Defining "Other Appropriate Equitable Relief" Post *Sereboff*: Support for the Adoption of the Made Whole Doctrine as a Default Rule in ERISA Plans

INTRODUCTION

On September 2, 1996, Justin Rose, a nine-year-old boy, was injured by an explosion "which occurred when an aerosol can was thrown into a picnic bonfire."[1] As a result of the incident Justin suffered second and third degree burns on 77% of his body.[2] The insurance company paid over $1.2 million in medical expenses on his behalf.[3] Justin's parents filed a lawsuit against the third parties responsible for his injuries and the case was eventually settled for $600,000.[4]

The insurance company sought injunctive relief under its subrogation clause to force Justin's parents to relinquish the settlement proceeds to the insurer.[5] Justin's parents asserted that the plan's subrogation provision did not expressly reject the made whole doctrine; therefore, the insurer should be precluded from exercising its subrogation rights because Justin was clearly not made whole.[6] The United States District Court of New Jersey granted summary judgment against Justin's parents on the grounds that the court had not adopted the made whole doctrine as a default rule for plans governed by the Employment Retirement Income Security Act (ERISA).[7] The court then awarded the insurer the entire settlement proceeds.[8] This decision left nine-year old Justin with no compensation for his personal injuries.[9]

Unfortunately, Justin's story is not uncommon. Insurance companies often utilize subrogation clauses in their policies.[10] These provisions grant the insurer priority to repayment in any settlement against a third party tortfeasor.[11] Under many states' common law an insurer may not recover until the insured has been fully made whole.[12] However, plans governed by ERISA pre-empt the enforcement of such state-law protections.[13]

ERISA plan participants must seek relief through the remedies provided in the statute itself.[14] Although ERISA is silent on the issue of subrogation, in *Sereboff v. Mid Atlantic Services Inc.*, the Supreme Court interpreted ERISA's "other appropriate equitable relief" provision to include

an insurer's right to seek enforcement of subrogation clauses.[15] However, the Supreme Court has not addressed whether this same remedy provision restricts an insurer's subrogation rights where the insured has not been made whole.[16] Although all the federal circuit courts agree that parties may contract out of the doctrine, the federal circuit courts are split on whether the made whole doctrine should be applied to insurance plans that do not specifically reject this doctrine.[17] Even the courts that apply the made whole doctrine as a default rule disagree on the language required to disavow the doctrine.[18] This results in differing treatment of subrogation provisions in ERISA plans which impedes on ERISA's uniform administrative scheme and frustrates the purpose of the statute.

This note argues that the federal circuit court split should be resolved in favor of the adoption of the made whole doctrine as a default rule because doing so is consistent with both the Supreme Court's interpretation of ERISA's "other appropriate equitable relief" provision and ERISA's purpose. Furthermore, the specific language required to reject this doctrine should assert a right to any full or partial recovery and priority over the funds recovered.

Part I of this note provides a brief overview of ERISA and explores its purpose and relationship to the equitable principles of subrogation, reimbursement, and the made whole doctrine. Part II discusses the Supreme Court's decisions interpreting ERISA's "other appropriate equitable relief" provision and examines whether the court's construction of this section supports the adoption of the made whole doctrine and effectuates ERISA's purpose. Part III analyzes the federal circuit court split on whether to adopt the made whole doctrine as a default rule. It determines that the adoption of this doctrine is consistent with both the purpose of ERISA and the Supreme Court's interpretation of ERISA's "other appropriate equitable relief" provision. It further concludes that in light of the Supreme Court's holding in *Sereboff*, the

specific rejection language requirements established by the Sixth federal circuit court to reject the made whole doctrine should be implemented in all federal circuit courts.

PART I: ERISA OVERVIEW

PURPOSE OF ERISA

ERISA is a complex regulatory scheme enacted in 1974 in response to the ongoing mismanagement of employee pension plans that resulted in many employees losing promised benefits.[19] ERISA's primary purpose is to ensure plans are equitably administered pursuant to the terms promised by employers.[20] To achieve this objective, ERISA instills a uniform set of federal regulations that govern employee benefit plans.[21] ERISA is premised on trust law and imposes a fiduciary duty on anyone who exercises material discretion over employee benefit plans.[22] Aggrieved ERISA fiduciaries and plan participants must seek relief under ERISA's remedy provisions, which are limited solely to equitable relief.[23]

INSURED AND SELF-FUNDED ERISA PLANS

ERISA divides employee benefit plans into two categories: insured and self-funded.[24] An insured plan is a group policy purchased from a health insurance carrier by employers for its employees. [25] The policy is funded by the premiums paid by the employer and the employee. Medical claims are paid by the insurance carrier up to the policy limits rather than by the employer. [26] Conversely, a self–funded ERISA plan is one in which the employer completely funds the plan and pays for its employee health care with company assets.[27] The distinction is important because the plan type dictates whether it is subject to state law or federal law.[28]

PREEMPTION: SAVINGS CLAUSE vs. DEEMERS CLAUSE

Generally, ERISA preempts state laws that "relate to" employee health plans.[29] However, the ERISA "savings clause" narrows the scope of this federal preemption by allowing states to enact

laws that regulate insurance.[30] For example, states have the authority to set specific levels of reserves and contributions.[31] These laws are not preempted as long as they do not conflict with the statute or frustrate its purpose.[32]

Directly under the text of the "savings clause" is the "deemer clause" which expressly states that self-funded plans are not "deemed to be an insurance company or other insurer...or engaged in the business of insurance... for purposes of any State purporting to regulate insurance..."[33] Consequently, self- funded plans are governed solely by ERISA, while insured plans are subject to both ERISA and state law.

SUBROGATION RIGHTS

The distinction between self-funded and insured plans is significant because the state and federal courts often differ in their treatment of subrogation clauses.[34] Subrogation claims usually occur in the context of personal injury claims where the issue of negligence is often disputed.[35] Injured parties are not expected to wait until the negligence issue is resolved before receiving medical attention.[36] Rather, insurance pays its policyholder's medical expenses while the issue of liability is determined.[37] If the insured recovers from the tortfeasor, many insurance companies seek recoupment of the expenses they paid.[38] This concept is based on the principles of subrogation and reimbursement.[39]

Subrogation and reimbursement are both equitable remedies.[40] Subrogation can arise either by contract (conventional subrogation) or by operation of law (equitable subrogation).[41] Equitable subrogation can occur when an insurer pays its insured's medical expenses for an injury caused by a negligent tortfeasor.[42] The insurer is entitled to step into the shoes of the insured and assume any rights the insured has against the tortfeasor.[43] The purpose of equitable subrogation is to prevent unjust enrichment of both the tort victim and the tortfeasor.[44]

In the context of the tort victim, unjust enrichment is rooted in the principle that tort victims should not recover twice from the same harm.[45] For example, Pete Plaintiff is injured in a car accident resulting from the negligence of a driver in another vehicle. He is rushed to the hospital. The hospital submits its invoices to Pete Plaintiff's insurance and the bills are subsequently paid. If a tort suit were filed against the negligent driver, it would be unjust if Pete Plaintiff did not reimburse his insurer for the medical expenses it paid on his behalf. This is because Pete has already been compensated for that expense by his insurer through the payment of the medical expenses. Thus, subrogation aims to preclude duplicate recovery.

