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THE PURSUIT OF PROCEEDS BY PLANS, PARTICIPANTS AND PLAINTIFFS' LAWYERS: DISSONANT SOLUTIONS TO AN ALLITERATIVE PROBLEM

JOHN R. CELLA, JR.

I. INTRODUCTION

An injured person's settlement with a tortfeasor becomes more complicated when that person is a participant¹ or beneficiary² of an employee welfare benefit plan³ ("plan"). After settling with the tortfeasor, the injured participant typically invokes state law to prevent enforcement of plan provisions requiring reimbursement for payments from the plan to providers. Because the Employee Retirement Income Security Act of 1974⁴ ("ERISA") governs such plans, the settlement process compels scrutiny of plan provisions addressing rights of subrogation and reimbursement out of settlement proceeds. When plans conflict with subrogation laws, wrongful death statutes, make-whole doctrines, and attorney fee arrangements, the battles begin. Plans, participants, and plaintiffs' lawyers compete for settlement proceeds, and such competition entails a fascinating examination of ERISA. Courts interpreting plan provisions and considering the sources and amounts of settlements have reached disparate results in their determination of which competitors prevail. As settlement proceeds decrease, the determination of the winners becomes more

1. *See* 29 U.S.C. § 1002(7)(1994) (defining "participant" as "any employee or former employee of an employer . . . who is or may become eligible to receive a benefit . . . from an employee benefit plan . . . or whose beneficiaries may be eligible to receive any such benefit").

2. *See id.* § 1002(8) (defining "beneficiary" as "a person designated by a participant, or by the terms of an employee benefit plan, who is or may become entitled to a benefit thereunder"). Participants often name spouses and dependents as beneficiaries under employee benefit plans.

3. *See id.* § 1002(1) (defining "employee welfare benefit plan" as "any plan . . . established or maintained by an employer . . . for the purpose of providing for its participants or their beneficiaries . . . medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment . . .").

4. *See id.* §§ 1001 - 1461 (1994 & Supp. 1996).

difficult, and courts must exercise their equitable powers or defer to the parties' existing bargain as revealed in the plan.

With emphasis on developments in the Fourth Circuit, this Article first describes the pursuit's origination in plan language and ERISA's statutory provisions; it then explores ERISA preemption and cases in which injured participants invoke state statutory and common law to contradict plan terms. A review of the attorney's role follows, including an inquiry into issues concerning attorney fees. With consideration of policies behind ERISA, the Article concludes that adherence to well-drafted plan terms legitimizes the parties' bargain, avoids development of disparate federal common law, and facilitates the allocation of proceeds.

II. HOW THE PURSUIT BEGINS

The debate over distribution of settlement proceeds is contentious.⁵ The Fourth Circuit's recent decision in *United McGill Corporation v. Stinnett*⁶ illustrates the problems posed in the pursuit of settlement proceeds. In *United McGill*, a plan participant incurred medical expenses of \$39,000 after an accident.⁷ After the participant settled her claim with the tortfeasor for \$100,000, the plan, which had covered \$31,418.89 of the medical expenses, sued for full reimbursement pursuant to plan terms.⁸ At the district court, the participant acknowledged the requirement to reimburse the plan, but argued for a one-third reduction in the reimbursement amount so that the plan could "share in the cost of obtaining the settlement."⁹ Accepting participant's argument, the district court considered its approval of the pro rata reduction the "fair,

5. See generally Ellen E. Schultz, *Health Plans Put the Bite on Some Cash Settlements*, Wall St. J., Sept. 20, 1994, at C1 (discussing the increase in litigation involving employer health plans' enforcement of subrogation clauses against participants' tort recoveries).

6. 154 F.3d 168 (4th Cir. 1998).

7. *Id.* at 170.

8. *Id.* The plan included provisions for reimbursement of medical expenses and subrogation of rights. See *id.* The reimbursement provision entitled the plan to a refund of the lesser of the amount recovered or the amount of benefits paid, and the subrogation provision granted a right of subrogation "to the extent of any benefits paid or payable under this plan." *Id.*

9. *United McGill Corp. v. Stinnett*, 950 F. Supp. 134, 137 (D. Md. 1996) (allowing participant to reduce reimbursement to plan by one-third for attorney fees incurred to secure settlement because absent participant's engagement of attorney, the plan would not have received any reimbursement).

appropriate, and equitable determination under the circumstances of [the] case.”¹⁰

Noting the district court’s failure to discuss relevant plan provisions and its neglect of “well-settled principles of ERISA law,” the Fourth Circuit vacated the district court’s judgment and ordered the participant to reimburse the plan in full.¹¹ The court examined the plan language and concluded that “[a]pplying federal common law to override the Plan’s reimbursement provision would contravene, rather than effectuate, the underlying purposes of ERISA.”¹²

Given the plan’s clear language and the adequacy of settlement proceeds for satisfaction of the plan’s lien and attorney fees, the issues in *United McGill* were manageable.¹³ Even so, courts’ treatment of situations in which the claims of plans and plaintiffs’ lawyers exceed settlement proceeds is unclear.¹⁴ If a plan’s reimbursement and subrogation provisions fail to address attorney fees, regardless of the plan’s participation in the suit against the tortfeasor, to what extent should courts resort to federal common law for allocation of settlement proceeds? Moreover, at what point do state statutes and common law survive ERISA preemption? An examination of state law challenges to plan provisions reveals that unambiguous, thorough plan terms, addressing a handful of potential settlement outcomes, suffice to fortify ERISA preemption of state law and check development of disparate federal common law.

III. RIGHTS OF SUBROGATION OR REIMBURSEMENT?

Clarification of the terms “subrogation” and “reimbursement” must precede discussion of participants’ legal challenges to plan

10. *Id.* at 137.

11. *United McGill*, 154 F.3d at 171.

12. *Id.* at 173.

13. The court pointed out that the participant could not “escape the unambiguous language that obligate[d] her to repay the benefits paid in full without mention of a pro rata deduction for her expenses.” *Id.* According to the plan administrator, the participant’s retention of “approximately \$67,000 [was] more than enough to reimburse the Plan \$31,418.89 for medical benefits payments received from the Plan.” *Id.* at 171.

14. *Id.* at 173. In a footnote, the court declined to address the hypothetical situation in which a plan’s reimbursement claim exceeds the remaining recovery amount after deduction of attorney fees. *See id.* The court indicated, however, that “future disputes over such an anomalous result can easily be avoided by more careful drafting of subrogation and reimbursement provisions.” *Id.*

administrators' enforcement of plan provisions.¹⁵ These distinct terms typically appear after plans' customary exclusions of coverage for medical expenses incurred as a result of some third party's tortious act.¹⁶ In a recent case involving a health plan outside ERISA's governance, the South Carolina Court of Appeals defined subrogation as

the substitution of one person in the place of another with reference to a lawful claim or right. The general rule is that when an insurer pays its insured for a loss resulting from the tortious conduct of a third party, the insurer is subrogated to the rights of its insured against the third party. Subrogation enables the insurer to recover the amount paid to its insured out of any judgment or settlement proceeds received by the insured from the third party. Subrogation can arise by statute, by contract, or through equity.

