

University of South Dakota School of Law

From the Selected Works of Roger Baron

2012

Revictimization of Personal Injury Victims by ERISA Subrogation Claims

Roger Baron, *University of South Dakota School of Law*



Available at: https://works.bepress.com/roger_baron/1/

THE REVICTIMIZATION OF PERSONAL INJURY VICTIMS BY ERISA SUBROGATION CLAIMS

ROGER M. BARON†
ANTHONY P. LAMB††

Seizing upon ERISA preemption, the health insurance industry imposed the right of subrogation in personal injury claims, thereby rendering enforceable in federal court that which was universally prohibited by law when Congress enacted ERISA in 1974.

According to industry statistics,¹ the Employee Retirement Income Security Act of 1974² (“ERISA”), plans and related insurers are collecting in excess of \$1 billion annually through the seizure of tort recoveries intended for personal injury victims.³ Collection agents, working for ERISA plans and their commercial insurers, aggressively pursue⁴ subrogation (or reimbursement) on a “first dollar priority” basis with absolutely no consideration for the impact reimbursement

† Roger M. Baron, Professor of Law at the University of South Dakota, is an expert on the area of ERISA reimbursement claims. He has published and lectured extensively on the topic. Prof. Baron may be contacted at Roger.Baron@usd.edu.

†† Anthony P. Lamb is a second-year law student at the University of South Dakota. He has a B.A. in Criminal Justice from Grand View University and was a police officer in Lincoln, Nebraska for six years prior to law school. Anthony may be contacted at Anthony.Lamb@usd.edu.

1. “Millions and potentially billions of dollars are recouped annually by health plans.” Brief for Soc’y for Human Res. Mgmt. and U.S. Chamber of Commerce as Amici Curiae at 15, *Sereboff v. Mid Atl. Med. Servs., Inc.*, 547 U.S. 356 (2006) (No. 05-260), 2006 WL 467695 at *15.

2. Pub. L. No. 93-406, 88 Stat. 832 (codified at 29 U.S.C. §§ 1001-1461 (2006)).

3. “During fiscal year 2000, Healthcare Recoveries, Inc., one of the largest private health care claims recovery services in the United States, recovered \$237.3 million in health claims, and had a backlog of over \$1.1 billion of potentially recoverable claims.” Motion of the Am. Ass’n of Health Plans, the Am. Benefits Council, the Blue Cross Blue Shield Ass’n, the Chamber of Commerce of the U.S., and the Health Ins. Ass’n of Am. for Leave to File a Brief as Amici Curiae and Brief of Amici Curiae in Support of Petitioners at 10, n.20, *Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204 (2002) (No. 99-1786), 2001 WL 487681 at *10, n.20.

4. “There are certain employers who perhaps have a terminator attitude with regard to pursuing subrogation even in the light of some of the most atrocious circumstances.” Audio tape: Radio Health Journal on ERISA Reimbursement (Mar. 19, 2011), available at <http://erisawithprofessorbaron.com/audio-and-video/radio-health-journal-episode-on-erisa-reimbursement/>. Gary Wickert, a Wisconsin attorney and spokesperson for the subrogation industry, spoke on an episode of the Radio Health Journal hosted by moderator Reed Pence, which was broadcast on approximately 440 radio stations nationwide in February 2008. Radio Health Journal is an award-winning weekly broadcast. *Id.*

leaves upon the insured.⁵ Language fostering these claims is found in documents created by ERISA plans, with enforcement made available through federal courts under the auspices of ERISA's broad grant of federal preemption.

