

Top 10 Mistakes Personal Injury Attorneys Make

Dealing with ERISA Health Care Subrogation Claims

by Eric Buchanan and Dacey Cockrill

When your client is hurt and has a personal injury claim, you know that in most cases your client's health insurance is going to pay for your client's medical treatment, but the insurance company is going to try to get its money back when you and your client recover from the person who injured your client.

Most clients get health insurance through work and almost all of those health insurance policies fall under ERISA. ERISA sets up complicated rules and procedures for health care recovery/subrogation claims made by health insurance companies against your client.

I have been studying and teaching ERISA and ERISA subrogation/health care reimbursement for close to fifteen years, and I regularly receive calls and emails from fellow trial lawyers asking for help and advice about how to deal with health care subrogation claims. I also regularly discuss these claims and answer questions when I lecture on ERISA subrogation at Trial Lawyers' conferences.

What I have learned is that the same mistakes are made over and over again by different attorneys. I aim to help attorneys avoid these mistakes, so that clients never repay a penny more than they should to a health care company. Starting with the most egregious mistake an attorney can make, here are the top 10 mistakes frequently made in ERISA health care subrogation claims.

1. Ignoring a possible healthcare lien entirely and hoping the health insurance company never goes after your client.

Several attorneys have told me that their strategy is to ignore the possibility of any health care recovery claim by the health care company, especially if the health insurance company never reaches out to the attorney or the client. Unfortunately, even if the insurance company does not find out about your case or even if your client's case is settled, the insurance company can come after you and your client years after the settlement and sue both of you for reimbursement.

There is no specific statute of limitations under ERISA limiting the number of years that an insurance company may sue you and your client; instead, ERISA case law adopts the "most analogous" statute of limitations from state law. Under Tennessee contract law, the insurance company could bring a claim for up to six years. Further, those six years might not begin running until the contract is breached, which does not occur until you distribute your client's settlement proceeds

without honoring the insurance's reimbursement claim. Depending on how courts interpret the "discovery rule" in ERISA cases, insurance companies may have a valid argument that the six years does not begin to run until the insurance company actually finds out that you distributed your client's money. If you ignore the potential reimbursement claim, you may force your client to look over his or her shoulder for years.

Also, there is at least one case that holds that you, as the attorney, can be jointly liable for the healthcare recovery claim if you distribute the money. In *Longaberger Co. v. Kolt*, 586 F.3d 459 (6th Cir. 2009) the Court of Appeals held that an attorney (Mr. Kolt) could be individually liable for failing to pay a subrogation/reimbursement claim.

If you distribute to your client, the health insurance company could sue both you and your client years after the settlement, and you will have to explain to your client why they are being sued years later. Even if your client was willing to take this risk, you, as the attorney, could be liable to reimburse the health insurance company if courts follow the precedent in *Longaberger*.

Recently in *Montanile v. Board of Trustees of the National Elevator Industry Health Benefit Plan*, the Supreme Court prohibited a health insurance company from recovering funds that had already been dissipated. , 577 U.S. ____, (2016); 136 S.Ct. 651 (2016). However, in *Montanile* the attorney communicated with the health insurance company, giving them a chance to protect their rights, but they failed to do so. *Id.* The attorney distributed the money only after warning the health insurance company that he would. *Id.* The court did not discuss whether this holding would apply if the attorney had not communicated with the health insurance company before distributing the money. Therefore, the *Longaberger* holding may still apply if you try to ignore potential reimbursement claims.

2. Waiting until after or just before settlement to deal with reimbursement claims.

The second most egregious mistake is waiting until settlement to deal with the health insurance company's claim. If you wait until settlement, you no longer have leverage to uncover what rights the insurance company has. These rights turn primarily on the terms of the ERISA plan. You lose the ability to negotiate with the health insurance company about whether they will offer a reduced lien in exchange for you working on the case and whether they will respect your attorney's fee. You will have foregone the opportunity to address this issue earlier,

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and you will likely hold up the settlement.

By dealing with the issue early on, you have the opportunity to request the plan documents from the Plan Administrator (and make sure you request documents from the correct party, as discussed below). Because the Plan Administrator has thirty days to produce the documents, if you order them early, you can review them to determine whether the health insurance company or plan has the right to recover from your client. (As I have discussed in other articles and papers, not all ERISA plan language is sufficient to allow health insurance companies to recover.) If you do not address reimbursement until settlement, you either forego the opportunity to view the plan documents or you delay settlement.

