

# Public Policy Considerations Warranting Denial of Reimbursement to ERISA Plans: It's Time to Recognize the Elephant in the Courtroom

by Roger M. Baron \*

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\* Professor of Law, University of South Dakota. University of Missouri-Columbia (B.S., 1973; J.D., 1976). The Author wishes to thank Robert A. Sachs, Attorney and Adjunct Professor of Law, as well as Professor Michael J. Myers, for their review of an earlier draft of this Article and for their insightful comments.

## I. INTRODUCTION

A number of recent federal court opinions,<sup>1</sup> including a decision by the United States Supreme Court, have denied plans falling under the Employee Retirement Income Security Act of 1974 (“ERISA”)<sup>2</sup> the opportunity to seek reimbursement for medical expenses paid for plan members.<sup>3</sup> Without delving into the weighty policy considerations that support these decisions, the courts rendering these decisions have constrained their analyses to simple statutory construction of the relevant provisions of ERISA. As a result, these decisions might appear to be hyper-technical on the surface. However, significant policy considerations underlie the results. This Article will explore the policy considerations that support the notion that reimbursement should be denied to ERISA plans. As suggested in the title to this Article, one does not have to go far to find them; they are as significant and as obvious as an elephant would be in the courtroom; an elephant that exists but is not acknowledged. This Article will also address opposing considerations, which are urged in support of reimbursement.

Given that these decisions reach the right result, the reader might question the need for this Article. Why write an article that “supports” these decisions? The answer is simple. The law is far from settled. The leading case in this area, *Great-West Life & Annuity Insurance Co. v. Knudson*,<sup>4</sup> was decided by the United States Supreme Court and leaves many unanswered questions. Litigation over reimbursement abounds. Furthermore, a few federal courts have established new reasons to permit reimbursement.<sup>5</sup> As this intense struggle continues in our judicial system, the time has come for the courts to look directly at the significant policy considerations at hand.

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I have previously published two articles which address the issues associated with the extension of subrogation into the arena of personal injury claims. This Article addresses related aspects of these same issues as they are now found to exist in the context of health insurance offered by ERISA plans. In that regard, this Article tends to “pick up” where the earlier articles have “left off.” My previously published articles, which serve as the foundation for this Article, will be found cited in some of the footnotes to this Article.

1. These cases are cited and discussed immediately below in the text and footnotes.
2. 29 U.S.C. § 1001-1461 (2003).
3. The denials also extend to commercial insurers having agreements with these plans.
4. 534 U.S. 204 (2002).
5. For cases discussing the “possession theory,” see *infra* notes 90-94 and accompanying text.

This Article will demonstrate that the public policy considerations that warrant denial of reimbursement are deeply rooted in equity and in common law. Furthermore, these historical considerations remain intact because ERISA itself neither permits nor endorses the concept of reimbursement. To the contrary, the declaration of congressional policy found in ERISA suggests that the scheme was designed to assure an “equitable character of such plans” for the benefit of “the interests of employees and their beneficiaries.”<sup>6</sup> Against the historical background that existed at the time ERISA was enacted, Congress has indicated that the goal of full and just compensation for employees and their beneficiaries should carry a higher priority than the goal of strictly upholding plan documents as unilaterally drafted and amended by ERISA plans.

This Article will also address the related assertion by ERISA plans and their insurers that without reimbursement, plan funds are drained, which adversely and significantly impacts rates. This Article will also address the argument that without reimbursement, the insured receives a “windfall”—an argument which still occasionally arises. The sad fact in the vast majority of these critical injury cases is that the insured is left not only seriously impaired for life, but, if reimbursement is permitted, the insured is also left financially destitute.

## II. EXISTING FEDERAL DECISIONS DENYING REIMBURSEMENT

### A. Knudson, *The Point of Beginning*

The chronological point of beginning lies in the decisional law of the United States Court of Appeals for the Ninth Circuit.<sup>7</sup> The most appropriate place to begin this discussion, however, is with the United States Supreme Court decision in *Great-West Life & Annuity Insurance Co. v. Knudson*,<sup>8</sup> which was decided on January 8, 2002. This case arose in California and was just one of many cases in which the Ninth Circuit simply followed its well-established rule in cases of this nature.<sup>9</sup>

Janette Knudson was injured in a car accident and rendered a quadriplegic. The ERISA plan paid \$411,157.11 of her medical expenses. Actually, the plan covered \$75,000 of the expenses, and the remainder

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6. 29 U.S.C. § 1001(a) (2000). This is discussed more fully in *infra* notes 130-31.

7. *FMC Med. Plan v. Owens*, 122 F.3d 1258 (9th Cir. 1997). See generally Lisa M. Bleed, *Enforcing Subrogation Provisions as “Appropriate Equitable Relief” under ERISA Section 502(a)(3)*, 35 U.S.F. L. REV. 727, 736-39 (2001).

8. 534 U.S. 204.

9. Bleed, *supra* note 7, at 738 n.83.

was paid by Great-West Life & Annuity Insurance Company pursuant to its “stop-loss” agreement maintained with the plan. Knudson sued the manufacturer of the car in which she was riding and other alleged tortfeasors in California state court. A settlement of \$650,000 was negotiated. Proceeds were allocated as follows: \$373,426 for attorney fees and costs; \$256,745.30 to a Special Needs Trust, which under California law exists to provide for continuing medical care for Knudson; \$5000 to the California state Medicaid program; and \$13,828.70 for reimbursement to the ERISA plan and supporting insurer. Eventually Great-West filed suit in federal court in California seeking injunctive and declaratory relief asking that the “reimbursement” provision of the plan be enforced and that Knudson be required to pay the entire \$411,157.11 to the plan and to Great-West.<sup>10</sup> Jurisdiction had been predicated upon § 502(a)(3) of ERISA, which provides as follows:

- (a) . . . A civil action may be brought—  
 . . .  
 (3) by a participant, beneficiary, or fiduciary  
 (A) to enjoin any act or practice which violates . . . the terms of the plan, or  
 (B) to obtain other appropriate equitable relief  
 (i) to redress such violations or  
 (ii) to enforce any provisions of . . . the terms of the plan.<sup>11</sup>

Existing case law in the Ninth Circuit had established that an action seeking a judicial decree of reimbursement was not “equitable” relief under this statutory provision and that such an action was, therefore, not authorized by ERISA.<sup>12</sup> Both the federal trial court and the Ninth Circuit held that relief could not be granted to the plan.<sup>13</sup>

The Supreme Court affirmed the Ninth Circuit.<sup>14</sup> Four justices dissented.<sup>15</sup> The majority opinion by Justice Scalia construed the ERISA provisions narrowly, restating the Court’s view that “‘strong evidence [exists] that Congress did *not* intend to authorize other remedies that it simply forgot to incorporate expressly.’”<sup>16</sup> The Court

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10. 534 U.S. at 208.

11. Section 502(a)(3) of ERISA, codified at 29 U.S.C. § 1132(a)(3) (2000).

12. *See supra* note 7 and accompanying text.

13. 534 U.S. at 208.

14. *Id.*

15. *Id.* at 221 (Ginsburg, J., dissenting). Justice Ginsburg wrote a dissenting opinion in which Justices Stevens, Souter, and Breyer joined. *Id.* at 224 (Ginsburg, J., dissenting). Justice Stevens also wrote a brief dissenting opinion, in addition to joining with Justice Ginsburg. *Id.* at 221-22 (Stevens, J., dissenting).

16. *Id.* at 209 (quoting *Mertens v. Hewitt Assocs.*, 508 U.S. 248, 254 (1993)).

recognized that *Knudson* was, in essence, simply a suit for personal liability—a suit for money damages.<sup>17</sup> The Court also rejected various arguments seeking to characterize the relief sought as “injunctive”<sup>18</sup> or as some other form of “equitable relief,”<sup>19</sup> stating,

The basis for petitioners’ claim is . . . that petitioners are contractually entitled to *some* funds for benefits that they conferred. The kind of restitution that petitioners seek, therefore, is not equitable—the imposition of a constructive trust or equitable lien on particular property—but legal—the imposition of personal liability for the benefits that they conferred upon respondents.<sup>20</sup>

The opinion’s effect is to deny reimbursement simply because such a suit is not authorized by the provisions of ERISA, not because reimbursement is unlawful or would violate public policy considerations. Of course, the end result was that allocation of the settlement proceeds for Janette Knudson was not disturbed. All of the money allocated under the settlement to the Special Needs Trust for Janette Knudson remained intact. Nor was there any disturbance in the payment of attorney fees and costs.<sup>21</sup>

On the other hand, had reimbursement been permitted, nothing would be left from the \$650,000 settlement for Janette Knudson, a quadriplegic victim. All of the funds would be expended for reimbursement to the ERISA plan, attorney fees, and costs.

The Supreme Court’s entire resolution of this case hinged on the statutory language found in ERISA, whether the suit was “equitable,”<sup>22</sup> and whether the plan was authorized to bring this sort of suit by the ERISA statute.<sup>23</sup> The Court did not discuss the appropriateness of allowing reimbursement. Nor did the Court mention the significant public policy considerations that support the proposition that reimbursement, in a situation like this, should be denied as a matter of law.

According to the *Knudson* majority, whether reimbursement would be available in other cases remains an open question:

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17. *Id.* at 210.

18. *Id.*

19. *Id.* at 212.

20. *Id.* at 214.

21. *Id.*

22. The *Knudson* decision falls in line with the previous recognition by the Court that ““equitable” relief must mean *something* less than *all* relief.” *Id.* at 209 (quoting *Mertens*, 508 U.S. at 258 n.8 (1993)).

23. *Id.*

We note, though it is not necessary to our decision, that there may have been other means for petitioners to obtain the essentially legal relief that they seek. We express no opinion as to whether petitioners could have intervened in the state-court action brought by the respondents or whether a direct action by petitioners against respondents asserting state-law claims such as breach of contract would have been pre-empted by ERISA. Nor do we decide whether petitioners could have obtained equitable relief against respondents' attorney and the trustee of the Special Needs Trust, since petitioners did not appeal the District Court's denial of their motion to amend their complaint to add these individuals as codefendants.<sup>24</sup>

This concession by the majority might appear beneficial for plans seeking reimbursement in subsequent cases, but the dissenting opinion by Justice Ginsburg aptly puts things in perspective by pointing out that the procedural history in this case shows that the plan and its insurer were out-manuevered in the interplay between state court and federal court orders.<sup>25</sup> Justice Ginsburg's dissent reveals that the majority opinion was indeed more preclusive than suggested:

After today, ERISA plans and fiduciaries unable to fit their suits within the confines the Court's opinion constructs are barred from a federal forum; they may seek enforcement of reimbursement provisions like the one here at issue only in state court. Many such suits may be precluded by antisubrogation laws [and] others may be preempted by ERISA itself . . . .<sup>26</sup>

Thus, the stage was set for future litigation. Was the Court's denial of a federal remedy for reimbursement under § 502(a)(3)(A) of ERISA a complete foreclosure of the reimbursement effort by ERISA plans? Or,

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24. *Id.* at 220.

25. *Id.* at 226-27 (Ginsburg, J., dissenting).

Great-West named the Knudsons as defendants before Janette Knudson's Special Needs Trust had been approved. There was no other defendant then in the picture. Seeking at that time to preserve the status quo, Great-West requested from the District Court preliminary injunctive relief to stop the Knudsons from disposing of the funds Hyundai paid to settle the state-court action. Only after the District Court denied that relief did the state court approve of, and order that the settlement funds be paid into, the Special Needs Trust. Great-West then moved for leave to amend its complaint to add the trustee as a defendant, but the District Court denied that motion without consideration in light of its judgment for the Knudsons on the merits.

*Id.* (Ginsburg, J., dissenting).

26. *Id.* at 227 (Ginsburg, J., dissenting).

could the matter of reimbursement be successfully pursued by an ERISA plan if it were to arise in a different posture?

