PROGRAM MATERIALS
Program #35214
December 16, 2025

Resolving ERISA Liens and Reimbursement Claims in Personal Injury Cases

Celesq® AttorneysEd Center
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5301 North Federal Highway, Suite 150, Boca Raton, FL 33487
Phone 561-241-1919

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PLAINTIFF LIEN RESOLUTION COUNSEL

Lien Resolution Seminar

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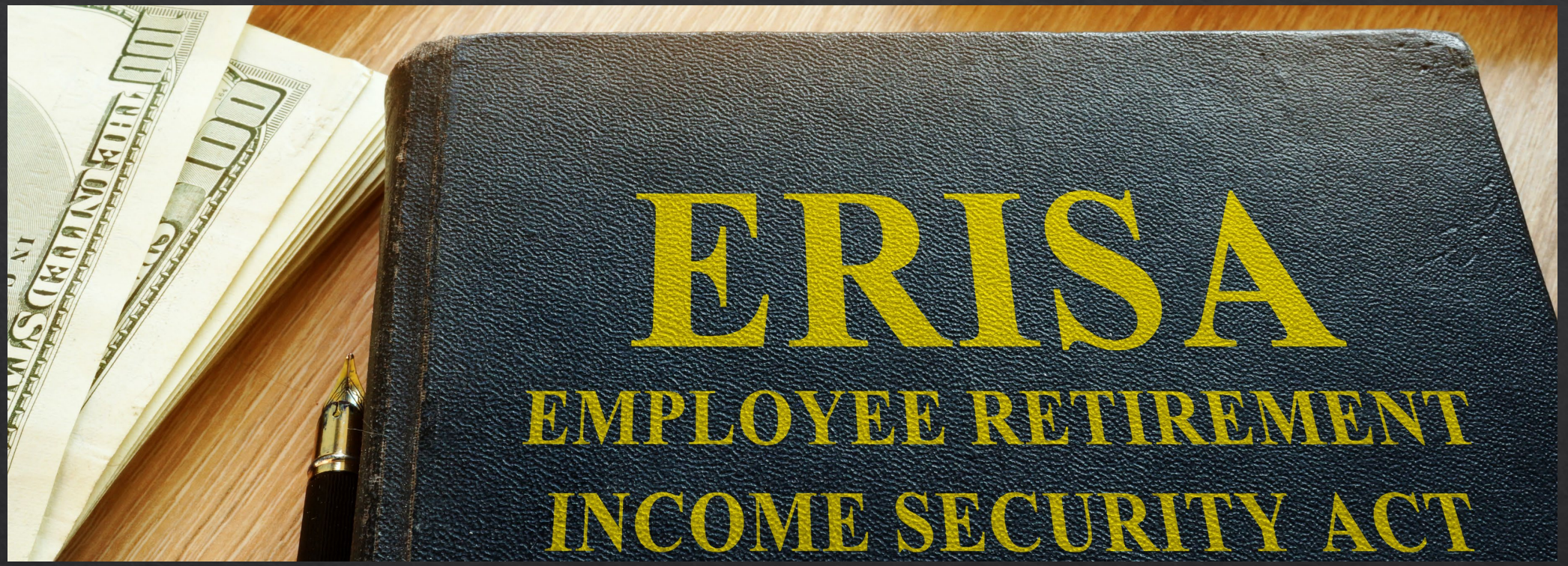
Presenter: David L. Place, Esq.

- Supreme Court of Kentucky
- District of Columbia Court of Appeals
- U.S. Federal District Court for the Eastern District of Kentucky
- U.S. Federal District Court for the Western District of Kentucky
- U.S. Court of Appeals for the Fourth Circuit
- U.S. Court of Appeals for the Sixth Circuit
- Supreme Court of the United States of America

Mr. Place exclusively assists personal injury victims and plaintiff counsel with complex lien resolution problems using his more than 25 years of subrogation experience to ensure the settlement dollars created by the trial attorney are protected.



ERISA

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What is ERISA?

"The Employee Retirement Income Security Act of 1974 (ERISA) is a federal law that sets minimum standards for most voluntarily established retirement and health plans in private industry to provide protection for individuals in these plans.

ERISA requires plans to provide participants with plan information including important information about plan features and funding; sets minimum standards for participation, vesting, benefit accrual and funding; provides fiduciary responsibilities for those who manage and control plan assets; requires plans to establish a grievance and appeals process for participants to get benefits from their plans; gives participants the right to sue for benefits and breaches of fiduciary duty…

In general, ERISA does not cover plans established or maintained by governmental entities, churches for their employees, or plans which are maintained solely to comply with applicable workers compensation, unemployment or disability laws. ERISA also does not cover plans maintained outside the United States primarily for the benefit of nonresident aliens or unfunded excess benefit plans."

-U.S. Department of Labor

In short – Unless the employer is a government or a church, employer sponsored health benefits are governed by ERISA.

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ERISA History

When ERISA was enacted by Congress in 1974, subrogation for health insurers was uniformly prohibited in this country. Such claims were deemed unlawful in all jurisdictions.

The first reported judicial decision involving a health insurer seeking subrogation on a personal injury claim is the 1982 decision in *Frost v. Porter Leasing Corp.*, 436 N.E.2d 387 (Mass. 1982), in which subrogation was denied.

These types of claims began arising as ERISA "reimbursement claims" in the late 1980s.

-Roger M. Baron, Esq., "Public Policy Considerations Warranting Denial of Reimbursement to ERISA Plans: It's Time to Recognize the Elephant in the Courtroom", 55 MERCER LAW REVIEW 595 (2004).

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ERISA PREEMPTION

The ERISA preemption scheme (enacted 1974) operates under three controlling provisions, known as the *preemption clause*, the *saving clause*, and the *deemer clause*. Those clauses are as follows:

The "preemption clause" – 29 U.S.C. 1144 (a):

> "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." (emphasis added)

The "saving clause" – 29 U.S.C. 1144 (b)(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."** (emphasis added)

The "deemer clause" – 29 U.S.C. 1144 (b)(2)(B):

> "*Neither an employee benefit plan* described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), *nor any trust established under such a plan,* ***shall be deemed*** *to be an insurance company or other insurer*, bank, trust company, or investment company *or to be engaged in the business of insurance* or banking *for purposes of any law of any State purporting to regulate insurance companies, insurance contracts*, banks, trust companies, or investment companies." (emphasis added)

“If you know yourself but not the enemy, for every victory gained you will also suffer a defeat.” Sun Tzu

'Bounty hunter' George Rawlings may be the richest Kentuckian you've never heard of

- Courier Journal
April 5, 2018

“it as a white-collar sweat shop where everything – and everyone – is micromanaged.”

- Courier Journal
April 5, 2018

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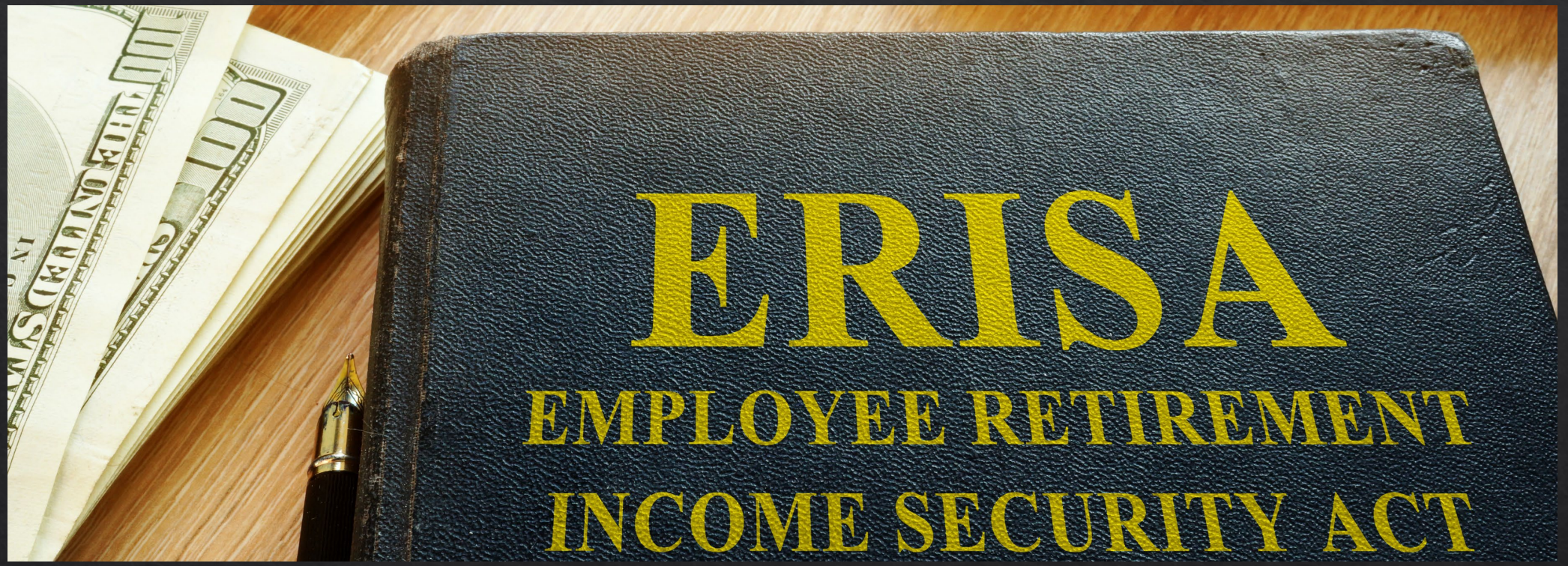
The Recovery Agent

- Typically not attorneys
- Well aware of the law – but in a scripted sense
- Large file loads
- Motivated to settle – have monthly/quarterly recovery goals
- Personal animosity greatly impacts ability to resolve
- Typically cost of litigation is paid by the recovery vendor and not the employer group or TPA.
- If reducing fee or waiving costs for client make sure recovery agent knows.

