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 LAW PROFESSORS AS *AMICI CURIAE* IN SUPPORT OF RESPONDENTS

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INTEREST OF THE *AMICI CURIAE*[1]

Amici are seven full-time legal academics who teach and write in the areas of insurance law, employee benefits law, and/or healthcare law, or who work in a clinical setting with clients who are affected by medical expense reimbursement. A list of individual *amici* is attached as Appendix A. *Amici* submit this brief to explain the broader context of how ERISA's subrogation-based right compares to other federal and state medical reimbursement schemes, in the hopes of informing the fair and consistent development of the law of ERISA.

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[1] The parties have consented to the filing of this brief. No counsel for any party authored this brief in whole or in part, and no person or entity, other than *amici* and their counsel, made a monetary contribution to the preparation or submission of this brief.

SUMMARY OF ARGUMENT

If U.S. Airways' subrogation-based rights are held to be free from any limitations on the availability of relief, that holding would place an ERISA plan's right to reimbursement at odds with nearly every other federal and state medical reimbursement scheme in the country. In virtually no area, statutory or otherwise, is a subrogee entitled to an absolute, unrestricted right to reimbursement of medical expenses from proceeds obtained from a third-party tortfeasor when the injured insured recovers less than the total amount of his damages and when the subrogee sits back and lets the insured bear the entire burden of litigation and collection, as the U.S. Airways plan did here.

The core equitable principles of prevention of double recovery and the common fund doctrine remain the bedrock upon which different models of medical expense reimbursement have developed. And there is no evidence that the continuing vitality of those principles in contemporary federal and state reimbursement models has caused an undue burden upon the courts or the coffers of private and public insurers.

ARGUMENT

It has long been recognized that subrogation is a "creature of equity" that allows the substitution of an insurer to the insured's rights so that the insurer is able to step into the shoes of the insured and acquire all the rights the insured may have against a third party. 16 *Couch on Insurance* § 223:8 (Lee R. Russ & Thomas F. Segalla eds., 3d ed. 2011); Johnny C. Parker, *The Made Whole Doctrine: Unraveling the Enigma Wrapped in the Mystery of Insurance Subrogation,* 70 Mo. L. Rev. 723, 724 (2005). Subrogation creates equitable outcomes by preventing unjust enrichment and furthering the principle of indemnity by preventing the insured from recovering twice for the same loss. Ronald C. Horn, *Subrogation in Insurance Theory and Practice* 24 (1964).

When Congress undertook its decade-long study of the country's private employee benefit system in the mid-1960s and early-1970s, subrogation and reimbursement clauses for medical expense claims were "virtually nonexistent." Roger M. Baron, *Public Policy Considerations Warranting the Denial of Reimbursement to ERISA Plans: It's Time to Recognize the Elephant in the Courtroom,* 55 Mercer L. Rev. 595, 612 (2004). While the idea of subrogation and reimbursement for property damage has been a longstanding legal doctrine accepted at common law that was routinely applied in property insurance, insurers have only recently attempted to place reimbursement and subrogation clauses into healthcare insurance coverage agreements. *Id.*; *see also* Roger

M. Baron, *Subrogation: A Pandora's Box Awaiting Closure*, 41 S.D. L. Rev. 237, 238-39 (1996).

Insurers only recently began seeking "reimbursement" because the common law prohibited the assignment of personal injury claims. Baron, *Denial of Reimbursement to ERISA Plans*, *supra*, at 602 n.36. To avoid this prohibition, insurers began characterizing their claims as ones of "reimbursement," not "subrogation," in an attempt to enforce their contractual rights against the insured and collect funds obtained by the insured from a tortfeasor.[2] *Id.*

As explained below, these equitable concepts are still considered by courts and legislatures in determining appropriate limits for subrogation-based rights. Some states prohibit subrogation outright in the context of medical expense reimbursement because of the historical distinction between property insurance and personal insurance, or because of the common law prohibition on assignment of personal injury claims. Other states, as well as federal statutes, limit subrogation-based rights through equity or law, depending on the nature of the action and the conduct of the parties. The prevention of double recovery continues to be recognized as the cornerstone of medical expense reimbursement.

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[2] "Subrogation" and "reimbursement" are not synonymous terms; however, the primary objective of an insurer seeking subrogation rights is to be reimbursed for its costs that it paid on behalf of an insured under its coverage terms. 16 *Couch on Insurance*, *supra*, § 222:2 ("Reimbursement . . . technically refers to any payment back of what has been expended, without regard to the reason for the recovery or the underlying theory for repayment.").

I. NEITHER MEDICAID, MEDICARE, NOR FECA ALLOWS THE GOVERNMENT AN ABSOLUTE, UNRESTRICTED RIGHT TO THIRD-PARTY PROCEEDS.

Several federal statutory schemes other than ERISA provide for a right to reimbursement of medical expenses following a beneficiary's settlement with a liable third party. Most notably, these federal schemes include Medicaid, Medicare, and the Federal Employees Compensation Act (FECA). Although the limits on reimbursement vary among these statutes, none go so far as to allow an absolute, unrestricted right to third-party proceeds, which is the interpretation of ERISA favored by Petitioner. To allow ERISA to be interpreted in such a way will cause it to be an outlier in the landscape of federal reimbursement schemes, nearly all others of which are limited in some meaningful way.

A. Under Medicaid, State Reimbursement Rights Are Limited to Only That Portion of the Settlement or Judgment That Represents Actual Past Medical Expenses.

