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Timing Is Everything: New Rules for Enforcing Medical Plan Reimbursement Rights

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Disputes about medical plan reimbursement clauses, (often referred to as "subrogation" clauses) have probably launched the careers of a thousand ERISA lawyers. The flood of these complicated medical plan reimbursement disputes has triggered a series of US Supreme Court decisions. Just 10 years ago, there was serious doubt as to whether medical plan reimbursement clauses could be enforced at all. Ultimately, the Supreme Court ruled that these group medical plan reimbursement provisions can be enforced by the federal

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law regulating employer-sponsored employee benefit plans—the Employee Retirement Income Security Act (ERISA).

The Supreme Court seems to accept one case each year on the issue of how equitable relief works under ERISA Section 502(a)(3).[1] Until 2006, it was doubtful whether subrogation clauses in medical plans were enforceable. The Supreme Court resolved the issue with a resounding "yes," in *Sereboff v. Mid Atlantic Medical Servs., Inc*.[2] However, since then the Supreme Court has made it clear that plan sponsors must carefully craft a medical plan's subrogation clauses, and this year ruled they must act promptly to enforce their reimbursement rights or risk losing them.

Carefully Crafted Subrogation Clauses Are Enforceable

In the wake of *Sereboff*, medical plan sponsors took comfort that the reimbursement provisions in their plans were enforceable. However, on April 16, 2013, the Supreme Court made it clear that in order to be enforced, plan language had to be very specific. In *U.S. Airways, Inc. v. McCutchen, et al*.,[3] the Supreme Court answered the question: Can a plan participant limit the ability of the medical plan to recover advanced medical expenses under the "common fund" or "make whole" equitable doctrines?

In *U.S. Airways v. McCutchen*, the Supreme Court resolved a circuit split about whether claims of unfairness, or equitable defenses, can override an ERISA medical plan's reimbursement provision. The Supreme Court has analyzed subrogation clauses as both questions of contract and questions of equity. In *McCutchen*, James McCutchen, a medical plan participant who did not like the plan's repayment demands, asked the Supreme Court to use equity to rewrite his medical plan contract. After considering what the phrase "appropriate equitable relief" means under ERISA Section 502(a)(3), the Supreme Court responded with a resounding "No."

What Is 'Appropriate Equitable Relief'?

A series of Supreme Court decisions provide guidance as to what constitutes "appropriate equitable relief" under ERISA Section 502(a)(3).

Mertens v. Hewitt Assocs

In *Mertens v. Hewitt Assocs*.,[4] the Supreme Court interpreted ERISA Section 502(a)(3) to prevent nonfiduciary plaintiffs from seeking "appropriate equitable relief." "Appropriate equitable relief," the Supreme Court ruled, only includes those categories of relief "typically

available in equity" in the days of "the divided bench." The *Mertens* plaintiffs were former employees who participated in the Kaiser Steel Corporation retirement plan. Defendant Hewitt Associates, the Kaiser plan's actuary, was sued as a nonfiduciary that participated in a fiduciary's (Kaiser's) breach. The Court ruled that ERISA does not permit suits for money damages against nonfiduciaries that knowingly participate in a breach. The Court further explained that injunction, *mandamus*, and restitution were the typical remedies available in equity, and compensatory damages, like monetary relief, was not an equitable remedy.

Varity Corp. v. Howe

On the heels of the Supreme Court's *Mertens* decision, courts generally recognized traditional forms of equitable relief such as injunction and restitution as available under ERISA Section 502(a)(3) and ruled that monetary relief was not a remedy available under this subsection. Three years after *Mertens*, however, in *Varity Corp. v. Howe,*[5] the Supreme Court changed course. It decided that ERISA Section 502(a)(3) permitted personal relief for breach of fiduciary duty in a case in which the lower courts found that the plan administrator had affirmatively misled plan participants about retiree medical and severance plan benefits. The Court indicated that when misrepresentations to ERISA plan participants are made by a fiduciary, both monetary damages and reformation of the plan were available as equitable relief.

