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Subrogation In Medical Service Plans And Medical Insurance Policies

Hospital Service Corporation v. Pennsylvania Insurance Company

The Hospital Service Corporation (Blue Cross) issued to its subscriber a hospital care plan which contained a subrogation clause. The clause provided that if the subscriber were injured by the tortious act of a third party and payments were made pursuant to the terms of the plan, Blue Cross would be subrogated to the subscriber's right of recovery against the tort-feasor and the subscriber would be required to pay over to Blue Cross all amounts recovered in a suit against the tort-feasor. The subscriber was injured by a negligent third party and incurred a hospital bill, part of which Blue Cross paid in accordance with its contract. Having received notification from Blue Cross of its subrogation rights under the contract, the tort-feasor and the tort-feasor's insurer nevertheless settled with the subscriber and obtained from him a release of all claims. The tort-feasor's payment to the subscriber under the terms of the settlement was in excess of the entire hospital bill. Upon refusal of its demand for reimbursement, Blue Cross brought suit against its subscriber, the tort-feasor, and the tort-feasor's insurer, as co-defendants. The Supreme Court of Rhode Island, considering the three questions certified to it by the trial court, concluded that: (1) by contract Blue Cross was subrogated to its subscriber's right of recovery against the tort-feasor; (2) the release procured by the tort-feasor, who was aware of Blue Cross' subrogation claim, was not a defense in Blue Cross' action to enforce its subrogation claim against the tort-feasor; and (3) Blue Cross under its contract could recover from its subscriber the amount it had paid for hospital expenses.

Subrogation is an equitable doctrine akin to the concept of suretyship. It is "". . . founded on the plainest principles of natural reason and justice, that the surety paying off a debt shall stand in the place of the creditor, and have all the rights which he has, for the purpose of obtaining his reimbursement." The Latin derivation of the word "subrogation" provides perhaps the best short definition: sub — "under" and rogare — "to ask." The theoretical purposes of subro-

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2. Such recovery, however, might not equal the full amount of the sum paid to the hospital because subscriber's "necessary and reasonable expenses" in seeking recovery from tort-feasor might be deducted. Id. at 111.
3. The suretyship concept, involving a situation in which one person promises to pay the obligation of another if that other does not pay, was highly developed in Roman law. During the Middle Ages, however, the surety was little more than a physical hostage, often loaded with chains to prevent flight. Modern suretyship is not quite so harsh. See Loyd, The Surety, 66 U. Pa. L. Rev. 40 (1917). See also Ager, The Doctrine of Subrogation Pro Tanto, 29 Ins. Counsel J. 426 (1962); McPharlin, Subrogation Rights of the Contract Bond Surety, 33 Ins. Counsel J. 93 (1966); Powers, The Problem of Balancing Equities in Subrogation Cases, 23 Ins. Counsel J. 104 (1956).
gation are the prevention of unjust enrichment and the attainment of substantial justice.6 Consistent with these purposes the courts have held that if the insured acts in such a manner as to defeat his insurer's subrogation rights, he will not be permitted to recover on the policy.7

Subrogation may be either "legal" or "conventional". Legal subrogation arises by operation of law even when there is no express contractual provision. Even if a liability or fire insurance policy, for example, does not contain a subrogation clause, the insurer is subrogated to the rights of the insured against a third-party tort-feasor upon payment by the insurer to the insured.8 On the other hand, conventional subrogation arises by agreement between the parties. Although property insurers sometimes contract for subrogation even though they would be entitled to legal subrogation,9 conventional subrogation is important primarily in situations where legal subrogation is not available.

Traditionally, subrogation has been available only to insurers of property; neither legal nor conventional subrogation has been extended to insurers of the person. Consequently, subrogation is not permitted in cases involving life insurance or insurance which pays a fixed rate for personal injury. Medical insurance payments, which are intended to compensate or indemnify the insured to the extent of the actual injury inflicted, fall somewhere between the traditional concepts of property and personal insurance. Such payments are similar to property insurance proceeds in that they compensate only for actual loss which can be objectively determined. At the same time they resemble personal insurance benefits in that the payments are made because of personal injury. Because medical payments lie in this gray area of insurance, courts reach conflicting results in cases involving subrogation under medical insurance policies.

The decisions of some courts with respect to subrogation in medical service plans, such as Blue Cross and Blue Shield, are influenced by the argument that such plans are not insurance.10 The

6. Trinity Universal Ins. Co. v. Moore, 134 A.2d 333, 335 (D.C. Mun. App. 1957); cf. Restatement of Restitution § 76 (1937): "A person who, in whole or in part, has discharged a duty which is owed by him but which as between himself and another should have been discharged by the other, is entitled to indemnity from the other...."

7. See, e.g., Miller v. St. Paul Ins. Co., 203 A.2d 923 (D.C. Mun. App. 1964). In Miller, the insured took out an insurance policy on his baggage for an airplane trip. After the airplane had replaced some damaged baggage, he tried to collect on the insurance policy. The court held that even without a subrogation clause the insurance company had a right of subrogation which, when defeated by the insured, became a "complete defense" to liability on the policy. See also Carstairs v. Mechanics & Traders' Ins. Co., 18 F. 473 (C.C.D. Md. 1883) (recovery on the policy was denied after the defeat of an express subrogation clause by plaintiff-insured); Ocean Accident & Guar. Corp. v. Hooker Electro-chemical Co., 240 N.Y. 37, 147 N.E. 351, 354 (1925).


