

# RESTORING SANITY TO SUBROGATION AFTER *SEREBOFF*

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## I. INTRODUCTION

*Sereboff v. Mid Atlantic Medical Services, Inc.*<sup>1</sup> single-handedly destroyed all of the equitable doctrines and approaches that states had developed to deal with reimbursement claims and paved the way for insurance companies to take more of tort victims' settlements than ever before. In *Sereboff*, the Supreme Court took Employment Retirement Income Security Act of 1974 ("ERISA") reimbursement claims out of the control of state contract law and placed them in the hands of the federal courts, which so far have shown little desire to uphold any of the equitable doctrines and approaches that states have used for decades.<sup>2</sup>

This Note explores the flaws in the *Sereboff* decision and the resulting devastating consequences. In Part II, this Note reviews the history and purposes of the ERISA legislation. Part III explores the purposes and history of subrogation. Part IV traces the Supreme Court decisions leading up to the *Sereboff* decision. Part V provides a detailed summary of the *Sereboff* decision and its rationale. Part VI explores the different state law approaches to subrogation and the federal courts' approach to subrogation in ERISA cases. Finally, Part VII provides an analysis of *Sereboff* and its impacts on insurance law and future ERISA litigation.

This Note argues the *Sereboff* Court's rationale is erroneous and that the federal courts' evisceration of the made whole doctrine and the pro rata approach in ERISA subrogation claims is inequitable, contrary to the purpose of the statute, and imposes costs that substantially outweigh any resulting benefits. Moreover, this Note contends that the circuit courts applying *Sereboff* have severely mischaracterized the decision, much to the detriment of the tort victim. This Note concludes that the pro rata approach is the most equitable way to address ERISA subrogation claims and should become a part of federal common law. Solidifying the pro rata approach in federal common law is the best solution for resolving ERISA subrogation claims because it will substantially reduce litigation and produce the most equitable result.

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<sup>1</sup> See generally *Sereboff v. Mid Atl. Med. Servs., Inc.*, 126 S. Ct. 1869 (2006).

<sup>2</sup> See *id.*

## II. ERISA

ERISA is the primary federal statute regulating employee benefit plans, including group health insurance.<sup>3</sup> ERISA was initially passed to protect private employee pension plans from abuse and mismanagement through the imposition of federal standards.<sup>4</sup> ERISA is a complex statute that has two purposes.<sup>5</sup> First, and most important, ERISA serves “to promote the interests of employees and their beneficiaries in employee benefit plans.”<sup>6</sup> The second purpose is to ensure “ERISA plans be uniform in their interpretation and simple in their application.”<sup>7</sup> Put simply, the first purpose of ERISA is to protect employees and the second is to protect employers.<sup>8</sup>

Whether ERISA governs a health insurance plan is a fairly complex question. However, satisfying the requirements for ERISA governance is not exceptionally difficult. As of 1998, 64.2% of non-elderly Americans had employment-based health insurance.<sup>9</sup> Thus, a majority of Americans have health insurance governed by ERISA. The Fifth Circuit outlined a three-part test for determining when ERISA controls a health insurance plan: (1) all the safe harbor provisions must be applicable; (2) the “plan” must be ascertainable from the surrounding circumstances; and (3) the plan must be “established or maintained” by the employer for the purposes of providing benefits to employees.<sup>10</sup> The “safe-harbor” provision from part one of this test states:

The terms “employee welfare benefit plan” and “welfare plan” shall not include a group or group-type insurance program offered by an insurer to employees . . . under which

- (1) No contributions are made by an employer . . .
- (2) Participation [in] the program is completely voluntary for employees . . .
- (3) The sole functions of the employer . . . with respect to the program are, without endorsing the program, to permit the insurer to publicize the program to employees . . . to collect premiums through payroll deductions . . . and to remit them to the insurer[s]; and
- (4) The employer . . . receives no consideration in the form of cash or otherwise in connection with the program other than reasonable compensation, excluding

<sup>3</sup> Jeffrey M. Gorris, Comment, *Waivers of ERISA Plan Benefits: Preventing Judicial Interpretations of a Complex Statute from Frustrating the Statute’s Simple Purpose*, 155 U. PA. L. REV. 717, 719 (2007).

<sup>4</sup> Len M. Nichols & Linda J. Blumberg, *A Different Kind of ‘New Federalism’? The Health Insurance Portability and Accountability Act of 1996*, HEALTH AFF., May-June 1998, at 25, 28, available at [http://www.wkkf.org/Pubs/Devolution/UI\\_A\\_Different\\_Kind\\_of\\_New\\_Federalism\\_The\\_Health\\_Insurance\\_Portability\\_And\\_Accountability\\_Act\\_Of\\_199\\_00331\\_02711.pdf](http://www.wkkf.org/Pubs/Devolution/UI_A_Different_Kind_of_New_Federalism_The_Health_Insurance_Portability_And_Accountability_Act_Of_199_00331_02711.pdf).

<sup>5</sup> Gorris, *supra* note 3, at 721.

<sup>6</sup> *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 90 (1983); Gorris, *supra* note 3, at 721.

<sup>7</sup> *McMillan v. Parrott*, 913 F.2d 310, 312 (6th Cir. 1990); Gorris, *supra* note 3, at 721.

<sup>8</sup> Gorris, *supra* note 3, at 721.

<sup>9</sup> Paul Fronstin, *64.2 Percent of Nonelderly Americans Have Employment-Based Health Insurance, 18.3 Percent Are Uninsured*, EBRI NOTES (Employee Benefit Research Inst., Washington, D.C.), Nov. 1998, at 1, 1, available at <http://www.ebri.org/pdf/notespdf/1198notes.pdf>.

<sup>10</sup> *McDonald v. Provident Indem. Life Ins. Co.*, 60 F.3d 234, 236 (5th Cir. 1995); THOMAS H. LAWRENCE & JOHN M. RUSSELL, ERISA SUBROGATION: ENFORCING RECOUPMENT PROVISIONS IN ERISA-COVERED HEALTH AND DISABILITY PLANS 10 (2000).

any profit, for administrative services actually rendered in connection with payroll deductions . . . .<sup>11</sup>

Thus, a health insurance plan must satisfy all four of the safe-harbor factors in order to be excluded from ERISA.<sup>12</sup> A “plan” is established if “from the surrounding circumstances a reasonable person can ascertain the intended benefits, beneficiaries, source of financing, and procedures for receiving benefits.”<sup>13</sup> Such a “plan” likely will be covered under ERISA if it falls outside at least one of the safe-harbor provisions, meets the statutory definition of an “employee welfare benefit plan,” and is “established or maintained” by an employer.<sup>14</sup> Furthermore, ERISA defines an “Employee Welfare Benefit Plan” as:

Any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (a) medical, surgical, or hospital care or benefits in the event of sickness, accident, disability, death or unemployment . . . .<sup>15</sup>

While this definition is seemingly complex, it “can be broken down into five elements:

- (1) a ‘plan, fund or program’;
- (2) established or maintained;
- (3) by an employer;
- (4) for the purpose of providing health care or disability benefits;
- (5) to participants or their beneficiaries.”<sup>16</sup>

To administer and enforce ERISA’s regulatory scheme so that it could coexist with state laws governing retirement benefits, Congress added an expansive preemption clause, dictating ERISA “shall supersede any and all State laws insofar as they . . . relate to any employee benefit plan.”<sup>17</sup> The Supreme Court interpreted this preemption clause broadly in *Boggs v. Boggs*,<sup>18</sup> when it held ERISA preempts state law that either “conflicts with the provisions of ERISA or operates to frustrate its objects.”<sup>19</sup> This expansive preemption provision creates gaps in the law where ERISA preempts the state law addressing the issue. However, the statute does not provide any information on how to deal with this problem.<sup>20</sup> Because the statute provides no guidance, federal common law must fill in the gaps created by this broad ERISA preemption.<sup>21</sup> Yet, the federal common law approach poses special problems in an

<sup>11</sup> 29 C.F.R. § 2510.3-1(j) (2008); LAWRENCE & RUSSELL, *supra* note 10, at 10.

<sup>12</sup> *Qualls v. Blue Cross of Cal., Inc.*, 22 F.3d 839, 843 (9th Cir. 1994); *Furgarino v. Hartford Life & Accident Ins. Co.*, 969 F.2d 178, 184 (6th Cir. 1992); *Hansen v. Cont’l Ins. Co.*, 940 F.2d 971, 977 (5th Cir. 1991); LAWRENCE & RUSSELL, *supra* note 10, at 11.

