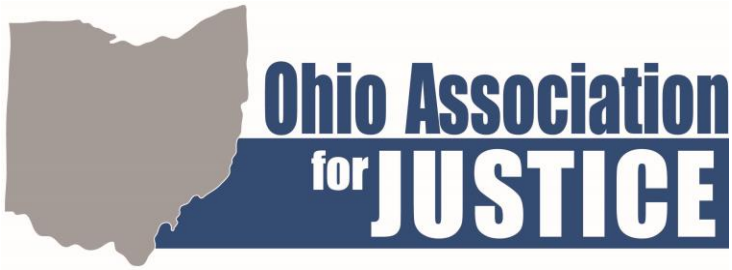

2014 Navigating Through Statutes, Insurance Policies, and Regulations

January 15, 2015 – Columbus, OH | January 22, 2015 – Cleveland, OH | January 29, 2015 – Cincinnati, OH

How to Reduce or Eliminate ERISA and Non ERISA Liens

Matt Nakajima, Esq., Cincinnati, OH

Subrogation & Reimbursement

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O'Conner, Acciani & Levy LPA
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Subrogation v. Reimbursement

- Under the doctrine of subrogation, the insurance company stands in the shoes of its insured (the injury victim) and asserts a direct tort action against the tortfeasor.
- Under the right of reimbursement the insurer has a direct right of repayment against the insured when he or she makes a recovery from another source.
- This right does not arise until after the insured has made a recovery from the responsible party.

Statute of Limitations

- Subrogation: An insurer seeking to pursue a right to subrogation is bound by the same limitations period as its insured.
- Reimbursement: ERISA does not have a statute of limitations governing reimbursement. The Sixth Circuit applies the fifteen-year statute of limitations for breach of written contract under Ohio law.

What Plan Am I Dealing With?

- ERISA Plan
  - Generally includes all employer-employee plans unless the employer is a governmental entity or church.
- Non-ERISA State Health Plan
  - Individual Plans
  - Government Plans
    - Cincinnati Police Department
    - University of Cincinnati - Faculty and Student plans
    - Exchanges/Obamacare

Self Funded v. Insured ERISA Plans

Self Funded Plan

- Does not purchase an insurance policy from an insurance company to satisfy its obligations to its participants.
- Self-funded plans have complete preemption of state laws

Self Funded v. Insured ERISA Plans

Insured ERISA Plan

- An insurance company bears the risk of loss.
- Insured plans are subject to federal law and state laws that regulate the business of insurance – the "savings" clause.

Get the Plan Documents

- In *CIGNA Corp. v. Amara*, 131 S.Ct. 1866, 1877-78 (2011), the U.S. Supreme Court held that the summary plan documents, do ***not*** themselves constitute the ***terms*** of the plan for purposes of § 502(a)(1)(B).

Get the Plan Documents

If possible, get the plan documents before deciding whether to take the case. Depending on the plan and the language, it may not be in your best interest to take the case.

The Plan documents will tell you:

