▶ LEAD ARTICLE

Service of a "Proper Request" Upon the Plan Administrator: A Key Step in Defending Against ERISA Reimbursement Claims

By Roger M. Baron[1]

***Professor Roger Baron**, University of South Dakota School of Law, has long been an advocate for victims' rights in connection with issues surrounding ERISA Reimbursement Claims. He worked, on a pro bono basis, as part of the legal teams affiliated with three separate ERISA Reimbursement cases taken to the U.S. Supreme Court:* Reynolds Metals Co. v. Ellis *(cert. granted in 2000 but voluntary dismissal subsequently entered);* Sereboff v. Mid Atlantic Medical Services Inc., *126 S. Ct. 4240 (2006); and* Wal-Mart v. Shank, *in which Prof. Baron worked with lawyers representing Deborah and James Shank. He assisted in the preparation of the briefing in the 8th Circuit Court of Appeals (main brief and petition for rehearing en banc) and also with the Petition for Writ of Certiorari filed in the U.S. Supreme Court. The injustice seen in the* Shank *case led to a public outcry against the practices of Wal-Mart concerning its reimbursement claims. Although the Supreme Court denied the Petition for Writ of Cert (3/17/08), the public outcry caused Wal-Mart to re-evaluate its policy. Upon re-evaluation, Wal-Mart permitted the Shanks to retain all of their settlement recovery and vowed to change its in-house regulations for the handling of future reimbursement cases.*

Prof. Baron has authored three significant law review articles which deal with subrogation issues in the context of personal injury claims. His 2004 Mercer Law Review article on ERISA Reimbursement has been cited by three federal district courts in written opinions handed down in Illinois, New Jersey, and Washington.

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Utilization of this procedure will result in the creation of a cause of action for penalties in favor of the beneficiary against a plan administrator who fails or refuses to comply with duties imposed upon it by ERISA.

When a personal injury lawyer is contacted about an ERISA lien, the contact typically comes from a purported "subrogation specialist." This specialist may be working for a subrogation law firm or corporate entity that specializes in collecting subrogation claims. The "specialist" may be a lawyer or non-lawyer. These subrogation entities and their representatives will be referred to as "bill collectors" in this article.[2] Although a collector may provide partial documentation to support the reimbursement claim, the ERISA beneficiary's lawyer will frequently request further documentation from the bill collector. Such requests invariably lead down a path fraught with frustration and confusion.

In my work assisting ERISA beneficiaries and their lawyers, I have consistently advised against engaging in such unfruitful exchanges with bill collectors. The fact of the matter is that these bill collectors are under no obligation to provide the ERISA beneficiary's lawyer with information. And if they do provide information, it is usually self-serving and inaccurate.

Having reviewed dozens of files involving ERISA reimbursement claims, I honestly do not believe I have seen a single instance where a bill collector has provided appropriate documentation applicable to the time period during which the beneficiary's injury occurred. To make matters worse, when the bill collectors neglect or otherwise refuse to provide accurate information, there is no sanction or recourse available.

Bill Collectors, Claims Administrators & Plan Administrators

It is important to understand the roles of the different entities involved in the ERISA setting. The "bill collector" works for the "claims administrator." The "claims administrator" works through a contractual arrangement with the "plan administrator." The "claims administrator," as the name suggests, handles the claims made by participants and beneficiaries insured through the ERISA plan.

The "plan administrator" is a specifically recognized entity under the ERISA scheme and is designated as such in the instrument under which the plan oper-

ates.[3] 29 U.S.C. 1002(16)(i). If there is no such designation, the plan administrator is deemed, by statute, to be the plan sponsor.[4] Customarily the employer itself serves as the "plan administrator" either by specific designation or on a default basis as the plan sponsor.

The role of the bill collector is not addressed in the ERISA scheme.[5] Both the bill collector and the claims administrator enjoy substantial freedom from regulation. This freedom derives from the fact that ERISA plans, particularly those deemed to be self-funded, generally enjoy preemption from state law. Bill collectors and claims administrators take full advantage of federal preemption. As stated above, the bill collector can act with impunity in ignoring good-faith requests made by ERISA beneficiaries and their attorneys. To be sure, there are situations where a bill collector's or claims administrator's conduct is so far afield from the operation of a health and welfare benefit plan that ERISA preemption will not provide a shield from state law claims for wrongdoing.[6] But, concerning the simple matter of refusing to provide accurate information to the beneficiary's attorney, a beneficiary or participant has no sanction or recourse available.

