

Med Pay, Reimbursement and *Chong*

By Jonathan G. Stein

Many auto insurance policies contain a provision called “medical payments”¹ or “med pay” coverage. Med pay coverage, at its most basic, provides for payment of reasonable and necessary medical bills to an insured incurred as a result of a covered accident. The med pay provision usually contains a reimbursement clause stating that the insured will reimburse the insurer after settlement of a claim with the tortfeasor.

Of course, the issue about the right of reimbursement is not a new one. Over a decade ago, the Ninth Circuit stated: “It is a general equitable principle of insurance law that, absent an agreement to the contrary, an insurance company may not enforce a right to subrogation until the insured has been fully compensated for [his or] her injuries, that is, has been made whole.” (*Barnes v. Independent Auto Dealers of California* (9th Cir. 1995) 64 F.3d 1389, 1394.)

However, the recent decision in *Chong v. State Farm Mut. Auto Ins. Co.* (2006) 428 F.Supp.2d 1136, sheds new light on the extent to which the insured must reimburse the insurer for amounts the insurer paid under the policy’s medical payments coverage, if at all. This article discusses med pay, the *Chong* case, and other cases that support the conclusion that the insured must be made whole prior to the insurer recovering any money from the insured.

Med Pay: What Is It?

In order to understand the issues, it is important to understand med pay coverage. Each med pay coverage is written a bit differently. Most of the provisions stem from ISO² language. However, because the ISO language is copyrighted, this article cannot use the language

contained in an actual auto policy. The language below is my interpretation of the ISO language, commonly referred to in the industry as the “standard language.” You must make sure to read the language in any policy you are dealing with as the policy language can differ. Med pay provisions generally read, in pertinent part, as follows:

Insuring Agreement: We will pay reasonable medical expenses sustained by an insured for injuries caused by an accident. We will pay only those expenses that are incurred within three (3) years³ from the date of the accident.

Reimbursement: If payment is made under this section, the insured agrees to reimburse us from the proceeds of any settlement or judgment obtained from a proceeding instituted by the insured against a responsible third party.⁴

So, what does all of this “insurance-speak” mean in plain English? Basically, if an insurance company with this hypothetical language receives medical bills that the insured incurs within three years of the accident which caused the injury, and the bills are reasonable and necessary, the insurance company will pay the medical bill on behalf of the insured. Then, if the insured settles the case against a third party or secures a judgment for damages against a third party,⁵ the insured must reimburse the insurer for those payments.

Subrogation: Quick and Dirty

The reimbursement concept described above is generally called a subrogation provision.

Subrogation is an equitable doctrine intended to prevent the insured from recovering twice for a single injury



Jonathan Stein is a sole practitioner and the founder of the Law Offices of Jonathan G. Stein, in Sacramento. Mr. Stein is a Chartered Property-Casualty Underwriter and former claims adjuster and trainer. His practice focuses on personal injury and insurance disputes and he can be reached through his website, www.jonathangstein.com.

and to reimburse the insurer for payments it made that should, in fairness, be borne by another. When the insured recovers the full amount of his damages from a third-party tort-feasor, the insurer is entitled to reimbursement of payments made on the policy. However, courts have generally held that no right of subrogation exists until the insured has recovered an amount in excess of his or her loss. (*International Underwriters/Brokers, Inc. v. Liao* (Ala. 1989) 548 So.2d 163, 164, citations omitted.)

However, in order to fully understand subrogation, you have to consider the make-whole doctrine. Make-whole was expressed simply by the Alabama court in *Liao* as: “the general rule that a subrogee is not entitled to recover, absent full recovery by the insured (i.e., unless the damages recovered plus the insurance proceeds exceed the insured’s loss).” (*Liao, supra*, 548 So.2d at 165.)

Chong: The Case

A recent decision of the United States District Court for the Southern District of California, *Chong v. State Farm Mutual* (2006) 428 F.Supp 2d 1136, may significantly alter the reimbursement

rights of insurers under the standard reimbursement provision quoted above. Although the case is on appeal to the Ninth Circuit, it is important to fully understand the *Chong* decision.

