No. 05-260

In The Supreme Court of the United States

JOEL SEREBOFF and MARLENE SEREBOFF,
Petitioners,

v.

MID ATLANTIC MEDICAL SERVICE, INC.,
Respondent.

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

AMICUS CURIAE BRIEF OF AMERICA'S HEALTH INSURANCE PLANS, INC., AMERICAN BENEFITS COUNCIL, AND NATIONAL ASSOCIATION OF MANUFACTURERS IN SUPPORT OF RESPONDENT

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I.
IDENTITY AND INTEREST OF THE *AMICI CURIAE*[1]

A. The *Amici*

This brief is being filed by three *amici curiae*, America's Health Insurance Plans, Inc. ("AHIP"), American Benefits Council ("ABC"), and the National Association of Manufacturers ("the NAM"), (collectively, the "*Amici*"), all of which maintain a common interest in the result of the instant Petition.[2]

America's Health Insurance Plans, Inc. is the national association representing the private health plan and insurer community. AHIP's mission is to advance health care quality and affordability through leadership in the health care community, advocacy, and the provision of services to its members. AHIP represents nearly 1,300 member companies that administer or insure benefits, including health, pharmaceutical, long-term care, disability, and supplemental coverage, to more than 200 million Americans, the majority of whom are participants in or beneficiaries of employee benefit plans under the Employee Retirement Income

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[1] This brief was prepared in its entirety by *Amici* and their counsel. No monetary contribution toward the preparation or submission of this brief was made by any person other than *Amici*, their members, and their counsel.

[2] All parties have consented to the filing of this brief in written consents filed with the Court on January 11, 2006, and January 13, 2006.

Security Act of 1974 ("ERISA"), 29 U.S.C. §§ 1001 *et seq*.

The American Benefits Council is a broad-based, nonprofit trade association founded in 1967 to protect and foster the growth of this nation's privately sponsored employee benefit plans. The Council's members include both small and large employer-sponsors of employee benefit plans, including many Fortune 500 companies. Its members also include employee benefit plan support organizations, such as actuarial and consulting firms, insurers, banks, investment firms, and other professional benefit organizations. Collectively, its more than 250 members sponsor and administer plans covering more than 100 million plan participants and beneficiaries.

The National Association of Manufacturers is the nation's largest industrial trade association, representing small and large manufacturers in every industrial sector and in all fifty states. The NAM's mission is to enhance the competitiveness of manufacturers by shaping a legislative and regulatory environment conducive to U.S. economic growth and to increase understanding among policymakers, the media, and the general public about the vital role of manufacturing to America's economic future and living standards.

B. Interests of the *Amici*

Employee benefit plan reimbursement provisions (also used herein to include plan subrogation provisions), such as those at issue in this case, are used extensively throughout the

insurance and managed care industries for both insured and self-funded employee benefit plans. Such provisions generally require a plan participant (or beneficiary) to reimburse the plan for funds expended on the participant's behalf, if the participant recoups money from a third party responsible for the participant's injuries.

The ability of ERISA plans to seek reimbursement of benefits from plan participants who have recovered funds from third parties is important to their continued financial security. Reimbursement provisions are critical cost-saving devices for employers and other plan sponsors facing strong health care cost inflation pressures. Hundreds of millions of dollars, at least, are recouped annually by employee health benefit plans offered, insured, or administered by the *Amici*'s member organizations by virtue of reimbursement recovery mechanisms. [3]

The cost savings achieved by subrogation recoveries are passed on to employers and employees in the form of lower health care costs, making health care coverage more available and affordable. The *Amici* are concerned that the Court's adoption of

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[3] During fiscal year 2003, one of the largest private health care claims recovery services in the United States recovered $235.9 million in health claims, and had a backlog of over $1.5 billion of potentially recoverable claims. *See* Trover Solutions, Inc., Form 10-K, for the fiscal year ended Dec. 31, 2003, at 29. Based on the recoveries made by this service, and the number of lives covered (approximately 40 million), it can be estimated that more than $1 billion is recovered annually on behalf of all plans.

