

How-To

Should I pay this ERISA claim?

A personal injury attorney's guide to evaluating a claim for reimbursement under ERISA.

by John D. Ayers and Angela E. Interrante

Until only a few years ago, personal injury attorneys would get the occasional request for reimbursement from health insurance plans. These requests were usually limited to clients who were employed by large corporations. But in response to the rising cost of healthcare, more and more health insurance plans are seeking reimbursement for medical expenses paid in automobile accident cases. Personal injury attorneys have been evaluating claims for reimbursement from health insurance plans for years, but it now seems to be getting both more difficult and more common. Determining whether a claimed lien is valid is often more trouble than its worth, and many personal injury attorneys would rather pay a reduced lien than fight the battle. Adjusters often tell us that the plan has an "administrative services only" contract with the insurance company, and that there was no "actual insurance contract," so the injured party must repay the plan for the cost of all of the medical bills. How do you know whether these and similar statements are true? Do you want to push the issue if the adjuster is offering to reduce the lien by a third if you are willing to settle with them now?

Introduction

The general rule is that Virginia's anti-subrogation statute prevents subrogation in contracts of health insurance policies.¹

The problem with this general rule is that there is, of course, a federal law known as ERISA (the Employee Retirement Income Security Act) that confers subrogation rights on health insurance plans established pursuant to ERISA, and the courts have held that this federal law preempts state anti-subrogation statutes. If the plan is indeed fully governed by the comprehensive statutes of ERISA, the Virginia anti-subrogation statute is preempted, and the plan has a valid right to claim reimbursement from the injured party.² Asking the plan whether they are ERISA-based is not enough, however, because most of them are ERISA-based, and are quick to put their hands out and claim a lien. On behalf of our clients, personal injury attorneys need to determine which reimbursement claims are valid.

Not every health insurance plan provided by an employer is governed by ERISA. Each plan must be analyzed to determine whether or not it is an ERISA plan. The Department of Labor has issued a regulation describing a "safe harbor" which allows certain benefit plans to be exempt from ERISA.³ The "safe harbor" provision's intended purpose is to exempt from ERISA those arrangements in which employer involvement is completely absent.⁴ If the employer conducts only a few limited functions outlined in the regulation, such as 1) permitting publicizing of the program, 2) collecting premiums, and

3) remitting them to the insurer, then the safe harbor provision applies.⁵ If the safe harbor provision applies, then the health insurance plan is not an ERISA plan, and the Virginia anti-subrogation statute applies.

Is the plan self-funded or insured?

The easiest way to determine if the safe harbor provision applies, and ultimately if it is a valid ERISA plan, is to determine whether the plan is self-funded or insured. If the plan is fully insured, then the ERISA preemption does not apply, the Virginia's anti-subrogation statute does apply, and the plan does not have a valid claim for reimbursement.⁶ If the plan is self-funded, then ERISA preemption applies, and the terms of the plan documents are controlling, including the plan's claimed right of subrogation (if the plan includes one).⁷ Making this determination is not as easy as it sounds because many states do not have anti-subrogation statutes, and often the plan language for an out-of-state employer will contain reimbursement or subrogation provisions even though the plan is not a self-funded ERISA plan. In the absence of a state anti-subrogation statute, these provisions are enforceable. These provisions are unenforceable, however, if a state anti-subrogation statute is applicable unless the plan is self-funded, but many times you will have to prove to the plan's own administrator that they do

not have a right to reimbursement.

In an insured plan, the employer (plan sponsor) has an insurance policy with a commercial insurance company. The insurance company collects premiums and is at risk to pay benefits from its own assets. Self-funded plans are those where benefits are paid directly from an employer's general assets. With a self-funded plan, an insurance carrier does not assume the risk of paying claims, and is only being paid to administrate the claims.⁸ The operative and distinguishing factor between self-funded and insured plans is who is ultimately liable to pay the claims of the covered persons. Under a self-funded plan, the employer who promises the benefit also incurs the liability for paying claims.⁹

Step one is to send a letter to the plan administrator asking them if they are making a claim for reimbursement. If the administrator is unknown, then use the contact information on the back of the client's health insurance card. Out-of-state benefit plans seem to always make a claim for reimbursement. In that initial letter, you should also ask them to provide you with the Summary Plan Description (SPD) and the Internal Revenue Service ("IRS") Form 5500. The SPD is the booklet that should be provided by the employer to the employee when they sign up for the health insurance plan. When you receive this lengthy group of documents, you

you should also look in the SPD for the actual name (or number) of the plan. There is still hope for your client if you discover on Form 5500 that the plan is an insured plan.

