ERISA-Governed Healthcare Liens

By Kristen S. Cross, Lee P. Fernon, Jr. and Thomas O. Sinclair

The acronym ERISA[1] is enough to trigger an instinctive urge to run away in most lawyers, but this complex law[2] often cannot be avoided entirely. According to the Bureau of Labor statistics, 52 percent of civilian workers received employer-sponsored medical coverage in March 2017, and the Kaiser Family Foundation used census information to determine that 46 percent of Alabamians were covered by employer insurance in 2015.[3] Thus, it seems fair to say that lawyers in numerous fields will have to deal with ERISA at some point. One of the most common instances where ERISA may pop up is in the context of a healthcare insurer's use of subrogation and reimbursement provisions to recover medical expenses.[4]

This article will consider, from a plaintiff's and a defendant's perspectives, those issues that may arise in managing ERISA-governed healthcare liens. Specifically, this article will address the implications of the Supreme Court's recent decision in *Montanile v. Bd. of Trustees of Nat. Elevator Indus. Health Benefit Plan*, 136 S. Ct. 651 (2016). Before delving into these issues we provide a brief overview of the terminology involved in our analysis.

ERISA "Plans" and Equity

The terms of an "ERISA Health and Welfare Benefits Plan" or "Plan" are most often found in the group healthcare contract between the employer and healthcare provider. Unfortunately, as with most things ERISA, courts and litigants struggle with whether other documents such as "Summary Plan Descriptions" or "SPD's" (think employee handbooks describing the benefits) are also considered to contain "Plan" terms.[5] This becomes important when consulting the plan terms to determine the extent of the obligation to honor the lien. Larger employers often will have engaged their own counsel to help craft the plan terms and will not rely solely on the insurance carrier to define the employer's plan, thus plan terms

may be contained in more than one single document. Smaller employers may only have the healthcare insurance contract to serve as the plan terms. Once the plan terms are defined, you most often find the scope of the lien defined in a "subrogation" or a "reimbursement" (also referred to a "right of recovery") provision within the plan. If an employee meets the requirements to participate in the plan, they then are referred to as a "plan participant."

Once you have defined the plan terms and thus the rights/obligations of the plan and plan participant as set out in those terms, remember that this is ERISA. Nothing is that easy in ERISA. Now, dust off those equity court decisions and prepare for discussions of equitable claims and remedies.

ERISA contains one type of claim under 29 U.S.C. § 1132(a)(1) that is primarily used by plan participants seeking to have their benefit claim paid by the plan or insurance carrier. A second type of ERISA claim under 29 U.S.C. § 1132(a)(3) is often referred to as the equitable remedy claim. It is this second type of claim that plans must use when seeking to recover their lien which now must also seek an "equitable remedy" (if you are wondering why, you are in good company[6]). Now armed with the requisite uncertainty of an experienced ERISA litigator, we turn to the Supreme Court's most recent attempt at "clarification."

The *Montanile* Decision

In *Montanile*, the insured was severely injured by a drunk driver who ran a stop light, and the ERISA-governed health insurance plan paid more than $121,000 in health benefits as a result. Montanile later obtained a settlement of $500,000, and roughly $240,000 remained after paying his attorneys' fees and repaying their case expenses. His attorneys retained the funds in a trust account while they attempted to resolve the lien with the plan, but eventually those negotiations fell apart. The attorneys then sent the plan a letter indicating that the full amount would be disbursed to Montanile unless the plan objected within 14 days. The plan took no action and Montanile's attorneys disbursed the entire remaining settlement funds.

