No. 14-487

IN THE

Supreme Court of the United States

THE RAWLINGS COMPANY, LLC, OXFORD HEALTH PLANS (NY), INC., AND UNITEDHEALTH GROUP INCORPORATED,

Petitioners,

v.

MEGHAN WURTZ, ET AL.,

Respondents.

On Petition for a Writ of Certiorari
to the United States Court of Appeals
for the Second Circuit

BRIEF IN OPPOSITION

Frank R. Schirripa
HACH ROSE SCHIRRIPA
& CHEVERIE LLP
185 Madison Avenue
14th Floor
New York, NY 10016
(212) 213-8311

Steven J. Harfenist
Counsel of Record
HARFENIST, KRAUT,
& PERLSTEIN LLP
3000 Marcus Avenue
Suite 2E1
Lake Success, NY 11042
(516) 355-9600
sharfenist@hkplaw.com

QUESTION PRESENTED

Whether a state-law action seeking to enforce a state anti-subrogation law is completely preempted by ERISA Section 502(a)(1)(B), where it is undisputed that state law provides the substantive rule of decision.

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STATEMENT OF THE CASE

A. Legal Background

1. The Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. § 1001 *et seq.*, sets minimum standards for pension and health benefit plans. Where private employers choose to establish plans for their employees, ERISA generally governs the provision of benefits. ERISA also charts a course between federal preemption of claims relating to plan benefits and the preservation of state law in traditional areas of state insurance regulation. The Act governs this interplay between federal and state law in two separate sections.

First, ERISA Section 502, 29 U.S.C. § 1132, ERISA's civil enforcement provision, may operate impliedly to convert state-law causes of action into federal claims, but only if they fall into a "select group" of claims that Congress has rendered "necessarily federal in character." *Metro. Life Ins. Co. v. Taylor*, 481 U.S. 58, 63-64 (1987). Section 502(a) authorizes an ERISA plan participant to bring a suit, among other things, "to recover benefits due to him under the terms of the Plan, to enforce his rights under the terms of his Plan, or to clarify his rights to future benefits under the Plan." 29 U.S.C. § 1132(a)(1)(B). Section 502 is accompanied by its own set of remedies. *See Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 52-54 (1987). This Court has held that a suit is converted into an ERISA claim only where a state-law claim is (1) the type of claim that could be brought under Section 502(a)(1)(B), and (2) where there is "no other independent legal duty that is implicated by a defendant's actions." *Aetna Health Inc. v. Davila*, 542 U.S. 200, 210 (2004).

Conversely, where either of these requirements is unsatisfied, the claim is not completely preempted and may remain a state-law claim, rather than one under ERISA Section 502(a).

Second, ERISA Section 514 expressly preempts state laws that "relate to" any ERISA employee benefit plan. 29 U.S.C. § 1144. However, Section 514 also contains a "savings" clause that exempts any state law from ERISA's preemptive force if that law "regulates insurance." 29 U.S.C. § 1144(b)(2)(A). This provision is designed to prevent ERISA from preempting "areas of traditional state regulation," including state laws regarding subrogation, which are "return[ed] . . . to state law." *FMC Corp. v. Holliday*, 498 U.S. 52, 61-62 (1990). ERISA's preemptive scheme thus recognizes that some state-by-state "disuniformities . . . are the inevitable result of the congressional decision to 'save' local insurance regulation." *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 381 (2002) (quoting *Metro. Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 747 (1984)).

2. As this case comes to this Court, the parties agree that the state insurance law at issue here – New York General Obligations Law (GOL) § 5-335 – is "saved" under Section 514 and will provide the substantive rule of decision in the courts below. Enacted in 2009, GOL § 5-335 provides that when a person enters into a personal injury settlement, "it shall be conclusively presumed" that "the settlement does not include any compensation for the cost of health care services, loss of earnings or other economic loss to the extent those losses or expenses have been or are obligated to be paid or reimbursed by a benefit provider." N.Y. GOL § 5-335. The New

York legislature found that this law was needed to protect settling insureds from being subjected to "a subrogation claim or claim for reimbursement by a benefit provider." *Id.* With the enactment of Section 5-335, the legislature "eliminated an asymmetry between jury verdicts and settlements that tended to discourage the settlement of personal injury lawsuits." Pet. App. 5a; *see* Pet. App. 5a n.3 (describing the New York legislature's purpose in more detail).

In 2013, in response to the district court's decision below, the New York legislature made amendments, retroactive to the original 2009 enactment, "to make clear" that the purpose of the statute was to prevent insurers from subrogating against settlements "so that the burden of payment for health care services, disability payments, lost wage payments or any other benefits for the victims of torts will be borne by the insurer and not any party to a settlement of such a victim's tort claim." 2013 N.Y. Sess. Laws Ch. 516.

