SUBROGATION: A PANDORA'S BOX AWAITING CLOSURE

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> A possible . . . reason [to allow subrogation], that of ultimately reducing insurance rates by virtue of subrogated recoveries by insurers, has simply not come to pass. Insurers consistently fail to introduce the factor of such recoveries into rate-determining formulae, but rather apply such recoveries to increasing dividends to shareholders.
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> -JOHN F. DOBBYN,
> INSURANCE LAW IN A NUTSHELL 284 (3d ed. West 1996)

I. INTRODUCTION

Although appropriate, the comparison of the doctrine of subrogation to "Pandora's Box"[1] in the title of this article is not altogether original. One of the leading minority opinions[2] which resisted the expansion of subrogation into personal injury claims stated that such expansion would be equivalent to "lifting the lid on a Pandora's Box crammed with both practical and legal problems."[3]

The expansion of subrogation into personal injury claims was initially

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1. "Pandora's Box" is a term used to describe a source of many troubles. It is derived from the Greek myth that the woman Pandora, acting out of curiosity, opened a box which was not to be opened and thereby released all that is evil to mankind. THE AMERICAN HERITAGE DICTIONARY 897 (2nd College ed. 1985).

2. Travelers Indem. Co. v. Chumbley, 394 S.W.2d 418 (Mo. Ct. App. 1965). *See also* J. A. Bock, Annotation, *Subrogation Rights of Insurer Under Medical Payment Provision of Automobile Insurance Policy,* 19 A.L.R. 3D 1054 (1968) (discussing the right of subrogation in personal injury claims).

3. *Chumbley,* 394 S.W.2d at 425. *See also* State Farm Fire and Casualty Co. v. Knapp, 484 P.2d 180 (Ariz. 1971) (quoting *Chumbley,* 394 S.W.2d at 181).

resisted by only a small minority of jurisdictions in the 1960s and the 1970s. This minority view has more recently developed a considerable following.[4] More and more jurisdictions have come to recognize the harsh results placed upon an insured through the doctrine of subrogation.[5] Restrictions and doctrines have been developed, primarily through the courts, so as to ameliorate the harshness of subrogation. In fact, it was recently reported that twenty-five jurisdictions have now adopted the "make whole" principle—the leading doctrine designed to alleviate the harshness of subrogation.[6]

This article will first discuss the origin and evolution of subrogation. The rationale behind subrogation will then be reviewed. Next, the article will address the harshness of subrogation and focus on those restrictions and doctrines which have been judicially recognized as being available to lessen the hardship of subrogation. There will be some additional discussion of subrogation as it has uniquely developed in the context of self-funded employee benefit plans.

II. ORIGIN AND EVOLUTION OF SUBROGATION

Subrogation allows 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.[7] The doctrine of subrogation is of equitable origin,[8] but in modern society it has existed most fully and unchallenged in matters regarding property insurance.[9] An insurer's right of subrogation may exist by statute, by virtue of a contractual provision in a policy of insurance (conventional subrogation), or by judicial creation (legal subrogation).[10]

The doctrine of subrogation, at least in the area of property insurance, has been fairly stable. Over the past thirty years, however, insurers have

4. *See generally* Roger M. Baron, *Subrogation on Medical Expense Claims: The "Double Recovery" Myth and the Feasibility of Anti-Subrogation Laws,* 96 DICK. L. REV. 581, 584-86 (1992) (analyzing the minority view on subrogation and its recent adoption by a number of jurisdictions).

5. *See, e.g.,* Allstate v. Reitler Ins. Co., 628 P.2d 667, 670 (Mont. 1981); Maxwell v. Allstate Ins. Co., 728 P.2d 812, 815 (Nev. 1986).

6. Elaine M. Rinaldi, *Apportionment of Recovery Between Insured and Insurer in a Subrogation Case,* 29 TORT & INS. L.J. 803, 807 (1994) (listing the 25 states in alphabetical order, with citations to the corresponding cases).

7. *See generally* ROBERT E. KEETON & ALAN I. WIDISS, INSURANCE LAW § 3.10 (1988) (defining the doctrine of subrogation and noting its equitable roots).

8. *Id.*

9. 3 APPLEMAN, INSURANCE LAW AND PRACTICE § 1675, at 495 (1967). The authors noted, "Subrogation rights are common under policies of property or casualty insurance, wherein the insured sustains a fixed financial loss and the purpose is to place that loss ultimately upon the wrongdoer." *Id.*

10. KEETON & WIDISS, *supra* note 7, § 3.10(a)(1), at 220. The authors explain that conventional subrogation is "expressly provided for by a clause that is included either in the applicable insurance policy or in a settlement agreement with an insured." *Id.* Legal subrogation is "[w]hen there is no contractual provision or legislative act that explicitly sets forth a right of subrogation," and whether the right exists is "significantly influenced by the type of insurance coverage and the circumstances." *Id.*

continually sought the creation and enforcement of subrogation rights for payments on medical expenses and other types of claims.[11] During this period, subrogation clauses have been placed in policies which provide medical and hospitalization coverage, uninsured motorist coverage, and underinsured motorist coverage, as well as first party medical payments coverage in automobile policies.[12]

The expansion of subrogation into personal injury claims initially ran afoul of two common law doctrines: (1) The public policy against assigning personal injury claims;[13] and (2) the prohibition against splitting a cause of action.[14] As a result, the insurance industry redesigned language used in policies to create conventional subrogation. Revised policy language began purporting to grant the insurer the lesser right of "reimbursement" from a subsequent tort recovery as opposed to the bolder step of actually allowing the insurer to initiate a subrogation lawsuit.[15] Although insurers did create the lesser right of reimbursement as opposed to subrogation, the standard "subrogation" language was frequently retained[16] or actually recreated[17] by rewording the existing language in the policy forms.[18]

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11. Baron, *supra* note 4, at 583 (discussing the extension of subrogation beyond property damage claims).

12. *Id.*

13. *E.g.*, Wrightsman v. Hardware Dealers Mut. Fire Ins. Co., 147 S.E.2d 860, 861 (Ga. Ct. App. 1966) (holding a subrogation provision "void and of no effect" because the provision "amounted to no more than an agreement to assign a personal injury claim").

14. *E.g.*, Nationwide Mut. Ins. Co. v. DeJane, 326 N.E.2d 701, (Ohio Ct. App. 1974). The court recognized that subrogation on property damage claims was an authorized exception to the prohibition against splitting a cause of action. *Id.* at 703-04. Nonetheless, the court stated, "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.

15. *E.g.*, Shook v. Pilot Life Ins. Co., 373 S.E.2d 813, (Ga. Ct. App. 1988). Here the court distinguished *Wrightsman*, on the basis that the policy language in *Wrightsman* purported to create a right of subrogation, but "actually constituted an assignment of the cause of action." *Id* at 814. No such language was present in the *Shook* policy, which "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.'" *Id.* at 815. (quoting the Pilot Life insurance policy). *See also* In Re Estate of Scott, 567 N.E.2d 605, 607 (Ill. App. Ct. 1991) (holding, "Contrary to the estate's assertion, the language of the Plan's subrogation provision does not call for the full assignment of the insured's rights but, rather, *mere reimbursement* of amounts forwarded by the Plan") (emphasis added).

16. *See, e.g.*, Schuldt v. State Farm Mut. Auto Ins., 238 N.W.2d 270, 270-71 (S.D. 1975).

17. Lee v. State Farm Mut. Ins. Co., 129 Cal. Rptr. 271, (Cal. Ct. App. 1976). The court found that with respect to "medical payments" coverage, the insurer had created the right of reimbursement and had imposed a duty on the insured to hold such recovered funds in trust for the insurer. *Id.* at 273. In the event the insured did not voluntarily wish to pursue the tortfeasor, the following language in the policy provided the insurer an alternative method of reimbursement:

> (d) if requested in writing by the company, such *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 therewith.

Id. at 274.

18. *Id.* at 278 (Friedman, J., concurring). The concurring justice stated:

> [T]hese two decisions represent a creeping erosion of the anti-subrogation principle established at common law . . . . The successive amendments of State Farm's "reimburse-

Some jurisdictions, including South Dakota, expressed a willingness to recognize the full-fledged doctrine of subrogation as being unaffected by the common law prohibition against assigning a personal injury claim.[19] Accordingly, in many jurisdictions, it was not necessary for the insurers to fall back to the "lesser" right of "mere" reimbursement.[20] A solid minority of jurisdictions refused to allow the expansion of subrogation or reimbursement into personal injury claims.[21] Today, however, the minority view has become increasingly popular.[22] Many of the jurisdictions which initially permitted subrogation on personal injury claims have retreated.[23] Even jurisdictions which allowed the expansion of subrogation into medical expense claims have not hesitated to apply the minority view when given the opportunity to do so through choice-of-law principles.[24] This anti-subrogation approach has been developed both judicially[25] and legislatively.[26]

> ment" clauses illustrate how eagerly and quickly the disingenuous draftsmen of insurance policies move into the gaps created by decisional erosion . . . . The cumulative effect of the policy provisions is to create the economic reality of subrogation to the personal injury claim without its language.

Id.

19. *See Schuldt,* 238 N.W.2d at 270 (proclaiming the validity of subrogation clauses in medical payments portion of automobile insurance policies).

20. *See* Rinehart v. Farm Bureau Mut. Ins. of Idaho, Inc., 524 P.2d 1343 (Idaho 1974) (upholding subrogation clause of medical payments provision of automobile insurance policy over claim that it violated public policy). This opinion cites an extensive list of similar authorities. *Id.* at 1345 n.2. *See also* Geertz v. State Farm Fire & Casualty, 451 P.2d 860 (Or. 1969) (upholding validity of subrogation clause in medical payments coverage).

21. *See, e.g., Chumbley,* 394 S.W.2d at 425; *Knapp,* 484 P.2d at 181 (both recognizing that allowing subrogation on medical payment claims would be tantamount to "lifting the lid on a Pandora's box crammed with both practical and legal problems"); Berlinski v. Ovellette, 325 A.2d 239, 242 (Conn. 1973) (stating that subrogation would "serve to prejudice the ultimate ability of the injured person to be compensated fully"); *Reitler,* 628 P.2d at 670; *Maxwell,* 728 P.2d at 815 (both holding that public policy required the denial of subrogation).

22. Rinaldi, *supra* note 6, at 807. Rinaldi reported that 25 jurisdictions have now adopted the "make whole" doctrine. *See also* Baron, *supra* note 4, at 584-85 (noting the growing acceptance of the minority view).

23. *Id.*

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

25. *See, e.g., Maxwell,* 728 P.2d at 815 (holding a subrogation clause for medical payments void as a matter of public policy); *Reitler,* 628 P.2d at 667 (finding that subrogation for medical payments was invalid).

