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 CHAMBER OF COMMERCE OF THE UNITED STATES OF AMERICA, AMERICAN BENEFITS COUNCIL, ERISA INDUSTRY COMMITTEE, AND SOCIETY FOR HUMAN RESOURCE MANAGEMENT AS *AMICI CURIAE* IN SUPPORT OF PETITIONER

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TABLE OF CONTENTS

Page

INTERESTS OF AMICI CURIAE 1

INTRODUCTION AND SUMMARY 2

ARGUMENT 5

I. ERISA PROTECTS EMPLOYEES BY SECURING PLAN RIGHTS AND PROMOTING PLAN FORMATION THROUGH THE ESTABLISHMENT OF UNIFORM REGULATION 5

II. IT IS NOT "APPROPRIATE" UNDER § 502(a)(3) TO PROVIDE EQUITABLE RELIEF AT ODDS WITH THE PLAN TERMS..... 8

A. Equitable Relief Under § 502(a)(3) Is Only "Appropriate" If It Is Consistent With The Plan Terms.....................................9

B. Recognizing Equitable Defenses To Enforcement Of Plan Terms Increases Litigation And Administrative Costs 13

1. *Allowing Any Equitable Exception To Enforcement Of Plan Terms Would Open A Pandora's Box Of Litigation-Increasing Exceptions* 13

2. *Equitable Refusal To Enforce Plan Reimbursement Provisions Depletes Plan Assets And Harms Other Beneficiaries*....... 16

3. *Increased Plan Costs Harm Beneficiaries* 18

III. ENFORCING PLAN REIMBURSEMENT PROVISIONS DOES NOT PRODUCE UNJUST RESULTS.. 20

TABLE OF CONTENTS
(continued)

Page

A. Reimbursement Provisions Reflect A Rational And Fair Contractual Bargain 20

B. This Court Should Not Recognize A General Equitable Exception To Enforcement Of Reimbursement Provisions Based On The Anomalous Facts Of This Case 22

CONCLUSION 24

TABLE OF AUTHORITIES

Page(s)

CASES

Abbott v. Blount Cnty.,
207 S.W.3d 732 (Tenn. 2006) 16

Admin. Comm. of Wal-Mart Stores, Inc. Assocs.' Health & Welfare Plan v. Shank,
500 F.3d 834 (8th Cir. 2007)...................14, 17, 21

Admin. Comm. of the Wal-Mart Stores, Inc. Assocs.' Health & Welfare Plan v. Varco,
338 F.3d 680 (7th Cir. 2003).........................14, 21

Aetna Healthcare Inc. v. Davila,
542 U.S. 200 (2004)... 7

Allstate Ins. Co. v. Druke,
576 P.2d 489 (Ariz. 1978) 15

Baltzer v. Raleigh & A.A.L.R. Co.,
115 U.S. 634 (1885)... 11

Black & Decker Disability Plan v. Nord,
538 U.S. 822 (2003)... 5

Bombardier Aerospace Emp. Welfare Benefits Plan v. Ferrer, Poirot & Wansbrough,
354 F.3d 348 (5th Cir. 2003)............................. 14

Cent. Laborers' Pension Fund v. Heinz,
541 U.S. 739 (2004)... 5

CGI Techs. & Solns. Inc. v. Rose,
683 F.3d 1113 (9th Cir. 2012).......................14, 23

Cigna Corp. v. Amara,
131 S. Ct. 1866 (2011).................................. 3, 10

Conkright v. Frommert,
130 S. Ct. 1640 (2010)................................5, 6, 13

Curtiss-Wright Corp. v. Schoonejongen,
514 U.S. 73 (1995)... 6

Fort Halifax Packing Co. v. Coyne,
482 U.S. 1 (1987)... 7

TABLE OF AUTHORITIES
(continued)

Page(s)

Garrity v. Rural Mut. Ins. Co.,
253 N.W.2d 512 (Wis. 1977) 15

Global Int'l Marine, Inc. v. US United Ocean Servs., LLC,
2011 WL 2550624 (E.D. La. June 27, 2011) 16

Great-West Life & Annuity Ins. Co. v. Knudson,
534 U.S. 204 (2002)... 8

Harris Trust & Sav. Bank v. Salomon Smith Barney, Inc.,
530 U.S. 238 (2000)... 8

Hershey v. Physicians Health Plan,
498 N.W.2d 519 (Minn. Ct. App. 1993)............. 15

Kennedy v. Plan Adm'r for DuPont Sav. & Inv. Plan,
129 S. Ct. 865 (2009)... 6

K-VA-T Food Stores, Inc. v. Hutchins,
2012 U.S. Dist. LEXIS 26575 (W.D. Va. Mar. 1, 2012) 23

Lockheed Corp. v. Spink,
517 U.S. 882 (2004).. 5, 6

Ludwig v. Farm Bureau Mut. Ins. Co.,
393 N.W.2d 143 (Iowa 1986) 16

Mass. Mut. Life Ins. Co. v. Russell,
473 U.S. 134 (1985)... 6

Maxwell v. Allstate Ins. Cos.,
728 P.2d 812 (Nev. 1986).................................. 15

