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DENYING SUBROGATION IN PERSONAL INJURY CLAIMS: A NEEDED CHANGE OF DIRECTION

Uriel Procaccia*

Insurance subrogation is a growing multimillion dollar concern. Underwriters tend to initiate proceedings against solvent tortfeasors in any case large enough to justify the effort. Although the ratio of net subrogation recoveries to net incurred losses varies according to the type of coverage and the aggressiveness of the insurer,¹ a growing industry-wide consciousness of the great potential of subrogation has resulted in a significant increase in the aggregate recovery ratio under all coverages.²

From a policy standpoint, the promotion of justice and prevention of hardship have been offered to justify the system’s existence. Proponents argue that the tortfeasor’s liability is primary while the underwriter’s is only secondary,³ and that if the secondary obligor has had to pay a

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²For some evidence of the existence of this upward slope in subrogation activities, especially with respect to fire insurance, see Sinnott, Subrogation Investigations of Fires and Explosions, 1962 Ins. L.J. 41.

claim, equity requires that he have recourse against the primary obligor. Moreover, they observe that mature loss-adjusting mechanisms should assure due compensation to the victim and effect a just allocation of the loss by holding a tortfeasor ultimately liable for his actions. Subrogation, it is argued, fulfills these criteria. If, however, the relative equities of the parties are not in favor of the insurer, and if the victim does not receive all to which he is entitled, the purpose of subrogation is defeated. Such a result is evident in the personal injuries area.

From a social perspective, the concept of a double recovery by a policyholder has been much maligned. Subrogation prevents a double recovery, but because of the peculiar nature of personal injury accident loss, where actual indemnity is only rarely achieved, the notion of collecting compensation twice should not be condemned. Since the process of balancing relative equities was developed judicially when the insurance industry was in its infancy, and since subrogation is often treated as a discretionary remedy rather than as one of right, the judicial precedents that have formulated the subrogation system should not be deemed incontrovertible.

This Article will examine personal injury subrogation in cases with and without a settlement. General fiscal theory will also be considered, with special emphasis on better allocation methods in the area than now exist. The American loss allocation system must lead the way in developing an equitable alternative to subrogation for personal injury claims.

**Personal Injury Subrogation Without a Settlement**

An uninsured accident victim who has been injured by the fault of another person may attempt to vindicate his rights in court. A long list of obstacles, however, obstructs actual monetary recovery through litigation. Proof of liability is lengthy and costly. Court dockets are clogged with endless lists of cases that await trial and appeal. Moreover, many final judgments are uncollectible because of the defendant's insolvency.

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5. In Ritter v. Cost, 99 Ind. 80 (1884), for example, an alleged subrogee's claim upon his insured's mortgage was held to be subordinated to the rights of a "purchaser of a judgment" who had no notice of the existence of the mortgage. For later developments in the same jurisdiction, see LaGrange v. Greer Wilkinson Lumber Co., 59 Ind. App. 448, 108 N.E. 373 (1915).

6. No progress seems to have been made in the solution of these problems. *Compare* Ehrenzweig, "Full Aid" Insurance For the Traffic Victim (1954), a leading study
The victim, however, could have purchased an accident insurance policy covering a part of his economic loss. There are three basic types of policies available: expense coverage, the most common being a policy covering hospital expenses and doctors' bills actually incurred by the insured; income coverage, providing the insured with a guaranteed income in the event of disablement from accidental injury; and fixed sum policies for the contingencies of death, dismemberment, or loss of sight.7

Common to all these policies is that none is designed to indemnify the insured for his physical pain, mental anguish, sleepless nights, feelings of humiliation, or social embarrassment. For such injuries, the insured must go to court and comfort himself with whatever damages he can collect from the tortfeasor. In no case, however, can money fully compensate him, especially if “complete” recovery must be sacrificed in the interest of a quick settlement and avoidance of a difficult courtroom battle. Furthermore, most insurance coverages do not completely compensate the insured for his out-of-pocket expenses. Thus, the pertinent policy question is whether a health insurance carrier defraying these expenses should be permitted to reduce his “losses” through subrogation by claiming a preemptive right in any recovery of the insured from the tortfeasor.

The positive law in the United States has not reached a definitive answer to this query, but its direction is toward legitimatizing subrogation practices. This tendency is most unfortunate.

Early Court Rulings

The problem raised by personal injury insurance subrogation is a comparatively recent one. Old English authorities, as well as the modern ones, have never squarely disposed of the issue. Most English commentators believe that subrogation cannot be permitted to health insurers8 but concede the lack of a clear holding to that effect.9

8. E.g., 22 Halsbury’s (Simonds) Laws of England 261: “The doctrine of subrogation does not apply to contracts of life insurance and personal accident insurance.” But then, in a footnote, it is said: “There is no direct authority as regards personal accident insurance: the absence of any right of subrogation seems, however, to follow from the principle that personal accident insurance is not a contract of indemnity”.
9. In Theobald v. Railway Passengers Assurance Co., 156 Eng. Rep. 349 (Ex. 1854), it was held that where the policy stipulated for payment of £1000 in case of the insured's death, and of a proportionate amount in case of a personal injury, the amount...
The leading decision disallowing health insurers' subrogation is *Gatzweiler v. Milwaukee Electric Ry & Light Co.*, in which it was held that in the absence of an express subrogation clause, no subrogation to health carriers could be sanctioned. The court drew a close analogy between life and personal injury coverages, holding that in both cases the policy proceeds are fixed without regard to actual indemnity and, in the absence of indemnity, subrogation should not be tolerated.

If it can be assumed that life and personal injury coverages are, indeed, analogous, *Gatzweiler's* qualified holding, which emphasized the lack of an express subrogation clause, is incompatible with the analogy. An express subrogation clause should be held ineffective in an accident contract just as it is in a life policy. If an express provision would legitimize subrogation, this must mean that there is an inherent distinction between the two types of coverage. However, no meaningful distinction has yet been demonstrated. Some courts have reacted sensitively to that realization and have denied personal injury subrogation notwithstanding an express contractual provision, but these courts are definitely in the minority.

re recoverable for personal injury was the actual damage, but not exceeding £1000. In *Bradburn v. Great W Ry.,* [1874] L.R. 10 Ex. 1, the court held that since a personal injury policy is not a contract of indemnity, the injured party could have recovered from the tortfeasor without making allowance for insurance proceeds recoverable from the health carrier.

