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## E.R.I.S.A. Subrogation As Interpreted Within the Seventh Circuit - A Roadmap for Managing First Dollar Recovery, 35 J. Marshall L. Rev. 765 (2002)

Gregory Pitts

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# E.R.I.S.A. SUBROGATION AS INTERPRETED WITHIN THE SEVENTH CIRCUIT – A ROADMAP FOR MANAGING FIRST DOLLAR RECOVERY

GREGORY PITTS\*

## THE PROBLEM

Lawyers representing injury victims now wrestle with this thorny scenario.<sup>1</sup> A new client consults about a collision in which he was blind-sided in an intersection. The client was severely injured, underwent multiple surgeries, and incurred medical expenses already exceeding \$100,000. He is still in treatment and will likely suffer permanent disability. The at-fault driver has only \$100,000 of liability insurance coverage. When the lawyer asks if the medical expenses have been paid, the client happily reports that his employer's health plan has paid everything. Unbeknownst to the client, in what seems to him a clear cut case, alarms are going off inside the lawyer's head in anticipation of what may terrorize both of them: ERISA subrogation.<sup>2</sup>

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\*J.D. Candidate, 2003. B.B.A. in Finance from The University of Wisconsin – Madison. I would like to thank my father, James, for his insight on this issue and the inspiration to tackle this profession and life in general. I would like to thank my mother, Elise, for her encouragement in all I pursue, and my wife, Leigh, for her patience and constant support.

1. See Martha Neil, *ERISA: Employee Benefits Law is Thorny As Ever, and Recent Changes Mean Lawyers Need to be Doubly Careful When Trekking Through the Brambles*, A.B.A. J., June 2001, at 54 (providing a real life example of the rigid effects of an Employee Retirement Income Security Act ("ERISA") plan's subrogation rights). Two New Jersey lawyers represented a 9-year-old boy who was severely burned by an exploding aerosol can that was thrown into a bon fire. *Id.* The boy incurred over \$1.2 million in medical expenses, which were paid by his parents' ERISA plan. *Id.* The plaintiffs settled the case for \$600,000 but a federal judge decided the ERISA plan's subrogation rights entitled it to recover all \$600,000. *Id.* The ERISA plan barred the injured boy from recovering any of the proceeds. *Id.* It also barred the attorneys from collecting contingent fees because no fund was available after the ERISA plan executed its first dollar priority. *Id.*

2. ERISA, prescribed under 29 U.S.C. §§ 1001 *et. seq.* (2000), is a set of federal laws that governs self-funded employee benefits programs. Among its many provisions is 29 U.S.C. § 1144(a)(2000), which provides federal preemption over any State laws that "relate to any employee benefit plan." 29 U.S.C. § 1144(a)(2000). This authorizes fiduciary plans to preempt State

Today, personal injury lawyers are reluctant to accept such cases on the customary contingent fee basis because they are aware of the problems presented by the Employee Retirement Income Security Act ("ERISA"), enacted by Congress in 1974.<sup>3</sup> In the above hypothetical, the \$100,000 of liability coverage would likely be collected from the at-fault driver without much dispute. However, both the client and attorney risk receiving nothing if the client's health plan is governed by ERISA. The health plan may be entitled to first dollar priority over any proceeds recovered by the client under its right to subrogation for medical expense payments.<sup>4</sup> If the health plan already paid over \$100,000 in medical expenses for the client, the health plan could take all of the \$100,000 settlement pursuant to its own right of subrogation prescribed in the plan. The attorney's lien for fees may be subordinate to the health plan's lien, and the permanently disabled client may never see a penny of the proceeds from his own case.<sup>5</sup>

This Comment seeks to provide a roadmap for managing ERISA subrogation within the Seventh Circuit. Part I discusses general issues to address when one confronts what appears to be an ERISA plan, and proposes ways to preclude ERISA subrogation. Specifically, Part I discusses the following issues: (A) the creation and applicability of federal and state common law,<sup>6</sup> such as the "make whole"<sup>7</sup> and "common fund"<sup>8</sup> doctrines; (B) whether the plan is indeed self-funded;<sup>9</sup> (C) whether the plan is

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subrogation laws and create their own rights to recovery of benefits paid. *Id.*

3. See Neil *supra* note 1, at 54-55 (stating that attorneys need to be on the lookout for ERISA issues); see also Earl Mettler, *Subrogation Rights of ERISA Plans*, TRIAL, Sept. 2000, at 57 (warning lawyers about the effects of ERISA and explaining how ERISA authorizes fiduciary plans to create provisions that preempt state subrogation laws, including attorney's liens for fees).

4. See Neil *supra* note 1, at 55 (stating that ERISA generally limits a plan participant's entitlement to recovery).

5. *Id.*

6. See Cutting v. Jerome Foods, Inc., 993 F.2d 1293, 1296 (7th Cir. 1993) (discussing the adoption of a federal common law rule preventing full reimbursement by ERISA plans).

7. See David M. Kono, *Unraveling the Lining of ERISA Health Insurer Pockets - A Vote for National Federal Common Law Adoption of the Make Whole Doctrine*, 2000 BYU L. REV. 427, 448-50 (2000) (explaining the equitable effects of the "make whole" doctrine and proposing its uniform application to all ERISA subrogation claims).

8. See Wal-Mart Stores v. Wells, 213 F.3d 398, 402 (7th Cir. 2000) (explaining that the common fund doctrine is a basic legal principle that entitles an attorney hired by one party to collect fees on a fund obtained for the benefit of several parties).

9. See 29 U.S.C. § 1003(b)(5) (2000) (requiring a plan to be completely self-funded in order to be covered by ERISA). The exact meaning of "self-funded" is an issue that is left somewhat open. See discussion *infra* at Part II. Also, note that this statute denies coverage to governmental and church plans,

seeking equitable relief or legal damages;<sup>10</sup> and (D) whether the plan can remove its claim to federal court.<sup>11</sup>

Part II of this Comment considers several issues that require scrutiny of the actual plan language, including: (A) whether the plan specifically provides for first dollar priority;<sup>12</sup> (B) the applicability of the plan's subrogation rights to the proceeds;<sup>13</sup> (C) whether there is a conflict between the actual plan language and the summary plan description;<sup>14</sup> and (D) the plan administrator's

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under 29 U.S.C. § 1003(b)(1) and (2) (2000), respectively.

10. See 29 U.S.C. § 1132(a)(3) (2000) (providing that a plan is only entitled to seek equitable relief in a civil action). The issue of whether enforcement of subrogation rights provides an equitable remedy, or whether it provides legal breach of contract damages, is a novel one. The Ninth Circuit ruled that a claim seeking to enforce subrogation rights is a claim for legal damages not permitted under ERISA. See generally *FMC Med. Plan v. Owens*, 122 F.3d 1258 (9th Cir. 1997); *aff'd by Reynolds Metals Co. v. Ellis*, 202 F.3d 1246 (9th Cir. 2000). See *infra* note 58, for further explanation of the case. On January 8, 2002, the United States Supreme Court ruled that an ERISA subrogation claim seeking to impose personal liability on the beneficiary for a contractual obligation to repay the plan constituted a claim for legal damages, which was not authorized by ERISA. *Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204, 122 S.Ct. 708, 712-13 (2002). The Supreme Court's decision affirmed the Ninth Circuit's opinion. *Id.* This decision will significantly affect ERISA subrogation claims and plan language in the future. The issue of whether a subrogation claim constitutes appropriate action for equitable relief under ERISA, or simply a prohibited legal claim for breach of contract damages, should now be more widespread in the Seventh Circuit. See discussion *infra* at Part III.

11. The Seventh Circuit in *Speciale v. Seybold*, 147 F.3d 612, 616 (7th Cir. 1998), followed its earlier decision in *Blackburn v. Sundstrand Corp.*, 115 F.3d 493, 494-95 (7th Cir. 1997) by holding that it was improper for an ERISA plan to remove the case to federal court in order to adjudicate liens. *Speciale*, 147 F.3d at 616. The ERISA plans' claims for subrogation were defenses to state claims seeking to apportion funds, and, therefore, the federal courts lacked subject matter jurisdiction because the claim did not arise under federal law. *Id.*; see also *Blackburn*, 115 F.3d at 494-95.

12. See *Sanders v. Scheideler*, 816 F.Supp. 1338, 1347 (W.D. Wis. 1993), *aff'd by unpublished order*, 25 F.3d 1053 (7th Cir. 1994) (holding that the common law make whole doctrine would be applied where a self-funded plan failed to assign priority rules to third party proceeds of settlement); see also *Schultz v. NEPCO Employees Mut. Benefit Ass'n, Inc.*, 528 N.W.2d 441, 445-46 (Wis. Ct. App. 1994) (holding that where an ERISA plan failed to set forth first dollar priority rules for third party settlements, the federal common law make-whole rule would apply).

13. See *Employers Health Ins. Co. v. Gen. Cas. Co. of Wis.*, 469 N.W.2d 172, 177 (Wis. 1991) (holding that a health insurer was not entitled to enforce subrogation rights against proceeds collected from the insured's uninsured motorist policy because the health plan's subrogation rights only applied to funds recovered from a "responsible third party," which the court determined did not include the insured's own automobile carrier).

14. See 29 C.F.R. § 2520.102-3 (2002) (requiring all ERISA plans to provide participants with a summary plan description ("SPD")); see also *Subrogation and Reimbursement Provisions Must Be Explained in SPDs Under DOL Regulations*, THOMPSON PUBLISHING GROUP, Jan. 2001, available at

discretion to interpret the plan language.<sup>15</sup>

Personal injury lawyers must be familiar with these issues when dealing with ERISA plans in order to maximize their clients' recoveries, and preserve their own fees.<sup>16</sup>

## I. HISTORY OF SUBROGATION IN PERSONAL INJURY CASES

Subrogation is based on the common law equitable doctrine that allows a party to gain priority over another party having a legal right or claim against a third party.<sup>17</sup> Insurance companies or self-insured employers paying their injured beneficiary's medical expenses often assert a right of subrogation over their beneficiary's legal claim against the third party that caused the injuries. In essence, the payor of benefits steps into the shoes of the injured person and collects the benefit legally owed to that person.<sup>18</sup> Although the right is derived from common law equity, today most claims base subrogation on conventional contractual principles.<sup>19</sup>

Subrogation has become controversial because of its effect on

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www.thompson.com (discussing the recent regulations issued by the U.S. Department of Labor that require plans to accurately explain their subrogation rights in their SPDs).

15. See *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989) (noting that if the plan fails to expressly confer discretion on the administrator to interpret the plan, a court may apply a de novo standard of review); see also *Fuller v. CBT Corp.*, 905 F.2d 1055, 1058 (7th Cir. 1990) (finding the plan trustees were given discretion over interpretation of terms).

16. See Neil *supra* note 1, at 54-55 (referring to ERISA as a "[h]ornets' [n]est" for unwary lawyers who have been victimized by ERISA subrogation).

