Analysis
As of: Apr 05, 2012

KRISTY SCHWADE, Plaintiff, v. TOTAL PLASTICS, INC., Defendant.

CASE NO. 8:10-cv-2436-T-23MAP

UNITED STATES DISTRICT COURT FOR THE MIDDLE DISTRICT OF FLORIDA, TAMPA DIVISION

2012 U.S. Dist. LEXIS 37091*; *23 Fla. L. Weekly Fed. D 174

February 22, 2012, Decided
February 22, 2012, Filed

PRIOR HISTORY: *Schwade v. Total Plastics, Inc., 2011 U.S. Dist. LEXIS 130393 (M.D. Fla., Nov. 10, 2011)*

CASE SUMMARY:

OVERVIEW: Reconsideration was denied because the correct legal standard was applied in concluding that plaintiff's failure to exhaust her administrative remedy barred her ERISA action, she had ample notice of any claim denials, and any futility argument was waived. Moreover, the plan correctly denied her equitable relief based on O'Hara. The court disregarded McCutchen in favor of O'Hara which understood that the certainty and uniformity needed for ERISA to operate properly qualified as important equitable principles that a court could not ignore when considering an action under ERISAS § 502(a)(3).

OUTCOME: Reconsideration denied.

LexisNexis(R) Headnotes

Civil Procedure > Judgments > Relief From Judgment > Motions to Alter & Amend
Civil Procedure > Judgments > Relief From Judgment > Motions to Reargue

[HN1] A *Fed. R. Civ. P. 59(e)* motion that re-argues a point or that raises a new point without a reason for the previous omission should fail.

Pensions & Benefits Law > Employee Retirement Income Security Act (ERISA) > Civil Claims & Remedies > Equitable Relief > General Overview
[HN2] *ERISA § 502(a)(3)* allows a suit by a participant, beneficiary, or fiduciary to obtain appropriate equitable relief (i) to redress a violation of ERISA or terms of an ERISA plan or (ii) to enforce any provisions of ERISA or the terms of the ERISA plan.

Pensions & Benefits Law > Employee Retirement Income Security Act (ERISA) > Civil Claims & Remedies > Equitable Relief > General Overview
[HN3] In fashioning appropriate equitable relief, a court should keep in mind the special nature and purpose of employee benefit plans. *ERISA § 502(a)(3)* does not, after all, authorize appropriate equitable relief at large, but only appropriate equitable relief for the purpose of redressing any violations or enforcing any provisions of ERISA or an ERISA plan.

Pensions & Benefits Law > Employee Retirement Income Security Act (ERISA) > Participation & Vesting > General Overview

Pensions & Benefits Law > Employee Retirement Income Security Act (ERISA) > Plan Establishment
[HN4] ERISA does not create any substantive entitlement to employer-provided health benefits or any other kind of welfare benefits. Employers or other plan sponsors are generally free under ERISA, for any reason at any time, to adopt, modify, or terminate welfare plans. Nor does ERISA establish any minimum participation, vesting, or funding requirements for welfare plans.

Pensions & Benefits Law > Employee Retirement Income Security Act (ERISA) > Civil Claims & Remedies > Equitable Relief > General Overview
[HN5] The terms "appropriate equitable relief" smuggle into ERISA no free-floating equitable principle that operates in each case independently of ERISA's larger purpose and structure. ERISA demands predictable liabilities, uniform standards, and uniform remedies. An untamed sense of "equity," detached from ERISA's purpose and context, is antithetical to ERISA because everyman's notion of equity is uncertain and variable. Congress sought to create a system that is not so complex that litigation expenses unduly discourage employers from offering ERISA plans in the first place.

Pensions & Benefits Law > Employee Retirement Income Security Act (ERISA) > Civil Claims & Remedies > Equitable Relief > General Overview
Pensions & Benefits Law > Employee Retirement Income Security Act (ERISA) > Plan Establishment
[HN6] ERISA's mandate that every employee benefit plan shall be established and maintained pursuant to a written instrument, *29 U.S.C.S. § 1102(a)(1)*, establishes the primacy of the written plan. Further, controlling plan cost is an "equitable principle"; in the context of ERISA, controlling plan cost is a paramount equitable principle. The text of § 502(a)(3) shows the importance of cost; why, if not to control the cost of the plan, would § 502(a)(3) allow a beneficiary appropriate equitable relief only to enforce the terms of the plan.

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For Total Plastics, Inc., Defendant: Andrew Froman, Michelle I. Anderson, LEAD ATTORNEYS, Fisher & Phillips, LLP, Tampa, FL.

JUDGES: STEVEN D. MERRYDAY, UNITED STATES DISTRICT JUDGE.

OPINION BY: STEVEN D. MERRYDAY

OPINION

AMENDED ORDER

Kristy Schwade moves (Doc. 40) under *Rule 59(e), Federal Rules of Civil Procedure*, for reconsideration of a summary judgment in favor of Schwade's former employer, Total Plastics.