In defense of the subrogation industry's efforts to seize these funds, it is claimed that subrogation is a lawful right with which insurers have been historically vested. Recently, an attorney spokesman for the industry claimed that the roots of ERISA subrogation trace back to the thirteenth century's Magna Carta.⁶

While it is true that subrogation in a *property insurance* setting has been permitted historically, subrogation by *health insurers* was forbidden by the common law.⁷ Furthermore, subrogation by health insurers was uniformly prohibited in all jurisdictions until 1974 when ERISA was adopted into law.⁸

Because of ERISA's preemptive effect, there is no oversight on the ability of ERISA plans and these insurers to pursue subrogation or reimbursement. It is no small irony that Congress originally passed ERISA for the purpose of uniformly protecting "[t]he interests of participants in employee benefit plans and their beneficiaries."⁹ The legislative history of ERISA establishes that Congress was motivated, at

5. See, e.g., *Admin. Comm. of Wal-Mart, Inc. v. Shank*, 500 F.3d 834 (8th Cir. 2007) (allowing subrogation against Wal-Mart employee rendered permanently disabled in car accident); *Cagle v. Bruner*, 112 F.3d 1510 (11th Cir. 1997) (permitting subrogation where insurer refused to pay medical bills until insured signed form acknowledging insurer's right to pursue subrogation and insured had suffered serious injuries in car accident requiring four-month hospital stay and four months of outpatient treatment); *Sunbeam-Oster Co. Group Benefits Plan v. Whitehurst*, 102 F.3d 1368 (5th Cir. 1996) (allowing subrogation of \$500,000 settlement though insured had suffered over \$2 million in damages); *In Re Paris*, 44 F. Supp. 2d 747 (D. Md. 1999) (allowing subrogation where defendant suffered permanent brain damage as a result of a motorcycle accident and defendant qualified as disabled, destitute adult).

6. "Insurance subrogation goes back to the Roman days and was reinforced in the Magna Carta in 1215 and by our own Supreme Court back in 1799 so it's not a new concept at all." See Audio tape: Radio Health Journal on ERISA Reimbursement, *supra* note 4.

7. Roger M. Baron, *Public Policy Considerations Warranting Denial of Reimbursement to ERISA Plans: It's Time to Recognize the Elephant in the Courtroom*, 55 *MERCER L. REV.* 595, 613-16 (2004); Roger M. Baron, *Subrogation: A Pandora's Box Awaiting Closure*, 41 *S.D. L. REV.* 237, 238-39 (1996) [hereinafter Baron, *Pandora's Box*].

8. The first reported judicial decision involving an effort of a health insurer to seek subrogation on a personal injury claim is the 1982 decision of *Frost v. Porter Leasing Corp.*, 436 N.E.2d 387 (Mass. 1982), in which subrogation was denied.

9. 29 U.S.C. § 1001(b) provides the following:

It is hereby declared to be the policy of this chapter to protect interstate commerce and the interests of participants in employee benefit plans and their beneficiaries, by requiring the disclosure and reporting to participants and beneficiaries of financial and other information with respect thereto, by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to the Federal courts.

least in part, by “the absolute need that safeguards for plan participants be sufficiently adequate and effective to prevent the numerous inequities to workers under plans which have resulted in tragic hardship to so many.”¹⁰ The opening section of ERISA, the portion which is designated as expressing findings and public policy,¹¹ provides that “the continued well-being and security of millions of employees and their dependents are directly affected by these plans . . . and that it is therefore desirable in the interests of employees and their beneficiaries . . . that minimum standards be provided assuring the equitable character of such plans.”¹² Notwithstanding this background, the health insurance industry has been able to seize upon the vacuum created by ERISA’s preemptive effect to create the reimbursement mechanism that has the effect of crushing personal injury victims who are victimized twice—initially by a tortfeasor and then again by their own health insurer.

I. INSURANCE REGULATION

The insurance industry has escaped regulation by the Federal government. The lack of federal regulation is not evidence of congressional apathy but is rather attributed to the 1868 United States Supreme Court ruling in *Paul v. Virginia*,¹³ which held an insurance policy was not an item of interstate commerce and therefore beyond the reach of Congressional authority.¹⁴ The aftermath of the Court’s ruling in *Paul* was the evolution of state regulation. The interests of the consuming public vis-à-vis commercial insurers became the proper subject for control and regulation by the various states.¹⁵ Each state moved into a position of aggressively and extensively regulating the insurance industry.¹⁶

States have been able to exercise regulatory authority through statutory provisions enacted directly by the state legislature, through common law as determined by the courts, and through administrative regulation created by the state agencies.¹⁷ Each and every state cre-

10. H. R. REP. NO. 93-533, at 9 (1974), reprinted in 1974 U.S.C.C.A.N. 4639, 4647; see also David M. Kono, *Unraveling the Lining of ERISA Health Insurer Pockets – A Vote for National Federal Common Law Adoption of the Make Whole Doctrine*, 2000 BYU L. REV. 427, 444 (2000).

