Virginia Trial Lawyers Association

LIENS

in personal injury actions

March 1999

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ERISA LIENS

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UNDERSTANDING ERISA LIENS AFTER UNITED McGILL CORP. v. STINNETT

QUESTIONS AND ANSWERS

By: Gerald A. Schwartz
Alexandria, Virginia

A. THE BASICS

1. QUESTION: What are subrogation and reimbursement?

ANSWER: Most health insurance policies have a subrogation clause requiring an injured person to pay back medical expenses the insurance company has paid directly from the plaintiff's settlement with the tortfeasor. The health insurer is said to "stand in the shoes of the plaintiff" regarding the plaintiff's claim against the third party for medical expenses. "Reimbursement" is similar to subrogation, except the health insurer does not "stand in the shoes of the plaintiff". Like subrogation, reimbursement requires that the plaintiff "reimburse" the health insurance company the medical expenses it has paid on behalf of the plaintiff from the plaintiff's recovery from the tortfeasor. Generally, if the plaintiff makes no recovery from the tortfeasor, she is not required to pay back the medical expenses paid by the health insurer. Health insurers claim that subrogation and reimbursement prevent the plaintiff from making a double recovery. This is not true since the plaintiff has paid premiums for the benefit of health insurance coverage and should get the benefit of what she has paid for.

2. QUESTION: Does Virginia law prohibit subrogation/ reimbursement in personal injury cases?

ANSWER: Yes. Virginia Code §38.2-3405, as amended, prohibits subrogation and reimbursement of any person's right of recovery for personal injury from a third person in a health insurance policy "providing for payment of benefits to or on behalf of persons residing in or employed in this Commonwealth".

3. QUESTION: What is ERISA?

ANSWER: ERISA stands for a federal law called the Employee Retirement Income Security Act of 1974, 29 U.S.C. §1001 *et seq.* ERISA regulates employer sponsored benefits, such as health insurance and retirement benefits.

4. QUESTION: What is an ERISA Plan?

ANSWER: The federal ERISA statute is very broad. It covers all employee benefit medical plans. Generally, the only exceptions are (1) "Government Plans" covering local, state or federal employees; or (2) "Church Plans" covering church employees.

5. QUESTION: Does the ERISA statute create a lien against plaintiff's personal injury recovery?

ANSWER: No. The ERISA statute, 29 U.S.C. §1001 *et seq.*, does not create a lien on your client's tort settlement. The terms "lien", "subrogation" and "reimbursement" are not set forth in the ERISA statute.

6. QUESTION: How is an ERISA lien created?

ANSWER: If the medical benefit plan, regulated by ERISA, contains a subrogation or reimbursement clause, requiring your

client to pay back medical benefits paid under the plan, a lien on your client's tort recovery is created -- not by the ERISA statute itself, but by the terms of the benefit plan governed by ERISA. Therefore, always analyze the plan language. If the plan fails to include a proper subrogation or reimbursement clause, no "ERISA lien" is created. Eppard v. Builders Transport, Inc., 1993 U.S. Dist. Lexis 1683 (W.D. Va. 1993).

7. QUESTION: Can a self-funded ERISA plan refuse to pay medical bills until the insured person signs a "reimbursement agreement"?

ANSWER: Yes. Buchannan v. Wayne Trace Local School Dist. Board of Education, 763 F.Supp. 1405 (N.D. Ohio 1991); LeHigh Valley Hosp. v. Rallis, No. 94-3082, 95-3511, 1996 U.S. Dist. Lexis 4974 (E.D. Pa. April 11, 1996)

8. QUESTION: What is the difference between a self-funded ERISA plan and a commercially insured ERISA plan?

ANSWER: The plan sponsor (usually an employer or labor union) pays the medical bills in a self-funded plan or through an insurance company acting as an intermediary. In a self-funded plan, the insurance company does not provide insurance benefits, but provides intermediary "administrative services only" (ASO) for the plan sponsor. If the plan's medical benefits are provided by a commercial insurance policy, such as a group health insurance policy marketed by an insurance company, such as Blue Cross Blue Shield, Aetna, etc., the plan is not self-funded.

9. QUESTION: How can you tell if a plan is self-funded?

ANSWER: Follow the advice of "Deep Throat" of Watergate fame: "Follow the Money". If the employer ultimately pays the medical bills and retains control, the plan is self-funded.

All ERISA plans must provide participants a summary of the plan called a "Summary Plan Description" (SPD). ERISA requires the "SPD" to set forth how the plan is funded, i.e., self-funded by the sponsor (employer or union) or through commercial insurance.

10. QUESTION: What questions should you ask to determine if a plan is self-funded or insured?

ANSWER: Theresa L. Kannon, an ERISA attorney practicing in Richmond, in the spring 1995 issue of the VTLA Journal at page 32, suggests:

> "...If you cannot determine whether a plan is insured or self-funded, some questions to ask include: How are claims for benefits processed? Who processes the claims? Is there an insurance policy or other contract with an insurance company with respect to the plan? If so, does the insurer pay all claims or only large claims? Is the plan described in any document other than an insurance policy? Does the insurance company bill the employer for amounts it pays to plan participants? Answers to these questins will help you understand whether an insurance company is serving as a third-party administrator that simply processes claims for a self-funded plan [administrative services only] or whether an insurance company pays the benefits."

11. QUESTION: Do subrogation/reimbursement provisions in ERISA health plans preempt the Virginia anti-subrogation statute?

ANSWER: Only subrogation/reimbursement provisions in self-funded ERISA plans preempt the Virginia anti-subrogation law. ERISA plans covered by a commercially obtained insurance policy cannot subrogate or require reimbursement from your client's tort recovery.

12. QUESTION: Is this distinction between self-funded and commercial insurance policies set forth in the ERISA statute?

ANSWER: Yes. §514 of ERISA has three clauses:

(1) a "preemption" clause;

(2) a "savings" clause; and

(3) a "deemer" clause.

The preemption clause declares that ERISA (and plans regulated by ERISA) "supersedes" state laws that "relate to an employee benefit plan". Therefore, the "preemption" clause contained in the ERISA statute preempts Virginia's anti-subrogation law.

However, the "savings" clause "saves" "state law that regulates insurance" from being "swollowed" (preempted) by the jaws of the ERISA "preemption" clause.

The "deemer" clause drops self-funded health plans back into the jaws the ERISA "preemption" clause. The "deemer" clause "deems" self-funded plans not to be an insurance company subject to state regulation. Therefore, ERISA preempts Virginia's anti-subrogation statute for self-funded plans only. Medical plans which have a commercial insurance company providing employee benefits are regulated by state law, i.e., Virginia's anti-

subrogation statute. (The "savings" clause "saves" state anti-subrogation laws from ERISA preemption for plans that are not self-insured.)

13. QUESTION: Has the United States Supreme Court held that ERISA preempts state anti-subrogation laws for self-funded plans, but does not preempt such laws for commercially insured plans?

ANSWER: Yes. FMC v. Holliday, 498 U.S. 52 (1990). In Holliday, the court described the plan as "The plan [was] self-funded; it does not purchase an insurance policy from any insurance company in order to satisfy it's obligations to its participants."

14. QUESTION: What was the basis for the Supreme Court's holding in FMC v. Holliday?

ANSWER: The court, in FMC v. Holliday, held, beginning at 498 U.S. 52, 62:

> "...State [anti-subrogation] laws directed toward the [self-funded] plans are preempted because they relate to an employee benefit plan but are not "saved" because they do not regulate insurance. State laws [anti-subrogation] laws that directly regulate insurance are "saved" but do not reach self-funded employee benefit plans because the plans may not be deemed to be insurance companies, other insurers, or engaged in the business of insurance for purposes of such state [anti-subrogation] laws. On the other hand, employee benefit plans that are insured are subject to indirect state insurance regulation [anti-subrogation] laws. An insurance company that insures a plan remains an insurer for purposes of state laws "purporting to regulate insurance" after application of the "deemer" clause. The insurance company is therefore not relieved from state insurance regulation [state anti-subrogation statutes]. The ERISA plan is consequently bound by state insurance regulations insofar as they apply to the plan's insurer [commercially funded plans].

> Our reading of the "deemer" clause is consistent with Metropolitan Life Ins. Co. v. Massachusetts, supra. ...We concluded [there] that the statute as applied to insurers of plans was not preempted because it regulated insurance and was therefore saved. ...By recognizing a distinction between insurers of plans and the contracts of those insurers, which are subject to direct state regulation [anti-subrogation laws] and self-insured employee benefit plans governed by ERISA, which are not, we observe Congress' presumed desire to reserve to the states the regulation of the "business of insurance".

The U.S. Supreme Court decision of FMC v. Holliday, 498 U.S. 52 (1990) is Attachment No. 1.

15. QUESTION: I received a letter from an out-of-state law firm representing a commercial health insurance company attempting to recover medical expenses from my client's third-party tort recovery. The letter states that my client's employer-sponsored commercial health insurance plan contains a subrogation clause and that the plan is covered by ERISA which preempts state law. Can they subrogate from my client's third-party recovery?

ANSWER: No. Virginia anti-subrogation statute, §38.2-3405, as amended, prohibits subrogation/reimbursement. ERISA does not preempt state anti-subrogation laws for commercially insured plans in contrast to self-funded plans. FMC v. Holliday, 498 U.S. 52 (1990).

A sample letter from the Rawlings Company Subrogation Division attempting to subrogate from the plaintiff's tort recovery under the guise of an ERISA "qualified" (but non-self-funded) Plan and this author's response is Attachment No. 2.

B. UNITED McGILL CORP. v. STINNETT

16. QUESTION: Is the pay-back of ERISA "liens" governed by federal or state law?

ANSWER: Federal law since ERISA is a federal statute passed by Congress.

17. QUESTION: I understand that self-funded ERISA health plans containing subrogation/reimbursement provisions must be paid back from the client's tort recovery the amounts it has paid toward the client's medical bills. What can I, as a plaintiff's attorney, do to reduce the amount of the lien to maximize my client's net recovery?

ANSWER: Since subrogation is an equitable doctrine, several equitable arguments have been made in an effort to reduce the ERISA lien:

1. Reduce the ERISA lien by a pro-rata percentage of the client's attorney's fee, i.e., by one-third since, by hiring an attorney, the plan will benefit by the tort recovery ("the common fund") by recouping it's lien; therefore, the plan ought to share the cost of the plaintiff's attorney's fee and expenses by reducing it's lien by one-third (the plaintiff's attorney's contingency fee).

2. If the plaintiff's tort recovery is inadequate (because of limited liability insurance coverage, for example) and the

plaintiff is not "made whole" by the tort recovery, subrogation provisions should not be enforced.

18. **QUESTION:** Has the Fourth Circuit Court of Appeals ruled on any of these issues?

ANSWER: Yes. On August 27, 1998, the Fourth Circuit decided United McGill Corp. v. Stinnett, 154 F.3d 168 (4th Cir. 1998). (Attachment No. 3.)

