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 Petition for a Writ of Certiorari to the United States Court of Appeals for the Third Circuit

BRIEF *AMICI CURIAE* FOR NATIONAL ASSOCIATION OF SUBROGATION PROFESSIONALS, THE SELF INSURANCE INSTITUTE OF AMERICA, INC., AND THE WESTERN PENNSYLVANIA TEAMSTERS AND EMPLOYERS WELFARE FUND IN SUPPORT OF PETITIONER

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TABLE OF CONTENTS

TABLE OF AUTHORITIES

Page

Cases

Statutes

Other Authorities

The National Association of Subrogation Professionals ("NASP"), Self-Insurance Institute of America, Inc. ("SIIA"), and the Western Pennsylvania Teamsters and Employers Welfare Fund ("WPTEWF") respectfully submit this brief supporting the Petitioner as amicus curiae.[1]

STATEMENT OF INTEREST

NASP. NASP is a non-profit trade association of insurance companies, third party administrators, subrogation specialists, and attorneys practicing in the field of subrogation and recovery. NASP has approximately 2,000 members, representing more than 150 insurance companies and self-funded entities. The purpose of NASP is to "create a national forum for the education, training, networking and sharing of information and, ultimately, the most effective pursuit of subrogation on an industry-wide basis."

Through NASP, members are able to retrieve, organize, exchange information, and expand the use of technology to promote subrogation efforts on a cost effective basis. The members of NASP recover hundreds of millions of dollars in health care expenditures every year for insured and self-funded employee benefit plans through subrogation and recovery practices.

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[1] Notice was provided to all counsel on November 16, 2012 and all parties have consented. No counsel for a party authored this brief in whole or in part. No party, or counsel for a party, made a monetary contribution intended to fund the preparation or submission of the brief. No one other than the *amici*, their members, and their counsel made such a contribution.

NASP has an interest in the issue presented in this case – whether ERISA allows courts to use equitable principles to re-write plan terms requiring reimbursement. The Court's decision will have a profound impact on employee benefit plans' financial stability, which in turn will have far reaching implications for the nation's health care system.

SIAA. SIAA is a non-profit organization with nearly 1,000 members, serving tens of millions of health plan beneficiaries, dedicated to the advancement and protection of the self-insurance industry. SIIA's membership includes self-insured entities such as employer plan sponsors, as well as service providers such as third party administrators, reinsurance companies, and other entities that support the self-insurance business. SIIA is the only organization in the United States that exclusively represents firms, professionals, and organizations that participate in the broad spectrum of self-insurance, including self-insured group health plans.

Through SIIA, its members coordinate their views and provide practical information and recommendations to government and the public at large on a range of subjects relevant to the effective functioning of the self-insurance system, including the provisions of the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§ 1001, *et seq.*, that concern self-insured health plans and plan participants. SIIA's mission includes rendering assistance to courts in their deliberations on significant self-insured health plan issues of broad concern to its members.

WPTEWF. The Western Pennsylvania Teamsters and Employers Welfare Fund is a self-insured multiemployer welfare fund administered in Pittsburgh, PA which provides medical and ancillary benefits to approximately 5,000 participants and beneficiaries. Its fiduciaries have a duty under ERISA to pursue subrogation under the written terms of a plan document which provides for broad subrogation of all rights when some other party may have liability for an occurrence which has caused the need for benefits. The WPTEWF joins this amicus brief in support of the petition in order to alert the Court to the serious disruptive impact of the Third Circuit's decision on itself and other self-insured plans throughout the country. As is typical with larger and even medium sized ERISA plans, the Welfare Fund has had participants with claim/subrogation matters situated throughout the United States. A conflict of authority between the Courts of Appeals raises the possibility that the Welfare Fund will be unable to uniformly administer its subrogation provisions because, depending on which federal circuit jurisdiction may be involved, courts may feel compelled to adjudicate equitable principles, rather than review the fiduciary's administration of plan provisions as written.

SIAA, NASP and WPTEWF have a strong interest in preserving their members' ability to recover plan funds from participants that accept medical benefits but then refuse to honor the reimbursement terms of their agreements after obtaining compensation from third parties through legal action or settlement. *Amici*'s members depend on reimbursement to ensure solvency of their plans and to provide benefits to all participants at lower costs. To the extent that Amici's members are barred from seeking reimbursement

according to the terms of the plan, they might be forced to take dramatic action, such as increasing contributions, reducing benefits, or otherwise amending plan terms to protect against the growing and unnecessary risk. Each of these scenarios would result in a reduction in health care insurance for the nation's workforce.

