**BRIEF OF *AMICI CURIAE* UNITED POLICYHOLDERS, THE ARIZONA ASSOCIATION FOR JUSTICE, THE UTAH ASSOCIATION FOR JUSTICE, THE SAN FRANCISCO TRIAL LAWYERS ASSOCIATION, THE MINNESOTA ASSOCIATION FOR JUSTICE, THE SOUTH DAKOTA TRIAL LAWYERS ASSOCIATION, THE NEW JERSEY ASSOCIATION FOR JUSTICE AND THE NEW YORK STATE TRIAL LAWYERS ASSOCIATION IN SUPPORT OF RESPONDENTS**

## INTERESTS OF *AMICI CURIAE*[1]

United Policyholders ("UP") is a non-profit 501(c)(3) organization founded in 1991 that serves as a voice and an information resource for insurance consumers in all 50 states. As part of its mission, UP is concerned about the implementation and application of laws and rules under ERISA, 29 U.S.C. § 1001 *et seq*., because a substantial percentage of the insurance market is governed by ERISA.

UP's work is divided into three program areas: *Roadmap to Recovery* (claim assistance), *Roadmap to Preparedness* (promoting insurance/financial literacy) and *Advocacy and Action* (advancing the interests of insurance consumers in courts of law, before regulators and legislators, and in the media). Donations, foundation grants and volunteer labor support the organization's work. UP does not accept funding from insurance companies.

Advancing the interests of policyholders through participation as *amicus curiae* in insurance-related cases throughout the country is an important part of UP's work. UP's reputation as a reliable friend of the court was enhanced when its *amicus curiae* brief was cited in this Court's opinion in *Humana v. Forsyth,* 525 U.S. 299 (1999), and its arguments were adopted by the Texas Supreme Court in *Excess Underwriters at Lloyd's, London, et al. v. Frank's Casing Crew & Rental Tools Inc.,* 2008 Tex. LEXIS 92, 51 Tex. Sup. J. (Tex. Feb. 1, 2008), as well as by the California Supreme Court in *Vandenberg v. Superior Court*, 88 Cal. Rptr.2d 366 (Cal. 1999) and numerous other proceedings including *TRB Investments, Inc. v. Fireman's Fund Ins. Co.,* 145 P.3d 472 (Cal. 2006). Other ERISA cases in which UP has been granted leave by the Supreme Court to participate as *amicus curiae* include: *Hardt v. Reliance Standard Life Insurance Co.*, 130 S. Ct. 2149 (2010); *Metro. Life Ins. Co. v. Glenn,* 554 U.S. 105 (2008); *Aetna Health, Inc. v. Juan Davila,* 542 U.S. 200 (2004); and *Rush Prudential HMO v. Moran*, 536 U.S. 355 (2002). UP also was

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[1] Pursuant to Supreme Court Rule 37.6, *amici curiae* state that no person or entity other than the *amici curiae,* and their undersigned counsel made a monetary contribution to the preparation or submission of this brief. No attorney for any party authored this brief in whole or in part. The parties' letters consenting to the filing of this brief have been filed with the Clerk's office in accordance with Supreme Court Rule 37.3(a).

granted leave to file an *amicus* brief in *Skinner v. Northrop Grumman Retirement Plan B*, No. 10-55161 (Doc. 53) (9th Cir. 2012);

We seek to assist the Court in this case because of its potential impact on millions of employees and policyholders enrolled in employee benefit plans governed by ERISA.

The following trial lawyer associations also join in this brief as *amici curiae* in support of Respondents:

The Arizona Association for Justice (AAJ), formerly known as the Arizona Trial Lawyers Association, is a voluntary association of approximately 700 lawyers dedicated to protecting the rights of their clients and the public to recover fair personal-injury and wrongful-death damages and to obtaining the insurance benefits that their clients and others have paid to receive.

The Utah Association for Justice (UAJ) is a voluntary association of 420 lawyers dedicated to protecting the rights of their clients and the public to recover fair personal-injury and wrongful-death damages, and to obtaining the insurance benefits that their clients and others have paid to receive.

The San Francisco Trial Lawyers Association (SFTLA) is a voluntary association of approximately 932 members dedicated to protecting the rights of their clients and the public to recover fair personal-injury and wrongful-death damages, and to obtaining the insurance benefits that their clients and others have paid to receive.

The Minnesota Association for Justice (MAJ) is a voluntary association of 907 lawyers dedicated to protecting the rights of their clients and the public to recover fair personal-injury and wrongful-death damages and to obtaining the insurance benefits that their clients and others have paid to receive.

The South Dakota Trial Lawyers Association (SDTLA) is a voluntary association of 322 attorneys who, *inter alia*, represent individual plaintiffs in personal injury cases and other civil actions in South Dakota. Since South Dakota is a small state in terms of population (total population of 814,180 as per the 2010 census), members of SDTLA frequently serve as defense counsel as well as plaintiff's counsel.

The New Jersey Association for Justice (NJAJ) is a voluntary association of 2,383 members, of which 2,134 are attorneys, dedicated to protecting the rights of their clients and the public to recover fair personal-injury and wrongful-death damages and to obtaining the insurance benefits that their clients and others have paid to receive.

The New York State Trial Lawyers Association (NYSTLA) is a voluntary association of 3300 members dedicated to protecting the rights of their clients and the public to recover fair personal-injury and wrongful-death damages and to obtaining the insurance benefits that their clients and others have paid to receive.

