COLLATERAL SOURCE MANUAL

MCELLISTREM FARGIONE RORVIG & MOE, P.A.

Attorneys at Law
7900 International Drive, Suite 700
Minneapolis, MN 55425
(952) 544-5501
www.mcfarg.com

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TABLE OF CONTENTS

Introduction

For purposes of this discussion, a "collateral source" is a third party (i.e. not the party injured and not the party causing the injury) who makes payments to or on behalf of the injured person. The collateral source is typically an insurance company, an employer, or a welfare agency that has paid medical or disability benefits.

When the injured party resolves the claims against a defendant, either by settlement or by jury verdict, what portion of the money must go to repay the collateral source? The answer to this question varies significantly depending upon the source of the payment.

In many cases, collateral sources do not present any problem. If liability is clear and if there is adequate liability insurance coverage, both the injured party and the collateral source(s) can be fully paid. However, if the liability insurance payment is not adequate to pay both the accident victim and the collateral source (due either to low liability insurance limits or to a recovery diminished by plaintiff's comparative fault), it is important to know what rights may be asserted by a collateral source.

From the perspective of the injured party, there are three questions which must be answered before the settlement of any claim:

(1) Who gets paid what and when? If there is not enough money to satisfy all claims, does the injured person get compensated before the collateral source claim is paid?

(2) Can the collateral source claim be reduced? If the plaintiff is 30% at fault and the plaintiff's recovery is therefore reduced by 30%, is the collateral source claim also reduced by 30%? If the plaintiff pays a one-third (1/3) contingent fee to an attorney, does the collateral source also have to pay a pro rata share of the attorney's fee? If, in a special verdict form, the jury awards less than the full amount of the collateral source claim (e.g. the collateral source is a health insurer whose claim is for $100,000 in medical services and the jury awards the plaintiff only $80,000 in medical damages), is the claim limited to the specific amount awarded by the jury, or can the collateral source seek reimbursement from general damages that the injured party receives?

(3) What happens if the claimant settles a claim, gives a general release to a defendant, and then pays nothing to the collateral source? Can the collateral source still pursue a claim against the original defendant or against the liability insurance company for the defendant despite the terms of the general release signed by the injured party? Or, if the injured person has given only a limited release, settling just the personal claim for pain and suffering, can the collateral source nevertheless seek reimbursement from the recovery of the injured person?

The answer to these questions will vary according to the nature of the collateral source. The discussion which follows has four parts. The first section discusses Minn. Stat. § 548.251, which provides the procedural framework for reviewing collateral source claims after a jury verdict. Part two reviews some of the federal and state statutes that govern specific types of collateral source claims for reimbursement or subrogation. Part three discusses those collateral source payments, made typically by private insurance companies, which are governed by more general provisions of Minnesota law. Part four reviews ERISA contracts, which are private contracts issued pursuant to a federal statute that makes them exempt from regulation by state law.

I. Collateral Source Statute: Minn. Stat. § 548.251

Minn. Stat. § 548.36 was renumbered § 548.251 in 2006. The Collateral Source Statute creates procedures that are to be used after a trial and verdict. The statute guides the court in determining the net amount of a plaintiff's recovery when some of the damages awarded at trial have already been paid by third parties.

A. Collateral Source Payments Generally not Admissible in Evidence

Subdivision 5 of the statute codifies a general rule of evidence requiring that the jury remain uninformed concerning the existence of any past or future collateral sources. Minn. Stat. § 548.251, subd. 5.

B. Definition of a "Collateral Source"

Subd. 1 of the statute provides a detailed definition of "collateral sources." If a third party payment does not fit within the definition of a "collateral source" under the statute, the offsets and procedures of this statute will not be applicable.

If a medical provider simply writes off a portion of the medical bills that were originally charged to the injured person, this reduction in the bill does not involve any third party payment and therefore does not come within the scope of the "collateral sources" definition. Consequently, the collateral source statute would not require that the jury award for past medical expenses be reduced, even though the plaintiff might be receiving a windfall from the verdict. See Davis v. St. Ann's Home, unpublished, No A06-1968, 2008 WL 126607 (Minn. Ct. App. Jan. 15, 2008).

Pension payments and payments made "pursuant to the United States Social Security Act" are excluded from the definition of a collateral source. Minn. Stat. § 548.251, subd. 1(2). It should be noted that the Social Security Act encompasses more than retirement and disability payments. The Social Security Act includes both Medicare (Title XVIII) and Medicaid (Title XIX, generally referred to as "Medical Assistance"). Consequently, these Social Security Act payments from Medicare and Medical Assistance do not come within the scope of the Collateral Source Statute. See Frumkin v. Mayo Clinic, 965 F.2d 620 (8th Cir. 1992). This was confirmed in the matter of Renswick v. Wenzel, 819 N.W.2d 198 (Minn. 2012) in which Medicare benefits were excluded from the collateral source offset provision of Minn. Stat. § 548.251, subd. 1. It was likewise further confirmed in Getz v. Peace, 934 N.W.2d 347 (Minn.2019), in which the court confirmed that Medical Assistance is not a collateral source. The net result is the plaintiff gets the windfall even when a private company administers the MA benefits.

Benefits from a private disability policy are excluded from the collateral source definition if "premiums were wholly paid for by the plaintiff." Minn. Stat. § 548.251, subd. 1(4). With respect to disability payments, the courts have drawn a distinction between certain "sick leave" benefits (which are not considered to be a collateral source) and other forms of disability pay or wage continuation (which would be considered collateral sources). See

Bruwelheide v. Garvey, 465 N.W.2d 96 (Minn. 1991).

The statute does no more than regulate the net recovery due to a plaintiff following the entry of a verdict. It deals only with potential offsets for past payments to or on behalf of the plaintiff by third parties. The statute did not authorize a disability insurer to avoid paying benefits under the terms of its contract on the grounds that the claimant had already made a tort recovery for wage loss covering the same period. Smith v. American States Ins. Co., 586 N.W.2d 784 (Minn. 1998).

The collateral source statute does not apply to tort claims seeking recovery for damage to property. Schmuckler v. Creurer, 585 N.W.2d 425 (Minn. Ct. App. 1998).

C. Procedure for Claiming an Offset

A claim for a collateral source offset must be made through a post-trial motion. The defendant must file a motion seeking the offset within ten days of the entry of the verdict. The "entry of verdict" has been construed to refer to the "filing of the district court's order for judgment." Wertish v. Salvhus, 555 N.W.2d 26, 28 (Minn. Ct. App. 1996), reversed on other grounds, 558 N.W.2d 258 (Minn. 1997). Typically, the district court's order for judgment is stayed for thirty days before judgment is actually entered. See Rule 125, General Rules of Practice for the District Courts. This allows the defendant ten days from the court's order to petition for collateral source offsets. The language of Wertish v. Salvhus interpreting the meaning of "entry of verdict" has been cited as authority in Lee v. Hunt, 641 N.W.2d 57, footnote 1 (Minn. Ct. App. 2002), although the Lee footnote incorrectly refers to the date of entry of judgment rather than the date of the court's order for judgment.

If a motion seeking offsets under the Collateral Source Statute is not filed within ten days, the jury verdict stands and no deduction of collateral sources is authorized by the statute.

The timeliness of a motion for a collateral source offset is of the utmost importance. In Johnson v. Princeton Public Utilities Commission, WL 22243, (Minn.Ct.App.2016), the jury came back with its verdict finding for the plaintiff and the defendant promptly filed a motion for a collateral source offset. The motion was filed on 10/29/2013. The District Court Judge gave a $48,450.00 collateral source offset. Judgment was entered on 7/14/2014. Plaintiff objected to the collateral source offset because the motion for the offset was untimely. Case law indicates that the "filing of a District Court's order for judgement pursuant to a jury's special verdict triggers the time to file a Motion for Determination of Collateral Sources." Braginsky v. State Farm, 624 N.W.2d 789 (Minn. Ct. App. 2001). The Court of Appeals says that the defendant in this case had filed its motion eight months before entry of the judgment. Because the defendant did not follow the collateral source statute, the District Court abused its discretion by granting an untimely motion for a collateral source offset. Consequently the collateral source offset is denied.

Once a written motion is filed, the court reviews written evidence concerning collateral sources. If the written evidence is not adequate, the court may request additional

written evidence or may schedule a conference at which further evidence can be considered.

The decision by the Minnesota Supreme Court in Gilhousen v. Illinois Farmers Insurance Group, 582 N.W.2d 571 (Minn. 1998) holds that this collateral source procedure can be applied even when ERISA subrogation claims are at issue. The Gilhousen decision effectively reverses the Court of Appeals analysis in Koch v. Mork Clinic, P.A., 540 N.W.2d 526 (Minn. Ct. App. 1995).

Following Lee v. Hunt, 641 N.W.2d 57, (Minn. Ct. App. 2002), these statutory procedures governing collateral source offsets will apply to the post-trial deductions for no-fault benefits. Although no-fault offsets are mandated by Minn. Stat. § 65B.51, the Lee v. Hunt decision will require the use of the collateral source statute's procedures for defendants seeking the offset of no-fault benefits. In Lee, the court of appeals elected not to adopt dicta in Wertish v. Salvhus, 558 N.W.2d 258 (Minn. 1997) that said procedures of the Collateral Source Statute would not apply to no-fault offsets. Since the holding in Lee is explicit, no-fault offsets will be governed by Minn. Stat. § 548.251.

D. Scope of Deduction

The general outline of the statute is clear. With respect to losses up to the time of the verdict, collateral sources covered by the statute are to be deducted from the verdict except with respect to those collateral source payments for which a subrogation right has been asserted. Minn. Stat. § 548.251, subd. 2(1).

When collateral source payments have been made and no subrogation is asserted, a deduction will be made by the court. Calculating the amount of the deduction is a two-step process. First, the court determines the amounts of the collateral sources that have been paid. Then, the court determines how much (if anything) was paid to secure the collateral source insurance during the two years prior to the accident. The net deduction will be the difference between these two numbers. Minn. Stat. § 548.251, subd. 3(a).

The intent of the law is clear. To the extent that the collateral source statute applies to a claim, the law prevents the plaintiff from making a double recovery. If $5,000 in wage loss has already been paid by disability insurance, and if the jury awards $5,000, there should be no payment by the defendant for the wage loss. However, if the premiums for the disability insurance over the two years prior to the accident were $500, the defendant in effect is required to cover the cost of the insurance. This is equitable since the defendant is benefiting financially from the purchase of the insurance. This adjustment for insurance premiums is to be made for the amounts "paid, contributed, or forfeited by, or on behalf of, the plaintiff or members of the plaintiff's immediate family . . . to secure the right of payment by the collateral source." Minn. Stat. § 548.251, subd. 2(2). There is no requirement that the plaintiff must have personally paid the premiums.

Difficulties often arise when a jury awards less than the amount claimed in the litigation for past medical expenses. In the procedures mandated by the statute, the district

court does have the ability to take additional evidence in attempts to determine the appropriate offset. See Heine v. Simon, 702 N.W.2d 752 (Minn. 2005). In Heine, the claimant was in two accidents about six months apart. In litigation concerning the second of the accidents, plaintiff claimed $27,000 in medical expenses but was awarded only $8,000. Collateral sources had paid a total of $23,000 for past medical. The Supreme Court notes that there should be a deduction only for medical expenses paid for injuries related to the second accident, and it remands the case to the district court to provide some factual findings on this topic.

Although the overall intent of the law is clear, a number of potential issues do exist.

1. Arbitration

The collateral source statute does not apply to an arbitration. The statute states that it applies to awards in "a civil action," and the term "action" does not include arbitrations. See Lucas v. American Family Mut. Ins. Co., 403 N.W.2d 646 (Minn. 1987).

Although as a general rule the statute will not apply in an arbitration, the Minnesota Supreme Court has determined that the collateral source statute must be applied by arbitrators in an underinsured motorist arbitration. Western National Mutual Insurance Company v. Casper, 549 N.W.2d 914 (Minn. 1996). The Casper decision involved a claimed offset for workers' compensation payments. Underinsured motorist insurance is intended to compensate an accident victim for amounts which the injured person is legally entitled to recover from the underinsured tortfeasor. The court reasoned that arbitrators in a UIM case should begin by determining the amount that the underinsured tortfeasor would legally owe to the claimant. This process would require the application of the collateral source statute. Although the same logic would appear to be applicable in the context of an uninsured motorist claim, an unpublished court of appeals ruling, Becker v. State Farm Mut. Auto. Ins. Co., No. C1-97-580, 2000 WL 1015867 (Minn. Ct. App. July 25, 2000) distinguished the Casper decision and held that a collateral source offset would not be applied to workers' compensation benefits in the context of an uninsured motorist claim.

2. Asserting Subrogation Rights

The defendant does not get a deduction for payments by a collateral source if "a subrogation right has been asserted." Minn. Stat. § 548.251, subd. 2(1). In Buck v. Schneider, 413 N.W.2d 569 (Minn. Ct. App. 1987) and in Austin v. State Farm Mut. Auto. Ins. Co., 486 N.W.2d 457 (Minn. Ct. App. 1992), the injured party negotiated an assignment of subrogation rights from a potential collateral source. The collateral source deduction was then avoided when the claimant "asserted" the subrogation rights that had been assigned. (If subrogation rights had simply been "waived," a collateral source deduction would have been made.)

In Kahnke v. Green, 695 N.W.2d 148 (Minn. Ct. App. 2005), the court noted that the collateral source statute is silent as to when the subrogation right must be asserted in order to be considered by the district court. The only requirement imposed by the court is that

the timing of the assertion of a subrogation right must be reasonable. Under existing case law, an asserted subrogation right is simply one that has not been waived. The court explicitly rejects the argument that the subrogation right has to be formally asserted before trial in order to be considered by the district court in post-trial motions.