Schwade's ERISA health benefits plan ("the Plan") declined to pay medical expenses for Schwade's son unless Schwade complied with the Plan by signing a subrogation agreement. Schwade refused. From August to November, 2007, the Plan sent Schwade an explanation of benefits denying each claim. The Plan requires Schwade to administratively appeal a denial within 180 days. Schwade failed to appeal on each occasion. For eighteen months (June, 2008, to December, 2009) after expiration of the time for administrative appeal, Schwade's attorney sent sporadic letters to the Plan proposing that the Plan pay benefits but compromise [*2] the contractual right to subrogation. The Plan twice refused further consideration of a claim unless Schwade signed a subrogation agreement. The Plan plainly declined further negotiation. Another year passed, and in November, 2010, Schwade sued Total Plastics, which administers the Plan, for the benefits. A November 10, 2011, order (Doc. 31; 2010 WL 5459649) concludes that Schwade's failure to exhaust her administrative remedy (that is, her failure timely to appeal) bars the action, and the order concludes further that under the Plan's unambiguous terms the Plan correctly denied Schwade's claims.

I.

Schwade's motion for reconsideration is more carefully crafted than her opposition to the motion for summary judgment; not coincidentally, the argument section is nearly four times longer. (Docs. 25 at 15-20; 40 at 4-23) Be that as it may, [HN1] a *Rule 59(e)* motion that re-argues a point or that raises a new point without a reason for the previous omission should fail. *Wilchombe v. TeeVee Toons, Inc., 555 F.3d 949, 957 (11th Cir. 2009)*; *Arthur v. King, 500 F.3d 1335, 1343 (11th Cir. 2007)*; *see also WTC Captive Ins. Co., Inc. v. Liberty Mut. Fire Ins. Co., 537 F.Supp.2d 619, 624 (S.D.N.Y. 2008)* [*3] ("motions for reconsideration are not intended to save the parties from the consequences of their own research neglects"); *Ctr. For Public Integrity v. F.C.C., 515 F.Supp.2d 167, 169 n.1 (D.D.C. 2007)* ("[a] plaintiff's failure to investigate a possible argument prior to the judgment does not make the results of its [later] research 'new evidence' for purposes of *Rule 59(e)*"). In

any event, Schwade's action continues to fail on the merits.

Schwade objects that the November 10th order wrongly applies ERISA's special legal standard when assessing whether Schwade exhausted her administrative remedy. Although Schwade misses the transition, the November 10th order (1) applies ERISA's six-step standard to review the Plan's decision to deny benefits and (2) applies the normal summary judgment standard to determine whether Schwade exhausted her administrative remedy. After discussing the Plan's decision to deny benefits, the order explicitly applies the special ERISA standard. (Doc. 31 at 16) ("the [Plan's refusal to pay benefits] was '*de novo* correct' under the terms of the Plan summary"). The order never mentions the ERISA standard after discussing whether Schwade exhausted her administrative [*4] remedy; instead, the order assesses the undisputed facts and concludes that no reasonable question exists as to whether Schwade failed to exhaust her administrative remedy. When discussing the action as a whole, the order states that "the *primary* issue is the reasonableness of the Plan administrator's decision" (Doc. 31 at 7) (emphasis added); but not the "only" issue, as the balance of the order demonstrates. Schwade's *Rule 59(e)* motion notwithstanding, no error appears.

In the *Rule 59(e)* motion, Schwade argues again that the Plan provided insufficient notice of the claim denials. As the November 10th order explains (Doc. 31 at 4, 20-21), in each 2007 explanation of benefits the Plan told Schwade repeatedly, even emphatically, that her claims were unpaid, that she needed to contact the Plan and to provide more information (contrary to Schwade's objection, this reminder means that the Plan informed Schwade of the reason for the claim denials), and that she faced an appeal deadline. The Plan provided abundant notice. Schwade adds the argument that exhaustion is excused because the Plan failed to comply with *29 C.F.R. § 2560.503-1(l)*, which purports to demand perfect compliance with each [*5] ERISA notice regulation. Without acknowledgment or apology, Schwade raises a regulation she evidently discovered while reading the November 10th order, which both notes Schwade's strange omission to mention *29 C.F.R. § 2560.503-1(l)* (perhaps "her most promising" argument) and explains that *29 C.F.R. § 2560.503-1(l)* is inapplicable. (Doc. 31 at 22 n.3)

Schwade continues to insist that, because of insufficient notice of each claim denial, the 180-day appeal limitation tolled until the Plan in 2008 responded to an inquiry from Schwade's attorney. Even if one ignores the plentiful notice Schwade received in the 2007 explanations of benefits and assumes a tolling until 2008, Schwade fails to explain and justify her ignoring the Plan's appeal procedure in 2008. Even considered in isolation, the Plan's 2008 letters contain the elements necessary to deny each claim. (The Plan summary states that the Plan will "usually" -- but not always -- label a claim denial notice an "Explanation of Benefits." (Doc. 3, Ex. 5 at 70)) Schwade concludes that she "constructively" appealed but cites no authority (none exists) that explains if and how a "constructive" appeal is possible. Schwade instead cites authority [*6] that addresses the futility exception to the exhaustion requirement.

