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No. 11-1285

In The Supreme Court of the United States

U.S. AIRWAYS, INC., IN ITS CAPACITY AS FIDUCIARY AND PLAN ADMINISTRATOR OF THE U.S. AIRWAYS, INC. EMPLOYEE BENEFITS PLAN,
Petitioner,
v.
JAMES E. MCCUTCHEN, ET AL.,
Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

BRIEF OF AMICI CURIAE AARP AND NATIONAL EMPLOYMENT LAWYERS ASSOCIATION IN SUPPORT OF RESPONDENTS

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INTERESTS OF AMICI CURIAE[1]

AARP is a non-partisan, non-profit organization dedicated to representing the needs and interests of people age fifty and older. Nearly one-third of AARP's members are currently employed with many working for employers which provide pension and health plans covered by the Employee Retirement Income Security Act (ERISA) of 1974, 29 U.S.C. § 1001. Many other members are retired and receiving or have received retirement benefits from those employers.

One of AARP's primary objectives is to foster the economic security of individuals as they age by attempting to ensure the availability, security, equity, and adequacy of public and private pension, health, disability, and other employee benefits through educational and advocacy efforts. Participants in private, employer-sponsored employee benefit plans rely on ERISA to protect their rights under those plans. *See* Title I – Protection of Employee Benefit Rights, 29 U.S.C. §§ 1001-1191(c). In particular, ERISA's

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[1] Pursuant to Supreme Court Rule 37, counsel of record received notice timely notice of the intent to file this brief and, on behalf of the parties, have consented to the filing of this brief. No counsel for a party authored this brief, in whole or in part; and no counsel or party made a monetary contribution intended to fund the preparation or submission of this brief. No party other than amicus or its counsel made a monetary contribution to its preparation or submission. Letters from the parties consenting to the filing of amicus briefs have been filed with the Clerk of the Court.

protections, and plan participants' opportunities to enforce the statute's protections, are of vital concern to workers of all ages and to retirees, since the quality of their lives depends heavily on their eligibility for and the amount of their retirement and welfare benefits. Indeed, since ERISA has been enacted, the Court has granted certiorari on numerous cases concerning the framework of ERISA's civil enforcement provisions, all of which have been crucial to the rights of participants and beneficiaries under ERISA.

The National Employment Lawyers Association (NELA) advances employee rights and serves lawyers who advocate for equality and justice in the American workplace. With 68 circuit, state and local affiliates, and 3,000 members across the country, NELA is the nation's largest professional organization composed exclusively of lawyers who represent individual employees in cases involving employment discrimination, wrongful termination, employee benefits, and other employment-related matters.[2]

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[2] AARP and NELA have, jointly and singly, participated as amicus curiae in this Court to protect the rights of workers and their beneficiaries under ERISA. *See, e.g., CIGNA Corp. v. Amara*, 131 S.Ct. 1866 (2011); *Sereboff v. Mid Atl. Med. Servs., Inc.,* 547 U.S. 356 (2006); *Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204 (2002); *Varity Corp. v. Howe,* 516 U.S. 489 (1996); *Mertens v. Hewitt Assocs.*, 508 U.S. 248 (1993); *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989).

Resolution of the issues in this case will have a direct and vital bearing on employee benefit plan participants' ability to make informed decisions concerning their benefits and whether they should take any action, at all, to sue third party tortfeasors where they may receive little or no recovery for themselves or, worse, as here, wind up owing the plan more than they receive from the tort case.[3] Consequently, AARP and NELA respectfully submit this brief amici curiae to facilitate a full consideration by the Court of the important issues presented.

SUMMARY OF ARGUMENT

A review of past Supreme Court ERISA decisions shows that the argument of Petitioner and its amici, that unless the Court adopts the precise position for which they are arguing, the sky will fall, and employee benefit plans as we know them will cease to exist, is exaggerated and should be rejected. Indeed, Petitioners and its amici provided no current and comprehensive evidence to the Court showing that reimbursement recoveries are at all significant. Moreover, these recoveries are not consequential enough to have any meaningful effect on rate setting

[3] It is not uncommon that after payment of attorneys' fees and expenses, the participant's recovery is less than the amount of medical benefits paid. *See, e.g.*, *FMC Corp. v. Holliday*, 885 F.2d 79, 80 (3d Cir. 1989), *vacated and remanded*, 498 U.S. 52 (1990); *Admin. Comm. of the Wal-Mart Stores, Inc. Assocs.' Health & Welfare Plan v. Shank*, 500 F.3d 834, 835 (8th Cir. 2007); *U.S. Airways, Inc. v. McCutchen*, 2010 U.S. Dist. LEXIS 89377, *2-3 (W.D. Pa. 2010).

or the trend of rising health care costs. Finally, not only is there no evidence of the underlying assumption of Petitioner and its amici that they will obtain more money if they insist on 100% reimbursement, but common sense suggests that participants are more likely to bring fewer lawsuits when they know they may have to pay money out of pocket, resulting in less money for the plans.