In regard to the significant underlying policy considerations, the dissenting opinions by Justices Stevens and Ginsburg are equally void of any discussion of the appropriateness of reimbursement. The focus of Justice Ginsburg's dissent<sup>27</sup> was almost entirely upon whether the "nature of the relief" sought is authorized by the ERISA statute.<sup>28</sup> Justice Stevens's additional solo dissenting opinion stated, "It is difficult for me to understand why Congress would not have wanted to provide a recourse in federal court for the plan violation disclosed by the record in this case."<sup>29</sup> If any "policy" ingredient exists in the dissenting opinions, it seems to be as Justice Stevens suggests—that there is a plan document, the plan document requires reimbursement, and the plan document has been violated.<sup>30</sup> It does not seem to matter to Justice Stevens that the plan document might contain provisions that violate public policy or are otherwise unlawful.<sup>31</sup>

#### *B. The Preemptive Nature of ERISA vis-à-vis the Matter of Reimbursement*

The absence of any discussion by the Court of the underlying policy considerations regarding reimbursement is most likely attributable to the basic nature of ERISA. Considerable judicial deference is accorded to the scheme of ERISA and its goal of providing a workable set of national rules for employee benefits.<sup>32</sup> The majority opinion by Justice Scalia recognizes that the ERISA scheme was designed by Congress to be "comprehensive and reticulated," the enactment having been

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27. With whom Justices Stevens, Souter, and Breyer join in. *Id.* at 224 (Ginsburg, J., dissenting).

28. *Id.* (Ginsburg, J., dissenting).

29. *Id.* at 223 (Stevens, J., dissenting).

30. *Id.* (Stevens, J., dissenting).

31. In *FMC Corp. v. Holliday*, 498 U.S. 52 (1990), the Court held that commercial insurers insuring ERISA plans are indeed subject to the antisubrogation laws of the states, by virtue of the "Saving Clause" found in § 514(b)(2)(A), codified at 29 U.S.C. § 1144(b)-(2)(A) (2000).

32.

Federal preemption is the keystone that gives ERISA's arch the ability to span the nation with a single, uniform, pension and welfare-benefit law. When Congress manifested its intent to create such an exclusive federal presence in that field of law, it expressly decreed perhaps the most comprehensive and pervasive preemption of the present era.

*Bauhaus USA, Inc. v. Copeland*, 292 F.3d 439, 445 (5th Cir. 2002) (Wiener, J., dissenting).

preceded by a decade of congressional study.<sup>33</sup> Justice Ginsburg's dissenting opinion also recognizes that the unique undertaking of ERISA was "to establish a uniform administrative scheme' and to ensure that plan provisions would be enforced in federal court, free of 'the threat of conflicting or inconsistent State and local regulation.'"<sup>34</sup>

Indeed, the preemptive nature of ERISA has been described by one federal judge as "perhaps the most comprehensive and pervasive preemption of the present era."<sup>35</sup> Understandably the Court might be reluctant to engage in an analysis of policy considerations, which support or oppose reimbursement—a mere component of a plan provision belonging to one of many plans governed by the ERISA scheme. The role of the Court in ERISA cases has been to interpret the statutes that set up the ERISA mechanism with an eye toward preserving the preemptive nature of the scheme.

However, ERISA does not require or even endorse the idea of reimbursement. The device of "reimbursement" only recently evolved as an alternative method for an insurer to secure money in situations when an insurer might have a subrogation interest but otherwise would be precluded from recovery.<sup>36</sup> In that regard, the prospect of subrogation in the area of medical expense claims (and the corresponding tool of

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33. *Knudson*, 534 U.S. at 209. "We have observed repeatedly that ERISA is a 'comprehensive and reticulated statute,' the product of a decade of congressional study of the Nation's private employee benefit system." *Id.* (quoting *Mertens*, 508 U.S. at 251).

34. *Id.* at 227 (Ginsburg, J., dissenting) (quoting *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 9 (1987)).

35. *Bauhaus USA*, 292 F.3d at 445 (Wiener, J., dissenting).

36. Because of the common-law prohibition against the assignment of personal injury claims, health insurers seeking subrogation rights soon learned that it was wiser to characterize their claims as ones of "reimbursement," not subrogation. In other words, the insurer would not be so bold as to actually seek to initiate a lawsuit for personal injuries as a subrogation claim (which would be prohibited under the common-law rule that prohibits the assignment of personal injury claims). Instead, the insurer would simply require that it be reimbursed by funds collected by the insured from a tortfeasor. See generally Roger M. Baron, *Subrogation: A Pandora's Box Awaiting Closure*, 41 S.D. L. REV. 237, 239 (1996). The evolution of reimbursement as an alternative tool to subrogation has been described by one jurist as, "a creeping erosion of the anti-subrogation principle established at common law." *Lee v. State Farm Mut. Ins. Co.*, 129 Cal. Rptr. 271, 278 (Cal. Ct. App. 1976) (Friedman, J., concurring).

“reimbursement”<sup>37</sup> is of relatively recent origin, having only been developed in the last thirty to forty years.<sup>38</sup>

When a decade-long congressional study<sup>39</sup> (which preceded the adoption of ERISA in 1974) was undertaken, the concept of “reimbursement” for medical expense claims was virtually nonexistent. This is because subrogation itself on personal injury claims had been disallowed by all courts until only recently.<sup>40</sup> Some jurisdictions have never permitted subrogation or reimbursement for medical expense claims.<sup>41</sup> Even today, some jurisdictions, which initially decided to permit subrogation on medical expense claims, have since reconsidered the appropriateness of doing so.<sup>42</sup> These jurisdictions have come to conclude, either by judicial decision or by statute, that subrogation and reimbursement on medical expense claims is inappropriate and should not be allowed.<sup>43</sup>

Despite the fact ERISA is unique and may represent “the most comprehensive and pervasive preemption of the present era,”<sup>44</sup> the fact remains that nothing in the ERISA scheme authorizes or endorses either the concept of reimbursement or the concept of subrogation in the matter of medical expense claims. Neither the matter of reimbursement nor the

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37. It now appears, with a twist of irony, that to distinguish the decision in *Knudson*, which dealt with a reimbursement provision, there has been an effort to characterize a subrogation provision as fundamentally different from the reimbursement provision utilized in *Knudson*. *Bauhaus USA*, 292 F.3d at 445 (Wiener, J., dissenting). “Another important distinction between *Great-West Life* and the instant case is the nature of the obligation that *Bauhaus* . . . asserts is to subrogation, not reimbursement . . . . The subrogation remedy contained in the instant provisions is doctrinally distinguishable from the varieties of restitution discussed in *Great-West Life*.” *Id.* at 451-52 (Wiener, J., dissenting).

The majority in *Bauhaus* concluded differently than Judge Wiener and stated, “We conclude that the facts of the instant case are indistinguishable in principle from *Great-West*.” *Id.* at 445.

The distinction between “pure subrogation” and reimbursement for the purpose of avoiding the stare decisis effect of *Knudson* was rejected in *Extendicare v. Crow*, 2002 WL 32079263, at \*2 (N.D. Tex. Oct. 23, 2002).

38. 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); Baron, *A Pandora’s Box*, *supra* note 36.

39. *Knudson*, 534 U.S. at 209.

40. Baron, *A Pandora’s Box*, *supra* note 36, at 238-41.

41. *Id.* at 240 n.21 and accompanying text; Baron, *Subrogation on Medical Expense Claims*, *supra* note 38, at 584-85.

42. Baron, *Subrogation on Medical Expense Claims*, *supra* note 38, at 584-85. Elaine M. Rinaldi, *Apportionment of Recovery between Insured and Insurer in a Subrogation Case*, 29 TORT & INS. L.J. 803, 807 (1994). Rinaldi reported that twenty-five jurisdictions have now adopted the “make whole” doctrine.

43. Baron, *Subrogation on Medical Expense Claims*, *supra* note 38, at 584-85 nn.26-33.

44. *Bauhaus USA*, 292 F.3d at 445.

matter of subrogation are to be found addressed or endorsed anywhere within the “complete and reticulated” ERISA statutory scheme.<sup>45</sup>

*C. Federal Judicial Opinions Subsequent to Knudson*

Several federal opinions, from both district courts and courts of appeals, decided after *Knudson*, have followed the majority opinion and denied a federal remedy to ERISA plans seeking reimbursement for medical expenses paid for plan members. Other opinions have permitted reimbursement. A few of these post-*Knudson* decisions will be reviewed in the following sections.

**1. Fifth Circuit Court of Appeals.** About four months after the Supreme Court handed down the decision in *Knudson*, the Fifth Circuit Court of Appeals decided *Bauhaus USA, Inc. v. Copeland*.<sup>46</sup> In *Bauhaus* the ERISA plan sought reimbursement of \$46,229.45 for medical expenses paid for a seven-year-old child injured in a car accident.<sup>47</sup> From the negotiated settlement of \$750,000, the sum of \$78,161.47 was deposited into the Registry of the Lee County Chancery Court in Mississippi. Under the applicable Mississippi law, court approval was required for the assignment of a minor’s right to the insurance proceeds. Preferring not to litigate its reimbursement claim in state court, the ERISA plan filed an action in federal court suing the minor, her mother, and the tortfeasors. The plan argued that Mississippi law was preempted by ERISA.<sup>48</sup> The trial court dismissed the plan’s complaint, finding “that ERISA did not preempt Mississippi’s anti-assignment rule, and therefore, that it did not have jurisdiction to hear the case.”<sup>49</sup> The trial court’s decision came in March 2001, some nine months *prior* to the Supreme Court’s decision in *Knudson*.<sup>50</sup> On appeal

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45. “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.” *Member Servs. Life Ins. Co. v. Am. Nat’l Bank & Trust Co. of Sapulpa*, 130 F.3d 950, 958 (10th Cir. 1997) (quoting *Ryan v. Fed. Express Corp.*, 78 F.3d 123, 127 (3d Cir. 1996)).

46. 292 F.3d 439 (5th Cir. 2002).

47. *Id.* at 440. The Plan document actually purported *not* to cover injuries to plan members which resulted from the acts of someone else. According to the opinion, the Plan “honored [the] request for benefits and elected to advance payments for [the minor’s] medical expenses.” *Id.*

48. *Id.* at 442.

49. *Id.* at 441-42.

50. 534 U.S. 204.

the Fifth Circuit did not reach the merits of the question as to whether the state “anti-assignment” law was preempted.<sup>51</sup> The appellate court, rather, followed *Knudson* and affirmed the dismissal because there was a failure of federal jurisdiction.<sup>52</sup> Judge Wiener dissented.<sup>53</sup> The majority opinion reviewed *Knudson* in detail and found that it was indistinguishable.<sup>54</sup> That the disputed proceeds had been deposited in a state court registry was of no consequence to the majority.<sup>55</sup> In his dissenting opinion, Judge Wiener expressed a belief that the location of the funds in the state court registry was sufficient reason to distinguish *Knudson*.<sup>56</sup>

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51. 292 F.3d at 442.

52. *Id.* at 445. “For reasons stated above, we affirm the district court’s dismissal of this suit for lack of federal jurisdiction because ERISA does not authorize this suit. Consequently, we do not reach the parties’ preemption arguments.” *Id.*

53. *Id.* (Wiener, J., dissenting).

54. *Id.* at 443-45.

We conclude that the facts of the instant case are indistinguishable from *Great-West*. Both cases involve ERISA-governed employee benefit plans that include reimbursement provisions allowing the plans to recover from any settlement proceeds any amount the plans advanced for medical expenses resulting from third party wrongdoing. Third-party tortfeasors injured the plan beneficiaries in both cases, and the plans advanced funds to the beneficiaries for medical expenses. In both cases, the plan beneficiaries made tort settlements with third-party tortfeasors following suit in state court. In both, the plan administrator or assignee filed suit in the federal district court seeking declaratory relief that it was entitled to repayment of the benefits it had conferred.

*Id.* at 445.

55. *Id.*

In *Great-West*, the proceeds of the settlement were placed in a private Special Needs Trust outside the possession and control of the plan beneficiary. Nevertheless, the defendants in this case, like the Knudsons in *Great-West*, are not in possession of the disputed funds, a fact that Justice Scalia found extremely important in *Great-West*.

*Id.* at 445.

56. *Id.* at 450-51 (Wiener, J., dissenting).

In deciding today’s case, the majority glides past the most salient factual distinction between this case and *Great-West* . . . . There was no parallel guardianship proceeding and thus no money in a state-court registry, as there are here. The posture of the instant case thus differs markedly from the posture that ultimately determined the outcome in *Great-West Life*.