17. 16 RONALD A. ANDERSON & MARK S. RHODES, *COUCH ON INSURANCE* 2D § 61:36 at 118-19 (2nd ed. Rev. 1983); see also ROBERT E. KEETON & ALAN I. WIDISS, *INSURANCE LAW* § 3.10(a)(1) (1988) (explaining how subrogation is based on equitable doctrines of common law). Subrogation is based on the idea that one who pays the expense of another is entitled to collect from the third party that caused such expense. ANDERSON & RHODES, *supra* at § 61:2. This prevents a debtor, or subrogor, from double recovery, on the grounds that if the subrogor were allowed to receive benefits from the creditor, or subrogee, he should not then be able to collect again from the third party that caused the original injury. *Id.* at § 61:18 at 93. The concept of subrogation is similar to the ordinary understanding of reimbursement, in that a creditor is entitled to repayment when the debtor obtains funds. See *BLACK'S LAW DICTIONARY* 1440 (7th ed. 1999) (defining subrogation as "[t]he substitution of one party for another whose debt the party pays, entitling the paying party to rights, remedies, or securities that would otherwise belong to the debtor"). See *id.* at 1290 (defining reimbursement as "repayment" or "indemnification"). Note that for the purposes of this Comment, no distinction will be made between the two concepts.

18. 16 ANDERSON & RHODES, *supra* note 17, § 61:36 at 118.

19. *Id.*; see *id.* § 61:2-3 at 75 (distinguishing legal and conventional subrogation on grounds that conventional subrogation is originated by contract, while legal subrogation "arises by operation of law").

the resolution of lawsuits.<sup>20</sup> Most states recognize the collateral source rule,<sup>21</sup> a rule adopted to ensure an injured party receives the total value of his or her loss.<sup>22</sup> This rule holds a tortfeasor liable for all damages, notwithstanding payments by a third party.<sup>23</sup> From a tort victim's perspective, subrogation sometimes frustrates the collateral source rule by preventing the victim from collecting all damages incurred.<sup>24</sup> If the payor of benefits has a right to subrogation, it is the payor, not the victim, who will collect

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20. See Roger M. Baron, *Subrogation: A Pandora's Box Awaiting Closure*, 41 S.D. L. REV. 237, 238 & 263 (1996) (explaining the history of subrogation and its harsh effects on personal injury cases today, including the windfalls for insurers that collect premiums from insureds, yet recoup all benefits provided upon recovery by the insureds).

21. See Dag E. Ytreberg, Annotation, *Collateral Source Rule: Injured Person's Hospitalization or Medical Insurance as Affecting Damages Recoverable*, 77 A.L.R.3d 415, 422 (discussing the general adoption of the collateral source rule and its effect on preserving full compensation for damages despite health insurance payments); see BLACK'S LAW DICTIONARY 256-57 (7th ed. 1999) (defining the collateral source rule as follows: "The doctrine that if an injured party receives compensation for its injuries from a source independent of the tortfeasor, the payment should not be deducted from the damages that the tortfeasor must pay.").

22. See *Koffman v. Leichtfuss*, 630 N.W.2d 201, 214-15 (Wis. 2001) (holding "the limitation is contrary to . . . the collateral source rule"); *Ellsworth v. Schelbrock*, 611 N.W.2d 764, 771 (Wis. 2000) (holding that the collateral source rule permits the injured party to collect the total value of his losses, and the amount of damages awarded is not reduced because the injured party received compensation from another source such as insurance).

23. *Koffman*, 630 N.W.2d at 214-15.

24. See generally Michelle Andrews, *Adding Insult to Injury: It's bad enough being hurt in an accident, but these days, health plans and hospitals are compounding the pain by claiming big parts of victims' settlements*, SMARTMONEY, July 1, 2000, at 130 (documenting several stories of individuals who were severely injured, collected from the tortfeasors, and were shocked to discover they had very little, if anything, coming to them personally due to the subrogation rights of their insurers). The lead story involves a 35-year-old man named Ridler who was hit head-on by an out-of-control minivan while riding his motorcycle only a block away from his home. *Id.* at 133. The accident left him severely crippled with multiple fractures and soft-tissue injuries. *Id.* Doctors questioned whether he would ever walk again. *Id.* Ridler settled his case against the adverse driver for \$450,000 while he remained hospitalized. *Id.* Ridler's pain was admittedly increased, however, upon learning that he would only be entitled to \$29,000 of the settlement after attorney's fees and subrogated liens were deducted. *Id.* Ridler's health insurer had a subrogated right to \$406,000 for medical expenses it paid, which was unavoidable in his jurisdiction. *Id.* Although the stories mentioned in the article do not involve ERISA plans, the subrogation clauses were just as effective because the cases proceeded in jurisdictions that did not recognize the make whole doctrine that would have prevented the majority of insurers involved from exercising their subrogation rights. The injured insureds in this article questioned why they are required to pay premiums when their insurers simply recoup their payments. *Id.* The article provides a view of subrogation from a personal and practical perspective. *Id.* at 133-36.

from the tortfeasor.<sup>25</sup> This can be particularly frustrating to victims who, upon notice of such subrogation, justifiably question why they paid premiums to the subrogor.<sup>26</sup> From the perspective of injured victims, subrogation may not seem so equitable after all.<sup>27</sup> Nevertheless, it remains a vital concept in many areas of insurance law.<sup>28</sup>

The response of some states to the discordant effects of subrogation is evident by their enactment or adoption of several common law doctrines, such as the make whole doctrine<sup>29</sup> and the common fund doctrine.<sup>30</sup> These doctrines mitigate some of the harsh effects of conventional subrogation by creating circumstantial exceptions to subrogation language in insurance policies or other contracts allowing for subrogation.

The make whole doctrine holds that a subrogated party cannot recover for payments rendered on behalf of an injured party unless or until the latter has recovered proceeds sufficient to compensate him for all damages in order to make him "whole" again.<sup>31</sup> This doctrine protects victims in situations where the tortfeasor only has a limited amount of insurance coverage from

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25. *Id.* at 133.

26. *Id.*

27. *Id.* at 133-36.

28. See Baron, *supra* note 20, at 238-39 (noting that subrogation existed without significant opposition in matters involving property insurance, but has now expanded to the health and automobile insurance industries).

29. See *id.* at 249-50 (listing the make whole doctrine as one doctrine created by state courts, which was designed to ameliorate the harshness of subrogation); see also Kono, *supra* note 7, at 449-50 (explaining the equitable effects of the make whole doctrine and proposing its uniform application to all ERISA subrogation claims); see generally 16 ANDERSON & RHODES, *supra* note 17, § 61:64 at 145-46 (explaining that no right of subrogation exists against the insured where compensation received by the insured is less than the actual loss).

30. See Baron, *supra* note 20, at 255-56 (listing the common fund doctrine as another doctrine created by state courts in order to ameliorate the harshness of subrogation); see generally 16 ANDERSON & RHODES, *supra* note 17, § 61:47 at 132 (explaining that litigation expenses, including contingent attorney fees, are paid out of the fund recovered before paying any money to the subrogated insurers).

31. See *Cutting* 993 F.2d at 1297-98 (weighing the pros and cons of the make whole doctrine that bars subrogation until the tort victim is fully compensated for his injuries). Judge Richard Posner, writing for the Seventh Circuit, discussed the plaintiff's request for federal common law adoption of the make whole doctrine. *Id.* at 1296. Judge Posner explained that the rule prohibits enforcement of subrogation rights until the "plan beneficiary has been made whole for the loss giving rise to the claim for benefits." *Id.*; see *Rimes v. State Farm Mut. Auto. Ins. Co.*, 316 N.W.2d 348, 355-56 (Wis. 1982) (adopting the make whole rule in Wisconsin and preventing an automobile insurance carrier from recovering medical payments made to its insured on the grounds that the insured was not fully compensated by the tortfeasor's liability insurer).

which to collect.<sup>32</sup> For example, in the above hypothetical, the client would collect the total \$100,000 from the tortfeasor's insurance (less attorney fees) since he clearly was not fully compensated for his damages. His medical expenses alone exceeded the amount recovered. Hence, the client was not made whole by the recovery, therefore his subrogated payor of benefits was not entitled to reimbursement. This doctrine has been recognized, although not always applied (because of state law inconsistencies) in all circuits, as an effective bar to subrogation claims.<sup>33</sup> It ensures that the injured party will receive all damages to the extent available before the payor of benefits is reimbursed.<sup>34</sup>

The common fund doctrine protects attorneys representing injured parties from subrogation rights otherwise jeopardizing their fees.<sup>35</sup> It permits an attorney to collect a contingent fee on a common fund collected through his own efforts for the benefit of several parties.<sup>36</sup> An attorney collecting from a tortfeasor often must distribute the proceeds to the injury victim and any additional parties with liens on such proceeds. The common fund doctrine allows an attorney to enforce his fee agreement as a lien superior to the fund before other liens are paid.<sup>37</sup> This prevents subrogated parties from reaping all the benefits a tort victim's attorney has produced. For example (again referring to the above hypothetical), this doctrine would prevent the subrogated health plan from taking all \$100,000 from the tortfeasor before the attorney collects his contingent fee share.

These two doctrines act as an established equitable check on subrogation by protecting an injured person's right to recovery from a tortfeasor and preserving attorney fees.<sup>38</sup> However, they

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32. See *Cutting*, 993 F.2d at 1298 (stating how the make whole doctrine prevents leaving the tort victim with an uncompensated injury).

33. See 16 ANDERSON & RHODES, *supra* note 17, § 61:64 at 145-46 (explaining the make whole rule and providing numerous citations to various circuits that follow it); see also Baron, *supra* 20, at 249-50 (noting that the make whole doctrine is the majority view).

34. See *Rimes*, 316 N.W.2d at 356 (noting that where the tort victim's damages "exceeded those received in settlement, the [victim] was not made whole" and the subrogated insurer was not entitled to any of the settlement proceeds).

35. See Neil, *supra* note 1, at 54 (demonstrating how attorneys who obtained a \$600,000 settlement on behalf of a burn victim were barred from collecting their contingent fees because ERISA said the money goes to the health insurance company).

36. See *Wal-Mart Stores v. Wells*, 213 F.3d 398, 402 (7th Cir. 2000) (explaining that the common fund doctrine is a basic principle that entitles the lawyer hired by one party to collect fees on the common fund he created for the benefit of several parties).

37. *Wells*, 213 F.3d at 402.

38. See *Agitation Over Subrogation and Coordination of Benefits*, ERISA LITIG. REP., October 1997, at 10 (complaining, from an ERISA plan's perspective, about the participants' lawyers' "joyful" discovery of how the



have occasionally been neutralized; and subrogation has burgeoned with the enactment of ERISA.

