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Track A – Session 1

Current Civil Litigation Topics - Subrogation Settlement Issues and Social Media Discovery

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About the Presenters...

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SOCIAL MEDIA: FROM THE DEFENSE PERSEPCTIVE

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I. Understanding the Landscape of Social Media:

Social media applications and websites cover almost all aspects of a person's life. Different platforms allow for sharing different types of information. While some platforms allow for the sharing of most day-to-day activities, some smaller platforms specialize in sharing information regarding a user's pictures, videos, career, fitness goals, or eating habits. The list below includes a snapshot of some of the most popular social networking sites.

a. Facebook: The most popular social networking site. Facebook allows users to post comments, videos, photos, and events. It also gives users the option to display their current emotions and current location. The website also contains a "chat" function, which allows users to have small group or one-on-one conversations with other users. Users can access Facebook both from their computers and through an app on their cell phone or tablet.

b. Instagram: An online mobile photo-sharing and video-sharing service. Instagram is owned by Facebook and the app allows its users to simultaneously share photos and videos on Facebook, Tumblr, Swarm, Twitter, and Flickr.

c. Myspace: An internet and mobile social media platform allowing users to communicate via messaging. Previously the most popular social networking site, Myspace experienced a significant loss in users after the launch of Facebook. A recent "relaunch" of Myspace is primarily focused on the music industry and includes editorial content, radio stations, music mixes, and videos.

d. Google +: An online social media service that allows users to organize their connections into "circles" and thereby share different content with different circles. The account also allows users to opt in to a Search Plus program which merges content and information from a users Google+ account and the users web search results. Google+ also contains a "hangout" service which allows free video conference calls for groups of up to 10 people.

e. Twitter: An online and mobile social networking service that allows users to post 140-character messages called "tweets." It also allows users to post links to internet websites, photos, and videos. Tweets often come as a "stream of consciousness" as users experience events.

f. Snapchat: A mobile image messaging application that allows users to take photos or record up to 10 seconds of video at a time. The user then has the option to share this information to individual connections or to place the information on the user's "story," which allows all connections to view the information. Snapchat also includes a private messaging service, which allows users to participate in one-on-one conversations. Like Twitter, users tend to use the application to show connections what they are experiencing in real-time.

g. Vine: A mobile social media platform that allows users to share video clips up to six seconds long. The clips then play on a loop. Users have the option to simultaneously share their videos with Facebook and Twitter.

h. Tumblr: A social media site that allows users to microblog. This allows users to post multimedia and short-form blogs and to follow other users' blogs.

i. Flickr: An online social media service that allows users to share and embed personal photographs and videos. It is used not only by those sharing photos and videos to an online community, but also by researchers and bloggers.

j. YouTube: A video-sharing website that allows users to upload, view, rate, share, and coment on videos.

k. LinkedIn: A business-oriented social networking service. It allows users to upload their educational and career information to their profile. Users also post career-

oriented comments, photos, and website links. The website also allows users to research companies they are interested in working at, and also allows job recruiters, head hunters, and HR personnel to post job listings and review the profiles of potential candidates.

l. MyFitnessPal: A mobile and internet social media platform that tracks an individuals diet and exercise to determine optimal caloric intake. Users share the food that they ate on a particular day and any exercise that they completed.

m. Fitbit: A mobile social media platform that is similar to MyFitnessPal. However the application connects to a wearable technology that measures data such as an individual's number of steps, heart rate, quality of sleep, and steps climbed. This information can then be shared with other users.

II. Rewards vs Risks for a Defendant Using Social Media

a. Rewards

   i. It quickly and effectively disseminates information to a large audience.

   ii. It can be a form of creative expression.

   iii. For corporations, it can act as a forum to quickly communicate with consumers and to address individual consumer concerns.

b. Risks

   i. For governmental defendants, the use of social media may implicate First Amendment concerns.

   ii. The use of social media may lead to the disclosure of confidential, sensitive, or proprietary information.

   iii. Posts on social media can be used to directly contradict a defendant's version of the incident at issue in litigation.

III. Expectations of Privacy Generally do not Exist in Social Media

a. What is considered a "reasonable expectation of privacy" evolves with changing technology. However, courts have generally taken the position that the public nature of social media has eroded the concept of an expectation of privacy in online communications.

   i. *Romano v. Steelcase, Inc.*, 30 Misc.3d 426, 907 N.Y.S.2d 650 (N.Y.Sup.2010)

1. "When plaintiff created her Facebook and MySpace accounts, she consented to the fact that her personal information would be shared with others, not withstanding her privacy settings. Indeed that is the very nature and purpose of these social networking sites else they would cease to exist. Since the Plaintiff knew that her information may become publicly available, she cannot now claim that she had a reasonable expectation of privacy. As recently set forth by commentators regarding privacy and social networking sites, given the millions of users, "[i]n this environment, privacy is no longer grounded in reasonable expectations, but rather in some theoretical protocol better known as wishful thinking."

2. The court allowed discovery on both past and present social media information, despite the privacy settings on the user's account.

IV. Organizational Defendants and the Duty to Monitor

a. An institution is under no affirmative duty to monitor the electronic communications of employee's using the organization's computers.

b. However, once an institution is aware that its computer system has been used to make inappropriate postings, the institution should take action to prevent its reoccurrence.

    i. *See, e.g. Doe v. XYC Corp.*, 887 A.2d 1156 (N.J. Super. A.D. 2005)

        1. A company discovered that one of its employees visited sexually explicit websites. The company took no steps other than giving the employee a verbal warning to stop visiting.

        2. Two years later, the same employee was accused of sexual abuse of a minor.

        3. The minor's mother sued the company, and the court sided with the mother, holding that once the company learned that its employee had used company computers to visit child pornography websites from work, it had a duty either to fire the employee or notify authorities.

V. Defendant's Informal Discovery of Social Media

a. Short of sending formal discovery requests, the defense may gain valuable information on the plaintiff simply by searching the internet for the plaintiff's social media footprint. However, during informal discovery, defendants should

stick to only that information that is on the plaintiff's "public" social media profile.

i. Public Information

1. A general social media search of the plaintiff often provides a wealth of information.

2. Methods:

   a. A Google search of the plaintiff.

      i. Type in everything known about the plaintiff. This includes their name, plus keywords related to their job, marital status, location, and school will likely bring up social media and other identifiable accounts.

   b. Using a social media search engine.

      i. These aggregate social media search engines can search up to 70 different social media sites by name, email, phone number, username, and address.

      ii. Examples: Spokeo, Whos Talkin, Social Mention.

   c. Search individual social media websites.

      i. Start with the larger forums, i.e. Facebook and Twitter, and work through the smaller forums.

      ii. Keeping an eye on the plaintiff's "friends" or "connections" on social media. The public portions of the plaintiff's social media accounts may assist the defense in finding additional witnesses.

ii. Private Information

1. During informal discovery, a defendant should not attempt to access the portions of the plaintiff's profile that the plaintiff has placed in "private" mode.

2. Deliberately concealing the purpose of a social media connection may be interpreted as inducing an adverse party to provide information.

3. This includes lawyers, and non-lawyer assistants such as paralegals and secretaries.

    a. The lawyer in charge of the case may be held responsible under the Model Rules of Professional Conduct Rule 8.4 governing misconduct, which prohibits dishonesty, deception, fraud, and misrepresentation.

VI. Defendant's Formal Discovery of Social Media

a. To date, many states have not directly addressed many of the issues surrounding formal discovery of social media, thus many questions remain unanswered. However, a number of concerns have been addressed by the courts.

  i. Is social media content discoverable?

   1. Yes, but it generally must be relevant to the issues surrounding the litigation.

    a. *Mackelprang v. Fidelity National Title Agency of Nevada, Inc*., No. 2:06-cv-00788, 2007 WL 119149 (D. Nev. Jan. 9, 2007).

    b. Plaintiff claimed sexual harassment and emotional distress during the course of her employment. The defendant submitted a motion to compel the production of email communications on two MySpace accounts allegedly set up by the plaintiff. The defendant had served a subpoena on Myspace.com to produce all records for the accounts, including private emails. Myspace produced certain public information but did not produce private information. The plaintiff also refused to sign a consent form.

    c. The court denied the defendant's motion to compel because the defendant had "no information" relating to the identities of the persons whom the plaintiff had exchanged emails with or about the content of those emails. Rather, the court considered the request merely a "fishing expedition."

   2. *Romano v. Steelcase Inc*., 30 Misc.3d 426, 907 N.Y.S.2d 650 (N.Y.Sup.2010)

    a. The defendant sought an order allowing access to the plaintiff's current and historical Facebook and Myspace pages and accounts, including all deleted pages. The defendant argued that the plaintiff had posted information

on these sites that was factually inconsistent with the plaintiff's claims about the extent and nature of her injuries. The defendant supported this argument with pictures and postings shown on the plaintiff's public Facebook and Myspace pages.

b. The court found that because public portions of the social networking sites contained material that was contrary to the plaintiff's claims, there was a reasonable likelihood that private portions of her sites might contain further relevant information relating to her activities and enjoyment of life.

ii. <u>Is private social media content discoverable?</u>

1. Yes. There is no discovery rule prohibiting access to information placed in a user's private setting. In fact, most discovery—social media or otherwise—involves disclosing information that a party would rather keep private.

iii. <u>To whom should defendants direct discovery requests?</u>

1. Avoid sending requests directly to the social networking company.

   a. Stored Communications Act, 18 U.S.C. §§ 2701-2712.

      i. Prohibits certain internet communication providers from disclosing private communications to certain non-governmental entities and individuals.

2. Send discovery requests to the plaintiff.

   a. Requests should not simply be a "fishing expedition."

   b. Requests should be narrowly tailored

      i. Date restrictions

      ii. References to particular portions of the case.