Six months *after* Montanile's attorneys disbursed, the plan sued Montanile in the Southern District of Florida, seeking reimbursement for the money paid by the plan to his medical providers. In circumstances such as this, because ERISA only allows plans to bring "equitable claims," the plan terms forming the basis of the plan's claim must seek equitable (not legal) relief and seek recovery from specifically identified funds. *See, e.g.*, *Sereboff v. Mid A. Med. Services, Inc.*, 547 U.S. 356, 364 (2006); *Popowski v. Parrott*, 461 F.3d 1367, 1374 (11th Cir. 2006) (refusing to enforce provision that failed to identify any specific fund or limit recovery to any portion thereof).[7]

By the time the plan filed suit against Montanile, it appeared he may have spent most or all of the settlement money. The district court rejected Montanile's arguments that there was no specific, identifiable fund separate from his general assets upon which the plan's equitable lien could be enforced.[8] The Eleventh Circuit subsequently affirmed that decision, finding that dissipation of the settlement funds could not destroy an equitable lien once it had attached.[9] The Supreme Court disagreed in an 8-1 decision.

The Court held that "when a participant dissipates the whole settlement on non-traceable items, the fiduciary cannot bring a suit to attach the participant's general assets under [29 U.S.C. § 1132(a)(3)]."[10] In *Montanile*, the Court remanded the case to the district court to determine whether Montanile had separated his settlement fund from his general assets and whether he had dissipated the whole of the settlement on non-traceable items. The holding makes clear that there is no equitable remedy available to the plan when a participant has dissipated settlement funds through the purchase of non-traceable items (such as services or consumable items) because an action to enforce on the general assets of the insured seeks a legal remedy. Those confounded by this result may find company (though little solace) in Justice Ginsburg's prediction in *Knudson*.

Plaintiff Practice Pointers

In the typical scenario, your office will receive a demand letter from your client's medical insurance carrier asserting a lien on any recovery. If the medical insurance was provided to your client as part of a group healthcare plan, it is likely an ERISA-governed plan.[11]

This form letter may attempt to default you into representing the plan's interests if you fail to respond or simply demand that you turn over all or a large portion of any settlement or judgment you obtain (after years of work). The plan may also assert it is not obliged to pay any of your costs or fees. Needless to say, this sort of communication from a party who does nothing to protect its own rights does not help your blood pressure.

The purpose of this section will be to generally[12] run through the steps that need to be taken regarding potential ERISA-governed healthcare liens.

Investigation Step 1

The first step after receiving such a demand should be to determine whether ERISA applies to some or all of the plan's lien. A good starting rule of thumb is to assume that it does if the medical insurance was provided by the client's employer.

Investigation Step 2

The second step would be to determine how the plan is funded. An ERISA plan may be 1) self-insured or self-funded (the plan pays the benefits out of its own pool of funds),[13] 2) fully-insured (an insurance company pays the benefits) or 3) stop-loss[14] (the plan pays benefits up to a certain amount and then an insurer pays the rest–akin to a deductible). This is important because claims from a self-funded ERISA plan are wholly governed by ERISA. On the other hand, fully-insured plans[15] may be subject to insurance-specific state laws, which are often more desirable.[16]

To find out how benefits were funded, often the fastest method is to check the federal filings mandated by ERISA. The form 5500 filings can be found on the Department of Labor's website at *https://www.efast.dol.gov/ portal/app/disseminatePublic?execution=e2s1*. Some practitioners also prefer to use *www.freeerisa.com* (free registration required). Make sure to look at the correct plan and year, and keep in mind that this will not always yield the necessary information.

Investigation Step 3

Regardless of what is found in Step 2, it is best to issue an ERISA document request pursuant to 29 U.S.C.A. § 1021(a)(1) and (2) and 29 U.S.C.A. § 1024(b)(4). These requests can be made (and generally are made) via correspondence before litigation. ERISA Plan Administrators (usually the employer) must respond to the request within 30 days or face statutory penalties.[17] Some courts have held that a litigation discovery request does not trigger the duties under these statutes, so this should be done as early as possible and via written request (in addition to subsequent discovery requests if these efforts fail). This request should be sent to the named plan administrator, the insurer and the employer (some of these may be the same entity), and it is imperative to explain that you are requesting the "Master Plan Document," the insurance policy and the summary plan description ("SPD").[18] It is not uncommon that only an SPD will be sent in response, but this document's terms may not control the subrogation or reimbursement rights of the plan if they differ from the governing plan documents.[19] *CIGNA Corp. v. Amara*, 563 U.S. 421 (2011); *US Airways, Inc. v. McCutchen*, 2:08CV1593, 2016 WL 1156778, at *1 (W.D. Pa. Mar. 16, 2016).[20]

