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.

MEGAN WURTZ, *et al.*,

Respondents.

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

BRIEF *AMICI CURIAE* FOR THE NATIONAL ASSOCIATION OF SUBROGATION PROFESSIONALS AND THE SELF INSURANCE INSTITUTE OF AMERICA, INC., IN SUPPORT OF PETITIONERS

Daran P. Kiefer
KREINER & PETERS CO., L.P.A.
2570 Superior Avenue
Suite 401
Cleveland, OH 44114

Bryan B. Davenport
LAW OFFICES OF BRYAN B. DAVENPORT, P.C.
160 Fairway Lakes Drive
Franklin, IN 46131

Laura D. Schmidt
Counsel of Record
DOWNS STANFORD, P.C.
2001 Bryan St.,Suite 4000
Dallas, TX 75093
(214) 748-7900
lschmidt@downsstanford.com

John D. Kolb
GIBSON & SHARPS, PSC
9420 Bunsen Parkway
Suite 250
Louisville, KY 40220

Counsel for Amici Curiae

Becker Gallagher · Cincinnati, OH · Washington, D.C. · 800.890.5001

TABLE OF CONTENTS

TABLE OF AUTHORITIES

CASES

STATUTES

OTHER AUTHORITIES

INTEREST OF *AMICI CURIAE* [1]

National Association of Subrogation Professionals ("NASP"). NASP is a non-profit trade association of insurance companies, third party administrators, subrogation specialists, and attorneys practicing in the field of subrogation and recovery. NASP has approximately 2,300 members, representing more than 425 insurance companies and self-funded entities. NASP'S mission is to create a national forum for the education, training, networking, advocacy and sharing of information and, ultimately, the most effective pursuit of subrogation on an industry-wide basis.

Through NASP, members are able to retrieve, organize, and exchange information, as well as expand the use of technology to promote subrogation efforts on a cost-effective basis. The members of NASP recover billions of dollars annually, including hundreds of million dollars in health care expenditures every year for insured and self-funded employee benefit plans through subrogation and recovery practices. One of NASP's goals is to be the "voice of subrogation" for the public, government, and other organizations.

NASP has an interest in whether insured ERISA plans seeking to enforce their subrogation and

---

[1] No counsel for a party authored this brief in whole or in part. No party, or counsel for a party, made a monetary contribution intended to fund the preparation or submission of the brief. No one other than the amici, their members, and their counsel made such a contribution. 10-day notice was given to the parties. The parties consented to the *amici* brief, as shown by the consent letters filed with this Court.

reimbursement terms are subject to state law or if state law is preempted by ERISA. The Court's decision will have a profound impact on employee benefit plans' financial stability, which in turn will have far-reaching implications for the nation's health care system.

Self-Insurance Institute of America, Inc. ("SIIA"). SIIA is a nonprofit organization with nearly 1,000 members, serving tens of millions of health plan beneficiaries, and is dedicated to the advancement and protection of the self-insurance industry. SIIA's membership includes self-insured entities such as employer plan sponsors, as well as service providers such as third party administrators, reinsurance companies, and other entities that support the self-insurance business. SIIA is the only organization in the United States that exclusively represents firms, professionals, and organizations that participate in the broad spectrum of self-insurance, including self-insured group health plans.

Through SIIA, its members coordinate their views and provide practical information and recommendations to government and the public at large on a range of subjects relevant to the effective functioning of the self-insurance system, including the provisions of the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§ 1001, *et seq*., which concern self-insured health plans and plan participants. SIIA's mission includes rendering assistance to courts in their deliberations on significant self-insured health plan issues of broad concern to its members.

Collectively, NASP and SIIA have strong interests in preserving their members' ability to recover funds

from participants that accept medical benefits but then refuse to honor the reimbursement terms of their agreements after obtaining compensation from third parties through legal action or settlement. NASP's and SIIA's members depend on reimbursement to control health care costs and to continue to provide benefits to all covered persons at lower costs. To the extent that NASP and SIIA's members are barred from seeking reimbursement according to individual state law, they might be forced to take dramatic action, such as increasing co-pays and deductibles, reducing benefits, postpone the payment of claims that may be accident-related until there is a determination of the reimbursement rights, or otherwise amending plan terms to protect against this growing and unnecessary risk.

