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NOTES

SUBROGATION OR SUBTERFUGE: THE MYTH OF ERISA HEALTH BENEFIT PLANS

Gerald F. Murphy

I. INTRODUCTION

John was a factory worker making $28,000 a year before taxes. Two years ago he was involved in a car accident in which he was struck by a drunk driver. The debilitating injuries he received severely limited his ability to work and support his family. John's medical expenses and related costs exceeded $500,000. Although he only received $300,000 from his employee benefit insurance plan and $200,000 in damages from the driver who hit him, John is still $200,000 in debt.

Employee health benefit plans are governed by the Employee Retirement Income and Securities Act [hereinafter ERISA].¹ Under an ERISA plan, both the employees and the employer contribute; however, the employers are the predominate contributors and are essentially put in the position of the insurer.² These plans usually contain subrogation and/or reimbursement provisions. These provisions stipulate that, in the event of recovery from a third party tortfeasor, the plan will be entitled to reimbursement for any money paid out for medical expenses. Neither ERISA itself, nor language contained in the plans, contemplate the aforementioned hypothetical involving the now heavily indebted factory worker.³

The “make-whole” doctrine is an equitable principle, which would have protected John. It states an insured who settles with a third-party tortfeasor is liable to the insurer-subrogee only for the excess received

². Sunbeam-Oster Co., Inc. Group Benefits Plan for Salaried and Non-Bargaining Hourly Employees v. Whitehurst, 102 F.3d 1368, 1370 (5th Cir. 1996) (“Participants were required to make contributions to the Plan, but as their total contributions were insufficient to pay the aggregate costs of covered services, claims were largely paid from the general assets of Sunbeam.”).
over the total amount of their loss. Judge Posner recognized that the "make-whole rule is most likely to apply in a case of catastrophic loss, where full insurance is rare."\(^4\) Seemingly, it would follow that this rule is in line with the very purpose of insurance, that of guarding against loss. Furthermore, it is quite doubtful that employees covered under such plans are cognizant of the fact that their "insurance" will seek to be indemnified from any recovery they may obtain, even if doing so may render them hundreds of thousands of dollars short of being able to pay for their medical bills. In such cases where an insured does not obtain third-party recovery, the plan will not seek reimbursement. However, if the insured does make a recovery, allowing him to break even, the plan will attempt to exercise its right to reimbursement. This may leave the insured debt-ridden and no better off than if they had not sought third-party recovery at all.

ERISA pre-empts state law and therefore, conflicts over rights to plan recovery fall exclusively under federal jurisdiction.\(^6\) The place of the federal common law make-whole rule has precipitated a dramatic circuit split, part of which was aired before the Supreme Court in Great-West Life Insurance and Annuity v. Knudson.\(^7\) The primary effect of the Court’s decision will be to further complicate subrogation/reimbursement litigation under ERISA. This note predominately focuses on the future application and vitality of the make-whole rule, and the potential impact of the Great-West decision, thoroughly exploring the rationale employed by the Sixth, Ninth and Eleventh Circuits in their persistent call for the rule's preservation.

II. PRIOR LAW

ERISA’s primary function is the protection of employees’ retirement expectations by creating a national standard that reserves the regulation of employee benefit plans to the federal government.\(^8\) Employee health plans fall under this broad mandate. "ERISA comprehensively regulates, among other things, employee welfare benefit plans that, ‘through the purchase of insurance or otherwise,’ provide

\(^4\) Cagle v. Bruner, 112 F.3d 1510, 1520 (11th Cir. 1997).
\(^5\) Cutting v. Jerome Foods, Inc., 993 F.2d 1293, 1298 (7th Cir. 1993).
\(^6\) FMC Corp., 498 U.S. at 52.
\(^7\) 534 U.S. 204 (2002).
medical, surgical, or hospital care, or benefits in the event of sickness, accident, disability or death.\textsuperscript{9}

\textbf{A. Supreme Court Decisions}

\textit{1. Pilot Life Insurance v. Dedeaux}

Central to ERISA is the notion of uniformity. Illustrative of this principle is the clear Congressional intent for “all suits brought by beneficiaries or participants asserting improper processing of claims under ERISA-regulated plans be treated as federal questions...”\textsuperscript{10} Having to rectify the laws of each and every one of the fifty states would contravene this express mandate. “The uniformity of decisions which the Act is designed to foster will help administrators, fiduciaries and participants to predict the legality of proposed actions without the necessity of reference to varying state laws.”\textsuperscript{11} The Court has found that disputes arising out of subrogation and reimbursement clauses clearly fit within their jurisdiction.\textsuperscript{12}

Having set forth the bounds of federal preemption of suits stemming from improper processing of claims, the Court pointed to ERISA’s civil enforcement provisions found in section 502(a)(3) as the exclusive means for obtaining relief under ERISA.\textsuperscript{13} Legislative history shows that this section was modeled on an equally powerful and preemptive provision, section 301 of the Labor Management Relations Act.\textsuperscript{14} It follows then,


\textsuperscript{10} Pilot Life Ins. Co., 481 U.S. at 56.

\textsuperscript{11} \textit{Id.} (citing H.R. Rep. No. 93-533, p. 12 (1973) reprinted in 2 Senate Committee on Labor and Public Welfare, Legislative History of ERISA, 94th Cong., 2d Sess., 2359 (Comm. Print 1976)).

\textsuperscript{12} FMC Corp., 489 U.S. at 61.

\textsuperscript{13} Pilot Life Ins. Co., 481 U.S. at 56.

\textsuperscript{14} \textit{Id.} at 55. ("All such actions in Federal or State courts are to be regarded as arising under the laws of the United States in similar fashion to those brought under section 301 of the Labor-Management Relations Act of 1947." (quoting H.R. Conf. Rep. No. 93-1280, at 327 (1974)) (emphasis added). The Court singled out § 301 of the LMRA as having “pre-emptive force...so powerful as to displace entirely any state cause of action ‘for violation of contracts between an employer and a labor organization.’ Any such suit is purely a creature of federal law...”) Franchise Tax Board of Cal. v. Construction Laborers Vacation Trust for Southern Cal., 463 U.S. 1, 23 (1983).
that as the sole vehicle for bringing such actions, any claim that does not comport with section 502(a)(3) cannot lie. "The six carefully integrated civil enforcement provisions found in section 502(a)(3) of the statute [ERISA] finally enacted...provide strong evidence that Congress did not intend to authorize other remedies that it simply forgot to incorporate expressly." The Court anticipated that its constriction of the source of available civil enforcement remedies might place too much of a burden on the courts to work within such a limited statutory framework.