10. Jordan v. Group Health Ass'n, 107 F.2d 239 (D.C. Cir. 1939); Group Health Ass'n v. Moor, 24 F. Supp. 445 (D.D.C. 1938) (medical service plan providing service and supplies held not to be insurance); Michigan Hosp. Serv. v. Sharpe, 339 Mich. 357, 63 N.W.2d 638 (1954); Commissioner of Banking & Ins. v. Community Health Serv., Inc., 129 N.J.L. 427, 30 A.2d 44 (Ct. Err. & App. 1943); Annot., 167 A.L.R. 322 (1947); Annot., 119 A.L.R. 1241 (1939); Annot., 106 A.L.R. 1449 (1936); Annot,
theoretical basis for this conclusion was explained in *State ex rel. Fishback v. Universal Service Agency*,11 in which a service agency which provided free medical service to its subscribers was held not to be an insurance company for the purposes of the state insurance code. The court suggested that in the absence of a “hazard or peril” the plan did not fall within the definition of insurance contained in the code.12 Thus, a practical consideration supports a distinction between medical service plans and medical insurance: if medical service plans were considered to be insurance, they would be subject to the stringent requirements which are often statutorily prescribed for insurance companies.13 Maryland, for example, distinguishes non-profit health service plans from insurance by statute.14 However, the question has never been judicially resolved in Maryland, and, in one of the few Maryland cases involving Blue Cross, the Court of Appeals of Maryland referred to it both as “hospitalization insurance” and as a “non-profit health service plan.”15 For purposes of subrogation, any distinction between medical insurance and medical service plans is without conceptual justification, since the policies for and against subrogation apply equally to both.

The few cases dealing with subrogation rights under medical service plans are in agreement. Absent an express subrogation clause creating conventional subrogation, subrogation has not been allowed.16 On the other hand, when a subrogation clause is included in the policy, it has been given effect against the subscriber.17 The courts have also upheld similar clauses of medical service plans which exclude coverage when the subscriber is tortiously injured, unless the subscriber at-

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63 A.L.R. 711 (1929). *But cf.* Cleveland Hosp. Serv. Ass'n v. Ebright, 36 Ohio L. Abs. 600, 45 N.E.2d 157 (Ct. App. 1942), aff'd, 142 Ohio St. 51, 49 N.E.2d 929 (1943). In the popular mind Blue Cross is insurance. *See Drake, New Strides Made in Health Insurance*, Philadelphia Inquirer, March 3, 1968, § 7, at 8, col. 1: “...insurance programs such as Blue Cross and Blue Shield... *But see* Hospital Serv. Corp. v. Pennsylvania Ins. Co., 227 A.2d 105, 111 (R.I. 1967): “It is generally agreed that a corporation ... which provides hospital care for its subscribers is not part of the insurance industry.”

11. 87 Wash. 413, 151 P. 768 (1915).
13. These requirements, involving such things as minimum capitalization, are intended to apply to profit making concerns which Blue Cross and Blue Shield are not. *See authorities cited notes 9 & 10 supra.*
16. Michigan Hosp. Serv. v. Sharpe, 339 Mich. 357, 63 N.W.2d 638 (1954). There is no other authority for this proposition because, following this decision, subrogation clauses began to be routinely inserted in medical service plans. The dissent in *Sharpe* suggests that defendant insured was primarily liable for the hospital bill, that unjust enrichment to the defendant should be avoided, and that there is no justification for preferring one class of indemnitors over another.
tempts to recover from the tort-feasor and fails. Conventional subrogation is given effect in medical service plans for a variety of reasons. The courts feel that subscribers should not receive windfalls and that duplicating coverage can justifiably be avoided. Further, if subrogation is permitted, the cost of such plans to the general public may be reduced. Because, by strict definition, these plans are not insurance, the long line of authority denying subrogation in personal injury cases is not so persuasive. Finally, the courts are probably much more inclined to grant subrogation to a non-profit medical service concern than to a profit-making insurance company.

In the more frequently litigated area of medical insurance, however, courts hold widely diverging views founded on various notions of public policy. A frequently used basis for denying subrogation is the concept that subrogation is available only where the insurance involves indemnity, i.e., making the insured whole. This concept is the basis of the traditional distinction, in subrogation cases, between property and personal insurance. The object of property insurance is the indemnification of the insured for a specific loss. Subrogation is allowed in this situation because of the obvious undesirability of double recovery. In personal insurance, however, the exact loss is not capable of ascertainment, and, thus, the reasons militating against double recovery are less clear. As a result, subrogation is not allowed under personal insurance contracts. Some courts, mechanically applying the traditional distinction, have rejected even conventional subrogation in medical insurance cases although the medical insurance pay-

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18. See, e.g., Smith v. Idaho Hosp. Serv., Inc., 89 Idaho 499, 406 P.2d 696 (1965); Barmeier v. Oregon Physicians' Serv., 194 Ore. 659, 243 P.2d 1053 (1952). In both cases the policy contained a clause providing that the benefits were not applicable in the event of injury caused by the wrongful act of another except to the extent that the injured subscriber should make all reasonable efforts to recover from the tort-feasor and be unable to do so. In spite of the fact that the injured subscriber recovered only enough for medical expenses without receiving additional general damages, the medical service was not held liable. See also Moeller v. Associated Hosp. Serv., 304 N.Y. 73, 106 N.E.2d 16 (1952) (clause denying coverage when subscriber received hospital care under workmen's compensation upheld).