As the November 10th order explains, the Plan evinced no sign that an appeal was futile; Schwade waived a futility argument by failing to at least attempt an appeal, *Lanfear v. Home Depot, Inc., 536 F.3d 1217, 1225 (11th Cir. 2008)*; and Schwade provides only "bare allegations of futility," which are "no substitute for the 'clear and positive' showing of futility" that justifies suspending the exhaustion requirement. *Bickley v. Caremark RX, Inc., 461 F.3d 1325, 1330 (11th Cir. 2006)*. In the *Rule 59(e)* motion Schwade appears to argue for the first time that the Plan's failure to respond to her final letters indicated that an appeal was futile. (More likely, the Plan reasonably concluded that continuing to engage Schwade was futile.) Without resort to, or even mention of, the Plan's appeal procedure, Schwade attempted to defeat the Plan's subrogation right. In response, the Plan twice informed Schwade that subrogation was non-negotiable (Doc. 31 at 5), but Schwade -- resolutely choosing not to appeal -- continued to send letters asking the Plan to sacrifice the subrogation right. The Plan bore no obligation to keep responding [*7] to Schwade's pointless and unilateral posturing.

Another argument that appears anew in Schwade's *Rule 59(e)* motion contends that after expiration of the appeal period the Plan still seemed willing to consider Schwade's claims if Schwade honored the Plan's right to subrogation. The Plan's perceived flexibility, says Schwade, precludes the Plan's arguing that the explanations of benefits officially denied the claims. Ironically, because she omits this waiver argument from her original response to the Plan's motion for summary judgment, Schwade now impermissibly advances a waived argument to the effect that the Plan advances a waived argument. That qualm aside, to establish whether a "waiver" argument under ERISA is even available, Schwade mentions only the avowedly uncertain *Glass v. United of Omaha Life Ins. Co., 33 F.3d 1341, 1348 (11th Cir. 1994)*, which declines to decide whether federal common law waiver applies to ERISA. Schwade recommends that the reader "see also" the wholly inapposite *Burger v. Life Ins. Co. of N. Am., 103 F.Supp.2d 1344, 1348 (N.D. Ga. 2000)*, which employs waiver to preclude a plan's recovering benefit "overpayments" that the plan had voluntarily [*8] paid for three years. Without explanation Schwade invites the court to "consider whether waiver

principles apply." (Doc. 40 at 17) The waiver argument arrives late and inchoate.

Schwade tries several new variations of an argument that the exhaustion requirement is excusable because the Plan never issued a sufficiently explicit claim denial. Even if the Plan never explicitly denied a claim -- and further, even if *29 C.F.R. § 2560.503-1(l)*'s "perfect compliance" requirement applies, and even if the Plan "waived" the appeal deadline that followed Schwade's receipt of explanations of benefits in 2007 -- this action remains barred by the exhaustion requirement. Both the Plan's terms and the ERISA regulation treat a "claim denial" and an "adverse benefit determination" as synonymous, (Doc. 3, Ex. 5 at 70-71); *29 C.F.R. § 2560.503-1(h)(1)*; *Midgett v. Wash. Group Intern. Long Term Disability Plan, 561 F.3d 887, 894 (8th Cir. 2009)*, and under the Plan an "adverse benefit determination" includes "a failure to provide or make payment, in whole or in part, for a benefit." (Doc. 3, Ex. 5 at 70) The 2007 explanations of benefits alerted Schwade that an "amount [was] not payable" (Doc. 31 at 20-21), [*9] and the 2008 letters confirmed that without a subrogation agreement the Plan would never pay the claims. *Cf. Springer v. Wal-Mart Assocs. Group Health Plan, 908 F.2d 897, 899-901 (11th Cir. 1990)*. On the one hand, if before receiving the Plan's letters in 2008 Schwade had "deemed" her administrative remedy exhausted and sued in federal court, whether *29 C.F.R. § 2560.503-1(l)* applies might matter. On the other hand, if in late 2008 Schwade had followed the Plan's appeal procedure, whether the Plan's "failure to provide or make payments" was official before the 2008 letters might matter. Neither occurred. Instead of suing in early 2008, Schwade wrote to the Plan for clarification and received a response unambiguously refusing payment absent a subrogation agreement. This rejection from the Plan foreclosed Schwade's opportunity, if any, to "deem" the administrative remedy exhausted under *29 C.F.R. § 2560.503-1(l)*. *See Tindell v. Tree of Life, Inc., 672 F.Supp.2d 1300, 1311-12 (M.D. Fla. 2009)* (Howard, J.) ("if the claimant waits for the plan administrator to issue a determination, then [notwithstanding *29 C.F.R. § 2560.503-1(l)*] the claimant should pursue the administrative route to its [*10] end"); *Hall v. United of Omaha Life Ins. Co., 741 F.Supp.2d 1348, 1357-58 (N.D. Ga. 2010)* (same). Instead of challenging each claim denial by an appeal in late 2008, Schwade -- in accord with the considered advice of counsel -- waited more than three months, asked the Plan (not the appeal unit) to waive the subrogation requirement, waited more than a year, asked the Plan (not the appeal unit) to waive the subrogation requirement, waited nearly another year, and sued Total Plastics in November, 2010. Hence, even if the Plan's 2008 responses (and not the 2007 explanations of benefits) started the 180 days for appeal, Schwade's desultory (and enigmatic) colloquy with the Plan neither exhausted her administrative remedy nor excused the exhaustion of her administrative remedy.

