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MONTHLY ELECTRONIC SUBROGATION NEWSLETTER AUGUST 29, 2006

TO CLIENTS AND FRIENDS OF MATTHIESEN, WICKERT & LEHRER, S.C.:

This monthly electronic subrogation newsletter is a service provided exclusively to clients and friends of Matthiesen, Wickert & Lehrer, S.C. The vagaries and complexity of nationwide subrogation have, for many lawyers and insurance professionals, made keeping current with changing subrogation law in all fifty states an arduous and laborious task. It is the goal of Matthiesen, Wickert & Lehrer, S.C. and this electronic subrogation newsletter, to assist in the dissemination of new developments in subrogation law and the continuing education of recovery professionals. If anyone has co-workers or associates who wish to be placed on our e-mail mailing list, please provide their e-mail addresses to Rose Thomson at rthomson@mwl-law.com. We appreciate your friendship and your business.

<<< SPECIAL HEALTH INSURANCE SUBROGATION ALERT >>>

HEALTH INSURANCE SUBROGATION

Fortis Benefits v. Vanessa Cantu and Ford Motor Company, 05-0791, In The Supreme Court of Texas

Texas Supreme Court Grants Petition For Review - NASP Amicus Brief Filed
Oral Argument Set For November 16, 2006 at 9:00 a.m.

Last December we reported to you on the NASP Amicus brief Gary Wickert filed with the Texas Supreme Court in the case of *Fortis Benefits v. Vanessa Cantu and Ford Motor Company*, No. 05-0791 (Texas Supreme Court). As you may recall, this case, appealed from the Texas Court of Appeals, involved the application of equitable defenses such as the made whole doctrine to contractual subrogation rights in the health insurance subrogation arena. In summary, the facts are that Cantu filed suit to recover for injuries sustained in a motor vehicle accident on April 12, 1998. Fortis Benefits intervened into the suit, asserting an interest in any recovery by Cantu by virtue of its payment of medical benefits under a health Plan issued to Cantu. This private, non-self-insured Plan contained subrogation and reimbursement language granting Fortis a right of recovery notwithstanding whether the policyholder was made whole. Cantu settled the suit for $1.445 million and claimed she was not "made whole". Fortis was not a party to the settlement.

The trial court found that Fortis could not recover its $250,000 subrogation interest because Cantu was not "made whole", and the Court of Appeals, with a strong dissent by one of the justices, affirmed. Fortis appealed the case to the Texas Supreme Court, and asked if NASP would consider filing an amicus brief in support of the Plan's subrogation rights. Gary Wickert filed an amicus brief on behalf of NASP which set forth in detail that the law in 28 of 33 states which have spoken on this issue, is that equitable/legal subrogation is totally different from contractual

subrogation, and that the equitable made whole doctrine can and should be overridden by contract terms in a policy of insurance. The intent of the parties to the insurance contract should be given effect. Even major insurance treatises such as *Couch on Insurance* state clearly that the general equitable made whole doctrine should only apply "in the absence of contrary statutory law or valid contractual obligation to the contrary". Trial lawyers are watching this case carefully.

We are pleased to announce that on August 25, 2006, the Texas Supreme Court granted our Petition for Review, and immediately scheduled oral arguments for November 16, 2006 at 9:00 a.m.

We are now more optimistic than ever that the Texas Supreme Court will reverse the Court of Appeals decision and follow the lead of the Ohio Supreme Court, which held in *Northern Buckeye Educational Counsel Group Health Benefits Plan v. Lawson*, 814 N.E.2d 1210 (Ohio 2004), that contractual subrogation provisions overrule equitable doctrines such as made whole and common fund. This success was due, in part, to a NASP Amicus brief filed with the Ohio Supreme Court.

We will keep you updated on the progress of this significant subrogation appeal, which we hope will continue the ripple effect throughout the country and reinforce the importance of the intent of the parties to insurance Plans, policies and contracts, with regard to avoiding the inequitable results of the made whole, common fund, and other "equitable" doctrines. For information on the appeal or for a copy of the Amicus Brief filed by NASP, please contact Gary Wickert at gwickert@mwl-law.com.

