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NOTE

Where the Windfall Falls Short: “Appropriate Equitable Relief” after *Sereboff v. Mid Atlantic Medical Services, Inc.*

I. Introduction

In June 1996, a motorcycle accident rendered twenty-four-year-old Shawn Paris permanently brain damaged.¹ In a settlement, Paris recovered \$100,000 against the party responsible for his injuries.² At the time of settlement, medical bills incurred to treat Paris’ injuries exceeded \$200,000.³ Paris’ health plan, which paid the medical expenses, attempted to recover its expenditures under a recoupment clause in the policy contract. In response, Paris sought a declaratory judgment that Maryland state law precluded his health plan from collecting the settlement as reimbursement for medical bills resulting from his accident. Ruling that state law did not apply and finding no parallel federal protection, the U.S. District Court for the District of Maryland granted summary judgment against Paris and awarded the entire \$100,000 settlement to the health plan.⁴ This decision left Paris’ mother to furnish both the attorney fees and a lifetime of costly medical expenses for her son, whom the district court labeled “a disabled, destitute adult child.”⁵

Although this situation may seem shocking, sadly, it represents a common occurrence. In fact, insurance providers regularly insert subrogation and reimbursement clauses in their policy contracts.⁶ These recoupment provisions allow a plan fiduciary to recover money from an injured plan participant who obtains damages through a settlement or judgment against a responsible third-party tortfeasor or third-party insurer.⁷ Cash settlements recovered through these provisions serve to repay the plan for past medical expenses resulting from the participant’s injuries.⁸ Specifically, employer-provided insurance

1. *In re Paris*, 44 F. Supp. 2d 747, 748 (D. Md. 1999), *aff’d*, 211 F.3d 1265 (4th Cir. 2000) (unpublished table decision).

2. *Id.*

3. Petition for Writ of Certiorari at 3-4, *Paris v. Iron Workers Trust Fund, Local No. 5.*, 531 U.S. 875 (2000) (No. 00-94), 2000 WL 33999984.

4. *Paris*, 44 F. Supp. 2d at 749.

5. *Id.* at 748.

6. Greta E. Cowart, *Subrogation and Equitable Relief Under ERISA—Waiting for Sereboff*, in *HEALTH PLANS, HIPAA AND COBRA UPDATE: CURRENT ERISA, TAX, AND OTHER ISSUES FOR ATTORNEYS, ADMINISTRATORS, INSURERS, AND CONSULTANTS* 600, 603 (ALI-ABA ed., 2006) (explaining the historic roots of the subrogation debate).

7. *Id.*

8. *Id.*

plans are governed by the Employee Retirement Income Security Act of 1974 (ERISA).⁹ Although a majority of states have enacted protections preventing or limiting insurers' ability to enforce these reimbursement provisions, ERISA preempts enforcement of such state-law protections against self-funded health plans.¹⁰

In May 2006, the United States Supreme Court issued its latest decision in the area of reimbursement and ERISA in the case of *Sereboff v. Mid Atlantic Medical Services, Inc.*¹¹ Until *Sereboff*, employer-provided insurance plans were often denied the ability to collect reimbursement from injured plan participants who had acquired third-party settlements.¹² The *Sereboff* decision, which the insurance industry heralded as a victory, simplified and expanded the ability of health plans to obtain reimbursement.¹³ For attorneys who represent injured plan participants, the outcome that Shawn Paris was forced to accept seems destined for repetition in the wake of the *Sereboff* decision. The Court's opinion, however, does not clearly resolve how the funds must be held to allow collection by the health plan through the available equitable remedy. This ambiguity and the absence of state-law protections result in an ethical dilemma for attorneys representing the catastrophically injured, who must attempt to both guard an undercompensated client's settlement and comply with the law. These considerations, combined with public policy, demand renewed consideration of whether, and under what circumstances, courts should enforce health plan recoupment clauses.

This Note will highlight the unanswered questions, new dilemmas, and a potential avenue of relief for injured plan participants resulting from the *Sereboff* decision. Part II will explore the legal background behind recoupment under both state law and ERISA. Part III will analyze and discuss the decision in *Sereboff*. Part IV will outline the facts behind the alleged "windfall" to plan participants, the vast public policy against reimbursement in many situations, and the legal and ethical challenges now facing those who represent injured plan participants. Based upon these findings, Part IV will argue that analysis of the statute—and its restriction that health plans seeking reimbursement may only obtain "appropriate equitable relief"—must include

9. Employee Retirement Income Security Act § 4, 29 U.S.C. § 1003 (2000).

10. See *infra* Part II.A.

11. 126 S. Ct. 1869 (2006).

12. Roger M. Baron, *Public Policy Considerations Warranting Denial of Reimbursement to ERISA Plans: It's Time to Recognize the Elephant in the Courtroom*, 55 MERCER L. REV. 595, 596 (2004).

13. Mark A. Hoffman, *Health Plan Wins Fight over Costs Recovery, Ruling Benefits Employers*, BUS. INS., May 22, 2006, at 1 (stating that the decision in *Sereboff* is "good news for plans and the employers that sponsor them").

a determination of whether the relief sought is truly appropriate. This note will conclude in Part V.

II. Background

A. Subrogation and Reimbursement Generally

The principle of subrogation permits an insurer who has indemnified a policyholder to assume legal standing in place of the policyholder to sue a third-party tortfeasor on the policyholder's claim for compensation.¹⁴ Reimbursement, by contrast, permits the insurer to assert a contractual right to repayment out of the proceeds of an insured's later recovery from a third party.¹⁵ The concepts of subrogation and reimbursement for personal injury claims "[are] of relatively recent origin, having only been developed in the last thirty to forty years."¹⁶

Historically, courts prohibited insurer subrogation in personal injury claims.¹⁷ In the 1960s, however, insurers began successfully couching subrogation clauses in terms of "reimbursement" to avoid the state laws prohibiting subrogation.¹⁸ Despite this change in pleading, some states continued to flatly reject an insurer's claim to recoupment of personal injury claims.¹⁹ Other jurisdictions applied the common law "make-whole doctrine," which limited an insurer's ability to recover from a beneficiary by requiring that the policyholder receive full compensation for any uninsured loss before enforcement of the insurer's recoupment rights.²⁰ Twenty-five states have adopted the make-whole doctrine.²¹ Another widespread limitation is the

14. BLACK'S LAW DICTIONARY 1467 (8th ed. 2004).

15. See Michelle J. d'Arcambal, *The Assault on Subrogation*, in ALI-ABA CONFERENCE ON LIFE INSURANCE LITIGATION 461, 463 (ALI-ABA ed., 1997) (defining subrogation and reimbursement).

16. Baron, *supra* note 12, at 602-03.

17. *Id.* at 603 (noting that "subrogation had been disallowed by virtually all courts until recently").

18. *Id.*

19. Roger M. Baron, *Subrogation on Medical Expense Claims: The "Double Recovery" Myth and the Feasibility of State Anti-Subrogation Laws*, 96 DICK. L. REV. 581, 584-85 (1992) (noting that Missouri, Arizona, Connecticut, Nevada, Montana, Pennsylvania, and Oklahoma adopt this view).

20. 16 LEE R. RUSS & THOMAS F. SEGALLA, COUCH ON INSURANCE § 223:134 (3d ed. 2000).