10. 136 Wis. 34, 116 N.W 633 (1908).

The Sharpe Era

A pair of Michigan cases, both styled *Michigan Hospital Service v. Sharpe*,\(^\text{14}\) marked a great reversal in judicial attitude toward the question of health insurance subrogation and the beginning of a new era of subrogation permissiveness.\(^\text{15}\) In *Sharpe I*, an accident victim had recovered $2,000 under a Blue Cross hospitalization policy. He then sued the tortfeasor and settled his claim for $18,000 in full satisfaction. In denying Blue Cross' alleged right of subrogation, the court stated that a contract of accident insurance is not one of indemnity. In addition, the health carrier's liability was held to be primary rather than secondary, and therefore a shifting of the economic loss to a third party (the tortfeasor) was refused.

In *Sharpe II*, the facts were identical, except that the insurer had included an express subrogation clause in the policy. The court rejected the contention that subrogation would unjustly enrich the health carrier and concluded that to hold “that the subrogation clause gave plaintiff no rights whatsoever is to read it out of the agreement by rendering it meaningless. This a court may not do.”\(^\text{16}\) Since, in the absence of an express clause, subrogation against the tortfeasor had been held unenforceable, and because the third party’s rights could not have been affected adversely by an agreement to which he had not consented, the carrier’s subrogation was held to be enforceable only as against the insured. In other words, the insured’s recovery from the third party had to be given to the successful subrogee.

It is submitted that *Sharpe II* is bad law. Considering the two cases together, the earlier *Sharpe* rests on two distinct grounds. First, the health coverage was held not to be a contract of indemnity; thus, recovery from the third party was held insufficient to make the insured whole again, and therefore an additional collection from a collateral source could not unjustly enrich or confer a windfall benefit upon the insured. Second, the insurer’s liability was said to be “primary.” This means that the insurer, vis-à-vis the third party, could not have claimed that he had paid the tortfeasor’s debt, as he could if he were the surety and the third party his principal debtor; in short, the “relative equities” were determined in favor of the third party.

Although the first ground denies subrogation because of the judicial commitment to do the utmost to assure the victim’s indemnification, the...

\(^\text{14}\) 339 Mich. 357, 63 N.W.2d 638 (1954); 339 Mich. 574, 64 N.W.2d 713 (1954).

\(^\text{15}\) See also Barmeier v. Oregon Physicians' Serv., 194 Ore. 659, 243 P.2d 1053 (1952).

\(^\text{16}\) 339 Mich. at 577, 64 N.W.2d at 714.
second rationale focuses upon the third party, recognizing his right to immunity from subrogation regardless of the insured’s indemnification. If this analysis is correct, there is no way to justify the second Sharpe decision. Since the Blue Cross coverage could not have indemnified the insured, a preemptive right given to Blue Cross in the third party recovery would unjustly enrich Blue Cross at the insured’s expense. Moreover, an express clause should not operate to reverse the result. Courts should be free to disregard the clause, as is done routinely in the other nonindemnity line, life insurance. If the relative equities of the parties are in favor of the tortfeasor rather than the underwriter, it is difficult to understand why the former should pay the injured party’s claim if such payment will benefit only the insurer.

The court conceded that there was no direct right of recovery by Blue Cross against the wrongdoer. Although this proposition was prompted by a desire to allocate a known economic loss in an appropriate manner, the objective clearly was frustrated by the sanctioning of a similar result through a circuitry of action.

The Aftermath of Sharpe

The distinction which the Sharpe decisions drew between insurance policies containing express subrogation clauses and those without such clauses brought about a proliferation of subrogation clauses18 and a rapid adoption of the Sharpe II holding in the majority of jurisdictions where the question arose.19 In many cases, courts opted to follow Sharpe II with no intelligible attempt to illuminate the problem with independent rea-


18. One interesting clause, to be found in the contracts of the Oregon Physician's Service (O.P.S.), an organization similar in its objectives and methods to Blue Cross, reads:

The benefits of this contract do not apply to any injury or illness of the member caused by the negligence or wrongful act of any other person, except to the extent that if the member shall make all reasonable efforts to recover from such other person O.P.S. will procure for the member the benefits of this contract which cannot be made available out of funds reasonably recoverable from, or through, such other person. Such funds shall be deemed not reasonably recoverable from, or through, such other person if it shall reasonably appear that should an action therefor be prosecuted, and judgment therefor obtained, against such person execution on such judgment would be unavailable.


19. For a notation of this development, see Barry, Subrogation of Medical Payment Claims, 17 FEDERATION OF INS. COUNSEL 46 (1967)
The most prevalent rationale given by courts to explain their position is that subrogation is a by-product of actual indemnity. It is argued that since the health insurance contract covers exactly the indemnifiable portions of the insured's loss—lost income and out-of-pocket expenses, there is no reason why the insured should collect twice for a liquidated expenditure which is so easily ascertained and so clearly documented.

This argument generally has been accepted with enthusiasm by academic writers, but it is nevertheless fallacious. Its flaw lies in the fact that the concept of indemnity is analyzed from the wrong direction. As far as the insurance company is concerned, the loss was ascertainable and liquidated, and the policy proceeds completely cover it. Unliquidated (uninsured) portions of the loss are not within the interest of the carrier and should not, from its point of view, be of any concern. It is the insured, however, and not the insurance carrier, who should be indemnified.