         1. Defenses.

         2. Specific claims made by the plaintiff.

VII. <u>Best Practices Regarding a Defendant's Social Media</u>

a. Check Privacy Settings

   i. Most social media platforms allow a user's information to be viewed in both a public and a private setting.

   ii. The defendant's social media platforms should be placed on a private setting.

   iii. The defendant should spend a few minutes Googling himself/herself. This may help uncover instances of others purporting to be the defendant or the voice of the defendant company without authorization or permission.

b. Deleting Posts

   i. The defendant should generally understand the duty to preserve evidence. The issue of deleting posts has not been fully litigated and states differ on their opinions. However, timing is important. After the commencement of discovery, and certainly after discovery requests have been made for the defendant's social medial information, a defendant should NOT delete social media posts.

      1. Florida Advisory Opinion 14-1

         a. Confirmed that attorneys can advise clients to increase privacy settings to conceal social media content from public eye AND could remove information relevant to the foreseeable proceeding from social medial so long as the data was preserved and no preservation and/or spoliation of evidence rules were broken.

      2. However, courts have imposed severe sanctions for altering social media content after litigation has commenced.

         a. Virginia: At attorney was fined $542,000 and a client $180,000 for spoliation of evidence when the lawyer directed the client to delete social media photographs.

         b. New Jersey: An adverse inference instruction was leveled against a plaintiff who deactivated social media accounts after the defendants requested access.

         c. Virginia: At attorney was suspended for five years for counseling a client to delete Facebook posts and photographs following a request for production.

c. Future Discovery

i. Anything the defendant posts on a social media platform regarding the incident going forward may be discoverable.

d. Avoid Strangers

i. The defendant should use caution when accepting connections on social media while litigation is pending. Although attorneys should not make a connection with a represented individual, it is best to keep the defendant's personal information as private as possible.

e. Privilege

i. The defendant may jeopardize privilege if he/she posts on a social media forum regarding conversations had between the defendant and his/her attorney.

f. Social Media Policies

i. Companies using social media should have a social media policy in place. This should include information regarding:

1. What social media platforms the company will use.

2. Who will have access to post on those platforms on behalf of the company.

3. When will social media postings occur.

4. What topics will the social media posts include.

5. A procedure to correct information posted on social media that was later determined to be false.

Social Media: From the Defense Perspective

Amy Doyle
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Understanding the Landscape

- Facebook
- Instagram
- Myspace
- Google+
- Twitter
- Snapchat
- Vine
- Tublr
- Flickr
- YouTube
- LinkedIn
- MyFitnessPal
- Fitbit

Social Media

- Can be relevant and material to claims
- Content contrary to claims and testimony
- Key is to find and obtain it

Pretrial/Informal Discovery

- Can access this information via general Google and social media searches.

Pretrial Discovery

- Many account setting on "public"
- Save a screen capture of account
- May be important with spoliation claims
- May consider preservation letter

If Setting Private

- Defendants should not try to obtain private information during informal discovery.
- Even if not public, learn about account

Formal Discovery

Is social Media content discoverable?

Yes, but it generally must be relevant to the issues surrounding litigation.

Formal Discovery

- Relevant information is discoverable.
- Includes information under a private setting
- Direct requests to the Plaintiff, not to the social media network.

Stored Communications Act

- 18 U.S.C. Sec. 2701-2712
- Social media sites cannot disclose non-public contents without user's consent.
- *Crispin v. Christian Audigier, Inc*. 717 F.Supp.2d 965 (C.D. Cal. 2010).

Requests directed to Plaintiff

- Courts can compel parties to execute authorizations
- Courts have taken restricted view
- Courts are wary of “fishing expeditions”

Mackelprang v. Fidelity National Title

- Plaintiff claimed sexual harassment at work
- Defendant requested emails on two MySpace accounts
- Court denied motion to compel—Fishing expedition

Romano v. Steelcase Inc.

- Defendants sought access to current and historical Facebook and Myspace accounts
- Public portions contained material that was contrary to plaintiff’s claims
- Reasonable likelihood that private portions may contain additional information relevant to claims
- “In this environment, privacy is no longer grounded in reasonable expectations, but rather in some theoretical protocol better known as wishful thinking.”

Nucci v. Target Corporation

- 160 So. 3d 146 (Fla. 4th DCA 2015)
- Slip and fall at a Target store
- Lawsuit put her physical/mental condition at issue
- Facebook contained 1285 photographs
- Plaintiff deleted 36 photographs
- Court ordered screenshots of photographs in last 2 years

Sanctions for Destruction

- Parties and attorneys sanctioned
- ***Allied Concrete Co. v. Lester***, 736 S.E.2d 699 (Va. 2013)
  - Sanction of $542,000 imposed against lawyer and $180,000 against client
- ***Gatto v. United Airlines***, U.S. Dist. Ct. NJ March 25, 2013
  - Adverse inference against plaintiff who deactivated account

Practical Considerations

- In order to avoid "fishing expedition" objections be prepared to show relevancy of discovery request.
- Consider sending preservation letter upon receipt of claim
- Make your social media requests specific
- Limit time frame
- Tailor requests to facts and issues of specific case

Social Media: From the Defense Perspective

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SUBROGATION RIGHTS AND THE EMPLOYEE RETIREMENT INCOME SECURITY ACT

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I. History Of ERISA

a. Employer sponsored plans prior to 1974
   i. Genesis is a private pension plan offered by The American Express Company to its employees in 1875
      1. The concept was rather simple—defer compensation until retirement
      2. Gave employer short term financial flexibility and, theoretically, the employee long term financial security.[1]
   ii. Over the next century, pension plans proliferated with little to no regulation.
   iii. Government liked the idea because it kept retirees out of public coffers.
      1. Internal Revenue Service required relatively minimal participation and disclosure requirements in order for qualified plans to receive tax incentives.[2]
   iv. In 1959, Congress passed the Welfare and Pension Plans Disclosure Act and gave the U.S. Department of Labor oversight of the plans.
      1. "This legislation was intended to provide employees with enough information regarding plans so that they could monitor their plans to prevent mismanagement and abuse of plan funds."[3]
   v. Sensing potential problems if the plans failed, President John F. Kennedy created The President's Commission on Corporate Pension Funds to review "the role and character of the private pension and other retirement systems in the economic security of the Nation."[4]
   vi. Crises strike
      1. Leading example, although there were many others, was in 1963 when Studebaker Corporation closed with a grossly underfunded pension plan
         a. Approximately 4,000 workers received 15% of their benefits and 2,900 workers received nothing.[5]

b. The enactment of ERISA
    i. Intention
        1. Congress launched investigations that resulted in the Employee Retirement Security Income Act.[6]
        2. Congress declared that "owing to the lack of employee information and adequate safeguards concerning their operation, it is desirable in the interests of employees and their beneficiaries, and to provide for the general welfare and the free flow of commerce, that disclosure be made and safeguards be provided with respect to the establishment, operation, and administration of such plans…"[7]
        3. These disclosures and safeguards include "requiring the disclosure and reporting to participants and beneficiaries of financial and other information… by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to the Federal courts" and "requiring them to vest the accrued benefits of employees with significant periods of service, to meet minimum standards of funding, and by requiring plan termination insurance."[8]
    ii. Pre-Emption
        1. In applying these safeguards, Congress pre-empted the menagerie of State laws "insofar as they may now or hereafter relate to any employee benefit plan…."[9]
        2. Congress also gave the law broad application over "any employee benefit plan if it is established or maintained:
            a. by any employer engaged in commerce or in any industry or activity affecting commerce; or
            b. by any employee organization or organizations representing employees engaged in commerce or in any industry or activity affecting commerce; or
            c. by both."[10]
        3. Exceptions to the application of ERISA include
            a. government and church plans,
            b. workers and unemployment compensation plans,
            c. disability insurance plans,
            d. plans maintained outside the United States for the benefit of nonresident aliens, and unfunded excess benefit plans.[11]
    iii. Savings clause
        1. Also exempted from ERISA preemption is

a. “any law of any State which regulates insurance, banking or securities.”[12]

iv. Deemer clause

1. In order to strengthen this “savings clause,” Congress included a “deemer clause,” which prevents States from opting out of Federal pre-emption by deeming self-funded employer sponsored plans to be insurance companies or engaged in the business of insurance.[13]

c. Challenges to ERISA

i. Many trial lawyers attempt to apply State subrogation laws by arguing that the State’s law is saved under the savings clause.

ii. This argument is arduous because application of the savings clause requires a showing that the subject State law governs the “the business of insurance,” which is done by meeting each of the following three prongs:

1. “[F]irst, whether the practice has the effect of transferring or spreading a policyholder's risk;
2. Second, whether the practice is an integral part of the policy relationship between the insurer and the insured; and
3. Third, whether the practice is limited to entities within the insurance industry."[14]

iii. The language of this law is thick and obnoxious. As stated by the U.S. Supreme Court:

1. “The two pre-emption sections, while clear enough on their faces, perhaps are not a model of legislative drafting, for while the general pre-emption clause broadly pre-empts state law, the saving clause appears broadly to preserve the States' lawmaking power over much of the same regulation. While Congress occasionally decides to return to the States what it has previously taken away, it does not normally do both at the same time.”[15]

iv. Learned treatises have also noted the puzzling language of ERISA:

1. The “pre-emption-saving-deemer mumbo-jumbo has puzzled the finest legal minds in the country.”[16]

d. Recent challenges

i. Unfair or Deceptive Practices Regarding the Business of Insurance

1. Rudel v. Hawaii Management Alliance Association[17]

a. Facts

i. Plaintiff sustained “catastrophic, life-altering injuries” necessitating “eight surgeries and twenty-eight procedures on his left leg, including partial

amputation… [as well as] six surgeries and twenty procedures done to his left forearm including partial amputation… [and] He remains at risk of further amputation of his left arm and leg."

