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No. 11-1285

IN THE

Supreme Court of the United States

U.S. AIRWAYS, INC., IN ITS CAPACITY AS FIDUCIARY AND PLAN ADMINISTRATOR OF THE U.S. AIRWAYS, INC. EMPLOYEE BENEFITS PLAN,

Petitioner,

v.

JAMES MCCUTCHEN AND ROSEN, LOUIK & PERRY, P.C.,

Respondents.

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

BRIEF *AMICI CURIAE* FOR THE NATIONAL ASSOCIATION OF SUBROGATION PROFESSIONALS AND THE SELF INSURANCE INSTITUTE OF AMERICA, INC. IN SUPPORT OF PETITIONER

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INTEREST OF *AMICI CURIAE*[1]

National Association of Subrogation Professionals ("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, and exchange information, as well as 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.

NASP has an interest in whether the Employee Retirement Income Security Act ("ERISA") allows courts to use equitable principles to rewrite plan terms in order to require 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.

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1. 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. The parties have filed letters with the Court consenting to all *amicus* briefs.

Self-Insurance Institute of America, Inc. ("SIIA"). SIIA 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 ERISA 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.

Collectively, SIIA and NASP 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 this growing and unnecessary risk. Each of these scenarios would have the unfortunate result of reducing the availability of health insurance for the nation's workforce.

SUMMARY OF THE ARGUMENT

The heart of ERISA is a congressional commitment to contractually defined benefits. Both plan fiduciaries and participants are entitled to rely on the express terms of the employee benefit plan. Reliance on the terms of the plan allows fiduciaries to administer the plan fairly and gives participants certainty that their benefits are secured by a binding contract.

To this end, Congress required "[e]very employee benefit plan [to] be established and maintained pursuant to a written instrument." 29 U.S.C. § 1102(a)(1). Congress also demanded ERISA plans be managed "in accordance with the documents and instruments governing the plan." 29 U.S.C. § 1104(a)(1)(D). The civil enforcement provision at issue in this case similarly reflects Congress' commitment to contractually defined benefits. In ERISA § 502(a)(3), Congress permitted civil actions "to obtain other appropriate equitable relief" to "enforce … the terms of the plan." 29 U.S.C. § 1132(a)(3).

The Third Circuit's decision is fundamentally inconsistent with this statutory scheme. US Airways' ERISA health plan promptly and fully paid for McCutchen's medical expenses after he was injured in an automobile accident. After McCutchen recovered from third parties

an amount greater than his medical expenses, US Airways sought recovery under the plan's reimbursement clause. When McCutchen refused to reimburse the health plan according to the express terms of the contract, US Airways sought a judicial remedy "typically available in equity," *Sereboff v. Mid Atl. Med. Servs. Inc.*, 547 U.S. 356, 361-62 (2006) (citation omitted), to "enforce … the terms of" the reimbursement clause, 29 U.S.C. § 1132(a)(3)(B)(ii). McCutchen countered that because his tort recovery (minus the 40% claimed by his attorneys) left him with less than the medical expenses paid by the health plan, it would be "unjust enrichment" for the plan to recover the full amount of his medical expenses. The Third Circuit agreed with McCutchen that because US Airways was seeking an equitable remedy, he was entitled to raise an equitable defense.

But ERISA § 502(a)(3) provides that "appropriate equitable relief" must "enforce … the terms of the plan," not subvert the plan. 29 U.S.C. § 1132(a)(3). Indeed, Congress emphasized throughout ERISA the primacy of enforcing plan terms. The Third Circuit's decision is incompatible with the statute's text and purpose because it subverts the terms of the plan and limits US Airways' right to an equitable lien. The Third Circuit's decision reads the phrase "enforce … the terms of the plan" right out of the statute.

Even if the Third Circuit's construction of ERISA were correct, however, it would make no difference at all. A court of equity in the days of the divided bench would *never* resort to unjust enrichment where an enforceable contract existed between the parties. An enforceable contract defines the obligations of the parties, displaces

any inquiry into unjust enrichment, and protects plan fiduciaries and participants alike. Accordingly, as a matter of equity jurisprudence, it is *never* unjust to enforce valid plan terms to require reimbursement. That is especially true where, as here, the plan has already performed its obligations under the contract by paying medical expenses.

The Court must presume that Congress enacted ERISA knowing a court of equity would never resort to unjust enrichment to negate an enforceable contract. *See Hall v. United States*, 132 S. Ct. 1882, 1889 (2012) ("We assume that Congress is aware of existing law when it passes legislation." (citation omitted)). "[I]f Congress desired to make such an abrupt departure from traditional equity practice as is suggested, it would have made its desire plain." *Hecht Co. v. Bowles*, 321 U.S. 321, 330 (1944). The Court thus should not enshrine in ERISA an equitable defense that would never make a difference in a fiduciary's action to enforce an equitable lien. In other words, the Court should not adopt an interpretation of ERISA that would lead to "futile results." *United States v. Am. Trucking Ass'ns, Inc.*, 310 U.S. 534, 543 (1940).

