

The Red-Haired Step-Children: Subrogating Fully-Insured ERISA and Non- ERISA Employee Welfare Benefit Plans

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Introduction: ERISA vs. Non-ERISA Health Plans

Two types of ERISA Plans:

- a“Self Funded” or “Self Insured” means: The employer pays the benefits directly or through a trust fund established for that purpose.
- “Fully Insured” (or Unfunded) means: The employer does not pay the benefits, but that the employer has purchased an insurance policy via the Plan, and an insurance company pays the losses.

Non-ERISA Plans

Non-ERISA Plans are Plans not sponsored by an employer or employee organization, and fall completely outside the scope of ERISA.

Example: A self-procured Health Plan.

The type of plan you are subrogating has a dramatic impact on your subrogation potential and recovery.

1. Self-Funded ERISA Plans always receive the benefits of ERISA preemption.
2. Fully Insured ERISA Plans sometimes receive the benefits of ERISA preemption.
3. Non-ERISA Plans never receive the benefits of ERISA preemption.

Subrogating the Fully Insured ERISA Plan: Fully Insured ERISA Plans may receive the benefit of ERISA preemption, but do not enjoy across the board preemption that Self-Funded ERISA Plans enjoy.

Introduction to ERISA

The term “ERISA” is an acronym for “Employee Retirement Income Security Act”. It is a federal law passed by Congress in 1974 which set the standards for administering private employee health benefit Plans, disclosing financial and other information to Plan participants, and the processing of health claims. Next to the Internal Revenue Code, it is perhaps the most misunderstood and confusing piece of legislation ever devised by man. Once understood, it can be an incredible subrogation tool. ERISA regulations apply to private employer Plans - both self-insured and fully insured. Examples of non-private Plans which are not covered or governed by ERISA are those provided by government agencies, Medicare, Medicaid, public schools, worker’s compensation, the military, churches, and any other Plans which are not covered by a private employer. As we will see, it is just as important to understand which Plans are or are not governed by ERISA, as it is to understand exactly what ERISA says. Before we get into the meat of ERISA, let’s discuss a little about the Act itself.

History of ERISA

ERISA is essentially *the* employee benefits’ law. It applies to all kinds of employee benefit Plans provided to workers as an incident of their employment. Mainly, ERISA

regulates pension Plans (retirement) and welfare Plans (health insurance) but it also regulates many other kinds of employee benefits, such as death, disability, vacation, day care, cafeteria Plans, profit-sharing Plans, etc. ERISA is probably more well-known as it applies to retirement benefit Plans, but in the insurance context it applies to employee group health insurance policies. Specifically, the statute applies to any employee benefit Plan established or maintained by any employer or employee organization engaged in commerce or in any industry or activity affecting commerce. Governmental and church Plans are exempted, but as the broad language “any employer engaged in commerce” suggests, almost all other employee benefit Plans are affected. Also, because of ERISA’s sweeping preemption provision, there is little chance that state insurance law will apply. Therefore, the ERISA statute and case law constitute practically the entire law of employee benefits in the United States.

What is an ERISA Plan?

In order for a Plan to be ERISA-covered, it must be an “employee welfare benefit Plan.”

“Welfare benefit Plan” means “any Plan, fund or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such Plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, daycare centers, scholarship funds, or prepaid legal services, or (B) any benefit described in Sec. 302 of the Labor Management Relations Act, 1947 (other than pensions or retirement or death, and insurance to provide such pensions.)”

To fall within ERISA, the employee benefit Plan must be:

1. a Plan, or program that is;
2. established or maintained by an employer or employee organization; and
3. for the purposes of providing for its participants’ or its beneficiaries’ medical, surgical or hospital care, or benefits in the event of sickness, accident, disability, death or unemployment, or the case of benefits, apprenticeship or other training program or day care centers, scholarship funds or pre-paid legal services.

A Plan is not an ERISA Plan if it falls within all four of these “safe-“harbor” regulations:

1. the employer makes no contributions toward the premiums;
2. the employer participation is voluntary;
3. the employer’s sole functions are, without endorsing the program, to allow the insurer to publicize it to the employees, to collect payments through the payroll deduction, and to remit them to the insurer; and

4. the employer receives no compensation for administering the program other than reasonable compensation for services rendered in connection with the payroll deductions.

If a welfare benefit Plan satisfies each of the above four “safe-harbor” regulatory conditions, then the Plan is not ERISA-covered.¹ If a Plan meets the three-prong test set forth above, it must still dodge fitting within all four of the “safe-harbor” regulations set forth above, or it will not be considered an ERISA Plan.² In short, a “Plan” will be an ERISA-covered Plan if it fails to meet at least one of the four safe-harbor elements above, satisfies the statutory definition of an “employee welfare benefit Plan”, and is “established or maintained” by an employer.

Even though a Plan is otherwise an “ERISA covered Plan” certain plans are exempt from ERISA:

- A. Government and Church Plans:
Some government Plans and church Plans are specifically exempted from ERISA and therefore will be subject to state law. Subrogation under these kinds of Plans is the same as ordinary state law subrogation. If the Plan insures employees of a federal or state governmental agency, or any subdivision or instrumentality thereof, it is a government Plan exempt from ERISA.³
- B. Trade Association Plans:
Trade association Plans for the self-employed are not subject to ERISA.⁴
- C. Plans that Cover Owners and Not Employees:
Plans which cover owners and not employees are not covered by ERISA.
- D. Multi-Employer Plans
- E. Entities not Engaged in Interstate Commerce.
Entities which are not engaged in interstate commerce are not subject to ERISA.⁵

¹ *Memorial Hosp. Sys. v. Northbrook Life Ins. Co.*, 904 F.2d 234 (5th Cir. 1990); *Qualls v. Blue Cross of Cal., Inc.*, 22 F.3d 839 (9th Cir. 1994); *Fugarino v. Hartford Life & Accident Ins. Co.*, 969 F.2d 178 (6th Cir. 1992).

² *Peckham v. Gem State Mct. Of Utah*, 964 F.2d 1043 (10th Cir. 1992); *Johnson v. Watts Regulator Co.*, 63 F.3d 1129 (1st Cir. 1995).

