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 E. MCCUTCHEN AND ROSEN, LOUIK & PERRY, P.C.,
Respondents.

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

BRIEF *AMICUS CURIAE* OF THE NATIONAL COORDINATING COMMITTEE FOR MULTIEMPLOYER PLANS IN SUPPORT OF PETITIONER

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The National Coordinating Committee for Multiemployer Plans ("NCCMP") is a nonprofit, tax-exempt organization that has participated for over a quarter of a century in the development of the law applicable to employee benefit plans.[1] The NCCMP's

[1] Pursuant to Rule 37.6 of the Rules of this Court, the undersigned hereby state that no counsel for Petitioner or Respondents authored any part of this brief. Moreover, no person or entity other than the NCCMP made a monetary contribution to the preparation or submission of this brief.

primary purposes are to assure an environment in which multiemployer plans can continue their vital role in providing medical, pension and other benefits to working men and women, and to participate in the development of sound employee benefits legislation, regulations and policy affecting benefit plans.

The NCCMP is the only national organization devoted exclusively to protecting the interests of multiemployer plans by advocating on behalf of these plans in Congress, in the courts and in the regulatory process. Multiemployer plans provide benefits to tens of millions of American workers. Hundreds of multiemployer plans and related organizations, with a nationwide participant base located across the United States, are affiliated with the NCCMP. The plans affiliated with the NCCMP represent a majority of the participants in multiemployer plans throughout the nation and are representative of the multiemployer plan community generally. Affiliated plans are active in every major segment of the multiemployer plan universe, including the airline, building and construction, entertainment, food production, distribution and retail sales, health care, hospitality, mining, maritime, industrial fabrication, service, textile and trucking industries.

Because of this broad range of experience of the NCCMP's constituent organizations, the NCCMP believes that it is uniquely qualified to state the position of the trustees of such plans on the issues in this case. The NCCMP and its constituent groups have a strong interest in ensuring that multiemployer plans continue to have an effective, efficient and uniform

equitable remedy available to them in the federal courts to recover amounts due to the plans. Moreover, in the case of self-funded multiemployer health plans, the NCCMP and its constituent groups have a strong interest in preserving the enforceability of these plans' subrogation and right of reimbursement provisions under § 502(a)(3) of the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1132(a)(3), and this Court's decision in *Sereboff v. Mid Atlantic Medical Services, Inc.*, 547 U.S. 356 (2006).[2]

INTRODUCTION

The Court's decision in *Great-West Life & Annuity Insurance Co. v. Knudson*, 534 U.S. 204 (2002) defined the narrow avenue through which an ERISA plan may seek to recover funds under § 502(a)(3) of the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1132(a)(3). Specifically, the Court held that an ERISA plan may seek restitution under § 502(a)(3) for a participant's failure to reimburse only if the plan's claim is equitable. *Knudson*, 534 U.S. at 213 (a plan may "seek restitution in *equity*, in the form of a constructive trust or an equitable lien" where the funds it seeks are specifically identifiable, belong in good conscience to the plan, and are within the possession and control of the participant or beneficiary). Prior to *Knudson*, beneficiaries routinely and voluntarily agreed on how and under what conditions they would satisfy a benefit

[2] Counsel for the Petitioner and Respondents have filed a blanket consent to the filing of amicus curiae briefs in support of either party or of neither party.

plan's equitable right to a share of payments received from responsible tortfeasors, and the vast majority of third-party recovery cases were resolved efficiently and fairly. In the rare case in which there was disagreement over the amount or fairness of the reimbursement demanded, the beneficiary and the benefit plan could negotiate a mutually agreeable resolution, or if no agreement could be reached, request that the federal courts resolve the matter. After *Knudson*, however, more and more beneficiaries began to accept health benefits from plans and then adopt a "come get us if you can" response to attempts by benefit plans to enforce their right to reimbursement. As a consequence, efforts to enforce such rights became increasingly complex, expensive and uncertain.

With the Court's decision in *Sereboff v. Mid Atlantic Medical Services, Inc.*, 547 U.S. 356 (2006), a significant level of certainty was restored. In *Sereboff*, the Court explained that an ERISA plan's right of reimbursement provision creates an "equitable lien by agreement" that is enforceable under § 502(a)(3), *id.* at 364-365, and concluded that the benefit plan's "action to seek reimbursement was brought to obtain *equitable* relief where the plan sought its recovery through a constructive trust or equitable lien on a specifically identified fund, not from the [beneficiary's] assets generally. . ." *Id.* at 363. While *Sereboff* did not restore the pre-*Knudson* ability of plan fiduciaries to make efficient and mutually satisfactory arrangements to perfect their right to recover amounts received from responsible tortfeasors, trustees were at least provided with concrete guidance concerning the scope of their right to

enforce subrogation and reimbursement of rights provisions. The Court in *Sereboff* did leave open the question whether equitable defenses "like the make-whole doctrine" might place limits on a benefit plan's ability under § 502(a)(3) to obtain relief. *Id.* at 368 n.2.