ii. The tort recovery was $1.5 million.
iii. The ERISA plan asserted a lien for reimbursement in the amount of $400,779.70.
iv. Plaintiff filed suit in state court challenging the validity of the lien on the basis of Hawaii's "unfair or deceptive practice" act regarding the "business of insurance."
v. Defendant removed to Federal Court.

b. Ruling
    i. This opinion reviews the recent Wurtz decision by the 2nd Circuit and rejects the Defendant's argument of "complete preemption," stating:
    ii. "In a factually similar case, the Second Circuit Court of Appeals recently held that the plaintiffs' state law claims could not have been brought under ERISA § 502(a). In Wurtz v. Rawlings Co., LLC, the plaintiffs filed suit in state court seeking to enjoin defendant insurers from obtaining reimbursement of medical benefits from plaintiffs' tort settlements under New York law. 761 F.3d 232, 236 (2d Cir. 2013).
    iii. On appeal, the Second Circuit had to decide whether the plaintiffs' state law claims were completely preempted by ERISA § 502(a)(1)(B). With respect to the first prong of the test, the court concluded that the plaintiffs could not have brought their claims under § 502(a)(1)(B).
    iv. The Court rejects [the ERISA plan's] efforts at distinguishing Wurtz.
    v. As in Wurtz, Rudel's ERISA plan is irrelevant to his state law claim, and the Court finds that Rudel's state law claim for determination of the validity of HMAA's claim of lien could not have been brought under § 502(a).
    vi. Consequently, [the ERISA plan] fails to satisfy the first prong of the Davila test, and the Court finds that

Rudel's claim is not completely preempted by § 502(a). …

vii. Because the claim is not completely preempted, [the ERISA plan] fails to establish federal question jurisdiction and the Court recommends that this action be remanded."

ii. Anti-Subrogation Statutes

1. Wurtz v. Rawlings Company[18]

a. Facts

i. A class of personal injury plaintiffs had employer-sponsored health plans funded through insurance arrangements (i.e., fully insured ERISA plans).

ii. Plaintiffs sued Rawlings, Oxford Health Plans, and UnitedHealth Group asserting, in part, that NY GOL 5-335 trumped any reimbursement rights that the health plans had under ERISA.

iii. A lower court dismissed the lawsuit, finding that the general rule that insured ERISA plans are subject to state law did not apply to NY GOL 5-335.

iv. Specifically, the Court determined that the New York state law was not "saved" from preemption," because the statute was neither (1) specifically directed toward insurance entities nor did it (2) "substantially affect the risk pooling arrangement between the insurer and the insured."

v. The Court found that NY GOL 5-335 was too limited in scope and excluded reimbursement and subrogation rights falling outside of the tort settlement realm.

b. Ruling

i. The Second Circuit reversed the lower court's decision holding that NY GOL 5-335 was "saved" from preemption after finding that 5-335 was a law regulating insurance and its application against fully insured ERISA plans did not disturb ERISA's goal of providing national uniformity.

ii. That is, the NY state anti-subrogation law is applicable to ERISA insurers, with a remedy available outside the ERISA remedies.

iii. Under the ruling in this case, the NJ state anti-subrogation law provides the "rule of decision" regarding subrogation/reimbursement claims, with a remedy provided under ERISA's § 502(a).

e. General rules for trial lawyers
   i. State subrogation laws "relate to" an employer sponsored plan and are pre-empted if the law has a "connection with or reference to such a Plan," a rule that is liberally construed;[19]
   ii. Absent a reversal by the U.S. Supreme Court, State law "bad faith" claims against Plans are pre-empted;[20] and,
   iii. Absent a reversal by the U. S. Supreme Court, punitive damages against Plans are pre-empted.[21]

II. ERISA Statutory Construction

a. At its core, an insurance plan must be a "welfare benefit plan" in order to be covered by ERISA, which is defined as follows:
   i. The terms "employee welfare benefit plan" and "welfare plan" mean any plan, fund, or program which… is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that [it] was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise,
      1. (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment….[22]

b. Donovan v. Dillingham[23]
   i. Eleventh Circuit Court of Appeals ruled that the following five-elements must be satisfied in order for an insurance plan to be covered by ERISA:
      1. a plan, fund or program,
      2. established or maintained,
      3. by an employer or by an employee organization, or by both,
      4. for the purpose of providing [benefits enumerated under sub (A)], and
      5. to participants or their beneficiaries.

c. "A Plan, Fund or Program"
   i. This "implies the existence of intended benefits, intended beneficiaries, a source of financing, and a procedure to apply for and collect benefits."[24]

ii. Both self-funded and self-insured plans can be covered by ERISA because both types are "funded" plans in which the employer pays benefits directly or through a trust.[25]

iii. Funded plans contrast with an unfunded or insured plans in which the employer does not pay for the benefits but rather purchases an insurance policy.

iv. Great confusion exists over whether unfunded or insured plans are covered by ERISA.

   1. Lawyers often throw around the concept that a "self-funded plan" is an ERISA plan, a "fully-insured plan" is not an ERISA plan and anything between is litigable.
   2. In general, this is a good rule of thumb; however, the unfortunate reality is that self-funded plans, fully-insured plans and everything in between can be covered by ERISA.
   3. But, fully-insured plans and plans that purchase too much insurance will, through the conflux of preemption and the savings and deemer clauses, be subject to certain state laws, including the equitable doctrines of made-whole and common fund.[26]
   4. Examples
      a. Self-funded plans
         i. On the one end of the spectrum is self-funded plans (where the source of benefits is exclusively the contributions of the employer and employee). Provided all five-elements under Donovan are met, these plans are ERISA-covered and will from the broad preemption afforded by the ERISA laws. The made-whole and common fund doctrines will not apply to these plans if the plan language disavows these doctrines.
      b. Fully insured plans
         i. On the other end of the spectrum is a fully-insured plan (where the source of benefits is exclusively insurance). These plans can be ERISA-covered; however, as noted above, through the conflux of preemption and the savings and deemer clauses, the made-whole and common fund doctrines will apply to these plans.
      c. Mixed plans
         i. In the middle of the spectrum is a plan that is both self-funded and insured (where the source of benefits

is both employer / employee contributions and insurance).

ii. An oft seen example is a plan that provides benefits through both employer / employee contributions and stop-loss coverage. These plans can be ERISA-covered; but, they are subject to more questions to determine whether state laws are saved from preemption. Courts have been uniform in ruling that true stop-loss coverage does not convert a plan into a fully-insured one.[27]

iii. However, stop-loss coverage cannot have such a low attachment point that it is, in essence, a fully-insured plan with a deductible.

1. Brown v. Granatelli[28]: the plan paid the first $500 of the claim, left the rest to the insurer and labeled it "stop-loss coverage."
2. The Fifth Circuit Court of Appeals ruled that such a scheme is the equivalent of a fully-insured plan with a deductible and not a self-funded plan with stop-loss coverage.
3. As such, the plan was subject to Texas law (which, in that case, was a specific provision of the tax code).

d. "Established or Maintained"

i. Established or maintained means that the plan, fund or program exists for specified purposes that are consistent with the purpose of ERISA.

ii. Stated differently, an ERISA plan is "established if from the surrounding circumstances a reasonable person can ascertain the intended benefits, a class of beneficiaries, the source of financing, and procedures for receiving benefits."[29]

e. "By An Employer or Employee Organization, or both"

i. The terms "employer" and "employee organization" are defined by statute.[30]

ii. Certain entities cannot establish an ERISA-covered plan. ERISA law specifically excludes:

1. government plans (including federal, state and Indian Tribal),
2. church plans,

3. plans maintained for complying with workers compensation / unemployment / disability insurance laws and
4. plans maintained primarily outside the United States.[31]

f. "For The Purpose Of Providing Specific Benefits"
   i. The plan must be created for the purpose of providing the benefits identified by 29 U.S.C. § 1002.

g. "To Participants Or Their Beneficiaries"
   i. The employer must provide specific benefits to participants or their beneficiaries.[32]
   ii. An important exception to this point occurs when an employer leaves its employees free to shop around for his or her own insurance.
      1. Brundage-Peterson v. Compcare Health Services Ins. Corp.[33]
         a. Facts
            i. An insured brought a bad-faith claim.
            ii. Compcare removed the claim to federal court and sought dismissal on the grounds that Wisconsin bad faith law was preempted by ERISA.
            iii. The insured countered that the plan was not ERISA-covered by ERISA because the employer gave eligible employees a choice between two insurance plans and merely collected insurance premiums from the employees and contributed to those premiums.
         b. Ruling
            i. While the plan at issue in Brundage-Peterson was determined to be ERISA-covered, the Seventh Circuit ruled, "If an employer offers no welfare benefit plan to its employees but leaves each employee free to shop around for his or her own health (accident, disability, life, etc.) insurance, ERISA does not apply."[34]

III. Identifying ERISA-Covered Plans In Practice: Key Documents

a. ERISA laws mandate the disclosure of specific documents to plan beneficiaries, including:
   i. Latest Summary Plan Description
   ii. Latest Annual Report (including Form 5500)
   iii. Any Terminal Report

iv. The bargaining agreement, trust agreement, contract, or other instruments under which the plan is established or operated[35]

b. These documents, particularly the Summary Plan Description / Master Plan Document and the Form 5500 (with Schedule A), are key in determining whether a plan is ERISA-covered.
    i. There is a difference between the Summary Plan Description and Master Plan Document.
    ii. As ruled by the United States Supreme Court, "We have made clear that the statements in a summary plan description 'communicat[e] with beneficiaries about the plan, but ... do not themselves constitute the terms of the plan.'"[36]
    iii. Given that the terms of the Master Plan Document govern, any request for the Summary Plan Description should include the Master Plan Document.