- The recovery agent only cares about the numbers.
    - Total settlement
    - Total Fees
    - Total Costs
    - Total out of pockets
    - Other liens
    - Lump sum vs. structure
    - Amount apportioned to plan participant
    - Amount apportioned for medical damages



Sending a Proper Document Request

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29 U.S.C. §1024(b)(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. The Secretary may by regulation prescribe the maximum amount which will constitute a reasonable charge under the preceding sentence."

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29 U.S.C. §1024(b)(4)

"The administrator shall, …"

In the application of this statutory obligation the federal bench has universally agreed that "administrator" is a term of art and ***only*** means the "Plan Administrator."

"The statutory language is clear and unambiguous and admits of no other interpretation."

- *McKinsey v. Sentry Ins.*, 986 F.2d 401, 404 (10th Cir. 1993) (citing *Griffin v. Oceanic Contractors, Inc.*, 458 U.S. 564, 571 (1982)

- *Tetreault v. Reliance Standard Life Ins. Co.*, 769 F.3d 49, 59 (1st Cir. 2014)
- *Coleman v. Nationwide Life Ins. Co.*, 969 F.2d 54, 62 (4th Cir. 1992), as amended (July 17, 1992)
- *Moran v. Aetna Life Ins. Co.*, 872 F.2d 296, 299–300 (9th Cir. 1989)
- *Davis v. Liberty Mut. Ins. Co.*, 871 F.2d 1134, 1138 (D.C. Cir. 1989)
- *Allena Burge Smiley v. Hartford Life and Accident Insurance Company, et. al*, No. 15-10056 (11th Cir. 2015)

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Best Practices

- Send your 29 U.S.C. §1024(b)(4) document request to the Plan Administrator.

Plan Administrator
The person or entity named by the Plan Sponsor to manage the Plan and answer questions about Plan details. **The Plan Administrator is not the Claims Administrator.**

Plan Sponsor
The legal entity that has adopted the Plan and has authority regarding its operation, amendment and termination. **The Plan Sponsor is not the Claims Administrator.**

- The employer is the default Plan Administrator. Unless the employer is a Union.

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29 U.S.C. §1024(b)(4)

"upon written request of any participant or beneficiary …"

"The term 'participant' means any employee or former employee of an employer, or any member or former member of an employee organization, who is or may become eligible to receive a benefit of any type from an employee benefit plan which covers employees of such employer or members of such organization, or whose beneficiaries may be eligible to receive any such benefit."

- 29 U.S.C. §1002(7)

"The term 'beneficiary' means a person designated by a participant, or by the terms of an employee benefit plan, who is or may become entitled to a benefit thereunder."

- 29 U.S.C. §1002(8)

- The request does not need to be made by certified or registered mail.
- The statute does not specifically authorize an agent or attorney to send this request.

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29 U.S.C. §1024(b)(4)

"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 purpose of this extremely broad language is to allow the plan member to fully understand how the plan is "established and operated" so that they can effectively participate, receive all their benefits, and to understand their rights and responsibilities.

- The definition of "other instruments under which the plan is established or operated" includes the agreements between the ERISA plan, the Third-Party Administrator (TPA) and the recovery vendor.
  - Administrative Services Agreements (ASA)
    - *Shaver v. Operating Eng'rs Local 428 Pension Trust Fund*, 332 F.3d 1198, 1202 (9th Cir. 2003)
    - *Heffner v. Blue Cross and Blue Shield of Alabama, Inc.*, 443 F.3d 1330, 1343 (11th Cir. 2006)
    - *Michael v. American International Group, Inc.*, No. 4:05CV02400 ERW, 2008 WL 4279582 (E.D. Mo. 2008)
    - *Grant v. Eaton*, S.D.Miss, Civil Action No. 3:10CV164TSL-FKB (2013)

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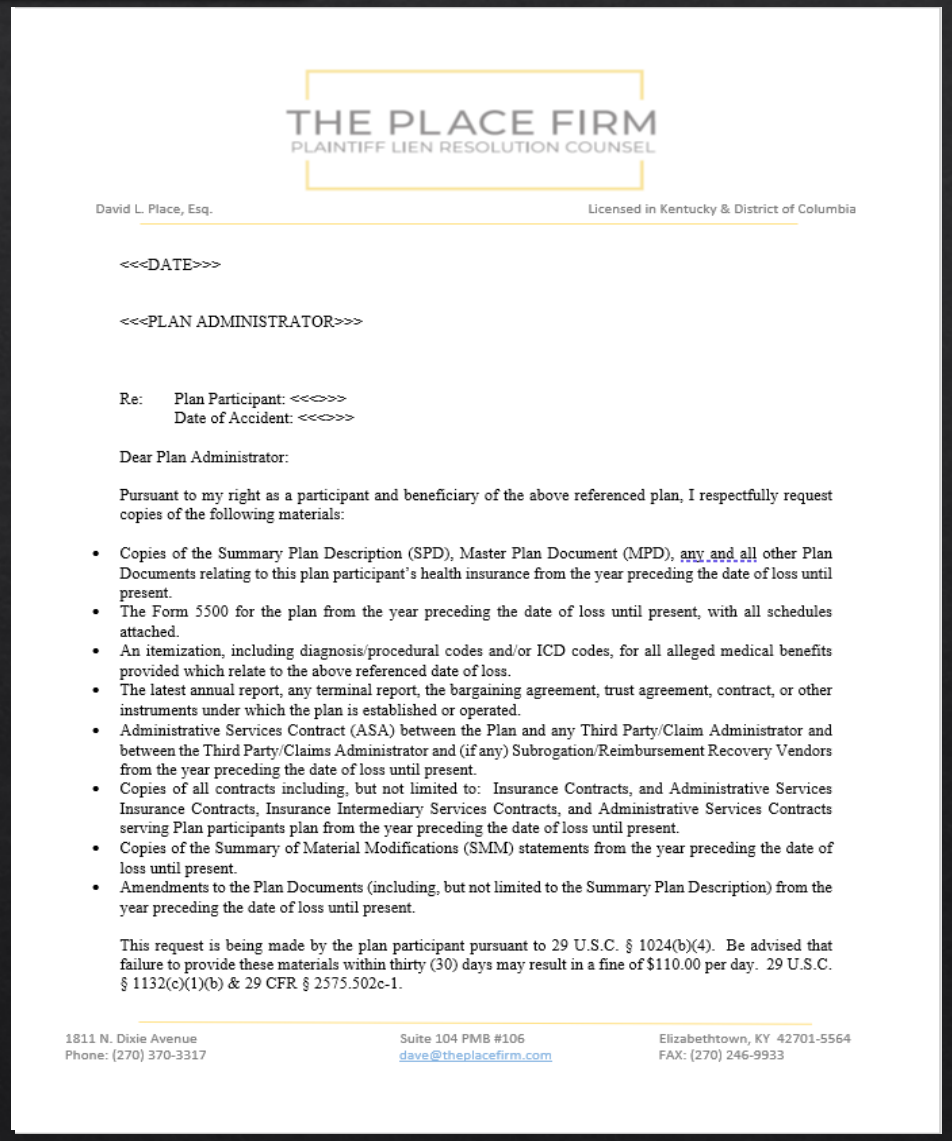
Sample Request



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David L. Place, Esq. Licensed in Kentucky & District of Columbia

<<<DATE>>>

<<<PLAN ADMINISTRATOR>>>

Re: Plan Participant: <<<>>>
Date of Accident: <<<>>>

Dear Plan Administrator:

Pursuant to my right as a participant and beneficiary of the above referenced plan, I respectfully request copies of the following materials:

- Copies of the Summary Plan Description (SPD), Master Plan Document (MPD), any and all other Plan Documents relating to this plan participant's health insurance from the year preceding the date of loss until present.
- The Form 5500 for the plan from the year preceding the date of loss until present, with all schedules attached.
- An itemization, including diagnosis/procedural codes and/or ICD codes, for all alleged medical benefits provided which relate to the above referenced date of loss.
- The latest annual report, any terminal report, the bargaining agreement, trust agreement, contract, or other instruments under which the plan is established or operated.
- Administrative Services Contract (ASA) between the Plan and any Third Party/Claim Administrator and between the Third Party/Claims Administrator and (if any) Subrogation/Reimbursement Recovery Vendors from the year preceding the date of loss until present.
- Copies of all contracts including, but not limited to: Insurance Contracts, and Administrative Services Insurance Contracts, Insurance Intermediary Services Contracts, and Administrative Services Contracts serving Plan participants plan from the year preceding the date of loss until present.
- Copies of the Summary of Material Modifications (SMM) statements from the year preceding the date of loss until present.
- Amendments to the Plan Documents (including, but not limited to the Summary Plan Description) from the year preceding the date of loss until present.

