

# ERISA: Tips and Traps for the Personal Injury Attorney

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## I. WHAT IS ERISA?

ERISA is an acronym for Employee Retirement Insurance Security Act of 1974. (“ERISA”, 29 U.S.C. §§ 1001-1461). ERISA governs all employee benefits provided by private employers or employee organizations (such as unions) in the U.S. It does **not** apply to benefits provided to employees of federal, state, and local governments, or to some benefits provided by religious organizations. The law governing employee benefits is diverse. In addition to the statute itself, an attorney must also be aware of:

- U.S. Department of Labor regulations, 29 C.F.R. §§ 2509.08-1 – 2590.736.
- Advisory Opinions, <http://www.dol.gov/ebsa/regs/AOs/main.html>.
- State insurance regulations of any kind (**if not preempted by ERISA**). See, e.g., Rev. Stat. Mo. § 376.697 (mandatory group life insurance plan provisions).
- Case law from their Circuit and firm interpreting ERISA.

Here are other laws you should know:

1. **29 U.S.C. § 1144. Preemption & Savings Clause.** You need to determine if the Federal ERISA Statute preempts State Law on

your case. *Ky. Ass'n of Health Plans, Inc. v. Miller*, 538 U.S. 329 (2003) (preemption test).

(a) Supersedure; effective date

Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter **relate to any employee benefit plan** described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975. . . .

(b) Construction and application

(1) This section shall not apply with respect to any cause of action which arose, or any act or omission which occurred, before January 1, 1975.

(2) (A) Except as provided in subparagraph (B), **nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.**

(4) The administrator shall, upon written request of any participant or beneficiary, furnish a copy of the latest updated summary plan description, and the latest annual report, any terminal report, the bargaining agreement, trust agreement, contract, or other instruments under which the plan is established or operated. The administrator may make a reasonable charge to cover the cost of furnishing such complete copies...

**2. 29 U.S.C. § 1024(b). Disclosure Requirements.** ERISA requires plan administrators to provide Summary Plan Descriptions, Summaries of Material Modifications, and other documents to plan participants, both automatically and upon request. Other documents may also be requested.

- 3. 29 U.S.C. § 1104(a)(1). Fiduciary Duties.** These are the duties that can give rise to a breach of fiduciary duty claim. In addition to these, courts also recognize a duty of disclosure. *See, e.g., Kalda v. Sioux Valley Physician Partners, Inc.*, 481 F.3d 639, 644 (8th Cir. 2007).

[A] fiduciary shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries and -

(A) for the exclusive purpose of:

(i) providing benefits to participants and their beneficiaries; and

(ii) defraying reasonable expenses of administering the plan;

(B) with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims;

(C) by diversifying the investments of the plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and

(D) in accordance with the documents and instruments governing the plan insofar as such documents and instruments are consistent with the provisions of this subchapter and subchapter III of this chapter.

- 4. 29 U.S.C. § 1132(a)(1), (c). Causes of Action.** Under ERISA, you can sue for civil penalties, to enforce ERISA or the terms of a plan, or for “appropriate equitable relief.”

29 U.S.C. § 1132(a)(1)(c) Causes of actions for benefits, for civil penalties, to enforce the terms of ERISA or for other appropriate equitable relief. Claims for benefits are governed by 29 U.S.C. (a)(1)(b).

Under 29 U.S.C. (a) (3) An action may be brought by a participant, beneficiary, or fiduciary to

(A) to enjoin any act or practice which violates any provision of this subchapter 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 this subchapter or the terms of the plan...

(a) Persons empowered to bring a civil action

A civil action may be brought –

(1) by a participant or beneficiary –

(A) for the relief provided for in subsection (c) of this section, or

(B) to recover benefits due to him under the terms of his plan, to

enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan; . . .

(3) by a participant, beneficiary, or fiduciary

(A) to enjoin any act or practice which violates any provision of this subchapter 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 this subchapter or the terms of the plan; . . .