Mertens v. Hewitt Assocs.,
508 U.S. 248 (1993).. 8, 9

Metro. Life Ins. Co. v. Glenn,
554 U.S. 105 (2008) 13

TABLE OF AUTHORITIES
(continued)

Page(s)

Moffett, Hodgkins & Clarke Co. v. City of Rochester,
178 U.S. 373 (1900)... 11

Moore v. CapitalCare, Inc.,
461 F.3d 1 (D.C. Cir. 2006)..........................18, 23

N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.,
514 U.S. 645 (1995)... 7

Pilot Life Ins. Co. v. Dedeaux,
481 U.S. 41, 54 (1987).. 9

Riegel v. Medtronic, Inc.,
552 U.S. 312 (2008)... 21

Schwade v. Total Plastics, Inc.,
837 F. Supp. 2d 1255 (M.D. Fla. 2012) ......passim

Sereboff v. Mid-Atl. Med. Servs., Inc.,
547 U.S. 356 (2006).. 8, 9

Swanson v. Hartford Ins. Co.,
46 P.3d 584 (Mont. 2002).................................. 15

Varity Corp. v. Howe,
516 U.S. 489 (1996).. 17

Zurich Am. Ins. Co. v. O'Hara,
604 F.3d 1232 (11th Cir. 2010)..................passim

STATUTES

29 U.S.C. § 1001a 7

29 U.S.C. § 1132 ....6, 8, 9

TABLE OF AUTHORITIES
(continued)

Page(s)

MISCELLANEOUS

The Henry J. Kaiser Family Foundation & Health Research & Education Trust, *Summary of Findings*, Employer Health Benefits 2011 Annual Survey (2011), available at http://ehbs.kff.org/pdf/2011/8225.pdf 18

The Chamber of Commerce of the United States of America, the American Benefits Council, the ERISA Industry Committee, and the Society for Human Resource Management respectfully submit this brief as *amici curiae* in support of petitioner.[1]

INTERESTS OF *AMICI CURIAE*

The Chamber of Commerce of the United States of America (the "Chamber") is the world's largest business federation. It represents 300,000 direct members and indirectly represents an underlying membership of more than three million businesses and professional organizations of every size, in every industry sector, and from every geographic region of the country. A principal function of the Chamber is to represent the interests of its members by filing amicus briefs in cases involving issues of vital concern to the nation's business community. Many Chamber members provide health benefits to employees and arrange for the provision of health care services through employee welfare benefit plans regulated under ERISA. The ability of its members to purchase affordable health care coverage for the benefit of their employees is of vital importance to them, their employees, and the employees' dependents, and to the Chamber.

The American Benefits Council ("ABC") is a broad-based nonprofit trade association founded to

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[1] No counsel for any party has authored this brief in whole or in part, and no person other than *amici*, their members, or their counsel have made any monetary contribution intended to fund the preparation or submission of this brief. The parties' letters consenting to the filing of this brief have been filed with the Clerk's office.

protect and foster the growth of this Nation's effective and important privately sponsored employee benefit plans under ERISA. The members of ABC include both small and large employer sponsors of employee benefit plans, as well as plan support organizations, such as consulting and actuarial firms, investment firms, banks, insurers and other professional benefit organizations. Collectively, its more than 250 members sponsor, administer or advise plans covering more than 100 million plan participants.

The ERISA Industry Committee ("ERIC") is a non-profit organization representing the Nation's largest employers with ERISA-covered pension, health-care, disability, and other employee-benefit plans. These employers provide benefits to millions of active workers, retired persons, and their families nationwide.

The Society for Human Resource Management ("SHRM") is the world's largest association devoted to human resource management. Representing more than 250,000 members in over 140 countries, the Society serves the needs of HR professionals and advances the interests of the HR profession. Founded in 1948, SHRM has more than 575 affiliated chapters within the United States and subsidiary offices in China and India. SHRM's membership comprises HR professionals who work for employers that sponsor health plans for their employees.

INTRODUCTION AND SUMMARY

For more than 30 years, the Employee Retirement Income Security Act ("ERISA") has encouraged the development of widespread employment-based

coverage for disability, health, and other benefits. ERISA does not require that employers adopt benefit plans, nor does it require that they offer any particular benefits if they do offer a plan. But it does require that employers honor the written terms of whatever benefit plan they decide to offer. ERISA thus places primacy on the written terms of benefit plans. Doing so benefits employers and participants alike; the participants know the benefits to which they are entitled, and employers are ensured a predictable set of liabilities and costs.

The decision below, by upsetting the parties' contractually-defined expectations, is plainly inconsistent with ERISA's text and purpose. Section 502(a)(3) of ERISA authorizes courts to grant "appropriate equitable relief" only to enforce the provisions of ERISA or the *terms of the benefit plan*. Instead of granting equitable relief that was an "appropriate" means to enforce the terms of the plan, the court below granted equitable relief to *rewrite* the terms of the plan. In reaching this result, the court below misread (and dramatically expanded) this Court's holding in *Cigna Corp. v. Amara*, 131 S. Ct. 1866 (2011). Properly understood, *Amara* simply applies the well-established contract law principle that a contract may be reformed where necessary to reflect the clearly demonstrated mutual understanding of the parties. It thus reinforces, rather than undermines, the well-established ERISA principle that the parties' contractually-defined benefits should be enforced.