The Third Circuit's decision not only misinterprets § 502(a)(3), it also undermines ERISA's basic purposes and will cause significant harm to employee benefit plans and participants. Foremost, the Third Circuit's decision places contractually defined benefits in jeopardy. No longer will a contract decide the scope of employee benefits and right to reimbursement; instead, whether an ERISA plan is entitled to reimbursement will turn on pliable notions of fairness and justice depending on the views of each judge and vagaries of each jurisdiction's commitment to equity. Put simply, allowing equitable doctrines to override the

express terms of a plan undermines the integrity of written plans.

Affirming the Third Circuit's regrettable decision will predictably undermine the uniform regulatory regime Congress intended to govern employee benefit plans. Given the nature of the inquiry the Third Circuit's decision requires, the rules of the road will obviously vary judge to judge, jurisdiction to jurisdiction, and circuit to circuit. Allowing judges to override the terms of a plan based on a malleable concept of unjust enrichment thus will force administrators to tailor their employee benefit plans to the law of each jurisdiction. For some employers, the same reimbursement clause may be upheld in one jurisdiction but not another. This uncertain and costly regime will weaken the solvency of employee benefit plans and discourage employers from offering generous benefit plans in the first place.

At base, the Third Circuit's rationale makes it more difficult and expensive to sponsor and maintain employee benefit plans. Subrogation and reimbursement are cost containment measures that are critical to preserving plan assets and keeping benefits affordable in a time of escalating costs. These tools enable employers and unions to sponsor and maintain self-funded employee welfare plans by allowing them to recover paid medical expenses that are the financial responsibility of third parties. Without subrogation, plan participants would face higher costs and plans could be forced to reduce benefits. In the end, it will be plan participants who will bear the brunt of the Third Circuit's misguided decision. It should be reversed.

ARGUMENT

I. THE THIRD CIRCUIT'S INTERPRETATION OF ERISA § 502(a)(3) SHOULD BE REVERSED.

A. ERISA § 502(a)(3) Does Not Incorporate Equitable Defenses That Subvert The Terms Of An Employee Benefit Plan.

1. ERISA is a "comprehensive and reticulated statute" governing employee benefit plans. *Mertens v. Hewitt Assocs.*, 508 U.S. 248, 251 (1993) (quotation omitted). It is "an enormously complex and detailed statute that resolved innumerable disputes between powerful competing interests." *Id.* at 262. "In ERISA cases, '[a]s in any case of statutory construction, [the] analysis begins with the language of the statute .... And where the statutory language provides a clear answer, it ends there as well.'" *Harris Trust & Sav. Bank v. Salomon Smith Barney Inc.*, 530 U.S. 238, 254 (2000).

The statutory provision at issue here, Section 502(a)(3), provides that "a participant, beneficiary, or fiduciary" may bring a civil action for "appropriate equitable relief ... to enforce any provisions of this subchapter or the terms of the plan." 29 U.S.C. § 1132(a)(3). US Airways' claim clearly met the statute's requirement. First, US Airways sought "appropriate equitable relief." As a "fiduciary" for purposes of Section 502(a)(3), US Airways sought a "constructive trust or an equitable lien," *US Airways, Inc. v. McCutchen*, 663 F.3d 671, 673 (3d Cir. 2011), a judicial remedy that is "*typically* available in equity," *CIGNA Corp. v. Amara*, 131 S. Ct. 1878, 1878 (2011) (citation omitted); *see also Mertens*, 508 U.S. at 256; *Great-West*

Life & Annuity Ins. Co. v. Knudson, 534 U.S. 204, 209-10 (2002); *Sereboff*, 547 U.S. at 361-62. Second, there is no dispute that US Airways sought to "enforce … the terms of" the reimbursement clause in McCutchen's employee benefit plan. Indeed, US Airways' decision to enforce the terms of the plan is the basis for the dispute between the parties. *See McCutchen*, 663 F.3d at 673 (explaining that "under the Plan description … a beneficiary is required to reimburse the Plan for any amounts it has paid out of any monies the beneficiary recovers from a third party").

Accordingly, the Third Circuit should have enforced US Airways' reimbursement clause as written. Because "Congress says in a statute what it means and means in a statute what it says there, … when the statute's language is plain, 'the sole function of the courts' … is to enforce it according to its terms." *Hartford Underwriters Ins. Co. v. Union Planters Bank, N.A.*, 530 U.S. 1, 6 (2000) (internal citations and quotation marks omitted). Nothing more is required to decide this case.

Courts are appropriately "reluctant to tamper with an enforcement scheme crafted with such evident care as the one in ERISA." *Mass. Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 147 (1985); *see also Knudson*, 534 U.S. at 209; *Admin. Comm. of Wal-Mart Stores, Inc. v. Shank*, 500 F.3d 834, 839 (8th Cir. 2007). Indeed, this Court has repeatedly declined invitations to extend benefits and remedies not specifically authorized by ERISA. *See, e.g.*, *Knudson*, 534 U.S. at 221 (refusing to "to adjust the 'carefully crafted and detailed enforcement scheme' embodied in the text that Congress has adopted" (citation omitted)); *Harris Trust & Sav. Bank*, 530 U.S. at 247 (explaining that "ERISA's 'comprehensive and reticulated'

scheme warrants a cautious approach to inferring remedies not expressly authorized by the text" (citation omitted)); *Mertens*, 508 U.S. at 262 (rejecting claim that ERISA affords a cause of action against a nonfiduciary who knowingly participates in a fiduciary breach); *Russell*, 473 U.S. at 144-48 (declining invitation to create an implied private cause of action for extracontractual damages because "the statutory provision explicitly authorizing a beneficiary to bring an action to enforce his rights under the plan—§ 502(a)(1)(B)—says nothing about the recovery of extracontractual damages"); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 56 (1987) (civil enforcement scheme codified at § 502(a) is not to be supplemented by state-law remedies).

