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ERISA liens and self-funded plans

HOW TO DEAL WITH "HIRED-GUN" SUBROGATION COMPANIES WHEN THE ERISA PLAN IS SELF-FUNDED BY A LARGE COMPANY

"This is a self-funded ERISA plan. The plan will not reduce for your fees and costs, regardless of how hard you had to fight for the settlement dollars. We demand 100% reimbursement of what was paid out by the Plan." – almost all ERISA self-funded plans.

As a plaintiff's attorney, you've no doubt seen your fair share of health insurance liens and dealt with the hired gun subrogation contractors that represent them. ERISA, FEHBA, Medicare, Medicaid, Workers Compensation, Military… and the list goes on. Each type of lien is guided by their own laws – some give them strength, others give them limitations. It's complicated.

Subrogation companies have multiplied year after year. In most situations, the laws have favored the health plan more and more, particularly ERISA plans. These subrogation companies and the defense firms representing the interests of the health insurance carrier are often very sharp; not only are they up to date on the law, they are pushing to create new laws that support their position. Because of this, it is often necessary to bring in a lien resolution expert to fight hand to hand with these subrogation firms. Subrogation companies love nothing more than to battle with a plaintiff's attorney who knows something about health insurance liens but doesn't deal with them day in and day out.

ERISA

The Employee Retirement Income Security Act of 1974 (ERISA) is a federal law that sets minimum standards for most voluntarily established employer-based pension and health plans, to provide protection for individuals in these plans. It was created to protect the employee and their funds that were contributed to covered plans via payroll deductions.

According to the Department of Labor, in FY 2013, ERISA encompassed roughly 684,000 retirement plans, 2.4 million health plans and 2.4 million additional welfare benefit plans. These plans cover about 141 million workers and beneficiaries and include more than $7.6 trillion in assets.

Unfortunately, ERISA has been twisted and spun by ERISA self-funded health plans and their recovery contractors to aggressively recover dollars spent by covered health insurance plans when there is a liability case and a subsequent settlement fund. While ERISA wasn't created for this purpose, it is being used in this way and U.S. Supreme Court decisions have often supported this spin.

According to the U.S. Census Bureau's report, *Health Insurance Coverage in the United States* (Berchick, Hood and Barnett 2018), 67.2 percent of Americans received health insurance from a private insurer and 56 percent received it as a benefit of their employment. That's a lot of ERISA plans. Depending on which side you are standing, ERISA is either a positive or a negative. From the perspective of the self-funded ERISA plan, ERISA protects the interests of employee benefit plan participants and their beneficiaries – although not necessarily the interest of the injured party, but rather, everyone else who is a participant of the plan. For subrogation purposes, it allows the plan to be reimbursed when there is another insurance carrier involved or an at-fault party. On the opposing side, injured plaintiffs and their attorneys negatively view the impact of ERISA because of its strong arm and aggressive pursuit of reimbursement from the personal injury victim.

Funding

So, what makes that ERISA plan so strong? It's the funding status of the plan. It is the source of the payment of claims that really matters, allowing the ERISA self-funded plan to preempt state law and applicable reduction doctrines. If the ERISA policy is an insured plan, then ERISA's federal law preemption doesn't apply, and rather, the relevant state law applies. This is by way of the "savings" and "deemer" clauses found in sections 1144(b)(2)(A) and § 1144(b)(2)(B) of title 29 of the United States Code. ERISA-covered group health insurance plans are funded in two ways.

Fully-insured

An employer with a small pool of workers will likely purchase an *insured plan*. The primary way that health insurance functions in the workplace has not changed in decades. The employee pays for insurance through payroll deductions and, in turn, the employer pays a premium for insurance coverage with a large health insurance company like Anthem, Aetna, Cigna, Kaiser or United Healthcare. The insurance company collects premiums from the employer and pays providers after medical bills are submitted. The premiums are revenue and claims are expenses of the health insurance company. The risk is held by the health insurance company. This is a plan that is subject to state law regarding subrogation and reimbursement rights against a personal-injury settlement even though it is an ERISA plan.

Self-funded

Alternatively, employers can create a pool of funds comprised of their own contributions and employee premiums. This fund is then used to pay for employees'

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health claims. This is a *self-funded plan*. The fund will often utilize a claims administrator – a large, well-known insurance carrier – to process claims. Thus, self-funded plans often look the same as fully insured plans because the claims still appear to be paid by Anthem, Aetna, Kaiser, United Healthcare, or another large insurance company. Your client will still believe that they have United Health insurance. The difference is where the funding for the payment of those claims comes from, and for self-funded plans, it comes from the self-funded pool. The employer utilizes a third-party administrator, claims management, and often stop-loss insurance to help them administer the plan.