These associations and their members have witnessed the devastating effects endured by individuals as a result of ongoing efforts by ERISA insurers and plan sponsors to enforce subrogation and reimbursement provisions since the 1990s. Personal injury cases were widely held to be inappropriate areas in which to afford a subrogation remedy to a health insurer when ERISA was enacted in 1974 and Congress has never authorized subrogation by an ERISA health plan. Thus, these efforts represent a unilateral attempt to create rights for insurers and plan sponsors which did not exist in 1974 and have never been approved by Congress.

## SUMMARY OF THE ARGUMENT

Contrary to the assumptions made by Petitioner and its *amici*, the US Airways, Inc. Health Benefit Plan ("the Plan") is not a negotiated agreement between US Airways, Inc. and its employee, James McCutchen, under which Mr. McCutchen assumed the risk of medical costs from a catastrophic accident caused by a third party. Nor was the Plan an arms-length, negotiated agreement that put Mr. McCutchen on notice that if he recovered damages as the result of an injury caused by another party, he would be required to reimburse the Plan a sum ***in excess of what he recovered,*** net of the attorneys' fees he incurred in prosecuting his third-party suit.

Instead, this Court has recognized that ERISA is the outgrowth of trust law and that courts are to fashion a "federal common law of rights and obligations under ERISA-regulated plans." *Firestone Tire & Rubber Co. v. Bruch,* 489 U.S. 101, 110 (1989). Thus, as the Third Circuit court correctly determined, reimbursement claims seeking equitable restitution must be accompanied by a rule that such claims are subject to equitable principles irrespective of contrary plan language. If plan terms are inequitable, unjust, or unconscionable as applied, courts retain the power to modify such terms in order to bring them into alignment with ERISA's paternalistic purpose, embodied in 29 U.S.C. § 1001(b), of protecting "the interests of participants in employee benefit plans and their beneficiaries," and its fiduciary goals, expressed in 29 U.S.C. § 1104(a)(1), requiring fiduciaries to act exclusively in the interest of the plan's participants and their beneficiaries. Unsupported assertions about the financial impact of reimbursements on plan rates ignore the realities of how health plans are funded and are an insufficient basis to undermine the language and purpose of ERISA.

## ARGUMENT

### A. Section 502(a)(3) Does Not Permit US Airways To Bring A Contract Action For Legal Relief

#### 1. The Terms Of The Plan Are Unclear

Contrary to the arguments advanced by Petitioner, the Subrogation and Right of Reimbursement Provision of the Plan is not merely a "simple *quid pro quo*," Brief for Petitioner at 2, strictly enforceable in accordance with its contract terms.

As a threshold matter, Petitioner provided Respondents with information that Mr. McCutchen was a participant in two different plans, at least one of which is funded by insurance. Defendants' Responsive Concise Statement of Material Facts In Opposition to Plaintiff's Motion for Summary Judgment ¶ 2 (JA 36); Affidavit of Jon R. Perry, Esq. ¶ 13 (JA 41). The reimbursement claim in this case originally was asserted by Ingenix Subrogation Services,[2] an organization retained by UnitedHealthcare Services to pursue reimbursement for medical benefits paid on behalf of Mr. McCutchen under the US Airways Group, Inc. America West Plan # 000704267. *See* Letter dated June 26, 2007 (JA 42); Letter from Ingenix, dated October 6, 2008 (Dist. Ct. Doc. 35-2 at page 23 of 33 (filed 12/04/2009)). Ingenix asserted that it was seeking recovery on behalf of United Healthcare SELECT Plan for America West Holdings Corporation, under which United Healthcare appeared to pay claims as insurer. (*See* Dist. Ct. Doc. 35-2 at pages 11, 13-14, 24 of 33 (filed 12/04/2009)).[3]

In this litigation, however, Petitioner seeks to enforce rights under the US Airways, Inc. Health Benefit Plan. (Dist. Ct. Doc. 30-3 (filed 10/30/2009)). According to the Company's Form 5500, filed to satisfy reporting requirements of both the Department of Labor and the IRS, *see* http://www.irs.gov/pub/irs-pdf/i5500.pdf, the Plan is funded through the general assets of the company and through insurance.[4] Thus, under the Plan, insurance may have covered Mr.

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[2] In April, 2011, the name of Ingenix, a subsidiary of United HealthGroup, was changed to OptumInsight. http://www.ama-assn.org/amednews/2011/04/25/bisd0426.htm.

[3] Neither a complete plan document nor SPD for this Plan is in the record or was provided to Respondents.

[4] The 2009 form 5500 filed by US Airways for its health plan shows that its funding arrangement on line 9a and its benefit arrangement on line 9b are from insurance, as well as assets of the plan sponsor. A copy of the US Airways Plan form 5500 is accessible on the database maintained by the U.S. Department of Labor, using search criteria seeking 2009 form 5500 for EIN 530218143, and the 3 digit plan number of 501, at http://www.efast.dol.gov/portal/app/disseminate?execution=e1s2. Schedule A lists United Healthcare Insurance Company as the insurer referenced in line 9. Schedule C of the form 5500 reveals that in 2009 alone, US Airways paid United Healthcare almost $11 million. *Id.* The 2010 form 5500, accessed at the website above, shows similar information,

McCutchen's medical expenses, a typical arrangement for a self-funded plan. *See* __ *infra*.[5]

Thus, insurance likely played a role in paying Mr. McCutchen's medical expenses. The Plan should not be enforced as though it were a contract between a plan sponsor and participant where its terms are either unclear or concealed.