The plan administrator won't provide the Form 5500, now what do I do?

Do not pay the reimbursement claim until you have the Form 5500. I have often found that a plan administrator will quickly provide the SPD, but the plans that are insured plans and do not have the right to reimbursement often do not provide the Form 5500. They probably hope that you will read the plan language, determine that they have the right to reimbursement, and pay their claim. Do not fall for this, and get the Form 5500 on your own. Furthermore, it is important to remember that sometimes adjusters simply do not fully understand the law governing their right to reimbursement and subrogation in a state which has an anti-subrogation statute. Your job will be to politely but firmly insist upon being provided the necessary information to determine whether the plan does indeed have the subrogation and reimbursement rights it claims to have.

Once you determine the name of the employer, and the name of the plan (or three digit plan number, a common example is '501') from the SPD, you can access the Form 5500 online.¹⁰ *FreeERISA.com* is a website that allows free access to the Form 5500's filed by most companies. You must sign up as a member with the website, and login to it, but there is no fee to become a member. You will need the exact name of the employer, and the exact name (or number) of the plan to find the corresponding Form 5500. Once you find the correct plan, review the most recent Form 5500, which is probably one or two years old (see below).

The IRS Form 5500 is probably the single most important document needed to determine whether your client has a duty to reimburse the plan. Title I of ERISA imposes various reporting requirements on benefit plans.¹¹ The main reporting requirement for plans is the Form 5500 annual filing. Plan administrators must submit the form and any required attachments on an annual basis.¹² A Form 5500 must be filed on each ERISA plan that has been established, and the individual policies (such as medical, life, dental, etc.) are listed as Schedules (attachments) to the Form 5500. The Form 5500 must be filed by the last day of the seventh month after the close of the ERISA plan year.¹³ So the most recent filing is usually two years old.

But there is a huge exception to this annual reporting rule: plans with fewer than 100 participants that are unfunded, fully-insured or a combination thereof are not required to file a Form 5500.¹⁴ This is actually just the exception that we are looking for, because if the plan falls under this exception, and does not file a Form 5500, then it is not self-

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will need to search them to determine whether they contain subrogation and reimbursement provisions in the SPD. Remember, if the plan documents contain no subrogation or reimbursement provisions then the plan cannot assert and enforce subrogation or reimbursement rights even if it is an ERISA-based plan. Even if the plan does contain subrogation or reimbursement rights, you will want to check the SPD to determine whether there are any limitations or conditions upon the subrogation or reimbursement rights which may be helpful to the injured plaintiff. For example, you should examine the plan documents to determine whether the subrogation or reimbursement rights allow the injured person a pro-rata setoff for litigation fees and expenses incurred in making a tort recovery. Most ERISA-based plans, of course, have reimbursement and subrogation provisions in the plan language which provide for full reimbursement and with few or no conditions or limitation of any benefit to the injured plaintiff. Studying the plan documents is important, because these documents control, but

funded and not entitled to reimbursement. But that is the easy battle, because plan administrators who do not file a Form 5500 usually do not even try to make a claim for reimbursement.

Once you have located the corresponding Form 5500, the most important component on the Form 5500, for personal injury attorneys, is the plan funding arrangement. This is found on section 9(a) of the Form 5500. There are up to four boxes that can be checked on the form, 1) insurance, 2) Section 412(i) insurance contracts, 3) Trust, and 4) General assets of the sponsor. All four of these boxes can be checked because this form reports the funding arrangement of all of the plan assets, not just the health insurance contracts. If only the insurance box is checked, then the plan is a fully-insured plan, and is not entitled to any reimbursement. This is also an easy battle because plan administrators who only have insurance contracts do not usually try to make a claim for reimbursement. These “easy battle” claims are often made by out-of-state adjusters and plan administrators who are unaware of Virginia’s anti-subrogation statute.

