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 *AMICI CURIAE* IBEW-NECA SOUTHWESTERN HEALTH & BENEFIT FUND AND THE CHAMBER OF COMMERCE OF THE UNITED STATES OF AMERICA SUPPORTING RESPONDENT

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QUESTION PRESENTED

Whether a beneficiary of a benefit plan governed by the Employee Retirement and Income Security Act of 1974 (ERISA) can defeat enforcement of the plan's valid equitable lien by agreement—after the lien attached—by spending the funds subject to the lien.

TABLE OF CONTENTS

	Page
Question Presented	i
Interest of *Amici Curiae*	1
Summary of Argument	3
Argument	5
I. Health And Benefit Plans Are Not-For-Profit Entities That Exist Solely To Serve Their Participants	5
II. Impediments To Reimbursement Impose Real Costs That The Plan Participants Must Bear	7
III. The Right To Recover Against The Beneficiary For Dissipated Funds Is The Most Efficient And Effective Protection Against Double Recovery	11
IV. Equity Disfavors A Beneficiary's Unlawful Dissipation	15
Conclusion	16

TABLE OF AUTHORITIES

Page

CASES

Bilyeu v. *Morgan Stanley Long Term Disability Plan*, 683 F.3d 1083 (9th Cir. 2012) 9

Coral Springs St. Sys., Inc. v. *City of Sunrise*, 371 F.3d 1320 (11th Cir. 2004) 16

Egelhoff v. *Egelhoff ex rel. Breiner*, 532 U.S. 141 (2001) 12, 15

Fort Halifax Packing Co. v. *Coyne*, 482 U.S. 1 (1987) 10

Ingersoll-Rand Co. v. *McClendon*, 498 U.S. 133 (1990) 15

Kress v. *Food Emp'rs Labor Relations Ass'n*, 391 F.3d 563 (4th Cir. 2004) 7

Milwaukee & M.R. Co. v. *Soutter*, 80 U.S. 517 (1871) 16

Precision Instrument Mfg. Co. v. *Auto. Maint. Mach. Co.*, 324 U.S. 806 (1945) 16

Timmons v. *Twin Cities Area New Party*, 520 U.S. 351 (1997) 9

Treasurer, Trs. of Drury Indus., Inc. Health Care Plan & Trust v. *Goding*, 692 F.3d 888 (8th Cir. 2012) 9

Zurich Am. Ins. Co. v. *O'Hara*, 604 F.3d 1232 (11th Cir. 2010) 10

STATUTES

26 U.S.C. § 501(c)(9) 6

TABLE OF AUTHORITIES—Continued

Page

29 U.S.C. § 1132(a)(3) 2, 4, 13, 15

OTHER AUTHORITIES

Baron & Lamb, *The Revictimization of Personal Injury Victims by ERISA Subrogation Claims*, 45 Creighton L. Rev. 325 (2012) 7

Br. of *Amicus Curiae* America's Health Ins. Plans, Inc. *et al.* in Support of Respondent, *Sereboff* v. *Mid Atl. Med. Servs.*, 547 U.S. 356 (2006), 2006 WL 460877 8

Healthcare Subrogation and Recovery, https://www.xerox.com/en-us/services/healthcare-payers/subrogation-recovery 8

Incurred Health and Disability Claims, Actuarial Standard of Practice No. 5 (Actuarial Standards Bd. 2011), http://www.actuarialstandardsboard.org/wp-content/uploads/2013/12/asop005_126.pdf 10

TIGTA, *Efforts Are Resulting in the Improved Identification of Fraudulent Tax Returns Involving Identity Theft* (April 24, 2015), https://www.treasury.gov/tigta/auditreports/2015reports/201540026fr.pdf 9

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INTEREST OF *AMICI CURIAE*[1]

The IBEW-NECA Southwestern Health & Benefit Fund ("the Fund") is a self-funded multiemployer welfare benefit plan subject to regulation under the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 *et seq.* The International

[1] All counsel of record consented to the filing of this brief by filing blanket consents with the Clerk. *Amici* state that no portion of this brief was authored by counsel for a party and that no person or entity other than *amici*, their counsel, or their members made a monetary contribution intended to fund the preparation or submission of this brief.