³ 29 U.S.C. § 1002(32) and § 1003 (1994) (29 U.S.C. § 1002(32) defines a government Plan as a Plan established or maintained for its employees by the government of the United States, by the government of any state or political subdivision thereof, or by any agency or instrumentality of any of the foregoing. *Bigelow v. United Health Care of Miss.*, 220 F.3d 339 (5th Cir. 2000).

⁴ *Cross v. Bankers Multiple Line Ins. Co.*, 810 F. Supp. 748 (N.D. Tex. 1993).

ERISA Preemption:

Preemption is the key to why ERISA subrogation is different and more powerful than ordinary insurance subrogation, and much more effective. ERISA's preemption provisions provide tremendous leveraging power when attempting to subrogate in a third party case. Preemption is also the reason why you are able to recover the lion's share or all of your subrogated interest - free of attorneys' fees in many cases - notwithstanding the fact that the beneficiary may not have been fully compensated for all of his damages in his settlement or recovery in the third party case.

The preemption section of ERISA is found in § 1144.[2] This section is unique in its magnitude and in the interplay between its three main clauses, the preemption clause, the saving clause, and the deemer clause. It is the breadth of this preemptive power as well as the interplay between these clauses that make ERISA useful but also unpredictable in subrogation cases.

The three clauses that constitute the mumbo-jumbo at the root of so much confusion with regard to ERISA preemption are the following:

1. PREEMPTION CLAUSE (29 U.S.C. § 1144(a) (1988))

All state law is preempted insofar as it "relates to employee benefit Plans".

"Except as provided in subsection (b) of this section, the provisions of this subchapter III of this chapter shall supersede any and all State laws in so far as they may now or hereafter relate to any employee benefit Plan . . ."

2. SAVING CLAUSE (29 U.S.C. § 1144(b)(2)(A)(2000))

"Saves" from preemption those state laws which regulate insurance.

"Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities."

3. DEEMER CLAUSE (29 U.S.C. § 1144(b)(2)(B)(2000))

Prevents states from "opting out" of Federal preemption of employee benefit law by "deeming" Plans to be the subject of the saving clause.

"Neither an employee benefit Plan described in § 1003(a) of this title, which is not exempt under § 1003(b) of this title, (other than a Plan established primarily for the purpose of providing death benefits), nor any trust established under such a

⁵ *Sheffield v. Allstate Life Ins. Co.*, 756 F. Supp. 309 (S.D. Tex. 1991) (the federal judge in Austin ruled that ERISA did not apply to this case involving a charitable organization that received most of its funding from a governmental entity and local contributions - the case immediately settled and no opinion was published).

Plan, shall be deemed to be an insurance company or other insurer . . . or to be engaged in the business of insurance . . . for purposes of any law of any state purporting to regulate insurance companies, [or] insurance contracts."

The "PREEMPTION CLAUSE" establishes as an area of exclusive federal concern the subject of every state law that "relates to" a Plan. The "SAVING CLAUSE" returns to the State the power to enforce state laws which "regulate insurance", except as provided in the "DEEMER CLAUSE", under which a Plan may not be "deemed" an insurer for the purpose of state laws "purporting to regulate" insurance companies or contracts.

In *Pilot Life Ins. Co. v. Dedeaux*, the Supreme Court adopted a two-prong test to determine whether a state law "regulates insurance", and is therefore saved from ERISA preemption. The term "state law" includes "all laws, decisions, rules, regulations, or other state action having the effect of law". 29 U.S.C. § 1144 (c)(1)(2). The first-prong of the test is to take a "common sense view" of the language of the saving clause itself. The second-prong makes use of case law interpreting the phrase "business of insurance" under the McCarran-Ferguson Act, 15 U.S.C. § 1011, et seq., in interpreting the saving clause. Three criteria have been used to determine whether a practice falls under the "business of insurance":

1. whether the practice has the effect of transferring or spreading a policy holder's risk;
2. whether the practice is an integral part of the policy relationship between the insurer and the insured; and
3. whether the practice is limited to entities within the insurance industry.

In order for a state law to be deemed "law which regulates insurance", and for it to be saved from preemption under ERISA, that law must be specifically directed toward entities engaged in insurance and it must substantially affect the risk pooling arrangement between an insurer and its insured.⁶ In particular, ERISA's saving clause does not require that state law regulate "insurance companies" or even "the business of insurance", in order to save state law from preemption. It needs only to be a "law . . . which regulates insurance." (*Id.*)

As a result of the preemption, saving, and deemer clauses, states cannot regulate employee benefit Plans, though they can regulate insurance companies. So if a Plan is self-funded (employer self-insures the Plan), then the states cannot regulate it by legislation or common law. If it is an unfunded (fully insured) Plan (Plan merely purchases insurance policy covering the employees), then the Plan can be indirectly regulated by the states as long as the law is one that applies specifically to the business of insurance, and as long as it is not simply a regulation specifically applying to employee benefit Plans. More specifically, the state can regulate the

⁶ *Kentucky Ass'n of Health Plans, Inc. v. Miller*, 123 S. Ct. 1471 (2003).

insurance policy purchased by an unfunded Plan, but it may not regulate the Plan itself.

Summary of Preemption, Savings and Deemer:

PREEMPTION: ERISA preempts all state laws in so far as they "relate to" any employee benefit Plan.

SAVING: State laws which "regulate insurance" are not preempted.

DEEMER: States cannot "deem" an employee benefit Plan to be insurance.

The preemption-saving-deemer mumbo-jumbo has puzzled the finest legal minds in the country. But the simple subrogation rule which generally follows from it is as follows:

If a state law "relates to" an ERISA Plan, it is preempted. But if that same state law also "regulates insurance", it is not preempted. But a self-funded ERISA-covered employee welfare benefit Plan is "deemed" not to be an insurance company for purposes of state laws regulating insurance, and ERISA, therefore, preempts such state laws. Therefore, self-funded ERISA Plans are exempt from state regulation in so far as that regulation relates to the Plan. However, this exemption does not apply to insured Plans.

The following steps must therefore be taken to determine whether a state law is preempted by ERISA:

- 1) Does the state law "relate to" the employee benefit Plan? If so, it is preempted.
- 2) Is the state law "saved" from preemption because it "regulates" insurance? If so, it is not preempted.

If the analysis survives these two steps, then you may move on to the third step.