2. FMC Corp. v. Holliday

FMC Corp. v. Holliday solidified federal preemption over state law claims regarding the enforcement of health benefit plan provisions. The circuits split once again, leading the Supreme Court to grant certiorari on a Third Circuit decision challenging Pennsylvania’s antisubrogation laws. In principle however, the Court sought to clarify ERISA’s preemption language, which lies in three conflicting clauses.

The pre-emption clause is conspicuous for its breadth. It establishes as an area of exclusive federal concern the subject of every state law that “relate[s] to” an employee benefit plan governed by ERISA. The saving clause returns to the States the power to enforce those state laws that “regulate insurance,” except as provided in the deemer clause. Under the deemer clause, an employee benefit plan governed by ERISA shall not be “deemed” an insurance company, an insurer, or engaged in the business of insurance for purposes of state laws “purporting to regulate” insurance companies or insurance contracts.

Seemingly incompatible, these three provisions are illustrative of the formidable task that courts face in interpreting ERISA. The Court acknowledged that these provisions are “not a model of legislative drafting.”


17. Id. at 58 (Pennsylvania’s anti-subrogation law precluded insurers from exercising subrogation rights on a claimant’s tort recovery, and specifically mentioned ERISA plans).

18. Id. The exact language contained in the clauses at issue reads:

Except as provided in subsection (b) of this section [the saving clause], the provisions of this subchapter and subchapter III of this chapter shall
Until the decision in *FMC Corp. v. Holliday*, there was no definitive answer as to which side of the line subrogation and reimbursement provisions would fall. These "self-funded plans" became a sole province of the federal courts after *FMC Corp. v. Holliday*, and theretofore did the adjudication of subrogation and reimbursement disputes. One ambiguity was traded for another, however, because ERISA is silent on the issue of subrogation clauses by neither calling for their inclusion nor seeking to regulate their content. This "gap" clearly implicates a situation where courts should exercise their right to make federal common law in ERISA cases. The drafters envisioned that "a federal common law of rights and obligations under ERISA-regulated plans would develop."23

3. *Mertens v. Hewitt Associates*

The Court in *Pilot Life Insurance* held ERISA's civil enforcement provision, section 502(a)(3), to be the exclusive means of achieving remedies. However, the *Mertens v. Hewitt Associates* decision sought to further limit the scope of relief available under ERISA. Plan participants

supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan.

Except as provided in subparagraph (B) [the deemer clause], nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

Neither an employee benefit plan . . . nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

*Id.* at 57-58 (citations omitted).

19. *Id.* at 58 (quoting Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724, 739 (1985)).


22. *See Pilot Life Ins. Co.*, 481 U.S. at 56. "[I]t is also intended that a body of Federal substantive law will be developed by the courts to deal with issues involving rights and obligations under private welfare and pension plans." *Id.* (quoting 120 CONG. REC. 29933 (1974) (statement of Sen. Javits)).


24. *Id.* at 56.


26. *Id.*
sought to recover monetary damages from an actuary working for the plan, whose miscalculations led to the ultimate demise of the plan, and qualified as a knowing breach of fiduciary duty. 27 ERISA section 502(a)(3) reads as follows:

[a] civil action may be brought...by a participant, beneficiary or fiduciary (A) to enjoin any act or practice which violates any provision of this title 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 title or the terms of the plan. 28

Succinctly put, Petitioners sought "compensatory damages—monetary relief for all losses their plan sustained as a result of the alleged breach of fiduciary duties." 29 The Court construed the phrase "appropriate equitable relief," in subparagraph B to be analogous to its interpretation of "any other equitable relief as the court deems appropriate," 30 finding that both precluded "awards for compensatory or punitive damages." 31 Refusing to render Congress's addition of the modifier "equitable" as superfluous, 32 "equitable relief" was held to refer to those remedies "typically available in equity (such as injunction, mandamus, and restitution, but not compensatory damages)." 33

B. Formation of a Circuit Split

Generally put, the Sixth, Ninth and Eleventh Circuits have adopted the rule as a "default" rule, while the remaining courts have either refused to apply the rule at all, or have at least declined to do so thus far. Although the latter courts may agree in principle, they are far divided as to the intensity and rationale of their respective positions.

1. Eleventh Circuit

Although the Ninth Circuit was first to adopt the make-whole rule as the default common law principle, the Eleventh Circuit employed the principle over ten years ago in Guy v. Southeastern Iron Workers' Welfare

27. Id.
28. 29 U.SC. § 1132 (a) (2000).
29. Mertens, 508 U.S. at 255.
31. Id. (quoting United States v. Burke, 504 U.S. 229, 238 (1992)).
32. Mertens, 508 U.S. at 258.
33. Id. at 256.
In *Guy*, the plan refused to honor an insured's claim for a subsequent unrelated injury to his wife because the insured had not yet reimbursed the plan for a claim arising out of a motorcycle accident involving his sixteen-year-old son. Guy's third-party recovery left him $4,784 short of being able to recover his son's medical expenses, yet the plan sought to recover $74,595 it had paid out under the policy. Therefore, if the provision had been enforced, the Guys would have been $79,379 in debt, as opposed to $4,784. Accordingly, the court held that because Guy's son had not been made whole by his third-party recovery, the plan's right to subrogation was not mature.

In *Cagle v. Bruner,* the Eleventh Circuit formally adopted the make-whole rule, relying principally on language promulgated by the Ninth Circuit. "An ERISA plan overrides the make-whole doctrine only if it includes language ‘specifically allow[ing] the [p]lan the right of first reimbursement out of any recovery [the participant] was able to obtain even if [the participant] were not made whole.’" Central to the court's adoption of the default rule is the proposition that standard subrogation language will not serve to specifically reject the make-whole doctrine. Essentially, the default rule forecloses interpretation on behalf of plan administrators. The default provision is implied into ambiguous language in insurance contracts. Therefore, unless there is specific language rejecting it, the rule applies.