Although, after *Sereboff*, enforcement of a plan's equitable right to reimbursement continues to be complex, expensive and uncertain, fiduciaries at least have access to the equitable relief necessary to enforce plan terms. The decision below, if upheld, will undermine that modest achievement by allowing a beneficiary to expand his rights by asserting so-called equitable defenses which essentially trump the plan's express terms. As this Court made clear in *CIGNA Corp. v. Amara*, 563 U.S. ___, 131 S. Ct. 1866, 1879 (2011), the circumstances in which a plan's terms can be overridden are limited to those in which reformation is necessary to redress violations of ERISA or of a plan. *See id.* 131 S. Ct. at 1879 (2011) (Where an employer intentionally misled its employees about the benefits of its pension plan the courts may reform the plan in order "to remedy the false or misleading information [the Employer] provided."). The court below failed to honor that fundamental premise.

If allowed to stand, the decision will only lead to additional complexity, expense and uncertainty for fiduciaries when they attempt to enforce their plans' subrogation and right of reimbursement provisions—an outcome that is antithetical to ERISA's basic purpose. Notably, plans are not required to advance medical expenses for injuries caused by third parties,

and it is entirely foreseeable that they will opt not to do so if their right to reimbursement becomes riddled with "equitable defense" exceptions based on each court's perception of what is fair to a particular beneficiary. *See generally Conkright v. Frommert*, 130 S. Ct. 1640, 1648 (2010) ("Congress enacted ERISA to ensure that employees would receive the benefits they had earned, but Congress did not require employers to establish benefit plans in the first place. We have therefore recognized that 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.'" (quoting *Aetna Health Inc. v. Davila*, 542 U.S. 200, 215 (2004)). The NCCMP submits this brief to urge the Court to reverse the decision below, and leave to multiemployer plans the remaining narrow, but extremely important, equitable remedy under § 502(a)(3).

SUMMARY OF ARGUMENT

At its core, the decision below is grounded on the overbroad premise that Congress enacted ERISA to protect the multiple and wide-ranging interests of individual plan participants and beneficiaries. In fact, the participant interests Congress sought to protect are those specified in written plans. The court further erred by expanding the equitable relief available under § 502(a)(3) to include a right to *reform* the terms of a plan to conform to a court's perception of what is "equitable" to a beneficiary in a given case. This would seriously limit a plan fiduciary's ability to obtain even the narrow equitable remedy prescribed in *Sereboff*.

It is crucial that self-funded health plans and other ERISA plans have a reliable means to utilize equitable relief under § 502(a)(3) to obtain payments that rightfully belong to the plans. The decision below, if left standing, will require plan fiduciaries to make difficult choices that do not advance the interests of participants and beneficiaries. Fiduciaries will have to expend significantly more plan assets to enforce a plan's reimbursement rights or they will be forced to agree to settle claims even where a beneficiary's third-party recovery may be well in excess of the plan's reimbursement claim, to the detriment of other plan participants. Worse, plans may conclude that it is not feasible to continue offering advance payment for medical costs resulting from injuries caused by others.

ARGUMENT

I. THE DECISION BELOW CONFLICTS WITH ERISA'S PURPOSE OF ENSURING THAT PLAN PROVISIONS WILL BE ENFORCED UNIFORMLY IN THE FEDERAL COURTS.

A. The Multiple Mandates Congress Has Placed on Self-Funded ERISA Health Plans Since the Enactment of ERISA Make It More Critical Than Ever that Courts Not Lightly Engage in the Alteration of Plan Terms.

In 1981, the Court emphasized that private parties, not the Government, control the level of benefits of an ERISA plan. *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 511 (1981). In 1983, the Court again stressed that ERISA "sets various uniform standards,

including rules concerning reporting, disclosure, and fiduciary responsibility, for both pension and welfare plans . . . , [but] ERISA *does not mandate that employers provide particular benefits. . .*" *Shaw v. Delta Air Lines*, 463 U.S. 85, 90-91 (1983) (emphasis added). In construing "appropriate equitable relief" under ERISA § 502(a)(3), the Court has cautioned against applying common law theories to alter express terms of an ERISA Plan and has instructed courts to "keep in mind the special nature and purpose of employee benefit plans." *Varity Corp. v. Howe*, 516 U.S. 489, 515 (1996) (internal quotation omitted). The reluctance to apply federal common law to override a plan's controlling language is grounded in the understanding that to do so typically "frustrate[s], rather than effectuate[s], ERISA's 'repeatedly emphasized purpose to protect contractually defined benefits.'" *Zurich Am. Ins. Co. v. O'Hara*, 604 F.3d 1232, 1237 (11th Cir. 2010), *cert. denied*, 131 S. Ct. 943 (2011) (quoting *Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 148 (1985)).