Following *Varity*, confusion reigned. Some courts proceeded toward monetary relief as equitable relief under ERISA Section 502(a)(3) by characterizing economic damages as "restitution." Not surprisingly, soon a circuit split developed over the issue of whether monetary relief was "appropriate equitable relief" under Section 502(a)(3).

Great-West Life & Annuity Ins. v. Knudson

Over the course of the next 10 years, the Supreme Court issued two decisions to resolve this "appropriate equitable relief" controversy: *Great-West Life & Annuity Ins. v. Knudson*,[6] and *Sereboff v. Mid Atl. Med. Servs., Inc*.[7] In *Great-West v. Knudson,* Jannette Knudson was in a car accident that left her as a quadriplegic. Under her husband's medical plan, $411,157.11 of her medical expenses were covered. In 1993, the Knudsons filed a tort lawsuit in California state court against the car manufacturer and others. The parties negotiated a $650,000.00 settlement that allocated $256,745.30 to a special needs trust, $373,426.00 to attorney fees and costs, $5,000.00 to reimburse the California Medicaid Program, and $13,828.70 to reimburse Great-West's subrogation claim under the plan. Notice of the settlement was sent to Great West.

But Great-West never cashed the $13,828.70 check. Instead, it filed action in the Central District of California seeking injunctive and declaratory relief under ERISA Section 502(a)(3).[8] Great-West sought to enforce the plan's subrogation provisions and asked the court to require the Knudsons to pay the plan $411,157.11 of any proceeds recovered from third parties. The plan's reimbursement provision gave it a "first lien upon any recovery, whether by settlement, judgment, or otherwise" that a beneficiary received from a third party.

Great-West lost its battle for reimbursement. The Supreme Court ruled that Great West could not recover "restitution" in the form of money from the Knudsons personally because this would be the equivalent of a suit for legal relief for breach of contract. The Supreme Court explained that a plaintiff could seek restitution in equity as a constructive trust or an equitable lien when "money or property identified as belonging in good conscience to the plaintiff could clearly be traced to particular funds or property in the defendant's possession." Here, that was not possible because the settlement funds were not in Knudson's possession but were distributed to the special needs trust and her attorney; Great-West was seeking "some funds" but not the exact funds recovered from the third party.

Sereboff v. Mid Atlantic Medical Services, Inc.

Because the federal courts of appeals disagreed about whether a medical plan could enforce its repayment provisions, the U.S. Supreme Court soon decided *Sereboff v. Mid Atlantic Medical Services, Inc.* Marlene and Joe Sereboffs suffered injuries in a car accident. The Mid Atlantic plan paid their associated medical bills. The Sereboffs filed a tort lawsuit in state court against several third parties. After the tort action was filed, Mid Atlantic sent the Sereboffs' attorney several letters asserting a $75,000 lien on the anticipated proceeds from the lawsuit for the Mid Atlantic plan's medical expenses. The Sereboffs ultimately settled their tort suit for $75,000, but the Sereboffs' and their attorney never sent Mid Atlantic the $75,000 it sought as reimbursement.

Mid Atlantic then filed suit against the Sereboffs in federal court in Maryland under ERISA Section 502(a)(3). Mid Atlantic sought the $75,000 in medical expenses it had paid on their behalf. Because the Sereboffs' attorney had already paid out the settlement proceeds to the Sereboffs, Mid Atlantic sought a temporary restraining order and preliminary injunction mandating that the Sereboffs retain and set aside at least $75,000 from the settlement proceeds. The district court approved a stipulation by the parties to "preserve $75,000" of the settlement funds in an investment account until the court ruled on the merits of the case and all appeals, if any, were exhausted.

On the merits, both the district court and the US Court of Appeals for the Fourth Circuit found in Mid Atlantic's favor and ordered the Sereboffs to pay Mid Atlantic $75,000 plus interest, with a deduction for Mid Atlantic's share of the attorney fees and court costs the Sereboffs had incurred in state court.