Funds in the registry of a court are deposited in the *court’s* bank, which is otherwise uninvolved in the case. Such funds are truly in legal limbo vis-à-vis parties in interest . . . . Here the disputed funds have not yet been distributed in the sense seized upon by the Court in *Great-West Life*, and the parties agree that the funds are more than sufficient to satisfy [the plan’s] claim. There is thus no conceivable danger, in this case’s current posture, of the district court’s imposing general, personal, contractual liability on anyone. The relief sought by [the plan]

**2. Seventh Circuit Court of Appeals.** In *Primax Recoveries, Inc. v. Sevilla*,<sup>57</sup> a unanimous Seventh Circuit decision authored by Judge Posner, the court found itself bound to the Supreme Court decision in *Knudson*.<sup>58</sup> Although the facts of the case and the posture of the parties were considerably different than those in *Knudson*, the same result was attained. The opinion in *Primax* is one of the more recent decisions by a federal court of appeals on this issue and was handed down on April 1, 2003.<sup>59</sup> The underlying dispute had been percolating for more than a decade, primarily in Illinois State Court.<sup>60</sup> *Primax* involved a medical expense claim of only \$2,483.71, for which the plan sought reimbursement when the plan member acquired a tort settlement of \$22,000. The tortfeasor's insurer issued a check for the claim amount, \$2,483.71, which was payable to the client, the client's lawyer, and to Primax Recoveries, Inc. ("Primax"), the ERISA plan's assignee for collection purposes. The check was never cashed because Primax would not agree to allow the client's lawyer to retain one-third of the \$2,483.71, pursuant to the Illinois "common fund" doctrine.<sup>61</sup> Primax retained possession of the check and initially brought suit in state court against the plan member and his lawyer, seeking 100 percent of the medical expense claim. In response, a class action counterclaim was asserted on behalf of other employees against whom Primax had similarly refused to permit a common fund deduction for attorney fees.<sup>62</sup> Unhappy with the attempted class action counterclaim,<sup>63</sup> Primax attempted to dismiss

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is not *in personam* against [the minor or her mother], but is *in rem* against funds possessed by a neutral stakeholder.

*Id.* (Wiener, J., dissenting).

57. 324 F.3d 544 (7th Cir. 2003).

58. *Id.* at 547.

59. *Id.* at 544.

60. *Id.* at 546. "This procedurally intricate ERISA case had its origins more than a decade ago . . ." *Id.*

61. *Id.* The "common fund" doctrine is explained in the opinion. *Id.* at 548-49. It is an exception to prevailing American view that attorney fees are not recoverable. This exception permits a deduction of an attorney fee when the attorney "creates a fund" that benefits more than just his client. The rationale is that each person or entity that benefits from the creation and preservation of a common fund should pay his or her share of the costs incurred in the process. The common fund approach in subrogation is one of several doctrines which are utilized to ameliorate the harshness encountered when insurers began asserting subrogation rights for medical expense payments. See Baron, *A Pandora's Box*, *supra* note 36, at 247-60 (discussing the common fund doctrine at 255-60).

62. *Primax*, 324 F.3d at 546.

63. The motion for certification had been made but not ruled upon by the state court. *Primax*, 324 F.3d at 546-47.

its state court action<sup>64</sup> and then filed suit in federal court basing jurisdiction on ERISA. Primax sought a declaration that the plan overrides the state-law common-fund doctrine. The federal trial court dismissed the suit. The court of appeals affirmed the dismissal, coming very close to imposing monetary sanctions against Primax for even bringing the law suit in federal court.<sup>65</sup>

Unlike in *Knudson*, in which the money had been set aside in a Special Needs Trust, in *Primax*, the money that could have reimbursed the ERISA plan was delivered as a check payable to the plan member, the member's attorney, and the ERISA plan's assignee.<sup>66</sup> This difference, however, was not a sufficient distinction to avoid the holding of *Knudson*:

Primax wants . . . \$2,431.78 from [plan member] Sevilla. It is true that Primax is holding on to the check from the third party's insurer, but the check is worthless without the endorsement of Sevilla's lawyer . . . , and while one could imagine construing Primax's suit as a suit for an injunction commanding the lawyer to do that, this would distort the reality of the claim. Primax doesn't want the check as such; it wants the money, and it claims that under the plan Sevilla owes the money to it. That is a claim of breach of contract, which is a classic legal claim. Almost any legal claim can be given the *form* of an equitable claim (that is, a claim seeking an order to do or not do something), but such games with form should be discouraged . . . . So to this day the fund remains in the hands of the insurer, who is not a defendant. You can impose a constructive trust only on a defendant . . . or someone in privity with the defendant.<sup>67</sup>

In describing the state of the law concerning the ability of a plan to sue a plan member, as a result of the decision in *Knudson*, the Seventh Circuit's opinion states,

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64. Primax attempted to release the plan member from any reimbursement obligation, but, as pointed out by Judge Posner, even if the dispute with the named plaintiff is rendered moot, the remaining class members' claims remain viable. *Id.* at 546.

65. *Id.* at 547-50.

Primax's suit has indeed been a travesty. Desperately seeking to derail a counterclaim filed in the forum that it itself had chosen for litigating its dispute with [the plan member], it filed a suit in federal court over which the court had no jurisdiction. Had [the plan member] not muddied the waters by refusing to accept the release of Primax's claim against it, we would consider Primax's claim deserving of monetary sanctions. As it is, let a sharp rebuke suffice. *Id.* at 550.

66. *Id.* at 546.

67. *Id.* at 547-48.

The Supreme Court, consistent with an earlier decision by this court<sup>68</sup>] . . . has now made clear that . . . an ERISA fiduciary . . . may not sue a plan participant or plan beneficiary under ERISA unless it is seeking equitable relief, such relief includes not just an injunction but also the imposition of a constructive trust on money claimed to be wrongfully withheld from the plaintiff.<sup>69</sup>

The opinion in *Primax* also goes to some length to demonstrate that the underlying dispute did not arise under ERISA but rather arose under the common fund doctrine of Illinois.<sup>70</sup> And, even if a state court defendant may be able to defend the common fund claim by interposing ERISA preemption, it would still be a state law claim.<sup>71</sup> The opinion states, “federal jurisdiction depends on the claim, not upon defenses, even ERISA preemption defenses. Anyway we have held that ERISA does *not* preempt common fund claims.”<sup>72</sup>

**3. Ninth Circuit Court of Appeals.** In *Westaff (USA), Inc. v. Arce*,<sup>73</sup> an ERISA plan sued its plan member seeking reimbursement of medical expenses when she acquired a settlement of \$15,000 against the tortfeasor. The check from the tortfeasor’s insurer was made payable to both the plan member and to Westaff, the ERISA plan, as co-payees. By agreement, the check was cashed and placed in escrow.<sup>74</sup> The ERISA plan attempted “to characterize its claim as one for equitable relief, labeling it a declaratory judgment action or action for specific performance.”<sup>75</sup> The trial court held that the action was basically an action seeking a money judgment, which was not permitted under the ERISA statutes. It dismissed the action and awarded attorney fees to

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68. The majority opinion in *Knudson*, authored by Justice Scalia, quotes Judge Posner’s opinion in *Wal-Mart Stores, Inc. v. Wells*, 213 F.3d 398, 401 (7th Cir. 2000). 534 U.S. at 210.

69. 324 F.3d at 547.

70. *Id.* at 548.

71. *Id.* at 549.

72. *Id.* Compare with *Arana v. Ochsner Health Plan*, 338 F.3d 433 (5th Cir. 2003), which holds that the insured’s declaratory judgment action filed in state court (seeking disposition of a tort settlement proceeds free of reimbursement) was completely preempted by ERISA despite the fact the claim was not conflict-preempted by ERISA. *Id.* at 439. In making the distinction between complete preemption and conflict preemption, the court stated, “Conflict preemption, also known as ordinary preemption, arises when a federal law conflicts with state law, thus providing a federal defense to a state law claim, but does not completely preempt the field of state law so as to transform a state law claim into a federal claim.” *Id.*

73. 298 F.3d 1164 (9th Cir. 2002).

74. *Id.* at 1166.

75. *Id.*

the plan member.<sup>76</sup> The Ninth Circuit affirmed both the dismissal and the award of attorney fees.<sup>77</sup> With regard to the fact that the money had been placed in escrow, the appellate court stated,

This case differs from our prior cases only in that the money at issue, a legitimate personal injury settlement to which the beneficiary is entitled, has been placed in an escrow account and remains specifically identifiable. The action remains one for money damages. The district court correctly recognized this and dismissed the case for failure to state a claim.<sup>78</sup>

With regard to the attorney fees awarded to the plan member, the argument was made that the trial court lacked jurisdiction to make the award.<sup>79</sup> This argument was rejected by the appellate court, which recognized that the dismissal was on the merits because the ERISA plan's complaint failed to state a claim, not due to a lack of subject matter jurisdiction.<sup>80</sup>

In a more recent opinion involving an assertion of restitution, but not in the context of a personal injury claim, the Ninth Circuit again denied a federal forum to an ERISA plan.<sup>81</sup> The court stated, "The Supreme Court cases interpreting § 1132(a)(3) mark a steadily shrinking field of 'appropriate equitable relief' available to plan fiduciaries."<sup>82</sup>

**4. Other Federal Opinions.** This Article will not attempt to present a review of all the federal court opinions which have been handed down since *Knudson*. A brief summary follows.

Few additional post-*Knudson* opinions exist in the federal courts of appeals which deal with situations involving reimbursement. Two

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76. *Id.*

77. *Id.*

78. *Id.* at 1167.

79. *Id.*

80. *Id.*

We have held that a district court lacks jurisdiction to award fees under a fee-shifting statute if it has dismissed a case for lack of subject matter jurisdiction, unless the fee-shifting statute provides an independent jurisdictional basis . . . . However, when an ERISA plan administrator brings a suit seeking non-equitable relief, dismissal is properly on the merits for failure to state a claim, rather than for lack of subject matter jurisdiction . . . . The district court had jurisdiction to enter a fee award.

*Id.*

81. Honolulu Joint Apprenticeship & Training Comm. of United Ass'n Local Union No. 675 v. Foster, 332 F.3d 1234 (9th Cir. 2003).

82. *Id.* at 1237 (denying federal forum to ERISA plan seeking repayment of \$13,183.92 for costs in training defendant as apprentice in plumbing and pipefitting industry, after defendant breached terms of contract for training by working for non-union employer).

opinions by the Sixth Circuit have denied ERISA plans the opportunity to seek reimbursement in federal court.<sup>83</sup> Both of these opinions were “Not Recommended for Full-Text Publication.”<sup>84</sup> Also, a Fourth Circuit decision permitted an ERISA plan to assert a lien on the proceeds of a settlement secured by a bankruptcy court debtor, affirming the decisions of both the bankruptcy court and the district court.<sup>85</sup> Similar to the Sixth Circuit cases, this case was “not selected for publication.”<sup>86</sup>

At the district court level, numerous opinions deny ERISA plans the right to seek reimbursement.<sup>87</sup> However, some opinions permit the

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83. *Cmty. Ins. Co. v. Morgan*, 54 Fed. Appx. 828, 29 Employee Benefits Cas. 2104, 2002 WL 31870325 (6th Cir. Dec. 20, 2002); *Unicare Life & Health Ins. Co. v. Saiter*, 37 Fed. Appx. 171, 2002 WL 1301574 (6th Cir. June 10, 2002).

84. *Morgan*, 54 Fed. Appx. at 828; *Saiter*, 37 Fed. Appx. at 171.

85. *In re Carpenter*, 36 Fed. Appx. 80, 2002 WL 1162277 (4th Cir. June 3, 2002).

86. *Id.* at 80.

87. There are many such reported opinions. Only a few are set forth here: *Primax Recoveries Inc. v. Goss*, 240 F. Supp. 2d 800 (N.D. Ill. 2002). In that case, the ERISA plan, which had paid \$491,641.78 in medical benefits, sought to impose a trust prospectively on recovery when it is realized by plan member. *Id.* at 801.

The only factual difference between this case and *Knudson* is that here plaintiffs seek to impose a trust on funds which have not yet been received (and may never be) by defendant . . . . We read the Court’s opinion in *Knudson* to stand for the proposition that, regardless of their motivation, Congress drew a clear line between suits-at-law and suits-at-equity, only the latter of which are authorized . . . . Allowing suits of this nature would allow parties to circumvent the statute based simply on *when* they file the lawsuit, rather than the relief they desire. We believe that suits like this are basically suits for money damages “since they seek no more than compensation for loss resulting from the defendant’s breach of legal duty.”

