⁴ The Fund then filed suit against Bruner, seeking declaratory judgment requiring a signed unmodified standard subrogation agreement as a condition to payment of Cobbie Bruner’s medical claims and injunctive relief order-

69. 112 F.3d 1510 (11th Cir. 1997).

70. *See id.* at 1513.

71. *See id.*

72. *See id.* The Fund’s subrogation form read as follows:

I (we) understand that if payments are made under the Plan for any treatment or services because of injury to, or sickness of, an eligible individual who has a lawful claim, demand or right against a third party or parties (including an insurance carrier) for indemnification, damages or other payment with respect to such injury or sickness, I (we) am (are) required to subrogate to the RWDSU Health and Welfare Fund, the Plan, to the extent of payments made under said plan, my (our) rights to receive or claim such indemnification, damages or other payment. . . .

In consideration thereof, if payments are made under said plan for treatment or service on account of the same injury or sickness and to the extent of such payments made (but not in excess of the proceeds of any recovery),

(a) I (we) agree to reimburse the Plan in full from the proceeds of any recovery received by me (us) because of such injury or sickness, and

(b) The Plan shall be subrogated in full to my (our) rights to such recovery and my (our) interest in the proceeds of such recovery;

if such recovery is based upon the eligible individual’s lawful claim, demand or right against a third party or parties (including an insurance carrier).

Id.

73. *Id.*

74. *See id.*

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ing Bruner to execute the agreement.⁷⁵ Bruner counterclaimed seeking a declaration that Cobbie Bruner be made whole before the Fund could participate in any recovery from a third party, a judgment for the amount of medical expenses covered by the Fund, and costs and attorneys' fees.⁷⁶ The district court granted Bruner's motion for summary judgment, and the Fund was eventually required to pay \$56,744.57 of Cobbie Bruner's medical bills.⁷⁷

On appeal, the Eleventh Circuit addressed the issue of "whether the 'make whole' doctrine applies where an ERISA plan neither explicitly adopts nor disavows the doctrine."⁷⁸ In formally recognizing the make whole doctrine as a default rule in ERISA cases, the court stated: "[T]he make whole doctrine applies to limit a plan's subrogation rights where an insured has not received compensation for his total loss and the plan does not explicitly preclude operation of the doctrine."⁷⁹ The court proceeded to reject the plan administrator limitation noted in both *Barnes*⁸⁰ and *Cutting*,⁸¹ indicating that a plan could not avoid application of the make whole doctrine merely by "giving itself discretion" to do so.⁸²

In short, with regard to the make whole doctrine, *Cagle* established the following premise: "Either the make whole doctrine is implied into the plan (the default scenario), or it is not (if there is clear language rejecting it). There is no interpretive question for [a] Fund to consider."⁸³ While *Cagle* provided a basis for enforcement of the make whole doctrine in ERISA plans, it left the door open for ERISA plans to simply insert language expressly rejecting the make whole doctrine.

75. *See id.* at 1513-14.

76. *See id.* at 1514.

77. *See id.*

78. *Id.* at 1512.

79. *Id.* at 1521 (italics omitted).

80. *See Barnes v. Independent Auto. Dealers Ass'n of Cal. Health and Welfare Benefit Plan*, 64 F.3d 1389, 1395 (9th Cir. 1995). *See supra* Part IV.A.3.

81. *See Cutting v. Jerome Foods, Inc.*, 993 F.2d 1293, 1299 (7th Cir. 1993). *See supra* Part IV.A.2.

82. *Cagle*, 112 F.3d at 1522.

83. *Id.*

B. The Flawed Foundation of Subrogation in the ERISA Health Plan Context

A composite summary of circuit court discourse reveals that the triumph of subrogation principles has come at the expense of proper consideration of legislative intent in enacting ERISA and correct adjudicative analysis of the issues of insurance savings and double recovery by insureds. Faulty analysis of these key factors has led to an unjustified deference given by courts to the concept of subrogation.

