SUBROGATION:
THE GOOD, THE BAD & THE UGLY

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Chairpersons: Rodney K. Nelson & Maria S. Diamond

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Brian J. Waid

ERISA SUBROGATION: A Practitioner's Primer

By Brian J. Waid[1]

The importance of identifying applicable law and issues relevant to health plan subrogation early in the representation is demonstrated by McIntosh v. Pacific Holding Co., 992 F.2d 882(8th Cir. 1993), cert. den'd, 510 U.S. 965, 114 S. Ct. 441, 126 L. Ed. 2d 375(1993); related proceeding, 928 F. Supp. 1464(D. Neb. 1996), reversed, 120 F.3d 911(8th Cir. 1997). Corollary to the need for early identification of important issues affecting our clients is the simple fact (as will become obvious to you as you review these materials) that this area of the law is complex and developing very rapidly. The risk to both you and your clients is substantial.

I. WHAT IS AN ERISA PLAN AND WHY SHOULD I CARE?

If the tort victim's health plan falls within the Employee Retirement Income Security Act of 1974 (ERISA), then the plan's subrogation/reimbursement rights are generally governed by federal, rather than state, law. Furthermore, under a variety of circumstances, subrogation and reimbursement disputes involving ERISA plans may give rise to **exclusive** federal jurisdiction creating important procedural issues for the personal injury practitioner. Finally, one who unwittingly files state tort claims against an ERISA plan may subject his/her client to an unexpected attorney's fee award against them.

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A. Basic Attributes Of An ERISA Plan

ERISA covers both "employee welfare benefit plans" and "employee pension benefit plans". 29 USCA 1002(1). An ERISA plan is "any plan, fund, or program. . .established or maintained by an employer. . .for the purpose of providing. . .medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment. 29 USCA 1002(1); Cvelbar v. CGI Illinois, Inc., 106 F.3d 1368, 1373(7th Cir. 1997).

An ERISA plan is established if, from the surrounding circumstances, a **reasonable person** can ascertain: (1) benefits, (2) a class of beneficiaries, (3) the source of financing, and (4) the procedures for receiving benefits. E.g., Laverty v. Savoy Industries, Inc., 954 F. Supp. 86(S.D.N.Y. 1997), quoting, Grimo v. Blue Cross/Blue Shield of Vermont, 34 F.3d 148, 151(2nd Cir. 1994).

In addition, the "touchstone" for determining the existence of an ERISA plan is whether a particular agreement creates an ongoing administrative scheme. Fort Halifax Packing Co. v. Coyne, 482 U.S. 1, 12, 107 S. Ct. 2211, 2217-2218, 96 L. Ed. 2d 1(1988); Thompson v. American Home Ass'n Co., 95 F.3d 429(6th Cir. 1996). The terms of the ongoing administrative scheme must be reasonably ascertainable. Cvelbar, supra at 1374. For example, in Delaye v. Agripac, Inc., 39 F.3d 235(9th Cir. 1994), cert. den'd, ___U.S.__, 115 S. Ct. 1402, 131 L. Ed. 2d 289(1995), the Court held that a contract calling for continuation of pay at one of two set formulas depending upon the reason for termination and for continuation of insurance and vacation benefits was not a plan because sending a single employee a check every month and continuing to pay his

insurance benefits for a time specified in the contract does not rise to the level of an ongoing administrative scheme.

The more elaborate analyses of whether an ERISA plan exists normally arise in the context of single employee or "top hat" plans, or employment contract cases. They also arise on appeal because of the Court of Appeals must confirm its jurisdiction.

However, because of the context in which subrogation claims generally arise (i.e. medical benefit plans), your client's health benefit package will generally include very clear indicators as to whether your client's plan comes within ERISA's broad parameters. For example, the presence in your client's employee benefit plan booklet of a "Summary Plan Description"[2] is a sure sign that you are almost certainly dealing with an ERISA plan. Or, the presence of a "Statement of Your Rights Under ERISA" is a sure sign that you are almost certainly dealing with an ERISA plan. Or, listing of the requisite disclosures under 29 USCA 1022(b)[3] is a sure sign that you are dealing with an ERISA plan. Absent these indicators, chances are that your client's health plan falls outside ERISA. But in order to make such a determination you must obtain and review the Plan and Summary Plan Description, and that must be done before litigation is commenced.

B. Exclusions From ERISA And Non-Qualifying Group Plans

There are two important exclusions from ERISA coverage, subject to the caveat that one of the excluded types of plan is allowed to elect ERISA coverage. In addition, group health

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[2]Section III(E), below.

[3]See Appendix A, attached.

insurance programs may, under certain circumstances, not be covered by ERISA.

Church Plan Exclusion

Plans established or maintained by a tax-exempt church or convention, or association of churches for its employees, is excluded from ERISA. 29 USCA 1003(b)(2). Substantially all of the covered individuals must be employees (and their beneficiaries) of a church, convention or association or churches. 29 USCA 1002(33)(B). However, a "church plan" may elect to be covered by ERISA. 29 USCA 1003(b)(2), as provided by 26 USCA 410(d). Accordingly, if you represent an employee covered by a "church plan", you still need to examine the SPD and Plan to determine whether an ERISA election has been made.

Governmental Plan Exclusion

Plans established or maintained by the United States, a state or local government, or any agency or instrumentality of the United States or a state or local government for its employees, are excluded from coverage under ERISA. 29 USCA 1003(b)(1), as defined by 29 USCA 1002(32). Unlike "church plans", governmental plans may not elect to be covered by ERISA.

Group Insurance Plans

Group insurance programs do not constitute ERISA plans if: (a) no contributions are made by the **employer;** (b) participation is completely voluntary; (c) involvement of the employer and/or employee organizations is minimal, and; (d) the employer received no consideration in connection with the plan except reasonable expenses. 29 CFR 2510.3-1(j). If the employer or employee

organization does anything beyond publicizing the plan, and collecting and remitting premiums, the plan will may qualify as an ERISA plan. 29 CFR 2510.3-1(j)(3).

ERISA plans may allow for an employee to obtain additional, optional benefits. However, such optional benefits may still be covered by ERISA because they may not be severed from the plan to fall within the group insurance exclusion. 29 CFR 2510.3-1(e),(j); Glass v. Omaha Life Insurance Co., 33 F.3d 1341, 1345(11th Cir. 1994).

C. Inapplicability Of State Subrogation Law To ERISA Plans (Or, Never Say Thiringer When You Ought to Say Barnes

ERISA supersedes (i.e. preempts) any and all State laws (including common law) insofar as they "relate to" any employee benefit plan. 29 USCA 1144(a). ERISA pre-emption has been described as perhaps the broadest such provision existing in federal law. For our purposes, FMC Corp. v. Holliday, 498 U.S. 52, 56, 111 S. Ct. 403, 406-407, 112 L.Ed.2d 356(1990) expressly holds that ERISA pre-empts state subrogation laws.

The Supreme Court has, quite recently, been scaling back its extraordinarily broad extension of pre-emption under ERISA, by rethinking its previous interpretation of "relate to". De Buono v. NYSA-ILA Medical & Clinical Services Fund, ___U.S.____, 117 S. Ct. 1747, 1752-1753, 138 L.Ed. 2d 21(1997); New York State Conference of Blue Cross/Blue Shield Plans v. Travelers Insurance Co., 514 U.S. 645, 115 S. Ct. 1671, 131 L. Ed. 2d 695(1995). For this reason, Blackburn v. Sundstrand Corp. (discussed in Section IV(F), below), may portend a trend limiting complete pre-emption of all subrogation-related state laws. However, whether the Court would

ultimately reverse FMC Corp. v. Holliday, at this early time, would seem unlikely.[4]

Because of the current uncertainty as to the scope of ERISA pre-emption, counsel should not automatically presume that ERISA will pre-empt all state law issues relating to subrogation. Conversely, FMC Corp. v. Holliday remains controlling precedent.

D. Procedural Ramifications Of An ERISA Subrogation/ Reimbursement Clause[5]

The second important ramification of ERISA application to subrogation and reimbursement claims is that such claims may be filed originally in, or removable to, the federal courts. This portion of the program, therefore, addresses the procedural issues and opportunities that arise when a subrogation dispute involving an ERISA plan results in litigation. The procedural issues created by ERISA always arise whenever the Plan intervenes in pending litigation, when claims against health plans are joined in the underlying tort litigation by plan beneficiaries, and when health plans commence litigation to protect their interests (which allows for choice of forum) against plan beneficiaries, tortfeasors, and even other insurers (for determination of primary responsibility).[6]

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[4]In Speciale v. Seybold, 951 F. Supp. 740, 743(N.D. Ill. 1996), the Court expressly rejected the Plan beneficiary's argument that ERISA pre-emption of state subrogation laws was changed by New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co., supra. FMC v. Holliday use of the same analysis as Travelers.

[5]This section of the materials was initially presented by the author at the King County Bar Association Subrogation seminar on November 7, 1997, copyright King County Bar Association, and is reprinted here (in updated form) with the consent of the KCBA. The author expresses his gratitude to the KCBA for authorizing this use.