INTRODUCTION AND SUMMARY OF ARGUMENT

The cost of health care affects every company and every individual receiving health care in the United States. According to the 2012 annual survey by the Kaiser Family Foundation and Health Research and Educational Trust, annual health care spending in the United States reached $2.6 trillion, which is 17.9% of the Gross Domestic Product.[2] The average cost of health care amounts to about $8,402 per person annually.[3] In spite of the recently enacted Affordable

---

[2] *See Health Care Costs, A Primer*, May 2012, http://kaiserfamilyfoundation.files.wordpress.com/2013/01/7670-03.pdf, p. 1 (accessed on 11/22/14).

[3] *Id*. (for the year of 2010).

Care Act, health care spending is expected to continue to rise faster than the national income for the foreseeable future.[4] The Maryland General Assembly has previously estimated that health insurance premiums for state workers would rise between 1% and 2% if insurers' access to subrogation mechanisms were eliminated.[5]

Because health insurance is not designed to cover injuries caused by third parties (as liability insurance is), when health dollars are spent on damages caused by a tortfeasor, it affects everyone in that insurance pool. Subrogation allows everyone in the pool to benefit when those dollars are returned, resulting in lower premiums. *Admin. Comm. of Wal-Mart Stores, Inc. Assocs. Health & Welfare Plan v. Shank*, 500 F.3d 834, 838 (8th Cir. 2007) ("Shank would benefit if we denied the Committee its right to full reimbursement, but all other plan members would bear the cost in the form of higher premiums").

The Second Circuit Court of Appeals decision below endangers an employee benefit plan's ability to implement these important cost savings measures. The decision violates ERISA's exclusive remedial scheme and creates a direct conflict between the circuit courts of appeals. The decision violates a primary purpose of ERISA by subjecting plan administrators and fiduciaries to a multitude of state law causes of action. Finally, the decision is contrary to the

---

[4] *Id*. at p.2.

[5] *See* "Fiscal Note," http://mlis.state.md.us/2000rs/fnotes /bil_0003 /sb0903.PDF, p.2 (accessed 11/22/2014).

established precedent of this Court. Therefore, NASP and SIIA urge this Court to grant certiorari and reverse the decision below.

ARGUMENT

I. ERISA § 502(a)(3) Actions are "Exclusive" and Prevent Other State Court Actions

Both NASP and SIIA urge this court to grant certiorari and reverse the Second Circuit Court of Appeals which found that a state cause of action seeking to void or override plan provisions was not subject to complete preemption under ERISA's civil enforcement section 29 U.S. C. § 1132 (also referred to as Sec. 502 of ERISA). The Second Circuit's ruling undermines this Court's consistent precedent that the actions and remedies under Sec. 502 are the exclusive actions and remedies available to ERISA fiduciaries and plan participants alike.

ERISA's civil enforcement section provides plan participants such as the putative class represented by Wurtz and Burnovksi four possible sections under which to bring a civil action under ERISA.[6] The Second Circuit incorrectly asserts that this Court's test under *Aetna Health Inc. v. Davila*, 542 U.S. 200 (2004) requires the court to discern if the claims to prevent enforcement of plan terms fall under Sec. 502. The Second Circuit's opinion points to *Davila,* claiming that only causes of action which involve plan interpretation are subject to "complete preemption."

---

[6] Those sections are (a)(1)(A), (a)(1)(B), (a)(2) and (a)(3).

NASP and SIIA urge this Court to grant certiorari on this case to reverse the Second Circuit's express recognition that a state cause of action by an ERISA plan participant may be maintained despite ERISA Sec. 502. If the Circuit Court's decision were to stand, the litigation floodgates would open to plan participants and beneficiaries to file state law claims arguing that their claims do not involve "plan language." Plan participants would be able to subject ERISA plan fiduciaries and insurers to a multitude of state actions by simply not invoking plan language. The purpose of ERISA is to prevent such a situation from occurring. The state law claims brought by Wurtz are essentially a declaratory judgment action seeking to void an ERISA plan. By allowing such a case, the state courts would turn uniform ERISA enforcement into a patchwork of inconsistent interpretation and rulings.

Any situation which forces a choice between exclusive federal remedies found in ERISA Sec. 502 and state insurance causes of action saved from preemption necessarily requires the state law of insurance to yield to ERISA. *See Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 377 (2002). In contrast, the Second Circuit's opinion allows the state law right to seek declaratory judgment to prevail over the limited and exclusive remedies of ERISA. "The deliberate care with which ERISA's civil enforcement remedies were drafted and the balancing of policies embodied in its choice of remedies agues strongly for the conclusion that ERISA's civil enforcement remedies were intended to be exclusive." *See Pilot Life Inc. Co. v. Dedeaux*, 481 U.S. 41, 54 (1987). Allowing state court causes of action, such as one seeking a

declaratory judgment of ERISA plans, would completely eviscerate the purpose of ERISA and the precedent of this Court.