B. Factual And Procedural Background

1. Respondents Meghan Wurtz and Mindy Burnovski are members of health plans insured by petitioner health insurance companies. In 2008, Wurtz was injured in an accident and received medical treatment covered under her "Freedom Plan Metro Access" insurance policy, issued by petitioner Oxford Health Plans (N.Y.), Inc. (Oxford), a wholly owned subsidiary of petitioner UnitedHealth Group, Inc. (United). Pet. App. 29a-30a. Also in 2008, Burnovski was injured in a separate accident and received medical treatment under her "Oxford

Freedom EPO Plan," a health insurance plan operated by Oxford. *Id.*

Respondents filed separate suits against the tortfeasors seeking damages arising from their accidents, and both settled their claims. Pet. App. 30a.

After learning of respondents' settlements, Oxford's subrogation recovery agent, petitioner Rawlings Company, LLC (Rawlings), sought to collect from those settlements under provisions of Oxford's insurance contracts. Rawlings claimed a lien against respondents' settlements and demanded $1,316.87 from Wurtz and $78,991.48 from Burnovski for medical expenses. Pet. App. 30a.

On January 10, 2012, Wurtz paid Rawlings the amount demanded to release the purported lien. Pet. App. 31a-32a. Burnovski, in contrast, has not complied with Rawlings' demand.

2. Respondents together filed a class-action complaint in New York state court, seeking a declaration under N.Y. GOL § 5-335 that petitioners did not have the right to seek subrogation of medical benefits against their settlements under New York law. Respondents also sought damages for unjust enrichment and for deceptive business practices under New York General Business Law (GBL) § 349. Pet. App. 32a.

Petitioners removed the case to the Eastern District of New York and moved to dismiss under Federal Rule of Civil Procedure 12(b)(6), arguing that respondents' state-law claims are preempted by ERISA. Pet. App. 26a. The district court agreed, finding both that respondents' state-law claims are

completely preempted under ERISA Section 502(a) and that N.Y. GOL § 5-335 is expressly preempted by ERISA Section 514. *Id.* The district court's complete-preemption holding allowed respondents' claims to be recast as ERISA claims, but the court then dismissed the suit, holding principally that respondents' claims could not proceed because they were preempted under Section 514. Pet. App. 75a-76a. The district court also suggested, but did not hold, that respondents had failed to exhaust their administrative remedies. Pet. App. 73a-75a.

3. The Second Circuit reversed. The court first held that the district court had jurisdiction under the federal Class Action Fairness Act. Pet. App. 12a. It then rejected the district court's conclusion that ERISA Section 514 expressly preempts New York's anti-subrogation provision. Pet App. 13a-15a. The court observed that "the district court's holding that N.Y. GOL § 5-335 does not fall within [Section 514's] savings clause is contrary to the Supreme Court's decision in *FMC Corp. v. Holliday*," which indicated that there was "*no dispute*" that state anti-subrogation laws "are 'saved' from express preemption." Pet. App. 13a (quoting *FMC Corp. v. Holliday*, 498 U.S. 52, 60-61 (1990)). As noted above, petitioners do not contest that holding in this Court. Pet. 5.

Next, the Second Circuit went on to determine that, under the two-pronged complete-preemption test articulated by this Court in *Aetna Health Inc. v. Davila*, 542 U.S. 200 (2004), respondents' claims are not completely preempted and thus could not be converted into ERISA claims under ERISA Section 502(a)(1)(B). Pet. App. 15a. It reversed the district

court's findings on the first prong of the *Davila* test, observing that because "the state right [respondents] seek to enforce – to be free from subrogation – is not provided by their plans," respondents' claims were not claims for benefits that could have been brought under ERISA Section 502(a)(1)(B). Pet. App. 16a. "Indeed," the court noted, "the terms of the [respondents'] ERISA plans are irrelevant to their claims." *Id.*

The Second Circuit also held that the claim did not satisfy *Davila*'s second prong because petitioners' actions implicated an independent state-law duty that "arises from section 5-335, which prohibits defendants from seeking subrogation or reimbursement from settling parties." Pet. App. 18a. The court of appeals observed that "[t]he duty is independent because it is unrelated to whatever plaintiffs' ERISA plans provide about reimbursement." *Id.*

The Second Circuit noted that its holding was "in some tension with" decisions of the Third, Fourth, and Fifth Circuits. Pet. App. 19a-20a. The court observed, however, that the Fourth and Fifth Circuit decisions pre-dated *Davila* and that the Third Circuit simply "follow[ed]" those decisions. *Id.* The Second Circuit explained that *Davila*'s "independent duty" requirement prohibited it from "expand[ing] complete preemption doctrine to allow removal of state law claims into federal court simply because they implicate ERISA benefits." Pet. App. 21a. It thus remanded the case to the Eastern District of New York for further proceedings on the merits. Pet. App. 23a.