[6]See, Allstate Insurance Co. v. The 65 Security Plan, 879 F.2d 90(3rd Cir. 1989) in which a no fault auto insurer sued an ERISA plan for a declaration as to which had primary responsibility for the insured's medical bills, and for subrogation. The Court held that Allstate's claims were not completely pre-

Because of the 30-day removal and 30-day remand limitations provided in 28 USCA 1446 and 1447, prompt decisions as to federal jurisdiction and removability (both whether to remove and whether to move to remand) must be made. After expiration of the 30-day removal period, the removing party may not amend the Notice of Removal to assert a new federal jurisdictional basis. E.g., Wyant v. National R.R. Passenger Corp., 881 F. Supp. 919, 924(S.D.N.Y. 1995). In Wyant, the Notice of Removal filed by the removing party (i.e. Amtrak) asserted diversity jurisdiction. Thereafter, a party was added who destroyed diversity. There was no question but that federal question jurisdiction would have existed had it been asserted in the Notice of Removal; however, because Amtrak had failed to allege federal question jurisdiction in its Notice of Removal and the 30-day removal period had expired, the case was remanded to the state court for lack of federal jurisdiction. The lesson to be learned is that, if your goal is to litigate your claim in the federal court system, you should allege **all** bases for invoking federal jurisdiction in either the original Complaint or the Notice of Removal. And, if you are trying to defeat either removal or federal jurisdiction, you should be alert to your opponent's potential omission of necessary jurisdictional allegations whether in the Complaint or in the Notice of Removal.

Grimo, supra illustrates one of the risks. In this case, the health plan had obtained a summary judgment in the trial court which was vacated and remanded because the Plan did not prove that

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empted, and remanded the case to the State Court for lack of federal jurisdiction. Based upon FMC v. Owens and De Buono, the decision may be correct but is subject to question under FMC v. Holliday. Refer to Section II(E), below.

it was "an employee welfare benefit plan" within ERISA. Without such proof, the Court of Appeals was unable to conclude that the federal trial court had subject matter jurisdiction.

Federal jurisdiction over, and removability of, subrogation and reimbursement claims is especially important because of the **exclusive jurisdiction** provisions of 29 USCA 1132. If the issues involved in litigation of a subrogation/reimbursement claim fall within the exclusive jurisdiction of the Federal Courts, **any judgment rendered by a State Court lacking jurisdiction will be subject to reversal (and dismissal) on appeal.**[7]

Conversely, as demonstrated by Grimo, any judgment rendered by a Federal Court lacking subject matter jurisdiction will also be subject to reversal on appeal and the party forced to refile in the State Court. Cf., Cvelbar v. CBI Illinois, Inc., supra; Laverty v. Savoy Industries, Inc., supra.

Subrogation/reimbursement disputes arising out of ERISA plans will presumably (under FMC v. Holliday), fall within exclusive ERISA jurisdiction. However, in light of the retrenchment in the reach of ERISA jurisdiction under De Buono, as demonstrated by Blackburn v. Sundstrand, 115 F.3d 493(7th Cir. 1997), even if a subrogation/reimbursement claim falls outside exclusive federal jurisdiction, it may still fall within the Federal Courts' diversity jurisdiction (if diversity is alleged, as discussed

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[7]Prior to June 19, 1986, a case falling within exclusive federal jurisdiction that was mistakenly filed in State Court would be dismissed after removal based upon the theory of "derivative jurisdiction" (i.e. the Federal Court could not obtain greater authority over the removed action than had the Court from which it was removed). As a result, the case would be dismissed and the plaintiff would then be required to re-file a second case in the Federal Court. However, this result was overruled by Congress, by virtue of 28 USCA 1441(e). Morda v. Klein, 865 F.2d 782, 783(6th Cir. 1989).

above).

A. Federal Question Jurisdiction

Application of state laws relating to subrogation and reimbursement may be pre-empted by virtue of 29 USCA 1144(a). However, pre-emption standing alone does not create federal question jurisdiction unless the cause of action falls within the exclusive jurisdiction of 29 USCA 1132. Warner v. Ford Motor Co., 46 F.3d 531(6th Cir. 1995); accord, Greater Lansing Ambulatory Surgery Center Co. L.L.C. v. Blue Cross & Blue Shield of Michigan, 952 F. Supp. 516, 519(E.D. Mich. 1997). This, of course, means that absent exclusive federal jurisdiction, substantive issues of federal law may be litigated and decided in state court proceedings. So a state law may be pre-empted, under 29 USCA 1144(a), because it "relates to" an ERISA plan, but determination of the issues under ERISA may still not give rise to federal question jurisdiction. Only a claim falling within the jurisdiction provided by 29 USCA 1132 gives rise to federal question jurisdiction under 28 USCA 1331. Metropolitan Life Insurance Co. v. Taylor, 481 U.S. 58, 107 S. Ct. 1542, 95 L. Ed. 2d 55(1987).

The pertinent exclusive jurisdiction provisions included in ERISA are as follows:

29 USCA 1132

(a) A civil action may be brought----

(1) by a participant or beneficiary. . .

(B) to recover benefits due to him under the terms of his 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;

(2) by the Secretary, or by a participant, beneficiary or fiduciary for appropriate relief under section 409 [29 USCA 1109];[8]

(3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain **other appropriate equitable relief** (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan. . .

(e)(1) Except for actions under subsection (a)(1)(B) of this section, the district courts of the United States shall have **exclusive jurisdiction** of civil actions under this subchapter brought by the Secretary or by a participant, beneficiary, fiduciary, or any person referred to in section 1021(f)(1) of this title. **State courts of competent jurisdiction shall have concurrent jurisdiction of actions under subsection (a)(1)(B).** [Emphasis added].

The asymmetrical language of the jurisdictional grant has resulted in equally awkward jurisdictional outcomes.

For example, in FMC Medical Plan v. Owens, 122 F.3d 1258(9th Cir. 1997), the Court considered whether the Federal Court had subject matter jurisdiction over a claim for reimbursement filed originally in the Federal Court by an ERISA plan. The Court only considered whether the Plan's reimbursement claim fell within the exclusive grant of federal jurisdiction provided by 29 USCA 1132(a)(3).[9]

In FMC v. Owens, the ERISA plan beneficiary (i.e. Owens) had been involved in an auto accident. The ERISA Plan paid medical

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[8]29 USCA 1109 creates ERISA liability, in favor of the Plan, for a Plan fiduciary's breach of fiduciary duty.

[9]Counsel representing the Plan informed the author that the Plan had, in fact, asserted jurisdiction under 29 USCA 1132(a)(1)(B) but that the Court chose not to discuss this issue.

expenses and both short and long-term disability benefits, totalling $50,066.76.[10] Owens settled his tort claim arising out of the accident, for $100,000. The ERISA Plan filed its Complaint to recover "equitable reimbursement", asserting that its claim was for "equitable relief" within the exclusive jurisdiction of 29 USCA 1132(a)(3).

The District Court concluded that the Plan's claim was one of "subrogation" holding that subrogation is "other appropriate equitable relief" within the jurisdictional statute. The Ninth Circuit, however, held that the Plan provided for reimbursement rather than subrogation; there is a difference between subrogation and reimbursement, and; reimbursement is not "other appropriate equitable relief" within the meaning of 29 USCA 1132(a)(3). Accordingly, the Federal Court lacked subject matter jurisdiction and the case was remanded with directions that the Trial Court dismiss it, the Court noting that the Plan could refile its claim in State Court.

One should not read FMC v. Owens as supporting the conclusion that subrogation claims, as distinguished from reimbursement claims, necessarily fall within the exclusive jurisdiction of the federal courts. Relying upon Watkins v. Westinghouse Hanford Co., 12 F.3d 1517(9th Cir. 1993) and Mertens v. Hewitt Associates, 508 U.S. 248, 113 S. Ct. 2063(1993), the Ninth Circuit indicated in FMC v. Owens that whether a claim involves "other appropriate equitable

[10]In 1996 the jurisdictional amount for diversity jurisdiction was increased to $75,000. FMC does not discuss possible diversity jurisdiction, assuming that the Complaint was filed prior to the effective date of the increase in the jurisdictional amount, diversity jurisdiction may have been available to the Plan.

relief" will turn upon "the substance of the **remedy** sought." [Emphasis added]. Therefore, if the relief sought is a money judgment, rather than traditional equitable relief such as injunction, mandamus or restitution, then the exclusive jurisdiction of 29 USCA 1132(a)(3) will not apply. The Court elaborated that by restitution, it meant "return of 'ill-gotten' assets or profits taken from a plan" such as "by fraud or wrongdoing."

Even as the status of federal question jurisdiction in respect to subrogation (as distinct from reimbursement claims) may be less than certain in the Ninth Circuit, other jurisdictions have reached different conclusions on the jurisdictional issue.

Grusznski v. Viking Insurance Co., 854 F. Supp. 586(E.D. Wis. 1994), involved a tort case, removed from State to Federal Court by the ERISA Plan, in which the injured ERISA plan beneficiary joined a declaratory judgment action, seeking determination of the ERISA Plan's subrogation rights under the Plan, with the underlying tort suit. The Plan counterclaimed for subrogation against any recovery by the Plan beneficiary against the tortfeasor. The Court held that by seeking declaratory relief, the Plan beneficiary did not assert either an equitable claim or a claim for enforcement of the provisions of the Plan. Accordingly, there existed no exclusive federal jurisdiction within 29 USCA 1132(a)(3).

In a very narrow holding, the Grusznski Court also held that the Plan beneficiary was not seeking clarification as to "future benefits" that would have brought the claim within the exclusive jurisdictional grant of 29 USCA 1132(a)(1)(B). However, had the

Plan beneficiary in Grusznski sought affirmative relief against the Plan, for example for damages due to termination of benefits by the Plan, then exclusive federal jurisdiction would have followed. Id at 589, citing, Shannon v. Shannon, 955 F.2d 542, 546(7th Cir.), cert. den'd, ___U.S.___, 113 S. Ct. 677, 121 L.Ed. 2d 599(1992). Had Ms. Gruszinski sought to force the Plan to honor future benefits, or sought a determination as to how the Plan's subrogation clause would apply if she made a recovery in the tort suit and still had future Plan-covered benefits available to her, the result probably would have been different.

