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Subrogation Under ERISA Post-Sereboff

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After the United States Supreme Court in 2002 decided *Great-West Life & Annuity Insurance Co. v. Knudson*,[1] a Circuit split developed on the issue of whether the Employee Retirement Income Security Act permits a plan fiduciary to assert in federal court a right to reimbursement from participants receiving a recovery from a third party. On one side of the split, the Fourth, Fifth, Seventh, and Tenth Circuits allowed plans to assert such claims for reimbursement in appropriate circumstances, while on the other side, the Sixth and Ninth Circuits prohibited federal suits for reimbursement.

In May 2006, the Supreme Court resolved the conflict. In *Sereboff v. Mid Atlantic Medical Services, LLC*,[2] the Court affirmed a Fourth Circuit decision[3] that ERISA provides federal courts with federal question jurisdiction over a plan's equitable claim to impose a constructive trust over funds that a plan participant recovers from a third party.

[1] *Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204, 27 EBC 1065 (2002).

[2] Mid Atlantic Medical Services, LLC v. Sereboff, 126 S. Ct. 1869, 34 EBC 2547 (2006).

[3] *Sereboff*, 407 F.3d 212, 34 EBC 2547 (4th Cir. 2005).

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This report reviews how the *Great-West* decision has and continues to shape plan enforcement of and recoveries under reimbursement provisions, reviews the subsequent Circuit split, summarizes and anallyzes *Sereboff*, and describes how the Circuits have responded to *Sereboff*. It also discusses steps ERISA plans can take to achieve the best possible outcome in light of *Sereboff* and post-*Sereboff* decisions. The report also considers the application of two other related subrogation issues: the ''make whole'' doctrine and the ''common fund'' doctrine.

The Great-West Decision. In *Great-West*, Ms. Knudson, the beneficiary of an ERISA plan established by her then-husband's employer, became a quadriplegic after a car accident. Her ERISA plan covered over $400,000 of the costs for her medical care, and Great-West paid the majority of those costs through a stop-loss insurance agreement with the employer. Ms. Knudson and her husband eventually sued the manufacturer of the car she was driving when her accident occurred, Hyundai Motors, in California state court. Hyundai and the Knudsons settled for $650,000. Her attorney received about half of the settlement. A small amount, $5,000, was paid to Medi-Cal to reimburse the California Medicaid program. Only five percent was allocated to medical costs and paid to Great-West. The remainder was placed directly into a ''special needs'' trust as required by California law. Significantly, none of the proceeds were ever paid directly to Ms. Knudson or her husband.

Great-West first became involved in the action after the Knudsons and Hyundai reached settlement. At that point, Great-West, as assignee of the ERISA plan's reimbursement rights, tried to intervene in the state court proceeding and remove the case to federal court. The federal court remanded the action back to state court. Simultaneously with its removal attempt, Great-West brought an injunctive and declaratory relief action under ERISA § 502(a)(3) in federal court to enforce the plan's reimbursement provision. ERISA § 502(a)(3) provides, among its terms, that a fiduciary may bring a civil

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action ''(A) to enjoin any act or practice which violates any provision of [ERISA] . . . or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of [ERISA] . . . or the terms of the plan.''[4]

The federal district court dismissed the action, holding that the plan's language limited Great-West's recovery to the amount received from Hyundai. Great-West appealed to the Ninth Circuit, which affirmed on different grounds. It held that claims for reimbursement of payments made to a beneficiary of an insurance plan by a third party are not claims for equitable relief as required by § 502(a)(3). Great-West appealed to the U.S. Supreme Court.

The Holding. Justice Scalia, writing for the five-justice majority, upheld the Ninth Circuit's decision. According to the Court, because the Knudsons never possessed the settlement proceeds, Great-West's lawsuit essentially asserted a claim of personal liability against the Knudsons, which the Court deemed to be ''traditional'' legal relief. The Court was not persuaded that the relief sought, whether cloaked as a claim for an injunction or a claim for restitution, was ''equitable.'' Since § 502(a)(3) of ERISA permits actions by a fiduciary only for equitable relief, the Court's ruling that Great-West was seeking legal relief meant that its claims must be dismissed.

The Court rejected Great-West's argument that, because it sought to enjoin the Knudsons' failure to reimburse the plan, as required by the terms of the plan, its action was ''equitable.'' The Court held that an injunction to compel payment of money under a contract was not typically available in equity, and accordingly did not fall within the scope of relief permitted under § 502(a)(3).[5]

The Court also was not convinced that Great-West's restitution claim constituted equitable relief. Delving into ''the days of the divided bench''[6]—that is, when there were separate courts of law and of equity—the Court distinguished *legal* restitution from *equitable* restitution, a distinction largely abandoned by the modern legal system. In sum, the court held that ''for restitution to lie in equity, the action generally must seek not to impose personal liability on the defendant, but to restore to the plaintiff particular funds or property in the defendant's possession.''[7] Applying the ''legal restitution versus equitable restitution'' dichotomy to the facts before it, the Court ruled that because the Knudsons did not have possession of the property at issue—the settlement funds—Great-West's claim was for legal restitution, and its action was one at law and not permitted under § 502(a)(3).

The Circuit Case Law after Great-West. After *Great-West*, a clear split among the Courts of Appeals developed on the issue of whether and what claims remained available to plans seeking reimbursement. The Fourth, Fifth, Seventh, and Tenth Circuits read *Great-West* to allow plans to seek a constructive trust when the funds are specifically identified and remain within the possession and control of the plan beneficiary or participant. In contrast, the Sixth and Ninth Circuits reasoned that *Great-West* disallowed any reimbursement claims that sought a judgment for the specific reimbursement amount.