Medicaid provides joint federal and state funding of medical care for people who are unable to pay for their own medical costs. The Medicaid Act requires states to seek reimbursement for medical assistance paid to beneficiaries when a third party is at fault, while at the same time it prohibits states from placing a lien against the property of Medicaid recipients

for the recovery of medical assistance. This Court reconciled these two apparently conflicting provisions in *Arkansas Department of Health & Human Services v. Ahlborn*, 547 U.S. 268 (2006), by holding that states are limited in their right to Medicaid reimbursement to only that portion of a settlement or judgment allocated to past medical expenses. Although states have enacted various models to determine the appropriate method for allocation of proceeds from a judgment or settlement under *Ahlborn*,[3] what remains firmly established is the recognition that states are not entitled to unrestricted access to third-party proceeds under Medicaid.

In *Ahlborn*, this Court struck down Arkansas' automatic lien law. *See Ahlborn*, 547 U.S. at 284-85. Arkansas, in response to the obligation placed on it by 42 U.S.C. § 1396a(a)(25)(H) (requiring states to seek reimbursement from liable third parties), passed a statute by which an automatic lien for the full amount of Medicaid services provided was placed on any settlement obtained by a Medicaid recipient. *Ahlborn*, 547 U.S. at 272. The Medicaid recipient in *Ahlborn* was a nineteen-year-old college student who suffered severe physical and mental disabilities as a result of a car accident. *Id.* at 272-73. After her case

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[3] This Court recently granted a petition for a writ of *certiorari* on the issue of whether North Carolina's Medicaid reimbursement scheme is valid under the Medicaid Act and *Ahlborn*. *Delia v. E.M.A.*, No. 12-98, 2012 WL 4343865 (U.S. Sept. 25, 2012). The question presented in that case is: "[W]hether N.C. Gen. Stat. § 108A-57 is preempted by the Medicaid Act's anti-lien provision as it was construed in [*Ahlborn*], an issue on which the North Carolina Supreme Court and the United States Court of Appeals for the Fourth Circuit are in conflict." Petition for Writ of Certiorari at i, *Delia v. E.M.A.*, No. 12-98, 2012 WL 3027168 (U.S. July 20, 2012).

against the tortfeasor settled, the Arkansas Department of Health and Human Services (ADHS) asserted a lien against the settlement proceeds for the total cost of Medicaid payments made on the student's behalf. *Id.* at 274. The student challenged the law on the basis that it permitted recovery for injuries other than past medical expenses. *Id.*

This Court held that the Arkansas law conflicted with the Medicaid Act and limited the State's Medicaid recovery to the portion of the settlement allocated to past medical expenses. *Id.* at 282-85. The student's claim was valued at $3,040,708.12; her case against the tortfeasor settled for $550,000; and ADHS's expenditures totaled $215,645.30. *Id.* at 274. The settlement with the tortfeasor therefore represented only about one-sixth of the student's total claim, and the State's right to reimbursement for Medicaid expenses was reduced proportionally, to $35,581.47. *See id.* at 280-81.

Rejecting ADHS's argument that a full recovery rule was necessary to avoid settlement manipulation in which the State's portion was allocated away, this Court reasoned that there is a "countervailing concern that a rule of absolute priority might preclude settlement in a large number of cases, and be unfair to the recipient in others." *Id.* at 288. In illustration, this Court noted the reasoning employed in *Flanigan v. Department of Labor & Industry*. *Ahlborn*, 547 U.S. at 288 n.19 (citing *Flanigan v. Dep't of Labor & Indus.*, 869 P.2d 14 (Wash. 1994)). The *Flanigan* court held that the State could not recover from damages awarded to the injured person's spouse for loss of consortium because the "department could not 'share in damages for which it has provided no compensation'" and allowing the State to do so would be

an "absurd and fundamentally unjust" result. *Ahlborn*, 547 U.S. at 288 n.19 (quoting *Flanigan*, 869 P.2d at 17).

In the wake of *Ahlborn*, states adjusted their statutory Medicaid reimbursement frameworks to ensure appropriate allocation of third-party proceeds, especially when Medicaid recipients obtain recoveries through undifferentiated settlements, rather than tort judgments. *See, e.g.*, 62 Pa. Stat. Ann. § 1409(b)(11) (West 2012); N.H. Rev. Stat. Ann. § 167:14-a (2012); Cal. Welf. & Inst. Code § 14124.76 (West 2012).

Thus, under *Ahlborn*, states may not recoup Medicaid expenses without ensuring that the allocation process has a mechanism by which it can be determined that the allocation fairly reflects the actual portion of the settlement or judgment attributable to medical expenses.

B. The United States' Right to Reimbursement of FECA Benefits Is Capped at Four-Fifths of the Net Third-Party Recovery.

Similar to Medicaid, the United States' right to reimbursement for medical expenses paid to a federal employee under the Federal Employees' Compensation Act (FECA) is not absolute; rather, it is limited by the statutory language to four-fifths of the *net* proceeds of any settlement after deducting costs and a proportional share of attorney's fees. *See* 5 U.S.C. § 8132.

FECA provides compensation to federal employees who sustain work-related injuries. 5 U.S.C. §§ 8101 *et seq.*; *see also United States v. Lorenzetti*, 467 U.S.

167, 168 (1984). The Act provides coverage for medical expenses and lost wages, but does not provide compensation for other damages such as pain and suffering. *Lorenzetti*, 467 U.S. at 169; *see* 5 U.S.C. §§ 8102-07, 8147, 8116(c).

