

# Service of a 'proper request' upon the plan administrator: a key step in defending against ERISA reimbursement claims



**By Roger M. Baron**

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. Although a collector may provide partial documentation to support the reimbursement claim, the ERISA beneficiary's lawyer frequently will request further docu-

mentation 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 is that these bill collectors are under no obligation to provide the ERISA beneficiary's lawyer with information, and if they do, 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 and 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 operates. 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. 29 U.S.C. 1002(16)(ii). 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. 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 pre-emption. 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, e.g. *Pruitt v. United Healthcare Services, Inc.*, 2007 WL 4244998 (W.D.Mo. 11/29/07).

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 re-

quest 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 benefi-

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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. Marilyn, a 2nd-year law student at the University of South Dakota School of Law, is a certified senior professional in human resources has worked in the field for more than 18.

The author also wishes to thank attorney Sarah Baron Houy of Rapid City, South Dakota, for her assistance in making this article more presentable.

Roger Baron is a professor at the University of South Dakota School of Law and has long been an advocate for victims' rights in connection with the issues surrounding ERISA Reimbursement Claims. He worked pro bono as part of the legal teams affiliated with three separate ERISA Reimbursement cases taken to the U.S. Supreme Court. He has authored three significant law review articles dealing with subrogation issues in the context of personal injury claims, and 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. He can be reached by e-mail at Roger.Baron@usd.edu.

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ary." 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.

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. See, e.g., *ACS/PRIMAX v. Polan*, 2008 WL 5213093 (W.D. Pa.) and *Gorman v. Carpenters' & Millwrights' Health Benefit Trust Fund*, 410 F.3d 1194 (10th Cir. 2005).

ERISA authorizes both the SPD and the Summary of Material Modifications. 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, I have developed a generic form to utilize in preparing specific requests in ERISA reimbursement situations. This generic form is set forth below:

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 percent 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, 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, e.g. *Huss v. IBM Medical and Dental Plan*, No. 07 C 7028, (N. Dis. Ill. Nov. 4, 2009).

## 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 is not possible to address here every issue that may arise in connection with making a "proper request" for documents under the ERISA statute, but I hope that this article will provide a starting point for the personal injury lawyer who is confronting an ERISA reimbursement claim.

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