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Securing Insurance Coverage of Medical Expense and Avoiding Subrogation

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Insurance Consumer Counsel's Column

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by Professor Greg Munro

After the auto accident, the claimant, a frail 83-year old Missoula woman, spent the last two months of her life in the hospital intensive care unit incurring over $250,000 in medical expenses before her death. She was entitled to Medicare benefits and had purchased a Medicare supplemental policy. She was an insured under Medical Pay coverage in the car in which she rode, her car and that of her daughter with whom she lived. Her driver carried moderate limits of liability insurance, and her daughter's policy contained underinsured motorist coverage. Unfortunately, it is still likely that medical expenses will exhaust all available insurance coverage.

Counsel representing such claimants know that securing payment of medical expenses in their cases is a complex task that requires one to know the policies, statutes, and state and federal case decisions that expand or limit the insurance consumer's rights. In this column, I will explore some of the law that will control issues encountered as counsel pursues payment of medical expenses under insurance policies and programs.

Medical Pay Coverage

Medical Pay Coverage in casualty policies, i.e., personal auto, homeowners, and commercial general liability policies, provides medical pay benefits to a person who is entitled by reason of being an "insured" under the policy. For example, auto policies generally pay reasonable medical and funeral expenses caused by accident and sustained by an "insured" within three years of the date of the accident. Under auto coverage, an "insured" likely includes the named insured and any family member living in the same household while occupying a motor vehicle or while being struck by one as a pedestrian. An "insured" also includes "any other person" while "occupying" the insured auto.[1] As in Evelyn's case, counsel should pay attention to living arrangements which may cause a person to be an "insured" under someone else's policy. For example, because of the prevalence of joint custody arrangements today, a minor child injured in an auto accident may be an "insured" under each and every medical pay policy coverage held by any parent or grandparent with whom the child lives even part time.

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Also, in *Farmers Alliance Mut. Ins. Co. v. Holeman*,[2] Judge Shanstrom used Montana's consumer-friendly "reasonable connection" test to determine whether a passenger was "occupying" a motor vehicle for purposes of being deemed an "insured" entitled to medical pay benefits. In *Holeman*, the claimant, Leonard, was standing outside and away from the insured pickup truck when he was killed by an approaching motor vehicle. His act of standing guard while waiting for emergency help was deemed a "reasonable connection" that meant he was "occupying" the vehicle. In *Nelson v. Iowa Mut. Ins. Co.*,[3] the court found the word "occupying" and its policy definition "in or upon or entering into or alighting from" to be ambiguous. There, Nora Rennie died of frostbite and exposure 143 feet from her stuck car while attempting to find help. The court applied the reasonable connection test to find the deceased was "occupying" the vehicle at the time of death. When analyzing coverage, counsel should think of the medical pay coverage on the auto policy as applying to anyone with a "reasonable connection" with the car.

Under a homeowner's policy, medical pay coverage will generally exclude from coverage the named insured and regular members of the household. Instead, coverage applies to others injured at the "insured location," or as a result of activities on the "insured location," or caused by "an animal owned by or in the care of an insured."[4]

Invariably, any casualty policy contains "other insurance" clauses which seek to coordinate benefits. These clauses may provide that, if there is other medical pay insurance applicable to the injury, the subject policy either shares pro-rata according to limits of the policy or is deemed excess and thereby available only if the other policy is exhausted by medical payments. If two medical payment coverages each contain "excess" insurance clauses, courts deem them mutually repugnant, and the policies pay on a pro rata basis. However, in the Maine case of *Carriers Ins. Co. v. American Policyholders' Ins. Co.*,[4] the court, in a well-reasoned opinion, adopted the minority position that each policy, regardless of limits, shares equally in the loss up to the limit of the lowest

policy after which the policy with the higher limit covers the remaining loss.