There is, however, a more effective strategy available—service of a proper request for documents on the plan administrator. Utilization of this procedure will result in the creation of a cause of action for penalties in favor of the beneficiary against a plan administrator who fails or refuses to comply with duties imposed upon it by ERISA.

Requesting Documents From the Plan Administrator

ERISA grants a plan beneficiary/participant the right to require the plan administrator to provide certain specified documents by making a written request. This right is granted by 29 U.S.C. 1024(b)(4), which provides as follows:

> 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.

A plan administrator's failure to provide this information within 30 days results in a cause of action in favor of the beneficiary/participant against the administrator for the recovery of a penalty of up to $110 per day for each day of noncompliance. 29 U.S.C. 1132(c)(1)(B). The statute sets the amount at $100 per day, but a federal regulation, 29 CFR § 2575.502c-1, effective August 1999, authorizes up to $110 per day.

One of the first tasks I undertake in many cases is to assist the beneficiary's attorney in preparing a "proper request" for the beneficiary/participant to serve on the plan administrator. The statute specifically authorizes that the request be made by "the participant or beneficiary."[7] Although some attorneys attempt to invoke this procedure on behalf of the client, it is not entirely clear as to whether or not the cause of action is triggered when an attorney makes such a request.

I have found several advantages when a request is sent to a plan administrator by the beneficiary/participant, as opposed to the attorney, such as: (1) if the plan administrator responds, the response is more candid; (2) a request made by the beneficiary/participant complies with the procedure prescribed by the statute; and (3) the request does not carry the red flag of intimidation/warning that might be raised by an attorney's letter (which may agitate rather than defuse the situation).

Targeting the Plan Administrator

There is an important distinction between the "plan administrator" and the "claims administrator." There is no obligation upon a claims administrator to provide documentation to the ERISA participant/beneficiary, but ERISA imposes this obligation on the plan administrator.

In addition to triggering the statutory cause of action for monetary penalties, there is further benefit in serving a "proper request" upon the plan administrator. Keeping in mind that the plan administrator is frequently the employer, requesting documents from the plan administrator will notify the plan administrator (employer) of the plight of the beneficiary or participant. Under the current state of affairs concerning ERISA health benefit plans, reimbursement claims are pursued by claims administrators for the benefit of the insuring entities. The claims administrator, in many situations, also serves as an insuring entity, which reaps the benefits of the right of reimbursement that has been written into the Summary Plan Description ("SPD").

Claims administrators and bill collectors undertake to collect reimbursement claims without regard to the devastating impact reimbursement may inflict upon beneficiaries and participants. The bill collectors, claims administrators and supporting insurers are not concerned about the adverse ramifications that so frequently ensue as a result of enforcement of reimbursement claims. If any entity in the ERISA health care scheme is likely to be sympathetic to the plight of the beneficiary/participant, it is the employer. Accordingly, service of a "proper request" for documents upon the plan administrator may help bring awareness of the potential injustice to the only entity that may actually be inclined to promote an ameliorative resolution of the claim.

Drafting a "Proper Request"

The request should seek the relevant documentation for the year preceding the injury, the year of the injury and subsequent years up to the date of the request. Requesting documentation for the year preceding the injury will accommodate the situation where the applicable SPD may actually be dated the preceding year. For example, an injury

which occurred on March 14, 2009, may be governed by an SPD which went into effect on July 1, 2008, and runs until June 30, 2009. A request for the 2009 SPD will not yield the appropriate SPD which was in effect at the time of the injury.

Claims administrators have rather consistently taken the position that they are able to amend SPDs and plan documents and apply those amendments retroactively. I have found that the bill collectors also assume this to be the case. There is a solid body of law, however, holding that ERISA plans may not apply new provisions retroactively.[8]

ERISA authorizes both the SPD and the Summary of Material Modifications (SMM). 29 U.S.C. 1022. Accordingly, the request should encompass not only the SPD itself but also all SMMs that have been invoked over the relevant time frame. Access to the SMMs provides the beneficiary's attorney opportunity to pinpoint the timing of amendments to the SPD. Thus, analysis of the SMMs and the SPDs should serve to validate the accuracy of the SPD and the exact language in effect at the time of the injury.

