CLEVELAND ACADEMY OF TRIAL LAWYERS
LUNCHEON SEMINAR
FIGHTING HEALTH INSURANCE SUBROGATION - ERISA PLANS
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I. Introduction.

The purpose of this presentation is not to provide the definitive law on whether or not health insurance plans or contracts that are governed by ERISA are entitled to subrogation. The purpose of this presentation is to provide some practical suggestions that will help Plaintiffs effectively fight Health Insurance Subrogation.

II. Advise your client of his or her risk and let them decide.

Can an ERISA carrier sue your client for subrogation? Yes. They may not win but they can sue your client.

Can an ERISA carrier cancel your client's health insurance for failing to agree to pay subrogation? Yes. You may ultimately be able to get that decision overturned but it is a possibility.

Advise your client of his or her risk and, if they instruct you not to pay subrogation, memorialize that discussion and decision in a letter. Also, incorporate it in your closing sheet.

III. Subrogation organizations.

Most subrogation organizations are not particularly well informed nor effective. When dealing with Primax, ingenix etc., I do the following.

Letter #1 - Ask for a copy of the contract and proof that is was sent to your client.

" I am in receipt of your most recent correspondence dated November 16, 2005. Please send me a complete and accurate copy of the health insurance contract between my client and your client. Please highlight for me any and all provisions that you think give your client a right of subrogation. Further, please provide me with documentation that my client was provided with a copy of this health insurance contract prior to the date of the subject incident."

A. Ask for a copy of the entire health insurance contract. Make sure to keep asking until you get the actual contract between your client and the health insurance carrier. Check the effective date. Check the parties.

B. Ask the subrogation company to highlight the language they are relying on. Remember, the right of subrogation comes from the contract. The Ohio Supreme Court ruled in Lawson that the contract is sacred. The right of subrogation must be articulated in the contract or it does not exist.

C. Ask for proof that the health insurance company sent a copy of the health insurance plan to your client, before the date they were injured. This is the key. I am not sure that I have ever received such proof. The right of subrogation comes from the contract. You cannot enforce a contract unless the party you are seeking to enforce the contract against has at least seen the contract. If your client has not been provided with a copy of the health insurance contract, I argue that the contract cannot possibly be enforced.

D. Third Party Beneficiaries. The obligations of a third party beneficiary to a contract are different than the obligations of an actual party to a contract. Your client did not bargain with the health insurance company for the health insurance. They did not play any role in drafting the terms of the contract. The contract is certainly a contract of adhesion so any ambiguities should be resolved in favor of your client. However, do not forget that your client is the third party beneficiary of the contract and therefore is not subject to the same obligations as his or her employer.

IV. When all else fails - argue the law. (With sincere thanks to attorney Doug Roberts)

Do not send a letter of protection to the ERISA carrier.

The Ninth Circuit Court of Appeals has held that where a plaintiff collected a tort settlement and then failed to repay his employer's health plan for $90,000 in medical bills, in violation of a subrogation agreement, the lawyer will not be held liable. The attorney cannot be a fiduciary for both his client and the ERISA plan. Hotel Emp. & Restaurant Emp. Internatl. Union Welfare Fund v. Genter, in LAWYERS WEEKLY USA, Mar. 1, 1995; Chapman v. Klemick (C.A.11, 1993), 3 F.3d 1508, certiorari denied, 127 L.Ed.2d 541. However, if the attorney has signed a letter of protection in favor of the plan, he or she is personally responsible for the bill. See, Shiepis Clinic of Chiropractice, Inc. v. Stevenson (July 8, 1996), Stark App. No. 95CA00343, unreported; S. Council of Indus. Workers v. Ford (C.A.8, 1996), 83 F.3d 996.

To the extent that the plaintiff has not been made whole, you should argue that the Plan's subrogation and/or reimbursement rights are limited to those available in equity, and, as such, are limited by the equitable doctrines of the Make Whole Rule and the Common Fund. Great-West Life & Annuity v. Knudson, 534 US 201, 112 S. Ct. 708, 151 L. Ed. 2d 625 (2002).

Federal Law Governs ERISA plans not State Law.
If a plan is an ERISA plan, state law will NOT govern the enforceability of the subrogation agreement. Furthermore, state law requiring that the insured be fully compensated before the medical carrier can enforce any of its subrogation rights will not apply. Blue Cross & Blue Shield Mut. of Ohio v. Hrenko (1995), 72 Ohio St.3d 120, 647 N.E.2d 1358. To the contrary, federal law will govern the enforceability of the subrogation agreement. Likewise, there is case authority for the proposition that the ERISA Administrator can recover subrogation , even though the insured has not been fully compensated. Electro-Mechanical Corp. v. Ogan (C.A.6, 1993) 9 F.3d 445. Under most plans, the Administrator also has the ability to withhold coverage until the insured signs a reimbursement agreement. LeHigh Valley Hosp. v. Rallis, No. 9403082, 95-3511, 1996 U.S. Dist. LEXIS 4974, (E.D.Pa.Apr. 11, 1996). The case law is split, however, regarding the insured's ability to reduce the amount of the claim by the attorney's fees and costs of the recovery. See, Scholtens v. Schneider (Ill.1996), 671 N.E.2d 657, holding that ERISA does not preempt application of the common fund doctrine because such doctrine does not "relate to" the plan. Accord, Carpenter v. Modern Drop Forge Co. (N.D.Ind.1995), 919 F.Supp. 1198; Dugan v. Nickla (N.D.Ill.1991), 763 F.Supp. 981; Serembus v. Mathwig (W.D. Wis.1992), 817 F.Supp. 1414. But see, Ryan v. Fed. Express Corp. (C.A.3, 1996), 78 F.3d 123, Land v. Chicago Truck Drivers Helpers & Warehouse Workers Union Health & Welfare Fund (C.A.7, 1994), 25 F.3d 509, United McGill Grop. v. Stinnett,

154 F.3d 168 (4th Cir. 1998) in which the Court held that the subrogated carrier's right of full subrogation was unimpeded and that the insurance provider did not even have to give credit for attorneys fees under the common fund doctrine.