(c) Administrator's refusal to supply requested information; penalty for failure to provide annual report in complete form

(1) Any administrator . . . (B) who fails or refuses to comply with a request for any information which such administrator is required by this subchapter to furnish to a participant or beneficiary (unless such failure or refusal results from matters reasonably beyond the control of the administrator) by mailing the material requested to the last known address of the requesting participant or beneficiary within 30 days after such request may in the court's discretion be personally liable to such participant or beneficiary in the amount of up to \$100 [**NOTE:** increased by regulation to \$110] a day from the date of such failure or

refusal, and the court may in its discretion order such other relief as it deems proper. For purposes of this paragraph, each violation described in subparagraph (A) with respect to any single participant, and each violation described in subparagraph (B) with respect to any single participant or beneficiary, shall be treated as a separate violation.

#### **5. 29 C.F.R. § 2560.503-1. Claim Review Procedures.**

For claims for benefits that are denied or appealed, this regulation describes what the plans have to do, and what the claimant's basic rights are, such as the right to request copies of all "relevant" information, free of charge.

## **II. ERISA CLAIM CHALLENGES:**

These provisions apply to claims for benefits; including health, welfare, & disability benefits.

*The Administrative Process.* No running to federal court upon a denial. Instead, the claimant has at least one right of appeal, and many plans give two rights of appeal. A claimant has 180 days filing a denial to appeal. **You have to be sure to meet those deadlines.** But once the denial is final, you can bring a suit.

*Statute of Limitations?* ERISA has no statute of limitations, except for breach of fiduciary duty claims. See 29 U.S.C. § 1113. For everything else, the limitation is borrowed from the most analogous state law claim.

*BUT . . .* In *Heimeshoff v. Hartford Life & Accident Ins. Co.*, 133 S. Ct. 1802, 1803 (U.S. 2013), the Supreme Court upheld a plan with a 3-year limitations period, giving a claimant just 12 months to sue after the final denial. Subsequent cases have upheld as short as 7 months after a denial. Bottom line: **You have to check the plan and comply with its limitations period.**

*No State Law Claims.* Some state insurance regulations may be “saved” from preemption, but not state law causes of action. So there are no state law breach of contract claims, fraud claims, negligence claims, etc. Neither can you get relief authorized by state law, such as punitive damages. Look for regulations governing the sale of insurance and claims practices to see if the insurer is violating any state regulations.

*No Jury Trials.* The case will be decided by a federal judge, not a jury.

*Limited Damages.* If a claim is denied, your relief is pretty much limited to getting the benefits that were denied, that’s it. No pain and suffering, lost wages, etc. Just whatever the claimant was entitled to under the Plan. *However*, if you prevail in federal court, you can move for an award of attorney’s fees and costs. See: 29 U.S.C. § 1132(g).

*BUT . . .* A **surcharge** is a claim for “make-whole relief”—that is, DAMAGES—against a plan fiduciary for harm caused by a breach of fiduciary duty. The U.S. Supreme Court ruled that a surcharge is “traditional equitable relief” that can be recovered under ERISA’s catch-all provision for “appropriate equitable relief.” See: *CIGNA Corp. v. Amara*, 131 S. Ct. 1866 (U.S. 2011).

*BUT . . .* claims for equitable relief are *barred* if adequate relief—a claim for benefits—already exists for the harm caused. So, for example, if a claimant gets denied benefits, you cannot seek a surcharge in order to try to recover those same benefits.

*Deferential Review.* Many times, the Standard of Review is Arbitrary and Capricious. A denial of benefits will be upheld if a court finds there is some evidence to support the denial. Provided the plan’s governing documents give the claims administrator the right to decide claims and interpret the plan. Even if the judge disagrees with the denial, he or she still has to uphold it. See: *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989).

*Administrative Record.* If you want to have a chance shot at winning, **get in your evidence during the administrative appeal!!!** Submit all of your medical records, your experts, and other evidence.

*Limited Discovery.* If the claim is entitled to deferential review, discovery

in a claim for benefits often limited to evidence of a fiduciary's financial conflict of interest. *See: Metro. Life Ins. Co. v. Glenn*, 554 U.S. 105 (2008). In a claim for equitable relief, however, we have successfully argued that plaintiffs are entitled to basic discovery rights. *See: Kostecki v. Prudential Ins. Co. of Am.*, 2014 U.S. Dist. LEXIS 144297 (E.D. Mo. Oct. 10, 2014); *See: Ennis v. Prudential Insurance Company of America*.