2. The Third Circuit nevertheless held that the term "appropriate" in the statute "limit[s] the equitable relief available under § 502(a)(3) through the application of equitable defenses and principles that were typically available in equity." *McCutchen*, 663 F.3d at 676. This "sweeping extratextual extension" of the statute finds no support in ERISA. *Boggs v. Boggs*, 520 U.S. 833, 850 (1997). *See* Brief for Petitioner 17-19 ("Pet'r Br.").

Even if the term "appropriate" could be read to incorporate some equitable limitations on the right to an equitable lien, it would not be in a case like this. Congress would never have intended to permit any limitation on equitable recovery that subverts "the terms of the plan." 29 U.S.C. § 1132(a)(3). Section 502 itself reflects the primacy of enforcing plan terms under ERISA, referring to "the terms of the plan" or "the terms of his plan" no less than six times. As the Court has explained, "ERISA provides for equitable remedies *to enforce*

plan terms." *Sereboff*, 547 U.S. at 363. Section 502(a)(3) "does not, after all, authorize 'appropriate equitable relief' *at large*, but only 'appropriate equitable relief' for the purpose of … 'enforc[ing] any provisions of ERISA or an ERISA plan.'" *Mertens*, 508 U.S. at 253. Under Section 502, then, a claim "stands or falls by 'the terms of the plan,' a straightforward rule that lets employers establish a uniform administrative scheme, [with] a set of standard procedures to guide processing of claims and disbursement of benefits." *Kennedy v. Plan Adm'r for DuPont Sav. & Inv. Plan*, 555 U.S. 285, 300 (2009) (quoting 29 U.S.C. § 1132(a)(1)(B)).

As noted above, McCutchen wants to invoke an equitable doctrine in order to limit US Airways' recovery in direct contravention of an enforceable reimbursement clause in a valid employee benefit plan. But the Court has instructed that "courts, in fashioning 'appropriate' equitable relief, will keep in mind the 'special nature and purpose of employee benefit plans,' and will respect the 'policy choices reflected in the inclusion of certain remedies and the exclusion of others.'" *Varity Corp. v. Howe*, 516 U.S. 489, 515 (1996) (citation omitted). The Third Circuit's decision ignores the Court's admonition by reading the phrase "enforce … the terms of the plan" out of Section 502(a)(3). *See Caraco Pharm. Labs., Ltd. v. Novo Nordisk A/S*, 132 S. Ct. 1670, 1684 (2012) (rejecting argument that "would all but read the term 'correct' out of the statute"). Those words have no meaning if plan participants can use equitable defenses to defeat, rather than enforce, the "terms of the plan."

The incorporation of equitable defenses that defeat otherwise enforceable plan terms also cannot be reconciled

with the many other ERISA provisions that emphasize the primacy of plan terms. ERISA requires "[e]very employee benefit plan [to] be established and maintained pursuant to a written instrument," 29 U.S.C. § 1102(a)(1), "specify[ing] the basis on which payments are made to … the plan," *id.* § 1102(b)(4). The plan administrator is required to manage ERISA plans "in accordance with the documents and instruments governing the plan." 29 U.S.C. § 1104(a)(1)(D). A reimbursement recovery is a payment "to" a plan under § 1102(b)(4). It is thus within the specific purview of the plan to define the basis upon which it secures reimbursement. The decision below blatantly ignores that statutory directive by eliminating, or at a minimum dramatically altering, the written requirement obligating payment to the plan.

None of the Court's cases deviates from the basic requirement that equitable relief must be for the purpose of enforcing the terms of a plan. *See, e.g.*, *Kennedy*, 555 U.S. at 300. Even *CIGNA*, in which the Court allowed reformation of plan terms under § 502(a)(3) where there was fraud and misrepresentation, authorized equitable relief to "essentially h[o]ld CIGNA to what it had promised" in the terms of the original plan. 131 S. Ct. at 1880. *See* Pet'r Br. 22-24. But there was no fraud or misrepresentation in this case, *see McCutchen*, 663 F.3d at 679, and McCutchen seeks to use the doctrine of unjust enrichment to subvert, rather than enforce, the terms of the plan. That is simply incompatible with the text of the statute.