19. **QUESTION:** What were the facts and the holding in United McGill Corp. v. Stinnett?

ANSWER: Stinnett recovered $100,000.00 against a negligent driver. His attorney's fee was one-third of the recovery. Stinnett's employer, United McGill Corp., through a self-funded health plan, paid $31,419.00 of Stinnett's medical expenses and asserted a lien against Stinnett's tort recovery for the full $31,419.00 that it had paid. The U.S. District Court granted summary judgment on the United McGill Corp.'s claim for reimbursement, but held the plaintiff was entitled to a pro-rata reduction for attorney's fees from the lien, i.e., (one-third of $31,419.00 = a $10,473.00 reduction). The express terms of the self-funded McGill ERISA health plan provided for full repayment stating: "Our right of subrogation will be to the extent of any benefits paid or payable under this plan..." (original emphasis).

The Fourth Circuit held that the "plain language of the plan" required full reimbursement ("to the extent of any benefits paid") even though the plan was silent regarding a pro-rata reduction of

the plaintiff's attorney's fees and expenses in obtaining the tort recovery. The Fourth Circuit held:

> "...One of the primary functions of ERISA is to ensure the integrity of written, bargained-for benefit plans. (citations omitted). To satisfy this objective, the plain language of an ERISA plan must be enforced in accordance with 'its literal and natural meaning'. (citation omitted). ...McGill is entitled to full recovery based on the plain language of the plan.

20. QUESTION: The plan language in United McGill Corp. v. Stinnett defined the specific amount of the ERISA lien repayment as, "to the extent of any benefits paid" - meaning 100%. What would be the result if the plan's subrogation/reimbursement language was silent regarding the specific amount of the ERISA lien repayment?

ANSWER: Citing cases from the Eighth Circuit (Waller v. Hormel Foods Corp., 120 F.3d 138, 141 (8th Cir. 1997) and McIntosh v. Pacific Holding Co., 120 F.3d 911 (8th Cir. 1997)) as "persuasive decisions" the Fourth Circuit in United McGill Corp. implied that it would follow a "default rule" if the "language of the benefits plan is inconclusive" regarding the specific amount of the ERISA lien repayment. The "default rule" would allow a pro-rata deduction of attorney's fees and expenses from the ERISA lien.

21. QUESTION: Assume the "default rule" applies; the plaintiff's attorney's fee is one-third; and a policy limits offer from the tortfeasor's liability insurer is obtained with little effort. Is the plaintiff entitled to a one-third pro-rata deduction for attorney's fees from the ERISA lien?

ANSWER: No. Waller v. Hormel Foods Corp., cited above, which provided for a "default rule" if the language of the benefits plan is inconclusive regarding the amount of the lien payback was cited by the Fourth Circuit in the United McGill Corp. case as "persuasive". The Eighth Circuit, in Waller, applied the "default rule" and held that the ERISA lien repayment should be reduced by pro-rata reduction of a reasonable attorney's fee. The court noted that the plaintiff's attorney "obtained a policy limits settlement with little effort". The court concluded, "Therefore, a contingent fee award would not be appropriate absent evidence that the plan would have hired counsel on this basis, and an award based on counsel's actual time devoted to the matter must exclude time devoted to Waller's dispute with the plan. The case was remanded to determine "a reasonable attorney's fee based upon the value of legal services to the plan".

22. QUESTION: What would be the result if the plaintiff's tort recovery, after payment of attorney's fees and the ERISA lien is not enough to make the plaintiff whole?

ANSWER: Most federal courts, including the decisions cited by the Fourth Circuit in United McGill Corp., hold that plain language of an ERISA plan must be enforced thereby allowing a well drafted subrogation clause to defeat the equitable "make whole doctrine". See, for example, Waller v. Hormel Foods Corp., 120 F.3d 138, 141 (8th Cir. 1997) which the Fourth Circuit stated was "persuasive".

Citing cases from the Sixth and Eighth Circuits, the Fourth Circuit, in United McGill Corp., stated, "Federal courts may not apply common law theories to alter the express terms of a written benefit plan." The Fourth Circuit quoted from its prior case of Coleman v. Nationwide Life Ins. Co., 969 F.2d 54, 58 (4th Cir. 1992), "Use of estoppel principles to effect a modification of a written employee benefit plan would conflict with ERISA's emphatic preference for written agreements". Further, quoting with approval from a Third Circuit Court of Appeals opinion, the Fourth Circuit in United McGill Corp. stated, "Enrichment is not unjust where it is allowed by the express terms of the... plan."

However, there is authority from the Ninth Circuit holding that the common law, equitable, "make whole doctrine" when used as "a default rule" prevents ERISA subrogation. In Barnes v. Automobile Dealers Ass'n. of Calif. Health and Benefit Plan, 64 F.3d 1389 (9th Cir. 1995), the plaintiff's case had a value of $65,000 according to an affidavit of her attorney filed with the court. Barnes recovered $5,000 in med pay and also recovered the defendant's liability policy limits of $25,000. Her medical expenses were $18,000 and her lost wages were $8,900. The plan's subrogation language provided, "If the plan makes payment... this plan is subrogated to all rights of recovery to the extent of its payment". The court, in Barnes, found that the plan language was silent regarding who had the first right of recovery when the plaintiff's tort settlement did not make her whole. Accordingly,

the court adopted a default rule, holding in the absence of clear plan language to the contrary, the plaintiff must be made whole before an ERISA plan can enforce its right of subrogation.

Unfortunately, the identical subrogation clause used in Barnes was used by the United McGill Corp., and was found by the Fourth Circuit in United McGill Corp. v. Stinnett to be plain and clear. Moreover, the Eighth Circuit, in Waller v. Hormel Foods Corp. cited as persuasive authority by the Fourth Circuit in United McGill Corp., held the absence of express "first priority" language did not activate the "make whole doctrine".

23. QUESTION: What would be the result if after the payment of attorney's fees, expenses, and the full amount of the ERISA lien, there is nothing left for the plaintiff, leaving a "zero" net recovery?

ANSWER: The Fourth Circuit, in United McGill Corp. v. Stinnett, at the end of it's decision in a footnote suggested that this scenario would be proper if the result of a "carefully drafted subrogation reimbursement provision". The court tacitly approved the subrogation provision which the Third Circuit approved in Ryan By Capria-Ryan v. Federal Express Corp, 78 F.3d 123 (3rd Cir. 1996), which provision provided "If the payment you receive from the third party, less your attorney's fees, and other legal expenses, is not enough to reimburse benefits payments at 100%, you must reimburse the plan 100% of what is left after paying your attorney's fees and other legal expenses". (emphasis added).

In hardship cases where the plaintiff is not made whole, the "doctrine of reasonable expectations" may be argued in an effort to avoid the harsh result of United McGill Corp. v. Stinnett.

The "doctrine of reasonable expectations" was first applied to a non-conspicuous, pre-existing condition exclusion in an ERISA plan by the Ninth Circuit in Saltarelli v. Bob Baker Group Md. Trust, 35 F.3d 382 (9th Cir. 1994). The court, at 35 F.3d 382, 386 held:

> "This doctrine (reasonable expectations) grew out of the law of adhesion contracts... and has been formulated as follows: In general, courts will protect the reasonable expectations of... insureds and intended beneficiaries regarding the coverage afforded by insurance carriers even though a careful examination of the policy provisions indicates that such expectations are contrary to the expressed intention of the insurer." (emphasis added).

Douglas S. Roberts and Peggy Noble, in their paper "Subrogated Claims Regarding ERISA and Non-ERISA Carriers", ATLA 1998 Annual Convention, suggest:

> "Using Saltarelli, one can attempt to limit the reach of both reimbursement and subrogation clauses by arguing that insureds do not expect - notwithstanding policy language to the contrary - that they will have to pay back their medical bills if they have not been fully compensated for their injuries, particularly if they have to incur all the collection costs and attorneys' fees."

24. QUESTION: What would be the result if the plaintiff's tort recovery was not sufficient to pay the plaintiff's attorney's fee and the self-funded ERISA plan's lien?

ANSWER: The Fourth Circuit, in United McGill Corp. v. Stinnett, in a footnote at the end of its opinion, stated: "We leave for another day how to treat situations where the beneficiaries' recovery from the third party, after deducting attorney's fees, is actually less than the plan's reimbursement claim, thus ostensibly requiring the beneficiary to pay out of her own pocket to meet the plan's claim..."

An instinctively felt sense of injustice to the injured person and his family cries out at this result and at the rationale behind United McGill Corp. v. Stinnett - - "enrichment is not unjust where it is allowed by the express terms of the... plan."

REFERENCES

1. "Liens A Practical Approach", Amy J. Thomasson and William G. Shields - VTLA Litigation Support Committee Report 8/13/98

2. "Protecting the Client's Recovery From ERISA Liens: An Analysis of the Issues", Teresa L. Kannan - VTLA May 1994 Annual Tort Seminar, Everyting You Need to Know to Settle Auto Accident Cases

3. "ERISA Preemption of State Anti-Subrogation Laws: A Practical Guide for Personal Injury Attorneys", Teresa L. Kannan, J. VTLA (Spring) 1995, pp. 30-33

4. "Liens - The Parasite on the Host Case", Arthur J. Donaldson - VTLA Annual Convention Paper 1997

5. "Subrogated Claims Regarding ERISA and Non-ERISA Carriers", Douglas S. Roberts and Peggy L. Noble, R.N., ATLA Annual Convention 1998, Insurance Section Paper

ATTACHMENTS

ATTACHMENT NO:

1 Sample letters from The Rawlings Company Subrogation Division attempting to subrogate from the plaintiff's tort recovery and this author's response

2 FMC v. Holliday, 498 U.S. 52 (1990)

3 United McGill Corp. v. Stinnett, 154 F.3d 168 (4th Cir. 1998)

ATTACHMENT NO. 1

The Rawlings Company
Subrogation Division

POST OFFICE BOX [illegible]
[illegible]SVILLE, KENTUCKY 402[illegible]
TELEPHONE (502) 587-1279
TELECOPIER (502) 587-5558

January 9, 1998

GERALD A SCHWARTZ ESQ
2827 DUKE STREET
ALEXANDRIA VA 22314

Re: Our Client: AETNA-US HEALTHCARE
Insured: [redacted]
Patient: SAME
Our File No.: [redacted]
Date of Loss: [redacted]
Your Client: [redacted]
Your No.: N/A

Dear MR. SCHWARTZ:

Our client has paid medical benefits expenses on behalf of the above referenced patient. I have sent you this letter to put you on notice that our client has a lien for medical expenses to the extent of the benefits it pays. We have been advised by our attorneys that these medical expenses were paid pursuant to an ERISA qualified plan, governed by the federal ERISA statute.

Therefore, PLEASE DO NOT SETTLE OR ENTER INTO A GENERAL RELEASE or any other release, THAT INCLUDES THESE MEDICAL EXPENSES, without our consent. I trust that we can look forward to your cooperation to resolve all claims to everyone's satisfaction. Please complete the enclosed form and return it to my attention.