4. Shortly after the Second Circuit's remand, the district court began moving the case to completion. On October 3, 2014, the court granted the insurers' motion to dismiss Burnovski's unjust-enrichment and N.Y. GBL § 349 claims because Burnovski has not paid any money to her insurer to release its purported lien, leaving her with only a declaratory judgment claim. *Wurtz v. Rawlings Co.*, No. 12-CV-01182 JFB AKT, 2014 WL 4961422, at *10 (E.D.N.Y. Oct. 3, 2014). It also rejected the insurers' arguments that the Contract Clause renders N.Y. GOL § 5-335 unconstitutional. *Id.* at *5. Finally, it held that, "at this juncture," it could not bar Wurtz's claims at the motion-to-dismiss stage under a New York-law defense known as the voluntary-payment doctrine, but it suggested that the issue could be revisited once the record was more fully developed. *Id.* at *6. As the petition to this Court is pending, the case thus continues to be litigated actively in the district court.

REASONS FOR DENYING THE WRIT

I. There Is No Genuine Split In Authority.

Review should be denied because the three court of appeals decisions comprising petitioners' claimed split in authority with the Second Circuit did not apply this Court's test for complete preemption announced in *Aetna Health Inc. v. Davila*, 542 U.S. 200 (2004). Two of these decisions pre-date *Davila*, and the third, though decided shortly after *Davila*, did not mention it or apply its two-part test.

1. This Court's unanimous decision in *Davila* announced a new test for finding complete preemption under ERISA Section 502(a)(1)(B). Under this test, a state-law claim is completely

preempted only where two requirements are met. First, the state-law claim must be brought by "an individual [who], at some point in time, could have brought his claim under ERISA § 502(a)(1)(B)." And, second, there must be "no other independent legal duty that is implicated by a defendant's actions." *Davila*, 542 U.S. at 210. Given this new articulation of the complete-preemption doctrine, "pre-*Davila* case law should be evaluated in light of the *Davila* test." 2 Lee T. Polk, *ERISA Practice and Litigation* § 11:46 (2014).

In the decade since *Davila*, courts of appeals generally have recognized that *Davila* established that two-part test for determining complete preemption under Section 502. *See, e.g.*, *Montefiore Med. Ctr. v. Teamsters Local 272*, 642 F.3d 321, 328 (2d Cir. 2011); *Pascack Valley Hosp. v. Local 464A UFCW Welfare Reimbursement Plan*, 388 F.3d 393, 400 (3d Cir. 2004); *Kuthy v. Mansheim*, 124 Fed. Appx. 756, 757 (4th Cir. 2004) (per curiam) (unpublished); *Lone Star OB/GYN Assocs. v. Aetna Health Inc.*, 579 F.3d 525, 529 (5th Cir. 2009); *Gardner v. Heartland Indus. Partners*, 715 F.3d 609, 613 (6th Cir. 2013) (cited in opinion below); *Franciscan Skemp Healthcare, Inc. v. Cent. States Joint Bd. Health & Welfare Trust Fund*, 538 F.3d 594, 597 (7th Cir. 2008) (cited in opinion below); *Marin Gen. Hosp. v. Modesto & Empire Traction Co.*, 581 F.3d 941, 946-47 (9th Cir. 2009) (cited in opinion below); *Salzer v. SSM Health Care of Oklahoma Inc.*, 762 F.3d 1130, 1134-35 (10th Cir. 2014); *Ehlen Floor Covering, Inc. v. Lamb*, 660 F.3d 1283, 1287 (11th Cir. 2011).

2. In its pre-*Davila* decision in *Singh v. Prudential Health Care Plan, Inc.*, 335 F.3d 278 (4th Cir.), *cert. denied*, 540 U.S. 1073 (2003), the Fourth Circuit determined that a Maryland statute prohibiting subrogation was completely preempted under Section 502(a) because the plaintiff was "seeking recovery of a plan benefit" under the insurer's health plan. *Id.* at 291. The court did not determine, as *Davila* would require a year later, whether the plaintiff's claims arose from a legal duty independent of any obligations under the ERISA plan.

In its pre-*Davila* decision in *Arana v. Ochsner Health Plan*, 338 F.3d 433 (5th Cir. 2003) (en banc), *cert. denied*, 540 U.S. 1104 (2004), the Fifth Circuit also did not apply the necessary independent-duty prong. The court reasoned only that the plaintiff was making a claim for benefits under the plan. *Id.* at 438. Although this reasoning resembles the inquiry required by the first prong of *Davila*, it does not address the second.

Contrary to petitioners' assertion that the Fifth Circuit has remained committed to *Arana*'s approach to complete preemption, Pet. 17-18, in fact, in cases after *Davila*, that court faithfully has applied the *Davila* framework. In *Lone Star OB/GYN Associates v. Aetna Health Inc.*, 579 F.3d 525, the court determined that state-law claims against an ERISA plan administrator for failure to promptly pay benefits due under an ERISA plan were not completely preempted, relying on *Davila*'s second, "independent duty" prong. *Id.* at 530-31. The court observed that "[w]hile Aetna is correct that any determination of benefits under the terms of a plan –

i.e., what is 'medically necessary' or a 'Covered Service' – does fall within ERISA, [appellant's state-law] claims are entirely separate from coverage and arise out of the independent legal duty contained in the contract." *Id.* (citation omitted); *see also McAteer v. Silverleaf Resorts, Inc.*, 514 F.3d 411, 418 (5th Cir. 2008) (recognizing *Davila* as the controlling test and finding no preemption of state tort claim).[1]

