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**Hot Cases, Including *Fortis Benefits*
(Subrogation Rights) and *Mills v. Fletcher*
(Recovery of Medical Benefits)**

David L. Plaut
Hanna & Plaut L.L.P.
Austin, Texas
dplaut@hannaplaut.com
512-472-7700

TABLE OF CONTENTS

	<u>Page</u>
A. <i>Fortis Benefits v. Cantu</i> : The “Made Whole” Doctrine Does Not Limit a Health Insurer’s Contractual Subrogation Rights Against Its Insured Tort Recovery	1
B. <i>Mills v. Fletcher</i> : TCPRC Section 41.0105 Precludes a Tort Plaintiff From Recovering Health Benefit Write-offs From The Tortfeasor	3
C. <i>Fortis Benefits</i> and <i>Mills</i> are Consistent	7
D. Other “Hot” cases	

TABLE OF AUTHORITIES

<u>Cases</u>	<u>Page</u>
<i>Bituminous Casualty Corporation v. Cleveland</i> , 223 S.W.3d 485 (Tex.App.–Amarillo 2006),	5
<i>Coppedge v. K.B.I., Inc.</i> , 2007 WL 1989840 (E.D. Tex. July 3, 2007).....	5, 6
<i>Esparza v. Scott and White Health Plan</i> , 909 S.W.2d 548 (Tex. App.–Austin 1995, writ denied);	2
<i>Fortis Benefits v. Cantu</i> , 2007 WL 1861000 (Tex. June 29, 2007).....	1
<i>Goryews v. Murphy Production and Exploration Co.</i> , 2007 WL 2274400.....	6, 7
<i>Means v. United Fidelity Life Insurance Co.</i> , 550 S.W.2d 302 (Tex. Civ. App.–El Paso 1977, writ ref'd n.r.e.)	2
<i>Mid-Century Ins. Co. v. Kidd</i> , 997 S.W.2d 265 (Tex. 1999).....	5
<i>Mills v. Fletcher</i> , 229 S.W.3d 765 (Tex. App.–San Antonio, May 16, 2007, no pet.).....	3
<i>Ortiz v. Great Southern Fire & Casualty Ins. Co.</i> , 597 S.W.2d 342 (Tex. 1980)	1
<i>Oss v. United Services Automobile Association</i> , 807 F.2d 457 (5 th Cir. 1987)	2
<i>Sereboff v. Mid Atlantic Medical Services, Inc.</i> , 126 S. Ct. 1869, 164 L. Ed.2d 612 (2006)	3
<i>Transportation Ins. Co. v. Moriel</i> , 879 S.W.2d 10, 16 (Tex.1994)	7
<i>Walker v. Wal-Mart Stores, Inc.</i> , 159 F.3d 938 (5 th Cir. 1998) (per curiam)	3
State Statutes	
Texas Civil Practices & Remedies Code Section 41.0105	3

Hot Cases, Including *Fortis Benefits* (Subrogation Rights) and *Mills v. Fletcher* (Recovery of Medical Benefits)

By David L. Plaut¹ and Jeff Glass²

Two recent opinions explore medical benefits recoveries in tort suits and the implications for the doctrine that tort damages are intended to make the injured party whole. Although one decision partially overrides this “made whole” doctrine and one appears to impliedly rely on it, the two decisions are reconcilable on practical grounds.

A. *Fortis Benefits v. Cantu*: The “Made Whole” Doctrine Does Not Limit a Health Insurer’s Contractual Subrogation Rights against Its Insured Tort Recovery.

In *Fortis Benefits v. Cantu*, 2007 WL 1861000 (Tex. June 29, 2007), the Texas Supreme Court held that the equitable “made whole” doctrine does not limit a health insurer’s right to contractual subrogation for medical benefits paid on behalf of an injured plaintiff. Under the “made whole” doctrine, a health insurer is not entitled to equitable subrogation to the extent of medical benefits paid on behalf of an injured party if the injured party’s total recovery is less than his or her loss. *Id.* slip op. at 2 (citing *Ortiz v. Great Southern Fire & Casualty Insurance Co.*, 597 S.W.2d 342, 343 (Tex. 1980)). In *Fortis Benefits*, however, the Supreme Court held that although the “made whole” doctrine limits rights of equitable subrogation, it yields to the superior right of contractual subrogation, such as that held by *Fortis Benefits*. *Id.*, slip op. at 5.

