

## **It's Payback Time — Obtaining Equitable Restitution In The Wake Of *Sereboff***

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### **I. Introduction**

Employee welfare benefits plans are supposed to be administered fairly, according to the plan's written terms. No party—not even plan beneficiaries—should unjustly profit. But when a beneficiary has unjustly profited by receiving greater benefits than authorized by the terms of the plan, ERISA does not make it easy for the plan fiduciary to recover the overpayment.

Whereas ERISA provides participants and beneficiaries with a variety of legal and equitable remedies, ERISA does not provide the same remedies to plan fiduciaries, who are relegated to obtaining only “appropriate equitable relief” under §502(a)(3) (29 U.S.C. §1132(a)(3)). *Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204 (2002) further narrowed the scope of restitutionary relief available under §502(a)(3) to those remedies that were available from a common law court of equity back in the days of the “divided bench.” *Id.*, at 212. Because most claims for restitution of overpaid benefits were generally characterized as legal in nature, *Great-West* foreclosed plan fiduciaries from recovering overpayments under ERISA.

*Great-West* turned §502(a)(3) into an empty promise, at least for fiduciaries seeking restitution of overpaid benefits. The Supreme Court took corrective action in *Sereboff v. Mid Atlantic Medical Services, Inc.*, 547 U.S. 356 (2006). *Sereboff* expanded the types of restitutionary claims that are available under §502(a)(3). But rather than reject common law distinctions between law and equity that prevailed during the days of the divided bench, *Sereboff* further embedded these antiquated principles into the law ERISA. As a result, recovering overpaid benefits in the wake of *Sereboff* can be tricky.

This article focuses on the practical application of *Sereboff*, including the fundamentals of stating a claim for equitable restitution of overpayments, and the defenses that fiduciaries are likely to encounter.

### **II. Stating A Claim For Equitable Restitution In The Wake Of *Sereboff*.**

*Sereboff* involved a relatively straightforward subrogation claim by a plan fiduciary, Mid Atlantic, to obtain reimbursement of medical expenses paid to the Sereboffs, who were beneficiaries of the plan. The plan contained an “Acts of Third Parties” provision that required beneficiaries who receive medical benefits under the plan to reimburse Mid Atlantic for those benefits from any recovery received from third parties. The Sereboffs obtained a settlement for their injuries from third parties, but refused to reimburse Mid Atlantic. Mid Atlantic filed a claim against the Sereboffs under §502(a)(3) in order to obtain reimbursement.

The Supreme Court held that Mid Atlantic was entitled to obtain reimbursement as a form of equitable relief authorized by §502(a)(3). The Court held that the plan's reimbursement provision created an equitable lien by agreement that attached to the

settlement funds when those funds were received by the Sereboffs, in the same way that the promise to pay specific funds created an equitable lien by agreement in *Barnes v. Alexander*, 232 U.S. 117 (1914). The Court cited “the familiar rul[e] of equity that a contract to convey a specific object even before it is acquired will make the contractor a trustee as soon as he gets a title to the thing.” *Sereboff*, 126 S.Ct. at 1875 (quoting *Barnes*, 232 U.S. at 119).

In *Barnes*, attorney Barnes orally agreed to pay attorneys Street and Alexander one-third of any fees obtained in representing Barnes’s client. Barnes’s promise created an equitable lien by agreement on a portion (one-third) of a specifically identifiable fund (the client fees), which was enforceable by Street and Alexander in equity.

The *Sereboff* Court reasoned that the plan’s reimbursement provision was enforceable in equity in the same way that the attorney’s promise to pay was enforceable in equity in *Barnes*:

Much like Barnes’ promise to Street and Alexander, the “Acts of Third Parties” provision in the Sereboffs’ plan specifically identified a particular fund, distinct from the Sereboffs’ general assets—“[a]ll recoveries from a third parties ...”—and a particular share of that fund to which Mid Atlantic was entitled—“that portion of the total recovery which is due [Mid Atlantic] for benefits paid.”

*Sereboff*, 126 S.Ct. at 1875. The plan’s reimbursement provision in *Sereboff* created an equitable lien by agreement that allowed Mid Atlantic to follow a portion of the settlement recovery into the Sereboffs’ hands as soon as the settlement fund was identified, and impose on that portion a constructive trust or equitable lien in the amount of the medical benefits paid by Mid Atlantic. *Id.*, at 1875.

*Sereboff* allows fiduciaries, in certain circumstances, to recover overpayments made to beneficiaries by imposing an equitable lien on those funds. The plan, however, must contain appropriate language supporting the creation of an equitable lien by agreement.

#### **A. The language of the Plan must contain a promise to repay**

In determining whether the fiduciary may pursue equitable restitution under §502(a)(3), the starting point is the language of the plan itself. Like attorney Barnes’s promise to pay a portion of a particular fund (her client fees) to attorneys Street and Alexander, the terms of the ERISA plan should contain a promise by the beneficiary to pay a portion of a fund to the plan or plan fiduciary. The beneficiary’s promise to repay creates the equitable lien by agreement, which is triggered by the beneficiary’s receipt of the fund.

The structure of an equitable lien by agreement is ideally suited for enforcing offset and reimbursement provisions in disability insurance plans. These plans typically provide that the amount of disability benefits payable are to be reduced by income received by the beneficiary from third party sources, such as Social Security disability benefits, disability benefits under other group insurance policies, or part time work earnings. The “fund” subject to the equitable lien by agreement is the monthly disability benefit paid to the beneficiary under the plan. The lien, in turn, is triggered when the beneficiary subsequently receives qualifying income from a third party, for example, Social Security disability benefits. The lien attaches to the excess portion of the monthly disability benefit that the beneficiary was not entitled to receive on account of the offset for Social Security disability benefits.

In pleading an equitable lien by agreement, it is important to allege that the lien attaches to the excess monthly disability benefits themselves rather than to the funds paid by the third party. This structure enhances the fiduciary’s equitable argument that the portion of the fund in the beneficiary’s possession subject to the lien (*i.e.*, the excess monthly disability benefit) constitutes property rightfully belonging to the plan. In addition, the funds paid by third parties might be subject to other unknown liens or may be protected from attachment by law (as is the case with Social Security benefits, discussed later in this article).

Pursuant to *Sereboff*, the Eighth Circuit Court of Appeals, in *Dillard’s Inc. v. Liberty Life Assurance Co. of Boston*, 456 F.3d 894 (8<sup>th</sup> Cir. 2006), held that the insurer’s claim to recover overpaid benefits, on account of the beneficiary’s receipt of Social Security benefits (which are an offset under the plan), constitutes an action to enforce an equitable lien by agreement under §502(a)(3). As stated in *Dillard’s*:

The present case is analogous to *Sereboff* in that Liberty seeks reimbursement for amounts paid to [the insured] from a third-party source, the Social Security Administration. [L]iberty seeks a particular share of a specifically identified fund—all overpayments resulting from the payment of social security benefits. Accordingly, Liberty’s complaint constitutes a request for equitable relief [.]