The Third Circuit's decision in *Levine v. United Healthcare Corp.*, 402 F.3d 156 (3d Cir.), *cert. denied*, 546 U.S. 1054 (2005), came less than a year after *Davila* and does not cite *Davila*, let alone apply the *Davila* test. Rather, *Levine*'s complete-preemption holding is sparsely reasoned, relying on the pre-*Davila* decisions in *Arana* and *Singh* to determine

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[1] Going forward, the Fifth Circuit's decision in *Arana* lacks any practical significance because no state in the Fifth Circuit has an anti-subrogation statute. In *Arana*, the Fifth Circuit ultimately determined that the Louisiana statute in question did not, in fact, prohibit subrogation and that therefore the plaintiffs had no state-law claims. *Arana v. Ochsner Health Plan*, 352 F.3d 973, 978 (5th Cir. 2003). Petitioners and their amici incorrectly cite the Louisiana statute as an anti-subrogation law. *Compare* Pet. 24 n.3, *and* Br. of the Chamber of Commerce of the U.S., et al., as Amici Curiae at 18 n.9, *with* Gary L. Wickert, *ERISA and Health Insurance Subrogation in All 50 States* § 3.19[1] (2d ed. 2006) ("Health insurers in Louisiana may enforce their contractual right of subrogation if the Plan contains adequate subrogation language."). Texas and Mississippi expressly authorize subrogation. *See* Tex. Civ. Prac. & Rem. Code Ann. § 140.004; Miss. Stat. § 83-41-315; *see also* Wickert §§ 3.44[1], 3.25[1].

that claims asserting that state law barred subrogation were for "benefits due" under the plan. Like the pre-*Davila* cases, then, *Levine* failed to consider *Davila*'s second prong.

The petition argues that the Third Circuit reaffirmed *Levine* in 2006 in *Wirth v. Aetna U.S. Healthcare*, 469 F.3d 305 (3rd Cir. 2006). Pet. 17. But this argument does not provide a basis for concluding that Third Circuit law genuinely conflicts with Second Circuit law. *Wirth* viewed *Levine* as controlling and did not cite *Davila*. Instead, it summarily determined that the state-law claim was one for benefits under the plan because "the actions undertaken by the insurer resulted in diminished benefits provided to the plaintiff insureds." *Wirth*, 469 F.3d at 309. Thus, like *Levine*, *Wirth* did not address *Davila*'s second prong.

II. This Case Implicates Only A Narrow Question Regarding The Application Of Section 502(a)(1)(B) To State Anti-Subrogation Laws, Which Has Little Practical Effect.

1. Petitioners assert that the Second Circuit's decision would "exclude from § 502(a)'s compass *any* suit enforcing *any* state law that a plaintiff alleges is saved from § 514 preemption, even if that law invalidates, modifies, or mandates ERISA plan terms, so long as the law does not also expand the remedies allowed by § 502(a)." Pet. 25. This assertion is belied by the structure and text of the Second Circuit's opinion.

For starters, the court of appeals carefully examined both types of preemption – ordinary and complete – in discrete, separately titled sections of its

opinion. Pet. App. 12a, 15a, 18a. Because it cited *Davila* and conducted both parts of the analysis that decision requires, the Second Circuit's opinion cannot plausibly be read to hold that any Section 502(a) complete-preemption determination is resolved whenever a state law is saved under Section 514 and does not offer damages beyond those allowed under ERISA.

The Second Circuit did not believe that its no-complete-preemption ruling was justified merely because the remedies sought by respondents mimic those authorized by ERISA. After all, the Second Circuit was aware that respondents seek remedies under N.Y. GBL § 349(h), Pet. App. 6a, which authorizes statutory damages. The Second Circuit held only that respondents' claims under the state anti-subrogation statute are not completely preempted under the *Davila* test.

2. Petitioners' amici complain that they "are barred from seeking reimbursement according to individual state law" and warn that, if the Second Circuit's decision is allowed to stand, ERISA plans would be subjected to "different legal obligations in different states . . . [r]equiring ERISA administrators to master the relevant laws of 50 States." Br. Amici Curiae for the National Ass'n of Subrogation Professionals et al. at 3, 10 (ellipsis and alteration in original) (quoting *Egelhoff v. Egelhoff* ex rel. *Baker*, 532 U.S. 141, 148-49 (2001)). These arguments are beside the point. As petitioner concedes, this case does not concern the validity of state anti-subrogation laws. Pet. 5, 11-12.

3. In the future, it is unlikely that insurers faced with an anti-subrogation statute will seek subrogation as the insurers did in this case. The Second Circuit has decided, and petitioners do not here dispute, that state laws that prevent insurers from subrogating are not expressly preempted under ERISA Section 514. GOL § 5-335 (and any other statute like it) will therefore govern insurance companies' conduct going forward and bar future attempts by insurers to subrogate.