### 2. US Airways May Not Bring A Claim For Legal Relief

Even if the Plan were an agreement by which US Airways would advance medical costs to treat injuries caused by a tortfeasor on the condition that Mr. McCutchen would reimburse those costs upon recovery from a third party, it cannot be concluded that Mr. McCutchen agreed to reimburse his employer from the underinsured motorist recovery he received from his own automobile insurer for which he paid separate premiums. Nor can it be concluded that Mr. McCutchen agreed that to turn over to the Plan a payment larger than his actual net recovery.

Undoubtedly, the promise of health benefits is a valuable inducement for individuals to accept employment with companies. However, it is pure speculation to suggest that Mr. McCutchen knowingly and voluntarily entered into the sort of *quid pro quo* that Petitioners and their *amici* maintain, by which the Plan benevolently advances the costs to cover catastrophic medical expenses, the risk of which is fully assumed by the beneficiaries. To the contrary, US Airways informed its employees that the goal of the Plan was to:

- Protect you and your family from major financial loss;
- Provide competitive benefits that will attract and retain qualified employees.

(Dist. Ct. Doc. 30-3 at page 2 of 110 (filed 10/30/2009)). Thus, U.S. Airways promised its employees, such as Mr. McCutchen, that as part of the terms and conditions of employment, protection from personal financial loss caused by large medical expenses due either to illness or injury. It does not contemplate that the employee would assume the full risk of loss caused by a third party. Any argument that the reimbursement clause should be enforced as part of a bargained-for exchange therefore rests on a false premise.

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except that in addition to United Healthcare, BlueCross BlueShield of NC is listed as a claims processor. The 2003 SPD for the Plan indicates that BlueCross BlueShield, not United Healthcare, is the claims administrator of the Plan, (Dist. Ct. Doc. 30-3 at pages 26, 100 of 110 (filed 10/30/2009)), suggesting that United Healthcare is an insurer.

[5] Petitioner sought a protective order to avoid producing documents from which Respondent could discern the provisions of the Plan. (*See* Dist. Ct. Doc. 16 (filed 07/16/2009)).

Further, as Brief for Petitioner at 5 admits, the employer designs and controls the terms of the plan; without judicial oversight permitting the application of equitable principles to equitable claims for reimbursement, Plan terminology could become unconscionable. If the Plan permitted double reimbursement, such a term would undoubtedly be unenforceable. Yet here Petitioner seeks to enforce a term requiring a plan participant to reimburse a larger sum than the net recovery he received.

While the Plan's reimbursement rights may be enforced through an action seeking "appropriate equitable relief" under 29 U.S.C. § 1132(a)(3), by the terms of the statute such action is exclusively an equitable, not a legal right. *Great-West Life & Annuity Insurance Co.*, *v. Knudson*, 534 U.S. 204, 221 (2002). Under analogous trust law principles, a trustee cannot simply enforce a provision of the trust that could cause substantial harm to beneficiaries, but rather is under a duty to modify the provision of the trust. Restatement (Third) of Trusts § 66(2) and cmt. on subsection(2) (2003). Thus, a fiduciary may not blindly enforce the terms of a plan without regard to the consequences to participants and beneficiaries and is limited in doing so by equitable principles.

In any event, Congress authorized only "a participant or beneficiary," but not a fiduciary like US Airways, to bring a contract-like claim to enforce his rights under the terms of the plan under 29 U.S.C. § 1132(a)(1)(B). *Knudson*, 534 U.S. at 221. A fiduciary is limited to pursuing "appropriate equitable relief" under § 502(a)(3), but as *Knudson* holds, that section does not authorize fiduciaries to seek legal relief, that is, the imposition of personal liability on a participant for a contractual obligation to pay money. *Id.* By seeking a recovery in excess of the funds actually received by Mr. McCutchen and which may only be satisfied from his personal assets, however, Petitioner's claim is quintessentially one for legal, not equitable, restitution, and is not authorized by § 502(a)(3). Thus, any argument premised upon the notion that US Airways and Mr. McCutchen entered into a *quid pro quo* is both legally and factually implausible. Even if there was some element of a *quid pro quo,* US Airways is limited to seeking equitable relief and therefore may not under any circumstances seek recovery from McCutchen's personal assets in excess of the funds over which US Airways may assert a lien by agreement in accordance with *Sereboff v. Mid-Atlantic Medical Services, Inc.,* 547 U.S. 356, 362-64 (2006).

### B. Any Reimbursement Recovery Will Inure To The Benefit Of United Healthcare Or The Company, Not To The Benefit Of Plan Participants and Beneficiaries

Nor is it correct to assert, as Petitioner maintains, that full reimbursement by Mr. McCutchen is necessary to preserve Plan assets to pay future claims. Brief for Petitioner at 27 *et seq.* It appears that Mr. McCutchen's medical expenses were

covered, at least in part, by United Healthcare pursuant to a policy of insurance. *See* Part A.1. *supra.* Thus, any reimbursement would flow to United Healthcare as insurer, and not to the Plan.[6]

Brief for Petitioner at 27 suggests that that any amounts recovered are Plan assets. Thus, permitting a reimbursement recovery by US Airways on behalf of United Healthcare poses serious problems under ERISA. As a fiduciary, US Airways must discharge its duties with respect to the Plan "solely in the interest of the participants and beneficiaries and . . . for the exclusive purpose of . . . providing benefits to participants and their beneficiaries." 29 U.S.C. § 1104(a)(1)(A). If US Airways is being used to direct reimbursement recoveries to United Healthcare, it stands in violation of the "exclusive benefit" rule of Section 1104(a).