19. See cases cited notes 17 & 18 supra.


21. Hospital Serv. Corp. v. Pennsylvania Ins. Co., 227 A.2d 105, 110 (R.I. 1967). A reduction in cost is significant when viewed in conjunction with the expected 140% increase in health cost by 1975. See Time, March 15, 1968, at 71. Other policy reasons may also be involved. See Contractors, Pacific Naval Air Bases v. Pillsbury, 105 F. Supp. 772 (N.D. Cal. 1952), in which the court gave effect to employee's hospital association subrogation agreement against employee's former employer when employee had been injured on his former job and was provided medical care by the association because of the philosophy of the Compensation Act which makes "... the cost of occupational diseases a business..." expense. Id. at 774.

22. This is understandable because in medical insurance subrogation, a novel legal relationship has outgrown traditional concepts. Life insurance presented unrelated but similar problems of grappling with developed rules. See Gordon v. Portland Trust Bank, 201 Ore. 648, 271 P.2d 653 (1954).


25. 3 J. Appleman, Insurance Law & Practice § 1675, at 495 (1941).
ments clearly involved the indemnification of a specific loss. The better reasoned view would be that when a medical insurer pays on the basis of an insured's actual expenses rather than according to a fixed scale, the insured is being made whole. Therefore, if no other factors are present, subrogation should be permitted.

An additional factor which precludes some courts from allowing subrogation under medical insurance policies is the common law rule of non-assignability of personal injury actions. Some courts have concluded that subrogation in the medical payments area necessarily involves an assignment of a personal injury claim. The right to subrogation in such cases will depend on whether or not the law of the particular state permits the assignment of personal injury actions. In *Travelers Insurance Co. v. Lutz*, a subrogation agreement between a medical insurer and insured was attacked as an unlawful assignment of a personal injury claim. The court permitted medical payments subrogation, concluding that: "... the law of Ohio now appears to be relatively clear to the effect that all courts will honor an assignment to a subrogated insurance company of a part of a cause of action arising from ... tortious injury." It is unclear from the decision whether or not the insured executed an assignment; the court apparently assumed that the subrogation agreement had that effect. Because personal injury claims were assignable under Ohio law, the assignment-subrogation was viewed by the court as "not definitely improper" and, consequently, permissible. The *Lutz* court suggested that the Superintendent of Insurance had full authority to review the subrogation clause and had not found it improper. The court reasoned that if the parties wished to make such an agreement they might do so, and that with insurance rates constantly increasing, anything "which might help

26. *E.g.*, *Travelers Indem. Co. v. Chumbley*, 394 S.W.2d 418, 423 (Mo. App. 1965) ("... we think it obvious that medical expense does not stand 'on the same footing as property damage'... "). *But see* *Peller v. Liberty Mutual Fire Ins. Co.,* 220 Cal. App. 2d 610, 34 Cal. Rptr. 41, 42 (Dist. App. 1963) (basing its decision on non-assignability, the court rejected the indemnity concept as a "purely verbal" distinction).

27. *See* *Dambesel v. Hardware Dealers Mut. Fire Ins. Co.,* 60 Ill. App. 2d 282, 209 N.E.2d 876, 878 (1965): "The contract was not one where a person was to be paid a certain amount for the loss of an arm and another certain amount for a broken leg. This contract was to indemnify the appellant for medical expenses resulting from an accident."

28. *See* *Fifield Manor v. Finston*, 54 Cal. 2d 632, 354 P.2d 1073 (1960); Annot., 40 A.L.R.2d 500, 502 (1955), where it was stated: "It seems that few legal principles are as well settled, and as universally agreed upon, as the rule that the common law does not permit assignments of causes of action to recover for personal injuries."

29. *See, e.g.*, *Rursch v. Gee*, 237 Iowa 1391, 25 N.W.2d 312, 315 (1946): "In the field of fire insurance the rule governing subrogation is well settled. The payment of the loss by the insurer operates as an assignment ... ." This confusion between subrogation and assignment is firmly entrenched. Legal subrogation is apparently viewed as an "... assignment by operation of law... ." Annot., 13 A.L.R.3d 140, 146 (1967). Insurance companies have further muddled the distinction between assignment and subrogation by including assignment requirements in their property insurance subrogation clauses. *See* *Roberts v. Fireman's Ins. Co.,* 376 Pa. 99, 101 A.2d 747, 748 (1954): "The subrogation clause of the policy required the insured to assign to the insurance company 'all right of recovery against any party for loss to the extent that payment therefor is made' by the company."

31. 210 N.E.2d at 759.
32. *Id.* at 756.
33. *Id.* at 759.
settle the disputes" and prevent double recovery by the injured insured should be permitted. On the other hand, medical payments subrogation was denied in the Missouri case of Travelers Indemnity Co. v. Chumbley, because the court concluded that the status of the insurer under the subrogation agreement was, "... in legal effect, that of an assignee..." and applied the prevailing Missouri rule that causes of action for personal injuries cannot be assigned.