*Id.* at 802-03 (internal citations omitted). This case also cites *Primax Recoveries, Inc. v. Carey*, 247 F. Supp. 2d 337 (S.D.N.Y. 2002), in which Judge Lynch held that a similar suit by an ERISA plan was barred by the decision in *Knudson*. *Id.* at 345. Judge Lynch stated, “Surely the same conclusion follows *a fortiori* when the ‘settlement proceeds’ are in nobody’s possession, because they are the entirely hypothetical fruit of a potential future settlement that does not yet exist and may never come into being at all.” *Id.* at 342 n.5.

In *Extencicare v. Crow*, 2002 WL 32079263 (N.D. Tex. Oct. 23, 2002), the liability insurer tendered policy limits of \$50,000, but the plan member had not yet settled. *Id.* at \*1. “In the instant case, however, Defendant Crow has made no settlement with any third-party tortfeasor. Like the plan beneficiaries in both *Great-West Life* and *Copeland*, Defendant Crow is not in possession of the disputed funds.” *Id.* at \*4. This opinion also rejects the urged distinction that the ERISA plan in this case was seeking “pure subrogation” as opposed to reimbursement as seen in *Knudson*. *Id.* at \*2.

In *Asbestos Workers Local No. 42 Welfare Fund v. Brewster*, 227 F. Supp. 2d 226 (D. Del. 2002), funds that were previously placed in an escrow account were fully paid out, and the court rejected the ERISA plan’s claim for reimbursement. *Id.* at 228.

In response to the Defendant’s Motion, the Plan attempts to distinguish this case from *Knudson* on the basis that the funds at issue in *Knudson* were in trust and not under the control of the plan participant, as is the case here where the funds

ERISA plan reimbursement, therefore finding a way to distinguish *Knudson*.<sup>88</sup> The most dominant “exception” to the *Knudson* result

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have been dispersed to the Defendants . . . . The Court is unpersuaded by the Plan’s attempt to distinguish this case from *Knudson*.

*Id.*

The court in *Carey* rejected an effort by the ERISA plan’s assignee to assert a lien on tort settlement or recovery while the tort action was still pending. 247 F. Supp. 2d at 345. “Although the majority’s reasoning was sharply criticized in two dissenting opinions, . . . *Knudson* authoritatively resolves the scope of ERISA’s civil enforcement provision.” *Id.* at 342. This opinion also stated that recovery is barred by the underlying substantive New York law, which excludes from recovery to the tort plaintiff “any such cost or expense [that] was or will with reasonable certainty, be replaced or indemnified from any collateral source.” *Id.* at 343. “Pursuant to that rule, if *Carey* prevails in her state court action, any judgment she receives will be reduced by the amount awarded to her under the Plan, specifically, by the \$91,688.88 *Primax* seeks.” *Id.*

88. A few such decisions are summarized here. In *Forsling v. Keller & Assocs.*, 241 F. Supp. 2d 915 (E.D. Wis. 2003), the action was commenced by a plan member against the plan. Defendant plan impleaded the liability insurer, which stood ready to pay the policy limit of \$50,000. *Id.* at 916.

[Plan] admits (as it must) that it is seeking to recover money, but argues that it has followed the lead of *Knudson* and has adequately stated grounds in equity for the imposition of a constructive trust on the property at issue here. It is not, as in *Knudson*, seeking to impose personal liability upon the plaintiffs, as plaintiffs are not in possession of the property in dispute, and the funds are held by a named defendant and have not been dissipated.

*Id.* at 918.

The court in *IBEW-NECA Southwestern Health & Benefit Fund v. Douthitt*, 211 F. Supp. 2d 812 (N.D. Tex. 2002), stated

The facts of the instant case are distinguishable from *Great-West Life and Copeland*. First, [p]laintiffs seek to impose a constructive trust over funds currently being held by [d]efendant’s attorney in his client trust account . . . . Second, unlike the settlement proceeds in *Copeland* and in *Great-West Life*, the funds held by [d]efendant in this case are presently within his possession and control.

*Id.* at 816. The court cited, as supporting authority, three additional federal district court opinions from the Middle District of Georgia, the Northern District of Illinois, and the District of North Dakota. *Id.*

In *Primax Recoveries, Inc. v. Lee*, 260 F. Supp. 2d 43, (D.D.C. 2003), the court stated,

[i]n this case, a portion of the settlement funds are being held in trust by defendant’s prior attorney . . . . While defendant’s current counsel is unaware of the amount of funds being so held, . . . the Court cannot conclude that the funds sought are so far dispersed that they no longer are traceable to defendant. On the contrary, it appears that defendant has set aside these funds for the precise purpose of reimbursing the Plan and that the money at issue therefore has been “dissipated” no farther than directly into a trust held by defendant’s former attorney . . . . Under post *Great-West* case law, plaintiff’s claim therefore seems to be a claim for restitution in equity (not in law), and the motion to dismiss therefore must be denied.

*Id.* at 48.

occurs when the funds are in the possession and control of a named defendant.<sup>89</sup> This exception has been termed as the “possession theory” exception to *Knudson*.<sup>90</sup> Under this theory, *Knudson* would prohibit actions by ERISA plans to seek reimbursement only “if the insured is not in the possession of clearly identifiable proceeds.”<sup>91</sup> Not all opinions that favor the ERISA plan fall under the possession theory.<sup>92</sup> Note that the possession theory is inconsistent with the view recently expressed by the Ninth Circuit that an ERISA plan simply has no cause of action for reimbursement.<sup>93</sup>

##### 5. Continued Absence of Public Policy Considerations.

Throughout the many federal decisions handed down since *Knudson*, any real discussion of the underlying public policy considerations as to why reimbursement should be permitted is absent. As with the majority and dissenting opinions in *Knudson*, the statutory scheme of ERISA is the primary point of focus. Additionally, most of the analyses by the lower courts attempt to review the language of the opinion in *Knudson* and to decipher exactly what it means. As suggested in the title to this Article, the time has come for judicial authorities to do more. The significant public policy reasons that warrant the denial of reimbursement to ERISA plans should now be considered.

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89. See *Forsling*, 241 F. Supp. 2d at 918; *IBEW-NECA*, 211 F. Supp. 2d at 816.

90. *Wellmark, Inc. v. Deguara*, 257 F. Supp. 2d 1209, 1214-16, (S.D. Iowa 2003).

Post-*Great-West* courts dealing with the issue of whether subrogation clauses can be litigated under ERISA have taken two different approaches. Several courts have reasoned that after *Great-West*, the type of relief the insurer seeks turns on whether the insured is in possession of funds . . . . On the other hand, the Ninth Circuit found that *any* attempt by an insurer to enforce the terms of a subrogation clause is a request for reimbursement which is legal relief and not available under § 502(a)(3) . . . . This Court finds the possession theory is the correct read of *Great-West*. That is, attempts by an ERISA plan or insurer to recover settlement proceeds to which it is entitled under a subrogation or reimbursement provision are only prohibited under § 502(a)(3) if the insured is not in the possession of clearly identifiable proceeds.

*Id.* at 1214-17.

91. *Id.* at 1216.

92. *E.g., Lee*, 260 F. Supp. 2d at 48.

93. *Westaff (USA)*, 298 F.3d at 1166 (“However, when an ERISA plan administrator brings a suit seeking non-equitable relief, dismissal is properly on the merits for failure to state a claim, rather than for lack of subject matter jurisdiction . . . . The district court had jurisdiction to enter a fee award.”).

The inconsistency between the “possession theory” and the Ninth Circuit view was recognized by the court in *Wellmark v. Deguara*, 257 F. Supp. 2d at 1215.

### III. PUBLIC POLICY CONSIDERATIONS SURROUNDING THE REIMBURSEMENT QUESTION

#### A. *Historically Disfavored*

The historical roots of the doctrine of subrogation lie in equity.<sup>94</sup> A long history of subrogation exists in connection with property insurance and property damage claims, but at common law, subrogation was not permitted on personal injury claims.<sup>95</sup> A personal injury claim could not be “assigned” at common law and, therefore, efforts to have subrogation on personal injury claims ran afoul of this principle.<sup>96</sup>

The effort to seek subrogation on personal injury claims also violated the common-law prohibition against splitting a cause of action.<sup>97</sup> The existing practice of permitting subrogation on property damage claims had been tolerated as an exception to this prohibition, but historically, courts were unwilling to permit an exception in the area of personal injury claims.<sup>98</sup>

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94.

The principle of subrogation will be applied or not, according to the dictates of equity and good conscience, and to consideration of public policy, resting, as it does, upon the maxim that no one should be enriched by another's loss. In fact, subrogation is not a matter of strict right, nor does it necessarily rest on a contract, but is purely equitable in nature, and will not be enforced when it would work injustice to the rights of those having equal equities. Subrogation is an established branch of equitable jurisprudence, being a creature of the courts of equity, and having for its basis, the doing of complete and perfect justice, without regard to form, in all cases where the equities demand it.

16 GEORGE J. COUCH, COUCH ON INSURANCE § 61:19 at 97-98 (2d ed. 1983).

“[T]he English doctrine of subrogation is a ‘local’ creation. Its beginnings may be found in equity, particularly during the Chancellorship of Hardwicke.” M.L. Marasinghe, *An Historical Introduction to the Doctrine of Subrogation: The Early History of the Doctrine II*, 10 VAL. U. L. REV. 275, 298 (1976).

See also Eric J. Pickar, *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, 323 (2002).

95. Baron, *Subrogation on Medical Expense Claims*, *supra* note 38, at 583; Baron, *A Pandora's Box*, *supra* note 36, at 238 nn.7-10.

96. Baron, *A Pandora's Box*, *supra* note 36, at 239 n.13; Baron, *Subrogation on Medical Expense Claims*, *supra* note 38, at 583 n.11 and accompanying text.

97. *E.g.*, *Nationwide Mut. Ins. Co. v. DeJane*, 326 N.E.2d 701 (Ohio Ct. App. 1974).

98. In *Nationwide* the court recognized that subrogation on property damage claims was an authorized exception to the prohibition against splitting a cause of action. *Id.* at 703-04. But, as to personal injury claims, the court stated, “We feel that by not permitting subrogation of medical expenses we are preserving the orderly nature of practice in this state by following the rule that one cannot split a cause of action, avoid multiplicity of suits

Efforts to create a right of subrogation on personal injury claims intensified in the 1960s. Insurers attempted to create the same sort of property damage subrogation right for those policy provisions that provided medical expense coverage in connection with automobile policies.<sup>99</sup> With persistence by insurers, the right of subrogation began to be recognized in first-party medical payments coverage in automobile policies, uninsured and underinsured motorist coverage, and eventually in medical and hospitalization coverage.<sup>100</sup>

Because the creation of a right of subrogation on a medical expense claim could be easily viewed as a transparent attempt to create an assignment of a personal injury claim, insurers also utilized the seemingly less offensive, but equally effective, "right of reimbursement."<sup>101</sup> Some jurisdictions refused to extend subrogation rights into personal injury claims, recognizing that to do so would be equivalent to

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and benefit the insured public and the public at large." *Id.* at 705.

99. A partial history of the "evolution" of the forms utilized from 1965 forward can be found in *Lee v. State Farm Mut. Ins. Co.*, 129 Cal. Rptr. 271 (Cal. Ct. App. 1976) (adjudicating the validity of the insurer's progressive efforts to establish an obligation of "reimbursement" for medical expense claims).

100. Baron, *Subrogation on Medical Expense Claims*, *supra* note 38, at 79.

101. *In re Estate of Scott*, 567 N.E.2d 605 (Ill. App. Ct. 1991).

The estate also argues that [the Plan's] subrogation interest amounts to an assignment of a personal tort, which is void against public policy . . . . Contrary to the estate's assertion, the language of the Plan's subrogation provision does not call for the full assignment of the insured's rights but, rather, mere reimbursement of amounts forwarded by the Plan.

*Id.* at 607. (ERISA plan, which had paid \$200,000 in medical expenses allowed to recover entire balance of settlement (\$82,000), recovered from tortfeasor following payment of court-approved fees, leaving nothing for plan beneficiary who was seriously injured while riding as a passenger on a motorcycle).

Plaintiffs place emphasis upon the fact that each of the challenged provisions is prefaced by the label "subrogation." Subrogation or assignment of a cause of action for personal injury operates to transfer from one person to another that cause against a third party. The reasons of policy against the assignment or subrogation of certain personal causes do not apply to insurance policy provisions that merely require the insured to reimburse the insurer out of any recovery or settlement.

