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 MCCUTCHEN and ROSEN LOUIK & PERRY, P.C.,

*Respondents*.

**On Writ of Certiorari to the United States Court of Appeals For The Third Circuit**

## BRIEF OF *AMICI CURIAE* THE BLUE CROSS BLUE SHIELD ASSOCIATION AND THE RAWLINGS COMPANY, LLC IN SUPPORT OF PETITIONER

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The Blue Cross Blue Shield Association (the "BCBSA") and The Rawlings Company, LLC ("Rawlings") respectfully submit this brief supporting the Petitioner as *amici curiae*.[1]

## INTEREST OF *AMICI CURIAE*

**BCBSA.** BCBSA is the trade association that coordinates the national interests of the independent, locally operated Blue Cross and Blue Shield companies. Together, the 38 independent, community-based and locally operated Blue Cross and Blue Shield companies provide health insurance benefits to nearly 100 million people—nearly one-third of all Americans—in all 50 states, the District of Columbia, and Puerto Rico. The companies offer a variety of insurance products to all segments of the population, including large public and private employer groups, small businesses and individuals.

The Blue Cross and Blue Shield companies are subject to regulations under a variety of federal and state statutes, including the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. §§1001 *et seq.* This case concerns whether ERISA plan participants can use equitable defenses to override the plain terms of a reimbursement provision in an ERISA plan.

The Blue Cross and Blue Shield companies administer or insure ERISA plans that often include

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[1]No counsel for a party authored this brief in whole or in part, and no party or counsel for a party made a monetary contribution intended to fund the preparation or submission of this brief. No one other than *amici curiae*, their members, or *amici*'s counsel made a monetary contribution to the preparation or submission of this brief. Letters from the parties consenting to the filing of *amicus* briefs have been filed with the Clerk of the Court.

such reimbursement provisions. The funds they collect through reimbursement help reduce employers' contributions and employees' premiums for ERISA plans. If plan participants are allowed to use equitable principles to rewrite contractual language to excuse them from reimbursing their plan for benefits paid, ERISA plans will not be able to consistently enforce reimbursement provisions, and the plans and their participants will suffer significant negative financial consequences.

**Rawlings.** Rawlings is the largest and most established health insurance subrogation company in the country. With over 30 years of experience and over 600 employees serving both self-funded and insured employer sponsored plans, Rawlings is the largest subrogation recovery organization in the country in terms of the number of health plans served and the volume of health subrogation claims processed. As the first organization dedicated to providing subrogation services to health plans, Rawlings has pioneered major innovations in the field and has created industry best practices. In its role implementing the subrogation and reimbursement programs on behalf of health plans, Rawlings has recovered hundreds of millions of dollars in health care expenditures for insured and self-funded employee benefit plans through subrogation and recovery.

Rawlings has an interest in the issue presented in this case because it will directly impact Rawlings' ability to administer subrogation and recovery claims, which in turn will have far reaching implications by raising the cost of, and increasing the uncertainty in, the nation's health care system.

## SUMMARY OF ARGUMENT

More than 160 million Americans get their health-care through employer-sponsored health insurance plans.[2] Of these covered workers, 60%—or approximately 96 million people—participate in a self-funded employer-sponsored plan.[3] And this number is expected to increase significantly in the coming years. Beginning in 2014, companies with 50 or more employees will be required to either provide qualified health insurance coverage to their full-time employees and their dependents or pay a per-employee fee to the government. 26 U.S.C. §4980H. While smaller companies may be able to purchase

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[2]Chad Terhune, *About 10% of Employers To Drop Health Benefits, Study Finds*, L.A. TIMES (July 24, 2012).

[3]Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits: 2011 Annual Survey* 150 (2011), *available at* http://ehbs.kff.org ("*Employer Health Benefits*").