Moreover, the Second Circuit's decision ignores this Court's further clarification that state law actions cannot be used to supplant ERSIA Sec. 502 actions. Again this Court's decision in *Davila* provides further guidance that ERISA's civil enforcement section provisions in Sec. 502 are the exclusive causes of action for plan participants. This Court unanimously held that "Congress' intent to make the ERISA civil enforcement mechanism exclusive would be undermined if state causes of action that supplement the ERISA Sec. 502(a) remedies were permitted, even if the elements of the state cause of action did not precisely duplicate the elements of an ERISA claim." *See Davila*, *supra*, 542 U.S. at 216. Contrary to the lower court's ruling, the *Davila* decision provides that the actions under Sec. 502 are exclusive actions for plan participants.

If the lower court's opinion were to stand, then ERISA plan participants could use general state laws allowing for declaratory judgment to strike, void or undermine plan provisions at will. Instead, NASP and SIIA urge this court to grant certiorari in this matter to reject such an expansion of ERISA plan participants' causes of action and to clarify that ERISA Sec. 502 is the only basis upon which a participant may seek enforcement of (or avoidance of) plan provisions.

II. The Second Circuit's Ruling Creates A Circuit Split On Issue of Critical National Importance

The Second Circuit decision in *Wurtz* addresses a question of critical national importance: "Whether an action seeking to invalidate an ERISA plan's reimbursement provision and seeking return of previously paid reimbursement may be properly filed under ERISA Sec. 502(a)?" The answer to this question impacts not only the causes of actions that may be filed, but also the jurisdiction of the federal courts to hear such actions.

The respondents, in part, seek a declaratory judgment that the reimbursement provision of their ERISA plan is unenforceable, and one respondent seeks return of reimbursement previously paid. The Second Circuit held that these claims were not subject to complete preemption because they were based on a state insurance statute not expressly preempted by ERISA. *Wurtz* at 242. Yet, Respondent's claims are not "based" upon New York Gen. Oblig. Law Sec. 5-335. In fact, Sec. 5-335 does not have a remedial scheme or provide a statutory cause of action. Instead, the Respondent's claims are brought under New York's common law of declaratory actions and unjust enrichment.

According to this Court's decision in *Aetna v. Davila*, a state cause of action is completely preempted by ERISA if it "duplicates, supplements or supplants" ERISA's exclusive remedial scheme. *Davila* at 209. The Second Circuit held that the respondents' claims were not completely preempted because Sec. 5-335 "does not impermissibly expand the exclusive remedies

provided by ERISA Sec. 502(a)." *Wurtz* at 242. Assuming *arguendo* that a state cause of action seeking to declare unenforceable a provision in an employee benefit plan does not expand ERISA's remedial scheme, it certainly duplicates remedies available if a similar claim can be filed under ERISA Sec. 502(a)(1)(B).

The Second Circuit, in cursory fashion, finds that the respondents' claims could not have been filed under ERISA Sec. 502(a)(1)(B) because the claims do not seek to "recover benefits…under the terms of the plan." The panel seemed to rely on the respondents' argument that they "have already received all the benefits that they were due…and make no claim for anymore." *Id*. In other words, the Second Circuit held that actions seeking reimbursement of benefits previously paid, do not fall within the type of benefit claims encompassed by Sec. 502(a).

The Second Circuit's narrow interpretation of ERISA Sec. 502 remedies has been specifically rejected by the Third, Fourth and Fifth Circuits. *See Levine v. United Healthcare Corp*., 402 F.3d 156 (3d Cir. 2005); *Singh v. Prudential Health Care Plan, Inc.*, 335 F.3d 278 (4th Cir. 2003); *Arana v. Ochsner Health Plan*, 33 F.3d 433 (5th Cir. 2003). As the Fourth Circuit reasoned, a "claim to recover the portion of benefits that was diminished…under the unlawful subrogation term of the plan is no less a claim for recovery of a plan benefit under §502(a) than if [the plan participant] were seeking recovery of a plan benefit that had been denied in the first instance." *Singh* at 291.