Contrary to the Third Circuit's conclusion, *see id.* at 676, neither *Knudson* nor any other decision supports its unfounded conclusion that Congress embraced the idea

that equitable defenses may be invoked to limit recovery in accordance with the terms of the plan. The Court's reference to "limitations upon its availability" in *Knudson* simply referred to whether the particular injunctive relief at issue was "typically available in equity." 534 U.S. at 211 & n.1. That issue is not in dispute here. *See supra* p. 7. And the fact that "Section 502(a)(3) invokes the equitable powers of the District Court," *CIGNA*, 131 S. Ct. at 1880, says nothing about whether Congress, under the auspices of the term "appropriate," haphazardly incorporated equitable defenses that subvert the terms of the plan. For all the reasons set forth above, Congress clearly did not.

B. Reimbursement Pursuant To An Enforceable ERISA Plan Is Never Inequitable.

Even if ERISA allowed equitable defenses to defeat enforceable plan terms, it would make no difference in this case or any other. *See, e.g.*, *Am. Trucking Ass'ns, Inc.*, 310 U.S. at 543 (Court will not construe a statute in a manner that leads to "futile results"). Contrary to the Third Circuit's conclusion, a court of equity would never have permitted an otherwise enforceable contract to be "defeated by equitable principles and defenses." *McCutchen*, 663 F.3d at 676. It is thus *never* inequitable to enforce valid contract terms to require reimbursement, particularly where the plan has already performed its obligations under the contract. *See* Pet'r Br. 41.

1. The unjust enrichment doctrine forms the basis of restitution. 1 Dan B. Dobbs, *Law of Remedies* § 4.1(1), at 551-52 (2d ed. 1993); *id.* § 4.1(3), at 564. It also forms the basis of "[b]oth the make-whole doctrine and the common fund doctrine," *CGI Techs. & Solutions Inc. v. Rose*, 683

F.3d 1113, 1121 (9th Cir. 2012), and has been described as "the modern designation for the older doctrine of quasi-contract," 26 Samuel Williston, *A Treatise on the Law of Contracts* § 68:1, at 23-24 (4th ed. 2003).

In the days of the divided bench, a court of equity would never have resorted to unjust enrichment when an otherwise enforceable contract existed between the parties. The Restatement explains the general rule that "[a] valid contract defines the obligations of the parties as to matters within its scope, displacing to that extent any inquiry into unjust enrichment." Restatement (Third) of Restitution & Unjust Enrichment § 2(2) (2011); *see also* Restatement (First) of Restitution § 107 (1937) (stating that "[a] person of full capacity who, pursuant to a contract with another, has performed services or transferred property to the other or otherwise has conferred a benefit upon him, is not entitled to compensation therefor other than in accordance with the terms of such bargain").

Numerous treatises explain that a "court properly resorts to quasi-contract only in the absence of an express contract or contract implied-in-fact." 1 Williston, *A Treatise on the Law of Contracts* § 1:6, at 43-44; *see also* 26 Williston, *A Treatise on the Law of Contracts* § 68:1, at 22. "Where the parties did in fact contract with reference to the same general subject matter, the contract itself, interpreted in the light of its gaps and silences as well as in the light of this express provisions, should control.... [W]here there is an express contract dealing with the subject matter, no implied contract or restitution claim will be permitted." 1 Dobbs, *Law of Remedies* § 4.9(4), at 694. Corbin further explains that where "there is an enforceable express or implied in fact

contract that regulates the relations of the party or that part of their relations about which issues have arisen, there is not room for quasi contract." 1 Arthur Linton Corbin, *Corbin on Contracts* § 1.20, at 64 (rev. ed. 1993); *see also* 1 George E. Palmer, *Law of Restitution* § 4.3, at 379 (1978) ("The general policy of holding parties to their contracts supports the refusal of restitution.").

The reason for the rule is straightforward. "Contract is superior to restitution as a means of regulating voluntary transfers because it eliminates, or minimizes, the fundamental difficulty of valuation." Restatement (Third) of Restitution & Unjust Enrichment § 2 cmt. c. "Considerations of both justice and efficiency" demand "that the parties' own definition of their respective obligations … take precedence over the obligations that the law would impose in the absence of agreement." *Id.* "Restitution is accordingly subordinate to contract as an organizing principle of private relationships, and the terms of an enforceable agreement normally displace any claim of unjust enrichment within their reach." *Id.*

Accordingly, "[c]ourts have recognized this principle and have stated their unwillingness to resort to the doctrine of unjust enrichment to override a contractual plan provision." *Member Servs. Life Ins. Co. v. Am. Nat'l Bank & Trust Co.*, 130 F.3d 950, 957 (10th Cir. 1997); *see also Zurich Am. Ins. Co. v. O'Hara*, 604 F.3d 1232, 1237 (11th Cir. 2010) (refusing to "override the Plan's controlling language"); *Shank*, 500 F.3d at 838 (equitable principles cannot "alter the express terms of a written plan"); *Albrecht v. Comm. on Emp. Benefits of Fed. Reserve Emp. Benefits Sys.*, 357 F.3d 62, 69 (D.C. Cir. 2004) (explaining that "there can be no claim for unjust enrichment when

an express contract exists between the parties" (citation omitted)); *Bombardier Aerospace Emp. Welfare Benefits Plan v. Ferrer, Poirot & Wansbrough*, 354 F.3d 348, 362 (5th Cir. 2003) (equitable principles do not "trump[] the Plan's express language"); *Singer v. Black & Decker Corp.*, 964 F.2d 1449, 1452 (4th Cir. 1992) (explaining that "resort to federal common law generally is inappropriate when its application would … threaten to override the explicit terms of an established ERISA benefit plan").