*Lee*, 129 Cal. Rptr. at 276; *Compare*

I concur, but with reluctance . . . [citation of two earlier California decisions omitted] . . . In composite, these two decisions represent a creeping erosion of the anti-subrogation principle established at common law . . . . The successive amendments of State Farm's "reimbursement" clauses illustrate how eagerly and quickly the disingenuous draftsmen of insurance policies move into the gaps created by decisional erosion . . . . The cumulative effect of the policy provisions is to create the economic reality of subrogation to the personal injury claim without its language.

*Id.* at 278 (Freidman, J., concurring).

“lifting the lid on a Pandora’s Box crammed with both practical and legal problems.”<sup>102</sup> Some jurisdictions that initially agreed to allow the extension have since reconsidered, either by judicial decision<sup>103</sup> or by legislative action,<sup>104</sup> and have retreated back to the historical view prohibiting subrogation and reimbursement for medical expense claims.<sup>105</sup>

The idea that the doctrine of subrogation for medical expense claims has “flourished under the law”<sup>106</sup> is simply wrong.<sup>107</sup> Even in the jurisdictions where it is permitted, tremendous litigation over its propriety has occurred.<sup>108</sup> The vast majority of jurisdictions have adopted restrictive doctrines designed to ameliorate the harshness which accompanies the allowance of subrogation or reimbursement in personal injury cases.<sup>109</sup> The most common of these restrictive doctrines is the

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102. *Travelers Indem. Co. v. Chumbley*, 394 S.W.2d 418, 425 (Mo. Ct. App. 1965); see also *State Farm Fire & Cas. Co. v. Knapp*, 484 P.2d 180 (Ariz. 1971) (quoting *Chumbley*, 394 S.W.2d at 425).

103. Baron, *Subrogation on Medical Expense Claims*, *supra* note 38, at 585 nn.26-29.

104. *Id.* at 585 nn.30-33.

105. *Id.* nn.33-36.

106. Brief of Amici Curiae The American Association of Health Plans et al. *Knudson*, 534 U.S. 204 (2002) (No. 99-1786). The amicus brief filed with the Supreme Court by the health insurance industry in the *Knudson* case asserted, “Private insurers have been relying on reimbursement mechanisms since at least the mid-eighteenth century to ensure that coverage remains accessible and affordable for all.” *Id.* at 8.

107.

The Health Insurance Industry Brief correctly states that doctrine of subrogation generally has a long history in the law, . . . but incorrectly suggests that subrogation by health insurers in personal injury cases has an equally long history. In fact, subrogation by health insurers is a practice of relatively recent origin, and the historic body of law permitting subrogation stems from property damage cases, and not from personal injury cases.

Brief of Amici Curiae Maryland HMO Subrogation Plaintiffs at 17, *Knudson*, 534 U.S. 204 (2002) (No. 99-1786).

108. See generally Baron, *A Pandora’s Box*, *supra* note 36, at 238-60.

109. *Id.* Five such doctrines have evolved. *Id.* Beginning with that which is most beneficial to the insured and progressing to the least beneficial, they are as follows: (1) outright denial of subrogation, *Id.* at 247; (2) the “make whole” doctrine where the actual amount considered is that received by the insured after payment of attorney fees and costs, *Id.* at 249; (3) the “make whole” doctrine where the insured is assumed to receive 100% of the recovery from the tortfeasor, *Id.*; (4) the “pro rata loss sharing” method where the insurer takes a corresponding reduction in its subrogated recovery to match the reduction taken by the insured, *Id.* at 252; and (5) the “common fund” doctrine. *Id.* at 256. See *id.* at 247-60.

“make whole” doctrine,<sup>110</sup> which has also been supported by federal courts through the application of “federal common law.”<sup>111</sup>

*B. “Because We Say So”—The Unilateral Nature of Reimbursement*

The primary argument asserted by ERISA plans for the enforcement of reimbursement provisions is simply that the plan has incorporated the right of reimbursement into the plan document and that it should be enforced.<sup>112</sup> The right of reimbursement, although unilaterally implanted into the plan document, was described by the petitioners in *Knudson* as “a vitally important provision of the Plan.”<sup>113</sup> Petitioners also urged the Court to consider that “another primary objective of ERISA is to ensure the enforcement of the terms of a plan.”<sup>114</sup>

This argument, articulated in the first person of the ERISA plans themselves, could be stated as follows: “We have given ourselves the right to reimbursement and it should be enforced without question.” Reduced to basic terms, the argument is simply, “Because we say so.” The simplicity of this argument also exists in Justice Stevens’s brief dissenting opinion, in which he stated the following:

Contrary to the Court’s current reluctance to conclude that wrongs should be remedied, I believe that the historic presumption favoring the provision of remedies for violations of federal rights should inform our construction of the remedial provisions of federal statutes. It is difficult for me to understand why Congress would not have wanted to provide recourse in federal court for the plan violation disclosed by the record in this case.<sup>115</sup>

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110. Elaine M. Rinaldi, *Apportionment of Recovery Between Insured and Insurer in a Subrogation Case*, 29 TORT & INS. L.J. 803, 807 (1994) (listing 25 states, in alphabetical order, which have adopted some version of the “make whole” doctrine).

111. 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, 437 (2000) (reviewing the many federal court decisions that have imposed the “make whole” doctrine as a matter of federal common law).

112. The following argument was set forth in the Brief filed by Petitioners in *Knudson*: As the U.S. Court of Appeals for the Sixth Circuit has stated, “a primary purpose of ERISA is to ensure the integrity and primacy of the written plans . . . .” Affirming the Ninth Circuit’s holding in this case, however, would leave the Plan without a remedy to enforce a vitally important provision of the Plan. . . . Petitioners’ Brief at 28, *Knudson*, 534 U.S. 204 (2002) (No. 99-1786).

113. *Id.* at 29.

114. *Id.* at 31.

115. *Knudson*, 534 U.S. at 223 (Stevens, J., dissenting) (footnotes omitted).

This view assumes that whatever is put into the plan document controls absolutely.<sup>116</sup> Whatever the plan deems as a “wrong” or a “violation” would automatically warrant a federal judicial remedy without regard to the lawfulness or appropriateness of the provision in question. This argument is further supported, in bootstrapping fashion, by the provision of the ERISA scheme that “requires fiduciaries to act in accordance with the terms of a plan.”<sup>117</sup>

What cannot be asserted is that ERISA itself provides for any right of reimbursement. ERISA statutorily requires a written plan.<sup>118</sup> ERISA includes statutory provisions that dictate what is required<sup>119</sup> to be in the plan, and statutory provisions dictate what optional features may be included.<sup>120</sup> But, nothing in the ERISA scheme endorses reimbursement or suggests that reimbursement is permitted under ERISA. The device of “reimbursement” was only recently created as part of the evolving law of subrogation on personal injury claims.<sup>121</sup> ERISA was adopted by Congress in 1974, and this adoption was preceded by a decade long congressional study.<sup>122</sup> During this time period of study, from the early 1960s to the early 1970s, it is doubtful that the matter of reimbursement was even in existence as an insurance lexicon.

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116. This view was also recently taken in the Seventh Circuit opinion in *Administrative Committee of the Wal-Mart Stores, Inc. Assocs. Health & Welfare Plan v. Varco*, 338 F.3d 680 (7th Cir. 2003), in which the court upheld the plan’s language which attempted to negate the common fund doctrine by granting itself the right to recover 100 percent of benefits paid, requiring the beneficiary to be solely responsible for attorney fees. *Id.* at 692. The court stated,

Finally, [the beneficiary] argues that by allowing the Committee to recoup its medical payments even though it did not pay for the legal prosecution of the action, we are essentially awarding them unjust enrichment. However, the unambiguous language of the Plan obligates her to repay the benefits paid in full without a pro rata deduction for her legal expenses, and thus any so-called enrichment is not unjust.

*Id.*

117. Petitioner’s Brief at 31, *Knudson*, 534 U.S. 204 (2002) (No. 99-1786). Footnote 13 of the brief cites § 404(a)(1)(D), codified at 29 U.S.C. § 1104(a)(1)(D) (2000), which provides, [A] fiduciary shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries and . . . in accordance with the documents and instruments governing the plan insofar as such documents and instruments are consistent with the provisions of this subchapter and subchapter III of this chapter.

118. 29 U.S.C. § 1102(a) (2000), compare with 29 U.S.C. § 1022 (2000) (requiring a written summary of the plan be furnished to participants and beneficiaries).

119. 29 U.S.C. § 1102(b) (2000).

120. 29 U.S.C. § 1102(c) (2000).

121. See *supra* notes 36-38, 101 and accompanying text.

122. *Knudson*, 534 U.S. at 209.

Certainly, the idea of reimbursement had yet to be presented or approved by the courts.<sup>123</sup>

Although the ERISA scheme contains some detailed reporting requirements,<sup>124</sup> plans are free to amend the language of their plan documents as they see fit.<sup>125</sup> In fact the Supreme Court held in 1995, “[W]e are mindful that ERISA does not create any substantive entitlement to employer-provided health benefits or any other kind of welfare benefits. Employers or other plan sponsors are generally free under ERISA, for any reason at any time, to adopt, modify, or terminate welfare plans.”<sup>126</sup>

Furthermore, amendment of plan language, under ERISA, is not subject to approval by any administrative or judicial authority. The plan documents are unilaterally written and amended.<sup>127</sup> The inclusion of

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123. Reimbursement for a medical expense claim was recognized in 1975 in South Dakota and in 1976 in California. *Schuldt v. State Farm Mut. Auto Ins.*, 238 N.W.2d 270 (S.D. 1975); *Lee v. State Farm Mut. Ins. Co.*, 129 Cal. Rptr. 271 (Cal. Ct. App. 1976).

124. 29 U.S.C. §§ 1021-1031 (2000).

125. In the ongoing litigation spurred by efforts to seek reimbursement, there have been decisions which may be “drafted around.” For example, in *Cagle v. Bruner*, 112 F.3d 1510 (11th Cir. 1997), the court adopted the “make whole” doctrine as a default rule unless “the plan does not explicitly preclude operation of the doctrine.” *Id.* at 1521. Countless ERISA plans have since been amended so as to exclude the operation of the “make whole” by stating something to the effect, “The plan has the right to be reimbursed from any money you collect from someone who caused your injuries, even if you are not fully compensated for your injuries.” *Id.* at 1518.

Similarly, plans have attempted to draft around the “common fund” doctrine, which is prevalent under Illinois law and has been upheld in the federal courts in the Seventh Circuit. It appears that at least one ERISA plan scored a recent victory with its self-serving unilateral amendment. In *Varco*, the court observed,

Significantly, for the purposes of appeal, the Plan includes a provision stating that the Committee has a right to “recover or subrogate 100 percent of the benefits paid or to be paid by the Plan on your behalf and/or your dependents to the extent of . . . [a]ny judgment, settlement or any payment made or to be made, relating to the accident, including but not limited to other insurance.” The Plan further provides that it “does not pay for nor is responsible for the participant’s attorney’s fees. Attorney’s fees are to be paid solely by the participant.”

338 F.3d at 683. In distinguishing prior case law in the Seventh Circuit, which upheld the “common fund” doctrine, the court in *Varco* stated,

The plan at issue in [the prior case] did not expressly require beneficiaries to pay their own attorney’s fees. In this case, the Plan specifically provides that it “does not pay for nor is responsible for the participant’s attorney’s fees. Attorney’s fees are to be paid solely by the participant.”

*Id.* at 689.

126. *Curtiss-Wright Corp. v. Schoonejongen*, 514 U.S. 73, 78 (1995).

127.

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

provisions relating to reimbursement or subrogation is neither specifically authorized nor is it specifically prohibited by statute. Accordingly, the assertion by ERISA plans that reimbursement should automatically be granted because the plan document provides for it should carry little weight.

As previously stated in this Article,<sup>128</sup> neither the matter of reimbursement nor the matter of subrogation is addressed or endorsed anywhere within the “complete and reticulated” ERISA statutory scheme.<sup>129</sup> On the other hand, in looking at legislative history, Congress was motivated, at 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.”<sup>130</sup> The very first statutory provision of the ERISA scheme sets forth a declaration of congressional policy, including the following statement: “[I]t is therefore desirable in the interests of employees and their beneficiaries, for the protection of the revenue of the United States, and to provide for free flow of commerce, that minimum standards be provided assuring the equitable character of such plans.”<sup>131</sup>

Was it within the stated policy of Congress for Janette Knudson, a quadriplegic, to be rendered penniless because her ERISA plan unilaterally required that she reimburse it for medical expenses paid? Is there an “equitable character” in such a result? When looking at the ERISA scheme and its legislative history, the inescapable conclusion is that the spirit and purpose of ERISA provide greater support for prohibition of reimbursement than for its authorization.