This split among the circuits presents an issue of national importance to all participants, beneficiaries and fiduciaries of employee benefit plans. If the Second

Circuit's logic is adopted, plan participants and beneficiaries will be deprived of ERISA's civil enforcement scheme as a mechanism to determine the validity of their plan's reimbursement provision. Instead, they will be forced to file their claims under the various state law actions that may be available. Likewise, plan administrators and fiduciaries will be subject to state law claims seeking to invalidate provisions in their employee benefit plans. Absent some other form of federal jurisdiction, these claims will not be removable to federal court. In such actions, the state courts would be without jurisdiction to entertain a claim by the plan fiduciary seeking enforcement of the plan terms, as such claims must be filed under ERISA Sec. 502(a)(3), over which the federal courts have exclusive jurisdiction. This dichotomy will result in multiple actions filed in different jurisdiction over the same subject matter.

III. Uniformity of Enforcement

In *Wurtz,* the Second Circuit takes the position that because ERISA does not mention the issue of subrogation, uniformity is not impacted. Nothing could be further from the truth. One of the principal goals of ERISA is to enable employers "to establish a uniform administrative scheme, which provides a set of standard procedures to guide processing of claims and disbursement of benefits." *Fort Halifax Packing Co. v. Coyne,* 482 U.S. 1, 9 (1987) "Uniformity is impossible however, if plans are subject to different legal obligations in different states…Requiring ERISA administrators to master the relevant laws of 50 States and to contend with litigation would undermine the congressional goal of "minimizing the administrative

and financial burdens on plan administrators-burdens ultimately borne by the beneficiaries." *Egelhoff v. Egelhoff,* 121 S.Ct. 1322, 1327 (2001).

If the decision in *Wurtz* is allowed to stand, employers, in the area of subrogation and reimbursement, will not be able to follow a set of standard procedures relative to processing claims involving personal injuries. ERISA administrators will be forced to master the diverse subrogation and reimbursement procedural schemes of the fifty different states. For example, if Indiana subrogation law applies, there is a scheme set forth for obtaining a partial reimbursement[7]. In Pennsylvania, a plan cannot enforce the terms of a subrogation or reimbursement provision in the event of a motor vehicle accident due to the provisions of the Pennsylvania Motor Vehicle Responsibility Act but could enforce its terms and provisions in a medical malpractice act.[8] Wisconsin requires that any party asserting a subrogation interest be joined as a party to the underlying personal injury litigation.[9] Florida has an extensive statutory scheme involving subrogation which contains specific notice, provision of document and timing limitations, which if violated obviate all rights of recovery.[10] The list could go on as there is

---

[7] *See* Indiana Code 34-51-2-19

[8] 75 Pa. C.S. sec 1720. Statutory prohibition relative to subrogation in motor vehicle accidents but no similar prohibition for other types of accidents.

[9] W.S.A. 803.03

[10] F.S.A. sec. 768.76

substantial divergence among the states as to issues of various procedures for enforcing reimbursement claims for benefits paid.[11] The confusion created by the *Wurtz* decision will mean that plan administrators must constantly review the law of the 50 states to determine if a particular state requires reimbursement claims to be brought through the administrative process or through a particular state's judicial process.

The Second Circuit's decision in *Wurtz* clearly frustrates the uniformity principal in ERISA and frustrates both the letter of the law and the intent of Congress, as was expressed by Senator Jacob Javits, R-N.Y. when he stated: "The emergence of a comprehensive and pervasive Federal interest and the interests of uniformity with respect to interstate plans required–but for certain exceptions–the displacement of State action in the field of private employee benefit programs."[12]

The matter will be made more complex, under *Wurtz*, due to choice of law issues. If the plan is located in a particular state and the plan participant is involved in a motor vehicle accident in a separate state, which law will apply to the matter? Litigation will most certainly ensue over this and other issues raised above which again argues that the N.Y. Gen. Oblig. Law Section 5-535 should be pre-empted by ERISA.

---

[11] For some sense of the difficulty required of a plan administrator to master all of these rules, see "Occupational Accident And Health Subrogation In All 50 States" chart published by Matthiesen, Wickert & Lehrer, S.C. Attorneys at Law, www.mwl-law.com/wp-content/uploads/2013/03/occupational-accidents

[12] 120 Cong. Rec. S15,737 S15,751 (daily ed. Aug.22, 1974)

If the *Wurtz* decision is allowed to stand, there will be a race to the courthouse to resolve disputes. Plan participants will repay their liens and seek refunds and damages under state anti-subrogation laws, as is the case in *Wurtz*. Plan Administrators will be forced to file pre-emptive actions in federal court under Sec. 502(a)(3) to seek either injunctive relieve or to enforce the terms of the plan. During the pendency of such litigation, plan participant's medical claims will be unpaid, resulting in potential loss of discounts that would benefit the plan and potentially damage the credit worthiness and financial stability of the participant. This is the precise type of havoc that ERISA seeks to avoid.

