BlueCross BlueShield Association

An Association of Independent Blue Cross and Blue Shield Plans

Legal Affairs

Bulletin

No. 983
December 2007

Blue Cross and Blue Shield Association
225 North Michigan Avenue
Chicago, Illinois 60601-7680
www.BCBS.com

Roger Wilson
Senior Vice President and General Counsel

Susan M. Varisco
Editor
Phone: 312.297.6034
Fax: 312.297.5956
susan.varisco@bcbsa.com

In This Issue:

I. Litigation

I. Litigation

- **Contract Interpretation—Cancellation**
  Court denies summary judgment in action alleging improper notice of cancellation.

  McVicker v. Blue Shield of California, No. 06-4846, 2007 WL 3407433 (N.D. Cal. 2007).

  Blue Shield of California issued a small group healthcare contract to San Francisco Media Fax. Douglas McVicker, as CEO, participated in the plan, and his wife, Nancy, was a beneficiary. McVicker failed to make the July 2002 premium payment for Media Fax. Blue Shield informed McVicker that unless it received payment by the last day of the current billing period, the coverage would be cancelled for nonpayment of premium, which occurred on August 6, 2002. The next day it received the July premium payment from McVicker. In a letter dated August 12, Blue Shield advised McVicker that the late payment was not accepted and would be refunded. The McVickers did not dispute the cancellation or request a reinstatement. Before the cancellation, Nancy McVicker had been diagnosed with cancer. One year after Blue Shield cancelled the policy, she began cancer treatment. Unable to obtain health insurance because of the diagnosis, the McVickers paid almost $48,600 for Nancy's treatment.

On August 11, 2006, the McVickers sued Blue Shield of California, seeking benefits under ERISA and alleging breach of fiduciary duty. They contended that the notice of cancellation provided by Blue Shield was defective and that they therefore were entitled to reimbursement for the cancer treatment. Blue Shield argued that notice was proper and that the action was barred by applicable statutes of limitations and the contract's limitation period. The parties moved for summary judgment.

Denying the motions, the court first held that the notice of cancellation was not in compliance with California law. The parties agreed that the billing period ended on August 1, 2002, at 12:01 a.m. Both the contract and cancellation letter stated that payment was due "by the last day of the current billing period." Plaintiffs asserted that the one minute on August 1 did not constitute a full day and that, therefore, Blue Shield did not provide the 15-day notice period as required under the contract and state law. Agreeing, the court said, "Although the billing period itself may have terminated one minute into the following day, the last day of the period was July 31. Accordingly, the notice of cancellation provided by Blue Shield was not in compliance with California law."

Regarding timeliness, the court found that a triable issue of material fact existed regarding the date that plaintiffs received notice of the cancellation. It therefore could not determine whether the action was barred by ERISA's four-year statute of limitations. The court rejected as unreasonable the contract's two-year limitation period absent controlling authority stating otherwise. It also found that plaintiffs' assertion that they were entitled to a ten day grace period was not supported by the evidence. Finally, the court rejected Blue Shield's argument that the claims were barred by laches and by failure to mitigate.

- **Contract Interpretation—Obesity Treatment Exclusion**
  Court finds that Plan properly denied coverage for treatment of blood clots as a complication of obesity surgery.

  Dillon v. Anthem Health Plans of Virginia, Inc., No. 7:07CV00069-00, 2007 WL 4244774 (W.D. Va. Nov. 29, 2007).

  Brenda Dillon sued Anthem Health Plans of Virginia, seeking reimbursement of expenses for hospitalization for deep-vein thrombosis (DVT) and pulmonary embolism. Anthem denied coverage under her plan's exclusion for obesity treatment and complications therefrom. Dillon had undergone an abdominoplasy, commonly known as a "tummy tuck," and six days later suffered DVT and pulmonary embolism.

  On cross-motions for summary judgment, the court found that Anthem's decision to deny coverage was well reasoned and supported by substantial evidence. Anthem had reviewed the medical determinations of three physicians. Dillon's primary surgeon initially concluded that she had "suffered a significant complication following abdominoplasty." During a phone conversation with Anthem, he changed his position, stating that the DVT "could occur at any time and may not be related to cosmetic surgery." The court found the second statement only served to lessen the certainty of the first.

