



THE LIEN, MEAN, SUBROGATION MACHINE

By Maribel Echeverry McLaughlin, Esq.

When you think of personal injury attorneys, you may imagine men in trench coats with cheesy tag lines with inflated promises, and commercials with ambulances blaring in the background. Fortunately, I do not like trench coats, my tag lines are only sometimes cheesy, and ambulances terrify me.

While attending law school, I worked for an attorney who became a state legislator, which meant I was forced to learn the ins and outs of running a practice in a very short period of time. That experience ultimately left a bad taste in my mouth for opening my own firm. Eventually, after graduating law school, I started my career as a junior associate in the personal injury firm down the street and became the partner's main resource for research... and coffee.

Working there opened my eyes to new experiences, such as the opportunity to practice law with a team of partners and senior associates. We met once a week and strategized on how to win the most amount of money for our clients and, obviously, for the firm. Sometimes those two goals conflicted with each other and we would work to find a resolution that would make sense for all parties involved.

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Interestingly enough, that typically meant negotiating with healthcare providers and health insurance plans. In my tenure with this firm, I may have come across at least five (5) liens from private self-funded benefit plans. After much negotiation and push back from the plans, each of them were resolved. But it was not until I left that world that I realized how little personal injury attorneys actually know about the Employment Retirement Income Security Act (ERISA), self-funded health plans, and how they function in our world.

Overview of the Law:

In 1990, the United States Supreme Court ruled in *FMC Corp. v. Holliday*¹, that state law will not prevent a private self-funded plan governed under ERISA from obtaining reimbursement. Additionally, the Court ruled that any state law that is contrary to ERISA would

be preempted if the Plan's language so provides or there is a clear contradiction to the federal law.

For years, this law went unchallenged until 2006, when Mr. and Mrs. Sereboff were involved in a motor vehicle accident, and the Mid Atlantic Medical Services Employee Health Plan paid related claims in the amount of \$74,869.37.

The Sereboffs eventually settled their personal injury claim for \$750,000.00 and did not reimburse the self-funded Plan. The Plan eventually filed suit in the U.S. District Court for the District of Maryland, claiming a right to collect from the Sereboffs under § 502(a)(3) of ERISA.

The Court ruled in *Sereboff v. Mid Atlantic Medical Services*² that the federal courts have subject matter jurisdiction over actions where an ERISA-covered Plan seeks equitable relief. The Court further ruled that if an ERISA-covered Plan has paid medical benefits arising from an act or omission of a third-party for which a plan participant obtains a settled or jury award, the Plan has a right to enforce the terms of the Plan Document pursuant to ERISA 502(a)(3), for equitable relief.

Shortly after, the Supreme Court held again in *US Airways, Inc. v. McCutchen*³, that the terms of an ERISA-covered Plan would be enforced as written, despite any contrary state law or equitable principle.