There are two types of employer-sponsored health plans: fully-insured and self-funded plans. In a fully-insured plan, the employer buys a health plan from an insurer or managed care organization, which assumes financial responsibility for the costs of enrollees' medical claims. A self-funded plan is an arrangement in which the employer assumes direct financial responsibility for the costs of enrollees' medical claims. Self-funded plans utilize employee cost sharing arrangements similar to fully-insured plans, *i.e.* deductibles, co-payments and employee monthly contributions (which are functionally the same as premiums). ERISA applies to all employer-sponsored health plans, regardless of funding status. However, the funding status of the health plan is relevant to whether ERISA preempts various state laws. For self-funded plans, ERISA always preempts state laws. For fully-insured plans, by contrast, it often does not. *See FMC Corp. v. Holliday*, 498 U.S. 52, 61-62 (1990). Accordingly, the issue in this case—whether plan participants can revive otherwise preempted state law doctrines through the use of equitable defenses—more significantly impacts self-funded plans.

health care benefits via state insurance exchanges, health care benefits experts expect many larger employers will choose to self-fund rather than buy commercial coverage.[4]

The benefits of self-funded plans are many,[5] but chief among them—at least until the decision below held otherwise—was that ERISA's preemption of state laws enabled them to maximize their resources to provide benefits by relying on the reimbursement rights and other cost savings provisions set forth in plan documents, without fear that a court would erase or alter those rights. Certainty with respect to their legal rights allows self-funded plans to minimize their litigation costs, maximize their recovery from third party tortfeasors and, ultimately, set lower employee contribution rates for all participants while offering the most comprehensive benefits the plan can afford.

The decision below holds that courts may apply equitable doctrines to alter plan terms—even when the plan includes unambiguous repayment provisions that plainly disclaim those doctrines. Although this may be appropriate where such provisions are lacking, it is inappropriate and ill-advised where, as here, the plan's reimbursement provision unambiguously requires the participant to fully reimburse the plan.[6]

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[4]Joanne Wojcik, *Reform Law Could Fuel Self Funding* (Feb. 19, 2012), *available at* http://www.businessinsurance.com/article/20120219/NEWS05/302199999.

[5]*See, e.g.*, Jonathan Edelheit & Daniel Pyne, *The Benefits and Flexibility of Self-funded Insurance*, SELF FUNDING MAGAZINE (Aug. 2, 2012), *available at* http://www.selffundingmagazine.com/article/the-benefits-and-flexibility-of-self-funded-insurance.html.

[6]As this Court has oft-repeated, the plain language of a

(. . . continued)

If not reversed by this Court, the rule adopted by the decision below would eliminate the certainty these plans have relied upon and would have potentially devastating effects on self-funded employer-sponsored plans and their nearly one-hundred million participants. Specifically, in the subrogation and reimbursement context, it will increase plans' litigation costs and decrease the amount they can recover from third party tortfeasors, which will jeopardize plans' financial viability and result in reduced benefits and/or higher out-of-pocket payments for participants.

And the financial harm to plans will go far beyond the subrogation context and lost subrogation recoveries. If equity can be used to deny enforcement of plan terms regarding subrogation, then it might also be applied to many other terms that plans use to manage costs—from beneficiary eligibility requirements to medical provider reimbursement rates to exclusions of non-medically necessary treatments. If all of these terms are at risk of being erased or altered by courts, plans' funds will be even further depleted. Indeed, the mere risk that such terms could be undermined will force plans to divert funds from the benefits that they would otherwise intend to provide.

And all for no good reason. Under the current system, plans can—and usually do—work out a

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(Continued . . .)
statute is the touchstone of statutory interpretation. *See Jimenez v. Quarterman*, 555 U.S. 113, 118 (2009). The plain language of Section 502(a)(3) permits plan fiduciaries to pursue and obtain "appropriate equitable relief" to "*enforce . . . the terms of the plan*." 29 U.S.C. §1132(a)(3) (emphasis added). In other words, the critical statutory text contains an explicit directive regarding the specific text courts should follow—the plan's plain terms.

mutually beneficial resolution with the participant. It is extraordinarily rare—indeed, in *amici*'s experience, virtually unprecedented—that a participant is ever called upon to reimburse the plan's equitable lien from his own assets. In *amici*'s decades of experience, subrogation and reimbursement clauses universally limit the plan's rights only to funds that the plan member receives from a third party, never from funds that were originally in the member's pocket. If that unusual situation arose here, it arose only because McCutchen agreed to a 40% contingency fee arrangement with his attorneys and then disposed of his personal injury settlement proceeds before he addressed his contractual obligation to reimburse US Airways.[7] The plan—and the remaining plan members—should not suffer so that an individual participant and his attorneys can take benefits from the plan in disregard of the plan's terms.