ARGUMENT

I. PETITIONER'S AMICI'S ARGUMENT THAT THE "SKY IS FALLING" IS HYPERBOLIC AND UNPERSUASIVE.

It has become a tradition for plans and amici supporting the plans to raise certain arguments in ERISA cases before this Court. They describe in exquisite detail the purported domino effect that any decision, except the exact one for which they are advocating, will have on employee benefit plans. Thus, the Court has heard ERISA plans contend the following: plans need near perfect uniformity in order to function; if the plan provisions as interpreted by plan fiduciaries do not control in all cases, plans will lack necessary predictability; and if the decisions of plan administrators are subject to challenge, plans will become more expensive due to increased litigation costs. The result if these occur, according to these plans and amici, will be that employers will cut benefits or refuse to offer plans altogether. *See*, *e.g.*, Brief for Petitioner, *Metro. Life Ins. Co. v. Glenn*, 554 U.S. 105 (2008) (No. 06-856), 2008 U.S. S. Ct. Briefs Lexis 258, at *51 (Feb. 25,

2008)("Increasing the litigation burdens on ERISA plans will drain their limited financial resources and discourage employers from establishing benefit plans - to the substantial detriment of existing and prospective plan participants and beneficiaries."); Brief for America's Health Insurance Plans et al. as Amici Curiae Supporting Petitioner, *Glenn,* 554 U.S. 105, 2008 U.S. S.Ct. Briefs Lexis 290, *27-28 (Mar. 3, 2008) ("Employers might respond to those costs in various ways - by reducing the available coverage, paying increased premiums, or discontinuing the plan entirely - but none of them would redound to the benefit of plan participants in the long run.); Brief for The ERISA Industry Committee as Amicus Curiae Supporting Respondents, *LaRue v. DeWolff, Boberg & Assoc. Inc.*, 552 U.S. 248 (2008) (No. 06-856), 2007 U.S. S.Ct. Briefs Lexis 729, at *15-16 (Sept. 11, 2007) ("Plans will suffer financially under the burden of mounting litigation costs-necessitating reductions in benefits, increases in required employee contributions, or both, and employer interest in sponsoring employee benefit plans will decline."); Brief for Chamber of Commerce as Amicus Curiae Supporting Petitioners, *Varity Corp. v. Howe,* 516 U.S. 489 (1996) (No. 94-1471), 1995 U.S. S. Ct. Briefs Lexis 347, at *6 (June 23, 1995) (Plans "would be forced to defend and pay recoveries under these additional claims, thereby increasing the overall cost of benefit plan administration and offsetting private sector efforts to manage health care spending").

Nevertheless, in each of the cases cited above, the Court has reached a decision contrary to that

urged by plans and amici. In fact, in some of those cases, the Court has specifically rejected those arguments either because the arguments had no support, *see Glenn*, 554 U.S. at 113 (rejecting MetLife's argument because "we have no reason, empirical or otherwise, to believe that our decision will seriously discourage the creation of benefit plans"), or because they constituted a strained reading of the statute and ignored the balance that Congress attempted to achieve. *See Varity Corp.*, 516 U.S. at 513-515. Petitioner and its amici here present no evidence that the sky has fallen as a result of the Court's decisions in these cases. Likewise, here, there will be no falling skies if the Plan's reimbursement rights are limited by the centuries' old and firmly entrenched equitable principles of "common fund" and "no double recovery."

II. THE INSIGNIFICANCE OF REIMBURSEMENT RECOVERIES IN THE RATE SETTING PROCESS CONTRADICTS THE ARGUMENT THAT FULL REIMBURSEMENT IS VITAL TO PLAN STABILITY.

A. Petitioner's Amici's Failure To Provide Any Recent and Complete Evidence Of The Amounts Of Reimbursement Recoveries Suggests That They Are Inconsequential.

