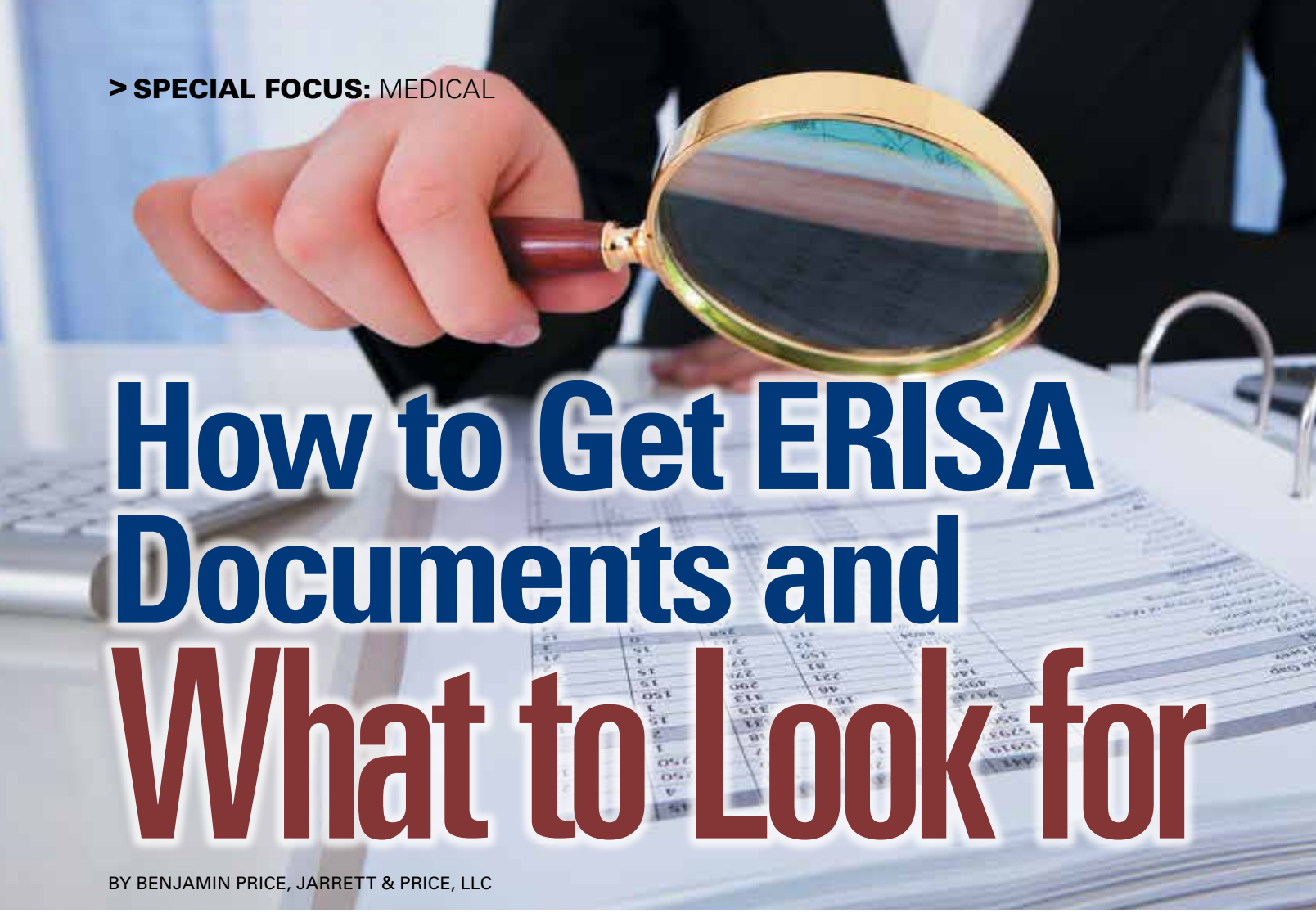

How to Get ERISA Documents and What to Look for

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The Employee Retirement Income and Security Act is the black hole of healthcare reimbursement from the plaintiff's lawyer's perspective. It is where all of your client's recovery proceeds seem to go in too many cases. What initially sounds like a good result for the client, turns into a bad one once you subtract tens of thousands from the client's share of the proceeds to pay back a private health insurer. The rights of these plans are so strong, and the risk of not paying them so catastrophic, that it is hard not to bow down to the annoying bill collectors who constantly harass you about their plan's right to dollar-for-dollar reimbursement. As the attorney, you have a nagging sense that you may be doing your client a disservice by paying all this money to the healthcare provider. Was the plan really entitled to 100-percent reimbursement and therefore you were fortunate to get any reduction? Was there some paragraph in the stack of plan documents on your desk that could have made the lien unenforceable? Did you put up enough of a fight with the "Rawlings" representative to save your client a few more dollars? Was it really an ERISA plan at all?

