No. 14-723

IN THE

Supreme Court of the United States

ROBERT MONTANILE,

Petitioner,

v.

BOARD OF TRUSTEES OF THE NATIONAL ELEVATOR INDUSTRY HEALTH BENEFIT PLAN,

Respondent.

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

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

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INTEREST OF AMICI CURIAE[1]

National Association of Subrogation Professionals ("NASP"). NASP is a non-profit trade association of insurance companies, third-party administrators, subrogation specialists, and attorneys practicing in the field of subrogation and recovery. NASP has approximately 2,300 members, representing more than 425 insurance companies and self-funded entities (including employers and groups of employees). NASP's mission is to create a national forum for education, training, networking, advocacy, sharing of information, and, ultimately, the most effective pursuit of subrogation on an industry-wide basis.

Through NASP, members are able to retrieve, organize, and exchange information, as well as expand the use of technology to promote subrogation efforts on a cost-effective basis. The members of NASP recover billions of dollars annually, including hundreds of millions of dollars in health care expenditures every year for insured and self-funded employee benefit plans through subrogation and recovery practices. One of NASP's goals is to be the "voice of subrogation" for the public, government, and other organizations.

Because the members of NASP recover hundreds of millions of dollars in health care expenditures every year for insured and self-funded employee benefit plans, NASP

1. No counsel for a party authored this brief in whole or in part, and no such counsel or party made a monetary contribution intended to fund the preparation or submission of this brief. No person other than the *amici curiae*, or their counsel, made a monetary contribution to its preparation or submission. The parties have consented to the filing of this brief.

has an interest in whether the Employee Retirement Income Security Act ("ERISA") permits parties who have agreed to use funds recovered from responsible parties to reimburse health plans for medical expenses advanced on their behalf to nonetheless avoid that promise through dissipation. The Court's decision will have a profound impact on employee benefit plans' financial stability, which in turn will have far-reaching implications for the nation's health care system.

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

Through SIIA, its members coordinate their views and provide practical information and recommendations to government and the public at large on a range of subjects relevant to the effective functioning of the self-insurance system, including the provisions of ERISA that concern self-insured health plans and plan participants. SIIA's mission includes rendering assistance to courts in their deliberations on significant self-insured health plan issues of broad concern to its members.

Collectively, SIIA and NASP have a strong interest in preserving their members' ability to recover plan funds from participants that accept medical benefits but then refuse to honor the reimbursement terms of their agreements after obtaining compensation for medical expenses through legal action against or settlement with persons not covered by the plan. *Amici*'s members depend on reimbursement to ensure solvency of their plans and to provide benefits to all participants at lower costs. To the extent that *Amici*'s members are barred from seeking reimbursement according to the terms of the plan, they might be forced to take dramatic action, such as increasing required plan contributions by covered employees (the equivalent of insurance premiums), reducing benefits, or otherwise amending plan terms to protect against this growing and unnecessary risk. Each of these scenarios would have the unfortunate result of reducing the availability of health insurance for the nation's workforce.

SUMMARY OF THE ARGUMENT

Employer-sponsored health plans offered pursuant to ERISA typically require beneficiaries (whose medical expenses are paid by the health plan) to reimburse the plan for that expenditure if the beneficiary later recovers a judgment or legal settlement from a responsible person (such as the driver at fault in a traffic accident). These reimbursement provisions provide a valuable source of cost recovery to the plan. The savings realized from reimbursement obligations help keep premiums and other plan costs lower, to the benefit of all participants. And they are eminently fair, as they seek only to recoup payments already made on behalf of the covered participant, and only from funds, benefits, or proceeds that the participant

receives from a party not covered by or administering the plan, and which arise from a tort or insurance claim.[2]

The Petitioner in this case, Robert Montanile, asks this Court to upend this established and important cost-containment practice and instead interpret ERISA's remedies provision, 29 U.S.C. § 1132(a), to prohibit actions for reimbursement when the beneficiary has spent the settlement funds he received—notwithstanding the Plan's existing equitable lien by agreement. Montanile contends that a beneficiary's dissipation of the fund cuts off the ability of a plan to obtain "appropriate equitable relief" under ERISA—even when the beneficiary was fully aware of the plan's requirement of reimbursement at the time he sought and accepted benefits from the plan, and even when the dissipation occurred after the beneficiary was aware of the plan's specific interest in a particular settlement. Under Montanile's desired ruling, participants would be encouraged—even incentivized—to knowingly and willfully spend settlement funds quickly to prevent the plan from recovering on its lien.

This Court should reject this argument and affirm the sound decision of the Eleventh Circuit below. The text and goals of ERISA, and the legal principles established by this Court's prior jurisprudence, make clear that a plan reimbursement provision gives rise to an enforceable

2. There are other sources of funds that also may be subject to reimbursement provisions, such as a plan beneficiary's other insurance policies. Regardless of the source of these funds, it is important to ensure the enforceability of plan reimbursement and subrogation provisions, and to discourage beneficiaries from avoiding their obligations under the plan by dissipating funds they have promised to repay.

equitable lien on any funds issued by the plan due to the occurrence of a particular event and thereafter recovered by a beneficiary arising from the same event. Any other holding would contradict the language and the logic of the ERISA statutory scheme and this Court's precedents. And the financial consequences for plans—and the other beneficiaries of them—would be swift and severe.

To begin, this Court must recognize that the primary purpose of ERISA's civil remedies provision, section 502(a)(3), is to *enforce* plan terms. As this Court has recognized, the plan is "at the center of ERISA," *US Airways, Inc. v. McCutchen*, 133 S. Ct. 1537, 1548 (2013). This Court's reading of the statute must be consistent with the statute's broader purpose of encouraging "a system that is [not] so complex that administrative costs, or litigation expenses, unduly discourage employers from offering welfare benefit plans in the first place." *Varity Corp. v. Howe*, 516 U.S. 489, 497 (1996).

