

Ninth Circuit Lets Plan Recoup Dissipated Tort Settlement from Future Medical Benefit Payments

By J. Stewart Borrow*

In 2016, sponsors of welfare plans authorizing subrogation of participant recoveries of third-party liabilities were surprised by the United States Supreme Court's opinion in *Montanile v Bd. Of Trs. of Nat'l Elev. Indus. Health Benefit Plan*, 577 U.S. 136 (2016) ("*Montanile*"). In *Montanile*, the Court denied the plan's imposition of an equitable lien on a participant's general assets after he dissipated the proceeds of his tort settlement. However, a recent decision from the Ninth Circuit appears to present a possible end-run around *Montanile*.

After reviewing this case and the plan's recoupment clause, this article will examine the potential application of recouping overpayments to other contexts which could facilitate plan administration. A discussion of some of the practical challenges likely to be encountered by plans implementing this remedy will follow, including the logistical difficulty of coordinating the plan's terms with the administrative practices of the plan's third-party contractors, such as contract administrators. This article will conclude with a review of some of the policy considerations that plan sponsors should take into account in designing a recoupment provision so as to ameliorate the potentially harsh impact of such clauses.

On July 25, 2022, the United States Court of Appeals for the Ninth Circuit issued its opinion in *Mull v. Motion Picture Industry Health Plan*, 41 F. 4th 1120 (9th Cir. 2022). In *Mull*, the Court held that a multiemployer welfare plan could offset prospective medical benefit payments to recoup up to the amount of a dissipated tort settlement recovered by a participant or dependent. This case, if followed by other circuits, has substantial implications, not only for plans which were too late to enforce their equitable liens, but also, possibly, in other contexts.

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NINTH CIRCUIT LETS PLAN RECOUP DISSIPATED TORT
SETTLEMENT FROM FUTURE MEDICAL BENEFIT PAYMENTS

I. *Mull v. Motion Picture Industry Health Plan*

A. Factual Background

Norman Mull (“Norman” or “Mull”) worked as a wrangler in the motion picture industry for more than twenty years. As a result of his employment and membership in the Teamsters Union, he was eligible to receive healthcare benefits under and was a participant in the Motion Picture Industry Health Plan (“Plan”). In addition, Norman’s wife and two daughters were enrolled as dependents in the Plan.

In February, 2010, Mull’s older daughter, Lenai (“Lenai”), sustained serious injuries after the driver of the car in which she rode as a passenger lost control and drove off a 20-foot embankment. Consequently, Lenai required multiple surgeries. The Plan sent Norman a letter informing him that it had received a claim for treatment of Lenai’s injuries which seemed to have been caused by a third party. The Plan refused to pay any benefits to cover Lenai’s treatment unless Norman signed certain documents with respect to any third-party recovery. The letter also advised Norman to take the time needed to review that portion of the Plan’s summary plan description (“SPD”) dealing with third party liability. To ensure the payment of benefits, Norman had to complete a Third Party Liability Statement. Both Norman and Lenai signed and returned the statement in April, 2010. By doing so, Norman acknowledged that he was responsible for reimbursing the Plan if Lenai recovered money from a third party. The Plan paid nearly \$148,000 in benefits to cover the cost of treating Lenai’s injuries. The following April, Lenai obtained a settlement for \$100,000 from the driver’s insurer. The entire settlement proceeds were paid directly to Lenai, who was then an adult.

The Plan contained two provisions of relevance to this case. The first, which the Court referred to as the Reimbursement Clause, stated that if a participant or dependent suffers an injury caused by a third party, the Plan will pay benefits only if the participant agrees to reimburse it from any amount that the participant or dependent ultimately recovers from the responsible third party. As part of this Reimbursement Clause, the Plan would pay benefits related to the injury only if the participant executes a lien in favor of the Plan for the amount of any potential third-party recovery. The Plan’s SPD also required that any amount recovered be kept separate from other funds and be held in trust until transferred to the Plan. If the recovery

NINTH CIRCUIT LETS PLAN RECOUP DISSIPATED TORT
SETTLEMENT FROM PROSPECTIVE MEDICAL BENEFIT PAYMENTS

was received by a dependent, the SPD provided that the obligation to reimburse the Plan remains the participant's ultimate liability.

