No.

IN THE
Supreme Court of the United States

AETNA LIFE INSURANCE CO.,

Petitioner,

v.

MATTHEW KOBOLD,

Respondent.

On Petition For A Writ Of Certiorari To The Court Of Appeals Of Arizona

PETITION FOR A WRIT OF CERTIORARI

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QUESTION PRESENTED

The Federal Employees Health Benefits Act ("FEHBA"), 5 U.S.C. § 8901 *et seq.*, governs the federal government's provision of health benefits to millions of federal employees and their dependents. FEHBA expressly "preempt[s] any State or local law" that would prevent enforcement of "[t]he terms of any contract" under FEHBA that "relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits)." *Id.* § 8902(m)(1). In this case, the Arizona Court of Appeals held—directly contrary to decisions of the Georgia Supreme Court, the Eighth Circuit, and other courts, but consistent with a decision of the Missouri Supreme Court, in a case now pending before this Court, *Coventry Health Care of Missouri, Inc.* v. *Nevils*, No. 13-1305 (docketed Apr. 28, 2014)—that FEHBA does not preempt state laws that bar FEHBA carriers from seeking reimbursement or subrogation, pursuant to the terms of FEHBA contracts, of benefits paid to plan participants who also recover (or stand to recover) from third parties.

The question presented is whether FEHBA preempts state laws precluding carriers that administer FEHBA plans from seeking reimbursement or subrogation pursuant to the terms of FEHBA contracts.

PARTIES TO THE PROCEEDING AND RULE 29.6 STATEMENT

All parties to the proceeding are named in the caption.

The Ryland Group, Inc., Ryland Homes of Arizona, Inc., dba Ryland Homes, and Pioneer Landscaping and Materials, Inc., were also defendants in the Superior Court of Arizona but did not participate in the appeal to the Arizona Court of Appeals.

Pursuant to this Court's Rule 29.6, petitioner Aetna Life Insurance Co. states that it is a wholly owned subsidiary of Aetna Inc. Aetna Inc. is a publicly traded corporation that has no parent corporation, and no publicly held corporation owns 10 percent or more of its stock.

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PETITION FOR A WRIT OF CERTIORARI

Petitioner Aetna Life Insurance Co. respectfully petitions for a writ of certiorari to review the judgment of the Arizona Court of Appeals.

OPINIONS BELOW

The Court of Appeals of Arizona's opinion (Pet. App. 1a) is reported at 309 P.3d 924. The Supreme Court of Arizona's order denying review (Pet. App. 18a) is not reported. The Superior Court of Arizona's relevant order (Pet. App. 12a) is not reported.

JURISDICTION

The Court of Appeals of Arizona entered its judgment affirming the final judgment of the Superior Court of Arizona on September 5, 2013. Pet. App. 1a. The Supreme Court of Arizona entered its order denying Aetna's timely request for discretionary review on March 21, 2014. *Id.* at 18a. This Court has jurisdiction under 28 U.S.C. § 1257(a).

CONSTITUTIONAL, STATUTORY, AND REGULATORY PROVISIONS INVOLVED

All pertinent constitutional, statutory, and regulatory provisions are reproduced in the Appendix at 21a.

STATEMENT

The federal government has made it emphatically clear that the administration of employee benefits for employees of the Nation's government requires uniform, national rules. In the Federal Employees Health Benefits Act ("FEHBA"), 5 U.S.C. § 8901 *et seq.*, Congress empowered the Office of Personnel Management ("OPM") to establish, in contracts with private insurance carriers, the terms and conditions on which benefits are provided to more than 8 million federal workers and their families. To prevent States from interfering with OPM's centralized oversight of FEHBA plans, Congress expressly preempted state laws that override "[t]he terms of any contract" under FEHBA "which relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits)." *Id.* § 8902(m)(1).

Faithfully implementing that congressional directive, the Executive Branch has consistently taken the view that States cannot prevent FEHBA carriers from recouping—pursuant to reimbursement and subrogation provisions of their FEHBA contracts—benefits that they have paid to plan participants who also recover for the same injuries from other sources. *See*, *e.g.*, Pet. App. 44a-46a. In this case and another pending before this Court, *Coventry Health Care of Missouri, Inc.* v. *Nevils*, No. 13-1305 (docketed Apr. 28, 2014), the government explained to the state courts that state laws impeding such recoveries fall squarely within FEHBA's preemptive scope. Pet. App. 52a, 58a-65a. Permitting States to impose a patchwork of parochial restrictions on reimbursement and subrogation by FEHBA carriers "destroys the uniformity Congress intended the FEHBA

preemption provision to establish." *Id.* at 52a. Such restrictions also undercut the efficient administration of FEHBA plans by obstructing crucial cost-saving efforts, in turn "increas[ing] the cost of the [FEHBA] program to the federal government" and to its workers. *Ibid*. Preventing such state interference is of paramount importance to the United States, which contributes more than $30 billion annually toward FEHBA premiums for its workers. *Ibid.*; *see also* App. to Pet. for Cert. 109a-32a, *Nevils*, No. 13-1305 (U.S. Apr. 28, 2014) ("*Nevils* App.").

Until recently, courts across the country consistently followed the statutory design as understood by Congress and the Executive. State and federal courts—including the Georgia Supreme Court, the Eighth Circuit, and others—uniformly construed FEHBA, as its text and purpose require, to preempt state laws restricting reimbursement and subrogation recoveries by FEHBA carriers. In this case and *Nevils*, however, the state courts upended that consensus. The Arizona Court of Appeals here, like the Missouri Supreme Court in *Nevils*, held that FEHBA allows States to stop FEHBA carriers from making such recoveries—notwithstanding the plain terms of their FEHBA contracts.

In so construing FEHBA, the state courts here and in *Nevils* severely distorted the statutory text and entirely disregarded Congress's purpose. Both courts, moreover, turned a blind eye to the well-established and well-reasoned views of the government—which not only had issued public guidance on this issue, but took the rare step of participating actively in the state courts as *amicus* to aid the courts in correctly interpreting the statute. Indeed, despite the government's urgent request for discretionary

review of the decision below, the Arizona Supreme Court refused to correct the court of appeals' error, leaving it as the law of Arizona until further notice.

Such a direct conflict on any question of federal preemption would amply warrant certiorari. This Court's intervention is particularly necessary here because of the vital importance of national uniformity to administration of FEHBA plans. Federal-employee benefit plans—especially those that cover workers across state lines—cannot sensibly be subject to a hodgepodge of local restrictions. The whole purpose of FEHBA's preemption provision is to safeguard FEHBA plans from such idiosyncratic intrusions. That objective is completely subverted by the conclusions reached by the state courts here and in *Nevils*, and by the conflict they create with other courts' rulings.

The government's submissions in this case and in *Nevils* tell this Court all it needs to know. The direct conflict on an important question of federal preemption urgently warrants this Court's intervention. And the position staked out by these state courts is untenable and, left uncorrected, will disrupt the administration of an important federal program. This Court should grant review, both here and in *Nevils*, to resolve this conflict and restore uniformity to federal law. At a minimum, the Court should hold this case pending its disposition in *Nevils*, and, after correcting the Missouri Supreme Court's error in that case, reverse or vacate the decision below.

1. The Federal Employees Health Benefits Program ("FEHB Program" or "Program"), created in 1959, provides health-insurance benefits for federal employees. *See* 5 U.S.C. §§ 8901-8914. The Program currently covers more than 8 million current and

former employees and dependents, and pays out approximately $45 billion in benefits annually.[1] OPM has broad authority to administer the Program. It can do so by issuing implementing regulations, 5 U.S.C. § 8913(a), and by entering contracts with private insurance carriers that administer plans on OPM's behalf, *id.* § 8902(a), in which OPM specifies the "limitations, exclusions, and other definitions of benefits as [OPM] considers necessary or desirable." *Id.* § 8902(d).

The cost of premiums is split between the government (which typically pays 72%) and participants (who pay the remainder). *See* 5 U.S.C. § 8906(b)(1). Premiums are deposited into a special U.S. Treasury fund (the "Fund"). *Id.* § 8909(a). "Community-rated" carriers—which set premiums based on demographics or other attributes of a pool of insured persons—receive premiums from the Fund up front, from which they pay benefits. 48 C.F.R. §§ 1632.170, 1602.170-2. "Experience-rated" plans—which set premiums based on enrollees' "actual paid claims" and other costs—draw on the Fund to pay benefits case by case. *Ibid.*

After more than a decade of experience with the Program, Congress concluded that state regulation of

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[1] OPM, OPM Announces 2014 Federal Employees Health Benefits Program Premium Rates (Sept. 24, 2013), http://www.opm.gov/news/releases/2013/09/fehb-rates-announcement/; *The Federal Employees Health Benefits Program: Is It A Good Value For Federal Employees?—Hearing Before the Subcomm. on Fed. Workforce, U.S. Postal Serv. and the Census of the H. Comm. on Oversight and Gov't Reform*, 113th Cong. 5 (2013) ("*2013 Hearing*") (statement of Jonathan Foley, Director, Planning and Policy Analysis, U.S. Office of Personnel Management).

FEHBA plans interfered with the Program's efficient operation, "[i]ncreas[ing] premium costs to both the Government and enrollees" and injecting a "lack of uniformity of benefits," even "for enrollees in the same plan." H.R. Rep. No. 94-1211, at 3 (1976). Congress responded by enacting an express-preemption provision, 5 U.S.C. § 8902(m)(1).

Further experience showed, however, that this preemption provision did not go far enough. In 1998, Congress accordingly amended Section 8902(m)(1) to "strengthen the ability of national plans to offer uniform benefits and rates to enrollees regardless of where they may live," and to "prevent carriers' cost-cutting initiatives from being frustrated by State laws." H.R. Rep. No. 105-374, at 9 (1997); *see also* Federal Employees Health Care Protection Act, Pub. L. No. 105-266, § 3(c), 112 Stat. 2363, 2366 (1998). As amended, Section 8902(m)(1) provides:

> The terms of any contract under this chapter [*i.e.*, FEHBA] which relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans.

5 U.S.C. § 8902(m)(1).

2. OPM's contracts with carriers typically include clauses requiring carriers to seek reimbursement or subrogation from participants.[2] Where a

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[2] *See*, *e.g.*, Standard Contract for Community-Rated Health Maintenance Organization Carriers § 2.5 (2000), *available at* https://www.opm.gov/healthcare-insurance/healthcare/carriers/-#url=1999 ("2000 Standard Contract").

beneficiary has received benefits under a FEHBA plan but also recovers from another source for the same injuries, such clauses generally require the beneficiary to reimburse his carrier for the federal benefits received. Pet. App. 44a. Where a beneficiary who receives FEHBA benefits has not yet recovered from another source but has a right to do so, the carrier is required to stand in the beneficiary's shoes and seek recovery of benefits directly. *Ibid.* Such reimbursement and subrogation recoveries by carriers tend to reduce (directly or indirectly) the premiums that the government and participants pay for the benefits that participants receive. *See id.* at 54-55a.[3]

The subrogation and reimbursement provisions in OPM's contracts generally apply even where state law otherwise would preclude the carrier from seeking subrogation or reimbursement. OPM's Standard Contract for the year 2000, for instance, provides that, if a carrier "subrogat[es] for at least one plan covered under the Employee Retirement Income Security Act of 1974 (ERISA)," it must subrogate for FEHBA plans it administers, state law notwithstanding. 2000 Standard Contract § 2.5(a)(2). This requirement puts public-sector FEHBA plans on equal footing with private-sector plans governed by ERISA, 29 U.S.C. § 1001 *et seq.*—which, as this

[3] Experience-rated carriers remit recoveries to the Fund; the recoveries are used to "increase [plan] benefits," reduce future premiums, or refund past premiums to participants and the government. 5 U.S.C. § 8909(a)-(b). Community-rated carriers may keep recovered funds but must take prior years' recoveries into account when calculating premiums. OPM, Community Rating Guidelines 6 (2014), *available at* https://www.opm.gov/-healthcare-insurance/healthcare/carriers/2013/2013-11a1.pdf.

Court has held, preempts state laws that preclude insurance administrators from seeking subrogation, *see FMC Corp.* v. *Holliday*, 498 U.S. 52, 58-60 (1990).

OPM has "consistently recognized that the FEHBA preempts state laws that restrict or prohibit … reimbursement and/or subrogation." Pet. App. 46a. OPM reiterated that view in 2012, explaining in a guidance letter addressed to FEHBA carriers (the "2012 Letter") that it "continue[s] to maintain" that view. *Ibid*.

3. Matthew Kobold, a federal employee, was at relevant times enrolled in a FEHBA plan administered by Aetna. Pet. App. 2a. The plan contained a subrogation and reimbursement provision, entitling Aetna to reimbursement or subrogation if it paid benefits to a participant who also recovered from a third party. *Id.* at 2a-3a & n.1; *see also id.* at 48a-50a.

In 2006, Kobold was injured in a motorcycle accident, and Aetna paid Kobold's medical providers $24,473.53 for his treatment. Pet. App. 2a. Kobold also brought an action against third parties allegedly responsible for his injuries and secured a settlement for $145,000. *Ibid*. Pursuant to the plan, Aetna asserted a lien on the settlement proceeds for the amount of the benefits that it had paid. *Id.* at 3a. The third parties with whom Kobold settled deposited $24,473.53 from the settlement proceeds with the Arizona Superior Court and filed an interpleader action against Aetna and Kobold. *Ibid*.

Kobold and Aetna each sought summary judgment, claiming entitlement to the disputed funds. Pet. App. 3a-4a. Kobold argued that Arizona common law rendered the plan's reimbursement provi-

sion unenforceable, while Aetna asserted that Arizona law barring reimbursement was preempted by FEHBA. *Id*. at 13a.

The Arizona Superior Court granted summary judgment for Kobold, rejecting Aetna's preemption argument. Pet. App. 13a-14a. "The United States Supreme Court," it reasoned, "has spoken on this very issue" in *Empire HealthChoice Assurance, Inc.* v. *McVeigh*, 547 U.S. 677 (2006). Pet. App. 13a-14a. The court accordingly entered final judgment for Kobold. *Id.* at 15a-17a.

4. Aetna appealed, arguing that FEHBA does preempt Arizona's anti-reimbursement doctrine. C.A. Appellant Br. 10-32 (July 26, 2012). The Arizona Court of Appeals affirmed. Pet. App. 2a.

The court first rejected the trial court's view—and Kobold's principal submission on appeal—that this Court's decision in *McVeigh* "resolved the issue" whether FEHBA preempts state laws barring reimbursement and subrogation. Pet. App. 5a. *McVeigh*, the Arizona Court of Appeals explained, addressed only federal courts' subject-matter jurisdiction over reimbursement suits by FEHBA carriers. *Id.* at 5a-7a. This Court had "expressly declined to decide whether" Section 8902(m)(1) "supersedes state laws governing subrogation and reimbursement." *Id.* at 6a. *McVeigh*, moreover, "affirmatively recognized the potential for alternative statutory interpretations." *Ibid.*

"[A]ddress[ing] the question" of FEHBA's preemptive scope "as one of first impression in Arizona," Pet. App. 7a, the court of appeals held that FEHBA does not preempt Arizona law barring Aetna from seeking reimbursement pursuant to its FEHBA

plan. *See id.* at 7a-11a. It "beg[an]" by applying a presumption against preemption, reasoning that "preemption is disfavored, and that when two plausible readings of a statute are possible," courts "'nevertheless have a duty to accept the reading that disfavors preemption.'" *Id.* at 7a (citation omitted). The court then applied that presumption to what it deemed Section 8902(m)(1)'s "operative terms": "'relate to,' 'coverage,' and 'benefits.'" *Ibid.* It construed "'relate to'" as "requiring a direct and immediate relationship." *Ibid.* "'[C]overage,'" the court held, "means the scope of the risks insured under a plan or policy." *Id.* at 8a. And "'benefits' … include[s] payments by the carrier on behalf of the insured," but "not payments to the insured by third parties." *Ibid.*

It followed from these definitions, the court held, that Aetna's "subrogation and reimbursement provision falls outside the scope of § 8902(m)(1)." Pet. App. 9a. While the reimbursement provision "creates a contingent right to repayment in favor of Aetna," it "bears no immediate relationship to the scope of Kobold's coverage under the Plan or his receipt of benefits under that coverage." *Ibid*. Even "[t]hough the provision would affect Kobold's net financial position in some circumstances," the court held that Aetna's ability to seek reimbursement "does not affect [Kobold's] right to coverage and receipt of benefits, nor is it essential to the uniformity of FEHBA coverage and benefits available to eligible employees." *Ibid*. The court expressly rejected the analogy drawn by other courts to a parallel express-preemption provision of ERISA, 29 U.S.C. § 1144(a), which it deemed "materially different." Pet. App. 4a n.2 (citing *Botsford* v. *Blue Cross & Blue Shield of Mont., Inc.*, 314 F.3d 390 (9th Cir. 2002)). It also specifically rejected "the contrary interpretations ad-

vanced by courts in some other jurisdictions." *Id.* at 10a n.3.