*Id.* at 901.

In *Gutta v. Standard Select Trust Ins.*, No. 04 C 5988, 2006 WL 2644955 (N.D.Ill. Sept. 14, 2006), a restitution case that I handled, the disability plan provided an offset for income received from third party sources, which included disability benefits received under any other group insurance policy. The plan also contained a provision obligating participants to “immediately reimburse” the plan for any overpayment. After the plaintiff, a physician, sued to recover unpaid benefits, the defendant counterclaimed to recover overpaid benefits, on account of the plaintiff’s receipt of disability benefits under a separate group insurance policy. The court held that the plan’s offset and

reimbursement provisions created an equitable lien by agreement on the excess disability benefits paid to the plaintiff under the plan:

[S]tandard Select may seek reimbursement of the benefits paid to Dr. Gutta if the plan created an equitable lien covering these benefits because the plan contains an offset provision preventing plan participants from receiving money from multiple group plans and provides that the participant must immediately reimburse Standard Select for any overpayments.

*Gutta*, 2006 WL 2644955, at \*27. The court, therefore, granted summary judgment for the plan, awarding approximately \$75,000 to the plan in overpaid benefits.

The *Gutta* decision highlights that in order to create an equitable lien by agreement, the terms of the plan not only must identify the subject of the lien (the overpaid disability benefits), but also must contain language obligating the beneficiary to repay any overpayment.

By contrast, a general plan provision that provides for certain benefit offsets, but without language requiring the participant to repay overpaid benefits, generally is insufficient to create an equitable lien by agreement.

For example, in *Kirchner v. G.E. Group Life Assur. Co.*, No. 1:06 CV 763, 2008 WL 52167 (W.D.Mich. Jan. 2, 2008), the defendant asserted a counterclaim against the plaintiff in order to obtain reimbursement of overpaid disability benefits, on account of the plaintiff's receipt of Social Security benefits. The plan provided an offset for Social Security benefits, but failed to specify that participants must reimburse the defendant for any overpayment. In the absence of a contractual obligation to repay, the terms of the plan did not create an equitable lien by agreement. The *Kirchner* court held, therefore, that the defendant failed to state a claim for equitable restitution under §502(a)(3):

[The] plan does not contain any provisions identifying a fund (e.g. overpayment of benefits) and giving G.E. the right to recover from that fund. Although the plan subtracts from the claimant's monthly benefits any income that qualified under the Other Income provisions, there is no provision giving it the express right to recover any overpayment resulting therefrom. Thus, because G.E.'s claim for reimbursement is not equitable in nature, G.E. does not have a remedy under ERISA.

*Id.*, at \*8. See also *Street v. Ingalls Memorial Hospital*, No. 06 C 2963, 2007 WL 844619 (N.D.Ill. Mar. 15, 2007) (“[B]ecause there is no agreement concerning an equitable lien or constructive trust, Street's failure to identify particular funds in Ingalls' possession makes the monetary relief Street seeks unavailable under Section 502(a)(3).”).

An unpublished decision from the Sixth Circuit, and numerous district court decisions, have held that offset and reimbursement provisions in an ERISA plan create an equitable lien by agreement on a specifically identifiable fund, which is enforceable under §502(a)(3). *See, e.g., Gilcrest v. Unum Life Ins. Co. of America*, No. 06-4143, 2007 WL 3037239, at \*8 (6<sup>th</sup> Cir. Oct. 17, 2007) (unpublished) (“[T]he Plan’s overpayment provision asserts a right to recover from a specific fund distinct from Gilcrest’s general assets—the fund being the overpayments themselves—and a particular share of that fund to which the plan was entitled—all overpayments due to the receipt of Social Security benefits . . .”); *Bosin v. Liberty Life Assur. Co. of Boston*, No. 1:06-CV-186, 2007 WL 1101187 (W.D.Mich. Apr. 11, 2007) (“[The] LTD policy and the repayment agreement signed by Bosin create the type of equitable lien ‘by agreement’ recognized and enforced by the Court in *Sereboff*.”); *Disability Reinsurance Management Services, Inc. v. DeBoer*, No. 2:06-CV-21, 2006 WL 2850120 (E.D.Tenn. Sept. 29, 2006) (holding that the plan fiduciary was entitled to enforce an equitable lien by agreement on overpaid disability benefits, due to the defendant’s receipt of deductible Social Security disability benefits and the plan’s provisions for offsets and reimbursement). *See also Admin. Comm. of the Wal-Mart Stores, Inc., Associates’ Health and Welfare Plan v. Shank*, 500 F.3d 834 (8<sup>th</sup> Cir. 2007) (holding that the plan was entitled to recover a portion of the participant’s settlement with a third party based on a subrogation provision similar to the “Acts of Third Parties” provision in *Sereboff*).

One recent district court case reflects that the requirement that the fund must be in the beneficiary’s possession—which is fundamental to obtaining equitable relief according to *Sereboff* and *Great-West*—may be relaxed in cases involving fraud and deceit. *See Northwestern Administrators, Inc. v. Cutter*, No. C07-988, 2008 WL 217731 (W.D.Wash. Jan. 24, 2008) (the fiduciary was entitled to recover medical benefits that were never in the defendant’s possession, but were paid to a third party’s medical providers, because the defendant fraudulently represented that the third party was his spouse).

## **B. Sometimes a promise to repay an identifiable fund is not enough**

The Eleventh Circuit Court of Appeals, in *Popowski v. Parrott*, 461 F.3d 1367 (11<sup>th</sup> Cir. 2006), interpreted *Sereboff* narrowly and, as a result, has created the initial crevice of a potential circuit split.

The *Popowski* court held that, in order to create an equitable lien by agreement, the plan’s subrogation language not only must identify a specific fund in the beneficiary’s possession that properly belongs to the plan, but also must state that the beneficiary’s repayment obligation must be satisfied using specific monies “out of” that particular fund. *Id.*, at 1373-1374.

The *Popowski* court considered the subrogation and reimbursement provisions of two separate medical expense plans: the United Distributors Plan and the Mohawk Plan. The United Distributors Plan created a lien and right of reimbursement on any amount recovered by a beneficiary from a third party, but further specified that the beneficiary

“must repay to the Plan the benefits paid on his or her behalf *out of* the recovery” obtained from the third party. *Id.*, at 1373-1374.