2. The Ninth Circuit's Approach

The Ninth Circuit has consistently applied the make-whole rule. It has been the default rule in that jurisdiction since the court's decision in *Barnes v. Independent Automobile Dealers Association of California*

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34. 877 F.2d 37 (11th Cir. 1989).
35. Id.
36. Id.
37. Id.
38. Id. at 39.
39. 112 F.3d 1510 (11th Cir. 1997).
40. Id. at 1522 (quoting Barnes v. Independent Automobile Dealers Association, 64 F.3d 1389, 1395 (9th Cir. 1995)).
41. Cagle, 112 F.3d at 1522 (citing Barnes, 64 F.3d at 1395-96 (general subrogation language does not override make-whole doctrine)); Guy, 877 F.2d at 38-9 (applying the make-whole doctrine even though the plan had a right to reimbursement from "all amounts recovered by suit, settlement or otherwise from any third person or his insurer to the extent of benefits provided hereunder.").
42. Cagle, 112 F.3d at 1521-22.
"It is a general equitable principle of insurance law that, absent an agreement to the contrary, an insurer may not enforce a right to subrogation until the insured has been fully compensated for her injuries, that is, has been made whole."\textsuperscript{44} \textit{Barnes} involved a crystalline make-whole scenario in which the plan did not contest that Barnes would remain indebted for over $18,000 for medical payments if she was found not to be entitled to retain her benefits under the plan.\textsuperscript{45} Nor, as is common practice in the rubric of third-party recovery under ERISA employee benefit plans, did the plan participate in Barnes's lawsuit against the tortfeasor.\textsuperscript{46} Although the Ninth Circuit may exhibit a higher propensity to find the language in a plan ambiguous, thereby applying the make-whole doctrine, it has surpassed its sister jurisdictions in its application of the principles behind the rule.

The Ninth Circuit has set itself apart from other circuits through its narrow interpretation of "appropriate equitable relief" under ERISA section 502(a)(3). Since its interpretation of the \textit{Mertens} decision in \textit{FMC Medical Plan v. Owens},\textsuperscript{47} the Ninth Circuit has held that the enforcement of subrogation and/or reimbursement provisions do not qualify as "appropriate equitable relief" under that section.\textsuperscript{48} It has been proposed that subrogation provisions are no longer enforceable in the traditional sense under ERISA in the Ninth Circuit.\textsuperscript{49} Indeed, this may now be the case in all federal jurisdictions, as the Supreme Court recently adopted that Circuit's stance on the issue.\textsuperscript{50}

This narrow approach has put the Ninth Circuit in direct conflict with the other circuits, even including those that employ the make-whole rule. A full discussion of the Ninth Circuit's rationale in \textit{Great-West Life & Annuity Insurance Co. v. Knudson},\textsuperscript{51} follows in the next section.

\textsuperscript{43} \textit{Barnes}, 64 F.3d at 1389.
\textsuperscript{44} \textit{Id.} at 1394 (citing \textit{Fields v. Farmers Ins. Co.}, 18 F.3d 831 (10th Cir. 1994) (diversity case listing jurisdictions following the rule); See also \textit{Guy v. Southeastern Iron Workers' Welfare Fund}, 877 F.2d 37, 39 (11th Cir. 1989) (ERISA case noting that subrogation right not mature until insured is reimbursed for loss.)
\textsuperscript{45} \textit{Barnes}, 64 F.3d at 1395.
\textsuperscript{46} \textit{Id.}
\textsuperscript{47} \textit{FMC Medical Plan v. Owens}, 122 F.3d 1258 (9th Cir. 1997).
\textsuperscript{48} \textit{Bleed, supra} note 21, at 737.
\textsuperscript{49} \textit{Id.}
\textsuperscript{50} \textit{Great-West}, 534 U.S. at 204.
\textsuperscript{51} \textit{Id.}
3. The Sixth Circuit's Approach

The Sixth Circuit has also adopted the make-whole rule as its default rule when interpreting ERISA subrogation and reimbursement provisions, and relied specifically on Barnes and Cagle in doing so. In Copeland Oaks v. Haupt, the Sixth Circuit held that, "in order for plan language to conclusively disavow the default rule, it must be specific and clear in establishing both a priority to the funds recovered and a right to any full or partial recovery." This language effectually put some teeth into the make-whole rule by requiring that plans spell out, in plain language, how subrogation and reimbursement provisions will be enforced. The Sixth Circuit acknowledges that it expanded the application of the make-whole rule in Copeland Oaks. Moreover, it has explicitly recognized that it has continued to apply the rule to plan language similar to that in which other circuits have found no ambiguity and refused to do so.

4. Objectors: The Remaining Circuits

The remaining circuits do not apply the make-whole doctrine as the default rule in their jurisdictions. The Fifth Circuit for example, specifically disavowed the prospect of its adoption, stating "we have serious doubts whether we would ever approve or adopt the Make Whole rule as this circuit's default rule for the priority of recovery in reimbursement or subrogation between an ERISA plan and its participant or beneficiary . . . ." Other circuits have similarly followed suit. The First and Fourth Circuits refused to adopt the make-whole rule, albeit using softer language. Both the Seventh and Tenth Circuits have also

53. 209 F.3d 811 (6th Cir. 2000).
54. Id. at 813.
56. Qualchoice, 14 Fed. Appx. at 8 (citing Waller v. Hormel Foods Corp., 120 F.3d 138 (8th Cir. 1997); Sunbeam-Oster Co. v. Whitehurst, 102 F.3d 1368 (5th Cir. 1996)).
57. See Sunbeam-Oster Co., Inc., 102 F.3d 1378.
58. Id. at 1378.
59. Qualchoice, 14 Fed.Appx. at 420 n.1 (citing Paris v. Iron Workers Trust Fund, 2000 U.S. App. Lexis 6883 (4th Cir.) (provision that "any amounts recovered" will be "applied first to reimburse plan" was not ambiguous; court does
considered whether or not to adopt the make-whole rule as a default position. In each particular case, although both circuits found that the plan language at issue was ambiguous and decided not to apply the rule, neither chose to preclude the prospect of adoption.  