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[7]The Third Circuit stated that McCutchen's net recovery was less than US Airways' $66,000 lien. Pet. App. 3a. It presumably reached that conclusion by assuming that McCutchen's attorneys took a 40% contingency out of the full settlement amount. But the record does not reflect this. It reflects, instead, that his attorneys took a 40% contingency out of one portion of the settlement. JA 59; *see also* Brief for Petitioner at 10 n.3.

## ARGUMENT

## I.

## ALLOWING COURTS TO VARY UNAMBIGUOUS PLAN TERMS WOULD INCREASE COSTS FOR PARTICIPANTS AND THREATEN PLANS' FINANCIAL VIABILITY

### A. Allowing Courts To Disregard Plan Terms Would Increase The Cost Of Administering ERISA Plans

Before the Third Circuit's decision in *McCutchen*, the rules governing plans' subrogation and reimbursement rights were clear and uniform: plans that included unambiguous repayment provisions in their plan documents were entitled to obtain full reimbursement of all medical benefits paid by the plan. *See Zurich Am. Ins. Co. v. O'Hara*, 604 F.3d 1232, 1237 (11th Cir. 2010), *cert denied*, 131 S. Ct. 943 (2011); *Admin. Comm. of Wal-Mart Stores Assocs.' Health & Welfare Plan v. Shank*, 500 F.3d 834, 838 (8th Cir. 2007); *Moore v. CapitalCare, Inc.*, 461 F.3d 1, 10 (D.C. Cir. 2006); *Bombardier Areospace Employee Welfare Benefits Plan v. Ferrer, Poirot, & Wansbrough*, 354 F.3d 348, 357 (5th Cir. 2003); *Admin. Comm. of Wal-Mart Stores Assocs.' Health & Welfare Plan v. Varco*, 338 F.3d 680, 692 (7th Cir. 2003). Plans did not have to delve into the specific facts of each unique case to assess whether they had a right to recovery; they could rely on the plain terms of the plan to work with the plan participant to obtain the reimbursement to which they were entitled, or otherwise to work out a mutually beneficial resolution with the participant.

Most often, this process is resolved through negotiation among the interested parties without the need for court intervention. And in the rare cases in which a lawsuit between the plan and the participant has arisen, the scope of the litigation was usually limited to a relatively straightforward question of contract interpretation: whether the plan terms obligated the beneficiary to reimburse the plan from any judgment or settlement received, regardless of possible equitable defenses like the "made whole" and "common fund" doctrines. *See* 16 LEE R. RUSS & THOMAS F. SEGALLA, COUCH ON INSURANCE §223:141-142 (3d ed. 2005) ("COUCH ON INSURANCE") (citing cases in which courts analyzed plan language to determine whether it was sufficient to disclaim the made whole rule). By contrast, if plan participants can induce courts to alter the unambiguous terms of an ERISA plan by invoking equitable defenses, even when the plan specifically disclaims these equitable defenses, that risk would introduce significant uncertainty—and significant new costs—into plan administration and litigation.