HEALTH INSURANCE SUBROGATION

Popowski and The Commerce Group (United Distributors' Health Plan) v. Deborah Parrott; BlueCross BlueShield of South Carolina v. Carillo, 2006 WL 2433481 (11th Cir. August 24, 2006)

Plan Language Takes Center Stage In Reimbursement Case

On August 24, 2006, the 11th Circuit Court of Appeals rendered a health insurance subrogation opinion involving two consolidated cases and two different Plans, each containing different Plan language, and each seeking reimbursement of health benefit payments they each had made to their respective Plan beneficiaries, each of whom had subsequently made third party recoveries. In what could be described as a knit-picking decision, this opinion shows the importance of having the correct Plan language contained within your Plan.

United Distributors' Plan

Mark Popowski, as fiduciary of the United Distributors', Inc. Employee Health Benefit Plan ("United Distributors' Plan"), and the Commerce Group, as its third-party administrator, brought suit against Deborah Parrott, an employee of United Distributors', Inc., who was injured in an accident in May 2003, for reimbursement of benefits it paid to Parrott. The United Distributors' Plan allegedly paid $152,889.65 in medical expenses on her behalf in connection with the accident. However, prior

to the United Distributors' Plan making any payment, Parrott signed a reimbursement agreement stating that she understood that the Plan:

> *"has a claim or lien against, and the first right to receive reimbursement from the Participant for, any recovery, settlement, or judgment obtained by Participant from or against any party at fault in the [accident at issue] or from any other source for the amount paid by the Plan as medical claims."*

This agreement echoed the Plan's own subrogation and reimbursement provision, which stated that:

> *"in any event, the Plan has a lien on any amount recovered by the Covered Person whether or not designated as payment for medical expenses. This lien shall remain in effect until the Plan is repaid in full. The Covered Person … must repay to the Plan the benefits paid on his or her behalf out of the recovery made from the third party or insurer."*

The Plan further explains that:

> *"[t]hese rights provide the Plan with a priority over any funds paid by a third party to a Covered Person relative to the Injury or Sickness, including a priority over any claim for non-medical or dental charges, attorney's fees, or other costs and expenses."*

In October 2003, Parrott obtained a settlement through her attorney for a total of $525,000. Of the portion paid by her uninsured motorist policy, $175,000 went to her attorney, $125,000 was placed in a structured annuity to her benefit, and the remainder, approximately $200,000, was paid directly to Parrott and deposited into a joint checking account that she held with her husband. Of the $25,000 paid by the tortfeasor's insurer, some went to cover medical expenses, some to cover attorney's fees and costs, and the remaining $2,374.64 went into the Parrots' account. After discovering that Parrott had received this settlement, Popowski and the Commerce Group attempted to collect under the policy's reimbursement provision and reinforcing reimbursement agreement. When they were unable to do so, they filed this suit along with a motion for a temporary restraining order and preliminary injunction to protect the settlement proceeds. Parrott filed motions to dismiss, first alleging failure to state a claim, then alleging lack of subject matter jurisdiction. Faced with a split among the circuits regarding the scope of equitable relief under ERISA, the district court concluded that it lacked jurisdiction over the Plan's claims because the Plan actually sought legal rather than equitable restitution in that they based their claim on the breach of a contract obligation to reimburse the Plan rather than on a property right in a "specifically identifiable fund." United Distributors' appealed.

Mohawk Plan

In June 2002, Josue Carillo and Vicente Carillo were involved in an accident. The Mohawk Plan allegedly paid medical benefits of $122,393.64 on behalf of Josue and $3,971.09 on behalf of Vicente. BlueCross BlueShield of South Carolina ("BCBS"), as fiduciary of the Mohawk Carpet Corporation Health and Welfare Benefits Plan ("Mohawk Plan"), sued Josue and Vicente Carillo for reimbursement of these benefits. The Mohawk Plan contains a subrogation and reimbursement provision which, *inter alia,* provided:

"If, however, the Covered Person receives a settlement, judgment, or other payment relating to the accidental injury or illness from another person, firm, corporation, organization or business entity paid by, or on behalf of, the person or entity who allegedly caused the injury or illness, the Covered Person agrees to reimburse the Plan in full, and in first priority, for any medical expenses paid by the Plan relating to the injury or illness."

