





# Subrogation Rights Under ERISA Governed Health Plans

By Robert E. Hoskins

One of the most frequently encountered situations where an attorney confronts the Employee Retirement Income Security Act of 1974 (ERISA) is when he or she just won or settled a personal injury case and the client's health insurer wants to be reimbursed out of the settlement proceeds for monies that the insurer previously paid to plaintiff's medical providers (i.e., a subrogation claim). Most health insurance policies are governed by ERISA, which can be tricky. The average practitioner may be forced to deal with ERISA on subrogation claims despite the fact that his or her practice has nothing to do with ERISA.

This article is not intended to be exhaustive, and certainly each case will have its own unique facts. However, this article will describe in general terms how to analyze subrogation rights of an ERISA governed health plan.

When you learn of a subrogation claim, you should immediately obtain the entire plan document containing the subrogation term giving rise to the claim. (If the insurer or plan won't provide it, which most will, the employer who sponsors the plan is required by ERISA to provide the plan document within 30 days of a written request (29 U.S.C.S. § 1132(c)).) Never take for granted that because someone is asserting a subrogation right, that the person actually has one. Always review the actual plan document giving rise to the subrogation interest and the specific language contained therein. If the plan is an ERISA plan, then any subrogation right will be governed by the specific language of the plan. (See 29 U.S.C.S. § 1104; See also *Lockhart v. UMWA 1974 Pension Trust*, 5 F.3d 74 (4th Cir. 1993), "The award of benefits under an ERISA plan is governed in the first instance by the language of the plan itself. Citing *Callahan v. Rouge Steel Company*, 941 F.2d 456, 460 (6th Cir. 1991)."

In fact, the Fourth Circuit has recognized that employers and insurers have almost complete con-

trol over the substance of their plans or policies as they relate to subrogation provisions. In *Kress v. Food Employers Labor Relations Association and United Food and Commercial Workers Health and Welfare Fund, et. al.*, 391 F.3d 563 (4th Cir. 2004), the court stated:

"We adhere to plan documents unless they contravene ERISA or other binding authority. But ERISA "does not mandate any minimum substantive content for [welfare benefit] plans." *Stinnett*, 154 F.3d at 172.

"Employers have large leeway to design disability and other welfare plans as they see fit." *Black & Decker Disability Plan v. Nord*, 538 U.S. 822, 833, 155 L.Ed.2d 1034, 123 S. Ct. 1965 (2003).

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Indeed, ERISA neither requires a welfare plan to contain a subrogation clause nor does it bar such clauses or otherwise regulate their content." *Ryan by Capria-Ryan v. Federal Express Corp.*, 78

F.3d 123, 127 (3d Cir. 1996). Subrogation clauses requiring reimbursement are, in fact, quite common. See Amber M. Anstine, Comment, *ERISA Qualified Subrogation Liens: Should They Be Reduced to Reflect a Pro Rata share of Attorney Fees?*, 104 Dick. L. Rev. 359, 360 (2000). ERISA allows plans broad discretion to draft such clauses. Plans could forego any reimbursement unless and until the participant is "made whole." They could provide for attorney fees to be paid in full before the plan is reimbursed at all. They could share the expense of legal fees in a pro-rata fashion, proportionally reducing their reimbursement to reflect the attorney fee. They could adopt a "reasonable fee" policy, meaning that they will subtract from the amount of the required reimbursement whatever they would have spent in legal fees to recover the advance they had paid. Or, as here, they may require that attorney fees be paid only after the Fund is reimbursed in full. See *Sunbeam-Oster Co., Inc.*

*Group Benefits Plan v. Whitehurst*, 102 F.3d 1368, 1372-74 (5th Cir. 1996) (discussing different possibilities but recognizing that it is the language of the plan that determines which applies)."

When reviewing plan language and even after obtaining the plan document from the insurer or employer, always ask the client whether he or she has any other plan booklets or documents. The logic of compiling all available plan documents is if there is more favorable language in one plan document or the other, an argument can be made that the more favorable language governs over more burdensome language. (See *Aiken v. Policy Management Services*, 13 F.3d 138 (4th Cir. 1993).) After compiling the plan documents, review and compare the language of the subrogation terms, if there are any. Usually subrogation terms will be under a heading of "Right to Reimbursement," "Right to Repayment," "subrogation" or some other such language. Sometimes, policies will even have an exclusion in the nature of a subrogation right such as "we do not pay benefits for treatment of an injury for which a third-party is responsible." Always review the whole policy including the exclusion and limitation sections.