3. No Deduction from Partial Recovery

The Collateral Source Statute provides a means for eliminating a double recovery. Consequently, a collateral source deduction should not be made in a case where the injured party is not being fully compensated. In Imlay v. City of Lake Crystal, 453 N.W.2d 326 (Minn. 1990), an uninsured motorist who was drunk caused severe damage. Following a jury verdict, the City of Lake Crystal was responsible for paying 40% of the damages, which totaled approximately $2.2 million. Collateral source payments totaled almost $1 million. Since the injured parties were not fully compensated by the combination of collateral source payments and the payment of 40% of the verdict, the City of Lake Crystal was not entitled to any deduction for collateral source payments. It was required to pay 40% of the full damage award.

4. Special Verdict Forms

If the jury verdict does not give a detailed award, a calculation of the collateral source deduction can be difficult. For example, assume that $25,000 in medical expenses is claimed from a motor vehicle accident. Of these expenses, no–fault insurance paid $15,000. The jury awards a total of $10,000 for past medical expenses. What is the collateral source deduction, if any?

Whenever a collateral source is identified (whether or not subject to a subrogation interest), it is safest for the plaintiff to prepare a special verdict form which separates potential collateral source awards or offsets from all other awards of damages. Whether the collateral source payment is to be deducted or paid through subrogation, the separate award by the jury will identify the amount at issue.

Collateral source offsets are intended to prevent a double recovery. The offset should therefore be calculated in a way which does not invade portions of a damage award for which collateral source payments have not been received. See Tuenge v. Konetski, 320 N.W.2d 420 (Minn. 1982).

Payments made by no-fault insurance following a motor vehicle accident are typically deducted from a jury verdict. Minn. Stat. § 65B.51, subd. 1. In Vandenheuvel v. Wagner, 690 N.W.2d 753 (Minn. 2005) the plaintiff had incurred over $40,000 in medical expenses. No-fault had paid for $20,000. The jury awarded only $30,000 in past medical expenses. Because the jury had not been asked to make specific findings that would allow a court to determine what bills were included in its award, the full $20,000 in no-fault was deducted from the verdict. One may infer from the Supreme Court's comments that medical expenses could be grouped in special verdict form questions, without advising the jury concerning collateral source payments, so that post-trial collateral source offsets would

be applied only to the portion of the award that had in fact been paid by a collateral source.

5. Adjustment of Offset Based on Premiums Paid

If a collateral source deduction is to be made, the deduction is offset by "amounts that have been paid, contributed, or forfeited" on behalf of the plaintiff or the plaintiff's immediate family. Presumably, health insurance premiums paid by an employer contain amounts paid on behalf of the injured party. Such premiums for the two years prior to the accrual of the cause of action can be substantial and should be documented.

If subrogation is being asserted but the amount of the subrogation involves bills paid at a discount, the discount may be considered a “collateral source” offset. Swanson v. Brewster, 784 N.W.2d 264 (Minn. 2010). Consequently, the court should also consider the premiums paid when calculating the net offset to the verdict. (See section “F” below.)

Since no-fault benefits are subject to the procedures of the Collateral Source Statute, a plaintiff may be able to claim an offset for premiums paid to obtain basic economic loss coverage in the motor vehicle insurance policy. In applying this general rule to no-fault benefits, Rush v. Jostock, 710 N.W.2d 570 (Minn. Ct. App. 2006) confirms that only the PIP portion of the premium, not the entire auto insurance premium, may be used by the plaintiff to reduce the collateral source offset. (A reasonable argument can be made, however, that the no-fault deduction is being made pursuant to the No-Fault Act, Minn. Stat. §65B.51, and that this statute does not provide any consideration of premiums paid for the no-fault insurance. Moshier v. Jarvis, No. A 18-0358, A 18-0742, 2019 WL 1104778 *14, (Minn. Ct. App. March 11, 2019))

E. Attorney's Fees

The statute makes explicit that contingent fees are to be based upon the net award after the deduction of collateral sources. The statute also makes explicit that any subrogation interest paid to a collateral source is subject to payment of the contingent fee percentage to plaintiff's counsel plus a proportionate share of costs, unless the subrogated provider is "separately represented by counsel." Minn. Stat. § 548.251, subd. 4.

F. Medical Bills Paid at a Discount

It is common for health insurance programs to pay medical bills at a discount. Medical bills of $10,000 may be incurred, and the bills may then be satisfied through a health insurance payment of $6,000. If a jury awards the full $10,000 as the reasonable value of the past medical treatment, how should a court respond to a defense motion for a collateral source offset? In the decision of Swanson v. Brewster, 784 N.W.2d 264 (Minn. 2010), the Supreme Court reversed two prior Court of Appeals decisions and took the benefit away from the plaintiff.

In Swanson v. Brewster, the court held that allowing the plaintiff the amount of the

bills incurred as opposed to the lesser amount paid to satisfy the bills would inappropriately allow plaintiff to "recover a sum of money based on a portion of his medical bills that he never paid and never will have to pay." Id. The court discussed that as one commenter pointed out, "If most [medical] providers in the community accept the same or similar 'paid charge' in full satisfaction of their claims, can it still be honestly suggested that the 'billed charge' is reasonable?" Id. As a result, the court overruled prior decisions in Foust v. McFarland, 698 N.W.2d 24 (Minn. Ct. App. 2005) and Tezak v. Bachke, 698 N.W.2d 37 (Minn. 2005), and limited the plaintiff's recovery to the amounts actually paid towards the medical bills in question, including co-pays, outstanding balances, health insurance premiums, and the amount paid by the health insurer. No longer is the plaintiff entitled to recover the billed amount unless the payments are made "pursuant to the United States Social Security Act" as addressed above. Minn. Stat. § 548.251, subd. 1(2).

II. Collateral Source Claims Governed by Specific Statutes

Government benefit programs often include statutory provisions requiring reimbursement of the government if a recovery is made from a tortfeasor or from some other source (e.g. no-fault insurance). Specific statutes may also regulate subrogation claims for certain private insurers (e.g. workers' compensation and no-fault). The discussion of statutory subrogation rights set forth below is certainly not exhaustive. The following general rule does apply in all cases where subrogation is governed by a specific statute: You cannot understand the scope of a subrogation claim without first reviewing the specific statute that creates the claim. The following is a summary of some, not all, of the most frequent collateral source (subrogation) claims governed by statute.

A. Federal Employees' Compensation Act

The federal workers' compensation program is a model for one aggressive type of statutory subrogation claim.

In United States v. Lorenzetti, 104 S.Ct. 2284 (1984), an FBI agent was injured in a motor vehicle accident in Pennsylvania. He received $1,900 in federal compensation benefits. In the state tort action, it was held that, due to some provision in the Pennsylvania No-Fault Law, the defendant would not be liable for lost wages and medical benefits,

Lorenzetti settled his case for $8,500. As a matter of law, this recovery did not duplicate the medical expenses and wage loss which he had received from FECA.

The federal statute in question, 5 U.S.C. § 8132, states that payments must be refunded to the federal government if (a) the injury in question is sustained under circumstances creating a legal liability to pay damages, and (b) the injured party receives money in satisfaction of that liability. Nothing in the statute suggests that the injured party must be compensated for those elements of damages actually paid by FECA. The statute does allow attorney's fees and allows the injured party to keep a portion of any recovery.

In another case arising under FECA, Green v. United States Dept. of Labor, 775 F.2d 964 (8th Cir. 1985), a federal employee had received about $94,000 in benefits. During the personal injury trial in state court, a jury awarded approximately $432,000 for pain, suffering, and loss of future income. No request was made of the jury for medical expenses or past wage loss. The injured party argued that no reimbursement of the FECA claim was necessary since there was no double recovery. This trial was held prior to the decision in Lorenzetti. After Lorenzetti, the 8th Circuit held that the attorney and the injured party were jointly and severally liable to the government and had to reimburse the government for the $94,000 collateral source payment made under FECA.

It appears that this FECA subrogation claim is not asserted against uninsured and underinsured motorist insurance recoveries. The United States Department of Labor enforces subrogation claims under this federal law. The federal agency seeks subrogation only with respect to recovery from a "third party." The agency interprets the statute to apply to recoveries from the tortfeasor – the party causing the injury. Consequently, with respect to first party contract claims against uninsured motorist coverage or underinsured motorist coverage, no subrogation claim is asserted by the agency. (Because the agency does not assert subrogation claims in UM and UIM cases, there have not been reported federal decisions on this topic. It would be reasonable to confirm with the federal Department of Labor that no FECA claim is being asserted against a UM or UIM recovery.)

B. Medical Care Recovery Act

The federal law at 42 U.S.C. §§ 2651-2653 provides a general subrogation right to the United States whenever the United States furnishes hospital, medical, surgical, or dental care to a person who was injured under circumstances creating a tort liability. This statute creates a subrogation right on behalf of the United States against the tortfeasor. Under a literal reading, the subrogation claim would not exist against the proceeds from first party coverages like uninsured motorist benefits. See Government Employees Ins. Co. v. Andujar, 773 F. Supp. 282 (D. Kan. 1991).

In Commercial Union Ins. Co. v. United States, 999 F.2d 581 (D.C. Cir. 1993), the court was faced with a situation in which the amount of insurance coverage was not sufficient both to reimburse the government and to pay the injured party. In these circumstances, who has the first priority claim to payment? The court reviewed the statute and held that it was silent as to the priority of the government's claim. In order to reach an equitable result, the court ordered the money distributed to both parties on a pro rata basis.

C. Medicare

Medicare was created in 1965 as Title XVIII of the Social Security Act. Subrogation rights were created and expanded during the 1980s. Statutory amendments clarifying subrogation provisions were added at the end of 2003 by the Medicare Modernization Act. See Brown v. Thompson, 374 F.3d 253 (4th Cir. 2004).

42 U.S.C. § 1395y(b)(2)(B) provides the statutory authorization for Medicare subro-

gation. Regulations implementing the statutory right to subrogation are codified at 42 C.F.R. §§ 411. 20 et seq.

Dealing with Medicare claims became more complicated with the addition of Medicare Part D in 2006 covering prescription drugs. And Medicare established requirements in 2007 to require money to be set aside to cover future medical expenses that might otherwise be incurred by Medicare following a tort settlement.

In December 2007, additional statutory changes to the Medicare recovery system were made by the "Medicare, Medicaid and SCHIP Extension Act of 2007" (referred to as the "MMSEA"). The new federal law placed additional burdens on liability, no-fault, and workers' compensation insurance companies, requiring an insurance company to report information to Medicare when handling injury claims by persons entitled to Medicare. These changes in the federal law are codified in 42 U.S.C. §1395y(b), and the federal rules that will implement the statute apply to all settlements occurring on or after July 1, 2009. Insurance companies, under this new system, will have some obligation to first determine if an injured claimant may be entitled to Medicare benefits, then to submit information to Medicare, and finally to pay Medicare's claims. There are potential sanctions for failure to cooperate with Medicare. Under these newer provisions of the law, an insurance company may face a penalty of $1,000 per day for each day of non-compliance with the Medicare rules.

The federal statute provides that Medicare should not have to pay for medical bills when some other insurance (including liability insurance or no-fault insurance) can reasonably be expected to pay for the bills. However, if a prompt payment from the primary insurance is not going to be made, Medicare can make a conditional payment and then be reimbursed. The federal law confirms that Medicare is to be a "secondary payer" with a right to recover its payments from any primary plan of insurance or self-insurance.

Under existing federal regulations, it is unwise for any party to ignore a potential Medicare claim when settling a case. 42 C.F.R. § 411.24 indicates that Medicare can assert a claim for repayment against the injured party, against the injured party's attorney, or against the liability insurance carrier for the defendant. It is unlikely that the creative drafting of any settlement document would limit Medicare's options in recovering. The federal statute allows Medicare to charge interest, at a rate set by the federal agency, when reimbursement is not made within 60 days of a final notice related to the agency's claim against the primary insurance. 42. U.S.C. § 1395y(b)(2)(B)(ii). Legislation in 2003 also provides that the United States can seek "double damages" if it brings a civil action to recover a payment. 42. U.S.C. § 1395y(b)(2)(B)(iii); 42 C.F.R. §411.24(c)(2).

In sorting out Medicare claims, the following elements should be kept in mind:

1. Medicare gets paid first

Medicare asserts a first priority claim. If Medicare's claim exceeds the available liability insurance, Medicare makes no provision for allowing a pro rata payment to the

injured party.

2. Medicare's claim is limited to the amount awarded for medical expenses in an arbitration or verdict

The statutory claim is against only those payments that are made with respect to a medical item or service covered by Medicare. 42 U.S.C. § 1395y(b)(2)(B)(iii). See Zinman v. Shalala, 67 F.3d 841 (9th Cir., 1995). See also Smith v. Travelers Indem. Co., 763 F. Supp. 554 (M.D. Fla. 1989). This should mean that, if a jury or an arbitrator reduces an award for percentage of fault or awards less than the amount of the Medicare claim for a specific medical service, the Medicare subrogation right will attach only to the amount actually awarded for the item or service.

The federal statute, following the 2003 amendments, says that the responsibility of the primary plan (e.g. liability insurance or self-insurance) can be demonstrated (1) "by judgment" or "award," (2) by "a payment conditioned upon the recipient's compromise, waiver or release (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary plan or the primary plan's insured," or (3) "by other means." 42 U.S.C. § 1395y(b)(2)(B)(ii). If there is a settlement, Medicare will generally assume that it is entitled to a full recovery on its claim, even though the settlement amount may in fact reflect a significant compromise of a disputed claim.