26. *E.g.,* Aetna Casualty and Sur. Co. v. State Bd. for Property and Casualty Rates, 637 P.2d 1251 (Okla. 1981) (re-adopting the minority view after legislative action). The Oklahoma statute rejecting subrogation for personal injury claims states:

> No provision in an automobile liability policy or endorsement . . . which grants the insurer the right of subrogation for payment of benefits under the expenses for the medical services coverage portion of the policy, to a named insured under the policy, or to any relative of the named insured who is a member of the named insured's household shall be valid and enforceable . . . .

OKLA. STAT. ANN. tit. 36, § 6092 (West 1990). *See also* the Pennsylvania statute which likewise rejects such subrogation claims:

> In actions arising out of the maintenance or use of a motor vehicle, there shall be no right of subrogation or reimbursement from a claimant's tort recovery with respect to workers' compensation benefits, benefits available under section 1711 (relating to required benefits), 1712 (relating to availability of benefits) or 1715 (relating to availability of adequate limits) or benefits paid or payable by a program, group contract or other arrangement whether primary or excess under section 1719 (relating to coordination of benefits).

75 PA. CONS. STAT. ANN. § 1720 (Supp. 1995).

Some jurisdictions have rejected subrogation on personal injury claims outright, while others permit it only conditionally or with ameliorating restrictions.[27]

It is clear that the common law prohibitions against the assignment of personal injury claims and splitting a cause of action are not the central issues for consideration. Rather, the real debate is now focused on the rationale for subrogation in the first instance, the untoward consequences which subrogation has on the insured, and an analysis of the premium paid by the insured for coverage. Upon an examination of these issues, it becomes clear that subrogation, even in the property insurance context, may warrant curtailment.[28]

III. THE FLAWED RATIONALE OF SUBROGATION

The most commonly asserted basis for subrogation relates to the indemnity notion of insurance.[29] In theory, the insured should enjoy the benefit of receiving prompt indemnification for loss, with the risk of ultimate recovery from the tortfeasor falling upon the insurer. The basis for subrogation is the notion that the insured should not unduly benefit from a loss and thereby enjoy a "double recovery" from both the insurer and the tortfeasor.[30] Certainly, the tortfeasor should not escape liability.[31] There-

27. For a detailed discussion of these themes, see *infra* notes 29-125 and accompanying text.

28. *E.g.*, Wimberly v. American Casualty Co. of Reading, Pa., 584 S.W.2d 200 (Tenn. 1979). In this case, property insurers which paid out $15,000 on a $44,619 loss sought subrogation for the full amount of the payments when the insured was about to collect another $25,000 from the tortfeasor. *Id.* at 201. The Tennessee Court of Appeals allowed a pro rata recovery to the subrogated insurers, but the Supreme Court of Tennessee denied subrogation altogether because the insured had not been made whole. *Id.* at 203. The court stated, "[W]e believe our resolution of this case must be guided by general principles of equity, to wit, that the insured must be made whole before subrogation rights arise in favor of the insurers." *Id.* *See also* Garrity v. Rural Mut. Ins. Co., 253 N.W.2d 512 (Wis. 1977). In *Garrity,* the property insurer had paid $67,227.12 on a fire loss alleged to be in the amount of $110,000, and then sought subrogation rights against a $25,000 settlement with the tortfeasor—the limit of the tortfeasor's policy. *Id.* at 513. The trial court's allowance of subrogation was reversed, with the Wisconsin Supreme Court holding that "the subrogee has no right to share in the fund recovered from the tort-feasor until the subrogor is made whole." *Id.* at 516.

29. Rinaldi, *supra* note 6, at 803. *See also* JOHN F. DOBBYN, INSURANCE LAW IN A NUTSHELL 284 (3d ed. West 1996). Dobbyn stated:

> The doctrine of subrogation in the insurance context has been closely interwoven with the doctrine of indemnity. The most frequently cited reason for its application is to prevent an insured from profiting from his loss—i.e., obtaining a double recovery, once from his insurer and once from the tort-feasor.

Id.

30. Rinaldi, *supra* note 6, at 803. Rinaldi noted:

> [S]ubrogation has its genesis in the principle of indemnity. Although an insured is entitled to indemnity from an insurer pursuant to coverage provided under a policy of insurance, the insured is entitled only to be made whole, not more than whole. Subrogation 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.

Id.

31. *Id.* Most agree that the tortfeasor should not profit from insurance paid for by the insured, and that the tortfeasor should bear the economic burden of the loss which was caused. *Id.* It is interesting to note, however, that in some situations the tortfeasor is, in fact, allowed to benefit from the insurance secured by the insured. Some state legislatures have enacted statutes which allow the negligent health care provider to introduce evidence of first party insurance at

fore, the insurer should enjoy the opportunity to "stand in the shoes" of the insured while pursuing a recovery of the amounts paid to the insured. For the most part, this rationale is flawed. The "double recovery" argument has been proven to be duplicitous. In most cases, there would not be any "double recovery" for the insured if subrogation is denied.[32] Rather, the great irony is that in the vast majority of cases, the insurer who asserts that the insured will receive an unwarranted "double recovery" is itself picking up a windfall recovery if subrogation is permitted.[33]

As a preliminary matter, one might suggest that it does not matter if the insured receives a double recovery. Does the insured's premium only guarantee that the insured will be made whole from *all* possible sources of recovery? Arguably, the insured ought to be entitled to receive the insurance benefits for which a premium has been paid (i.e. seek a recovery on a "contract" theory from the insured's own insurer) and, if feasible, also be allowed to pursue the tortfeasor who caused the damages (i.e. also seek a recovery in "tort").[34] After all, the "collateral source rule"[35] has long dictated that the tortfeasor should not gain an advantage and thereby pay less than the actual damages just because the victim had wisely invested years of insurance premiums to assure medical care.[36] Why, then, should the insured victim be limited to the same total recovery that a non-insured victim would receive? Some courts have recognized exactly this—that the insured is not gaining a double recovery, but is simply recovering on a contract for which a premium has been paid.[37]

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trial so as to mitigate damages by showing the jury that the injured party's insurer—and not the injured party—did, in fact, pay for the damages caused by the negligent party. *E.g.*, CAL. CIV. CODE § 3333.1 (West Supp. 1995) and S.D.C.L. § 21-3-12 (1987).

32. Baron, *supra* note 4, at 589. The author notes that the insured can rarely recover for mental anguish and physical pain and that determining the insured's exact loss is difficult due to the nature of those types of injuries (citing *State Bd.*, 637 P.2d at 1255).

33. *See id.* at 582 and 587-91 for a more detailed analysis of this theme. The insurer receives a windfall, in that, "[i]n 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." *Id.* at 582.

34. *Lee*, 129 Cal. Rptr. at 278 (Friedman, J., concurring). The concurring justice stated:

> 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 argument is singularly unmoving.

Id.

35. *See* 22 AM. JUR. 2D *Damages* § 566 (1988). It has been noted that "the courts generally have held that benefits received by the plaintiff from a source wholly independent of and collateral to the wrongdoer will not diminish the damages otherwise recoverable from the wrongdoer." *Id. See also* Helfend v. Southern Cal. Rapid Transit Dist., 465 P.2d 61 (Cal. 1970). Therein the court stated, "The collateral source rule . . . embodies the venerable concept that a person who has invested years of insurance premiums to assure his medical care should receive the benefits of his thrift. The tortfeasor should not garner the benefits of his victim's providence." *Id.* at 66.

36. For a discussion of how some tortfeasors do gain such an advantage, despite the collateral source rule, see *supra* note 31 and accompanying text.

37. *See, e.g.*, *Reitler*, 628 P.2d at 670. Therein the court stated, "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. See also* Allstate Ins. Co. v. Druke, 576 P.2d 489, 492 (Ariz. 1978) (reasoning that to require the injured policyholder to return to the insurer the benefits for

On the other hand, if an insurer is allowed to subrogate and recover the money it paid its insured on the claim, then it finds itself in the position of having suffered no loss. Additionally, the insurer retains the premium initially charged to cover that risk.[38] By virtue of this analysis, it appears as though the insurer receives a pure windfall,[39] at least on those claims where there is a tortfeasor or other third party liable for the injuries sustained by the insured.

The ultimate resolution of the conflict between the insurer, which argues that the insured receives a "double recovery" and the insured who argues that the subrogated insurer receives a "windfall" is best achieved by focusing the inquiry on the premium charged for coverage.[40] In particular, does the premium reflect subrogated recoveries?[41] If the insured pays a premium which is proportionately lower because subrogation is permitted, at least then it does not appear that the insurer receives a "windfall."

It should be noted that even if the premium reflects subrogated recoveries, one can make a policy argument that subrogation should be denied anyway. Arguably, society as a whole would be better off if subrogation were entirely eliminated from the insurance industry. This would be more consistent with the common person's view of insurance.[42]

In a commercial insurance setting, the successful collection of a subro-

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which premiums have been paid is to deny the policyholder the "benefits of his thrift and foresight").

38. *See* Baron, *supra* note 4, at 588. It has been argued that if subrogation is permitted, then first party insurance coverage becomes an illusion because the insured receives nothing for the separate premium paid to the insurer when a tortfeasor is liable for damages. *Id.* The illusory nature of first party insurance in an automobile policy is even more apparent in those jurisdictions which statutorily require every driver of an automobile to be covered by liability insurance or have other proof of financial responsibility. *Id.* The plaintiff could never recover on her own medical payments policy because the party at fault would always be financially responsible. *Id.* *See also* Milbank Ins. Co. v. Henry, 441 N.W.2d 143 (Neb. 1989) (Fahrnbruch, J., dissenting). The dissent argued:

> 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. at 149.

39. *Maxwell*, 728 P.2d at 815. The court noted, "Allowing subrogation deprives the insured of the coverage for which he had paid and results in a windfall recovery for the insurer." *Id.*

40. DeCespedes v. Prudence Mut., 193 So. 2d 224, 227-28 (Fla. Dist. Ct. App. 1966), *aff'd*, 202 So. 2d 561 (Fla. 1967). The court noted, "Admittedly, subrogation has been a two-edged sword. Unfortunately, it has frequently become a source of windfall to insurers in that the anticipated recoveries under subrogation rights are generally not reflected in the computation of premium rates." *Id.*

41. Frost v. Porter Leasing Corp., 436 N.E.2d 387 (Mass. 1982). The court in *Frost* denied the health insurer's subrogation claim for $22,679.57 from settlement proceeds of $250,000, stating, "Subrogation played no part in the bargain between insurer and insured." *Id.* at 390.

