**Damages in Personal Injury**

**NBI October 2018**

**V. Sources of Recovery and Liens**

**A. Collateral Source Rule**

Oklahoma has long applied the Collateral Source Rule:

Upon commission of a tort it is the duty of the wrongdoer to answer for the damages

wrought by his wrongful act, and that is measured by the whole loss so caused and the

receipt of compensation by the injured party from a collateral source wholly independent

of the wrongdoer does not operate to lessen the damages recoverable from the person

causing the injury. *Denco Bus Lines v. Hargis,* 1951 OK 11, 229 P.2d 560.

Oklahoma still adheres to the collateral source rule. See: *C&H Power Line Const. Co. v. Enterprise Products Operating, LLC*, 2016 OK 102, ¶21, 386 P.3d 1027: Oklahoma still recognizes rule that insurance payment evidence violates collateral source rule, citing Estrada v. Port City Properties, Inc., 2011 OK 30, ¶ 27, 258 P.3d 495,505.

The rule seems contrary to rules against double recovery and “windfall,” but public policy dictates if there is to be a “windfall,” the windfall is to go to the innocent (or more innocent) plaintiff, than to the responsible party. That is particularly so when the injured plaintiff has had the foresight to purchase insurance coverage. The injured party’s insurance premium should not flow to the benefit of the tortfeasor. The rationale is also explained as a mechanism to offset rules that prevent a plaintiff from ever fully recovering all damages.

The Rule applies to workers compensation benefits, health insurance (subject to 12 O.S. 3009.1, discussed below), disability coverage, life insurance, uninsured motorists coverage, sick and vacation leave, salary paid during convalescence, etc. If the payment is not made by the Defendant, then the jury is not entitled to hear evidence of the payment.

There is a “special” abrogation of the rule in medical negligence cases, under 63 O.S. 1-1708:

A.  In every medical liability action, the court shall admit evidence of payments of medical bills made to the injured party, unless the court makes the finding described in paragraph B of this section.

B.  In any medical liability action, upon application of a party, the court shall make a determination whether amounts claimed by a health care provider to be a payment of medical bills from a collateral source is subject to subrogation or other right of recovery.  If the court makes a determination that any such payment is subject to subrogation or other right of recovery, evidence of the payment from the collateral source and subject to subrogation or other right of recovery shall not be admitted.

Looks like a special law indeed.

There is an exception under the OGTCA in 51 O.S. 155, which absolves governmental entities where there is workers’ compensation available to the injured party. This rule applies whether the comp is provided by the at-fault governmental entity, or by some other entity.

The rule even keeps out evidence of remarriage of the injured party. *Kimery v. Public Service Co.,* 1980 OK 187, 622 P.2d 1066.

Beware, though, the collateral source rule has been eroded (even apart from “paid versus incurred”) where the collateral benefit is not tied in some manner to the plaintiff’s efforts. So, while payment of bills by Medicare is a collateral source where the Medicare is a benefit of the plaintiff’s years of employment, a few courts have held the same is not so with respect to gratuitous benefits such as Medicaid. See, e.g., *Bozeman v. Louisiana,* 879 So.2d 692 (La. 2004).

**Getting Medical Bills Into Evidence**

We have a statute that lets the patient/plaintiff introduce medical bills:

12 O.S. 3009:

Upon the trial of any civil case involving injury, disease or disability, the patient, a member of his family or any other person responsible for the care of the patient, shall be a competent witness to identify doctor bills, hospital bills, ambulance service bills, drug bills and similar bills for expenses incurred in the treatment of the patient upon a showing by the witness that such bills were received from a licensed practicing physician, hospital, ambulance service, pharmacy, drug store, or supplier of therapeutic or orthopedic devices, and that such expenses were incurred in connection with the treatment of the injury, disease or disability involved in the subject of litigation at trial. Such items of evidence need not be identified by the person who submits the bill, and it shall not be necessary for an expert witness to testify that the charges were reasonable and necessary.

So, we can get the bills into evidence with the patient’s testimony that “these are the bills.” No need to have an expert testify that the bills were reasonable and necessary. This works well by itself if you have an “objective injury” of the kind that does not require expert testimony regarding causation (broken bones and such). See, *Reed v. Scott,* 1991 OK 113, 820 P.2d 445.

But, if you need the expert testimony anyway, you may want to get a treating doctor the sponsor the bills as well, showing the jury they were necessary, related, and reasonable.

**Future Medical Bills**

Beware, expert testimony is needed to introduce the topic of future medical bills, whether the injury is objective or subjective. *Reed v. Scott,* 1991 OK 113, 820 P.2d 445.

**Paid versus Incurred Statute**

**12 O.S 3009.1 hurdle:**

A. Upon the trial of any civil action arising from personal injury, the actual amounts paid for any services in the treatment of the injured party, including doctor bills, hospital bills, ambulance service bills, drug and other prescription bills, and similar bills shall be the amounts admissible at trial, not the amounts billed for such expenses incurred in the treatment of the party. If, in addition to evidence of payment, a party submits a signed statement acknowledged by the medical provider or an authorized representative or sworn testimony that the provider will accept the amount paid as full payment of the obligations, the statement or testimony shall be admitted into evidence. The statement or testimony shall be part of the record as an exhibit but need not be shown to the jury. If a medical provider has filed a lien in the case for an amount in excess of the amount paid, then the bills in excess of the amount paid, but not more than the amount of the lien, shall be admissible.

B. If no payment has been made, the Medicare reimbursement rates in effect when the personal injury occurred, not the amounts billed, shall be admissible if, in addition to evidence of nonpayment, a party submits a signed statement acknowledged by the medical provider or an authorized representative or sworn testimony that the provider will accept payment at the Medicare reimbursement rate less cost of recovery as provided in Medicare regulations as full payment of the obligation. The statement or testimony shall be admitted into evidence and shall be part of the record as an exhibit but need not be shown to the jury. If a medical provider has filed a lien in the case for an amount in excess of the Medicare rate, then the bills in excess of the amount of the Medicare rate, but not more than the amount of the lien, shall be admissible.

C. If no bills have been paid, or no statement acknowledged by the medical provider or sworn testimony as provided in subsections A and B of this section is provided to the opposing party and listed as an exhibit by the final pretrial hearing, then the amount billed shall be admissible at trial subject to the limitations regarding any lien filed in the case.

D. This section shall apply to civil actions arising from personal injury filed on or after November 1, 2015.

This statute adds a twist to the collateral source rule where medical bills have been paid by health insurance, workers compensation, Medicare/Medicaid, or the like. The billed amount is not admissible, but only the part that is (or will be) paid.

The first question is to what claims does it apply: “**any civil action arising from personal injury**.”