15. See *Cagle v. Ford*, 59 F. Supp. 2d 548, 553 (E.D.N.C. 1999) (noting that use of "subrogation" and "reimbursement" interchangeably is improper). The court concluded that the written plan documents were clear, yet it cautioned "the Fund, and other ERISA-regulated plans, to draft their plans and agreements more carefully in the future." *Id.* at 556 n.3.

16. See, e.g., *North Carolina Baptist Hosp., Inc. v. Sturgill*, No. 96-1270, 1997 WL 722776, at *2 (4th Cir. Nov. 21, 1997) (quoting summary plan description which stated that "[m]edical care and disability benefits are not payable to or for a person covered under this plan when the injury or illness to the covered person occurs through the act or omission of another person"); *Layne v. Montgomery Ward & Co.*, No. 94-1549, 1994 WL 719673, at *1 (4th Cir. Dec. 30, 1994) (quoting summary plan description which excluded coverage for "[t]reatment of any illness, disease, or injury that is, or is expected to become, the subject of a civil suit."); *Provident Life & Accident Ins. Co. v. Waller*, 906 F.2d 985, 986 (4th Cir. 1990) (quoting self-funded plan which stated that "[m]edical . . . benefits are not payable to or for a person covered under the [plan] when the injury or illness to the covered person occurs through the act or omission of another person."); *Health & Welfare Plan for Employees of S. Md. Elec. Coop., Inc. v. Eagleston* (*In re Eagleston*), 236 B.R. 183, 189 (Bankr. D. Md. 1999) (quoting plan provision that relieves plan from obligation "to make payments on claims arising from . . . injuries to the extent that they . . . may be paid by a third party" who causes "an [i]llness, a sickness, or a bodily injury"); *Cagle*, 59 F. Supp. 2d at 551 (quoting plan provision that gives plan right to seek repayment if benefits paid from plan for "[i]njuries caused by someone else"); *Devine v. American Benefit Corp.*, 27 F. Supp. 2d 669, 672 (S.D. W. Va. 1998) (quoting plan provision excluding coverage for "expenses incurred in connection with . . . [a]ny illness or injury or other condition for which any person, corporation, organization or other entity may be liable or legally responsible by reason of negligence, an intentional act or breach of any legal obligation"); *McInnis v. Provident Life & Accident Ins. Co.*, 853 F. Supp. 880, 882 (M.D.N.C. 1993) (quoting plan provision that triggers reimbursement and lien rights "when [participant or beneficiary] is injured through the act or injury of another person").

Conventional subrogation arises by contract and is specifically bargained for by the parties.¹⁷

Accordingly, subrogation entails the “insurer stepping into the shoes of the insured and attempting to recover from the third party who caused the injury.”¹⁸ The Virginia Supreme Court also has noted that “substitution as to both the rights *and remedies* is a crucial characteristic of subrogation.”¹⁹

Therefore, in the employee welfare benefit plan context, a provision that grants the plan its participants’ rights to sue tortfeasors is appropriately characterized as a subrogation provision.²⁰ For example, one summary plan description states that “[t]o the extent that benefits are paid under this plan, the plan *shall be subrogated and succeed to any right of recovery* of the participant or beneficiary for benefits paid against any [tortfeasor]. . . .”²¹ These provisions also include language requiring participants’ cooperation with the plan in the event of a suit.²² A simple interpretation of these subrogation provisions would lead

17. *Shumpert v. Time Ins. Co.*, 496 S.E.2d 653, 656 (S.C. Ct. App. 1998) (citations omitted).

18. *Waller*, 906 F.2d at 989-990 n.7 (4th Cir. 1990) (citation omitted). The court stated that the plan administrator was simply “seek[ing] . . . the money it paid out to the insured; it [was not seeking] to step into [the participant’s] shoes and proceed against the third party tortfeasor.” *Id.*

19. *Reynolds Metals Co. v. Smith*, 241 S.E.2d 794, 796 (Va. 1978) (emphasis added) (defining subrogation as the “substitution of one person in the place of another with reference to a lawful claim, demand or right . . . so that he who is substituted succeeds to the rights of the other in relation to the debt or claim, and its rights, remedies, or securities”) (citation omitted).

20. *Cagle*, 59 F. Supp. 2d at 553 (pointing out that “subrogation in effect assigns (or requires assignment of) the tort claim to the subrogee (the plan)”) (quoting *Waller v. Hormel Foods Corp.*, 950 F. Supp. 941, 944 (D. Minn. 1996)).

21. *West Virginia-Ohio Valley Area I.B.E.W. Welfare Fund v. The American Tobacco Co.*, 29 F. Supp. 2d 733, 734 (S.D. W. Va. 1998) (emphasis added).

22. *Id.* at 734-35 (requiring participant to “furnish such information, execute such documents, and take such other action as may be necessary to enforce the rights of the plan to recover any payments made”). *See also* *Devine v. American Benefit Corp.*, 27 F. Supp. 2d 669, 671 (citing plan provision that requires participant or beneficiary “to provide information with respect to other persons, corporations, organization[s], or other entities which may be liable for expenses paid by the Plan”); *Blue Cross & Blue Shield of Alabama v. Cooke*, No. 4:97-CV-30-H3, 1998 WL 181260, at *1 (E.D.N.C. Mar. 5, 1998) (ordering participants to pay plan’s attorney fees for bad faith violation of plan provision requiring participant or participant’s attorney to “notify [the plan] before filing any suit or settling any claim so [the plan] may take part in the suit or settlement to protect and enforce [the plan’s] rights”).

one to believe that plans 'step into the injured participant's shoes' and sue tortfeasors directly, but case law indicates that plans typically invoke reimbursement provisions *after* participants recover from tortfeasors.²³ Depending on the plan, reimbursement provisions constitute a distinct set of rights,²⁴ combine with subrogation provisions,²⁵ or fall within the comprehensive umbrella of plan subrogation rights.²⁶

Plans' express rights to reimbursement allow for recovery of benefits advanced on behalf of participants and beneficiaries for treatment of injuries caused by some third party.²⁷ These reimbursement provisions give plans rights to tap any or all settlement proceeds obtained from the tortfeasor,²⁸ prevent reductions in the reimbursement amount for the participant's attorney fees,²⁹ and

23. See, e.g., *Hampton Indus., Inc. v. Sparrow*, 981 F.2d 726, 728 (4th Cir. 1992) (stating that employer with self-funded plan sought reimbursement of medical expenses from beneficiary and attorney who had settled claim with tortfeasor); *Cagle*, 59 F. Supp. 2d at 554 (recognizing that plaintiffs typically "assert claims against tortfeasors which are ostensibly subrogated elsewhere, and fight over allocation afterwards.") (quoting *Waller*, 950 F. Supp. at 944).

24. See, e.g., *Great-West Life & Annuity Ins. Co. v. Barnhart*, 19 F. Supp. 2d 584, 587 (N.D. W. Va. 1998) (citing plan provision granting plan assignee "a first lien upon any recovery, whether by settlement, judgment, mediation or arbitration, that the covered person receives from [a third party, its insurer or guarantor, or the covered person's uninsured and/or underinsured motorist insurance].").

25. See, e.g., *Layne*, 1994 WL 719673, at *1 n.1 (citing "official Plan document" with heading "Subrogation and Right of Reimbursement").

