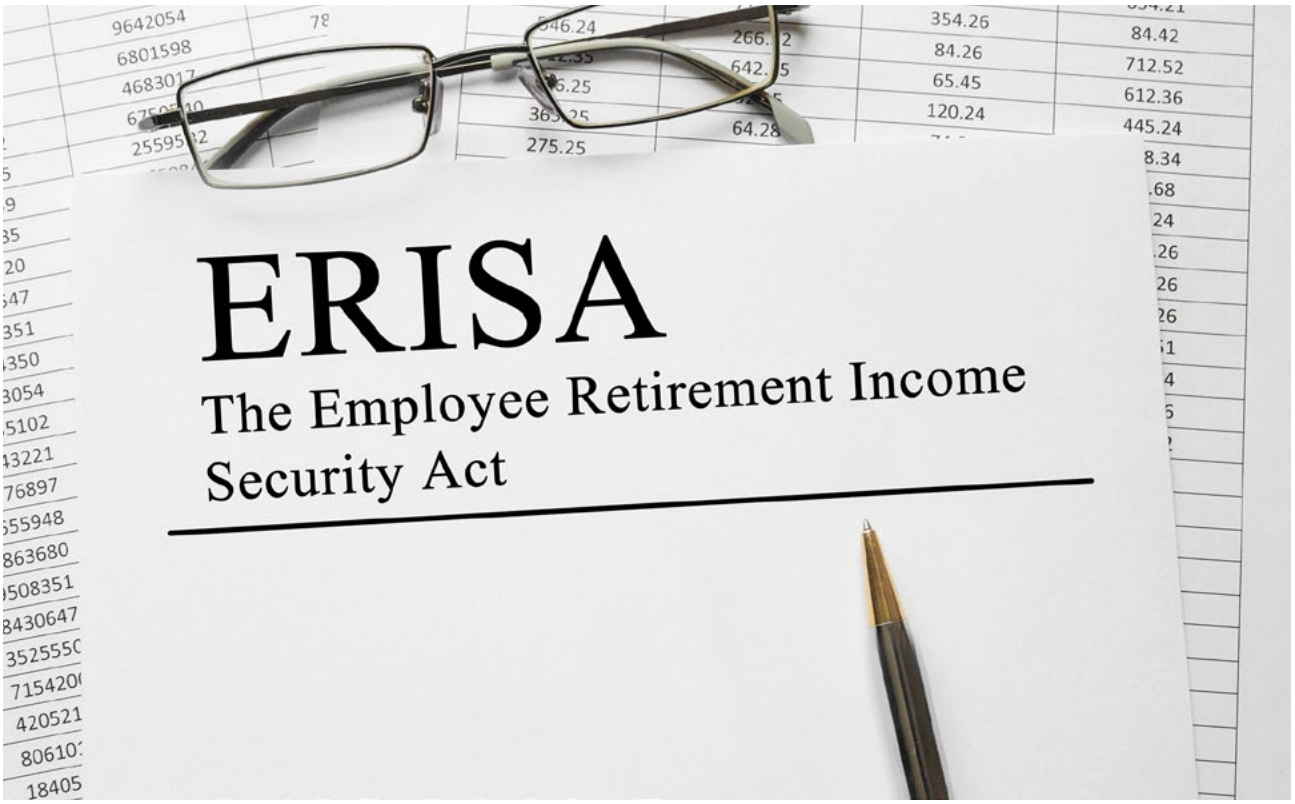

IN SUBROGATION: SUPERIOR CONTRACT LANGUAGE MATTERS

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The United States Congress enacted the Employee Retirement Income Security Act ("ERISA") in 1974 to protect employees and place requirements on pension and health care plans.

The legislation arose from the discourse and fallout that occurred after Studebaker-Packard (Studebaker), an automobile manufacturer that was very poorly fiscally managed, closed its plant in South Bend, Indiana, effectively eliminating employee pensions for thousands of employees.

The problem wasn't a new one or limited to Studebaker's closure, which came about in 1963, but rather a systemic one: the lack of corporate accountability in financial reporting and management of pension and health care plans poses significant risks, prompting Congress to protect employees nationwide.[1]


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Since that time, ERISA qualified employer-sponsored pension and health care plans preempt state laws and, as such, are exclusively regulated by ERISA (and the resultant federal cases that interpret ERISA throughout the jurisdiction of the United States). To be clear, ERISA is by no means a simple piece of legislation, and courts have often been called to interpret provisions of the statute in relation to employer-sponsored pensions, health plans and their respective beneficiaries.

In fact, over the past six decades, the U.S. Supreme Court has made several landmark rulings on health care subrogation cases, specifically impacting the interpretation and understanding of ERISA's reach in this area, as well as its restrictions on both employers and employees.