While the courts have adhered to this particular principle of judicial restraint, Congress and the federal agencies have undertaken a significant role in dictating the level and types of benefits that plans must provide. Beginning in 1986, when Congress first required plans to provide continuation coverage to employees and beneficiaries in the event of termination or other qualifying events, Congress, the Department of Labor, the Internal Revenue Service and the Department of Health and Human Services have steadily increased the number of mandated benefits required of self-funded health plans. ERISA,

as amended through 2009, now requires plans to provide continuation coverage to employees on qualified family or medical leave, to honor qualified medical child support orders, to provide reconstructive surgery following a covered mastectomy, to limit restrictions on benefits for preexisting conditions, to eliminate limits on hospital length of stays connected with childbirth, to establish parity between mental health and substance abuse benefits and medical benefits, and to provide that dependent college students maintain coverage in the event of medical leaves of absence from school or changes in enrollment.[3] And the impact of the foregoing requirements pales in comparison to that of the Patient Protection and Affordable Care Act ("PPACA").[4] Among other things, PPACA

[3] The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), Pub. L. No. 99-272, 100 Stat. 82 (1986); The Family and Medical Leave Act of 1993 (FMLA), Pub. L. No. 103-3, 107 Stat. 6 (1993); The Child Support Performance and Incentive Act of 1998 (CSPIA), Pub. L. No. 105-200, 112 Stat. 645 (1998); The Women's Health and Cancer Rights Act, Pub. L. No. 105-277, Title IX, 112 Stat. 2681-436 (1998); The Health Insurance Portability and Accountability Act of 1996 (HIPAA), Pub. L. No. 104-191, 110 Stat. 1936 (1996); 45 C.F.R. parts 160 and 164, 65 Fed. Reg. 82,462 (Dec. 28, 2000); The Newborns' and Mothers' Health Protection Act of 1996 (NMHPA), Pub. L. No. 104-204, 110 Stat. 2935 (1996); Mental Health Parity Act of 1996 (MHPA), Pub. L. No. 104-204, 110 Stat. 2944 (1996); Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), Pub. L. No. 11-343, 122 Stat. 3765 (2008); Michelle's Law, Pub. L. No. 110-381, 122 Stat. 4081 (2008). This is not an exhaustive list but it does include the more burdensome changes in the law since ERISA's enactment.

[4] Pub. L. No. 111-148, 124 Stat. 119 (2010).

requires group health plans (including self-funded health plans) to eliminate lifetime benefit limits by 2011, to phase out annual benefit limits for essential benefits by 2014, to provide dependent coverage for adult children up to age 26, to eliminate cost-sharing for preventive services and immunizations, to limit rescissions in eligibility to cases of fraud and intentional misrepresentation, to eliminate any pre-existing condition exclusions on children under age 19 by 2011, to eliminate all pre-existing condition exclusions by 2014, and to eliminate waiting periods in excess of 90 days.

This radically changed regulatory landscape for self-funded health benefit plans reinforces the need for courts to adhere to the principle that they do not sit to decide the nature or levels of benefits that must be provided by ERISA plans. More than ever, trustees of multiemployer health plans must wrestle with escalating health care costs, including the costs of complying with new expensive PPACA minimum coverage requirements, at a time when the employers in the industries that fund these plans struggle to recover from the nation's worst recession since the Great Depression. As a practical matter, the decision below, issued on the heels of the enactment of PPACA, could not come at a worse time for multiemployer health plans, their participants and beneficiaries, and their contributing employers. Thus, the NCCMP urges the Court to reject the Third and Ninth Circuits'[5] efforts to place general equitable limitations on a fiduciary's right to seek restitution under

[5] *CGI Technologies & Solutions v. Rose*, 683 F.3d 1113 (9th Cir. 2012).

the express terms of a plan providing for recovery of third-party payments.

B. Other Circuits Have Correctly Recognized that ERISA § 502(a)(3) Should Not Be Applied so as to Allow the Circumstances of an Individual Right of Reimbursement Case to Trump the Plan's Express Terms.

