

# **COLLATERAL SOURCE ISSUES**

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## 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 sources 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 first? 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. § 548.36, 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. § 548.36**

Minn. Stat. § 548.36 took effect on August 1, 1986. 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. § 548.36, 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. § 548.36, 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).

Benefits from a private disability policy are excluded from the collateral source definition if "premiums were wholly paid for by the plaintiff." Minn. Stat. § 548.36, 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 “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.

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. § 548.36.

## **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. § 548.36 subd. 2(1).

When collateral source payments have been made and no subrogation is asserted, a deduction will be made by the court. Figuring 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. § 548.36 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. § 548.36 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. 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 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 which 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. § 548.36, 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 Vandeneuvel 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.

It should be stressed that this consideration of amounts paid for premiums occurs only if there is no subrogation claim so that a collateral source offset is going to be made. Under these circumstances, the amount of the offset is reduced by the premiums paid for two years prior to the injury.

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.

#### **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. § 548.36, 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 two 2005 decisions, the Court of Appeals gave the benefit of the discount to the plaintiff.

Foust v. McFarland, 698 N.W.2d 24 (Minn. Ct. App. 2005), Blue Cross had apparently satisfied about \$115,000 in medical bills by payment of \$43,000. The jury award, pursuant to stipulation, was for the full amount of the bills. One would infer from the decision that Blue Cross had waived its subrogation rights (or had been paid by defendant); in any event, no claim was being made for the \$43,000 paid by Blue Cross. The issue was whether or not the plaintiff was entitled to recover the \$72,000 remaining after the set off for the Blue Cross payment. Without too much analysis, the court denied the claim for an offset based upon the health insurance discount. The court mentions the Supreme Court decision in Stout v. AMCO, Inc., 645 N.W.2d 108 (Minn. 2002) that denied a no-fault insurance carrier the benefit of a health insurance discount, and suggests that the purposes of the collateral source statute and no-fault statute have similarities.

A different panel of judges heard a similar case in Tezak v. Bachke, 698 N.W.2d 37 (Minn. 2005). In this case, the only claim involved medical expenses, because the plaintiff had died of unrelated causes before the injury claim went to trial. The facts were not disputed. Bills of over \$100,000 had been satisfied by health insurance payments of \$32,000. Subrogation was asserted and there was no dispute over the payment of the \$32,000. The issue before the court was whether or not the defendant also had to pay the remaining \$68,000. The court gives a more thorough analysis of the issue in Tezak than in Foust. In Tezak, the court concludes that the real issue is whether the discounted amount is governed by the collateral source statute or by common law rules. 698 N.W. 2d at 41. Under the collateral source statute, the district court is told to "determine amounts . . . that have been paid" by collateral sources. An offset is then to be granted for the "amounts

determined” unless subrogation has been asserted. This language has no application to gaps in payments created by the provider discounts given to health insurance. Applying common law principles to this discounted amount (in this case, \$68,000) the defendant remains liable for the full amount awarded as damages.

## **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 tortfeasors 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 which creates the claim.

### **A. Federal Employees' Compensation Act**

The federal workers' compensation program is a model for the most aggressive type of statutory subrogation that can exist.

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.

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 should be noted that this FECA claim is not applied to 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 are no contested cases leading to reported decisions on this topic.) The position of the federal agency with respect to claims in Minnesota can be verified through the Office of the Solicitor, U.S. Department of Labor, 230 South Dearborn Street, Chicago, Illinois 60604 (address current as of 2001).

## **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 to both reimburse the government and pay the injured party. In these circumstances, who has the claim to a first priority 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 (4<sup>th</sup> Cir. 2004).

42 U.S.C. § 1395y(b)(2)(B) provides the statutory authorization for Medicare subrogation. Regulations implementing the statutory right to subrogation are codified at 42 C.F.R. §§ 411.20 et seq.

Dealing with Medicare claims will become more complicated with the addition of Medicare Part D in 2006 covering prescription drugs. And Medicare is establishing requirements in 2007 to require money to be set aside in trusts 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 places 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 are scheduled to apply to all settlements occurring on or after July 1, 2009. Insurance companies, under this new system, will have some obligation first to 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 new provisions of the law, an insurance company may face a penalty of \$1,000 per day for each day of non-compliance with the new Medicare rules. As of May, 2008, the implementing rules have not yet been published, so it is not possible to assess the extent to which the Medicare bureaucracy will complicate attempts by the parties to a claim to settle injury claims by Medicare recipients.