After she sustained serious injuries in an auto accident, Vanessa Cantu sued the driver of the vehicle in which she was riding, his employer, the vehicle seller, and the vehicle manufacturer. *Fortis Benefits*, Cantu’s medical insurer, intervened in the suit, asserting its right to contractual subrogation and reimbursement from any recovery by Cantu for amounts it had paid for Cantu’s medical costs (\$247,534.14) under her health insurance policy. Prior to trial, however, Cantu settled her claims against the tort defendants for \$1.445 million.

Fortis Benefits sought to recover its medical payments from the settlement payment pursuant to its contractual subrogation rights set forth in the health policy with Cantu. Cantu, however, moved for summary judgment arguing *Fortis* was not entitled to any settlement proceeds because she had not been “made whole” by the settlement. Included in her summary judgment evidence were two “life care plans” that estimated her future medical expenses at well

¹David L. Plaut is a partner with Hanna & Plaut, LLP. He graduated from Johns Hopkins University with honors in 1985 and the University of Texas School of Law in 1989. He was articles editor of the *Texas Law Review* and served as a law clerk for United States District Judge Edward Prado in San Antonio for two years before beginning private practice. His practice focuses on insurance coverage matters, insurance “bad faith” litigation, school district litigation, trial and appellate work.

²Jeff Glass is an associate with the Austin law firm Hanna & Plaut, LLP. He graduated from Abilene Christian University (B.A., with highest honors) in 1980 and the University of Texas School of Law (J.D. with honors) in 1984. He served as a law clerk to the Honorable Robert M. Hill of the U.S. Fifth Circuit Court of Appeals before entering private practice. His current practice focuses on insurance coverage matters, insurance “bad faith” litigation, and appellate work.

over \$1.7 million. Thus, Cantu’s past and future medical expenses, exclusive of other amounts such as pain and suffering, exceeded the settlement proceeds plus the medical benefits she had already received from Fortis. The trial court granted Cantu’s summary judgment and a divided court of appeals affirmed. *See* 170 S.W.3d 755 (Tex. App.–Waco 2006).

The Supreme Court reversed. The Court stated that *Ortiz*, the case in which the court first recognized the “made whole” doctrine, “would govern if Fortis were merely asserting a claim for equitable subrogation.” Slip op. at 2 (emphasis in original). Fortis Benefits, however, relied on two separate contractual rights of recovery in the insurance policy, one styled “subrogation” and one styled “reimbursement.” *Id.*³ The Court held that these contractual rights were not “displaced” by the “made whole” doctrine. *Id.*

Noting that *Ortiz* did not apply the “made whole” doctrine in the context of contractual subrogation, the court emphasized the distinctions between contractual and equitable subrogation rights. 2007 WL 1861000, slip op. at 2-5. The latter is governed by equitable principles, whereas “conventional” or contractual subrogation is governed by the terms of the contract in question and rules of contractual interpretation. *Id.* at 3. The court pointed out that Texas courts have given the right of subrogation “unusually hospitable treatment” particularly express or contractual subrogation rights, which are given “considerable weight” and which, in the right circumstances, override the relative equities between the parties. *Id.*

The court then discussed and disapproved, cases from the Fifth Circuit and the Texas Courts of Appeals that had held that the “made whole” doctrine applies to both contractual and equitable subrogation rights. 2007 WL 1861000, slip op. at 3-4 (citing *Esparza v. Scott and White Health Plan*, 909 S.W.2d 548, 551-52 (Tex. App.–Austin 1995, writ denied); *Oss v. United Services Automobile Association*, 807 F.2d 457 (5th Cir. 1987); *Means v. United Fidelity Life Insurance Co.*, 550 S.W.2d 302, 309 (Tex. Civ. App.–El Paso 1977, writ ref’d n.r.e.)). The Court concluded that contractual subrogation clauses, like those in health policies, “express the parties’ intent that reimbursement should be controlled by agreed contract terms rather than external rules imposed by the courts.” *Id.* at 4.