Subrogation is permitted in the property insurance lines in order to avoid a double recovery by one who actually has been indemnified. As has been demonstrated, however, an accident victim is often indemnified for only one portion of his loss, usually the most insignificant one. From his point of view, the ascertainability of his out-of-pocket expenses and its reimbursement do not, and cannot, affect indemnification. For example, assume an accident has resulted in the loss of an eye to the insured. If the tortfeasor's solvency was limited to $500, approximately the cost of hospital and doctors' bills, the modest third party recovery will be consumed by the health carrier, leaving the insured completely "indemnified" with regard to his actual expenses, but with no recovery for other portions of his loss.


23. Even this assumption may be shaken in the case of a settlement between the insured and a third party. See notes 46-62 infra & accompanying text.

24. This idea can be extended in certain circumstances to property insurance. Suppose, for example, that an insured owns two houses, each worth $50,000, and that he
Furthermore, even if the third party's resources are sufficient to meet a judgment entered against him, including maximum recovery for pain and suffering, the idea that this represents indemnity still would be misleading. From the point of view of the accident victim, such a judgment represents a liquidated sum, consisting of compensation for the indemnifiable expenses, and an unliquidated amount payable for pain and suffering. The combination of these two amounts is necessarily unliquidated, unascertainable and, therefore, unindemnifiable. Thus, the concept of indemnity can be sustained only from the indemnifier's viewpoint; it cannot be supported from the perspective of the one to be "indemnified."  

Personal Injury Subrogation and Workmen's Compensation

The misguided theory that subrogation should be permitted for liquidated portions of a loss resulting from personal injury is carried beyond litigation into almost all workmen's compensation schemes. In most jurisdictions, a tortfeasor cannot be held liable more than once for the same wrongful act. Therefore, an employee cannot possibly sue him for general damages and leave the litigation for medical expenses and loss of earnings to the workmen's compensation carrier. Hence, the has purchased a fire policy to protect only one of them. If a tortfeasor whose solvency is limited to $50,000 causes a fire that completely demolishes both houses, his limited resources could either be channeled to indemnify the insured for his actual loss or made to satisfy the subrogation claim of the fire underwriter, thereby rendering the insurance policy economically valueless. Conceding that the first alternative is preferable, an analogous result should be encouraged in the field of health insurance.

25. There are additional reasons advanced for the adoption of the Sharpe II rule. Some courts say that there could not possibly be a valid public interest against the promulgation and enforcement of subrogation clauses, for otherwise the state insurance commissioner would certainly have refused to allow their insertion into policies. Associated Hosp. Serv. Inc. v. Milwaukee Auto. Mut. Ins. Co., 33 Wis. 2d 170, 147 N.W.2d 225 (1967); Travelers Ins. Co. v. Lutz, 32 Ohio App. 2d 469, 210 N.E.2d 755 (1964). This judicial dependency upon the use of administrative discretion, without any evidence that the commissioner's attention has even been directed to the question, is inappropriate. Other courts declare that since assignments of tort actions for personal injuries are permissible in a given jurisdiction, conventional subrogation also should be tolerated. Davenport v. State Farm Mut. Auto. Ins. Co., 81 Nev. 361, 404 P.2d 10 (1965). This approach obviously ignores the question whether an assignment of a subrogation right should be permitted in the first instance. There is also the popular argument that subrogation penalizes wrongdoing by allocating the financial consequences of a tort to its originator, hopefully reducing premiums by so doing. Hospital Serv. Corp. v. Pennsylvania Ins. Co., 101 R.I. 708, 227 A.2d 105 (1967). The flaw in this theory is that it incorrectly identifies technical fault with moral turpitude.

26. E.g., King v. Chicago M. & St. P Ry., 80 Minn. 83, 82 N.W. 1113 (1900) Compare
victim can recover just one lump sum from the tortfeasor, which in many cases would be an amount less than his actual loss.\textsuperscript{27} Considering this, should the employer or his liability carrier be permitted full reimbursement for "losses" by having a preemptive right in the third party recovery? If so, should allowance then be made for the employee's recovery expenses and attorney's fees, or must the employee shoulder these expenses alone? The answer varies among jurisdictions.

In most states, the employer (or his carrier) is entitled to a full refund of benefits previously paid to the employee. In some jurisdictions, the employee is not even permitted to keep the excess over that amount, on the theory that the carrier should be given an incentive to conduct the third party litigation and not settle for an undersized recovery.\textsuperscript{28} A much more desirable system was promulgated in Florida. There, if the employee relinquishes control of the litigation to his employer, the latter's subrogative pursuits are fully legitimized. If, however, the victim conducts the proceedings on his own, the statute provides:

> Upon suit being filed \(\text{against the third party}\), the employer or the insurance carrier may file in the suit a notice of payment of compensation and medical benefits to the employee which shall be recorded and the same shall constitute a lien upon any judgment recovered to the extent that the court may determine to be their pro rata share for compensation benefits paid or to be paid based upon such equitable distribution of the amount recovered as the court may determine, less their pro rata share of all court costs expended by the plaintiff including reasonable attorney's fees for plaintiff's attorney.\textsuperscript{29}

Some experts have expressed disapproval of the broad discretion the Florida statute gives to the courts,\textsuperscript{30} because it necessarily results in

\begin{footnotes}
\textsuperscript{27} Patterson & Colvin, \textit{Injury to Persons and Property—One Action or Two?}, 2 Ala. L. Rev. 75 (1949), \textit{with} Brunsden v. Humphrey, [1884] 14 Q.B. 141 (C.A.).

\textsuperscript{28} Hudson v. Lazarus, 217 F.2d 344, 346 (D.C. Cir. 1954).

\textsuperscript{29} Patterson & Colvin, supra note 27.

\textsuperscript{29} Larson, supra note 28.


\textsuperscript{30} E.g., Larson, supra note 28.
\end{footnotes}
confusion and lack of certainty, and might invite abuse. For example, the figure claimed by the injured employee as his actual damages might be used to apportion the third party recovery. A literal use of the Florida statute, however, can easily avoid these pitfalls, and in the absence of abuse, it is much more progressive than some of its widely accepted counterparts. Not only does the statute recognize in principle the possibility that subrogation should be limited when justice so requires, but it also specifically allows for the actual expenses and attorney’s fees incurred by the insured. In the absence of such a provision, most jurisdictions would not make that allowance, with the result that the employee would receive what remains after a full deduction of court expenses, attorney’s fees (usually amounting to about one-third of the gross recovery), and the insurance carrier’s “losses.”