Essentially, the employer collects premiums to create their own asset pool to pay the claims of the employees and their dependents. The employer carries the risk, although this is usually offset by stop-loss coverage after a certain dollar amount. Because of this financial setup, the plan is exempt from state laws pertaining to subrogation and reimbursement rights that otherwise serve to protect an injured party where there is a settlement due to third-party liability. Instead, according to federal law, it is the terms of the health insurance contract that provide the rights and responsibilities of the plan and its participants.

Fiduciary duty

Under ERISA, the employer (Plan Sponsor) is a fiduciary for the Plan. As a fiduciary, the Sponsor owes a strict duty to the Plan to act in the best interest of all the beneficiaries when carrying out the administration and payment of benefits. This also impacts subrogation and reimbursement. Because the Plan Sponsor is responsible to all beneficiaries of the Plan, it is this fiduciary duty that is the reason given to not ignore the Plan language and provide a reduction.

The argument goes like this: If the Plan reduces its claim in an amount less than the Plan's full entitlement, then they are not upholding their fiduciary duty to ensure that the funds and assets of the Plan are preserved to pay future claims. In theory this works; but, failing to provide an additional $10,000 reduction to Joe in order to put more funds in the self-funded pot just doesn't balance the numbers. Even if you multiplied it out by the number of Joes who have third-party claims and settlement funds available to reimburse the Plan, it's a small piece of the pie overall. But that is not the message you'll receive from aggressive subrogation companies such as The Rawlings Company and Optum. As they tell it, if it were not for subrogation, health insurance as we know it would collapse, particularly self-funded plans. And it is a $1 billion a year industry for health plans alone, so why wouldn't the largest companies pursue it?

The *Wal-Mart v. Shank* case

You may recall the case of *Wal-Mart v. Shank,* 500 F.3d 834 (8th Cir. 2007). In that case, the lower court was affirmed in finding that a severely disabled accident victim had to turn over her remaining settlement funds and then some to reimburse the self-funded health plan of Wal-Mart – because the contract language gave them the right. Ms. Shank was permanently brain damaged, restricted to a wheelchair and required 24-hour care in a nursing home. The funds from the settlement were placed in a special needs trust for her future life care. Wal-Mart wanted reimbursement, their policy language said they had a right to be reimbursed, and the court agreed that they should be reimbursed.

Then the public shaming began. There was a strong sense of outrage that a multi-billion-dollar company was challenging this disabled employee and taking her small recovery. As the case was covered by the media, the human-interest piece took flight. After months of on-and-off media attention, Wal-Mart, as the employer, had a change of heart. Because they were being smeared in the media, they decided to call this subrogation interest a loss and made a public statement that Ms. Shank could keep her settlement funds. They also decided to modify their policy language going forward to allow for more discretion in individual cases. Specifically, Wal-Mart claimed that their contract would be updated so that when the injury or illness results in death or other serious conditions such as paraplegia, quadriplegia, severe burns or total or permanent physical or mental disability, they would not seek reimbursement or subrogation.

As I was writing this article, I grew curious as to how Wal-Mart's contract reads now, particularly as so much has developed in the courts and self-funded plans have gained super strength. To my surprise, in the 2018 Associate Benefit Book, the limitation is still there. Way to go, Wal-Mart. Kind of. Later in the provisions for subrogation is this: "The Plan's rights apply regardless of whether a covered person has been made whole or fully compensated for his or her injuries," so for everyone else, you still must pay. What about someone who had a limb amputated? With this policy language, Wal-Mart might not care unless they think back to this case. The same goes for other employers. For that reason, sometimes you need to get to the employer directly as you may not gain enough traction just working with the third-party subrogation company.

Subrogation companies

As discussed above, you're not always talking with the employer. Most self-funded plans have insurance carriers acting as their third-party administrators by physically paying the claims. From there, most insurance carriers hire subrogation recovery vendors to collect on the subrogation interest. These companies include industry giants such as Equian, The Rawlings Company, Optum, and Conduent as well as numerous defense law firms specializing in subrogation. How do you deal with these companies? You communicate with them. You make the appropriate requests for Plan documents. You study the policy language. You potentially hire an expert in lien resolution. Let's examine each of these steps more closely.

Some attorneys have developed a habit of ignoring the subrogation company and simply refuse to complete forms, provide information, or even try to negotiate the lien. These attorneys just leave

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the asserted liens for their client to handle, not seeing lien resolution as their responsibility as legal representative of the injured party. That is not a recommended action for several reasons including the risk of the attorney being held personally liable for the payment of the ERISA lien. Then there are ethical issues like a potential bar complaint or legal malpractice claim.

