ELEVENTH CIRCUIT HOLDS THAT COMMON LAW "MAKE WHOLE DOCTRINE" DOES NOT PRECLUDE PLAN FIDUCIARY FROM SEEKING REIMBURSEMENT ACCORDING TO THE PLAN

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In Zurich American Insurance Company v. O'Hara, 604 F.3d 1232 (11th Cir. 2010), the Eleventh Circuit Court of appeals recently granted summary judgment in favor of the plan fiduciary, thereby granting the fiduciary's request for reimbursement for medical expenses that the plan had paid to the plan beneficiary who sustained serious injuries in an automobile collision and later obtained settlement from the other driver. Keith O'Hara ("O'Hara"), beneficiary of the Zurich Medical Plan (the "Plan"), sustained serious bodily injuries in an automobile collision. Following the accident, the Plan paid $262,611.92 in medical expenses on O'Hara's behalf. O'Hara later sued the other driver and obtained a settlement of $1,286,457.11, which did not fully compensate O'Hara for his loss. After learning of O'Hara's third-party recovery, Zurich sought reimbursement of the full amount previously paid to O'Hara pursuant to the Plan's subrogation and reimbursement provision. When O'Hara refused to repay the Plan, Zurich filed suit under ERISA § 502(a)(3), seeking to enforce the reimbursement and subrogation provision of the Plan.

O'Hara defended Zurich's claim primarily on the ground that he was not made whole by his third-party recovery and, therefore, Zurich's claim was barred by the make-whole doctrine, which at common law required an insured who settled with a third-party tortfeasor to reimburse the insurer-subrogee only for the excess received over the total amount of the insured's loss. Upholding its decision in Cagle v. Bruner, 112 F.3d 1510, 1529 (11th Cir. 1997), the court determined that the make-whole doctrine is a default rule that applies only in the absence of specific and unambiguous language precluding it. The court determined that "[t]he Plan's reimbursement and subrogation provision, which state[d] that 'the Plan may collect from a covered person the proceeds of any full or partial recovery' he obtains from a third-party tortfeasor, 'regardless of whether the covered person has been fully compensated or made whole' [was] clearly sufficient to disclaim any 'make-whole' limitation on Zurich's right to reinstatement."

The court rejected O'Hara's argument that the application of the make-whole doctrine was necessary to effectuate the purposes of ERISA. The court reasoned that applying federal common law to override the Plan's express language, thereby denying an employer its right to reimbursement pursuant to a written plan, would discourage employers from offering welfare benefits in the first place. Additionally, the court concluded that enforcement of Zurich's contractual right to full reimbursement did not conflict with ERISA's policy of protecting Plan beneficiaries. The court explained as follows:

> Although O'Hara himself will be in a better position if the subrogation provision is not enforced, plan fiduciaries must take impartial account of the interests of all beneficiaries. Reimbursement inures to the benefit of all participants and beneficiaries by reducing the total cost of the Plan. If O'Hara were relieved of his obligation to reimburse Zurich for the medical benefits it paid on his behalf, the cost of those benefits would be defrayed by other plan members and beneficiaries in the form of higher premiums.

Finally, the court found no merit in O'Hara's argument that Zurich's claim for reimbursement violated ERISA's anti-discrimination provision, 29 U.S.C. § 1182(h), in that it forced him to make a greater contribution to the Plan than similarly situated participants. Permitting Zurich to recover specific and identifiable funds, advanced to cover O'Hara's medical expenses, was not the equivalent of requiring O'Hara to pay a premium or contribution greater than such premium or contribution for similarly situated individuals enrolled in the Plan on the basis of a health status-related factor. Moreover, to the extent the reimbursement and subrogation provision was more accurately described as a "limitation" or "restriction" on the level of benefits conferred by the Plan under ERISA § 702(a)(2)(B), it was not impermissibly discriminatory because it applied uniformly to all participants and required reimbursement from any participant or beneficiary who received medical benefits under the Plan and then subsequently recovered from a third party.