At least several other jurisdictions do not distinguish between subrogation and assignment. In fact, one court has suggested: "While subrogation and assignment have certain technical differences, each operates to transfer from one person to another a cause of action against a third, and the reasons of policy which make certain causes of action non-assignable would seem to operate as forcefully against the transfer of such causes of action by subrogation." Several courts, however, have recognized a distinction between subrogation and assignment. The Rhode Island court in the principal case pointed out what are, perhaps, the essential differences:

Assignment involves dangers of champerty and maintenance. Subrogation does not. Assignment generally involves some con-

34. Id. at 759-60. "It is the opinion of the court that some clarification of this entire matter by the Legislature would be helpful but that until such clarification takes place there is no rule against the subrogation on medical payments." Id. at 760.
35. 394 S.W.2d 418 (Mo. App. 1965). In that case a clause in an automobile insurance policy which subrogated the insurer to the extent of any medical payments made under the policy was not enforced. See Annot., 19 A.L.R.3d 1054 (1966).
36. 394 S.W.2d at 423. Cf., Comment, Automobile Insurance — Assignment, Subrogation and the Real Party in Interest Statute in Missouri, 26 Mo. L. Rev. 62, 63 (1961): "[T]he leading Missouri cases... have recognized the distinction between assignment and subrogation." See also Kisling v. MFA Mut. Ins. Co., 399 S.W.2d 245 (Mo. App. 1966). Judge Stone wrote the opinions in both Chumbley and Kisling and in the latter held that when insured was injured in a three car accident with an insured motorist and an uninsured motorist the insured could not recover from the insurer for bodily injury under an uninsured motorist clause when the insured, without the consent of insurer, settled with the insured motorist. As Judge Stone suggested in Kisling, "In the absence of inhibition by statute or public policy, the parties to an insurance policy are free to make their own contract and to include therein such limitations and restrictions upon the insurer's liability as the contracting parties are willing to accept and adopt." 399 S.W.2d at 252-53.

Subrogation presupposes an actual payment and satisfaction of the debt or claim to which the party is subrogated although the remedy is kept alive in equity for the benefit of the one who made the payment under circumstances entitling him to contribution or indemnity while assignment necessarily contemplates the con-
sideration moving from the assignee to the assignor. In subroga-
tion the consideration . . . moves in the opposite direction. It
goes from the subrogor to the subrogee. An assignment is made
after a loss to a volunteer who was under no obligation to the
assignor. [The subrogee has already assumed a liability which
matures] . . . into a cause of action against it whenever the
loss occurs. . . .

Because of the failure of some courts to distinguish between sub-
rogation and assignment,41 insurance companies in several jurisdictions
use the device of the loan receipt or trust agreement as a means of
securing indemnity. These agreements provide either that the payment
by the insurer to the insured is a loan to be repaid only out of the
proceeds of any judgment against the tort-feasor or that upon pay-
ment by the insurer, the insured will hold the proceeds of any judg-
ment in trust for the insurer.42 These agreements create no rights
against the tort-feasor,43 but merely act as an "... equitable lien by
subrogation against any recovery . . ." by the insured.44 The courts
which permit such devices view them as assignments of the proceeds
of the action rather than as assignments of the action itself.45 The
insured thus remains the proper party plaintiff.46

Although the issue has not yet been litigated with respect to
medical insurance or medical service plans, the availability of subro-


41. Insurers, by requesting assignments from their insureds under medical pay-
ments subrogation clauses, have undoubtedly also confused the distinction. See, e.g.,
(insurer refused to pay unless insured "... assigned . . . his right to recovery to the
extent of said payments"). See also note 29 supra.

499 (1965) (insured could not recover from insurer after settling with tort-feasor and
defeating subrogation lien in favor of insurer in case involving medical payments); Remsen v. Midway Liquors, Inc., 30 Ill. App. 2d 132, 174 N.E.2d 7 (1961) (a trust
agreement is a valid means of securing indemnity and is not an assignment); Penn-
sylvania Fire Ins. Co. v. Harrison, 94 So. 2d 92 (La. 1957) (when insured recovers
from tort-feasor an amount in excess of the loss, he holds as trustee for insurer); Houston Transit Co. v. Goldston, 217 S.W.2d 435 (Tex. Civ. App. 1949) (a loan
receipt is valid because it helps adjust insurance losses promptly, may keep insurance
rates lower, and is not against the public interest). See also Neighbours v. Harleys-
ments are customary in Maryland, and the practice has recently been approved by the
Fourth Circuit"). See Boynton, The Myth of the "Loan Receipt" Revisited Under
Rule 17(a), 18 S.C.L. Rev. 624 (1966).