The best course of action is to handle the lien, and the easiest way to ensure that the handling is as efficient as possible is to have an open line of communication with the representative at the subrogation company. From a subrogation company perspective, if the attorney is deemed uncooperative, the attorney will likely be flooded with letters and phone calls. After a certain period, your client will start being flooded with letters and phone calls as if they were an unrepresented party. This can create a very negative relationship between the attorney and his client.

The subrogation companies generally train their representatives well. The goal is to have the representative be a well-rehearsed speaker only stating the side of the law that is most favorable to them. It is general practice of subrogation companies to not advise their representatives on the competing argument of the law. Instead, they are informed that this other argument is just wrong. This often causes the representative to be shocked when an injured party's attorney brings an argument that is so contradictory to what they have been trained to believe and say. This is by design. The subrogation company does not want the representative to put too much analysis into the underlying legal theory, but instead just push forward the legal theory asserted from the top.

Many of the examiners handling subrogation files have 500+ files in their inventory at one time. Some have double that. They are hard-pressed to touch as many files a day as possible. They are tasked with keeping an updated status on the underlying case, updating the lien amount every 60-90 days, reviewing policy language, etc. They may allocate 10 minutes per file touched because they must get on to the next. They have quotas to meet, phone calls to make and are balancing all the competing interests of their time. Because of that, it is hard to break through and create a good relationship with the representative, but it's important to try. As you know, an established, respectful relationship can be the most important part to negotiating.

Plan documents

Some carriers, such as certain Blue Cross Blue Shield entities, have in-house subrogation units. These carriers have various plan documents at their disposal, but there is a lot of information that they do not have. They would have to make outreach to their self-funded group client to obtain them. They do not like to do this. For subrogation companies, it's another step removed. Their client is the health insurance carrier acting as a claim's administrator. For the subrogation company to obtain additional documents, they must go through the carrier to get to the group. The goal of the subrogation company is to handle everything on their own. In most situations, this subrogation work is being done without either the health insurance carrier or the self-funded group knowing anything about the individual case.

An ERISA self-funded plan is as strong as its policy language. This is the mantra of subrogation recovery vendors when training subrogation recovery examiners. Therefore, it is extremely important for you to have the appropriate plan documents when assessing the health plan's recovery right. You must arm yourself with the documents that govern the plan and you should not just accept what is given to you. It could be wrong.

There is the laundry list of items that the plan participant is entitled to receive under the ERISA statute § 1024(b)(4).

> The administrator shall, upon written request of any participant or beneficiary, furnish a copy of the latest updated summary, [sic] plan description, and the latest annual report, any terminal report, the bargaining agreement, trust agreement, contract, or other instruments under which the plan is established or operated.

- This Plan Document (written instrument pursuant to 29 U.S.C. § 1102) in effect on date of injury as well as any document amending, supplementing, or otherwise modifying the Plan Document; Summary Plan Description and employee benefits booklet in effect at the time of injury as well as all documents issued subsequently during any year in which benefits were paid;
- SPD Wrap Documents;
- Bargaining Agreement, Trust Agreement, Contract etc. under which Health Plan is established;
- Trust Agreement or other document establishing funding for the Plan;
- Annual Return/Report (IRS/DOL Form 5500), including all attached Financial Schedules;
- Administrative Services Agreement with any Third-Party Administrator for the Plan;
- An affidavit from the Plan Administrator attesting to self-funded status of the Plan;
- Complete statement of benefits paid to or on behalf of claimant/beneficiary;
- Specific plan component(s) paying benefits (e.g., health, dental, vision, AD&D, disability, etc.);
- "Stop-loss" or excess/re-insurance coverage (insurer, policy numbers and attachment points).

An administrator is required to provide the requested documents. The ERISA statute has created a civil penalty under section 1132(c)(1) of title 29 of the United States Code which has been increased to $110/day under 29 Code of Federal Regulations part 2575.502c-3. Subrogation vendors and defense firms will state that they do not have the documents, that they are not the proper party for requesting the documents, that the documents are not necessary to ascertain the funding status of the plan, etc. Essentially, they think that they are not subject to the penalty for their failure to comply, which includes the failure to comply completely. But then, they express their aversion to your outreach to the proper party, which is the Plan

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Sponsor. Subrogation vendors try to have it both ways.