The key to eliminating this uncertainty is to investigate these plans early in the case. That requires you to know how to obtain the necessary plan documents and then know what to look for when you get them. Most importantly, your greatest source of leverage may be the fact that you have not yet resolved the liability case–and cannot resolve the liability case–unless the plan agrees to significant movement on the lien.

START EARLY

One of the most frustrating aspect of healthcare liens is that we plaintiff attorneys often wait to deal with the plans until the end of the case. Too often, that leads to a scramble for plan documents, last-second haggling with "Rawlings" or some other bill collector for the plan, and unhappy clients who want to know why so much of their recovery proceeds are tied up in trust for months after the case has settled. The alternative to this type of last-minute deal making is to start investigating the healthcare plan early in the case. This really needs to begin at intake. If you know what kind of healthcare plan the client is going to use to pay for treatments, you will have some idea how much of their recovery they will actually keep, and how much will be sucked out of the trust account to repay the plan. I recommend adding these questions to your new-client intake process if you are not asking similar questions already:

1. Do you have health insurance?
2. What is the source of this insurance, (ex. your employer; or the government healthcare exchange, etc.)
3. What is the name of your employer, and who is your primary HR contact, if known.

4. Are you, or your spouse, a state or government employee, and if so, is your insurance provided by a state or government employer?
5. Are you a fulltime employee, or a part-time employee, contract employee, or other?
6. Please make a copy of the front and back of your healthcare card and attach it to this questionnaire.

The answers to these questions can tell you a lot about the client's potential share of the recovery before you even start on the case. Remember that most healthcare plans provided by the state have no right to reimbursement if your client is not "made whole" pursuant to O.C.G.A. § 33-24-56.1. Single-payer insurance and health insurance purchased under the government healthcare exchange are also subject to the protections of this statute. So if your client tells you in this questionnaire that he receives healthcare through his spouse who is a public school teacher, you know immediately that this is state insurance and the client will most likely owe nothing to the healthcare plan (thanks to O.C.G.A § 33-24-56.1). Thus a potentially huge drain on his take of the settlement will not be an issue. However, if his insurance is through a private employer, you know that reimbursement will likely be an issue and you have some additional work to do to investigate this plan. I recommend requesting documents from the healthcare provider the moment you start requesting medical records.

WHERE AND HOW TO REQUEST THE PLAN DOCUMENTS

The key to investigating these plans is to obtain the plan documents necessary to determine if the plan really is subject to ERISA. ERISA is governed by United States Code 29 U.S.C § 1001-1461. Plans cite 29 U.S.C. § 1132(a)(3) as giving Federal subject matter jurisdiction for reimbursement and subrogation claims involving ERISA plans. This exempts ERISA from state laws like O.C.G.A. § 33-24-56.1 that would prevent your client from having to pay unless they were made whole. Thus, these plans make their own rules, and evaluating their rights is a multi-step process.

DETERMINE IF THE PLAN TRULY IS ERISA

Generally, ERISA regulates "employer-funded" healthcare plans. This is commonly referred to as a "self-funded plan." That means that the employer has created a healthcare program, usually by funding a trust, which is then used to pay for the covered employees treatments. The key is that the employer is funding the plan and paying the claims with its assets. Most ERISA plans contract with private healthcare companies like BlueCross or Aetna to "administer" the plans by reviewing claims and coordinating with medical providers and the insureds. However, so long as the claims are being paid for by the employer, that type of plan will most likely be an ERISA plan. (Note that some employers offer multiple types of plans to employees. Some of their plans may be self-funded, other plans may be offered at a different rate and may be fully insured. You won't know until you request documents and start asking questions). The important thing to remember is that 1) just because the plan or Rawlings says it is an ERISA plan does not mean it really is an ERISA plan; and 2) just because it is an ERISA plan, does not mean there is an automatic right to reimbursement. It takes time to acquire these documents and to critically read through them to look for these arguments. It is often impossible to gather this much information if you wait until the end of your case to try to evaluate the plan.