This point is not limited to states within the Second Circuit. Because no one disputes that state laws that prevent insurers from subrogating are saved from express preemption, the issue here will arise only if there is some legitimate confusion about what state law provides. This Court held in *FMC Corp. v. Holliday* that there was "no dispute" that because state anti-subrogation statutes are "aimed at" the insurance industry, they are "saved" under 29 U.S.C. § 1144(b)(2)(A) and thus "not pre-empted" by ERISA. 498 U.S. 52, 60-63 (1990). Therefore, wherever state law prohibits subrogation by insurers, insurance companies should not attempt to subrogate, beneficiaries will not need to file suits under state law to resist attempts to subrogate, and the complete preemption question will not arise. The Section 502(a)(1)(B) issue in this case is largely academic.

III. This Case Is A Poor Vehicle For Review Because It Comes To This Court In An Interlocutory Posture While Potentially Dispositive Issues Are Being Litigated On Remand.

The Court should deny certiorari because this case's interlocutory posture makes it a poor vehicle for reviewing the question presented. The case is being actively litigated on remand, and resolution of the issues now under review below could obviate the need for this Court's involvement.

1.a. This case is not worthy of review because it comes to the Court in an interlocutory posture, and litigation will continue regardless of how this Court rules. "Ordinarily, this court should not issue a writ of certiorari to review a decree of the circuit court of appeals on appeal from an interlocutory order, unless it is necessary to prevent extraordinary inconvenience and embarrassment in the conduct of the cause." Robert L. Stern et al., *Supreme Court Practice* § 4.18 at 282 (10th ed. 2013) (internal quotation marks omitted); *see also Va. Military Inst. v. United States*, 508 U.S. 946, 946 (1993) (opinion of Scalia, J., respecting the denial of certiorari) ("We generally await final judgment in the lower courts before exercising our certiorari jurisdiction.").

This litigation will proceed in federal court regardless of the outcome of the complete-preemption question because the Class Action Fairness Act, 28 U.S.C. § 1332(d), provides for federal jurisdiction. Pet. App. 12a. And, regardless of any decision on the merits of the complete-preemption question, N.Y. GOL § 5-335 will provide the substantive rule of decision, as petitioners acknowledge. *See* Pet. 5, 7.

Therefore, this litigation will proceed in the same federal district court under the same substantive state law regardless of whether this Court grants certiorari.

b. Not only will litigation continue no matter how this Court might rule, but other issues already being litigated on remand may render the question presented irrelevant to the outcome of the case.

In light of a recent ruling on remand from the Second Circuit, only Wurtz now has claims for damages, which are the only claims that could potentially yield relief beyond the relief available under ERISA. Originally, Wurtz and Burnovski each had claims for (1) a declaratory judgment; (2) violations of New York's business practices act, N.Y. GBL § 349; and (3) unjust enrichment. But because Burnovski has not paid anything in response to her insurer's subrogation claim, the district court on remand concluded that the "complaint fail[ed] to allege that defendants benefitted at Burnovski's expense." *Wurtz v. Rawlings Co.*, No. 12-CV-01182 JFB AKT, 2014 WL 4961422, at *10 (E.D.N.Y. Oct. 3, 2014). The district court therefore dismissed Burnovski's claims under N.Y. GBL § 349 and for unjust enrichment. *Id.* Burnovski retains only a declaratory-judgment claim.

Wurtz, by contrast, did pay $1,316.87 to her insurer. Wurtz's unjust-enrichment and N.Y. GBL § 349 claims therefore were allowed to proceed, at least for now. *Wurtz*, 2014 WL 4961422, at *7, *10. But if, as petitioners assert, the voluntary-payment defense applies, there would be no damages left in the case. The voluntary-payment doctrine "precludes a plaintiff from recovering payments made with full

knowledge of the facts and with a lack of diligence in determining his contractual rights and obligations." *Spagnola v. Chubb Corp.*, 574 F.3d 64, 72 (2d Cir. 2009) (internal quotation marks omitted). Application of that doctrine would eliminate Wurtz's N.Y. GBL § 349 and unjust-enrichment claims, thereby eliminating her declaratory-judgment claim as well. As the district court observed, the doctrine generally is not assessed at the motion-to-dismiss stage; rather, it is an affirmative defense that should be heard after a responsive pleading is filed and the underlying facts are clarified. *Wurtz*, 2014 WL 4961422, at *6. This determination will be made on summary judgment or at trial in the district court.

In sum, if the voluntary-payment defense applies, the only remaining claim would be Burnovski's request for a declaratory judgment, which is a remedy available under ERISA. *See Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 53 (1987). In that situation, it would make no difference, even in remedy, whether respondents' claims proceeded under New York law or under ERISA Section 502(a)(1)(B).