This request is being made by the plan participant pursuant to 29 U.S.C. § 1024(b)(4). Be advised that failure to provide these materials within thirty (30) days may result in a fine of $110.00 per day. 29 U.S.C. § 1132(c)(1)(b) & 29 CFR § 2575.502c-1.

1811 N. Dixie Avenue
Phone: (270) 370-3317
Suite 104 PMB #106
dave@theplacefirm.com
Elizabethtown, KY 42701-5564
FAX: (270) 246-9933

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David L. Place, Esq. Licensed in Kentucky & District of Columbia

Please forward these materials to **David L. Place Esq., The Place Firm, PLLC, 1811 N. Dixie Ave. Suite 104, PMB #106, Elizabethtown, KY 42701-5564**.

Thank you,

_____ _____
Plan Participant/Beneficiary Plan Participant/Beneficiary
Print

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Requested Materials

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- The Form 5500 for the plan from the year preceding the date of loss until present, with all schedules attached.
- An itemization, including diagnosis/procedural codes and/or ICD-9 codes, for all alleged medical benefits provided which relate to the above referenced date of loss
- The latest annual report, any terminal report, the bargaining agreement, trust agreement, contract, or other instruments under which the plan is established or operated.
- Administrative Services Contract (ASA) between the Plan and any Third Party/Claims Administrator and between the Third Party/Claims Administrator and (if any) Subrogation/Reimbursement Recovery Vendors from the year preceding the date of loss until present.
- Copies of all contracts including, but not limited to: Insurance contracts, Stop Loss Contracts, Health Insurance Contracts, Insurance Intermediary Services Contracts, and Administrative Services Contracts serving Plan participants plan from the year preceding the date of loss until present.
- Copies of the Summary of Material Modifications (SMM) statements from the year preceding the date of loss until present.
- Amendments to the Plan Documents (including, but not limited to the Summary Plan Description) from the year preceding the date of loss until present.

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29 U.S.C. §1132(c)(1)(B)

"ADMINISTRATOR'S REFUSAL TO SUPPLY REQUESTED INFORMATION; PENALTY FOR FAILURE TO PROVIDE ANNUAL REPORT IN COMPLETE FORM

Any administrator … 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 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 … with respect to any single participant or beneficiary, shall be treated as a separate violation."

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29 CFR § 2575.502c-1

"Adjusted civil penalty under section 502(c)(1)

In accordance with the requirements of the 1990 Act, as amended, the maximum amount of the civil monetary penalty established by section 502(c)(1) of the Employee Retirement Income Security Act of 1974, as amended (ERISA), is hereby increased from $100 a day to $110 a day. This adjusted penalty applies only to violations occurring after July 29, 1997."

- *Law v. Ernst & Young*, 956 F.2d 364, (1st Cir. 1992)
- *Gorini*, 94 Fed. Appx. 913, (3rd Cir. 2004)
- *Bartling v. Fruehauf Corp.,*29 F.3d 1062, (6th Cir.1994)
- *Leister v. Dovetail, Inc.,* 546 F.3d 875, (7th Cir. 2008)
- *Brown v. Aventis Pharma.,* 342 F.3d 822, (8th Cir. 2003)
- *Daughtrey v. Honeywell, Inc.,* 3 F.3d 1488, (11th Cir.1993).
- *Huss v. IBM Medical Plan*, No. 07 C 7028, (N.D Dis. Ill. Nov. 4, 2009)
- *Harris-Frye v. United of Omaha*, (E.D. Tenn. Sept. 21, 2015)

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Common Responses

➢ The Recovery Vendors

"Optum has received your request for plan documents. It is our position that section 104(b) of ERISA [29 U.S.C. sec. 1024(b)] does not apply to Optum, since Optum is not the plan administrator. See, e.g., *Nechis v. Oxford Health Plans*, Inc., 421 F.3d 96, 104 (2d Cir. 2005). Nevertheless, without waiving any objections or defenses, and solely as an accommodation, we are enclosing copies of the following documents:"

❖ The Form 5500
❖ Incomplete copy of an outdated SPD
❖ Demand for full repayment

➢ The Plan Administrator

"We are sorry to hear about your injury, please tell us exactly what you need."
"We are sorry to hear about your injury, please contact (Rawlings, Optum, Equian, Conduent, Phia, etc.)"
"We are sorry to hear about your injury, but we don't have copies of the Administrative Services Agreements."

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Next Steps

- The Recovery Vendors
  - They are correct in that they owe no obligation to provide any documentation to the plan participant.
  - They operate as a volume-based business and have specific instructions not to contact the ERISA plans for routine matters.
  - They are motivated to make recoveries, not provide documents – use this dynamic!
  - "If you are going to demand 100% repayment then my client has no choice but to demand 100% compliance."

- The Plan Administrator
  - After 30 days have expired, and every 30 days thereafter, send a letter to the Plan Administrator advising them of the breach and include a calculation of the potential penalties.
  - "Thank you for your courteous response; however, as we are in a potentially adversarial posture I do not believe it appropriate for me to provide guidance on how to comply with your statutory obligations. I recommend you hire counsel."

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Fiduciary Duty

"The purpose of the penalty is not to punish defendants' bad faith actions or for any resulting prejudice to plaintiffs, but rather "to induce administrators to timely provide participants with requested plan documents, and to penalize failures to do so."

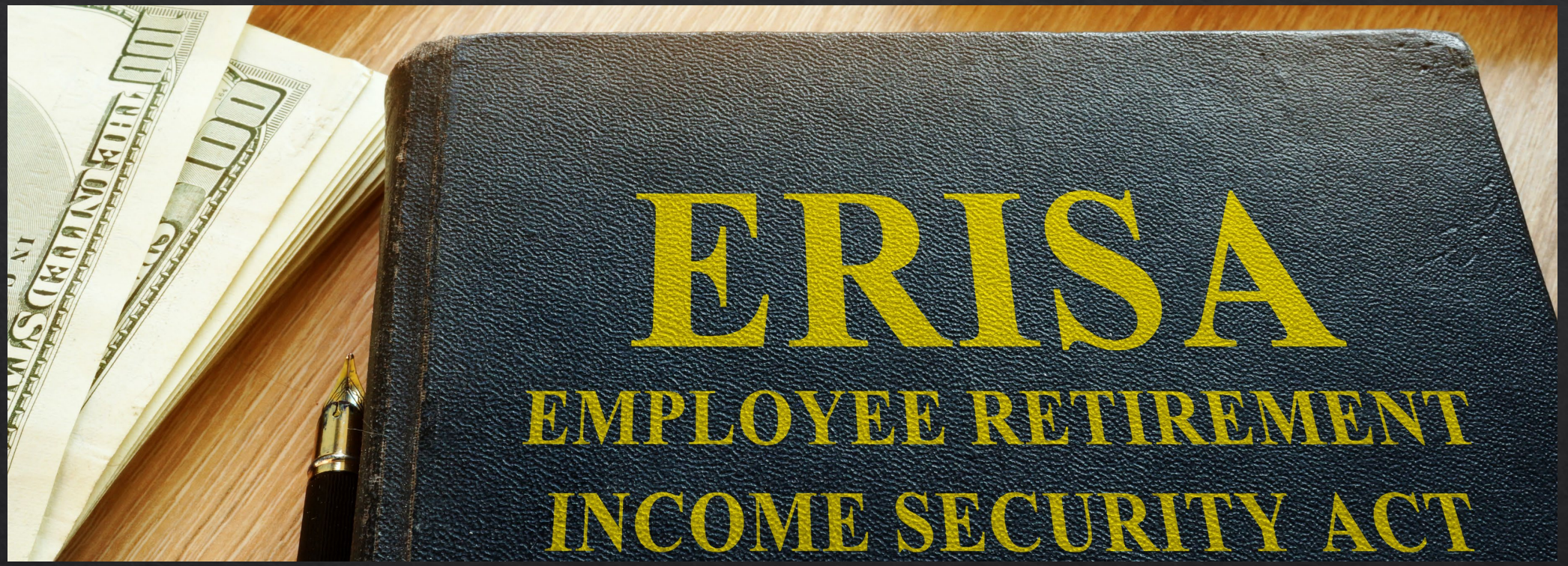
- *Bartling v. Fruehauf Corp.*, 29 F.3d 1062, 1068 (6th Cir.1994).

