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ERISA Benefit Plan Lien

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I. [12.1] SCOPE OF CHAPTER

This chapter addresses the effect of an Employee Retirement Income Security Act of 1974 (ERISA) governed benefit plan lien on a personal injury tort action in Illinois. It explores the differences between traditional private insurance and ERISA-governed health plans as they relate to subrogation and reimbursement liens.

In the United States in 1993 there were more than 200,000 defined benefit plans, including more than 3,000 Taft-Hartley multi-employer plans and more than 600,000 defined contribution plans governed by ERISA. These ERISA-governed benefit plans cover more than 15 million participants and beneficiaries. Lee T. Polk, ERISA PRACTICE AND LITIGATION, §1:05 (1993). Therefore, the attorney engaged in personal injury litigation is likely to encounter an ERISA-governed lien in addition to those discussed in other chapters of this text and supplement. Because ERISA preempts most state laws relating to liens, the attorney must be familiar with the impact of the ERISA lien on a personal injury action.

This chapter defines the important terminology of ERISA and the benefit plan lien, reviews the cases decided by the courts as they relate to the ERISA-governed benefit plan lien on tort actions, and analyzes how the courts apply ERISA to personal injury actions.

II. ERISA GENERALLY

A. [12.2] Purpose

Congress established the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. §1001, *et seq.*, for the purpose of protecting persons covered by employee benefit plans by requiring disclosure of the plan's terms and coverage to the participants and by creating easy access to the courts for participants to redress violations of the terms of the plan. See §12.40.

To that end, courts have consistently ruled in favor of participants when the benefit plan did not properly meet the disclosure requirements outlined in ERISA. The practitioner must be aware of this important distinction: ERISA regulates the administration, reporting, and disclosure of a benefit plan's provisions, but it does not dictate the contents of those plans. *Land v. Chicago Truck Drivers, Helpers & Warehouse Workers Union (Independent) Health & Welfare Fund,* 25 F.3d 509, 18 BNA EBC 1471 (7th Cir. 1994); *Cutting v. Jerome Foods Inc.,* 820 F.Supp. 1146, 1152 (W.D.Wis. 1991), *aff'd,* 993 F.2d 1293 (7th Cir. 1993).

B. Relevant Statutory Sections

1. [12.3] Standing, Jurisdiction, and Civil Enforcement

Standing to sue under ERISA is granted to participants and beneficiaries who are covered by a welfare benefit plan, and to fiduciaries to the plan, as those terms are defined in the statute. 29 U.S.C. §1132(a). Fiduciaries include named persons who have authority to control and manage the plan's operation. 29 U.S.C. §1102(a)(1). A civil action may be brought by a participant or beneficiary, or by a fiduciary, to enforce the terms of a benefit plan, to recover benefits due under a plan, or to clarify rights under a plan. See §12.41.

Jurisdiction over ERISA-sponsored benefit plans is generally vested in the federal courts, although actions brought by a participant or beneficiary to enforce rights under the plan may be heard in state courts, which have concurrent jurisdiction. 29 U.S.C. §1132(e). See §12.41.

2. [12.4] Preemption

Because Congress meant ERISA to be a nationwide statutory scheme, Congress provided that only federal law will control ERISA-governed plans. State laws are preempted by ERISA under 29 U.S.C. §1144. See §12.42.

For a discussion of the analysis necessary to determine if preemption applies, see §12.10 below. Without preemption, state lien laws control.

3. [12.5] Employee Welfare Benefit Plan

ERISA defines "employee welfare benefit plan" to include a plan established by an employer or employee organization to provide benefits to cover medical, hospital, and surgical expenses of the employee and beneficiaries. See §12.43.

This chapter refers to employee welfare benefit plans as "benefit plans" or "plans."

C. Lien Terminology

1. [12.6] Subrogation and Reimbursement

The terms "subrogation" and "reimbursement" are often used interchangeably. Both theories of recovery were created so that a health insurer or other payor could recover from a third party the amounts it paid on behalf of a beneficiary as a result of the third party's liability. However, the two terms describe different rights and obligations and involve different parties. *See Cutting v. Jerome Foods Inc.,* 993 F.2d 1293, 1297 – 1298, 16 BNA EBC 2492 (7th Cir. 1993), and Chapter 15 of this handbook. In a tort action, both doctrines will give a benefit plan a right to participate in a recovery from a tortfeasor.

"Reimbursement" refers to the right of a plan to get paid back the money it has paid to a health care provider on behalf of a participant; the repayment of this money comes from the participant's own funds. There is a concomitant duty on the participant to pay back this money. The source of reimbursement is often from the participant's settlement with a third-party tortfeasor's liability insurer. However, a benefit plan will sometimes seek reimbursement directly from the participant's own funds, *e.g.,* when a participant fails to repay a plan from a third-party recovery or when a participant fails to file a claim with the tortfeasor's insurer. See 16 Mark S. Rhodes, COUCH ON INSURANCE 2D §61:29 (Rev.ed. 1983, Supp. 1994).

"Subrogation," on the other hand, refers to a plan's right to sue a responsible third party, nominally on behalf of its participant, for money it was obligated to pay under the plan's terms because of the tortfeasor's conduct. Subrogation transfers the participant's legal right to claim these expenses from a tortfeasor to the welfare plan. *Harmond v. Teamsters Joint Council No. 83 Health & Welfare Fund,* 795 F.Supp. 783, 789 (E.D.Va. 1992), *aff'd,* 1 F.3d 1233 (4th Cir. 1993). Often, the plan makes the payment of benefits contingent on this

transfer. Polk, ERISA PRACTICE AND LITIGATION §12:29 (1993); §12.17 of this chapter. The subrogation recovery comes from a third-party source; the reimbursement recovery comes from the participant.

What many benefit plans call "subrogation" or "reimbursement" is often a hybrid containing terminology from both theories of recovery. *See Cutting v. Jerome Foods, Inc.,* 820 F.Supp. 1146, 1149 – 1150 (W.D.Wis. 1991), *aff'd,* 993 F.2d 1293 (7th Cir. 1993) (plan language). The attorney dealing with the plan needs to understand the difference between the two theories. Furthermore, plaintiff attorneys routinely collect the cost of the plaintiff's medical bills as part of the plaintiff's recovery and agree to pay back the plan, thereby releasing the tortfeasor from further liability. Most plans allow a participant's attorney to do this. *See Tenney v. American Family Mutual Insurance Co.,* 128 Ill.App.3d 121, 470 N.E.2d 6, 83 Ill.Dec. 251 (4th Dist. 1984). A clear understanding of the differences between the two theories is essential when determining the scope of the ERISA plan's lien.