Is the plan an ERISA plan? The answer is usually "yes".

To qualify as an ERISA plan, the plan must be (a) a plan, fund or program (b) established or maintained by an employer or employee organization, or both, (c) for the purpose of providing medical, surgical, hospital care, sickness, accident, disability, or other encumbered benefits stated in ERISA, and (d) to participants or their beneficiaries. In order to get the preferential tax treatment afforded by ERISA, employers must meet a number of requirements:

(1) Administrators of the plan are required to provide each participant and each beneficiary of the plan with a "summary description of the plan drafted in language understandable by the average plan participant." Section 1022(a)(1), Title 29, U.S. Code; see also, Wadsworth v. Whalend (C.A.1, 1977), 562 F.2d 70, certiorari denied, 435 U.S. 980;

(2) The employer must also make available to the plan participants and plan beneficiaries a copy of the plan's annual report as filed with the Secretary of Labor. Section 1023(a)(1)(A), Title 29, U.S. Code; Wadsworth v. Whalend, supra;

(3) The actual plan, the summary description of the plan, and the annual report must be filed with the Secretary of Labor in order to come within the gambit of ERISA regulation. Sections 1021(b) and 1024, Title 29, U.S. Code. Such plan description and summary must contain:

(a) the name and type of administration of the plan;

(b) the name and address of the statutory agent for the plan;

(c) the name and address of the administrator;

(d) the name and address of the trustee or trustees;

(e) the plan's requirements respecting eligibility or participation in benefits;

(f) circumstances which could result in the disqualification in eligibility or denial of benefits;

(g) the source of financing for the plan;

(h) the procedures to be followed in presenting claims for benefits under the plan and other similar requirements.

Moreover, Section 1022 requires that the plan description be filed "on forms prescribed by the Secretary" as are required by Section 1024(a)(1).

(4) The management of the employment pension and welfare benefits plans must meet certain fiduciary standards which include in part:

(a) that the plan be in writing, Section 1102(a)(1)(1), Title 29, U.S. Code;

(b) that the assets be held in trust, Section 1103(a), Title 29, U.S. Code;

(c) that the assets be held exclusively for the benefits of the employees, Section

1104(a)(1)(A)(I), Title 29, U.S. Code; and
(d) that a fund be created from which to finance the plan. Sections 1051 through 1061, Title 29, U.S. Code.

It is important to remember, however, that ERISA does not apply to plans that are not maintained by the employer, 29 U.S.C. Section 1002(1). Medical coverage that an individual purchases for himself outside of the employment context is not subject to ERISA. Sole proprietors, partners, and their spouses are exempt, so long as the business does not provide benefits under the policy to a common-law employee [See 29 C.F.R. sections 2510.3-3(b)(1) and (c)(1)]. In Robertson v. Alexander Grant & Co. (C.A. 5 1986) 798 F.2d 868, the Court relied on those regulations in "[f]inding ERISA inapplicable to plans covering only partners." Similarly, in Meredith v. Time Insurance Co. (C.A. 5 1993) 980 F.2d 352, the court held that "an insurance plan purchased by a sole proprietor, covering only herself and her spouse, [does not] constitute…an 'employee welfare benefit plan' as that term is defined in ERISA." Further, in Fugarino v. Hartford Life & Acc. Ins. Co. (C.A. 6 1992) 969 F.2d 178, the Court held that a business owner is exempt from ERISA, stating that "a plan whose sole beneficiaries are the company's owners cannot qualify as a plan under ERISA." And in Slamen v. Paul Revere Life Insurance Co. (C.A. 11 1999) 166 F.3d 1102, 1104, the Court stated that "in order to establish an ERISA employee welfare benefit plan, the plan must provide benefits to at least one employee not including an employee who is also the owner of the business in question." and thus that ERISA does not apply where "the disability insurance policies at issue were for the sole interest and benefit of the plaintiff, and not his employees."

Also, ERISA does not apply to church, government, or foreign plans (Section 1002, Title 20, U.S. Code, et seq.), or self-pay insurance contracts, i.e. where the employer purchases group health insurance but does not administer or control any of the benefits. Accordingly, if your client works for the state, county, township, city, or some other political subdivision, he or she will not have an ERISA plan.

(2) If the plan is an ERISA plan, do its terms preempt state law?

The United States Supreme Court has held that the terms of an ERISA plan preempt any state laws which "relate to" a self-insured or self-funded ERISA plan. ERISA's preemption provisions are deliberately broad to establish exclusive federal regulation. As a practical matter, most health plans today are ERISA plans.

In dealing with a preemption issue, the attorney should always ask: "Who is paying the bill?" If the employer is, and it retains control, then there is federal preemption; if not, state law will apply. If the plan is nothing more

than a group policy, marketed by the insurance company, and funded exclusively by the employee, ERISA does not preempt state law. See FMC Corp. v. Holliday (1990), 498 U.S. 52, 111 S.Ct. 403, 112L.Ed.2d 356. Experts say, however, that roughly 60% of the employee benefit plans are self-funded. See Personal Injury Plaintiffs are Trapped by Health Insurance, LAWYERS WEEKLY USA, June 4, 1994.

What is the "regulation of insurance"? The McCarren-Ferguson test provides three criteria that must be met before a regulation will be identified as the regulation of insurance. First, the practice must have the effect of spreading the policyholder risk. Second, the practice must be an integral part of the policy relationship between the insurer and the insured. Third, the practice has to be limited solely to entities within the insurance industry. See, Blue Cross/Blue Shield of Alabama v. Neilsen (N.D. Ala. 1996), 917 F. Supp. 1532. Since most state anti-subrogation statues apply to entities other than insurance companies, these often fail their third prong of this state. However, the United State Supreme Court has recently held that it is not necessary for all three McCarran-Ferguson factors to be satisfied for a state law to considered as "regulating insurance" under ERISA's savings clause. Unum Life Ins. Co. of Am. v. Ward, 119 S. Ct. 1380, 1386 (1999). It is unclear whether the make whole rule is saved from preemption, and the answer to such a question turns on whether such a rule "regulates" insurance. Although the cases are split on this issue, see, Blue Cross and Blue Shield v. Fondren, 966 F. Supp. 1093 (M.D. Ala. 1997)(saved) with Baxter ex. rel. Baxter v. Lynn, 886 F. 2d 182, 185-86 (8th Cir. 1989 (not saved), it is to note that the Supreme Court in Unum Life demonstrated that a common-law rule (in that case, California's "notice-prejudice" rule) can be saved from ERISA preemption. Such a holding appears to indicate that the common law make whole rule may enjoy the same protection.