### III. PERSONAL INJURY LIENS

If a client gets medical care, and his or her employer-sponsored health insurance pays for any or all of it, then you have to deal with the ERISA plan's lien for what it paid. The first step is to find out if a plan is "**self-funded**" or not, i.e., whether the employer assumes the risk for providing health care benefits to the plan participants. Because, while many states bar subrogation by health insurers, such state laws are preempted by ERISA for self-funded plans.

*How to find out if the plan is self-funded.* The plan's SPD likely states one way or the other. Obtain the plan's Form 5500 through a document request under 29 U.S.C. § 1024(b)(4). Or check **FreeErisa.com** for the plan's prior filings to see if they state the plan is funded by the General Assets of the employer.

*Third-party administrators.* A third-party administrator may be involved in a self-funded plan in order to process claims and administer the benefits. Even in these cases, ERISA applies, and the participant has to repay the health insurance company benefits the plan paid for, if he or she recovers any money from the tortfeasor.

*Reimbursement Agreements.* See page 6. The same considerations apply in a Third-Party Liability case.

#### **EXAMPLE: Auto Accident Case**

Plaintiff was injured by a person with \$50,000 in liability coverage and \$250,000 in underinsured coverage. Plaintiff had a closed head injury and broken bones with surgery and internal fixation and a life flight from the scene of the accident. The health insurer paid over \$500,000 in benefits. Plaintiff wants to settle with Defendant for the \$50,000 limits of liability coverage and is seeking \$250,000 in underinsured benefits. When the health insurer writes the attorney a letter claiming that the Health Insurance Plan is governed by ERISA

and it has a full right of reimbursement, which would consume the entire settlement, leaving the client with nothing. The insurer claims that the attorney's fees aren't deducted from any recovery and that the whole policy limits are to be paid back to the insurance company.

**What do you do?** Failing to do anything to protect the interests of the health insurer will subject the client *and the law firm* to a lawsuit for equitable relief and/or damages, restitution, or injunctive relief.

Investigate the claim of the Health insurer prior to settling the case. Obtain the Form 5500 and plan documents. Under box 9(a), the plan funding was marked with funding through the "general assets" of the company. However, under this section "insurance" was also checked.

**Is the plan self-funded so it can obtain full reimbursement, or not?** The plan was partially self-funded and partially insured. The plan insured participants' vision, dental, and life insurance benefits, but paid health insurance benefits from General Assets of the company and a trust does not hold the assets. Courts have held that in such a situation, a health-insurance plan can be self-funded despite the fact that the plan's life insurance and accidental death and dismemberment benefits were paid for partially with insurance. *United Food & Commercial Workers v. Pacyga*, 801 F.2d 1157, 1162 (9th Cir. 1986); *State Farm Mut. Auto Ins. Co. v. Smith*, 342 F.Supp.2d 541 (W.D. Va. 2004) (fact that vision portion of health plan was insured did not preclude plan from being self-funded within meaning of ERISA).

The attorney obtains the SPD, which states the insurance was for health benefits, but also clearly states the plan was self-funded. Thus, the health insurer had a reimbursement claim for the **full \$500,000** without any reduction for attorney's fees. Attorney should seek a **compromise** from insurer allowing attorney to be paid to collect the money and allow a small amount to client. If the insurer refuses, the attorney risks finishing the case and having to repay entire settlement to the health insurer or risks being sued along with client. In some states a common fund argument can apply so that the amount of the fund obtained is reduced pro-rata by the amount of fees and expenses charged in the case. Check plan and state and Federal Law in your state to see if the Common Fund Doctrine applies. In the actual case, the health insurer compromised and allowed the attorney to charge his full fee, and allowed 1/3 to go to the client.



- a) If a loss of consortium claim applied it would be interesting to note whether the ERISA reimbursement claim can be made against the recovery.