<sup>13</sup> *Donovan v. Dillingham*, 688 F.2d 1367, 1373 (11th Cir. 1982) (en banc); LAWRENCE & RUSSELL, *supra* note 10, at 11.

<sup>14</sup> LAWRENCE & RUSSELL, *supra* note 10, at 11-12.

<sup>15</sup> 29 U.S.C. § 1002(1) (2006); LAWRENCE & RUSSELL, *supra* note 10, at 11.

<sup>16</sup> LAWRENCE & RUSSELL, *supra* note 10, at 11.

<sup>17</sup> 29 U.S.C. § 1144(a) (2006); *Gorris*, *supra* note 3, at 721.

<sup>18</sup> *Boggs v. Boggs*, 520 U.S. 833, 841 (1997).

<sup>19</sup> *Id.* at 841 (1997); *Gorris*, *supra* note 3, at 722.

<sup>20</sup> *Gorris*, *supra* note 3, at 722.

<sup>21</sup> *Id.*

area such as ERISA subrogation, where the states and the circuits are split on how to effectively deal with the issue. While the Supreme Court shirked the issue in *Sereboff*, recent circuit court decisions clearly indicate that the Supreme Court should provide a definite rule on how to effectuate subrogation clauses in the ERISA context.<sup>22</sup>

### III. SUBROGATION DEFINED

While subrogation used to be strictly limited to equity cases, today subrogation is generally recognized “as a doctrine with rather broad dimensions, having been extended by the courts to embrace nearly every situation where the debt of the one is paid by a nonvolunteer who is only secondarily liable for such debt.”<sup>23</sup> Subrogation is rooted in the idea that the “law places the financial burden of loss on the member(s) of society who ultimately has (have) the primary legal responsibility for the loss.”<sup>24</sup> The word “subrogation” is derived from the Latin word, *subrogare*, meaning “to put in place of another or to substitute.”<sup>25</sup> There are four essential elements of the general subrogation doctrine:

- (1) the party claiming subrogation must first pay the debt;
- (2) the person seeking subrogation has a direct interest in the discharge of the debt;
- (3) the person seeking subrogation is secondarily liable for the debt or discharge of the lien; and
- (4) no injustice will be done to the other party by allowing the equity.<sup>26</sup>

Subrogation is often applied in the insurance context when an insurance company reimburses its insured for injuries he suffered because of a tortfeasor’s negligence.<sup>27</sup> Although subrogation technically only permits the insurer to pursue the tortfeasor alone, an insurer has other rights enabling it to recover from an insured who has already been compensated.<sup>28</sup> The purposes of subrogation are several: to prevent the insured from double recovery, discourage carelessness, prevent unjust enrichment, ensure that the wrongdoer is the one who actually pays for the harm caused, and reimburse the insurer for the payment which was made.<sup>29</sup> Doctor Ronald Horn<sup>30</sup> argues that “the general

<sup>22</sup> See *Sereboff v. Mid Atl. Med. Servs., Inc.*, 126 S.Ct. 1869 (2006); *Admin. Comm. of Wal-Mart Stores, Inc. Assocs.’ Health & Welfare Plan v. Shank*, 500 F.3d 834 (8th Cir. 2007); *Moore v. Capitalcare, Inc.*, 461 F.3d 1 (D.C. Cir. 2006).

<sup>23</sup> RONALD C. HORN, *SUBROGATION IN INSURANCE THEORY AND PRACTICE* 3 (1964).

<sup>24</sup> *Id.* at 4-5 (footnote omitted).

<sup>25</sup> *Id.* at 12.

<sup>26</sup> *Hampton Loan & Exch. Bank v. Lightsey*, 152 S.E. 425, 427 (S.C. 1930); HORN, *supra* note 23, at 12.

<sup>27</sup> Jeffrey A. Greenblatt, *Insurance and Subrogation: When the Pie Isn’t Big Enough, Who Eats Last?*, 64 U. CHI. L. REV. 1337, 1338 (1997).

<sup>28</sup> *Id.*

<sup>29</sup> HORN, *supra* note 23, at 24; Melissa A. Perry, Comment, *Is the Made-Whole Requirement More Than We Bargained For?: From Franklin to Tallant—A Call to Reexamine the Made-Whole Doctrine in Arkansas*, 60 ARK. L. REV. 295, 296 (2007).

<sup>30</sup> Dr. Horn was the Director of Educational Services for the American College of Life Underwriters and Professor of Insurance and Statistics at Syracuse University. HORN, *supra* note 23, at ix-x.

purpose of subrogation is to facilitate placement of the financial consequences of loss on the party primarily responsible for such loss."<sup>31</sup> He notes that most of the other purposes cited for subrogation "are really reasons that the party breaching a duty should be held liable (and, accordingly, reasons that subrogation should be encouraged). It is the distribution of responsibility, not subrogation, which helps prevent unjust enrichment."<sup>32</sup>

Historians generally agree that the subrogation doctrine is derived from the Roman civil law doctrine of *Cessio Actionum* and was subsequently built upon by French writers.<sup>33</sup> Robert Pothier<sup>34</sup> conceptualized subrogation as "a fiction of law by which a creditor is regarded as giving up his rights and privileges to one from whom he receives payment."<sup>35</sup> The English courts recognized subrogation as early as 1637.<sup>36</sup> Even though the doctrine itself was well established by the middle of the seventeenth century, the basis for the right remained unclear until the early part of the twentieth century.<sup>37</sup> In 1815, in the seminal case of *Cheeseborough v. Millard*,<sup>38</sup> the Chancery Court of New York decided the right to subrogation would be available to insurers under the equitable principle of unjust enrichment.<sup>39</sup> Hence, in the mid-1800s, subrogation was treated as an equitable principle, to be administered to secure justice, and independent of any contractual relations between the parties.<sup>40</sup>

Until the mid-twentieth century, the doctrine of subrogation was generally inapplicable to accident and health insurance.<sup>41</sup> In *Gatzweiler v. Milwaukee Electric Co.*,<sup>42</sup> the Supreme Court of Wisconsin held, in the absence of an indemnity feature, an accident insurance contract should be read as an investment contract concerning only the insurer and the insured or beneficiary.<sup>43</sup> Moreover, the court noted accident insurance contracts could not be called indemnity contracts because they provide for payments not derived from the amount of damages sustained by the injured party.<sup>44</sup> In *Aetna Life Insurance Co. v. J.B. Parker & Co.*,<sup>45</sup> the Supreme Court of Texas held that the insured's right to recover under accident insurance is a property right that is purchased and not a right to indemnity for a definitely ascertainable loss.<sup>46</sup> The New

<sup>31</sup> *Id.* at 24.

<sup>32</sup> *Id.*

<sup>33</sup> *Id.* at 15; Greenblatt, *supra* note 27, at 1339.

<sup>34</sup> Pothier was a celebrated eighteenth-century French lawyer who arranged texts of the Roman Law and wrote several treatises. He is primarily known for publishing *Les Coutumes d'Orléans* in 1760. See Auguste Boudinhon, *Robert Joseph Pothier*, in THE CATHOLIC ENCYCLOPEDIA XII, 321 (1911), available at <http://www.newadvent.org/cathen/12321a.htm>.

<sup>35</sup> HORN, *supra* note 23, at 15.

<sup>36</sup> *Id.* (citing Leon J. Hopper, *Insurer's Rights to Subrogation in Alabama*, 5 ALA. L. REV. 276 (1953)).

<sup>37</sup> *Id.* at 16.

<sup>38</sup> *Cheeseborough v. Millard*, 1 Johns Ch. 409 (N.Y. Ch. 1815).

<sup>39</sup> HORN, *supra* note 23, at 16.

<sup>40</sup> HENRY N. SHELDON, THE LAW OF SUBROGATION 2 (Boston, Soule and Bugbee 1882).

<sup>41</sup> See HORN, *supra* note 23.

<sup>42</sup> *Gatzweiler v. Milwaukee Elec. Ry. & Light Co.*, 116 N.W. 633 (Wis. 1908).

<sup>43</sup> *Id.* at 634; HORN, *supra* note 23, at 198-99.

<sup>44</sup> *Gatzweiler*, 116 N.W. at 634; HORN, *supra* note 23, at 198-99.

<sup>45</sup> *Aetna Life Ins. Co. v. J.B. Parker & Co.*, 72 S.W. 168 (Tex. 1903).

<sup>46</sup> *Id.* at 168; HORN, *supra* note 23, at 199.