The Court then discussed U.S. Supreme Court and Fifth Circuit precedent in ERISA subrogation cases, in which the courts had refused to apply the “made whole” doctrine to contractual reimbursement rights. 2007 WL 1861000, slip op. at 4 (citing *Sereboff v. Mid Atlantic Medical Services, Inc.*, -- U.S. --, 126 S. Ct. 1869, 164 L. Ed.2d 612 (2006) (holding that the “made whole” doctrine did not apply to contractual subrogation rights under an ERISA

³The policy provisions in question stated as follows:

Subrogation Right. Upon payment of benefits, we will be subrogated to all rights of recovery a Covered Person may have against any person or organization. . . . such right extends to the proceeds of any settlement or judgment; but is limited to the amounts of benefits We have paid.

* * *

Right of Reimbursement. If any benefits are paid under this plan, and any Covered Person recovers against any person or organization by settlement, judgment or otherwise, We have a right to recover from that Covered Person an amount equal to the amount We have paid.

See Fortis Benefits, 2007 WL 1861000, slip op. at 1 n.11.

health plan); *Walker v. Wal-Mart Stores, Inc.*, 159 F.3d 938, 939-40 (5th Cir. 1998) (per curiam) (holding contractual subrogation clause under an ERISA health plan that granted a right of recovery against “any and all” third-party settlements applied to a tort settlement as first-money reimbursement for medical benefits paid)).

Thus, under the principle that “equity follows the law,” equitable doctrines must conform to contractual and statutory mandates and if “a valid contract prescribes particular remedies or imposes particular obligations, equity generally must yield unless the contract violates positive law or offends public policy.” 2007 WL 1861000, slip op. at 4. The Court was careful to point out that subrogation and reimbursement clauses do not violate public policy. The Court also observed that “balancing dueling policy concerns is generally for non-judicial bodies,” and indicated that it was more appropriate for the Legislature and/or the Texas Department of Insurance to change the policy terms to strike whatever balance they believed best protects the interests of Texans. *Id.* at 4-5, n. 51. The Court therefore declined to re-write the parties’ contract pursuant to equitable principles and concluded that “contract-based subrogation rights should be governed by the parties express agreement and not invalidated by equitable considerations that might be controlled by default in the absence of an agreement.” *Id.* at 5.⁴

Examining the specific policy language in the Fortis Benefits policy, the court noted the clarity of the language and that the only limitation on the subrogation right was the amount of recovery, *i.e.*, what Fortis Benefits had paid under the contract. 2007 WL 1861000, slip op. at 5. The Court held that this language overrode the equitable defense and that Fortis Benefits was contractually entitled to recover the benefits paid to Cantu (\$247,534.14) out of the \$1.445 million settlement. *Id.*

As of this writing, *Fortis Benefits* has not been cited by any other court.

B. *Mills v. Fletcher*: TCPRC Section 41.0105 Precludes a Tort Plaintiff from Recovering Health Benefit Write-offs from the Tortfeasor.⁵

While *Fortis Benefits* expanded a health insurer’s right to subrogation for amounts it actually paid on behalf of an injured party, another recent case out of the San Antonio Court of Appeals construed a Texas statute to preclude a tort plaintiff from recovering from the tortfeasor those amounts a health insurer **did not** actually pay. In *Mills v. Fletcher*, 229 S.W.3d 765 (Tex. App.–San Antonio, May 16, 2007, no pet.), the court issued the first decision interpreting Texas Civil Practices & Remedies Code Section 41.0105, a provision of H.B. 4 passed as a part of the tort reform legislation of 2003. The court held that the statute precluded an injured plaintiff from recovering medical expenses that were originally billed by his health care provider, but were ultimately “adjusted” down or written off pursuant to an agreement between the provider and the health insurance carrier. 229 S.W.3d at 769.