III. IMPACT OF DEVELOPMENT – RESOLUTION?

A. Great-West Life Insurance v. Knudson – Ninth Circuit

Keeping in line with the progeny of *FMC Medical Plan v. Owens*, the Ninth Circuit has consistently held that enforcement of subrogation and reimbursement provisions under ERISA section 502(a)(3) does not constitute “appropriate equitable relief.” District courts in the Ninth Circuit have followed this line of reasoning in similar cases arising out of the ERISA context. In *Great-West*, the insured obtained a third-party settlement in the amount of $650,000 sanctioned by the California State Court, thereby resolving the status of numerous competing lienholders.

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The plan sought reimbursement for $411,157 that it paid out for medical expenses under the plan, even though the settlement attributed only five percent or $13,828 to medical expenses. In its most recent decision on the issue, Great-West Life Insurance v. Knudson, the Ninth Circuit relied on the core holding in FMC Medical. “[A]ctions brought by fiduciaries to enforce recovery provisions in ERISA plans are actions not for ‘equitable relief within the meaning of §1132(a)(3),’ but rather for money damages.” By virtue of this narrow interpretation of the Mertens decision, the court held that equitable relief was limited to its traditional forms such as injunction, mandamus or restitution; it specifically excluded monetary damages. In further explicating its somewhat arcane interpretation, the “Ninth Circuit explained that the right of reimbursement is not an equitable one of subrogation, in which the plan administrator ‘step[s] into the shoes’ of the beneficiary, nor of ‘restitution,” which the court defined as ‘the return of ‘ill-gotten assets’ but rather one for money damages.”

This line of Ninth Circuit decisions does not directly apply the make-whole rule. However, the court’s commitment to its underlying principles is plainly implicit, as it has effectively precluded plans from enforcing subrogation and/or reimbursement provisions in situations where the insured would be left “incomplete,” insofar as repayment of the financial obligations arising from his claim. The language in these cases could be construed to preclude any enforcement of subrogation and/or reimbursement clauses, even when the insured may achieve double recovery.

B. Great-West Life Insurance v. Knudson – Supreme Court

The Supreme Court granted certiorari to Great-West Life Insurance v. Knudson in order to provide an answer to the following question: “Did the [Ninth] 9th Circuit err in holding that an employee benefit plan regulated by the Employee Retirement Income Security Act (ERISA) cannot sue in federal court to recoup reimbursement for the medical

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64. Id.
66. FMC Medical, 122 F.3d at 1261.
benefits paid to a beneficiary from the winnings of that beneficiary's personal injury settlement?" The Court previously granted certiorari to another Ninth Circuit case, Reynolds Metal Co. v. Ellis, where the parties subsequently reached a private settlement and the suit was dismissed. Principally the Court sought to resolve a circuit split. The Great-West decision expressly contravened rulings of the Seventh, Eighth and Eleventh Circuits.

In an unexpected 5-4 decision, the Supreme Court upheld the Ninth Circuit's reasoning. Reiterating its holding in Mertens, the Court maintained, "equitable relief must mean something less than all relief." It is established Court practice to consider only those issues before it.

70. Reynolds Metal Co. v. Ellis, cert. granted, 531 U.S. 1009 (2000).
71. Bleed, supra note 21, at 738.
74. Mayer, Brown & Platt, supra note 65 (citing decisions that directly conflict with Great-West in that a claim for monetary relief is 'equitable' under section 502(a)(3)). See Administrative Committee v. Gauf, 188 F.3d 767 (7th Cir. 1999); Southern Council of Industrial Workers v. Ford, 83 F.3d 966 (8th Cir. 1996); Blue Cross and Blue Shield of Alabama v. Sanders, 138 F. 3d 1347 (11th Cir. 1998). "The Seventh and Eleventh Circuits have reasoned that such an action seeks specific performance of the reimbursement clause of the contract, an equitable remedy." Blue Cross and Blue Shield of Alabama, 138 F.3d at 1347. (citing Gauf, 188 F.3d at 771).
75. Robert N. Eccles, David E. Gordon, O'Melveny & Meyers, Washington, D.C. and Los Angeles, CA, ERISA Litigation Reporter, October 2001, Section: From the Editors, Vol. 9, No. 4, p.1 (2001) ("We think it's unlikely that the Court will agree with the 9th [Ninth] Circuit's rationale, but beyond that, it's anyone's guess as to what the Court will say.").
76. Great-West, 534 U.S. at 208.
77. Id. at 209.
78. Owasso Independent School Dist. v. Falvo, 122 S.Ct. 934, 938 (2002) (quoting Bragdon v. Abbott, 524 U.S. 624, 638 (1998)) ("We need not resolve the question here as it is our practice 'to decide cases on the grounds raised and considered in the Court of Appeals and included in the question on which we granted certiorari.'").
However, the opinion written by Justice Scalia is so narrowly tailored that there is sparse mention of the underlying facts, rendering the opinion merely an esoteric and methodical construction of what ‘equitable relief’ means under section 502(a)(3). The Court gave considerable deference to ERISA’s enforcement scheme first by labeling the act a “comprehensive and reticulated statute,”79 and then noting its reluctance “to tamper with [the] enforcement scheme embodied in the statute by extending remedies not specifically authorized by its text.”80 Through this abstract treatment of the case at bar, the Court has essentially taken the Ninth Circuit’s end run around the increased difficulty of applying the make-whole rule, and created a dubious precedent. The questionable effect of the Great-West decision is outlined in the subsequent discussion.

IV. ANALYSIS

The arguments voiced by those opposed to the adoption of the make-whole doctrine as the default rule in ERISA subrogation and/or reimbursement actions have not fallen on deaf ears. Since the Ninth Circuit began to decide such disputes on the grounds it set forth in FMC Medical, and received its blessing by the Supreme Court in Great-West, only two circuits still employ the rule as a default.81 The battle between the conflicting principles of subrogation and the make-whole doctrine will now be further complicated by those circuits that continue to oppose the rule, as they exploit the vast loopholes inherent in the Court’s decision. The following analysis first lays out the ultimate inefficacy of the Great-West decision. The subsequent discussion will dissect some of the more prevalent contentions raised in favor of per se enforcement of subrogation and/or reimbursement rights, and theretofore discard the make-whole rule as an applicable federal common law doctrine.