York Supreme Court, Appellate Division, rounded out the early subrogation cases in *Suttles v. Railway Mail Association*<sup>47</sup> stating:

The theory and basis of the right of the insurer to subrogation is that the insured has a claim against a third person, which he could enforce for the loss insured against. But although the assured may be able to recoup his loss, partially or in full, by enforcing some contract, or other right, he may have, which is not dependent upon the direct responsibility of such person for the loss insured against, that fact does not clothe the insurer with the right of subrogation thereto, at least in the absence of an agreement in the policy to that effect.<sup>48</sup>

The rationale behind excluding subrogation from health and other personal insurances (and not other common policies of property or casualty insurance) was that, in the common policies, the insured sustained a fixed financial loss and the purpose was to place the loss ultimately on the wrongdoer.<sup>49</sup> However, in personal insurance contracts, the loss cannot be exactly ascertained.<sup>50</sup> Thus, the reasons for preventing double recoveries are not the same.<sup>51</sup> However, this rationale only applies to health insurance contracts, which do not contain express subrogation provisions.<sup>52</sup> John Alan Appleman's<sup>53</sup> insurance law treatise notes, "if a subrogation provision were expressly contained in such contracts, it probably would be enforced quite uniformly."<sup>54</sup>

The expansion of subrogation into the personal insurance arena is the result of the insurance industry taking a cue from decisional law and including subrogation provisions in their personal and health insurance plans.<sup>55</sup> The insurance companies also used their prominence to "hail[ ] subrogation as the chief mechanism for maintaining low insurance premiums."<sup>56</sup> Today, virtually all insurance policies contain a subrogation clause.<sup>57</sup>

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<sup>47</sup> *Suttles v. Ry. Mail Ass'n*, 141 N.Y.S. 1024 (N.Y. App. Div. 1913).

<sup>48</sup> *Id.* at 1025.

<sup>49</sup> 3 JOHN ALAN APPLEMAN & JEAN APPLEMAN, *INSURANCE LAW AND PRACTICE* § 1675, at 495 (4th reprint 1987).

<sup>50</sup> APPLEMAN, *supra* note 49, § 1675, at 495. *See also* HORN, *supra* note 23, at 200 (quoting 3 JOHN ALAN APPLEMAN, *INSURANCE LAW AND PRACTICE* § 1675, at 278 (Vernon Law Book Co. 1949)).

<sup>51</sup> APPLEMAN, *supra* note 49, § 1675, at 495. *See also* HORN, *supra* note 23, at 200 (quoting 3 JOHN ALAN APPLEMAN, *INSURANCE LAW AND PRACTICE* § 1675, at 278 (Vernon Law Book Co. 1949)).

<sup>52</sup> HORN, *supra* note 23, at 201.

<sup>53</sup> John Alan Appleman has published two treatises on insurance law, including APPLEMAN, *supra* note 49, and ERIC M. HOLMES & JOHN ALAN APPLEMAN, *HOLMES' APPLEMAN ON INSURANCE* (2d ed. 1997).

<sup>54</sup> APPLEMAN, *supra* note 49, § 1675, at 497. *See also* HORN, *supra* note 23, at 200 (quoting 3 JOHN ALAN APPLEMAN, *INSURANCE LAW AND PRACTICE* § 1675, at 278 (Vernon Law Book Co. 1949)).

<sup>55</sup> Johnny C. Parker, *The Made Whole Doctrine: Unraveling the Enigma Wrapped in the Mystery of Insurance Subrogation*, 70 MO. L. REV. 723, 736 (2005).

<sup>56</sup> *Id.*

<sup>57</sup> *See id.*

IV. THE ROAD TO *SEREBOFF*

In order to be covered by ERISA, a reimbursement claim must fall under one of the specific types of civil actions outlined in the ERISA statute.<sup>58</sup> The only provision in ERISA remotely supporting a reimbursement claim is 29 U.S.C. § 1132(a)(3), which concerns claims for equitable relief to enforce a term of the plan.<sup>59</sup> This section states:

(a) Persons empowered to bring a civil action

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 . . . .<sup>60</sup>

If the claim qualifies under subsection (a), then the federal court has exclusive jurisdiction to hear the claim pursuant to subsection (e):

(1) Except for actions under subsection (a)(1)(B) of this section, the district courts of the United States shall have exclusive jurisdiction of civil actions under this subchapter brought by the Secretary or by a participant, beneficiary, fiduciary, or any person referred to in section 1021(f)(1) of this title. State courts of competent jurisdiction and district courts of the United States shall have concurrent jurisdiction of actions under paragraphs (1)(B) and (7) of subsection (a) of this section.<sup>61</sup>

The only other place in the extensive ERISA statute where subrogation is discussed is in 29 U.S.C. § 1403(c)(2)(B), regarding withdrawal liability payment funds.<sup>62</sup> Until *Sereboff*, the Supreme Court struggled with defining “equitable relief” under section 1132.<sup>63</sup> Beneficiaries argued that reimbursement claims sought money; therefore, the claim could not be upheld as one for equitable relief.<sup>64</sup> The insurers, on the other hand, argued that “money can be part of an equitable claim for restitution, to enforce or lien, or under the equity clean-up doctrine.”<sup>65</sup>

The first major case to address the equitable relief issue was *Mertens v. Hewitt Associates*.<sup>66</sup> In *Mertens*, a class of former employees of the Kaiser Steel Corporation (Kaiser) sought monetary damages for the defendants’ alleged breach of their fiduciary duties.<sup>67</sup> Kaiser mismanaged the retirement plan such that the plan’s assets were insufficient to satisfy its benefit obligations.<sup>68</sup> The plan was terminated pursuant to 29 U.S.C. § 1341, and the employees were left with only the benefits guaranteed by ERISA, which were

<sup>58</sup> James T. Nyeste, *Health Plans’ Claims for Reimbursement from Personal Injury Recovery: Recent ERISA Rulings, Unanswered Questions*, ILL. B.J., May 2007, at 244, 245.

<sup>59</sup> *Id.*

<sup>60</sup> 29 U.S.C. § 1132(a)(3) (2006).

<sup>61</sup> *Id.* § 1132(e).

<sup>62</sup> *Id.* § 1403(c)(2)(B).

<sup>63</sup> Nyeste, *supra* note 58, at 245.

<sup>64</sup> *Id.*

<sup>65</sup> *Id.*

<sup>66</sup> *Mertens v. Hewitt Assocs.*, 508 U.S. 248 (1993).

<sup>67</sup> *Id.* at 250.

<sup>68</sup> *Id.*

substantially less than they would have received under their fully vested pension plan.<sup>69</sup> In addition to suing the fiduciaries of the plan, the employees also sued Hewitt, the plan's actuary, alleging that it was responsible for causing the losses by breaching its professional duties to the plan.<sup>70</sup> The district court dismissed the complaint, and the Ninth Circuit affirmed.<sup>71</sup>

The Supreme Court granted certiorari on the question of "whether ERISA authorizes suits for money damages against nonfiduciaries who knowingly participate in a fiduciary's breach of fiduciary duty."<sup>72</sup> Because Hewitt was not a fiduciary under ERISA, the employees argued that section 1132(a)(3) supported their claim, because their claim constituted "other appropriate equitable relief" under section 1132(a)(3).<sup>73</sup> The Court noted that the employees were not seeking a traditional equitable remedy, such as injunction or restitution: "Although they often dance around the word, what petitioners in fact seek is nothing other than compensatory *damages*—monetary relief for all losses their plan sustained as a result of the alleged breach of fiduciary duties. Money damages are, of course, the classic form of *legal* relief."<sup>74</sup> The Court decided that the remedies afforded under ERISA to beneficiaries harmed by a nonfiduciary constitute relief that was typically available in a court of equity, i.e. "injunction, mandamus, and restitution, *but not* compensatory damages."<sup>75</sup> "Equitable relief must mean *something* less than *all* relief."<sup>76</sup> Because the employees were seeking nothing more than compensatory damages, the Supreme Court affirmed the Ninth Circuit's ruling.<sup>77</sup>

*Mertens* created extreme disparities in the circuits over what constituted equitable relief in the ERISA context.<sup>78</sup> In *Health Cost Controls v. Skinner*,<sup>79</sup> the Seventh Circuit held that restitution and a constructive trust were permissible forms of relief under *Mertens*.<sup>80</sup> The Ninth Circuit had a very different interpretation of equitable relief. It held, under *Mertens*, claims for restitution could not be made under ERISA unless the monies were acquired "as the return of 'ill-gotten' assets or profits taken from a plan."<sup>81</sup> In *FMC Medical Plan v. Owens*,<sup>82</sup> the Ninth Circuit found that "Owens did not obtain FMC's funds by any fraud or wrong-doing. Owens obtained the funds pursuant to the Plans, which obligated the funds to be paid to him . . ."<sup>83</sup> The *FMC* court held that FMC was ultimately seeking monetary relief for a breach of contract claim and

<sup>69</sup> *Id.*

<sup>70</sup> *Id.*

<sup>71</sup> *Id.* at 251.