It is interesting to note that if a Plan does preempt state law, the ERISA claim may also reach those monies that the client used to pay the attorney. In short, the ERISA carrier may not only be able to get the client's portion of the recovery, but also the attorney's fees!

Not all courts have agreed with this analysis, however. In Leasher v. Leggette & Platt, Inc. (1994), 96 Ohio App.3d 367, 645 N.E.2d 91, the Twelfth District Court of Appeals held that an ERISA plan did not, in fact, preempt state subrogation law because it did not "relate to" the plan. In that case, the court held that the ERISA plan did not get first claim to the insured's recovery from the tortfeasor. The court further required the ERISA insurer to reimburse the insured for a portion of the attorney fees he incurred in obtaining the recovery against the tortfeasor. Up until a few years ago, Lesher expressed a minority position. However, the tide may be turning as a number of courts have forced

ERISA plans to pay their proportionate share of attorney's fees under the "common fund doctrine." See, Scholtens v. Schneider (Ill.1996), 671 N.E.2d 657, holding that ERISA does not preempt application of the common fund doctrine because such doctrine does not "relate to" the plan. Accord, Carpenter v. Modern Drop Forge Co. (N.D.Ind.1995), 919 F.Supp. 1198; Dugan v. Nickla (N.D.Ill.1991), 763 F.Supp. 981; Serembus v. Mathwig (E.D.Wis.1992), 817 F.Supp. 1414. But see, Ryan v. Fed. Express Corp. (C.A.3, 1996), 78 F.3d 123; Land v. Chicago Truck Drivers Helpers & Warehouse Workers Union Health & Welfare Fund (C.A. 7, 1994), 25 F.3d 509.

The 12th District Court of Appeals continues to follow Leasher. In Bradburn v. Merman (Oct. 25, 1999), Case No. CA99-02-011, unreported,, the Court held that (1) the ERISA carrier was not entitled to remove the state court action when the plaintiff challenged the Plan's Subrogation rights; (2) that the terms of the ERISA plan did not preempt state law; and (3) that the plaintiffs could force the ERISA carrier to pay a prorata portion of its attorney fees and expenses.

Under state law, a creditor has a claim against the settlement proceeds of a survivor claim, but not a wrongful death claim. See Tennant v. State Farm Mut. Ins. Co. (1991), 77 Ohio App.3d 723, 603 N.E.2d 322; Fogt v. United Ohio Ins. Co. (1991), 76 Ohio App.3d 24, 600 N.E.2d 1109; and In re Estate of Craig (1993), 89 Ohio App.3d 80, 623 N.E.2d 620. Although these cases are not controlling with an ERISA plan, there is some authority that an ERISA carrier's subrogated claim does not extend to a wrongful death recovery because the "death portion" of the wrongful death statute did not "relate to" the terms of the ERISA plan (hence, no federal preemption). See, Liberty Corporation v. NCNB National Bank of South Carolina (C.A. 4 1998), 984 F.2d 1383; Contra, McInnis v. Provident Life & Acc. Ins. Co. (C.A. 4 1994), 21 F. 3d 586; see also, Morstein v. Natl. Ins. Servs., Inc. (C.A.11, 1996), 93 F.3d 715, certiorari denied, 136 F.Ed.2d 715; Coyne & Delany Co. v. Selman, in LAWYERS WEEKLY USA, Oct. 25, 1996 (where an insurance agent told a business that a new health plan would cover all pre-existing conditions—but did not—the business can sue him for malpractice under state law; suit is not preempted by ERISA as it does not "relate to" an employee benefit plan because the standard of care would be the same regardless of whether the malpractice involves an ERISA plan or a run-of-the-mill automobile insurance policy; thus, the duty of care does not depend on ERISA in any way.).

(3) Does the Plan provide for subrogation or reimbursement?

Make sure you obtain the plan and examine it thoroughly. Does it cover UM or first party insurance process? Some do not. Does it specify that the Administrator gets first dibs at any recovered monies, even though the client has not been made whole. Under Section 1024(b)(4), Title 29, U.S. Code, the Administrator is

required, upon written request of any participant, to furnish copies of the latest plan description, annual report, terminal report, bargaining agreement, trust agreement, contract, or other instruments under which the plan is established. If the Administrator fails to provide these within thirty days from the date of written request, the Administrator is personally liable to the participant for $100 per day thereafter, although such fine is subject to the discretion of the court. See, Section 1132(c)(1), Title 29, U.S. Code; VanderKlok v. Provident Life & Ass. Ins. Co., Inc. (C.A.6, 1992), 956 F.2d 610.

You can obtain copies of the most current plan documents by calling the Department of Labor, Public Disclosure, and Affairs Office at 1-202-219-8771. If you have any questions about any of the ERISA regulations, you can contact Eric Raps, Esq. at 1-202-219-8515 or Mural Feldman, Esq., at 1-202-219-8521, both of which are in the Department of Labor. You can also obtain an advisory opinion from the Department regarding whether they think a plan is an ERISA plan by following the procedure in ERISA Proc. 76-1.

Given the above, the attorney should always send a request, via certified mail, for copies of the plan documents to verify that a right of subrogation exists. Moreover, if a significant amount of time passes with no response, you may have some leverage in negotiating a reduction of the ERISA claim.