In contrast to FMC v. Owens and Grusznski, Musinski v. Staudacher, 928 F. Supp. 739(N.D. Ill. 1996) held that the ERISA Plan beneficiary's Motion to Adjudicate [an ERISA Plan's] Lien, filed in the settled state court tort action, was properly removed by the Plan because within exclusive federal jurisdiction under 29 USCA 1132(a)(1)(B). In Musinski, the Plan beneficiary had received all benefits available under the Plan. Nevertheless, the Musinski Court, relying upon Rice v. Panchal, 65 F.3d 637(7th Cir. 1995), concluded that a Plan participant's action comes within exclusive ERISA jurisdiction if the participant's state law claim "rests upon the terms of the plan" or "requires construing the ERISA plan." Musinski at 743. The Court also rationalized:

> Though it may involve some stretching of that statutory language, Musinski's effort to retain the Plan benefits that were previously paid to him and to do so in the face of a Plan provision that expressly obligates him to return those benefits. . .might well be characterized as seeking to "recover benefits due to him under the terms of his plan.

Id at 743 n.5; accord, Cortez v. Michael Reese Health Plan, Inc.,

980 F. Supp. 277, 278-279(N.D. Ill. 1997); Fravel v. Stankus, 936 F. Supp. 474, 478(N.D. Ill. 1996).

The analysis in Musinski simply cannot be reconciled with the Ninth Circuit analysis in FMC v. Owens, except through recognition that the Ninth Circuit only considered the possible application of 29 USCA 1132(a)(3), and did not consider any other possible basis for federal jurisdiction including 29 USCA 1132(a)(1)(B). However, Musinski and Grusznski are in irreconcilable conflict because both considered applicability of 29 USCA 1132(a)(1)(B). Considering the limited analysis in FMC v. Owens, ultimate resolution of the federal jurisdictional issues in the courts of the Ninth Circuit is far from clear.

Crump v. Wal-Mart Group Health Plan, 925 F. Supp. 1214(W.D. Ky. 1996) demonstrates just how complicated this issue can become. In Crump, the ERISA Plan beneficiary (i.e. Crump) was in an auto accident and was sued in State Court as a defendant by another victim injured in the same accident. Crump asserted a cross-claim seeking damages. The ERISA Plan intervened asserting subrogation rights against the alleged tortfeasor (i.e. Young). Crump (the Plan beneficiary) then cross-claimed against the Plan asserting, inter alia, a violation of ERISA by the Plan and requesting injunctive relief. Shortly before trial, the State Court severed[11]

[11]In Fravel v. Stankus, supra at 478-479, the Court held that the ERISA Plan did not need the consent of all parties to the removal, as is normally required by 28 USCA 1441(a), because the subrogation claim was separate and independent under 28 USCA 1441(c). Accordingly, removal of subrogation and reimbursement claims can be accomplished without the consent of the defendant tortfeasor in the underlying tort litigation.

The Court in Fravel also remanded the underlying tort claim under 28 USCA 1441(c). Accord, Crump at 1220. Take particular note of the result--the injured victim is now litigating in two separate forums.

Crump's cross-claim against the Plan and realigned the parties. The case proceeded to trial and a verdict of approximately $4M, including $250,000 on the subrogation claim resulted. **Then** the Plan removed the case to the Federal Court.[12]

Relying upon Grusznski, the Crump Court held that the Plan's subrogation claim is a non-preempted state subrogation claim and that no federal subject matter jurisdiction arose because of the Plan's intervention. The Court also noted that Crump's cross-claim was, essentially, an attempt to enforce provisions of the Plan and for that reason within the exclusive jurisdiction of the federal courts, stating:

> Had this Court not found jurisdiction to hear Crump's claim and ultimately remanded this case per her request, an unfortunate result would surely have happened. . .The state court would have had no option but to dismiss her request for injunctive relief, since it would not have possessed the requisite subject matter jurisdiction.

The Crump Court also held that removal based upon diversity jurisdiction (in light of the severance of the cross-claim and realignment of parties) over the subrogation claim was proper, and that the one-year removal time limit provided by 28 USCA 1446(b) did not commence running until the State Court severed the cross-claim.

Consistent with Warner, the Courts in Musinski and Fravel

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[12]The removal petition was filed more than 30 days after the Court granted Crump leave to file her cross-claim against the Plan. The Court held that the removal was timely because filed within 30 days of the Trial Court's severance of the cross-claim and realignment of parties. The Western District of Washington, however, adheres to a 30-day "bright line" rule that may cause a different result. In Re Estate of Sellers, 657 F. Supp. 168, 170(W.D. Wash. 1987). Defeating removal on the basis of untimeliness, however, may be a pyrrhic victory if the removed claim is within exclusive federal jurisdiction, as discussed above.

expressly held that, absent jurisdiction within 29 USCA 1132, federal pre-emption under 29 USCA 1144 does not provide federal question jurisdiction. But Musinski and Fravel also held that determination of a Plan participant's rights and obligations under the subrogation/reimbursement clause comes within ERISA's grant of federal jurisdiction and therefore provides federal question jurisdiction. In contrast with Musinski and Fravel, and consistent with FMC v. Owens, Grusznski and Crump hold that an ERISA Plan's subrogation/reimbursement claim does not come within ERISA"s exclusive federal jurisdiction and, as a result, there exists no federal question jurisdiction over such claims. In the midst of this confusion, Blackburn v. Sundstrand Corp., 115 F.3d 493, 495(7th Cir. 1997) held that Illinois' "common fund" law allowing the tort victim's attorney to recover fees on subrogated amounts does not "relate to" ERISA; therefore, there existed no federal question jurisdiction to support removal. While these anomalies may at times be explained by virtue of the limitations in 29 USCA 1132(a)(1), the results are inconsistent, and create opportunities in certain situations for an alert plaintiff's counsel to choose between a state or federal forum. In that regard, 28 USCA 1441(c) allows, **but does not require**, the federal courts to remand (or abstain from deciding) an underlying tort claim joined with a subrogation/reimbursement claim within federal question jurisdiction.

B. Diversity Jurisdiction

There is no such similar problem in respect to diversity jurisdiction because jurisdiction in the seminal United States

Supreme Court case of FMC v. Holliday, supra, was based upon diversity. Accord, Pilot Life Insurance Co. v. Dedeaux, supra; Ryan v. Capria-Ryan v. Federal Express Corp., 78 F.3d 123(3rd Cir. 1996).

Particular note should be paid to Crump which held that, for purposes of determining complete diversity, only the citizenships of the Plan and the adverse party (normally the plan beneficiary/ participant) are considered. Thus, diversity jurisdiction may exist even though diversity is not complete in respect to the underlying tort claim.[13]

C. The Well-Pleaded Complaint Rule

Absent the allegation and existence of diversity jurisdiction, however, federal question jurisdiction is generally determined from the face of the pleadings under the "well-pleaded complaint" doctrine. In this manner, the plaintiff may normally avoid federal question jurisdiction through artful pleading. However, in respect to a claim which is "completely pre-empted" by federal law, removal will be proper even if the federal question is not apparent within the four corners of the well-pleaded complaint. Fravel v. Stankus, supra at 478 n.2 involved just such a result, with the Court holding that state law applicable to ERISA subrogation and reimbursement was completely pre-empted by federal and removal proper under the Court's federal question jurisdiction. Accord, Speciale v. Seybold, supra at 742. Nevertheless, Fravel premised its conclusion upon Musinski and the rationale that the subrogation

[13]In McIntosh, supra at 928 F. Supp. 1464, the Court found diversity jurisdiction in a controversy as to whether the tort victim's attorneys could recover fees.

claim fell within exclusive ERISA jurisdiction, rather than pre-emption under 29 USCA 1144. That conclusion must be viewed with caution in light of FMC v. Owens.

In order to fully evaluate the propriety of federal jurisdiction in respect to subrogation and reimbursement claims, one must first determine whether the health plan involved is an ERISA plan. Because of the time limitations applicable to removal and remand, as well as the consequences of erroneously litigating a claim in either a state or federal court that ultimately has no jurisdiction, development of facts relevant to whether the subrogation or reimbursement claim comes within ERISA must be done early in the representation and preferably prior to commencement of litigation, in order for the party to make the most advantageous choice of forum.

II. THE FEDERAL LAW OF SUBROGATION/REIMBURSEMENT UNDER ERISA

A. The Contract Controls

As a matter of Washington state law, subrogation is "an equitable doctrine." Thiringer v. American Motors Insurance Co., 91 Wn.2d 215, 588 P.2d 191(1978). In contrast, ERISA subrogation does not arise in equity.

ERISA does not intend to regulate the **content** of employee benefit plans; that is left to the contracting parties.[14] Land v. Chicago Truck Drivers, Union Health and Welfare Fund, 25 F.3d 509, 514(7th Cir. 1994). This important conclusion is explained in

[14]Indeed, ERISA does not require that an ERISA plan contain any subrogation or reimbursement clause. E.g., Land. In the absence of such a clause, there will be no right to subrogation or reimbursement.

Waller v. Hormel Foods Corp., 120 F.3d 138, at 140(8th Cir. 1997), as follows:

> A subrogation provision affects the level of benefits conferred by the plan, and **ERISA leaves that issue to the private parties creating the plan.** Thus, **this issue turns solely upon the proper interpretation of the Plan's subrogation provision. . .(citations omitted)**
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> **The Wallers argue that we should construe the word "subrogated" in the Plan to include the make-whole principle that has been engrafted onto the subrogation clauses in insurance policies under state law. But there is good reason not to read ERISA plans like insurance policies.** "The very heart of the bargain when the insured purchases insurance is that if there is a loss he or she will be made whole. The cases that originally applied subrogation to insurance contracts never envisioned the use of subrogation as a device to fully reimburse the insurer at the expense of leaving the insured less than fully compensated for his loss." **Employer-funded medical benefit plans should not be viewed in this fashion.** [Emphasis added; citations omitted].[15]

Accordingly, proper interpretation of the Plan's contractual provisions pertaining to subrogation and reimbursement will be determinative of the parties' rights under the Plan.