I received your 12/31/97 correspondence and understand your position but as I am given to understand(see enclosure) ERISA preempts Va. Law.

Sincerely,

Roy V. Nall
Sr. Subrogation Rep.

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R & A LEGAL MEMORANDUM

January 9, 1998

Re: ERISA Pre-emption of State Law

This memorandum is written to clarify the legal status of health plans governed by ERISA and the effect of conflicting state laws. At times, the specific terms of a health plan may be contrary to an existing state law which restricts or limits the plan's rights of subrogation and/or reimbursement. Health plans governed by ERISA enjoy a statutory right of pre-emption. This means that the terms of the ERISA plan will prevail over the conflicting state law.

The issue of pre-emption is a matter of exclusive federal concern. FMC Corp. v. Holliday, 111 S.Ct. 403 (1990). The statutory pre-emption provided in the ERISA Statute with respect to state laws is the most sweeping federal preemption statute ever enacted by Congress. Holland v. Burlington Industries, 772 Fed. 2d 1140, 1146 (4th Cir. 1985). This statutory basis for pre-emption of state laws is provided in 29 USC Section 1144 which states:

> [T]he provisions of this title...shall supersede any and all state laws in so far as they may now or hereinafter relate to any employee benefits plan....

In other words, if any state law which "relates to" an ERISA qualified plan conflicts with the terms of that plan, the terms of the plan will prevail over the state law.

Since the enactment of this statute, courts have liberally construed the phrase "relates to" an ERISA qualified plan. One of the earliest decisions addressing this clause noted the Court's history of providing a broad common sense meaning to the phrase "relate(s) to any benefit plan...." Pilot Life Insurance Co. v. Dedaux, 107 S.Ct. 1549 (1987). Thereafter, the Supreme Court has ruled that a state law relates to a covered benefit plan if it refers to or has a connection with such a plan, even when the law at issue was not designed to effect the plan. District of Columbia v. Greater Washington Board of Trade, 1113 S.Ct. 580 (1992).

In FMC Corp., the Supreme Court found that state laws which prohibit or limit health subrogation and/or reimbursement "relate to" an ERISA qualified health plan. This is the only decision to date that has directly addressed the issue of state pre-emption in respect to health subrogation and reimbursement laws. Once again, the Court held that Congress intended ERISA pre-emption of state laws to be broadly construed and the terms of the ERISA plan prevailed.

In summary, the terms of an ERISA health plan pre-empt state laws which prohibit or limit health subrogation and/or reimbursement. Please be advised.

RAWLINGS & ASSOCIATES

JERVIS C. MOBLEY, JR.

LAW OFFICES

GERALD A. SCHWARTZ

REPRESENTING INJURED PEOPLE SINCE 1975

GERALD A. SCHWARTZ*
L. DOUGLAS BANKS

2827 DUKE STREET
ALEXANDRIA, VIRGINIA 22314
(703) 823-0055

PERSONAL INJURY LAW
FAX (703) 370-7732
*ALSO DC BAR

January 15, 1998

The Rawlings Company
ATTN: Mr. Roy V. Nall, Sr. Subrogation Rep.
P.O. Box 740027
Louisville, KY 40201-7427

Our Client: [redacted]
Insured: [redacted]
Your Client: Aetna-US Healthcare
Your File No.: [redacted]
Date of Accident: [redacted]

Dear Mr. Nall:

This is in response to your letter of January 9, 1998, a copy of which is attached, which was in response to our letter of December 31, 1997, setting forth Virginia's anti-subrogation law.

Your letter of January 9, 1998, advises that your plan is an ERISA qualified plan and that the U.S. Supreme Court decision of FMC Corp. v. Holliday, 498 US 52 (1990), holds that the federal ERISA statute preempts the public policy of Virginia as reflected in the Virginia anti-subrogation statute, Virginia Code §38.2-3405.

Your letter and the attached "R&A Legal Memorandum" fails to state that the United States Supreme Court in FMC Corp. v. Holliday, 498 US 52 (1990), held that the federal ERISA statute preempts state anti-subrogation statutes only where the health plan is self-funded, such as a union plan. The Supreme Court of the United States in FMC v. Holliday specifically held that plans which are not self-funded do not pre-empt state anti-subrogation statutes.

Your letter indicates that your client is "Aetna-US Healthcare." Therefore, it appears that your plan is not self-funded, but involves insurance which, the Supreme Court in FMC Corp. v. Holliday, 498 US 52 (1990), held is the subject of proper regulation by state insurance laws, such as the Virginia anti-subrogation statute and is not preempted by the ERISA statute.

Most importantly, you have failed to submit clear and convincing documentation that the health insurance plan involved in this case is self-funded within the meaning of the United States Supreme Court decision of FMC Corp. v. Holliday, 498 US 52 (1990). The Virginia anti-subrogation statute mandates that your attempt at subrogation is improper. Accordingly, your request for reimbursement is denied.

Sincerely yours,

Gerald A. Schwartz
Attorney at Law

GAS/isd
Enclosure

The Rawlings Company
Subrogation Division

POST OFFICE BOX 740027
LOUISVILLE, KENTUCKY 40201-7427

TELEPHONE (502) 587-1279
TELECOPIER (502) 587-[illegible]

January 19, 1998

GERALD A SCHWARTZ ESQ
2827 DUKE STREET
ALEXANDRIA VA 22314

RE: Our Client: AETNA-US HEALTHCARE
Injured Party: [redacted]
Our File No.: [redacted]
Date of Loss: [redacted]

Dear Mr. Schwartz:

In response to yours of 1/15/98.

I am aware of your points in regards to FMC vs Holliday but beg to differ with you in regard to our client and this plan not being ERISA qualified. In many instances they administer plans for employer's, groups, or unions and therefore do indeed fall under ERISA guidelines.

I have requested the language and ERISA information from our client in regards to this particular plan and will send it to you as soon as I receive it.

I take this opportunity to reassert a lien in regard to this incident, pending further proof of ERISA qualification. **PLEASE DO NOT SETTLE OR ENTER INTO A GENERAL RELEASE** or any other release, **THAT INCLUDES THISE MEDICAL EXPENSES**, without our consent.

Again, please complete the enclosed form and return it to my attention.

Sincerely,

Roy V. Nall

FMC CORPORATION, Petitioner,
v.
Cynthia Ann HOLLIDAY.

No. 89-1048.

Supreme Court of the United States

Argued Oct. 2, 1990.

Decided Nov. 27, 1990.

Employer, which operated self-funded health care plan, brought suit seeking declaratory judgment that it was entitled to subrogation for amounts it had paid for medical expenses of employee's daughter. The United States District Court for the Eastern District of Pennsylvania, 731 F.Supp. 710, granted summary judgment for daughter, and employer appealed. The Court of Appeals, 885 F.2d 79, affirmed, and certiorari was granted. The Supreme Court, Justice O'Connor, held that ERISA preempted application of Pennsylvania Motor Vehicle Financial Responsibility Law to self-funded health care plan.

Vacated and remanded.

Justice Souter did not participate.

Justice Stevens filed dissenting opinion.

[1] STATES ⚖18.3
360k18.3
Preemption may be either express or implied, and is compelled whether Congress' command is explicitly stated in statute's language or implicitly contained in its structure and purpose; Court looks to congressional intent.

[2] PENSIONS ⚖22
296k22
ERISA preempted application of Pennsylvania Motor Vehicle Financial Responsibility Law, which precluded reimbursement from a claimant's tort recovery for benefit payments by a program, group contract or other arrangement, to employer's self-funded health care plan; the state law related to the plan, but the plan could not be deemed an insurer. 75 Pa.C.S.A. §§ 1719, 1720; Employee Retirement Income Security Act of 1974, § 514(a), (b)(2)(A, B), as amended, 29 U.S.C.A. § 1144(a), (b)(2)(A, B).

[2] STATES ⚖18.41
360k18.41
ERISA preempted application of Pennsylvania Motor Vehicle Financial Responsibility Law, which precluded reimbursement from a claimant's tort recovery for benefit payments by a program, group contract or other arrangement, to employer's self-funded health care plan; the state law related to the plan, but the plan could not be deemed an insurer. 75 Pa.C.S.A. §§ 1719, 1720; Employee Retirement Income Security Act of 1974, § 514(a), (b)(2)(A, B), as amended, 29 U.S.C.A. § 1144(a), (b)(2)(A, B).

[3] PENSIONS ⚖28
296k28
"Deemer clause" exempts self-funded plans under the Employee Retirement Income Security Act (ERISA) from state laws that "regulate insurance" within meaning of the saving clause, and thus self-funded ERISA plans are exempt from state regulation insofar as that regulation relates to the plans. Employee Retirement Income Security Act of 1974, § 514(a), (b)(2)(A, B), as amended, 29 U.S.C.A. § 1144(a), (b)(2)(A, B).

[3] STATES ⚖18.51
360k18.51
"Deemer clause" exempts self-funded plans under the Employee Retirement Income Security Act (ERISA) from state laws that "regulate insurance" within meaning of the saving clause, and thus self-funded ERISA plans are exempt from state regulation insofar as that regulation relates to the plans. Employee Retirement Income Security Act of 1974, § 514(a), (b)(2)(A, B), as amended, 29 U.S.C.A. § 1144(a), (b)(2)(A, B).

**404 Syllabus [FN*]

FN* NOTE: The syllabus constitutes no part of the opinion of the Court but has been prepared by the Reporter of Decisions for the convenience of the reader. See United States v. Detroit Lumber Co., 200 U.S. 321, 337, 26 S.Ct. 282, 287, 50 L.Ed. 499.

After petitioner FMC Corporation's self-funded

health care plan (Plan) paid a portion of respondent's medical expenses resulting from an automobile accident, FMC informed respondent that it would seek reimbursement under the Plan's subrogation provision from any recovery she realized in her Pennsylvania negligence action against the driver of the vehicle in which she was injured. Respondent obtained a declaratory judgment in Federal District Court that § 1720 of Pennsylvania's Motor Vehicle Financial Responsibility Law--which precludes reimbursement from a claimant's tort recovery for benefit payments by a program, group contract, or other arrangement--prohibits FMC's exercise of subrogation rights. The Court of Appeals affirmed, holding that the Employee Retirement Income Security Act of 1974 (ERISA), which applies to employee welfare benefit plans such as FMC's, does not preempt § 1720.

Held: ERISA pre-empts the application of § 1720 to FMC's Plan. Pp. 406- 411.

(a) ERISA's pre-emption clause broadly establishes as an area of exclusive federal concern the subject of every state law that "relate[s] to" a covered employee benefit plan. Although the statute's saving clause returns to the States the power to enforce those state laws that "regulat[e] insurance," the deemer clause provides that a covered plan shall not be "deemed to be an insurance company or other insurer ... or to be engaged in the business of insurance" for purposes of state laws "purporting to regulate" insurance companies or insurance contracts. Pp. 406-407.