The Medicare recovery procedures were modified somewhat in response to the nationwide class action, Zinman v. Shalala, 67 F.3d 841 (9th Cir., 1995). In late 1994, the Medicare Intermediary Manual provisions dealing with subrogation and recoupment issues were revised to provide some procedural safeguards for recipients. Nevertheless, dealing with the agencies that Medicare designates to do its subrogation work typically involves responding to a series of demands for payment from agents who have no authority to negotiate a compromise.

3. Medicare discounts medical bills

As noted in the discussion of Minnesota's collateral source statute, a payment made pursuant to the Social Security Act is not within the definition of a "collateral source." Minn. Stat. § 548.251. Consequently, the tortfeasor (and its liability insurance carrier) is responsible for paying the reasonable value of the medical bills incurred, even if the Medicare subrogation claim is for an amount substantially less than the actual bills. See Renswick v. Wenzel, 819 N.W.2d 198 (Minn. 2012). Federal regulations explicitly state that the obligation of a primary payer (e.g. liability insurance or no-fault insurance) is not diminished because Medicare has paid at a reduced rate. See 42 C.F.R. §411.31.

4. Attorney's fees

The federal regulations do permit a reduction of the Medicare claim to provide a pro rata payment for attorney's fees and expenses. 42 C.F.R. § 411.37.

However, if Medicare sues the plaintiff in order to obtain its claimed reimbursement, Medicare will no longer discount its claims based upon the plaintiff's attorney's fees or other procurement costs. 42 C.F.R. §411.37(e).

5. Private Companies

Medicare is often administered by private health insurance carriers, and private companies also administer many Medicare subrogation claims.

It should be noted, however, that in some cases Medicare contracts with private health care organizations to replace the coverage that would otherwise be afforded by Medicare. In these cases, Medicare is not paying the medical bills. Instead, Medicare is in effect paying an insurance premium to the private company. The private company is then responsible for paying the medical expenses. What effect does this have on subrogation claims? Does the private insurer have the same rights as Medicare with respect to its subrogation claims? The scope of such private subrogation claims appears to be an open issue.

A literal reading of applicable federal statutes and regulations clearly creates subrogation rights for Medicare. But the statutes and regulations that permit Medicare to contract with private health insurance providers for replacement coverage contain no explicit language extending first priority subrogation rights to these private health insurers. See 42 U.S.C. § 1395mm and 42 C.F.R. § 417, authorizing Medicare contracts with prepaid health plans.

The federal statute at § 1395mm(e)(4) permits, but does not require, the private insurer to assert subrogation claims.

6. Medicare Advantage Plans (Part C-Coverage)

Medicare Advantage Plans ("MAP"), otherwise known as Medicare Part C, have gained significant popularity as many baby-boomers begin retirement. A MAP is a type of Medicare health plan only offered by a private insurer that contracts with Medicare. Such a plan provides both Part A and Part B (often times referred to as Medicare supplement coverage). The majority of MAP also provide prescription drug coverage (otherwise known as Medicare Part D.) The so called "bundling" of different types of coverage has created confusion regarding rights of subrogation and reimbursement from the injured

Minnesota law (Minn. Stat. §62A.095) requires that a health insurance carrier may assert subrogation only if the injured beneficiary has first received a full recovery. Id. subd. 2 (1). Medicare supplemental coverage (Part B coverage) is governed by §62A.095. See Minn. Stat. §62A.011, subd. 3 (1). However, Medicare and Medicare Advantage Plans (Part C plans) are specifically excluded from the "full recovery" rule that applies to a Medicare supplement (Part B coverage). See Minn. Stat. §62A.3099,

subd. 18 (*Minnesota legislature confirms that by definition a Medicare Advantage plan is not a supplement plan and therefore not a requisite health plan governed by §62A.095*). As a result, based on this statutory analysis, it would seem that a MAP by default would have the right to assert the same subrogation rights as Medicare itself pursuant to the Medicare Secondary Payer Act.

Nevertheless, the fact remains that the MAP is providing benefits that otherwise on their own are subject to §62A.095 – Medicare Part B coverage. For example, should a Medicare beneficiary simply purchase supplemental coverage from XYZ insurance company, and rely on Medicare for Part A coverage, the subrogation rights of XYZ insurance are subject to Minnesota law and "full recovery." However, those same supplemental benefits if processed through a bundled MAP are not subject to §62A.095 due to the statutory definitions. The blaring difference and obvious consequence to the injured Plaintiff is unexplainable.

On the national scene, a similar debate has been occurring. The issue there is whether to treat the right of a MAP like that of Medicare versus a private health insurer subject to relevant state law. These decisions may not have much effect on Minnesota based MAP liens due to our current statutory definition. However, the inevitable outcome of this national debate may impact the handling of subrogation liens for an MAP based in different states.

The first major decision involving a MAP is from the Third Circuit. In re: Avandia Marketing Sales Practice, and Products Liability Litigation, 685 F.3d 353 (3rd. Cir.2012), the court held that a MAP may assert a private cause of action against an insurer under the Medicate Secondary Payer Act. This decision stands for the proposition that a MAP has all of the same rights of recovery as Medicare itself. The Supreme Court denied *cert*.

In 2013, the Ninth Circuit decided just the opposite. The court in Parra v. PacifiCare, 715 F.3d 1146 (9th Cir. 2013) held that the MAP did not have a private cause of action under the Medicare Secondary Payer Act. The decision failed to address what are the rights then of a MAP to recover from insurers. Again, *cert* was denied by the Supreme Court.

Two recent 2016 decisions, led by one of the largest providers of MAPs, provide further support that the private administrator of a MAP has all the same rights with regard to reimbursement as the federal government.

As has been known for quite some time, failure to pay back a conditional payment to CMS will result in a debt to the Department of Treasury Offset Program along with an eventual referral to the Department of Justice for collection. Federal law authorizes the federal government to collect double damages from any party that is responsible for resolving the matter but who fails to make the payback. 42 U.S.C. § 1395y(b)(2)(B)(iii). The law also provides a private cause of action for private insurers to pursue regarding similar failures to pay back conditional payments but does not specifically address the ability of those private plaintiffs to collect double damages. *Id*. §

1395y(b)(3). The Eleventh Circuit decision, Humana Med. Plan, Inc. v. W. Heritage Ins. *Co.*, 832 F.3d 1229 (11th Cir. 2016), held in a 2-1 decision that Humana, as a Medical Advantage Plan provider, was entitled to the same right of double recovery for failure to reimburse Medicare conditional payments as the federal government.

Consistent with that decision, albeit disconcerting for those practicing in this area, is that the U.S. District Court in Richmond, Virginia granted Humana, as a Medicare Advantage Plan provider, the right to collect a double recovery from a lawyer who failed to reimburse conditional payments following a successful motor vehicle liability claim. Humana v. Paris Blank LLP, et al., 187 F. Supp. 3d 676 (E.D. Va. 2016). In that case, Paris Blank represented an injured party in a motor vehicle crash. Humana paid over $191,000 in medical expenses related to the crash. The injured party and his counsel obtained a settlement of $475,600. Counsel confirmed no lien existed from CMS but failed to determine and resolve the Humana lien. As such, Humana was granted the right of double recovery – consistent with the Eleventh Circuit decision.

This was further confirmed in an 8th circuit district court, *Cupp v. Johns* the United States District Court for the Western District of Arkansas, where it was held that a Part C plan's claim for reimbursement must be challenged through the Medicare review and appeals process and that no state law could limit the scope of this reimbursement. *Id*. 2:14-CV-02016-PKT; (WD.DC.Ark.2018).

The impact on practicing attorneys in Minnesota is that further attempts to defend against Medicare Advantage Plans by citing the "made whole" doctrines of Minn. Stat. § 62A.095 can subject them, if unsuccessful, to double damages. Along with the Renswick decision, this further seems to confirm that, from the perspective of collateral offsets, a Medicare Advantage Plan is not a collateral source. Minn. Stat. § 548.251.

One more wrinkle in dealing with potential subrogation claims based on payments made through Part C: as of 2021, the "Medicare Secondary Payer Recovery Portal" (https://www.cob.cms.hhs.gov/MSPRP) that provides information concerning Medicare subrogation claims does not necessarily report the Medicare beneficiary's enrollment in part C (or Part D – prescription drugs). This gap in information may be remedied by the PAID (Provide Accurate Information Directly) Act, which became effective December 11, 2021.

7. Prescription Drug Coverage (Part D)

Congress provided prescription drug coverage through Medicare when it created Part D in 2003. The new law indicated that the "secondary payer" rights to subrogation would be exercised in the same manner as Part C Plans. As noted above, the Medicare Secondary Payer Recovery system has not, through 2021, been modified to provide information about payments that may have been made under Part D. The PAID Act, which

became effective December 11, 2021, may address that shortcoming.

8. Medicare and future medical expenses

Medicare was created in 1965 as an ancillary program for people who have worked and paid into the Social Security System. Generally, a person eligible for social security retirement benefits at age 65 will be eligible for Medicare. In addition, someone who has been eligible for social security disability benefits for 24 months will also be eligible for Medicare.

Starting in 2005, CMS (Center for Medicare Services) issued a report indicating that persons currently eligible or eligible in the next 2.5 years would have to "reasonably protect Medicare's interests" with regard for the need for future care that Medicare would be responsible for paying. In the context of a workers' compensation claim, certain cases necessitated a set-aside trust for future care in order to insure Medicare would not have to foot the bill. There was no similar provision for liability cases prior to 2005.

The extent of what "reasonably protect" requires and whether a set-aside trust is required for liability cases is an open question. Initially in 2007 legislation was passed requiring insurers ("primary payers") to report claims involving Medicare beneficiaries. The legislation was pushed back until 2010 when it went into effect. It included penalties for $1,000 a day and excluded cases with settlements of $300 or less.

At about the same time in 2007, CMS indicated that cases with settlements of less than $25,000 would not require a set aside trust for those Medicare eligible or who would be in the next 30 months. Note, to date (January 2022) there is still no mechanism in place for CMS to review set asides trusts stemming from liability claims.

To add further confusion, on January 10, 2011 CMS issued an advisory letter indicating that it did "not require liability set asides." However, "if a liability settlement includes money for future services, or if you believe that significant future medical will be needed for which Medicare would normally pay, then all parties should ensure that money is set aside." Later in 2011, Charlotte Benson on behalf of CMS issued a letter indicating that if a treating physician in a liability claim certifies in writing that treatment has been completed as of the date of settlement, the issue of protecting Medicare with regard to future care has been satisfied.

Although case law certainly indicates that some reasonable analysis of future accident-related medical needs should be done in any settlement involving potential Medicare payments for future needs, there is no specific and practical direction from the Federal Government. This was confirmed by a federal district court judge in Arizona who decided the matter of Aranki v. Burwell, 151 F. Supp 3d 1038 (D. Ariz. 2015). In that case, following a tort recovery in state court, the plaintiff, a Medicare beneficiary, brought an action against the Secretary of Health and Human Services (HHS) seeking declaratory judgment that she was not obligated to create a Medicare Set-Aside (MSA). The district court dismissed the

case, finding that it was not ripe for adjudication since "no federal law mandates CMS to decide whether Plaintiff is required to create a MSA. That CMS has not responded to Plaintiff's petitions on the issue, is not reason enough for this Court to step in and determine the propriety of its actions." Aranki, 151 F. Supp.3d, 1042.

A 2017 decision out of the District Court for New Mexico, based upon an action to determine whether a Medicare Set-Aside was needed in a matter involving a personal injury suit, Silva v. Burwell, LEXIS 195032, (D.N.M. Nov. 28, 2017), has further muddied this issue. There, the court held, "[t]here is no law or regulation currently in place that requires the CMS to decide whether Plaintiff is required to create a MSA for personal injury settlements. [However]…CMS provides no other procedure by which to determine the adequacy of protecting Medicare's interests for future medical needs and/or expenses in conjunction with the settlement of third-party claims." Id. at 12. The court in this opinion seems to imply, contrary to the Aranaki decision that an MSA is a recognized and preferred method for an injured party to reasonable consider Medicare's future interests. Without some clear direction from CMS, courts will continue to share the confusion felt by many practitioners when grappling with the issue of how to deal with a tort recovery and a potential need for future medical for a Medicare beneficiary.

Proposed Rule 77 FR 35917-02, which would have provided specific directions to practitioners regarding what options were available following such a situation, was set to go into effect on April 1, 2014. However, this proposal was withdrawn. Industry observers had expected that CMS would redesign and submit a similar rule proposal in the future. Until then, however, we are left without clear direction, as illustrated by the holding in Cole-Hoover v. New York Dep't of Corr. Servs., 2013 WL 5652751 (W.D.N.Y. Oct. 16, 2013). In Cole-Hoover, the defense insisted that in order to reasonably protect Medicare's future interest should Plaintiff seek further accident-related treatment, defense required a "physician's letter stating that she [plaintiff] will not require further treatment, or else agree to a 'Medicare Set-Aside Agreement.'" *Id*. The court's holding, consistent with a reasonable review of the rules and decisions to date, states that "litigants and their attorneys are left without official guidance as to how to avoid liability for failing to protect Medicare's interest. It is therefore up to the litigants and their attorney to determine how best to protect themselves." *Id*.