⁴In this context, the court rejected Cantu’s argument that contractual abrogation of the “made whole” doctrine is unconscionable in light of the insurance policies’ nature as they are “contract[s] of adhesion.” *Id.* at 5, n. 53.

⁵The author of this paper served as appellate counsel to the appellant, Alisa Mills, in the *Mills v. Fletcher* case.

Kevin Fletcher was injured in an automobile collision with Alisa Mills and subsequently received medical treatment for his minor injuries.⁶ Fletcher then sued Mills for negligence. At trial, Fletcher introduced the standard medical provider affidavits showing medical expenses in the total amount billed by the providers. Relying on Section 41.0105, however, Mills offered evidence that Fletcher's health insurance carrier paid less than the full amounts charged for the medical services and that the medical providers subsequently "wrote-off" the unpaid portions, leaving zero balances due from Fletcher. The trial court refused to admit the evidence, however, and Mills preserved the issue in a bill of exceptions. 229 S.W.3d at 767 n. 1. Ultimately, Fletcher won a jury verdict in the trial court, which issued a judgment that included medical expenses in the full amounts charged, including the provider write-offs.

Pursuant to Section 41.0105, a divided court of appeals⁷ reversed, holding that Fletcher's medical expenses recovery should have been reduced by the amounts of the "write-offs." 229 S.W.3d at 771. Section 41.0105, titled "Evidence Relating to Amount of Economic Damages," provides as follows:

In addition to any other limitation under law, *recovery of medical or health care expenses incurred is limited to the amount actually paid or incurred by or on behalf of the claimant.*

Tex. Civ. Prac. & Rem.Code Ann. § 41.0105 (Vernon Supp.2006) (emphasis added).

Fletcher argued that he "incurred" the medical charges at the time of his doctor's visit and that any amounts later written off were nevertheless "incurred" even if not "actually paid" on his behalf. 229 S.W.3d at 771. Mills responded that "the word incur, in legal parlance, means simply 'to become liable to pay,'" and that because the amounts were written off, Fletcher would never become liable to pay the write-offs. 2007 WL 1423883, slip op. at *1.

The San Antonio Court agreed with Mills, finding that a plain reading of the statute precluded recovery for past medical charges that were written off or adjusted by the provider because they were not "actually paid or incurred" by or on behalf of the plaintiff. 229 S.W.3d at 768. The court analyzed the individual phrases of the statute's main language, which states, in part: "recovery of medical or health care expenses incurred is limited to the amount actually paid or incurred by or on behalf of the claimant." The court held that the first use of the word "incurred" signifies the amount of medical expenses initially billed, that is the amounts plaintiff "incurred" at the time services were rendered. *Id.* The Court then observed that the word "limited" clearly indicates the legislature's intent to place a limitation on the amount a plaintiff can recover. *Id.* Thus, the court held that the last phrase of the statute, limiting plaintiff's recovery to "the amount *actually* paid or incurred by or on behalf of the claimant" precludes a plaintiff from recovering the full amount charged if some lesser amount ultimately was actually paid. *Id.* The court therefore held that, as applied to the facts presented, the phrase "actually incurred" referred to "expenses incurred after an adjustment of the health care providers bill."

⁶The Court of Appeals opinion is somewhat thin on the facts, so the facts recited in this paper are based on the author's familiarity with case.

⁷Judge Angelini wrote the opinion and Judge Hilbig concurred in the judgment only. Judge Stone filed a dissent.

Id. The court observed that, by contrast, Fletcher’s interpretation of “actually incurred” did not limit the word “incurred” in any manner. *Id.*

These arguments were presented in the shadow of the “collateral source” rule, a common law rule of evidence and damages that “bars a wrongdoer from offsetting his liability by insurance benefits independently procured by the injured party.” *Id.* at 769, n. 3 (quoting *Mid-Century Ins. Co. v. Kidd*, 997 S.W.2d 265, 274 (Tex.1999)). Fletcher had argued that Mills’ interpretation of the statute would impermissibly violate the collateral source rule by allowing her, as the tortfeasor, to benefit from Fletcher’s health insurance by reducing her recovery in the amount of the write-offs. In a footnote, the San Antonio Court of Appeals agreed that Mills’ interpretation of Section 41.0105 did conflict with the collateral source rule, but stated that the legislature had the power to abolish the common law rule and concluded that the language of the statute demonstrated its intent to do so. *Id.* That the legislature passed Section 41.0105 as part of sweeping tort reform to the civil justice system intended to limit damages in civil cases provided further support for the court’s holding. *Id.* at 769 (citing House Comm. on State Affairs, Bill Analysis, Tex. H.B. 4, 78th Leg., R.S. (2003)). The court declined to consider further the legislative history of the statute because the text, it found, was clear and unambiguous. *Id.*