c. Summary Plan Description / Master Plan Document
    i. The Summary Plan Description / Master Plan Document should provide the following information that can be used in determined whether a plan is ERISA-covered:
        1. Plan name, address, and contact information;
        2. What the plan benefits are;
        3. How to get the benefits;
        4. Duties of the plan and/or employee;
        5. The plan's claims procedure;
        6. A participant's basic rights and responsibilities under ERISA; and
        7. Information on any applicable premiums, cost-sharing, deductibles, co-payments, etc.

d. Form 5500 And Schedule A
    i. All ERISA-covered plans are required to file a Form 5500 and Schedule A with the IRS.
    ii. The Form 5500 / Schedule A will identify how the plan is funded, including insurance, insurance contracts, trust or general assets of the plan sponsor.

e. Terminal Report
    i. The terminal report is filed by the plan sponsor with the Department of Labor when the plan is being terminated.

f. Bargaining agreement, trust agreement, contract, or other instruments under which the plan is established or operated

i. In an advisory opinion, the Department of Labor stated that

1. "only TPA contracts, or provisions thereof, that establish, amend or constitute part of an employee benefit plan or that otherwise are instruments under which the plan is established or operated are subject to mandatory disclosure under section 104(b)(4). For example, if a TPA contract, or any part of the contract, establishes or amends the plan in question, establishes a claims procedure, specifies procedures, formulas, methodologies, or schedules to be applied in determining or calculating a participant's or beneficiary's benefit entitlement, or does any of the other things described in sections 402(b) and 402(c) of ERISA, it would have to be furnished in accordance with the terms of section 104(b)(4)."[37]

IV. Identifying ERISA-Covered Plans In Practice: Case Intake To Litigation

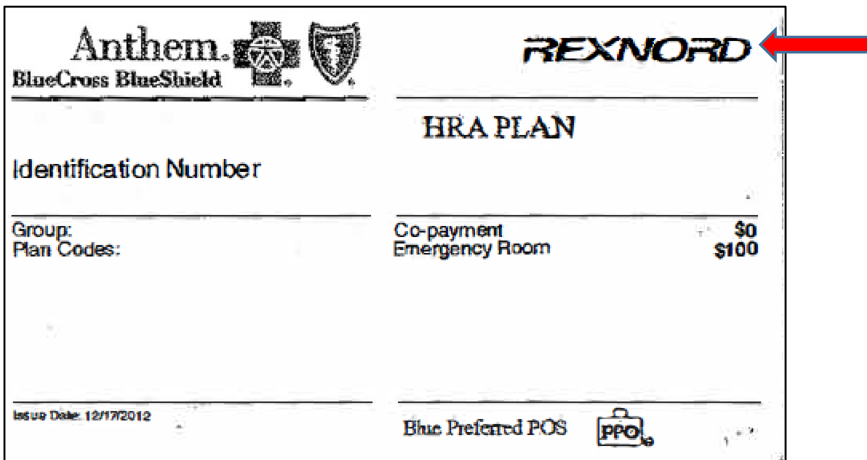
a. Pre-Suit

i. Initial Client Interview

1. It is incumbent upon the trial lawyer to inquire of their client all sources of health insurance given the statutory and contractual obligations of an insured to notify their health insurer of a potential liability claim.
2. During the initial meeting, the trial lawyer should ask where the client gets their health insurance from.
3. If the client states that their health insurance is provided by a federal, state or tribal government, or is provided through a church, then issues involving ERISA are non-existent as these plans cannot be ERISA-covered.[38]
4. If the client states that their health insurance is from their employer, the next question should be the name of the employer.
   a. Larger employers (those with more than 200 employees) are more likely to establish ERISA-covered plans than smaller employers.[39]

ii. The trial lawyer should also have the client produce their health insurance card.

1. A good initial indicator that the insurance plan is ERISA-covered is when the name of the employer or its logo appears on the front of the card:



2. Plans that are named after the employer or where the insurance company (i.e.: Anthem Blue Cross Blue Shield) is denoted as A.S.O. (Administrative Services Only) or HRA (Health Reimbursement Arrangement) are likely ERISA-covered Plans.
3. Plans that are denoted as HMO, POS or PPO are generally Plans that have mixed funding arrangements (general assets of the sponsor and insurance) or are fully-insured.

iii. Regardless of whether the name or logo is seen, if the client has private health insurance, the initial client interview is a great time to do what trial lawyers are educated and trained to do–ADVISE!

1. This advice should include the reason for asking about health insurance (right of subrogation) and the differing rights between health insurers governed by State law (the rights of the health insurer are less than those of the client) versus health insurers governed by ERISA (the rights of the health insurer are greater than those of the client).
2. As stated by the Fourth Circuit:
    a. "Attorneys considering taking a case on contingency commonly factor the likelihood of success and the magnitude of recovery into their decision. Many tort claims involve considerable risk and insufficient reward. Attorneys, however, carefully screen these claims and reject a large portion, including most denominated as high risk. A given plan's subrogation rules obviously make the payment of fees more or less likely, and prudent attorneys would factor those rules into their calculus as well. If the participant and his attorney conclude that private litigation will not produce a

sufficient recovery to make the litigation worthwhile, they need not bring the case. Often, however, an attorney might estimate that a jury award or settlement—with possible pain and suffering damages—will far exceed the amount to be reimbursed to a plan. This is the same calculation commonly made in non-ERISA contexts, but with one further factor to add to the equation."[40]

iv. Searching for the Form 5500

1. "The Form 5500 [ ] is part of ERISA's overall reporting and disclosure framework, which is intended to assure that employee benefit plans are operated and managed in accordance with certain prescribed standards and that participants and beneficiaries, as well as regulators, are provided or have access to sufficient information to protect the rights and benefits of participants and beneficiaries under employee benefit plans."[41]
2. There are two websites that provide access to Form 5500s.
   a. EFAST2
      i. The U.S. Department of Labor allows users to search for a Form 5500 that was received by EFAST2[42] for plan years 2009 and after.
      ii. The search engine is available at https://www.efast.dol.gov/ (click on "Form 5500/Form 5500SF Search").
      iii. Knowing that the client is employed by Rexnord (see insurance card above), the term "Rexnord" can be searched.
      iv. The result are Form 5500s from 2009 to the present for numerous of Rexnord's ERISA-covered plans, including pension plans, master trust plans, 401(k) and, most importantly, the Rexnord Welfare Plan. Schedule A of the Form 5500 for the Rexnord Welfare Plan denotes that it provides health insurance benefits.
      v. The Form 5500 itself includes the name and address of the Plan Sponsor (Box 2a), Plan Administrator (signature line), the Plan funding arrangements (Box 9a) and the Plan benefit arrangement (Box 9b):

Part II	Basic Plan Information—enter all requested information
1a Name of plan REXNORD WELFARE PLAN	
2a Plan sponsor's name and address; include room or suite number (employer, if for a single-employer plan) REXNORD LLC 4701 W GREENFIELD AVE MILWAUKEE, WI 53214-5310	

SIGN HERE	Filed with authorized/valid electronic signature.	09/07/2012	ARRIEL KUDELA
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator

9a Plan funding arrangement (check all that apply)			**9b** Plan benefit arrangement (check all that apply)		
(1)	X	Insurance	**(1)**	X	Insurance
(2)		Code section 412(e)(3) insurance contracts	**(2)**		Code section 412(e)(3) insurance contracts
(3)		Trust	**(3)**		Trust
(4)	X	General assets of the sponsor	**(4)**	X	General assets of the sponsor

vi. As seen above, the Rexnord Welfare Plan states that it is funded by both insurance and the general assets of the sponsor.

1. This funding mixture generally means that the Plan has likely purchased stop-loss insurance.
2. The majority of ERISA-covered plans purchase stop-loss insurance.[43]
3. Purchasing stop-loss insurance does not defeat the ERISA-covered status of the Plan unless the attachment point is low enough to render the Plan fully-insured.[44]
4. This begs the question: What level of stop-loss insurance coverage will result in the loss of ERISA preemption? Unfortunately, there is no bright line rule. Rather, as ruled by the Fifth Circuit, the answer depends on the Plan's loss experience and how the stop-loss coverage is utilized by the Plan:

a. "If, for example, a plan paid only the first $500 of a beneficiaries' health claim, leaving all else to the insurer, labeling its coverage stop-loss or catastrophic coverage would not mask the reality that it is close to a simple purchase of group accident and sickness coverage. We look beyond form to the substance of the relationship between the plan, the participants, and the insurance carrier to see whether the plan is in fact purchasing insurance for itself and not for the plan participants, recognizing that as insurance is less for catastrophic loss, it is increasingly like accident and sickness insurance for plan participants. In this case the fact that the Plan has only had to call on NALAC to reimburse it for its payments to four individuals in five years supports the Plan's assertion that the insurance is for itself and not for the plan participants. In short, if the Plan were merely a conduit for claims from participants to NALAC we could not reach the same conclusion."[45]

b. FreeERISA.com
   i. FreeERISA is a private organization that retrieves Form 5500s from the Department of Labor and posts them to its website.
   ii. Whether a Form 5500 is available on FreeERISA is entirely the prerogative of FreeERISA.

v. Submitting the initial document request to the Plan
   1. The purpose of the initial document request is two-fold.
      a. First, the documents will provide information on whether the Plan is ERISA-covered.

b. Second, the request lays the groundwork for a potential penalty against the Plan Administrator.
    i. ERISA law mandates the disclosure of specific documents, including the Summary Plan Description, Annual Report, Terminal Report, and others, to the Plan beneficiary.[46]
    ii. The failure of the Plan Administrator to provide these documents within 30 days can subject the Plan Administrator to a penalty of up to $110 per day per document.[47]
        1. The amount of the penalty is left to the discretion of the court.[48]
        2. Courts have awarded the maximum penalty[49] and significantly less than the maximum penalty[50]

c. Procedurally, the document request must to be sent to the Plan Administrator.[51]
    i. Neither the Third Party Administrator nor the subrogation vendor are the Plan.
    ii. However, there is no harm in sending a copy of the document request to the Third Party Administrator as some Plans have agreements wherein the Third Party Administrator responds to document requests.
    iii. The request should be sent by mail that includes delivery confirmation. Suggested wording of the request is as follows:
        1. "If there will be a claim that the Plan is governed by ERISA, then, pursuant to 29 U.S.C. §§ 1024(b)(4) & 1132(c), you are hereby directed by my client, the Plan beneficiary, to provide (1) the Summary Plan Description, (2) the Master Plan Document, (3) the trust agreement, (4) Form 5500 from the year of the subject incident referenced above, (5) any document appointing plan fiduciaries, (6) any document relative to the funding and/or insuring of the Plan, (7) the latest annual report, (8) any terminal report, and (9) the bargaining agreement, within 30 days of this letter."