For instance, under the equitable principle known as the common fund doctrine, a plan may be held responsible to share the costs and fees incurred as a result of the plan participant's efforts to recover from the third party tortfeasor. But the doctrine only applies if the costs incurred by the plan participant are actually "of benefit" to the plan. 16 COUCH ON INSURANCE §223:116 (explaining that a plan may have a colorable claim that they received no benefit if the plan participant proceeds against the tortfeasor without informing the plan, and the plan could have proceeded proceed directly against the tortfeasor under a subrogation theory). Accordingly, the parties would have to engage in discovery and

litigation to determine whether "[the plan participant's] efforts benefited [the plan] or were reasonably necessary to [the plan's] recovery." *Desmond v. Liberty Nw. Ins. Corp.*, 817 P.2d 872, 875 (Wash. Ct. App. 1991) (holding the record inadequate "to allow the trial court to determine whether [the plan participant's] efforts benefited [the plan] or were reasonably necessary to [the plan's] recovery" and remanding to the trial court "to take such further evidence as will permit it to properly make this determination").

Moreover, under the common fund doctrine, a plan is only liable for a share of *reasonable* attorney's fees. The reasonableness of fees is not determined solely by reference to the contingency fee agreement between the plan participant and his attorney. Rather, in determining the reasonable fees, courts must consider "the amount and nature of the services rendered and all factors relevant." *Barreca v. Cobb*, 668 So. 2d 1129, 1132 (La. 1996). Accordingly, the rule adopted below would require plans to seek substantial discovery and devote substantial time and resources to investigate and prove the number of hours spent by the participant's attorney, the complexity of the legal issues and the strength of the legal claims presented in the underlying case against the tortfeasor, and other "factors relevant" to establishing reasonable attorney's fees.

The same adverse effects would ensue by application of another equitable doctrine, the made whole doctrine, under which a plan would not be permitted to recover funds it was owed until the plan participant was fully compensated. That doctrine, too, requires a substantial case-specific analysis. Whether a plan participant has, in fact, been made

whole can be a complicated and fact-intensive inquiry. Among the factors to be considered are:

> 1) the ability of parties to prove liability; 2) the comparative fault of all parties involved in the accident[8]; 3) the complexity of the legal and medical issues; 4) future medical expenses; 5) nature of injuries; and 6) the assets or lack of assets available above and beyond the insurance policy. (*Provident Life & Acc. Ins. Co. v. Bennett*, 483 S.E.2d 819, 825 (W. Va. 1997))

Investigating these factors will require additional fact discovery by plans. 16 COUCH ON INSURANCE §223:152 (noting that "[e]ach of these items is discoverable through the use of interrogatories and a notice to produce documents which should include all pleadings and discovery of the underlying action, including any discovery and investigation conducted therein and decisions of the court"). And litigating the question of whether the plan participant has been made whole would unjustifiably place an additional burden on plans and on the courts. *See* Jeffrey A. Greenblatt, *Insurance and Subrogation: When the Pie Isn't Big Enough, Who Eats Last?*, 64 U. CHI. L. REV. 1337, 1344 (1997) ("*Who Eats Last?*") ("Courts confronting this issue often conduct a mini-trial to determine whether the insured has been made whole").

The equitable defense at issue below was unjust enrichment. Pet. App. 16a. In applying this principle to US Airways' claim for reimbursement, the

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[8]Negligent plan participants are "made whole" when they receive payment for the percentage of their damages for which they were not at fault. *See, e.g.*, *Sorge v. Nat'l Car Rental Sys., Inc.*, 470 N.W.2d 5, 7 (Wis. Ct. App. 1991), *aff'd*, 512 N.W.2d 505 (Wis. 1994).

court expressed its view that, "[b]ecause the amount of the judgment exceeds the net amount of McCutchen's third party recovery, [and] leaves him with less than full payment for his emergency medical bills," it would be inequitable to require McCutchen to provide full reimbursement to US Airways. *Id.* In this respect, the equitable defense of unjust enrichment closely resembles the common fund or made whole doctrines. And the Third Circuit acknowledged that application of the equitable principle of unjust enrichment would require "'full factual findings'" in the trial court. *Id.* at 17a (quoting *Nat'l City Mortg. Co. v. Stephen*, 647 F.3d 78, 87 n.8 (3d Cir. 2011)); *see also id.* (remanding to the District Court with instructions to "engage in any additional fact-finding it finds necessary" and noting that "factors such as the distribution of the third-party recovery between McCutchen and his attorneys . . ., the nature of their agreement, the work performed, and the allocation of costs and risks between the parties to this suit" may all be relevant).

