

# Health Insurance & ERISA Subrogation

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## PART 2: WHAT IS AN ERISA PLAN

In order for a Plan to be ERISA-qualified, it must be an "employee welfare benefit Plan." The ERISA statute defines a "welfare benefit Plan" as follows:

"The terms 'employee welfare benefit Plan' and 'welfare Plan' means any Plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such Plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or daycare centers, scholarship funds, or prepaid legal services, or (B) any benefit described in § 302(c) of the Labor Management Relations Act, 1947 (other than pensions or retirement or death, and insurance to provide such pensions)." 29 U.S.C. § 1002(1).

The ERISA statute makes clear that the "Plan" is an entity which may sue and be sued. The "Plan" is also used in the industry to refer to the Plan documents. The Plan documents include the master Plan and "Summary Plan Description" (SPD) which the employer distributes to the participants. The SPD must be consistent with the master Plan document, must contain all of the relevant language important to subrogation, and yet must be simple enough that the employee can understand it. Although the "Plan" is an entity under law, it is not corporeal - it is essentially a piece of paper - but functions like a contract which governs how the sponsor, administrator, participants and beneficiaries should behave and relate to one another. Like a corporation, the Plan must act through others, usually the Third Party Adjuster

(TPA) or the Plan sponsor. The TPA is usually given duties by the Plan document and may act on behalf of the Plan for purposes of legal actions. The sponsor may act on behalf of the Plan for legal and other purposes. If they have sufficient discretionary authority when acting for the Plan, the TPA, the sponsor, and sometimes other persons may be "fiduciaries" for the Plan to the extent that they exercise discretionary authority over Plan assets.

### *Self-Funded Plans Versus Insured Plans.*

From case law we know that whether or not a Plan is "ERISA-qualified" depends on whether or not the Plan is funded or unfunded.<sup>1</sup> Funded means "self-insured". This means that the employer pays the benefits directly or through a trust fund established for that purpose. Unfunded means that the employer does not pay the benefits, but that the employer has purchased an insurance policy via the Plan, and an insurance company pays the losses. An unfunded Plan, although subject to ERISA, may be indirectly regulated by state law. This is the result of confusing interplay between the preemption and savings clauses,<sup>2</sup> which will be discussed and explained in Parts 4 and 5 of this series. As a result, the insurance company that insures the Plan is subject to state subrogation law just like any other insurance subrogation case. Generally, the favorable subrogation effects of ERISA discussed below are only applicable when the Plan is self-funded.

The term "ERISA-qualified" is actually a misnomer. A welfare benefit Plan may be "ERISA-covered" even though it is not "ERISA-qualified". Only pension Plans are required to be "qualified". A court will ask whether "from the surrounding circumstances a reasonable person could ascertain the intended benefits, beneficiaries, source of financing, and procedures for receiving benefits."<sup>3</sup> This so-called Donovan test is evidence that the courts have become more sophisticated in examining

whether a "Plan, fund, or program" is ERISA-covered". ERISA either applies to a welfare benefit Plan or it does not. There still may be compliance deficiencies with the Plan, but that is a separate issue that more than likely will not impact upon subrogation/reimbursement recovery efforts. If the particular Plan at issue satisfies the Donovan test, then the "Plan" will likely be held to be an ERISA-covered "Plan". If an affidavit is presented in support of a Motion for Summary Judgment that satisfies the elements of the Donovan test, and the participant or beneficiary cannot controvert any of the facts, then the affidavit is sufficient in most cases to establish that the Plan is an ERISA-covered Plan.<sup>4</sup> There may still be compliance issues that are raised, however, such as whether or not a Form 5500 was filed or can be located. The existence of a Form 5500 does not necessarily mean that a subrogation/reimbursement provision is not enforceable, and it certainly does not mean that the "Plan" is a "Plan". If the Donovan test is satisfied, then the only other question that may be raised against the Plan is whether the Plan falls within the "safe harbor" established by the Department of Labor. This "safe harbor" exempts a Plan from ERISA coverage in a narrow range of circumstances. The "safe harbor" regulation does not even apply to self-funded Plans.<sup>5</sup> Additionally, the employee must pay the entire cost of contribution for the safe harbor regulation to apply, and the safe harbor does not apply if the employer "endorses the Plan".

*Stop-Loss Coverage.* What if the Plan is partially funded and partially unfunded? This describes the "stop-loss" coverage situation, which is like reinsurance for benefit Plans. A Plan or an employer may purchase stop-loss coverage to recover what it pays out for higher losses. For instance, where the loss from any one occurrence exceeds \$30,000, insurance will pick up the excess.

For the entire loss, the self-funded Plan would respond with Plan funds, but it would be protected (reimbursed) for severe losses by the stop-loss policy.

Naturally, a Plan could also purchase stop-loss coverage for all losses in excess of a very low amount, say \$500, in an attempt to obtain the benefits of ERISA while functioning like an unfunded (insured) Plan with a \$500 deductible. The Plan would merely be a conduit for claims from participants to the stop-loss insurer. Could the Plan obtain the benefits of preemption and ERISA with this scheme, even though it would be essentially unfunded? Probably not. The courts would see through this scheme. At what level of stop-loss coverage will ERISA preempt state law? The answer is “it depends on the Plan’s loss experience and how often the stop-loss coverage is called upon by the Plan”.