Chief Justice Roberts, writing for a unanimous Supreme Court, ruled that enforcing a medical plan's repayment agreement qualifies as "equitable" relief under ERISA. *Sereboff* begins with a description of the plan's terms:

> The plan provides for payment of certain covered medical expenses and contains an "Acts of Third Parties" provision. This provision "applies when [a beneficiary is] sick or injured as a result of the act or omission of another person or party," and requires a beneficiary who "receives benefits" under the plan for such injuries to "reimburse [Mid Atlantic]" for those benefits from "[a]ll recoveries from a third party (whether by lawsuit, settlement, or otherwise)…." The provision states that "[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."

For Chief Justice Roberts, the medical plan acted properly by enforcing its repayment provision because it "follow[ed]" the money that the Sereboffs had obtained in the settlement. This holding indicates that because ERISA plans are in essence contracts, they can use equitable remedies to enforce their terms. To paraphrase the Supreme Court, an ERISA-regulated medical plan's contractual agreement for repayment can be enforced through "equity" under ERISA Section 502(a)(3) by filing an action for an equitable lien or for a constructive trust.

The Court left an opening for future litigants to argue that the contract-based relief Mid Atlantic requested was "equitable" but not "appropriate" under ERISA Section 502(a)(3) because it contravened principles like the "make-whole doctrine."

U.S. Airways, Inc. v. McCutchen

In *McCutchen*, the Supreme Court considered the meaning of the word "appropriate" in the context of ERISA Section 502(a)(3). In January 2007, James McCutchen was seriously injured when a driver lost control of her car and collided with his car. McCutchen, a participant in the U.S. Airways self-funded medical plan, had $66,866 in medical expenses arising from the accident paid on his behalf by the U.S. Airways plan. The U.S. Airways plan contained a standard subrogation provision that required plan participants to reimburse the plan "out of any monies

recovered from a third party." McCutchen successfully sued third parties and recovered a total of $110,000. After deducting his lawyer's fee, he was left with $66,000. The U.S. Airways plan demanded repayment of the $66,866 it had paid in medical expenses on McCutchen's behalf. However, he refused to repay the medical plan.

The fiduciaries for the U.S. Airways plan sued McCutchen, seeking to enforce the plan's reimbursement provision. McCutchen argued to the trial court that because the plan did not contribute any share of the costs that McCutchen incurred to obtain his recovery from the third parties, the plan's reimbursement must be reduced by 40 percent to cover the contingency fee he paid his attorneys. Rejecting McCutchen's arguments, the district court granted summary judgment to the group medical plan because the plan "clear[ly] and unambiguous[ly]" provided for full reimbursement of medical expenses paid. The US Court of Appeals for the Third Circuit reversed. It instructed the district court to determine what amount would qualify as "appropriate equitable relief" for McCutchen under ERISA. It viewed the reimbursement of the full $66,866 to the medical plan as inequitable to McCutchen because McCutchen would be left with less than full payment for his medical bills while U.S. Airways recovered a windfall because it did not have to contribute at all to the cost of obtaining the settlement.

In a 5 to 4 decision, the Supreme Court reversed the Third Circuit. It ruled that the written terms of the medical plan prevail over any potential equitable considerations or equitable defenses such as the "common fund" or "make whole" doctrines. The Supreme Court's decision, however, did not end there. It found a "contractual gap" in the U.S. Airways Group Medical Plan. The plan's reimbursement provision did not indicate how to allocate the costs of recovery. Because the U.S. Airways plan was silent about this issue, the majority ruled that the common-fund doctrine provided the best indication of the parties' intent. Applying the common-fund doctrine would mean that McCutchen's attorney fees must be paid before the medical plan was reimbursed.

The four dissenting justices agreed with the majority that the written terms of the medical plan take precedent over any potential equitable considerations or defenses. But, they opined, that should have been the end of the discussion. The dissent found that the "contractual gap" analysis provided by the majority was neither helpful nor necessary. According to the dissent, the issue of whether the plan was ambiguous as to attorney fees was not before the court. As a result, there was no basis for the court to apply the common-fund doctrine.

The rule adopted by this decision is that the written terms of the ERISA medical plan will prevail over potential equitable defenses. Plan sponsors that seek to avoid the potential application of the common fund doctrine, or other equitable defenses, can do so by expressly stating so in the subrogation clause. The *McCutchen* court

ruled unanimously that when a plan expressly rejects equitable defenses, the plan's written terms will control.

