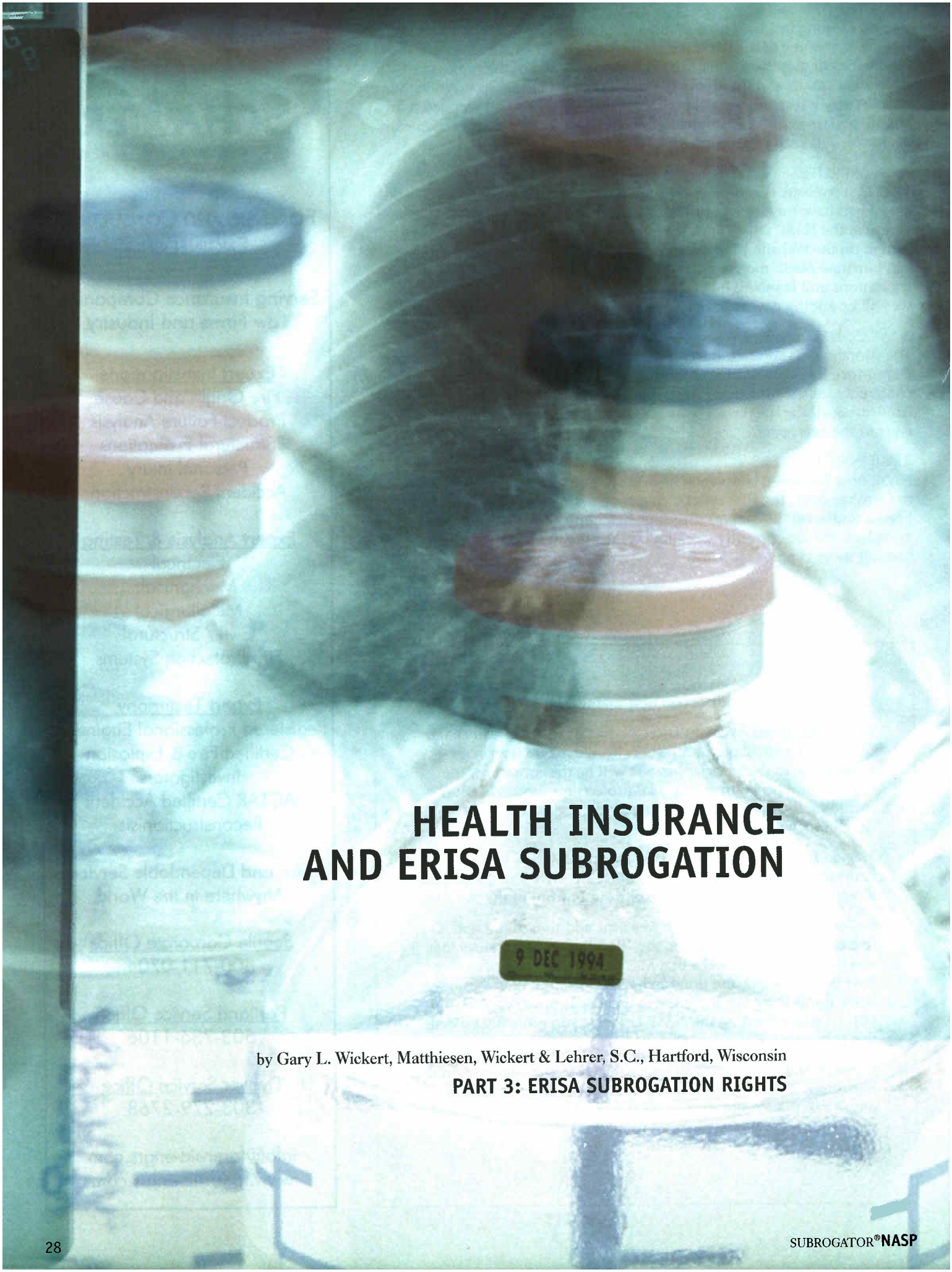

HEALTH INSURANCE AND ERISA SUBROGATION

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PART 3: ERISA SUBROGATION RIGHTS

not for medical expenses, where the Plan language was not broad enough to reach any recovery.[9]