The Court referred to the second Plan provision as the Recoupment Clause. It established a self-help remedy that the Plan could use if the participant or dependent failed to comply with the Reimbursement Clause. Under the Recoupment Clause, if the participant or dependent fails to reimburse the Plan from the amount recovered, the amount of future benefit payments that the Plan otherwise would have paid to the participant or the medical provider for treating an illness or injury would be deducted from such benefit payments until the overpayment was completely recovered by the Plan. Until then, the participant and any eligible dependent would continue to owe the Plan the amount recovered, as reduced by the total amount of the recouped benefit payments.

Applying the Reimbursement Clause, the Plan requested that Lenai reimburse it for up to the full amount of benefit payments she had received. The Plan also informed Lenai that if she failed to respond within 30 days, it would begin to deduct the un-reimbursed amount in accordance with the Recoupment Clause. Lenai refused to pay the full amount demanded by the Plan. Instead, she made a counter-offer to repay a substantially lower amount, which the Plan rejected. Accordingly, the Plan triggered the Recoupment Clause. As the Plan received claims for the Mulls, it would verify the claimant's eligibility and process the claim. However, it applied its share of covered expenses as a credit against Norman's reimbursement obligation instead of making claims payments to the claimant's service provider. Lenai's counsel submitted an appeal to the Plan's benefits appeals committee, which denied the appeal. As a result, the Plan continued to apply its recoupment procedure.

B. Procedural History

The Mulls then sued the Plan and its Board of Directors,¹ asserting the following claims for relief: (1) a request for injunctive relief under ERISA § 502(a)(3); and (2) a claim for withheld benefits under ERISA § 502(a)(1)(B). After the Plan filed its answer, the Supreme Court decided *U.S. Airways, Inc. v. McCutcheon*, 569 U.S. 88 (2013) ("*US Airways*"), which held that when an ERISA plan administrator sues a beneficiary under ERISA § 502(a)(3) to

¹ The plaintiffs included the entire Mull family. Lenai Mull remained Norman's dependent under the Plan until she obtained health coverage through her employer in 2015.

NINTH CIRCUIT LETS PLAN RECOUP DISSIPATED TORT
SETTLEMENT FROM PROSPECTIVE MEDICAL BENEFIT PAYMENTS

enforce a reimbursement provision, the terms of the Plan control. Therefore, a beneficiary cannot invoke certain equitable defenses to override the plan's terms. In light of *U.S. Airways*, the Plan sought leave to amend its answer to assert a counterclaim against Norman and Lenai, which the district court granted. In its counterclaim, the Plan sought to impose a constructive trust and/or equitable lien upon the proceeds of Lenai's third-party recovery. Lenai then filed for Chapter 7 bankruptcy, which automatically stayed the Plan's counterclaim. The bankruptcy court issued a discharge to Lenai.

The district court granted judgment for Lenai against the Plan on its counterclaim. Concurrently, the district court granted Norman's motion to dismiss the Plan's counterclaim against him. The court then granted the Mulls' motion for summary judgment on the complaint, reasoning that the SPD did not constitute a formal part of the Plan. Therefore, the Court found that any provisions in the SPD, specifically, the Reimbursement Clause and the Recoupment Clause, were unenforceable.

The Plan appealed the district court's final judgment to the Ninth Circuit which vacated and remanded the matter to the district court. *Mull v. Motion Picture Industry Health Plan*, 865 F. 3d 1207, 1210 (9th Cir. 2017). The Ninth Circuit concluded that "by clear design reflected in the provisions" *Id.* at 1210, of both the trust agreement and the SPD, "the two documents together constitute 'an employee benefit plan under ERISA.'" *Id.*

On remand, the district court initially granted summary judgment for the Plan, concluding that because the SPD constitutes a Plan document with enforceable terms, the Mulls were "effectively seeking benefits to which they were not entitled under the terms of the [P]lan." However, eight months after reaching its decision, the district court came to the completely opposite conclusion and vacated its prior judgment, by granting summary judgment for the Mulls. The district court reached the following conclusions on the ERISA issues: (1) because the Plan could not prevail in an action for equitable relief under ERISA § 502(a)(3), it may not use a self-help measure to recoup overpaid benefits; (2) the recoupment clause constituted an extra-judicial remedy in violation of ERISA's exclusive civil enforcement scheme; and (3) the Recoupment Clause runs afoul of equitable principles by imposing obligations on family members who recovered nothing and cannot repay the recovery to the Plan. The Plan then appealed the district court's grant of the Mulls' motion for summary judgment.