In *Administrative Committee of the Wal-Mart Stores, Inc. Associates' Health and Welfare Plan v. Shank*, 500 F.3d 834 (8th Cir. 2007), the Eighth Circuit considered a plan's right to recover medical expenses advanced to a beneficiary injured in an automobile accident from funds obtained by the beneficiary in a third-party settlement. Although the settlement was for $700,000, after deducting attorney's fees and costs the plan's medical costs of $469,216 exceeded the amount placed in the beneficiary's special needs trust. *Id.* at 835-836. In upholding the plan's right to enforce its reimbursement provision, the Eighth Circuit recognized that the interests of one participant cannot override the written plan document without harming all other participants:

> We acknowledge the difficulty of Shank's personal situation, but we believe the purposes of ERISA are best served by enforcing the Plan as written. Shank would benefit if we denied the Committee its right to full reimbursement, but all other plan members would bear the cost in the form of higher premiums. . . . Reimbursement and subrogation provisions are crucial to the financial viability of self-funded ERISA plans, and, as a fiduciary,

> the Committee must "preserve assets to satisfy future, as well as present, claims," and must "take impartial account of the interests of all beneficiaries." *Varity Corp.*, 516 U.S. at 514.

Shank, 500 F.3d at 838 (citation and internal quotation omitted).

The NCCMP agrees with the Eighth Circuit's reasoning in *Shank*. *See also O'Hara*, 604 F.3d at 1237; *Moore v. CapitalCare, Inc.*, 461 F.3d 1, 9 (D.C. Cir. 2006); *Bombardier Aerospace Employee Welfare Benefits Plan v. Ferrer, Poirot, & Wansbrough*, 354 U.S. 348, 357 (5th Cir. 2003), *cert. denied*, 541 U.S. 1072 (2004); *Administrative Comm. of Wal-Mart Stores Inc. Assocs.' Health and Welfare Plan v. Varco*, 338 F.3d 680 (7th Cir. 2003), *cert. denied*, 542 U.S. 945 (2004). Moreover, in the context of multiemployer health plans, where increasing employee premiums to offset increased plan costs typically is not an option, a plan's reimbursement rights against third-party recoveries are critical to the maintenance of benefit levels for all participants and beneficiaries. Because funding of multiemployer health plans is primarily through employer, and occasionally employee, contributions[6] at rates set forth in collective bargaining agreements that have durations typically of three or more years, the trustees of these plans would have to cut benefits to offset the costs of reducing a plan's reimbursement claim.

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[6] Many multiemployer health plans are funded solely by employer contributions.

The court below overlooks the practical implications of inserting so-called "equitable principles" into a health plan's subrogation and right of reimbursement provision, and in the process fails to acknowledge how its decision will adversely impact other plan participants and beneficiaries. "Because maintaining the financial viability of self-funded ERISA plans is often unfeasible in the absence of reimbursement and subrogation provisions. . . , denying [a plan] its right to reimbursement would harm other plan members and beneficiaries by reducing the funds available to pay those claims. . . . [A]ny inequity in this case would lie in permitting [the beneficiary] 'to partake of the benefits of the Plan and then after he had received a substantial settlement, invoke common law principles to establish a legal justification for his refusal to satisfy his end of the bargain.'" *O'Hara*, 604 F.3d at 1238 (quoting *Ryan v. Federal Express*, 78 F.3d 123, 127-28 (3d Cir. 1996)).

The concern regarding the link between effective enforcement of reimbursement and subrogation provisions and the preservation of plan assets for present and future claims has special significance to the self-funded multiemployer health and welfare plans which are among the NCCMP's constituency. Such plans must ensure that contributions paid in accordance with the terms of collective bargaining agreements are sufficient to cover the costs of providing benefits. A small seemingly well-funded multiemployer health benefit plan that has been providing benefits to a few hundred employees and dependents for decades could be rendered insolvent in a matter of months if suddenly hit with three or four cata-

strophic claims.[7] While the efforts of trustees of such plans vigorously to enforce reimbursement and subrogation provisions may appear harsh when viewed from the perspective of a severely injured beneficiary, in fact these trustees are fulfilling their fiduciary duty to ensure that their plan may continue to provide benefits to all participants and beneficiaries. *See* ERISA § 404(a)(1)(A), 29 U.S.C. § 1104(a)(1)(A)("a fiduciary shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries and . . . for the exclusive purpose of . . . providing benefits to participants and their beneficiaries; and defraying reasonable expenses of administering the plan. . .").

