UNDERSTANDING THE LEGISLATIVE EFFECTS ON STATE-LAW BENEFIT PLANS

written by Harry Horton

When it comes to subrogation and reimbursement, self-funded employee benefit plans enjoy greater latitude when it comes to enforcing the terms of the plan document.

To be certain the landmark *US Airways, Inc. v. McCutchen*[1] case indicated that these benefit plans receiving preemption of state law under ERISA can enforce the terms of their plan, as written, despite any contrary state law or equitable principle.

As a result, ERISA plans undoubtedly obtain greater recoveries through subrogation and reimbursement. It is undisputed that these recoveries directly contribute to the plan's cost savings and thus reduce the overall cost to the plan. These savings are enjoyed by plan participants in the form of either greater benefits or a reduced contribution dollar amount during the next fiscal year.

Not all self-funded employee benefit plans however receive these benefits. ERISA provides that four distinct types of benefit plans are specifically carved out from enjoying preemption of state law. These are government/municipality plans, tribal plans, religious affiliations, and multiple employer welfare arrangements.

Focusing on government/municipality plans, these self-funded plans are regulated by state law rather than ERISA. A self-funded benefit plan is funded by the plan sponsor and/or employees. Since both the plan sponsor and employees of a municipality plan receive their funding or salary from state taxpayer money, ERISA logically concludes that the state would have the authority to regulate them.

However, this is where the logic appears to end when it comes to regulating self-funded benefit plans in certain states. Take New Jersey for example – the state legislature adopted a collateral source rule which barred a plaintiff from recovering medicals that were paid by a third-party (ex: an insurer).[2] The state Supreme Court held that this rule also barred subrogation and reimbursement.[3] In 2010, that same Court ruled that even municipality plans are subject to this regulation despite the ambiguity in the statute.[4]

The logic of this decision rests on the Court's analysis of legislative intent. The Court states, "There is no evidence to suggest that the Legislature intended to favor public entities under Section 97 or that it was not intended to apply to amounts received by a tort plaintiff from public sources… the best indicator of [Legislative] intent is the statutory language."

The Legislature had not commented on whether this is true or not – the Court simply determined that since the Legislature was silent, it could not have intended a different result for municipality plans.

It is undeniable that our country is facing an unprecedented crisis when it comes to the inflating costs of healthcare. In fact, many political hopefuls are running entire campaigns on addressing this problem. We have all heard of the "death spiral" – the idea that the affordability of healthcare will continue to spiral out of control as the "healthy" population leaves the risk pool.

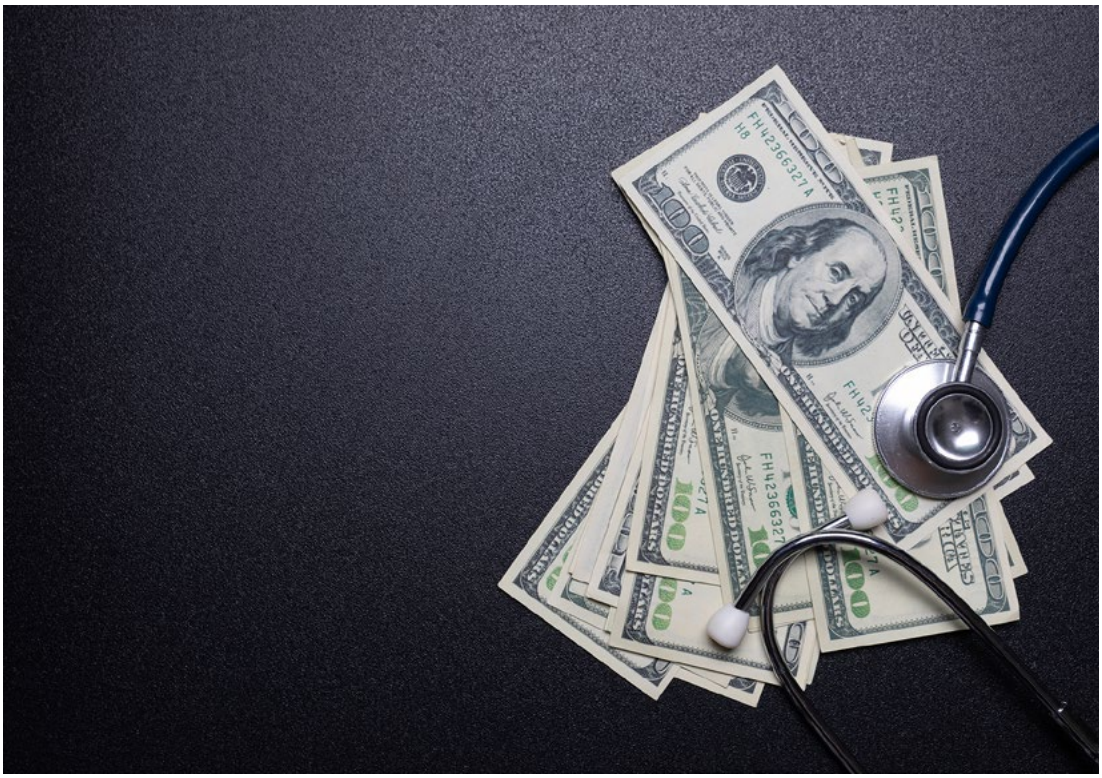
With the removal of the individual mandate, millions of healthy Americans left the risk pool which, inevitably, will result in higher premiums or contributions from those individuals who choose to maintain coverage. Subrogation and reimbursement cannot fix this problem, nor can it fix other pertinent problems such as inconsistent medical billing.

