

**ERISA Subrogation/Reimbursement/Offsets:  
Unraveling the Mystery**

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We, as attorneys who represent injured people, are now obliged to delve into third party claimant demands against our clients' recoveries whether the recovery is the proceeds of settlement or verdict from a third party tortfeasor or from workers compensation payments. We must determine which ones are valid, which ones rise to the level of perfected liens, and which ones, although not a perfected lien, have consequences down the road to the client. Sorting out the various third party claimants' rights requires due diligence. Due diligence means the attorney must first determine who has a perfected lien and who doesn't. The results of our due diligence must then be shared with our client. In many instances the client has the final say-so as to final disposition of the proceeds..

Due diligence brings us to the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. § 1001, et seq., as it relates to claims by self-funded health plans for reimbursement or subrogation out of the proceeds recovered by injured plaintiffs from third parties or offsets against workers compensation payments.. This article cannot address all the complex and troubling aspects of ERISA, but it will attempt to give a "heads-up" to those who must attempt to decipher this sometimes cryptic Act.

Because many of us represent injured parties against third party tortfeasors this presentation will first examine ERISA plan claims for subrogation or reimbursement to the proceeds of settlement or verdict. This initial examination will illustrate the nature of ERISA plan claims and the broad scope of ERISA and the wide ranging authority of ERISA health plans to seek such subrogation or reimbursement. A portion of this presentation will focus on ERISA as it relates to claims by both ERISA self funded health insurance plans and non-health insurance ERISA plans against workers compensation payments. The non-health insurance plans usually asserting claims against workers compensation proceeds are short and long term disability policies.

**I. INTRODUCTION**

ERISA is a comprehensive statute that regulates retirement and other welfare benefit plans provided by an employer<sup>1</sup> - excluding church<sup>2</sup> and governmental<sup>3</sup> employers which are not subject to ERISA's provisions. ERISA specifically excludes preemption of state worker compensation laws.<sup>4</sup> The statute contemplates the development of federal law by the federal courts.<sup>5</sup>

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<sup>1</sup> 29 U.S.C. § 1002(1).

<sup>2</sup> 29 U.S.C. § 1321(b)(2).

<sup>3</sup> 29 U.S.C. § 1321(b)(1).

<sup>4</sup> 29 U.S.C. § 1321(b)(3).

Unfortunately uniformity has not been achieved, and we now have a patchwork of rulings by the federal circuits with the Supreme Court from time-to-time settling some of the differences.

To complicate the practitioner's work one cannot be satisfied with just knowing your federal circuit ERISA cases, as venue in an action brought by an ERISA plan is not dependent upon where the underlying injury occurred.<sup>6</sup> ERISA actions are in the exclusive jurisdiction of federal courts<sup>7</sup> and venue is where the plan is administered, where the breach took place, or where the defendant resides or may be found.<sup>8</sup> Thus if a plan is administered in Illinois and the injured beneficiary resides in North Carolina the plan has the choice of filing a lawsuit in federal court in Illinois or in North Carolina.

## **II. HISTORICAL BACKGROUND FOR ENACTMENT OF ERISA**

Because of the many pension funds that had irregularities or went broke prior to 1974 Congress passed legislation which intended to standardize and control corporate pension plans. In the process of negotiating enabling legislation, which later became known as ERISA, business interests extracted concessions which, in effect, allowed them to set up employee welfare plans free of the legal restraints imposed on traditional health insurance policies enacted by the various states. The federal courts were charged with fashioning federal common law combining the enabling statute with the rulings of pertinent departments and agencies of the federal government such as the Department of Labor.

## **III. CLAIMS OF ERISA HEALTH INSURANCE PLANS TO PERSONAL INJURY RECOVERIES**

As a result of the enactment of ERISA, and development of federal common law mandated by ERISA, most of the rights of insureds previously recognized against traditional insurance companies are nullified. The evolution of ERISA, and federal common law interpreting ERISA, now control or impact upon practically all employee benefit plans, including employer-sponsored health insurance plans. Lawsuits for "bad faith" and punitive damages are preempted by ERISA and, not surprisingly, abolished. In most cases the insured employee is limited to suing the plan on the ground of "abuse of discretion." The most that an aggrieved plan participant can usually recover in a lawsuit is the amount of benefits due, interest, costs and a discretionary award of attorney fees.

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<sup>5</sup> *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 107 S.Ct. 2211 (1987).

<sup>6</sup> ERISA provides that where an action is brought in federal court, "it may be brought in the district where the plan is administered, where the breach took place[,] or where a defendant resides or may be found, and process may be served in any other district court where a defendant resides or may be found." 29 U.S.C. § 1132(e)(2). This provision, which provides for nationwide service of process, "has been interpreted for purposes of personal jurisdiction as a national contacts test." *Strategic Outsourcing, Inc. v. Commerce Benefits Group Agency, Inc.*, 54 F.Supp.2d 566, 570 (W.D.N.C.1999).

<sup>7</sup> 29 U.S.C. § 1132(e)1

<sup>8</sup> 29 U.S.C. § 1132(e)2

#### **IV. STATUS OF EMPLOYEE WELFARE BENEFIT PLANS PRIOR TO ERISA**

Those employers who provided health insurance benefits did so mostly through traditional insurance carriers. Self-funding of welfare benefits by employers was limited, the notable exception being the early HMO structures such as Kaiser Permanente in California. It was well understood that health care insurance companies and their insuring contracts were regulated by state statutes and state commissioners of insurance.

#### **V. SIGNIFICANCE OF AN ERISA PLAN BEING SELF-FUNDED OR INSURED**

Now every health insurance plan provided by an employer must be analyzed to determine whether or not it is an ERISA governed plan.<sup>9</sup> Most health insurance plans provided by employers are governed by ERISA. Assuming the plan is ERISA governed, the pivotal issue in North Carolina is whether it is a self-funded plan. If the plan is self-funded, the terms of the plan documents control the breadth and width of its reach including the extent, if any, of its claimed right of subrogation or reimbursement.<sup>10</sup>

If the plan is not self-funded but rather fully insured, North Carolina's anti-subrogation prohibition contained in the Administrative Code prevents subrogation in contracts of health insurance policies.<sup>11</sup> There are instances when a fully insured plan contains subrogation language. This occurs most often when the employer is a national or regional company and obtains a single health insurance policy from an out of state health insurance company. In such an instance the subrogation or reimbursement provision probably would not be enforceable in North Carolina.

#### **VI. DETERMINING WHETHER OR NOT A PLAN IS SELF-FUNDED OR INSURED**

Determining whether or not a plan is self-funded is not always easy. To simplify - if the employer purchases an insurance policy and pays a premium and the insurance company assumes all of the risk, then it is an insured plan. But, if the financial risk falls in any way upon the employer (or to a combination of employer and employee funding) then it is a self-funded plan. The purchase of stop-loss or reinsurance coverage does not necessarily convert an otherwise self-funded plan into an insured plan.<sup>12</sup> However, it has been opined that a self-funded ERISA plan may purchase such a large amount of stop-loss insurance that it no longer operates as a self-funded plan but as an insurance company.<sup>13</sup>

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<sup>9</sup> 29 U.S.C. § 1003(a).

<sup>10</sup> *Hampton Industries v. Sparrow*, 981 F.2d 726, 730 (4th Cir. 1992); *McGill Corp. v. Stinnett*, 154 F.3d 168, 172 (4th Cir. 1998).

<sup>11</sup> N.C. Administrative Code T11-C12.0319 entitled SUBROGATION PROHIBITED provides:  
Life or accident and health insurance forms shall not contain a provision allowing subrogation of benefits.

<sup>12</sup> *Thompson v. Talquin Building Products Company*, 928 F.2d 649 (4th Cir.1991); *Am. Med. Sec. Inc. v. Bartlett*, 111 F.3d 358 (4<sup>th</sup> Cir. 1997).