26. See, e.g., *Blue Cross & Blue Shield of Alabama v. Cooke*, 3 F. Supp. 2d 668, 670 (E.D.N.C. 1997) (quoting relevant plan terms, including the "Right of Reimbursement," set forth "under the heading 'SUBROGATION'").

27. *Cagle*, 59 F. Supp. 2d at 553-54 ("Reimbursement simply requires the successful owner of the tort claim (the beneficiary) to repay the plan's advances") (quoting *Waller*, 950 F. Supp. at 944).

28. See *In re Paris*, 44 F. Supp. 2d 747, 748 (D. Md. 1999) (quoting plan provision that required, upon resolution of third party's liability, reimbursement of union fund "up to the *full* amount of the recovery for the *full* amount of loss of time benefits and/or medical benefits received" (emphasis added)); *Rhodes, Inc. v. Morrow*, 937 F. Supp. 1202, 1210-11 (M.D.N.C. 1996) (citing plan provision conditioning receipt of benefits on agreement to repay plan with recovery from third party; plan stated that "[r]ecovery includes *any* amount received, whether by judgment, settlement or otherwise" (emphasis added)).

29. See *Paris*, 44 F. Supp. 2d at 749 (quoting signed subrogation agreement with statement that union fund "shall not be responsible for any of the Claimant's attorneys' fees or the costs of the Claimant's litigation"); *Great-West*, 19 F. Supp. 2d at 587 (quoting plan's statement that "first lien rights will not be reduced . . . due to attorney's fees and costs"). *But cf.* *Liberty Corp. v. NCNB*

even recover amounts from non-tortfeasors, such as the injured participant's uninsured and underinsured motorist carriers.³⁰ Because an injured participant's settlement with a tortfeasor could occur without the plan's knowledge, and therefore render any subrogation rights ineffective,³¹ carefully drafted reimbursement provisions safeguard the plan's potential for recovery from all possible sources.³² The Seventh Circuit has observed that:

Nat'l Bank of South Carolina, 984 F.2d 1383, 1385 n.1 (4th Cir. 1993) (quoting plan reimbursement provision that permitted deduction of "reasonable pro-rata expenses, such as lawyer's fees and court costs, incurred in effecting the third party payment"); *Rhodes*, 937 F. Supp. at 1211 (quoting plan provision that prohibited payment to the plan in an amount exceeding the "proceeds of any such recovery after deducting reasonable and necessary expenditures in effecting such recovery, including attorney's fees"). The fact that the plans in *Liberty* and *Rhodes* allowed for reductions in the reimbursement amount to cover reasonable attorney fees illustrates the significance of written, bargained-for plan terms that contemplate the allocation of proceeds.

30. See *Great-West*, 19 F. Supp. 2d at 587 (quoting plan that expressly provided for reimbursement from "payment which the covered person is entitled to receive from . . . uninsured and/or underinsured motorist insurance"); *Cooke*, 3 F. Supp. 2d at 670 (quoting plan's requirement that participant "pay [the plan] the first dollars [the participant] recover[s] from any source. . . . [including the participant's] own insurance company"); *Harmond v. Teamsters Joint Council No. 83 of Virginia Health & Welfare Fund*, 795 F. Supp. 783, 788-89 (E.D. Va. 1992) (adopting magistrate's opinion that trustees' interpretation that provision subrogating plan to participant's rights "against any person, firm, corporation, or other entity" included entitlement to participant's uninsured motorist coverage was reasonable). Compare *Harmond*, 795 F. Supp. at 788 with *Eagleston*, 236 B.R. at 191-92 (rejecting plan's argument that language providing for recovery of "any payment for . . . benefits . . . receive[d] from [a] third party" encompassed payments from participant's uninsured motorist policy; court ruled that "third party" limited to tortfeasor). Note the range of specificity in the quoted plan provisions. Arguably, the *Great-West* plan language is most resilient.

31. In *Devine*, 27 F. Supp. 2d at 675, the court pointed out that the plan's coverage exclusion concerning injuries resulting from tortious acts of a third party, effective only when such party "makes restitution for expenses incurred," was "obviously designed to prevent two asset-draining evils." *Id.* The court expounded:

First, the provision prevents a participant from defeating the subrogation right by settling first with a third-party tortfeasor and then making a claim for benefits. Second, it prevents a participant's double recovery, i.e., recovering benefits first, settling with the tortfeasor and pocketing the windfall. The "exclusion" is a simple means for helping a participant injured at the hands of a recalcitrant or judgment-proof tortfeasor.

32. *Schultz*, *supra* note 5, at C1 (quoting health plan's lawyer, who emphasized that "reimbursement provisions are intended to eliminate windfall

[u]nlike subrogation, . . . reimbursement is a contractual right governed by ERISA and comes into play only after a plan member has received personal injury compensation. While subrogation and reimbursement may have similar effects, they are distinct doctrines.³³

Interestingly, ERISA does not require summary plan descriptions to include language describing a plan's rights to subrogation and reimbursement, though such language arguably facilitates participants' and beneficiaries' understanding of their responsibilities under a plan.³⁴ Even though ERISA does not mandate such language, a clear explanation of the plan's subrogation and reimbursement rights in the summary plan description undoubtedly enhances the plan's legal position in any dispute over such provisions.³⁵

IV. PRE-PURSUIT PERUSAL OF THE PLAN (AND ERISA)

The pursuit of settlement proceeds requires careful review of the plan itself and ERISA's civil enforcement provisions. Such review is necessary to determine the proper initiator of an action, the statutory grounds for such action, and the appropriate relief sought.

To determine who can sue and be sued, the plan and ERISA's "carefully integrated civil enforcement provisions"³⁶ must be read together. The plan, which reveals the responsibilities and functions of persons and entities, facilitates classification of parties under ERISA's statutory definitions³⁷ and civil enforcement

double recoveries . . . [and] keep the cost of coverage and medical care down for everyone").

33. *Unisys Medical Plan v. Timm*, 98 F.3d 971, 973 (7th Cir. 1996).

34. *Rhodes*, 937 F. Supp. at 1209. The court noted that ERISA does not include rights of subrogation or reimbursement in its list of information required for all summary plan descriptions. *Id.* at 1209 (citing 29 U.S.C. § 1022(b)(1994)). The court also rejected the participant's contention that such provisions fall under the statutory requirement of "a description . . . of circumstances which may result in disqualification, ineligibility, or denial or loss of benefits." *Id.* at 1209; see also 29 U.S.C. § 1022(b) (1994).

35. See, e.g., *Layne*, 1994 WL 719673, at *4 n.16 (concluding that a participant's and beneficiary's "concession that the language in both the Official Plan and the SPD authorized the Administrator to require participants to agree to subrogate to the Plan monies received from third party tortfeasors (and such tortfeasors' insurers) . . . [was] fatal to their cause of action").

36. *Mertens v. Hewitt Assoc.*, 508 U.S. 248, 252 (1993) (quoting *Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 146 (1985)).

