On May 15, 2006, in a case called Sereboff v. Mid Atlantic Medical Services, Inc.,[1] *the U.S. Supreme Court unanimously preserved the right, created by the Employee Retirement Income Security Act of 1974 (ERISA), of a self-funded health plan to obtain reimbursement under a plan subrogation clause from a participant who had recovered damages from a third party in a personal injury tort action. The Supreme Court confirmed that reimbursement is an "equitable" remedy that a self-funded health plan may properly pursue under ERISA §502(a)(3). This decision resolved a split of opinions that existed among several federal circuit courts of appeal. It is of particular importance to self-funded health plans in the Sixth and Ninth Circuits, because it effectively restores their ERISA-based rights to reimbursement from third-party proceeds.*

Preservation of Plan Assets Through Subrogation and Reimbursement Rights

by Philip R. O'Brien and Sarah A. Huck

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Since ERISA was enacted in 1974, self-funded health plans have typically cited ERISA §502(a)(3)[2] in seeking reimbursement from participants who refused to repay the plan for benefits from third-party recoveries for injuries caused by third parties.[3] Almost 30 years later, the Supreme Court decided *Great-West Life & Annuity Insurance Co. v. Knudson*[4] by a slim 5-4 majority and fundamentally altered the legal discussion regarding the subrogation and reimbursement rights for ERISA health plans.

Surprisingly, the facts presented in *Knudson* did not reflect a typical reimbursement claim against third-party proceeds. Janette Knudson was severely and permanently injured in a car accident. After she settled her personal injury lawsuit against the third-party tortfeasor, the plan received partial payment of its medical payments advanced on Knudson's behalf. The settlement proceeds were placed in a special needs trust established for her benefit pursuant to state law. The plan sued Knudson, demanding reimburse-

ment for the remaining medical expenses that the plan paid on her behalf. The Supreme Court ruled that the plan was not entitled to reimbursement from the special needs trust, finding that the plan's cause of action represented legal, rather than equitable, relief because Knudson did not have possession of the balance of the personal injury award, given that the money was deposited in a special needs trust. While Knudson was the beneficiary of the trust, she did not have control of the trust to do with as she pleased.

In the wake of *Knudson,* several federal circuit courts of appeal applied the decision in varying ways, leading to a split in different areas of the country over the scope of subrogation and reimbursement remedies available (or more aptly, the lack thereof) under ERISA §502(a)(3). The Sixth and the Ninth Circuits essentially shut out ERISA plans from pursuing a federal action against a plan participant for reimbursement from the participant's third-party settlement, regardless of the language adopted in plan documents.[5] In contrast, the Fourth, Fifth, Seventh and Tenth Circuits ruled that *Knudson* did not completely bar a plan's right to subrogation or reimbursement under ERISA §502(a)(3) if the plan document embodied the plan's right to subrogation and the disputed funds were both specifically identifiable and within the defendant's possession.[6] The significant split created by *Knudson* prompted the Supreme Court to further examine the fate of self-funded plan subrogation and reimbursement claims under ERISA §502(a)(3). That case turned out to be *Sereboff v. Mid Atlantic Medical Services, Inc.*[7]

What Happened to the Sereboffs?

Joel and Marlene Sereboff were beneficiaries under a self-funded health plan sponsored by Ms. Sereboff's employer. Mid Atlantic served as the claims fiduciary of the plan. The plan contained an "Acts of Third Parties" provision that subrogated the plan to a participant's right to recover damages from a third party and gave the plan the "right to recover any payments" made to beneficiaries by third parties for injuries caused by the acts of "another person or organization." The plan provision was quite detailed, providing sweeping subrogation and reimbursement rights.[8]

The Sereboffs were involved in an automobile accident in California. The plan advanced the Sereboffs' medical expenses, which totaled $74,869.37. The Sereboffs filed a personal injury lawsuit in California state court. The plan advised the Sereboffs on a number of occasions—both before and after the Sereboffs filed their personal injury action—of the plan's subrogation lien, and asked the participants to sign a reimbursement agreement. The Sereboffs refused to sign the agreement and their lawyer indicated to the plan that "insurance carriers are not permitted to recover subrogation liens" under Ninth Circuit case law.[9] The plan paid additional benefits, but continued to reassert its lien rights, sending regular correspondence to the Sereboffs updating the dollar amount of the plan's lien.

Without notifying Mid Atlantic or seeking its consent, the Sereboffs settled their state court personal injury action against responsible third parties for $750,000. Their lawyer disbursed the funds to the Sereboffs and his law firm, and the Sereboffs placed their share into personal investment accounts. While still hiding from Mid Atlantic the fact that the case had settled, the Sereboffs' lawyer wrote to Mid Atlantic reasserting that the liens were not enforceable, citing *Knudson* and a followup Ninth Circuit Court of Appeals decision, *Westaff (USA), Inc. v. Arce.*[10]

After discovering that the personal injury case had settled, Mid Atlantic started a lawsuit in the federal District Court of Maryland (the Sereboffs' home state) under ERISA §502(a)(3). Mid Atlantic asserted the plan's subrogation and reimbursement rights and requested, among other forms of relief, restitution of, and a constructive trust or equitable lien over, the disputed funds held by the Sereboffs in their investment accounts. In layman's terms, Mid Atlantic claimed that the amount the plan paid out for medical bills was an amount that never belonged to the Sereboffs in the first place and that the Sereboffs were obligated to protect and pay directly to the plan that specific sum out of the settlement. The plan also sought emergency relief to prevent the Sereboffs from dissipating the disputed funds, and the Sereboffs agreed to freeze $74,869.37 in a separate account until the district court could rule on the merits of the dispute and any appeals were exhausted.