The Subrogation Problem

Subrogation is a device in equity designed to compel the ultimate payment of a debt by one who in justice, equity, and good conscience should pay.[5] Subrogation may be classified as legal, arising by operation of law because the insurer has made a payment, or conventional, arising under contract between the parties.[6] Regardless of whether the insurer's subrogation is classified as legal or conventional, the Montana Supreme Court, in *Skauge* stated the theory underlying the insurer's right:

> The theory behind this principle is that absent repayment of the insurer the insured would be unjustly enriched by virtue of recovery from both the insurer and the wrongdoer, or in absence of such double recovery by the insured, the third party would go free despite his legal obligation in connection with loss.[8]

Hence, the moral imperative behind insurance subrogation is to prevent situations where: (1) the plaintiff makes a double recovery, or (2) the wrongdoer goes free. The corollary is that insurance subrogation clauses should not apply if (1) the plaintiff makes no double recovery, or (2) makes the wrongdoer pay the damages.

Invariably, casualty insurance policies contain subrogation clauses which, in standard form, may appear as follows:

Our Right to Recover Payment —

A. If we make a payment under this policy and the person to or for whom payment was made has a right to recover damages from another we shall be subrogated to that right. That person shall do:
   1. Whatever is necessary to enable us to exercise our rights;
   2. Nothing after loss to prejudice them.
B. If we make payment under this policy and the person to or for whom payment is made recovers damages from another, that person shall:
   1. Hold in trust for us the proceeds of the recovery;
   2. Reimburse us to the extent of our payment.

Note that this language is consistent with the theory of subrogation but does not expressly contemplate those situations where there has been no double or duplicate recovery or where the wrongdoer has been made to pay.

The insurer's rights of subrogation can be triggered by payment of benefits to the insured under any policy coverage. Hence, under standard policy language, if the insurer pays medical benefits under medical pay coverage, it is entitled to be reimbursed to the extent of its payment in the event that the insured makes a claim against any third party responsible. The insurer is only entitled to recover under subrogation the amount it has actually paid.[9]

While the insurer's imperative is to prevent unjust enrichment by double recovery or "duplicate payments for the same element of loss,"[10] the problem for the plaintiff's lawyer is to prevent the insurer from subrogating where there has been no double recovery or duplicate payment by the injured plaintiff. In practice, the problem is that the insurer's subrogation can result in the insurer being made whole while its insured has only recovered a fraction of her damages. This occurs when both the injured claimant and her insurer are vying for the same pool of money, i.e., the wrongdoer's insurance or assets, in an effort to satisfy their right to compensation. For example, in 1975, the Montana Supreme Court held that either the partially subrogated insurer, the partially paid insured, or both may bring the action against the tortfeasor. Conflict between the insureds' rights to recover under tort law and the broad rights of subrogation the insurers accorded themselves in the policies was inevitable.

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However, in the landmark case of *Skauge v. Mountain States Tel. & Tel. Co.*,[12] the court placed limits on insurance subrogation to resolve the conflict in a manner harmonious with the underlying theory. The Skauges suffered $11,267.32 in personal property damage and incidental living expense when their rental home exploded and burned. Unigard Insurance provided them personal property coverage with $4,000 limits and incidental living expense with $400 limits each of which Unigard paid. To recover their unpaid losses, Skauges pressed their tort claims against Montana Dakota Utilities (MDU) alleging the company was responsible for the explosion and fire. Unigard filed a third party complaint claiming reimbursement by right of subrogation against any amount to be paid by MDU to the

Skauges. The court realized the import of granting Unigard its broad right of subrogation: the Skauges might receive the amount of their loss, $11,267.32 from MDU, from which Unigard would take $4,400, and the Skauges would have to pay their own contingent attorney fees and costs of litigation from the balance. In the end, the insurer, which collected premiums to cover the risk, would have been fully reimbursed for the risk, and the insureds would have only netted a small part of their loss. The court avoided that result by holding that the insurer was not entitled to exercise a right of subrogation until the insured has been made whole including expenses of litigation and attorney fees.[13] The court reasoned that, if a party must bear the loss, it should be the insurer, since that is the risk the insured paid the insurer to assume.[14] The court expressly noted that, under its ruling, the Skauges would not be unjustly enriched nor would the tortfeasor go free from its legal obligation so that the decision honored the theory of insurance subrogation.[15] This rule has become known as the "Make-Whole" rule.