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 claims exceed 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 (9<sup>th</sup> 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 (9<sup>th</sup> 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. § 548.36. Consequently, the tortfeasor (and the 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. On some occasions, this provides a benefit to the injured party. For example, in Rybicki v. Hartley, 792 F.2d 260 (1st Cir. 1986), medical bills of approximately \$31,000 were satisfied by a Medicare payment of \$9,000. Because the hospital had accepted Medicare’s payment in full satisfaction of its bill, the Medicare subrogation claim was the only one that needed to be satisfied from the claimant's recovery.

It should also be noted that federal law explicitly states 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 has to sue 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 Insurers under contract with Medicare

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

It should be noted, however, that in some cases Medicare actually 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 comparable 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. Consequently, the nature and extent of potential subrogation claims are likely to be governed by the contract under which the private company provides benefits. It can then be argued that such health insurance contracts should be reviewed under applicable state laws. (One may contrast this federal Medicare system to the state system created for MinnesotaCare. The MinnesotaCare statute permits the state to contract with private insurance companies but the state statute then explicitly provides that the term "state agency," for purposes of subrogation liens, "includes prepaid health plans under contract with the commissioner." Minn. Stat. § 256L.03 subd. 6.) In the absence of any federal law to the contrary, it can reasonably be argued that Minnesota's private insurers that provide Medicare replacement coverage pursuant to a contract with Medicare are subject to the subrogation limitations on Minn. Stat. § 62A.095 requiring full recovery for the injured person prior to payment on any subrogation claim. Minn. Stat. § 62A.095 applies generally to any health plan sold to cover a resident of the state and, if read literally, could apply to a private insurer being paid premiums by Medicare.

Issues concerning subrogation claims by private companies providing "replacement

coverage” for Medicare are reviewed in Humana Medical Plan, Inc. v. Valdez, 25 F.Supp. 2d 1347 (M.D. Fla. 1997); Share Health Plan of Illinois, Inc. v. Alderson, 674 N.E.2d 69 (Ill. App. 1996); and Care Choices HMO v. Engrstrom, 330 F. 3d 786 (6<sup>th</sup> Cir. 2003). Each case confirms that applicable federal laws do not detail the nature and extent of potential subrogation claims for these entities.

In a dispute over subrogation claims asserted by a private health insurance company providing replacement Medicare coverage, it would certainly be appropriate to obtain a copy of the contract between the provider and Medicare to determine if subrogation issues are even mentioned in the provider agreement.

#### 6. Medicare may require a trust to cover 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.

If a Medicare eligible individual wants to settle a claim for \$25,000 or more, Medicare will claim the right to review the proposed settlement to determine what portion needs to be placed in trust to cover future medical expenses.

As of January, 2007, this system is just being put into place. At this point it is difficult to predict the extent to which the Medicare system will limit the ability of a Medicare recipient to receive any benefit from a potential tort recovery.

### **D. Veteran's 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**

The state Medical Assistance program is set up to administer the federal Medicaid

program, which is Title XIX of the Social Security Act. In 1987, in response to federal requirements, the state set up a new statutory scheme for asserting its subrogation rights.

The statutory system for asserting Medical Assistance liens was found to be invalid by the Minnesota Supreme Court in Martin v. Hoff, 642 N.W.2d 1 (Minn. 2002), *cert. denied*, 123 S.Ct. 2668 (2003).

Under Martin, Medical Assistance's subrogation claim is limited to the injured person's recovery for medical expenses and does not attach to any recovery for other types of damages. Under Martin, Medical Assistance actually owns the injured person's claim for medical expenses, since this claim has been assigned to the welfare agency in the Medical Assistance application process.

In 2006, the United States Supreme Court issued a decision confirming the basic holding in Martin. In Arkansas Dept. of Health and Human Services v. Ahlborn, 126 S.Ct. 1752 (2006), the court held that a Medicaid claim for reimbursement by the state is limited by federal law to that portion of a recovery representing payment for past medical expenses.

In Guzman v. U.S. West, Inc., 667 N.W.2d 489 (Minn. Ct. App. 2003), the defendant settled the Medical Assistance subrogation claim directly with Medical Assistance and obtained a general release of all claims – past, present and future. Because the injured person had assigned to Medical Assistance “all claims for medical care,” the general release executed by Medical Assistance was interpreted to be a bar to the plaintiff's claims for future medical expenses. The court of appeals decision notes that this result is inequitable and unfair, since the plaintiff has no guarantee that future bills will in fact be paid by Medical Assistance. The court, however, determines that the result is required by existing law and issues of fairness will have to be resolved by the legislature.