- 3) If the Plan is not deemed to be an insurance company and thus is a self-funded Plan, it is then exempted from the "saving clause" and ERISA preemption applies.

Preemption is an affirmative defense which must be timely pled or it is waived. The effect of preemption on state non-subrogation law is also sweeping. It appears that Congress wished to fully federalize the law of employee benefits, providing all necessary remedies and enforcement devices under federal law, with U.S. courts creating a federal common law of employee benefits. In the area of benefit claims, ERISA has been interpreted to completely preempt the field, eliminating all of the state law remedies which existed prior to enactment.

ERISA Preemption of State Law Where Plan Is Insured and Not "Self-Funded".

There has been a lot of confusion and debate surrounding when, if ever, a fully insured ERISA Plan preempts state law which would otherwise limit or eliminate the

Plan's subrogation reimbursement rights. **Just because an ERISA Plan is not self-funded, does not mean that all state law will apply to limit your subrogation rights.** As discussed above, the distinction between "self-funded" and "insured" ERISA Plans stems from the language contained in the deemer clause. The "Deemer Clause" deceptively exempts "self-funded" ERISA Plans from state laws that "regulate insurance" within the meaning of the "Saving Clause". Therefore, self-funded ERISA Plans are exempt from state law insofar as the law "relates to" the Plan. State laws directed toward a Plan are preempted because they "relate to" a Plan, but are not "saved" because they do not regulate insurance. State laws that directly regulate insurance are "saved", but do not reach self-funded Plans because the Plans may not be deemed to be insurers under the "Deemer Clause".

On the other hand, Plans that are fully insured may be subject to indirect state insurance regulation. An insurance company insuring the Plan remains an insurer for purposes of state laws purporting to "regulate insurance" even after application of the deemer clause. The insurance company is therefore not relieved from state insurance regulations. As a consequence, the insured/self-funded status of an ERISA Plan is not dispositive on the issue of preemption. A deemer clause analysis is necessary only if the saving clause exception applies, and only in the context of a state law which "regulates insurance" within the meaning of the saving clause.

The Supreme Court in *FMC Corporation v. Holliday*⁷ and *Metropolitan Life Insurance Company v. Massachusetts*⁸, drew a distinction between fully insured and self-funded Plans. Any reliance upon this distinction is misplaced, however, where the claims are not saved by the saving clause and where the deemer clause would therefore be rendered immaterial. If the saving clause applies, then the Court must determine whether the Plan in question is "deemed" to be an insurance company under the deemer clause. If a state law does not fall within the saving clause (i.e., does not regulate insurance), the deemer clause analysis (i.e., whether it is self-funded or fully insured) is irrelevant. If a state law⁹ "relates to" a Plan, that law may be "saved" from preemption if it "regulates insurance", using the two-tier test set forth in *Pilot Life*.¹⁰ As a consequence, any law is preempted by ERISA if it relates to the Plan, but it isn't preempted if it "regulates insurance". Therefore, even in fully insured Plans, if a law does not "regulate insurance" it would not be saved from preemption - and it will therefore be preempted. The ultimate question to be asked when attempting to determine whether or not a state law affecting the subrogation rights of a fully insured Plan is preempted, depends on whether the state law "relates to" the Plan, and then whether or not the state law "regulates insurance".

⁷ 498 U.S. 52 (1990).

⁸ 471 U.S. 724 (1995).

⁹ "State law" can include state statutory law, Court of Appeals or Supreme Court opinions, common law, regulations, or other application of rules by the state applied to the ERISA Plan.

¹⁰ *Pilot Life Ins. Co. v. Debeaux*, 481 U.S. 41 (1987).

When Does State Law “Relate to” an Employee Benefit Plan? There has been much controversy and litigation with regard to when a state law “relates to” an employee benefit Plan. Plaintiffs’ attorneys will try to argue that state “made whole” and “common fund” laws do not “relate to” an employee benefit Plan because they have nothing to do with ERISA Plans. They will argue that such laws are generally applied to subrogation in general - including property subrogation - so they shouldn’t be preempted. The United States Supreme Court has held that a state law “relates to” an employee benefit Plan if it has a “connection with or reference to such a Plan.”¹¹

One **8th Circuit** decision involved the subrogation of an ERISA Plan under **Iowa** law. In *Stillmunkes v. Hy-Vee*,¹² an ERISA Plan attempted to subrogate under **Iowa** law. The Plan provided that it would be reimbursed for any benefits paid under the Plan. The Stillmunkes argued that § 668.5(3) of the **Iowa** Statutes should reduce Hy-Vee’s claim for attorneys’ fees and costs. Section 668.5(3) states:

Contractual or statutory subrogated persons shall be responsible for a pro-rata share of the legal and administrative expenses incurred in obtaining the judgment or verdict.

The court held that because this **Iowa** statute regulated insurance, the ERISA Plan was exempt from the effect of this state law pursuant to ERISA’s preemption clause. The Stillmunkes also argued that the common fund doctrine under federal common law required the reduction of Hy-Vee’s claim by its proportionate share of attorneys’ fees. The court held that the bankruptcy court in this case did not err in denying these arguments, and the Plan was not responsible for paying a pro rata share of costs and attorneys’ fees in obtaining the judgment.

The **5th Circuit** has recognized the connection or reference test as the applicable standard for determining ERISA conflict preemption.¹³ The **5th Circuit** has also described conflict preemption under § 1144 as “clearly expansive”, has a “broad scope”, “expansive sweep”, is “broadly worded”, “deliberately expansive”, and “conspicuous for its breadth”.¹⁴ The **5th Circuit** has held that a claim “relates to a Plan” when the very essence of the claim is premised on the existence of an employee benefit Plan.¹⁵ If the claim could not be made if the Plan ceased to exist,

¹¹ *Shaw v. Delta Airlines, Inc.*, 463 U.S. 85 (1983); *Lee v. E.I. DuPont de Nemours & Co.*, 894 F.2d 755 (**5th Cir.** 1990).

¹² *Stillmunkes v. Hy-Vee Employee Benefit Plan and Trust*, 127 F.3d 767 (**8th Cir.** 1997).

¹³ *Texas Pharmacy Ass’n v. Prudential Ins. Co. of America*, 105 F.3d 1035, 1037 (**5th Cir.**), cert. denied, 522 U.S. 820 (1997); *CIGNA Health Plan, Inc. v. Louisiana*, 82 F.3d 642, 647 (**5th Cir.**), cert. denied, 519 U.S. 964 (1996).