Stop-loss coverage must be less like direct insurance of the participants and beneficiaries and more like reinsurance for the Plan itself. In one Fifth Circuit case, the court said that if the Plan paid only the first \$500 of the claim, leaving all else to the insurer and labeling its coverage “stop-loss” or “catastrophic” coverage, this would not mask the reality that it is close to a simple purchase of group accident and sickness

participants and beneficiaries.<sup>8</sup>

In the Wisconsin case of *Ramsey County Medical Center, Inc. v. Hartzell Corporation Employee Trust Fund*,<sup>9</sup> the issue was whether or not this was an ERISA-qualified Plan so as to preempt the Wisconsin “made whole doctrine”. The trial court had concluded that ERISA did not preempt the application of Wisconsin law because Hartzell Manufacturing’s purchase of stop-loss insurance rendered the Hartzell Plan “insured”. The trial court therefore concluded that under Wisconsin subrogation law, the Hartzell Plan was not entitled to subrogation until the beneficiary had been made whole. The Court of Appeals indicated that the sole issue in this case was whether or not the purchase of stop-loss insurance rendered the Plan an “insured Plan” subject to state law. The court noted that Hartzell Manufacturing purchased the stop-loss policy which would cover losses after a certain amount was paid in a given year. The stop-loss policy was held not to be health insurance and it did not pay benefits directly to the participants. Rather, the policy was designed to protect Hartzell Manufacturing (“the Plan sponsor”) from catastrophic losses. The policy did not cover participants of the Plan, but instead covered the Plan itself.

insurance and even if the stop-loss insurer becomes insolvent. Conversely, if the employer becomes insolvent, the solvency of the stop-loss insurer may not benefit Plan participants and beneficiaries. This is because their claims against the insurer would be derivative of the Plan’s claim against the insurer, which arises only after the Plan actually makes benefit payments beyond the agreed attachment point. In contrast, when a Plan buys health insurance for participants and beneficiaries, the Plan participants and beneficiaries have a legal claim directly against the insurance company, thereby securing the benefit even in the event of the Plan’s insolvency. Participants and beneficiaries in self-funded Plans may not have the security of the insurance company assets because stop-loss insurance insures the Plan and not the participants.<sup>10</sup>

Therefore, the argument to be made is that even in stop-loss insurance situations, the stop-loss carrier may pay benefits as a third party adjusting company to the member but not as an insurer. The insured/insurer relationship is only between the stop-loss carrier and the Plan. Courts have interpreted the definition of what is an “employee welfare benefit Plan”.<sup>11</sup>

## In order for a Plan to be ERISA-qualified, it must be an *Employee Welfare Benefit Plan*.

insurance directly covering the participants and beneficiaries.<sup>6</sup> Therefore, the court said it looked beyond the form to the substance of the relationship between the Plan, the participants, and the insurance carrier to see whether the Plan is in fact purchasing insurance for itself and not the Plan participants, recognizing that as insurance is less for catastrophic loss, it increasingly like accident and sickness insurance for the Plan participants.<sup>7</sup> Since the stop-loss coverage in *Granatelli* had only been called upon twice in five years to pay larger losses, the support of the Plan’s assertion that it was indeed insurance for the Plan, and not simply for the

Therefore, they concluded that the stop-loss insurance did not alter the uninsured status of the Hartzell Plan and that ERISA preempted the application of the made whole doctrine in Wisconsin as to this Plan.

In one 4th Circuit case, the court explained how stop-loss insurance provides protection to a self-funded Plan but does not elevate the Plan from funding all of the benefits promised:

Under a self-funded Plan, the employer who promises the benefit incurs the liability defined by the Plan’s terms. That liability remains the employer’s even if it has purchased stop-loss

To fall within ERISA, the employee benefit Plan must be:

1. a Plan, fund or program that is;
2. established or maintained by an employer or an employee organization; and
3. for the purpose of providing for its participants’ or its beneficiaries’ medical, surgical or hospital care, or benefits in the event of sickness, accident, disability, death or unemployment or the case in benefits, apprenticeship or other training programs or day care centers, scholarship funds or prepaid legal services.<sup>12</sup>

### **A Plan is not an ERISA Plan if:**

1. the employer makes no contributions toward the premiums;
2. the employer participation is voluntary;
3. the employer's sole functions are, without endorsing the program, to allow the insurer to publicize it to the employees, to collect payments through the payroll deduction, and to remit them to the insurer; and
4. the employer receives no compensation for administering the program other than reasonable compensation for services rendered in connection with the payroll deductions.<sup>13</sup>

### **Plans Not Subject to ERISA.**

*Government Plans and Church Plans.* Some government Plans and church Plans are specifically exempted from ERISA and therefore will be subject to state law. Subrogation under these kinds of Plans is the same as ordinary state law subrogation. If the Plan insures employees of a federal or state governmental agency, or any subdivision or instrumentality thereof, it is a government Plan exempt from ERISA.<sup>14</sup>

