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Montanile v. Board of Trustees: New Model for Recovery

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At times, money may be owed back to the benefit plan which paid benefits to or on behalf of a participant. For example, most health plans include a right to recover from a third party recovery amounts the plan paid. In the context of disability plans, the claim may have been overpaid as a result of the claimant's subsequent receipt of benefits from other sources or even a miscalculation. The ***Supreme Court***'s recent decision in ***Montanile v. Board of Trustees of National Elevator Industry Health Benefit Plan***, 577 U.S. __ (2016), threw the proverbial monkey wrench into efforts to recover money owed back to ERISA-governed employee benefit plans by their participants. Prior to the decision, most plans assumed that as long as they had a "lien by agreement" they could recover against the participants' personal assets. In *Montanile*, the Court placed significant restrictions on a plan's right of recovery when the funds have been spent. Therefore, benefit plans must consider new ways to preserve their rights.

The starting point for any claim under *ERISA* is Section 502(a). In relevant part, Section 502(a)(3) of ERISA authorizes civil suits "by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates … 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 … the terms of the plan." 29 U.S.C. § 1132(a)(3). In ***Great-West Life & Annuity Insurance Co. v. Knudson*, 534 U.S. 204 (2002)**, the Court considered the scope of relief available under Section 502(a)(3). Great-West was the insurer of a health plan which paid a significant amount in medical expenses after Knudson was left a quadriplegic from a car accident. The plan included a provision in which participants agreed that they were "personally liable to [the Plan] … up to the amount of the first lien" if they failed to reimburse the plan from a third party recovery. *Id.* at 207. Only a fraction of Knudson's third party settlement was allocated for payment of paid medical expenses, much less than was paid. Therefore, Great-West sued to recover the remainder. The Supreme Court concluded that the claim was not viable under ERISA. The Court explained that the plan's attempt to impose personal liability on Knudson "was not typically available in equity." Significantly, the money sought by Great-West already had been distributed to a trust and to her attorney. As such, the plan was really seeking the "imposition of personal liability for the benefits that they conferred upon respondents" and this is not equitable relief allowed under Section 502(a)(3) of ERISA. *Id.* at 214.

The Court's subsequent decision in *Sereboff v. Mid Atlantic Medical Services, Inc.,* 547 U.S. 356, 359 (2006), seemed to provide a road map for plans seeking reimbursement against participants. The Sereboffs also received a settlement following a car accident and they too failed to reimburse the health insurer for expenses paid on their behalf. This time, the Court concluded that the claim by the

plan sought equitable relief. The Court held that the plan created an “equitable lien by agreement” which was, as its name states, “equitable” and thus permitted. *Id*. at 368. Following *Sereboff*, many believed that as long as the plan included this “equitable lien by agreement” language, a claim could be brought against the participant under ERISA even when the funds were not strictly traceable. Perhaps lost on most of us was the fact that the funds claimed in *Sereboff* were still “specifically identifiable funds … within the possession and control of the Sereboffs [and] set aside and preserved [in the Sereboffs’] investment accounts.” *Id.* at 362-63.

US Airways, Inc. v. McCutchen, 569 U.S. __, 133 S.Ct. 1537, 1548 (2013), was also a favorable decision for plans seeking recovery against participants under ERISA. McCutchen challenged the employer’s right to recover on equitable grounds. The Court rejected the equitable defenses which would effectively “override” the terms of the plan. Of note, the funds being claimed in *McCutchen* were also specifically identifiable and still in the possession of the defendant.

Montanile resolved an apparent split in the circuits over whether an equitable claim for relief can be brought when the participant has spent the entirety of the money received from the third party on “nontraceable” items. Under these facts, the Court concluded that the suit was not seeking “appropriate equitable relief” and must fail. The health plan stated that moneys received from third parties were considered “assets of the plan” and prohibited participants from distributing such funds without a written release from the plan. The plan also required claimants to “promptly” reimburse the plan upon receipt of a judgment or settlement. Once again, the Court was presented with “bad” facts. Montanile was struck and seriously injured by a drunk driver. Montanile’s attorney held a portion of the third party settlement sufficient to reimburse the plan in full in a client trust account but took the position that the plan was not entitled to any portion. The attorney told the health plan that the funds would be distributed unless the Board objected within 14 days, which it failed to do. It then waited six months to file suit against the participant.