Read the plan language carefully. Just because the plan provides a subrogation right does not necessarily mean that it is applicable to your client's recovery.

By way of example, there was a case several years ago where a firm settled a wreck case and received \$15,000 from the liability carrier and a significant amount from an underinsured motorist carrier (UIM). The client's health insurer paid approximately \$90,000 in benefits for medical bills from the accident. Of course, the health insurer asserted its subrogation claim. The specific language of the plan document only provided the insurer a subrogation right against any liability coverage. The subrogation provision said nothing about recovery against UIM coverage. Ultimately, the insurer accepted a very small pro rata amount of

the \$15,000 liability coverage in satisfaction of the entire subrogation claim because it agreed that its subrogation right only extended to liability coverage and not UIM.

Evaluating the specific language of the plan should always be the first course of action. However, if after reviewing the language of the plan it appears repayment cannot be avoided based upon the plan's plain language, then further analysis is appropriate. At this next juncture, some critical issues should be evaluated. First, *never* assume that a case is governed by ERISA, which can be a rather burdensome law. South Carolina subrogation law is more "plaintiff friendly." (If ERISA applies it preempts most state law (29 U.S.C.S. § 1144).) ERISA only applies to health insurance provided as a part of an employee benefit plan. (See 29 U.S.C.S. § 1002(3) (the definition of "employee benefit plan" and *Custer v. Pan American Life Insurance Company*, 12 F.3d 410 (4th Cir. 1993) discussing what constitutes an ERISA plan).) There are many factors that go into evaluating whether a case is governed by ERISA, but suffice it to say, never assume conclusively that a case is governed by ERISA without a proper analysis. It is essential in determining whether a case is governed by ERISA to know the identity of your client's employer who sponsors the plan. 29 U.S.C.S. § 1003 provides that ERISA does not apply to "governmental plans" or "church plans." Governmental plans cover state employees, city employees, county employees and employers of other quasi-public entities such as public hospitals. (A good analysis for determining whether a plan is a governmental plan is described in *Rose v. Long Island Railroad Pension Plan*, 282 F.2d 910 (2d Cir. 1987), *cert. denied*, 485 U.S. 936, 108 S. Ct. 1112; 99 L.Ed.2d 273 (1988).

Religious plans govern employees of churches and church related entities and may apply to individuals who are employed with private hospitals or schools with strong ties to a particular religion. (Government plans and church plans are defined in 29 U.S.C.S. § 1002; See also *Lown v. Continental Casualty Company*, 238 F.3d 543 (4th Cir. 2000), (addressing factors to be

considered in determining what is a church plan).) There are other ways to "get out" of ERISA, so do not automatically concede ERISA's applicability without a careful analysis.

One of the reasons you may want to "get out" of ERISA, if you can, is because South Carolina has some equitable statutes that apply to subrogation claims but that *may* be preempted if the subrogation claim is governed by ERISA. South Carolina Code § 38-71-190 provides that if a subrogation interest would result in inequity, then the plaintiff may appeal to the director of the South Carolina Insurance Department to have the subrogation claim reduced or even disallowed. The statute further provides that "attorneys fees and costs *must* be paid by the insurer from the amounts recovered." If § 38-71-190 applies, then the insurer must reduce its lien to allow for the costs of recovery.

Additionally, South Carolina Code § 38-77-160 provides that UIM benefits are not subject to subrogation or assignment. Obviously, if the case is not governed by ERISA, then state statutes may apply.

If ERISA is applicable, then there is another evaluation to be made. If ERISA is applicable and state law is preempted, all may not be lost. Even if a plan is an ERISA plan, an argument can be made on the applicability of the above state statutes. Although ERISA preempts most state laws, it does not preempt state laws that "regulate insurance" (See 29 U.S.C.S. § 1144). In order to determine the applicability of the above state statutes, it is crucial to determine whether the ERISA plan asserting the subrogation right is "self funded" or "insured." An example of a self funded plan is a situation where an employer has set aside money to fund a health plan for its employees or pays claims out of its general assets. Often such self-funded plans hire an administrator to run the plan. When claims are made, all of the dollars used to pay the claims are being paid by the employer, and therefore, the fund is referred to as a self funded plan. Sometimes self funded plans will purchase reinsurance or "stop loss" insurance coverage, and it