¹⁴ *Heimann v. Nat’l Elevator Indus. Pension Fund*, 187 F.3d 493 (**5th Cir.** 1999).

¹⁵ *Christopher v. Mobil Oil Corp.*, 950 F.2d 1209 (**5th Cir.**), cert. denied, 506 U.S. 820 (1992).

they are preempted by ERISA.¹⁶ Similarly, the **5th Circuit** has held claims “relate to” an employee benefit Plan and are “conflict preempted” when they affect employee benefit structures or administration.¹⁷ In *Franks v. Prudential Healthcare Plan, Inc.*, Franks maintained that the ERISA Plan improperly sought reimbursement from him for amounts its providers typically “bill” for their services, instead of the amount Prudential actually “paid” for them. Franks filed suit in federal court seeking a declaratory judgment and alleging 24 causes of action under state and federal law, including breach of contract, breach of implied covenant of good faith and fair dealing, bad faith, breach of fiduciary duty, accounting, unconscionability, intentional misrepresentation, misrepresentation and negligence, wrongful conversion, unjust enrichment, fraud, negligence and gross negligence, insurance code violations, enforcement of the terms of the Plan documents under § 502(A)(1)(B) of ERISA breach of fiduciary duty, unjust enrichment under common law, and many others. All of Franks’ claims were dismissed as being preempted by conflict preemption, with the exception of his claim for common fund doctrine attorneys’ fees which remained pending for disposition.

The **4th Circuit** decided a case which dealt with state statutes limiting the recovery of medical expenses in wrongful death cases.¹⁸ **North Carolina** law limits the recovery of medical expenses in a wrongful death action to \$4,500.¹⁹ With regard to whether or not ERISA preempted this medical expense recovery cap, the Court of Appeals held that even though ERISA preemption is “conspicuous for its breadth” and not limited to “state laws specifically designed to effect employee benefit Plans”, some state actions may affect employee benefit Plans in too tenuous, remote, or peripheral of manner” to warrant a finding that the law “relates to” the Plan.²⁰ ERISA was held not to preempt this state law.

¹⁶ *Gibson v. Wyatt Cafeterias, Inc.*, 782 F.Supp. 331 (E.D. Tex. 1992) (state law claim in *Lee v. E.I. DuPont de Nemours & Co.* was related to benefit Plan because without the Plan the cause of action would not have existed).

¹⁷ *Texas Pharmacy Ass’n v. Prudential Ins. Co. of America*, 105 F.3d 1035 (**5th Cir.** 1997); *Franks v. Prudential Healthcare Plan, Inc.*, 2001 WL 682736 (W.D. Tex. - Feb. 28, 2001).

¹⁸ *Liberty Corp. v. NCNB Nat’l Bank of South Carolina*, 984 F.2d 1383 (**4th Cir.** 1993).

¹⁹ N.C.G.S.A. § 29A-18-2 (1997).

²⁰ *Liberty Corp.*, *supra.*; *Shaw v. Delta Airlines, Inc.*, 103 S. Ct. 2890 (1983); *Powell v. Chesapeake and Potomac Tel. Co. of Virginia*, 780 F.2d 419 (**4th Cir.** 1985).

When Does State Law “Regulate Insurance”? ERISA subrogation professionals dealing with non-ERISA Plans or fully insured Plans will often be called upon to analyze whether or not a particular state law, which they are trying to avoid the harsh effects of, “regulates insurance”. This question is the key to preemption for insured Plans, that otherwise will not be saved by the deemer clause because they are not “self-funded”. Even with fully insured Plans, if the law does not “regulate insurance”, it will not be saved from preemption. In *FMC Corporation v. Holliday*²¹, a Pennsylvania anti-subrogation statute was held to regulate insurance. A law that merely impacts the insurance industry will not be saved, but a law that is “aimed at” the insurance industry, will be.²² The Supreme Court held that the issue with regard to subrogation was returned to the state via the saving clause, unless it was excluded from the saving clause by the deemer clause (i.e., a self-funded Plan), it is not preempted.

The **11th Circuit** has interpreted *FMC Corporation* to stand for the proposition that subrogation laws are a “regulation of insurance”.²³ The **4th Circuit** has indicated that limits on subrogation recoveries appear to come within the saving clause also.²⁴ In **Wisconsin**, the made whole doctrine has been held to “regulate insurance”.²⁵ On the other hand, the **8th Circuit** has held that common law rules with regard to subrogation were not the type of state insurance regulations intended to survive the broad scope of ERISA preemption, and were not saved as “regulating insurance”.²⁶ A Federal Court within the **6th Circuit** has held that **Tennessee’s** common law of subrogation, including its made whole doctrine, was preempted by ERISA because this common law was not limited to the insurance industry, and was a law of general application.²⁷ Therefore, it did not regulate insurance”. That same Federal Court within the **6th Circuit** has held that **Tennessee’s** common law “common fund doctrine”, however, did regulate insurance and was saved from preemption.²⁸

The Supreme Court of **Alabama** has held that the right of subrogation exists only after the insured has been “made whole”. However, this law of subrogation was held by a federal court within the **11th Circuit** not to “regulate insurance”, because it did not

²¹ 498 U.S. 52 (1990).

²² *Id.*

²³ *O’Neal v. Kemmamer*, 958 F.2d 1044 (**11th Cir.** 1992).

²⁴ *Hanson Indus. v. Sparrow*, 981 F.2d 726 (**4th Cir.** 1992).

²⁵ *Kavelaris v. MFI*, 631 N.W.2d 665 (Wis. App. 2001).

²⁶ *Baxter by Baxter v. Lynn*, 886 F.2d 182 (**8th Cir.** 1989).

²⁷ *Marshall v. Employees Health*, 927 F. Supp. 1068 (M.D. Tenn. 1996).