Moreover, this Court already has held that a reimbursement provision like the one at issue here gives rise to an equitable remedy, and thus falls squarely within section 502(a)(3)'s provision of "appropriate equitable relief." *Sereboff v. Mid Atlantic Medical Services, Inc.*, 547 U.S. 356, 361-63 (2006). Under *Sereboff*, once the beneficiary obtains control over the settlement funds, an equitable lien by agreement attaches and "no tracing requirement … applies[.]" *Id.* at 365. The decision in *Sereboff* controls the outcome here.

Montanile and his *amici* rely extensively on *Great-West Life & Annuity Ins. Co. v. Knudson*, in which this Court held that no equitable lien attaches when a

beneficiary *never* acquires possession over a settlement fund. 534 U.S. 204, 214 (2002). But that is not the case here; Montanile concedes that he gained control over the settlement fund, and that he already had agreed to repay the Plan from that fund. *Sereboff* makes clear that tracing rules that applied to claims for restitutionary liens do not apply to equitable liens by agreement, and that Montanile's dissipation of the settlement fund cannot be used to avoid the Plan's equitable lien by agreement.

A contrary construction of ERISA's remedies provision would have disastrous consequences for plans. The right to recover costs through reimbursement and subrogation are critically important to ensuring the solvency of plans. This is particularly so for the large segment of plans that are self-insured and for which the recovery of every dollar directly benefits all other participants in the plan. Self-insured plans already represent a majority of participants covered through large employer-sponsored plans. This segment of the market is expected to increase with the ongoing implementation of health care reform.

If this Court were to deprive plans of the ability to recoup costs from dissipating beneficiaries by accepting Montanile's reading of section 502(a)(3), there would be no other effective way for plans to protect their right to reimbursement for costs advanced to beneficiaries. To begin, there is no way for plans to ensure that they receive notice of pre-litigation settlements, for which no public records exist. For those cases that do end up in court, monitoring the thousands of potential jurisdictions where a beneficiary may file a tort claim would be prohibitively expensive. Ultimately, with the ever-increasing rush of

jurisdictions looking to limit the rights of benefit plans to recoup funds, there is no guarantee that a plan could intervene in any state court tort action and thus be assured of direct participation in settlement negotiations.

Plans asserting a subrogation claim directly against the alleged tortfeasor may face an additional hurdle in a number of states that have prohibited insurers from seeking subrogation of any medical expenses. New York, for example, has made repeated attempts through its legislature to avoid ERISA's preemption scheme and create hurdles to recovery for insured and employer sponsored benefits plans alike. These same efforts have seemingly leached into the Second Circuit. *See Wurtz v. Rawlings Co., LLC*, 761 F.3d 232 (2d Cir. 2014), *cert. denied,* 135 S. Ct. 1400 (Feb. 23, 2015) (holding that ERISA did not pre-empt enforcement of New York state statute prohibiting subrogation actions). Nor do the professional rules governing attorneys' obligations to the creditors of clients provide any effective protection, as those rules contain numerous caveats and differ substantially among jurisdictions. And all of these alternative enforcement mechanisms highlighted by Montanile and his *amici* run counter to the organizing principle of ERISA: "to provide a *uniform* regulatory regime over employee benefit plans." *Aetna Health Inc. v. Davila*, 542 U.S. 200, 208 (2004) (emphasis added).

Montanile also suggests that plans can protect themselves by seeking a protective injunction in federal court, but this is not an effective or practical option in most cases. It would do nothing in the substantial number of cases where plans cannot ensure they receive notice of pre-litigation settlements. And even when plan administrators

learned of a potential settlement fund, they would face substantial legal and evidentiary obstacles to obtaining a federal injunction that would effectively prevent the dissipation of settlement funds. Moreover, requiring plan administrators (who have fiduciary obligations to the plan) to seek a protective injunction in every case would overwhelm the federal judiciary and drive up plan costs.

Because reimbursement and subrogation remedies are important to plans' solvency, if there is no effective way to enforce a beneficiary's reimbursement obligation, plans will have to make other adjustments to protect themselves and the majority of participants who have not dissipated funds from which they promised to repay medical expenses. Plans may raise required contributions or premiums to account for the increased financial risk that arises from dissipation. They may limit or cease advances to participants, waiting to pay medical bills until any alternative source has been definitively identified and held responsible. Or they may entirely exclude coverage for traffic accidents or other sources of large claims, which would force participants to purchase additional insurance coverage on the open market. All of these proposals would harm plan participants and disrupt a federal scheme for employer-sponsored benefit plans that has been remarkably effective to date.

In sum, there are no legitimate legal or policy reasons supporting Montanile's effort to secure a right to dissipation that overcomes his agreement to reimburse the plan for payments advanced on his behalf. Holding otherwise would contravene the logic of *Sereboff* and Congress's unmistakable intent to ensure an enforcement scheme that is uniform, cost-effective, and predictable.

This Court should affirm the decision of the Eleventh Circuit.

ARGUMENT

I. ERISA Requires The Enforcement Of Plan Terms, And Should Not Be Read To Allow Beneficiaries To Avoid Reimbursement Obligations Through Dissipation.

Montanile's attempt to undermine the enforceability of plan terms strikes at the heart of ERISA. It is inconsistent with the statute's text and its broader purpose of encouraging the creation of employer-sponsored benefit plans and providing uniformity and predictability as to the enforcement of the terms of those plans. It also runs afoul of prior decisions of this Court, which already have held that a plan's reimbursement provision creates an equitable lien by agreement that attaches to a subsequent settlement as soon as it comes into the possession of the beneficiary. This Court should adhere to the statutory framework and its prior decisions and reject Montanile's attempt to create a loophole to plan enforcement that would frustrate a plan's right to reimbursement.