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very thing subrogation was created to prevent. As noted by Freedman, “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.”

Pickar, *supra* note 94, at 338 (quoting WARREN FREEDMAN, FREEDMAN’S RICHARDS ON INSURANCE 360 (6th ed. 1990)).

128. See *supra* note 44-45 and accompanying text.

129. “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.” *Member Servs. Life Ins. Co. v. Am. Nat’l Bank & Trust Co. of Sapulpa*, 130 F.3d 950, 958 (10th Cir. 1997) (quoting *Ryan v. Fed. Express Corp.*, 78 F.3d 123, 127 (3d Cir. 1996)).

130. H.R. REP. NO. 93-533, at 9 (1974), *reprinted in* 1974 U.S.C.C.A.N. 4639, 4647. See also Kono, *supra* note 111, at 444 (“The clear focus of ERISA intent was on its intended beneficiaries, the ‘workers.’”).

131. 29 U.S.C. § 1001(a) (2000).

C. *Compensation or Windfall?*

Recalling the facts in *Knudson*, a healthy Janette Knudson was rendered quadriplegic by a car accident. The ERISA plan and its insurer paid \$411,157.11 of her medical expenses. She recovered a settlement from the tortfeasors in the amount of \$650,000. Following payment of attorney fees, costs, and partial reimbursements, Janette Knudson was to receive the benefit of \$265,745.30 through a Special Needs Trust.<sup>132</sup>

The amicus curiae brief filed by several members of the health insurance industry<sup>133</sup> asserted that the “lower court’s holding . . . allows a few ERISA beneficiaries to be unjustly enriched at the expense of their fellow plan beneficiaries.”<sup>134</sup> The brief also argued that the lower court’s decision resulted in a “windfall to one plan member [which] must inexorably come out of the pockets of the rest.”<sup>135</sup>

Has Janette Knudson been unjustly enriched? Has she secured a windfall? Or, has she simply secured just compensation, albeit still less than her actual damages, which she should be permitted to retain?

Thus lies the real crux of the reimbursement proposition. Is it a “windfall” to allow this quadriplegic victim to keep her \$265,745.30 Special Needs Trust? Should all of the net recovery be turned over to the ERISA plan and its insurer? Do the interests of the ERISA plan and its insurers outweigh the interests of the injured member who suffers a catastrophic loss? At first blush, these may appear to be hard questions. And, lying just beneath the surface of these questions are additional questions: If reimbursement is permitted, will the recovered funds *really* benefit the plan members? If so, to *what extent*? If reimbursement is denied, will the plan still operate and provide continued benefits for plan members?

Reflecting upon the situation in *Knudson*, only \$75,000 was actually spent by the ERISA plan. The remainder of the \$411,157.11 was paid by Great-West Life & Annuity Insurance Company. Accordingly, in the event reimbursement had been permitted, the ERISA plan itself would have actually received less than twenty percent of the amount reim-

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132. 534 U.S. at 207.

133. Brief filed on behalf of The American Associations of Health Plans, The American Benefits Council, The Blue Cross Blue Shield Association, The Chamber of Commerce of the United States, and The Health Insurance Association of America. Brief of Amici Curiae the American Associations of Health Plans et al., *Knudson*, 534 U.S. 204 (2002) (No. 99-1786).

134. *Id.* at 11.

135. *Id.* at 16.

bursed, with the remainder going to the commercial insurer, which had agreed to assume the risk for catastrophic losses.

A considerable sum of money is at stake in the ultimate resolution of the reimbursement issue. In *Knudson* the Supreme Court was told that “[m]illions and potentially billions of dollars are recouped annually by health plans and insurers by virtue of subrogation and other recovery mechanisms.”<sup>136</sup> This creates yet another problem for the insured plan member. As the efforts to seek subrogation and reimbursement for medical expense claims has grown, so too has the development of private collection firms,<sup>137</sup> which seek recovery of these dollars through assignments from the ERISA plan and their insurers.<sup>138</sup> Certainly this industry provides employment to many people, as do the private subrogation departments of existing insurers and ERISA plans. But, is this what society desires? Does society want to provide jobs for bill collectors that are funded by tort recoveries of innocent victims who have suffered catastrophic losses? Now that these bill-collecting entities have been established, they become additional sources of lobby influence in our legislatures and additional sources of input to courts in their judicial decision-making capacity, promoting their own self-interest.<sup>139</sup>

The spawning of bill collectors and “aggressive” collection efforts necessarily creates additional burdens for the plan members who become victims. For example, when reimbursement is sought by some health care plans and their collection agencies, it is sometimes sought for amounts greater than the actual cost expended for the insured.<sup>140</sup> In one case in West Virginia, the insured’s health plan sought \$128,000 reimbursement for medical expenses for a ten-year-old boy who was hit while on his bike. The boy and his parents had secured \$950,000 from the tortfeasor and their underinsurance coverage. It was discovered that the actual amount paid by the health plan was far less than the claimed

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136. *Id.* at 10. “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. . . .” *Id.* n.20.

137. Health Care Recoveries, Inc. is described as the largest private collection firm. *Id.* at 10.

138. There are numerous cases cited in this Article that involve Primax Recoveries, Inc., another such collection entity. *E.g.*, *Primax Recoveries, Inc. v. Sevilla*, 324 F.3d 544 (7th Cir. 2003).

139. See Brief of Amicus Nat’l Ass’n of Subrogation Professionals, Inc., *Knudson*, 534 U.S. 204 (2002) (No. 99-1786).

140. Michelle Andrews, *Adding Insult to Injury*, SMART MONEY MAG., July 2000, at 130. (“It’s one thing for a health plan or hospital to get reimbursed for its costs. It’s quite another for it to seek money it never paid out. Yet that’s what some managed-care companies are doing with subrogation.” *Id.* at 134.)

amount of \$128,000.<sup>141</sup> The actual expenses paid by the HMO ran from \$70,000 to \$100,000.<sup>142</sup> The HMO sued the victim and his family for the claimed amount of \$128,000.<sup>143</sup> In response to the suit, the family filed a counterclaim which was “expanded into a class action on behalf of 3,500 other patients billed for reimbursement at full rates.”<sup>144</sup> The case was eventually settled,<sup>145</sup> but a quote by the young boy’s attorney is memorable: “If you have a devastating injury like this, the last thing you expect is the HMO comes back and says all that (premium) payment doesn’t matter, and you have to pay us. They sued a paralyzed child.”<sup>146</sup>

Aside from individual cases prosecuted by individual attorneys, no ongoing organized group<sup>147</sup> or other voice for victims exists in the public debate on reimbursement. The affected plan members who suffer catastrophic losses are not identified until the catastrophe occurs. Then, each victim stands alone in his or her situation.

Returning to the question of whether quadriplegic Janette Knudson secured a windfall when the Court left her Special Needs Trust intact, obviously there was no windfall. Equally obvious, Janette Knudson will

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141. *Id.*

Since she worked in the business office of a doctors’ practice, Susan DeGarmo [the victim’s mother] was familiar with subrogation. Still, the \$128,000 that the HMO, the Health Plan of the Upper Ohio Valley, was demanding seemed high to her. So she did some research. She called the hospital in Columbus, Ohio, where Stephen had been treated, and got an itemized list of charges. What she discovered infuriated her. The HMO had paid much less than the \$128,000 it now was seeking.

*Id.*

142. *Id.*

Then DeGarmo’s HMO, Health Plan of the Upper Ohio Valley, sued the family to recover \$128,000 for Stephen’s care. DeGarmo’s lawyer, Don Kresen, found documents that he says showed that the HMO paid less to treat Stephen. Kresen estimates that the HMO spent \$70,000; the HMO says the figure was more than \$100,000.

William M. Welch, *HMOs Exercising Right to Sue Patients*, USA TODAY, July 19, 2001, at 11A.

143. *Id.*

144. *Id.*

145. *Id.* “The health plan settled for \$9 million. Last month, a federal judge approved another \$3 million settlement by the health plan’s collection agency.” *Id.*

146. *Id.*

147. Brief of Amici Curiae Maryland HMO Subrogation Plaintiffs, *Knudson*, 534 U.S. 204 (2002) (No. 99-1786). Groups may be formed for the purpose of litigation, but such groups do not exist on an ongoing basis, leaving the plights of the victims collectively unrepresented in decision-making forums of this country. *E.g.*, Maryland Subrogation HMO Plaintiffs who filed an Amicus Brief in *Knudson*, 2001 WL 740868 (S. Ct. June 29, 2001) (U.S. Amicus Brief).

live the rest of her life as a quadriplegic, and she will never be made whole. She will always remain grossly undercompensated for her injuries.

Given that ERISA plans' asserted rights of reimbursement have been largely upheld in circuits other than the Ninth Circuit prior to *Knudson*, there have been numerous situations in which a plan member has suffered a catastrophic loss and has been left with no money, despite recovering a monetary settlement from the tortfeasor.<sup>148</sup> ERISA plans and their insurers do not pursue a rule of reason. They pursue a rule of absoluteness—they seek reimbursement without regard to the situation of the plan member.<sup>149</sup>

The windfall argument fails. Ample authority supports the proposition that it is the insurer itself that receives a windfall through subrogation.<sup>150</sup> This would be especially true with respect to commer-

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148. *E.g.*, *In re Paris*, 44 F. Supp. 2d 747 (D. Md. 1999) (Entire recovery of \$100,000 from tortfeasor's insurer went to pay legal fees, costs, and partial reimbursement of ERISA plan. "The practical result of the court's decision was that the remainder of the \$100,000 settlement . . . was to be paid to the Fund while Ms. Paris and her adult, destitute child were left with nothing other than the remainder of the Fund bill debt and years of future financial challenges." 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 B.Y.U. L. REV. 427, 436 (2000)); *In re Estate of Scott*, 567 N.E.2d 605 (Ill. 1991) (ERISA plan that had paid \$200,000 in medical expenses allowed to recover entire balance of settlement (\$82,000) recovered from tortfeasor following payment of court-approved fees, leaving nothing for plan beneficiary who was seriously injured while riding as a passenger on a motorcycle).

The current state of subrogation law . . . works to disadvantage injured persons . . . . In many cases, insurers who were paid to assume the risk of loss are themselves made whole by subrogation while their insureds are not made whole.

This is inequitable since the insurer has agreed to assume the risk of nonrecovery, and has been paid for this.

Keith E. Edeus, *Subrogation of Personal Injury Claims: Toward Ending an Inequitable Practice*, 17 N. ILL. U. L. REV. 509, 526 (1997) (reviewing *In re Estate of Scott*, 567 N.E.2d 605 (Ill. 1991)).

149. In pursuing this absolute rule, the Health Insurance Industry brief rather audaciously suggests, "Should the Ninth Circuit believe that it is helping individual plan participants or beneficiaries retain additional monies by invalidating reimbursement clauses, it could not be more wrong. In fact, a plan's enforcement of its reimbursement clause simultaneously serves the interest of both the plan and the beneficiary." Brief of Amici Curiae The American Association of Health Plans et al. at 15, *Knudson*, 534 U.S. 204 (2002) (No. 99-1786).

150. *DeCespedes v. Prudence Mut. Cas. Co.*, 193 So. 2d 224, 227-28 (Fla. Dist. Ct. App. 1967) (admitting that "subrogation has been a two-edged sword" frequently resulting in a windfall to insurers because "anticipated recoveries under subrogation rights are generally not reflected in the computation of premium rates").