1. What type of claim am I dealing with?

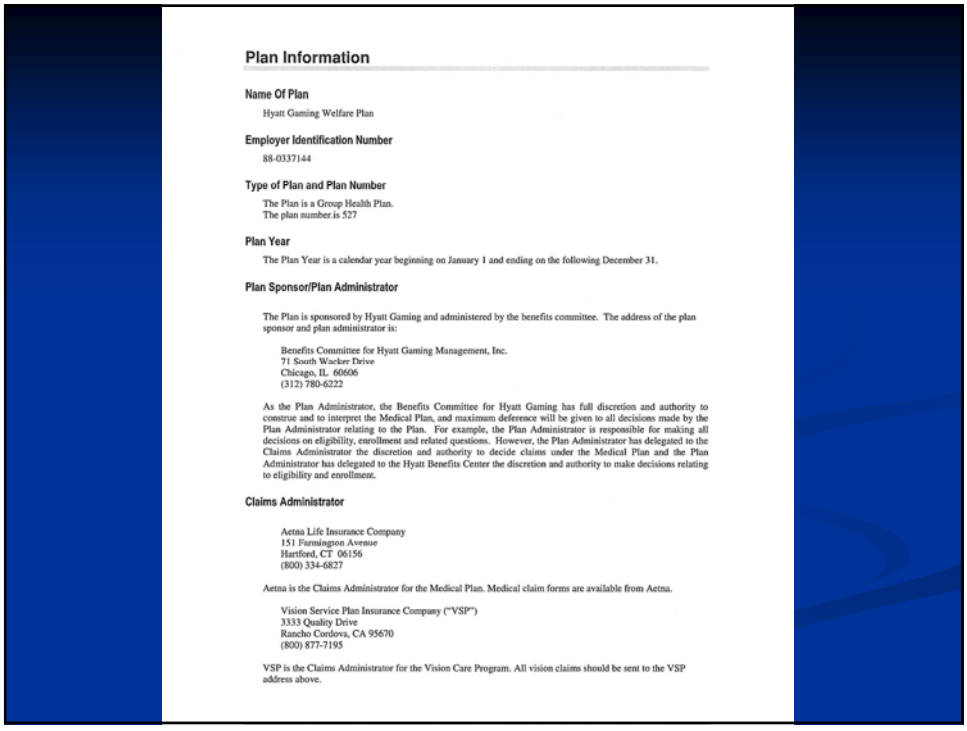
2. What is the actual plan language?

3. What laws govern the plan language?

4. Who am I negotiating or litigating with?

Get the Plan Documents

- Plans with greater than 100 members are required to file a Form 5500 annually detailing whether the Plan is insured or self-funded. Many Form 5500s are available on www.FreeERISA.com;
- If your client works for a small business have your client get the plan documents from his or her employer;
- Look in the Summary Plan Description ("SPD") or Form 5500s and determine the Plan Administrator. Send a formal request to the Plan Administrator for Plan documents.



Plan Information

Name Of Plan

Hyatt Gaming Welfare Plan

Employer Identification Number

88-0337144

Type of Plan and Plan Number

The Plan is a Group Health Plan.
The plan number is 527

Plan Year

The Plan Year is a calendar year beginning on January 1 and ending on the following December 31.

Plan Sponsor/Plan Administrator

The Plan is sponsored by Hyatt Gaming and administered by the benefits committee. The address of the plan sponsor and plan administrator is:

Benefits Committee for Hyatt Gaming Management, Inc.
71 South Wacker Drive
Chicago, IL 60606
(312) 780-6222

As the Plan Administrator, the Benefits Committee for Hyatt Gaming has full discretion and authority to construe and to interpret the Medical Plan, and maximum deference will be given to all decisions made by the Plan Administrator relating to the Plan. For example, the Plan Administrator is responsible for making all decisions on eligibility, enrollment and related questions. However, the Plan Administrator has delegated to the Claims Administrator the discretion and authority to decide claims under the Medical Plan and the Plan Administrator has delegated to the Hyatt Benefits Center the discretion and authority to make decisions relating to eligibility and enrollment.