9 U.S. HEALTH CARE, INC. V. O'BRIEN, 868 F. SUPP. 607 (S.D.N.Y. 1994).

Therefore, if the Plan language is adequate, settlement language which characterizes the recovery by category - such as damages other than medical expenses - to defeat a Plan's reimbursement claim, is unlikely to be successful. Because the Plan language determines all of the subrogation rights of the Plan, the Plan will not be bound by the characterization of the recovery in the settlement agreement, if the Plan language is adequate.[10]

10 HERBERGER'S, INC. V. ERICKSON, 17 F. SUPP.2D 932 (D. MINN. 1998).

One possible exception to this may be the 7th Circuit.[11]

11 BLACKBURN V. SUNSTRAND CORPORATION, 115 F.3D 493, 496 (7TH CIR. 1997), CERT. DENIED, 522 U.S. 997 (1997). (SUGGESTING THAT AN INJURED BENEFICIARY CAN FOREGO CLAIMING MEDICAL EXPENSES IN A TORT CLAIM AND THEN OWE NO REIMBURSEMENT).

Subrogating for More than Benefits Paid. It is generally assumed that an ERISA Plan can subrogate only for the payment benefits it has made under the terms of the Plan. However, the 8th Circuit held that where the Plan language defined a subrogation interest as extending to the "reasonable value" of services and benefits provided, the Plan was entitled to recover the fair value of the services rendered and was not limited to a recovery for actual cash expenditures only.[12]

12 INCE V. AETNA HEALTH MANAGEMENT, INC., 173 F.3D 672 (8TH CIR. 1999).

In this case, the participants also argued that the Plan and Plan administrator breached their fiduciary duties by failing to disclose that they were asserting subrogation claims for greater amounts than the Plan in fact paid for the medical services provided.

Gray Areas. In ERISA, the gray areas predominate over black letter law. There is no statutory provision on subrogation under ERISA, and subrogation is allowed only if the written document Plans provide for it. Likewise, the different rules of subrogation under ERISA are governed by the terms of the Plan. Many subrogation issues have not been decided under federal ERISA law, primarily because there are an infinite number of subrogation issues which can arise with the various Plans out there. Whether or not you will be successful in subrogating depends mainly on the language in the ERISA-qualified Plan, as well as the unique facts of your case and the circuit in which your court sits. ERISA has not been around for very long, and there are many issues on which there are no decided cases under state law subrogation.

Causation. An ERISA Plan still must bear some burden of proving that its subrogated interest was causally related to the tortfeasors's conduct. In an Arkansas District Court decision, the court held that where the participant seeks damages for multiple medical conditions and is forced to abandon a portion of her claim because she cannot prove the tortfeasors's fault proximately caused by one of her medical conditions, the Plan may not, without establishing a connection between the tortfeasors's conduct and the medical condition, seek reimbursement for medical expenses incurred as a result of that condition.[13]

13 ADMINISTRATIVE COMMITTEE V. KERN, 72 F. SUPP.2D 1051 (W.D. ARK. 1999).

Therefore, where state law may have relatively few gray areas, ERISA has mostly gray areas, with very little guidance in the case law. This is compounded by the fact that the terms of the Plan will govern, usually even if the Plan is silent, and the Plan subrogation clauses do not usually say much except that the Plan can subrogate and the participants and beneficiaries must reimburse the Plan. A Plan will usually not provide any terms that help a plaintiff's attorney, and ERISA does not require Plans to include any subrogation terms favorable to the participants, beneficiaries or their attorneys. Therefore, when in doubt about a rule, stick with the basic principle of ERISA subrogation: *The terms of the self-insured employee benefit Plan will govern, even if state law contradicts the terms of the Plan and even if the Plan is silent on the issue.* In other words, if the Plan does not specifically say the plaintiff's attorney can do something, then he cannot do it - even if state law says he can. But remember there are exceptions to this rule and the number of exceptions are growing.

