EIGHT WAYS TO DEFEAT OR MINIMIZE ERISA REIMBURSEMENT CLAIMS

By Roger M. Baron[1]

Reimbursement claims by ERISA plans continue to impede the efforts of Plaintiffs' attorneys who try to secure just and fair settlements for their clients. The recent U.S. Supreme Court decision in *Mid Atlantic Medical Services, Inc. v. Sereboff*[2] has cast a shadow on this area of the law; as a result, many ERISA plans have become even more aggressive in seeking full reimbursement. Yet, critical issues remain viable in defending against these claims. Eight such issues are addressed below.

1. Make Certain the Plan Language Actually Creates a Lien

Prior to the Supreme Court's decision in *Sereboff*, it was unclear as to whether or not an ERISA plan could even state a claim for "appropriate equitable relief" under § 502(a)(3)(B) of ERISA. Extensive briefing in *Sereboff* by the ERISA plan and amicus curie suggested that the plan's cause of action was one which was in the nature of an equitable subrogation action. Somewhat surprisingly, the Supreme Court rejected this idea, holding rather that the plan's cause of action is one for the enforcement of a lien created by contract. The Court followed the precedent set in its 1914 opinion in the case of *Barnes v. Alexander*.[3] In the unanimous decision, Chief Justice Roberts stated the following:

> But Mid Atlantic's claim is not considered equitable because it is a subrogation claim. As explained, Mid Atlantic's action to enforce the 'Acts of Third Parties' provision qualifies as an equitable remedy because it is indistinguishable from an action to enforce an equitable lien

> established by agreement, of the sort epitomized by our decision in *Barnes*.[4]

This holding has a significant impact on pending cases because many ERISA plans have not included language in their plan documents which is adequate to create a lien on settlement proceeds. Some of these plan documents are fairly thorough in many respects, but they fall short of using language that effectively creates a lien on settlement proceeds. In a recent post-*Sereboff* decision, the 11th Circuit Court of Appeals acknowledged that language in the plan document did indeed create an obligation to repay but that the language was only a "trigger" which imposed an obligation and was otherwise insufficient to actually create a lien on the settlement proceeds. Reimbursement was denied.[5]

2. Determine Whether the Plan Language Sufficiently Negates the "Make Whole" Doctrine

The "make whole" doctrine invokes the notion that the injured person should be first fully compensated for her injuries before subrogation or reimbursement for medical expenses will be permitted. The "make whole" doctrine has been widely adopted among the states, as a matter of state law. In federal court, it has evolved along a different path. The "make whole" doctrine currently exists as a matter of "federal common law" in situations where the plan document does not specifically negate or override the "make whole" principle. This has been described as a "default" rule. As recently explained by the federal district court for the Northern District of Georgia,

> If the plan does not include language explicitly providing the fund with a right to first recovery even when a participant or beneficiary is not made whole, the fund cannot avoid the application of the make whole doctrine.

> Standard subrogation language providing the fund the right to seek repayment of settlement or other funds obtained from a third party is not a sufficient explicit rejection of the make whole doctrine.[6]

In a more recent decision, the Western District Court for Washington applied the "make whole" doctrine as a "gap filler" provided by "federal common law," stating,

> Nowhere in the plan language is there a suggestion, let alone a clear statement, that a plan beneficiary is signing away his or her make whole rights. Neither the make whole doctrine nor any euphemism sounding like the make whole doctrine is mentioned in the plan.[7]

Notably, both of these cases were decided after *Sereboff*.

3. Are There Traditional Equitable Defenses?

With the *Sereboff* decision, we know that an ERISA plan may pursue an equitable remedy for the enforcement of an equitable lien arising out of contract. The issue which was resolved in *Sereboff* was narrow. In fact, the Court confined itself to the following: "The only question is whether the relief Mid Atlantic requested from the District Court was 'equitable' under § 502(a)(3)(B)."[8]

Given *Sereboff*'s recognition of a remedy under the *Barnes* rationale, it now becomes relevant to explore whether or not any traditional equitable defenses might apply in any given case. The U.S. Supreme Court itself has recognized a number of traditional equitable defenses over the years. There is an established body of case law in the Supreme Court data base alone which deals with those defenses. For example, under appropriate facts, an ERISA beneficiary may be able to assert the defense of *laches,*[9] the defense of *equity will not aid in the enforcement of a forfeiture,*[10] or the defense of *unclean hands*.[11]