  Dillon's treating physician also had described her condition as a result of the abdominoplasty. The court found that while the onset of the DVT and the pulmonary embolus occurred within a week of the abdominoplasy, neither the chronological sequence of events nor the doctor's determination were sufficient by themselves to evince a cause and

effect relationship. The court nonetheless found that when weighed with the other statements, the determination did not oppose Anthem's decision to deny coverage.

Lastly, Dillon's attending physician indicated that she had a remote history of DVT resulting from a leiden deficiency, putting her at an increased risk for forming DVTs. The court found that those statements, while supporting the conclusion that Dillon was more susceptible to DVTs than the average patient, did not directly support the argument that the DVT and pulmonary embolus occurred independently from the abdominoplasty and were not complications of the cosmetic surgery.

- **Contracts With Physicians**
  Court allows doctor's breach of contract and fraud claims to continue against Plan.

  Highmark West Virginia v. Jamie, No. 33309, 2007 WL 4152011 (W. Va. Nov. 20, 2007).

  Sharooz Jamie, M.D., was a participating provider with Highmark West Virginia, Inc., d/b/a Mountain State Blue Cross Blue Shield. In 2002, he allegedly began to overbill Mountain State for claims and received $115,000 in overpayments. Mountain State recouped $56,000 through remittance adjustments. Jamie denied that he overbilled and asserted that Mountain State improperly recouped the money. He terminated the participation agreement and refused to make any reimbursements.

  In 2004, Mountain State sued Jamie to recover overpayments, alleging breach of contract and unjust enrichment. Mountain State also sought punitive damages based on allegations of fraud and an order compelling him to provide access to his records for an audit. Jamie counterclaimed, alleging (1) breach of contract, (2) the retroactive denial of payments in violation of state law, (3) breach of the covenant of good faith and fair dealing, (4) fraudulently withholding payments, (5) fraudulently charging deductibles, (6) fraudulently charging copayments, (7) negligence, and (8) defamation. Mountain State moved to dismiss the counterclaim for failure to state a claim. The trial court dismissed the counterclaim with prejudice and entered final judgment in favor of Mountain State. Jamie appealed.

  Reversing in part, the West Virginia Supreme Court of Appeals held that the trial court erred in dismissing Counts 1 through 4 of the counterclaim and therefore reinstated them. In Count 1, Jamie alleged that after he terminated the participation agreement, Mountain State improperly extended the agreement for several months, causing him to incur damages. In Count 2, he alleged that Mountain State violated a law prohibiting the retroactive denial of previously paid claims after one year. In Count 3, he alleged that Mountain State failed to fully reimburse him. The court said that although those counts alleged a breach of the participation agreement, each count was grounded upon a different basis of recovery. Count 1 focused on the agreement's termination, Count 2 relied in part on a statutory violation, and Count 3 alleged breach of contact and covered different matters than those of Counts 1 and 2. The court also found that Count 4 properly alleged a claim of fraud. But it affirmed the dismissal of the remaining counts, finding that Jamie could not prove a set of facts that would entitle him to relief.

- **Coordination of Benefits**
  Court refuses to enter summary judgment for Plan, even though it properly rejected claims as the secondary insurer.

  Vanegas v. Board of the Trustees of the Health and Welfare Fund for the Int'l Union of Operating Engineers, No. JFM 07-52, 2007 WL 4180548 (D. Md. Nov. 20, 2007).

  In 1986, plaintiff received severe burn injuries to his face and right eye at work. He underwent reconstructive surgeries at the time of the accident. He did not receive workers' compensation benefits because his employer did not have workers' compensation insurance. In 2004, plaintiff sought medical treatment for his right eye, which required reconstructive surgeries. He submitted claims for the surgeries to his wife's employee benefit plan, the Blue Ridge Plan. CareFirst BlueCross BlueShield, the plan's administrator, paid the claims until it learned that plaintiff was a subscriber of the Health and Welfare Fund of the International Union of Operating Engineers (the Local 99 Plan). It then rescinded all payments it had made to plaintiff's healthcare providers under the coordination of benefits provision of the Blue Ridge Plan.