Petitioners' position in this case would render plan reimbursement provisions unenforceable with the following adverse effects:

- the cost of providing employee health plan benefits would rise, deterring employers from sponsoring and funding employee benefit plans;

- additional costs would be shifted to participants and beneficiaries, deterring participation in employee benefit plans;

- some participants and beneficiaries would be unjustly enriched by retaining double recoveries, at the expense of the plan and other participants and beneficiaries;

- fiduciaries would be unable to administer employee benefit plans in accordance with plan documents; and

- the national uniformity of administering plan provisions would be sacrificed, creating an administrative burden for plan administrators.

II.
SUMMARY OF ARGUMENT

ERISA Section 502(a)(3) specifically authorizes civil actions ". . . (B) to obtain other appropriate equitable relief . . . (ii) to enforce . . . the terms of [a] plan." ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3). In *Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204, 220-21 (2002), in a 5-4 decision, this Court precluded the insurer of an employee benefit plan from enforcing a plan reimbursement provision because, under the particular facts of that case, the relief sought was determined not to constitute "equitable relief" within the meaning of Section 502(a)(3). Unlike *Knudson*, this case requires the Court to squarely address the issue of whether it is reasonable to conclude that Congress, in enacting ERISA, intended to preclude an employee benefit plan from **ever** being able to enforce under ERISA a vital and customary provision of employee benefit health plans.

In *Knudson*, the majority specifically held that a plan reimbursement and/or subrogation provision could not be enforced against a plan participant (or beneficiary) who was **never in possession of the settlement funds at issue**. Notably, the majority explicitly distinguished situations involving the enforceability of plan reimbursement provisions where, as here, a party **in possession of the settlement funds** has been sued. *Knudson*, 534 U.S. at 214. The majority explained that equitable restitution generally was available if "money or property . . . belonging in good conscience to the plaintiff could clearly be traced to particular funds or

property in the defendant's possession." *Knudson*, 534 U.S. at 213 (*citing* 1 D. Dobbs, Law of Remedies § 4.3, at 587-88 (2d ed. 1993); Restatement of Restitution, Comment *a*, at 641-42 (1936); 1 G. Palmer, Law of Restitution § 1.4, p.17; § 3.7, p. 262 (1978)).

In contrast to this situation described in *Knudson*, Petitioners ask this Court to now hold that the object of **any suit** to enforce the terms of a plan reimbursement provision is "'in essence, to impose personal liability on [Petitioners] for a contractual obligation to pay money . . . '" (Petitioners' Brief, at 23 (*quoting Knudson*, 534 U.S. at 210)), regardless of whether a defendant, as in the present case, was in possession of the particular settlement funds at issue.

Such a result is inconsistent not only with this Court's careful differentiation between money damages and equitable relief in *Knudson*, but also with both ERISA's structure and the objectives by which this Court has stated that interpretations of Section 502(a)(3) should be informed. *See Varity Corp. v. Howe*, 516 U.S. 489, 515 (1996). Plan reimbursement provisions were commonly included in both insured and self-insured health plans at the time of ERISA's enactment as a means of reducing potentially enormous costs to the plan which could adversely affect the cost and availability of coverage to its participants. It cannot reasonably be concluded that Congress, while explicitly authorizing civil actions to "enforce the terms of [a] plan," and mandating the plan fiduciaries act "in accordance with the documents and instruments governing the

plan,"[4] intended to omit the enforcement of such vital plan reimbursement provisions from ERISA's "comprehensive and reticulated" scheme. *See Nachman Corp. v. Pension Benefit Guar. Corp.*, 446 U.S. 359, 361 & 361 n.1 (1980) (noting that ERISA is a "comprehensive and reticulated statute" which provides civil and criminal enforcement).

Interpreting ERISA to exclude such provisions from its enforcement provisions contravenes **every one** of what this Court has called the sometimes "competing congressional purposes" for enacting ERISA in the first place. *See Varity Corp.*, 516 U.S. at 497. Those purposes include the desire to: (1) create incentives for the creation and maintenance of employee benefit plans (*see Fort Halifax Packing Co., Inc. v. Coyne*, 482 U.S. 1, 11 (1987)); (2) "protect plan participants and beneficiaries" (*Boggs v. Boggs*, 520 U.S. 833, 845 (1997) (citation omitted)); (3) ensure the enforcement of the terms of employee benefit plans (*Gulf Life Ins. Co. v. Arnold*, 809 F.2d 1520, 1523 (11th Cir. 1987)); and (4) assure uniformity and efficiency in plan administration. *N. Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 656-57 (1995).

