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 FOR RESPONDENTS

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QUESTION PRESENTED

Section 502(a)(3) of the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. § 1132(a)(3), authorizes a fiduciary, including an ERISA plan, to seek "appropriate equitable relief to . . . enforce any provisions of [ERISA] or the terms of the plan." This Court has previously held that this provision limits plans to relief that was "typically available" in equity. *E.g.*, *Mertens v. Hewitt Assocs.*, 508 U.S. 248, 256 (1993). In this case, an ERISA plan seeks reimbursement of medical expenses it paid from an injured beneficiary who recovered only a small fraction of his total damages from a tortfeasor. Based on the language of its plan, Petitioner argues that it is entitled to 100 percent reimbursement of its payments, regardless of the amount of the underlying recovery and without any deduction for attorney's fees or costs.

The question presented is whether ERISA plan reimbursement claims under § 502(a)(3) are subject to the following well-established equitable rules that prevent unjust enrichment:

1. The rule that prohibits insurers from recovering more than the amount of an insured's "double recovery."

2. The "common fund" rule that requires that those seeking to recover a portion of a fund pay a portion of the costs and attorney's fees incurred in obtaining that fund.

RULE 29.6 DISCLOSURE STATEMENT

Respondent Rosen Louik & Perry is a professional corporation. Rosen Louik & Perry does not have any parent companies, and there is no publicly held corporation that owns 10 percent or more of its stock.

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INTRODUCTION

James McCutchen worked as an airline mechanic for 18 years until his career was cut short by a car crash that left him permanently disabled and in chronic pain. His employer, Petitioner U.S. Airways, paid his medical expenses, as required by his ERISA plan, for which he had paid premiums throughout his employment.

U.S. Airways had the right to sue the tortfeasor directly to recover its insurance payments. But U.S. Airways instead chose to sit back and wait to see how Mr. McCutchen fared in his own effort to recover from the driver. With the help of his attorneys, Mr. McCutchen was able to recover some money for his injuries, but due to the limited assets and insurance of the teenage driver who hit him, it was only a tiny fraction of his total damages. Nevertheless, U.S. Airways then sued Mr. McCutchen and his attorneys in federal court, seeking to recover out of Mr. McCutchen's recovery all of the money it paid for his medical expenses, without any deduction for a portion of the costs or fees required to generate the recovery.

The law does not permit this result. U.S. Airways' suit was brought under a federal statute—§ 502(a)(3) of ERISA—that gives fiduciaries like U.S Airways the right to seek "appropriate equitable relief." In the days of the divided bench, when courts of equity considered reimbursement claims in the insurance context, those courts applied the principle of unjust enrichment in two concrete ways: to limit double recoveries by the insured and to make sure that attorneys were compensated by all beneficiaries of

the recovered sum. This was true whether or not the right to reimbursement was articulated in an agreement.

U.S. Airways repeatedly insists, however, that, although ERISA limits its relief to what was recoverable in equity, it is entitled to recover whatever its unilaterally drafted subrogation clause says it is entitled to—which, here, is 100 percent of the medical expenses it covered. In other words, Petitioner asks this Court to treat its equitable claim as if it arose in law.

This approach is neither "appropriate" nor "equitable." In reality, every equitable authority says that claims just like Petitioner's must be measured according to the equitable principle of unjust enrichment, not by rote enforcement of contract terms. That is the only approach consistent with all the language of the governing statute; it is the approach adopted by the lower court; and it is the approach that should be affirmed by this Court.

Ultimately, what U.S. Airways seeks is a rule that would liberate ERISA plans from the sort of limitations applicable to reimbursement claims in virtually every other reimbursement context, including Medicare, Medicaid, and state insurance regimes. If this Court agrees with Petitioner, ERISA will become the only place where insurers are free to recover whatever relief they write into their plans, regardless of the extent to which injury victims have been compensated for the full range of their injuries, and without contributing a penny to costs or fees. In the context of a statute with the primary purpose of

protecting plan participants and beneficiaries, this cannot have been the result intended by Congress.

STATEMENT

A. Statutory Background.

In passing ERISA, "the crucible of congressional concern was misuse and mismanagement of plan assets by plan administrators." *Mass. Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 140 n.8 (1985). Congress's primary goal was to "protect . . . the interests of participants in employee benefit plans . . . [by] providing for appropriate remedies . . . ." 29 U.S.C. § 1001(b). As this Court has stated, "Congress' desire to offer employees enhanced protection for their benefits" "outweighed" other considerations, including reduction of costs associated with ERISA plans. *Metro. Life Ins. Co. v. Glenn*, 554 U.S. 105, 113-14 (2008); *see also Varity Corp. v. Howe*, 516 U.S. 489, 513 (1996) (holding that ERISA's "basic purposes" of "protect[ing] the interests of participants and beneficiaries" trump "the need for a sensible administrative system," which was, at most, a "subsidiary congressional purpose").

One way Congress sought to achieve this goal was by passing a set of "carefully integrated civil enforcement provisions," which conferred different rights to relief on different categories of plaintiffs for violations of the statute. *Russell*, 473 U.S. at 146-47. Under this scheme, plan fiduciaries are limited to seeking "appropriate equitable relief" under ERISA § 502(a)(3). This term has been interpreted to mean that plans are limited to seeking only that relief that was "*typically* available in equity." *Mertens v. Hewitt*

Assocs., 508 U.S. 248, 256 (1993) (emphasis in original)

In 2006, this Court decided *Sereboff v. Mid Atlantic Medical Services, Inc.*, 547 U.S. 356, 361 (2006), which considered whether an ERISA plan's reimbursement claim could be brought under § 502(a)(3). *Sereboff* clarified that two key questions lie at the heart of any inquiry into the meaning of §502(a)(3): (1) whether a party's *claim* qualifies as "equitable" within the meaning of the statute; and (2) whether the *relief* a party seeks on that claim would have been "appropriate" in equity. *Id.* at 361-63.

In *Sereboff*, the Court's analysis was limited to the first of these questions. *See id.* at 363. After canvassing the relevant authority, this Court held that the plan's claim—arising from an express subrogation agreement and tied to a to-be-created fund—was cognizable in equity because it was "indistinguishable from an action to enforce an equitable lien established by agreement." *Id.* at 364-68. Having determined that the *claim* qualified as equitable under § 502(a)(3), this Court then declined to decide what *relief* would have been "appropriate" in the days of the divided bench, because that issue had not been preserved below. *Id.* at 368 n.2.

B. <u>This Litigation.</u>

1. In early 2007, James McCutchen was grievously injured when "a young driver lost control of her car, crossed the median of the road, and struck" Mr. McCutchen's vehicle. Pet. App. 3a. The accident was tragic; one of the four teenage passengers in the young driver's car was killed and

two suffered traumatic brain injuries. Joint Appendix ("JA") 40, 61. Mr. McCutchen survived only after emergency surgery and subsequently required extensive medical care. *Id.* at 61-62. He remains permanently disabled and suffers from chronic pain that cannot be relieved with medication. *Id.*

Uncontroverted evidence established that Mr. McCutchen's and his wife's total damages from the accident were between $1 million and $1.75 million. Pet. App. 29a. In addition to past medical expenses of $66,866, Mr. McCutchen suffered economic damages for past lost wages, future lost wages, and loss of earning capacity, and non-economic damages for pain and suffering, loss of enjoyment of life, and disfigurement. Mrs. McCutchen suffered loss of consortium. *See* JA 60-62.

Mr. McCutchen's health benefit plan, administered by U.S. Airways (the "Plan"), paid his medical expenses of $66,866. Pet. App. 3a. The policy under which the Plan paid Mr. McCutchen's medical expenses was not negotiated or signed by Mr. McCutchen. Under its terms, the Plan was obliged to pay Mr. McCutchen's medical bills regardless of whether (1) his injuries were caused by a third-party and (2) he would later decide to pursue relief against a third party. *Id.* at 4a.

Several months after the accident, the McCutchens retained a law firm, Respondent Rosen Louik & Perry, P.C., to represent them in a claim against the driver. With the firm's help, the McCutchens also made a claim for underinsurance coverage from their own separate automobile policy

because the driver had limited assets and liability coverage to compensate all four people injured in the accident. *Id.* at 3a.

On June 26, 2007, one of Mr. McCutchen's lawyers, Jon Perry, was contacted by Ingenix Subrogation Services, which informed Mr. Perry that it had been hired by United Healthcare to pursue a subrogation/reimbursement claim against Mr. McCutchen should he recover for his injuries. JA 42. The letter claimed that the Plan was governed by ERISA and that it was entitled to "a subrogation and/or reimbursement interest in this matter under applicable law." *Id.* at 42-43. It also instructed that "[o]nce settlement funds come into your possession, you should hold them in trust until such time as our client's interest has been severed from the interest of your client." *Id.* at 43.

Mr. Perry replied that same day, asking Ingenix to provide documentation that the Plan was in fact governed by ERISA and "self-funded." He also asked for a "complete copy of the plan or trust document." *Id.* at 44-45. This information was important because, if the Plan was governed by state law, its claim would have been barred by a Pennsylvania statute prohibiting insurers from seeking reimbursement from persons injured in motor vehicle accidents. *See* 75 Pa. Cons. Stat. § 1720.[1]

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[1] Until recently, Respondents had never seen the Plan that Petitioner claims governs this case, despite repeated requests that it be provided to them. The governing Plan was finally provided to all parties in June 2012, after this Court granted review, in response to a request from the Office of the Solicitor

(*Footnote continued*)

Ingenix provided neither a copy of the plan nor adequate documentation that it was self-funded. After waiting almost a year, on April 24, 2008 Mr. Perry contacted Ingenix again. JA 46-47. This time, he notified Ingenix that he and the other injured parties were trying to settle their claims out of what little money existed from the tortfeasor's insurance. He explained that "the accident at issue in this case involved multiple claimants with a very limited amount of insurance possessed by the at-fault driver," and he included correspondence detailing the proposed payments to the four claimants. *Id.* at 46-49. Mr. Perry further explained that, because the other injury victims were even worse off than Mr. McCutchen, the proposal allotted him only $10,000. Given the wholly "inadequate proceeds," Mr. Perry asked Ingenix to waive any alleged lien. *Id.* at 46-47. In a later letter, Mr. Perry also advised Ingenix that, although he planned to pursue a recovery out of Mr. McCutchen's own underinsured motorist ("UIM") policy, the Plan was not entitled to assert a lien on that claim under Pennsylvania law. *Id.* at 50.