42. Most insureds do not understand subrogation and do not realize the consequences of an insurer's right of subrogation until after a loss has occurred and they are attempting to reach a settlement with the tortfeasor's insurer, only to learn that from that settlement, a portion may have to be returned to the first party insurer. After the insured's costs and attorney fee are paid, there may be little or nothing left for the insured if the subrogated insurer must be reimbursed. For further discussion of this point, *see infra* notes 141-42 and accompanying text.

gated claim does indeed result in a windfall to the insurer.[43] 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 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 the total estimated losses for the pool, as well as the insured's pro rata share of the costs, expenses, and profit margin to be borne by the insurer for setting up and administering the insurance undertaking.[44] The prospect of a successful subrogation collection is not a factor in the insurer's rate determination.[45] In fact, the conjectural and remote nature of subrogation militates against its inclusion as a factor for consideration in the setting of premium rates.[46] 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.[47] A number of courts have also come to recognize that the allowance of subrogation results in a pure windfall to the insurer with no corresponding adjustment in the premium charged.[48] Even courts which do permit subrogation have, on occasion, admitted that it results in a windfall gain to the insurer which is not reflected in the setting of rates.[49]

43. EDWIN W. PATTERSON, ESSENTIALS OF INSURANCE LAW § 33 (2d ed. 1957). Patterson stated, "Subrogation is a windfall to the insurer. It plays no part in rate schedules . . . ." *Id.* at 151-52.

44. KEETON & WIDISS, *supra* note 7, § 1.3(b)(2). The following is a list of factors taken into consideration when setting an insurance premium:

> (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.

Id.

45. PATTERSON, *supra* note 43, at 151-52.

46. In essence, the first party insurer is contractually required to pay the claim regardless of whether or not a tortfeasor or other third party may be liable for the damages. Insurance benefits flow to insureds who are at fault themselves or who otherwise find themselves injured without the involvement of tortfeasors. The actuarial analysis of the pool is geared toward the anticipated losses to be incurred by the pool—not the anticipated losses caused by solvent tortfeasors in situations where the insured is not contributorily negligent or otherwise guilty of some behavior which would bar recovery. Of course, if it were possible to accurately factor successful subrogation into the rate-making process, the total projected losses would be lower and the premiums would also be lowered.

47. This observation that subrogation is a windfall to the insurer is not appropriate for reciprocal insurance, self-insurers, or self-funded plans, where the insured's contribution for the transference of the risk is directly tied to the exact losses as they arise.

48. *See, e.g., Druke,* 576 P.2d at 492. The court in *Druke* stated:

> [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 Chumbley, 394 S.W.2d at 425. The court in *Chumbley* 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." *Id. See also Maxwell,* 728 P.2d at 815 (reasoning that "the only justification for allowing subrogation for medical payments would be lowering of premium rates as a result of recoupment" and that such lowering did not generally follow recoupment).

49. *E.g., DeCespedes,* 193 So. 2d at 227-28 (admitting that "subrogation has been a two-

Leading scholars in the insurance field have continued to recognize the windfall nature of subrogated recoveries for commercial insurers.[50]

Aside from the notion that subrogation results in a windfall for the insurer, there are numerous other troubling features that accompany the doctrine of subrogation. These other undesirable features of subrogation are discussed in greater detail elsewhere,[51] but are summarized here as follows. First, even with the denial of subrogation, a true "double recovery" is unlikely to ever occur.[52] This is true due to the fact that the "exact loss" is difficult, if not impossible to ascertain, because items such as mental anguish and physical pain are not insurable and are rarely fully recoverable from tortfeasors.[53] Moreover, agreed upon settlements are frequently set at amounts lower than the total damages because the injured parties are required to compromise their recoveries in a number of situations.[54] The settlement may be for less than actual damages when liability of the tortfeasor is disputed and uncertain, or because the tortfeasor has limited assets or limited insurance coverage. Furthermore, if the applicable law does not provide for recovery of certain losses, such as future income or other future damages, the amount of the settlement may be limited. Similarly, when the parties have assumed (mistakenly or otherwise) that the injured party's expenses have or will be paid by other sources, settlement for complete damages and a full recovery is doubtful.

Second, subrogation is disruptive of the settlement process which takes place between the insured and the tortfeasor. Tortfeasors are less inclined to settle meritorious claims because the insured may not have sufficient authority to fully release the tortfeasor.[55] As a result, the tortfeasor is indi-

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edged sword" frequently resulting in a windfall to insurers "because anticipated recoveries under subrogation rights are generally not reflected in the computation of premium rates").

50. PATTERSON, *supra* note 43, at 151. Patterson stated, "Subrogation is a windfall to the insurer. It plays no part in rate schedules . . . ." *Id. See also* DOBBYN, *supra* note 29, at 284. Dobbyn stated, "A possible third reason, that of ultimately reducing insurance rates by virtue of subrogated recoveries by insurers, has simply not come to pass. Insurers consistently fail to introduce the factor of such recoveries into rate-determining formulae, but rather apply such recoveries to increasing dividends to shareholders." *Id.*

51. *See* Baron, *supra* note 4, at 587-93 (discussing the rationale behind disallowing subrogation).

52. *Id.* at 589.

53. *E.g., State Bd.*, 637 P.2d at 1255 (noting the difficulty of ascertaining exact loss and reasoning that this militates against finding double recovery).

54. *See, e.g., Maxwell,* 728 P.2d at 815 (noting that the injured party may be unable to fully recover actual damages); *Reitler,* 628 P.2d at 670 (discussing how expenses such as the costs of litigation limit a recovery); *Druke,* 576 P.2d at 492 (noting the ways in which a recovery falls short of providing complete indemnification).

55. A general release from the injured party has been held not to protect the tortfeasor from subsequent subrogation claims brought by the injured party's own insurer. *See* Home Ins. Co. v. Hertz, 375 N.E.2d 115 (Ill. 1978) (deciding that unlimited release by insured subrogor did not bar subrogee's action for subrogation on medical payments coverage of auto policy); Travelers Indem. Co. v. Vaccari, 245 N.W.2d 844 (Minn. 1976) (finding that a general release did not bar subrogation claim on medical expenses portion of auto policy); Time Ins. Co. v. Opus Corp., 519 N.W.2d 470 (Minn. Ct. App. 1994). The court in *Opus* held:

> Subrogation generally is not available if the injured party has not obtained full recovery. But where an alleged tortfeasor willfully disregards notice of the subrogation claim of the

rectly encouraged to prolong the litigation.[56] In some cases, the insured's own insurer may even intervene in the lawsuit against the tortfeasor, thereby protracting the litigation even further.[57]

Third, in situations involving multiple subrogation claims, disagreements between the insured and the insurers or disagreements between the multiple subrogees also tend to complicate and prolong the settlement process.[58] This, in turn, runs afoul of fundamental policy notions that protracted litigation should be discouraged and the pathways to voluntary settlements should remain unimpeded.[59]

Finally, subrogation encourages delay in the payment of first party benefits because the first party insurer has a motive to deny payment, hoping that the insured will first obtain a recovery from the tortfeasor.[60] A settlement directly with the tortfeasor may excuse payment altogether on the basis that the insured has impaired the insurer's right of subrogation.[61] It should be noted, however, that with the development of the first party

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> injured person's insurer and enters into a separate agreement with the injured person, such a settlement does not defeat the insurer's subrogation rights.

Id. at 474. The court in *Opus* went on to find that the tortfeasor had "wilfully excluded Time from the settlement negotiations." *Id. But cf.* Group Health, Inc. v. Heuer, 499 N.W.2d 526 (Minn. Ct. App. 1993) (holding that a tortfeasor who settles with an insured without actual notice of the subrogated insurer's claim cannot be subjected to a subsequent claim for subrogation); *Henry,* 441 N.W.2d at 143 (following Wisconsin law, and holding that, where the tortfeasor and his liability insurer had notice of a subrogation claim, settlement with the injured party did not destroy the subrogated insurer's claim); Continental Western v. Farm Bureau Ins., 511 N.W.2d 559 (Neb. Ct. App. 1994) (holding that where the tortfeasor's liability insurer, acting with notice of an insurer's right of subrogation, procures a general release by making a settlement with the insured, the release will not affect the insurer's right of subrogation).

56. *See generally* Baron, *supra* note 4, at 591.

57. Such intervention often results in appeals, which protract the litigation. *E.g.,* Hamler v. Marshall, 518 N.E.2d 575 (Ohio Ct. App. 1986) (upholding denial of health insurer's assertion of an unqualified right to intervene). The court stated, "[Without an] adequate demonstration of any right to intervene . . . . [t]he bald assertion of subrogation without proof thereof does not entitle [the insurer] to participate." *Id.* at 576. *See also* Tierny v. American Group Benefit Services, Inc., 406 N.W.2d 579 (Minn. Ct. App. 1987) (denying the insurer's request to intervene as of right).

58. *Chumbley,* 394 S.W.2d at 425 (finding that the nurturing of subrogation would give substance to an "unwelcome specter of *multiple* subrogation claims").

59. *Id.* The court noted 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. See also* Baron, *supra* note 4, at 591-92.

60. *See generally* Baron, *supra* note 4, at 592-93 (noting that most policies contain provisions relating to the conduct of the insured and, in particular, allow for the denial of first party benefits in the event the insured releases the tortfeasor).

61. *E.g.,* Amert v. Continental Casualty, 409 N.W.2d 660 (S.D. 1987). The insured's collection from providers of insulation served as the basis for summary judgment on the insured's claim against property insurers. *Id.* at 661-62. Summary judgment was granted in favor of the insurers, despite the fact the insurers denied payment during the pendency of the products liability claim, forcing the insured to institute separate lawsuits against the tortfeasors and the first party insurers. *Id.* at 663-64. *See also* Hart v. State Farm Mut. Auto. Ins. Co., 248 N.W.2d 881 (S.D. 1977). In *Hart,* the settlement of $4,242.39 with the tortfeasor served to defeat the insured's claim for the policy limit of $1,000 on medical payments coverage because the insurer's right of subrogation was destroyed. *Id.* at 882. *See also* Ruby v. Midwestern Indem. Co., 532 N.E.2d 730 (Ohio 1988). The court in *Ruby* denied a claim for underinsured motorist coverage because the insured materially breached her insurance contract by executing a release that precluded the insurer from exercising its subrogation rights. *Id.*

bad faith cause of action, an insurer runs the risk of an insured bringing a successful bad faith claim if the insurer simply denies payment without a reasonable basis.[62]

IV. DOCTRINES DESIGNED TO AMELIORATE THE HARSHNESS OF SUBROGATION

In recognition of the harsh effects of subrogation, a number of doctrines and restrictions have developed which serve to ameliorate those effects. These doctrines have been created primarily by the courts, and span the range from an outright denial of subrogation to the unimpeded allowance of subrogation. The discussion which follows is an effort to synthesize the doctrines as they have developed. They are addressed in the relative order of being most effective to least effective in alleviating the harsh effects of subrogation.