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[4] ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3); ERISA § 404(a)(1)(D), 29 U.S.C. § 1104(a)(1)(D).

III.
ARGUMENT

A. A Claim To Enforce The Terms Of An Employee Benefit Plan Is Explicitly Authorized By ERISA Section 502(a)(3) So Long As The Remedy Sought Is "Appropriate Equitable Relief"

Petitioners' assertions that any claim to enforce a plan reimbursement provision is not authorized under Section 502(a)(3) because it is in essence a breach of contract claim for money damages, and not equitable relief, is specious.[5] The language of ERISA Section 502(a)(3) explicitly authorizes civil actions by a plan fiduciary (as well as a participant and beneficiary) "to **enforce . . . the terms of [a] plan**" or "to redress such violations" of plan terms.[6] This straightforward grant by Congress of the right of a plan fiduciary to enforce plan terms belies Petitioners' assertions. Indeed, ERISA *obligates* a plan fiduciary to act in accordance with plan terms.[7]

The only relevant limitation in Section 502(a)(3) on an action seeking to enforce the terms of a plan is that the **remedy** or **remedies** sought in connection with such a claim must constitute "appropriate equitable relief." Refusing to

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[5] *See* Petitioners' Brief, at 23 (*citing Knudson*, 534 U.S. at 210).

[6] *See* ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3) (emphasis added).

[7] *See* ERISA § 404(a)(1)(D), 29 U.S.C. § 1104(a)(1)(D).

enforce the terms of an employee benefit plan or allow redress for its violation under Section 502(a)(3) solely because such claim is gratuitously characterized as "in substance" a breach of contract claim for money damages renders the relevant language from Section 502(a)(3) completely superfluous. *See*, *e.g.*, *Admin. Comm. of Wal-Mart Assocs. Health & Welfare Plan v. Willard*, 393 F.3d 1119, 1125 (10th Cir. 2004) (explaining that "[a]fter all, any equitable relief, including those forms explicated by the [Supreme] Court as available under [Section] 502(a)(3), must involve the direct or indirect transfer of money, **and we cannot read the statute to proscribe all forms of relief.**") (emphasis added).

B. The Relief Sought In This Case Constitutes Equitable Relief Within The Meaning Of ERISA Section 502(a)(3)

Respondent's brief amply demonstrates that the relief sought in this case clearly falls within the guidelines for determining "equitable relief" set forth by this Court in *Knudson* and the authorities relied upon by the Court in articulating such guidelines. Thus, despite acknowledging the "fairness" of enforcing plan reimbursement provisions in circumstances like these in this case,[8] Petitioners would ascribe to Congress (without a scintilla of legislative history) an intent to preclude the enforcement of such important employee benefit plan provisions under precisely the circumstances that

[8] Petitioners' Brief, at 21.

this Court has stated gives rise to a basis for seeking equitable restitution.

To deny such relief where the settlement funds are in defendant's possession and undoubtedly belong "in good conscience to respondent" is to interpret the term "equitable relief" without regard to the primary objectives of ERISA and in a fashion which disregards a reasonable interpretation of the language of ERISA Section 502(a)(3) according to guideposts carefully articulated by the majority in *Knudson*. Following Petitioners' path would turn innumerable cases involving the interpretation of "appropriate equitable relief" into precisely the immersion into the esoteric pronouncements of relevant treatises and ancient cases that both the majority and minority in *Knudson* hoped to avoid.

C. The Equitable Relief Which Respondent Seeks Is "Appropriate" Within The Meaning Of ERISA Section 502(a)(3)

Petitioners assert that, even if the relief which Respondent seeks is "equitable relief" within the meaning of ERISA Section 502(a)(3), it nevertheless is not "appropriate."[9] Such an assertion is inconsistent with this Court's guidelines for interpreting that term set forth in *Varity Corp. v. Howe*, 516 U.S. 489 (1996), and with ERISA's primary policy objectives which are an important touchstone in determining whether particular relief is "appropriate." *Id.* at 515 ("We should expect that courts, in fashioning 'appropriate' equitable relief, will keep in mind the 'special nature and purpose of

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[9] Petitioners' Brief, at 30-35.

employee benefit plans,' and will respect the 'policy choices reflected in the inclusion of certain remedies and the exclusion of others.'" (*quoting Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 54 (1987)).