43. If insured settles with tort-feasor in contravention of the agreement in the
policy he will not be able to recover on the policy. Bernardini v. Home & Auto. Ins.


gation in these areas would present a potential problem of splitting a cause of action. The problem arises from the widely accepted procedural rule that "[f]or a single indivisible tort but one suit can be brought." A strict application of this rule would permit only one suit to be brought when, as a result of a single tort, an insured suffers general damages as well as medical expenses. Consequently, where the rule is applied, a subrogated insurer must join in a suit initiated against the tort-feasor by the insured or be barred from asserting his rights. At least one jurisdiction has held that while one individual cannot bring separate actions for a single tort, a subrogor and subrogee

47. Another somewhat related problem is the real party in interest rule. Real party in interest statutes require that an action be commenced in the name of the person with the beneficial interest in the subject matter of the action. Although the wording of these statutes is virtually uniform, they have not been uniformly interpreted by the courts. See generally Kessner, Federal Court Interpretations of the Real Party in Interest Rule in Cases of Subrogation, 39 Neb. L. Rev. 452 (1960); Note, Subrogation: Proper Party Plaintiff in Action Against Tort-Feasor, 7 S.C.L.Q. 463 (1955); Note, Subrogation Claims in Insurance and the Real Party in Interest Statute, 16 Mont. L. Rev. 101 (1955); 11 Okla. L. Rev. 83 (1958); Annot., 13 A.L.R.3d 140 (1967); Annot., 13 A.L.R.3d 229 (1967). The real party in interest rule does not, however, substantively affect the rights of an insurer-subrogee because, if the insured does not prosecute the action, the insurer may then become the real party in interest and, if the insurer or insured alone is pursuing the defendant and the defendant does not object to the absence of one of the parties, objection will probably be considered to be waived. For example, under the Federal Rules both insurer and insured are "proper" and "necessary" parties but neither is "indispensable." United States v. Aetna Cas. & Sur. Co., 338 U.S. 366 (1949); United States v. South Carolina State Highway Dept', 171 F.2d 893 (4th Cir. 1948). See also Braniff Airways, Inc. v. Falkingham, 20 F.R.D. 141 (D. Minn. 1957). The rule has probably its greatest effect in cases in which an insurer wishes to conceal its interest from the jury and is not allowed to do so.

48. Packham v. German Fire Ins. Co., 91 Md. 515, 526, 46 A. 1066, 1068 (1900). Maryland has reached what must be the ultimate result of the rule against splitting a cause of action. In Vane v. C. Hoffberger Co., 196 Md. 450, 77 A.2d 152 (1950), the defendant, while servicing an oil burner, caused smoke to damage Mr. & Mrs. Vane's building. The Vanes carried separate insurance policies on their food and their building. After assignments were executed to both insurers following their separate payments of the loss, the food insurer brought suit against defendant in Peoples Court and was awarded a judgment of $75.00. Before trial in the Peoples Court, the building insurer, unaware of the pending Peoples Court suit, brought suit in Baltimore City Court seeking to recover its payment of $598.65. The Court of Appeals held that there was only one cause of action and that the prior judgment in the Peoples Court barred the subsequent suit.

can bring individual suits to enforce their separate rights.\textsuperscript{50} Furthermore, because the doctrine which prohibits the splitting of a cause of action is designed to protect the tort-feasor, the tort-feasor can waive the application of the doctrine by consenting to the split.\textsuperscript{51} Thus, when the defendant tort-feasor settles with the insured after notice of the insured's rights of subrogation, he may be considered to have acquiesced in the splitting of the cause of action.\textsuperscript{52}

A concept which has been invoked by some courts to deny legal subrogation in certain cases is the rule that the right of subrogation is not available to one who is primarily liable.\textsuperscript{53} Thus, in the medical payments area, the result of the application of this rule is that subrogation is not available when the insurer has paid the insured because required to do so by an unqualified contractual duty.\textsuperscript{54} Where no express provision is made for subrogation, the medical service plan or insurance policy, on its face, renders the insurer absolutely liable to provide medical payments or services under the terms of the policy. Under the primary liability rule, legal subrogation would be denied in such cases. The primary liability theory appears to be only an artificial expression of the unwillingness of the courts to extend the rights of the insurer beyond the express terms of the policy. It is difficult to understand, for example, why the theory applies to medical insurers, to whom legal subrogation is denied, but not to property insurers, to whom legal subrogation is available. In short, the primary liability theory is not an adequate conceptual justification for the denial of subrogation to medical insurers and should be discarded.

In addition to the technical problem of subrogation in medical insurance and medical service plans, a corollary question of public policy is involved. Whether subrogation is permitted in medical payments cases will necessarily affect the scope of the collateral source or double recovery rule. This rule provides that, if defendant is liable,

\textsuperscript{50} Hoosier Cas. Co. v. Davis, 172 Ohio St. 5, 173 N.E.2d 349 (1961). It may be desirable to have only one cause of action, but the insurer-assignee-subrogee should be entitled to bring his own cause of action. However, if the tort-feasor so desires, joinder can be required on motion.