## II. ERISA ALTERS THE PLAYING FIELD

In 1974, Congress enacted ERISA as a set of federal laws to govern multi-state employers with self-funded employee benefit programs.<sup>39</sup> The ostensible purpose was to provide a uniform set of laws protecting employers from inconsistent state laws affecting their employee benefit program, that were threatened by prior laws.<sup>40</sup> ERISA added protection and stability to beneficiaries and interstate commerce by setting uniform standards of conduct and reporting requirements for fiduciary plans.<sup>41</sup>

Although ERISA encompasses numerous provisions governing fiduciary plans, it does not specifically establish subrogation rights for such fiduciaries.<sup>42</sup> ERISA is silent on subrogation, but it does provide that a plan shall be enforced according to the terms of the plan documents.<sup>43</sup> The private contractual provisions set forth in plan documents preempt certain state laws.<sup>44</sup>

Congress specifically prescribed for fiduciary plan provisions to “supersede any and all State laws” that “relate to any employee benefit plan.”<sup>45</sup> Courts commonly refer to this as the “preemption clause.”<sup>46</sup> Although various courts interpret the phrase “relate to” differently,<sup>47</sup> this provision is regularly interpreted to allow

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make whole and common fund doctrines make it easier to subvert subrogation claims).

39. See generally 29 U.S.C. §§ 1001(a)-(c)(2000) (codifying ERISA).

40. See LEE R. RUSS & THOMAS F. SEGALLA, COUCH ON INSURANCE 3D § 7:9 at 7-19 (1997) (explaining the many purposes and policies of ERISA).

41. *Id.*

42. See *Sanders v. Scheideler*, 816 F.Supp. 1338, 1345 (W.D. Wis. 1993) (stating that, “ERISA itself does not establish the terms upon which benefits are paid or reimbursed”); see also *Carpenter v. Modern Drop Forge Co.*, 919 F. Supp. 1198, 1201 (N.D. Ind. 1995) (stating that, “ERISA does not speak directly to the issue of subrogation rights”).

43. 29 U.S.C. § 1104(a)(1)(D) (2000)

44. 29 U.S.C. § 1144(a) (2000) states:

Supersede; effective date. Except as provided in subsection (b) of this section, the provisions of this title and title IV shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 4(a) [1003(a) of this title] and not exempt under section 4(b) [1003(b) of this title]. This section shall take effect on January 1, 1975.

*Id.*

45. *Id.*

46. *UNUM Life Ins. Co. of Am. v. Ward*, 526 U.S. 358, 363 (1999); *FMC Corp. v. Holliday*, 498 U.S. 52, 57 (1990) (discussing the breadth of 29 U.S.C. § 1144(a)'s “preemption clause”).

47. The phrase “relate to” has been the subject of much debate far beyond the scope of this Comment. The Supreme Court addressed the issue in several renowned opinions, including *Holliday*, 498 U.S. at 57-8; *Pilot Life Ins. Co. v.*

fiduciary plans to maintain first dollar priority over recoveries made by injured participants, notwithstanding attorneys fees liens, make whole doctrines, or any other contrary state law claims.<sup>48</sup> ERISA plans are given free reign to incorporate strong subrogation provisions into the plan language, which state laws cannot circumvent.<sup>49</sup> In other words, state laws protecting tort victims from non-ERISA insurers and health plans do not apply to ERISA plans.<sup>50</sup>

Congress enacted two additional provisions known as the “savings clause”<sup>51</sup> and the “deemer clause”<sup>52</sup> that narrow the breadth of ERISA preemption.<sup>53</sup> The savings clause provides that any state law that “regulates insurance” is exempted or saved from preemption.<sup>54</sup> Congress intended this clause to preserve the

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Dedeauz, 481 U.S. 41, 43-7 (1987); and Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724, 738-40 (1985). For more information on the differing interpretations of the phrase, see Horace Green, *Developments in ERISA Preemption and Standard of Review*, THE BRIEF, Spring 2001, 59, at 59-60 (discussing how the phrase “relate to” is too broad to be [a] useful” measure, and explaining the courts’ attempts to clarify the statute).

48. See *Holliday*, 498 U.S. at 65 (holding that ERISA preempted a Pennsylvania statute that precluded subrogation in actions arising out of the use of a motor vehicle); see also *Cutting*, 993 F.2d at 1296-99 (noting that any common law that prevents a subrogated party from full reimbursement would be preempted by clear ERISA plan language requiring full reimbursement without deduction).

49. See Ronald B. Grayzel, *Subrogation*, NEW JERSEY LAW., June 2001, 22, at 23 (stating that, “[w]hile the federal statute [ERISA] does not convey a right of subrogation, the plans have a right to incorporate a repayment provision in their enabling documents”).

50. See *Holliday*, 498 U.S. at 65 (holding that an ERISA plan is not subject to a state statute governing insurance companies).

51. See 29 U.S.C. § 1144(b)(2)(A) (2000) (stating: “[e]xcept as provided in subparagraph (B), nothing in this title shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities”).

52. 29 U.S.C. § 1144(b)(2)(B) (2000) states:

Neither an employee benefit plan described in section 4(a) [1003(a) of this title], which is not exempt under section 4(b) [1003(b) of this title] (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

*Id.*

53. See generally *Ward*, 526 U.S. at 363, 373-78; *Holliday*, 498 U.S. at 57-65; and *Metro. Life*, 471 U.S. at 732-748 (discussing the effects of, and interaction between, the “savings clause” and the “deemer clause,” prescribed under 29 U.S.C. §§ 1144(b)(2)(A) (2000) and 1144(b)(2)(B) (2000), respectively).

54. See 29 U.S.C. § 1144(b)(2)(A) (2000) (stating that ERISA does not preempt any state law that “regulates insurance”). Whether a law “regulates insurance” is subject to much debate, which, like the preemption clause, is

states' lawmaking power over the insurance industry as a whole.<sup>55</sup> The deemer clause provides that no fiduciary plan shall be deemed to be an insurance company within the scope of any state law purporting to regulate insurance companies or insurance contracts.<sup>56</sup> This clause modified the savings clause by explicitly prohibiting fiduciary plans from being treated as insurance companies for purposes of state insurance law.<sup>57</sup>

These statutes continue to generate considerable controversy

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beyond the scope of this Comment. However, the Supreme Court has created an analytical framework for determining whether a law falls within the savings clause, beginning with a common-sense interpretation of the clause. See *Metro. Life*, 471 U.S. at 740 (using a common-sense view of the phrase); See *Ward*, 526 U.S. at 367 (stating that precedent provides a framework for interpreting the phrase, starting with a "common-sense view"). The second step involves a three-factor test to determine whether a law fits within the "business of insurance," as that phrase has been interpreted by the McCarran-Ferguson Act, prescribed under 15 U.S.C. §§ 1011-1015 (2000), and enacted in 1948 to regulate insurance. *Metro. Life*, 471 U.S. at 743; see also 15 U.S.C. § 1011 (2000) (declaring the policy of the Act). A law is interpreted to regulate insurance if: (1) the law "transfer[s] or spread[s] a policyholder's risk"; (2) the law affects "an integral part of the policy relationship between the insurer and insured"; and (3) the law is "limited to entities within the insurance industry." *Metro. Life*, 471 U.S. at 743. In *Metro. Life*, the Supreme Court held that a Massachusetts mandated-benefit statute requiring minimum mental healthcare benefits be provided to an insured was a law that "regulates insurance" and was not preempted by ERISA. *Id.* at 746. The Court also noted that there is a "presumption against preemption," and "that [courts] are not inclined to read limitations into federal statutes in order to enlarge their preemptive scope." *Id.* at 741. In *Ward*, the Supreme Court held that a California notice-prejudice law, prohibiting an insurer from denying an untimely claim unless it can show it was prejudiced by the delay, was saved from preemption because it regulated insurance. *Ward*, 526 U.S. at 363, 373. In both cases, the Supreme Court analyzed the law under the framework described above.

55. See *Pilot Life*, 481 U.S. at 50 (holding that the common sense understanding of the savings clause means that "in order to regulate insurance, a law must not just have an impact on the insurance industry, but must be specifically directed toward that industry").

56. See 29 U.S.C. § 1144(b)(2)(B)(2000) (reciting the deemer clause).

57. See *Holliday*, 498 U.S. at 62 (following *Metro. Life* by holding that the deemer clause was intended to prevent benefit plans from being deemed as insurance companies for the benefit of protection under the savings clause). The Supreme Court explained that it was merely preserving Congress's intent to distinguish insured from uninsured plans. *Id.* Only insured plans are subject to state regulation because ERISA governs all qualified uninsured plans. *Id.* The Court held that a Pennsylvania statute precluding subrogation in actions arising out of the use of a motor vehicle was preempted by ERISA. *Id.* at 65. The Court acknowledged that the law "regulates insurance" under the savings clause, but explained that it also fell within the deemer clause. *Id.* at 60-61. The Court further explained that the deemer clause was intended to exclude self-funded ERISA plans from the reach of the savings clause, and that the plan involved in this case qualified as a self-funded ERISA plan. *Id.* at 62.

in personal injury subrogation law because they drastically change the rights of all interested parties. On January 8, 2002, the United States Supreme Court offered its interpretation in a limited decision to settle the federal circuits' differing interpretations of ERISA preemption, although it has made the topic increasingly debatable and arguably more complex.<sup>58</sup> Personal injury lawyers have developed strategies for dealing with ERISA subrogation<sup>59</sup> that this Comment presents in roadmap form.

### III. WAYS TO PRECLUDE ERISA SUBROGATION

The first step toward managing ERISA subrogation is to discover ways to preclude its application in the first instance. A personal injury lawyer should immediately address several issues when presented with a possible ERISA subrogation claim to unfold any effective means of barring preemption.

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58. See *Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204; 122 S.Ct. 708, 712-13 (2002) (affirming a Ninth Circuit decision barring an ERISA plan from enforcing its subrogation rights because the plan sought to impose personal liability on the beneficiary for a contractual obligation to repay the plan, which did not constitute a claim for equitable relief). This decision marks the first instance of agreement with, or acceptance of, the Ninth Circuit's position on the issue. See *FMC Med. Plan v. Owens*, 122 F.3d 1258, 1262 (9th Cir. 1997), *aff'd* by *Reynolds Metals Co. v. Ellis*, 202 F.3d 1246, 1249 (9th Cir. 2000) (holding that an ERISA plan is not entitled to enforce its subrogation rights because it is limited to seeking equitable relief under 29 U.S.C. §§ 1132(a)(3)). These Ninth Circuit opinions provided the most obvious distinction among the federal circuits prior to the United States Supreme Court decision in *Great-West*. The Ninth Circuit held that a claim for subrogation is actually a claim for legal damages resulting from breach of contract, which is prohibited by the statute. *Owens*, 122 F.3d at 1262. The Ninth Circuit's position has been scrutinized by other circuits prior to *Great-West*. See discussion *infra* at Part III.