"The health insurance company financial data that could most directly demonstrate specific plan level medical and administrative expenses that drive premiums generally is propriety and confidential." Mark Newsom & Bernadette Fernandez, Cong. Research Serv. R41588, *Private Health Insurance Premiums and Rate Reviews* 3, n.10 (2011), *available at* http://assets.opencrs.com/rpts/R41588_20110111.pdf. Despite their claims, Petitioner and its amici have not provided current comprehensive information demonstrating the purported correlation between reimbursement recoveries and rate setting for health plans, even though they are the ones in control of this information. Although amici volunteer a limited amount of outdated and incomplete data – after it has been cherry-picked by them, this evidence in fact does not support their arguments.[4] *See* Brief for Blue Cross Blue Shield

[4] If the amounts cited as recovered are gross amounts, plans will in fact receive less after collection expenses. *E.g.*,

Ass'n et al. as Amici Curiae Supporting Petitioner at 12, *U.S. Airways, Inc. v. McCutchen,* No. 11-1285 (U.S. Sept. 5, 2012), citing Brief for America's Health Ins. Plans, Inc. et al. as Amici Curiae Supporting Respondent, *Sereboff v. Mid Atl. Med. Servs., Inc.*, 547 U.S. 356 (2006) (No. 05-260), 2006 WL 460877, at *3 n.3 (Feb. 23, 2006) (using estimated statistics from 2003); Motion of the Am. Ass'n of Health Plans et al. For Leave to File a Brief as Amici Curiae and Brief as Amici Curiae Supporting Petitioners, *Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204 (2002) (No. 99-1786), 2001 WL 487681 at *10, n.20 (May 2, 2001) (using data from the year 2000). Instead, it demonstrates that the impact of these recoveries on each plan is miniscule.

The citation to American Health Insurance Plans' brief in *Sereboff by* amici Blue Cross Blue Shield and Rawlings sheds no light on the amount and impact of reimbursement recoveries on plans. That citation estimated that in 2003, plans recovered in excess of $1 billion through reimbursement provisions. *See* Brief for Blue Cross Blue Shield Ass'n et al. as Amici Curiae Supporting Petitioner, at 12, *McCutchen*, No. 11-1285, citing Brief for America's Health Ins. Plans, Inc. et al. as Amicus Curiae Supporting Respondent, *Sereboff*, 547 U.S. 356, 2006 WL 460877, at *3, n.3. Amici does not provide a comparison to the total amount of health expenditures paid during that same year for the

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Sedgwick Claims Management Services, Central Subrogation (2012), *available at* https://www.sedgwickcms.com/services /docs/SubrogationOverview.pdf. (collection expense ranges between 15-40% of the recoveries obtained).

same plans, which would provide an indication of the percentage of recovery for the plan or a comparison to the total number of covered lives, which would provide an indication of the impact on each participant. However, further analysis of the underlying report reveals that approximately $300 billion is paid in premiums to those plans, resulting in reimbursement recoveries of merely one-third of 1 percent of premiums.[5] *See* Barents Group, *Impacts of Four Legislative Provisions on Managed Care Consumers: 1999-2003* (1998).

Another exemplar cited by amici Blue Cross Blue Shield and Rawlings was the recovery of $237.3 million by one of the United States' "largest private health care claims recovery services." *See* Brief for Blue Cross Blue Shield Ass'n et al. as Amici Curiae Supporting Petitioner, at 12, n. 9, *McCutchen*, No. 11-1285, citing Motion of the Am. Ass'n of Health Plans et al. For Leave to File a Brief as Amici Curiae and Brief as Amici Curiae Supporting Petitioners, *Knudson*, 534 U.S. 204, 2001 WL 487681 at *10 n.20 (emphasis added). However, on closer inspection

[5] Amici AARP and NELA note that at least a portion of this recovery is due to overpayments or mistaken payments. We urge the Court not to expand its decision to such disputes because they tend to be extremely very fact-intensive, ranging for example from participant fraud on the plan, *Trustees of the AFTRA Health Fund v. Biondi*, 303 F.3d 765 (7th Cir. 2002) (keeping ex-spouse on health plan in violation of plan eligibility rules), to a plan's mistaken approval for health procedures that was relied upon to the participant's detriment, *cf. Kenseth v. Dean Health Plan, Inc.*, 610 F.3d 452 (7th Cir. 2010) (after approval for gastric bypass surgery, participant underwent surgery and plan refused to pay).

this recovery amount was for 52,500,000 covered lives, or $4.52 per person per year or $0.38 per person per month. See Healthcare Recoveries, Inc., Form 10-K, for the fiscal year ended Dec. 31, 2000, at 22, http://www.sec.gov/Archives/edgar/data/858629/000095014401004044/g67733e10-k405.txt.