ARGUMENT

The decision below is a danger to employer-sponsored health plans. The principle endorsed in *McCutchen* will make it more difficult and expensive for employers to sponsor benefit plans. It will increase ERISA administrative costs and litigation burdens. It will impose new burdens on *other* plan participants. And by splitting the circuits, it destroys the legal uniformity ERISA was designed to foster. The petition for certiorari should be granted, and the Third Circuit's decision reversed.

I. THE DECISION BELOW WILL MAKE IT MORE DIFFICULT AND EXPENSIVE TO SPONSOR AND MAINTAIN AFFORDABLE EMPLOYEE BENEFIT PLANS.

A. Subrogation and Reimbursement Provisions Help Keep Health Care Coverage Affordable.

The healthcare industry is one of the largest and most expensive industries in the United States. Evidence of an impending health care cost crisis is clear. According to an annual survey by the Kaiser Family Foundation and Health Research and Educational Trust, annual healthcare spending in the

United States reached $22 trillion in 2007, which is 16.2% of the Gross Domestic Product. *See Health Care Costs, A Primer* (March 2009).[2] The average cost of health care amounts to approximately $7,421 per person annually. *Id.* at 2. Since 1999, premiums have significantly outpaced both inflation and wage increases. *Id.* at 10.

The importance of subrogation and reimbursement as a mechanism to preserve plan assets can hardly be disputed. In an era of rising health care expenses, cost containment measures such as subrogation and reimbursement are critical to the ability to keep benefits affordable. The elimination or reduction of these recoveries would make health coverage, which is already difficult for many Americans to afford, even more expensive. The Maryland General Assembly, for example, has estimated that health insurance premiums for state workers would rise between 1% and 2% if insurers' ability to enforce subrogation and reimbursement provisions were eliminated.[3] And those sorts of premium increases in turn restrict individuals' access to coverage. For every 1% increase in premiums, approximately 300,000 Americans are unable to afford health coverage and employees experience a $12.3 billion wage loss.

Subrogation and reimbursement provisions are particularly important in allowing employers and unions to sponsor and maintain self-funded employee

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[2] http:/www.kff.org/insurance/upload/7670_02.pdf (accessed on 5/17/12).

[3] mlis.state.md.us/2000rs/fnotes/bil_0003/sb0903.rtf

welfare plans. For self-funded plans, subrogation and reimbursement recoveries "inure[ ] to the benefit of all participants and beneficiaries by reducing the total cost of the plan." *Zurich Am. Ins. Co. v. O'Hara*, 604 F.3d 1232, 1237 (11th Cir. 2010). That is important because access to affordable coverage becomes even more difficult when employers are no longer able to offer welfare plans that subsidize the cost of the benefits. A survey by the United States Census Bureau, as reported in the *New York Times*, showed that after four years of rising health care costs, the percentage of people receiving health benefits from their employer dropped from 63.6% in 2000 to 59.8% in 2004.[4]

The cost savings generated by subrogation and reimbursement, in short, are passed on to employers and employees in the form of lower premiums for insured plans, or contributions for self-funded plans. One legal scholar at the University of Chicago explained how subrogation impacts the insurance premium calculation:

> An insurance company sets its rates based on historical net costs. Thus, if the insurer had one hundred policy holders in the experience period, and experienced a total of $20,000 in claim costs, it will set its actuarial premiums at $200 per policy holder. If, on the other hand, the insurance company experienced $20,000 in claim costs and received $5,000 in subrogation

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[4] *See* David Leonhardt, *Poverty in U.S. Grew in 2004, While Income Failed to Rise for 5th Straight Year*, N.Y. Times, August 31, 2005 at A9.

> [or over payment reimbursement], it will set its actuarial premiums at $150 per policy holder.[5]

As Judge Posner opined in *Cutting v. Jerome Foods, Inc.*, 993 F.2d 1293, 1297 (7th Cir. 1993): "Without subrogation, a part of the risk is shifted back to the insured. He pays more for the insurance because he retains . . . a right to obtain through litigation a recovery that may actually exceed the actual loss that (after receiving insurance proceeds) he suffered."

B. The Decision Below Will Increase The Cost of Pursuing Subrogation And Reimbursement, Hindering Plan Fiduciaries' Ability to Protect Plan Assets.

This Court has held that plan asset protection is a critical policy goal underlying ERISA. Specifically, this Court has stated:

> A fair contextual reading of the statute makes it abundantly clear that its draftsmen were primarily concerned with the possible misuse of plan assets *and with remedies that would protect the entire plan, rather than the rights of an individual beneficiary*.