Brotherhood of Electrical Workers, a union with approximately 750,000 members, created the Fund to provide benefits to many of its members. The Fund pays out substantial benefits each year, but only on the condition that injured participants or beneficiaries will reimburse the Fund if they recover the same expenses from responsible third parties.

The Chamber of Commerce of the United States of America ("the Chamber") is the world's largest business federation. It represents 300,000 direct members and indirectly represents the interests of more than three million businesses and organizations of every size, in every sector, and from every region of the country. An important function of the Chamber is to represent the interests of its members in matters before Congress, the Executive Branch, and the courts. To that end, the Chamber regularly files *amicus curiae* briefs in cases that raise issues of vital concern to the Nation's business community.

This case concerns the circumstances under which a plan fiduciary can bring a civil action under Section 502(a)(3) of ERISA, 29 U.S.C. § 1132(a)(3), to enforce its reimbursement rights for plan-paid medical expenses. Reimbursement provisions serve a vital role in limiting a plan's costs and preserving its ability to provide meaningful benefits to all participants. When costs rise, plans face pressure to increase everyone's plan contributions or reduce the overall level of benefits. Reimbursement provisions restore balance to a plan's promise to provide medical coverage to its participants: those participants receive immediate payment of their medical expenses in return for the participant repaying the plan in the event of a subsequent recovery from responsible third parties. This upfront bargain guarantees that plan assets are preserved for all participants and avoids the inequitable windfall of a double recovery—a beneficiary's attempt to

collect medical expenses once from the plan and again from responsible third parties. Due to obvious fiscal considerations—and common notions of fairness—these provisions are ubiquitous in ERISA-regulated employee-benefit plans, including the Fund and many of the plans of the Chamber's members.

Amici have a strong interest in this case because of the costs that would result if plan beneficiaries are allowed to accept plans' medical benefits without also accepting their corresponding reimbursement obligations. If Petitioner's self-interested loophole is allowed to stand, reimbursement will be transformed into an empty obligation. Beneficiaries will be able to avoid their reimbursement obligations by quickly spending any tort recoveries on consumable or intangible goods or services. That result would undermine the long-term financial health of ERISA plans, increase the costs of providing benefits to all participants, and impair each plan's ability to maintain existing benefit levels without demanding additional contributions from employers and employees alike.

SUMMARY OF ARGUMENT

Nearly half of Americans rely on ERISA health and benefit plans to protect them in their darkest hours. These not-for-profit plans provide much needed financial support in times of great stress and tragedy. In doing so, the plans shield their participants from the devastating financial burdens that often accompany severe injuries and illnesses. But these plans can fulfill that vital function only if they remain financially solvent. Part of maintaining their financial health comes from receiving contributions from participants and their employers. Also important are the reimbursements that plans receive from the third parties responsible for their participants' injuries.

This latter funding stream is what is at stake here. Health and welfare plans immediately pay the medical

expenses of a plan participant who is injured by a third party. What they require in return is that the beneficiary reimburse them for those costs out of any tort recovery from that third party. The question in this case is whether a beneficiary can shirk that obligation by spending the tort recovery on consumable or intangible goods or services before the plan brings a legal action to enforce its undisputed right to reimbursement.

Respondent has ably explained why ERISA allows an equitable lien by agreement to be enforced even where the promisor has dissipated the funds subject to the lien. See Resp. Br. 25-46. This brief explains in further detail why a contrary rule would undermine the financial health of these plans and be fundamentally inconsistent with the equitable nature of Section 502(a)(3) of ERISA. Plans recover over $1 billion from reimbursement every year. That important funding stream will be threatened if beneficiaries could so easily avoid surrendering a double recovery to the plan. Even with rigorous and costly enforcement efforts, plans will not be able to keep up with the speed at which beneficiaries can secure and spend their tort recoveries. Each time a plan loses that race, more dollars will flow out of the plan and into the hands of a double-recovering beneficiary. To make matters worse, the expenses of these enforcement efforts will further erode a plan's financial ability to provide the same level of benefits without increasing the required contributions.