Mid Atlantic asserted that the claim to "recover the disputed proceeds" sought "appropriate equitable relief" under ERISA §502(a)(3). The Sereboffs countered that the plan sought "monetary damages that are not permissible" under ERISA. The district court and, on appeal, the Fourth Circuit, agreed with Mid Atlantic, stating that the disputed funds "have not been dissipated and . . . are specifically identifiable," "belong in good conscience" to the plan, and "are within the possession and control of the Sereboffs," allowing for proper reimbursement to the plan. The Sereboffs appealed to the Supreme Court, which agreed to hear the case to decide whether Mid Atlantic had indeed sought "appropriate equitable relief" under ERISA.

The Supreme Court Settles the Confusion

The Sereboff Court answered one question: whether the relief that Mid Atlantic requested was "equitable" under ERISA §502(a)(3). A unanimous Supreme Court concluded that it was equitable, because the plan sought recovery through a constructive trust or equitable lien on specifically identifiable funds that the plan had paid out to its participants, as opposed to merely making an unspecified claim on the Sereboffs' general assets.

In reaching this conclusion, the Court stated the obvious: The case facts in *Knudson* and *Sereboff* were significantly different. The imposition of a constructive trust or equitable lien on particular funds or property in the Sereboffs' possession was, in fact, "equitable relief" under ERISA §502(a)(3). In contrast, *Knudson* failed to satisfy this requirement because the funds to which Great-West claimed an entitlement were not in Knudson's possession, but had instead been placed in a special needs trust. Chief Justice Roberts, writing for the Court, summarized the distinction between *Knudson* and *Sereboff* as follows: "This Court in *Knudson* did not reject Great-West's suit out-of-hand because it alleged a breach of contract and sought money, but because Great-West did not seek to recover a particular fund from the defendant. Mid Atlantic does."

But the opinion required further discussion in order to shoehorn the previous

Continued on next page

reasoning of *Knudson* into a more workable precedent for use in the everyday legal world. Having determined that the *nature* of the recovery (a constructive trust) was equitable in this case, the Court next tackled the issue of whether the basis for Mid Atlantic's claim was equitable.

The Court concluded that the basis of the plan's claim was equitable because the "Acts of Third Parties" provision identified a particular portion of the Sereboffs' recovery to which the plan was entitled. A claim is "equitable" if the plan limits the amount of its claim to the money that the plan advanced on behalf of a participant or beneficiary and limits the scope of the recovery to the participant's or beneficiary's recovery from a third party. Under the terms of the "Acts of Third Parties" provision, the Court explained that at the moment the Sereboffs received money from a third party, a wall was constructed (the constructive trust) that segregated the amount that the plan paid on behalf of the Sereboffs from the entire pot of money received by the Sereboffs.

Contrast the "Acts of Third Parties" provision, which created a constructive trust that could be enforced under ERISA §502(a)(3), with a "legal" remedy that cannot be enforced under ERISA. An equitable remedy, such as a constructive trust, requires the participant to receive a pot of money, which triggers the creation of the trust. A *legal remedy* is a claim to *any* asset of the participant; the claim is not dependent upon the receipt of a specific pot of money.[11]

***Following the* Sereboff *decision, the most important step plan administrators and trustees can take is to* review and update the language contained in their plan documents and summary plan descriptions.**

Sereboff Requires Plan Administrators to Act Now

Review Plan and Summary Plan Description Language

Following the *Sereboff* decision, the most important step plan administrators and trustees can take is to *review and update the language contained in their plan documents and summary plan descriptions.* Be sure that the updated language in plan documents and summary plan descriptions is consistent with one another to avoid challenges regarding which document controls.[12]

A subrogation and reimbursement provision should address the following concepts in light of the *Sereboff* result. Each of these principles should be reviewed individually and tailored to the jurisprudence of the jurisdiction in which the self-funded plan resides, and should be consistent with current plan terms, policies and procedures.

- **Individuals covered by provision.** The plan should state that the plan's rights extend to any participant and beneficiary under the plan, including individuals or entities that may receive a recovery on behalf of a participant or beneficiary, such as dependents, heirs, estates, trusts and any other person or entity that may receive a benefit. It is helpful to define this entire group of people as the "claimant" or "covered person."
- **Right to subrogate.** The document should provide that the plan is subrogated to any and all rights of recovery and causes of action that the claimant may have against any third party. Third parties may include spouses, other family members and various forms of insurance coverage (uninsured, underinsured, no-fault, medical payments, personal injury protection and any others) for either the claimant or the individual responsible for the claimant's injuries.[13]
- **Right to reimbursement.** The document should grant the plan a specific and first right of reimbursement from any proceeds that a claimant receives from a third party to the extent of benefits paid, or to be paid, by the plan on behalf of the claimant. The document should also specify the sources of recovery from which the plan expects reimbursement.
- **First priority/rejection of make-whole doctrine.** This doctrine will be discussed in more detail in a subsequent article, but generally, the *make-whole* doctrine refers to a defense often asserted by participants in an attempt to defeat or limit plans' subrogation and reimbursement rights by claiming that injured participants must be fully compensated for any harm to them before they have any obligation to repay the plan. Plans can disavow the application of the make-whole doctrine. To do so, the document should provide that the right to reimbursement comes first, even if the participant is not paid for all of his claims for damages or if the payment received is for nonmedical expenses. If possible, the document should also specifically reject the make-whole doctrine by name.
- **Right to lien and participant consent.** The plan should specifically state that the plan is granted an equitable lien by agreement and constructive trust to which the claimant consents.
- **Cooperation.** The plan should require the participant to cooperate with the plan to enforce the plan's subrogation and reimbursement rights, including a requirement to execute a separate subrogation and reimbursement agreement that reflects the plan, summary plan description provisions, or both. The document should prohibit the claimant from evading, innocently or otherwise, the plan's subrogation and reimbursement rights.
- **Nonrecognition of other common law doctrines.** Although *Sereboff* did not definitively address the applicability of other common law defenses to a plan's claim for subrogation or reimbursement, many circuits have upheld a plan's express rejection of common law doctrines, such as the make-whole doctrine or the common fund doctrine (which can require a subrogated party to pay a portion of the participants' attorney fees). This means that in all likelihood, a plan can immunize itself from these defenses if it includes such language.
- **Subrogation and reimbursement agreements.** *Sereboff* did not address the role of a subrogation and reimbursement agreement in a plan's claim under ERISA §502(a)(3). Al-