Significantly, ERISA does not give the Administrator a lien in any amounts that you may recover from third parties. Accordingly, if an Administrator says that, insist that he or she show you the provision in ERISA which gives him or her such a right. It certainly is not contained in the statue, although, I suspect that the Administrator could draft a plan in such a manner that he or she would have a security interest or lien in settlement proceeds. If the Plan does give the Administrator such a lien or interest, an attorney would not be able to disburse the money to the client without incurring some personal liability for conversion.

Are the subrogation or reimbursement provisions of the ERISA plan ambiguous or contrary to the reasonable expectations of the insured?

Most plans do not specify who gets paid first when there is an inadequate amount of insurance. Keep in mind that the 6th Circuit has been particularly strict regarding plan construction here. Unless the Plan specifically overrides the “make whole rule,” then the Plan will not get first bite of the recovery by creating federal common law. See, Copeland Oaks v. Haupt, 2000 FED App 0125 (6th Cir., 4-7-2000). See Saltarelli v. Bob Baker Group Med. Trust (C.A.9, 1994), 35 F.3d 382, and McGurl v. Teamsters Local 560 Trucking Emps. of N. New Jersey Welfare Fund (D.N.J.1996), 925 F.Supp. 280 (“It has become incumbent upon federal courts to develop federal common law of rights and obligations under ERISA regulated plans to deal with legislative “gaps” in ERISA.”)

In Saltarelli, the court also adopted the doctrine of "reasonable expectations" as a principle of uniform federal common law regarding the interpretation of ERISA governed insurance contracts. The court recognized that such a doctrine is often necessary to protect insureds where they have little or no bargaining power in the contract negotiating process. Where one is dealing with such adhesion contracts, the court said that the courts should take some measure to protect the "reasonable expectations" of plan participants regarding coverage, even though a careful review of the policy indicates that expectations are contrary to the expressed intent of the insurer.

"An insurer wishing to avoid liability on a policy purporting to give general or comprehensive coverage must make exclusionary clause conspicuous, plain and clear, placing them in such a fashion as to make obvious their relationship to other policy terms, and must bring such provisions to the attention of the insured." Saltarelli, supra.

Using Saltrarelli, one can argue that insureds do not expect – notwithstanding policy language to the contrary—that they will have to pay back their medical bills if they have not been fully compensated for their injuries, particularly if they have to incur all of the collection costs and attorney fees.

The Northern District of Ohio, Western Division, in McConocha v. Blue Cross and Blue Shield of Ohio (N.D. Ohio 1996), 930 F.Supp. 1182 has adopted the Saltarelli Doctrine of Reasonable Expectations. The court required insurance companies to set forth liability limitations clearly enough for non-lawyers to understand. The court held that this doctrine applied as a principle of federal common law to ERISA-governed insurance contracts. See also, Wheeler v. Dynamic Engineering, Inc. (C.A. 4), 62 F.3d 634 (holding that where a term is ambiguous, it must be construed against the drafter, and in accordance with the reasonable expectations of the insured, citing Saltarelli.) The court's standard was what the average man purchasing insurance would contemplate from a reading of the contract.) Although not citing Saltarelli, The Northern District of Illinois, Eastern Division, in Hartenbower v. Electrical Specialties Co. Health Benefit Plan (N.D. Ill. 1997), 977 F.Sup.. 875, applied rationale similar to that in Saltarelli, and held that employees should unequivocally know if their plan disallows application of the make whole rule in order to allow reimbursement of insurers prior to the insured being made whole.

If the ERISA plan does not specify who is to get "first bite" at the settlement proceeds, some cases are creating a federal common law that the insurer is not entitled to subrogation until the insured is made whole. See, Barnes v. Auto.

Dealers Assn. Of California Health & Benefit Plan (C.A. 9 1995), 64 F.3d 1389, and those other cases cited in the Answer to Question (10) below. We should make the very most of these cases. See also, Schultz v. Nepco Emp. Mut. Benefit Assn., Inc. (Wis.App.1994), 528 N.W.2d 441, citing Sanders v. Scheideler (W.D.Wis.1993), 816 F.Supp 1338, affirmed (C.A.7, 1994), 25 F.3d 1053, holding that the "Make Whole" rule applies to ERISA plans where the plan fails to designate priority rules or provides its fiduciaries the discretion necessary to construe the plan accordingly. But see also, Harris v. Harvard Pilgrim Health Care , Inc., Case No. 97-10259-PBS, August 7, 1998, U.S. District Court, Massachusetts, Lawyers Weekly USA No. 9914109, rejecting the make whole, joining the Fifth, Seventh, and Eighth Circuits, while the Sixth, Ninth and Eleventh Circuits have held the opposite.

As mentioned, some courts hold that an incomplete recovery does not affect ERISA's recovery. Provident v. Linthicum (C.A. 8 1991), 930 F.2d 14; The Sunbeam-Oster Company, Inc., Group Benefits Plan for Salaried and Non-Bargaining Hourly Employees v. Leonard Whitehurst, Jr.(C.A. 5 1996), 102 F.3d 1368; National Employee Benefit Trust of The Associates General Contractor of American and Manning Billeaud As Trustee v. Edith C. Sullivan and Freddie D. Sullivan (W.D. La. 1996), 940 F.Supp. 956; Shell v. Amalgamated Cotton Garment Fund, (D. Minn. 1994) 871 F.Supp. 1173, aff'd (C.A. 8 1994), 43 F.3d 364 (refusing to adopt make-whole rule as federal common law; plan vested with discretion); Trustees of Hotel Employees v. Kirby (D. Nev. 1995), 890 F. Supp. 939 (declining to follow rule, Plan vested with discretion). Other courts, however, say differently; See, Barnes v. Auto. Dealers Assn. Of California Health & Benefit Plan (C.A. 9 1995), 64 F.3d 1389, where the court created a federal common law rule under ERISA that the insurer should not be able to subrogate against the insured until the insured is made whole, assuming that there is no language in the ERISA plan to the contrary; Accord: Speciale v. Seybold, No. 96 C 2993, 1996 U.S. Dist. LEXIS 19328, (N.D. Ill. Dec. 19, 1996) (Plaintiff settled claim for $41,000, subrogation claim was $54,000, Administrator claimed he was entitled to entire settlement; court hold that Administrator must present evidence to justify such claim as reasonable in light of settlement amount; Court followed the make-whole doctrine set forth in Murzyn v. Amoco Corp. (N.D. Ind. 1995), 925 F. Supp. 594, and Sanders v. Scheideler (W.D. Wis. 1993), 816 F. Supp. 1338, affirmed (C.A. 7, 1994), 25 F.3d 1053); Marshall and Marshall v. Employers Health Insurance Company (M.D. Tenn. 1996), 927 F. Supp 1068; Copeland Oaks v. Haupt, 2000 FED App. 0125 (6th Cir.); Toledo Area Construction Workers Health & Welfare Plan v. Lewis, Case No. 3:97-CV-7374; 1998 U.S. Dist. LEXIS 21759; Hiney v. Brantner (C.A. 6 2001), 243 F. 3d 956; Hiney Printing Co. v. Brantner (N.D. Ohio 1999), 75 F. Supp. 2d 761, Eagle v. Bruner (C.A. 11 1996), 112 F.3d 1510; Hartenblower v. Electrical Specialties Co. Health Benefit Plan (N.D. Ill. 1997), 977 F.Sup.. 875 (Court adopted the make whole rule as the default rule where no Plan