The November 10th order concludes that an ERISA plan's terms are strictly construed, *Hunt v. Hawthorne Assocs., Inc., 119 F.3d 888, 911 (11th Cir. 1997)*; that the Plan enjoys a "standard" ERISA plan subrogation right; and that the Plan explicitly entitles the Plan to deny a benefit if a beneficiary refuses subrogation. Schwade proposes that *US Airways, Inc. v. McCutchen, 663 F.3d 671 (3d Cir. Nov. 16, 2011)*, which issued [*11] the week after the November 10th order, constitutes an "intervening change in the law" that undermines the Plan's subrogation right. According to Schwade, *McCutchen* "intervenes" by contradicting *Zurich American Insurance Company v. O'Hara, 604 F.3d 1232 (11th Cir. 2010)*, a decision that the November 10th order cites frequently as support for enforcing the Plan's right to subrogation.

First, Schwade reverses herself. Moving for summary judgment, Total Plastics argued that *Cagle v. Bruner, 112 F.3d 1510, 1519-20 (11th Cir. 1997)*, validates the Plan's refusal to pay benefits without a subrogation. *Cagle* concludes that a subrogation provision nearly identical to the Plan's provision permits a plan to deny a benefit if the beneficiary refuses subrogation. Opposing summary judgment, Schwade claimed that *Cagle* "do[es] not apply under the facts of this case" because the beneficiary in *Cagle* "[first] obtained a recovery from a third-party and then sought to avoid the plan's subrogation interest." (Doc. 25 at 19) Before suing Total Plastics, Schwade obtained no third-party recovery. Like *Cagle*, *McCutchen*, on which Schwade now vigorously relies, involves a beneficiary who recovers from a third [*12] party and seeks to avoid the plan's subrogation interest. Schwade now applies wholeheartedly the same facts that she earlier applied not at all.

Further, in the 2008 letters to the Plan, Schwade's counsel "finds it hard to believe" that the Plan may require subrogation. Schwade now defends her counsel's statement, despite the Eleventh Circuit's controlling authority in *Cagle*, because under *McCutchen*, decided in 2011, counsel's statement "was correct in 2008." (Doc. 40 at 19) The claim that Schwade's letters correctly ignored then-current and binding Eleventh Circuit law in 2008 in anticipation of a late 2011 circuit split exhibits an unconvincing but singular revisionist hauteur, to put it mildly. *See* B. Fischhoff, "Debiasing," *Judgment Under Uncertainty: Heuristics and Biases* 422, 429 (Kahneman, Slovic, & Tversky, eds. 1982) ("one possible attraction of hindsight bias is that it may be quite flattering to represent oneself as having known all along what was going to happen"). One "need hardly add that even if there [is] a relevant circuit split, the district court is bound by controlling *Eleventh Circuit* precedent."

Springer, 908 F.2d 900 n.1 (emphasis in original). A fundament of [*13] maintaining stability in the law, obedience to circuit precedent (a discipline the Eleventh Circuit follows with rigor) is alone a sufficient reason to disregard *McCutchen.*

II.

The irreconcilable difference between *O'Hara* and *McCutchen* merits focused attention. *O'Hara* obeys familiar rules of ERISA benefit plan interpretation, rules that protect and preserve the express terms of a plan (so that a plan means what a plan plainly says) and that generally respect the expertise and superior vantage of a plan's fiduciary, who (unlike a court) is well positioned to consider simultaneously the welfare of each plan beneficiary at each moment in the life of the plan. *McCutchen* exhibits two main features. First, *McCutchen* announces a broad, judicially manufactured alteration of ERISA (certain to increase the cost to each participant in each plan) based on a little-explained reading of several narrow Supreme Court decisions. Second, *McCutchen* revises a plan over the objection of the plan's managers, contrary to the interests of other participants, and on behalf of a single beneficiary.