Medical Plans That Sit on Their Reimbursement Rights Might End up Unintentionally Footing the Bill

On January 20, 2016, the Supreme Court clarified what must constitute the nature of the underlying remedies sought in a Section 502(a)(3) subrogation claim. Specifically, the Court considered the issue of whether a medical plan can recoup reimbursement from a plan participant's general assets when the participant has spent the monies contained in his settlement fund on nontraceable goods and services.

Just as in *Great-West*, *Sereboff,* and *McCutchen*, the dispute in *Montanile v. Board of Trustees of the National Elevator Industry Health Benefit Plan*[9] arose out of a car accident. Robert Montanile's vehicle was hit by a drunk driver who ran a stop sign. Montanile had at least $121,044.02 of his initial medical care paid for by a health plan administered by the Board of Trustees of the National Elevator Health Benefit Plan, in which he was a participant. The National Elevator plan contained a reimbursement provision that stated: "Amounts that have been recovered by a [participant] from another party are assets of the Plan … and are not distributable to any person or entity without the Plan's written release of its subrogation interest." It further stated that "any amounts" that a participant "recover[s] from another party by award, judgment, settlement, or otherwise … will promptly be applied first to reimburse the Plan in full for benefits advanced by the Plan … and without reduction for attorney fees, costs, expenses, or damages claimed by the covered person." Montanile signed a reimbursement agreement that reaffirmed his responsibility to reimburse the National Elevator plan for any recovery he secured "as a result of any legal action or settlement or otherwise."

Montanile filed a state court claim against the drunk driver and also made a claim for uninsured motorist benefits under his own car insurance. After reaching a $500,000 settlement, Montanile divided up the settlement proceeds as follows: $200,000 in attorney fees and $60,000 to repay an advance received from his attorneys. Of the remaining $240,000, most was held in a client trust account by Montanile's attorneys. The Board of Trustees of the National Elevator Plan sought reimbursement from Montanile for the money spent on his medical expenses. Montanile's attorney disputed the claim. After trying to reach an agreement about reimbursement, discussions broke down. Montanile's attorney then informed the Board that, unless he received an objection within 14 days, he would release the remaining settlement

funds directly to Montanile. When the Board failed to respond, Montanile was paid out the remainder of the settlement funds.

Six months later, the Board sued Montanile seeking reimbursement for the $121,044.02 the National Elevator plan had paid for his medical expenses. The Board brought a claim in federal district court under ERISA Section 502(a)(3). The Board sought to enforce an equitable lean against any settlement funds or property in Montanile's possession and sought to enjoin Montanile from spending any of those funds.

The district court granted summary judgment in favor of the Board. In doing so, it rejected Montanile's argument that he had already spent almost all of the settlement funds, so there was no specific, identifiable fund against which the Board's equitable lien could be enforced. Even if Montanile had already spent some, or even all, of the settlement funds, the district court ruled that the Board should be reimbursed from Montanile's general assets. The US Court of Appeals for the Eleventh Circuit affirmed, reasoning that a dissipation of the specific fund to which a lien is attached cannot destroy the participant's underlying obligation to reimburse a plan.

The Supreme Court reversed. The Supreme Court first walked through the analysis of what kind of relief constitutes "equitable relief" for purpose of Section 502(a)(3). After reviewing the Section 502(a)(3) analysis set forth in *Great-West*, *Sereboff*, and *McCutchen*, the Court ruled that the Board's claim in this instance was equitable:

> Under these principles, the basis for the Board's claim here is equitable: The Board had an equitable lien by agreement that attached to Montanile's settlement fund when he obtained title to that fund. And the nature of the Board's underlying remedy would have been equitable had it immediately sued to enforce the lien against the settlement fund then in Montanile's possession.[10]

The Court recognized, however, that a novel issue existed in the *Montanile* case. That is, "whether a plan is still seeking an equitable remedy when the defendant, who once possessed the settlement fund, has dissipated it all, and the plan then seeks to recover out of the defendant's general assets."[11]

The Supreme Court began its analysis by looking at the law of equity. Under traditional equitable principles, "a plaintiff could ordinarily enforce an equitable lean only against specifically identified funds that remain in defendant's possession or against traceable items that the defendant purchased with the funds (*e.g.*, identifiable property like a car.)" Thus, if the defendant has spent the identifiable fund on nontraceable items like food or travel, he has destroyed the equitable lien. The plaintiff is then only left with a legal remedy—bringing a personal claim against the defendant's general assets.