The Fourth, Fifth, Seventh and Tenth Circuits held that ERISA provided federal courts with federal question jurisdiction over a plan's equitable claim to impose a constructive trust over funds that a plan participant or beneficiary recovers from a third party.[8] These Circuits took their cue from the statement in *Great-West* that a plan does not seek equitable restitution unless it claims ''particular funds that, in good conscience, belong to'' the plan. [9] Relying on this statement, for example, the Fifth Circuit, in *Bombardier Aerospace Employee Welfare Benefits Plan v. Ferrer, Poirot and Wansbrough*,[10] fashioned a three part inquiry to determine whether a claim seeks legal or equitable restitution, asking whether the plan seeks to recover funds that (1) are specifically identifiable, (2) belong in good conscience to the plan, and (3) are within the possession and control of the defendant beneficiary. A claim is equitable when the answer to each question is yes.[11] This three-part approach was adopted expressly by the Tenth Circuit in *Admin. Comm. of the Wal-Mart Assoc. Health and Welfare Plan v. Willard*,[12] and the three part test was implicitly adopted by the Fourth Circuit in *Sereboff*.[13]

The plan beneficiaries in both *Bombardier* and in the Seventh Circuit's decision in *Administrative Committee of the Wal-Mart Stores, Inc. v. Varco*[14] had settled with third-party tortfeasors, and placed into reserve bank accounts money from the settlement equivalent to the amounts claimed by the health plans. In *Sereboff*, the plan beneficiaries agreed to preserve funds sufficient to satisfy the plan's reimbursement lien in their own investment accounts.[15] Thus, as the Seventh Circuit put it, there was an ''identifiable res'' to which the plan could trace its property.[16] According to both courts, these identifiable funds, ''in good conscience'' belonged to the plans based upon the plain and unambiguous language contained in the plan documents that required 100 percent reimbursement.[17] Finally, whereas the funds involved in *Great-West* were under the control of a trustee ''totally independent of the plan beneficiary,'' the funds at issue in *Bombardier* were ''simply being held in a bank account in the name of the participant's attorneys.''[18] Therefore, the funds remained ''within the

[4] ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3).
[5] *Great-West*, 27 EBC at 1067.
[6] *Id.* at 1070.
[7] *Id.*

[8] *Sereboff*, 407 F.3d 212, 34 EBC 2547 (4th Cir. 2005); Bombardier Aerospace Employee Welfare Benefits Plan v. Ferrer, Poirot and Wansbrough, 354 F.3d 348, 31 EBC 2505 (5th Cir. 2003); Admin. Comm. of the Wal-Mart Stores, Inc. v. Varco, 338 F.3d 680, 30 EBC 2409 (7th Cir. 2003); Admin. Comm. of the Wal-Mart Assoc. Health and Welfare Plan v. Willard, 393 F.3d 1119, 34 EBC 1129 (10th Cir. 2004).
[9] *Id.*
[10] 354 F. 3d 348, 356.
[11] *Id. See also* Admin. Comm. of the Wal-Mart Stores, Inc. v. Varco, 338 F.3d 680, 687, 30 EBC 2409 (claim is equitable when funds are identifiable, not yet ''dissipated,'' and still in control of the beneficiary).
[12] 393 F.3d 1119, 1122, 34 EBC 1129
[13] 407 F.3d 212, 219, 34 EBC 2547.
[14] *Varco*, 338 F.3d 680, 30 EBC 2409 (7th Cir. 2003).
[15] *Sereboff*, 407 F.3d at 216.
[16] *Varco*, 338 F.3d at 688.
[17] *Bombardier*, 354 F.3d at 356; *Varco*, 338 F.3d at 687.
[18] *Bombardier*, 354 F.3d at 356.

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possession and control of the defendant.''[19] According to the Seventh Circuit, at least, equitable relief can include imposition of a constructive trust over a ''fund of money like a bank account.''[20]

The Sixth Circuit rejected this approach, finding that a plan's reimbursement claim is a legal claim and therefore unavailable under § 502(a)(3). In *QualChoice v. Rowland*,[21] Rowland was injured when she drove her car into a railcar on an unlit rail crossing. The railroad was uninsured, but agreed to pay $147,688 over the course of 44 months. It is not clear from the decision whether the settlement fund existed as a separate fund at the time of the lawsuit.

The Sixth Circuit began its analysis by recognizing the ''conundrum'' that a restitution claim for money was, historically, a legal claim, but that certain restitution claims seeking title or security interest in particular property were equitable claims.[22] The court, however, then held that the presence of a specifically identifiable fund does not change the nature of the action. Rather, in order to be considered equitable restitution, the reimbursement obligation must confer upon the plan ''a property right in any *particular* fund.''[23] Thus, unless the plan has a property right in the settlement fund, its claims are legal. The source of QualChoice's claim, according to the Sixth Circuit, was the beneficiary's contractual reimbursement obligation.[24] This personal contractual obligation did not confer upon QualChoice any rights in the recovered funds, the court found; rather, QualChoice has a breach of contract claim that historically would have been brought as ''an action for assumpsit.''[25] Further, a constructive trust would not be a proper mechanism for enforcing this right because ''such relief would not have traditionally been awarded for a court of equity in a breach of contract action.''[26]

The Ninth Circuit is aligned with the Sixth Circuit. In *Carpenters Health and Welfare Trust for Southern California v. Vonderharr*,[27] the beneficiaries' minor daughter incurred permanent brain damage in a car accident. The beneficiaries recovered $30,000 from the other driver and an undisclosed amount from Ford Motor Company. After unsuccessfully seeking to negotiate reimbursement, the plan filed suit to enjoin any distribution of the settlement proceeds.