The lack of guidance regarding future care was acknowledge by CMS in December 2018 when the Office of Information and Regulatory Affairs, published HHS/CMS RIN 0938-AT85 – "Miscellaneous Medicare Secondary Payer Clarifications and Updates (CMS-6047-P). The document correctly points out that "Medicare does not provide its beneficiaries with guidance to help them make choice regarding their future medical care expenses" when they have resolved their tort claim. Presumably some guidelines comparable to those contained in the aforementioned Proposed Rule 77 FR 35917-02 may be put into effect.

CMS has issued guidelines to be used for an injured person receiving workers' compensation – see Workers' Compensation Medicare Set-Aside Arrangement (WCMSA) Reference Guide, version 3.2 dated October 5, 2020. The same federal statute, 42 U.S.C. § 1395(b)(2), governs future medical expenses both under workers' compensation and under liability settlements. In the absence of a specific federal rule relating to liability settlements, this workers' compensation guide likely provides a reasonable approach to dealing with CMS and

potential future Medicare claims when resolving tort claims.

9. Medicare Supplemental Coverage (Part-B)

As mentioned above, a Medicare eligible person must pay to receive Part-B coverage that is generally responsible for physician charges that Medicare Part-A does not provide. Private insurers provided this Part-B coverage. Medicare supplemental coverage (Part B coverage) is governed by §62A.095. See Minn. Stat. §62A.011, subd. 3 (1) and therefore its rights of subrogation are subject to a full recovery by the Plaintiff. Because supplemental payments are not made "pursuant to the United States Social Security Act" they are considered collateral sources fall outside the favorable plaintiff's order in Renswick v. Wenzel, 819 N.W.2d 198 (Minn. 2012).

D. Veterans Benefits

A veteran who is injured may be entitled to receive medical services through a veteran's hospital. Claims for reimbursement by the Veteran's Administration were routinely asserted under the Medical Care Recovery Act discussed above. This act, however, authorized claims only against a tortfeasor. No claim existed against a no-fault carrier. See United States v. Travelers Indem. Co., 729 F.2d 735 (11th Cir. 1984).

In response to this limitation, a new federal law was enacted. The law was amended in 1991 and recodified at 38 U.S.C. § 1729. The law applies to all services provided after November 3, 1981. It authorizes the V.A. to make a claim against first-party benefits, including workers' compensation and no-fault. See United States v. State Farm Ins. Co., 599 F. Supp. 441 (E.D. Mich. 1984).

E. Medical Assistance

Medicaid is a program providing health care coverage to low income people. It is jointly funded by the federal and state governments. The Minnesota statutory framework refers to Medicaid coverage as Medical Assistance. MINN. STAT. § 256B.02, SUBD. 8.

In past years, the state had recovered Medical Assistance benefits from recoveries in a personal injury claims pursuant to Minnesota Statutes sections 256B.042 and 256B.37. These statutes provide a specific formula for distribution of any recovery. This statutory system for asserting Medical Assistance liens was later found to be invalid by the Minnesota Supreme Court in Martin v. City of Rochester*, 642 N.W.2d 1* (Minn. 2002)*, cert. denied*, 123 S. Ct. 2668 (2003). MINN. STAT. § 256B.37, SUBD. 4. Under *Martin*, Medical Assistance's subrogation claim had to be limited to the injured person's specific recovery for medical expenses. The claim for subrogation did not extend to any recovery for other types of damages. In addition, under *Martin*, Medical Assistance actually owns the injured person's claim for medical expense because this claim has been assigned to the welfare agency in the Medical Assistance application process.

This was confirmed by the United States Supreme Court's 2006 decision in Arkansas Department of Health and Human Services v. Ahlborn, and 2013 decision in Wos v. E.M.A. See Arkansas Dep't of Health and Human Servs. v. Ahlborn, 547 U.S. 268 (2006); Wos v. E.M.A., 133 S. Ct. 1391 (2013).

In Ahlborn, the parties stipulated that the total damages were over three million dollars. The plaintiff was able to recover only $550,000 in a settlement. Arkansas's Medical Assistance program had paid about $215,000. Because the plaintiff was recovering only one-sixth of her damages, she wanted to pay only one-sixth of the Medical Assistance claim ($35,580). Arkansas, under its medical assistance statute, claimed a right to recovery of the full amount paid. It asserted that Medical Assistance could recover on its claim even if such a recovery by the state invaded portions of the recovery designated for income loss or for pain and suffering. The United States Supreme Court rejected this interpretation of the claims permitted by federal Medicaid statutes. Like the Minnesota Supreme Court in Martin, the United States Supreme Court in Ahlborn held that a claim for reimbursement of Medical Assistance payments under the federal Medicaid statutes is limited to the portion of the plaintiff's recovery allocated to "payment for medical care."

In addressing issues related to the assignment of claims under the Medicaid program, the United States Supreme Court analysis suggests that the term "assignment" is really equivalent to a lien. "Ahlborn retained the right to sue for medical care payments, and the State asserted a right to the fruits of that suit once they materialized." Ahlborn, 547 U.S. at 286. This assessment of the law may call into question the foundation for holdings such as the one in Guzman by Losoya v. US West, *Inc.,* 667 N.W.2d 489 (Minn. Ct. App. 2003), which held that a settlement between the defendant and Minnesota's Medical Assistance program effectively deprived the injured person of the right to claim future medical expenses. In Guzman, a child had suffered a significant brain injury. Medical Assistance had a lien for past medical expenses for approximately $330,000. The defendant, US West, paid Medical Assistance $315,000 in return for a release of all Medical Assistance claims (past, present, and future). The district court reasoned that all claims for medical expenses, including claims for future medical needs, had been assigned to the Medical Assistance program when the application for Medical Assistance benefits was made. This reasoning, however, would appear to be inconsistent with the analysis of the federal law provided by the United States Supreme Court. It is the view of the United States Supreme Court that a Medicaid assignment does not deprive an injured Medical Assistance recipient of the right to sue for medical payments. Instead, the assignment simply designates the portion of the plaintiff's recovery that will be subject to the medical assistance lien.

In WOS v. E.M.A., *133 S. Ct. 1391 (2013)*, the U.S. Supreme Court further considered the applicability of the decision from Ahlborn. The issue presented was whether a North Carolina statute, with a formula similar to that found at Minnesota Statutes section 256B.042, subdivision 4, was preempted by the earlier Ahlborn decision. Did the North Carolina state lien statute govern the distribution of the third-party recovery that arguably included Medicaid payments, or did North Carolina have to show what portion of the settlement actually duplicated the Medicaid payments that had been made?

The Supreme Court concluded that federal law preempted North Carolina's irrefutable statutory presumption that one-third of the injured person's recovery should be allocated for the Medicaid claim. The Court stated that, "what a state cannot do is what North Carolina did here: adopt an arbitrary one-size fits all allocation." WOS, 133 S. Ct. at 1402. Some system other than a simple distribution formula must be used to provide a factual basis for assessing the portion of the recovery that should be attributed to the Medical Assistance payments.

In each of these three cases, state laws governing Medicaid subrogation claims were preempted by provisions of federal law in the Social Security Act. (The federal Budget Act of 2013 had contained a provision, §202(b), removing the federal preemption and allowing states to make broader recoveries from tort settlements. However, the effective date of this 2013 amendment was postponed each year and then, in the 2018 Budget Act §53102(b)(1), the provision was retroactively repealed effective September 30, 2017. As a practical matter, it never actually took effect.)

1. Scope of Claim

Both the lien statute (Minn. Stat. § 256B.042) and the subrogation statute (Minn. Stat. § 256B.37) create claims with respect to those injuries that led to the medical care. If a jury should find that only a portion of the claimed medical expenses were related to the injuries at issue, the Medical Assistance claim should be limited to the amount awarded by the jury.

The lien and subrogation state statutes assert claims against all parts of the injured person's recovery. In Martin and Ahlborn, this broad claim was held to violate federal law. Now the claim by Medical Assistance must be limited to the amount recovered for medical expenses. Consequently, if the injured person's recovery were to be limited by comparative fault, the subrogation claim by Medical Assistance should also be limited to the net recovery for medical expenses. As a practical matter, such issues should be negotiated with the agency at the time of any settlement.

2. Naig-Type Settlements

In workers' compensation cases it is possible to settle the worker's claims separately from the subrogation claims of the insurer. Naig v. Bloomington Sanitation, 258 N.W.2d 891 (Minn. 1977). The Medical Assistance lien statute did not permit such a partial settlement. Minn. Stat. § 256B.37, subd. 1 creates a right of subrogation and imposes this subrogation claim on "all portions of the cause of action, notwithstanding any settlement allocation or apportionment that purports to dispose of portions of the cause of action not subject to subrogation." See State, Dep't of Human Servs. v. Bengston, 506 N.W.2d 38, 39 (Minn. App. 1993), *pet. for rev. denied* (Minn. Nov. 16, 1993). Under unusual circumstances, a distribution of settlement proceeds to someone other than the injured party may be exempted from the Department of Human Services' lien. Krause v. Merickel, 344 N.W.2d 398, 402-04 (Minn. 1984).

These statutory limits have been changed by the Martin decision. Since Martin limits

the Medical Assistance claim to the recovery for medical expenses, a Naig type settlement should now be an option. However, the agency may not agree to this procedure since it claims to have a first priority right to any payment made to the injured person.

3. Payment of Medical Expenses at Reduced Rate

Like Medicare, Medical Assistance typically pays only a small fraction of the actual medical bills submitted. Nevertheless, the medical provider is obligated by federal law to accept the Medical Assistance payment as payment in full. The medical provider may not seek any additional recovery. For example, in Evanston Hosp. v. Hauck, 1 F.3d 540, 542-43 (7th Cir. 1993), a hospital accepted $113,000 from Medicaid in satisfaction of a $270,000 bill. When the injured party later recovered $9,000,000 in a judgment, the hospital was unable to seek reimbursement for its full medical expenses. Id.

Liability insurance carriers face an unusual situation when medical bills have been paid by Medicare or Medical Assistance. For example, if a jury awards $10,000 in medical expenses and these medical bills have been satisfied by a $4,000 Medical Assistance payment, the liability carrier may still be obligated to pay the full $10,000 jury award. There does not appear to be any provision in the law which would authorize the court to reduce the jury award. The Collateral Source Statute does not apply to Medicare and Medical Assistance payments since they are made pursuant to the Social Security Act. See Renswick v. Wenzel, 819 N.W.2d 198 (Minn. 2012), dealing with Medicare and Getz v. Peace, 934 N.W.2d 347 (Minn. 2019), dealing with Medical Assistance.

In the Medical Assistance decision, the Supreme Court held that payments made by private health insurance companies that were administering pre-paid Medical Assistance Plans were payments made “pursuant to” the Social Security Act.

In effect all MA payments, like Medicare payments under Renswick v Wenzel, are exempt from the collateral source statute. Such payments are not “collateral sources” as defined in the statute. The windfall due to the gap that results in what is billed to Medicare and Medical Assistance and what is actually paid to satisfy these bill goes to the Plaintiff. (At trial, of course, the Plaintiff must either obtain an admission or otherwise prove that the amount of the original bill was a reasonable charge for the medical services or goods at issue in order to obtain a verdict awarding the costs.)

4. Allocation of Settlement Proceeds

Based on the recent decisions by the Supreme Court, it would be helpful to have a judicial allocation of the proceeds from a compromise settlement to determine what portion of the settlement should be allocated to past medical expenses and therefore subject to a medical assistance subrogation claim. In the unpublished decision of Rodriquez v. Southern, WL 773379 (Minn.Ct.App.2010), an injured plaintiff attempted to do just that. After settling a medical malpractice claim, which arguably included medical bills paid for by a Medicaid plan, the plaintiff attempted to set the money aside and allow

the court to make a formal allocation. The court denied that request on the basis the health plan was not a party to the original settlement or claim. As a result, it was not offered an "appropriate step" to protect its claim.

Going forward, assuming a potential recovery through settlement of a plaintiff's claim for less than the policy limits, if one would want a judicial allocation as contemplated by the decision in WOS v. E.M.A., the plaintiff would need to implead the health insurance carrier/Medicaid provider as an involuntary plaintiff. Doing so would take away this defense that the plaintiff has not followed the appropriate steps and is trying to bind Medicaid to a settlement that it had no part in reaching. Once Medicaid is impleaded, the Supreme Court was very supportive of different types of procedures, such as a Henning type hearing with regard to making sure the Medicaid lien doesn't simply attach to the entire amount of the plaintiff's recovery.

F. Workers' Compensation

A person who is injured in the course and scope of employment may have a claim for workers' compensation as well as a claim for damages against a third party. In such cases workers' compensation will assert a subrogation claim in order to be partially reimbursed for payments which it has made. The options available for handling these claims have become increasingly complicated, and a detailed discussion of each option is beyond the scope of this article. Chapter 16 of the Workers' Compensation Deskbook published by the Minnesota Bar Association, Continuing Legal Education, provides a more complete analysis of the issues outlined below.

Amendments to the workers' compensation statute in 2000 indicate that the workers' compensation claim against a defendant may include items of damages that could not be claimed directly by the injured worker. For example, the statute states that an employer may claim reimbursement for increased workers' compensation insurance premiums related to its payments for an injury. Minn. Stat. § 176.061, subd. 5(b). However, in Zurich Am. Ins. Co. v. Bjelland, 710 N.W.2d 64 (Minn. 2006), the Supreme Court found ambiguity in the 2000 amendments and reaffirmed that the workers' compensation claims are true subrogation claims so that the rights of an employer against the defendant can be no greater than the rights of the employee.

The claimant employee, when attempting either a full or partial settlement, should be aware of the mandatory notice provisions contained in Minn. Stat. § 176.061.