Ingenix never answered whether the Plan would waive any lien claim, prompting Mr. Perry to send *another* letter, on July 3, 2008, imploring Ingenix to respond so that he could settle the underlying claim with the other claimants. "As you can see," Mr. Perry

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General of the United States. As it turns out, the express subrogation clause in the Plan contains several material differences from how that clause is explained in the Summary Plan Description. Whether these differences establish a basis for reformation under § 502(a)(3) is an issue to be explored on remand. *See CIGNA Corp. v. Amara*, 131 S. Ct. 1866, 1871 (2011).

explained, another claimant's attorney has "now threatened to move to impose sanctions on me for the unreasonable delay in resolving this matter. This matter remains unresolved because you have failed to respond to my prior correspondence relating to your alleged lien." *Id.* at 52.

With no other option, and still having heard nothing from Ingenix, Mr. Perry agreed to the proposed settlement, which allotted Mr. McCutchen only $10,000 for his injuries. He also successfully settled the McCutchens' UIM claim for policy limits of $100,000. He then sent a letter to Ingenix, advising it that that he had "resolved Mr. McCutchen's case for a payment of $10,000" and requesting that he be notified if the Plan still intended to assert a lien. *Id.* at 56.

Three months later, Mr. Perry received a notice from Ingenix that it was in fact asserting an alleged lien on Mr. McCutchen's combined recovery of $110,000—$10,000 from the tortfeasor's insurance and $100,000 from his own UIM policy—which amounted to, at most, 11% of his total damages. *See Id.* at 58.[2] Mr. Perry responded with yet another request for documentation substantiating the Plan's right to assert a lien. *Id.* at 58-59. Mr. Perry nonetheless escrowed $41,500 in his account, the amount of the Plan's asserted claim less a 40%

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[2] $110,000 is 11% of $1 million, the low-end estimate of the uncontroverted value of Mr. McCutchen's injuries. *See* Pet. App. 29a.

deduction for fees and expenses that should be borne by the Plan. *Id.*[3]

2. U.S. Airways then sued Mr. McCutchen and his lawyers in the Western District of Pennsylvania, seeking a constructive trust or equitable lien on the $41,500 held in trust by Mr. Perry and the remaining $25,366 personally from Mr. McCutchen. Pet. App. 4a. U.S. Airways based its claim for reimbursement on a provision in the Summary Plan Description that stated, among other things, that "[y]ou will be required to reimburse the Plan for amounts paid for claims out of *any monies recovered* from a third party, including, but not limited to, your own insurance company." *Id.* U.S. Airways argued that, under this language, the court was required to award the Plan 100 percent of the money it paid for medical expenses without deduction for the costs and fees incurred in obtaining that sum.

The district court granted U.S. Airways' request for 100% reimbursement, holding that it was duty-bound, under "established precedent of the Third Circuit" decided prior to this Court's decision in *Sereboff*, 547 U.S. 356, to apply contract law in measuring the award. Pet. App. 30a.

3. A unanimous panel of the Third Circuit reversed, holding that the phrase "appropriate

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[3] In light of the severity of Mr. McCutchen's injuries and his inadequate legal recovery, his attorneys ultimately decided to refund their fee, although they had a contractual right to forty percent of the recovery. That decision has no bearing on whether the Plan must share in the costs and fees incurred in obtaining the portion of the funds it seeks.

equitable relief" in § 502(a)(3) means "more than just that the relief [an ERISA Plan] seeks must be of an equitable *type*; courts must also exercise their discretion to limit that *relief* to what is 'appropriate' under traditional equitable principles." *Id.* at 9a (emphasis added).

In reaching this conclusion, the Third Circuit followed the roadmap set out by this Court's trilogy of § 502(a)(3) cases—*Mertens*, 508 U.S. 248, *Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204 (2002), and *Sereboff*—to determine whether the measure of relief sought by the Plan was "appropriate" in light of the "equitable principles and defenses that were typically applied." Pet. App. 10a-12a. It held that the district court had improperly discarded the treatises relied on by this Court in all of its § 502(a)(3) cases, which "*all* support [the] . . . position that the principle of unjust enrichment" applies to Petitioner's claim. *Id.* at 11a.

The court of appeals ultimately held that a judgment requiring Mr. McCutchen to provide full reimbursement to U.S. Airways "constitutes 'inappropriate' and 'inequitable' relief." *Id.* at 16a. "Because the amount of the judgment exceeds the net amount of McCutchen's third-party recovery," the court observed, the judgment "leaves him with less than full payment for his emergency medical bills, thus undermining the entire purpose of the Plan." *Id.* "At the same time," awarding full reimbursement to the Plan would amount "to a windfall for U.S. Airways, which did not exercise its subrogation rights or contribute to the cost of obtaining the third-party recovery." *Id.*

Concluding that "[e]quity abhors a windfall," *id.*, the Third Circuit vacated the district court's final judgment granting 100 percent reimbursement to U.S. Airways and remanded for a determination of what relief would be appropriate under relevant equitable principles.

SUMMARY OF ARGUMENT

A claim brought under § 502(a)(3) of ERISA turns on equity, not contract. The question in this case, then, is how courts would have treated claims like Petitioner's in the days of the divided bench.

In equity, where—as here—an insurer attempted to recover tort proceeds from an injured beneficiary, the insurer's potential relief was limited in two key respects, both based on the principle of unjust enrichment. First, where the beneficiary suffered damages beyond those covered by insurance, the insurer could only recover, at most, the share of the proceeds that compensated the beneficiary for losses paid for by the insurer—an amount equivalent to the beneficiary's "double recovery." Second, where the proceeds were generated by the efforts of the beneficiary's attorney, the insurer had to pay a proportionate share of the costs incurred in creating the "common fund," including attorney's fees. Absent fraud or other improper conduct on the part of the insured, those were the "appropriate" limits equity placed on every type of subrogation or reimbursement claim made in equity by an insurer.

Petitioner tries to avoid these principles by attempting to divorce this case from subrogation. Petitioner's truncated analysis of historical equity is

that (1) in equitable lien cases *not* involving subrogation, (2) equitable limits on subrogatory relief were not mentioned, so therefore (3) equitable liens are free from subrogatory limits. No credible authority concurs.

In reality, in cases involving tort subrogation, limiting rules such as "double recovery" and "common fund" were not suspended simply because the insurer sought to enforce its equitable right through an "equitable lien by agreement." Indeed, irrespective of the remedial *vehicle* used to invoke equity jurisdiction—including, yes, equitable liens by agreement—the authorities are quite clear that the available *relief* was subject to double recovery and common fund limits. To conclude otherwise would be to wipe out entire chapters of what equity courts considered appropriate relief.

Ultimately, Petitioner seeks to pervert ERISA's enforcement scheme by enforcing whatever terms it writes into an ERISA plan, regardless of equity's view of those terms, and to obtain a judgment for contractual damages against an individual for breach. This sort of relief has a name—"contractual legal relief"—and whatever the appeal of contractual relief, it is not contemplated by § 502(a)(3). To be sure, § 502(a)(3) contains a reference to the "terms of the plan," but that language governs the types of *claims* a plan can bring and does not override the fact that § 502(a)(3) limits the *relief* to "appropriate equitable relief."

In this respect, the Legislature's will must be followed regardless of Petitioner's policy concerns about the result. In any event, those concerns are

unsubstantiated. Petitioner and its numerous *amici* have offered no evidence that the lower court's approach will wreak havoc on ERISA plans. This alone is reason enough to reject their conjecture and scare tactics. Additionally, the available evidence reveals that the Third Circuit's approach, which simply authorizes courts to apply the same rules that have always applied to subrogation cases in equity, will not have any substantial impact on either ERISA plans or beneficiaries.

At base, Petitioner's hyperbole should be dismissed for what it is: an attempt to hide the fact that a claim for 100 percent reimbursement against an injured beneficiary who has only recovered a fraction of his damages is not "appropriate equitable relief" within the meaning of § 502(a)(3).

ARGUMENT

THE DECISION BELOW IS FAITHFUL TO ERISA, HISTORICAL PRINCIPLES OF EQUITY, AND PUBLIC POLICY.

I. The Third Circuit's Approach Is Consistent with How Petitioner's Claim Would Have Been Measured In the Days of the Divided Bench.

This case is about "subrogation," a term used to describe the right of an insurer to either (1) stand in the shoes of the insured on a claim for compensation against a third party, usually a tortfeasor, or (2) directly pursue repayment against an insured who has recovered compensation from a third party. *See*

29A Am. Jur. Subrogation § 1719, at 797-98 (1962); *id.* § 1736, at 812-13.[4]

Petitioner, an insurer, paid Mr. McCutchen, an insured, for medical losses he suffered under an insurance policy that contains an express subrogation provision, which by its terms authorizes the Plan to exercise either of the above rights. In this case, Petitioner opted for the latter, pursuing reimbursement directly against Mr. McCutchen. But whether an insurer chooses to sue a tortfeasor directly, or—as here—waits to seek reimbursement from an insured's third-party recovery, the insurer's relief is measured by the same specific equitable rules that applied to all subrogation-based claims. *Knudson*, 534 U.S. at 204 n.1.

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[4] A brief word about terminology: As one scholar has observed, "For those who do not often visit the field of subrogation, the basic terminology can be confusing to the point of frustration." 16 Couch on Insurance 3d § 222:2 (L. Ross & T. Segalla eds., 3d ed. 2012). Generally speaking, "subrogation" is an umbrella term that encompasses several distinct, but related, rights. First, an insurer has the right to pursue relief directly against a third party to recover expenses paid on behalf of an insured. That right is typically—and confusingly—called "subrogation." *Id.* Second, in cases where—as here—an injured beneficiary has alone pursued relief directly against a tortfeasor, the insurer has the right to pursue repayment from the insured after the underlying case has been concluded. That right is typically called "reimbursement," although it falls under the umbrella use of the term "subrogation." *Id.* In equity and still today, the two doctrines are functionally intertwined, and, for present purposes are governed by the same controlling principles. *See Newcomb v. Cincinnati Ins. Co.*, 22 Ohio St. 382 (Ohio 1872); 73 Am. Jur. 2d Subrogation § 6 (2012).