In *Chong*, the plaintiff-insured had purchased an automobile policy with \$5,000 in med pay coverage. (The terms of the policy in the *Chong* case are similar to the terms of the hypothetical insurance provisions quoted above.) The insurer paid Chong the \$5,000 coverage limit towards plaintiff's incurred medical bills. The plaintiff then filed a personal injury claim against the third party tortfeasor. As a result of that litigation, Chong obtained a settlement of \$65,000. However, in obtaining that settlement with the third party's insurance company, plaintiff incurred \$28,000 in attorney's fees. Chong's insurer, State Farm, while aware of the third party lawsuit, chose not to participate through intervention in the lawsuit and subsequently sought reimbursement under the terms of the policy. Faced with the reimbursement claim,⁶ Chong filed a class action lawsuit, alleging that State Farm's application of the reimbursement provisions of her automobile policy violated California's common law make-whole rule because her net recovery, after deducting her attorney fees and costs, fell far below the amount required to make her whole. State Farm moved to dismiss the class action complaint for failure to state a claim and to strike the insured's class allegations.

Pre-cursors to *Chong*

In order to fully understand the decision in *Chong*, it is important to understand the cases that lead up to *Chong*. In 2000, the Court of Appeal decided *Plut v. Fireman's Fund Ins. Co.* (2000) 85 Cal.App.4th 98, 104. In *Plut*, the court affirmed the general rule that an insurer who pays a policyholder's first-party damages claim may be subrogated, based on policy language, to the rights of the insured against the third-party tortfeasor. The court noted, in *Plut*: "Subrogation is the insurer's right to be put in the position of the insured, in order to recover from third parties who are legally responsible to the insured for a loss paid by the insurer." (*Id.*)

However, in a personal injury action, the insurer cannot assert its subrogated claim directly against the tortfeasor. Personal injury claims are not assignable under California law. (*Fifield Manor v. Finston* (1960) 54 Cal.2d 632.) Nonassignable claims are not subject to subrogation absent express statutory authorization, and no statute expressly authorizes subrogation under these circumstances. (*Fireman's Fund Ins. Co. v. McDonald, Hecht & Solberg* (1994) 30 Cal.App.4th 1373, 1384.)

Rather, the insurance company is left with two options: either intervene into the insured's action against the tortfeasor or, the more common practice, wait until the insured recovers money from the tortfeasor and then seek reimbursement from the insured. If the insurance carrier chooses the second option, i.e., the wait-and-recover-from-the-insured option, the common law make-whole rule – which provides that, "when an insurer does not participate in the insured's action against a tortfeasor despite knowledge of that action, the insurer cannot recover any funds obtained through settlement of the action unless the full amount received exceeds the insured's actual loss" – can and will act as a limit on what the insurance carrier can recover from its insured. (*Progressive West Ins. Co. v. Yolo County Superior Court* (2005) 135 Cal.App.4th 263, 272-3.)

In other words, under the make-whole rule, an insurance carrier may only recover from the insured after the insured pursues a third-party case if the insured's recovery exceeds the insured's actual loss. (*Plut* at 104-105.) The insurers can and do argue about the definition of "actual loss." However, the actual loss is not just the value of the claim, but includes the expenses that the insured incurs in collecting the proceeds. The *Plut* court clearly states that the insurer's subrogation interests arise only after the insured recovers the loss and some or all of the incurred expenses. (*Id.*)

The starting point for analysis is to understand there may be a right to subrogation and then to use the common law make-whole rule to limit the subrogation claim. However, the insurer and the insured can contract around the make-whole rule. (*Samura v. Kaiser Foundation Health Plans Inc.* (1993) 17 Cal.App.4th 1284.)

The catch is that, in the auto insurance context,⁷ the only way to contract around the make-whole rule is by inclusion of clear language stating that the insurer's reimbursement rights are first dollar reimbursement rights. (*Sapiano v. Williamsburg Nat'l Ins. Co.* (1994) 28 Cal.App.4th 533, 537-38.) Circumvention of the common law make-whole rule requires the use of language that is clear and specific. (*Id.* at 538-9.)

The court in *Chong* ruled that the language in the State Farm policy did not meet the clear and specific test of *Sapiano*, where the language of first dollar reimbursement was clear. (*Chong* at 1141.) The reimbursement provision in the *Chong* policy, which is standard text in most insurance company policies, was a general claim to reimbursement, which clearly does not clearly advise the insured that there is "first dollar" recovery by the insurer.