The obvious target would be third party liability claims. But what about UM claims? It should since a UM claim “arises out of personal injury.” But how does a UM carrier, which has an obligation to evaluate a claim “on the front end,” determine whether it will ever be able to apply the statute?

What about medpay? Perhaps.

**Burden of Proof**

Don’t assume because some of the medical bills have been paid by health insurance that the statute automatically applies. The paid amounts, as opposed to the billed amounts, seem only to be admissible if someone (presumably only the defendant would have an interest in so limiting damages) obtains written statements or sworn testimony, that the paid provider accepts the paid amount as payment in full. The current version of the statute makes more clear that the party wishing to limit evidence to the paid amount has the burden of obtaining the statements from the providers:

C. If no bills have been paid, or no statement acknowledged by the medical provider or sworn testimony as provided in subsections A and B of this section is provided to the opposing party and listed as an exhibit by the final pretrial hearing, then the amount billed shall be admissible at trial subject to the limitations regarding any lien filed in the case.

This raises the question, touched upon earlier, whether a UM carrier, which owes damages an insured is “legally entitled to recover” from the liable party, can apply the statute at the claim evaluation stage, making an assumption that it would be able to obtain the statements set out in the statute. Some think it constitutes bad faith to do so. I’m not so sure. But we don’t yet have an answer.

Letter to UM Carrier re: using Paid versus Incurred to discount UM evaluation:

I believe you are committing Travelers to a path of bad faith if you intend to evaluate medical bills on the basis of the “paid” amount rather than “incurred” amounts. I presume you do so on the basis of 12 O.S. 3009.1. That statute by its terms does not apply to a first-party contract claim, but only to “civil actions arising from personal injury.”

A more fundamental problem for a UM carrier trying to evoke the statute, though, is that it is not self-executing. Instead, the statute imposes a burden on the party evoking the statute to obtain statements from the providers agreeing to accept the paid amounts as payment in full:

C. If no bills have been paid, or no statement acknowledged by the medical provider or sworn testimony as provided in subsections A and B of this section is provided to the opposing party and listed as an exhibit by the final pretrial hearing, then the amount billed shall be admissible at trial subject to the limitations regarding any lien filed in the case.

*Lee v. Bueno,* which upholds the constitutionality of 3009.1, decided an older version of the statute, that did not include the language above which now imposes a burden on the party invoking the statute. Thus the current version, unlike that at issue in *Lee,* does not apply to all personal injury cases, but only to those in which the required statements are produced by the Defendant, by time of pretrial.

Also, to the extent a UM carrier may invoke 3009.1, it can only be because the damages available in a UM *contract* case, are determined by the damages that *would have been available* in the underlying *tort* case. If you intend to evaluate the claim on the basis of the paid amounts, please show me that you have obtained the required statements. As shown by 3009.1(C) quoted above, you never get to apply 3009.1 unless and until you obtain the statements. More often than not these statements never materialize (I have seen three of them (and only from one provider in those cases) and none of those complied with the statute). In other words it is more probably true than not true that you would never be able to meet the burden of the statute. For you to assume at the outset (if the statute even applies to a UM claim) that you will some day obtain the statements that are so rarely obtained, and you were then to evaluate the UM claim on that basis, I believe you violate the insurer’s duty of good faith and fair dealing.

Until you provide the statements, the default rule is that the collateral source doctrine is alive and well.  *C&H Power Line Const. Co. v. Enterprise Products Operating, LLC*, 2016 OK 102, ¶21, 386 P.3d 1027.

Additionally, I would refer you to *Falcone v. Liberty Mutual Insurance Co*., 2017 OK 11, 391 P.3d 105. This case holds that, even in the face of unsettled substantive law, the existence or not of bad faith is a jury question where the UM acts “arbitrarily” to limit UM liability. Presuming you will obtain statements that in reality are almost never obtained smacks of the very kind of arbitrary decision-making that got the carrier in a bad faith bind in *Falcone.* Now that we have the benefit of the reasoning of *Falcone* in that regard, Travelers will be even more so without excuse.

**APPLICATION OF OKLAHOMA’S 12 O.S. §3009.1 IN FEDERAL COURT**

This statute is a state evidentiary rule that says (under certain circumstances) in a personal injury case, a plaintiff may only introduce evidence of the amount of medical bills paid (or liened), rather than the full, as billed amounts. While the statute abrogates strict application of the collateral source rule under Oklahoma law, there is some question of whether the collateral source rule operates as procedural or substantive law for purposes of a federal diversity analysis. If the collateral source rule, and 12 O.S. 3009.1, operates as procedural law, a federal court sitting in diversity would not be obligated to follow Oklahoma law on the issue, but would apply its own procedural law.[[1]](#footnote-1) The rules of evidence are typically considered procedural. The weight of authority, though, suggests that the collateral source rule operates as “substantive” rather than “procedural” rule of law.[[2]](#footnote-2) As such, a federal court sitting in diversity would apply Oklahoma law on the issue, and would likely determine that 12 O.S. §3009.1 applies, such that a party is limited to evidence of the amount actually paid by Plaintiff’s health insurance carrier, rather than the full amount incurred.

Only a few federal cases have touched on the conflict between the collateral source rule and 12 O.S. §3009.1, Oklahoma’s 2009 statute restricting evidence of medical bills to the amount actually paid by an injured party and its health insurer (rather than the amount billed out by the healthcare provider). Two of these, *Compton v. Hale[[3]](#footnote-3)* and *Brown v. USA Truck, Inc*.[[4]](#footnote-4) were filed before the statute went into effect, but recognized that the statute would control if the claims had arisen later. In *Hodge v. Stan Koch & Sons Trucking, Inc.,[[5]](#footnote-5)* the court did not address the conflict upon defendant’s motion in limine, stating that the defendant could present evidence of collateral payments pursuant to §3009.1, only after the plaintiff opened the door by presenting evidence at trial of actual damages in excess of the amount paid. As such, no case provides a definitive answer to the questions of the applicability of §3009.1 in federal court.

Be aware of the disparity in how various federal courts have ruled on the collateral source question overall. A number of courts have held that the collateral source rule bars evidence that plaintiff’s bills were written-off by a health insurance or Medicare provider.[[6]](#footnote-6) Others have held the opposite to be true, holding that state statutes limiting the evidence of medical bills to those actually paid preempt the collateral source rule.[[7]](#footnote-7) Almost invariably, these federal court decisions have interpreted state law in deciding this as a substantive evidentiary issue.

**Don’t put any Medicals into Evidence**

Given the “Paid versus Incurred” dichotomy, consider another option for “getting medical bills into evidence”—don’t. Many believe medical bills, particularly after health insurance discounts are applied create only a “low anchor” that drives verdicts downward. See, e.g., <http://www.gigaxlaw.com/medical-bills-in-personal-injury-trials-ask-the-jury-to-award-them-the-low-anchoring-effect-of-medical-expenses/>.