O'Hara suffered a car accident, received medical benefits from his ERISA plan, and obtained a tort settlement. Although [*14] the settlement left O'Hara undercompensated for his injuries, the plan, invoking a subrogation provision, sued O'Hara for re-payment from the settlement under [HN2] *Section 502(a)(3) of ERISA*, which allows a suit "by a participant, beneficiary, or fiduciary . . . to obtain [] appropriate equitable relief (i) to redress [a violation of ERISA or the terms of the ERISA plan] or (ii) to enforce any provisions of [ERISA] or the terms of the [ERISA] plan." O'Hara objected that subrogation would grant the plan more than "appropriate" equitable relief because any reimbursement had to come from an already insufficient settlement. *604 F.3d at 1236*. O'Hara contended that "equity" prevents an "unjust enrichment" of the plan and demanded a compromise of the subrogation right. *604 F.3d at 1237*. The Eleventh Circuit enforced the subrogation provision:

> O'Hara contends that, as a matter of equity . . . the make-whole rule must be applied because allowing [the Plan] to recoup the medical expenses it paid on his behalf . . . unjustly enriches [the Plan]. We disagree.
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> . . . .
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> We cannot conclude that . . . a balancing of the equities in this case requires application of the make-whole doctrine to defeat the Plan's [*15] unambiguous reimbursement requirement. Although O'Hara himself will be in a better position if the subrogation provision is not enforced, plan fiduciaries must take impartial account of the interests of all beneficiaries. Reimbursement inures to the benefit of all participants and beneficiaries by reducing the total cost of the Plan . . . . Plan fiduciaries must [] ensure that the assets of employee health plans are preserved in order to satisfy present and future claims. Because maintaining the financial viability of self-funded ERISA plans is often unfeasible in the absence of reimbursement and subrogation provisions like the one at issue in this case, denying [the Plan] its right to reimbursement would harm other plan members and beneficiaries by reducing the funds available to pay those claims. Moreover, O'Hara availed himself of the benefits of the Plan with the knowledge that the Plan would be entitled to full reimbursement for those benefits in the event he was injured and received full or partial recovery from a third party tortfeasor. As the Third Circuit has pointed out, any inequity in this case would lie in permitting O'Hara 'to partake of the benefits of the Plan and then [*16] after he had received a substantial settlement, invoke common law principles to establish a legal justification for his refusal to satisfy his end of the bargain." *Ryan v. Fed Express Corp., 78 F.3d 123, 127-28 (3d Cir. 1996)*; *see also* [*Admin. Comm. Of Wal-Mart Stores, Inc. Assocs.' Health and Welfare Plan v. Shank, 500 F.3d 834, 839 (8th Cir. 2007)]* (enforcement of ERISA plan, which expressly precluded make-whole rule, was "appropriate" where plan "conferred benefits on both parties," by requiring payment of premiums plus a promise to reimburse the plan in exchange for the "certainty that the plan would pay beneficiary's medical bills immediately if beneficiary was injured").

O'Hara, 604 F.3d at 1237-38 (emphasis removed).

Much authority favors *O'Hara's* view of the pertinent equities. [HN3] "In fashioning 'appropriate' equitable relief, [a court should] keep in mind the special nature and purpose of employee benefit plans." *Varity Corp. v. Howe, 516 U.S. 489, 515, 116 S. Ct. 1065, 134*

L. Ed. 2d 130 (1996). "*[Section 502(a)(3)*] does not, after all, authorize 'appropriate equitable relief' *at large*, but only 'appropriate equitable relief' for the purpose of redressing any violations or enforcing any provisions of ERISA or an [*17] ERISA plan." *Mertens v. Hewitt Assocs., 508 U.S. 248, 253, 113 S. Ct. 2063, 124 L. Ed. 2d 161 (1993)* (emphasis in original). An employer volunteers to provide a plan; encouraging an employer to volunteer requires, as explained throughout ERISA's case law, both predictable regulation and reliable construction of the plan. As the Supreme Court explains:

> We are mindful that [HN4] ERISA does not create any substantive entitlement to employer-provided health benefits or any other kind of welfare benefits. Employers or other plan sponsors are generally free under ERISA, for any reason at any time, to adopt, modify, or terminate welfare plans. Nor does ERISA establish any minimum participation, vesting, or funding requirements for welfare plans . . . .

Curtiss-Wright Corp. v. Schoonejongen, 514 U.S. 73, 78, 115 S. Ct. 1223, 131 L. Ed. 2d 94 (1995) (citations omitted); *Conkright v. Frommert, 130 S.Ct. 1640, 1648-49, 176 L. Ed. 2d 469 (2010)*. In consequence, ERISA aims at "inducing employers to offer benefits by assuring a predictable set of liabilities under uniform standards of primary conduct and a uniform regime of ultimate remedial orders and awards when a violation has occurred." *Rush Prudential HMO, Inc. v. Moran, 536 U.S. 355, 379, 122 S. Ct. 2151, 153 L. Ed. 2d 375 (2002)* (citations omitted).

[HN5] The terms "appropriate [*18] equitable relief" smuggle into ERISA no free-floating equitable principle that operates in each case independently of ERISA's larger purpose and structure. As *Rush* notes, ERISA demands predictable liabilities, uniform standards, and uniform remedies. An untamed sense of "equity," detached from ERISA's purpose and context, is antithetical to ERISA because everyman's notion of equity is uncertain and variable. "Congress sought to create a system that is not so complex that . . . litigation expenses[] unduly discourage employers from offering ERISA plans in the first place." *Conkright, 130 S.Ct. at 1649*.