11. The title to 29 U.S.C. § 1001 is “Congressional findings and declaration of policy.”

12. 29 U.S.C. § 1001(a).

13. 75 U.S. 168 (1868).

14. *Paul v. Virginia*, 75 U.S. 168 (1868).

15. Roger M. Baron, “*Consumer Protection*” and ERISA, 56 S.D. L. REV. 405 (2011).

16. DVD: Understanding ERISA Liens, Presentation to North Dakota Association for Justice (May 13, 2010) (on file with author).

17. *Id.*

ated its own division or department of insurance and its own unique set of statutory provisions regulating insurance. The states have, through this process, successfully struck a balance that accommodates consumer protection and also fosters an environment where insurance companies are able to conduct business.¹⁸

The rather tenuous basis for the Court's decision in *Paul*—the notion that a policy of insurance is not an item of interstate commerce—did not endure. On June 5, 1944, the United States Supreme Court handed down *United States v. South-Eastern Underwriters Ass'n*,¹⁹ overruling *Paul*. In *South-Eastern Underwriters Ass'n*, the Court held that insurance was indeed part of interstate commerce. As a result, Congress was now fully authorized to regulate the insurance industry.

The framework for extensive regulation by the states, however, had already been laid into place. The states had developed significant expertise as regulators.²⁰ It must also be noted that the *South-Eastern Underwriters Ass'n* decision was handed down the day before D-day and America's entrance into the European theater of World War II.²¹ It is no surprise, therefore, that Congress elected "not" to step into a regulatory role concerning the insurance industry. Instead, Congress quickly enacted the McCarran-Ferguson Act²² to respond to the *South-Eastern Underwriters Ass'n* ruling.²³ Federal public policy, as set forth in the McCarran Ferguson Act, is as follows:

Congress hereby declares that the continued regulation and taxation by the several States of the business of insurance is in the public interest, and that silence on the part of Congress shall not be construed to impose any barrier to the regulation or taxation of such business by the several States.²⁴

The McCarran Ferguson Act also expresses a presumptive form of "reverse preemption" or "deference to the states" through another provision, which provides:

No Act of Congress shall be construed to invalidate, impair or supersede any law enacted by any State for the purpose of

18. *Id.*

19. 322 U.S. 533 (1944).

20. Baron, *supra* note 15.

21. "The U.S. Supreme Court's 1944 decision in *U.S. v. South-Eastern Underwriters Association* probably didn't receive much public attention at the time. Besides covering the tedious domain of insurance regulation, it was released June 5, the eve of D-Day." John Gibeaut, *Forces of Change*, A.B.A. J., January 2007, at 40, 41.

22. Ch.20, 59 Stat. 33 (1945) (codified at 15 U.S.C. § 1011 (2006)).

23. "Congressional reaction was swift and equally bold. In less than a year, President Franklin D. Roosevelt signed the 1945 McCarran-Ferguson Act." Gibeaut, *supra* note 21, at 41.

24. 15 U.S.C. § 1011.

regulating the business of insurance . . . unless such Act specifically relates to the business of insurance . . .²⁵

The McCarran-Ferguson Act is still with us today, and it continues to be a strong expression of federal public policy that the business of insurance is appropriate for state regulation.