A. In Equity, All Subrogation-Based Claims Were Capped by the Amount of an Insured's Double Recovery.

1. At its most fundamental level, the doctrine of subrogation embodies a desire to ensure parity between three related parties—a tortfeasor, an injured beneficiary (often referred to as an "insured"), and an insurer—by allowing the insurer to recoup money it paid out on its beneficiary's behalf, either by suing the tortfeasor directly or (as in this case) seeking reimbursement from the beneficiary in the event he recovers damages from the tortfeasor. *See generally* 174 John Appleman & Jean Appleman, Insurance Law and Practice § 4054, at 142-46 (1981); 16 Couch on Insurance 2d § 61:18, at 93-96 (Rev. ed. 1983); 4 G. Palmer, Law of Restitution § 23.16(b), at 444-48 (1978).

An insurer's rights of subrogation or reimbursement can arise in one of two ways: either (1) contractually, when the insurer's subrogation and reimbursement rights were provided for by agreement, or (2) impliedly, where, in the absence of an express agreement, an insurer who has paid some loss under a policy may then later seek to recover for that payment. 29A Am. Jur. Subrogation § 1719, at 797-98; *see id.* at § 1736, at 812. (The implied right of subrogation is sometimes referred to as a "freestanding" subrogation claim. *See Sereboff*, 547 U.S. at 368 (distinguishing between an implied, or "freestanding," subrogation claim and one based on an "express agreement")). Either way, because these rights were "properly a matter of equitable cognizance," a party who sought to enforce a

subrogation-based right typically did so in a court of equity. *See* 60 C.J. § 125. And, as explained below, the same principles applied to the relief available for all subrogation and reimbursement claims presented in equity, regardless of whether they were based on a written agreement.

2. In equity, subject to certain limits not relevant here, one key rule governed *all* subrogation-based claims between an insurer and insured: the principle of unjust enrichment, which limited the insurer to recovering no more than the amount of the insured's double recovery. *See* 16 Couch on Insurance 3d, *supra*, § 222:8 (explaining that the doctrine of subrogation "has the objective of preventing the insured from recovering twice for one harm"); *see* 174 Appleman, *supra*, § 4054, at 143 (noting that the doctrine "rests on maxim that no one should be enriched by another's loss").

"Double recovery" is said to occur when an injured beneficiary recovers money from both his insurer and a third party, such as a tortfeasor, for the same loss, for example, medical expenses. For reimbursement claims, the rule capping an insurer's recovery at the amount of the insured's double recovery means an insurer can recover no more than the "part of the recovery which the claimant establishes was in compensation for the same loss." 4 Palmer, *supra*, § 23.16(b), at 444.[5]

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[5] This rule dates back centuries. *See, e.g.*, *Randal v. Cockran*, 27 Eng. Rep. 916, 916 (1748) (explaining that once the insurer provided payment for loss, "the assured stands as a

(*Footnote continued*)

In a case where the injured party is fully compensated for all of his damages, the double-recovery rule does not limit the insurer's recovery in any respect. Thus, for example, assume a case in which an injured beneficiary incurs $10,000 in medical expenses, which are paid by his insurance plan. He then sues the tortfeasor and ultimately recovers an amount—say, $50,000—that compensates him fully for *all* his damages, which include (for example) both medical expenses and loss of future earnings. In that situation, because the beneficiary was fully compensated for his injuries, his "double recovery" consists of the full amount of his medical expenses—$10,000—which he recovered from both his insurer and the tortfeasor. In equity, this is the amount the insurer would be entitled to recover, minus its fair share of attorneys' fees and costs. *See, e.g.*, 176 Appleman, *supra*, § 4096, at 283.[6]

But in cases where the injury victim only recovers a fraction of his total damages (where, for example, multiple claims have been made against the wrongdoer, or the wrongdoer is insolvent), or where he recovers for *other* damages unrelated to the insurer's payments, application of the double recovery rule means that the insurer is only entitled

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trustee for the insurer, in proportion for what he paid" for any losses "restored *in specie* or compensation made for them"); *Comegys v. Vasse*, 26 U.S. 193, 214 (1828) ("Whatever may be afterwards recovered or received . . . *as a compensation for the loss*, belongs to the underwriters.") (emphasis added).

[6] The deduction of attorney's fees and costs is pursuant to the common fund doctrine, a separate equitable principle discussed below at Part I.B.

to recover the portion of the recovery that was covered by the insurance policy. *See id.* at 287 (explaining that the insured is "only liable for the insurer's pro rata share of a recovery . . . where the insured has also recovered for other items of damage"); 29A Am. Jur. Subrogation § 1739, at 815 (explaining that, although an insurer has "a right to share in the proceeds of a recovery against or settlement with the tortfeasor in favor of the insured," that right does not permit recovery of proceeds that "represent the satisfaction" of the insured's other losses); 16 Couch on Insurance 2d, *supra*, § 61:29, at 111-12 ("[W]hen the insurer is partially subrogated by virtue of having paid the property damage of the insured and the latter then brings an action for both property and personal damage, the insured holds *that part of the fund recovered which represents the damages to the car* as a trustee for the benefit for the insurer.") (emphasis added).

Example: Assume, in the above case, that the injured beneficiary recovers only one-half of his total damages from the tortfeasor ($25,000, in the above example) due to, say, limited insurance. In that instance, the double recovery rule would limit the insurer's recovery to that portion of the fund that compensated for the medical expenses, minus a proportionate share of costs and fees. This apportionment ensures that the insurer only recovers to the extent that the beneficiary has been

"unjustly enriched" by recovering twice for the element of damage covered by the insurance.[7]

3. This limitation on an insurer's recovery, importantly, applied regardless of whether a subrogation claim was based on an express agreement or simply arose by virtue of payment. So long as an insurer seeks to recoup insurance proceeds in equity—whether its action sprung from a written agreement or not—its relief was subject to the double recovery limitation rooted in equity's prohibition against unjust enrichment. *See* 16 Couch on Insurance 2d, *supra*, § 61:20, at 98 (explaining

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[7] In practice, courts applied one of several approaches to measuring an insured's double recovery, including (1) an approach that limited insurers to a pro rata share of advanced medical expenses, measured by comparing the insured's recovery with his total damages, *see, e.g.*, 176 Appleman, *supra*, § 4906, at 287, and (2) a rule of proof method, in which a court might use a rebuttable presumption that the fund either did or did not amount to compensation for insured harms, subject to rebuttal by either the insurer or the insured. *See* 29A Am. Jur. Subrogation §1739, at 815; 4 Palmer, *supra*, §23.16(b), at 444; *see also Peterson v. Ohio Farmers Ins. Co.*, 191 N.E.2d 157 (Ohio 1963). (As explained below, the "make-whole" rule is sometimes viewed as another variant of the double recovery rule, but Respondents are not urging its application here.) Importantly, *none* of the accepted approaches involved doing what Petitioner contends a court *must* do, which is to refer exclusively to the terms of the subrogation provision. That view transforms the nature of relief from one based on an insured's double recovery to one based on an insurer's loss under the contract. Nonetheless, which approach is appropriate here, and how a court will ascertain how much of Mr. McCutchen's recovery constitutes compensation for losses paid by Petitioner, are questions properly left for the district court on remand. *See CIGNA*, 131 S. Ct. at 1880.

that subrogation-based rights "remain[ ] basically equitable in character, and hence, subrogation is to be accorded upon equitable principles *even though the right thereto . . . is contractually declared*.") (emphasis added); 6A Appleman, *supra*, § 6503, at 441 (observing that subrogation-based rights are "required to be so administered as to secure real and essential justice *without regard to form*, and is deemed to be *independent of any contractual relations* between the parties affected") (emphasis added).

Indeed, the leading treatise on restitution, cited by this Court in *Sereboff*, 547 U.S. at 368, states that the "principle of unjust enrichment," in the form of a rule capping an insurer's recovery to the insured's double recovery, applies across the board to subrogation-based claims brought in a court of equity. *See* 4 Palmer, *supra*, § 23.18(d), at 470 (principle of unjust enrichment applies to freestanding subrogation-based claims) *with id.* at 472-74 ("that same principle" applies to claims based on express subrogation agreement).[8]

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[8] Certain exceptions exist, though none are relevant here. In some cases, equity courts permitted an insurer to modify the *timing* of its right to pursue subrogation. *Compare Morrow v. U.S. Mortgage Co.*, 96 Ind. 21, 26-27 (1884) *with Home Ins. Co. v. Hartshorn*, 91 So. 1, 2 (Miss. 1922). In others, an insurer was permitted to pursue its reimbursement claim in a court of law, seeking damages on a breach of contract theory. *See, e.g.*, *Ill. Auto. Ins. Exch. v. Braun*, 124 A. 691 (Pa. 1924); *Universal Ins. Co. v. Millside Farms, Inc.*, 197 A. 648, 649-50 (N.J. 1938); *Home Ins. Co. v. Bernstein*, 16 N.Y.S.2d 45, 48-49 (N.Y. Mun. Ct. 1939); *James v. Emmco Ins. Co.*, 30 S.E.2d 361 (Ga. Ct. App. 1944). In *Braun*, for example, the court allowed the insurer to

(*Footnote continued*)

So—whether an insurer brought a freestanding claim for reimbursement or a claim based on an express subrogation clause—if that claim was in equity, the insurer could not have recovered any more than the part of the recovery that was in compensation for the loss it had paid. This held true in medical insurance cases no less than in property insurance cases. *Compare id.* at 474 ("[T]he insurer's claim should be limited to the net amount recovered by the insured *for medical expense*.") (emphasis added) *with* 29A Am. Jur. Subrogation § 1739 (the insurer's claim is limited to the amount recovered for "damages to the insured property"); *see also* 4 Palmer, *supra*, § 23.18(d), at 473-74 (the double recovery rule "should serve to limit the effectiveness of contract provisions which in terms provide for reimbursement out of the insured's tort recovery without regard to whether or the extent to which, that recovery includes medical expense").