<sup>72</sup> *Id.*

<sup>73</sup> *Id.* at 253.

<sup>74</sup> *Id.* at 255.

<sup>75</sup> *Id.* at 256 (emphasis added).

<sup>76</sup> *Id.* at 258 n.8.

<sup>77</sup> *Id.* at 263.

<sup>78</sup> See *Blue Cross & Blue Shield of Ala. v. Sanders*, 138 F.3d 1347 (11th Cir. 1998); *FMC Med. Plan v. Owens*, 122 F.3d 1258 (9th Cir. 1997); *Health Cost Controls v. Skinner*, 44 F.3d 535 (7th Cir. 1995); see also LAWRENCE & RUSSELL, *supra* note 10, at 21.

<sup>79</sup> *Health Cost Controls*, 44 F.3d 535.

<sup>80</sup> *Id.* at 538 n.7.

<sup>81</sup> *FMC Med. Plan*, 122 F.3d at 1261.

<sup>82</sup> *FMC Med. Plan*, 122 F.3d 1258.

<sup>83</sup> *Id.* at 1261.

such relief did not constitute “equitable reimbursement” under ERISA.<sup>84</sup> The Eleventh Circuit took yet another view, arguing that the Ninth Circuit in *FMC* interpreted *Mertens* too narrowly.<sup>85</sup> It concluded in *Blue Cross & Blue Shield of Alabama v. Sanders*<sup>86</sup> that specific performance was a permissible form of equitable relief under *Mertens*.<sup>87</sup>

Taking a cue from the extreme confusion in the circuits, the Supreme Court addressed a benefits reimbursement claim in *Great-West Life & Annuity Insurance Co. v. Knudson*.<sup>88</sup> In that case, Mrs. Knudson was rendered a quadriplegic by a car accident.<sup>89</sup> Mrs. Knudson was covered by her then husband’s health insurance, which he had acquired through his employer, Earth Systems, Inc.<sup>90</sup> The plan covered over \$400,000 of Mrs. Knudson’s healthcare costs, most of which Great-West paid.<sup>91</sup> The plan contained a reimbursement provision giving Great-West the right to recoup any benefits it paid to the beneficiary if the beneficiary later recovered those benefits from a third party in the form of damages.<sup>92</sup> The provision further provided that if the beneficiary recovered from a third party and failed to reimburse the plan, the beneficiary would be personally liable for the amount the plan expended for medical expenses.<sup>93</sup>

The Knudsons filed a tort action against Hyundai and other tortfeasors and settled the dispute for \$650,000.<sup>94</sup> A little less than \$14,000 was allotted to Great-West for the medical expenses it paid.<sup>95</sup> Almost all of the settlement was placed in a special needs trust for the future care of Mrs. Knudson.<sup>96</sup> Great-West filed an action under ERISA in federal court for reimbursement of the full amount of medical costs it had paid.<sup>97</sup> The Ninth Circuit affirmed the district court’s dismissal, holding, “judicially decreed reimbursement for payments made to a beneficiary of an insurance plan by a third party is not equitable relief and is therefore not authorized by § 502(a)(3).”<sup>98</sup>

The Supreme Court granted certiorari and denied relief to Great-West, finding it was seeking to impose personal liability on the Knudsons “for a contractual obligation to pay money – relief that was not typically available in equity.”<sup>99</sup> The Court noted that Great-West had failed to characterize the relief sought as “equitable” under the standard set by *Mertens*.<sup>100</sup> Great-West argued

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<sup>84</sup> *Id.*

<sup>85</sup> *Blue Cross & Blue Shield of Ala. v. Sanders*, 138 F.3d 1347, 1353 n.5 (11th Cir. 1998).

<sup>86</sup> *Blue Cross & Blue Shield of Ala.*, 138 F.3d 1347.

<sup>87</sup> *Id.* at 1353 n.5.

<sup>88</sup> *Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204, 204 (2002).

<sup>89</sup> *Id.* at 207.

<sup>90</sup> *Id.*

<sup>91</sup> *Id.*

<sup>92</sup> *Id.*

<sup>93</sup> *Id.*

<sup>94</sup> *Id.*

<sup>95</sup> *Id.* at 208.

<sup>96</sup> *Id.* at 207-08.

<sup>97</sup> *Id.* at 208.

<sup>98</sup> *Id.* at 209.

<sup>99</sup> *Id.* at 209-10.

<sup>100</sup> *Id.* at 210.

it was seeking restitution, a form of equitable relief.<sup>101</sup> The Court noted the funds Great-West was seeking for reimbursement were not in the Knudsons' possession because they had been placed in a trust.<sup>102</sup> Thus, Great-West was not claiming that the Knudsons were holding funds, which in good conscious belonged to it, but that Great-West was contractually entitled to recoup some of the funds for the benefits it paid out.<sup>103</sup> "The kind of restitution that petitioners seek, therefore, is not equitable—the imposition of a constructive trust or equitable lien on particular property—but legal—the imposition of personal liability for the benefits that it conferred upon respondents."<sup>104</sup> The Court clarified that restitution is not exclusively an equitable remedy and determining whether it is equitable or not is dependent on the type of relief sought.<sup>105</sup> In this case, the relief sought was clearly legal restitution, not equitable.<sup>106</sup>

*Knudson* created enormous confusion for lower courts construing health care plan reimbursement claims.<sup>107</sup> Some courts read *Knudson* as creating a "possession test," which allowed reimbursement "if the beneficiary was in possession of clearly identifiable funds from personal injury settlement."<sup>108</sup> Other courts read *Knudson* as barring plan reimbursement claims, because the claims were for legal damages as "they do not seek the recovery of the actual benefits payments by the plan and, thus, do not seek equitable restitution."<sup>109</sup> Four years after *Knudson* was decided, the Supreme Court addressed the disagreement in *Sereboff v. Mid Atlantic Medical Services, Inc.*<sup>110</sup>

#### V. MOVING IN A NEW DIRECTION—*SEREBOFF*

From the *Mertens* and *Knudson* decisions, it appeared the Supreme Court was moving towards prohibiting group health plans from claiming reimbursement under ERISA. However, in the landmark decision of *Sereboff v. Mid Atlantic Medical Services, Inc.*, the Supreme Court unexpectedly changed course and allowed the insurance company to sustain its claim for reimburse-

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<sup>101</sup> *Id.* at 212.

<sup>102</sup> *Id.* at 214.

<sup>103</sup> *Id.*

<sup>104</sup> *Id.*

<sup>105</sup> *Id.* at 215.

<sup>106</sup> *Id.* at 218.

<sup>107</sup> Nyeste, *supra* note 58, at 246.

<sup>108</sup> *Id.* See also *Mid Atl. Med. Servs., LLC v. Sereboff*, 407 F.3d 212, 218-19 (4th Cir. 2005); *Admin. Comm. of Wal-Mart Assocs.' Health & Welfare Plan v. Willard*, 393 F.3d 1119, 1124-25 (10th Cir. 2004); *Admin. Comm. of Wal-Mart Stores, Inc. Assocs.' Health & Welfare Plan v. Varco*, 338 F.3d 680, 687 (7th Cir. 2003); *Bombardier Aerospace Employee Welfare Benefits Plan v. Ferrer, Poirot & Wansbrough*, 354 F.3d 348, 356 (5th Cir. 2003); *Great-West Life & Annuity Ins. Co. v. Brown*, 192 F. Supp. 2d 1376, 1380-81 (M.D. Ga. 2002).

<sup>109</sup> Nyeste, *supra* note 58, at 246. See also *Qualchoice, Inc. v. Rowland*, 367 F.3d 638, 648-50 (6th Cir. 2004); *Providence Health Plan v. McDowell*, 385 F.3d 1168, 1174 (9th Cir. 2004) (en banc); *Westaff (USA) Inc. v. Arce*, 298 F.3d 1164, 1166-67 (9th Cir. 2002).