A. Outright Denial of Subrogation

As indicated above, a small minority of jurisdictions have judicially denied subrogation on personal injury claims.[63] Other jurisdictions have legislatively adopted this view.[64] The fundamental notion underlying an outright denial is that a subrogated recovery constitutes a windfall for the insurer and that the insured is denied the benefit for which the premium dollars served as consideration.[65]

Even in jurisdictions which permit subrogation, a rather strong body of case law has developed which denies subrogation *in toto* in situations where the subrogated insurer is also the tortfeasor's insurer. As unusual as it may sound, there are many instances where the same insurer is contractually required to pay first party benefits to the insured and also provide liability coverage to the tortfeasor. If subrogation were permitted, then the insurer would only be required to pay out on one policy.

In its purest scenario, the very same insurer seeks to avoid a double

62. Isaac v. State Farm Mut. Ins. Co., 522 N.W.2d 752 (S.D. 1994) (holding that the insurer acted in bad faith in denying uninsured motorist benefits because of insured's receipt of worker's compensation benefits). *Cf. Burnaby,* 20 Cal. Rptr. 2d at 58 (holding that the right of subrogation is waived when the insurer engages in conduct that amounts to a breach of contract); Buzzard v. Farmer's Ins. Co., Inc., 824 P.2d 1105, 1114 (Okl. 1991) (holding that insurer was estopped from claiming the insured impaired its right of subrogation, because the insurer unreasonably delayed payment for underinsured motorist coverage). *See also* Dobbyn, *supra* note 29, at 329-39 (discussing bad faith causes of action).

63. *See supra* note 21 and accompanying text.

64. For the text of the Oklahoma and Pennsylvania statutes which reject subrogation to varying degrees, see *supra* note 26.

65. *See generally* Baron, *supra* note 4, at 587-91. *See Isaac,* 522 N.W.2d at 755 (recognizing the value of the premium dollar and the merits of the collateral source rule in an attempted set-off for worker's compensation benefits in uninsured motorist coverage). *See also* National Farmers Union Property & Casualty v. Bang, 516 N.W.2d 313, 320 (S.D. 1994). The South Dakota Supreme Court stated, "The rationale is . . . first, uninsured motorist coverage is paid for by a separate premium, and to give the uninsured motorist carrier a set-off based on the fortuitous existence of a collateral source would result in a windfall to the carrier . . . ." *Id.* (quoting Risks Ins. v. Thompson, 522 A.2d 1382, 1388 (Penn. 1989)).

payment even though clearly named insureds are covered.[66] This frequently arises in the context of the insurer's denial of first party benefits, after it previously settled the case on behalf of the tortfeasor. The insurer is put in the position of complaining about having been deprived of the right to sue its own insured (the tortfeasor) as a result of the settlement. The overwhelming response has been, even in those jurisdictions which otherwise permit subrogation, that the insurer must pay twice—it is not permitted to assert subrogation rights against its own insured.[67]

There are many variations on the principle that an insurer may not assert subrogation rights against its own insured. This principle was upheld in a situation where two related corporations had issued the respective policies, but were considered to be the "same corporate entity" for purposes of resolving the subrogation issue.[68] Courts have also stretched the concept of who is insured by the policy to cover individuals and entities which were not specifically named as insured under the policy.[69] Even where the insured is covered under a policy issued by a different insurer, the right of subrogation has been denied.[70]

66. Control Specialists Co. Inc. v. State Farm Mut. Ins. Co., 423 N.W.2d 775, 776 (Neb. 1988) (allowing the injured party to recover from the tortfeasor's insurer and also to recover on his own first party benefits for property damage); Dupre v. Vidrine, 261 So. 2d 288 (La. Ct. App. 1972) (holding that insurer was not discharged from first party coverage even though it had been deprived of the right to subrogate against another of its own insureds).

67. *See, e.g.,* Stetina v. State Farm, 243 N.W.2d 341 (Neb. 1976). In *Stetina,* the insurer was required to pay $10,000 on "med pay" coverages, notwithstanding its claim that coverage was extinguished as a result of the insured's release of the tortfeasor—where settlement in the amount of the policy limit of $50,000 had, in fact, been arranged by the subrogated insurer's agent acting on behalf of the tortfeasor. *Id.* at 347. The court stated, "Where no subrogation exists, there can be no impairment of subrogation rights." *Id.* (quoting Norris v. Allstate Ins. Co., 293 So. 2d 918, 921-22 n.2 (La. Ct. App. 1974)).

68. Home Ins. Co. v. Pinski Bros., Inc., 500 P.2d 945 (Mont. 1972). The court held that "Home Indemnity Company," the liability insurer, was considered to be the same corporate entity as "Home Insurance Company," the subrogated insurer, which was ultimately denied the right of subrogation. *Id.* at 948-49. *See also* National Union Fire Ins. Co. of Pittsburgh v. Engineering-Science, Inc., 673 F. Supp. 380, 382-84 (N.D. Cal. 1987) (denying subrogation and rejecting the argument that a "Chinese Wall" existed between the department handling "builder risk" coverage and the department handling "errors and omissions" coverage).

69. *See, e.g.,* Long, Inc. v. Brennan's of Atlanta, Inc., 252 S.E.2d 642 (Ga. Ct. App. 1979) (disallowing the owner's insurer from bringing subrogation action against general contractor to recover monies paid out for damages from explosion and fire, even though contractor may have caused the damages—the contractor was considered a co-insured); Reeder v. Reeder, 348 N.W.2d 832 (Neb. 1984) (disallowing a fire insurer from bringing subrogation claim for $139,760 against the insured's niece, who negligently started the fire by igniting the gas fireplace without opening the damper, because the niece was considered a co-insured); State Regents of New Mexico State Univ. v. Siplast, 877 P.2d 38 (N.M. 1994) (rejecting a subrogation claim by the contractor's insurer against a supplier of material because the supplier was considered a co-insured under the policy); Fireman's Ins. of Newark, N.J. v. Wheeler, 566 N.Y.S.2d 692, 695 (N.Y. App. Div. 1991) (denying the fire insurer's subrogation claim against the president and principal shareholder of insured closely-held corporation, even though fire loss was allegedly caused by president's negligence—the court presumed that the president and the insured corporation were "fully united in economic interest").

70. Pennsylvania Gen. Ins. Co. v. Austin Powder Co., 502 N.E.2d 982 (N.Y. 1986). In denying the lessor's insurer of the truck the right to be subrogated against lessee, who was also covered under lessor's policy, despite the fact lessee was insured by separate insurer, the court stated:

> An insurer has no right of subrogation against its own insured for a claim arising from the very risk for which the insured was covered. This rule applies even where the insured has

The development of the line of cases which denies subrogation outright whenever it appears, or can be successfully argued, that the insurer is seeking to be subrogated against its own insured, is perhaps the best evidence of the reality that subrogation has turned into a "Pandora's Box." It is in these cases that the insurer's duplicitous motive of simply looking for a reason to deny payment is perhaps most clearly seen. It is also in these cases that the vulnerable position of the insured, as contrasted with the superior position of the insurer, is most apparent.[71] When subsequent subrogation litigation ensues, the insurer is able to utilize information gathered in connection with processing one insured's claim to the disadvantage of the other insured.

As the discussion now flows into a presentation of doctrines which permit subrogation, albeit according to certain limitations or restrictions, one final benefit of the outright denial doctrine bears consideration. Unlike the doctrines discussed below, outright denial of subrogation does not require policing on a case-by-case basis, and thus helps to streamline the tort recovery process. Although the intermediate approaches set forth below may appear to have some appealing qualities, it should be remembered that so long as the insurer is given the prospect of even a *partial* subrogated recovery, the process of settling with a tortfeasor continues to be disrupted by the necessary involvement of those subrogated insurers. The intermediate approaches also provide fertile ground for posturing by the subrogated insurers. Such posturing hampers the judicial process and also places the attorney for the insured in the unnatural position of being asked to serve two masters—the insured and the subrogated insurer.

B. The "Make Whole" Doctrine

Perhaps the most attractive of the intermediate doctrines is the "make whole" doctrine. Under this doctrine, subrogation is permitted only after the insured has been fully compensated or "made whole."[72] This approach

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> expressly agreed to indemnify the party from whom the insurer's rights are derived and has procured separate insurance covering the same risk.

Id. at 983.

71. *See Pinski Bros., Inc.*, 500 P.2d at 949. The court stated:

> To permit the insurer to sue its own insured for a liability covered by the insurance policy would violate these basic equity principles [of the clean hands doctrine], as well as violate sound public policy. Such action, if permitted, would (1) allow the insurer to expend premiums collected from its insured to secure a judgment against the same insured on a risk insured against; (2) give judicial sanction to the breach of the insurance policy by the insurer; (3) permit the insurer to secure information from its insured under the guise of policy provisions available for later use in the insurer's subrogation action against its own insured; (4) allow the insurer to take advantage of its conduct and conflict of interest with its insured; and (5) constitute judicial approval of a breach of the insurer's relationship with its own insured.

Id.

72. Complete Health, Inc. v. White, 638 So. 2d 784 (Ala. 1994) (denying the subrogated insurer's effort to collect $74,252 in paid health care costs from a settlement of $500,000 because the insured had not been fully compensated). The court in *White* stated, "In Alabama, the rule is that an insurer is not entitled to subrogation unless and until the insured has been made whole for his or her loss." *Id.* at 786.

acknowledges the realistic nature of tort recoveries and rejects the blind assertion that subrogation is necessary in order to prevent the insured from realizing a "double recovery."[73] The "make whole" doctrine has also been invoked in matters regarding property insurance,[74] a line of insurance traditionally viewed as the most hospitable environment for subrogation.[75] It was recently reported that the "make whole" doctrine now serves as the majority view,[76] having been adopted in twenty-five jurisdictions.[77]

When a tort recovery is made by an insured, a number of jurisdictions have recognized that the amount of the settlement does not *ipso facto* equal the amount of the insured's damages.[78] The burden has thus been appropriately placed on the subrogated insurer to establish that the insured has been fully compensated prior to the allowance of subrogation rights.[79] At least one jurisdiction has decided that the determination of whether or not the insured has been fully compensated is properly made by the trial court alone, rejecting the subrogated insurer's motion for a jury trial.[80]

Under the "make whole" doctrine, recent decisions have come to focus on the real or "net" compensation actually received by the insured.[81] If

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73. *E.g.*, Westendorf v. Stasson, 330 N.W.2d 699, 703 (Minn. 1983). The court stated, "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." *Id. See generally* Rinaldi, *supra* note 6 (discussing the origin and policies underlying subrogation); 16 GEORGE J. COUCH, COUCH ON INSURANCE 2D § 61:64 (1983) (discussing the situation where loss exceeds the amount recovered).