What to Do with the Information

If the plan only references subrogation, then one could argue the plan should be willing to help with expenses or costs or have their attorney appear and help with the claim against the third party because the plan is stepping into the insured's shoes. Since reimbursement is the insurer's right to seek repayment from your client, you could argue that a plan's failure to exercise subrogation rights should impair their reimbursement claim (if there is a reimbursement provision at all).

It is also important to determine whether the plan is silent regarding the made-whole doctrine, common fund doctrine or reimbursement in general. *US Airways, Inc. v. McCutchen*, 133 S. Ct. 1537, 1542-43 (2013), made it clear that the terms of the plan will control subrogation rights and defenses, but any gaps in those provisions might be filled with federal common law equitable defenses such as the common fund doctrine. *Id.* at 1543 ("We hold that neither of those equitable rules can override the clear terms of a plan."). This would obligate the plan to pay a pro rata share of the legal fees out of its recovery via subrogation. *See, e.g.*, *Cagle v. Bruner*, 112 F.3d 1510, 1521 (11th Cir. 1997) (discussing the make-whole doctrine and finding that it is a default rule if it has not been contracted out of).

It is vital to know these things early and possibly before agreeing to take the case. For instance, in a situation where the plan documents state that the right to reimbursement is free of any legal expenses, it may still be in the plan's best interest to agree to allow the deduction of legal fees if the case is in its early stages. In these situations, any attempt to enforce a plan's reimbursement rights would be an attempt to seek enforcement of an "equitable" lien on any judgment or settlement. Because it is unlikely you will be willing to work for free, the plan would be looking at little to no award or settlement from which to be reimbursed. If you were to wait to negotiate this issue *after* settlement is reached, then the plan has no reason to worry about whether you will receive any compensation from that settlement, and it is unlikely you will have any recourse.

The Alabama State Bar has made it clear that no additional fee regarding the negotiation or reduction of a lien can be obtained absent extraordinary circumstances. Formal Opinion 2015-01. The Alabama State Bar views these services as being tied in with the lawyer's services in obtaining the settlement, so there is little prospect of receiving extra compensation from these efforts after settlement has been reached or a judgment has been obtained. While the opinion does not prohibit the outsourcing of lien resolution (in complex matters such as ERISA-governed liens), waiting to resolve the issue until the end of litigation puts the plan (and insurance carriers) in a more advantageous bargaining position.

In sum, practitioners will first want to find out whether state laws apply because those may be more (or less) favorable and allow for a stronger negotiating position regarding ERISA healthcare liens (or negate them entirely). You would then want to examine the terms of the subrogation and/or reimbursement provisions in the plan document and ensure that there is such a right and that it is properly drafted under *Sereboff* and *Popowski*.

Assuming the plan is fully funded, you would then check to see whether the federal common law equitable defenses have been explicitly waived under the contract. If they have not, then any subrogation or reimbursement claim may be reduced under the make-whole doctrine, common fund doctrine or any other available. It is also important to determine what portion of the settlement is for medical expenses and to ensure the plan is only asking for reimbursement of expenses related to the injury at issue in your litigation. It is unlikely the medical plan would be entitled to seek payment out of settlement awards for lost wages or general damages. Finally, it may be necessary to point out that you do not intend to work for free and that any strict enforcement of a plan provision negating all or most of your fee award (and your client's recovery) would force you to decline taking on the case. Neither you nor your client would have any reason to prosecute the case in that situation.

Montanile left open numerous questions regarding what an attorney should do with these claims, and it would be a mistake to simply assume the best course of action is to disburse the funds in question to the client. *Alabama Rule of Professional Conduct* 1.15 should be referenced before making any decision regarding disbursement. A good rule of thumb would appear to be to give the plan a minimum of 14 days' notice before disbursing any disputed funds because the Supreme Court took no issue with this timeframe in *Montanile*. However, careful consideration of the risks and rewards of such a strategy is advisable. Fighting one lawsuit only to start another is rarely good practice.