In sum, if courts were permitted to use equitable principles to rewrite contractual language and refuse to order participants to reimburse their plan, even where the plan's terms give it an absolute right to reimbursement, ERISA plans would be forced to investigate and demonstrate the propriety of reimbursement in each individual case. The net effect would be a substantial increase in the costs of pursuing subrogation/reimbursement claims.

### B. Allowing Courts To Disregard Plan Terms Would Decrease The Amount Of Money In The Plan's Fund

With the introduction of equitable defenses to evade the enforcement of the plain plan language,

plans inevitably would not be able to recover the full amounts that they are entitled to under their subrogation and reimbursement rights. The fiscal impact to plans would be substantial. It has been estimated that plans recover over $1 billion each year through subrogation and reimbursement. Br. of Amicus Curiae America's Health Ins. Plans, Inc. et al., in Support of Respondent, *Sereboff v. Mid Atl. Med. Servs.*, 547 U.S. 356 (2006) (No. 05-260), 2006 WL 460877, at *3 n.3 (Feb. 23, 2006).[9] Every dollar blocked from subrogation or reimbursement recovery by an equitable defense is one less dollar for all plan participants to use for their current and future claims.

Moreover, the decision below opens the door to deny enforcement of plan terms used to manage costs beyond those concerning subrogation and reimbursement rights. Plan documents generally include cost management provisions such as beneficiary eligibility requirements, medical provider reimbursement rates and exclusions for non-medically necessary treatments. In situations where plans mistakenly overpay benefits—*e.g.*, for an uncovered person, to a non-credentialed provider, for non-medically necessary treatment, or simply in error—they bring an action under Section 502(a)(3) to enforce plan provisions that reserve the right to

[9]In fiscal year 2000, one of the largest private health care claims recovery services in the United States recovered $237.3 million in health claims, and had a backlog of over $1.1 billion of potentially recoverable claims. Motion of the Am. Ass'n of Health Plans et al. For Leave to File a Brief as Amici Curiae and Brief of Amici Curiae in Support of 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 3, 2001).

recover such overpayments.[10] As it now stands, plans know they can rely on these plan terms to obtain full recovery in these actions. If all of these provisions are at risk of being erased or altered by courts, the size of the plan's fund could shrink even further.

Indeed, the mere risk that such cost management terms could be undermined will cause a reduction in the funds available for other benefits and beneficiaries. For instance, if a plan knows that its exclusion of non-medically necessary cosmetic surgery will be enforced, it can offer better coverage for medically necessary procedures. But if that plan is concerned that it may not be able to recover a mistaken payment for cosmetic surgery, it will need to reserve money to account for that risk—money that would otherwise be available for other benefits.

Put simply, application of equitable defenses would reduce the overall size of the pie for all plan participants.

### C. Higher Costs And Lower Recoveries Would Jeopardize Plans' Financial Viability And Result In Reduced Benefits And/Or Higher Out-Of-Pocket Payments For Participants

With higher litigation costs, lower recoveries and less reliable enforcement of other cost management terms, the financial viability of plans will be

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[10] *See, e.g.*, *Kolbe & Kolbe Health & Welfare Benefit Plan v. Med. College of Wis.*, 657 F.3d 496 (7th Cir. 2011) (Section 502(a)(3) action to recover payment on behalf of an uncovered person); *Trustmark Life Ins. Co. v. Univ. of Chicago Hosps.*, 207 F.3d 876 (7th Cir. 2000) (Section 502(a)(3) action to recover payment for non-medically necessary procedures); *Cent. States, Se. & Sw. Areas Health & Welfare Fund v. Neurobehavioral Assocs., P.A.*, 53 F.3d 172 (7th Cir. 1995) (Section 502(a)(3) action to recover accidental overpayment due to clerical error).

threatened. As a result, plans will be forced to (1) raise participants' premiums/contributions or (2) alter the terms of their plan documents to reduce or delay the payment of benefits.