²⁸ *Sims v. Ewing*, 1993 WL 827327 (M.D. Tenn. 1993).

solely apply to entities within the insurance industry.²⁹ The **Louisiana** Supreme Court has held that Louisiana's law on subrogation do not transfer or spread a policyholder's risk, even though they can be an integral part of the policy relationship between the insurer and the insured. However, because subrogation law is not limited to entities within the insurance industry, these state laws do not "regulate insurance", and are not safe from ERISA preemption.³⁰ The **9th Circuit** has held that **Arizona**'s common law prohibiting subrogation of tort claims did "regulate insurance".³¹ However, that analysis was decided prior to the *Pilot Life* decision, which added an additional factor - whether the law was specifically directed toward the insurance industry. A later decision by a Federal Court in **Arizona** held that the anti-subrogation law was not specifically directed toward the insurance industry, as is required by *Pilot Life*, but is aimed at a broad spectrum of incidents involving subrogation, and is therefore not saved from preemption.³²

New Jersey's collateral source rule³³ contains anti-subrogation provisions which the **3rd Circuit** recently held were "not specifically directed toward the insurance industry", and therefore, was not saved from preemption by the savings clause of ERISA.³⁴ In addition, the **4th Circuit** has held that the subrogation provision of Maryland's HMO Act was saved from preemption as a legitimate state regulation of insurance.³⁵ By and large, state laws with regard to subrogation, while generally applicable to insurance contracts, have been held not specifically directed toward the insurance industry.³⁶ The **8th Circuit** has opined that while the laws regulating subrogation rights apply in part to holders of insurance, they do not regulate the insurance industry directly.³⁷ Application of differing state subrogation laws to Plan providers throughout the United States would frustrate ERISA's uniform treatment of benefit Plans, contrary to the intent of ERISA.³⁸ **California's** collateral source rule³⁹ was

²⁹ *Blue Cross and Blue Shield of Ala. v. Sanders*, 974 et seq. 1416 (M.D. Ala. 1997).

³⁰ *A. Copeland Enter., Inc. v. Slidell Memorial Hosp.*, 657 So.2d 1292 (La. 1995).

³¹ *United Feed & Commercial Workers v. Pacyga*, 801 F.2d 1157 (**9th Cir.** 1986).

³² *Baughtry v. Union Centennial Life Ins. Co.*, 33 F. Supp. 1174 (D. Ariz. 1999).

³³ N.J.S.A. 2A:15-97.

³⁴ *Levine v. United Healthcare*, 402 F.3d 156 (**3rd Cir.** 2005).

³⁵ *Singh v. Prudential Healthcare Plan*, 335 F.3d 278 (**4th Cir.** 2003).

³⁶ *Baxter by Baxter v. Lynn*, 886 F.2d 182 (**8th Cir.** 1989).

³⁷ Id.

³⁸ Id.

³⁹ Cal. Civ. Proc. Code § 3333.1.

held preempted by ERISA because the Plan was self-funded and it was exempt from being saved by the deemer clause.⁴⁰ However, the question of whether it regulated insurance was referred to as “a close one” according to the courts, but they didn’t decide that issue. A federal court in **Arkansas** cited the **8th Circuit Baxter** decision, and held that Arkansas’ made whole rule did not regulate the insurance industry directly.⁴¹ An **Ohio** statute⁴² which prohibited an insurer from bringing a subrogation action against the political subdivision was held to be a statute which “regulated insurance” within the meaning of ERISA.⁴³

In order to “regulate insurance”, a state law must govern the substantive content of the insurance contract.⁴⁴ It is not sufficient to merely govern the procedural aspects of claims processing.⁴⁵ **Indiana’s** common fund doctrine⁴⁶ was held to “regulate insurance” and was saved from preemption.⁴⁷ On the other hand, **Indiana’s** lien reduction statute⁴⁸ was held not to be saved from preemption because it did not “refer to” ERISA Plans.⁴⁹ The statute was held not to act exclusively on ERISA Plans or rely upon ERISA Plans for its existence and therefore did not “refer to” ERISA Plans.⁵⁰ The **7th Circuit** did not have to decide whether **Wisconsin** state law “regulated insurance” in one case, because the Plan at issue was self-insured.⁵¹ The court did, however, state that if a Plan purchases insurance, as opposed to

⁴⁰ *FMC Corp. v. Good Samaritan Hosp.*, 1998 WL 424459 (N.D. Cal. 1998).

⁴¹ *Provident Life and Accident v. Linthicum*, 743 F. Supp. 662 (W.D. Ark. 1990).

⁴² O.R.S. § 2744.05(B).

⁴³ *Community Ins. Co. v. Hambden Twp.*, 718 N.E.2d 944 (Ohio App. 1998).

⁴⁴ *Metropolitan Life*, *supra*.

⁴⁵ *Metropolitan Life*, *supra*; *Dutenhaver v. Teachers Ins. & Annuity Ass’n of America*, 1987 WL 26138 (N.D. Ill. 1987); *Buehler, Ltd. v. Home Life Ins. Co.*, 722 F. Supp. 1554 (N.D. Ill. 1989).

⁴⁶ I.C. § 34-4-41.

⁴⁷ *Hoover v. Health Cost Controls*, 1998 WL 102509 (N.D. Ill.), vacated on other grounds, 1998 WL 299821 (N.D. Ill.) (held **Illinois** law applied instead of **Indiana** law).

⁴⁸ I.C. § 34-4-33-12 (predecessor to § 34-51-2-19, known as the Indiana Lien Reduction Statute).

⁴⁹ *Hoover*, *supra*.

⁵⁰ *Id.*

⁵¹ *Reilly v. Blue Cross*, 846 F.2d 4167 (**7th Cir.** 1988) cert. denied, 488 U.S. 856.

being self-insured, it is directly affected by state laws that regulate the insurance industry.⁵²

The **6th Circuit** has held that a Michigan statute requiring a no-fault insurer to place primary responsibility for medical expenses on health Plans was a statute “regulating insurance”, because the statute had the effect of directly regulating the ERISA Plan.⁵³ **Illinois** courts have developed a rule prohibiting subrogation of a minor’s tort settlement to reimburse the party who paid the child’s medical expenses. This anti-subrogation law was held to “regulate insurance” and was saved from preemption, because the rule was directed toward the insurance industry.⁵⁴ The **Michigan** Supreme Court addressed a conflict between coordination benefits clauses in an ERISA Plan and a Michigan auto policy which resulted from M.C.L.A. § 500.3109(a) and M.C.L.A. § 24.13109(1) - providing that the health Plan should provide primary coverage.⁵⁵ The court held that even though the Michigan statute purported to regulate insurance, they concluded that it had a direct effect on the administration of ERISA Plans and the court found that the no-fault insurer would be primary.