The decision below also contravenes ERISA's well-established purposes of promoting the creation of employee benefit plans and protecting the indi-

viduals who participate in those benefit plans. If this Court affirms the decision below, plans or their employer sponsors will incur significant costs litigating equitable defenses on a case-by-case basis. And denial of reimbursement will deplete plan assets, forcing them to compensate by increasing premiums or other costs, or by reducing benefits. The inevitable result of doing "equity" in particularized instances is to harm participants generally, by increasing their costs or reducing their benefits. Given the number of Americans who receive health care through employer-based benefit plans, the adverse consequences will likely be significant.

By contrast, enforcing written plan reimbursement provisions does not produce unjust or inequitable results. It merely enforces a rational and fair contractual bargain. The participant here received a clear benefit (immediate payment of his medical bills), and he knew that in exchange for that benefit he would have to reimburse the plan if he ultimately recovered monies from the third party who was responsible for his injuries. Even if the plan in this case recovered slightly more than the participant's net third-party recovery—a fact that the record does not actually establish—that result is anomalous. It does not provide reason to open a Pandora's box of equitable defenses to enforcement of plan reimbursement provisions, undermining contractual expectations, increasing litigation and administrative costs, and ultimately harming the very employees and beneficiaries ERISA was enacted to protect.

ARGUMENT

I. ERISA PROTECTS EMPLOYEES BY SECURING PLAN RIGHTS AND PROMOTING PLAN FORMATION THROUGH THE ESTABLISHMENT OF UNIFORM REGULATION

ERISA was enacted to promote the interests of employees in health and welfare benefit plans in two distinct but related respects.

First, ERISA establishes important contractual and procedural protections for employees of those private employers who choose to establish employee benefit plans. The statute neither compels employers to establish benefit plans nor restricts their freedom to define the benefits they choose to provide. *See Lockheed Corp. v. Spink*, 517 U.S. 882, 887 (2004) ("Nothing in ERISA requires employers to establish employee benefits plans. Nor does ERISA mandate what kind of benefits employers must provide if they choose to have such a plan."). Employers have "large leeway" to design benefit plans "as they see fit." *Black & Decker Disability Plan v. Nord*, 538 U.S. 822, 833 (2003). But ERISA does ensure that, if an employer establishes a plan, the participants in the plan have a federal forum and cause of action to enforce the terms of that plan, whatever those terms may be. "There is no doubt about the centrality of ERISA's object of protecting employees' justified expectations of receiving the benefits their employers promise them." *Cent. Laborers' Pension Fund v. Heinz*, 541 U.S. 739, 743 (2004); *see Conkright v. Frommert*, 130 S. Ct. 1640, 1648 (2010) ("Congress enacted ERISA to ensure that employees would re-

ceive the benefits they had earned"); *Lockheed*, 517 U.S. at 887 ("Congress . . . wanted to mak[e] sure that if a worker has been promised a defined pension benefit upon retirement—and if he has fulfilled whatever conditions are required to obtain a vested benefit—he actually will receive it'" (quotation omitted) (alteration in original)). ERISA's "repeatedly emphasized purpose," in short, is "to protect [the] contractually defined benefits" set forth in the employer's plan. *Mass. Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 148 (1985).

The written terms of the plan thus establish the substantive employee rights Congress sought to protect. *See Curtiss-Wright Corp. v. Schoonejongen*, 514 U.S. 73, 83 (1995) (ERISA is "built around reliance on the face of written plan documents"). As the central enforcement action created by ERISA expressly provides, a participant may sue to "recover benefits due to him *under the terms of his plan*, or to enforce his rights *under the terms of the plan*, or to clarify his rights to future benefits *under the terms of the plan*." 29 U.S.C. § 1132(a)(1)(B) (emphasis added). And as this Court has emphasized, the plan administrator is legally bound to adhere to the written documents governing the plan. *Kennedy v. Plan Adm'r for DuPont Sav. & Inv. Plan*, 129 S. Ct. 865, 875 (2009).

Second, in addition to securing participants' contractual rights to whatever benefits their employers choose to provide, Congress sought to "'induce[]" employers to offer such benefits, "by assuring a predictable set of liabilities, under uniform standards of primary conduct and a uniform regime of ultimate remedial orders and awards.'" *Conkright*, 130 S. Ct.

at 1649 (quoting *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 379 (2002)); *see* 29 U.S.C. § 1001a(c)(2) (ERISA enacted "to alleviate certain problems which tend to discourage the maintenance and growth of" employee benefit plans). In enacting ERISA, Congress recognized "that employers establishing and maintaining employee benefit plans are faced with the task of coordinating complex administrative activities," and that a "patchwork scheme of regulation" causes "considerable inefficiencies in benefit program operation, which might lead those employers with existing plans to reduce benefits, and those without such plans to refrain from adopting them." *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 11 (1987); *see N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 657 (1995) (quoting legislative history). It is thus a central "purpose of ERISA" to reduce administrative costs by "provid[ing] a uniform regulatory regime over employee benefit plans." *Aetna Healthcare Inc. v. Davila*, 542 U.S. 200, 208 (2004).