A. Requiring A Beneficiary To Comply With His Or Her Reimbursement Obligation Advances Congress's Goal Of Ensuring The Enforcement Of Plan Terms.

This case turns on the meaning of section 502(a)(3) of ERISA, which permits "a participant, beneficiary, or fiduciary" to seek "appropriate equitable relief ... to enforce any provisions of this subchapter *or the terms*

of the plan." 29 U.S.C. § 1132(a)(3) (emphasis added). That is precisely what the Plan seeks here: enforcement of Montanile's agreement to reimburse the plan for expenses it advanced to pay for his medical care. Allowing a beneficiary to ignore this express promise and instead convert or dissipate the portion of the settlement that he agreed to repay would frustrate, rather than enforce, the terms of the Plan. Because section 502(a)(3) reflects Congress's intent to strengthen—rather than weaken—the enforceability of plan terms, this Court should affirm the decision below.

ERISA is a "'comprehensive and reticulated statute,' the product of a decade of congressional study of the Nation's private employee benefit system." *Mertens v. Hewitt Assocs.*, 508 U.S. 248, 251 (1993) (quoting *Nachman Corp. v. Pension Benefit Guaranty Corporatio*n, 446 U.S. 359, 361 (1980)). The written plan is at the heart of this "interlocking, interrelated, and interdependent remedial scheme." *Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 146 (1985). This Court has repeatedly observed that ERISA "is built around reliance on the face of written plan documents." *Curtiss-Wright Corp. v. Schoonejongen*, 514 U.S. 73, 83 (1995); *see also US Airways, Inc. v. McCutchen*, 133 S. Ct. 1537, 1548 (2013). ERISA expressly requires "[e]very employee benefit plan" to "be established and maintained pursuant to a written instrument." 29 U.S.C. § 1102(a)(1). The plan's administrator must in turn act "in accordance with the documents and instruments governing the plan[.]" *Id.* § 1104(a)(1)(D). "The plan, in short, is at the center of ERISA." *McCutchen*, 133 S. Ct. at 1548.

Given the statute's "repeatedly emphasized purpose to protect contractually defined benefits," *Russell*, 473 U.S. at 148, it is unsurprising that Congress provided remedies through ERISA that would serve to advance the terms of the plan, not defeat them. Section 502(a)(3) "does not, after all, authorize 'appropriate equitable relief' at large[.]" *McCutchen*, 133 S. Ct. at 1548 (quotations omitted). "[R]ather, it countenances only such relief as will enforce '*the terms of the plan*' or the statute." *Id.* (emphasis in original). *See also Mertens*, 508 U.S. at 253 (noting that section 502(a)(3) authorizes "'appropriate equitable relief' for the purpose of 'redress[ing any] violations or … enforc[ing] any provisions' of ERISA or an ERISA plan.").

That is all that Respondent is seeking here: enforcement of the reimbursement provision in the Plan. Montanile no longer disputes that he agreed to reimburse the Plan for medical expenses it paid on his behalf from any settlement or judgment he later obtained. Petitioner's Brief ("Pet. Br.") at 11 & n.4. In reliance on this promise, the Plan advanced more than $121,000 to pay Montanile's medical expenses. Pet. Br. at 2. Montanile later obtained possession of a settlement that included funds from a party alleged to have been responsible for his injuries. *Id.* But despite his knowledge of his reimbursement obligation and the Plan's assertion of a claim to a portion of the resulting proceeds, Montanile failed to reimburse the plan. He now contends that by spending all the money, he is freed from his reimbursement promise, and the Plan is without any recourse. *Id.*

Permitting such easy avoidance of plan terms would undermine not only the express terms of section 502(a)(3),

but also the broader statutory goal of encouraging "a system that is [not] so complex that administrative costs, or litigation expenses, unduly discourage employers from offering welfare benefit plans in the first place." *Varity Corp.*, 516 U.S. at 497. In other contexts, this Court has "recognized the particular importance of enforcing plan terms as written," *Heimeshoff v. Hartford Life & Acc. Ins. Co.*, 134 S. Ct. 604, 612 (2013), and this principle should apply with no less force here. The text of section 502(a)(3) and this Court's prior interpretations of ERISA's remedial provisions strongly weigh in favor of the Plan's attempt to enforce the reimbursement provision, rather than Montanile's blatant effort to avoid it.

B. *Sereboff* Held That ERISA Permits A Plan's Action For Reimbursement From A Particular Fund Without The Need To Satisfy Any Strict Tracing Rules.

To be sure, section 502(a)(3) permits "appropriate *equitable* relief" to enforce a plan's terms. 29 U.S.C. § 1132(a)(3) (emphasis added). Plans therefore may not enforce a particular term by bringing a claim for purely legal relief—that is, "the imposition of personal liability for the benefits that [a plan] conferred upon respondents." *Knudson*, 534 U.S. at 214. In *Sereboff*, however, this Court squarely held that reimbursement provisions like the one at issue here give rise to an equitable lien by agreement, which attaches to a subsequent settlement once the beneficiary obtains possession of the settlement funds. 547 U.S. at 362-63. And *Sereboff* further held that once the lien attaches, "no tracing requirement … applies to equitable liens by agreement or assignment[.]" *Id.* at 365.

That rule decides this case. An equitable lien by agreement in favor of the Plan attached to the settlement fund as soon as it came into Montanile's control. Under *Sereboff*, it is of no consequence that, after receiving the dedicated settlement, Montanile ignored his reimbursement obligation and spent that money. Because the Plan's claim is consistent with section 502(a)(3)'s text, traditional principles that apply to equitable liens by agreement, and the broader statutory goal of ensuring enforcement of the plan's terms, this Court should affirm the Eleventh Circuit's decision.

