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CLIENT ALERT

Supreme Court Alters Enforcement of Subrogation Clauses

by Jason Luter, Gray Reed & McGraw

Attention Insurance Providers and Self-Insured Providers

A recent U.S. Supreme Court ruling has overturned past precedent, more narrowly defining the circumstances under which providers may collect, from participants, money received from third parties.

Nearly all employee benefit plans (e.g. healthcare, disability insurance, and retirement) contain subrogation clauses allowing the plan's benefit provider (e.g. the employer sponsoring the plan or the insurance company responsible for paying benefits) to recover payments made on behalf of plan participants, if a third-party later pays the participant for the same claim.

For example, if a participant is hit by a truck and incurs substantial medical and disability bills, the benefit provider would pay those bills as they are incurred by the participant. If the injured participant later receives a monetary settlement from the truck driver who injured him/her, then, based on past precedent, the participant must reimburse his/her provider for the amount of benefit payments already made. The rationale behind this is to prevent a provider from paying for injuries caused by a third-party and for which that third-party is legally responsible.

A Supreme Court case just complicated this practice.

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ERISA ALERT

Supreme Court redefines enforcement of subrogation clauses

by Jason Luter, Gray Reed & McGraw

In a recent ruling, the Supreme Court held that, under ERISA § 502(a)(3) (the federal statute governing employee benefit plans), a provider may not recover monies already paid to or on behalf of a plan participant from that plan participant's general assets, if he/she has already spent the settlement money on non-traceable items. In other words, if a participant is hit by a truck, his/her provider pays the medical bills, and the participant later receives a large monetary settlement from the truck driver, the provider cannot recover any money if the participant has already spent the settlement money and has no hard assets to show for it (e.g., rather than purchasing cars or real estate, the participant blew the money at a casino).

Moral of the Story

If your client or you has/have subrogation rights in an ERISA Plan, which is nearly always the case, it is critical that you enforce those rights immediately—before the participant spends any money he/she receives from that third-party. Please contact Jason Luter of Gray Reed & McGraw at 469.320.6076 or jluter@grayreed.com for assistance with implementing best practices and procedures for protecting your clients' and your rights.

The Case

Montanile v Board of Trustees of National Elevator Industry Health Benefit Plan

In December 2008, Montanile was injured by a drunk driver. The accident resulted in $121,044 in medical claims, which his ERISA-covered health benefit plan provided by the Board of Trustees of Trustees National Health Benefit Plan reimbursed.

Montanile filed a negligence claim against the drunk driver and ultimately obtained a $500,000 settlement—$240,000 of which remained after paying his attorney. Under his health plan's subrogation clause, his provider had the right to demand reimbursement for any claims paid if Montanile recovered medical claims from a third-party. Subsequently, the Board (as the provider of the plan) sought reimbursement from Montanile, but his attorney argued the Board was not entitled to recovery.

After negotiations broke down, Montanile's attorney informed the Board he would distribute the remaining settlement funds to Montanile unless the Board objected within 14 days. The Board did not respond within that time frame, and the attorney gave Montanile the remaining funds. Six months later, the Board sued Montanile in district court under ERISA § 502(a)(3), seeking reimbursement for the $121,044 in medical claims

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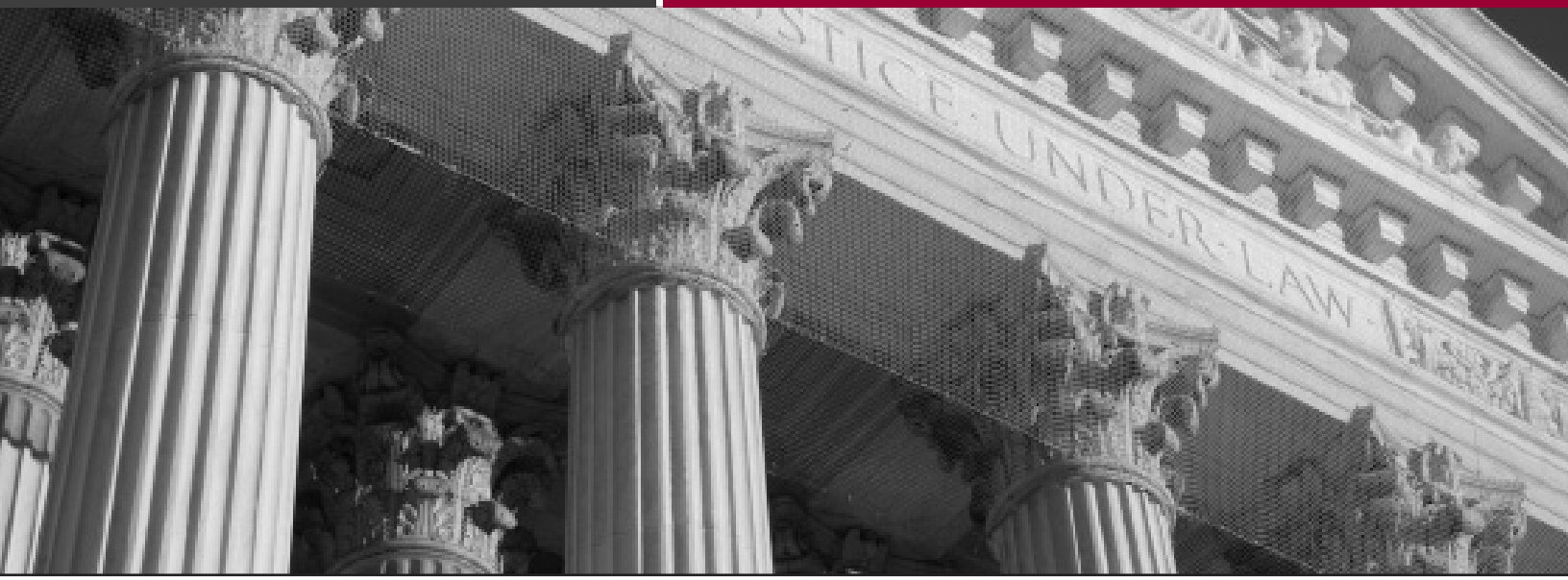