Claims Administrator

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156
(800) 334-6827

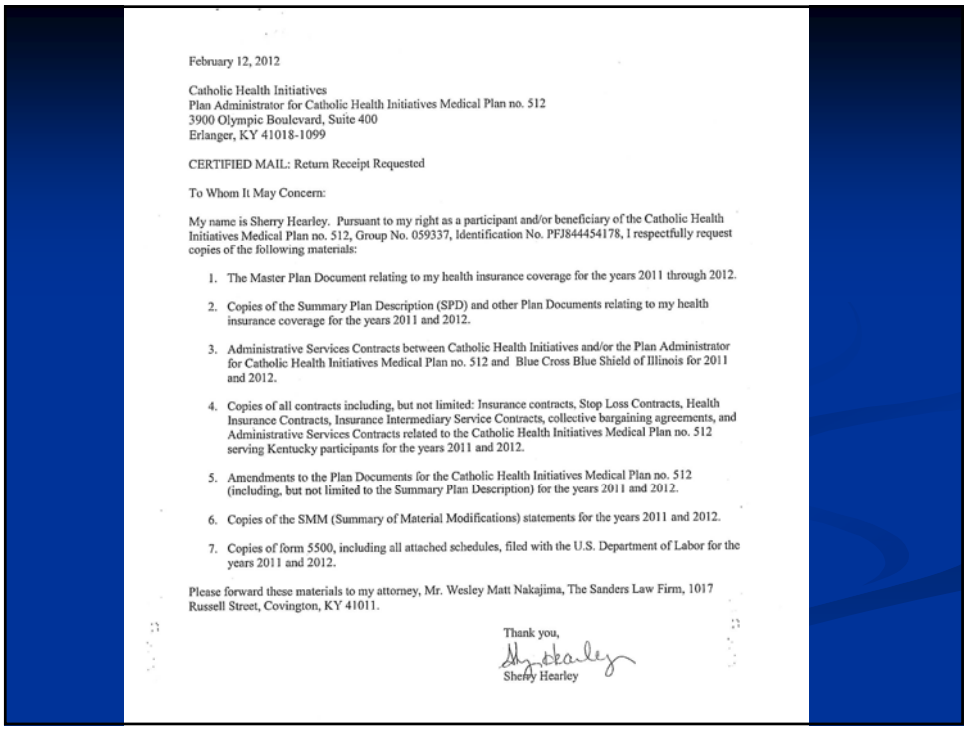
Aetna is the Claims Administrator for the Medical Plan. Medical claim forms are available from Aetna.

Vision Service Plan Insurance Company ("VSP")
3333 Quality Drive
Rancho Cordova, CA 95670
(800) 877-7195

VSP is the Claims Administrator for the Vision Care Program. All vision claims should be sent to the VSP address above.

Get the Plan Documents

- Request plan documents under 29 U.S.C.A. § 1024(b)(4)
  - The Request Should Come from your Client.
  - The Request Should go to the Plan Administrator, not the Claims Administrator or the third-party recovery Company.



February 12, 2012

Catholic Health Initiatives
Plan Administrator for Catholic Health Initiatives Medical Plan no. 512
3900 Olympic Boulevard, Suite 400
Erlanger, KY 41018-1099

CERTIFIED MAIL: Return Receipt Requested

To Whom It May Concern:

My name is Sherry Hearley. Pursuant to my right as a participant and/or beneficiary of the Catholic Health Initiatives Medical Plan no. 512, Group No. 059337, Identification No. PFJ844454178, I respectfully request copies of the following materials:

1. The Master Plan Document relating to my health insurance coverage for the years 2011 through 2012.
2. Copies of the Summary Plan Description (SPD) and other Plan Documents relating to my health insurance coverage for the years 2011 and 2012.
3. Administrative Services Contracts between Catholic Health Initiatives and/or the Plan Administrator for Catholic Health Initiatives Medical Plan no. 512 and Blue Cross Blue Shield of Illinois for 2011 and 2012.
4. Copies of all contracts including, but not limited: Insurance contracts, Stop Loss Contracts, Health Insurance Contracts, Insurance Intermediary Service Contracts, collective bargaining agreements, and Administrative Services Contracts related to the Catholic Health Initiatives Medical Plan no. 512 serving Kentucky participants for the years 2011 and 2012.
5. Amendments to the Plan Documents for the Catholic Health Initiatives Medical Plan no. 512 (including, but not limited to the Summary Plan Description) for the years 2011 and 2012.
6. Copies of the SMM (Summary of Material Modifications) statements for the years 2011 and 2012.
7. Copies of form 5500, including all attached schedules, filed with the U.S. Department of Labor for the years 2011 and 2012.

Please forward these materials to my attorney, Mr. Wesley Matt Nakajima, The Sanders Law Firm, 1017 Russell Street, Covington, KY 41011.

