

ERISA Health Care Subrogation, Reimbursement, and Overpayments

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I. Introduction: Types of claims subject to ERISA subrogation or overpayment recovery clauses.

Employers often provide health insurance, life insurance, long-term disability insurance, and other benefits to their employees. Most of the time, disputes over these benefits fall under the Employee Retirement Security Act of 1974 (ERISA), 29 U.S.C. § 1001 *et. seq.*. Many of these plans contain terms that allow an insurance company or plan administrator to recover benefits that have been “overpaid” or that were paid for medical expenses that eventually are recovered from someone else. This paper discusses how such claims are handled under ERISA.

A. Health insurance subrogation/reimbursement clauses:

When your client suffers a personal injury caused by a third party, your client’s health insurance will normally pay the medical expenses related to your client’s injuries. Many, if not most, of our clients who have medical insurance are covered by an insurance policy through work or through an employer’s self-funded plan.

When you and your client later recover from the third-party tortfeasor, the insurance company will claim that person should have paid your client’s medical bills. The insurance company will usually claim that it can recover all of the money paid for medical expenses. If you and your client do not pay the insurance company back, the insurance company will usually sue both of you. Many policies also contain language allowing the insurance company to sue a tortfeasor directly.¹

B. Long-term disability overpayment recovery clauses:

Many people who become disabled file claims for both social security benefits and for benefits under long-term disability (“LTD”) policies provided by their employers. In order to best advise the disabled person, an attorney who handles either ERISA LTD claims or social security claims should have a working understanding of how the two benefits are coordinated.²

¹ Technically, the right of subrogation is the right to step into another party’s shoes. In the case of an ERISA plan, a right of subrogation would give the plan the right to step into the shoes of the injured plan participant and become a co-plaintiff in the underlying lawsuit. A “reimbursement” claim is one by the ERISA plan to recover directly from the injured plan participant after that person recovers from a third party. However, courts use the terms “subrogation” and “reimbursement” interchangeably in most cases.

² Most LTD policies are written so that the insurance company gets to take advantage of the favorable social security decision, by offsetting the social security benefits. Often, insurance

Because the provisions of ERISA, and the case law interpreting those provisions, apply to medical subrogation/overpayment cases and to LTD overpayment cases, this paper discusses the case law generally and how it applies to subrogation and reimbursement claims in tort cases, as well as social security overpayments in LTD cases.

II. Is it an ERISA Plan?

First, in order to determine whether the law discussed in this paper applies, an attorney should determine whether a claim falls under ERISA or not. ERISA applies in almost every case involving benefits provided by an employer. ERISA preemption means that almost all employee benefit plans that provide such benefits as health insurance, life insurance, or disability insurance are preempted by federal ERISA law; however, plans sponsored by governmental employers and churches are not usually preempted by ERISA. ERISA § 4(a), 29 U.S.C. § 1003(a) provides that ERISA

shall apply to any employee benefit plan if it is established or maintained—
(1) by any employer engaged in commerce or in any industry or activity affecting commerce; or
(2) by any employee organization or organizations representing employees engaged in commerce or in any industry or activity affecting commerce; or
(3) by both.

However, ERISA does not apply to all employee benefit plans. ERISA § 4(b), 29 U.S.C. § 1003(b) provides:

(b) The provisions of this subchapter shall not apply to any employee benefit plan if--
(1) such plan is a governmental plan (as defined in §3(32) [29 U.S.C. § 1002(32) of this title];
(2) such plan is a church plan (as defined in §3(33) [29 U.S.C. § 1002(33) of this title) with respect to which no election has been made under section 410(d) of the Internal Revenue Code of 1954 [Title 26];

companies attempt to recover the disabled person's back benefits, when the disabled person eventually is awarded social security disability benefits.

Under most LTD policies, if a person is disabled, the disabled person is paid a percentage of his or her pre-disability wage. This percentage varies from policy to policy but is often around 60%. The LTD benefit is then further reduced by social security benefits and other income, such as workers' compensation. For example: If the disabled person made \$24,000 per year before becoming disabled, her pre-disability income was \$2,000 per month. If her LTD pays 60%, her gross monthly LTD benefit would be \$1,200. If she also wins her social security benefits, and her PIA is \$900 per month, her net LTD benefits are only \$300 per month. If the person is paid \$1,200 per month for 24 months, and then later wins the social security benefits of \$900 per month, the insurance company will seek to recover the \$21,600 (24 x \$900) the person was "overpaid."

- (3) such plan is maintained solely for the purpose of complying with applicable workmen's compensation laws or unemployment compensation or disability insurance laws;
- (4) such plan is maintained outside of the United States primarily for the benefit of persons substantially all of whom are nonresident aliens; or
- (5) such plan is an excess benefit plan (as defined in § 3 [29 U.S.C. § 1002(36)] of this title) and is unfunded.

Courts have interpreted ERISA's preemption provisions very broadly, such that ERISA preemption has been referred to as "super preemption." For example, ordinarily, determining whether a particular case arises under federal law turns on the " 'well-pleaded complaint' " rule, looking only to those claims raised in the plaintiff's allegations. *Franchise Tax Bd. of Cal. v. Constr. Laborers Vacation Trust for Southern Cal.*, 463 U.S. 1, 9-10 (1983). Also, the existence of a federal defense does not provide federal court jurisdiction. *Louisville & Nashville R. Co. v. Mottley*, 211 U.S. 149 (1908). "A defendant may not [generally] remove a case to federal court unless the *plaintiff's* complaint establishes that the case 'arises under' federal law." *Franchise Tax Bd.*, 463 U.S. at 10. As the Supreme Court has consistently re-affirmed, ERISA's preemption is so broad that it is an exception to those rules:

"[W]hen a federal statute wholly displaces the state-law cause of action through complete pre-emption," the state claim can be removed. *Beneficial Nat. Bank v. Anderson*, 539 U.S. 1, 8 (2003). This is so because "[w]hen the federal statute completely pre-empts the state-law cause of action, a claim which comes within the scope of that cause of action, even if pleaded in terms of state law, is in reality based on federal law." *Id.* ERISA is one of these statutes.

Aetna Health Inc v. Davila, 542 U.S. 200 (2004) (holding a Texas state law, allowing a participant in an employer sponsored HMO to sue the HMO for damages if the HMO unreasonably denied coverage, to be preempted by ERISA.) Most Courts have held that claims by a plan administrator to enforce the terms of an ERISA plan are preempted by ERISA.³ ERISA preempts "any and all state laws insofar as they may now or hereafter relate to any employee benefit plan." ERISA § 514, 29 U.S.C. § 1144. However, by statute, ERISA does not apply to governmental employees or to church employees, unless the church "opts in" to ERISA. ERISA § 4, 29 U.S.C. § 1003.

If ERISA does not apply to an insurance company's claim, then ordinary state contract law applies, and the insurer may recover the benefits to the extent permitted by state law (except as prohibited by Social Security's anti-assignment provision. 42 U.S.C. § 407, discussed below).⁴

³ The Ninth Circuit held to the contrary in *Providence Health Plan v. McDowell*, 361 F.3d 1243 (9th Cir. 2004) (holding that a state law claim for reimbursement by a plan against a beneficiary can survive ERISA preemption), but this case is an outlier.

⁴ For a more detailed explanation of whether or not an insurance policy is part of an ERISA plan, contact the author at ebuchanan@buchanandisability.com for a copy of a longer paper on ERISA preemption.

III. ERISA plan's rights of recovery and subrogation

A. Language of ERISA statute and its interpretation by the Supreme Court

ERISA itself only provides for certain remedies. ERISA § 502, 29 U.S.C. § 1132 sets out what parties may bring a cause of action under ERISA and what causes of action may be brought:

(a) Persons empowered to bring a civil action

A civil action may be brought--

(1) by a participant or beneficiary--

(A) for the relief provided for in subsection (c) of this section, or

(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;

(2) by the Secretary, or by a participant, beneficiary or fiduciary for appropriate relief under section 1109 of this title;

(3) by a participant, beneficiary, or fiduciary

(A) to enjoin any act or practice which violates any provision of this subchapter 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 this subchapter or the terms of the plan;

[Subsections 4-9 all give a cause of action only to the Secretary of Labor, not individuals]

(emphasis added). Congress, in passing ERISA, “set forth a comprehensive civil enforcement scheme” that included Congress’s choice to allow certain remedies related to employee benefits plans and to prohibit others. *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 54 (1987).

Remember that a plan’s right to recovery under ERISA § 502(a)(3), *supra*, is limited to enforcing the terms of the plan or of ERISA itself. Because ERISA itself has no general right of subrogation or reimbursement, the right to recover must be in the plan. For a long time, it was assumed that such a right could be found in either the formal plan document or the summary plan description, known as the “SPD.” However, the Supreme Court in *Cigna v. Amara* explained that “the summary documents, important as they are, provide communication with beneficiaries about the plan, but . . . their statements do not themselves constitute the terms of the plan.” 563 U.S. 421, 438 (2011). Therefore, it is worth checking to make sure that the subrogation or reimbursement language is actually in the plan, and not just an SPD. However, if the language is only in the SPD, despite *Amara*, the language may still control if the SPD is also the only plan document. *Bd. of Trustees v. Moore*, 800 F.3d 214, 219 (6th Cir. 2015). Also, presumably, if the plan document says the SPD is part of the plan, then it would be. It is an interesting question

whether a document that clearly says it is just an SPD can also say it is part of the actual master plan, if there is a different master plan document that does not say that.

In recent years, the remedies available to a plan have swung back and forth like a clock pendulum. In *Great-West Life & Annuity Ins. Co. v. Knudson*, the Court held that a claim by an ERISA plan to recover a subrogation claim was not one for which a remedy was provided under ERISA. 534 U.S. 204 (2002). However, more recently, the Supreme Court issued another decision, allowing ERISA Plans and Plan Administrators to recover in most cases. *See, Sereboff v. Mid Atlantic Medical Services, Inc.*, 547 U.S. 356 (2006).

Later, in *US Airways, Inc. v. McCutchen*, the Supreme Court addressed the question left unaddressed in *Sereboff*, which was, since ERISA plan administrators may only seek equitable remedies, would a plan participant or beneficiary, against whom recovery is sought, be allowed to raise equitable defenses? 569 U.S. 88 (2013). In *McCutchen*, the Court held that, no, equitable defenses cannot be used to overcome the clear language of a plan.

Then in 2016, Supreme Court again swung the pendulum the other way in *Montanile v. Board of Trustees of the National Elevator Industry Health Benefit Plan*. 136 S.Ct. 651 (2016). The Court held that when an ERISA plan participant spends the recovery on “nontraceable items,” the plan fiduciary cannot maintain a suit under ERISA § 502(a)(3) to obtain a judgment to recover from the participant's other assets. *Id.* at 2. These cases, and other important cases, will be explained in more detail below.