In terms of a tortfeasor, subrogation prohibits such a wrongdoer from "being unjustly enriched by escaping the consequences of his or her actions."[46] If the insured's losses are covered by insurance, the incentive to file a claim against the tortfeasor is reduced.[47] If the insured does not file a claim, the negligent party will "unjustly keep monies that otherwise would be used to satisfy the judgment."[48] The rationale in this context is that an insurer, which has been compelled under its policy to pay the loss, should "in fairness . . . be reimbursed by the party which caused the loss."[49]

REIMBURSEMENT

Unlike subrogation, an insurer seeking reimbursement does not pursue an action against the tortfeasor.[50] Rather, it is the insured that pursues a claim against the tortfeasor.[51] Once the claim is settled, the insurer is reimbursed by its insured for the expenses the insurer paid.[52] The distinction between subrogation and reimbursement has eroded over time because both are governed by the same equitable principles.[53] It is not uncommon for an insurance policy to use both terms interchangeably or to include both rights as separate provisions in the agreement.[54]

MADE WHOLE DOCTRINE

Subrogation rights may be subject to some limitations. For example, the made whole doctrine is an equitable remedy that restricts insurers' subrogation rights.[55] Under the made whole doctrine, an insurer is entitled to receive reimbursement from the insured's settlement proceeds only if the insured has been fully compensated for the losses sustained from the injury.[56] If not, the insurer is precluded from exercising its subrogation rights or at most, the insurer would only be entitled to a pro rata share of the recovery.[57] The rationale is that the equitable nature of subrogation precludes an insured from recovering twice.[58] Thus, if the insured has not been made whole there is no double recovery-the insured is in fact undercompensated.[59]

All but five states have adopted some form of the made whole doctrine.[60] Approximately twenty-six states and the District of Columbia utilize this doctrine as the default rule, and an estimated nineteen states prohibit any plan from contracting out of this doctrine.[61] However, because ERISA pre-empts state laws, federal courts do not consider state common law in ERISA plans.

PART II

ERISA REMEDIES

Due to the preemption of state-law protections, ERISA plan participants must look to the statute itself for recourse.[62] If the statute is silent, the federal courts may implement a federal common law that does not conflict with the statute.[63] ERISA provides three remedy provisions.[64] The focus of this note is section 502(a)(3) which serves as a catchall provision for injuries not specifically addressed in the ERISA's other two provisions.[65] Section 502(a)(3) is commonly referred to as ERISA's "other appropriate equitable relief" provision.[66] It authorizes "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."[67]

Mertens v. Hewitt Associates: The Death of Legal Relief

The United States Supreme Court heard three cases pertaining to the interpretation of the phrase "equitable relief" in this provision.[68] The Supreme Court first interpreted this phrase in *Mertens*.[69] At issue in *Mertens* was whether the monetary damages sought against a non-fiduciary that knowingly participated in a fiduciary's breach of fiduciary duty were permitted under this section.[70] The court held the monetary damages being pursued were compensatory damages.[71] Because compensatory damages were a "classic form of legal relief" the insureds were precluded from recovering under ERISA.[72]

The court noted that under the common law of trust, a court in equity could "establish purely legal rights and grant legal remedies which would otherwise be beyond the scope of its authority."[73] Thus, ERISA's "other appropriate equitable relief" provision could mean either 1) "whatever relief a court in equity is empowered to provide in a case at issue" which could include legal remedies or 2) "those categories of relief that were typically available in equity (such as injunction, mandamus, and restitution, but not compensatory damages)."[74] Therefore, the former category precluded monetary relief because it was traditionally legal in nature.[75]

Because Congress had used the phrase "equitable" to modify "relief," the court concluded Congress intended to limit the relief available to something less than all relief.[76] Thus, the court determined that Congress intended to include only the type of equitable relief available at the time when the courts were divided between courts of equity and courts of law.[77] It therefore chose the latter most restrictive interpretation of the statute.[78] By construing the statute this way,

the *Mertens* decision effectually eliminated the ability for ERISA plan participants to seek legal remedies even though such remedies were permissible under common trust law.[79]

In his colorful dissent Justice Byron White noted the court's decision created an anomaly on interpreting ERISA in a way that provided plan participants with less protection then they had pre-ERISA under common trust law.[80] Justice Richard Posner of the United States Seventh Circuit Court of Appeals also criticized this decision in *Health Cost Controls of Ill. v. Washington*, in which he stated that it "was . . . fanciful to attribute to Members of the 93rd Congress familiarity with those "needless and obsolete distinctions," and that "[t]here is nothing to suggest that ERISA's drafters wanted to embed their work in a time warp."[81] Thus, Justice Posner argued the meaning of "equitable relief" in section 502(a) (3) should have been determined based on "the state of the law when ERISA was enacted."[82]

Great-West Life & Annuity Insurance Co v. Knudson: Redefining Restitution

In *Great-West Life & Annuity Insurance Co v. Knudson* the Supreme Court had a second opportunity to interpret the phrase "other appropriate equitable relief."[83]At issue here was whether restitution was exclusively an equitable remedy.[84] In this case, the court held restitution claims were a form of both legal and equitable relief.[85] Restitution claims were considered equitable in nature provided they met three requirements: 1) the money pursued was identifiable, 2) belonged to the claimant in good conscience, and 3) within the control of the defendant.[86] These requirements created a constructive trust or an equitable lien, in which money or property identified as belonging in good conscience to the plaintiff could clearly be traced to … property in the defendant's possession.[87] In contrast, claims seeking to hold a defendant personally liable were legal in nature and precluded under ERISA.[88] Therefore, determining whether a claim is equitable depends on the nature of the claim and the relief being sought.[89]

Knudson sharpened the technical distinction between legal and equitable restitution and provided insurers with a means to couch monetary claims as equitable reimbursement.[90] This decision subsequently created a federal circuit court split on whether an ERISA fiduciary could utilize ERISA's "other appropriate equitable relief" provision to enforce a plan's contractual subrogation clause.[91]

Sereboff: Subrogation Madness

The federal circuit court split was resolved four years later when the Supreme Court decided *Sereboff*.[92] The Court determined that actions to enforce subrogation agreements were an equitable remedy within the scope of section 502 (a)(3).[93] The court reached this conclusion because it distinguished this type of "equitable lien by agreement" from an action to impose personal liability that arises from a contractual obligation to pay money.[94] This means claims seeking the enforcement of a plan's subrogation provisions are a form of "other appropriate equitable relief" as opposed to a legal remedy precluded by ERISA.[95]

In *Sereboff*, Marlene Sereboff and her husband Joel were severely injured when their rental vehicle was struck from behind forcing the Sereboffs into a concrete barrier.[96] The plan paid $74,896.37 in benefits to the Sereboffs.[97] The couple filed suit against several third party tortfeasors.[98] Shortly after the suit was commenced, the plan sent the Sereboffs' attorney a letter indicating it was asserting a lien on the anticipated recovery.[99] The case eventually settled for $750,000.[100] The Sereboffs' attorney disbursed the funds directly to the Sereboffs.[101] This prompted the plan to file a temporary restraining order requiring the couple to set aside a portion on the proceeds to satisfy the lien.[102]

The court analogized this case to that of *Barnes v. Alexander*.[103] In *Barnes* the Court enforced a fee sharing agreement between attorneys under the theory it created an equitable lien by

agreement the moment the lawyer who accepted the case received his fee.[104] In *Barnes* two attorneys, Street and Alexander, performed work for Barnes, also an attorney, who promised them "one-third of the contingent fee he expected in the case."[105] The Supreme Court upheld their equitable claim for their portion of the fee.[106] It reasoned that Barnes' undertaking "create[d] a lien upon the portion of the monetary recovery due to Barnes from the client which Street and Alexander could "follow . . . into the hands of . . . Barnes" as soon as the funds were identified.[107] This meant Barnes became trustee of the one-third fee for the benefit of the lawyers to whom it was promised as soon as the funds were identified.[108] The court also revisited its holding in *Knudson* and reiterated, "one feature of equitable restitution was that it sought to impose a constructive trust or equitable lien on particular funds or property within the defendant's possession."[109] Thus, the court retained the possession requirement it established in *Knudson.*[110]

The Sereboffs argued that equitable subrogation actions were subject to equitable defenses such as the made whole doctrine.[111] The Supreme Court rejected this argument reasoning that the plan's "Acts of Third Parties" provision created an equitable lien by agreement because it specifically identified particular funds and the plan's right to a particular share of that fund.[112] Such language meant the plan did not have to "characterize its claim as a freestanding action for equitable subrogation."[113] Therefore, Mid Atlantic was entitled to use this "familiar [rule] of equity" to seek reimbursement for the medical bills it had paid by imposing a constructive trust or equitable lien on those funds.[114] The court therefore dismissed the Sereboffs' argument stating that the "parcels of equitable defenses . . . [that] accompany . . . such actions are beside the point."[115] The *Sereboff* decision means that in order to establish an equitable lien or constructive

trust on settlement proceeds, such funds must be 1) identifiable as opposed to being part of the insured's general assets and 2) the funds must be within the insured's possession.[116]

The effect of this decision places claims to enforce subrogation provisions into the realm of equitable remedies. This means ERISA fiduciaries can enforce contractual subrogation clauses, which are legal in nature, by labeling them as equitable liens or constructive trusts. The Supreme Court's decisions interpreting ERISA's "other appropriate equitable relief" provision, has been subject to much criticism and scholarly debate. Rather than rehashing the debates on whether any of these decisions were erroneous, this note contends the made whole doctrine should be adopted as a default rule because it comports with the Supreme Court's construction of its "other appropriate equitable relief" provision and the purpose of ERISA.

