



Health Insurance and *ERISA* *Subrogation*

PART 4: ERISA PREEMPTION AND THE MADE WHOLE DOCTRINE

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PREEMPTION AND THE MADE WHOLE DOCTRINE

Preemption is the key to why ERISA subrogation is different and more powerful than regular health insurance subrogation - and much more effective. It is because of the preemption provisions of ERISA that you have such tremendous leverage when attempting to subrogate in a third party case that may have been pending for years. 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 and not withstanding the fact that the beneficiary may not have been fully compensated in his settlement or recovery in the third party case for all of his injuries.

Preemption, Saving and Deemer.

Under § 1003(a)¹ ERISA applies to any employee benefit Plan established or maintained by any employer (or employee organization) engaged in commerce or in any industry or activity effecting commerce. If the Plan is not an ERISA regulated Plan per § 1003(a), then state law will not be preempted. Given the expansive definition of "commerce" under federal constitutional law, almost all employee benefit Plans will fall under § 1003(a) and be subject to ERISA's broad preemption provisions. But exactly how does preemption work and what is preempted? The preemption section of ERISA is found in § 1144.² This section is unique in its magnitude and in the interplay between 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 makes ERISA useful but also unpredictable in subrogation cases.

Preemption Clause. The heart of the ERISA statute is a complicated preemption section designed to preempt *all* state law, even *consistent* state law, which "relates" to an employee benefit Plan as defined under § 1003(a). The preemptive sweep of § 1144 has been called "deliberately expansive" by the United States Supreme Court.³

Saving Clause. § 1144(b)(2)(A) is the clause which "saves" from preemption

those state laws which regulate *insurance, banking or securities*. The Supreme Court has adopted a two prong test to determine whether a state law "regulates" insurance.⁴

Deemer Clause. § 1144(b)(2)(B) attempts to prevent states from "opting out" of federal preemption of employee benefit law by "deeming" Plans to be the subject of the saving clause. This provision prevents states from labeling or "deeming" employee benefit Plans to be in the business of insurance, banking or securities or deeming a Plan to be an insurance company, a bank or an investment firm. Since states cannot deem a Plan to be an insurance company, state laws specifically targeting ERISA Plans will not be saved from preemption by the saving clause.

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As a result of the preemption, savings and deemer clauses, states cannot regulate employee benefit Plans, though they can regulate insurance companies. So if a Plan is self funded (the employer self insures the Plan), then the states cannot touch it by legislation or common law. If it is an unfunded Plan (the Plan merely purchases an 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 this insurance policy purchased by an unfunded Plan, but it may not regulate the Plan.⁵ As further explained by the United States Supreme Court in the case of *FMC Corporation v. Holliday*:⁶

State laws directed toward the (self funded) Plans are preempted because they relate to an employee benefit 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 employee benefit Plans because the Plan may not be deemed to be insurance companies, other insurers, or engaged in the business of insurance for purposes of such state laws. On the other hand, employee benefit Plans that are insured are subject to indirect state insurance regulation. An insurance company that insures a Plan remains an insurer for purposes of state laws "purporting to regulate insurance" after application of the deemer clause.

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

State subrogation law will generally be preempted from applying to a self funded Plan, but state subrogation law will generally apply to insurance provided by an unfunded Plan.

For these reasons, ERISA is despised by plaintiff's attorneys and is cherished by subrogating insurance carriers. It is one of our strongest subrogation tools. The main reason that subrogating Plans have a stronger position under ERISA than they have under state laws is because many state law "anti subrogation" doctrines and defenses are preempted.

Two Types of Preemption Complete versus Conflict. There are two types of preemption under ERISA - complete and conflict. Complete preemption is a narrow doctrine limited to claims that seek "to recover benefits due a beneficiary under the terms of the Plan, to enforce his rights under the terms of the Plan or to clarify his rights to future benefits under the terms of the Plan."⁷ Conflict preemption is broader and arises out of § 1144 of ERISA, which provides ERISA

“shall supercede any and all state laws in so far as they . . . relate to any employee benefit Plan.”⁸