In *Lorenzetti*, this Court addressed whether a FECA beneficiary was required to reimburse the United States for medical expenses and lost wages paid to him even though his third-party recovery compensated him solely for non-economic damages, such as pain and suffering. *Id.* at 168. Although this Court held that the United States was entitled to reimbursement under § 8132 "regardless of whether the award or settlement is for losses other than medical expenses and lost wages," *id.* at 179, this Court also noted that the United States' right to reimbursement was not unlimited. *Id.* at 170-71. Specifically, this Court noted that § 8132 required that, at a minimum, beneficiaries are entitled to retain one-fifth of the net settlement after litigation costs and attorney's fees are deducted.[4] *Id.* at 170-71 & nn.1-2; *see also* 20 C.F.R. § 10.712.

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[4] In the *amicus* brief filed by the United States in this case, the government contends that FECA is similar to ERISA to the extent that FECA embraced equitable principles, and that despite the incorporation of equity into FECA, this Court in *Lorenzetti* rejected an argument analogous to Respondents' here, which sought to limit the United States' reimbursement under FECA to only that portion of a settlement or judgment representing FECA-covered economic damages. Brief for the United States as *Amicus Curiae* Supporting Neither Party at 17-19, *U.S. Airways, Inc. v. McCutchen*, No. 11-1285, 2012 WL 3864275 (U.S. Sept. 5, 2012).

That is an incorrect characterization of both § 8132 of FECA and *Lorenzetti*. While it is true that this Court in *Lorenzetti* refused to limit the United States' reimbursement to only that

Additionally, beneficiaries are entitled to retain any portion of a settlement representing damages to real or personal property, loss of consortium, wrongful death and survival actions. 20 C.F.R. § 10.711. All these monies, as well as attorney's fees and litigation costs, are subtracted from the gross recovery amount to calculate net proceeds. 20 C.F.R. § 10.712. It is from this net proceeds calculation that a beneficiary's minimum one-fifth retention and the government's maximum four-fifths recovery are calculated. *Id.*

Moreover, the United States is not entitled to reimbursement from any proceeds that an insured recovers under his own insurance – like the uninsured/underinsured motorist (UIM) insurance proceeds that McCutchen recovered in this case – because they are not considered monies recovered from a third party. 20 C.F.R. § 10.718.

This framework is designed to provide an incentive for FECA beneficiaries to pursue claims against

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portion of the third-party recovery that represented FECA-covered losses, it did *not* do so in the context of any statutory language in FECA addressing equity. The only reference that the United States makes to the relationship between a FECA claim and equity is an observation in *Lorenzetti* that FECA, generally, is intended to treat federal employees "in a fair and equitable manner." *Id.* at 18-19 (citing *Lorenzetti*, 467 U.S. at 177 (quoting S. Rep. No. 93-1081, at 2 (1974))). Unlike § 502(a)(3) of ERISA, FECA says nothing about how the relief available is limited to only that relief that was typically available in equity. Contrary to the United States' attempt to analogize § 8132 of FECA with § 502(a)(3) of ERISA, FECA simply demonstrates that Congress can *statutorily* authorize a greater amount of recovery for reimbursement, like it did in FECA. But that does not address the issue here regarding the limits that would typically have been applicable to the claim in equity.

third parties. *See Gonzalez v. Dep't of Labor*, 609 F.3d 451, 455 n.2 (D.C. Cir. 2010).

C. Even Under Medicare's Reimbursement Scheme, The United States' Right to Reimbursement is Subject to a Deduction for Attorney's Fees and Includes a Relief Mechanism for Equitable Purposes.

Medicare's right to reimbursement is by far the most expansive of the federal reimbursement schemes and is unique among the federal statutory schemes in that it creates a super-priority automatic right to reimbursement when a third party is liable for the medical expenses incurred. *See* 42 U.S.C. § 1395y(b)(2)(B)(ii). Even so, as explained below, Medicare's reimbursement right is less expansive than the approach advocated by the ERISA plans in this case.

Medicare Secondary Payer legislation provides that Medicare will serve as a secondary payer when a beneficiary has overlapping coverage. *See Zinman v. Shalala*, 67 F.3d 841, 843 (9th Cir. 1995). Therefore, when a beneficiary suffers an injury that is covered by a group health plan or liability, workers' compensation, automobile, or no-fault insurance, Medicare will conditionally pay for the needed medical services, but is entitled to be reimbursed by the beneficiary for its conditional outlays should the beneficiary receive settlement from a primary insurer or third party. *Id.*

The Medicare statute provides for a "separate and distinct" right of recovery against any entity that is

responsible for the payment of, or has received payment for, Medicare services. *Id.* at 845; *see also* 42 U.S.C. § 1395y(b)(2)(B)(ii).

It is because of this separate and distinct reimbursement right that the government under Medicare, unlike Medicaid, is not limited to recovering the portion of a settlement allocated to past medical expenses. *Zinman*, 67 F.3d at 844. Rather, the responsibility of the beneficiary to reimburse Medicare is "ultimately defined by the scope of his own claim against the third party." *Hadden v. United States*, 661 F.3d 298, 302 (6th Cir. 2011) (emphasis omitted). In creating the separate right to reimbursement, decoupled from its historical ties to subrogation, Congress took the United States' reimbursement claim out of equity and, in doing so, conferred upon the United States a more expansive right to recovery. Thus, Medicare is entitled to full reimbursement from a beneficiary if that beneficiary claimed his medical expenses in full, regardless of whether or not he actually received complete compensation for the claim.