*Trade Association Plans.* Trade association Plans for the self-employed are not subject to ERISA.<sup>15</sup>

*Plans that Cover Owners and Not Employees.* Plans which cover owners and not employees are also not covered by ERISA.<sup>16</sup>

*Multi-Employer Plans.* Multi-employer Plans are also not automatically covered by ERISA. A group of similar employers who buy coverage as a group do not qualify as an ERISA Plan.<sup>17</sup> In addition, a multi-employer Plan that is an entrepreneurial venture does not qualify as an ERISA Plan.<sup>18</sup>

*Entities Not Engaged in Interstate Commerce.* Entities which are not engaged in interstate commerce are also not subject to ERISA.<sup>19</sup>

### **Subrogating Non "ERISA-Qualified" Plans.**

It should be remembered that even if a Plan is fully insured or otherwise does not meet the criteria to be an "ERISA-qualified" Plan, you may still subrogate, subject to common law defenses, the made whole doctrine, state anti-subrogation statutes, and the like.

Subrogating an "ERISA-Qualified" Plan merely cloaks you in the protection of ERISA preemption and federal common law.<sup>20</sup>

### **Plans Subject to ERISA.**

*HMO Plans.* Health Maintenance Organization Plans qualify as an ERISA Plan.<sup>21</sup>

*Plans Administered by Employer.* Many Plans administered by an employer will qualify under ERISA where the employer provides full-time employee benefits and employs a full-time employee benefits administrator who accepts claim forms and submits the forms to the insurer.<sup>22</sup>

## **NEXT: PART 3: ERISA SUBROGATION RIGHTS**

## **FOOTNOTES:**

<sup>1</sup> Metropolitan Life Insurance Co. v. Massachusetts, 471 U.S. 724, 105 S. Ct. 2380 (1985); FMC Corporation v. Holliday, 498 U.S. 52, 111 S. Ct. 403 (1990).

<sup>2</sup> 29 U.S.C. § 1144.

<sup>3</sup> Donovan v. Dillingham, 688 F.2d 1367 (11th Cir. 1992) (en banc).

<sup>4</sup> Health and Welfare Plan for Employees of REM, Inc. v. Ridler, 942 F. Supp. 431 (D. Minn. 1996), aff'd., 124 F.3d 207 (8th Cir. 1997).

<sup>5</sup> 29 C.F.R. § 2510.3-1(j).

<sup>6</sup> Brown v. Granatelli, 897 F.2d 1351 (5th Cir. 1990).

<sup>7</sup> Id. at 1355.

<sup>8</sup> See also, Jeffery G. Lenhart, *ERISA Preemption: The Effect of Stop-Loss Insurance on Self-Insured Health Plans*, 14 Va. Tax. Rev. 615 (1995).

<sup>9</sup> Ramsey County Medical Center, Inc. v. Hartzell Corporation Employee Trust Fund, 189 Wis.2d 269, 523 N.W.2d 321 (Ct. App. 1994).

<sup>10</sup> American Medical Security v. Bartlett, 111 F.3d 358 (4th Cir. 1997).

<sup>11</sup> Donovan v. Dillingham, 688 F.2d 1367 (11th Cir. 1982).

<sup>12</sup> 29 U.S.C. § 1002(1); Donovan v. Dillingham, 688 F.2d 1367 (11th Cir. 1982).

<sup>13</sup> 29 C.F.R. § 2510.3-1(j)

<sup>14</sup> 29 U.S.C. § 1002(32) and § 1003 (1994). 29 U.S.C. § 1002 (32) defines a government Plan as a Plan established or maintained for its employees by the government of the United States, by the government of any state or political subdivision thereof, or by any agency or instrumentality of any of the foregoing. Bigelow v. United Health Care of Mississippi, 220 F.3d 339 (5th Cir. 2000).

<sup>15</sup> Cross v. Bankers Multiple Line Insurance Company, 810 F. Supp. 748 (N.D. Tex. 1993).

<sup>16</sup> Parker v. Parker, 897 S.W.2d 918 (Tex. App. - Ft. Worth 1995, writ denied).

<sup>17</sup> MD Physicians & Associates v. Wrotenberry, 762 F. Supp. 695 (N.D. Tex. 1991).

<sup>18</sup> Longoria v. Cearly, 796 F. Supp. 997 (W.D. Tex. 1992).

<sup>19</sup> Sheffield v. Allstate Life Insurance Company, 756 F. Supp. 309 (S.D. Tex. 1991). (The federal judge in Austin ruled that ERISA did not apply to this case involving a charitable organization that received most of its funding from the governmental entity and local contributions - the case immediately settled and no opinion was published.)

<sup>20</sup> Marshall v. Employers Health Insurance Company, 1997 WL 809997 (6th Cir. Tenn. 1997) (unreported decision).

<sup>21</sup> Waddell v. Kaiser Foundation, 877 S.W.2d 341 (Tex App. - Dallas 1994, writ denied).

<sup>22</sup> Hanson v. Continental Insurance Company, 940 F.2d 971 (5th Cir. 1991).