II. SUBROGATION ON PERSONAL INJURY CLAIMS

Subrogation allows an insurer who has indemnified an insured to stand in the shoes of the insured on a claim for compensation against a third party, usually a tortfeasor.²⁶ Historically, subrogation existed primarily in the area of property insurance and has remained largely stable.²⁷ In the 1960s automobile insurers attempted to expand subrogation into medical expenses and other non-property claims.²⁸ During this period, subrogation clauses were inserted into first party medical payments coverage in automobile policies, uninsured and underinsured motorist coverage, and medical and hospitalization coverage.²⁹ Initially, the common law successfully resisted the expansion of subrogation rights given the law's prohibitions against the assignment of personal injury claims³⁰ and splitting causes of action involving personal injuries.³¹ The continued efforts of the insurance industry, however, eventually led many jurisdictions to allow subrogation directly.³²

The states developed a wide variety of approaches regarding how to handle subrogation in personal injury claims.³³ Some states chose to preserve the common law prohibition and never permitted subroga-

25. 15 U.S.C. § 1012(b).

26. See generally ROBERT E. KEETON & ALAN I. WIDISS, *INSURANCE LAW* § 3.10 (1988) (defining the doctrine of subrogation).

27. Roger M. Baron, *Subrogation on Medical Expense Claims: The "Double Recovery" Myth and the Feasibility of Anti-Subrogation Laws*, 96 DICK. L. REV. 581, 583 (1992).

28. *Id.*

29. *Id.*

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

31. See, e.g., *Nationwide Mut. Ins. Co. v. DeJane*, 326 N.E.2d 701, 705 (Ohio Ct. App. 1974) ("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 . . .").

32. See, e.g., *Smith v. Travelers Ins. Co.*, 362 N.E.2d 264 (Ohio 1977) (effectively overruling *DeJane*).

33. Johnny C. Parker, *The Made Whole Doctrine: Unraveling the Enigma Wrapped in the Mystery of Insurance Subrogation*, 70 MO. L. REV. 723, 737 (2005) (providing a separate analysis for each state's approach).

tion on personal injury claims.³⁴ It should also be noted that some of the states that originally permitted subrogation in personal injury claims later changed course and retreated after learning that personal injury subrogation would be problematic in a number of scenarios.³⁵ There has been much activity in the development of the law in this regard. States have explored their options, including the option of returning to the common law prohibition against subrogation on personal injury claims. Such anti-subrogation principles have been adopted both judicially and legislatively.³⁶ Numerous ameliorative doctrines have also been adopted so as to avoid harsh results in individual cases.³⁷ In addition to outright denial as a protective measure for consumers, states have utilized other doctrines such as (1) make whole doctrine; (2) pro rata loss sharing; (3) equitable apportionment; and (4) common fund doctrine.³⁸

It is important to remember that this development of the law in the 1960s and 1970s occurred only in the context of automobile insurance coverage. There were no efforts by health insurers to seek subrogation on personal injury claims until the 1980s. The first reported judicial decision involving an effort by a health insurer to seek subrogation on a personal injury claim is the 1982 decision of *Frost v. Porter Leasing Corp.*³⁹ in which the court denied subrogation. Prior to this decision there are no reported cases in which a health insurer sought subrogation on a personal injury claim. It is also important to note, of course, that the Employee Retirement Income Security Act of 1974⁴⁰ was enacted in 1974—eight years prior to any documented efforts by health insurers to pursue subrogation.

III. RELEVANT PROVISIONS IN ERISA

The health insurance industry has argued that Congress, through its enactment of the Employee Retirement Income Security Act of 1974⁴¹ (“ERISA”) in 1974, considered and endorsed subrogation in the context of health insurance. Such a notion is absurd. When Congress passed ERISA, subrogation by a health insurer was non-existent.

34. See Baron, *Pandora's Box*, *supra* note 7, at 237 & nn.2-3 (discussing Arizona and Missouri).

35. See *id.* at 238-41 & nn.10-28.

36. See *id.* at 240 & nn.22-26 (discussing Oklahoma, Pennsylvania, Nevada, and Kansas).

37. Parker, *supra* note 33, at 737 (providing a separate analysis for each state's approach).

38. Baron, *Pandora's Box*, *supra* note 7, at 247-60; see also Parker, *supra* note 33, at 737 (providing a separate analysis for each state's approach).