Moreover, 29 U.S.C. § 1103(c) mandates that "assets of a plan shall never inure to the benefit of any employer and shall be held for the exclusive purpose of providing benefits to participants in the plan and their beneficiaries." The payment of a reimbursement award to United Healthcare, as a health insurer, could violate ERISA's anti-inurement provision because it diverts assets from the mandated purpose of "providing benefits to participants in the plan and their beneficiaries" and will not be used to "fund" the Plan. Without any showing in this record that the recovery will benefit the Plan and its participants, it appears the money will flow to United Healthcare in violation of ERISA's anti-inurement provision.

Even if the reimbursement payment is received by US Airways, there is nothing in the record from which to conclude that the funds would be used to provide benefits to plan participants and their beneficiaries or to defray future expenses. As noted above, the Plan is funded by insurance and general assets. Thus, any recovery that does not flow to an insurer would be directed to the general assets of US Airways, which has no obligation to continue to fund the Plan. *See* 2003 SPD for the Plan (Dist. Ct. Doc. 30-3 at page 101 of 110 (filed 10/30/2009)).[7]

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[6] It does not appear that United Healthcare's role in the Plan is as a claims administrator of a self-funded Plan, because the record shows that the only "claims administrator" for the Plan during the time in question was BlueCross BlueShield. (Dist. Ct. Doc. 30-3 at pages 26, 100 of 110 (filed 10/30/2009)).

[7] It is possible that any recovery will be used to increase the company's or its insurer's executive compensation or shareholder dividends, not to reduce premiums or rates. *See* Scott M. Aronson, *ERISA's Equitable Illusion: The Unjust Justice of Section 502(a)(3)*, 9 Empl. Rts. & Emply. Pol'y J. 247, 286 (2005). The use of subrogated or reimbursement recoveries to enhance executive compensation and dividends is consistent with reports regarding United Healthcare. *See*, *e.g.*, Patrick Kennedy, *UnitedHealth CEO Stephen Hemsley was paid $102M in '09*, Minneapolis Star Tribune, April 12, 2010; Tom Murphy, *Report hints reform offers growth for carriers* (Oct. 2, 2012), available at http://www.benefitspro.com/2012/10/02/report-hints-reform-offers-growth-for-carriers (reporting that United Healthcare expects higher earnings per share than previous forecasts).

In addition, a recovery in 2013 for expenses incurred by a participant in 2007 or 2008, when Mr. McCutchen's accident occurred and the expenses were paid, would at best lessen only the Company's share of a predetermined contribution made on an actuarial basis for 2013. The employee's contribution is determined "prior to the beginning of each Plan Year (the 12-month period, beginning each January 1, used by the Plan to conduct its finances), based on an evaluation of expected medical and dental administrative and claim expenses for the upcoming year." 2003 SPD for the Plan (Dist. Ct. Doc. 30-3 at page 16 of 110 (filed 10/30/2009)). According to the SPD, the employee's contribution is based on expected expenses and does not take into account potential reimbursements. Thus, it would be sheer speculation to conclude that a reimbursement recovery is used to defray employee contributions for future years.

It is important to remember that when ERISA was enacted in 1974, subrogation remedies were generally not afforded to health insurers in personal injury cases. *See* Brendan S. Maher & Radha A. Pathak*, Understanding and Problematizing Contractual Tort Subrogation*, 40 Loy. U. Chi. L. J. 49, 66 *et seq*. (2008). The first reported judicial decision involving an effort by a health insurer to seek subrogation or reimbursement from the proceeds of a personal injury recovery is *Frost v. Porter Leasing Corp*., 436 N.E.2d 387 (Mass. 1982), in which the court flatly rejected an insurer's claim of implied subrogation. This Court has been careful to protect pre-ERISA rights enjoyed by employees and beneficiaries. *Firestone*, 489 U.S. at 113-14 ("Adopting Firestone's reading of ERISA would require us to impose a standard of review that would afford less protection to employees and their beneficiaries than they enjoyed before ERISA was enacted.")

The result urged by Petitioner could confer on insurers that provide coverage in the context of so-called self-funded plans greater rights than they enjoy outside of ERISA . The Court should not adopt a rule in this case that eliminates protections from subrogation and reimbursement claims that employees and their beneficiaries enjoyed before ERISA was enacted.

### C. The Plan Does Not Allocate To Participants The Risk Of Catastrophic Medical Costs Caused By A Third Party

The record is devoid of evidence suggesting that Mr. McCutchen understood he was assuming the risk of the medical costs he incurred when he was injured, which costs the Plan, in its benevolence, covered with the expectation that he would repay.[8] If he considered such a risk at all, the fact that he purchased underinsured motorist coverage suggests he sought to protect himself against such risk.

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[8] The Plan is not necessarily the first in line to pay medical expenses caused by an accident. For example, automobile insurers in Pennsylvania must pay at least the first $5000 of first party medical expenses. *See*, *e.g.,* 75 Pa. C. S. §§ 1711. The Plan also does not cover medical expenses covered by workers' compensation insurance. (*See* (Dist. Ct. Doc. 35-2 at page 24 of 33 (filed 12/04/2009)).