Complete Preemption. ERISA provides a means for an ERISA Plan participant “to recover benefits due to him under the terms of the Plan - *to enforce his rights under the terms of the Plan* or to clarify his rights to future benefits under the terms of the Plan.”⁹ State law claims which attempt to accomplish these ends, regardless of how they are pleaded, are “completely preempted” by ERISA.¹⁰ As an example, ERISA completely preempts state law claims for breach of contract. By its very nature, a breach of contract claim purports to “enforce” rights under Plan documents and, as such, is subject to complete preemption under ERISA.¹¹ Claims for intentional and negligent misrepresentation are also preempted by ERISA. In asserting such claims, a member necessarily contends his rights under the Plan are altered by certain representations. Accordingly, these are claims to enforce his purported Plan rights and, therefore, they are completely preempted.¹² Other claims such as breach of fiduciary duty, accounting, unconscionability, wrongful conversion, unjust enrichment, fraud, negligence and insurance code violations are also preempted.

Conflict Preemption. Conflict preemption involves state law claims, which do not fall within the narrow confines of complete ERISA preemption but yet do satisfy the broader conflict preemption standard set forth in § 1144.¹³ The usual type of preemption that we deal with is conflict preemption. A state law claim is preempted under conflict preemption for “relating to” an ERISA Plan “if it has a connection or reference to such a Plan.” Conflict preemption applies to statutory claims as well as any causes of action brought under state common law.¹⁴

Therefore, the narrower notion of “complete preemption” exists under 29 U.S.C. § 1132, which governs civil enforcement of the terms of the Plan by civil action. Any efforts to enforce rights under the terms of an ERISA Plan under applicable state law are completely preempted. The broader notion of “conflict preemption” exists under 29 U.S.C. § 1144, which specifically states that ERISA supercedes any and all state laws “in so far as they may now or hereafter relate to any employee benefit Plan described in § 1003(a) of this title and not exempt under § 1003(b)

of this title.” As you will see below, a state law claim is preempted under § 1144 for “relating to” an ERISA Plan “if it has a connection with or reference to such a Plan.”¹⁵

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 so they should not be considered 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.”¹⁶

Erosion of Preemption. Federal preemption under § 1144 of ERISA has been attacked, criticized and eroded by federal and state courts throughout the country. Most of the cases that purport to arrive at “exceptions” to ERISA preemption do so in the context of the made whole or common fund doctrines. Pre existing confusion about ERISA preemption and the United States Supreme Court opinion in *Unum Life Insurance Company of America v. Ward*, 119 S. Ct. 1380 (1999), has contributed to much of the confusion and misinformation with regard to determining when ERISA preemption would apply. In *Unum*, the Supreme Court weakened ERISA preemption because it no longer required state laws to satisfy all three criteria under the McCarran Ferguson Act, in order for the law to be interpreted as “the business of insurance” under that Act. The *Unum* decision gives judges more discretion and leeway in ruling on preemption issues when subrogating ERISA claims. While both the made whole and common fund doctrines satisfy all elements of the *Pilot Life* two pronged test,¹⁷ it can be seen that they might satisfy some of the requirements and not others, thereby subjecting them to qualification under the saving clause. It should be noted, however, that the *Unum* case involved an insured welfare benefit Plan, which was governed by ERISA. Its application may be distinguished in cases involving self funded, employer sponsored health insurance Plans under ERISA. The entire concept of the erosion of ERISA recovery rights as a result of the recent Supreme Court decision of *Great-West Life & Annuity Insurance Co. v. Knudson*¹⁸ will be address in Part 10 of this series.



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THE MADE WHOLE DOCTRINE

Generally. The made whole doctrine of most states stands for the proposition that if the insured is not “made whole” from a third party recovery for all elements of the damages he or she has suffered, subrogation will not be allowed. Generally, where the ERISA Plan documents specify that the Plan gets “first money,” there will be no made whole doctrine applied.¹⁹ However, other circuits have held that under federal common law, in the absence of clear contractual Plan provisions to the contrary, a beneficiary has the right to be made whole before the Plan can enforce its right to subrogation.²⁰ If the Plan does not clearly specify an allocation scheme, the made whole doctrine may be applied.²¹

Made Whole Doctrine as Default Rule. The 6th, 9th and 11th Circuits have adopted the made whole doctrine into common federal law as a default rule. This means that unless there is ERISA Plan language to the contrary, the made whole doctrine will apply in ERISA subrogation cases. It appears that many of the federal circuit courts have adopted the made whole doctrine into federal common law as a default rule.²² The 1st, 5th and 8th Circuits have declined to do so.²³ The 10th Circuit has yet to decide whether it will do so, although one unpublished opinion has mildly addressed the issue.²⁴