Amicus Central States provides more recent data, but it also does not support the other amici's arguments that reimbursement recoveries are significant to the financial viability of its plan. Comparing the average 240,000 participants in the Central States Health Plan[6] with the cited average recoveries of $5.7 million per year during the period of 2002-2011, Brief for Central States as Amicus Curiae Supporting Petitioner at 1, 3, *McCutchen*, No. 11-1285 (U.S. Sept. 5, 2012), results in an average recovery per person annually of $21.13, or $1.76 per person monthly. Central States pays roughly $1 billion in benefits annually. Central States Funds, *supra* note 6. Therefore, on average, for this plan, subrogation and reimbursement recoveries represent a mere one-half of one percent (about .57%) of benefits paid.

No matter how one looks at reimbursement recovery amounts, they are insignificant in relation both to the total benefits paid as well as when viewed on a per capita basis.

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[6] *See* Central States Funds, *About Central States Funds*, https://www.centralstatesfunds.org/CSF/plans/ourcompany.aspx (last visited Oct. 18, 2012) (Central States' website stating it covers approximately 250,000 participants)

B. Amounts Recovered Through Reimbursements Are So Insignificant That Actuaries Do Not Afford Them Their Own Category In Rate Setting.

Actuaries use mathematics, statistics and financial theory to evaluate how risk and uncertainty will affect financial costs. By analyzing the likelihood an event will occur, they aid entities like insurance companies and employee benefit plans in minimizing the cost of risk. Bureau of Labor Statistics, U.S. Dep't of Labor, Occupational Outlook Handbook, 2012-13 Edition, *Actuaries*, *available at* http://www.bls.gov/ooh/math/actuaries.htm (last visited October 18, 2012). Actuaries review historical statistics showing how likely it is that a claim will be made by a insured, how much the entity will have to pay in claims, and how much the entity will need to charge to pay these claims and make a profit, without being at odds with the marketplace. *Id*. Reimbursement recoveries are not significant enough to merit their own category during the rate setting process. *See generally* Mark Newsom & Bernadette Fernandez, Cong. Research Serv., R41588, *Private Health Insurance Premiums and Rate Reviews* Summary (2011), *available at* http://assets.opencrs.com/rpts/R41588_20110111.pdf (reimbursement recoveries are not a separate category); AHIP Coverage, How Are Health Insurance Premiums Determined (Sept. 8, 2010), http://www.ahipcoverage.com/wp-content/uploads/2010/09/The-Hay-Group-How-Health-Insurance-Premiums-Are-Determined.pdf (rate setting is based on

actuarial calculations, but reimbursement recoveries are not a separate category).

Because reimbursement recoveries are such a miniscule amount, it merits no particular attention from actuaries.

C. Rising Health Care Costs Are A Serious Concern, But No One Has Suggested That Increasing Reimbursement Recoveries Will Have Any Effect On This Trend.

An underlying theme discussed in this case is rising health care costs. However, not only do actuaries *not* account for reimbursement recoveries as a separate category in rate setting, but among the thousands of studies, papers, articles, and editorials written on reining on the increase in health care costs, regardless of their authors' philosophical or political leanings, none could be found that suggests that increasing, or holding the line on, reimbursement amounts from third-party tort recoveries had or would have any significance in breaking the increases. *E.g,* Politico Pro, *AHIP's Ignagni Addresses Drivers of Health Care Costs* (Oct. 10, 2012), http://www.ahipcoverage.com/2012/10/10/politico-pro-ahips-ignagni-addresses-drivers-of-health-care-costs/ (focusing on insurance premium tax, age rating and essential health benefits); *Issues: Healthcare*, U.S. Chamber of Commerce, http://www.uschamber.com/issues/health/health-care-archives (last visited Oct. 20, 2012) (suggesting among numerous factors that will lower health care

costs, enacting meaningful medical liability reform, reining in fraud and abuse, realigning incentives to award quality not quantity); Comm. on the Learning Health Care System in America, *Best Care at Lower Cost: The Path to Continuously Learning Health Care in America* (Mark Smith et al. eds., 2012), *available at* http://iom.edu/Reports/2012/Best-Care-at-Lower-Cost-The-Path-to-Continuously-Learning-Health-Care-in-America.aspx (focusing on three factors); Robert A. Berenson, Paul B. Ginsburg, Jon B. Christianson & Tracy Yee, *The Growing Power Of Some Providers To Win Steep Payment Increases From Insurers Suggests Policy Remedies May Be Needed*, 31 Health Aff. No. 5 at 973-981 (May 2012), *available at* http://content.healthaffairs.org/content/31/5/973.full?keytype=ref&siteid=healthaff&ijkey=%2F16n5xjmN8506 (focusing on provider costs); Bipartisan Policy Ctr., *What is Driving U.S. Health Care Spending? America's Unsustainable Health Care Cost Growth* 6-7 (2012) (providing a laundry list of factors), *available at* http://bipartisanpolicy.org/sites/default/files/BPC%20Health%20Care%20Cost%20Drivers%20Brief%20Sept%202012.pdf; Kaiser Family Found., *What is driving health care spending?*, U.S. Health Care Costs, Background Brief, http://www.kaiseredu.org/Issue-Modules/US-Health-Care-Costs/Background-Brief.aspx, What is driving health care spending? (last visited Oct. 19, 2012) (same); United Health Grp., *Why Are Health Care Costs Rising*? (March 2010), *available at* http://www.unitedhealthgroup.com/hrm/UNH-Health-Care-Costs.pdf (focusing on hospital and physician payment rate increases); Jason Fodeman, M.D. &