Sereboff involved a plan—like the one at issue here—that required, among other things, a beneficiary receiving benefits under the plan to reimburse the plan for those benefits from any settlement or other recovery from a responsible party. *Compare* 547 U.S. at 359, *with* Pet. App. 5-7. As in this case, the beneficiary in *Sereboff* was injured, and thus received benefits toward medical care from the plan. 547 U.S. at 360. And, as here, the beneficiary later settled litigation with the person alleged to have been responsible for the injuries. *Id.* Most importantly, in both cases the beneficiary exercised control of a single settlement fund. *Compare id. with* Pet. App. at 12.

Once that occurred, this Court held, the equitable lien by agreement attached to those proceeds. *Sereboff* relied upon *Barnes v. Alexander*, 232 U.S. 117, 121 (1914), which applied "the familiar rul[e] of equity that a contract to convey a specific object even before it is acquired will make the contractor a trustee as soon as he gets a title to the thing." *Sereboff*, 547 U.S. at 363-64. The Court found that the plan covering the Sereboffs "specifically identified a particular fund, distinct from the Sereboffs' general

assets—'[a]ll recoveries from a third party (whether by lawsuit, settlement, or otherwise)'—and a particular share of that fund to which Mid Atlantic was entitled—'that portion of the total recovery which is due [Mid Atlantic] for benefits paid.'" *Id.* at 364. The plan could therefore "'follow' a portion of the recovery 'into the [Sereboffs'] hands' 'as soon as [the settlement fund] was identified,' and impose on that portion a constructive trust or equitable lien." *Id.*

The same is true here. An equitable lien by agreement attached to Montanile's settlement fund when that money—distinct from his other assets—came into his control. The fact that he exchanged or dissipated the funds thereafter is irrelevant, in light of *Sereboff*'s holding that "no tracing requirement … applies to equitable liens by agreement." *Id.* at 365. "[A]ll that matters is that the beneficiary did, at some point, have possession and control of the specific portion of the particular fund sought by the insurer." *Thurber v. Aetna Life Ins. Co.*, 712 F.3d 654, 664 (2d Cir. 2013).

And, as Respondent explains in detail, *see* Respondent's Brief ("Resp. Br.") at 25-46, this rule is in conformity with the general principles of equity and the established practice in the days of the divided bench. *See, e.g.,* 2 Joseph Story, *Commentaries on Equity Jurisprudence as Administered in England & America* § 798 (Isaac F. Redfield ed. 10th ed. 1870) (discussing substitutionary monetary decrees when assets at issue were transferred without notice to bona fide purchaser); Fed. Equity R. 10 (1912) (permitting deficiency judgments for any shortfall upon sale of the property in question). And equity courts of the past would not permit an equitable lien by agreement to be easily discharged by simply spending down the fund

with full knowledge of the lienor's claim; such a result is antithetical to equity, which "eschews mechanical rules" and "depends on flexibility." *Holmberg v. Armbrecht*, 327 U.S. 392, 396 (1946) (Frankfurter, J.).

Nothing in this straightforward application of principles from *Sereboff* contradicts the decision in *Knudson*. In *Knudson*, the plan was pursuing a claim of equitable restitution—not an equitable lien by agreement. For restitutionary claims, the court held, it was necessary to trace the claim to particular funds in the defendant's possession. It thus was decisive that the beneficiary in *Knudson never* came into possession or control of the particular fund of settlement agreement. Under those circumstances, no equitable restitution claim against the beneficiary could be traced to those funds, and the action was indistinguishable from an attempt "to impose personal liability … for a contractual obligation to pay money." *Knudson*, 534 U.S. at 210. It is thus incorrect to assume—as both the United States and Montanile do—that *Knudson* "endorsed … restitutionary tracing rules … to every action for an equitable lien under § 502(a)(3)." *Sereboff*, 547 U.S. at 365. To the contrary, *Sereboff* left no doubt that "no tracing requirement … applies to equitable liens by agreement." *Id.* at 365.

Knudson remains good law with respect to claims for equitable restitution seeking funds that never come into the control of a beneficiary who agreed to reimburse a plan. But *Sereboff* teaches that a beneficiary who has granted a plan an equitable lien by agreement may recover on its lien from the beneficiary without any need to trace its ultimate recovery to the actual funds turned over to the beneficiary. This Court should hold fast to the principles set forth in *Sereboff*, and affirm the decision below.

II. Permitting Beneficiaries To Avoid Reimbursement Obligations Would Have Drastic And Detrimental Effects On Plans And Their Participants

Adopting Montanile's misguided interpretation of section 502(a)(3)[3] would directly threaten the financial stability of thousands of employer-sponsored health plans. The elimination of effective reimbursement remedies will inevitably increase those plans' annual costs by millions of dollars. These losses cannot easily be recouped or offset through other methods of reimbursement or subrogation.

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3. Contrary to the suggestion of the Petitioner, *see* Pet. Br. at 19-20, section 502(a)(3) of ERISA is not the only statutory provision that imposes liability on plan participants who wrongfully retain or dissipate plan funds. Anybody who acts as a fiduciary over plan assets is personally liable for resulting damages, and the plan may obtain all appropriate relief—not just equitable relief—to enforce that liability. *See* 29 U.S.C. §§ 1109, 1132(a)(2). ERISA's provisions of fiduciary liability includes a "participant" who exercises "control over assets" of a plan, 29 U.S.C. § 1104(C)(1)(A), and a number of courts have applied the statutory language and concluded that beneficiaries who wrongfully retain or dissipate assets they know are not theirs qualify as fiduciaries, and thus are properly liable under § 1132(a)(2). *See, e.g., West Virginia Laborers Pension Trust Fund v. Burkhammer*, No. 2:10-cv-01120, 2013 WL 3754822, at *2 (S.D. W. Va. July 15, 2013) (holding that a "person who wrongly retains benefit payments" is liable as a fiduciary under section 502(a)(2) and entering default judgment against beneficiary); *Int'l Painters and Allied Trades Indus. Pension Fund v. Aragones*, 643 F. Supp. 2d 1329, 1336-37 (M.D. Fla. 2008) (same); *Carpenters Pension and Annuity Plan v. Grosso*, No. 07-5013, 2009 WL 2431340, at *5-6 (E.D. Pa. Aug. 6, 2009) (same). While this route to relief does not alter the sound legal and policy reasons for permitting the enforcement of plan reimbursement provisions pursuant to section 502(a)(3) as an equitable lien by agreement, any decision by this Court should leave open this alternate form of liability.