1. The cost savings generated by predictable rates of subrogation and reimbursement are passed on to plan participants in the form of lower premiums for fully-insured plans, or contributions for self-funded plans. Insurance companies set premiums based on historical net costs and lower costs lead to lower premiums for participants.[11] As one scholar has explained:

> [I]f the insurer had one hundred policyholders in the experience period, and experienced a total of $20,000 in claim costs, it will set its actuarial premiums at $200 per policy holder. If, on the other hand, the insurance company experienced $20,000 in claim costs and received $5,000 in subrogation, it will set its actuarial

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[11] *See, e.g.*, F. Joseph Du Bray, *A Response to the Anti-Subrogation Argument: What Really Emerged From Pandora's Box*, 41 S.D. L. REV. 264, 273-74 (1996); Bernadette Fernandez, Congressional Research Service, Library of Congress, *Health Insurance: A Primer* 3 (Feb. 3, 2005) ("The premium generally reflects several factors, including the expected cost of claims for using services in a year, administrative expenses associated with running the plan, and a risk or 'profit' charge"); *Zurich Am. Ins. Co. v. O'Hara*, 604 F.3d 1232, 1237-38 (11th Cir. 2010) ("Reimbursement inures to the benefit of all participants and beneficiaries by reducing the total cost of the Plan. If O'Hara were relieved of his obligation to reimburse Zurich for the medical benefits it paid on his behalf, the cost of those benefits would be defrayed by other plan members and beneficiaries in the form of higher premium payments"), *cert. denied*, 131 S. Ct. 943 (2011); *Admin. Comm. of Wal-Mart Stores Assocs.' Health & Welfare Plan v. Shank*, 500 F.3d 834, 838 (8th Cir. 2007) ("Shank would benefit if we denied the Committee its right to full reimbursement, but all other Plan members would bear the cost in the form of higher premiums").

> premiums at $150 per policy holder. (*Who Eats Last?*, 64 U. CHI. L. REV. at 1355)

Taking this hypothetical one step further, assume—as relevant here—that the insurance company experienced $20,000 in claim costs but was forced to spend more (say $500) in litigation fees to recover less (say $4,000) in subrogation or reimbursement. In this situation, the premiums would go up from $150 to $165 per policy holder.

This effect is amplified in self-funded plans. Fully-insured plans calculate premiums on a state- or nation-wide basis. A self-funded plan has a much smaller risk pool of members. Accordingly, funds returned to a self-funded plan have an even more dramatic effect on historical net costs—and higher litigation costs and lower recoveries will have an even more dramatic effect on their future contribution rates.

For good reason, Congress preempted all state laws that relate to self-funded employee benefit plans in order to protect self-funded plans from the varying state laws that would create uncertainty, drive administrative costs up and reduce subrogation recoveries. As this Court has explained, in enacting ERISA, Congress intended

> to ensure that plans and plan sponsors would be subject to a uniform body of benefits law; the goal was to minimize the administrative and financial burden of complying with conflicting directives among States or between States and the Federal Government . . . , [and to prevent] the potential for conflict in substantive law . . . requiring the tailoring of plans and employer conduct to the peculiarities of the law of each jurisdiction. (*Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 142 (1990))

If courts could use equitable principles to rewrite unambiguous plan terms, their application of equitable defenses would undoubtedly differ from jurisdiction to jurisdiction (and even court to court), thereby frustrating Congress' purpose in preempting state laws and, ultimately, causing participants to face higher out-of-pocket payments.[12]

2. ERISA does not require that an employer provide any particular benefits. *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 91 (1983). And "employers . . . are generally free under ERISA, for any reason at any time, to adopt, modify or terminate welfare plans." *Curtiss-Wright Corp. v. Schoonejongen*, 514 U.S. 73, 78 (1995).[13] Accordingly, if plan subrogation and other cost management provisions cannot be fully enforced, plan sponsors may be forced to amend their plans to alter the provisions concerning payment of benefits for which third parties might be liable. That effect would

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[12]It is notable that premiums are higher in fully-funded plans, where state law doctrines like the common fund and made whole doctrine frequently apply. In 2011, premiums for single workers were 3.3% higher in fully-insured versus self-funded plans ($5,324 versus $5,499); for families, premiums were 7.3% higher ($14,434 versus $15,492). *See Employer Health Benefits* at 26-27.