2. [12.7] Summary Plan Description/Plan Document

ERISA-governed plans are "established and maintained pursuant to a written instrument." 29 U.S.C. §1102(a). All plans established pursuant to ERISA must contain a summary plan description and a plan document. The contents of these two written instruments are mandated by ERISA. 29 U.S.C. §1022. The plan document is a detailed written description of the terms of the benefits provided by the plan.

The summary plan description (SPD) contains the same information as the plan document, but the "lengthy and complex plan provisions" are accurately summarized "into a concise format to ensure that beneficiaries receive notice of their rights" in a manner calculated to be understood by the average plan participant. *Sanders v. Scheideler,* 816 F.Supp. 1338, 1344 (W.D.Wis. 1993); 29 U.S.C. §1022(a)(1). See §12.44.

3. [12.8] Participant and Beneficiary

The terms "participant" and "beneficiary" refer to those persons who are eligible to receive benefits from a welfare benefit plan. A "participant" is an employee who is or may become eligible to receive a benefit. 29 U.S.C. §1002(7). A "beneficiary" is a person designated by a participant who receives or may become entitled to receive a benefit or a person who, by the terms of the plan, is or may become entitled to receive a benefit under the plan. 29 U.S.C. §1002(8). Unless otherwise specified, the terms are used interchangeably in this chapter.

4. [12.9] Reimbursement Agreement

The "subrogation/reimbursement agreement" is a document, executed by both the participant and the plan, in which the participant ratifies an obligation to reimburse the plan for any health care benefits paid by the plan on behalf of the participant, or in which the participant assigns a right of subrogation to the welfare plan. This document is always in addition to concomitant plan language with the same effect. The reimbursement agreement is not mandated by ERISA; rather, it is a device adopted by some benefit plans. See §12.17 of this chapter.

III. ERISA PREEMPTION OF STATE LAWS

A. [12.10] Generally

As discussed above, ERISA preempts all state laws that relate to benefit plans. 29 U.S.C. §1144. An attorney dealing with a welfare benefit plan must first determine whether the state laws are preempted when applied to that plan. If the plan at issue is not an ERISA-governed plan, then the discussion in this chapter does not apply, and state lien laws as discussed elsewhere in this handbook apply. This distinction is a primary concern to the practitioner dealing with a lien on a tort action because the laws concerning ERISA-governed plans differ greatly from state subrogation and lien laws. Therefore, this section gives a detailed description of ERISA preemption.

B. [12.11] Laws That "Relate to" Benefit Plans

The U.S. Supreme Court clarified the reach of ERISA preemption by drawing a distinction between benefit plans that merely purchase insurance versus those that are "self-funded." *FMC Corp. v. Holliday,* 498 U.S. 52, 112 L.Ed.2d 356, 111 S.Ct. 403 (1990). In that case, the Court analyzed the preemption provision by using a three-step process.

First, the Court reviewed 29 U.S.C. §1144(a), which contains the general supersedure language. That section states that ERISA will preempt all state laws that "relate to" an employee benefit plan. The courts construe the "relates to" provision broadly: "The pre-emption clause is conspicuous for its breadth." 112 L.Ed.2d at 364. Courts are most likely to find that a state law "relates to" an employee benefit plan.

Second, the Court applied the statute's "savings clause," which returns to the states "the power to enforce those state laws that 'regulat[e] insurance.'" *Id.;* 29 U.S.C. §1144(b)(2)(A). The savings clause therefore acts to return certain power to the states to regulate the business of insurance unless the benefit plan is "deemed" to be governed by ERISA.

The third part of the Court's analysis refers to the "deemer clause," which states that a welfare benefit plan shall not "be deemed to be an insurance company or other insurer . . . or to be engaged in the business of insurance." 29 U.S.C. §1144(b)(2)(B). The Court distinguished self-funded benefit plans from those that purchase insurance:

> **We read the deemer clause to exempt self-funded ERISA plans from state laws that "regulat[e] insurance" within the meaning of the savings clause.** 112 L.Ed.2d at 366.

The deemer clause applies to any law that purports to regulate a benefit plan, not just those directed at the insurance industry. 112 L.Ed.2d at 367.

If this analysis seems confusing, the Supreme Court itself recognized that "these provisions 'are not a model of legislative drafting.'" [Citation omitted.] 112 L.Ed.2d at 364. However, the practitioner must be aware of the distinction and be able to determine whether the plan at issue is self-funded or merely purchases insurance.

C. [12.12] Self-Funded Plans vs. Insured Plans

A self-funded benefit plan is one in which the employer pays all benefit claims for participants. *Hampton Industries, Inc. v. Sparrow,* 981 F.2d. 726, 727, 16 BNA EBC 1360 n.1 (4th Cir. 1992). An employer may do this by paying claims out of pocket or by establishing and making contributions to a trust fund on behalf of participants. The trust fund is often administered by a third-party administrator. *See Singleton v. Board of Trustees of IBEW Local 613 Health & Welfare Fund,* 815 F.Supp. 448 (N.D.Ga. 1993). A self-funded plan may also be a Taft-Hartley Trust, which is a trust fund jointly managed by one or more employers and one or more labor unions. 29 U.S.C. §186(c)(5). Pursuant to a collective bargaining agreement, an employer makes contributions into the fund. The fund, in turn, provides welfare benefits to members of a union. *See Serembus ex rel. UIU Health & Welfare Fund v. Mathwig,* 817 F.Supp. 1414, 16 BNA EBC 1493 (E.D.Wis. 1992); *Central States, Southeast & Southwest Areas Health & Welfare Fund v. State Farm Mutual Automobile Insurance Co.,* 17 F.3d 1081 (7th Cir. 1994).