"29 U.S.C. § 1132(c), therefore, seeks to punish administrators for their failure to respond to beneficiaries' requests, not to compensate beneficiaries for their lack of access to requested documents."

- *Harris-Frye v. United of Omaha*, (E.D. Tenn. 9/21/15)

"[A]n ERISA 'fiduciary may not, in the performance of [its] duties, 'materially mislead those to whom the duties of loyalty and prudence are owed.'" . . . This responsibility encompasses "not only a negative duty not to misinform, but also an affirmative duty to inform when the trustee knows that silence might be harmful.' *Unisys Corp. Retiree Med. Benefits Erisa Litig. v. Unisys Corp.*, 579 F.3d 220, 228 (3d Cir. 2009), cert. denied sub nom. *Unisys Corp. v. Adair*, 559 U.S. 940 (2010)"

- *U.S. Airways v. McCutchen*, Case 2:08-cv-01593-DSC (W.D. PA. March 16, 2016).



Deciphering the Documents

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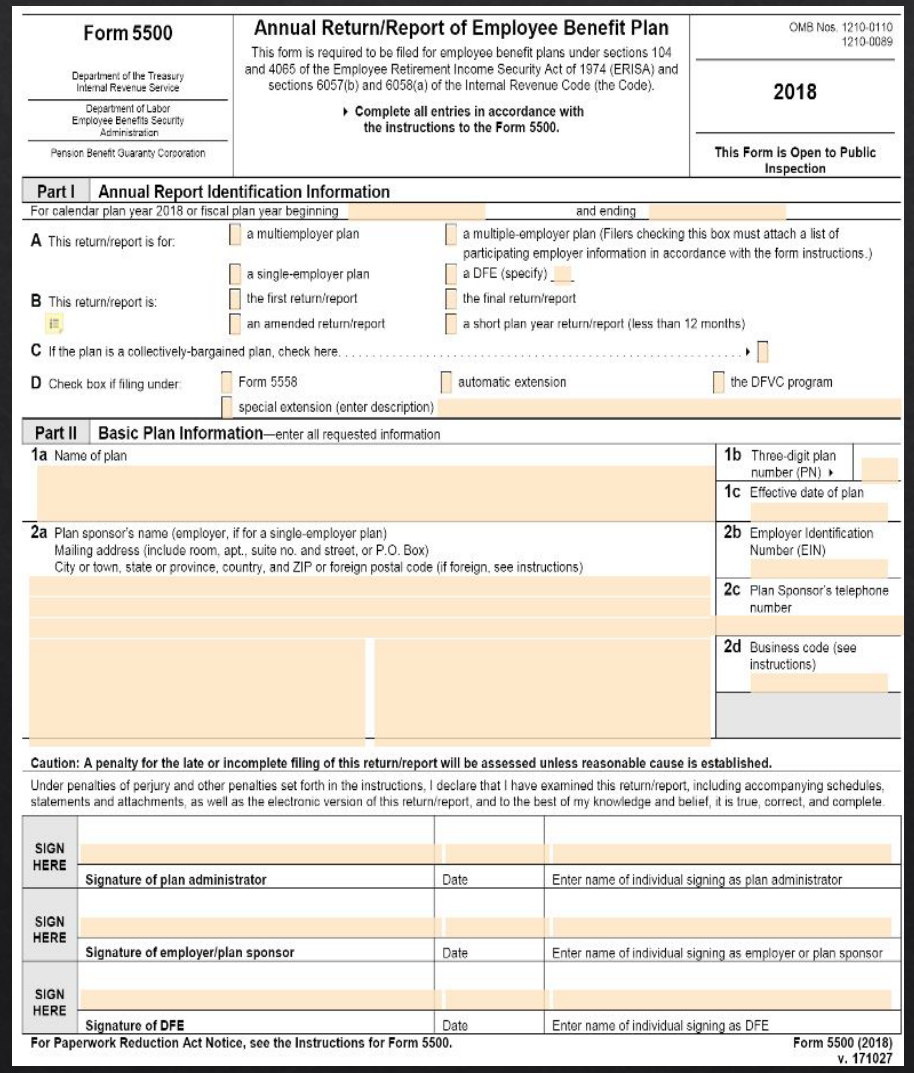
IRS Form 5500



Form 5500

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6057(b) and 6058(a) of the Internal Revenue Code (the Code).

▸ **Complete all entries in accordance with the instructions to the Form 5500.**

OMB Nos. 1210-0110
1210-0089

2018

This Form is Open to Public Inspection

Part I **Annual Report Identification Information**

For calendar plan year 2018 or fiscal plan year beginning _____ and ending _____

A This return/report is for: ☐ a multiemployer plan ☐ a multiple-employer plan (Filers checking this box must attach a list of participating employer information in accordance with the form instructions.)
☐ a single-employer plan ☐ a DFE (specify) _____

B This return/report is: ☐ the first return/report ☐ the final return/report
☐ an amended return/report ☐ a short plan year return/report (less than 12 months)

C If the plan is a collectively-bargained plan, check here. . . . . ▸ ☐

D Check box if filing under: ☐ Form 5558 ☐ automatic extension ☐ the DFVC program
☐ special extension (enter description) _____

Part II **Basic Plan Information**—enter all requested information

1a Name of plan

1b Three-digit plan number (PN) ▸

1c Effective date of plan

2a Plan sponsor's name (employer, if for a single-employer plan)
Mailing address (include room, apt., suite no. and street, or P.O. Box)
City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions)

2b Employer Identification Number (EIN)

2c Plan Sponsor's telephone number

2d Business code (see instructions)

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.

Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete.

SIGN HERE	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE	Signature of DFE	Date	Enter name of individual signing as DFE

For Paperwork Reduction Act Notice, see the Instructions for Form 5500. Form 5500 (2018) v. 171027

9a Plan funding arrangement (check all that apply)		9b Plan benefit arrangement (check all that apply)	
(1)	☐ Insurance	(1)	☐ Insurance
(2)	☐ Code section 412(e)(3) insurance contracts	(2)	☐ Code section 412(e)(3) insurance contracts
(3)	☐ Trust	(3)	☐ Trust
(4)	☐ General assets of the sponsor	(4)	☐ General assets of the sponsor

All the boxes are checked?

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SPD vs MPD

"We have made clear that the statements in a summary plan description 'communicat[e] with beneficiaries about the plan, but . . . do not themselves constitute the terms of the plan'."

- *U.S. Airways v. McCutchen*, 133 S. Ct. 1537(2013) citing *CIGNA v. Amara*, 131 S. Ct. 1866 (2011)

"Justice SCALIA, with whom Justice THOMAS joins, concurring in the judgment

I agree with the Court that § 502(a)(1)(B) of the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. § 1132(a)(1)(B), does not authorize relief for misrepresentations in a summary plan description (SPD). I do not join the Court's opinion because I see no need and no justification for saying anything more than that."

- *CIGNA v. Amara*, 131 S. Ct. 1866 (U.S. 2011)

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Words Matter

"[T]he provisions of this title . . . Shall supersede any and all state laws in so far as they may now or hereafter relate to any employee benefits plan."

- 29 U.S.C. § 1144(a)

"PERSONS EMPOWERED TO BRING A CIVIL ACTION- A civil action may be brought—
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; …"

- 29 U.S.C. § 1132(a)(3); ERISA §502(a)(3)

If it is not in the language, then they can't do it!

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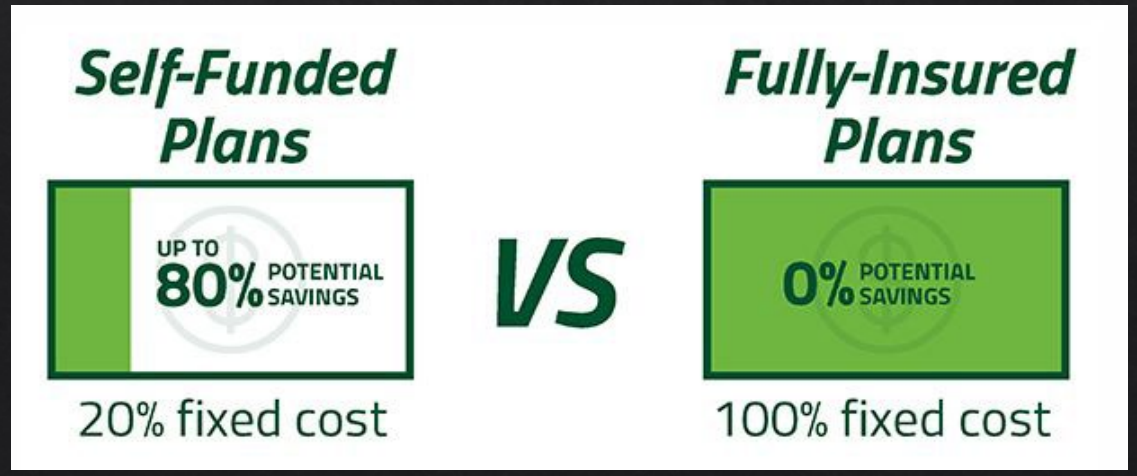
Funding Status

Self-Funded Plan: An insurance arrangement in which the employer assumes direct financial responsibility for the costs of enrollees' medical claims. Employers sponsoring self-funded plans typically contract with a third-party administrator or insurer to provide administrative services for the self-funded plan.