The Arizona Court of Appeals also refused to "defer to the contrary interpretation provided by [OPM]" in the 2012 Letter. Pet. App. 10a. OPM's view did not merit deference under *Chevron USA, Inc.* v. *Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984), the court reasoned, because the 2012 Letter was not the "result of a formal rulemaking or adjudication process," and the court "s[aw] nothing in the FEHBA to indicate that Congress intended to delegate to the OPM the authority to make determinations having the force of law." Pet. App. 10a. Nor did OPM's view otherwise merit deference, the court held, because OPM did not undertake "the same term-by-term analysis of the statute" that the court had performed and was issued "recent[ly]" and "in response to other jurisdictions'" rulings on the issue. *Ibid*.

5. Aetna sought discretionary review in the Supreme Court of Arizona, arguing that the court of appeals' preemption ruling contravened FEHBA's text, its purpose, and this Court's precedent construing a closely analogous statute. Pet. for Review 7-13 (Ariz. Nov. 6, 2013). Aetna also explained that the Arizona Court of Appeals' ruling conflicted with numerous other federal and state decisions, and improperly failed to accord any deference to OPM's established and well-reasoned view. *Id.* at 11-15.

The United States urged the Arizona Supreme Court to grant review, filing an *amicus* brief authorized by the Solicitor General in support of Aetna's petition. Pet. App. 51a-65a. The government explained that it "has a substantial interest" in the "review and correct[ion]" of "the court of appeals' error,

which concerns an important question of federal law affecting the health-insurance benefits the federal government provides to millions of federal employees and their families." *Id.* at 52a. The court of appeals' "holding," it argued, "is directly contrary to FEHBA." *Ibid.* As the government explained, "[a] right to reimbursement of benefits clearly and directly relates to benefits and benefit payments as numerous court decisions have recognized." *Ibid.* The Arizona Court of Appeals' decision, moreover, "destroys the uniformity Congress intended the FEHBA preemption provision to establish as to benefits and premiums, and threatens to increase the cost of the FEHB program to the federal government, which was $31.5 billion in 2012 alone." *Ibid*.

The government's arguments in support of Aetna's petition for review here echoed its submission to the Missouri Supreme Court in *Nevils* v. *Group Health Plan, Inc.*, 418 S.W.3d 451 (Mo. 2014), *petition for cert. filed*, No. 13-1305. The government urged that court to affirm a lower-court decision holding that FEHBA does preempt state laws barring subrogation. *See Nevils* App. 109a, 116a-26a. As the United States explained in successfully seeking to participate in oral argument, the "government is responsible for the lion's share of the premiums"—more than $30 billion "in 2012 alone"—and it "has a substantial interest in ensuring that [FEHBA carriers] may pursue subrogation." *Id.* at 131a.

Notwithstanding the United States' support of Aetna's petition for review, the Arizona Supreme Court denied the petition. Pet. App. 18a.[4]

REASONS FOR GRANTING THE PETITION

The decision below deepens a direct conflict among state and federal courts concerning FEHBA's preemptive scope. The Georgia Supreme Court, the Eighth Circuit, and other courts have held that FEHBA does preempt state laws barring FEHBA carriers from seeking reimbursement or subrogation pursuant to the terms of FEHBA contracts. In a case already pending before this Court, *Nevils*, 418 S.W.3d 451, *petition for cert. filed*, No. 13-1305, the Missouri Supreme Court reached exactly the opposite conclusion, holding that state law can trump reimbursement and subrogation provisions of FEHBA contracts. The Arizona Court of Appeals here adopted the same view, and its decision—which the state supreme court declined to review—is now in effect the law of Arizona. Its holding, like that in *Nevils*, is irreconcilable with FEHBA's text, Congress's purpose, and this Court's case law.

The decision below, like *Nevils*, also compounds lower-court confusion regarding the deference due to the views of OPM, the agency charged by Congress to administer FEHBA. The decision below accorded no weight to OPM's well-established and well-reasoned interpretation, in direct contravention of this Court's teaching and the overwhelming weight of authority.

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[4] On May 8, 2014, the court of appeals stayed its mandate to allow for the filing and disposition of a petition for a writ of certiorari. Pet. App. 19a-20a.

The stakes of this conflict are difficult to overstate—as the federal government's active participation in the state courts here and in *Nevils* amply demonstrates. The FEHB Program provides tens of billions of dollars in benefits annually to millions of federal employees and their families. The decisions below and in *Nevils* obliterate the uniformity that Congress recognized was essential to efficient administration of this massive, nationwide program. And both decisions undercut the cost-saving efforts that Congress sought to safeguard for the benefit of federal employees and the taxpaying public.

I. THE DECISION BELOW DEEPENS A DIRECT CONFLICT CONCERNING THE SCOPE OF FEHBA PREEMPTION AND CONTRAVENES THE STATUTE AND THIS COURT'S PRECEDENT.

A. The Decision Below Exacerbates A Conflict Among State And Federal Courts Regarding Preemption Of State Laws Barring Reimbursement.

The decision below deepens a split that has divided state and federal courts across the country. Before the decision below, the Georgia Supreme Court, the Eighth Circuit, and numerous other state and federal courts had correctly held that FEHBA preempts state laws barring carriers from seeking reimbursement or subrogation. The decision below reached exactly the opposite conclusion, as did the Missouri Supreme Court in *Nevils*. The Arizona Supreme Court's refusal to review the court of appeals' ruling cements this direct conflict. This Court's review is needed to resolve the conflict and to bring clarity to this important area of federal law.

1. The vast majority of state and federal courts to address the issue—led by the Georgia Supreme Court and the Eighth Circuit—have held that FEHBA preempts state laws nullifying subrogation and reimbursement provisions in FEHBA contracts. In *Thurman* v. *State Farm Mutual Automobile Insurance Co.*, 598 S.E.2d 448 (Ga. 2004), the Supreme Court of Georgia held that that FEHBA preempted a state law that would preclude a FEHBA carrier from seeking subrogation. In *Thurman*, as here, a federal employee was injured in an automobile accident and received benefits from her FEHBA carrier. *Id.* at 449-50. And, as here, the employee also secured a settlement from a third party—the insurer of the tortfeasor who caused her injuries—and the FEHBA carrier claimed part of the settlement under a subrogation provision of its contract. *Ibid.* The third party's insurer paid part of the settlement to the FEHBA carrier directly, reducing the funds available (under the tortfeasor's policy limit) to pay the settlement amount to the injured employee. *Id.* at 450.

In determining whether the injured employee could recover from her *own* automobile insurer under an underinsured-motorist policy, *Thurman* squarely confronted the question whether the FEHBA carrier could lawfully seek reimbursement of the benefits that it had paid. *See* 598 S.E.2d at 450-51. Georgia law generally barred "an injured party's medical insurer" from "seek[ing] reimbursement from the injured party unless and until" the injured party fully recovered all of her "economic and noneconomic damages." *Id.* at 451. But the Georgia Supreme Court held that FEHBA preempted state law in this respect. The employee's "benefits are governed by federal law" and the carrier's contract. *Ibid.* And because that contract provided for subrogation, the

FEHBA carrier had a "subrogation lie[n] and w[as] able to enforce [it] upon the injured party's receipt of a settlement from the liable third party, *regardless of* Georgia's requirement that such action be preceded by a determination that the injured person had been fully compensated." *Ibid.* (emphasis added).

The Eighth Circuit reached the same conclusion in *MedCenters Health Care, Inc.* v. *Ochs*, 26 F.3d 865 (8th Cir. 1994). Although Minnesota's "full recovery rule" would have precluded subrogation on the facts at hand, the court held that Section 8902(m)(1) of FEHBA "pre-empted the state-law [full-recovery] rule." *Id.* at 867.[5] The Eighth Circuit has subsequently reiterated that subrogation and reimbursement are integrally related to benefits under FEHBA. *See Jacks* v. *Meridian Res. Co.*, 701 F.3d 1224, 1233-35 (8th Cir. 2012) (holding "the subrogation provision" in a FEHBA plan was "necessarily a product of the benefit payment process").

Numerous courts across the country have agreed. As the Sixth Circuit explained in *Shields* v. *Government Employees Hospital Ass'n*, 450 F.3d 643 (6th Cir. 2006), *overruled on other grounds by Adkins* v. *Wolever*, 554 F.3d 650, 652 (6th Cir. 2009) (en banc), "[b]ecause federal law preempts state law, [a State] cannot stop [a FEHBA plan] from requiring reim-

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[5] The Eighth Circuit also affirmed a ruling by the district court that FEHBA provided federal-court jurisdiction for the suit. *See* 26 F.3d at 867; *MedCenters Health Care, Inc.* v. *Ochs,* 854 F. Supp. 589, 593 n.3 (D. Minn. 1993). That jurisdictional ruling was abrogated by *McVeigh*, 547 U.S. at 689-701. But, as the Arizona Court of Appeals recognized, *McVeigh* has no bearing on the distinct question whether FEHBA preempts state laws barring reimbursement by carriers. *See* Pet. App. 5a-7a.

bursement." *Id.* at 648; *see also Calingo* v. *Meridian Res. Co.*, 2013 WL 1250448, at *3-4 (S.D.N.Y. Feb. 20, 2013); *NALC Health Benefit Plan* v. *Lunsford*, 879 F. Supp. 760, 762-63 (E.D. Mich. 1995); *Aybar* v. *N.J. Transit Bus Operations, Inc.*, 701 A.2d 932, 937-38 (N.J. App. Div. 1997).

2. The Missouri Supreme Court, in *Nevils*, 418 S.W.3d 451, flatly rejected this consensus view. Relying heavily on the Arizona Court of Appeals' reasoning in this case, *Nevils* held that FEHBA does *not* preempt state laws barring subrogation or reimbursement. *See id.* at 453-57. The Missouri Supreme Court also expressly refused to accord any deference to OPM's interpretation of the statute. *Id.* at 457 n.2. And its holding directly contradicted the position of the United States, which filed an *amicus* brief and participated in oral argument arguing in favor of preemption. *See Nevils* App. 109a-32a.

The Missouri Supreme Court acknowledged the contrary rulings of other courts—including the Georgia Supreme Court in *Thurman*—as well as Missouri state-court precedent dating back nearly two decades. *See* 418 S.W.3d at 454, 457 (overruling *Buatte* v. *Gencare Health Sys., Inc.*, 939 S.W.2d 440, 441-42 (Mo. Ct. App. 1996)). But it specifically repudiated these rulings, deeming them overtaken by passing dictum in this Court's decision in *McVeigh*, 547 U.S. 677. *See* 418 S.W.3d at 454-55. Although acknowledging that *McVeigh*—which addressed only federal-court *jurisdiction* to adjudicate FEHBA carriers' claims for reimbursement and subrogation—was "not dispositive" of whether FEHBA preempts state laws barring subrogation and reimbursement, *Nevils* held that *McVeigh* compelled a "'cautious'" interpretation

of Section 8902(m)(1). *Id.* at 455-56 (citation omitted).

3. The decision below—which the state supreme court has declined to review—deepens this conflict. The Arizona Court of Appeals, like the Missouri Supreme Court in *Nevils*, held that state laws barring FEHBA carriers from seeking reimbursement are not preempted—even when authorized by FEHBA contracts—because, in the court's view, reimbursement does not "relate to" "coverage" or "benefits." Pet. App. 7a-10a. Indeed, *Nevils* drew much of its analysis directly from the decision in this case, citing it nine times. *See* 418 S.W.3d 455-57 & n.2. Like *Nevils*, the decision below also acknowledged but expressly rejected the "contrary interpretations" of courts in "other jurisdictions" that hold that FEHBA preempts state laws barring subrogation and reimbursement. Pet. App. 10a n.3.

The court of appeals' decision is now effectively the law of Arizona. The Arizona Supreme Court's denial of Aetna's request—backed by the United States—for discretionary review (Pet. App. 18a) means that the decision below will govern in Arizona courts for the foreseeable future. As the state courts have long held, "[a] decision by the Arizona Court of Appeals has statewide application." *Scappaticci* v. *Sw. Sav. & Loan Ass'n*, 662 P.2d 131, 136 (Ariz. 1983). "[T]he Court of Appeals," although composed of two divisions, "constitute[s] a single court." *Ibid.* Accordingly, "[a]bsent a decision by the Arizona Supreme Court compelling a contrary result, a decision by one division of the Court of Appeals is persuasive with the other division." *Ibid.*; *see also*, *e.g.*, *State* v. *Brown*, 2008 WL 2876075, at *2 (Ariz. Ct. App. July

25, 2008); *Neil B. McGinnis Equip. Co.* v. *Henson*, 406 P.2d 409, 412 (Ariz. Ct. App. 1965).

No decision from the state supreme court can be expected to rectify this error. That court evidently has concluded that the effect of a federal statute that governs tens of billions of dollars in benefits paid out annually for millions of federal workers and dependents—an issue that has divided courts across the country—does not merit its attention. Unless and until that court changes its mind, the decision below will continue to steer future Arizona courts to the same misguided conclusion.

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State and federal courts, in short, have splintered on the preemptive scope of a federal statute that applies in every State and Circuit and affects millions of employees and their families nationwide. The decision below—now entrenched in Arizona law by the state supreme court's refusal to exercise review—deepens this direct conflict and erases any doubt that this Court's guidance is urgently needed.

B. The Decision Below Cannot Be Squared With FEHBA's Text, Its Purpose, Or This Court's Precedent.

The state-court decisions here and in *Nevils* not only are irreconcilable with other courts' conclusions, but also contravene FEHBA's text and purpose and this Court's precedent. Preemption is always a question "of statutory intent." *Morales* v. *Trans World Airlines, Inc.*, 504 U.S. 374, 383 (1992). Courts, therefore, must resolve it by "'reading the whole statutory text, considering the purpose and context of the statute, and consulting any precedents … that inform the analysis.'" *Kasten* v. *Saint-Gobain Per-*

formance Plastics Corp., 131 S. Ct. 1325, 1330 (2011) (citation omitted). All of those touchstones of congressional intent foreclose the conclusion reached below and in *Nevils*. The construction of FEHBA adopted by both courts contradicts the statute's plain language—as confirmed by this Court's decisions construing closely analogous statutory provisions—and rests on a fundamental misunderstanding of the presumption against preemption. And the courts' holdings allowing state law to override FEHBA carriers' right to reimbursement thwart Congress's core aims.

1. Because FEHBA "contains an express preemption clause," courts construing it must "focus on the plain wording of the clause, which necessarily contains the best evidence of Congress's preemptive intent." *Chamber of Commerce of United States* v. *Whiting*, 131 S. Ct. 1968, 1977 (2011) (internal quotation marks omitted). Courts cannot cherrypick particular terms and disregard others; they "must have regard to *all* the words used by Congress," *United States* v. *Atl. Research Corp.*, 551 U.S. 128, 137 (2007) (emphasis added) (internal quotation marks omitted), and must "give effect, if possible, to every clause and word," *Duncan* v. *Walker*, 533 U.S. 167, 174 (2001) (internal quotation marks omitted). The decision below, like *Nevils*, contravened these commands, distorting the plain meaning of the words that it did consider, and entirely ignoring other, equally critical terms.

a. The court below held that state laws barring FEHBA carriers from seeking reimbursement of previously paid benefits pursuant to FEHBA-plan provisions are not preempted because reimbursement does not "'relat[e] to the nature, provision, or extent

of benefits.'" Pet. App. 9a. Although conceding that reimbursement "affect[s] [participants'] net financial position," the court concluded that reimbursement "has no effect" on "benefits" because it does not alter the amount participants are "entitled" to receive in the first instance. *Ibid.* "Kobold," the court reasoned, "would have been entitled to the same benefits" under his FEHBA plan "had he never even brought an action for damages" against the third parties responsible for his injuries. *Ibid.* Aetna's "contractual right to reimbursement" thus "bears no immediate relationship" to Kobold's "receipt of benefits." *Ibid.*; *see also Nevils*, 418 S.W.3d at 455-57.