<sup>13</sup> *Bill Gray Enterprises Inc. v. Gourley*, 248 F.3d 206 (3<sup>rd</sup> Cir. 2001); *Mulholland v. UFCW Local 1776*, 2007 WL 2814648 (D.N.J.)

In order to determine whether a plan is self-funded, it is useful to obtain an authorization from the beneficiary to request information from the plan. (APPENDIX). The request for plan documents must be made to the plan administrator.<sup>14</sup> The plan administrator is usually identified in the Summary Plan Description (SPD). Most often, but not always, the plan administrator is the employer. The third party administrator or the subrogation company representing a plan is not a plan administrator within the meaning of ERISA.

The request to the plan administrator must be specific. At a minimum, copies of the following documents should be specifically requested: the plan's three digit identification number, the summary plan descriptions (and amendments) for all relevant years, all contracts or agreements establishing the plan, the declaration pages of all insurance contracts with the plan (including reinsurance and stop-loss coverage), the IRS Form 5500s (and attached schedules) for each relevant year, written policies, memoranda, minutes of meetings and any other written documentation addressing reimbursement or subrogation, enforcement or waiver of the same from the date of establishment of the plan until the present. (APPENDIX).

Failure of the plan administrator to provide the requested information within thirty (30) days exposes the plan to a penalty of \$110.00 per day.<sup>15</sup>

IRS Form 5500 is the Annual Return/Report of Employee Welfare Plan. Part 1 section 9a reflects the plan's funding arrangement as reported by the plan. The indicated funding arrangement in section 9a is not conclusive as to whether or not a plan is self-funded. Quite often, "Insurance" and "Trust" or "General assets of the sponsor" are checked. In such a case the plan is probably self-funded and has purchased stop-loss or reinsurance coverage. (If stop-loss coverage is present, consideration should be given to an argument that the amount of reimbursement to which the plan is entitled is limited to the amount not covered by stop-loss insurance). If only "Insurance" is checked then it would reflect that the plan is probably fully insured and any claim for reimbursement would be controlled by the principles of state law including state anti-subrogation laws preventing the plan from seeking reimbursement. An online source for IRS Form 5500s for most companies can be found at FreeERISA.<sup>16</sup>

## **VII. NO SUBSTITUTE FOR REVIEWING PLAN DOCUMENTS**

In spite of easy access to IRS Form 5500s online there is no substitute for obtaining and studying the plan documents requested from the plan administrator. If the plan has no provision for subrogation or reimbursement, then there is no subrogation or reimbursement. If the plan states that it seeks subrogation or reimbursement from just a liability carrier, then that would be the extent of its recovery. Not surprisingly, most plans seek recovery from all sources including underinsured, uninsured and medical payment sources.

Employee welfare benefit plans frequently change their plan language. Therefore the

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<sup>14</sup> 29 U.S.C. § 1024(b)(4).

<sup>15</sup> 29 U.S.C. § 1132(C)(1)(B); 29 C.F.R. § 2575.502c-1.

<sup>16</sup> Available at <<http://www.freeerisa.com/>>.

practitioner should make sure that she has in hand all the plan documents and amendments for all relevant periods. Especially important are the plan documents in force during the time a plan paid out any benefits to the insured employee.

The importance of reviewing the plan documents and the specific plan language by the legal practitioner cannot be stressed enough as reflected in an Eleventh Circuit case which held a constructive trust may be imposed on identifiable proceeds where the subrogation and reimbursement provision of the plan claimed a lien “on any amount recovered by the [plan beneficiary] whether or not designated as payment for medical expenses...” and “...the [plan beneficiary] must repay to the Plan the benefits paid on his or her behalf out of the recovery made from the third party or insurer” (emphasis added). But in the same case, and with respect to a different plan, the court declined to impose a constructive trust where that plan claimed a right to reimbursement “in full, and in first priority, for any medical expenses paid by the Plan relating to the injury or illness,” but did not specify that the reimbursement be made out of any particular fund, (emphasis added) as distinct from the beneficiary’s general assets.<sup>17</sup> The first plan stated an “identifiable fund” (the recovery made from the third party or insurer) from which reimbursement or subrogation would be sought, whereas, in the second plan the language did not specify the source of the reimbursement fund leaving the court to conclude that the source of repayment was not from an “identifiable fund” but rather from the general assets of the plan beneficiary. In the latter situation the ERISA plan was without a remedy.

## VIII. SELF-FUNDED PLANS HAVE LIMITED REMEDIES

Having established that the plan is a self-funded ERISA plan, and that the language in the plan covers the sources of recovery received by the injured person, the next inquiry is what remedy does the plan have against the injured person or the attorney for the injured person? In part the question was answered in *Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204, 122 S. Ct. 708, 151 L. Ed. 2d 635 (2002). In that case the plan sought reimbursement from the plan beneficiary out of funds already disbursed. The Supreme Court found that only an equitable remedy is available to the plan and held that ERISA plans may not seek reimbursement in an action at law for monetary damages from the client after settlement and disbursement. The Court based its decision on the remedy portion of the statute<sup>18</sup> which the court interpreted as providing that the only remedy available to a plan was an equitable remedy. And that equitable remedy must be against identifiable funds.<sup>19</sup>

In the wake of *Knudson*, ERISA plans often seek the imposition of a constructive trust - an equitable remedy - against specifically identifiable funds from settlement or verdict either in

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<sup>17</sup> *Popowski v. Parrott*, 461 F.3d 1367 (11th Cir. 2006).

<sup>18</sup> 29 U.S.C. § 1132(a)(3). A civil action may be brought by a fiduciary

(A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan.

<sup>19</sup> *Primax Recoveries Inc. v. Carey*, 2002 U.S. Dist. LEXIS 15818, 2002 WL 1968339, (S.D.N.Y. 2002); *Primax Recoveries v. Goss*, 240 F. Supp. 2d 800 (N.D.Ill. 2002); *Mid Atl. Med. Servs. v. Sereboff*, 407 F.3d 212 (4th Cir.2005) *aff'd Sereboff v. Mid-Atlantic Medical Services, Inc.*, 547 U.S. 356, 126 S.Ct. 1869 (2006).

an attorney's trust account, in possession of a court, in an escrow account or otherwise not commingled with client funds.<sup>20</sup>

Prior to the case of *Sereboff v. Mid-Atlantic Medical Services, Inc.* 547 U.S. 356, 126 S.Ct. 1869 (2006) which affirmed *Mid-Atlantic Medical Services, Inc. v. Sereboff*, 407 F.3d 212 (4<sup>th</sup> Cir. 2005) the Federal Circuits were split regarding whether a constructive trust may be imposed against identifiable funds held by a plan beneficiary. The Fourth<sup>21</sup>, Fifth<sup>22</sup>, Seventh<sup>23</sup> and Tenth<sup>24</sup> Circuits had focused solely on the remedy sought and concluded that it was appropriate for plans to seek imposition of a constructive trust on identifiable proceeds because such relief was equitable in nature. On the other hand the Sixth<sup>25</sup> and Ninth<sup>26</sup> Circuits had focused on the basis for the remedy and concluded that because the basis was contractual in nature, there can be no remedy seeking imposition of a constructive trust.

The split in the circuits was at least partially resolved by the Supreme Court in *Sereboff v. Mid-Atlantic Medical Services, Inc.* when it held that the imposition of an equitable constructive trust was appropriate against identifiable funds when it answered the following question in the affirmative:

Can a plan fiduciary bring a civil action against a plan participant to obtain “appropriate equitable relief” under Section 502(a)(3) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1132(a)(3), where a term of the plan requires the participant to reimburse medical expenses advanced by the plan if the participant recovers money from a third-party tortfeasor and possesses such payments in an identifiable fund?