Yet, ERISA plans are at least limited by the imaginations of the their drafters. With that in mind, disputes often arise as to the proper interpretation of ERISA plans, including operation of their subrogation and reimbursement provisions. When an ERISA plan is silent on an issue, the federal courts are called upon to develop a body of federal common law uniformly applicable to ERISA disputes. Firestone Tire & Rubber, infra at 489 U.S. 110, 109 S. Ct. 954; Pilot Life Insurance Co. v. Dedeaux, 481 U.S. 41, 56, 107

[15]Waller is particularly interesting because the Court held that the Plan's subrogation clause was sufficiently specific to defeat application of the "make whole" rule as to the victim's recovery. However, because the Plan was silent on the issue of attorney's fees, the Court adopted the "make whole" rule on the issue of whether the victim's attorneys would recover fees on the subrogated amounts.

S. Ct. 1549, 1557-1558, 95 L. Ed.2d 39(1987).

B. The "Make Whole" Rule And Its Applicability To ERISA Subrogation

The inapplicability of Thiringer to ERISA subrogation does not mean that the "make whole" rule is completely irrelevant to your analysis. Indeed, the "make whole" rule has been applied as part of the federal common law of ERISA.

For the uninitiated, the "make whole" rule provides that the subrogee (i.e. insurer/ERISA plan) receives "last dollars", and only recovers the subrogated amounts if (and only if) and only to the extent that the subrogor (tort victim) is first fully compensated.

If the Plan expressly rejects the "make whole" rule, then the Plan's primacy controls and the "make whole" rule does not apply. The question thus becomes whether each Plan has, in fact, sufficiently rejected the "make whole" rule and, if not, whether the "make whole" rule will apply as a default (or "gap filler") rule.

Numerous courts, including the Ninth Circuit, have applied the "make whole" rule in various contexts. Barnes v. Independent Auto. Dealers, 64 F.3d 1389(9th Cir. 1995); Cagle v. Bruner, 112 F.3d 1510(11th Cir. 1997); Hartenbower v. Electrical Specialties Co. Health Benefit Plan, 977 F. Supp. 875(N.D. Ill. 1997); National Employee Benefit Trust of the Associated Gen. Contractors of America v. Sullivan, 940 F. Supp. 956(W.D. La. 1996); Marshall Employers Health Insurance Co., 927 F. Supp. 1068(M.D. Tenn. 1996); Trustees of Hotel Employees Int'l Union Welfare Fund v. Kirby, 890 F. Supp. 939(D. Nev. 1995).

However, in keeping with the primacy of the contract, a subrogation/reimbursement clause that expressly rejects the "make whole" rule will be enforced. Ryan by Capria-Ryan v. Federal Express Corp., 78 F.3d 123(3rd Cir. 1996); Waller v. Hormel Foods Corp., 120 F.3d 138, 141(8th Cir. 1997). In Sunbeam-Oster Co. v. Whitehurst, 102 F.3d 1368(5th Cir. 1995), the Court went further and suggested that the "make whole" rule may be inappropriate for adoption as the ERISA default rule. Id at 1378.

In Barnes[16], the Ninth Circuit held that the "make whole" rule applies, as a federal common law, in the absence of its rejection by the Plan, stating:

> We adopt, as federal common law this generally accepted rule [i.e. make whole] that, **in the absence of a clear contract provision to the contrary**, an insured must be made whole before an insurer can enforce its right to subrogation. . .
>
> We would not apply the interpretative "make-whole-rule" as a "gap-filler" if the subrogation clause in the Plan document specifically allowed the Plan the right of first reimbursement out of any recovery Barnes was able to obtain even if Barnes were not made whole. . .
>
> The Plan argues that because the subrogation clause states that if the Plan makes payment it is subrogated "to all rights of recovery," the make-whole rule does not apply. . .[W]hen the insurance company makes no payment to the injured insured to cover expenses, and places all the cost and risk of seeking recovery from a third party on the injured insured, the make-whole rule remains in place **despite the "all rights" language in the contract.** [Id at 1395, 1396; Emphasis added].

In Cagle, the Court went even further, applying "make whole" as the default rule **even though the Plan administrator had the**

[16]One must recognize that the Barnes Plan did not give the plan administrator discretion to interpret the Plan. Accordingly, the Court reviewed the Plan de novo. In contrast, Cagle and Cutting involved review for abuse of discretion, with the Courts reaching opposite results.

discretion to interpret the Plan. Cagle, supra at 1522. In doing so, Cagle held that the make whole rule will apply unless the Plan **explicitly** rejects "make whole" or specifically allows the Plan "first reimbursement." This result will follow even if the Plan includes "all rights" or "any rights of recovery" language.

More recently, Cagle was applied in Hartenbower, in which the Court held that "make whole" will apply unless the Plan states that it has "the right of first reimbursement" or the "right to reimbursement even if the plan participant is not made whole." Hartenbower, supra at 977 F. Supp. 883.

Therefore, in the Ninth Circuit, whether an ERISA subrogation/ reimbursement clause allows application of the make whole rule will probably[17] depend upon whether it includes "clear" language either rejecting the rule or specifically providing that the Plan receives "first reimbursement. Absent such explicit language, the make whole rule should apply even in ERISA cases.

C. Real Live Subrogation Clauses, Or; Read The Plan!

MAKE WHOLE RULE APPLIED DESPITE THESE CLAUSES

Barnes v. Ind. Auto. Dealers Ass'n of Calif. Health And Welfare Plan, 64 F.3d 1389(9th Cir. 1994)

> SUBROGATION--This plan may withhold payment of benefits when a party other than the employee or dependent may be liable for expenses until liability is legally determined. However, if this plan makes payment which the employee, dependent or any other party is or may be entitled to recover against any person or organization responsible for an accident or illness, this Plan is subrogated to **all rights of recovery** to the extent of its payment. The

[17]A Ninth Circuit court could, conceivably, reach a different result than Barnes based upon a Plan that granted the plan administrator discretion to interpret the Plan, or in a case in which the Plan had already made payments. Application of Cagle, however, would be the more likely result.

employee, dependent, or other person or organization receiving payment from this Plan shall execute and deliver instruments and papers and do whatever else is necessary to secure such rights to the Plan, and shall do nothing either before or after payment by the Plan to prejudice such rights. [Emphasis added].

Cagle v. Bruner, 112 F.3d 1510(11th Cir. 1997)

If you or one of your dependents, for example, should receive benefits from the Fund for injuries caused by someone else (such as an automobile accident,) the Benefit Fund through subrogation has the right to seek repayment from the other party or his insurance company, or in the event you or your dependent recovers the amount of medical expense paid by the Fund by suit, settlement or otherwise from any third person or his insurer, the Fund has the right to be reimbursed therefore through subrogation.

The Benefits Fund will provide benefits to you and your dependents at the time of need, but you may be asked to execute documents or take such other action as is necessary to assure the rights of the Fund.

Hartenbower v. Electric Specialties Co. Health Benefit Plan, 977 F. Supp. 875(N.D. Ill. 1997)

In the event any benefits or services of any kind are furnished. . .for a physical condition or Injury caused by a third party or for which a third party may be liable, the Plan shall be subrogated and shall succeed to individual rights or recovery against any such third party to the full extent of the value of any such benefits or services furnished or payments made or credit extended. The Covered Person or Covered Dependent shall, at the Plan's request, take such action, furnish such information and assistance, and execute such documents as the Plan may require to facilitate enforcement of its rights hereunder. In the event of the covered Person's or Covered Dependent's failure to comply with any such request, the Plan shall be entitled to withhold benefits. . .

MAKE WHOLE RULE HELD INAPPLICABLE UNDER THESE CLAUSES

Cutting , 993 F.2d 1293, 1295(7th Cir. 1993)

[beneficiary] agrees that the Plan shall be subrogated to all claims, demands, actions and rights or recovery of the individual against any third party or any insurer, including Workers' Compensation, to the

extent of any and all payments made or to be made hereunder by the Plan.

Waller v. Hormel Foods Corp., 120 F.3d 138(8th Cir. 1997)

> [The Plan] shall be subrogated to all rights of recovery which you or your dependent. . .may have against any person or organization.[18]

Ryan by Capria-Ryan v. Federal Express Corp., 78 F.3d 123 (3rd Cir. 1996)

> if benefits are paid on account of an illness resulting from the intentional actions or from the negligence of a third party, the Plan shall have the right to recover, against any source which makes payments or to be reimbursed by the Covered Participant who receives such benefits, **100% of the amount of covered benefits paid.** (Subrogation in connection with the Insured Options shall be governed by the provisions of those Options.) If the 100% reimbursement provided above exceeds the amount recovered by the Covered Participant, **less legal and attorney's fees incurred by the Covered Participant** in obtaining such recovery (the Covered Participant's "net Recovery"), **the Covered Participant shall reimburse the Plan the entire amount of such Net Recovery.**

Sunbeam-Oster Co. Group Benefit Plan v. Whitehurst, 102 F.3d 1368(5th Cir. 1996)

> [s]ubrogation allows the Plan to recover duplicate benefit amounts. . .[i]f the plan has already paid benefits, it has the right to recover payment from you.