74. *Wimberly*, 584 S.W.2d at 201 (denying altogether subrogation claims by fire insurers for $15,000, where total damages exceeded $44,000 and the only recovery the insured was able to obtain from the tortfeasor was a settlement of $25,000—meaning, from all sources, the insured would only collect a total of $40,000 if subrogation were denied); *see also Garrity*, 253 N.W.2d at 513 (reversing trial court's allowance of subrogation where the subrogated fire insurer sought recovery from $25,000 settlement with tortfeasor for its payment of $67,227.12, where alleged total damages of $110,000 would not be recovered by the insured).

75. DOBBYN, *supra* note 29, at 285. Dobbyn noted, "Because property insurance is the most clear form of indemnity—payment measured and limited by the value of the thing lost—subrogation applies most universally to this line of insurance." *Id.*

76. *Id.* at 293. Dobbyn also noted:

> [T]he majority of courts direct that the insured is to be compensated first out of the fund to the extent to which his loss exceeds insurance proceeds. The insurer is then to be compensated up to the amount of proceeds paid to the insured, and the remainder of the fund, if any, goes to the insured.

Id.

77. Rinaldi, *supra* note 6, at 807.

78. *See White*, 638 So. 2d at 787, wherein the Alabama Supreme Court stated, "In allocating an amount received by an insured from a third-party tort-feasor, Utah, like Alabama, does not assume that the amount of the settlement determines the amount of the plaintiff's damages." *Id.* (citing Hill v. State Farm Mut. Auto. Ins. Co., 765 P.2d 864, 867 (Utah 1988)).

79. *Id.* The court held that "the burden is on the insurer to prove that the insured has been fully compensated before the insurer can assert its subrogation rights against the insured . . . ." *Id.*

80. *Id.* at 786-87. The court found that the "trial court is the appropriate factfinder" for whether there has been full compensation and that the "trial court properly denied [the insurer's] motion for a jury trial." *Id.*

81. *See, e.g.*, DeTienne Ass'n v. Farmers Union Mut. Ins., 879 P.2d 704 (Mont. 1994). The court in *DeTienne* noted:

> [W]e are cognizant of two guiding concerns based upon prevailing equitable principles: 1) [The insured] must be made whole for its losses, including the attorney fees it incurred in the litigation against the tortfeasor, and 2) if either the insured or the [subrogated]

the insured has been required to hire an attorney and incur court costs in order to effectuate a recovery against the tortfeasor, those attorney's fees[82] and costs should be considered in determining whether the insured has been fully compensated.[83] In most cases the insured retains an attorney on a contingency basis, usually giving up one-third of the recovery in order to proceed against the tortfeasor.[84] By considering the insured's attorney's fees and costs, the essential inquiry in most cases becomes whether two-thirds of the settlement fully compensates the insured.[85] The insurance industry will naturally oppose the growth of this sort of realistic inquiry into the "net" compensation received by the insured. However, given the "windfall" nature of subrogation, consideration of the equities militates in favor of resolving this issue for the insured.[86]

Although the "make whole" doctrine appears to reach an equitable result, one drawback is that it requires policing on a case-by-case basis.[87] It has also been argued that, especially in cases that are settled, the satellite litigation over whether or not the insured has been fully compensated would be counter-productive and further diminish the funds available for compensation.[88] Despite these drawbacks, the "make whole" doctrine remains the most equitable doctrine available for protecting the insured,

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> insurer must to some extent go unpaid, equity prescribes that the loss should be borne by the insurer.

Id. at 709.

82. It should be noted that the issue of attorney's fees comes up in two different contexts in this article. Under the "make whole" doctrine, the issue is whether the insured has been fully compensated—a necessary occurrence before the allowance of subrogation. In making that analysis, some courts (cited in this article) have held that the question of whether the insured has been "fully compensated" should be answered by looking at the insured's *net* recovery—meaning the amount that the insured actually receives after the costs and attorney's fees are deducted from the settlement (in most cases, this would be approximately two-thirds of the recovery). Under the "common fund" principle, the issue is simply whether the subrogated insurer must pay its pro rata share of the insured's attorney's fees—meaning, in most cases, that the subrogated insurer would receive two-thirds of the subrogated claim and that the attorney would retain one-third as the fee for collecting it. From the standpoint of the insured, the "make whole" doctrine is much more desirable because it is an effort to see that the insured is fully compensated. The "common fund" theory, while helpful in ameliorating some of the harshness of subrogation, falls dramatically short of the mark when compared with the "make whole" doctrine.

83. *See* COUCH, *supra* note 73, § 61:64. Couch has pointed out that "no right of subrogation against the insured exists upon the part of the insurer where the insured's actual loss exceeds the amount recovered from both the insurer and the wrongdoer, after deducting costs and expenses." *Id.*

84. Youngblood v. American States Ins. Co., 866 P.2d 203 (Mont. 1993) (denying subrogation on payment made pursuant to PIP endorsement where insured had to pay one-third of $85,229 settlement in attorney's fees).

85. *E.g., id.* at 203.

86. *DeTienne,* 879 P.2d at 709. The court in *DeTienne* recognized the concern for the insured, noting:

> [E]quity prescribes that the loss should be borne by the insurer . . . . To do otherwise would mean that the insured looses [sic] money (money paid for litigation . . . plus money paid as premiums to insurer) and the insurer gains by such a financial arrangement (insurer has received premiums plus has been fully recompensed for money it paid to the insured).

Id.

87. For a general discussion of the "make whole" doctrine, see *supra* notes 72-74 and accompanying text.

88. *Frost,* 436 N.E.2d at 387 (denying subrogation claim of $22,679.57 to be taken from lump-

short of an outright denial of subrogation. The concept itself—making the insured whole—simultaneously addresses and dispels the insurer's concern that the insured might receive a "double recovery."

C. Pro Rata Loss Sharing by Insured and Insurer

Another approach to dealing with the matter of subrogation is to have both the insured and insurer reach a compromise concerning those funds which would otherwise be turned over completely to the insurer. This has been described as an effort "to split the fund pro rata between the insured and insurer according to the percentage of the loss borne by each."[89] This approach has received little judicial endorsement[90] and is utilized mainly in out-of-court settlements between the insured and subrogated insurer.[91]

Formulas for loss-sharing may vary. One approach would be for the subrogated insurer to share in the recovery realized from the tortfeasor in an amount reflecting the percentage which its first-party insurance payment bears to the total loss incurred. Borrowing from a recently published article by Elaine M. Rinaldi, the following hypothetical is set forth for discussion:

> For example, when the insured has sustained a total loss of $100,000 and the insurer has paid the insured the limit of a $60,000 policy, a litigation agreement would provide for a sharing of any recovery, as well as expenses, on the basis of a 40 percent share for the insured and a 60 percent share for the insurer.[92]

Under this formula, if the recovery from the tortfeasor is $50,000, the insured keeps $20,000 (forty percent of $50,000) and the subrogated insurer is given $30,000 (sixty percent of $50,000). If the recovery from the tortfeasor is $100,000, then the insured keeps $40,000 and the subrogated

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sum settlement of $250,000). In denying the subrogation claim, the Massachusetts Supreme Court stated:

> [D]etermination of the extent of excess recovery could be equally as complex as the personal injury trial the original parties sought to avoid by settlement. Thus, litigation over subrogation would impose additional burdens on the insured, and cut into his overall compensation for injury. Moreover, this added step in the adjustment of rights would detract from any generalized benefits that subrogation might bring to the sound use and distribution of resources available to compensate loss. Much of the "windfall" produced by overlapping coverage would be absorbed by the costs of dividing it . . . .

Id. at 391.

89. Dobbyn, *supra* note 29, at 293. *See also* Keeton & Widiss, *supra* note 7, § 3.10. The pro rata loss sharing is described by the authors: "The recovery from the third person is to be prorated between the insurer and the insured in accordance with the percentage of the total original loss for which the insurer provided indemnification to the insured under the policy." *Id.*

90. Rinaldi, *supra* note 6, at 806. Rinaldi noted that "[s]urprisingly few courts have utilized the proration formula . . . despite its apparent logic." *Id.*

91. This approach has been described to the author in numerous conversations with South Dakota lawyers over the past two years. In particular, the author would herein reference a conversation between the author and attorney Dennis Duncan, General Counsel for Dakota Care, at the Company Headquarters in Sioux Falls, South Dakota on December 20, 1994, during which Mr. Duncan described the pro rata loss sharing as an approach which he has utilized in effecting settlements.

92. Rinaldi, *supra* note 6, at 815.

insurer is given $60,000.[93]

This pro rata loss sharing may appear equitable in theory; however, in application, there are at least three drawbacks. First, it may be difficult to get the parties to agree to a "total loss" figure. Second, although the pro rata agreement set forth calls for a sharing of "expenses," it does not specifically address the issue of attorney's fees. Third, it allows a subrogated insurer to recover without regard to whether the insured has been "made whole" or fully compensated.

With respect to the first drawback, it may be difficult to get the insured and his subrogated insurer to come to an agreement regarding a "total loss" figure prior to a judicial determination of the insured's total damages. Keeping in mind that the problem cases are usually not in the area of property insurance, the insured is understandably hesitant to agree to a "total loss" figure prior to submission of the claim to the factfinder. Furthermore, most rules of pleading provide that plaintiffs in personal injury cases "shall not" affix a dollar amount to unliquidated damages in their prayer for relief.[94] The subrogated insurer, on the other hand, would be reluctant to agree to an exaggerated amount for the "total loss," because such a figure would diminish its subrogated recovery. In the hypothetical given above, it may be unrealistic to assume that the insured and the subrogated insurer would readily agree that the insured's total loss is $100,000.

With regard to the second drawback, the issue of the insured's attorney's fees also comes into play in the pro rata settlement process. In essence, should 100% of the recovery from the tortfeasor be apportioned on a pro rata basis, or should just the insured's net share of the recovery (usually two-thirds) be considered as the amount to be apportioned? Using the hypothetical set forth above, suppose the tortfeasor's policy limit is only $25,000 and that amount is deemed a reasonable settlement, although far from being truly compensatory. Should the subrogated insurer be allowed sixty percent of the $25,000 settlement or, more appropriately, sixty percent of $16,667 (the insured's *net* portion of the settlement, after paying the attorney one-third)?