**Personal Injury Subrogation and the Collateral Source Rule**

The constant expansion of subrogation in the personal injury area is not universally accepted. On a closely related question, the overwhelming weight of authority is opposed to the current tendency to accept Sharpe II as positive law. This related doctrine is known as the collateral source rule. Generally deplored by academic writers, the doctrine dictates that if the insured has recovered from someone other than the tortfeasor for some compensable consequences of his loss, allowance should not be made in the computation of damages against the third party for such previous recoveries. The benefits paid or payable by the collateral source may be numerous. They include the continued retention of an injured employee on his employer’s payroll, a complete defrayal of hospital and doctors’ bills, life and accident insurance benefits, and social

31. E.g., Southern Farm Bureau Cas. Ins. Co. v. Bennett, 131 So. 2d 499 (Fla. 1961). This holding places an obvious premium on inflated suits.

32. A. Larson, supra note 28, § 74.32. But see Southern Quarries & Contracting Co. v. Hensley, 313 Ky. 640, 232 S.W.2d 999 (1950), where the court allowed for attorney’s fees but otherwise recognized the insurer’s preemptive right by subrogation over the victim’s residual interest in the proceeds of recovery. The carrier can thus clearly profit from the proceedings initiated by the victim against the third party, but he cannot lose. If the victim loses his lawsuit or if the judgment is uncollectible, the carrier is under no obligation to share the expenses of the litigation.


34. For a complete compilation of cases, see Annot., 7 A.L.R.3d 516 (1966)
benefits such as pensions, workmen’s compensation awards and social security. Against this background, the question is raised whether the tortfeasor should nevertheless pay his victim as if none of these benefits were conferred.

In most western countries, social benefits are the rule rather than the exception, and the question is therefore heavily litigated. Almost unanimously, the law in countries such as France, Germany, Switzerland, and Israel permits a full recovery notwithstanding a previous conferral of collateral benefits. In all these countries, however, the injured party becomes liable to a subrogation claim brought by the collateral source. English law is unclear, but it seems to recognize the collateral source rule while denying subrogation. In light of all relevant factors, this is clearly a preferable arrangement.

The law in this country recognizes the collateral source rule in three discernible versions. According to one line of authority, the tortfeasor should not be permitted to exploit the relationship between his victim and the collateral source. He is not allowed, therefore, to deduct the value of the collateral benefits from the damages recovered. However, since it is considered disadvantageous to confer upon the injured plaintiff the windfall of a double satisfaction, the collateral source is permitted to be subrogated to the amount collected from the third party.

35. West, supra note 33.
37. In Parry v. Cleaver, 1 All E.R. 555 (H.L.) (1969), a policeman was injured by the defendant's negligent conduct. The defendant contended that from the plaintiff's damages for loss of income, the pension payable by the police force should be deducted. The House of Lords held that the pension fund was paid for by the accrued wages of policemen and therefore should be regarded as accrued withheld wages rather than as unaccrued future wages.
38. In Metropolitan Police Dist. Receiver v. Craydon, 1 All E.R. 78 (C.A.) (1957), the court held that the employer can be subrogated only to the injured employee's rights. The employee, being paid his full salary during disability, was not entitled to sue for loss of earnings, which was fatal to the employer's subrogation claim. Note, however, the apparent inconsistency between this decision and Parry v. Cleaver, 1 All E.R. 555 (H.L.) (1969).
39. In a minority of jurisdictions, the rule is not recognized at all. See, e.g., Feeley v. United States, 337 F.2d 924 (3d Cir. 1964). The Court in Feeley held that the tortfeasor was not liable under Pennsylvania law to the accident victim for items of damage reimbursed by the Veterans' Administration.

The threefold approach to the collateral source rule as discussed in the text refers to jurisdictions recognizing it in one way or another.
The New York theory presents a slightly different solution. If the source of the collateral benefits is a fund to which the victim contributed (for example, a voluntary group employees' emergency fund), the rule is recognized, because the injured party's additional protection was purchased personally and was not intended for the wrongdoer's benefit. If the benefits were conferred gratuitously with no corresponding right of subrogation, however, application of the collateral source rule is considered unjust enrichment of the plaintiff.41

A third approach follows the English model and applies the collateral source rule while denying subrogation. For courts adhering to this theory, it is irrelevant whether the collateral source had paid gratuitously or in consideration for a quid pro quo.42 The reasons for this are twofold: first, subrogation negates making an allowance for attorney's fees paid by the victim,43 and, second, subrogation assigns a dollar value to the victim's health that is never sufficient to give the victim full compensation.44

The third approach is clearly to be preferred. Recognizing that the price most juries attach to physical injury is almost always undercompensating, that many cases are settled for less than what would have been awarded in court, and that one-third of that unsatisfactory amount may go to the plaintiff's attorney, it is difficult to accept the reasoning of either of the first two collateral source theories.

All of the arguments for the application of the collateral source rule and against subrogation of the collateral source apply also in the situation under consideration. The only pertinent factual difference is that if the
insured has had the foresight to purchase additional protection in the form of an accident insurance policy, and if he has paid for that policy out of his own pocket, he should expect his legal position to be better than that of a gratuitous beneficiary, who has not acted prudently nor paid for the additional benefit. It would indeed be unjust, however, to put a collateral source which has voluntarily cared for an injured accident victim in a worse position than that of a calculating insurer, which may be presumed to have rejected all applications that have not met its standard expectations and which has charged all its policyholders the full cost of and a profit for underwriting the risk involved. 46

45. The subrogation problem in personal injury lines is not always solved in a simple manner; its solution varies according to the stand the jurisdiction has taken on the issue of the Sharpe cases. There is a great variety of difficult problems that will have to be resolved according to the personal conviction and philosophy of the court, often without the aid of precedent.