Beware, though, you will likely have to fight the defendants’ efforts to introduce the medical bills as going to the extent of plaintiff’s injury or bearing on the claim for pain and suffering. See, e.g., <http://www.iadclaw.org/assets/1/19/TrialTechniquesTactics_April_2015.pdf>.

**B. Insurance Coverage**

**Passenger Insured Under Driver’s Policy on Uninvolved Car.** *Russell v. American States Ins. Co,* 813 F.2d 306 (10th Cir. 1987),suggests an unusual source for passenger UM coverage. In *Russell,* a passenger was killed in a wreck. The driver, unrelated to the deceased, was using someone else’s car at the time of the wreck. The deceased collected liability money from the car policy and from the driver’s policy, and collected UM as a Class I insured (named insured or resident relative) from his dad’s policy (on a different car).

The owner of the car had UM, on the policy on the car, and the driver, had UM on his own, separate policy, both of which were with American States. The declaratory action was to decide whether the deceased was entitled to UM under these two policies. We would normally expect the policy on the car to provide UM for the passenger as a Class II insured (insured by virtue of “occupying” the insured car). The District Court held (erroneously) that policy did not cover the passenger because the policy definition of an “uninsured vehicle” did not include an “insured highway vehicle.” That would seem to negate the requirement of the UM statute that coverage extend to “underinsured” cars. Indeed, no big surprise, that is what the Court of Appeals decided.

More interesting here, though, is the UM on the driver’s policy. Remember, the driver did not own the car and so his policy was on a noninvolved auto, such that the passenger would not be a typical class II “occupant” insured. That policy, though, had a provision that defined an “insured highway Vehicle” to include a car “being operated by the named insured . . . or a resident [relative].” Since the car “operated by” the named insured was thus an insured vehicle, the deceased passenger became a Class II insured by virtue of occupancy of an “insured vehicle.” From review of our office “specimen policy” bank, somewhere around half of the policies out there likely have this language.

**Oklahoma Governmental Tort Claims Act and UM Coverage.** What is the interaction between UM and the Governmental Tort Claims Act. 51 O.S. § 151, *et seq*.First, the OGTCA exempts governmental entities from “any loss to any person covered by any workers’ compensation act . . . .” 51 O.S. § 155(14). The exemption applies to both workers’ compensation claims by governmental employees as well as those by non-governmental employees. *Smith v. State ex rel. DOT,* 1994 OK 61, 875 P.2d 1147. There is a silver lining, though, in an auto case. The OGTCA exemption makes the governmental entity “uninsured” for purposes of UM. *Karlson v. City of OKC,* 1985 OK 45, 711 P.2d 72.

But, is an OGTCA entity entitled to a set-off for UM payments made? A lot of OGTCA entities cite the exemption for “any claim based on the theory of indemnification or subrogation,” (51 O.S. § 155(28) for this proposition. That provision seems clearly only to preclude a subrogated entity from subrogating against the GTCA entity. But apparently this bluff is working. I don’t know how they are still doing this in the face of *Salazar Roofing & Const. Co. v. City of OKC,* 2010 OK 34, 249 P.3d 950, but apparently they still are. See, e.g., *Moore v. Park View Hospital Trist Authority, et al.,* S. Ct. Case No. 112,134 (Okla. Ct. App. 2014 (not for publication). A related argument is based upon a stilted reading of 51 O.S. § 158, which gives a governmental entity a setoff when *its own coverage* pays a claim. The OGTCA entity claims Subparagraph E creates the setoff:

The state or a political subdivision shall not be liable for any costs, judgments or settlements paid through an applicable contract or policy of insurance but shall be entitled to set off those payments against liability arising from the same occurrence.

This setoff provision should be read in context with the rest of the statute, which tells how OGTCA settlements and verdicts may be negotiated and paid. Subparagraph E merely gives the OGTCA entity credit for payments made under any insurance policy covering that entity. Nothing about that statute suggests the governmental entity is allowed to reach out and take credit for the injured party’s insurance.

The final OGTCA topic worth mentioning concerns the “waiver” of immunity created by the purchase of liability insurance. We had a car wreck case against a county, with bad injuries. The county had a liability policy with limits equal to the $125,000 OGTCA limits applicable to the county. The driver of the car (personal car used on OGTCA entity business) also had her own liability policy with $50,000 limits. Though the driver was immune from suit under the OGTCA, her policy had a provision required by the OGTCA entity, that made the county an additional insured (a definition of “insured” included any organization for acts or omissions of an insured).

We argued the OGTCA entity had waived immunity to the full extent of the available liability coverage, citing *Lamont Independent School Dist. v. Swanson*, 1976 OK 38, 548 P.2d 215. The OGTCA entity (well, NAICO, its insurance, really) claimed an offset for the $50,000, citing a provision *in its liability policy* that said the liability coverage “does not waive” the OGTCA limits. We argued the insurance company cannot, by such a provision, negate Oklahoma law with respect to such waivers of immunity. NAICO claimed it did not seek an “offset,” but that its policy only paid amounts the entity was “legally obligated to pay,” and that once the $50,000 had been tendered, that reduced that “obligation” to $75,000. The case settled before we could get it up on appeal, so we do not have an answer.

**UM and the Oklahoma Guarantee Fund.** When does the Oklahoma Property and Casualty Insurance Guarantee fund (26 O.S. 2001 *et seq.*) provide UM coverage. We have run across this with both Pride Insurance and now Santa Fe in receivership. Who pays in this situation? The injured party has recourse to the state Guarantee fund, which pays claims for insolvent insurance companies. But what about UM? The UM statute (subparagraphs D and E) defines a car with insolvent liability coverage as an “uninsured” car, so that the UM steps in for the insolvent coverage. Also, the Guarantee fund requires exhaustion of all other available coverage before the fund kicks in. Though UM was at one time excluded from the exhaustion requirement (and before that included), UM is currently not excluded by 36 O.S. § 2012. Also, *Welch v. Armer,* 1989 OK 117, 776 P.2d 847. The tortfeasor is also protected by the payment under the Fund, but only up to the limits of the insolvent policy.

An unresolved issue is whether the UM statute’s definition of insolvency as creating an “uninsured” car is limited to those becoming insolvent within one-year of the wreck. While 36 O.S. § 3636(C) defines insolvency to create uninsured status, subsection D purports to limit “[a]n insurer’s insolvency protection” to insolvency occurring within one year of the accident.