Instead, they will require substantial adjustments to plan practices that currently benefit participants. This Court should not impose restrictions on ERISA's remedies that inevitably will harm plans and their participants.

A. The Enforceability Of Reimbursement Provisions Is Important To Plans' Solvency.

Subrogation and reimbursement are important mechanisms for preserving plan assets. In an era of rising health care expenses, cost containment measures are essential to keep benefits affordable. The elimination or reduction of recoveries from settlements or judgments would make health coverage, which is already difficult for many Americans to afford, even more expensive. One state has estimated that health insurance premiums for state workers would rise between 1% and 2% if insurers' ability to enforce subrogation and reimbursement provisions were eliminated.[4]

The importance of reimbursement and subrogation is a matter of basic economics. "Funds recovered through subrogation serve as a source of revenue" for plans or their insurers, and this revenue is taken into account when calculating the historical cost to determine "the basis of future actuarial rate setting" or required contributions. J. Thomas Allen, *ERISA Subrogation and Reimbursement Claims: A Vote to Reject Federal Common Law Adoption*

4. *See* Department of Legislative Services, Maryland General Assembly, Senate Bill 903: Contracts Between Health Maintenance Organizations and Subscribers or Groups of Subscribers – Subrogation Provisions (2000), *available at* http://mlis.state.md.us/2000rs/fnotes/bil_0003/sb0903.PDF (last accessed Oct. 1, 2015).

of A Default "Make Whole" Rule, 41 Ariz. St. L.J. 223, 240 (2009). As an example:

> [S]uppose an insurance plan covers 100 people and during the first year the plan pays a total of $20,000 in damage claims. Based on that year, the calculation for the cost of insurance the following year will be $200 per person in order to cover the entire risk (assuming that, in the following year, the trend will stay the same and $20,000 in damage claims will be paid). Now suppose that the insurance company is able to subrogate and recover $5,000 of the $20,000 it paid that first year. The cost per person will now be $150, because of the increased revenue brought in through subrogation.

Id; *see also* Jeffrey A. Freenblatt, *Insurance and Subrogation: Where the Pie Isn't Big Enough, Who Eats Last?* 64 U. Chi. L. Rev. 1337, 1355 (1997) ("An insurance company sets its rates based on historical net costs," and when subrogation or reimbursement lower those costs, the corresponding savings will affect the resulting actuarial premium.). "Without subrogation, a part of the risk is shifted back to the insured, [who] pays more for the insurance because he retains ... a right to obtain through litigation a recovery that may actually exceed the actual loss that (after receiving insurance proceeds) he suffered." *Cutting v. Jerome Foods, Inc.*, 993 F.2d 1293, 1297 (7th Cir. 1993) (Posner, J.).[5]

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5. Indeed, the federal government itself recognizes the economic importance of this cost-recovery mechanism, imposing similar obligations upon recipients of medical benefits through

Subrogation and reimbursement provisions are particularly important for self-funded employee welfare plans sponsored by employers and unions. Allowing these plans to recover paid medical expenses that are the financial responsibility of third parties permits them to eliminate duplicative payments to beneficiaries and preserve limited benefit dollars for the benefit of all participants. This permits employers to offer enhanced benefits to covered participants. For self-funded plans, there is no question that subrogation and reimbursement recoveries "inure[] to the benefit of all participants and beneficiaries by reducing the total cost of the plan." *Zurich American Ins. Co. v. O'Hara*, 604 F.3d 1232, 1238 (11th Cir. 2010) (enforcing reimbursement provision over participant's argument that recovery did not make participant whole).

Some of Montanile's *amici* minimize the importance of self-funded plans, citing nearly 10-year-old court filings to suggest that self-insured plans are an insignificant piece of the market. *See* Amicus Curiae Brief for American Association for Justice in Support of Petitioner ("AAJ Br.") at 17. This grossly understates the continued growth of self-insured plans, which cover a majority of employer-sponsored plans. This growth is likely to continue as the Patient Protection and Affordable Care Act ("ACA") continues to reshape the health insurance market.

Medicare. *See* 42 U.S.C. § 1395y(b)(2); *Taransky v. Secretary of the U.S. Dept. of Health and Human Servs.*, 760 F.3d 307, 321-22 (3d Cir. 2014) (holding that the Medicare Secondary Payer Act "authorizes the Government to seek reimbursement from Taransky's settlement, as she has received funds from a primary plan under the statute that has a demonstrated responsibility for her medical expenses").

Companies choose to self-fund employee health benefit plans because they allow employers greater freedom to offer benefits tailored to their particular needs. Under ERISA, "employers have large leeway to design disability and other welfare plans as they see fit." *Black & Decker Disability Plan v. Nord*, 538 U.S. 822, 833 (2003). By offering self-insured plans, employers are able to exercise direct control over claim settlements, to take advantage of greater flexibility in the design and administration of health plans to meet specific employee needs, to better manage cash flows,[6] and to avoid onerous state insurance regulations.