21. Elaine M. Rinaldi, *Apportionment of Recovery Between Insured and Insurer in a Subrogation Case*, 29 TORT & INS. L.J. 803, 807 (1994) (reporting that Alabama, Arkansas, Colorado, Connecticut, Florida, Illinois, Indiana, Iowa, Louisiana, Maine, Massachusetts, Michigan, Minnesota, Mississippi, Montana, New Jersey, North Carolina, Rhode Island, Tennessee, Texas, Utah, Vermont, Washington, West Virginia, and Wisconsin have adopted

“common-fund doctrine,” which requires that the injured plan participant’s attorney receive reimbursement before compensation of the plan through the third-party settlement.²² Thus, more than half of the states, through total refusal to enforce the provisions or limitations on recovery, challenge the ability of an insurer to transfer its losses to an injured policyholder who obtains a third-party recovery.

B. Subrogation and Preemption by ERISA

Although Congress enacted ERISA primarily to protect workers’ pension benefits,²³ the statute’s preemption language has extended into areas far beyond Congress’s original intended purpose. During its drafting, ERISA came to encompass not only pension plans, but also medical and other employee benefit plans.²⁴ Unfortunately, Congress “gave very little explicit consideration to the implications of this expansion.”²⁵ Indeed, the preemption language within ERISA remains one of the most perplexing and most litigated portions of the statutory scheme.²⁶

ERISA contains two provisions that have been held to preempt state laws. First, ERISA provides express preemption language in section 514.²⁷ Within that section, three distinct clauses interact to form the express ERISA preemption. The “preemption clause” provides that ERISA “shall supersede any and all State laws . . . [that] relate to any employee benefit plan.”²⁸ The United States Supreme Court has interpreted this clause broadly, stating that a state law relates to a benefit plan “in the normal sense of the phrase, if it has a connection with or reference to such a plan.”²⁹ Next, the “savings clause” exempts from preemption any state law “which regulates insurance, banking,

the make-whole doctrine).

22. 16 RUSS & SEGALLA, *supra* note 20, § 223:113. For further discussion of the arguments for inclusion of the common-fund doctrine in federal common law, see Amber M. Anstine, Comment, *ERISA Qualified Subrogation Liens: Should They Be Reduced to Reflect a Pro Rata Share of Attorneys Fees?*, 104 DICK. L. REV. 359 (2000) (arguing that the common-fund doctrine should be recognized by courts in ERISA subrogation actions).

23. Russell Korobkin, *The Failed Jurisprudence of Managed Care, and How to Fix It: Reinterpreting ERISA Preemption*, 51 UCLAL. REV. 457, 464 (2003).

24. *Id.* at 465.

25. *Id.*

26. Donald T. Bogan, *ERISA: The Savings Clause, § 502 Implied Preemption, Complete Preemption, and State Law Remedies*, 42 SANTA CLARA L. REV. 105, 108 (2001).

27. Employee Retirement Income Security Act § 514, 29 U.S.C. § 1144 (2000).

28. *Id.* § 514(a), 29 U.S.C. § 1144 (“Except as provided in [the savings clause], the provisions of this subchapter . . . shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan [covered by ERISA].”).

29. *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 45 (1987) (quoting *Metro. Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 739 (1985)).

or securities.”³⁰ Finally, the “deemer clause” modifies the effect of the savings clause by nullifying any state attempt to regulate a self-funded employee benefit plan as if it were an insurance company.³¹ In *FMC Corp. v. Holliday*, the Supreme Court interpreted these complicated provisions of ERISA, specifically the deemer clause, as exempting self-funded health plans from any state laws dealing with subrogation rights.³² As a result, state law limitations on recoupment do not apply to nearly half of all employer-provided benefit plans.³³

Courts have also applied an implied preemption analysis in ERISA claims arising from the statute’s express civil enforcement scheme. ERISA provides:

A civil action may be brought . . .

(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.³⁴

The Supreme Court has interpreted this enforcement scheme as providing exclusive relief for plan fiduciaries.³⁵ Section 502(a)(3) allows plan fiduciaries to recover only “appropriate *equitable* relief.”³⁶ In addition, the ERISA express preemption language bars a fiduciary’s potential state law claim for breach of contract.³⁷ Consequently, the only option available to the plan

30. Employee Retirement Income Security Act § 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A) (“Except as provided in [the deemer clause], nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.”).

31. *Id.* § 514(b)(2)(B), 29 U.S.C. § 1144(b)(2)(B) (providing that certain employee benefit plans may not be “deemed to be an insurance company” within the meaning of the savings clause).

32. 498 U.S. 52, 61 (1990) (“We read the deemer clause to exempt self-funded ERISA plans from state laws that ‘regulate insuranc[e]’ within the meaning of the saving clause.” (alteration in original)).

33. At least forty percent of all employer-provided plans qualify as self-funded. See NAT’L CTR. FOR POLICY ANALYSIS, THE IMPACT OF ERISA 2 (1995), available at <http://www.ncpa.org/pub/ba/pdf/ba167.pdf>; see also Frederick D. Hunt, Jr., Soc’y of Prof’l Benefit Adm’rs, Self Funding: An Overview & Explanation of Misconceptions, <http://users.erols.com/spba/p0000008.html> (last visited Mar. 31, 2008) (“In truth, about 85% of employer health plans currently use some form of self-funding, and are subject to ERISA regulation.”).

34. Employee Retirement Income Security Act § 502(a), 29 U.S.C. § 1132(a).

35. Bogan, *supra* note 26, at 110-11.

36. Employee Retirement Income Security Act § 502(a)(3)(B), 29 U.S.C. § 1132(a)(3)(B) (emphasis added).

37. Bogan, *supra* note 26, at 110-11.

fiduciary is to couch its recoupment action as a claim seeking equitable relief under section 502(a)(3).³⁸

Although federal courts have subsumed ERISA plan recoupment actions, the fate of the make-whole doctrine at the federal level remains unclear. In some situations, state laws enacting the make-whole doctrine survive preemption by ERISA under the savings clause.³⁹ The circuits have split over whether to apply the make-whole doctrine as the default rule under federal common law where the policy contract does not clearly prohibit such application.⁴⁰ Regardless, even jurisdictions that recognize the make-whole doctrine as a default rule allow the plan language to expressly override the protection.⁴¹ The possible absence of the make-whole doctrine at the federal level has thereby generated continued debate on what constitutes appropriate equitable relief for the purposes of the statute.

C. *Mertens v. Hewitt Associates*

In 1993, the United States Supreme Court issued its first decision dealing with the scope of appropriate equitable relief under ERISA section 502(a)(3). In *Mertens v. Hewitt Associates*,⁴² plan participants sought compensation for an alleged breach of an ERISA fiduciary duty that resulted in the loss of a significant part of their pension benefits.⁴³ The policyholders brought a claim under section 502(a)(3) asserting that the relief they sought qualified as “appropriate equitable relief” due to “ERISA’s roots in the common law of trusts.”⁴⁴

Ruling five to four, the Court discredited the plan participants’ argument. The majority opinion, authored by Justice Scalia, succinctly stated that “[a]lthough they often dance around the word, what petitioners in fact seek is nothing other than compensatory *damages*—monetary relief for all losses their

38. *Id.*

39. *FMC Corp. v. Holliday*, 498 U.S. 52, 61 (1990) (“[E]mployee benefit plans that are [fully] insured are subject to indirect state insurance regulation.”).