C. The Ninth Circuit Decision

The Ninth Circuit found that (1) the equitable defenses of illegality, impossibility of performance and unconscionability could not defeat the Plan's enforcement of its Recoupment Clause; (2) because the Plan was a defendant in an action to prevent enforcement of its Recoupment Clause and not a plaintiff seeking to enforce it under ERISA § 502(a)(3), the subrogation line of cases, such as *Great-West Life & Annuity Insurance Co. v. Knudson*, 534 U.S. 204 (2002), and its progeny, were inapposite; and (3) since a plan may bargain for a self-help remedy in enforcing its terms, the Plan's application of its Recoupment Clause did not violate ERISA's exclusive civil enforcement scheme.

With respect to illegality, impossibility of performance and unconscionability, which the Mulls asserted as defenses to the Plan's counterclaim, the Court held that these were the types of equitable defenses that the Supreme Court in *U.S. Airways* held were incapable of overriding the Plan's terms. As to the *Great-West* line of cases, the court noted that they "do not limit, or even address, the types of self-help measures that may appear in an ERISA plan." *Mull*, 41 F. 4th at 1135. The Ninth Circuit also rejected the district court's conclusion that the Plan's Recoupment Clause violated ERISA's exclusive civil enforcement scheme by noting that (a) the case law relied upon by the Mulls "did not address, let alone limit, a plan's ability to bargain for self-help measures that may be used without bringing a legal action," *Id.* at 1136, and (b) the Mulls' argument that ERISA § 502(a) was intended to be exclusive could not be reconciled with the fact that "numerous courts ... have upheld self-help remedies similar to the one in this case." *Id.* at 1137. The Court determined that "plan fiduciaries may bargain for and implement self-help remedies that do not require judicial enforcement." *Id.* at 1138. Therefore, it reversed and remanded the case with directions to the district court to enter an order granting the Plan's motion for summary judgment.

II. Considerations for Plan Sponsors Who Contemplate Adding Recoupment Clauses.

A. Application to Other Plan Overpayment Situations.

In addition to its application to the subrogation context, as in *Mull*, there are a number of other situations in which a welfare plan could overpay benefits,² under circumstances in which recouping the overpayment is both administratively and economically feasible for the plan. The following are examples of a few areas in which a welfare plan might consider applying a recoupment provision:

- Under a long-term disability plan under which benefits are subject to offset by the amount of Social Security disability benefits received by the participant, especially when the participant is retroactively awarded such disability benefit payments;
- Under a group health plan when it is determined that the participant has been covering an individual who is determined, after a dependent verification audit, to no longer qualify as the participant's dependent.
- When a group health plan pays a claim which it later determines was overpaid based on the application of the plan's coordination of benefits provisions.

The Court in *Mull* cited a number of cases in which the recoupment of overpaid long-term disability benefits was permitted in situations in which there was a retroactive award of Social Security disability benefits to the participant. In *Stuart v. Metropolitan Life Insurance Company*, 664 F. Supp. 619 (D. Me 1987), *aff'd.*, 849 F. 2d 1534 (1st Cir. 1988), participants who were determined, under the employer's long-term disability plan, to be eligible for disability benefits were required to sign an agreement in which they promised to reimburse the long-term disability plan if they were awarded retroactive Social Security disability benefits. The agreement also contained language which authorized the plan to enforce its right to reimbursement by offsetting or reducing future long-term disability benefit payments. After the participants failed to repay the plan, the plan began to withhold their long-term disability benefit

² As applied to a group health plan, it is assumed, for purposes of Part II of this article, that the plan is a self-funded plan and is not an insured plan. If the plan is partially insured, it is assumed that this Part II applies solely to the self-funded portion of such plan. If the plan is insured, state law insurance mandates would be exempt from ERISA preemption, including any state statutes prohibiting or limiting subrogation. However, as applied to long-term disability plans, it is assumed that this Part II applies equally to insured and self-funded plans.

NINTH CIRCUIT LETS PLAN RECOUP DISSIPATED TORT
SETTLEMENT FROM PROSPECTIVE MEDICAL BENEFIT PAYMENTS

payments. A participant sued the plan to recover the withheld benefit payments. The Court determined that the recoupment provision was part of the “plain and unambiguous language of the plan,” *Id.* at 623-24, *quoted in Mull, supra*, at 1137, and upheld it, granting the plan’s summary judgment motion. Other cases similarly allowing the plan to enforce a recoupment provision include *Madden v. ITT Long-Term Disability Plan for Salaried Employees*, 914 F. 2d 1279 (9th Cir. 1990), *White v. Coca Cola Co.*, 514 F. Supp. 1353 (N.D. Ga. 2007), *aff’d*, 542 F. 3d 848 (11th Cir. 2008), *Nesom v. Brown & Root, U.S.A., Inc.*, 987 F. 2d 1188 (5th Cir. 1993) (applying reduction of long-term disability benefits after recipient obtained a retroactive worker’s compensation award), *Northcutt v. General Motors Hourly-Rate Employees Pension Plan*, 467 F. 3d 1031 (7th Cir. 2006).