For example, if a state statute subrogated an employer's liability carrier against a third party who had wrongfully injured an employee and fixed the amount of the subrogation recovery as equal to the compensation paid to the injured employee, the third party could argue that an amount of recovery reached without his consent, in proceedings to which he was not a party, cannot constitutionally determine the limits of his own liability. It is submitted that the personal well-being of the parties justifies an acceptance of such an argument. See Cal. Labor Code §§ 3850 et seq. (West 1955); Lasky, Expanded Scope of Recovery in Industrial Third Party Litigation, 41 Cal. S.B.J. 383 (1966).

Furthermore, in many jurisdictions operation of the comparatively novel "uninsured motorist" coverage in the subrogation context has not been litigated. Should an uninsured motorist carrier be subrogated to the insured's rights against a negligent uninsured motorist, which would probably result in the latter's destitution, or should the motorist's liability be relaxed for the reasons noted in the text? The major reason that can be advanced against recognition of subrogation in this context is that since most uninsured motorist clauses subrogate the carrier to all of the third party recovery, apparently including the portion allowable to pain and suffering and other uninsured portions of the loss, there is a resulting unfair exploitation of unsuspecting insurance consumers. See Kisling v. M.F.A. Mut. Ins. Co., 399 S.W.2d 245 (Mo. 1966).

Thirdly, what should be done with statutory provisions subrogating the insurer to third party recoveries allocable to uninsured portions of the loss? If the statutory protection seriously intends to protect the insured, circuitous action which leaves the insured with the same recovery as if no insurance had existed would certainly frustrate the statutory purpose. If the statutory purpose were any different, it would have deprived the insured of property without due process of law. See Jordan v. Orcutt, 279 Mass. 413, 181 N.E. 661 (1932).

Finally, may a casualty carrier be subrogated, statutorily or otherwise, to recoveries made by the dependents of a deceased insured who died as a result of the wrongful act? In spite of the universal denial of subrogation to life underwriters, some state statutes seem to confer such subrogative rights. See Pennsylvania Workmen's Compensation Act § 319, Pa. Stat. tit. 77, § 561 (1952); Anderson v. Borough of Greenville, 442 Pa. 11, 273 A.2d 512 (1971). A narrow construction of such statutes would seem proper in light of the ideas heretofore expressed. 
THE LEGAL CONSEQUENCES OF A SETTLEMENT BETWEEN THE INSURED AND THE THIRD PARTY

In the personal injury insurance context, where the victim's expenses are sometimes indemnified but his original pre-accident condition almost never restored, a quick settlement recovery may alleviate the plight of many claimants. The dollar volume of a settlement recovery obviously may be smaller than the conceivable maximum, but it is certainly much larger, and more quickly obtained, than the conceivable minimum. Thus, an unrehabilitated accident victim may feel a need to avail himself of what may be offered to him in a reasonable settlement proposal. Nevertheless, American law seems to discourage settlements between insured victims and potential defendants by limiting the insurer's liability to the amount of the settlement. Allowance is not made to accommodate the insured's own sacrifice of being less than actually indemnified. This policy has obvious adverse social repercussions. Its ramifications are particularly burdensome in the personal injury context, where victims generally need immediate compensation for their losses.

Early Decisions

Since subrogation is said to be a derivative rather than an independent right, a settlement discharging the third party's obligation to the insured also fixes the rights of the insured vis-à-vis the underwriter.46 In a series of English decisions, the destruction of the underwriter's subrogation claim against the tortfeasor was held to create a restitutionary right in the paid insurance proceeds, or a pro tanto discharge in payable insurance proceeds, whichever was applicable.

In Horse, Carriage & General Ins. Co Ltd. v. Petch,47 the insured purchased insurance coverage on his automobile and on the life of his brother. Subsequently, the brother was killed and the automobile damaged in a traffic accident. The company paid the insured £81 for the car and a negligible sum for the death of his brother. The policyholder

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46. This unanimous result may be reached regardless of the terms of the settlement. Thus, where an insured released a tortfeasor for a token recovery of his $50 deductible, it was held that the settlement also was final as to the underwriter. Gulf Ins. Co. v. White, 242 S.W.2d 663 (Tex. 1951) One possible exception exists where the third party has been aware of the pending subrogation claim at the time of the settlement. Nationwide Mut. Ins. Co. v. Canada Dry Bottling Co., 268 N.C. 503, 151 S.E.2d 14 (1966) But see Inter Ins. Exch. v. Anderson, 331 Ill. App. 250, 73 N.E.2d 12 (1947), where it was held that the duty to protect the insurer's subrogative expenditures rests solely on the insured.

47. 33 T.L.R. 131 (1916).
then collected from the third party tortfeasor an unapportioned sum of £1250, which amount probably was less than his actual damage. The court held that the insured party’s failure to apportion the recovery into subrogable and nonsubrogable items created a presumption that the value of the car had been fully compensated and allowed subrogation for £81. This decision crystallized earlier cases that supported the proposition in a more nebulous way.  

Early American law also considered the legal consequences of a settlement, declaring that it effects a pro tanto discharge of the insurance policy. This was held to follow from the nature of the policy as an indemnity contract not intended to bestow upon the insured more than actual compensation for his loss.

The Conflict Between Doctrinal Theory and Practice

Most of the cases indicated above, on which recent decisions now rely, were decided in the context of property insurance rather than in the personal injury insurance context. It would appear that in situations where the insured’s property has been fully covered by insurance, early judicial pronouncements are doubtlessly valid; a discharge having been effected, the only contestants to the recovered fund are a fully indemnified insured and a loss-sustaining insurance company. A subordination of the latter’s subrogative pursuit to the former’s claim for a windfall double recovery would not serve any legitimate purpose and would merely increase the moral hazard. The same holdings, however, would be inapposite in the typical personal injuries situation.