The *Mills* court also rejected Fletcher’s cross-points based on constitutional challenges to Mills’ interpretation of the statute, which was adopted by the court. The court held that its interpretation complied with substantive due process and the open court’s provision of the Texas Constitution, and that it was not unconstitutionally vague. 229 S.W.3d at 770. The court therefore remanded the case for entry of judgment consistent with its opinion. *Id.* at 771.

Justice Stone’s dissent disagreed with the majority’s interpretation of Section 41.015 on several grounds. 229 S.W.3d at 771-772. The “most compelling” reason for rejecting the majority’s interpretation was, in Justice Stone’s view, that “it does not produce a just or reasonable result.” *Id.* at 772. Justice Stone wrote that it adds insult to injury “when the injured party pays premiums for medical insurance coverage and then watches the benefits of that coverage lower the accountability of the tortfeasor for negligent conduct.” *Id.* Justice Stone’s dissent also relied on various hypothetical practical issues relating to application of the statute, none of which was actually raised in the case before the court. *Id.* Finally, Justice Stone believed the majority’s interpretation elevated the private interests of liability insurers over the “public interest” in the continued viability of the collateral source rule. *Id.*

Texas courts have also recently addressed procedural issues relating to applying Section 41.0105. In *Bituminous Casualty Corporation v. Cleveland*, 223 S.W.3d 485, 488-89 (Tex. App.–Amarillo 2006), the court noted, with apparent approval, that following the receipt of the jury’s verdict, the trial court had reduced the award of medical expenses pursuant to Section 41.0105 by excluding medical expenses not incurred. In *Coppedge v. K.B.I., Inc.*, 2007 WL 1989840 (E.D. Tex. July 3, 2007), the court granted a tort plaintiff’s motion in limine, which sought to prevent the defendant from introducing evidence of medical bill write-offs. The court held that Section 41.0105 “does not, on its face, prohibit the introduction of the full amount of the medical bills [including amounts written off by the health care provider], allowing the trial court to reduce them if the jury finds liability and awards damages for past medical expenses.”

Id. slip op. at 2. The court concluded that the statute “speaks not to the admissibility of medical records, but to the recovery of plaintiff” and “the introduction of medical bills reflecting amounts that are ‘written’ off or ‘adjusted’ would suggest to a reasonable juror that insurance was involved and only serve to confuse them or complicate the issue.” *Id.* The court therefore granted plaintiff’s motion in limine, precluding defendant from introducing evidence of medical bill write-offs. *Id.*⁸

It should be noted that Governor Perry recently vetoed House Bill No. 3281 of the 80th Texas Legislature, which would have limited the application of Section 41.0105 to health care liability claims under Chapter 74 of the Civil Practice and Remedies Code.⁹ Among other things, the Governor stated as follows:

The purpose of damages in a civil lawsuit is to make an injured individual whole by reimbursing the actual amount they have been deprived by the defendant’s actions. It should not be used to artificially inflate the recovery amount by claiming economic damages that were never paid and never required to be paid.

Id. The Governor’s statement also indicated that Section 41.0105 does not abrogate the collateral source rule inasmuch as “[n]othing in Section 41.0105 allows a defendant to introduce this evidence [of benefits obtained from a collateral source] or hinders an individual’s ability to recover the amount of the medical bills paid by their insurance company.” *Id.* Thus, Section 41.0105 remains generally applicable to tort claims for medical expenses in Texas.