Although I’m told I am crazy, do not think this means that UM does not apply to insolvency that occurs more than one year after the wreck. I take comfort that a majority of our Supreme Court, *in dicta* at least, seems to agree (from *Burch v. Allstate Ins. Co.,* 1998 OK 129, 977 P.2d 1057):

The dissent argues that in enacting [§ 3636 (D)](https://advance.lexis.com/GoToContentView?requestid=f03a1349-2535-9bb1-9d78-699abb5f0c50&crid=151cf3ef-b856-c127-194e-9d8005369df4), the Legislature explicitly limited the use of UM coverage as a substitute for liability coverage to the situation in which the liability carrier becomes insolvent within one year after the date of the accident. The dissent is mistaken. Subsection (D) merely deals with an insolvent insurer as a special subclass of available UM insurance from indemnitors who become insolvent.

I think maybe Subsection (D) speaks to the right of the UM carrier to look to the Guarantee Fund for repayment after the UM pays a claim based on the liability carrier’s insolvency. That’s my story--until the Supreme Court confirms I really am crazy.

Another unresolved issue is whether the Fund gets a pass once UM pays, though the injuries exceed the UM. The Fund, I’m told, takes the position that the insolvent insurance company’s limits are “fully reduced” by the UM payment, apparently regardless the extent of damages. That seems to be a misreading of the exhaustion statute, which says in Subparagraph (A)(2):

Any amount payable on a covered claim under the Oklahoma Property and Casualty Insurance Guaranty Association Act shall be reduced by the full applicable limits stated in the insurance policy or by the amount of the recovery under the insurance policy as provided herein. The Association shall receive a full credit for the stated limits, unless the claimant demonstrates that the claimant used reasonable efforts to exhaust all coverage and limits applicable under the other insurance policy. If the claimant demonstrates that the claimant used reasonable efforts to exhaust all coverage and limits applicable under the insurance policy, or if there are no applicable stated limits under the policy, the Association shall receive a full credit for the total recovery.

If the Fund is right, the badly injured UM claimant loses any real benefit from the UM since that prevents payment by the Fund. If I were on the other side, I would argue, where injuries warrant, the exhaustion statute just reverses the priority of payment, making the UM pay first, with the Fund then kicking in after the UM. It seems that if the legislature intended by Subparagraph 2 to give the Fund a pass once another policy pays, it would have been much easier to say that than to create the “credit” that really negates any potential for coverage. I hear there is a case poised to address this question.

**Multiple Policyholders**

***Morris* and *Connor and UM Coverage Under Resident Relative Coverage.*** For some 40 years, we have relied upon a mantra in Oklahoma: “While an insurance company is free to decide at the outset who is and is not a UM insured, once it defines someone as a UM insured, it is not free to limit coverage based upon the particular vehicle occupied at the time of injury.” And, “it is up to the legislature to carve out any exceptions to this rule.” The mantra comes from a trilogy of cases:

First, *Cothren v. Emcasco,* 1976 OK 137, 555 P.2d 1037 invalidated an “owned but uninsured vehicle” exclusion in a UM policy (that policy excluded coverage to an insured while occupying a vehicle owned by an insured, but not insured under the policy). That was not okay since it took UM coverage away from someone already defined as a UM insured.

In *Shepard v. Farmers Ins. Co.,* 1976 OK 137, 555 P.2d 1037. by contrast, the Court upholds a policy definition of insured which said a resident relative who owned her own car was not a UM insured under the policy. That was okay since it did not take coverage away from a defined insured.

*State Farm Mut. Auto. Ins. Co. v. Wendt,* 1985 OK 75, 708 P.2d 581, then synthesizes the above two cases: Once one is defined as a UM insured (Class I, only—since Class II UM does not follow the person) “subsequent exclusions inserted by the insurer in the policy which dilute and impermissibly limit uninsured motorists coverage are void as violative of the public policy expressed by [the UM statute].”

In 2004 the legislature accepted the Court’s “challenge” and carved out an exception:

For purposes of this section, there is no coverage *for any insured* while occupying a motor vehicle owned by, or furnished or available for the regular use of the named insured, a resident spouse of the named insured, or a resident relative of the named insured, if such motor vehicle is not insured *by a motor vehicle insurance policy*.(emphasis added)

The exception seems by its terms to apply only where the UM insured occupies a car that is not covered *for liability.* Apparently looks are deceiving.

In *Connor v. American Commerce Ins. Co*., 2009 OK CIV APP 61, 216 P.3d 850, a son who lived with his parents owned his own motorcycle, *which he insured for liability only* with AIG. His parents had a policy with American Commerce, which had UM that included a resident relative in the definition of UM insured. That policy then had *an exclusion* to the UM coverage when a resident relative occupied a car that was *not insured for UM.* This seems inconsistent with *Cothren/Shepard/Wendt,* so what about the only exception “carved out by the legislature?” Doesn’t the exception apply only when the occupied car is without liability coverage? COCA recites the amendment, and even notes it applies only where the occupied car is devoid of coverage, but then simply holds a policy exclusion that does not allow UM to extend to a vehicle Defendant insurance company does not insure and which is not otherwise covered for UM is “not inconsistent with” the UM statute.

We tried to get Supreme Court to overrule *Connor* in *Morris v. America First Ins. Co.,* 2010 OK 35, 240 P.3d 661. Instead, the Court limited *Connor* to where the resident relative has no other UM (that resident relative insured had liability but not UM on the occupied car (as in *Connor*), but also happened to have another policy on his semi, which did have UM. So, under these cases, if the resident relative has a separate policy that has UM, the resident relative is also entitled to the UM on the relative’s policy, but if the resident relative’s separate policies have no UM, then there is no UM under the relative’s policy either.

**Stacking of Commercial and Personal Policies**

Employee who causes injury while on the clock is insured under his own auto policy, as well as under the employer’s commercial auto policy, as an “additional insured,” under the omnibus coverage provision. The coverage on the auto will usually be primary, with the coverage on the “non-owned” policy being excess.

Beware, if the policy has (and it likely will) a “Limits of Liability Clause,” restricting total coverage to the “limits provided by the policy with the highest limits,” that will be enforced. *Gordon v. Gordon,* 2005 OK 5, 41 P.3d 391. That is because our compulsory insurance laws mandate only one legal limit of coverage.

But, if the policies have no “Limits of Liability Clause, but both have “other insurance clauses” making each “excess,” the provisions cancel each other out and both have pro rata primary coverage up to the cumulative limit. *Equity Mut. Ins. Co., v. Spring Valley Wholesale Nursery, Inc.,* 1987 OK 121, 747 P.2d 947 (this case involves the commercial coverage on tractor trailer and personal coverage on the trailer). Don’t expect to see this very often.

*Shelter General Ins. Co. v. Earthsmart Const., Inc.,*2015 WL 6672216, holds you cannot stack coverage on semi-tractor, with separate coverage on semi-trailer, when written by same company.

**Excess Coverage**

*Smith v. Geico,*1976 OK 190, 558 P.2d 1160, holds liability coverage may condition coverage on exhaustion of all other available coverage. (upholds clause making coverage on driver of non-owned auto excess to coverage on auto).