OTHER REPRESENTATIVE CLAUSES

HERE Health Trust (emphasis added)

> If a third party causes your or your dependent's accidental injury, illness or physical disability, the Board of Trustees is **subrogated to any rights to recovery for any expense or damages (whether or not for health care expenses)** that you or your dependent has against any third party (including an insurance company). You or your dependent must **reimburse** the Board of Trustees **from any**

[18]Although the Court held that the Plan language was sufficient to provide the Plan "first priority" on any recovery, the Court went on to hold that the Plan's silence on the attorney's fee issue allowed the Court to allocate a reasonable attorney's fee to the victim's attorney.

recovery from third parties (including any settlement) for the amounts paid under the Plan for your or your dependent's expenses.

Western Council of Industrial Workers-Timber Operators Council Health and Welfare Fund (Through Regence Life and Health Ins. Co.)

Here are some rules which apply in these third party liability situations:

*If a claim for health care expense is filed with us and you have not yet received recovery from the responsible person, we may advance benefits for covered expenses if the enrollee agrees in writing to hold any recovery in trust for us up to the amount of benefits we pay. We may require that the enrollee sign an agreement guaranteeing our right to reimbursement before we advance any benefits.

*If we have already paid benefits, we will be entitled to reimbursement of the benefits we have paid from proceeds of any recovery the enrollee receives from or on behalf of the third party.

*We are entitled to full reimbursement of the benefits we have paid from the proceeds of any recovery the enrollee received from or on behalf of the third party. This is so regardless of whether:

--the recovery is the result of a court judgment, arbitration award, compromise settlement or any other arrangement;

--the third party or the third party's insurer admits liability; or

--the health care expenses are itemized or expressly excluded in the third party recovery.

*We will allow a deduction of a proportionate share of the reasonable expenses of obtaining a recovery such as attorney fees and court costs from the amount reimbursed to us.

Stewart/Walker Co. Health Plan

When injury or injuries (for which any benefits are now payable under this Plan) are caused under circumstances which create a legal liability for some other person or party, and whenever the Plan pays any benefit under the Plan to or on behalf of you or your Dependent, the Plan shall be subrogated to you or your Dependent's

right of recovery to the extent of the payments under the Plan.

Subrogation means that the Plan can regain by legal action, if necessary, the benefits paid by it to you or your Dependent or on that person's behalf from any person against whom you or your Dependent has a claim or against that person's insurance company or plan. . . The Plan is also subrogated and has a right of subrogation to any underinsured, insured, uninsured, or any other insurance plan under which you or your Dependent is covered.

Stewart/Walker Co. Employee Benefit Plan (second plan)

Amount subject to subrogation or refund. The Covered Person agrees to recognize the Plan's right to subrogation and reimbursement. These rights provide the Plan with a priority over any funds paid by a third party to a Covered Person relative to the Injury or Sickness, including priority over any claim for non-medical or dental charges, attorney fees, or other costs and expenses. Notwithstanding its priority to funds, the Plan's subrogation and refund rights. . .are limited to the extent to which the Plan has made, or will make, payments for medical or dental charges as well as any costs and fees associated with the enforcement of its rights under the Plan.

D. Discounts!!!!!

ERISA plans routinely receive substantial discounts in the cost of services and supplies based upon their separate contracts with health providers. Under no circumstances will an ERISA plan have a right to recover amounts that it does not pay (because subrogation only operates when the plan actually pays). A Plan's subrogation demand for the face amount of the Plan participant's medical bills when the Plan has actually paid a lesser amount has been held to be a breach of fiduciary duty. Ries v. Humana Health Plan, Inc., 1995 WL 669583(N.D. Ill. 1995), on class certification, 1997 WL 158337(N.D. Ill. 1997).

So before you enter into any negotiation with a Plan, you must

determine exactly how much the Plan has actually paid (or will pay). Negotiations then proceed from the discounted amount to determination of whether the "Make Whole" rule applies, and whether other deductions (e.g. attorney's fees, litigation expenses) apply.

E. Co-ordination Of Benefits Between ERISA Plan And Other Insurance.

Most ERISA plans will provide that their coverage will be secondary (or "subordinated") to other available insurance. In the event of a conflict (i.e. if the ERISA plan and the other insurance both provide that they are subordinate) the ERISA plan will be secondary and the other insurance primary. Auto Owners Insurance Co. v. Thorn Apple Valley, Inc., 31 F.3d 371(6th Cir. 1994); Allstate Ins. Co. v. American Medical Security, Inc., 975 F. Supp. 1005(E.D. Mich. 1997). However, if the ERISA plan is not, by its terms, subordinate, it will be primary. Dayton Hudson Department Store Co. v. Auto-Owners Insurance Co., 953 F. Supp. 177(W.D. Mich. 1995).

F. The Difference Between Subrogation And Reimbursement

At least in the Ninth Circuit, the distinction between subrogation and reimbursement may be important because of the differing jurisdictional result implied by FMC v. Owens.[19]

In subrogation, the subrogee (i.e. the Plan) "steps into the shoes" of the subrogor (i.e. the plan participant or beneficiary), and is legally authorized to assert the rights of the subrogor even independently from the subrogor. Thus, a Plan with rights of subrogation may file its own lawsuit against the tortfeasor,

[19]See Section I(B), above.

regardless of whether the injured victim chooses to do so.

Reimbursement, in contrast, **only** allows the Plan to recover **from the plan participant or beneficiary**, and the Plan itself has no independent cause of action against the tortfeasor.

In practice, ERISA plans mix and match the terms subrogation and reimbursement, often including both terms in a single clause of the Plan, without any apparent distinction between the two terms intended. While such practice is perhaps explained by the ERISA requirement that plans be understandable[20], or the intent of plan drafters to cover as many bases as possible, it results in an imprecision that creates difficulties for plan participants and beneficiaries. In addition, for those representing tortfeasors and their insurers, the existence of an independent subrogation claim that can foreseeably be asserted against their client in the future, requires that they obtain a release from the subrogated Plan as part of any settlement.[21]

III. ADMINISTRATIVE ISSUES

A. Implicit Denial/Limitations of Actions Within the Plan

ERISA Plan administrative review procedures have been applied to subrogation disputes between the Plan and the participant/ beneficiary. E.g., Cagle v. Bruner, 112 F.3d 1510(11th Cir. 1997). The administrative procedures will be described in the Summary Plan Description.

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[20]See Section III(E), below.

[21]While an indemnification clause in settlement documents may be of marginal help, if a subrogated ERISA Plan makes demand upon the tortfeasor after payment of settlement funds to the Plan beneficiary, the likelihood that the tortfeasor will be able to recover from the tort victim/plan beneficiary on a third party complaint is not high. In the meantime, the tortfeasor (or their insurer) is paying additional attorney's fees on a case they thought had been settled.

The Plan administrator is required to notify the affected individual of its decision on a particular claim within a reasonable period not to exceed ninety (90) days. 29 CFR 2560.503-1(e)(1), (3). Many plans impose a shorter period. The initial period can be extended for ninety days. 29 CFR 2560.503(1)(e)(3). If the claim is denied, the notice of denial must be understandable and include: (a) specific reasons for denial; (b) specific reference to the plan provisions on which denial is based; (c) a description of any additional documentation or information needed and an explanation as to why it is needed; (d) an explanation of steps the person can take to appeal. 29 CFR 2560.503(1(f). Even if a plan provides a notice of denial, if these requirements are not met, the appeal period provided in the Plan does not begin to run. White v. Jacobs Engineering Group Long Term Disability Benefit Plan, 887 F.2d 913, 918-920(9th Cir. 1989).

If no denial notice is given within the applicable time limitations, the claim should be considered denied and the claimant may then proceed to the administrative appeal stage. 29 CFR 2560.503-1(e)(2). In fact, some ERISA plans include an explicit statement that the lack of a decision shall be "deemed" to be a denial.

The concept of "implicit denial" can be extremely troubling, when coupled with the potential for a contractually-specified period for administrative appeal and the potential for a contractually-shortened statute of limitations. [See Section IV(G), below]. However, in Price v. Provident Life and Accident Insurance Co., 2 F.3d 986(9th Cir. 1993), the Court held that the

Plan may not both refuse to decide the claim and then assert a statute of limitations defense. Accordingly, plan participants/ victims should not generally be placed in a position of unwittingly missing the statute of limitation (or limitations on administrative review) while awaiting an administrative decision.

In any event counsel should review the administrative review procedures (which will appear in the SPD) to ensure that all deadlines are met.

B. Exhaustion Of Remedies

The Plan must provide an administrative review procedure that will typically apply to any plan participant or beneficiary who is "otherwise adversely affected" by any action of the plan administrator. 29 USCA 1133(2).[22] Such broad language will normally encompass subrogation disputes with the Plan. These remedies are supposed to be simple and quick. Amato v. Bernard, 618 F.2d 559, 568(9th Cir. 1980).

ERISA does not, on its face, require exhaustion of administrative remedies. However, the courts have generally held that failure to pursue the administrative remedies provided by ERISA precludes judicial review. E.g., Amato, supra at 567-568; Fallick v. Nationwide Mutual Insurance Co., 957 F. Supp. 1442, 1444(S.D. Ohio 1997); Tiger v. AT & T Technologies Plan for Employees' Pensions, Disability Benefits, 633 F. Supp. 532, 534(E.D.N.Y. 1986).

In the Ninth Circuit, exhaustion of administrative remedies is

[22]The specific requirements for the review process are set forth at 29 CFR 2560.503-1.

not required if: (a) the Plan provided inadequate notice of claim denial; (b) administrative review is futile; (c) the plan participant or beneficiary has been denied meaningful access to the administrative procedures. White v. Jacobs Engineering Group Long Term Disability Benefit Plan, supra at 920 n.2. The mere fact that the Plan trustees themselves administer the appeal does not render the process inadequate. Amato, supra at 569.