With the help of my assistant, Marilyn Trefz,[9] I have developed a generic form to utilize in preparing specific requests in ERISA reimbursement situations. *(See box right.)*

Date
(Name of Plan Administrator – should be set forth in SPD)
Plan Administrator for __________Medical Plan
Street Address
City, State, Zip Code

CERTIFIED MAIL: Return Receipt Requested

Dear Mr./Ms.,

My name is_____________. Pursuant to my right as a participant and beneficiary of _____________ Plan, I respectfully request copies of the following materials:

Copies of the Summary Plan Description (SPD) and other Plan Documents relating to my health insurance coverage for the years ______, ______, ______, and ______. (year preceding date of injury through current year); and

Administrative Services Contract between ______________ (Employer/Plan) and ____________(Plan Insurer(s)/Claims Administrator) for the years______, ______, ______, and ______. (year preceding date of injury through current year); and

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 related to _________ Medical Plan serving (insert name of state or region encompassing client) participants for the years ______, ______, ______, and ______. (year preceding date of injury through current year); and

Amendments to the Plan Documents for ________ Medical Plan (including, but not limited to the Summary Plan Description) for the years ______, ______, ______, and ______. (year preceding date of injury through current year); and

Copies of the SMM (Summary of Material Modifications) statements for the years ______, ______, ______, and ______. (year preceding date of injury through current year); and

Copies of form 5500, including all attached schedules, filed with the U.S. Department of Labor for the years ______, ______, ______, and ______. (year preceding date of injury through current year).

Please forward these materials to my attorney, Mr./Mrs. _______, (street address), (city), (state), (zip code).

Thank you.

______________________________ (signature)
(Name of Participant/Beneficiary – Printed)
Plan Participant
Plan Beneficiary

Responses to the "Proper Request"

I have found that very few plan administrators comply with these requests in a forthright manner. In about 40% of the cases, the request is ignored altogether. In the remaining cases, the response is almost always late (beyond the 30 days allowed by ERISA) and woefully inadequate, with the administrator withholding important information.

Occasionally plan administrators object to the production of contracts it has entered into with insuring entities. When this issue comes up, it is important to remember that the U.S. Department of Labor has addressed this matter

by regulation. By virtue of the Code of Federal Regulations ("CFR"), a plan administrator is required to produce all insurance contracts under which the Plan was established or is operated. In particular, CFR § 2520.102-3, found in the Model Statement of ERISA rights, states that a participant/beneficiary may "obtain upon written request to the plan administrator, copies of documents governing operation of the plan, including *insurance contracts*…" (emphasis added).

As previously stated, when the plan administrator fails to comply with its statutory duty (imposed by ERISA) by either not providing information or by refusing to provide all of the requested documents, it does so at the risk of a court-imposed penalty of up to $110 per day for each day of noncompliance. Furthermore, judicial resolution of the issues which may develop in this process is not immediately available.

For example, a plan administrator may assert that it is not required to provide copies of former SPDs, even though the current SPD was not in effect at the time of the injury. The "contest" at this point, however, is not like a discovery dispute in court where a simple ruling from a court will reconcile the parties' positions. When a plan administrator assumes the position that certain documents need not be provided, an immediate judicial resolution is not available—rather, the plan administrator is undertaking a long-term commitment to a position for which a day of reckoning may ultimately deliver severe consequences. Hefty penalties have been imposed in recent cases against plan administrators that have chosen the path of noncompliance.[10]

Conclusion

The validity of an ERISA reimbursement claim rests upon an analysis of the underlying SPD, plan language and plan funding arrangements. Access to the controlling documents is critical. Gaining access to those documents is best facilitated by making a "proper request" to the plan administrator. It isn't possible to address in this brief article every issue that may arise in connection with making a "proper request" for documents under the ERISA statute. But it is hoped that this article will provide a starting point for the personal injury lawyer who is confronting an ERISA reimbursement claim. ▲

Endnotes

1 The author wishes to thank his assistant Marilyn Trefz her help in writing this article and in helping prepare the generic "proper request" form set forth in this article. The author also wishes to thank attorney Sarah Baron Houy of Rapid City for her assistance in making this article more presentable. Questions and/or comments about this article are invited. The author may be contacted by e-mail at Roger.Baron@usd.edu.

2 The role of the "subrogation specialist" is similar to the role of a collection agency employed to collect consumer debts, receiving as compensation for its work a percentage or portion of the money recovered. Subrogated recoveries do not flow to the benefit of those insured, but are utilized as a source of revenue for the commercial insurer, with a substantial portion of those recoveries being used first to pay those engaged in the work of pursuing the subrogation or reimbursement claims. *Roger M. Baron, Public Policy Considerations Warranting the Denial of Reimbursement to ERISA Plans: It's Time to Recognize the Elephant in the Courtroom*, 55 Mercer Law Review 595, 627-31 (2004).