SUPREME COURT'S CONSTRUCTION OF ERISA

For example, in *Sereboff* the court noted in its dicta that Mid Atlantic did not have to characterize its claim as a freestanding action for equitable subrogation because it had implemented language that established an equitable lien or constructive trust.[117] It also determined that such actions were not subject to common law equitable defenses.[118] At first blush it may appear as though the *Sereboff* decision prohibits the adoption of the made whole doctrine as a default rule because it is a common law equitable remedy. However, the court's decision only addressed whether actions seeking to enforce subrogation clauses were equitable relief. It did not address whether such relief was appropriate where the insured had not been made whole.[119] This is because the Sereboff's attorney failed to raise this issue at the trial and appellate court level.[120] Based on the court's rationale in *Mertens*, the text of the provision should be strictly construed.[121] Therefore, the phrase "other appropriate equitable relief," should be construed so that "appropriate" modifies "equitable" which in turn modifies "relief."[122] This

means that equitable relief cannot be awarded if doing so is not appropriate based on the circumstances of the case.[123]

A determination of what is considered "appropriate" in certain circumstances depends upon the language and purpose of the statute.[124] As discussed *supra*, ERISA's purpose is to ensure equitable administration of plans.[125] "Equitable" is defined as "[j]ust; consistent with principles of justice and right."[126] As this definition illustrates, equity is rooted in the concept of fairness requiring parties involved in the suit to act equitably.[127] In personal injury cases, insureds are often inadequately compensated for several reasons. First, many states have implemented tort reform which limits the amount an injured person can recover for non-economic damages.[128] These damages include disfigurement, pain, and loss of enjoyment of life.[129] This coupled with the fact that courts have difficulty accurately placing an economic value on these types of injuries, has drastically reduced the amount of damages awarded to injured individuals.[130] Furthermore, tort victims are often forced to "accept less than full compensation because the tortfeasor has inadequate insurance coverage or assets to cover the actual damages."[131] Denying a tort victim the ability to be fully compensated for his or her damages clearly does not comport with the principles of fair and just required under ERISA.[132] Therefore, ERISA's "other appropriate equitable relief" provision should be construed to preclude insurers from exercising their subrogation rights until the insured as been made whole because doing so would not be appropriate under such circumstances.

PART III

THE MADE WHOLE DOCTRINE AND AN ERISA INSURER'S RIGHT TO SUBROGATION: FEDERAL CIRCUIT COURT SPLIT

Based on the Supreme Court's history of construing ERISA's "other appropriate equitable relief provision" and ERISA's purpose, there is prevalent support in favor of adopting the made

whole doctrine as the default rule. However, with no direction from the Supreme Court, the federal circuit courts' split on whether to apply the doctrine as a default rule remains unresolved.[133] Furthermore, even the courts that have adopted the doctrine disagree on the language required to disavow it. The result is inconsistent treatment of subrogation clauses throughout the federal circuit courts. These indecisions among the federal circuit courts frustrate the uniform administration of ERISA plan. The following section briefly explores the differing language requirements in the federal circuit courts that adopt the doctrine. It then analyzes the rationale of the courts that refuse to adopt the doctrine and determines that the reasoning employed in these federal courts is flawed.

Ninth Circuit: Gap Filler

The Ninth Circuit announced its adoption of the made whole doctrine as a gap filling provision in *Barnes v. Independent Automobile Dealer's Ass'n.*[134] The court held the doctrine must be implemented where the insurance policy does not provide a clear provision to the contrary.[135] In its dicta it determined that the phrase "all rights of recovery" was sufficient language to reject the made whole doctrine.[136]

Eleventh Circuit: Standard Language is Insufficient

Likewise, the Eleventh Circuit also adopts the doctrine as a default provision.[137] In *Cagle v. Bruner* this circuit held boilerplate subrogation language was not a specific rejection of the made whole doctrine.[138] It determined that a plan must explicitly state it had the "right to first recovery."[139]

Sixth Circuit: Specific Language Requirement

In *Copeland Oakes v. Haupt*, the Sixth Circuit not only reiterated its adoption of the made whole doctrine as a default rule, it went one step further than the Ninth and Eleventh Circuits by

creating an additional requirement for plan language to conclusively disavow it.[140] First, as set forth in *Bruner*, the plan must establish the priority to the funds recovered.[141] Second, it must establish a right to any full or partial recovery.[142]

Conversely, the Seventh, Fourth and First Federal Circuit Courts reject the made whole doctrine as a default rule. The Seventh Circuit Court holds that the doctrine impedes on ERISA's uniform statutory scheme.[143] The Fourth and First Circuit Courts reason that ERISA requires plans be drafted in a manner understandable by laypersons; therefore, ERISA plans that use standard subrogation language should not be penalized as being ambiguous or silent.[144] These arguments, although clever are misplaced. These decisions will be discussed in turn.

Seventh Circuit: Bargained for Benefits

In *Cutting v. Jerome Foods, Inc.* the Seventh Circuit rejected the made whole doctrine.[145] In *Cutting,* Diane Cutting incurred $90,000 in medical expenses and suffered serious injuries in an automobile accident.[146] Cutting was successful in her claim against an uninsured motorist policy and a products liability action.[147] The plan refused to pay the medical expenses unless Cutting executed its reimbursement agreement which would mean she acknowledged that the acceptance of any plan payments arising out of illness, injury or medical condition constituted an acceptance to her insurer's subrogation clause.[148] Cutting refused to sign the agreement alleging "her recoveries left her nearly $400,000 from being made whole."[149] She subsequently sought declaratory relief and to compel the insurer to disburse its funds without its subrogation or reimbursement rights until she was fully compensated.[150] The plan filed a counterclaim to require Cutting to execute the reimbursement agreement prior to the plan paying out any benefits.[151]

The Federal District Court noted in its dicta that the adoption of the made whole doctrine would impede on ERISA uniform administration of plans and was therefore conflict

preempted.[152] The court reasoned that modeling a federal common law based upon state subrogation law would hinder insurers' ability to calculate uniform premiums nationwide.[153] Additionally, the court determined that because the states differ in their treatment of subrogation clauses, a federal common law developed from a state's common law would render a "subrogation provision enforceable in one federal court but not another."[154] The District Court's arguments are flawed in several aspects.

First, the Seventh Circuit's reasoning that insurance companies consider reimbursement from benefits paid when calculating their premiums is incorrect. Insurance companies use actuarial statistics to distribute the losses incurred by a few persons evenly to a large number of persons who face similar risks.[155] This is achieved by establishing a fund that is funded "through the collection of premiums from each member of this large group of insureds."[156] These premiums are "calculated based upon actually incurred losses . . . adjusted, of course, to allow the company to pay its costs and make a profit."[157] It is important to note that the "premiums do not take subrogation recoveries into account."[158] This means that the cost of insurance premiums is not dependant on factors such as subrogation and the made whole doctrine.[159] Therefore, the Seventh Circuit's rationale that the adoption of the default rule would hinder the uniform calculation of premiums is unfounded.