40. *See Waller v. Hormel Foods Corp.*, 120 F.3d 138, 140 (8th Cir. 1997) (indicating that the make-whole doctrine should not be applied in ERISA cases); *Cagle v. Bruner*, 112 F.3d 1510, 1521 (11th Cir. 1997) (adopting the make-whole doctrine as a default rule in ERISA cases); *Cutting v. Jerome Foods, Inc.*, 993 F.2d 1293, 1298 (7th Cir. 1993) (rejecting a make-whole qualification to an ERISA plan’s subrogation rights); *see also* David M. Kono, Note, *Unraveling the Lining of ERISA Health Insurer Pockets: A Vote For National Federal Common Law Adoption of the Make Whole Doctrine*, 2000 BYU L. REV. 427.

41. Anstine, *supra* note 22, at 367.

42. 508 U.S. 248 (1993).

43. *Id.* at 250-51.

44. *Id.* at 255-56 (emphasis omitted).

plan sustained as a result of the alleged breach of fiduciary duties. Money damages are, of course, the classic form of *legal relief*.⁴⁵

The Court acknowledged that, at common law, the courts of equity had exclusive jurisdiction over virtually all actions by beneficiaries for breach of trust and that those courts typically permitted the recovery of money damages.⁴⁶ The Court further noted, however, that although courts of equity might hear such claims, such claims nevertheless constituted an adjudication of legal rights and legal remedies.⁴⁷ The Court's majority opinion recognized that "equitable relief" had two possible meanings. First, Congress may have intended the term to reference "whatever relief a court of equity is empowered to provide in a particular case."⁴⁸ Alternatively, the Court noted that equitable relief could also refer to the types of relief typically available at equity, including "injunction, mandamus, and restitution, but not compensatory damages."⁴⁹ Based in part on the determination that Congress could not have intended equitable relief to mean all relief, the five-member majority adopted the limited view of equitable relief.⁵⁰ Despite the Court's own admission that this meaning was increasingly unlikely, the Court limited equitable relief for the purposes of section 502(a)(3) to those remedies that the Court interpreted as typically available at equity.

D. *Great-West Life & Annuity Insurance Co. v. Knudson*

The Court faced the issue of defining appropriate equitable relief again in the 2002 case of *Great-West Life & Annuity Insurance Co. v. Knudson*.⁵¹ The *Knudson* case involved a lawsuit, brought under ERISA section 502(a)(3), to recover medical benefits pursuant to a recoupment provision.⁵² The beneficiary, Janette Knudson, became a quadriplegic following an automobile accident.⁵³ Great-West, acting as claims administrator for a self-funded medical plan, paid \$411,157 in medical expenses.⁵⁴ Knudson sued the car manufacturer on a products liability claim and ultimately settled for \$650,000.⁵⁵ Pursuant to California law, the state court placed a portion of the

45. *Id.*

46. *Id.* at 255-56.

47. *Id.* at 255.

48. *Id.* at 256.

49. *Id.*

50. *Id.* at 262.

51. 534 U.S. 204 (2002).

52. *Id.* at 207-08.

53. *Id.* at 207.

54. *Id.*

55. *Id.*

settlement proceeds in a special needs trust established for Knudson.⁵⁶ The court distributed the remainder of the settlement between Knudson's attorney, California Medicaid, and specifically, by a check to Great-West in the amount of \$13,828.⁵⁷ Seeking reimbursement for the entirety of the medical expenses paid, Great-West refused to cash the check and sued Knudson under ERISA section 502(a)(3).⁵⁸ Notably, Great-West failed to appeal the denial of the motion to add the special needs trust that held the majority of the product liability settlement funds as a defendant.⁵⁹

In another five to four decision authored by Justice Scalia, the Supreme Court clarified its *Mertens* decision. The Court stated that as used in ERISA, the term equitable relief "must refer to those categories of relief that were typically available in equity."⁶⁰ The Court rejected Great-West's argument that seeking an injunction or restitution to recover money owed to the plan constituted equitable relief.⁶¹ The Court noted that "an injunction to compel the payment of money past due under a contract, or specific performance of a past due monetary obligation, was not typically available in equity."⁶² Consequently, the Court held that the form of restitution sought by Great-West did not qualify as "equitable relief." The Court distinguished between legal and equitable restitution, stating that the distinction hinged on the "basis for [the plaintiff's] claim and the nature of the underlying remedies sought."⁶³ Under the Court's rubric, legal restitution occurred where the plaintiff sought to "obtain a judgment imposing a merely personal liability upon the defendant to pay a sum of money."⁶⁴

As a corollary, the Court then explained when restitution would qualify as an equitable remedy:

In contrast, a plaintiff could seek restitution *in equity*, ordinarily in the form of a constructive trust or an equitable lien, where money or property identified as belonging in good conscience to the

56. *Id.* at 207-08.

57. *Id.* at 208.

58. *Id.*

59. *Id.* at 220.

60. *Id.* at 210 (quoting *Mertens v. Hewitt Assocs.*, 508 U.S. 248, 256 (1993)) (internal quotation marks omitted).

61. *Id.* at 210-11.

62. *Id.*

63. *Id.* at 213 (citing *Reich v. Cont'l Cas. Co.*, 33 F.3d 754, 756 (7th Cir. 1994)) (internal quotation marks omitted) (alteration in original).

64. *Id.* (quoting RESTATEMENT OF RESTITUTION § 160 cmt. a (1936)).

plaintiff could clearly be traced to particular funds or property in the defendant's possession.⁶⁵

Therefore, where the Court could identify property belonging to the plaintiff and trace it into the defendant's hands, the Court could impose a constructive trust.⁶⁶ In contrast, if the property had dissipated to the extent that no identifiable product remained, the plaintiff's claim shifted to one for general money damages, or legal relief.⁶⁷ Under those circumstances, the plaintiff could not enforce an equitable lien or constructive trust.⁶⁸

In *Knudson*, the plan participant no longer controlled the funds. Following the third-party settlement, they were distributed to the special needs trust and to Knudson's attorney.⁶⁹ Because the health plan did not appeal the district court's denial of their motion to amend the complaint to add these individuals as co-defendants, the United States Supreme Court did not consider whether Great-West could have sought equitable relief against Knudson's attorney and the trustee of the special needs trust.⁷⁰ In *Knudson*, the Court held that Great-West sought legal rather than equitable relief, and as a result, the Court denied reimbursement.⁷¹

E. The Circuit Split After Knudson

Following *Knudson*, the majority of circuits interpreted the dicta in that decision as opening the door to claims by health plans for equitable relief through constructive trusts or equitable liens. In fact, nearly every circuit after the *Knudson* decision followed what would become known as the "possession theory."⁷² The possession theory allows recovery where funds in the actual or constructive possession of a plan beneficiary are traceable to money or property identified as belonging in good conscience to the ERISA plan.⁷³ Where this occurs, the plan may seek a constructive trust or equitable lien as other equitable relief available under ERISA.⁷⁴

65. *Id.*

66. *Id.*

67. *Id.* at 213-14.

68. *Id.*; Cowart, *supra* note 6, at 605.

69. *Knudson*, 534 U.S. at 214.

70. *Id.*

71. *Id.* at 220.

72. David D. Leishman, Note, *Adding Insult to Injury: ERISA, Knudson, and the Error of the Possession Theory*, 89 MINN. L. REV. 1214, 1223-26 (2005) (noting that "[c]ourts in the Fourth, Fifth, Seventh, Eighth, Tenth, Eleventh, and D.C. Circuits have adopted the possession theory" (internal footnotes omitted)).