The Ninth Circuit held that the substance of the remedy sought by the health plan was not the injunction barring distribution of settlement funds, but an action seeking compensatory damages. According to the court, ''monetary relief'' is not an allowable ERISA remedy.[28] This, it said, is true even when the money is in an escrow account and specifically identifiable.[29] While the court recognized that a constructive trust is a form of equitable relief, it held that such a remedy is only available at equity when there is ''some form of ill-gotten gain of another's property.''[30] (The Sixth Circuit expressly held that constructive trust is available even in the absence of wrongdoing, though not in the case before it.) Similarly, equitable restitution, the Ninth Circuit reasoned, is only available when fraud or wrongdoing is shown.[31]

The Sereboff Decision. The Supreme Court in *Sereboff* affirmed the position taken by Fourth, Fifth, Seventh and Tenth Circuits, and, addressing a matter raised but unanswered in *Great-West*, the Court confirmed that plans may seek reimbursement by claiming ''particular funds that in good conscience, belong to'' the plan. [32]

The Facts. In *Sereboff*, Mr. and Mrs. Sereboff were injured in an automobile accident. Their medical expenses were paid under a health insurance plan sponsored by Mrs. Sereboff's employer and administered by Mid Atlantic Medical Services, Inc. When the Sereboffs sued several third parties for compensatory damages related to the accident, Mid Atlantic asserted a lien against the anticipated proceeds of the lawsuit for the value of health care services paid for under the plan. Throughout the course of the lawsuit, Mid Atlantic repeated its claim in follow-up letters to the Sereboffs' attorney, detailing the medical expenses as they accrued and were paid.[33]

The Sereboffs eventually settled the lawsuit and received $750,000. When Mid Atlantic's lien was not satisfied, the plan sued for nearly $75,000 in paid medical expenses. Mid Atlantic then sought an injunction to have the Sereboffs set aside the disputed amount pending outcome of the lawsuit. The funds were preserved in an investment account until the resolution of the litigation.[34]

Holding. In a unanimous decision, the Court held that because the Plan sought recovery ''through a constructive trust or equitable lien on a specifically identified fund,'' the relief sought was equitable and therefore allowed under § 502(a)(3).[35] The Court distinguished *Great-West*, where the settlement was paid directly into a trust, from the facts in *Sereboff*, where the settlement was paid directly to the beneficiaries and then, by agreement of the parties, was placed in an investment account pending resolution of the lawsuit.[36]

Relying on a 1914 case,[37] the Court found that an equitable lien existed on the funds even though the money in the investment fund could not be traced directly back to the payments made by the plan for medical expenses.[38] While tracing is required when asserting an equitable lien based on restitution, the Court found that

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[19] *Id.*

[20] *Varco*, 338 F.3d at 687 (quoting 1 Dan B. Dobbs, *Dobbs on the Law of Remedies: Damages-Equity-Restitution* § 4.3 p. 591 (2d Ed. 1993)).

[21] QualChoice, Inc. v. Rowland, 367 F.3d 638, 649, 32 EBC 2601 (6th Cir. 2004).

[22] *Id.*

[23] *Id.* (emphasis added).

[24] *Id.* at 649 n.4.

[25] *Id.* (citing *Dobbs on Remedies* 551, 571, 578-79 (2d ed. 1993)).

[26] *Id.*

[27] Carpenters Health and Welfare Trust for Southern California v. Vonderharr, 384 F.3d 667, 33 EBC 1929 (9th Cir. 2004).

[28] *Id.* at 671.

[29] *Id.* (citing *Westaff (USA), Inc. v. Arce*, 298 F.3d 1164, 28 EBC 2096 (9th Cir. 2002)).

[30] *Id.* (quoting *FMC Medical Plan v. Owens*, 122 F.3d 1258, 1261, 21 EBC 1724 (9th Cir. 1997)).

[31] *Id.* at 672.

[32] Sereboff v. Mid Atlantic Medical Svc., Inc., 126 S. Ct. 1869 (2006).

[33] *Id.* at 1872.

[34] *Id.* at 1873.

[35] *Id.* at 1874.

[36] *Id.*

[37] Barnes v. Alexander, 232 U.S. 117, 34 S. Ct. 2786 (1914).

[38] *Sereboff*, 126 S. Ct. at 1875.

in an equitable lien by agreement, ''a contract to convey a specific object even before it is acquired will make the contractor a trustee as soon as he gets title to the thing.''[39] The Sereboffs' benefit plan required reimbursement from all third party recoveries, creating a lien on the portion of the third party settlement that represented the benefits paid by Mid Atlantic, which Mid Atlantic could then follow into the hands of the Sereboffs as soon as the funds were identified.[40]

Because it was not raised below, the Court declined to consider the Sereboffs' argument that the relief, even if it was equitable, was not ''appropriate equitable relief'' under § 502(a)(3) where the award supposedly might be inconsistent with the ''make whole'' doctrine.[41]

The Circuits' Response to Sereboff. In the nearly two years since *Sereboff* was decided, no Circuit which previously took a position on subrogation after *Great-West* has decided a similar case. However, the Eighth and Eleventh Circuits have followed *Sereboff* in affirming claims for reimbursement based on equitable liens. The Eighth Circuit allowed the plan to seek reimbursement from a special needs trust.[42] In *Admin. Committee of the Wal-Mart Stores, Inc. Associates' Health and Welfare Plan v. Shank*, Shank was injured in a car accident and recovered $700,000 from the responsible parties. The district court had placed the net proceeds into a special needs trust for the benefit of Shank, with her husband as trustee. Affirming summary judgment for the plan, the Eighth Circuit found that the claim met *Sereboff*'s three-pronged test for equitable restitution: the claim sought (1) the specific funds owed under the terms of the plan; (2) from a specifically identifiable fund that is distinct from the [beneficiary's] general assets; and (3) that is controlled by [the defendant trustee].[43]

In a consolidated Eleventh Circuit case, language in plan documents was the determining factor in whether either Plan had asserted an equitable lien under the *Sereboff* test. In *Popowski v. Parrott*,[44] Parrott was injured in an accident and signed a reimbursement agreement before any of her medical expenses had been paid by here employer under the United Distributors health plan. The agreement mirrored the language in the plan document and required that she repay the plan for benefits paid on her behalf out of any recovery she received. The plan sued for reimbursement of over $150,000 in medical expenses after Parrott received a $525,000 settlement from the responsible third party. Holding that the plan had asserted a claim for ''appropriate equitable relief,'' the Eleventh Circuit found the reimbursement provision was nearly identical to plan language in *Sereboff*: it specified ''the fund out of which reimbursement is due to the plan and the portion due the plan.''[45]