2. Petitioners assert that this case provides a good vehicle for addressing the question presented because a finding of complete preemption would "require dismissal" on account of respondents' supposed failure to exhaust administrative remedies. Pet. 27. Although the district court suggested that respondents' claims could be dismissed for failure to exhaust, the Second Circuit never addressed the issue.

Respondents likely would have prevailed on this issue if the Second Circuit had been required to

decide it. First, as respondents explained below, if their claims had arisen under ERISA, they would not have been required to exhaust because exhaustion would have been futile. *See Engler v. Cendant Corp.*, 434 F. Supp. 2d 119, 128 (E.D.N.Y. 2006). Exhaustion would have been futile here because defendants persisted in trying to receive reimbursement from plaintiffs, even though subrogation was expressly prohibited by the New York anti-subrogation statute. Second, plaintiffs are not required to have exhausted administrative procedures when they allege a statutory ERISA violation because "administrators have no expertise in deciding a claim that asserts a statutory right." *Engler*, 434 F. Supp. 2d at 127-28; *see also Nechis v. Oxford Health Plans, Inc.*, 421 F.3d 96, 101 (2d Cir. 2005) (observing that district courts in the Second Circuit routinely dispense with the exhaustion requirement for statutory ERISA claims). If there were complete preemption here, respondents would not have had to exhaust administrative remedies because they would then be treated as claiming a statutory violation of ERISA. The decision of plan administrators would depend on a legal application of a non-preempted New York statute to an ERISA plan – a topic outside of their expertise.[2]

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[2] It is similarly incorrect for petitioners to assume that respondents could not amend their complaint to assert claims under ERISA if their state-law claims were held completely preempted. *See* Pet. 27. Whether or not they may amend, or if they even need to, is at the district court's discretion. *See, e.g.*, *Ackerman v. Fortis Benefits Ins. Co.*, 254 F. Supp. 2d 792, 818 (S.D. Ohio 2003) (finding that, after a state-law contract claim

IV. The Second Circuit's Decision Faithfully Applied *Davila* And Is Fully Consistent With This Court's Other Precedent.

The Second Circuit's decision faithfully applied *Davila*'s two-part complete-preemption test. Moreover, its decision honored this Court's ERISA jurisprudence more generally.

A. Respondents' Claims Are Not For Benefits "Under The Terms Of" Their Insurance Plans, And Arise From A State Law That Imposes A Legal Duty Independent Of Those Plans.

1. Respondents' claims are not claims for benefits under the terms of their insurance plans because, as this case comes to this Court, respondents are entitled to the funds at issue under the state statute rather than under the terms of their plans.

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was expressly preempted, plaintiff did not need to amend the complaint to state an ERISA claim because the defendant, "as demonstrated by its complete preemption argument, [was] fully aware of the ERISA claim set forth" by the plaintiff); *Termini v. Life Ins. Co. of N. Am.*, 464 F. Supp. 2d 508, 519 (E.D. Va. 2006) (allowing amendment to add ERISA claims after state-law claims were held completely preempted, because the "interests of justice support such an amendment"); *see also Krispin v. May Dep't Stores Co.*, 218 F.3d 919, 924-25 (8th Cir. 2000) (allowing plaintiffs to amend their complaint to state a claim under the National Bank Act because "appellants faced a Hobson's choice: risk dismissal for failure to invoke the NBA, or plead an NBA claim, perforce defeating their own main argument that the case should remain in state court based on a lack of federal question jurisdiction").

Section 502(a)(1)(B) represents the vehicle for claims to "recover benefits," "enforce . . . rights," or "clarify . . . rights" "*under the terms of* [an ERISA-regulated] plan." 29 U.S.C. § 1132(a)(1)(B) (emphasis added). Thus, under *Davila*, where a claim is pled under state law, it nonetheless constitutes a claim under Section 502(a)(1)(B) if it ultimately seeks "to rectify a wrongful denial of benefits promised under ERISA-regulated plans." *Aetna Health Inc. v. Davila*, 542 U.S. 200, 214 (2000).

The plaintiffs in *Davila* sought to recover for injuries suffered as a result of their insurers' "refusal to cover . . . requested services." 542 U.S. at 205. They brought their claim under the Texas Health Care Liability Act (THCLA), which imposes a duty to "exercise ordinary care when making health care treatment decisions." *Id.* (quoting Tex. Civ. Prac. & Rem. Code Ann. § 88.002(a)). This Court observed that the THCLA applied only to the extent that plan administrators had to exercise ordinary care when making benefits determinations "under the terms of the relevant plan." *Davila*, 542 U.S. at 213. Therefore, the claim in *Davila* "complain[ed] only about denials of coverage promised under the terms of ERISA-regulated employee benefit plans." *Id.* at 211.

Respondents' claims, in contrast, involve their entitlement to funds that, according to petitioners, are *unavailable* under the terms of their plans. As the petition puts it, "[t]he plans . . . provide that if the insurer pays a participant's medical expenses as a benefit under the plan, and the participant later receives compensation for those expenses from a third-party tortfeasor, then the insurer is entitled to

be reimbursed by the participant for the payment of medical benefits." Pet. i. To the extent that this suit involves no disagreement regarding whether respondents are entitled to the funds in question under the terms of their plans (because the plans preclude any such entitlement), respondents' claims are *not* "brought to remedy only the denial of benefits under ERISA-regulated benefit plans." *Davila*, 542 U.S. at 221.