Applied to ERISA Plans. Most courts have declined to apply the made whole doctrine to ERISA subrogation. These courts either view the rule as preempted because it is a state law rule or are unwilling to consider the Plan language ambiguous or silent. In *Sunbeam Oster Company v. Whitehurst*,²⁵ the district court applied the made whole doctrine because the Plan did not specify a ranking or a priority for allocation of the proceeds. On

appeal, 5th Circuit found the Plan language sufficiently comprehensive even though it did not contain specific provisions about partial recovery situations. The court held the Plan to lower standard for clarity of drafting than it would have applied to a standard individual insurance contract. The 6th Circuit has even declared that there is a default “made whole” rule of federal common law which applies unless the subrogation provision of the self funded ERISA medical Plan by its own terms opts out of that rule.²⁶ This means that unless the subrogation language of the ERISA Plan is adequate to avoid the default “made whole” rule of federal common law, the insured must be made whole before the insurer can enforce its rights to subrogation. The language of the Plan must establish its priority right over any partial recovery. At least in the 6th Circuit, a subrogation provision which stated that “Plan would be subrogated to extent of any health care payments under Plan to participant’s right of recovery in necessitating health care, regardless of entity or the individual for whom recovery was due,” was ambiguous as to whether the right of subrogation applied to a partial recovery by the participant and therefore the default made whole rule applied.

To further complicate matters, some Plans include language such as:

“If we are precluded from exercising our right of recovery, we may exercise our right of reimbursement.”

The idea behind this is that if the Plan cannot recover the payments made on behalf of the employee by subrogation, then the reimbursement provision should be applied because any contrary interpretation would make the reimbursement provision moot and surplusage.

Virtually every case in America that discusses the made whole doctrine parrots the mantra that because subrogation is an equitable doctrine, equitable principals, including the made whole doctrine, should apply.



Notwithstanding this intention, the 6th, 7th, 9th and 11th Circuits have applied the made whole doctrine to ERISA qualified Plans containing various forms of subrogation and reimbursement language.²⁷ The 11th Circuit case has also indicated that the “made whole doctrine” is the “default rule” in ERISA cases and applies to limit ERISA Plan subrogation rights where the Plan does not explicitly preclude operation of the doctrine.²⁸ Still, in the 5th, 7th, 8th and 9th Circuits, it has been held under various fact scenarios that with regard to ERISA qualified Plans, it is not necessary that the injured party receive full benefits or be made whole before subrogation will be allowed.²⁹ In most cases it is the precise language of the Plan which determines whether or not the made whole doctrine will be applied to an ERISA Plan’s subrogation rights.³⁰ Even in the D.C. Circuit, the court has followed other circuits’ lead in rejecting the made whole doctrine.³¹

Doctrine Affected by Reimbursement Provision. The 6th Circuit adopted the holding in *Barnes*, *supra*, ruling that an insured must be made whole before an insurer can enforce its right to subrogation under ERISA unless the Plan “sets up the extent of the subrogation right or states that the participant’s right to be made whole is superseded by the

Plan’s subrogation right...”³² The Plan subrogation language in *Marshall v. Employers Health Insurance Company* did not specifically allow the Plan the right of first reimbursement out of any recovery.³³ The 1st Circuit, however, has held in a recent case that full reimbursement is required for an ERISA qualified Plan where the Plan did not specifically state that the Plan must share in a participant’s attorneys’ fees.³⁴

Presumption Against Made Whole Doctrine. In the 5th and 8th Circuits, the made whole doctrine will generally not apply unless the Plan expressly states that it will apply.³⁵ Again, in these Circuits the language of the Plan remains very important and some Plans still contain language which indicates it will have subrogation rights and will be reimbursed only if the participant or beneficiary is made whole. Watch this Plan language carefully.

Made Whole Doctrine is Default. In the 9th Circuit, the made whole doctrine has been held to be applicable as a sort of default rule, unless the Plan establishes a priority of payment under its terms.³⁶ Again, the language of the Plan remains paramount.