In the companion case, the Eleventh Circuit found that language in the Mohawk Carpet plan was not specific enough to create an equitable lien. In *Blue Cross Blue Shield of South Carolina v. Carillo*, the plan paid over $125,000 in medical expenses for two beneficiaries injured in an accident, then sought reimbursement from a $200,000 settlement. The trial court granted a temporary restraining order to prevent the Carillos from dissipating the settlement funds, but ultimately dismissed the claim because the plan claim was not equitable in nature but an attempt to force the Carillos to pay money under provisions of the benefit plan. The Eleventh Circuit affirmed the district court, finding that plan language failed to specify that the ''reimbursement be made out of any particular fund as distinct from the beneficiary's general assets.''[46] On that basis, and because the plan language did not limit recovery to a specific portion of a particular fund and made the general reimbursement obligation effective upon receipt of the settlement, the court found that the claim was not an equitable lien for the purposes of 29 U.S.C. § 1132(a)(3).[47]

Before *Sereboff*, the Sixth and Ninth Circuits had rejected recovery based on constructive trust over identifiable funds. Neither Circuit has addressed the issue since *Sereboff*, but in the Sixth Circuit, a Kentucky district court relied on *Popowski* to find that based on plan language, a plan could not assert an equitable lien for reimbursement over a beneficiary's third party recovery.[48] In *Fleetwood Enterprises, Inc. v. Taylor*, Taylor was injured in a car accident and received a $100,000 settlement from the liable party and $25,000 from her own auto insurance company. The Fleetwood plan sought to recover the $44,000 it paid in medical expenses. The district court found that the reimbursement clause did not specify the portion of any recovery that would be due to the plan, in contrast to the more specific subrogation clause, which provided for recovery ''to the extent of the benefits it has paid.''[49]

In the Ninth Circuit, an Arizona district court cited both *Sereboff* and *Popowski* in finding that a plan asserted an equitable claim because specific language in the plan documents created an equitable lien by agreement.[50] In *Administrative Committee for the Wal-Mart Stores, Inc. Associates' Health and Welfare Plan v. Salazar*, Salazar was permanently disabled as a result of an automobile collision. The Wal-Mart plan paid nearly $65,000 of her $161,000 medical expenses. After Salazar received a settlement of $250,000, the plan unsuccessfully tried to negotiate reimbursement for a lower portion of the actual benefits paid. After the plan filed suit for recovery, the court enjoined Salazar's counsel from distributing the disputed amount of the settlement pending the outcome of the litigation. In granting partial summary judgment for the plan, the court found that the claim complied with *Sereboff* because it specified both the fund out of which recovery

[39] *Id.*, quoting *Barnes*, 232 U.S. at 121.
[40] *Sereboff*, 126 S. Ct. at 1875.
[41] *Id.* at 1877 n.2.
[42] Admin. Committee of the Wal-Mart Stores, Inc. Associates' Health and Welfare Plan v. Shank, 41 EBC 1681 (8th Cir. 2007).
[43] *Id.*
[44] Popowski v. Parrott, 461 F.3d 1367, 39 EBC 1484 (11th Cir. 2006).
[45] *Id.* at 1373.
[46] *Parrott*, 461 F.3d at 1373.
[47] *Id.*
[48] Fleetwood Enterprises, Inc. v. Taylor, 2007 U.S. Dist. LEXIS 74802, at *9 (W.D. Ky. September 28, 2007).
[49] Id. at *9 n.3.
[50] Administrative Committee for the Wal-Mart Stores, Inc. Associates' Health and Welfare Plan v. Salazar, 42 EBC 1976 (D. Ariz. 2007).

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would be taken and the portion of the fund to which the fund was entitled.[51]

Also in the Ninth Circuit, a Nevada district court found that *Sereboff* allows a plan to ''recover amounts paid for medical expenses where a constructive trust was sought over a specifically identifiable fund.''[52] In *Mutual of Omaha Insurance Co. v. Estate of Arachikavitz*, Arachikavitz was injured while he was a patient in a hospital and spent five years in various hospitals until his death. The net recovery from third parties was placed in a special needs trust and a qualified fund, whose combined value at the time of the lawsuit was over $1 million. After his death, Mutual of Omaha sought reimbursement from the estate, the administrator, and the trust. The court, ruling that the plan could maintain an equitable relief action against the special needs trust and the settlement fund, cited *Salazar* in finding that the *Sereboff* requires only that ''the Plan identify a fund, distinct from the plan beneficiary's general assets, from which reimbursement will be taken and specify a particular share to which the Plan is entitled.''[53]

Practice Tip: Determine *Great-West's* application to your insured and self-insured plans. The *Great-West* decision applies to both fully insured and self-funded ERISA plans, but will be of less significance to fully-insured ERISA plans in states that prohibit subrogation and reimbursement (because plans in those states generally cannot seek reimbursement in the first place). Of course, in states where reimbursement and subrogation are not prohibited, fully insured plans will need to address the effect of the decision to the same extent as self-insured plans.

Review plan documents to be sure that under subrogation and reimbursement provisions the plan can:

- claim a lien ''on any amount recovered by the Covered Person whether or not designated as payment for medical expenses'' and
- state that ''the 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.''[54]

Plans should also take timely action to enjoin dissipation of third party recoveries in order to preserve the distinction between the specific funds from which reimbursement is sought and general personal assets.

Is State Court Reimbursement Enforcement a Viable Option? Some commentators suggested, following *Great-West*, that ERISA plans could try to obtain reimbursement in state court proceedings.[55] The Supreme Court in *Great-West* said, ''[w]e express no opinion as to whether petitioners could have intervened in the state-court tort action brought by respondents or whether a direct action by petitioners against respondents asserting state-law claims such as breach of contract would have been preempted by ERISA.''[56] Now under *Sereboff*, plans have an ERISA remedy to seek equitable relief in reimbursement situations. Efforts to seek reimbursement based on state law are likely to be preempted in accordance with *Aetna v. Davila*,[57] since that case and its predecessors hold that state law cannot provide remedies alternative to or in addition to those offered through ERISA.