Of course, neither of these alternatives would come close to making the insured whole, the third drawback. Even if the settlement with the tortfeasor is for $100,000 (the stipulated "total loss"), the insured falls far short of being fully compensated because $60,000 would be given to the

93. An interesting question is raised and addressed in Rinaldi's article as to the scenario where such an agreement is utilized and its application results in the insurer being allowed to collect more than its subrogated claim because the recovery from the tortfeasor is greater than anticipated. *Id.* at 816-17.

94. *E.g.*, IOWA R. CIV. P. 95 (West 1996), MO. R. CIV. P. 55.05 (West 1996) and TEX. R. CIV. P. ANN. r. 47 (West 1995). *See also* Roger M. Baron, *Pleading Unliquidated Damages: An Unnecessary Requirement*, SOUTH DAKOTA BARRISTER 6 (July-Aug. 1991) (pointing out that it is in the interest of both plaintiffs and defendants to support the modern trend, which prohibits the statement of a dollar figure for items of unliquidated compensable damages [such as pain and suffering, future loss of wages, bodily impairment, etc.] and require, in lieu thereof, a prayer for such damages as are fair and reasonable).

subrogated insurer and the insured's attorney would be required to exact the attorney's fees[95] from the remaining $40,000.

An even more stifling approach from the standpoint of the insured is an analysis which focuses on the exact make-up of the settlement fund. Since medical expenses are customarily included as a foundation for computing a settlement, an insurer can argue that the insured has been made whole on that portion of the damages which represents medical bills, even though the insured may not have been made whole as to other unliquidated items of compensable damage. A rule has been adopted in Iowa which holds that subrogation is permitted when the insured has been 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.[96] The settlement document may or may not specify how the settlement amount was determined. If allocations in the settlement fund are set forth, then specified amounts can be used as a basis for determining how much should be allowed as targets for subrogation.[97] In situations involving a lump sum settlement, however, further litigation may be necessary to determine what portion, if any, of the recovery from the tortfeasor qualifies for subrogation.[98]

Once again, while this approach may seem appealing in theory, it nonetheless overlooks the established fact that subrogation is indeed a windfall for the insurer, with the insured falling short of being fully compensated. This is perhaps best illustrated in *Iowa American Insurance Co. v. Pipho.*[99] In this case, the insured's total damages were determined by the court to be $418,778, of which actual medical expenses were approximately $19,000.[100] The insured was able to negotiate a settlement of *only* $25,000—the liability limit of the tortfeasor's liability insurance policy.[101] The subrogated insurer sought reimbursement of $11,778.[102] The trial court allowed full subrogation, but the Iowa Court of Appeals remanded the case for a " 'mini-trial' to determine the share of the medical bills attributed to the settlement figure."[103] If the share of the medical bills is considered on a straight pro rata basis with the other damages which were included the $418,778 total figure, then the subrogated insurer should be allowed approximately $703,[104] in lieu of $11,778.[105]

95. If the fee agreement utilizes the traditional one-third contingency basis, the attorney's fees would be $33,333.

96. Ludwig v. Farm Bureau Mut. Ins. Co., 393 N.W.2d 143, 145 (Iowa 1986).

97. *Id.* at 146. The court stated, "In the present case, the settlement amounts attributed to medical expenses were made clear by the settlement documents." *Id.* at 146 n.2.

98. *Id.* The court in *Ludwig* also observed that "[w]hen the amount attributed to the subrogation claim cannot be determined by other means, a mini-trial . . . might be required." *Id.*

99. 456 N.W.2d 228 (Iowa Ct. App. 1990).

100. *Id.* at 229.

101. *Id.*

102. *Id.*

103. *Id.* at 230.

104. $11,718 is 2.8% of $418,778 and 2.8% of $25,000 is $703.

105. *Pipho,* 456 N.W.2d at 229. The trial court in *Pipho* had originally followed the rule in

The facts in the *Pipho* case can be utilized to demonstrate the differing approaches to subrogation. If subrogation were permitted in the *Pipho* scenario without the use of some ameliorating doctrine, the trial court would have been correct in giving the subrogated insurer $11,778, leaving the remainder of $13,222 to be divided between the insured and her attorney. Under the "make whole" doctrine discussed in the preceding section, there would be no recovery at all for the subrogated insurer since the settlement of only $25,000 (together with the $11,778 of first party benefits) did not even come close to fully compensating the insured. Under the "pro rata" apportionment theory, the subrogated insurer enjoys a partial recovery while the insured receives a net recovery of less than ten percent of the total loss.[106]

The facts in *Pipho* serve well to illustrate the harsh effect of subrogation and the differences in the approaches of the ameliorating doctrines. It is no surprise that a majority of jurisdictions have now adopted the "make whole" doctrine as the most appropriate approach to utilize in the matter of subrogation.[107]

D. The "Common Fund" Theory

The "common fund" approach basically upholds the doctrine of subrogation, but requires the beneficiary of any settlement or recovery (i.e., the subrogated insurer) to pay its share of the attorney's fees and costs.[108] The

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Ludwig, which holds that the insured need only 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. *Ludwig,* 393 N.W.2d at 146. The trial court in *Pipho* then determined that the insured had been made whole on the medical expenses portion of damages and, therefore, that the subrogated insurer was entitled to the entire amount of its claim. *Pipho,* 456 N.W.2d at 229.

106. Under the facts found by the trial court in *Pipho,* the total damages amounted to $418,778. *Id.* Even assuming that the insured paid nothing in attorney's fees and costs, the recovery of $25,000 from the tortfeasor, combined with the first party insurance benefits of $11,778, would give the insured a total of $36,778, which constitutes only 8.8% of the total damage figure.

107. Rinaldi, *supra* note 6, at 807 (listing the 25 states in alphabetical order, together with citations to the appropriate cases).

108. Amica Mut. Ins. Co. v. Maloney, 903 P.2d 834, 839-40 (N.M. 1995). The court stated:

> The [insureds] now ask us to extend the application of the common fund doctrine to insurance cases in which the insured incurs attorney's fees in recovering a judgment or settlement that benefits the subrogated insurer. We agree and join with the majority of jurisdictions that have considered this issue in extending the common fund doctrine to the present cases. As one commentator noted, "It is grossly inequitable to expect an insured, or other claimant, in the process of protecting his own interest, to protect those of the [insurer] as well and still pay counsel for his labors out of his own pocket . . . ."

Id. (quoting Appleman & Appleman, Insurance Law & Practice § 4903.85 (1981)). For further discussion of the "common fund" theory, see Bowen v. American Family Ins. Group, 504 N.W.2d 604 (S.D. 1993), addressed *infra* at notes 113-25, and accompanying text. *See also* D'Archangel v. Allstate Ins. Co., 656 N.E.2d 294 (Ind. Ct. App. 1995). In extending the subrogated insurer's statutory obligation to pay its pro rata share of attorney's fees and costs incurred in a prelitigation dispute mediation, the Indiana court held:

> An insurer claiming reimbursement rights must pay, out of the amount received from an insured, a pro rata share of the reasonable and necessary costs and expenses of asserting a claim against a third party tortfeasor where the claim was settled prior to the insured filing suit against the tortfeasor.

Id. at 297. *Accord* Motor Club Ins. Ass'n v. Bartunek, 526 N.W.2d 238, 243 (Neb. Ct. App. 1995)

underlying theory is that when the insured hires an attorney and becomes obligated to pay attorney's fees[109] and court costs, the insured is in the process of creating a "common fund" for the benefit of the insured and the subrogated insurer(s).[110] Although the American judicial system generally does not allow for the recovery of attorney's fees,[111] there has been a long-recognized exception that those other entities which benefit from the creation or preservation of this "common fund" should be required to pay their share of the costs so incurred in the process.[112]

The South Dakota Supreme Court has at least partially recognized the soundness of the common fund approach in *Bowen v. American Family Insurance Group*.[113] In that case, the subrogated insurer was required to pay its share of the attorney's fees (one-third) and its share of sales tax and costs out of the subrogated recovery of $2,000, where the total settlement with the tortfeasor was $16,500. The court basically followed the "common fund" approach;[114] however, in dictum, the court suggested that the subro-

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(permitting subrogated claim for $5,000, but allowing the insured to set off $1,666.67 for the subrogated insurer's proportionate share of the attorney's fees). In doing so, the court found that "[t]he general rule is that an insurer who is a subrogee and does not come into the action but accepts the avails of the litigation is liable for a proportionate share of the expenses of the litigation, including attorney fees." *Id. See also* Jackson v. Browning, 908 P.2d 641 (Kan. Ct. App. 1995) (allowing insured, under Kansas statute, to set-off an apportionment of attorney's fees against subrogated insurer seeking reimbursement of PIP benefits).

109. The dilemma of attorney's fees also arises in the context of the "make whole" doctrine; for a complete discussion of that aspect of the issue, see *supra* notes 81-86 and corresponding text.

110. *Lee,* 129 Cal. Rptr. at 277. The court observed:

> "When a number of persons are entitled in common to a specific fund, and an action brought by a plaintiff or plaintiffs for the benefit of all results in the creation of or preservation of that fund, such plaintiff or plaintiffs may be awarded attorneys fees out of the fund."

Id. (quoting D'Amico v. Board of Medical Examiners, 520 P.2d 10, 27 (Cal. 1974)).

111. Kenneth W. Starr, *The Shifting Panorama of Attorneys' Fees Awards: The Expansion of Fee Recoveries in Federal Court,* 28 S. TEX. L.J. 189 (1986). Starr noted:

> A prevailing party in the United States is generally not entitled to an award of reasonable attorneys' fees from the losing party. This requirement that even the winning party must bear the burden of paying his or her own attorneys' fees to enforce a right, enjoin a wrong, or defend against a claim has come to be known as "the American Rule."

Id. at 189. *See also* Alyeska Pipeline Serv. Co. v. Wilderness Soc'y, 421 U.S. 240, 245 (1975) (stating that "[i]n the United States, the prevailing litigant is ordinarily not entitled to collect a reasonable attorneys' fee"); Arcambel v. Wiseman, 3 U.S. 306, 306 (1796) (noting that the general practice in the United States is in opposition to awarding attorney's fees); Thomas D. Rowe, Jr., *The Legal Theory of Attorney Fee Shifting: A Critical Overview,* 1982 DUKE L.J. 651, 651 (1982) (noting the "general rule that each side in civil litigation has ultimate responsibility for its own lawyer's fees").

112. Hartford Accident & Indem. Co. v. Gropman, 209 Cal. Rptr. 468, 472 (Cal. App. Dep't Super. Ct. 1984) (citing Estate of Stauffer, 346 P.2d 748, 752-53 (Cal. 1959)). The bases for this equitable rule have been listed as follows:

> [1] Fairness to the successful litigant, who might otherwise receive no benefit because his recovery might be consumed by the expenses; [2] correlative prevention of an unfair advantage to the others who are entitled to share in the fund and who should bear their share of the burden of its recovery; [3] encouragement of the attorney for the successful litigant, who will be more willing to undertake and diligently prosecute proper litigation for the protection or recovery of the fund if he is assured that he will be promptly and directly compensated should his efforts be successful.