As the United States has forcefully shown in this case and in *Nevils*, that reasoning blinks both the statutory text and reality. The "subrogation provision of [Aetna's] plan," the government explained below, relates to benefits because "Kobold's right to *retain* those benefit payments" has "always been contingent on whether he has received a separate tort recovery." Pet. App. 59a (emphasis added). Indeed, as the United States argued in *Nevils*, a FEHBA participant who happens to recover from a third party *before* receiving FEHBA benefits will never receive the duplicative benefits at all (or will receive less). *See Nevils* App. 124a.

This Court, in fact, has recognized that reimbursement does "relat[e] to" employee "benefits" in the closely analogous context of benefit plans for *private* employees governed by ERISA. Pet. App. 60a. ERISA contains a parallel preemption clause providing that ERISA "supersede[s] any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." 29 U.S.C. § 1144(a). In *FMC*, 498 U.S. 52, the Court held that this language

preempts state laws that "prohibi[t] plans from … requiring reimbursement." *Id.* at 58-60.

FMC's reasoning forecloses the court of appeals' holding here. State laws barring reimbursement "relate to" ERISA plans, this Court explained, precisely because reimbursement does affect a plan's calculation of benefits: Such state laws "requir[e] plan providers to calculate benefit levels in" States *with* anti-subrogation laws "based on expected liability conditions that differ from those in States" *without* them. 498 U.S. at 60. That "frustrate[s] plan administrators' continuing obligation to calculate uniform benefit levels nationwide." *Ibid.* The court of appeals' conclusion that reimbursement does not "relate to" benefits thus is irreconcilable with this Court's analysis in *FMC*.

FMC's analysis is fully applicable to FEHBA. Numerous courts have recognized that, given the parallels between the texts and contexts of ERISA's and FEHBA's preemption provisions, "precedent interpreting the ERISA provision" is "authority for cases involving the FEHBA provision." *Botsford*, 314 F.3d at 393-94; *accord Aybar*, 701 A.2d at 935-36; *Pharm. Care Mgmt. Ass'n* v. *Rowe*, 429 F.3d 294, 299-300 n.2 (1st Cir. 2005) (per curiam) (because Section 8902(m)(1) "is nearly identical to ERISA's preemption provision," courts "look to ERISA precedent in determining the scope of the preemption pro-

vision under FEHBA").[6] If anything, *FMC*'s reasoning applies with even greater force to FEHBA. As the government explained below, "[i]t is exceedingly unlikely that Congress intended a *broader* role for state law," or "desired *less* uniformity," "in the case of federal employees than in the case of private employees." Pet. App. 60a (emphases added).

b. The court of appeals' contrary view rests on an entirely artificial distinction between benefits paid to a participant initially and benefits he ultimately can *keep*. This Court has repeatedly rejected just such illusory distinctions in construing the preemptive effect of other federal statutes.

Just two months ago, in *Northwest, Inc.* v. *Ginsberg*, 134 S. Ct. 1422 (2014), the Court held that a state-law claim alleging a failure to provide benefits promised through a frequent-flyer program was expressly preempted by the Airline Deregulation Act's strikingly similar express-preemption provision, which nullified state laws "'relate[d] to'" an airline's "'rates, routes, or services.'" *Id.* at 1430-31 (citation omitted). *Northwest* reiterated the Court's earlier

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[6] The First Circuit noted in *López-Muñoz* v. *Triple-S Salud, Inc.*, __ F.3d __, 2014 WL 1856769 (1st Cir. May 9, 2014), that, although FEHBA's and ERISA's express-preemption provisions are "'nearly identical,'" the two statutory schemes differ in that ERISA creates an exclusive federal cause of action sufficient to confer federal jurisdiction, *id.* at *5 (citing *Metro. Life Ins. Co.* v. *Taylor*, 481 U.S. 58, 66-67 (1987); other citation omitted)); *see also* 29 U.S.C. § 1132(a), whereas FEHBA (as construed in *McVeigh*) does not, *see* 2014 WL 1856769, at *5. *López-Muñoz*, however, casts no doubt on *Pharmaceutical Care's* recognition that case law construing ERISA is instructive in determining the substantive scope of FEHBA's express-preemption provision.

holdings that Congress's use of the phrase "'related to' expresses a 'broad pre-emptive purpose.'" *Id.* at 1428. As the Court explained, "the frequent flyer program" was "connected to the airline's 'rates'" because it affected the net prices program participants paid for airline services. *Id.* at 1431. "When miles are used" to obtain "tickets and upgrades," "the rate that a customer pays, *i.e.*, the price of a particular ticket, is either eliminated or reduced." *Ibid.* "The program is also connected to 'services,' *i.e.*, access to flights and to higher service categories." *Ibid.* The Court saw no merit in the plaintiff's argument that his claim concerned only his frequent-flyer-program status and did not directly "'challenge access to flights and upgrades.'" *Ibid*. The plaintiff's "proffered distinction," the Court held, "has no substance": The obvious purpose of the plaintiff's claim concerning his frequent-flyer status was precisely "to obtain reduced rates and enhanced services." *Ibid.*

Even without reliance on sweeping "related to" preemptive language—present in FEHBA, ERISA, and the Airline Deregulation Act—the Court has rejected equally contrived distinctions deployed in similar efforts to evade federal preemption. *Hillman* v. *Maretta*, 133 S. Ct. 1943 (2013), which addressed a federal law regarding federal employee life insurance, refused to distinguish initial payment of benefits from a later *transfer* of benefit payments. *See id.* at 1952. Federal law required that benefits be paid to the employee's named beneficiary. *Id.* at 1948. The respondent argued that state law requiring a subsequent transfer of benefit payments from the beneficiary to the employee's widow was not preempted. *Id.* at 1948-49. The Court saw through this empty distinction. It "makes no difference," the Court held, whether state law withholds benefits in

the first instance or instead takes them away after they have been paid. *Id.* at 1952. "In either case, state law displaces the beneficiary selected" under federal law. *Ibid.*

c. Even if the court of appeals' crabbed reading of the terms it *did* construe were defensible, its conclusion that state laws overriding reimbursement provisions in FEHBA contracts "fal[l] outside the scope of § 8902(m)(1)" is foreclosed by other statutory terms that the court ignored. Section 8902(m)(1) shields from state-law interference not only contract terms that "relate to" "benefits," but *also* terms that "relate to … *payments with respect to* benefits." 5 U.S.C. § 8902(m)(1) (emphasis added).

Reimbursement and subrogation provisions like the one in Aetna's plan here undoubtedly "relate to" "payments" made "with respect to benefits." As the government demonstrated below, "[s]ubrogation rights relate to benefit payments because they require a beneficiary to return benefits to the extent the beneficiary has been separately reimbursed for those benefits from a tort recovery." Pet. App. 59a. Indeed, the whole point of a reimbursement provision is to facilitate *repayments* of benefits back to carriers—effectively reducing or even undoing a prior benefit payment. Even if the court of appeals' parsing of FEHBA's so-called "operative terms" could be squared with the statute and this Court's case law, the "'statutory text'" read as a "'whole'" (*Kasten*, 131 S. Ct. at 1330 (citation omitted)) thus refutes the court's bottom-line conclusion.

2. The decision below also is at war with Congress's purpose in enacting FEHBA's express-preemption clause—the "ultimate touchstone of preemption analysis," *Wis. Dep't of Ind., Labor & Hu-*

man Relations v. *Gould Inc.*, 475 U.S. 282, 290 (1986) (internal quotation marks omitted). FEHBA's history shows that Congress enacted Section 8902(m)(1) to meliorate concerns that States' imposition of divergent requirements on FEHBA plans—for example, laws mandating provision of specific benefits—could cripple uniformity and make administration of nationwide plans unmanageable. *See* Pet. App. 61a-62a; S. Rep. No. 95-903, at 7 (1978); H.R. Rep. No. 95-282, at 3-7 (1977); H.R. Rep. No. 94-1211, at 3. Congress later broadened Section 8902(m)(1) "to strengthen the ability of national plans to offer uniform benefits and rates to enrollees regardless of where they may live," and to "prevent carriers' cost-cutting initiatives from being frustrated by State laws." H.R. Rep. No. 105-374, at 9; *see also* S. Rep. No. 105-257, at 9, 14-15 (1997).

All of these objectives are undermined by allowing States to bar carriers from seeking reimbursement as expressly authorized by their plans. That intrusion by the States into FEHBA-plan administration will give rise to a diverse patchwork of idiosyncratic restrictions and will impose significant administrative burdens, particularly for plans that serve employees across state lines. Such state-by-state inconsistency also hamstrings the cost-cutting efforts that Congress specifically intended to encourage.

The court of appeals never attempted to square its reading of FEHBA with Congress's purpose. Indeed, although controlling precedent required the court below to construe Section 8902(m)(1) in light of Congress's aims, the decision below never considered those aims at all.

3. Like the Missouri Supreme Court in *Nevils*, the court below skewed the statutory analysis by "begin[ning]" with a presumption against preemption. Pet. App. 7a. Drawing on case law addressing federal statutes concerning pesticide labeling, the court reasoned that if "two plausible readings of a statute are possible, '[the Court] would nevertheless have a duty to accept the reading that disfavors preemption.'" *Ibid.* (quoting *Bates* v. *Dow Agrosciences LLC*, 544 U.S. 431, 449 (2005)). But that presumption, properly understood, has no application here at all.

As *Bates* itself makes clear, the presumption against preemption is merely a starting "assum[ption]" that, "[i]n areas of traditional state regulation," state law is not preempted "unless Congress has made such intention clear and manifest." 544 U.S. at 449 (internal quotation marks omitted). It thus is overcome where Congress *has* clearly swept aside state law. Indeed, even "state laws 'governing'" issues of paradigmatic state concern—such as "family law"—"'must give way to clearly conflicting federal enactments.'" *Hillman*, 133 S. Ct. at 1950 (citation omitted).

Moreover, the benefits available to federal employees pursuant to federal contracts can scarcely be described as an "are[a] of traditional state regulation." The presumption "is not triggered" in the first place "when the State regulates in an area where there has been a history of significant federal presence," *United States* v. *Locke*, 529 U.S. 89, 108 (2000), or where the "interests at stake are 'uniquely federal' in nature," *Buckman Co.* v. *Plaintiffs' Legal Comm.*, 531 U.S. 341, 347 (2001) (citation omitted). Both are true of "the relationship between a federal

agency and the entity it regulates." *Ibid.* That relationship "is inherently federal in character because the relationship originates from, is governed by, and terminates according to federal law." *Ibid.*

These principles foreclose the court of appeals' conclusion that the presumption against preemption justifies a narrow reading of FEHBA's preemptive scope. The presumption is entirely irrelevant to a statute governing federal contracts for provision of benefits to millions of federal employees and their families—an area of inherently federal concern, and one in which the federal government has played the primary regulatory role for decades. But even if the presumption were applicable, it is easily overcome by FEHBA's plain text, its purpose, and OPM's well-reasoned view. The tie-breaking presumption the court of appeals invoked cannot remotely trump those dispositive sources of statutory meaning.

II. THE DECISION BELOW DEPARTS FROM THIS COURT'S AND OTHER COURTS' CASE LAW BY REFUSING TO ACCORD ANY DEFERENCE TO OPM'S INTERPRETATION OF FEHBA.

Like the Missouri Supreme Court in *Nevils*, the court below diverged further from this Court's teaching and other courts' case law by refusing to give any weight to OPM's well-reasoned interpretation of FEHBA.

1. Courts owe "great deference to the interpretation given the statute by the officers or agency charged with its administration." *Udall* v. *Tallman*, 380 U.S. 1, 16 (1965). In many contexts, an agency's understanding of a statute it administers is controlling unless it is unreasonable. *See Chevron*, 467 U.S. at 842-45; *see also Entergy Corp.* v. *Riverkeeper, Inc.*,

556 U.S. 208, 218 & n.4 (2009). Although dispositive deference under *Chevron* is usually reserved for agency interpretations promulgated through "administrative action with the effect of law," such as "notice-and-comment rulemaking or formal adjudication," that is not always true. *United States* v. *Mead Corp.*, 533 U.S. 218, 230 (2001). This Court has "sometimes found reasons for *Chevron* deference even when no such administrative formality was required and none was afforded." *Id.* at 231.

Moreover, regardless whether full-fledged *Chevron* deference applies, an agency's reasonable statutory interpretation is still "entitled" at a minimum "to a measure of respect under" *Skidmore* v. *Swift & Co.*, 323 U.S. 134 (1944). *Fed. Express Corp.* v. *Holowecki*, 552 U.S. 389, 399 (2008) (internal quotation marks omitted); *see also*, *e.g.*, *Kasten*, 131 S. Ct. at 1335-36. "*Chevron*," in short, "did nothing to eliminate *Skidmore*'s holding that an agency's interpretation may merit some deference whatever its form." *Mead*, 533 U.S. at 234.

As the government and Aetna each argued below, OPM's cogent, consistent interpretation of Section 8902(m)(1) merits considerable deference here. *See* Pet. App. 64a-65a; C.A. Appellant Br. 24; Pet. for Review 13-15. Congress authorized OPM to administer FEHBA—not only by issuing regulations, but also by prescribing the terms of FEHBA carriers' contracts. *See* 5 U.S.C. §§ 8902(a), (d), 8913(a). And OPM has "consistently recognized that the FEHBA preempts state laws that restrict or prohibit FEHB Program carrier reimbursement and/or subrogation recovery efforts." Pet. App. 46a. Indeed, it has long *required* FEHBA carriers to seek reimbursement or subrogation when plan participants recover from

other sources, even in "State[s] in which subrogation is prohibited." 2000 Standard Contract § 2.5.

2. The court of appeals' refusal to ascribe any weight to OPM's interpretation flies in the face of this Court's teaching. And the court's reasons for withholding deference altogether only compound its disagreement with other courts and magnify existing confusion.

The decision below deemed OPM's view categorically unworthy of *Chevron* deference because it was not articulated in notice-and-comment rulemaking or formal adjudication. Pet. App. 10a. Federal courts of appeals, however, have deferred to OPM's interpretations of FEHBA even when not articulated by such formal means. *See Blue Cross & Blue Shield of Fla., Inc.* v. *Dep't of Banking & Fin.*, 791 F.2d 1501, 1506 (11th Cir.), *reh'g denied*, 797 F.2d 982 (11th Cir. 1986); *Dyer* v. *Blue Cross & Blue Shield Ass'n (In re Bolden)*, 848 F.2d 201, 206-07 (D.C. Cir. 1988).

Moreover, many lower courts—faithfully applying this Court's teaching, *see*, *e.g.*, *Holowecki*, 552 U.S. at 399—have recognized that agencies' views of statutes they administer "are entitled to 'great weight'" however they are expressed, whether through "interpretive letters," "amicus briefs," or otherwise. *Cmty. Bank of Ariz.* v. *G.V.M. Trust*, 366 F.3d 982, 987 (9th Cir. 2004) (interpretive letters); *see*, *e.g.*, *Sai Kwan Wong* v. *Doar*, 571 F.3d 247, 260-62 (2d Cir. 2009) (manual); *Doe* v. *Leavitt*, 552 F.3d 75, 79-86 (1st Cir. 2009) (guidebook and informal decision); *see also State Farm Bank, FSB* v. *Reardon*, 539 F.3d 336, 341 n.3 (6th Cir. 2008) (opinion letter). Indeed, a federal district court, finding OPM's interpretation of Section 8902(m)(1) in the 2012 Letter "persuasive," relied on the agency's in-

terpretation to overturn the court's *own* prior reading of FEHBA. *Calingo*, 2013 WL 1250448, at *3-4. The Arizona Court of Appeals' refusal to accord any deference to OPM's view based on the manner in which it was promulgated thus exacerbates the conflict over FEHBA's scope.