39. 436 N.E.2d 387 (Mass. 1982).

40. Pub. L. No. 93-406, 88 Stat. 832 (codified at 29 U.S.C. §§ 1001-1461 (2006)).

41. Pub. L. No. 93-406, 88 Stat. 832 (codified at 29 U.S.C. §§ 1001-1461 (2006)).

Courts have indeed recognized that ERISA's statutory scheme neither authorizes nor prohibits "reimbursement" or "subrogation" for payments made on medical expense claims.⁴² Additionally, the United States Supreme Court has stated that ERISA's "[c]arefully crafted and detailed enforcement scheme provides strong evidence that Congress did not intend to authorize other remedies that it simply forgot to incorporate expressly."⁴³

Recall that in the McCarran-Ferguson Act,⁴⁴ Congress declared it was a matter of federal public policy that states, not the federal government, should regulate insurance. Congress carried this notion forward in ERISA. The "saving clause" of ERISA, found at 29 U.S.C. § 1144 (b)(2)(A), provides as follows:

Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.⁴⁵

A substantial body of case law has developed concerning the application of state law in an ERISA setting.⁴⁶ A detailed review of those decisions is beyond the scope of this Article. Nonetheless, it should be noted that there is substantial authority supporting the proposition that a state's law concerning subrogation on personal injury claims—whether prohibited altogether or ameliorated by doctrines

42. *Member Servs. Life Ins. Co. v. Am. Nat'l Bank & Trust Co. of Sapupla*, 130 F.3d 950, 958 (10th Cir. 1997) (quoting *Ryan v. Fed. Exp. Corp.*, 78 F.3d 123, 127 (3d Cir. 1996)) ("ERISA says nothing about subrogation provisions. ERISA neither requires a welfare plan to contain a subrogation clause nor does it bar such clauses or otherwise regulate their content.").

43. *Mertens v. Hewitt Assocs.*, 508 U.S. 248, 254 (1993) (quoting *Mass. Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 147 (1985)).

44. Ch.20, 59 Stat. 33 (1945) (codified at 15 U.S.C. § 1011).

45. 29 U.S.C. § 1144(b)(2)(A) (emphasis added).

46. The U.S. Supreme Court has recognized the importance of upholding the application of state insurance law on "regulatory" matters. See *Ky. Ass'n of Health Plans, Inc. v. Miller*, 538 U.S. 329 (2003) (holding that Kentucky statutes making it unlawful for health insurer to discriminate through the use of exclusive healthcare provider networks against any willing health care provider willing to comply with an insurer's terms and conditions are laws that "regulate insurance" and, as such, are applicable to HMOs operating under ERISA scheme); *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355 (2002) (holding HMO was an "insurer" subject to Illinois state regulatory law requiring binding independent medical review of HMO's decision to deny benefits); *Metro. Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985) (holding Massachusetts statute mandating minimum health care benefits not preempted by ERISA).

There has also been significant litigation, much of which reached the Supreme Court, over the issue of whether a "state law" is one that regulates insurance and is thereby "saved" under the saving clause of ERISA. *UNUM Life Ins. Co. v. Ward*, 526 U.S. 358 (1999) (opining state judicial opinions or "common law" may be regulatory in nature and thereby "saved" and applicable to ERISA insurers); *Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. 41 (1987) (opining common law bad faith cause of action is not a "regulatory" law and is not "saved").

such as the “make whole” or “common fund”—are indeed applicable to insurers covering all or portions of health insurance risks for participants and beneficiaries covered by ERISA plans.⁴⁷

47. The case of *FMC Corp. v. Holliday*, 498 U.S. 52 (1990), sets forth the controlling principles of law for a situation where insurance is provided through an ERISA plan. In this case, the payments were made by a self-funded plan, not by an insurer. A Pennsylvania statute prohibited subrogation on personal injury claims. In making the appropriate analysis for ERISA preemption, the Court noted that, under ERISA’s preemption clause, “any and all state laws” that “relate to an employee benefit plan” are preempted. Under the preemption clause, Pennsylvania’s “anti-subrogation” statute was subject to preemption, meaning the health plan could enforce the right of subrogation.