The facts in *Sereboff* are pertinent. Marlene Sereboff and her husband were covered under her employer's self-insured health plan administered by MAMSI when she and her husband were involved in a car wreck in California. The plan had the usual

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<sup>20</sup> *Moore v. Crawford*, 130 U.S. 122, 9 S.Ct. 447, 32 L.Ed. 878 (1889). “Whenever the legal title to property is obtained through means or under circumstances 'which render it unconscientious for the holder of the legal title to retain and enjoy the beneficial interest, equity impresses a constructive trust on the property thus acquired in favor of the one who is truly and equitably entitled to the same, although he may never, perhaps, have had any legal estate therein; and a court of equity has jurisdiction to reach the property, either in the hands of the original wrong-doer, or in the hands of any subsequent holder, until a purchaser of it in good faith and without notice acquires a higher right, and takes the property relieved from the trust.' 2 Pom. Eq. Jur. § 1053”; *Wellmark, Inc. v. Deguara*, 257 F. Supp. 2d 1209 (S.D. Iowa 2003).

<sup>21</sup> *Mid Atl. Med. Servs v. Sereboff*, 407 F.3d 212 (4th Cir.2005) *aff'd Sereboff v. Mid-Atlantic Medical Services, Inc.*, 547 U.S. 356, 126 S.Ct. 1869 (2006)

<sup>22</sup> *Bombardier Aerospace Employee Welfare Benefits Plan v. Ferrer et al.*, 354 F.3d 348 (5th Cir. 2003).

<sup>23</sup> *Admin. Comm. of Wal-Mart Stores, Inc. Assocs.' Health & Welfare Plan v. Varco*, 338 F.3d 680 (7th Cir. 2003).

<sup>24</sup> *Admin. Comm. of Wal-Mart Assocs. Health & Welfare Plan v. Willard*, 393 F.3d 1119 (10<sup>th</sup> Cir. 2004).

<sup>25</sup> *Qualchoice, Inc. v. Rowland*, 367 F.3d 638 (6th Cir. 2004).

<sup>26</sup> *Westaff (USA) Inc. v. Arce*, 298 F.3d 1164 (9th Cir. 2002); but see, *Honolulu Joint Apprenticeship & Training Committee of United Ass'n Local Union No. 675 v. Foster*, 332 F.3d 1234 (9th Cir. 2003), where the court held that the distinction between legal and equitable restitution rests on whether there is an identifiable fund.

subrogation/reimbursement language if there was a recovery for any injuries from any third-party. In particular the plan provided that MAMSI's "...share of the recovery will not be reduced because [the beneficiary] has not received the full damages claimed unless [MAMSI] agrees in writing to a reduction."

The Sereboffs settled their third-party claim for \$750,000. MAMSI claimed \$74,869.37 by way of a claimed lien. The Sereboffs' attorneys disbursed the proceeds to the Sereboffs without paying anything to MAMSI. MAMSI filed suit seeking to collect \$74,869.37 and sought a temporary restraining order and preliminary injunction requiring the Sereboffs to retain and set aside the claimed amount. The parties agreed to preserve the claimed amount in an investment account until the courts decided who was entitled to the account.

The statute in question is:

29 U.S.C. § 1132. Civil enforcement

(a) Persons empowered to bring a civil action  
A civil action may be brought—

(1) by a participant or beneficiary—

(A) for the relief provided for in subsection (c) of this section, or

(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;

(2) by the Secretary, or by a participant, beneficiary or fiduciary for appropriate relief under section 1109 of this title;

(3) by a participant, beneficiary, or fiduciary

(A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or

(B) to obtain other **appropriate equitable** relief

(i) to redress such violations or

(ii) to enforce any provisions of this subchapter or the terms of the plan;

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The Supreme Court, in a unanimous opinion authored by Chief Justice Roberts, held that the relief sought by MAMSI was equitable and therefore based on *Mertens v. Hewitt Associates*, 508 U.S. 248 (1993) and *Great-West v. Knudson*, 534 U.S. 204 (2002) imposition of a constructive trust was appropriate against the identifiable funds in the investment account.

The Supreme Court analyzed *Great-West* and reiterated that the relief Great-West sought

was “not equitable-the imposition of a constructive trust or equitable lien on particular property-but legal-the imposition of personal liability for the benefits that [Great-West] conferred upon [Knudson].” *Great-West v. Knudson*, 534 U.S. 204, 214. Because the funds in Knudson were placed in a “Special Needs Trust” they were not in Knudson’s possession or control. Therefore the funds may have been identifiable but they were not in the Knudson’s possession thus no constructive trust could be imposed.

But, because the Sereboffs agreed to keep the funds in an identifiable account in their control an equitable constructive trust could be imposed upon the account. MAMSI was not seeking recovery from the Sereboffs’ general assets. Not only was MAMSI not seeking a money judgment against the general assets of the Sereboffs, it was seeking restitution only out of the recovery from the third-party. Therefore, MAMSI could rely on a “familiar rule of equity” to collect for the medical bills it had paid on behalf of the Sereboffs.

This rule allowed them [MAMSI] to “follow” a portion of the recovery “into the [Sereboffs’] hands” “as soon as [the settlement fund] was identified,” and impose on that portion a constructive trust or equitable lien.

With respect to the Ninth and Sixth Circuits’ decisions the Supreme Court held:

ERISA provides for equitable remedies *to enforce plan terms*, so the fact that the action involves a breach of contract can hardly be enough to prove relief is not equitable; that would make §502(a)(3)(B)(ii) an empty promise. The Court in *Knudson* did not reject Great-West’s suit out of hand because it alleged a breach of contract and sought money, but because Great-West did not seek to recover a particular fund from the defendant. *Mid Atlantic* does. [underlining added]

The Sereboffs argued that the claim of MAMSI is for equitable subrogation and as such the Sereboffs should “...be able to assert certain equitable defenses such as the defense that subrogation may be pursued only after a victim has been made whole for his injuries.” The Court stated

But *Mid Atlantic*’s claim is not considered equitable because it is a subrogation claim. As explained, *Mid Atlantic*’s action to enforce the “Acts of Third Parties” provision qualifies as an equitable remedy because it is indistinguishable from an action to enforce an equitable lien established by agreement... (A subrogation lien is “not an express lien based on agreement, but instead is an equitable lien impressed on moneys on the ground that they ought to go to the insurer”). *Mid Atlantic* need not characterize its claim as a freestanding action for equitable subrogation. Accordingly, the parcel of equitable defenses the Sereboffs claim accompany any such action are beside the point.”

Of course the equitable defenses the Sereboffs wanted the court to consider included the made-whole doctrine and the common fund doctrine. However in footnote two (2) of the opinion the Court noted

The Sereboffs argue that, even if the relief Mid Atlantic sought was “equitable” under §502(a)(3), it was not “appropriate” under that provision in that it contravened principles like the make-whole doctrine. Neither the District Court nor the Court of Appeals considered the argument that Mid Atlantic’s claim was not “appropriate” apart from the contention that it was not “equitable,” and from our examination of the record it does not appear that the Sereboffs raised this distinct assertion below. We decline to consider it for the first time here. (Citation omitted).

A few observations about the implications of the decision:

- The Sereboff court reiterated that the only relief available to a self-funded ERISA plan is equitable relief. This means that the plan may not claim against the general assets of the injured party in an action at law.
- ERISA plans are “allowed” [but not required] to “follow” a portion of a recovery and impose on that identifiable portion a constructive trust or lien by way of court order.
- Equitable defenses that we used to negotiate reductions in claims such as the made-whole doctrine are not available unless plan language so provides or unless you are not in the Eighth Circuit. [See *Wal-Mart v. Shank* below]
- However, we have some negotiating room with respect to whether a plan’s equitable claim is “appropriate” or not (footnote 2 of the opinion). In other words we can no longer rely on the equities of the situation, only whether the claim is “appropriate” given the circumstances of a particular case. [See *Wal-Mart v. Shank* discussed below]
- The issue of what is an “identifiable fund” will be an evolving issue.
- The issue of what funds are in the possession of the injured party will be an evolving issue. We know from *Knudson* that if a Special Needs Trust is established before the imposition of a constructive trust the corpus of that trust is not in the possession of the defendant and untouchable. If a structured settlement is employed is that annuity in the “possession” of the injured party such that a constructive trust can be imposed on the annuity? Indeed, a recent case held that the identity of who is holding the funds in question is not as important as finding that the funds are intact.<sup>27</sup>

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<sup>27</sup> *Administrative Committee Wal-Mart Stores, Inc. v. Horton*, \_\_\_ F.3d \_\_\_, (11<sup>th</sup> Cir. 2008)

- ERISA plans will be emboldened by the decision.
- The need for high UM and UIM coverage is apparent.
- The need to communicate with the potential client in the first instance is paramount as to the consequences of what might happen to any recovery made.
- Plaintiff attorneys need to evaluate a case to determine the efficacy of even taking the case. Consideration should be given, with the potential client's consent, to contact the ERISA plan first and determine if a negotiated compromise of the claim can be reached before taking on the case.