ERISA, in sum, balances two complementary objectives: "ensuring fair and prompt enforcement of rights under a plan," on the one hand, and encouraging "the creation of such plans" by reducing the administrative costs and "litigation expenses" associated with disuniform regulation, on the other. *Id.* at 215 (quoting *Varity Corp. v. Howe*, 516 U.S. 489, 497 (1996) (alteration omitted)).

II. IT IS NOT "APPROPRIATE" UNDER § 502(a)(3) TO PROVIDE EQUITABLE RELIEF AT ODDS WITH THE PLAN TERMS

This case involves the scope of relief available under § 502(a)(3), the cause of action provided to "enforce" or "redress . . . violations" of ERISA or the plan terms. 29 U.S.C. § 1132(a)(3). Although both beneficiaries and fiduciaries may bring suit under § 502(a)(3), beneficiaries most commonly proceed under § 502(a)(1)(B), the cause of action afforded specifically to beneficiaries to obtain plan benefits or enforce plan rights. *Id.* § 1132(a)(1)(B). Fiduciaries seeking to enforce plan terms are limited to § 502(a)(3), and their remedies under that provision, in turn, are limited to "appropriate equitable relief." *Id.* § 1132(a)(3).

Multiple precedents of this Court have grappled with the meaning of that important phrase. *See 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); *Harris Trust & Sav. Bank v. Salomon Smith Barney, Inc.*, 530 U.S. 238 (2000); *Mertens v. Hewitt Assocs.*, 508 U.S. 248 (1993). This case presents the question whether "equitable relief" in a § 502(a)(3) action may be deemed "appropriate" under this provision when the relief ordered is squarely contrary to the express terms of the plan itself. The answer to that question is no. As shown below, when a court orders equitable relief that overrides the plan terms, that relief contradicts both of the core ERISA objectives discussed above, i.e., protecting employees' contractually-defined rights, and promoting plan formation through uniform regulation.

A. Equitable Relief Under § 502(a)(3) Is Only "Appropriate" If It Is Consistent With The Plan Terms

The phrase "appropriate equitable relief" in § 502(a)(3) does not appear in a vacuum. The relief must be provided only to "redress . . . violations" of ERISA or "the terms of the plan," or to "enforce" ERISA or "the terms of the plan." 29 U.S.C. § 1132(a)(3). There are no freestanding ERISA violations at issue here or in cases like this one—the sole question is what equitable remedy, if any, is "appropriate" to enforce the *terms of the plan*. Section 502(a)(3) thus on its face commands adherence to the plan terms—the *whole point* is to enforce plan terms, not override them in the exercise of freewheeling equitable discretion. *See Mertens*, 508 U.S. at 253 (ERISA "does not, after all, authorize 'appropriate equitable relief' at large, but only 'appropriate equitable relief' for the purpose of 'redress[ing any] violations or . . . enforc[ing] any provisions' of ERISA or an ERISA plan"); *Sereboff*, 547 U.S. at 363 ("ERISA provides for equitable remedies to *enforce plan terms*" (emphasis in original)). As this Court has emphasized, "courts, in fashioning 'appropriate' equitable relief," should "keep in mind the 'special nature and purpose of employee benefit plans,' and respect the 'policy choices reflected in the inclusion of certain remedies and the exclusion of others.'" *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 54 (1987). And as discussed above, no "policy choice" in ERISA is more central than Congress's determination that written plan documents must be enforced as written. *See supra* at 5-6.

The court of appeals in this case turned that principle on its head, holding that straightforward enforcement of the plan terms is the one remedy that would *not* be "appropriate" here. That holding cannot be squared with § 502(a)(3)'s express emphasis on the plan terms, or with Congress's more general objective of ensuring that employers and employees alike can rely on the plain terms of the plans they agree upon.

The court's holding also finds no support in the precedent on which it principally relies, *Cigna Corp. v. Amara*, 131 S. Ct. 1866 (2011). As pertinent here, *Cigna* holds that when an employer or plan fiduciary intentionally misrepresents plan benefits, it may be "appropriate equitable relief" under § 502(a)(3) for the court to reform the plan's written terms to reflect the employer's representations. *See id.* at 1879 ("reformation of the terms of the plan, in order to remedy the false or misleading information CIGNA provided" was within "a traditional power of an equity court"). Although recognizing that "the basis for the reformation in *Cigna* was intentional misrepresentations by the employer and fiduciary," the court below read *Cigna* to stand for the more general point that "the importance of the written benefit plan is not inviolable," despite the precedents and principles discussed above. Pet. App. 15a.

