Subrogation Rights of Health Plans Established Under ERISA

by Evan P. Banker

This article explains the process of determining the reimbursement rights of ERISA-based health plans, current legal trends, equitable defenses, and negotiation strategies.

The Employee Retirement Income Security Act of 1974 (ERISA) governs nearly all employer-maintained benefit plans.1 Sixty percent of American workers who have employer-sponsored health insurance are enrolled in self-funded ERISA plans,2 which are exempt from state laws regarding insurance and subrogation.3 This represents an 81.7% increase in self-funded plan enrollees over the last ten years.4 Of relevance to the practitioner representing personal injury plaintiffs is the self-funded plan’s right to bring a federal civil action “to enforce any provisions . . . of the terms of the plan.”5

When a tort settlement or verdict is reached, payors of health benefits frequently assert a subrogation interest in the recovery. Plans established under ERISA routinely claim exemption from Colorado’s made whole and common fund statute, CRS § 10-1-135, although only those that are self-funded and with appropriately drafted plan language are entitled to the exemption.6 This article explains the process for determining a health plan’s status and subrogation rights.

Plan Funding and Federal Preemption

When an ERISA plan is self-funded by the employer, it is exempt from state laws governing insurance.7 The plan document will be construed under federal law and, if appropriately drafted, its terms will be given full effect.8 Plan drafters typically include onerous subrogation rights, providing for reimbursement of every dollar paid without regard for procurement costs or attorney fees.

On the other hand, where a plan established under ERISA holds one or more policies of insurance that pay for the injured employees’ health benefits, state laws regulating insurance apply to the plan equally as they would to the insurer.9 ERISA preserves the states’ traditional role of regulating insurance policies issued within their borders.10 Therefore, when the employer does not bear the risk of loss—but rather puts that burden on an insurer—it is not entitled to federal preemption.11

The plan’s funding determines the applicable law. Thus, the first step for the practitioner dealing with an asserted subrogation interest from an ERISA plan is to ascertain whether the plan is funded by the assets of the employer or by policies of insurance.

The key to understanding the plan’s funding can be found in its required federal filings. Employers maintaining ERISA plans must file an IRS form 5500 annually with the U.S. Department of Labor (DOL). These are publicly available documents, and can be found at www.freeerisa.com (registration required), or requested from the plan administrator. The form 5500, with its Schedule As and Cs, will give the practitioner the best understanding of the plan’s funding.

Form 5500, page one, elements 9a and 9b—“plan funding arrangement” and “plan benefit arrangement”—each lists the following options: (1) insurance; (2) section 412(e)(3) insurance contracts; (3) trust; and (4) general assets of the sponsor. If only boxes (3) and/or (4) are selected in both elements, the inquiry ends there. Trust and general assets of the sponsor specifically exclude all policies of insurance.12 The plan is fully self-funded and federal law controls subrogation issues.

If any other funding arrangement is selected, the practitioner must consult the attached Schedules to find the relationship between the payor of benefits and the plan. Large companies may maintain many plans of insurance for various employee benefits, such as health, vision, dental, life, and disability coverage. There-
fore, multiple funding arrangements may be selected, describing the multiple plans. To add to the confusion, the party seeking reimbursement usually is not the employer directly, but rather is a company whose primary business is insurance. This is true even in cases where the plan is fully funded by the assets of the employer. In those situations, the insurance company is acting as a claims administrator.

Hypothetical

A personal injury plaintiff had been receiving health benefits through a United Healthcare (United) plan, provided by her employer. The attorney receives a letter from United stating that the plan is established under ERISA and will be seeking full reimbursement. The diligent attorney must retrieve the employer’s form 5500 and attached schedules. United may be acting as an insurer, or merely as a claims administrator. The attorney should first search the Schedule As for the one relating to the United Healthcare Health and Welfare Benefits Plan.

If the attorney finds a Schedule A related to United, box 8 of Schedule A should describe the benefit type paid on behalf of the beneficiary, usually “health.” Any matching selection but “stop loss (large deductible)” ends the inquiry. The plan is insured and subject to state laws regarding insurance and subrogation. (See the accompanying sidebar entitled “Schedule A.”)

If the benefits provider is not listed on a Schedule A, the practitioner likely will find it in Schedule C. The “service codes” in Part I, element (2)(b) of the schedule may include: (1) claims processing; (2) contract administrator; and/or (3) plan administrator (codes 12, 13, and 14, respectively). These codes indicate that the health benefits are being paid by the employer directly, with the insurance company acting only as an administrator. State laws are preempted by federal law, and the plan document will control subrogation issues. A company providing insurance would not be listed on schedule C. (See the accompanying sidebar entitled “Schedule C.”)