3. The court of appeals' other reasons for assigning no significance to OPM's view also fall apart upon inspection. The court "s[aw] nothing in the FEHBA to indicate that Congress intended to delegate to the OPM the authority to make determinations having the force of law" (Pet. App. 10a) because it did not look. Congress expressly delegated to OPM power to promulgate regulations, 5 U.S.C. § 8913(a), and to prescribe contract terms that States may not override, *see id.* § 8902(a), (d), (m)(1).

The decision below also dismissed OPM's interpretation because it "does not reflect the same term-by-term analysis of the statute that [the court] ha[d] performed." Pet. App. 10a. But OPM's parsing of the statutory text and context was *more* thorough than the court of appeals'. *Id.* at 45a. It considered *all* of the statutory terms—including "payments with respect to benefits," a phrase the decision below entirely disregarded. *Ibid.* And the agency explained the effects of reimbursement provisions on the net benefits that participants are able to retain and on the premiums that participants and the government pay for benefits in the future. *See ibid.*

The court of appeals also discounted the 2012 Letter because it was "recent." Pet. App. 10a. But the 2012 Letter itself explains that it merely reiterated the agency's "consistently recognized" position, which OPM "continue[s] to maintain." *Id.* at 46a. The decision below did not credit this assertion be-

cause the 2012 Letter did not catalogue all the occasions on which it has taken that view. *Id.* at 10a-11a. But OPM's standard contracts show that it has understood FEHBA to preempt state antisubrogation laws for at least the last 14 years; otherwise, the contracts' provisions requiring subrogation and reimbursement even where state law forbids it, *see*, *e.g.*, 2000 Standard Contract § 2.5, would make no sense. Moreover, neither the court below nor Kobold cited any evidence that the 2012 Letter departed from the agency's prior position.

The court of appeals finally reasoned that OPM's reiteration of its views in the 2012 Letter deserves no deference because it was issued "in response to other jurisdictions' interpretations of" FEHBA. Pet. App. 10a. To be sure, as OPM explained, it issued the letter because the agency had learned that "[s]ome states" had departed from OPM's settled understanding of FEHBA, and were "not allowing FEHB Program carriers to collect subrogation and/or reimbursement recoveries." *Id.* at 44a. But that is hardly a reason why OPM's views merit less respect. That some States had become confused about the preemptive scope of a statute that OPM administers showed that further guidance from the agency was needed to restore uniformity to federal law.

III. THIS CASE IS AN EXCELLENT VEHICLE TO ADDRESS AN IMPORTANT PREEMPTION ISSUE, AND AT MINIMUM SHOULD BE HELD PENDING THIS COURT'S DISPOSITION IN *NEVILS*.

As the government has explained here and in *Nevils*, and as its active involvement in the state courts in both cases attests, the question presented is extraordinarily important—for the federal govern-

ment, its workforce, and OPM's contracting partners who administer the Program.

1. FEHBA carriers administer a nationwide program that distributes tens of *billions* of dollars in benefits "to millions of federal employees and their families." Pet. App. 52a; *see also Nevils* App. 131a. The state courts' holdings here and in *Nevils*, however, put carriers in an impossible position and severely impede their ability to carry out the responsibility OPM has delegated to them. As OPM has explained, carriers "are required to seek reimbursement and/or subrogation recoveries" under their OPM contracts, even where state law forbids it. Pet. App. 45a; *see*, *e.g.*, 2000 Standard Contract § 2.5. Consistent with that mandate, carriers' agreements with participants specifically grant carriers the right to seek reimbursement or subrogation. *E.g.*, Pet. App. 48a-50a. But *Nevils* and the decision below *forbid* carriers from pursuing those remedies, and compel them to disregard their duties to OPM.

The burdens imposed by that misreading of FEHBA are increased exponentially where carriers, including Aetna, administer plans that cross state lines. The plan in which Kobold enrolled, for example, served employees not only in Arizona, but also in 18 other States in 2006. Pet. App. 47a. As the United States has explained, allowing any State to impose its own parochial restrictions on plans "destroys the uniformity Congress intended the FEHBA preemption provision to establish as to benefits and premiums." *Id.* at 52a. That eradication of uniformity, in turn, "threatens to increase the cost of the FEHB program to the federal government, which was $31.5 billion in 2012 alone." *Ibid.*

2. The distorted interpretation of FEHBA adopted below and in *Nevils* will perversely harm the very federal employees and dependents that these state courts seek to protect, as well as the taxpaying public. As the government explained below, subrogation and reimbursement recoveries "tend to reduce" the premiums that both participants and the federal government pay for benefits. Pet. App. 54a-55a, 62a; *see also id.* at 45a. Precluding such recoveries would eliminate those savings, increasing the cost to federal workers, the government, and ultimately taxpayers.

Allowing state-specific rules to bar carriers from fulfilling their duties to OPM to seek reimbursement or subrogation compounds this problem. As the government has explained, "[i]f Arizona's anti-subrogation rule survives preemption, then, the losers will be FEHB enrollees in states that permit subrogation, who will be subsidizing the more generous benefits that Arizona law effectively mandates that FEHB carriers provide." Pet. App. 62a. The decision below, in short, permits a privileged few employees to retain duplicative benefits—solely because of their State of residence—at the expense of other employees covered by the same plan. The discord among lower courts on whether laws like Arizona's are preempted exacerbates this arbitrary inconsistency, making participants' experience depend not only on idiosyncrasies of state law, but also on the happenstance of whether courts in the relevant jurisdiction construe FEHBA as allowing state law to override FEHBA contracts.

3. This case, like *Nevils*, provides an ideal opportunity for the Court to bring much-needed clarity to this important area of federal law. The preemption

issues were pressed and passed upon below, and they are outcome-determinative here: The trial court entered, and the court of appeals affirmed, final judgment in Kobold's favor based entirely on the erroneous conclusion that FEHBA does not preempt Arizona law precluding Aetna from seeking reimbursement pursuant to the terms of its FEHBA plan. Pet. App. 4a-11a, 13a-14a, 16a-17a. And the Arizona Supreme Court's refusal to overturn that ruling—over the strong objection of the United States—means that the decision below likely will govern Arizona cases for years to come. *See supra* at 18-19.

The Court, therefore, should grant certiorari both in this case and in *Nevils* and consider the cases in tandem to resolve definitively whether FEHBA preempts laws barring carriers from seeking subrogation and reimbursement. At an absolute minimum, the Court should hold this case pending its adjudication of *Nevils*. If the Court grants review in *Nevils* and reverses or vacates the Missouri Supreme Court's decision, it should grant certiorari in this case and reverse the judgment below here, or else vacate and remand with clear instructions to the Arizona courts faithfully to apply this Court's teaching.

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The state courts' explicit rejection, here and in *Nevils*, of the correct view of FEHBA preemption embraced by other state and federal courts proves that this Court's guidance is needed. And the stakes of the dispute—underscored by the United States, which took the extraordinary step of actively participating in the state courts in each case—are difficult to overstate. The benefits of millions of employees and their dependents, which cost participants and

taxpayers tens of billions of dollars each year, hang in the balance. The Court should grant review and resolve this issue once for all.

CONCLUSION

The petition for a writ of certiorari should be granted, and the case should be considered on the merits together with *Nevils*, No. 13-1305. At a minimum, the Court should hold this petition pending the Court's disposition in *Nevils*.

Respectfully submitted.

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APPENDIX

APPENDIX A

[SEAL]

DIVISION ONE
FILED: 9/5/2013
RUTH A. WILLINGHAM,
CLERK
BY: mjt

IN THE COURT OF APPEALS
STATE OF ARIZONA
DIVISION ONE

MATTHEW KOBOLD, a single man, Plaintiff/ Counterdefendant/ Appellee, v. THE AETNA LIFE INSURANCE COMPANY, a foreign insurer Third-Party Defendant/Appellant.	No. 1 CA-CV 12-0135 Department A **O P I N I O N**

Appeal from the Superior Court in Maricopa County

Cause No. CV2008-023699

The Honorable John A. Buttrick, Retired Judge

AFFIRMED

SWANN, Judge

¶1 Arizona law generally forbids subrogation in personal injury cases. This case presents the question whether 5 U.S.C. § 8902(m)(1) of the Federal Employee Health Benefits Act ("FEHBA") preempts that Arizona law. We answer the question in the negative, and hold that Arizona law barring subrogation governs this dispute between an injured insured and his FEHBA insurer.

FACTS AND PROCEDURAL HISTORY

¶2 In October 2006, Kobold, a federal employee, was injured in a motorcycle accident. At the time of the accident, Kobold was entitled to health care benefits under an insurance plan ("Plan") governed by the FEHBA. The carrier for the Plan, Aetna, paid Kobold's medical providers $24,473.53 for his treatment related to the accident.

¶3 Kobold brought a negligence action against the parties allegedly responsible for the accident, and eventually settled the case for $145,000. Under the terms of the Plan, Aetna had a right to subrogation and a right to reimbursement in the event that Kob-

old recovered from a responsible third party.[1] Aetna asserted a lien on the settlement proceeds for the medical expenses it had paid, and Kobold disputed Aetna's entitlement to reimbursement. The alleged tortfeasors paid $120,526.40 of the settlement sum to Kobold, deposited the remaining $24,473.53 with the superior court, and filed an interpleader action against Kobold and Aetna.

¶4 In the interpleader action, Kobold and Aetna filed cross-motions for summary judgment in which they disputed the preemptive effect of 5 U.S.C. § 8902(m)(1), which provides that certain types of

---

[1] The Plan provided:

> When you receive money to compensate you for medical or hospital care for injuries or illness caused by another person, you must reimburse us for any expenses we paid.
>
> ….
>
> You specifically acknowledge our right to subrogation. When we provide health care benefits for injuries or illnesses for which a third party is or may be responsible, we shall be subrogated to your rights of recovery against any third party to the extent of the full costs of all benefits provided by us, to the fullest extent permitted by law.…
>
> You also specifically acknowledge our right of reimbursement. This right of reimbursement attaches, to the fullest extent permitted by law, when we have provided health care benefits for injuries or illnesses for which a third party is or may be responsible and you and/or your representative has recovered any amounts from the third party or any party making payments on the third party's behalf. By providing any benefit under this Plan, we are granted an assignment of the proceeds of any settlement, judgment or other payment received by you to the extent of the full cost of all benefits provided by us. Our right of reimbursement is cumulative with and not exclusive of our subrogation right and we may choose to exercise either or both rights of recovery.

FEHBA contract terms preempt state laws. Concluding that the United States Supreme Court had "spoken on this very issue" in *Empire Healthchoice Assurance, Inc. v. McVeigh*, 547 U.S. 677 (2006), the superior court found no preemption, granted summary judgment in favor of Kobold, and awarded him attorney's fees and costs. Aetna timely appeals. We have jurisdiction under A.R.S. § 12-2101(A)(1).

DISCUSSION

¶5 The single issue presented by this appeal is whether the Plan's subrogation and reimbursement provision falls within the scope of 5 U.S.C. § 8902's preemption clause, which provides that FEHBA contract terms that

> relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans.

5 U.S.C. § 8902(m)(1).[2]

---

[2] We note that though the FEHBA may bear some similarities to the Employee Retirement Income Security Act ("ERISA"), the FEHBA's preemption clause is materially different from the ERISA's preemption clause. The ERISA's preemption clause, 29 U.S.C. § 1144(a), provides that the provisions of the ERISA itself – not provisions of ERISA contracts – are preemptive. We therefore limit our opinion to FEHBA cases. *But see Botsford v. Blue Cross & Blue Shield of Mont., Inc.*, 314 F.3d 390, 393-94 (9th Cir. 2002) ("The new [FEHBA preemption] provision closely resembles ERISA's express preemption provision, and precedent interpreting the ERISA provision thus provides authority for cases involving the FEHBA provision." (footnote omitted)).

¶6 If the Plan's subrogation and reimbursement provision falls within the statute's preemption clause, then the provision governs and Aetna is entitled to reimbursement. But if the Plan's provision does not fall within the preemption clause, then Arizona law applies and makes the provision void. *E.g., Allstate Ins. Co. v. Druke*, 118 Ariz. 301, 304, 576 P.2d 489, 492 (1978) (explaining that anti-subrogation rule protects insureds whose medical coverage may not indemnify them for all aspects of their loss, and does not affect rate schedules because insurers still receive the full benefit of the premiums paid).

¶7 Our review is de novo. *Ballesteros v. Am. Standard Ins. Co. of Wis.*, 226 Ariz. 345, 347, ¶ 7, 248 P.3d 193, 195 (2011) (summary judgment and statutory interpretation are reviewed de novo); *State Farm Mut. Auto. Ins. Co. v. Connolly*, 212 Ariz. 417, 418, ¶ 4, 132 P.3d 1197, 1198 (App. 2006) (insurance contract interpretation is reviewed de novo); *Hutto v. Francisco*, 210 Ariz. 88, 90, ¶ 7, 107 P.3d 934, 936 (App. 2005) (federal preemption is reviewed de novo).

I. MCVEIGH DID NOT DECIDE WHETHER CONTRACT-BASED REIMBURSEMENT RIGHTS FALL WITHIN § 8902'S PREEMPTION CLAUSE.

¶8 As an initial matter, we disagree with Kobold's argument and the superior court's conclusion that the Supreme Court's decision in *McVeigh* resolved the issue before us. *McVeigh* held that § 8902(m)(1) does not provide a basis for federal jurisdiction over carrier reimbursement disputes because (1) a right to reimbursement arises from the contract and not from the FEHBA itself, and (2) the statute does not purport to replace any and all state

laws that in some way bear on FEHBA plans. 547 U.S. at 696-98. The Court expressly declined to decide whether the statute supersedes state laws governing subrogation and reimbursement. *Id.* at 698. Indeed, the Court affirmatively recognized the potential for alternative statutory interpretations:

> Section 8902(m)(1) is a puzzling measure, open to more than one construction, and no prior decision seems to us precisely on point. Reading the reimbursement clause in the master [insurance] contract as a condition or limitation on "benefits" received by a federal employee, the clause could be ranked among "[contract] terms … relat[ing] to … coverage or benefits" and "payments with respect to benefits," thus falling within § 8902(m)(1)'s compass. On the other hand, a claim for reimbursement ordinarily arises long after "coverage" and "benefits" questions have been resolved, and corresponding "payments with respect to benefits" have been made to care providers or the insured. With that consideration in view, § 8902(m)(1)'s words may be read to refer to contract terms relating to the *beneficiary's* entitlement (or lack thereof) to Plan payment for certain health-care services he or she has received, and not to terms relating to the carrier's postpayments right to reimbursement.
>
> *To decide this case, we need not choose between those plausible constructions.* If contract-based reimbursement claims are not covered by FEHBA's preemption provision, then federal jurisdiction clearly does not exist. But even if FEHBA's preemption provi-

> sion reaches contract-based reimbursement claims, that provision is not sufficiently broad to confer federal jurisdiction.

Id. at 697-98 (first alteration and second emphasis added). We therefore address the question as one of first impression in Arizona.

II. SECTION 8902'S PREEMPTION CLAUSE DOES NOT PREEMPT ARIZONA LAW GOVERNING CONTRACT-BASED SUBROGATION RIGHTS.

¶9 We begin by noting that preemption is disfavored, and that when two plausible readings of a statute are possible, "we would nevertheless have a duty to accept the reading that disfavors preemption." *Bates v. Dow Agrosciences LLC*, 544 U.S. 431, 449 (2005). Section 8902(m)(1) provides that contract terms that "relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits)" preempt state law. The operative terms are "relate to," "coverage," and "benefits." We examine each in turn.

¶10 First, the term "relate to" generally means "having a connection with." *Botsford*, 314 F.3d at 394 (interpreting latter half of § 8902(m)(1), which provides for preemption of any state law that "relates to" health insurance or plans). We construe "relate to" as requiring a direct and immediate relationship, because "[i]f 'relate to' were taken to extend to the furthest stretch of its indeterminacy, then for all practical purposes pre-emption would never run its course, for 'really, universally, relations stop nowhere.'" *Roach v. Mail Handlers Benefit Plan*, 298 F.3d 847, 849-50 (9th Cir. 2002) (quoting *N.Y. State*

Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 655 (1995)).