[**PRACTICE POINTER:** If you intend to sue an ERISA plan, you may need to include an allegation demonstrating that the plan's administrative procedures have either been exhausted or explaining why exhaustion of the plan's administrative procedures is unnecessary].

C. Standard Of Judicial Review

The standard of judicial review applicable to ERISA disputes can have important implications for resolution of subrogation issues. For example, in Cutting, supra, the Court based its rejection of the make whole rule in large part due to the deference it afforded the plan administrator's interpretation of the subrogation clause.

Decisions of ERISA plan administrators are reviewed for an abuse of discretion **if** the plan specifically gives the administrator the authority to construe the terms of the plan. Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 115, 109 S. Ct. 948, 956-957, 103 L.Ed. 2d 80(1989); Atwood v. Newmont Gold Co., Inc., 45 F.3d 1317(9th Cir. 1995). Such language will ordinarily be boilerplate within the Plan.[23] However, you should still check

[23]In Cagle v. Bruner, 112 F.3d 1510, 1517(11th Cir. 1997), the Court held

for it, because absent the grant of discretion to construe the plan's terms, the administrator/fiduciary's interpretation will be reviewed by the courts de novo. Firestone Tire & Rubber, supra.

Often, however, there will exist conflicts of interest within the administrative process, e.g. if the plan insurer is also the plan administrator. In the Ninth Circuit, if the plan administrator has a conflict of interest, the Court applies "heightened scrutiny" to the administrative decision. Atwood, supra at 1322-1323. Under this standard, **if** the plan beneficiary provides evidence (beyond the mere fact of the apparent conflict) to show that the fiduciary's self-interest caused a breach of the administrator's fiduciary obligations to the beneficiary, then the administrator's decision is **presumptively void** and will be reviewed de novo unless the Plan demonstrates that the decision was not made to serve the administrator's conflicting interest. Id; cf., Armstrong v. Aetna Life Insurance Co., 128 F.3d 1263, 1265(8th Cir. 1997). [**Practice Pointer:** Discovery of Plan practices, and internal documents concerning those practices, become relevant for purposes of discovery. See Section IV(I), below].

D. The "Trust Agreement (Or, Does My Client Have to Sign This #@%&* Thing?)"

Generally, no right of subrogation arises until a payment has been made. For example, in Barnes, because the Plan provided that **"if this plan makes payment"** the Court held that the Plan's right to subrogation only arose after payment has been made. Barnes, supra at 1393. Accordingly, in Hartenbower v. Electric Specialties

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that inclusion of such discretionary authority within the Plan, but not the SPD, was sufficient.

Co. Health Benefit Plan, 977 F. Supp. 875, 886(N.D. Ill. 1997), in which the Plan included the same language as involved in Barnes, the Court held that the Plan's refusal to pay **any** benefits until the beneficiary executed a subrogation agreement was an **abuse of discretion** and possibly **arbitrary** (if the Plan does not always insist upon execution of subrogation agreements).

However, if the Plan contains explicit language that allows the Plan to withhold payment of benefits unless and until the Plan beneficiary signs a subrogation agreement, then the Plan may refuse to pay benefits unless the agreement is executed. Preze v. Board of Trustees, Pipefitters Welfare Fund Local 597, 5 F.3d 272(7th Cir. 1993). Similarly, in Cagle v. Bruner, 112 F.3d 1510, 1519, 1520(11th Cir. 1997) the Court ruled that the Plan (which had made an initial payment of benefits) was not arbitrary and capricious[24] in withholding **additional** payments until the Plan beneficiary executed the subrogation agreement. Accord, Hartenbower, supra.

The typical Plan will provide for execution of a subrogation agreement on a form "satisfactory to" the administrator or trustees. But it is not uncommon for plans to submit subrogation agreements that differ materially from the controlling language of the SPD or the Plan. It is therefore critical that you read the proposed subrogation agreement carefully and actually compare it (word-for-word) with the SPD and the Plan. Indeed, in Preze, the Plan beneficiary refused to execute the proffered subrogation

[24]The Plan beneficiaries had asserted that the Plan was arbitrary and capricious because it did not always require a signed subrogation agreement. The Plan responded that it only required execution of the agreements if the amount was large and the tort victim (or their lawyer) indicated that they may challenge the plan's subrogation rights. Cagle at 1519-1520.

agreement because the form submitted was "inconsistent" with the subrogation article of the Plan. Preze, at 5 F.3d 274 n.4, 5. Nevertheless, the Court refused to decide the parties' dispute over the language of the subrogation agreement, stating that "[b]ecause no subrogation agreement has been executed here, the contents of such an agreement are irrelevant. Id at n. 5.[25] Similarly, in Cagle, the beneficiary appended a note to the subrogation agreement stating that it does not "in any way expand the subrogation rights" of the Fund. Cagle, supra at 1513. The Plan refused to accept the modified form, and its decision was upheld as not constituting an abuse of discretion. Id at 1518-1519.

Conversely, in Wright v. Aetna Life Insurance Co., 110 F.3d 762, 764-765(11th Cir. 1997), the SPD granted the Plan reimbursement from "any recovery", while the reimbursement agreement provided for the Plan's recovery only to the extent attributable to recovered medical expenses paid by the Plan. The Court enforced the terms of the reimbursement agreement, which would be much to the beneficiary's benefit, as merely interpretive of the ambiguous provision of the SPD. Id at 763-765.

If you have an SPD or Plan that contains subrogation language favorable to your client, you do not want your client to sign a separate subrogation agreement that purports to grant the Plan greater rights than it would otherwise have. (But you may want to

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[25] Cf., Leingang v. Pierce County Medical Bureau, Inc., Wn.2d P.2d (1997)(Applying Washington law to a case in which the insurer paid medical benefits even though the victim failed to execute the proposed subrogation agreement. The Court held that the insurer's conduct did not violate the WCPA. The subrogation agreement demanded by the insurer in Leingang appeared to substantially expand the insurer's subrogation rights beyond the contract. Query: did the victim assert the **wrong** CPA violation?

execute a subrogation agreement that grants your client greater rights than provided for under the terms of the plan). At the same time, you do not want payment of your client's medical bills by the Plan delayed, and you certainly do not want to do anything arguably prejudicial to the rights of the Plan. If you find yourself in this situation, at a minimum you will want to provide the Plan with all pertinent information concerning the third-party tort claim so that it cannot claim prejudice. Furthermore, at a minimum you will want to affirm your client's willingness to execute a subrogation agreement that conforms precisely to the terms of the SPD and Plan, and then (even though it failed in Cagle) go about the business of submitting a proposed subrogation agreement to the Plan that carefully preserves whatever rights your client may have under the terms of the Plan. If the dispute nevertheless results in litigation, you will at least have the benefit of having demonstrated good faith in the face of Plan intransigence.

D. Amendment of the Plan/Estoppel

An ERISA Plan may be amended, but amendments must be in writing. The Plan must include a procedure for amending the Plan, as required by 29 USCA 1102(b)(3), and a summary of any material modifications must be provided to plan participants, as required by 29 USCA 1022(a). However, mere existence of a procedure does not entail protection of the employee from unexpected amendment of the Plan, because the plan sponsors are free under ERISA to adopt, modify or terminate the plan at any time. Curtiss-Wright Corp. v. Schoonejongen, ____U.S._____, 115 S. Ct. 1223, 1228, 131 L.Ed. 2d 94(1995); Ryan, supra at 126. This can become a particularly

vexing problem if the subrogation clause is amended during the course of the tort victim's treatment.

Because the Plan can only be modified in conformity with the procedures described above, oral and informal amendments to the Plan are completely unenforceable. E.g., Cerasoli v. Xomed, Inc., 952 F. Supp. 152, 151(W.D.N.Y. 1997). Therefore, **estoppel normally does not apply.** HealthSouth Rehabilitation Hospital v. American National Red Cross, 101 F.3d 1005, 1009(4th Cir. 1996), cert. den'd, 117 S. Ct. 2432, 138 L. Ed. 2d 194(1997)(hospital could not recover $82,000 in medical bills incurred after Plan administrator repeatedly, but incorrectly, assured hospital that patient was covered under the Plan).

Estoppel will, however, be available as a matter of Federal common law if: (a) the Plan is ambiguous, and; (b) the Plan participant relied to his detriment on representations made in regard to the ambiguous provision of the Plan. Spink v. Lockheed Corp., 125 F.3d 1257, 1261-1262(9th Cir. 1997); DeVoll v. Burdick Painting, Inc., 35 F.3d 408, 412(9th Cir. 1994); Greany v. Western Farm Bureau Life Ins. Co., 973 F.2d 812, 921-822(9th Cir. 1992).[26] A plan participant/beneficiary may not, however, enlarge his rights against the Plan based upon statements that conflict with unambiguous language of the plan. DeVoll, supra at 822; cf further, Glass, supra at 1347-8(waiver).

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[26]The Ninth Circuit recognition of estoppel in connection with ERISA is the minority view. Most circuits completely reject application of estoppel in ERISA cases. In Spink, the Ninth Circuit stated a 5-part test: (a) material misrepresentation; (b) reasonable and detrimental reliance; (c) extraordinary circumstances; (d) the provisions of the plan were ambiguous; (e) an oral interpretation of the plan.

So, for our purposes, **if** the subrogation clause in the Plan is ambiguous, the Plan's representative agrees that the "make whole" rule applies, and you then settle the tort claim based upon that understanding, estoppel may be available to you if the Plan thereafter attempts to change its position. But if the Plan is not ambiguous, estoppel will not be protect you from erroneous representations by Plan representatives. This can become especially troublesome in negotiation.