<sup>110</sup> *Sereboff v. Mid Atl. Med. Servs., Inc.*, 126 S. Ct. 1869 (2006); Nyeste, *supra* note 58, at 246.

ment under ERISA because it constituted “appropriate equitable relief” pursuant to section 1132(a)(3).<sup>111</sup>

In *Sereboff*, Marlene Sereboff’s employer sponsored a group health insurance plan covered by ERISA that Mid Atlantic Medical Services (“Mid Atlantic”) administered.<sup>112</sup> Marlene and her husband Joel were beneficiaries under the plan.<sup>113</sup> The plan included a standard reimbursement clause, stating that a beneficiary who received benefits under the plan for injuries caused by a third party was required to reimburse Mid Atlantic for those benefits from any and all recoveries from a third party.<sup>114</sup> The plan also contained a clause which stated Mid Atlantic was entitled to fully recover all benefits paid regardless of whether the beneficiary was fully compensated in his lawsuit or not.<sup>115</sup>

The Sereboffs were injured in a car accident, and the plan paid the couple’s medical expenses.<sup>116</sup> The couple commenced a personal injury action against several tortfeasors.<sup>117</sup> Shortly thereafter, Mid Atlantic asserted a lien on the anticipated damages from the suit for the medical expenses it had paid out.<sup>118</sup> The Sereboffs settled their suit for \$750,000, but never satisfied Mid Atlantic’s lien, which was close to \$75,000.<sup>119</sup>

Mid Atlantic filed a suit in district court under section 1132(a)(3), seeking reimbursement of the medical expenses it had paid.<sup>120</sup> The Sereboffs’ attorney had already distributed the settlement proceeds to the Sereboffs, so Mid Atlantic sought a temporary restraining order and preliminary injunction requiring the couple to set aside \$74,869.73 from the settlement.<sup>121</sup> The Sereboffs agreed to set aside the amount in an investment account until the court decided the merits of the case.<sup>122</sup> The district court ruled in Mid Atlantic’s favor and ordered the Sereboffs to pay the amount related to medical expenses, plus interest, with a deduction for Mid Atlantic’s share of attorney’s fees and costs that the Sereboffs had incurred during their tort suit.<sup>123</sup> The Sereboffs appealed, and the Fourth Circuit affirmed, noting the circuits were divided on the question of whether ERISA authorizes recovery under these circumstances.<sup>124</sup> The Supreme Court granted certiorari to resolve the issue.<sup>125</sup>

The Court first noted there was no question that Mid Atlantic was a fiduciary under ERISA seeking to enforce a term of its plan.<sup>126</sup> Thus, “the only

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<sup>111</sup> *Sereboff*, 126 S. Ct. at 1873.

<sup>112</sup> *Id.* at 1872.

<sup>113</sup> *Id.*

<sup>114</sup> *Id.*

<sup>115</sup> *Id.*

<sup>116</sup> *Id.*

<sup>117</sup> *Id.*

<sup>118</sup> *Id.*

<sup>119</sup> *Id.* at 1873.

<sup>120</sup> *Id.*

<sup>121</sup> *Id.*

<sup>122</sup> *Id.*

<sup>123</sup> *Id.*

<sup>124</sup> *Id.*

<sup>125</sup> *Id.*

<sup>126</sup> *Id.*

question is whether the relief Mid Atlantic requested from the [d]istrict [c]ourt was 'equitable' under § 502(a)(3)(B)."<sup>127</sup>

The Court stated that in *Knudson*, it noted "one feature of equitable restitution was that it sought to impose a constructive trust or equitable lien on 'particular funds or property in the defendant's possession.'"<sup>128</sup> The requirements for an equitable lien in *Knudson* were not met, because the settlement proceeds were not in the Knudson's possession but instead were placed in a special needs trust.<sup>129</sup> However, in this case, there was no such impediment to equitable relief because "Mid Atlantic sought 'specifically identifiable' funds that were 'within the possession and control of the Sereboffs' . . . ."<sup>130</sup> Even though the claim alleged breach of contract and sought money damages, Mid Atlantic sought recovery through an equitable lien on a specifically identifiable fund and not from the Sereboff's assets, which would be the case in a contract action at law.<sup>131</sup> In *Knudson*, the Court did not reject the claim because it was a contract suit for money damages, but rather, because the plaintiffs did not seek damages from the defendant himself.<sup>132</sup> Because Mid Atlantic sought money damages from the defendants themselves, there was no problem characterizing the relief sought as equitable relief under section 502(a)(3)(B)(ii).<sup>133</sup>

The Court held that Mid Atlantic had established its claim for reimbursement as equitable.<sup>134</sup> The Court analogized the case to *Barnes v. Alexander*,<sup>135</sup> in which attorneys Street and Alexander were promised one third of the contingent fee for performing work for Barnes.<sup>136</sup> In *Barnes*, the Court upheld Alexander and Street's equitable claim to their portion of the fee on the basis of the rule in 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."<sup>137</sup> Thus, the Court concluded Barnes' agreement "create[d] a lien" upon the monetary recovery to which Barnes was entitled, which Street and Alexander could "'follow . . . into the hands of . . . Barnes,' 'as soon as [the fund] was identified.'"<sup>138</sup>

In *Sereboff*, the Court stated that, like Barnes' promise to Alexander and Street, the reimbursement provision in the Sereboffs' plan "specifically identified a particular fund . . . and a particular share of that fund to which Mid Atlantic was entitled."<sup>139</sup> Therefore, Mid Atlantic could rely on the rule used in *Barnes* to collect the money it had paid out for the Sereboffs' medical

<sup>127</sup> *Id.*

<sup>128</sup> *Id.* at 1874 (citing *Great-West Life & Annuity Ins. Co. v. Brown*, 534 U.S. 204, 213 (2002)).

<sup>129</sup> *Id.*

<sup>130</sup> *Id.* (quoting *Mid Atl. Med. Servs., LLC v. Sereboff*, 407 F.3d 212, 218 (4th Cir. 2005)).

<sup>131</sup> *Id.* at 1872.

<sup>132</sup> *Id.*

<sup>133</sup> *Id.* at 1874-75.

<sup>134</sup> *Id.*

<sup>135</sup> *Barnes v. Alexander*, 232 U.S. 117 (1914).

<sup>136</sup> *Sereboff*, 126 S. Ct. at 1874-75 (citing *Barnes*, 232 U.S. at 119).

<sup>137</sup> *Id.* at 1875 (quoting *Barnes*, 232 U.S. at 121).

<sup>138</sup> *Id.* (quoting *Barnes*, 232 U.S. at 123).

<sup>139</sup> *Id.*

expenses.<sup>140</sup> This rule allowed Mid Atlantic to “follow” a part of the settlement proceeds “‘into the [Sereboffs’] hands’ ‘as soon as [the settlement fund] was identified,’” and imposed a constructive trust or equitable lien on that part of the fund.<sup>141</sup>

The Court rejected the Sereboffs’ argument that Mid Atlantic’s suit would not satisfy the strict tracing rules required for this type of relief.<sup>142</sup> The Court noted the strict tracing rules applied to equitable liens as a matter of *restitution*, but not equitable liens by *agreement*, like those in *Barnes* and the case at bar.<sup>143</sup> The fact that Great-West had sought equitable restitution in *Knudson* did not foreclose Mid Atlantic from seeking recovery under a different equitable lien theory—that of an equitable agreement.<sup>144</sup> The Court also noted that it was of no consequence that the fund in dispute was not in existence when the equitable lien over the fund was created.<sup>145</sup> The Supreme Court therefore affirmed the Fourth Circuit and held that the Sereboffs were required to reimburse Mid Atlantic for funds expended to cover medical expenses under the plan.<sup>146</sup>

*Sereboff* had the important consequence of bringing reimbursement claims into the realm of ERISA by holding that “where the ERISA plan is enforcing its reimbursement provision against personal injury settlement proceeds that are still identifiable and in the beneficiary’s possession, the recovery is ‘equitable relief’ under section 502(a)(3) in the way of an equitable lien by agreement.”<sup>147</sup> In addressing an issue that was creating turmoil in the circuit courts, the Court only scratched the surface, as many questions were left unanswered by the *Sereboff* decision, the most pressing of which is what happens when the reimbursement provision leaves the beneficiary with little or nothing from the settlement.

## VI. APPROACHES TO SUBROGATION CLAIMS

### A. *The Made Whole Doctrine*

The made whole doctrine, in its original form, is an equitable principle requiring that the insured be fully compensated before the insurer can assert its subrogation rights.<sup>148</sup> Several jurisdictions use a “modified made whole doctrine” grounded in contract theory, which permits the parties to contract out of the requirement that the insured be fully compensated prior to the insurer asserting its subrogation rights.<sup>149</sup> However, contracting out of the made whole doctrine requires that the agreement clearly and explicitly reflect the intentions

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<sup>140</sup> *Id.*

<sup>141</sup> *Id.* (quoting *Barnes*, 232 U.S. at 123).