#### **IV. CIVIL PENALTIES**

You can read about civil penalties in more detail, including claims for penalties, at [http://www.bollwerkttatlow.com/library/Your\\_guide\\_to\\_ERISA\\_penalties](http://www.bollwerkttatlow.com/library/Your_guide_to_ERISA_penalties). Under 29 U.S.C. § 1132(c), a plan participant or beneficiary can potentially get up to \$110 for each day the plan administrator fails to provide certain documents upon request. Here's how to make a claim for penalties:

##### **1. Find out who the "Plan Administrator" is.**

Usually, penalties can only be sought from the "plan administrator." The plan administrator is listed in the Summary Plan Description. The plan administrator is usually the employer (sometimes the insurance company providing the insurance). If you don't have an SPD or you're just not sure, send your request for plan documents to the employer, the insurer, and any other relevant entity you can identify (Parent Corporation; I.E. Cigna Insurance Company or LINA).

##### **2. Draft a written request.**

Specifically request all the documents identified in 29 U.S.C. § 1024(b)(4). If the request is associated with a claim for benefits, you should also ask for all *past* documents that might apply to the claim.

##### **3. Send the request to the plan administrator.**

Penalties are assessed per day, so dates are important. You need to be able to prove when your request was sent and when it was received by the plan administrator. A fax is good if you keep the confirmation page. Certified mail is good if you get a confirmation or return receipt. But make sure you keep a copy of your request and the proof it was received someplace safe. The plan administrator cannot condition documents upon a release or waiver, but they can make a "reasonable charge" for copies. At the most, it will be 25 cents per page plus mailing costs.

##### **4. Wait 30 days, then figure out what they did not give to you.**

They have 30 days to comply with the request. After that, penalties start.

## **5. Sue for penalties, plus costs and attorney's fees.**

\$110 a day is the maximum. The judge has complete discretion, but will consider the following factors: harm, bad intent, the importance of the documents withheld, the length of the delay, and the number of requests sent.

See cases:

Dieser v. Continental Casualty Company, DBA CNA Insurance, Compucom Systems, Inc., 440 F.3d 920 (8th Cir. 2006): Denial of LTD Benefits case wherein the CNA Insurance Company was found by Judge Limbaugh to have acted arbitrarily and capriciously in denial of Mr. Dieser's benefits. The plan was also criticized for failing to timely produce all of the documents requested and was fined a daily penalty for the failure to provide Mr. Dieser or his attorney the plan documents upon request. The total penalties were for 441 days and the lump sum for penalties was for \$7,938.00

Huss v. IBM Med. & Dental Plan, 2011 U.S. App. LEXIS 7563 (7<sup>th</sup> Circuit).

## **V. THE INTERPLAY BETWEEN ERISA, SSD, AND WORKERS' COMPENSATION**

Injured clients who cannot work will often have multiple, interrelated claims relating to their disability, including Worker's Compensation, Social Security Disability, long term disability, and possibly total and permanent disability benefits under a life insurance plan. It is crucial for attorneys to understand ERISA's impact in order to maximize recoveries for their client and also to prevent potential Bar complaints or malpractice claims against them.

If a worker has an LTD policy, it usually requires the claimant to have a "permanent and total disability." The definition of disability may vary from plan to plan. Sometimes the plans have a less stringent standard for the first year or first two years of the disability. After a one or two year period a more stringent standard may apply. For example, some long term disability plans have an "**own occupation**" definition of disability that applies for the first year or two of the disability. After one or two years of being disabled from the person's "own" occupation, the person must satisfy the definition of disability

for “**any occupation**”. At this point, the LTD plan’s right to recover overpayments must be taken into account.

Any “**coordination or reduction of benefits**” clause in the LTD or Life plan must be examined if you are representing a person under Workers’ Compensation or SSD, and you are claiming the person is “permanently and totally disabled”. After you have obtained the entire policy and plan documents, you need to determine whether or not the “**coordination of benefits**” clause applies. There is often an **offset provision** in the plan that states that if the employee has other sources of income or benefits, the plan is entitled to reduce the LTD benefits by the amounts of those other sources. It is important to understand the language of the LTD plan to determine what other sources of benefits have to be subtracted from the LTD benefits, should they be awarded. If granted LTD benefits under an ERISA plan, as well as SSD benefits and WC benefits, all under a “permanent and total disability” standard, most LTD plans require a reduction for both the SSD and the WC benefits. **For example:** \$3,000 (LTD benefit per month *before* offset) – \$1,000 per month (SSD) – \$1,000 per month (WC) = \$1,000 (LTD benefit *after* offset).