What Is a Constructive Trust? One issue that has not been discussed in the above cases is how a plan traces the funds at issue to satisfy the requirements of a constructive trust claim. It is not usually enough to simply assert a claim for a constructive trust against the person who holds the funds at issue—and expect to win. At some point a plan participant or beneficiary (or his attorney) may challenge such a broad-brushed application of the doctrine.

A constructive trust (or equitable lien) arises when one party has possession of some property or money that, in good conscience, belongs to another.[58] The claimant bears the burden of proof in tracing the trust property to some identifiable property, or *res*.[59]

Tracing, especially when the property at issue is money, can create difficulties for plans wishing to place a constructive trust on settlement funds or other recoveries. For funds deposited in an existing beneficiary account—and commingled with the existing funds in that account—the ''lowest intermediate balance'' rule applies. This rule is based on the fiction that, when withdrawing funds from commingled account, a trustee withdraws nontrust monies first.[60]

Examples best illustrate this principle as it applies to commingled funds in an account. The resulting conclusion is that if a third-party recovery has been disbursed, the most effective way to protect those funds may be (as discussed above) a temporary restraining order.

Assume for the following examples that a beneficiary, Tom Smith, recovers $20,000 from a third party for injuries covered by an ERISA plan. The beneficiary deposits the money in an account that already has $10,000 in it, bringing the total balance to $30,000. The plan seeks to place a constructive trust of $20,000 on the account.

Example 1: Tom Smith withdraws $5,000 from the account and two days later places other funds (such as a paycheck) into the account. The account balance has never fallen below $20,000. *Result:* The trust of $20,000 remains intact and is enforceable in its entirety.

Example 2: Tom Smith withdraws all money from the account and two days later places other funds (such as a paycheck) into the account. *Result:* The trust is completely destroyed.

Example 3: Tom Smith withdraws $25,000 from the account, leaving a balance of $5,000. He later deposits $30,000, bringing the account balance to $35,000. *Result:* There is $5,000 left in the trust. This is the lowest intermediate balance.

Based on these examples, it is evident that in order to succeed on a constructive trust claim, not only must

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[51] *Id*.

[52] Mutual of Omaha Insurance Co. v. Estate of Arachikavitz, 2007 U.S. Dist. LEXIS 71172, at *6.

[53] *Arachikavitz*, 2007 U.S. Dist. LEXIS 71172, at *7, citing *Salazar*, 2007 U.S. Dist. LEXIS 61273, at *7.

[54] *Popowski*, 461 F.3d at 1373.

[55] *See* ''*Great-West Life & Annuity Ins. Co. v. Knudson*: Supreme Court Announces That It Was Not Kidding in *Mertens v. Hewitt Associates*,'' ERISA Litigation Reporter, Vol. 9 No. 6 (Feb. 2002).

[56] 534 U.S. at 220.

[57] Aetna v. Davila, 542 U.S. 200, 209-210, 32 EBC 2569 (2004).

[58] *Harris Trust & Sav. Bank v. Salomon Smith Barney Inc.*, 530 U.S. 238, 251, 24 EBC 1654 (2000).

[59] Schuyler v. Littlefield, 232 U.S. 707 (1934).

[60] *See, e.g.*, Connecticut General Life Ins. Co. v. Universal Ins. Co., 838 F.2d 612 (1st Cir. 1988).

plans move quickly in their suits against participants or beneficiaries, but must also be able to trace the funds.

Practice Tip: When you know a participant or beneficiary has hired counsel, consider requiring the participant or beneficiary to have his or her counsel sign a reimbursement agreement. In appropriate circumstances, it may be possible to get such an agreement before paying claims. Check local ethics rules and opinions to determine whether you are protected without such a separate agreement or formal lien. In any event, while it is appropriate to remind counsel of his or her ethical responsibilities, proceed with caution because threatening to turn counsel over to his or her local bar authority if your reimbursement demand is not met can be, in and of itself, an ethical violation.[61]

The Common Fund Doctrine. The ''common fund'' doctrine often is asserted by plan beneficiaries in subrogation disputes. In general, the common fund doctrine states that those who benefit from a common fund should share in the costs of obtaining the recovery that created the fund.[62] Arguing that the common fund doctrine applies in the context of a plan seeking reimbursement from a participant or beneficiary who recovers from a third party, the doctrine reduces the plan's reimbursement by an amount equal to the plan's pro-rata share of the participant's legal costs in recovering from the third party. For example, if a participant's attorney takes 30 percent of a recovery as a contingency fee, the plan's reimbursement from the participant generally would be reduced by 30 percent as well.

The majority of federal appellate cases have found that the common fund doctrine does not apply in ERISA contexts where the plan itself addresses the issue of the allocation of attorney fees.[63] While federal common law principles may sometimes be applied to fill the gaps in ERISA plans, ''it is inappropriate to fashion a common law rule that would override the express terms of a private plan unless the overridden plan provision conflicts with statutory provisions or other policies underlying ERISA.'' [64] As an example, one court found that the following language in the plan documents explicitly addressed the issue of attorneys' fees and therefore refused to apply the common fund doctrine to reduce the reimbursement amount:

> The Plan has the right to full subrogation and reimbursement of any and all amounts paid by the Plan, to or on behalf of, a Covered Person, if the Covered Person receives any sum of money from any third party in connection with any accident, the Covered Person shall be responsible for all expenses of recovery from such third parties, including but not limited to, all attorneys' fees, *which fees and expenses shall not reduce the amount of reimbursement to the Plan required of the covered person*.[65]

When the plan does not contain any language addressing attorney fees, the Eighth Circuit applies a federal common law common fund doctrine.[66] The First Circuit, however, has declined to apply a federal common law common fund doctrine even in the absence of an express plan provision.[67]

Practice Tip: Spell it out—the best way to ensure that the plan's reimbursement is not reduced to account for attorneys' fees paid by a participant in recovering from a third party is to explicitly preclude such a reduction in the plan documents.