However, despite Medicare's expansive right to reimbursement, it is not, in fact, completely unlimited. Three important limits are placed on Medicare. First, beneficiaries are entitled to subtract from the Medicare reimbursement a portion of the attorney's fees paid to obtain the settlement. 42 C.F.R. § 411.37; *see also Hadden*, 661 F.3d at 300. Second, the United States Department of Health and Human Services is required to waive reimbursement where recovery would cause financial hardship to the beneficiary or otherwise be "against equity and good conscience." 42 C.F.R. § 1395gg(c); *see also Zinman*, 67 F.3d at 843 n.1. Third, when proceeds are obtained through a

judgment on the merits, Medicare reimbursement is limited to the amount allocated for past medical expenses when explicit allocation of medical and non-economic damages is made by a court. Medicare Secondary Payer Manual, CMS Pub. 110-5, ch.7, § 50.4.4 (2008) ("The only situation in which Medicare recognizes allocations of liability payments to nonmedical losses is when payment is based on a court order on the merits of the case. If the court or other adjudicator of the merits specifically designate[s] amounts that are for payment of pain and suffering or other amounts not related to medical services, Medicare will accept the Court's designation. Medicare does not seek recovery from portions of court awards that are designated as payment for losses other than medical services."). Thus, even the most expansive federal reimbursement scheme allows for the subtraction of attorney's fees and other limitations, and recognizes the double recovery cap where the allocations are specifically designated.

In short, virtually every other federal statutory context that involves a right to reimbursement imposes some limitations on the extent of the recovery – in the form of a limitation on the amount of the lien itself and/or a requirement that the lien holder contribute to a portion of the attorney's fees. Even a statute that was passed in response to an urgent fiscal crisis – the Medicare Secondary Payer Act – places some limitations on the rights to subrogation and reimbursement. Thus, if Petitioner here has its way, ERISA will be an outlier among federal programs in which reimbursement is permitted. It is hard to imagine that, in the context of a federal statute which limits ERISA plans to "appropriate equitable relief," this is the result that Congress intended.

II. EQUITABLE PRINCIPLES ARE APPLIED BY STATE COURTS WHEN DETERMINING AN INSURER'S SUBROGATION-BASED RIGHTS FOR REIMBURSEMENT OF MEDICAL EXPENSES.

The unlimited reimbursement remedy sought by Petitioner here is also at odds with the vast majority of state laws governing private insurance. If Congress were to undertake a comprehensive study of the fifty states and their treatment of reimbursement provisions in medical insurance contracts today, it would find that many states frequently use equitable principles to restrict the ability of insurers to seek reimbursement for medical expenses paid to insureds. These restrictions are achieved in several different ways: (1) applying different public policies to medical insurance coverage than to property insurance coverage; (2) ensuring that no party receives a double recovery; and (3) applying the common fund doctrine.

A. The Policies and Principles Underlying Subrogation-Based Rights in Property Insurance Do Not Fit Well With Medical Insurance.

Some states prohibit subrogation-based rights for medical payments altogether, ruling that the nature of personal insurance as distinct from property insurance (where subrogation first arose) does not logically or traditionally support subrogation. Others hold that subrogation in the medical context is akin to an assignment of a personal injury claim, which violates public policy.

The distinctions between property insurance and personal insurance rest on the historical concept of "indemnity." *See* Robert H. Jerry, II & Douglas R. Richmond, *Understanding Insurance Law* § 96(c) (4th ed. 2007). "Indemnity," in this sense, refers to the compensation necessary to reimburse an insured for any loss and the idea that the insured should not receive a windfall for suffering a loss. *See id.* § 41; Black's Law Dictionary 837 (9th ed. 2009). Based on this idea of "indemnity," subrogation by the insurer is useful to prevent an insured from receiving a "double recovery windfall" by collecting from both the insurer and the tortfeasor for a loss. *See* Jerry & Richmond, *supra*, § 96(C).

The concept of indemnity operates easily in the property insurance arena, but has a more difficult fit in personal insurance. Commentators have noted that life insurance, in particular, is viewed as more of an investment contract, rather than a contract for indemnity like property insurance, because a life insurance contract cannot provide a "dollar-for-dollar" exchange in order to make the beneficiary whole. *Id.*;

see also 1 *Couch on Insurance*, *supra*, § 1:39 (stating life insurance is not a contract of indemnity because a death is not a "loss" in the sense that the term is applied in a property insurance setting); Roger M. Baron, *Subrogation on Medical Expense Claims: The "Double Recovery" Myth and the Feasibility of Anti-Subrogation Laws*, 96 Dick. L. Rev. 581, 583 (1992) (noting that subrogation has its "genesis" in property insurance).

Other forms of insurance coverage, such as motor vehicle insurance, liability insurance, and accident insurance, that may provide medical coverage for personal injuries sustained by an insured, cannot be distinctly classified as property insurance or life insurance. Instead, these forms of insurance rest in a middle ground and present a difficult question for courts about subrogation-based rights. *See* Robert E. Keeton & Alan I. Widiss, *Insurance Law*, § 3.10(a)(6), at 230-31 (1988).

While there are some traces of indemnity in medical coverage situations, when looking at the incident that caused the need for medical coverage, it is "rather artificial" to take into account merely the medical expenses paid. *Id.* Like life insurance, the injured insured will never be fully compensated for her loss despite the fact that medical expenses are paid, because pain and suffering, disability, and limitations imposed by physical impairments or diminished earning capacity are not taken into account. *See id.* at 231; Jerry & Richmond, *supra*, § 96(c).