Mass. Mut. Life Ins. Co. v. Russell, 473 U.S. 134, 142 (1985) (emphasis added). In fact, ERISA specifically requires that a plan fiduciary act solely in the interest

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[5] *See* Jeffrey A. Freenblatt, *Insurance and Subrogation: Where the Pie Isn't Big Enough, Who Eats Last?* 64 U. Chi. L. Rev. 1337, 1355 (1997).

of all plan participants and beneficiaries for the exclusive purpose of: (1) providing benefits to participants and beneficiaries; and (2) defraying the reasonable expenses of administering the plan. 29 U.S.C. § 1104(a)(1)(A).

The *McCutchen* decision completely disregards this requirement when interpreting the scope of "appropriate equitable relief" under 29 U.S.C. § 1132(a)(3). *U.S. Airways, Inc. v. McCutchen,* 663 F.3d 671, 679 (3d Cir. 2011) ("Finally, U.S. Airways raises a practical concern that the application of equitable principles will increase plan costs and premiums. This concern does not address the statutory language[.]"). Instead, *McCutchen* crafts a mechanism for plan participants and beneficiaries to avoid the unambiguous terms of an ERISA plan. It encourages participants and beneficiaries to accept benefits under the plan's terms, but then to refuse to honor those terms at the expense of all other participants and beneficiaries.

That approach will be harmful for plans both because it reduces their subrogation recoveries and because it dramatically increases their administrative and litigation burdens. First, in order to meet ERISA's mandate that fiduciaries administer the plan "in accordance with the documents and instruments governing the plan," plan fiduciaries will be forced to litigate subrogation and reimbursement claims in federal district court. Thus, the *McCutchen* decision will generate more ERISA litigation.

Second, each personal injury case is different and the use of "equitable remedies" (such as unjust enrichment or the make-whole or common fund

doctrines) to subvert plain plan language unnecessarily increases the administrative burdens on plans. Instead of relying on the predictability offered by the plan's terms, plans will be required to thoroughly investigate and verify each element of the damages claim in order to determine, for example, if the injured plan participant is being fully compensated for medical expenses.[6] This activity will needlessly increase the cost of operating a plan while at the same time reducing plan recoveries.

Third, the *McCutchen* approach will cause ERISA litigation to take more of the court's time and increase litigation costs for the parties. No longer will ERISA litigation be a matter of determining whether the plan administrator is acting according to plan terms. Instead, each case will require a factual hearing in which the outcome depends solely upon an individual judge's notion of fairness.

The increased cost of litigating an ERISA subrogation or reimbursement claim will lead to: (1) higher administrative costs of sponsoring and maintaining an employee welfare plan; and/or (2) the loss of subrogation and reimbursement recoveries as enforcement of the claims becomes economically unfeasible. Either outcome will result in increased

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[6] See *Cutting*, 993 F.2d at 1298 (" "It can also be argued against the make-whole rule that it is administratively more complex, requiring the medical insurer to calculate the insured's total medical and nonmedical loss, and therefore that it makes insurance (or its equivalent in this case) more expensive to the insured – and makes it more expensive to him for the additional reason that he will have to pay for the additional coverage that the rule in effect provides.")

premium or contributions for all participants and beneficiaries.

That is not how ERISA is supposed to work, either under the statute or this Court's case law. The fact of the matter is, someone must pay the cost of benefits provided under self-funded ERISA plans. If the plan's right to full reimbursement is denied, the cost of paying for the underlying benefits falls to the plan's sponsor and to others who make the contributions that support plan benefits. Plan reimbursement and subrogation provisions help to preserve the assets of self-funded plans, so that those assets remain available to pay present and future claims for all participants. *See Admin. Comm. of the Wal-Mart Stores, Inc. Assocs. Health & Welfare Plan v. Shank*, 500 F.3d 834, 838 (8th Cir. 2007), *cert. denied*, 128 S.Ct. 1651 (2008) ("Shank would benefit if we denied the committee its right to full reimbursement, but all other Plan members would bear the costs in the form of higher premiums"). The decision below should be reversed so that those reimbursement and subrogation provisions can continue to function as they were intended.