It is also unclear what the best advice would be regarding what a client should do with those disbursed funds. For instance, it is uncertain what the effect would be if the client combined the disbursed funds with their general assets. This is undoubtedly more convenient for most people, and it could even mean the funds are no longer traceable. The *Montanile* court's discussion of substitute money decrees and deficiency judgments clearly stated these were merely legal remedies available in equity courts, but its discussion of the swollen assets doctrine left open the question of whether commingling funds allowed a lien to be enforced against the entire commingled pot. The Court's dismissive discussion of the swollen assets doctrine and observation that "most equity courts and treatises rejected that theory" gives the impression that it was merely assuming *arguendo* the doctrine could apply before noting that it was irrelevant because there had been no commingling.[21] Thus, failing to keep the disbursement in a separate account could also potentially allow the insurer to enforce its claim against any general assets that were commingled with the disbursement. Some practitioners also advise their clients to document all of their purchases from the disbursement so that dissipation, rather than concealment or commingling, can be demonstrated at a later date if necessary.

The main point of all this is to explain that members of the plaintiff's bar should never simply take an insurer's word that it has a valid ERISA lien, and it is our obligation to flesh out all of the details before responding or agreeing to any request for payment of the lien. It is also important to address these issues as soon as they appear because delay can be just as damaging as any statute of limitations, given the possibility that it could wipe out all of your bargaining power and recovery by the client. This is undoubtedly something you should consider when deciding whether to take a case, and waiting to address the issue may cause substantial delays to settlement.

Defense Practice Pointers

Although the Supreme Court's decision in *Montanile* was surprising to many, it should not have been in light of the Court's earlier ruling in *Sereboff v. Mid-Atlantic*

Medical Services, Inc., 126 S. Ct. 1869 (2006). The Sereboffs recovered $750,000 from a tortfeasor, but refused to reimburse their health plan $75,000 in accident-related medical bills. When the plan fiduciary filed suit, the Sereboffs agreed to set aside the reimbursement amount of $75,000 pending a final court ruling. The federal district court, as well as the 4th Circuit Court of Appeals, ruled in favor of the plan. The Supreme Court affirmed on the basis that the plan sought to enforce its equitable lien against "specifically identifiable" funds which were in the possession and control of the Sereboffs. The *Sereboff* Court emphasized that in such cases, both the claim and the remedy had to be equitable–a proposition which *Montanile* fully supports.

The surprising thing about the *Montanile* decision is that the result seems, well, inequitable. The plan did exactly what it needed to do to create an equitable lien by agreement. The plan specifically provided as follows: "Amounts that have been recovered by a [participant] from another party are assets of the Plan … and are not distributable to any person or entity without the Plan's written release of its subrogation interest." The plan also took the extra step of having Montanile sign a reimbursement agreement guaranteeing that he would repay the plan from any recovery he received from a third party in a lawsuit or settlement. Montanile reneged on that agreement when he spent the settlement money rather than repaying the plan. The plan should have some avenue of redress, right?

Unfortunately, the question is complicated by the laws of equity that require a lien to attach to an "identifiable fund," which an insured's general assets are not. Most, if not all, of today's healthcare plans contain subrogation language which is sufficient to create a lien by agreement that requires reimbursement of medical expenses from any judgment or recovery received from a third-party tortfeasor. Likewise, it is commonplace for health insurers to require a participant to sign a separate agreement to repay the insurer from any proceeds received from a settlement with or judgment against a tortfeasor. What *Montanile* confirms is that the area where things now have the potential to go wrong for a plan is in the monitoring of and involvement in any action by the participant against the tortfeasor.