¶11 Next, "coverage" means the scope of the risks insured under a plan or policy. Black's Law Dictionary 394 (8th ed. 2004) (defining "coverage" as "[i]nclusion of a risk under an insurance policy; the risks within the scope of an insurance policy"); *see also, e.g.*, *Kepner v. W. Fire Ins. Co.*, 109 Ariz. 329, 330, 509 P.2d 222, 223 (1973) (analyzing scope of risks contemplated by homeowner's insurance policy coverage). Nothing in the Plan's subrogation provision purports to affect the scope of risk that Aetna accepted, and we therefore conclude that the provision does not relate to coverage.

¶12 Finally, the term "benefits" means the financial assistance that the insured receives as a consequence of the coverage. Black's Law Dictionary 167 (defining "benefit" as "[f]inancial assistance that is received from … insurance … in time of sickness, disability, or unemployment"). In this context, we read the term "benefits" to include payments by the carrier on behalf of the insured, not payments to the insured by third parties. Indeed, even where subrogation is allowed by Arizona statute, we have read the term "benefits" not to include tort settlement proceeds. In *Arizona Health Care Cost Containment System v. Bentley*, 187 Ariz. 229, 928 P.2d 653 (App. 1996), we considered the right of subrogation in favor of Arizona's Medicaid program created by A.R.S. § 36-2903. Though the statute prescribed a right to assignment of "all types of medical benefits" to which a person was entitled, we rejected the attempt to extend the term to include tort settlements, noting that "[t]he term 'medical benefits' ordinarily means payments for medical treatment to which a person

has some entitlement by contract or statute." *Id.* at 232, 928 P.2d at 656.

¶13 Here, the fact that Aetna's contractual right to reimbursement is *triggered* by the payment of benefits does not mean that it "relate[s] to the nature, provision, or extent of" benefits. The "benefits" to which Kobold was entitled under the Plan were not dependent on recovery from a third party – they existed independently. Kobold would have been entitled to the same benefits had he never even brought an action for damages. "When 'benefits' are understood to include every financial incident of an illness or injury, national uniformity is unattainable without a federal takeover of the entire tort system." *Blue Cross Blue Shield of Ill. v. Cruz ("Cruz II")*, 495 F.3d 510, 514 (7th Cir. 2007).

¶14 We therefore conclude that the Plan's subrogation and reimbursement provision falls outside the scope of § 8902(m)(1). The provision creates a contingent right to repayment in favor of Aetna. It bears no immediate relationship to the scope of Kobold's coverage under the Plan or his receipt of benefits under that coverage, because it has no effect on Kobold's entitlement to receive financial assistance from Aetna when he suffers injury or illness contemplated by the Plan. Though the provision would affect Kobold's net financial position in some circumstances, it does not affect his right to coverage and receipt of benefits, nor is it essential to the uniformity of FEHBA coverage and benefits available to eligible employees nationwide. *See Cruz II*, 495 F.3d at 513 ("The amount of benefits is determined by the plan and is indeed uniform across states and is unaffected by [Illinois'] common fund doctrine. That doctrine just affects how much of a tort judgment or

other judgment against (or settlement with) a third party the plaintiff gets to keep and how much he must give the insurer. The disuniformity that results is not a disuniformity in benefits.").

¶15 We reject Aetna's argument that we must defer to the contrary interpretation provided by the Office of Personnel Management ("OPM"), the federal agency in charge of contracting with FEHBA carriers, in its letter addressed to FEHBA carriers.[3] The letter does not appear to be the result of a formal rulemaking or adjudication process, and we see nothing in the FEHBA to indicate that Congress intended to delegate to the OPM the authority to make determinations having the force of law. Therefore, the letter does not command the deference prescribed by *Chevron, U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984). *See Cathedral Candle Co. v. U.S. Int'l Trade Comm'n*, 400 F.3d 1352, 1361 (Fed. Cir. 2005). Nor are we otherwise required to accept the letter's interpretation. When *Chevron* deference does not apply, we need not defer to an agency's interpretation of a statute it administers unless the agency has conducted a careful analysis and its position has been consistent, reflects agency-wide policy, and is reasonable. *Id.* at 1365-66. The OPM's letter does not reflect the same term-by-term analysis of the statute that we have performed. Moreover, the letter is recent (dated June 2012), itself acknowledges that it was drafted in response to other jurisdictions' interpretations of the statute, and does not support with evidence its claim that OPM

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[3] We are also not persuaded by the contrary interpretations advanced by courts in some other jurisdictions, such as the Missouri Court of Appeals in *Nevils v. Group Health Plan, Inc.*, ___ S.W.3d ___, 2012 WL 6689542 (Mo. Ct. App. 2012).

has "consistently recognized" the interpretation it advances.

CONCLUSION

¶16 We affirm the grant of summary judgment in favor of Kobold. Kobold requests attorney's fees on appeal pursuant to A.R.S. § 12-341.01. In our discretion, we deny Kobold's request. As the prevailing party, Kobold is entitled to an award of costs pursuant to A.R.S. §§ 12-341 and -342, upon his compliance with ARCAP 21.

/s/
PETER B. SWANN, Judge

CONCURRING:

/s/
PATRICIA A. OROZCO, Presiding Judge

/s/
KENT E. CATTANI, Judge

APPENDIX B

Michael K. Jeanes, Clerk of Court
Electronically Filed
11/07/2011 8:00 AM

SUPERIOR COURT OF ARIZONA
MARICOPA COUNTY

CV 2008-023699	11/04/2011
HONORABLE JOHN A. BUTTRICK	CLERK OF THE COURT C. Castro Deputy
MATTHEW KOBOLD	NEAL S. SUNDEEN
v.	
RYLAND GROUP INC., THE, et al.	ROSARY HERNANDEZ ERNEST S. BUSTAMANTE JOHN C. WEST

RULING

Plaintiff Matthew Kobold ("Kobold") and Third-Party Defendant The Aetna Life Insurance Company ("Aetna") have filed cross-motions for summary judgment on August 18, 2011 and August 19, 2011, respectively. Those Motions have been fully briefed and are now ruled upon.

This case concerns whether the sum of $24,473.53 interpleaded by Defendant The Ryland

Group, Inc. as a result of a personal injury settlement with Kobold, should be paid to Kobold or Aetna, Kobold's insurer which provided health care coverage to Kobold. Aetna claims a right of reimbursement pursuant to its policy with Kobold, an employee of the United States Post Office.

Kobold argues that Arizona law renders the reimbursement provision void, relying upon Preferred Risk Mut. Ins. Co. v. Vargas, 157 Ariz. 17, 19 (App. 1988) (citing numerous Arizona cases holding reimbursement provisions void).

Aetna asserts that Arizona law is preempted by the Federal Employee Health Benefit Act ("FEHBA"), 5 U.S.C. §§8901-14.

The specific provision of FEHBA at issue here reads in its entirety as follows:

> *The terms of any contract under this chapter which relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any state or local law, or any regulation issued there under, which relates to health insurance or plans*.
>
> 5 U.S.C. §8902(m)(1)

The pivotal legal question is whether the phrase "coverage or benefits" includes reimbursement provisions such as that at issue here. If it does, then the relevant Arizona law may be preempted. If it does not, then the Arizona law controls and Kobold's position is vindicated.

The United States Supreme Court has spoken on this very issue. "FEHBA contains a preemption clause, §8902 (m)(1), displacing state law on issues

relating to "coverage or benefits" afforded by healthcase plans…The Act contains no provision addressing the subrogation or reimbursement rights of carriers." Empire HealthChoice Assur., Inc. v. McVeigh, 547 U.S. 677, 683 (2006).

This Court agrees with the Supreme Court's exercise in statutory interpretation and the scope of FEHBA's preemption clause. As the Court noted, "a claim for reimbursement ordinarily arises long after "coverage" and "benefits" questions have been resolved" Id. at 697. If Congress had intended the scope of preemption to have included reimbursement issues, it could easily have said so. In the absence of such language the preemption clause of §8902(m)(1) should be accorded its ordinary and limited meaning.

Kobold's Motion is granted and Aetna's Motion is denied.

Counsel shall lodge a form of judgment by November 18, 2011.

* * *

APPENDIX C

Mar 8 2012 FILED *3:15 pm*
MICHAEL K. JEANES, Clerk
By /s
Deputy

IN THE SUPERIOR COURT OF THE STATE OF ARIZONA
IN AND FOR THE COUNTY OF MARICOPA

MATTHEW KOBOLD, a single man Plaintiff, vs. THE RYLAND GROUP, INC., et al. Defendants.	CV 2008-023699 **JUDGMENT**
The Ryland Group, Inc., a Maryland Corporation; RYLAND HOMES OF ARIZONA, INC., an Arizona Corporation, dba RYLAND HOMES, Counterclaimant, vs. MATTHEW KOBOLD, a single man, Counterdefendant,	(Assigned to the Honorable John Buttrick)

The Ryland Group, Inc., a Maryland Corporation; RYLAND HOMES OF ARIZONA, INC., an Arizona Corporation, dba RYLAND HOMES, Third-party Plaintiffs, vs. The AETNA INSURANCE COMPANY, a foreign insurer; Third-party Defendant.

This matter having come on before the Court on Plaintiff's Motion for Summary Judgment, Plaintiff's Response to Defendants' Motion for Summary Judgment, Plaintiff's Reply to Defendants' Response and Defendants' Motion for Summary Judgment, Defendants' Response to Plaintiff's Motion for Summary Judgment, and Defendants' Reply and the Court having reviewed same and finding good cause therefor,

IT IS HEREBY ORDERED, ADJUDGED AND DECREED that

A. Plaintiff, Matthew Kobold, be awarded Judgment against the Third-Party Defendant, The Aetna Insurance Company, and that the $24,473.53 that has been interpled into this Court by Defendant, the Ryland Group, be awarded to the Plaintiff, Matthew Kobold.

B. The Court further orders that plaintiff be awarded his taxable costs, pursuant to A.R.S. § 12-341, in the amount of $ *24.00* ;

C. The Court further orders that Plaintiff be awarded attorneys' fees in the amount of $ *14,345.00* , pursuant to A.R.S. § 12-341.01;

D. That Plaintiff be awarded interest on the attorneys' fees and costs at the rate of 4.25% per annum until paid; and

The Court further orders that there is no just reason for delay and that final judgment shall be entered pursuant to Rule 54(b) of the Arizona Rules of Civil Procedures.

DONE IN OPEN COURT this *7th* day of *March 2012*.

/s

THE HONORABLE JOHN A. BUTTRICK

APPENDIX D

SUPREME COURT
STATE OF ARIZONA

March 21, 2014

RE: MATTHEW KOBOLD v AETNA LIFE INSURANCE CO.
Arizona Supreme Court No. CV-13-0299-PR
Court of Appeals, Division One No. 1 CA-CV 12-0135
Maricopa County Superior Court No. CV2008-023699

GREETINGS:

The following action was taken by the Supreme Court of the State of Arizona on March 21, 2014, in regard to the above-referenced cause:

ORDERED: Petition for Review = DENIED.

FURTHER ORDERED: Request for Attorneys Fees (Appellee Kobold) = DENIED.

Vice Chief Justice Bales did not participate in the determination of this matter.

Janet Johnson, Clerk.

* * *

APPENDIX E

[SEAL]

DIVISION ONE
FILED: 5/8/2014
RUTH A. WILLINGHAM,
CLERK
BY: dn

IN THE COURT OF APPEALS
STATE OF ARIZONA
DIVISION ONE

MATTHEW KOBOLD, a single man, Plaintiff/ Counterdefendant/ Appellee, v. THE AETNA LIFE INSURANCE COMPANY, a foreign insurer Third-Party Defendant/Appellant.	Court of Appeals Division One No. 1 CA-CV 12-0135 Maricopa County Superior Court No. CV2008-023699

ORDER RE: STAY OF ISSUANCE OF MANDATE

The Court, Judge Patricia A. Orozco presiding and Judges Peter B. Swann and Kent E. Cattani participating, has received and considered both Appellant's Request To Stay Issuance of Mandate, pending application to the United States Supreme Court for a writ of certiorari, and Appellee's Response to same, which concurs in the request.

IT IS ORDERED granting the motion and staying the issuance of the mandate in this case for 90 days from the date of this order.

/s/
Peter B. Swann, Judge

* * *

APPENDIX F

U.S. Const. art. VI, cl. 2 provides:

This Constitution, and the Laws of the United States which shall be made in Pursuance thereof; and all Treaties made, or which shall be made, under the Authority of the United States, shall be the supreme Law of the Land; and the Judges in every State shall be bound thereby, any Thing in the Constitution or Laws of any State to the Contrary notwithstanding.

5 U.S.C. § 8902 provides:

§ 8902. Contracting authority

(a) The Office of Personnel Management may contract with qualified carriers offering plans described by section 8903 or 8903a of this title, without regard to section 6101(b) to (d) of title 41 or other statute requiring competitive bidding. Each contract shall be for a uniform term of at least 1 year, but may be made automatically renewable from term to term in the absence of notice of termination by either party.

(b) To be eligible as a carrier for the plan described by section 8903(2) of this title, a company must be licensed to issue group health insurance in all the States and the District of Columbia.

(c) A contract for a plan described by section 8903(1) or (2) of this title shall require the carrier—

> (1) to reinsure with other companies which elect to participate, under an equitable formula based on the total amount of their group health insurance benefit payments in the United States

during the latest year for which the information is available, to be determined by the carrier and approved by the Office; or

(2) to allocate its rights and obligations under the contract among its affiliates which elect to participate, under an equitable formula to be determined by the carrier and the affiliates and approved by the Office.

(d) Each contract under this chapter shall contain a detailed statement of benefits offered and shall include such maximums, limitations, exclusions, and other definitions of benefits as the Office considers necessary or desirable.

(e) The Office may prescribe reasonable minimum standards for health benefits plans described by section 8903 or 8903a of this title and for carriers offering the plans. Approval of a plan may be withdrawn only after notice and opportunity for hearing to the carrier concerned without regard to subchapter II of chapter 5 and chapter 7 of this title. The Office may terminate the contract of a carrier effective at the end of the contract term, if the Office finds that at no time during the preceding two contract terms did the carrier have 300 or more employees and annuitants, exclusive of family members, enrolled in the plan.

(f) A contract may not be made or a plan approved which excludes an individual because of race, sex, health status, or, at the time of the first opportunity to enroll, because of age.

(g) A contract may not be made or a plan approved which does not offer to each employee, annuitant, family member, former spouse, or person having continued coverage under section 8905a of this

title whose enrollment in the plan is ended, except by a cancellation of enrollment, a temporary extension of coverage during which he may exercise the option to convert, without evidence of good health, to a nongroup contract providing health benefits. An employee, annuitant, family member, former spouse, or person having continued coverage under section 8905a of this title who exercises this option shall pay the full periodic charges of the nongroup contract.

(h) The benefits and coverage made available under subsection (g) of this section are noncancelable by the carrier except for fraud, over-insurance, or nonpayment of periodic charges.

(i) Rates charged under health benefits plans described by section 8903 or 8903a of this title shall reasonably and equitably reflect the cost of the benefits provided. Rates under health benefits plans described by section 8903(1) and (2) of this title shall be determined on a basis which, in the judgment of the Office, is consistent with the lowest schedule of basic rates generally charged for new group health benefit plans issued to large employers. The rates determined for the first contract term shall be continued for later contract terms, except that they may be readjusted for any later term, based on past experience and benefit adjustments under the later contract. Any readjustment in rates shall be made in advance of the contract term in which they will apply and on a basis which, in the judgment of the Office, is consistent with the general practice of carriers which issue group health benefit plans to large employers.

(j) Each contract under this chapter shall require the carrier to agree to pay for or provide a health service or supply in an individual case if the Office finds that the employee, annuitant, family member,

former spouse, or person having continued coverage under section 8905a of this title is entitled thereto under the terms of the contract.

(k)(1) When a contract under this chapter requires payment or reimbursement for services which may be performed by a clinical psychologist, optometrist, nurse midwife, nursing school administered clinic, or nurse practitioner/clinical specialist, licensed or certified as such under Federal or State law, as applicable, or by a qualified clinical social worker as defined in section 8901(11), an employee, annuitant, family member, former spouse, or person having continued coverage under section 8905a of this title covered by the contract shall be free to select, and shall have direct access to, such a clinical psychologist, qualified clinical social worker, optometrist, nurse midwife, nursing school administered clinic, or nurse practitioner/nurse clinical specialist without supervision or referral by another health practitioner and shall be entitled under the contract to have payment or reimbursement made to him or on his behalf for the services performed.