The Mohawk Plan also contained language creating a lien and right of reimbursement on any amount recovered by a beneficiary from a third party. The Mohawk Plan, however, did not specify that the reimbursement must be made *out of* any particular fund, as opposed to from the beneficiary’s general assets.

The *Popowski* court held that the language of the United Distributors Plan created an equitable lien by agreement pursuant to *Sereboff*, whereas the language of the Mohawk Plan merely created a legal obligation to reimburse the Plan from the participant’s general assets. *Id.* Thus, in the Eleventh Circuit, based on *Popowski*, in order to create an equitable lien by agreement, the plan documents must identify (i) a particular fund, (ii) a portion of that fund that is due to the plan, (iii) a promise to reimburse, and (iv) specify that the reimbursement obligation must be made *out of* that particular fund.

*Popowski* construed *Sereboff* narrowly, as though the Supreme Court, in *Sereboff*, was establishing technical language requirements that must be incorporated into the plan’s reimbursement provision in order to create an equitable lien by agreement.

*Popowski*’s interpretation of *Sereboff* misses the overall thrust of the Supreme Court’s decision: when an insured promises to reimburse the plan in the event his claim is overpaid, an equitable lien properly attaches to the funds upon the insured’s receipt of the overpayment. The equitable lien attaches because the insured receives specifically identifiable monies that properly belong to the plan, which the insured promised to reimburse. The holding of *Sereboff* does not suggest that plans must contain precise language requiring the insured to satisfy his or her reimbursement obligation using only monies “out of” that particular fund.

In *Barnes v. Alexander*, 232 U.S. 117 (1914), on which the *Sereboff* Court relied, attorney Barnes did not promise that she would satisfy her payment obligation exclusively “out of” specific monies from the fund (*i.e.*, from the client contingency fee), yet that did not foreclose Street and Alexander from seeking equitable relief. Indeed, the agreement in *Barnes*, which was an oral agreement, was recounted by Justice Holmes in *Barnes*:

The whole matter rests on conversations, in one of which Barnes said to Street and Alexander: “If you will attend to this case I will give you one third of the fee which I have coming to me on a contingent fee from Shattuck, Hanninger, and Marks. Mr. O’Connell, who is associated with me, is entitled to the other third.”

Barnes’s promise to pay identified a specific fund (the contingency fee), and a specific portion of that fund (one-third) that properly belonged to Street and Alexander. But Barnes did not promise to pay Street and Alexander using only monies out of that fund.

It was sufficient to obtain equitable relief that Barnes obtained possession of a portion of an identifiable fund that properly belonged to Street and Alexander.

It is difficult to predict whether *Popowski's* narrow construction of *Sereboff*, or *Dillard's* broad construction of *Sereboff*, will become the majority view. Most district courts appear to be following *Dillard's*. Perhaps the Seventh Circuit's anticipated disposition of the *Gutta* case, which was argued before the Seventh Circuit panel on September 11, 2007, will signal a shift toward the broader application of *Sereboff*, as reflected in *Dillard's*, and *Popowski* will be consigned solely to the subrogation subset of equitable reimbursement cases.

### **C. Statutory standing to enforce an equitable lien by agreement**

Obviously the party seeking to enforce an equitable lien by agreement under §502(a)(3) must have statutory standing to assert the claim. Statutory standing considers whether the party seeking relief falls within the zone of interests of the statute. *See Harzewski v. Guidant Corp.*, 489 F.3d 799 (7<sup>th</sup> Cir. 2007).

Section §502(a)(3) authorizes only *participants, beneficiaries and fiduciaries* to seek appropriate relief. In most cases, statutory standing is easy to establish, because the party seeking equitable relief is the plan's insurer. The insurer usually qualifies as a fiduciary, because it administered claims and exercised discretion in the disposition of plan assets. *See* 29 U.S.C. §1002(21)(A) (defining "fiduciary" under ERISA as a person who exercises control over the plan, plan assets, or plan administration). In the complaint or counterclaim, it is important to allege that the insurer is a fiduciary under ERISA with respect to the disposition of benefits, in order to establish statutory standing to obtain equitable relief under §502(a)(3).

The issue of statutory standing becomes more complicated when the party seeking equitable relief is the ERISA plan itself. The issue is further complicated by a circuit split on whether a plan has statutory standing to seek relief under §502(a)(3), with the Seventh Circuit saying "Yes" and the Second Circuit saying "No."

Consider, for example, a participant who sues to recover benefits under §502(a)(1)(B), but who names the plan as the sole defendant. The plan, in turn, desires to assert a counterclaim to recover overpayments. The plan cannot be a fiduciary under ERISA, and therefore, the plan does not fall within the class of participants, beneficiaries and fiduciaries expressly authorized to sue under §502(a)(3). *See Hunter v. Caliber Systems, Inc.*, 220 F.3d 702, 708 (6<sup>th</sup> Cir. 2000) ("[t]he Caliber Plans were not fiduciaries ..."); *Todd v. AIG Life Ins. Co.*, 47 F.3d 1448, 1458 (5<sup>th</sup> Cir. 1995) ("Given that an ERISA plan as an entity cannot have discretionary authority over itself, we conclude that the GAI Plan does not fall within the statutory definition of a fiduciary ..."); *Sorensen v. SBC Umbrella Plan No. 1*, No. 05 C 278, 2006 WL 335440, at \*4 (E.D. Wis. Feb. 9, 2006) ("ERISA benefit plans ... are not fiduciaries as defined by 29 U.S.C. §1002(21) [.]").

The plan, however, may rely on §502(d)(1) to establish statutory standing under §502(a)(3). Section 502(d)(1) provides: “An employee benefit plan may sue or be sued under this subchapter as an entity.” 29 U.S.C. §1132(d)(1).

The Seventh Circuit has held that §502(d)(1) is jurisdictional in nature and confers ERISA plans with statutory standing to seek relief under §502(a), even though ERISA plans are not within the delineated class of participants, beneficiaries or fiduciaries specifically designated by §502(a). *See, e.g., Automobile Mechanics Local 701 Welfare and Pension Funds v. Vanguard*, 502 F.3d 740, 744-745 (7<sup>th</sup> Cir. 2007); *Peoria Union Stockyards Co. Retirement Plan v. Penn Mutual Life Ins. Co.*, 698 F.2d 320 (7<sup>th</sup> Cir. 1983) (holding that §502(d)(1) confers ERISA plans with statutory standing to initiate civil actions under §502(a)).