B. ERISA subrogation law starting with *Great-West v. Knudson*

The Supreme Court addressed what remedies were available to an ERISA plan administrator/ERISA fiduciary in *Great-West Life & Annuity Ins. Co. v. Knudson*, a case that, for a while, changed the landscape of the ability of an ERISA LTD plan to seek and pursue claims for the recovery of money properly paid in the first instance from an ERISA beneficiary. 534 U.S. 204 (2002).

Great-West paid over \$411,000 to medical providers treating injuries sustained by Janette Knudson. Ms. Knudson also sued Hyundai on a products liability theory for her injuries. Ms. Knudson settled with Hyundai for \$650,000, allocating as part of the judicially supervised settlement a little more than \$13,800 to repay Great West for its plan created lien on her personal injury claims.

Great-West sued for recovery of the entire amount of its lien, refusing to negotiate the check payable to it pursuant to the terms of the judicially supervised settlement. The Supreme Court held *inter alia* that ERISA did not permit Great-West to pursue a legal remedy to enforce the terms of the plan. *Great-West*, 534 U.S. at 220-21 (*citing* 29 U.S.C. § 1132(a)(3) (ERISA § 502(a)(3))). The Court's rationale rested on the form of restitution sought by Great-West, a money judgment from undifferentiated assets of Ms. Knudson. Because that action is classified as “legal” rather than “equitable,” the limited grant of authority given to plans and their fiduciaries by 29 U.S.C. § 1132(a)(3) deprived Great-West of a cognizable theory of equitable relief under ERISA. The majority opinion written by Justice Scalia clearly states the law:

We have observed repeatedly that ERISA is a “‘comprehensive and reticulated statute,’ the product of a decade of congressional study of the Nation's private employee benefit system.” *Mertens v. Hewitt Associates*, 508 U.S. 248, 251 (1993) (quoting *Nachman Corp. v. Pension Benefit Guaranty Corporation*, 446 U.S. 359, 361 (1980)). We have therefore been especially “reluctant to tamper with [the] enforcement scheme” embodied in the statute by extending remedies not specifically authorized by its text. *Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 147 (1985). Indeed, we have noted that ERISA’s “carefully crafted and detailed enforcement scheme provides `strong evidence that Congress did *not* intend to authorize other remedies that it simply forgot to incorporate expressly.” *Mertens, supra*, at 254 (quoting *Russell, supra*, at 146-47).

In sum, *Knudson* stands for the following proposition: If an insurance company or other ERISA Plan Administrator provides benefits under a plan that is preempted by ERISA and the administrator is seeking to recover from a beneficiary of the plan, the only cause of action available to the administrator is one found in ERISA. Under ERISA, the only cause of action available to the administrator is ERISA § 502(a)(3), which limits remedies to “equitable” remedies. The Supreme Court held that “equitable remedies” were the narrow set of remedies available in a court sitting in equity prior to the merger of equity and law courts. Thus, if an administrator is seeking to enforce the terms of an insurance policy or similar document, the administrator is really seeking to enforce a contract, which is a cause of action at law and not available under ERISA. However, the Court reserved the question whether or when equitable remedies are available to administrator.

C. The rules change more in favor of ERISA plans and fiduciaries in *Sereboff*.

The next important U.S. Supreme Court case dealing with ERISA subrogation is *Sereboff v. Mid Atlantic Medical Services, Inc.* 547 U.S. 356 (2006). In *Sereboff*, the pendulum swung almost all the way back to the insurance companies. The Sereboffs were involved in an automobile accident in California and suffered injuries; Mid Atlantic provided medical benefits to the Sereboffs totaling \$74,869.37. The Sereboffs filed a lawsuit against the tortfeasors. Mid Atlantic notified Sereboffs' attorney of its asserted lien on the anticipated proceeds from the suit over the two and a half years the case was pending; however, after the case settled for \$750,000, neither the Sereboffs nor their attorney sent any money to Mid Atlantic.

Mid Atlantic filed a claim as an ERISA fiduciary under ERISA § 502(a)(3) to enforce the terms of the plan, which gave Mid Atlantic a subrogation right. The Supreme Court distinguished *Great-West v. Knudson* on the grounds that, in *Knudson*, the recovery in the underlying tort case was placed directly in a special needs trust and was never in the hands of the Knudsons. Then, despite the clear language in *Knudson* that only equitable causes of action can provide an equitable remedy, the Court in *Sereboff* held that the character of the underlying cause of action does not “prove relief is not equitable; that would make § 502(a)(3)(B)(ii) an empty promise.” *Sereboff*, 547 U.S. at 363.

The Court relied on a 90 year old case, *Barnes v. Alexander*, for the proposition that equity provides for a rule “that a contract to convey a specific object even before it is acquired

will make the contractor a trustee as soon as he gets a title to the thing.” *Id.* at 121 (quoting 232 U.S. 117 (1914)). The Court then explained that the Court’s previous analysis in *Knudson*, that equity only provided for certain remedies where the specific assets could be traced to specific funds, did not provide a complete list of all available equitable remedies. The Court declared:

Knudson simply described in general terms the conditions under which a fiduciary might recover when it was seeking equitable restitution under a provision like that at issue in this case. There was no need in *Knudson* to catalog all the circumstances in which equitable liens were available in equity; Great-West claimed a right to recover in restitution, and the Court concluded only that equitable restitution was unavailable because the funds sought were not in *Knudson's* possession.

Id. at 365. Thus, while the Court did not explicitly overrule *Knudson*, *Sereboff* effectively overruled most of *Knudson* in that a plan administrator or ERISA fiduciary can recover money from a beneficiary to enforce the terms of the plan even without specifically being able to trace identifiable funds into the beneficiary’s possession. Thus, the only part of *Knudson* left is that if the funds are not paid directly to the plaintiff, but are placed in a trust, then either a plan cannot recover or would need to at least establish a constructive trust over the funds.

Lastly, the Court added insult to injury by rejecting *Sereboff*’s argument that any equitable claim by the ERISA fiduciary would be subject to equitable defenses. The Supreme Court explained that the ERISA fiduciary’s claim was not truly an equitable claim but rather was an ERISA claim to recover under the terms of the plan; therefore, “the parcel of equitable defenses the *Sereboffs* claim accompany any such action are beside the point.” *Id.* at 368. Then, in footnote 2, the Court left the door open to arguments that, a recovery by a plan fiduciary that does not take into account equitable defenses, such as the made-whole doctrine, may not be an “appropriate” equitable remedy under ERISA § 502(a)(3), but, because that issue was not raised below, the Supreme Court declined to consider it for the first time. Therefore, the Supreme Court has left open the question whether equitable defenses, such as the made-whole doctrine (which, for example, is the default rule in ERISA cases in the Sixth Circuit prior to *Knudson*), are still available after *Sereboff*.

The bottom line holding of *Sereboff* is that the ERISA Plan could recover to “enforce the terms of the plan” and that the relief sought was equitable. Thus, if an ERISA plan allows a recovery from a beneficiary, the likely outcome in most cases will be that the recovery will be allowed. However, ERISA does not provide for general equitable relief to enforce a subrogation claim as a general rule. ERISA’s limited remedies only allow a plan to recover under the terms of ERISA or the terms of a plan. ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3). Therefore, attorneys should carefully review the terms of the relevant ERISA plan documents to ensure that the plan actually allows the recovery sought by the insurance company or ERISA administrator.

D. Important Circuit Case Law after *Sereboff*

1. *Popowski v. Parrott*

Probably the most influential case addressing what language allows an insurance company or ERISA administrator to recover under ERISA and *Sereboff* is the case of *Popowski v. Parrott*. 461 F.3d 1367, 1369 (11th Cir. 2006)⁵.

Popowski is a very instructive case, in that the Court was able to compare two plans that both had claims for reimbursement under ERISA § 503(a)(3). The Court of Appeals found that one plan's language allowed it to state a claim under ERISA but the other one did not.

The first plan claimed a lien "on any amount recovered by the Covered Person whether or not designated as payment for medical expenses," and clarified that "[t]he Covered Person ... must repay to the Plan the benefits paid on his or her behalf *out* of the recovery made from the third party or insurer." *Id.* at 1373. The court found that this first plan contained language allowing it to recover because the plan language identified both the funds out of which a recovery can be made (recovery from the third party or insurer) and the portion due the plan (benefits paid by the plan on behalf of the defendant). *Id.* The plan did not seek to impose personal liability on the defendant but to restore to the plan particular funds or property in the defendant's possession. *Id.*

The second plan was found to have language that did not allow for a recovery, because it did not allow for the assertion of an equitable lien. *Id.* at 1374. The subrogation and reimbursement provisions of the second plan purported to allow the plan a right to reimbursement "in full, and in first priority, for any medical expenses paid by the Plan relating to the injury or illness," but did not specify that the reimbursement be made out of any particular fund. *Id.* at 1373-74. The Court of Appeals for the Eleventh Circuit found that the receipt of a "settlement, judgment, or other payment relating to the accidental injury or illness," was a trigger for the general reimbursement obligation. *Id.* at 1374. The Court of Appeals also found that the plan language requiring reimbursement "in full" failed to limit recovery to a specific portion of a particular fund. *Id.*

2. *Admin. Comm for Wal-Mart Stores, Inc. Assoc.'s Health and Welfare Plan v. Horton*

The Eleventh Circuit weighed in to the ERISA subrogation and recovery issue again in the case of *Administrative Committee for Wal-Mart Stores, Inc. Associates' Health and Welfare Plan v. Horton*. 513 F.3d 1223, 1224 (11th Cir. 2008). In *Horton*, a fourteen-year-old suffered injuries in a car accident. The juvenile's mother was employed by Wal-Mart and was a participant in the Wal-Mart health care plan, and the injured son was covered under the plan. The Wal-Mart Plan paid \$51,446.03 in medical benefits for the injured son.

The settlement of \$100,000 was approved by the superior court to be \$1,000 to the mother, \$33,000 in attorney's fees, and \$65,000 was deposited into the Probate Court for the benefit of the injured boy. Pursuant to Georgia law, the probate court appointed the mother as her

⁵ Courts in other circuits have cited *Popowski*. In the Sixth Circuit, *See, e.g. Fleetwood Enterprises, Inc. v. Taylor*, 2007 WL 2826180 (W.D. Ky. 2007) (unpublished).

son's conservator, who in turn took possession of her son's portion of the settlement and deposited it in a trust account at a bank. *Horton*, 513 F.3d at 1224.

The claim by Wal-Mart made its way to the Court of Appeals. The Court first reiterated its interpretation of Supreme Court precedent that a claim by an administrator for equitable relief can lie only when a participant is actually in possession of the funds at issue. *Id.* at 1227. However, the Court analyzed whether the administrator may "use §502(3) to recover a specifically identified fund in the possession of a third party, such as a trustee or conservator, by suing the third party directly." *Id.* The Eleventh Circuit said yes, the Plan administrator may sue third parties in possession of a specifically identifiable fund to which it asserts title and right to possession. *Id.* at 1228-29.

The key language from the *Horton* decision explains:

Under *Knudson*, *Sereboff*, and the other authorities cited above, the most important consideration is not the identity of the defendant, but rather that the settlement proceeds are still intact, and thus constitute an identifiable *res* that can be restored to its rightful recipient. Had the Administrative Committee solely sued parties not in possession of the disputed funds, the claim would have failed under *Knudson* because it merely would have sought to impose personal liability on those parties.