Crippling plans' ability to recover reimbursements will harm the participants themselves the most. They are the ones who will pay the increased premiums or make do with the reduced benefits required to bridge that billion-dollar shortfall. Thus, the loophole Petitioner seeks would enrich the few on the backs of the many. A relatively small percentage of participants would use it to obtain double recoveries to which they *concededly* have no

legal claim, and their fellow participants will pay the price for those windfalls. A statute grounded in equity cannot tolerate that unjust result.

ARGUMENT

I. HEALTH AND BENEFIT PLANS ARE NOT-FOR-PROFIT ENTITIES THAT EXIST SOLELY TO SERVE THEIR PARTICIPANTS

Health and benefit plans and related trust funds provide health and welfare benefits to their participants. That is their sole function, and there is no profit in it. These plans must amass assets to cover contingent liabilities and the costs of administration, but they do not produce any profit. Instead, the contributions, reimbursements, and other sources of revenue go towards funding the participants' benefits. Any excess is used to provide an insurance reserve to cover future contingencies (increased future health costs; decreased employer and employee contributions in times of unemployment; and fluctuations in market investments). Accordingly, plan participants have the greatest interest in the financial stability of the plans. They gain the most from a funding surplus, and they lose the most from a funding shortfall. Since there is no "deep pocket" insurance company or for-profit corporation behind the health fund (especially in the case of multiemployer funds, such as the one at issue in this case), a funding shortfall imperils participants' benefits and increases their costs. The bottom line is that these plans are created for workers (and often by workers), and anything that harms them harms the workers as well.

A. *Amicus* the Fund illustrates these basic facts. The Fund is the result of collective bargaining between the International Brotherhood of Electrical Workers union and the National Electrical Contractors Association contractors. Workers in the construction industry often work by the job and change employers frequently, mak-

ing it difficult to maintain health and welfare benefits. The Fund solves that problem by offering those benefits directly to the union participants who work in the industry rather than routing them through a particular employer.

Actuarial calculations estimate the cost of providing the benefits and yield a recommended contribution rate for employers and workers so that the Fund can remain solvent. The Fund's Board of Trustees (which is divided equally between representatives from management and labor) then sets the contribution rate based on that analysis.

The Fund makes no profit for the employers. Indeed, it is statutorily prohibited from doing so. The Fund is a Voluntary Employees Beneficiary Association under Internal Revenue Code Section 501(c)(9), which specifically prohibits any "part of the net earnings of such association inur[ing] * * * to the benefit of any private shareholder or individual." 26 U.S.C. § 501(c)(9). The only statutorily authorized distributions are those "for the payment of life, sick, accident, or other benefits to the members of such association or their dependents or designated beneficiaries." *Ibid.* Any excess funds that are not needed for that sole purpose remain in the Fund and create a surplus. The surplus provides a reserve against future costs, which in turn holds down premiums.

B. As the Fund's example demonstrates, workers depend on these plans and count on them being financially stable. That is why the plans place so much emphasis on cost projection, premium calibration, and obtaining reimbursement when possible. This last focus is particularly important because these plans are zero-sum games. Each extra dollar distributed to a plan participant is a dollar that cannot secure benefits for the other workers covered by the plan absent an added dollar in plan premiums.

Plans have developed detailed rules for payment and reimbursement of benefits to address that issue. As highlighted in this case, one common rule provides that the plan will pay benefits for a worker injured by a third party on the condition that the worker will reimburse the plan for those payments out of any tort recovery secured from the third party. See *Kress* v. *Food Emp'rs Labor Relations Ass'n*, 391 F.3d 563, 569 (4th Cir. 2004) ("Subrogation clauses requiring reimbursement are * * * quite common."). The purpose of that rule is not to enrich plan administrators or employers, but to ensure equitable distribution of plan funds to the participants. Indeed, plans do not charge workers interest on the large sums advanced for payment of medical expenses prior to recovery from a third party. All they ask is that the worker pay the plan back the principal if the responsible third party is ultimately called to account.