This flexibility has increased the attractiveness of self-funded plans, particularly for large employers or groups of employers. A recent report submitted by the Department of Labor to Congress indicated that as of 2012 (the last year for which data was available), plans with some self-insurance component covered more than 58 million participants.[7] This number in fact *understates* the percentage of the workforce covered by self-insured plans, as it excludes all self-insured plans with fewer than 100 participants (i.e., most small businesses).[8] The same

6. For example, self-funded plans gain the financial advantage of the time-value of their capital. Because medical claims are paid as submitted, company assets can be retained as working capital and invested. Thus, interest can be earned on funds that are retained by the employer and that otherwise would be paid in the form of premiums for conventional insurance.

7. Annual Report on Self-Insured Group Health Plans, at iv (March 2015), *available at* https://www.dol.gov/ebsa/pdf/ACAReportToCongress2015.pdf (last accessed Oct. 1, 2015).

8. *Id.* at ii.

report indicated ongoing growth in both the number of self-insured plans and the number of people covered by them.[9] Other analysis indicates similar growth: "[s]elf-insured plans provided insurance to 61 percent of all U.S. workers covered by an employer-sponsored health plan in 2011, up from 41 percent in 1998."[10] These numbers confirm employers' preference for self-insured plans as a cost-effective way to provide health insurance to employees and their dependents.

The increase in participant coverage by self-insured plans is likely to continue in the wake of the enactment of the ACA. One industry observer noted that "[e]mployers generally, and small employers particularly, are concerned about the rising cost of providing health coverage and may view self-insurance as a better way to control expected cost increases."[11] Self-insured plans also are exempt from some of the ACA's mandates, leading some employers to "view self-insurance as a way to avoid additional costs under the ACA" while retaining the ability to provide beneficial and affordable coverage to their employees.[12]

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9. *Id.* at iv.

10. Stephen Miller, *House Hearing Scrutinizes Self-Insured Plans*: *Federal regulators eye restrictions on stop-loss coverage* (Feb. 28, 2014), *available at* http://www.shrm.org/hrdisciplines/benefits/articles/pages/self-insured-plans-scrutinized.aspx (last accessed Oct. 1, 2015).

11. Stephen Miller, *More Employees Covered by Self-Insured Health Plans* (Dec. 3, 2012), *available at* http://www.shrm.org/hrdisciplines/benefits/articles/pages/self-insured-health-plans.aspx (last accessed Oct. 1, 2015).

12. Miller, *supra* n.10.

The ongoing growth in self-insured plans—which undoubtedly share the benefit of any reimbursement with all other plan participants—underscores the importance of retaining remedies that benefit all participants when they are able to enforce plan requirements for reimbursement and recover costs from settlements. Such recoveries are essential to "protect the solvency of employee benefit plans to ensure that the valid claims of employees and their beneficiaries will be paid." *McGann v. H & H Music Co.*, 742 F. Supp. 392, 393 (S.D. Tex. 1990) (citation omitted). These plans, and the participants they serve, should not be handcuffed by a cramped reading of section 502(a)(3)'s right to "appropriate equitable relief."

B. Plans Cannot Reliably Protect Their Right To Reimbursement Outside Of An Enforcement Action Under § 502(a)(3).

Some of Montanile's *amici* contend that plans retain adequate remedies to recover reimbursement even if ERISA's remedies are constrained so as not to permit an action to recover settlements that have been dissipated. For example, the American Association for Justice contends that a plan "can assert its right of subrogation and file its own action against the tortfeasor," or "intervene in the action filed by its beneficiary and participate in settlement negotiations to ensure its reimbursement rights are protected." AAJ Br. at 24-25; *see also* Amicus Curiae Brief of the United States in Support of Petitioner ("U.S. Br.") at 30-31. But these proposals are neither a realistic nor efficient substitution for simple enforcement of the plan's reimbursement terms. Indeed, the cost and complications of directly intervening in each case would likely be so substantial as to leave plans looking

at alternative protections that will damage beneficiaries' interests in the long run.

Consider first the suggestion that plans simply seek to timely intervene in any dispute between a fiduciary and a tortfeasor to protect their rights. To begin, "[i]t is common knowledge that a large percentage of the claims covered by insurance are settled without litigation and that this is one of the usual methods by which the insured receives protection." *Dairyland Ins. v. Herman*, 954 P.2d 56, 61 (N.M. 1997) (citation omitted); *see also Langdon v. Champion*, 752 P.2d 999, 1003 n.9 (Alaska 1988) ("[I]t is well known that only a small fraction of [automobile accident] claims involve litigation. The vast majority are settled without litigation and without lawyers.").

Several surveys have confirmed the prevalence of pre-litigation settlements. For example, a report from Washington State determined that lawsuits were filed only 47.3 percent of the time, but for claims without litigation, claimants were compensated 51.8 percent of the time. *See* 2014 Medical Malpractice Annual Report, Washington State Office of the Insurance Commissioner (Aug. 2014), http://www.insurance.wa.gov/about-oic/commissioner-reports/documents/2014-med-mal-annual-report.pdf; *see also* Marc A. Franklin et. al., *Accidents, Money, and the Law: A Study of the Economics of Personal Injury Litigation*, 61 Colum. L. Rev. 1, 10 (1961) (noting that of 193,000 accident victims with personal injury claims in New York annually, 39,000 proceed without counsel, and "[a]pproximately 116,000 are closed without suit"). This is especially likely to be true when the injuries and financial damages are serious and fault is not in doubt—not an uncommon occurrence in serious automobile accidents. In

such cases, a plan is dependent almost entirely upon the beneficiary to disclose the settlement process; there are not, and never will be, any court records to check or filings to monitor. Pre-litigation settlements may thus result in a transfer of funds that the plan has no easy way to timely discover, let alone intervene and participate in.