Subrogating Fully Insured ERISA Plans vs. Subrogating Non-ERISA Plans:

It is important to note at the onset, that the language of any Plan, whether Self-Funded, Fully insured or Non ERISA, forms the basis for the analysis of the Plan’s subrogation rights. Thus, it is important that all Plans contain superior language to protect the subrogation interests of the Plan and to maximize its recovery.

Subrogating Fully Insured ERISA Health Plans: As noted above, in certain circumstances, a Fully insured ERISA Plan will not receive the benefit of ERISA Preemption. In that case, subrogating fully insured ERISA Plans is much like subrogating Non-ERISA Plans (see below).

If, however, it is determined that the fully insured ERISA Plan preempts certain state laws (as discussed above), the Plan language will control the extent of the Plan’s subrogation rights. As such, it is essential that every fully insured ERISA Plan have superior Plan language, not only because the vast majority of the Plan’s rights stem from its Plan language, but also, because you never know whether your ERISA Plan will ultimately preempt state law.

ERISA itself is silent with respect to subrogation and reimbursement. Amazingly, it says nothing about a Plan’s right to recover benefit payments once they are made. It neither requires a welfare Plan to contain a subrogation and/or reimbursement

⁵² Id.

⁵³ *Lincoln Mutual v. Lectron Products*, 970 F.2d 206 (**6th Cir.** 1992).

⁵⁴ *General Business Forms v. Thornburg*, 1989 WL 103382 (N.D. Ill. 1989); *Health Cost Controls v. Ross*, 1997 WL 222877 (N.D. Ill. 1997).

⁵⁵ *Auto Club Ins. Ass’n v. Frederick & Herrud*, 505 N.W.2d 820 (Mich. 1993).

clause, nor bars such clauses or otherwise regulates their content. Therefore, subrogation and reimbursement rights of an ERISA Plan will be determined largely by the Plan language itself. Reimbursement and subrogation are distinct remedies. Subrogation empowers the Plan to stand in the shoes of its beneficiary, and thus to enforce the Plan's beneficiary's rights and remedies against third parties through litigation.⁵⁶ By contrast, reimbursement affords the Plan a direct right of recovery against the Plan beneficiary himself.⁵⁷ **It is important to remember that even if the fully insured ERISA Plan does not preempt a given state's anti-subrogation law, that a Plan with a right to reimbursement may still have a viable claim against the Plan beneficiary. Therefore, it is essential to have Plan language granting such a right.**

Plan Language:

Subrogation Provisions. A Plan's subrogation provision delineates the Plan's subrogation rights against parties responsible for causing the injuries which result in the necessitated healthcare for which the Plan has paid benefits. In many ways, this provision gives the Plan the right to "stand in the shoes" of the Plan beneficiary or covered person, granting them legal standing to file suit against the tortfeasor to recover the benefits paid. A sample subrogation clause might look something like this:

This Plan will be subrogated to any and all rights which a covered individual or beneficiary has against any and all parties responsible for causing the injuries or illnesses for which benefit payments are made under this Plan.

As you can see, such a provision purports to give the Plan any rights which the covered individual or Plan beneficiary had against anyone responsible for causing the injuries. The Plan "steps into the shoes" of the Plan beneficiary. A provision such as this grants the Plan a contractual right of subrogation, which is different than a right of reimbursement.

Reimbursement Provisions. A Plan's reimbursement provision provides the Plan with something much different than a right of subrogation. A reimbursement clause provides that the beneficiary or covered person has an obligation to "pay the Plan back" if the Plan pays for an injury and the beneficiary or covered person later recovers for the same injury from the third party. Rather than giving the Plan a substantive legal right, it places an obligation on the covered person. If the covered person fails to pay back the benefits he received from the Plan after making a recovery from a third party, the Plan will have a right to sue the covered person for breach of this reimbursement clause. A typical reimbursement clause might read as follows:

⁵⁶ *Harris v. Harvard Pilgrim Healthcare, Inc.*, 208 F.3d 274 (1st Cir. 2000).

⁵⁷ *Provident Life & Accident Ins. Co. v. Williams*, 858 F. Supp. 907 (W.D. Ark. 1994).

This Plan is granted a specific right of reimbursement out of the proceeds of any settlement, judgment, or other payment by a third party tortfeasor, person, or entity to or on behalf of the covered individual. This right of reimbursement is separate and apart from the subrogation rights of the Plan set forth below, and are limited only by the amount of the actual benefits paid under the Plan or as otherwise stated herein.

As you can see, this provision is significantly different than the subrogation provision, and for good reason. It is an obligation owed by the covered person directly to the Plan.

Where there is no specific language granting a right to reimbursement, such a right may still be obtained under equitable law, depending of the state or federal jurisdictions. Where there is no contractual right to reimbursement, many courts create an equitable right of reimbursement when an insured settles with a tortfeasor and thereby destroys the Plan's subrogation interest.⁵⁸ The general body of state common law favors the creation of such an equitable right under such circumstances.⁵⁹ However, where such an equitable right of reimbursement is recognized, there are many factors which may operate to prevent a recovery by a Plan or to limit the amount or character of such a recovery.

Recovery Priorities. If the Plan language provides for subrogation, against what recovery or elements of damages does it claim an interest? May the Plan recover against non-economic damages, such as pain and suffering, mental anguish, and the like? Or is the Plan limited to recovery from only those elements of damages which represent medical expenses? What happens if the jury awards only a portion of the Plan beneficiary's medical expenses for which he is seeking in his third party lawsuit? May the Plan recover all of its medical benefit payments even though the Plan beneficiary recovered only a portion of his medical expenses from the third party? These questions become increasingly important for subrogation professionals as plaintiff's attorneys step up their efforts to eliminate a Plan's subrogation rights. Subrogation clauses are often read broadly and Plan language claiming reimbursements out of "any recovery relating to injury" or "any funds" have been held by the **8th Circuit** to reach all monies recovered, whether or not for medical expenses.⁶⁰ In *Cagle*, the Plan received full reimbursement even though the participant recovered less than the medical benefits paid.