1. Legislative intent in enacting ERISA

Perhaps the initial inquiry in determining the validity of subrogation in an ERISA plan setting should be, “Is that what Congress intended?” The legislative history of ERISA reveals that Congress was, in large part, motivated by “the absolute need that safeguards for plan participants be sufficiently adequate and effective to prevent the numerous inequities to workers under plans which have resulted in tragic hardship to so many.”⁸⁴ The clear focus of ERISA intent was on its intended beneficiaries, the “workers.”

Furthermore, ERISA provisions do not speak at all to the issue of a health insurance plan’s right to subrogation. At best, “ERISA does not preclude a self-insured medical plan from enforcing a subrogation provision contained in the plan against a participant.”⁸⁵

Because of ERISA’s silence on the topic of subrogation, federal common law has governed subrogation right enforcement in ERISA welfare benefit plans.⁸⁶ Not only has federal common law belied the intent of ERISA legislators, it has generally coupled the lack of ERISA subrogation preclusion with the broad discretion of plan trustees to establish protocol of plan eligibility and participation, upholding subrogation claims even in the face of *numerous inequities to workers under plans which have resulted in tragic hardship*.

2. The “double recovery” myth

One of the most commonly advanced rationales for the existence of subrogation is that an insured should not benefit from an injury beyond being made whole. In other words, the policy against double

84. H.R. REP. NO. 93-533, at 9 (1974), *reprinted in* 1974 U.S.C.C.A.N. 4639, 4647.

85. 3 EMPLOYMENT COORDINATOR, *supra* note 14, ¶ B-13,003.

86. *See id.*

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recovery dictates that an injured insured should not be able to receive fully compensating benefits by way of his or her insurance contract and then “come out ahead” by suing a third-party tortfeasor.

The theoretical basis for subrogation, then, is that the insured benefits from immediate indemnification by the health insurer for losses sustained at the hands of a third-party tortfeasor. Based on the policy justification that a tortfeasor should not benefit from the indemnification act of the injured’s insurer, subrogation allows the insurer to “stand in the shoes” of the insured and recover whatever amount has been indemnified.⁸⁷ Any dollar figure over the indemnification amount must go to the insured. According to insurers, double recovery occurs when an insured is made whole by his or her health insurance policy and then receives full compensation again from the tortfeasor. By way of mathematical analogy, if the insured begins on the number line at “1” (one—representing “wholeness”), moves to “0” (zero) as a result of the tortfeasor’s actions, back to “1” (one) by way of the health insurance policy and then to “2” (two) as a result of a recovery from the tortfeasor, the insured has allegedly “benefited” from the injury.

However, some commentators have noted that a post-recovery result of “+2” on the number line is unproblematic.⁸⁸ For example, the collateral source rule requires a tortfeasor to pay the full liability of damages caused even if the victim was sufficiently wise to procure insurance.⁸⁹ In this context, then, the commentators question why an insured victim should be limited to the same overall recovery as an imprudent uninsured victim.⁹⁰ Some courts have pondered the same question. In *Lee v. State Farm Mutual Automobile Insurance Co.* (discussed in Part II), Justice Friedman’s concurrence discredited the double recovery theory as follows:

The defendant insurance company argues that these [subrogation] clauses prevent double recovery. A liability insurance policy is a piece of merchandise. 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

87. See Baron, *supra* note 3, at 241-42.

88. See *id.* at 242.

89. See *id.*

90. See *id.* at 243.

which it exacted a premium. *The double recovery argument is singularly unmoving.*⁹¹

Similarly, in *Allstate Insurance Co. v. Drake*,⁹² the Arizona Supreme Court noted that imposing reimbursement obligations upon an injured policyholder would result in denying the well-deserved “benefits of his thrift and foresight.”⁹³

It is worthy of mention that although this note does not argue for the institution of “double recovery” by insureds, the denial of full recovery from both the insurer and the tortfeasor almost always results in a double recovery by the insurer. The insurer recovers once through premiums and a second time through reimbursement from the tortfeasor. The insurer’s second recovery, then, will always come at the expense of either a full or a second recovery by the insured. It is highly debatable that public policy would favor placing an additional windfall into the pockets of an insurance company rather than into the hands of an injured individual.