When a health insurance plan pays significant medical bills on behalf of an insured, it has an obligation to other plan participants to moderate its costs by pursuing reimbursement to the fullest extent permissible under the terms of the plan. One of the most effective ways to accomplish that goal is to have an attorney get involved right away to protect the plan's rights. While a health insurer may be inclined to have its own employees or affiliates monitor the status of an insured's litigation against a third party, the earlier that the insurer gets a lawyer involved, the better it protects its rights. If there was ever any doubt, there can be none after *Montanile*–once an insured has reached a settlement with a third party, it may well be too late to enforce a reimbursement provision. Thus, as soon as a plan becomes aware that an insured has engaged an attorney to pursue litigation against a tortfeasor, the plan should consider the extent to which it should involve itself in that litigation. The plan does not want to be in the position of relying on the insured or the insured's attorney to notify it of the status or result of any legal action. Automatically-generated form letters and similar "notices" of a subrogation right are probably fine if the dollar value of a claim is relatively low, but when the stakes are higher there is no substitute for personal communications between the plan's lawyer and the insured's lawyer. Additionally, the more involved the plan's attorney is in the resolution of the lawsuit against the tortfeasor, the less likely it is that either the insured or the plan will be caught unaware when the proceeds of the lawsuit are disbursed. You can most effectively protect your client's rights by encouraging your client to allow you to have a high level of involvement in the insured's tort claim from the outset.

You cannot begin your pursuit of the plan's claim until you know what tools are in your arsenal to help ensure full cooperation from the insured's attorney. In most instances, you can expect the insured's attorney to take issue with the extent to which the plan is entitled to payment. Before communicating with the insured's attorney, you will want to fully educate yourself on the specifics of the plan's terms. In cases where an insurer has successfully pursued reimbursement, the plan at issue has unequivocally provided that if the insured recovers compensation from a third party, the insured must repay the insurer. How strong is the reimbursement language in the applicable plan? Does the plan speak to the issue of the insured's attorney's fees or is that an issue open for negotiation? Does the plan expressly include or exclude any equitable doctrines such as the "made-whole" doctrine, or is it silent on those issues? Does the plan have full discretion to negotiate regarding the reimbursement amount, or is another party, such as a stop-loss insurer, involved? Each of these issues needs consideration.

Likewise, you will want to know what other agreements or communications exist on the issue of reimbursement exist. If the insured has signed a separate agreement promising to repay the plan from any monies received from a lawsuit against the tortfeasor, that is a fact that needs to be made known to the insured's attorney. If no such agreement exists, even early letters from the insurer to the insured explaining the plan's right to reimbursement will bolster your position.

Whether your preferred method for communications with the insured's lawyer is phone, email or old-school letters, it is important to have something in writing to the lawyer for the insured detailing the plan's rights, your expectations of the lawyer in complying with the insured's obligations and the level of involvement you anticipate having. In today's environment, we should all expect that settlement negotiations between an injured party and a tortfeasor will begin immediately, maybe even before a lawsuit has been filed. Accordingly, even in the very early stages of these cases, it is important not to delay in taking action. In all likelihood, the insured's attorney is going to have two people to negotiate with–you and the tortfeasor's attorney. The sooner you begin a dialogue with the insured's attorney about the plan's expectations, the more potential there is for things to go smoothly when it comes time for the insured and the tortfeasor to come to an agreement. The insured's lawyer is in a better position to negotiate if he or she knows what the plan requires, and it may well fall to you to educate the insured's lawyer regarding the plan's provisions and the case law relating to the enforcement of those provisions.

Occasionally, it may happen that a busy practitioner places cases on the back burner, which are, to some extent, merely being "monitored." Other times, a lawyer may hesitate to pester a fellow lawyer too often for updates. Nevertheless, *Montanile* makes it abundantly clear that lawyers who represent plans in subrogation or reimbursement claims must be extremely vigilant in pursuing those recoveries. Be the squeaky wheel. You should know, at all times, the status of the litigation as well as the status of settlement negotiations. You may even want to ask to be involved directly in any settlement discussions or decisions. The more involved you are in the settlement, the fewer questions there may be later about what portion of the settlement is intended to be for medical expenses.