3 29 U.S. C. 1002 (16)(i).

4 29 U.S.C. 1002 (16)(ii).

5 A cottage industry of "bill collectors," sparked by the evolution of ERISA reimbursement claims, now thrives because protective state law is avoided through federal preemption. This industry collects "millions and potentially billions of dollars annually" according to its own statistics. Being funded by tort recoveries secured by innocent victims (many of whom have suffered catastrophic losses), this bill-collecting industry perpetuates itself by aggressively establishing lobby influence in Congress and providing amicus curiae support in judicial proceedings. Roger M. Baron, *Public Policy Considerations Warranting the Denial of Reimbursement to ERISA Plans: It's Time to Recognize the Elephant in the Courtroom*, 55 Mercer Law Review 595, 621 (2004) (citing statistics provided by the amicus brief filed on behalf of *The American Association of Health Plans, The American Benefits Council, the Blue Cross Blue Shield Association, The Chamber of Commerce of the United States, and the Health Insurance Association of America in Great-West Life and Annuity Insurance Co. v. Knudson*, 534 U.S. 204 (2002)).

6 In *Pruitt v. United Healthcare Services*, Inc., 2007 WL 4244998 (W.D.Mo. 11/29/07), the U.S. District Court, Western District of Missouri, remanded to state court a "tortious interference with contract and expectancy" claim filed against United Healthcare Services, Inc., and Trover Solutions, Inc., d/b/a Healthcare Recoveries. When these ERISA reimbursement "bill collectors" were sued in Missouri state court, they removed the case to federal court asserting that plaintiff's claims were completely preempted by ERISA. This decision grants the plaintiff's motion to remand, holding that plaintiff's claims are not "completely preempted" by ERISA.

More recently, the U.S. District Court for the Northern District of Texas handed down a decision on December 8, 2009, in *Texas Health Resources v. Group & Pension Administrators, Inc.*, No. 4:09-CV-547-A. In this case the plaintiff hospitals sued an ERISA claims administrator in state court for defamation, business disparagement, tortious interference with existing contracts and prospective contractual relations. Plaintiffs sought exemplary damages in addition to actual damages from the defendant ERISA administrator. The suit arose from allegedly false statements about the hospitals made to patients in letters mailed by the defendant claims administrator. The ERISA administrator removed the action to federal court, arguing that "complete preemption" by ERISA. This decision grants the plaintiff's motion to remand.

7 The term "participant" is defined in 29 U.S.C. 1002 (7) and generally encompasses employees and former employees. The term "beneficiary" is defined in 29 U.S.C. 1002(8) as "a person designated by a participant or by the terms of an employee benefit plan, who is or may become entitled to benefit thereunder."

8 Recent ERISA cases have addressed the issue of whether a plan may retroactively apply amended provisions and have rejected the ERISA plans' efforts to do so. Please note that in the first case discussed, not only

did the original plan document control for medical expenses incurred under that document, but also for future medical bills for services rendered during the time period when the amended provision was in effect. This case holds and cites other cases which hold that "the Original Plan should govern the entirety of the Plaintiff's [reimbursement] claim."

In *ACS/PRIMAX v. Polan*, 2008 WL 5213093 (W.D. Pa.), handed down 12/12/08, the Plan sought reimbursement in the amount of $236,744 from a medical malpractice settlement of $3 million relating to the birth of baby Jacob. This court, after conducting a de novo review, adopts the report and recommendation of the referee to deny reimbursement. Important holdings in this case are as follows:

(1.) The plan in effect at the time of malpractice controls. The Plan unsuccessfully argued that its subsequently amended plan document should control because the new language was in effect at the time of tort settlement. The opinion states, "This position lacks logical appeal and it is unsupported in the law. It is unreasonable for the coverage decision (payment of medical expenses) to have been governed by one plan or contract, i.e., the Original Plan, and the Plan's reimbursement for those medical expenses be governed by another, i.e. the Amended Plan…. [A] plan cannot garner greater rights for itself simply by amending the terms of the plan [case citations omitted] … Because the medical expenses at issue here were paid under the terms of the Original Plan, Plaintiff's effort to recoup those same medical expenses is governed by the terms of the Original Plan." *Id.* at *3-*4.

(2.)The Original Plan also controls as to those medical expenses which were paid after the Amended Plan went into effect. Here $13,640 of the $236,744 was paid for "continuing treatment" after the Amended Plan went into effect. The court cites three other cases supporting the proposition that "the Original Plan should govern the entirety of the Plaintiff's [reimbursement] claim." *Id.* at *4.