If the language of the plan documents suggests that the health insurance company does not have reimbursement rights, you have missed leverage you could have used to achieve a better settlement for your client. By the time of settlement, the health insurance company has all the leverage. You and your client simply want to end the case, and the health insurance company has ample incentive to pursue reimbursement from the settlement money. If you had negotiated earlier, the health insurance company may have been more amenable to making a deal.

3. Not discussing subrogation/health insurance recovery with the client early in the case AND 4. Not including it in the fee agreement.

I submit it is ethical to charge your client a fee of a percentage out of the total recovery, and any amount that is paid back to the health insurance company due to their subrogation/recovery claim could come out of the client's share of the recovery. However, if you choose to do it this way, you should have this clearly spelled out in your fee agreement with the client, and you should go over this with your client at the intake.

If you do not cover this in the fee agreement, I submit that it would not be unreasonable for the client to assume that your fee would come as a percentage of the net recovery after paying back the insurance company. The client would understandably be upset if you did not explain to your client how this worked up front.

5. Not sending a certified request for documents to the plan administrator (usually the employer) early in the case.

The plan, and the language in it, is key. Under ERISA, a plan or fiduciary, like an insurance company, can only seek "to enjoin any act or practice which violates [ERISA] or the terms of the plan, or (B) to obtain other *appropriate equitable relief* (i) to redress such violations or (ii) to enforce any provisions of [ERISA] or the terms of the plan." ERISA § 502(a)(3). In an ERISA plan, health insurance companies can only seek to recover from your client if the plan has appropriate language allowing for reimbursement or subrogation; there is no general

right of reimbursement or subrogation in ERISA. Additionally, even if the plan has language that purports to allow the insurance company to recover, the case law requires that the language meet specific requirements in order to allow recovery. "The plan, in short, is at the center of ERISA." *US Airways, Inc. v. McCutchen*, 569 U.S. 88, 100 (2013).

The bottom line is that plaintiffs' attorneys must obtain the ERISA plan to determine whether the insurance company has a right of recovery or not and the parameters of that right. If our clients might face the subrogation/reimbursement issue at some point in their injury case, I submit that the best practice is for the attorney to order a copy of the plan documents from the plan administrator very early in the injury case, find out the plan rules early, and deal with the possible subrogation/reimbursement claim early on.

Fortunately, under ERISA a plan participant or beneficiary has the right to obtain the plan documents controlling an ERISA plan, such as a health insurance plan. If a participant or beneficiary sends a written request for the plan documents to the correct entity (the plan administrator) and the documents are not provided within 30 days of receipt of the written request, the plan administrator can be sued for penalties up to \$110 per day. ERISA § 502(c), 29 U.S.C. § 1132(c). If a plan administrator is particularly uncooperative, these plan document penalties can be substantial. For a full discussion of how to obtain these penalties in court, please visit our website, and check out the article at <https://www.buchanandisability.com/helpful-resourcesandarticles/erisa-502c-actions/>.

6. Only asking for the official plan documents from the insurance company or requesting plan documents from the collection company.

When you ask for the plan documents, ERISA case law requires that you ask for the documents from THE PLAN ADMINISTRATOR. The Plan Administrator is almost never the health insurance company and is never the collections agency hired to pursue reimbursement. In most circuits, including the Sixth, only the designated Plan Administrator, normally the employer or union providing benefits, is liable for the \$110 per day penalty under ERISA § 502(c), discussed above. *Caffey v. UNUM Life Ins. Co.*, 302 F.3d 576, 584 (6th Cir. 1989); *Hiney Printing Co. v. Brantner*, 243 F.3d 956, 960 (6th Cir. 2001); *VanderKlok v. Provident Life & Accident Ins. Co.*, 956 F.2d 610, 618 (6th Cir. 1992). Furthermore, the Sixth Circuit has expressly held that "an insurance company, which is not a plan administrator, cannot be held liable for statutory damages [under § 1132(c)] for failure to comply with an information request." *Caffey*, 302 F.3d at 58 (citing *VanderKlok*, 956 F.2d at 618); See also, our case *Addison v. Hartford Life and Accident Ins.*, 32 Emp. Ben. Cas. 1640, No. 1:03-CV-172, 2003 WL 23413737 (E.D.Tenn. Dec. 12, 2003) (unpublished).