In short, "one who is enriched by what he is entitled to under a contract or otherwise is not unjustly enriched." 1 Dobbs, *Law of Remedies* § 4.1(2), at 558. Cases adopting this line of reasoning are legion. *See, e.g.*, *Craig v. Bemis Co.*, 517 F.2d 677, 684 (5th Cir. 1975) ("enrichment [is] not 'unjust,' where it is allowed by the express terms of the Plan"); *Admin. Comm. of the Wal–Mart Stores, Inc. v. Varco*, 338 F.3d 680, 692 (7th Cir. 2003); *Harris v. Harvard Pilgrim Health Care, Inc.*, 208 F.3d 274, 279 (1st Cir. 2000); *Elmore v. Cone Mills Corp.*, 187 F.3d 442, 449 (4th Cir. 1999) (per curiam); *United McGill Corp. v. Stinnett*, 154 F.3d 168, 173 (4th Cir. 1998); *Member Servs. Life Ins. Co.*, 130 F.3d at 957; *Ryan v. Fed. Express Corp.*, 78 F.3d 123, 127 (3d. Cir. 1996); *Cummings v. Briggs & Stratton Retirement Plan,* 797 F.2d 383, 390 (7th Cir. 1986); *Van Orman v. Am. Ins. Co.*, 680 F.2d 301, 312 (3d Cir. 1982).

This rule protects plan fiduciaries and participants alike. *See Shank*, 500 F.3d at 839. It protects the plan US Airways administers by enforcing the reimbursement clause in the contract. McCutchen "contributed premium payments, plus a promise to reimburse the Committee for medical expenses in the event []he was injured and received a judgment or settlement from third parties. In

exchange, []he received the certainty that the Committee would pay [his] medical bills immediately if []he was injured." *Id.* McCutchen thus received the benefit of the bargain when the "plan administered by US Airways paid $66,866 for his medical expenses" resulting from his automobile accident. *McCutchen*, 663 F.3d at 672. Indeed, most covered persons would prefer "having their medical expenses paid up-front in third-party liability situations instead of refusing the benefits (and therefore not having to reimburse the plan) and paying their medical expenses out of their settlement." *Varco*, 338 F.3d at 692; *see also Cutting v. Jerome Foods, Inc.*, 993 F.2d 1293, 1297-98 (7th Cir. 1993). McCutchen, however, never fulfilled his end of the bargain—he did not reimburse the plan after recovering medical expenses from the tortfeasor claiming it would be unjust. But there is nothing unjust about asking McCutchen to honor the agreement. Quite the opposite, this case illustrates that an ERISA plan is never unjustly enriched when a valid reimbursement clause is enforced.

If anything, it is McCutchen who would be unjustly enriched if this reimbursement clause is not enforced. "[I]t is axiomatic that a party who retains funds 'belonging in good conscience to another' is unjustly enriched at that other party's expense." *Bombardier*, 354 F.3d at 360; *see also* Restatement (First) of Restitution § 107 cmt. a (explaining that "a person is not entitled to compensation on the ground of unjust enrichment if he received from the other that which it was agreed ... the other should give in return"). Because McCutchen was "required to reimburse the Plan for any amounts it has paid out of any monies the beneficiary recovers from a third party," *McCutchen*, 663 F.3d at 673, "the disputed funds 'belong in good conscience' to the Plan," *Bombardier*, 354 F.3d at 360. His "continued

retention of these funds" after US Airways had already paid his medical expenses "unjustly enrich[es him] at the Plan's expense." *Id.*; *see also O'Hara*, 604 F.3d at 1238; *Ryan*, 78 F.3d at 127-28; 4 Palmer, *Law of Restitution* § 23.18, at 470 ("In short, principles of unjust enrichment are controlling, because in this context equitable lien is merely a remedy for preventing unjust enrichment of the insured.").

The rule that requires enforcement of the plan's terms also protects participants where there is *not* an enforceable reimbursement clause in the contract. Without the rule, plans could seek to recoup medical expenses from participants under a theory of unjust enrichment in the absence of an enforceable reimbursement clause. *See Member Servs. Life Ins. Co.*, 130 F.3d at 957-58. But when participants have secured "a contractual right to payment unburdened by any right to subrogation or recoupment," "consideration of the unjust enrichment doctrine would not be proper" for the very same reason McCutchen's claim is improper here: because it would "override an express contractual provision." *Id.* at 958.

2. The Third Circuit simply ignored this rule despite the presence of an enforceable reimbursement clause in the contract. It concluded that "requiring McCutchen to provide full reimbursement to US Airways" consistent with the terms of the contract would result in "unjust enrichment" to US Airways. *McCutchen*, 663 F.3d at 679. The Third Circuit's application of unjust enrichment was mistaken for several reasons.