Second, the Seventh Circuit incorrectly premised part of its argument on conflict preemption because it reasoned that states treat subrogation clauses differently.[160] Therefore a subrogation provision would be enforceable in one jurisdiction but not another.[161] Notably, in *FMC Corp. v Holliday* the Supreme Court held that federal courts can create common law in ERISA plans provided the common law did not conflict with statute's purpose.[162] As discussed *supra* in Part II of this note, the made whole doctrine as a default rule is consistent with ERISA's purpose

because it ensures the equitable administration of plans; therefore, there is no conflict preemption. Furthermore, the Seventh Circuit failed to consider that the federal circuits themselves do not uniformly administer ERISA plans because of the circuit courts are split on when, if ever, to apply the made whole doctrine. Even if all the federal circuits where to apply the doctrine uniformly as the default rule, the effect still creates varying language requirements that depend on what federal circuit court has jurisdiction. This varying language would be interpreted differently among the federal courts. Moreover, insurers would still have to look to the federal common law in the relevant jurisdiction to determine what language is required. Clearly, this does not comport with ERISA's uniform administration of plans. Therefore, the most effective way to resolve this issue is to require specific rejection language. Because the made whole doctrine is permitted by ERISA it makes the most sense to adopt this doctrine as the default rule into federal common law and require all federal circuit courts to mandate the same rejection language.

First and Fourth Circuits: Unqualified Right to Reimbursement

The First and Fourth Circuits also refuse to adopt the made whole doctrine as a default rule. In *Harris v. Harvard Pilgrim*, the First Circuit rejected the Eleventh Circuit's holding that subrogation provisions must express denounce the made whole doctrine.[163] In *Harris*, the insured was personally injured in a motorcycle accident.[164] The plan paid $102,874.29 towards Harris's medical expenses.[165] When the Harrises sued the third party at fault, the plan filed a lien against any potential settlement awarded to the Harrises.[166] Their case settled for $737,500.00 of which $264,727.31 went towards attorney fee and expenses.[167]

The insured asserted that because he had not been made whole, the insurer should not be entitled to any of the settlement proceeds.[168] The subrogation provision in the contract granted

the insurer standing to pursue a claim against a third-party tortfeasor to recoup expenses paid to its plan participant.[169] The plan further stated that it was "entitled . . . to recover from a [insured] the value of services provided, arranged, or paid for, when the [insured] was reimbursed for the cost of care by another party."[170] Thus, the plan contained both subrogation and reimbursement language.[171] Therefore, the issue the court faced was whether to adopt the made whole doctrine as a default rule and if so, whether such boilerplate language was sufficient enough to reject this doctrine.[172]

The court acknowledged that it could import federal common law into ERISA plans.[173] However, it concluded that it would only do where it was necessary to "effectuate legitimate ERISA policy objectives."[174] The court based its reasoning on ERISA's policy that plans be written in a manner that is sufficient enough to be understood by the average plan participant.[175] It concluded the requirement that plans utilize particularized legal jargon to reject the made whole doctrine was contrary to that policy.[176] Therefore, the First Circuit rejected the made whole doctrine as the default rule and does not require any specific rejection language.

Likewise, the Fourth Circuit contends that boilerplate subrogation language is sufficient to disavow the doctrine.[177] The court faced this issue for the first time in *Paris v. Iron Workers' Trust Fund Local No. 5*.[178] In this case, twenty-four year old Shawn Paris was severely injured in a motorcycle accident.[179] Shawn's parents subsequently filed suit against the negligent driver on Shawn's behalf.[180] He was awarded $100,000.[181] The plan contained a standard subrogation clause which stated in part that the acceptance of benefits from the plan entitled the plan to first reimburse if the insured recovered from a third party tortfeasor.[182] The court reasoned that "contracts subject to the provisions of ERISA are very different from ordinary insurance contracts and are not subject to the same rules of construction."[183]

The court contrasted ERISA plans that "require [the] use [of] clear, ordinary language that is readily understandable by laypersons," to "ordinary insurance contracts [which] contain more particular and precise language, as well as confusing legalese and boilerplate [language]."[184] It determined that, "the same doctrines and rules of construction to ERISA contracts that generally apply to insurance contracts, such as the make-whole doctrine... would frustrate the purposes of ERISA."[185]

This rationale is parallel to that of the First Circuit that rejects the adoption of the made whole doctrine as the default rule on similar grounds discussed *supra*. The reasoning of these courts is flawed in several aspects. First they incorrectly conclude that ERISA preempts all canons of construction. Second, they fail to consider that specific rejection language would clarify the scope of plan benefits which effectuates ERISA's purpose. For example, in *Firestone Tire and Rubber Co. v. Bruch* the Supreme Court held plan administrator had the discretionary authority to construe the plan's terms provided the plan expressly granted itself such authority.[186] This logically infers that plans lacking such language are subject to the rule of *contra proferentum* because they did not reserve its right to interpret the plan.[187] *Contra proferentum* is a well-established canon of construction that requires all ambiguities, errors, and omissions be construed in favor of the non-drafting party.[188]

The rationale for this rule in the context of insurance is that insurance policies are "drafted by specialists employed by the insurer with experience, education and expertise in this area."[189] Therefore, the insurer should have the burden of setting forth any liability limitations that are clear enough for the average plan participant to understand.[190] "[I]f it fails to do [so], it should not be allowed to take advantage of the very ambiguities that it could have prevented with greater diligence."[191] Furthermore, plans signed by the insured are usually not permitted to be

amended by the insured, even if the insured later notices a mistake or ambiguity.[192] The reasoning of the First and Fourth Circuit Courts forces insureds "to guess and hope regarding the scope of coverage" and allows insurers to benefit from their own drafting errors.[193] This type of outcome clearly conflicts with the equitable administration of plans and therefore conflicts with ERISA's purpose. Therefore, the rule of *contra profentum* applies to ambiguous ERISA plan provisions so long as the insurer has not expressly reserved its authority to interpret the plan.

Second, specific rejection language ensures equitable administration of plans because it prevents the insurer from drafting ambiguous subrogation provisions which the insurer can later construe in its favor. Congress stated that ERISA's most important goal was to establish and implement adequate safeguards to protect insureds and prevent the reoccurrence of past inequities to them.[194] Therefore, not only did Congress enact ERISA with the primary intent to benefit insureds, it also sought to prevent inequitable acts by insurers to such plan participants.[195] Allowing an insurer to benefit from the very mistakes it could have prevented through clear plan terms is inequitable and therefore inconsistent with ERISA's purpose. The specific rejection language requirement effectuates the purpose of ERISA because it mandates and helps ensure that plans use clear and unambiguous language. Either the plan has the necessary language to reject the made whole doctrine or it does not. There is nothing for the plan to interpret.

In short, the made whole doctrine as a default rule is consistent with ERISA's purpose of ensuring equitable administration of plans. The harsh effects of poorly drafted or ambiguous plans should give way to the canons of construction and principles of equity, both of which provide insureds with fair and just relief.[196] Even though the made whole doctrine should be adopted as the default rule, it is not enough for the federal circuit courts to simply declare their adoption of the doctrine. As mentioned *supra* in the beginning of this section, in order to adhere

to ERISA's uniformity objective, all the federal circuit courts must require the same language. Otherwise, plans will still be subject to varying interpretations that depend on which federal court has jurisdiction over the plan in question. Thus, the final issue this note addresses is what specific rejection language best comports with the Supreme Court's construction of ERISA's "other appropriate equitable relief provision" and should therefore be required in all federal circuit courts.