Id. at 1229. This decision reinforces the concept that funds recovered from a tort settlement or judgment must still be in the possession of the person against whom an ERISA plan administrator files a lawsuit to enforce its lien. So, for example, if the money is in a trust, if the trustee is sued, the plan may be able to recover under this case.

3. *Longaberger Co. v. Kolt*

Since *Sereboff*, the Court of Appeals for the Sixth Circuit has issued one extremely important decision that all attorneys should be worried about. In *Longaberger Co. v. Kolt*, the Court of Appeals held that an attorney could be individually liable for failing to pay a subrogation/reimbursement claim. 586 F.3d 459 (6th Cir. 2009). The case also creates several other questions about the current state of ERISA subrogation in the Sixth Circuit.

In *Longaberger*, Kolt represented his clients in an auto accident case. The accident occurred in June 2003, and in July 2004 Kolt reached a settlement amounting to a total of \$135,000. *Id.* at 461. After settling, in August 2004 Kolt notified the ERISA plan of the settlement and offered to amicably resolve the subrogation. *Id.* The reported opinion does not say whether the plan responded or if any further communication took place, but in December 2004 Kolt disbursed \$86,082.18 to his client and \$45,000 in attorney's fees to himself.⁶

⁶ The underlying case settled, and the money was distributed, during the time frame after *Knudson* had been followed in the Sixth Circuit, and the rule at the time was that ERISA plan administrators had no cause of action or remedy to recover a reimbursement claim under an ERISA plan under ERISA § 502(a)(3). Subsequent to the settlement and distribution, *Sereboff*

The Longaberger Company Health Plan is a self-funded plan under ERISA that contained all three types of “subrogation” clauses. *Id.* The plan contained an exclusionary clause, stating it did not cover injuries caused by third-parties. *Id.* The plan also had a true subrogation clause allowing the plan to step into the shoes of the injured person. *Id.* The plan also contained a right of recovery provision that stated:

The Plan shall have a first priority claim against any proceeds paid by or on behalf of a liable third party and shall be entitled to reimbursement or subrogation regardless of whether you or your Dependent(s) have been made whole. The Plan's rights shall not be subject to reduction under any common fund or similar claims or theories. However, the Employer or its authorized representative may agree to a reduction from amounts recovered to pay reasonable and necessary expenditures, including attorney's fees, incurred in obtaining the recovery of Plan benefits. This may occur when, in the judgment of Plan Administrator, it would be in the best interests of the Plan to agree to such terms. These rights of reimbursement and subrogation are reserved whether the liability of a third party arises in tort, contract or otherwise. Regardless of how proceeds are designated, the Plan's rights shall attach to any full or partial judgment, settlement or other recovery.

Id.

The Plan sued both Kolt and his client under ERISA § 502(a)(3) under theories of constructive trust, equitable lien, and unjust enrichment. *Id.* at 464. After the Supreme Court issued its decision in *Sereboff*, the Plan amended its complaint to clarify it was seeking an “equitable lien by agreement.” *Id.*

The district court found that the Plan “automatically acquired a valid lien on the tort recovery fund when the funds became identifiable.” *Id.* The district court granted judgment to the Longaberger Plan in the amount of \$37,889.44 against Kolt and \$75,889.87 against his client. *Id.*

The Court of Appeals affirmed the judgment of the district court. The Court of Appeals held that, under *Sereboff*, even though the funds had been distributed, the plan could still recover; “an equitable lien by agreement does not require tracing or maintenance of a fund in order for equity to allow repayment.” *Id.* at 6. The court explained that the Plan’s language sufficiently identified the fund out of which a recovery could be made, by identifying “any recovery by you or your dependent(s) from such party to the extent of any benefits provided to your or your Dependent(s) by the Plan.” *Id.*

The Court of Appeals also held that the attorney could be liable for returning his share of the recovery, even though the attorney was not an ERISA party or fiduciary. *Id.* at 467-68 (citing

was decided, reviving the cause of action. Note that *Sereboff* did not overrule *Knudson* and was only a “clarification” so that this did not technically represent a change in the law.

Ward v. Wal-Mart Stores, Inc., 194 F.3d 1315, 1991 WL 801532 (6th Cir. Sept 30, 1999) (unpublished table decision)). The Court reasoned that ERISA § 502(a)(3) does not limit the individuals or entities that could be subject to a claim under ERISA, so there was no limit preventing a plan from suing an attorney for a plan participant, so long as the relief sought lies in equity. *Id.*

Kolt also argued that the plan language at issue did not give the Plan a right to enforce its recovery, since the language did not allow it to recover without a signed agreement. *Id.* at 471. The Court of Appeals disagreed and held that “Longaberger's Plan was self-executing and that the Plan language provides for an automatic and valid lien on the settlement funds to the extent of the benefits [Kolt’s client] Billiter received from the Plan.” *Id.*

Kolt also argued that he should not have to return his attorney’s fees because his attorney’s lien over the funds attached prior to when the Plan provided benefits to the injured person, which would give his lien a priority under Ohio law. *Id.* The Court of Appeals disagreed and found that any such Ohio law was not a law regulating insurance, and thus was preempted by ERISA; as such, the ERISA plan’s language would control and give the plan priority over the funds.

Additional comments on this case:

Because the language in this Plan was so specific and contained all the necessary language to overcome the made-whole doctrine and to establish a valid right to an equitable remedy under ERISA, the Court of Appeals did not address whether the older Sixth Circuit cases prior to *Great West v. Knudson* were still good law. In those older cases, the Court of Appeals had held that the “made whole” doctrine was the default rule in ERISA cases and would apply unless the plan had specific language overcoming that doctrine. I submit that those cases are still good law, and it is still very important to look at what the plan actually says to see what rights the ERISA Plan Administrator has to recover. These cases are discussed in more detail, *infra*.

Longaberger Co. v. Kolt also does not address the situation where the attorney is not given notice of a lien by the ERISA plan, because in this case, the attorney communicated with the plan and, therefore, must have knowledge about the plan’s subrogation interest.

Lastly, a bit of advice: at the time Kolt distributed the proceeds of the settlement to his client, the law in the Sixth Circuit very clearly precluded a claim by the insurance company under ERISA § 502(a)(3) to recover. However, Kolt did nothing to negotiate an agreement with the insurance company, nor did he file suit to seek a judgment verifying that there would be no right to recover. Because *Sereboff* “clarified” the law, Attorney Kolt and his client had no protection and could be sued. As will be discussed in more detail below, taking into account the more recent *Montanile* case, attorneys really should continue communicating with plans and probably should never distribute funds without telling the plan first.

E. The Supreme Court speaks again in *US Airways, Inc. v. McCutchen*, finding that equitable defenses cannot overcome plan terms but may be used to fill in the gaps.

In the case of *US Airways, Inc. v. McCutchen*, the Supreme Court addressed the question left unaddressed in *Sereboff*, which was, since ERISA plan administrators may only seek equitable remedies, would a plan participant or beneficiary against whom recovery is sought be allowed to raise equitable defenses? 569 U.S. 88 (2013). In short, the Court held: no, equitable defenses cannot be used to overcome the clear language of a plan.

The Court reasoned that since the ERISA plan documents were, in effect, a contract documenting the “expressed commitments” of the parties, that “when parties demand what they bargained for in a valid agreement,” one of the parties cannot then ignore the plain language of the agreement by applying equitable defenses. In effect, the Supreme Court has held that ERISA plans are, for these purposes, contracts, and, while the plan’s remedy is to seek an equitable lien by agreement, that lien is created by the agreement and is bound by the terms of the agreement. “[I]f the agreement governs, the agreement governs,” reasoned the court. *Id.* at 99.

However, in the second part of the *McCutchen* decision, the Court found there is still a place for equitable rules in interpreting the provisions of ERISA plans. In this case, in addition to arguing that equitable defenses should bar the recovery by the plan of McCutchen, the beneficiary, McCutchen’s attorneys also argued that their fair share of the attorneys’ fees earned in obtaining the funds should be protected under the common fund doctrine. Under that doctrine, any reimbursement to the plan should be reduced by the costs incurred in recovering the funds; therefore, the plan should not recover from the costs of the recovery but rather should share in the cost of the fees paid to the attorneys.

The court agreed that the common fund doctrine could apply, but *not* because that is an equitable principle that trumps the terms of the plan. Rather, the Court found that the plan did not address whether it could recover out of attorneys’ fees. Since the plan was silent on the allocation of attorneys’ fees, the Court reasoned that equitable principles could still be used in construing the contract. While the Plan may have been able to depart from the common-fund doctrine by drafting its terms to say so, where it did not, the Court could use “the well-established common-fund rule” to construe the rules where a plan was silent.

Lessons learned from *McCutchen* and the preceding cases:

The rights of an ERISA plan to recover previously paid health care benefits or overpaid LTD benefits or any other rights are not common law rights or rights found in the ERISA statute; therefore, if the plan does not contain those provisions, the plan does not have that right. However, where the plan has language allowing it to bring those claims, ERISA § 502(a)(3) gives plans the ability to enforce the terms of a plan.

Because ERISA § 502(a)(3) limits the remedies available when enforcing plan terms to “appropriate equitable remedies,” plans must still have language that allow them to seek funds in a way that creates a lien by agreement or through other equitable remedies. And, if the plan seeks to enforce those provisions, it should seek an equitable remedy. But if the plan allows that, ERISA participants and beneficiaries cannot use general equitable principles to defeat the terms of the plan.

Further, attorneys who represent ERISA participants and beneficiaries in other cases, such as underlying tort cases, may not have their attorneys' fees protected if the plan allows the recovery with clear language overcoming the common-fund doctrine. Only if the plan is silent on a disputed term can courts look to general equitable principles to fill in the gap.

What this case means to most lawyers who practice in the areas of personal injury, medical malpractice, and the like is that attorneys now have even more reasons to obtain copies of their client's ERISA healthcare plans early on in the representation. If the plans have language that allow the recovery (and most do), then attorneys and their clients will likely have to recognize the plan's rights and should plan on having to deal with the plan.

E. In *Montanile*, the ERISA Subrogation Pendulum Swings Back in Favor of a Plan Participant.

Early in 2016, the U.S. Supreme Court again addressed the remedies available to a plan fiduciary under ERISA in *Montanile v. Board of Trustees of the National Elevator Industry Health Benefit Plan*. 136 S. Ct. 651 (2016). The Court held that when an ERISA plan participant obtains funds from a third party that are subject to a reimbursement or subrogation claim but spends the whole amount on “nontraceable items (for instance, on services or consumable items like food),” the plan fiduciary cannot maintain a suit under ERISA § 502(a)(3) to obtain a judgment to recover from the participant's other assets. *Id.* at 659. Specifically, “when a participant dissipates the whole settlement on nontraceable items, the fiduciary cannot bring a suit to attach the participant's general assets under [ERISA] § 502(a)(3) because the suit is not one for ‘appropriate equitable relief.’” *Id.*

Montanile was severely injured by a drunk driver that ran a stop sign, and the plan paid over \$121,000 for Montanile's health care. Montanile ultimately settled his claim against the drunk driver for \$500,000. The plan had very strong language that gave it a first right of recovery without reduction for other damages, attorney's fees, etc. The plan also required its written permission before any settlement funds could be distributed, and also required plan participants to notify the plan and obtain the plan's consent before settling any claim. Montanile also signed a reimbursement agreement “reaffirming his obligation to reimburse the plan from any recovery he obtained ‘as a result of any legal action or settlement or otherwise.’” *Id.* at 655-56.