First Money Recovered. Another recurring issue is whether or not the Plan is entitled to a first money recovery. Some courts have held that the Plan language must expressly claim priority in order to be entitled to first dollars recovered. Under this view, the Plan must specify whether the made whole doctrine applies, whether

⁵⁸ *Provident Life and Accident Ins. Co. v. Williams*, 858 F. Supp. 907 (W.D. Ark. 1994).

⁵⁹ See 51 A.L.R.2d 697 (1957) for an exhaustive discussion on this topic.

⁶⁰ *McIntosh v. Pac. Holding Co.*, 992 F.2d 882 (8th Cir. 1993), cert. denied, 510 U.S. 965 (1993).

there is a pro rata sharing of proceeds, or whether the Plan gets paid “off the top”. If the Plan does not clearly specify an allocation scheme, the made whole doctrine may be applied.⁶¹ The issue of whether an ERISA Plan is entitled the “first money” recovered in a third party settlement or judgment is arguably an extension of the made whole doctrine. If a Plan beneficiary claims that it is entitled to receive its damages before the Plan does, it is basically arguing that it is entitled to be “made whole” before the Plan is entitled to recover anything.

Example of superior ERISA Plan Language: This Plan language is superior for a self-funded or fully insured ERISA Plan.

“This Plan will be subrogated to any and all rights which a covered individual or beneficiary has against any and all parties responsible for causing the injuries or illnesses for which benefit payments are made under this Plan. This Plan will also be reimbursed for any and all benefit payments it makes to or on behalf of a covered individual as a result of injuries or illnesses which result from the action or liability of a third party, and/or which result in a settlement, judgment, or other award or recovery to or by a covered individual from a third party tortfeasor, including any person or entity liable for or indemnifying the covered individual. The Plan subrogation rights are listed below and this Plan will provide benefits, otherwise payable under this Plan and its terms, to or on behalf of a covered individual subject to an only upon fulfillment of the following terms and conditions:

This Plan, once it has made payment of any benefits, is granted a lien on the proceeds of any payment, settlement, judgment, or other remuneration received by the covered individual from a third party tortfeasor, person or entity, and the covered individual hereby consents to this lien and agrees to take any actions or steps necessary to secure this lien and help the Plan administrator recover same.

This Plan is granted a specific right of reimbursement out of the proceeds of any settlement, judgment, or other payment by a third party tortfeasor, person, or entity to or on behalf of the covered individual. This right of reimbursement is separate and apart from the subrogation rights of the Plan set forth below, and are limited only by the amount of the actual benefits paid under the Plan or as otherwise stated herein.

If this Plan makes any benefit payments to or on behalf of the covered individual, it shall be fully subrogated to any and all rights of recovery and causes of action which the covered individual may have against any third party, person, entity, or tortfeasor, and the covered individual shall execute, sign, and deliver any and all instruments, documents, or papers necessary to affect and/or secure such subrogation.

The covered individual agrees to and is obligated to cooperate with the Plan and/or any and all representatives of the Plan, including subrogation counsel, in completing discovery, attending depositions, and/or attending or cooperating in trial in order to

⁶¹ *Himey Printing Co. v. Brantmer*, 75 F. Supp.2d 761 (N.D. Ohio 1999) (citing an unpublished 6th Circuit Court of Appeals case); *Cagle v. Bruner*, 112 F.3d 1510 (11th Cir.1997); *Equity Fire and Casualty Co. v. Youngblood*, 927 P.2d 572, 576 (Okla. 1996) (citing state court cases in a court).

affect the Plan's subrogation rights. Furthermore, the covered individual shall do nothing after loss to prejudice the aforementioned subrogation rights. The covered individual must freely give any and all information surrounding any accident which the Plan or its subrogation counsel or representatives may deem necessary to fully investigate the loss or effect subrogation rights under the terms of the Plan.

The Plan's subrogation, reimbursement and lien rights, as stated above applies to any recoveries made by the covered individual as a result of the injuries sustained or illness suffered, for which benefit payments were made, including but not limited to the following:

- a. Any award or settlement or benefits paid under any workers' compensation law or award;
- b. Any and all payments made directly by a third party tortfeasors, person, or entity or any insurance company on behalf of the third party tortfeasor or any payments or installments made to the covered individual on behalf of the third party tortfeasors, person, or entity responsible for indemnifying the third party tortfeasors;

Any arbitration awards, payments, settlements, structured settlements or other benefits paid by an insurance company under an uninsured or underinsured motorist coverage policy, whether on behalf of the covered individual, his employer, or any other person;

- d. Any other payments designated, delineated, earmarked, or intended to be paid to a covered individual as compensation, restitution, or remuneration, for injuries sustained or illnesses suffered as the result of the negligence, or liability, including contractual, of a third party.

No covered individual may assign any rights or causes of action that he or she might have against a third party tortfeasor, person, or entity, which would grant the covered individual the right to recover medical expenses or other damages, without the express, prior written consent of the Plan and the Plan administrator. The Plan's subrogation and reimbursement rights apply even if the covered individual has died as a result of his or her injuries and is asserting a wrongful death or survivor claim against the third party tortfeasor under the laws of any state. The Plan's right to recover by subrogation or reimbursement shall thus apply to any settlements, recoveries, or causes of action owned or obtained by a decedent, minor, incompetent or disabled person.

The Plan's right of subrogation and reimbursement, as set forth herein, will not be affected, reduced, or eliminated by the "made whole doctrine" or any other equitable doctrine or law which requires an insured be "made whole" before subrogation rights are allowed. Furthermore, it is prohibited for a covered individual or beneficiaries to settle a claim against a third party for certain elements of damages, but eliminating damages relating to medical expenses incurred.

The Plan's right of subrogation and reimbursement will not be reduced or effected as a result of any fault or claim on the part of the covered individual, whether under the doctrines of imperative causation, comparative fault or contributory negligence, or

any other similar doctrine in law. Accordingly, any so called “lien reduction statutes,” which attempt to apply such laws and reduce a subrogating Plan’s recovery for any reason, including contributory negligence will not be applicable to the Plan and will not reduce the Plan’s subrogation recovery. The benefits provided under this Plan are secondary to any benefits or coverage provided under any no-fault or similar legislation or no-fault type insurance.