3. *The “insurance savings” myth*

Another widely held justification for the existence of subrogation in the health insurance context is that subrogation ultimately protects the insurance “consumer” by lowering the cost of insurance premiums. However, if subrogation savings truly are passed on to insureds, the analysis in the previous section fails. In other words, if insurance premiums reflect actuarization for subrogation payments, then insurers could stake a rightful claim upon amounts beyond that required to make an insured whole. If premiums reflect discounts due to potential subrogation, allowing an insured to recover from both an insurer and a tortfeasor would be, in essence, a triple recovery—a recovery from the lower premiums paid, a recovery from the health insurance benefits, and a recovery from the tortfeasor.

However, despite this proposition advanced by insurers, premium calculations do not reflect potential subrogation collections.⁹⁴ In fact, “[i]nsurers consistently fail to introduce the factor of such recoveries into rate-determining formulae, but rather apply such re-

91. *Lee v. State Farm Mut. Auto. Ins. Co.*, 129 Cal. Rptr. 271, 278 (Cal. Ct. App. 1976) (emphasis added).

92. 576 P.2d 489 (Ariz. 1978).

93. *Id.* at 492.

94. See JOHN F. DOBBYN, *INSURANCE LAW IN A NUTSHELL* 284 (3d ed. 1996).

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coveries to increasing dividends to shareholders.”⁹⁵ The consideration of subrogation is conspicuously absent from the following list of factors used by commercial insurers when establishing rates for insurance premiums:

- (1) the proportionate part of the total predicted cost of meeting specified types of losses in the ventures that have been grouped by the insurer 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.⁹⁶

So, in reality, subrogation is not accounted for in the formulation of insurance premiums, and justifiably so, since “the conjectural and remote nature of subrogation militates against its inclusion as a factor for consideration in the setting of premium rates.”⁹⁷ Although legitimately excluded from the actuarial calculations, allowing subrogation provides an illegitimate windfall to the insurance company.

In the truest sense, then, allowing subrogation by a health insurer guarantees a double recovery on the part of the insurer. Even when paying for an insured’s damages caused by a third party, insurers still remain profitable, or maintain one “recovery” due to the payment of insurance premiums. Subrogation provides the potential of additional profits, or a double recovery, each time an insured is injured by a third-party tortfeasor. Again, the purpose of this note is not to make a general argument against health insurer subrogation, although many have.⁹⁸ The simple plea of this note, and of all injured insureds, is to let them at least be made whole, or recover once, before a health insurance conglomerate is allowed to pad its bottom line through the double recovery windfall of subrogation.

C. The Reality of Subrogation

After the foregoing discussion of the theoretical underpinnings of subrogation, this note will take a brief look at the contextual real-

95. *Id.*

96. Baron, *supra* note 3, at 244 n.44 (quoting ROBERT E. KEETON & ALAN I. WIDISS, INSURANCE LAW § 1.3(b)(2) (1988)).

97. *Id.*

98. *See id.*

ity of subrogation. In most instances, an injured policyholder does not face the prospect of a double recovery due to the extent of his or her injuries and the limitations of the tortfeasor's insurance coverage.⁹⁹ In most large cases, an injured insured pays a contingency fee of thirty-three to forty percent for legal representation. Then, because of insurance policy limitations, aversion to litigation, financial need, or other reasons, cases are often settled for considerably less than the amount needed to make the victim whole. Additionally, third-party tortfeasors sometimes use the existence of collateral sources such as health insurance to negotiate a lower settlement amount.

Finally, the threat of subrogation itself hinders the settlement process. Tortfeasors may slacken their efforts to settle cases when subrogation clauses create questions as to whether an insured has the authority to release the tortfeasor from all other claims, or conversely, health insurers may be tardy in paying first party claims in hopes that the insured will recover from the tortfeasor.¹⁰⁰ Also, in cases where multiple insurers make subrogation claims, the waters of settlement negotiations are muddied, and a significant additional hurdle is placed in an insured's pathway to recovery.