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[7] Prior to the enactment of PPACA, many small multiemployer plans established relatively low annual and lifetime maximums in order to control costs in the event of a catastrophic claim. The reality for beneficiaries of these plans who may have suffered a catastrophic illness or injury was that often the plan was no longer the source of providing necessary medical benefits. Although these outcomes were extraordinarily difficult on beneficiaries, they also reflect the difficult choices trustees are required to make when determining what level of benefits the plan can provide based on contribution rates outside the control of the trustees. The trustees of many of these plans are now struggling with the process of losing these cost containment provisions under PPACA. PPACA § 2711, 42 U.S.C. §§ 300gg-11, provides that by 2014 "group health plan . . . may not establish . . . lifetime limits on the dollar value of benefits for any participant or beneficiary; or annual limits on the dollar value of benefits for any participant or beneficiary."

C. The Decision Below Will Deter Plans from Offering to Advance Medical Payments for Injuries Caused by Third Parties, to the Detriment of Participants and Beneficiaries as a Group.

The value of benefits that a self-funded multiemployer health and welfare plan can provide is limited by the contribution rate paid by employers as established through collective bargaining. In addition, benefit levels are subject to factors that are largely outside of either the trustees' or the bargaining parties' control: hours worked, employer delinquencies and bankruptcies, investment performance of plan assets, medical inflation, and minimum coverage requirements and other statutory mandates, just to name a few. These factors ultimately define the amount of benefits trustees may provide plan participants and beneficiaries. Thus, while the trustees of these plans may within limits be able to determine the menu of benefits a plan may provide, they have much less control over the amount of plan assets available to pay those benefits.[8]

Self-funded multiemployer health and welfare plans are not obligated by any law to pay medical benefits when a beneficiary is injured by a third party. If the decision below is affirmed and individ-

[8] Of course, in their capacity as ERISA fiduciaries, trustees are responsible for defraying the reasonable expenses of administering the plan and must diversify investments so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so. ERISA § 404(a)(1)(A)(ii) and (C), 29 U.S.C. § 1104(a)(1)(A)(ii) and (C).

ual federal judges begin exercising "broad equitable powers" to determine whether a plan's equitable lien to enforce its contractual right to reimbursement is "appropriate equitable relief" in a given case, the result will be to significantly limit a plan administrator's ability to enforce the plan's equitable right to reimbursement. Such a difficulty, along with the complexities and uncertainties certain to follow, will undoubtedly lead to a reassessment of whether the plan should continue to pay any medical benefits when a beneficiary is injured by a third party. Thus, beneficiaries of more and more self-funded health plans likely will be placed in the unwanted situation of having no medical benefit coverage following an unexpected accident caused by a tortfeasor. *Cf. Varco*, 338 F.3d at 692 (". . . most covered persons—if given an option—would readily give up a 'common fund-type' reduction in exchange for 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." (citation omitted)).

The vast majority of multiemployer self-funded health plans affiliated with the NCCMP have not agreed to pay medical benefits for injuries caused by others.[9] The written plans commonly provide that

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[9] Absent from the long list of mandates added to ERISA's regulatory framework over the past three decades is any requirement that self-funded health plans cover injuries or illnesses caused by third parties. Nor has Congress deemed it necessary to impose limitations on right to reimbursement or subroga-

benefits are not payable if a sickness or injury is the responsibility of a third party. Recognizing that beneficiaries will need to pay for extraordinary medical expenses in the event of unexpected sickness and injuries, multiemployer plan trustees often include plan provisions to allow for advancing benefits. That advance, however, is conditioned on the beneficiary's promise to honor the plan's equitable right to reimbursement if and when the beneficiary obtains compensation from the responsible third party. *See*, *e.g.*, *Kress v. Food Employers Labor Relations Ass'n & United Food and Commercial Workers Health and Welfare Fund*, 391 F.3d 563, 570 (4th Cir. 2004) (plan refused to pay benefits for injuries from auto accident when beneficiary refused to acknowledge equitable reimbursement right); *Harris v. Harvard Pilgrim Health Care, Inc.*, 208 F.3d 274, 279 (1st Cir. 2000) ("[I]f the ERISA plan expressly provides that its members are obligated to reimburse the plan for 'the value of services provided, arranged, or paid for,' we do not think it can be considered 'unfair' to require plan members to abide by the agreement.").

The terms of a typical multiemployer health plan of benefits are illustrated by the plan considered by the Fourth Circuit in *Kress*:

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tion provisions. Nor, for that matter, has Congress exercised its lawmaking authority to require the federal courts to adopt "the make-whole doctrine and the common fund doctrine" when considering a plan's right to enforce an equitable lien under ERISA § 502(a)(3), notwithstanding the Ninth Circuit's recent decision in *Rose*, 683 F.3d at 1119.

