ERISA Subrogation and Reimbursement
Who is this woman named “Erisa” and why is she wrecking my case?

I. Core Concepts.


   i. **DOL and IRS.** The Department of Labor (DOL) and the Internal Revenue Service (IRS) share enforcement responsibility of ERISA-governed plans. Specifically, the Employee Benefits Security Administration (EBSA) is the agency within the DOL that enforces ERISA.

   ii. **Application.** ERISA applies to all employee benefit plans provided to employees by their employer (retirement, health, disability, life, etc.). ERISA does not apply to governmental plans, church plans and plans purchased by individuals out-right from the insurance company.

   iii. **Documents required under ERISA.** Health plans are usually organized under two documents: (1) the Plan Document, and (2) the Summary Plan Description (SPD). The SPD is the only document required to be automatically distributed to participants. Recent Supreme Court case law tells us that the SPD does not constitute part of the Plan and the terms in the underlying Plan Document control.

b. **Subrogation vs. Reimbursement.**

   i. **Subrogation** – The Plan steps into the shoes of the participant and actually brings a lawsuit against a third party for the injury.

   ii. **Reimbursement** – After the participant brings a lawsuit, the Plan looks for reimbursement of claims paid from any recovery made by the participant.

c. **Key Players.**

   i. **Plan.** The Plan is a legal entity that may sue and be sued.

   ii. **Plan Sponsor.** The Plan Sponsor is generally the employer.

   iii. **Plan Administrator.** The Plan Administrator is required to be listed in the SPD. It is normally the employer or a benefits committee.

   iv. **Third Party Administrator (TPA).** The TPA is the entity that actually administers claims. This is usually an insurance company.
v. **Fiduciary.** A person is a fiduciary with respect to the Plan to the extent that they exercise any discretionary authority over management of the Plan or disposition of Plan assets.

vi. **Participant.** The employee or former employee eligible for benefits.

vii. **Beneficiary.** Dependents of the Participant who are eligible for benefits – usually the spouse and children.

d. **Health Plan Funding.** In the employer market there are two basic funding arrangements for ERISA health plans: (1) fully-insured, and (2) self-funded or self-insured. Most employees do not know how their plan is funded. From an employee’s perspective, everything is the same – employees pay premiums and are given an insurance card from a major carrier.

i. **Fully-insured.** Premiums collected in a fully-insured plan are paid to an insurance company for the purchase of an insurance policy. The insurance company assumes the risk of paying claims that exceed the amount of premiums collected. The employer’s risk is limited to the established premium amounts.

ii. **Self-insured.** Premiums collected in a self-insured plan are deposited into a trust account which is used to pay claims. The employer assumes the risk of paying claims which exceed the amount of premiums collected. To offset this risk, many employers purchase stop-loss insurance to place a ceiling on the potential cost. Employers use one of the major insurance companies as an administrator to process claims. They also buy into that insurance company’s network. This explains why participants will receive an insurance card with the insurance company’s logo and customer service and claims processing information. Self-insured plans often utilize the insurance company’s plan document as well. Thus, from the outside looking in, it can be very hard to distinguish plan funding.

e. **ERISA Preemption.** Three important clauses:

i. **Preemption Clause** – 29 U.S.C. § 1144(a). All state law is preempted insofar as it relates to an employee benefit plan.

ii. **Savings Clause** – 29 U.S.C. § 1144(b)(2)(A). State laws which regulate insurance are “saved” from preemption. This refers mainly to state laws which are directed at insurance companies and tell insurance companies how to operate and what can and cannot be in the policies that they sell. For example, mandatory benefits, reserve requirements and, of course, anti-subrogation laws.
iii. **Deemer Clause** – 29 U.S.C. § 1144(b)(2)(B). States cannot “deem” self-insured plans to be insurance companies. Therefore, laws that apply under the savings clause cannot be applied to self-insured plans.

First Step in any Subrogation/Reimbursement claim is to discover the Plan funding.