Current federal case law harmoniously concurs, to the detriment of injured insureds, that language such as "this subrogation clause supercedes the make whole doctrine" is sufficient to grant first-dollar priority to health insurers over an injured insured who still has not been made whole. Although ERISA provides discretion to plan administrators and does not prescribe parameters for plan language, current case law provides unbridled power to health plans to mercilessly leave injured insureds in a less-than-whole state, simply by including specific language abrogating the make whole doctrine. Perhaps the most insidious characteristic of this standard is that an insured really is left unprotected against health plan contract language. As a matter of practical reality, it is unlikely that many insureds read the fine print of cumbersome 100-page summary plan descriptions. Even if they do, they are left with the choice of accepting the language as is or being left without insurance coverage.¹⁰¹

99. See *supra* text accompanying notes 35-83.

100. See Baron, *supra* note 3, at 245-46.

101. See, e.g., *Cagle v. Bruner*, 112 F.3d 1510 (11th Cir. 1997).

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D. A Vote for Federal Common Law Adoption of the Make Whole Doctrine

Considering the interests of the three major subrogation players—the health insurer, the injured insured, and the tortfeasor—three hypothetical scenarios represent the spectrum of possible solutions to subrogation cases after an insured is injured by a third-party tortfeasor.

In the first hypothetical situation, the health insurer pays for the insured's medical bills, the insured is made whole, and because the insured is made whole, the tortfeasor does not have to pay. Under this scenario, the health insurer and the injured insured received just treatment, but the tortfeasor unjustly escapes accountability.

In a second scenario, the health insurer pays for the insured's medical bills, the tortfeasor pays until all available funds are exhausted, and the insured still is not made whole yet is required to reimburse the health insurer out of the insufficient recovery received from the tortfeasor. In this instance, the health insurer pays nothing on the claim while retaining the insured's premiums. The result is that the tortfeasor has essentially met his or her obligation to the extent possible, but the health insurer is enriched by the reimbursement to the detriment of the injured insured who is still left without full compensation.

Finally, in a third hypothetical situation, the health insurer pays for the insured's medical bills, the tortfeasor pays until available funds are exhausted, the insured is still not made whole by the sum of both payments, so the insurer keeps the premiums and pays out on the insured's policy without reimbursement. This scenario provides for the tortfeasor to meet his responsibility as far as he is able, the health insurer to pay out claims for which it has already received premiums, and the insured to receive funds from all possible sources.

Clearly, this final scenario is the only setting in which justice is served. As discussed above, no plausible justification exists for allowing subrogation claims in cases where an insured has not been made whole from a tortfeasor-caused injury. ERISA does not require it, and, in fact, such a scenario actually belies the underlying intent of ERISA. The answer is simpler than the sum of adjudicative discourse has indicated. A nationwide adoption of the make whole doctrine deals most equitably with the health insurer, the injured insured, and the third-party tortfeasor. Despite any plan language explicitly disposing of the make whole doctrine, the doctrine should govern cases

where a health insurer has paid claims on an injury sustained by an insured at the hands of a third-party tortfeasor. Until an insured is properly compensated for his or her injuries, monies received from a third-party tortfeasor should be kept safe from the inequitable grasp of subrogation claims by health insurers.

V. CONCLUSION

In summary, current case law allows ERISA health insurers to be refunded even when an injured insured has not been sufficiently compensated for damages resulting from the act of a third-party tortfeasor. The make whole doctrine, barring subrogation until an injured party has been “made whole,” has been allowed by some circuits in situations where insurance plan language does not explicitly override the doctrine. In light of the highly questionable rationale for the existence of health insurer subrogation, the lack of guidance from ERISA itself, and the windfall for health insurers at the expense of its own insured, adoption of the make whole doctrine on a federal level will insure that all interested parties receive equitable treatment. Most importantly, consistent application of the make whole doctrine will guarantee that insurance premiums will more frequently buy an ally than an adversary, and that insurance company subrogation rights will not be valued more highly by the legal system than the rights of suffering injured insureds who, as a result of tortfeasor-caused injuries, are often left in physically and financially devastating circumstances.

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