In the absence of explicit language addressing attorneys' fees, courts must look to the reimbursement language that the plan does use. Before looking at examples of language, it is important to ask whose interpretation of the reimbursement language will govern—the plan administrator's or the court's. If the plan documents give the plan administrator discretion to interpret the reimbursement provisions, its interpretation will be given deference by the courts and will be overturned only if the court finds that the administrator has abused its discretion.[68] As one court stated: ''[T]he administrator or fiduciary's decision will not be disturbed if it is reasonable, even if this court would have come to a different conclusion independently.''[69] However, the standard of review may be less deferential in circumstances where the administrator is also the employer who has a financial interest in maximizing reimbursement.[70] If plan administrators have not been given discretion to interpret the reimbursement provisions, the court will interpret the plan on its own, giving no deference to the plan's interpretation.

Practice Tip: Grant plan administrators discretion to interpret the plan's reimbursement provisions. If the administrator has discretion, courts often will accept an administrator's interpretation if it is reasonable, even if the court's interpretation would have been different on its own.

Below are examples of language in plan documents or subrogation/reimbursement agreements that federal circuit courts have interpreted to preclude reduction of reimbursement to account for attorneys' fees (based on

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[61] *See, e.g.*, D.C. Rules of Professional Conduct 8.4(g): ''It is professional misconduct for a lawyer to . . . seek or threaten to seek criminal charges or disciplinary charges solely to obtain an advantage in a civil matter.''

[62] Skelton v. General Motors Corp., 860 F.2d 250, 252 (7th Cir. 1988) (''The common fund doctrine . . . is based on the equitable notion that those who have benefited from litigation should share its costs.'') (internal quotations omitted); *In re* Thirteen Appeals Arising Out Of The San Juan Dupont Plaza Hotel Fire Litig., 56 F.3d 295, 305 n.6 (1st Cir. 1995) (''The common fund doctrine is founded on the equitable principle that those who have profited from litigation should share its costs.'').

[63] *Varco*, 338 F. 3d at 692; *Ryan by Capria-Ryan v. Federal Express Corp*., 78 F.3d 123, 19 EBC 2889 (3d Cir. 1996). *See also Sereboff*, 407 F.3d at 220 (enforcing plan term which required reduction of reimbursement amounts to pay reasonable attorney fees).

[64] *Varco*, 338 F. 3d at 692; *Ryan by Capria-Ryan v. Federal Express Corp*., 78 F.3d 123, 126, 19 EBC 2889 (3d Cir. 1996), *quoting Singer v. Black & Decker Corp.*, 964 F.2d 1449, 1452 (4th Cir. 1992).

[65] *Fairfield Mfg. Co. v. Hartman*, 132 F. Supp. 2d 1142 (N.D. Ind. 2001) (emphasis added).

[66] McIntosh v. Pacific Holding Co., 120 F.3d 911 (8th Cir. 1997); Waller v. Hormel Foods Corp., 120 F.3d 138, 141 (8th Cir. 1997).

[67] *Harris v. Harvard Pilgrim Health Care, Inc.,* 208 F.3d 274, 278-79 (1st Cir. 2000).

[68] *United McGill Corp. v. Stinnett*, 154 F.3d 168, 170-171 (4th Cir. 1998). However, plans must be clear that the administrator's discretion covers reimbursement provisions. In *Wal-Mart Stores v. Wells*, 213 F.3d 398, 24 EBC 1673 (7th Cir. 2000), the court found that an administrator's discretion regarding benefits determinations did not extend to reimbursement provision of the plan documents.

[69] *Ellis v. Metropolitan Life Ins*. Co., 126 F.3d 228, 232 (4th Cir. 1997).

[70] *United McGill Corp.*, 154 F.3d at 171.

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deference to the plan administrators' interpretation or the court's own reading of the plan documents). The participant will reimburse:

- ''100 percent of the amount of covered benefits paid,''[71]
- ''any payments resulting from a judgment or settlement, or other payment or payments, made or to be made by any person or persons considered responsible for the condition giving rise to the medical expense or by their insurers,''[72]
- ''the amount of benefits [the plan] pays'' and the plan ''expects full reimbursement,''[73]
- ''the value of services [paid] for by the plan'' and ''any monies received for services provided or arranged by [the plan].''[74]

Additionally, and even more obviously, no reduction for attorney fees was permitted where the plan terms stated that the plan ''does not pay for nor is responsible for the participant's attorney's fees. Attorney's fees are to be paid solely by the participant.''[75]

The "Make Whole" Doctrine. In addition to the common fund doctrine, plan beneficiaries often seek to raise the ''make whole'' doctrine in order to limit a health plan's reimbursement right. While many courts have found that the doctrine has no application to ERISA, or is preempted by ERISA, other courts have allowed the doctrine's application to bar an ERISA plan from recovering from a participant's third-party settlement.

Under the make whole doctrine, an insurer's right to subrogation of any proceeds an insured recovers against a third party is limited to the extent that the funds the insurer has paid to the insured, in combination with the proceeds from the insured's recovery from a third party, exceed the insured's actual damages. Therefore, the insurer's right of subrogation can only be exercised if the insured is ''made whole.''

Example: An insurer pays $50,000 to cover an insured's medical expenses following an automobile accident. The insured later recovers $25,000 from the tortfeasor, representing the tortfeasor's automobile insurance policy limits. The insured is not ''made whole'' by the settlement because his or her medical expenses exceeded the settlement amount, not to mention any other losses the insurer may have incurred such as attorneys' fees and lost wages.

Example: An insurer pays $50,000 to cover an insured's medical expenses following an automobile accident. The insured later recovers a $100,000 settlement from the tortfeasor. The insured may argue that he or she was not ''made whole'' by the $100,000 settlement because the settlement covers not only medical expenses incurred, but future medical expenses, lost wages, and attorneys' fees.

Court decisions. The federal courts have not adopted a uniform approach to the make whole doctrine in the ERISA context. While some courts have barred the application of the doctrine in ERISA cases, other courts have permitted use of the doctrine under some circumstances. The following cases illustrate the approaches of some of the courts to have reached the issue.