Some state courts have recognized these distinctions in explaining the difference between medical insurance and other forms of casualty insurance. The Oklahoma Supreme Court in *Aetna Casualty and Surety Co. v. State Board for Property and Casualty*

Rates, 637 P.2d 1251 (Okla. 1981), examined whether certain insurance forms complied with a state statute prohibiting automobile liability insurers from seeking subrogation for medical expenses. In examining the language of the forms and declaring them inconsistent with the statute, the court remarked that:

> Subrogation rights are commonly allowed when the insured sustains a fixed financial loss.
>
> In personal insurance contracts however, the exact loss is never totally capable of ascertainment, and therefore the same reasons militating against double recovery do not obtain. The general rule, therefore, is that the insurer is not subrogated to the insured's right or the beneficiary's rights under contract of personal injury.

Id. at 1255 & n.5 (citing 3 John Appleman & Jean Appleman, *Insurance Law & Practice* § 167 (1967)).

The Washington Supreme Court noted the "complexities" that arise in subrogation when medical payments are involved as compared to when property loss is at issue. *See Mahler v. Szucs*, 957 P.2d 632, 641 (Wash. 1998) (en banc). The court recognized that, unlike in property insurance cases where the insured is fully compensated for her loss and thus has no incentive to file suit against a third-party tortfeasor, the injured insured in a personal insurance context will often sue to recover her non-economic damages, and include as an item of damages the medical expenses incurred as result of her injury. *Id.* For this reason the court remarked that unlike in a property insurance case, the "injured insured does not abandon its shoes, and its insurer

thus has no shoes to step into to pursue subrogation." *Id.*

Besides the general distinction between property insurance and more personal forms of insurance, a number of states have applied public policy considerations to prohibit an insurer's subrogation-based rights for medical expenses. For example, in *Allstate Insurance Co. v. Druke*, 576 P.2d 489, 492 (Ariz. 1978) (in banc), the Arizona Supreme Court found that neither equitable nor contractual subrogation rights were enforceable to recover medical expenses because it would amount to an assignment of a personal injury claim, which violated "sound public policy." The *Druke* court noted that medical expenses usually constitute only a portion of the insured's loss:

> [i]n addition to other 'out-of-pocket' losses, such as loss of income or earning power and the costs of asserting said claim such as court costs and attorney's fees, an accident victim often suffers non-economic losses such as physical pain and mental anguish which are often not monetarily indemnifiable and never insurable.

Id. at 492. Because the repayment provision at issue in that case would have allowed the insurer to obtain full reimbursement regardless of whether the insured was fully compensated for his loss, and because it would have required the insured to return to the insurer the benefits for which he paid premiums, the provision was unenforceable as against public policy. *Id.*; *see also Allstate Ins. Co. v. Reitler,* 628 P.2d 667 (Mont. 1981) (holding medical payment subrogation clauses are invalid for public policy reasons); *Maxwell v. Allstate Ins. Co.*, 728 P.2d 812

(Nev. 1986) (per curiam) (stating that assignment of a personal injury claim was prohibited at common law and violative of Nevada's public policy).

Thus, some scholars and state courts have recognized that subrogation-based rights should not exist at all in the medical insurance context because the concept of indemnity may not be logically extended to personal injuries for which an injured insured recovers damages from a third-party tortfeasor.

B. In States That Allow Subrogation-Based Rights for Medical Expenses, the Principles Used in Determining the Distribution of Third-Party Proceeds Center on the Prevention of Double Recovery.

Like U.S. Airways' self-funded ERISA plan, many insurance coverage provisions that are governed by state law also contain reimbursement and subrogation clauses requiring the insured to pay back the insurer for the medical expenses it paid if the insured recovers from a third party for its loss. As explained *supra*, subrogation and reimbursement produce equitable outcomes by preventing unjust enrichment and furthering the principle of indemnity by preventing the insured from recovering twice for the same loss. Horn, *supra*, at 24. Based on this principle, even when the insurer has paid the insured's medical expenses, and the insured recovers damages from a third-party tortfeasor, the right to reimbursement is not absolute. *See* 16 *Couch on Insurance*, *supra*, § 226:36. Rather, in order for an insurer to have a right to reimbursement, the recovery the insured receives from the third party must correspond to the

benefits paid out by the insurer. *Id.*; *see, e.g.*, *Ferrell v. Nationwide Mut. Ins. Co.*, 617 S.E.2d 790, 796 (W. Va. 2005) (allowing an insurance company to seek reimbursement because the requirement that the insured's recovery clearly duplicated the medical expense payments paid by the insurer was met).

Iowa provides a good example of this principle. In *Ludwig v. Farm Bureau Mutual Insurance Co.*, 393 N.W.2d 143 (Iowa 1986), the Iowa Supreme Court addressed the apportionment of settlement proceeds in an action brought against a trucking company by three insureds injured in an accident by the company's truck driver. The insurer sought to enforce a conventional subrogation right to recover medical expenses it paid on behalf of the three injured insureds. The insureds claimed that they were not made whole by the settlement proceeds and therefore the insurer should not be able to recoup its medical expenses.[5] But the court held that the principle of preventing unjust enrichment was the primary purpose of subrogation, *id.* at 146 (citing Restatement of Restitution § 162 (1937)), and therefore, the settlement should be apportioned accordingly. Because the amount of the settlement proceeds designated for

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[5] The "made whole" rule is an equitable insurance principle requiring that an insured be fully compensated for all its loss before the insurer acquires a right to subrogation, or reimbursement. 16 *Couch on Insurance*, *supra*, § 223:134. Most states have adopted the "made whole" rule in some fashion, but some states allow contractual language to modify the "made whole" rule. The states that have allowed for modification of this rule, have done so by treating the claim as a legal claim and enforcing contractual provision, not as a claim arising in equity. *See, e.g.*, *Wine v. Globe Am. Cas. Co.*, 917 S.W.2d 558 (Ky. 1996); *Fortis Benefits v. Cantu*, 234 S.W.3d 642 (Tex. 2007).

medical expenses was clearly set forth in the settlement documents, the insurer was permitted to recover that amount. *Id.* at 146-47.