37. 29 U.S.C. § 1002 (1994).

provisions.³⁸ The plan also provides information concerning the plan administrator's role in interpreting plan terms, a critical determinant of standard of review.³⁹ ERISA allows only four entities to sue for specified relief under section 502: participants, beneficiaries, fiduciaries, and the Secretary of Labor.⁴⁰ Entities disputing the validity of plan subrogation and reimbursement provisions must satisfy the statutory definitions of terms in section 502. Under ERISA section 502(a)(1)(B), only participants and beneficiaries are entitled "to recover benefits due . . . under the terms of [the] plan, to enforce . . . rights under the terms of the plan, or to clarify . . . rights to future benefits under the terms of the plan."⁴¹ Moreover, ERISA section 502(a)(3) permits participants, beneficiaries, and fiduciaries to "enjoin any act . . . which violates . . . the terms of the plan" or to "obtain other appropriate

38. 29 U.S.C. § 1132 (1994).

39. For a recent discussion of the Fourth Circuit's "framework for review of the denial of benefits under ERISA plans," see *Ellis v. Metropolitan Life Insurance Co.*, 126 F.3d 228, 232-34 (4th Cir. 1997). Plaintiffs' appeals from summary judgment are reviewed *de novo*, and benefit denials by plan administrators vested with discretion to construe plan terms are reviewed for abuse of discretion. *Id.* at 232. See also *id.* at 233 (detailing the lessened deference standard employed by courts "to neutralize any untoward influence resulting from the [fiduciary's] conflict [of interest]"); *Booth v. Wal-Mart Stores, Inc. Assoc. Health & Welfare Plan*, 201 F.3d 335 (4th Cir. 2000) (setting forth eight factors that a court may consider when reviewing a plan administrator's decision to deny benefits under a welfare benefit plan). When subrogation and reimbursement provisions are at issue, plans sometimes deny benefits until participants sign agreements reinforcing such provisions; the denials therefore trigger this standard of review analysis. See, e.g., *Trident Reg'l Health Sys. v. Polin*, 948 F. Supp. 509, 516-19 (D.S.C. 1996).

40. *Coyne & Delany Co. v. Blue Cross & Blue Shield of Va., Inc.*, 102 F.3d 712, 714 (4th Cir. 1996) (observing that "[s]ection 502(a) provides the exclusive statement of civil actions available under ERISA to the Secretary of Labor, participants, beneficiaries, and fiduciaries") [hereinafter "Coyne II"].

41. 29 U.S.C. § 1132(a)(1)(B)(1994). This statutory provision is "explicitly directed at wrongs suffered by individual [participants or] beneficiaries, referring to 'benefits due to him' and 'his rights under the terms of the plan.'" *Coyne II*, 102 F.3d at 715. Note that the provision does not give plan administrators a federal cause of action for recovery of plan benefits. *Waller*, 906 F.2d at 987-88. If a person is not a participant or beneficiary as defined by ERISA, then that person does not have standing to sue a plan administrator or fiduciary for recovery of benefits. *HealthSouth Rehabilitation Hosp. v. American Nat'l Red Cross*, 101 F.3d 1005, 1008 (4th Cir. 1996) (ruling that hospital lacked standing).

equitable relief to redress such violations or to enforce . . . the terms of the plan."⁴²

Disputes concerning the interpretation of plan subrogation and reimbursement provisions prompt entities to sue for enforcement of rights under plan terms or conflicting state law. Entities seek recovery of benefits,⁴³ declaratory relief,⁴⁴ injunctive relief,⁴⁵ and even class certification.⁴⁶ Regardless of claimant or relief sought, these disputes always entail scrutiny of plan terms.

V. THE COLLISION OF ERISA AND STATE LAW

When participants and beneficiaries allege that plan terms violate state law, courts inevitably address ERISA preemption. In resolving the pursuit of settlement proceeds, courts encountering allegations of state law applicability must review ERISA preemption with appropriate consideration of specific plan terms and broader ERISA principles. With minor exceptions, ERISA preemption continues to leave intact plans' enforcement of subrogation and reimbursement rights under federal law.

A. *Post-Travelers ERISA Preemption*

Because the pursuit of settlement proceeds necessitates evaluation of written plan terms that implicate relations among

42. 29 U.S.C. § 1132(a)(3)(1994). See also *WV-OVA Welfare Fund*, 29 F. Supp. 2d at 735 (recognizing that "[m]any courts hold actions brought by a plan to enforce subrogation rights based on benefits paid by it are actions within the scope of section 1132(a)(3)").

43. See *McInnis v. Provident Life & Accident Ins. Co.*, 21 F.3d 586 (4th Cir. 1994) (preempting North Carolina's wrongful death statute for conflicting with plan's reimbursement condition; beneficiary had sought full payment of medical benefits to deceased participant's estate and limitation on reimbursement pursuant to state law).

44. See *FMC Corp. v. Holliday*, 498 U.S. 52 (1990) (providing declaratory relief for employer with self-funded plan; Court preempted Pennsylvania anti-subrogation statute pursuant to ERISA's deemer clause); *Paris*, 44 F. Supp. 2d at 747 (ruling on case initially filed as petition for declaratory judgment in state court).

45. *Great-West*, 19 F. Supp. 2d at 585-86 (listing relief sought by plaintiff plan, including an "injunction that prevents [beneficiary] from violating the terms of the benefit plan").

46. *Health Plan of the Upper Ohio Valley, Inc. v. DeGarmo*, No. 5:93CV7, 1996 WL 780508, at *1 (N.D. W. Va. Oct. 28, 1996) (granting class certification to injured plan enrollees alleging unlawful subrogation and reimbursement practices by health plan under ERISA, RICO, and the FDCPA).

ERISA entities, the apparent post-*Travelers*⁴⁷ atrophy of ERISA's preemptive muscle has not hampered a plan's ability to enforce its provisions under federal law.

The Fourth Circuit recently enunciated its preemption analysis in *LeBlanc v. Cahill*:⁴⁸

Our analysis of this issue begins with the normal presumption that Congress does not intend to preempt state law. We next . . . apply a pragmatic approach of looking to the objectives of ERISA to determine whether the normal presumption against preemption has been overcome . . . ERISA's main objective is to protect . . . the interests of participants in employee benefit plans and their beneficiaries . . . [C]ongress intended to ensure that plans and plan sponsors would be subject to a uniform body of benefits law; the goal was to minimize the administrative and financial burden of complying with conflicting directives among States or between States and the Federal Government . . . [and to prevent] the potential for conflict in substantive law . . . requiring the tailoring of plans and employer conduct to the peculiarities of the law of each jurisdiction . . . Congress intended ERISA to preempt at least three categories of state laws that can be said to have a connection with an ERISA plan. First, Congress intended ERISA to preempt state laws that mandate employee benefit structures or their administration Second, Congress intended to preempt state laws that bind employers or plan administrators to particular choices or preclude uniform administrative practice, thereby functioning as a regulation of an ERISA plan itself . . . Third, . . . Congress intended to preempt state laws providing alternative enforcement mechanisms for employees to obtain ERISA plan benefits. Finally, . . . Congress did not intend to preempt traditional state-based laws of general applicability that do not implicate the relations among the traditional ERISA plan entities, including the principals, the employer, the plan, the plan fiduciaries, and the beneficiaries.⁴⁹

47. *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 656 (1995)(criticizing ERISA's "unhelpful text . . . and look[ing] instead to the [statute's] objectives . . . as a guide to the scope of the state law that Congress understood would survive"). Rejecting preemption of a New York statute imposing surcharges on hospital patients with coverage bought by ERISA plans, Justice Souter's opinion for a unanimous Court suggested a retreat from preemption analysis based on "infinite relations."