1. Full Settlement

a. Statutory Formula

Minn. Stat. § 176.061 describes subrogation rights which are held by a workers' compensation carrier. Subdivision 6 of this statute provides a formula which may be applied in distributing the settlement proceeds. Under the formula, the injured person

receives one-third (1/3) of the recovery which remains after attorney's fees and costs have been paid. The workers' compensation insurer is then paid, after reducing its claim to account for a pro rata share of attorney's fees and costs. Any amount remaining goes to the injured person, but this remaining payment also counts as a credit for the workers' compensation insurer with respect to future workers' comp claims.

The existence of the statutory formula does not mean that the injured person may settle the entire claim without the consent of the workers' compensation insurer and then force a distribution according to the statute. Since the employer holds an independent statutory right to recovery, its consent must generally be obtained if its rights are being compromised in the settlement. Jackson v. Zurich Am. Ins. Co., 542 N.W.2d 621 (Minn. 1996).

b. Henning Distribution

In Henning v. Wineman, 306 N.W.2d 550 (Minn. 1981), the court created an alternative procedure for apportioning settlement proceeds between an injured worker and a workers' compensation insurer asserting a subrogation claim. Generally, the employer must first agree that the total settlement is reasonable before the alternative distribution procedure may be used. Sargent v. Johnson, 303 N.W.2d 767 (Minn. 1982).

In a Henning distribution, the district court makes an allocation between amounts recoverable and non-recoverable under workers' compensation. The employee forfeits the statutory right to one-third of the recovery and is bound by the court's determination. The allocation by the court will be affirmed on appeal if the settlement allocation is reasonable in light of the total recovery and not patently arbitrary. Krause v. Merickel, 344 N.W.2d 398 (Minn. 1984). However, a distribution by the district court which totally excluded recovery for the workers' compensation insurer was judged to be unreasonable and arbitrary. Kliniski v. Southdale Manor, Inc., 518 N.W.2d 7 (Minn. 1994).

2. Partial Settlements

a. By Employee

Naig v. Bloomington Sanitation, 258 N.W.2d 891 (Minn. 1977) permits an injured person to settle with the defendant for those portions of the damages which are not duplicated by any workers' compensation payment. There is no future credit for the workers' compensation insurer in this type of settlement. The Naig settlement does not disturb the right of the workers' compensation carrier to pursue its independent subrogation claim.

The employee must provide the workers' compensation insurer advance notice of the intention to negotiate a Naig settlement so that the insurer will have an opportunity to participate in settlement negotiations. Minn. Stat. § 176.061 subd. 8a. See also Easterlin v. State, 330 N.W.2d 704 (Minn. 1983).

Following a Naig settlement the employer may pursue its subrogation claim. In Tyroll v. Private Label Chemicals, Inc., 505 N.W.2d 54 (Minn. 1993) the court outlined the manner in which damages in such a claim should be sought. If the workers' compensation carrier is seeking subrogation for payment of economic recovery compensation it will be important to obtain a jury award in a specific category on a special verdict form so that money will be allocated to this aspect of the subrogation claim. Janesville Auto Transport Co. v. Foreign Domestic Car Service, No. C5-95-2315, 1996 WL 266426 (Minn. Ct. App. May 21, 1996), *rev. den.* (Minn. Aug. 6, 1996).

b. By Employer

In Folstad v. Eder, 467 N.W.2d 608 (Minn. 1991) the court approved a separate settlement between the workers' compensation insurer and the tortfeasor. The settlement did not interfere with the injured person's right to seek damages not covered by workers' compensation. When calculating the net payment to the plaintiff in this case, the Supreme Court explicitly rejected any application of the collateral source statute or of the workers' compensation statutory formula. Rather, the court held that the plaintiff could simply ask for those damages which did not duplicate the workers' compensation subrogation claim.

In Berg v. Jasper Development Corp., No. C7-96-1998, 1997 WL 177655 (Minn. Ct. App. April 15, 1997), *rev. den.* (Minn. May 18, 1997), the defendant paid off the subrogation interest prior to trial pursuant to Folstad v. Eder. Following trial, the district court deducted from the jury verdict those portions of the jury award that would have constituted a double recovery, using the principles of Tyroll v. Private Label Chems., Inc., 505 N.W.2d 54 (Minn. 1993) to assess the proper deductions. This procedure was affirmed by the court of appeals as being appropriate.

3. UM and UIM Claims

The workers' compensation insurer does not have subrogation rights against the injured person's contractual claims for uninsured motorist benefits or underinsured motorist benefits. Janzen v. Land O'Lakes, Inc, 278 N.W.2d 67 (Minn. 1979); Cooper v. Younkin, 339 N.W.2d 552 (Minn. 1983); Fryer v. National Union Fire Insurance Co., 365 N.W.2d 249 (Minn. 1985).

It may be appropriate for a statutory collateral source deduction (Minn. Stat. § 548.251) to be applied to workers' compensation payments when calculating a UIM claim, since there is generally no subrogation claim to be asserted. See Western Nat'l Mut. Ins. v. Casper, 549 N.W.2d 914 (Minn. 1996). However, if subrogation rights based on workers' compensation have already been applied to the underlying liability insurance recovery, then subrogation has in fact been asserted against the damages claim and the UIM insurer should not be permitted an offset for workers' compensation payments.

With respect to an offset of workers' compensation payments in UM claims, see Becker v. State Farm Mut. Ins. Co., unpublished opinion, No. C1-97-580, 2000 WL 1015867 (Minn. Ct. App. July 25, 2000), which denied the offset.

The injured worker may avoid a collateral source offset by settling the workers' compensation claim and obtaining an assignment of the workers' compensation subrogation interest. This was done in Buck v. Schneider, 413 N.W.2d 569 (Minn. Ct. App. 1987) and in Austin v. State Farm Mut. Auto Ins. Co., 486 N.W.2d 457 (Minn. Ct. App. 1992) in the settlement of liability insurance claims. Salib v. Allstate Ins. Co., unpublished, NoA07-252, 2008 WL 570600 (Minn. Ct. App. Feb. 25, 2008) extended the logic of these cases to an Underinsured Motorist verdict reasoning that the insured was to be placed in the same position he would have been had the negligent motorist been adequately insured.

4. Comparative Fault

a. Employee

If there is a single settlement or recovery, the employer participates in the recovery according to the statutory formula. This is true even though the injured person's recovery has been diminished based upon that person's percentage of fault. Duenow v. Midwest Excavating Co. 32 W.C.D. 511 (1980).

However, if the employee has settled on a Naig release so the employer is pursuing its independent subrogation claim against a tortfeasor, the tortfeasor's liability to the employer will be reduced based upon the fault attributed to the employee. Haase v. Haase, 369 N.W.2d 311 (Minn. Ct. App. 1985). Indeed, the fault of the employee may be aggregated with any additional fault of the employer to reduce the recovery against the tortfeasor. Kempa v. E.W. Construction Co., 370 N.W.2d 414 (Minn. 1985).

b. Employer

As noted above, to the extent that the employer is pursuing an independent claim, its percentage of a fault will be used to diminish its claim against the tortfeasor. This involves a fairly simple application of principles of comparative fault.

Things become more complicated when a defendant who is liable to an injured worker attempts to obtain contribution from an at-fault employer. Because the employer's liability to the injured employee is governed exclusively by workers' compensation, the employer and the tortfeasor cannot be jointly liable for the damages to the injured worker. In Lambertson v. Cincinnati Corporation, 257 N.W.2d 679 (Minn. 1977), the court created a system to allow some equitable contribution claim to proceed against an at-fault employer. Lambertson type contribution claims are generally limited to the amount of workers' compensation benefits paid by the employer. Fish v. Ramler Trucking, Inc., 935 N.W.2d 738 (Minn. 2019) confirms that the Lambertson contribution limitations have not been altered by changes in the joint and several liability statute.

G. No-Fault Payments

As a general rule, no-fault insurance carriers do not have subrogation rights based upon their no-fault payments. A liability insurance carrier is simply entitled to a deduction for no-fault benefits paid. Minn. Stat. § 65B.51, subd. 1.

Minn. Stat. § 65B.53 does permit no-fault subrogation (1) for accidents occurring outside of Minnesota and (2) for accidents not arising from the operation, maintenance or use of a motor vehicle. Minn. Stat. § 65B.53, subds. 2 and 3. These subrogation rights exist, however, only if the recovery would otherwise produce a duplication of benefits. See Principal Financial Group v. Allstate Ins. Co., 472 N.W.2d 338, 342 (Minn. Ct. App. 1991).

Minn. Stat. § 65B.53, subd. 1 allows indemnity claims by a no-fault carrier against certain at-fault commercial vehicles with a curb weight of 5,500 pounds. This indemnity claim is independent of the claims which an injured individual may assert. Nat'l Indem. Co. v. Mut. Serv. Cas. Co., 311 N.W.2d 856 (Minn. 1981).

H. Minnesota Care/Public Assistance Payments

When the state human services department pays medical, subsistence or other payments to a person, there is a lien for these costs against any cause of action which arises from the occurrence which necessitated the payments. Minn. Stat. § 256.015. Health benefits paid through state subsidized Minnesota Care are also covered by Minn. Stat. § 256.015. See also Minn. Stat. § 256L.03 subd. 6. Private health plans that provide the health services for Minnesota Care and General Assistance based upon prepaid premiums have the same rights as the state agency. Minn. Stat. § 256.015, subd. 1.; Erickson v. Fullerton, 619 N.W.2d 204 (Minn. Ct. App. 2000). In Erickson, the court held that the general provisions of the collateral source statute do not apply to benefits paid under the MinnesotaCare program.

Liens are to be perfected according to Minn. Stat. §§ 514.69, 514.70 and 514.71, but the state agency is not subject to any of the limitations periods in these statutes. The state agency has one year from receiving its first notice of the claim or one year from the date of first paying medical bills, whichever is later, to file its lien. Minn. Stat. § 256.015 subd. 2(b). Under Minn. Stat. § 256.015, subd. 4, the legal representative of any party to a claim is among those required to give notice to the agency of any claim or settlement.

Under Minn. Stat. § 256.015 attorney's fees and costs are paid first. From the net recovery, the injured party is then entitled to receive at least 1/3 prior to payment of the lien.

III. Private Insurance Contracts (other than ERISA)

A. General Equitable Principles

As a general rule, subrogation is a creature of equity and exists even when no specific contract language creates a subrogation right. Time Ins. Co. v. Opus Corp., 519 N.W.2d 470, 473 (Minn. App. 1994) (equitable subrogation available to insurer in absence of subrogation clause in health care contract); Great Northern Oil Co. v. St. Paul Fire &

Marine Ins. Co., 189 N.W.2d 404, 406 (Minn. 1971). Equitable subrogation can exist even when third party payments are made voluntarily rather than because of a contractual obligation. Olson v. Blessener, 633 N.W.2d 544 (Minn. Ct. App. 2001).

A subrogation claim, by definition, means that the collateral source stands in the shoes of the injured party. The collateral source asserting a subrogation claim will be entitled to no greater rights than those possessed by the person who received the benefits. St. Paul Fire and Marine Ins. Co. v. Perl, 415 N.W.2d 663, 665 (Minn. 1987).

If the defendant in a personal injury claim has notice that a subrogation claim is being asserted by a collateral source, the liability insurance carrier can be held responsible for the subrogation claim even after receiving a general release from the injured party. Travelers Indem. Co. v. Vaccari, 245 N.W.2d 844, 847-48 (Minn. 1976). In order to preserve its subrogation claim against a tortfeasor, however, the party asserting the subrogation claim must take some action to provide the liability insurance carrier with formal notice of the claim. Group Health, Inc. v. Heuer, 499 N.W.2d 526, 529 (Minn. Ct. App. 1993).

In asserting an equitable subrogation claim, the private insurance carrier making collateral source payments generally does not receive anything until the injured party has been fully compensated. Westendorf v. Stasson, 330 N.W.2d 699, 703 (Minn. 1983). But see Time Ins. Co. v. Opus Corp., 519 N.W.2d 470, 473 (Minn. Ct. App. 1994) (settlement procured by willful exclusion of insurer does not bar insurer's subrogation rights even where injured person has not made full recovery).

Equitable subrogation claims will generally be limited to claims against the tortfeasor and the tortfeasor's liability insurance. In Medica, Inc. v. Atlantic Mut. Ins. Co., 566 N.W.2d 74 (Minn. 1997) a health insurance carrier sought to enforce an equitable subrogation claim against the medical payment coverage of a property owner. The health insurance carrier had paid bills for a person who was injured on a premises insured by Atlantic Mutual. Since Atlantic Mutual did not insure any wrongdoer, there was no equitable basis shifting the costs from health insurance to medical payment coverage.

The court of appeals applied the same logic in rejecting an equitable subrogation claim against a UIM insurance policy. Suchy v. Illinois Farmers, 474 N.W.2d 93 (Minn. App. 1998).

B. Private Insurance Contracts

1. Enforcement of Contract Language

In subrogation claims based solely on equitable considerations, Westendorf v. Stasson, 330 N.W.2d 699, 703 (Minn. 1983) establishes the equitable principle that an injured party must be fully compensated before any subrogation claim may be asserted. Basically, the injured person was entitled to be paid first, before a third party would be reimbursed. In Hershey v. Physicians Health Plan of Minn., Inc., 498 N.W.2d 519, 520

(Minn. 1993), the court was faced with a contract provision that explicitly asserted a first priority subrogation claim. The court interpreted the Westendorf decision as stating that the equitable principle of full recovery rule could be modified by contract. Accordingly, the court in Hershey enforced the first priority subrogation claim in the contract, even though the injured party was not fully compensated. [With respect to payments by private health insurance, the holding in Hershey is now superseded by statute. See Minn. Stat. § 62A.095.]