As explained above, a court properly resorts to unjust enrichment *only* in the absence of an enforceable

contract. The presence of an enforceable reimbursement clause here forecloses consideration of this doctrine. That is particularly true where, as here, the plan has already performed its end of the bargain. Indeed, a court of equity would not have found US Airways unjustly enriched by fulfilling its end of the bargain—paying McCutchen's emergency medical bills—and then insisting that McCutchen honor his promise to reimburse the plan because it had "rendered in full the performance that [which it] promised." 12 Corbin, *Corbin on Contracts* § 1104, at 12 (interim ed.).

It is also irrelevant that McCutchen was left "with less than full payment for his emergency medical bills" because his lawyers kept 40% of the recovery for themselves. *McCutchen*, 663 F.3d at 679. He cannot complain that the value of the employee benefit plan "has turned out to be less than he expected or that the terms of the agreement now appear to have been more advantageous to [US Airways] than to himself." 12 Corbin, *Corbin on Contracts* § 1104, at 12. "The fact that he may have to satisfy some part or even all of this personal obligation out of his own pocket in no way diminishes his pre-existing reimbursement obligation to the Plan vis-à-vis the funds recovered from his tortfeasor." *Bombardier*, 354 F.3d at 357. Indeed, "the unambiguous language of the Plan obligates h[im] to repay the benefits paid in full without a pro rata deduction for h[is] legal expenses, and thus any so-called enrichment is not unjust." *Varco*, 338 F.3d at 692.

The only situation in which a court of equity would have resorted to unjust enrichment was if the contract was unenforceable. In the days of the divided bench, "a claim for unjust enrichment was allowed despite the existence

of an express contract between the parties, where there was an allegation that one of the parties had acted in bad faith during the formation of the contract." 26 Williston, *A Treatise on the Law of Contracts* § 68:1, at 16; *see also* 1 Corbin, *Corbin on Contracts* § 1.20, at 65. In other words, restitution was appropriate notwithstanding an express contract when "the transaction [wa]s rescinded for fraud, mistake, duress, undue influence or illegality, or unless the other has failed to perform his part of the bargain." Restatement (First) of Restitution § 107(1).

CIGNA vindicates this principle. *See* Pet'r Br. 23-24. There, the Court approved the equitable remedy of contract reformation "to prevent fraud." 131 S. Ct. at 1879. As the Court explained, "reformation of the terms of the plan, in order to remedy the false or misleading information CIGNA provided[,] … is a traditional power of an equity court." *Id.*; *see also id.* at 1881; *id.* at 1884 (Scalia, J., concurring). By contrast, the Third Circuit did "not suggest that US Airways' conduct was fraudulent or dishonest in the way that Cigna's was." *McCutchen*, 663 F.3d at 679. The Third Circuit's application of *CIGNA* here to diminish "the importance of the written benefit plan" cannot be reconciled with *CIGNA* or basic contract principles. *Id.* at 678.

II. THE THIRD CIRCUIT'S DECISION UNDERMINES THE BASIC PURPOSES OF ERISA AND WILL CAUSE WIDESPREAD HARM.

ERISA embraces basic purposes necessary for employee benefit plans to function as Congress intended. Among those principles, the plan 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 Third Circuit's decision undermines every one of these purposes and, if left undisturbed, will cause significant harm to plans and participants. *See* Pet'r Br. 24-29, 42-50.

A. The Third Circuit's Decision Undermines The Basic Purposes Of ERISA.

ERISA's "repeatedly emphasized purpose [is] to protect contractually defined benefits." *Russell*, 473 U.S. at 148; *see also Varity*, 516 U.S. at 515. Indeed, ERISA "is built around reliance on the face of written plan documents," *Curtiss-Wright Corp. v. Schoonejongen*, 514 U.S. 73, 83 (1995), and provides that "[e]very employee benefit plan shall be established and maintained *pursuant to a written instrument*," 29 U.S.C. § 1102(a)(1) (emphasis added); *see also Kennedy*, 555 U.S. at 301; *Varco*, 338 F.3d at 691 (explaining that "one of ERISA's primary purposes is to ensure the integrity of written plans"); *Health Cost Controls v. Isbell*, 139 F.3d 1070, 1072 (6th Cir. 1997); *Shank*, 500 F.3d at 838-39; *O'Hara*, 604 F.3d at 1236; *Van Orman*, 680 F.2d at 312; *Duggan v. Hobbs*, 99 F.3d 307, 309-10 (9th Cir. 1996). Thus, courts "have held that to ensure the integrity of pension and welfare plans courts should confine the benefits to the terms of the plans as written." *Varco*, 338 F.3d at 692; *see also Shank*, 500 F.3d at 838; *O'Hara*, 604 F.3d at 1236.

The Third Circuit's decision undermines the integrity of written plans and contractually defined benefits. It

superimposes "equitable doctrines" on plans under the guise that ERISA requires such a result. If upheld, the ability of plan administrators and participants to rely on their written plan documents will be nullified. Courts will be free to modify the express terms of the plan even where, as here, there is no fraud or other allegation of unclean hands. *Cf. CIGNA*, 131 S. Ct. at 1880. Using equitable principles to "override the Plan's reimbursement provision would contravene, rather than effectuate, the underlying purposes of ERISA." *Varco*, 338 F.3d at 692; *see also O'Hara*, 604 F.3d at 1237. Such judicial modifications unnecessarily frustrate the specific requirement 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. "ERISA's purposes of upholding the integrity of written plans and protecting the interest and expectations of all participants and beneficiaries are best served by enforcing the [administrator's] contractual right to reimbursement." *Shank*, 500 F.3d at 839-40.