Workers who obtain a double recovery by avoiding their reimbursement obligations are, in effect, taking money out of the pockets of their fellow participants. That is why plans need the most effective tools possible to enforce these reimbursement provisions that safeguard the financial health of the plan and prevent the inequitable distribution of plan funds.

II. IMPEDIMENTS TO REIMBURSEMENT IMPOSE REAL COSTS THAT THE PLAN PARTICIPANTS MUST BEAR

Allowing beneficiaries to avoid their undisputed reimbursement obligations imposes steep costs on plans, costs that ultimately fall on the plan participants. Reimbursements from tort recoveries constitute a substantial funding stream for plans. Petitioner's own *amicus* The American Association for Justice ("AAJ") cites a study concluding that such reimbursements return "in excess of $1 billion" to plans every year. AAJ Br. 20 n.2 (citing Baron & Lamb, *The Revictimization of Personal Injury Victims by ERISA Subrogation Claims*, 45 Creighton L.

Rev. 325, 325 (2012)).[2] Each impediment to enforcing those reimbursement rights results in more of that money remaining an inequitable windfall to a few beneficiaries that cannot be returned to the plans to work for the benefit of all participants.

A. The sheer size of that $1 billion-plus figure speaks for itself. It represents a staggering amount of doctor visits, medications, surgeries, and other needed benefits for participants.

Amicus AAJ attempts to downplay the enormity of this $1 billion funding stream by dividing it by the 137 million people covered by these plans. The result, it argues, is that Petitioner's rule may only impose a "miniscule" cost of $5.84 per covered person per year. AAJ Br. 21. This per-person metric is misleading, because many of the 137 million covered persons are family members of a worker who gain coverage under a family health plan. Accordingly, that few dollars per person per year becomes tens of dollars per family, which can add up over time to many hundreds of dollars.

More fundamentally, however, AAJ's argument proves too much. Unwarranted windfalls to a select few can always be minimized by dividing them among a large group that bears the cost. But such math ignores the aggregate impact of these windfalls and the fact that organizations must work to hold down costs on numerous fronts. For example, the Treasury Inspector General for

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[2] See also Br. of *Amicus Curiae* America's Health Ins. Plans, Inc. *et al.* in Support of Respondent, *Sereboff* v. *Mid Atl. Med. Servs.*, 547 U.S. 356 (2006), 2006 WL 460877, at *3 n.3 (independently calculating reimbursement recoveries at over $1 billion per year); Healthcare Subrogation and Recovery, https://www.xerox.com/en-us/services/healthcare-payers/subrogation-recovery (last visited September 4, 2015) (noting that Xerox recovery services "has recovered over a billion dollars on behalf of our healthcare subrogation clients" in just the past three years).

Tax Administration ("TIGTA") has estimated that the IRS paid out $3.3 billion in refunds for fraudulent tax returns in 2013. See TIGTA, *Efforts Are Resulting in the Improved Identification of Fraudulent Tax Returns Involving Identity Theft* (April 24, 2015), https://www.treasury.gov/tigta/auditreports/2015reports/201540026fr.pdf. Yet this fraud obviously cannot be justified or minimized by dividing that number by the 318 million residents of the United States.

It is undisputed that participants in these cases have agreed and have a legal obligation to reimburse the plan with funds recovered from third parties. The attempts of some to escape that obligation and obtain a double recovery clearly cannot be justified under equity by the fact that this windfall will be financed by a large number of plan participants.