Rather, the information distributed by US Airways to its employees indicates that US Airways assumed the risk of catastrophic loss. *See* Part A.2. *supra.* Further, US Airways had the ability to shift that risk to an insurer like United Healthcare, and did so. Thus, there is no basis to conclude that limiting the reimbursement will threaten the solvency of the Plan.

The Second Amendment to US Airways, Inc. Health Benefit Plan (January 1, 1982 Restatement), adopted on December 30, 1998, replaced section 6.1 of the Plan to provide:

> Benefits under the Plan shall be paid from the general assets of the Employer, provided through a group contract with an insurance carrier or health maintenance organization as determined by the Company and/or provided through a trust established by the Employer.... In the event any benefit is to be provided, in whole or in part, through a group contract with one or more insurance companies and/or health maintenance organizations, the Employer shall remit to such insurance companies and/or health maintenance organizations as premium payments its contributions and any Participant contributions in respect of such benefits, as appropriate.[9]

Employees contribute to the cost of coverage. (Dist. Ct. Doc. 30-3 at page 16 of 110 (filed 10/30/2009)).

Even if the Plan is "self-funded," Pet. App. 22a, or "self-financed," Pet. App. 3a (a fact that is not clear from the record), that is not to say that US Airways is "self-insured" such that it pays all claims under the Plan. "Self-funded" is not the same as "self-insured." An entity that "self-insures" retains the insured risks without any risk transfer to a commercial insurer. Robert E. Keeton & Alan I. Widiss, *Insurance Law: A Guide to Fundamental Principles, Legal Doctrines, and Commercial Practices* (Hornbook Series), §§ 1.2, 1.3(b) (1988).

In contrast, under a self-funded benefit plan, an employer assumes the risk of providing health insurance to its employees, instead of ceding the risk to a third-party insurance company. The employer then either sets aside funds for its employees' covered medical expenses or pays for such expenses out of its general

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[9] The plan document is not in the record of this case because it was never provided to Mr. McCutchen or his counsel, despite their repeated requests for it while this case was pending in the district court. *See* notes 3, 5 *supra.* We have been advised that Respondents only received the plan document recently, after the Court granted the petition, after it was requested by the Solicitor General. Because it is the relevant document, we cite it here.

accounts. *Texas Dept. of Ins. v. Am. Nat. Ins. Co.,* 10-0374, 2012 WL 1759457 *1 (Tex. May 18, 2012), reh'g denied (Aug. 31, 2012).

However, a self-funded ERISA health plan may allocate risk by blending "self-insured" coverage, that is payment of claims from its own assets, with "insured" coverage, paid by an insurer, which is what apparently happened in this case with the group policy issued by United Healthcare. *See* Part A.1. *supra.* A self-funded health plan also may purchase "reinsurance" or "stop-loss" insurance as a way to protect the employer's corporate assets against the risk of catastrophic claims.[10] Self-funded plans typically hire third parties to administer the plan and often purchase stop-loss insurance to limit financial exposure to catastrophic losses.[11] Section 6.1 of the Plan clearly contemplates a role for insurance.

Thus, a Plan may be self-funded and still use insurance to limit its risk of loss. Such arrangement is beneficial to the stop-loss insurer, which thus may be permitted to evade state law regulating insurance. As discussed in *FMC Corp. v. Holliday*, 498 U.S. 52 (1990), ERISA's "deemer" clause permitted a self-funded plan to evade Pennsylvania law. However, as to insured plans, this Court explained:

> [E]mployee benefit plans that are insured are subject to indirect state regulation. An insurance company that insures a plan remains an insurer for purposes of state laws, "purporting to regulate insurance" after application of the deemer clause [of ERISA]. The insurance company is therefore not relieved from state insurance regulation. The ERISA plan is consequently

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[10] There are two types of stop loss insurance that are typically available for a self-funded plan: (1) specific stop-loss, which protects against a high claim from an individual, and (2) aggregate stop-loss, which puts a ceiling on the amount of expenses the employer pays during the contract period and where the employer is reimbursed at the end of the contract for aggregate claims. *Texas Dept. of Ins. v. Am. Nat. Ins. Co.*, 2012 WL 1759457 *3. *See also* Jonathan Edelheit & Daniel Pyne, *The Benefits and Flexibility of Self-Funded Insurance*, SELF FUNDING MAGAZINE (Aug. 2, 2012), *available at* http://www.selffundingmagazine.com/article/the-benefits-and-flexibility-of-self-funded-insurance.html (cited in BCBS *Amicus* Br. at 4 n.5) (recommending that risk of catastrophic claims handled through stop loss insurance, no mention of subrogation or reimbursement). The dollar amount above which the employer is covered by the stop loss, and therefore not at risk, is called the attachment point. Katheryn Linehan, *Self-insurance and the Potential Effects of Health Reform on the Small-Group Market,* National Health Policy Forum (Dec. 20, 2012), *available at* http://www.nhpf.org/library/details.cfm/2839 (cited in BCBS/Rawlings *Amicus* Brief at 16 note 13) (discusses mechanisms for shifting risk, but does not mention anything about relevance of reimbursement or subrogation in determining cost and risk). In *Knudson*, it was the stop loss insurer that paid for the loss above the first $75,000 seeking reimbursement against the plan participant. *See Knudson*, 534 U.S. at 207.

[11] A self-funded plan may use a commercial insurer, called a "claims administrator" or "third party administrator" ("TPA") to handle "claims." According to the SPD for the Plan, BlueCross BlueShield acted as the administrator of the Plan. (Dist. Ct. Doc. 30-3 at pages 26, 100 of 110 (filed 10/30/2009)).

bound by state insurance regulations insofar as they apply to the plan's insurer.