Thank you,

Sherry Hearley

Request Plan Documents

- A plan administrator's failure to provide the requested information within 30 days results in a cause of action in favor of the beneficiary against the administrator for the recovery of a penalty of up to $110 per day for each day of noncompliance. *See* 29 U.S.C. 1132(c)(1)(B) and 29 CFR §2575.502c-1.

Request Plan Documents

- In *Bartling v. Fruehauf Corp.*, 29 F.3d 1062, 1065 (6th Cir. 1994), the Sixth Circuit affirmed the Southern District of Ohio's decision to award $25,200.00 in civil penalties to the plan beneficiaries for an ERISA plan's failure to provide plan documents.

- In *Gatlin v. Nat. Healthcare Corp.*, 16 Fed.Appx. 283, 287 (6th Cir. 2001), the Sixth Circuit awarded $12,100.00 to the insured based on the plan's failure to produce plan documents for 121 days.

Sereboff v. Mid Atlantic Medical Services, Inc., 126 S. Ct. 1869 (2006)

- Before an ERISA plan can establish an "equitable" lien by agreement, it must meet two criteria, the plan language must:
  - (1) identify a specific fund distinct from the member's general assets from which the reimbursement is to be made; and
  - (2) identify the particular share of that fund to which the plan is entitled.

Sereboff v. Mid Atlantic Medical Services, Inc., 126 S. Ct. 1869 (2006)

- If you or your dependent receives benefits and have a right to recover damages from a third party, the Company is subrogated to this right. All recoveries from a third party (whether by lawsuit, settlement, or otherwise) must be used to reimburse the Company net of reasonable attorney fees and court costs prorated to reflect that portion of the total recovery which is due the Company for benefits **paid**. Any remainder will be yours or your dependents. The Company's share of the recovery will not be reduced because you or your dependent has not received the full damages claimed, unless the Company agrees in writing to a reduction.

Sereboff v. Mid Atlantic Medical Services, Inc., 126 S. Ct. 1869 (2006)

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Popowski v. Parrott,
461 F.3d 1367 (11th Cir. 2006)

United Distributors Plan stated:

"The Covered Person ... must repay to the Plan the benefits paid on his or her behalf out of the recovery made from the third party or insurer."

***Popowski v. Parrott,* 461 F.3d 1367 (11th Cir. 2006)**

United Distributors Plan stated:

"The Covered Person ... must repay to the Plan **the benefits paid** on his or her behalf **out of the recovery** made from the third party or insurer."

***Popowski v. Parrott,* 461 F.3d 1367 (11th Cir. 2006)**

Mohawk Plan stated:

If, however, the Covered Person receives a settlement, judgment, or other payment relating to the accidental injury or illness from another person, firm, corporation, organization or business entity paid by, or on behalf of, the person or entity who allegedly caused the injury or illness, the Covered Person agrees to reimburse the Plan in full, and in first priority, for any medical expenses paid by the Plan relating to the injury or illness.

Popowski v. Parrott, 461 F.3d 1367 (11th Cir. 2006)

Mohawk Plan stated:

If, however, **the Covered Person receives a settlement,** judgment, or other payment relating to the accidental injury or illness from another person, firm, corporation, organization or business entity paid by, or on behalf of, the person or entity who allegedly caused the injury or illness, **the Covered Person agrees to reimburse the Plan in full**, and in first priority, for any medical expenses paid by the Plan relating to the injury or illness.

Popowski v. Parrott, 461 F.3d 1367 (11th Cir. 2006)

- The Sixth Circuit adopted the reasoning in *Popowski* in *Gilchrest v. Unum Life Ins. Co. of Am.*, 255 Fed. Appx. 28 (6th Cir. 2007)

Example 1

- Client injured due to defective farm equipment.
- 2 neck surgeries for herniated disks.
- Humana paid $45,000.00 in medical expenses and demands full reimbursement.
- Insured ERISA Plan.