2. Trial lawyers should not give short-shrift to the document request.
    a. The framework of ERISA and interpretative case law on the subrogation rights of the Plan tips the scale almost completely in favor of the Plan.
    b. When it comes time to negotiate or litigate an ERISA-covered subrogation lien, often the best leverage your client will have is the penalty for failing to timely produce the requested documents.

vi. Document Review
1. The three most important documents to review will be the Master Plan Document, Summary Plan Description and Form 5500.
    a. These Plan documents describe the funding mechanism used to determine if the Plan is ERISA-covered.
    b. Additionally, these Plan documents dictate the subrogation rights of ERISA-covered Plans as ERISA statutory law is silent on the issue of subrogation.

2. Funding Policy
    a. Every ERISA-covered Plan must provide a procedure for establishing and carrying out a funding policy, describe the allocation of responsibilities for the operation and administration of the plan, provide a procedure for amending the plan and specify the basis on which payments are made to and from the plan.[52]
    b. It is the Master Plan Document that establishes the terms of the Plan and the agreement between the Plan and its beneficiaries.
    c. No case better underscores the importance of using the Master Plan Document than U.S. Airways v. McCutchen[53].
        i. In McCutchen, the parties treated the Summary Plan Description as the governing document. The Supreme Court noted the problem with this:
            1. "We have made clear that the statements in a summary plan description "communicat[e] with beneficiaries *about* the plan, but . . . do not themselves constitute the *terms* of the plan." CIGNA Corp. v. Amara, 563 U. S. ___, ___ (2011) (slip op., at 15). Nonetheless,

the parties litigated this case, and both lower courts decided it, based solely on the language quoted above. See 663 F. 3d 671, 673 (CA3 2011); App. to Pet. for Cert. 26a. Only in this Court, in response to a request from the Solicitor General, did the plan itself come to light. See Letter from Matthew W. H. Wessler to William K. Suter, Clerk of Court (Nov. 19, 2012) (available in Clerk of Court's case file). That is too late to affect what happens here: Because everyone in this case has treated the language from the summary description as though it came from the plan, we do so as well."[54]

ii. McCutchen update:

1. On remand, the District Court ruled that the Plan Document, as opposed to the Summary Plan Description, did not include sufficient language to allow the Plan to subrogate against the first-party UIM recovery and the common fund doctrine applied to the Plan's subrogation rights against the third-party recovery from the tortfeasor.[55]

3. Common fund and made whole doctrines
   a. In addition to determining the funding arrangement of the Plan, the Master Plan Document and Summary Plan Description must be reviewed to determine whether the common law doctrines of made whole and common fund are overcome by the terms of the Plan.
      i. "[S]ubrogation provisions of self-funded ERISA plans trump state subrogation rules."[56]
      ii. This includes the common fund and made whole doctrines.[57]
      iii. If the Plan is silent on these doctrines, then the doctrines will apply by default.[58]
   b. In the Seventh Circuit, the made whole doctrine is overcome if the Plan has sufficient, clear language.[59]
   c. Following the Seventh Circuit, the Wisconsin Supreme Court ruled that Plan language is sufficient if it provides that

the Plan "is entitled to reimbursement from the beneficiary of the Plan for 'expenses incurred as the result of, or that arose out of, an accident' when a third party 'may be liable' for the payment of those expenses and the beneficiary obtains a settlement from the third party."[60]

d. Likewise in the Seventh Circuit, if the Plan document does not specifically repudiate the common fund doctrine, such as by indicating that the Plan is entitled to 100 percent of any benefits paid to a participant to the extent of "any payment resulting from a judgment or settlement, or other payment or payments, made or to be made by any person or persons considered responsible for the condition giving rise to the medical expense or by their insurers", then the common fund doctrine will apply.[61]

4. Contributory Negligence
   a. Plans can also include language that provides the Plan's right to recovery is not reduced by the insured's / beneficiary's contributory negligence.
   b. Gerke v. Coyier[62]
      i. "Gerkes next argue that even if make whole doctrines are preempted, state contributory negligence law should not be. Therefore, because Gordon was found fifty percent at fault for the accident, WCHF's recovery should be reduced to fifty percent of the payments it made.
      ii. They cite to Wisconsin case law which provides that a subrogated insurer generally "may recover that percentage of [its] payments attributable to the tortfeasor's negligence" when its own insured bears partial responsibility for his injuries. Sorge v. National Car Rental System, Inc., 182 Wis.2d 52, 63, 512 N.W.2d 505, 509 (1994).
      iii. However, Sorge did not involve an ERISA plan.
      iv. Additionally, we have already addressed this precise question in Newport News. There the tortfeasors' insurer argued that Newport News, as successor to the rights of its plan beneficiaries, must establish the defendants' negligence as a condition precedent to recoupment of payments made, because the extent of

the tortfeasors' negligence was a limitation on Newport News' right to recoup payments it had made for medical expenses.

v. In rejecting that insurer's contributory negligence argument, we pointed out that the plan has a contractual right to reimbursement from the beneficiaries which cannot be limited by the tort of its insured or of a third-party. Newport News, 187 Wis.2d at 374, 523 N.W.2d at 273.

vi. So too, WCHF's right is contractual and contained within the plan. As we review the plan's language, we conclude there is no support therein for any limitation on the contractual right of WCHF to be fully repaid from the judgment Gerkes obtained, prior to Gerkes receiving any payment."

5. Subrogation Agreements
    a. Once notified of the potential liability claim, the Plan may submit a document to the beneficiary or his attorney entitled "Subrogation Agreement," which is, essentially, an after-the-fact contract intended to bind the beneficiary, and his attorney, to the Plan's right of subrogation.
    b. Courts have ruled that a Plan may require the participant, and his attorney, to sign a subrogation agreement as a condition of paying medical claims provided that the Summary Plan Description plainly requires such an agreement and the agreement does not broaden the rights contained in the Master Plan Document or Summary Plan Description.[63]
    c. The New Jersey Supreme Court Advisory Committee on Professional Ethics expressed reservation on an attorney's ethical obligation in signing such an agreement:
        i. "If the subrogation agreement at issue here requires the lawyer to personally guarantee the client's repayment to the Plan out of monies disbursed to the client by the lawyer, then ethical issues arise. Rule of Professional Conduct 1.8(e) prohibits a lawyer from providing financial assistance to a client in connection with pending or contemplated litigation; a personal guarantee is considered improper financial assistance to a client. See Opinion 719, 202

N.J.L.J. 997 (December 13, 2010). If, however, the agreement requires the lawyer to acknowledge the lien and satisfy it out of funds in the lawyer's possession, and the plan does not attempt to control the direction of the litigation or otherwise interfere with the lawyer's duties to the client, ethical issues do not arise."[64]

d. Cagel v. Ford[65]

   i. Facts

      1. The Plan was notified of a potential third-party liability claim.
      2. The Plan mailed a Subrogation Agreement to its beneficiary, Ford, and his attorney.
      3. The Subrogation Agreement provided that benefits were being requested for treatment of injuries caused by a third-party; that the Plan would pay these claims; in consideration for the Plan paying the claims, Ford would reimburse the Plan in full; and that the Plan was subrogated to the rights of Ford.
      4. The Subrogation Agreement was signed by Ford and his attorney.
      5. The Plan paid $41,719 in claims on behalf of Ford.
      6. Ford settled his case for the $25,000 policy limits of the tortfeasor.
      7. Ford's attorney sent a check to the Plan in the amount of $18,604, which represented the policy limits less attorney fees and advanced costs.
      8. The Plan did not accept the check and filed suit against Ford, his attorney and the law firm.

   ii. Ruling

      1. The court struggled with its decision knowing that the recovery by Ford was less than the amount paid. However, at the end of the day, the court was bound to uphold the terms of the Plan and Subrogation Agreement. As to the latter, the court ruled:

2. “The Agreement states: "I (we) agree to reimburse the Plan in full from the proceeds of any recovery received by me (us) because of such injury or sickness." The court perceives that these provisions represent a clear and unambiguous agreement between the Fund and Ford and his attorney that the Plan would be reimbursed in full to the extent of a recovery by Ford without regard to the costs of the recovery.
3. The court notes that the Stinnett footnote leaving for another day "situations where the beneficiaries' recovery from the third party after deducting attorney's fees is actually less than the plan's reimbursement claim," implies that the attorney in such a case would recover his fees at the expense of the beneficiary. However, the court believes that the Fourth Circuit's comment envisions a case in which the attorney is not a party to the Plan's subrogation /reimbursement agreement. In this case, Ford's attorney, Phipps, signed an agreement that clearly indicates that the Plan would be fully reimbursed to the extent of medical benefits paid without reference to the costs of recovery. Thus, this court perceives that Ford's attorney and his firm are bound by the clear language of that agreement, and thus are not entitled to deduct their contingency fee from the amount of the recovery.”[66]

e. The ruling in Cagel underscores the need for the trial lawyer to review the Master Plan Document and Summary Plan Description before contemplating anyone’s signature on a Subrogation Agreement.
f. Additionally, as warned by the New Jersey Supreme Court Advisory Committee on Professional Ethics, the trial lawyer should not enter into an agreement that binds the trial lawyer or law firm beyond that already required by law, such as acknowledging the lien and agreeing to satisfy it from the settlement / judgment proceeds.