On the other hand, a benefit plan in which the employer purchases an insurance policy from a private health care insurer as the primary method of supplying benefits to participants is not self-funded. ERISA would not preempt state laws that govern that type of plan. *Cutting v. Jerome Foods, Inc.,* 993 F.2d 1293, 1296, 16 BNA EBC 2492 (7th Cir. 1993). In *Pacificare, Inc. v. Martin,* 34 F.3d 834, 837, 18 BNA EBC 2146 (9th Cir. 1994), the court delineated four criteria used to determine that an employee benefit plan is not governed by ERISA:

> **(1) No contributions are made by an employer or employee organization;**
>
> **(2) Participation in the program is completely voluntary for employees or members;**
>
> **(3) The sole function of the employer or employee organization** [is] **to permit the insurer to publicize the program . . . to collect premiums through payroll deductions or dues checkoffs and to remit them to the insurer; and**
>
> **(4) The employer or employee organization receives no consideration in the form of cash or otherwise in connection with the program, other than reasonable compensation, excluding any profit, or administrative services actually rendered in connection with payroll deductions or dues checkoffs.** Quoting *Kanne v. Connecticut General Life Insurance Co.,* 867 F.2d 489, 492 (9th Cir. 1988), quoting in turn 29 C.F.R. §2510.3 – 1(j).

D. [12.13] Choice of Law Clauses

The parties to the plan may waive the preemption of ERISA by including a "choice of laws" provision in the plan document or SPD. *See, e.g., General Business Forms Employee Health Care Plan v. Thornburg,* No. 88 C 8549, 1989 U.S.Dist. LEXIS 10192 (N.D.Ill. Aug. 28, 1989). If so, the courts will enforce the choice of law provision and apply state substantive law according to the clause's terms.

E. Determining the Plan's Status

1. [12.14] Documents

The attorney dealing with a benefit plan lien must review the documents that establish the lien claimant's rights to determine whether the plan was established as an ERISA plan. If so, the practitioner can determine from the documents the scope and extent of the lien claimed and the type of lien to which the claimant is entitled (*e.g.,* subrogation versus reimbursement; see §12.6 of this chapter). These documents are important because the ERISA-governed benefit plan is entitled to reimbursement or subrogation only to the extent set forth in the plan's provisions or contained in the SPD. *See Germany v. Operating Engineers Trust Fund of Washington, D.C.,* 789 F.Supp. 1165, 15 BNA EBC 1407 (D.D.C. 1992).

The practitioner must obtain the SPD in its entirety, not just the subrogation/reimbursement provision. The client or participant should have a copy of the SPD. An injured claimant can rely on the terms of the SPD to the exclusion of the plan document. See §12.16 of this chapter. The attorney should also obtain other relevant documents, such as the subrogation/reimbursement agreement executed by the participant and any information sheet that seeks factual details from the participant of the circumstances of the claim for benefits. Many plans require a participant to sign both documents early in the claims process.

The attorney must obtain copies of all relevant documents because the ERISA plan's right to reimbursement arises from and is governed by these documents. *See Travitz v. Northeast Department ILGWU Health & Welfare Fund,* 818 F.Supp. 761, 764 (M.D.Penn. 1993), *aff'd,* 13 F.3d 704 (3d Cir.), *cert. denied,* _____ U.S. _____, 128 L.Ed.2d 888 (1994), for a list of documents supplied by the benefit plan in support of its contention that it was an ERISA-governed plan.

The plaintiff's attorney should review these documents before the client signs any agreements. The provisions for subrogation/reimbursement in all of the documents should be similar. Neither the SPD nor the subrogation/reimbursement agreement should give more rights to the plan than the plan document does. For example, the agreement may contain an unlawful assignment of the entire cause of action to the plan. *See Thompson v. Federal Express Corp.,* 809 F.Supp. 950 (M.D.Ga. 1992); §12.16 of this chapter.

2. [12.15] Is the Plan an ERISA Plan?

The attorney must review the documents and supporting materials to determine if the plan is established and governed pursuant to ERISA. *See Travitz v. Northeast Department ILGWU Health & Welfare Fund,* 818 F.Supp. 761, 764 (M.D.Penn. 1993), *aff'd,* 13 F.3d 704 (3d Cir.), *cert. denied,* _____ U.S. _____, 128 L.Ed.2d 888 (1994) (list of documents supplied by benefit plan in support of contention it was governed by ERISA).

IV. THE SUMMARY PLAN DESCRIPTION AND THE REIMBURSEMENT AGREEMENT

A. [12.16] The Terms of the SPD and Plan Document Control Relationship

A court reviewing subrogation/reimbursement language in a plan will give full effect to the terms of the plan, the SPD, and the provisions of the subrogation/reimbursement

agreement. *Serembus ex rel. UIU Health & Welfare Fund v. Mathwig,* 817 F.Supp. 1414, 16 BNA EBC 1493 (E.D.Wis. 1992). There is no federal common law right to subrogation under ERISA. The courts can create a common law of interpretation, however, according to *Cutting v. Jerome Foods, Inc.,* 993 F.2d 1293, 16 BNA EBC 2492 (7th Cir. 1993), and *Senkier v. Hartford Life & Accident Insurance Co.,* 948 F.2d 1050 (7th Cir. 1991), in which the court interpreted the plan provisions under federal common law.

When a participant relies only on the terms of the SPD and there is a conflict between the SPD and the plan document, the terms of the SPD control. *Senkier,* 948 F.2d at 1051, and cases cited therein. *See also Lutheran Medical Center of Omaha v. Contractors, Laborers, Teamsters & Engineers Health & Welfare Plan,* 25 F.3d 616 (8th Cir. 1994) (SPD creates expectation in participant). ERISA requires that the SPD be "sufficiently accurate and comprehensive to reasonably apprise" the participant of his rights under the plan. *Senkier,* 948 F.2d at 1051. The benefit provider cannot disclaim reliance on the SPD provided to the covered employees. *Thompson v. Federal Express Corp.,* 809 F.Supp. 950, 956 (M.D.Ga. 1992).

See also Alco Standard Corp. v. Gilbert, No. 91 C 4849, 1992 U.S.Dist. LEXIS 6074 at *5 (N.D.Ill. Apr. 24, 1992), in which the court refused to apply the subrogation provision of plan document because the "absence of a right of subrogation or reimbursement [in the SPD], a central right to the administration of the Plan, is a significant omission."

B. [12.17] Signature on Reimbursement Agreement Before Paying Benefits

Often, a plan will ask a claimant for benefits to execute a subrogation/reimbursement agreement prior to granting benefits. If the SPD or plan document requires that the claimant execute the agreement in order to qualify for benefits, then the plan can legally withhold payment of benefits until it receives the signed agreement. *Preze v. Board of Trustees, Pipefitters Welfare Fund Local 597,* 5 F.3d 272 (7th Cir. 1993); *Cutting v. Jerome Foods, Inc.,* 820 F.Supp. 1146 (W.D.Wis. 1991), *aff'd,* 993 F.2d 1293 (7th Cir. 1993). *See also Harmond v. Teamsters Joint Council No. 83 Health & Welfare Fund,* 795 F.Supp. 783 (E.D.Va. 1992), *aff'd,* 1 F.3d 1233 (4th Cir. 1993).