81. The Sixth and the Eleventh Circuits continue to have the default rule in place. Although the Ninth Circuit has in no way repudiated its adoption of the make-whole rule, the court employs a different rationale to reach the same result. See FMC Medical, 122 F.3d 1258 (9th Cir. 1997).

82. Kono, supra note 60, at 434.
A. The Great-West Decision: The Exceptions that Swallowed the Rule

Great West has done little, if anything, to obviate the actual controversy created by subrogation and reimbursement language in ERISA cases. The most poignant lack of redress is to be felt where beneficiaries are not made whole:

We express no opinion as to whether petitioners could have intervened in the state-court tort action brought by respondents or whether a direct action by petitioners against respondents asserting state-law claims such as breach of contract would have been pre-empted by ERISA. Nor do we decide whether petitioners could have obtained equitable relief against respondents' attorney and the trustee of the Special Needs Trust [for distribution settlement proceeds]... 

These few sentences take the teeth out of an opinion that can otherwise be read to embody make-whole principles, as the Ninth Circuit clearly intended by FMC Medical and its progeny. In establishing the litmus test for whether a remedy sought is legal or equitable in nature, thereby permitted under section 502(a)(3), the Court looks to the "nature of the underlying remedies sought." More telling is the condition upon an equitable lien that "the money or property identified belong in good conscience to the plaintiff..." An insurer that purports to cover a beneficiary for a loss and then seeks to effectively take back that coverage simply because there was a third-party recovery, even though the "beneficiary" has not achieved recovery, claim subrogation or reimbursement of funds in "good conscience."

In the recent Seventh Circuit decision, Administrative Committee of Wal-Mart v. Varco, the district court denied a defendant-beneficiary's motion to dismiss, "insofar as it state[d] a claim for imposition of [a] constructive trust on particular property in the hands of defendants..." The beneficiary's attorney had control of funds obtained in the third-party settlement, and began the process of dispersing them to various lienholders. Based on the Supreme Court's language in Great-West,

83. Great-West, 534 U.S. at 220.
84. Id. at 213. (citing Reich v. Continental Casualty Co., 33 F.3d 754, 756 (7th Cir. 1994) (Posner, J.).
85. Id. at 213. (citing 1 D. DOBBS, LAW OF REMEDIES, § 4.3(1), at 587-88 (2d ed. 1993); Restatement of Restitution, §160, Comment a, at 641-42 (1936); 1 G PALMER, LAW OF RESTITUTION § 1.4, p. 17; § 3.7, p 262 (1978).
87. Id. at *5.
“where the ‘property [sought to be recovered] or its proceeds have been dissipated so that no product remains, [the plaintiff’s] claim is only that of a general creditor,’ and the plaintiff ‘cannot enforce a constructive trust of or an equitable lien upon other property of the [defendant].”' Here, the court allowed an action almost substantively identical to that of a typical ERISA subrogation or reimbursement claim against a beneficiary under section 502(a)(3) on the basis that it was the beneficiary’s attorney, rather than the beneficiary who was in possession of the third-party settlement funds; the funds had yet to be dispersed, and therefore not ‘dissipated’. Simply by allowing the beneficiary’s attorney to be named as a co-defendant, the district court circumvented any binding effect of Great-West. The court noted, however, that the defendants did not seek state court adjudication of their third-party tort claim prior to disbursement of the settlement proceeds. This is a significant departure from the facts in Great-West.

Allowing such claims to proceed facially contravenes not only established Supreme Court precedent set forth in Pilot’s Life Insurance and FMC Corp., but goes against ERISA’s well-defined goal of uniformity. The same holds true for Justice Scalia’s allusion that a breach of contract claim to enforce subrogation and/or reimbursement rights may lie as a direct action under state-law, or at least the question unanswered as the Court has yet to be confronted with the issue. What is certain, however, is that ERISA plan providers will attempt to invoke that rationale when seeking subrogation and/or reimbursement. If any of these claims are allowed to proceed, whether by naming the beneficiary’s attorney or trustee as a co-defendant, or by allowing state court breach of contract claims to adjudicate ERISA subrogation/reimbursement clauses, the Great-West decision is rendered utterly meaningless. Moreover, every state and circuit jurisdiction retains its prerogative to decide which claims will go forward, and as a result it eliminates ERISA’s goal of uniformity.

90. Id. at *7-8.
92. FMC Corp., 489 U.S. at 58.
In deciding *Great-West*, the Court dismissed the aforementioned concerns, "even assuming . . . that petitioners are correct about the pre-emption of previously available state court actions’ or the lack of other means to obtain relief, vague notions of a statute’s ‘basic purpose’ are nonetheless inadequate to overcome the words of its test regarding the *specific* issue under consideration." The language of section 502(a)(3), restricting the remedies available to fiduciaries to those equitable in nature, allowed the Court to avoid resolving the subrogation/reimbursement dispute that was the substantive issue in *Great-West*. Nonetheless, the Court has effectively turned up the heat on this issue and the nationwide disparity will continue to persist until it again comes before the Supreme Court. The aforementioned escape route will not be available in that instance, on two distinguishing grounds. First, it is submitted that the goal of uniformity strikes at the very heart of ERISA, as evidenced by legislative intent. Second, ERISA is silent on the issue of subrogation. Upholding the federal common law enactment of the make-whole rule by granting certiorari to any one of the cases up for consideration, preferably one arising out of the Sixth Circuit, would avert dealing with this potentially insoluble conflict and advance the true purpose of ERISA.