(2) Nothing in this subsection shall be considered to preclude a health benefits plan from providing direct access or direct payment or reimbursement to a provider in a health care practice or profession other than a practice or profession listed in paragraph (1), if such provider is licensed or certified as such under Federal or State law.

(3) The provisions of this subsection shall not apply to comprehensive medical plans as described in section 8903(4) of this title.

(l) The Office shall contract under this chapter for a plan described in section 8903(4) of this title with any qualified health maintenance carrier which offers such a plan. For the purpose of this subsection, "qualified health maintenance carrier" means any qualified carrier which is a qualified health maintenance organization within the meaning of section 1310(d)(1) of title XIII of the Public Health Service Act (42 U.S.C. 300c-9(d)).

(m)(1) The terms of any contract under this chapter which relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans.

(2)(A) Notwithstanding the provisions of paragraph (1) of this subsection, if a contract under this chapter provides for the provision of, the payment for, or the reimbursement of the cost of health services for the care and treatment of any particular health condition, the carrier shall provide, pay, or reimburse up to the limits of its contract for any such health service properly provided by any person licensed under State law to provide such service if such service is provided to an individual covered by such contract in a State where 25 percent or more of the population is located in primary medical care manpower shortage areas designated pursuant to section 332 of the Public Health Service Act (42 U.S.C. 254e).

(B) The provisions of subparagraph (A) shall not apply to contracts entered into providing prepayment plans described in section 8903(4) of this title.

(n) A contract for a plan described by section 8903(1), (2), or (3), or section 8903a, shall require the carrier—

(1) to implement hospitalization-cost-containment measures, such as measures—

(A) for verifying the medical necessity of any proposed treatment or surgery;

(B) for determining the feasibility or appropriateness of providing services on an outpatient rather than on an inpatient basis;

(C) for determining the appropriate length of stay (through concurrent review or otherwise) in cases involving inpatient care; and

(D) involving case management, if the circumstances so warrant; and

(2) to establish incentives to encourage compliance with measures under paragraph (1).

(o) A contract may not be made or a plan approved which includes coverage for any benefit, item, or service for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997.

5 U.S.C. § 8906 provides in relevant part:

§ 8906. Contributions

(a)(1) Not later than October 1 of each year, the Office of Personnel Management shall determine the weighted average of the subscription charges that will be in effect during the following contract year with respect to—

(A) enrollments under this chapter for self alone;

(B) enrollments under this chapter for self plus one; and

(C) enrollments under this chapter for self and family.

(2) In determining each weighted average under paragraph (1), the weight to be given to a particular subscription charge shall, with respect to each plan (and option) to which it is to apply, be commensurate with the number of enrollees enrolled in such plan (and option) as of March 31 of the year in which the determination is being made.

(3) For purposes of paragraph (2), the term "enrollee" means any individual who, during the contract year for which the weighted average is to be used under this section, will be eligible for a Government contribution for health benefits.

[(4) Omitted. Pub. L. 105-33, Title VII, § 7002(a), Aug. 5, 1997, 111 Stat. 662]

(b)(1) Except as provided in paragraphs (2), (3), and (4), the biweekly Government contribution for health benefits for an employee or annuitant enrolled in a health benefits plan under this chapter is adjusted to an amount equal to 72 percent of the weighted average under subsection (a)(1)(A) or (B), as applicable. For an employee, the adjustment begins on the first day of the employee's first pay period of each year. For an annuitant, the adjustment begins on the first day of the first period of each year for which an annuity payment is made.

(2) The biweekly Government contribution for an employee or annuitant enrolled in a plan under this chapter shall not exceed 75 percent of the subscription charge.

(3) In the case of an employee who is occupying a position on a part-time career employment basis (as defined in section 3401(2) of this title), the biweekly Government contribution shall be equal to the percentage which bears the same ratio to the percentage determined under this subsection (without regard to this paragraph) as the average number of hours of such employee's regularly scheduled workweek bears to the average number of hours in the regularly scheduled workweek of an employee serving in a comparable position on a full-time career basis (as determined under regulations prescribed by the Office).

(4) In the case of persons who are enrolled in a health benefits plan as part of the demonstration project under section 1108 of title 10, the Government contribution shall be subject to the limitation set forth in subsection (i) of that section.

(c) There shall be withheld from the pay of each enrolled employee and (except as provided in subsection (i) of this section) the annuity of each enrolled annuitant and there shall be contributed by the Government, amounts, in the same ratio as the contributions of the employee or annuitant and the Government under subsection (b) of this section, which are necessary for the administrative costs and the reserves provided for by section 8909(b) of this title.

(d) The amount necessary to pay the total charge for enrollment, after the Government contribution is deducted, shall be withheld from the pay of each enrolled employee and (except as provided in subsection (i) of this section) from the annuity of each enrolled annuitant. The withholding for an annuitant shall be the same as that for an employee enrolled in the same health benefits plan and level of benefits.

* * *

(f) The Government contribution, and any additional payments under subsection (e)(3)(A), for health benefits for an employee shall be paid—

(1) in the case of employees generally, from the appropriation or fund which is used to pay the employee;

(2) in the case of an elected official, from an appropriation or fund available for payment of other salaries of the same office or establishment;

(3) in the case of an employee of the legislative branch who is paid by the Chief Administrative Officer of the House of Representatives, from the applicable accounts of the House of Representatives; and

(4) in the case of an employee in a leave without pay status, from the appropriation or fund which would be used to pay the employee if he were in a pay status.

* * *

5 U.S.C. § 8909 provides in relevant part:

§ 8909. Employees Health Benefits Fund

(a) There is in the Treasury of the United States an Employees Health Benefits Fund which is administered by the Office of Personnel Management. The contributions of enrollees and the Government described by section 8906 of this title shall be paid into the Fund. The Fund is available—

(1) without fiscal year limitation for all payments to approved health benefits plans; and

(2) to pay expenses for administering this chapter within the limitations that may be specified annually by Congress.

Payments from the Fund to a plan participating in a letter-of-credit arrangement under this chapter shall, in connection with any payment or reimbursement to be made by such plan for a health service or supply, be made, to the maximum extent practicable, on a checks-presented basis (as defined under regulations of the Department of the Treasury).

(b) Portions of the contributions made by enrollees and the Government shall be regularly set aside in the Fund as follows:

(1) A percentage, not to exceed 1 percent of all contributions, determined by the Office to be reasonably adequate to pay the administrative expenses made available by subsection (a) of this section.

(2) For each health benefits plan, a percentage, not to exceed 3 percent of the contributions toward the plan, determined by the Office to be reasonably adequate to provide a contingency reserve.

The Office, from time to time and in amounts it considers appropriate, may transfer unused funds for administrative expenses to the contingency reserves of the plans then under contract with the Office. When funds are so transferred, each contingency reserve shall be credited in proportion to the total amount of the subscription charges paid and accrued to the plan for the contract term immediately before the contract term in which the transfer is made. The income derived from dividends, rate adjustments, or other refunds made by a plan shall be credited to its

contingency reserve. The contingency reserves may be used to defray increases in future rates, or may be applied to reduce the contributions of enrollees and the Government to, or to increase the benefits provided by, the plan from which the reserves are derived, as the Office from time to time shall determine.

(c) The Secretary of the Treasury may invest and reinvest any of the money in the Fund in interest-bearing obligations of the United States, and may sell these obligations for the purposes of the Fund. The interest on and the proceeds from the sale of these obligations become a part of the Fund.

* * *

5 U.S.C. § 8913 provides in relevant part:

§ 8913. Regulations

(a) The Office of Personnel Management may prescribe regulations necessary to carry out this chapter.

* * *

28 U.S.C. § 1257 provides in relevant part:

§ 1257. State courts; certiorari

(a) Final judgments or decrees rendered by the highest court of a State in which a decision could be had, may be reviewed by the Supreme Court by writ of certiorari where the validity of a treaty or statute of the United States is drawn in question or where the validity of a statute of any State is drawn in question on the ground of its being repugnant to the Constitution, treaties, or laws of the United States, or where any title, right, privilege, or immunity is

specially set up or claimed under the Constitution or the treaties or statutes of, or any commission held or authority exercised under, the United States.

* * *

29 U.S.C. § 1144 provides in relevant part:

§ 1144. Other laws

(a) Supersedure; effective date

Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

* * *

5 C.F.R. § 890.503 provides in relevant part:

§ 890.503. Reserves.

* * *

(c)(1) Contingency reserve. The contingency reserve for each plan is credited with—

(i) The three one-hundred-and-fourths of the enrollment charge set aside for the contingency reserve from the enrollment charges for employees and annuitants enrolled for that plan;

(ii) Amounts transferred in accordance with law from other contingency reserves and the administrative reserve;

(iii) Income from investment of the reserve;

(iv) Its proportionate share of the income from investment of the administrative reserve; and

(v) Any return of reserves of the plan.

(2) Contingency reserve minimum balance. The preferred minimum balance for the contingency reserve for community-rated plans is 1 month's subscription charges at the average recurring monthly rate paid from the Employees Health Benefits Fund for the plan during the most recent contract period. The preferred minimum balance for the contingency reserve for experience-rated plans is 1 1/2 times an amount equal to the sum of an average month's paid claims plus an average month's administrative expenses and retentions, as determined under paragraph (c)(3) of this section. Amounts in excess of the preferred minimum balance for a contingency reserve account may be used with respect to the plan from which the reserve derives: To defray increases in future rates; to increase plan benefits, or to reduce contributions of eligible subscribers and the Government under the program through devices such as temporary suspension of, or reduction in, required contributions or a refund of contributions to eligible subscribers and the Government.

(3) OPM/carrier reserve transfers. The target level for total reserves of an experience-rated plan is 3 1/2 times an amount equal to the sum of an average month's paid claims plus an average month's administrative expenses and retentions. Reserves include funds set aside for incurred-but-unpaid benefit claims and the "special" reserve representing the cumulative difference be-

tween income to the plan (subscription income plus interest on investments) and plan expenses (benefit costs plus administrative expenses and retentions). Included as carrier reserves is the balance in the letter of credit (LOC) account maintained by OPM for the plan. For the purposes of this section, an average month's paid claims is one-sixth of the total claims paid during the last 6 months of the most recent contract period, and an average month's administrative expenses and retentions is one-twelfth of the administrative expenses and retentions for the most recent contract period.

(i) When, as of the end of a contract period, the total of all the reserves for an experience-rated plan is less than the target level described in the first four sentences of paragraph (c)(3) of this section, the carrier is entitled to payment from the contingency reserve. Such contingency reserve payment shall equal the lesser of: An amount equal to the difference between the target level for the plan's reserves and the total of the reserves for the plan, or an amount equal to the excess, if any, of the contingency reserve over the preferred minimum balance. OMP must authorize this payment promptly after accepting the accounting statement for the contract period. The contingency reserve payment so authorized will be made available to the carrier's LOC account.

(ii) When, as of the end of a contract period, the total of all reserves of an experience-rated plan amounts to more than the plan's target level, the excess over the plan's target level must be credited to the contingency reserve maintained

by OPM for the plan. OPM will withdraw the excess amount from the plan's LOC account, based on reporting in the annual accounting statement for the year, no sooner than May 1, of the following year. If the accounting statement is not filed by the time limit specified in the plan's contract with OPM, OPM will estimate the amount of the excess reserves and may withdraw that amount from the plan's LOC account, or begin the process of offsetting that amount from subscription payments, no sooner than May 1. The amount withdrawn from the plan's LOC account, or offset from subscription payments, will be credited to that plan's contingency reserve.

(4) OPM may, by agreement with the carrier, approve community rating for a comprehensive plan. If the contingency reserve of the carrier of a community-rated plan exceeds the preferred minimum balance, as described in paragraph (c)(2) of this section, the carrier may request OPM to pay to the plan a portion of the reserve not greater than the excess of the contingency reserve over the preferred minimum balance. The carrier shall state the reason for the request. OPM will decide whether to allow the request in whole or in part and will advise the plan of its decision.

(5) Special contingency reserve transfers. In addition to those amounts, if any, paid under paragraphs (c)(2) through (c)(4) of this section, OPM may authorize such other payments from the contingency reserve as in the judgment of OPM may be in the best interest of employees and annuitants enrolled in the program. A carrier for a plan may apply to OPM at any time for a

payment from the contingency reserve when the carrier has good cause, such as unexpected claims experience and variations from expected community rates. In the administration of this part, OPM will accord a high priority to deciding whether to allow requests under this paragraph in whole or in part and will promptly advise the carrier of its decision. Amounts paid from the contingency reserve under paragraphs (c)(2) through (5) of this section shall be reported as subscription income in the year in which paid. By agreement with the carrier and where good cause exists, OPM may accept payment from carrier reserves for credit to the contingency reserve in an amount and under conditions other than those specified in paragraph (c) of this section. For carriers funded by LOC, the returned amount will be withdrawn from the plan's LOC account.

(6) Subsidization penalty reserve. This reserve account shall be credited with all subsidization penalties levied against community rated plans outlined in 48 CFR 1615.402(c)(3)(ii)(B). The funds in this account shall be annually distributed to the contingency reserves of all community rated plans subject to the FEHB–specific medical loss ratio threshold on a pro-rata basis. The funds will not be used for one specific carrier or plan.

48 C.F.R. § 1609.7001 provides:

§ 1609.7001. Minimum standards for health benefits carriers.

(a) The carrier of an approved health benefits plan shall meet the requirements of chapter 89 of ti-

tle 5, United States Code; part 890 of title 5, Code of Federal Regulations; chapter 1 of title 48, Code of Federal Regulations, and the following standards. The carrier shall continue to meet the requirements of chapter 89 of title 5, United States Code, and the standards cited in this paragraph while under contract with OPM. Failure to meet these requirements and standards is cause for OPM's withdrawal of approval of the health benefits carrier and termination of the contract in accordance with 5 CFR 890.204.

(1) It must be lawfully engaged in the business of supplying health benefits.

(2) It must have, in the judgement of OPM, the financial resources and experience in the field of health benefits to carry out its obligations under the plan.

(3) It must keep such reasonable financial and statistical records, and furnish such reasonable financial and statistical reports with respect to the plan, as may be requested by OPM.

(4) It must permit representatives of OPM and of the General Accounting Office to audit and examine its records and accounts which pertain, directly or indirectly, to the plan at such reasonable times and places as may be designated by OPM or the General Accounting Office.

(5) It must accept, subject to adjustment for error or fraud, in payment of its charges for health benefits for all enrollees in its plan, the enrollment charges received by the Employees Health Benefits (EHB) Fund less amounts set aside for the administrative and contingency reserves prescribed in 5 CFR 890.503. OPM makes

available or pays the amounts within 30 days of receipt by the EHB Fund.

(6) A carrier that is an employee organization must continue coverage, without requirement of membership, of any eligible survivor annuitants, former spouses continuing coverage with the carrier under 5 CFR 890.803, children temporarily continuing coverage with the carrier under 5 CFR 890.1103(a)(2), or former spouses temporarily continuing coverage with the carrier under 5 CFR 890.1103(a)(3).

(7) It must timely submit to OPM a properly completed and signed novation or change-of-name agreement in accordance with subpart 1642.12 of this chapter.

(b) In addition to the standards in paragraph (a) of this section, the carrier must perform the contract in accordance with prudent business practices. A carrier's sustained poor business practice in the management or administration of a health benefits plan is cause for OPM's withdrawal of approval of the health benefits carrier and termination of the carrier's contract. Prudent business practices include, but are not limited to, the following:

(1) Timely compliance with OPM instructions and directives.

(2) Legal and ethical business and health care practices.

(3) Compliance with the terms of the FEHB contract, regulations and statutes.

(4) Timely and accurate adjudication of claims or rendering of medical services.

(5) A system for accounting for costs incurred under the contract, when required, which includes segregating and pricing FEHB medical utilization and allocating indirect and administrative costs in a reasonable and equitable manner.

(6) Accurate accounting reports of actual, allowable, allocable, and reasonable costs incurred in the administration of the contract.