Another key "purpose of ERISA is to provide a uniform regulatory regime over employee benefit plans." *Aetna Health Inc. v. Davila*, 542 U.S. 200, 208 (2004); *see also Raymond B. Yates, M.D., P.C. Profit Sharing Plan v. Hendon*, 541 U.S. 1, 17 (2004); *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 9 (1987). Congress designed ERISA to ensure that plans and 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" jurisdictions. *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 142 (1990). Otherwise, courts "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." *Id.* "Such an outcome is fundamentally at odds with the goal of uniformity that Congress sought to implement." *Id.* "Uniformity is impossible … if plans are subject to different legal obligations in different" jurisdictions. *Egelhoff v. Egelhoff*, 532 U.S. 141, 148 (2001); *see also Conkright v. Frommert*, 130 S. Ct. 1640, 1650-51 (2010).

The Third Circuit's decision guarantees that equitable principles will be fashioned differently in different jurisdictions. Equitable relief is, of course, a broad and malleable concept. Different courts, exercising equitable powers, will develop different versions of that relief, requiring plans to tailor their conduct to the peculiarities of the law of each jurisdiction. The version of equity to which each plan will be subject will vary depending on the jurisdiction where a case is brought and the sources a court references to determine how "equity" applies. It will badly undermine the well-defined, uniform and easily administered law that has developed 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.

Moreover, plan reimbursement provisions will have to be adjudicated on a case-by-case basis to ensure the plan is not unjustly enriched. Under this theory, a court must become involved any time a participant refuses to repay an ERISA plan with an otherwise enforceable reimbursement provision. That approach would frustrate Congress' goal to promote the uniform enforcement of employment benefit plans.

ERISA's commitment to solvency is also clear. *See, e.g.*, 29 U.S.C. § 1001(b) (explaining that ERISA was enacted to "protect … the interests of participants in employee benefit plans and their beneficiaries"). ERISA is "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." *Russell*, 473 U.S. at 142. Fiduciaries must "preserve assets to satisfy future, as well as present, claims," and must "take impartial account of the interests of all beneficiaries." *Varity*, 516 U.S. at 514; *see also O'Hara*, 604 F.3d at 1238.

The Third Circuit's decision weakens the solvency of employee benefit plans. "Reimbursement and subrogation provisions are crucial to the financial viability of self funded ERISA plans." *Shank*, 500 F.3d at 838. "Reimbursement inures to the benefit of all participants and beneficiaries by reducing the total cost of the Plan." *O'Hara*, 604 F.3d at 1237-38. "Because maintaining the financial viability of self-funded ERISA plans is often unfeasible in the absence of reimbursement and subrogation provisions like the one at issue in this case, denying … reimbursement would harm other plan members and beneficiaries by reducing the funds available to pay those claims." *Id.* (citation omitted). Unfortunately, plan participants will ultimately pay the price "in the form of higher premium payments" to compensate for the inability to obtain reimbursement. *Id.*; *see also Shank*, 500 F.3d at 838.

Finally, Congress adopted ERISA to encourage employers to offer welfare benefit plans. Congress set out in ERISA to "induc[e] employers to offer benefits by assuring a predictable set of liabilities," *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 379 (2002), "but

Congress did not require employers to establish benefit plans in the first place," *Conkright*, 130 S. Ct. at 1648. "ERISA represents a 'careful balancing' between ensuring fair and prompt enforcement of rights under a plan and the encouragement of the creation of such plans." *Id.* at 1649 (citation omitted). Because "maintaining the financial viability of self-funded ERISA plans is often unfeasible in the absence of reimbursement and subrogation provisions," *O'Hara*, 604 F.3d at 1238, the Third Circuit's decision to deny reimbursement will to some degree "discourage employers from offering welfare benefit plans in the first place," *Varity*, 516 U.S. at 497.

B. The Third Circuit's Decision Will Make It More Difficult And Expensive To Sponsor And Maintain Affordable Employee Benefit Plans.

1. The centrality of subrogation and reimbursement as a mechanism for preserving 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. One state 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.[2] Those sorts of premium increases in turn restrict individuals' access to coverage.

2. Department of Legislative Services, Maryland General Assembly, Senate Bill 903: Contracts Between Health Maintenance Organizations and Subscribers or Groups of Subscribers - Subrogation Provisions (2000), *at* http://mlis.state.md.us/2000rs/fnotes/bil_0003/sb0903.rtf (last visited Sept. 4, 2012).

Subrogation and reimbursement provisions are particularly important in allowing employers and unions to sponsor and maintain self-funded employee welfare plans. By allowing plans to recover paid medical expenses that are the financial responsibility of third parties, eliminating duplicative payments and preserving limited benefit dollars for the benefit of all participants, right to reimbursement provisions enable employers to offer enhanced benefits to covered participants. 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." *O'Hara*, 604 F.3d at 1235. 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 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. *See* David Leonhardt, *Poverty in U.S. Grew in 2004, While Income Failed to Rise for 5th Straight Year*, N.Y. Times, Aug. 31, 2005, at A9.