language clearly excludes it; further, Court also refused to allow discretionary interpretation to determine whether a Plan has clearly overruled the make whole rule; Vizcaino v. Microsoft Corporation (C.A. 9 1996), 97 F.3d 1187; Provident Life and Accident Ins. Co. v. Williams (W.D. Ark. 1994), 858 F. Supp. 907; Badger Equipment Co. v. Brennan (Minn. Ct. App. 1988), 431 N.W. 2d 900; Fenicle v. Michigan Livestock Exchange, (N.D.Ohio Jan. 8, 1998), No. 3:96 CV 7183, unreported (An insurance policy holder is entitled to recover the balance of his full loss out of the proceeds of a judgment against a third-party tortfeasor before having to account to the insurance company upon a subrogation assignment.) See also, Waller v. Hormel Foods Corporation and Hormel Foods Corporation Medical Plan (D. Minn. 1996), 950 F.Supp. 941(Court rejected the make whole rule in favor of a pro-rata distribution between the claimant the subrogated carrier); Equity Fire & Cas. Co. v. Youngblood (Okla.1996), 927 P.2d. 572 (The Oklahoma Supreme Court held that the Make Whole Rule is the Majority Rule – Oklahoma adopts the Make Whole Rule where (1) the subrogation or reimbursement agreement neither expressly sets priorities for repayment of benefits, nor otherwise gives a right of reimbursement or subrogation before any funds are paid to the beneficiary, nor vests that plan's manager's discretionary authority to interpret ambiguous provisions of the plan; and (2) the compensation recovered represents less than full compensation. Under such circumstances, the subrogation and reimbursement terms of the contract will be unenforceable. Courts cited in agreement: Sanders v. Scheideler (W.D.Wis.1993), 816 F.Supp. 1338, affirmed (C.A.7, 1994), 25 F.3d 1053; Murzyn v. Amoco Corp. (N.D.Ind.1995), 925 F.Supp. 594; Scholtens v. Schneider (Ill. 1996), 671 N.E.2d 657; Schultz v. Nepco Emps. Mut. Benefit Assn. (1994), 190 Wis.2d 742, 528 N.W.2d 441; Blue Cross-Blue Shield of Rhode Island v. Flam (Minn.App.1993), 509 N.W.2d 393; Leasher v. Leggette & Platt, Inc. (1994), 96 Ohio App.3d 367, 645 N.E.2d 91.

As mentioned above, at least two Circuits, the 6th (Marshall v. Employers Health Insurance, C.A.6 1997, U.S. LEXIS 36769, unreported) and the 11th (Cagle v. Bruner, 112 F.3d 1510), as well as a lower Federal Court in the 7th Circuit (Hartenbower v. Electrical Specialities Co. Health Benefit Plan, 1997 U.S. Dist. LEXIS 14580, unreported), have adopted the Make-Whole Doctrine. We should make the very most of these cases.

The 11th Circuit has merged reimbursement and subrogation together. The court cites Couch on Insurance _____ (2nd Ed. 1983), [I]f an insurer pays less than the insured's total loss, the insurer cannot exercise a right of reimbursement or subrogation until the insured's entire loss has been compensated. The court determined that any right for an insurer does not mature until the insured is made whole. The court referred to their earlier decision in Guy v. Southeastern Iron Workers' Welfare Fund (C.A. 11 1989), 877 F.2d 37, which held that the make whole doctrine applied even though a plan had a right of reimbursement from all amounts recovered by suit, settlement or otherwise from any third person

or his insurer to the extent of benefits provided hereunder. The court further recognized that because the make whole doctrine is a default rule, the parties can contract out of the doctrine by specifically rejecting the make whole doctrine.

The 7th Circuit Lower Federal Court has followed the 11th Circuits lead, by allowing reimbursement only if the plan explicitly disallows the make-whole doctrine. This court looked for plan language such a right of reimbursement or right to reimbursement even if the plan participant is not made whole.

Further, this court applies rationale similar to that in Saltarelli, holding that employees should unequivocally know if their plan disallows application of the make whole rule.

Is the defendant a political subdivision?

In Ohio, a plaintiff must reduce a judgment by the amount of subrogated medical bills if the defendant is a political subdivision. According to R.C. Section 2305.17, the subrogated carrier cannot bring a subrogation claim against the political subdivision. If the plaintiff settles with the tortfeasor prior to settling with the ERISA carrier, there is a danger that the plaintiff will end up paying the ERISA plan for amounts that the plaintiff never recovered from the tortfeasor. See Buchman v. Wayne Trace Local School District (N.D. Ohio, 1991), 763 F. Supp. 1405; Electro-Mechanical Corp. v. Ogan (C.A.6, 1993), 9 F.3d 445. Recent case law indicates, however, that the terms of the plan may preempt these statutes. See Danowski v. United States (D.N.J.1996), 924 F.Supp. 661, preventing such a harsh result by holding that ERISA preempted New Jersey's collateral source rule.