E. The Importance Of The "Master" Contract And The SPD

There are two (2) Plan documents that you will need to obtain: (1) the Plan, and; (2) the Summary Plan Description ("SPD"). They are frequently incorporated into a single employee benefit booklet. The SPD must be filed with the U.S. Department of Labor and distributed to Plan participants. 29 USCA 1021(a). **PRACTICE POINTER: When a new client schedules an appointment, routinely ask them to bring their health plan with them to the initial appointment.** (Please refer to Section IV(A) relative to how you obtain a copy of the Plan and SPD, if your client does not have them).

The SPD is particularly important for two reasons. First, if there exists a conflict or inconsistency between the SPD and the Plan, the SPD will normally control. E.g., Arnold v. Arrow Transportation Co. of Delaware, 926 F.2d 782, 785 n.3(9th Cir. 1990); Williams v. Mid-West Operating Engineers Welfare Fund, 1997 WL 601077(7th Cir. 1997); Hansen v. Continental Insurance Co., 940 F.2d 971, 981-982(5th Cir. 1991). However, in order to be controlling, the SPD must satisfy the twelve (12) specific

requirements of 29 USCA 1022(b) and the more general requirement of 29 USCA 1022(a).[27]

For your purposes, perhaps the most important requirement is that the SPD "shall be" understandable, accurate and comprehensive enough to enable the ordinary employee to sense when there is a danger that benefits could be lost or diminished. 29 USCA 1022(a)(1). See, Atwood v. Newmont Gold Co., 45 F.3d 1317, 1321(9th Cir. 1995).[28]

If the SPD does not satisfy all of the requirements imposed by law, then the Plan (rather than the SPD) will control the outcome of the controversy. Hicks v. Flemming Companies, Inc., 961 F.2d 537, 542-543(5th Cir. 1992); Conner v. Mid South Insurance Agency, 943 F. Supp. 647, 662(W.D. La. 1995); Fogarty v. Grasso Production Management, Inc., 1997 WL 187393(1997)(E.D. La. 1997).

IV. REMEDIES

A. Penalty For Failing To Provide A Copy Of The Plan

The plan participant is entitled to receive a copy of the Summary Plan Description and Plan. 29 CFR 2520.104b-1(Rev. 7/1/97). A plan administrator who fails to provide the requested information to you within thirty (30) days of your request may be liable for a penalty of up to $100 per day and such "other relief" as the Court "deems proper." 29 USCA 1132(c)(1)(B). The penalty attaches 31 days after the request. Bartling v. Freuhauf Corp., 29

[27]29 USCA 1022 is attached as Appendix "A".

[28]Format and presentation requirements applicable to the SPD are specified in 29 CFR 2920.102-2(a) and (b).

F.3d 1062, 1069(6th Cir. 1994).[29]

B. Are Monetary (Compensatory/Punitive) Damages Ever Recoverable?

Not in the context of non-payment of medical expenses in in connection with subrogation disputes. Claims for breach of fiduciary duty under 29 USCA 1109(a) and 1132(a)(2) lie only in favor of the Plan, and are generally not available to plan participants and beneficiaries. Massachusetts Life Insurance Co. v. Russell, 473 U.S. 134, 105 S. Ct. 3085, 87 L. Ed. 2d 96(1985).[30] Similarly, extra-contractual damages are unavailable under 29 USCA 1132(a)(3). Mertens v. Hewitt Associates, 508 U.S. 248, 255, 113 S. Ct. 2063, 2068, 2069-2070, 124 L.Ed. 2d 161(1993). State law causes of action (e.g. tort, bad faith, consumer protection, etc.) are pre-empted by 29 USCA 1144. E.g., Greany v. Western Farm Bureau Life Ins. Co., 973 F.2d 812, 818-819(9th Cir. 1992); Gaylor v. John Hancock Mutual Life Insurance Co., 112 F.3d 460(10th Cir. 1997). Therefore, plans will not be liable for monetary damages (beyond the amount of benefits due) for failing to pay your clients' medical bills and expenses. Cf., e.g., Turner v. Fallon Community Health Plan, Inc., 127 F.3d 196, 198-199(1st Cir. 1997); Andrews-Clarke v. Travelers Insurance Co., 21 Empl. Ben. Cases 2137(D. Mass. 10/30/97).

C. Equitable And Declaratory Relief

Plan participants and beneficiaries are authorized by ERISA to

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[29]Explicit and exclusive federal jurisdiction is provided by 29 USCA 1132(a)(1)(A).

[30]But see, Varity Corp. v. Howe, ___U.S.____, 116 S. Ct. 1065, ___L. Ed. 2d ___(1996), in which the Court approved equitable relief in the form of a mandatory injunction.

institute litigation for purposes of: (1) recovering benefits due them, 29 USCA 1132(a)(1)(B); (2) clarifying their rights to future benefits under the Plan, 29 USCA 1132(a)(1)(B); (3) obtaining "appropriate relief" for breach of fiduciary duty, 29 USCA 1132(a)(2); (4) enjoining any act or practice which violates ERISA or the plan; (5) obtaining appropriate equitable relief to redress violations, and; (6) enforcing ERISA or the terms of the plan.

Monetary damages are not considered other "appropriate" or equitable relief. Sokol v. Bernstein, 803 F.2d 532, 538(9th Cir. 1986). Instead, the remedies of Plan participants and beneficiaries will be limited to declaratory or injunctive relief. Id.

D. Attorney's Fees For Seeking Affirmative Relief

The Courts are authorized by 29 USCA 1132(g)(1) to award attorney's fees and costs to either party in an action by a plan participant, beneficiary or fiduciary. Needless to say, clients should be apprised of the potential risk of an adverse fee award prior to filing an ERISA claim for affirmative relief on their behalf.

Exercise of the Court's discretion, as to whether to award fees, depends upon: (1) the degree of the opposing parties' culpability or bad faith; (2) the ability of the opposing parties to satisfy an award of attorney's fees; (3) whether awarding fees would serve a deterrent purpose; (4) whether the requesting party sought to benefit all participants and beneficiaries or an ERISA plan or to resolve a significant legal question concerning ERISA itself; (5) the relative merits of the parties' position. E.g., Estate of Shockley v. Alyeska Pipeline Service Co., 130 F.3d 403,

407-408, 21 Empl. Ben. Cases 2121(9th Cir. 1997)(awarding attorney's fees **to the Plan** and **against** the estate of the deceased **employee**!); Todd v. AIG Life Insurance Co., 47 F.3d 1448, 1458(5th Cir. 1995).

A "lodestar" approach, with appropriate recognition of risk, is used in determining the amount of fees. Todd, supra; Florin v. Nations Bank of Georgia, N.A., 34 F.3d 560(7th Cir. 1994); McLendon v. Continental Group, Inc., 872 F. Supp. 142(D.N.J. 1994); but see, Estate of Shockley, supra, in which the Court affirmed award of 10% of the fees actually incurred. Pre-litigation fees are not recoverable. Cann v. Carpenters' Pension Trust, 989 F.2d 313, 316(9th Cir. 1993).

E. Attorney's Fees For Recovery Of Subrogated Amounts

Many ERISA plan subrogation and reimbursement provisions specifically acknowledge and allow for the reduction of the plan's claim by a pro rata share of attorney's fees and expenses incurred in recovering the subrogated amount. A representative example of such a provision, excerpted from the Western Council of Industrial Workers-Timber Operators Council Health and Welfare Fund, is as follows:

> We will allow a deduction of a proportionate share of the reasonable expenses of obtaining a recovery such as attorneys fees and court costs from the amount to be reimbursed to us.

Even if the Plan does not expressly provide for such an allocation of fees, as a practical matter, the Plan's interest is usually best served by cooperating with the victim's recovery without having to expend Plan time and money (i.e. to pay its own

attorney's fees and litigation expenses) to obtain that recovery. This is especially in cases which have either difficult liability issues or are extraordinarily expensive to litigate. Even if the Plan might otherwise consider pursuing its subrogation claim without the victim's assistance, many claims would be doomed absent the active participation of the victim. Conversely, especially in cases involving multiple defendants in which partial settlements are possible, tort victims are best served by having the Plan share in the litigation risks and participate in the settlement evaluation without the victim risking later exposure to the Plan. For these reasons, strong practical considerations favor an allocation of attorney's fee by the Plan to the victim's counsel, and early resolution of that issue should always be explored. In light of the strong economic disincentives for ERISA plans to litigate subrogation claims, as well as the procedural opportunities for victims discussed in Section I(D), particularly stringent positions advanced by ERISA plans should not go unchallenged by litigation.

As in McIntosh, circumstances may arise in which the Plan and the victim cannot agree upon an allocation of fees to the victim's attorney. The Circuits appear split on how to resolve the issue. Waller v. Hormel Foods Corp., 120 F.3d 138, 141(8th Cir. 1997) decided that federal common law must be determined, and applied the "make whole" default rule when the Plan did not explicitly address the issue of attorney's fees (even though the Court found that the Plan rejected the "make whole" rule). Similarly, in Ryan v. Federal Express, 78 F.3d 123(3rd Cir. 1996) held that federal law

under ERISA controlled, and strictly enforced plan subrogation language that expressly prohibited an allocation of attorney's fees from the recovery of any third party recovery of subrogated amounts.

However, Blackburn v. Sundstrand Corp., 115 F.3d 493(7th Cir. 1997), citing with approval, Scholtens v. Schneider, 671 N.E.2d 657, 660(Ill. 1996) held that the Illinois common fund rule allowing recovery of attorney's fees does not "relate to" ERISA. Accord, Hartenbower v. Electric Specialties Co. Health Benefit Plan, 977 F. Supp. 875, 885(N.D. Ill. 1997).[31] A fortiori there could be no pre-emption. See further, New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co., supra (limiting pre-emption to those issues "related to" ERISA). Thus, if the state rule controls, whether attorney's fees will be recoverable by the victim's counsel may depend upon State rather than Federal law.