59. See Nancy G. Ross and Michael T. Graham, *Great-West v. Knudson: The Impact on Subrogation and Reimbursement Rights and Section 502(a)(3) Remedies*, 15 BENEFITS L.J. 27, at 37-40 (announcing new strategies for ERISA plans to enforce their subrogation rights in the wake of *Great-West*). This article provides an ERISA plan's perspective on the aftermath of *Great-West*. It warns ERISA plans to ensure third-party recoveries remain traceable to the plan beneficiary in order to recover under a constructive trust or equitable restitution claim. *Id.* at 37-39. The article advises seeking the "issuance of preliminary injunction[s]" against beneficiaries to "enjoin dispersal of the third-party recovery after a . . . settlement or judgment." *Id.* at 38. Attorneys for beneficiaries should be wary of such novel approaches. See also ERISA LIT. REP., *supra* note 38, at 10 (expressing concern, from an ERISA plan's perspective, over legal loopholes that have been discovered by attorneys for beneficiaries to avoid ERISA subrogation); Ford & Harrison, LLP, *Avoiding the Make Whole Doctrine in ERISA Subrogation Cases*, MGMT. UPDATE, Dec. 1998, v. 20, no. 6 (describing methods for ERISA plans to uphold their subrogation rights against efforts to suppress such rights by beneficiaries).

### A. Utilize Federal or State Common Law When Applicable

An attorney should seek application of federal and state common law, such as the make whole and common fund doctrines, when confronted with an ERISA subrogation claim.<sup>60</sup> Although these doctrines have typically been preempted by ERISA,<sup>61</sup> they are worth asserting because of their popular acceptance and equitable effect.<sup>62</sup> Indeed, some cases give these doctrines credence and permit them to govern the ERISA subrogation claim by creative interpretation and strict construction of ERISA statutes.<sup>63</sup>

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60. See *Pilot Life*, 481 U.S. at 56 (stating that Congress intended federal courts to create federal common law to govern the rights and obligations under ERISA plans).

61. See *Holliday*, 498 U.S. at 65; *Newport News Shipbuilding Co. v. T.H.E. Ins. Co.*, 523 N.W.2d 270, 272-73 (Wis. Ct. App. 1994); and *Serembus v. Mathwig*, 817 F. Supp. 1414, 1423 (E.D. Wis. 1992) (holding that Wisconsin's make-whole doctrine would not be adopted as federal common law for self-funded employee plans subject to ERISA).

62. See *Cutting*, 993 F.2d at 1297-98 (commenting on the predominant acceptance of the make whole doctrine and implying that it is a good "thing").

63. See *Kavelaris v. MSI Ins. Co.*, 631 N.W.2d 665, 668-69 (Wis. Ct. App. 2001) (holding that the make whole doctrine satisfied all three McCarran-Ferguson Act factors, and, hence, was found to regulate insurance in accordance with the savings clause). This case involved a claim for reimbursement for \$130,900.78 of medical expenses paid by an ERISA plan to an injured tort victim when the victim settled with the tortfeasor's insurer for its \$200,000 policy limits. *Kavelaris*, 631 N.W.2d at 667. It was undisputed the victim was not made whole by the settlement. *Id.* at 668. The issue was whether ERISA preempted the make whole doctrine and entitled the plan to full reimbursement. *Id.* at 667. The court looked to the savings clause that bars preemption of "any law of any State which regulates insurance, banking, or securities." *Id.* at 668, citing 29 U.S.C. § 1144(b)(2)(A)(2000). In order to determine whether the make whole doctrine regulates insurance, the court used a "common sense view." *Id.* citing *Ward*, 526 U.S. at 367. The court also cited *Pilot Life*, 481 U.S. at 50, which proposed three additional factors derived from the McCarran Ferguson Act. *Kavelaris*, 631 N.W.2d at 668. The court did state, however, that not all three factors were required to prove a law falls within the savings clause. *Id.*, citing *Moran v. Rush Prudential HMO, Inc.*, 230 F.3d 959, 969 (7th Cir. 2000). The court applied the three-factor test to the make whole doctrine. *Id.* at 668-69. It explained that the doctrine was a requirement to be followed by the insurance industry and shifted the risk of recovery from the insured to the insurer. *Id.* at 669. The doctrine was found to be an integral part of the policy relationship between the insurer and insured because it affected the cost of every policy. *Id.* The court determined the doctrine was directed at insurance companies and was consistent with the savings clause. *Id.* See also *Blackburn v. Sundstrand Corp.*, 115 F.3d 493, 496 (7th Cir. 1997) (holding that the common fund doctrine was not preempted by ERISA, as it is a general law not "related to any employee benefit plan," as required under 29 U.S.C. § 1144(a) (2000)). The Seventh Circuit distinguished the common fund doctrine from the anti-subrogation law held preempted in *Holliday*. *Blackburn*, 115 F.3d at 496. The common fund doctrine's effect on the ERISA plan was determined to be merely "incidental." *Id.* See also *Wells*, 213 F.3d at 404 (holding that the plan was responsible for a pro rata share of attorney fees incurred by participant in obtaining settlement in personal

In *Cutting v. Jerome Foods, Inc.*, the Seventh Circuit Court of Appeals discussed the pros and cons of the make whole doctrine.<sup>64</sup> The court recognized that the make whole doctrine prevents the tort victim from an uncompensated injury in circumstances where, without the doctrine, all recovery from the tortfeasor would be paid to the subrogated plan.<sup>65</sup> The Seventh Circuit acknowledged that rejection of the make whole doctrine “makes subrogation a lot like assignment.”<sup>66</sup> On the other hand, it explained that rejection of the make whole doctrine might reduce the price of insurance and enable insureds to obtain more coverage.<sup>67</sup> Nevertheless, the Seventh Circuit declined to take a definitive stance on the issue, and decided the case on the basis that the plan fiduciary had administrative discretion to interpret the plan in the most favorable manner to it.<sup>68</sup>

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injury action). Wells was injured in a motor vehicle accident, and her ERISA plan paid \$10,982.61 for her medical expenses. *Id.* at 400. Wells settled her case for \$75,000 from the adverse driver’s insurer, which wrote out separate checks to Wells’s attorney for \$25,000, to the ERISA plan for \$10,982.61, and to Wells for the remainder. *Id.* at 400. Wells instructed her attorney not to distribute the check to the ERISA plan because it should be held responsible for a percentage of the attorney fees since it had benefited from collection. *Id.* at 400. The court stated:

“The plan documents entitled the [ERISA] plan to reimbursement of 100 percent of any [and all] benefits paid to a participant to the extent of ‘any payment resulting from a judgment or settlement, or other payment or payments, made or to be made by any person or persons considered responsible for the condition giving rise to the medical expense or by their insurers.’” *Id.* at 404.

Judge Posner explained that the ERISA plan was a contract that is founded on basic legal principles. *Id.* at 402. One basic principle is the common fund doctrine that entitles the lawyer hired by one party to collect fees on the common fund he created for the benefit of several parties. *Id.* The plan documents in this case failed to expressly repudiate the common fund principle. *Id.* Therefore, Judge Posner was able to hold that the plan did not alter the background understanding of the allocation of attorney fees. *Id.*

Judge Posner distinguished several conflicting cases that refused to reduce the ERISA plan’s lien by attorney fees. *Id.* at 403. He indicated that the plans in those cases had either included a provision that barred the application of the common fund doctrine, or expressly authorized the plan’s administrator with discretion to interpret the plan. *Id.* In cases where the administrator is given such discretion, the court’s review is deferential. *Id.* Judge Posner noted, however, that the presumption is against deference and that no reference to discretion was mentioned in the plan’s documents in this case. *Id.* Therefore, the court held that Wells was entitled to a pro rata reduction of the subrogation lien for attorney fees. *Id.* at 404.

64. See *Cutting*, 993 F.2d at 1297-98 (weighing the pros and cons of the make whole doctrine as well as the pros and cons of subrogation, and noting the difficulty in deciding which is the better rule).

65. *Id.* at 1298.

66. *Id.*

67. *Id.*

68. *Id.* at 1298-99; see also discussion *infra* at Part III.D.

Several courts have proposed, considered, and even accepted the adoption of the make whole doctrine as universal common law.<sup>69</sup> The United States District Court for the Western District of Wisconsin adopted the make whole doctrine as federal common law.<sup>70</sup> It held that the doctrine serves as a default rule, "consistent with the congressional mandate to fashion federal common law to facilitate the ERISA scheme."<sup>71</sup> The Seventh Circuit Court of Appeals affirmed the decision in an unpublished opinion, suggesting its acceptance of the make whole doctrine as federal law.<sup>72</sup>

Indiana and Illinois are two of the few states that have not adopted the make whole doctrine.<sup>73</sup> Indiana incorporated a pro rata reduction scheme when apportioning third party proceeds.<sup>74</sup> Under this method, a subrogation lien is reduced in proportion to the uncompensated damages of the plaintiff. For example (again using the above hypothetical), if the client's damages are \$300,000, but he can only collect \$100,000 from the tortfeasor, the subrogation lien for medical expenses would be reduced by two-

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69. *Cutting*, 993 F.2d at 1297-98; see also *Sanders*, 816 F.Supp. at 1347 (adopting the make whole doctrine as federal common law); see also *Hartenbower v. Elec. Specialties Co.*, 977 F. Supp. 875, 883 (N.D. Ill. 1997) (noting that considerable momentum and precedent exist for applying the make whole doctrine as a default rule, and holding that the make whole doctrine would be read into the ERISA plan).

70. *Sanders*, 816 F.Supp. at 1347.

71. *Id.*

72. *Murzyn v. Amoco Corp.*, 925 F. Supp. 594, 601 (N.D. Ind. 1995)

73. See *id.* at 600 (stating that Indiana is unlike the majority of jurisdictions in that it does not follow the make whole doctrine); *Capitol Indemnity Corp. v. Strike Zone*, 646 N.E.2d 310, 312 (Ill. App. Ct. 1995) (stating that Illinois declines to adopt equitable principles espoused by foreign authority, such as the make whole doctrine, so as not to upset the settled expectations of the parties as expressed in the policy); see also *In re Estate of Scott*, 567 N.E.2d 605, 607 (Ill. App. Ct. 1991) (stating that Illinois has never made a statement analogous to that of the *Rimes* court, which adheres to the make whole doctrine).

74. *Murzyn*, 925 F. Supp. at 600; IND. CODE ANN. § 34-51-2-19. Liens or claims to diminish in same proportion as claimant's recovery is diminished. The statute provides:

If a subrogation claim or other lien or claim that arose out of the payment of medical expenses or other benefits exists in respect to a claim for personal injuries or death and the claimant's recovery is diminished: (1) by comparative fault; or (2) by reason of the uncollectability of the full value of the claim for personal injuries or death resulting from limited liability insurance or from any other cause; the lien or claim shall be diminished in the same proportion as the claimant's recovery is diminished. The party holding the lien or claim shall bear a pro rata share of the claimant's attorney's fees and litigation expenses.

*Id.* see also Roy T. Tabor and Sue Rempert, *Subrogation Claims and Liens*, TABOR FELS & TABOR, 1, at 5-7 (citing the language changes in Indiana's statutes governing subrogation and calling them "fair and equitable").

thirds. The subrogated health plan would only receive one-third of its lien because the client was able to collect only one-third of his damages.