The Second Circuit, on the other hand, has held that §502(d)(1) does not confer statutory standing upon ERISA plans to seek equitable relief under §502(a)(3). *See Pressroom Unions-Printers League Income Security Fund v. Continental Assurance Co.*, 700 F.2d 889, 893 (2<sup>nd</sup> Cir.). *cert. denied*, 463 U.S. 1233 (1983) (holding that the omission of employee benefit plans from the list of enumerated “persons” in §502(a) manifests Congress’ intent to deprive employee benefit plans of standing to sue under ERISA).

It is true that §502(a)(3) does not list ERISA plans among the “persons” authorized to seek equitable relief, as *Pressroom Union* points out. But that does not compel the conclusion that Congress intended to deprive ERISA plans of the right to assert claims under §502(a)(3). It must be emphasized that §502(a) merely identifies the class of “persons” authorized to sue under ERISA. An employee benefit plan is not a “person” as defined by ERISA. *See* 29 U.S.C. §1002(9). Indeed, §502(d)(1) expressly states that an employee benefit plan “*may sue or be sued under this subchapter as an entity.*”

### **III. Do Federal Common Law Claims Survive *Sereboff*?**

Section 502(a)(3) is not the only way for plans and plan fiduciaries to obtain restitution of overpaid benefits. Back in the days of *Great-West*, courts generally treated claims for reimbursement as actions seeking legal relief, because money, unlike personal property, is fungible. *Great-West* generally foreclosed plans and plan fiduciaries from seeking legal restitution under §502(a)(3).

After *Great-West*, in some federal circuits, plan fiduciaries largely were left without any recourse to obtain restitution under ERISA. *See, e.g., Qualchoice, Inc. v. Rowland*, 367 F.3d 638 (6<sup>th</sup> Cir. 2004), *cert. denied*, 544 U.S. 942 (2005); *Cooperative Benefit Administrators, Inc. v. Ogden*, 367 F.3d 323, 332 (5<sup>th</sup> Cir. 2004).

In other federal circuits, courts have suggested that plan fiduciaries may obtain legal restitution by fashioning a federal common law of ERISA. These courts recognized that it was fundamentally inequitable to allow beneficiaries to retain a windfall simply

because the ERISA statute did not provide an avenue to obtain legal restitution. These courts responded by allowing plans and plan fiduciaries to recover overpayments under the federal common law of ERISA. *See, e.g., Leipzig v. AIG Life Ins. Co.*, 362 F.3d 406 (7<sup>th</sup> Cir. 2004); *Admin. Comm. of Wal-Mart Assoc. Health & Welfare Plan v. Willard*, 393 F.3d 1119 (10<sup>th</sup> Cir. 2004); *Bombardier Aerospace Employee Welfare Benefits Plan v. Ferrer, Poirot & Wansbrough*, 354 F.3d 348 (5<sup>th</sup> Cir. 2003), *cert. denied*, 541 U.S. 1072 (2004); *Admin. Comm. of Wal-Mart Stores, Inc. v. Varco*, 338 F.3d 680 (7<sup>th</sup> Cir. 2003), *cert. denied*, 542 U.S. 945 (2004).

Do federal common law theories survive *Sereboff*? Certainly *Sereboff*'s expansion of the scope of equitable relief under §502(a)(3) lessens the judicial perception that common law remedies are necessary to prevent inequitable results. Indeed, courts may be less sympathetic to fiduciaries who cannot satisfy the requirements for equitable relief under §502(a)(3). In this regard, *Sereboff* might be construed as placing fiduciaries on notice that the reimbursement language in ERISA plans must be modified to mirror the language of the reimbursement provision in *Sereboff*. This analysis certainly suggests that the inequities that lead to the judicial creation of common law remedies pre-*Sereboff* may be less compelling to courts—and less frequently available to fiduciaries—in the post-*Sereboff* world.

While it is likely that *Sereboff* will narrow the avenues of relief under federal common law theories, it is unlikely that these avenues will be foreclosed completely. Indeed, even after *Sereboff*, some courts have continued to recognize that plan fiduciaries may obtain legal restitution under the federal common law of ERISA. *See Plan Administrator v. Kienast*, No. 2:06-CV-1529, 2008 WL 202115, at \*4 (W.D.Pa. Jan. 23, 2008) (“[P]laintiffs have distinct and overlapping remedies under the [ERISA] statute and federal common law to accomplish this equitable restitution.”); *Unum Life Ins. Co. of America v. Wolf*, No. 07-CV-71, 2008 WL 356540, at \*4-5 (D.Colo. Jan. 22, 2008) (granting summary judgment to the plaintiff/insurer for equitable relief under §502(a)(3) and under a common law theory of unjust enrichment, based on the defendant’s receipt of Social Security benefits). *Cf., Verizon Employee Benefits Committee v. Adams*, No. 2:07-CV-476, 2007 WL 4150928, at \* (W.D.Pa. Nov. 19, 2007) (dismissing the plaintiff’s unjust enrichment claim because the plaintiff stated a cognizable claim under §502(a)(3), and noting that it is unresolved in the Third Circuit as to whether federal common law unjust enrichment claims are recognized under ERISA).

#### **A. Restitution under the federal common law of ERISA**

The availability of a federal common law right of restitution depends upon whether the reviewing court determines that a gap exists in ERISA’s statutory scheme. But creating a federal common law cause of action is not merely filling a minor gap in ERISA’s statutory scheme. Rather, it entails the creation of a substantive federal remedy.

Many courts, therefore, have refused to recognize a federal common law right to obtain restitution. The reasoning of these courts is that if Congress had intended to provide such a right, Congress would not have limited the relief available under

§502(a)(3) to only appropriate equitable relief. *See, e.g., Cooperative Benefit Administrators v. Ogden*, 367 F.3d 323, 335 (5<sup>th</sup> Cir. 2004) (“[P]lan fiduciaries do not have a federal common law right to sue a beneficiary for legal (as distinct from equitable) relief on a theory of unjust enrichment or restitution.”); *Provident Life & Accident Ins. Co. v. Cohen*, 423 F.3d 413, 425 (4<sup>th</sup> Cir. 2005) (“[I]t is at odds with ERISA to recognize a federal common law cause of action for unjust enrichment in this case.”); *North Am. Coal Corp. Ret. Sav. Plan v. Roth*, 395 F.3d 916, 917-918 (8<sup>th</sup> Cir.), *cert. denied*, 546 U.S. 862 (2005) (“[T]here is no gap in ERISA’s text regarding a fiduciary’s right to bring a civil action for legal remedies to enforce plan terms or ERISA provisions . . . .”); *Eldridge v. Wachovia Corp. Long-Term Disability Plan*, 383 F.Supp.2d 1367, 1374 (N.D.Ga. 2005) (holding that there is no federal common law right to recover overpaid benefits based on a theory of unjust enrichment).