SIXTH CIRCUIT v. SUPREME COURT'S CONSTRUCTION OF "OTHER APPROPRIATE EQUITABLE RELIEF"

Sixth Circuit: Specific Language Requirement and Sereboff

The decision in *Copeland Oaks* predates *Sereboff* by six years. Even so, the Sixth Circuit is most consistent with the Supreme Court's interpretation of ERISA's "other appropriate equitable relief provision" because the specific language it requires helps create the equitable lien by agreement necessary in *Sereboff*. In *Copeland Oaks*, Haupt's minor daughter, Brooke sustained serious permanent injuries in an automobile accident.[197] The driver-tortfeasor's insurance settled the case for the maximum coverage provided in the policy: $100,000 for bodily injury and $5,000 for medical expenses.[198] The Haupt's insurer agreed to pay over $300,000 of Brooke's medical expenses on the condition that the Haupts complied with the plan's subrogation provision in the plan. Brooke and her father initially both signed the agreement, which Brooke later disavowed on the grounds she was a minor.[199]

Here, the plan failed to establish its priority over any partial recovery.[200] As a result, the $100,000 was not subject to subrogation under the plan because it was designated as compensation for bodily injury not medical expenses.[201] However, the $5,000 would be subject to the recoupment provision provided Brooke was made whole by the total recovery from all

sources.[202] The court then remanded the case to determine whether Brooke had in fact been made whole.[203] If so, the $5,000 would be allocated to the insurer.[204]

Upon review, the court not only reiterated its adoption of the made whole doctrine as a default rule, it created two requirements for plan language to conclusively disavow the made whole doctrine.[205] First, the plan must establish a right to any full or partial recovery."[206] The court reasoned this phrase provided an unambiguous rejection of the made whole doctrine because it referred to both full and partial settlements.[207] Second, the plan must establish priority over the funds recovered therefore granting the insurer a right to be reimbursed first, even over the insured.[208] Although the Sixth Circuit's reasoning was focused on establishing unambiguous language to reject the made whole doctrine, this language is also the most conducive to the Supreme Court's reasoning in *Sereboff*. This is because it helps create the required constructive trust or equitable lien on settlement proceeds. Therefore, the Sixth Circuit language requirement provides an unambiguous rejection of the made whole doctrine and ensures that insurers use the appropriate to establish an equitable claim.

Specifically Identifiable

For example, the Sixth Circuit requires plans specifically reject the made whole doctrine by using language that gives the insurer a "right to any full or partial recovery."[209] This phrase serves a dual purpose. First, it unambiguously rejects the made whole doctrine because it expressly grants the insurer a right to any settlement funds as discussed *supra*. Second, it identifies particular funds and establishes a right to those funds within the insured's possession.[210] For example, the word "any" qualifies this phrase to grant insurers a right to the insured's proceeds regardless of how they are designated.[211] The effect of this provision allows insurers to assert an equitable lien on any of the settlement proceeds, not just the portion

designated as medical expenses.[212] This is significant because *Sereboff* requires that funds be identifiable in order to establish a constructive trust or equitable lien.[213] If the funds are indistinguishable from the insured's general assets, the insurer cannot create an equitable lien.[214] With few exceptions, most settlements are not specifically designated towards certain damages. Plans that contain this language ensure reimbursement from any of the damages awarded.[215] This ensures the funds being sought for reimbursement are specifically identifiable, as required by *Sereboff*.[216] Therefore, the phrase "a right to any full or partial recovery" is broad enough to encompass any portion of the settlement proceeds and establishes the insurer's right to specifically identifiable funds.

Possession/Control Requirement

Additionally, the Sixth Circuit mandates that plan language establish priority over the funds recovered.[217] This requirement also helps impose an equitable lien on settlement proceeds because it grants the insurer priority over the funds.[218] Priority language prevents the insured from disposing of the proceeds to avoid coming into possession of those funds.[219] In *Sereboff*, the court reiterated part of its decision in *Knudson* in which the court held restitution claims were equitable in nature as opposed to legal so long as the action did not seek to "impose personal liability on the defendant, but [rather] to restore to the plaintiff particular funds or property in the defendant's possession."[220] A plan provision that grants the insurer priority over settlement proceeds establishes an equitable lien on any settlement proceeds which attaches to the settlement proceeds as soon as they are identified.[221] This is significant because it prevents insureds from employing creative means to keep the proceeds out of the hands of insurers and therefore not within the insured's possession.[222]

For example, in *Knudson* discussed *supra* in Part II, the Supreme Court held funds placed into a Special Needs Trust are not within the insured's control.[223] As a result, the plan could not establish an equitable lien against the settlement proceeds.[224] Additionally, the Northern District of Illinois held in *Leipzig v. AIG* that proceeds held in particular funds that are spent on ordinary living expenses or intangibles such as educational expenses are no longer within the insured's possession and therefore not subject to a lien.[225] Because the language established in *Copeland Oaks* best comports with the identifiable and possession elements established in *Sereboff* it should be adopted in all federal circuit courts.

CONCLUSION

The adoption of the made whole doctrine as a default rule is consistent with ERISA's purpose and the Supreme Court's history construing its "other appropriate equitable relief" provision. Because ERISA depends on uniform application, all the federal circuit courts need to use the same rejection language to disavow the doctrine. The Sixth Circuit provides the most conducive rejection language. It protects the insured because it provides clear understandable terms regarding the scope of coverage to its insureds. It also protects the insurer because the language helps establish an equitable lien or constructive trust on the settlement proceeds. This results in equitable administration of plans which accomplishes the purpose of ERISA.

[1] Walker v. Rose, 22 F. Supp. 2d 343, 345 (3rd Cir. 1998).
[2] *Id.* at 345.
[3] *Id.*
[4] *Id.*
[5] *Id.*
[6] *Id.* at 350.
[7] *Id.*
[8] *Id.* at 351 (stating, "When read in context and viewed in light of all of the circumstances, this language can only mean that the Plan is entitled to be reimbursed by defendants for amounts the defendants receive from a third-party." "Thus, under the unambiguous terms of the Plan, plaintiffs are entitled a full first-lien reimbursement of the $600,000 settlement in the state court action.").
[9] *Id.*
[10] Brendan S. Maher and Radha A. Pathak, *Understanding and Problematizing Contractual Tort Subrogation*, Comment, 40 Loy. U. Chi. L.J. 49, 75 (2008) (noting that "Insurers have become very fond of . . . subrogation provision[s].").
[11] *Id.*
[12] *See* Johnny C. Parker, Comment, *The Made Whole Doctrine: Unraveling the Enigma Wrapped in the Mystery of Insurance Subrogation,* 70 Mo. L. Rev. 723, 736 (2005) (analyzing the various states that have adopted the made whole doctrine).
[13] 29 U.S.C. § 1144(a) (2006).
[14] *Id.* § 1144(a).
[15] Sereboff v. Mid Atlantic Med. Servs., Inc., 547 U.S. 356, 368 (2006); Walker v. Rose, 22 F. Supp. 2d 343, 351 (noting "ERISA says nothing about subrogation/reimbursement provisions.").
[16] Sereboff, 547 U.S. at 369.
[17] Walker v. Rose, 22 F. Supp. 2d at 350 (stating that the "Federal courts are in disagreement over whether the make whole rule should apply to ERISA cases.").
[18] Barnes v. Independent Automobile Dealer's Ass'n of Cal., 64 F3d 1389, 1395 (9th Cir. 1995). Cagle v. Brunner, 112 F.3d 1510, 1512 (11th Cir. 1997); Copeland Oaks v. Haupt 209 F.3d 811, 813 (6th Cir. 2000). (These cases will be discussed further within the body of this paper).
[19] *See* 29 U.S.C. § 1001(a) (2009) (stating, "Congress was prompted to enact ERISA of 1974 due to the lack of procedural safeguards concerning the operation of employee plans, inadequate current minimum standards, and lack of employee information endangered employees by depriving them of their anticipated benefits because plans terminated early due to poor management and inadequate funding." "The intent for enacting ERISA was to establish minimum standards to ensure plans were equitable administered.").
[20] ERISA Pub. L. No. 93-406, 88 Stat. 829 (1974) codified as amended at 29 U.S.C. § 1001(a)-(c) (2006) (citing the public policy of protecting the interest of plan participants and their beneficiaries). S*ee also* Shaw v. Delta Air Lines Inc., 463 U.S. 85, 90 (1983) (stating, "ERISA is a comprehensive statute designed to promote the interest of employees and their beneficiaries in employee benefit plans."); Alessi v. Raybestos Manhattan, Inc., 451 U.S. 504, 515 (1981) (stating that ERISA's primary purpose was to benefit employees).