(b) Section 1720 "relate[s] to" an employee benefit plan within the meaning of ERISA's pre-emption provision, since it has both a "connection with" and a "reference to" such a plan. See Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 96-97, 103 S.Ct. 2890, 2899-**405 2900, 77 L.Ed.2d 490. Moreover, although there is no dispute that § 1720 "regulates insurance," ERISA's deemer clause demonstrates Congress' clear intent to exclude from the reach of the saving clause self-funded ERISA plans by relieving them from state laws "purporting to regulate insurance." Thus, such plans are exempt from state regulation insofar as it "relates to" them. State laws directed toward such plans are pre-empted because they relate to an employee benefit plan but are not "saved" because they do not regulate insurance. State *53 laws that directly regulate insurance are "saved" but do not reach self-funded plans because the plans may not be deemed to be insurance companies, other insurers, or engaged in the business of insurance for purposes of such laws. On the other hand, plans that are insured are subject to indirect state insurance regulation insofar as state laws "purporting to regulate insurance" apply to the plans' insurers and the insurers' insurance contracts. This reading of the deemer clause is consistent with Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724, 735, n. 14, 747, 105 S.Ct. 2380, 2387 n. 14, 2393, 85 L.Ed.2d 728, and is respectful of the presumption that Congress does not intend to pre-empt areas of traditional state regulation, see Jones v. Rath Packing Co., 430 U.S. 519, 525, 97 S.Ct. 1305, 1309, 51 L.Ed.2d 604, including regulation of the "business of insurance," see Metropolitan Life Ins. Co. v. Massachusetts, supra, 471 U.S., at 742-744, 105 S.Ct., at 2390-2391. Narrower readings of the deemer clause--which would interpret the clause to except from the saving clause only state insurance regulations that are pretexts for impinging on core ERISA concerns or to preclude States from deeming plans to be insurers only for purposes of state laws that apply to insurance as a business, such as laws relating to licensing and capitalization requirements--are unsupported by ERISA's language and would be fraught with administrative difficulties, necessitating definition of core ERISA concerns and of what constitutes business activity, and thereby undermining Congress' expressed desire to avoid endless litigation over the validity of state action and requiring plans to expend funds in such litigation. Pp. 407-411.

885 F.2d 79 (CA3 1989), vacated and remanded.

O'CONNOR, J., delivered the opinion of the Court, in which REHNQUIST, C.J., and WHITE, MARSHALL, BLACKMUN, SCALIA, and KENNEDY, JJ., joined. STEVENS, J., filed a dissenting opinion, post, p. 411. SOUTER, J., took no part in the consideration or decision of the case.

H. Woodruff Turner argued the cause for petitioner. With him on the briefs was Charles Kelly.

Deputy Solicitor General Shapiro argued the cause for the United States as amicus curiae urging

reversal. With him on the brief were Solicitor General Starr, Christopher J. Wright, Allen H. Feldman, Steven J. Mandel, and Mark S. Flynn.

Charles Rothfeld argued the cause for respondent. On the brief were Thomas G. Johnson and David A. Cicola.*

*Briefs of amici curiae urging reversal were filed for the Central States, Southeast and Southwest Area Health and Welfare Fund by Anita M. D'Arcy, James L. Coghlan, and William J. Nellis; for the Chamber of Commerce of the United States of America by Harry A. Rissetto, E. Carl Uehlein, Jr., and Stephen A. Bokat; for the National Coordinating Committee for Multiemployer Plans by Gerald M. Feder, David R. Levin, and Diana L.S. Peters; for the Teamsters Health and Welfare Fund of Philadelphia & Vicinity et al. by James D. Crawford, James J. Leyden, Henry M. Wick, Jr., and Jack G. Mancuso; and for Travelers Insurance Co. by A. Raymond Randolph, M. Duncan Grant, and Waltraut S. Addy.

Briefs of amici curiae urging affirmance were filed for the American Chiropractic Association by George P. McAndrews and Robert C. Ryan; for the American Optometric Association by Ellis Lyons, Bennett Boskey, and Edward A. Groobert; for the National Conference of State Legislatures et al. by Benna Ruth Solomon and Charels Rothfeld; and for the Pennsylvania Trial Lawyers Association by John Patrick Lydon.

Briefs of amici curiae were filed for the American Podiatric Medical Association by Werner Strupp; and for the Self-Insurance Institute of America, Inc., by George J. Pantos.

For U.S. Supreme Court Briefs See:

1993 WL 340029 (Pet.Brief)

1990 WL 507662 (Resp.Brief)

1990 WL 507664 (Reply.Brief)

For Transcript of Oral Argument See:

1990 WL 601334 (U.S.Oral.Arg.)

*54 Justice O'CONNOR delivered the opinion of the Court.

This case calls upon the Court to decide whether the Employee Retirement Income Security Act of 1974 (ERISA), 88 Stat. 829, as amended, 29 U.S.C. § 1001 et seq., pre-empts a Pennsylvania law precluding employee welfare benefit plans from exercising subrogation rights on a claimant's tort recovery.

I

Petitioner, FMC Corporation (FMC), operates the FMC Salaried Health Care Plan (Plan), an employee welfare benefit plan within the meaning of ERISA, § 3(1), 29 U.S.C. § 1002(1), that provides health benefits to FMC employees and their dependents. The Plan is self-funded; it does not purchase an insurance policy from any insurance company in order to satisfy its obligations to its participants. Among its provisions is a subrogation clause under which a Plan member agrees to reimburse the Plan for benefits **406 paid if the member recovers on a claim in a liability action against a third party.

Respondent, Cynthia Ann Holliday, is the daughter of FMC employee and Plan member Gerald Holliday. In 1987, *55 she was seriously injured in an automobile accident. The Plan paid a portion of her medical expenses. Gerald Holliday brought a negligence action on behalf of his daughter in Pennsylvania state court against the driver of the automobile in which she was injured. The parties settled the claim. While the action was pending, FMC notified the Hollidays that it would seek reimbursement for the amounts it had paid for respondent's medical expenses. The Hollidays replied that they would not reimburse the Plan, asserting that § 1720 of Pennsylvania's Motor Vehicle Financial Responsibility Law, 75 Pa.Cons.Stat. § 1720 (1987), precludes subrogation by FMC. Section 1720 states that "[i]n actions arising out of the maintenance or use of a motor vehicle, there shall be no right of subrogation or reimbursement from a claimant's tort recovery with respect to ... benefits ... payable under section 1719." [FN1] Section 1719 refers to benefit payments by "[a]ny program, group contract or other arrangement." [FN2]

FN1. Section 1720 of Pennsylvania's Motor

Vehicle Financial Responsibility Law is entitled "[s]ubrogation" and provides:

"In actions arising out of the maintenance or use of a motor vehicle, there shall be no right of subrogation or reimbursement from a claimant's tort recovery with respect to workers' compensation benefits, benefits available under section 1711 (relating to required benefits), 1712 (relating to availability of benefits) or 1715 (relating to availability of adequate limits) or benefits in lieu thereof paid or payable under section 1719 (relating to coordination of benefits)."

FN2. Section 1719, entitled "[c]oordination of benefits," reads:

"(a) General rule.--Except for workers' compensation, a policy of insurance issued or delivered pursuant to this subchapter shall be primary. Any program, group contract or other arrangement for payment of benefits such as described in section 1711 (relating to required benefits), 1712(1) and (2) (relating to availability of benefits) or 1715 (relating to availability of adequate limits) shall be construed to contain a provision that all benefits provided therein shall be in excess of and not in duplication of any valid and collectible first party benefits provided in section 1711, 1712 or 1715 or workers' compensation.

"(b) Definition.--As used in this section the term 'program, group contract or other arrangement' includes, but is not limited to, benefits payable by a hospital plan corporation or a professional health service corporation subject to 40 Pa.C.S. Ch. 61 (relating to hospital plan corporations) or 63 (relating to professional health services plan corporations)."

*56 Petitioner, proceeding in diversity, then sought a declaratory judgment in Federal District Court. The court granted respondent's motion for summary judgment, holding that § 1720 prohibits FMC's exercise of subrogation rights on Holliday's claim against the driver. The United States Court of Appeals for the Third Circuit affirmed. 885 F.2d 79 (1989). The court held that § 1720, unless pre-empted, bars FMC from enforcing its contractual subrogation provision. According to the court, ERISA pre-empts § 1720 if ERISA's "deemer clause," § 514(b)(2)(B), 29 U.S.C. § 1144(b)(2)(B), exempts the Plan from state subrogation laws. The Court of Appeals, citing Northern Group Services, Inc. v. Auto Owners Ins. Co., 833 F.2d 85, 91-94 (CA6 1987), cert. denied, 486 U.S. 1017, 108 S.Ct. 1754, 100 L.Ed.2d 216 (1988), determined that "the deemer clause [was] meant mainly to reach back-door attempts by states to regulate core ERISA concerns in the guise of insurance regulation." 885 F.2d, at 86. Pointing out that the parties had not suggested that the Pennsylvania antisubrogation law addressed "a core type of ERISA matter which Congress sought to protect by the preemption provision," id., at 90, the court concluded that the Pennsylvania law is not pre- empted. The Third Circuit's holding conflicts with decisions of other Courts of Appeals that have construed ERISA's deemer clause to protect self-funded plans from all state insurance regulation. See, e.g., Baxter v. Lynn, 886 F.2d 182, 186 (CA8 1989); Reilly v. Blue Cross and Blue Shield United of Wisconsin, **407 846 F.2d 416, 425-426 (CA7), cert. denied, 488 U.S. 856, 109 S.Ct. 145, 102 L.Ed.2d 117 (1988). We granted certiorari to resolve this conflict. 493 U.S. 1068, 110 S.Ct. 1109, 107 L.Ed.2d 1017 (1990), and now vacate and remand.

II

[1] In determining whether federal law pre-empts a state statute, we look to congressional intent. " 'Pre-emption may be either express or implied, and "is compelled whether Congress' *57 command is explicitly stated in the statute's language or implicitly contained in its structure and purpose." ' " Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 95, 103 S.Ct. 2890, 2899, 77 L.Ed.2d 490 (1983) (quoting Fidelity Federal Savings & Loan Assn. v. De la Cuesta, 458 U.S. 141, 152-153, 102 S.Ct. 3014, 3022, 73 L.Ed.2d 664 (1982), in turn quoting Jones v. Rath Packing Co., 430 U.S. 519, 525, 97 S.Ct. 1305, 1309, 51 L.Ed.2d 604 (1977)); see also Chevron U.S.A. Inc. v. Natural Resources Defense Council, Inc., 467 U.S. 837, 842-843, 104 S.Ct. 2778, 2781- 2782, 81 L.Ed.2d 694 (1984) ("If the intent of Congress is clear, that is the end of the matter; for the court ... must give effect to the unambiguously expressed intent of Congress" (footnote omitted)). We "begin with the language employed by Congress and the assumption that the ordinary meaning of that language accurately expresses the legislative purpose." Park 'N Fly, Inc. v. Dollar Park and Fly, Inc., 469 U.S. 189, 194, 105 S.Ct. 658, 661, 83 L.Ed.2d 582 (1985). Three provisions of ERISA speak expressly to the question of pre- emption:

"Except as provided in subsection (b) of this section [the saving clause], the provisions of this subchapter and subchapter III of this chapter shall

supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." § 514(a), as set forth in 29 U.S.C. § 1144(a) (pre-emption clause).