In 1994, the court followed *Skauge* when deciding *Detienne Assoc. v. Farmers Union Mut. Ins. Co.*[16] There, Detienne Associates, the owners of the Park Plaza Hotel in downtown Helena, suffered several hundred thousand dollars in loss when a Montana Rail Link (MRL) train wreck caused loss of power and heat at the hotel during severe cold weather which resulted in breaks in the plumbing and water loss to the facility. Farmers Union paid Detienne $411,155.49 which was less than their loss and then sought to be reimbursed from any amount Detienne secured in its tort action against MRL. On the same principles set out in *Skauge*, the court held that the insurer had to pay the insured's attorney fees and costs, before it could proceed to recover under its subrogation claim. Again, the court reiterated that the insured must be made whole including costs and attorney fees before the insurer can subrogate, and, as between insurer and insured, the insurer must bear the risk that there will not be enough recovery to make both the insured and insurer whole.

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This "Made-Whole" rule has also been used in *Francetich v. State Comp. Mut. Ins. Fund*[17] and *Connery v. Liberty Northwest Ins. Co.*[18] to void insurance subrogation statutes giving workers' compensation insurers a percentage offset against benefits payable if the injured worker pressed a claim against any third party. The court's expressed basis for voiding those statutes that infringed the Made-Whole rule was that they violated the Full Legal Redress provision of Article II § 16 of the Montana Constitution.

In 1981, in *Allstate Ins. Co. v. Reitler*,[19] the court prohibited subrogation by auto insurers to recover amounts paid under medical pay coverage citing three public policy grounds. First, the insured paid a premium for the medical pay coverage. Second, the injured insured was the party most likely to suffer if the medical pay benefit had to be reimbursed out of the recovery from the tortfeasor. Third, the tortfeasor's insurer could take the fact of the medical pay benefit received into account in settling with the claimant.[20] The court also held subrogation for benefits paid under medical pay coverage actually constituted an impermissible assignment of a personal injury chose in action, but later repudiated that ground as being incorrect in *Youngblood v. American States Ins. Co.*[21] The prohibition against subrogation was limited to benefits under medical pay coverage, since, three years later, in *Farmers Ins. Exch. v. Christenson*,[22] the court upheld an insurer's subrogation to recover amounts paid under Uninsured Motorist Coverage. For the next 16 years following *Reitler*, it was accepted in Montana that auto insurers could not subrogate to recover benefits they paid under auto medical pay coverage.

In *Youngblood*,[23] the court sought to clarify that the *Reitler* decision on medical pay subrogation and the *Christenson* decision on uninsured motorist subrogation were not matters of assignment, but of subrogation. The court reaffirmed that insurer subrogation to secure reimbursement of medical expenses was against public policy on the three grounds cited above from *Reitler*. Importantly, the court refused the insurer's argument that the medical pay subrogation clause was validated by the then-existing provision from what Montana lawyers call the "anti-stacking" statute which then provided:

> A motor vehicle liability policy may also provide for other reasonable limitations, exclusions, or reduction of coverage which are designed to prevent duplicate payments for the same element of loss.[24]

The court was not convinced that the provision covered subroga-

tion as a limitation, exclusion, or reduction and said that the legislature could have easily included it. In response, the legislature amended the clause in 1997 adding subrogation into it so that it reads as follows:

> A motor vehicle liability policy may also provide for other reasonable limitations, exclusions, reductions of coverage, or subrogation clauses that are designed to prevent duplicate payments for the same element of loss under the motor vehicle liability policy or under another casualty policy that provides coverage for an injury that necessitates damages or benefit payments or to prevent the adding together of insurance coverage limits in one policy or from more than one policy issued by the same company.[25]

After the statute was amended, insurers immediately asserted their right to press subrogation claims to recover benefits extended under automobile medical pay coverage. Apparently, some even assert that this amendment in some way overturned the *Skauge* and *Detienne* rule that the insurer may only subrogate after the insured is made whole including attorney fees and costs.

However, review of the legislative history of this amendment from Senate Judiciary Committee hearings on Senate Bill 266 reveal that proponents expressed a universal concern about preventing duplicate payments for the same element of loss, some concern for making sure that the wrongdoer pays, and no comment regarding the rule in *Skauge* or *Detienne*.[26] Consequently, we should be clear that the amended statute does nothing more than state that an insurer may include in a policy "subrogation clauses designed to prevent duplicate payments for the same element of loss." This is consistent with the theoretical basis for insurance subrogation originally stated in *Skauge* but neither expressly nor impliedly infringes the rule that such subrogation cannot take place until the insured is made whole for loss, attorney fees, and costs of litigation.