[21] McMillian v. Parrott, 913 F.2d 310, 312 (6th Cir. 1990) (stating that the secondary purpose of "ERISA [was to]to ensure plans be uniform in their interpretation and simple in their application."). *See also* Jeffrey M Gorris, Comment, *Waivers of ERISA Plan Benefits: Preventing Judicial Interpretations of a Complex Statute from Frustrating the Statute's Simple Purpose*, 155 U. Pa. L. Rev. 717, 721 (2007).
[22] 29 U.S.C. § 1002(21)(A) (2000) (stating, "Except as otherwise provided in subparagraph (B), a person is a fiduciary with respect to a plan to the extent (i) he exercises any authority or discretionary control respecting management of such plan or exercises any authority or control respecting management or disposition of its assets . . .or he has discretionary authority . . .in the administration of such plan."). *See also* Varity Corp. v. Howe, 516 U.S. 489, 496-97 (1996) (stating, "ERISA draws from the common law of trusts.").
[23] Mertens v. Hewitt Associates, 508 U.S. 248, 248 (1993) (holding, "The text of ERISA leaves no doubt that Congress intended 'equitable relief to include only those types of relief that were typically available in equity, such as injunction, mandamus, and restitution.").
[24]29 U.S.C. § 1002(1).
[25] Metropolitan Life Insurance Co. v. Massachusetts, 471 U.S. 724, 732 (1985).
[26] *Id.*
[27] *Id.*
[28] *Id.*
[29] 29 U.S.C. § 1144(a) (stating, "[T]his chapter shall supersede any and all State laws insofar as they may...relate to any employee benefit plan...").
[30] *Id.* §1144 (b)(2)(B) (2006). S*ee also* Metropolitan Life Insurance Co. v. Massachusetts, 471 U.S. at 733 (stating, "Nothing in ERISA 'shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.'").
[31] 29 U.S.C. § 1144 (b)(6)(A)(I).
[32] *See, e.g.*, Boggs v. Boggs, 520 U.S. 833, 841 (1997) (stating, ERISA preempts state law that either "conflicts with the provisions of ERISA or operates to frustrate its objects."). *See, e.g.,* Alessi v. Raybestos Manhattan, Inc., 451 U.S. 504, 517 (1981).
[33] 29 U.S.C. § 1144 (b)(2)(B). S*ee also* FMC Corp. v. Holliday, 498 U.S. 52, 61 (1990) (stating, "[E]mployee benefit plans that are insured are subject to indirect state insurance regulation.").
[34] Holly Ludwig, Note, *Restoring Sanity After* Sereboff, 9 Nev. L.J. 431, 445 (2009).
[35] *See generally* Roger M. Baron, *Subrogation on Medical Expense Claims: The "Double Recovery" Myth and the Feasibility of Anti-Subrogation Laws*, 96 Dick. L. Rev. 581, 584-86 (1992).
[36] *Id.*
[37] *Id.*
[38] *Id.*
[39]*Id.*
[40] Parker, *supra* note 12, at 737.
[41] *See* E. Farish Percy Comment, *Applying the Common Fund Doctrine to an ERISA-Governed Employee Benefit Plan's Claim for Subrogation or Reimbursement*, 61 Fla. L. Rev. 55, 61 (2009).
[42] *Id.* at 61-2.

[43] Welch Foods, Inc. v. Chicago Title Ins. Co., 341 Ark. 515, 17 S.W.3d 467 (2000). *See also* 73 Am. Jur. 2d Subrogation 1 (2007) (stating "Subrogation, a legal fiction, is broadly defined as the substitution of one person in the place of another with reference to a lawful claim or right.").
[44] Maher and Pathak *supra* note 10, at 55 (2008) (noting that subrogation serves to prevent unjust enrichment of the loss causer and to prevent unjust enrichment of the loss-victim).
[45] 46A *C*.J.S. Insurance 1993 (2007) (stating, "Subrogation prevents...unjust enrichment to the insured ... that would result from double recovery.").
[46] Maher and Pathak, *supra* note 10, at 55. *See also* 46A C.J.S. Insurance 1993 (2007) (stating, "Subrogation prevents...unjust enrichment to the tortfeasor that would result if the tortfeasor were absolved from liability, despite its wrongful actions . . . because the insured procured and paid for insurance.").
[47] Maher and Pathak, *supra* note 10, at 56 (quoting John R. Nicholson, Note, *Mahler v. Szucs: An Impediment to Interinsurers: Arbitration and Affordable Personal Injury Protection Coverage*, 23 Seattle U.L. Rev. 213, 221 (1999)) (noting that where an insured's loss does not exceed coverage limits of the policy, the insured has little reason to litigate with the tortfeasor because the insured has already received compensation).
[48] Maher and Pathak, *supra* note 10, at 56.
[49] Federal Ins. Co. v. Arthur Andersen & Co., 75 N.Y.2d 366, 553 N.Y.S.2d 291, 552 N.E.2d 870 (1990).
[50] Mahler v. Szucs, 135 Wn.2d 398, 420 n.9, 957 P.2d 632 (1998) (quoting 1 Irvin E. Schermer, Automobile Liability Insurance 3D §19.01, at 19-2 (1995)) (stating, "The term 'reimbursement' comes into play where an insurer is permitted to recoup its payment out of the proceeds of an insured's recovery from the tortfeasor." "In this situation the insurer's right of recoupment is contingent upon a third-party recovery by the insured.").
[51] *Id.*
[52] *Id.*
[53]Parker, *supra* note 12, at 736 (stating that "[T]he insurance industry, . . . moved quickly to include subrogation provisions in medical and hospital coverages, uninsured motorist coverage and medical payment coverages in automobile policies."). *See also* Sereboff v. Mid Atlantic Med. Servs., Inc., 547 U.S. at 368 (holding that enforcement of subrogation clauses could be equitable).
[54]*Id.* at 736. *See also* Ludwig, *supra* note 34, at 440.
[55] Parker, *supra* note 12, at 737.
[56] *Id.* at 737. S*ee also* Black's Law Dictionary 1041 (9th ed. 2009) (defining the made whole doctrine as: "The principle that, unless the insurance policy provides otherwise, an insurer will not receive any of the proceeds from the settlement of a claim, except to the extent that the settlement funds exceed the amount necessary to fully compensate the insured for the loss suffered.").
[57] *See* Parker, *supra* note 12, at 773. (The pro rata approach is not within the scope of this note and is not further discussed). *See* Jeffrey A. Greenblatt, *Insurance and Subrogation: When the Pie Isn't Big Enough, Who Eats Last?* 64 U. Chi. L. Rev. 1337, 1338 (1997) for a discussion on the pro rata approach).
[58] Maher and Pathak, *supra* note 12, at 57 (stating, subrogation aims to ensure insureds are not unjustly enriched by "recovering more money for their loss then they are entitled to keep.").