Other courts, however, have recognized a federal common law right to recover overpaid benefits based on a theory of unjust enrichment. The reasoning of these courts is that *dicta* in *Great-West* suggests that §502(a)(3) may not be the only vehicle for plans and plan fiduciaries to obtain restitution: “We note, though it is not necessary to our decision, that there may have been other means for petitioners to obtain the essentially legal relief that they seek.” *Great-West*, 534 U.S. at 220. *See, e.g., Harris Trust and Savings Bank v. Provident Life and Accident Ins. Co.*, 57 F.3d 608, 615 (7<sup>th</sup> Cir. 1995) (recognizing the validity of the plaintiff’s claim for restitution based on alternative theories of §502(a)(3) and the federal common law of ERISA); *Provident Life & Accident Ins. Co. v. Waller*, 906 F.2d 985 (4<sup>th</sup> Cir.), *cert. denied*, 498 U.S. 982 (1990) (“[i]t is appropriate for a federal court to weave into the statutory fabric of ERISA the federal common law remedy of unjust enrichment”); *Fick v. Metropolitan Life Ins. Co.*, 347 F.Supp.2d 1271, 1288 (S.D.Fla. 2004) (“[t]he *Knudson* Court does not bar suits for unjust enrichment brought pursuant to federal common law of ERISA”); *Unum Life Ins. Co. of America v. O’Brien*, No. 6:03-CV-1433, 2004 WL 2283559, at \*4 (M.D. Fla. Oct. 4, 2004) (“[t]he Court agrees that creation of a federal common law claim of unjust enrichment in this instance ‘furthers the purposes of ERISA [.]’”).

Claims for legal restitution under the federal common law of ERISA are founded on state law principles of unjust enrichment. The fiduciary must allege a reasonable expectation of payment, or that society’s reasonable expectations of property would be defeated if the beneficiary does not repay the fiduciary. *Trustmark Life Ins. Co. v. Univ. of Chicago Hospitals*, 207 F.3d 876, 883 (7<sup>th</sup> Cir. 2000).

In jurisdictions recognizing federal common law claims for restitution, it is advisable to plead such claims in the alternative, in addition to pleading a §502(a)(3) claim for equitable relief through enforcement of an equitable lien by agreement.

## **B. Establishing federal jurisdiction over federal common law claims**

Although federal common law claims are federal in nature, they require an independent basis for federal jurisdiction. In short, an action for restitution under the

federal common law of ERISA does not create federal question jurisdiction under 28 U.S.C. §1331.

There are two ways to establish jurisdiction when initiating a claim for restitution in federal court. The first way is to satisfy the requirements of diversity jurisdiction. Thus, even if the §502(a)(3) claim is dismissed, federal jurisdiction remains secure over the federal common law claim.

The second way is to allege supplemental jurisdiction under 28 U.S.C. §1367(a), based on a federal jurisdiction over the separate §502(a)(3) claim. When a federal common law claim for unjust enrichment is asserted as a counterclaim to a plaintiff's suit to recover benefits under §502(a)(1)(B), it is paramount to plead §1367(a) as the basis for jurisdiction over the counterclaim.

The wisdom of expressly pleading jurisdiction based on §1367(a) is demonstrated by the Seventh Circuit's holding in *Leipzig*. In *Leipzig*, the plaintiff sought to recover benefits under §502(a)(1)(B). The defendant, the plan's insurer, filed a counterclaim under §502(a)(3) and based on principles of unjust enrichment, in order to recover benefits previously paid to the plaintiff under a reservation of rights. The Seventh Circuit affirmed the dismissal of the defendant's §502(a)(3) counterclaim pursuant to *Great-West*, because the relief sought was monetary and, hence, not a form of equitable relief. *Leipzig*, 362 F.3d at 409.

The Seventh Circuit, in *Leipzig*, further held that it lacked jurisdiction to adjudicate the defendant's counterclaim under the federal common law of ERISA—not because such claims cannot exist, but because there was no jurisdictional basis alleged in the counterclaim to entertain a federal common law claim. The defendant had invoked jurisdiction based solely on federal question under §502(a)(3). When the §502(a)(3) claim was dismissed, there was no basis for jurisdiction over the common law claim.

The defendant in *Leipzig* argued that because federal common law claims are federal, there must be federal question jurisdiction. The Seventh Circuit rejected the defendant's proposition that federal common law claims confer courts with federal question jurisdiction. As stated by the court in *Leipzig*:

[The defendant states] that, because it has a good claim under federal law, there *must* be federal jurisdiction. Why so? Until 1875 the federal courts had no federal-question jurisdiction at all. State courts were, and remain, empowered to entertain claims arising under federal law. Although today almost every federal claim can be heard in federal court under §1331, *Great-West* shows that there are still lacunae. [The defendant] can pursue its claim in state court without encountering a defense of preemption; ERISA preempts state-law theories, not claims arising under federal law.

*Leipzig*, 362 F.3d at 410.

In stating a claim for restitution under the federal common law of ERISA, therefore, it is crucial to allege the appropriate jurisdictional basis for the claim.

#### **IV. Defenses To Restitution Under §502(a)(3): Is Equitable Relief Appropriate?**

*Sereboff* clearly broadened the scope of equitable restitution available to plans and plan fiduciaries under §502(a)(3). But what are the possible defenses available to beneficiaries under §502(a)(3)? The Supreme Court noted, in a footnote to the *Sereboff* opinion, that the Sereboffs disputed whether equitable relief was appropriate under the circumstances. *Sereboff*, 126 S.Ct. at 1876 n.2. Section 502(a)(3) authorizes only “appropriate” equitable relief. The Supreme Court declined to address the issue, because it was not raised before the lower courts. *Id.* The critical question left unanswered by *Sereboff* is what criteria courts should use to determine whether equitable relief is appropriate in any given case. See Prof. Colleen Medill, “Sereboff and the Future of ERISA Remedies,” [http://lawprofessors.typepad.com/laborprof\\_blog/2006/05/sereboff\\_and\\_th.html](http://lawprofessors.typepad.com/laborprof_blog/2006/05/sereboff_and_th.html).

Courts have begun to fill the gap in *Sereboff* by evaluating whether equitable relief is appropriate under §502(a)(3) according to the same general state law principles that applied to claims for restitution under the federal common law of ERISA. These general principles include the relative fault of the parties, and whether there would be unjust harm or prejudice in granting equitable relief. See *Pohl v. DS&P*, No. 04 C 6223, 2006 WL 208710 (N.D.Ill. Jan. 25, 2006) (holding that the fiduciary’s equitable claim to recover an erroneous payment was appropriate under §502(a)(3), because the beneficiary was partly at fault and he would not be harmed except for the “natural disappointment” of having to “cough up money”) (citation omitted).