However, the reimbursement/subrogation agreement required to be signed by the participant cannot expand the plan's right to recover from the participant's settlement or lawsuit proceeds. *Germany v. Operating Engineers Trust Fund of Washington, D.C.,* 789 F.Supp. 1165, 15 BNA EBC 1407 (D.D.C. 1992). In *Germany,* the SPD described the plan's right to reimbursement as arising only if the participant obtained a double recovery for medical care costs. The plan's trustee attempted to require the participant to sign an agreement giving to the plan the right to reimbursement from any settlement proceeds. The participant sued the plan, seeking to force the plan to distribute benefits and seeking a declaration of his rights if he refused to sign.

The court ruled in favor of the participant. The court relied specifically on the fact that the SPD limited the plan's right to reimbursement. Meanwhile, the terms of the reimbursement agreement were not disclosed to plan participants before the plan required the participant's signature. The court, noting ERISA's affirmative disclosure requirement, declared the reimbursement agreement an invalid attempt to expand the plan's reimbursement rights. *Germany, supra. See also Thompson v. Federal Express Corp.,* 809 F.Supp. 950 (M.D.Ga. 1992).

C. [12.18] Reimbursement in the Absence of a Signed Reimbursement Agreement

If the SPD provides for reimbursement, the courts will enforce the reimbursement provision when the participant refuses to sign a reimbursement agreement. *Travitz v. Northeast Department ILGWU Health & Welfare Fund,* 818 F.Supp. 761 (M.D.Penn. 1993), *aff'd,* 13 F.3d 704 (3d Cir.), *cert. denied,* _____ U.S. _____, 128 L.Ed.2d 888 (1994). However, the SPD must contain a reimbursement provision; there is no federal right to equitable subrogation. See §12.31 of this chapter.

D. [12.19] Parent's or Guardian's Signature on Minor's Behalf

When the payment of benefits on a minor's claim is contingent on signing a subrogation agreement, the participant must sign the subrogation/reimbursement agreement on the minor's behalf to obtain benefits for the minor. *Wahl v. Northern Telecom, Inc.,* 726 F.Supp. 235, 243, 11 BNA EBC 2610 n.6 (E.D.Wis. 1989). A plan can require a parent to sign the agreement on the minor's behalf. *Preze v. Board of Trustees, Pipefitters Welfare Fund Local 597,* 5 F.3d 272 (7th Cir. 1993). *See also Sanders v. Scheideler,* 816 F.Supp. 1338 (W.D.Wis. 1993), in which the participant parent signed an assignment agreement pursuant to a provision in the SPD (although the court held the assignment invalid for other reasons). The agreement signed by the parent will be binding on the minor.

V. EFFECT OF ERISA PREEMPTION AND ERISA LIENS ON ILLINOIS TORT ACTIONS

A. [12.20] The Illinois Family Expense Statute

The status of the family expense statute, 750 ILCS 65/15, as it applies to an ERISA-governed benefit plan, is still unclear in Illinois. Two Northern District of Illinois cases have applied the ERISA preemption analysis doctrine directly to the statute with different results. In *General Business Forms Employee Health Care Plan v. Thornburg,* No. 88 C 8549, 1989 U.S.Dist. LEXIS 10192 (N.D.Ill. Aug. 28, 1989), the court determined that the family expense statute prohibits employers from structuring employee benefit plans in a manner that requires reimbursement from a minor's tort recovery, and thus the law was preempted under ERISA.

The court concluded that Illinois courts interpreting this statute "directed the rule at the insurance industry" because all of the Illinois cases litigating this statute were brought by insurance companies trying to enforce subrogation provisions in their policies. However, for the reasons discussed in §12.3 of this chapter, the court applied state law because the benefit plan contained a choice of law clause that referred the resolution of disputes back to state laws. 1989 U.S.Dist. LEXIS 10192 at *10.

The court in *Prudential Insurance Co. v. Rodriguez,* 1991 U.S.Dist. LEXIS 19640 (N.D.Ill. Dec. 23, 1991), applied the same preemption analysis but reached a different conclusion. The court interpreted the family expense statute as "regulat[ing] the rights of minors and the debtor-creditor relationship of a minor and his medical provider" rather than "curtail[ing] the right of subrogation." 1991 U.S.Dist. LEXIS 19640 at *8. Thus, the statute does not "relate to" an employee benefit plan, and state law is not preempted. Although these cases reach inconsistent conclusions, in both cases the benefit plan was not allowed reimbursement from the minor's tort recovery.

The Seventh Circuit upheld a benefit plan's right to require a participant to sign a reimbursement agreement on behalf of his minor daughter. *Preze v. Board of Trustees, Pipefitters Welfare Fund Local 597,* 5 F.3d 272 (7th Cir. 1993). In that case, the lower court ruled that ERISA preempted the state's anti-subrogation laws as they relate to a minor's cause of action. 5 F.3d at 274 n.3. The participant did not challenge that ruling on appeal. The Seventh Circuit interpreted the SPD as requiring the participant to sign the subrogation agreement on his minor daughter's behalf, granting a right of reimbursement to the benefit plan from the minor's tort recovery. Therefore, to the extent that this ruling conflicts with the family expense statute and the Illinois doctrine that prohibits subrogation from a minor's cause of action, it appears that the Seventh Circuit would hold that ERISA preempts this doctrine.

The Illinois appellate court has ruled that the family expense statute is not preempted by ERISA. *Kelleher v. Hood,* 238 Ill.App.3d 842, 605 N.E.2d 1018, 179 Ill.Dec. 4, 5 (2d Dist. 1992). In that case, the court ruled that ERISA does not preempt the family expense statute because the statute had too tangential an impact on the benefit plan at issue.

As a practical matter, many plaintiff attorneys either sue the tortfeasor on behalf of the parents to recover the cost of medical care for the minor, or the parents assign the parents' cause of action for medical expenses to the minor to maximize the minor's recovery. Several courts have referred approvingly to such assignments. *See General Business Forms, Inc., supra; Prudential Insurance Co., supra. See also Kennedy v. Kiss,* 89 Ill.App.3d 890, 412 N.E.2d 624, 45 Ill.Dec. 273 (1st Dist. 1980) (such assignment is valid in Illinois under family expense statute).