Significantly, the application of the set off occurs even where the insured has not been fully compensated or "made whole" for his or her injuries. However, to exercise the set off, there must be a matching of benefits and recovery.

That is, if the political subdivision wants to set an amount of a medical bill off, there has to be a showing that the jury, in fact, awarded the medical bill as a part of the Plaintiff's damages. See, Holeton v. Crouse (2001), 92 Ohio St. 3d 115, 748 N.E.2d 1111.

If ERISA preempts state law, then the question is answered by federal law. If it does not, then it answered by state law.

Federal law is usually spelled out in the contract. If the ERISA's plan can get "first bite" under its contract with the insured to any recovery, then that language will be controlling, regardless of what state law says. However, if the courts are starting to formulate some federal common law which is helpful to the insureds. In Saltarelli v. Bob Baker Group Med. Trust (C.A.9, 1994), 35 F.3d 382, the court applied the doctrine of reasonable expectations to an ERISA contract – a doctrine that grows out of adhesion contracts and the construction of

ambiguities in insurance policies.

“An insurer wishing to avoid liability on a policy purporting to give general or comprehensive coverage must make exclusionary clauses conspicuous, plain and clear, placing them in such a fashion as to make obvious their relationship to other policy terms, and must bring such provisions to the attention of the insured.”

“ERISA preemption does not mean that general principles of state law are irrelevant to interpreting ERISA governed contracts, but rather courts are directed to formulate nationally uniform federal common law to supplement provisions set out in ERISA, referring to principles of state law when appropriate.”

However, as a general rule, most of the law under ERISA is not helpful to the plaintiff. Accordingly, most practitioners try to avoid preemption, i.e. federal law, if at all possible.

Although the issue of preemption is complicated, the five second sound bite is this: If the ERISA plan is a self-insured plan which is paying benefits out of its own pocket, then the terms of the plan will preempt state law. If , on the other hand, the ERISA plan is paying benefits by way of a contract that they have with an insurance company, then the terms of the plan do not preempt state law. So, the key question is this: Where is the money coming from that is paying the medical bills?

Comment: Assume that the Plan Administrator insists, prior to the plan paying any of your client’s medical bills, that your client sign a subrogation agreement. Assume further that the ERISA plan has a subrogation agreement but does not have anything in it that specifically makes the payment of the medical bills contingent upon the insured signing the letter. If the client sues the ERISA plan that he or she should not be “held hostage” by such an agreement, who wins?

The Administrator does. See, LeHigh Valley Hosp. v. Rallis, No. 94-3082, 95-3511, 1996 U.S. Dist. LEXIS 4974, (E.D. Pa. Apr. 11, 1996). The court found that this was an appropriate exercise of his fiduciary responsibilities. Accord, Buchman v. Wayne Trace Local School Dist. Bd. of Edn. (N.D. Ohio 1991), 763 F.Supp. 1405.Under ERISA, a plan participant can bring an action to enforce or clarify the terms of a plan in either state or federal court. However, if the Plan Administrator wishes to bring an action to enforce subrogation rights, he or she must file his or her action in federal court. A. Copeland Ents., Inc. v. Slidell Mem. Hosp. (La.1995), 657 S.2d 1292, Funk Mfr. Co. v. Franklin (Kan.1996), 927 P.2d 944. Accordingly, if the subrogated carrier files suit against

your client in state court, the court should dismiss the Complaint for lack of subjective matter jurisdiction.

A common complaint from plaintiff attorneys is the ability of the ERISA carrier to remove the state court personal injury action when the plaintiff brings the carrier into the action, usually as a result of the defense lawyer raising a Rule 19.1 (indispensable party) or Rule 17 (real party in interest) defense. Although the Circuits are split on this issue, recent cases have held that an assertion of subrogation rights by the Plan is not sufficient to trigger federal jurisdiction. See, Grusznski v. Viking Ins. Co (E.D. Wis. 1994)., 854 F.Supp. 586. See also, Speciale v. Administrative Committee of the Wal-Mart Stores, Inc. (C.A. 7 1998), 147 F.3d 612; Blackburn v. Sundstrand (CA. 7 1997), 115 F.3d 493; Traynor v. O'Neill (W.D. Wis 2000), 94 F. Supp. 2d 1016; Washington v. Humana Heath Plan (N.D. Ill. 1995), 883 F. Supp. 264.

In "Great-West Life & Annuity Ins. Co. v. Knudson: How to Close the Door on Federal ERISA Subrogation Actions," Ohio Trial Volume 13, Issue 1, author, Brenda M. Johnson, writes:

In most instances, plans claim they are entitled to remove these state actions to federal court based on the argument that any claim by a participant or beneficiary relating to the terms of a plan falls within the scope of Section 502(a)(1)(B) of ERISA's civil enforcement provision, which authorizes a participant or beneficiary to "enforce his right under the terms of the plan, or to clarify his right to future benefits under the terms of the plan." The Seventh Circuit, however, has found no merit to this position:

A…doctrine, misleadingly called "complete preemption," does permit removal when the plaintiff's own claim depends on ERISA, and the effort to craft a claim under state law reflects artful pleading. Section 502 of ERISA provides the sole authority for a participant's claim to benefits from a welfare or pension plan. Thus if the [plaintiffs] had sought to require [the plan] to pay additional benefits, their claim would have arisen under ERISA and [the plan] could have removed it. But neither the original tort action nor the petition to adjudicate adverse claims to the settlement sought a payment from the plan. Section 502 is irrelevant…."

Blackburn, supra, at 496 (Easterbrook, J.)