McCutchen suffered a car accident, received medical benefits from his ERISA plan, and recovered money from third parties. Like O'Hara, McCutchen recovered less than full compensation for his injuries, and like O'Hara's ERISA plan, McCutchen's ERISA plan sued under *Section 502(a)(3)*. McCutchen advocated judicially modifying the plan's subrogation right to prevent "unjust enrichment." The Third Circuit agreed with McCutchen and ordered the district court to curtail McCutchen's obligation to subrogate the plan. *663 F.3d at 676-77*. *McCutchen* faults *O'Hara* for failing to ask "whether the relief [*19] sought in the action is 'appropriate' under traditional equitable principles and doctrines." According to the Third Circuit, *O'Hara* erred by "categorically excluding the equitable limitations that *§ 502(a)(3)*'s reference to equitable remedies necessarily contains." *663 F.3d at 678*.

Although *McCutchen* claims to reject *O'Hara* for "categorically excluding" an "equitable limitation" in favor of a beneficiary, *O'Hara* carefully "balances the equities." *McCutchen* appears to reject as insufficiently sympathetic to the beneficiary both *O'Hara*'s rich analysis of "equitable principles" and *O'Hara*'s reasoned exclusion of an "equitable limitation."

In *McCutchen*'s view, four Supreme Court decisions, *Mertens v. Hewitt Associates, 508 U.S. 248, 113 S. Ct. 2063, 124 L. Ed. 2d 161 (1993), Great-West Life & Annuity Ins. Co. v. Knudson, 534 U.S. 204, 218, 122 S. Ct. 708, 151 L. Ed. 2d 635 (2002), Sereboff v. Mid Atlantic Medical Services, 547 U.S. 356, 126 S. Ct. 1869, 164 L. Ed. 2d 612, (2006)*, and *CIGNA Corp. v. Amara, 131 S.Ct. 1866, 1878, 179 L. Ed. 2d 843 (2011)*, find "equitable principles" in *Section 502(a)(3)* that favor a beneficiary and disfavor the plan. These decisions discuss the meaning of "equitable relief" in *Section 502(a)(3)*, but explain only that "equitable relief" includes no traditionally "legal relief." These [*20] decisions mention "appropriate" equitable relief, but decline to discuss how or whether "appropriate" modifies "equitable relief." *CIGNA* allows a court to remedy a plan's fraud against beneficiaries, but says nothing more -- certainly nothing applicable to a case such as McCutchen's, in which the plan acts entirely in accord with a contractual right. *McCutchen* concludes that the Supreme Court through subtle hints sharply limited a fiduciary's right to enforce an ERISA plan. *Mertens, Knudson, Sereboff*, and *CIGNA* at no point support *McCutchen's* claim that a court applying *Section 502(a)(3)* now enjoys broad power to alter the terms of the plan in favor of a beneficiary based on an amorphous notion of fairness.

In order to provide an unprecedented advantage to a beneficiary, *McCutchen* ignores equitable factors that apply to ERISA; *O'Hara* considers the proper factors and rightly rejects a beneficiary's unjust enrichment. *O'Hara* understands that the certainty and uniformity needed for ERISA to operate properly qualify as important "equitable principles" that a court cannot ignore when considering an action under *Section 502(a)(3)*.

McCutchen balances the equities as follows:

> [The plan] raises [*21] a practical concern that the application of equitable principles will increase plan costs and premiums. This concern does not address the statutory language and is, in any event, unsubstantiated by the circumstances of this case. [The plan] cannot plausibly claim it charged lower premiums because it anticipated a windfall.
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> . . . .
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> Applying the traditional equitable principle of unjust enrichment, we conclude that the judgment requiring McCutchen to provide full reimbursement to [the plan] constitutes inappropriate and inequitable relief. Because the amount of the judgment exceeds the net amount of McCutchen's third-party recovery, it leaves him with less than full payment for his emergency medical bills, thus undermining the entire purpose of the Plan. At the same time, it amounts to a windfall for [the plan], which did not exercise its subrogation rights or contribute to the cost of obtaining the third-party recovery. Equity abhors a windfall.

663 F.3d at 679 (citation omitted).

First, "nothing in the statute suggests Congress intended that *section 502(a)(3)*'s limitation of the [plan's] recovery to 'appropriate equitable relief' would upset [] contractually defined expectations. Indeed, [*22] [HN6] ERISA's mandate that 'every employee benefit plan shall be established and maintained pursuant to a written instrument,' *29 U.S.C. § 1102(a)(1)*, establishes the primacy of the written plan." *Shank, 500 F.3d at 839*; *see also Morales v. Pan American Life Ins. Co., 914 F.2d 83, 87 (5th Cir. 1990)* (concluding that *Section 502(a)* "focuses on the terms of the plan" and includes "no provision . . . for quasi-contractual damages" based on an unjust enrichment). * Further, as discussed, controlling plan cost is an "equitable principle"; in the context of ERISA, controlling plan cost is a paramount equitable principle. The text of *Section 502(a)(3)* shows the importance of cost; why, if not to control the cost of the plan, would *Section 502(a)(3)* allow a beneficiary "appropriate equitable relief" only "to enforce . . . the terms of the plan"? *See Hozier v. Midwest Fasteners, Inc., 908 F.2d 1155, 1160 (3d Cir. 1990)* ("Congress analyzed all of the provisions in ERISA on the basis of their projected costs in relation to the anticipated benefit to the employee participant") (quoting H.R. Rep. No. 533, 93rd Cong., 2d Sess., *reprinted*, 1974 U.S.C.C.A.N. at 4639-40).