Cases prior to the law-equity merger consistently applied this rule to subrogation claims based on an express subrogation clause, even where that clause expressly sought to disclaim this limit. In *Svea Assurance Co. v. Packham*, 92 Md. 464 (1901), for example, an insurer's express subrogation clause

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recover damages under its policy (which contained a subrogation clause) where the insured had settled with the wrongdoer without giving notice to the insurer. 124 A. at 692; *see generally* 51 A.L.R. 2d 697, at § 4 (1957) (discussing *Braun* and other cases). In this case, because Petitioner's claim arises under § 502(a)(3), it may not pursue a claim for damages under a contract.

authorized recovery to "the extent of [its] payment" from "all right[s] of recovery by the insured." *Id.* at 360. The insurer argued that this clause defeated the double recovery cap and entitled it to recover everything it had paid to the insured. *Id.* The court refused to award the insurer this relief, explaining that, because only a portion of the underlying settlement compensated for the losses covered by the insurer, the insurer was limited to recovering no "more than its proportion of the amount recovered, after deducting costs and expenses." *Id.* at 363. "It would be very inequitable," the court admonished, to permit the insurer to "refuse to take part in a suit brought by the insured," let him settle "for an agreed amount," and then "come into a court of equity and exact payment in full of him, when the others only get a part." *Id.*; *see also Knaffl v. Knoxville Banking & Trust Co.*, 182 S.W. 232, 233 (Tenn. 1916); *Fire Ass'n of Phila. v. Wells*, 84 N.J. Eq. 484, 486 (N.J. 1915); *Camden Fire Ins. Ass'n v. Prezioso*, 93 N.J. Eq. 318 (N.J. Ch. 1922).

Petitioner's approach here was no different than that of the insurer in *Svea*. As in that case, Petitioner was informed of the underlying case but refused to respond when asked repeatedly whether it planned to assert or waive its lien (it even refused to prove that it had an enforceable lien). Petitioner then argued that its express subrogation clause should override the reimbursement limits that would typically have applied to its relief. No court in equity would have allowed it to so profit. *See Svea*, 92 Md. at 363 (rejecting insurer's attempt to "seek to profit by its refusal to take part in that proceeding, on the theory that it was not a party to the settlement, and

hence is not bound by it"); *see also Shawnee Fire Ins. Co. v. Cosgrove*, 116 P. 819, 820 (Kan. 1911) (holding that where insurer made no effort to intervene, it could not hold the insured responsible for settling the case as he thought best); *but see Peterson*, 175 Ohio St. at 38 (permitting 100 percent reimbursement based on express subrogation agreement where insurer "cooperat[ed] and assisted in proceedings against the wrongdoer").

Courts that still sit in equity continue to apply the double recovery cap on an insurer's relief. For instance, the Supreme Court of Tennessee, reviewing an equity court, was presented with a subrogation provision that purportedly gave the insurer the right to recover everything it paid even though the insured had not obtained a double recovery. The court held that, because the insurer's claim for reimbursement sounded in equity, it could not defeat those equitable principles by contract, on the ground that "[t]he purpose of insurance subrogation is to prevent either the unjust enrichment of the insured through a double recovery or a windfall benefit to the principal tortfeasor." *Wimberly v. Am. Cas. Co. of Reading, Pa. (CNA)*, 584 S.W.2d 200, 203 (Tenn. 1979); *see also N. River Ins. Co. v. McKenzie*, 74 So.2d 599, 605-06 (Ala. 1954) (explaining that absent fraud by insured, insurer's recovery from insured's settlement limited to amount awarded for damages covered by the insurance contract); *Emp'r's Liab. Assur. Corp., Ltd., of London v. Daley*, 51 N.Y.S.2d 567, 570 (N.Y. Sup. Ct. 1944) (explaining that insurer has no right of subrogation for damages claims other than the types of damages covered by the insurance contract).

The double recovery cap was in fact so well-established that many courts of *law* have applied this limit on relief to legal claims for reimbursement. *See, e.g.*, *Am. Auto. Ins. Co. v. Seaboard Surety Co.*, 318 P.2d 84, 87 (Cal. Dist. Ct. App. 1957) ("The principle of equitable subrogation overrides the terms of the insurance policies."); *Miller v. Liberty Mut. Life Ins. Co.*, 48 Misc. 2d 102, 107, 264 N.Y.S.2d 319 (N.Y. Sup. Ct. 1965), *aff'd mem.* 289 N.Y.S.2d 726 (1968) (limiting insurer to only those settlement proceeds allocable to medical expenses despite agreement claiming right to recover "the proceeds of any settlement or judgment"); *DeCespedes v. Prudence Mut. Cas. Co.*, 193 So.2d 224, 227 (Fla. App. 1966), *aff'd* 202 So.2d 561 (Fla. 1967) ("So long as subrogation, as applied to this medical pay provision, serves to bar double recovery, it should be upheld."); *Aetna Life & Cas. Co. v. Nelson*, 492 N.E.2d 386, 390 (N.Y. 1986) ("[I]n cases where an injured person, who has obtained reimbursement for . . . medical expenses from an insurer, is subsequently reimbursed by the tort-feasor for the same injuries, a lien attaches on behalf of the insurer to that portion of the recovery.").[9]

Some courts and state legislatures have, in the interest of protecting insureds, elected to apply the

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[9] The rare circumstances in which courts refused to apply the double recovery cap to an insurer's claim for reimbursement have no bearing on this case. These exceptions were largely limited to cases of fraud or gamesmanship on behalf of the insured, *e.g.*, *N. River Ins. Co.*, 74 So.2d at 605 (fraud); *Hayward v. State Farm Mut. Auto Ins. Co.*, 4 N.W. 2d 316 (Minn. 1942) (same), which did not occur here.

"double recovery" cap *after* an insured has first recovered all of its losses, so that an insurer could only recover in cases where the insured has been made whole for his injuries. *See, e.g.*, *Washtenaw Mut. Fire Ins. Co. v. Budd*, 175 N.W. 231, 232 (Mich. 1919). These decisions, adopting what is known as the "make-whole rule," do not change the overall *ceiling* on an insurer's recovery, which remains the amount of an insured's "double recovery"; they simply change *when* that measure will be applied (only after the insured has recovered its damages). In this case, Respondents have not pressed application of the make-whole rule, arguing only that Petitioner's recovery must be capped by the measure of Mr. McCutchen's double recovery, the traditional ceiling on an insurer's recovery under any subrogation-based claim in equity.

Were Petitioner's contrary view correct—that is, if the assertion of an equitable lien based on an express subrogation agreement would be free of all equitable limitations—then every lawyer over the past two centuries who sought reimbursement based on an express subrogation clause could have defeated equity's rules simply by styling the claim as one for an "equitable lien by agreement." This did not happen because it was well understood that an equity court would apply the double recovery cap no matter how the claim was styled, so long as it was brought as an exclusively equitable claim. Because Petitioner's claim is, by necessity, exclusively equitable (otherwise it would not be cognizable under § 502(a)(3)), that cap necessarily applies in this case.

B. In Equity, Every Claimant Who Stands to Benefit from the Creation of a Common Fund Must Pay Its Proportional Share of the Fees and Costs Incurred to Create the Fund.

The second rule of limitation applicable to Petitioner's claim is one of the most well-settled rules in equity: the common fund rule. "Since the decisions in *Trustees v. Greenough*, 105 U.S. 527 (1881), and *Central RR & Banking Co. v. Pettus*, 113 U.S. 116 (1885), this Court has recognized consistently that a litigant or a lawyer who recovers a common fund for the benefit of persons other than himself or his client is entitled to a reasonable attorney's fee from the fund as whole." *Boeing Co. v. Van Gemert*, 444 U.S. 472, 478 (1980) (citations omitted).

1. Like the double recovery cap, the common fund rule rests on the principle of unjust enrichment. *See id.* at 478; *Mills v. Elec. Auto-Lite Co.*, 396 U.S. 375, 392 (1970). And, because this rule "reflects the traditional practice in courts of equity," *Boeing*, 444 U.S. at 478, a court sitting in equity possesses the authority to apply it "in any situation in which the work of the attorney has produced a fund . . . and in which the benefits are accepted by others." 1 Dobbs, D., Law of Remedies, § 3.10(2), at 393 (2d ed. 1993). When that occurs, "those who share in the fund . . . are therefore responsible for a proportionate part of the attorney fee and other reasonable costs of litigation." *Id.* at 393; *Boeing*, 444 U.S. at 478.

2. Although the common fund doctrine has been applied in a number of different settings, courts have consistently found that it applies in cases involving an insurer's exercise of its subrogation and

reimbursement rights in equity. As Dobbs explains, the "ordinary automobile collision may produce a common fund if the car owner who has been paid by his collision insurer recovers sums from the tortfeasor that include car damages. In such a case the insurer is entitled to share in the recovery . . . *but with a deduction for its share of the attorney fee*." 1 Dobbs, *supra*, § 3.10(2), at 394 (emphasis added).

That is exactly this case. Mr. McCutchen was involved in an automobile collision that "produce[d] a common fund" when he "recover[ed] sums from the tortfeasor" that "include[d] . . . damages." As every equitable authority confirms, "[w]here the insured prosecutes the suit against the tortfeasor, thereby incurring legal expenses and court costs, . . . the insurer must at least pay its proportionate share of the expenses." 16 Couch on Insurance, *supra*, § 61:47, at 131; *see also* 4 Palmer, *supra*, § 23.18(d), at 471-72 (any award must "take account of the costs of collecting medical expenses from the tortfeasor, in order to limit the insurer's claim to the insured's *net recovery*") (emphasis added); 203A Appleman, *supra*, § 4903.85, at 335 ("It is *grossly inequitable* to expect an insured, or other claimant, in the process of protecting his own interest, to protect those of the company as well and still pay counsel for his labors out of his own pocket or out of the proceeds of the remaining funds.") (emphasis added).

This is the view of an "overwhelming majority" of decisions, both pre-merger and after: "[A] proportionate share of fees and expenses must be paid by the insurer or may be withheld from its share." *Id.* at 335. In *Faust v. Luke*, 364 N.Y.S.2d

344, 347 (N.Y. Civ. Ct. 1975), for example, the court held that "[i]t is manifestly unjust to require the recipient of medical payments, who pays a premium for such coverage, and who is called upon to grant a right of subrogation to the payor, to then, through his or her lawyer, act as a collection agency for the paying carrier in a suit against the tortfeasor." Numerous other cases are in agreement.[10]

Courts endorsing the common fund rule all recognize that allowing an insurer—like Petitioner here—to "sit back and become enriched by the fruits of [the insured's] efforts and endeavors" would unjustly enrich the insurer. *Id.* at 347; *see also* 4 Palmer, *supra*, § 23.18(d), at 472 n.56 (an "insurance carrier is unjustly enriched if the insured is forced to bear the cost of recovering medical payments for the carrier's benefit"). Indeed, here, Petitioner made no attempt to participate in the underlying action. Instead, it sat idly by and now seeks to collect the fruits of Mr. McCutchen's and his lawyers' labor. No court of equity would permit this result.[11]

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[10] *See, e.g.*, *Lee v. State Farm Mut. Auto. Ins. Co.*, 129 Cal. Rptr. 271, 275 (Cal. Ct. App. 1976); *Baier v. State Farm Ins. Co.*, 361 N.E.2d 1100, 1102 (Ill. 1977); *Nat'l Union Fire Ins. Co. v. Grimes*, 153 N.W.2d 152, 155-56 (Minn. 1967); *State Farm Mut. Auto. Ins. Co. v. Clinton*, 518 P.2d 645, 646-47 (Or. 1974); *Hospital Service Co. v. Pa. Ins. Co.*, 227 A.2d 105, 111 (R.I. 1967); *Metro. Life Ins. Co. v. Ritz*, 422 P.2d 780, 783 (Wash. 1967).