## **IX. APPROPRIATE EQUITABLE RELIEF AFTER *SEREBOFF***

It didn't take long for the issue of "appropriate equitable relief" to find its way to the Eighth Circuit in the case of *Administrative Committee of the Wal-Mart Stores Inc. v. Shank*, \_\_\_ F.3d \_\_\_ (8<sup>th</sup> Cir. 2007), pet for cert. pending. *Shank* was presented with the question whether "appropriate equitable relief" allowed for consideration of the "made-whole" rule where it was clear that the plaintiff (beneficiary of the plan) was not "made-whole" because of a limited recovery from the third party tortfeasor. The *Shank* court held that the "made-whole" rule is not a rule of federal common law that governs interpretation of a written benefit plan, therefore the terms of the plan entitled the plan to full subrogation, regardless of whether the beneficiary is fully compensated for his injuries. The court's reasoning was as follows:

...the made-whole doctrine originated in the law of insurance where the overriding purpose of an insurance policy is to fully compensate the insured in case of loss, but that many ERISA-regulated benefit plans do not share that purpose. We thus concluded that the make-whole doctrine does not carry over from the insurance context to ERISA...

Among the primary purposes of ERISA is to insure the integrity of written plans and to protect the expectations of participants and beneficiaries. [citation omitted]...

Reimbursement and subrogation provisions are crucial to the financial viability of self-funded ERISA plans, and, as a fiduciary, the Committee must "preserve assets to satisfy future, as well as present, claims, and must "take impartial account of the interests of the beneficiaries." [citations omitted]

(Note: The Shanks also advanced a pro-rata theory that the Committee's right of reimbursement is limited to that portion of the settlement that covers medical expenses as previously held by the Eighth Circuit and affirmed in *Arkansas Department of Health & Human*

*Servics v. Ahlborn*, 126 S. Ct. 1752 (2006). The *Shank* court rejected that argument because *Ahlborn* turned on the application of the federal Medicaid statute which conflicted with the Arkansas scheme for reimbursement)

## **X. ERISA PLANS HAVE A “CLAIM,” NOT A “POSSESSORY” OR “PERFECTED” LIEN UNTIL RELIEF IS SOUGHT IN FEDERAL COURT**

There is a difference between a “lien” as commonly understood and a “perfected” or “possessory lien” as understood in the context of ERISA. Commonly we understand a lien as an enforceable ‘gotcha.’ It is a perfected charge against particular and identifiable funds or property in the hands of the person possessing such funds or property to be charged. Therefore disbursement of such funds is done at the risk of being personally liable for failure to “honor” the lien without comporting with the disposition requirements.

On the other hand we also commonly misuse, or misinterpret, the meaning of a “lien” when we equate the word “lien” with “claim.” Indeed, the Supreme Court in *Great-West v. Knudson* referred to the claim of the ERISA plan as a “lien” but declined to declare that such a “lien” attaches to anything declaring instead that it might be enforced by a court after an equitable remedy, such as a constructive trust, was imposed on such funds. So even the Supreme Court in *Great-West v. Knudson* understood that the “lien” of an ERISA plan is not a lien in the common usage of the term until the ERISA plan takes some further action such as seeking the court’s imposition of a constructive trust, or other equitable remedy, on identifiable and traceable funds in the possession of the beneficiary. The meaning of a “lien” in ERISA is best understood as not being a charge against particular property or funds until the “lien” is “perfected.” And it is “perfected” in the ERISA world through court imposition of an equitable remedy such as a constructive trust. Thus when it becomes “perfected” a lien in the common usage of the term is created but before it is “perfected” it is merely a claim that might arise to the level of a “lien” upon court intervention.

## **XI. LIABILITY OF ATTORNEY TO PLAN AFTER DISBURSEMENT**

Generally there has been no personal liability placed on the attorney for the injured party who has disbursed settlement funds to the injured party.<sup>28</sup> However a plan may pursue settlement funds in the trust account of a plan beneficiary's attorney.<sup>29</sup> In one instance it was held

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<sup>28</sup> *Hotel Employees & Restaurant Employees International Union Welfare Fund v. Gentner*, 50 F.3d 719, 720-22 (9<sup>th</sup> Cir.1995); *Chapman v. Klemick*, 3 F.3d 1508 (11th Cir.1993), cert. den., 510 U.S. 1165 (1994); *Health Cost Controls of Illinois, Inc. v. Washington*, 187 F.3d 703, 709 (7th Cir. 1999), cert. denied, 528 U.S. 1136 (2000); *Southern Council of Industrial Workers v. Ford*, 83 F.3d 966 (8th Cir. 1996); *Md. Elec. Indus. Health Fund v. Levitt*, 155 F. Supp. 2d 482 (DMd 2001); *Mid Atl. Med. Servs., Inc. v. Do*, 294 F. Supp. 2d 695 (D. Md. 2003); *Great-West Life & Annuity Ins. Co. v. Bullock*, 202 F. Supp. 2d 461 (E.D.N.C. 2002).

<sup>29</sup> *Bombardier Aerospace Employee Welfare Benefits Plan v. Ferrer et al.*, 354 F.3d 348 (5th Cir. 2003)(section 1132(a)(3) authorizes a cause of action against an attorney who holds disputed settlement funds on behalf of a participant in an ERISA plan); *IBEW-NECA Southwestern Health & Benefit Fund v. Douthitt*, 211 F. Supp. 2d 812, 816 (N.D. Tex. 2002)(finding that the settlement funds at issue, which were being held in the attorney's trust account for the plan beneficiary, were within the plan beneficiary's possession and control).

(without reaching the merits of the case) that a plan stated a cause of action against a law firm that distributed all the funds to the client for conversion of the portion of the settlement proceeds to which the plan had a first lien.<sup>30</sup>

It has also been stated in a district court case that personal liability might be imposed on the injured party's attorney where the attorney acted in bad faith and breached some unspecified equitable duty owed to the plan, but, in the absence of such a duty, the attorney is free to choose distribution options that appear to favor the client.<sup>31</sup>

It has been held that it is not an abuse of discretion for a plan to withhold payment of claims prior to a plan's requirement that the beneficiary sign and return the plan's reimbursement and subrogation agreement.<sup>32</sup> It has even been held that it is not an abuse of discretion for the plan to require counsel for plaintiff to sign a subrogation agreement before paying claims when the plan documents so specify.<sup>33</sup> The signing of such an agreement probably would cinch a later claim against the attorney by the plan should it not be reimbursed.