48. 153 F.3d 134 (4th Cir. 1998).

49. *Id.* at 147 (emphasis added) (citations and internal quotation marks omitted).

The italicized portions of the court's analysis suggest that ERISA convincingly preempts state laws invoked to pursue outcomes contrary to plan provisions or achievable pursuant to federal law. The policies of uniformity, protection of *all* participants and beneficiaries, and adherence to written plan terms coalesce to strengthen ERISA's preemption of such state laws.

B. *The Preeminence of Plan Provisions*

Before turning to ERISA preemption of state laws alleged to govern the pursuit of settlement proceeds, the time-honored deference to written plan terms warrants discussion.⁵⁰ Section 502(a)(1) of ERISA mandates that "[e]very employee benefit plan . . . be established and maintained pursuant to a written instrument."⁵¹ In addition, ERISA requires establishment of "a procedure for amending such plan" and specification of the "basis on which payments are made to and from the plan."⁵² ERISA also requires fiduciaries to "discharge [their] duties with respect to a plan . . . in accordance with the documents and instruments governing the plan insofar as such documents and instruments are consistent with the provisions of [titles I and IV]."⁵³ In *United McGill*, the Fourth Circuit echoed ERISA's respect for written plans:

Although ERISA establishes a comprehensive regulatory scheme for employee welfare benefit plans, it does not mandate any minimum substantive content for such plans. Rather, one of the primary functions of ERISA is to ensure the integrity of written, bargained-for benefit plans. To satisfy this objective, the plain language of an ERISA plan must be enforced in accordance with its literal and natural meaning.⁵⁴

In *Mertens* the United States Supreme Court cautioned that federal courts' authority to develop ERISA common law "is not the authority to revise the text of the statute."⁵⁵ The District of South

50. See, e.g., *Cagle*, 59 F. Supp. 2d at 554 ("[O]ne of the primary functions of ERISA is to ensure the integrity of written, bargained-for benefit plans.").

51. 29 U.S.C. § 1102(a)(1) (1994).

52. 29 U.S.C. § 1102(b)(3)-(4).

53. 29 U.S.C. § 1104(a)(1)(D) (emphasis added). Congress designated Titles I and IV of ERISA "Protection of Employee Benefit Rights" and "Plan Termination Insurance," respectively.

54. 154 F.3d at 172 (citations and internal quotation marks omitted).

55. 508 U.S. at 259 (quoted in *Trident*, 948 F. Supp. at 514).

Carolina extended this caveat by stating that “federal courts do not rewrite the unambiguous terms of an ERISA plan.”⁵⁶

These inveterate principles, when heeded by plan drafters, should minimize plan silence and ambiguity by translating into thorough, well-written subrogation and reimbursement provisions. It is also possible (and prudent) to include simplified versions of these elaborate plan provisions in summary plan descriptions, which must be “written in a manner calculated to be understood by the average plan participant, and . . . sufficiently accurate and comprehensive to reasonably apprise . . . participants and beneficiaries of their rights and obligations under the plan.”⁵⁷ *Eppard v. Builders Transport, Inc.*,⁵⁸ an unreported decision, illustrates the consequences of plan silence concerning subrogation rights. Eppard was a participant in her employer’s self-funded employee benefit plan that paid roughly \$29,000 in medical bills that arose from an accident caused by a third party.⁵⁹ The participant and tortfeasor entered into a structured settlement that failed to address subrogation rights asserted by the employer.⁶⁰ The plan neither included a subrogation provision nor required the participant to sign a subrogation agreement prior to remittance of benefits.⁶¹ The court rejected the employer’s assertion of a right to subrogation because the plan was silent on the matter.⁶² The court also refused to fashion a federal common law remedy of unjust enrichment; *Waller*⁶³ was distinguished because that plan “provided for repayment of the advanced monies.”⁶⁴ The court emphasized that the “plan contained no provision providing a right of subrogation” and concluded that it “need proceed no further.”⁶⁵ Having left the parties’ settlement agreement intact, the court justified its ruling:

56. *Trident*, 948 F. Supp. at 514.

57. 29 U.S.C. § 1022(a)(1) (1994). *See also supra* note 34 and accompanying text (pointing out that ERISA does not require the summary plan description to include subrogation and reimbursement provisions, but such inclusion would be helpful to participants and beneficiaries).

58. No. CIV.A.92-0002-C, 1993 WL 28813, at *1 (W.D. Va. Feb. 4, 1993).

59. *Id.* at *1.

60. *Id.*

61. *Id.*

62. *Id.*

63. 906 F.2d 985.

64. *Eppard*, 1993 WL 28813, at *4.

65. *Id.*

ERISA demands adherence to the written terms of [a] . . . plan. [The court] has no discretion under ERISA to add clauses the parties have neglected to include . . . [T]he Fourth Circuit has specifically cautioned the federal courts . . . to avoid nullifying the statute by smuggling in state common law principles without regard for the statutory text. Should the court grant an implied right here, many would follow seeking to add terms . . . they find convenient. Such editing by the courts would thwart ERISA's . . . goals of uniform and efficient plan administration. This court must decline to open such a floodgate.⁶⁶

Eppard exemplifies judicial reluctance to modify or supplement terms of written employee welfare benefit plans. Written plan provisions should always prevail. If such provisions fail to (or inadequately) address subrogation and reimbursement, the plan should sustain the loss. On the other hand, unambiguous, forearmed plan terms should prevail over defiant participants and their attorneys. Courts' deference to written plan provisions not only complies with ERISA's letter and spirit, but also allows parties to realize expectations generated by their contract as revealed in the plan.

C. *Participants' Refusals to Cooperate With Plans*

When plans expressly require participants' cooperation concerning subrogation and reimbursement rights, the pursuit of settlement proceeds often engenders intransigence by plans and defiance by participants. Cooperation with plans includes giving plans notice of suits against or settlement negotiations with third party tortfeasors,⁶⁷ signing agreements that reinforce express subrogation and reimbursement rights of the plan⁶⁸ or that condition receipt of benefits on recognizing such rights,⁶⁹ and promising

66. *Id.* (citations omitted).

67. *See, e.g., Cooke*, 1998 WL 181260, at *1 (citing plan provision requiring "notification] before filing any suit or settling any claim so [the plan] may take part in the suit or settlement to protect and enforce [the plan's] rights").

68. *See, e.g., Sturgill*, 1997 WL 722776, at *2 (citing plan provision that granted plan administrator "the right to recover in full the medical or disability expenses advanced regardless of whether [the covered person] actually signs the repayment agreement").

