The Road to Recovery: Subrogation Gets Its Day In Court … Again
July 6, 2015
By: Chris Aguiar

By Christopher M. Aguiar, Esq.

(As published within The Self-Insurer)

In a country with a seemingly infinite amount of regulation and concerns regarding benefit plan compliance following the passage of the Affordable Care Act in 2010, one would expect much attention from courts in the employee sponsored health benefits arena. Most might be surprised when they realize the amount of attention that subrogation has received in The Supreme Court of the United States, the highest court in the land, over the last 25 years. Subrogation, a concept few truly understand and even fewer recognize, has been reviewed by The Supreme Court several times since 1990. Even legal practitioners unfamiliar with the world of insurance law might struggle to provide a satisfactory explanation of it. Many an industry practitioner can tell tales of their encounters with even subrogation professionals with questionable understanding of the concept.

In the 226 years of The Supreme Court's existence, It has reviewed approximately 1,742 cases, or eight cases per year. Most courts in America review more than that per day. With such limited volume, it is surprising that the issue of subrogation has been directly dealt with four times since 1993 (i.e. 4 of the last 469 cases). While two applications for review have been denied, a fifth case, *Montanile v. Board of Trustees of the National Elevator Industry Health Benefit Plan*, case # 14-723, is now slated to be heard by The Supreme Court in 2015.

To be clear, it is somewhat disingenuous to say that subrogation, specifically, has merited so much attention. To understand why subrogation has been reviewed so often, one must understand the legal framework that is actually being implicated. The issues The Court is really tackling are the circumstances under which a plan can enforce a right to be reimbursed from the injury settlement of plan participants, and if so, to what extent. The Employee Retirement Income Security Act of 1974, better known as ERISA, allows a plan to seek "appropriate equitable relief" and The Court is being asked to define the framework to be applied. Stated more simply, whose definition of equity, or fairness, is more appropriate – the states, or the benefit plans providing benefits to employees of companies in America?

Therein lies the crux of the problem – words and phrases like "fair" or "appropriate equitable relief" – as utilized in ERISA – lack any definite meaning. Certainly, definitions for them exist, but they are relative terms, the actual meaning of which reasonable people can (and will) disagree upon. They are the kind of terms that allow lawyers to make a living, those that lend themselves to disagreement, advocacy and, ultimately, the opinions of an appointed arbiter. So what exactly is the issue? In layman's terms, The Court is trying to answer a simple question; when is it fair for a benefit plan that provides health benefits, *with the explicit understanding* that if those benefits arise due to the acts of a third party, and the beneficiary receives a settlement from a third party to the health benefits arrangement, to expect those funds to be returned to the

health plan? Most reasonable minds will agree that, theoretically, *it is* fair for a benefit plan to recoup those funds because a person who causes damages should be held responsible for them. As a practical matter, however, the persons who cause these injuries rarely have the means to atone for them financially, and those who suffer the injuries are often the ones left feeling undercompensated for their losses. For that reason, The Court has stepped in repeatedly to try to resolve this issue

The Court has, for the most part, sided with the employee benefit plans. As set forth in *Great West Life & Annuity Insurance Co. Et Al. v. Knudson*, 534 U.S. 204 (2002), and then reaffirmed in *Sereboff v. Mid Atlantic Medical Services, Inc., 547 U.S 356 (2006)*, a benefit plan that establishes an equitable right of reimbursement can enforce that right in equity as long as the fund is 1) identifiable, 2) traceable, and 3) in the possession of the party against whom the claim is made. Indeed, the benefit plan in *Great West Life* lost its case because the plan brought action against the plan participant, Knudson, but the funds were being held in a trust on her behalf. Since the Plan failed to bring suit against the party in possession of the funds, i.e. the trust, The Court held the Plan had not protected its rights and could not enforce its action in equity. What followed were misinterpretations and overstatements, leading to substantial unrest in the world of subrogation and a concern that a benefit plan could not enforce its equitable rights on the whole.