## **XII. LIABILITY OF BENEFICIARY TO PLAN AFTER DISBURSEMENT**

Prior to *Great-West v. Knudson* the Fourth Circuit held in *Provident Life & Accident Insurance Co. v. Waller*, 906 F.2d 985 (4th Cir. 1990) that a plan could, under the theory of unjust enrichment, sue at law to recover funds advanced by a plan to a beneficiary as compensation for injuries caused by a third party after the beneficiary recovers a compensatory award from the at-fault party. Notice the distinction between the action at law endorsed in *Provident Life v. Waller* where personal liability was imposed for the total amount claimed by the plan regardless of whether or not the defendant possessed any traceable fund, and the action in equity promulgated in *Great-West v. Knudson* which prohibits an action at law and limits the imposition of a constructive trust only to that identifiable and traceable fund in the possession of the defendant. As a result of *Great-West v. Knudson* the efficacy of *Provident Life v. Waller* came into play when the Fourth Circuit observed "...the justification for the court's recognition of a federal common law unjust enrichment claim in *Waller* is in serious doubt, as it is no longer debatable that Provident has an "explicit remedy" under § 1132(a)(3)."<sup>34</sup> The "explicit remedy" is the imposition of a constructive trust on identifiable funds in the hands of the plan beneficiary – not the imposition of a money judgment at law. It is now clear that federal courts will impose a constructive trust on identifiable proceeds in the possession of the plan beneficiary as an equitable remedy but may not impose "personal liability" or a "money judgment" in an action at law against a plan beneficiary as such a remedy at law is beyond the purview of the ERISA equitable remedy scheme.<sup>35</sup>

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<sup>30</sup> *Great-West Life & Annuity Ins. Co. v. Smith*, 180 F. Supp. 2d 1311 (M.D. Fla. 2002)

<sup>31</sup> *Mank v. Green*, 368 F. Supp. 2d 102, (D. Me., 2005).

<sup>32</sup> *Peterson v. Hotel Employees And Restaurant Employees International Union Welfare Fund*, 288 F. Supp. 2d 1145 (NV 2003)

<sup>33</sup> *Kress v. Food Employers Labor Relations Association And United Food And Commercial Workers Health And Welfare Fund*, 285 F. Supp. 2d 678 (Md. 2003).

<sup>34</sup> *Provident Life v. Cohen*, 423 F.3<sup>rd</sup> 413 (4<sup>th</sup> Cir. 2005).

<sup>35</sup> *Primax Recoveries v. Young*, 83 Fed. Appx. 523; 2003 U.S. App. LEXIS 25786 (unpublished decision).

### **XIII. ERISA CLAIMS AGAINST WRONGFUL DEATH PROCEEDS**

There are state wrongful death statutes which, by their nature, prescribe who can make the claims, who the beneficiaries are, the nature of the recovery, and the manner in which the distribution of proceeds is made. North Carolina's wrongful death statute was examined by the Fourth Circuit in the case of *Liberty Corp. v. NCNB Nat'l Bank of South Carolina*, 984 F.2d 1383 (4<sup>th</sup> Cir. 1993). *Liberty* held that an ERISA plan's right of reimbursement was limited to the recovery of medical expenses (then \$1,500) prescribed by statute with the balance going to the heirs free of the ERISA plan's claim. The later case of *McInnis v. Provident Life & Accident Ins. Co.*, 21 F.3d 586 (4<sup>th</sup> Cir. 1994) upheld this principle when it denied an estate's right to recover from the plan for benefits because the damage claim belonged to the decedent and the estate.<sup>36</sup>

### **XIV. CLAIMS OF ERISA PLANS AGAINST WORKERS COMPENSATION PAYMENTS**

Usually the workers compensation claimant is not faced with ERISA issues because ERISA does not preempt state workers compensation laws and the funding requirements imposed by states. However there are situations when the interplay with an ERISA plan comes into effect. At least two examples come to mind: where the employee is injured on the job as a result of an accident and the employer denies the claim forcing the employee to use his or her self funded health insurance plan to pay the bills; and where the employee's claim is accepted (or ordered) and a long term (or short term) disability ERISA plan has made or is obligated to make periodic benefit payments under the policy.

### **XV. EMPLOYEE FORCED TO MAKE CLAIM UNDER SELF-FUNDED HEALTH INSURANCE PLAN**

Consider the situation when an employer denies an employee's workers compensation claim. The denial forces the employee to use the employer's self funded ERISA health insurance plan to obtain medical care for the injuries received on the job. The employee continues to receive medical care under the plan (but without the benefit of wage replacement). The claim is ultimately accepted by the workers compensation carrier or ordered by a compensation board. Thereupon the employer, or the employer's worker's compensation carrier, picks up future medical bills. The worker's compensation carrier is most often not self funded and therefore is not anxious to reimburse the ERISA self funded plan for the medical and hospitals bills already paid. Usually the employee has no dog in this fight and can let the carriers thrash it out between them.

Where the workers compensation carrier accepts the claim it usually will be willing to reimburse the ERISA health insurance plan. However in those states where clincher agreements are common the ERISA plans have been known to lay claim to a portion of the proceeds. But where the workers compensation carrier continues to deny the claim and only makes future

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<sup>36</sup> See also *Diamond Crystals Brands, Inc. v. Wallace*, Civil Action 1:07-CV-3172-JTC (N.D. Ga. January 22, 2008)

medical and hospital payments (and wage replacement payments) as a result of an order it is less receptive to voluntarily paying past medical and hospital bills. It's in this instance where the employee gets caught in the middle. The ERISA plan wants its money back for the medical payments and now there is an identifiable fund it can pursue. The workers compensation carrier won't pay it and the plan demands payment from the proceeds of the clincher agreement. If the state compensation board orders the carrier to pay the past bills then there is no problem. But often the compensation board is unwilling to order such reimbursement as being outside its authority and the workers compensation carrier is unwilling to voluntarily reimburse the plan.

At this point the client/employee should be informed about the principles that apply to remedies of ERISA plans. Generally the same principles that apply in third party tort recoveries apply in this instance. An ERISA plan has the right to seek the assistance of a federal court to impose a constructive trust on the identifiable proceeds. However there may be some defenses not available in the typical third party recovery case.

Although identifying, segregating and allocating proceeds in third party tort recoveries has not shielded portions of a settlement from imposition of a constructive trust there may be a place for allocation in the workers compensation context. After all, in those states allowing clincher agreements, the agreements must be approved by the compensation board and cover the bases that typically a compensation board is concerned about. In effect the compensation board may have the right to allocate in a clincher so it can identify the medical portion from the wage replacement and disability components and (and required allocation for Medicare and Social Security Disability Income purposes) to determine fairness. And where the clincher agreement does not provide for the payment of medical bills incurred prior to acceptance of a claim by a carrier no amount of money is set aside for this purpose in the clincher and therefore there is no identifiable and traceable fund which the ERISA health plan can pursue. So in those situations where there are unpaid medical bills, or medical bills paid by an ERISA plan, and the understanding is that the workers compensation carrier will not be paying such bills then that fact should be spelled out in the clincher.

Furthermore consideration should be given to taking the position that the attempt of an ERISA health insurance plan to go after funds from a clincher in the possession of the injured worker is contrary to ERISA's stated exclusion of regulation of workers compensation laws. In other words the attempt by the employer to assert rights of subrogation or reimbursement for what would have otherwise been required of the employer to pay on account of a covered worker's injury under the workers compensation act is merely an end run around the prohibition of not using an ERISA plan (self funded or not) to supplant workers compensation insurance requirements.

Lastly the ERISA plan subrogation and reimbursement language itself needs to be studied thoroughly. If it requires subrogation for the acts of third parties question whether or not the employer (plan sponsor) is in fact a third party. The plan sponsor, usually the employer, would in effect not be a third party from whom a recovery was had against which subrogation would lie.