Example 1

Plan language:

- If benefits are paid under the master group contract and you recover from any legally responsible person, their insurer, or any uninsured motorist, underinsured motorist, medical payment/expenses, no-fault, or other similar coverage, we have a right to recover from you an amount equal to the amount we paid.

Example 1

Plan language:

- If benefits are paid under the master group contract and you recover from any legally responsible person, their insurer, or any uninsured motorist, underinsured motorist, medical payment/expenses, no-fault, or other similar coverage, we have **a right to recover from you** an amount equal to the amount we paid.

Example 2

- MVA in Clermont County.
- Chronic neck strains
- $11,0000 in medical expenses paid by Aetna
- Self Funded ERISA Plan

Example 2

Plan language:

- If, however, the Covered Person receives a settlement, judgment, or other payment… the Covered Person agrees to reimburse the Plan in full, and first priority, for any medical expenses paid by the Plan relating to the injury or illness."

Example 2

Plan language:

- If, however, the Covered Person receives a settlement, judgment, or other payment… **the Covered Person agrees to reimburse the Plan** in full, and first priority, for any medical expenses paid by the Plan relating to the injury or illness."

- *** Doesn't identify separate fund from which reimbursement is to be made (i.e., out of the settlement or recovery).

Made Whole Doctrine

- The made whole doctrine generally states that an insured must receive compensation sufficient to put him back into the position he would have been before being injured by the at fault party.

Made Whole Doctrine

- A plan avoids the make-whole doctrine if the Plan language establishes both: (1) that the insurer has a right to a full or partial recovery of amounts paid by it on the insured's behalf and (2) that the insurer will be accorded priority over the insured as to any funds recovered.

- *See Copeland Oaks v. Haupt*, 209 F.3d 811, 813-14 (6th Cir. 2000); and *N. Buckeye Edn. Council Group Health Benefits Plan v. Lawson,* 103 Ohio St. 3d 188, ¶ 25 (2004).

Applying the Made-Whole Doctrine

- MVA in Cincinnati. Plaintiff incurs $40,000.00 in medical expenses, $30,000.00 of which are paid by the University of Cincinnati Student Health Insurance Plan, a non-ERISA state health plan. The case settled for limits of $25,000.00.
- Plan language states: "If benefits are paid under the Policy and any person recovers from a responsible third party by settlement, judgment or otherwise, We have a right to recover from that person an amount equal to the amount We paid."

Applying the Made-Whole Doctrine

- The plan says nothing about "partial recovery" or that it has "priority" to the fund recovered.
- Since the Plaintiff has to be fully compensated for her injuries before the Plan's right to subrogation arises and her medical expenses are greater than the recovery, the made-whole doctrine applies and the plan gets nothing.

Applying the Made-Whole Doctrine when the case settled for less than policy limits

- Assume a MVA occurs in Clermont County. Plaintiff suffer a lumbar strain and incurs $10,000.00 in medical expenses that were paid by an insured ERISA plan.
- Liability limits are 25,0000 and there is no UIM coverage. The case settled pre-suit for $23,000.00.
- **In Ohio, is the Plaintiff precluded from arguing that he was not made whole if he settles for less than policy limits?**

Answer: In Ohio the voluntary settlement by an insured of his claims against a tortfeasor, without proof to the contrary, is persuasive evidence that the insured was fully compensated *Allen v. Binckett,* 5th Dist. No. CT2008-0027, 2009-Ohio-2969, at ¶ 28

Ohio Courts have created a presumption that the insured was made whole if he/she settles for less than policy limits, but have allowed evidence to rebut this presumption.

Release Language

- By accepting this settlement, [Client] is not admitting or conceding that she was "made whole." [Client] was not "made whole" and is accepting less than the full value of her claim because of the risk of her potential case expenses exceeding her potential recovery after protracted litigation and the risk of a jury adopting the defense's position that her medical expenses were related to a pre-existing medical conditions unrelated to the subject accident and that she failed to mitigate her damages by delaying treatment.