Sue in the Name of Plan or Third Party Administrator? In order to determine whether suit or intervention needs to be filed in the name of the Plan or the third party administrator, you must look at the subrogation clause in the Plan documents and see who has the right to pursue subrogation. Theoretically, unless the Plan document gives the TPA the right to sue, the TPA must sue on behalf of the Plan, or the Plan must sue as an entity. If in doubt, it is advisable to sue in the name of the TPA, but mention that TPA is suing on behalf of the Plan. There is probably no need to name the Plan, just explain that the TPA is subrogated to the rights of the injured person under the terms of employee benefit Plan that paid their medical benefits. If you want to name the Plan, just add "employee benefits Plan" to name of your employer. If you sue the participant or beneficiary for reimbursement under § 1132 of ERISA, the TPA must be a fiduciary and you must name it as the plaintiff.

Credit Rights. Under workers' compensation subrogation scenarios, once the worker receives a large settlement, and the carrier has been reimbursed, the balance is usually calculated as a credit against future benefits. Unless and until that credit is used up, the worker's compensation carrier doesn't have to make any future benefit payments. With regard to an ERISA Plan, any rights are once again dictated by the Plan. A Plan is not entitled to get a credit against future benefits, regardless of how much the beneficiary recovers in the third party personal injury action, unless the Plan so provides.[14]

14 DAVIS V. NEPCO EMPLOYEES MUTUAL BENEFIT ASSOCIATION, 51 F.3D 752 (7TH CIR. 1995); SHELL V. AMALGAMATED COTTON GARMENT, 43 F.3D 364 (8TH CIR. 1994).

Summary Plan Description (SPD). An ERISA Plan must advise its beneficiaries in clear and understandable terms of all applicable provisions, and any beneficiary who is not informed may not be bound by the terms of the Plan.[15]

15 MANGINARO V. WELFARE FUND OF LOCAL 771, 21 F. SUPP. 284 (S.D.N.Y. 1998).

ERISA ▶ 31

ERISA requires a Plan to make available to its covered persons a disclosure document known as the Summary Plan Description or SPD.[16]

16 29 U.S.C. ' 1022; ERISA REQUIRES A PLAN TO PROVIDE A SUMMARY PLAN DESCRIPTION WHICH IS "SUFFICIENTLY ACCURATE AND COMPREHENSIVE TO REASONABLY APPRIZE SUCH PARTICIPANTS AND BENEFICIARIES OF THEIR RIGHTS AND OBLIGATIONS UNDER THE PLAN."

A summary description of the subrogation right that differs from the Plan language may be held to be controlling. For example, where the Plan gave reimbursement rights against the recovery from a "liable" person, but the Summary Plan Description referred to a recovery from a person whose "negligence" caused the injury, the summary language could have the effect of denying reimbursement from a recovery arising from uninsured motorist coverage.[17]

17 HAMILTON V. PILGRIM=S PRIDE GROUP HEALTH PLAN, 37 F. SUPP.2D 817 (E.D. TEX. 1998).

In Ninaus v. State Farm Mutual Automobile Insurance Company,[18]

18 NINAUS V. STATE FARM MUT. AUTO INS., 220 WIS.2D 869, 589 N.W.2D 545 (CT. APP. 1998).

a Wisconsin court held that where the terms of a SPD and an ERISA Plan conflict, and where the SPD is more favorable to the employee, the summary controls, even where the Plan itself contains a disclaimer to the contrary. One Kansas district court has held that the SPD doesn't have to include subrogation rights in it. [19]

19 JOHN DEERE HEALTH BENEFIT PLAN FOR SALARIED EMPLOYEES V. CHUBB, 45 F. SUPP.2D 1131 (D. KAN. 1999).

Summary Plan Description Determines Subrogation Rights.