This article will focus on health care subrogation from an employer's perspective under ERISA, highlighting key ERISA requirements and outlining the best way to protect the assets of an employer-sponsored fund expressly in the plan's contract with the plan member.

From the outset, when a confirmed ERISA plan member has been injured due to an accident potentially caused by a third-party (someone other than the plan member), it is important to gather as much information about the accident and the plan as possible.

As an employer-sponsored plan, it should be easy to determine of which plan the member is an active participant and accordingly eligible for benefits.

However, for employees of larger organizations, there may be different plan designs and coverage options, so it is always best to confirm exactly which plan the member is participating in and therefore which plan they are eligible for benefits under when an accident or injury has occurred.

It is important to note, however, that not all health care plans are ERISA plans. ERISA, as will be discussed in depth below, has granted protections to plans and plan beneficiaries that improve a plan's ability to recover against a responsible third-party if the right steps are taken to protect the plan.

First, in order to qualify as an ERISA plan and to maintain a cause of action under ERISA, § 502 (a) (3) (B)[2], the plan needs to be defined as an "employee welfare benefit plan" or "employee pension benefit plan."[3]

Furthermore, the ERISA-governed plan must be established by the plan sponsor and maintained by a "written instrument."[4]

Lastly, while almost all private employer plans are subject to ERISA, church, governmental and state plans are generally excluded.[5]

For the sake of subrogation claims, once the employer or its recovery agent has confirmed the plan is governed by ERISA, then the plan fiduciaries, plan participants, and beneficiaries must look to § 502(a)[6] to determine the applicable causes of action.

Moreover, ERISA § 502 (a)(1)(B) allows a "participant" or "beneficiary" to bring an action (1) "to recover benefits due under the plan," (2) "to enforce rights under the terms of the plan," or (3) "to clarify his/her rights to future benefits under the terms of the plan."[7]

The § 502 (a)(1)(B) claim may be brought in either state or federal court.[8] ERISA § 502(a)(3) allows a "fiduciary, participant, or beneficiary" (1) "to enjoin any act or practice which violates the terms of the plan," or (2) "to obtain other appropriate equitable relief to either redress violations or to enforce the provisions of ERISA or the terms of the plan."[9]

With respect to actions brought under ERISA § 502(a)(3), the statute grants federal courts exclusive jurisdiction over these claims.[10]

An employer or its recovery agent should be careful to confirm the ERISA status and to not make the costly mistake of trying to treat a fully insured health plan the same as a self-funded ERISA plan.

To be clear, a fully insured health plan exists when the employer has purchased a group insurance policy from a health plan, insurer, or HMO to cover the health care claims that arise under the plan.

The other defining feature of a fully insured health plan is that state law would apply to its reimbursement rights.[11]

Since health care subrogation law varies from state to state and is often more restrictive to a plan's recovery rights than ERISA federal law, every attempt to clarify the ERISA status and preemptive rights should be made. It's often not easy to tell by the outward observance of plan operations, without delving into the plan documents and founding instruments of the plan.

In short, a self-funded ERISA plan is a plan sponsored by the employer and funded by contributions directly from its employees.[12] In most scenarios, self-funded plans contract separately with a third-party administrator ("TPA") to administer claims under the plan (although the claims are funded and paid with the employer's and employee's contributions alone and not by any purchased insurance policy).

Utilizing a TPA is allowed under ERISA because although the TPA assists the plan in processing and paying claims, it is still the self-funded plan that bears the risk for the claims.[13] Furthermore, self-funded plans also preempt state laws (not federal) that relate to employee benefit plans or regulate insurance.[14]

To determine the employer plan's rights, the contract between the plan (employer) and the beneficiary is the first place to look.[15]

The contract, the Master Service Agreement ("MSA") or Summary Plan Description ("SPD"), typically includes a provision which outlines the rights of each party to the contract under multiple benefit related scenarios, including payment of claims and/or responsibility for payment of claims or reimbursement of monies paid for claims when an injury or accident has occurred that may be deemed the responsibility of a third-party.

Once you have the document, be prudent in making sure that it is the actual plan document that governs the benefits being paid and is not simply an SPD.

In *Cigna v. Amara*, the Court found that the CIGNA SPD was not a "plan document," as it was only a summary and therefore did not properly outline all applicable plan provisions of an actual "plan document." Moreover, the Court held that only the terms of a plan (MSA and/or plan document) are enforceable, not the terms set forth in summaries.[16]

When an accident or injury involves a member of an ERISA plan, the employer-sponsored health plan must have expressly stated its very strong recovery rights in the plan document, addressing key issues that have been litigated through the years, many of which have been decided by the U.S. Supreme Court.

Additionally, the recovery provision addressing the plan's rights when an at-fault third-party causes injury to the plan member is critical for determining the employer's right to be reimbursed from any recovery made from said third-party for claims paid on the injured employee's behalf.

