Conflicting Policies and Courts: When Plan Language Creates More Litigation than Coverage

By: Catherine Dowie

Mostly, working on any given subrogation file for a private, self-funded benefit plan is all about the hurry up and wait. Hurry to communicate with the injured party, their attorney, the adjusters, investigators, and make sure everyone knows to about the plan's involvement and rights. Then wait for the completion of treatment, the compilation of damages and some initial negotiations before racing to remind everyone of those rights, and potentially racing to the courthouse to make sure those rights are preserved.

As the Supreme Court reminded us in *Montanile v. Board of Trustees of the National Elevator Industry Health Benefit Plan*, timing is everything. 136 S. Ct. 651 (2016).

For the most part, the bulk of the plan's cost-containment opportunity has always come at the resolution of some liability claim, which is usually years after the bulk of the treatment and payments. Although many states require Medical Payments Coverage, Personal Injury Protection or some other form of no-fault coverage, they are typically in very small amounts.

There are exceptions, of course, Michigan's unlimited PIP scheme, potential advancement of funds in Montana under *Ridley v. Guaranty National Insurance Co.*, and high-minimum states like New York and New Jersey, but usually very little coverage is available to alleviate the burden on a plan to pay up front or leave a member to address bills with providers directly. 951 P 2d 987 (Mont. 1997).

In some circumstances, however, acting quickly when the case begins does turn up a policy that will meaningfully impact the plan's liability from the start, where there is a policy for a specific loss or a high no-fault policy. The problem arises when these policies are designed to be excess, which they usually are.

An excess policy is a policy designed to provide coverage only when no other coverage exists. They are often inexpensive because they are designed to often only bear liability for a patient's copayment or deductible obligations, rather than the bulk of the responsibility for medical claims. Some are also only designed to cover bills associated with a specific event or activity, such as high school sports.

This issue frequently arises not only in the context of automobile no-fault coverage, but with school and recreational policies. Schools will often secure excess policies for athletes or even students hurt in gym class, and they are common in adult recreational leagues (usually soccer, but I've handled a case where an adjuster was shocked to find that his company had issued a policy for a lawnmower racing league…).

So, what happens when a health plan has a valid excess provision, but the accident or automobile policy that covers a specific incident does as well? Although ERISA might allow a plan to preempt state laws, policy or plan provisions may call for a slightly different analysis.

Various Federal Circuit Courts of Appeal have heard this question and have reached a somewhat surprising conclusion, especially following the *Montanile* decision from the Supreme Court in 2016. There is a long-standing split between the circuits on this question. *See Auto Owners Ins. Co. v. Thorn Apple Valley, Inc.,* 31 F.3d 371 (6th Cir. 1994) (terms of an ERSIA plan are enforceable over conflicting policy language of an insurer) *c.f. Winstead v. Ind. Ins. Co.*, 855 F.2d 430 (7th Cir. 1988) (apportioning liability for claims *pro rata*).