vii. Disbursing the funds without Plan approval

1. Montanile v. Board Of Trustees Of The National Elevator Industry Health Benefit Plan[67]

    a. Facts

        i. Employee benefits plans regulated by the Employee Retirement Income Security Act of 1974 (ERISA or Act) often contain subrogation clauses requiring a plan participant to reimburse the plan for medical expenses if the participant later recovers money from a third party for his injuries.

        ii. Here, petitioner Montanile was seriously injured by a drunk driver, and his ERISA plan paid more than $120,000 for his medical expenses. Montanile later sued the drunk driver, obtaining a $500,000 settlement. Pursuant to the plan's subrogation clause, respondent plan administrator (the Board of Trustees of the National Elevator Industry Health Benefit Plan, or Board), sought reimbursement from the settlement. Montanile's attorney refused that request and subsequently informed the Board that the fund would be transferred from a client trust account to Montanile unless the Board objected.

        iii. The Board did not respond, and Montanile received the settlement.

        iv. Six months later, the Board sued Montanile in Federal District Court under §502(a)(3) of ERISA, which authorizes plan fiduciaries to file suit "to obtain . . . appropriate equitable relief . . . to enforce . . . the terms of the plan." 29 U. S. C. §1132(a)(3). The Board sought an equitable lien on any settlement funds or property in Montanile's possession and an order enjoining Montanile from dissipating any such funds. Montanile argued that because he had already spent almost all of the settlement, no identifiable fund existed against which to enforce the lien. The District Court rejected Montanile's argument, and the Eleventh Circuit affirmed, holding that even if Montanile had completely dissipated the fund, the

plan was entitled to reimbursement from Montanile's general assets.

b. Ruling
   i. When an ERISA-plan participant wholly dissipates a third-party settlement on nontraceable items, the plan fiduciary may not bring suit under §502(a)(3) to attach the participant's separate assets.
   ii. (a) Plan fiduciaries are limited by §502(a)(3) to filing suits "to obtain . . . equitable relief." Whether the relief requested "is legal or equitable depends on [1] the basis for [the plaintiff's] claim and [2] the nature of the underlying remedies sought." Sereboff v. Mid Atlantic Medical Services, Inc., 547 U. S. 356, 363.
   iii. This Court's precedents establish that the basis for the Board's claim—the enforcement of a lien created by an agreement to convey a particular fund to another party—is equitable. See Sereboff, 547 U. S., at 363–364. The Court's precedents also establish that the nature of the Board's underlying remedy—enforcement of a lien against "specifically identifiable funds that were within [Montanile's] possession and control," id., at 362–363—would also have been equitable had the Board immediately sued to enforce the lien against the fund. But those propositions do not resolve the question here:
      1. whether a plan is still seeking an equitable remedy when the defendant has dissipated all of a separate settlement fund, and the plan then seeks to recover out of the defendant's general assets.
   iv. This Court holds today that a plan is not seeking equitable relief under those circumstances. In premerger equity courts, a plaintiff could ordinarily enforce an equitable lien, including, as here, an equitable lien by agreement, only against specifically identified funds that remained in the defendant's possession or against traceable items that the defendant purchased with the funds. See 4 S. Symons, Pomeroy's Equity Jurisprudence §1234, pp. 692–695. If a defendant dissipated the entire fund on

nontraceable items, the lien was eliminated and the plaintiff could not attach the defendant's general assets instead. See Restatement of Restitution, §215(1), p. 866.

v. The Board's arguments in favor of the enforcement of an equitable lien against Montanile's general assets are unsuccessful. Sereboff does not contain an exception to the general asset-tracing requirement for equitable liens by agreement. <u>See</u> 547 U. S., at 365.

vi. Nor does historical equity practice support the enforcement of an equitable lien against general assets. And the Board's claim that ERISA's objectives are best served by allowing plans to enforce such liens is a "vague notio[n] of [the] statute's 'basic purpose' . . . inadequate to overcome the words of its text regarding the specific issue under consideration." <u>Mertens v. Hewitt Associates</u>, 508 U. S. 248, 261.

vii. The case is remanded for the District Court to determine, in the first instance, whether Montanile kept his settlement fund separate from his general assets and whether he dissipated the entire fund on nontraceable assets.

b. During Litigation

   i. Naming The Plan

      1. Wisconsin procedural law requires that a "party asserting a claim for affirmative relief shall join as parties to the action all persons who at the commencement of the action have claims based upon subrogation to the rights of the party asserting the principal claim…"[68]
      2. This statutory scheme "clearly contemplates joining a plaintiff's insurer that has a subrogated claim for medical expenses as party plaintiff."[69]
      3. This procedural law, along with the penalties associated therewith, as discussed below, applies to ERISA-covered plans.[70]
      4. Once joined, a Plan must either participate in the prosecution of the action, agree to have its interest represented by the party who caused the joinder, or move for dismissal with or without prejudice.[71]

a. If the Plan chooses to participate, then they have an equal voice with other claimants in the prosecution.[72]
b. If the Plan chooses to have its interests represented by the party who caused the joinder, then the Plan must file a waiver and may be required to pay reasonable attorney fees.[73]
c. If the Plan chooses to be dismissed without prejudice, then the Plan must show that it would be unjust to require its claims to be prosecuted with the principal claim.[74]
d. The failure of an ERISA-covered plan to make an election or participate in the prosecution of the case exposes the Plan to sanctions.

ii. Discovery
1. Interrogatories and request for production of documents are excellent tools for determining whether the Plan is ERISA-covered.
2. In addition to re-requesting the documents that were requested as part of the initial pre-suit document request, the interrogatories should be geared at challenging the ERISA-covered status of the Plan. For example:
    a. Has the Department of Labor or Internal Revenue Service ever submitted a letter of non-compliance with the reporting requirements of ERISA?
    b. Has the Plan Administrator ever interpreted the provisions of the Plan that address attorney fees or the made whole doctrine inconsistently?
        i. If so, this could lead to a determination that the Plan Administrator is interpreting the Plan arbitrarily and capriciously.
    c. Does the Plan Administrator have a conflict of interest?
        i. That is, does the Plan Administrator owe a duty it her employer in addition to her fiduciary duty to the Plan beneficiaries?
3. The discovery requests should include the documents requested from the Plan Administrator (see above)
    a. HOWEVER, trial lawyers should note that
        i. A representation by an attorney that he is making a request on behalf of a participant or beneficiary triggers the Plan Administrator’s duty to respond

under § 1024(b)(4) when the Plan Administrator has no reason to question the attorney's authority.[75]

ii. BUT discovery requests made by attorneys in litigation to the attorney representing the Plan are not sufficient to trigger the duty to respond under § 1024(b)(4).[76]

b. If the case is in suit and documents have not been requested, then:

i. The Plan beneficiary (your client) should send document requests to the Plan Administrator <u>AND</u>

ii. The attorney for the Plan beneficiary should send document requests to the attorney for the Plan.

iii. Sanctions For Non-Participation

1. An ERISA-covered Plan must make an election once it has been named as an involuntary plaintiff.

2. As ruled by the Wisconsin Court of Appeals,

a. "Mere presence as a party, by virtue of being joined, does not constitute 'participat[ion]' under § 803.03(2)(b), Stats. Otherwise, 'participat[ion]' would be instant and automatic at the moment of joinder, obviating the need for the statutory reference to what the joined party 'may' do. See § 803.03(2)(b)." This includes, as provided by § 803.03(2)(b), Wis. Stats., participating "in the prosecution of the action." When an ERISA-covered Plan does nothing to participate in the prosecution of the action, the court may extinguish the Plan's lien[77] or require the Plan to pay its fair share of attorney fees and costs[78].

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[1] Pension Benefit Guarantee Corporation, History of PBGC, *available at* http://www.pbgc.gov/about/who-we-are/pg/history-of-pbgc.html (last visited March 13, 2015).

[2] United States Department of Labor, The History of EBSA and ERISA, *available at* http://www.dol.gov/ebsa/aboutebsa/history.html (last visited March 15, 2015).

[3] <u>Id</u>.

[4] The President's Committee on Corporate Pension Funds and Other Private Retirement and Welfare Programs, (1965), *available at* http://www.ssa.gov/policy/docs/ssb/v28n7/v28n7p39.pdf (last visited March 13, 2015).

[5] James A. Wooten, The Most Glorious Story of Failure in the Business: The Studebaker-Packard Corporation and the Origins of ERISA, 49 BUFFALO LAW REVIEW 683 (2001).

[6] Special Committee on Aging, United States Senate (August 1984). The Employee Retirement Income Security Act of 1974: The First Decade, at p. 11, *available at* http://www.aging.senate.gov/imo/media/doc/reports/rpt884.pdf (last visited March 15, 2015).

[7] 29 U.S.C. § 1001(a)

[8] 29 U.S.C. § 1001(b)-(c)

[9] 29 U.S.C. § 1144(a)

[10] 29 U.S.C. § 1003(a)

[11] 29 U.S.C. § 1003(b)

[12] 29 U.S.C. § 1144(b)(2)(A)

[13] 29 U.S.C. § 1144(b)(2)(B)

[14] Pilot Life Ins. Co. v. Ddeaux, 481 U.S. 41, 49 (1987), *citing* Union Labor Life Ins. Co. v. Pireno, 458 U. S. 119, 129 (1982).