In order to avoid preemption, the beneficiary argued that the “saving clause” applied to “save” the state anti-subrogation law. ERISA’s saving clause provides that “any law . . . which regulates insurance” is not preempted by ERISA. The Supreme Court agreed that Pennsylvania’s “anti-subrogation” statute was a “law which regulate[d] insurance,” and it therefore fell within the purview of the “saving clause.”

Unfortunately for the beneficiary, however, the “deemer clause” was also held applicable. Under the “deemer clause,” the “employee benefit plan” itself shall *not* “be deemed to be an insurance company or other insurer.” As a result, the anti-subrogation statute of Pennsylvania, although saved, was not applicable to the reimbursement claim of the employee benefit plan by operation of the deemer clause.

In summary, although the anti-subrogation state statute was saved from preemption, it was not applicable to an employee benefit plan by virtue of the deemer clause.

Despite this unfortunate conclusion reached as a result of application of the deemer clause, the *Holliday* Court was careful to explicitly recognize that a state law “which regulates insurance” would be saved for (i.e., applicable to) an insurance company or insurer providing coverage to the plan. With regard to plan insurers, the Court held that while the ERISA plan may enjoy its preemptive effect, the insurer that insures such a plan does not. Such insurers are indeed subject to the states’ laws concerning subrogation and reimbursement.

Employee benefit plans that are insured are subject to indirect state 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 [of ERISA]. The insurance company is therefore not relieved from state insurance regulation. The ERISA plan is consequently bound by state insurance regulations insofar as they apply to the plan’s insurer.

Holliday, 498 U.S. at 62.

Numerous federal courts across the country have upheld the principle that state law applies to an insurer offering coverage through an ERISA Plan. *Benefit Recovery, Inc. v. Donelon*, 521 F.3d 326, 329 (5th Cir. 2008) (finding Louisiana’s “make-whole doctrine” was “saved” and applicable to ERISA insurers); *Singh v. Prudential Health Care Plan, Inc.*, 335 F.3d 278 (4th Cir. 2003) (finding Maryland law prohibiting subrogation was “saved” and applicable to ERISA HMO insurer); *Med. Mut. of Ohio v. deSoto*, 245 F.3d 561 (6th Cir. 2001) (finding California law prohibiting reimbursement of medical expenses was “saved” and applicable to ERISA insurer); *Providence Health Plans of Or. v. Simnitt*, No. 08-44-HA, 2009 WL 700873 (D. Or. Mar. 13, 2009) (quoting *Lincoln Mut. Cas. Co. v. Lectron Prods. Inc., Emp. Health Plan*, 970 F.2d 206, 210 (6th Cir. 1991)) (holding stop loss insurer bound by state law concerning subrogation through ERISA’s saving clause citing and quoting); *Smith v. Life Ins. Co. of N. Am.*, No. 1:05-CV-2215-JEC, 2006 WL 2842529 (N.D. Ga. Sept. 28, 2006) (finding Georgia anti-subrogation law was “saved” and applicable to the insured ERISA plan); *Magellan Health Servs., Inc. v. Highmark Life Ins. Co.*, 755 N.W.2d 506 (Iowa 2008) (finding Iowa law was “saved” and applicable to ERISA stop loss insurer).