<sup>142</sup> *Id.*

<sup>143</sup> *Id.*

<sup>144</sup> *Id.* at 1876.

<sup>145</sup> *Id.*

<sup>146</sup> *Id.* at 1878.

<sup>147</sup> Nyeste, *supra* note 58, at 246. See also *Sereboff*, 126 S. Ct. at 1874.

<sup>148</sup> Parker, *supra* note 55, at 737.

<sup>149</sup> *Id.* at 773.

of the parties that the equitable doctrine is inapplicable.<sup>150</sup> Jurisdictions throughout the country have applied the made whole doctrine in three distinct ways: (1) common law equitable made whole doctrine, (2) made whole doctrine subject to contractual modification, and (3) made whole doctrine subject to a balancing of the equities.<sup>151</sup>

*1. Common Law Equitable Made Whole Doctrine*

This view of the made whole doctrine states that subrogation is to be governed by principles of equity.<sup>152</sup> The insurance agreement is not determinative of “the extent to which the right of subrogation [can] be exercised.”<sup>153</sup> In other words, “the made whole doctrine cannot be contractually modified” under any circumstances.<sup>154</sup>

*2. Made Whole Doctrine Subject to Contractual Modification*

This view holds that parties are free to contract out of the made whole doctrine.<sup>155</sup> However, the jurisdictions adopting this view disagree on how specific the contractual language has to be in order to be valid.<sup>156</sup> There are four prevailing views concerning the specificity of the contract language:

- (1) general language is sufficient;
- (2) the language must be “clear, explicit and/or specific;”
- (3) the language must be clear and specific and the insurer must actively participate in the recovery process; or
- (4) the agreement must use “magical or unequivocal words.”<sup>157</sup>

*3. Made Whole Doctrine Subject to a Balancing of the Equities*

Under this view, the court takes into account “the facts and circumstances of the case, conduct of the parties, contractual language and the general public policy that the insured should be made whole . . . .”<sup>158</sup> Generally, the courts adopting this view favor complete compensation of the insured before enforcing a subrogation clause.<sup>159</sup>

*B. Other Approaches: Pro Tanto and Pro Rata*

While most jurisdictions follow one of the three forms of the made whole doctrine,<sup>160</sup> others subscribe to either a “pro tanto” or “pro rata” sharing approach in subrogation cases.<sup>161</sup> The pro tanto approach permits the insurer

<sup>150</sup> *Id.*

<sup>151</sup> *Id.* at 773-75.

<sup>152</sup> *Id.* at 774.

<sup>153</sup> *Id.*

<sup>154</sup> *Id.*

<sup>155</sup> *Id.*

<sup>156</sup> *Id.* at 774-75.

<sup>157</sup> *Id.* at 775.

<sup>158</sup> *Id.*

<sup>159</sup> *Id.*

<sup>160</sup> *See id.* at 774-75.

<sup>161</sup> Greenblatt, *supra* note 27, at 1339.

be paid before the insured is made whole.<sup>162</sup> The pro rata approach falls between the made whole doctrine and the pro tanto approach and requires the recovery to be split pro rata.<sup>163</sup> “Each party recover[s] an amount in proportion to the percentage of the total loss it bore minus its pro rata share of the costs incurred in recovering from the tortfeasor.”<sup>164</sup>

### C. Federal Common Law and the Made Whole Doctrine

All of the aforementioned doctrines are derived from *state* contract law principles. However, under the *Sereboff* decision, state law no longer controls subrogation. Therefore, federal common law’s treatment of subrogation claims becomes important. Unfortunately, the federal courts’ decisions all consistently point to the demise of the use of the made whole doctrine and the pro rata approach in ERISA subrogation claims.<sup>165</sup>

Congress intended that the judiciary develop federal common law to supplement ERISA’s provisions.<sup>166</sup> “Federal common law can only be applied as a gap-filler where a clause is found to be ambiguous or silent on a particular issue.”<sup>167</sup> Some of the federal courts have adopted a common law “made whole” rule that “prevents health plans from obtaining reimbursement until a covered person has been compensated fully for his injuries.”<sup>168</sup> The Ninth Circuit defined the common law made whole rule as the “generally accepted rule that, in the absence of a clear contract provision to the contrary, an insured must be made whole before an insurer can enforce its right to subrogation.”<sup>169</sup>

However, the circuits are split over “when, if ever,” the made whole doctrine applies.<sup>170</sup> Before the *Sereboff* decision, the Fifth and Eighth Circuits held the federal common law made whole doctrine only applied if it was expressly stated in the plan.<sup>171</sup> These circuits heavily favored insurance companies’ subrogation rights.<sup>172</sup> Other circuits, including the Ninth and Sixth, held that if the plan established priority of payment, the federal common law made whole rule would not apply.<sup>173</sup> Finally, the Eleventh Circuit held the

<sup>162</sup> *Id.* at 1343.

<sup>163</sup> *Id.*

<sup>164</sup> *Id.*

<sup>165</sup> See, e.g., *Admin. Comm. of Wal-Mart Stores, Inc. Assocs.’ Health & Welfare Plan v. Shank*, 500 F.3d 834, 839 (8th Cir. 2007).

<sup>166</sup> *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 56 (1987); LAWRENCE & RUSSELL, *supra* note 10, at 71.

<sup>167</sup> LAWRENCE & RUSSELL, *supra* note 10, at 71. See also *Sanders v. Scheideler*, 816 F. Supp. 1338, 1346 (W.D. Wis. 1993), *aff’d*, No. 93-3044, 1994 WL 234497, at \*2 (7th Cir. June 1, 1994).

<sup>168</sup> LAWRENCE & RUSSELL, *supra* note 10, at 72.

<sup>169</sup> *Barnes v. Indep. Auto. Dealers Ass’n of Cal. Health & Welfare Benefit Plan*, 64 F.3d 1389, 1395 (9th Cir. 1995); LAWRENCE & RUSSELL, *supra* note 10, at 72.

<sup>170</sup> LAWRENCE & RUSSELL, *supra* note 10, at 72.

<sup>171</sup> See *Waller v. Hormel Foods Corp.*, 120 F.3d 138, 140 (8th Cir. 1997); *Sunbeam-Oster Co. Group Benefits Plan v. Whitehurst*, 102 F.3d 1368, 1376 (5th Cir. 1996); LAWRENCE & RUSSELL, *supra* note 10, at 73.

<sup>172</sup> LAWRENCE & RUSSELL, *supra* note 10, at 73.

<sup>173</sup> See *Marshall v. Employers Health Ins. Co.*, Nos. 96-6063, 96-6112, 1997 WL 809997, at \*4 (6th Cir. Dec. 30, 1997); *Barnes*, 64 F.3d at 1395; *In re Paris*, 44 F. Supp. 2d 747, 748 (D. Md. 1999); LAWRENCE & RUSSELL, *supra* note 10, at 75.

federal common law made whole doctrine applied unless the plan specifically stated otherwise.<sup>174</sup> Even though three of the circuits adopted the made whole doctrine into federal common law as a default rule, it appears all of the circuits agree that the doctrine can be superseded if there is a clear contractual provision to the contrary.<sup>175</sup>

After the *Sereboff* decision, the Eighth Circuit went a step further in promoting insurance companies' subrogation rights in *Administrative Committee of Wal-Mart Stores, Inc. Associates' Health and Welfare Plan v. Shank*.<sup>176</sup> In *Shank*, the Eighth Circuit acknowledged that the made whole doctrine "is not a rule of federal common law that governs our interpretation of the written provisions of ERISA-regulated plan benefits."<sup>177</sup> The court noted the made whole doctrine "originated in the law of insurance, where the overriding purpose of an insurance policy is to fully compensate the insured in case of loss, but that many ERISA-regulated benefit plans do not share that purpose."<sup>178</sup> Unlike individual insurance plans, one of the primary purposes of ERISA is to "ensure the integrity of written plans and to protect the expectations of participants and beneficiaries."<sup>179</sup> The court rejected the Shanks' argument that not applying the made whole doctrine is contrary to ERISA's main purpose of protecting plan participants and beneficiaries because, without it, beneficiaries could only recover a small amount of their injuries and would be no better off than if they had not joined the group health plan in the first place.<sup>180</sup> The court said the better approach was to enforce the plan as written, because if the plan did not allow full reimbursement, the Shanks would be better off, but everyone else in the plan would suffer from higher premiums.<sup>181</sup>

*Sereboff* brought subrogation claims under the governance of ERISA, leaving the federal courts, such as the Eighth Circuit in *Shank*, to establish federal common law to address such claims.<sup>182</sup> *Shank* is an alarming case, because it holds the made whole doctrine will not be adopted into federal common law.<sup>183</sup> *Shank* is a terrible precedent that other circuits should not follow because the case ignores the fact that subrogation claims are analogous to equitable liens and are therefore subject to equitable doctrines and principles.<sup>184</sup> Moreover, courts should not follow *Shank* because the case derogates from critical tenants of federal common law.<sup>185</sup>

<sup>174</sup> *Cagle v. Bruner*, 112 F.3d 1510, 1521 (11th Cir. 1997); *King v. Pan Am. Life Ins. Co.*, 998 F. Supp. 1455, 1458 (N.D. Ga. 1996); *LAWRENCE & RUSSELL*, *supra* note 10, at 77.