In 2006, The Court clarified much of the confusion that arose from Its decision in *Great West Life* when it reviewed *Sereboff*. Essentially, The Court ruled in *Sereboff* that when a benefit plan follows the blueprint laid out in *Great West Life*, it can enforce an equitable remedy against the plan participant. Unfortunately, The Court left one issue unresolved and to the interpretation of lower courts: when a plan seeks to enforce an equitable remedy, will that remedy be limited by traditional rules of equity, i.e. the Common Fund and Made Whole Doctrine? While most jurisdictions were in support of the enforcement of clear language in favor of preemption of equitable limitations, a few still sought to avoid application of the plan terms. Such was the status of the law until 2013 when The Court once again granted review of a subrogation case, *U.S. Airways, Inc. v. McCutchen*, 133 S. Ct. 1537.

In *McCutchen*, The Court finally resolved this very prevalent issue. Most reasonable people can agree that a plan should be able to recover funds from a party who causes injuries to a plan participant – it is when the available funds are lacking that disagreements arise. Naturally, nearly everyone believes the injured person deserves to be compensated. Thanks to The Supreme Court and Its decision in *McCutchen*, however, a benefit plan can craft its provisions such that the plan is reimbursed first, in full, regardless of the impact that reimbursement has on the patient's situation. Many a plaintiff's attorney will argue incredulously that an outcome wherein the participant is not made whole, or the plan benefits from the efforts of the injured person and their attorney to secure a recovery without having to pay for that benefit, is not fair. The Supreme Court, as ultimate arbiter establishing the supreme law of the land, has decided that it is fair for a benefit plan to provide for and enforce reimbursement without equitable limitations.

With all the attention in the last 25 years, one might think that The Supreme Court has had Its fill of subrogation and resolved the disputes around the law … enter *Montanile*. In *Montanile*, The Court will tackle yet another pivotal issue – when exactly does a benefit plan's right attach to

recovered funds? Stated even more simply, can a benefit plan's right be defeated if the plan participant spends all the money? In *Montanile*, the plan participant was involved in an accident with a drunk driver and incurred over $121,000.00 in medical claims that were paid by the plan. As a result of that accident, the plan participant brought a lawsuit against the driver and received a settlement of $500,000.00, which he claims he then spent on everyday living expenses. Since he spent the money, he argued, the plan could no longer enforce its reimbursement right. Both the trial court and the Eleventh Circuit ruled that the plan can still enforce its right. Eight federal jurisdictions have now ruled on this issue, six of them agree that simply spending the money does not defeat a plan's interest. This split in authority has laid the groundwork for The Supreme Court's review of Montanile.

If The Court rules in favor of *Montanile*, plaintiff's lawyers will unquestionably threaten to spend settlement proceeds unless the plan takes action to protect the recovery. Benefit plans can take some solace in the overwhelming nature in which the Court has previously ruled in favor of the plan. In *Sereboff*, for example, the Court ruled unanimously their favor. In *McCutchen*, five justices ruled against the plan, however, in that case the benefit plan lacked the necessary language to avoid equitable limitations, but the opinion made clear that the terms of the language create a valid contract and therefore should govern the rights of the parties. If those cases are any indication, and The Court continues with its theme of strict enforcement of established plan terms, we should see another favorable decision.

Regardless of the outcome of this case, though, benefit plans should always look to follow established best practices. A plan can put itself in the best position to succeed by ensuring it has clear language that establishes automatic attachment of its lien. Great language is not always enough, though. Early intervention and follow through on the status of the case provides the plan with the opportunity to monitor the case and, if necessary, intervene to protect its interest. By taking these relatively simple actions, the plan can maximize its chance of recovery – and maybe, plans will get a little bit of help from The Supreme Court in *Montanile*. Oh, and for all you subrogation enthusiasts out there, do not fret – there are a few more issues that could use some clarification from The High Court, I am guessing It gets Its hands dirty on some subrogation cases a few more times in the next few years.