Having determined that State Farm's reimbursement clause did not circumvent the "default make-whole rule," the *Chong* court then had to determine the proper application of California's make-whole rule. More precisely, in determining whether the insured was made whole, should the court take into account (i.e., deduct from the insured's recovery) the insured's attorney fees?

The plaintiff in *Chong* argued that she was not made whole because she did not recover the full value of the case which, she alleged, was at least \$65,000. According to the plaintiff, no surplus remained from which the insurer could be reimbursed, after deducting her attorney's fees and associated costs of the litigation (\$28,000) and adding back the med pay coverage that she received from the insurer (\$5,000).

State Farm, on the other hand, argued that, in seeking reimbursement, it only needed to contribute a pro-rata share of the fees and costs under the common fund doctrine and that "its responsibility for attorney fees and costs is limited to its pro rata portion." (*Chong* at 1143). Thus, hypothetically, if the amount recovered in settlement is \$25,000 and the insurer paid \$5,000 in med pay coverage, the insurer would argue that they are only obligated to pay one-fifth of the attorney's fees and costs. According to State Farm, "Plaintiff's version of the make whole rule would

amount to an improper shift of attorney fees and costs to insurance carriers.” (*Id.*)

The *Chong* court found no California authority on point with regard to determining if the insured was made whole. (*Id.*) It is important to remember *Chong* is a Federal District Court case. Thus, according to the court, “the federal court’s role is to attempt to predict the result that the state supreme court would reach if it considered the issue” which the court “reluctantly” proceeded to do. (*Id.*) After reviewing decisions of out-of-state jurisdictions which “have directly addressed the effect of attorney fees and costs on the make whole analysis,” the court concluded that “the California Supreme Court would hold that, absent a contractual provision to the contrary, the make whole rule requires that a policyholder fully recover her loss and litigation expenses, including attorney fees and costs, before a nonparticipating carrier can seek reimbursement from her tort recovery.” (*Id.* at 1146). As the court stated, “when a policyholder’s attorney fees and costs exceed the amount the carrier paid in policy benefits, there is no surplus.” (*Id.*) The court reasoned that inclusion of this factor in the analysis puts the insured closer to the position the insured would have been in had no loss occurred – which is, after all, the purpose of insurance.

State Farm believed this was an unfair result. The court reviewed the company’s argument, and responded with four reasons supporting the court’s determination that the result was, in fact, fair. First, citing *Skauge*, the court pointed out that the insurer should bear the loss as the insured had paid premiums for the insurer to assume the risk of such loss. (*Skauge v. Mountain States Telephone & Telegraph Co.* (1977) 565 P.2d 628, 632.) As an interesting aside, you could otherwise argue that any repayment should include a deduction for the premiums paid by the insured since the insured ended up with a loan and not with coverage, especially if the insured is paying back the insurer.

Second, this result only occurs if the carrier elects to “sit and watch” and not actively participate in the litigation against the third party. Thus, the insurer is encouraged to participate in the litigation.

Third, the carrier could add language similar to the provision in *Sapiano* to

avoid this result. This would make the entire decision moot.

Other jurisdictions specifically allow contractual language to abrogate the rule premising recovery upon full compensation. (See, *Ex parte Cassidy*, 772 So. 2d 445 (Ala. 2000) (insurer is not entitled to subrogation unless insured has had full recovery, but this rule is superseded by parties’ agreement to contrary); *Samura v. Kaiser Foundation Health Plan*, 17 Cal.App.4th 1284, 22 Cal.Rptr.2d 20 (1993) (contract provision expressly gave insurer priority to proceeds from tort-feasor without regard to whether insured was first made whole); *Kapadia v. Preferred Risk Mut. Ins. Co.*, 418 N.W.2d 848 (Iowa 1988) (conventional subrogation rights are not subject to rule that stays their enforcement until insured is made whole). (*Blue Cross and Blue Shield of Nebraska, Inc v. Dailey* (2004) 687 N.W.2d 689. See also *Fields v. Farmers Ins. Co., Inc.* (10th Cir. 1994) 18 F.3d 831 [applying Oklahoma law]; *Ex parte State Farm Fire and Casualty Co.* (Ala. 2000) 764 So. 2d 543; *In re Estate of Scott* (1991) 208 Ill.App.3d 846, 567 N.E.2d 605, 153 Ill. Dec. 647; *Culver v. Insurance Co. of North America* (1989) 115 N.J. 451, 559 A.2d 400; *Peterson v. Ins. Co.* (1963) 175 Ohio St. 34, 191 N.E.2d 157.)