In Medica, Inc. v. Atlantic Mut. Ins. Co., 566 N.W.2d 74 (Minn. 1997), a Medica contract had general subrogation language giving it a subrogation claim against any other entity that may be legally responsible for the injuries. This contractual language was sufficient to create a valid subrogation claim against Atlantic Mutual, which provided medical payment coverage for the premises where the injury occurred. (No subrogation would have existed based solely on equitable principles.)

2. Competing Subrogation Claims

On occasion more than one company asserts a subrogation claim against a limited tort recovery. This occurred in Commercial Union Ins. Co. v. Minn. Sch. Bd. Ass'n, 600 N.W.2d 475 (Minn. Ct. App. 1999) when both the health insurance and auto insurance (underinsured motorist coverage) asserted subrogation claims against a tortfeasor with limited assets. The court found that the auto insurance was closer to the risk when injuries were caused in a motor vehicle accident, so reimbursement from the limited assets should go to the health insurance carrier rather than to the motor vehicle insurance.

3. Subrogation Statute - Private Health Insurance

Minn. Stat. § 62A.095 limits the type of subrogation claim that may be asserted by a private health insurance contract. (The statute does not govern ERISA claims, since ERISA plans cannot be regulated by state statutes.) Furthermore, by statute, plans issued as a supplement to Medicare, "as defined in section 62A.3099 to 62A.44 are not exempt from this anti-subrogation statute." § 62A.011, subd.3 (10).

Under this statute subrogation applies only after the injured person has received full compensation. The amount of the subrogation claim must be reduced for a pro rata share of attorney's fees and expenses, unless the health insurance carrier is separately represented by an attorney.

Minn. Stat. § 62A.096 requires that, whenever an injured person makes a claim that includes a claim for repayment of medical expenses incurred, the person must also provide timely notice of the claim in writing to the health carrier. The health carrier's statute of limitations for seeking reimbursement from the injured party will not begin until the notice has been given.

C. Wrongful Death Claims

In Share Health Plan, Inc. v. Marcotte, 495 N.W.2d 1, 4-7 (Minn. App. 1993), *pet. for rev. denied* (Minn. March 30, 1993), the court held that first priority contractual subrogation claims do not apply to wrongful death actions under Minn. Stat. § 573.02.

Wrongful death claims did not exist at common law. The claim was created by statute. The claim can be pursued only by the trustee for the next-of-kin of the decedent. The trustee in a wrongful death action is not the personal representative of the decedent's estate. The wrongful death recovery is not part of the decedent's estate. In Marcotte, the court held that there was no contractual relationship whatsoever between the health insurance carrier and the trustee for the next-of-kin. Consequently, no contractual subrogation claim could exist.

The health insurance carrier can continue to assert an equitable subrogation claim. They will be entitled to payment if the next-of-kin are fully compensated, since the wrongful death statute does permit the trustee to include a damage claim for medical expenses.

Procedurally, a district court judge will issue an order distributing the wrongful death settlement among the next-of-kin pursuant to Minn. Stat. § 573.02. A party with a potential subrogation claim should appear at the district court hearing in order to assert subrogation rights. See Nelson v. State Dep't of Natural Resources, 305 N.W.2d 317, 319 (Minn. 1981). It would be reasonable to provide appropriate prior notice of the wrongful death distribution hearing to the party with a potential subrogation claim if disputes are anticipated.

D. Claims Involving Children

There remain a few unresolved issues with respect to the application of Minnesota law to "subrogation" claims against bodily injury recoveries by children.

In a typical subrogation claim, the party that has made collateral source payments assumes the same rights as the insured. St. Paul Fire & Marine Ins. Co. v. Perl, 415 N.W.2d 663, 665 (Minn. 1987).

It is well established by Minnesota law that a child possesses absolutely no legal claim for reimbursement of medical expenses. The medical expense claim belongs to the child's parents. Only the parent may assert a claim for reimbursement. See Dentinger v. Uleberg, 171 Minn. 81, 213 N.W. 377 (1927).

The effect of the child's having no claim for medical expenses is seen in two cases, Hondl v. Chicago Great Wt. Ry. Co., 249 Minn. 306, 82 N.W.2d 245, 251-52 (1957) and Ostrander v. Cone Mills, Inc., 445 N.W.2d 240 (Minn. 1989). In Hondl, a 12-year-old girl was injured while a passenger in a car being operated by her father. Because the father was partially at fault for causing the accident the old doctrine of contributory negligence barred the father's claim for reimbursement of medical expenses. The child could recover personal damages, but the damages did not include past medical expenses. In Ostrander, a child who was injured at one year of age brought a lawsuit eight years later. Although the

child's claim for damages was within the applicable statute of limitations, the six-year statute of limitations barred a claim by the parents for medical expenses. The defendant in Ostrander was not liable for medical expenses incurred by the parents for the care of the child.

Any claim for a child's personal injury can be settled only with court approval. Minn. Stat. § 540.08. As noted above, the child's damages do not include payment for past medical benefits. This claim exists only for the parents. If a private health insurance carrier is asserting a subrogation claim, it should not take any portion of the child's recovery. Only money paid to the parents would be within the scope of a subrogation claim since the legal right of recovery for these damages rests exclusively with the parents. The health insurance carrier has a claim only to the extent that it "stands in the shoes" of the parent because the parent alone has a legal claim for reimbursement of medical expenses.

It is possible for a health insurance carrier to draft contract language that would require a child to reimburse the health insurance carrier from the child's general damages. Clearly, this is no longer a subrogation claim. See the discussion below on ERISA claims concerning the validity of a contract in which the parents attempts to give away the child's recovery to reimburse a health insurance carrier.

As a procedural matter, if there is a need to separate a child's injury claim from the parents' claim for past medical expenses, it would be reasonable to appoint a *guardian ad litem* for the child and to negotiate the two separate claims independently. The recovery for the parents can then be tendered to satisfy any potential medical subrogation claim.

IV. ERISA Contracts

A. The Federal Statute

1. What is ERISA?

The Employment Retirement Income Security Act (ERISA), 29 U.S.C. §§ 1001 - 1461, is a federal statute which governs certain employee benefit programs. Large employers or unions often use ERISA to create benefits packages for employees or for union members.

ERISA plans are simply contracts created pursuant to this governing federal law. As noted below, these benefit plans are governed exclusively by federal law and cannot be regulated by the states.

2. What Subrogation Rights are Created by ERISA?

The federal statute does not create any subrogation rights. Rather, the federal law simply allows an ERISA contract to establish a benefit plan without being regulated by state laws. Whatever subrogation rights an ERISA plan may wish to assert must first be created by the ERISA contract.

3. How does an ERISA Plan Become Exempt from State Laws?

29 U.S.C. § 1144(a) provides that any state law relating to an employee benefit plan is preempted by ERISA. Congress intends that a corporation or a union that operates in a number of states should be able to adopt a uniform benefit plan for its employees or members. State laws governing benefit plans are therefore preempted and cannot modify the provisions of an ERISA contract.

The federal preemption of state law is not absolute. The ERISA statute provides that preemption does not relieve any person from any state law that regulates insurance. 29 U.S.C. § 1144(b)(2)(A). But the ERISA plan itself may not be deemed to be an insurance company. 29 U.S.C. § 1144(b)(2)(B).

For purposes of subrogation, the law is as follows. For a self-funded ERISA plan (one in which the employer or union pools its own funds to provide payment of benefits), the plan is exempt from state laws governing subrogation. Hunt by Hunt v. Sherman, 345 N.W.2d 750 (Minn. 1984); FMC Corp. v. Holliday, 111 S.Ct. 403 (1990). However, if an ERISA plan simply purchases health or disability insurance as a benefit for employees, that insurance plan's subrogation claims may be controlled by state laws regulating insurance. (This would include Minn. Stat. § 62A.095 regulating subrogation clauses.) See Metropolitan Life Ins. Co. v. Massachusetts Travelers Ins. Co., 471 U.S. 724, 105 S.Ct. 2380 (1985), and FMC Corp. v. Holliday, supra, at 410. See also Jader v. Principal Mut. Life Ins. Co., 925 F.2d 1075, 1076-77 (8th Cir. 1991) (remanding to district court to determine whether a group health insurance policy purchased by claimant's employer was an ERISA plan not controlled by state subrogation laws).

The fact that a self-funded plan has purchased stop-loss insurance to protect itself from catastrophic losses does not affect its status as a self-funded plan. ERISA still preempts the application of state law to a plan that has stop-loss coverage. Health & Welfare Plan for Employees of REM, Inc. v. Ridler, 124 F.3d 207, 211 (8th Cir. 1997).

The Minnesota Supreme Court has held that ERISA's preemption of state law does not apply to the state statute that governs the procedures for deducting collateral source payments following a verdict. The procedures of Minn. Stat. § 548.251 will apply to ERISA claims. Gilhousen v. Ill. Farmers Ins. Group, 582 N.W.2d 571 (Minn. 1998).

It should also be noted that substantive state laws unrelated to employee benefit plans are not preempted by ERISA. For example, substantive laws governing tort recoveries in wrongful death claims or in claims for minor children should not pre-empted by ERISA. These are not statutes that relate to employee benefits plan, and 29 USC §1144(a) should not authorize pre-emption. As noted below in the discussion of death claims and claims for children, Minnesota's substantive law governing such claims may have implications concerning the manner in which an ERISA subrogation claim can be asserted.

B. Facing ERISA Subrogation: Step One – Get the Contract

Assuming that a subrogation claim is being asserted by a self-funded ERISA plan, what can be done?

1. Is the Contract Ambiguous?

The rights of the plan begin and end with its contract. The contract must be studied. If the wording of the contract is clear and unambiguous, it will be enforced. See, for example, Serembus v. Mathwig, 817 F. Supp. 1414 (E.D. Wis. 1992); Riley ex rel. Swanson v. Herbes, 524 N.W. 2d 523 (Minn. App. 1994). When faced with a clear and unambiguous ERISA contract claiming reimbursement, negotiations with the ERISA plan would generally be limited to begging, pleading and other appropriately humble tactics.

2. Who Determines if a Contract is Ambiguous?

Some ERISA plans explicitly give the trustees or administrators of the plan authority to interpret the meaning of the contract. When this occurs, judicial review of the contract is limited to determining whether or not the trustees have abused their discretion in construing contract terms. Kennedy v. Ga. Pacific Corp., 31 F.3d 606 (8th Cir. 1994). Such an abuse of discretion has been found when plan administrators failed to follow the plain language in the contract. Shell v. Amalgamated Cotton Garment, 43 F.3d 364 (8th Cir. 1994).

If the plan document does not explicitly grant discretion to the trustees or administrator in construing contract terms, the court may review the contract de novo. Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 109 S.Ct . 948, 956-957 (1989).

3. What Standards are used when Interpreting an ERISA Contract?

If a court is reviewing a contract de novo, it will first give the contract language its ordinary meaning, and it may then consider relevant extrinsic evidence in construing the contract. If ambiguities remain, the court will construe the ambiguities against the drafter of the contract. Delk v. Durham Life Ins. Co., 959 F.2d 104 (8th Cir. 1992). The ordinary meaning would be the intent of the language as understood by "an average plan participant." Brewer v. Lincoln Nat'l Life Ins. Co., 921 F.2d 150, 154 (8th Cir. 1990).

The summary plan descriptions distributed to plan members are considered part of the plan documents. When interpreting the plan documents, the court is generally applying principles from the law of trusts. Jensen v. SIPCO Inc., 38 F.3d 945 (8th Cir. 1994).

C. Common Issues

1. Causation

Even unambiguous contract language calling for repayment of ERISA expenditures can be enforced only if the expenses were incurred as a direct result of the actions of a

tortfeasor. ERISA claims based on treatment for preexisting conditions or for other unrelated health problems will not give rise to a claim for repayment.

2. Subrogation or Reimbursement

Read the contract carefully to determine if the ERISA plan has a right of "subrogation" or a right of "reimbursement."

The term "subrogation" has an established meaning. It places the insurer in the position of the insured in order to recover from a third party who is legally responsible to the insured for a loss which the insurer has paid. See 16 Couch on Insurance 2d Sec. 61.1 (1983). In a true "subrogation" claim, for example, the reduction of a plaintiff's recovery due to comparative fault (Minn. Stat. § 604.01) would also reduce the claim of the ERISA plan.

A claim for reimbursement on the other hand simply states that the insurer wants to be repaid in full after the injured party makes a recovery. See MedCenters Health Care v. Ochs, 23 F.3d 865 (8th Cir. 1994). A right to reimbursement is more broad than a right to subrogation.

If a contract creates only a right to "subrogation", that language may allow an injured party to dispute an obligation to repay some or all of the ERISA claim. See Shell v. Amalgamated Cotton Garment, 43 F.3d 364 (8th Cir. 1994); Barnes v. Independent Auto. Dealers Ass'n of Cal., 64 F.3d 1389 (9th Cir. 1995); Provident Life & Accident Ins. Co. v. Williams, 858 F. Supp. 907 (W. D. Ark 1994).

A contract will often contain language creating right to both subrogation and reimbursement. In Vercellino v Optum Insight, Inc., ___ F4th ___, (8th Cir. 2022) a right to reimbursement was enforced even though a subrogation claim was barred by the statute of limitations.

3. Reducing Claim for Comparative Fault

In a subrogation claim, the insurer "stands in the shoes" of the injured person and has only those rights which the injured person possesses. Consequently, if the injured person's recovery is limited due to comparative fault, the subrogation claim is subject to the same limitation.