Reasons why You settle for less than Policy Limits

- The uncertainty of prevailing at trial
- the expense of litigation
- the tortfeasor's ability to pay
- Time commitment and stress of litigation

- Because of these factors an insured will almost always agree to accept in settlement an amount less than is necessary to fully compensate for the loss. ***Thus, an insured should not be deemed to have been fully compensated simply because of entering into a settlement with the tortfeasor***. *See* Insurance Claims and Disputes, 5th edition, section § 10:6. (emphasis added).

Common Fund Doctrine

- Black's Law Dictionary defines "***common fund doctrine***" as providing that "a private plaintiff, or plaintiff's attorney, whose efforts create, discover, increase, or preserve a fund to which others also have a claim is entitled to recover from the fund the costs of his litigation, including attorney's fees." ***BLACK'S LAW DICTIONARY*** 276 (6th ed.1990).

Common Fund Doctrine

- The Sixth Circuit ***had*** essentially eliminated the federal common fund doctrine. *See Health Cost Controls v. Isbell*, 139 F.3d 1070, 1072 (6th Cir. 1997)(holding language such as "full reimbursement" is sufficient to disavow common fund).
-

US Airways, Inc. v. McCutchen no. No. 11–1285, 2013 WL 1567371 (U.S. April 16, 2013)

Plan language:

- [y]ou will be required to reimburse [US Airways] **for amounts paid** for claims out of any monies recovered from [the] third party, including, but not limited to, your own insurance company as the result of judgment, settlement, or otherwise."

US Airways, Inc. v. McCutchen no. No. 11–1285, 2013 WL 1567371 (U.S. April 16, 2013).

- "the plan provision here leaves space for the common-fund rule to operate. [The Common Fund], as earlier noted, addresses not how to allocate a third-party recovery, but instead how to pay for the costs of obtaining it."
- "The plan's terms fail to select …whether the recovery to which US Airways has first claim is every cent the third party paid or, instead, the money the beneficiary took away."

Common Fund Doctrine

- In *Thatcher v. Sowards*, 2000 WL 310239 at *4 (Ohio App. 4 Dist. 2000), the Court held that an insurer, who does not utilize its right to subrogation, must pay reasonable attorneys' fees to Plaintiff's counsel for recovering a settlement on its behalf.

Common Fund Doctrine

- When dealing with a Self Funded or Insured ERISA plan or a non ERISA state health plan, argue that common fund applies unless the plan specifically disavows the doctrine or a reduction for attorney's fees.

Applying the common fund doctrine

- Plaintiff was injured in a MVA. A State health plan, administered by Humana, paid 1,399.55 in medical expenses on Plaintiff's behalf.
- After settling with the tortfeasor, Plaintiff 's counsel sent a letter to Humana stating: Counsel's fee was 33% out of any recovery that it obtained on Plaintiff's behalf. Assuming that the same percentage applies to the money that Plaintiff's counsel obtained for the Plan, the Plan owes Plaintiff's counsel $461.85 (33% of $1,399.55) in attorney's fees.
- Humana agreed to reduce its lien by $461.85.

What is "appropriate" equitable relief under § 502(a)(3)?

- *US Airways, Inc. v. McCutchen* no. No. 11–1285, 2013 WL 1567371 (U.S. April 16, 2013).
- Equitable principal cannot override clear and unambiguous contract terms.

U.S. Airways, Inc. v. McCutchen

- Take Away:
  - Master Plan document controls not the SPD.
  - ERISA plan sponsors can disclaim all equitable doctrines in their reimbursement provisions and Federal Courts will enforce grossly unfair reimbursement provisions against plan participants.
  - Eventually , all ERISA master plans will be updated and will exclude all equitable defenses.

What Can We Do

- Refuse to take certain cases until the plan sponsors and insurers agree to reasonably reduce liens.
- Lobby the legislature for anti-subrogation legislation.