So, how is an attorney to know who to write to in order to get the plan documents? Under ERISA § 3(16), 29 U.S.C. § 1002(16), the Plan Administrator is the person specifically



designated in the plan. If you have a copy of the plan, you can easily see who is named as the Plan Administrator. If you do not have the plan, the best guess you can make is to assume it is the Plan Sponsor, because ERISA § 3(16), 29 U.S.C. § 1002(16), states that when no Plan Administrator is named in the plan, the Plan Sponsor (the employer or union that offers the benefits) is deemed to be the Plan Administrator. In my experience, most documents name the employer or union as the Plan Administrator. If you do not have the plan documents, write to the employer or union first, and address your letter "attention Plan Administrator of the Health Care Plan."

Also, because ERISA fiduciaries, which include insurance companies and Plan Administrators, have a fiduciary duty to truthfully answer questions when asked, I believe it is the best practice to ask the employer and insurance company who the Plan Administrator is so you know who to write the proper request to in a follow-up letter.

7. Accepting a one page statement of subrogation rights as the official plan documents.

In almost every case where I am called later in the process and when the attorney knew to request the plan documents, the document that has been provided is just one or two pages that supposedly contains the policy's ERISA subrogation and reimbursement language. DO NOT ACCEPT THIS!

When you request the plan documents from the Plan Administrator, make sure they send you the whole plan. I have seen cases where the language sent over by the collections agency or insurance company is only the summary plan description ("SPD") and not the actual plan. For a long time, it was assumed that such a right could be found in either the formal plan document or the summary plan description. However, the Supreme Court in *Cigna v. Amara*, explained that "the summary documents, important as they are, provide communication with beneficiaries about the plan, but . . . their statements do not themselves constitute the terms of the plan." 563 U.S. 421, 438(2011). Therefore, check that the subrogation or reimbursement language is actually in the plan and not just in the SPD. In order for the language in an SPD to be controlling, the plan must contain language saying that the SPD is part of the plan, or, according to some courts, if the SPD says it is part of the plan. This type of language is rare though, so usually the SPD is just a summary. Therefore, the health insurance will not have reimbursement rights if such rights are only granted in the SPD.

Another reason to demand the entire plan documents is that occasionally the health insurance company will respond to an initial request with one or two pages that are not even in the SPD. The given pages may not be in anything except perhaps a sample policy or a file at the collection agency's office. They send you this one or two page document asserting reimbursement rights hoping you will accept it, when in fact there is no such language in the plan document at all.

8. Assuming a policy is or is not ERISA based on what the policy says.

Whether or not your client's health insurance policy falls under ERISA is crucial in determining the health insurance company's reimbursement rights. If Tennessee law applies, rather than ERISA, then your client only has to reimburse the health insurance company if your client was made whole. On the other hand, if ERISA applies, the insurance company can put language in the plan that overcomes the made-whole doctrine. Also, if ERISA applies, the insurance company can sue you and your client in federal court.

ERISA typically applies if an employer offers the health benefits, or at least endorses the benefits. However, ERISA does not apply if the benefits are offered by a government entity. ERISA does apply, however, if a government employee gets his or her benefits through a union. Also, if the health insurance is offered by a church or church-run organization, ERISA does not apply unless the church chooses to opt in to ERISA.

If a non-government employer offers the benefits, ERISA applies even if the employee pays all of the premiums. On the other hand, ERISA does not apply if there was no employer involved. For example, if a person buys his policy directly from an agent or buys a policy from the Affordable Healthcare Act website, the policy does not fall under ERISA.

For a full discussion of when ERISA applies, please visit our website and read the article, <https://www.buchanandisability.com/helpful-resourcesandarticles/how-to-tell-if-an-insurance-claim/>.

The bottom line is this: if an employer endorses the benefits, the health benefits fall under ERISA, unless it is a government plan or church plan from a church that has not opted in. Under ERISA case law, the policy's own statement of whether or not it falls under ERISA is not determinative. If no employer is involved, an insurance company cannot turn a non-ERISA policy into an ERISA policy no matter how many times the policy claims "this is an ERISA policy". Similarly, if an employer offers a benefit, it is subject to ERISA, even if the policy never mentions ERISA. Simply put, whether the policy says it is ERISA or not is never a factor to be considered.