In *Sheet Metal Workers Local 27 Health & Welfare Fund v. Beenick*, 2008 WL 5156663, December 9, 2008, the U.S. District Court for New Jersey rejected the Plan's argument that its 2007 SPD should be applied retroactively to cover its right of subrogation on medical bills for a death in 2004 which occurred as a result of medical malpractice. The court states in footnote 3 that the ERISA Plan's "attempt to characterize the current, updated 2007 SPD as merely providing 'significant explanation' of the subrogation rights in the 1995-2006 SPD is not persuasive; this court must give the language of the 1995-2006 SPD its 'intended effect.'"

See also the case of *Burgett v. MEBA Medical And Benefits Plan*, 2007 WL 2815745 (E.D.Tex.), where the federal court held that a plan administrator abused its discretion in attempting to require the beneficiary to execute a subrogation agreement as a "condition" to processing and paying ongoing medical bills. The SPD in effect at the relevant time did not permit such an action by the plan administrator. The plan administrator sought to justify its actions based upon another document entitled the "Plan Rules and Regulations." The court rejected this assertion, holding at * 3:

ERISA requires that an SPD be furnished to each participant and beneficiary. 29 U.S.C. § 1022. The SPD must be written in a manner calculated to be understood by the average plan participant, and must be sufficiently accurate and comprehensive to reasonably apprise such participants and beneficiaries of their rights and obligations under the plan. *Id.*

In a similar vein, *see Gorman v. Carpenters' & Millwrights' Health Benefit Trust Fund*, 410 F.3d 1194 (10th Cir. 2005) which holds that the 1999 SPD was controlling, in lieu of the more recent 2003 SPD.

The Fund contends that the district court erroneously relied on the 1999 SPD, rather than the 2003 SPD. It contends that a reasonable interpretation of the subsequent Plan and SPD amendments would allow the Fund to require execution of the terms of its SAC. We agree with the district court that the controlling document is the 1999 SPD. "Because plan administrators have an obligation imposed by ERISA to operate the plan according to current plan documents, a post hoc amendment clearly cannot alter a plan provision in effect at the time performance under the plan became due." *Member Services Life Ins. Co. v. American National Bank and Trust Co.*, 130 F.3d 950, 957 (10th Cir.1997). The Fund contends that the 2003 SPD controls because it provided notice of the amendments within the 120 days following their adoption as required by ERISA, 29 U.S.C. § 1024(b)(1), and the SAC was signed after the effective date of the 2003 SPD. However, Plaintiff's benefits were vested prior to the effective date of the 2003 SPD. A welfare plan's benefits vest when performance is due. Member Services, 130 F.3d at 956.

Gorman, 410 F.3d at 1198.

9 Marilyn, currently a 2nd year law student at the University of South Dakota School of Law, has worked in the field of Human Resources in excess of 18 years. She is a certified Senior Professional in Human Resources (SPHR).

10 Two recent cases imposing penalties against plan administrators are summarized here:

On Oct. 22, 2009, the Central District, Illinois Federal Court entered an order in *Leister v. Dovetail, Inc.*, No. 05-2115, imposing penalties against the ERISA plan administrator in the amount of $377,600 for 3,776 days of non-compliance. This calculation is applied to three separate requests for documents made by the beneficiary/participant.

In *Huss v. IBM Medical and Dental Plan*, No. 07 C 7028, (N.Dis.Ill. Nov. 4, 2009), the court assessed the maximum statutory penalty against a plan administrator for failure to deliver requested documents. This court recognized that it had discretion to assess less than the maximum but was unfavorably impressed with the bad faith conduct of the plan administrator who was apparently trying to hide a prior version of the Summary Plan Description (SPD). The *Huss* court stated, "Defendants affirmatively misrepresented to Plaintiff that 2004 SPDs were not available to send (four versions of the 2004 SPD were issued, documents (2), (3), (4), and (5) respectively). This constitutes both bad faith and intentional conduct. Furthermore, as stated previously, all of these documents reflect amendments made to the SPD between 2004 and 2006 and were therefore material to Plaintiff's evaluation of her rights. Finally, a 104-day delay is undeniably egregious. Because of Defendants' bad faith, the materiality of these documents, the unreasonable delay in providing these documents to Plaintiff, and the number of documents involved in this request, I assign the maximum penalty of $110 per diem amounting to a total penalty of $11,440.00."