It surely would be surprising if *Cigna*—without discussion or debate—announced such a dramatic break from this Court's longstanding recognition of ERISA's core objective of enforcing the benefit plan terms. And indeed the decision does no such thing. The Court's emphasis in *Cigna* on fraud or mistake as the basis for reformation (131 S. Ct. at 1879) was

not merely a happenstance of the facts of that case. Rather, the existence of fraud or mistake was *essential to the exercise of reformation in equity*. And it was essential for a reason wholly consistent with ERISA's emphasis on protecting employees' contractual expectations: reformation at equity was understood as a means of enforcing the "real" contract as reflected in the parties' communications and actual understanding.

As this Court long ago explained, "[w]here the agreement as reduced to writing omits or contains terms or stipulations contrary to the common intention of the parties, the instrument will be corrected so as to make it conform to their real intent." *Moffett, Hodgkins & Clarke Co. v. City of Rochester*, 178 U.S. 373, 384 (1900) (quoting *Hearne v. Marine Ins. Co.*, 87 U.S. 488, 490 (1874)). But precisely because the written contract was so important, equity courts would not reform a writing unless the fraud or mutual mistake was "clearly shown." *Baltzer v. Raleigh & A.A.L.R. Co.*, 115 U.S. 634, 645 (1885). "'The party alleging the mistake must show exactly in what it consists and the correction that should be made. The evidence must be such as to leave no reasonable doubt upon the mind of the court as to either of these points. The mistake must be mutual . . . . It must appear that both have done what neither intended.'" *Moffett*, 178 U.S. at 385 (quoting *Hearne*, 87 U.S. at 490); *see Baltzer*, 115 U.S. at 645 ("If the proofs are doubtful and unsatisfactory, and if the mistake is not made entirely plain, equity will withhold relief.").

The equitable plan reformation approved in *Cigna* is thus entirely "appropriate" under

§ 502(a)(3) because it applies only in the exceedingly narrow circumstance where it is clearly shown that the parties mutually understood the plan to provide something other than what its written terms say. In that situation, the remedy advances, rather than contradicts, § 502(a)(3)'s express objective of providing a remedy to "enforce" the "terms of the plan." *Cigna* decidedly does *not* enunciate a broader rule that an action to enforce plan terms is subject to any and all defenses to contract enforcement that were generally available in equity. Literally nothing in *Cigna* suggests such a general principle, which would be directly at odds with ERISA precedents and principles long-settled and not even mentioned in the decision.

When the employer has intentionally misled participants in a Summary Plan Description, or where it is clearly shown that the employer and participants mutually misunderstood the plan, reformation may make sense as a means of vindicating all parties' contractual expectations. But where a court decides, in its own personal exercise of equitable discretion, that a plan term is not fair when applied to one participant, the court is not enforcing the plan or the parties' contractual expectations in any sense. The court instead is simply doing what it thinks is "fair" or "just" for one individual in one situation—and something another court may think is *not* fair or just for a similarly situated plan beneficiary. Whatever the power of equity courts generally to exercise such authority, courts adjudicating ERISA actions are constrained by the plain language of § 502(a)(3), which restricts equitable relief in circumstances like these to enforcement of "the terms of the plan."

In this case, the governing benefit plan provided for reimbursement of health benefits when there was a subsequent third-party recovery. The decision below improperly negates that express provision.

B. Recognizing Equitable Defenses To Enforcement Of Plan Terms Increases Litigation And Administrative Costs

Enforcing plans as written (absent fraud or mutual mistake) not only protects contractual expectations, it also ensures that plans and employers face "a predictable set of liabilities, under uniform standards of primary conduct and a uniform regime of ultimate remedial orders and awards.'" *Conkright*, 130 S. Ct. at 1649; *see supra* at 6-7. "[C]ertainty and predictability are important criteria under ERISA." *Metro. Life Ins. Co. v. Glenn*, 554 U.S. 105, 122 (2008) (Roberts, C.J., concurring). Allowing individual courts to decide for themselves, under the guise of equity, which plan provisions will be enforced and under what circumstances, is squarely at odds with ERISA's objective of establishing uniformity, certainty, and predictability. Plan benefits are not established by equity but by plan terms, which should not be overridden because a court might have provided for different plan benefits and terms.

1. *Allowing Any Equitable Exception To Enforcement Of Plan Terms Would Open A Pandora's Box Of Litigation-Increasing Exceptions*

The decision below purportedly avoided addressing some equitable defenses to reimbursement, such as the "make whole" doctrine. Pet. App. 9a n.2. But its broad logic encompasses *any* defense "'typically

available in equity" (*id.* at 9a) and thus invites other courts to apply any and all such defenses.