Even for those tort cases that do end up in court, establishing a process to monitor the thousands of jurisdictions where a tort claim may be filed is prohibitively expensive. For although claims under ERISA are subject to exclusive jurisdiction in federal court, those injured in automobile accidents, slip-and-falls, or other personal injury torts may sue alleged tortfeasors in state or federal court (provided the requirements of diversity jurisdiction are satisfied). Plans whose coverage extends nationwide may have tens of thousands of potential reimbursement claims a year. Each plan would have to implement "very careful monitoring of all beneficiaries, which may prove to be very costly [because each] plan would have to devise a way to flag claims that have the potential for tort litigation down the line." Randal M. Whitlatch, *Subrogation Under ERISA and the Search for "Appropriate Equitable Relief,"* 41 Tort Trial & Ins. Prac. L.J. 1049, 1075 (2006).[13]

Additionally, there is no guarantee that a plan will be permitted to intervene in a tort action, particularly if one is pending in state court. Plans face potential variations among local jurisdictions in the standards, deadlines, and

13. Although plan terms often require a beneficiary to notify the plan of any potential third-party claim, a beneficiary intent on avoiding their reimbursement obligation is unlikely to comply with the notice requirement—and would have no incentive to do so if Montanile prevails in this Court.

procedures for intervention. And even when those varying requirements are met, there is still no assurance that state courts would permit a plan to intervene in a pending action. ERISA grants federal courts exclusive jurisdiction in almost all cases, including actions by a plan for relief against a beneficiary. *See* 29 U.S.C. § 1132(e)(1). Thus, "a plan may intervene only to have its case dismissed due to the complete preemption of ERISA." Whitlach, *supra*, at 1075. Although the plan could still file a separate action for enforcement against its beneficiary in federal court, its ability to participate directly in the state court action and secure a right against dissipation is very much in doubt—assuming state law does not prohibit exercise of that right in the first place. *See Wurtz*, 761 F.3d at 245 (holding that state law may prohibit enforcement of subrogation rights notwithstanding contrary terms of an ERISA plan).

The same issues of notice and cost apply equally to the argument that plans could protect themselves against dissipation by filing subrogation actions directly against tortfeasors. But this proposal comes with an additional significant hurdle, at least for insured plans: state anti-subrogation laws.[14] The United States implicitly acknowledges this restriction, noting (without further elaboration) that "plans may exercise that option *when subrogation is permitted under state law*." U.S. Br. at 30 (emphasis added). A number of states have anti-subrogation statutes specifically designed to prevent insurers from

14. Although ERISA generally preempts state laws that affect benefit plans subject to the statute, 11 U.S.C. § 1144(a), it excludes from preemption "any law of any State which regulates insurance, banking, or securities." *Id.* § 1144(b)(2)(A).

directly enforcing reimbursement provisions.[15] *See, e.g.*, C.G.S.A. § 52-225a; Kan. Admin. Regs. § 40-1-20; N.J.S.A. § 2A:15-97; 11 N.C.A.C. § 12.0319; Va. Stat. § 38.2-3405. These laws may prevent a plan from directly asserting a claim over any judgment or settlement in a case initiated by a beneficiary, again forcing it to seek relief through a parallel federal action that may ultimately be insufficient to prevent a beneficiary's dissipation of the actual dollars received in a litigation settlement.

Nor can plans rely on attorneys' professional obligations under state law to protect their right to reimbursement and the equitable lien created thereby. Such rules have no applicability whatsoever when a case is settled via insurance agents, where no attorney needs to get involved. *See supra* at 23-24. Even for those cases that reach litigation, states do not have uniform rules regarding an attorney's obligation to ignore client instructions to disburse funds subject to an agreed-upon lien. *See* Resp. Br. at 53-54. And even where *some* state's professional code *might* require an attorney to ignore her client's direction to disburse funds that are subject to a "*valid* assignment of rights to the proceeds of a settlement or [] a consensual lien on the settlement," *see* Virginia Legal Ethics Opinion 1747, *Attorney Breaching Contract to Pay Medical Bills Out of Settlement Proceeds* (emphasis added), there is little to stop a creative attorney from alleging that the plan's

15. "Unlike subrogation, which arises under state law and allows the insurer to stand in the shoes of its insured, reimbursement is a contractual right governed by ERISA and comes into play only after a plan member has received personal injury compensation. While subrogation and reimbursement may have similar effects, they are distinct doctrines." *Unisys Medical Plan v. Timm*, 98 F.3d 971, 973 (7th Cir. 1996).

lien is somehow invalid or subject to a dispute, thereby taking them out of the letter of the rule. *See id*; *see also* Ga. R. Prof. Cond. 1.15(I)(b) (noting that "[t]he lawyer may disregard the third person's claimed interest if the lawyer reasonably concludes that there is a valid defense to such lien, judgment, or agreement").

This case illustrates the point: Montanile's attorney alleged that the Plan's reimbursement provision was unenforceable because it appeared only in the plan summary—a claim uniformly rejected by the courts below and which has since been abandoned. Pet. Br. at 11. But Montanile's attorney did not wait for resolution of that question by a court, or initiate an interpleader action to preserve the funds. It disbursed them as directed, resulting in their dissipation. *Id.* at 11-12. There is no evidence that professional discipline awaits—let alone that there is an available legal remedy against an attorney for improper disbursement that might make a plan whole.