B. The minority view held by the Eighth and Ninth Circuits threatens to cut off, or at least substantially reduce, the sizeable funding stream represented by reimbursements. See *Treasurer, Trs. of Drury Indus., Inc. Health Care Plan & Trust* v. *Goding*, 692 F.3d 888, 897 (8th Cir. 2012); *Bilyeu* v. *Morgan Stanley Long Term Disability Plan*, 683 F.3d 1083, 1095 (9th Cir. 2012). Only a few years have passed since those troubling decisions, and plan participants in those circuits may not yet be aware of their new route to double recovery created by these courts. The passage of time will change that, particularly if this Court enshrines that flawed approach as the law of the land. See *Timmons* v. *Twin Cities Area New Party*, 520 U.S. 351, 357, 364-365 (1997) (recognizing possible ill effects of permitting multi-party candidates despite the fact a few states allow such candidates); cf. *id.* at 375 n.3 (Ginsburg, J, dissenting).

Once participants learn that spending any tort recovery on consumable or intangible goods or services immunizes them from later claims of reimbursement from

the plans, the strategic choice for some participants will be to do just that. The participant will spend the recovery as quickly as possible on consumables and intangibles or risk losing it altogether when the plan comes around to collect its reimbursement.

The impact of this reduced funding will be borne by all participants, as they must reach into their own pockets to make up the difference in the form of higher contributions or reduced benefits. See *Fort Halifax Packing Co.* v. *Coyne*, 482 U.S. 1, 11 (1987) ("[I]nefficiencies in benefit program operation * * * might lead those employers with existing plans to reduce benefits * * * ."); *Zurich Am. Ins. Co.* v. *O'Hara*, 604 F.3d 1232, 1238 (11th Cir. 2010) ("If O'Hara were relieved of his obligation to reimburse Zurich for the medical benefits it paid on his behalf, the cost of those benefits would be defrayed by other plan members and beneficiaries in the form of higher premium payments.").

C. AAJ attempts to obscure this fact, questioning the mechanism by which reduced reimbursement recovery could affect plan premiums. See AAJ Br. 15-21. But the mechanism is basic economics. Plans are not-for-profit entities, and actuarial standards demand taking reimbursement recoveries into account when recommending contribution levels: "The actuary should take into account the relevant organizational practices and regulatory requirements related to * * * 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 * * * subrogation, or other adjustments or recoveries." Incurred Health and Disability Claims, Actuarial Standard of Practice No. 5, § 3.3.5 (Actuarial Standards Bd. 2011), http://www.actuarialstandardsboard.org/wp-content/uploads/2013/12/asop005_126.pdf. Thus, under actuarial practice, each dollar returned to the plan through reim-

bursement is one less dollar that must be raised through contributions paid by plan participants.

AAJ speculates that actuaries might not follow these standards and claims there is inadequate proof that reduced reimbursements in fact affect premiums. See AAJ Br. 17-18. Yet AAJ offers no explanation of why, in a not-for-profit entity, reduced costs would not, in the long run, be passed on to the ultimate consumer. See *ibid.* Instead, it simply offers the glib and unsupported claim that "[t]here are plenty of uses for found money." *Id.* at 17. That assertion ignores the not-for-profit nature of ERISA plans. These plans obtain funding from three sources: contributions, reimbursements, and investment income. A reduction in any of these three sources demands a corresponding increase in one of the other two funding streams or a reduction in expenses, *i.e.*, benefit payments. Therefore, the workers necessarily will pay for decreased reimbursements one way or another. Either premiums will rise to make up the shortfall, with the workers contributing to those premiums directly or indirectly, or the workers' benefits will be cut. There is no free lunch in these plans, and the workers who abide by the terms of the plans will be the ones who foot the bill for the few participants who fail to honor their reimbursement obligations.

III. The Right To Recover Against The Beneficiary For Dissipated Funds Is The Most Efficient And Effective Protection Against Double Recovery

A. There is only one surefire way to deter double recoveries and correct them when they do occur: authorizing a direct action against the offending beneficiary for the reimbursement owed. The mere existence of such a right will stop most of the reimbursement violations before they happen. It eliminates the incentive to dissipate tort recoveries that rightly belong to the plan. Partici-

pants will abide by the terms of the plan agreement if they know the plan can effectively enforce those terms against them.