Numerous different equitable defenses have been asserted over the years to try to defeat enforcement of plan terms on grounds of unfairness or injustice or harshness in individual cases. *See, e.g.*, *Admin. Comm. of Wal-Mart Stores, Inc. Assocs.' Health & Welfare Plan v. Shank*, 500 F.3d 834, 837 (8th Cir. 2007) (asking the court to "apply either the 'make-whole' doctrine or a pro rata share requirement as a rule of federal common law"); *Bombardier Aerospace Emp. Welfare Benefits Plan v. Ferrer, Poirot & Wansbrough*, 354 F.3d 348, 360-62 (5th Cir. 2003) (asking court to apply "common fund" doctrine); *CGI Techs. & Solns. Inc. v. Rose*, 683 F.3d 1113, 1119 n.3 (9th Cir. 2012) (invoking a "derivative version of the make-whole doctrine"); *Admin. Comm. of the Wal-Mart Stores, Inc. Assocs.' Health & Welfare Plan v. Varco*, 338 F.3d 680, 692-93 (7th Cir. 2003) (invoking common fund doctrine and doctrine of unjust enrichment). McCutchen himself raised four different potential defenses at various stages of this litigation. Pet. App. 5a, 28a-32a; Appellants' C.A. Br. 16 n.7, 2011 WL 791769 (3d Cir. Feb. 16, 2011). Equity being equity, and lawyers being lawyers, the number and variety of equitable defenses asserted to defeat disagreeable plan terms will surely multiply if the decision below is affirmed.

There is certainly every reason for beneficiaries and their lawyers to be creative in resisting reimbursement. As one court has observed, "they may get lucky"—since "all depends . . . on the contingency of a court's conscience," they may as well refuse to reimburse and see if they draw a judge willing to

conclude that following the plan is just too harrowing to contemplate. *Schwade v. Total Plastics, Inc.*, 837 F. Supp. 2d 1255, 1278 (M.D. Fla. 2012). Litigation will follow as the night follows the day: "For each person whom a court in 'fairness' allows to skip re-payment, there will blossom many lawsuits from others who aspire to skip re-payment . . . ." *Id.*

The broad application of equitable defenses in this context is not a matter of speculation—they are common in the closely related context of insurance subrogation. The court in *Swanson v. Hartford Insurance Co.*, 46 P.3d 584 (Mont. 2002), for example, refused to enforce an unambiguous subrogation clause in an insurance policy, holding that subrogation would not be available "until the insured has been made whole for all losses, as well as costs of recovery." *Id.* at 588; *accord Garrity v. Rural Mut. Ins. Co.*, 253 N.W.2d 512, 515 (Wis. 1977) (applying "make whole" doctrine to subrogation clause). Other courts have refused to recognize express subrogation provisions on the ground that such provisions represent an invalid assignment of the insured's right to recover against a third-party tortfeasor. *See, e.g.*, *Maxwell v. Allstate Ins. Cos.*, 728 P.2d 812, 814-15 (Nev. 1986); *Allstate Ins. Co. v. Druke*, 576 P.2d 489, 491 (Ariz. 1978). In reaching this result, one court pronounced subrogation to be a "windfall" for the insurer (*Druke*, 576 P.2d at 492), even though the policy specifically limited subrogation to the amount of the insurer's payment (*id.*). Other state courts have rejected such objections and have required subrogation provisions to be enforced according to their plain terms. *See*, *e.g.*, *Hershey v. Physicians Health Plan*, 498 N.W.2d 519, 521 (Minn. Ct. App. 1993). Still

other cases have recognized the fact-intensive, individualized nature of equitable defenses to subrogation. *See*, *e.g.*, *Global Int'l Marine, Inc. v. US United Ocean Servs., LLC*, 2011 WL 2550624, at *13 (E.D. La. June 27, 2011); *Abbott v. Blount Cnty.*, 207 S.W.3d 732, 735 (Tenn. 2006); *Ludwig v. Farm Bureau Mut. Ins. Co.*, 393 N.W.2d 143, 145 (Iowa 1986).

As experience in the insurance subrogation context shows, it is no exaggeration to say that if an "ungoverned notion of equity" under § 502(a)(3) "becomes pandemic, consistent plan operation becomes impossible, inconsistent judicial ruling becomes commonplace, and some beneficiaries become profiteers at the expense of others." *Schwade*, 837 F. Supp. 2d at 1279. Applying equitable defenses to enforcement of clear and permissible plan provisions will effectively either undermine the enforcement of legitimate plan provisions or force most subrogation provisions (and perhaps other plan terms) to survive the gauntlet of costly litigation every time they are applied. Allowing courts to make individual judgments about whether and when to follow plan terms thus directly contravenes ERISA's goal of reducing litigation and administrative costs—and thereby promoting plan formation—by ensuring uniform and reasonably predictable regulation. *See Zurich Am. Ins. Co. v. O'Hara*, 604 F.3d 1232, 1237 (11th Cir. 2010).

2. *Equitable Refusal To Enforce Plan Reimbursement Provisions Depletes Plan Assets And Harms Other Beneficiaries*

Equitable refusal to enforce reimbursement provisions also increases plan costs by depriving plans

of assets they would use to pay other claims. Reimbursement allows plans to keep premiums and other participant costs lower than they otherwise would be. Denial of reimbursement means plans must make up the difference elsewhere, ultimately producing increased costs for other participants or reduced benefits. As this Court has recognized, plans must "preserve assets to satisfy future, as well as present, claims." *Varity Corp. v. Howe*, 516 U.S. 489, 514 (1996). By shifting the costs of medical expenses that would otherwise be borne by the plan to persons or entities that bear legal responsibility for those expenses, plans are best able to preserve their assets. This, in turn, makes it easier for employers to offer employee benefit plans and to do so at lower costs to participants and beneficiaries. *See O'Hara*, 604 F.3d at 1237-38; *Shank*, 500 F.3d at 838.