The Court stated its holding in *Montanile* simply: “A defendant’s expenditure of the entire identifiable fund on nontraceable items (like food or travel) destroys an equitable lien.” Although the Court recognized that the dissipation of the fund was “wrongful,” the plan could not then seek to enforce its lien against the defendant’s general assets. Perhaps naively, the Court stated that plans often have provisions which obligate participants to notify the plan of any third party claim/recovery. The Court further stated that plans have an incentive to investigate and track claims. While the participant in *Montanile* provided notice of the settlement which was disregarded for several months, this is not always the case. Many times plans do not learn of the recovery giving rise to the reimbursement claim until after the funds have been disbursed.

Following the decision in *Montanile*, plans that are potentially owed money from participants must take a step back and reevaluate the way they investigate potential recovery claims, the language in their plans and the language in any reimbursement agreement. First, the holding in *Montanile* only applies when the funds have been dissipated on nontraceable items “such as food or travel.” What are traceable items? Examples likely include funds placed in a retirement account or trust under the control of the participant. If a claimant pays off a house mortgage with settlement funds, this too is traceable. A plan should immediately seek bank records and other information to determine how the money received from a third party was spent.

Hopefully, plans will be made aware of the settlements before the funds are spent. In those cases, the plans must act diligently. Once the plan in *Montanile* learned that the attorney was not going to honor the reimbursement language in the plan, it should have filed its lawsuit and sought a restraining order against any distribution of the funds. Moreover, the participant should not be the

only named defendant. Since the attorney has the funds, the attorney should also be named. The potential for disciplinary action and even individual liability if the attorney disburses the funds after receiving notice of a lawsuit may encourage cooperation.

Some practitioners have suggested that once the participant receives money owed to the plan, they become a fiduciary who may be sued under ERISA. In the case of insured plans, the argument appears to be a stretch because the money goes back to the insurer's general assets, not the "plan." But what if the plan document identifies the participant as a fiduciary? Nothing appears to prevent a plan from designating a participant as a fiduciary to the extent that the person receives money owed back to the plan and its insurers.

Benefit plans should also consider including penalty provisions to discourage a participant's failure to comply with reimbursement requirements. For example, the plan document can state that a participant's (1) failure to timely notify the plan of any claim or settlement which may implicate the reimbursement provision or (2) failure to reimburse the plan will result in the immediate termination of any additional benefits and the forfeiture of participant status and all rights under the plan. This may not be permissible for health plans based on federal requirements but there is nothing that prevents a disability plan from implementing this language. Employer-sponsored life insurance plans should also consider using this language since mistaken payments sometimes occur. Plans should also consider adding language stating that it is entitled to recover attorney's fees and costs associated with any action necessary to recover an overpayment that is withheld contrary to the terms of the plan.

Plans frequently require participants to sign reimbursement agreements. These agreements can go further in protecting the benefit plans' rights. As with the plan document itself, the reimbursement agreement should identify the funds that are subject to it (third party recovery, Other Income Benefits, etc.), the participant's obligation to notify the plan of potential recoveries as well as actual receipt of money, the necessity of reimbursing the plan and the consequences of failing to do so. In addition, the reimbursement agreement should state that the participant acknowledges and agrees that the agreement creates rights and obligations *under state laws* on the part of the participant, separate from any rights under ERISA.

Can a reimbursement agreement create a state law cause of action that is not preempted by ERISA? Perhaps. In the context of health plan provider agreements, many courts have recognized the applicability of state law. According to these courts, the provider agreement creates an *independent* legal duty; therefore, claims made under it are not preempted. *See e.g., Grasso Enterprises, LLC v. Express Scripts, Inc.,* 809 F.3d 1033, 1041 (8th Cir. 2016); *North Cypress Medical Center v. Cigna Healthcare*, 781 F.3d 182, 201 (5th Cir. 2015); *CardioNet, Inc. v. Cigna Health Corp*., 751 F.3d 165 (3d Cir. 2014). While the issue of preemption has not been addressed in the context of a reimbursement agreement, these cases suggest that such a claim is permissible.

Plans should also consider ways to avoid a reimbursement situation. Most disability plans reduce a monthly benefit by the amount of income a claimant receives from other identified sources. These sources often include Social Security and disability retirement benefits a claimant receives or is *eligible to receive*. This language permits a plan to reduce the monthly benefit under the plan by the estimated benefit the claimant is eligible to receive. Many plans will forego the estimated offset if the claimant signs a reimbursement agreement. Claim administrators should reconsider whether agreeing to waive the estimated offset is in their best interest.

Summary

While *Montanile* makes it more difficult for benefit plans to seek reimbursement and recover

overpayments, it does not shut the door completely on these claims. Insurers and self-funded plans should consider amending their language in the manners discussed above. In addition, *Montanile* teaches us that plan fiduciaries must act promptly when made aware of a potential recovery. If they fail to do so, the claim may be lost.

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