II. **Handling an ERISA Reimbursement Claim.**

   a. **Discover the Plan Funding.**

      i. *Participant Request.* The best way to discover Plan funding is to send an informational request to the Plan Administrator asking for detailed funding information including copies of stop-loss contracts, any agreements between the Plan and insurance companies and asking for a certification that there is no “insurance on the risk.” This should be sent to the Plan Administrator and be signed by the Participant. Failure to respond to this request for information within 30 days could cost the Plan Administrator up to $110 per day.

      ii. *Stop-loss.* Self-insured plans often purchase stop-loss coverage to act as a ceiling to the potential risk. At certain points, called attachment points, the stop-loss insurance kicks in and pays claims. Stop-loss is generally reserved for catastrophic claims. If the attachment point is too low, courts may hold that the plan is actually insured. Again, in Missouri and Kansas, insured = no subrogation. Another important consideration in the facts and circumstances test of whether or not stop-loss creates an insured plan is how many times the stop-loss has paid claims in the past 5 or so years.

      iii. *Form 5500.* The Form 5500 is essentially a tax return for an employee benefit plan. It is filed by a plan’s three-digit ERISA plan number. All welfare plan numbers begin with a 5. The DOL and IRS allow employers to adopt a wrap document which encompasses all welfare plans provided by the employer. This welfare program is then given a plan number and

![Diagram](image-url)
only required to file one Form 5500. Therefore, when looking at funding information on a Form 5500, “insurance” may be selected along with “general assets of the plan sponsor.” However, a person reviewing the Form 5500 cannot tell which plan to which the funding information refers. For example, a company may have the ABC Company, Inc. Welfare Benefit Program. The Program includes the health plan, dental plan, short-term disability, long-term disability, and life insurance plans. The health plan is self-insured but the other benefits are fully-insured. ABC Company would select both “insurance” and “general assets” at the program level but not distinguish between the different benefits. Bottom line – in my opinion, for funding information, the Form 5500 is usually meaningless.

b. Discover the Plan Language.

   i. The plan language may not be sufficient to create a lien.

1. New Supreme Court case – *Cigna v. Amara* (May 16, 2011). One holding from this case is that the terms in the SPD are not incorporated into the Plan. Therefore, if the subrogation and reimbursement language is not included in the underlying plan document, there is a good argument that no right for subrogation or reimbursement exists.

2. Example: *Reinhart Companies Employee Benefit Plan v. Vial*, Case No. 2:09-CV-169 (W.D.Mich. March, 17, 2011). This case arose out of a medical malpractice claim which was settled with neither side admitting fault. The plan language provided reimbursement from a “responsible or liable party.” The court held that no lien was created because the medical providers who paid the settlement were never found to be responsible or liable.

3. Example: *Cooper Tire & Rubber Co. v. St. Paul Fire & Marine Ins. Co.*, 48 F.3d 365 (8th Cir. 1995). The Plan limited recovery to the extent that the beneficiary recovers for “medical expenses.” The 8th Circuit indicated that the plan was bound by the settlement allocation pronounced by the court. In response, most subrogation provisions now include language entitling the plan to reimbursement from “any recovery.”

ii. The plan language may not sufficiently negate the made whole doctrine or the common fund doctrine.
c. Discover the Appropriate Amount of the Alleged Lien.

i. Plaintiff’s attorneys should always ask for claim detail to determine that the plan only seeks reimbursement of claims actually related to the lawsuit. Also ask for any discounts applied to the claims.

ii. A recent case held that the plaintiff’s attorney was not bound by answers to interrogatories in the underlying tort action which claimed that all medical bills were related to the accident. *Rotech Healthcare Inc. v. Huff*, (Cent.Dis. Ill., 3/8/11).

d. Discover Where the Money Will Go.

i. In accordance with ERISA, participants have the right to ensure that plan benefits do not inure to the benefit of the company. Therefore, it is appropriate to inquire about where any reimbursement proceeds will go – back to the plan or to the employer.

ii. If part of the recovery would go to a stop-loss insurer because the stop-loss insurer paid that portion of the claim, there is a good argument that that portion is subject to the state anti-subrogation laws.

e. Discover Arguments Unique to Your Case.

i. Unclean hands.

ii. Special Needs Trusts, Annuities – funds are not in participant’s possession.

iii. State laws that do not relate to insurance and are therefore not preempted by ERISA.

iv. ERISA provides only for “appropriate equitable relief.” ERISA does not define “appropriate.” Other sections of ERISA tell us to look to state law. For example, to determine the statute of limitations in most ERISA cases, the attorney must look to the most analogous state statute of limitations. In anti-subrogation states such as Missouri and Kansas, plaintiffs may have an argument that “appropriate” should be interpreted by looking to state law and public policy which would prevent subrogation and reimbursement.

III. Conclusion. Often times, when faced with notice of an ERISA lien, the best thing to do is exhibit to the recovery agent that you understand the landscape and can speak their language. The way to do this is to start off with a thorough and appropriate request for information. Next, you should scour the information provided (or maybe noticeably omitted) to determine your challenges to reimbursement.