In *U.S. Airways, Inc., v. McCutchen*, a landmark U.S. Supreme Court case, the Court addressed the enforceability of a plan's contract head-on when ascertaining each party's respective rights when a recovery is made by an injured plan member.

The case in *McCutchen*[17] arose, when James McCutchen, an employee of U.S. Airways, participated in and received benefits from the company's self-funded health plan.

Unfortunately, McCutchen, while covered under the plan, was injured in a motor vehicle accident, sustaining significant injuries that necessitated the plan paying $66,866 for medical treatment on his behalf.

As a result of his injuries, McCutchen filed a lawsuit against the third-party who caused the accident. He subsequently recovered $110,000 from the third-party's liability policy and his own underinsured motorist coverage. The plan (employer) sought from his recovery the amount which they had expended on his behalf, relying on the following plan language from the contract:

> If [the plan] pays benefits for any claim you incur as the result of negligence, willful misconduct, or actions of a third-party…[y]ou will be required to reimburse for amounts paid for claims out of any monies recovered from third-party, including, but not limited to, your own insurance company as a result of the judgment, settlement or otherwise.[18]

The Court held that the "clear and unambiguous" contract language in the actual plan document/agreement between the employer and the employee controls a plan's right to be reimbursed from the settlement against the at-fault third-party.[19]

Key Issues that should be addressed and included in the plan language in support of the Employer's recovery rights:

- The plan has a first priority right to recovery from the settlement/monies available to the injured plan member as a result of the accident or injury.
- The plan should require recovery from the plan member's recovery or directly from the at-fault third-party regardless of whether the plan member has been partially or fully compensated for third-party injuries from the available total recovery.
- The member's recovery shall not be construed as being only for pain and suffering and must include the medical claims paid by the employer.
- The plan will not participate in the common fund (paying for the employee's personal injury legal fees) or in the ascertaining of the settlement or recovery on behalf of the member. The member shall bear sole responsibility for the costs of obtaining the recovery.
- What is expressly written in the plan document matters as where the plan is silent or ambiguous, the plan member will have an equitable defense where there is a "gap" in the language.[20]

While *McCutchen* was a great result for those responsible for protecting the plan's assets when a plan member has been injured because of a third-party accident, it does place a responsibility on the plan to have the proper recovery language expressly written into the plan document's subrogation provision.

The plan must have clear and strong terms of reimbursement in its written contracts for when these accidents and injuries to the plan's beneficiaries arise. Ignorance of the law or how to address it is no excuse. The language is either there or it's not. If it's not in the contract, then the employer may not be able to recover the benefits that it paid out for the accident.

Additionally, in that instance of missing language, the Court allowed plan beneficiaries to argue equitable defenses against the plan's alleged recovery rights.[21] So, what does all this mean for employers and sponsors of self-funded ERISA health plans?

First, the plan has a fiduciary obligation to protect the fund, and, secondly, unlike when there is an insurance policy, this money is contributed by employees and set aside for them to actually "fund" the plan to pay for coverable claims from the "fund" when an employee/plan member requires medical treatment. It is the plan's fiduciary responsibility to proceed in the best interest of the plan and its participants and beneficiaries to protect plan assets.

By not having the right language in the contract with the employee, the employer may be unable to recover from the third-party settlement and subject itself to a claim for breach of its fiduciary obligation to ALL plan members of the fund for inadequately protecting plan assets.

Indeed, this is a tricky landscape to navigate properly. For that reason and given what's at stake for the plan, employers are strongly recommended to consult with experts to ensure they are doing all they can to protect plan assets in such matters that are often litigated by plaintiff's attorneys seeking to maximize recovery for their client, the injured plaintiff/employee. ■

End Notes

1 Sarah Steers, ERISA History, Jurist, (Oct. 4, 2013, 12:01 PM), http://www.jurist.org/feature/2013/10/erisa-history.php.
2 § 502(a)(3), 29 U.S.C. § 1132(a)(3).
3 29 U.S.C. § 1002 (3).
4 29 U.S.C. § 1102 (a)(1).
5 ERISA § 4, 29 U.S.C. 1003.
6 29 U.S.C. § 1132
7 ERISA §502(a)(1)(B), 29 U.S.C. §1132(a)(1)(B).
8 Id.
9 Id.
10 Id.
11 FMC Corp. v. Holliday, 498 U.S. 52 (1990).
12 John MacDonald, Health Plan Differences: Fully-Insured vs. Self-Insured, Employee Benefit Research Institute, www.ebri.org/.../ffe114.11feb09.fin.
13 Id.
14 FMC Corp., supra note 15.
15 U.S. Airways, Inc., v. McCutchen, 133 S. Ct. 1537 (2013).
16 Id.
17 Id. at 1543.
18 Id. at 1543.
19 Id.
20 Id.
21 Id.