## **XVI. LONG TERM OR SHORT TERM DISABILITY INSURANCE CARRIER OFFSETS BENEFIT PAYMENTS**

Typically a disability policy provides that periodic benefits will be reduced by the amount of workers compensation or Social Security Disability Income (SSDI) benefits received by the beneficiary. Efforts to recoup overpayments of benefits on account of SSDI payments received by a beneficiary have been successful.<sup>37</sup> But, it is noted that recent cases have rejected the efficacy of disability plans recovering alleged overpayments of benefits when a beneficiary receives SSDI benefits for the reason that 42 U.S.C. § 407(A) provides immunity (or a safe haven) of such funds from levy or other garnishment.<sup>38</sup>

That ERISA disability insurers and disability pension plans may offset (or reduce) the payments it would otherwise be required to make by reason of the beneficiary's receipt of workers compensation benefits is not in doubt.<sup>39</sup> But the ability of the disability insurer to offset depends on the language of the plan and the nature or character of the workers compensation payment. If the language of the plan provides that the benefit is reduced for X but the character of the workers compensation payment is Y then there is no offset. Unfortunately plan administrators have wide discretion and authority to determine whether or not the character of the benefit and payments under workers compensation are of the same nature. In fact the discretion is so far reaching that the beneficiary must prove an abuse of discretion or an arbitrary or capricious action on the part of the administrator in order to prevail in nullifying the offset.<sup>40</sup> It has been held that, even if the disability benefit and the workers compensation payment be of the same character, the amount of the attorney fees that are deducted from a workers compensation award should not be included in the offset amount.<sup>41</sup> However, courts have held otherwise declaring that if the plan does not allow for such a deduction then the administrator's decision not allowing a credit for attorney fees is final.<sup>42</sup>

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<sup>37</sup> *Dillard's Inc. v. Liberty Life*, \_\_\_ F.3rd \_\_\_ (8<sup>th</sup> Cir. 2006).

<sup>38</sup> *Mote v. Aetna Life*, 435 F.Supp.2d 827 (N.D. Ill. 2006); *Ross v. Pa. Mfrs. Ass'n Ins. Co.*, No. Civ. A. 1:05-0561, 2006 WL 1390446 (S.D.W.Va. May 22, 2006)

<sup>39</sup> *Leonard v. Southwestern Bell Corporation Disability Income Plan*, 341 F.3d 696 (8<sup>th</sup> Cir. 2003).

<sup>40</sup> *Ibid.*

<sup>41</sup> *Ibid.*

<sup>42</sup> *Trujillo v. Cyprus Amax Minerals Co. Retirement Plan*, 203 F.3d 733 (10<sup>th</sup> Cir. 2000).

## CONCLUSION

From the attorney's perspective, it is extremely important that the client be involved from the outset when the presence of a self-funded ERISA plan is suspected. The client should be given options such as allowing the attorney to negotiate with the plan up front to reduce the amount claimed by the plan. Any compromise agreement with the plan should be in writing. The agreement, whether by letter or more formal, should include the plan's forbearance from seeking repayment from the health care providers it already paid and waiver of any rights it might have to credit or draw down against future benefits for the amount waived in the compromise.

An ERISA claim is not a "perfected" lien and only the imposition of a constructive trust upon identifiable funds creates a "perfected" lien. While cases interpreting ERISA refer to both "subrogation" and "reimbursement" the distinction, and the consequences of the distinction, are rarely recognized. The same is true with respect to cases which do not acknowledge the difference between a "lien," a "perfected lien," and a "claim."

Finally, if the client instructs her attorney to disburse the funds to her and not pay the plan, a written disbursement directive should be signed by the client.

**AUTHORIZATION FOR RELEASE OF  
EMPLOYEE WELFARE BENEFIT PLAN INFORMATION**

Pursuant to 29 U.S.C. § 1024(b)(4), the undersigned \_\_\_\_\_ hereby authorizes my Employer/Former Employer to furnish to my attorneys, \_\_\_\_\_, a copy of all employee welfare benefit plan documents in existence during my employment. This authorization includes any and all documents enumerated in Section 1024(b)(4), including but not limited to the latest updated summary plan descriptions, plan descriptions, latest annual reports, terminal reports, applicable collective bargaining agreements, trust agreements, contracts or other instruments under which any of the plans at issue were established or are presently operated.

**NOTICE:** Neither the employee welfare benefit plan administrators nor my employer/former employer is authorized to disclose to any third party including insurance adjusters, insurance companies, or any other person or entity, any personal information pertaining to me or the medical treatment I received or the cost thereof. The undersigned claims every confidentiality privilege whether federal or state and whether created by statute, rule or case law. Such personal information includes any information in my personnel file or any other information obtained by my employer/former employer, the plan or its agents in the course of administering the plan and paying benefits pursuant to the plan.

**ALL PRIOR AUTHORIZATIONS ARE HEREBY CANCELLED,** and I hereby waive any privilege I have regarding release of said information to my attorneys. A photocopy of this authorization shall be considered the same as the original

Date: \_\_\_\_\_

Employee: \_\_\_\_\_

Signature

## LETTER REQUESTING PLAN DOCUMENTS

XYZ Corporation  
Plan Administrator  
P.O. Box \_\_\_\_\_  
Raleigh, NC

Re: Request for plan documents

Dear Plan Administrator:

I represent \_\_\_\_\_. Enclosed is an **AUTHORIZATION FOR RELEASE OF EMPLOYEE WELFARE BENEFIT PLAN INFORMATION** which has been properly executed by my client.

My client was injured on January 1, 2008 as a result of the actions of a third-party who might be legally responsible. Your health plan may have paid some medical and hospital bills that may have been related to the actions of the third-party. If your health plan claims any right of subrogation or reimbursement out of the proceeds of settlement or verdict I request of you, pursuant to 29 U.S.C. § 1024 (and related statutes) and applicable case law, the following documents:

- ▶ All underlying plan documents, agreements and contracts which established the plan.
- ▶ The plan's three digit identifying number.
- ▶ The summary plan description and any amendments thereto for the year 2005 and all subsequent years.
- ▶ The declaration pages of all insurance contracts covering or affecting the plan for each year since 2005 including, but not limited to, stop-loss, reinsurance, and excess loss coverage.
- ▶ The plan's IRS Form 5500s filed in each year from 2005 to the present.
- ▶ All written (and oral) policies, memoranda, minutes of meetings and any other written documentation addressing reimbursement or subrogation, and enforcement or waiver of the same from the date of establishment of the plan until the present.
- ▶ All written or oral policies implemented by the plan with respect to assisting your beneficiaries in pursuing third-party actions by way of subrogation
- ▶ A full and complete detailed itemization of all payments made by the plan to health

care providers for the benefit of your insured arising out of the injury on January 1, 2008.

I will assume that if you do not timely respond to my request for documents that you do not have a right to subrogation or reimbursement, or, if you do have such a right do not intend on exercising that right and make any claim. Also, if you do claim such a right please identify the sources of recovery to which the plan lays claim.

If you do intend on exercising subrogation or reimbursement claims please supply me the requested documents and let me know how the plan is willing to participate in or contribute to achieving a recovery. The issue of liability remains undecided, and, as you know, the law in North Carolina recognizes contributory negligence on your insured's part as a complete bar to any recovery.

We need the above documentation and answers to our questions promptly so that we can make an informed decision as to whether or not to proceed against the third-party. If it is not cost effective to proceed we will abandon any claim we have. On the other hand if you are willing to compromise your claim based on the equities of the situation please let us know so we might discuss a strategy which will be mutually beneficial.

Very truly yours,

**RELEASE OF ALL CLAIMS**

The undersigned ERISA Plan (Plan), or its authorized agent signing below, herewith releases and forever discharges \_\_\_\_\_ who is a plan participant and/or beneficiary of the Plan upon payment to the Plan of the sum of \$ \_\_\_\_\_. Such payment shall be in full satisfaction of any claim, equitable or legal, that the Plan might have, or will have in the future, against said plan participant or beneficiary arising out of medical or hospitals bills paid by the Plan on account of the treatment of any injuries by health care providers arising out of an injury incurred by the plan participant or plan beneficiary on or about the \_\_\_ day of \_\_\_\_\_ 20\_\_.

The undersigned represents that it has the full authority to settle and compromise any claim of the Plan for subrogation or reimbursement. Such settlement and compromise shall be effective as a total and complete compromise in full satisfaction of the Plan's claim for subrogation or reimbursement or the right to drawn down, deny or otherwise exhaust future benefits due the plan participant or beneficiary for health care provided to the participant or any other beneficiary arising out of the same injury for which the Plan seeks subrogation or reimbursement or arising out of any other cause, or the right to seek recoupment from any health care provider already paid or promised to be paid.

This the \_\_\_ day of \_\_\_\_\_ 20\_\_.