73. *Id.* at 1220.

74. *Id.*

The test most cited for the possession theory originated in the Fifth Circuit Court of Appeals. In *Bombardier Aerospace Employee Welfare Benefits Plan v. Ferrer, Poirot & Wansbrough*,⁷⁵ the Fifth Circuit found that when the participant's attorney had identifiable settlement funds in a trust account, the plan's action against the participant's law firm did not seek to impose personal liability on the participant or his counsel, but rather to impose a constructive trust, and thus fell subject to suit under ERISA section 502(a)(3). In its analysis, the Fifth Circuit held that an ERISA insurer may impose a constructive trust or equitable lien upon specifically identifiable funds that belong in good conscience to the plan and that are within the possession and control of the plan participant.⁷⁶

In nearly all cases where the plan sought damages from a specifically identifiable fund of money traceable to a third-party settlement, courts would allow the imposition of a constructive trust or equitable lien under ERISA section 502(a)(3).⁷⁷ Furthermore, courts construed the possession theory broadly, allowing the plan to trace funds into a beneficiary's bank account,⁷⁸ trust account,⁷⁹ or to the third-party tortfeasor's attorney.⁸⁰

Nevertheless, the Sixth and Ninth circuits declined to follow the possession theory in the *Knudson* dicta.⁸¹ These circuits generally refused to validate plan or plan fiduciary attempts to assert equitable claims, finding "the spirit, if not the letter, of the request to be [for legal relief]."⁸² As a result, the Supreme Court granted certiorari to solve this dispute between the circuits. In *Sereboff v. Mid Atlantic Medical Services, Inc.*, the Supreme Court intended to clarify under what facts health plans could assert a constructive trust or equitable lien, allowing the claim to fall under ERISA's requirement that claims seek appropriate equitable relief.

75. 354 F.3d 348 (5th Cir. 2003).

76. *Id.* at 355-56.

77. Leishman, *supra* note 72, at 1221.

78. *See* Mid Atl. Med. Servs., Inc. v. Sereboff, 303 F. Supp. 2d 691, 696 (D. Md. 2004) (allowing reimbursement where the defendants held the settlement funds in an investment account), *aff'd*, 407 F.3d 212 (4th Cir. 2005), *aff'd*, 126 S. Ct. 1869 (2005).

79. *See* Great-West Life & Annuity Ins. Co. v. Brown, 192 F. Supp. 2d 1376, 1381 (M.D. Ga. 2002) (allowing recovery where the defendant held funds in a trust account).

80. *See* Primax Recoveries, Inc. v. Young, 83 Fed. App'x 523, 525 (4th Cir. 2003).

81. *See* Qualchoice, Inc. v. Rowland, 367 F.3d 638, 650 (6th Cir. 2004), *overruled by Sereboff*, 126 S. Ct. 1869; Westaff (USA) Inc. v. Arce, 298 F.3d 1164, 1166-67 (9th Cir. 2002), *overruled by Sereboff*, 126 S. Ct. 1869.

82. Leishman, *supra* note 72, at 1241.

III. Sereboff v. Mid Atlantic Medical Services, Inc.

A. Statement of the Case

On June 22, 2000, Joel and Marlene Sereboff suffered injuries in an automobile accident in California.⁸³ The Sereboffs were beneficiaries under a self-funded health plan administered by Mid Atlantic Medical Services, Inc.⁸⁴ Accordingly, the Sereboffs' plan with Mid Atlantic provided for payment of certain covered medical expenses. The plan also contained an "Acts of Third Parties" provision, requiring that a participant who received benefits under the plan must fully reimburse Mid Atlantic from any recoveries obtained from a third-party tortfeasor.⁸⁵ Furthermore, the provision required reimbursement of funds to Mid Atlantic regardless of whether the third-party had fully compensated the plan participant for their injuries, unless Mid Atlantic agreed in writing to a reduction.⁸⁶ This final provision would, arguably, preclude a contracting party from asserting a make-whole defense as a matter of ERISA common law.

After the Sereboffs' accident, Mid Atlantic paid their medical expenses, totaling \$74,869.37.⁸⁷ Subsequently, the Sereboffs filed a tort action in state court against several third parties, seeking compensatory damages for injuries suffered as a result of the accident.⁸⁸ Soon after the Sereboffs initiated their suit, Mid Atlantic sent the Sereboffs' attorney a letter asserting a "lien" on the anticipated proceeds of the suit. The asserted lien sought the medical expenses Mid Atlantic paid on the Sereboffs' behalf.⁸⁹ During the course of the litigation, Mid Atlantic sent the Sereboffs details of the medical expenses as they accrued and were paid, and repeated its claim to a lien on a portion of the beneficiaries' recovery.⁹⁰

The Sereboffs' litigation with the third parties resulted in a settlement of \$750,000.⁹¹ When the Sereboffs refused to pay Mid Atlantic any of the settlement proceeds, Mid Atlantic sued the Sereboffs in federal district court under section 502(a)(3) of ERISA.⁹² Additionally, Mid Atlantic sought a

83. Brief for Petitioners at 3, *Sereboff*, 126 S. Ct. 1869 (No. 05-260), 2006 WL 165865.

84. *Sereboff*, 126 S. Ct. at 1872.

85. *Id.*

86. *Id.*

87. *Id.* at 1873.

88. *Id.* at 1872.

89. *Id.*

90. *Id.* at 1872-73.

91. *Id.* at 1873.

92. *Id.*

temporary restraining order and preliminary injunction requiring the beneficiaries to retain and set aside at least \$74,869.37 from the settlement proceeds.⁹³ The Sereboffs and their counsel agreed to preserve the disputed amount in a separate, segregated investment account until the district court ruled on the merits of the case and the Sereboffs' exhausted all appeals.⁹⁴

The United States District Court for the District of Maryland entered summary judgment for Mid Atlantic and ordered the Sereboffs to pay the \$74,869.37, plus interest, with a deduction for Mid Atlantic's share of the attorney fees and court costs the Sereboffs incurred in state court.⁹⁵ The judge later awarded attorney fees to Mid Atlantic for expenses incurred in obtaining reimbursement.⁹⁶ The Sereboffs appealed, and the Fourth Circuit Court of Appeals affirmed the decision of the district court.⁹⁷ In the opinion, the Fourth Circuit noted the split in the circuits on the issue of whether section 502(a)(3) authorizes recovery under the circumstances present in *Sereboff*.⁹⁸ The United States Supreme Court granted certiorari to resolve the conflict among the circuits.

B. Issue and Holding

The Court observed that a fiduciary may bring a civil action under section 502(a)(3) to obtain appropriate equitable relief to redress or enforce violations of ERISA provisions or the terms of the plan. The Court further observed that Mid Atlantic qualified as a fiduciary under ERISA and that it filed suit in district court to enforce the terms of the Acts of Third Parties provision. Therefore, the Court found the only true question for review was whether the relief Mid Atlantic's suit requested constituted appropriate equitable relief under section 502(a)(3).⁹⁹

In a unanimous decision, the Supreme Court affirmed the decision of the Fourth Circuit Court of Appeals. In an opinion by Chief Justice Roberts, the Court held that the type of relief sought by Mid Atlantic properly constituted equitable relief as contemplated by ERISA section 503(a)(3).¹⁰⁰

93. *Id.*

94. *Id.*

95. *Id.*

96. *Id.*

97. *Id.*

98. *Id.*

99. *Id.*

100. *Id.* at 1878.

