From: Anders Blewett
To: E-OHPSCA-STOPLOSS.EBSA
Subject: Statement Concerning Stop Loss Insurance - US Department of Labor
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To whom it may concern:

I agree in full with the assessment of Professor Roger M. Baron regarding the Department of Labor requiring the disclosure of stop-loss insurance on form 5500 filings. See below letter.

Statement Concerning Stop Loss Insurers

By: Professor Roger M. Baron

In the context of ERISA reimbursement, I have found that stop loss insurers seek refuge under ERISA preemption to give them unfettered access to subrogated recoveries. Much of the ERISA Reimbursement recoveries gathered today is paid directly to stop loss insurers and is of no benefit to the ERISA participants and beneficiaries. I believe that this violates ERISA's anti-inurement provision.[1] The insurance industry is currently recovering in excess of $1 Billion annually through ERISA reimbursement claims.[2]

In the process of pursuing these subrogated recoveries, the effort is maintained in the name of a "self-funded" plan. Please keep in mind that "self-funded" does not mean "self-insured." Collection agents like Rawlings, Ingenix, ACS, and Anthem will not reveal stop loss insurance coverage upon inquiry and most plan administrators also refuse to do so. Furthermore, if a TPA or claims administrator is also providing stop loss coverage, the existence of stop loss coverage does not have to be revealed on the form 5500.

There is significant authority from the U.S. Supreme Court[3] and lower federal courts holding that stop loss insurers must comply with state law protections for consumers.[4] Furthermore, the Texas Supreme Court and the Iowa Supreme Court have recently held that stop loss insurers must comply with state law.[5]

Many states have consumer protection provisions which prohibit or limit subrogation so as to ameliorate the harshness which readily occurs in the context of subrogation on personal injury claims. These provisions are applicable to stop loss insurers under ERISA's "saving clause" and existing authorities. Avoidance of the application of state law concerning subrogation is one of the reasons why stop loss insurers attempt to remain concealed. When a stop loss insurer is operating in the context of a "self-funded" plan, the true nature of the insurance relationship is masked from the public and also from the ERISA participants and beneficiaries.

It is my recommendation and hope that ERISA plans should be compelled to disclose the existence of stop loss insurance and all aspects of the stop loss relationship, including attachment points. Disclosure should be mandatory in documents which are provided to all participants and beneficiaries such as the Summary Plan Descriptions. Furthermore, I recommend full disclosure should also be required in all form 5500 filings.

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[1] ERISA § 403(c), [29 U.S.C. § 1103(c)] mandates that "the assets of a plan shall never inure to the benefit of any employer and shall be held for the exclusive purpose of providing benefits to participants in the plan and their beneficiaries and defraying reasonable expenses of administration."

[2] *See* Brief for Society for Human Resource Management and U.S. Chamber of Commerce as Amici Curiae Supporting Respondent. 126 S.Ct. 1869 (2006), 2006 WL 467695, * 15-16.

[3] *See FMC Corp. v. Holliday*, 498 U.S. 52 (1990). With regard to commercial insurers on all or part of the risk, the Supreme Court held that while the ERISA plan may enjoy its preemptive effect, the insurer that insures such a plan does not. Such insurers are indeed subject to the states' laws concerning subrogation and reimbursement. In *FMC Corp. v. Holliday* 498 U.S. 52, the ERISA plan secured 100% of the plan participant's tort recovery of $49,825 despite the fact the plan member's medical expenses alone exceeded $178,000. The Court noted that the reimbursement was sought by the plan on behalf of itself and not for an insurer of the plan. As to any such affiliated insurers on the risk, the Court stated,

> "On the other hand, employee benefit plans that are insured are subject to indirect state regulation. An insurance company that insures a plan remains an insurer for purposes of state laws, 'purporting to regulate insurance' after application of the deemer clause [of ERISA]. The insurance company is therefore not relieved from state insurance regulation. The ERISA plan is consequently bound by state insurance regulations insofar as they apply to the plan's insurer." *Id.* at 62.

[4] ERISA's saving clause, 29 U.S.C. 1144 (b)(2)(A) provides as follows:

> 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)

It is well established that state law prohibiting subrogation is a "regulatory law" saved by ERISA's saving clause. *FMC Corp. v. Holliday*, 498 U.S. 52 (1990). *FMC Corp*. held that the Pennsylvania antisubrogation law, although preempted by the preemption clause of ERISA, was nonetheless saved by ERISA's savings clause.

Federal courts of appeal have also recognized that a state law concerning subrogation is "saved" and applicable through the ERISA's saving clause. For example, in *Benefit Recovery, Inc. v. Donelon*,, 521 F.3d 326 (5th Cir. 2008), the 5th Circuit Court of Appeals was asked to determine whether a directive entered by the Louisiana Commissioner of Insurance was a state law that regulates insurance and is therefore saved under ERISA's savings clause. The Commissioner's directive required that insurers comply with Louisiana's make-whole doctrine. The court held that this Insurance directive is "state law which regulates insurance" and is thereby saved by ERISA's saving clause and is applicable to insurers providing coverage to ERISA plans.

Similarly, in *Singh v. Prudential Health Care Plan, Incorporated*, 335 F.3d 278 (4th Cir. 2003), the court held that the subrogation prohibition found in a Maryland HMO statute was "saved" from preemption under the saving clause (and also escapes "complete preemption"). The court stated concluded that "the subrogation prohibition of the Maryland HMO Act applicable before June 2000 is a state-law regulation of insurance that is saved from preemption under § 514(b)(2)(A). ... [I]t is difficult to imagine an antisubrogation law of this type as anything other than an insurance regulation, as it addresses who pays in a given set of circumstances and is therefore directed as spreading policyholder risk." *Singh*, 335 F.3d at 286.

Connecticut's anti-subrogation law was addressed by the U.S. District Court for Connecticut in *Connecticut Steel Corp. v. Steven Cordova and Nicole Cordova*, Civil No. 3:95cv27289 (AVC) (Ruling on Cross Motions for Summary Judgment, October 30, 1996). In the *Connecticut Steel Corp.*ruling, U.S. District Judge Alfred V. Covello held,

> In this case, the Plan was not completely self-funded, and was partially insured by Safeco Insurance Co. Safeco, unlike the Plan, remains an insurer for purposes of Conn.Gen.Stat. § 225(b) and (C). Pursuant to this statute, an insurance company may not demand reimbursement for medical expenses where, as here, a beneficiary recovers in tort from a third party. Accordingly, the court concludes that the plaintiff is not entitled to reimbursement for that portion paid by Safeco Insurance. Co., i.e., $7,698.75.

[5] *Texas Department of Insurance v. American National Insurance Company*, 2012 WL 1759457, (Tex. May 18, 2012). *Magellan Health Services, Inc v. Highmark Life Insurance Company*, 755 N.W.2d 506, 2008 WL 2221979 (Iowa).