1. Petitioners' interpretation of ERISA Section 502(a)(3) would essentially preclude the enforcement of any plan reimbursement provision, or any other plan provision which entails an obligation to pay money to a plan.

An affirmance in this case would, effectively, eliminate the right and ability to enforce under ERISA any plan reimbursement provision.[10] Reimbursement provisions, such as those at issue in this case, prevent the dissipation of a limited pool of health care funds that would lead to increases in health benefit plan costs, discourage employers from maintaining health benefit plans, and inevitably increase the ranks of the uninsured.

Functionally, reimbursement provisions operate to allow insurance companies and health benefit plans to recoup funds directly from participants or beneficiaries who ultimately recover

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[10] The same reasoning could be used to foreclose plan fiduciaries from recouping *overpaid* health and pension plan benefits. *See N. Am. Coal Corp. v. Roth*, 395 F.3d 916, 917 (8th Cir. 2005) (district court may properly award equitable relief to plan and its administrator who brought lawsuit against individuals who refused to return monies mistakenly overpaid from pension benefit plan), *cert. denied*, 126 S. Ct. 145 (2005).

payments for the same injuries from responsible third parties. Reimbursement differs from the more costly and burdensome alternative of subrogation in that under a reimbursement provision, a health benefit plan does not actually commence an action in the beneficiary's name, as it would under a subrogation provision, but instead acts as a first lienholder upon any third-party funds collected by the beneficiary.

A primary objective of ERISA is to ensure the enforcement of terms of a plan. *See*, *e.g.*, *Arnold*, 809 F.2d at 1523 ("The purpose essential to section 1132(a)(3)(B) is to enforce the terms of [a] plan . . ."). Such an objective is manifest in the structure of ERISA which, among other things (i) requires fiduciaries to act in accordance with the terms of a plan,[11] (ii) provides plan participants and beneficiaries with a cause of action to enforce their "rights under the terms of the plan,"[12] and (iii) authorizes participants, beneficiaries, and fiduciaries "to enjoin any act or practice which violates . . . the terms of [a] plan" or "to obtain other appropriate equitable relief . . . to redress such violations."[13]

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[11] ERISA § 404(a)(1)(D), 29 U.S.C. § 1104(a)(1)(D).

[12] ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B).

[13] ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3).

2. The type of relief sought in this case promotes the availability and affordability of health insurance.

Not only does the Petitioners' interpretation undermine the enforcement of a critically important plan provision, but it contravenes the intent of Congress that ERISA be used to protect plan participants and beneficiaries[14] and create incentives for the creation and maintenance of employee benefit plans.[15]

Employer-based health insurance is the keystone of the American health care system. In 2003, approximately 131 million people in the United States had some kind of private health coverage through ERISA-governed group health plans.[16] As the number of privately insured individuals decreases, the financial burden of health

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[14] *See Boggs*, 520 U.S. at 845 ("The principal object of the statute is to protect plan participants and beneficiaries.") (*citing Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 90 (1983)). ERISA itself notes that the express purpose is "to protect interstate commerce and the interests of participants in employee benefit plans and their beneficiaries." ERISA § 2(b), 29 U.S.C. § 1001(b).

[15] *See Coyne*, 482 U.S. at 11 (1987) ("A patchwork scheme of regulation would introduce considerable inefficiencies in benefit program operation, which might lead those employers with existing plans to reduce benefits, and those without such plans to refrain from adopting them.").

[16] Department of Labor Deputy Assistant Secretary for Policy Bradford P. Campbell, Testimony Before the Subcommittee on Labor, Health and Human Services, and Education Committee on Appropriations, April 2, 2004, *available at* http://www.dol.gov/ebsa/newsroom/ty040204.html.

care is shifted to the already-strained federal and state systems.[17] National public policy is clearly against altering the health insurance and ERISA plan industry in any way that would significantly increase premium rates and deductibles.[18]

Insurance companies and employee health care plans base their rates and benefit levels on actuarial predictions of future claims and expense levels which are based, in part, on past claims experience. Reimbursement and subrogation results