[15] Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724, 739-40 (1985).

[16] Gary L. Wickert, ERISA AND HEALTH INSURANCE SUBROGATION IN ALL 50 STATES at § 5.01 (4th ed. 2010).

[17] 2016 WL 1271465 (D. Hawaii 3/31/16).

[18] 761 F. 3d 232 (2nd Cir. 2014), cert denied, 135 S. Ct. 1400 (2015).

[19] FMC Corp. v. Holliday, 498 U.S. 52 (1990).

[20] Moffett v. Halliburton Energy Services, Inc., 291 F. 3d 1227 (10th Cir. 2002) ("The Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001, can be a fruitless and thorny ground for plaintiffs, and many seek to avoid it entirely by bringing their insurance claims under state law. The Supreme Court has increasingly circumscribed such state-law claims, however, finding the pre-emptive sweep of ERISA to be so "extraordinary" that it bars all claims of close relation."), *citing* Metropolitan Life Ins. Co. v. Taylor, 481 U.S. 58, 65 (1987).

[21] Dependahl v. Falstaff Brewing Corp., 653 F.2d 1208 (8th Cir. 1981), *cert. denied*, 454 U.S. 968, ("We believe that, as a matter of federal common law, an award of punitive damages is inappropriate to a claim of interference with employee benefit plans.")
[22] 29 U.S.C. § 1002.

[23] The Donovan test was adopted by the Seventh Circuit Court of Appeals in Ed Minat Inc. v. Globe Life Ins. Group, Inc., 805 F.2d 732 (7th Cir. 1986).

[24] Donovan, at 1372.

[25] Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724 (1985).

[26] Id., and FMC Corp. v. Holliday, 498 U.S. 52 (1990).

[27] Tri State Mach., Inc. v. Nationwide Life Ins. Co., 33 F.3d 309 (4th Cir. 1994); American Medical Sec., Inc. v. Bartlett, 111 F.3d 358 (4th Cir. 1997), cert. denied, 524 U.S. 936 (1998).

[28] 897 F.2d 1351 (5th Cir. 1990).

[29] Donovan, at 1373.

[30] 29 U.S.C. §§ 1002(4) & (5).

[31] 29 U.S.C. §§ 1003(b), 1002(32) & (33).

[32] 29 U.S.C. § 1002.

[33] 877 F.2d 509 (7th Cir. 1989).

[34] Id. at 510.

[35] 29 U.S.C. § 1024(b)(4)

[36] U.S. Airways v. McCutchen, 133 S. Ct. 1537, n.1 (2013) citing CIGNA Corp. v. Amara, 131 S.Ct. 1866, 1878 (2011).

[37] John J. Canary, PWBA Office of Regulations and Interpretations, Advisory Opinion (April 10, 1997), available at https://www.dol.gov/ebsa/programs/ori/advisory97/97-11a.htm (last visited July 4, 2015).

[38] 29 U.S.C. §§ 1003(b), 1002(32) & (33)

[39] As of 2014, 91% of workers in companies that employ 5,000 or more workers were beneficiaries of ERISA-covered plans whereas 15% of workers in companies that employ 3-199 workers were beneficiaries of ERISA-covered plans. The Henry J. Kaiser Family Foundation, 2014 Employer Health Benefits Survey at Exhibit 10.1, available at http://kff.org/health-costs/report/2014-employer-health-benefits-survey/ (last visited August 25, 2015).

[40] Kress v. Food Emp'rs Labor Relations Ass'n, 391 F.3d 563, 570 (4th Cir. 2004).

[41] United States Department of Labor, Form 5500 Series, available at http://www.dol.gov/ebsa/5500main.html (last visited August 18, 2015).

[42] "EFAST2 is an all-electronic system designed by the Department of Labor, Internal Revenue Service, and Pension Benefit Guaranty Corporation to simplify and expedite the submission, receipt, and processing of the Form 5500 and Form 5500-SF." U.S. Dept. of Labor, EFAST2 Electronic Filing System, available at http://www.dol.gov/ebsa/faqs/faq-EFAST2.html (last visited August 18, 2015).

[43] 79% of ERISA-covered plans with 50-199 workers purchase stop-loss insurance whereas 90%, 91% and 48% of employers with 200 – 999, 1,000 – 4,999 and 5,000+ of ERISA-covered plans, respectively, purchase stop-loss insurance. The Henry J. Kaiser Family Foundation, *supra* n.2, at Exhibit 10.10.

[44] Compare Tri State Mach., Inc. v. Nationwide Life Ins. Co., 33 F.3d 309 (4th Cir. 1994) (stop-loss insurance does not defeat ERISA-covered status) and American Medical Sec., Inc. v. Bartlett, 111 F.3d 358 (4th Cir. 1997), cert. denied, 524 U.S. 936 (1998) (same) with Brown v. Granatelli, 897 F.2d 1351 (5th Cir. 1990) (stop-loss insurance with a $500 attachment point renders the Plan fully insured and therefore defeats the application of ERISA).

[45] Granatelli, at 1355.

[46] 29 U.S.C. § 1024

[47] 29 U.S.C. § 1132(c)(1) as modified by 29 C.F.R. § 2575.502c-1

[48] Gorini v. AMP Inc., 94 Fed. Appx. 913 (3d Cir. 2004).

[49] Leister v. Dovetail, Inc., No. 05-2115, (C. Dis. Ill. 2009) ($377,600); Huss v. IBM Medical & Dental Plan, No. 07 C 7028, (N.D Dis. Ill. 2009) ($11,440); Law v. Ernst & Young, 956 F.2d 364, 375 (1st Cir. 1992) (affirming penalty

of $100 per day); Kollman v. Hewitt Assoc., 2005 WL 2746659 (E.D. Pa. 2005) ($100 per day); Freitag v. Pan Am. World Airways, Inc., 702 F.Supp. 128, 132 (E.D. Vir. 1988) ($100 per day); Tait v. Barbknecht & Tait Profit Sharing Plan, 997 F.Supp. 763 (N.D. Tex. 1998) ($100 per day); Kreuger Intl v. Blank, 225 F.3d 806, 811 (7th Cir. 2000) (affirming $100 per day); Brown v. Aventis Pharma., 342 F.3d 822, 825-826 (8th Cir. 2003) (affirming maximum penalty); Koegan v. Towers, Perrin, Forster & Crosby, 2003 WL 21058167 (D. Minn. 2003) ($100 per day); Conger v. Univ. Marketing, Inc., 2000 WL 1818521 (D. Or. 2000) ($100 per day).

[50] Blazejewski v. Gibson, 1999 WL 1044892, at 3 (N.D. Ill. 1999) ($10/day for about 400 days); Jackson v. E.J. Brach Corp., 937 F. Supp. 735, 742 (N.D. Ill. 1996) ($10/day for 692 days; $6,920 total); Harsch v. Eisenberg, 1994 U.S. Dist. LEXIS 21235 at 22 (E.D. Wis. 1994) ($4,089 total penalty for four plaintiffs); Thomas v. Jeep-Eagle Corp., 746 F.Supp. 863, 864-865 (E.D. Wis. 1990) ($50/day for 129 days; $6,450 total); Lowe v. SRA/IBM Macmillan Pension Plan, 2003 U.S. Dist. LEXIS 4519 at 10 (N.D. Ill. 2003) ($50/day; $35,050 total); Knipe v. Reuters Am., 1997 U.S. Dist. LEXIS 4675 at 6 (N.D. Ill. 1997) (penalty of $2,000); Villagomez v. AT&T Pension Plan, 1991 U.S. Dist. LEXIS 1788 at 5 (N.D. Ill. 1991) ($100/day for 144 days; $14,400 total); and Piggot v. Livingston Co., 1989 U.S. Dist. LEXIS 11155 at 8 (N.D. Ill. 1989) (nominal penalty of $2/day for 309 days).

[51] 29 U.S.C. § 1024(b)(4)

[52] 29 U.S.C. § 1102(b)

[53] 133 S. Ct. 1537 (2013).

[54] Id. at n. 1 (italics in original).

[55] Case No. 2:08CV01593 (W.D. PA 2016).

[56] Palmerton v. Associates Health & Welfare Plan, 2003 WI App 41, ¶ 14.

[57] Steffens v. BlueCross BlueShield of Illinois, 2011 WI 60, ¶ 52 ("Subrogation clauses in ERISA plans trump the Wisconsin make-whole doctrine."); Johnson v. Ziegler, 2002 WI App 103, ¶ 18, 255 Wis. 2d 751, 648 N.W.2d 480 (ruling that the parties to an ERISA plan could disclaim the common fund doctrine as well as the made whole doctrine).

[58] McCutchen, at 1548.

[59] Cutting v. Jerome Foods Inc., 993 F.2d 1293 at 1298-1299 (7th Cir. 1993).

[60] Steffens, at ¶ 2.

[61] Wal-Mart Stores Inc. Associates Health and Welfare Plan v. Wells, 213 F.3d 398, 400 (7th Cir. 2000).

[62] Wisconsin Court of Appeals No. 96AP3218 (unpublished).

[63] Gorman v. Carpenter's & Millwright's Health Fund, 410 F.3d 1194 (10th Cir. 2005) ("Because that requirement [to sign a subrogation agreement] was not contained in the 1999 SPD, it was arbitrary and capricious for the Fund to impose the new condition as a prerequisite to paying Plaintiff his benefits under the 1999 SPD.") citing Administrative Committee of the Wal-Mart Associates Health and Welfare Plan v. Willard, 393 F.3d 1119 (10th Cir.2004) and Kress v. Food Employers Labor Relations Ass'n., 391 F.3d 563 (4th Cir.2004).