Can the SPD be the Plan? – Insurer's argument

- When there are "no actual 'plans' separate and apart from the [SPD] themselves," as is the case here, "the only relevant plan documents," if indeed there are any relevant plan documents, "are the [SPD]." *Shaffer v. Rawlings Co.*, 424 F.App'x 422, 426 (6th Cir. 2011)

- In *L & W Associates Welfare Benefit Plan v Estate of Terance R. Wines*, 2014 WL 3338424 (MI Dist. Ct. Jan. 13, 2014), a Michigan District Court held that if "no formal Plan document was in existence, the SPD (here the Handbook and the Workbook) *is* the Plan document."

Can the SPD be the Plan? Insured's argument

- ERISA defines the word "plan" as "an employee welfare benefit plan or an employee pension benefit plan or a plan which is both," 29 U.S.C. § 1002(3), and it requires that a "plan" "be established and maintained pursuant to a written instrument," § 1102(a)(1).

- An SPD, in contrast, is a disclosure meant "to reasonably apprise [plan] participants and beneficiaries of their rights and obligations under the plan." § 1022(a)..

Can the SPD be the Plan? Insured's argument

- Plan Sponsor (e.g., the employer) executes a written instrument (the plan) containing the terms and conditions of the plan. CIGNA Corp. v. Amara, 131 S. Ct. 1866, 1877, 179 L. Ed. 2d 843 (2011)
- The plan's administrator manages the plan and writes the summary documents that describe the plan. Id.

Can the SPD be the Plan? Insured's argument

- My position: SPD can **never** been the actual plan.
  1. The SPD is written by the plan administrator.
  2. The plan administrator is not a party to the contract between the employer (plan sponsor) and employee.
  3. Thus, the SPD is not part of the ERISA plan, because it was not written by the plan's sponsor. *Amara*, at 1884-85 (Scalia, concurring in judgment).

Notice of Plan's Right to Reimbursement

Community Ins. Co. v. Ohayon
73 F.Supp.2d 862, 864 (N.D.Ohio,1999)

Facts:

- Jonathan Ohayon, a minor, was seriously injured in a MVA incurring $115,756.21 in paid medical expenses;
- $100,000 in liability limits;
- Case settled for $99,935.00;
- Insured ERISA Plan demanded full reimbursement under the reimbursement language in the certificate of coverage;
- Ohayon argued that the Plan was not entitled to reimbursement under the made whole doctrine and because Jonathan's parents did not receive the policy certificate providing the Plan a right to reimbursement prior to signing the enrollment application.

Notice of Plan's Right to Reimbursement

Community Ins. Co. v. Ohayon
73 F.Supp.2d 862, 864 (N.D.Ohio,1999)

- The Court held that the Plan was not entitled to reimbursement because (1) Jonathan was not made whole; and (2) there was no evidence that the Certificate of coverage existed at the time that the Ohayon's employer signed the Trust Application/Participation Agreement for insurance and **because the Plan could not provide any evidence that the Ohayons received a copy of the policy certificate before they signed the enrollment application.**

Attorney Liability

Longaberger v. Kolt, 586 F.3d 459 (6th Cir. 2009)

- Facts:
  - Client involved in MVA and incurred $113,000.00 in medical expenses paid by the Longaberger plan.
  - Attorney Kolt settled his client's case for $135,000.00.
  - Placed the funds in his IOLTA account and sent a letter to the Longaberger Plan to settle the reimbursement lien.
  - After 4 months without hearing from the Plan, Kolt disbursed the funds to his client and keep 45k as his attorney's fee.
  - The Plan filed suit against Kolt and his client

Attorney Liability

Longaberger v. Kolt, 586 F.3d 459 (6th Cir. 2009)

- The Sixth Circuit ordered Kolt to reimburse the Longaberger Plan $37,889.44 after he disbursed the settlement funds to his client without resolving the Plan's ERISA lien.

- Moral of the Story: **Do not disburse the settlement funds to the client until you resolve the ERISA lien.**

THE END

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