*Id.* at 62.

A reimbursement recovery that flowed to United Healthcare, as insurer, would, by application of ERISA's "saving clause," violate Pennsylvania law prohibiting insurers from obtaining recovery from an insured's tort recovery and enable United Healthcare to disregard Pennsylvania's anti-subrogation law. This Court should not countenance United Healthcare's apparent attempt to circumvent Pennsylvania's prohibition against subrogation and reimbursement by bringing this action in the name of the Plan administrator even though the record shows it seeks reimbursement on its own account, rather than on account of the Plan.

This issue is not an isolated problem. The fact that self-funded plans are governed by ERISA, which preempts state law, *see FMC Corp.*, 498 U.S. at 61, provides an advantage to an employer that self-funds, as opposed to one that fully insures its health plan. Self-funded plans can and do mitigate risk by relying on stop-loss coverage, but they are not subject to the same level of state regulation as fully-insured plans. *See Texas Dept. of Ins. v. Am. Nat. Ins. Co.*, 2012 WL 1759457 * 4; Christine Eibner et al., *Employer Self-Insurance Decisions and the Implications of the Patient Protection and Affordable Care Act as Modified by the Health Care and Education Reconciliation Act of 2010 (ACA),* RAND Health (2011), p. 21, *available at* http://www.rand.org/pubs/technical_reports/TR971.html (cited in Blue Cross Blue Shield Assoc., et al. Amicus Br. (hereinafter "BCBS *Amicus* Br.,") at 16 n. 3); Joanne Wojcik, *Reform Law Could Fuel Self Funding* (Feb. 19, 2012), available at http://www.businessinsurance.com/article/20120219/NEWS05/302199999?tags=|74|278|305|339|342, cited in BCBS *Amicus* Br. at 4 n. 4 (other advantages are that self-funded benefit plans are not subject to state benefit mandates or the same premium taxes as fully insured plans). Employers can determine exactly how much risk to assume, and can purchase stop-loss coverage to assume the risk above the chosen attachment point.

In short, the Court should not permit a reimbursement recovery that flows to the benefit of an insurer, contrary to ERISA's protections of the interests of participants and beneficiaries, and that evades "saved" state insurance law.

It is unclear how insurance purchased from United Healthcare was used in this case. However, any suggestion that a self-funded plan is unable to protect itself against catastrophic losses, unless it is entitled to full reimbursement from beneficiaries' third party recoveries, regardless of the beneficiaries' net recovery or the fees and costs incurred, ignores the reality that self-funded plans can and do protect themselves through their own purchase of insurance. Further, information available in this case indicates that the US Airways shifted some or all of the risk of catastrophic loss to United Healthcare. *See* Part A.1 *supra.*

Typically, so-called self-funded plans are able to rationally allocate the risk of catastrophic loss. US Airways did so in this case. Thus, applying equitable limitations on reimbursement claims will not threaten the solvency of plans that have purchased insurance to protect them from such losses.

## D. Affirmance Of The Third Circuit's Opinion Will Not Weaken Or Otherwise Affect The Solvency Of Employer-Sponsored Health Plans

### 1. Equitable Limitations On Reimbursement Rights Will Not Affect Rates For Self-Funded Plans

There is no support in either the record or which may be derived from empirical studies for the speculative arguments made by Petitioner and its *amici* that any limitations on reimbursements from third party recoveries by employer-sponsored health plans, whether self-funded or insured, will cause premium rates to skyrocket or will threaten plans' solvency. Indeed, there is no such evidence whatsoever.

In the case of insured plans, the setting of insurances rates for the transfer of the risk from the insured to the insurer encompasses the insured's *pro rata* share of the total estimated losses for the pool, as well as the insured's pro rata share of the costs, expenses and profit margin to be borne by the insurer for setting up and administering the insurance undertaking. Keeton & Widiss, *supra,* § 1.3(b)(2)(1988). The prospect of a successful recovery from a third party, which is conjectural and remote in nature, is not utilized as a factor in the insurer's rate determination. *See*, *e.g.*, Aronson, *supra* note 6, at 285; Edwin W. Patterson, *Essentials of Insurance Law* § 33, at 151-52 (2d ed. 1957); John F. Dobbyn, *Insurance Law in a Nutshell* 384 (4th ed. West 2003). Many states prohibit reimbursement or subrogation recoveries since insurers have already been paid a premium to cover the loss, regardless of its cause. *See, e.g., Allstate Ins. Co. v. Druke*, 576 P.2d 489, 492 (Ariz. 1978); *Maxwell v. Allstate Ins. Co.*, 728 P.2d 812, 815 (Nev. 1986); *Travelers Indem. Co. v. Chumbley*¸ 394 S.W. 2d 418, 425 (Mo. App. 1965); *DeCespedes v. Prudence Mut. Cas. Co.*, 193 So. 2d 224, 227-28 (Fla. Dist. Ct. App. 1966).[12]

There is no basis to conclude that ratemaking for self-funded plans is any different, as argued by Petitioner's *amici*.[13] There have been no valid industry-wide

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[12] The role of subrogation and reimbursement in rate making is discussed at length in Roger M. Baron, *Subrogation: A Pandora's Box Awaiting Closure*, 41 SD L. Rev. 237, 243-245 (1996).