**UM Priority and is Umbrella Counted in Determining Liability Limits?** Is there priority among UM and is an Excess/Umbrella policy considered in determining tortfeasor coverage limits? We still hear from some adjusters that some other UM policy should pay before theirs. For instance, some still say, the UM on the car pays before the UM on the person. In fairness, these adjusters may be remembering *dicta* in *Keel v. MFA Ins. Co.,* 1976 OK 86, 553 P.2d 153, to that effect. Though there is such priority with respect to liability coverage, there is not with respect to UM. That is because UM is first party coverage for which the insured (or someone on their behalf) has paid a premium.

This is made clear in *Mustain v. United States Fid. & Guar. Co.,* 1996 OK 98, 925 P.2d 533. In *Mustain,* the injured party was defined as a UM insured under an employer’s policy and under his own policy. When he settled the claim against the employer’s UM for less than limits, his personal policy refused to pay, claiming he had to exhaust the employer’s policy on the truck he was in at the time of the injury.

On certified question for the Western District of Oklahoma, the Supreme Court determined all UM, with respect at least to the UM insured, is “primary” and thus there is no UM “priority.” *Mustain* makes clear, though, once the UM is paid, the insurance companies may still have a right to apportionment amongst themselves as to which ultimately bears the burden of the UM paid. *Burch v. Allstate Ins. Co.,* 1998 OK 129, 977 P.2d 1057, teaches since UM is primary, once the insured shows damages in excess of liability limits, the UM must pay the amount in excess of the liability, up to its limit, from “dollar one” without waiting for the insured to “exhaust” the liability coverage. If multiple UM carriers, all have duty to pay first, resolve priority amongst themselves. *Pentz v. Davis,* 1996 OK 89, 927 P.2d 538

On a different, but sort of related matter, *Geico v. Northwestern Pacific Ind. Co.,* 2005 OK 40, 115 P.3d 856, holds that a UM insured need not count excess or umbrella liability coverage in determining whether injuries exceed liability limits. This is because the UM statute is intended to provide “minimum” protection when the primary *automobile* liability policy does not. The UM statute just does not “contemplate” the excess coverage found in a “comprehensive public liability policy.” *Moser v. Liberty Mut. Ins. Co.,* 1986 OK 78, 731 P.2d 406.

**Oklahoma UM no Longer Stacks—**The UM statute 36 O.S. 3636 was amended in 2014: (subparagraph B) *Policies issued, renewed or reinstated after November 1, 2014, shall not be subject to stacking or aggregation of limits unless expressly provided for by an insurance carrier.*

Does this mean the policy must say “this policy stacks”? or is it enough if the policy contains language interpreted to allow stacking?

Does this prevent “stacking” of liability and UM for a passenger?

Does this prevent “stacking of UM policies under different policies? For instance, we sometimes look to UM on the policy on: (1) the insured person; (2) the occupied car; (3) on a “Resident Relative”; (4) on an employer; and (5), on passenger’s uninvolved car (see discussion below, or *Russell v. Am. States Ins. Co.*

**Is Imputed UM Stackable UM?**

Though becoming rarer, it still sometimes happens that an insurance company is unable to produce a valid, signed, UM rejection. What happens when this is so with respect to a policy insuring multiple cars? Is the UM that is “imputed” by reason of the insurance company failure to produce a rejection stackable UM? This question was answered in *Mid-Continent Group v. Henry,* 2003 OK CIV APP 46, 69 P.3d 1216—imputed UM does stack. But *Henry* was then overruled by *Spears v. Glens Falls Ins. Co.,* 2005 OK 35, 114 P.3d 448. We argued in a case last year that *Henry* was overruled on other grounds and that *Spears* actually affirms the holding regarding imputed stacking—at least where the underlying policy has “Stacking” language:

*[U]nder the facts presented*, where the UM/UIM coverage form provided to the insured conforms with the requirements of 36 O.S. Supp.2004 § 3636, the policy is renewed annually over a ten-year period with the insured being provided coverage summaries at each renewal, a single premium is charged for multiple vehicles having UM/UIM coverage, and *policy language provides that liability for UM/UIM coverage is limited to the maximum amount payable for all damages regardless of the number of vehicles insured*, an insurance company need not provide insureds with pre-policy notice that stacking of UM/UIM coverage is prohibited. (emphasis added)

Taken together, *Henry* and *Spears* seem to say that imputed coverage will stack if policy language supports stacking, but will not stack if the policy is otherwise not a stackable policy.In our case, some good arguments were presented for both sides of this coin. The case settled before we got an answer, though.

**Dog bite coverage—**Oklahoma has strict liability in dog bite cases, as long as not in a “rural area.” 4 O.S. 42.1-42.3. But, many homeowners policies now have exclusions for dog bite in general, or for bites by particular breeds of dogs, or by dogs with a prior bite history. Also keep in mind, dog bite coverage on the HO policy is not limited to the residence premises, but includes coverage for off-residence bites.

**C. Significant Case Law**

**BAD FAITH - *Falcone v. Liberty Mutual Insurance Co.*, 2017 OK 11, 391 P.3d 105**

**UM Carrier *May Be* in Bad Faith for:**

**1 Submitting Medical Bills to Medical Review for Reasonableness AND**

**2 on that basis offering less than the policy limits**

Liberty paid its $1,000 med-pay

Liberty refused to pay $100,000 UM limit

Offering only $37,855.23 UM

Liberty Mutual justification:

In suit, Liberty paid the $100,000 limit and Falcone dismissed policy claim

Proceeded with bad faith claim

Supreme Court reversed

Not bad faith to question reasonableness of medical billing

But UM carrier ***may be***in bad faith for:

Potentially arbitrary offers leading up to filing of suit and then paying the limits only after forcing suit

Questions for the jury

**No UM Subrogation Against Underinsured Motorist’s Excess or Umbrella Liability Policy**

**UM - *Raymond v. Taylor*, 2017 OK 80, \_\_P.3d \_\_**

**But there is says the Trial Court**

**Yup says the COCA**

**Not so fast says the Supreme Court:**

Consistent with whole of 36 O.S. 3636, there is no right of subrogation against excess coverage

*Moser v. Liberty Mut. Ins. Co.*, 1986 OK 78, 731 P.2d 406

No offer of UM needed with excess coverage

*GEICO Gen. Ins. Co. v. NPIC,* 2005 OK 40, 115 P.3d 856

Need not exceed excess coverage to trigger UM

Majority ties decision directly to 3636(F) and to 3636(C)

3636C. …"uninsured motor vehicle" shall include an insured motor vehicle where the liability insurer thereof is unable to make payment with respect to the legal liability of its insured within the limits specified therein because of insolvency. For the purposes of this coverage the term "uninsured motor vehicle" shall also include an insured motor vehicle, the liability limits of which are less than the amount of the claim of the person or persons making such claim, regardless of the amount of coverage of either of the parties in relation to each other.