The Board made three arguments supporting its claim that it can enforce an equitable lien against Montanile's general assets. Each was rejected. First, the Board argued that the general rule that a lien must be attached to a "specific, identifiable fund" has an exception when the parties have entered into an agreement with respect to the equitable lien. But the Supreme Court ruled that an equitable lien by agreement does not eliminate the entity asserting the lien from identifying the specific fund in the other party's possession against which the lien will be enforced.

Next, the Board argued that, historically, equity courts employed practices that would support an equitable lien against general assets, including substitute money decrees, deficiency judgments, and the swollen assets doctrine. But the Supreme Court was not convinced, noting that equity courts had the authority to award certain legal remedies as part of their ancillary jurisdiction to award complete relief and, that when an equity court awards money decrees as a substitute for the value of an equitable lien, it was still awarding a legal remedy. "[L]egal remedies—even legal remedies that a court of equity could sometimes award—are not 'equitable relief' under Section 502(a)(3)."[12]

Last, the Board argued that the goal of ERISA, to enforce plan documents in accordance with their terms and to protect plan assets, would best be served by allowing a plan to enforce an equitable lien against a participant's general assets. Generalized arguments about the purpose of ERISA have been made in the past, and the Supreme Court was not persuaded. The Court noted that if Congress had wanted to advance the policy rationale set forth by the Board in the Section 502(a)(3) context, it could have mirrored the relief available in other ERISA actions. But it did not. Furthermore, the Court noted that "our interpretation of Section 502(a)(3) promotes ERISA's purposes by allocat[ing] liability for plan-related misdeeds in reasonable proportion to respective actors' power to control and prevent the misdeeds."[13]

The Supreme Court remanded the case back to the district court to determine whether Montanile kept his settlement fund separate and apart from his general assets and whether he spent the entire fund on nontraceable assets.

Seven Steps

Group medical plan sponsors need to review their subrogation and reimbursement provisions to make sure these clauses assert constructive trusts or equitable liens on any third-party recovery. Second, these clauses should state any recovery by a plan participant or beneficiary will be promptly applied to first reimburse the plan for any benefits advanced by the plan. Third, these clauses should state the plan is first in line in the event of a recovery from a third-party—before attorneys,

court costs, expenses, and damages are paid. Fourth, plan participants should be required to notify the plan and obtain the plan's consent before settling third-party claims. Fifth, once a group medical plan sponsor has been notified of a settlement, it should immediately seek reimbursement from the participant. Sixth, if a participant hesitates, the plan should request that the participant agree to not spend the settlement funds until the reimbursement issue has been resolved. Seventh, if the participant refuses, the plan must take appropriate legal measures to secure a lien on the settlement proceeds so as to prevent them from being dissipated.

Notes

1. 29 U.S.C. § 1132(a)(2).
2. *Sereboff v. Mid Atlantic Medical Servs., Inc.*, 547 U.S. 356 (2006).
3. *U.S. Airways, Inc. v. McCutchen, et al.*, 569 U.S. ___, 133 S.Ct. 1537 (2013).
4. *Mertens v. Hewitt Assocs.*, 508 U.S. 248 (1993).
5. *Varity Corp. v. Howe,* 516 U.S. 489 (1996).
6. *Great-West Life & Annuity Ins. v. Knudson*, 534 U.S. 204 (2002).
7. *Sereboff v. Mid Atl. Med. Servs., Inc.*, 547 U.S. 356 (2006).
8. 29 U.S.C. § 1132(a)(3).
9. *Montanile v. Board of Trustees of the National Elevator Industry Health Benefit Plan*, ___ U.S. ___, 136 S.Ct. 651 (2016).
10. *Id.,* Slip op. p.7.
11. *Id.*
12. *Id.* at 12.
13. *Id.* at 13 (internal citations omitted).