Like Iowa, other states focus on the prevention of double recovery when determining an insurer's subrogation-based rights, whether that determination is made before or after an insured is made whole. *See, e.g.*, *Teichman v. Cmty. Hosp. of W. Suffolk*, 663 N.E.2d 628 (N.Y. 1996) (holding that insurer was entitled to reimbursement under principles of subrogation but only to the extent of that portion of undifferentiated settlement that prevented double recovery); *Shelter Mut. Ins. Co. v. Bough*, 834 S.W.2d 637, 641 (Ark. 1992) ("[W]hile the general rule is that an insurer is not entitled to subrogation unless the insured has been made whole for his loss, the insurer should not be precluded from employing its right of subrogation when the insured has been fully compensated and is in a position where the insured will recover twice for some of his or her damages.").

C. The Common Fund Doctrine is an Equitable Principle Used by States to Limit the Ability of an Insurer to Seek Reimbursement from Insureds.

"The common fund doctrine reflects the traditional practice in courts of equity." *Boeing Co. v. Van Gemert*, 444 U.S. 472, 478 (1980). Under the common fund doctrine, a party who passively benefits from a fund created or preserved through litigation by another party is required to share in the cost of the litigation incurred by the insured. Dan B. Dobbs, *Law of Remedies: Damages-Equity-Restitution* § 4.3(4) (2d ed. 1993). The passive party shares in the cost of liti-

gation by paying a proportional share of the insured's attorney's fees and expenses in the action that the passive party financially benefitted from. 16 *Couch on Insurance*, *supra*, § 223:8. This protects against unjust enrichment which would occur if the passive party could receive reimbursement without paying the costs of obtaining it. *Id.*

Virtually every state has adopted the common fund doctrine in order to prevent unjust enrichment. *See* E. Farish Percy, *Applying the Common Fund Doctrine to an ERISA-Governed Employee Welfare Benefit Plan's Claim for Subrogation or Reimbursement*, 61 Fla. L. Rev. 55, 67 (2009). The common fund doctrine is applicable in a number of different contexts, ranging from insurance reimbursement, class action claims, and creation and/or preservation of a trust estate. Dobbs, *supra*, § 3.10(2). In the context of insurance (not including ERISA, federal statutes or state worker's compensation), at least thirty-one states have adopted the common fund doctrine in some capacity: twelve of those states have adopted some version of the common fund rule by statute that limits the ability of an insurer to be reimbursed;[6] while nineteen states have applied the common fund

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[6] *See* Ark. Code Ann. § 23-79-146(a)(2) (2012); Colo. Rev. Stat. § 10-1-135 (2012); Ga. Code Ann. § 33-24-56.1(b)(2) (2012); Ind. Code § 34-51-2-19 (2012); Iowa Code § 668.5 (2012); Kan. Stat. Ann. § 40-3113a (2012); Ky. Rev. Stat. Ann. § 304.39-070(5) (West 2012); Me. Rev. Stat. tit. 24-A, § 2729-A (2012); Md. Code Regs. § 11-112 (2012); Minn. Stat. § 62A.095 (2012); Or. Rev. Stat. § 742.538 (2012); 42 Pa. Cons. Stat. § 2503 (2012).

doctrine where an insurer was seeking a reimbursement or subrogation claim.[7]

As Respondent notes, various courts have rejected attempts by insurers to override the common fund doctrine by contract. To highlight one recent example, in *Hamm v. State Farm Mutual Automobile Insurance Co.*, 88 P.3d 395 (Wash. 2004), the Washington Supreme Court, in a case involving reimbursement of personal injury protection (PIP) benefits, reasoned that "the rule requiring a pro rata sharing of legal expenses is based on equitable principles and not on construction of specific policy language," indicating that the language of an insurance agreement does not matter when the insurer is seeking reimbursement. *Id.* at 403.

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[7] *Blue Cross & Blue Shield v. Freeman*, 447 So. 2d 757 (Ala. Civ. App. 1983); *Sidney v. Allstate Ins. Co.*, 187 P.3d 443 (Alaska 2008); *Lee v. State Farm Mut. Auto. Ins. Co.*, 129 Cal. Rptr. 271 (Cal. Ct. App. 1976); *Forsyth v. S. Bell Tel. & Tel. Co.*, 162 So. 2d 916 (Fla. Dist. Ct. App. 1964); *Wensman v. Farmers Ins. Co. of Idaho*, 997 P.2d 609 (Idaho 2000); *Health Cost Controls v. Sevilla*, 718 N.E.2d 558 (Ill. App. Ct. 1999); *Barreca v. Cobb*, 668 So. 2d 1129 (La. 1996); *Foremost Life Ins. Co. v. Waters*, 337 N.W.2d 29 (Mich. Ct. App. 1983); *Keisker v. Farmer*, 90 S.W.3d 71 (Mo. 2002) (en banc); *Mountain W. Farm Bureau Mut. Ins. Co. v. Hall*, 38 P.3d 825 (Mont. 2001); *United Servs. Auto. Ass'n v. Hills*, 109 N.W.2d 174 (Neb. 1961); *Amica Mut. Ins. Co. v. Maloney*, 903 P.2d 834 (N.M. 1995); *Wiswell v. Shelby Mut. Ins. Co.,* 515 N.E.2d 1214 (Ohio Ct. App. 1986); *Jennings v. Nationwide Ins. Co.,* 669 A.2d 534 (R.I. 1996); *Peppertree Resorts Ltd. v. Cabana Ltd.*, 431 S.E.2d 598 (S.C. Ct. App. 1993); *Kline v. Eyrich*, 69 S.W.3d 197 (Tenn. 2002); *Allstate Ins. Co. v. Edminster*, 224 S.W.3d 456 (Tex. App. 2007); *Guiel v. Allstate Ins. Co.*, 756 A.2d 777 (Vt. 2000); *Hamm v. State Farm Mut. Auto. Ins. Co.,* 88 P.3d 395 (Wash. 2004); *State Farm Mut. Auto. Ins. Co. v. Geline*, 179 N.W.2d 815 (Wis. 1970).