The Summary Plan Description language may affect the subrogation rights of the Plan. In one federal district court case, the court held that no subrogation needed to be paid to the ERISA Plan because the Summary Plan Description only provided that the employee reimburse the Plan. Since the benefits were paid to the children and his former wife, the Plan was not entitled to reimbursement.[20]

20 HAMILTON V. PILGRIM=S PRIDE EMPLOYEE HEALTH PLAN, 37 F. SUPP.2D 817 (E.D. TEX. 1998).

In *Hamilton*, the court stated the general rule with regard to Summary Plan Descriptions as follows:

"The SPD is interpreted as a whole *(citations omitted)*. The SPD is binding, and if there is a conflict between the SPD and the terms of the policy, the SPD shall govern *(citations omitted)*. Further, any ambiguity in the SPD must be resolved in favor of the employee and made binding against the drafter *(citations omitted)*. The 5th Circuit has also rejected the notion that the SPD should be interpreted in the light of the language of the Plan. It is the SPD and not the Plan upon which the average beneficiary has relied, and the SPD most nearly represents the intention of the parties."

In almost every other 5th Circuit case, the SPD has been construed in favor of the ERISA Plan, so the *Hamilton* decision is a rare example of how following the SPD can sometimes help the claimant.

Plan Fiduciary's Interpretation of Plan Language.
§ 1102(a)(1) requires every employee benefit Plan to have a

named fiduciary who shall have the authority to control and manage the operation and administration of the Plan. In 1989, the U.S. Supreme Court held that where an ERISA Plan expressly vests the Plan's fiduciaries with power to interpret the terms of the Plan document, such interpretive decision by the fiduciaries is subject to review under an "abuse of discretion" standard.[21]

21 FIRESTONE V. BSRUCH, 498 U.S. 948 (1989).

Unlike a de novo standard, under which a court can reverse the fiduciaries' decision if the court disagrees with the decision, the "abusive discretion" standard requires the court to uphold the fiduciaries' decision - even if the court believes the decision is wrong - so long as the decision is not "arbitrary and capricious". Under the "arbitrary and capricious"[22]

22 BROWN V. BLUE CROSS & BLUE SHIELD OF ALABAMA, 898 F.2D 1556 (11TH CIR. 1990), CERT. DENIED, 498 U.S. 1040 (1991); JETT V. BLUE CROSS & BLUE SHIELD OF ALABAMA, 890 F.2D 1137(11TH CIR. 1989).

standard of review, the court first determines de novo whether the fiduciary erred when it made its decision. If the fiduciary erred, the court must then decide whether the erroneous determination was nevertheless a reasonable determination or whether it amounted to an abuse of discretion.[23]

23 COX V. MID-AMERICA DAIRYMEN, INC., 965 F.2D 569 (8TH CIR. 1992); FINLEY V. SPECIAL AGENTS MUTUAL BENEFIT ASSOCIATION, INC., 957 F.2D 617 (8TH CIR. 1992).

This makes overturning a fiduciary's interpretation of the Plan quite difficult, and gives the fiduciary great power to assist the Plan in making subrogation recoveries by interpreting subrogation provisions favorably. However, the Plan must first vest a Plan fiduciary with this power to interpret it terms.

Most employee benefit Plans in the country should have language vesting the Plan fiduciary with this discretion, and those that do not will lose subrogation battles. This language allows the Plan fiduciary to stretch the literal, often general, and sometimes even vague terms of the Plan subrogation provisions to defeat contrary and perhaps just as reasonable, interpretations, set forth by plaintiff's attorneys attempting to defeat your subrogation interest. This power gives the fiduciaries the flexibility to expand the literal terms of the subrogation provisions to effectively deal with new situations and new anti-subrogation arguments raised by plaintiff's attorneys and insureds.

Purpose of ERISA Subrogation. The unstated but clear purpose and intent of self-funded ERISA Plans is to provide health benefits to the employees of their employers. Because this mission is dependant on the Plans continued economic viability, this mission is facilitated by the Plan being reimbursed for payments it has made on behalf of covered employees.[24]

24 BILL GRAY ENTERPRISES, INC. V. GOURLEY, 248 F.3D 206 (3RD CIR. 2001).

Reimbursement and subrogation rights are vital to ensuring the financial stability of self-funded Plans.

NEXT: PART 4:
ERISA PREEMPTION AND THE MADE WHOLE DOCTRINE