"Except as provided in subparagraph (B) [the deemer clause], nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities." § 514(b)(2)(A), as set forth in 29 U.S.C. § 1144(b)(2)(A) (saving clause).

"Neither an employee benefit plan ... nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or *58 investment companies." § 514(b)(2)(B), 29 U.S.C. § 1144(b)(2)(B) (deemer clause).

We indicated in Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724, 105 S.Ct. 2380, 85 L.Ed.2d 728 (1985), that these provisions "are not a model of legislative drafting." Id., at 739, 105 S.Ct., at 2389. Their operation is nevertheless discernible. The pre-emption clause is conspicuous for its breadth. It establishes as an area of exclusive federal concern the subject of every state law that "relate[s] to" an employee benefit plan governed by ERISA. The saving clause returns to the States the power to enforce those state laws that "regulat[e] insurance," except as provided in the deemer clause. Under the deemer clause, an employee benefit plan governed by ERISA shall not be "deemed" an insurance company, an insurer, or engaged in the business of insurance for purposes of state laws "purporting to regulate" insurance companies or insurance contracts.

III

[2] Pennsylvania's antisubrogation law "relate[s] to" an employee benefit plan. We made clear in Shaw v. Delta Air Lines, supra, that a law relates to an employee welfare plan if it has "a connection with or reference to such a plan." Id., 463 U.S., at 96-97, 103 S.Ct., at 2899-2900 (footnote omitted). **408 We based our reading in part on the plain language of the statute. Congress used the words " 'relate to' in § 514(a) [the pre-emption clause] in their broad sense." Id., at 98, 103 S.Ct., at 2900. It did not mean to pre-empt only state laws specifically designed to affect employee benefit plans. That interpretation would have made it unnecessary for Congress to enact ERISA § 514(b)(4), 29 U.S.C. § 1144(b)(4), which exempts from pre-emption "generally" applicable criminal laws of a State. We also emphasized that to interpret the pre-emption clause to apply only to state laws dealing with the subject matters covered by ERISA, such as reporting, disclosure, and fiduciary duties, would be incompatible with the provision's legislative history because the House and Senate versions of the bill that became ERISA *59 contained limited pre-emption clauses, applicable only to state laws relating to specific subjects covered by ERISA. [FN3] These were rejected in favor of the present language in the Act, "indicat[ing] that the section's pre-emptive scope was as broad as its language." Shaw v. Delta Air Lines, 463 U.S., at 98, 103 S.Ct., at 2901.

FN3. The bill introduced in the Senate and reported out of the Committee on Labor and Public Welfare would have pre-empted "any and all laws of the States and of political subdivisions thereof insofar as they may now or hereafter relate to the subject matters regulated by this Act." S. 4, 93d Cong., 1st Sess., § 609(a) (1973). As introduced in the House, the bill that became ERISA would have superseded "any and all laws of the States and of the political subdivisions thereof insofar as they may now or hereafter relate to the fiduciary, reporting, and disclosure responsibilities of persons acting on behalf of employee benefit plans." H.R. 2, 93d Cong., 1st Sess., § 114 (1973). The bill was approved by the Committee on Education and Labor in a slightly modified form. See H.R. 2, 93d Cong., 1st Sess., § 514(a) (1973).

Pennsylvania's antisubrogation law has a "reference" to benefit plans governed by ERISA. The statute states that "[i]n actions arising out of the maintenance or use of a motor vehicle, there shall be no right of subrogation or reimbursement from a claimant's tort recovery with respect to ... benefits ... paid or payable under section 1719." 75 Pa.Cons.Stat. § 1720 (1987). Section 1719 refers to "[a]ny program, group contract or other arrangement for payment of benefits." These terms "includ[e], but [are] not limited to, benefits payable by a hospital plan corporation or a professional health service corporation." § 1719 (emphasis

added).

The Pennsylvania statute also has a "connection" to ERISA benefit plans. In the past, we have not hesitated to apply ERISA's pre-emption clause to state laws that risk subjecting plan administrators to conflicting state regulations. See, e.g., Shaw v. Delta Air Lines, supra, at 95-100, 103 S.Ct., at 2898-2902 (state laws making unlawful plan provisions that discriminate on the basis of pregnancy and requiring plans to provide specific benefits "relate to" benefit plans); Alessi v. Raybestos-*60 Manhattan, Inc., 451 U.S. 504, 523-526, 101 S.Ct. 1895, 1906-1908, 68 L.Ed.2d 402 (1981) (state law prohibiting plans from reducing benefits by amount of workers' compensation awards "relate[s] to" employee benefit plan). To require plan providers to design their programs in an environment of differing state regulations would complicate the administration of nationwide plans, producing inefficiencies that employers might offset with decreased benefits. See Fort Halifax Packing Co. v. Coyne, 482 U.S. 1, 10, 107 S.Ct. 2211, 2217, 96 L.Ed.2d 1 (1987). Thus, where a "patchwork scheme of regulation would introduce considerable inefficiencies in benefit program operation," we have applied the pre-emption clause to ensure that benefit plans will be governed by only a single set of regulations. Id., at 11, 107 S.Ct., at 2217.

Pennsylvania's antisubrogation law prohibits plans from being structured in a manner requiring reimbursement in the event of recovery from a third party. It requires plan providers to calculate benefit levels in Pennsylvania based on expected liability conditions that differ from those in States that have not enacted similar antisubrogation legislation. **409 Application of differing state subrogation laws to plans would therefore frustrate plan administrators' continuing obligation to calculate uniform benefit levels nationwide. Accord, Alessi v. Raybestos-Manhattan, Inc., supra (state statute prohibiting offsetting worker compensation payments against pension benefits pre-empted since statute would force employer either to structure all benefit payments in accordance with state statute or adopt different payment formulae for employers inside and outside State). As we stated in Fort Halifax Packing Co. v. Coyne, supra, at 9, 107 S.Ct., at 2216, "[t]he most efficient way to meet these [administrative] responsibilities is to establish a uniform administrative scheme, which provides a set of standard procedures to guide processing of claims and disbursement of benefits."

There is no dispute that the Pennsylvania law falls within ERISA's insurance saving clause, which provides, "[e]xcept as provided in [the deemer clause], nothing in this subchapter *61 shall be construed to exempt or relieve any person from any law of any State which regulates insurance," § 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A) (emphasis added). Section 1720 directly controls the terms of insurance contracts by invalidating any subrogation provisions that they contain. See Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S., at 740-741, 105 S.Ct., at 2389-2390. It does not merely have an impact on the insurance industry; it is aimed at it. See Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 50, 107 S.Ct. 1549, 1554, 95 L.Ed.2d 39 (1987). This returns the matter of subrogation to state law. Unless the statute is excluded from the reach of the saving clause by virtue of the deemer clause, therefore, it is not pre-empted.

[3] We read the deemer clause to exempt self-funded ERISA plans from state laws that "regulat[e] insurance" within the meaning of the saving clause. By forbidding States to deem employee benefit plans "to be an insurance company or other insurer ... or to be engaged in the business of insurance," the deemer clause relieves plans from state laws "purporting to regulate insurance." As a result, self-funded ERISA plans are exempt from state regulation insofar as that regulation "relate[s] to" the plans. State laws directed toward the plans are pre-empted because they relate to an employee benefit plan but are not "saved" because they do not regulate insurance. State laws that directly regulate insurance are "saved" but do not reach self-funded employee benefit plans because the plans may not be deemed to be insurance companies, other insurers, or engaged in the business of insurance for purposes of such state laws. On the other hand, employee benefit plans that are insured are subject to indirect state insurance regulation. An insurance company that insures a plan remains an insurer for purposes of state laws "purporting to regulate insurance" after application of the deemer clause. The insurance company is therefore not relieved from state insurance regulation. The ERISA plan is consequently bound by state insurance regulations insofar as they apply to the plan's insurer.

*62 Our reading of the deemer clause is consistent with Metropolitan Life Ins. Co. v. Massachusetts, supra. That case involved a Massachusetts statute requiring certain self-funded benefit plans and insurers issuing group health policies to plans to provide minimum mental health benefits. Id., 471 U.S., at 734, 105 S.Ct., at 2386. In pointing out that Massachusetts had never tried to enforce the portion of the statute pertaining directly to benefit plans, we stated, "[i]n light of ERISA's 'deemer clause,' which states that a benefit plan shall not 'be deemed an insurance company' for purposes of the insurance saving clause, Massachusetts has never tried to enforce [the statute] as applied to benefit plans directly, effectively conceding that such an application of [the statute] would be pre-empted by ERISA's pre-emption clause." Id., at 735, n. 14, 105 S.Ct., at 2387, n. 14 (citations omitted). We concluded that the statute, as applied to insurers of **410 plans, was not pre-empted because it regulated insurance and was therefore saved. Our decision, we acknowledged, "results in a distinction between insured and uninsured plans, leaving the former open to indirect regulation while the latter are not." Id., at 747, 105 S.Ct., at 2393. "By so doing, we merely give life to a distinction created by Congress in the 'deemer clause,' a distinction Congress is aware of and one it has chosen not to alter." Ibid. (footnote omitted).

Our construction of the deemer clause is also respectful of the presumption that Congress does not intend to pre-empt areas of traditional state regulation. See Jones v. Rath Packing Co., 430 U.S., at 525, 97 S.Ct., at 1309. In the McCarran-Ferguson Act, 59 Stat. 33, as amended, 15 U.S.C. § 1011 et seq., Congress provided that the "business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business." 15 U.S.C. § 1012(a). We have identified laws governing the "business of insurance" in the Act to include not only direct regulation of the insurer but also regulation of the substantive terms of insurance contracts. Metropolitan Life Ins. Co. v. Massachusetts, supra, 471 U.S., at 742-744, 105 S.Ct., at 2390-2392. *63 By recognizing a distinction between insurers of plans and the contracts of those insurers, which are subject to direct state regulation, and self-insured employee benefit plans governed by ERISA, which are not, we observe Congress' presumed desire to reserve to the States the regulation of the "business of insurance."

Respondent resists our reading of the deemer clause and would attach to it narrower significance. According to the deemer clause, "[n]either an employee benefit plan ... nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies [or] insurance contracts." § 514(b)(2)(B), 29 U.S.C. § 1144(b)(2)(B) (emphasis added). Like the Court of Appeals, respondent would interpret the deemer clause to except from the saving clause only state insurance regulations that are pretexts for impinging upon core ERISA concerns. The National Conference of State Legislatures et al. as amici curiae in support of respondent offer an alternative interpretation of the deemer clause. In their view, the deemer clause precludes States from deeming plans to be insurers only for purposes of state laws that apply to insurance as a business, such as laws relating to licensing and capitalization requirements.