The Court's opinion does not explain at what point the plan and Montanile's attorney began to communicate, but Montanile's attorney did originally keep Montanile's proceeds (more than enough to cover the subrogation claim) in his trust account while he negotiated with the plan. Montanile's attorney argued with the plan administrator that it was not entitled to any recovery but attempted to settle the matter. After settlement discussions broke down, Montanile's attorney wrote to the plan administrator that he would distribute the remaining settlement funds to Montanile unless the plan administrator objected within 14 days. The plan administrator did not respond within that time, and the attorney released the funds to Montanile. Six months after the settlement negotiations ended, the plan administrator sued Montanile under ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3). *Id.*

The Court explained that this case was another in the line of cases including *Mertens v. Hewitt Associates*, 508 U.S. 248 (1993), *Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204 (2002), and *Sereboff v. Mid Atlantic Medical Services, Inc.*, 547 U.S. 356 (2006) examining what is an “appropriate equitable remedy” available for an ERISA fiduciary under ERISA § 502(a)(3). As explained above, the Court had held that “equitable” was a limit on all remedies, and that word matters and meant that it limited remedies to those available to courts of equity in equity cases. The Court emphasized that equitable remedies were not all the remedies that an equity court might grant, because in many cases, equity courts could provide legal remedies, but instead, “the term ‘equitable relief’ in § 502(a)(3) is limited to ‘those categories of relief that were typically available in equity’ during the days of the divided bench (meaning, the period before 1938 when courts of law and equity were separate).” *Id.* at 657 (citing *Mertens*, 508 U.S. at 256). The Court explained that “whether the remedy a plaintiff seeks “is legal or equitable depends on [(1)] the basis for [the plaintiff’s] claim and [(2)] the nature of the underlying remedies sought.” *Id.* (citing *Sereboff*, 547 U.S. at 363). Also, to determine what is a “purely equitable remedy,” the Court will rely on “standard treatises on equity, which establish the ‘basic contours’ of what equitable relief was typically available in premerger equity courts.” *Id.* (citing *Knudson*, 534 U.S. at 217).

The Court explained that, as previously set out in *Sereboff*, the equitable cause of action that would be available to a plan in this situation was an equitable lien by agreement, and, had the plan sued Montanile while the funds were still in his possession, the plan would have had an equitable remedy. The Court again examined equitable treatises and determined that an equitable lien could not be enforced,

if the defendant once possessed a separate, identifiable fund to which the lien attached, but then dissipated it all. The plaintiff could not attach the defendant's general assets instead because those assets were not part of the specific thing to which the lien attached. This rule applied to equitable liens by agreement as well as other types of equitable liens.

Montanile, 136 S. Ct. at 659. Therefore, because Montanile had spent the money, the plan could not recover.

The Court rejected several arguments by the plan administrator that some rules of equity would have allowed the recovery here, generally because those rules required exceptions that were not met here. The Court also rejected the general arguments that this outcome was inconsistent with ERISA’s purposes and that tracking and participating in legal proceedings would be costly. The Supreme Court addressed the first point by explaining that the plain language of a statute cannot be overcome by a statute’s general purpose. In response to the argument that plans would incur additional costs tracking litigation and settlements, the Court rejected this as inconsistent with the facts of this case. Here, the plan administrator had notice of the settlement in time that the plan could have taken steps to protect its lien while Montanile still had the funds; the plan “could have—but did not—object [within the 14 days notice the attorney gave] . Moreover, the Board could have filed suit immediately, rather than waiting half a year.” *Id.* at 662.

Lastly, the Court remanded the case to the district court because the record was not clear whether Montanile in fact dissipated every penny of the settlement funds or whether he still

maintained some of the funds, because the plan could recover those funds that were not dissipated. *Id.*

F. Putting all the Supreme Court cases together.

The remedies available to ERISA fiduciaries and the obligations of ERISA participants and beneficiaries have swung back and forth like a pendulum over the last two decades. Beginning with *Great–West Life & Annuity Ins. Co. v. Knudson*, *supra*, in 2002, plans went from having no right to recover, to later cases where they could easily recover, to *Montanile*, where plans face another significant hurdle if they don't act quickly enough.

Specifically, in *Knudson*, the Court set out two important rules. First, the Court held that an ERISA plan administrator's subrogation or reimbursement claim under the terms of an ERISA plan was essentially a cause of action to enforce a contract, which would be a legal cause of action, for which only a legal, not equitable, remedy would be available. Under that part of *Knudson*, ERISA plans essentially had no way to ever enforce a reimbursement clause in an ERISA plan. The second part of *Knudson* held that, even if a cause of action were available, equity would only allow a party to recover specifically identifiable funds and not obtain a general judgment.

But, shortly after that, in 2006, the Court went the other way in *Sereboff v. Mid Atlantic Medical Services, Inc.*, *supra*. Without specifically overruling *Knudson*, the Court in *Sereboff* made it very clear that ERISA § 502(a)(3) would be a nullity if no remedy were available. The court went all the way back to a 1914 case on “equitable liens by agreement” to allow the ERISA fiduciary to recover. The court went further to say that strict tracing was not necessarily required, so long as the ERISA fiduciary properly seeks a remedy typically available in equity. Some lower courts essentially held this to be a “magic language” test; so long as the plan alleges it is seeking specifically identifiable funds and the language of the plan allows for the recovery from specific funds, the fact that specific funds might not be identifiable was not a bar to ERISA fiduciaries and plans recovering, because “strict tracing” was not required. Thus, with carefully drafted plans and well-drafted pleadings, ERISA plans could recover subrogation or reimbursement claims with regularity. Also, in *Sereboff*, the plan participant argued that if equitable remedies were all that were available, then equitable defenses should be available too. The court refused to answer that question because it was not raised sooner and allowed the ERISA plan to recover.

Then, more recently, in *US Airways, Inc. v. McCutchen*, the pendulum swung even more in favor of ERISA plans and ERISA fiduciaries. 569 U.S. 88 (2013). The Court in *McCutchen*, addressed the question it refused to answer in *Sereboff*—whether ERISA participants and beneficiaries could use the parcel of equitable defenses when an ERISA plan seeks an equitable remedy. The Court in *McCutchen* held that equitable defenses could not be used to overcome the plain language of an ERISA plan, so again, ERISA plans had the upper hand and could continue to recover so long as the plan was carefully drafted. However, the Court did throw one bone to plan participants, by also holding that principles of equity could be used appropriately to fill in gaps in an ERISA plan where the plan language did not address an issue.

Now, in *Montanile* the pendulum has swung back the other way, at least a little. This case clarifies that tracing is important, and not only must a plan have proper language and must

the cause of action a plan brings be the right cause of action in equity, but the plan must also be able to specifically identify funds in the plan participant's possession not just include "magic language". It is significant that the Court said that the plan could have recovered had it acted quickly enough. Now, if a plan has notice of a settlement or funds in the participant's possession and fails to act before the funds are dissipated, the plan may have no recovery.

One of the questions plaintiff's attorneys should ask now is whether they can rely on this case to simply distribute funds to a client as quickly as possible and advise the client to go spend the money as soon as possible. I believe the short answer is, "no." In this case the court faulted the plan administrator for sitting on its hands when the attorney gave the plan 14 days' notice before distributing the funds, and then the plan waited six months before bringing suit, which gave *Montanile*, the plan participant, six months to spend the money, probably on past due bills, living expenses, etc.

The court rejected several arguments made by the plan fiduciaries that other equitable remedies might be available, but I submit that if a plan participant or his or her attorney fails to notify the plan, communicate with the plan, and give the plan sufficient notice before the funds are distributed, then a court is more likely to find that the plan would have an equitable remedy. My advice is that the best practice is still to communicate with the plan early, try to work something out early, and to communicate with the plan throughout the case. If, after regular communications, the plan and the participant cannot reach an agreement, then the attorney can give 14 days notice that the funds are being distributed. But, if that becomes a regular practice for plaintiff's attorneys, I believe plans are going to be much more likely to file suit early.

Another important point from *Montanile* is that the record was not fully fleshed out below as to how much of the proceeds had been dissipated, and the Supreme Court held that those funds that were not dissipated could still be recovered. If a plaintiff's attorney gives notice to the plan, and the plan still does not take action so that the funds can be released to the client, it would be important to tell the client to keep records of how the money is spent and be prepared to prove that the funds are gone. If an issue like this is litigated, the attorney for the plan participant should document and make a record for the court that the funds have been dissipated.

One last point about this case is the impact it will have on ERISA long-term disability ("LTD") claims and the overpayments that ERISA LTD plans and fiduciaries seek to recover. Most ERISA LTD plans provide that a disabled beneficiary receives a monthly benefit, such as 60% of the person's pre-disability earnings. However, most plans also allow the LTD benefits to be reduced by other benefits, such as social security disability benefits. In many cases, a disabled person may be paid the full LTD benefits for many months, typically 24 to 36 months, before winning their social security benefits. At that point, the ERISA LTD plan typically asks the person to pay back the amount of LTD benefits that were overpaid. So, for example, if a person is receiving \$1500 a month for 24 months and then is found disabled for the same time period by the Social Security Administration and receives, say, \$1000 per month in social security benefits, then the LTD plan will say, "We should have only been paying \$500 per month" and the disabled person is asked to pay back \$24,000 in back pay.⁷

⁷ Fortunately for most disabled beneficiaries, if the person hires a social security attorney and pays 25% of the back pay to the attorney, almost all insurance companies do not ask the person

Most people receiving LTD benefits are living off those benefits month-to-month and usually have dissipated those benefits by living off of them. When the disabled person is eventually awarded social security disability benefits and the LTD fiduciary seeks to recover what it has paid, the LTD fiduciary usually cannot seek the specifically identifiable funds it paid because those are gone. The social security benefits will be in the hands of the beneficiary, but there are several problems collecting those benefits. First, those are not the same dollars the LTD fiduciary paid, so the LTD fiduciary cannot claim it is seeking the same LTD dollars back. Second, if the plan allows the LTD fiduciary to recover the actual social security benefits, that is money that is sent directly to the beneficiary and can be easily and quickly dissipated before the LTD fiduciary has time to take legal action to obtain the funds. Third, if the dollars the disabled beneficiary has are social security benefits, a provision in the Social Security Act, 42 U.S.C. § 407 provides for very broad protections against anyone getting a lien, judgement, etc. or otherwise taking someone's social security benefits. The bottom line is that *Montanile* will make it much more difficult for LTD fiduciaries to recover social security overpayments when the disabled beneficiary is awarded social security benefits.