C. Rationale of the Court

The Court began its analysis by comparing the Sereboff's situation to that of its prior decision in *Great-West Life & Annuity Insurance Co. v. Knudson*. The Court identified that the key distinction between *Sereboff* and *Knudson* was the way the plan enforced the reimbursement clause. Applying the earlier decision in *Mertens v. Hewitt Associates*, the Court stated that equitable relief consisted of "those categories of relief that were typically available in equity."¹⁰¹ The Court explained that the imposition of a constructive trust or equitable lien on particular funds or property in the defendant's possession constituted one traditionally recognized form of equitable restitution, as established by the dicta in *Knudson*.¹⁰² The funds in *Knudson* did not meet this requirement because the funds that petitioners sought were held by the state in a special needs trust and therefore not in Knudson's possession. In contrast, the Court noted that the "impediment to characterizing the relief in *Knudson* as equitable is not present" in the Sereboffs' case.¹⁰³ Mid Atlantic sought specifically identifiable funds reserved from the third-party settlement in a segregated investment account pursuant to a stipulation agreed to by the Sereboffs and their lawyer. Thus, the Court distinguished the situation in *Sereboff* from the earlier decision in *Knudson*, a case with facts admittedly "similar to those in [*Sereboff*]."¹⁰⁴

After distinguishing the facts of *Sereboff* from *Knudson*, the Court evaluated whether Mid Atlantic had adequately established the equitable basis for its claim. In making this evaluation, the Court revisited a 1914 opinion "from the days of the divided bench."¹⁰⁵ In *Barnes v. Alexander*,¹⁰⁶ two attorneys performed work for a third, in exchange for one third of the expected contingent fee.¹⁰⁷ In upholding their equitable claim, Justice Holmes recited "the familiar rule[] of equity 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."¹⁰⁸ On the basis of this rule, Justice Holmes concluded that Barnes' undertaking "create[d] a lien" upon the portion of the monetary

101. *Id.* at 1873 (quoting *Mertens v. Hewitt Assocs.*, 508 U.S. 248, 256 (1993)).

102. *Id.* at 1874.

103. *Id.*

104. *Id.*

105. *Id.* at 1874-75.

106. 232 U.S. 117 (1914).

107. *Id.* at 119.

108. *Id.* at 121.

recovery due Barnes from the client, which Street and Alexander could “follow . . . into the hands of . . . Barnes” once the fund was identified.¹⁰⁹

Applying the *Barnes* decision to the matter at hand, the Court found that Mid Atlantic had properly followed the steps established in *Barnes*. The Acts of Third Parties provision “specifically identified a particular fund, distinct from the Sereboffs’ general assets.”¹¹⁰ Therefore, as in *Barnes*, Mid Atlantic could successfully follow a portion of the settlement funds into the Sereboffs’ hands once the fund was identified and impose on that portion a constructive trust or equitable lien.¹¹¹

The Court rejected the beneficiaries’ contention that *Knudson* and *Barnes* imposed a strict “tracing requirement” on all recoveries.¹¹² Tracing would require that Mid Atlantic directly trace the funds it sought to recover to funds received in the third-party settlement identified in the plan contract. In rejecting this claim, the Court distinguished “an equitable lien sought as a matter of restitution” and an equitable lien imposed “by agreement.”¹¹³ Historically, only the former required strict tracing at equity, and the Court declined to apply all the restitutionary conditions to enforcement of an equitable lien by agreement under section 502(a)(3).¹¹⁴ In addition, the Court dismissed the beneficiaries’ contention that the fund must exist at the time of equitable lien agreement formation.¹¹⁵ Thus, the fact that no third-party recovery existed at the time of plan document execution did not impede the creation of an equitable lien by agreement.¹¹⁶

D. The Failed Defense: Appropriate Equitable Relief

Finally, the Sereboffs contended that the lower courts erred in allowing the enforcement of the Acts of Third Parties provision without imposing traditional limitations on subrogation.¹¹⁷ The Sereboffs argued that they should have the ability to assert equitable defenses in an equitable subrogation action, such as the defense that the plan may pursue subrogation only in the case of a fully compensated victim.¹¹⁸ The Court, however, found that Mid Atlantic’s claim to enforce the Acts of Third Parties provision qualified as an

109. *Id.* at 122-23.

110. *Sereboff*, 126 S. Ct. at 1875.

111. *Id.*

112. *Id.*

113. *Id.*

114. *Id.* at 1876.

115. *Id.*

116. *Id.*

117. *Id.* at 1877.

118. *Id.*

equitable lien established by agreement.¹¹⁹ Therefore, Mid Atlantic did not need to characterize its claim as a freestanding action for equitable subrogation.¹²⁰ The Court characterized the equitable subrogation defenses the Sereboffs claimed accompanied such an action as “beside the point.”¹²¹

Alternatively, the Sereboffs argued that, even if the relief Mid Atlantic sought qualified as “equitable” under section 502(a)(3), it was not “appropriate” under that provision because it contravened principles such as the make-whole doctrine.¹²² To their detriment, the Sereboffs did not raise the assertion that Mid Atlantic’s claim was not “appropriate” apart from the contention that it did not qualify as “equitable” in the lower courts.¹²³ Therefore, the Court declined to determine this issue in the first instance.¹²⁴

IV. Analysis

A. Response to the Decision

At a mere eleven pages long and containing only two footnotes, one commentator declared the unanimous *Sereboff* opinion “a breath of fresh air” in comparison to the much longer and divided decision in *Great-West*.¹²⁵ Although *Sereboff* eliminated some of the confusion created by *Great-West*, ambiguity in the opinion rendered the decision a “subtle change” rather than a total simplification of ERISA and reimbursement.¹²⁶

Following the decision, three areas remain unclear. First, the Court did not explicitly delineate what steps are necessary to create an equitable lien by agreement. Theoretically, the plan could establish an equitable lien by agreement simply through execution of an Acts of Third Parties reimbursement clause. Alternatively, the equitable lien by agreement may require a separate agreement or court order to preserve a specified amount in a segregated account, as in *Sereboff*.¹²⁷ Next, the opinion did not state how the funds that the plan seeks to recover must be identified or held.¹²⁸ In *Sereboff*,

119. *Id.*

120. *Id.*

121. *Id.*

122. *Id.* at 1877 n.2.

123. *Id.*

124. *Id.*

125. Posting of Colleen Medill to Workplace Prof Blog, http://lawprofessors.typepad.com/laborprof_blog/2006/05/sereboff_and_th.html (May 20, 2006).

126. *Id.*

127. John K. DiMugno, *Oklahoma Supreme Court Allows Health Insurer to Bring State Law Breach of Contract Action Against Insured for Breach of Reimbursement Clause in ERISA-Governed Health Plan*, 28 INS. LITIG. REP. 433, 433 (2006).