These views are unsupported by ERISA's language. Laws that purportedly regulate insurance companies or insurance contracts are laws having the "appearance of" regulating or "intending" to regulate insurance companies or contracts. Black's Law Dictionary 1236 (6th ed.1990). Congress' use of the word does not indicate that it directed the deemer clause solely at deceit that it feared state legislatures would practice. Indeed, the Conference Report, in describing the deemer clause, omits the word "purporting," stating, "an employee benefit plan is not to be considered as an insurance company, bank, trust company, or investment *64 company (and is not to be considered as engaged in the business of insurance or banking) for purposes of any State law that regulates insurance companies, insurance contracts, banks, trust companies, or investment companies." H.R.Conf.Rep. No. 93-1280, p. 383 (1974), U.S.Code Cong. & Admin.News 1974, pp. 4639, 5162.

Nor, in our view, is the deemer clause directed solely at laws governing the business of insurance. It is plainly directed at "any law of any State purporting to regulate insurance companies,

insurance contracts, banks, trust companies, or investment companies." § 514(b)(2)(B), 29 U.S.C. § 1144(b)(2)(B). Moreover, it is difficult to understand why Congress would have included **411 insurance contracts in the pre-emption clause if it meant only to pre-empt state laws relating to the operation of insurance as a business. To be sure, the saving and deemer clauses employ differing language to achieve their ends--the former saving, except as provided in the deemer clause, "any law of any State which regulates insurance" and the latter referring to "any law of any State purporting to regulate insurance companies [or] insurance contracts." We view the language of the deemer clause, however, to be either coextensive with or broader, not narrower, than that of the saving clause. Our rejection of a restricted reading of the deemer clause does not lead to the deemer clause's engulfing the saving clause. As we have pointed out, supra, at 409-410, the saving clause retains the independent effect of protecting state insurance regulation of insurance contracts purchased by employee benefit plans.

Congress intended by ERISA to "establish pension plan regulation as exclusively a federal concern." Alessi v. Raybestos-Manhattan, Inc., 451 U.S., at 523, 101 S.Ct., at 1706 (footnote omitted). Our interpretation of the deemer clause makes clear that if a plan is insured, a State may regulate it indirectly through regulation of its insurer and its insurer's insurance contracts; if the plan is uninsured, the State may not regulate it. As a result, employers will not face " 'conflicting or inconsistent State and local regulation of employee benefit plans.' " *65 Shaw v. Delta Air Lines, Inc., 463 U.S., at 99, 103 S.Ct., at 2901 (quoting remarks of Sen. Williams). A construction of the deemer clause that exempts employee benefit plans from only those state regulations that encroach upon core ERISA concerns or that apply to insurance as a business would be fraught with administrative difficulties, necessitating definition of core ERISA concerns and of what constitutes business activity. It would therefore undermine Congress' desire to avoid "endless litigation over the validity of State action," see 120 Cong.Rec. 29942 (1974) (remarks of Sen. Javits), and instead lead to employee benefit plans' expenditure of funds in such litigation.

In view of Congress' clear intent to exempt from direct state insurance regulation ERISA employee benefit plans, we hold that ERISA pre-empts the application of § 1720 of Pennsylvania's Motor Vehicle Financial Responsibility Law to the FMC Salaried Health Care Plan. We therefore vacate the judgment of the United States Court of Appeals for the Third Circuit and remand the case for further proceedings consistent with this opinion.

It is so ordered.

Justice SOUTER took no part in the consideration or decision of this case.

Justice STEVENS, dissenting.

The Court's construction of the statute draws a broad and illogical distinction between benefit plans that are funded by the employer (self-insured plans) and those that are insured by regulated insurance companies (insured plans). Had Congress intended this result, it could have stated simply that "all State laws are pre-empted insofar as they relate to any self-insured employee plan." There would then have been no need for the "saving clause" to exempt state insurance laws from the pre-emption clause, or the "deemer clause," which the Court today reads as merely reinjecting *66 into the scope of ERISA's pre-emption clause those same exempted state laws insofar as they relate to self-insured plans.

From the standpoint of the beneficiaries of ERISA plans--who after all are the primary beneficiaries of the entire statutory program--there is no apparent reason for treating self-insured plans differently from insured plans. Why should a self-insured plan have a right to enforce a subrogation clause against an injured employee while an insured plan may not? The notion that this disparate treatment of similarly situated beneficiaries is somehow supported by an interest in uniformity is singularly unpersuasive. If Congress **412 had intended such an irrational result, surely it would have expressed it in straightforward English. At least one would expect that the reasons for drawing such an apparently irrational distinction would be discernible in the legislative history or in the literature discussing the legislation.

The Court's anomalous result would be avoided by a correct and narrower reading of either the basic pre-emption clause or the deemer clause.

I

The Court has endorsed an unnecessarily broad reading of the words "relate to any employee benefit plan" as they are used in the basic pre-emption clause of § 514(a). I acknowledge that this reading is supported by language in some of our prior opinions. It is not, however, dictated by any prior holding, and I am persuaded that Congress did not intend this clause to cut nearly so broad a swath in the field of state laws as the Court's expansive construction will create.

The clause surely does not pre-empt a host of general rules of tort, contract, and procedural law that relate to benefit plans as well as to other persons and entities. It does not, for example, pre-empt general state garnishment rules insofar as they relate to ERISA plans. Mackey v. Lanier Collection Agency & Service, Inc., 486 U.S. 825, 108 S.Ct. 2182, 100 L.Ed.2d 836 (1988). Moreover, the legislative history of the provision indicates that *67 throughout most of its consideration of pre-emption, Congress was primarily concerned about areas of possible overlap between federal and state requirements. Thus, the bill that was introduced in the Senate would have pre-empted state laws insofar as they "relate to the subject matters regulated by this Act," [FN1] and the House bill more specifically identified state laws relating "to the fiduciary, reporting, and disclosure responsibilities of persons acting on behalf of employee benefit plans." [FN2] Although the compromise that produced the statutory language "relate to any employee benefit plan" is not discussed in the legislative history, the final version is perhaps best explained as an editorial amalgam of the two bills rather than as a major expansion of the section's coverage.

FN1. S. 4, 93d Cong., 1st Sess., § 609(a) (1973), reprinted at 1 Legislative History of the Employee Retirement Income Security Act of 1974 (Committee Print compiled by the Subcommittee on Labor of the Senate Committee on Labor and Public Welfare) 93, 186 (1976) (Leg.Hist.).

FN2. H.R. 2, 93d Cong., 1st Sess., § 114 (1973); 1 Leg.Hist. 51.

When there is ambiguity in a statutory provision pre-empting state law, we should apply a strong presumption against the invalidation of well-settled, generally applicable state rules. In my opinion this presumption played an important role in our decisions in Fort Halifax Packing Co. v. Coyne, 482 U.S. 1, 107 S.Ct. 2211, 96 L.Ed.2d 1 (1987), and Mackey v. Lanier Collection Agency & Service, Inc., supra. Application of that presumption leads me to the conclusion that the pre-emption clause should apply only to those state laws that purport to regulate subjects regulated by ERISA or that are inconsistent with ERISA's central purposes. I do not think Congress intended to foreclose Pennsylvania from enforcing the antisubrogation provisions of its state Motor Vehicle Financial Responsibility Law against ERISA plans--most certainly, it did not intend to pre-empt enforcement of that statute against self-insured plans while preserving enforcement against insured plans.

*68 II

Even if the "relate to" language in the basic pre-emption clause is read broadly, a proper interpretation of the carefully drafted text of the deemer clause would caution against finding pre-emption in this case. Before identifying the key words in that text, it **413 is useful to comment on the history surrounding enactment of the deemer clause.

The number of self-insured employee benefit plans grew dramatically in the 1960's and early 1970's. [FN3] The question whether such plans were, or should be, subject to state regulation remained unresolved when ERISA was enacted. It was, however, well recognized as early as 1967 that requiring self-insured plans to comply with the regulatory requirements in state insurance codes would stifle their growth:

FN3. See Comment, State Regulation of Noninsured Employee Welfare Benefit Plans, 62 Geo.L.J. 339, 340 (1973).

"Application of state insurance laws to uninsured plans would make direct payment of benefits pointless and in most cases not feasible. This is because a welfare plan would have to be operated as an insurance company in order to comply with the detailed regulatory requirements of state insurance codes designed with the typical operations of insurance companies in mind. It

presumably would be necessary to form a captive insurance company with prescribed capital and surplus, capable of obtaining a certificate of authority from the insurance department of all states in which the plan was 'doing business,' establish premium rates subject to approval by the insurance department, issue policies in the form approved by the insurance department, pay commissions and premium taxes required by the insurance law, hold and deposit reserves established by the insurance department, make investments permitted under the law, and comply with all filing and examination requirements of the insurance department. The result would be to reintroduce *69 an insurance company, which the direct payment plan was designed to dispense with. Thus it can be seen that the real issue is not whether uninsured plans are to be regulated under state insurance laws, but whether they are to be permitted." Goetz, Regulation of Uninsured Employee Welfare Plans Under State Insurance Laws, 1967 Wis.L.Rev. 319, 320-321 (emphasis in original).

In 1974 while ERISA was being considered in Congress, the first state court to consider the applicability of state insurance laws to self-insured plans held that a self-insured plan could not pay out benefits until it had satisfied the licensing requirements governing insurance companies in Missouri and thereby had subjected itself to the regulations contained in the Missouri insurance code. Missouri v. Monsanto Co., Cause No. 259774 (St. Louis Cty.Cir.Ct., Jan. 4, 1973), rev'd, 517 S.W.2d 129 (Mo.1974). Although it is true that the legislative history of ERISA or the deemer clause makes no reference to the Missouri case, or to this problem--indeed, it contains no explanation whatsoever of the reason for enacting the deemer clause--the text of the clause itself plainly reveals that it was designed to protect pension plans from being subjected to the detailed regulatory provisions that typically apply to all state-regulated insurance companies--laws that purport to regulate insurance companies and insurance contracts.

The key words in the text of the deemer clause are "deemed," "insurance company," and "purporting." [FN4] It provides *70 that an employee welfare plan shall not be deemed to be an insurance company or to be engaged in the business of insurance for the purpose of determining whether it is an entity that is regulated by any state law purporting to regulate insurance companies and insurance contracts.

FN4. Section 514(b)(2)(B), as set forth in 29 U.S.C. § 1144(b)(2)(B), provides:
"Neither an employee benefit plan ... nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies." (Emphasis added.)