[59] David M. Kono, Comment, *Unraveling the Lining of ERISA Health Insurer Pockets-A Vote for National Federal Common Law Adoption of the Made Whole Doctrine*, 2000 B.Y.U.L. Rev. 427, 445 (2000).
[60]Parker, *supra* note 12, at 723, 736 (analyzing each state and whether or not they have adopted the made whole doctrine). *See also* Kristen L. Huffaker, Note, *Where the Windfall Falls Short: "Appropriate Equitable Relief" After Sereboff v. Mid Atlantic Services, Inc.*, 61 Okla L. Rev. 233 (2008) (citing, Elanie M. Rinaldi, *Appointment of Recovery Between Insured and Insurer in a Subrogation Case*, 29 Tort & Ins. L.J. 803, 807 (1992)).
[61]Parker, *supra* note 12, at 737.
[62] *See generally* 29 U.S.C. § 1144 (b)(2)(A).
[63] *Id.* § 1144 (b)(2)(A); *See generally* 29 U.S.C. § 1144 (6)(A)(i). *See also* Walker v. Rose, 22 F. Supp. 2d 343, 351 (D. N.J. 1998) (stating, that "ERISA says nothing about subrogation/reimbursement provisions); Barnes v. Independent Auto. Dealer's Ass'n of Cal. Health and Welfare Benefit Plan, 64 F.3d 1389, 1395 (stating, "[B]ecause ERISA does not include a specific provision to resolve such questions, this court has the authority, indeed obligation, to adopt a federal rule-that is a rule that best comports with the interests served by ERISA's regulatory scheme.").
[64] 29 U.S.C. § 1132 (2009) (titled Civil [E]nforcement).
[65] *Id.* § 1132 (a)(3)(B).
[66] *Id.* § 1132(a)(3).
[67] *Id.* § 1132.
[68] Mertens v. Hewitt Assoc., 508 U. S. at 255-56 (holding that it had construed ERISA's other appropriate equitable relief provision to "those categories of relief that were *typically* available in equity."); Great-West Life & Annuity Ins. Co. v. Knudson, 534 U. S. at 207 (holding, not all restitution claims were equitable relief.); Sereboff v. Mid Atlantic Med. Servs., Inc., 547 U.S. at 356 (determining that claims to enforce subrogation provisions are a type of equitable relief).
[69] Mertens v. Hewitt Assocs., 508 U.S. at 248.
[70] *Id.* at 250.
[71] *Id.* at 255.
[72] *Id.*
[73] *Id.* at 256.
[74] *Id.* at 243.
[75] *Id.* at 255-56.
[76] *Id.* at 258.
[77] *Id.* 256 (stating the type of relief typically available in a court of equity included, "injunction, mandamus, and restitution, but not compensatory damages.").
[78] *Id.* at 257-58.
[79] *Id.*
[80] *Id.* at 263 (stating, "The majority today holds that in enacting ERISA Congress stripped ERISA trust beneficiaries of a remedy against trustees and third parties that they enjoyed in the equity courts under common law.").
[81] Health Cost Controls of Ill. v. Washington, 187 F.3d 703, 711 (7th Cir. 1999) (Posner, J.) (criticizing the majority opinion in Mertens v. Hewitt Assocs., 508 U.S. 248).
[82] *Id.*
[83] Great West Life & Annuity Ins. Co. v. Knudson, 534 U.S. 204 at 209 (2002).

[84] *Id.* at 207.
[85] *Id.* at 206 (stating, "[N]ot all relief falling under the rubric of restitution is available in equity.") (citing 1 Dan B. Dobbs, Law of Remedies 1.2, at 11 (2d ed. 1993)).
[86] *Id.* at 215.
[87] *Id.*
[88] *Id.* at 214. (stating, "Thus, for an action to lie in equity, the action generally must seek not to impose personal liability on the defendant, but to restore to the plaintiff particular funds or property in the defendant's possession.").
[89] *Id.* at 213.
[90] *Id.* at 214.
[91] Ludwig, *supra* note 34, at 440.
[92] Sereboff v. Mid Atlantic Med. Servs., Inc., 547 U.S. 356 at 369.
[93] *Id.* at 363 and 368.
[94] *Id.*
[95] *Id.* at 365.
[96] *Id.* at 360.
[97] *Id.*
[98] *Id.*
[99] *Id.* at 360-61.
[100] *Id.* at 360.
[101] *Id.*
[102] *Id.* at 360-61.
[103] *Id.* at 363-64.
[104] *Id.*
[105] *Id.*
[106] *Id.* at 361.
[107] *Id.* at 363-64 (quoting Barnes v. Alexander, 232 U.S. 117, 121 (1914).
[108] *Id.* at 365 (quoting Barnes v. Alexander, 232 U.S. 117 at 119).
[109] *Id.* at 363.
[110] *Id.*
[111] *Id.* at 364.
[112] *Id.*
[113] *Id.* at 368.
[114] *Id.* at 364.
[115] *Id.*
[116] *Id.* at 362-63 (reiterating that the *Knudson* case held that equitable restitution required the funds to be within the insured's possession).
[117] *Id.* at 363.
[118] *Id.* at 368.
[119] *Id.*
[120] *Id.* 368.
[121] Mertens v. Hewitt Assocs., 508 U.S. 228 at 258 (stating, "We will not read the statute to render the modifier superfluous.").
[122] *Id.* at 256 (reasoning that the term "equitable" must be construed to modify "relief").
[123] *Id.*

[124] *See Id.*
[125] Barnes v. Independent Automobile Dealer's Ass'n of Cal., 64 F3d 1389, 1394 (9th Cir. 1995) (stating that the made whole doctrine was consistent with ERISA's purpose of protecting plan participants).
[126] Black's Law Dictionary 617 (9th ed. 2009).
[127] *See* Ludwig, *supra* note 34, 449 (stating that because subrogation clauses are considered equitable, equitable principles apply).
[128] Kristen L. Huffaker, Note, *Where the Windfall Falls Short: Appropriate Equitable Relief" After Sereboff v. Mid Atlantic Services,* Inc., 61 Okla L. Rev. 233, 249 (2008) (relying on Amicus Curiae Brief of the Association of Trial Lawyers of America in Support of Petitioners at 21, Sereboff v. Mid Atlantic Servs., Inc., 126 S. Ct. 1869 (2006). (No. 05-260), 2006 WL 165866).
[129] Huffaker, *supra* note 129, at 250.
[130] *Id.*
[131] *Id. See also* Roger M. Baron, *Subrogation: A Pandora's Box Awaiting Closure*, 41 S.D. L. Rev. 237, 245, (1996).
[132] *See generally* Ludwig *supra* note 34, at 449 (discussing the lack of compensation received by tort victims).
[133] *Id.*
[134] Barnes v. Independent Automobile Dealer's Assn of Cal., 64 F3d 1389, 1394 (holding, "We adopt as federal common law this generally accepted rule that, in the absence of a clear contract provision to the contrary, an insured must be made whole before an insurer can enforce its right to subrogation.").
[135] *Id.*
[136] *Id.* at 1395 (stating, plans referencing "any" or "all" rights to subrogation clauses disavow the made whole doctrine).
[137] Cagle v. Brunner, 112 F.3d 1510, 1512 (11th Cir. 1997) (stating, "We conclude that the [made whole] doctrine applies where the plan does not expressly disavow it.").
[138] *Id.* at 1522 (stating, "[I]f the fund wants to escape the made whole doctrine, it need only include language in the plan explicitly providing the Fund with the right to first recovery, even when a plan participant or beneficiary is not made whole.").
[139] Copeland Oaks v. Haupt 209 F.3d 811, 813 (6th Cir. 2000).
[140] *Id.* at 813.
[141] *Id. See also* Cagle v. Brunner 112 F.3d 1510, 1522.
[142] Copeland Oaks v. Haupt 209 F.3d 811, 813 (stating, "Hence, we now hold 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.").
[143] Cutting v. Jerome Foods, Inc., 820 F. Supp. 1127, 1153 (7th Cir. 1991) aff'd, 993 F.2d 1293, 1294 (7th Cir. 1993). (This note does not discuss the appellate court's opinion because the court did not directly address the issue, it only stated in its dicta that it would reject the made whole doctrine as a default rule).
[144] Harvard v. Pilgrim Health Care, Inc., 208 F.3d, 274 (1st Cir. 2000); In re Paris, 44 F. Supp. 2d 747, 748 (D. Md. 1999), aff'd, 211 F.3d 1265 (4th Cir. 2000). (unpublished table decision).
[145] Cutting v. Jerome Foods, Inc., 820 F. Supp. 1127, 1153.
[146] *Id.* at 1149.