  Thereafter, plaintiff submitted CareFirst's explanations of benefits to the Local 99 Plan, which denied his claim because the injury and treatment fell under the plan's work-related injuries exclusion. The Fund's board of trustees reviewed the appeal and affirmed the denial. Plaintiff then filed this lawsuit against the Fund's board and CareFirst, alleging that the Fund abused its discretion in denying his claims. Alternatively, he asserted that if the denial was proper, then he was entitled to benefits from CareFirst under the Blue Ridge Plan. The parties moved for summary judgment.

  Entering summary judgment for the Fund, the court found that it properly denied the claims under the work-related injuries exclusion. The court then found that CareFirst reasonably determined that the Local 99 Plan was plaintiff's primary insurer and that it therefore properly rescinded payment. The court, however, denied summary judgment to CareFirst. In so doing, it found that the Blue Ridge Plan's secondary coverage provision, requiring payment only when the primary coverage does not cover the full benefit, did not clarify whether CareFirst was obligated to cover plaintiff's claims when his primary insurer paid nothing. In response, CareFirst argued that the Blue Ridge Plan excluded coverage for benefits available under worker's compensation. The court found that argument unpersuasive, because plaintiff was not entitled to and did not receive such benefits. It said that CareFirst's argument might have merit if the Blue Ridge Plan had a provision specifically excluding (1) claims for work-related injuries or (2) claims that have been excluded by the insurer's primary health plan. The record did not include the entire Blue Ridge Plan, so the court could not determine if it had such exclusions.

- **ERISA—Fiduciary Duties**
  Court rules that PBM did not act as a fiduciary when administering plan's pharmacy benefits.

  Moeckel v. Caremark, Inc., No. 3:04-0633, 2007 WL 3377831 (M.D. Tenn. Nov. 13, 2007).

  Plaintiff participated in the John Morell employee benefits plan. The plan's prescription drug benefits were administered by Caremark, Inc., a pharmacy benefits manager (PBM). Plaintiff sued Caremark Inc. and its parent company, Caremark Rx Inc., for breach of fiduciary duty under ERISA. He alleged that Caremark had discretionary authority over the management

and administration of his employer's drug benefit plan and exercised discretion and control of the plan's assets. Specifically he contended the Caremark acted as a fiduciary under ERISA when it (1) set the price the plan paid for generic prescriptions; (2) selected the average wholesale price reporting source that it used to set the price the plan paid for brand-name prescriptions; (3) determined whether a particular prescription would be considered a brand-name or generic drug; (4) decided when it would dispense a brand-name drug as a generic prescription at its mail order facilities; and (5) managed the formulary that defined the scope of the plan's prescription drug benefit. According to plaintiff, the discretionary authority Caremark retained and exercised with respect to each of these acts directly affected both the total cost of the prescription drug benefit and a participant's copayment. The court previously dismissed Caremark Rx from the lawsuit. The parties moved for summary judgment.

Entering summary judgment for defendant, the court found that Caremark did not exercise discretionary authority or control over the management of the plan and that the activities of which plaintiff complained were outside the scope of ERISA's regulatory framework. The court said that Caremark's activities related to the administration of its business, which was nonfiduciary. Likewise, Morrell & Co.'s contracting decisions with Caremark were also nonfiduciary.

- **Federal Employees Health Benefits Act**
  Court dismisses complaint alleging negligence and breach of fiduciary duty against Plan and psychologist.

  Russell v. Gennari, No. 1:07CV793, 2007 WL 3389998 (E.D. Va. Nov. 8, 2007).

  Benjamin Russell had health benefits through his father's Service Benefit Plan administered by Anthem Health Plans of Virginia. Benjamin's parents were divorced. His mother took him to Dr. Michael Gennari for psychological counseling. When Benjamin's father found out about the counseling, he demanded that his ex-wife stop the treatment. After receiving a letter from Anthem approving additional visits, Mr. Russell informed Anthem that Dr. Genarri had been submitting fraudulent claims. Anthem began an investigation of Dr. Genarri for potentially fraudulent billing. Dr. Gennari subsequently ended Benjamin's treatment. Benjamin filed a complaint in state court, alleging professional negligence and breach of fiduciary duty by Anthem and Dr. Gennari. Following removal to federal court, defendants moved to dismiss for failure to state a claim.