Hence, State Farm cannot pay medical expenses under medical pay coverage to one insured party in an auto accident and then subrogate against their own insured tortfeasor.

One could argue that there is nothing inherently unfair about making each insurer who collected a premium on a promise to pay the insured's medical expense, pay them, even if the insured receives duplicate payments. Indeed, the court in *Reitler*[27] and in *Youngblood*[28] alluded to that point. Nevertheless, the overarching principle that underlies all of insurance subrogation, whether granted by the court or by the legislature under this statute, is its purpose (1) to prevent duplicate payment for the same element of loss, and (2) not to grant the insurer subrogation rights that leave the insured less than whole.

Counsel should also keep in mind court-imposed restrictions on parties against whom the insurer can subrogate. Given the fact that insurers like State Farm, Allstate, and Farmers hold substantial shares of the auto insurance market, it is not uncommon for one of them to insure more than one party to an accident. Consequently, it is important that the insurer in Montana may not be subrogated against its own insured. Hence, State Farm cannot pay medical expenses under medical pay coverage to one insured party in an auto accident and then subrogate against their own insured tortfeasor. In *Home Ins. Co. v. Pinski Bros., Inc.*,[29] the court did not allow Home, which had paid a large loss to Montana Deaconess Hospital at Great Falls, to subrogate against the architects blamed for the hospital's loss, since they were also insured by Home. In *Continental Ins. Co. v. Bottomly*,[30] the court blocked subrogation against the insured's brother who was blamed for burning down the insured's cabin where he was a guest. The court did so on the ground that the guest is in the same shoes as the insured. Finally, the insurer may not recover from an additional insured in subrogation.[31]

The Hospital Lien Problem

A related problem for counsel who recovers insurance proceeds on behalf of the injured tort victim and seeks to protect that victim is the hospital or other medical lien claimant which asserts full lien rights to the recovered fund with no intention of sharing the burden of the victim's expenses from attorney fees and litigation costs. Technically, the medical provider is not subrogated to the injured patient's rights and can argue that it is not bound by the rule of *Skauge* and *Detienne* that the patient must be made whole before the lienor can be satisfied. However, the Supreme Court of Nebraska, in *Guardianship and Conservatorship of Bloomquist*,[32] applied the common fund doctrine, a principle normally applied to situations involving subrogation interests, to the interest of a medical lienholder. The court noted that the basis of the common fund

doctrine is "the equitable concept that an attorney who performs services in creating a fund should in equity and good conscience be allowed compensation out of the whole fund from all those who seek to benefit from it."[33] The court observed that the hospital lien on a personal injury claim is worthless "unless and until through the expenditure of funds and effort by the attorney the claim is successfully asserted to completion."[34] The court held that the lien-holding hospital had to pay its proportionate share of the patient's contingent plaintiff's attorney fee and litigation costs.

The Supreme Court of New Mexico also applied the common fund doctrine to a hospital lienholder who refused to reduce its statutory lien to accommodate the contingent attorney fees and costs incurred by the patient.[35] There, the court held that the hospital's lien must be reduced by its proportionate share of attorney fees and costs and that the net recovery to the hospital after attorney fees and costs satisfied the lien in its entirety.[36]

The ERISA Problem

Unfortunately, the Employee Retirement Income Security Act of 1974,[37] known as ERISA, preempts employers' self-funded health care plans from state law regulating insurance.[38] Under ERISA, the United States Supreme Court has read the "deemer" clause of the act to exempt the self-funded ERISA plans from state laws that "regulate insurance."[39] In the case of such plans, state common law is also preempted.[40] Thus, Montana case law controlling the insurer's right to subrogation will not apply. However, the Ninth Circuit Court of Appeals, in the 1994 case of *Barnes v. Independent Auto. Dealers Ass'n of California Health and Welfare Benefit Plan,*[41] adopted the "Make-Whole" rule stating, "absent an agreement to the contrary, an insurance company may not enforce a right to subrogation until the insured has been fully compensated for her injuries, that is, has been made whole."[42] The court found the rule to be consistent with the principle of preventing unjust enrichment but did not indicate whether attorney fees and costs were included in making the insured whole.