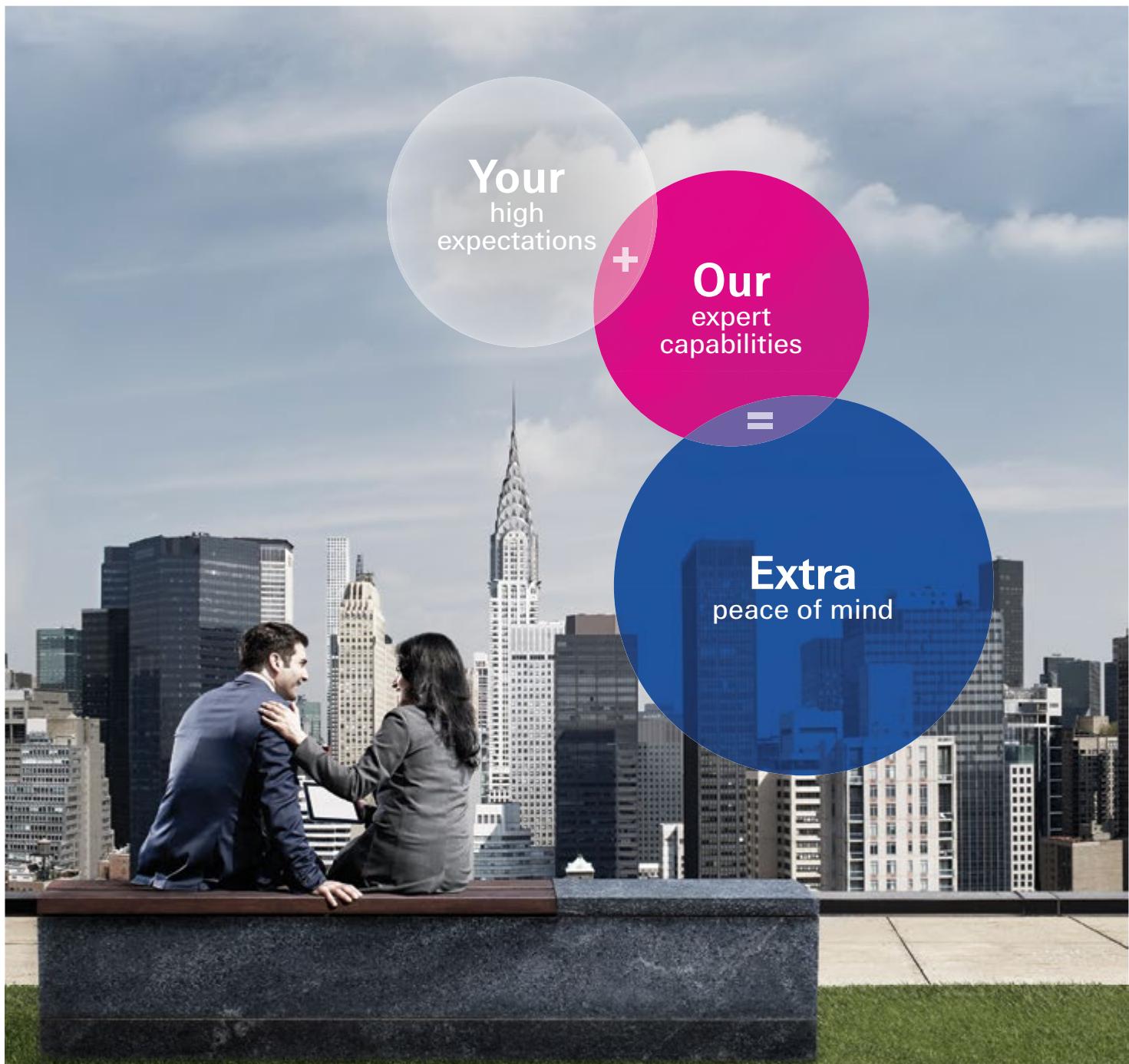
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This was a landmark decision as it clarified that the "common fund" and "made-whole" doctrines could be disclaimed by an ERISA Plan in their Plan Document language. Whether adopted by state statute or relying on common law, neither of these doctrines can be used to defeat the Plan's right of full reimbursement as long as there is clear language in the Plan Document disclaiming the application of these principles.

Most recently, the Court decided in *Montanile v. Board of Trustees of Nat. Elevator Industry Health Benefit Plan*⁴, when a participant in an ERISA plan dissipates a third-party settlement on non-traceable items, the plan fiduciary may not bring suit to attach the participant's separate assets⁵. In other words, the Plan is only entitled to "their" money, but if it cannot be traced in an asset that was paid for with that money, then the Plan cannot sue for the member's general assets.

Decisions to Settle and Negotiate Liens by Personal Injury Attorneys:

While working for the trench coats, I realized that large insurance carriers, such as Blue Cross, United, etc., were willing to settle without much work and negotiation. At that time, it was easier to settle those liens than trying to work out a balance with a provider and proved to be more financially sound for the member.

After negotiating with many private self-funded Plans, I realized they were, and still are, the most difficult to negotiate. Attorneys will advocate zealously for their clients, whether they are victims of a horrific car accident

case, or for the Plans themselves. I received a letter not too long ago, from a lien resolution company in California, that was fifteen pages long, filled with arguments for the Plan to reduce their lien. Interestingly enough, after doing a quick internet search, it happens to be a string of arguments that many plaintiff attorneys are making to work through the private self-funded Plans governed by ERISA.