One other question neither *Montanile* nor any of the other Supreme Court ERISA cases has addressed is whether an ERISA fiduciary can use "self-help" to recover overpayments and reimbursements out of future benefits. For example, if a person refuses to pay back health insurance benefits because the money is dissipated, can the ERISA plan refuse to pay for future health claims and instead apply the dollars due for those claims toward the previous debt? Or, in the case of LTD benefits, if the disabled beneficiary does not pay the social security benefits over to the LTD fiduciary, can the LTD plan or insurance company refuse to pay future benefits due and apply those dollars toward the alleged debt?

This case clarifies the ERISA subrogation/reimbursement landscape, by settling the question whether it really matters that a plan beneficiary must have funds in his or her possession before an ERISA fiduciary can get an equitable remedy to collect those funds. However, this case also creates more work and confusion about what the best practices will be going forward, both for ERISA fiduciaries and for plaintiff's attorneys.

G. Special rules regarding ERISA subrogation in the Sixth Circuit.

In *Marshall v. Employers Health Insurance Co.*, the Court of Appeals for the Sixth Circuit established that the made-whole doctrine is, as a matter of federal common law, the default rule in our circuit. Nos. 96-6063, 96-6112, 1997 WL 809997 (6th Cir. Dec. 30, 1997). The "made whole" doctrine holds that a victim must recover all his own losses and be "made whole" before he is obligated to re-pay a third party. As the court explained in *Marshall*, the made-whole rule "is consistent with the equitable principle that the insurer does not have a right of subrogation until the insured has been fully compensated, unless the agreement itself provides to the contrary." *Id.* at *4. However, "if a plan sets out the extent of the subrogation right or states that the participant's right to be made whole is superseded by the plan's subrogation right, no silence or ambiguity exists," and the Plan may recover, even if the plaintiff is not made whole. *Id.* at *4.

to pay back the amount that was paid to the attorney. So, if the person paid the social security attorney a \$6000 fee, most LTD insurance companies would ask for \$18,000 back.

In *Copeland Oaks v. Haupt*, the Court of Appeals for the Sixth Circuit recognized that the “made whole” doctrine is the default rule in ERISA cases and that for the plan language to “conclusively disavow the default rule” of the made whole doctrine, “it must be specific and clear in establishing *both* a priority to the funds recovered *and* a right to any full or partial recovery.” 209 F.3d 811 (6th Cir. 2000). The plan language in that case read as follows:

The Covered Person agrees to recognize the Plan’s right to subrogation and reimbursement. These rights provide the Plan with a priority over any funds paid by a third party to a Covered Person relative to the Injury or Sickness, including a priority over any claim for non-medical or dental charges, attorney fees, or other costs and expenses.

Id. at 813.

While the plan in *Copeland Oaks* established its right to priority, it did not do so explicitly with regard to a partial recovery, and thus the made whole doctrine applied. It is, therefore, important to scrutinize the plan language to determine whether the plan has completely and unambiguously renounced the made whole doctrine. Also, the made whole doctrine applies in ERISA-covered subrogation and reimbursement claims. *See, also, Phillips v. Humana Health Plans of Kentucky*, No. 98-6368, 2000 WL 1872058 (6th Cir. Dec. 15, 2000) (the made whole doctrine applied because the ERISA plan language did not sufficiently establish the plan’s priority over a partial recovery.)

Unless the Plan language allows an attorney to be paid for a recovery or otherwise has language protecting the attorneys’ fees, an attorney has no implied or common law right to be paid attorneys’ fees out of a subrogation recovery. *Smith v. Wal-Mart Associates Group Health Plan*, No. 99-6464, 2000 WL 1909387 (6th Cir. Dec. 27, 2000). *But, see, US Airways, Inc. v. McCutchen*, 569 U.S. 88 (2013) (where the plan is silent on the issue of attorneys’ fees, equitable principles can be used, and the common-fund rule should be used and the attorneys’ fees should be protected).

Smith v. Wal-Mart Associates Group Health Plan is an unreported opinion, but it offers the Sixth Circuit’s analysis regarding whether the plan’s interest could be reduced to account for reasonable attorney’s fees where the plan was silent as to such fees. The plaintiff suffered injuries to her neck and back in a car wreck. The plan paid for medical bills relating to the wreck. After the plaintiff settled her tort case, her attorney disbursed two-thirds of the settlement to her and retained one-third for himself. The plan argued that it was entitled to the full amount of its interest, even though the plaintiff’s settlement proceeds were not enough to pay the plan in full.

In dissecting the plan, the court found that the language unambiguously required the plaintiff to fully reimburse the plan. Because the plan was clear on this point, the court concluded that the absence of an attorney’s fee provision was unimportant. The Court held:

A fair interpretation of this language is that full reimbursement is required without a deduction for attorneys' fees expended to obtain a settlement. *See Wal-*

Mart Stores, Inc. Associates' Health and Welfare Plan v. Scott, 27 F.Supp.2d 1166, 1174 (W.D. Ark. 1998). The language of the Plan does not limit or restrict its right to full reimbursement in any manner. Of course, it would have been preferable for the Plan to state specifically that it does not permit a deduction in reimbursement amounts for attorneys' fees expended to obtain a settlement; nonetheless, when a plan is clear and unambiguous, we cannot apply a common-law rule of interpretation but, instead, must give the plain language of a plan its natural meaning.

Id. at *3-4.

In *Qualchoice Inc. v. Williams*, the Court of Appeals found that an ERISA plan “did not establish in specific and clear terms that the Plan had either a priority over any funds recovered or a right to any full or partial recovery.” No. 00-3485, 2001 WL 856951 at *3 (6th Cir. June 22, 2001). Therefore, the made whole doctrine applied. The Court also reiterated that the made whole rule applies to reimbursement provisions.

In *Hiney Printing Co. v. Brantner*, the Court of Appeals applied the holding of *Copeland Oaks v. Haupt* and found that the ERISA subrogation and reimbursement provisions were ambiguous because they failed to clearly establish a right to priority over a partial recovery from a third party, thus the made-whole default rule was not overcome. 243 F.3d 956 (6th Cir. 2002)(applying 209 F. 3d 811 (6th Cir.)).

In another case involving a “Reimbursement Agreement⁸,” *Hamrick’s, Inc. v. Roy*, the plaintiff and her lawyer signed a reimbursement agreement but settled and distributed the money without paying the ERISA plan back. 115 S.W.3d 468 (Tenn. Ct. App. 2002). Roy sustained injuries in a wreck caused by Nguyen. Roy’s employer, Hamrick’s, paid her health care expenses through a self-insured ERISA plan. Roy and her lawyer signed a “Reimbursement Agreement” in which they agreed to reimburse Hamrick’s out of any recovery. Without the knowledge of Hamrick’s, Roy accepted a settlement of \$25,000 from Nguyen. Roy took two-thirds of the settlement, and her lawyer kept one-third. Hamrick’s then filed suit against Roy and her lawyer seeking to enforce the reimbursement agreement and recover the sums it paid on Roy’s behalf.

Attempting to reduce the amount of the reimbursement claim, Roy argued on appeal that only certain medical bills paid by Hamrick’s were related to the wreck. The court gave deference to the trial court’s conclusion, however, that most of the bills were related to the wreck. Roy also argued that she had not been made whole by the \$25,000 settlement, but the

⁸ A frequent question that arises is whether an insurance company can add to its subrogation or recovery rights by requiring a beneficiary to sign a reimbursement agreement that contains language more favorable to the insurance company that is found in the plan. The Supreme Court has held that an employer, as plan sponsor, is free to amend an ERISA plan at any time, so long as it does not deprive employees of vested rights; however, any amendment must be done in accordance with the Plan’s procedures for amendment and by the person authorized by the plan to make such amendments. See, e.g., *Curtiss-Wright Corp. v. Schoonejongen*, 514 U.S. 73, 115 S.Ct. 1223 (1995), discussing the requirements of ERISA § 402.

court agreed that Roy had not proved this contention in the trial court. The court agreed that Roy was required to execute the reimbursement agreement under the terms of the benefit plan. Interestingly, the court of appeals held that Roy's suit could proceed in state court. In so holding, the court relied upon the U.S. Supreme Court's decision in *Great West Life & Annuity Ins. Co. v. Knudson*, which barred claims for legal relief for contractual damages. The court did not discuss ERISA preemption of Roy's claims and apparently this issue was not raised.

In *Rodriguez v. Tennessee Laborers Health & Welfare Fund*, the Court of Appeals again read the language of an ERISA plan very strictly to determine the made-whole doctrine still applied. 89 Fed. Appx. 949 (6th Cir. 2004). The Court of Appeals also ruled that a "subrogation agreement" sent to the participant by the plan did not disavow the made-whole doctrine. *Id.* at 957.

Relying on the ERISA statutory scheme, the U.S. District Court for the Middle District of Tennessee has held that the lawyer for the injured person has a legal duty to send the portion of settlement funds owed to the plan under the subrogation clause. *Greenwood Mills v. Burris*, 130 F. Supp. 2d 949 (M.D. Tenn. 2001). In this case, the court agreed that a lawyer does not have a fiduciary duty to an ERISA plan, even though the lawyer is aware of the existence of a subrogation agreement between the plan and the beneficiary. ERISA, the court concluded, "requires that a fiduciary exercise 'authority or control respecting management or disposition' of plan assets." *Id.* at 957. Because the settlement funds received by the lawyer did not become 'plan assets' when he received them, he did not fall within the definition of a fiduciary.

However, the judge found the lawyer and his firm liable for violating the plan's terms under Section 1132(a)(3), which provides:

A civil action may be brought . . . by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of this plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations of (ii) to enforce any provisions of this subchapter or the terms of the plan.

Id. at 958.

The court relied on Tennessee law on this topic since it did not contradict the policies of ERISA. Under such law, a Tennessee lawyer:

will be held civilly liable to a non-client where he knowingly participates in the extinguishment of a subrogation interest of a non-client third party and delivers to his client funds that he knows belong to the third party and knows or should know, that he has already placed the funds beyond the reach of the third party.

Id. at 961. For that reason, the court ruled that the plaintiff's lawyer was liable for failing to honor his client's obligation under the ERISA plan to pay the subrogation interest.

Sixth Circuit/Tennessee ERISA law post *Sereboff*.

Since *Sereboff* has been decided, the Sixth Circuit has not yet addressed whether the presumption of the made whole doctrine still survives nor has it addressed what language would

allow a plan to overcome the made whole doctrine presumption. In fact, the few cases since *Sereboff* have been unpublished and have been related to other aspects of ERISA § 502(a)(3) litigation; however, the reasoning in those cases is still instructive.

While the Court of appeals has not addressed what language would still allow for a subrogation claim after *Sereboff*, it has been addressed at the District Court level in the case of *Fleetwood Enterprises, Inc. v. Taylor*. No. 5:06CV-124-R, 2007 WL 2826180 (W.D.Ky. 2007) (unpublished). In this case, an employer established a self-funded ERISA plan that paid health benefits to an employee who had been in an accident, and then the Plan sought to recover its subrogation right under the terms of the Plan.