(7) Application of performance standards for assuring contract quality as required by 1646.270(d).

(8) Establishment and maintenance of a system of internal control that provides reasonable assurance that:

(i) The provision and payments of benefits and other expenses are in compliance with legal, regulatory, and contractual guidelines;

(ii) FEHB funds, property, and other assets are safeguarded against waste, loss, unauthorized use, or misappropriation; and,

(iii) Data are accurately and fairly disclosed in all reports required by OPM.

(c) The following types of activities are examples of poor business practices which adversely affect the health benefits carrier's responsibility under its contract. A pattern of poor conduct or evidence of misconduct in these areas is cause for OPM to withdraw approval of the carrier:

(1) Presenting false claims by charging expenses to the contract which according to the contract terms are not chargeable to the contract;

(2) Using fraudulent or unethical business or health care practices or otherwise displaying a lack of business integrity or honesty;

(3) Repeatedly and knowingly providing false or misleading information in the rate setting process;

(4) Repeated failure to comply with OPM instructions and directives;

(5) Having an accounting system that is incapable of separately accounting for costs incurred under the contract and/or that lacks the internal controls necessary to fulfill the terms of the contract; and

(6) Failure to assure that the plan provides properly paid or denied claims, or providing medical services which are inconsistent with standards of good medical practice.

(7) Entering into contracts or employment agreements with providers, provider groups, or health care workers that include provisions or financial incentives that directly or indirectly create an inducement to limit or restrict communication about medically necessary services to any individual covered under the FEHB Program. Financial incentives are defined as bonuses, withholds, commissions, profit sharing or other similar adjustments to basic compensation (e.g., service fee, capitation, salary) which have the effect of limiting or reducing communication about appropriate medically necessary services. Providers, health care workers, or health plan sponsoring organizations are not required to discuss treatment options that they would not ordinarily discuss in their customary course of practice be-

cause such options are inconsistent with their professional judgment or ethical, moral or religious beliefs.

(d) The Director or his or her designee will determine whether to propose withdrawal of approval and hold a hearing based on the seriousness of the carrier's actions and its proposed method to effect corrective action.

48 C.F.R. § 1632.170 provides:

§ 1632.170. Recurring premium payments to carriers.

(a)(1) Recurring payments to carriers of community-rated plans. OPM will pay to carriers of community-rated plans the premium payments received for the plan less the amounts credited to the contingency and administrative reserves, amounts assessed under paragraph (a)(2) of this section, and amounts due for other contractual obligations. Premium payments will be due and payable not later than 30 days after receipt by the Federal Employees Health Benefits (FEHB) Fund.

(2) The sum of the two performance factors applicable under 1609.7101-2 will be multiplied by the carrier's total net-to-carrier premium dollars paid for the preceding contract period. The amount obtained after the total premium is multiplied by the sum of the factors will be withheld from the carrier's periodic premium payment payable during the first quarter of the following contract period unless an alternative payment arrangement is made with the carrier's contracting officer. OPM will deposit the withheld funds in the carrier's contingency reserve for the plan. The aggregate amount withheld annually for per-

formance for any carrier will not exceed one percent of premium for any contract period.

(3) Any subsidization penalty levied against a community rated plan as outlined in 48 CFR 1615.402(c)(3)(ii)(B) must be paid within 60 days from notification. If payment is not received within the 60 day period, OPM will withhold from the community rated carriers the periodic premium payment payable until fully recovered. OPM will deposit the withheld funds in the subsidization penalty reserve described in 5 CFR 890.503(c)(6).

(b)(1) Recurring payments to carriers of experience-rated plans. OPM will make payments on a letter of credit (LOC) basis. Premium payments received for the plan, less the amounts credited to the contingency and administrative reserves and amounts for other obligations due under the contract, will be made available for carrier drawdown not later than 30 days after receipt by the FEHB Fund.

(2) Withdrawals from the LOC account will be made on a checks-presented basis. Under a checks-presented basis, drawdown on the LOC is delayed until the checks issued for FEHB Program disbursements are presented to the carrier's bank for payment.

(3) OPM may grant a waiver of the restriction of LOC disbursements to a checks-presented basis if the carrier requests the waiver in writing and demonstrates to OPM's satisfaction that the checks-presented basis of LOC disbursements will result in significantly increased liability under the contract, or that the checks-

presented basis of LOC disbursements is otherwise clearly and significantly detrimental to the operation of the plan. Payments to carriers that have been granted a waiver may be made by an alternative payment methodology, subject to OPM approval.

APPENDIX G

FEHB Program Carrier Letter

All Carriers

U.S. Office of Personnel Management

Federal Employee Insurance Operations

Letter No. 2012-18

Date: June 18, 2012

Fee-for-service [15] Experience-rated HMO [15] Community-rated HMO [17]

SUBJECT: FEHBA Preemption of State Law re: Subrogation and Reimbursement

The purpose of this letter is to address concerns raised about the ability of Federal Employees Health Benefits (FEHB) Program carriers to collect subrogation and/or reimbursement recoveries. These recoveries occur when an enrollee who is injured obtains benefits from his or her FEHB Program plan and either 1) the plan recovers payment for those benefits from a third party tortfeasor as a subrogee of the enrollee or 2) the enrollee pursues an action against a third party tortfeasor and the terms of the plan require the enrollee, as a result of recovery, to reimburse the plan for benefits initially paid.

Some states are not allowing FEHB Program carriers to collect subrogation and/or reimbursement recoveries due to state law that either prohibits or limits these recoveries. This is to advise you that the Federal Employees Health Benefits Act (FEHBA) preempts state laws prohibiting or limiting subrogation and reimbursement. As a result, FEHB Pro-

gram carriers are entitled to receive these recoveries regardless of state law.

The FEHBA, as codified at 5 U.S.C. § 8902(m)(1) provides:

> The terms of any contract under this chapter which relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans.

FEHB Program contracts and the applicable statement of benefits (brochures) require enrollees to reimburse the plan in the event of a third party recovery. Carriers are required to seek reimbursement and/or subrogation recoveries in accordance with the contract. The funds received by experience-rated carriers from these recoveries are required to be credited to Employees Health Benefits Fund established by 5 U.S.C. § 8909, held by the Treasury of the United States, and for experience-rated carriers and most community-rated carriers, subrogation and reimbursement recoveries serve to lower subscription charges for individuals enrolled in the Federal Employees Health Benefits Program. The carrier's right to subrogation and /or reimbursement recovery is both a condition of, and a limitation on, the payments that enrollees are eligible to receive for benefits; the carrier's contractual obligation to obtain them necessarily relates to the enrollee's coverage or benefits (including payments with respect to benefits) under the FEHB Program. These recoveries therefore fall within the purview of the FEHBA's preemption clause, and supersede state laws that relate to health insurance or health plans.

The United States Supreme Court provided, in *Empire Healthchoice Assurance, Inc. v. McVeigh* that it is plausible to construe subrogation and reimbursement contract terms as a condition or limitation on benefits received by a Federal employee, allowing these FEHB Program contract requirements to preempt state law according to 5 U.S.C. § 8902(m)(1). See, 547 U.S. 677, 697-698 (2006). OPM maintains this construction of the statute allowing for preemption of state laws relating to subrogation and reimbursement.

In support of OPM's position, Federal courts have held that state laws restricting or prohibiting subrogation and/or reimbursement activities "relate" to plans for purposes of triggering the state law preemption provisions of FEHBA. See, e.g.. *Medcenters Health Care v. Ochs*, 26 F.3d 865 (8th Cir. 1994); *NALC Health Benefit Plan v. Lunsford*, 879 F. Supp. 760 (E.D. Mich. 1995); *Botsford v Blue Cross and Blue Shield of Montana, Inc.* 314 F.3d 390 (9th Cir. 2002)(as to conflict preemption).

As the Federal agency with regulatory authority over the FEHB Program, OPM has consistently recognized that the FEHBA preempts state laws that restrict or prohibit FEHB Program carrier reimbursement and/or subrogation recovery efforts, and we continue to maintain this position.

Please utilize this correspondence as needed in your recovery efforts.

Sincerely,

John O'Brien
Director
Healthcare and Insurance

APPENDIX H

Aetna Open Access ®
(formerly Aetna)

2006

A Health Maintenance Organization

Serving: Arizona, California, Colorado, Connecticut, Georgia, Illinois, Indiana, Kansas, Kentucky, Missouri, Nevada, New Jersey, New York, Ohio, Oklahoma, Pennsylvania, Tennessee, Texas and Washington.

* * *

Introduction

This brochure describes the benefits of Aetna® under our contract (CS 2867) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. The address for the Aetna administrative office is:

Aetna
Federal Government Department
980 Jolly Road
Mail Stop U11N
Blue Bell, PA 19422

This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure. It is your responsibility to be informed about your health benefits.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self and Family coverage, each eligible

family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2006, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2006, and changes are summarized on pages 13-14. Rates are shown at the end of this brochure.

* * *

When others are responsible for injuries

When you receive money to compensate you for medical or hospital care for injuries or illness caused by another person, you must reimburse us for any expenses we paid. However, we will cover the cost of treatment that exceeds the amount you received in the settlement.

The words "Third Party" or "Any party making payments on the third party's behalf" includes not only the insurance carrier(s) for the responsible party, but also any uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers' compensation coverage, no-fault automobile insurance coverage or any other first party insurance coverage. The words "Member," "you" and "your" include anyone on whose behalf the Plan pays or provides any benefits.

If you do not seek damages you must agree to let us try. This is called subrogation. If you need more information, contact us for our subrogation procedures.

You specifically acknowledge our right of subrogation. When we provide health care benefits for injuries or illnesses for which a third party is or may

be responsible, we shall be subrogated to your rights of recovery against any third party to the extent of the full cost of all benefits provided by us, to the fullest extent permitted by low. We may proceed against any third party with or without your consent.

You also specifically acknowledge our right of reimbursement. This right of reimbursement attaches, to the fullest extent permitted by law, when we have provided health care benefits for injuries or illnesses for which a third party is or may be responsible and you and/or your representative has recovered any amounts from the third party or any party making payments on the third party's behalf. By providing any benefit under this Plan, we are granted an assignment of the proceeds of any settlement, judgment or other payment received by you to the extent of the full cost of all benefits provided by us. Our right of reimbursement is cumulative with and not exclusive of our subrogation right and we may choose to exercise either or both rights of recovery.

You and your representatives further agree to:

- Notify us in writing within 30 days of when notice is given to any third party of the intention to investigate or pursue a claim to recover damages or obtain compensation due to injuries or illnesses sustained by you that may be the legal responsibility of a third party; and
- Cooperate with us and do whatever is necessary to secure our rights of subrogation and/or reimbursement under this Plan; and
- Give us a first-priority lien on any recovery, settlement or judgment or other source of compensation which may be had from a third party to the extent of the full cost of all benefits provided by

us associated with injuries or illnesses for which a third party is or may be responsible (regardless of whether specifically set forth in the recovery, settlement, judgment or compensation agreement); and

- Pay, as the first priority, from any recovery, settlement or judgment or other source of compensation, any and all amounts due us as reimbursement for the full cost of all benefits provided by us associated with injuries or illnesses for which a third party is or may be responsible (regardless of whether specifically set forth in the recovery, settlement, judgment, or compensation agreement), unless otherwise agreed to by us in writing; and
- Do nothing to prejudice our rights as set forth above. This includes, but is not limited to, refraining from making any settlement or recovery which specifically attempts to reduce or exclude the full cost of all benefits provided by us.

We may recover the full cost of all benefits provided by us under this Plan without regard to any claim of fault on the part of you, whether by comparative negligence or otherwise. We may recover the full cost of all benefits provided by us under this Plan even if such payment will result in a recovery to you which is insufficient to make you whole or fully compensate you for your damages. No court costs or attorney fees may be deducted from our recovery without the prior express written consent of us. In the event you or your representative fails to cooperate with us, you shall be responsible for an benefits paid by us in addition to costs and attorney's fees incurred by us in obtaining repayment.

APPENDIX I

IN THE SUPREME COURT OF ARIZONA

MATTHEW KOBOLD, a single man, Plaintiff/ Counterdefendant/ Appellee, v. THE AETNA LIFE INSURANCE COMPANY, a foreign insurer Third-Party Defendant/Appellant.	Arizona Supreme Court No. CV-13-0299-PR Court of Appeals Division One No. 1 CA-CV 12-0315 Maricopa County Superior Court No. CV2008-023699

AMICUS CURIAE BRIEF OF THE UNITED STATES IN SUPPORT OF PETITIONER

* * *

STATEMENT OF INTEREST AND SUMMARY

The United States respectfully submits this *amicus curiae* brief in support of the petition for review.

Under the Federal Employee Health Benefits Act (FEHBA), the federal government contracts with insurance carriers to provide health insurance for federal employees and their families. One type of FEHBA contract term is a right of subrogation, which requires insurance carriers to seek reim-

bursement for any benefits paid to the extent a beneficiary has also received a tort recovery or settlement compensating for the very same medical costs covered by those benefits.

The court of appeals has held that FEHBA does not preempt Arizona's anti-subrogation rule and therefore that FEHB carriers may not enforce rights of subrogation under Arizona law. That holding is directly contrary to FEHBA, which provides that contract terms that "relate to … benefits" and "payments with respect to benefits" preempt state law. 5 U.S.C. § 8902(m)(1). A right to reimbursement of benefits clearly and directly relates to benefits and benefit payments as numerous court decisions have recognized. *See Buatte* v. *Gencare Health Sys., Inc.*, 939 S.W.2d 440, 442 (Mo. Ct. App. 1996); *MedCenters Health Care* v. *Ochs*, 26 F.3d 865, 867 (8th Cir. 1994); *NALC Health Benefit Plan* v. *Lunsford*, 879 F. Supp. 760, 762-63 (E.D. Mich. 1995). The court of appeals' contrary ruling destroys the uniformity Congress intended the FEHBA preemption provision to establish as to benefits and premiums, and threatens to increase the cost of the FEHB program to the federal government, which was $31.5 billion in 2012 alone.

The federal government has a substantial interest in this Court's granting review and correcting the court of appeals' error, which concerns an important question of federal law affecting the health-insurance benefits the federal government provides to millions of federal employees and their families.

ISSUE PRESENTED FOR REVIEW

FEHBA provides that "[t]he terms of any contract under this chapter which relate to the nature,

provision, or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans." 5 U.S.C. § 8902(m)(1). The issue presented is whether FEHBA preempts state anti-subrogation rules.

FACTS MATERIAL TO THE ISSUE PRESENTED

A. Statutory Background

1. Congress enacted the Federal Employees Health Benefits Act of 1959, Pub. L. No. 86-382, 73 Stat. 708, to establish a comprehensive program that would "assure maximum health benefits for [federal] employees at the lowest possible cost to themselves and to the Government." H.R. Rep. No. 86-957, at 4 (1959). Through FEHB plans, the federal government provides health insurance to millions of federal employees and their families.

The U.S. Office of Personnel Management administers FEHBA. The Act gives OPM authority to contract with insurance carriers to offer benefits to federal employees, annuitants, and dependents, 5 U.S.C. §§ 8902, 8903, to seek civil penalties against FEHB insurance carriers who engage in misconduct in administering federal health plans, *id.* § 8902a(d), and to promulgate regulations implementing FEHBA, *id.* § 8913(a). Each contract must "contain a detailed statement of benefits offered and shall include such maximums, limitations, exclusions, and other definitions of benefits as the Office considers necessary or desirable." *Id.* § 8902(d).

Federal employees may enroll in FEHB plans under the terms of the contracts between OPM and

insurance carriers. 5 U.S.C. § 8905(a). OPM must provide to federal employees the information necessary to make an informed choice among the various plans offered under FEHB, and OPM issues each enrolled employee a detailed statement setting forth the plan terms and procedures for obtaining benefits under the plan. *Id.* § 8907.

The federal government shares responsibility with enrolled employees for paying the premiums under FEHB plans. 5 U.S.C. § 8906. The federal government pays on average approximately 70% of the employee's plan premium. *Id.* § 8906(b). FEHB premiums are generally deposited into the Employees Health Benefits Fund in the U.S. Treasury. *Id.* § 8909(a).