3636F. In the event of payment to any person under the coverage required by this section and subject to the terms and conditions of such coverage, the insurer making such payment shall, to the extent thereof, be entitled to the proceeds of any settlement or judgment … Provided, however, with respect to payments made by reason of the coverage described in subsection C of this section, the insurer making such payment shall not be entitled to any right of recovery against such tort-feasor in excess of the proceeds recovered from the assets of the insolvent insurer of said tort-feasor.

**BAD FAITH - *Martin v. Gray*, 2016 OK 114, 385 P.3d 64**

**Proper Conflict of Laws Rule for a Bad Faith Case Is the Tort Rule, Not the Contract Rule, So It Was Improper to Apply Kansas Law. As the Law of the State In which the Policy Was Written Where the Loss Occurred in Oklahoma and the Claim was Adjusted in Oklahoma**

Kansas policy with UM

Wreck in Oklahoma

Certified choice of law issue for interlocutory appeal

Supreme Court granted *certiorari*

Held trial court should have applied tort choice of law test

Look to which state had most significant relationship to transaction

*Brickner v. Gooden,* 1974 OK 91, 525 P.2d 632

the rights and liabilities of parties with respect to a particular issue in tort shall be determined by the local law of the state which, with respect to that issue, has the most significant relationship to the occurrence and the parties.

Oklahoma

Pennsylvania

Kansas

Court would have remanded for determination which state had most significant relationship

But parties settled case

Exception to Mootness Doctrine

**D. Claims Against Recovery**

**1. Medicare Set-Asides**

We all know we have to “consider” Medicare’s interests in resolving our liability claims. We have, for years, had rules regarding what we must pay back to Medicare for medical bills paid by Medicare to the point of resolution of the liability claim. But what about future bills Medicare may have to pay as a result of the injury? This is where we talk about Medicare “set-asides.” A Set aside is a fund carved out of any settlement or judgment that is “set aside” in a trust or similar arrangement to pay those future medical bills so the burden does not fall on Medicare. Medicare set-asides have long been the rule in workers’ compensation claims. If a Medicare recipient is likely to have future claims related to the work injury, resolution of the comp claim must include consideration of those future claims and the most common way to handle that is through a set aside. Indeed, Medicare will even review and “approve” the set aside.

Keep in mind also, if you have both a comp and a liability claim, you cannot shift the future medical bills onto the liability claim in order not to have to create a set aside for the comp claim. In that situation, even if you do not allocate future bills in the comp recovery, a set aside will be required.

But what about liability claims in the absence of a parallel comp claim? While the enabling rules and regulations have been in place for years with respect to workers’ compensation, there are no such rules and regulations when it comes to liability cases. So, while the statutory scheme is broad enough to encompass liability claims, there are no rules in place to require them.

First, it should be noted there are not regulatory guidelines with respect to liability claims as there are with comp claims.

So, then, does that mean we are off the hook when it comes to liability set asides? Not really. I think most of us know that liability set asides are coming. We got a hint of this in the 2007 act instituting mandatory reporting of settlements and judgements in liability claims. While that may have been done to help ensure Medicare was capturing past payments, it may suggest Medicare was building the mechanisms to ultimately require LMSAs.

2012-2014—Medicare issued Advanced Notice of Proposed Rulemaking and then withdrew that ANPR in 2014.

In 2016, Medicare announced it was (again) considering expanding the review process to include liability claims. Nothing really came of the announcement, though, other than discussion of setting some “town hall” meetings to get input. Those have as yet not occurred.

In 2017, Medicare contracted a new entity for its workers’ compensation set aside review. In that process, Medicare requested that any new entity be prepared to conduct review of liability set asides as well. I think the moral of this story is that it is just a matter of time before liability MSAs are here.

In February 2017, Medicare directed its contractors to deny payments where a liability (or no-fault) MSA should have been created. The “guidance” was rescinded in October 2017.

As late as November 2017, at least one federal court in New Mexico (which is in the 10th Circuit), declined to exercise jurisdiction to rule that a liability set aside was necessary. *Silva v. Burwell,* 2017 WL 5891753. In that case though, CMS (Medicare) declined to approve a set aside in a medical negligence case and the hospital defendant was seeking the declaration (that none was required). Perhaps the result would be different had it been CMS seeking the declaration—though the holding would seem to suggest the end result would be the same, as the court declined to exercise jurisdiction in the absence of a regulatory scheme addressing liability set asides.

What happens, though, if Medicare ultimately determines there should have been a set aside in a particular liability case? Medicare has the power of “self-help.” The remedy is Medicare simply refuses to pay future bills until the appropriate amount of the recovery has been matched. To be sure, when that happens, you will be taken off the client’s Christmas list.

Until we have real guidance, then, what is one to do? The safest approach, in the appropriate case (decent recovery and likely future medical care falling to Medicare), is to have the client set up a voluntary MSA. As yet, though, know that Medicare will not “approve” such arrangements, so you have no real guarantee yours will be adequate. If you wish to limit the set aside potential to that portion of the recovery allocated to future medicals, you will need to get a court to order the allocation. Medicare will honor the court order, but will not honor the parties allocation.

Alternatively (and perhaps the best solution, when true) is to document the file with a letter from the client’s medical providers stating that the client is fully recovered and will need no future care.

At a minimum on the plaintiff’s side, you should advise the client (in a writing signed by the client) regarding the potential for a Medicare “holiday” and recommend that the client retain some portion of the recovery should Medicare refuse to pay the future bills. Will that protect you from an angry client? Perhaps not, but it may be enough to protect you from a malpractice suit.

Also, there seems to be no requirement for a set aside where past payments have not been made, since that is the trigger for Medicare Secondary Payer Statute only applies when a beneficiary (as opposed to a potential beneficiary) is involved. That should mean (knock on wood) that you do not have to consider a set aside for a “future Medicare recipient.”

**2. Workers' Compensation Liens**

**(Talk to Bob Burke or Danny Talbot, who helped me to understand the following with respect to subrogation under the new administrative scheme** (The Administrative Workers’ Compensation Act (AWCA)).

*Prettyman* is abrogated, and the rule that the District court had jurisdiction to determine subrogation in a “compromise case,” has been abolished. The new rule allocates, if the carrier joins suit with the injured worker, 2/3 of the third-party recovery, after “reasonable costs of collection.” It is not clear whether “reasonable costs of collection” include the worker’s attorney fee for collecting the carrier’s subrogation. Alternatively, the employer can file suit, giving notice to the injured worker, and then gets to keep 100% of the proceeds up to the amount or compensation paid.

This is likely a “substantive” statute that will apply only to injury arising after the enactment. See, *Cole v. Silverado Foods, Inc.,* 1993 OK 81, 78 P.3d 542.