Suppose, for instance, that an automobile accident victim had to be hospitalized for one month and miss work for five years and also that his car was partially or completely wrecked. Suppose further that the victim’s first-party automobile coverage pays him $2,000 for the damaged property and that the driver of the other car contests his liability but is ready to pay $20,000 for the sake of a quick settlement. Finally, assume that the victim’s actual losses amount to $30,000 in expenses, plus an unknown amount for pain and suffering. The victim’s attorney advises him that recovery would be rather doubtful and extremely slow.

48. In Phoenix Assurance Co. v. Spooner, [1905] 2 K.B. 753, the insured released a confiscating authority from the duty to pay damages for the confiscation. The release had not served any legitimate purpose and merely destroyed the insurer’s right of subrogation. See also West of Eng. Fire Ins. Co. v. Isaacs, [1897] 1 Q.B. 226, where there was a double recovery by the insurer.
and since he cannot afford to wait so long for the mere hope of a larger recovery, he accepts the settlement. After having paid a 25 percent contingency fee and five percent for recovery expenses, the victim is left with $14,000. The property insurer then asserts its subrogation right to recoup its $2,000 loss; if successful, this leaves the victim with $12,000. The insufficiency of the victim’s compensation is manifest.51

These realities pass unheeded by American courts, and the general praise of subrogation continues. Two major schools of thought have developed. One, slightly better entrenched than the other, permits subrogation to its fullest extent notwithstanding either the terms of the settlement or the recovery expenses.52 This generosity toward insurers clearly penalizes the victim. Upon the assumption that in most severe accident cases the third party is neither totally insolvent nor sufficiently affluent to pay for the entire loss,53 settlement looms large as a realistic alternative to litigation. There is little sense in litigating when a defendant cannot afford more than what he proposes by way of settlement. Thus, the liberal judicial approach to subrogation channels the third party’s limited resources away from a true compensation situation to the economic detriment.

51. This hypothetical situation is rather common. In cases of light injuries, most victims’ economic losses are attributable to “medical loss,” which includes hospitalization, surgery, doctors’ bills and the like. Only a smaller portion is allocable to loss of income. Thus, where the economic loss ranges from $1 to $500, 68.4 percent is allocable to medical loss and only 27.2 percent to loss of income. The picture is entirely different in cases of severe injury. In accidents entailing an economic loss of $25,000 or more, only 21 percent is attributable to medical loss, but 65.4 percent is lost income. AUTOMOBILE PERSONAL INJURY CLAIMS Table IV-1, at 29 (1970). In spite of what these statistics show, the risk of medical loss is much more heavily insured than the risk of lost income. Out of $6.1 billion of health insurance benefits paid to Americans in 1968, $1.3 billion was paid for loss of earnings. Benefits paid by casualty companies (totaling $805 million in 1968) are apportioned similarly INSTITUTE OF LIFE INSURANCE, LIFE INSURANCE FACT BOOK 52-53 (1970). This shows that in cases of severe injuries, the major part of the economic loss is uninsured.

The term “economic loss” does not include general damages such as pain and suffering, which usually are much larger than economic loss. This means that only a comparatively insignificant portion of the total loss is made good by the health carrier, the attempted subrogee. Nor do victims of severe accidents fare much better in their attempts to be indemnified by sources other than their own health carriers. The most seriously injured one percent of all accident victims account for six percent of the total economic losses in all automobile crashes, yet they recover only one percent of the total recoveries for all crashes. Since theirs is also the heaviest noneconomic loss, the ratio of their actual recoveries to the true total loss is being even further reduced.


53. This assumption seems very realistic. Many insured motorists carry only $10,000 coverage per victim, with a maximum of $20,000 per two or more victims. After exhaustion of this minimal fund, most motorists would remain virtually judgment proof.
ment of the insured, thereby frustrating the economic purpose of the insurance policy.

Nevertheless, the courts are adamant. Judges frequently presume that, had it not been for the settlement, a larger recovery would have been forthcoming; thus, they impose upon the insured the obligation to defeat that presumption, a burden which, in reality, amounts to a virtual impossibility. As one New Jersey court has stated:

"[T]he policy condition presently under consideration contemplates no qualifications on the undertaking assumed by the assured which would place a burden on the carrier of establishing affirmatively the existence of any particular degree of likelihood of recovery against the third person. It may well be that if the insured, in the litigation with the carrier, could establish conclusively or overwhelmingly the absence of any liability case against the third person, the breach of condition might be held merely technical and not effective to absolve the carrier of its liability on the policy."

Only in a few holdings adhering to the approach expressed by the New Jersey decision have the courts consented to an allocation of a part of the litigation costs and attorney's fees to the subrogation beneficiary. Similarly, the victim's hope for adequate compensation has been frustrated by judicial apportionments of his total recovery into subrogable and nonsubrogable items. This is an absolute impossibility in cases of settlement.

A second line of authority makes an important concession to the insured victim. It treats the settlement interchangeably as a breach of the insurance contract or as a tort committed against the underwriter and imposes upon the insurer the duty to prove his damages. Thus, if the

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third party's liability or his solvency cannot be established, the underwriter would not be able to prove his actual loss, and no subrogation recovery would be permitted.

This approach could easily be extended one step further to produce a better result. If, indeed, a settlement is treated as a wrong committed against the underwriter, one should begin by defining the legal duty allegedly breached by the settlement rather than by assuming the breach and computing damages. The mere commencement of an action against the third party obviously does not constitute a breach, even if the tortfeasor were judicially declared not liable.58 In many jurisdictions, where splitting the cause of action for the same wrongful act is not permitted, even a settlement including an express stipulation between the plaintiff-insured and defendant-tortfeasor purporting to leave the underwriter's rights intact still results in the destruction of the insurer's subrogation right.60 This indicates that sometimes the impairment of the subrogation right as a result of settlement cannot be avoided. In such situations, the insured's conduct does not seem to be sufficiently reprehensible to justify the finding of a tort. Nor would the typical situation of a settlement with an alleged wrongdoer whose liability is unknown and whose solvency is limited warrant such a conclusion, especially if the settlement was motivated by economic and personal needs. Only in cases of obvious recklessness in the conduct of litigation or negotiations toward settlement can an attachment of liability be justified.61

The reasons for requiring at least an allocation of legal fees between insurer and insured should be even more obvious. Unless these unavoidable expenses are fully considered for subrogation purposes, as presently they are not, even in the more advanced statutory schemes, they clearly are detrimental to the victim's indemnity. Since subrogation is tolerated to avoid a double recovery, and since fees and costs prevent indemnity,

these expenses should not be apportioned between the victim and his carrier. They should be borne by the carrier alone.