Benefits from SSD are almost always subtracted from the LTD benefits. If back benefits are obtained under SSD (i.e., a lump sum for a period of disability in the past), then the client may have been **overpaid** LTD benefits for that same period, entitling the LTD plan to seek **repayment** of those excess benefits. Most ERISA LTD plans will demand repayment of what has already been paid to the beneficiary, claiming they can offset the SSD back benefits from the LTD benefits already paid. If the attorney is not aware of this or does not take precautions, it creates a potential claim against both the attorney and the client.

LTD plans often ask the insured and the attorney to sign **REIMBURSEMENT AGREEMENTS** that promise to pay the carrier back if the client receives other sources of deductible income such as, Social Security benefits or worker’s compensation benefits. If the client refuses to sign such agreement, a plan may refuse to pay any benefits to the insured. This can create a financial hardship on the client so the attorney must determine the enforceability of such agreement. It also creates a potential ethics problem for the attorney if he/she has signed the agreement. If the attorney has signed the agreement, he/she is obligated to honor it. However, if the client obtains long term disability and Social Security/Disability income but instructs the

attorney not to pay back the long term disability carrier; this creates a conflict of interest. The attorney has a conflict of interest and may have to withdraw or file an interpleader action and place the funds into the registry of the court to have a court decide on the issue.

## ERISA Health Plans, Tips, and Strategies to Reduce Liens, Claim for Reimbursement

### SUMMARY:

#### Insured Plans versus Self-Funded Plans

It is crucial to determine whether the plan is self-funded through the general assets of the employer or whether the plan is an insured plan and not subject to ERISA requirements.

Preemption: ERISA preempts state law in the governance of employee health plans.

Exception: Savings clause saves state laws from preemption if they regulate insurance...If health insurer sells policies to employees they are subject to state insurance regulations.

–Thus, read Missouri State Insurance regulations to see if insurer broke state regulations.

However, (under Deemer clause) a self-funded employee benefit plan is not deemed to be an insurance company. Thus, self-funded plans aren't subject to state law, they are subject to Federal ERISA law.

#### Insured Health Plans –

Insured ERISA plans are subject to state law. Under Missouri State law, subrogation of insurance plan is not favored so often times such claims in a plan are stricken.

If plan asserts a lien against a PI case, it is insurer attempting to recoup benefits. If fully insured, argue such lien is invalid and can't be enforced.

#### Self-Funded Health Insurance Plans–

Such plans are exempt from state law and ERISA preempts State law claims.

Such plans benefit from ERISA preemption. Why? Because their reimbursement provisions are generally enforceable in Federal Court.

### ERISA Liens:

#### **Strategies to avoid ERISA reimbursement claims:**

- i) Is the plan a church plan or religious or government plan? If so, ERISA does not apply.
  - a) Some hospital plans have a primary religious purpose listed in their corporate bylaws. Obtain the corporate records from the Secretary of State's Corporation Division. If it was set up as a church plan or has religious purposes, argue it is not subject to ERISA, even if the plan says that it is. If it is under State law, reimbursement provisions are void.

--See: Patton v. Cigna Insurance Co, and St. Luke's Hospital, St. Louis County Circuit Court, 18SL-CC03438. St. Luke's is a religious plan and the ERISA policy is not actually an ERISA plan so state law applies.

This raises issues of vexatious refusal to pay. Did the health plan vexatiously refuse to pay benefits?

- b) Does the purpose of the corporation list a religious purpose?
  - c) Find out if the corporation opted into ERISA even though it is exempt from ERISA
- ii) If the plan is exempted from ERISA argue that state law applies. In Missouri, anti-subrogation policies apply and the public policy is to afford the injured party the greatest possible health insurance proceeds possible.
- iii) If funds are already received and paid out and the plan has not sought a reimbursement agreement from any parties, the attorney does not have an obligation to repay the plan. However, the plan may come after the insured claiming equitable remedies. If the

attorney still holds the funds, the plan may sue the attorney in equity in Federal Court.