though the parties stipulated that the Sereboffs had refused to sign a subrogation and reimbursement agreement, the Supreme Court did not find this fact important enough to merit mention in their decision in favor of the plan. Although *Sereboff* did not find a subrogation and reimbursement agreement necessary to mount a successful reimbursement claim, ERISA plans should still consider including in their plan documents a provision requiring participants to execute subrogation and reimbursement agreements as a condition precedent to obtain medical benefits.[14] The subrogation and reimbursement agreement requires the participant to acknowledge affirmatively the plan's lien and is another opportunity for the plan to notify the participant of the extent of the plan's lien. Such agreements are not only a helpful administrative tool, but also help create a chronology of the plan's efforts to recover the benefits advanced and place participants' attorneys on notice regarding the plan's lien.

- **Right to offset against future payments.** Plans may reduce future payment of benefits to participants and beneficiaries as an offset against amounts owed to the plans. Offset is a common practice, and it also provides a useful tool when negotiating reimbursement payments with recalcitrant participants.

Administrative Vigilance

ERISA imposes a fiduciary duty on plan boards of trustees to *reasonably, diligently and systematically* seek to recover money owed to an ERISA plan.[15] Staff members at the Department of Labor recently confirmed that this duty requires designated plan administrators to investigate each potential subrogation or reimbursement claim and determine whether the time, effort and expense of pursuing a particular claim is in the best interest of the plan and its participants.

Plan administrators should review the plan's policies and procedures and, if necessary, implement new measures to identify and evaluate these potential subrogation or reimbursement claims. Plan administrators should also follow previously adopted procedures that allow the plan to quickly and effectively protect its subrogation and reimbursement rights when the plan decides to pursue a claim in a particular case.

If the plan document so permits, the plan administrator should consistently require the participant to sign a reimbursement agreement as a condition to receiving benefits for the injury or illness. Regardless of whether the plan document permits suspension of benefits until the reimbursement agreement is executed and returned, plan administrators should be persistent in regularly notifying all interested parties (the participant, the participant's attorney, third-party insurers, etc.) of the plan's lien against any recovery that the participant obtains from a third party. Typical notices include correspondence to interested parties and obtaining a signed reimbursement agreement from the participant. Although *Sereboff* confirms that a plan does not need a signed reimbursement agreement to assert its rights for equitable relief, the plan cannot recover unless the participant's tort recovery is held in an identifiable fund. The reimbursement agreement provides additional notification to the participant of the plan's identifiable lien.

Plans must have administrative protocols in place to refer appropriate claims to plan counsel before the participant receives a tort recovery. For example, litigation is more likely if the participant or the participant's attorney refuses to acknowledge the plan's lien. Thus, referral to plan counsel is vital to ensure prompt action, including the option of enforcement in federal district court, is taken to protect the plan's subrogation and reimbursement rights.

In Part Two of this article, appearing in the February issue of Benefits & Compensation Digest, *the discussion of the impact the* Sereboff *decision has had on ERISA self-funded plans will continue, featuring model plan language for trustees and plan administrators to consider when reviewing their own plan provisions on subrogation and reimbursement. There will also be a focus on tips for effective litigation to enforce plans' subrogation and reimbursement rights.* **B&C**

Endnotes

1. 126 S.Ct. 1869 (2006).

2. 29 U.S.C. 1132(a)(3) ("A civil action may be brought . . . by a participant, beneficiary, or fiduciary . . . to obtain other appropriate relief to enforce . . . the terms of the plan.").

3. No specific section of ERISA addresses subrogation or reimbursement rights of self-funded plans. The legislative history of ERISA is also silent on the issue. The equitable remedy under ERISA §502(a)(3) traces back to common law contractual rights.

4. 534 U.S. 204 (2002).

5. *Qualchoice, Inc. v. Rowland,* 367 F.3d 638 (6th Cir. 2004), *cert. denied,* 544 U.S. 942 (2005); *Westaff (USA, Inc.) v. Arce,* 298 F.3d 1164 (9th Cir. 2002); *Carpenters Health & Welfare Trust For S. Cal. v. Vonderharr,* 384 F. 3d 667 (9th Cir. 2004), *cert. denied,* 546 U.S. 1030 (2005).

6. *Mid Atlantic Medical Services, Inc. v. Sereboff,* 407 F.3d 212 (4th Cir. 2005); *Bombardier Aerospace Employee Welfare Benefits Plan v. Ferrer, Piorot & Lansbrough,* 354 F.3d 348 (5th Cir. 2003), *cert. denied,* 541 U.S. 1072 (2004); *Admin. Comm. of Wal-Mart Stores, Inc. Assocs.' Health & Welfare Plan v. Varco,* 338 F.3d 680 (7th Cir. 2003), *cert. denied,* 542 U.S. 945 (2004); *Admin. Comm. of Wal-Mart Assocs.' Health & Welfare Plan v. Willard,* 393 F.3d 1119 (10th Cir. 2004).