that were paid by the plan.

The district court ruled in favor of the Board, rejecting Montanile's argument that, by the time of the suit, he had spent almost all of the settlement funds and there were no specific assets against which the Board's equitable lien could be enforced. The Eleventh Court upheld the decision.

The Supreme Court overturned the Eleventh Circuit, ruling that when an ERISA plan participant has spent all of the proceeds from a third party settlement on non-traceable items, as Montanile had allegedly done, the Board, as plan fiduciary, is not permitted to bring suit under ERISA § 502(a)(3) and place an equitable lien on Montanile's separate assets.

When a plaintiff seeks an equitable lien, the Court held that, under principles of equity, the lien could be enforced only against specifically identified funds still in the defendant's possession—or against traceable items purchased with the funds. If the funds were spent on non-traceable items, the plaintiff could not request reimbursement from the defendant's general assets.

It's important to note, even if a plan includes a subrogation clause to safeguard against a participant's efforts to evade reimbursement, according to this new ruling, the plan still needs to trace the third-party amount to specific, identifiable assets.

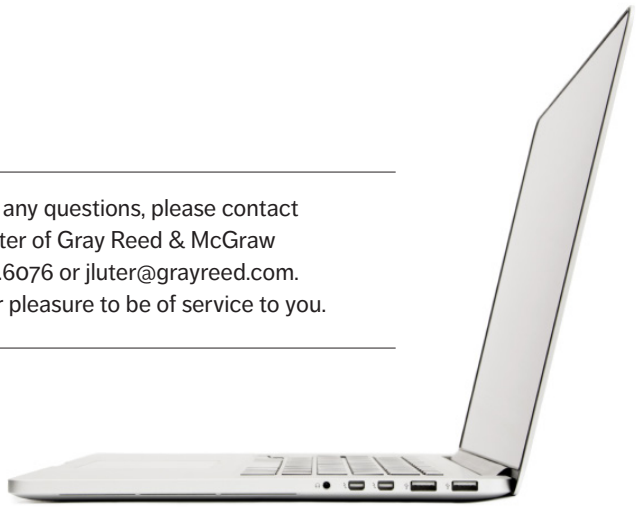
The Court also rejected the Board's position that equity courts may employ an equitable lien on general assets under the principles of substitute money decrees, deficiency judgements and the swollen assets doctrine. It found this type of relief was not typically available in equity, and the Board's claim for relief from Montanile's general assets confirms that the Board was seeking legal, rather than equitable, remedies.

Conclusion

According to the Court, ERISA § 502(a)(3) does not permit "legal" remedies, which is why the Board's claim was rejected and remanded to the district court to determine whether Montanile had kept his settlement funds separate from his general assets or had spent the entirety of the funds on non-traceable assets.

The Court pointed out that if the plan had responded to Montanile's attorney with an objection within the 14-day deadline before he disbursed the remaining settlement funds to Montanile, or if the plan had filed suit before six months post-negotiations, then the Board might have succeeded in its claim for equitable relief.

While this case refers specifically to an ERISA health plan, this ruling, presumably, applies to all ERISA plans—a plan seeking ERISA § 502(a)(3) equitable relief against a participant may only proceed if the participant has in his/her possession specifically identifiable, traceable funds.



If you have any questions, please contact
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It's always our pleasure to be of service to you.