[64] Supreme Court of New Jersey Advisory Committee on Professional Ethics, Opinion 727 (September 9, 2013), available at http://www.judiciary.state.nj.us/notices/2013/n130927c.pdf.

[65] 59 F.Supp.2d 548 (E.D. N.C. 1999).

[66] Id. at 555-556.

[67] 136 S. Ct. 386 (2015).

[68] Wis. Stat. § 803.03(2)(a)

[69] Anderson v. Garber, 160 Wis. 2d 389, 339, 466 N.W.2d 221 (Ct. App. 1991); Sampson v. Logue, 184 Wis. 2d 20, 28, 515 N.W.2d 917, 920 (Ct. App. 1994).

[70] Ninaus v. State Farm Mut. Auto. Ins. Co., 220 Wis. 2d 869, 584 N.W.2d 545 (1998).

[71] Wis. Stat. § 803.03(b)

[72] Wis. Stat. § 803.03(b)(2)

[73] Wis. Stat. § 803.03(b)(3)

[74] Wis. Stat. § 803.03(b)(4)

[75] Daniels v. Thomas & Betts Corp., 263 F.3d 66, 77-78 (3rd Cir. 2001).

[76] Hughes v. Nat. Res. Consultants, 77 Fed. App'x 973, 974 (9th Cir. 2003).

[77] See Radloff v. General Casualty Co. of Wisconsin, 147 Wis. 2d 14, 432 N.W.2d 597 (Ct. App. 1998).

[78] Ninaus, at 887-888.

SAMPLE DISCOVERY FOR ERISA-COVERED INVOLUNTARY PLAINTIFFS

INTERROGATORIES

INTERROGATORY NO. 1: When did the Plan first establish a purported self-funded ERISA plan for health benefits?

INTERROGATORY NO. 2: Identify the manner in which the Plan received its funding for health benefits for every year from the date stated in response to Interrogatory No. 1 to the present time.

INTERROGATORY NO. 3: For each claim received by the Plan for health benefits on behalf of the plaintiff from the date of the incident that is the subject of this lawsuit to the present, identifier the payer of said claims and the source of the funds used to pay said claims.

INTERROGATORY NO. 4: Identify each insurance company from whom the Plan has purchased insurance to pay or provide any portion of health benefits paid from the date

stated in response to Interrogatory No. 1 to the present time, providing the name of the insurer and the dates during which said insurance was in effect. For each insurance company identified, state:

a. The type of insurance purchased from said company;

b. The premiums paid by the Plan for said insurance;

c. The attachment point of said insurance, if any;

d. The deductible, if any, applicable to said insurance; and,

e. The fees and/or commissions paid by the Plan for said insurance;

INTERROGATORY NO. 5: Has the Plan received any notice of any kind whatsoever from the United States Department of Labor, and/or Internal Revenue Service, and/or any subdivision of either agency, advising it that it does not qualify as an ERISA plan, and/or that its filings with either agency are deficient in any manner?

INTERROGATORY NO. 6: Does the Plan claim to have a first priority lien with respect to recovering from a personal injury settlement or award on the amount of health care benefits paid on behalf of a Plan participant or beneficiary? If so, state when, if ever, said provision was first inserted into the Plan language and identify said provision.

INTERROGATORY NO. 7: Does the Plan claim that it is not required to reduce its lien for attorney's fees or costs incurred by a Plan participant or beneficiary in recovering a personal injury settlement or award? If so, state when, if ever, said provision was first inserted into the Plan language and identify said provision.

INTERROGATORY NO. 8: Does the Plan claim that its lien is not subject to the made whole doctrine? If so, state when, if ever, said provision was first inserted into the Plan language and identify said provision.

INTERROGATORY NO. 9: On how many occasions after the date stated in response to Interrogatory No. 1 to the present time has the Plan agreed to accept an amount less than the total amount of its claimed lien out of any personal injury settlement and/or recovery achieved by or on behalf of a Plan participant or beneficiary?

INTERROGATORY NO. 10: With respect to each instance identified in response to Interrogatory No. 9, provide the following additional information:

i. The total amount of the Plan's claimed lien;

ii. The amount ultimately accepted by the Plan in full and final satisfaction of its lien; and,

iii. State with specificity the reason the Plan accepted less than the total amount.

INTERROGATORY NO. 11: On how many occasions after the date stated in response to Interrogatory No. 1 to the present time has the Plan agreed to accept less than the total amount of its claimed lien in recognition of the attorney fees and/or costs incurred by a Plan participant's or beneficiary's attorney in achieving a personal injury settlement and/or recovery?

INTERROGATORY NO. 12: With respect to each instance identified in response to Interrogatory No. 12, provide the following additional information:

i. The total amount of the Plan's claimed lien; and

ii. The amount ultimately accepted by the Plan in full and final satisfaction of its lien.

INTERROGATORY NO. 13: On how many occasions after the date stated in response to Interrogatory No. 1 to the present time has the Plan agreed to accept less than the total amount of its claimed lien in recognition of the Plan participant or beneficiary not being made whole?

INTERROGATORY NO. 14: With respect to each instance identified in response to Interrogatory No. 13, provide the following additional information:

i. The total amount of the Plan's claimed lien; and

ii. The amount ultimately accepted by the Plan in full and final satisfaction of its lien.

INTERROGATORY NO. 15: Identify every administrator of the Plan from the date stated in response to Interrogatory No. 1 to the present time. For each administrator identified:

i. Provide their dates of employment with the plaintiff's employer; and

ii. Provide their title and job duties at the plaintiff's employer.

INTERROGATORY NO. 16: Identify, as that term is defined above, the Plan's third party administrator from the date of the incident that is the subject of this lawsuit to the present and identify the person with said administrator that you believe is the most knowledgeable about the administration of the Plan's subrogated interests.

INTERROGATORY NO. 17: State with specificity the process used by the Plan for the administration of medical claims and subrogation claims.

REQUEST FOR PRODUCTION OF DOCUMENTS

REQUEST NO. 1: Copies of:

a. All insurance policies, plans, or other agreements under which you claim to have a right of subrogation, reimbursement, or repayment for, or the right to offset future benefits by, any payments you have made or will make to or on behalf of the plaintiff(s) due to the injuries the plaintiff(s) suffered as a result of the collision that is the subject of this lawsuit.

b. An itemization of the payments you made on behalf of the plaintiff(s) that you claim were made as a result of the incident that is the subject of this lawsuit.

REQUEST 2: If you claim that any policy, plan, or other agreement providing benefits to the plaintiff(s) is governed by the Employee Retirement Income Security Act of 1974, then provide the following:

a. The Master Plan Document which existed as of the date of the incident that is the subject of this lawsuit.

b. The Summary Plan Description which existed as of the date of the incident that is the subject of this lawsuit.

c. All changes or amendments made to the Master Plan Document after the date of the incident that is the subject of this lawsuit.

d. All changes or amendments made to the Summary Plan Description after the date of the incident that is the subject of this lawsuit.

e. All subrogation and/or reimbursement provisions in the Master Plan Document, including changes and amendments thereto, from the date stated in response to Interrogatory No. 1 to the present time.

f. All subrogation and/or reimbursement provisions in the Summary Plan Description, including changes and amendments thereto, from the date stated in response to Interrogatory No. 1 to the present time.

g. All documents that in any way describe or demonstrate any sources of contributions used to fund the Plan from the date identified in response to Interrogatory No. 1 to the date of the incident that is the subject of this lawsuit, regardless of whether said funding came from the Plan sponsor, the Plan participants, the Plan beneficiaries or other entities.

h. All policies of insurance purchased to provide any portion of the plan's funding and/or to pay any portion of the medical benefits available under the Plan, and/or any documents

that show that a portion of the Plan's funding and/or a portion of the medical benefits available under the Plan is provided through the purchase of insurance, from the date identified in response to Interrogatory No. 1 to the present time.

i. All written guidelines, policies, procedures, and training manuals that were established, implemented or prepared by and/or that are employed by the Plan that in any way describe or pertain to the circumstances under which the Plan should consider accepting less than the full amount of its claimed lien out of the proceeds of any personal injury settlement or award on behalf of a Plan participant and/or beneficiary.

j. If the Plan has agreed to accept in full and final satisfaction of its lien interest an amount less than the amount of its total claimed lien, all documents setting forth the date, rationale and/or basis for the Plan agreeing to said reduction.

k. Form 5500 along with all Schedules filed with the Internal Revenue Service or Department of Labor from five years before the date of the incident that is the subject of this lawsuit to the present.

l. The administrative service contract between the Plan, the sponsor of the Plan, the administrator of the Plan and/or any company providing insurance to the Plan.

m. Any documents that the Plan provides to its third party administrator relative to the administration of medical claims and the administration of subrogation claims.

n. The annual report the Plan filed with the Secretary of Labor from 2008 to the present.

Subrogation Issues in Settling a Personal Injury Case

Presented by Attorney Matthew R. Falk, Falk Legal Group

Introduction

Learning Objective: Subrogation and reimbursement claims continue to play a large role in the prosecution of personal injury claims. This Presentation highlights trending issues in the area of subrogation that should concern personal injury practitioners. It includes:

- Pleading and Practice
- Mediation
- Pre-trial and Trial
- Key Decisional Cases
- Issues on the Horizon

Pleading and Practice

The subrogated party as an "Involuntary Plaintiff" or something else?

Mediation

Unique issues regarding subrogation at mediation

Pre-trial and Trial

Problem: the Pre-trial Order that provides for "Non-Appearance" until after the Trial.

Key Decisions

- Medicare Advantage
- Self-funded ERISA
- FEHBA
- Medicaid
- Medical Payment/ Fully Insured/ Subject to State Law

Legislative Issues

- Collateral Source Legislation
- Immunity– Get out of jail free cards
- No pay, No play

Thank You!

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