What if the plan is both self-funded and insured?

The tough reimbursement battles are fought when “Insurance” is checked on the Form 5500, but “Trust” or “General assets of the sponsor” are also checked. Since employee benefit plans contain more than just health insurance policies, it can be difficult to determine whether the health insurance plan for your client is a fully-insured or self-funded plan. Thankfully the attachments to the Form 5500, namely the Schedule ‘A’ and the Schedule ‘C’, can shed some light on the situation.

Traditional insurance contracts are listed on a Schedule ‘A’. The plan administrator must include a Schedule ‘A’ if any plan benefits are provided by an insurance company, insurance service or other similar organization (such as Blue Cross/Blue Shield or a health maintenance organization).¹⁵ At least one Schedule ‘A’ is required if “Insurance” is checked in section 9(a) on the Form 5500.¹⁶ To a personal injury attorney, the most important parts of the Schedule ‘A’ are line 1(a), which reports the name of the insurance carrier, and line 7, which reports the type of benefit or contract. You will need to review all of the Schedule A’s to find the insurance carrier and contract that corresponds to your client’s specific case. If you cannot find a Schedule ‘A’ for the health insurance plan used by your client, that is good evidence that it is a self-insured plan, and is entitled to reimbursement.

The Schedule ‘C’ lists the “Administrative services only” (ASO) contracts, which is the best indicator that the plan is self-insured and must be repaid by your client. ASO contracts are “services provided in an employee benefit plan such as a Pension Plan. An employer provides the clerical staff

to operate the plan, in effect acting as custodian. The trustee provides direction for investment of the plan’s funds, usually in a self-directed investment account. In a self-insured property or liability plan the group may have an ASO contract with an insurance company or a third-party administrator to handle claims processing and administration.”¹⁷

A Schedule ‘C’ is required to report contract administrators for the plan, and any other persons receiving, directly or indirectly, \$5,000 or more in compensation for all services rendered to the plan during the plan year.¹⁸ To a personal injury attorney, the most important part of the Schedule ‘C’ is line 2, which in section (a) reports the name of the contract administrator, and section (g) which reports the type of service performed (13 means administration).¹⁹ If indeed the plan only has an “administrative services only” (ASO) contract for its health insurance benefits, then a Schedule ‘A’ should not be filed because it is not an “insurance” contract.²⁰ If your client’s health insurance carrier is listed on the Schedule ‘C’ as an administrator, and not listed on any Schedule ‘A’, then the plan is definitely self-funded and your client must reimburse the plan.

I have determined that the plan is self funded and has a valid ERISA claim. Do I just pay them?

Once you determine that you have to pay back the plan, you can still negotiate with the adjuster. After all, your client has incurred litigation fees and expenses and you have worked hard to make a tort recovery. The funds from the tort recovery are in the nature of a windfall to the ERISA-plan, since the plan has to provide health insurance benefits regardless of whether a tort recovery is ever made. There is a good argument in justice and fairness that the ERISA-plan should accept some discount on its reimbursement recovery. If you confirm, however, that the ERISA-plan reimbursement rights are fully enforceable and you are unable to negotiate a voluntary discount with the ERISA-plan, then you should pay the reimbursement claim. If you do negotiate a discount, make sure that you receive written confirmation from the adjuster that your compromised agreement is in full satisfaction of all past and future payments by the plan for injuries arising from this accident. This language is important because some I have seen plans accept the payment from the attorney, then make a claim for the remainder with the client after the case is settled.

Conclusion

It is very important for a personal injury attorney to determine the validity of a claim for reimbursement from a health insurance carrier. With surprising frequency, plan administrators initially make a claim for reimbursement and then promptly retract that claim once the personal injury attorney obtains the Form 5500 (or determines that there is not one).