> * Schwade seeks relief similar to [*23] McCutchen's, but preemptively - before receiving benefits. *McCutchen* states that Congress in *Section 502(a)(3)* "limited" a fiduciary to "appropriate equitable relief," but *Section 502(a)(3)* "limits" a participant, a beneficiary, and a fiduciary; each may receive only "appropriate equitable relief" "to enforce . . . the terms of the plan." If Schwade had sued for "appropriate equitable relief" under *Section 502(a)(3)*, under no remotely plausible reading of *Section 502(a)(3)* would Schwade seek "appropriate equitable relief" to "enforce the terms of the plan." Schwade seeks to *escape* a term of the plan. To allow Schwade to "enforce" the plan by changing the plan requires a "*carte blanche* power to rewrite [ERISA] to satisfy [the court's] proclivities." *Coop. Ben. Adm'rs, Inc. v. Ogden, 367 F.3d 323, 329-30 (5th Cir. 2004)*. But "the authority of courts to develop a 'federal common law' under ERISA is not the authority to revise the text of the statute." *Mertens, 508 U.S. at 259*.

McCutchen produces trouble by claiming that a concern about costs is "unsubstantiated by the circumstances of this case." By nullifying the plan's subrogation right, *McCutchen* leaves other beneficiaries worse off. [*24] If a plan cannot trust a court to enforce a subrogation right, a beneficiary cannot receive lower premiums or better benefits in exchange for pledging to re-pay the plan from a tort award or an insurance payment. *See* Easterbrook, *The Court and the Economic System*, *98 Harv. L. Rev. 4, 10-11 (1984)*. Even worse, higher premiums will rise even higher and worse benefits will worsen even further because *McCutchen* likely increases each plan's litigation cost (and heightens each plan administrator's anxiety). For each person whom a court in "fairness" allows to skip re-payment, there will blossom many lawsuits from others who aspire to skip re-payment (and why not; they may get lucky; under *McCutchen*, all depends - the ERISA plan aside - on the contingency of a court's conscience). The losers, again, are the other beneficiaries. Judge Easterbrook provides an apt warning:

> The nature of litigation invites judges to treat the parties' circumstances as fixed and to apportion gains and losses . . . . [But] the principles laid down today will influence whether similar parties will be in similar situations tomorrow. [] Judges who look at cases merely as occasions for the fair apportionment of gains [*25] and loses almost invariably ensure that

> there will be fewer gains and more losses tomorrow.

supra, 98 Harv. L. Rev. at 10-11; *see Evans v. Eaton Corp. Long Term Disability Plan, 514 F.3d 315, 323 (4th Cir. 2008)* (A court must not "forget its duty of deference and its secondary rather than primary role in determining a claimant's rights to benefits").

McCutchen asserts the puzzling notion that the plan "cannot plausibly claim it charged lower premiums because it anticipated a windfall." Were McCutchen's employer compelled to provide a plan, were that plan immune from insolvency, were money but manna from heaven, the pejorative term "windfall" might apply. Needless to say, none of those assumptions is true. *McCutchen* leaves a mystery: How can a plan obtain a "windfall" by merely enforcing a contractual right that protects plan assets? "Windfall" means unearned money; McCutchen's ERISA plan sought re-imbursement of money paid by the plan and owed by McCutchen. In fact, *McCutchen* both preserves a windfall (McCutchen holds other beneficiaries' money) and ensures the creation of future windfalls. "Deference to plan administrators, who have a duty to all beneficiaries to preserve limited plan [*26] assets, [] helps prevent [a] windfall[] for particular employees." *Conkright, 130 S.Ct. at 1650*. Conversely, if *McCutchen's* ungoverned notion of equity becomes pandemic, consistent plan operation becomes impossible, inconsistent judicial ruling becomes commonplace, and some beneficiaries become profiteers at the expense of others.

McCutchen answers that subrogating the plan produces a windfall because subrogation occurs without an "exercise [of the plan's] subrogation rights" and without the plan's contributing to McCutchen's attorney fees. How the plan never exercised a subrogation right is obscure; McCutchen's plan at each moment enjoyed an unconditional right to subrogation -- without stepping into McCutchen's shoes to sue and without requiring McCutchen to sign a supplemental subrogation agreement. As for the plan's declining to pay a portion of McCutchen's attorney fees, the plan merely acted in accord with the parties' bargain. McCutchen's situation appears unfair only if viewed in hindsight and without a thought for whether McCutchen's agreeing to join the plan benefitted McCutchen at the time he agreed to join. At that time, McCutchen "traded the possibility of having the Plan [*27] participate in attorney's fees for the guarantee that medical bills would be paid immediately," *Admin. Comm. of the Wal-Mart Stores, Inc. v. Varco, 338 F.3d 680, 692 (7th Cir. 2003)* -- an appealing trade for the plan to offer, a rational trade for McCutchen to accept, and therefore a beneficial trade not susceptible to dissolution or avoidance by the operation of equity.