REQUEST PLAN DOCUMENTS

The only way to learn anything about the plan's rights is to request plan documents directly from the employer. If a client is treating with employer-based insurance regulated by ERISA, the client has the right under 29 U.S.C. 1024 to obtain numerous documents from the plan's designated "Plan Administrator." The plan administrator is not Rawlings or any other third-party bill collector that is faxing you nasty letters. The plan administrator is an entity that must be designated by the plan and has a duty to provide your client with these documents. If you cannot figure out who the plan administrator is, write to Rawlings or whoever is contacting you and request the contact info for the plan administrator. If you have the Form 5500 (a document all plans are required to be filed with the Dept. of Labor) it should list the plan administrator's contact information. If you don't have any documents designating a plan administrator, ask your client to find out who is the head of their employer's human resources department. Oftentimes the head of HR is the designated "Plan Administrator," or they can at least provide your client with that information.

WHAT TO REQUEST

Once you have a contact for the plan administrator, send a request for all documents related to the plan pursuant to 29 U.S.C. 1024(b). The plan administrator has a duty to provide these documents for each year that the client received benefits. I usually put the following language in my request:

"I am making this request on my client's behalf, pursuant to her rights under the Employee Retirement Income Security Act (ERISA), United States Code 29 U.S.C

§ 1001-1461, specifically code section 29 U.S.C. 1024.

Pursuant to the act, please provide:

- Copies of the entire Summary Plan Description (SPD) and other Plan Documents relating to my client's health insurance coverage for the years, 2013 to 2016;
- Copies of the *entire healthcare plan/contract* for the above-referenced insurance plan for years 2013 to 2016.
- Copies of the Form 5500, including all attached schedules, filed with the U.S. Dept. of Labor for the years 2013 to 2016.
- An itemized list of payments the above-referenced plan paid for benefits which you maintain are related to her injuries from this accident.
- The Administrative Services Contract prepared by the above-referenced healthcare plan for the years 2013 and 2016.
- Copies of all contracts including, but not limited to: insurance contracts, Stop Loss Contracts, Health Insurance Contracts, Insurance Intermediary Services Contracts and Administrative Services Contracts related to the above-referenced plan serving Georgia for 2013 to 2016; and
- Any amendments to the Plan Documents for the above-referenced plan (including but not limited to the Summary Plan Description) for the years 2013 to 2016; and
- Copies of the SMM (Summary of Material Modifications) statements for the years 2013 to 2016; and

Please provide the above documents in accordance with the ERISA act within the next 30 business days, or the plan administrator will be personally liable to my client for $110 a day penalty for every day you fail to provide these documents, pursuant to the ERISA Act. In a good faith effort to resolve this claim quickly, I would request you provide these documents well prior to 30 days if at all possible.

Note that there is a penalty referenced at the end of this document that asserts a fine of $110 a day for failing to provide the requested documents. See 29 U.S.C. 1132 and 29 CFR § 2575.502c-1. If the plan administrator does not provide the requested documents within 30 days, be sure to remind of them of their oversight and that it is costing $110.00 per day.

Your greatest source of leverage may be the fact that you have not yet resolved the liability case—and cannot resolve the liability case—unless the plan agrees to significant movement on the lien.

REVIEW THE PLAN DOCUMENTS

Assuming you do receive a response to your request to the plan administrator, don't be alarmed when a thousand pages of plan documents land on your desk. A primary purpose for requesting the documents is simply to determine if they exist. If they do not exist, then there is a good chance the plan is not really an ERISA plan, or they are dramatically out of compliance. The main document to look at is usually referred to as the "Summary Plan Description," or SPD. This document usually provides most of the information you need to learn how the plan was created and funded, as well as the plan's reimbursement rights.

KNOWING WHAT TO LOOK FOR

1. ***Is the Plan Self-Funded?***

   You should first look for some information in the plan documents about how the plan was created and funded. This will usually be a chapter in the Summary Plan Description (SPD). There should be some language regarding a trust or a similar type of financial instrument to fund the plan and pay the claims. If you do not see any mention of how the employer funds the plan, argue it is not ERISA unless and until they can provide it.