The Plan will not be responsible for any expenses, fees, costs, or other monies incurred by the attorney for the covered individual or his/her beneficiaries, commonly known as the common fund doctrine. The covered individual is specifically prohibited from incurring any expenses, costs or fees on behalf of the Plan in pursuit of his rights of recovery against a third party or the Plan’s subrogation/reimbursement rights as set forth herein. No court costs, expert’s fees, attorneys’ fees, filing fees, or other costs or expenses of litigation nature may be deducted from the Plan’s recovery without prior, expressed written consent of the Plan.”

Grey Areas: In ERISA, the gray areas predominate over black letter law. There is no statutory provision on subrogation under ERISA and subrogation is usually allowed only if and to the extent the written Plan document provides for it. Likewise, the different rules of subrogation under ERISA are largely dependent on the terms of the Plan. Many subrogation issues have not been decided under federal ERISA law, primarily because there are an infinite number of subrogation variables which can arise with the number of Plans out there. Whether you will be successful in subrogating depends mainly on the language in the ERISA-qualified Plan, the jurisdiction you are in, and the unique facts of your case. ERISA has not been around for very long and there are many issues on which there simply are no decided cases under state or federal law. Only aggressive and proactive subrogation policies will shape new law being made every day in the favor of subrogating Plans.

It is important to note that even in the absence of any subrogation agreement, equitable rights of subrogation and reimbursement are frequently granted by the courts. In such circumstances, where such a right of reimbursement does not exist under the written Plan or a subsequent subrogation agreement, the federal common law of ERISA may utilize equitable principles where necessary to prevent injustice.⁶² This remedy may take the form of a common law cause of action for equitable estoppel.⁶³ If such equity is granted, it may be subject to the beneficiary’s right to receive full compensation for all their injuries and legal expenses before the Plan may exercise its right to reimbursement.⁶⁴

⁶² *Fitch v. Ark. Blue Cross & Blue Shield*, 795 F. Supp. 904 (W.D. Ark. 1992); *Slice v. Norway*, 978 F.2d 1045 (8th Cir. 1992).

⁶³ *Slice*, supra.

⁶⁴ *Shelter Mut. Ins. Co. v. Bough*, 834 S.W.2d 637 (Ark. 1992).

Subrogating Non-ERISA Health Plans: Certain Plans fall completely outside the scope of ERISA, and thus, do not enjoy the benefits of ERISA preemption. As such, these plans are routinely subject to state law, including the made whole doctrine, common fund doctrine and anti-subrogation statutes. Also, fully insured ERISA Plans that do not enjoy the benefit of ERISA Preemption (because the state law is determined to regulate insurance) must deal with the reality of the various state laws limiting subrogation recoveries.

RIGHT TO SUBROGATION:

Whether a Non-ERISA Plan (or fully insured ERISA Plan without the benefit of preemption) has the right to subrogate is based primarily on the Plan's language. Because a health insurance policy or Plan usually has only those rights which are granted to it by the Plan itself, a Plan's specific language becomes one of the most important things to carefully look at in evaluating subrogation in the health insurance area. Sloppy, ambiguous, or unclear language can mean the difference between a full recovery and no recovery at all.

Subrogation Provisions Like ERISA Plans with the benefit of preemption, a Non-ERISA Plan must specifically indicate the Plan's subrogation rights against parties responsible for causing the injuries which result in the necessitated healthcare for which the Plan has paid benefits. In many ways, this provision gives the Plan the right to "stand in the shoes" of the Plan beneficiary or covered person, granting them legal standing to file suit against the tortfeasor to recover the benefits paid.

If the plan does not have language granting it the right to subrogation, we must turn to whether the state in which we are subrogating recognizes equitable subrogation.

Equitable subrogation means that the Plan has no subrogation language at all, and the only rights of subrogation it has are those which are bestowed upon it by common law equitable subrogation, or the equitable subrogation rights granted to it by the particular state in which you are pursuing subrogation. The problem with equitable subrogation (with an ERISA or Non-ERISA policy) is that many states simply prohibit equitable subrogation, so it may not be available to use. If no subrogation language exists in the Plan, and the Plan must rely on equitable subrogation, then there will be no corresponding language to assist in the defeating the applicable equitable defenses, such as the made whole doctrine and the common fund doctrine, which may be asserted against it (whether the Plan is Self Funded, fully insured, or Non-ERISA).

Right of Recovery: If the Plan has the right to subrogate, we must look to the Plan's right to recovery. Is the Plan subject to the state's made whole doctrine? What about anti-subrogation statutes? Common Fund Doctrine? Although Non-ERISA Plans are routinely subject to each state's law, good plan language can assist in negotiating settlements with a Plaintiff's attorney. This is particularly true when you are subrogating in a state without the made whole or common fund doctrines, with Plaintiff's attorneys who nevertheless like to argue such doctrines apply. If your plan indicates it is not subject to the common fund doctrine, made whole, and any other relevant state laws, you have a better argument that the Plan is entitled to a full recovery. Thus, the Plans reimbursement provision is important to maximizing your subrogation recovery.

Reimbursement Provisions. Non-ERISA Plans (and fully insured ERISA Plans with no right to preemption) should include a reimbursement provision, providing that the beneficiary or covered person has an obligation to "pay the Plan back" if the Plan pays for an injury and the beneficiary or covered person later recovers for the same injury from the third party. Rather than giving the Plan a substantive legal right, it places an obligation on the covered person. If the covered person fails to pay back the benefits he received from the Plan after making a recovery from a third party, the Plan will have a right to sue the covered person for breach of this reimbursement clause.

TIPS FOR MAXIMIZING YOUR RECOVERY ON FULLY INSURED AND NON-ERISA PLANS

Make sure you have good plan language, and that your plan language grants the Plan a right of subrogation, right of reimbursement and a right of recovery, and that it does not limit your subrogation recovery (i.e. by making the plan's recovery contingent on the insured being made whole).

Know the relevant law in the state you are subrogating, so that if the made whole doctrine does not apply, and your plan language indicates that made whole does not apply, you can defend arguments by the Plaintiff's attorney and maximize your recovery.

Always assert your subrogation interest even if you do not have good plan language or even if your plan language does not provide you with a right of subrogation or reimbursement. You never know how sophisticated the plaintiff or defense attorney will be in each particular case. Also, you may discover that another state's law actually applies to your Plan.

Consider asserting your Plan's right to reimbursement if you are prevented from subrogating in an anti-subrogation state.