69. *See, e.g., Dillard v. Teamsters Joint Council No. 83 of Va. Health & Welfare Fund*, No. CIV.A. 84-0164-L, 1985 WL 17724, at *2 (W.D. Va. Oct. 31, 1985) (citing plan provision that "required participants and beneficiaries to execute written subrogation agreements as a condition of payment on claims arising from injuries caused by third parties").

not to release any third party tortfeasor from liability.⁷⁰ The intensity of participants' refusals to cooperate with plans often depends on the clarity of plan terms. Problematic plans, for example, include those that assert general rights of subrogation and reimbursement but fail to specify sources such as a participant's underinsured and uninsured motorist coverage.⁷¹ On the other hand, some plans invite legal challenges by asserting broad subrogation and reimbursement rights that conflict with plan terms that are too precise. For example, to justify its application of the plain meaning rule, the *Rhodes* court cited cases in which "plan recovery was limited only to funds designated as 'medical benefits'" because "the language of the plan document itself provided the limitation."⁷² Such a narrow plan term, if exclusive, bolsters the participant's argument against reimbursement from settlement proceeds earmarked as compensation for injuries such as pain and suffering.⁷³ Again, plans can avoid these disputes by drafting with care. Indeed, courts frown upon participants and attorneys whose failure to cooperate with plans opposes clear plan terms.⁷⁴

D. Preempted Statutory Law

For the most part, courts in the Fourth Circuit have ruled that ERISA preempts state statutes that interfere with the terms

70. See, e.g., *Harmond v. Teamsters Joint Council of the Va. Health & Welfare Fund*, No. 92-2043, 1993 WL 306100, at *1 (4th Cir. Mar. 30, 1993) (citing plan provision requiring participant or beneficiary to "covenant that he [or she] has not discharged or released any such right . . . against any third party").

71. *Id.* at *2 (citing subrogation agreement that failed to mention participant's uninsured motorist coverage but entitled plan to participant's "rights . . . against 'any person . . . or other entity'").

72. *Rhodes*, 937 F. Supp. at 1213 (citing *Cooper Tire & Rubber Co. v. St. Paul Fire & Marine Ins. Co.*, 48 F.3d 365, 371 (8th Cir. 1995)).

73. *Id.*

74. See, e.g., *Cooke*, 1998 WL 181260, at *2 (warning that recovery of attorney fees by plan administrator should discourage "other members of the self-funded plan from attempting to secretly pocket funds owed as reimbursement to the plan"); *Sturgill*, 1997 WL 722776, at *2 (stating that the participants' "continued litigation of a frivolous and meritless claim more than justifies the awarding of reasonable attorneys' fees to [the employer]"); *Devine*, 27 F. Supp. 2d at 678 (placing considerable weight on bad faith factor because participant's attorney "omitted critical language from a Plan provision at the heart of [the] dispute" and consequently "misled the Court"), *vacated*, *Devine v. Am. Benefit Corp.*, 56 F. Supp. 2d 679, 683 (S.D. W. Va. 1999) (reconsidering participant's liability for attorney fees sua sponte because of attorney's "skeletal representation on [participant's] ability to pay" such fees).

of employee benefit plans. Even so, participants invoking Virginia and North Carolina statutory law to prevent subrogation and reimbursement have obtained mixed results that depend on the plan and the allegedly applicable state statute.

Virginia's anti-subrogation statute has been an element of participants' argument against subrogation and reimbursement in the employee benefit plan context. The Western District of Virginia addressed these issues in 1985 and held that ERISA preempted Virginia's anti-subrogation statute.⁷⁵ The injured plan participant had attempted to use state law to invalidate her self-funded plan's subrogation provisions, but the court ruled that her "contention . . . overlook[ed] the preemption provisions of ERISA."⁷⁶ The court appropriately examined ERISA's legislative history and repeated Congress' intent "to eliminate the threat of conflicting or inconsistent state or local regulation and establish in its stead a predictable, uniform source of federal law to govern employee benefit plans."⁷⁷

The reasoning in *Dillard* did not apply to the dispute in *Health Cost Controls v. Whalen* because the plan in the latter case was an insured group plan and was therefore subject to state insurance laws.⁷⁸ The *Whalen* court rendered the plan's subrogation and reimbursement provisions unenforceable based on Virginia law,⁷⁹ yet it failed to analyze the state statute as falling under ERISA's savings clause.⁸⁰ The propriety of such analysis is questionable given ERISA's broad governance of employee welfare benefit plans.

The Fourth Circuit has ruled that ERISA preempts a North Carolina apportionment statute that limits medical providers' liens on personal injury awards to no more than "fifty percent of the amount of damages recovered."⁸¹ The statute expressly excludes attorney fees from this calculation.⁸² In *Hampton Industries* the beneficiary of a self-funded plan refused to honor the plan's subrogation and reimbursement provisions after recovering

75. *Dillard*, 1985 WL 17724, at *1.

76. *Id.* at *3.

77. *Id.* at *4.

78. *Health Cost Controls v. Whalen*, No. CIV.A.1:96-66A, 1996 WL 787163, at *1 (E.D. Va. Aug. 14, 1996).

79. *Id.* at *2.

80. For a concise discussion of ERISA's savings clause, see *Tri-State Machine, Inc. v. Nationwide Life Ins. Co.*, 33 F.3d 309, 312 (4th Cir. 1994).

81. 981 F.2d at 728.

82. *Id.* at 728.

from a tortfeasor.⁸³ The district court held that the beneficiary was “bound to the terms of . . . the subrogation clause,” but that the apportionment statute governed apportionment of settlement funds.⁸⁴ Following the Supreme Court’s decision in *FMC Corp. v. Holliday*, the Fourth Circuit ruled that ERISA preempted the statute. It then remanded “to determine the allocation of settlement proceeds.”⁸⁵

The finding of ERISA preemption in *Hampton Industries* was straightforward, but the remand for allocation of proceeds raises an interesting point. The court limited relief on remand to the employer’s request for “the balance of the settlement fund . . . less the attorneys’ fees due [to the beneficiary’s law firm]” because the beneficiary failed to mention the issue in her brief.⁸⁶ Of course, this footnote may be a simple judicial signal to the beneficiary’s lawyer to cover all issues on brief, but, more significantly, it raises the question whether the plan’s position concerning such fees was based on an express plan provision. Assuming no subtraction of fees from the reimbursement amount and plan silence concerning such fees, how would a court divide the settlement proceeds?

ERISA plans have also encountered challenges based on North Carolina’s wrongful death statute.⁸⁷ In *Liberty*, a group health plan participant died several days after sustaining injuries in a motor vehicle accident.⁸⁸ *Liberty*, the deceased participant’s employer and the plan’s administrator, paid “\$93,829.50 in medical bills on [the participant’s behalf].”⁸⁹ The plan’s subrogation provision stated that “[t]he insured individual will reimburse the Plan the amount of benefits paid.”⁹⁰ *Liberty* and the participant’s personal representative had agreed that the estate would fully reimburse the plan in the event of a third party recovery; however, a subsequent, court-approved settlement with the tortfeasors specified distribution of proceeds in accordance with North Carolina’s wrongful death statute.⁹¹ According to the court, ERISA did not preempt the statute’s \$1,500 limit on the amount paid from a wrongful death recovery for “reasonable hospital and medical

83. *Id.* at 727-28.

84. *Id.* at 728.

85. *Id.* at 728-30.

86. *Id.* at 730 n.9.

87. *McInnis*, 21 F.3d at 586; *Liberty*, 984 F.2d at 1383.

88. *Liberty*, 984 F.2d at 1385.

89. *Id.*

90. *Id.* at 1385 n.1.