[11] Those "few decisions in which attorney's fees have been denied," 203A Appleman, *supra*, § 4903.85, at 339, arose under well-defined exceptions, not applicable here. *See, e.g.*, *Cary v. Phoenix Ins. Co.*, 78 A. 426 (Sup. Ct. Err. 1910) (fraud); *Braun*, 124 A. 691 (insurer brought purely legal claim to enforce plan

(*Footnote continued*)

3. The common-fund rule is applicable regardless of whether the subrogation claim is based on an express agreement. The doctrine applies to *any* case "in which the work of the attorney has produced a fund . . . and in which the benefits are accepted by others." 1 Dobbs, *supra*, § 3.10(2), at 394. Permitting an insurer to defeat this equitable rule of limitation through contract "would allow the plan to free ride on the efforts of the plan participant's attorney, contrary to the equitable concept of 'common fund' that governs the allocation of attorney's fees" in this type of case. *Wal-Mart Stores, Inc. Assocs.' Health & Welfare Plan v. Wells*, 213 F.3d 398, 402 (7th Cir. 2000).

Wells went on to illustrate the unfairness that would result if an insurer could defeat the common-fund doctrine by disclaiming it in an insurance contract:

> Suppose [the insured] had obtained a settlement of $12,000 of which her lawyer got $4,000 pursuant to a standard contingent-fee contract, leaving her with $8,000. Since the settlement would exceed $10,982.61 [the amount paid by the insurer], the plan under its theory would be entitled to that entire amount, leaving her worse off by $2,982.61 than she would have

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terms); *Bradford v. Am. Mut. Liab. Ins. Co.*, 245 A.2d 478 (Pa. Super. Ct. 1968) (no claim had been made under an insurer's medical payment provision so that no subrogation arose); *Travelers Ins. Co. v. Williams*, 541 S.W.2d 2d 587 (Tenn. 1976) (insurer notified insured that it would handle the matter personally).

> been had she not sued. This would be true even if she had sought no medical benefits, or any other benefits available under the plan, in that suit—it might have been a suit purely for damage to her car.

Id. at 402.

That scenario is not just a hypothetical—it is this case. The Plan's rule leaves Mr. McCutchen "worse off" than if he had not sought to recover for his injuries. *Id.* "This prospect," as the *Wells* court observed, "might well deter a suit likely to result in a judgment or settlement not much larger than the benefits available under the plan," and would "produce undercompensation for harms that were unrelated to the type of harm to which the benefits pertain." *Id.*

4. Petitioner's assertion that its claim takes precedence over the lawyer's claim for attorney's fees is mistaken for another reason. The common fund charge attaches not only to all portions of the fund, no matter who claims a right to them, but also attaches *before* any other party can assert its right to the fund. *See generally Winslow v. Harold G. Ferguson Corp.*, 153 P.2d 714, 719 (Cal. 1944) ("[C]ounsel fees are customarily made senior to other claims against the fund."); *Puett v. Beard*, 86 Ind. 172, 174 (1882) ("It is generally agreed . . . that a solicitor has a lien for his costs upon a fund recovered by his aid, paramount to that of persons interested in the fund, or those claiming as their creditors."); *see also* John P. Dawson, *Lawyers and Involuntary Clients: Attorney Fees From Funds*, 87 Harv. L. Rev. 1597, 1606-07 (1974) (explaining that

the common fund charge on a fund "is a first charge on the fund and must be satisfied before any distribution occurs").

Beyond this, the common fund rule operates to confer *a separate* equitable lien upon the attorney, implied to prevent unjust enrichment, which allows *the attorney himself* to come into a court of equity seeking enforcement. *See Pettus*, 113 U.S. at 127. In *Pettus*, this Court explained that the common fund rule permitted a court in equity to "declar[e] a lien upon the property in question to secure such compensation as [the attorneys] were entitled," because "an attorney at law or solicitor in chancery has a lien upon a judgment or decree obtained . . . to the extent to which he is entitled to recover, viz., reasonable compensation for the services rendered." *Id.*; *see Kuhn v. Colorado*, 924 P.2d 1053, 1058 (Colo. 1996) (noting that this Court "has consistently recognized a substantive right held by the attorney who participates in litigation that creates a common fund to be reasonably compensated out of that fund").[12]

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[12] The United States agrees that attorney's fees should be apportioned between Mr. McCutchen and U.S. Airways under the common fund rule, and that apportionment should be subject to a reasonableness determination. Gov't Br. 26, 27 n.10 (citing *Pettus*, 113 U.S. at 128). The Third Circuit also concluded that an inquiry into the reasonableness of attorney's fees was appropriate, and properly remanded for that purpose. Pet. App. 17a. And courts are more than competent to handle reasonableness determinations. *See, e.g.*, *Mathews v. Bankers Life & Cas. Co.*, 690 F.Supp. 984, 988-89 (M.D. Ala. 1988).

Thus, an attorney can assert this lien irrespective of any other liens already existing or that come into existence when the fund is created, *see, e.g.*, *Wash. Gas Light Co. v. Baker*, 195 F.2d 29, 33-34 (D.C. Cir. 1951); *Krause v. State Farm Mut. Auto. Ins. Co.*, 169 N.W.2d 601, 605-06 (Neb. 1969), and the attorney's lien may not be defeated by any contractual provision disclaiming such a lien between client and plan, so long as the fund was created through the attorney's effort and for the benefit of multiple parties. *See Baier*, 361 N.E.2d at 1102.

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In short, Petitioner's understanding that, "as best as [it] can tell," courts sitting in equity have "*never* done what the Third Circuit did here"—limit Petitioner's subrogation-based claim by applying the principles of unjust enrichment—gets it exactly wrong. Pet. Br. 34. What the Third Circuit did here was *precisely* what courts have done for centuries when resolving purely equitable claims brought by insurers to obtain subrogation.

II. Petitioner's Attempt to Avoid Subrogation Principles Should be Rejected.

Petitioner tries to avoid subrogation principles entirely, arguing that because this case involves an equitable vehicle called "lien by agreement," its subrogation agreement must be enforced as written.

Petitioner advances two arguments justifying its claim: first, that *Sereboff* itself supposedly wiped subrogation principles off the table; and, second, that equitable-lien-by-agreement cases from outside the

subrogation setting dictate that the relief must be based entirely on the agreement. Neither argument withstands scrutiny.

A. *Sereboff* Did Not Foreclose Application of Principles of Subrogation.

Petitioner misreads *Sereboff* as foreclosing the application of centuries-old equitable principles when determining the value of a reimbursement claim. *Sereboff* solely involved the question of whether the plan there had asserted a claim that was cognizable in equity. It did not involve the question of what relief a plan was entitled to receive on proof of that claim, because the Sereboffs failed to "raise[] this distinct assertion below." 547 U.S. at 368 n.2.

The Sereboffs argued that the plan's claim was not cognizable in equity, because the tracing requirements that served as a necessary condition for "freestanding" action for equitable subrogation, were not met. *Id.* at 368. This Court explained that the Sereboffs were missing the point, because there are different vehicles by which a claimant can open equity's doors, and the plan's reimbursement claim was "indistinguishable" from a lien by agreement—which, although different from a "freestanding" subrogation claim—was nonetheless a claim that equity typically recognized. *Id.*

There was no suggestion by either the Court or the plan in *Sereboff* that the relief available under a lien by agreement could contravene the traditional limits that equity imposed on subrogation and reimbursement claims. Indeed, the plan in Sereboff

actively *embraced* the foregoing principles, taking pains to explain that its "claim for reimbursement, unlike a breach-of-contract claim, limits recovery to the amount received for the particular loss that the insurer has already indemnified." Brief for Respondent at 14-15, *Sereboff v. Mid Atl. Med. Servs., Inc.*, 547 U.S. 356 (2006) (No. 05-260). Citing Palmer, the plan explained further that "an insurer's subrogation-based rights are driven by the fundamentally equitable concern to prevent or reverse unjust enrichment, rather than to make the insurer whole through breach-of-contract damages." *Id.* at 15.

Now, just six years after this Court *agreed* with the plan there and allowed it to bring its claim under § 502(a)(3), Petitioner vehemently rejects the way the plan characterized its claim in *Sereboff* and reads this Court's ruling as authority for categorically departing from equity's limits on reimbursement. This "have-my-cake-and-eat-it-too" approach is not, as Petitioner claims, mandated by *Sereboff*. *Sereboff* was a limited decision about the different species of equitable vehicles that could win reimbursement relief, not an opinion expanding beyond equitable recognition the relief available in reimbursement cases.

As explained above, regardless of which vehicle was used to pursue relief in equity, the rules limiting the availability of relief were the same: an unjust enrichment-based cap on the amount of an insurer's recovery and a requirement to apply a common-fund deduction. It bears reiterating Palmer's teaching on this exact point: The principle of unjust enrichment

applies to a reimbursement lien claim based on an express subrogation clause. 4 Palmer, *supra*, § 23.18(d), at 473-74.

Under the Plan's contrary approach, these equitable limitations have no application. The Plan insists that, so long as an insurer's subrogation provision meets the initial "criteria" identified in *Sereboff*—the provision "identifies a particular fund distinct from [a beneficiary's] general assets" and a "particular share of that fund to which [the Plan] was entitled"—that "should be the end of the matter." Pet. Br. 22, 31. After that, a court sitting in equity must award the Plan whatever that provision says it can get.