First Circuit. The U.S. Court of Appeals for the First Circuit ruled in *Harris v. Harvard Pilgrim Health Care Inc.*[76] that when the terms of an ERISA plan give the plan the unqualified right to reimbursement, the plan will not be obligated under the make whole doctrine to demonstrate that the participant's third-party settlement fully compensated the participant.

In *Harris*, an ERISA health plan paid $102,874 toward a participant's medical costs after the participant was involved in a motorcycle accident. The participant brought a tort action against the party responsible for the accident and settled the lawsuit for $737,000, of which $264,727 went towards his attorneys' fees and costs. According to the court, the lawsuit was purportedly settled at two-thirds its estimated value. The participant argued that, because his settlement amounted to only two-thirds of its estimated value, he was not made whole and therefore he was not required to reimburse the plan.

Ruling for the plan, the First Circuit said, ''Where an ERISA plan requires—*without qualification*—that plan participants reimburse the plan for benefits paid, the plan should not be construed to depend upon an implied contingency such as the 'make whole' doctrine, particularly since ERISA specifically envisions that covered plans be written in straightforward language comprehensible by the average plan participant.'' The court also noted that if the make whole doctrine were adopted, participants such as the participant involved in the case might benefit financially, but ''ultimately the costs would be borne by all other plan members in the form of higher premiums for coverage.

Fourth Circuit. In the unpublished opinion of *Paris v. Iron Workers Trust Fund* (*In re* Paris),[77] the U.S. Court of Appeals for the Fourth Circuit declined to adopt the make whole doctrine as a matter of federal common law in ERISA cases where ERISA-governed plans' subrogation clauses unambiguously give the plans the right of reimbursement against plan participants without regard to whether participants are made whole by third-party tort settlements.

In *Paris*, a health fund paid over $200,000 in medical benefits to a plan participant after he was involved in an automobile accident. The fund entered a subrogation agreement with the participant's guardian that obligated the participant to ''reimburse the Fund up to the full amount of the recovery for the full amount of loss of . . . benefits received.'' The participant settled his third-party tort action for $100,000, which was the tortfeasor's insurance coverage limit. The participant then filed an action in a Maryland state court contending that the fund was not entitled to assert its right of subrogation because the participant was not made whole by the third party settlement. The case was removed to federal court.

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[71] *Ryan by Capria-Ryan v. Federal Express Corp.*, 78 F.3d 123, 19 EBC 2889 (3d Cir. 1996).

[72] *Walker v. Wal-Mart Stores*, 159 F.3d 938, 22 EBC 2150 (5th Cir. 1998)(administrators had discretion); United McGill Corp. v. Stinnett, 154 F.3d 168 (4th Cir. 1998) (administrators had discretion).

[73] *Green v. Hotel Employees & Restaurant Employees Int'l Welfare-Pension Funds*, 1997 U.S. App. LEXIS 401 (9th Cir. 1997).

[74] *Harris v. Harvard Pilgrim Health Care*, 208 F.3d 274, 24 EBC 1432 (1st Cir. 2000) (no direction to plan administrators).

[75] *Varco*, 338 F.3d at 689.

[76] *Harris v. Harvard Pilgrim Health Care* Inc., 208 F.3d 274, 24 EBC 1432 (1st Cir. 2000).

[77] *Paris v. Iron Workers Trust Fund* (In re Paris), 211 F.3d 1265, 24 EBC 2547 (4th Cir. 2000).

The Fourth Circuit rejected the participant's argument, declining to adopt the make whole doctrine in ERISA cases. Comparing ERISA plans to ordinary insurance contracts, the appeals court said, ''Applying the same doctrines and rules of construction to ERISA contracts that generally apply to insurance contracts, such as the make whole doctrine or the rule requiring courts to construe insurance contracts strictly against their drafters, would frustrate the purposes of ERISA.''

Sixth Circuit. The U.S. Court of Appeals for the Sixth Circuit has addressed the make whole doctrine in the ERISA context on several occasions. In *Copeland Oaks v. Haupt*,[78] the Sixth Circuit found that the make whole doctrine is a default rule and that ERISA plans may disavow the rule only if the plan clearly establishes both the plan's priority and the plan's right to any full or partial recovery from a participant's third-party settlement.

In *Copeland Oaks*, an ERISA plan paid $300,000 in medical expenses for a plan participant's minor daughter. Although the participant and his daughter signed a subrogation agreement, after they settled their claim with the third-party tortfeasor for $100,000, the daughter disaffirmed the subrogation agreement based on her noncapacity as a minor to enter into the agreement. The plan then sued, seeking a declaratory judgment that it was entitled to the $100,000.

Ruling for the participant and his daughter, the Sixth Circuit found that the plan was precluded from exercising its rights to subrogation because the daughter was not ''made whole'' by the settlement. In so ruling, the court found that the plan's subrogation language failed to state that the plan had a priority right over any partial recovery received by the participant and his daughter. ''[I]n order for plan language to conclusively disavow the default [make whole] rule, it must be specific and clear in establishing *both* a priority to the funds received *and* a right to any full or partial recovery. In the absence of such clear and specific language rejecting the make whole rule—with clarity and specificity ultimately determined by the reviewing court—it is arbitrary and capricious for a plan administrator not to apply the default,'' the court said.[79]

In *Hiney Printing Co. v. Brantner*,[80] the Sixth Circuit reiterated that an ERISA plan's failure to clearly disavow the make whole doctrine in its subrogation and reimbursement provisions precludes the plan from enforcing the provisions against a participant who was not made whole in her third-party tort settlement.

In *Hiney*, a plan participant incurred $57,106 in medical expenses after she was injured in an automobile accident. Due to her injuries, the participant was rendered disabled and unable to return to work. According to the court, the participant's estimated future lost earnings exceeded $200,000. The participant eventually settled her tort action for $103,000 and the plan asserted a subrogation and reimbursement claim seeking $36,708 the plan had paid for the participant's medical expenses.