If courts were to begin applying a wide range of equitable defenses to override express reimbursement provisions, it could significantly reduce employers' anticipated recovery through their reimbursement provisions and increase the costs of offering these plans. *Schwade*, 837 F. Supp. 2d at 1274 (McCutchen decision is "certain to increase the cost to each participant in each plan"). Under some equitable defenses, plans may be denied reimbursement altogether. Under "make-whole doctrine," for example, a beneficiary who settles with the tortfeasor will be liable to the plan only to the extent the settlement exceeds his total loss. *See O'Hara*, 604 F.3d at 1236. And beneficiaries will often persuade courts that the tortfeasor settlement did not make them whole, thereby denying the plan any recovery of its medical care payments, even though the settlement compen-

sated for the exact same medical costs. *See, e.g.*, *id.* at 1234 n.1 ("It is undisputed that [the participant] was not made whole by receipt of the funds under the settlement agreement."); *Moore v. CapitalCare, Inc.*, 461 F.3d 1, 10 (D.C. Cir. 2006) ("It is undisputed that the $1.3 million settlement did not fully compensate Alistaire for her injuries."). Under other defenses, reimbursement for medical payments may be significantly reduced by claimed attorneys' fees and costs (which can be thirty to forty percent of the beneficiaries' recovery), even if the net recovery still exceeds the amount of reimbursement.

3. *Increased Plan Costs Harm Beneficiaries*

If the decision below is affirmed, and courts begin opening equitable escape hatches to the enforcement of unambiguous reimbursement provisions and other plan terms, there is little doubt that premiums will increase, or benefits will be reduced, or both. "If a plan cannot trust a court to enforce a subrogation right, a beneficiary cannot receive lower premiums or better benefits in exchange for pledging to re-pay the plan from a tort award or an insurance payment." *Schwade*, 837 F. Supp. 2d at 1278. Even if courts allow such defenses only occasionally, the significant costs of litigating these defenses will sap resources that would otherwise have gone to paying benefit claims and otherwise undermine the uniform administration of benefit terms.[2]

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[2] Indeed, even with reimbursement provisions and other cost-saving measures in place, premiums for employer-sponsored health insurance have increased significantly over the past decade. *See* The Henry J. Kaiser Family Foundation & Health Research & Education Trust, *Summary of Findings*,

And that is the least of it. Some employers will conclude that they cannot defray the higher costs the decision below will produce simply by passing them onto other participants and beneficiaries. Instead, they will decide that it no longer makes sense to offer a benefit plan or to offer the same level of benefits they currently provide. Thus, some employers may eliminate their plans, or they may reduce benefits to a more cost-effective level.

Other employers may elect to address the reimbursement issue more directly, amending their plans to stop providing payments for medical benefits in cases where a third party is responsible for the underlying illness or injury. Plans provide for the payment of these medical expenses as an important convenience to their participants and to ensure that medical providers are paid in a timely manner. If plan sponsors lack confidence they will be reimbursed if those costs are recovered from the responsible third party, they may stop providing this accommodation and exclude payments for illnesses or injuries for which third parties may be liable. Or they may suspend payment until it is established that the potentially liable third party bears no responsibility for the payments. Participants will be stuck negotiating on their own for medical services, without the assurance of insurer-payment, often at a time when they are physically unable or ill-prepared to do so.

Employer Health Benefits 2011 Annual Survey 1 (2011), *available at* http://ehbs.kff.org/pdf/2011/8225.pdf ("[s]ince 2001, average premiums for family coverage have increased 113%").

Any of these alternatives would be permissible under ERISA, which, as noted above, does not force employers to provide plans or any particular benefits. *See supra* at 5-6. Yet they are not necessarily desirable outcomes, which is precisely why so many employers and participants agree to plan terms that require beneficiaries to reimburse plans for up-front medical payments when they subsequently obtain recovery for their medical costs. *See infra* at 20-21. Equitable relief that enforces that agreement is, virtually by definition, "appropriate" equitable relief.

III. ENFORCING PLAN REIMBURSEMENT PROVISIONS DOES NOT PRODUCE UNJUST RESULTS

A. Reimbursement Provisions Reflect A Rational And Fair Contractual Bargain

When an employer sponsors an employee benefits plan, it is agreeing to provide only those benefits that are specified in the text of the governing documents, and only on such terms as those documents provide. Here, the governing documents could hardly be more clear that the plan would be entitled to reimbursement to the full extent of any third-party recovery. As the Plan's Summary Plan Description explained, "[t]he purpose of the Plan is to provide coverage for qualified expenses *that are not covered by a third party*." Pet. App. 4a (emphasis added). Thus, participants are "required to reimburse the Plan for amounts paid for claims out of *any monies* recovered from a third party." *Id.* at 4a-5a (emphasis added).