2) See *US Airways, Inc. v. McCutchen*, 133 S. Ct. 1537 (2013):  
The court discusses Section 502 (a)(3) which provided that a plan administrator may bring a civil action to enjoin any act or practice which violates any provision of the ERISA or terms of the plan, or (B) to obtain other appropriate equitable relief to (i) to redress such violations or (ii) to enforce any provisions of the ERISA Act or the terms of the plan

iv.) If client has received funds and spends the money on consumer goods, can they be traceable? What if the funds were spent on an investment account?

a.) If funds are co-mingled with non-personal injury funds and spent on rent, food, or bills, it is unlikely the fund can impose a constructive trust to obtain reimbursement.

b.) What about a surcharge?

Define surcharge- Can the plan obtain money against the insured in the form of a surcharge?

## § 1132 (a)(3) Appropriate equitable relief

See 11<sup>th</sup> Circuit case 2006:

*Popowski v. Parrot*, 461 F3d 1367(11<sup>th</sup> Cir. 2006).

2 plans sought reimbursement for expenses of medical bills paid out of the recovery from the third-party tortfeasor.

The Court applied the S.Ct. case *Sereboff*. It found that the plan made a valid claim under “other appropriate relief” 1132(a)(3) because the plan language specified both the fund out of which reimbursement was due to the plan and the benefits paid by the plan on behalf of the Defendant.

However, in *Popowski*, the court disapproved of another plan (a second claim) seeking reimbursement because the plan simply stated it had a right to reimbursement in full and in first priority, for any medical expenses paid by the plan relating to the injury or illness, without stating that the recovery was to be made by specific funds recovered. The court banned the plan from seeking recovery of payments.

Lesson: obtain the plan and examine the plan language.

1. Is the plan language really specific and does it identify a specific fund that the reimbursement amount applies to?
  2. Does the plan seem vague and ambiguous and just give it a general right of recovery? If it is vague, argue that it is unenforceable in the 7<sup>th</sup> or 8<sup>th</sup> Circuit and seek a waiver or reduction of their claim, due to the uncertainty in their claim.
- 
1. May a plan's reimbursement provision be reduced or avoided by structuring your settlement a certain way?

In a personal injury or wrongful death case:

- a.) Plaintiff may have a recovery that is not for medical bills or is for loss of consortium or companionship.

If a claim is limited to consortium, or pain, or suffering, or emotional distress, arguably no ERISA lien would attach.

However, the pleadings & documents may be examined by the plan to dispute this. If the Plaintiff pled medical bills, an ERISA plan could sue under equity to seek reimbursement.

In some Keenan/Reptile approaches to litigation, no medical expenses are claimed or recovered arguably (no reimbursement on ERISA subrogation claim would apply). Without divulging any secrets, if you don't plead or obtain medical bills; the ERISA lien should not apply.

See: Wright v. Aetna Life 110 F3d 762 (11<sup>th</sup> Cir. 1997).

#### CASE DISCUSSION:

1. Sereboff v. Mid-Atlantic Medical Services, Inc.

Specific identifiable Fund/Not recoverable from the general assets of the beneficiary. See plan language.

2. Make-whole Doctrine-

If it applies to your State/case, this limits insurer's right to subrogation.

Does settlement less attorney's fees & expenses & subrogation rights make the beneficiary whole or not?

a.) Does your Circuit enforce policy language and ignore such arguments?

I.E. 8<sup>th</sup> Circuit. WalMart case

3. Common Fund Doctrine: Insurer should contribute attorney's fees for the recovery to the fund the third party obtains that benefits the insurer. The lien should be reduced by the proportion of attorney's fees and expenses incurred in obtaining the funds.

8<sup>th</sup> Circuit

7<sup>th</sup> Circuit

4. Plaintiff's use of equity:

Laches/Unclean hands-

Presence or lack of Common Fund Language

Insurer's Failure to Produce Documents/ Breach of Fiduciary Duty.  
Penalties as an offset to the lien.

5. ERISA § 502(a)(3)- Equitable Relief

Montanile v Bd of Trustees of Nat'l Elevator Ind. Health

Benefit Plan, 577 vs, (1/20/2016)

a) An ERISA healthcare plan with reimbursement rights can only obtain, "appropriate equitable relief" when enforcing its rights/lien against a



third-party settlement. Thus limiting the plan's recovery to settlement funds still held by or on behalf of the participant:

“When a participant dissipates the whole settlement on non-traceable items, the fiduciary cannot bring a suit to attach the participant's general assets under ERISA § 502(a)(3), because the suit is not one for appropriate equitable relief.”