  Granting the motion, the court found that both claims were barred by a two-year statute of limitations. The court also found that the complaint was legally null when it was filed, because Mr. Russell had signed the complaint as Benjamin's "next friend." According to the court, Mr. Russell had no claims of his own and did not have the right to act as his son's attorney. The court then found that the Federal Employees Health Benefits Act preempted the claims against Anthem. It further found that the breach of fiduciary duty claim was barred by the governmental discretionary function immunity, which extends to private contractors when they are participating in a fraud investigation of a government subsidized program.

- **Indemnification**
  Court finds that declaratory action challenging indemnification of class actions was ripe for review.

  Executive Risk Specialty Insurance v. Blue Cross and Blue Shield of Florida, No. 3:07-CV-358-J-16TEM, 2007 WL 4206642 (M.D. Fla. Nov. 27, 2007).

  Blue Cross and Blue Shield of Florida (BCBSFL) tendered three class actions, *Thomas*, *Solomon*, and *Stein*, to Executive Risk Specialty Insurance for indemnity. Executive Risk filed this lawsuit, seeking a declaration that it had no duty to defend or indemnify BCBSFL. It contended that the policy excluded the proposed settlement of *Thomas* and that the expenses allegedly incurred in the defense of the class actions were unreasonable. BCBSFL moved to dismissed, arguing that the matter was not ripe for adjudication. It contended that the information developed in the case might have an adverse impact on its ability to defend itself in *Solomon* and *Stein*. Alternatively, it sought a stay of the parts of the complaint pertaining to *Solomon* and *Stein*.

  The court denied the motion, finding that the matter was ready for review, because BCBSFL had demanded from Executive Risk immediate payment of $8 million in expenses for the defense of the class actions and the *Thomas* settlement. The court said that Executive Risk was not seeking an indemnification declaration about *Solomon* and *Stein*. Instead, it was seeking a declaration of expenses incurred for those lawsuits. The court found that BCBSFL had lumped together the defense expenses for all three suits and that it therefore could not ask the court to dismiss the action or stay the parts of it related to *Solomon* or *Stein*. It said that BCBSFL could eliminate the need for the declaratory action by providing Executive Risk with a detailed and action-specific accounting.

- **Medicare**
  Eighth Circuit holds that plaintiff who had not alleged an injury could not sue on behalf of the government under the Medicare Secondary Payer statute.

  Stalley v. Catholic Health Initiatives, Nos. 06-3884, 06-4121, 2007 WL 416575 (8th Cir. Nov. 27, 2007).

  Douglas Stalley, in separate actions, sued two hospitals and their insurers on behalf of the government under the Medicare Secondary Payer (MSP) statute. Stalley alleged that defendants Catholic Health Initiatives and Triad Hospitals provided medical services to Medicare beneficiaries who suffered harm from those services and that the hospitals were subsequently reimbursed by Medicare. He further alleged that the insurer defendants knew that the provider defendants had injured the Medicare beneficiaries and that the insurer defendants were liable as primary payers but did not reimburse Medicare for the cost of treatment. Stalley did not allege that he was either a Medicare beneficiary or that he was injured by defendants. Rather, he argued that the MSP statute was a qui tam statue that authorized him to bring suit as a relator for the United States and that he had standing to sue because he asserted injury to the United States. Defendants in both cases moved to dismiss for lack of jurisdiction and failure to state a claim. The district court in *Catholic Health Initiatives* found no support for Stalley's argument that the MSP statute was a qui tam statute and dismissed that action for lack of standing. Alternatively, the court found that Stalley had not alleged a cause of action under the MSP statute. The court in *Triad Hospitals* relied on

Catholic Health Initiatives and dismissed that action. The cases were consolidated on appeal.

Affirming, the Eighth Circuit held that the MSP statute did not authorize a qui tam action. Instead, it authorized a private cause of action, which required a plaintiff to have standing in his own right. The court said that Congress added a private right of action to the MSP statute in 1986, which granted a Medicare beneficiary a private right of action for double damages against an insurer or other primary payer that failed to pay the amounts it owed. The court therefore concluded that "there is no need to read the statute as permitting a plaintiff to assert the public's rights in contravention of the plain language creating a private right of action." It then found that Stalley, who lacked any injury in fact, did not have standing to pursue a qui tam action.