Most FEHB program contracts provide for a right of subrogation. A right of subrogation requires FEHB beneficiaries to reimburse the plan if the beneficiary recovers a tort judgment or settlement that compensated the insured, in whole or in part, for medical costs the plan paid. Carriers must seek reimbursement in accordance with the FEHB contract. The funds received from subrogation recoveries by experienced-rated carriers—which pay claims as they are incurred, like a fee-for-service carrier—are credited to the Employees Health Benefits Fund held by the Treasury. See 5 U.S.C. § 8909(a). Any surplus in that fund may be used, based on negotiations between OPM and the carrier, to reduce future government and employee contributions, increase plan benefits, or refund money to the government and plan enrollees. 5 U.S.C. § 8909(b); 5 C.F.R. § 890.503(c)(2). Subrogation recoveries credited to the FEHB fund thus translate to direct savings for the federal government and FEHB enrollees.

FEHB carriers also include community-rated carriers. Subrogation recoveries by community-rated carriers also lower subscription charges for enrollees and the federal government, but through a different mechanism. The premiums of community-rated carriers generally depend on the expected, not the actual, cost of providing benefits. Subrogation recoveries by community-rated carriers tend to reduce those expected costs, and thus the premiums.

2. In 1978, in response to concerns that state health-insurance legislation affecting FEHB plans was resulting in "[i]ncreased premium costs to both the Government and enrollees," as well as "[a] lack of uniformity of benfits [sic] for all enrollees in the same plan," H.R. Rep. No. 94-1211, at 3 (1976), Congress added a preemption provision to FEHBA. *See* Act of Sept. 17, 1978, Pub. L. No. 95-368, 92 Stat. 606. In 1998, Congress broadened that provision. *See* Federal Employees Health Care Protection Act of 1998, Pub. L. No. 105-266, § 3(c), 112 Stat. 2363, 2366. As amended, FEHBA provides that "[t]he terms of any contract under this chapter which relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans." 5 U.S.C. § 8902(m)(1).

B. Factual Background

In October 2006, Matthew Kobold, a federal employee, sustained injuries in a motorcycle accident. App. 2-3.[1] Kobold was enrolled in a FEHB plan ad-

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[1] Citations to "App." are to the Appendix to the petition for review.

ministered by the Aetna Life Insurance Company, which paid his medical bills resulting from the accident in the amount of $24,473.53. App. 31. Kobold sued the allegedly responsible parties for negligence and settled the case for $145,000. App. 30-31. Kobold's FEHB plan gave Aetna a right of subrogation. That right entitled Aetna to recover against any third-party tortfeasors for the medical expenses Kobold had incurred that were covered and paid for by the plan. App. 58-59. It alternatively gave Aetna a right to reimbursement for any medical expenses the plan had paid from amounts Kobold recovered in a tort action or settlement he brought himself against any third-parties who tortiously caused his injuries. *Ibid.*

Aetna asserted a lien on Kobold's tort settlement for the $24,473.53 it had paid for Kobold's medical expenses. App. 18. Arizona, however, does not permit medical insurance subrogation. *See Allstate Ins. Co.* v. *Druke*, 576 P.2d 489, 492 (Ariz. 1978). The alleged tortfeasors therefore paid Kobold $120,526.40 and deposited $24,473.53 with the court so that Aetna and Kobold could ascertain whether the FEHB contract term defeated Arizona's anti-subrogation rule and thus entitled Aetna to the $24,473.53. App. 13.

The superior court concluded that FEHBA did not supersede state anti-subrogation rules, based on the premise that the U.S. Supreme Court had so ruled in *Empire Healthchoice Assurance, Inc.* v. *McVeigh*, 547 U.S. 677 (2006), and thus granted Kobold summary judgment. App. 61-62. In *McVeigh*, the Supreme Court held that there was no federal jurisdiction over a suit brought by an FEHB health-insurance carrier to recover money that an FEHB

beneficiary owed the FEHBA program under a FEHB contract. 547 U.S. at 683.

On appeal, the court of appeals agreed with the result reached by the superior court, but not its reasoning. The court of appeals disagreed that *McVeigh* had already resolved the question whether the FEHBA preempts state anti-subrogation rules, noting that "[t]he Court expressly declined to decide" that question and, indeed, "affirmatively recognized the potential for alternative statutory interpretations." Op. 6 (citing *McVeigh*, 547 U.S. at 697-98).

The court of appeals nonetheless ruled that FEHBA did not preempt Arizona's anti-subrogation rule. The court viewed Aetna's subrogation right unrelated to benefits within the meaning of the preemption clause because it believed that right "has no effect on Kobold's entitlement to receive financial assistance from Aetna when he suffers injury or illness contemplated by the Plan." Op. 10. The court of appeals also refused to defer to the contrary interpretation expressed by the U.S. Office of Personnel Management. Op. 10-11.

On November 6, 2013, Aetna petitioned this Court for review of the court of appeals' decision.

REASONS FOR GRANTING THE PETITION

The petition should be granted because the court of appeals has incorrectly decided an important question of federal law in a matter of first impression in Arizona. *See* Ariz. R. Civ. App. P. 23(c)(4).

The Federal Employee Health Benefits Act Unambiguously Preempts Anti-Subrogation Rules.

Like most health-insurance contracts, FEHB contracts generally provide for a right of subrogation. A subrogation right, among other things, permits the FEHB plan to receive reimbursement for any benefits paid under the plan to the extent that the enrollee has separately received a tort recovery that also compensates for the very same medical costs paid by the plan. Subrogation rights, in other words, prevent enrollees from receiving double reimbursement for their medical expenses. The vast majority of state jurisdictions permit subrogation if provided for by the express terms of a health-insurance contract. Arizona, however, is in the minority of jurisdictions that do not permit such subrogation. *See* Johnny C. Parker, *The Made Whole Doctrine: Unraveling the Enigma Wrapped in the Mystery of Insurance Subrogation*, 70 Mo. L. Rev. 723, 735 & n.56 (2005); *Allstate Ins. Co.* v. *Druke*, 576 P.2d 489, 492 (Ariz. 1978).

1. The question in this case is whether FEHBA preempts Arizona's anti-subrogation rule. FEHBA provides that "[t]he terms of any contract under this chapter which relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans." 5 U.S.C. § 8902(m)(1).

The sweeping terms of this express preemption provision comfortably encompass anti-subrogation rules. FEHB contract terms that provide a right of subrogation directly "relate to the … extent of cover-

age or benefits" or, at the very least, "payments with respect to benefits." 5 U.S.C. § 8902(m)(1). Subrogation rights relate to benefit payments because they require a beneficiary to return benefits to the extent the beneficiary has been separately reimbursed for those benefits from a tort recovery. And "prohibiting" the carrier "from seeking reimbursement from its insured would clearly differ the extent of coverage or benefits." *Buatte* v. *Gencare Health Sys., Inc.*, 939 S.W.2d 440, 442 (Mo. Ct. App. 1996); *accord MedCenters Health Care* v. *Ochs*, 26 F.3d 865, 867 (8th Cir. 1994) (holding Minnesota anti-subrogation rule preempted by § 8902(m)(1)); *NALC Health Benefit Plan* v. *Lunsford*, 879 F. Supp. 760, 762-63 (E.D. Mich. 1995) (holding that § 8902(m)(1) preempted Michigan law to the extent Michigan law prohibited subrogation).

The court of appeals believed a right to reimbursement of benefit payments unrelated to benefits because "[t]he 'benefits' to which Kobold was entitled under the Plan were not dependent on recovery from a third party." Op. 9. But Kobold's right to retain those benefit payments, under the subrogation provision of the plan, has indeed always been contingent on whether he has received a separate tort recovery. Kobold received $24,473.53 from Aetna's FEHB plan to compensate for the medical bills he incurred as a result of his motorcycle accident, and also received $145,000 in a tort settlement to compensate for that accident. App. 26. There is no dispute that the plan entitles Aetna to reimbursement from that settlement of the $24,472.53 in benefits previously paid. If Kobold succeeds in invoking Arizona's anti-subrogation rule to defeat that right, he will retain FEHB benefit payments that he is simply not entitled to keep under the contract. That right directly

relates to benefits and therefore preempts contrary state law.

2. The conclusion that anti-subrogation rules relate to benefits and coverage, as well as payments with respect to benefits, draws support from Supreme Court cases construing the term "relating to" in a preemption provision to "express a broad preemptive purpose." *Morales* v. *TWA*, 504 U.S. 374, 383 (1992). The Supreme Court has, with regard to the similarly worded preemption clause applicable to health-care plans regulated by the Employee Retirement Income Security Act of 1974, held that state anti-subrogation rules "relate to" such plans. *See FMC Corp.* v. *Holliday*, 498 U.S. 52, 58-59 (1990); *see also Botsford* v. *Blue Cross & Blue Shield of Montana, Inc.*, 314 F.3d 390, 393-94 (9th Cir. 2002) (applying ERISA case law to interpreting 5 U.S.C. § 8902(m)(1)). In reaching that conclusion, the Supreme Court observed that anti-subrogation rules are related to the provision of benefits in that they "require[] plan providers to calculate benefit levels … based on expected liability conditions that differ from those in States that have not enacted similar anti-subrogation legislation," thus "frustrat[ing] plan administrators' continuing obligation to calculate uniform benefit levels nationwide." *FMC Corp.*, 498 U.S. at 60. ERISA regulates the benefit plans that private employers offer their employees, while the FEHBA governs the health-benefit plans that the federal government provides. It is exceedingly unlikely that Congress intended a broader role for state law in the case of federal employees than in the case of private employees, or that Congress desired less uniformity in the case of federal employees.

3. The history and purpose of the FEHBA preemption provision confirms that Congress intended it to supersede state anti-subrogation rules.

In the mid-1970s, states began undermining the uniformity of the FEHB program by mandating that insurance companies provide health-insurance benefits that were not covered under the terms of FEHB contracts. *See, e.g.*, H.R. Rep. No. 95-282, at 6 (1977). Congress became concerned that those laws resulted in FEHB enrollees in some states paying for benefits that they were not receiving, since some benefits were only provided in states that had mandated-benefit laws. *See* H.R. Rep. No. 94-1211, at 3 (1976). Congress also expressed concern that state mandated-benefit laws were increasing the cost of the FEHB program to the federal government, *see id.*, which pays the lion's share of FEHB premiums. In response to those developments, Congress broadly preempted state laws related to benefits or coverage that were inconsistent with FEHB contract terms, and later broadened preemption to supersede even state laws that merely relate to FEHB contract terms. *See* Pub. L. No. 95-368, 92 Stat. 606 (1978); Pub. L. No. 105-266, § 3(c), 112 Stat. 2363, 2366 (1998).

Arizona's anti-subrogation rule is indistinguishable from the state mandated-benefit laws that Congress expressly targeted with the FEHBA preemption provision. By permitting an FEHB enrollee to retain benefit payments that have been separately reimbursed by a tort recovery, Arizona law effectively requires FEHB carriers to provide Arizona consumers with FEHB benefits that consumers in other states do not receive under the terms of the same FEHB contract. Most FEHB enrollees receive benefits under nationwide plans with uniform rates. If

Arizona's anti-subrogation rule survives preemption, then, the losers will be FEHB enrollees in states that permit subrogation, who will be subsidizing the more generous benefits that Arizona law effectively mandates that FEHB carriers provide. That kind of cross-subsidization creates precisely the disuniformity that Congress intended to preclude when it enacted the preemption provision, which it intended to "strengthen the ability of national plans to offer uniform benefits and rates to enrollees regardless of where they may live." H.R. Rep. No. 105-374, at 9 (1997).

Anti-subrogation rules also run contrary to another key aim of Congress in providing for preemption, which was to "prevent carriers' cost-cutting initiatives from being frustrated by State laws." H.R. Rep. No. 105-374, at 9 (1997). Although not all FEHB contracts necessarily provide for a right of subrogation, the vast majority do. Any subrogation recoveries obtained by the carrier tend to reduce the premiums charged both to individuals enrolled in the FEHB program and to the federal government, which pays the bulk of FEHB premiums. The federal government's share of those premiums amounted to approximately $31.5 billion in 2012 alone.

Even if a right of subrogation did not relate to benefits under § 8902(m)(1), then, Arizona's anti-subrogation rule would still be in conflict with the FEHBA because it would "'stand[] as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress.'" *Hillman* v. *Maretta*, 133 S. Ct. 1943, 1950-55 (2013) (quoting *Hines* v. *Davidowitz*, 312 U.S. 52, 66-67 (1941)).

4. Kobold in his response to the petition for review (at 4-5) invokes *Empire Healthchoice Assurance,*

Inc. v. *McVeigh*, 547 U.S. 677 (2006), to defend the conclusion that Arizona's anti-subrogation rule survives preemption under FEHBA. The question presented in *McVeigh*, however, was whether there is federal jurisdiction over a suit brought by a FEHB health-insurance carrier to recover reimbursement that a beneficiary allegedly owed the FEHB program under an FEHB contract. 547 U.S. at 683.

In the course of resolving that jurisdictional issue, the Supreme Court did in *dicta* explore the meaning of the FEHBA preemption provision. *Id.* at 697. "Reading the reimbursement clause" in the FEHB contract "as a condition or limitation on 'benefits' received by a federal employee," the Court explained, "the clause could be ranked among '[contract] terms … relat[ing] to … coverage or benefits' and 'payments with respect to benefits,' thus falling within § 8902(m)(1)'s compass." *Id.* at 697 (alterations the Supreme Court's). "On the other hand," the Court continued, "a claim for reimbursement ordinarily arises long after 'coverage' and 'benefits' questions have been resolved, and corresponding 'payments with respect to benefits' have been made to care providers or the insured." *Ibid.* "With that consideration in view, § 8902(m)(1)'s words may be read to refer to contract terms relating to the *beneficiary's* entitlement (or lack thereof) to Plan payment for certain health-care services he or she has received, and not to terms relating to the carrier's postpayments right to reimbursement." *Ibid.* (Court's emphasis). The Court, however, explained that it "need not choose between those plausible constructions" of the preemption clause "[t]o decide this case." *Id.* at 698.

Contrary to Kobold's apparent suggestion, the Supreme Court in *McVeigh* did not decide, and in

fact expressly declined to decide, that state laws affecting a FEHB carrier's right to reimbursement do not relate to coverage or benefits under § 8902(m)(1). On the contrary, the Court found it "plausible" to construe a carrier's right to reimbursement for benefits as directly relating to benefits, or at least "payments with respect to benefits." *McVeigh*, 547 U.S. at 698.

5. Since the Supreme Court decided *McVeigh*, the U.S. Office of Personnel Management, the agency Congress entrusted with administering the FEHBA, *see Dyer* v. *Blue Cross & Blue Shield Ass'n, Inc.*, 848 F.2d 201, 203 (D.C. Cir. 1988); *Blue Cross & Blue Shield* v. *Dep't of Banking & Fin.*, 791 F.2d 1501, 1506 (11th Cir. 1986), has in an opinion letter construed 5 U.S.C. § 8902(m)(1) to preempt state anti-subrogation rules, adopting the interpretation that the Supreme Court found plausible in *McVeigh*. *See* FEHB Program Carrier Letter No. 2012-18 (June 18, 2012). App. 63. OPM's letter confirms that a right of subrogation "is both a condition of, and a limitation on, the payments that enrollees are eligible to receive for benefits," and therefore preempts state laws that defeat subrogation rights. *Ibid*. OPM's letter also explains the strong federal interest in preemption of state anti-subrogation rules, which tend to increase the expense of the FEHB program to the federal government. *Ibid.*

Although OPM's opinion letter lacks the force of law that typically accompanies a regulation promulgated after notice-and-comment rulemaking, OPM's authoritative construction of FEHBA is nonetheless entitled to substantial weight. *See Christensen* v. *Harris County*, 529 U.S. 576, 587 (2000) (citing *Skidmore* v. *Swift & Co.*, 323 U.S. 134, 140 (1944));

see also Dyer, 848 F.2d at 205; *Blue Cross & Blue Shield*, 791 F.2d at 1506 (OPM's construction of § 8902(m)(1) entitled to deference as long as it is "reasonable"). The Court should defer to OPM's plausible conclusion that Arizona's anti-subrogation rule is preempted.

CONCLUSION

The petition for review should be granted.

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