**B. Double-Dipping**

The policy against double recovery is to prevent an insured, who has been fully compensated by the benefits paid out under his policy as set forth in the insurance contract, from "coming out ahead" by suing a third-party tortfeasor. "Recognition and enforcement of a right of subrogation for health insurers is primarily premised on precluding duplicative recoveries." The make-whole rule is wholly in accordance with this principle. The mere fact that it can be applied in a given situation is indicative of that absence of one full recovery, much less two. In his Amicus Brief on behalf of the plan in *Great-West*, the Solicitor General contends, that “[i]f equitable reimbursement is ordered in these circumstances, respondents [insured] will not lose anything to which they

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97. *Great-West*, 534 U.S. at 220 (quoting Mertens, 508 U.S. 248, 261 (1993)).  
98. *Id.*  
100. *See Bleed, supra* note 21.  
102. *Sunbeam-Oster Co.*, 102 F.3d at 1376 n.24 (citing KEETON, ROBERT E., & WIDISS, ALAN I., INSURANCE LAW § 3.10(a)(7), at 231 (1988)).
Subrogation or Subterfuge

are entitled under the terms of the plan, and the plan will not gain anything to which it is not entitled under the terms of the plan.\textsuperscript{103}

ERISA was enacted in order to comprehensively regulate employee benefit plans, which are those, 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, or benefits in the event of sickness, accident, disability, death or unemployment . . . . \textsuperscript{104}

If ERISA plans are created to provide employees [insured] with said benefits, then it is wholly incongruous to allow plans (through subrogation and/or reimbursement rights) to “take back” the benefits they paid, when the insured will be left unable to pay the debt arising out of the very events or incidents for which they were to be insured. Plan subrogation and/or reimbursement rights do not accrue until the insured has obtained recovery from a third party, nor may the plan seek reimbursement in the excess of that third-party recovery “[i]f a beneficiary’s recovery from a third-party is less than the total expenses paid by the plan . . . .”\textsuperscript{105} Is an insured that has not been made whole in fact any different than one who failed to obtain any third-party recovery at all?

The facts in \textit{Sunbeam-Oster}, the most vehement refusal to adopt the make-whole rule, illustrate the fundamental flaw in this reasoning. The district court found that the insured incurred a total of $2,500,000 in damages.\textsuperscript{106} He received $137,000 of benefits paid from the plan towards his medical bills\textsuperscript{107} and obtained a $500,000 lump sum settlement from the tortfeasor.\textsuperscript{108} In declining to adopt the make-whole rule, the Fifth Circuit ordered the insured to reimburse the plan, dollar for dollar, for all

\begin{footnotesize}
\begin{enumerate}
\item[105.] Brief of the United States as Amicus Curiae Supporting the Petitioner, supra note 103.
\item[106.] \textit{Sunbeam-Oster Co.}, 102 F.3d at 1372 (The total amount reflects $2,000,000 allocated to the insured, and an additional $500,000 for his wife and son).
\item[107.] \textit{Id.} at 1370.
\item[108.] \textit{Id.}
\end{enumerate}
\end{footnotesize}
qualifying expenditures made on its behalf. In essence, it is the plan that obtains double recovery from the vantage point of a single participant in a make-whole situation. In the absence of a third-party recovery, the plan may have to pay out benefits, but it still has one “recovery” based upon the payment of insurance premiums. Subrogation then, provides for a second “recovery” by the plan if the insured collects damages from a third party, and if that right is indeed enforceable.

C. Unjust Enrichment

Legislative background of ERISA clearly indicates that Congress’ chief concern was protecting the interests of the workers, citing that, “the absolute need that safeguards for plan participants be sufficiently adequate and effective to prevent the numerous inequities to workers under plans which have resulted in tragic hardship to so many.” If the make-whole rule is not applied, the plan, at the end of the day, will have provided no benefits except forestalling bill collectors. Those in favor of unconditional enforcement of subrogation and/or reimbursement provisions cast the insured as an opportunist, when a plan expressly conditions the payment of medical benefits on a subsequent reimbursement to the plan out of funds recovered from a third party tortfeasor, the participant or beneficiary is unjustly enriched when he or she retains the amount recovered from a third party and does not reimburse the plan.

Pursuant to the clear logic that there is no “double recovery” when the make-whole rule applies, it follows that there cannot be unjust enrichment. Applying the make-whole rule to subrogation under an ERISA plan is “consistent with the prevention of unjust enrichment.”

109. Id. at 1379.
110. Kono, supra note 60, at 446.
111. Id. at 443-44.
113. Brief of United as Amicus Curiae Supporting the Petitioner, supra note 103.
114. Barnes, 64 F.3d at 1394 (citing Germany v. Operating Eng’rs Trust Fund, 789 F. Supp. 1165, 1171 (D.D.C. 1992) (stating prevention of unjust enrichment is the rationale for the equitable doctrine of subrogation, and that avoiding double recovery, which is the purpose of subrogation as per the SPD, will not be served in the instant case because the insured’s anticipated recovery is far exceeds his losses).
Restitution is the classic remedy for unjust enrichment in the subrogation/reimbursement context. The general principle of restitution is that "one person should not be permitted to unjustly enrich himself at the expense of another, but should be required to make restitution of or for property or benefits received . . . where it is just and equitable that such restitution be made . . . ." In FMC Medical, the Ninth Circuit held that a claim for restitution required a showing of ill-gotten assets, further constricting its interpretation of Mertens. Using the following hypothetical fact pattern, the unjust enrichment rationale also fails: $100,000 total loss, $30,000 plan provided benefit, $70,000 third-party recovery; followed by reimbursement to the plan for the $30,000 of benefit provided.

Justice Ginsberg's dissent in Great-West proposes that ERISA insurers have a substantive basis for an unjust enrichment claim based on the beneficiary's "unjust gain." Justice Ginsberg posits that an employee's right to backpay awards under Title VII of the Civil Rights Act of 1964 is analogous to the ERISA insurer's right to the beneficiary having received what she believes properly belongs to the insurer. This analogy only succeeds if the beneficiary recovers an amount in excess of what is necessary to make them whole. Otherwise it is fundamentally flawed. Another caveat to this comparison is that backpay awards are "specifically authorized as equitable relief under Title VII," whereas ERISA is silent on the subrogation issue. In a Title VII claim, it is the employer's illegal act(s) that trigger the employee's right to backpay, whereas the ERISA beneficiary in the make-whole scenario is wholly innocent of any wrongdoing and most likely the victim of a horrific accident.

The Court's rendering of ERISA's enforcement scheme in Great-West should be expounded upon to allow the insurer to seek restitution for unjust enrichment under section 502(a)(3) only if the beneficiary recovers in excess, as this would be an "unjust gain" by any gauge.