\textsuperscript{53} Machined Parts Corp. v. Scheider, 289 Mich. 567, 286 N.W. 831, 834 (1939); Merchants' Bank & Trust Co. v. Bushnell, 142 Tenn. 275, 218 S.W. 709, 710 (1920): "The doctrine of subrogation arises only in favor of one who pays the debt of another, and not in favor of one who pays the debt in performance of his own covenants. This right never follows a primary liability." Accord, Hazel v. Bondy, 173 Ill. 302, 50 N.E. 671 (1898); Brown v. Sheldon State Bank, 139 Iowa 83, 117 N.W. 289 (1908); St. Louis & S.F. Ry. v. Excello Feed Milling Co., 215 S.W. 755 (Mo. App. 1919); Luikart v. Buck, 131 Neb. 866, 270 N.W. 495 (1936).\textsuperscript{54} Publix Cab Co. v. Colorado Nat'l Bank, 135 Colo. 205, 338 P.2d 702, 714 (1959). The court in that case refused to grant legal subrogation to a hospital association which had supplied medical service as required by an employee hospital plan. The court concluded: "[W]e are unable to perceive that the equities demand expansion of the subrogation principle. . . . [T]he Association was legally and primarily obligated to furnish these services . . . in exchange for the payments which . . . had [been] made." See also Southland Life Ins. Co. v. Aetna Cas. & Sur. Co., 366 S.W.2d 245, 249 (Tex. Civ. App. 1963) ("Southland paid . . . merely what its policy required it to pay"); State Farm Mut. Auto. Ins. Co. v. McCarty, 176 Neb. 718, 127 N.W.2d 284 (1964).
the extent or amount of his liability will not be reduced by payment to plaintiff from sources other than defendant. The essential purpose of the rule is to prevent the wrongdoer from escaping the consequences of his tortious act and, at the same time, to award to a prudent plaintiff the benefit of his foresight. Because of the collateral source rule, plaintiffs have been allowed to recover from tort-feasors the cost of medical services even if they received the services free of charge or recovered the cost from their own insurers. If subrogation is permitted in medical payments insurance, many plaintiffs would no longer receive double recovery. Dissatisfaction with the double recovery allowed under the collateral source rule is, perhaps, a major but generally unarticulated reason why subrogation agreements have uniformly been upheld in cases involving medical service plans.

For practical purposes, the distinction between medical service plans and medical insurance is minor. The chief difference is that medical insurance is provided by profit making concerns whereas medical service plans, as a rule, are administered by non-profit organizations. This is the prime reason for the statutory distinction between them; from the insured's point of view, however, there is no practical difference. The policy reasons for and against subrogation are equally applicable to both types of medical coverage. The basic policy justification for denying subrogation was articulated in Travelers Indemnity Co. v. Chumbley. In that case, the court felt that if subrogation

55. The Propeller Monticello v. Mollison, 58 U.S. 152 (1854); Rayfield v. Lawrence, 253 F.2d 209 (4th Cir. 1958); Harding v. Town of Townsend, 43 Vt. 536 (1871).

56. If subrogation is allowed, while the tort-feasor still must pay damages for the whole injury, the plaintiff does not receive the benefit of his foresight. See Ghiardi, The Collateral Source Rule: Multiple Recovery in Personal Injury Actions, 1967 Ins. L.J. 457; West, The Collateral Source Rule Sans Subrogation: A Plaintiff's Windfall, 16 Okla. L. Rev. 395 (1963); Comment, Unreason in the Law of Damages: The Collateral Source Rule, 77 Harv. L. Rev. 741 (1964); Note, The Collateral Source Rule in the American Law of Damages, 46 Minn. L. Rev. 669 (1962). The law review articles are critical of the rule. Courts with perhaps some justification have disregarded this criticism. A person who is injured can never really recoup the full amount of his damages because injury necessarily involves many intangible factors. Therefore, it seems unreasonable to mitigate damages for which the tort-feasor is liable simply because plaintiff has usually paid in the form of premiums or by other means for his collateral benefits. Additionally, the abolition of the collateral source rule would result in additional problems of proof and additional splitting of hairs. See McWeeney v. New York, N.H. & H.R.R., 282 F.2d 34 (2d Cir.), cert. denied, 364 U.S. 870 (1960); Grayson v. Williams, 256 F.2d 61 (10th Cir. 1958); Hudson v. Lazarus, 217 F.2d 344 (D.C. Cir. 1954); Roth v. Chatlos, 97 Conn. 282, 116 A. 332 (1922).


58. Publix Cab Co. v. Colorado Nat'l Bank, 135 Colo. 205, 338 P.2d 702, 715 (1959): "A ruling in favor of subrogation in this case would undermine the principle that one who carries health and hospital insurance nevertheless has a right to recover these amounts from the wrongdoer."


were permitted, the courts would be faced with the "... unwelcome specter of multiple subrogation claims by an automobile insurer and others making payments to the same individual... [which] inevitably would lead to conflicts and disputes between subrogation claimants, would complicate and make more difficult the negotiation of voluntary settlements with third-party tort-feasors, and would encourage and promote suits and interpleaders, all running counter to the policy of the law." This factor militates equally against the recognition of either legal or conventional subrogation in the medical protection area. On the other hand, because, under the consumer choice basis of the insurance industry, an individual can obtain multiple coverage to protect him against the occurrence of a single contingency, the possibility of a windfall to that individual upon the occurrence of that contingency is considerable. The incidence of excessive recovery in such a situation would be greatly reduced by subrogation.

Even if conventional subrogation is allowed in medical insurance and medical service plans, the existence of a settlement between the insured and the tort-feasor presents additional questions of policy and justice. In the instant case, a subrogation clause in a Blue Cross policy was given effect against a tort-feasor and his insurer, who, with knowledge of Blue Cross' subrogation claim, settled with and obtained a release from the injured subscriber. If this rule were not applied, the tort-feasor who is aware of the insurer's subrogation rights would be able to bar the insurer's recovery by deliberately splitting the cause of action by obtaining a release from the insured. Such a settlement would constitute a fraud upon the rights of the insurer and, thus, cannot be a defense in the insurer's action to enforce his subrogation rights.