Stop-Loss Insurance

If a plan is fully self-funded, subrogation issues are governed by federal law. If it is fully insured, it is governed by state law. Stop-loss insurance is an arrangement whereby the employer is respon-

---

**SCHEDULE A**

*(Form 5500)*

| Department of the Treasury |
| Internal Revenue Service |
| Employee Benefits Security Administration |
| Pension Benefit Guaranty Corporation |

**Insurance Information**

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

- File as an attachment to Form 5500.
- Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

| OMB No. 1210-0110 |
| 2010 |

**This Form is Open to Public Inspection**

For calendar plan year 2010 or fiscal plan year beginning January 01, 2010 and ending July 31, 2010

| A Name of plan |
| COPPER MOUNTAIN WELFARE PLAN |

| B Three-digit plan number (PN) |
| 501 |

| C Plan sponsor’s name as shown on line 2a of Form 5500 |
| POWDR-COPPER LLC |

| D Employer Identification Number (EIN) |
| 27-1291328 |

**Part I: Information Concerning Insurance Contract Coverage, Fees, and Commissions**

Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information:

(a) Name of insurance carrier

REGENCY BLUECROSS BLUESHIELD OF UTAH

| (b) EIN |
| 87-0200138 |

| (c) NAIC code |
| 54550 |

| (d) Contract or identification number |
| 10005237 |

| (e) Approximate number of persons covered at end of policy or contract year |
| 796 |

| (f) From |
| 01/01/2010 |

| (g) To |
| 07/31/2010 |

**Part III: Welfare Benefit Contract Information**

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

- [x] Health (other than dental or vision)
- [ ] Dental
- [x] Vision
- [x] Life insurance
- [ ] Temporary disability (accident and sickness)
- [ ] Long-term disability
- [ ] Supplemental unemployment
- [ ] Prescription drug
- [ ] Stop loss (large deductible)
- [ ] HMO contract
- [ ] PPO contract
- [ ] Indemnity contract

*This condensed Schedule A shows an ERISA health plan that is insured by BlueCross BlueShield of Utah. It would be subject to state laws regarding subrogation.*
sible for paying benefits up to a predetermined maximum loss, either in aggregate or per employee. After that limit is reached, the plan is insured against further losses. Policies of stop-loss insurance reported on Schedule A are those funded with employee contributions, and therefore are considered assets of the plan.

Although this seemingly creates a gray area between insured and self-funded plans, circuit courts that have decided the issue (the Second, Third, Fourth, Fifth, Sixth, Eighth, and Ninth) have held that a plan that limits its liability with a stop-loss policy maintains its self-funded status. The Tenth Circuit has not considered the issue, and there is a split of authority from the district court judges within the Circuit. Judge Kane of the District of Colorado has held that the shifting of risk renders the plan insured, and thus subject to state laws on subrogation. However, the District of Kansas has sided with the majority trend in a more recent decision.

Plan Language and Federal Common Law

If a plan is insured and subject to state law, issues of subrogation are governed by CRS § 10-1-135. A thorough analysis of that statute was published in *The Colorado Lawyer* in February 2011.

If the practitioner determines that a plan is self-funded and therefore governed by the plan document and federal common law, it is imperative that the attorney read the plan document.

A fully self-funded plan may bring a federal action seeking “appropriate equitable relief” to enforce the terms of the plan document, including subrogation rights. To pass muster, the subrogation language must meet the requirements that it is seeking equitable (rather than legal) relief, and that it seeks reimbursement from a specifically identified fund. A well-drafted plan document immediately creates an equitable trust on any personal injury recovery. If the plan document is so drafted, the practitioner has little law-based leverage for negotiating the plan’s interest.

On the other hand, if the plan fails to identify a specific fund to which it is entitled, fails to limit its recovery to that fund, or attempts to impose liability on the beneficiary instead of creating an equitable lien on the fund, the subrogation provision may be held unenforceable. A study in comparing and contrasting two plan provisions was undertaken by the Eleventh Circuit in *Popowski v. Parrott*.

---

The Schedule C is indicative of a fully self-funded plan in which Aetna acts as the contract administrator, but pays claims with the employer’s assets.
[The] United Distributors Plan creates a lien “on any amount recovered by the Covered Person whether or not designated as payment for medical expenses.” It further clarifies that “[t]he 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.”