B. [12.21] Minors' Lawsuits and Family Expense Statutes in Different States

Federal courts reviewing family expense statutes in other states have ruled that ERISA preempts these laws as they relate to ERISA-governed employee benefit plans. *Serembus ex rel. UIU Health & Welfare Fund v. Mathwig,* 817 F.Supp. 1414, 16 BNA EBC 1493 (E.D.Wis. 1992); *Wahl v. Northern Telecom, Inc.,* 726 F.Supp. 235, 11 BNA EBC 2610 (E.D.Wis. 1989); *McIntosh v. Pacific Holding Co.,* 992 F.2d 882, 16 BNA EBC 2540 (8th Cir. 1993).

C. [12.22] Fund Doctrine: Plaintiff's Attorney Fees for Collecting Reimbursement from Tortfeasor

The "fund doctrine," as developed under Illinois law, is preempted when applied to ERISA-governed benefit plans. The fund doctrine holds that a plaintiff's attorney "who performs services in creating a fund should in equity and good conscience be allowed compensation out of the whole fund from all those who seek to benefit from it." *Baier v. State Farm Insurance Co.,* 66 Ill.2d 119, 361 N.E.2d 1100, 1102, 5 Ill.Dec. 572 (1977). It is a concept developed along with the law of subrogation. See discussion in §2.31 of this handbook.

The Seventh Circuit has ruled that the fund doctrine as developed under state law does not apply to ERISA-governed benefit plans. *Land v. Chicago Truck Drivers, Helpers & Warehouse Workers Union (Independent) Health & Welfare Fund,* 25 F.3d 509, 18 BNA EBC 1471 (7th Cir. 1994). In *Land,* the attorney represented a plan participant who settled his personal injury action for $182,500. Plaintiff acknowledged that $42,604.92 of that settlement was intended to reimburse the benefit plan for medical expenses that the plan advanced. The plaintiff's attorney sought to reduce the reimbursement by one third for his fee through application of the fund doctrine.

The district court denied this request for a reduction, holding that ERISA preempted the Illinois fund doctrine as applied to the Truck Drivers' plan; the plaintiff appealed. Instead of proceeding under the terms of ERISA, however, the plaintiff sought to have the court declare ERISA unconstitutional under several constitutional law theories. 25 F.3d at 511, 512. The Seventh Circuit affirmed the district court's denial of the reduction for attorney's fees and upheld ERISA's constitutionality. 25 F.3d at 514.

The court reasoned that ERISA does not prevent a benefit plan from including a subrogation/reimbursement provision in its coverage because ERISA does not regulate the substantive terms of the plan. If the plan does include a reimbursement provision, the courts will enforce it as written. 25 F.3d at 514. Under the terms of the plan before the court, the plaintiff was not entitled to reduce the plan's lien to compensate the plaintiff for attorney's fees incurred in collecting that money because the plan's terms did not provide for such a reduction. The court refused to apply the fund doctrine to alter the plan's terms.

Compare Serembus ex rel. UIU Health & Welfare Fund v. Mathwig, 817 F.Supp. 1414, 1423, 16 BNA EBC 1493 (E.D.Wis. 1992) ("Since the Fund benefits from defendant's pursuit of her claims, a one-third reduction of the Fund's subrogation amount of the settlement fairly apportions the attorney's fees"), *and Dugan v. Nickla,* 763 F.Supp. 981, 984 – 985, 13 BNA EBC 2310 (N.D.Ill. 1991) ("Since the Fund benefits from defendant's pursuit of his case, [a] one-third reduction of the Fund's share of the verdict fairly apportions the attorney's fee"). *But see Thompson v. Federal Express Corp.,* 809 F.Supp. 950 (M.D.Ga. 1992) (district court denied reduction in benefit plan lien for participant's attorney's fees because plan's terms did not provide for reduction under this doctrine).

D. [12.23] Depletion of Settlement Proceeds To Satisfy the Benefit Plan Lien

One federal court ruled that an ERISA-governed benefit plan can be allowed to totally deplete the proceeds of a participant's tort recovery to satisfy its lien. *Hampton Industries, Inc. v. Sparrow,* 981 F.2d. 726, 16 BNA EBC 1360 (4th Cir. 1992).

E. [12.24] The Make-Whole Doctrine

The Seventh Circuit has determined that the "make whole" rule is preempted by ERISA, but that the courts should apply it when the plan's terms do not designate priority of payment rules. The court reasoned that the "make whole" rule is not a universal rule but rather a principle of interpretation. *Cutting v. Jerome Foods, Inc.,* 993 F.2d 1293, 1297 (7th Cir. 1993). The "make whole" rule states that an insurance company may not seek reimbursement until its beneficiary has been "made whole." That is, the benefit plan cannot seek the repayment of the medical expenses it paid until the beneficiary has been fully compensated for his injuries. According to the court, the "make whole" rule "can be overridden by clear language in the plan." 993 F.2d at 1298 – 1299.

In another Wisconsin case, the district court applied the "make whole" rule. *Sanders v. Scheideler,* 816 F.Supp. 1338 (W.D.Wis. 1993). In that case, the reimbursement provision at issue did not address the priority of the plan's reimbursement rights. According to the court, in the absence of a priority provision, the majority of states "preclude[] an insurer from exercising a right of reimbursement until the insured's entire loss has been paid." 816 F.Supp. at 1345. The court adopted the "make whole" rule as a principle of federal common law under ERISA. However, the court limited the application of the rule to "serve strictly as a default rule to be applied only when a plan fails to designate priority rules or provide its fiduciaries the discretion necessary to construe the plan accordingly." 816 F.Supp. at 1347.

Compare the Illinois rule in *In re Estate of Scott,* 208 Ill.App.3d 846, 567 N.E.2d 605, 607, 153 Ill.Dec. 647 (2d Dist. 1991), in which the court ruled that a health insurer could deplete settlement proceeds to satisfy its lien even though the insured had not been made whole by the settlement.

F. [12.25] Effect of Release of Tortfeasor

A release executed by a participant will not release a tortfeasor's subrogation liability to a benefit plan. *Central States, Southeast & Southwest Areas Health & Welfare Fund v. State Farm Mutual Automobile Insurance Co.,* 17 F.3d 1081 (7th Cir. 1994). In that case, the benefit plan sought inter alia a right to subrogation from a liability insurer who had settled several personal injury cases with persons who were also plan beneficiaries.