91. *Id.* at 1385.

expenses.”⁹² Because the decedent’s beneficiaries, not the decedent himself, had the right to sue the tortfeasors for wrongful death, and given that the plan expressly subrogated only the decedent’s rights, the court held that “the cap on medical expenses [did] not ‘relate to’ the Plan within the meaning of ERISA.”⁹³

With minimal discussion of plan terms and ERISA’s policy, the majority in *Liberty* prohibited the plan from recovering any amount exceeding \$1,500 of the \$1,500,000 settlement.⁹⁴ Judge Hall’s dissent, which concluded that ERISA preempted North Carolina’s wrongful death provision, called for reimbursement to the plan of any settlement proceeds designated to compensate for the deceased participant’s medical expenses.⁹⁵ Furthermore, after declaring that “North Carolina may not . . . deprive an ERISA plan of its subrogation rights”, the dissent keenly observed that the majority opinion would force the plan, which covered “employees in 24 states”, to comply with “directly conflicting . . . approaches to the subrogation of medical costs paid on behalf of deceased tort victims.”⁹⁶

McInnis also entailed analysis of ERISA’s relationship to North Carolina’s wrongful death statute.⁹⁷ In *McInnis*, the widower of a plan participant, as successor in interest, sought payment of his deceased spouse’s medical expenses from her employee benefit plan but refused to sign a reimbursement agreement required by the plan.⁹⁸ Distinguishing *Liberty*, the Fourth Circuit stated that “the answer to the question of whether a claim under North Carolina’s wrongful death statute belongs to the deceased plan participant or to a beneficiary of the decedent defines the line between remoteness and relatedness under [*Liberty*].”⁹⁹ Because the judicially approved settlement order “included [damages] belonging to [the deceased participant] and her estate,” the court held that ERISA preempted the statute “to the extent that [it] preclude[d] operation of the terms of the . . . clause in the plan.”¹⁰⁰

The *McInnis* court considered the parties’ agreement and the “expectations of all other plan participants who have an interest

92. *Id.* at 1388-89, 1387 n.2.

93. *Id.* at 1388-89.

94. *Liberty*, 984 F.2d at 1387.

95. *Id.* at 1390-91.

96. *Id.* at 1391-92.

97. *McInnis*, 21 F.3d at 586.

98. *Id.* at 587.

99. *Id.* at 589.

100. *Id.* at 590.

in the plan's funds and benefits,"¹⁰¹ but failed to address how the expectations of the *Liberty* plan and its participants were distinct. Moreover, both decisions seemed to accord undue weight to terms of court-approved settlements at the expense of plan terms and a thorough review of ERISA's policies. Although the *McInnis* court concluded that "[a] state statute that would alter these benefits would impermissibly interfere in an area preempted by ERISA,"¹⁰² it nevertheless failed to elaborate sufficiently as to how the facts in *Liberty* justified the wrongful death statute's alteration of benefits, revision of expectations, and interference with the ERISA plan in that case.

E. Preempted Common Law

In addition to state statutory law, participants invoke common law doctrines to determine the allocation of settlement proceeds. In one case involving injured minors who were also beneficiaries under their parent's employee welfare benefit plan, the district court ruled that ERISA preempted North Carolina's doctrine of necessities.¹⁰³ Respecting plan provisions that defined the rights and obligations of 'covered persons,' the court concluded that the children's acceptance of plan benefits "obligated [them] to reimburse the plan from any third party recovery."¹⁰⁴ The court stated:

the North Carolina necessities doctrine would prevent seamless administration of nationwide or multi-state plans. Plan administrators would have to calculate the diminished recovery that could be obtained in the event a child was injured and received payments under the ERISA plan in a state with a provision similar to the necessities doctrine. Plans would have to be restructured and benefits for minors or dependents could be correspondingly diminished as a result. This is precisely the type of situation the ERISA preemption provision . . . was designed to address. They . . . should not be allowed to deplete Plan assets to the detriment of other . . . employees through creative legal argument.¹⁰⁵

The court's concern with depletion of plan assets is consistent with Congress' interest in the "continued well-being and security

101. *Id.*

102. *Id.*

103. *Rhodes*, 937 F. Supp. at 1211.

104. *Id.*

105. *Id.* at 1212.

of millions of employees and their dependents [who] are directly affected by [employee benefit] plans.”¹⁰⁶

Fourth Circuit court decisions finding preemption of the common law make-whole doctrine also use language that appears deferential to ERISA policies. In such cases, injured participants alleging inadequacy of compensation invoke the make-whole doctrine to invalidate plan subrogation and reimbursement provisions. In *Trident*, an injured participant violated plan terms by failing to notify the plan of her suit against the tortfeasor, neglecting to obtain the plan’s consent to settlement, and refusing to sign a subrogation agreement.¹⁰⁷ The court rejected application of “a ‘make whole’ rule . . . requiring that a plan participant’s expenses be fully satisfied prior to the participant reimbursing the plan.”¹⁰⁸ After citing several decisions that recognized control of the issue by plan terms, the court concluded that:

[t]he plain language of the Plan dictates that [the participant] reimburse it for all of its expenses, and there is no requirement that [the plan] postpone enforcing its subrogation rights until [the participant’s] expenses have been fully satisfied. Indeed, mandating such a requirement via creation of a federal common law rule contravenes ERISA.¹⁰⁹

The Northern District of West Virginia also looked to plan language in *Great-West*.¹¹⁰ The plan in that case contained a strongly worded provision granting “first lien rights” to the plan in the event of any third party recovery.¹¹¹ The court held that “the plain language of the Plan preclude[d] the need to fashion federal common law,” but it did not discuss “whether the make-whole doctrine should apply to self-funded ERISA plans as a matter of federal common law.”¹¹² At a minimum, though, the court’s application of ERISA preemption and examination of plan terms

106. 29 U.S.C. § 1001(a)(1994). A recent article points out that insured ERISA plans cover approximately seventy-seven million Americans while self-funded ERISA plans cover another forty-six million. See Sarah A. Klein, *Supreme Court Considers ERISA Preemption*, AM. MED. NEWS, Mar. 22, 1999.

107. *Trident*, 948 F. Supp. at 511-12.

108. *Id.* at 513.

109. *Id.* at 516. The District of Maryland reached a similar result in *Paris*. See *Paris*, 44 F. Supp. 2d at 747. Recognizing the “clear and unequivocal plan language”, the court soundly rejected application of the “make whole doctrine” as ERISA common law. *Id.* at 748-49.

110. *Great-West*, 19 F. Supp. 2d at 584.

111. *Id.* at 587.

112. *Id.* at 586.

indicate that development of common law is a judicial last resort, which is consistent with principles enunciated by the Fourth Circuit in *Singer v. Black & Decker*.¹¹³ Even so, clear plan language is the optimal protection against adoption of the make-whole doctrine as part of the federal common law of ERISA.¹¹⁴

VI. ATTORNEY FEES: DEDUCT, DISREGARD, OR DEMAND?

Absent application of ERISA section 502(g)¹¹⁵ and the *Quesinberry* factors¹¹⁶ to determine attorney fee awards, plaintiffs' attor-

113. *Singer v. Black & Decker Corp.*, 964 F.2d 1449 (4th Cir. 1992) (“[R]esort to federal common law generally is inappropriate when its application is would conflict with the statutory provisions of ERISA, discourage employers from implementing plans governed by ERISA, or threaten to override the explicit terms of an established ERISA benefit plan.”) (citing *Waller*, 906 F.2d at 992).