2. ***Does the Plan Reject the Made Whole Doctrine?***

   Even if the plan is truly a self-funded ERISA plan, it's possible the made-whole doctrine can still apply depending on the wording in the plan language. In addition to Georgia's statutory made-whole law, O.C.G.A. § 33-24-56.1, there is a recognized common law made-whole doctrine. Currently, the 11th Circuit rule is that the common law made-whole doctrine applies unless there is a clear and unambiguous rejection of the doctrine in the plan language. If you read through the plan, and there is no rejection of made whole, argue the plan has no right to any reimbursement, pursuant to *Cagle v. Bruner*, 112 F. 3d 1510, 1522 (11th Cir. 1997) and a host of other precedent. See also *Parker v. Ross*, 147 F. Supp. 2d 1376 (M.D. Ga. 2001); *Adelstein v. Unicare*, 31 Fed Appx. 935 (11th Cir. 2002) and *Summerlin v. Georgia-Pacific*, 366 F. Supp. 2d 1203 (M.D. Ga. 2005).

3. ***Does the Plan reject the "Common Fund Doctrine?"***

   The common fund doctrine is the defense that the plan should have to contribute to the Plaintiff's attorney's fees by reducing its lien by a pro-rata share of attorneys fees and expenses. If this is not specifically rejected, you should argue the doctrine applies and they should reduce the lien accordingly. See *Bombadier Aerospace v. Ferrer, Poirot & Wasnbrough*, 354 F. 3d 348 (5th Cir. 2003).

4. ***Does the Reimbursement Language Identify a "Specific Fund?"***

   The plan must identify the funds from which it is seeking reimbursement. For instance, repayment "out of the recovery" from the third party is enforceable. *Popowski v. Parrott*, 461 F. 3d 1367 (11th Cir. 2006). While simply stating "a reimbursement right" without identifying a particular fund, is unenforceable. *BlueCross BlueShield of S.C. v. Carillo*, 372 F. Supp. 2d 628 (N.D. Ga. 2005). If have never found this to be very useful, but any argument you can make may gain you a little leverage in reducing your client's lien.

5. ***Is There Other Favorable Language in the Plan?***

   When reading through the statement of reimbursement rights, look for express limitations on the lien. Sometimes plans will include language that it will reduce by the share of attorney's fees and expenses. It sounds unbelievable in 2016, but I have seen this language before in plans.

6. ***Compare the SPD and Plan Language***

   The SPD is not always the only plan document. Technically, the SPD should be a "summary" of the actual healthcare contract. However, for complicated reasons, they are often the same document. But if you have a contract and an SPD when you receive the plan documents,

always compare them to one another. The Supreme Court has explained the role of these two documents in *Cigna Corp. v. Amara*, 131. S. Ct. 1866 (2011). *Amara* holds that in the event of a conflict between the terms of the SPD and the terms of the actual plan document, the plan document controls. For example, if the right to reimbursement is stated only in the SPD – and not in the plan document – then there is no right to reimbursement. If the made-whole doctrine is rejected in the SPD, but not in the actual plan document, the doctrine should apply.

NEGOTIATE BEFORE YOU SETTLE THE CASE

If at all possible, try to negotiate a reduction to the lien prior to resolving the case. If you are in-fact dealing with an ERISA healthcare plan with tight plan language that gives them a right to 100-percent reimbursement, your greatest leverage will be that you have not settled the case. Make it clear your client will simply walk away from the case if their share of the recovery mostly wiped out by the lien. Why would a client want an attorney to pursue a case where the only beneficiary will be the healthcare plan and the attorney? Tell them to reduce significantly or you and the client are walking away.

The second benefit of evaluating the plan early is that you may be able to negotiate a lien amount prior to negotiating your liability case. This eliminates the "x-factor" of the client's obligation to repay the plan. Too often practitioners go into mediation knowing exactly what number they need from the liability carrier to settle the case, but the client's obligation to repay the healthcare provider is still completely unknown. Why not make every effort to negotiate the lien a few days prior to the mediation? If you can get to a number that is satisfactory for you and your client, you'll know exactly what your client's obligations will be to repay the plan when you pick up the phone to start settlement negotiations or walk into mediation. Another strategy is to include the healthcare plan's representatives in your negotiations of the liability claim. Let them know there is money on the table, and the only reason it cannot be accepted is they will not provide enough movement on their lien.

The key to all of this is that it requires getting out in front of this issue early in the case. Eliminate endless haggling on the phone and the frustration of not having plan documents by investigating plans early in the case when time is on your side. This will remove a lot of the guesswork associated with resolving liens at the very end of the case and create confidence you are getting your client the best possible result under the circumstances. None of that is possible without a systematic approach that starts at client intake and continues until the end of the case. ●

ABOUT THE AUTHOR

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