128. *Id.*; see also Posting of Charles Stewart & Robin Schachter to SCOTUSblog,

the Court found that Mid Atlantic occupied a stronger position than that of Great-West because Mid Atlantic sought recovery of a specifically identified fund within the Sereboffs' control.¹²⁹ Nevertheless, it appears that circumstances still remain where the plan may fail to reach the third-party settlement proceeds because of the lack of a segregated investment account or where the participant does not possess the settlement funds. Finally, because the Sereboffs did not raise the argument until the final appeal, the Court did not address whether it is "appropriate" within the meaning of 502(a)(3) to grant a health plan reimbursement from the settlement funds of an undercompensated plan participant.¹³⁰ Because the Court in *Sereboff* declared the traditional subrogation defenses such as the make-whole doctrine "beside the point," this particular unanswered question offers potential hope for plan participants. Despite the complicated questions the *Sereboff* opinion created, the *Sereboff* decision elicited the same simple and decisive response from both the insurance companies and plan participants: act fast to catch the windfall.

B. The Problem: Where the Windfall Falls Short

The insurance industry presents several arguments to support collecting reimbursement from third-party settlements. The insurance companies maintain that, in the absence of reimbursement, plan participants benefit from a "windfall." Insurers suggest that plan participants have their medical bills paid for them twice; once by the plan and again as an element of damages recovered in the third-party settlement.¹³¹ In addition, insurance carriers assert that they rely on reimbursement proceeds to reduce costs and premiums.¹³² According to America's Health Insurance Plans, a national trade association of health insurers, reimbursement helps plans recoup more than one billion dollars annually.¹³³

In response, plan participants argue that insurance companies do not use recoupment proceeds to reduce premiums.¹³⁴ In fact, "[i]nsurers consistently

<http://www.scotusblog.com/wp/uncategorized/monday%E2%80%99s-decision-in-sereboff-v-mid-atlantic-medical-services/> (May 18, 2006, 16:13 EST).

129. Arthur D. Postal, *High Court Lets Plans Share in Patients' Recoveries*, NAT'L UNDERWRITER LIFE & HEALTH, May 22, 2006, at 8, available at Westlaw, 2006 WLNR 11361332.

130. DiMugno, *supra* note 127, at 433; Medill, *supra* note 125.

131. Hoffman, *supra* note 13, at 1.

132. *Id.*

133. Matt Brady, *Subrogation Provision Ditched: The Provision in the Pension Bill Was Keenly Desired by Health Insurers*, NAT'L UNDERWRITER LIFE & HEALTH, Aug. 7, 2006, at 8, available at Westlaw, 2006 WLNR 14909756.

134. JOHN F. DOBBYN, *INSURANCE LAW IN A NUTSHELL* 384 (4th ed. 1996) ("A possible third reason, that of ultimately reducing insurance rates by virtue of subrogated recoveries by

fail to introduce the factor of such recoveries into rate-determining formulae, but rather apply such recoveries to increasing dividends to shareholders.”¹³⁵ Furthermore, policyholders assert that they pay premiums “to cover their risk of paying medical expenses.”¹³⁶ Most importantly, for injured policyholders suffering from severe and life-long injuries, the disputed “windfall” sought through reimbursement often simply does not exist.

1. For The Severely Injured, The Loss of a Windfall or Financial Security?

In almost every case, a severely injured plan participant will never be made fully whole. Unfortunately, in the vast majority of critical injury cases, “the insured is left not only seriously impaired for life, but, if reimbursement is permitted, the insured is also left financially destitute.”¹³⁷ The policy against double recovery by plan participants arose in the context of property insurance, where a court may ascertain the damage suffered by a property owner with reasonable accuracy.¹³⁸ In personal injury cases, however, an injured plan participant will often not receive adequate compensation.¹³⁹ This deficient compensation results from a variety of factors.

First, the calculation of damages in a personal injury action presents unique challenges. Damages often include “permanent disability, mental anguish, physical pain, loss of income, and future aspects of each of these components.”¹⁴⁰ Unlike property damages, courts encounter difficulties in accurately estimating the economic value of these complicated injuries.¹⁴¹ In many jurisdictions, state tort reform initiatives have further restricted personal injury awards. Many states have limited or abolished the collateral-source rule,¹⁴² which requires a tortfeasor in a personal injury action to compensate a prevailing plaintiff for medical expenses, regardless of whether those expenses were covered by the plaintiff’s health plan or insurer.¹⁴³ Moreover,

insurers, has simply not come to pass.”).

135. *Id.*

136. Brady, *supra* note 133, at 8.

137. Baron, *supra* note 12, at 597.

138. Leishman, *supra* note 72, at 1227.

139. *Id.*

140. Baron, *supra* note 12, at 625.

141. *Id.*

142. Amicus Curiae Brief of the Association of Trial Lawyers of America in Support of Petitioners at 21, *Sereboff v. Mid Atl. Med. Servs., Inc.*, 126 S. Ct. 1869 (2006) (No. 05-260), 2006 WL 165866 [hereinafter ATLA Brief].

143. RESTATEMENT (SECOND) OF TORTS § 920A(2) (1979); *see also id.* § 920A(2) cmt. b (“[I]t is the position of the law that a benefit that is directed to the injured party should not be shifted so as to become a windfall for the tortfeasor. If the plaintiff was himself responsible for

tort reform has led to damage caps on awards for non-economic damages.¹⁴⁴ In some states, the law may not permit recovery of some elements, such as the future aspect of certain damages.¹⁴⁵ Finally, most personal injury cases end in settlement.¹⁴⁶ These third-party settlements rarely result in full compensation for the victim.¹⁴⁷

Several factors may lead to the victim's acceptance of less than full compensation in a settlement agreement. Most prominently, the plaintiff may agree to accept less than full compensation to avoid the cost and delay of litigation.¹⁴⁸ Additionally, tortfeasor liability could involve assertions of contributory negligence on the part of the victim as well as a number of other factors that could complicate or dispute the liability.¹⁴⁹ Often, victims accept less than full compensation because the tortfeasor has inadequate insurance coverage or assets to cover the actual damages.¹⁵⁰ Once the parties finally reach an agreement, attorney fees and the extensive costs of litigation will generally reduce the victim's recovery by at least one-third.¹⁵¹ Consequently, even where a seriously injured policyholder receives a large settlement, this award seldom represents a "windfall."¹⁵²

In *Sereboff*, Joel and Marlene Sereboff's medical expenses sought by the health plan totaled \$74,869.37. The Sereboffs received \$750,000 from the third-party settlement. Although the record provides limited information about the Sereboffs' injuries, the settlement on its face seems adequate to compensate both the health plan and the Sereboffs. Nevertheless, Supreme Court jurisprudence contains many examples where third-party settlements clearly fell short of fully compensating the victim's injuries.

In *Knudson*, discussed above, Janette Knudson suffered severe injuries in a car accident that rendered her quadriplegic.¹⁵³ Knudson reached a settlement against several parties responsible for her accident. After reducing the total settlement amount by attorney fees, Medicaid fees, and a \$13,828 payment to

the benefit, as by maintaining his own insurance or by making advantageous employment arrangements, the law allows him to keep it for himself.").

144. ATLA Brief, *supra* note 142, at 20-23.

145. Baron, *supra* note 12, at 626.

146. ATLA Brief, *supra* note 142, at 17.

147. Baron, *supra* note 12, at 625.

148. ATLA Brief, *supra* note 142, at 17.

149. Roger M. Baron, *Subrogation: A Pandora's Box Awaiting Closure*, 41 S.D. L. REV. 237, 245 (1996).

150. *Id.*

151. *Id.*

152. ATLA Brief, *supra* note 142, at 17.

153. *See supra* Part II.D.