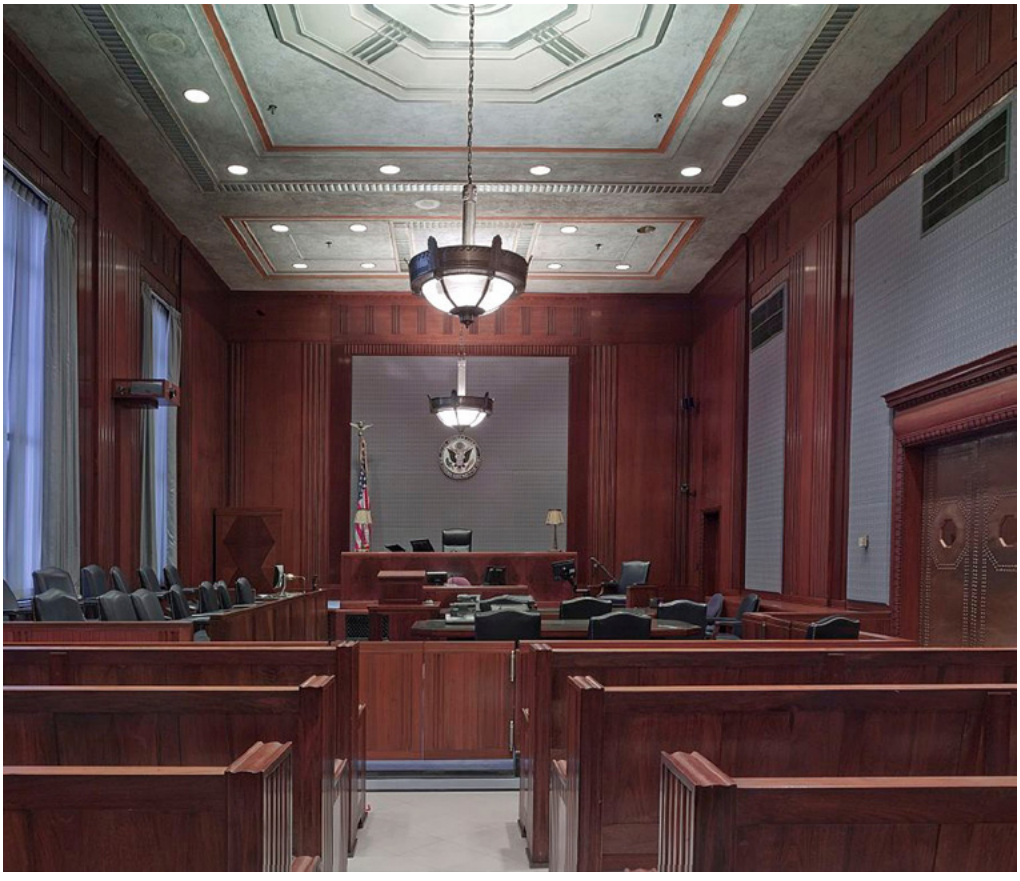
Both of these cases addressed Michigan PIP policies, which provide unlimited coverage for, among other things, medical bills related to automobile accidents. Both the PIP policy and the health plans involved in the dispute had excess provisions, and in both cases the auto insurer filed suit, asking the court to declare that the that the health plan should pay the bills as primary.

The 6th Circuit concluded that the ERISA plan terms were not entitled to any deference over the terms of the auto policy and ordered the two litigants to pay the claims on a prorated basis. Straightforward enough. Neither policy had a cap on coverage, and the outstanding bills could be split on a 50/50 basis.

One significant problem with this decision as applied to slightly different facts, is how does one pro-rate a theoretically infinite policy with a more standard PIP policy which might have limits of $10,000 or less. *McGurl v. Trucking Emps. of N.J. Welfare Fund, Inc.* , 124 F.3d 471, 485 (3d Cir. 1997) (noting that it is "unclear how the rule [prorating] would operate in practice").

The 7th Circuit, when faced with the same issue, gave more weight to the primary purpose of ERISA. These conclusions were perfectly in line with what the Supreme Court would later point out, the whole reason that the plan, "in short, is at the center of ERISA" and "[t]his focus on the written terms of the plan is the linchpin of 'a system that is [not] so complex that administrative costs, or litigation expenses, unduly discourage employers from offering [ERISA] plans in the first place.'" *Helimeshoff v. Hartford*, 134 S.Ct. 604, 612 (2013) (quoting *Varity Corp. v. Howe*, 516 U.S. 489, 497 (1996)). Without giving force to valid and clear terms, uniform nationwide enforcement would be undercut.

In the last 5 years, this issue has been somewhat frequently litigated in the context of non-automobile excess policies.[1] In addition to the existing split on what weight to give the terms of an ERISA plan, courts have now drawn a distinction based on if the plan paid claims before initiating suit.



Courts have allowed plans to pursue declaratory relief, obligating the insurer to issue payment in the future, but not recover from insurance policies with excess provisions once the plan has already paid claims.

This pre/post payment distinction is based on the idea that plans can only seek a monetary award with a court if they can identify a specific pool of money that they have a right to, like a settlement fund, which does not exist when benefits are being coordinated between two payors.

Additionally, some insurers have argued that ERISA is irrelevant even to the determination of primary liability for payment, asking courts to leave these "run-of-the-mill contract disputes" to state courts.

As one court noted:

The paradoxical result [of this argument] is that as an ERISA plan, has fewer remedies than it would if it were a non-ERISA plan, and its beneficiary, through no fault of his own, is considerably worse off for having two policies that coincidentally had conflicting language than he would be if he had only one. One might think that the underlying purposes of ERISA and of equitable relief generally would permit a court to fashion an appropriate remedy.