Fully Insured Plan: An insurance arrangement in which the employer contracts with a health plan that assumes financial responsibility for the costs of enrollees' medical claims

"[ERISA] exempts self-funded plans from state insurance laws, including reserve requirements, mandated benefits, premium taxes, and consumer protection regulations."
"2013 Employer Health Benefits Survey," Kaiser Family Foundation, August 20, 2013



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Exceptions

"The Exception of Certain Plans - The provisions of this subchapter shall not apply to any employee benefit plan if
(1)such plan is a governmental plan (as defined in section 1002(32) of this title);
(2)such plan is a church plan (as defined in section 1002(33) of this title);"

- 29 U.S.C. §1003(b)

"The term "governmental plan" means a plan established or maintained for its employees by the Government of the United States, by the government of any State or political subdivision thereof, or by any agency or instrumentality of any of the foregoing..."

- 29 U.S.C. §1002(32)

"The term "church plan" means a plan established and maintained ... by a church or by a convention or association of churches which is exempt from tax..."

- 29 U.S.C. §1002(33)

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How do you know if its is ERISA?

The question of ERISA or not is actually easy to answer, it is the question of funding status that can cause the most confusion.

ERISA governs group health plans that are provided by an employer. Unless the employer is a church or a governmental agency then almost certainly the plan is an ERISA Plan.

Determining if the Plan is fully-insured vs. self-funded is the essential question. The Master Plan Document is the document that will contain this information.

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Plan Funding

Type of Administration

The Plan is a self-funded welfare Plan and the administration is provided through one or more third party administrators.

Plan Name:	Central Bancompany, Inc. Welfare Benefit Plan
Plan Number:	502
Employer ID:	43-0959114
Plan Type:	Welfare benefits plan
Plan Year:	January 1 - December 31
Plan Administration:	Self-Insured
Source of Plan Contributions:	Employee and Company
Source of Benefits:	Assets of the Company

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Sereboff

Two Part Test

1. "… equitable lien on a specifically identified fund, not from the Sereboffs' assets generally…"
    - *Sereboff v. Mid Atlantic Medical Services, Inc.,* 547 U.S. 356 (2006)

❖ The language must identify a particular fund distinct from the member's assets from which reimbursement is to be made

2. "…seek to recover a particular fund from the defendant…"
    - *Sereboff v. Mid Atlantic Medical Services, Inc.,* 547 U.S. 356 (2006)

❖ The language must identify the particular share of that fund to which the medical benefits plan is entitled

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Sereboff- In Practice

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

"The Plan has a lien on any amount recovered by the Covered Person whether or not designated as payment for medical expenses. This lien shall remain in effect until the Plan is repaid in full. 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."

- United Distributors Plan

"If … 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."

- Mohawk Plan

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Extent of Recovery Rights

- Does the language reach to first party coverage? (i.e. UIM, UM)
  - Often language is silent or vague.

- Does the language overcome "made whole"?
  - The Plan language need only confer an unqualified right to recover.
    1st, 3rd, 4th, 5th , and 8th
  - Specific Plan language is required.
    6th, 7th, 9th , and 11th
  - No default rule.
    2nd , 10th , and D.C.

- Does the language overcome "common fund"?
  If language is silent then a reduction of attorney fees may be appropriate.
  "If [The Plan] wishe[s] to depart from the well-established common-fund rule, it ha[s] to draft its contract to say so
  - *U.S. Airways v. McCutchen*, 133 S. Ct. 1537 (2013)

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McCutchen

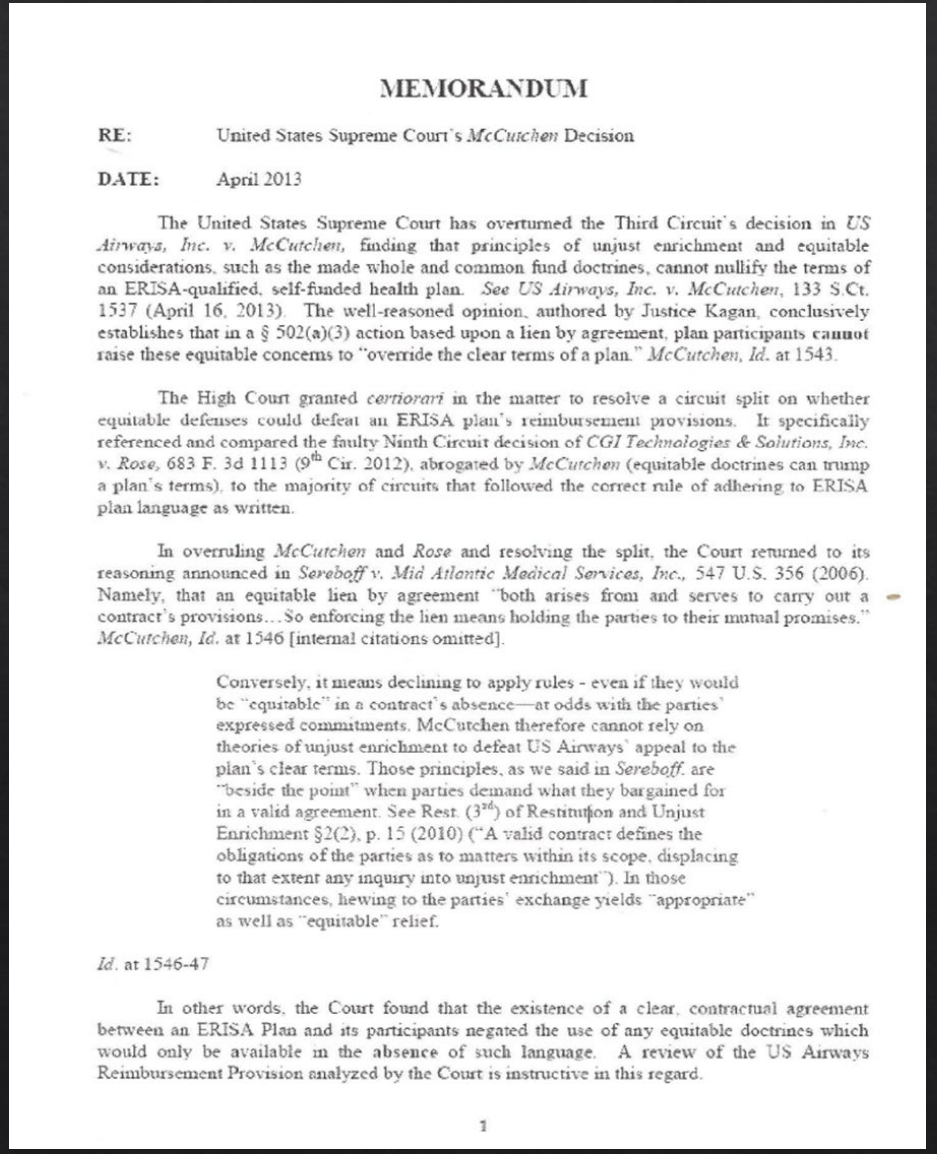
Is it really as bad as the Rawlings memo says?

"McCutchen [ ] cannot rely on theories of unjust enrichment to defeat US Airways [ ] plan's clear terms. Those principles … are 'beside the point' when parties demand what they bargained for in a valid agreement."

"The agreement itself becomes the measure of the parties' equities; so, if a contract abrogates the common-fund doctrine, the insurer is not unjustly enriched by claiming the benefit of its bargain."

"[If] [t]he express contract term … contradicts the background equitable rule … the agreement must govern."

- *U.S. Airways v. McCutchen*, 133 S. Ct. 1537 (2013)



MEMORANDUM

RE: United States Supreme Court's *McCutchen* Decision

DATE: April 2013

The United States Supreme Court has overturned the Third Circuit's decision in *US Airways, Inc. v. McCutchen*, finding that principles of unjust enrichment and equitable considerations, such as the made whole and common fund doctrines, cannot nullify the terms of an ERISA-qualified, self-funded health plan. *See US Airways, Inc. v. McCutchen*, 133 S.Ct. 1537 (April 16, 2013). The well-reasoned opinion, authored by Justice Kagan, conclusively establishes that in a § 502(a)(3) action based upon a lien by agreement, plan participants **cannot** raise these equitable concerns to "override the clear terms of a plan." *McCutchen, Id.* at 1543.

