HEALTH INSURANCE AND ERISA SUBROGATION

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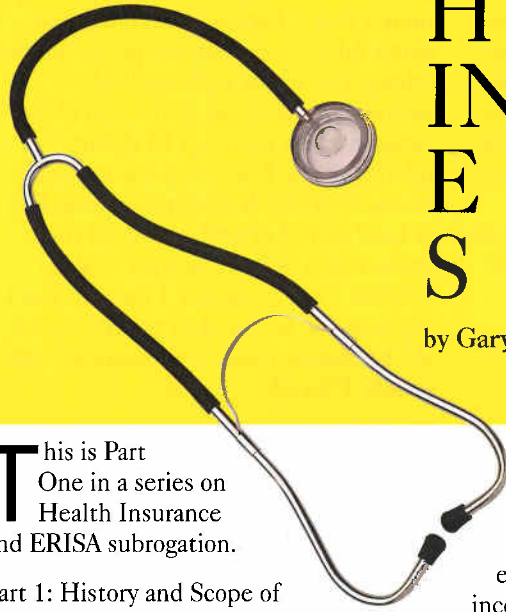

This is Part One in a series on Health Insurance and ERISA subrogation.

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PART 1: HISTORY AND SCOPE OF ERISA

Background. In the early 1970's, an increasing number of employees were participating in employee benefit Plans. Absent minimum standards, some of these Plans were depriving Plan participants of anticipated benefits.[1]

[1] 29 U.S.C. §1001(a). This is the "congressional findings and declaration of policy" provision of ERISA.

In response to this dilemma, President Gerald Ford signed the "Employee Retirement Income Security Act (ERISA)" into law in 1974. ERISA sought to protect employee benefit Plan participants by establishing minimum standards, "providing appropriate remedies" and providing "ready access to the federal courts."

Enactment and Purpose. Additionally, ERISA was designed to standardize the regulation of employee benefit Plans by "preempting the field for federal regulation, thus eliminating the threat of conflicting or inconsistent state and local regulation." Put another way, by enacting ERISA, Congress was attempting to protect employees from unfair employee benefit Plan practices while federally protecting them from inappropriate remedies. The statute established fiduciary duties to regulate those with authority over the assets and operation of employee benefit Plans. These duties are brought to bear by private civil enforcement mechanisms applicable to Plan fiduciaries, participants, and beneficiaries, and complemented by mechanisms for official enforcement by the Secretary of Labor. Specific problems Congress attempted to address with ERISA includes:

1. Inadequate reporting and disclosure by employees (sponsors) to regulators, participants and beneficiaries;

2. Inadequate operational standards (funding, vesting, minimum participation);

3. Insecurity of funds and destruction of beneficiaries' and participants' financial expectations;

4. Inadequate standards of conduct for those with control over administration and\or assets; and

5. Inadequate enforcement and unfair dispute resolution mechanisms.

One important point to be made about ERISA is that it does not require employers to establish or maintain benefit Plans. Providing benefit Plans is completely voluntary, although employers are strongly encouraged to provide benefits by favorable tax laws, collective bargaining, and basic economic incentives. ERISA only comes into play to regulate those Plans which an employer has already chosen to establish and maintain. Therefore, Congress had to be careful not to over-regulate so as to discourage the creation of benefit Plans. This tension still exists and may become the rationale for future legislation or court decisions on ERISA.

Scope of ERISA. §1003 of ERISA frames the scope of the Act's coverage.[2]

[2] 29 U.S.C. §1003 (1994).

The scope of ERISA is broad because it applies to any employee benefit plan that is established or maintained by either an employer or an employee organization which is engaged in activities of commerce.[3]

[3] *Id.* §1003(a)(1)-(3).

ERISA does not apply to several stated exceptions, namely: government plans; church plans; plans "maintained solely for the purpose of complying with applicable workers' compensation laws"; plans "maintained outside the United States"; and funded "excess benefit plans".[4]

[4] *Id.* Sections §1003(b)(1)-(5).

In general, ERISA will apply to a self-insured or self-funded employee benefit Plan and not to an insured or unfunded employee benefit plan.[5]

[5] *FMC Corporation v. Holliday*, 49 U.S. 52, 111 S.Ct.403 (1990).

Definitions - The Language of ERISA. Like any comprehensive and detailed statute, ERISA has its own language. Below are some of the more commonly encountered definitions in the subrogation context. Special care should be taken to evaluate each subrogation case to determine

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where the various parties fit into this definitional scheme. No less care should be taken in reviewing the language of the Plan documents to determine the specific rights and obligations of each of the defined parties.

Sponsor: The "Plan sponsor" is the employer in most circumstances. Unions or employer organizations which establish multi-employer Plans may also be Plan sponsors.

Administrator: Under the statute, the administrator is the person so designated in the Plan document. In the medical benefits context, it is usually an insurance company or other company providing the service to the sponsor for a fee. In the industry, the insurance company acting as an administrator is called a "third party administrator" or "TPA".