Even in those cases in which the jurisprudence has looked to ERISA to answer the question of whether the victim's counsel may recover fees in respect to subrogated amounts, **if** the Plan is silent on the issue of the participant/beneficiary's attorney's fees, then the "make whole" default rule will apply and attorney's fees will be recoverable. Waller v. Hormel Foods Corp., 120 F.3d 138, 140-141(8th Cir. 1997); Wal-Mart Stores, Inc. Associates' Welfare Plan v. Bond, 21 Empl. Ben. Cases 1010(E.D. Pa. Case no. 96-7522, 5/7/97).

[31] See further, Schmid v. Kaiser Foundation Health Plan, 963 F. Supp. 942, 944(D. Or. 1997)("Where a state action affects a benefit plan in a tenuous, remote, or peripheral manner, the law does not "relate to" the plan").

However, the **amount** of fees will be determined based upon the **value** of the attorney's services **to the Plan.** Waller, at 141-142. Nevertheless, if the victim can deduce evidence that the Plan retains subrogation counsel on a contingent fee basis, an argument that victim's counsel should likewise recover a contingent fee. Waller, supra at 142. [**PRACTICE POINTER:** The Plan's fee arrangements with its subrogation counsel become relevant for purposes of discovery]. If, as happened in McIntosh, the liability insurer is willing to tender its policy limits early in the litigation (or before litigation commences), the **value** of services provided by the victim's counsel to the Plan may be minimal. McIntosh, supra at 120 F.3d 911.

The moral to the story is that counsel should be exquisitely sensitive to whether the potential recovery warrants the time and energy of both the client and counsel (e.g. if the subrogated amounts substantially exceed the amount of insurance available), if their labors will only benefit the health plan. In such situations, serious consideration should be given to whether the vicissitudes of litigation are warranted if the Plan subrogation provisions are particularly onerous and the Plan expresses an unwillingness to provide an incentive to the victim and counsel to pursue the claim.

F. Double Damages For Medicare Recipients

ERISA plans are primarily liable for benefits, as compared to Medicare. 42 USCA 1395y(b)(2). An ERISA plan's failure to assume primary liability for covered expenses may provide Medicare and Medicare-eligible plan participants with an action for double

damages. 42 USCA 1395y(b)(3)(A).

G. Statute Of Limitations

ERISA does not provide a statute of limitations in respect to subrogation issues and claims.[32] The courts therefore look to the analogous state statute of limitations periods, which (in this context) will presumably be the six-year statute of limitations for actions on contracts. E.g., Flanagan v. Inland Empire Electrical Workers Pension Plan & Trust, 3 F.3d 1246, 1252(9th Cir. 1993); accord, Williams v. Unum Life Ins. Co. of America, 113 F.3d 1108, 1111(9th Cir. 1997). The statute will not begin running until the cause of action accrues (determined according to federal law), which should be the date that the claim was denied or the date the participant has reason to know his/her claim has been denied. Williams, supra at 113 F.3d 1111-1112; Daill v. Sheet Metal Workers' Local 73 Pension Fund, 100 F.3d 62, 65(7th Cir. 1996).

However, the Plan may provide a separate limitations period (this is in addition to the contractually-specified administrative review periods) shorter than the state statute of limitations. If reasonable,[33] such shortened limitations periods included within ERISA plans have been upheld. Doe v. Blue Cross & Blue Shield United of Wisconsin, 112 F.3d 869, 875(7th Cir. 1997)(39 months is reasonable, but the plan waived enforcement).

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[32]29 USCA 1113 provides a limitation period, in respect to breach of fiduciary duty claims, of 3 years from actual knowledge or 6 years from the last act constituting the breach, whichever first expires. See, Vann v. National Rural Electric Co-Operative Ass'n Retirement & Security Program, 978 F. Supp. 1025(M.D. Ala. 1997).

[33]For insurance contracts, RCW 48.18.200 establishes one year as the shortest period of time reasonable. This statutory authorization may be of persuasive value by analogy. Cf., Williams, supra at 113 F.3d 1112.

Counsel should, therefore, **always** review the Plan to determine whether it includes a shortened statute of limitations period.

H. Interest

Pre-judgment interest is recoverable under ERISA. E.g., Landwehr v. Dupree, 72 F.3d 726, 739(9th Cir. 1995); Hansen v. Continental Insurance Co., 940 F.2d 971, 983(5th Cir. 1991). State law provides "guidance" for determining the appropriate rate of interest (because federal law does not provide a pre-judgment interest rate). Hansen, supra at 984. In the Ninth Circuit, the court may consider the presence or absence of bad faith in determining whether pre-judgment interest should be allowed. Landwehr, supra at 739. **[PRACTICE POINTER: THIS MEANS THAT BAD FAITH MAY BECOME A RELEVANT ISSUE FOR PURPOSES OF PLEADING AND DISCOVERY]!**

I. Access To Plan Attorney's Work Product

The clients, of an attorney advising a plan administrator or other fiduciary concerning plan administration, are the plan beneficiaries for whom the fiduciary acts. Wildbur v. ARCO Chemical Co., 974 F.2d 631, 645-6(5th Cir. 1992), citing, Washington-Baltimore Newspaper Guild, Local 35 v. Washington Star Co., 543 F. Supp. 906, 909(D.D.C. 1982). The plan attorney's work product relating to fiduciary conduct, therefore, is discoverable and not subject to attorney-client privilege. However, the attorney-client privilege remains as to work product information that relates solely to non-fiduciary matters. In Re Long Island Lighting Co., 21 Empl. Ben. Cases 2025(1st Cir. 11/12/97).

J. Right To Jury Trial

There may be no right to trial by jury in federal court ERISA proceedings, because ERISA claims are "inherently equitable." DeFelice v. American International Life Assurance Co., 112 F.3d 61, 64(2nd Cir. 1997).

V. LIABILITY FOR IGNORING SUBROGATION CLAIM

Attorneys who ignore ERISA subrogation and reimbursement claims do so at the peril of both themselves and their clients.

A. Liability Of Client to Plan

If the Plan has a valid subrogation or reimbursement claim and the participant/beneficiary recovers third party funds without honoring that claim, the client will be liable to the Plan. E.g., Unisys Medical Plan v. Timm, 98 F.3d 971(1996). In Timm, the tort victim sued various third parties. The Plan was impleaded into the lawsuit, but failed to plead (which was required by the applicable procedural rules) because it thought the case would settle. The Trial Court later denied the Plan's motion for leave to answer late, and the victim settled the claim. However, even after default, there was no waiver or estoppel and the Plan obtained summary judgment against the tort victim/Plan beneficiary. Accord, Southern Coucil of Industrial Workers v. Ford, 83 F.3d 966(8th Cir. 1996).

However, the Plan's recovery will still be limited to the amounts actually paid and recoverable under the express terms of the Plan, as discussed above. So even if the client's claim has been settled without payment of the subrogated claims, counsel should not forego evaluation of whether, and to what extent, the

Plan is actually entitled to reimbursement.

B. Liability Of Victim's Attorney To Plan, For Failure To Honor Subrogation Agreement

The jurisprudence has become relatively uniform in holding that a victim's attorney who neither signs the subrogation agreement nor agrees to protect the Plan's claim is not personally liable to the Plan for failing to withhold the subrogated amounts from any tort recovery. Hotel Employees & Restaurant Employees International Union Welfare Fund v. Gentner, 50 F.3d 719(9th Cir. 1995); Rhodes, Inc. v. Morrow, 937 F. Supp. 1202, 1214-1216 (M.D.N.C. 1996).

However, if the attorney makes any promise to withhold sums for payment to the Plan, she will be liable for her failure to do so. E.g., Gentner, supra at 50 F.3d 721; Southern Council of Industrial Workers v. Ford, 83 F.3d 966, 969(8th Cir. 1996); Western States Insurance v. Louis E. Olivero & Associates, (Ill. App. 11/21/96)(Attorney sent tort settlement check, payable to the client and the health insurer, to the insurer for endorsement with his promise that he would send the insurer its claimed amount when the settlement checks cleared. The client subsequently instructed the attorney not to disburse any funds because he was filing bankruptcy. The attorney nevertheless disbursed all funds to the client after deduction of attorney's fees and expenses. HELD: attorney liable to health plan).

Moreover, the Plan's claim against the attorney may fall within the exclusive or diversity jurisdiction of the federal courts. Ford, supra at 83 F.3d 968-969(ERISA jurisdiction);

McIntosh, supra at 928 F. Supp. 1464(diversity jurisdiction).

VI. "DO'S" AND "DON'T'S"

DO

--Have your client bring their health plan to first meeting

--Make sure that you've got the right plan.
--Contact plan early in the process
--Read and understand the plan before you contact its representative
--Confirm amounts **actually paid by the plan (i.e. check for discounts)**
--Utilize the Plan's administrative review procedures
--Include an authorized representative of the plan in any ADR
--Read and revise the plan's proposed trust agreement to comply with the express terms of the plan.
--Forewarn your client about the possibility of an adverse attorney's fee award
--Check for contractually-shortened administrative and statute of limitations deadlines.

DON'T

--Mention Thiringer
--Settle the tort claim without evaluating and advising the client as to effect of the third party subrogation claim
--Settle the tort claim without withholding sufficient amounts to satisfy the third party subrogation claims, absent a firm agreement with the Plan
--Rely upon oral agreements and representations by the Plan
--Presume the plan has paid or will pay the face amount of known medical bills
--Let your client sign a trust agreement without limiting it it to the terms of the plan
--Withhold information from the plan, in violation of the plan's cooperation clause
--Negotiate prior to reading and understanding the Plan's subrogation provisions
--Ignore administrative procedures and deadlines