4. Invoke the Disposition of Ahlborn (pro rata loss sharing) as "Appropriate Equitable Relief"

Sereboff holds that an ERISA plan may seek "appropriate equitable relief" under § 502(a)(3)(B) of ERISA. Just exactly what constitutes "appropriate equitable relief" was not, however, addressed in *Sereboff*. This remains to be decided by the courts on a case by case basis. There is a significant school of thought suggesting that the "pro rata loss sharing" method represents an equitable solution, including a very recent endorsement of this method by the U.S. Supreme Court. To illustrate this method, assume that the amount needed to compensate the beneficiary for all damages is $ 400,000. If we further assume that she is only able to recover $100,000, then the most that should be recoverable by the ERISA plan is one-forth or 25% of its payment for medical bills since the beneficiary has been required to accept only 25% of her total damages by way of settlement. The ERISA plan's cause of action should face the same constraint upon recovery as that faced by the beneficiary. This is the exact method which was adopted by the Supreme Court in its unanimous decision in *Arkansas Department of Health and Human Services et al. v. Ahlborn*,[12] decided May 1, 2006. In *Ahlborn*, the Court held that Medicaid reimbursement was limited to only 1/6 of the state's payment for medical bills where the insured collected only 1/6 of her total damages. Furthermore, the Court was implicitly critical of the Arkansas Supreme Court for not rendering an equitable interpretation of Arkansas statutes which dictated this result.[13]

One may question the application of a decision involving Medicaid to an ERISA reimbursement claim. Yet, it was exactly this "equitable" resolution that was discussed in the Oral Argument in *Sereboff*. In the transcript of the oral argument for *Sereboff*, one

can find the following colloquy between Justice Stevens and the attorney for the ERISA plan:

> JUSTICE STEVENS: Well, are you – do you contend it's always applied first to the medical damages? In other words, supposing there was – instead of the $750,000 settlement, it had been $100,000 here. $75,000 was medical, and they had a lot of substantial other claims, pain, suffering, loss of earnings, and so forth. Would you always get your full amount if – if the amount of the settlement is over the amount of the medical expense?
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> MR. COLEMAN: I think we would be entitled to it under the – the terms of the plan.
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> JUSTICE STEVENS: You think that's the equitable rule?
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> MR. COLEMAN: Obviously, in – in doing these things, there's a practical side on – on the business side when they work these things out. But the reason that claim would settle for $100,000 again speaks to the strength of their claim for other kinds of damages.
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> JUSTICE STEVENS: Well, it might be because – it might be because there's contributory negligence, all sorts of things. They might have compromised at 20 cents on the dollar across the board. Why should you get 100 cents when they – when the rest of the recovery only gets 20 – 20 cents?
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> MR. COLEMAN: Again, it's – it's because of the nature of the allocation.
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> JUSTICE STEVENS: That's equitable in your view? What?
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> MR. COLEMAN: It is because –
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> JUSTICE STEVENS: You think that's the equitable rule.
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> MR. COLEMAN: Yes. Courts in equity in – in – modern courts in equity in – in analyzing these types of – of claims have permitted these types of allocation –
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> JUSTICE STEVENS: And some do, but some do not I think.[14]

Importantly, Justice Stevens authored the unanimous *Ahlborn* decision which, at the time of the *Sereboff* oral argument, was under consideration by the Court.[15] It is clear that the Court was in the process of deciding what was "equitable" in the *Ahlborn* case at the same time the Court was entertaining oral argument in *Sereboff*. The decision in *Ahlborn* was handed down on May 1, 2006, just two weeks before the *Sereboff* decision was handed down on May 15, 2006.

As to the prospect of determining what constitutes full compensation for the

injured person, the Court in *Ahlborn* accepted the parties' stipulation on that issue. With respect to the concern raised as to future cases, the *Ahlborn* Court rejected the argument that determination of full compensation would involve an "inherent danger of manipulation" in cases which are settled "without judicial oversight."[16] The Court specifically acknowledged that courts should be able to adopt rules and procedures to address the concern of "manipulation."[17]

5. Expose the Commercial Insurance Connection and Apply State Law to the Insurer which is Underwriting All or Part of the Risk

In the event a traditional insurer is on the risk for the medical bills paid by the ERISA plan, the obligation of that insurer is governed by law of the appropriate state concerning subrogation. In *FMC Corp. v. Holliday*,[18] the Supreme Court held:

> On the other hand, employee benefit plans that are insured are subject to indirect state regulation. An insurance company that insures a plan remains an insurer for purposes of state laws, 'purporting to regulate insurance' after application of the deemer clause [of ERISA]. The insurance company is therefore not relieved from state insurance regulation. The ERISA plan is consequently bound by state insurance regulations insofar as they apply to the plan's insurer.[19]

This principle has been upheld in numerous federal court opinions over the past decade.[20]

It should be noted that the involvement of a regulated insurer may be found as a "reinsurer," an "excess insurer," a "stop gap insurer," or an "umbrella insurer." Also, the fact that a regulated insurer may be on some portion of the risk may not be obvious or even recognizable from the complaint filed in federal court. It may be necessary to undertake "discovery" in order to reveal how much, if any, of the reimbursement claim is

allocated to the commercial insurer.