\_\_\_\_\_  
ERISA Plan

By: \_\_\_\_\_  
Authorized Agent for ERISA Plan

**CLIENT AUTHORIZATION AND DIRECTION  
FOR DISBURSEMENT**

The undersigned client acknowledges being advised by my attorney that my health insurance plan may have paid some or all of my medical and hospital expenses associated with the treatment of the injuries for which I am receiving a settlement or verdict. My attorney has informed me that my health insurance plan may seek reimbursement, restitution or subrogation from these proceeds or from me personally.

I have been advised by my attorney that if I don't reimburse my health insurance plan

- my health insurance plan may cut off (or draw down) future benefits due me or other beneficiaries of the plan until its claim is satisfied
- my health insurance plan might prevail upon my health care providers to pay it back in which case my health care providers might bill me for such amounts paid back.
- my health insurance plan may sue me or other family members/beneficiaries of the plan seeking reimbursement
- if my health insurance plan files a lawsuit against me I may be liable for the plan's attorney fees and costs if I lose
- if my health insurance plan files a lawsuit my attorney is not obligated to represent me in such action

Having been fully informed of the consequences of my decision I authorize and direct my attorney to NOT disburse any funds to the plan and further direct my attorney to disburse such funds to me.

Date: \_\_\_\_\_

Client: \_\_\_\_\_

Signature

NORTH CAROLINA  
\_\_\_\_\_ COUNTY

IN THE GENERAL COURT OF JUSTICE  
SUPERIOR COURT DIVISION  
FILE NO. \_\_\_\_ CvS \_\_\_\_

\_\_\_\_\_, )  
 )  
Plaintiff, )  
 )  
v. )  
 )  
\_\_\_\_\_, )  
Defendants. )

---

\_\_\_\_\_, )  
 )  
Plaintiff, )  
v. )  
 )  
Health Care Provider # 1; )  
Health Care Provider # 2; )  
 )  
Defendants. )

**COMPLAINT FOR INTERPLEADER AND DECLARATORY RELIEF TO  
DETERMINE VALUE OF SERVICES AND LIENS, AND ORDER OF DISBURSEMENT**  
(N.C. Rules of Civil Procedure 22 and 57)  
(N.C.G.S. §§ 44-49 et seq.)

\_\_\_\_\_, through his counsel Arthur J. Donaldson, alleges and says  
as against Health Care Provider #1 and Health Care Provider #2 as follows:

**PARTIES**

1. \_\_\_\_\_ is a resident of \_\_\_\_\_ County, North Carolina.
2. Original Defendant #1 is a North Carolina corporation with its principal place of business in \_\_\_\_\_ County, North Carolina.
3. Original Defendant #2 is a resident of \_\_\_\_\_ County, North Carolina.

4. The interplead defendant Health Care Provider #1 is a corporation incorporated under the law of North Carolina having its principal office in \_\_\_\_\_ County, North Carolina.

5. The interplead defendant Health Care Provider #2 is a corporation incorporated under the law of North Carolina having their principal offices in \_\_\_\_\_ County, North Carolina.

### **JURISDICTION**

6. Jurisdiction is asserted pursuant to N.C.G.S. §§ 44-49 et seq. and the order of the Honorable \_\_\_\_\_ Superior Court Judge, entered in open court in \_\_\_\_\_ County on \_\_\_\_\_ and signed on \_\_\_\_\_ as reflected in Attachment "A."

### **FACTS**

7. \_\_\_\_\_ was injured in a collision on \_\_\_\_\_ in \_\_\_\_\_ County, North Carolina when the automobile he was operating was struck by the original defendants' vehicle.

8. As a result of the injuries received \_\_\_\_\_ was treated by, or received services from, numerous health care providers including the defendants in this interpleader action.

9. \_\_\_\_\_ filed a negligence action on \_\_\_\_\_ against Original Defendants

10. After a discovery period, mediation was ordered by the court which resulted in a settlement of Plaintiff's claim for \$\_\_\_\_\_, without an admission of liability, which settlement was memorialized in an order entered in open court on \_\_\_\_\_ and later signed by the Honorable \_\_\_\_\_, Superior Court Judge on \_\_\_\_\_ as

reflected in Attachment "A."

11. Plaintiff did not have health insurance at any time during treatment of his injuries incurred in the wreck.

12. Plaintiff is now 66 years of age, lives in a trailer in \_\_\_\_\_ County, has few personal property assets, is disabled as a result of the wreck of \_\_\_\_\_, now draws Social Security benefits as his sole means of survival, and is charged with the care of his two grandchildren.

13. \_\_\_\_\_ has been billed a total of \$ \_\_\_\_\_ by the interplead defendant health care providers who rendered services or treatment to Plaintiff as a result of the wreck and resulting injuries, and all such bills remain unpaid and outstanding.

14. Disbursement of the proceeds in this case pursuant to N.C.G.S. §§ 44-49 et seq., without examination and scrutiny by the court of the charges and claimed liens, would result in alleged lienholders being paid some but not all of their bills and non-lienholders receiving nothing.

15. In an attempt to pay all the alleged lienholder health care providers the amount allegedly due them under N.C.G.S. §§ 44-49 et seq., and the remaining non-lienholder health care providers some amount of money, Plaintiff's counsel offered to reduce his fee and apply the amount of his fee reduction pro-rata to all the health care providers (all the defendants in this interpleader action) in full satisfaction of their bills as reflected in a letter from Plaintiff's counsel dated \_\_\_\_\_ and identified in Attachment "B."

16. The majority of the interplead defendant health care providers have accepted the compromise proposed in full satisfaction of their outstanding bills.

17. A minority of the interplead defendant health care providers, holding the majority of the charged or billed amounts, either declined or failed to respond to the compromise proposal.

18. The interplead defendant health care providers who accepted the proposed compromise in full satisfaction of their claims are: \_\_\_\_\_

19. The interplead defendant health care providers who did not respond or rejected the compromise proposed are: \_\_\_\_\_

20. Upon information and belief the following health care providers have asserted a lien under N.C.G.S. §§ 44-49 et seq.: \_\_\_\_\_

21. Upon information and belief \_\_\_\_\_ is the only health care provider claiming a lien that has not agreed to a compromise in full satisfaction of its claimed bill.

22. Plaintiff acknowledges the valid liens of \_\_\_\_\_ and further acknowledges that their charges are fair and reasonable and are just and bona fide claims under N.C.G.S. § 44-50 and such defendants should be included in any order of disbursement so long as such payments (along with a pro-rata share of the amount generated as a result of the fee reduction proposed by Plaintiff's counsel) are accepted by them as payment in full satisfaction of their outstanding charges.

23. Plaintiff does not acknowledge the claimed lien of interplead defendant \_\_\_\_\_, nor does plaintiff acknowledge that its charges are usual and customary nor that the charges are just and bona fide under N.C.G.S. § 44-50 and such defendant should not be included in any order of disbursement or if included that such charges be reduced to those amounts that are just and bona fide.

24. Plaintiff does not acknowledge the claimed charges of the following non-lienholder interplead defendants as fair and reasonable nor are they just and bona fide claims under N.C.G.S. § 44-50: \_\_\_\_\_ and such defendants should not be included in any order of disbursement or if they are included in an order of disbursement that such order be predicated upon the receipt of such disbursement as payment in full of their charges.

25. Plaintiff does acknowledge the non-lienholder claims of interplead defendants \_\_\_\_\_ and plaintiff acknowledges that their charges are usual and customary and their charges are just and bona fide under N.C.G.S. § 44-50 and such defendant should, without any further showing, be included in any order of disbursement predicated upon the receipt of such disbursement as payment in full of their charges.

26. Plaintiff represents to the court that as to those interplead defendant health care providers that accepted the compromise proposed he accepts their charges as reasonable and fair and asks that such of their claims as amount to liens be honored without further showing on their part so long as the order of disbursement is predicated upon the receipt of such disbursements by as payment in full of their charges

27. By reason of the conflicting claims of the interplead defendants, plaintiff is in great doubt as to which defendants are entitled to be paid out of the proceeds of settlement.