> Waiting for a third party to pay for these injuries may be difficult. Recovery from a third party can take a long time (you may have to go to court), and your creditors will not wait patiently. Because of this, as a service to you, the Fund will pay your (or your eligible dependent's) expenses based on the understanding that you are required to reimburse the Fund in full from any recovery you or your eligible dependent may receive, no matter how it is characterized. This process is called "subrogation." . . . The Fund extends benefits to you and your dependents only as a service to you. The Fund must be reimbursed if you obtain any recovery from another person or entity's insurance coverage.

Kress, 391 F.3d at 566. Thus, far from having contracted to bear the risk associated with the costs of injuries caused by third parties, benefit plans typically expressly disavow any obligation to pay benefits under those circumstances.

However, recognizing the difficult circumstances presented to beneficiaries, benefit plans typically agree to advance medical costs to tide over beneficiaries in difficult times, but only if the beneficiary promises to reimburse the benefit plan later. As emphasized by the Fourth Circuit, these plan provisions

> . . . broadened rather than narrowed the options of Fund participants. Nothing required [the beneficiary] to accept the subrogation option; he was free to reject it and com-

> mence litigation at once, with no obligations whatever to the Fund. But if he did accept the Fund's offer, and then recovered in tort, it was not wrongful for the Fund to seek to recoup this expenditure to provide for future participants who may find themselves in similarly straitened circumstances. The Fund "must serve the best interests of all Plan beneficiaries, not just the best interest of one potential beneficiary."

Kress, 391 F.3d at 570-71 (footnote omitted) (quoting *Ellis v. Metropolitan Life Ins. Co.*, 126 F.3d 228, 234 (4th Cir. 1979)).

If the Court further restricts plans' ability to obtain a constructive trust or equitable lien, the result will not be a greater recovery for beneficiaries in personal injury lawsuits. Instead, benefit plans likely will respond by simply not advancing these payments in the first place, leaving beneficiaries to deal on their own with medical bills, creditors and delays during the uncertain and lengthy process of personal injury lawsuits. This cannot be good public policy.

Placing so-called "equitable limits" on benefit plans' reimbursement rights and granting individual federal judges discretion to apply their own brand of "broad equitable principles" to individual reimbursement cases will lead to such uncertainty and inconsistency as to force administrators to reconsider the appropriateness of advancing benefits to beneficiaries. Currently, as described above, plans typically advance benefits to beneficiaries in their time of need, based on a promise to reimburse in the

event that a future recovery is obtained. In some cases, at a point of time far in the future, the beneficiary may eventually recover a payment from the tortfeasor and be required to reimburse the plan. However, in far more common situations, the beneficiary decides not to pursue an action against the responsible tortfeasor, or based on the uncertainties and expense of litigation agrees to a settlement which is less than full compensation. In these common scenarios, the beneficiary retains the benefit of having had his medical expenses paid on his or her behalf. This benefit will be lost if self-funded health plans stop advancing medical costs because they cannot effectively enforce an equitable claim for reimbursement.

D. The Typical Subrogation and Right of Reimbursement Provisions in Self-Funded Multiemployer Health Plans Are Carefully Drawn to Protect against Risks to the Collective Interests of Participants and Beneficiaries and Are Administered so as to Accommodate Beneficiaries to the Extent Possible; the Decision Below Would Negate Those Protections and Benefits.

Self-funded multiemployer health and welfare plans generally incorporate subrogation and right of reimbursement provisions that strive to be "airtight" in terms of the obligations of beneficiaries who accept advanced payment of medical expenses.[10] In

[10] Most self-funded multiemployer health plans include provisions that establish the plans' right of subrogation and right to reimbursement. Although the terms are often used inter-

fact, many of these plans have subrogation and right of reimbursement provisions that are quite similar to the one found in the Petitioner's plan. *See U.S. Airways, Inc. v. McCutchen*, 663 F.3d 671, 673 (2012). Generally, such plan provisions will unequivocally provide: (1) that the plan's primary purpose is to provide benefits that are not covered by a third party; (2) that the plan is only obligated to provide covered benefits resulting from the actions of a third party that exceed any amounts recovered from another party regardless of whether the amount recovered is designated to cover medical expenses; (3) that amounts recovered by a beneficiary from another party are assets of the plan by virtue of the plan's subrogation interest and are not distributable to any person or entity without the plan's release of its subrogation interest; and (4) that the plan has a right to first reimbursement out of any recovery without reduction for attorneys' fees, costs, expenses or damages claimed by the beneficiary and regardless of whether the beneficiary is made whole or recovers only part of his or her damages.