[147] *Id.*
[148] *Id.*
[149] *Id.* at 1150.
[150] *Id.* at 1150.
[151] *Id.* 1148.
[152] *Id.* at 1151.
[153] *Id.* at 1152.
[154] *Id.*
[155] *See* Keith E. Edeus, Comment, *Subrogation of Personal Injury Claims: Toward Ending an Inequitable Practice,* 17 N. Ill. U. L. Rev. 509. (1997). *See also* Lee R. Russ, Couch on Insurance § 48:26 (3d ed. 1984) (showing that the insurance industry routinely uses actuary tables to ascertain risk and price of insurance); Patterson, *Essentials of Insurance Law*, 151-52 (2d ed. 1957) (stating "subrogation is a windfall to the insurer." "It plays no part in the rate schedules (or only a minor one.")).
[156] Edeus, *supra* note 155, at 515.
[157] *Id.*
[158] *Id.*
[159] *Id.*
[160] *Id.*
[161] *Id.*
[162] FMC Corp. v. Holliday, 498 U.S. 52, 61 (1990).
[163] Harris v. Harvard Pilgrim Health Care, Inc., 208 F.3d 274, 280.
[164] *Id.* at 276.
[165] *Id.*
[166] *Id.*
[167] *Id.*
[168] *Id.* at 280.
[169] *Id.* at 276.
[170] *Id.*
[171] *Id.*
[172] *Id.*
[173] *Id.* at 280.
[174] *Id.*
[175] *Id.* (stating, "ERISA creates . . . the . . . presumption . . . [that] unqualified plan provisions need not explicitly rule out every possible contingency in order to be deemed unambiguous." "ERISA merely requires that covered plans be 'sufficiently accurate and comprehensive to reasonably apprise [the] [average plan] participants and beneficiaries of their rights ...under the plan.'"). (quoting Walker v Hormel Foods Corp., 120 F.3d 138 (8th Cir. 1997) (quoting 29 U.SC. § 1022 (a)(1) (2009)).
[176] Harris v. Harvard Pilgrim Health Care, Inc., 208 F.3d 274, 280. *See also* In re Paris, No. 99-1158, 2000 WL 33999984, at *2 (4th Cir. April 17, 2000) (stating that "[T]he made whole doctrine as a default fault would frustrate the purposes of ERISA by requiring plan drafters to inject legalese into plans rather than use clear, ordinary language explaining the plan's provisions." "Laypersons generally would not understand a reference to the make-whole doctrine.").

[177] Paris, 2000 WL 33999984, at *2.
[178] *Id.* at 1.
[179] *Id.*
[180] *Id.*
[181] *Id.*
[182] *Id.*
[183] *Id.* at 2.
[184] *Id.*
[185] *Id.*
[186] Firestone Tire and Rubber Co. v. Bruch 489 U.S. 101,102 (1989) (stating that the "Principles of the law of trusts-which must guide the present determination under ERISA's language and legislative history and this Court's decisions interpreting the statute-establish that a denial of benefits challenged under [ERISA] must be reviewed under a *de novo* standard unless the benefit plan expressly gives the plan administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the plan's terms, in which cases a deferential standard of review is appropriate.").
[187] *Id.* at 102 (agreeing that *contra proferentum* is not preempted by ERISA). *See also* Delia M. Druley, Note, *South Dakota State Medical Holding Company, Inc v. Hoffer: A Differential Standard of Review* 54 S.D. L. Rev. 266, 298-99 (2009); Mark Trayhnor, *Kunin v. Benefit Trust Life Insurance Co.: Protecting Employees Under ERISA by Construing Ambiguous Plan Terms Against the Insurer*, 77 Minn. L. Rev. 1219, 1237 (1993) (stating that ERISA does not preempt the doctrine of *contra proferentum*). *But see* Kunin v. Benefit Trust Life Ins. Co., 910 F.2d 534, 539 (9th Cir. 1990). (acknowledging "There is room for disagreement as to whether a uniform federal rule of construction applies when we construe an ambiguous provision in an ERISA insurance contract or whether the applicable state rule of construction is incorporated into federal law for that purpose.").
[188] *See* Black's Law Dictionary 377 (9th ed. 2009) (defining *Contra proferentum* as: "The doctrine that, in interpreting documents, ambiguities are to be construed unfavorably to the drafter."). *See also* Kunin v. Benefit Trust Life Ins. Co., 910 F.2d 534 at 539 (stating, "Th[e]rule of *contra proferentem* has been called 'the most familiar expression in the reports of insurance cases.'") (quoting 2 G. Couch, R. Anderson, and M. Rhodes, Couch on Insurance 2d, § 15:74, at 334 n. 6 (rev. ed. 1984)).
[189] Kunin v. Benefit Trust Life Ins. Co., 910 F.2d 534 at 539.
[190] *Id.*
[191] *Id.*
[192] *Id.*
[193] *Id.*
[194] 9 Empl. Rts. & Employ. Pol'y J. 247 (citing H.R. Rep. No. 95-533, at 9 (1974), reprinted in 1974 U.S.C.C.A.N. 4639, 4647).
[195] *Id.*
[196] *See* Mark Trayhnor, *Kunin v. Benefit Trust Life Insurance Co.: Protecting Employees Under ERISA by Construing Ambiguous Plan Terms Against the Insurer*, 77 Minn. L. Rev. 1219, 1237 (1993).
[197] Copeland Oaks v. Haupt 209 F.3d 811, 812.
[198] *Id.*

[199] *Id.*
[200] *Id.* at 813.
[201] *Id.* at 814.
[202] *Id.*
[203] *Id.*
[204] *Id.*
[205] *Id.* at 813 (stating, "We now hold that the 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.").
[206] *Id.*
[207] *Id.*
[208] *Id.*
[209] *Id.*
[210] *Id.*
[211] *Id.* at 814 (stating that the $100,000 awarded to Brooke was not subject to the plan's subrogation provision because it was not designated as payment for medical expenses).
[212] *Id.*
[213] Sereboff v. Mid Atlantic Med. Servs., Inc., 547 U.S. at 362.
[214] *Id.* at 362. *See also* Copeland Oaks v. Haupt 209 F.3d 811, 814 (stating that the because the language in Copeland Oak's Plan did not establish a right to over any partial recovery, the $100,000 which represented partial compensation was subject to the made whole doctrine).
[215] *See* Copeland Oaks v. Haupt 209 F.3d 811, 814.
[216] Sereboff v. Mid Atlantic Med. Servs., Inc., 547 U.S. at 364 (stating that once the funds were identifiable a constructive trust or equitable lien could be imposed).
[217] Copeland Oaks v. Haupt 209 F.3d 811, 813.
[218] *Id.*
[219] *See* Great West Life & Annuity Ins. Co. v. Knudson, 534 U.S. at 213-14 (stating "[W]here "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]."). (quoting Restatement of Restitution § 213, Comment a, pp. 867 (1936). *See also* Robert C. Sheres, Note and Comment, *Setting the Stage for Creative Lawyering in ERISA Reimbursement Actions*, 31 Nova L. Rev. 187, 202 (2006) (stating that "Beneficiar[ies] [may be] able to avoid enforcement of an ERISA reimbursement provision by simply allocating third party settlement funds so that the insurer could not satisfy the *possession theory* requirements.").
[220] Sereboff v. Mid Atlantic Med. Servs., Inc., 547 U.S. at 363.
[221] *Id.*
[222] Sheres, *supra* note 215, at 202-03.
[223] Great West Life & Annuity Ins. Co. v. Knudson, 534 U.S. 204 at 213-14.
[224] *Id.*
[225] Leipzig v. AIG Life Ins. Co., 362 F.3d 406 (7th Cir. 2004).