Beneficiary: The term beneficiary means a person designated by a participant or by the terms of a Plan who is entitled to benefits under the Plan. Spouses and children of employees are usually beneficiaries.

Participant: A participant is any employee or former employee who is eligible for benefits or whose beneficiaries are entitled to benefits.

Fiduciary: Under the statute, a person is a "fiduciary" with respect to a Plan to the extent he or she exercises any discretionary authority respecting management of the Plan or disposition of Plan assets. The TPA will usually qualify as a fiduciary because the Plan will ordinarily give it authority to determine entitlement to benefits under the terms of the Plan. In circumstances where the sponsor (employer) maintains discretionary authority, it will be a fiduciary.

The Plan: The term "Plan" is defined in the statute to refer to either a welfare or pension Plan or both. An "employee welfare benefit Plan" or "welfare Plan" is any Plan, fund, or program maintained by the employer which was established for the purpose of providing for its participants and beneficiaries, through the purchase of insurance or otherwise, medical, surgical or hospital care benefits, or benefits in the event of sickness, accident, death, disability, unemployment, vacation benefits, training programs, day care, scholarship funds or prepaid legal services, etc. Subrogation will only apply to welfare benefit Plans that provide health insurance.

Courts have consistently held that the "typical managed health care Plan" falls within the ERISA definition.[6]

[6] *Schwartz v. FHP International Corp.*, 947 F. Supp. 1354, 1358 (D. Ariz. 1996); and *Roessert v. Health Net*, 929 F. Supp. 343, 346 (M.D. Cal. 1996).

Trust, Contract, and Labor Law Parallels. ERISA and the case law interpreting it are heavily influenced by the common law of trusts, contracts, and federal labor law. One or more of the differing policies and doctrines underlying these areas may provide the rationale for decision on ERISA matters. In the subrogation context, contract law issues will likely predominate.

Trust Law. Notions of the high standards of care arising from the law of trusts permeate the provisions of ERISA. It codifies the common law duties of trustees and applies them to ERISA fiduciaries. Trust concepts regulate how fiduciaries handle assets and manage the Plan, as well as the remedies and penalties applicable to breaches of fiduciary duty. Delivery of benefits is one of the primary duties of Plan fiduciaries, and enforcement of this duty is a fundamental element of fiduciary law under ERISA. Likewise, another of the primary fiduciary duties is to administer the Plan according to its terms.

Contract Law. The common law of contracts influences the area of benefit claims. For many purposes particularly relevant to welfare benefit Plans, the Plan document is considered a contract between the sponsor, the administrator, the participants and beneficiaries. Under older law, employee benefits were considered gratuitous and revocable at will by the employer. Now, although establishing a Plan is not mandated by ERISA, if benefits are provided they are considered deferred compensation for the services rendered by the employee. Continued employment is viewed as consideration for the benefits. Accordingly, the employer and employee must comply with the conditions of the Plan. Often, where the common law of trusts does not provide the rationale for decision, contract doctrines will fill the gaps. And in regard to subrogation, the subrogation/reimbursement provisions in the Plan document is the source of the Plan's right to recover from third parties. Accordingly, the courts will look to the subrogation/reimbursement provisions to determine the limitations and qualifications of the Plan's rights vis-a-vis the participant/beneficiary, and vice versa. Ordinary doctrines of contract interpretation will generally apply.

Labor Law. Employee benefits are considered a part of the bargain between labor and management. The National Labor Relations Act (NLRA) requires the employer to bargain in good faith regarding wages and other terms and conditions of employment, which includes benefits. Also, there are provisions in ERISA which are directly modeled after key provisions of the NLRA. This labor law influence has served to make it clear that, in the legal relationship between employer and employee, benefits are to be accorded the same status as wages and other conditions of employment.

Federal Common Law of Employee Benefits. In enacting ERISA, Congress encouraged the courts to develop a body of federal employee benefits law, taking into account the special nature and operations of employee benefit Plans. Congress recognized that the specific requirements of ERISA could not cover every conceivable circumstance. Therefore, even if the statutory text does not regulate a matter, it could be governed by decisional law. If there is no statute or decision on point, lawyers can make new law. In formulating this federal common law, the courts are permitted to take into account other federal and state statutes and cases which are consistent with ERISA's underlying policies.

Therefore, though state law is preempted even if consistent with ERISA and the terms of the Plan, courts can still look to state law for guidance in establishing the federal common law. Thus, state subrogation law can sneak in through the back door. For example, as discussed further below, this notion was used by one circuit court to apply the made whole doctrine in an ERISA subrogation case to deny the Plan's subrogation recovery. But one thing is certain: The Plan can preclude such subrogation law by the express terms of the Plan document. If the Plan's terms are inconsistent with a state law doctrine, it will not be applied.