Under § 502(a)(3), suit may be brought to enjoin any act that violates Title I of ERISA or the terms of the plan or for other “appropriate equitable relief.”

#### REVIEW:

##### Equitable Remedies Concepts:

–SUR-CHARGE: A penalty against a beneficiary for violating the terms of the plan and not reimbursing the plan with money representing benefits paid.

–Constructive trusts: The Court may impose in equity a constructive trust upon the law firm's trust account for any proceeds coming into the firm on the personal injury case representing a fund to reimburse the fund for medical expenses.

–Quantum Meruit: Latin for What one has earned and in contracts the reasonable value of the services. The defendant was enriched, the enrichment was at plaintiff's expense and the circumstances were such that equity and good conscious require defendants to make restitution.

–Restitution: Give up the gains to the other side and pay your share of a loss, or restore the party to the status quo.

##### Example of ERISA Plan Language to Look for in Your Case:

##### **Subrogation:**

Immediately upon paying or providing any benefit under the Plan, the Plan shall be subrogated to (stand in the place of) all rights of recovery a Covered Person has against any Responsible Party with respect to any payment made by the Responsible Party to a Covered Person due to a Covered Person's Injury, Illness or condition to the full extent of benefits provided or to be provided by the Plan.

##### **Reimbursement:**

In addition, if a Covered Person receives any payment from any Responsible Party or Insurance Coverage as a result of an Injury, Illness or condition, the Plan has the right to recover from, and be reimbursed by, the Covered Person for all amounts the Plan has paid and will pay as a result of the Injury, Illness or condition, up to and including the full amount the Covered Person receives from any Responsible Party.

***Constructive Trust:***

By accepting benefits (whether the payment of such benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the Plan, the Covered Person agrees that if he or she receives any payment from any responsible party as a result of an Injury, Illness or condition, he or she will serve as a constructive trustee over the funds that constitute such payment. Failure to hold such funds in trust will be deemed a breach of the Covered Person's fiduciary duty to the Plan.

***Lien Rights***

Further, the Plan will automatically have a lien to the extent of benefits paid by the Plan for treatment of the Illness, Injury or condition for which the Responsible Party is liable. The lien shall be imposed upon any recovery whether by settlement, judgment or otherwise related to treatment for any Illness, Injury or condition for which the Plan paid benefits. The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the Plan including, but not limited to, the Covered Person; the Covered Person's representative or agent; Responsible Party; Responsible party's insurer, representative or agent; and/or any other source possessing funds representing the amount of benefits paid by the Plan.

***First-Priority Claim:***

By accepting benefits (whether the payment of such benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the Plan, the Covered Person acknowledges that the Plan's recovery rights are a first-priority claim against all Responsible parties and are to be paid to the Plan before any other claim for the Covered Person's damages. The Plan shall be entitled to full reimbursement on a first-dollar basis from any Responsible Party's payments, even if such payment to the Plan will result in a recovery to the Covered Person which is insufficient to make the Covered Person whole, or to compensate the Covered Person in part or in whole, for the damages sustained. The Plan is not required to participate in or pay court costs or attorney fees to any attorney hired by the Covered Person to pursue the Covered Person's damage claim.

***Cooperation:***

The Covered Person shall fully cooperate with the Plan's efforts to recover its benefits paid. It is the duty of the Covered Person to notify the Plan within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of the Covered Person's intention to pursue or investigate a claim to recover damages or obtain compensation due to Injury, Illness or condition sustained by the Covered Person. The Covered Person and his or her agents shall provide all information requested by the Plan, the Claims Administrator or its representatives including, but not limited to, completing and submitting any applications or other forms or statements as the Plan may reasonably request. Failure to provide this information may result in the termination of health benefits for the Covered Person or the institution of court proceedings against the Covered Person.

#### APPENDIX:

The above language is taken from a current demand letter to a local Plaintiff's Attorney and from a policy from New York Life Insurance Company. The plan language regarding Subrogation, Reimbursement, Constructive Trust, Lien Rights, First Priority Claim and Cooperation Clause, is part of a demand to the attorney and client for repayment out of a personal injury case for a large sum of health insurance benefits paid out under a self-funded plan.