Great-West, Knudson received an award of \$256,745.¹⁵⁴ Although Great-West failed to reach Knudson's funds because of the special needs trust, the loss of this recovery would have resulted in disastrous consequences for Knudson. The California state court estimated that Knudson faced \$2,593,900 in future medical expenses and \$819,829 in lost future earnings.¹⁵⁵ Furthermore, Janette Knudson served as the sole provider for her nine-year-old daughter.¹⁵⁶

In *FMC Corp. v. Holliday*,¹⁵⁷ fifteen-year-old Cynthia Holliday suffered serious and permanent injuries in an automobile accident.¹⁵⁸ As a result, Holliday recovered \$49,825 in a settlement with the third-party tortfeasor.¹⁵⁹ This award represented the maximum amount available to Holliday under the driver's liability policy.¹⁶⁰ At the time of the lawsuit, Holliday's medical expenses exceeded \$178,000.¹⁶¹ Her injuries, including a skull fracture, resulted in permanent brain damage that affected both her motor and cognitive functions.¹⁶² The extent and permanency of her injuries, combined with her age, assured substantial costs for Holliday's future medical care.¹⁶³ The ERISA plan that paid a portion of her medical expenses sued Holliday for the entire balance of the settlement.¹⁶⁴ Interpreting the express preemption language, the Supreme Court determined that Holliday's self-funded health plan could not be "deemed" an insurer.¹⁶⁵ Therefore, the Court held that ERISA preempted Pennsylvania's anti-subrogation statute and awarded the entire third-party settlement to the health plan.¹⁶⁶ Cynthia Holliday retained nothing from her settlement to compensate for her extensive past or future injuries.

In cases such as *Great-West* and *Holliday*, where victims suffer severe and permanent injuries, the entire concept of a windfall rings hollow. As a result,

154. *Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204, 208-09 (2002).

155. Brief of Respondent Janette Knudson at 8, *Knudson*, 534 U.S. 204 (No. 99-1786), 2001 WL 740905.

156. *Id.* at 5.

157. 498 U.S. 52 (1990).

158. *Id.* at 54-55.

159. Brief for Respondent at 2, *Holliday*, 498 U.S. 52 (No. 89-1048), 1990 WL 507662.

160. *Id.* Because several individuals were injured in the same accident as Holliday, the tortfeasor's liability insurance proceeds, totaling \$100,000, were divided between Holliday and three other claimants. *Id.*

161. *Id.* at 1.

162. *Id.*

163. *Id.*

164. *Id.* at 3.

165. *Holliday*, 498 U.S. at 61.

166. *Id.* at 65.

the controversy should shift, in a pragmatic way, to consider which party should bear the burden of the shortcomings.

2. *Where the Windfall Falls Short, Who Should Bear the Burden?*

The argument that the insurance company should not receive reimbursement to the detriment of a severely injured and undercompensated policyholder gains support from a collection of public policy arguments with such gravamen that one commentator referred to them as the “[e]lephant in the [c]ourtroom.”¹⁶⁷ When considering who should bear the burden, public policy clearly favors protecting the injured plan participant, “who exhibited the foresight and prudence to acquire insurance in the first place.”¹⁶⁸ That view prevails in the states, which historically regulated the field of insurance law, as evidenced by the presence of common law limitations on subrogation in most states.¹⁶⁹

In addition, some argue that courts should not enforce reimbursement provisions because of their unilateral nature. In non-insured ERISA plans, for example, the health plan may freely draft and amend the reimbursement language inserted into the policy agreement.¹⁷⁰ Further, these policy contracts do not fall under any bargaining, administrative, or judicial authority.¹⁷¹ The complete control exercised by the ERISA sponsors and plan insurers has led some to refer to the reimbursement agreements as mere “contracts of adhesion.”¹⁷²

Finally, ERISA’s stated purpose argues against such injustice to severely injured policyholders. In 1974, Congress enacted ERISA in response to a national crisis involving the widespread abuse of pension funds by employers that left many workers without retirement benefits.¹⁷³ In drafting ERISA, Congress found motivation in “the absolute need that safeguards for plan participants be sufficiently adequate and effective to prevent the numerous inequities to workers under plans which have resulted in tragic hardship to so many.”¹⁷⁴ Proper interpretation of the statute requires deference to the group

167. Baron, *supra* note 12, at 595.

168. Leishman, *supra* note 72, at 1228.

169. *See supra* Part II.A.

170. Baron, *supra* note 12, at 616-19.

171. *Id.*

172. ATLA Brief, *supra* note 142, at 28.

173. *See generally* James A. Wooten, “The Most Glorious Story of Failure in the Business”: *The Studebaker-Packard Corporation and the Origins of ERISA*, 49 BUFF. L. REV. 683 (2001).

174. H.R. REP. NO. 93-533, at 9 (1974), *as reprinted in* 1974 U.S.C.C.A.N. 4639, 4647.

it sought to protect, “employees and their beneficiaries in employee benefit plans.”¹⁷⁵

3. *The Added Quandary for Advisors of Injured Plan Participants*

To the delight of the insurance industry,¹⁷⁶ the Court in *Sereboff* firmly established the enforceability of reimbursement clauses under ERISA. Subsequent lawsuits have provided insight into the “magic words” needed for effective Acts of Third Parties provisions, thereby sending insurance companies scrambling to review and possibly revise their contract language.¹⁷⁷ Nevertheless, the Court emphasized that an equitable claim may only arise where “the property sought to be recovered or its proceeds have [not] been dissipated.”¹⁷⁸ In order to guarantee the plan’s ability to recover, the insurance industry advises health plans to act quickly once a plan beneficiary obtains a third-party judgment or settlement.¹⁷⁹ Such diligence requires that the insurance companies engage in close monitoring to ensure that the recovery is not dissipated or placed beyond the possession of the beneficiary.¹⁸⁰

In contrast, the *Sereboff* decision caused concern for those who represent injured plan participants. Faced with plans’ expanded capability to seek third-party settlement funds and the lack of common law subrogation defenses, those who represent policyholders sought novel measures to protect their clients—especially those with “catastrophic injuries and limited insurance”—from losing third-party settlement proceeds.¹⁸¹ A prominent labor law journal advises that policyholders seeking to avoid reimbursement may possibly achieve this by “depositing settlement funds in trust accounts or other assets that place the funds outside [the plan participant’s] possession and control,”

175. *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 113 (1989) (citing *Shaw v. Delta Airlines, Inc.*, 463 U.S. 85, 90 (1983)).

176. *See supra* Part IV.A.

177. *Popowski v. Parrott*, 461 F.3d 1367, 1374-75 (11th Cir. 2006) (contrasting reimbursement agreement language used by two different ERISA plan providers in a consolidated case, finding one allowed reimbursement and one did not).

178. Gerard Sinzduk, Recent Cases, *Sereboff v. Mid Atlantic Medical Services, Inc.: The Supreme Court’s Current View on the Enforceability of Third-Party Reimbursement Clauses Under ERISA*, 27 BERKELEY J. EMP. & LAB. L. 523, 529 (2006) (citing *Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204, 213 (2002)).

179. C. Mark Humbert, *The Supreme Court Revisits Third-Party Reimbursement Claims Under ERISA: Sereboff v. Mid-Atlantic Medical Services, Inc.*, HEALTH LAW., Aug. 2006, at 1, 4.