6. Examine language of Plan Document for Favorable Provisions

In each case, it is important to thoroughly examine the language of plan document. In many situations, the applicable language is from a former era when plan documents were more favorable to beneficiaries. For example, the plan document may itself invoke the common fund principle which requires the ERISA plan to bear its share of the attorney fee incurred by the beneficiary in pursuing the tort settlement. Also, the language in the plan document may not adequately "create" a lien, as discussed in Point 1, *supra*, and/or it may not adequately overcome the "make whole" doctrine, as discussed in Point 2, *supra.*

7. Look for Relevant State Law that Escapes Preemption Because it does not "Relate To" an Employee Benefit Plan

In some situations, favorable state law may still be applicable because that law escapes preemption by ERISA. This occurs when the state law does not "relate to" an employee benefit plan.[21] For example, in *Liberty Corporation v. NCNB National Bank of South Carolina*, 984 F.2d 1383 (4th Cir. 1993), an ERISA plan sought to recover a pro-rata share of $93,829.50 which it paid on medical bills from a settlement of $1,500,000 secured for a wrongful death claim. Under the law of North Carolina, as found in its wrongful death statute, the maximum amount allowable for payment of medical expenses was $1,500. The ERISA plan argued that the state law was preempted by ERISA's preemption clause. The 4th Circuit Federal Court of Appeals disagreed, holding that the

preemption clause did not apply because the wrongful death statute is not a law which "relates to" an employee benefit plan. Furthermore, the wrongful death claim did not belong to the deceased's estate, but rather the claim belonged to the statutory beneficiaries and was not capable of being subrogated.

8. Has there been a Taking of the Beneficiary's Property without Due Process of Law?

Another argument is that an ERISA reimbursement claim, if sustained, would constitute an unconstitutional "taking" of the beneficiary's property, and therefore violate the 5th Amendment.[22] The *Ahlborn* decision recognized that an injured person's cause of action for pain and suffering, lost wages, future lost wages, etc., constituted "property" which was protected under federal anti-lien statutes.[23] The Court specifically rejected the assertions by the State of Arkansas and the United States that it was inappropriate to consider the victim's cause of action "property." In addition to holding that the cause of action (for damages other than medical bills) constituted "property," the *Ahlborn* Court also held the Medicaid reimbursement effort could lawfully "lay claim" to only that portion of the recovery which was allocated to medical bills.[24]

Conclusion

The *Sereboff* case announced the simple rule that an action seeking enforcement of a lien created by contract may indeed be pursued as "appropriate equitable relief." But this holding does little to resolve many other issues regarding the propriety of the reimbursement action itself.

Some of these issues deal with the proper wording of the plan document. The attorney opposing reimbursement would be well-advised to examine the document thoroughly in addition to the appropriate federal case law.

Other issues relate to the merits of the claim. A traditional equitable defense may be warranted. Moreover, resolution of what constitutes "appropriate equitable relief" may lead to a pro rata loss sharing remedy.

Still other issues may be found in connection with the preemption issues underlying ERISA. Favorable state law will apply if that law does not "relate to" an employee benefit plan. Furthermore, favorable state-law anti-subrogation principles may apply via the "savings' clause to commercial insurers that have paid part of the medical expenses. It is also possible that the entire ERISA preemption and enforcement scheme constitutes a deprivation of the plan beneficiary's property without due process of law, in violation of the 5th Amendment.

This Article, admittedly, does not present an exhaustive discussion of every issue that may arise in connection with the litigation of an ERISA reimbursement claim. Hopefully, however, this Article will help attorneys identify some key issues and thereby facilitate just and fair recoveries for the beneficiaries.

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[2] 126 S.Ct. 1869 (2006).

[3] 232 U.S. 117 (1914).

[4] *Sereboff*, 126 S.Ct. at 1877.

[5] Popowski v. Parrott, 461 F.3d. 1367 (11th Cir., 2006). This post-*Sereboff* case consolidated *Parrott* and *BCBS v. Carillo* and ruled for the beneficiary in the *Carillo* case. The plan document in *Carillo* did not specify that reimbursement was to be made from any particular fund. There was no language which specifically created a lien. The language from the plan documents in *Parrott* and *Carrillo* are set forth and contrasted. Although the language for *Carillo* is pretty typical, it fails to establish a lien and therefore fails to fall under the ruling in *Sereboff*.