- **Mergers**
  Court affirms commissioners' orders approving Plans' merger.

  Capital BlueCross v. Pennsylvania Ins. Dep't, Nos. 1215 C.D. 2006, 1238 C.D. 2006, 2007 WL 3355367 (Pa. Commw. Ct. Nov. 14, 2007).

  In these consolidated appeals, Capital BlueCross and a physician challenged two insurance commissioners' orders approving the merger of Blue Cross of Western Pennsylvania and Pennsylvania Blue Shield into Highmark, Inc. In 1996, Commissioner Linda Kaiser issued an order (1996 Approval Order) approving the bylaws of Highmark and the change in control of six subsidiaries. However, she determined that she lacked subject matter jurisdiction over the merger because the Insurance Holding Companies Act excluded Blue Plans from regulation. She determined that the merger instead was controlled by the Nonprofit Law.

  Thereafter, Robert Sklaroff, M.D., and others petitioned the court for review of the commissioner's order. The court determined that the 1996 Approval Order was not appealable and transferred the matter to Commissioner M. Diane Koken for an administrative review. Dr. Sklaroff and other objectors filed petitions to intervene, which Commissioner Koken granted. After a hearing, Commissioner Koken issued an order (2006 Koken Order) confirming Commissioner Kaiser's determinations and dismissing Dr. Sklaroff's challenges. Dr. Sklaroff and Capital BlueCross separately appealed the 2006 Koken Order. Highmark intervened, seeking to quash the appeals for lack of standing.

  Rejecting Highmark's motion to quash Dr. Sklaroff's appeal, the court found that Dr. Sklaroff had standing because he was a Blue Shield subscriber, provider, and a former corporate member. It then rejected Dr. Sklaroff's objections and affirmed the commissioners' orders. In so doing, the court found that the commissioners did not err when they held that the Department of Insurance lacked jurisdiction over the merger. The court also agreed with the commissioners' conclusions that Highmark fulfilled the benevolent purposes of its predecessors, that its bylaws met statutory standards, that it could operate as both a hospital and a health service plan under the Nonprofit Law, and that its predecessors' certificates of authority passed as property rights to it.

  In its petition for review, Capital argued that Commissioner Koken erred in concluding that the merger met the Insurance Holding Companies Act competitive standard test. It also argued that it was harmed by Highmark's dual certificate of authority, allowing Highmark to operate as a nonprofit hospital and a health service plan, because of the significant and

unfair competitive advantages the status conveyed. The court found that Capital waived its opportunity to establish standing because it did not attempt to participate in the administrative proceedings before Commissioner Koken. It said that Capital's decision not to participate deprived the court of any record supporting Capital's claim that it suffered a competitive injury. It rejected Capital's argument that it could not timely assert competitor standing to participate in the hearing because, at the time, a joint operating agreement barred Highmark from competing with Capital in its service area. It therefore quashed Capital's appeal.

- **Taxes**

  Court holds that the Fresh Start Basis Rule applies to loss deductions arising from the termination or cancellation of healthcare contracts.

  Hospital Services Ass'n v. United States, 78 Fed. Cl. 434 (2007).

  Hospital Services Association of Northeastern Pennsylvania (HSA) sought to recover federal income taxes alleged to have been erroneously overpaid for the years 1991 through 1997. It did so under the Fresh Start Basis Rule, part of the 1986 Tax Reform Act, which subjected Blue Plans to federal income taxes effective January 1, 1987. The Fresh Start Basis Rule provided that Plans would not be taxed on gains or losses that occurred before January 1, 1987.

  Entering summary judgment for HSA, the court found that the Fresh Start Basis Rule applied to the loss deductions arising from the termination or cancellation of HSA's healthcare contracts. In so doing, it rejected defendant's argument that the rule applied only to gains or losses upon the sale or exchange of assets. The court said, "The phrase 'gain or loss' in the statute includes *any* gain or loss without limitation, and cannot be read to require a 'sale or exchange,' as defendant argues."

II. In-Depth

ERISA SUBROGATION – THE "MAKE-WHOLE" DOCTRINE AS A BARRIER TO REIMBURSEMENT

By

Lars C. Golumbic
Dipal A. Shah[1]

This article is intended for informational purposes only and is expressly not intended to create an attorney-client relationship. It sets forth the views of the authors only and does not express the opinions of the Blue Cross and Blue Shield Association or of any of its member Plans.