#### **FIRST CLAIM FOR RELIEF**

The billed charges of interplead defendants \_\_\_\_\_ are not reasonable nor reflective of usual and customary charges to all patients (insured and uninsured) and the discounts routinely afforded to insured patients, Medicare patients and Medicaid patients.

#### **SECOND CLAIM FOR RELIEF**

The billed charges of interplead defendants \_\_\_\_\_ should be reduced to their *quantum meruit* value.

### **THIRD CLAIM FOR RELIEF**

The billed charges of interplead defendants \_\_\_\_\_ should be scrutinized and reduced to reflect the just and bona fide claims pursuant to N.C.G.S. § 44-50.

**WHEREFORE:** Plaintiff prays the court that it

1. conduct a hearing to determine the value of services rendered by the interplead health care providers;
2. determine which interplead health care providers have liens pursuant to N.C.G.S. § 44-49 et seq.;
3. determine which claims of the interplead health care providers are fully established and are just and bona fide claims pursuant to N.C.G.S. § 44-50;
4. allow the funds generated on account of the reduction of the plaintiff's counsel fees to be credited to those claimants, lienholders and non-lienholders alike, who have accepted the proposed compromise without such reduction in fees flowing solely to the benefit of that alleged lienholder who has not accepted the proposed compromise;
5. determine the disbursement of proceeds pursuant to N.C.G.S. § 44-51
6. for such other and further relief as is just and proper.

This the \_\_\_ day of \_\_\_\_\_, 2006.

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Arthur J. Donaldson  
North Carolina State Bar # 1207  
Virginia State Bar # 72430

NORTH CAROLINA  
\_\_\_\_\_ COUNTY

IN THE GENERAL COURT OF JUSTICE  
SUPERIOR COURT DIVISION  
FILE NO.

\_\_\_\_\_, )  
 )  
Plaintiff, )  
 )  
v. )  
 )  
\_\_\_\_\_ and \_\_\_\_\_ )  
 )  
Defendants. )

---

\_\_\_\_\_, )  
 )  
Plaintiff, )  
 )  
v. )  
 )  
HCP # 1; )  
HCP # 2, )  
 )  
Defendants. )

**DECLARATORY JUDGMENT AND ORDER OF DISBURSEMENT**

This matter coming on to be heard and being heard by the undersigned Superior Court Judge on the \_\_\_ day of \_\_\_\_\_, 2006 and the court having reviewed the file and having determined that the matter before the court is based on an interpleader action seeking declaratory relief to determine the value of health care provider services and the efficacy of liens pursuant to N.C.G.S. §§ 44-49 et seq. and to enter an order of disbursement accordingly,

And it appearing to the court from the file that

1. all interplead health care provider defendants have been duly served; and
2. some interplead defendants have either answered or otherwise acknowledged

that they accept the initial proposed offer of counsel for plaintiff, Arthur J. Donaldson, dated January 11, 2006 in full satisfaction of their accounts with \_\_\_\_\_ for medical care and hospital services rendered him for injuries received on \_\_\_\_\_, 2004; and

3. this court entered an order on \_\_\_\_\_, 2006 acknowledging the agreement of the parties in the underlying action to settle the plaintiff's claim for the sum of \$\_\_\_\_\_ and this court retaining jurisdiction to hear any interpleader action that may be filed against health care providers; and
4. all parties have been duly and in apt time notified of the time and place of this hearing as evidenced by the Notice of Hearing sent by counsel for \_\_\_\_\_ to all parties or their counsel;

And it further appearing to the court that counsel for plaintiff, Arthur J. Donaldson, and the plaintiff \_\_\_\_\_ are present in person for this hearing and that counsel for the original defendants \_\_\_\_\_ is present in person and that no interplead defendants or their counsel are present for this duly noticed hearing.

And the court having considered the pleadings, the evidence offered by the plaintiff, the stipulation of \_\_\_\_\_ that those health care providers who accepted the offer of January 11, 2006 should be allowed the compromise amount as payment in full for their services, and the written representations from some of the interplead health care provider defendants accepting the proposal of January 11, 2006 as payment in full for the interplead defendants health care services, the court determines the following

FINDINGS OF FACT:

1. \_\_\_\_\_, plaintiff in the underlying action, was injured in a motorcycle accident on \_\_\_\_\_, 2004; and
2. as a result of the injuries received in said accident \_\_\_\_\_ received health care services in one form or another from the interplead health care providers; and
3. \_\_\_\_\_ filed a negligence action against the original defendants seeking compensation for the injuries received on \_\_\_\_\_, 2004; and
4. the amounts charged by the health care providers for the services rendered remain unpaid although some health care providers have been paid partially on the amounts billed to \_\_\_\_\_; and
5. \_\_\_\_\_ did not have any health insurance coverage of any kind at the time of the accident; and
6. there was an offer made by plaintiff's counsel to all health care providers on January 11, 2006, as evidenced by a letter from \_\_\_\_\_' counsel, wherein counsel for plaintiff acknowledged a conditional offer of \$\_\_\_\_\_ from the original defendants in the underlying negligence action and proposed that he reduce his fee and the amount realized by such reduction be added to the pool of funds available to all the health care providers pro rata so long as such health care providers accept the offered amounts in full satisfaction for the services rendered by them, and on the further condition that all the providers accept the proposal (Exhibit "B" of the interpleader complaint); and
7. all the interplead health care providers, except \_\_\_\_\_ P.A., accepted

the offer of January 11, 2006; and

8. \_\_\_\_\_, through counsel, has asked the court as part of his evidence to find that the amounts proposed, accepted and agreed upon by those health care providers who accepted to the proposal of January 11, 2006 be determined to be fully earned and otherwise just and *bona fide* under N.C.G.S. § 44-50 and the court so finds; and
9. the interplead defendant, \_\_\_\_\_ has not answered the interpleader action, declined to accept the offer of January 11, 2006 or otherwise failed to be present or offer any evidence as to the value of their services;

And based on the above findings of fact the court CONCLUDES AS A MATTER OF LAW the following;

1. all interplead defendants have been duly served with summons and complaint and are properly before this court; and
2. all interplead defendants have been notified in apt time of the date, time and place of this hearing; and
3. the court has jurisdiction to determine the *quantum meruit* value of the services rendered to \_\_\_\_\_ and to determine the just and *bona fide* claims of health care providers pursuant to N.C.G.S. § 44-50 and to determine the disbursement of proceeds pursuant to N.C.G.S. § 44-51; and
4. the interplead health care providers, except for \_\_\_\_\_ have accepted the offer of January 11, 2006 in full payment for their services and the court determines that such amounts are just and *bona fide* and should be paid in full

satisfaction of the claims in the amounts indicated in plaintiff's counsel's letter of January 11, 2006; and

5. \_\_\_\_\_ has not proven its claim in contract or otherwise, however, plaintiff has conceded that its claim to the extent of \$\_\_\_\_\_ should be paid if accepted by it as payment in full, thus, the court finds that the *quantum meruit* value for its services is \$\_\_\_\_\_; and

Based on the above findings of fact and conclusions of law the court enters the following

**ORDER OF DISBURSEMENT:**

The original defendants shall pay to \_\_\_\_\_ and his counsel the sum of \$\_\_\_\_\_ and said sum shall be deposited in the trust account of counsel for plaintiff and from that trust account \_\_\_\_\_' counsel shall disburse to the interplead defendants the sums indicated in plaintiff's counsel letter to the interplead defendants dated January 11, 2006 (Exhibit "B" attached to the interpleader complaint) indicated as **Proposed Enhanced Payment In Full** in full satisfaction for all services rendered, whether legal, medical or otherwise arising out of the motorcycle accident on \_\_\_\_\_, 2004,

The court retains jurisdiction in this matter should further adjudication be necessary.

**SO ORDERED** this the \_\_\_ day of \_\_\_\_\_, 2006.

\_\_\_\_\_  
Superior Court Judge Presiding