III. WORKERS' COMPENSATION SUBROGEES ARE ALSO LIMITED IN THEIR RIGHT TO REIMBURSEMENT FROM THIRD-PARTY PROCEEDS, ESPECIALLY WHEN AN INJURED EMPLOYEE RECOVERS UNDER HIS OWN UIM POLICY.

Like the federal and state medical expense reimbursement schemes explained above, no state workers' compensation system gives a subrogee a categorically unrestricted right to reimbursement of benefits from third-party proceeds. And, notably, the majority of states hold that workers' compensation subrogees generally have *no* right to reimbursement out of proceeds of a claimant's uninsured/underinsured motorist (UIM) policy, like the policy under which James McCutchen recovered some of his damages with the assistance of his privately retained counsel. Nearly all states require employers to participate in their workers' compensation systems. *See Howard Delivery Serv., Inc. v. Zurich Am. Ins. Co.*, 547 U.S. 651, 662-65 (2006) (explaining the nature of a state workers' compensation system as "a classic social trade-off" that gives an injured employee the right to receive limited benefits for a work-related injury or illness regardless of fault and relieves an employer of common-law and statutory tort liability) (quoting Peter M. Lencsis, *Workers' Compensation: A Reference and Guide* 9 (1998)). And every state workers' compensation statute provides some statutory mechanism enabling an employer, fund, or insurance carrier who has paid benefits to an injured employee to be subrogated to the employee's rights against a third party. *See* 6 *Larson's Workers' Compensation Law* § 116.01[1] (2007).

The primary concern of many states in distributing third-party tort proceeds between an injured employee and a workers' compensation subrogee, whether after trial or settlement, has been avoiding double recovery by the employee. To that end, several states have carefully fashioned their workers' compensation systems in various ways to specifically avoid double recovery, while at the same time ensuring fairness and equity in the process.

Ohio is a good example. In *Holeton v. Crouse Cartage Co.*, 748 N.E.2d 1111 (Ohio 2001), the Ohio Supreme Court held that the then-existing workers' compensation subrogation provision violated the takings and due process clauses of the Ohio constitution because, *inter alia*, it operated to allow the subrogee to take more of the claimant's tort recovery than was duplicative of the subrogee's expenditures. *Id.* at 1121-24. Moreover, the subrogation provision treated post-trial judgments and settlements differently: whereas a plaintiff could have special jury interrogatories designate portions of the tort recovery so they fell outside the category of reimbursable benefits, the plaintiff who settled could do no such thing and, therefore, the subrogee collected the entire settlement amount up to the amount of past and future benefits. The court found that unconstitutional. *Id.*

In response to *Holeton*, the Ohio legislature enacted a new subrogation provision that fixed a formula for the proportional distribution of the third-party proceeds; the formula divided the net third-party recovery so that the subrogee received a proportionate share based on its subrogation interest, while the employee received a proportionate share based on his uncompensated damages. *Groch v. Gen. Motors Corp.*, 883 N.E.2d 377 (Ohio 2008) (explaining the

legislative response to *Holeton* in the 2003 enactment of Ohio Rev. Code Ann. § 4123.931). The new formula made no distinction between proceeds from a judgment and a settlement. The Ohio Supreme Court ruled in *Groch* that the new subrogation provision was constitutional under Ohio law because the provision – while still potentially leading to some unfairness on both sides – reasonably balanced the equities between an undercompensated injured employee and a subrogee. *Id.* at 393.

Similarly, New Mexico, recognizing that one of the primary purposes of its workers' compensation subrogation mechanism is to prevent double recovery by the employee, only allows a subrogee to recoup the amount of the employee's duplicative recovery. *Gutierrez v. City of Albuquerque*, 964 P.2d 807, 808-10 (N.M. 1998); *Chavez v. S.E.D. Lab.*, 14 P.3d 532, 534 (N.M. 2008).

Other states also distribute third-party proceeds through procedures that allow for apportionment and take into account the equities in bearing the costs of litigation. Kansas carves out from the subrogee's interest any damages representing loss of consortium or loss of services of a spouse, whether after trial or settlement. Kan. Stat. Ann. § 44-504 (2012). Arkansas and Minnesota allow an injured employee to keep a set portion of the net recovery protected from any right of subrogation. Ark. Code Ann. § 11-9-410 (2012) (after attorney's fees, costs, and expenses are deducted, injured claimant entitled to keep at least one-third of net recovery in all circumstances); Minn. Stat. § 176.061 (2012) (same); s*ee also* Conn. Gen. Stat. Ann. § 31-293 (West 2012) (allowing employee to keep one-third of net recovery only if subrogee does not participate in suit). In Montana, if a

subrogee chooses not to participate in the third-party action, it waives 50% of its subrogation right; plus, an employee is entitled to keep one-third of the net recovery if the amount of recovery is insufficient to provide the employee with that amount after payment of subrogation. Mont. Code Ann. § 39-71-414 (2011).