would make sense to argue that the reinsured plan is not really a self funded plan. However, the Fourth Circuit has held that a self funded plan that is reinsured is still a self funded plan. (*See American Medical Security v. Bartlett*, 111 F.3d 358 (4th Cir. 1997).) Because self-funded plans are often administered by national health insurance companies, they sometimes appear at first glance to be insured plans when, in reality, they are not. The plan document is required to disclose the source of funding and structure for the plan, which is another reason why the entire document should be obtained. (*See* 29 U.S.C.S. § 1022 requiring the plan's summary plan document to set forth both the name of the plan and the source of the funding.)

If a plan is not self funded, then it is insured. An insured plan is one where the employer simply purchases health insurance for its employees. The importance of determining whether a plan is self funded or insured is evident in reviewing ERISA's preemption section. (29 U.S.C.S. § 1144.) Although ERISA preempts most state laws, it saves from preemption those laws specifically regulating insurance. (29 U.S.C.S. § 1144(b)(2)(A).) Although there is no published case directly on point, a good argument can be made that the above South Carolina subrogation statutes "regulate insurance." Several of our district court judges and the Court of Appeals have held that other sections found in Title 38 of the South Carolina Code are not preempted by ERISA because the statute at issue regulates insurance. (*See Newton v. Blue Cross Blue Shield, et. al.*, C/A No.: 6:97-12-20 (D.S.C. 1997) and *Greenville Hospital System v. Provident Life and Accident Insurance Company*, 330 S.C. 436, 499 S.E.2d 232 (1989).) *See also ERISA Pre-emption*. . . § S.C.L.Rev. 743 (1991) (which discusses how to determine whether a particular statute regulates insurance).

Even if the plan is an ERISA plan, an argument can be made that the above state laws are not preempted. However, the argument that the South Carolina subrogation laws are not preempted can *only* be

made with insured plans. The "savings" clause, which exempts from ERISA preemption laws "regulating insurance," *only* applies in the case of insured plans. ERISA specifically states that no self funded plan shall be deemed an insurance company for the purposes of the savings clause. (29 U.S.C.S. § 1144(b)(2)(B).) Therefore, if the ERISA plan is self funded, then all South Carolina statutory law is preempted.

However, all is not lost even if the ERISA plan is self funded. Some federal courts have adopted the "make whole" doctrine as a part of the federal common law. The make whole doctrine basically says that where the language of a specific ERISA plan does not address whether a claimant must be compensated for all of his damages before a subrogation right will be honored, then the court will adopt the make whole doctrine so that a subrogation claim will not be valid unless and until the person has been "made whole." (*See Fields v. Farmers Insurance Company*, 18 F.d. 831 (10th Cir. 1994); *Guy v. Southeastern Iron Workers Welfare Fund*, 87 F.2d 37 (11th Cir. 1989); *Cutting v. Gerome Foods, Inc.*, 993 F.2d 1293 (7th Cir. 1993), *cert. denied*, 114 S.Ct. 308 (1993); *Cagle v. Bruner*, 112 F.d. 1510 (11th Cir. 1997).) However, the Fourth Circuit has specifically rejected the make whole doctrine when the language of the plan document is unambiguous. (*See United McGill Corporation v. Stimet*, 154 F.3d 168 (4th Cir. 1998).) The Fourth Circuit has not addressed, in a published case, the make whole doctrine when a plan has ambiguous language. The make whole doctrine only serves as a last ditch theory if the other means of reducing or avoiding the subrogation claim fail and then can only be argued in this circuit if the language of the plan is ambiguous.

Another federal common law theory that can be employed is the "common fund" doctrine. Unlike the make whole doctrine, which in equity protects the entitlement of the injured person, the common fund doctrine theoretically protects the entitlement of attorneys to their fees (again, South Carolina Code § 38-71-190 provides that an insurer assert-

ing a subrogation claim must pay costs and attorneys fees). The common fund doctrine basically is a common law theory mirroring § 38-71-190 and holds that, where a lawyer is responsible for obtaining a lump sum of funds, all of those who benefit from the recovery must pay their fair share of attorneys' fees. By asserting the common fund doctrine, an attorney can argue that the health insurer or subrogating party must pay its fair share of fees. (*See Ryan v. Federal Express Corp.*, 78 F.d. 123 (3rd Cir. 1996); *Bollman v. Root*, No. 96-1191 (3rd Cir. 1997); and *Waller v. Hormel Foods Corp.*, 120 F.d. 138 (8th Cir. 1997).) The Fourth Circuit Court of Appeals has not recognized the doctrine in an ERISA context, and in *United McGill*, the court specifically rejected such an argument.