The Supreme Court's recent decision in *Sereboff v. Mid-Atlantic Med. Servs., Inc.,* 126 S. Ct. 1869 (2006), involved the question of what "appropriate equitable relief" is available under Section 502(a)(3) of ERISA. The health insurance carrier in *Sereboff* brought a restitution claim under this ERISA enforcement provision. The carrier sought to enforce a subrogation lien on tort settlement proceeds obtained by the Sereboffs, who were participants in a health plan maintained by the carrier. *Id.* at 1873-74. The carrier identified the Sereboffs' settlement proceeds as property over which it sought to impose a constructive trust. *Id.*

In the Supreme Court's decision, the Court recognized that the carrier's restitution claim is the kind of "equitable relief" that is available under ERISA Section 502(a)(3). *Id.* at 1874-75. Because the carrier could point to an existing fund (i.e., the settlement proceeds) that was "specifically identified" by the terms of the plan as the source from which reimbursement should be made, the Court concluded that the carrier properly could seek equitable restitution against the Sereboffs by the imposition of a constructive trust upon the specifically identified fund.[2] *Id.* For the Supreme Court, the matter boiled down to contract enforcement. Since the terms of the plan imposed on the Sereboffs a repayment obligation that was tied to funds they had received from a third party, the Court simply enforced the plan document.

While the Supreme Court was willing to enforce the terms of the Sereboffs' plan, the Court sidestepped the question of whether the equitable "make-whole" doctrine could be applied as a defense by the Sereboffs to the insurance carrier's subrogation claim. The make-whole doctrine is an equitable insurance law principle. At common law, this general rule provides that the insurer's right to contribution only arises after the insured has been fully compensated for his or her loss. *See* 16 Lee R. Russ, et al., *Couch on Insurance* § 223:134

---

[1] Lars Golumbic and Dipal Shah are members the litigation group at Groom Law Group, Chartered, in Washington, DC. Lars and Dipal have represented a broad range of clients in health matters related to ERISA. For questions or other information regarding this article, please contact Lars at lcg@groom.com or Dipal at das@groom.com.

[2] The Supreme Court's ruling in *Sereboff* is consistent with its earlier decision in *Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204 (2002). There, the Court observed that a constructive trust may be imposed when "money or property identified as belonging in good conscience to the plaintiff [can] be clearly traced back to particular funds or property in the defendant's possession." *Id.* at 214.

(3d ed. 2000). The Sereboffs belatedly invoked the make-whole doctrine in their case and asserted that, because they had not been fully compensated for their medical injuries, the reimbursement sought by the insurer was not "appropriate." Even so, the Supreme Court declined to address the Sereboffs' argument because they had not raised it earlier in their suit. *Sereboff*, 126 S. Ct. at 1877 n. 2.

Since *Sereboff*, plan participants have tried to rely on the term "appropriate" in ERISA Section 502(a)(3) to import the make-whole doctrine into subrogation proceedings. Thus far, the answer from the lower courts is "no," participants cannot import the make-whole doctrine if the clear, unambiguous language of those participants' plans forecloses application of the doctrine.

Even before *Sereboff*, a number of circuit courts had held that the "default" rule in ERISA subrogation actions is to apply the make-whole doctrine unless the terms of the plan clearly and unequivocally provide otherwise. *See, e.g., Copeland Oaks v. Haupt*, 209 F.3d 811, 813 (6th Cir. 2000); *Cagle v. Bruner*, 112 F.3d 1510, 1521 (11th Cir. 1997); *Barnes v. Independent Auto. Dealers Ass'n of Cal. Health & Welfare Ben. Plan*, 64 F.3d 1389, 1395 (9th Cir. 1995). Post-*Sereboff*, the Eighth Circuit has followed this "default" rule and has held that the make-whole doctrine is presumed to apply unless the plan language clearly dictates otherwise. In *Administrative Committee of the Wal-Mart Stores v. Shank*, 500 F.3d 834 (8th Cir. Aug. 31, 2007), participants in Wal-Mart Stores' self-funded health benefit plan obtained settlement proceeds from a third-party tortfeasor over medical expenses related to an automobile accident. *Id.* at 835. The plan's administrator brought suit under ERISA Section 502(a)(3) and sought to impose a constructive trust over the settlement funds. *Id.* at 836. In turn, the plan participants invoked the make-whole doctrine and claimed that the plan was barred from enforcing the subrogation clause under the plan until the participants were first fully compensated for their injuries. *Id.* at 837.