The High Court granted *certiorari* in the matter to resolve a circuit split on whether equitable defenses could defeat an ERISA plan's reimbursement provisions. It specifically referenced and compared the faulty Ninth Circuit decision of *CGI Technologies & Solutions, Inc. v. Rose*, 683 F. 3d 1113 (9th Cir. 2012), abrogated by *McCutchen* (equitable doctrines can trump a plan's terms), to the majority of circuits that followed the correct rule of adhering to ERISA plan language as written.

In overruling *McCutchen* and *Rose* and resolving the split, the Court returned to its reasoning announced in *Sereboff v. Mid Atlantic Medical Services, Inc.*, 547 U.S. 356 (2006). Namely, that an equitable lien by agreement "both arises from and serves to carry out a contract's provisions…So enforcing the lien means holding the parties to their mutual promises." *McCutchen, Id.* at 1546 [internal citations omitted].

> Conversely, it means declining to apply rules - even if they would be "equitable" in a contract's absence—at odds with the parties' expressed commitments. McCutchen therefore cannot rely on theories of unjust enrichment to defeat US Airways' appeal to the plan's clear terms. Those principles, as we said in *Sereboff*, are "beside the point" when parties demand what they bargained for in a valid agreement. See Rest. (3rd) of Restitution and Unjust Enrichment §2(2), p. 15 (2010) ("A valid contract defines the obligations of the parties as to matters within its scope, displacing to that extent any inquiry into unjust enrichment"). In those circumstances, hewing to the parties' exchange yields "appropriate" as well as "equitable" relief.

Id. at 1546-47

In other words, the Court found that the existence of a clear, contractual agreement between an ERISA Plan and its participants negated the use of any equitable doctrines which would only be available in the absence of such language. A review of the US Airways Reimbursement Provision analyzed by the Court is instructive in this regard.

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Lessons from *McCutchen*

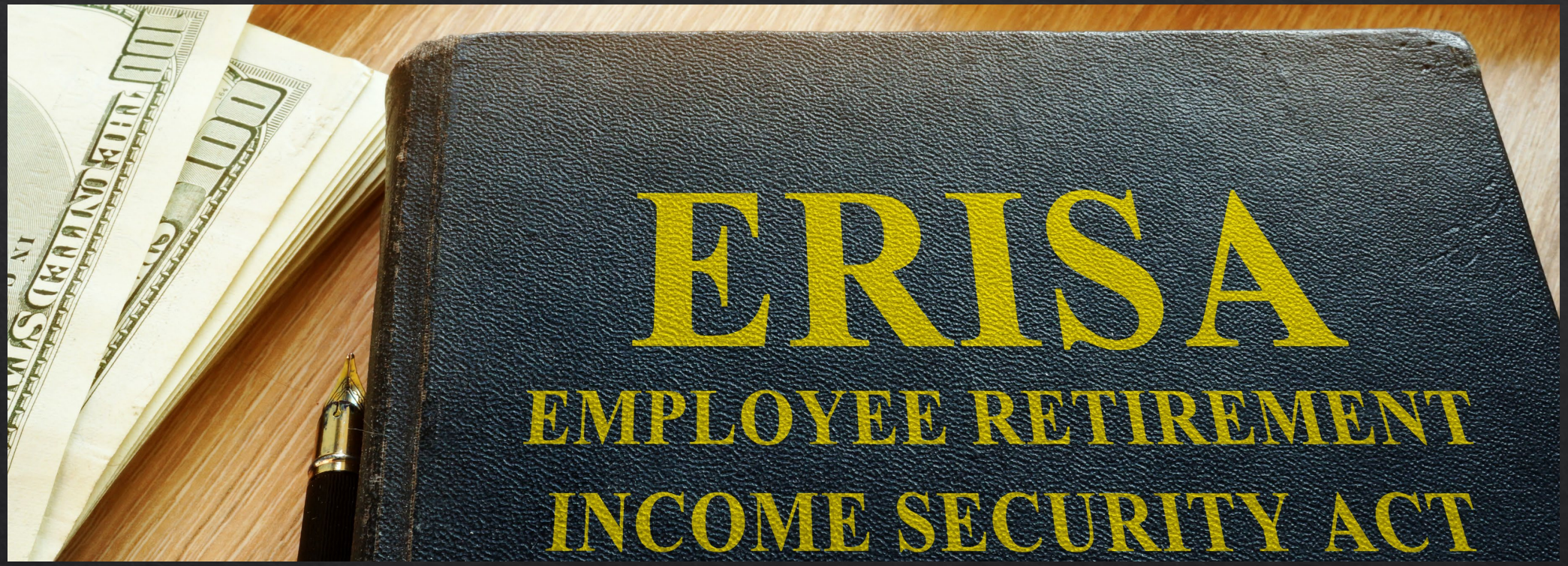
- Use 29 U.S.C. §1024(b)(4) – This would have changed everything in this case.
- Read the Master Plan Document (MPD) – This alone reduced the repayment to U.S. Airways by 85%
- "Common Fund," "Attorney Fund," and "Fund Doctrine" are magic words – without them there is a strong argument that this existing background equitable principal should be applied.

"The words of a plan may speak clearly, but they may also leave gaps. And so, a court must often "look outside the plan's written language" to decide what an agreement means. *CIGNA v. Amara*, 563 U. S. , (slip op., at 13); see *Curtiss-Wright*, 514 U. S., at 80–81."

- *U.S. Airways v. McCutchen*, 133 S. Ct. 1537 (2013)

"In their brief in opposition to the petition they conceded that, under the contract, 'a beneficiary is required to reimburse the Plan for any amounts it has paid out of any monies the beneficiary recovers from a third-party, without any contribution to attorney's fees and expenses."

- *U.S. Airways v. McCutchen*, 133 S. Ct. 1537 (2013) Scalia's dissent citing Brief in Opposition 5 (emphasis added); See Brief for Petitioner 18, and n. 6; Brief for Respondents 29; Brief for United State as *Amicus Curiae* 21.



Resolution & Disbursement

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Montanile

Montanile v. Board of Trustees of Nat. Elevator Industry Health Benefit Plan, 135 S. Ct. 651 (2016)

"We hold that, when a participant dissipates the whole settlement on nontraceable items, the fiduciary cannot bring a suit to attach the participant's general assets under §502(a)(3) because the suit is not one for 'appropriate equitable relief'."

"[W]here a person wrongfully dispose[d] of the property of another but the property cannot be traced into any product, the other . . . cannot enforce a constructive trust or lien upon any part of the wrongdoer's property."

"The Board had sufficient notice of Montanile's settlement to have taken various steps to preserve those funds. Most notably, when negotiations broke down and Montanile's lawyer expressed his intent to disburse the remaining settlement funds to Montanile unless the plan objected within 14 days, the Board could have—but did not—object. Moreover, the Board could have filed suit immediately, rather than waiting half a year."

"[T]he nature of the Board's underlying remedy would have been equitable had it immediately sued to enforce the lien against the settlement fund then in Montanile's possession."

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Attorney Liability

"[T]he claims against the Attorney Defendants are cognizable because they hold the settlement proceeds in trust or possess the funds."

"Indeed, 'the most important consideration is not the identity of the defendant, but rather that the settlement proceeds are still intact, and thus constitute an identifiable *res* that can be restored to its rightful recipient.'"

- *Publix v Figareau* 2019 WL 6311160 (M.D. Fla. Nov. 25, 2019); citing, *Treasurer, Trs. of Drury Indus., Inc. Health Care Plan v. Goding*, 692 F.3d 888 (8th Cir. 2012)
- *McKesson v Dillow*, 2020 WL 1469461 (S.D. Ohio March 25, 2020)
- *Publix v Figareau* 2020 WL 5513344 (M.D. Fla. Sept. 14, 2020);
- *Longaberger Co. v. Kolt*, 586 F.3d 459, 468 (6th Cir. 2009)

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SCOTUS Anecdotal Support

It is important to note that The Supreme Court of the United States has made it clear over the past 20 years, starting with *Knudson*, that the correct party to name in an ERISA subrogation/reimbursement suit is whomever is holding the funds.

- Banks, Courts, Trusts, Annuities, Individuals, And now seemingly the trial attorney.

- During oral arguments for *Montanile* Justice Breyer mused aloud "We know where some of the money is. Can't the Plan go after the attorney under a theory of fraud?"

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Litigation Tactics- Removal

- Be Assertive in Choosing the Forum and Issues
  - ERISA 29 U.S.C. § 1132(e)(1) and § 1132(a)(1)(B) vests concurrent jurisdiction in state court of claims brought by ERISA beneficiaries to recover benefits due, to enforce rights under the plan, or to clarify rights to future benefits under the plan.
  - Concurrent Jurisdiction for state courts – Use Show Cause, probate "creditor", but note the Plan can't be included as a defendant as the goal is to avoid removal if possible.
  - Entities which are not "named defendants" lack statutory authority to remove a case to federal court. *In re Notice of Removal Filed by William Einhorn*, 481 F.Supp.2d 345 (D.N.J.2007) (removal unsuccessfully attempted by the Administrator of the Teamsters Health and Welfare Fund of Philadelphia & Vicinity); *Ludwig v. New York Cent. Mut. Fire Ins. Co.* ., 2009 WL 909672 (W.D.N.Y.2009); *Thomas v. Powell*, 2010 WL 1849080 at *3 (W.D. Wash. May 7, 2010) (awarding plaintiff his costs and attorney fees upon remanding case, where entity filing notice of removal "was not even a party to the case").