**414 Pennsylvania's insurance code purports, in so many words, to regulate insurance companies and insurance contracts. It governs the certification of insurance companies, Pa.Stat.Ann., Tit. 40, § 400 (Purdon 1971), their minimum capital stock and financial requirements to do business, § 386 (Purdon 1971 and Supp.1990-1991), their rates, e.g., § 532.9 (Purdon 1971) (authorizing Insurance Commissioner to regulate minimum premiums charged by life insurance companies), and the terms that insurance policies must, or may, include, e.g., § 510 (Purdon 1971 and Supp.1990-1991) (life insurance policies), § 753 (Purdon 1971) (health and accident insurance policies). The deemer clause prevents a State from enforcing such laws purporting to regulate insurance companies and insurance contracts against ERISA plans merely by deeming ERISA plans to be insurance companies. But the fact that an ERISA plan is not deemed to be an insurance company for the purpose of deciding whether it must comply with a statute that purports to regulate "insurance contracts" or entities that are defined as "insurance companies" simply does not speak to the question whether it must nevertheless comply with a statute that expressly regulates subject matters other than insurance.

There are many state laws that apply to insurance companies as well as to other entities. Such laws may regulate some aspects of the insurance business, but do not require one to be an insurance company in order to be subject to their terms. Pennsylvania's Motor Vehicle Financial Responsibility Law is such a law. The fact that petitioner's plan is not deemed to be an insurance company or an insurance contract does not have any bearing on the question whether

petitioner, *71 like all other persons, must nevertheless comply with the Motor Vehicle Financial Responsibility Law.

If one accepts the Court's broad reading of the "relate to" language in the basic pre-emption clause, the answer to the question whether petitioner must comply with state laws regulating entities including, but not limited to, insurance companies depends on the scope of the saving clause. [FN5] In this case, I am prepared to accept the Court's broad reading of that clause, but it is of critical importance to me that the category of state laws described in the saving clause is broader than the category described in the deemer clause. A state law "which regulates insurance," and is therefore exempted from ERISA's pre-emption provision by operation of the saving clause, does not necessarily have as its purported subject of regulation an "insurance company" or an activity that is engaged in by persons who are insurance companies. Rather, such a law may aim to regulate another matter altogether, but also have the effect of regulating insurance. The deemer clause, by contrast, reinjects into the scope of ERISA pre-emption only those state laws that "purport to" regulate insurance companies or contracts--laws such as those which set forth the licensing and capitalization requirements for insurance companies or the minimum required provisions in insurance contracts. While the saving clause thus exempts from the pre-emption clause all state laws that have the broad effect of regulating insurance, the deemer clause simply allows pre-emption of those state laws that expressly regulate insurance and that would therefore be applicable to ERISA plans only if States were allowed to deem such plans to be insurance companies.

FN5. Section 514(b)(2)(A), as set forth in 29 U.S.C. § 1144(b)(2)(A), provides:
"Except as provided in subparagraph (B) nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities."

*72 Pennsylvania's Motor Vehicle Financial Responsibility Law fits into the broader category of state laws that fall within the saving clause only. The Act regulates persons in addition to insurance companies and affects subrogation and indemnity agreements that are not necessarily insurance contracts. Yet **415 because it most assuredly is not a law "purporting" to regulate any of the entities described in the deemer clause--"insurance companies, insurance contracts, banks, trust companies, or investment companies," the deemer clause does not by its plain language apply to this state law. Thus, although the Pennsylvania law is exempted from ERISA's pre- emption provision by the broad saving clause because it "regulates insurance," it is not brought back within the scope of ERISA pre-emption by operation of the narrower deemer clause. I therefore would conclude that petitioner is subject to Pennsylvania's Motor Vehicle Financial Responsibility Law.

I respectfully dissent.

END OF DOCUMENT

UNITED McGILL CORPORATION, Plaintiff-Appellant,
v.
Sharon STINNETT, Defendant-Appellee.

No. 97-1046.

United States Court of Appeals,
Fourth Circuit.

Argued June 3, 1998.

Decided Aug. 27, 1998.

ERISA health plan participant, who had been injured in an automobile accident, entered a settlement in a third-party tort action against the negligent driver, and the plan administrator asserted a subrogation claim against the settlement. The administrator moved for summary judgment. The District Court, Alexander Williams, Jr., J., 950 F.Supp. 134, granted summary judgment for the administrator, but required it to share in the costs of the third-party recovery. Administrator appealed. The Court of Appeals, Phillips, Senior Circuit Judge, held that the health plan unambiguously required the participant to reimburse the plan in full, with no reduction for the costs of obtaining the third-party recovery.

Vacated and remanded.

[1] PENSIONS ⚿139
296k139
Interpretive decisions by administrators of ERISA plans are generally subject to de novo review. Employee Retirement Income Security Act of 1974, § 2 et seq., 29 U.S.C.A. § 1001 et seq.

[2] PENSIONS ⚿139
296k139
If ERISA plan expressly grants plan administrator discretionary authority to construe provisions, administrator's interpretive decision is reviewed for abuse of discretion. Employee Retirement Income Security Act of 1974, § 2 et seq., 29 U.S.C.A. § 1001 et seq.

[3] PENSIONS ⚿139
296k139
Although ERISA plan gave administrator discretionary authority to "construe the terms of the Plan and resolve any disputes which may arise with regard to the rights of any persons under the terms of the Plan," its interpretation of plan's reimbursement provision was entitled to less deference where employer served as both employer and administrator and retained financial interest in reducing payments under plan. Employee Retirement Income Security Act of 1974, § 2 et seq., 29 U.S.C.A. § 1001 et seq.

[4] PENSIONS ⚿23
296k23
In enacting ERISA, Congress intended for judiciary to develop body of federal common law to supplement statute's express provisions. Employee Retirement Income Security Act of 1974, § 2 et seq., 29 U.S.C.A. § 1001 et seq.

[5] FEDERAL COURTS ⚿419
170Bk419
Courts should fashion federal common law only when necessary to effectuate purposes of ERISA. Employee Retirement Income Security Act of 1974, § 2 et seq., 29 U.S.C.A. § 1001 et seq.

[5] FEDERAL COURTS ⚿421
170Bk421
Courts should fashion federal common law only when necessary to effectuate purposes of ERISA. Employee Retirement Income Security Act of 1974, § 2 et seq., 29 U.S.C.A. § 1001 et seq.

[6] PENSIONS ⚿138
296k138
Unambiguous language of ERISA health plan obliged participant to reimburse benefits paid in full without pro rata deduction for her expenses in obtaining third-party tort recovery from which plan administrator sought reimbursement. Employee Retirement Income Security Act of 1974, § 2 et seq., 29 U.S.C.A. § 1001 et seq.

[7] PENSIONS ⚿138
296k138
Applying federal common law to override health plan's unambiguous reimbursement provision and to require plan administrator to pay pro rata share of costs of obtaining third-party tort recovery would contravene, rather than effectuate, underlying purposes of ERISA. Employee Retirement Income Security Act of 1974, § 2 et seq., 29 U.S.C.A. §

1001 et seq.

*169 ARGUED: Matt R. Ballenger, Baltimore, Maryland, for Appellant. Robyn B. Lupo, Eric S. Slatkin & Associates, Burtonsville, Maryland, for Appellee. ON BRIEF: Eric S. Slatkin, Eric S. Slatkin & Associates, Burtonsville, Maryland, for Appellee.

Before MURNAGHAN and ERVIN, Circuit Judges, and PHILLIPS, Senior Circuit Judge.

Vacated and remanded by published opinion. Senior Judge PHILLIPS wrote the opinion, in which Judge MURNAGHAN and Judge ERVIN joined.

OPINION

PHILLIPS, Senior Circuit Judge:

This is an appeal by United McGill Corporation from a district court judgment holding that an ERISA plan participant who recovers *170 from a third party is entitled to a pro rata reduction for attorney's fees when reimbursing the plan for benefits paid. Although granting summary judgment for McGill on its claim for reimbursement, the district court held that McGill, the employer and administrator of the welfare benefit plan, must share in the costs of third-party recovery and, therefore, reduced McGill's reimbursement from Sharon Stinnett, the employee, by one-third. Because the express terms of the ERISA plan provide otherwise, we vacate and remand with instructions.

I.

On May 9, 1993, Sharon Stinnett was involved in a motor vehicle accident and suffered considerable injuries. At the time, Stinnett was an employee of United McGill Corporation and participated in McGill's welfare benefit plan ("the Plan"). Following the accident, she incurred medical bills totaling $39,000 and received medical benefit expenses from the Plan in the sum of $31,418.89. Stinnett then brought suit against the driver who caused the accident and eventually settled the claim for $100,000. Pursuant to a contingency fee arrangement, Stinnett's attorney received one-third of the settlement proceeds.

McGill, as administrator of the Plan, sought to recover the full amount of medical expenses paid to Stinnett and perfected a lien on the settlement proceeds. The terms of the Plan provide:

> REFUND TO U.S. FOR OVERPAYMENT OF BENEFITS
>
> If you or your dependent recover money for medical, hospital, dental or vision expenses incurred due to an illness or injury for which a benefit has been paid under this plan, we will have the right to a refund from you or your dependent. The amount refunded to us will be the lesser of:
>
> 1. the amount you or your dependent recover;
> 2. the amount of benefits we have paid .
>
> RIGHT OF SUBROGATION
>
> If you or your covered dependent has a claim for damages or a right to recover damages from a third party or parties for any illness or injury for which benefits are payable under this plan, we are subrogated to such claim or right of recovery. Our right of subrogation will be to the extent of any benefits paid or payable under this plan, and shall include any compromise settlement....

(J.A. at 69 (emphasis added).) Based on these provisions, McGill filed a complaint for declaratory judgment and then moved for summary judgment.

In both her answer to the complaint and response to the summary judgment motion, Stinnett acknowledged McGill's right to reimbursement for the medical expenses but insisted that McGill must reduce the amount of the lien by one- third to account for the attorney's fees expended in order to recover from the negligent driver. The district court agreed and, although granting summary judgment in favor of McGill, reduced McGill's award because it was "the fair, appropriate, and equitable determination under the circumstances of this case." (J.A. at 112.)

McGill now appeals that portion of the district court's decision reducing its reimbursement of benefits paid by one-third to cover Stinnett's attorney's fees.

II.

We review de novo the district court's ruling on summary judgment and are therefore guided by the appropriate standard of review of McGill's decision, as administrator of the Plan, not to apportion Stinnett's attorney's fees. Bailey v. Blue Cross & Blue Shield of Va., 67 F.3d 53, 56 (4th Cir.1995).