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[17] *See* John Sheils & Lisa Alecxih, The Lewin Group, Inc., *Recent Trends in Employer Health Insurance Coverage and Benefits*, Final Report, 7 (Oct. 21, 1996) (projecting that as the percentage of people with employer-sponsored health care as their primary health care coverage decreases, the percentage of people with Medicare or Medicaid as their primary source of health care coverage will increase), *available at* http://www.lewin.com/Lewin Publications/Uninsured And Safety Net/Publications-23.htm. *See also* U.S. Census Bureau, *Income, Poverty, and Health Insurance Coverage in the United States: 2004*, Current Population Reports (August 2005) (the percentage and number of people covered by government health insurance programs increased between 2003 and 2004, while the percentage of people covered by employment-based health insurance decreased).

[18] While the rate of increase has slowed recently, premiums for employer-sponsored health insurance still increased by 9.2% in 2005. Kaiser Family Foundation & Health Research and Educational Trust, *Employer Health Benefits 2005 Annual Survey*, *available at* http://www.kff.org/insurance/7315/index.cfm.

are factored into claims experience.[19] With the inability to recoup plan funds, the inevitable result will be that rates will ultimately increase or benefits will decrease for all members of employee health benefit plans, or in some cases benefits will be discontinued entirely. The impact of the loss of the ability to enforce reimbursement provisions may be particularly harsh for smaller plans, where a single, unreimburseable loss could lead to a significant rate increase for a plan because of the size of the loss relative to the plan's aggregate claims experience.[20]

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[19] *See*, *e.g.*, *Incurred Health and Disability Claims*, Actuarial Standard of Practice No. 5, § 3.3.5 (Actuarial Standards Bd. 2000), which states:

> Coordination of Benefits (COB) or Subrogation - The actuary should take into account the relevant organizational practices and regulatory requirements related to COB or subrogation. In particular, the actuary should consider how these items are reflected in the data (for example, negative claims or income) and make appropriate adjustments for COB, subrogation, or other adjustments or recovery.

See also Documentation in Health Benefit Plan Ratemaking, Actuarial Standard of Practice No. 31, § 3.5.4 (Actuarial Standards Bd. 1997).

[20] A simple mathematical example confirms this:

Assume a group with $4M of claims in 2005 is renewing their contract with the same plan and population. Assuming further a 10% increase due to changes in cost and utilization, a 3% increase for the aging of the population, and no reduction in claims in the past for recoupment, then the expected claims for 2006 might be calculated as $4.52M, a 13% increase. For insured plans, premiums would be based on this expected claims number.

Even a one percent increase in health plan costs nationally "results in a potential loss of insurance coverage for about 315,000 individuals" over a five-year period.[21] Thus, as reported in the New York Times on August 31, 2005, a new survey by the U.S. Census Bureau shows that, after four years of rapidly rising health costs, the percentage of people receiving health care from employers decreased from 63.6% in 2000 to 59.8% last year (2004).[22] Cost containment mechanisms such as reimbursement provisions are critical to ensure that the number of privately insured individuals does not further decrease.[23]

Petitioners appear to recognize that a subrogation claim brought directly by a plan or insurer against a third-party tortfeasor would constitute "equitable relief" within the meaning of

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However, if during the prior year the group had a $200K net recoupment recovery then the actuary would reduce the prior year's claims experience to $3.8M. Applying the 13% increase to this experience results in an expected claims number of $4.29M. This is approximately 5% less than the projected claims without allowing recoupment.

[21] *See* Health Econ. Practice, Barents Group, LLC, *Impacts of Four Legislative Provisions on Managed Care Consumers*: 1999-2003, iii (prepared for the Am. Ass'n of Health Plans, 1998).

[22] *See* David Leonhardt, *Poverty in U.S. Grew in 2004, While Income Failed to Rise for 5th Straight Year*, N.Y. Times, August 31, 2005, at A9.

[23] *See Relationship Between Health Care Costs and America's Uninsured: Hearing Before the Subcomm. on Employer-Employee Relations of the House Comm. on Educ. & the Workforce*, 106th Cong. 63 (statement of Dan Crippen, Director, Congressional Budget Office).