Affected by Plan Administrator’s Interpretation. In every Circuit except the

6th and 11th Circuit, a Plan administrator’s interpretation that straightforward Plan language disclaims the made whole doctrine will be held reasonable and not arbitrary and capricious.³⁷

A subrogation agreement signed by a participant and its attorney may also entitle the Plan to reimbursement “in full” from the proceeds of any recovery the participant receives from a third party.³⁸ In *Cagle*, the court held that the Plan was entitled to reimbursement in full without regard to the costs of recovery and was entitled to full reimbursement even though the participant recovered less than the medical benefits paid.

Made Whole Doctrine Is Applicable Unless Specifically Negated by Plan Language. In the 6th and 11th Circuits, the made whole doctrine will be applicable unless a Plan provision specifically negates the application of the made whole rule and references it by name, in order to avoid the effect of that doctrine.³⁹ According to these decisions, Plan language that clearly establishes the priority of payment may not be sufficient to avoid the application of the made whole doctrine.

As you see, the made whole doctrine provides a fertile area for plaintiff’s attorneys to chip away at the ERISA code of armor. Virtually every case in America that discusses the made whole doctrine parrots the mantra that because subrogation is an equitable doctrine, equitable principals, including the made whole doctrine, should apply. Many courts either ignore or gloss over the fact that most subrogation rights are established by contract, by statute or contained within the terms of a Plan or policy. Such rights are no longer equitable, but are contractual in nature. Unfortunately, traditional subrogation rights have been eroded over the years. We can expect the same sort of trend to occur within ERISA subrogation, unless we zealously and aggressively take a stand to prevent it.

**NEXT: PART 5:
ERISA PREEMPTION
AND THE COMMON
FUND DOCTRINE**

Footnotes on page 98.

Footnotes

(Health Insurance and ERISA Subrogation)

1 29 U.S.C. § 1003(a) (1999).

2 29 U.S.C. § 1144 (1999).

3 *Pilot Life v. Dedeaux*, 481 U.S. 41 (1987).

4 *Pilot Life Insurance Co. v. Dedeaux*, **supra**. 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) and (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 holders’ 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.

5 *Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. 724, 105 S. Ct. 2380 (1995).

6 *FMC Corporation v. Holliday*, 498 U.S. 52, 111 S. Ct. 403 (1990).

7 29 U.S.C. § 1132(a)(1)(B); *Warner v. Ford Motor Company*, 46 F.3d 531, 534 (6th Cir. 1995).

8 29 U.S.C. § 1144(a).

9 29 U.S.C. § 1132(a)(1)(B).

10 *Warner*, **supra**; *Metropolitan Life Insurance Co. v. Taylor*, 481 U.S. 58, 67 (1987).

11 *Anderson v. Electronic Data Systems Corp.*, 11 F.3d 1311 (5th Cir.), *cert. denied*, 513 U.S. 808 (1994) (ERISA completely preempts state breach of contract cause of action).

12 *Anderson v. Humana, Inc.*, 24 F.3d 889, 891 (7th Cir.). (Misrepresentations regarding HMO Plan are completely preempted.)

13 U.S.C. § 1144.

14 *Lee v. E.I. DuPont de Nemours & Co.*, 894 F.2d 755 (5th Cir. 1990). (State law claims for fraud and negligent misrepresentation are preempted by ERISA.)

15 *Shaw v. Delta Airlines, Inc.*, 463 U.S. 85 (1983); *Lee v. E.I. DuPont de Nemours & Co.*, 894 F.2d 755, 757-758 (5th Cir. 1990).

16 *Shaw v. Delta Airlines, Inc.*, **supra**; *Lee v. E.I. DuPont de Nemours & Co.*, **supra**.

17 See Footnote 4, **supra**.

18 534 U.S. 204 (January 8, 2002).

19 *Cutting v. Jerome Foods, Inc.*, 993 F.2d 1293 (7th Cir.), *cert. denied*, 114 S. Ct. 308 (1993).