[1][2] Interpretive decisions by administrators of ERISA plans are generally subject to de novo review. Firestone Tire and Rubber Co. v. Bruch, 489 U.S. 101, 115, 109 S.Ct. 948, 103 L.Ed.2d 80 (1989). If, however, the plan expressly grants the plan administrator discretionary authority to construe the provisions, the administrator's decision is reviewed for abuse of discretion. Id. (indicating that courts should defer when the administrator is granted interpretive discretion). Under this deferential standard, "the administrator or fiduciary's *171 decision will not be disturbed if it is reasonable, even if this court would have come to a different conclusion independently." Ellis v. Metropolitan Life Ins. Co., 126 F.3d 228, 232 (4th Cir.1997) (citations omitted). In certain circumstances, this deference is "lessened to the degree necessary to neutralize any untoward influence resulting from [ ] conflict[s] [arising from the administrator's financial interest in the outcome of the decision]." Bailey, 67 F.3d at 56 (citations omitted); Ellis, 126 F.3d at 233 ("The more incentive for the administrator or fiduciary to benefit itself by a certain interpretation of benefit eligibility or other plan terms, the more objectively reasonable the ... decision must be and the more substantial the evidence must be to support it.").

[3] In this case, the Plan grants McGill discretionary authority to "construe the terms of the Plan and resolve any disputes which may arise with regard to the rights of any persons under the terms of the Plan." (J.A. at 80.) Thus, McGill's interpretation of the Plan's reimbursement provision is entitled to some deference. However, because McGill serves as both employer and administrator and apparently retains a financial interest in reducing payments under the Plan, its decision is judicially reviewed under a less deferential abuse of discretion standard. Jenkins v. Montgomery Indus. Inc., 77 F.3d 740, 742 (4th Cir.1996).

McGill argues that the Plan clearly, concisely, and unambiguously requires Plan beneficiaries to refund the Plan from any third-party recovery to the extent of any benefits paid. Here, Stinnett recovered $100,000 and, after paying her negotiated attorney's fees, retained approximately $67,000--more than enough to reimburse the Plan $31,418.89 for medical benefits payments received from the Plan. Accordingly, McGill contends that the district court erroneously disregarded the plain language of the Plan and crafted a solution outside the contractual arrangement between the parties.

In response, Stinnett maintains that the "obvious inequities" of allowing McGill to benefit without contributing to the recovery should control our decision. Even conceding that the language of the Plan is clear, Stinnett reasons that but for her retention of an attorney to pursue the claim, the Plan would not have recovered any of the benefits paid. She argues that federal common law should not allow McGill to profit from its inaction. If McGill had exercised its right of subrogation to pursue the claim itself, McGill, and not Stinnett, would have incurred attorney's fees for recovery of the medical expenses. Therefore, according to Stinnett, McGill should not be permitted to avoid these costs by simply shifting the burden of third-party recovery to the Plan beneficiary.

The district court found Stinnett's position to be persuasive. Apparently balancing the equities in favor of Stinnett and without discussing the content of either the reimbursement or subrogation provisions in the Plan, the district court ordered that McGill share in the cost of obtaining the settlement proceeds. Because this approach ignores well-settled principles of ERISA law, we must reject it.

[4][5] In enacting ERISA, Congress intended for the judiciary to develop a body of federal common law to supplement the statute's express provisions. Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 56, 107 S.Ct. 1549, 95 L.Ed.2d 39 (1987). This law-making authority is limited however to situations in which it is "necessary to fill in interstitially or otherwise effectuate the [ERISA] statutory pattern enacted in the large by Congress." Bollman Hat Co. v. Root, 112 F.3d 113, 118 (3d Cir.1997), cert. denied, --- U.S. ----, 118 S.Ct. 373, 139 L.Ed.2d 290 (1997) (quotation and citation omitted); see Jenkins, 77 F.3d at 743 (indicating that the federal common law of rights and obligations under ERISA-regulated plans exists merely to fill in the statute's gaps). Courts should only fashion federal common law when "necessary to effectuate the purposes of ERISA." Singer v. Black & Decker Corp., 964 F.2d 1449, 1452 (4th Cir.1992) (citations omitted). In reviewing ERISA-related disputes,

> [r]esort to federal common law generally is inappropriate when its application would conflict with the statutory provisions of ERISA, discourage

> employers from implementing plans governed by ERISA, or threaten to override the explicit terms of an established ERISA benefit plan. And, courts should remain circumspect to utilize federal common law to address issues that *172 bear at most a tangential relationship to the purposes of ERISA.

Id. (citations omitted).

Although ERISA establishes a comprehensive regulatory scheme for employee welfare benefit plans, it does not mandate any minimum substantive content for such plans. See Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 91, 103 S.Ct. 2890, 77 L.Ed.2d 490 (1983); Hamilton v. Air Jamaica, Ltd., 945 F.2d 74, 78 (3d Cir.1991). Rather, one of the primary functions of ERISA is to ensure the integrity of written, bargained-for benefit plans. Duggan v. Hobbs, 99 F.3d 307, 309-10 (9th Cir.1996); Van Orman v. American Ins. Co., 680 F.2d 301, 302 (3d Cir.1982). To satisfy this objective, the plain language of an ERISA plan must be enforced in accordance with "its literal and natural meaning." Health Cost Controls v. Isbell, 139 F.3d 1070, 1072 (6th Cir.1997).

Applying these principles, several of our sister circuits have expressly declined to achieve the result reached here by the district court through the application of federal common law at variance with comparable reimbursement provisions in ERISA plans. In Ryan by Capria-Ryan v. Federal Express Corp., 78 F.3d 123 (3d Cir.1996), the Third Circuit refused to reduce an administrator's reimbursement award by prorating the covered participant's attorney's fees where the ERISA plan expressly provided otherwise. In that case, the plan provided, in pertinent part:

> [T]he Plan shall have the right to recover, against any source which makes payments or to be reimbursed by the Covered Participant who receives such benefits, 100% of the amount of covered benefits paid.... If the 100% reimbursement provided above exceeds the amount recovered by the Covered Participant, less legal and attorneys' fees incurred by the Covered Participant in obtaining such recovery ..., the Covered Participant shall reimburse the Plan the entire amount of such Net Recovery.

Id. at 124. Because the covered participant's recovery, after expenses, was sufficient to reimburse the Plan in full, the court interpreted the contractual language unambiguously to require repayment of all money received without a pro rata reduction for attorney's fees. The court explained that federal common law may not "override a subrogation provision in an ERISA- regulated plan on the ground that the plan would be unjustly enriched if it were to be enforced as written." Id. Therefore, it held that the district court erroneously "established a new federal common law right of recovery under ERISA; i.e. a right under federal common law to deduct from a subrogation lien a pro rata share of attorneys' fees incurred in pursuing a claim, despite explicit contrary language in the Plan's subrogation clause." Id. at 125.

The language in Ryan is arguably distinguishable, because in the operative provision, the plan did mention attorney's fees and their treatment in relation to a situation where the award minus fees was less than the benefits paid. Recently, however, the Third Circuit reiterated the Ryan approach in a case with language virtually identical to McGill's Plan. Bollman, 112 F.3d at 116 (explaining that the plan provided for reimbursement "to the extent off[any] payment" by the plan). In that case, the court further declined to incorporate general common law principles of subrogation into ERISA law because the employee had not established that full reimbursement conflicted with ERISA's policies or that adoption of a pro rata rule was necessary to effectuate such policies. Id. at 118 (citation omitted).

The Sixth and Eighth Circuits have arrived at similar conclusions. In reviewing a reimbursement provision similar to that in Ryan, the Sixth Circuit denied pro rata distribution because "federal courts may not apply common law theories to alter the express terms of written benefit plans." Health Cost Controls v. Isbell, 139 F.3d 1070, 1072 (6th Cir.1997) (citations omitted). The Eighth Circuit has also expressed agreement with the Ryan holding but created a default rule if the language of the benefits plan is inconclusive. Waller v. Hormel Foods Corp., 120 F.3d 138, 141 (8th Cir.1997). In that case, the subrogation clause merely stated that the company would be subrogated to all rights of recovery but did not delineate any specific amount and lacked any language like that found in the McGill Plan. Id. Because of this "silence," the court concluded as a matter of federal common law that the employee was entitled to a pro rata offset of the

value *173 of the legal services to the employer. Id.; see also McIntosh v. Pacific Holding Co., 120 F.3d 911 (8th Cir.1997) (same). We find these decisions persuasive.

[6] Notwithstanding the above authority, Stinnett maintains that it would be unconscionable to force a Plan beneficiary to reimburse the Plan for full benefits without deducting a pro rata share of the costs required to obtain the reimbursement funds. If, as in Waller, the Plan was silent as to the amount of reimbursement, Stinnett's argument would be more compelling. Under the McGill Plan, however, Stinnett cannot escape the unambiguous language that obligates her to repay the benefits paid in full without mention of a pro rata deduction for her expenses. See Ryan, 78 F.3d at 127 ("Enrichment is not 'unjust' where it is allowed by the express terms of the ... plan.") (quoting Cummings by Techmeier v. Briggs & Stratton Retirement Plan, 797 F.2d 383, 390 (7th Cir.1986)).

[7] Where, as here, the language of the Plan does not qualify the right to reimbursement by reference to the costs associated with recovery, we are bound to enforce the contractual provisions as drafted. Applying federal common law to override the Plan's reimbursement provision would contravene, rather than effectuate, the underlying purposes of ERISA. See Coleman v. Nationwide Life Ins. Co., 969 F.2d 54, 58 (4th Cir.1992) ("Use of estoppel principles to effect a modification of a written employee benefit plan would conflict with ERISA's emphatic preference for written agreements.") (quotation and citation omitted). "The interpretive tool of a growing body of federal common law applicable to ERISA actions is not a license to rewrite the Plan to the Court's tastes." Health and Welfare Plan for Employees of REM, Inc. v. Ridler, 942 F.Supp. 431, 435 (D.Minn.1996), aff'd, 124 F.3d 207, 1997 WL 559745 (8th Cir. Sept. 10, 1997) (unpublished). Irrespective of how federal common law would divide the settlement proceeds absent contractual guidance, McGill is entitled to full recovery based on the plain language of the Plan. [FN*]

FN* We leave for another day how to treat situations where the beneficiaries' recovery from the third party after deducting attorney's fees is actually less than the plan's reimbursement claim, thus ostensibly requiring the beneficiary to pay out of her own pocket to meet the plan's claim. See Bollman, 112 F.3d at 117 (refusing to address this hypothetical scenario because the third party settlement in that case fully financed both the attorney's fees and the plan's claim). We do note that future disputes over such an anomalous result can easily be avoided by more careful drafting of subrogation and reimbursement provisions. See Health Cost Controls, 139 F.3d at 1071 (indicating that plan specified that "in no event will the amount of reimbursement ... exceed ... [t]he amount actually recovered from that part of judgment or settlement in excess of the amount necessary to fully reimburse the Employee ... for out- of-pocket expenses incurred, including attorney fees"); Ryan, 78 F.3d at 125 (reciting that subrogation provision provided that "if the payment you receive from the third party, less your attorneys' fees and other legal expenses, is not enough to reimburse benefit payments at 100%, you must reimburse the plan 100% of what is left after paying your attorneys' fees and other legal expenses").

We therefore vacate the judgment of the district court and remand with instructions to enter judgment for McGill for the full amount of reimbursement claimed.

SO ORDERED.

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