[13]Although the Patient Protection and Affordable Care Act applies to self-funded plans, these plans are specifically exempted from some notable requirements, including providing coverage with minimum essential benefits. *See* Kathryn Linehan, *Self-Insurance and the Potential Effects of Health Reform on the Small-Group Market*, National Health Policy Forum (Dec. 20, 2010), *available at* http://www.nhpf.org/library/details.cfm/2839; Christine Eibner et al., *Employer Self-Insurance Decisions and the Implications of the Patient Protection and Affordable Care Act as Modified by the Health Care and Education Reconciliation Act of 2010 (ACA)*, RAND Health (2011), *available at http://www.rand.org/pubs/technical_reports/TR971.html.*

redound to the detriment of plan participants as a whole.

In order to offset escalating costs and lower recoveries associated with the availability of equitable defenses, plan sponsors will need to either increase participant costs or reduce benefits. They could well defer or delay payment of claims for medical expenses related to third party negligence until the accident liability issues have been resolved completely or until third party litigation has concluded. *See, e.g.*, *Kress v. Food Employers Labor Relations Ass'n*, 391 F.3d 563, 568 (4th Cir. 2004) (noting that "it makes little sense to argue that ERISA precludes imposing conditions on the receipt of benefits that are in effect an interest-free loan").

Alternatively, to combat the uncertainty that comes with the risk of the use of equitable defenses, plans could choose to secure the certainty of recovery by amending plans to offset future benefits. In other words, a plan could amend an existing subrogation provision to permit the fiduciary to deny *future benefits* equal to the amount of money that should have been subrogated under the terms of the plan. *See, e.g.*, *McIntyre v. Carpenters Health & Sec. Trust*, No. C05-5724FDB, 2006 WL 118249, at *9 (W.D. Wash. Jan. 13, 2006) ("Nothing required [the plan participant] to accept the reimbursement option; she was free to reject the advancement of benefits. But where she did accept the advanced benefits offer, and then recovered against the third party, it was not wrongful for the Trust to seek to recoup the advanced benefits and to cease making further advancements"). Or, more drastically, employers might be compelled to amend their plans to exclude entirely coverage for medical expenses related to negligent third party claims. *See, e.g.*, *Kress*, 391

F.3d at 568 (noting that "third-party accident and sickness benefits are not even covered by the Fund, nor required by ERISA").

This result, which would negatively impact all plan participants, would also be contrary to a primary goal of Congress in enacting ERISA—to encourage employers to offer the most comprehensive benefits possible by assuring a "predictable set of liabilities" and "a uniform regime" of remedies. *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 379 (2002).

The decision below should be reversed to ensure that employer-sponsored plans remain financially viable and able to cover all of their participants' claims without increasing premiums/contributions.

## II.

## ALLOWING COURTS TO VARY UNAMBIGUOUS PLAN TERMS WOULD CREATE PERVERSE INCENTIVES THAT UNDERMINE THE PURPOSES OF SUBROGATION

The Third Circuit appears to have been troubled by the prospect that plan participants may be required to reach into their own pockets to repay plans. Pet. App. 16a.[14] It is, however, extremely rare

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[14]As noted above, the Third Circuit apparently believed that McCutchen's net recovery was less than US Airways' lien. *See* note 7, *supra*. But this is not established in the record. *Id.* The Third Circuit also stated that the plan would receive a "windfall" if permitted to seek reimbursement because the District Court required McCutchen to provide full reimbursement to the plan even though the plan did not exercise its subrogation rights or contribute to the cost of obtaining third party recovery. Pet. App. 16a. However, it is unclear how the majority rule—which merely suggests that courts should

(. . . continued)

that a plan participant would ever be called upon to reimburse the plan's equitable lien from his own assets. To understand why—and to prevent this unique bad fact from driving bad law—it is useful to understand how subrogation/reimbursement claims generally proceed.