The fact is that if the Plan cannot produce the documents required under the ERISA statute, then the Plan should not be shielded by ERISA and all subsequent case law to receive 100% of the entitlement that they otherwise stake claim to after a case is settled. Are all the documents required to prove funding status and to know that the Plan has a right of reimbursement? No, but that is not a limitation of the statute. The plan participant is entitled to the documents without qualification. Who is the subrogation company to tell the plan participant what they *need*? Especially when the subrogation vendor thinks the participant only needs documents readily available to them. It is important to remember though that the 1024(b)(4) request must be made to the plan itself, not the recovery contractor or third-party administrator.

The policy language matters

Most subrogation examiners will assert that the U.S. Supreme Court case of *US Airways v. McCutchen*, (2013) 133 S.Ct. 1537 stands for the fact that ERISA self-funded plans do not have to reduce for attorney fees and are not subject to the made-whole rule. But that's just not the case. It still very much depends on what is contained in the policy language for each plan.

In *McCutchen*, the Court found that the existence of a clear, contractual agreement between an ERISA Plan and the participant negated the use of any equitable doctrines which would otherwise be available in the absence of such language. "[S]o if a contract abrogates the common fund doctrine, the insurer is not unjustly enriched by claiming the benefit of its bargain." (*Id* at 1548.) The problem is that the policy language can be updated time and time again, which just makes the ERISA self-funded plan stronger and meaner. But if the Plan does not clearly lay out the terms, the plan participant benefits. In *McCutchen*, the Court stated that "[o]rdinary principles of contract interpretation point toward this conclusion. Courts construe ERISA plans, as they do other contracts, by "looking to the terms of the plan" as well as to "other manifestations of the parties' intent." (*Ibid.*)

What does this mean for plaintiff's attorneys? You must have the correct plan documents, you must read them carefully, and you must understand how each word can provide a limitation. The way each provision is worded matters. In most jurisdictions, contracts of adhesion with conflict or ambiguity are interpreted against the drafter. "An ambiguity exists when a party can identify an alternative, semantically reasonable, candidate of meaning of a writing." (*Solis v. Kirkwood Resort* (2001) 94 Cal.App.4th 354, 360.) The basis for *contra proferentem* is that the party who wrote the contract had the opportunity to choose the perfect words and if they did not, and instead chose words that did not clearly lay out their expectations, then they should suffer the consequence for the lack of clarity. This is particularly the case with health insurance policies which are a "contract of adhesion," where the terms are not open to negotiation and must be accepted by the "insured." This was clearly stated by the U.S. Supreme Court in the *McCutchen* case, "if US Airways wished to depart from the well-established common-fund rule, it had to draft its contract to say so – and here it did not."

If the policy language provides that the Plan may subrogate against *third-party* insurance, there is a strong argument that it is *not* entitled to reimbursement from a *first-party* settlement. Likewise, if the policy provides the Plan the right to subrogation but not the right to reimbursement, then the Plan should not attempt to collect reimbursement from the injured party's settlement. Instead, the Plan is limited to subrogating by going directly to the tortfeasor's insurance carrier and asserting their direct claim, which doesn't always work out for them. If their subrogation effort fails, and if the policy does not allow the reimbursement, then their opportunity for recovery is effectively over.

You, as the plaintiff's attorney, must know the terms of the plan in order to know what the plan can and cannot do. You must ensure that the Plan is acting within their own confines. The Plan may just proceed as if it has full rights in all situations. There's no guarantee that they are following the terms of the plan, especially when you're dealing with a subrogation firm with a representative who will reap a bonus from each check received. Those blinders can certainly prevent the representative from staying in their lane.

Conclusion

We live in a world of specialization. Subrogation companies understand this and know they are at an advantage when dealing with trial attorneys and their staff. With a singular focus on recovering dollars on behalf of health insurance companies, subrogation companies have refined a process that has created a multi-million-dollar industry almost out of thin air. They know that trial attorneys have demanding schedules, are juggling multiple plates at any given time, and that most simply cannot afford to spend the time needed to properly fight an ERISA lien.

As a trial attorney, the key question becomes, how do you approach fighting the subrogation company? While most law firms *could* spend the time, resources, and money required to create an effective ERISA lien fighting machine, the pivotal question is *why*? Why would you bear the cost of hiring experienced subrogation lawyers, investing in consistent training and quality control, and continuing to spend invaluable firm man-hours when you could instead partner with a lien resolution expert that already has those pieces in place? For many attorneys the way to level the playing field is to outsource lien resolution.

For an ERISA self-funded plan, if the contract language is airtight, they do not have to be persuaded with equitable arguments. That doesn't mean that they are not influenced; however, the harsh reality is that the more the representative collects for the health plan, the more he sees on his paycheck. Enforcing technical compliance, by finding cracks in the policy language and poking holes in the

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subrogation vendor's arguments, is often the path to successful negotiations.

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