The validity of the Guzman decision is called into question by the United States Supreme Court decision in Arkansas Dept. of Health and Human Services v. Ahlborn. In Ahlborn, the court discusses the “assignment” permitted by federal law governing Medicaid. The court rejects the states argument “that the automatic assignment effected by the Arkansas statute rendered the proceeds the property of the State.” 126 S.Ct., at 1763. Despite the assignment, the injured person “retained the right to sue for medical care payments, and the State asserted a right to the fruits of that suit once they materialized.” 126 S.Ct., at 1764. The state's only valid claim is a lien to the portion of the recovery that represents payment for past medical expenses.

After Martin, it is clear that the state agency is willing to negotiate a settlement of its claims directly with either the injured party or with the defendant. As a practical matter, the agency generally contacts the attorney for the injured individual to determine if the claimant's attorney will agree to protect the agency's interests. In the absence of cooperation, the agency will be separately represented by the office of the Minnesota Attorney General and may elect to settle its claims separately with the defendant.

The following summary describes procedures that appear to apply following the Martin decision.

### **1. Obligation to Notify**

Prior to 1993, the welfare recipient was the only one with the obligation to notify the state agency concerning potential claims. A defendant who settled a case before the filing of any Medical Assistance lien would be insulated from subsequent claims by the state agency. See State, Dept. of Human Servs. v. Mohs, 496 N.W.2d 817, 820 (Minn. App. 1993), *pet. for rev. denied* (Minn. April 29, 1993).

After the Mohs decision, the statute was amended to provide that any person who is a party to a claim in which the state may be entitled to a lien shall notify the state about the potential lien prior to negotiating a settlement. Minn. Stat. § 256B.042, subd. 4(c) (Supp. 1995). The change in the statute may expose a defendant to Medical Assistance liens filed after a settlement, if the defendant had actual notice of Medical Assistance payments at the time of settlement.

These notification requirements were not at issue in Martin, so they should remain in effect.

### **2. Distribution Of Settlement - Attorney's Fees**

Minn. Stat. § 256B.042, subd. 5, provides a formula for distributing proceeds of personal injury claims. This statutory formula in many cases would now be inconsistent with the Martin decision, since the formula would sometimes allow the Medical Assistance claim to invade portions of the recovery other than those for medical expenses. Nevertheless, it is useful to understand how the statutory formula operates, since it may provide a basis for negotiations even if it is not mandatory.

Under the statutory formula, attorneys' fees and expenses are paid first. Second, the welfare department is paid. Third, the injured party gets what is left. However, the 1987 law does guarantee that the injured party receive some portion of the proceeds. The injured party must get at least one-third (1/3) of the proceeds after attorneys' fees and expenses.

After Martin, the agency still takes the position that its independent claim for medical expenses is a first priority claim which must be paid before the injured person makes any recovery. However, the agency does appear willing to negotiate with the plaintiff and to reduce its claim for a pro rata share of attorney's fees and costs. This reduction in the total MA claim, based on its pro rata share of attorney's fees, was not done prior to the Martin decision, since it was not required by the lien statute. See Dixon v. Johnson, 430 N.W.2d 253, 256-57 (Minn. Ct. App. 1988).

### **3. 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 statutes assert claims against all parts of the injured person's recovery. In Martin and in the U.S. Supreme Court decision in 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. Such issues should be negotiated with the agency at the time of any settlement.

#### **4. 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, Dept. 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, however, 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. Again, 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.

#### **5. 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.)

## **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 damage claim against a third party. In such cases, workers' compensation will likely 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 book. 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 American 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 American Insurance Company, 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 nonrecoverable 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 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 Company 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 which 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. § 548.36) to be applied to workers' compensation payments when calculating a UIM claim, since there is generally no subrogation claim to be asserted. See Western National 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 damage 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 that he would have occupied 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. Since the facts leading to Lambertson type contribution claims are not common in motor vehicle claims, it is sufficient to note that the contribution claim will generally be limited to the amount of workers' compensation benefits paid by the employer.

#### **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. National Indemnity Company v. Mutual Service Casualty Company, 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 arise 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 which 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 holds 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 Mutual Insurance Company, 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 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 Minnesota, Inc., 498 N.W.2d 519, 520 (Minn. 1993), the court was faced with a contract provision which 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, even though the injured party was not fully compensated. [With respect to payments by private health insurance, the holding in Hershey was superceded by statute. See Minn. Stat. §62A.095.]

In Medica, Inc. v. Atlantic Mutual 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 which may be legally responsible for the injuries. This contractual language is 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. Minnesota School Board Ass'n, 600 N.W.2d 475 (Minn. Ct. App. 1999) when both 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 which 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.)