Consequently, the defenses to claims for equitable restitution under §502(a)(3) likely will be no different than the defenses asserted to claims for legal restitution under the federal common law of ERISA.

##### **A. Equitable estoppel**

Under familiar common law principles of equity, estoppel occurs when one party detrimentally relies on a misrepresentation made by another party. An insured may invoke equitable estoppel as a defense to a claim for restitution of overpaid benefits under an individual insurance policy not subject to ERISA, when the overpayment was due to the insurer’s negligence and the insured was prejudiced by the error. Beneficiaries will attempt to make the same arguments in attempting to thwart a fiduciary’s claim for equitable restitution under §502(a)(3).

Consider, for example, a beneficiary who received \$5,000 in monthly disability benefits instead of the correct \$1,000 monthly benefit amount. Applying state law

principles of equitable estoppel, the beneficiary endeavors to place the focus on the fiduciary's alleged negligence in making the overpayment before fully investigating all possible offsets. As a result, the fiduciary finds itself defending the thoroughness of its administrative investigation, rather than prosecuting its claim to recover an overpayment.

It is crucial to establish at the outset of the litigation, therefore, that state law principles of equitable estoppel are different from principles of ERISA estoppel. Under ERISA estoppel, the beneficiary seeks to estop the fiduciary from enforcing the terms of the plan, and thereby retain greater benefits than authorized by the terms of the plan. Only extreme circumstances warrant the court to override the terms of the plan through the doctrine of estoppel. *Sandstrom v. Cultor Food Science, Inc.*, 214 F.3d 795 (7<sup>th</sup> Cir. 2000); *Keiser v. CDC Inv. Mgmt. Corp.*, No. 99 C 12101, 2004 WL 516212 (S.D.N.Y. Mar. 17, 2004).

For example, estoppel may not be used to override the clear and unambiguous terms of the plan. See *High v. E-Systems Inc.*, 459 F.3d 573, 580 (5<sup>th</sup> Cir. 2006) (“[A]llowing ‘estoppel to override the clear terms of plan documents would be to enforce something other than the plan documents themselves. That would not be consistent with ERISA.’”) (quoting *Sprague v. General Motors Corp.*, 133 F.3d 388, 404 (6<sup>th</sup> Cir.), cert. denied, 524 U.S. 923 (1998)).

In *Burger v. Life Ins. Co. of North America*, 103 F.Supp.2d 1344 (N.D.Ga. 2000), the plaintiff sought to estop the defendant from enforcing the disability plan's offset for part time work earnings, because the defendant paid full benefits for three years with full knowledge of these work earnings. The court rejected the plaintiff's theory of equitable estoppel, because the policy's terms “clearly puts one on notice that if an employee continues working and earns wages while disabled, the policy benefits are reduced ....” *Id.*, at 1350.

Although not necessary to its holding, the *Burger* court noted that the plaintiff had detrimentally relied on the defendant's overpayment, by purchasing a new home and a car. *Burger* reflects that the requirement of detrimental reliance is not always hard to satisfy.

In addition, estoppel is inappropriate when the fiduciary's conduct was merely negligent. A beneficiary is not entitled to retain a windfall simply because the fiduciary's administrative investigation arguably might have been more searching. It would be absurd to suppose that if a plan owed a beneficiary \$1 and through its own negligence tendered payment for \$1 million, simply on the basis that the plan should have avoided making the mistake. Otherwise, disability claimants might be less forthcoming in their disclosure of information, in order to prevent the discovery of possible offsets or reductions. Plan fiduciaries, too, would be faced with the Hobson's choice of either incurring the administrative expense of conducting a relentless and exhaustive investigation, or simply accepting the financial risk of overpaying claims.

In *Brosted v. Unum Life Ins. Co. of America*, 521 F.3d 459 (7<sup>th</sup> Cir. 2005), the plaintiff sought to recover a higher level of benefits than authorized by the plan's written

terms, based on the defendant's mathematical error in calculating benefits. The plaintiff claimed that the defendant should be equitably estopped from enforcing the plan's benefit calculation provisions, because the plaintiff detrimentally relied on the defendant's erroneous benefit calculation in negotiating a severance package from his employer. The Seventh Circuit held that the plaintiff's equitable estoppel claim failed because the defendant's error was merely negligent and not intentional. "[T]o prevail on an equitable estoppel claim, among other things, Brosted must establish a knowing misrepresentation by the defendant." *Id.*, at 464.

*See also Decatur Memorial Hosp. v. Connecticut Gen. Life Ins. Co.*, 990 F.2d 925, 926-27 (7<sup>th</sup> Cir. 1993) ("Arguments that negligent misrepresentations 'estop' sponsors or administrators from enforcing the plans' written terms have been singularly unsuccessful."); *Luby v. Teamsters Health, Welfare, and Pension Trust Funds*, 944 F.2d 1176, 1186 (3<sup>rd</sup> Cir. 1991) (noting that "under the federal common law of unjust enrichment, restitution of a mistaken payment is permitted even if payment was caused by the negligence of the party seeking restitution"); *Kaliszewski v. Sheet Metal Worker's Nat'l Pension Fund*, No. 03-216, 2005 WL 2297309, at \*7 (W.D.Pa. July 19, 2005) ("A fund's negligence in making a mistaken payment does not, in itself, bar restitution.").

## **B. Waiver**

Waiver occurs when a party intentionally relinquishes a known right. The defense of waiver, like estoppel, is in many respects inconsistent with the important goals of ERISA, including uniformity in plan administration and protecting the financial integrity of plans. Nevertheless, most courts acknowledge that ERISA does not expressly prohibit knowing and voluntary waivers. *See Rodriguez-Abreu v. Chase Manhattan Bank, N.A.*, 986 F.2d 580, 587 (1<sup>st</sup> Cir. 1993); *Dist. 29, United Mine Workers v. New River Co.*, 842 F.2d 734, 737 (4<sup>th</sup> Cir. 1988).

Unlike estoppel, waiver does not require the beneficiary to establish detrimental reliance on the overpayment. Rather, the critical elements of waiver are the fiduciary's knowledge of the overpayment, and conduct evidencing the fiduciary's intention to abandon the right to recover the overpayment.

In the context of claims for restitution or unjust enrichment, the defense of waiver may be articulated as the voluntary payment doctrine, which is a state common law principle. The voluntary payment doctrine provides that a payment voluntarily made with full knowledge of the facts cannot be recovered in the absence of fraud, misrepresentation or mistake of fact. *See, e.g., Rivera v. Network Health Plan of Wisconsin, Inc.*, No. 02 C 1055, 2003 WL 22794439, at \*12 (E.D.Wis. July 11, 2003).

