



ERISA Pre-emption Assault by States Could Complicate Subrogation Rights

by Bruce Shutan

There's little doubt that the Employee Retirement Income Security Act is under siege in courts and statehouses 40 years after the landmark law's passage, which is cause for alarm among self-insured health plan sponsors who will find countless devils lurking in the details.

Adam Russo, an attorney who co-founded the Phia Group, LLC in Braintree, Mass., has seen "a deepening erosion of ERISA, whether it's case law on a state or federal level." He believes the effort extends beyond state insurance commissioners who want to dictate coverage terms to self-insured employers in a post-health care reform environment.

"There have been three cases on subrogation in the last decade" argued before the U.S. Supreme Court, observes Russo, whose firm helps self-funded plan sponsors control health care costs and protect plan assets. Fueling this trend is the fact that ERISA doesn't specify how subrogation should work in any given state. "There are all kinds of gray area in regard to what's pre-empted and what's not, what's regulating insurance," he adds.

There's confusion about self-funding and ERISA across the Obama Administration, Russo believes – even among various federal agencies and health insurance brokers – because so many laws are tailored around fully insured coverage from

established health insurance carriers that charge monthly premiums.

What's worrisome is "plaintiff and regulator misinterpretation" of how these various state laws affect self-funded plan designs and sponsorship, Ron E. Peck, SVP and general counsel with the Phia Group, recently cautioned in an e-mail to SIIA's Government Relations Committee.

New York state of mind

One such culprit is New York, where a law was passed codifying a "collateral-source" rule, which not only excuses tortfeasors for damages they cause, but also eliminates subrogation or reimbursement efforts made by

self-insured health plans. Proponents argue that ERISA pre-emption does not apply.

Peck noted that these efforts, which often tend to be recycled rather than new, are promoted under the guise of “preventing health insurers from seeking unwarranted reimbursements, and removing the uncertainty hanging over future settlements in personal injury, medical malpractice and wrongful death cases.”

Daran Kiefer, a health care subrogation attorney with Kreiner & Peters Co., L.P.A., in Cleveland, Ohio, and president of the National Association of Subrogation Professionals, believes many of these changes taking place at the state level “aren’t necessarily directly aimed at self-insurers or ERISA plans,” nor is the objective to eliminate their subrogation rights.

The thinking is that any medical bills paid by self-funded health plans are deducted from the amount awarded to injured parties in jury trials who are prohibited from recovering on responsible tort fees or bills paid by self-funded plans under state collateral-source rules.

While legislative activity at the state level seen as limiting the scope of ERISA pre-emption will not necessarily undermine self-insurance, “it certainly will impact the reality of self-funding,” adds David Adams, president of Caprock Health Group in Lubbock, Texas, which provides an integrated solution for self-funded health plan management.

Egregious billing in Texas

Adams references a series of lawsuits brought in Texas over the past few years by hospital systems intended to bind self-funded employers to PPO

contracts. “The result was that the hospitals gained a tremendous upper hand using their leverage, which then had impact over a lot of the self-funded health plans,” he reports.

It’s also worth noting that each of these cases ended up in state court rather than a federal jurisdiction because that’s where contract law issues are decided. The powerful hospital lobby in Texas has used state courts to advance other legislation, notes Adams, who says this venue means that technically speaking these cases do not involve ERISA pre-emption.

“Some of the contracts are so onerous that they say that you can’t even request an itemized bill or negotiate outside of what the contract parameters say,” he explains. “And so you’ll end up with a very high dollar claim that is egregiously billed.” Hospital bills in the Lone Star State are averaging anywhere from 500% to 1,000% of Medicare and higher, Adams notes, with PPO contracts requiring provider payments in the neighborhood of 250% to 400% of Medicare.

The upshot is that “it really leaves the self-funded plan with limited options on how they manage the cost, which obviously has a direct impact on the consumer,” he says, adding that many plans have been forced to consider eliminating PPO contracts and instead use a reference-based pricing model that is negotiated or a Medicare derivative reimbursement schedule.

Adams spotlights the Texas Prompt Pay Act as a particularly aggressive piece of legislation whose rules and penalties are thought to supersede a self-insured health plan’s right under ERISA to examine claims and their fiduciary duty to ensure that only eligible claims are paid.

“What’s happened is the legal

community has seized upon the opportunity to aggressively go after all plan types by partnering with the hospitals to identify claims that may not have been paid exactly in the timely manner as the law requires, and chase down those dollars, plus the lost discount dollars, and then share them with the hospitals,” he explains.

Restricting stop-loss coverage

Russo sees a trend toward restricting or considering restricting the availability of stop-loss coverage “spreading like wildfire” across several state lines, including California, Colorado, Utah, North Carolina and Rhode Island. “The more limitations there are in regards to people being able to purchase it, the less likely they are to be a self-funded plan,” he laments.

He also cites another significant development at the state level in Vermont, where self-funded employers argued that ERISA pre-empted a state law requiring all health insurance plans to provide information on doctors and hospitals.

“The interesting part about that case was the Department of Labor actually filed an amicus brief on behalf of the state, which is very strange,” Russo says. “Usually the Department of Labor sides with ERISA.”

In Ohio, Kiefer says “sometimes third-party administrator licensing can be predicated on TPAs not writing or agreeing to policies that would allow for full reimbursement, despite the state law that says the injured party has to be made whole.”

He has noticed a big push in this direction by the injury attorney bar, “especially in light of some of their losses on the ERISA side of things. They’re really looking at how to

ratchet up states demanding or requiring, as well as legislators, that injured parties be made whole first before any recovery of subro."

There more than likely will be some reduction of the subrogation rights for attorney fees based on a formula or no recovery will be allowed if injured parties aren't made whole under rules associated with the Affordable Care Act (ACA) and U.S. Department of Health and Human Services (HHS), Kiefer surmises. If this happens, "then there'll be a ton of litigation over what that means, he says, including whether damages include pain and suffering beyond medical bills and lost wages. He predicts that plan costs "definitely" would rise as a result of recovery dollars plummeting.

Kiefer says there also could be changes to subrogation rights for ERISA health plans that lose their grandfathered status or fall within the ACA if they run afoul of what HHS allows. While HHS hasn't made any subrogation-provision recommendations, he says the key will be determining whether injured parties first have to be made whole. ■

Bruce Shutan is a Los Angeles freelance writer who has closely covered the employee benefits industry for 26 years.



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2013036