One court held that the terms could be modified, but that the policy language was not sufficient to modify the basic rule. (See *Hill v. State Farm Mut. Auto. Ins. Co.* (Utah 1988) 765 P.2d 864 [recognizing equitable principles underlying subrogation can be modified by contract, but applying equitable principles because record

did not include alleged contractual modification], disapproved on other grounds, *Sharon Steel v. Aetna Cas. and Sur.* (Utah 1997) 931 P.2d 127.)

This does not always hold true, however. As the *Blue Cross* court stated:

[A] different result was reached in *Rimes v. State Farm Mut. Auto. Ins. Co.* (1982) 106 Wis.2d 263, 266, 316 N.W.2d 348, 350, wherein an insurer was attempting to enforce a subrogation provision which stated: “Upon payment ... the company shall be subrogated to the extent of such payment to the proceeds of any settlement or judgment that may result from the exercise of any rights of recovery which the injured person ... may have against any person ... and such person shall execute and deliver instruments and papers and do whatever else is necessary to secure such rights....” The court stated: “[O]ne who claims subrogation rights, whether under the aegis of either legal or conventional subrogation, is barred from any recovery unless the insured is made whole.” *Id.* at 272. (*Blue Cross, supra*, at 743.)

Of course, the issue becomes one of whether the provision would then be enforceable. A provision may be unconscionable if it is hidden, oppressive, overly harsh, and results in a one-sided application of risks or costs not justified by the circumstances. (*Samura v. Kaiser Foundation Health Plan, Inc.* (1993) 17 Cal.App.4th 1284, 1296.) Even when an insurance carrier puts in language that appears to create a priority lien, the language may not suffice. (*Wheat v. Blue Cross of California, Inc.* (2002) 2002 WL 798718.)

BICYCLE EXPERT

PRODUCTS LIABILITY • FAILURE ANALYSIS
ROADWAY EFFECTS • RIDER OPERATION
BICYCLE ACCIDENT RECONSTRUCTION

BICYCLE
ACCIDENT
INVESTIGATION

Phone (408) 294-2412
FAX (408) 294-8649
E-mail: alex@BikeXpert.com
www.bikexpert.com



Alexander W. LaRivière
Consultant • Expert Witness

702 S. First St., San Jose, CA 95113

Even if a provision would be enforceable, you must consider what language is necessary. In Alabama, the court found this language to be acceptable:

If [Alfa] make[s] a payment under this policy and [the insured] recovers damages from another, [the insured] shall hold in trust for [Alfa] the proceeds of the recovery and shall reimburse [Alfa] to the extent of [Alfa's] payment, costs and fees. (*Wolfe v. Alfa Mutal* (2003) 880 So.2d 1163.)

This was also the outcome in *In Westfield Insurance Co. v. Rowe ex rel. Estate of Gallant* (S.D. 2001) 631 N.W.2d 175, where the South Dakota court held similar language to be acceptable to circumvent the make-whole rule. The Ohio Court of Appeals reached a similar conclusion in *Risner v. Erie Insurance Co.* (1993) 91 Ohio App.3d 695, 633 N.E.2d 588.

So, the insurance companies have sample language from other states that has been upheld. They could modify their policies to include this language and thus, they would avoid the issue raised in *Chong*.

Fourth, an opposite ruling would result in the insurance carrier, the party with more resources, sitting out the third-party case and letting the insured gamble with their own money. If the insured wins, the carrier only pays a pro-rata share; if the insured loses, the carrier pays nothing and has suffered no loss. (*Chong* at 1145-6.)

The Future

How will this affect the handling of personal injury cases? First, the rule in *Chong* is narrow in its application, applying only to its particular facts. It should also be kept in mind that this is a federal court decision that predicts the direction the California Supreme Court would take, which may not be binding on California state courts.