9. Failing to ask the insurance company for their file and then failing to review the file.

In addition to asking the Plan Administrator for the controlling plan documents, you should ask the insurance company for a copy of their claim file that shows what claims have and have not been paid and the amount paid for those claims. While not subject to the \$110 a day penalty discussed above, insurance companies, as other ERISA administrators, must comply with the regulations requiring them to turn over the "relevant" documents. Specifically, the Secretary of Labor's ERISA claim procedures regulations, set out in 29 C.F.R. § 2560.503-1(h)(2)(iii), describe what documents an administrator must provide. The regulations state that, in order to provide a full and

fair review, the Plan must:

Provide that a claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits. Whether a document, record, or other information is relevant to a claim for benefits shall be determined by reference to paragraph (m)(8) of this section.

Paragraph (m)(8) requires that the following relevant documents be produced:

A document, record, or other information shall be considered "relevant" to a claimant's claim if such document, record, or other information.

(i) Was relied upon in making the benefit determination;

(ii) Was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination;

(iii) Demonstrates compliance with the administrative processes and safeguards required pursuant to paragraph (b)(5) of this section in making the benefit determination; or

(iv) In the case of a group health plan or a plan providing disability benefits, constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

In *Bartling v. Freuhauf Corp.*, the Sixth Circuit interpreted these disclosure provisions broadly. 29 F.3d 1062 (6th Cir. 1994) (holding that, because ERISA requires a plan to maintain actuarial reports, such documents must be provided to a participant on request.).

Once you receive the entire claim file, review it to make sure that the insurance company is not claiming a subrogation/reimbursement right over medical expenses not related to the injuries from the lawsuit. Additionally, if you find medical treatment you did not know about, request those medical records and follow-up on that additional treatment.

10. Not bringing in an ERISA subrogation attorney early in the process, especially in cases with large claims.

Insurance companies know that most personal injury attorneys are not experts in ERISA law or in subrogation/reimbursement claims. Too frequently the insurance companies attempt to bully personal injury attorneys into paying 100% of the insurance company's reimbursement claim. They will use their knowledge of ERISA law to take advantage of attorneys who do not have the resources to fight back.

If the subrogation/reimbursement claim is large enough, there are attorneys who will fight the health insurance compa-

ny, which can be done at no cost to the personal injury attorney and no "real" cost to the client. ERISA attorneys assisting the personal injury attorney will often work on a reverse-contingency basis. In other words, the ERISA attorney gets paid a fraction, customarily one-third of the money saved for the client that does not have to be paid back to the insurance company.

For example, consider a client with \$750,000 in actual damages, including \$200,000 in medical bills the insurance company wants paid back, and the defendant has only \$500,000 in insurance. Let's say the case is settled for \$500,000. If the insurance company prevails, the client would have to pay back \$200,000. If the attorney's fee agreement was clear that he or she is paid 33% out of the whole settlement, then he or she collects \$166,666.66, and the client only gets \$133,333.34.

But, if the personal injury attorney hires an experienced ERISA subrogation attorney, that attorney finds evidence that the insurance company is not entitled to reimbursement, and settles by getting the insurance company to agree to take perhaps \$50,000, then the ERISA attorney saved the client \$150,000 that would have been paid back. The ERISA attorney gets paid \$50,000, and the client gets to keep another \$100,000, or a total of \$233,333.34.

In addition, the personal injury attorney is able to turn over to the ERISA attorney all the work and effort of dealing with the health insurance company. The ERISA attorney can worry about all the special ERISA rules and getting the ERISA plan documents, and the personal injury attorney can worry about working on this or other cases. Additionally, the personal injury attorney does not have to spend a bunch of time learning ERISA.

ABOUT THE AUTHORS

Eric Buchanan represents disabled people and other policyholders across the United States in both ERISA and non-ERISA disputes, focusing primarily in the areas of disability, life, and health insurance. Eric served as President of the Tennessee Trial Lawyers Association (TTLA, also known as the Tennessee Association for Justice, or TAJ) from 2015 to 2016 and is a lifetime member of that organization.

Eric graduated from the Washington and Lee University School of Law magna cum laude in the top 10% of his class. While in law school he was inducted into the Order of the Coif and the Omicron Delta Kappa honorary leadership fraternity. Eric is a graduate of the Virginia Military Institute and served as an officer in the U.S. Navy from 1989 to 1994, where he served as a naval aviator (pilot), plane commander, and mission commander of P-3C Orion aircraft.

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