In addition to deterrence, this direct approach also provides the plans a relatively inexpensive method of enforcing their reimbursement rights. Maintaining a constant state of readiness and the ability to pounce on tort recoveries before funds are dissipated is a costly proposition. But that will not be necessary if the plans can secure reimbursement directly from the offending beneficiaries even if they have already dissipated the recovery that rightly belongs to the plans. Under that regime, plans will be able to conduct a proper investigation of each claim before filing suit, rather than immediately filing suit whenever any reimbursement right may possibly exist. The result will be significant cost savings. This common-sense path achieves "ERISA's objective of efficient plan administration." *Egelhoff* v. *Egelhoff ex rel. Breiner*, 532 U.S. 141, 149 n.3 (2001).

B. Petitioner and his *amici* suggest a number of half-measures and circuitous routes to recovery as alternatives to this direct method. See Pet. Br. 44; AAJ Br. 24-25. But all of those fall woefully short of the benchmark set by the direct action against the wrongdoer for the amount of the reimbursement. Some of the suggested alternatives might offer the plans some relief, but at the cost of significant expenses that they would not otherwise incur. Filing suit against the tortfeasor directly is a perfect example. See AAJ Br. 24. A plan could take this route pursuant to its subrogation rights, but it would incur many legal expenses in the process. And those are in addition to the administrative expenses of managing what would be a massive litigation docket and investigating all the potential suits it might have to file. Intervening in a suit initiated by a participant is another option, but that too entails steep costs. See *id.* at 24-25. Inter-

vention also does nothing to ensure that plans secure reimbursement from tort suits settled before the initiation of litigation or before intervention is feasible.

As an alternative to full-fledged involvement in the underlying litigation, Petitioner points out that a plan could enjoin a participant from dissipating a tort recovery that rightfully belongs to the plan. See Pet. Br. 44. That is technically an option under 29 U.S.C. § 1132(a)(3), but it is almost impossible to execute effectively and consistently. As Respondent explains, courts have sometimes denied injunctive relief in these situations, and even when relief is forthcoming, it may not be timely enough to prevent dissipation. See Resp. Br. 51-52.

Additionally, the injunctive relief program envisioned by Petitioner is not a realistic option given the administrative realities of these plans. Plans often serve a large number of participants with a small administrative staff. Yet Petitioner expects them to both discover and then monitor in real time all of the litigation and out-of-court negotiations between their beneficiaries and tortfeasors. Not only that, but the plans also must be able to act at a moment's notice, seeking an injunction as soon as it learns of a participant's recovery. That is unrealistic. In a race between an individual beneficiary dissipating a tort recovery and a plan taking action to enjoin that dissipation, the beneficiary will win almost every time. Even if plans were capable of such nimbleness, the reimbursements likely would not be worth the astronomical costs of monitoring all of these potential tort recoveries and maintaining a constant state of readiness.

Take the Fund as an example. It provide benefits to over 15,000 people, and it does so quite efficiently, with a team of only 11 people overseeing that massive operation. The alternatives discussed above are not feasible with such a small administrative team. Adopting Petitioner's approach would require the Fund to overhaul its opera-

tions and significantly expand the size of the team running the Fund. Each additional employee hired would take more money away from providing benefits and reduce the efficiency of the Fund's operations.

C. The alternatives get worse from there. If the beneficiary uses the settlement funds to purchase an asset rather than a consumable or intangible good or service, then the plan can enforce its equitable lien against that asset. See Pet. Br. 44. And if the beneficiary gives the tort recovery to someone else, the plan can enforce its lien against that person. See *ibid.* But those are not solutions. They are acknowledgements that plans may have recourse in the unlikely event a beneficiary inexplicably fails to avail himself of the huge legal loophole Petitioner seeks to create. And, in any event, these measures would be more complicated and more costly than a direct suit against the dissipating beneficiary.