In both fatal and non-fatal workers’ compensation cases, 85(A) O.S. § 43 gives an employer a first lien on a third-party recovery of two thirds of the recovery, up to the amount of benefits paid (after deducting a “reasonable” attorney’s fees and costs).

Subsection A gives the employer the right of recovery if the employer joins the third-party lawsuit.

Subsection B gives the employer the right to bring a direct action against the negligent third party, after proper notice is given to the injured worker. The injured employee is entitled to any recovery in excess of the benefits paid.

Section 43 (B)(4) gives the employer the right to maintain a third-party action against its own uninsured motorists’ coverage. That subsection says nothing about the employer having a subrogation interest in what the injured worker receives from UM, it simply gives the employer the right to sue its own UM carrier.

The Oklahoma Supreme Court has not spoken regarding the above. Two unpublished Court of Civil Appeals (one based upon the old workers’ compensation law, and the other pending on a Petition for Certiorari) provide our guidance, beyond the statute itself.

**Subrogation in Death Cases**

While there is no word from the Supreme Court, Burke notes a recent decision from Grady County, *Rogers v. Sims and UPS*, Intervenor, CJ-2015-2 where District Judge Richard Van Dyck ruled that any subrogation right granted employers or their insurance carriers by Section 43 of Title 85A is "in violation of Article 23, Section 7 of the state constitution." UPS did not appeal that decision.

Burke also finds guidance in an older (2015) unpublished COCA case, *Stump v. Vargas,* Case No. 112,448. *Stump* is based on the older Workers’ Compensation Code, which, in 85 O.S. 348, gave the employer “the right to subrogation …for death claims . . .,” which tracks with the ACA.

*Stump,* holds subrogation in a death case violates Article 23, § 7 of the Constitution, the same grounds upon which the Grady County district court order was based under the AWCA.

*Stump* points out that workers’ compensation death benefits and wrongful death damages are different. Workers’ compensation benefits are limited to a percentage of the worker’s average weekly wage. In a wrongful death action, by contrast, there is no limit. There is, similarly, no recovery for pain and suffering and mental anguish in compensation, while these are a substantial component of a wrongful death action. If the subrogation is allowed, this imposes a constitutionally impermissible statutory limitation on wrongful death damages.

*Stump* discusses dicta in a line of Oklahoma Supreme Court, that subrogation would improperly limit the heirs’ rights to wrongful death damages. See *Updike Advertising Sys. v. State Industrial Commission,* 1955 OK 19, 282 P.2d 759, and *Earnest, Inc. v. LeGrand,* 1980 OK 180, 621 P.2d 1148, and *McBride v. Grand Island Express, Inc.,* 2010 OK 93, 246 P.3d 718.

*Stump* has some problems. The COCA remanded, holding the carrier could recover under an interpretation of the statute that substitutes “indemnity” for “subrogation,” subject to defenses that might be raised. The case then settled.

**Subrogation in Non-Fatal cases**

Nor has the Supreme Court ruled on the constitutionality of the two-thirds---one-third subrogation split contained in § 43. *Talbot v. Cudd Pressure Control, Inc.,* No. 116,336, Division III of the COCA upholding the provision, is pending on a Petition for Certiorari to the Supreme Court.

The injury in *Talbot* occurred in Montana, whose Supreme Court applied the make-whole rule to negate the subrogation claim.

In the Oklahoma action, the COCA holds the Montana decision only affects past benefits. To allow the employer and its carrier a holiday, or suspension of benefits in the future, COCA said there is a right of “recoupment.” That even if there is no right of subrogation, there is a right of recoupment, which sort of gets the carrier to the same result—as long as there are future benefits due. See *ACCOSIF v. American States Insurance Company,* 2000 OK 21, 1 P.3d 987 for discussion of recoupment. There, the injured worker settled the third party claim without telling the comp carrier. The Supreme Court extended the statute of limitations that would have otherwise run on a “subrogation,” letting the carrier sue for “recoupment” to recover the lost subrogation. In *Talbot,* the comp carrier was a party to the litigation and lost its right for subrogation in the Montana Supreme Court. The question for the Supreme Court is now whether the comp carrier, having lost the subrogation action, gets a second bite through recoupment.

**3. Medical Provider Liens**

**Hospital and Physician Liens Both Attach to UM**

This is not really new “news,” but still worth repeating, both physician and hospital liens attach to UM. It used to be physician liens (42 O.S. § 46) attached to both liability and UM, but hospital liens (42 O.S. § 43) did not. The legislature “fixed” this problem in 2012. The two statutes now have similar language, making both kinds of liens attach both to “claims against another” and to “claims against an insurer” (this was missing from the hospital lien statute and catches UM). See, *Broadway Clinic v. Liberty Mutual Ins. Co.,* 2006 OK 29, 139 P.3d 873.

The physician lien statute was also broadened to include “any other professional who engages in the healing arts.” That would include physical therapists, MRI clinics, and many others.

Also, it used to be the provider had one-year from the filing of the lien to sue to enforce the lien (or renew the lien). That was changed in 1994. Now the providers have one year from the time they learn of settlement or verdict to enforce the lien. Much harder now to extinguish an old lien.

**Validity of Lien**

I just settled one with coverage on the driver and the car with way more in liens than coverage. The bulk of the coverage was on the driver, but none of the liens listed that carrier, but only listed the car’s carrier. I had the carriers send me the drafts with the pertinent lienholders on them. I think that prevents the lienholders from amending to fix this problem (and other potential defects). I plan to argue they only have a lien against the one coverage. The carrier for the driver seemed to agree with my logic, because they agreed to only list the lienholders who named them in their liens. I know the lien statutes are strictly construed (*Kratz v. Kratz).* I have also seen some COCA cases that say that means there must be “strict compliance,” while others say the subject of the lien statutes are strictly construed, but that substantial compliance is sufficient to perfect a lien that falls within the subject of a lien statute.

But then Rex Travis pointed out: I’m sort of struck by your statement that: “I had the carriers send me the drafts with the pertinent lienholders on them. I think that prevents the lienholders from amending to fix this problem (and other potential defects).” Before you rely on that, read *St. Francis Hosp. v. Vaughn*, 1998 OK CIV APP 167, 971 P.2d 401: Lien filed after settlement but before lawyer cashed settlement check attached to the funds in the lawyer’s hands.

There the fact that the lien was not even filed when the settlement checks were written didn’t prevent the lien from attaching to funds in the lawyer’s hands because he had not yet disbursed the funds.