Cent. States, Se. & Sw. Areas Health & Welfare Fund v. Gerber Life Ins. Co., 771 F.3d 150, 159 (2d Cir. 2014).

As long as these issues remain unresolved, health plan liability will remain uncertain, and insurers and plans alike will be encouraged to leave claims denied and turn to courts before issuing payments.

This leaves plan participants to deal with bills everyone agrees will not ultimately be their responsibility, and forces plans into a position where they may risk loss of discounted rates

What are clients saying about our EmCap® program?

"You have become a key partner in our company's attempt to fix what's broken in our healthcare system."

- CFO, Commercial Construction Company

"Our clients have grown accustomed to Berkley's high level of customer service."

- Broker

"The most significant advancement regarding true cost containment we've seen in years."

- President, Group Captive Member Company

"EmCap has allowed us to take far more control of our health insurance costs than can be done in the fully insured market."

- President, Group Captive Member Company

"With EmCap, our company has been able to control pricing volatility that we would have faced with traditional Stop Loss."

- HR Executive, Group Captive Member Company

People are talking about Medical Stop Loss Group Captive solutions from Berkley Accident and Health. Our innovative EmCap® program can help employers with self-funded employee health plans to enjoy greater transparency, control, and stability.

Let's discuss how we can help your clients reach their goals.

This example is illustrative only and not indicative of actual past or future results. Stop Loss is underwritten by Berkley Life and Health Insurance Company, a member company of W. R. Berkley Corporation and rated A+ (Superior) by A.M. Best, and involves the formation of a group captive insurance program that involves other employers and requires other legal entities. Berkley and its affiliates do not provide tax, legal, or regulatory advice concerning EmCap. You should seek appropriate tax, legal, regulatory, or other counsel regarding the EmCap program, including, but not limited to, counsel in the areas of ERISA, multiple employer welfare arrangements (MEWAs), taxation, and captives. EmCap is not available to all employers or in all states.

Stop Loss | Group Captives | Managed Care | Specialty Accident

 BAH AD2017-09 7/17 www.BerkleyAH.com

Berkley
Accident and Health
| a Berkley Company

or access to other benefits that are only available if payment is made within a specific timeframe.

Health plans can seek to preserve enforcement of their terms through diligent investigation and coordination with – and education of – all parties and payors as soon as claims are incurred. ■

Catherine Dowie advanced from The Phia Group's recovery department to The Phia Group's legal team in 2014 and took on the role of Manager of Legal Subrogation and Reimbursement Services in 2017. Catherine and her team are responsible for handling complex subrogation and recovery cases and recover millions of dollars each year for self-funded employers. Catherine also spearheads legal research efforts for The Phia Group, ensuring that Phia can assist health plans in taking full advantage of their recovery rights. Catherine not only assists The Phia Group's clients with cases that require litigation, but has worked on amicus briefs for cases before the Supreme Court of the United States.

Catherine is expected to graduate with her J.D. from Suffolk University School of Law in May of 2018. Catherine passed the Uniform Bar Exam in Vermont during her final semester of law school and will be seeking admission to the Vermont and Massachusetts Bars upon receipt of her degree. She earned her B.A. in American Government and Computer Science from Smith College and is also a Certified Subrogation Recovery Professional ("CSRP").

References

1 Dakotas & W. Minn. Elec. Indus. Health & Welfare Fund v. First Agency, Inc., 865 F.3d 1098 (8th Cir. 2017); Cent. States, Se. & Sw. Areas Health & Welfare Fund v. Am. Int'l Grp., Inc., 840 F.3d 448 (7th Cir. 2016); Cent. States v. Student Servs., 797 F.3d 512, 60 EBC 1857 (8th Cir. 2015); Cent. States, Se. & Sw. Areas Health & Welfare Fund v. Gerber Life Ins. Co., 771 F.3d 150 (2d Cir. 2014); Cent. States, Se. & Sw. Areas Health & Welfare Fund v. First Agency, Inc., 756 F.3d 954 (6th Cir. 2014); Cent. States, Se. & Sw. Areas Health & Welfare Fund v. Health Special Risk, Inc., 756 F.3d 356 (5th Cir. 2014); Cent. States, Se. & Sw. Areas Health & Welfare Fund v. Bollinger, Inc., 573 F. App'x 197 (3d Cir. 2014).