IV. OVERSIGHT (THE NEED FOR, AND THE FAILURE OF)

Both primary and secondary authorities have long recognized that subrogated recoveries are not reflected in rate determinations but rather are utilized as discretionary funds.⁴⁸ The portion of the recovery that flows to commercial insurers is treated as a source of profit and may be utilized for enhanced executive compensation or other parochial matters. Any portion of the recovery that flows to the employer (plan sponsor) results in a windfall recovery to the employer on a risk that had previously been distributed on an actuarial basis for the pool of insureds. Frequently, the employer then utilizes the windfall recovery simply to offset (lower) contributions by the employer for a future plan year and a different pool of insureds (Employee Retirement Income Security Act of 1974⁴⁹ (“ERISA”) participants and beneficiaries).⁵⁰

In *US Airways, Inc. v. McCutchen*,⁵¹ the United States Court of Appeals for the Third Circuit recently recognized the windfall nature of ERISA reimbursement recoveries. McCutchen, the ERISA participant had been “grievously injured” and the ERISA plan, sponsored by the employer US Airways, sought reimbursement from McCutchen’s tort recovery. The trial court granted summary judgment for the ERISA plan. A three-judge panel of the Third Circuit reversed, holding that to permit full reimbursement in this case would be “inappropriate

48. JOHN F. DOBBYN, *INSURANCE LAW IN A NUTSHELL* 284 (3d ed. 1996), states the following:

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.

See also Baron, *Pandora’s Box*, *supra* note 7, at 244-45 & nn.43-50.

49. Pub. L. No. 93-406, 88 Stat. 832 (codified at 29 U.S.C. §§ 1001-1461 (2006)).

50. Consider the following example:

Reimbursement recoveries, subrogated recoveries, are not factored into the setting of the rates, and so the employees’ contribution will be determined before the plan year begins. . . . When the money comes in, if it comes in 2011, and the testimony, as I understand it, that Martin Meyers (plan administrator) gave in his deposition, was that he just simply takes the money and deposits it into the fund. Well, 100 percent of that deposit offsets the employer’s contribution. And then that frees up—he has 40,000 more dollars as the employer than he would otherwise have. So it’s a windfall for the employer, of no benefit to the participants and beneficiaries, and certainly of no benefit to the participants and beneficiaries of the year 2006.

Deposition of Roger M. Baron at 54:15-55:7, Ozarks Coca-Cola/Dr Pepper Bottling Co. v. Ritter, No. 10-3067-CV-S-REL (W.D. Mo. Dec. 6, 2010) (transcript on file with authors) (establishing that the plan administrator’s own testimony demonstrates that the reimbursement is a windfall for the employer and of no benefit to plan participants), available at mms://video02.usd.edu/usd/course_videos/streaming_videos/2010/law851/20101206-095703-10.wmv.

51. No. 10-3836, 2011 U.S. App. LEXIS 22883 (3d Cir. Nov. 16, 2011).

and inequitable,” and therefore not permissible under ERISA §503(a)(3).⁵² Responding to the argument that the reimbursement proceeds were needed for the operation of the plan as a cost saving measure, the Third Circuit stated, “US Airways cannot plausibly claim it charged lower premiums because it anticipated a windfall. . . . [The reimbursement award for the plan] amounts to a windfall for US Airways, which did not exercise its subrogation rights or contribute to the cost of obtaining the third-party recovery. Equity abhors a windfall.”⁵³ Clearly, the utilization of subrogated recoveries never flows to the benefit of the pool of insureds for which the risk of loss had previously been distributed.⁵⁴

ERISA plans and their insurers create the right of subrogation (reimbursement) through provisions in the plan document. These documents are unilaterally drafted and implemented without oversight by any regulatory authority. Absent ERISA’s preemption of state law, the matter of subrogation would be subject to conformity with state law in accordance with the historical background for regulation of the insurance industry.⁵⁵ Furthermore, ERISA plans are free to amend these documents at any time, for any reason, and without the necessity of securing approval of any regulatory authority.⁵⁶

The need for oversight is critical. Insureds are vulnerable. Corporate entities (both employers and insurers) and their executives are allowed to profit in unchecked fashion at the expense of those who were promised insurance coverage.⁵⁷ The respected lawyer, scholar,

52. *US Airways, Inc. v. McCutchen*, No. 10-3836, 2011 U.S. App. LEXIS 22883, at *7 (3d Cir. Nov. 16, 2011).

53. *McCutchen*, 2011 U.S. App. LEXIS 22883, at *20-21 (citing *Prudential Ins. Co. of Am. v. S.S. American Lancer*, 870 F.2d 867, 871 (2d Cir. 1989)).