115. Brief of the United States as Amicus Curiae Supporting the Petitioner, supra note 103, at 7.
117. Bleed, supra note 21, at 742.
118. Great-West, 534 U.S. at 229 (Ginsburg, J., dissenting).
120. Great-West, 534 U.S. at 230 (Ginsburg, J., dissenting) (citing Teamsters v. Terry, 494 U.S. 558, 572 (1990)).
121. Bleed, supra note 21, at 734 n.47.
Whenever the legal title to property is obtained through means or under circumstances which render it unconscientious for the holder of the legal title to retain and enjoy the beneficial interest, equity impresses a constructive trust on the property thus acquired in favor of the one who is truly and equitably entitled to the same . . . .

A beneficiary who was made whole has no right in equity, nor legal title, to any excess plan proceeds; he can fully reimburse the insurer and still remain "complete." An example of reimbursement language embodying this rationale, as well as the make-whole rule, is the following:

[i]n no event will the amount of reimbursement to the US [the insurer] exceed the lesser of [t]he amount actually paid under the policy; or [t]he amount actually recovered from that part of the judgment or settlement in excess of the amount necessary to fully reimburse the Covered Person for out-of-pocket expenses incurred, including attorney fees.

Ironically, in Primax Recoveries, Inc., v. Sevilla, a recent case in which the above clause was considered, the district court postulated that Great-West would render any claim for reimbursement under section 502(a)(3) outside of its federal subject matter jurisdiction, clearly highlighting the inadequacy of that decision.

C. Posner—Economic Reliance?

In Cutting v. Jerome Foods, the Seventh Circuit declined to adopt the make-whole rule even though it recognized that the insured, Mrs. Cutting, would incur an additional $90,000 in uncompensated non-medical costs if subrogation was permitted. Many state courts, in applying the rule, have held that boilerplate subrogation language was not intended to have the effect of curtailing coverage. In Cutting, Judge Posner highlighted this reasoning.

To put this differently, rejection of the 'make-whole' makes subrogation a lot like assignment. If insurance contracts required the insured to assign any tort claim he might have to the insurer, the price of the insurance would be lower but...
effective coverage would also be lower. The insured would recover only the policy limits, and not his full damages, even in a case in which the judgment had been secured against the tortfeasor, and collected for those damages.\textsuperscript{128}

Although the Seventh Circuit ultimately chose not to adopt the make-whole rule, it did not go as far as some of its sister circuits and eliminate the possibility altogether.\textsuperscript{129}

Judge Posner postulates however, that the "[a]ssignment. . . [of the] insured's tort rights to the insurance company, reduces the price of insurance and thus enables the insured to obtain more coverage."\textsuperscript{130} This theory makes the assumption that insurance providers take collections made attributable to enforcement of subrogation and reimbursement rights into account. "[P]remium calculations do not reflect potential subrogation collections"\textsuperscript{131} and they are not a factor in the rate-determining formulae used by commercial insurers to establish premiums.\textsuperscript{132} The "conjunctural and remote nature of subrogation militates against its inclusion as a factor for consideration in the setting of premium rates,"\textsuperscript{133} thereby making its exclusion a legitimate one. It is the resulting windfall to the insurer, however, that is illegitimate.\textsuperscript{134}

\textit{D. Pervasive Trend – The Limiting of the Application of the Make-Whole Rule}

Even the Sixth Circuit, the most ardent supporter of the make-whole rule in both application and rhetoric, acknowledges that it is merely a

\textsuperscript{128} \textit{Id.} at 1298.
\textsuperscript{129} \textit{Id.} at 1298-99.
\textsuperscript{130} \textit{Id.} at 1298.
\textsuperscript{131} See Kono, \textit{supra} note 60, at 446 (citing \textit{John V. Dobbin, Insurance Law in a Nutshell} 284 (3d ed. 1996)).
\textsuperscript{132} \textit{Id.} at 446-47.

(1) the proportionate part of the total predicted cost of meeting specified types of losses in the ventures that have been grouped by the insurer into a "pool of risks," (2) appropriate amounts for a reserve fund in the event the total risk was underestimated, (3) the administrative costs of the insurer, (4) other expenses of doing business (including fees for sales representatives such as agents and brokers), and (5) profits for companies engaging in insurance as a business enterprise.


\textsuperscript{133} \textit{Id.}
\textsuperscript{134} \textit{Id.}
default rule. Generally speaking, if a plan adequately sets out its extent of subrogation/reimbursement rights, the deciding court will be forced to recognize that no silence or ambiguity exists and enforce the provision at issue. It follows then, that plan providers will eventually be able to write plan language sufficient enough to preclude any application of the make-whole rule. Inherent in its origin as a doctrine of federal common law, it can "only be applied as a gap-filler where a clause is found to be ambiguous or silent on a particular issue."

By adopting the Ninth Circuit's interpretation of what constitutes "appropriate equitable relief," the Supreme Court called into question the enforceability of ERISA subrogation/reimbursement provisions under federal subject matter jurisdiction. However, this is no more equitable to insurers, who may be defrauded by beneficiaries, than subrogation/reimbursement enforcement is in the absence of complete recovery. Furthermore, this directly contravenes ERISA's goal that "plans and plan sponsors should be subject to a uniform body of benefits law," as demonstrated to wit: "[O]ne participant (Edgar) should not be allowed to retain benefits belonging to the plan, while another (Susan) is held to the terms of the plan – all participants must be uniformly held to the terms of the plan." Given that ERISA pre-emption precludes plans from being able to seek enforcement of their subrogation and/or reimbursement rights in state court, federal courts must remain open to

136. This statement must be couched as a generalization, for different courts interpreting similar, if not identical language have reached juxtaposed conclusions as to the presence of ambiguity, thereby causing a disparity of standards among the federal appellate circuit. Qualchoice, Inc. v. Williams, 14 Fed. Appx. 417, 420 n.1 (6th Cir. 2001).
137. See Kono, supra note 60, at 443.
139. FMC Medical, 122 F.3d at 1261.
141. Bleed, supra note 21, at 741 n.108 (citing Ingersoll-Rand Co. v. McClendon, 498 U.S. 133, 142 (1990); FMC Corp. v. Holliday, 498 U.S. 52, 60 (1990) (stating that the "[a]pplication of differing state subrogation laws to plans ... frustrate plan administrators' continuing obligation to calculate uniform benefit levels nationwide.").
142. Bleed, supra note 21, at 748.
hear these claims or no remedy will exist.\textsuperscript{144} The Supreme Court's decision in Great-West has done little to resolve this issue, and most likely created a plethora of new controversies.