Straining credulity, Petitioner and AAJ promise that obtaining reimbursement will not be a problem because legal ethics rules require personal-injury attorneys to withhold the portion of the tort recovery subject to the plans' reimbursement rights. See Pet. Br. 42-43; AAJ Br. 25-26. The real-world result is not as Petitioner and AAJ claim. Where such ethics rules exist, they often place the plaintiff's attorney's interest in recovering his contingent fee in direct conflict with the plan's reimbursement right. Here, for example, the plan requires full reimbursement of tort recoveries, "without reduction for attorneys' fees." Resp. Br. 5 (quoting J.A. 46). Thus, where the plaintiff's attorney facilitates reimbursement, he is often working again his own interest—a dollar reimbursed to the plan is a dollar not recovered by the contingency-fee attorney.

The best evidence of this continuing reimbursement problem despite whatever ethics rules may exist is this case and the multitude of other cases that eventually re-

sulted in the circuit split on this very issue. These cases arose only because a beneficiary obtained the tort recovery and dissipated it before the plan could claim its fair share. The reality is that legal ethics rules are not protecting plans' reimbursement rights.

D. In the final stop on its tour of implausible alternatives, AAJ recommends that plans "compromise" with the participant over the amount of reimbursement. See AAJ Br. 25. In other words, plans should recognize their weakened legal position in light of Petitioner's loophole and look the other way as long as the double recovery is not too egregious. Even if that were a solution, it is unclear why a participant armed with a right to dissipate would bring his case to the plan's attention and then make an attractive settlement offer. But putting that aside, the best-case scenario still leaves plans with a greatly reduced reimbursement funding stream.

All of these suggested alternatives "undermine the congressional goal of 'minimiz[ing] the administrative and financial burden[s]' on plan administrators—burdens ultimately borne by the beneficiaries." *Egelhoff*, 532 U.S. at 149-150 (quoting *Ingersoll-Rand Co.* v. *McClendon*, 498 U.S. 133, 142 (1990)). None of them can hold a candle to the common-sense approach of allowing plans to seek reimbursement from the person denying them that right—the dissipating beneficiary. That direct method offers the only efficient and effective way to enforce the plans' critical reimbursement rights.

IV. Equity Disfavors A Beneficiary's Unlawful Dissipation

At bottom, the issue in this case is whether the relief the Respondent seeks is "appropriate equitable relief" under 29 U.S.C. § 1132(a)(3). Respondent has ably explained why the relief sought here qualifies as equitable under this Court's precedents and the historical understanding of that term. See Resp. Br. 25-46.

But the more basic point is that a statutory provision grounded in equity should not be read to allow a beneficiary to retain his ill-gotten double recovery. Petitioner's attempt to do so flies in the face of the most fundamental equitable principles. "[A] court of equity [w]as a vehicle for affirmatively enforcing the requirements of conscience and good faith." *Precision Instrument Mfg. Co.* v. *Auto. Maint. Mach. Co.*, 324 U.S. 806, 814 (1945). Yet Petitioner uses equity as a shield to avoid those very requirements, claiming that equity cannot reach the funds that rightfully belong to the plan once he has converted them to consumable or intangible goods or services. See Pet. Br. 23-36. Equity does not reward wrongdoers: "He that hath committed iniquity shall not have equity." *Milwaukee & M.R. Co.* v. *Soutter*, 80 U.S. 517, 523-524 (1871). Nor does it create loopholes: "[C]ourts of equity are loath to allow loopholes, technicalities, or gameplaying to dictate results when those results would violate basic notions of equity and fair play." *Coral Springs St. Sys., Inc.* v. *City of Sunrise*, 371 F.3d 1320, 1340 (11th Cir. 2004). Equity thus offers no aid to a dissipating beneficiary like Petitioner, for he is a wrongdoer in search of a loophole to avoid honoring his reimbursement obligation to his plan and, by extension, to his fellow plan participants.

CONCLUSION

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

Respectfully submitted.

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