2. In addition, respondents' claims arise from a state law that imposes a legal duty independent of their insurance plans because the application of New York's anti-subrogation law requires no interpretation of those plans' terms.

Davila's second prong states that a claim is completely preempted under Section 502(a)(1)(B) only "where no legal duty (state or federal) independent of ERISA or the plan terms is violated." 542 U.S. at 210. In determining what constitutes an "independent duty," *Davila* considered this Court's precedent under the Labor Management Relations Act (LMRA), because Section 502(a)(1)(B) of ERISA "mirror[s] the pre-emptive force of LMRA § 301." *Id.* at 209. Although Section 301 "governs claims founded directly on rights created by collective-bargaining agreements," *Caterpillar Inc. v. Williams*, 482 U.S. 386, 394 (1987), it does not preempt "state rules that proscribe conduct, or establish rights and obligations, independent of a labor contract." *Id.* at 395 (quoting *Allis-Chalmers Corp. v. Lueck*, 471 U.S. 202, 212 (1985)).

This Court's cases under LMRA Section 301 recognize that where a claim's resolution does not require interpretation of a contract's terms, the claim

is based on a duty that is independent of that contract. In *Lingle v. Norge Division of Magic Chef, Inc.*, 486 U.S. 399 (1988), for example, the Court considered "whether an employee covered by a collective-bargaining agreement that provides her with a contractual remedy for discharge without just cause may enforce her state-law remedy for retaliatory discharge." *Id.* at 401. The employee there asserted that she had been fired for requesting workers' compensation for an on-the-job injury. *Id.* Although the plaintiff's suit under Illinois retaliatory-discharge law sought compensatory and punitive damages resulting from her loss of employment, the Court found it dispositive that her state-law claim required a showing only that (1) she was "discharged or threatened with discharge" and (2) the employer's motive in discharging her was "to deter [her] from exercising [her] rights under [Illinois law]." *Id.* at 407. Because "[n]either of the elements require[d] a court to interpret any term of a collective-bargaining agreement," the Court held that "the state-law remedy in this case is 'independent' of the collective-bargaining agreement in the sense of 'independent' that matters for § 301 pre-emption purposes: resolution of the state-law claim does not require construing the collective-bargaining agreement." *Id.*

The Court confirmed this conception of an "independent duty" in *Livadas v. Bradshaw*, 512 U.S. 107 (1994). There, California law assessed a penalty against employers that failed to timely pay wages owed to discharged employees. *Id.* at 110. The Court observed that, although a calculation of the penalty required a court to refer to the wages to which a

union employee was entitled under the collective-bargaining agreement, "the mere need to 'look to' the collective-bargaining agreement for damages computation is no reason to hold the state-law claim [preempted]." *Id.* at 125. The question was one of "state law, entirely independent of any understanding embodied in the collective-bargaining agreement." *Id.*

This Court in *Davila* found that ERISA Section 502(a)(1)(B) completely preempted the claims at issue because "interpretation of the terms of [the] benefit plans form[ed] an essential part" of those claims. *Davila*, 542 U.S. at 213. The Court observed that the THCLA avoided creating an independent duty, like those present in *Lingle* and *Livadas*, because the statute "create[d] no obligation on the part of the health insurance carrier . . . to provide to an insured or enrollee treatment which is not covered by the health care plan of the entity." *Id.* (quoting Tex. Civ. Prac. & Rem. Code Ann. § 88.002(d)) (internal quotation marks omitted). Because the THCLA governed only decisions involving the approval or denial of plan-covered treatments, the Court found that plaintiffs' claims "derived entirely from the particular rights and obligations established by the benefit plans," rather than an independent state-law duty. *Id.*

This case involves the type of "independent duty" this Court found missing in *Davila*. Like adjudication of the state lawsuit in *Lingle*, adjudication of respondents' claims does not require any interpretation of their federally regulated contract. To grant respondents the relief they seek, a court must determine only that their insurers

unlawfully sought to recover a portion of respondents' settlement awards under an alleged right of subrogation. Put another way, the terms of respondents' plans are immaterial to their claims because petitioners' actions are unlawful under N.Y. GOL § 5-335 regardless of whether the insurance plans actually contain a subrogation clause. Upon receiving a letter from an insurer asserting a right to a portion of a settlement, an individual knowing *only* that New York law prohibits the subrogation of medical benefits (but lacking any knowledge of the terms of her particular plan) could seek on that basis the same declaratory judgment that respondents seek here – namely, that N.Y. GOL § 5-335 bars the insurer's recovery.