Some cases say that there is no obligation to pay attorney's fees unless the Plan specifically asks the attorney to protect its interests. Land v. Chicago Truck Drivers Helpers & Warehouse Workers Union Health & Welfare Fund (C.A.7, 1994) 25 F.3d 509; Green v. Hotel Emps. & Restaurant Emps. Internatl. Welfare Pension Funds, No. 95-16314, 1997 U.S. App. LEXIS 401, (C.A.9, Jan. 7, 1997), (Court refused to reduce its ERISA based subrogation claim for its pro rata share of attorney fees. Court of Appeals affirmed, refusing to create federal common law because the express terms of the insurance contract rule and, moreover, the terms were not unreasonable, as participant argued.) Gaier v. Midwestern Group (1991), 76 Ohio App.3d 334, 601 N.E.2d 624; Wisell v. Shelby Mut. Ins. Co. (1986), 33 Ohio App.3d 297, 515 N.E.2d 1214. See also, Health Cost Controls v. Isbell (C.A. 6 1997), 139 F.3d 1070, finding that Plan did not have to pay attorney's fees because plan provisions explicitly requires full reimbursement when damages are recovered from a third party.

Other cases hold differently, however. See, United McGill Corp. v. Stinnett, No. AW-96-1402, 1996 U.S. Dist. LEXIS 19416, (D. Md. Dec. 16, 1996). Court permitted one-third reduction of ERIRA plan lien for attorney fees, even though plan policy gave plan first and full bite of the apple. Court cited the following decisions as persuasive for allowing attorney fees: Carpenter v. Modern Drop Forge Corp. (N.D.Ind.1995), 919 F.Supp. 1198; Serembus v. Mathwig (E.D.Wis.1992), 817 F.Supp. 1414; Cutting v. Jerome Foods, Inc. (C.A.7, 1993), 993 F.2d 1293, certiorari denied, 114 S. Ct. 308; Dugan v. Nickla (N.D.Ill.1991), 763 F.Supp. 981. See also, U.S. District Court for the Western District of Michigan, Ward v. Wal-Mart Stores, Inc., No. 1:96-CV-866, February 6, 1998; Lawyers Weekly USA No. 9912715. (Even though a health plan that paid medical expenses is entitled to reimbursement from the victim's tort recovery, it must pay its prorata share of her attorney fees. The health plan paid $101,000 in medical bills and sought reimbursement from the victim's tort settlement of $200,000. The plans policy allowed it to recover benefits "…to the extent…of any payment resulting from a judgment or settlement.: However, the court cited the common fund doctrine, which says that attorney fees should be apportioned among everyone who will share in the recovery that that attorney helped to obtain. It said the policy was "ambiguous" as to whether this doctrine applied, and construed it in favor of the victim. "The right to recover benefits in the plan is not preceded by 100% or by "any" or "all" the court noted. "Where a plan is silent, it would constitute unjust enrichment if it did not pay its pro rata share of the attorneys fees," said the Court. See also, U.S. Court of Appeals, 7th Circuit, Wal-Mart Stores, Inc. v. Wells, No. 99-2018, May 17, 2000, Lawyer Weekly USA No. 9918228, and Harris v. Harvard Pilgrim Health Care, Inc., Case No. 97-10259-PBS, August 7 1998, U.S. District Court, Massachusetts, Lawyers Weekly USA No. 9914109, holding that insurance company had to pay their portion of fees and expenses under the common fund doctrine.

As an aside, plaintiffs have not been able to successfully defeat ERISA subrogated claims by settling for pain and suffering only simply because the Plan language usually does not limit their reimbursement rights to only what the insured has recovered for his or her medical bills. Accordingly, every federal court to consider this argument has consistently rejected it. Singleton v. IBEW Local 613 (N.D. Ohio, 1991), 830 F.Supp.630; XTraveitz v. Northeast ILGWU Fund (M.D. Pa 1993), 818 Supp. 761, 770 n. 11 (court notes that despite beneficiary's characterization of her sizable settlement as one for pain and suffering, settlement agreement itself recites complete discharge of all claims, reimbursement not limited to recovery earmarked for medical expenses); Dugan v. Nickla (N.D. Ill. 1991), 763 F. Suppl. 981, 984 (jury's apportionment of tort award irrelevant where reimbursement provision in ERISA plan included any recovery). Accordingly, a plaintiff is not able to defeat an ERISA subrogated claim by creatively recharacterizing their tort recovery to avoid repayment.

Now, with federal preemption, some subrogation questions get little tricky, particularly where the defendant is protected by an anti-subrogation statute. In Ohio, subrogated carriers cannot bring their subrogation claims against political subdivisions (R.C. 2744.05(B). Where the plaintiff has sued a political subdivision, he or she will be unable to recovery a medical bills from the political subdivision when the bills are paid by another party. In these situations, the Ohio Supreme Court has held that such subrogated carriers cannot seek reimbursement from the insureds. Okay, all fine and good. But what happens when the plaintiff sues a political subdivision and the medical carrier is an ERISA plan? If the terms of the plan preempt state law, then the medical carrier can, in fact, force the political subdivision to reimburse the carriers for amounts spent on medical bills. In a similar fashion, the ERISA plan can recover this amount from the insured, if the insured has given the tortfeasor a general release. So here is the danger: Client is hit by a school bus that has tortfeasor liability of $10. Client incurs medical bills of $10. Claim is worth $20. ERISA carrier pays the $10 in medical bills. Client then settles with the tortfeasor for the $10. Attorney then turns to the ERISA plan to try to work out a deal. ERISA says that since they cannot go after the tortfeasor because of the release, the client must pay them the $10. Attorney and client are caught in a box. Client ends up paying, if you will, the medical bills twice. ERISA carrier ends up with the $10, the client with $0. See Buchman v. Wayne Trace Local School District (N.D. Ohio 1991), 763 F. Supp. 1405; Electro-Mechanical Corp. v. Ogan (C.A.6, 1993), 9 F.3d 445.

See, Community Insurance Co. v. Hambden Township, Court of Appeals for Geauga County, Case No. 97-G-2115 (August 28, 1998), Lawyers Weekly No. 111-192-98, in which the Court held that an ERISA Plans Subrogation clause preempted R.C. Section 2744.05(B), thereby allowing the Plan to bring a subrogation claim against a political subdivision. See also, Danowski v. United States (D.N.J.1996), 924 F. Supp. 661, preventing such a harsh result by holding that ERISA preempted New Jersey's collateral source rule.