The United States District Court for the Northern District of Indiana adopted and applied the make whole doctrine to an ERISA subrogation claim as federal law.<sup>75</sup> It declined to apply Indiana's "pro rata" doctrine to ERISA subrogation for fear that it would undermine the express purpose of ERISA - uniformity among the states.<sup>76</sup> The district court determined that the make whole doctrine was the best approach, in light of the Seventh Circuit's acquiescence.<sup>77</sup>

A Wisconsin court of appeals recently upheld the make whole doctrine and found that it "regulates insurance" within the meaning of the savings clause.<sup>78</sup> Wisconsin recognizes the make whole doctrine as an essential part of subrogation claims.<sup>79</sup> The court determined that the make whole doctrine shifts policyholder risk from the insured to the insurer, an integral part of the policy relationship between the insured and insurer, and affects the cost of every insurance policy.<sup>80</sup> This detailed interpretation of the make whole doctrine should lead to a more liberal construction of ERISA preemption.

Wisconsin also recognizes the common fund doctrine as an equitable concept entitling an attorney to be compensated from the whole fund and those who directly benefit from its accumulation.<sup>81</sup> The United States District Court for the Eastern District of Wisconsin permitted a one-third reduction of an ERISA plan's subrogated interest to reflect the attorney's fees generated in obtaining recovery from the tortfeasor.<sup>82</sup> The court so decided on

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75. *Murzyn*, 925 F. Supp. at 601.

76. *Id.*

77. *See id.* (stating that the legal precedent currently supports application of the make whole doctrine to bar ERISA preemption when the beneficiary has not been fully compensated).

78. *Kavelaris*, 631 N.W.2d at 668-69.

79. *See Rimes v. State Farm Mut. Auto. Ins. Co.*, 316 N.W.2d 348, 355-56 (Wis. 1982) (adopting the make whole doctrine that prevents an insurer from obtaining reimbursement when the beneficiary has not been fully compensated for underlying tort injuries).

80. *See Kavelaris*, 631 N.W.2d at 668-69 (holding that the make whole doctrine satisfied the McCarran-Ferguson Act three prong test).

81. *See State Farm Mut. Auto. Ins. Co. v. Geline*, 179 N.W.2d 815, 819-21 (Wis. 1970) (adopting the common fund doctrine as an equitable concept subject to the following conditions: creation of a fund; timely notice to the subrogated party of the intent to collect fees on the entire fund; lack of joinder of the subrogated party; and reasonable attorney fees).

82. *See Serembus v. Mathwig*, 817 F. Supp. 1414, 1423 (E.D. Wis. 1992) (holding that the subrogation amount should be reduced by one-third because the ERISA plan benefited from the beneficiary's pursuit of her claims). *But see also Johnson v. Ziegler*, 27 Employee Benefits Cas. 2591, 2002 WL 725126, at \*18 (Wis. Ct. App. June 11, 2001) (holding that the common fund doctrine does



the basis that the ERISA plan would not have recovered anything but for the attorney's success in the underlying tort action.<sup>83</sup>

Indiana codified the common fund doctrine in a separate statute applicable to all subrogation claims by insurers.<sup>84</sup> However, the United States District Court for the Northern District of Indiana held that the statute and common law may preempt ERISA if the plan specifically requires the beneficiary to pay his or her own attorney's fees.<sup>85</sup>

Illinois recently permitted the common fund doctrine to withstand ERISA preemption under some circumstances.<sup>86</sup> The Illinois Supreme Court held that ERISA did not preempt the common fund doctrine because that doctrine is a common law rule of general application, which was outside the scope of ERISA preemption.<sup>87</sup> The court determined that an attorney's claim under the common fund doctrine was an independent action based

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not apply when the ERISA plan contains an "opt-out" provision specifically barring its application). This case was decided on April 25, 2002, and has been recommended for publication.

83. *Supra* note 82.

84. IND. CODE § 34-53-1-2 states:

An insurer claiming subrogation or reimbursement rights under this chapter shall pay, out of the amount received from the insured, the insurer's pro rata share of the reasonable and necessary costs and expenses of asserting the third party claim. These reasonable and necessary costs and expenses include and are not limited to the following: (1) The cost of depositions. (2) Witness fees. (3) Attorney's fees to the lesser of: (A) the amount contracted by the insured for the insured's portion of the claim; or (B) thirty-three and one-third percent (33 1/3%) of the amount of the settlement.

*Id.*

85. See *Carpenter v. Modern Drop Forge Co.*, 919 F. Supp. 1198, 1206 (N.D. Ind. 1995) (following *Serembus* and entitling the beneficiary to a one-third reduction of the subrogation amount to represent the portion of attorney's fees incurred in recovering from the tortfeasor); *but see* *Engle v. Wal-Mart Assoc. Health & Welfare Plan*, 48 F. Supp. 2d 1114, 1120-21 (N.D. Ind. 1999) (distinguishing *Carpenter* on the grounds that the ERISA plan language in this case specifically required 100% reimbursement, notified participants that they were responsible for their own attorney's fees, and vested discretion in the plan administrator to interpret the plan in a light most favorable to the plan).

86. See *Bishop v. Burgard*, 764 N.E.2d 24, 34 (Ill. 2002) (holding that ERISA does not preempt the application of the common fund doctrine); *see also* *Scholtens v. Schneider*, 671 N.E.2d 657, 668 (Ill. 1996) (holding that the common fund doctrine's effects on ERISA plans are "too tenuous, remote, or peripheral" to justify finding that the doctrine "relates to" such plans); *but see* *Estate of Lake v. Marten*, 946 F. Supp. 605, 611, n.5 (N.D. Ill. 1996) (disagreeing with *Scholtens* and holding that the common fund doctrine affects the contractual relationship between the ERISA plan and the participant where the doctrine's only purpose was to reduce the subrogation lien); *but see also* *Blackburn*, 115 F.3d at 495-96 (upholding *Scholtens* and the application of the common fund doctrine to ERISA subrogation claims).

87. *Bishop*, 764 N.E.2d at 29.

upon the attorney's rights, which was wholly unrelated to the ERISA plan.<sup>88</sup> The Illinois Supreme Court stated that the policy behind the common fund doctrine is to prevent "freeloading" by subrogated parties.<sup>89</sup>

An earlier Illinois Supreme Court opinion determined that the common fund doctrine could not be characterized as an antisubrogation law because it applies to a wide range of civil cases.<sup>90</sup> The court also noted that the common fund doctrine did not arise out of any subrogation agreement between the tort victim and the ERISA plan, but was simply a "quasi-contractual right" to compensation invoked by the attorney obtaining recovery in the victim's underlying tort action.<sup>91</sup>

The United States District Court for the Northern District of Illinois has explicitly disagreed with the Illinois Supreme Court.<sup>92</sup> The district court determined that an action for application of the common fund doctrine is not an action for unpaid attorney fees independent of the subrogation claim.<sup>93</sup> Rather, the district court concluded that it was an action to avoid reimbursing the ERISA plan the full amount of benefits it paid to the tort victim.<sup>94</sup> The district court noted that the common fund doctrine benefited the tort victim only by reducing the subrogation lien, and that the attorney would have recovered attorney fees notwithstanding its application.<sup>95</sup> Thus, the district court held that the common fund doctrine did affect the contractual relationship between the tort victim and the ERISA plan, thereby bringing it within the preemption authority of ERISA.<sup>96</sup>

The Seventh Circuit Court of Appeals subsequently clarified the common fund issue.<sup>97</sup> It held that the common fund doctrine was not preempted by ERISA, and permitted a pro rata reduction of the medical expense subrogation lien to reflect attorney fees incurred in generating the settlement.<sup>98</sup> The Seventh Circuit held that the common fund doctrine is a general law not related to any employee benefit plan.<sup>99</sup> It further noted that the doctrine's effect on ERISA subrogation was merely incidental.<sup>100</sup> However, the

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88. *Id.* at 32.

89. *Id.* at 34.

90. *Scholtens*, 671 N.E.2d at 664.

91. *Id.* at 664-65.

92. *Estate of Lake*, 946 F. Supp. at 611, n.5.

93. *Id.*

94. *Id.*

95. *Id.*

96. *Id.*

97. See *Blackburn*, 115 F.3d at 495-96 (holding that the common fund doctrine is not sufficiently related to an ERISA plan to warrant preemption).

98. *Id.* at 496.

99. *Id.*

100. *Id.*

court did suggest that the plan would have a better argument if its documents expressly required its participants to pay their own attorney fees.<sup>101</sup> This dicta implies that ERISA plans can obviate the common fund doctrine by including language sufficient to give it first dollar priority over all liens.<sup>102</sup> Although attorneys should be wary of such language once they obtain the actual plan,<sup>103</sup> they should strive for application of the common fund doctrine early in the litigation on the substantive grounds discussed above.

The foregoing cases created a self-confessed “web of ERISA confusion,”<sup>104</sup> which leaves attorneys ample opportunity to present novel, yet sound arguments on their clients’ behalf. Attorneys for beneficiaries should argue for application or adoption of state common law make whole and common fund doctrines in federal common law to preclude first dollar recovery by ERISA plans.

### B. Discover Whether the Plan is Truly Self-Funded

An attorney should always ascertain whether a plan is actually self-funded, or whether an insurance policy pays its participants’ claims. A plan must be completely self-funded in order for ERISA preemption to apply.<sup>105</sup> If a plan purchased insurance for its participants, state laws regulating the insurance industry, including the make whole and common fund doctrines, apply and the plan will avoid ERISA preemption.<sup>106</sup>

The Wisconsin decision of *Kavelaris*, which saved the make whole doctrine from ERISA preemption, also ruled that the plan was not subject to ERISA preemption under the deemer clause because it was not completely self-funded.<sup>107</sup> The court noted that the employer purchased an insurance policy from a separate insurance company and paid premiums to cover medical expenses

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101. *Id.*

102. See *Johnson*, 2002 WL 725126, at \*18 (Wis. Ct. App. 2002) (barring application of the common fund doctrine pursuant to the ERISA plan’s opt-out provision).

103. See discussion *infra* at Part III. A. (explaining the importance of scrutinizing the plan language).

104. *Murzyn*, 925 F. Supp. at 601.

105. See *Holliday*, 498 U.S. at 61 (stating that only self-funded ERISA plans are exempt from state regulation, and that an insurance company that insures a plan remains subject to state laws); see also *Metro. Life*, 471 U.S. at 732 (stating that ERISA plans that purchase insurance are governed by state insurance regulation).

106. See *Kavelaris*, 631 N.W.2d at 669 (holding that the plan was subject to state insurance regulation including the make whole doctrine because the ERISA plan purchased insurance for its participants).

107. See *id.* (noting that the deemer clause does not apply to negate the ERISA savings clause because the ERISA plan was insured under a policy regulated by Wisconsin insurance laws, which included the make whole doctrine).

of its employees.<sup>108</sup> The court differentiated uninsured employee benefit plans directly governed by federal law from insured plans governed by state law.<sup>109</sup> The court then held that the make whole doctrine governed the plan under Wisconsin common law.<sup>110</sup>

Attorneys must also be mindful of “stop-gap” or “stop-loss” insurance that is insurance over an underlying limit.<sup>111</sup> Some employer plans purchase this form of umbrella insurance to protect employer assets if an employee should sustain a catastrophic injury generating massive medical expenses.<sup>112</sup> Although attorneys can make a plausible argument that such a plan is not completely self-funded, the only case addressing this issue within the Seventh Circuit reached the opposite conclusion.<sup>113</sup> The court ruled that a self-funded employee benefit plan with stop-loss insurance covering the plan itself, rather than individual beneficiaries, is not deemed an insurance provider under ERISA, hence, the plan was not subject to state laws regulating insurance.<sup>114</sup> However, it should be noted that the Seventh Circuit subsequently ruled ERISA does not preempt state laws requiring state assessments on stop-loss insurers.<sup>115</sup> This decision may pave the way for the argument that ERISA should not preempt state subrogation laws relating to payments made by stop-loss insurers.