This cannot be right. Under Petitioner's approach:

1. Fiduciaries could enforce plan language conditioning the payment of insured medical expenses on acceptance of a lien against the entirety of any future tort settlement with (or judgment against) a third party whose conduct generated the need for medical treatment. Such would be true even if the value of the settlement or judgment were five, ten, or even one-hundred times the value of medical expenses advanced.[13]

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[13] Such a lien would be unheard of today; however, it is not fanciful. Indeed, it is a proposal championed by a notable economist and a current Harvard Law School professor. Kenneth S. Reinker and David Rosenberg, *Unlimited Subrogation: Improving Medical Malpractice Liability by Allowing Insurers to Take Charge*, 29 J. Legal Stud. S261, S262 (2007) ("[W]e advocate

(*Footnote continued*)

2. Fiduciaries could condition the payment of insured medical expenses on acceptance of a lien against property entirely unrelated to the sickness or accident triggering the medical payment (for example, "100 percent of any future inheritance received by the insured").

3. Perhaps most troubling, fiduciaries could obtain recoupment of overpayments (often already spent, in good faith, by their recipients on basic life needs) through enforcement of an equitable lien by agreement even if the overpayment was based on a fiduciary's breach of some obligation. As Petitioner and its *amici* correctly note, *see* Blue Cross Blue Shield Br. 12; Chamber of Commerce Br. 16, § 502(a)(3) is the provision that permits fiduciaries to seek recoupment of overpayments made to participants and/or beneficiaries. Under the status quo, claims for recoupment cannot succeed when the need for overpayment is caused by a breach of fiduciary duty. *Adams v. Brink's Co.*, 261 Fed. App'x 583, 596-97 (4th Cir. 2008) (no overpayment restitution where plan breaches its fiduciary duty). If Petitioner's position is accepted, that would ostensibly change.

These hypotheticals may seem far-fetched, but they are all perfectly consistent with Petitioner's theory. If, as Petitioner says, an "equitable lien by

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allowing insurers to subrogate the full potential medical malpractice claims of their insureds without regard to how much the insurer may recover by way of subrogation or how much it pays or promises the insured.").

agreement"—any lien that "identifies a particular fund" and a "particular share of that fund to which [the plan is] entitled"—must be enforced as written in any case absent a showing of fraud, usury, or mistake, why would Plans stop with merely requesting 100 percent reimbursement out of third party recoveries? By decoupling its remedy from the traditional subrogation-based limits, Petitioner's approach has no logical stopping point. It defies reason to think that Congress intended such a result when it limited plan fiduciaries to seeking "appropriate equitable relief" under § 502(a)(3).

B. Equitable Lien by Agreement Cases Outside the Subrogation Context Shed No Light on How These Claims Would Have Been Limited Within the Subrogation Context.

Petitioner's second conceptual move is to pretend that this case has nothing to do with subrogation. Of the twenty-two equitable lien by agreement cases Petitioner cites in its brief, *not a single one* arises within the subrogation setting or is based upon a subrogation agreement. Petitioner's entire view of this case requires convincing this Court to turn a blind eye to this body of equity. That approach cannot be correct.

1. To begin, Petitioner's argument rests on a central confusion between the equitable rules describing the *creation* of an equitable right and those that governed the *enforcement* of that right. As Dobbs explains, rules governing the *creation* of an equitable right, including equitable liens, are wholly distinct from rules that govern a court's *enforcement*

of that right. The first question is "whether the plaintiff has a right at all" cognizable in equity, which for equitable liens is answered by looking to an agreement's terms, as this Court did in *Sereboff* and *Barnes v. Alexander*, 232 U.S. 117 (1913). 1 Dobbs, *supra*, § 4.1(1), at 552; *see also* 51 Am. Jur. 2d Liens § 39 (2012) ("An equitable lien may be created by an express contract . . . , or it may arise by implication from the relations and dealings of the parties whose interests are involved."); 53 C.J.S. Liens § 18 (2012) ("Contract as basis").

However, when it comes to enforcing equitable liens, the rules did not vary with the method of creation. As the Government explained in *Knudson*, an "equitable lien is another equitable remedy intended to prevent unjust enrichment and may arise out of an express agreement or may be judicially implied." Brief of United States as *Amicus Curiae* Supporting Petitioners at 24, *Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204 (2002) (99-1786); *see also Cheff v. Haan*, 257 N.W. 894, 896 (Mich. 1934); *Kelly v. Kelly*, 19 N.W. 580, 588 (Mich. 1884); 51 Am. Jur. 2d Liens § 82; 53 C.J.S. Liens § 49.[14]

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[14] If the relief available to an insurer is governed by exactly the same equitable rules whether or not the plan includes a subrogation clause, one might ask why an insurer would ever include an express subrogation provision in its policy. First, before the 1930s, courts prohibited medical insurers from pursuing subrogation *at all* unless the insurer included an express clause. 10A Couch on Insurance 3d § 144:6 (L. Ross & T. Segalla eds., 3d ed. 2011). *See also Amer. Indem. Co. v. N.Y. Fire & Marine Underwriters, Inc.*, 196 So. 2d 592 (La. App.

(*Footnote continued*)

2. That cases in equity awarded a measure of relief that *looked* like contractual damages does not change this fact. In many cases, the "appropriate" measure of relief consistent with the defendant's unjust enrichment was *coextensive* with the relief specified by the terms of the agreement, and the plaintiff's loss. *See* 1 Dobbs, *supra*, § 4.1, at 227-28.

Indeed, in most lien-by-agreement cases, there is no reason why enforcing the terms of the agreement would even implicate, let alone offend, other equitable principles. For instance, in *Barnes*, once the right to an equitable lien was established, this Court granted Alexander and Street a measure of relief under their equitable lien consistent with the agreement's terms—"one-third" of any contingent fee recovered. 232 U.S. at 120-21. Petitioner sees this outcome as proof that equitable liens by agreement must be enforced according to their terms, and not based on a "generalized concept of unjust enrichment." Pet. Br. 36. But the result in *Barnes* was *consistent* with the principle of unjust enrichment because the agreement created a measure of recovery that would *always* correspond with the defendant's unjust gain. The lien in *Barnes* was tied to a percentage, which can slide according to the relative size of the fund. Thus, there was no question of measurement, and no possibility that the

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1967). Moreover, as explained above (at n.8), in some cases insurers could pursue *legal* relief based on a breach of contract claim, but, by definition, only where the policy contained an express subrogation clause. Finally, for ERISA-governed plans in particular, an express subrogation clause is required if the Plan is to have *any* right to subrogation. *See infra* at Part II.C.

lien could exhaust the entire fund or exceed the amount of the fund constituting the defendant's unjust gain.[15]

Equally unpersuasive is Petitioner's claim that cases involving the equitable remedy "specific performance" prove that equity courts must enforce contracts as written. *See id.* at 29 (citing *Good v. Jarrard*, 76 S.E. 698, 702 (S.C. 1912)). Contrary to Petitioner's insistence, these cases demonstrate that courts often *refused* to award a measure of relief consistent with the terms of an agreement where doing so would conflict with the principle of unjust enrichment.

As this Court put it: "Specific performance is not of absolute right. It rests entirely in judicial discretion, exercised, it is true, according to the settled principles of equity, and not arbitrarily or capriciously, yet always with reference to the facts of the particular case." *Hennessy v. Woolworth*, 128 U.S. 438, 442 (1888); *see also Willard v. Tayloe*, 75 U.S. 557, 566 (1870) (explaining the "settled principle that a specific performance of a contract of sale is not a matter of course,'" but rather within the "discretion of the court upon a view of all the circumstances").

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[15] Petitioner is wrong to suggest that the Court's "reject[ion]" of Mrs. Barnes' attempt to limit the lien is somehow controlling here. *See* Pet. Br. 35. There was no question that the lien attached *only* to the whole of Mr. Barnes' share, *see Barnes*, 232 U.S. at 123, and not to his law partner's. If anything, this fact illustrates why allowing the Plan to impose a lien over portions of Mr. McCutchen's fund *not* in compensation for the losses it paid would have been improper in equity.

This case, of course, does not involve specific performance. Petitioner's claim that agreements abolish equitable limits, however, does not—either specifically with respect to reimbursement claims or generally with respect to how agreements were treated in equity—hold water.

Nor are Petitioner's multiple "mortgage lien" cases any more persuasive. *See* Pet. Br. 34-35. Those cases just illustrate what the above authorities say: There are specific rules (that often look a lot like contract rules) governing the *creation* of equitable liens based on agreement, but those rules do not necessarily control an equity court's fashioning of relief pursuant to the lien. *See, e.g.*, *Foster Lumber Co. v. Harlan Cnty. Bank*, 80 P. 49, 50-51 (Kan. 1905) (applying maxim that equity "treats that as done which a party, under his agreement, ought to have done" to establish the lien, but enforcing it because the defendant made "[n]o effort . . . to exclude any of the items utilized in computing the amount of the lien"); *S. Ice & Coal Co. v. Alley*, 154 S.W. 536, 539 (Tenn. 1913) (explaining that the maxim "equity looks upon things agreed to be done as actually performed" applies to the "creat[ion] of a mortgage in equity, or a specific equitable lien on the property") (alteration omitted).

These mortgage lien cases are unpersuasive for another reason: They are frequently "two party" cases in which the defendant caused the plaintiff's loss. *See, e.g.*, *Southern Ice*, 154 S.W. at 537 (ice company sought to enforce lien against defendant after he refused to honor property agreement); *Adkinson & Bacot Co. v. Vornado*, 47 So. 113, 113

(Miss. 1908) (husband and wife executed mortgage and then refused to transfer property under agreement). As these cases demonstrate, the unjust enrichment inquiry is virtually always straightforward: A party who has caused a loss to another (and as a result has unjustly gained) should be forced to disgorge that gain.

In this case, however, like in all subrogation cases, because the party causing the loss is often an unrelated third party, the rules that equity courts apply are not the same. *See* 4 Palmer, *supra*, § 23.1, at 341-42 (including discussion of subrogation-based claims in chapter on "Three-Party Problems: Two Parties Separately Liable to a Third"). Where the wrongdoer who causes the loss is a third party, determining who has been unjustly enriched, and by how much, requires a different set of rules for adjusting the rights and relief among the parties. *See id.* § 23.1, at 342-45. Sometimes, the measure of relief will look similar to two-party cases, for instance where the insured recovers an amount from the tortfeasor that includes complete compensation for the losses paid by the insured. *See, e.g.*, *Manley v. Montgomery Bus Co.*, 82 Pa. Super. Ct. 530, 533-34 (1923). But this does not always happen, as this case illustrates. Lumping this case in with those two-party cases fails to account for this difference, and ignores the jurisprudence requiring a different approach.