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

cial insurers.<sup>151</sup> Additionally, the whole idea of a windfall or “double recovery” was developed within the historical beginnings of subrogation and that beginning lies exclusively within the realm of property insurance.<sup>152</sup> In a property insurance context, the numbers are fixed, and the insured rarely runs the risk of not being fully compensated.<sup>153</sup> Subrogation is far more logical in a property insurance setting. For example, if a \$30,000 building is destroyed by fire by a tortfeasor, the insurer pays the insured \$30,000 and then is permitted to pursue the tortfeasor for \$30,000 on a subrogation claim. There is no dispute over the damage and how much the insured needs to be made whole. Subrogation on property insurance claims has been relatively easy and efficient. Additionally, subrogation was a better alternative than allowing the tortfeasor to have the benefit of the victim’s wisdom (and premium payment) in securing an insurance policy.<sup>154</sup> This idea of not letting the tortfeasor enjoy the benefit of the victim’s insurance is known, of course, as the “collateral source” rule.<sup>155</sup>

The original justification for allowing subrogation traces back to two ideas: First, the tortfeasor should not get the benefit of the insurance (the collateral source rule); and second, if the insured is also permitted

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

“On the other hand, if an insurer is allowed to subrogate and recover the money it paid its insured on the claim, then it finds itself in the position of having suffered no loss. Additionally, the insurer retains the premium initially charged to cover that risk.” Baron, *A Pandora’s Box*, *supra* note 36, at 243.

151. *Id.* at 245; Baron, *Subrogation on Medical Expense Claims*, *supra* note 38, at 586-87.

152. Baron, *supra* note 38, at 583; Baron, *A Pandora’s Box*, *supra* note 36, at 238 nn. 7-10; JOHN ALAN APPLEMAN & JEAN APPLEMAN, *INSURANCE LAW AND PRACTICE* § 1675 (1967).

153. Subrogation can also be unfair to the insured in a property insurance setting. *See, e.g.,* *Wimberly v. Am. Cas. Co.*, 584 S.W.2d 200 (Tenn. 1979) (adopting the “make whole” doctrine in property insurance case when insurance coverage was \$15,000 on total loss of \$44,619.10 and insured settled with tortfeasor’s insurer for \$25,000, still yielding a total recovery to insured of only \$40,000).

154. This idea is, of course, known as the “collateral source” rule—the notion that a tortfeasor should not be permitted to lessen his obligation simply because the victim has received a payment from a collateral source. The “collateral source” rule was recognized by the Supreme Court in *Propeller Monticello v. Mollison*, 58 U.S. 152 (1854).

155. *Id.* *See also* Calvin R. Wright, *The Collateral Source Rule in Georgia: A New Method of Equal Protection Analysis Brings a Return to the Old Common Law Rule*, 8 GA. ST. U. L. REV. 835 (1992); and Baron, *A Pandora’s Box*, *supra* note 36, at 242 n.35 and accompanying text.

to collect from the tortfeasor (in addition to receiving the insurance proceeds), the insured would secure a double recovery or windfall.<sup>156</sup> The fundamental reasoning for this second idea has itself been shown to be questionable.<sup>157</sup> However, even if one accepts this second idea as a “given” in the world of property insurance, one will soon find that its logic does not extend into the world of medical expense claims and the possibility of subrogation or reimbursement vis-à-vis personal injury claims. Losing an item of property valued at \$30,000 is much different than suffering a personal injury.<sup>158</sup> In a personal injury situation, damages may involve permanent disability, mental anguish, physical pain, loss of income, and future aspects of each of these components. Computation of the total loss is more complicated than in a property damage situation. In addition to the fact that computation of the loss is not easily determinable, the recoveries actually secured by the victim against the tortfeasor rarely amount to full compensation. Factors frequently come into play which make it reasonable and appropriate for the victim to accept less than the total loss in settlement.<sup>159</sup> These settlements are for less than the actual damages for a number of reasons: (1) the liability of the tortfeasor is disputed and uncertain, (2) there may be an assertion of contributory negligence or comparative fault on the part of the victim, or (3) the tortfeasor has limited assets or

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156. A fundamental flaw with this logic is that the insurer itself ends up with a windfall because, in the end, it is relieved of its obligation to pay on a claim that it accepted a premium to cover. Additionally, the argument can be made that the insured's right to recover against the insurer is premised upon contract, and the insured's right to recover (again) against the tortfeasor is premised upon tort. As such the insured has two separate rights and causes of action, as compared to the uninsured victim who would only have a cause of action against the tortfeasor. The underlying distinction is that the premium assures the insured a cause of action against the insurer. See Baron, *A Pandora's Box*, *supra* note 36, at 241-42 nn.29-37.

157. *Id.*

158.

A number of courts have recognized that prohibiting subrogation does not result in a “double recovery” by the insured. A “double recovery” in favor of the insured is unlikely to arise due to the fact that the “exact loss” suffered by the insured is often impossible to accurately ascertain. This is particularly apparent when factors such as mental anguish and physical pain are considered. Also, the amount of the settlement agreed upon is often going to “be less than actual damages,” particularly when the liability of the tortfeasor is disputable, “or because the tortfeasor has limited assets or limited insurance coverage.” Lastly, after attorney fees are considered, the insured is left with a substantially reduced recovery.

Pickar, *supra* note 94, at 326.

159. Baron, *A Pandora's Box*, *supra* note 36, at 245.

limited insurance coverage.<sup>160</sup> Additionally, the applicable law may not permit recovery of certain elements of damage, such as the future aspect of certain damages.<sup>161</sup> On top of these considerations, when a settlement is finally secured, the victim will most likely receive only two-thirds of the settlement or less, depending upon payment of attorney fees and costs of litigation.<sup>162</sup>

Given the intrusive and unfair nature of subrogation in the area of personal injury claims, not surprisingly at least one state supreme court has declared statutory provisions permitting such subrogation to be unconstitutional.<sup>163</sup> One might well expect to see future challenges upon constitutional grounds as to reimbursement and subrogation in the area of personal injury claims.<sup>164</sup>

The most logical response to the windfall argument is a simple and well-supported proposition: Reimbursement will be permitted only after the plan member has been made whole. If the plan member has not been fully compensated for his or her loss, then reimbursement should be denied. If the plan member has been fully compensated, then the plan may seek reimbursement against that amount which exceeds full compensation. The "make whole" doctrine is well-recognized in the state courts of this country.<sup>165</sup>

Many, but not all, federal courts have also acknowledged the appropriateness of the make whole doctrine, as a matter of federal

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160. *Id.*

161. *Id.*

162. *Id.* at 250-52 nn.81-85 and accompanying text. *See also* Allstate Ins. Co. v. Reitler, 628 P.2d 667, 670 (Mont. 1981) (discussing how expense, including cost of litigation, limits ultimate recovery).

163. *Holeton v. Crouse Cartage Co.*, 748 N.E.2d 1111 (Ohio 2001) (holding that statute permitting subrogation for worker compensation benefits violated provisions of the Ohio state constitution).

164. *See Denton v. Con-Way S. Express, Inc.*, 402 S.E.2d 269 (Ga. 1991) (holding statute, which abrogated the "collateral source" rule in Georgia civil cases, unconstitutional on the basis of the Georgia state constitution). *See also* James L. Branton, *The Collateral Source Rule*, 18 ST. MARY'S L.J. 883, 888 nn.29-31 and accompanying text (1987) (reviewing cases involving constitutional challenges to statutes abolishing the collateral source rule).

165. Baron, *A Pandora's Box*, *supra* note 36, at 91.

Perhaps the most attractive of the intermediate doctrines is the "make whole" doctrine. Under this doctrine, subrogation is permitted only after the insured has been fully compensated or "made whole." This approach acknowledges the realistic nature of tort recoveries and rejects the blind assertion that subrogation is necessary in order to prevent the insured from realizing a "double recovery . . ." It was recently reported that the "make whole" doctrine now serves as the majority view, having been adopted in twenty-five jurisdictions.  
*Id.* at 245-50 (internal citations omitted).

common law,<sup>166</sup> in reimbursement cases.<sup>167</sup> This country, its employees, and their beneficiaries would be well-served if all of its courts adopted and enforced the make whole doctrine in all reimbursement cases, irrespective of language in plan documents to the contrary. Such has already been urged.<sup>168</sup>

#### D. Rates

The health insurance industry asserts that the denial of reimbursement “necessarily drains plan funds.”<sup>169</sup> The industry also claims that “[i]nsurance companies and employee health benefit plans base rates and benefit levels on actuarial determinations that factor in the effect of subrogation and reimbursement provision recoveries.”<sup>170</sup>

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166. Gerald F. Murphy, *Subrogation or Subterfuge: The Myth of ERISA Health Benefit Plans*, 19 J. CONTEMP. HEALTH L. & POL'Y 309, 314-18 (2002) (reviewing the existing federal court decisions on the “make whole” doctrine). “Generally put, the Sixth, Ninth and Eleventh Circuits have adopted the [‘make whole’ doctrine] as a ‘default’ rule, while the remaining courts have either refused to apply the rule at all, or have at least declined to do so thus far.” *Id.*

For one of the more recent references to this matter, see *Unicare Life & Health Insurance Co. v. Saiter*, 276 Fed. Appx. 171 (6th Cir. 2002) wherein the trial court had applied the federal common law “make whole” doctrine and denied the claim for reimbursement when the plan beneficiary had received only \$100,000 in settlement, and the ERISA plan had paid \$164,000 in benefits, recognizing that her total damages “undisputedly approaches \$500,000.” *Id.* at \*173.

167. There is also authority for the proposition that there is a “federal common fund doctrine,” which would help ameliorate the harshness of reimbursement in many cases. In *Varco* the court stated that

the federal common fund doctrine which is similar to, but not identical in application to the Illinois doctrine, has existed independently in the federal system since 1882 . . . . Although primarily used only in situations involving class action law suits, federal courts have interpreted the doctrine to apply in single-party ERISA disputes despite the absence in the suit of the affected attorney.

338 F.3d at 691 (internal citations omitted).

168.

A nationwide adoption of the make whole doctrine deals most equitably with the health insurer, the injured insured, and the third-party tortfeasor . . . . In light of the highly questionable rationale for the existence of health insurer subrogation, the lack of guidance from ERISA itself, and the windfall for health insurers at the expense of its own insured, adoption of the make whole doctrine on a federal level will insure that all interested parties receive equitable treatment.

Kono, *supra* note 111, at 449-50.

169. Brief filed on behalf of The American Association of Health Plans, The American Benefits Council, The Blue Cross Blue Shield Association, The Chamber of Commerce of the United States, and the Health Insurance Association of America (may be collectively referred to as “Health Care Industry” in text). Brief of Amici Curiae The American Association of Health Plans et al. at 11, *Knudson*, 534 U.S. 204 (2002) (No. 99-1786).

170. *Id.*

Historically, subrogated recoveries are not reflected<sup>171</sup> in the setting of rates.<sup>172</sup> This is especially true with respect to commercial insurers.<sup>173</sup>

When one considers the nature of the insurance provided by ERISA plans, it becomes apparent that subrogated recoveries have less likelihood of impacting premium rates than the industry suggests. For example, when a plan beneficiary is seriously injured incurring medical bills of \$200,000, the plan will be required to pay the bills, regardless of how the beneficiary is injured. If the beneficiary was struck by lightning, the plan will have to pay the \$200,000 in bills. If the beneficiary was injured in a tornado or earthquake, the plan will have to pay the \$200,000 in bills. If the beneficiary was involved in a one-car accident in which the beneficiary was negligent, the plan will have to pay the \$200,000 in bills. If the beneficiary was in a multi-car collision and also primarily at fault, the plan will have to pay the \$200,000 in bills. If the beneficiary was not at fault and was injured by a tortfeasor with no assets and with no applicable insurance, the plan will have to pay the \$200,000 in bills. If the beneficiary suffers from a disease or ailment, the plan will have to pay the \$200,000 in bills. In each of these

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171. Pickar, *supra* note 94, at 338.

It has been argued that insurance companies who collect on subrogated recoveries will in turn lower their premium, but this has yet to happen. In the determination of insurance premiums, many factors are considered, but successful recoveries of subrogated claims are not one of them. 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.

*Id.*

172. See generally *supra* note 150; *Maxwell v. Allstate Ins. Co.*, 728 P.2d 812, 815 (Nev. 1986) (“Allowing subrogation deprives the insured of the coverage for which he had paid and results in a windfall recovery for the insurer.”); see also Kono, *supra* note 111, at 446-47 (discussing “insurance savings’ myth”).

In paying the loss, the insurer simply pays an anticipated loss on a risk that has been actuarially distributed over a pool of similarly-situated insureds. The setting of the insurance premium for the transfer of the risk from the insured to the insurer encompasses the insured’s pro rata share of the total estimated losses for the pool, as well as the insured’s pro rata share of the costs, expenses, and profit margin to be borne by the insurer for setting up and administering the insurance undertaking. The prospect of a successful subrogation collection is not a factor in the insurer’s rate determination. In fact, the conjectural and remote nature of subrogation militates against its inclusion as a factor for consideration in the setting of premium rates. Thus, when an insurer pays out on an insured risk, any recovery that the insurer is able to obtain through subsequent subrogation is a windfall to the insurer.