With that said, it makes no logical sense why a state legislature would prohibit the state from recovering medical expenses effectively paid by taxpayer money from third-party liability cases.

The effect of these anti-subrogation rules against municipality plans goes further than one might imagine. The obvious effect is that the lack of cost savings generated by the specific plan will result in higher dollar amount contributions from the plan participants.

The employees that assist our state and local governments are forced into a situation where their paychecks take hits year after year as the plan fails to recover on third-party liability cases. To make matters worse, consider the source of both the plan sponsor and employee's funding: taxpayer money.

On the topic of legislative intent, it is important to look at why the state legislature enacted a collateral source rule to begin with. The Court in New Jersey made a perfect reference to this point. "The purpose underlying N.J. Stat. Ann §2A:15-97 is twofold: to eliminate the double recovery to plaintiffs that flowed from the common-



law collateral source rule and to *allocate the benefit of that change to liability carriers."*

This logic makes little sense on either point. The collateral source rule does in fact eliminate double recovery to plaintiffs, however that point is moot when you consider that the collateral source rule only applies in scenarios where, usually, an insurer is the entity paying the medical bills.

If the insurer was able to effectuate a subrogation/reimbursement provision, then there would be no double recovery! In fact, that is the entire rationale behind equitable subrogation.

More importantly, however, is the State's concern with reducing the exposure of liability carriers. If you read between the lines, the State made a conscious decision to lower the cost of liability insurance at what is effectively the expense of health insurers.

The cost of liability insurance is a real problem and arguably disincentivizes certain professionals from engaging in their respective services. However, the State's answer to this problem is currently to shift the burden onto health insurers.

Liability insurance applies in instances where an individual or entity commits an act or omission causing injury, illness, or death to an individual. By limiting a plaintiff or insurer from recovering the medical bills associated with that injury, the state is giving tortfeasors a huge shield in the amount they should be liable for.

Why shouldn't a victim of negligence be able to hold a tortfeasor completely accountable for their actions? It can be argued that the collateral source rule and other similar laws is grossly unfair to the victims.

In the context of third-party liability cases, health insurers are undoubtedly victims. Of course, the nature of their injury is vastly different than the real injuries suffered by their plan participants. It makes little sense that the State would be so concerned with the increased unaffordability of healthcare costs and increased tax rates all the while shielding tortfeasors from their liability.

If an anti-subrogation state was serious about addressing the affordability of healthcare, they should remove restrictions such as the collateral source rule and adopt the ERISA model for subrogation and reimbursement. Plan participants should be able to claim the full extent of their damages.

Health insurers should be able to then recover those funds from the settlements and judgements awarded to the plan participants. Reform will be necessary to help prevent the increased cost this would have to liability carriers such that professionals are not discouraged from purchasing liability coverage. However, shifting the financial burden onto the victims of negligence cannot be the state's best answer.

If you are the plan administrator or a third-party administrator for a self-funded benefit plan subject to state law, it is imperative that you understand how your state legislature treats subrogation and reimbursement provisions within your plan document.

Having this knowledge enables you to forecast your estimated statistical recoveries ultimately

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resulting in better financial planning. At the end of the day, it is the plan administrator's fiduciary duty to prudently manage plan assets. Consulting with an expert in the subrogation and reimbursement field will give you the tools you need to help your employee benefit plan thrive for years. ■

Harry A Horton joined The Phia Group, LLC in October of 2017. As a Senior Claims Recovery Specialist in The Phia Group's recovery department, Harry has quickly established himself as an invaluable asset in reimbursement matters for self-funded benefit plans. Harry handles many of the company's most challenging and complex recovery matters across all jurisdictions. Harry spearheads negotiations between plan administrators, brokers, third-party liability attorneys, and plan participants on both state and federal law matters. His focus is on ERISA preemption, stop-loss / reinsurance, plan document review, coordination of benefits, dispute resolution and cost containment for self-funded benefit plans.

Harry earned his B.S. in Criminal Justice from Northeastern University. He then attended New England Law | Boston concentrating specifically in civil matters. Harry has prior experience working in both personal injury and legal malpractice litigation. After graduating law school, Harry passed the Uniform Bar Examination with a score sufficient for admission to all UBE jurisdictions. Harry's licensure is currently pending in the Commonwealth of Massachusetts.

References:

1) *US Airways, Inc. v. McCutchen, et al., 133 S.Ct. 1537 (2013)*

2) *N.J. Stat. Ann. §2A:15-97*

3) *Perreira v. Rediger, 778 A.2d 429 (N.J. 2001)*

4) *County of Bergen Employee Benefit Plan v. Horizon Blue Cross Blue Shield of NJ, et al., 988 A.2d 1230 (N.J. 2010)*