II. THE DECISION BELOW VIOLATES FOUNDATIONAL PRINCIPLES OF ERISA.

A. The Third Circuit's Decision Creates Uncertainty And Burdens That ERISA Was Designed To Avoid.

ERISA contains certain foundational principles necessary for plans to function as Congress intended. Among those principles: The plan administrator has the right to design its plan without courts dictating the

terms and conditions. The administrator has the right to have the plan's terms enforced as written. And plan administrators and participants have the right to rely on the written plan document, the uniform application of the law, freedom from undue administrative costs and burdens, and freedom from excessive litigation. The decision below frustrates each and every one of these foundational principles and, if it is not overturned, will make consistent administration of ERISA plans unnecessarily difficult.

1. ERISA "does not regulate the substantive content of welfare-benefit plans." *Metropolitan Life Ins. Co. v. Massachusetts,* 471 U.S. 724, 732 (1985). Federal courts are likewise loath to "dictate the content of a welfare benefit plan." *Hickey v. A.E. Staley Mfg.,* 995 F.2d 1385, 1392 (7th Cir. 1993). Under ERISA "employers have large leeway to design disability and other welfare plans as they see fit." *Harris v. Harvard Pilgrim Health Care, Inc.,* 208 F.3d 274, 277 (1st Cir. 2000). "A subrogation provision affects the level of benefits conferred by the plan, and ERISA leaves that issue to the private parties creating the plan." *Waller v. Hormel Foods Corp.,* 120 F.3d 138, 140 (8th Cir. 1997). All of these principles flow from a fundamental fact about the statute: "ERISA's statutory scheme is built around reliance on the face of written plan documents." *Kennedy v. Plan Adm'r for DuPont Sav' & Inv.*, 555 U.S. 285, 301 (2009).

The decision in *McCutchen* departs from these principles and superimposes "equitable doctrines" on plans under the guise that the "other appropriate equitable relief" provision of ERISA requires such a result. If *McCutchen* is not reversed, the right of plan administrators and plan participants to rely on their

written plan documents would be nullified. Courts would be free to modify plan provisions even when the modification is against the express terms of the plan, as is the case in *McCutchen*. Federal common law would be allowed to trump clear plan language – an abrogation of established ERISA law. Such modifications unnecessarily frustrate the specific requirement of ERISA that every employee benefit plan be established and maintained pursuant to a written instrument that specifies the basis on which payments are made to and from the plan.

2. Indeed, ERISA specifically identifies a key feature of plan documents: They "specif[y] the basis on which payments are made *to* . . . the plan." 29 U.S.C. § 1102(b)(4). A subrogation or reimbursement recovery is a payment "to" a plan. It is therefore the specific purview of the plan documents to define the basis upon which a plan receives subrogation or reimbursement payments. The decision below ignores that statutory directive. As this Court pointed out in *Kennedy*, there is "wisdom" in protecting the "plan documents rule"—i.e., the fundamental ERISA principle that the plan's terms should govern. 555 U.S. 285, 303. *McCutchen* flies in the face of that wisdom by eliminating, or at least altering, the written requirement obligating payment to the plan.

3. The decision below also causes inequity for all the other members of a plan. Courts have consistently acted to protect contractually defined benefits in an ERISA plan, *see Duggan v. Hobbs,* 99 F.3d 307, 309-10 (9th Cir. 1996), and are loath to apply common-law principles to override unambiguous plan provisions based on perceived exigencies. *Davidian v. S. Calif. Meat Cutters Union & Food Emps. Benefit Fund,* 859

F.2d 134, 136 (9th Cir. 1988); *Ryan v. Fed. Express Corp.,* 78 F.3d 123, 127-28 (3d Cir. 1996) ("[I]t would be inequitable to allow a plan participant to partake of the benefits of the Plan and then, after they had received a substantial settlement, invoke common law principles to establish a legal justification for their refusal to satisfy their end of the bargain."). Allowing plan participants to escape their obligations to reimburse plans from third party settlements harms other plan members by reducing the amounts available to pay other claims. That approach undermines a basic purpose of ERISA: to protect *all* beneficiaries of a Plan. *See Mass. Mut. Life*, 473 U.S. at 142.

B. The Decision Below Splits The Circuits And Creates The Risk Of Non-Uniform Outcomes.

Finally, the decision below undermines ERISA uniformity – and splits the circuits in the process.

1. The express intent of ERISA is to ensure that plans and plan sponsors "would be subject to a uniform body of benefits law; the goal was to minimize the administrative and financial burden of complying with conflicting directives among States or between States and the Federal Government. Otherwise the inefficiencies created could work to the detriment of plan beneficiaries." *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 142 (1990). As the Court in *Ingersoll-Rand* observed: "It is foreseeable that state courts, exercising their common law powers, might develop different substantive standards applicable to the same employer conduct, requiring the tailoring of plans and employer conduct to the peculiarities of the law of each jurisdiction. Such an outcome is fundamentally at odds

with the goal of uniformity that Congress sought to implement." *Id.* at 142.