\textbf{E. Preservation of Principle}

As the viability of the make-whole rule is continually called into question, alternative grounds must be presented to entrench its place in the ERISA scheme. The Sixth Circuit's activist approach in Copeland Oaks, requiring affirmative preclusion of reading the make-whole rule into plan language,\textsuperscript{145} is a step in the right direction. Nevertheless, artfully written plan provisions may still be able to sidestep the default rule. If Copeland Oaks was expanded however, it could prove a formidable obstacle. "ERISA insists that the SPD [Summary Plan Description, hereinafter SPD] be couched in ordinary conversational terms, understandable by the average reasonable employee, and not in verbose 'legalese' or 'insurance speak.'\textsuperscript{146} It is doubtful that a "person of average intelligence and experience,"\textsuperscript{147} would realize the prospective ramifications of the following statement taken from typical plan language:

\begin{quote}
[a]s a condition to the Plan making payments for any medical or dental charges, the Covered Person must assign to the Plan his or her rights to any recovery arising out of or related to any act or omission that caused or contributed to the Injury or Sickness for which such benefits are to be paid.\textsuperscript{148}
\end{quote}

Wording analogous to "the plan will seek to recoup its payment of benefits to you in the event of any third-party recovery, irrespective of the reality that such action may leave you debt-ridden, insolvent, or without further remedy," may be more appropriate.

It is unequivocally clear that employees can contract away their right to be made whole.\textsuperscript{149} If the SPD were required to set forth a hypothetical scenario, perhaps akin to the fact pattern in Sunbeam-Oster where the insured was left to contend with over $2,000,000 in uncompensated damages,\textsuperscript{150} the bargaining regime of ERISA health plans would be

\begin{footnotes}
\item[144.] Blue Cross and Blue Shield of Alabama v. Sanders, 138 F.3d 1347, 1352 n.5 (11th Cir. 1998).
\item[145.] Copeland Oaks, 209 F.3d at 813.
\item[146.] Sunbeam-Oster, 102 F.3d at 1375 n. 20 (citations omitted).
\item[147.] Id.
\item[148.] Copeland Oaks, 209 F.3d at 814.
\item[149.] Cutting, 993 F.2d at 1295.
\item[150.] Sunbeam-Oster, 102 F.3d at 1372.
\end{footnotes}
fundamentally altered. Suppose also that employees were apprised of the harsh reality that with the combined burden of insurance policy limitations, aversion to litigation, high contingency fees and exigent financial need, their cases will often be settled in amounts insufficient to make them whole. In fact, "[e]mployer compliance with the provision of understandable summary annual reports was so weak as to prompt Department of Labor regulations specifying the language of those reports."  

Another remedial solution under a make-whole rule, albeit one subject to potential uniformity issues, would be to give binding effect to court sanctioning of an insured's settlement and/or damage award, so that a court certified pro rata amount allocable to medical expenses could be dispersed to the plan under their subrogation and/or reimbursement lien. Failure of the beneficiary to take action to have the third-party settlement adjudicated in state court was one of the distinguishing facts from Great-West, that allowed the insurer's claim to move forward in Administrative Committee of the Wal-Mart Stores, Inc. v. Varco. The district court in Great-West limited the plan's reimbursement to $13,828, even though it had paid out $411,157 in benefits. The California state court oversaw the settlement in which only five percent, or $13,828, was apportioned to medical expenses. When disputes over the proper division of settlement awards arise, it is the duty of the factfinder to provide the proper solution, as is the case with questions of duplicative recovery. The Sixth Circuit has in fact remanded cases where there was significant question as to the extent of the insured's injuries with respect to being made whole. The logical consequence of these types of decisions will be increased litigation. This is in line with the argument that the make-whole rule is "administratively more complex, requiring the medical insurer to calculate

151. See Kono, supra note 60, at 448 (In most large cases, an injured insured pays a contingency fee of thirty-three to forty percent for legal representation).
152. Id.
155. Great-West, 534 U.S. at 207-09.
156. Id. at 209.
the insured's total medical loss and nonmedical loss," thereby making insurance more expensive, as the 'additional coverage' provided under the rule will surely raise costs.\textsuperscript{159} Given the alternative—recovery from a catastrophic injury while facing monstrous debt or even the prospect of insolvency, the "person of average intelligence and experience,"\textsuperscript{160} would clearly incur the additional, moreover minimal, costs of full coverage under the make-whole rule.

V. CONCLUSION

Equity is "the body of principles constituting what is fair and right."\textsuperscript{161} Although the Supreme Court's decision in \textit{Great-West} can be built upon or even be considered as a step in the right direction, it will easily be bypassed by fancy lawyering without a decision formally adopting the make-whole rule as the default rule in enforcing subrogation and reimbursement rights under ERISA. The rule has proved to be a salient and workable solution in those jurisdictions where it has been implemented. As the following remarks of Justice Stevens clearly annunciate:

\begin{quote}
[f]rom the standpoint of the beneficiaries of ERISA plans—who after all are the primary beneficiaries of the entire statutory program—there is no apparent reason for treating self-insured plans differently from insured plans. Why should a self-insured plan have a right to enforce a subrogation clause against an injured employee while an insured plan may not? The notion that this disparate treatment of similarly situated beneficiaries is somehow supported by an interest in uniformity is singularly unpersuasive. If Congress had intended such an irrational result, surely it would have expressed it in straightforward English. At least one would expect that the reasons for drawing such an apparently irrational distinction would be discernible in the legislative history or in the literature discussing the legislation.\textsuperscript{162}
\end{quote}

\begin{footnotes}
\item[159.] \textit{Cutting}, 993 F.2d at 1298.
\item[160.] \textit{See} Kono, \textit{supra} note 60, at 443-44.
\item[161.] \textsc{BLACK'S LAW DICTIONARY} 560 (7th ed. 1999).
\item[162.] \textit{FMC Corp.}, 498 U.S. at 66 (Stevens, J. dissenting).
\end{footnotes}