Some courts solve the problem of splitting the cause of action by ruling that a tort-feasor consents to a separation of the cause of action by settling with the insured with knowledge of the insurer's subrogation rights. When the tort-feasor does not have notice of

60. 394 S.W.2d at 425.
62. 227 A.2d at 112. This rule rests on the presumption that once a tort-feasor knows of the insurer's subrogation rights or claim, settlement with the insured will not defeat the right of the insurer because it is an attempt to defeat the subrogation. Under ordinary circumstances, Blue Cross could not have instituted an action in its own name against the third party tort-feasor because of the Rhode Island real party in interest rule, for although there is an exception to that rule which permits a subrogee-insurer who has paid all or part of a loss, to institute suit in the name of the insured, Blue Cross is not considered to be an insurer. Therefore, absent the fact that notice had been given and a presumption of fraud had arisen, Blue Cross could not avail itself of this exception. Id. at 111. See also Associated Hosp. Serv. v. Milwaukee Auto. Mut. Ins. Co., 33 Wis. 2d 170, 147 N.W.2d 225 (1967), which permitted Blue Cross to recover payments it had made to its subscriber from third party tort-feasor's insurer who had settled with subscriber after notice.
63. Cf. Western Maryland Ry. v. Employers' Liability Assur. Corp., 163 Md. 97, 161 A. 5 (1932), which held that subrogation is not considered to be an insurer. Therefore, absent the fact that notice had been given and a presumption of fraud had arisen, Blue Cross could not avail itself of this exception. Id. at 111. See also Associated Hosp. Serv. v. Milwaukee Auto. Mut. Ins. Co., 33 Wis. 2d 170, 147 N.W.2d 225 (1967), which permitted Blue Cross to recover payments it had made to its subscriber from third party tort-feasor's insurer who had settled with subscriber after notice.
the subrogation claim, the reasons against allowing a settlement with the insured to bar the subrogation claim are less persuasive. As a result, the tort-feasor who settles in good faith is not liable to an insurer-subrogee.68

In Davenport v. State Farm Mutual Automobile Insurance Co.,67 a medical insurer was allowed to recover medical payments it had made to its insured in a suit against a third party tort-feasor who had settled with the insured. The dissent argued persuasively that the insurer clearly had an action at law on the contract against its insured and should be required to "... seek relief at law first... before considering equitable remedies."68 Permitting insurers to seek relief in suits against tort-feasors who have settled not only permits double recovery by the insured but imposes double liability on the tort-feasor. On the surface it might seem that a tort-feasor who settles with insured in disregard of insurer's known subrogation rights should be liable to insurer. This ignores, however, the problem of the avaricious insured who receives payment from a tort-feasor who fears the danger of a large jury verdict if he does not settle. One court dimly glimpsed this problem but nevertheless concluded that the insurer "... should be reimbursed by the party whose negligence caused..." the damage.69

In the principal case, the Rhode Island court indicated that, depending on the facts, the "insurer" could collect either from the "insured" or from the tort-feasor.70 Because subrogation is founded on equitable principles, it would seem more consistent in terms of balancing the equities to require insurer to first attempt collection from insured before attempting to recover from the tort-feasor. This would prevent unjust enrichment to the insured on the one hand and the imposition of excessive liability on the tort-feasor on the other.71 As a practical matter, nonetheless, the tort-feasor should usually be able to protect himself from double liability by making any check in settlement payable to the order of both insurer and insured when he has notice of insurer's interest. Usually it would seem to be more

66. See, e.g., Sharp v. Bannon, 258 S.W.2d 713 (Ky. 1953). See also Robins Dry Dock & Repair Co. v. Flint, 275 U.S. 303 (1927) (Holmes, J.): "[A]s a general rule, at least, a tort to the person or property of one man does not make the tort-feasor liable to another merely because the injured person was under a contract with that other, unknown to the doer of the wrong."


68. 404 P.2d at 14. Judge Collins suggested that the insured by settling with tort-feasor "... did exactly what they promised and contracted not to do... thereby precipitating this litigation. ... [The] court... should [not] open its doors to the... [insurer] under these circumstances. It... [encourages] contracting parties to breach their agreement, and in fact reward[s] them for an apparent breach..."


71. See Reconstruction Fin. Corp. v. Maryland Cas. Co., 23 F. Supp. 1008 (D. Md. 1938): Subrogation "... is... a thoroughly well established equitable right not to be denied except on some definite adequate reason therefor." Id. at 1011. See also Ragan v. Kelly, 180 Md. 324, 335, 24 A.2d 289, 295 (1942) ("Subrogation always will be granted when an equitable result will be obtained"); Maryland Trust Co. v. Poffenberger, 156 Md. 200, 207, 144 A. 249, 251 (1929) ("... to entitle one to subrogation his equity should be strong and his case clear...").
equitable to require insurer to seek recovery at law from the insured, but in those situations involving gross bad faith the tort-feasor should probably be held liable.