[13] For example, Gary L. Wickert, *The Societal Benefits of Subrogation*, available at http://www.mwl-law.com/CM/Resources/The-Societal-Benefits-of-Subrogation.pdf, cited in BCBS *Amicus* Br.at 21, contains no citations.

studies performed or empirical data assembled that demonstrate the impact of subrogation recoveries on health plan rates. Holly Ludwig, *Restoring Sanity to Subrogation After Sereboff*, 9 Nev. L.J. 431, 450 (2009).[14] The studies cited by *amici* describe the rise in cost of employer-sponsored coverage, but there is neither any mention nor suggestion that there is a link between reimbursement and subrogation and the costs or solvency of health plans.[15]

Thus, the Court is left without grounds to conclude that limiting reimbursement in this case will somehow lead to increased rates paid by other employees or trigger plan insolvency.

### 2. Any Consideration Of Reimbursement And Subrogation In Setting Rates Would Have To Consider The Historical Limitations

Despite suggestions to the contrary, the right to subrogation or reimbursement by health insurer from personal injury recoveries has historically been limited or banned altogether. *See* Johnny C. Parker, *The Made Whole Doctrine: Unraveling the Enigma Wrapped in the Mystery of Insurance Subrogation*, 70 Mo. L. Rev. 723, 737 *et seq*.(2005) (setting out a state-by-state approach). As noted in Part B above, the first reported judicial decision involving an effort by a health insurer to seek subrogation on a personal injury claim is *Frost*,

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[14] As discussed in Christine Eibner et al., *Employer Self-Insurance Decisions and the Implications of the Patient Protection and Affordable Care Act as Modified by the Health Care and Educatin Reconciliation Act of 2010 (ACA),* RAND Health (2011), *available at* http://www.rand.org/pubs/technical_reports/TR971.html (cited in BCBS *Amicus* Br. at 16 n. 3), there is generally a lack of reliable data on premiums for self-funded plans, a lack of information concerning use of stop-loss policies and an absence of data linking employees, employers and health expenditures.

[15] While the cost of employer-sponsored coverage is increasing, limits on reimbursement is never cited as the reason for the rise in costs. *See, e.g.,* The Henry J. Kaiser Family Foundation & Health Research & Education Trust, *Summary of Findings*, Employer Health Benefits 2011 Annual Survey (2011), available at http://ehbs.kff.org/pdf/2011/8225.pdf (cited in Chamber of Commerce of the United States of Am., *et al. Amicus* Brief at 18-19 n. 2; BCBS *Amicus* Br. at 3, 16). In fact, that organization's 2012 report shows that at large firms (200 or more workers), the average family premium for covered workers in firms that are fully insured has grown at a similar rate to premiums for workers in fully or partially self-funded firms from 2007 to 2012. The Kaiser Family Foundation and the Health Research & Educational Trust, Employer Health Benefits 2012 Annual Survey (2012) available at http://ehbs.kff.org/pdf/2012/8345.pdf. Since, as discussed in the next section, state laws often limit or prohibit subrogation by health insurers, this statistic suggests that the rise in rates is due to some other factor than the plans' ability to recoup costs from third parties. Chad Terhume, *About 10% of Employers To Drop Health Benefits, Study Finds*, L.A. Times (July 24, 2012) (cited in BCBS *Amicus* Br. at 3 n. 2) states that employers attribute increased medical costs to hospitals, inefficiencies and unhealthy lifestyles, not lack of reimbursement or subrogation.

*supra*, which denied the insurer's claim of implied subrogation. Some states, such as Arizona and Missouri, never permitted subrogation on personal injury claims. *See Chumbley*, *supra*; *State Farm Fire & Casualty Co. v. Knapp*, 484 P.2d 180 (Ariz. 1971). Other states, such as Oklahoma, Pennsylvania and Nevada, have either judicially or legislatively rejected subrogation and/or reimbursement of medical expense claims. *See* 36 Okla. Stat. Ann. § 6092 (West 1990); 75 Pa. Cons. Stat. Ann. § 1720 (Supp. 1995); *Maxwell*, *supra*. Others have applied other limitations.[16]

Since the subrogation and reimbursement rights of health insurers have historically been limited, health plans have no basis for arguing that they set rates based on experience regarding expected subrogation and reimbursement recoveries.

There is also no legitimate expectation, based on experience, to full reimbursement in all cases. In fact, Petitioner's *amici* admit that plans generally receive less than full reimbursement for medical costs paid:

> plans can—and usually do—work out a mutually beneficial resolution with the participant. It is extraordinarily rare—indeed, in *amici's* experience, virtually unprecedented—that a participant is ever called upon to reimburse the plan's equitable lien from his own assets.

BCBS *Amicus* Br. at 5-6. *See also* Nat'l Coordinating Comm. for Multiemployer Plans *Amicus* Br. at 23 (as a practical matter, trustees often agree to reduce a plan's equitable lien against a participant's third party recovery). However, employers and plans cannot always be trusted to apply equitable principles on their own.[17]

In view of the legal and practical limitations on reimbursement, health plan cannot possibly set rates based on the expectation or experience of full reimbursement from their participants' third party recoveries. In fact, as revealed by Petitioner's *amici*, the norm is that in a situation where the medical expenses exceed the participant's recovery, the parties agree on a resolution that does not require injured participants to reimburse plans from their own assets. Petitioner is

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[16] In Elaine M. Rinaldi, *Appportionment of Recovery Between Insured and Insurer in a Subrogation Case*, 29 Tort & Ins. L. J. 803, nn. 19-46 and accompanying text (1994), the author reports that based on this Court's decision in *American Society Co. v. Westinghouse Electric Manufacturing Co.*, 296 U.S. 133 (1935), a majority of jurisdictions, apply an "insured-whole rule," that is, that the insured must be fully compensated for any uninsured loss before the insurer may share in the proceeds of a recovery from the tortfeasor.