Ultimately, the Eighth Circuit was not persuaded. Applying the make-whole rule as the "default" rule of construction, the court reviewed the terms of plaintiffs' plan to determine whether the plan provided for anything different. *Id.* at 837-38. The Eighth Circuit found, in fact, that the plain, direct plan language left no room for importation of the make-whole doctrine.[3] Therefore, the court refused to recognize the doctrine "in the face of clear plan language to the contrary." *Id.* at 839. In defense of its position, the Eighth Circuit claimed that "the purposes of ERISA are best served by enforcing the Plan as written." *Id.* at 838. The court noted further that application of the doctrine in the face of clear language to the contrary would increase costs to the plan in the form of higher premiums. *Id.* In view of these considerations, the Eighth Circuit rejected the participants' contention that it was necessary to apply the make-whole doctrine even when the clear, direct language of a plan provides otherwise. *Id.* at 839.

While the Eighth Circuit has applied the default rule in *Administrative Committee of the Wal-Mart Stores*, the DC Circuit has rejected that rule of construction post-*Sereboff*. Instead, the DC Circuit has streamlined the interpretive inquiry by holding that the plan language controls the question of whether to apply a make-whole bar to reimbursement. In *Moore v. CapitalCare*, 461 F.3d 1 (D.C. Cir. 2006), a health insurance carrier asserted a subrogation right under ERISA Section 502(a)(3) to settlement proceeds obtained by a beneficiary

[3] As the Eighth Circuit noted, the plan provided that the plan had the right to reimbursement "regardless of whether . . . the participant has been made whole (i.e., fully compensated for his/her injuries." *Id.* at 838 (citing to plan document).

covered by the carrier's health policy. *Id.* at 7. The participant urged the DC Circuit to adopt the make-whole doctrine as a default rule of construction. *Id.* at 8. The appeals court, however, refused to decide the question because the beneficiary's plan "unambiguously establishes a plan priority to any third party recovery . . . regardless [of] whether the beneficiary has been made whole by the recovery." *Id.* at 10. Based on the plan language, the DC Circuit held that the insurance carrier had a right to recover all amounts the plan had paid to the beneficiary that she had recovered from a third party. *Id.*

The lesson from *Moore* and *Administrative Committee of the Wal-Mart Stores* is pretty straightforward. These courts have taken their cue from *Sereboff*, where the Supreme Court treated the subrogation action as a question of contract enforcement. Thus, the Court enforced the terms of the Sereboffs' plan document, which provided for reimbursement from an identifiable fund that was tied to amounts the Sereboffs had recovered from a third party. Post-*Sereboff*, the Eighth Circuit and DC Circuit courts appear willing to enforce the contractual terms of a plan and not apply the make-whole rule if the plan's language forecloses its application. If, however, the plan document is not clear or is silent on make-whole, courts may be willing to supply a default, make-whole rule. Indeed, in one recent subrogation proceeding, a federal district court reviewed the applicable plan language and concluded that, because there was no "suggestion, let alone a clear statement" in the plan language "that a plan beneficiary is signing away his or her make whole rights," the default rule applied. *Providence Health System-Washington v. Bush*, 461 F. Supp. 2d 1226, 1235 (W.D. Wash. 2006).

As evident from *Provident Health System-Washington*, if parties do not want the make-whole rule, a plan's subrogation provision should not be silent or ambiguous on the subject. Therefore, it would be wise for parties to take steps to ensure that subrogation provisions are unambiguous as to whether reimbursement rights apply to a partial recovery. If parties do not want the make-whole doctrine to apply, the language of a reimbursement provision should refer to make-whole and then preclude its application. The language should also provide for a priority to any third-party recovery, regardless of whether the participant has been fully compensated for his or her loss. Poor drafting could mean that a court applies make-whole to fill in any gap as to what is provided for under the plan.