Also, the *Chong* decision is pending appeal. Nevertheless, other insurance carriers should consider the wisdom of following this rule until the matter is resolved in its entirety. Until there is a final decision, there may be room for argument on either side of the issue. Some insurance carriers are taking the position that *Chong* does not apply to them. However, even if *Chong* only technically applies to State Farm at this point, the reasoning behind

Chong is solid and applies to all insurance companies.

Second, the "make whole" amount may not equal the amount recovered in settlement with the third-party tortfeasor. It may be more. For example, a plaintiff may decide to take \$50,000 today instead of waiting two years to receive a verdict of \$60,000, which may be the true value of the case. Therefore, the insured may agree to less than the actual loss to settle the case. Or, a plaintiff may elect to sue in Small Claims court, with no attorney's fees but a \$7,500 cap, in order to avoid retaining counsel and being dragged through expensive litigation. However, that plaintiff's case may be worth \$10,000 or \$12,000. That same plaintiff may not be able to find representation on such a case, thus affecting the plaintiff's ability to recover the full value.

By the same token, the actual loss may be less than the settlement figure. An insurance company may be willing to pay \$15,000 policy limits on a case that is only worth \$10,000 to avoid the potential for an excess verdict. Thus, there are times when the plaintiff may end up with a windfall and may be made whole, even with attorneys fees and costs.

Along these lines, the *Chong* decision noted, in a footnote, that "plaintiff's [sic] may take their attorney fees into account when deciding what is an acceptable settlement amount, particularly when they have entered a contingent fee arrangement" and that "[d]iscovery may demonstrate that in this case Plaintiff did take her attorney fees into account when she settled her tort claim and that the amount that really fully compensated her for her losses and made her whole is something less than the \$65,000 for which she settled." (*Id.* at 1146).

Note that some courts have analyzed the issue of determining whether the insured has been made whole. In *Shelter v. Frohlich*, the Nebraska court stated: "Whether Shelter's subrogation right can be enforced against Frohlich requires resolution of factual issues, such as the amount of medical costs incurred by Frohlich and other damages sustained by her." (*Shelter Ins. Cos. v. Frohlich* (1993) 243 Neb. 111, 498 N.W.2d 74.) However, in *Bartunek v. Hormel*, the Nebraska Court of Appeals used collateral estoppel to decide that a jury verdict is

the full loss suffered by an insured. (*Bartunek v. Hormel* (1994) 513 N.W.2d 545.)

Third, insurance companies may change the reimbursement clauses in their med pay policies to comply with the language in *Sapiano*. In that event, they would be able to receive first dollar reimbursement. The common fund doctrine could still apply, but the insurer would still be able to recover the money it paid out. This could force insureds to not pursue claims against the third-party so as not to take the risk of doing all of the work and not being able to recover.

Conclusion

Med pay subrogation is an evolving area of law. Although *Chong* is on appeal, its analysis is useful. The cases relied on by the *Chong* court have analyzed the issue of reimbursement. If an insurance company will not follow *Chong*, a letter explaining the reasoning behind *Chong* should be effective in resolving the dispute. If all else fails, make sure you discuss the options with the client and advise the client as to the likely outcome, including the client being potentially sued by the insurance carrier. ■

¹ This article is going to discuss reimbursement in terms of med pay. You will, on occasion, run into an out-of-state policy with PIP coverage ("Personal Injury Protection"). The same analysis should apply.

² ISO is Insurance Services Office. They write exemplar policies that are adopted by most insurance companies.

³ Some policies only pay for one year. This is a crucial part of the policy and must be read very carefully!

⁴ Some policies contain language requiring the insured to hold the money in trust. This language must be closely scrutinized.

⁵ The insurance policy does not require reimbursement from an uninsured motorist settlement. However, case law provides for a credit for the med pay against the damages.

⁶ Note that this is not a "lien." It is a claim of reimbursement. A lien is a statutory creature. Calling this reimbursement claim a lien can create further complications for you and your client.

⁷ While this may apply in other contexts, this article is focusing on the med pay reimbursement and the ability of the insurer to collect through subrogation.