54. Roger M. Baron & Delia M. Druley, *ERISA Reimbursement Proceeds: Where Does the Money Go?*, MINNESOTA TRIAL, Spring 2010, at 10. This article has been also been published or is scheduled to be published in journals sponsored by trial lawyers in Pennsylvania, California, Colorado, Wyoming, North Dakota, and South Dakota.

55. As already pointed out, intensive state regulation of insurance evolved as a result of the Supreme Court’s ruling in 1868 that Congress lacked authority to do so. When the Supreme Court reversed itself on this issue in 1944, Congress responded by expressing its satisfaction with state regulation through its enactment of the McCarran-Ferguson Act.

56. “Employers or other plan sponsors are generally free under ERISA, for any reason at any time, to adopt, modify, or terminate welfare plans.” *Curtiss-Wright Corp. v. Schoonejongen*, 514 U.S. 73, 78 (1995).

57. “When an insurer recovers under the right of subrogation, it has basically reinsured itself, and thus has suffered no loss, i.e., it has received a windfall, the very thing subrogation was created to prevent.” Eric J. Pickar, Comment, *Westfield Insurance Company, Inc. v. Rowe: The South Dakota Supreme Court Rejects the Common Law “Made Whole” Doctrine on a Property Insurance Subrogation Claim*, 47 S.D. L. REV. 316, 338 (2002).

and judge Warren Freedman addressed this particular vulnerability⁵⁸ as follows:

The doctrine of subrogation was conceived unilaterally, nurtured unilaterally, and cast upon the courts for the unilateral interest of insurers generally. It must be thoroughly reexamined from time to time.⁵⁹

V. STEPPING INTO THE VOID CREATED BY ERISA PREEMPTION

It is clear that subrogation or reimbursement under the Employee Retirement Income Security Act of 1974⁶⁰ (“ERISA”) exists for the benefit of the insurers and employers (plan sponsors). The financial benefit yielded by this device flows exclusively for the benefit of these corporate entities, either as direct profit for insurers or as a device to lessen the employer’s contribution to insurance coverage down the road for a different pool of insureds. This is done at the expense of injured victims for whom coverage had been previously assessed on an actuarial basis.

Subrogation on personal injury claims was prohibited at common law, and it was uniformly prohibited for health insurers in all jurisdictions in 1974 when Congress enacted ERISA. The reason that ERISA subrogation (reimbursement) exists today is because it has been fostered as a self-given right—a right created without oversight and contrary to the law in effect in all jurisdictions at the time ERISA was enacted. The health insurance industry has taken advantage of the void created by ERISA’s preemptive effect, enhancing the opportunity for profit at the expense of the insured who is victimized twice—once by a tortfeasor and then again by his health insurer. The health insurance industry has, in unabated fashion, established as lawful that which was unlawful in 1974 when Congress enacted ERISA. As a result—and notwithstanding the fact Congress has never endorsed ERISA subrogation—the health insurance industry has bootstrapped itself into a \$1 billion per year stream of profit, at the expense of personal injury victims.

The Third Circuit’s recent decision in *US Airways, Inc. v. McCutchen*,⁶¹ presents a golden opportunity for all federal courts to re-examine the ERISA reimbursement effort. This is an excellent time for all federal courts to look at the reality that underlies the reimbursement effort. Not only do ERISA reimbursement recoveries pro-

58. Warren Freedman died, at the age of 89, on September 6, 2010.

59. WARREN FREEDMAN, *FREEDMAN’S RICHARDS ON INSURANCE* 360 (6th ed. 1990).

60. Pub. L. No. 93-406, 88 Stat. 832 (codified at 29 U.S.C. §§ 1001-1461 (2006)).

61. No. 10-3836, 2011 U.S. App. LEXIS 22883 (3d Cir. Nov. 16, 2011).

duce a “windfall” to the employer and their insurers, but also the judicial enforcement of reimbursement claims is tantamount to a “revictimization” of personal injury victims.