The Seventh Circuit ruled that the releases executed by the injured claimants did not "extinguish the Trustees' subrogation rights." 17 F.3d at 1084, citing 16 George J. Couch, et al., COUCH ON INSURANCE 2D §61:201, pp. 261, 265 (2d ed. 1966). The court relied on Couch for the proposition that a "release given by subrogor does not bar the subrogee's claim, so long as the defendant was on notice of the subrogee's claim before the release was given." *Id.* See also §15.9 of this handbook.

The court concluded: "The Trustees are in the same position as they have always been with respect to their ability to enforce their rights of subrogation." 17 F.3d at 1084. The trustees' remedy, according to the court, could also lie in reimbursement from the participant rather than subrogation against the tortfeasor. Therefore, a participant's release of a tortfeasor will not bar a plan's action for subrogation from the tortfeasor.

G. [12.26] Allocation of Proceeds to Noneconomic Losses To Defeat the Benefit Plan's Recovery

Often a beneficiary will attempt to defeat a plan's recovery by allocating litigation proceeds to noneconomic losses. However, the federal courts have held that a beneficiary cannot defeat the benefit plan's recovery by such an allocation. The plan's reimbursement provision will always determine the extent of the right to recovery.

In *Dugan v. Nickla,* 763 F.Supp. 981, 13 BNA EBC 2310 (N.D.Ill. 1991), the participant received a jury verdict in the amount of $140,750 on his medical malpractice action. The benefit plan had paid $60,690 in medical benefits and more than $8,000 in disability benefits arising from the same claim. Pursuant to a special jury verdict, the jury apportioned only $7,000 of the award to medical expenses. The plan sought full reimbursement of its lien from the jury's award.

The court followed the rule that the terms of the ERISA-governed benefit plan will govern any disputes between the parties. The court found that the reimbursement provision stated that the plan was entitled to reimbursement from "the monies paid" by the tortfeasor irrespective of any allocation of the proceeds to medical expenses. Even had the jury apportioned 100 percent of the damages to noneconomic losses, the benefit plan would still be entitled to reimbursement.

See also McIntosh v. Pacific Holding Co., 992 F.2d 882 (8th Cir. 1993), in which the court reasoned that, based on the plan's specific reimbursement language, the plan had a right to reimbursement from the noneconomic proceeds of the minor beneficiary's tort recovery. *See also Kennedy v. Georgia-Pacific Corp.,* 31 F.3d 606, 18 BNA EBC 1593 (8th Cir. 1994)

(reimbursement from participant's underinsured motorist insurance recovery not allowed because plan language limited reimbursement to those amounts paid "for medical expenses").

H. [12.27] Lien Recovery from Uninsured/Underinsured Motorist Liability Insurance

A benefit plan may obtain reimbursement for medical expenses from a beneficiary from proceeds received pursuant to an uninsured or underinsured motorist coverage claim. *Harmond v. Teamsters Joint Council No. 83 Virginia Health & Welfare Fund,* 795 F.Supp. 783, 786 (E.D.Va. 1992), *aff'd,* 1 F.3d 1233 (4th Cir. 1993). In *Harmond,* the court relied on plan language creating a right to reimbursement from the proceeds of the beneficiaries' claim "against any person, firm, corporation, or other entity as respects such injuries, expenses, or loss." The court interpreted this plan provision as allowing the plan to obtain reimbursement from the participant's $100,000 recovery from his uninsured motorist coverage under his own automobile insurance policy.

See also Cutting v. Jerome Foods, Inc., 820 F.Supp. 1146, 1155 (W.D.Wis. 1991), *aff'd,* 993 F.2d 1293 (7th Cir. 1993) (benefit plan provided for subrogation in claim against any insurer, including participant's uninsured motorist insurance).

In contrast, the Eighth Circuit Court of Appeals refused to interpret plan language as giving a right to reimbursement to the benefit plan from the injured beneficiaries' underinsured motorist coverage. *Kennedy v. Georgia-Pacific Corp.,* 31 F.3d 606, 610, 18 BNA EBC 1593 (8th Cir. 1994). In that case, the plan language granted the right of reimbursement to the plan from any payments made "on behalf of the responsible person." The court interpreted this provision not to include payments made by a participant's own automobile insurer. The court reasoned that payments made from the tortfeasor's liability insurer would be made on behalf of the responsible person, but payments made from the injured participant's own insurance coverage could not reasonably be meant to be made "on behalf of" the tortfeasor.

See also McIntosh v. Pacific Holding Co., 992 F.2d 882, 18 BNA EBC 2540 (8th Cir. 1993), in which the court stated that reimbursement would not ordinarily apply in circumstances when the injured beneficiary had personal coverage under a second insurance policy.

I. [12.28] Tortfeasor's Obligations to Benefit Plan on Settlement of Claim

A tortfeasor's insurance company does not owe a fiduciary duty to a benefit plan when settling a liability claim with an injured participant even when the insurer has notice of the benefit plan's lien. *Central States, Southeast & Southwest Areas Health & Welfare Fund v. State Farm Mutual Automobile Insurance Co.,* 17 F.3d 1081 (7th Cir. 1994). In that case, the Central States' benefit fund sought an injunction against State Farm's practice of settling automobile accident liability claims with injured plan participants without protecting the plan's lien rights despite notice.

The Seventh Circuit refused to impose liability on State Farm for this practice. The court reasoned that the plan failed to identify any language, either in the plan or in ERISA, imposing an obligation on State Farm or parties similarly situated to protect the plan's lien. Furthermore, the court ruled that State Farm could not be bound by the reimbursement agreement because State Farm was not a party to that agreement. Finally, the court ruled

that State Farm was not a fiduciary under ERISA because it was not the benefit plan's agent. *See also Cooper Tire & Rubber Co. v. St. Paul Fire and Marine Insurance Co.,* 18 BNA EBC 2891 (8th Cir. Feb. 27, 1995), in which the court refused to impose liability on the negligent physician or his insurer for tortious intereference with the benefit plan's right to subrogation.

J. [12.29] Reimbursement from Recovery for Wrongful Death Proceeds

The Fourth Circuit has twice ruled on whether a benefit plan may obtain reimbursement from the proceeds of a wrongful death cause of action. *Liberty Corp. v. NCNB National Bank,* 984 F.2d 1383 (4th Cir. 1993); *McInnis v. Provident Life & Accident Insurance Co.,* 21 F.3d 586, 18 BNA EBC 1085 (4th Cir. 1994). In both cases, the court, interpreting a North Carolina wrongful death statute that limited a medical benefits insurer's right to reimbursement to $1,500, ruled that the nature of the action controls whether this type of statute is preempted under ERISA.