Some of these arguments are easy to argue away, such as the common fund and made-whole arguments, especially if they are disclaimed in the Plan's language.

The attorney from the lien resolution company was representing a member and their attorney, for reimbursement and subrogation claims. He sent me exactly what the member's attorney had requested for a reimbursement, and interestingly enough, the Plan had previously refused to reduce their

interest. He made many arguments throughout those 15 pages and frankly only two stuck out to me.

He titled one "Deficiencies in the Plan Documentation"⁶; in which he alleged that the Plan administrator must properly disclose any reimbursement provision to Plan beneficiaries in the Plan document.

He opined that the Ninth Circuit, 29 C.F.R. 2520.102-2(b) requires that "(1) the description of summary of [a] restrictive provision must be placed in close conjunction with the description or summary of benefits, or (2) the pages on which the restrictive provision is described must be noted adjacent to the benefit description"⁷.

The Court ruled that a reasonable Plan participant should not have to read every provision of a Plan's documentation in order to ensure they have read every restrictive provision⁸. The Court invalidated an inconspicuously-placed





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provision where the limitations for third party liability and out-of-pocket maximums were separated from the Plan's description of benefits by multiple unrelated plan provisions, without cross-references or indexing.

Our client's Plan had the reimbursement provision entirely isolated from other provisions of the Plan's documentation, and as such, would be invalidated by the Ninth Circuit.

The second argument cited was titled "Out of Pocket Maximum⁹." Here, he alleged that the Plan Document provided that individual beneficiaries would not pay more than a specific amount toward medical expenses. He explained that the "Out of Pocket Maximum" should be a defined term, but in this document, it was not. He also pointed out that the Plan Document does not define the terms "reimbursement", "subrogation", "lien" or other terms relevant to the third-party provision¹⁰.

As a former plaintiff's attorney, I can understand and appreciate the zealous advocacy that this attorney was providing to his client. It is difficult to balance all the interests especially when the common understanding is that the insurance companies have an abundance of money and that this lien interest would not break the bank.

In reality, after explaining the concept of self-funding and paying claims out of the pool of money for all members that pay their premiums, attorneys tend to appreciate the advocacy we provide on behalf of these Plans. These are not big bad insurance

companies, as many people perceive; these are usually smaller companies, with the hope of keeping the risk low, and claims paid. The opportunity for reimbursement for third party claims keeps the premiums low for the members, a concept that eventually attorneys or members understand completely.

After reviewing these arguments with other attorneys in our office, we agreed that we should amend our major medical template to include these definitions and add references to certain places in our Flagship Plan document, in order to avoid these sorts of arguments from other attorneys in the future.

Specialists in plan document drafting and subrogation attorneys will be able to review your plan document to ensure we address all of the arguments to meet the needs of self-funded groups and their members. ■



Maribel E. McLaughlin joined The Phia Group as a subrogation attorney in 2016. Previously, she was a plaintiff's attorney, representing clients in medical malpractice and personal injury lawsuits. She is licensed to practice in the Commonwealth of Massachusetts and in the United States District Court for the District of Massachusetts.

References

- 1 *FMC Corp. v. Holliday*, 498 U.S. 52 (1990)
- 2 *Sereboff v. Mid Atlantic Medical Services*, 547 U.S. 356 (2006)
- 3 *US Airways, Inc. v. McCutchen, et al.*, 133 S.Ct. 1537 (2013)
- 4 *Montanile v. Board of Trustees of Nat. Elevator Industry Health Benefit Plan*, 135 S.Ct. 651 (2016),
Id. at 655
- 5 *John J. Rice, Esq, LTR #3 to Phia - Clariza* (2018)
- 6 *Spinedex Physical Therapy USA Inc. v. United Healthcare of Arizona, Inc.*
(9th Cir. 2014) 770 F.3d 1282, 1295
- 7 *Id. at 1296.*
- 8 *John J. Rice, Esq, LTR #3 to Phia - Clariza* (2018)
- 9 *Id.*



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