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Litigation Tactics- Minors

- Use Probate for Minors
  - There is a recognized body of case law which holds that a state's court's role in supervising tort settlements for minors is not preempted by ERISA.
  - The ERISA Plan claim [federal subject matter jurisdiction] cannot "reach the same res over which the probate court has custody" *AEP v Fitch*, 2022 WL 3794841 (6th Cir. Aug. 30, 2022)
  - "Family law is an area traditionally regulated by the states. There is a presumption against pre-emption. Although ERISA does state its intent to pre-empt state law by positive enactment, there is no clear intention of Congress to pre-empt cases dealing with minors' rights. Moreover, there is no damage to any clear and substantial federal interest." *In re Guardianship of Holmes*, 965 So.2d 662 (Miss. 2007), *cert denied* 552 U.S. 1243 (2008).
  - *Bauhaus USA, Inc. v. Copeland*, 292 F.3d 439 (5th Cir. 2002) ("*Bauhaus II*")
  - *The Northern Dist. of Miss. in the Matter of O.D. v. Ashley Healthcare Plan,* 2013 WL 5430458 (9/27/13)
  - *Estate of Ashmore v. Healthcare Recoveries, Inc.*, 1998 WL 211778 (N.D. Mar. 25, 1998)
  - *Methodist Hosp. of Memphis v. Marsh*, 518 So.2d 1227, 1228 (Miss. 1988)
  - *Clardy v. ATS, Inc. Employee Welfare Benefit Plan,* 921 F Supp. 394. (N.D. Miss. 1996)

Attorney Liability:
FEHBA

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FEHBA- Resolution Tactics

- We will not reduce our share of any recovery unless, in the exercise of our discretion, we agree in writing to a reduction (1) because you do not receive the full amount of damages that you claimed or (2) because you had to pay attorneys' fees.

- "We conclude, however, that the statute, not a contract, strips state law of its force. … FEHBA contract terms have preemptive force "
  Coventry Health Care of Mo., Inc. V. Nevils, 492 S. W. 3d 918
- This is completely within the Plan's discretion, but they do look a the "totality of circumstances," so equity is a valid argument.
- The biggest obstacle to resolution is that each FEHBA file is scrutinized by auditors from the U.S. Office of Personnel Management.
- The care inordinate amount about whether or not an attorney has reduced his fee.

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False Claims Act

"Liability for certain acts.

(1) In general. … any person who —

(G) knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the Government, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the Government, is liable to the United States Government for a civil penalty of not less than $ 5,000 and not more than $ 10,000, … plus **3 times** the amount of damages which the Government sustains because of the act of that person.

- 31 U.S.C. §3729(a)(1)(G)

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Anthem/Meridian's Bulldog

- Jason Suter, Esq.
- Partner at Ermer & Suter, PLLC

"If this is not agreeable and your client chooses to file the Interpleader, please let me know so we can promptly remove the case to federal court and pursue full reimbursement and any other remedies available under federal law."

Third Party Recovery Services
Provided by Ermer & Suter, PLLC

"Dave, a couple months ago, we were set to move forward on a FCA claim, but we were able to settle with the attorney's malpractice carrier. It was a pretty egregious case and would have been a big deal. I felt badly for the guy."

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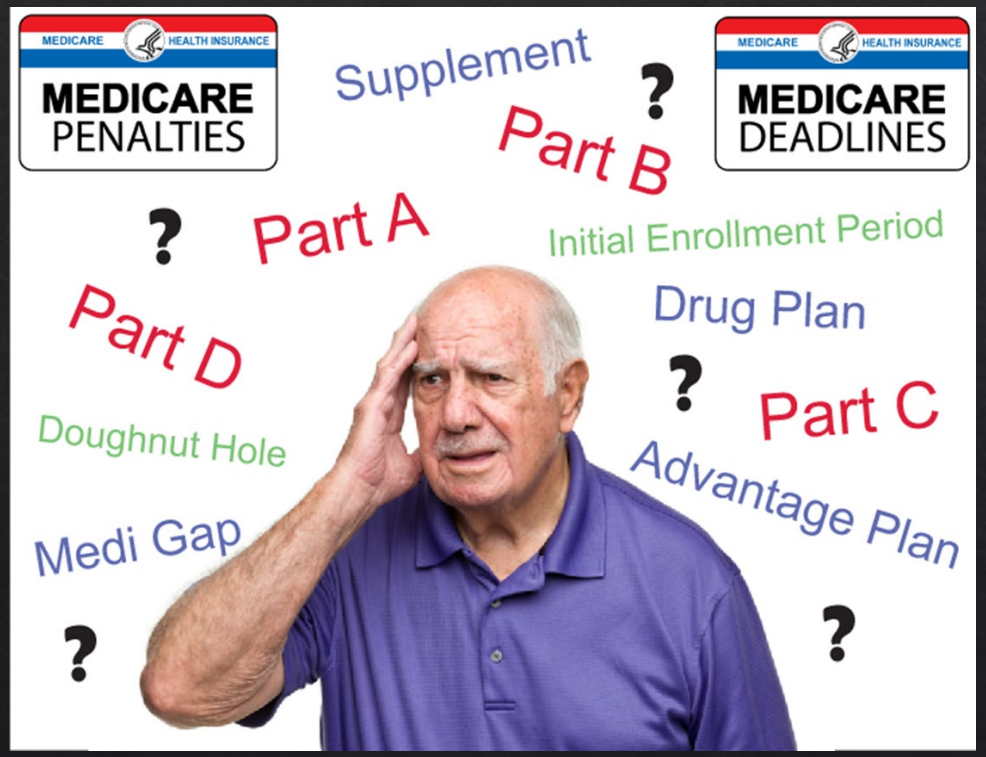
Medicare Advantage Organizations



- Medicare Parts C & D
- Provides all of Part A (Hospital Insurance) and Part B (Medical Insurance) coverage. May offer extra coverage, such as vision, hearing, dental, and/or health and wellness programs. Medicare pays a fixed amount for your care every month to the companies offering MAO Plans.
- These companies must follow rules set by Medicare.

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Resolution

- Administered by private insurance companies so many of the difficulties that dealing with BCRC or CMS can entail are avoided.
- Often will consider equity and fairness
- The Medicare Secondary Payer Act is their recovery vehicle.
- Apply §1862(b) & §1870(c) of the Social Security Act and 31 U.S.C § 3711.

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Attorney Liability

- CMS has a right of action to recover its payments from any entity, including a beneficiary, provider, supplier, physician, **attorney**, state agency or private insurer that has received a primary payment." 42 C.F.R. §411.24(g)
  - *United States v. Weinberg*, 2002 U.S. Dist. LEXIS 12289 (E.E. Pa. July 1, 2002).
  - *United States v. Harris*, 2009 U.S. Dist. LEXIS 23956 (N.D. W. Va. March 26, 2009) affirmed, 334 F. App'x 569 (4th Cir. 2009).
  - *Denekas v. Shalala*, 943 F. Supp. 1073 (S.D. Iowa 1996).

- The United States may … collect **double damages** against any [ ] entity … that has received payment from a primary plan or from the proceeds of a primary plan's payment to any entity."

- *Humana v. Paris Blank LLP*, 2016 U.S. Dist. LEXIS 61814

Post Payment of Final Demand Waiver/Compromise

Involves application for a compromise or waiver to both the Benefits Coordination and Recovery Center (BCRC) as well as the Center for Medicare and Medicaid Services (CMS)

There are three statutory authorities under which Medicare may accept less than the full amount of its claim:

1. **§1870(c) of the Social Security Act – done by BCRC (*Financial Hardship Waiver*)**
2. **§1862(b) of the Social Security Act – done by CMS (*Best Interest of the Program Wavier*)**
3. **The Federal Claims Collection Act (FCCA) – done by CMS (*Compromise*)**

If successful, a refund is issued by Medicare

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Financial Hardship Waiver

"There shall be no recovery if such recovery would ***defeat the purposes of this chapter*** or would be ***against equity and good conscience***."

- 1st Criteria--- "[D]efeat the purpose of this chapter"
  - Person needs substantially all of his current income (including social security monthly benefits) to meet current ordinary and necessary living expenses.
- 2nd Test --- "[A]gainst equity and good conscience"
  - "Totality of circumstances"
    - The degree to which recovery would cause undue hardship for the beneficiary;
    - Recovery of the full overpayment amount is contraindicated by especially compelling mitigating facts and circumstances of the beneficiary's case;
    - Age and physical/mental impairments of beneficiary.

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Hardship Examples

The Medicare Secondary Payer Manual does provide example situations of financial hardship that would justify a full or partial waiver consideration.