In *Liberty Corp.,* the court found that the action belonged not to the decedent but to the decedent's beneficiaries. The beneficiaries, who were not liable for the decedent's medical expenses, did not recover for those expenses. The court reasoned that the statute's application was too remote from the benefit plan, and therefore ERISA did not preempt the state law. The plan was not allowed reimbursement from the decedent's beneficiaries' action.

In *McInnis,* on the other hand, the decedent's estate brought an action against the tortfeasor. Part of the estate's recovery included payment for medical bills incurred by the decedent prior to his death. The court reasoned that the North Carolina statute was preempted by ERISA in this case because it had the effect of limiting the benefit plan's right to reimbursement from the decedent's estate.

In Illinois, the legislature has separated the causes of action that arise out of a person's wrongful death. The Wrongful Death Act, 740 ILCS 180/0.01, *et seq.,* creates a cause of action for the benefit of the decedent's surviving spouse and next of kin. Medical expenses incurred as a result of the wrongful injury and death are not ordinarily a part of a wrongful death cause of action in Illinois. See 740 ILCS 180/2. However, medical expenses may be a part of a survival action. See 755 ILCS 5/27-6. Based on the Fourth Circuit's reasoning, it appears that a benefit plan would not have a right to reimbursement from the proceeds of a wrongful death action in Illinois. *But see Thatcher v. Eichelberger,* 102 Ill.App.3d 231, 429 N.E.2d 1090, 57 Ill.Dec. 816 (4th Dist. 1982); §15.5 of this handbook.

K. [12.30] Right of Participant To Receive Future Benefits After Settling with Tortfeasor

At least one court has released a benefit plan from further liability for medical benefits as a result of the original claim after the participant and the plan settled the plan's reimbursement claim. See the court's order in *Serembus ex rel. UIU Health & Welfare Fund v. Mathwig,* 817 F.Supp. 1414, 16 BNA EBC 1493 (E.D.Wis. 1992). The plaintiff's attorney should refer to the plan's terms to see if the participant will be entitled to claim further benefits for an injury after the participant settles a claim with the tortfeasor or with the benefit plan.

L. [12.31] Equitable Subrogation

Equitable subrogation is a remedy by which a court will allow subrogation by an injured person against one who in good conscience ought to pay for the injured person's loss. *See Reich v. Tharp,* 167 Ill.App.3d 496, 521 N.E.2d 530, 118 Ill.Dec. 248 (5th Dist. 1987), and Chapter 15 of this handbook.

The Ninth Circuit Court of Appeals has ruled that an ERISA-governed benefit plan does not have a right to equitable subrogation. *Pacificare, Inc. v. Martin,* 34 F.3d 834, 18 BNA EBC 2146 (9th Cir. 1994). The Ninth Circuit in *Pacificare* based its ruling on the principle that the federal courts should not create federal common law causes of action under ERISA.

Compare Provident Life & Accident Insurance Co. v. Waller, 906 F.2d 985 (4th Cir.), *cert. denied,* 498 U.S. 982 (1990) (court created cause of action for equitable subrogation under federal question jurisdiction), *with Alco Standard Corp. v. Gilbert,* No. 91 C 4849, 1992 U.S.Dist. LEXIS 6074 (N.D.Ill. Apr. 24, 1992) (court declined to apply unjust enrichment to require participant to reimburse benefit plan when plan's terms did not require reimbursement).

For contrast, *see Dix Mutual Insurance Co. v. LaFramboise,* 149 Ill.2d 314, 597 N.E.2d 622, 173 Ill.Dec. 648 (1992), in which the Supreme Court of Illinois ruled that there is a right to equitable subrogation in Illinois. *But see Schultz v. Gotlund,* 138 Ill.2d 171, 561 N.E.2d 652, 149 Ill.Dec. 282 (1990), in which the court ruled that equitable subrogation does not apply to a group health benefit plan.

M. [12.32] Lien for Disability Benefits

A benefit plan may enforce a lien on a tort action for disability benefits. *See Thompson v. Federal Express Corp.,* 809 F.Supp. 950 (M.D.Ga. 1992); *Dugan v. Nickla,* 763 F.Supp. 981, 13 BNA EBC 2310 (N.D.Ill. 1991).

VI. PARTIES LIABLE FOR BREACH OF LIEN

A. Fiduciary Liability of Persons Handling Plan Assets

1. [12.33] Plaintiff/Injured Participant's Attorney

An attorney who represents an injured participant in that participant's personal injury action will not be held as a fiduciary under ERISA for his role in handling the settlement proceeds. *Chapman v. Klemick,* 3 F.3d 1508 (11th Cir. 1993); 29 U.S.C. §1002(21)(A). In *Chapman,* the court refused to impose fiduciary liability on a plaintiff's attorney. The injured beneficiary's attorney received a settlement check in his client's personal injury action payable to himself and his client. The participant's benefit plan held a lien on the action for medical benefits paid pursuant to the plan's documents and a signed subrogation agreement. The attorney and client both signed the check and split the proceeds according to their fee agreement. The benefit plan sued the attorney, arguing that because the attorney had control over the distribution of the money, he should be held liable for reimbursement as a plan fiduciary.

The court refused to hold the attorney liable as an ERISA fiduciary. The court reasoned that the attorney owed a duty of loyalty to his client. If the court were to impose a fiduciary

duty toward the benefit plan, then the attorney would owe "competing allegiances" to both his client and the benefit plan. The court refused to impose such an obligation.

The Northern District of Illinois has reached the same result. *Vest ex rel. Chicago District Council of Carpenters Welfare Fund v. Gleason & Fritzshall,* 832 F.Supp. 1216 (N.D.Ill. 1993). In *Vest,* the court for three reasons refused to impose fiduciary liability under ERISA on a plaintiff's attorney who endorsed the plan's name on a settlement check. First, the court reasoned that to impose liability on one person who receives money from a settlement distribution, the court would have to impose it on all persons who received money from that distribution, including other parties with liens on the proceeds. ERISA does not contemplate such a broad reach of fiduciary liability.

Second, the court would be required to impose fiduciary liability on any plaintiff's attorney who handles settlement funds, regardless of whether he knew that he was exercising authority over an ERISA benefit plan's funds.

Finally, the court reasoned that finding fiduciary liability in these circumstances would create an unacceptable conflict of interest. *See also Hotel Employees & Restaurant Employees International Union Welfare Fund v. Gentner,* 815 F.Supp. 1354 (D.Nev. 1993), in which the court refused to allow a benefit plan to obtain reimbursement from that portion of settlement proceeds attributable to plaintiff's attorney's fees.