7. See note 1.

8. The "Acts of Third Parties" provision states, in pertinent part, "This subrogation provision applies when you are sick or injured as a result of the act or omission of another person or party. Subrogation means the Company's right to recover any payments made to you by a third party . . . because of an injury or illness caused by a third party. If you receive benefits and have a right to recover damages from a third party, the Company is subrogated to this right. All recoveries from a third party must be used to reimburse the Company net of reasonable attorney fees and court costs prorated to reflect the portion of the total recovery which is due the Company for benefits paid. . . . The Company's share of the recovery will not be reduced because you . . . have not received the full damages claimed, unless the Company agrees in writing to a reduction."

9. The absence of a signed reimbursement agreement did not factor into the Court's decision-making process; the agreement between the plan and the Sereboffs, pursuant to the "Acts of Third Parties" provision in the plan document, was the factual touchstone used by the Court in reaching its decision in favor of the plan.

10. 298 F. 3d 1164 (9th Cir. 2002) (holding that the plan's claims for declaratory relief and specific performance were not cognizable under ERISA even though the disputed funds were placed into a joint escrow account pending determination of to whom the money was owed).

11. The Sereboffs also argued that Mid Atlantic did not satisfy the tracing rules they claimed were principal elements for establishing equitable restitution. "Tracing" requires the plan to follow the money belonging to the plan to some particular fund or asset. The Supreme Court rejected this argument because Mid Atlantic did not seek an equitable lien by restitution; rather, Mid Atlantic's claim was an "equitable lien by agreement." Funds need not be "traceable" when an "agreement is first entered into" because no tracing requirement applies to equitable liens by agreement or assignment. The Court noted that *Knudson* did not intend to describe all of the circumstances in which equitable liens were available.

12. See, e.g., *Admin. Comm. of the Wal-Mart Stores, Inc. Assocs.' Health & Welfare Plan v. Gamboa,* 479 F. 3d 538 (8th Cir. 2007); *Admin. Comm.*

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of Wal-Mart Stores, Inc. v. Salazar, 2007 WL 2409513 (D.Ariz. Aug. 20, 2007).

13. *South Dakota State Medical Holding Co., Inc. d/b/a/ DakotaCare v. Hofer,* 2007 WL 2121276 (D.S.Dak. Jul. 24, 2007) (discussing definition of *third party*).

14. See, e.g., *Burgett v. MEBA Med & Benefits Plan,* No. 2:06-C-117, 2007 WL 2815745 (E.D.Tex. Sept. 25, 2007) (plan could not condition payment of medical claims on execution of subrogation agreement because plan documents did not include a provision imposing such a requirement).

15. ERISA §404, 29 U.S.C. 1104; DOL Prohibited Transaction Exemption 76-1, 41 *Fed. Reg.* 12740 (March 26, 1976) (as corrected by 41 *Fed. Reg.* 16620, Apr. 20, 1976).

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Preservation of Plan Assets Through Subroga

In the January 2008 issue of Benefits & Compensation Digest, *the first part of this article discussed the legal and administrative significance of the recent U.S. Supreme Court decision* Sereboff v. Mid Atlantic Medical Services, Inc.,[1] *a case that unanimously preserved the right of self-funded health plans to pursue subrogation and reimbursement rights under the Employee Retirement Income Security Act (ERISA). Plan administrators were advised to review their subrogation provisions in their current plan documents and summary plan descriptions and amend them accordingly in order to preserve their rights. It was also strongly suggested that administrative procedures be honed to ensure that subrogation claims are regularly and properly monitored. This second half of the article discusses the legal fallout from* Sereboff *and gives practical advice on how to perfect subrogation claims and maximize recovery for ERISA self-funded health plans.*

Preservation of Plan Assets Through Subrogation and Reimbursement Rights—*Part 2*

by Philip R. O'Brien and Sarah A. Huck

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Lessons and Observations: One Year of *Sereboff* in the Courts

Since *Sereboff* was decided, there have been a handful of additional decisions by lower federal courts applying this important U.S. Supreme Court ruling—all of which help explain how this decision will affect plans' subrogation and reimbursement interests.

First and foremost, *Sereboff* made it clear that subrogation and reimbursement can be, under appropriate circumstances, appropriate equitable relief available under the Employee Retirement Income Security Act (ERISA).[2] This decision is extremely significant for self-funded plans located in the Sixth and Ninth Circuits.[3] Those plans are now free to pursue reimbursement rights in third-party cases under ERISA, using §502(a)(3).

In the cases that have been decided since *Sereboff,* it appears that most courts will apply its holding in a straightforward manner and conclude that an equitable lien by agreement existed because the plan's terms created an agreement to convey specifically identified funds.[4] Courts have, however, refused to enforce subrogation and reimbursement provisions when they do not believe that the circumstances match those analyzed in *Sereboff.*

While it is impossible to predict with perfect clairvoyance how a court will rule in particular circumstances, a close reading of cases decided to date, including *Sereboff* itself, suggest the following lessons.

Sue the Right Parties

Plan administrators and plan sponsors must ensure that the plan document allows the plan to seek reimbursement from any party that could hold a third-party recovery on behalf of the participant, such as a legal guardian, a representative or trustee, in addition to seeking reimbursement directly from the participant.

The ability to sue the correct individual could be the difference between success and failure in court. For example, the plan in *Great-West Life & Annuity Co. v. Knudson*[5] sued Ms. Knudson directly but did not sue the trustee of the special needs trust that held the settlement proceeds from which the plan sought to collect its lien. The Supreme Court denied the plan's claim because the defendant, Knudson, did not have possession of the settlement proceeds. The trustee of Knudson's special needs trust, not Knudson, had actual possession of the settlement proceeds.