Contrary to petitioners' assertion, respondents do not aim "to invalidate plan provisions governing reimbursement of plan benefit payments." Pet. 2. Nor does "the right respondents seek to enforce exist[] only because of the plan provisions requiring reimbursement." *Id.* 22. To the contrary, respondents wield New York's anti-subrogation statute directly against petitioners' *conduct*, seeking relief from an unlawful attempt by insurance companies to obtain funds that under state law belong to the recipients of tort settlements. For these reasons, Section 502(a) does not completely preempt respondents' claims under that statute.

B. None Of The Cases Petitioners Rely On Undermine The Second Circuit's Decision.

1. Petitioners' reliance on *UNUM Life Insurance Co. of America v. Ward*, 526 U.S. 358 (1999), and *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355

(2002), is misplaced. Both cases involved straightforward claims for ERISA plan benefits, and neither raised any question concerning complete preemption. *UNUM* concerned a California law that prohibited an insurer from rejecting a claim as untimely without a showing of prejudice. *UNUM*, 526 U.S. at 366-67. Although the state law affected the procedure by which the insurance company determined whether a claimant was entitled to benefits, the plaintiff's case remained a "suit to recover disability benefits under an ERISA-governed insurance policy." *Id.* at 363. *Rush* involved a state law requiring independent review of the "medical necessity" of a denied treatment where the plan's terms "guarantee[d] medically necessary care." *Rush*, 536 U.S. at 383. The resolution of the case thus hinged on which interpretation of those plan terms – the insurer's or the independent reviewer's – would control. The plaintiffs in *UNUM* and *Rush* ultimately "complain[ed] only about denials of coverage promised under the terms of ERISA-regulated employee benefit plans." *Davila*, 542 U.S. at 211.

In any case, this Court had no occasion in either *UNUM* or *Rush* to determine whether the state laws at issue imposed an independent duty because in both cases the claim in question was before this Court as a Section 502(a) action rather than as an action under state law. *See UNUM*, 526 U.S. at 365; *Rush*, 536 U.S. at 364-65. *Davila* makes clear that the mere possibility that a plaintiff "could have brought" a claim under Section 502(a)(1)(B) satisfies only one prong of the complete-preemption test. 542 U.S. at 210; *cf. Lingle v. Norge Div. of Magic Chef,*

Inc., 486 U.S. 399, 410 (1988) (permitting a claim to proceed under state law even where it would involve "addressing precisely the same set of facts" as an analogous suit under federal law); *Caterpillar Inc. v. Williams*, 482 U.S. 386, 394-95 (1987) ("It is true that respondents, bargaining unit members at the time of the plant closing, possessed substantial rights under the collective agreement, and could have brought suit under § 301. As masters of the complaint, however, they chose not to do so."). Because in both cases the claims came to the Court under Section 502(a), the Court regarded questions about complete preemption as irrelevant. *See UNUM*, 526 U.S. at 377 (determining that because the plaintiff "sued under § 502(a)(1)(B) . . . [t]he case . . . does not raise the question whether § 502(a) provides the sole launching ground for an ERISA enforcement action"); *Rush*, 536 U.S. at 362 (not addressing the question of complete preemption under 502(a)).

2. *U.S. Airways, Inc. v. McCutchen*, 133 S. Ct. 1537 (2013), and *Sereboff v. Mid Atlantic Medical Services, Inc.*, 547 U.S. 356 (2006), are even further afield. Petitioners argue that these decisions, which involved Section 502(a)(3) suits "to enforce . . . the terms of the [ERISA] plan," represent the "mirror image" of the present dispute. Pet. 23. But those cases did not involve preemption at all. They decided only that plan administrators seeking to enforce a clause authorizing reimbursement of certain amounts paid to insureds by third parties had pursued "appropriate equitable relief" by suing under Section 502(a)(3) to compel compliance with the terms of their contracts. *Sereboff*, 547 U.S. at 361; *McCutchen*, 133 S. Ct. at 1543-44. That conclusion

has nothing to do with complete preemption under Section 502(a)(1)(B).

Rather than support petitioners' argument, *McCutchen* and *Sereboff* reinforce the essential difference between a suit under the terms of a plan, which requires an interpretation of those terms, and the present case, which requires only the application of an independent state law. A suit under Section 502(a)(3) to enforce a reimbursement clause is predicated on the presence of such a clause within the insurance contract – a court will look to and interpret the scope and meaning of that clause when assessing the merits of the case. That type of suit contrasts starkly with respondents' claims under N.Y. GOL § 5-335, which, as explained above, will proceed regardless of whether their contracts contain a subrogation clause.

CONCLUSION

For the foregoing reasons, the petition for a writ of certiorari should be denied.

Respectfully submitted,

Frank R. Schirripa
HACH ROSE SCHIRRIPA
& CHEVERIE LLP
185 Madison Avenue
14th Floor
New York, NY 10016
(212) 213-8311

Steven J. Harfenist
Counsel of Record
HARFENIST, KRAUT
& PERLSTEIN LLP
3000 Marcus Avenue
Suite 2E1
Lake Success, NY 11042
(516) 355-9600
sharfenist@hkplaw.com

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