**STATUTORY SUBROGATION FOR PERSONAL INJURIES: CONFUSED ECONOMIC POLICY**

Since personal injuries present serious social and economic problems, different schemes have been devised to alleviate the suffering of accident victims. Foremost are monetary contributions by federal and state governments, accident funds, and workmen's compensation boards. The financial sources of these funds vary according to the fiscal policy of the statute creating them. The fund may be financed by the general public through taxation, by the beneficiary of the statutory protection, by the enterprises creating the risk, or by particular segments of society.

Subrogation shifts the cost of an accident from the insurance fund to the subrogation target. Sometimes the overall fiscal ramifications are hardly noticeable. For example, if the fund were created by contributions of employees and subrogation shifted the cost of an accident to a negligent automobile driver, the cost would be shifted to a member of the motoring community, the composition of which would not be much different from the community of employees. Although the cost is borne by the same people, it is somewhat larger due to the expense of additional recovery. Sometimes, however, subrogation may frustrate the statutory fiscal policy, as it does when it shifts the cost from a fund financed by general taxation to the motoring community.

Examination of the numerous statutory plans in the field of personal injuries is beyond the scope of this Article. Attention should be called, however, to the existence of the fiscal problem and its connection with the particular machinery devised for loss allocation and distribution. If it is considered socially advantageous to allocate economic burdens resulting from certain accidents to a special segment of society, then any statutory reallocation that shifts those burdens to other segments must be considered socially counterproductive. On the other hand, if the ultimate allocation through subrogation is the socially desirable one, then the initial presubrogation allocation apparatus must be considered economically wasteful.

**Subrogation by the Federal Government**

An excellent illustration of this problem is presented in cases of government

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ernmental subrogative pursuits for medical benefits conferred upon injured governmental employees. For obvious reasons, the government may be interested in shouldering the expenses of hospitalization and medical payments incurred by an employee following an accident. This governmental contribution is financed by the general budget. Subrogation against a tortfeasor responsible for personal injury would thus shift the loss from the general public to whoever may be responsible for the accident—in most cases the motoring public. If drivers can be considered better targets than the general public to absorb the cost—in itself a doubtful premise—it seems that a driving tax or highway toll could be more justified as a potential source of financing accident losses than general taxation. If the correct source were selected to pay for the loss, subrogation actions and the resulting cost of recovery could be eliminated.

The Supreme Court has demonstrated that it is well aware of this dilemma. When the federal government paid for the hospitalization and medical treatment of a serviceman negligently injured by a third party, the Court in United States v. Standard Oil Co \(^{64}\) refused to allow the government to recover against the tortfeasor. The Court stated: "The issue comes down in final consequence to a question of federal fiscal policy, coupled with considerations concerning the need for an appropriateness of means to be used in executing the policy sought to be established. Congress, not this Court or the other federal courts, is the custodian of the national purse." \(^{65}\)

Responding to the Court's denial of a right of recovery, Congress enacted the Medical Care Recovery Act. \(^{66}\) This statute confers upon the government a right of action for all expenses incurred in providing hospital, medical, and dental care to a government employee negligently injured by a third party.

The Act has been received with enthusiasm by courts and academic

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64. 332 U.S. 301 (1947)
65. Id. at 314.
66. 42 U.S.C. § 2651 (1970). In pertinent part, the statute provides:

In any case in which the United States is authorized or required by law to furnish hospital, medical, surgical or dental care and treatment to a person who is injured or suffers a disease under circumstances creating a tort liability upon some third person to pay damages therefor, the United States shall have a right to recover from said third person the reasonable value of the care and treatment so furnished and to be furnished and shall, as to this right, be subrogated to any right or claim that the injured or diseased person has against such third person to the extent of the reasonable value of the care and treatment so furnished or to be furnished.
The courts have declared that the statutory substitution is unimpaired by most of the obstacles usually interfering with the enforcement of a subrogated claim. For example, one court has stated that the right of action is unaffected by a shorter limitation period relating to personal injuries because the government's claim is not for personal injuries. It also has been held that a release given by an injured employee to the tortfeasor does not discharge the latter's obligation to the federal government, nor does the government have to notify the tortfeasor of its pending subrogation claim at the time of the settlement negotiations between the employee and the wrongdoer. Furthermore, despite a conceivable due process problem, the government's list of expenses submitted to the tortfeasor in the subrogation proceedings has been held to be conclusive and not open to attack. Finally, a federal district court has sanctioned the possibility of exposing the tortfeasor to two different lawsuits occurring simultaneously in different courtrooms.

Amidst all the favorable judicial response and academic blessing, as well as the proliferation of other legislation promoting a similar approach to the problem of loss allocation, one must pause to consider the basics of the problem. An examination of the legislative history behind the Medical Care Recovery Act reveals only scant evidence of any deliberate congressional policy. The bill has quite obviously arisen from a desire to undo the Supreme Court's denial of subrogation, but apart from that purpose and from the hollow argument that subrogation would eliminate windfall recoveries under the collateral source rule, the congressional history is silent.

68. United States v. Fort Benning Rifle & Pistol Club, 387 F.2d 884 (5th Cir. 1967).
69. United States v. York, 398 F.2d 582 (6th Cir. 1967).
The Medical Care Recovery Act is an antisocial piece of legislation because it relieves the federal government of a given financial burden and reallocates it to individuals or small groups. It does exactly the opposite of statutory schemes which shift financial losses from individuals regardless of wrongdoing to society at large. Although it may not be improper to unsocialize a risk, it is disturbing that no deliberate intention to accomplish that goal is apparent on the record. Moreover, if the attempt was deliberate, it could have been better served by funding medical compensation through taxation of the target enterprise rather than by taxing the general public and wasting a part of the proceeds in subrogation recoveries.