You also have to keep in mind that plan administrators who do not have a valid claim for reimbursement often ignore letters requesting the Form 5500 and the SPD. Be sure to obtain a waiver from your client before disbursing funds to them that may be owed to the health insurance plan. And before making any such disbursement to the client make sure the client understands that, if the plan's reimbursement rights are valid and enforceable, the plan can seek reimbursement from your client directly and might also deny benefits in the future, and these events can cause an unhappy former client. For a much more thorough discussion of the remedies of self-funded plans and the liability of your client, I highly recommend the ERISA subrogation article by Art Donaldson in the VTLA's liens notebook.²¹



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Endnotes

1. Va. Code Ann. § 38.2-3405 (2006):
 - A. No insurance contract providing hospital, medical, surgical and similar or related benefits, and no subscription contract or health services plan delivered or issued for delivery or providing for payment of benefits to or on behalf of persons residing in or employed in this Commonwealth shall contain any provision providing for subrogation of any person's right to recovery for personal injuries from a third person.
 - B. No such contract, subscription contract or health services plan shall contain any provision requiring the beneficiary of any such contract or plan to sign any agreement to pay back to any company issuing such a contract or creating a health services plan any benefits paid pursuant to the terms of such contract or plan from the proceeds of a recovery by such a beneficiary from any other source; provided, that this provision shall not prohibit an exclusion of benefits paid or payable under workers' compensation laws or federal or state programs, nor shall this provision prohibit coordination of benefits provisions when there are two or more such accident and sickness insurance contracts or plans providing for the payment of the same benefits. Coordination of benefits provisions may not operate to reduce benefits because of any benefits paid, payable, or provided by any liability insurance contract or any benefits paid, payable, or provided by any medical expense or medical payments insurance provided in conjunction with liability coverage.
 - C. ...
2. *Madonia v. BC/BS of Virginia*, 11 F.3d 444 (4th Cir. 1993).
3. (j) Certain group or group-type insurance programs. For purposes of Title I of the Act and this chapter, the terms "employee welfare benefit plan" and "welfare plan" shall not include a group or group-type insurance program offered by an insurer to employees or members of an employee organization, under which:
 - (1) No contributions are made by an employer or employee organization;
 - (2) Participation [in] the program is completely voluntary for employees or members;
 - (3) The sole functions of the employer or employee organization with respect to the program are, without endorsing the program, to permit the insurer to publicize the program to employees or members, to collect premiums through payroll deductions or dues checkoffs and to remit them to the insurer; and
 - (4) The employer or employee organization receives no consideration in the form of cash or otherwise in connection with the program, other than reasonable compensation, excluding any profit, for administrative services actually rendered in connection with payroll deductions or dues checkoffs.
4. *Vazquez v. Paul Revere Life Ins. Co.*, 289 F. Supp. 2d 727, 731 (D. Va. 2001).
5. *Casselman v. Am. Family Life Assur. Co.*, 143 Fed. Appx. 507, 509 (4th Cir. 2005).
6. *FMC Corp. v. Holiday*, 498 U.S. 52, 63-64 (1990).
7. *Hampton Ind. v. Sparrow*, 981 F.2d 726 (4th Cir. 1992).
8. Thomas H. Lawrence & John M. Russell, "ERISA Subrogation: Enforcing Recoupment Provisions in ERISA-Covered Health and Disability Plans," 53 (A.B.A. 2000).
9. *American Med. Sec., Inc. v. Bartlett*, 111 F.3d 358 (4th Cir. 1997).
10. Available at <http://www.freeerisa.com/>
11. 29 C.F.R. § 2520.104 (2006).
12. 2005 Instructions to Form 5500 - Available at <http://www.dol.gov/>, page 1.
13. *Id.* at 4.
14. *Id.*
15. *Id.* at 8.
16. *Id.* at 21.
17. Harvey W. Rubin, *Dictionary of Insurance Terms*, 15 (Barron's Educ. Series, Inc., 4th ed. 2000).
18. 2005 Instructions to Form 5500 - Available at <http://www.dol.gov/>, page 32.
19. *Id.* at 33.
20. *Id.* at 21.
21. David A. Buzard et al., Va. Trial Lawyers Ass'n, *Liens in Personal Injury Actions* (LexisNexis 2d ed. 2005 & Supp. 2006).