Section 502(a)(3).[24] Such an approach, however, is far more administratively complex, costly, and unpredictable than the relatively simple enforcement of a reimbursement provision. Indeed, for that reason many plans contain only reimbursement provisions. The legal costs alone incurred by a plan or insurer in pursuing an action against the third-party tortfeasor often can exceed the amount which the plan or insurer is seeking to recover as reimbursement for the benefits which it paid.

Thus, in the present case, where the amount at issue is approximately $75,000, a direct suit against the tortfeasor probably would not have been cost effective. Moreover, again as demonstrated by the facts in this case, the plan participant or beneficiary often fails to cooperate with the plan or insurer with respect to the latter's participation and often (if not usually) may arrive at a settlement with a tortfeasor before the plan or insurer is made aware that the participant or beneficiary is seeking recovery from a third party. Most significantly, it is inconceivable that Congress could have intended, as Petitioners argue, to authorize a subrogation action, but not one for reimbursement, because of purportedly different treatment of those actions under antiquarian equity principles.

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[24] *See* Petitioners' Brief, at 28-30.

3. Petitioners' assertion that reimbursement provisions undermine the protection of beneficiaries is without merit.

Petitioners argue that "[i]t strains credulity to suggest that [the enforcement of a plan reimbursement provision] is 'appropriate[]'" because such enforcement might result in making the plan or its insurer "whole at the expense of [an injured] beneficiary who is left 'in part.'" Petitioners' Brief, at 34 (*citing and quoting* Rodger M. Baron, *Public Policy Considerations Warranting Denial Of Reimbursement to ERISA Plans: It's Time to Recognize The Elephant In The Courtroom,* 55 Mercer L. Rev. 595, 631 (2004)). This assertion, based upon an article which itself relies primarily on conjecture and anecdotal comment rather than empirical evidence, ignores several fundamental facts which render such an assertion untenable.

First, the Petitioners' argument is based only upon the perspective of an injured participant or beneficiary, as distinguished from the perspective of what is in the best interest for a plan's participants and beneficiaries as a whole, including the injured participant. ERISA, however, requires plan fiduciaries to discharge their "duties with respect to a plan solely in the interest of the participants and beneficiaries,"[25] and to "act to ensure that a plan receives all funds to which it is entitled, so that those funds can be used on behalf of participants and

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[25] ERISA § 404(a)(1), 29 U.S.C. § 1104(a)(1).

beneficiaries." *Cent. States, Southeast & Southwest Areas Pension Fund v. Cent. Transp., Inc.*, 472 U.S. 559, 571 (1985). The statute's deliberate use of the plural reflects that the interests of those plan members in the aggregate are paramount, and one member should not be allowed to benefit disproportionately at the expense of the group. *See Ellis v. Metro. Life Ins. Co.*, 126 F.3d 228, 234 (4th Cir. 1997) (a fiduciary "must serve the best interests of all Plan beneficiaries, not just the best interest of one potential beneficiary"). Yet Petitioners completely disregard that a failure of the plan or its insurer to recover benefits paid to an injured beneficiary or participant out of a judgment against or a settlement from the tortfeasor responsible for the injury may increase the plan's insurance premiums and/or uninsured costs to the detriment of **all** of its participants and beneficiaries.

Second, reimbursement provisions eliminate double payment for the same claim, as well as ensure that the liability for tort claims falls only on those who cause injury rather than innocent plan participants, beneficiaries, or their health plans. *See Health Cost Controls of Ill., Inc. v. Washington*, 187 F.3d 703, 711-12 (7th Cir. 1999) (noting that "[t]he obvious purpose of [an ERISA plan's document's reimbursement provision] is to prevent double payment for the same claim"), *cert. denied*, 528 U.S. 1136 (2000). Barring enforcement of a plan reimbursement provision allows unjust enrichment of one participant or beneficiary at the expense of all other participants.