- "The beneficiary has spent the settlement proceeds and the only remaining income from which the beneficiary could attempt to satisfy Medicare's claim would be from the money that is needed for the beneficiary's monthly living expenses;
- Beneficiary income and resources are at a poverty level standard
- An unforeseen severe financial circumstance- For example, waiver would be appropriate if the beneficiary became legally responsible for their grandchildren."

Medicare Secondary Payer Manual (MSP), Chapter 7 § 50.6.5.1 Examples of Financial Hardship

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Financial Hardship Waiver

- §1870(c) of the Social Security Act;
- Pay the Final Demand amount and then attempt to obtain a partial or full waiver.
- Waiver of recovery should not be requested until the case is settled and Medicare has issued a demand for repayment letter.
- Requests for waiver must be submitted in writing
- Medicare may grant a full or partial waiver if recovery would negatively affect the beneficiary's standard of living compared to how it was before the accident/injury/illness.
  - http://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Downloads/SSA-632-Request-for-Waiver.pdf
  - Form is from the Social Security Administration and appears odd but is correct form

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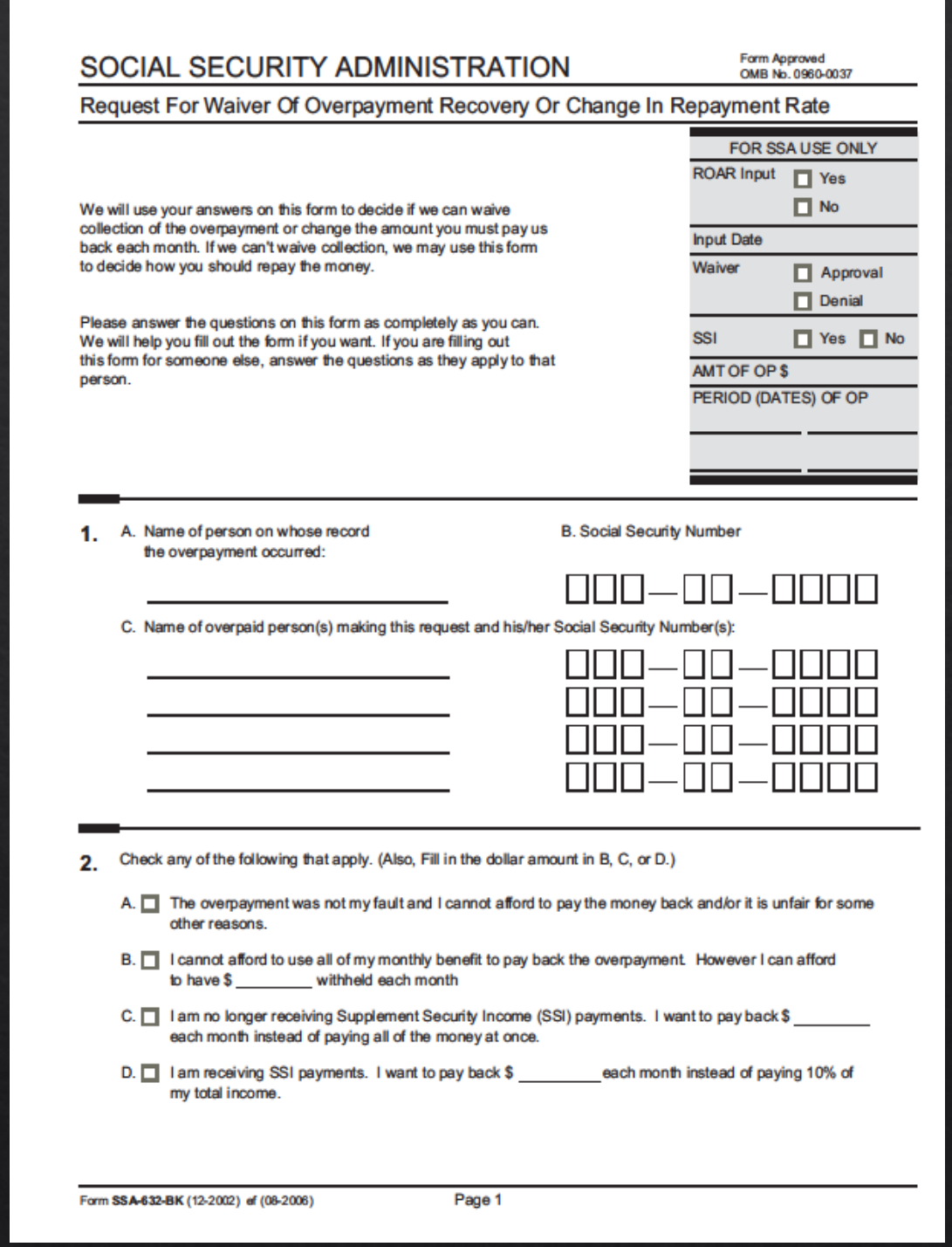
Medicare Form

Form: SSA-632-BK



SOCIAL SECURITY ADMINISTRATION

Form Approved
OMB No. 0960-0037

Request For Waiver Of Overpayment Recovery Or Change In Repayment Rate

FOR SSA USE ONLY	
ROAR Input	☐ Yes ☐ No
Input Date	
Waiver	☐ Approval ☐ Denial
SSI	☐ Yes ☐ No
AMT OF OP $	
PERIOD (DATES) OF OP	

We will use your answers on this form to decide if we can waive collection of the overpayment or change the amount you must pay us back each month. If we can't waive collection, we may use this form to decide how you should repay the money.

Please answer the questions on this form as completely as you can. We will help you fill out the form if you want. If you are filling out this form for someone else, answer the questions as they apply to that person.

1. A. Name of person on whose record the overpayment occurred: _____

B. Social Security Number ☐☐☐—☐☐—☐☐☐☐

C. Name of overpaid person(s) making this request and his/her Social Security Number(s):

_____ ☐☐☐—☐☐—☐☐☐☐

_____ ☐☐☐—☐☐—☐☐☐☐

_____ ☐☐☐—☐☐—☐☐☐☐

_____ ☐☐☐—☐☐—☐☐☐☐

2. Check any of the following that apply. (Also, Fill in the dollar amount in B, C, or D.)

A. ☐ The overpayment was not my fault and I cannot afford to pay the money back and/or it is unfair for some other reasons.

B. ☐ I cannot afford to use all of my monthly benefit to pay back the overpayment. However I can afford to have $ _____ withheld each month

C. ☐ I am no longer receiving Supplement Security Income (SSI) payments. I want to pay back $ _____ each month instead of paying all of the money at once.

D. ☐ I am receiving SSI payments. I want to pay back $ _____ each month instead of paying 10% of my total income.

Form **SSA-632-BK** (12-2002) *ef* (08-2006) Page 1

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Post-Settlement Compromise

- The Federal Claims Collection Act (FCCA)
  - Basis for Compromise
    - Inability to Pay
    - Litigative probabilities
    - Cost of collecting the claim
- 31 U.S.C.3711
  - The cost of collection does not justify the enforced collection of the full amount of the claim;
  - There is an inability to pay within a reasonable time on the part of the individual against whom the claim is made; or
  - The chances of successful litigation are questionable, making it advisable to seek a compromise settlement."
  - Medicare Secondary Payer Manual (MSP), Chapter 7 § 50.7.2

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Post-Settlement Compromise

CMS may suspend or end collection action on a claim when it appears that no person liable on the claim has the present or prospective ability to pay a significant amount of the claim or the cost of collecting the claim is likely to be more than the amount recovered.

- Basic conditions.

  (1) The claim does not exceed $100,000, or such higher amount as the Attorney General may from time to time prescribe, exclusive of interest; and

  (2) There is no indication of fraud, the filing of a false claim, or misrepresentation

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"Best Interest of the Program" Waiver

- § 1862(b) of the Social Security Act;
- A separate and distinct evaluation than a request under §1870(c) of the Social Security Act (Financial Hardship Wavier) and a request for a Compromise under the Federal Claims Collection Act (FCCA)
- The Secretary may waive (in whole or in part) the provisions of this subparagraph in the case of an individual claim if the Secretary determines that the waiver is in the ***best interests of the program*** established under this title

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Our Mission

The Injury Victim Comes First!

The Place Firm was founded with one guiding principle - the injury victim is more in need of the settlement funds created by their trial attorney than any other party.

Our Approach

The Place Firm works with plaintiff's counsel to address the healthcare repayment demands that may be made against the injury victim's settlement. We will ensure that Medicare's "super lien" is resolved in compliance with federal law and guidelines, eliminating the exposure to the Medicare beneficiary as well as the trial attorney. Additionally, our representation in resolving ERISA, FEHBA, and Medicare Advantage subrogation demands will allow the trial attorney to settle the underlying case sooner, and with a larger net recovery for the injury victim.

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Thank You!

If you would like more information on or assistance in deal with ERISA, FEHBA, Medicare or Medicare Advantage subrogation/reimbursement matters please contact The Place Firm, PLLC.

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