The Carillos received a settlement of $200,000 and they refused to reimburse the Mohawk Plan for the medical expenses it paid on their behalf. BCBS brought suit pursuant to § 1132(a)(3) of ERISA, seeking enforcement of the subrogation and reimbursement provision through "equitable relief, including but not limited to, restitution, imposition of a constructive trust, and equitable lien." BCBS also sought a temporary restraining order and preliminary injunction preventing the Carillos from dissipating the settlement funds. The court granted a temporary restraining order but deferred ruling on the preliminary injunction pending further briefing by the parties. Prior to any ruling, the Carillos filed a motion to dismiss asserting that the district court lacked jurisdiction because the Plan's allegations "failed to state a claim for equitable relief". Adopting the reasoning of the 6th and 9th Circuits, the court concluded that BCBS's claim "regardless of whether it is styled as a claim for a constructive trust, for equitable restitution, or for an equitable lien, simply seeks to enforce a provision of a Plan document that would require Defendants to pay money. It further concluded that "[s]uch a claim is not equitable in nature, and is not 'appropriate equitable relief' under ERISA." The court also ruled that because BCBS failed to "seek recovery of specified, identifiable funds, but instead [sought] recovery of funds that have been commingled into various checking accounts and spent, in part, to purchase a truck . . . relief under § 1132(a)(3) [was] unavailable." BCBS appealed.

After the appeals were perfected and the briefing was done, the U.S. Supreme Court rendered its decision in *Sereboff v. Mid Atlantic Medical Services, Inc.,* 126 S. Ct. 1869 (2006). *Sereboff* characterized the Plan language provision in that case as requiring "a beneficiary who 'receives benefits' under the Plan for such injuries to 'reimburse [the Plan]' for those benefits *from* '[a]ll recoveries from a third party (whether by lawsuit, settlement, or otherwise).'" The 11th Circuit Court of Appeals then focused on the language contained in the Mohawk and United Distributors Plans.

The 11th Circuit's Opinion

The United Distributors' Plan. The 11th Circuit noted that the subrogation and reimbursement provision in the United Distributors' Plan claims a lien "on any amount recovered by the Covered Person whether or not designated as payment for medical expenses." It further clarifies that "[t]he Covered Person . . . must repay to the Plan the benefits paid on his or her behalf *out of* the recovery made from the third party or insurer." Thus, language essentially identical to that in *Sereboff,* specifies both the fund (recovery from the third party or insurer) out of which reimbursement is due to the Plan and the portion due the Plan (benefits paid by the Plan on behalf of the defendant). Thus, at the time they filed their suit, Popowski and the Commerce Group sought not to impose personal liability on Parrott, but to restore to the plaintiffs particular funds or property in Parrott's possession. Accordingly, the 11th Circuit held that the United Distributors' Plan stated a claim for "appropriate equitable relief" under § 1132(a)(3) and that the district court erred in dismissing the suit for lack of subject matter jurisdiction.

Mohawk Plan. The Court of Appeals held that the subrogation and reimbursement provision in the Mohawk Plan, unlike that of the United Distributors' Plan, claims a right to reimbursement "in

full, and in first priority, for any medical expenses paid by the Plan relating to the injury or illness," but does not specify that reimbursement be made out of any particular fund, as distinct from the beneficiary's general assets. Instead, it makes receipt of "a settlement, judgment, or other payment relating to the accidental injury or illness" a trigger for the general reimbursement obligation. Further, in requiring reimbursement "in full", the Mohawk Plan failed to limit recovery to a specific portion of a particular fund. Accordingly, the 11th Circuit concluded that, because the Mohawk Plan failed to specify that a reimbursement recovery comes from an identifiable fund or to limit that recovery to any portion thereof, it fails to meet the requirements outlined in *Sereboff* for the assertion of an equitable lien for the purposes of § 1132(a)(3) of ERISA. They held it was not an error to dismiss The Mohawk Plan's claims.

Significance Of This Decision

Plan language, for years so critical in determining whether or not the made whole or common fund doctrines would apply to reduce your health insurance subrogation recoveries, has now also become critical in evaluating whether or not your reimbursement action will qualify as equitable relief under ERISA – at least in the 11th Circuit. Plan language which merely claims a right to reimbursement "in full, and in first priority, for any medical expenses paid by the Plan relating to the injury or illness," but does not specify that reimbursement be made out of any particular fund, as distinct from the beneficiary's general assets, will not support a claim for equitable relief in the 11th Circuit, because it does not identify a fund from which the reimbursement will come. Once again, Plan language becomes critical when it comes to subrogation. For an evaluation of your Plan language vis-à-vis this new 11th Circuit decision, please contact Ryan Woody at rwoody@mwl-law.com.