The Mohawk Plan, unlike that of the United Distributors Plan, claims a right to reimbursement “in full, and in first priority, for any medical expenses paid by the Plan relating to the injury or illness,” but does not specify that that reimbursement be made out of any particular fund, as distinct from the beneficiary’s general assets.

The first subrogation provision was enforced and the second was not.25 The United Distributors Plan survived scrutiny because it created a lien on the specific fund—the amount recovered—and claimed a right to repayment only from that fund.26 The Mohawk plan failed because it simply claimed a right to recovery directly from the beneficiary.27

**Equitable Defenses**

When dealing with a fully self-funded plan with a subrogation interest properly asserted in equity, defenses to repayment are limited. There exists a relatively even split among the circuits as to whether equitable defenses, such as made whole, may be raised in defense of a constructive trust on the settlement fund. The First, Fourth, and Eighth Circuits have rejected the made whole defense to self-funded ERISA subrogation interests,28 and the Sixth, Seventh, Ninth, and Eleventh Circuits endorse it, provided the plan language has not specifically disclaimed its availability.29

The Tenth Circuit has been silent on the issue. This allows the practitioner some negotiating leverage where a plan has not specifically disclaimed made whole. However, practitioners should be cautioned that, although the U.S. Supreme Court has not explicitly resolved the Circuit split, the decision in *Sereboff v. Mid-Atlantic Med. Servs., Inc.* did seem to foreclose the use of equitable defenses. In that case, the Court characterized Mid-Atlantic’s reimbursement claim as one to enforce an equitable lien by agreement, rather than a claim of equitable subrogation, which would have opened the door to equitable defenses like made whole, common fund, *laches*, and unjust enrichment.30

The Third Circuit is the first to uphold equitable defenses since *Sereboff*.31 In a case where an ERISA subrogated benefits provider sought reimbursement of the full amount paid—despite the fact that after attorney fees, the beneficiary would have had to reach into his own pocket to repay the plan—the court decided, “[e]quity abhors a windfall.”32 The court applied the doctrine of unjust enrichment and remanded the case. In distinguishing *Sereboff*, the Third Circuit relied on the provision of 29 U.S.C. § 1332(a)(2) allowing a plan to seek “appropriate equitable relief,” and the *Sereboff* Court’s decision not to decide what is “appropriate.”33 This may be a case destined for *certiorari*.

**Negotiation Strategies**

Even in cases where the fully self-funded subrogated benefits provider has a legally enforceable entitlement to full reimburse-
ment, viable negotiating strategies exist. With a catastrophically injured client, public perception may help. For example, in a case where a Wal-Mart employee was rendered severely brain-damaged and reimbursement would have entirely wiped out the employee’s tort recovery, widespread negative publicity forced Wal-Mart’s hand, and it forgave the lien.34

In smaller cases, negotiation is centered on the practicalities of litigation. If a personal injury client would not be willing to initiate a case without an agreement in place regarding subrogation reimbursement, a lien holder may agree in advance to a reduction so that the claimant has an incentive to litigate. If, during mediation, settlement offers being made by the tortfeasor are financially untenable without some yield in the subrogation interest, the lien holder may accept a reduction to mitigate its risk. In any case, it is paramount that the perfected ERISA subrogation interest be negotiated before the settlement is finalized.

Conclusion

With the proliferation of self-funded ERISA plans, the ability to determine an ERISA plan’s funding status and the enforceability of plan language, coupled with practical negotiating skills, are essential elements of representing the personal injury client. Familiarity with the form 5500 and federal case law will provide a solid basis for well-reasoned advice to clients and good-faith negotiation of ERISA-based subrogation claims.

Notes

4. Id.
8. FMC Corp., supra note 3.
10. Id.
11. Id.
13. Id. at 26-27.
14. Id. at 25.
15. FMC Corp., supra note 3.
16. Id.
18. DOL, supra note 12 at 23.
26. Id.
27. Id.
29. Barnes v. Ind. Auto Dealers Benefit Plan, 64 F.3d 1389, 1395 (9th Cir. 1995); Copeland Oaks v. Haupt, 209 F.3d 811, 813 (6th Cir. 2000); Cutting v. Jerome Foods, Inc., 993 F.2d 1293, 1297-98 (7th Cir. 1993); Cagel v. Bruner, 112 F.3d 1510, 1521 (11th Cir. 1997).
30. Sereboff, supra note 6 at 368.
32. Id.
33. Id.