Robert A. Book, Ph.D., "Bending the Curve": What Really Drives Health Care Spending (Feb. 17, 2010), *available at* http://www.heritage.org/research/reports/2010/02/bending-the-curve-what-really-drives-health-care-spending (pricing system provides wrong incentives to patients and providers); Dustin Chambers, *What is Driving Rising Healthcare Costs*?, The American (May 18, 2009), *available at* http://www.american.com/archive/2009/may-2009/What-is-driving-rising-healthcare-costs (insurance-based payment system, low labor-productivity growth, and constrained supply of healthcare providers).

None of these organizations lists the failure to obtain total reimbursements of medical costs where third party tortfeasors have caused the injury to the insured as a method of ameliorating the increase in health care costs. The reason for this conspicuous silence is simple: such recoveries have minimal, if any, impact and, quite literally, are not worth mentioning.

D. The Plan's Argument Here Is Contrary To Common Sense And The Self-Interest Of Plans More Broadly.

The position of Petitioners and its amici that a plan's reimbursement cannot, and should not, be limited by the centuries' old concepts of "common fund" and "no double recovery" is at odds with common sense and plans' self-interest. Potential plaintiffs will be less likely to go to court to attempt

to vindicate their rights against a third party tortfeasor if they end up worse off than before they sued, having to pay money out of their pockets back to their health plans. Amici here doubt that Mr. McCutchen would have pursued his claim if he had been made aware of the result urged by the Plan here. There will be no incentive for participants to bring suits to recover from third party tortfeasors where there is the chance for little or no gain, or if there is a chance that the participant will, in fact, have to pay money out of pocket to pay the plan's share of attorneys' fees and costs. It is these circumstances that will have a much greater effect on the plans than the failure to recover the entirety of what plans pay out to beneficiaries injured by third parties.

The plan and its amici have not proffered any evidence that demonstrates that they would be better off receiving 100% of their lien from fewer law suits.[7] Nor have they proffered any evidence to refute the Seventh Circuit's point in *Blackburn v. Sundstrand Corp.*, 115 F.3d 493, 496 (7th Cir. 1997), that such a provision would likely give the injured person "every reason to disclaim any demand for medical expenses in tort suits, throwing on plans the burden and expense of collection." This burden will not necessarily inure to the interests of all

[7] Although some amici claim that they may compromise their lien, they have no obligation to do so, and participants cannot rely on whether the trustees are feeling generous on a particular day. A result favorable to the plans here would certainly substantially reduce such generosity.

beneficiaries; in fact, the opposite is more likely to be true.

Moreover, in contrast to Petitioner's amici "sky is falling" arguments, there is evidence that the inability to obtain reimbursement recoveries has not threatened the viability of plans that are insured, rather than self-funded. In states that have prohibited or limited such reimbursement, these plans have survived, with comparable or lower premiums to those of self-funded ERISA plans. Kaiser Family Found. & Health Research & Educ. Trust, *Employer Health Benefits: 2012 Annual Survey* 14, 20, 28 (2012), *available at* http://ehbs.kff.org/pdf/2012/8345.pdf. Although many states prohibit subrogation and reimbursement provisions in insurance contracts, each of those states continues to have insurance companies offering health insurance in their states. *See* Brief for Respondent, at 51-54, *McCutchen*, No. 11-1285 (June 5, 2012).

And, it appears that some health plans have concluded that they obtain more reimbursements by agreeing to pay their shares of reasonable attorneys' fees and expenses where participants sue third-party tortfeasors. Indeed, the plan in *Sereboff* expressly agreed to pay its share of the reasonable attorneys' fees and court costs. *See Mid Atl. Med. Servs., LLC v. Sereboff,* 407 F.3d 212, 215 (4th Cir. 2005).

CONCLUSION

For the foregoing reasons, amici AARP and NELA respectfully urge the Court to affirm the judgment of the court of appeals.

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