The court discussed *Sereboff* and also found the 11th Circuit case of *Popowski v. Parrott*, instructive. 461 F.3d 1367, 1369 (11th Cir. 2006). The District Court explained:

In *Popowski*, two plans sought recovery from Defendants under § 502(a)(3) of ERISA for reimbursement for medical expenses paid by each plan on behalf of the respective defendants. 461 F.3d 1367, 1369 (11th Cir. 2006). The court, comparing the provisions of the two plans, determined that one plan had stated a claim for appropriate equitable relief whereas the other plan had failed to meet the requirements, as outlined in *Sereboff*, for the assertion of an equitable lien for the purposes of 29 U.S.C. § 1132(a)(3).

The first plan claimed a lien "on any amount recovered by the Covered Person whether or not designated as payment for medical expenses" and clarified that "[t]he Covered Person ... must repay to the Plan the benefits paid on his or her behalf *out* of the recovery made from the third party or insurer." *Id.* at 1373. The Court stated that these provisions specified both the fund--recovery from the third party or insurer--out of which reimbursement is due to the plan and the portion due the plan--benefits paid by the plan on behalf of the defendant. *Id.* The court found that this plan had stated a claim for appropriate equitable relief under 29 U.S.C. § 1132(a)(3) as the plan sought not to impose personal liability on the defendant but to restore to the plaintiffs particular funds or property in the defendant's possession." *Id.*

However, the court found that the second plan failed to meet the requirements for the assertion of an equitable lien. *Id.* at 1374. The subrogation and reimbursement provisions of this plan claimed a right to reimbursement "in full, and in first priority, for any medical expenses paid by the Plan relating to the injury or illness," but did not specify that the reimbursement be made out of any particular fund. *Id.* at 1373-74. The court found instead that the receipt of a "settlement, judgment, or other payment relating to the accidental injury or illness" was a trigger for the general reimbursement obligation. *Id.* at 1374. The court also found that in requiring reimbursement "in full" the plan failed to limit recovery to a specific portion of a particular fund. *Id.*

Fleetwood Enterprises, Inc. at *3. Based on its reading of *Sereboff* and *Popowski*, the District Court held that the Fleetwood Plan's language did not allow a recovery. The plan language stated, "[t]he Plan shall have the right of first reimbursement from any recovery a covered

Member receives, even if the covered Member has not been made whole.” *Id.* at *4. The District Court reasoned that, even though “the Fleetwood Plan specifies the fund—any recovery a covered Member receives—out of which reimbursement is due to the plan,” the language in the Fleetwood Plan “fails to specify the portion due the plan.” *Id.* Thus, because the Plan failed to identify the portion due the plan, it “fails to meet the requirements for the assertion of an equitable lien.” *Id.*

In the case of *Reliance Standard Life Ins. Co. v. Smith*, the insurance company accidentally issued too much in payments under an ERISA life insurance policy to the widow of Smith, who was the beneficiary under the plan. No. 3:05-CV-467, 2006 WL 2993054 (E.D. Tenn. Oct. 18, 2006). The widow admitted she could trace the funds to specific investments she had made. The Court allowed the insurance company to recover under ERISA S 502(a)(3) and *Sereboff*.

Reliance does not seek to impose personal liability on Smith. Rather, it seeks relief to restore to itself particular funds or property in Smith's possession. Smith has admitted that the funds have not been dissipated but have been invested in a stock purchase. Accordingly, the court finds that Reliance is entitled to a constructive trust/equitable lien on Smith's stock assets traceable to the overpayment.

Id. at *3. While the Court did not address what language was actually in the Plan, this was a fairly easy case, where Smith still had the money in an identifiable fund, and it was clear that the insurance company had made a mistake in calculating how much to send out to the widow.

H. Special rules for LTD overpayment cases

1. The Social Security Act should preclude the recovery of social security benefits from a disabled person who is paid LTD benefits and later paid social security benefits.

When an ERISA LTD plan's terms allow it to recover from a claimant who is later awarded social security benefits, courts should not allow a recovery out of those social security benefits, because such recovery would be barred by the Social Security Act's anti-assignment provision. 42 U.S.C. § 407 provides:

Assignment of benefits. (a) In general. The right of any person to any future payment under this title shall not be transferable or assignable, at law or in equity, and none of the moneys paid or payable or rights existing under this title shall be subject to execution, levy, attachment, garnishment, or other legal process, or to the operation of any bankruptcy or insolvency law.

(b) No other provision of law, enacted before, on, or after April 20, 1983, may be construed to limit, supersede, or otherwise modify the provisions of this section except to the extent that it does so by express reference to this section.

The law itself is fairly self-explanatory. “[N]one of the moneys paid or payable...shall be subject to execution, levy, attachment, [etc.]” Congress has been known to create exceptions

to this law for certain recoveries sought by state and federal governments. *See, e.g., Omegbu v. United States Dept. of Treasury*, 118 F. App'x 989 (7th Cir. 2004) (allowing for government garnishment of social security benefits to repay federal student loan debt because amendments to federal student loan law allowed for recovery “notwithstanding” 42 U.S.C. § 407(a); and , therefore, it expressly referenced the section.); *Mote v. Aetna Life Ins. Co.*, 435 F. Supp. 2d 827, 829-30 (N.D. Ill. 2006) (describing Congress’s amendment of a different law, allowing states or their political subdivisions to collect from social security benefits). “But that change by Congress really reconfirms that the unmodified language of Section 407(a) as it was construed in *Philpott* continues to apply to *private* parties such as defendants.” *Id.* at 830 (emphasis original) (citing *Philpott v. Essex County Welfare Bd.*, 409 U.S. 413 (1973) (the Supreme Court case which spurred Congress to create the aforementioned exception)). So, although Congress has created exceptions to § 407 for certain situations, it has not created such an exception in ERISA. “Private parties,” such as insurance companies seeking repayment, are still limited by the law.

Notably, § 407 speaks not only of protecting social security benefits “payable” (i.e., future benefits cannot be assigned and benefits cannot be garnished before received), but also of benefits “paid” (i.e., even once received, social security benefits cannot be taken from recipients). *See, e.g., Fahringer v. Paul Revere Insurance Company*, 317 F. Supp. 2d 504, 521-22 (D.N.J. 2003) (LTD insurer cannot impose lien on future social security benefits to recover overpayment); *Mote*, 435 F. Supp. 2d at 830 (Section 407’s protections extend to social security benefits currently in recipient’s possession, not only to future payments). *See also Hall v. Liberty Life Assur. Co. Of Boston*, 595 F.3d 270, 274 -75 (6th Cir. 2010) (holding that section 407 prohibits liens directly on social security benefits; lien must be imposed instead on “the overpayments themselves”).

2. Cases allowing the insurance company to recover:

Despite the language in 42 U.S.C. § 407, several courts have allowed insurance companies to recover from disabled claimants who were paid LTD benefits then later were awarded social security benefits. Unfortunately, in many cases, courts have ruled in an insurance company’s favor without reference to 42 U.S.C. § 407. In other cases, courts have more carefully carved out the relief allowing the insurance company to recover out of the “LTD benefits that were overpaid.”

For example, in *Dillard’s Inc. v. Liberty Life Assur. Co. of Boston*, the Eight Circuit, without any citation to cases denying a recovery such as *Ross* or *Mote*⁹, *infra*, or to 42 U.S.C. § 407 (the portion of the Social Security Act which precludes anyone from obtaining a judgment against Social Security benefits), held that the insurance company/administrator was permitted to maintain its action for equitable reimbursement related to social security payments. 456 F.3d 894 (8th Cir. 2006). The court reasoned that “Liberty seeks a particular share of a specifically identified fund – all overpayments resulting from the payment of social security benefits.”

⁹ *Ross v. Pennsylvania Manuf. Assc. Ins. Co.*, 2006 WL 1390446 (S.D. W.Va. May 22, 2006) and *Mote v. Aetna Life Ins. Co.*, 435 F. Supp. 2d 827 (N.D. Ill 2006), discussed *infra*, are cases denying claims to recover overpaid social security benefits, yet are not discussed by the court who allowed the recovery.

Dillard's, 456 F.3d at 901. It is unknown why the Court did not address the impact of social security law, but certainly the case is distinguishable due to its failure to address all relevant law, in particular the anti-assignment provisions of the Social Security Act.

In an unpublished Sixth Circuit Court of Appeals case, *Gilchrest v. Unum Life Ins. Co. of America*, the Court of Appeals addressed whether ERISA § 502(a)(3) allowed an insurance company to recover money paid under an LTD plan if the person is paid social security benefits. 2007 WL 3037239 (6th Cir. 2007) (unpublished). The Court looked at the language in the plan, which said:

[disability benefits] may be reduced by deductible sources of income, [including the amount the employee receives or is entitled to receive in Social Security disability benefits.]

Unum has the right to recover any overpayments due to:

- fraud;
- any error Unum makes in processing a claim; and
- your receipt of deductible sources of income.

You must reimburse us in full. We will determine the method by which the repayment is to be made. Unum will not recover more money than the amount we paid you.

Id. at *8.

Based on this language, the Court of Appeals held that “the Plan's overpayment provision asserts a right to recover from a specific fund distinct from Gilchrest's general assets-the fund being the overpayments themselves-and a particular share of that fund to which the plan was entitled-all overpayments due to the receipt of social security benefits, but not to exceed the amount of benefits paid.” *Id.* Thus, the court allowed the recovery by the insurance company.

Interestingly, again the Court did not address 42 U.S.C. § 407, (again, the provision of the Social Security Act that precludes anyone from obtaining a judgment against Social Security benefits). The interesting question is this: if Gilchrest had already spent the LTD benefits that had been paid, then from what specific, identifiable funds could the insurance company recover? The LTD benefits are gone, and the only other specific, identifiable funds are the social security benefits which are exempt from recovery under the Social Security Act.

At the district court level within the Sixth Circuit, a court allowed a recovery of an “overpayment” of disability benefits in *Disability Reinsurance Management Services, Inc. v. DeBoer*. No. 2:06-CV-21, 2006 WL 2850120 (E.D. Tenn Sept. 29, 2006)(Unpublished). The court held, “The relief the plaintiff seeks is equitable in nature and permissible under ERISA. The Plan calls for the deduction of SS benefits from the LTD benefits received under the Plan; thus, the plaintiff seeks a specifically identified fund--all overpayments resulting from the payments of Social Security benefits.” *Id.* at *4. However, just like the *Dillard's Inc.* and *Gilchrest* decisions, discussed *supra*, the court did not address 42 U.S.C. § 407 of the Social

Security Act, so the court did not explain what funds the Plan could recover from if the LTD benefits had been spent. That question was not raised in this case because Deboer appeared *pro se*, and this issue was apparently never brought to the court's attention.

