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Employment Law Daily
September 8, 2015

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PENSION AND BENEFIT PLANS—9th Cir.: Health plan cannot recover from employer on contract claim for health benefits paid to ineligible workers

By Ronald Miller, J.D.

A health and benefit plan governed by ERISA could not recover damages on a breach of contract claim against an employer and two ineligible workers who received health care benefits, ruled the Ninth Circuit. The plan's claim for "specific performance of the reimbursement provisions of the plan" was foreclosed because specific performance is typically a legal, not equitable, remedy unless it is "sought to prevent future losses that either were incalculable or would be greater than the sum awarded." The appeals court rejected the plan's characterization of the reimbursement of the plan as an equitable lien by agreement, because funds were never "actually transferred" to the employer or workers but paid directly to medical providers. Judge Fletcher filed a separate concurring opinion (*Oregon Teamsters Employers Trust v. Hillsboro Garbage Disposal, Inc.*, September 8, 2015, Bayslon, M.).

The health and benefit plan provided health and welfare benefits to employees whose employers entered into collective bargaining agreements with a Teamster affiliate. In September 2003, Hillsboro Garbage and Teamsters Local Union No. 305 entered into a collective bargaining agreement which made Hillsboro a subscriber to the plan. The CBA was renewed in April 2007 through February 28, 2012. Under the terms of the subscription agreements, Hillsboro and the union agreed to be bound by the provisions of the plan's trust agreement, chose the plan for eligible employees and their dependents, and agreed that Hillsboro Garbage would be subject to periodic audits to detect unauthorized contributions.

The trust agreement also authorized the plan's trustees to enter into special agreements with Hillsboro under which the plan would provide health and welfare benefits for the company's non-bargaining unit employees. Only individuals with a *bona fide* employment relationship with Hillsboro were eligible to participate in the benefit plans.

Ineligible employees. Starting in 2003, the plan received contributions for health care benefits coverage for two workers, purportedly as employees of Hillsboro. In fact, the two workers were not employed by Hillsboro but by a separate company that had common ownership with Hillsboro. An audit in 2006 revealed that Hillsboro had made unauthorized contributions on behalf of the two workers. The plan then sent Hillsboro a copy of the audit report, advising that $70,000 in unauthorized contributions had been uncovered, and that it had six months to make a written refund request. But the plan continued to accept contributions from Hillsboro on behalf of the workers and to pay medical claims for their benefit.

Recovery of excess benefits paid. A second audit was conducted in 2011 after which the plan removed the workers from the plan and filed this lawsuit seeking to recover benefits paid in excess of contributions received from Hillsboro on their behalf. The plan's complaint asserted claims for restitution, specific performance, and common law breach of contract. The district court granted summary judgment in favor of the employer and dismissed the case.

Breach of contract. The district court found the plan's state law breach of contract claims preempted by ERISA because they were "premised on the existence of an ERISA plan, and they had a "genuine impact . . . on a relationship governed by ERISA"—that relationship between the plan and the employer. In determining whether a common law claim has "reference to" an ERISA plan, "the focus is whether the claim is premised on the existence of an ERISA plan, and whether the existence of the plan is essential to the claim's survival."

Here, the plan's primary argument was that the district court's preemption ruling was contrary to the Ninth Circuit's ruling in *Providence Health Plan v. McDowell*. However, the district court distinguished *McDowell,* finding that the key question in this case was the eligibility of the two workers to participate in the health care plan. The district court properly rejected the plan's contention that *McDowell* was controlling because adjudication of its breach of contract claims did not require an interpretation of the plan or any distribution of benefits. *McDowell* did not turn on whether the beneficiaries were eligible plan participants, explained the appeals court. Although analysis of the employment status of the two workers and whether their employer had entered the CBA was admittedly straightforward, analysis of the terms of the ERISA plan was nonetheless required.

Potential liability under LMRA. The LMRA bars employers from contributing to a trust fund on behalf of individuals who are not employees of the contributing employer. It also prohibits contributions by employers into employee trust funds made other than in conformity with the provisions of written agreements detailing the basis on which those payments are to be made. The plan thus argued that the appeals court must interpret ERISA to be consistent with the LMRA and ensure that the plan is not in violation of the LMRA.

But the appeals court found purely speculative the plan's assertion that the preemption finding would subject it to LMRA liability. It noted that the dominant purpose of LMRA Sec. 302 was to prevent employers from tampering with the loyalty of union officials and to prevent union officials from extorting tribute from employers. Those objectives were plainly not implicated in this case. To the extent that there was an LMRA violation, the plan was partially responsible, concluded the appeals court, pointing out that it learned in 2006 that Hillsboro had allowed ineligible workers to enroll and had made contributions on their behalf, but it took no action to address the issue until the second audit in 2011.

Specific performance. Section 502(a)(3) of ERISA authorizes civil suits "by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates . . . the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of . . . the terms of the plan."

In support of its specific performance claim, the plan relied on a statement in *Sereboff v. Mid Atlantic Medical Services, Inc.*, that "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." However, the Ninth Circuit concluded that the plan's claim for

"specific performance of the reimbursement provisions of the plan" was squarely foreclosed by the Supreme Court's decision in *Great-West Life & Annuity Insurance Co. v. Knudson*, and *McDowell*. *Knudson* held that specific performance is typically a legal remedy unless it is "sought to prevent future losses that either were incalculable or would be greater than the sum awarded."

Restitution. The plan characterized the reimbursement provision as an equitable lien by agreement, allowing for recovery under *Sereboff*. However, the appeals court pointed out that the plan did not seek recovery from an identifiable *res*, as *Sereboff* requires. Here, the plan wished to recover from the general assets of Hillsboro and the workers funds that were never "actually transferred" to them, but paid directly to medical providers. Moreover, the plan's reimbursement provision "specifically provides for the remedies sought," which "reinforces the conclusion that this is essentially an action at law to remedy . . . breach of a legal obligation."

Moreover, the plan could not meet the "three criteria for securing an equitable lien by agreement in an ERISA action" that the Ninth Circuit has interpreted *Sereboff* to require. Although the plan contained "a promise by the beneficiary to reimburse" the plan, it did not "specifically identify a particular fund, distinct from the beneficiary's general assets, from which the fiduciary will be reimbursed"—that is, there is no *res* from which the plan seeks recovery. Moreover, even if the agreement specifically identified funds from which the plan could recover, the amounts it paid for the individual defendants' medical expenses were not in their "possession and control."

Concurrence. Judge Fletcher filed a separate concurring opinion. Although he agreed that *McDowell* could be distinguished from this case, he argued that the better course would be to take this case en banc to reverse *McDowell*. According to Fletcher, under McDowell, "insurers may sue plan participants for reimbursement based on provisions in the insurance contract, but … plan participants cannot file suits or counter-claims[] against insurers for breach of contract or bad faith in claim administration under the contract." He argued that *McDowell* was wrongly decided and that the court should take this opportunity to rehear this case and overrule *McDowell*.

The case number is 13-35555.

Attorneys: Michael J. Morris (Bennett, Hartman, Morris & Kaplan) for Oregon Teamsters Employers Trust. Iris K. Tilley (Barran Liebman) for Hillsboro Garbage Disposal, Inc.

Companies: Oregon Teamsters Employers Trust; Hillsboro Garbage Disposal, Inc.

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