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

which 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 Dept. of Natural Resources, 305 N.W.2d 317, 319 (Minn. 1981).

### **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 which 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 in 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 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 parent 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 which would require a child to reimburse the health insurance carrier from the child's general damages. Clearly, this is no longer a subrogation claim. Nevertheless, in Riley ex rel Swanson v. Herbes, 524 N.W.2d 523 (Minn. Ct. App. 1994), the court enforced an ERISA contract which asserted a first priority subrogation interest against any third party, with the subrogation claim to be paid by or from "any recovery due from that party to the participant or the participant's dependent." Id. at 527. The court permitted the subrogation claim to be paid from the minor's settlement proceeds even though the opinion does not suggest that there was any recovery of medical expenses by the child's parents. Since the claim involved an ERISA contract, which is not governed by Minnesota law, the same contract provision may well be invalid as conflicting with Minnesota public policy. These issues are not addressed in Riley ex rel Swanson v. Herbes.

Even in an ERISA context, however, a Naig type release might be tried, if the defendant is willing and if the ERISA contract language does not prohibit its use. Cooper Tire & Rubber Co. v. St. Paul Fire & Marine Ins. Co., 48 F.3d 365, 368 (8<sup>th</sup> Cir. 1995). In Cooper Tire, the valid release provided for the following:

It is expressly understood that the subrogation and other rights of [the employer] as provided by the Plan and the Receipt and Subrogation agreement [are] reserved and this settlement and release is not intended by the parties to in any way affect such subrogation and other rights [of the employer under the plan].

Id. at 371.

In Badger Equip. Co. v. Brennan, 431 N.W.2d 900, 904 (Minn. Ct. App. 1988), an ERISA plan was not permitted to claim the proceeds from a Naig settlement made on

behalf of a young adult who was injured as a child and whose medical bills were paid by his father's ERISA plan. This holding in Badger was reaffirmed in Blue Cross / Blue Shield of Rhode Island v. Flam, 509 N.W.2d 393, 398, n. 2 (Minn. Ct. App. 1993), *rev. den.* (Minn. Feb. 24, 1994).

If a subrogation claim has been asserted, the insurance company may have a due process right to notice of the hearing approving the settlement of the child's claim. Even if the child is legally entitled to be fully compensated before a subrogation claim would exist, the insurance carrier may wish to contend that the settlement is based upon and includes compensation for medical expenses. See Kleven v. Elm, No. C9-99-1872, 2000 WL 782007 (Minn. Ct. App. June 20, 2000).

## **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 provides that any state law relating to an employee benefit plan is preempted by ERISA. Congress intends that a corporation or a union which 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 which 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 Corporation 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 Insurance Company v. Massachusetts Travelers Insurance Company, 471 U.S. 724, 105 S.Ct. 2380 (1985), and FMC Corporation v. Holliday, *supra*, at 410. See also Jader v. Principal Mut. Life Ins. Co., 925 F.2d 1075, 1076-77 (8<sup>th</sup> 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 (8<sup>th</sup> Cir. 1997).

The Minnesota Supreme Court has held that ERISA's preemption of state law does not apply to the state statute which governs the procedures for deducting collateral source payments following a verdict. The procedures of Minn. Stat. § 548.36 will apply to ERISA claims. Gilhousen v. Illinois Farmers Insurance Group, 582 N.W.2d 571 (Minn. 1998).

It should also be noted that substantive state laws unrelated to employment contracts are not preempted by ERISA. For example, substantive laws governing tort recoveries in wrongful death claims or in claims for minor children are not pre-empted by ERISA. 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. Georgia 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 Company 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 Insurance 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 National 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 once 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 Automobile Dealers Association of California, 64 F.3d 1389 (9th Cir. 1995); Provident Life and Accident Insurance Co. v. Williams, 858 F. Supp. 907 (W.D.Ark 1994).

### **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. 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 or not 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 which 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 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 (8<sup>th</sup> 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.

## **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 On Behalf of 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 Corporation, 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.

## **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.

## 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, 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 which 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).

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 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, 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 supercede 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 , 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 which 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. Minnesota School Board Association, 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 based on medical payments made "as a result of illnesses or injuries for which another party is responsible." 600 N.W.2d at 479.

## **10. Ethical Considerations – Attorney's Obligations**

What 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 (11<sup>th</sup> 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 11<sup>th</sup> 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 (11<sup>th</sup> Cir. 1993).