In such a circumstance, the client ends up paying, in effect, her medical bills twice and is left with $0. The only way to avoid this is to bring the ERISA carrier into the case so it can pursue its subrogated claims under federal law. This has to be done, of course, before the client gives the tortfeasor a release. If she does this (and the tortfeasor is not on notice of the carrier's subrogated claims), the client will destroy ERISA carrier's subrogation rights. See, Electro-Mechanical Corp. v. Ogan (C.A.6, 1993), 9 F.3d 445; Provident Life & Acc. Ins. Co. v. Linthicum (C.A.8, 1991), 930 F.2d 14; Auto Owners Ins. Co. v. Thorne Apple Valley, Inc. (C.A.6, 1994), 31 F.3d 371, certiorari denied, 115 S. Ct. 1177.

Because of recent decisions of the United States Supreme Court, plaintiffs' counsel should carefully examine the relief requested by the Plan in any ERISA action. Claims must seek "appropriate equitable relief" under 29 U.S.C. § 1132(a)(3). See Mertens v. Hewitt Assocs., 508 U.S. 248, 262, 124 L. Ed. 2d 161, 113 S. Ct. 2063 (1993). In Mertens, the Supreme Court held that the term "equitable relief" in 29 U.S.C. § 1132(a)(3) refers only to "those categories of relief that were typically available in equity (such as injunction, mandamus, and restitution, but not compensatory damages)." Id. at 256. Mertens made clear that compensatory and punitive damages are not considered "equitable relief" for the purposes of 29 U.S.C. § 1132(a)(3). Id. at 255. Although the Mertens Court did conclude that "equitable relief" included restitution, the Supreme Court has recently explained that only traditionally "equitable" restitutionary remedies are available under this section.

In Great-West Life & Annuity Insurance Co. v. Knudson (2002), 534 U.S. 204, 122 S. Ct. 708, 151 L. Ed. 2d 635 held that ERISA does not authorize an action for money damages brought by an ERISA plan fiduciary against a plan beneficiary to enforce a reimbursement provision in the plan. - In that case, the Court held that, regardless of how the fiduciary framed the complaint, it sought to impose personal liability on the plan beneficiary for a contractual obligation to pay money. Such an action, the Court held, is not an action in equity, but an action at law, and 29 U.S.C. § 1132(a)(3) authorizes only actions seeking equitable relief. 122 S. Ct. at 712.

In Knudson, the proceeds of the settlement in question were allocated to a Special Needs Trust. This fact was of consequence to the Supreme Court. In order to give the term "equitable relief" meaning, the Court explained, courts must "limit restitution to the return of identifiable funds (or property) belonging to the plaintiff and held by the defendant-that is, . . . limit restitution to the form of

restitution traditionally available in equity." Id
But this analysis does not mean that a Plan's ability to recover is dead. The Court approved the analysis of Wal-Mart Stores, Inc. v. Wells (C.A. 7 2000), 213 F.3d 398, which held that Section 502(a)(3) of the Act authorizes a Plan to seek to impose a constructive trust upon funds it alleges it is due under its reimbursement provisions.

Note that this equity analysis cuts both ways. In Caffey v. UNUM Life Ins. Co. (C.A. 6 2002), 302 F.3d 576, the Court cited Knudson in rejected a plan participant's action seeking reinstatement of her health and life insurance benefits.
The Knudson case is carefully analyzed in an excellent article by Brenda M. Johnson in Volume 13, Issue 1 of Ohio Trial.
The fallout from Knudson remains to be seen. Probably the most significant question is this: If an ERISA carrier's remedies are limited to those in equity, then are such remedies subject to the equitable defenses of the make whole rule and the common fund doctrine? At the very least, Knudson forces the ERISA carrier to get into the action much earlier, i.e., when the funds are still around. This is generally contrary to their earlier strategy of waiting until the plaintiff has done most of the work, and then pouncing upon him (or the settlement proceeds) with great delight and gusto, fangs and talons extended. This approach to subrogation has left scars on the backs of many plaintiff attorneys.

In Community Health Plan of Ohio v. Mosser, Case No. 01-4095 (6th Cir. 10-21-2003), the ERISA carrier filed suit against its insurer to recover amounts spent on medical bills. Following Knudson, the 6th Circuit dismissed the case, holding that it did not have jurisdiction to hear the case. While the ERISA argued that subrogation was an equitable remedy, the Court held to the contrary, saying that if the ERISA carrier wanted to go after the insured for reimbursement, they needed to "follow the money," i.e., that is, they needed to trace the settlement funds so that a constructive trust could be imposed upon the funds. Here they did not do that.

The 6th Circuit has continued to crank out decisions that make it difficult for an ERISA carrier to pursue its reimbursement rights. In QualChoice v. Rowland, Case No. 02-3614 (6th Cir, 5-2004), the Court held that an ERISA carrier was not able to pursue its reimbursements rights against an insured, even when the carrier could trace and identify the settlement proceeds, simply because the ERISA carrier was limited to equitable remedies, only. Such a suit still smelled like a collection action.The Ninth Circuit agreed with QualChoice in Westaff

v. Arce, 298 F.3d 1164, Ninth Circuit (2002). Can the ERISA carrier accordingly file suit in state court to enforce its reimbursement rights? Perhaps not, at least in the 6th. Again, the Court has held that such right appear to be preempted by ERISA which limits the Administrator's remedies to equitable remedies only, regardless of what may be in the health plan contract. See, Community Insurance v. Morgan, 2002 WL 31870325 (12-20-2000). See also, Meba Medical & Benefits Plan v. Lago, 867 S. 2d 1184 (Fla. App. 4th District, 2004 and Liberty Northwest Insurance Corporation v. Kemp, 192 Or. App. 181 (Or. App. 2004). But see, Providence Health Plan v. McDowell, 361 F. 3d 1243 (9th Cir., 2004).

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