180. *Id.*

181. A Georgia Lawyer, <http://ageorgialawyer.blogspot.com/2006/05/erisa-sereboff-decision-and-work.html> (May 16, 2006, 07:21 EST).

thereby replicating the situation present in *Knudson*.¹⁸² Another attorney postulates that issuance of the settlement check in the names of both the attorney and the client, thus avoiding clear possession of the funds by the injured policyholder, might prevent reimbursement.¹⁸³ An additional—yet troubling—possibility, revealed anecdotally, allows the plan participant to avoid possession through a quick transfer of settlement funds to an off-shore account.¹⁸⁴

All of these options present possible ethical conflicts for those who represent injured plan participants. Clearly, attorneys have a duty not to assist clients in committing fraud; however, attorneys for plan participants also bear a duty to advocate on behalf of their clients.¹⁸⁵ Many cases suggest that attorneys will not face liability for failure to pay reimbursement to an ERISA plan from a third-party recovery in a personal injury action.¹⁸⁶ Nevertheless, courts have yet to conclusively settle the issue,¹⁸⁷ and attorneys continue to confront the issue. In situations involving severely injured plan participants where the third-party settlement has left the victims undercompensated for their injuries, an attorney's failure to protect their client by avoiding clear possession of settlement funds seems unethical.

C. A Solution: "Appropriate Equitable Relief" Must Be Appropriate

A potential solution for protecting severely injured plan participants who are not made whole by third-party settlements lies in the *Sereboffs'* untimely defense.¹⁸⁸ As discussed, ERISA section 502(a)(3) allows health plans to seek "appropriate equitable relief."¹⁸⁹ Fundamentally, the Court in *Sereboff* sought to define "equitable" for the purpose of this section. Nonetheless, in

182. Sinzdak, *supra* note 178, at 529.

183. A Georgia Lawyer, *supra* note 181.

184. Interview with Don Bogan, Professor, Univ. of Okla. Coll. of Law, in Norman, Okla. (Feb. 6, 2006).

185. *See generally* MODEL RULES OF PROF'L CONDUCT R. 1.2(d) (2006) ("A lawyer shall not counsel a client to engage, or assist a client, in conduct that the lawyer knows is criminal or fraudulent, but a lawyer may discuss the legal consequences of any proposed course of conduct with a client and may counsel or assist a client to make a good faith effort to determine the validity, scope, meaning or application of the law.").

186. *See* *Chapman v. Klemick*, 3 F.3d 1508, 1551 (11th Cir. 1993) (holding that an attorney did not breach an ERISA fiduciary duty to dispose of settlement funds in a manner inconsistent with the client's subrogation agreement); *see also* *Hotel Employees & Restaurant Employees Int'l Union Welfare Fund v. Gentner*, 50 F.3d 719, 722-23 (9th Cir. 1995) (agreeing with the holding in *Chapman*).

187. *See* *Greenwood Mills, Inc. v. Burris*, 130 F. Supp. 2d 949, 960 (M.D. Tenn. 2001) (holding an attorney liable for failing to follow the client's subrogation agreement).

188. *See supra* Part III.D.

189. Employee Retirement Income Security Act § 502(a), 29 U.S.C. § 1132(a) (2000).

examining the availability of relief under the language of the statute, courts should consider not only the “equitable” nature of the desired remedy but also whether the remedy seems *appropriate*. As the petitioners in *Sereboff* asserted, this limitation “serves as an essential judicial check.”¹⁹⁰

The petitioners, in arguing the importance of the modifier “appropriate,” pointed to a previous case where the Court emphasized this qualification. In *Varity Corp. v. Howe*,¹⁹¹ the Court found that section 502(a)(3) operates as a “catchall provision[] . . . to act as a safety net, offering appropriate equitable relief for injuries caused by violations that [section] 502 does not elsewhere adequately remedy.”¹⁹² Because the relief sought by the respondents in *Varity Corp.* undisputedly constituted equitable relief, the Court considered the issue of whether the relief was appropriate in light of the apparent lack of alternative remedies.¹⁹³ The Court stated that such a determination must respect “the special nature and purpose of employee benefit plans, and . . . the policy choices reflected in the inclusion of certain remedies and the exclusion of others.”¹⁹⁴

Under the analysis in *Varity Corp.*, reimbursement sought by health plans in the case of a severely injured and undercompensated plaintiff does not qualify as “appropriate.” In the *Sereboff* case, the ERISA plan argued, and the district court agreed, that the make-whole doctrine did not apply because the reimbursement agreement specifically disclaimed it.¹⁹⁵ The Court in *Varity Corp.*, however, required consideration of not only the plan language, but also the underlying public policy. Twenty-five of the states that allow subrogation apply the make-whole doctrine to protect severely injured policyholders from the extreme inequity that results when subrogation strips them of their settlement proceeds.¹⁹⁶ When weighing appropriateness, courts should not disclaim such a widely accepted and well supported limitation on reimbursement simply because the plan language dismisses it. Consideration of whether the plaintiff has received adequate compensation, combined with the other arguments for limiting recoupment, must enter the analysis of whether relief sought through reimbursement qualifies under section 502(a)(3).

190. Reply Brief for Petitioners at 15, *Sereboff v. Mid Atl. Med. Servs., Inc.*, 126 S. Ct. 1869 (2006) (No. 05-260), 2006 WL 717048.

191. 516 U.S. 489 (1996).

192. *Id.* at 490 (internal quotation marks omitted).

193. *Id.* at 515.

194. *Id.* (quoting *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 54 (1987)) (internal quotation marks omitted).

195. Brief for Petitioners, *supra* note 83, at 33-34.

196. *See supra* Part II.A.

Such consideration does not require complicated legal analysis; in fact, such analysis requires mere common sense.

V. Conclusion

Since the decision in *Sereboff*, the United States Congress, backed by the insurance lobby, attempted to create a new federal cause of action under ERISA that would definitively place insurers first in line to collect reimbursement from settlement funds, regardless of whether the victim receives adequate compensation.¹⁹⁷ Similarly, in a footnote, one lower court already dismissed any arguments of reimbursement “appropriateness” where the plaintiff has not been made whole.¹⁹⁸ With *Sereboff*, the Court has allowed health plans to pursue recoupment under ERISA despite general state refusal to enforce such subrogation provisions. In addition, the Court has set aside typical state-law protections for injured policyholders, including the make-whole doctrine. The issues presented by the *Sereboff* decision require courts to re-examine the ERISA statute’s clear language to determine whether the remedies sought by the health plans adequately qualify for the available remedy. Health plans seek reimbursement as “appropriate equitable relief” through ERISA. Although *Sereboff* characterizes the relief sought as equitable, this determination should not end the analysis. The relief must also be appropriate. The modifier “appropriate” requires relief “suitably fitting” for a particular purpose.¹⁹⁹ Is awarding a \$100,000 third-party settlement to an ERISA health plan where the victim has sustained severe and lifelong injuries truly “appropriate?”²⁰⁰ As courts explore this new terrain, we can only hope that the issues surrounding the windfall debate will lead to careful consideration of not only *equitable*, but also *appropriate* relief.

Kristin L. Huffaker

197. Brady, *supra* note 133, at 8.

198. Moore v. CapitalCare, Inc., 461 F.3d 1, 9 n.9 (D.C. Cir. 2006) (“[E]ven assuming the Moores preserved the issue on appeal CC/BCBS are nonetheless entitled to reimbursement.”).

199. WEBSTER’S THIRD NEW INTERNATIONAL DICTIONARY 106 (1976).

200. See *supra* Part I.