Compare the result in *Knudson* with the result in a different case decided after *Sereboff,* where an ERISA plan successfully pursued a reimbursement claim against the trustee of a special needs trust to which the participant was a beneficiary. In *Administrative Committee of Wal-Mart Stores, Inc. Associates' Health and Welfare Plan v. Shank,*[6] the plan paid more than $450,000 in medical bills on behalf of a participant injured in an automobile accident. The participant settled a personal injury case against a responsible third party for $700,000. After deducting attorney fees and costs, the balance of the settlement ($414,477) was placed in a special needs trust of which the participant was a beneficiary. The plan sued the trust and the trustee, not the participant, for reimbursement under ERISA §502(a)(3). The court in *Shank* ruled that the plan's right to reimbursement could not be defeated by placing the settlement proceeds in a special needs trust. Citing *Sereboff,* the court determined that the plan sought appropriate equitable relief because it sued the person in possession of the particular funds from which the plan sought recovery of its lien for the medical expenses advanced on behalf of the participant.[7]

Plan Language Counts—A Lot

Specifically Identifying the Fund

It is critical to adequately define the extent of the plan's lien. A case decided by the Court of Appeals for the Eleventh Circuit, *Popowski v. Parrott,* illustrates the importance of identifying in the plan document the specific portion of the recovery to which the plan is entitled.[8] *Popowski* is actually two cases that the court consolidated on appeal. In the first case, the court found that the plan had stated a proper cause of action under ERISA §502(a)(3) because it sought equitable relief. The plan provision at issue stated, "[t]he Covered Person . . . must repay to the Plan the benefits paid on his or her behalf out of the recovery made from the third party or insurer."

Conversely, in the second case, the court dismissed the plan's claim because it did not state a claim for equitable relief. The plan provision at issue in the second case provided only as follows:

> If, however, the Covered Person receives a settlement, judgment, or other payment relating to the accidental injury or illness from another person, firm, corporation, organization or business entity paid by, or on behalf of, the person or entity who allegedly caused the injury or illness, the Covered Person agrees to reimburse the Plan in full, and in first priority, for any medical expenses paid by the Plan relating to the injury or illness. . . ."

Although the two provisions sound very similar, the court carefully dissected them and determined that the second provision failed to limit the plan's recovery to a specific portion of a particular fund.

In a recent case from the Court of Appeals for the Eighth Circuit, *Administrative Committee of the Wal-Mart Stores, Inc. Associates' Health and Welfare Plan v. Gamboa,*[9] a plan participant was seriously injured and permanently disabled in an auto accident. The personal injury lawsuit settled all claims for $1 million. The plan had advanced $177,136 in medical benefits for Mr. Gamboa and demanded reimbursement pursuant to the subrogation provision in the plan associates' benefits handbook. Trying to avoid the plan's contractual reach, Gamboa executed a release with the tortfeasor's insurance company rendering the settlement proceeds solely for the benefit of his wife and children. The plan rejected this argument and filed suit in federal court. Gamboa then switched tactics, claiming for the first time that the subrogation provision was not officially part of the plan because it was only found in the benefits handbook, but not in the formal plan wrap document.

The Eighth Circuit concluded that the plan's decision to consider the subrogation provision of the associates' benefits book as part of the formal plan document was reasonable. The case was sent back to the district court to rule on the effect of the written release. But this factual scenario once again magnifies the importance of making sure subrogation language not only exists in both the summary plan description and the formal plan document, but also that the provisions accurately mirror each other.

Avoid Common Law Defenses

There are two defenses frequently asserted by plan participants in subrogation and reimbursement cases—One is known as the make-whole doctrine[10] and the second is called the common fund doctrine. The make-whole doctrine, in particular, can have a huge impact on a plan's ability to recover funds. While there are some differences as applied state to state, in general, the *make-whole doctrine* is a common law defense to a subrogation and reimbursement claim. The participant typically argues that the recovery did not make him or her "whole"; thus, he or she is not liable to repay the lien holder because the amount received was less than the amount originally claimed as damages for pain and suffering, wage loss, future medical costs and loss of earning capacity. Courts in various jurisdictions differ over whether and how the make-whole doctrine applies: Several have adopted the make-whole doctrine as a default rule that applies unless the plan expressly disavows it.[11]

The make-whole doctrine was discussed as part of the briefing and oral argument in *Sereboff,* but the topic ultimately received nothing more than a dismissive footnote in the opinion itself. In his oral argument to the Court, the Sereboffs' attorney discussed at length the application of the make-whole doc-

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Sample Language

Individuals Covered by Provision

The plan shall be entitled to subrogation and/or reimbursement of all rights of recovery of a participant, his or her parent(s) and dependant(s) or a representative, guardian or trustee of the participant, parent(s) or dependant(s) (hereinafter, collectively "claimant").

Right to Subrogate

The plan is subrogated to any and all rights of recovery and causes of action that the claimant may have against any third party, whether by suit, settlement or otherwise, that may be liable for a claimant's injury or illness for which the plan has paid or is obligated to pay benefits on the claimant's behalf.

Rights to Reimbursement With Source of Funds Specifically Identified

The plan shall also be entitled, to the extent of payments made or to be made on account of the claim, to the proceeds of any settlement, judgment or payment from any source liable for making a payment relating to the claimant's injury, illness or condition. A source includes, but is not limited to, a responsible party and/or responsible party's insurer (or self-funded protection), no-fault protection, personal injury protection, medical payments coverage, financial responsibility, uninsured or underinsured insurance coverage, an employer under the provisions of a workers' compensation law and an individual policy of insurance maintained by a claimant.