Petitioner's error is to equate its cases with a black-letter rule of exclusion that prioritizes the terms of an agreement over all other equitable principles that might apply to the subject of the

agreement or the relief a party could obtain. Certainly a lien's terms should be enforced to the extent they do not conflict with other equitable principles. But where absolute enforcement of a lien's terms would conflict with subrogation principles, cases not involving subrogation-based rights say precisely nothing about whether those principles should be set aside. And the treatises say the opposite: Regardless of whether the asserted equitable right arises from "agreement" or not, the equitable limits apply.

3. The real question, and the relevant one in this case, is what happens when the unjust enrichment measurement diverges from a contractual damages measure? Petitioner views liens by agreement as magic documents that shrink equity to the four corners of an agreement, with no recourse to supervening equitable principles applicable to the circumstances or subject of the agreement. This convenient and self-serving approach to equity jurisprudence is contradicted not only by the equitable authorities, as explained above, but also by Petitioner's own cases.

Consider: Petitioner relies heavily on *Manufacturers' Finance Co. v. McKey*, 294 U.S. 442 (1935), for the proposition that "equity cannot change contractual terms 'in the absence of fraud' or the like." Pet. Cert. Reply at 7; Pet. Br. 24. What Petitioner neglects to mention is that *McKey* went on to hold that when a party comes into a court of equity seeking exclusively *equitable* relief, he will "be required to submit to the operation of a rule which always applies in such cases, and do equity in order

to get equity." 294 U.S. at 449. As this Court explained, unlike the enforcement of a legal right in equity—where the "terms of the legal obligation" control even if "the court thinks that these terms are harsh or oppressive or unreasonable"—when a party seeks to enforce a purely equitable right, he must take his relief subject to those limiting principles (or defenses) of equity that would have typically applied to his claim. *Id.* at 448-49.

Petitioner cannot deny that it is presently seeking equitable relief; were that not so, it would be forbidden from proceeding under § 502(a)(3). Against that fact, Petitioner simply cannot avoid application of equitable principles with regard to the enforcement of its equitable lien.

C. Petitioner's Statutory Argument Fails.

Petitioner also argues that, because § 502(a)(3) allows for appropriate equitable relief "to enforce[] the terms of the plan," a court must enforce plan language as written. This argument fails for several reasons.

1. Petitioner's argument misconstrues the point of Congress' language. The reference to the "terms of the plan" was intended to restrict the types of *claims* that a party may assert under § 502(a)(3) to only those arising out of the plan itself. *See Mertens*, 508 U.S. at 254 (Section 502(a)(3) "does not, after all, authorize 'appropriate equitable relief' *at large*, but only 'appropriate equitable relief' for the purpose of 'redressing any violations or enforcing any provisions' of ERISA or an ERISA plan.") (alterations omitted; emphasis in original). Those claims,

Congress stated, must arise out of violations of ERISA itself or the terms of the plan—and be levied against *only* those subject to ERISA's duties or a party to the plan—but may not include generalized freestanding equitable claims for relief against anybody within shooting distance.

In the context of this case, that means Petitioner, or any plan fiduciary, could not maintain a *freestanding* claim for reimbursement, where its plan contained no express subrogation clause. But although this limitation serves an important gatekeeping function, it does not override § 502(a)(3)'s limitation that a party may only obtain that relief which was appropriate in equity. *See, e.g.*, *Peacock v. Thomas*, 516 U.S. 349, 353 (1996) (holding that because "alleged wrongdoing 'did not occur with respect to the administration or operation of the plan'," the complaint "failed to allege a claim under § 502(a)(3) for equitable relief"); *Mertens*, 508 U.S. at 253 (noting that a claim against an actuary would likely be improper because his actions were not alleged to have violated any terms of the plan or of ERISA itself, *and therefore did not fall within the scope of § 502(a)(3)*).[16]

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[16] *See also Cataldo v. U.S. Steel Corp.*, 676 F.3d 542, 556 (6th Cir. 2012) (dismissing claim for various forms of "equitable relief" under § 502(a)(3) where plaintiffs failed to allege a violation of ERISA); *Fotta v. Tr. of United Mine Workers of Am.*, 319 F.3d 612, 617 (3d Cir. 2003) (holding that plan beneficiary can sue under § 502(a)(3) for interest on delayed benefits "only if those benefits were wrongfully withheld or wrongfully delayed, that is, only if they were withheld or delayed in violation of ERISA or an ERISA plan"); Colleen Medill, *Resolving the Judi-*

(*Footnote continued*)

2. Petitioner's interpretation of § 502(a)(3)—that it contemplates the strict enforcement of plan terms—is further undermined by the fact that Congress included just such a contractually based enforcement provision in the statutory provision immediately preceding § 502(a)(3). Section 502(a)(1)(B), authorizes participants and beneficiaries to enforce their rights "under the terms of a plan." 29 U.S.C. § 1132(a)(1)(B). Tellingly absent from this provision is any reference to plan fiduciaries; to the contrary, Congress specified that a civil action brought to "enforce . . . rights under the terms of the plan" may *only* be brought by plan "participant[s] or beneficiar[ies]." *Id*. Yet that is precisely the relief being sought by Petitioner here.

Had Congress intended to allow a plan to secure precisely the type of relief authorized under § 502(a)(1)(B), surely it would have said so. But Congress said no such thing—an omission that speaks volumes. *See Knudson*, 534 U.S. at 217-18; *Russell*, 473 U.S. at 146 ("The assumption of inadvertent omission is rendered especially suspect upon close consideration of ERISA's interlocking, interrelated and interdependent remedial scheme . . . .").

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cial Paradox of "Equitable" Relief Under ERISA Section 502(a)(3), 39 J. Marshall L. Rev. 827, 943 (2006) (noting that "[t]he language of Section 502(a)(3) is clear that the nature of the claim must be limited to a violation of the statutory provision of title I of ERISA or a violation of plan terms").

Notably, Petitioner's brief barely mentions § 502(a)(1)(B), other than to state that it provides participants and beneficiaries "alike" mechanisms to enforce the terms if the plan. Pet. Br. 2, 5-6. Of course, (a)(1)(B) and (a)(3) are not "alike" in their enforcement mechanisms. Petitioner does not address this difference, pretending instead that § 502(a)(1)(B) has no bearing on § 502(a)(3). As this Court has recognized, however, ERISA's carefully crafted and detailed enforcement scheme "provide[s] strong evidence that Congress did *not* intend to authorize other remedies that it simply forgot to incorporate expressly." *Russell*, 473 U.S. at 146 (emphasis in original).

Applying a categorical rule of "enforc[ing] the terms of the plan" would up-end this enforcement scheme by permitting Plans to perform an end-run around the limitations imposed by § 502(a)(3). That move should not be sanctioned by this Court. Whatever else, a request to "enforce the terms of the plan" will be "inadequate to overcome the words of [ERISA's] text regarding the *specific* issue under consideration" where doing so would render those words "devoid of reason and effect." *Knudson*, 534 U.S. at 220 (citation omitted; emphasis in original).[17]

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[17] The United States makes much of the term "appropriate" in § 502(a)(3). Gov't Br. at 13-14. Thus, the Government argues that "the word 'appropriate' . . . direct[s] the court to choose a particular remedy that is well suited to the circumstances." *Id.* at 14. Respondents agree with this uncontroversial proposition, as far as it goes. Where Respondents and the Government diverge is over what *relief* is "well suited to the circumstances," given the "particular remedy."

III. Petitioner's Claim that Imposing Limits on Reimbursements Would Harm ERISA Plans and Beneficiaries Is Unsupported and Untrue.

1. Petitioner and its *amici* (most of which are themselves ERISA plans) strenuously assert that placing any equitable limits on reimbursement would seriously threaten the financial viability of self-funded ERISA plans and limit employees' access to affordable, quality health care. However, the plans have not offered a scintilla of actual evidence that their apocalyptic vision of life under the Third Circuit's approach will come to pass. This is telling, given that it is the plans themselves who are in the position to provide the data proving their point.[18]

At *no* time during this case—or during any other case of which Respondents are aware—has any plan ever provided any actual evidence that subrogation recoveries factor into rate-setting, or that, if these recoveries are limited in the modest ways equity requires, insurers would be forced to abandon ship or slash coverage. Petitioner had ample opportunity to present evidence about, for example, the size of its reimbursement revenue or the percentage of claims in which reimbursement is sought, but it chose not to. The same is true of Petitioner's *amici*—who, after all, are not limited by the evidence in the record. Not one *amici* brief sheds any factual light on these

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[18] ERISA plans, unlike insurance providers subject to state law, are not required to disclose information regarding rate-setting and other internal practices, so this information is hard to come by—unless, of course, the plans themselves choose to disclose it, which they have not.

questions; instead, the briefs rely exclusively on unsupported statements in case law and hypotheticals in law review notes. This alone is reason enough to disregard their gloomy predictions.[19]

2. Meanwhile, what evidence *is* publicly available suggests that the economic concerns raised by the plans are grossly exaggerated. For starters, a number of courts and scholars have concluded that plans do not take reimbursement proceeds into account when setting premium rates.[20]

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[19] For example, the plans rely on *Zurich American Insurance Co. v. O'Hara*, 604 F.3d 1232, 1238 (11th Cir. 2010), in which the court relied on *Wal-Mart Stores, Inc. Associates' Health & Welfare Plan v. Shank*, 500 F.3d 838 (8th Cir. 2007), which, in turn, relied on *Harris v. Harvard Pilgrim Health Care, Inc.*, 208 F.3d 274, 280-81 (1st Cir. 2000), which relied on *Sunbeam-Oster Co. Group Benefits Plan for Salaried & Non-Bargaining Hourly Employees v. Whitehurst*, 102 F.3d 1368, 1376 n.23 (5th Cir. 1996), which relied on *Cutting v. Jerome Foods, Inc.*, 993 F.2d 1293, 1298 (7th Cir. 1993), which cited no authority. *See also* Jeffrey A. Greenblatt, *Insurance and Subrogation: When the Pie Isn't Big Enough, Who Eats Last?*, 64 U. Chi. L. Rev. 1337, 1354-55 (1997) (posing a hypothetical).