<sup>175</sup> *See, e.g., Copeland Oaks v. Haupt*, 209 F.3d 811, 813 (6th Cir. 2000); *Cagle*, 112 F.3d at 1521; *Barnes*, 64 F.3d at 1395.

<sup>176</sup> *Admin. Comm. of Wal-Mart Stores, Inc. Assocs' Health & Welfare Plan v. Shank*, 500 F.3d 834 (8th Cir. 2007).

<sup>177</sup> *Id.* at 837 (citing *Waller v. Hormel Foods Corp.*, 120 F.3d 138 (8th Cir. 1997)).

<sup>178</sup> *Id.* at 837-38.

<sup>179</sup> *Id.* at 838.

<sup>180</sup> *Id.*

<sup>181</sup> *Id.*

<sup>182</sup> *See Sereboff v. Mid Atl. Med. Servs., Inc.*, 126 S. Ct. 1869 (2006).

<sup>183</sup> *Shank*, 500 F.3d at 839.

<sup>184</sup> *See Sereboff*, 126 S. Ct. 1869; discussion *infra* Part VII.

<sup>185</sup> *See* discussion *infra* Part VII.

VII. ANALYSIS OF THE IMPACT OF THE *SEREBOFF* DECISION  
ON ERISA SUBROGATION CLAIMS

The *Sereboff* decision's flawed reasoning has, and likely will continue to have, devastating impacts on subrogation claims. The decision is flawed in that it mischaracterizes ERISA reimbursement claims as equitable liens by agreement. Moreover, subjecting identifiable proceeds in the beneficiary's possession to an equitable lien will create more problems than it solves. Even though the *Sereboff* decision permits federal courts to ignore the made whole doctrine and the pro rata approach in subrogation claims, the courts should instead opt to incorporate these state law equitable doctrines into ERISA federal common law. Specifically, the pro rata approach should become the majority rule for dealing with ERISA subrogation claims because it is the most equitable and insurers have failed to prove that its application would result in higher premiums.

A. *Sereboff Erroneously Concludes that Reimbursement Claims under ERISA Constitute Equitable Liens by Agreement*

The Supreme Court's characterization of Mid Atlantic's reimbursement claim as an equitable lien by agreement is troubling for several reasons. First, the analogy to *Barnes* is flawed in one important respect: the agreement between Barnes, Alexander and Street, which involved Alexander and Street agreeing to work for their colleague, Barnes, in exchange for a portion of the attorneys' fees, was a direct agreement where each party had equal bargaining power and was faced with a rational choice. Barnes could either choose to ask Alexander and Street for help and share his fee with them, or he could do all the work himself and keep the entire fee. Alexander and Street shared a similar rational choice: they could agree to help Barnes and share the fee, or they could not help him and dedicate their time to other money-making endeavors.

However, in the ERISA context, the insured (beneficiary) does not have a rational choice. Consider the hypothetical case of Worker Bob. Worker Bob is hired at Company X, and as part of his benefits package he receives health insurance. Worker Bob does not get to choose whether he gets health insurance or not; in fact, one of the safe-harbor provisions of ERISA states that participation in the plan should be mandatory.<sup>186</sup> He does not have the option of asking for additional compensation instead of health insurance. While Worker Bob does have the option of going out and purchasing private health insurance in addition to the insurance provided for him by Company X, no rational person would choose to do so because it would involve purchasing something one already has (or involve paying for another full policy in order to avoid subrogation).

Additionally, Worker Bob does not have the option of obtaining health insurance from Company X that is not subject to subrogation, because the entire company has to have the same plan. Moreover, even if paying a higher premium so that one does not have to be subject to subrogation was an available option, no company would exercise that choice. A company would forego

<sup>186</sup> 29 C.F.R. § 2510.3-1(j) (2008); LAWRENCE & RUSSELL, *supra* note 10, at 10.

this option because it would have to pay more to insure its employees and would receive nothing in return because all the benefits of not having a subrogation clause would go directly to the employees, not the employer. Finally, Worker Bob's other option is to decline the job offer from Company X and find a job with another company that provides better health benefits. However, as previously stated, the odds of Worker Bob finding a company that will provide him with health insurance that is not subject to subrogation are poor, and declining a job on that basis is irrational.

While the definition of an agreement is broad, it still requires "a manifestation of mutual assent."<sup>187</sup> One could argue Worker Bob assented to the group health insurance subrogation clause by agreeing to work at Company X. However, this statement does not end the inquiry. The agreement still has to *equitable*. Equity implies fairness. Surely when Worker Bob has no other rational choice but to agree to the group health insurance plan, that agreement cannot be considered *equitable*. In light of the patent differences between agreeing to work for a colleague in exchange for a cut of the fee (as in *Barnes*) and basically being forced to accept one's company health insurance because one has no other rational choice, the *Sereboff* Court's characterization of a subrogation clause in an ERISA plan as an equitable lien "by agreement" wholly misses the mark.

*B. Sereboff's Rule that Identifiable Proceeds in the Beneficiary's Possession are Subject to an Equitable Lien is an Unworkable Standard*

The *Sereboff* Court left unanswered what constitutes identifiable proceeds in the beneficiary's possession.<sup>188</sup> However, the Court did reaffirm the holding in *Knudson* that funds placed in a special needs trust were not subject to an equitable lien because they were not in the defendant's possession.<sup>189</sup> The proceeds also have to be "identifiable," yet the Court failed to define the scope of this term as well.

This rule requiring the defendant to be in possession of the funds in order to be subject to an equitable lien has and will continue to spawn all sorts of undesired consequences. The rule encourages tort victims to hide their settlement proceeds, find creative ways to keep it out of their legal possession, and/or make the settlement recovery not legally "identifiable." Such tactics can only result in additional litigation and costs. Therefore, simply implementing a bright line pro rata rule not only would be equitable, but would also prevent such tactics.

*C. Eviscerating the Made Whole Doctrine and the Pro Rata Approach in ERISA Subrogation Claims is Inequitable*

ERISA could not be more clear—"A civil action may be brought . . . by a participant, beneficiary, or fiduciary . . . to obtain other appropriate *equitable*

<sup>187</sup> BLACK'S LAW DICTIONARY 74 (8th ed. 2004).

<sup>188</sup> *Sereboff*, 126 S. Ct. at 1874.

<sup>189</sup> *Id.* (citing *Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204, 207, 214 (2002)).

relief.”<sup>190</sup> Under *Sereboff*, the equitable relief arose from the fact that Mid Atlantic sought recovery through an equitable lien.<sup>191</sup> *Black’s Law Dictionary* defines “equitable lien” as: “[a] right, enforceable only in equity, to have a demand satisfied from a particular fund or specific property, without having possession of the fund or property.”<sup>192</sup> Because *Sereboff* defined the type of relief Mid Atlantic was seeking as an “equitable lien,” equitable principles applied. *Black’s Law Dictionary* defines “do equity” as follows: “(Of one who seeks an equitable remedy) to treat or offer to treat the other party as fairly as is necessary, short of abandoning one’s own legal rights, to bring about a fair result. The phrase derives from the maxim ‘One who seeks equity must do equity.’”<sup>193</sup>

Equity is grounded in the concept of fairness and, as the definition illustrates, the requirement to do equity is only between the parties to the suit. Therefore, for the circuits to abandon the made whole doctrine and the pro rata approach because it *might* result in higher premiums to the other plan members<sup>194</sup> is contrary to the definition of doing equity. Moreover, how can denying a tort victim his entire damage recovery be fair? Over ninety percent of tort claims are settled; thus, “[v]irtually by definition[,] the claimants in these cases receive less than full compensation.”<sup>195</sup>

In light of the limited equitable remedies afforded under ERISA, the most equitable standard to use is the pro rata approach. This approach allows both the insured and the insurance company to take an equal share of the recovery and is most consistent with the principle of “one who seeks equity must do equity.”<sup>196</sup>

#### *D. The State Law Equitable Doctrines and Approaches Should be Incorporated into ERISA Federal Common Law*

State law principles governed subrogation litigation for several decades, up until the *Sereboff* decision in 2006. Unfortunately, private parties enter into insurance contracts with the mistaken expectation that state law standards will govern their rights because they lack knowledge of the *Sereboff* case. Specifically, “[t]he presumption that state law should be incorporated into federal common law is particularly strong in areas in which private parties have entered legal relationships in the expectation that their rights would be governed by state-law standards . . . .”<sup>197</sup> Moreover, this expectation occurs because state law has been traditionally governed by contract law.