Rejection of Make-Whole Doctrine

Such subrogation and reimbursement rights shall apply on a priority, first-dollar basis to any recovery, whether by suit, settlement or otherwise, whether there is a partial or full recovery and regardless of whether the amounts are characterized or described as medical expenses or as amounts other than for medical expenses.

Equitable Lien by Agreement

Once the plan makes or is obligated to make payments on behalf of a claimant, the plan is granted, and the claimant consents to, an equitable lien by agreement or a constructive trust on the proceeds of any payment, settlement or judgment received by the eligible employee or dependant from any source to the extent of payments made or to be made by the plan on the claimant's behalf.

trine to his clients' case, arguing that the lower courts should have imposed the same limitations on Mid Atlantic's recovery that would have applied to "truly equitable relief grounded in principles of subrogation," such as the make-whole doctrine. The Mid Atlantic plan document expressly disavowed the make-whole doctrine.[12] Chief Justice Roberts declined to decide this question and briefly noted that Mid Atlantic's claim was equitable because it was indistinguishable from actions to enforce an equitable lien established by agreement, not because it was a subrogation claim.[13] Thus, "the parcel of equitable defenses the Sereboffs claim accompany any such action are beside the point."

Because the Supreme Court declined to decide whether the make-whole doctrine applied to *Sereboff,* litigants continue to assert the make-whole doctrine as a defense to a plan's reimbursement claim, and plans must be ever vigilant in combating this tactic.[14] Decisions by other courts, however, highlight the importance of clear plan language disclaiming the doctrine. For example, in *Providence Health System—Washington v. Bush,*[15] the court found that the plan failed to disclaim the doctrine because the plan language did not "expressly mention (the doctrine) . . . and eliminated it or include provisions which clearly left no room for the make-whole doctrine." While the plan stated that the provider had a right to be reimbursed up to 100% and that the provider would not provide benefits that duplicate other coverage, the Court held that the plan did not disavow the make-whole doctrine because the plan document did not mention it specifically, and that the doctrine could be applied without being inconsistent with any of the plan's provisions.

Where the plan language more clearly disclaims the doctrine, courts post-*Sereboff* have refused to permit participants to assert this equitable defense.[16] The sample language in the sidebar provides a good example of the type of language courts will accept as a clear disavowal of the make-whole doctrine.

Another common law defense that participants routinely assert is the common fund doctrine. Broadly stated, the *common fund doctrine* states that the plan's recovery will be reduced by a fair share of the attorney fees and costs incurred by a beneficiary in the pursuit of a third-party recovery. The common fund doctrine is based on the theory that the beneficiary's proactive legal actions benefit the plan as a whole; therefore, the plan should pay a portion of the beneficiary's costs incurred on behalf of the plan. Plans can avoid the application of the common fund doctrine by stating in the plan document and summary plan description that this defense does not apply to the plan's subrogation and reimbursement rights.[17]

Quickly Assert the Plan's Subrogation and Reimbursement Rights

One of the major problems created by *Knudson* is that its requirement that the settlement funds be identifiable and not paid out provides an incentive for plan participants to try to "hide" and "dissipate" settlement funds. Wherever possible, it is vital that plans act quickly to put participants on notice of their reimbursement interests and to monitor continuously the underlying actions to ensure that funds are not spent before the plans are reimbursed.

In *Sereboff,* the funds were set aside in a separate retirement account, but were commingled with the Sereboffs' other retirement assets. This fact did not matter to the Court's analysis, probably because the

parties had stipulated that the amounts advanced by the plan were separate and identifiable. Since *Sereboff,* participants have had mixed success with the courts based on the argument that funds received had been commingled, although it is important to note that these cases have arisen only in nonreimbursement contexts.[18]

Recover Funds by Offsetting Against Other Payments

When participants or their beneficiaries who owe reimbursement remain active participants, plans might consider asserting the appropriate plan document provision that allows for the offsetting of future payments against the amounts owed.[19] This tactic typically means that plans will not need to institute an action in federal court or hunt for the settlement funds paid. Of course, participants might still bring suit against the plan for payment of benefits.

Recover Funds Spent to Recover Funds

Plans incur additional costs in order to fulfill fiduciary responsibilities and enforce their reimbursement and subrogation rights. Plans may be able to recover the costs of litigation by asking courts to order the participants who resisted making the reimbursement, and sometimes even their attorneys, to pay the plans' attorney fees and costs. ERISA §502(g) expressly provides that courts may, in their discretion, order attorney fees to be paid to the party that wins in litigation.

Attorneys for participants who withhold funds that should be reimbursed may face both ethical and legal complaints. State ethics rules contain provisions relating to how an attorney must treat client trust accounts and settlement funds. In at least one case, a court permitted an ERISA action to proceed against attorneys on the grounds that they were ERISA fiduciaries to the extent the attorneys held or controlled "plan assets"—the funds over which the plan effectively maintained it had a constructive trust or equitable lien.[20]

Sample Language

Claimant Must Set Aside Funds

The claimant shall hold in trust for the plan's benefit that portion of the total recovery from any source that is due for payments made or to be made. The claimant shall reimburse the plan immediately upon recovery. The claimant shall immediately notify the plan if he or she is involved in or suffers an accident or injury for which a third party may be liable. The claimant shall again notify the plan if he or she pursues a claim to recover damages or other relief relating to an injury or illness for which the plan may make payments on the claimant's behalf. The claimant shall do nothing to impair, release, discharge or prejudice the plan's rights to subrogation and/or reimbursement. The claimant shall assist and cooperate with representatives the plan designates. The claimant shall do everything necessary to enable the plan to enforce its subrogation and reimbursement. The claimant shall immediately notify the plan upon receiving a judgment, settlement offer or compromise offer and shall not settle or compromise any claims without the plan's consent.