[6] Smith v. Life Insurance Company of North America, 2006 WL 2842529 (N.D. Ga. Sept. 28, 2006) at *9.

[7] Providence Health System-Washington v. Bush, 2006 WL 3249199 (W.D.Wash. Nov. 8, 2006) at *6.

[8] *Sereboff*, 126 S.Ct. at 1873.

[9] National R.R. Passenger Corp. v. Morgan, 536 U.S. 101, 121-22; 122 S.Ct. 2061, 2077 (2002).

[10] In *Oregon & California Railroad Company v. United States*, 238 U.S. 393 (1915), the Court stated: "And it is a general principle that a court of equity is reluctant to (some authorities say never will) lend its aid to enforce a forfeiture." *Id.* at 420. (applying this principle to the United States Government's attempt to enforce a forfeiture provision found in a public land grant). *See also Hobbs v. Head & Dowst Company*, 231 U.S. 692, 701 (1914) ("Certainly it is an inadequate ground for the intervention of equity to enforce forfeiture of a claim that could not be defeated, if at all, except by a most technical application of the law . . . .") (applying this principle to bankruptcy trustee's attempt to challenge, on technical grounds, state court's award of mechanic's lien).

[11] Precision Instrument Mfg. Co. v. Automotive Maintenance Machinery Co., 324 U.S. 806, 814 (1945).

[12] 126 S.Ct. 1752, 74 U.S.L.W. 4214 (2006).

[13] *See Ahlborn*, 126 S. Ct. at 1760 ("That this is what the Arkansas statue requires has been confirmed by the State's Supreme Court. In *Arkansas Dept. of Human Servs. v. Ferrel*, 336 Ark. 297, 984 S.W.2d 807 (1999), the court refused to endorse an equitable, nontextual interpretation of the statute.").

[14] Transcript of Oral Argument at 33-34, *Sereboff*, 126 S.Ct. 1869 (No. 05-260), *available at* http://www.supremecourtus.gov/oral_arguments/argument_transcripts.html. *Sereboff* was argued on March 28, 2006.

[15] Oral argument in *Ahlborn* took place on 2/27/06, approximately one month prior to oral argument in *Sereboff* on 3/328/06.

[16] *Ahlborn*, 126 S. Ct. at 1764-65.

[17] *Id*. at 1765 n.17.

[18] 498 U.S. 52.

[19] *Id.* at 62.

[20] *See*, *e.g.*, American Medical Security, Inc. v. Auto Club Insurance Association of Michigan, 238 F.3d 743, (6th Cir. 2001), c*ert denied*, 532 U.S. 1066 (2001); Smith v. Life Insurance Company of North America, 2006 WL 2842529 (N.D. Ga. Sept. 28, 2006); Singh v. Prudential Health Care Plan,

Incorporated, 335 F.3d 278 (4th Cir. 2003); Medical Mutual of Ohio v. deSoto, 245 F.3d 561 (6th Cir. 2001); Blue Cross and Blue Shield of Alabama v. Fondren, 966 F.Supp. 1093 (M.D. Ala. 1997); *Health Cost Controls v. Ross*, 1997 WL 222877 (N.D. Ill. Apr. 24, 1997); Citizens Ins. Vo. v. Am. Med. Sec., 92 F.Supp.2d 663, 668-71 (W.D.Mich. 2000); Progressive Michigan Ins. Co. v. United Wisconsin Life, 84 F.Supp.2d 848, 853 (E.D.Mich. 2000); American Medical v. State Farm Auto, 82 F.Supp.2d 717, 719 (E.D.Mich. 2000).

[21] The ERISA pre-emption clause, §514(a), states: "Except as provided in subsection (b) of this section [the savings clause], the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan . . . ." 29 U.S.C.A. § 1144(a) (West 2006).

[22] It has been suggested that governmental endorsement of reimbursement might result in a unconstitutional deprivation of property. *See* Roger M. Baron, *Public Policy Considerations Warranting Denial of Reimbursement to ERISA Plans: It's Time to Recognize the Elephant in the Courtroom,* 55 Mercer Law Review 595, 632 (2004). ("The unilateral nature in which the ERISA plans create and enforce their rights of reimbursement certainly fails to afford any due process to the plan members. To the extent that state action may be attributed to the insurers seeking such deprivation, application of the Fourteenth Amendment of the United States Constitution will be triggered. In situations of direct federal involvement, such as that seen in the federally-protected ERISA plans themselves, application of the Fifth Amendment Due Process Clause may be invoked.")

[23] *Ahlborn*, 126 S. Ct. at 1762-65 (Part IV of opinion).

[24] *Id*. at 1760-63 (Part III of opinion).