- 20 *Barnes v. Independent Auto Dealers Assoc. of California H&W Benefit Plan*, 64 F.3d 1389 (9th Cir. 1995); *Sanders v. Scheideler*, 25 F.3d 1053 (7th Cir. 1994), **appealed from** *Sanders v. Scheideler*, 816 F. Supp. 1338 (W.D. Wis. 1993); *Provident Life and Accident Ins. Co. v. Williams*, 858 F. Supp. 907 (W.D. Ark. 1994); and *Serenbus on Behalf of UIU v. Mathwig*, 817 F. Supp. 1414 (E.D. Wis. 1992).
- 21 *Cagle v. Brunner*, 112 F.3d 1510 (11th Cir. 1997).
- 22 *Copeland Oaks v. Haupt*, 209 F.3d 811 (6th Cir. 2000); *Hiney Printing Co. v. Brantner*, 243 F.3d 956 (6th Cir. 2001); *Cagle v. Brunner*, 112 F.3d 1510 (11th Cir. 1997); *Barnes v. Independent Auto Dealers Assoc. of California H&W Benefit Plan*, 64 F.3d 1389 (9th Cir. 1995).
- 23 *Harris v. Harvard Pilgrim Healthcare, Inc.*, 208 F.3d 274 (1st Cir. 2000) (Declined to adopt the made whole doctrine as federal common law, citing *Sunbeam-Oster's* proposition that to adopt the made whole rule would be a disservice to the spirit behind ERISA's requirement of straightforward language. The court noted that although Plan members would benefit financially, ultimately the cost would be born by our other Plan members in the form of higher premiums for coverage.); *Waller v. Hormel Foods Corp.*, 120 F.3d 138 (8th Cir. 1997) (Finding standard subrogation language in SPD provided Plan with priority subrogation rights and rejecting made whole rule because reasons for adoption under insurance law do not transport easily into employee benefit Plans); *Sunbeam-Oster Co. v. Whitehurst*, 102 F.3d 1368 (5th Cir. 1996).
- 24 *Alves v. Silverado Foods, Inc.*, 246 F.3d 679 (10th Cir. 2001).
- 25 *Sunbeam-Oster Company v. Whitehurst*, 102 F.3d 1368 (5th Cir. 1996).
- 26 *Copeland Oaks v. Haupt*, 209 F.3d 811, 24 Employee Benefits Cas. (BNA) 1357, 2000 FED App. 125 P. (6th Cir. 2000); *Hiney Printing Co. v. Brantner*, 243 F.3d 956 (6th Cir. 2001).
- 27 *Sanders v. Scheideler*, 816 F. Supp. 1338 (W.D. Wis. 1993), *aff'd* without op., 25 F.3d 1053 (7th Cir. 1993); *Waller v. Hormel Foods Corp.*, 120 F.3d 138 (8th Cir. 1997); *Barnes v. Independent Auto Dealers Association Health and Benefit Plan*, 64 F.3d 1389 (9th Cir. 1995); *Guy v. Southeastern Iron Workers Welfare Fund*, 877 F.2d 37 (11th Cir. 1989); and *Copeland Oaks v. Haupt*, 209 F.3d 811 (6th Cir. 2000); *Scholtens v. Schneider*, 671 N.E.2d 657 (Ill. 1996); *Waupaca Foundry, Inc. v. Gehlhausen*, 104 F. Supp. 1052 (S.D. Ind. 2000); *Cutting v. Jerome Foods, Inc.*, 993 F.2d 1293 (7th Cir. 1993) (stating that it is not unreasonable for a Plan to disclaim the made whole doctrine).
- 28 *Cagle v. Brunner*, 112 F.3d 1510 (11th Cir. 1997), *reh'g and suggestion for reh'g en banc denied*, 124 F.3d 223 (11th Cir. 1997) (Held that Plan provision must specifically negate the made whole doctrine); and *King v. Pan American Life Insurance Co.*, 998 F. Supp. 1455 (N.D. Ga. 1996).
- 29 *Sunbeam-Oster Company Group Benefits Plan v. Whitehurst*, 102 F.3d 1368 (5th Cir. 1996); (Plan language stated that Plan is entitled to obtain reimbursement for "duplicate benefit amounts" or "benefits duplicated from another source" and the Court held that meant Plan was entitled to full reimbursement); *National Employee Benefit Trust V. Sullivan*, 940 F. Supp. 956 (W.D. La. 1996); *Cutting v. Jerome Foods, Inc.