Id.

113. 504 N.W.2d 604 (S.D. 1993).

114. *Id.* at 606. The court in *Bowen* held that "American Family was a beneficiary of Bowen's

gated insurer might avoid this result by getting a commitment directly from the tortfeasor's liability insurer to include it in the settlement process, and in turn, aided by revised policy language, the insurer could give its insured notice that it will not be responsible for any attorney's fees.[115] This argument, also asserted to be the "active participant" exception to the "common fund" doctrine,[116] was recently rejected by the New Mexico Supreme Court in *Amica Mutual Insurance Co. v. Maloney,*[117] a case involving subrogated insurers seeking to avoid payment of their pro rata share of the insured's attorney's fees.[118]

In the overall scheme of things, one should keep in mind that the "common fund" theory is, at best, a negligible approach to dealing with the harsh effects of subrogation. The "common fund" theory simply allows the insured and the attorney to retain a pro rata share of the attorney's fees and costs from the subrogated recovery. In a jurisdiction which follows only the "common fund" approach, there is no consideration given to the windfall nature of the subrogated recovery to the insurer, nor to whether the insured is "made whole" or fully compensated. It is minimal relief at best.

Furthermore, under the dictum in the *Bowen* decision, such maneuvering by the subrogated insurer to secure its own subrogated recovery from the tortfeasor's insurer would have a double impact on the real or "net" compensation received by the insured. Attorneys would be justified in adjusting their contingency fees upward if the contingency is to be applied to less than the full recovery.[119] As a result, the insured will receive even less

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settlement. It naturally follows that American Family should bear a proportionate share of the attorney fees that were incurred in obtaining the settlement." *Id.*

115. *Id.* at 607. The court suggested:

> Further, it is fairly obvious that a company can avoid attorney fees by simply providing for same in their contract of insurance or subrogation agreement. At a bare minimum, a company should at least make their insured aware that the company has settled its subrogation claim with the other party's insurer and will not be responsible for any attorney fees incurred by its insured in obtaining a settlement or judgment for their damages.

Id.

116. *Maloney,* 903 P.2d at 840. The court described that exception by stating, "The first [exception] is the active participation exception. Under this exception, if the insurer demonstrates that it *actively participated* in or *substantially contributed* to the recovery, the trial court may reduce or waive the insurer's proportionate contribution [to the attorney's fees]." *Id.*

117. 903 P.2d 834 (N.M. 1995).

118. *Id.* at 840. In rejecting the active participation exception, the court stated:

> As for the actions taken in the present case, the insurers followed normal industry practice by sending to the tortfeasors' insurer what were essentially form letters stating that they had a subrogation interest and asking for repayment after settlement. Amica and Farmers then sat back and waited for their insureds to reach a settlement before asserting their rights to their subrogated interest in full. The insurers neither participated in the negotiations between the insured and the tortfeasor nor contributed to the final settlement. For the reasons discussed above, we conclude as a matter of law that Amica's and Farmers' actions in sending out standard letters informing the tortfeasors' insurers of their subrogated interest did not amount to active participation in the settlement.

Id.

119. For example, the attorney can charge 40%, 45%, or 50% of the recovery in lieu of a mere one-third. *See Jackson,* 908 P.2d at 641 (allowing a deduction of 40% from the subrogated recovery of $4,500 in recognition of the insurer's share of the attorney's fees under the 40% contingent fee contract).

"net" recovery. The subrogated recovery, under the court's dictum in *Bowen*, would be sent directly from the liability insurer to the subrogated insurer, thereby bypassing the normal settlement disbursement. Furthermore, in lieu of two-thirds, the insured may now receive only fifty-five or sixty percent of that portion of the settlement proceeds which excludes the subrogated recovery. The end result is that the insured receives a lesser percentage of a lesser sum. The practicalities of the situation suggest that the insured cannot effectively shift this loss to the attorney.[120] In the end, the insured, not the attorney, suffers more.

By analogy, it is helpful to observe that in the area of worker's compensation in South Dakota, the right of subrogation is statutorily granted to the employer.[121] The adoption of the "common fund" approach in conventional or contractual subrogation is, therefore, entirely consistent with the public policy of this state, as seen in the express recognition of the "common fund" approach in statutory subrogation. Under this scheme, the legislature has recognized the "common fund" theory by authorizing the pro rata deduction of up to thiry-five percent of the damages to compensate the injured party's attorney for the creation and preservation of the

120. *Bowen*, 504 N.W.2d at 606. Dictum in the *Bowen* opinion suggests that, armed with notice that the subrogated insurer will not pay its share of the attorney's fees, the insureds can avoid incurring any obligation to pay attorney's fees on that portion of the recovery. The court noted, "If the insured is aware that his insurer will not pay any attorney fees, the injured insured can then avoid being obligated for attorney fees to his attorney on the total amount of a settlement or judgment." *Id.* at 607. This author respectfully suggests that two other factors need consideration. (1) The matter of subrogation is sufficiently complex that very few lay persons actually understand it. The idea itself (that the first party insurers have a right to be repaid *only* if there is a recovery) is a fairly sophisticated concept which most lawyers find takes time to explain to their clients. It may be unrealistic to expect that the client, without the aid of a lawyer, is to understand that whatever contingency fee arrangement is negotiated with the attorney should be applied only to the portion of the recovery which does not include the subrogated claim—thereby "avoid[ing] being obligated for attorneys fees on the total amount" as suggested by the *Bowen* dictum. Of course, the actual amount to be paid on the subrogated claim may still be negotiated by the attorney and, in the interest of the client, lessened. The client usually goes to the attorney because, *inter alia*, the client has trouble understanding the nuances of the basic contract of insurance. It may not be possible for the typical insured, without securing separate counsel for the purpose of entering into the contingency fee agreement itself, to prescribe the terms of the contingency fee agreement. (2) Even assuming that the client could do what is suggested by the *Bowen* dictum and avoid agreeing to pay a contingency on the subrogated portion of the recovery, what is to prevent the lawyer from adjusting the fee upward? Certainly, the lawyer has office overhead, secretarial staff, and other bills to pay, and cannot afford to serve as free legal aid. A greater contingency may simply be exacted, such as 40% or 45%—or even 50%—on smaller claims. In the end, it may be unrealistic to assume that the loss can be shifted to the lawyer. The allowance of subrogation continues to diminish the client's ultimate recovery and defeat the opportunity of the client to be made whole.

121. The statute, entitled "Compensation paid by employer—Reimbursement from damages recovered from third party" provides as follows:

> If compensation has been awarded and paid under this title and the employee has recovered damages from another person, the employer having paid the compensation may recover from the employee such an amount equal to the amount of compensation paid by the employer to the employee, less the necessary and reasonable expense of collecting the same, which expenses may include an attorney's fee not in excess of thirty-five percent of compensation paid, subject to § 62-7-36.

S.D.C.L. § 62-4-39 (1995).

fund which benefits both the insured and the subrogated insurer.[122] Furthermore, one of the fundamental considerations in the initial inception of the "common fund" theory was that it would serve as an incentive for the attorney to work diligently for the primary client, as well as for those other beneficiaries interested in the "common fund."[123]

As a matter of public policy, it appears to be fundamentally unfair to require the insured to hire an attorney and, as suggested in *Bowen*, require that the attorney also collect money for the subrogated insurer, but be compensated entirely from the insured's portion of the recovery. Furthermore, an attempt to evade the "common fund" principle through a private agreement between subrogated insurers and the tortfeasor's liability insurer bespeaks a conspiracy among the insuring entities which is destined to complicate and protract the legal process. The insured's lawyer will be required to develop strategies designed to promote the client's interests over the interests of the subrogated insurers, in addition to dealing with the tortfeasor on the primary claim. The sideline skirmishes with the subrogated insurers may turn into the main event, especially in smaller claims. Infighting among the beneficiaries of the common fund will take its toll on the settlement process and the ultimate recovery achieved by the insured—a rather strange development, given the fact that the insured initially paid a premium to the insurer for, *inter alia*, security and peace of mind.

As a final note on the "common fund" theory, recent decisions have expanded this principle beyond the insurance industry. There have been a number of cases in a variety of states which have required hospitals asserting liens for services to pay their pro rata share of the legal expenses incurred by the patients in pursuing recoveries from tortfeasors.[124] The underlying notion of unjust enrichment continues to serve as the basis for

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122. S.D.C.L. § 62-4-40 (1995). That section, "Recovery by employer from third party—Excess held for employee," provides:

> If compensation is awarded under this title, the employer having paid the compensation, or having become liable therefor may collect in his own name or that of the injured employee, or his personal representative, if deceased, from any other person against whom legal liability for damage exists, the amount of such liability and shall hold for the benefit of the injured employee or his personal representative, if deceased, the amount of damages collected in excess of the amount of compensation paid such employee or his representative, less the proportionate necessary and reasonable expense of collecting the same, which expenses may include an attorney's fee not in excess of thirty-five per cent of damages so collected, and shall be subject finally to the approval of the department.

Id.

123. *Gropman*, 209 Cal. Rptr. at 472. The court stated that the purposes for the "common fund" principle include: "[e]ncouragement of the attorney for the successful litigant, who will be more willing to undertake and diligently prosecute proper litigation for the protection or recovery of the fund if he is assured that he will be promptly and directly compensated should his efforts be successful." *Id.* (quoting *Estate of Stauffer,* 346 P.2d at 752-53, and citing In re Reade's Estate, 191 P.2d 745, 746 (Cal. 1948)).