This limitation is easy to calculate if there is a trial and a special verdict form. It is more difficult when there is simply a lump sum settlement prior to a trial or a verdict. Consideration might be given to completing a partial settlement for general damages and doing a cost-effective ADR with respect to those claims subject to subrogation, perhaps stipulating to the amount of the claim and doing a binding arbitration on issues of comparative fault and causation.

4. Priority of Recovery

If the contract language clearly states that the ERISA plan must be reimbursed first, regardless of whether the injured person is being fully compensated, this language will be enforced.

When a contract is not explicit, federal common law will apply to determine the rights of the parties. In Waller v. Hormel Foods Corp., 120 F.3d 138 (8th Cir. 1997), the court interpreted a contract that asserted the following rights: The ERISA plan is subrogated to all rights of recovery that the injured party may have against any person or organization. In this case, Mrs. Waller was seriously injured. The ERISA plan had paid about $150,000 in medical expenses. The available insurance recovery totaled only $200,000 ($100,000 in liability insurance and $100,000 in underinsured motorist coverage). The court held that this general subrogation language was sufficient to provide the ERISA plan with a first priority right to be paid prior to any recovery by the injured individual.

The court held that the contract language was not ambiguous when interpreted by ordinary rules of construction. The court also stated that an employer funded medical benefit plan should not be viewed in the same fashion as private health insurance for which the injured person had paid a premium. 120 F.3d at 140. The court examines cases from the Eighth Circuit and from other jurisdictions and rejects the theory that under federal common law injured person must be "made whole" before the ERISA plan can be paid on its subrogation claim.

If an ERISA plan explicitly claims a right to full reimbursement of all amounts paid the Minnesota courts are not likely to place any limits on the enforcement of these rights. In Administrative Committee of Wal-Mart Stores, Inc. Associates Health and Welfare Plan v. Shank, 500 F.3d 834 (8th Cir. 2007), a Wal-Mart employee was badly injured in a car accident and the fund paid about $470,000 in medical expenses. She obtained a settlement of $700,000 and, after paying attorney's fees and costs, she made a net recovery of about $420,000. This money was placed in a special needs trust. The fund sued in federal court to take all of the money in the trust. The federal court had jurisdiction over this claim (see discussion of Sereboff in section "D" involving the enforcement of ERISA claims). The court rejected the arguments of the trust that principles of federal common law required that the injured person either be "made whole" by the settlement (i.e., the fund could recover only after the injured woman was first compensated for her other losses) or be permitted a "pro-rata" distribution of the settlement proceeds (i.e. if the settlement represented a 50% recovery of full damages, the fund and the injured woman would each recovery 50% of the damages). The purpose of the ERISA plan is to benefit all members, and this purpose is served by enforcing the fund's claim to full recovery. The injured woman in paying premiums for participation in the plan did bargain for the right to have her medical bills paid promptly by the plan, but this was conditioned on her obligation to repay the plan from any future tort settlement. The court concluded that "federal courts lack authority to fashion a rule of federal common law that conflicts with the written plan and that is unnecessary to achieve the purposes of ERISA." 500 F.3d, at 839.

The Supreme Court reviewed this issue in U.S. Airways, Inc. v. McCutchen, 133 S. Ct. 1537, 185 L. Ed. 2d 654 (2013). In that decision, the Court held that unless there is

some ambiguity with regard to the Plan language, the Plan has the authority and ability to enforce a first priority right of recovery.

5. Attorney's Fees

When an ERISA plan is being paid, may the ERISA claim be reduced for its fair share of costs, including attorney's fees?

If the contract clearly prohibits payment of attorney's fees, the claim need not be reduced. Riley ex rel Swanson v. Herbes, 524 N.W.2d 523 (Minn. App. 1994). However, if the contract is silent with respect to fees, it may be argued that equitable considerations under federal common law require a pro-rata payment of fees and expenses. See Serembus v Mathwig, 817 F. Supp. 1414, at 1423 (E.D. Wis. 1992).

In Waller v. Hormel Foods Corp., 120 F.3d 138 (8th Cir. 1998), the court does require the ERISA plan to pay attorney's fees when the written contract is silent with respect to such fees. However, the court rejects the argument that a contingent fee of one-third may automatically be imposed on the plan if the injured party has entered into this type of contingent fee arrangement with an attorney. The amount of the fee must be determined by judging the value of the work of the attorney to the plan. In a case where both liability and damages are clear, it is unlikely that the plan would have retained an attorney on a contingent fee basis. The case is remanded to the district court for a factual finding concerning the reasonable value of the attorney's work from the perspective of the ERISA plan.

In U.S. Airways, Inc. v. McCutchen, 133 S. Ct. 1537, 185 L. Ed. 2d 654 (2013), the Court confirmed that, unless the Plan allows for attorney's fee or the Plan has ambiguity, the Plan does not have to reduce its subrogation interest by the attorney's fees generated by the Plaintiff in making the recovery.

O'Brien & Wolf, LLP v. South Central Minn. Electrical Workers' Family Health Plan, 923 N.W.2d 310 (Minn. App. 2018) involved an attempt by a law firm to collect attorney's fees from an ERISA plan by imposing an equitable lien on the payment made to the plan. The law firm's client was injured in a snow mobile collision. The ERISA plan paid over $150,000 in medical expenses. The law firm negotiated a policy limits liability settlement of $800,000. The firm paid the full ERISA claim but also asserted a lien for a contingent fee of 1/3. The ERISA contract with the injured client said that the plan would not pay fees. The Minnesota Court of Appeals, after reviewing the facts of the case, concluded that the law firm did not have an equitable against the ERISA plan. (Because there was no lien, the Court of Appeals did not address any issue as to whether or not ERISA would have pre-empted the law firm's petition to enforce a lien.)

6. Obligation to Sign Additional Lien Documents

Many ERISA plans send out additional lien documents to the injured party,

instructing the person to sign the documents as a precondition to any payment.

On occasions when the plan contract requires signing additional documents as a precondition to payment, such a requirement would be enforceable. However, in the absence of a contractual requirement to sign the additional document, the ERISA plan remains obligated to honor its coverage obligations under the original contract. See Shell v. Amalgamated Cotton Garment, 43 F.3d 364 (8th Cir. 1994).

7. Wrongful Death Claims

In Minnesota, any party (including an ERISA plan) will find it difficult to enforce contractual subrogation rights in a wrongful death action. This is true because the only person authorized to bring a wrongful death claim (i.e. the trustee for the next of kin) is not a party to the ERISA contract. Contractual claims generally cannot be asserted against one who is not a party to the contract. Consequently, the only subrogation claims that are likely to exist in a wrongful death action under Minn. Stat. § 573.02 are equitable claims. Under equitable principles, subrogation will not apply until those suffering the loss have been fully compensated, but subrogation will be permitted in order to avoid a double recovery. See Share Health Plan, Inc. v. Marcotte, 495 N.W.2d 1 (Minn. App. 1993).

In Makey v. Johnson, 868 F.3d 726 (8th Cir. 2017), a wrongful death claim was successfully made as a result of medical negligence claim. Following resolution, the Trustee and Plaintiff's counsel were sued by the ERISA carrier for failing to reimburse it for past payment of medical expenses made on behalf of the deceased. The trial court found in favor of the ERISA carrier and the 8th Circuit affirmed since there was evidence that underlying settlement agreement included a claim for medical expenses of the deceased. In fact, during the hearing before the magistate, it was agreed by Plaintiff's counsel that the "settlement agreements included the claim for medical expenses, although…the claim was settled for no money." Id. The inclusion of a claim for medical expense in the settlement documents in Makey distinguishes this decision from that Marcotte decision.

Given the decision in Makey, it will be essential for a trustee who anticipates a subrogation issue (due either to inadequate insurance coverage or to compromises based upon comparative fault) to separate the past medical payments or other potential subrogation claims from the claims of the next-of-kin in every settlement proposal or mediation statement. If these potential claims are used as leverage in negotiation, an equitable subrogation claim may have merit despite any language used in a final settlement or release.

The party asserting an ERISA claim cannot successfully argue that Minn. Stat. § 573.02 is a state statute preempted by ERISA. The statute does nothing to regulate employee benefits or rights under ERISA. It simply creates a cause of action on behalf of a trustee for the next of kin. In Minnesota, there is no cause of action for a wrongful death without compliance with Minn. Stat. § 573.02. See Regie de l'Assurance Auto. du Quebec v. Jensen, 399 N.W.2d 85 (Minn. 1987). The wrongful death cause of action, if pursued,

belongs to one who is not a party to the ERISA contract. Marcotte, 495 N.W.2d at 1.

To the extent that an ERISA subrogation claim (or any other subrogation claim) may be asserted in a wrongful death distribution, it is appropriate to give notice to the third party making the claim prior to the district court hearing concerning the distribution of the wrongful death proceeds. Nelson v. State Dept. of Natural Resources, 305 N.W.2d 317 (Minn. 1981). To the extent that the recovery duplicates medical benefits paid by a third party, an equitable subrogation right may be asserted.

If it is expected that competing claims of ERISA subrogation (or reimbursement) will be litigated, it may be helpful to appoint a trustee who is not a family member to represent the next of kin. This will make more obvious the claim that the trustee, who is the only one with a legal claim under the wrongful death statute, is not a party to the ERISA contract. The issue will then be, on distribution of the proceeds from the wrongful death settlement, whether ERISA subrogation claims somehow supersede the statutory rights of the next of kin to be compensated for losses under the wrongful death act. This issue should arise only when the recovery is inadequate to compensate the next of kin for their losses. If a full recovery is made, the ERISA subrogation claim may be included in the distribution.

In all cases it reasonable to negotiate an equitable result rather than to litigate technicalities if the ERISA plan is in fact willing to negotiate its claim.

8. Subrogation and Future Payments

In Shell v. Amalgamated Cotton Garment, 43 F.3d 364 (8th Cir. 1994), a contract created a subrogation right for the "amounts paid" by the ERISA plan. When the injured party refused to sign an additional lien document, the plan refused payment. A federal court ultimately ordered payment because the original ERISA contract did not require the signing of an additional lien. The injured person settled the liability claim when the ERISA plan had made about $13,000 in payments. The plan ultimately paid about $90,000 in medical bills. The plan's subrogation claim in the contract was for the amount which the plan "has paid." The court therefore limited the subrogation claim to the amount which had been paid at the time of settlement. Payments after the date of settlement would not be part of the subrogation claim against the settlement.

9. Uninsured and Underinsured Claims

Contract language will determine whether or not the ERISA claim exists with respect to the injured person's claims against uninsured or underinsured motorist insurance. If the contract language explicitly claims a right to recover from a party responsible for causing the injury, the subrogation claim exists only against the tortfeasor and against the liability policy which insures the tortfeasor. However, contract language that claims subrogation against any party responsible for damages would generally be broad enough to include insurance companies providing uninsured or underinsured motorist coverage. See, for example, Commercial Union v. Minn. Sch. Bd. Ass'n, 600 N.W.2d 475 (Minn. Ct. App.

1999). Although this is not an ERISA case, it does allow a medical subrogation claim against an underinsured motorist policy based on contract language creating subrogation rights for medical payments made "as a result of illnesses or injuries for which another party is responsible." 600 N.W.2d at 479.

10. ERISA Claims Involving Children

As noted in the discussion above on private insurance claims involving payments for children, the claim for past medical payments belongs exclusively to the parent. A claim for past medical expenses is not part of the child's claim for damages. Dentinger v. Uleberg, 171 Minn. 81, 213 N.W. 377 (Minn. 1927); Hondl v. Chicago Great Wt. Ry. Co., 249 Minn. 306, 82 N.W.2d 245, 251-52 (Minn. 1957); Ostrander v. Cone Mills, Inc., 445 N.W.2d 240 (Minn. 1989). These are general principles of Minnesota tort law. They are not preempted by the federal ERISA statute because they are not state laws relating to an employee benefit plan. See 29 U.S.C. §1144(a).

Just as the child does not own the parent's claim for past medical expenses, the parent does not own the child's independent claim for personal damages. Ostrander v. Cone Mills, Inc., 445 N.W.2d 240 (Minn. 1989). Typically, in the settlement of a child's claim through court approval under Rule 145 of the Rules of General Practice, a Minnesota district court judge would not allow the child's tort recovery to be used for the payment of an obligation owed by the parent. In this setting, does a parent have the ability in a contract with an ERISA plan to give the plan access to the child's money when the parent does not own this right? Under general contract principles, a party cannot convey in a contract rights that the party does not own.

These general principles support an argument that an ERISA plan should not have contractual rights to invade a child's settlement. In 2022, however, the Eighth Circuit Court of Appeals reached the opposite conclusion. In Vercellino v Optum Insight, Inc., ____ F.4th ____ , (8th Cir. 2022), an ERISA plan paid over $800,000 in medical expenses for a child who was struck by an ATV. The child was a "covered person" under his mother's ERISA plan as an enrolled dependent. The child's mother did not commence litigation on her personal claim for medical expenses within the six-year statute of limitations. Consequently, ERISA could make no subrogation claim arising from the mother's claim for medical expenses. The ERISA plan, however, also contained a reimbursement clause saying that any covered person had to reimburse the plan to the extent that the covered person made a recovery related to the injuries for which he plan made payment. The child's bodily injury claim had been settled for $800,000. The court held that the plain language of the plan required the child to reimburse the $800,000 to ERISA.