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changeably and are often confused, they technically involve different concepts. The right of subrogation allows the plan to step into the shoes of the beneficiary so as to have the benefit of the beneficiary's rights and remedies against a tortfeasor. The right to reimbursement provides the plan with a lien on property, a beneficiary's settlement for example, that prevents distribution prior to satisfaction of the plan's lien. As a practical matter, when dealing with third party responsibility, self-funded multiemployer health plans rarely exercise a true right of subrogation, such as by filing suit against the tortfeasor. Instead, such plans typically rely on their right to reimbursement. Accordingly, in this brief, the NCCMP has focused on the latter process.

There are at least three reasons why a board of trustees will go to such lengths to protect a health and welfare plan's reimbursement rights. First, a number of courts of appeal have demonstrated a willingness to interpret arguably ambiguous reimbursement provisions using state insurance law principles or "unique" common law equity principles as their guide. *See Cagle v. Bruner*, 112 F.3d 1510, 1522 (11th Cir. 1997) ("[T]he make whole doctrine exists because parties to an insurance contract do not always explicitly address what happens when the insurer pays less than the insured's total loss, and the insured achieves a recovery from a third party. The effect of the doctrine is to imply into ambiguous insurance contracts (including ERISA plans) a default provision governing that situation."); *Waller v. Hormel Foods Corp.*, 120 F.3d 138, 141-142 (8th Cir. 1997) (reading the common fund doctrine into ERISA plan's subrogation provision). Therefore, specificity is a necessity. Second, the trustees seek to establish an unambiguous equitable basis for the plan's right to reimbursement that satisfies the requirements of ERISA § 502(a)(3).[11] Third, the trustees seek to avoid having the plan's amount of recovery exposed to factors outside the trustees' control. A non-exhaustive

[11] It is the NCCMP's understanding that many boards of trustees of multiemployer health and welfare plans amended their plans' subrogation and right of reimbursement provisions soon after the Court issued its decision in *Knudson*. Other boards of trustees amended their plans' right of reimbursement provisions soon after certain Circuit Courts began reading the common-fund doctrine or make-whole doctrine into a self-funded plan's arguably ambiguous right of reimbursement provision.

list of such factors may include how settlements or judgments designate payments, the quality of legal representation of the beneficiary or third party, state laws that may limit recovery, the depth of the pockets of the third party, the level of insurance of the third party, any contributory negligence or comparative negligence on the part of the beneficiary, the vagaries of individual jury verdicts, any immunity defenses of the third party, or the unwillingness of the beneficiary's attorney to reduce his or her fees.

Thus, it would be incorrect to assume that trustees of multiemployer health and welfare plans have incorporated airtight subrogation and right of reimbursement provisions out of an unwillingness to compromise a plan's claims. Rather, the manner in which these provisions are drafted reflects the trustees' recognition that it is not in the collective interest of participants and beneficiaries to have plan assets exposed to factors outside the trustees' control.

As a practical matter trustees often agree to reduce a plan's equitable lien against a participant's third-party recovery. Many multiemployer plans have established formal procedures that govern when a compromise will be appropriate, and the amount of the lien reduced. For example, the trustees may give the plan's attorney authorization to reduce a lien by a certain fixed percentage if the participant's attorney agrees to reduce his or her fee by a certain percentage. Trustees may also agree to settle a claim for the amount of a beneficiary's third-party recovery, less the amount of the beneficiary's attorney's fees and costs. In other cases, the full board of trustees

will consider a beneficiary's request that the plan reduce its lien at a meeting of the full board in accordance with ERISA's claims procedures. 29 C.F.R. § 2560.503-1(h) (Appeal of adverse determinations). Although these procedures allow the trustees to consider the beneficiary's circumstances and to weigh the beneficiary's interests against the interests of the plan and other participants and beneficiaries, the outcome is typically determined exclusively by the trustees. *Cf. Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 109 (1998) (In the case of a denial of benefits under ERISA § 502(a)(1)(B), where the plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan, the determination of the administrator is reviewed under the abuse of discretion standard). The decision below would take the process of compromising claims out of the hands of the plan's fiduciaries and allow individual federal judges to apply their own brand of "broad equitable principles" to each case.

II. IF THE COURT ENDORSES THE REASONING UNDERLYING THE DECISION BELOW, IT WILL LEAD TO UNCERTAINTY AND NON-UNIFORM ENFORCEMENT OF ERISA PLAN PROVISIONS.

It would be wrong to assume that, if the Third and Ninth Circuits' holdings are upheld, the cost to self-funded health plans will be limited to reductions in reimbursement deemed appropriate by federal courts applying "equitable principles" to individual cases. The court below deemed the Petitioner's "practical concern that the application of equitable

principles will increase plan costs and premiums . . . unsubstantiated by the circumstances of this case." *McCutchen*, 663 F.3d at 679. This short-sighted view of the implications of the court's decision misses the mark.