124. *See, e.g.,* City & County of San Francisco v. Sweet, 38 Cal. Rptr. 2d 620 (Cal. Ct. App. 1995) (holding that a county's hospital lien against an indigent patient's tort recovery from a tortfeasor was subject to a pro rata reduction commensurate with the attorney's fee); In re Guardianship and Conservatorship of Bloomquist, 523 N.W.2d 352 (Neb. 1994) (holding that two hospitals which had filed liens, but had done nothing beyond the filing, were required to pay their pro rata share of the legal expenses incurred by the patients in pursuing the tortfeasor).

these decisions.[125]

V. SELF-FUNDED PLANS

In *FMC Corp. v. Holliday,*[126] the United States Supreme Court held that under ERISA,[127] a self-funded employee benefit plan was not subject to a Pennsylvania anti-subrogation statute.[128] In *Holliday,* the insured was able to recover only $49,825.50 from the tortfeasor's liability insurer.[129] The actual medical expenses exceeded $178,000,[130] yet the self-funded plan demanded reimbursement.[131] The 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"[132] controlled the issue of reimbursement.[133] Therefore, the Court held that ERISA preempted application of the Pennsylvania statute to the self-funded plan.[134] Notably, the Court did specifically observe that a regulated commercial insurer insuring an employee benefit plan would be subject to the anti-subrogation statute of Pennsylvania.[135]

The distinction between self-funded plans and regulated commercial insurers in the *Holliday* decision is appropriate. The harshness of subrogation is more palatable in the self-funded plan scenario because there is no windfall as a result of the subrogated recovery. Insurance coverage through a self-funded plan is similar to self-insurance or reciprocal insurance because the participants' contributions to the undertaking are determined by actual losses.[136] Even though there is a hardship on the injured party when expenses exceed coverage and there will never be full compensation (as in *Holliday*), at least the other members of the plan do not also

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125. Martinez v. St. Joseph Healthcare Sys., 871 P.2d 1363, 1367 (N.M. 1994). The court stated, "If we did not allow the division of the legal costs, hospitals would be encouraged to sit back and reap the rewards of another's labor at that party's expense." *Id. See also Bloomquist,* 523 N.W.2d at 360, stating, "But for the efforts of the patients' attorneys and the incurring of costs by the patients, it is unlikely that the hospitals would receive any payment . . . . If the injured person elects not to prosecute a claim, then the lien itself is worthless." *Id.*

126. 498 U.S. 52 (1990).

127. "ERISA" is the acronym for the Employee Retirement Income Security Act, codified at 29 U.S.C. §§ 1001-1461 (1988).

128. *Holliday,* 498 U.S. at 65.

129. FMC Corp. v. Holliday, 885 F.2d 79, 80 (3rd Cir. 1989).

130. *Id.*

131. *Holliday,* 498 U.S. at 54.

132. *See* 29 U.S.C. § 1144(b)(2)(B) (1988).

133. *Holliday,* 498 U.S. at 61.

134. *Id.* at 65.

135. *Id.* The Court stated:

> 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 . . . insofar as they apply to the plan's insurer.

Id. at 61.

136. Baron, *supra* note 4, at 587 (noting that subrogation is not a windfall in the context of self-insurance). *See generally* KEETON & WIDISS, *supra* note 7, §§ 1.3(b)(3) and 2.1(a)(3) for a discussion of self-insurance and mutual insurers.

suffer an extraordinary loss. In addition, in many self-funded plans, the pool is smaller than one created with a commercial insurer, making the repercussion of a singular catastrophic loss significantly greater.[137]

There has been an interesting development in the post-*Holliday* cases. Notwithstanding the absence of a windfall effect for self-funded plans, a number of courts are applying the "make whole" doctrine and denying subrogation even for self-funded plans.[138] These recent decisions have been based on federal common law[139] and are seen primarily in instances where the insurance contract or plan document is susceptible to an interpretation in favor of the insured.[140]

VI. CONCLUSION

The doctrine of subrogation has been historically engrafted into our present legal system, primarily in matters of property insurance. The courts have generally honored the doctrine in deference to its historical pedigree. When the insurance industry sought the expansion of the doctrine into the realm of personal injury claims, most jurisdictions willingly followed. At one point, the vast majority of jurisdictions agreed to permit subrogation on medical expense claims. However, the harshness of subrogation soon came to light. The courts now take a more realistic approach to subrogation, with the majority of jurisdictions adopting a variety of doctrines designed to ameliorate the harshness of subrogation.

At the least, the evolution of subrogation into personal injury claims

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137. Baron, *supra* note 4, at 582, 587 (pointing out that subrogated recoveries are not a factor in rate-setting for commercial insurers).

138. *E.g.*, Provident Life and Accident Ins. Co. v. Williams, 858 F. Supp. 907 (W.D. Ark. 1994). The court found that serious injuries, including brain damage, were sustained by the insured. *Id.* From a settlement of $6,500,000 with the tortfeasor, the employee benefit plan sought subrogation for medical bills of $658,907. *Id.* The federal district court opined that "[i]f the settlement fully compensates [the insured], then reimbursement will be proper." *Id.* at 913. The court further acknowledged, "This court is conscious of the fact that it is making federal common law in this case. In the absence of a well-developed body of precedent, it is left to the district courts 'in the first instance' to develop a body of federal common law on subrogation and reimbursement in ERISA cases." *Id.*

139. *Id. See also* Sanders v. Scheideler, 816 F. Supp. 1338 (W.D. Wis. 1993), *aff'd*, 25 F.3d 1053 (7th Cir. 1994). The court in *Sanders* noted, "Adoption of the make-whole doctrine as a default priority rule appears consistent with the congressional mandate to fashion federal common law to facilitate the ERISA scheme." *Id.* at 1347.

140. *E.g.*, Barnes v. Independent Auto. Dealers Ass'n of Calif. Health & Welfare Benefit Plan, 64 F.3d 1389, 1395 (9th Cir. 1995). The court in *Barnes* interpreted a subrogation clause against a self-funded plan because the clause did not specifically allow for subrogation prior to making the payment under the plan, i.e., the clause created the right to subrogation only after the plan had made payment to the employee. *Id.* In interpreting the clause in that manner, the court 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." *Id. See also Sanders,* 816 F. Supp. at 1346-47, stating, "It is well established that state subrogation doctrines are preempted under ERISA . . . . In this case, however, application of the make-whole doctrine would not supplant or dictate the terms of the plan." *Id. See also* Blue Cross/Blue Shield of Rhode Island v. Flam, 509 N.W.2d 393 (Minn. Ct. App. 1993) (interpreting the insurer's policy provision on subrogation to be insufficient to overcome the federal common law that the insured must be fully compensated). The court in *Flam* held, "[W]e cannot construe the language of the contract here in such a manner as to permit subrogation recovery by [the insurer] prior to [the insured's] full recovery." *Id.* at 398.

over the past forty years has shown that certain misconceptions have plagued this area of the law. The idea that without subrogation, the insured would enjoy a "double recovery" is simply not true and the argument is duplicitous. The allowance of subrogation to the commercial insurer actually results in a windfall recovery that is retained by the insurer, not a windfall to the insured. Furthermore, the subrogated recovery is not reflected in lower rates for the benefit of the premium-paying consumer.

Why then is subrogation tolerated at all? The entire process of allowing subrogation and deciding what restrictions to place on it serves to impede the legal process. The insured's attorney is constantly being asked to serve two masters—the insured and the subrogated insurer. Settlements are delayed. Satellite litigation may become more complicated than the original prosecution of the claim against the tortfeasor itself. There is also a sound policy argument that society as a whole is better off without subrogation even if the subrogated recoveries are somehow reflected in rate adjustments.[141] Most insureds do not really understand the impact of subrogation until after a loss has occurred. The otherwise dull, unintelligible language of their insurance policy means that they will have to give back the money if they hire a lawyer and pursue a tortfeasor. The pool of insureds would be better served by allowing full compensation for their losses even if they would be required to pay slightly higher rates.[142] At least there would be no surprises when and if a loss occurs and they are put in the position of trying to collect on their policy and also pursue a tortfeasor. The elimination of subrogation entirely from the insurance industry may very well produce a system of insurance which is far more consistent with the common person's understanding.

In addition to its historical pedigree, subrogation is also tolerated because insurers continue to contractually create it. Assuming subrogation will continue to be permitted, the time has come for the courts to realize the harsh effects created by it. The courts are acting well within their authority when they adopt ameliorating doctrines, since subrogation itself is of equitable origin.

As a matter of fundamental justice, the "make whole" doctrine seems to be the most appealing. The insured should be fully compensated for his or her loss before requiring reimbursement to the first party insurer. After all, the insured (or someone on his or her behalf) paid a premium to that insurer for the purpose of obtaining security and peace of mind in the event a loss should occur. A realistic approach to this issue also requires the court look at the net recovery received by the insured. If the insured has to

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141. This argument is bolstered by the development of the "federal common law" which requires that the insured be made whole before permitting reimbursement or subrogation, even in those cases involving self-funded plans (where subrogated recoveries are reflected in the premiums assessed against the participants). For a discussion of the application of federal common law in this area, see *supra* notes 138-40 and accompanying text.

142. There is no suggestion here that rates would, in fact, have to be raised in the commercial insurance setting. This statement is made hypothetically.

pay one-third of the recovery to an attorney in order to obtain a recovery, then the court should not be blind to that reality. This would seem to be especially true where the court is faced with the choice of either truly making the insured whole or allowing the subrogated insurer to collect on a claim for which it received a premium, thereby allowing that windfall collection to go to the profit coffer of the insurer.

There are other ameliorating doctrines. The insurer can either agree, or be required, to give up part of the subrogated claim. This may occur on a straight pro rata basis with the insured. It can also occur under the "common fund" theory whereby the insurer is required to pay its share of the attorney's fees and costs incurred in the creation and preservation of the settlement fund which benefits both the insured and the subrogated insurer. These latter two devices are, however, minimally effective in dealing with the overall harshness seen in subrogation. Nonetheless, they have some effect and should be promoted by the courts where the "make whole" doctrine is not utilized. These ameliorating doctrines are also available in matters of property insurance,[143] although the issues are typically less critical in the property insurance context.

In the end, the decision must be made as to whether the insurer's interest in securing a subrogated recovery should prevail over the insured's interest in being compensated for a loss. In the resolution of this question, there can be no dispute with the fact that, in the vast majority of cases, the allowance of subrogation truly defeats the opportunity for the insured to be fully and justly compensated. Consequently, the best way to close the Pandora's Box that has plagued the insurance industry is to deny subrogation altogether for personal injury claims.

143. *E.g.*, *Wimberly*, 584 S.W.2d at 201. In this case the property insurers which paid out $15,000 on a $44,619 loss sought subrogation for the full amount of their payments when the insured was about to collect another $25,000 from the tortfeasor. *Id.* The Tennessee Court of Appeals allowed a pro rata recovery to the subrogated insurers, but the Supreme Court of Tennessee denied subrogation altogether because the insured had not been made whole. *Id.* at 204. The court stated, "[W]e believe our resolution of this case must be guided by general principles of equity, to wit, that the insured must be made whole before subrogation rights arise in favor of the insurers." *Id.* at 203. *See also Garrity*, 253 N.W.2d at 512. In *Garrity*, the property insurer paid $67,227.12 on a fire loss alleged to be in the amount of $110,000 and then sought subrogation rights against a $25,000 settlement with tortfeasor—the limit of the tortfeasor's policy. *Id.* The trial court's allowance of subrogation was reversed with the court holding that "the subrogee has no right to share in the fund recovered from the tort-feasor until the subrogor is made whole." *Id.* at 516.