There was no discussion in the Vercellino decision about the mother's ability to convey to ERISA rights of reimbursement against the minor child. A somewhat related issue concerning a parent's ability to limit a child's tort claim was decided in Justice v. Marvel, LLC, 965 N.W.2d 335 (Minn. App. 2021). In this case, the court of appeals held that no public policy was violated when a parent signed an "exculpatory clause" effectively waiving her son's right to bring a negligence claim relating to injuries the child suffered

when using some inflatable amusement equipment. The Court of Appeals held as a matter of first impression that the parent could in effect waive a child's right to recover. The Minnesota Supreme Court has granted review of this decision. Justice v. Marvel, LLC, 2021 Minn. LEXIS 574 (October 19, 2021). To the extent that the Minnesota Supreme Court may, in its review of Justice v Marvel, LLC, limit a parent's rights to waive or invade a child's tort claim, it may then be possible to question the parent's ability to infringe on the child's recovery in an ERISA contract. However, as the law stands in February 2022, if there is plain language in an ERISA plan requiring the child to reimburse ERISA, the reimbursement provision will be enforceable.

It should also be acknowledged that other reported decisions also permit an ERISA plan to take money from a child's recovery. See McIntosh v. Pacific Holding Co., 992 F.2d 882 (8th Cir. 1993), and Riley ex rel. Swanson v. Herbes, 524 N.W.2d 523 (Minn. Ct. App. 1994). However, the legal theory outlined above was not at issue in these decisions. In each case, no separate recovery was made by the parent for the past medical expenses.

D. Equitable Enforcement of ERISA Claims

1. Equitable Claims and Federal Jurisdiction

Great West Life & Annuity Ins. Co. v. Knudson, 122 S. Ct. 708 (U.S. 2002) limits the ability of an ERISA plan to bring a civil action in federal court when the ERISA plan wants to obtain a money judgment on a subrogation claim. The scope of the holding in Great West v. Knudson has been clarified in Sereboff v. Mid Atlantic Medical Services, 126 S.Ct. 1896 (2006). Both cases will be discussed below.

Great West v. Knudson involved federal jurisdiction under § 502(a)(3) of the 1974 ERISA statute, 29 U.S.C. §1132(a)(3). This portion of the law authorizes a civil action to enjoin a practice which violates the ERISA plan or to obtain other appropriate "equitable relief" to redress violations or to enforce provisions of the plan. Relying on old common law distinctions between courts of equity and courts of law, the court held that the ERISA statute did not create federal jurisdiction over ERISA claims for money damages because such a claim was not seeking equitable relief.

On the facts of Knudson, the ERISA plan had paid over $400,000 on behalf of a woman rendered quadriplegic in a car accident. (The plan had actually recovered all but $75,000 from a stop loss insurance policy with Great West, but this fact was not relevant to issues decided by the court.) The injured person eventually settled a product liability claim against Hyundai, obtaining a total of $650,000. Of this settlement amount, $373,000 went to costs and attorneys' fees. A very small portion went to medical expenses, and about $256,000 went into a special needs trust for the injured woman. Great West sued, saying that it was entitled to declaratory and injunctive relief requiring the injured woman to pay $411,000 of any proceeds recovered from a third-party. The court holds that this is essentially an action at law seeking money damages. Under the only portion of the ERISA statute creating jurisdiction, jurisdiction is limited to claims for equitable relief. Framing the complaint as a request for an injunction does not alter the essential character of the claim

as one for money damages for breach of contract. The funds at issue are not in the possession of the injured person (having been placed in trust or having been paid for attorney's fees and costs). There is no equitable claim for an equitable lien on particular property, but rather an attempt to impose personal liability for benefits paid under the contract. The federal court does not have jurisdiction over this type of claim.

After Great West v. Knudson, an ERISA plan may have to seek to enforcement of its subrogation claims for money damages in a state court proceeding. In the alternative, the ERISA plan may seek "equitable relief" in federal court. Sereboff v. Mid Atlantic Medical Services, 126 S. Ct. 1869 (2006), discusses the standards to be met in seeking such jurisdiction over equitable claims.

The Sereboffs settled a tort claim from an auto accident for $750,000. The ERISA plan administered by Mid Atlantic had paid about $75,000 in medical expenses related to the injuries. When no money was paid to the ERISA plan, the plan sued in federal court asking for an injunction requiring the Sereboffs to set aside money from the settlement in order to satisfy the claimed lien. Under the ERISA statute, an ERISA fiduciary may bring a civil action to enjoin an act that violates the ERISA plan or to obtain other appropriate equitable relief to enforce the terms of the plan. 29 U.S.C. § 1132(a) (3). On the facts of this case, the Supreme Court recognized this as a valid claim for "equitable relief by agreement." The decision relies primarily on the analysis of equitable claims in Barnes v. Alexander, 232 U.S. 117, 34 S.Ct. 276 (1914) which cites a "familiar rule of equity that a contract to convey a specific object even before it is acquired will make the contractor a trustee as soon as he gets a title to the thing." 232 U.S. 117, 121, 34 S.Ct. 276. The ERISA contract therefore did create an equitable lien. The Court distinguished the result in Sereboff from the result in Great West v. Knudson on the grounds that the funds in Knudson were no longer in the possession of Knudson, the party to the contract, but had been placed in a special needs trust governed by California law.

In Sereboff, the Supreme Court did not address arguments that equitable defenses, including the equitable "make-whole" doctrine (injured person should be "made-whole" before equitable subrogation would apply) because these arguments had not been asserted in the lower courts.

To the extent that Knudson does deprive the federal court of jurisdiction over some ERISA subrogation claims for money damages, the ERISA plan can still pursue claims for money damages in state court.

U.S. Airways v. McCutchen, 133 S.Ct. 1537 (U.S.2013) finally gave the Supreme Court a chance to put to rest the equitable defenses asserted by Plaintiffs. The Court held that "neither general unjust enrichment principles nor specific doctrines reflecting those principles – such as double recovery or common fund rules invoked by McCutchen – can override the applicable contract. As a result, the terms of the self-funded ERISA contract will conclusively govern the rights of subrogation. That is of course assuming there is no ambiguity and that the plan is not silent on the allocation of attorney's fees.

In 2016, the Supreme Court further clarified the boundaries of an ERISA plan's equitable remedies in a situation where it was not paid by its insured. In Montanile v. Board of Trustees of the National Elevator Industry Health Benefit Plan, 577 U.S. 136, 136 S. Ct. 651 (2016), Montanile was seriously injured by a drunk driver and his ERISA plan paid more than $120,000.00 for his medical expenses. The underlying case against the drunk driver was later settled for $500,000. After payment to his lawyer of $260,000.00, there remained $240,000.00 left. Montanile's attorneys held most of that sum in a client trust account. This was enough money to satisfy the ERISA plan's subrogation lien. Montanile's lawyers and the Board of Trustees for the ERISA plan attempted to resolve the lien. They never reached an agreement, and Montanile's attorney informed the Board that he would distribute the remaining settlement funds to his client unless the Board objected within 14 days. The Board did not respond in the requested time frame and the money was given to Montanile. Six months later, the Board sued Montanile seeking full reimbursement and asked the court to enforce an equitable lien upon any settlement funds or any property that was in Montanile's "actual or constructive possession." The problem was that by the time of the Board's suit, Montanile had spent almost all of the settlement funds and there was no specific, identifiable fund separate from his general assets that the Board's equitable lien could be enforced against.

The Supreme Court remanded the case to the district court to make a factual determination as to whether Montanile kept his settlement funds separate from his general assets or dissipated the entire amount of funds on nontraceable assets. It was the Court's opinion the ERISA plan had an equitable lien by agreement that attached to the settlement funds when Montanile obtained title to those funds. However, based on common law principles of equity, a plaintiff ordinarily could not enforce any type of equitable lien if the defendant once possessed a separate, identifiable fund to which the lien attached but then dissipated it all. Likewise, an ERISA plan cannot simply attach the defendant's general assets in place of the dissipated funds because those assets were not part of the specific thing to which the lien attached. Presumably, the trial court will hold an evidentiary determination of what was done with these settlement proceeds and whether any of it could be clearly traced to particular funds or property in Montanile's possession. But, if no partial remnants of the settlement are found, the plan has "merely a personal claim against the wrongdoer [Montanile] – a quintessential action at law." Id. citing Restatement (First) of Restitution § 215(1) at 866. In such case, the equitable lien is destroyed.

2. Attorney Liability & Ethical Concerns

What liability and ethical obligations does an injured party's attorney have to an ERISA plan?

As in any subrogation situation, an attorney must be careful to avoid potential conflicts of interest. An attorney should agree to represent the rights of a party with a subrogation claim only if this will not compromise the rights of the injured client. Active representation of the subrogation interest should be undertaken with the client's consent.

If the attorney for the injured party explicitly does not represent the subrogation

interests of an ERISA plan, may the ERISA plan nevertheless hold the attorney liable for failing to honor the subrogation claim?

In Chapman v. Klemick, 3 F.3d 1508, 1512 (11th Cir. 1993), an attorney disbursed the net proceeds of a personal injury settlement to his client. The client quite promptly spent all of the money. Since the client was poor and had no ability to pay the ERISA claim, the ERISA plan sought payment from the client's attorney, arguing that the attorney had some fiduciary duty to honor the ERISA "lien" against the recovery. The 11th Circuit rejected the ERISA claims against the attorney. The attorney was free to follow his client's instructions and to release the settlement proceeds to the client. The attorney had not agreed to serve in a fiduciary relationship with the ERISA plan, and the ERISA contract could not impose such an obligation on the attorney. Citing what it characterized as a well-known authority, the court noted that no one can serve two masters, that you cannot serve both God and mammon. "A trust fund [ERISA plan] is not exactly 'mammon,' but an attorney's duty of loyalty to his client is very nearly sacred." Chapman v. Klemick, 3 F.3d 1508, 1512 (11th Cir. 1993).

The Eighth Circuit reached a similar conclusion in Southern Council of Industrial Workers v. Ford, 83 F.3d 966 (8th Cir. 1996). In that case, the ERISA plan sued the participant's lawyer and the third-party insurance carrier with which he settled for breach of fiduciary duty. The Eight Circuit refused to impose fiduciary liability on either given the "unacceptable conflicts of interest" such liability could create. Id. However, the attorney did become liable to the ERISA plan because he had signed the "subrogation agreement" that the ERISA plan had drafted.

If an attorney signs on to a client's agreement that an ERISA subrogation or reimbursement claim will be honored, this may very well support an equitable claim by contract against the attorney if the subrogation claim is not honored. The scope of equitable relief in federal court will then be governed by the Supreme Court decisions discussed above.

That is not to say that the lawyer is free to simply ignore an ERISA lien, especially if the proposed net recovery is insufficient to resolve an underlying lien. Minnesota Rules of Professional Conduct 1.15(b) require that if a lawyer is holding settlement funds in his or her trust account, and the right of the lawyer or the law firm to receive funds from that settlement recovery is disputed by a third-person claiming entitlement to the funds, the disputed portion shall not be withdrawn until the dispute is finally resolved. In Montanile, the lawyer appears to have satisfied that ethical duty by first providing notice that the sum he was holding in trust after a reduction for his fees and expenses was enough to satisfy the lien, and that he would distribute those funds to his client unless the Board objected within 14 days. Because the ERISA Board did not make a timely objection, he disbursed the remaining sum. Nevertheless, the requirements of safekeeping property required by Rule 1.15(b) are an area of concern when dealing with unreasonable lien holders, clients, and limited funds.

V. Medical Provider Liens

Unlike subrogation or reimbursement liens, which generally involve health insurance companies, unpaid medical providers have direct provider claims against injured Plaintiffs for unpaid bills. The relevance of provider liens with regard to a subrogation analysis pertains to a settlement technique that is sometimes used by settling defendants to protect themselves from further liability. The technique of the settling defendant is to add the name of either the medical provider or health insurer who may have a potential lien, and to list on the settlement check the name of said provider or health insurer. The purpose, of course, is to force the Plaintiff to have all other necessary parties sign off on the settlement by endorsing the check.

In 2014, both Adan v. Allstate Ins. Co., 2014 WL 30406 (Minn. Ct. App. 2014) and Aden v. Allstate Indemnity Co., 2014 WL 2013449 (Minn. Ct. App. 2014) addressed the appropriateness of this settlement technique. In Adan, a motor vehicle liability claim was settled for $6,500. Plaintiff Adan had received MRI scans at SUMA (Stand Up Mid America). SUMA filed a UCC lien against the liability claim for unpaid services. SUMA asked Allstate to put its name on the settlement check. Allstate followed the instructions of SUMA and was sued by Adan for breach of contract. The court held that Allstate acted appropriately to avoid risk of having to pay twice.

In Aden, we have similar parties but a different result. Plaintiff reached a liability settlement with Allstate for $4,000. Again, SUMA had filed a UCC lien insisting it had to be listed on any settlement checks. Allstate confirmed with Plaintiff that it would not issue the check without making it jointly payable to both Plaintiff and SUMA. Plaintiff sued for breach of contract. The court's holding goes against Allstate, since a "court may not grant equitable relief when the parties' rights are governed by a valid contract." Id. Allstate was to pay Aden $4,000 in return for a release of claims.

These decisions illustrate that, as a practical matter, when resolving claims it is best to include with precision all subrogation and provider liens that are or are not included as terms of the settlement. See Tomlinson v. Landers, 2009 WL 1117399 (M.D. Fla. 2009) (holding that the decision to "list Medicare as a payee on the settlement check may have been in [defendant's]…best interest, however [defendant]….was not required by federal law to include Medicare on the settlement check."); Zaleppa v. Seiwell, 2010 PA Super 208, 9 A.3d 632 (2010) (likewise confirming that following a successful verdict for the Plaintiff in which Medicare may have paid some of the involved medical bills that it was not satisfaction of the verdict to add Medicare to the award payment.)