In yet another district court case within the Sixth Circuit, *Bosin v. Liberty Life Assur. Co. of Boston*, a district court first held that the plaintiff was not entitled to ongoing benefits under an LTD plan. No. 1:06-CV-186, 2007 WL 1101187 (W.D. Mich. April 11, 2007). The court further held that the plan in *Bosin* allowed for a recovery; on top of that, Bosin had signed a reimbursement agreement. The court held, "The Steelcase LTD policy and the repayment agreement signed by Bosin create the type of equitable lien 'by agreement' recognized and enforced by the Court in *Sereboff*." *Id.* at *10. This court finally addressed the portion of the Social Security Act, 42 U.S.C. § 407 that should be a bar to recovery of social security benefits. The court held that that provision of the Social Security Act was not a bar to the plan's recovery, because the plan was found to be seeking the LTD benefits that were overpaid, not the social security money. It is unclear from this opinion whether Bosin argued that he no longer had the previously paid LTD benefits.

In *Mattox v. Life Ins. Co. of N. Am.*, the court found that the plaintiff was entitled to benefits but also found that the insurance company could recover overpaid LTD benefits previously paid because the Plaintiff was later awarded social security benefits. 536 F. Supp. 2d 1307, 1327 (N.D. Ga. 2008).

In *Mattox*, the plaintiff agreed that, generally speaking, the insurer's claim was a permitted equitable remedy under ERISA § 502(a)(3) but argued that the insurer's claim should be barred because the only monies the plaintiff had with which to pay back the "overpayment" were the plaintiff's ongoing social security benefits. *Mattox* argued that 42 U.S.C. § 407, *supra*, protects social security benefits from judgment or lien. *Id.* at 1327. However, the court reasoned that the insurance company was not seeking the social security benefits themselves but instead was seeking to recover the LTD payments that were already made. The court explained:

One court has held that an insurance company's attempt to impose a constructive trust on a claimant's future Social Security disability payments would violate § 407(a). *See Ross v. Pa. Mfrs. Ass'n Ins. Co.*, No. Civ.A. 1:05-0561, 2006 WL 1390446, at 8 (S.D.W.Va. May 22, 2006). However, the better reasoned opinions that have addressed this issue hold that § 407(a)'s prohibition is not triggered by this kind of reimbursement provision because the insurance company "seeks the amount it overpaid [the claimant rather than] any of [the claimant's] Social Security benefits." *Gilcrest v. Unum Life Ins. Co. of Am.*, No. 05-CV-923, 2006 WL 2251820, at 2 (S.D. Ohio, Aug. 4, 2006). The fact that *Mattox* may have to use her Social Security disability benefits to repay the amount LINA has overpaid her does not alter the Court's analysis. *See, e.g., Dillard's Inc. v. Liberty Life Assurance Co. of Boston*, 456 F.3d 894, 901 (8th Cir.2006).

Id. Similarly, a district court followed the same reasoning in *Herman v. Metropolitan Life Ins. Co.*, No. 8:08-cv-1192-T-23MAP, 2008 WL 5246319 (M.D. Fla. Dec. 16, 2008) (denying Motion to Dismiss equitable lien claim because, even though social security funds were protected from

execution, levy, attachment, garnishment, or other legal process, the insurer sought the amount it overpaid the insured rather than any of the insured's social security funds.)

3. Cases denying the insurance company's claim to recover.

In May 2006, one of the first cases to rely upon social security law to reject an attempt to recover this type of overpayment was decided in reliance upon 42 U.S.C. § 407 of the Social Security Act. In *Ross v. Pennsylvania Manuf. Assc. Ins. Co.*, the plaintiff filed suit seeking reinstatement of his LTD benefits after they were terminated by the Pennsylvania Manufacturers Association Insurance Company ("PMAIC"), the ERISA plan administrator of his company's disability benefit plan. No. Civ. A. 1:05-0561, 2006 WL 1390446 (S.D. W.Va. May 22, 2006). After LTD payments had been made, Ross received social security disability benefits but did not pay PMAIC back after his LTD benefits were terminated. In the litigation, PMAIC filed a counter-claim seeking reimbursement for the overpayment which occurred for those months where Ross received both LTD and social security disability benefits. Ross lost his claim to have his benefits reinstated, but PMAIC also lost its claim to obtain reimbursement.

The district court in *Ross* held that the text of the Social Security Act prevented the recovery sought by PMAIC. 2006 WL 1390446 at *7-8. Relying upon §407, the court held that Social Security law prevented equitable assignment or any efforts to obtain any type of constructive trust over Social Security payments. Notably, the court reasoned that nothing prevented the plan from reducing LTD payments while they were being paid pursuant to the plan's terms related to the receipt of "other income," but the plan was prohibited from filing an action seeking reimbursement by the terms of the Social Security Act. *Id.*

A decision issued one month later, *Mote v. Aetna Life Ins. Co.*, relied upon nearly identical reasoning to find that 42 U.S.C. §407(a) shields social security disability benefits from this type of reimbursement action, despite the ERISA case law finding that reimbursement actions may be equitable. 435 F. Supp. 2d 827 (N.D. Ill 2006). In *Mote*, the court recognized longstanding case law which treats social security benefit monies, even those held in an unsegregated bank account, as maintaining their character as social security benefits subject to protection by §407(a) after they are paid. *Id.* at 829.

In a similar case, *Reichert v. Liberty*, a district court found:

Like the claim in *Sereboff*, the basis for Liberty's claim is equitable in nature. Under the terms of the Policy, Plaintiff owes Liberty reimbursement for overpayment of benefits. However, this case differs from *Sereboff* in that Plaintiff claims she no longer has any of the back benefits from SSDI in her possession. It is no longer in a specially identifiable fund as the funds were in *Sereboff*. Therefore, imposition of liability on Plaintiff for this money would be of a legal nature, resulting in personal liability, and not an equitable remedy. As a result, the Court denies summary judgment with regard to Liberty's cross-claim for reimbursement.

Civil No. 05-2518(RBK) 2007 WL 433321 at *12 (D.N.J. Feb. 5, 2007)

More recent cases show a continued trend toward denying recovery of an overpayment upon a claimant's receipt of social security benefits, depending on the circumstances. For example, in *Herman v. Metropolitan Life Ins. Co.*, a plaintiff's attorney helped his client avoid the insurance company's claimed lien by ensuring that the court had evidence before it that his client has dissipated the LTD benefits that had been paid in the past, and thus there was no traceable funds in the possession of the beneficiary and any recovery must come from social security benefits. 689 F. Supp. 2d 1316, 1317-18 (M.D. Fla. 2010).

In *Herman*, MetLife had argued:

[R]estitution in this case provides an equitable remedy. However, whether restitution "is legal or equitable depends on the 'basis for [the plaintiff's] claim,' and the nature of the underlying remedies sought." *Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204, 213 (2002). Restitution is available under Section 1132(a)(3) "not to impose personal liability on the defendant but to restore to the plaintiff particular funds or property in the defendant's possession." *Knudson*, 534 U.S. at 214. Thus, MetLife's restitution claim is equitable if the parties' Agreement Concerning Long Term Disability Benefits "specifically identify[s] a particular fund, distinct from the [plaintiff's] general assets. . . and a particular share of that fund to which [MetLife is] entitled." *Sereboff v. Mid Atl. Med. Servs.*, 547 U.S. 356, 364 (2006); see also *Dillard's Inc. v. Liberty Life Assurance Comp. of Boston*, 456 F.3d 894, 900-01 (8th Cir. 2006). MetLife objects that MetLife need not "submit evidence of an identifiable fund that remains 'intact' and in Plaintiff's possession to prevail on its counterclaim.

Id. at 1317-18.

The court in *Herman* considered these arguments and noted that, "[i]n *Sereboff*, . . . the fund sought by the fiduciary remained in a separate account maintained by the defendant; *Sereboff* fails to address the imposition of a constructive trust or equitable lien over a dissipated fund." *Id.* However, in this case, the plaintiff submitted a declaration that she no longer possessed any of the funds that were paid, and the only funds that she will have to satisfy the judgment is from her monthly social security check.

The court found:

Because no identifiable fund exists, MetLife seeks to recover a money judgment (which would allow MetLife to levy on the plaintiff's general assets) and not the transfer of title to an existing fund in the possession of the plaintiff. See *Administrative Comm. For the Wal-Mart Stores, Inc. Associates' Health & Welfare Plan v. Horton*, 513 F.3d 1223, 1229 (11th Cir. 2008) ("Under *Knudson*, *Sereboff*, and the other authorities cited above, the most important consideration is . . . that the settlement proceeds are still intact, and thus constitute an identifiable res that can be restored to its rightful recipient.").

Id. at 1318.

Courts have begun to recognize that the timing of the payment of LTD benefits, and the later receipt of social security benefits, matters. When the LTD benefits have been dissipated before the person wins his or her social security claim and there is no evidence that the LTD benefits are still in the possession of the claimant at the time the social security benefits are paid, there are no funds over which a lien can attach. The LTD insurer typically only has a right to claim a lien over the LTD funds it paid.

For example, in *Epolito v. Prudential Ins. Co. of Am.*, Epolito was awarded social security benefits resulting in a claimed overpayment of her LTD claim. 737 F. Supp. 2d 1364 (M.D. Fla. 2010). She defended herself against Prudential's reimbursement claim, arguing that 1) she was no longer in possession of the funds Prudential was seeking, and 2) that 42 U.S.C. § 407(a) prohibited any lien on her social security benefits. Prudential argued that *Sereboff* did away with the requirement of "strict tracing" when enforcing an equitable lien by agreement and therefore recovery should be available without a showing that any specific funds were still in Epolito's possession.

The *Epolito* court analyzed *Sereboff* and found that although strict tracing was no longer required, the Supreme Court's earlier ruling in *Knudson* was still good law for the following point:

Where 'the property [sought to be recovered] or its proceeds have been dissipated so that no product remains, [the plaintiff's] claim is only that of a general creditor,' and the plaintiff 'cannot enforce a constructive trust of or an equitable lien upon other property of the [defendant].'

Epolito, 737 F. Supp. 2d at 1381-82 (quoting *Knudson*, 534 U.S. at 213-14). Applying this rule to the facts of the case, the *Epolito* court wrote:

It is undisputed that Prudential paid LTD benefits to Epolito for the period spanning from August 2, 2003, through August 31, 2005. Because Epolito received a retroactive award of SSD benefits covering that period ... Epolito received LTD benefits in excess of the amount to which she was entitled. Moreover, the terms of the Plan and the Reimbursement Agreement authorize Prudential to recover any such overpayments. However, Prudential has not submitted any evidence that those overpaid benefits still remain in Epolito's possession such that the Court could impose an equitable lien on those particular funds. Although, Prudential notes that Epolito has not provided "any conclusive evidence that the funds are indeed no longer in her possession," it is Prudential's burden to establish that its claim is for equitable relief, and to do so it must show, not only that Epolito "once had property legally or equitably belonging to [Prudential], but that [she] still holds the property or property which is in whole or in part its product." Restatement of Restitution § 215 cmt. a (1936). In the absence of such an identified fund, Prudential's "claim is only that of a general creditor." *Knudson*, 534 U.S. at 213 (quoting Restatement of Restitution § 215 cmt. a (1936)). Because Prudential has not submitted any evidence that the LTD benefits paid to Epolito remain in her possession, Prudential has not demonstrated that it is entitled to equitable relief under §

1132(a)(3)(B). Accordingly, Prudential's Motion for Summary Judgment is due to be denied to the extent it seeks judgment on Prudential's reimbursement counterclaim.