It is entirely predictable that, if the decision below is upheld, plans will be confronted with every purported equitable defense under the sun, regardless of the circumstances underlying any particular case. During the time between the Court's decisions in *Knudson* and *Sereboff*, there was a high degree of uncertainty regarding the extent to which plans could continue to seek equitable relief under § 502(a)(3) to enforce their right to reimbursement. During this period of uncertainty, it became commonplace for beneficiaries to accept health benefits from plans and then adopt a "come get us if you can" response to the legitimate assertion that a benefit plan had an equitable claim to a share of payments recovered from third parties. Even after *Sereboff*, enforcement of an equitable right to reimbursement continues to be complex and expensive for benefit plans because many beneficiaries simply refuse to honor their obligation to reimburse.

There is little doubt that the Third Circuit below and the Ninth Circuit in *Rose* have given beneficiaries and their attorneys an open invitation to respond to a plan's reimbursement claim with an "everything but the kitchen sink" equitable defense strategy. For example, the Third Circuit left open the question of whether the "make-whole" doctrine could be used as an equitable defense to the plan's reimbursement claim. *McCutchen*, 663 F.3d at 676 n.2. The Circuit

Court merely directed the district court that when it "exercise[s] . . . its discretion to fashion 'appropriate equitable relief,'" it should consider "factors such as the distribution of the third-party recovery between McCutchen and his attorneys. . . , the nature of their agreement, the work performed, and the allocation of costs and risks between the parties to this suit . . . " *Id.*, at 679. The Ninth Circuit in *Rose* exhibited the same unwillingness to provide plans and beneficiaries with a clear understanding of what would be "appropriate" equitable relief:

> [N]otwithstanding the express terms of the Plan disclaiming the application of the make-whole doctrine and the common fund doctrine, it is within the district court's broad equitable powers under § 502(a)(3) not to give those provisions a controlling weight in fashioning "*appropriate* equitable relief." . . . We express no opinion at this time on what result the district court, in exercising those powers should reach. . .

Rose, 683 F.3d at 1124.

Without placing any qualifiers on the district courts' "broad equitable powers," the Third and Ninth Circuits invite beneficiaries and their attorneys to propose a host of equitable defenses that may or may not pass muster with the lower courts, but will certainly increase the costs to plans in enforcing subrogation or reimbursement rights and will likewise increase the degree of uncertainty concerning meaningful recoveries. The NCCMP further fears that, by inviting the district courts to apply so-called equitable principles and defenses in right of reimburse-

ment cases, the decision below will invite challenges from plan participants and beneficiaries in a broader range of cases involving both ERISA welfare plans and ERISA pension plans. Prior to the Court's decision in *Knudson*, for example, the lower federal courts had no difficulty creating an unjust enrichment remedy as part of the federal common law, permitting benefit plans to seek restitution against third parties who wrongfully or mistakenly received money from an ERISA plan. *See*, *e.g.*, *Heller v. Fortis Benefits Ins. Co.*, 142 F.3d 487, 495 (D.C. Cir. 1998); *Luby v. Teamsters Health, Welfare & Pension Trust Funds*, 944 F.2d 1176, 1186 (3d Cir. 1991); *Blue Cross & Blue Shield of Ala. v. Weitz*, 913 F.2d 1544, 1548-49 (11th Cir. 1990); *Provident Life & Accident Ins. Co. v. Waller*, 906 F.2d 985, 994 (4th Cir. 1990). However, after *Knudson*, the lower courts began to question whether an ERISA benefit plan could sue under § 502(a)(3) to recover benefits in any context. *See*, *e.g.*, *Cooperative Benefit Admin'rs, Inc. v. Ogden*, 367 F.3d 323 (5th Cir. 2004) (holding benefit plan had no remedy under § 502(a)(3) to recover pension benefits advanced to participant waiting for social security disability payments to begin); *Honolulu Joint Apprenticeship & Training Comm. v. Foster*, 332 F.3d 1234 (9th Cir. 2003) (holding benefit plan had no remedy under § 502(a)(3) to recover costs of apprenticeship training); *Trustees of the AFTRA Health Fund v. Biondi*, 303 F.3d 765, 771 (7th Cir. 2002) (noting district court's dismissal of benefit plan's action under § 502(a)(3) to recover fraudulently obtained benefit payments). The very narrow equitable remedy of constructive trust or equitable lien prescribed by the Court in *Knudson* and *Sereboff* is vital to any

benefit plan seeking to recover plan assets from third parties.

CONCLUSION

For the foregoing reasons, the NCCMP respectfully urges the Court to reverse the decision below.

Respectfully submitted,

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