<sup>190</sup> 29 U.S.C. § 1132(a) (2006) (emphasis added).

<sup>191</sup> *Sereboff*, 126 S. Ct. at 1874.

<sup>192</sup> BLACK’S LAW DICTIONARY, *supra* note 187, at 942.

<sup>193</sup> *Id.* at 521.

<sup>194</sup> See *Admin. Comm. of Wal-Mart Stores, Inc. Assocs.’ Health & Welfare Plan v. Shank*, 500 F.3d 834 (8th Cir. 2007).

<sup>195</sup> Kenneth S. Abraham, *Twenty-First-Century Insurance and Loss Distribution in Tort Law*, in *EXPLORING TORT LAW* 81, 95 (M. Stewart Madden ed., 2005).

<sup>196</sup> 30A C.J.S. *Equity* § 100 (2008).

<sup>197</sup> *New York v. Nat’l Serv. Indus.*, 460 F.3d 201, 208 (2d Cir. 2006) (quoting *Kamen v. Kemper Fin. Servs.*, 500 U.S. 90, 98 (1991)).

In *Wallis v. Pan American Petroleum Corp.*,<sup>198</sup> the Supreme Court held that “[i]n deciding whether rules of federal common law should be fashioned, normally the guiding principle is that a significant conflict between some federal policy or interest and the use of state law in the [property] must first be specifically shown.”<sup>199</sup> In subrogation claims, no conflict between ERISA and state law arises that would warrant derogation from the equitable doctrines and approaches fashioned by the states in dealing with subrogation. The whole premise behind bringing subrogation claims under ERISA governance is that the liens are *equitable* liens derived from *equitable* agreements. Therefore, the application of the state law equitable doctrines and approaches cannot rationally be in conflict with resolving *equitable* liens.

*E. The Argument that Subrogation Prevents Premiums from Rising is a Tenuous Argument at Best*

Although some argue that subrogation prevents premiums from rising, this rationale lacks standing. For example, Professor Edwin Patterson<sup>200</sup> notes:

Subrogation is a windfall to the insurer. It plays no part in rate schedules (or only a minor one), and no reduction is made in the insuring interests, such as that of the secured creditor, where the subrogation right will obviously be worth something. Hence, in such a case, no reason appears for extending it. Even as to tortfeasors, it is arguable that since the insurer is paid to take the risk of negligent losses, it should not shift the loss to another.<sup>201</sup>

Doctor Ronald Horn<sup>202</sup> conversely argues that subrogation is not a windfall to the insurers but concedes that subrogation collection data is not readily available.<sup>203</sup> No industry-wide studies of subrogation exist, and the sole sources for such information are the *insurers themselves*.<sup>204</sup> The lack of comprehensive data makes it difficult to assess the impact subrogation has on insurance companies. “What does seem clear, despite a lack of complete statistical documentation, is that net losses would be substantially higher for some [types of] insurances, in both a relative and an absolute sense, in the absence of the subrogation doctrine.”<sup>205</sup> Therefore, Doctor Horn suggests subrogation is not a windfall to insurers, nor can it properly be labeled a proximate cause of profit.<sup>206</sup> “Underwriting gains are possible whenever relative subrogation results are greater than those implicitly assumed in the rate structure, but such gains are conceptually no different from gains arising out of other areas wherein the insurer is more efficient than all the companies combined into a

<sup>198</sup> *Wallis v. Pan Am. Petroleum Corp.*, 384 U.S. 63 (1966).

<sup>199</sup> *Id.* at 68.

<sup>200</sup> Professor Patterson was a Cardozo Professor of Jurisprudence at Columbia University and the Former Deputy Superintendent of Insurance of New York. See EDWIN W. PATTERSON, *ESSENTIALS OF INSURANCE LAW* (2d ed. 1957).

<sup>201</sup> *Id.* at 151-52.

<sup>202</sup> Dr. Horn was the Director of Educational Services for the American College of Life Underwriters and Professor of Insurance and Statistics at Syracuse University. HORN, *supra* note 23, at ix-x.

<sup>203</sup> *Id.* at 146.

<sup>204</sup> *Id.* (emphasis added).

<sup>205</sup> *Id.* at 193.

<sup>206</sup> *Id.*

single rate base.”<sup>207</sup> However, Doctor Horn’s conclusions are unreliable because they are derived from piecemeal statistics generated from surveys sent to insurance companies.

Many courts have also criticized the double recovery rationale for subrogation and asserted that the insurer is actually the one “who is unjustly enriched and gains a windfall” if allowed to collect both subrogation and premiums paid by the insured.<sup>208</sup> One persuasive argument is that subrogation merely shifts the losses from one insurer to another and has no impact on premiums whatsoever, because insurance companies are only going to seek subrogation rights against tortfeasors who are insured.<sup>209</sup> Thus, one insurance company pays another insurance company and, over time, everything comes out even in the end.<sup>210</sup> Moreover, while one of the main purposes of subrogation is to prevent an insurer from becoming unduly enriched, “the same principle is not applied to insurers who, if they do not recover any money paid to the insured, have lost nothing and have gained the premiums.”<sup>211</sup>

Even if one were to accept the idea that subrogation lowers insurance premiums (which this Note is not conceding), the benefit of lower premiums is substantially outweighed by the negative costs that subrogation imposes on the public.<sup>212</sup> Subrogation disrupts the settlement process,<sup>213</sup> because the insured knows that the insurance company is going to take a large portion of his settlement. Therefore, the insured is less likely to settle in hopes that he can be fully compensated at trial. This behavior prolongs the litigation process and creates unnecessary litigation costs. The settlement process especially stalls “in [cases] involving multiple subrogation claims, [because] disagreements between the [parties] tend to complicate and prolong the settlement process,” resulting in unnecessary costs.<sup>214</sup> Subrogation also encourages insurance companies not to pay the tort victim’s medical costs to begin with, as doing so will encourage the victim to initiate suit and allow the insurer to recover from the tortfeasor.<sup>215</sup> The delay of payment of benefits to the tortfeasor could lead to costly bad faith litigation in addition to a tort suit and subsequent subrogation suit.

### VIII. CONCLUSION

*Sereboff* was incorrectly decided, and its progeny has devastated tort victims’ settlement rights. First, *Sereboff* erroneously concluded that subrogation claims under ERISA constitute equitable liens by agreement. The Court’s analogy to *Barnes* can only be described as suspect at best. Further, *Sereboff*’s rule that identifiable proceeds in the beneficiary’s possession are subject to an equi-

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<sup>207</sup> *Id.*

<sup>208</sup> Parker, *supra* note 55, at 737.

<sup>209</sup> JOHN LOWRY & PHILIP RAWLINGS, *INSURANCE LAW: CASES AND MATERIALS* 621 (2004).

<sup>210</sup> *Id.*

<sup>211</sup> *Id.*

<sup>212</sup> *Id.*

<sup>213</sup> Parker, *supra* note 55, at 736.

<sup>214</sup> *Id.*

<sup>215</sup> *Id.* at 736-37.

table lien is an unworkable standard that will result in tort victims hiding their settlement proceeds and increased litigation.

In light of the conflicting views on whether subrogation has any positive impact on insurance premiums, federal courts are acting recklessly when they disregard both the made whole doctrine and the pro rata approach under ERISA, leaving the insured to face one hundred percent subrogation in all cases. Therefore, if *Sereboff* cannot be overturned, some damage control must be implemented. Until the insurance companies can unequivocally prove subrogation is in fact proportionally lowering premiums and the negative costs of subrogation are in fact outweighed by the reduction in premiums, the most reasonable alternative is for the federal courts to use the pro rata approach and allow the insurer and the insured to share equally in the tort recovery. Additionally, the pro rata approach is consistent with the principles of equity embodied in equitable agreements and equitable liens. Moreover, this state law principle is not in conflict with the federal policies embodied in ERISA. Consequently, the pro rata approach developed by the states should be adopted into federal common law.