Attorneys must promptly discover whether a plan is indeed self-funded. Such investigation can be made through plan tax returns and plan language. Correspondence with plan trustees or

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108. *Id.* at 667.

109. *Id.* at 669.

110. *Id.*

111. BLACK'S LAW DICTIONARY 807 (7th ed. 1999) defines “stop-loss insurance” as:

Insurance that protects a self-insured employer from catastrophic losses or unusually large health costs of covered employees. Stop-loss insurance essentially provides excess coverage for a self-insured employer. The employer and the insurance carrier agree to the amount the employer will cover, and the stop-loss insurance will cover claims exceeding that amount.

*Id.*

112. *Id.*

113. *See* Ramsey County Med. Center, Inc. v. Breault, 525 N.W.2d 321, 325 (Wis. Ct. App. 1994) (holding that a self-funded plan is entitled to first dollar subrogation even though stop-loss insurance coverage existed for catastrophic losses payable by the plan above a prescribed annual limit).

114. *Id.*

115. *See* Safeco Life Ins. Co. v. Musser, 65 F.3d 647, 653-54 (7th Cir. 1995) (discussing the relation between stop-loss insurers and ERISA plans, and holding that state assessments on insurance policies sold to ERISA plans do not interfere with the ERISA plan's administration significantly enough to implicate preemption). The court noted that the state assessments could reduce the benefits an ERISA plan would offer its participants, but concluded that the assessments had applied to all insurers and was not sufficiently connected to ERISA plans. *Id.*

administrators, and discovery of all plan documents, including the summary plan description or booklet, is imperative to verifying the uninsured and self-funded status of the plan. This step is vital in determining which laws govern the claim, and will significantly affect the rights of all involved parties.

*C. Distinguish Between Equitable Relief and Legal Damages*

Under ERISA, a plan may only bring a civil action for equitable relief against a plan participant.<sup>116</sup> Attorneys for beneficiaries may validly argue that a plan seeking enforcement of its subrogation rights is actually seeking legal damages for breach of contract, which is not permitted under ERISA.<sup>117</sup> The United States Supreme Court has upheld this argument by affirming a Ninth Circuit decision on similar grounds.<sup>118</sup>

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116. 29 U.S.C. § 1132(a)(3) (2000) states:

[A] civil action may be brought. . .

by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this title 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 title or the terms of the plan.

*Id.* See *Great-West*, 122 S.Ct. at 713 (stating that “an injunction to compel payment of money due under a contract, or specific performance of a past due monetary obligation, was not typically available in equity” and were not considered equitable remedies permitted under ERISA); see also *Mertens v. Hewitt Assoc.*, 508 U.S. 248, 255 (1993) (discussing equitable relief versus money damages in ERISA); *Health Cost Controls of Ill., Inc. v. Wash.*, 187 F.3d 703, 710 (7th Cir. 1999) (distinguishing legal damages from equitable relief, and stating that where an ERISA plan seeks either restitution for breach of fiduciary duty, or imposition of a constructive trust, it is properly regarded as an equitable remedy).

117. See *Great-West*, 122 S.Ct. at 719 (holding that an ERISA subrogation claim seeking to impose personal liability on the beneficiary to pay the plan pursuant to a contractual obligation was not authorized by ERISA as it did not constitute a claim for equitable relief); see also *Ross & Graham*, *supra* note 60, at 34-37 (distinguishing available equitable claims from prohibited legal claims and “conclud[ing] that equitable relief under [29 U.S.C. § 1132(a)(3)] does not include the following: (1) injunctive relief to compel payment of money past due or (2) ‘restitution’ of amounts due unless the money, or its proceeds remain in the possession of the defendant”); The court in *Wells* stated:

[A] plaintiff cannot convert a claim of damages for breach of contract into an equitable claim by the facile trick of asking that the defendant be enjoined from refusing to honor its obligation to pay the plaintiff what the plaintiff is owed under the contract and appending to that request a request for payment of the amount owed.

*Wells*, 213 F.3d at 401.

118. See *Great-West*, 122 S.Ct. at 719 (affirming a Ninth Circuit decision barring ERISA subrogation where the plan sought to impose personal liability on the beneficiary to repay the full extent of benefits provided). This case marked the first Supreme Court decision barring ERISA subrogation on the basis of improper legal relief. *Id.* at 715. The Supreme Court distinguished

In *Great West*, the ERISA plan beneficiary was rendered quadriplegic from a motor vehicle accident.<sup>119</sup> The underlying tort action was settled, and a substantial portion of the proceeds was set aside in a special needs trust for future medical care pursuant to state law.<sup>120</sup> The rest of the settlement was distributed among the injured beneficiary, her attorney, Medi-Cal and the ERISA plan, with the plan recouping only a fraction of its lien.<sup>121</sup> The plan then sued to collect the entire amount of benefits paid.<sup>122</sup> The Ninth Circuit affirmed a summary judgment to the beneficiary on the basis that reimbursement through funds provided by a third party was not equitable relief permitted under ERISA.<sup>123</sup> The Supreme Court granted certiorari to address the issue.<sup>124</sup>

The Supreme Court noted that the plan language held the beneficiary “personally liable to the plan” for any funds not reimbursed after recovery from a third party.<sup>125</sup> The Supreme Court held that equitable relief under ERISA does not encompass “injunction[s] to compel payment” under a contract, or specific performance to pay a contractual obligation.<sup>126</sup> It also

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legal damages from equitable relief by using a historical analysis of equitable remedies. *Id.* at 712-19. The Supreme Court concluded that “injunction[s] to compel the payment of money past due . . . or specific performance of a past due monetary obligation, [were] not typically available in equity.” *Id.* at 713. The Supreme Court also distinguished between equitable and legal restitution. *Id.* at 714-17. It determined that equitable restitution is only permitted when the defendant has possession of something that rightfully belongs to the plaintiff. *Id.* at 714. Therefore, an ERISA plan could not recover money from a beneficiary unless that beneficiary actually had the money in her possession. *Id.* at 715. In this particular case, the settlement proceeds were in possession of a special needs trust set aside for future medical care, so the ERISA plan had no viable claim for equitable restitution. *Id.* See also *FMC Med. Plan v. Owens*, 122 F.3d 1258, 1262 (9th Cir. 1997), re-affirmed by *Reynolds Metals Co. v. Ellis*, 202 F.3d 1246, 1249 (9th Cir. 2000) (holding that a claim for subrogation by an ERISA plan is actually a legal claim for breach of contract damages against a beneficiary, which is not permitted by 29 U.S.C. §§ 1132(a)(3)).

119. *Great-West*, 122 S.Ct. at 711.

120. *Id.*

121. *Id.* The injured beneficiary settled her underlying tort action for \$650,000.00. *Id.* The settlement allocated \$256,745.30 to a special needs trust for future medical care pursuant to a California statute; “\$373,426.00 to attorney’s fees and costs; \$5,000 to reimburse a California Medicaid program;” and \$13,828.70 to the ERISA plan for reimbursement of past medical expenses. *Id.* The plan had already paid \$411,157.11 for the beneficiary’s medical expenses. *Id.* The plan never cashed the check received from settlement, which only amounted to three percent of its total lien, and brought suit against the beneficiary to recover the full extent of benefits provided. *Id.* at 712.

122. *Id.* at 712.

123. *Id.*

124. *Id.*

125. *Id.* at 711.

126. *Id.* at 713.

distinguished equitable restitution from legal restitution by explaining that the former requires money or property to belong "in good conscience" to the plaintiff and to be clearly in the "defendant's possession."<sup>127</sup> In this case, the settlement proceeds did not "in good conscience" belong to the plan and were not in the defendant's possession.<sup>128</sup> The Supreme Court noted that a substantial portion of the proceeds were in the rightful possession of the special needs trust.<sup>129</sup> This was the critical factor for the decision because the beneficiary did not have possession of the proceeds.<sup>130</sup> Therefore, the plan could not claim equitable restitution against the beneficiary and was barred from making any legal claims under the express language of ERISA.<sup>131</sup> Unlike the Ninth Circuit, the Supreme Court did not bar all ERISA subrogation on this basis, and implied that a plan could still recoup its payments in equity by seeking to impose a constructive trust under different facts.<sup>132</sup> Nevertheless, this decision barring the imposition of personal liability on a beneficiary to reimburse an ERISA plan has opened the door to another effective argument against ERISA subrogation.

Courts within the Seventh Circuit have generally upheld ERISA plan subrogation rights.<sup>133</sup> However, even prior to the Supreme Court decision, the Seventh Circuit had seemed partial to adoption of the Ninth Circuit's reasoning.<sup>134</sup> In dicta, the Seventh Circuit stated that "money due . . . [on] a contract is 'quintessentially an action at law,'"<sup>135</sup> and an ERISA plan could not make it an equitable action merely by seeking specific performance of the duty to pay.<sup>136</sup>

The Seventh Circuit did note that the settlement proceeds in

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127. *Id.* at 714.

128. *Id.* at 715.

129. *Id.*

130. See Ross & Graham, *supra* note 59, at 35 (explaining the Supreme Court's rationale in *Great-West* that the ERISA plan could not recover under equitable restitution because the settlement proceeds did not go directly to the beneficiary, rather to her special needs trust and attorney).

131. *Great-West*, 122 S.Ct. at 717.

132. *Id.* at 714.

133. See *Admin. Comm. v. Jay*, 135 F. Supp. 2d 941, 943 (N.D. Ill. 2001) (enforcing ERISA subrogation rights as an equitable remedy on the grounds that the ERISA plan language prescribed for "100% repayment of the loan," which constituted a "classic instance of restitution."); see also *Wells*, 213 F.3d at 401 (enforcing ERISA subrogation on the grounds that the ERISA plan was seeking to impose a constructive trust, which is within the concept of equity).

134. See *Wells*, 213 F.3d at 401 (stating that an ERISA plan cannot convert a claim for money due on a contract to an equitable claim in order to validate a claim under ERISA preemption).

135. *Id.* (quoting *Hudson View II Assoc. v. Gooden*, 644 N.Y.S.2d 512, 516 (N.Y. App. Div. 1996)).