My response:

That was what I have always understood the law to be, but I’m hoping the Supreme Court reads the statute differently. The lien statutes both say something along these lines (my emphasis):

No lien which is provided for in this section shall be effective unless, *before the payment of any monies to the injured person****, the attorney for the injured person****, or legal representative* as compensation for such injuries or death:

1. A written notice is sent setting forth a statement of the amount claimed, *identifying the insurance policy or policies against which the lien is asserted*, if any, and containing the name and address of the physician or professional person licensed under Title 59 of the Oklahoma Statutes claiming the lien, the injured person, and the person, firm, or corporation against whom the claim is made, is filed on the mechanic's and materialman's lien docket in the office of the county clerk of the county where the principal office of the physician or professional person licensed under Title 59 of the Oklahoma Statutes is located.

Hope springs eternal.

**Don’t Try to Stiff a Medical Lienholder**   
*State ex rel. Oklahoma Bar Association v. Bedford*, 1997 OK 83, 956 P.2d 148, holds that the lawyer owes a duty to a medical lien claimant to see that the lien claimant got paid out of a settlement. This was so even though the Professional Responsibility Tribunal (which is the fact-finding body in a bar disciplinary case) found the lawyer had no actual notice of the lien. By paying out the settlement proceeds to the client and failing to protect the medical lien claimant, the lawyer committed an ethical violation. The same rule may or may not apply to subrogation claims. Scary.

It gets worse. *State ex rel. Oklahoma Bar Association v. Taylor,* 2003 OK 56, 71 P.3d 18, holds that, at least under the peculiar circumstances of that case, the lawyer had a duty not only to segregate the funds claimed by medical lien claimants, he also had a duty to interplead funds to pay the lien claimant. The case may be somewhat limited to its facts because the lawyer involved had told the lien claimants he would interplead the funds if the lien claimants could not agree to a distribution. Hopefully, that is what the Supreme Court meant to hold. It may be that the lawyer may just notify the claimants he holds the funds and leave it to the claimants to file some action to resolve disputes as to whether the client owes the money and, if so, how much.

You may also face personal liability in a civil case for failing to honor a lien. *St. Francis Hosp. v. Vaughn*, 1998 OK CIV APP 167, 971 P.2d 401. *Vaughn* also holds the lien attached to the funds in the lawyer’s hands, even though the lien was not yet filed when he settled. Read these cases before getting into a dispute with lien or subrogation claimants to your clients’ recovery. It could save you a bar complaint or civil liability.

Finally, with respect to medical claims, be careful if you want to do what some lawyers do and misrepresent your fee so you can avoid the lien/subrogation claims in order to put money in your client’s pocket. It is admirable of you to do whatever (legally) you can to avoid leaving a client without a recovery. Just don’t do that by lying to the claimants and to the tribunal about where the recovery is going. Be mindful of ORPC 4.1, which makes it a violation to make a false statement or fail to disclose a material fact to a third person. Though I couch the issue in terms of “misrepresentation” and “lying” there are good attorneys out there who think this is simply a matter of them choosing what to do with an earned fee.

**4. Health Insurance Liens**

**Don’t Ignore ERISA Subrogation**  
Employer-sponsored health plans will claim that a lawyer who fails to make his client pay a subrogation claim to the plan may be personally liable to the health insurance plan or company, under ERISA. An Oklahoma federal court reached that result, rendering judgment for $83,819.15 against a lawyer who failed to force his client to repay an ERISA subrogation claim. *Colony Ins. Co. v. Burke*, 698 F.3d 1222 (10th Cir. 2012). The rationale is that the lawyer becomes a fiduciary (involuntary) for the ERISA plan, and so is obligated to protect the health plan against the client because he has discretionary authority to dispose of the settlement proceeds contrary to his client’s wishes.

Oklahoma and the Tenth Circuit have ruled differently as to the validity of the make whole rule. *Equity Fire and Cas. Co. v. Youngblood*, 1996 OK 123, 927 P.2d 572, disapproving *Fields v. Farmers Ins. Co., Inc.*, 847 F.Supp. 160 (W.D.Okla. 1993), aff’d, 18 F.3d 831 (10th Cir. 1994).

Because ERISA is a federal law, the federal courts have concurrent jurisdiction with the state courts. Which court you are in will determine whether this important rule applies.  
This remains a threat, even though the case on which the Oklahoma federal judge relied has been reversed on appeal. The only safe way to protect yourself from this potential source of liability is to sue the ERISA plan for a declaratory judgment as to the plan’s entitlement to the funds.

**Make Whole Rule**

Make whole rule applies unless contract negates. *Equity Fire and Cas. Co. v. Youngblood*, 1996 OK 123, 927 P.2d 572.

**Common Fund Doctrine**

Also applies in the absence of contrary language in the contract. *Equity Fire and Cas. Co. v. Youngblood*, 1996 OK 123, 927 P.2d 572.

1. See *Hanna v. Plumer*, 380 U.S. 460, 465 (1965) [↑](#footnote-ref-1)
2. *See* *Manderson v. Chet Morrison Contractors, Inc*., 666 F.3d 373, 381 (5th Cir. 2012); *Davis v. Odeco, Inc.,* 18 F.3d 1237, 1243 (5th Cir. 1994); *Bradford v. Bruno's, Inc*., 41 F.3d 625, 626 (11th Cir. 1995); *Shelley v. White*, 711 F. Supp. 2d 1295, 1297 (M.D. Ala. 2010); *Lindholm v. Hassan*, 369 F. Supp. 2d 1104, 1106 (D.S.D. 2005) [↑](#footnote-ref-2)
3. No. CIV-11-319-RAW, 2012 WL 5385680 (E.D. Okla. Oct. 2, 2012) [↑](#footnote-ref-3)
4. No. CIV-11-856-D, 2013 WL 653195 (W.D. Okla. Feb. 21, 2013) [↑](#footnote-ref-4)
5. No. CIV-13-071-KEW, 2015 WL 540815, at \*1, ¶3 (E.D. Okla. Feb. 9, 2015) [↑](#footnote-ref-5)
6. *See Reed v. Nat'l Council of Boy Scouts of Am., Inc*., 706 F. Supp. 2d 180, 194 (D.N.H. 2010); *McConnell v. Wal-Mart Stores, Inc*., 995 F. Supp. 2d 1164, 1169 (D. Nev. 2014*); Pipkins v. TA Operating Corp*., 466 F. Supp. 2d 1255, 1262 (D.N.M. 2006); *Lindholm v. Hassan*, 369 F. Supp. 2d 1104, 1107 (D.S.D. 2005); *Blige v. M/V GEECHEE GIRL*, 180 F. Supp. 2d 1349, 1357 (S.D. Ga. 2001) [↑](#footnote-ref-6)
7. Shelley v. White, 711 F. Supp. 2d 1295, 1297 (M.D. Ala. 2010); McAmis v. Wallace, 980 F. Supp. 181, 184 (W.D. Va. 1997); Stanley v. Walker, 906 N.E.2d 852, 858 (Ind. 2009) [↑](#footnote-ref-7)