The requirement of knowledge was strictly construed to mean actual knowledge in *Gutta*, a decision from the Northern District of Illinois discussed in section II (A) of this article. The plaintiff, a plan participant, argued that the defendant waived its right to enforce the plan's provision that provided an offset for disability benefits received by the participant under any other group insurance policy. During the administrative review

process, the plaintiff disclosed that he was receiving disability benefits under five insurance policies; however he failed to indicate whether any of these policies were group insurance policies. The defendant mistakenly assumed that all the policies were individual policies and paid full benefits for over two years. In fact, one of the plaintiff's policies was a group insurance policy. The district court held that the defendant did not waive its right to recover the overpayment, because the defendant lacked actual knowledge that one of the plaintiff's policies was a group insurance policy. *Gutta*, 2006 WL 2644955, at \*27. The *Gutta* court rejected the plaintiff's argument that the knowledge element of waiver is satisfied if the defendant could have determined, through further investigation, that an offset was available.

*Gutta* instructs that knowledge, for purposes of waiver, means actual knowledge based on the information in the fiduciary's possession, and not constructive knowledge based on information that the fiduciary might have obtained through further investigation.

When the fiduciary possess all the pieces of the puzzle needed to identify an offset, yet fails to do so, some courts have found that the fiduciary waived its right to obtain restitution based on constructive knowledge. Inadvertence may be sufficient to constitute waiver in some cases. *See Cohn v. Anthem Life and Health Ins. Co.*, 965 F.Supp. 1119, 1123 (N.D.Ill. 1997) (holding that the defendant waived its right to recover a benefit overpayment resulting from a clerical error).

Whereas the *Burger* decision, discussed above, rejected the plaintiff's equitable estoppel theory, the court accepted the plaintiff's waiver theory, based on the defendant's constructive knowledge that offsets were available. During the administrative review process, the plaintiff in *Burger* submitted his tax returns to the defendant reflecting his receipt of part time work earnings. The court, in essence, charged the defendant with constructive knowledge of the contents of the tax returns. Accordingly, the court held that the defendant waived its right to recover past benefit overpayments, and also waived its right to offset the plaintiff's part time working earnings from future benefit payments.

In countering allegations of waiver by inadvertence, it is important to provide the court with the details of *all aspects* of the fiduciary's administrative investigation, including minutiae about the fiduciary's investigation of the medical evidence. One should present the issue of offsets within the larger context of the fiduciary's overall investigation. By doing so, evidence of an offset that might seem obvious in isolation, becomes a "needle in a haystack" against the backdrop of the entire administrative record.

### **C. Offsets for Social Security benefits**

Section 407(a) of the Social Security Act shields Social Security benefits from attachment either at law or in equity. Section 407(a) provides:

The right of any person to any future payment under this subchapter shall not be transferable or assignable, *at law or in*

*equity*, and none of the moneys paid or payable or rights existing under this subchapter shall be subject to execution, levy, attachment, garnishment, or other legal process, or to the operation of any bankruptcy or insolvency law.

42 U.S.C. §407(a) (emphasis added).

Does §407(a) thwart a fiduciary from recovering overpayments resulting from the participant's receipt of Social Security disability benefits? The answer depends on how the object of the equitable lien (the fund) has been alleged in the fiduciary's complaint or counterclaim.

In *Ross v. Pennsylvania Manufacturers Association Ins. Co.*, No. 1:05-561, 2006 WL 1390446 (S.D.W.Va. May 22, 2006), the court held that §407(a) barred the defendant from recovering overpaid benefits by reason of the plaintiff's receipt of Social Security disability benefits, even though the defendant properly alleged a claim for equitable restitution under §502(a)(3) and *Sereboff*. The defendant, therefore, was precluded from enforcing the plan's offset for Social Security benefits, and the plaintiff, consequently, was entitled to retain the windfall.

The decisive factor in *Ross* was that the defendant sought to impose an equitable lien upon a portion of the plaintiff's future Social Security disability benefits:

[Defendant] seeks the imposition of a constructive trust on future SSDI payments to plaintiff to the extent necessary to extinguish the overpayment and an order directing plaintiff to restore such sums to the Plan.

*Id.*, at \*7. Because the "fund" alleged to be subject to the equitable lien by agreement was the Social Security disability benefits themselves, §407(a) shields the fund from attachment. *Accord Kay v. American Elec. Power Service Corp.*, No. 3:05-612, 2006 WL 2228992, \*8 (S.D.W.Va. Aug. 3, 2006).

Section 407(a) will not preclude recovery of overpaid benefits, however, when the insurer seeks to impose the equitable lien on the excess plan benefits paid to the participant. The object of the lien is the excess monthly benefit paid by the insurer, rather than the monthly Social Security benefit received by the participant. This distinction was crucial in *Bosin v. Liberty Life Assur. Co. of Boston*, No. 1:06-CV-186, 2007 WL 1101187 (W.D.Mich. Apr. 11, 2007) (holding that §407(a) did not bar the defendant from imposing an equitable lien on the amount of overpaid plan benefits).

One district court decision has adopted an expansive interpretation of §407(a). In *Mote v. Aetna Life Ins. Co.*, 435 F.Supp.2d 827 (N.D.Ill. 2006), the court concluded that the defendant could not obtain reimbursement of overpaid disability payments because the benefits had been placed into an unsegregated account with Social Security payments. The *Mote* court held that when the participant deposits his long term disability benefits

and his Social Security benefits into a single commingled account, all the funds in that account are protected from attachment by §407(a).

*Mote*, however, represents an extreme viewpoint and has been rejected by a court within the same federal district. See *Smith v. Accenture U.S. Group Long-Term disability Ins. Plan*, No. 05 C 5942, 2006 WL 2644957, at \*4 (N.D.Ill. Sept. 13, 2006) (holding that the plaintiff cannot use §407(a) to protect all liquid assets from legal process merely by commingling those assets with Social Security payments, and granting defendant's §502(a)(3) claim to recover overpaid benefits). Accord *Fregeau v. Life Ins. Co. of North America*, 490 F.Supp.2d 928, 932 (N.D.Ill. 2007) (“[B]ecause the lien is on the money paid by defendant to plaintiff, not on SSD benefits received by plaintiff, §407(a) does not apply.”).

#### **D. Offsets for group insurance benefits**

Disability plans also may provide an offset for benefits received under any other group disability insurance policy. This type of offset provision is designed to prevent double-dipping of benefits from multiple group policies, thereby reducing the risk that participants might have a greater financial incentive to seek disability status rather than to continue working. See, e.g., *Loggins v. Nortel Networks, Inc.*, 2006 Fed.Appx. 329 (5<sup>th</sup> Cir. 2006) (upholding the offset of disability benefits received under a group travel insurance policy) (unpublished disposition).