In cases where liability is reasonably clear, the injured claimant's medical bills can be submitted to the insurer for the third party tortfeasor with demand for payment.

Ironically, in the Montana Federal District Court, Judge Molloy decided *Marquis v. Ironworkers Intermountain Health and Welfare Trust Fund,*[43] which involved an ERISA plan that expressly blocked the "Make-Whole" doctrine. The plan provided that "[t]he Fund shall be entitled, up to the amount of benefits paid hereunder in connection with such illness or injury, to the proceeds of any settlement or judgment that results in a recovery from the third party, whether or not the Participant is made whole by such recovery . . .."[44] Marquis was quadriplegic from his accident, and his tort damages against primary tortfeasor, Lewis and Clark County, were limited under Montana law to $750,000. Marquis sought to allocate his $800,000 settlement ($750,000 from the county and $50,000 from the state) between his claim and his wife's claim for loss of consortium and to make no claim or settlement for the benefits he received from the Ironworkers' ERISA plan. In that manner, he hoped to avoid subrogation. Because the language of the plan voided the Make-Whole rule and ERISA preemption, the federal court had to allow the subrogation against that part of the settlement allocated to the quadriplegic Marquis. However, Judge Molloy then applied the common fund doctrine in ordering the plan to pay its proportionate share of the attorney fees and litigation costs incurred by Marquis. Nevertheless, in a clear illustration of ERISA's preemption of state court protections, Marquis ultimately had to reimburse the plan $317,073.93 from his already inadequate $800,000 settlement for his catastrophic injury.

Securing Medical Payments from Third Party Liability Coverage

In cases where liability is reasonably clear, the injured claimant's medical bills can be submitted to the insurer for the third party tortfeasor with demand for payment. Until 1997, it was common practice in the insurance industry to accept the bills for payment but refuse to pay them until the claimant agreed to a final settlement under the liability coverage. In 1997, the Supreme Court decided, in *Ridley v. Guarantee Nat'l Ins. Co.,*[45] that, under the Montana Unfair Trade Practices Act,[46] the insurer has an obligation to pay medical expenses as incurred by an injured third-party tort victim when the liability of its insured is reasonably clear. The decision was based on two subsections of the act which provide that the insurer may not:

(6) neglect to attempt in good faith to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear;

(13) fail to promptly settle claims, if liability has become rea-

sonably clear, under one portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage . . .

The court found that refusing to promptly pay one type of damage, i.e., medical expense, in an effort to force settlement of other damages such as lost wages, pain and suffering, or disability was a form of leveraging which violated MCA § 33-18-201 (13) above. The only viable way the insurer can avoid paying medical bills as incurred is to assert that the bills are not reasonably causally related to accident they insure.

The court in *Ridley* left open the issue of whom the insurer pays when it makes advance payment of medical expense. Does the tortfeasor's insurer pay advance medical expenses directly to the injured plaintiff's medical providers or by check made out to the plaintiff? In *Shilhanek v. D-2 Trucking, Inc.*,[47] because plaintiffs' medical expenses had been paid by plaintiffs' own insurance sources, the defendant's insurer refused to pay them directly to the plaintiffs and instead deposited the money representing past medical expenses into court. After the verdict, the defendant's insurer asked the court, pursuant to the collateral source reduction statutes, MCA §§ 27-1-307 and 308, to grant it an offset against the judgment for the amount of medical expense money on deposit. The district court refused, and the Montana Supreme Court affirmed finding that the action of the insurer in depositing the funds simply did not constitute a payment made to the plaintiffs. The insurer could have obtained the offset, if it had paid the medical expenses directly to providers or paid to the plaintiffs.

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Stacking Medical Pay Coverage

In 1997, the legislature purported to end all stacking of insurance policy coverages when it amended the "anti-stacking" statute, MCA § 33-23-203.[48] While the statute's expressed legislative intent was to block all stacking, and its language appears to do so, it appears to be under challenge in a couple of courts in Montana at this time. Prior to the 1997 amendments, the court in *Holeman* held that the statute did not apply to medical pay coverage, which was deemed an optional coverage. The amended statute's effective date was May 2, 1997, and it applied to policies entered into from May 3, 1997 on. Consequently, for policies in effect as late as May 2, 1998, one may still be able to stack medical pay coverage for purposes of securing payment of medical expenses that would exhaust a single coverage.