With respect to dependent verification audits, under the Affordable Care Act, it is clear that a group health plan generally cannot retroactively revoke the medical coverage of an individual who is determined not to qualify as an eligible dependent, unless there was fraud or an intentional misrepresentation of material fact in enrolling (or continuing the enrollment of) such individual under the plan.³ Therefore, as applied to an individual who is determined by the audit not to qualify as an eligible dependent, in the absence of fraud or such intentional misrepresentation, such individual’s medical coverage could only be revoked prospectively, with a prospective adjustment to the employee’s salary reduction contributions to reflect the removal of such individual as a dependent. Otherwise, there is scant guidance from the case law and regulatory agencies regulating and enforcing welfare plans on the permissible range and scope of remedies for recovering benefits paid to persons who were determined not to qualify as the participant’s dependents as a result of the audit.⁴

³ In cases where retroactive revocation of coverage is permitted with respect to a group health plan, the plan would also have to provide at least thirty days’ advance notice to the ineligible individual of its intent to do so. *Public Health Service Act* § 2712 (42 U.S.C. § 300gg-12 (incorporated by reference into *Internal Revenue Code* § 9815 and *ERISA* § 715); *Affordable Care Act Implementation FAQs* (“FAQs”), Q&A-7. Treasury Regulation § 54.9815-2712(a)(1); 29 C.F.R. § 2590.715-2712(a)(1). However, in cases where other health-related plans, such as certain dental or vision plans, constitute stand-alone plans, to which the Affordable Care Act does not apply, such coverages can be retroactively revoked. Moreover, if a group health plan does not cover a former spouse, except to the extent such individual elects COBRA continuation coverage, and the plan is not notified of the participant’s divorce, the termination of the former spouse’s medical coverage retroactive to the date of the divorce does not constitute a prohibited rescission. *FAQs* Q&A-7.

⁴ Given the lack of clear guidance of the permissible range and scope of remedies available to the plan, on a self-help basis or otherwise, to deal with the coverage of an ineligible individual as a dependent, any discussion of these topics is beyond the scope of this article.

NINTH CIRCUIT LETS PLAN RECOUP DISSIPATED TORT
SETTLEMENT FROM PROSPECTIVE MEDICAL BENEFIT PAYMENTS

Although this article discusses three possible applications of a recoupment provision outside of the subrogation context, there are likely a number of other possible areas in welfare plan administration to which a recoupment provision could be practically and economically applied.

**B. Practical and Logistical Implications of Operating a Welfare Plan
with a Recoupment Provision.**

If a plan is amended to adopt a recoupment provision, there are a number of practical and logistical hurdles that need to be considered before the plan's operation could be considered to be in accordance with the plan's terms. The following are among the many tasks that need to be coordinated by the plan administrator and third parties retained to provide services to the plan to enable a recoupment provision to be implemented operationally:

- Many self-funded group health plans retain a contract administrator to adjudicate benefit claims and pay benefits as reimbursements to medical care providers for health plan costs incurred by participants or dependents. Usually, such contract administrators are also providers of health insurance contracts to employers, groups and/or individuals and/or providers of stop-loss insurance to self-funded plans. When the contract administrator adjudicates benefit claims after the plan's deductible is satisfied, in accordance with the plan's typical operations and terms, the plan will make payments to the participant's or dependent's medical care provider for the portion of the cost payable under the plan⁵. If the plan has a recoupment provision which is triggered due to a third-party liability which occurs when the claimant receives cash proceeds from a judgment or settlement obtained against the third party, and s/he fails to comply with the plan's reimbursement provision, the plan administrator will need to do the following:
 - Notify the claimant that it believes that s/he has received the proceeds of a judgment or settlement from the third party. The plan could condition the payment of benefits upon the claimant's execution of an agreement consenting to the imposition of an equitable lien in favor of the plan with respect to the recovery

⁵ By the plan's "typical operations," it is assumed either that (a) the plan does not have a recoupment provision, (b) the reimbursement/recoupment provisions of the plan are not triggered in the typical case because there is no third-party liability or (c) the reimbursement/recoupment provisions of the plan are not triggered because the claimant does not bring suit against the third party at fault for causing the claimant's injuries.