136. *Id.*

the underlying tort action were being held by the beneficiary's lawyer, presumably in an escrow account.<sup>137</sup> The ERISA plan was seeking to impose a constructive trust on the money that had been intercepted by the lawyer.<sup>138</sup> The Seventh Circuit explained that a constructive trust is a "form of equitable relief against someone . . . who is holding property that is rightfully the [claimant's]."<sup>139</sup> Therefore, the plan was authorized by ERISA to pursue its subrogation claim against the beneficiary because it constituted a claim for equitable relief.<sup>140</sup>

In making its decision, the Seventh Circuit noted its prior decision in *Admin. Comm. v. Gauf*, where the court concluded that "all claims of reimbursement by an ERISA plan [qualified] as equitable" claims under its broad preemption clause.<sup>141</sup> It also observed that the Ninth Circuit had reached an opposite result in three decisions, where it held that subrogation claims constituted legal claims for breach of contract damages.<sup>142</sup> Nevertheless, the Seventh Circuit declined to further address the issue, holding that a suit for constructive trust was well within the concept of equity.<sup>143</sup>

Courts within the Seventh Circuit have subsequently interpreted the United States Supreme Court's decision differently.<sup>144</sup> The United States District Court for the Northern District of Illinois has upheld an ERISA plan's subrogation rights under equitable restitution claims,<sup>145</sup> yet denied another plan's rights asserted under a constructive trust theory.<sup>146</sup> These

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137. *Id.*

138. *Id.*

139. *Wells*, 213 F.3d at 401.

140. *Id.*

141. *Id.*; see *Admin. Comm. v. Gauf*, 188 F.3d 767, 770-71 (7th Cir. 1999) (holding that a claim for subrogation is a claim for specific performance of a contract, which is equitable relief authorized by ERISA).

142. *Wells*, 213 F.3d at 401; see discussion *supra* note 58 (explaining the Ninth Circuit opinions in *Owens* and *Ellis*).

143. *Wells*, 213 F.3d at 401.

144. See *Ross & Graham*, *supra* note 60, at 37-40 (discussing the impact of *Great-West* on subsequent cases, and citing two recent district court opinions within the Seventh Circuit that came to opposite results with regard to ERISA subrogation claims).

145. See *Admin. Comm. of Wal-Mart Stores, Inc. v. Varco*, No. 01-C-8277, 2002 WL 47159, at \*2 (N.D. Ill. Jan. 14, 2002) (distinguishing *Great-West* and upholding the ERISA plan's claim for equitable restitution where the plan sought to recover funds in the beneficiary's possession); see also *Primax Recoveries, Inc. v. Duffy*, 204 F. Supp 2d. 1111, 1113 (N.D. Ill. 2002) (distinguishing *Great-West* and upholding equitable restitution where the specific funds sought had not yet been received by the beneficiary).

146. See *Primax Recoveries, Inc. v. Sevilla*, No. 00-C-6869, 2002 WL 58816, \*4 (N.D. Ill. Jan. 15, 2002) (citing *Great-West* and denying the ERISA plan's subrogation rights under a constructive trust theory on the basis that it constitutes a legal claim for the imposition of an obligation to pay money).



decisions demonstrate the ongoing complexity of and problems associated with ERISA subrogation claims within the Seventh Circuit.

Attorneys for beneficiaries may assert that a claim for ERISA subrogation is actually one for legal breach of contract damages, or legal restitution, prohibited by ERISA.<sup>147</sup> The Supreme Court decision has significantly limited an ERISA plan's right to subrogation by emphasizing the distinction between equitable relief and legal damages.<sup>148</sup> This decision has provided the opportunity for the Seventh Circuit to preclude ERISA subrogation by limiting the scope of available remedies.

#### D Prevent Removal to Federal Court

A plan raising ERISA preemption as a defense is not thereby entitled to remove a case to federal court.<sup>149</sup> The Seventh Circuit has ruled that federal courts lack subject matter jurisdiction over state law claims seeking to apportion funds.<sup>150</sup> In *Speciale v. Seybold*, the plaintiff was injured in an automobile collision and the ERISA plan paid a majority of the medical expenses.<sup>151</sup> The plaintiff brought a state law tort claim against the adverse driver and settled prior to trial.<sup>152</sup> The plaintiff filed a motion to adjudicate liens in state court.<sup>153</sup> The ERISA plan removed the case to federal court upon assertion of preemption.<sup>154</sup> The United States District Court for the Northern District of Illinois ordered complete reimbursement to the plan.<sup>155</sup> On appeal, the Seventh Circuit ruled that removal was improper because the original suit involved a state law claim, and the ERISA plan had raised its preemptive status as a defense to a motion brought within a state law case.<sup>156</sup> The court stated, "The issues raised in the plaintiff's complaint, not those added in the defendant's response, control the litigation."<sup>157</sup> The court held that while ERISA confers complete preemption in actions brought by plan participants to recover

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147. See *Great-West*, 122 S.Ct. at 719 (barring ERISA subrogation where the plan sought to impose personal liability on the beneficiary for failure to reimburse the plan pursuant to a contractual obligation).

148. *Id.* at 717-19.

149. See *Speciale v. Seybold*, 147 F.3d 612, 616-17 (7th Cir. 1998), (following *Blackburn*, 115 F.3d at 494-95 (7th Cir. 1997) stating "emphatically that removal under ERISA preemption was improper based on the well-pleaded complaint rule").

150. *Speciale*, 147 F.3d at 617.

151. *Id.* at 614.

152. *Id.*

153. *Id.*

154. *Id.*

155. *Id.*

156. *Speciale*, 147 F.3d at 616-17.

157. *Id.* at 614 (quoting *Jass v. Prudential Health Care Plan, Inc.*, 88 F.3d 1482, 1486 (7th Cir. 1996)).

benefits, it does not apply to defenses raised by a plan.<sup>158</sup> The court reversed and remanded the case back to state court for adjudication of the liens under state law.<sup>159</sup>

This holding authorizes state trial courts within the Seventh Circuit to adjudicate liens on settlements of or judgments on state law claims. Attorneys should submit motions to adjudicate liens in state court actions when an ERISA subrogation claim is identified, and assert the “well-pleaded complaint” rule<sup>160</sup> when the ERISA plan seeks removal to federal court in its responsive pleading. Pursuant to the latest Seventh Circuit decisions, a court should prohibit removal when only an apportionment of funds issue is presented in conjunction with a state law cause of action.<sup>161</sup>

#### IV. SCRUTINIZE PLAN LANGUAGE FOR LOOPHOLES

If an attorney realizes that ERISA subrogation cannot be obviated on general grounds, the next step is to scrutinize the ERISA plan language for alternative means of negating the subrogation claim. Several issues, when raised, may effectively preclude an ERISA plan from first dollar recovery, or at least force it to prove entitlement to the proceeds.

##### A *Look for First Dollar Priority*

It is imperative to scrutinize the plan’s policy language to determine if in fact it provides for first dollar priority. As discussed above, some courts have adopted the make whole doctrine as a default common law rule applicable when a self-funded plan fails to assign priority to third party settlement proceeds.<sup>162</sup> If an ERISA plan merely includes a right to recovery

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158. *Speciale*, 147 F.3d at 615-16.

159. *Id.* at 617.

160. BLACK’S LAW DICTIONARY 279 (7th ed. 1999) defines a “well-pleaded complaint” as follows:

An original or initial pleading that sufficiently sets forth a claim for relief – by including the grounds for the court’s jurisdiction, the basis for the relief claimed, and a demand for judgment – so that a defendant may draft an answer that is responsive to the issues presented. A well-pleaded complaint must raise a controlling issue of federal law for a federal court to have federal-question jurisdiction over the lawsuit.

*Id.*; see also *Speciale*, 147 F.3d at 614-15 (stating that the well-pleaded complaint rule “prevents the defendant from controlling the litigation and obtaining a transfer to federal court by federal preemption when the defendant raises a federal question in the responsive pleadings”).

161. See *Speciale*, 147 F.3d at 617 (remanding a federal case to state court for adjudication of liens incidental to a state law tort action).

162. See *Sanders*, 816 F.Supp. at 1347 (applying the make whole doctrine as default federal common law); see also *Schultz v. NEPCO Employees Mut. Benefit Ass’n, Inc.*, 528 N.W.2d 441, 445-46 (Wis. Ct. App. 1994) (holding that the federal common law make-whole rule applied to an ERISA plan which failed to set forth first dollar priority rules for third party settlements); see

of benefits paid, counsel for the beneficiary should contend that it failed to expressly assert superiority over other liens or to repudiate state law doctrines governing lien adjudication.

Several Seventh Circuit decisions have refused to enforce an ERISA subrogation lien because the plan language failed to expressly require first dollar priority over all other liens.<sup>163</sup> The Seventh Circuit has also upheld the common fund doctrine when an ERISA plan failed to expressly require its participants to either pay their own attorney fees, hire an attorney waiving the common fund doctrine, or remit the gross rather than the net recovery.<sup>164</sup> If it is determined that the plan language does not specifically require first dollar priority or fails to disclaim common law doctrines,<sup>165</sup> the ERISA plan's subrogation rights may be suppressed.

### B Determine Whether the Plan's Subrogation Rights Apply

It must be determined whether the ERISA plan's subrogation rights apply to the particular nature of recovery. An automobile collision victim may recover directly from the offending motorist, and/or from his or her own insurance via uninsured or underinsured coverage. A plan may limit subrogation to proceeds collected from "a party that caused the injury."<sup>166</sup> If the proceeds

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*also* *Ninaus v. State Farm Mut. Auto. Ins. Co.*, 584 N.W.2d 545, 551 (Wis. Ct. App. 1998) (stating that the default application of the make whole doctrine was not inconsistent with other cases in which there is an absence of a first dollar priority clause in the policy language).

163. *See Blackburn*, 115 F.3d at 496 (stating that an ERISA plan would have had a better argument for enforcing its subrogation rights if it expressly required participants to pay their own legal fees); *see also Wells*, 213 F.3d at 402 (upholding the common fund doctrine where the ERISA plan failed to expressly repudiate it); *see also* discussion *supra* note 161 (citing *Sanders* and *Schultz* as cases that applied the make whole doctrine by default where the ERISA plan failed to expressly provide for first dollar priority).

164. *Blackburn*, 115 F.3d at 496.

165. *Accord Cagle v. Bruner*, 112 F.3d 1510, 1520-21 (11th Cir. 1997) (holding that the make whole doctrine applies where ERISA plan does not expressly disavow it); *see also Ford & Harrision, LLP, supra* note 59 (listing "Disclaim the 'make whole' doctrine in your plan" as the number one affirmative step plan administrators should take to enforce ERISA subrogation).

166. *See Employers Health Ins. Co. v. Gen. Cas. Co. of Wis.*, 469 N.W.2d 172, 177 (Wis. 1991) (holding that the language in a health insurance policy providing for subrogation against any "responsible third party" was insufficient to allow subrogation against the proceeds of a uninsured motorist policy, because the uninsured motorist carrier was not an insurer of the tortfeasor, and, hence, was not "responsible"); *but see Dailey v. Secura Ins.*, 476 N.W.2d 299, 301 (Wis. Ct. App. 1991) (holding that the language in a health insurance policy providing for subrogation against "any party who may be liable" was broad enough to include an uninsured motorist carrier). Although these cases did not involve ERISA plans, there is no reason to believe the same arguments, analysis, and decisions could not be made against

come from the victim's own uninsured motorist policy, such plan will have no claim because the uninsured motorist carrier obviously did not cause the injury.<sup>167</sup>

Attorneys should also be aware of which party is bound by the plan language. If the language binds only the employee personally, any benefits provided to members of his family may be beyond the reach of plan subrogation.<sup>168</sup> This is important for attorneys to realize when dealing with ERISA subrogation claims for benefits paid to people other than the individual employee.