[20] *See, e.g.*, *Cooper v. Argonaut Ins. Co.*, 556 P.2d 525, 527 (Alaska 1976); *Allstate Ins. Co. v. Druke*, 576 P.2d 489, 492 (Ariz. 1978) (in banc); *DeCespedes*, 193 So.2d at 227-28; *Travelers Indem. Co. v. Chumbley*, 394 S.W.2d 418, 425 (Mo. Ct. App. 1965); *Maxwell v. Allstate Ins. Co.*, 728 P.2d 812, 815 (Nev. 1986); *Rimes v. State Farm Mut. Auto. Ins. Co.*, 316 N.W.2d 348, 355 (Wis. 1982); John F. Dobbyn, Insurance Law in a Nutshell 284 (3d ed. 1996); Edwin W. Patterson, Essentials of Insurance Law § 33 (2d ed. 1957); 2 G. Richards, The Law of Insurance § 183 (5th ed. 1952); Andrew H. Koslow, *"Appropriate Equitable Relief" in Wal-Mart v. Shank: Justice for Whom?*, 12 Quinnipiac Health L.J. 277, 279 (2009). *See also* Johnny C.

(*Footnote continued*)

The conclusion that reimbursement rates have close to zero impact on coverage and premium rates is supported by the fact that, for at least one of the *amici* plans, reimbursement recovery is miniscule in comparison to the total value of the claims the plan pays out. *Amicus* Central States, Southeast and Southwest Areas Health and Welfare Fund ("Central States"), a multiemployer self-funded ERISA plan, points out in its brief (at 3) that that it has an average annual reimbursement recovery of $5.7 million, while paying out over $1 billion in benefits each year, making its reimbursement rate approximately one half of one percent.[21]

There is no reason to doubt that this is par for the course. The amount of reimbursement is likely so small relative to total pay-outs because reimbursement is inherently unpredictable and available in only narrow circumstances: A beneficiary's injury must have been caused by a third party; the injuries must be severe enough for the beneficiary to bring a lawsuit; and the beneficiary must have actually recovered.

Parker, *The Made Whole Doctrine: Unraveling the Enigma Wrapped in the Mystery of Insurance Subrogation*, 70 Mo. L. Rev. 723, 736-37 (2005); Roger M. Baron, *Subrogation: A Pandora's Box Awaiting Disclosure*, 41 S.D. L. Rev. 237, 243-45 (1996).

[21] *See* Central States, Southeast and Southwest Areas Health and Welfare Fund Comments on the Proposed and Interim Rules Relating to Internal Claims and Appeals and External Review Processes Under the Patient Protection and Affordable Care Act 2 (Sept. 24, 2010), *available at* http://www.dol.gov/ebsa/pdf/1210-AB45-0087.pdf.

Assuming a one-half-of-one-percent rate of reimbursement is more or less typical, it is hard to imagine that the rate of premiums (or the level of plan benefits) would change perceptibly if, in some cases, plans were required by equity to limited reimbursement. Add to this the fact that the overwhelming number of these cases settle, and it seems likely that the financial difference on premiums between the right to 100 percent reimbursement with no deduction for costs and fees and equitably limited reimbursement is relatively small. *See* Blue Cross Blue Shield Br. 5-6 (explaining that most reimbursement claims are settled); Nat'l Coordinating Comm. Br. 23 (same).

If the plans were correct that any limitations on full reimbursement will inevitably increase premiums, one would expect that to be true where reimbursement is prohibited or limited. But all evidence is to the contrary. Plans that are not self-funded are already subject to state-law prohibitions or limitations on reimbursement, but in 2012, premiums for those plans are actually *lower* than in self-funded ERISA plans. Kaiser Family Found. & Health Research & Educ. Trust, Employer Health Benefits: 2012 Annual Survey 20 (2012), *available at* http://ehbs.kff.org/pdf/2012/8345.pdf.[22] Further,

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[22] Over the last 14 years, for large employers, self-funded plans had lower average premiums in half the years, and insured plans had lower premiums in the other half. Kaiser Family Found., Employer Health Benefits, at 28. In all years, the premiums were similar, indicating that the extent of reimbursement available has no or virtually no impact on premium rates. *Id.* at 14, 28.

outside of the self-funded ERISA plan context, states with the most significant restrictions on reimbursement—where it is prohibited or subject to the make-whole doctrine—do not appear to have higher healthcare premiums than states where insurers may contract for unrestricted reimbursement.[23]

Nor have insurers left the marketplace in states where reimbursement is categorically prohibited by statute—Kansas, Kan. Admin. Regs. § 40-1-20; Virginia, Va. Code Ann. § 38.2-3405; and, in the car accident context, Pennsylvania, 75 Pa. Cons. Stat. § 1720—or where insurers cannot seek reimbursement until the beneficiary is made whole, for example, Georgia, Ga. Code Ann. § 33-24-56.1; Nebraska, *Blue Cross Blue Shield of Neb., Inc. v. Dailey*, 687 N.W.2d 689, 699-700 (Neb. 2004); and Wisconsin, *Rimes*, 316 N.W.2d at 350.

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[23] To cite just a few examples, the average premium in 2010 in Virginia, where reimbursement is prohibited, was $240, while the average premium in neighboring West Virginia, where a plan can contract for full reimbursement, was $333. Henry J. Kaiser Family Found., *Average Per Person Monthly Premiums in the Individual Market, 2010*, http://www.statehealthfacts.org/comparemaptable.jsp?ind=976&cat=5 (last visited Oct. 15, 2012); Va. Code Ann. § 38.2-3405 (Virginia anti-subrogation statute); *Bush v. Richardson*, 484 S.E.2d 490, 494 (W. Va. 1997) (in West Virginia, make-whole rule may be overridden by express plan terms to that effect). So too between Wisconsin (made-whole applies, premiums average $201) and Minnesota (contract rules govern, premiums average $250). *Rimes*, 316 N.W.2d at 350; *Medica, Inc. v. Atl. Mut. Ins. Co.*, 566 N.W.2d 74, 77 (Minn. 1997).

Nor is there any evidence that the lower court's approach would dramatically increase plans' administrative costs by requiring "mini-trials" over each claimant's share of recovery. The reality, which some of *amici* recognize, is that the majority of reimbursement claims are settled. *See* Blue Cross Blue Shield Br. 5-6 (explaining that plans usually resolve reimbursement claims to the satisfaction of the beneficiary rather than seeking full reimbursement); Nat'l Coordinating Comm. Br. 23 (same). Further, other federally regulated reimbursement schemes are subject to equitable limitations, and these regimes have not been crippled by a litigation explosion. For example, Medicaid claims for reimbursement are subject to double recovery principles, *Ark. Dep't of Health & Human Servs. v. Ahlborn*, 547 U.S. 268, 274-75 (2006), and Medicare claims are subject to common fund, 42 C.F.R. § 411.37. And, as the United States explains in its brief, reimbursement under the Longshore and Harbor Workers' Compensation Act and the Federal Employees Health Benefits Act is subject to reductions for attorney's fees and costs, Gov't Br. 30-32; *see* 33 U.S.C. § 933(f) (Longshore Act), yet there is no indication that extensive resources are being consumed in reimbursement-related litigation.

If anything, there is every reason to believe that Petitioner's full-reimbursement approach would *increase* litigation costs by making it less likely that tort claimants would be willing to settle cases. As this Court has recognized, there is a strong public policy interest in the expeditious resolution of lawsuits through settlement. *See, e.g.*, *McDermott,*

Inc. v. AmClyde, 511 U.S. 202, 215 (1994). Under Petitioner's proposed scheme, an injury victim who acts reasonably to settle his tort claim would automatically make himself liable for repayment of the total amount of medical expenses irrespective of the actual amount of the settlement that is allocable to those expenses. Under this regime, many injury victims would have virtually no incentive to settle their claims. Instead, in many cases it would make better economic sense to "roll the dice" in hopes of obtaining a larger recovery through trial, thereby burdening the courts with cases that otherwise would have settled, and driving up litigation costs for both the beneficiary and the plan. *Cf. Ahlborn*, 547 U.S. at 288 (explaining that 100 percent reimbursement would deter settlement); *Bradley v. Sebelius*, 621 F.3d 1330, 1339 (11th Cir. 2010) (explaining that a rule of absolute priority would "compel[ ] plaintiffs to force their tort claims to trial, [thereby] burdening the court system," and creating "a financial disincentive" to settlement).

That the approach espoused by Petitioner would deter settlement is a view shared by both sides of the bar. In the same Medicare context as *Bradley*, the insurance industry and defense bar have argued that allowing an insurer to obtain 100 percent reimbursement would defeat the "strong public interest in the expeditious resolution of lawsuits through settlement," thereby driving up the costs of litigation for all parties and burdening the courts. *Id.* at 1339; Brief of DRI—The Voice of the Defense Bar as *Amicus Curiae* Supporting Petitioner at 11-18, *Hadden v. United States*, No. 11-1197, (U.S. Oct. 1, 2012); Brief of Property Casualty Insurers of

America, *et al.* at 6-8, *Hadden*, No. 11-1197, (U.S. Oct. 1, 2012). *See also* Mark Galanter, *The Hundred-Year Decline of Trials and the Thirty Years War*, 57 Stan. L. Rev. 1255, 1272-74 (2005).

Regardless, if plans are really concerned that anything but full reimbursement would dramatically increase costs and decrease revenues, there is nothing to prevent them from exercising their subrogation rights and suing the third-party tortfeasors directly. To be sure, this would entail some additional expense, but because most reimbursement cases settle, the costs should be within reason. That plans would prefer to freeride on the efforts of the beneficiaries and their lawyers highlights that what the plans are seeking here is a windfall that would have been unavailable to them under traditional equitable principles of unjust enrichment.

3. In short, available evidence suggests that placing some limits on the ability of ERISA insurers to recover full reimbursement in every case, without contributing to costs or fees, will not harm either plans or beneficiaries in any significant respect.

Petitioner's claim to the contrary should be seen for what it is: a smoke screen to disguise the fact that a rule of unlimited reimbursement would make ERISA an outlier among reimbursement schemes. To Respondents' knowledge, *no* federal statute permits an insurer from obtaining unlimited reimbursement when the insured has recovered against a third party. *See* 5 U.S.C. § 8132 (Federal Employees' Compensation Act); 33 U.S.C. § 933(f) (Longshore and Harbor Workers' Compensation Act); *Ahlborn*,

547 U.S. at 274-75 (Medicaid); 42 C.F.R. § 411.37 (Medicare); Gov't Br. 31-32 (Federal Employees Health Benefits Act). Many states, too, place at least some limitations on the availability of this relief. *See generally* Parker, *supra* (surveying states). There is no reason to make an exception for ERISA, particularly when Congress has specifically provided that only "appropriate equitable relief" is available under § 502(a)(3).

CONCLUSION

For the foregoing reasons, the judgment of the court of appeals should be affirmed.

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