Once a plan determines that claims are related to an accident, the plan notifies the member and his or her attorney of the member's contractual obligation to reimburse the plan, and the plan further notifies the potentially at-fault party and his or her liability insurance carrier that the plan has a subrogation claim with respect to any right to recovery. The plan then monitors the injured party's claim, provides claims information and legal support for the plan's position to the member and at-fault party, and in some instances, intervenes in the plan's name in underlying personal injury action as a third party plaintiff. *Amici*'s preferred method of recovery is to recover the amount it paid in benefits to the member directly from the at-fault party. However, plans routinely negotiate resolution of claims with the member or his counsel. In this way, the plan can balance the interests of the individual participant and the other members to help reach a result that is fair and equitable for all interested parties.[15]

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(Continued . . .)
enforce the reimbursement provision as written in the plan—would give the plan a "windfall." "Windfall" means unearned money, and enforcing a provision that protects a plan's assets cannot, by definition, be a windfall.

[15]The plan and the participant have a common interest in the success of an action against the at-fault party—and in facilitating a settlement when that is the best option for maximizing recovery. Plans can, and frequently do, agree to compromise the amount of their liens in order to facilitate a settlement that is beneficial to all plan participants and responsive to the facts of the particular case. The decision below

(. . . continued)

If the unusual situation of a plan seeking reimbursement from the participant's personal assets arose here, it arose only because—with full knowledge of his pre-existing obligation to reimburse US Airways for benefits paid in the event he recovered from a third party—McCutchen (1) agreed to a 40% contingency fee arrangement with his attorneys and (2) agreed to a $10,000 settlement with the third party tortfeasor and $100,000 in underinsured motorist coverage without first informing US Airways of the larger of the two settlements. JA 41, 58. If US Airways had been kept fully informed, the plan could have attempted to negotiate for a larger share of the third party tortfeasor's insurance limits, intervened in the action against the third party tortfeasor to pursue its rights in subrogation or agreed to an acceptable compromise on its potential lien.

But if equitable defenses can reduce a plan's lien, plan participants have an incentive to exclude plans from negotiations and attempt to structure their settlements in a manner that precludes plans from exercising their repayment rights—*e.g.*, by allocating the majority of settlement funds to a spouse for loss of consortium. *See Aetna Life Ins. Co. ex rel. Lehman Bros. Holdings, Inc. v. Kohler*, No. C 11-0439 CW, 2011 WL 5321005, at *5 (N.D. Cal. Nov. 2, 2011) (rejecting the application of equitable defenses and the plan participant's efforts "to allocate the bulk of the money to [his wife for loss of consortium] and a small amount to [himself] in a transparent attempt to circumvent [the plan's] right to recover treatment

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(Continued . . .)
substitutes post hoc reformation of the contract by the court for the individualized determinations of the parties, that is, it interjects judicial decision-making into a process best resolved by the parties.

costs"). That gamesmanship undermines a primary purpose of subrogation, which is to "place the burden for a loss on the party ultimately liable or responsible for it and . . . relieve entirely the insurer . . . who indemnified the loss and who in equity was not primarily liable for the loss." Gary L. Wickert, *The Societal Benefits of Subrogation*, *available at* http://www.mwl-law.com.

In sum, there is no evidence that the current process is inadequate. To the contrary, plans work efficiently and equitably in a predicable system. And although individual participants, like McCutchen, may occasionally benefit if the decision below is affirmed, millions of other plan participants will suffer: increased costs and decreased recoveries will jeopardize plans' financial viability and the application of equitable defenses will incentivize gamesmanship and lead to unpredictable results.

## CONCLUSION

The judgment of the Third Circuit should be reversed.

Respectfully,

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September 5, 2012.