Conclusion

The ever-rising costs of medical treatment dictate that plaintiff's counsel is often faced with a client who has incurred massive medical expenses in a matter of weeks. Insurers are ever vigilant in an effort to contain their own liability for medical expense under their policy promises. Plaintiff's counsel must analyze the situation in light of statutes and case law to determine the right tactical moves and timing in making claims to secure payment of medical expenses. Techniques for avoiding the insurers subrogation, offsets and limitations are tools of claimant's lawyers' trade, and counsel must be aware of them and share them.

Notes

1. 1 Susan J. Miller & Philip Lefebvre, MILLER'S STANDARD INSURANCE POLICIES ANNOTATED, *Form PP 00 01 06 94*, form PAP, provision B1C at 5 (4th ed. 1995)[hereinafter MILLER'S].
2. 22 M.F.R. 32 (1996)(citing *Sayers v. Safeco Ins. Co. of America*, 628 P.2d 659, 661 (Mont. 1981).
3. 515 P.2d. 362, 364 (Mont. 1973).
4. *See e.g.* MILLER'S, *Form HO 00 03 04 91*, form HO, provision 2.1F at 214.
5. 404 A.2d 216, 221-222 (Me. 1979).
6. *Skauge v. Mountain States Tel. & Tel. Co.*, 565 P.2d 628, 630 (Mont. 1977); *Youngblood v. American States Ins. Co.*, 866 P.2d 203, 205 (Mont. 1993).
7. *Skauge*, 565 P.2d at 629; *Youngblood*, 866 P.2d at 205.
8. 565 P.2d at 629.
9. *Farmers Ins. Exch. v. Christenson*, 683 P.2d. 1319, 1321 (Mont. 1984).
10. MCA §33-23-203 (2).
12. 565 P.2d 628 (Mont. 1977).
13. *Id.* at 632.
14. *Id.*
15. *Id.*
16. 879 P.2d 704 (Mont. 1994).
17. 827 P.2d 1279 (Mont. 1998).
18. 960 P.2d 288 (Mont. 1998).
19. 628 P.2d 667 (Mont. 1981).
20. *Id.* at 670.
21. 866 P.2d at 207.
22. 683 P.2d 1319, 1322 (Mont. 1984).
23. 866 P.2d at 207.
24. MCA § 33-23-203 (2)(1995).
25. *Id.*(quote reflects amendment by Ch. 263 L. 1997 and by Ch. 495, L. 1997).
26. Draft unofficial 1997 Legislative Committee Minutes of Senate Judiciary hearings on February 11, 13 and 18, 1997.
27. 628 P.2d at 670.
28. 866 P.2d at 207.
29. 500 P.2d 945 (Mont. 1972).
30. 760 P.2d 73 (Mont. 1991).
31. *Truck Ins. Exch. v. Transport Indem. Co.*, 591 P.2d 188 (Mont. 1979).
32. 523 N.W.2d 352 (Neb. 1994).
33. *Id.* at 358.
34. *Id.* at 360.
35. *Martinez v. St. Joseph Healthcare Sys.*, 871 P.2d 1363 (N.M. 1994).
36. *Id.* at 1366.
37. § 514 (a), (b) (2) (A)-(B) as amended by 29 U.S.C.A. § 1144 (a), (b) (2) (A)-(B).
38. *FMC Corp. v. Holliday*, 498 U.S. 52 (1990).
39. *Id.* at 60.
40. *Scott v. Gulf Oil Corp.*, 754 F.2d 1499, 1502 (9th Cir. 1985).
41. 64 F.3d 1389 (9th Cir. 1995).
42. *Id.* at 1394.
43. 24 M.F.R. 68 (1998).
44. *Id.* at 70.
45. 951 P.2d 987, 992 (Mont. 1997).
46. MCA § 33-18-201.
47. 2000 MT 16, P.2d (2000).
48. Ch. 495, L. 1997. ■