Id. at 1382-83.

Within the Sixth Circuit, despite the cases cited above allowing recovery of an overpayment, more recent cases have questioned whether such recovery should be allowed in all circumstances and have denied recovery at times. For example, in a district court case within the Sixth Circuit, a court held that an insurance company could not recover “overpaid” social security benefits when the insurance company did not make a claim for those benefits from the claimant and raised the issue for the first time in court. In *Allen v. Life Ins. Co. of North America*, the court explained:

LINA argues that Allen's retroactive award of social security benefits reduces the amount of any LTD benefits previously paid under the Plan. LINA maintains that Allen is required to reimburse it for the overpayment of LTD benefits for the period of January 1997 to January 1999. LINA argues that the matter must be remanded to the Plan Administrator for a determination of the reimbursement amount owed by Allen.

In May of 2000, the Social Security Administration awarded Allen retroactive disability benefits commencing October 4, 1996. In January of 2002, Allen filed this instant action in response to LINA's denial of her physical disability benefit claim. In its answer to Allen's Complaint, LINA asserted the Plan's right of offset as an affirmative defense to “any remedy granted by this Court.” (Answer, ¶ 18.) *However, it does not appear from the record that LINA ever made a claim against Allen for reimbursement of any disability benefits previously paid by LINA pursuant to the Plan. The Court has not granted any remedy to Allen and it will not consider this request as an independent claim now.* Thus, the Court declines to remand this matter to the Plan Administrator for consideration of this claim.

No. 1:02CV-3-M, 2010 WL 989159 at *13 (W.D. Ky. Mar. 12, 2010).

None of these overpayment cases were decided since *Montanile*, which draws the conclusions in these cases into great doubt when all the LTD benefits have been dissipated.

I. Ethics Concerns:

Formal Ethics Opinion No. 87-F-109 requires plaintiffs' attorneys to recognize the lien of an insurance company or health care plan and would make it an ethical violation for the attorney to release all of the recovery directly to the client in a manner that would interfere with the health care lien. The opinion reads, in part:

This ethics opinion holds that a lawyer who has notice that a creditor or the client has a lien or assignment to the funds held on behalf of the client is ethically obligated to segregate and retain the disputed funds until the dispute is resolved.

Payment of the disputed amount into court for a resolution of the matter is permissible after the parties have had a reasonable opportunity to resolve the dispute.

Formal Opinion 95-F-136 provides that a lawyer may represent both the injured person and her health insurer if there is full disclosure to both clients. If a conflict arises (as when the made whole doctrine raises its head), significant problems may result. The authors' best advice is that a plaintiff's attorney should represent *only* the injured person but should honor the legal and contractual rights of the subrogated carrier consistent with applicable law. The underlying theory is that, because the carrier simply stands in the shoes of the client, the carrier should reduce its claim to account for the applicable fees just as the client must do. The carrier should not be unjustly enriched by your work.

Also, attorneys frequently ask, so how far do I have to go to protect the subrogation claim by the insurance company? Relying on the ERISA statutory scheme, the U.S. District Court for the Middle District of Tennessee has held that the lawyer for the injured person has a legal duty to send the portion of settlement funds owed to the plan under the subrogation clause. *Greenwood Mills v. Burris*, 130 F.Supp.2d 949, 960-61 (M.D.Tenn 2001). In that case, the court agreed that a lawyer does not have a fiduciary duty to an ERISA plan, even though the lawyer is aware of the existence of a subrogation agreement between the plan and the beneficiary. ERISA, the court concluded, "requires that a fiduciary exercise 'authority or control respecting management or disposition' of plan assets." *Id.* at 957. Because the settlement funds received by the lawyer did not become 'plan assets' when he received them, he did not fall within the definition of a fiduciary.

However, the judge found the lawyer and his firm liable for violating the plan's terms under Section 1132(a)(3), which provides:

A civil action may be brought . . . by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of this plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations of (ii) to enforce any provisions of this subchapter or the terms of the plan.

Id. at 958.

The court relied on Tennessee law on this topic since it did not contradict the policies of ERISA. Under such law, a Tennessee lawyer:

will be held civilly liable to a non-client where he knowingly participates in the extinguishment of a subrogation interest of a non-client third party and delivers to his client funds that he knows belong to the third party and knows or should know, that he has already placed the funds beyond the reach of the third party.

Id.

The court explained:

The court finds that the Tennessee rule on attorney conduct in this area does not conflict with ERISA's purposes and underlying policies. It will therefore furnish the federal rule of law in this case. A lawyer who is fully aware of his client's obligation under an ERISA plan to honor the subrogation interest of his employer may be held liable under § 1132(a)(3). The emphasis on the sanctity of plan provisions does not allow lawyers to be the enablers for participants to avoid following an ERISA plan's provisions without being called to account for such actions under ERISA's remedial scheme. Congress' stated goal of ensuring the security of participants' interests in ERISA plans, an interest that necessarily includes the solvency of the plan, will be advanced by erecting a barrier to beneficiaries' lawyers' interference with the plan's (or its related entity's) rightful recoupment of paid benefits under subrogation provisions. Holding lawyers liable for diverting monies due plans into the pockets of their clients or themselves is to uphold the established policy, exemplified in ERISA's remedial scheme, of equity to all involved with plans—a principle thwarted if lawyers were allowed to enrich themselves unjustly in direct contradiction of the plan's terms.

Id. at 960-61. For that reason, the court ruled that the plaintiff's lawyer was liable for failing to honor his client's obligation under the ERISA plan to pay the subrogation interest.

However, Tennessee more recently issued another formal ethics opinion, 2010-F-154, citing RPC 1.15 (c) of our new ethics rules. The 2010 ethics opinion says the attorney has a duty to notify a third party (i.e. the insurance company or self-funded plan) when the attorney receives the funds that are the property of a third party, the attorney must turn over the funds, and the attorney must render an accounting of the funds. However, the ethics opinion states this is only true in the case where the funds are undisputed property of the third party.

Ethics opinion 2010-F-154, on page five, goes on to state those specific situations under which the attorney has a duty to protect the funds. Those situations are:

- 1) An attachment or garnishment arising out of a valid judgment relating to the disposition of the funds;
- 2) A valid and perfected statutory [including hospital liens and Medicare liens], contractual or judgment lien against the property;
- 3) A letter of protection or similar obligation specifically entered into to aid in obtaining the funds;
- 4) A written assignment or authorization signed by the client, counsel, or other individual with authority conveying interest in the funds to the third person or entity;
or
- 5) A court order relating to the funds in the attorney's possession.

If the ownership of the funds is disputed, the lawyer should keep the funds separate and safeguard them until the dispute is resolved, and the lawyer has a duty to protect third-party claims against wrongful interference by the client.

Also, according to the ethics opinion, if disputed, the lawyer may file the funds into court and file an interpleader action and should not take it upon himself to arbitrate the dispute.

The ethics opinion also properly points out that the opinion does not relieve a lawyer from obligations under substantive law that may hold the lawyer liable to pay claims of third parties who are not on the list, and the opinion points out that under substantive law the lawyer may be sued directly by the third party. The ethics opinion, at pages seven through eight, explains:

If the attorney ignores a duty owed to a third person and pay the disputed amount directly to the client, the attorney may be held liable to the third person. Such liability is a matter of substantive law beyond the scope of this opinion. *Aetna Cas & Sur. Co. v. Gilreath*, 625 S.W.2d 260, 274 (Tenn. 1981)(citing *Motors Ins. Corp v. Blakemore*, 584 S.W. 2d 204, 207 (Tenn. App. 1978)) held:

A lawyer will be held civilly liable to a non-client where he knowingly participates in the extinguishment of a subrogation interest of a non-client third party and delivers to his client funds that he knows belong to the third party and knows or should know, that he has thereby placed funds beyond the reach of the third party. . .

See also, Hankins v. Seaton, No. 03Ao1-9710-CV-00468, 1998 WL 334389 (Tenn. Ct. App. June 25, 1998) (attorney liable for failure to honor a signed subrogation agreement); *Greenwood Mills, Inc. v. Burris et. al.*, 130 F. Supp. 2d 949 (D.C. Tenn. 2001) (attorney liable for failure to pay ERISA subrogation interest).

There are other cases that have similar holdings to those cited in the ethics opinion, such as *Longaberger Co. v. Kolt, supra*, which allowed an insurance company to recover directly from the client and his attorney. 586 F.3d 459 (6th Cir. 2009).

This 2010 ethics opinion is valuable in that it clarifies those situations in which an attorney has an ethical obligation to segregate funds and to withhold them from his client, because it lists five specific circumstances where that is required. If one of those circumstances does not exist, it is not an ethical violation to release the funds. But if it is disputed whether one of the five circumstances exist, the attorney cannot take it upon himself or herself to resolve the dispute. Further, as is also noted by the opinion, and other cases not cited therein, such as *Longaberger v. Kolt*, there are times the attorney and his client may both be held liable, even if one of the five situations is not met.

About the author:

Eric Buchanan is founding partner of the firm of Eric Buchanan and Associates, PLLC, a firm that represents disabled people in claims for disability insurance and social security disability, as well as individuals and policyholders who have been denied ERISA benefits and

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Eric Buchanan is past President of the Chattanooga Trial Lawyers. He is also past-chair of the Tennessee Bar Association Disability Law Section. He was also elected to two positions within the American Association of Justice (AAJ) (Formerly the Association of Trial Lawyers of America (ATLA)); Mr. Buchanan is past chair of the AAJ ERISA Health Care and Disability Litigation Group and past chair of the AAJ Social Security Disability Section. Eric Buchanan is a sustaining member of NOSSCR. He is Vice President for East Tennessee of the Tennessee Association for Justice (TAJ) (formerly the Tennessee Trial Lawyers Association (TTLA)), as well as a lifetime member of TAJ.

Eric Buchanan has written numerous articles on ERISA law, including the chapter on ERISA subrogation for the West's *Auto Torts Litigation* manual. He is also a frequent speaker on ERISA law, subrogation, and disability law at both the state and national levels.

Eric Lane Buchanan is a 1989 graduate of The Virginia Military Institute, and a 1997 *magna cum laude* graduate of the Washington and Lee School of Law. In law school, he was inducted in the ODK honorary leadership fraternity in January 1997 and inducted into Order of the Coif upon graduation.

Prior to attending law school, Eric Buchanan served as an officer and naval aviator in the United States Navy, serving as a pilot of P3-C "Orion" aircraft. He served in the East Coast of the U.S., in the Atlantic, Mediterranean, and Arctic Oceans, and was deployed throughout Europe, including eleven months spent in Iceland.