First-Dollar Recovery

The plan's subrogation and reimbursement rights shall apply on a priority first-dollar basis to any recovery whether by suit, settlement or otherwise, regardless of whether a claimant is made whole.

Disavowal of Common Fund Doctrine

The plan's subrogation and reimbursement rights apply to any recovery by the claimant without regard to legal fees and expenses of the claimant. The claimant shall be solely responsible for paying all legal fees and expenses in connection with any recovery for the underlying injury, sickness, accident or condition, and the plan's recovery shall not be reduced by such legal fees or expenses, unless the plan administrator, in his or her sole discretion, agrees in writing to discount the plan's claim by an agreed-upon amount of such fees or expenses.

The plan specifically disavows any claims that an eligible employee or dependant may make under any federal or state common law defense including, but not limited to, the make-whole doctrine and/or the common fund doctrine.

Cooperation

The plan administrator may require the claimant to complete and/or execute certain documentation to assist the plan in the enforcement of its subrogation rights including, but not limited to, a subrogation and reimbursement questionnaire and a repayment agreement. The completion and/or execution of any documents requested by the plan administrator shall be a condition to receiving payment for a claim. Further, the plan shall have the right to suspend all benefit payments due to a claimant, the employee of whom a claimant is a dependent and/or any other dependent of such an employee if the claimant fails to complete and/or execute such documentation.

Conclusion

The *Sereboff* decision has solidified subrogation and reimbursement rights for ERISA self-funded health plans. Plans should take advantage of their legal advantages in this regard by making sure that the subrogation provisions in their plan document and summary plan description are in line with the suggestions contained within this article. A practical administrative plan must also be in place and followed in vigilant fashion in order to ensure maximum recovery from responsible third parties of dollars advanced on behalf of participants. **B&C**

Endnotes

1. 126 S.Ct. 1869 (2006).
2. See, e.g., *Beveridge v. Benefit Recovery, Inc.*, No. C-04-2729, 2006 WL 2052696 (D.Ariz. July 21,

Continued on next page

2006) (recognizing that the Ninth Circuit's interpretation of *Great-West Life & Annuity Insurance Co. v. Knudson* to deny all plan reimbursement claims had been overruled by *Sereboff*).

3. States located in the Sixth Circuit are Michigan, Ohio, Kentucky and Tennessee. States located in the Ninth Circuit are Washington, Oregon, Idaho, Montana, California, Nevada, Arizona, Alaska and Hawaii.

4. See *Admin. Comm. of Wal-Mart Stores, Inc. Assocs.' Health and Welfare Plan v. Shank,* No. 105-CV-00129, 2006 WL 2546797 (E.D.Mo. Aug. 31, 2006) *aff'd* 06-3531, WL 2457664 (8th Cir. August 21, 2007); *Moore v. CapitalCare, Inc.,* 461 F.3d 1 (D.C. Cir. Aug. 29, 2006) (unpublished); *Beveridge v. Benefit Recovery, Inc.,* No. C-04-2729 2006 WL 2052696 (D.Ariz. July 21, 2006).

5. 534 U.S. 204 (2002).

6. No. 105-CV-00129, 2006 WL 2546797 (E.D.Mo. Aug. 31, 2006).

7. Even courts within the Ninth Circuit have taken the lessons of *Sereboff* to heart. For example, in *Providence Health System—Washington v. Bush,* 461 F.Supp. 2d 1226, 1234 (W.D.Wash. 2006), the plan sought reimbursement from the trustee of a "special needs trust" that was set up for a plan beneficiary. The court held that the plan may sue a trustee of a special needs trust for reimbursement provided that the trustee has the funds in his possession and is not being held personally liable. Several other courts have reached similar conclusions. See also *Beveridge v. Benefit Recovery, Inc.,* No. C-04-2729, 2006 WL 2052696 (D.Ariz. July 21, 2006). See, e.g., *Moore v. CapitalCare, Inc.,* No. 04-7121, 04-7122 (D.C. Cir. Aug. 29, 2006).

8. *Popowski v. Parrott,* 461 F.3d 1367 (11th Cir. 2006).

9. 479 F.3d 538 (8th Cir. 2007).

10. The make-whole doctrine provides that the plan may not recover any benefits paid on behalf of a participant from the participant's third-party recovery unless the participant has been fully compensated for his or her damages by the third party. The defense can be statutorily based or cited as recognized under state or federal common law, which is commonly known as an antisubrogation law.

11. See, e.g., *Copeland Oaks v. Haupt,* 209 F.3d 811, 813 (6th Cir. 2000); *Barnes v. Indep. Auto. Dealers Ass'n of Cal. Health & Welfare Benefit Plan,* 64 F.3d 1389, 1394-95 (9th Cir. 1995); *Cagle v. Bruner,* 112 F.3d 1510, 1521-22 (11th Cir. 1997).

12. The plan provision states "[Mid Atlantic's] share of the recovery will not be reduced because [the beneficiary] has not received the full damages claimed, unless [Mid Atlantic] agrees in writing to a reduction."

13. In a footnote, the Court "declines to consider it for the first time here" because the Sereboffs never raised the argument in the lower courts and neither of those courts considered it. Thus, the precedential value of this discussion remains unclear.