Georgia appears to go the farthest in protecting an injured employee's interest in third-party proceeds. Georgia's workers' compensation subrogation provision essentially codifies the "made-whole" doctrine and only allows a subrogee to recoup expenses when the injured employee has been fully compensated for the full amount of both economic and non-economic damages, whether by judgment or settlement. *See Austell Healthcare, Inc. v. Scott*, 707 S.E.2d 599, 601-02 (Ga. Ct. App. 2011) (explaining Ga. Code Ann. § 34-9-11.1).

Even in those states that give a subrogee a first lien on any third-party proceeds, the subrogee is not automatically entitled to attorney's fees, costs, and expenses incurred by the injured employee; rather those monies are either subtracted to arrive at a net recovery or the subrogee must pay a proportionate share of the fees and expenses incurred in bringing the third-party liability action. *See, e.g.*, Ala. Code § 25-5-11 (2012) (pro rata share); Ariz. Rev. Stat. Ann. § 23-1023 (2012) (net recovery); Cal. Lab. Code § 3856 (West 2012) (net recovery); *Breen v. Caesars Palace*, 715 P.2d 1070 (Nev. 1986) (interpreting Nev. Rev. Stat. § 616C.215, which is silent on issue, to provide for proportionate share of attorney's fees and costs); Utah Code Ann. § 34A-2-106 (West 2012) (pro rata share); Vt. Stat. Ann. tit. 21 § 624(f) (2012) (fees and expenses divided by court).

A different approach is taken when an injured employee is compensated through the employee's own UIM policy. In that circumstance, the vast majority of states distinguish an employee-purchased UIM recovery from a third-party tort action and hold that a workers' compensation subrogee has no right to reimbursement from proceeds under an UIM policy. *See* 6 *Larson's Workers' Compensation Law* § 110.05[1] (2007). The reasoning underlying this distinction focuses mainly on the fact that most workers' compensation statutes limit subrogation to those damages available from liable third parties, and because the proceeds from an injured employee's own UIM policy are not derived from third parties, subrogation rights do not apply. *See, e.g.*, *Pinkerton's Inc. v. Ferguson*, 824 N.E.2d 789 (Ind. Ct. App. 2005); *Cas. Reciprocal Exch. v. Demock*, 130 S.W.3d 74 (Tex. App. 2002); *Am. Red Cross v. W.C.A.B. (Romano)*, 745 A.2d 78 (Pa. Commw. Ct. 2000), *aff'd*, 766 A.2d 328 (Pa. 2001). *Contra Progressive Cas. Ins. Co. v. Keenan*, 937 A.2d 630 (Vt. 2007) (requires proceeds from employee-purchased UIM policy to be apportioned between economic and non-economic damages, with workers' compensation carrier entitled to lien on economic damages to prevent double recovery).

IV. APPORTIONMENT OF THIRD-PARTY SETTLEMENT PROCEEDS HAS NOT RESULTED IN UNDUE BURDEN OR EXPENSE.

Given the history and prevalence of apportionment of third-party settlement proceeds pursuant to subrogation-based claims, as described above –

whether by statute under the federal reimbursement and workers' compensation schemes or by application of equitable doctrines – it is significant that no evidence appears to exist showing that apportionment has resulted in an undue burden for the courts or a financial calamity for insurers. *Amicus* counsel have not been able to find any statement by courts, Congress, state legislators, or scholars decrying any added burdens or expenses as a result of the apportionment processes mandated by *Ahlborn*, FECA, or workers' compensation schemes. Neither has criticism arisen as a result of courts' practices of holding apportionment hearings to determine the distribution of undifferentiated settlements. *See, e.g.*, *Magsipoc v. Larsen*, 639 So. 2d 1038, 1043 (Fla. Dist. Ct. App. 1994) (holding that trial court is empowered as "fact-finder to determine what portion (if any) of the settlement is fairly allocable to medical costs and expenses in the equitable distribution proceeding" and remanding for further clarification of apportionment).

Furthermore, this Court has previously dismissed arguments similar to those presented by Petitioner and its *Amici* that requiring the allocation of settlements would result in unmanageable burdens on both the Plans and the courts. This Court rejected similar arguments made in *Ahlborn* by ADHS and the United States, reasoning that the "risk that parties to a tort suit will allocate away the State's interest can be avoided either by obtaining the State's advance agreement to an allocation or, if necessary, by submitting the matter to a court for decision." *Ahlborn*, 547 U.S. at 288. This Court further suggested that "special rules and procedures for allocating settlements," such as those used in private in-

surance cases, "might be employed to meet concerns about settlement manipulation." *Id.* at 288 n.18.

Such reasoning suggests that this Court did not believe that any added burden resulting from apportionment would outweigh its value. There was no suggestion that requiring settlement proceeds to be allocated would result in either an undue additional burden to the States or an explosion of litigation in the courts. Nothing in the United States' *amicus* argument presented in this case compels a different conclusion, especially in light of the fact that the same "countervailing concern" – namely "that a rule of absolute priority might preclude settlement in a large number of cases, and be unfair to the recipient in others," *id.* at 288, – is also applicable here.

CONCLUSION

For the abovementioned reasons, and for the reasons stated by Respondent, the judgment of the Third Circuit Court of Appeals should be affirmed.

Respectfully submitted,

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APPENDIX A

Amici file this brief in their individual capacities, and not as representatives of the institutions with which they are affiliated.

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