Relying primarily on *Copeland Oaks*, the court found that although the plan's subrogation clause established first priority to any funds recovered from a third party, the plan did not unambiguously establish a right to any full or partial recovery. The Sixth Circuit rejected the plan's argument that the make whole rule, while it applied to the plan's subrogation clause, did not apply to the plan's reimbursement clause. ''While subrogation and reimbursement are distinct doctrines, we see no principled reason for treating them differently when it comes to the default application of the make-whole rule to ambiguous provisions,'' the court said.

Seventh Circuit. In *Cutting v. Jerome Foods Inc.*,[81] the U.S. Court of Appeals for the Seventh Circuit ruled that an ERISA plan could recover its subrogation interests from a plan participant, despite the fact the participant was not made whole by a third-party tort settlement.

The participant in *Cutting* incurred $90,000 in medical expenses and recovered a $126,000 tort settlement. The participant alleged that her total damages exceeded $1 million, and thus the settlement had not made her whole. Citing the make whole doctrine, the participant refused to reimburse the plan for the $90,000 it had paid in medical claims.

Ruling for the plan, the Seventh Circuit rejected the participant's contention that the court should adopt a federal common law rule to the effect that rights of subrogation are enforceable only after the plan beneficiary has been made whole for the loss giving rise to the claim for benefits. In so ruling, the court found that the make whole doctrine may be overridden by clear language in the plan and, in this case, the plan stated ''rather flatly'' that the plan shall be subrogated to ''all claims'' by the covered individual against a third party ''to the extent of 'any and all payments' made (or to be made) by the plan.''

Eighth Circuit. The U.S. Court of Appeals for the Eighth Circuit rejected the make whole doctrine in the ERISA arena in *Waller v. Hormel Foods Corp*.[82] In *Waller*, an ERISA health plan paid over $157,000 for a participant's automobile accident-related medical expenses. After the participant received a $200,000 settlement, the plan, citing its subrogation provision, demanded full reimbursement from the settlement proceeds. The participant objected to the plan's demand, arguing that because she was not made whole by the settlement, the plan had no right of subrogation.

The Eighth Circuit found that employer-funded medical benefit plans should not automatically be read to include the make whole doctrine. Unlike insurance policies, where the insured purchases a policy with the understanding that he or she will be made whole, employer-funded medical benefits are not provided to the employee with the same understanding as between the insured and the insurer, the court said. In addition, the court found that the absence of specific language granting the plan ''first priority'' did not preclude the plan's subrogation recovery.

Ninth Circuit. The U.S. Court of Appeals for the Ninth Circuit in *Barnes v. Independent Automobile Dealers Association*[83] adopted the make whole doctrine as federal common law rule in ERISA cases.

The participant in *Barnes* incurred $23,075 in medical expenses and received a $25,000 settlement. When

[78] *Copeland Oaks v. Haupt*, 209 F.2d 811, 24 EBC 1357 (6th Cir. 2000).

[79] *Id.*

[80] *Hiney Printing Co. v. Brantner*, 243 F.3d 956, 25 EBC 2233 (6th Cir. 2001).

[81] *Cutting v. Jerome Foods Inc.*, 993 F.2d 1293, 16 EBC 2492 (7th Cir. 1993).

[82] *Waller v. Hormel Foods Corp.*, 120 F.3d 138, 21 EBC 1390 (8th Cir. 1997).

[83] *Barnes v. Independent Auto. Dealers Ass'n*, 64 F.3d 1389, 19 EBC 1958 (9th Cir. 1995).

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her health plan asserted a subrogation right to the settlement monies, the participant argued that the plan was barred from recovering from the settlement because she was not made whole by the settlement in that her total damages exceeded $65,000.

The Ninth Circuit found that the plan at issue did not spell out what rights the plan had when a participant was not made whole by a settlement. ''Because the Plan is silent on this point, and because ERISA does not include a specific provision to resolve such questions, this court 'ha[s] the authority, indeed the obligation, to adopt a federal rule—that is, a rule that best comports with the interests served by ERISA's regulatory scheme,' '' the court said. In addition, the court found that the make whole doctrine is supported by substantial authority in existing insurance law, and it is consistent with ERISA's purpose of protecting participants in employee benefit plans.

Eleventh Circuit. In *Cagle v. Bruner*,[84] the U.S. Court of Appeals for the Eleventh Circuit ruled that, under the make whole doctrine, an ERISA plan could not seek subrogation from a participant until the plan first paid the participant's complete claim.

In *Cagle*, a health plan paid for a plan beneficiary's emergency room expenses, but declined to pay for the beneficiary's eight months of rehabilitative treatment unless the beneficiary's mother first signed a subrogation agreement. When the mother refused to sign the agreement, the plan sued the beneficiary and the mother asking a federal court to declare that the beneficiary and the mother were required to execute the plan's standard subrogation agreement.

The Eleventh Circuit found that the plan had the right to require the beneficiary and his mother to sign the subrogation agreement before it paid for the beneficiary's medical claims. But the court also held that the make whole doctrine should be treated as a default rule that is read into insurance contract, except where it is explicitly excluded. In this case, the plan's subrogation clause did not specifically reject the make whole doctrine, and thus the doctrine applied to the case, the court ruled.

In the unpublished decision of *Adelstein v. Unicare Life & Health Insurance Co.*,[85] the Eleventh Circuit found that an ERISA plan participant was not insulated under the make whole doctrine from reimbursing a plan for expenses the plan paid on behalf of the participant's child where the participant engaged in misconduct by failing to inform the plan of a third-party tort action. According to the court, nothing in the make whole doctrine ''authorizes an insured to freely and intentionally breach his obligations and duties to the insurer under an insurance contract without consequence.''

[84] *Cagle v. Bruner*, 112 F.3d 1510, 21 EBC 1113 (11th Cir. 1997).

[85] *Adelstein v. Unicare Life & Health Ins. Co.*, 27 EBC 1370 (11th Cir. 2002).