Workmen’s Compensation Legislation

A similar problem is presented within the framework of workmen’s compensation legislation. Subrogation of a workmen’s compensation fund against the negligent third party frustrates the worker’s attempt to be truly indemnified and works hardship on the tortfeasor. For that reason, it is highly undesirable and is not permitted in the absence of a subrogation statute. Such statutes, however, exist in nearly all states, and their effect is often much harsher than common law subrogation would have been. For example, they sometimes shift to the third party the burden of all expenses incurred by the carrier, without allowing the third party to challenge the amount. Often the carrier is permitted to be reimbursed from portions of the third party recovery allocable to pain and suffering for which it had not previously compensated the victim.

When the concept of subrogation is applied judicially outside the scope of the statute, the courts appear to be convinced that an important social policy is being served by their zeal. In cases of difficult statutory interpretation, doubts usually are resolved in favor of a broad interpre-

77. A. Larson, supra note 28, § 74.11; Kimball & Davis, supra note 13, at 847
81. This is not always the case. For a recent illustration of a narrow interpretation, perhaps symbolic of a change of attitude, see Anderson v. Borough of Greenville, 442 Pa. 11, 273 A.2d 512 (1971).
tation of the subrogation clause. All in all, the workmen’s compensation area is marked by a complete victory of the concept of subrogation, arrested by a carefully drafted statute and thus effectively immune from judicial review. The purpose behind it all is that, in the name of socializing a risk, it is again being unsocialized; it merely alleviates the right of the immediate victim, the injured employee, and sacrifices the third party instead. The system disregards torts committed by the injured employee, whose individual blameworthiness is considered irrelevant for purposes of awarding him the statutory benefits, yet it penalizes the wrongdoing of the unlucky third party, who may happen to be an employee himself or, even worse, an unemployed or unemployable person.

The rationale for the conflicting statutory trends cannot be explained by a desire to protect insureds qua insureds regardless of consequences vis-à-vis uninsureds. It is common for many automobile liability insurance statutes, for example, to subrogate judgment creditors of a negligent insured driver to the driver’s liability policy against the carrier. A social statute striving for public welfare cannot victimize some individuals, arbitrarily scattered among all sectors of society, in the name of rescuing others. The broad spectrum of important issues necessitates a thorough revision.

CONCLUSION

Most accident victims with severe economic losses are not indemnified by either their insurance carriers or independent sources. Despite the fact that nine out of ten seriously injured persons receive some compensation for economic losses, those with the greatest loss do not receive reparations of more than one-fifth of their total economic loss. From this one-fifth, the most frequent subrogees, medical benefit carriers, usually pay only a small share—in severe cases they pay as little as five percent. These statistics relate, of course, only to compensation for

82. E.g., City of St. Paul v. Sorenson, 283 Minn. 158, 167 N.W.2d 17 (1969). In Minnesota, a tort action for personal injuries dies with the person of the plaintiff. The court nevertheless held that a deceased’s carrier is subrogated to the claim of the tortfeasor.


84. Of whatever source: medical, life, auto or collision insurance, tort recoveries, workmen’s compensation, social security, etc.


86. Id. at 39.

87. Id. at 45.
economic losses, which usually are much smaller than the victim's justified expectation to be compensated for pain and suffering.

Because an accident victim is almost never truly compensated, subrogation should be denied to health insurers. In a few rare cases, the victim's economic loss may be fully compensated and his general damages partly or wholly satisfied through third party tort action. In that extraordinary contingency, the case against subrogation is considerably weaker. Nevertheless, it must be remembered that whatever the compensation, the value of life and a healthy body is much greater, and no double recovery would possibly befall the victim if he should be permitted to collect from both the third party and the collateral source.

This analysis does not exclude the possibility of a nonsubrogative recovery by the insurer against a defaulting third party. Recovery in this context should be denied only to the extent that it defeats the victim's expectation of indemnification. If a full recovery to the insured is guaranteed, there seems to be no theoretical reason to exclude an additional recovery by the victim's carrier to the extent of the value of the benefits paid. Since the tortfeasor has already paid once for his wrongdoing, and since his ability to bear risks or spread losses would a priori be inferior to the underwriter's, this new right of recovery should be permitted only after thorough consideration of the relative equities.88

88. In some extraordinary cases, a negligent interference by the tortfeasor with the contractual relations between the victim and his insurer also should suffice to justify recovery. Thus, where an individual has been injured by the negligent act of a third party, medical expenses consequently incurred by his or her spouse are chargeable to the tortfeasor in an action brought by the spouse in his or her own behalf. Saunders v. Schultz, 20 Ill. 2d 301, 170 N.E.2d 163 (1960). Where the injured person is a married woman, her husband can sue not only for the immediate economic expenditure but also for more remote items such as loss of consortium. Kilkenny v. Kenney, 68 N.M. 266, 361 P.2d 149 (1961).

The cases discussed above and situations of interference with a medical benefits insurance policy are rather analogous. In denying such an analogy, the California Supreme Court said: "The analogy must fall because the wife's recovery depended upon familial status and the duty of support of her husband imposed on her by statutory law while plaintiff's claim for recovery is based solely upon a contractual liability between itself and decedent." Fifield Manor v. Finston, 54 Cal. 2d 632, 354 P.2d 1073, 7 Cal. Rptr. 377 (1960). It is difficult to perceive in this context the difference between contractual and statutory obligations, and it is submitted that the distinction is without a difference. Naturally, a wife would be in a poorer position to spread her economic losses than an insurance carrier, and some of her losses, such as loss of consortium, would be completely unspreadable. This distinction justifies a greater generosity in recognizing her independent tort right than in recognizing that of the underwriter. The question is one of degree and not principle, however. Moreover, in cases where it would not seem desirable to grant the underwriter an independent right of action, there is no reason to uphold its subrogative claims.