14. *Moore v. CapitalCare, Inc.,* No. 04-7121, 04-7122 (D.C. Cir. Aug. 29, 2006) (declining to reach the question of whether the make-whole doctrine should apply to limit the plan's recovery as a matter of federal common law because the plan document at issue expressly disavowed the make-whole doctrine but noting that the Sixth, Eleventh and Ninth Circuits have adopted the make-whole doctrine as a default rule where the plan document does not contain a clear provision to the contrary); *Beveridge v. Benefit Recovery, Inc.,* No. C-04-2729, 2006 WL 2052696 (D.Ariz. July 21, 2006) (noting that, although the participant did not raise the make-whole doctrine as an issue, *Sereboff* did not decide what is "appropriate" relief under principles like the make-whole doctrine).

15. 461 F.Supp. 2d at 1235.

16. See, e.g., *Beveridge v. Benefit Recovery, Inc.,* No. C-04-2729, 2006 WL 2052696, at *5 (D.Ariz. July 21, 2006) (the plan's terms stated "the [p]lan's right of subrogation and repayment is not subject to the insured/injured party first being made whole"); *Moore v. CapitalCare, Inc.,* No. 04-7121, 04-7122 (D.C. Cir. Aug. 29, 2006) (the plan document provided that the "[p]articipant shall pay the [c]orporation all amounts recovered by suit, settlement, or otherwise from any third party or his insurer to the extent of the benefits provided by this contract. . . ."); (*Admin. Comm. of Wal-Mart Stores v. Shank,* 2006 WL 2546797 62280, at *5 (the plan's terms made clear that "the plan has first priority with respect to its right to . . . reimbursement"); *Findlay Indust., Inc. v. Bohanon,* Case No. 3:07 CV 1210 (N.D.Ohio Aug. 14, 2007) (rejecting participant's federal common law defense that she was not made whole by the settlement with the tortfeasor, and thereby precluding the plan's claim for reimbursement because the "plan in this case is sufficiently specific not only in detailing a right to recovery," but also in establishing priority in that recovery by requiring that the insured "shall do nothing to prejudice the rights of the Plan to such reimbursement and recovery").

17. Several circuit courts of appeal have refused to read the common fund doctrine into the unambiguous provisions of a plan document. *Harris v. Harvard Pilgrim Health Care, Inc.,* 208 F.3d 274, 279 (1st Cir. 2000) (holding that importing the common fund doctrine into the plan document would not serve any purpose of ERISA when the plan expressly stated that participants were obligated to reimburse the plan for the value of services provided); *Capria-Ryan v. Fed. Express Corp.,* 78 F.3d 123, 127-28 (3rd Cir. 1996) (holding that application of the common fund doctrine would be inequitable because the plan unambiguously requires the participant to repay all of the money received from the plan); *United McGill Corp. v. Stinnett,* 154 F.3d 168, 173 (4th Cir. 1998) (refusing to apply common fund doctrine when the plan document unambiguously requires the participant to repay benefits in full without mention of a pro-rata deduction for legal expenses); *Walker v. Wal-Mart Stores, Inc.,* 159 F.3d 938 (5th Cir. 1998) (holding that common fund doctrine does not apply when plan document unambiguously requires the participant to repay benefits in full without mentioning reduction for payment of legal expenses); *Bombardier Aerospace Employee Benefits Plan v. Ferrer, Piorot and Lansbrough,*354 F.3d 348 (5th Cir. 2003) (holding that when a plan's terms give it the right to recover benefits and specifies who bears the responsibility for fees and costs, the plan is entitled to full recovery of the amount of benefits paid without offset for fees and costs); *Health Cost Controls v. Isbell,* 139 F.3d 1070, 1072 (6th Cir. 1997) (holding that the common fund doctrine cannot apply to alter the unambiguous terms of the plan document because such application would not serve any purpose of ERISA); *Administrative Comm. of the Wal-Mart Stores, Inc. Associates' Health and Welfare Plan v. Varco,* 338 F.3d 680, 692 (7th Cir. 2003) (holding that the common fund doctrine cannot override the express terms of an unambiguous plan document).

18. *Curran v. Camden Nat'l Corp.,* 477 F.Supp. 2d 247, 257 (D.Maine 2007) (denying relief under §502(a)(3) because a trust sought "money from [a corporation's] general, commingled assets" in a dispute involved how much money a corporation had to pay to a trust to withdraw from a health care agreement); *Vacca v. Trinitas Hosp.,* No. 05-CV-0368, 2006 WL 3314637 (E.D.N.Y. Nov. 14, 2006) (finding that plan provider did not seek equitable relief within the meaning of ERISA §502(a)(3) when it asked for reimbursement for overpayments made to hospital because, even though the plan provider could identify the specific checks and bank accounts associated with the overpayments, the defendant had deposited those funds into its general accounts); *Reichert v. Liberty Life Assurance Co. of Boston,* No. CIV. 05-2518, 2007 WL 433321, at *12 (D.N.J. Feb. 5, 2007) (despite plan provision requiring that overpayment of benefits be repaid to the plan provider, the court held that because the participant had spent the funds, there was no longer a specifically identifiable fund and, without a specifically identifiable fund, no equitable lien could be established to provide relief under ERISA §502(a)(3)).

19. See *Dillard's Inc. v. Liberty Life Assurance Co. of Boston,* 456 F.3d 894 (8th Cir. 2006) (holding a claim for overpayment of benefits resulting from concurrent payment of Social Security benefits is indistinguishable from an equitable lien established by agreement when a provision allowing for reimbursement of benefits is present); *Gutta v. Standard SelectTrust Ins.,* No. 04-5988, 2006 WL 2644955 (N.D.Ill. Sep. 14, 2006) (holding an offset provision within the plan's terms creates an equitable lien on the monies paid by the provider).

20. *Trustees of Teamsters v. Papero,* 485 F.Supp. 2d 67 (D.Conn. 2007).

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