*, 993 F.2d 1293 (7th Cir. 1993), *cert. denied*, 510 U.S. 916; *UIU Health and Welfare Fund v. Mathwig*, 817 F. Supp. 1414 (E.D. Wis. 1992) (Stating that the court could not adopt Wisconsin's common law made whole doctrine as federal common law because ERISA-qualified Plans are governed by ERISA); *FMC Corp. v. Holliday*, 498 U.S. 52 (1990); *Carpenter v. Modern Drop Forge Company*, 919 F. Supp. 1198 (N.D. Ind. 1995); *Provident Life & Accident Insurance Company v. Lanthicum*, 930 F.2d 14 (8th Cir. 1991); *Shell v. Amalgamated Cotton Garment*, 871 F. Supp. 1173 (D.C. Minn. 1994); *Waller v. Hormel Foods Corp.*, 120 F.3d 138 (8th Cir. 1997); *Barnes v. Independent Auto Dealers Association Health and Benefit Plan*, 64 F.3d 1389 (9th Cir. 1995); Plan established priority of payment, and stated that the made whole doctrine applied only where the parties are silent - it is a gap filler; *Trustees of Hotel Employees and Restaurant Employees International Union Welfare Fund v. Kirby*, 890 F. Supp. 939 (D.C. Nev. 1995); *Walker v. Rose*, 22 F. Supp.2d 343 (D.N.J. 1998); Plan language provided that Plan had a "first lien upon any recovery"; and *Great-West Life & Annuity Insurance Co. v. Barnhart*, 19 F. Supp.2d 584 (N.D.W.V. 1998); Plan language provided that the Plan had a "first lien" on any recovery.
- 30 *Engle v. Wal-Mart Association Health & Welfare Plan*, 48 F. Supp. 1114 (N.D. Ind. 1999); *Bishop v. Burgard*, 741 N.E.2d 306 (Ill. App. 3 Dist. 2000), *reversed*, 2002 WL 93124 (January 25, 2002). (While the Court of Appeals in this decision held that the Plan's language determined whether the common fund doctrine applied, the Supreme Court on January 25, 2002, reversed the appellate court's decision and held that because the attorney's claim for fees under the common fund doctrine was an independent action and totally unrelated to the Plan itself, it was not preempted by ERISA).
- 31 *Moore V. Blue Cross and Blue Shield*, 70 F. Supp.2d 9 (D.D.C. 1999).
- 32 927 F. Supp. 1068 (M.D. Tenn. 1996), *aff'd*, No. 96-6063, *aff'd*, 1997 WL 809997 (6th Cir. 1997) (unpublished opinion).
- 33 927 F. Supp. 1068 (M.D. Tenn. 1996).
- 34 *Harris v. Harvard Pilgrim*, 208 F.3d 274 (1st Cir. 2000) (Declined to adopt the made whole doctrine as federal common law, citing *Sunbeam-Oster's* proposition that to adopt the made whole rule would be a disservice to the spirit behind ERISA's requirement of straightforward language. The court noted that although Plan members would benefit financially, ultimately the cost would be born by our other Plan members in the form of higher premiums for coverage.)
- 35 *Sunbeam-Oster, Inc. v. Whitehurst*, 102 F.3d 1368 (5th Cir. 1996); and *Waller v. Hormel Foods, Inc.*, 120 F.3d 138 (8th Cir. 1997).
- 36 *Barnes V. Independent Automobile Dealers Association of California Health and Welfare Benefit Plan*, 64 F.3d 1389 (9th Cir. 1995).
- 37 *Firestone Tire & Rubber Company v. Bruch*, 489 U.S. 101 (1989) (The arbitrary and capricious standard of review applies where the "Plan gives discretionary authority to determine eligibility for benefits or to construe the terms of the Plan".); *Ellis v. Metropolitan Life Insurance Company*, 126 F.3d 228 (4th Cir. 1997); *Health and Welfare Plan for Employees of REM, Inc. v. Ridler*, 942 F. Supp. 431 (D. Minn. 1996), *aff'd*, 124 F.3d 207 (8th Cir. 1997); *Cutting v. Jerome Foods, Inc.*, 820 F. Supp. 1146, *aff'd*, 993 F.2d 1293 (7th Cir. 1993); *Trident Regional Health Systems v. Polin*, 948 F. Supp. 509 (D.S.C. 1996); and *Cagle v. Brunner*, 112 F.3d 1510 (11th Cir. 1997).
- 38 *Cagle v. Ford*, 59 F. Supp.2d 548 (E.D. N.C. 1999).
- 39 *Cagle v. Brunner*, 112 F.3d 1510 (11th Cir. 1997); and *Copeland Oaks v. Haupt*, 209 F.3d 811 (6th Cir. 2000).