[17] It was only after its victory in the Court of Appeals in *Administrative Committee of Wal-Mart Stores v. Shank*, 500 F.3d 834 (8th Cir. 2007), *cert. denied*, 552 U.S. 1275 (2008), which became a public relations nightmare for the retail giant, Wal-Mart decided to let the victim keep the proceeds of her third party recovery. *See* Randy Kaye, *Wal-Mart*: *Brain-damaged former employee can keep money* (April 2, 2008) available at http://articles.cnn.com/2008-04-02/us/walmart.decision_1_wal-mart-retail-giant-health-care-plan?_s=PM:US.

simply trying to use the preemptive scope of ERISA to expand rights of reimbursement and subrogation that it never had and to squeeze from Mr. McCutchen more than what it is entitled to recover under state law. The opinion of the Third Circuit below simply sends the parties back to work out a sensible solution, in keeping with longstanding practices and well-recognized principles of equity, and should be affirmed.

### 3. Rates Are Likely To Be Impacted More By The PPACA Than The Decision In This Case

As noted above, there are no data to support the proposition that reimbursement rights affect the costs of providing employer sponsored health benefits or that affirming the opinion of the Third Circuit will impact the costs of the Plan. What is much more likely to impact the cost of the Plan and to achieve significant cost savings is the implementation of the Patient Protection and Affordable Care Act ("PPACA"), Pub. L. No. 111-148, 124 Stat. 119 (2010), the constitutionality of which was upheld by this Court in *National Federation of Independent Business v. Sebelius*, 132 S. Ct. 2566 (2012). Sections 1511 and 1513 of the PPACA require employers to enroll employees in an employer-sponsored health plan or pay an assessment. 26 U.S.C. § 4980H, 29 U.S.C. § 218A. *See also* EBSA, DOL, Tech. Rel. 2012-01 (Feb. 9, 2012) http://www.dol.gov/ebsa/pdf/tr12-01.pdf. Thus, employers may decide whether to offer health coverage or pay the assessment. The cost of coverage will likely be impacted by PPACA's 80/20 Medical Loss Ratio (MLR) rule, requiring health insurers that spend less than 80% of premiums on medical care and quality (or less than 85% in the large group market) to rebate the portion of premium dollars that exceed this limit. http://www.healthcare.gov/law/resources/reports/mlr-rebates06212012a.html.

The PPACA mandates requiring employers to provide insurance or to pay assessments will dictate to employers the costs of employer-sponsored health coverage and the type of coverage offered to their employees in the near future.[18] Given the mandates under the PPACA, there seems little long-term relevance to whether health plans may seek reimbursement from a beneficiary's third party recovery to keep down the costs of health coverage.

While the cost of employer-sponsored coverage has increased over the years, *see* The Henry J. Kaiser Family Foundation, *The Uninsured: A Primer: Key Facts About Americans Without Health Insurance*, at 16-18 (Oct. 2011) (cited in Nat'l

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[18] Insurers will undoubtedly benefit from the mandate, which will direct millions of new customers and their premium dollars to health insurers. *See* Tom Murphy, *Report hints reform offers growth for carriers* (Oct. 2, 2012), available at http://www.benefitspro.com/2012/10/02/report-hints-reform-offers-growth-for-carriers (citing estimate that 12 million people will find coverage on insurance exchanges in 2014 and pay a total of $55 billion in premiums).

Assoc. of Subrogation Professionals, *et al. Amicus* Br. at 29), that study does not mention or even suggest that limits on reimbursement are responsible for the high cost, which is, in any event, addressed by the PPACA.

### E. Limiting Plans To "Appropriate Equitable Relief" Will Not Generate More ERISA Litigation

Petitioner and its *amici* raise the specter of increased litigation as a last ditch effort to defeat any equitable limitations on the rights of self-funded plans to reimbursement. This Court has previously recognized that the threat of increased litigation is insufficient to outweigh the proper application of the statute as written by Congress. *See Firestone*, 489 U.S. at 114-115.

Moreover, as noted above, plans generally work out a mutually beneficial resolution with the participant. Hence, there is no reason to believe that limiting plans to "appropriate equitable relief" with corresponding consideration of equitable principles will disturb the *status quo* or preclude a continuation of sensible resolutions of reimbursement claims.

As for the need for uniformity, there cannot be perfect uniformity because the language of plans varies widely and "such disuniformities . . . are the inevitable result of the congressional decision to 'save' local insurance regulation." *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 381 (2002) (quoting *Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. 724, 747 (1985)). In fact, one reason an employer may want to adopt a self-funded health plan is to tailor the plan to the needs of its own workforce. *See* authorities cited note 10, *supra.* Thus, permitting trial courts to continue exercising their traditional role of tailoring the outcome to the specific facts of the situation presented is far more beneficial than applying a mechanical rule that results in the type of unfairness and public outcry that *Shank* engendered. *See* note 17, *supra.*

An unfounded threat of increased litigation should not defeat the application of equitable principles in accordance with the very purpose of ERISA.

## CONCLUSION

For the foregoing reasons, the decision of the Third Circuit should be affirmed.

Respectfully submitted,

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