Further, Illinois has recognized a qualified immunity from subrogation liens for minors extending to ERISA subrogation claims.<sup>169</sup> This rule is based on a statute holding parents of an injured minor responsible for the minor's medical expenses.<sup>170</sup> Thus, the parents, not the minor, benefit from payments for medical expenses by the ERISA plan.<sup>171</sup> Subrogation liens against a minor are deemed invalid because the payments were not made to or on behalf of the minor.<sup>172</sup> Hence, the ERISA plan cannot recover its payments from the minor or the minor's estate.<sup>173</sup>

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their subrogation interests as well.

167. See *Employers Health*, 469 N.W.2d at 177 (holding that the ERISA plan did not have a right to enforce subrogation against proceeds recovered under an uninsured motorist policy, as they were not proceeds collected from the tortfeasor).

168. See *Wahl v. N. Telecom, Inc.*, 726 F. Supp. 235, 242-43 (E.D. Wis. 1989) (holding that an ERISA plan's language, entitling the plan to subrogation if the employee received any benefits from the plan, was insufficient to enforce subrogation rights against the employee's minor daughter). The employee signed the ERISA plan agreement that required him to "promptly repay the employee benefit plan if and when [he] receive[d] payment(s) for the injury or sickness from or on behalf of the responsible person." *Id.* at 242. The court noted that the employee's daughter had never signed the contract and that only she had received benefits from the plan. *Id.* at 242-43. The court concluded that the ERISA plan had no contractual right to subrogation and to enforce subrogation against the employee's daughter would essentially change the contract, which the court was not prepared to do. *Id.* at 243.

169. See *Klem v. Mann*, 665 N.E.2d 514, 517 (Ill. App. Ct. 1996) (stating that "[a] firm line of [Illinois] appellate cases [have] established the rule that subrogation liens against recoveries received by minors' estates are not valid.>").

170. See 750 ILL. COMP. STAT. 65/15(a)(1) (2000) (stating that "[t]he expenses of the family . . . shall be chargeable upon the property of both husband and wife . . ."). This statute is referred to as the Family Expense Act. *Klem*, 665 N.E.2d at 517.

171. See *Klem*, 665 N.E.2d at 517 (stating that since the parents are responsible for making medical payments, it is they who receive the benefit ERISA plan payments).

172. *Id.*

173. *Id.*; see *Estate of Aimone v. Health Benefit Plan*, 619 N.E.2d 185, 187 (Ill. App. Ct. 1993) (holding insurer's subrogation lien against recoveries made by a minor's estate invalid because it was the parents who benefited from the medical expense payments, not the minor or the minor's estate); see also *Kelleher v. Hood*, 605 N.E.2d 1018, 1022-23 (Ill. App. Ct. 1992) (holding that

One exception to this rule entitles a plan to subrogation against a minor's recovery from the tortfeasor. The exception exists when a minor, or his/her parents on his/her behalf, manifests an intent for the minor to become a third-party beneficiary of the plan.<sup>174</sup> This occurs when a minor, or his/her parent on his/her behalf, signs a plan contract agreeing to reimburse the plan to the extent of benefits provided.<sup>175</sup>

### C Look for a Conflict Between the Plan Language and SPD

ERISA plans must provide participants with a summary plan description ("SPD").<sup>176</sup> These SPDs provide a synopsis of the actual plan language to inform the beneficiary of both contracting parties' rights.<sup>177</sup> The actual plan language should be compared to the language used in the SPD. Recent changes to the federal regulations now require SPDs to explain subrogation and reimbursement rights.<sup>178</sup>

A Wisconsin court of appeals noted, in *Ninaus v. State Farm Mut. Auto. Ins. Co.*, that if the terms of the SPD and a plan conflict, the document favoring the participant governs.<sup>179</sup> In that case, the SPD "precluded subrogation unless the insured [was] 'made whole'."<sup>180</sup> However, the SPD included a disclaimer that the actual plan language governed the nature and extent of benefits.<sup>181</sup> The court held that "when terms of an [SPD] and policy conflict,

an ERISA plan's subrogation lien against a minor's settlement proceeds is invalid because medical expenses paid on behalf of the minor are deemed to benefit the parents, not the minor); *see also* Estate of Woodring v. Liberty Mut. Fire Ins. Co., 389 N.E.2d 211, 212 (Ill. App. Ct. 1979) (holding that an insurer's subrogation lien is invalid against a minor's settlement proceeds because the minor's estate has not received any benefit from the payment of medical expenses).

174. *See* Sosin v. Hayes, 630 N.E.2d 969, 972 (Ill. App. Ct. 1994) (holding that the insurer's subrogation lien against the minor's estate was valid because the minor's mother assigned her rights to reimbursement for medical expenses to the minor, thereby making the minor a third-party beneficiary to payments made under the policy).

175. *Id.*; *see also* In re Estate of Scott, 567 N.E.2d 605, 606 (Ill. App. Ct. 1991) (upholding an ERISA plan's subrogation lien against a minor's settlement proceeds because the minor was "named as a covered dependent under his father's health plan . . .," and "the parties manifested their intent" to make the minor a third-party beneficiary).

176. 29 C.F.R. § 2520.102 (2001).

177. 29 C.F.R. § 2520.102-2 (2001); *see also* THOMPSON PUBLISHING GROUP *supra* note 14 (stating that "[SPDs] must clearly explain a plan's subrogation . . . rights.>").

178. 29 C.F.R. § 2520.102-3(k)(1)(2001).

179. *See Ninaus*, 584 N.W.2d at 550 (holding that when terms of an SPD conflict with the actual plan language, the terms that favor the participant will govern).

180. *Id.* at 547.

181. *Id.* at 548.

the terms which favor the participant will govern, regardless of disclaimers (read or unread) or detrimental reliance.<sup>182</sup> The court found the conflict sufficient to extinguish the ERISA plan's subrogation rights since the plaintiff was not made whole by the settlement in her underlying tort action.<sup>183</sup>

Subsequently, an Indiana appellate court issued a similar decision.<sup>184</sup> In *United of Omaha v. Hieber*, the court held that an ERISA plan may be bound to the terms of the SPD when the latter conflicts with the plan language, upon a showing of detrimental reliance upon the SPD.<sup>185</sup> The court added the element of detrimental reliance to the beneficiary's burden of proof. Thus, counsel must ask beneficiaries for all the plan documents they relied on, as well as the actual plan, when confronted with ERISA subrogation.

#### D Measure the Administrator's Discretion

The administrator's discretion to interpret the plan must be assessed. The United States Supreme Court has determined that a deferential standard of review is appropriate where the plan administrator has discretionary authority to construe plan terms.<sup>186</sup> In such instances, the court limits review to an abuse of discretion standard.<sup>187</sup> However, if the plan fails to expressly confer such discretion to the administrator, a de novo standard of review may apply.<sup>188</sup>

The Seventh Circuit has ruled that ERISA does not unconstitutionally delegate authority to preempt state law to plan administrators where first dollar recovery contravenes the make whole doctrine.<sup>189</sup> Indeed, the Seventh Circuit refused to apply the

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182. *Id.* at 550 (quoting *Springs Valley Bank & Trust Co. v. Carpenter*, 885 F.Supp.1131, 1139-42 (S.D.Ind. 1993)).

183. *Id.* at 547.

184. *See United of Omaha v. Hieber*, 698 N.E.2d 869, 875 (Ind. App. Ct. 1998) (stating that when a beneficiary detrimentally relies on the SPD's subrogation language, and the SPD conflicts with the ERISA plan language, the ERISA plan is bound to the SPD).

185. *Id.*

186. *See Bruch*, 489 U.S. at 111 (holding that "[T]rust principles make a deferential standard of review appropriate when a trustee exercises discretionary powers.").

187. *Id.* at 111-12; *see also Fuller v. CBT Corp.*, 905 F.2d 1055, 1058 (7th Cir. 1990) (holding that where a plan empowers a trustee or administrator to interpret the plan, the court can only overturn that person's determination by finding abuse of discretion).

188. *Bruch*, 489 U.S. at 112.

189. *See Land v. Chicago Truck Drivers*, 25 F.3d 509, 513-14 (7th Cir. 1994) (dismissing a participant's claim that ERISA unconstitutionally delegates congressional authority to plan administrators by permitting them to, in essence, determine what laws will govern employee benefit plans). The court concluded that ERISA plans are contracts between private parties, and that

make whole doctrine where the ERISA plan vested discretion in the plan administrator.<sup>190</sup> The Seventh Circuit held that the plan administrator was not unreasonable in interpreting the plan language to disclaim the make whole doctrine.<sup>191</sup> Other courts within the Seventh Circuit have followed this approach<sup>192</sup> that significantly impairs a beneficiary's opportunity to bar ERISA subrogation. Nevertheless, attorneys should take advantage of ERISA plans that fail to confer discretion to the plan administrator.

#### CONCLUSION

Today, ERISA subrogation affects many personal injury claims. To effectively handle them, lawyers must know and understand ERISA. If not timely detected or recognized, ERISA subrogation will create financial hardship for clients and their lawyers.<sup>193</sup> Attorneys must be ready to deal with ERISA subrogation claims when presented, and be able to intelligently inform clients of their effects. If handled appropriately, ERISA subrogation will not constitute a complete bar to recovering first dollar proceeds for a tort victim. This Comment seeks to provide a valuable recipe of strategies for coping with ERISA subrogation within the Seventh Circuit.

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ERISA specifically refrained from dictating the substantive content of such plans. *Id.*

190. See *Cutting*, 993 F.2d at 1298-99 (stating that the court was fortunate it did not have to decide whether to apply the make whole doctrine on the merits of the rule because it was bound to a deferential standard of review). Since the plan expressly conferred discretion to the plan administrator, the court concluded that it was not unreasonable for the plan administrator to interpret the plan as barring application of the make whole doctrine. *Id.* at 1299.

191. *Id.*

192. See *Bruzas v. Quezada-Garcia*, 642 N.W.2d 207, 212 (Wis. Ct. App. 2002) (affording substantial deference to the administrator's interpretation of the plan and enforcing the plan's subrogation rights); see also *Newport News Shipbuilding*, 523 N.W.2d at 272-73 (holding that an ERISA plan vested discretion in the trustees to interpret the plan, and since the plan was interpreted as granting first dollar priority in a subrogation claim, the state make-whole rule was trumped); see also *Siska v. Travelers*, 467 N.W.2d 174, 178-79 (Wis. Ct. App. 1991) (stating that an ERISA plan giving authority to the plan administrator to construe the plan provisions is reviewable only by an arbitrary and capricious standard).

193. Neil, *supra* note 1, at 54.