114. Notwithstanding *Trident*, *Waller*, and *United McGill*, decisions in which courts in the Fourth Circuit addressed federal common law issues with favorable results to plans, the adoption of a default rule by other courts suggests that such issues will not disappear—after all, “federal common law should be consistent across the circuits.” *Singer*, 964 F.2d at 1453. In *Marshall v. Employers Health Ins. Co.*, Nos. 96-6063, 96-6112, 1997 WL 809997, at *1 (6th Cir. Dec. 30, 1997), the Sixth Circuit adopted the make-whole rule as a default rule:

Such a rule is consistent with the equitable principle that insurer does not have a right of subrogation until the insured has been fully compensated, unless the agreement itself provides to the contrary If a plan sets out 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[, then] no silence or ambiguity exists. *Id.* at *4.

See also *Cagle v. Bruner*, 112 F.3d 1510, 1521 (11th Cir. 1997) (applying make whole doctrine as a default rule to “limit a plan's subrogation rights where an insured has not received compensation for his total loss and the plan does not explicitly preclude operation of the doctrine” (emphasis added)); *Copeland Oaks v. Haupt*, 41 F. Supp.2d. 747 (N.D. Ohio 1999), reversed on other grounds, No. 99-3471, 2000 WL 354135 (6th Cir. Apr. 7, 2000) (applying make-whole rule because plan language did not “explicitly override the make-whole rule” or “claim priority over funds when the recovery is only partial or incomplete”). *But cf. Paris*, 44 F. Supp. 2d at 749 (“To the extent that the [beneficiary's] opposition memorandum can be read to suggest that the plan documents must mention the ‘make-whole doctrine’ in haec verba, the Court rejects such contention as unsupported by authority and unsound.”). Accordingly, despite favorable decisions by courts in the Fourth Circuit, application of the make whole doctrine as a default rule in other circuits should be viewed as a red flag alerting plans to reassess the language of subrogation and reimbursement provisions.

115. 29 U.S.C. § 1132(g)(1)(1994) (“In any action . . . by a participant, beneficiary, or fiduciary, the court in its discretion may allow a reasonable attorney's fee and costs of action to either party.”).

116. See *Sturgill*, 1997 WL 722776 at *2 n.2. The court listed the five considerations in determining an award of attorney fees under ERISA:

neys are left to the mercy of contingency fee agreements, plan reimbursement provisions, or judicial intervention. Although attorneys who hold settlement proceeds in escrow are not fiduciaries,¹¹⁷ their conduct before, during, and after settlement negotiations significantly affects the final disposition of settlement proceeds. Attorneys should review terms of their clients' plans carefully before asserting a legal position in obvious contravention of contractual duties and judicial precedent. Because courts value their time, there is little tolerance for hearing unnecessary disputes over unambiguous plan provisions.¹¹⁸

Plans also should be reviewed for any mention of attorney fees. Attorney fees can be deducted or disregarded pursuant to plan terms, or parties can demand them in the courtroom. Accordingly, plan subrogation and reimbursement provisions should expressly contemplate whether attorney fees are fully deducted, proportionately shared, or entirely discounted in the pursuit of proceeds. Clear contractual provisions are preferable to unpredictable, judge-made rules of federal common law.¹¹⁹

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- (1) [the] degree of opposing parties' culpability or bad faith;
 - (2) [the] ability of opposing parties to satisfy an award of attorneys' fees;
 - (3) whether an award of attorneys' fees against the opposing party would deter other persons acting under similar circumstances;
 - (4) whether the parties requesting attorneys' fees sought to benefit all participants and beneficiaries of an ERISA plan or to resolve a significant legal question regarding ERISA itself; and
 - (5) the relative merits of the parties' positions.

117. *Rhodes*, 937 F. Supp. at 1214-15 ("The Fourth Circuit recently refused to impose fiduciary status on an attorney for a health plan [citation omitted], and the Court is certainly wary to impose that status on the attorney for a plan beneficiary.")

118. *See, e.g., Sturgill*, 1997 WL 722776, at *2 (upholding fees award against attorney personally for "fail[ing] to put forth a coherent legal argument" and causing a "waste of judicial resources"); *Devine*, 27 F. Supp. 2d at 678 (refusing to "ignore the apparent lack of any basis for suing [the administrator] in the first place"); *Cooke*, 1998 WL 181260, at *2 (emphasizing "the lack of merit in [participants'] contentions" and compelling payment of fees "to deter such conduct by other insureds").

119. *See, e.g., Waller v. Hormel Foods Corp.*, 120 F.3d 138, 141 (8th Cir. 1997) (establishing federal common law rule that reduced plan's recovery by "the amount of a reasonable attorney's fee" because the plan's "subrogation clause contain[ed] no provision regarding attorney's fees"); *Harris v. Harvard Pilgrim Health Care, Inc.*, 20 F. Supp. 2d 143, 152-53 (D. Mass. 1998) (allowing pro rata reduction for reasonable attorney fees in absence of plan provision concerning such fees), *distinguished in Paris*, 44 F. Supp. 2d at 749.

In *United McGill*, the Fourth Circuit declined to address the hypothetical situation in which settlement proceeds are inadequate to reimburse a plan, satisfy attorney fees, and compensate an injured participant.¹²⁰ Plans should expressly contemplate the inadequate recovery to prevent courts' development of federal common law to rectify silent or ambiguous plan provisions.¹²¹

VII. CONCLUSION

Put simply (and alliteratively), plans prevail in the pursuit of proceeds by paying attention to their provisions. Plans must protect their participants and beneficiaries from the "asset-draining evils"¹²² that elevate costs for everyone.¹²³ Arguably, the degree of specificity in plans is inversely proportional to the extent courts develop federal common law to resolve disputes concerning subrogation and reimbursement provisions. 'Get back to basics,' though a trite imperative, is particularly applicable to such disputes: bed-rock ERISA principles of uniformity, protection, and formality outweigh disparate notions of equity and isolated extracontractual modifications. 'Filling the interstices'¹²⁴ is not difficult. Well-written plans should require ongoing cooperation of participants and their attorneys with plan administrators, specify reasonably possible sources of recovery other than tortfeasors, address the impact of attorney fees on reimbursement amounts, and provide a fair, workable formula for allocation of inadequate proceeds. Certainty is ERISA's cornerstone;¹²⁵ the clearest plans will inevitably change the dissonance to resonance in the pursuit of proceeds.

120. 154 F.3d at 173.

121. For examples of plan provisions addressing attorney fees, see *supra* note 29.

122. *Devine*, 27 F. Supp. 2d at 675.

123. See *supra* notes 5 and 32.

124. *Bollman Hat Co. v. Root*, 112 F.3d 113, 118 (3d Cir. 1997) (declaring that courts "may adopt a common law principle only if 'necessary to fill in interstitially or otherwise effectuate [ERISA's] statutory pattern enacted . . . by Congress'" (citations omitted)). If plan drafters do not fill the gaps, then, after considerable expense to all parties, courts ultimately will do so.

125. 29 U.S.C. § 1002(a)(1994) ("The Congress finds . . . that . . . it is desirable in the interests of employees and their beneficiaries . . . that disclosure be made and safeguards be provided with respect to the establishment, operation, and administration of [employee benefit] plans").