NINTH CIRCUIT LETS PLAN RECOUP DISSIPATED TORT
SETTLEMENT FROM PROSPECTIVE MEDICAL BENEFIT PAYMENTS

of a third-party tort liability and to reimburse the plan. If the claimant fails to turn over the proceeds to the plan within a specified number of days, as required under the plan's reimbursement provision, it will invoke the plan's recoupment provision, with the result that no benefits under the plan will be payable to the participant or any of its medical providers until either the full amount owed to the plan or the amount recovered from the third party is repaid.

- Notify the contract administrator and closely coordinate with it the handling of benefit claims so that the contract administrator does *not* make payment to the provider or the participant;
- If the plan has a recoupment provision, verify that the contract administrator credits the amounts received to the plan. In this scenario, the contract administrator will need to maintain accounts reflecting the amount that the participant owes the plan under its reimbursement clause, from which the sum of the amounts recouped in prospective claims is deducted, until the remaining amount owed is reduced to zero.
- As applied to a high-deductible health plan, however, the recoupment provision should most likely not be applied to medical costs incurred prior to the participant's satisfaction of the plan's individual and/or family annual deductible. Thus, any benefits not payable by the plan prior to satisfying such deductible should not be credited against the amount owed by the participant to the plan pursuant to the plan's reimbursement provision.

**C. Policy Reasons for Limiting the Application and
Scope of Plan Recoupment Provisions.**

If a welfare plan sponsor is contemplating a plan amendment which will add a recoupment provision with respect to prospective benefit payments, the following are some of the reasons why it may want to limit the scope and application of such a provision:

- In the subrogation context, where it is likely that the plan has expended significant amounts of money (which could very likely exceed one hundred thousand dollars) to reimburse the claimant for injuries sustained in an automobile accident, the application of a recoupment provision to enforce the subrogation provision could effectively deprive the participant and his/her dependents of medical coverage for an extended period of time, possibly exceeding one or more years. In this context,

NINTH CIRCUIT LETS PLAN RECOUP DISSIPATED TORT
SETTLEMENT FROM PROSPECTIVE MEDICAL BENEFIT PAYMENTS

especially as applied to lower-paid employees, it might be advisable to limit the recoupment to a specified percentage of each benefit payment in order to ameliorate the harsh impact of the recoupment upon such participants and their dependents;

- Even if the percentage of participants who are subject to the plan's subrogation provisions is relatively small, if the recoupment provision is applied to reduce or eliminate any payment to the participant's medical providers, there is a risk that the affected medical providers will treat the participant as if s/he is not covered by medical insurance and either demand payment at the point of service or charge a higher fee to cover the costs of possible collection.⁶

III. Conclusion

Although *Mull* appears to provide an optimal solution for a self-help remedy for welfare plan sponsors with respect to the recovery of benefit overpayments, there are several practical and logistical considerations that should be taken into account by welfare plan sponsors before adding a recoupment provision to their plans. More importantly, for those plans that are administered outside of the Ninth Circuit, it is not completely clear to what extent recoupment provisions will be accepted as valid by other Circuits at the Court of Appeals level. In short, a recoupment clause is not a plan's panacea to all problems encountered in recovering from tort settlement proceeds from injured participants and/or dependents in subrogation. Nor do recoupment clauses constitute the ultimate solution in recovering benefit overpayments in other facets of welfare plan administration.

Until they are more widely accepted by other circuits, plan sponsors, except for those administering their plans within the Ninth Circuit, would be wise to exercise caution and contract with proactive subrogation vendors who will reach out to participants and/or dependents who are making claims for injuries similar to those incurred in motor vehicle accidents. Once recoupment clauses become more widely accepted, it would be advisable to continue retaining these proactive contractors and resort to recoupment as a possible second line of defense for the plan.

⁶ In addition to those items referenced above, plan sponsors should also consider whether recoupment provisions are suitable in their application to the sponsor's workforce.

NINTH CIRCUIT LETS PLAN RECOUP DISSIPATED TORT
SETTLEMENT FROM PROSPECTIVE MEDICAL BENEFIT PAYMENTS

If you have any questions about *Mull*, recoupment clauses and their application to welfare plan administration or you are considering the design and adoption of a recoupment provision for your plan, please do not hesitate to reach out to me for assistance.

To the extent that this article can be construed as attorney advertising, the author asserts that no portion of this article has been reviewed or approved by the Supreme Court of New Jersey.