Once the insured and the third-party tortfeasor have reached an agreement, you will want to confirm again in writing the amount you expect (and demand) will be paid to the plan from the settlement proceeds. Depending on the plan language, you may have to put pencil to paper to calculate the amount to which the plan is entitled. Even if the plan language contemplates that the plan will be reimbursed every dollar it has expended on the insured's behalf, compromise is probably worth considering if it will help the insurer avoid litigating the amount. If you and the insured's attorney have not already come to an understanding about the amount that will be paid to the plan, those negotiations can wait no longer. And if you and the insured's attorney cannot quickly come to an agreement, it is imperative that the insured's attorney agree to place the disputed funds into a separate account (thus creating an "identifiable fund") until an agreement is reached or until the court decides the issue.

Should the insured refuse to voluntarily reimburse the plan at all or in the amount to which the plan is entitled, you will need to advise your client on whether to file a claim under 29 U.S.C. § 1132(a)(3). As in any other matter where litigation is being contemplated, there has to be a cost-benefit analysis: does the potential recovery under the plan terms justify the cost of litigation? And, of course, no cost-benefit analysis is complete without an assessment of the likelihood of success in the litigation. To evaluate these issues, you will need to turn back not only to the plan terms in order to judge the strength of the "equitable claim," but you will also need to evaluate how carefully the plan acted to protect its right to reimbursement from an identifiable fund (or "equitable relief").[22] The *Montanile* Court was not bashful about criticizing the plan, not only for failing to respond to Montanile's attorney's letter stating that funds were going to be released within 14 days in the absence of any objection, but also for waiting six months thereafter to file suit. You will do your clients and yourself a favor if you can fully represent to the court that the plan did not sleep on its rights, but, instead, pursued them with vigor.

Conclusion

ERISA-governed liens arise in a wide spectrum of cases, such as personal injury, product liability and medical malpractice claims. For both plaintiffs and defendants, the early involvement and advice of experienced ERISA counsel is advisable. ▲