Some claimants have attempted to distinguish between group insurance and franchise insurance, arguing that an offset for benefits received under any group insurance policy does not extend to benefits received under a franchise insurance policy. For example, in *Hall v. Life Ins. Co. of North America*, 317 F.3d 773 (7<sup>th</sup> Cir. 2003), the defendant reduced the plaintiff's disability benefits by the amount of benefits payable under a separate insurance policy purchased by the plaintiff through her membership in the Society of Certified Public Accountants. The defendant argued that “group insurance” should be construed literally to encompass coverage obtained through membership in a group.

The plaintiff in *Hall* argued, however, that coverage obtained through membership in a professional society constitutes franchise insurance and not group insurance. The plaintiff argued that “group insurance” means all-or-nothing coverage provided to entire groups, whereas franchise insurance provides optional coverage offered to members of a group on a voluntary basis. As construed by the plaintiff in *Hall*, “group insurance” is designed to reduce the risk of adverse selection, meaning the tendency of persons safer than the norm to drop out of the pool of insureds, which increases the average risk and, in turn, raises the premium cost. *Id.*, at 775.

The Seventh Circuit in *Hall* ultimately found that it was unnecessary to decide whether “group insurance” necessitates an all-in or all-out coverage feature, because the ERISA plan at issue specifically included “franchise insurance” by name as a type of insurance benefit subject to the plan's offset provision. *Id.*, at 776. *Hall*, therefore,

acknowledges the possibility that group insurance does not necessarily encompass all forms of franchise insurance, but fails to decide that issue. Nonetheless, the Seventh Circuit, arguably *in dicta* in *Hall*, noted that franchise insurance “looks very much” like group insurance as defined by *Couch on Insurance. Id.*, at 776.

*Couch on Insurance* distinguishes between group insurance and franchise insurance based on how the overall insurance relationship is structured. Group insurance entails three parties: the insurer, a central entity (to whom the policy is issued), and the group members (who typically receive certificates of insurance):

Group insurance involves three parties: the employer or other “central entity,” the insurer, and the insured group members. A group insurance policy is the contract between the insurer and an employer, association, creditor, or some other central entity, for the benefit of a group of people that have some relationship to the central entity, such as employees, association members, or debtors. [I]ndividual group members typically receive certificates proving they are insured and listing what coverage is provided. Thus, group insurance policies are “contracts for the benefit of third parties.”

1A *Couch on Ins.*, §7:1 (2005).

Franchise insurance, on the other hand, avoids the tripartite relationship that is generally characteristic of group insurance. In franchise insurance, the insured contracts directly with the insurer and receives an individual insurance policy:

Group insurance is an arrangement by which a single insurance policy is issued to a central entity—commonly an employer, association, or union—for coverage of the individual members of the group. Franchise insurance is a variation on group insurance, in which all members of the group receive individual policies. While franchise insurance avoids the 3-party relationship that complicates group insurance, it multiplies the administrative burden for insurers, and is not nearly as common as group insurance.

1 *Couch on Ins.*, §1:29.

Although the Seventh Circuit, in *Hall*, passed on deciding the broad issue of whether group insurance encompasses franchise insurance, the district court in *Gutta* specifically decided the issue in favor of the ERISA plan. *Gutta*, 2006 WL 2644955, at \*28. The defendant in *Gutta* sought to recover an offset for disability benefits received by the plaintiff under a group insurance policy issued to the American Medical Association. The plaintiff countered that the AMA policy was franchise insurance and not group insurance.

Unlike *Hall*, however, the ERISA plan at issue in *Gutta* did not list franchise insurance as a type of group insurance policy subject to the plan's offset for group disability insurance benefits. The court, adhering to the distinction between group insurance and franchise insurance as elaborated in *Couch on Insurance*, held that the plaintiff's AMA coverage constituted group insurance and, hence, the defendant was entitled to the offset. The *Gutta* court observed that the AMA coverage constituted group insurance coverage because (i) the plaintiff had received a certificate of coverage rather than an individual policy, (ii) the policy issued to the AMA specifically was titled "Group Policy," (iii) the policy provided that certificate holders could covert their coverage to individual coverage. *Gutta*, 2006 WL 2644955, at \*28.

### **E. Exhaustion of administrative remedies**

Beneficiaries may attempt to defeat claims for equitable restitution by arguing that the fiduciaries failed to exhaust administrative remedies prior to asserting their equitable claims. The exhaustion doctrine arises out of the requirements for a "full and fair" review under §503 of ERISA, 29 U.S.C. §1133. This defense also relies upon the familiar principle that a fiduciary may not advance in court a new basis for denying a claim that was not asserted during the administrative proceeding. *See, e.g., Glista v. Unum Life Ins. Co. of America*, 378 F.3d 113, 129-131 (1<sup>st</sup> Cir. 2004).

The exhaustion of administrative remedies, however, applies when a plan participant or beneficiary seeks to recover benefits under §502(a)(1)(B), and does not apply to claims for restitution under §502(a)(3). In short, a plan fiduciary is not required to submit a claim to itself, and decide its own claim, as a prerequisite to filing suit under §502(a)(3). *See Reliance Standard Life Ins. Co. v. Smith*, No. 05 C 467, 2006 WL 2993054, at \*3 (E.D.Tenn. Oct. 18, 2006) ("As Reliance is not a beneficiary/participant under the plan, it is not required to exhaust any administrative procedures on the overpayment claim").

When there has not been an administrative proceeding with respect to the restitution issue, however, the court's review of the restitution claim will be under the *de novo* standard. If the fiduciary seeks deferential review in the context of a claim for restitution, the fiduciary should raise the issue of reimbursement in the context of administering the fiduciary's benefit claim. Otherwise, the court may apply the arbitrary and capricious standard with respect to the beneficiary's claim for benefits, and the *de novo* standard with respect to the fiduciary's counterclaim for equitable restitution. *See, e.g., Gutta*, 2006 WL 2644955.

### **V. Conclusion**

Equitable claims for restitution have become an important part of the ERISA fiduciary's litigation arsenal. Litigation in the wake of *Sereboff* likely will focus on whether equitable relief under §502(a)(3) is "appropriate" under the circumstances of any given case. Beneficiaries, under the theory of arguing that equitable relief is not appropriate, will attempt to introduce the array of common law equitable defenses that

were available in the days of the divided bench. As a result, it will be important to ensure that these state law equitable defenses are properly constrained and limited so as not to conflict with well established principles of ERISA.