Moreover, all of these suggestions that plans resort to various state laws to protect their interests ignore the overriding purpose of ERISA: "to establish a uniform administrative scheme, which provides a set of standard procedures to guide processing of claims and disbursement of benefits." *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 9 (1987); *see also Aetna Health Inc. v. Davila*, 542 U.S. 200, 208 (2004) ("The purpose of ERISA is to provide a uniform regulatory regime over employee benefit plans."). "Uniformity is impossible however, if plans are subject to different legal obligations in different states …. Requiring ERISA administrators to master the relevant laws of 50 States and to contend with litigation would undermine the congressional goal

of 'minimizing the administrative and financial burdens on plan administrators--burdens ultimately borne by the beneficiaries.'" *Egelhoff v. Egelhoff*, 532 U.S. 141, 149-150 (2001) (quoting *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 142 (1990)). To address this concern, Congress gave plans a right to an exclusive federal forum to resolve disputes. 29 U.S.C. § 1132(e)(1). Removing that right and forcing ERISA plans to seek relief under the varying procedural and substantive restrictions available in the states is a recipe for the "administrative costs" and "litigation expenses" that "unduly discourage employers from offering plans in the first place." *Varity Corp.*, 516 U.S. at 497.

Montanile suggests that even without the ability to intervene or file an action for subrogation, a plan may seek and obtain an injunction in federal court. *See* Pet. Br. at 3, 22 n.13. But even assuming that a plan becomes aware of a potential settlement, as Respondent explains, there is no guarantee that it will be able to meet the strict standards for Article III standing or injunctive relief at that time. *See* Resp. Br. at 51-52 (citing *City of Los Angeles v. Lyons*, 461 U.S. 95, 102 (1983) and *Winter v. NRDC*, 555 U.S. 7, 24 (2008)). And if an administrator waits until a settlement is actually consummated, it may be too late to stop the beneficiary from evading the equitable lien and spending the funds. Moreover, reliance on protective injunctions invites a tidal wave of federal litigation, as ERISA fiduciaries may feel compelled to file for a protective injunction in every single case.

A final suggestion from Montanile's *amici* is particularly telling—they argue that plans should simply accept the fact that they are powerless to prevent dissipation, and

therefore they should "compromise with its beneficiary on a lower reimbursement, rather than litigate for the full amount, with the attendant risk of loss or inability to collect on a judgment." AAJ Br. at 25. This, of course, is not an alternative method to *enforcing* a reimbursement obligation; it is instead a capitulation to the party who is refusing to honor the agreement to reimburse. This "alternative" reveals the real goal of many supporters of Montanile in this case: to enact new substantive hurdles to plan enforcement that they were unsuccessful in obtaining from this Court in *McCutchen* and *Sereboff*.

C. If Plans Cannot Enforce Reimbursement Provisions, They Will Impose Offsetting Cost-Control Mechanisms That Will Be Detrimental To Plan Participants.

If this Court eliminates the ability of plans to enforce reimbursement provisions against beneficiaries who ignore the terms they agreed to and dissipate settlement funds, it ultimately will harm plan participants. Plan administrators have the ability and fiduciary obligation to impose alternative cost-control mechanisms. The predictable options all involve eliminating, or at least restricting, practices that currently benefit injured plan participants.

First, employers may be forced to reduce or eliminate certain benefits, increase premiums, or do both, because a plan's ability to obtain reimbursement from participants is a significant factor in establishing benefit levels and plan rates. If the plan's right to reimbursement is denied, the cost of paying for the underlying benefits falls to those who make the contributions that support plan benefits.

In the absence of a predictable right to recovery, plans will be forced to protect against the resulting risk by raising rates or decreasing benefits for all participants. Plan participants that honor their obligations under plan reimbursement provisions should not be forced to bear these costs.

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

Third, to secure the certainty of recovery of medical expenses if section 502(a)(3) remedies are weakened, plans could choose to offset future benefits. In other words, a plan could add language to an existing reimbursement provision permitting the fiduciary to deny future benefits equal to the amount of money that should have been reimbursed under the terms of the plan. Or more drastically, plan sponsors might be compelled to amend their plans to exclude coverage for medical expenses related to the negligence of other parties. Such restrictions are permissible because, as this Court has recognized, ERISA "does not regulate the substantive content of

welfare-benefit plans." *Metropolitan Life Ins. Co. v. Mass.,* 471 U.S. 724, 732 (1985), and nothing in federal law "requires a welfare plan to contain a subrogation clause nor does it bar such clauses or otherwise regulate their content." *Ryan by Capria Ryan v. Federal Express Co.*, 78 F.3d 123, 127 (3d Cir. 1996). If plans were to eliminate this coverage, participants will ultimately have to pay retail rates for their medical expenses out of their own pockets because individuals cannot negotiate the more favorable group rates available to an employee benefit plan.

The net consequences of all of these possible outcomes would be higher plan costs and reduced plan benefits, harms that will be shifted to all plan participants, including plan participants that honor the terms of their agreements. This unnecessary and unwarranted shift of risk allocation would come at a time when employers are finding it increasingly difficult to provide benefits to their employees. "Cost of employer-sponsored coverage is the most common reason employers cite for not offering health coverage."[16] Indeed, premiums have more than doubled since 2001, and system-wide increases in health care costs going forward are expected to outpace the growth in national income for the foreseeable future—despite the enactment of the ACA.[17] The relief requested

16. The Henry J. Kaiser Family Foundation, *The Uninsured: A Primer: Key Facts About Americans Without Health Insurance* (Jan. 2015), *available at* http://files.kff.org/attachment/the-uninsured-a-primer-key-facts-about-health-insurance-and-the-uninsured-in-america-primer (accessed on Oct. 1, 2015).

17. *See* The Henry J. Kaiser Family Foundation, *Health Care Costs, A Primer* at 2 (May 2012), *available at* http://kaiserfamilyfoundation.files.wordpress.com/2013/01/7670-03.pdf (accessed on Oct. 1, 2015).

by Montanile threatens to further increase costs, upend beneficial aspects of qualified plans for all participants, and provide a benefit only to those who seek to avoid abiding by disclosed plan terms to which they agreed. Neither law nor policy compels such an unwarranted and inequitable result.

CONCLUSION

For the reasons stated, NASP and SIIA respectfully ask that the Court affirm the judgment below.

Respectfully submitted,

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