Endnotes

1. The Employment Retirement Income Security Act of 1974. 29 U.S.C. § 1001 *et seq*.
2. "ERISA is, we have observed, a 'comprehensive and reticulated statute, ...' *Mertens v. Hewitt Associates*, 508 U.S. 248, 251 (1993).
3. *Employee Benefits in the United States–March 2017*, Bureau of Labor Statistics, *https://www.bls.gov/ news.release/pdf/ebs2.pdf*; *2015 Health Insurance Coverage of the Total Population*, The Henry J. Kaiser Family Foundation, *http://www.kff.org/other/state-indicator/total-population/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D*.
4. Subrogation is the right to step into the insured's shoes to pursue the claim directly against the third party, and reimbursement is the right to seek repayment from the insured if they recover funds from the third party.
5. *See, e.g., Cigna Corp., et. al., v. Amara*, 131 S. Ct. 1866 (2011).
6. *Great-West Life & Annuity Ins. Co. v. Knudson*, 122 S. Ct. 708, 726 (2002) (dissent by Justice Ginsburg) ("Today's decision needlessly obscures the meaning and complicates the application of § [1132](a)(3). The Court's interpretation of that provision embroils federal courts in "recondite controversies better left to legal historians," . . . , and yields results that are demonstrably at odds with Congress's goals in enacting ERISA. Because in my view Congress cannot plausibly be said to have "carefully crafted" such confusion, . . .").
7. *Popowski* involved two subrogation provisions, one of which was upheld, so it is an excellent case for practitioners to use as a measuring stick when evaluating the enforceability of a subrogation provision.
8. *Bd. of Trustees of Nat. Elevator Indus. Health Benefit Plan v. Montanile*, 2014 WL 8514011 (S.D. Fla.).
9. *Bd. of Trustees of Nat. Elevator Indus. Health Ben. Plan v. Montanile*, 593 Fed. App'x 903, 909 (11th Cir. 2014) (unpublished), *rev'd and remanded sub nom. Montanile v. Bd. of Trustees of Nat. Elevator Indus. Health Benefit Plan*, 136 S. Ct. 651 (2016), and *vacated and remanded,* 644 Fed. App'x 984 (11th Cir. 2016) (unpublished).
10. *Montanile*, 136 S. Ct. at 655.
11. These comments assume your client is the person who received the medical care forming the basis of the claim and is the plan participant. If that is not the case, such as in a wrongful-death claim, further consultation with an experienced ERISA attorney is recommended.
12. There are a plethora of caveats, so we do mean generally here.
13. These types of plans still typically have an insurance company act as the claims administrator to process claims and handle other administrative tasks, so don't just assume it is fully insured if you see an insurance company being involved or have received a demand from one.
14. Every circuit to address the question has found that stop-loss plans are considered self-insured, so this article will presume that a plan is either self-insured or fully-insured.
15. Keep in mind that some benefits under a plan may be self-insured and others fully-insured, so it is important to know how the particular coverage in question was funded.
16. This is not to say all state claims and defenses are available. That is another complex question that is beyond the scope of this article, but we will point out that *Kentucky Ass'n of Health Plans, Inc. v. Miller*, 538 U.S. 329 (2003), represents the current two-part test regarding preemption here.
17. The Plan Administrator is potentially subject to a daily fine for every day after 30 days if they fail to provide these documents. However, finding the entity charged with fulfilling this important fiduciary function as one learned author noted has become a bit of a "shell game." Hon. William M. Acker, Jr., *Can the Courts Rescue ERISA?*, 29 Cumb. L. Rev. 286, 293 (1999) ("A beneficiary's finding a target under ERISA has become a shell game.").
18. To be clear, you should not limit your request to these materials. You should generally ask for all documents relating to any of your client's healthcare claims, including any payments that were made by the plan and a breakdown of those payments.
19. It is rarely a good idea to take an insurer's word for it, but it is possible that the court may find that the SPD and Plan document are one and the same. *See Bd. of Trustees of Nat. Elevator Indus. Health Ben. Plan v. Montanile*, 593 Fed. App'x 903, 909 (11th Cir. 2014) (unpublished), *rev'd and remanded sub nom. Montanile v. Bd. of Trustees of Nat. Elevator Indus. Health Benefit Plan*, 136 S. Ct. 651 (2016), and *vacated and remanded,* 644 Fed. App'x 984 (11th Cir. 2016) (unpublished). The Supreme Court's decision did not address the panel's comments regarding the SPD and Plan document often being the same in health plans.
20. The SPD, rather than the Plan document, was cited to by both lower courts, and the Supreme Court was the first to demand a copy of the Plan. The Court assumed *arguendo* that the SPD's terms were identical because that is what had been done throughout the lower courts. On remand, the district court found that the Plan did not contain the SPD's reimbursement provision, so this remedy was not even available. A lot of time and effort could have been avoided if this had been obtained earlier on, and the participant also ran the risk of forfeiting this argument.
21. *Montanile*, 136 S.Ct. at 661.
22. Another part of the analysis might be whether the decision to file an ERISA claim is the plan fiduciary's to make alone. In some cases, the plan fiduciary may have an obligation to some other party, like a stop-loss insurer, which requires it to pursue litigation to enforce subrogation/reinforcement provisions.

Kristen S. Cross

Kris Cross is a shareholder at Sirote & Permutt and has more than 17 years of general litigation experience with a concentration in defending businesses and insurers in ERISA-governed life, health and disability insurance claims and state law bad faith claims.

Lee P. Fernon, Jr.

Lee Fernon is an associate attorney at Sinclair Law Firm LLC in Birmingham and has primarily focused on ERISA and general insurance litigation after spending four years as a federal law clerk in Texas and Arkansas.

Thomas O. Sinclair

Tom Sinclair is the founding partner of Sinclair Law Firm LLC in Birmingham. His firm focuses on insurance benefits, including group and individual life insurance benefits, as well as disability, pension and health insurance benefits, including ERISA.