The current trend in cases considering subrogation in medical service plans and insurance policies is apparently to permit conventional subrogation where medical payments have been made. One cause of this trend may be that the courts, encouraged by the fact that statutory subrogation is becoming increasingly widespread, are taking a new look at personal injury subrogation. Virtually every workmen's compensation statute, for example, provides that an employer's carrier is subrogated to the rights of the employee against third party tort-feasors. Furthermore, the Federal Medical Care Recovery Act of 1962 has nullified the holding of United States v. Standard Oil Co., in which the government was denied the right to recover from a tort-feasor the cost of medical care rendered to a soldier because of an injury caused by the negligence of that tort-feasor. Under the 1962 Act, the government can now recover medical care costs from negligent third parties.

Although it might appear that a clear line has been drawn by the courts, with subrogation clauses being uniformly given effect in medical service contracts and generally being disallowed in medical insurance contracts, such a conclusion cannot be stated as a definite proposition. California is apparently the only state having decisions dealing with both types of contracts; under the California decisions subrogation was granted to a hospital association but was denied to

72. See note 68 supra and accompanying text.
75. 332 U.S. 301 (1947).
76. See Bernzweig, Public Law 87-693: An Analysis and Interpretation of the Federal Medical Care Recovery Act, 64 Colum. L. Rev. 1257 (1964); Gotting, Recovery of Medical Expenses and the Medical Care Recovery Act, 20 JAG J. 75 (1965-66).
medical insurers.\textsuperscript{77} Litigation in both areas is too scant to permit an inference that the other jurisdictions which have allowed subrogation in medical service plans would not allow conventional subrogation in the medical insurance area or a parallel inference that jurisdictions which have denied medical insurance subrogation would allow conventional subrogation under medical service plans. The point really is that such a distinction should not be made; the crucial question should be whether subrogation should be allowed in the general area of medical payments.

The answer to this question is not simple, for there are public policy reasons militating both for and against the extension of insurance subrogation in medical payments. The possibility of lower insurance rates\textsuperscript{78} and fewer windfalls to plaintiffs on the one side are, perhaps, balanced by the possibility of multiple subrogation claims and additional litigation on the other. Because the problem of multiple claims is the result of the existence of duplicating policies, an obvious solution would be to restrict the issuance of duplicating policies either by statute or by a system of self-regulation on the part of insurance companies and medical service organizations. In any event, medical insurance subrogation clauses should be given effect at law on a contract theory at least against the insured. In jurisdictions where the courts do not distinguish between assignment and subrogation and deny subrogation as an invalid assignment of a cause of action for personal injuries, subrogation devices such as trust agreements or loan receipts should be upheld. There is no substantive difference between medical insurance and medical care plans such as Blue Cross, and the courts, therefore, should permit conventional subrogation in both. If the courts were willing to accept the fact that medical payments are really indemnifications and to distinguish the concept that subrogation is not available in cases of primary liability, even legal subrogation might be allowed. However, it does not appear unreasonable to require insurers who desire subrogation to include a subrogation clause in their policy.\textsuperscript{79}

Perhaps the major significance of the instant case is its recognition of the distinction between assignment and subrogation. The recognition of this distinction removes the barrier to the granting of subrogation in medical service plans and insurance policies which had

\textsuperscript{77} Subrogation has been allowed in medical insurance policies in Florida, Illinois, Minnesota, Nevada, New Jersey (apparently), New York (apparently), and Ohio. Medical insurance subrogation may be available in Maryland as well. Subrogation has been allowed in medical service plans in Michigan, Rhode Island, Wisconsin, and indirectly, in Idaho and Oregon. Subrogation has not been permitted in medical insurance policies in Arizona, Georgia, Missouri, Nebraska, and perhaps, Texas. Subrogation has been denied to hospital associations in Michigan and Colorado. See cases cited herein.

\textsuperscript{78} Hospital Serv. Corp. v. Pennsylvania Ins. Co., 227 A.2d 105, 110 (R.I. 1967). \textit{But see} DeCespedes v. Prudence Mut. Cas. Co., 193 So. 2d 224, 228 (Fla. Dist. Ct. App. 1966), aff'd per curiam, 202 So. 2d 561 (Fla. 1967): "[A]nticipated recoveries under subrogation rights are generally not reflected in the computation of premium rates. . . . This, however, is a legislative or administrative problem rather than one that bears on the inherent validity of such a clause."

\textsuperscript{79} Cf. State Farm Mut. Auto. Ins. Co. v. McCarty, 176 Neb. 718, 127 N.W.2d 284, 286 (1964): "If the insurer wanted a subrogation clause, it knew how to require one."
been posed by the rule against assigning personal injury claims and opens the way to a resolution of the subrogation issue based on practical considerations of public policy. The limitation upon the effect of the collateral source rule achieved by medical payments subrogation is in the final analysis a desirable result. The purpose of medical service plans and medical insurance should be protection against loss, not a hopeful gamble on double recovery.⁸⁰ Although problems of public policy remain, the Rhode Island decision serves as a useful guide in the yet largely uncharted area of medical payments subrogation.

⁸⁰ The implicit irony in excessive and unjustified recovery from insurers was recognized even at the very beginnings of the modern insurance industry. As W.S. Gilbert in *The "Bob" Ballads* remarked:

> Down went the owners — greedy men whom hope of gain allured:
> Oh, dry the starting tear, for they were heavily insured.