For the Third Circuit to say that McCutchen's paying his remaining medical bills undermines "the entire purpose of the Plan" assumes replacement of the plan's actual purpose with the Third Circuit's idealized purpose. McCutchen's plan states, "the purpose of the Plan is to provide coverage for qualified expenses that are not covered by a third party." *663 F.3d at 673*. "Qualified" expenses; not "all" expenses. McCutchen's plan -- like Schwade's plan -- supplies only a defined benefit; the plan includes no guarantee to "make whole" a beneficiary. "The make-whole doctrine originated in the law of insurance, where the overriding purpose of an insurance policy is to fully compensate the insured in case of loss, but [] many ERISA-regulated benefit plans do not share that purpose." *Shank, 500 F.3d at 837-38*. [*28] The Third Circuit divines *ex nihilo* the plan's supposed obligation to erase McCutchen's residual medical bill. Although perhaps momentarily gratifying to the sensibilities of a judge, foisting an involuntary and unpredictable obligation on an ERISA plan endangers both the statutory ERISA regime and the salutary benefits broadly available as a result of the regime.

The Third Circuit notes that the plan's subrogation right possibly entitled the plan to a payment "from McCutchen's pocket" (only "possibly" because McCutchen never disclosed the amount of disbursements to him from either his insurance or his lawsuit). *663 F.3d at 673, 677 n.3*. That appears an important distinction, but only at first. The typical person losing from his pocket a thousand dollars of past earnings feels more aggrieved than a person losing from a settlement a thousand dollars meant to compensate lost future earnings. A person palpably possesses the former and palpably feels the loss; a person only abstractly possesses the latter and more abstractly feels the loss. *See O Centro Espirita Beneficente Uniao do Vegetal v. Ashcroft, 389 F.3d 973, 1016 (10th Cir. 2004)* (McConnell, J., concurring) (discussing "loss [*29] aversion" -- "the tendency to attach greater value to losses than to foregone gains of equal amount"); Cohen & Knetsch, *Judicial Choice and Disparities Between Measures of Economic Values*, 30 Osgoode Hall L.J. 738 (1992). However, McCutchen's re-paying his plan with past wages leaves him little or no worse off than, for example, O'Hara, who re-paid his plan with settlement money that compensates lost future wages.

In any event (and most importantly), in exchange for the enjoyment of the plan's paying an immediate and near-certain benefit after an injury, a beneficiary bears the risk of a subsequent lawsuit against a third party. If the beneficiary's recovery pays both the plan and the beneficiary's lawyers and leaves a remainder, the benefi-

ciary reaps the benefit. But the beneficiary undertakes the lawsuit at the risk that the lawsuit will generate less money for the beneficiary -- especially, after the lawyers extract a fee, probably near forty percent -- than the amount of money owed to the plan. If the beneficiary recovers a small amount, the plan bears no responsibility for the undesirable consequence of the beneficiary's choice to sue. Bearing the obligation to reimburse the plan, [*30] will a beneficiary struggle to find a lawyer willing to assume the risk of the suit? Probably not. And if the small size of the potential award leaves no attorney willing to share the beneficiary's risk, this merely shows that the beneficiary correctly chose an immediate and safe benefit from the plan rather than an uncertain tort award (and the cumbrous, enervating, and expensive machinery of litigation) as the means of paying his medical bill. Although perhaps imperfect in the arcane circumstance, ERISA is a salutary and stalwart aid to almost every beneficiary -- unless the judges foul it up by tinkering.

Based on a dubious reading of recent Supreme Court decisions, *McCutchen* mischievously expands a beneficiary's ability to avoid re-paying an ERISA plan for medical benefits paid to the beneficiary with promptness and certainty. Even if *Section 502(a)(3) of ERISA* bestows broad discretion to alter a plan, *McCutchen* abuses that discretion by favoring affective over statistical judgment and a retrospective over a prospective view of fair contract. The misjudgments serve a hollow and counterproductive sense of "fairness" that ignores those with the most knowledge of what is truly "fair" [*31] -- which is to say, of maximum benefit to each beneficiary rather than to a single, contract-breaking claimant. In muscling aside established law, *McCutchen* invokes the venerable axioms of equity, but equity neither contrives to indulge the disqualified ERISA applicant of today nor contrives to burden the qualified ERISA applicant of tomorrow; *McCutchen* contrives to effect both. The wisdom and restraint of *O'Hara* govern here.

Schwade's motion (Doc. 40) is **DENIED.**

ORDERED in Tampa, Florida, on February 22, 2012.

/s/ *Steven D. Merryday*

STEVEN D. MERRYDAY

UNITED STATES DISTRICT JUDGE

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