It bears mentioning that the plaintiff's attorney in a personal injury case actually has an ethical obligation to address any subrogation claim of which he or she has notice. (*See* S.C.R.P.C. Rule 1.15 and South Carolina Bar Ethics Advisory Opinions 93-14, 93-31, 94-20, 9-29.) If an attorney has actual knowledge of a subrogation claim, then the "attorney must hold the disputed funds in trust until such time as the dispute" over the subrogation claim is resolved. (South Carolina Bar Ethics Advisory Opinion 05-08.) However, if the attorney is not aware of the lien and funds are disbursed to the client, then what are the plan's rights to pursue recovery on its subrogation claim?

There have been some significant cases in the last several years that answer the foregoing question. The U.S. Supreme Court has held that a health insurer cannot sue its plan participant to recover monies (or damages) under ERISA. (*See Great West v. Knudson*, 534 U.S. 204; 122 S. Ct. 708; 151 L.Ed.2d 635 (2002).) *Great West* is significant for several reasons. First, the court does *not* state that a plan is foreclosed from suing under ERISA to establish a constructive trust on identifiable monies. The insurer or plan may file a declaratory judgment action under ERISA to impose a constructive trust prior to distribution of the money. (*See Griggs v. E.I. DuPont De Nemours & Company*, 237 F.3d 371

(4th Cir. 2001); and more recently, *Primax Recoveries, Inc. v. Young*, 2003 U.S. App. LEXIS 25786 (4th Cir. 2003), (unpublished, where the Fourth Circuit specifically held that establishment of a constructive trust or equitable lien was appropriate under ERISA "when money or property identified as belonging in good conscious to the (insurer) could clearly be traced to particular funds or property in the (insured's) possession."). In *Primax*, the court noted that whether an insured was in possession of disputed funds was key. Insurers can actually sue attorneys prior to distribution of settlement monies from their trust accounts, asking a court to establish a constructive trust and to obtain an order compelling the lawyer to pay the subrogation lien out of the proceeds of the tort settlement. Recently, the court verified the *Primax* holding in a published opinion. (See *Mid Atlantic Medical Services, LLC v. Sereboff, et. al.*, 407 F.3d 212 (4th Cir. 2005).)

The second significant point of *Great West* is that at first read the case appears to defeat an insurer's right to sue on a subrogation claim

if monies have been distributed. However, a close reading of the case establishes that it only holds that a plan cannot sue *under ERISA* to recover its subrogation interest if the settlement money has already been distributed. The court left open the possibility that an ERISA plan can proceed against its participant under state law theories. Oftentimes, health insurers will require its insureds to sign a repayment agreement or other contract extraneous of the ERISA plan document before paying claims. *Great West* does not prohibit an insurer from suing on an extraneous document between the plan or the insurer. (The Fourth Circuit has not yet had an opportunity to address the legal issue, but the U.S. District Court for the District of South Carolina has addressed the issue in a slightly different factual context in *Provident Life and Accident Insurance Company v. Thurmond*, C/A No.: 6:02-3808-25.) Besides suing on contract theories, an insurer may be able to proceed under other state theories such as unjust enrichment.

It is not uncommon these days

for a health insurer to sue a law firm to protect its subrogation interests. Such suits are becoming increasingly prevalent because recent developments such as *Great West* dictate that a health insurer must act promptly and aggressively to protect its subrogation rights. Accordingly, any attorney representing a plaintiff with a health insurer who has a subrogation claim should be conscious of the subrogation claim throughout the course of the personal injury case and deal with the claim accordingly.

Never take for granted anything that the insurer or plan tells you about its alleged right to subrogation. The client may not owe anything on a subrogation claim. Before honoring a subrogation claim with the client's money, always use the above analysis to determine whether or not the insurer's allegations regarding its subrogation claim are accurate. With proper analysis and handling, you may be able to negotiate a favorable settlement of the subrogation claim for the client.

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