2. That is precisely the problem plans face in light of the decision below. In *McCutchen*, the Third Circuit imposed the common fund and make-whole doctrines under the rubric of "unjust enrichment," even though the plan specifically provided for a right of full recovery. That destroyed a lower-court consensus: Application of those doctrines to properly drafted plans has been soundly rejected in over one hundred federal court decisions, including several in the Third Circuit itself. Those decisions enforced clear language requiring reimbursement, whether by relying on specific language disclaiming the applicability of equitable doctrines, or by relying upon clearly defined rights of full recovery.

In *Bill Gray Enterprises, Inc. Employee Health & Welfare Plan v. Gourley,* 248 F.3d 206 (3d Cir. 2001), for example, the court noted that "courts have held that importing federal common law doctrines to ERISA plan interpretation is generally inappropriate, particularly when the terms of an ERISA plan are clear and unambiguous." *Id.* at 220 n.13. *Accord Bollman Hat Co. v. Root*, 112 F.3d 113, 117 (3d Cir.), *cert. denied*, 522 U.S. 952 (1997); *Ryan*, 78 F.3d at 126; *Cagle v. Bruner*, 112 F.3d 1510 (11th Cir. 1997), *reh'g denied*, 124 F.3d 223 (1997) ("Because the make whole doctrine is a default rule, the parties can contract out of the doctrine."); *Cutting*, 993 F.2d at 1297 ("Because the make whole rule is just a principle of interpretation it can be overridden by clear language in the plan"). Likewise, in *Harris*, the First Circuit wrote: "Where an ERISA plan requires without qualification that plan participants reimburse the plan

for benefits paid, the plan should not be construed to depend upon an implied contingency such as the 'make whole' doctrine particularly since ERISA specifically envisions that covered plans be written in straightforward language comprehensible by the average plan participant." 208 F.3d at 279. Those decision are straightforward applications of a basic ERISA principle: "The authority of the courts to develop a 'federal common law' under ERISA is not the authority to revise the text of the statute." *Mertens v. Hewitt Assocs.,* 508 U.S. 248, 260 (1993); *accord Ryan*, 78 F.3d at 126 ("straight forward language . . . [in an ERISA plan document] should be given its natural meaning"). Applying that principle, federal courts long have rejected attempts to apply doctrines arising out of the theory of unjust enrichment—such as both the make-whole and the common fund doctrines—to ERISA plans in the manner envisioned by *McCutchen*.

Indeed, the court below acknowledged that its opinion is at odds with the Fifth, Seventh, Eighth and Eleventh Circuits.[7] In those latter cases, plan members posited the same theory as McCutchen – that "equitable relief" must be judged "appropriate" versus "inappropriate" by examining whether requiring the individual to reimburse the plan is "equitable" or "inequitable." And in all of those cases, the courts rejected the argument. They determined that the plans' actions to enforce the reimbursement provisions

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[7] *McCutchen*, 663 F.3d at 678, referencing the decisions of *Zurich,* 604 F.3d 1232 (11th Cir.); *Shank,* 500 F.3d at 838 (8th Cir.); *Bombardier Aerospace Emp. Welfare Benefits Plan v. Ferrer, Poirot & Wansbrough,* 354 F.3d 348 (5th Cir. 2003); *Admin. Comm. of the Wal–Mart Stores, Inc. Assoc. Health & Welfare Plan v. Varco,* 338 F.3d 680 (7th Cir. 2003).

constituted "appropriate" equitable relief despite the fact that the participants had not been made whole by their tort settlements.

3. Were *McCutchen* to stand, it would badly undermine the well-defined, uniform and easily administered law that has developed on this issue and put in its place an uncertain, non-uniform, costly regime that will benefit a relatively few individuals at the cost of all plan participants. But it also would allow for still more disunity to develop among the federal courts, because the courts would not just divide on *whether* to apply equitable remedies; they also likely would divide on *how* to apply them.