2. [12.34] Tortfeasor's Insurance Company

For a thorough discussion of the liability of a tortfeasor's insurance company when handling settlement proceeds, see §12.28 above.

3. [12.35] Benefit Plan's Attorney

For a thorough discussion of a benefit plan's attorney's fiduciary liability under ERISA, see Polk, ERISA PRACTICE AND LITIGATION §4:09 (1993). Such a discussion is beyond the scope of this handbook.

B. [12.36] Extent of Liability of Participant for Paying Back Plan

A participant is responsible for paying back a benefit plan pursuant to a reimbursement provision and agreement only to the extent of the terms of the provision or agreement. *See Germany v. Operating Engineers Trust Fund of Washington, D.C.,* 789 F.Supp. 1165, 15 BNA EBC 1407 (D.D.C. 1992); §12.16 of this chapter.

VII. ACTIONS TO ENFORCE LIENS

A. [12.37] Exhaustion of Administrative Remedy Under Plan's Terms

Under certain circumstances, a plan participant is required to exhaust her remedy granted by the plan prior to seeking judicial review of her claim. See Polk, ERISA PRACTICE AND LITIGATION §11:05 (1993). The courts created the exhaustion doctrine to promote judicial economy by encouraging settlement of claims, to promote consistent treatment of claims, to promote non-adversarial dispute resolution, and to further the "strong federal policy [by] encouraging private resolution of ERISA-related disputes." *Healy v. Axelrod Construction Co. Defined Benefit Pension Plan & Trust,* 787 F.Supp. 838, 842 (N.D.Ill. 1992).

Furthermore, an ERISA-governed plan is required to establish claim review procedures. See 29 C.F.R. §2560.503-1 for minimum requirements for claim procedures. The claims procedure generally applies to claims for benefits and may not always apply in the reimbursement lien situation. The courts have not yet addressed the issue of whether a participant must exhaust the benefit plan's review procedure to compromise a plan lien on a tort action. See Polk, ERISA PRACTICE AND LITIGATION §11:05 (1993).

B. [12.38] Standard of Review of Plan Administrator's Interpretation of the Plan's Provisions

A reviewing court will use a deferential standard to the plan administrator's interpretation when reviewing an ERISA plan administrator's action if the plan's documents grant discretion to the administrator to interpret the document and she has in fact interpreted the document. *Central States, Southeast & Southwest Areas Health & Welfare Fund v. State Farm Mutual Automobile Insurance Co.,* 17 F.3d 1081 (7th Cir. 1994). Otherwise, a reviewing court will review an administrator's determination de novo. *Cutting v. Jerome Foods, Inc.,* 993 F.2d 1293, 1295, 16 BNA EBC 2492 (7th Cir. 1993), citing *Firestone Tire & Rubber Co. v. Bruch,* 489 U.S. 101, 103 L.Ed.2d 80, 109 S.Ct. 948 (1989).

In *Mason v. Jones,* No. 92 C 2241, 1993 U.S.Dist. LEXIS 453 (N.D.Ill. Jan. 14, 1993), the court affirmed the benefit plan's decision that the participant was required to reimburse the benefit plan in full from his tort recovery. The court relied on the benefit plan's trustees prior consistent interpretations of the plan to require participants to pay back all benefits in full from any tort recovery to find the trustees' actions in this case reasonable. The court decided this case under a deferential standard of review because the trustees had the authority to interpret the plan, all plan documents, rules, and procedures.

C. [12.39] Standing, Jurisdiction, and Civil Enforcement

Standing to sue under ERISA is granted to participants and beneficiaries who are covered by a welfare benefit plan and to fiduciaries to the plan as defined in the statute. 29 U.S.C. §1132(a). Fiduciaries include named persons who have authority to control and manage the operation of the plan. 29 U.S.C. §1102(a)(1). A civil action may be brought by a participant or beneficiary or a fiduciary to enforce the terms of a benefit plan, to recover benefits due under a plan, or to clarify rights under a plan. See §12.41.

Jurisdiction over ERISA-sponsored benefit plans is generally vested in the federal courts, although actions brought by a participant or beneficiary to enforce rights under the plan may be heard in state courts, which have concurrent jurisdiction. 29 U.S.C. §1132(e). See §12.41.

Generally, federal jurisdiction extends only to equitable remedies. Therefore, many ERISA lien actions are brought as declaratory judgment actions. *See Pacificare, Inc. v. Martin,* 34 F.3d 834, 18 BNA EBC 2146 (9th Cir. 1994), in which the court stated it had no jurisdiction to enforce a benefit plan's reimbursement lawsuit against the participant because the complaint was based on contract and did not seek an equitable remedy.

VIII. APPENDIX

A. [12.40] 29 U.S.C. §1001(b)

Congress established ERISA to

protect . . . participants in employee benefit plans and their beneficiaries, by requiring the disclosure and reporting to participants and beneficiaries of financial and other information . . . and by providing for appropriate remedies, sanctions, and ready access to the Federal courts.

B. [12.41] 29 U.S.C. §§1132(a), 1132(e)

29 U.S.C. §§1132(a) and 1132(e) state:

(a) Persons empowered to bring a civil action

A civil action may be brought —

(1) by a participant or beneficiary —

* * *

(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;

* * *

(3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan;

* * *

(e) Jurisdiction

(1) Except for actions under subsection (a)(1)(B) of this section, the district courts of the United States shall have exclusive jurisdiction of civil actions under this subchapter brought by the Secretary or by a participant, beneficiary, or fiduciary. State courts of competent jurisdiction and district courts of the United States shall have concurrent jurisdiction of actions under subsection (a)(1)(B) of this section.

C. [12.42] 29 U.S.C. §1144(a)

29 U.S.C. §1144(a) states in part:

> **Except as provided in subsection (b) of this section, the provisions of this subchapter . . . shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan.**

D. [12.43] 29 U.S.C. §1002(1)

ERISA defines "employee welfare benefit plan" to include

> **any plan, fund, or program . . . established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits.**

E. [12.44] 29 U.S.C. §1022(a)(1)

29 U.S.C. §1022(a)(1) states:

> **The summary plan description shall include the information described in** [the plan document], **shall be written in a manner calculated to be understood by the average plan participant, and shall be sufficiently accurate and comprehensive to reasonably apprise such participants and beneficiaries of their rights and obligations under the plan.**

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