The agreement was, in short, unambiguous. McCutchen thus was necessarily aware that when

he accepted the plan's immediate payment of his medical bills, he would be required to reimburse the plan fully out of any recovery he received from a third party. *See O'Hara*, 604 F.3d at 1238. That agreement was an entirely rational one for plan participants to enter into. *See Shank*, 500 F.3d at 839; *Schwade*, 837 F. Supp. at 1279. Participants (and their medical providers) receive certainty that the plan will pay their medical bills immediately, avoiding the difficult—and sometimes practically impossible—task of having to negotiate provider fees and arrange payment out-of-pocket. In exchange for that assurance of payment, participants promise to reimburse the plan for those payments if they receive settlements or judgments that cover their medical bills. There is nothing unjust about that exchange. Just the opposite: the promise of reimbursement is eminently reasonable consideration for the assurance of up-front payment. *See Varco*, 338 F.3d at 692 ("plan participants have traded the possibility of having the Plan participate in attorney's fees for the guarantee that medical bills will be paid immediately").

Moreover, as already noted, it is a bargain *all* participants accept when they join the plan. To treat one participant differently on grounds of equity is not only *in*equitable to other participants, it imposes concrete injury on them by depleting overall plan assets, causing increased premiums and other costs and diminished benefits. As this Court recently noted in a different context, it may be difficult for courts, which see only one case at a time, to appreciate the consequences that one equitable decision will have on other beneficiaries. *See Riegel v. Medtronic, Inc.*, 552 U.S. 312, 325 (2008) ("A jury . . . sees only

the cost of a more dangerous design, and is not concerned with its benefits; the patients who reaped those benefits are not represented in court.").

B. This Court Should Not Recognize A General Equitable Exception To Enforcement Of Reimbursement Provisions Based On The Anomalous Facts Of This Case

This case exemplifies the risk of making individualized decisions about enforcement of plan terms under the guise of equity. The court of appeals thought that adhering to the plan was too harsh because McCutchen's tort recovery, *net of claimed attorneys' fees*, was allegedly less than the payments already made on his behalf. According to the court of appeals, then, equity requires that McCutchen satisfy his contractual obligation to his attorneys before he satisfies his contractual obligation to his plan.

If equity has anything at all to say about the priority of his contractual obligations, it appears to favor enforcement of a plan reimbursement obligation first, because it is an "equitable lien by agreement," as petitioner explains. Pet'r Br. 29-41. But either way, the particular result in this case is unquestionably anomalous. McCutchen's alleged net loss results from a relatively small difference between the plan's payment ($66,866) and the third-party recovery ($110,000), as well as the high 40% lawyers' contingency fee, which allegedly reduced his recovery so severely (down to $66,000) as to leave him $866 short on his reimbursement obligation. Petitioner's brief indicates that the record does not actually es-

tablish that he was left short (Pet'r Br. 10 n.3), but if he was, his case is atypical. More commonly the third-party recovery is substantially higher than the plan's payment, leaving the participant with a net recovery even after reimbursing the plan and paying his attorneys. In *Rose*, for example, the Ninth Circuit applied *McCutchen* to override the plan terms and authorized the district court to deny full reimbursement of approximately $32,000, even though the beneficiary obtained a third-party recovery of $376,906.84. 683 F.3d at 1116. In *Moore*, the beneficiary sought to avoid fully reimbursing the plan for $200,000 in medical costs after she recovered $1.3 million in a personal-injury settlement. 461 F.3d at 4; *see also O'Hara*, 604 F.3d at 1234 ($262,611 benefit plan payment versus $1.2 million third-party recovery); *K-VA-T Food Stores, Inc. v. Hutchins*, 2012 U.S. Dist. LEXIS 26575, at *6-7 (W.D. Va. Mar. 1, 2012) (noting that "allowing full recovery by the plan" will not put the participant "'in a worse position than if he had not pursued a third-party recovery at all'").

Even if one thinks equity must preclude full reimbursement—despite an express contractual obligation—when it would result in a net loss given the beneficiary's other contractual obligations, there is surely no basis for allowing any equitable defense when the beneficiary's net recovery does permit full reimbursement, or for allowing any equitable defense that would preclude reimbursement up to the full amount of the net recovery.[3] Equitable relief

[3] To be clear, *amici* believe ERISA requires adherence to the plan terms in all cases (unless they violate some substantive provision of ERISA or involve fraud or mutual mistake).

under § 502(a)(3) must be "appropriate," and relief that violates the parties' contractually-defined expectations, while inviting further asset-depleting litigation, is not "appropriate" in any sense of the term.

CONCLUSION

For the foregoing reasons, and for the reasons stated by the petitioner, the judgment below should be reversed.

But if equity compels some exception where full reimbursement pursuant to a plan term would result in a net loss, the exception should be categorically limited *to that situation*, given ERISA's emphasis on following plan terms and establishing clear, uniform rules. That is, if there must be an equitable exception for a case like this, it should simply provide that a beneficiary cannot be compelled to reimburse the plan *beyond the extent of his net recovery*, but that the beneficiary otherwise must adhere to his plan reimbursement obligations. That categorical exception here would relieve McCutchen of the obligation to pay the $866 representing his net loss (assuming there is actually such a loss), but would require reimbursement of the remaining $66,000 paid on his behalf.

Respectfully submitted,

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