Equitable relief is, of course, a broad and malleable concept. It is foreseeable that different federal courts, exercising common law powers, will develop different versions of that relief, requiring plans to tailor their conduct to the peculiarities of the law of each jurisdiction. Indeed, the make-whole doctrine provides a good example, because the precise contours of the doctrine vary widely by jurisdiction. Some jurisdictions apply it in a strict fashion, holding that if an injured individual's damages exceed his or her recovery, there is no entitlement to subrogation. Other jurisdictions apply the doctrine using a sliding-scale approach. Still others prohibit subrogation or reimbursement in the case of automobile accidents but not medical malpractice.

The point is simple: If *McCutchen* were the law, it would not impose some uniform equitable principle on plans. Instead, the version of equity to which a plan was subject would vary depending on the jurisdiction where a case is brought and the sources a court

references to determine how "equity" applies. This Court has held, in *Ingersoll* and elsewhere, that that type of outcome is unacceptable and fundamentally at odds with the goals of Congress. It should grant review here and reaffirm the fundamental principle designed to ward off just such disunity: ERISA requires reliance on the face of the written plan document.

* * *

The intent of ERISA is to create a uniform system for the administration of claims. ERISA was specifically enacted so that plan administrators could avoid having to master the laws of multiple jurisdictions and contend with large amounts of litigation. The goal of Congress was to minimize the administrative and financial burdens of operating a plan enforcing them as written. *Egelhoff v. Egelhoff,* 532 U.S. 141, 121 S.Ct. 1322, 149 (2001). The decision below is in direct opposition to the specific reasons that ERISA was enacted.

III. The Decision Below Is Based on A Fundamentally Flawed Interpretation of 29 U.S.C. 1132(a)(3).

For all of the above reasons, *McCutchen* endangers employer-sponsored benefit plans and undercuts legal uniformity. But it is also incorrect. Its requirement that "equitable relief" is subject to the further test of whether it is "appropriate" for a specific individual contradicts well-established ERISA law and policy.

1. Contrary to the reasoning in the *McCutchen* decision, "appropriate" merely modifies "equitable

relief" in the context of the entire provision. As this Court explained, "appropriate" as used under 29 U.S.C. 1132(a)(3) describes whether a particular remedy is available. *Varity Corp. v. Howe*, 516 U.S. 489, 515 (1996) ("[W]here Congress elsewhere provided adequate relief for a beneficiary's injury, there will likely be no need for further equitable relief, in which case such relief normally would not be 'appropriate.' ")

This Court has placed a high value on the appropriateness of "protect[ing] contractually defined benefits." *Russell*, 473 U.S. at 148. While individual plan participants' positions are centered on their personal concerns, the courts reflect broader considerations. The "appropriateness" of the relief must not be measured based on one individual but on the entire plan. Further, courts are instructed to enforce the plain language of an ERISA plan "in accordance with its literal and natural meaning" and to refrain from applying common law theories to "alter the express terms of an ERISA plan." *Shank*, 500 F.3d at 838 (internal citations omitted).

2. *McCutchen*'s interpretation of "appropriate" is also inconsistent with the holding in *Sereboff v. Mid Atl. Med. Servs., Inc.,* 547 U.S. 356 (2006). In an action also arising under 29 U.S.C. § 1132(a)(3), the *Sereboff* Court held that by seeking an equitable lien, the ERISA plan could "rely upon a familiar rule of equity to collect for the medical bills it paid on the Sereboff's behalf." *Id.* at 363-64. Not only did the Court hold that imposition of a constructive trust or equitable lien constituted "appropriate equitable relief," but it held that the "parcel of equitable defenses the Sereboffs claim accompany any such action are beside the point." *Id.* at 368. The equitable

defenses did not matter because the plan's enforcement of its equitable lien by agreement was in and of itself appropriate equitable relief.

After *Sereboff* was decided, plan administrators throughout the country came to rely on the holding that it is "appropriate equitable relief" for a plan to seek to enforce a constructive trust and equitable lien. *McCutchen* now prevents reliance upon the approved remedy of seeking to enforce a constructive trust and equitable lien.

If the *McCutchen* interpretation were upheld, it would mean plan reimbursement provisions must be adjudicated on a case-by-case basis so the injured party can have a determination on whether he or she was made whole by a third party settlement. *McCutchen* theorizes that reimbursement is only acceptable if the plan participant has been made whole from the settlement and still has funds left over to reimburse the ERISA plan. Under this theory, a court must become involved any time a plan participant refuses to repay an ERISA Plan with a reimbursement provision. That approach would frustrate one of Congress' primary goals in enacting ERISA: to promote a uniform enforcement of employment benefit plans. *See Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 9 (1987).

CONCLUSION

For the foregoing reasons, the petition for a writ of certiorari should be granted.

Respectfully submitted,

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