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

Jeffrey A. Freenblatt, *Insurance and Subrogation: Where the Pie Isn't Big Enough, Who Eats Last?* 64 U. Chi. L. Rev. 1337, 1355 (1997). As Judge Posner has opined: "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." *Cutting*, 993 F.2d at 1297.

2. The Third Circuit's decision thus will harm employee benefit plans in several ways. First, it reduces the subrogation recoveries plans need to ensure their financial viability. *See supra* p. 23. The Third Circuit crafted a perverse 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 will harm plans as more money is expended to pay medical expenses without the benefit of reimbursement to replenish plan funds for future benefit payments.

Second, the Third Circuit's decision will generate more ERISA litigation and dramatically increase litigation costs. In order to meet ERISA's mandate that

fiduciaries administer the plan "in accordance with the documents and instruments governing the plan," 29 U.S.C. § 1104(a)(1)(D), plan fiduciaries will be forced to litigate subrogation and reimbursement claims in federal district court. 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. *See supra* pp. 21-22.

Third, the decision will needlessly increase the cost of operating a plan. Reducing reimbursement will damage self-funded benefit providers and generally undermine ERISA's goal of making health benefits affordable for the Nation's workforce. Because each personal injury case is different, the use of "equitable remedies" (such as unjust enrichment or the make-whole or common fund doctrines) will unnecessarily subvert plan terms. 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. *See, e.g.*, *Cutting*, 993 F.2d at 1298.

3. The Third Circuit's decision, if allowed to stand, ultimately will harm plan participants. It will produce predictable responses by employers because of the reduction in funds available for benefit payments.

First, it could force many employers to reduce or eliminate certain benefits, increase premiums, or do both, because a plan's ability to obtain reimbursement from participants is a significant factor in establishing benefit

levels and plan rates. If the plan's right to reimbursement is denied, the cost of paying for the underlying benefits falls to those who make the contributions that support plan benefits. In the absence of a predictable right to recovery, plans will be forced to protect against the resulting risk by raising rates or decreasing benefits for all participants. Plan participants that honor their obligations under plan reimbursement provisions will be forced to bear these costs.

Second, to counter an erosion of reimbursement rights, plan providers may be forced to adopt alternate approaches that shift greater burdens to plan participants. Thus, one option for plan providers faced with escalating costs would be to defer or delay payment of claims for medical expenses related to third-party negligence until the accident liability issues have been fully resolved or until third-party litigation has concluded. *See, e.g.*, *Kress v. Food Emp'rs Labor Relations Ass'n*, 391 F.3d 563, 568 (4th Cir. 2004) ("Since third-party accident and sickness benefits are not even covered by the Fund, nor required by ERISA, it makes little sense to argue that ERISA precludes imposing conditions on the receipt of benefits that are in effect an interest-free loan.").

Third, to secure the certainty of recovery that judicial misinterpretation of § 502(a)(3) would deny, plans could choose to offset future benefits. In other words, a plan could add language to an existing reimbursement provision permitting the fiduciary to deny future benefits equal to the amount of money that should have been reimbursed under the terms of the plan. Or more drastically, plan sponsors might be compelled to amend their plans to exclude coverage for medical expenses

related to negligent third-party claims. *See, e.g.*, *Ryan*, 78 F.3d at 127 ("ERISA neither requires a welfare plan to contain a subrogation clause nor does it bar such clauses or otherwise regulate their content."). In this situation, participants will ultimately have to pay retail rates for their medical expenses out of their own pockets because individuals cannot negotiate the more favorable group rates available to an employee benefit plan.

The net effect of all of these possible outcomes will be higher plan costs that will be shifted to all plan participants, including those plan participants that honor the terms of their agreements. This unnecessary and unwarranted shift of risk allocation would come at time when employers are finding it increasingly difficult to provide benefits to their employees. "The cost of employer-sponsored coverage is the most common reason employers cite for not offering health coverage." The Henry J. Kaiser Family Foundation, *The Uninsured: A Primer: Key Facts About Americans Without Health Insurance*, at 16-18 (Oct. 2011). Indeed, premiums have more than doubled since 2001. *Id.*

In turn, increased costs inevitably will lead to a reduction in the number of individuals that are able to afford insurance. Even a one-percent increase in costs has devastating effects: "each one percent increase in managed care plans' costs … results in a potential loss of insurance coverage for about 315,000 individuals." Health Economics Practice, Barents Group, LLC, *Impacts of Four Legislative Provisions on Managed Care Consumers: 1999-2003*, at iii (1998). The Court should not endorse a rule that allows some participants to benefit from inequitable practices to the detriment of all plan

participants. It is impossible to reconcile such a rule with the plain language of § 502(a)(3), the Court's precedent, or the core purposes of ERISA.

CONCLUSION

For the reasons set forth herein, and in the Brief for Petitioner, the judgment of the court of appeals should be reversed.

Respectfully submitted,

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