## 11. ERISA Claims Involving Children

There is an issue of law which may be raised when an ERISA plan seeks reimbursement of medical payments made for treatment of an injured child. It can reasonably be argued that the child's recovery of damages for bodily injury is not subject to the ERISA contract. The argument has two parts. First, under Minnesota law, the parent does not own the child's right of recovery for bodily injury. Second, under federal common law, the parent cannot by contract convey rights that the parent does not own.

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 does 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 which do not regulate ERISA contracts and which are not superseded by any ERISA contract. Consequently, the starting point for the legal argument is to separate the child's legal claim for damages under Minnesota law from the parent's claim for past medical expenses.

ERISA contract language will typically assert a right to repayment from any recovery made either by the parent or by the child. Generally, explicit ERISA contract language is enforceable despite any conflicting state law, because states are not permitted to regulate ERISA contracts. 29 U.S.C. § 1144; FMC Corp. v. Holliday, 498 U.S. 52, 111 S. Ct. 403 (1990). However, even ERISA contracts are not exempt from all established legal principles. Common law principles recognized by federal law do apply to and do limit ERISA contracts. Pilot Life Ins. Co. v. Dedeaux, 107 S.Ct. 1549 (1987). Consequently, even the clear and unambiguous language of an ERISA contract may be unenforceable if it does not comply with federal common law.

Using common law principles, a federal district court decision questions the ability of an ERISA plan to take money from a child's recovery for personal damages. Clardy v. ATS, Inc. Employee Welfare Benefit Plan, 921 F. Supp. 394 (N.D. Miss. 1996). In Clardy, an ERISA plan paid medical expenses for a child (Kenneth Clardy) who was injured in an accident. The ERISA contract stated that ERISA would be reimbursed from the proceeds of any tort settlement. Did the father (Ernest Clardy) have the ability to convey such a right to the ERISA employer? Under Mississippi's substantive law, the father could not assign his child's right to liability insurance proceeds. This substantive Mississippi law was not an attempt to regulate any employment contract. Rather, the state law established the rights which exist between the parents and the child. Mississippi's laws regulating such domestic relationships are not in anyway preempted by an ERISA contract. Such state laws simply establish the respective rights of Mississippi parents and children.

Having clarified that the parent did not have the legal right to assign the child's claim

to liability insurance proceeds, the Clardy court then held that the proposed assignment of rights to the welfare benefit plan in the ERISA contract was invalid. “It is a fundamental premise of law that a person generally does not have the right to assign or control the rights and property of another. This is true even between parent and child.” 921 F. Supp. at 399.

The Clardy court went on to observe that, even if ERISA did somehow preempt Mississippi’s substantive law concerning parents and children, there was still no federal common law principle which allowed a parent to forfeit rights owned by his child. “If the state law is displaced by federal in this regard, from whence does the parents’ power to assign their child’s rights arise? If they have none, then the ‘reimbursement agreement’ in the case at bar is still void because the parents had no authority to assign their child’s rights.” *Id.* at 400.

This common law analysis begins with fundamental questions about the ERISA contract. Who are the parties to the contract? Generally, the parties will be an employer and the employee (the parent). Under federal common law, the employer should not be able to receive in a contract with the parent something which the parent has no legal right to convey. Under Minnesota law, the parent does have a claim for past medical expenses incurred for the child’s care. The ERISA contract can create a valid claim for subrogation or for reimbursement with respect to the parent’s claim for past medical expenses. However, Minnesota law, Minn. Stat. §540.08, does not give the parent ownership of the child’s personal claim for damages from a bodily injury. Before the ERISA plan can assert any valid claim against a child’s recovery for damages that the child has suffered, the ERISA plan must explain how it could, in its contract with the child’s parent, acquire from the parent (the employee) rights which the parent never possessed.

It must be acknowledged that reported decisions do permit an ERISA plan to take money from a child’s recovery. See McIntosh v. Pacific Holding Co., 992 F.2d 882 (8<sup>th</sup> 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.

The legal distinctions in this argument are best made clear if a guardian ad litem is appointed for the child and if separate recoveries are then negotiated for the child and for the parent. The recovery by the parent is subject to the ERISA claim for subrogation or reimbursement, and it can be paid to ERISA. It can then be argued that the child’s separate claim, asserted by the guardian ad litem, has never been conveyed to the ERISA plan, because the parent never owned any portion of this recovery. Proceeding in this manner (i.e., with two separate settlements) also may also help in distinguishing the adverse decisions in the McIntosh and Herbes cases, each of which involved settlement in a single sum of money.

#### **D. Enforcement of ERISA claims**

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 majority of the court determined 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.

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