C. *Fortis Benefits and Mills Are Consistent.*

In a recent opinion, Judge Rainey of the U.S. Southern District Court followed *Mills*’ interpretation of Section 41.0105 and buttressed his decision with the “made whole” doctrine, discussed in the *Fortis Benefits* case. In *Goryews v. Murphy Production and Exploration Co.*, 2007 WL 2274400 (S.D. Tex.), the plaintiff sustained injuries while working on an offshore oil platform owned by Defendant Murphy. Among other things, the jury awarded the plaintiff \$181,870.24 for past medical expenses, which included amounts not paid by plaintiff’s workers compensation carrier. *Id.* slip op. at 3.

The Defendant maintained that the plain language of Section 41.0105 required the court to reduce the amount recovered by Plaintiff for past medical expenses to the amount “actually

⁸ The language of the motion granted by the court was as follows:

Any evidence, statement, or argument that any of [plaintiff’s] medical expenses have been reduced, discounted, adjusted or written off by virtue of the medical care provider accepting payment from a collateral source.

* * *

Plaintiff is entitled to present the full amount of medical expenses that were charged by his medical care providers, and therefore ‘incurred’ by Plaintiff. Any effort to present evidence of discounts, adjustments, reductions, or write-offs, would inject collateral source payments into the trial and the relevance of such information would be outweighed by the unfair prejudice it would cause Plaintiff.

⁹ See Office of the Governor, Message dated June 15, 2007, found at the following Web address: http://www.governor.state.tx.us/divisions/press/bills/veto_statements/message-hb3281.

paid.” Plaintiff responded that the disjunctive language in the provision referring to the “amount actually paid *or* incurred” allows the Plaintiff to recover either the amount paid or the amount billed or charged to Plaintiff, despite the lower, negotiated rate paid on behalf of Plaintiff by his workers compensation carrier. *Id.* slip op. at 3.

The Court, following *Mills*, agreed with the Defendant’s interpretation of the statute and ordered that plaintiff’s recovery for medical expenses be reduced to \$103,979.86, the amount paid by Plaintiff’s workers compensation carrier. Although it adopted *Mills*’ interpretation of the statute, the *Goryews* court found it unnecessary to decide whether the statute completely abrogated the collateral source rule “because no evidence of a collateral source was presented to the jury.” *Id.* slip op. at 4.

Responding to plaintiff’s argument “that the wrongdoer will benefit from the payments made on behalf of Plaintiff,” the Court pointed out that this contention “ignores the equally important policy that tort damages are designed to make the victim whole.” *Id.* slip op. at 5 (citing *Transp. Ins. Co. v. Moriel*, 879 S.W.2d 10, 16 (Tex.1994) (stating compensatory damages are intended to make the plaintiff “whole”)). The court noted that because plaintiff and his workers compensation carrier “were only obligated to pay the reduced amount, it would undermine the ‘make-whole’ tort principle to allow the Plaintiff to receive medical expenses above and beyond those which he or his carrier were actually obligated to pay.” *Id.* That is, “[n]either side should reap a windfall.” Therefore, the amount of Plaintiff’s damages for past medical expenses should be reduced to the amount actually paid on Plaintiff’s behalf.

This language connects *Mills* and *Fortis Benefits*. Although they appear to take opposite approaches to the “made whole” doctrine – with *Fortis Benefits* overriding it and *Goryews* relying on it – the cases are reconcilable on practical grounds. Under *Fortis Benefits*, the carrier’s contractual subrogation interest, although it overrides the equitable “made whole” doctrine, is, for all practical purposes, limited by the insurance policy provisions which, in that case as in most similar policies, limits the subrogation/reimbursement interest to amounts actually paid by the carrier. *See Fortis Benefits*, 2007 WL 1861000, slip op. at 1 n.11, 4-5. *See*, above, note 1. This limitation prevents the carrier’s subrogation interest against the insured/injured party from conflicting with the statutory limitation on the injured party’s right to recover medical expenses from the tortfeasor. That is, because the carrier cannot proceed against the insured for amounts written off by the provider, prohibiting the insured from recovering write-off amounts from the tortfeasor in the first place makes practical sense under Section 41.0105.