Baron, *A Pandora’s Box*, *supra* note 36, at 244.

173. *Id.* at 245; Baron, *Subrogation on Medical Expense Claims*, *supra* note 38, at 586-87.

cases, the obligation to pay medical bills exists—such is the nature of the insurance provided. But, even assuming that the right of reimbursement or subrogation is permitted, there would be no subrogated recovery in any of these scenarios because either the plan beneficiary lacks a viable cause of action against a tortfeasor, or there is no source of funds available for settlement. Yet, the obligation to insure continues.

The foregoing examples illustrate the obligation of the insurer and its need to establish rates and premiums, which are based on the probability of medical need for everyone in the pool, regardless of the cause of injury. On an actuarial basis, whether the insured was injured by his own fault or by the fault of a tortfeasor or by an act of God creates no distinction. The obligation persists for the insurer to pay the medical bills without regard to cause of injury.<sup>174</sup> True enough, in some cases the injury is inflicted by a tortfeasor, from whom a monetary settlement may be attained. But, from the standpoint of actuarial prediction, such an occurrence is speculative at best. What is important, from an actuarial basis, is the overall incidence of loss. Stated differently, the insurers must actuarially look at the overall incidence of loss for the purpose of setting rates, not the incidence of loss “for all plan members except those who have an injury caused by a tortfeasor against whom lies a subrogated recovery.”<sup>175</sup>

This same pattern exists with respect to property insurance, wherein lies the origin of subrogation. If a \$30,000 house burns down, the insurer of the house is required to pay the \$30,000 to the insured regardless of whether the fire was started by lightning or by a tortfeasor. Actuarially, the property insurers look at the incidence of fire loss for the purpose of setting rates, not “fire loss caused by anything other than a tortfeasor with assets.”<sup>176</sup> Thus, the nature of subrogation as it

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174. The plan in the case of *Bauhaus USA, Inc. v. Copeland*, 292 F.3d 439 (5th Cir. 2002), purported to do otherwise. See *infra* note 175.

175. The plan in the case of *Bauhaus USA*, purported to do exactly this and then agreed to “advance” medical expenses when an injury took place. 292 F.3d at 440. “Although the Plan did not cover injuries resulting from the acts of another, the Plan honored Copeland’s request for benefits and elected to advance payments for . . . medical expenses in the amount of \$46,229.45.” *Id.* (quoting provisions of plan document). Apparently this provision was designed to avoid the application of Mississippi’s anti-assignment law. *Id.* at 441.

176. *Compare Wimberly v. Am. Cas. Co.*, 584 S.W.2d 200 (Tenn. 1979).

Finally, although defendant insurers must pay the full limits of their policies without reimbursement by way of subrogation, the insured loss was a risk that the insureds paid for them to assume. Had the tortfeasor been judgment-proof and uninsured, defendants would still have been required to bear the loss to the full extent of the policies.

relates to premium rate setting is too speculative to be “planned on,” yet the overall incidence of loss is, indeed, “planned for” on an actuarial basis.

The concession must be made that an insuring entity (whether an ERISA plan or a commercial insurer) that receives substantial subrogated recoveries into its coffer will be financially healthier than one that lacks those recoveries. Any additional revenue, from any source, helps an insurer become financially healthier. Similarly, an insurer, which has set aside substantial reserves for claims, gains a financial boon if and when the claims are favorably adjudicated, and it is not required to pay out those reserves that had been set aside. The unused reserves may now be brought back into general revenue for the insurer, and it is healthier. But, simply because an insurer has the opportunity to recover reserves and become financially healthy, this opportunity does not directly translate into premium reductions.

The concession that if the decision is made to deprive subrogation or reimbursement recoveries from any insuring entity, that entity will receive less overall revenue is also recognized. Additionally, it is conceded that a decline of revenue for the entity will have an impact to some degree on its operation. That degree of impact becomes an important matter. The decision concerning approval or denial of reimbursement should also be informed by the ramifications on both sides of the question. The ERISA plans and insurers are quick to point out that they may be drained of funds, but they fail to mention the impact on the plan member. In many of these cases, the plan member is not only seriously injured as a result of the catastrophic event, but is also left financially destitute when reimbursement is permitted. What is the choice to be? Permit the ERISA plans and insurers to have this

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*Id.* at 203-04 (adopting the “make whole” doctrine in property insurance case where insurance coverage was \$15,000 on total loss of \$44,619.10 and insured settled with tortfeasor’s insurer for \$25,000, still yielding a total recovery to insured of only \$40,000).

“[I]nsurance companies expect to pay their insureds for negligently caused fire, and they adjust their rates accordingly. In this context, an insurer should not be allowed to treat a tenant, who is in privity with the insured landlord, as a negligent third party when it could not collect against its own insured had the insured negligently caused the fire” . . . . It occurs to us that if the reasoning underlying the denial of a subrogation claim applies between a landlord and a tenant, then we conclude that this reason is even more compelling when the relationship is that of host and guest, particularly when the host has assured the guest that there is insurance coverage.

Reeder v. Reeder, 348 N.W.2d 832, 837 (Neb. 1984) (quoting the Washington Court of Appeals opinion in *Rizzuto v. Morris*, 592 P.2d 688, 690 (Wash. Ct. App. 1979)).

billion dollar per year<sup>177</sup> supplemental income while plan members are left devastated both physically and financially? Allow the victims to attempt to be fully compensated, while requiring the plans and insurers to stand behind their commitment to render insurance for the plan members?

In resolving the rate issue and in also resolving the entire reimbursement issue, perhaps the most relevant approach is to look back and to reflect upon the commodity or service being provided. What is it that ERISA plans are providing? Is it health insurance coverage? Is it something less than health insurance coverage? If indeed the plan is providing health insurance coverage, then the allowance of reimbursement indeed negates that coverage. The plan beneficiary who believes he or she has health insurance coverage will eventually learn that the coverage is “illusory”<sup>178</sup> if and when the member suffers a catastrophic loss.

#### IV. CONSTITUTIONAL DIMENSION

When one considers the plight of the victims of catastrophic injury and the effect of reimbursement on those victims, words become inadequate in describing the consequences. As the ERISA plans and insurers aggressively pursue and seize any possible hope for financial security that these victims may have, the results are incomprehensible.<sup>179</sup>

In the vast majority of such cases, due to liability insurance policy limits or lack of resources, these victims will never recover from the

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177. Brief of Amici Curiae The American Association of Health Plans et al. at 10, *Knudson*, 534 U.S. 204 (2002) (No. 99-1786). “Millions and potentially billions of dollars are recouped annually by health plans and insurers by virtue of subrogation and other recovery mechanisms.” *Id.* “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 . . .” *Id.*

178. Baron, *Subrogation on Medical Expense Claims*, *supra* note 38, at 588.

Subrogation on non-property damage claims renders insurance coverage “illusory” because the insured receives nothing for the separate premium paid to the insurer when a tortfeasor is liable for damages. The “illusory” nature of first party medical payments coverage in an automobile policy is even more apparent in those jurisdictions that statutorily require every driver of an automobile to be covered by liability insurance or other proof of financial responsibility.

*Id.*

179. These concerns are explored in a well-documented article published in a magazine of national circulation. Appropriately, the title to the article is “Adding Insult to Injury.” Michelle Andrews, *Adding Insult to Injury*, SMART MONEY MAG., July 2000, at 134.

tortfeasor a settlement which fully compensates them for their damages.<sup>180</sup> Then, after payment of attorney fees and costs, the victims actually receive two-thirds or less of that settlement. But, if allowed to keep this settlement, they would at least have something to help them deal with the heavy financial burden awaiting them in life. No mercy is shown for the victim in the reimbursement provisions utilized by ERISA plans. Absolutely no protection exists for the victim's right to be compensated for injuries.

Constitutional challenges to subrogation and reimbursement on personal injury claims have been successful on the basis of individual state constitutional provisions.<sup>181</sup> It is reasonable to expect additional challenges to surface, with the victims urging that they are being deprived of "liberty, or property, without due process of law."<sup>182</sup> These victims surely have a liberty or property interest, which merits protection. The unilateral nature in which the ERISA plans create and enforce their rights of reimbursement certainly fails to afford any due process to the plan members.

To the extent that state action may be attributed to the insurers seeking such deprivation, application of the Fourteenth Amendment of the United States Constitution will be triggered.<sup>183</sup> In situations of direct federal involvement, such as that seen in the federally protected ERISA plans themselves, application of the Fifth Amendment Due Process Clause may be invoked.<sup>184</sup>

In the meantime, our courts may eschew the inevitable constitutional confrontation through denial of reimbursement on technical grounds such as that witnessed in *Knudson*. Courts may also avoid the constitutional clash through renewed and continued application of the make whole doctrine by operation of federal common law. Lastly and, perhaps most appropriately, courts may choose simply to recognize that reimbursement efforts by ERISA plans are unlawful because they violate public policy.

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180. In this regard, could "any amount of money" fully compensate Janette Knudson, who has been rendered quadriplegic?

181. *Denton v. Conway Express, Inc.*, 402 S.E.2d 269 (Ga. 1991); *Holeton v. Crouse Cartage Co.*, 748 N.E.2d 1111 (Ohio 2001).

182. U.S. CONST. amend. XIV.

183. *Id.*

184. U.S. CONST. amend. V.

## V. CONCLUSION

The ERISA scheme exists to facilitate benefit plans for employees and their beneficiaries.<sup>185</sup> Congress has declared that an equitable character of these plans be assured in the interest of the employees and their beneficiaries.<sup>186</sup> The concept of reimbursement or subrogation for medical expense claims has no support in ERISA's statutory scheme. It exists because it has been unilaterally implanted in plan documents.<sup>187</sup> For certain plan members, the utilization of reimbursement has the effect of completely nullifying the coverage afforded under the plan. Unfortunately, this happens mainly in situations in which the plan beneficiary has encountered serious and debilitating physical injuries. Although there is some rationale for reimbursement, in that it does provide revenue for a plan and its insurers, the corresponding detriment is far too significant to permit its continued usage. The underlying concept of subrogation in the field of personal injury claims is problematic and has caused not only much litigation, but also tremendous hardship on insureds. The extension of this concept, through the tool of reimbursement, is especially burdensome on this nation's employees and their beneficiaries—the very subjects intended to be protected by Congress when it enacted the ERISA scheme in 1974.

Due to an absence of oversight mechanisms and the preemptive nature of ERISA, there have been many judicial decisions which have the result of allowing these hardships to continue at the insistence of plan administrators. With the recent decision by the Supreme Court in *Knudson*, which denies a federal remedy to plans seeking reimbursement,<sup>188</sup> there now exists the opportunity to reflect upon the true merits of reimbursement. In so reflecting, one must conclude the allowance of unqualified reimbursement was wrong to begin with, and it is wrong today. It is not supported historically. It is not supported by federal statute. Lastly, it is not supported by any consideration of equity or fairness.

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185. 29 U.S.C. § 1001 (2000).

186. 29 U.S.C. § 1001(a) (2000) (“[T]hat it is therefore desirable in the interests of employees and their beneficiaries . . . that minimum standards be provided as assuring the equitable character of such plans . . .”).

187. As noted by Freedman, “[T]he 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.” Pickar, *supra* note 94, at 338 (quoting WARREN FREEDMAN, FREEDMAN’S RICHARDS ON INSURANCE 360 (6th ed. 1990)).

188. 534 U.S. at 221.

In many situations the enforcement of reimbursement provisions amounts to a complete deprivation of a victim's right to be compensated for injuries. As such, reimbursement may work an unconstitutional deprivation of liberty and property without due process of law.

Society, as a whole, would benefit from the elimination of the reimbursement effort. Hundreds of thousands of this nation's employees and their beneficiaries are at risk of being rendered destitute by this arbitrary rule of reimbursement, a rule which is designed to enhance revenues primarily for the commercial insurers who agree to assume part of the risk undertaken by ERISA plans.

The result of the Supreme Court's ruling in *Knudson* is indeed the right result, but it is supported by far more than simple statutory interpretation. The time has come for our courts to address the reimbursement issue head on. Unless eliminated or moderated by the make whole doctrine, reimbursement remains a tyrannical oppression upon our nation's employees and their beneficiaries—those whom Congress intended to protect through the enactment of ERISA.