Third, Petitioners ignore the well-recognized fact that in enacting ERISA, Congress intended to leave to the discretion of plan sponsors the design, benefits, benefit exclusions, and other terms of employer benefit welfare plans. *Land v. Chicago Truck Drivers, Helpers & Warehouse Workers Union (Indep.) Health & Welfare Fund*, 25 F.3d 509, 514 (7th Cir. 1994) ("This court similarly has observed that 'Congress never intended ERISA to dictate the *content* of welfare benefit plans' and that decisions as to the content are within the discretion of the plan administrators") (citation omitted); *Dzinglski v. Weirton Steel Corp.*, 875 F.2d 1075, 1078 (4th Cir. 1989) ("'Congress left employers much discretion in designing their plans' under ERISA and in determining the level and conditions of benefits.") (*quoting Hlinka v. Bethlehem Steel Corp.*, 863 F.2d 279, 283 (3d Cir. 1988)), *cert. denied*, 493 U.S. 919 (1989). Thus, nothing in ERISA prevents a plan sponsor from including the type of reimbursement provisions at issue, or even conditioning the advance payment of benefits to someone injured by a third party on the presence of an enforceable reimbursement agreement. *Kress v. Food Employers Labor Relations Ass'n*, 391 F.3d 563, 569-70 (4th Cir. 2004).

No legal mandate requires employers to sponsor benefit plans, nor is there any mandate regarding "what kind of benefits employers must provide if they choose to have such a plan." *Lockheed Corp. v. Spink*, 517 U.S. 882, 887 (1996) (citations omitted). To the contrary, the Court has recognized that in enacting ERISA, Congress did not intend that the federal judiciary, as Petitioners

would have it, substitute its views as to what constitutes appropriate plan design for the judgments of employers and plan sponsors. *Black & Decker Disability Plan v. Nord*, 538 U.S. 822, 831-34 (2003); *Pegram v. Herdrich*, 530 U.S. 211, 232-34 (2000); *see also Dzinglski*, 875 F.2d at 1078 ("The judicial role is not to rewrite [ERISA] plan provisions, but to assure that they are fairly administered."). Instead, this Court has been adamant that ERISA not be interpreted in a manner which "unduly discourage[s] employers from offering welfare benefit plans in the first place." *Varity Corp.*, 516 U.S. at 497 (citations omitted). Petitioners' argument in this case, by failing to give effect to a critical cost-saving provision of most health and welfare plans, unfortunately does just that.

4. Rejection of enforcement of ERISA reimbursement claims would adversely affect the uniform administration of employee benefit health plans.

Another important objective of ERISA is to assure uniformity in plan administration. *Egelhoff v. Egelhoff*, 532 U.S. 141, 148 (2001) ("One of the principal goals of ERISA is to enable employers 'to establish a uniform administrative scheme, which provides a set of standard procedures to guide processing of claims and disbursement of benefits.'") (*quoting Coyne*, 482 U.S. at 9). *See also Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 379 (2002) ("ERISA's [basic] policy [is to] induc[e] employers to offer benefits by assuring a predicable

set of liabilities, under uniform standards of primary conduct and a uniform regime of ultimate remedial orders and awards when a violation has occurred.") (citation omitted); *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."). This goal, too, would be undermined by the adoption of Petitioners' arguments. Petitioners sought review of the present case by this Court because of a split among federal circuit courts in interpreting and applying its holding in *Knudson*. The adoption of Petitioners' position in this case almost certainly will not dispositively resolve the detrimental effects of this conflict, but rather will compound them.

Although derived from what the majority in *Knudson* admitted was an "antiquarian inquiry," the distinction which it articulated between legal and equitable relief clearly captured the essence of that distinction as set forth by the sources on which the majority relied. Petitioners, on the other hand, urge this Court to go beyond that distinction in a never-ending search for more esoteric and less universal distinctions to achieve the result which they seek in this case. Given the complexity of such an exercise, it is reasonable to expect that the lower courts will proceed in multiple, inconsistent directions, if they are required to disregard the clear *Knudson* guideposts.

Nor, finally, is it satisfactory to assume that employee benefit plans can effectively enforce these important plan rights in the state courts. No one seriously disputes that the varying and divergent

laws in the states relating to plan reimbursement and subrogation provisions would lead to a patchwork of different results in state courts applying state law. The national, uniform administration of a provision central to most employee benefit plans would be destroyed as a consequence -- making benefits all the more costly to provide, thereby threatening the financial viability of employer-sponsored plans.

IV.
CONCLUSION

For the above reasons, *Amici*, the America's Health Insurance Plans, Inc., the American Benefits Council, and the National Association of Manufacturers, respectfully request that this Court affirm the decision of the Court of Appeals for the Fourth Circuit.

Dated: February 23, 2006

Respectfully submitted,

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