ERISA expressly sets forth particular and exclusive remedies available to plans and plan participants in the event of a dispute. Relative to plan participants, section 502 limits those remedies to certain fines or penalties for failure to provide certain information, attorney's fees in certain situations, recovery of benefits under the terms of a plan, enforcements of rights under the terms of a plan, clarification of rights to future benefits, injunction and other appropriate equitable relief to redress violations or enforce plan provisions. In *Wurtz*, the Second Circuit Court of Appeals refused to hold that N.Y. Gen. Oblig. Law 5-335 is pre-empted by ERISA. In doing so, the Court appears to permit Wurtz the right to move forward and seek damages for unjust enrichment and deceptive business practices against the plan. There is no doubt that Wurtz has brought suit against an ERISA plan and that the basis for that suit is a state law. If the decision in *Wurtz* is upheld, the door will be open to

remedies that are different from and in excess of the remedies that are available under 502(a) of ERISA.

> In *Dedeaux,* this Court stated: "The deliberate care with which ERISA's civil enforcement remedies were drafted and the balancing of policies embodied in its choice of remedies argue strongly for the conclusion that ERISA's civil enforcement remedies were intended to be exclusive. This conclusion is fully confirmed by the legislative history of the civil enforcement provision." (At 54.) Allowing the *Wurtz* decision to stand will frustrate one of the basic policies of ERISA which is to "help administrators, fiduciaries and participants to predict the legality of proposed actions without the necessity of reference to varying state laws" (*Dedeaux*, p.56)

IV. The Second Circuit Ruling Undermines ERISA Reimbursement Cases

ERISA reimbursement and subrogation claims are not new to this Court. However, the Second Circuit decision has ignored the precedent established in the developed body of case law. When an ERISA plan sought to enforce the terms of its reimbursement provisions in *Great-West Life & Annuity Ins. Co. v Knudson*, 534 U.S. 708 (2002), this Court addressed the issue of whether Sec. 502(a)(3) of ERISA allowed the plan to seek reimbursement after a third party settlement. Justice Scalia cited several cases of developed ERISA law serving as strong evidence that "Congress did *not* intend to authorize other remedies that it simply forgot to incorporate [into ERISA] expressly." (*Knudson*, p. 712, emphasis in original.) In

reviewing the relief expressly authorized by Sec. 502(a)(3), the Court discusses what is and what is not authorized relief under the statute. Because the ERISA plan sought relief that could not be categorized as "appropriate equitable relief," it was seeking something outside of the contemplation of Congress's intended and limited relief; therefore, such relief was not allowed. *Knudson* noted that the only relief that Congress authorized for an ERISA plan is under Sec. 502(a)(3). *Knudson*, p. 221. If the plan itself can only enforce its reimbursement rights under federal law, it is illogical that a plan member seeking to escape those same plan provisions can seek relief under state law, as the Second Circuit ruled below.

The decision in *Sereboff v. Mid Atlantic Medical Services. Inc*., 547 U.S. 356 (2006) further defined an ERISA plan's rights of enforcing a reimbursement provision after a third party settlement. A unanimous court held that an ERISA plan seeks appropriate equitable relief when it seeks to impose a constructive trust and equitable lien by agreement over settlement funds from a third party. The decision relied heavily upon the case of *Barnes v Alexander*, 232 U.S. 117, 119 (1914), citing "the familiar rul[e] of equity that a contract to convey a specific object even before it is acquired will make the contractor a trustee as soon as he gets a title to the thing." In applying *Barnes*, the *Sereboff* court ruled that the ERISA plan could "'follow' a portion of the recovery 'into the [Sereboffs'] hands' 'as soon as [the settlement fund] was identified,' and impose on that portion a constructive trust or equitable lien." *Sereboff*, p. 364, internal citations omitted. Thus, since *Sereboff* holds that the ERISA plans' constructive trusts and equitable liens by agreement

were imposed against the settlement funds at the moment the funds were identified, how could the plan members represented by Wurtz then seek to obtain legal relief under state law to reverse the constructive trusts and equitable liens? Allowing such action renders the *Sereboff* holding irrelevant and unenforceable for ERISA plans.

The most recent Supreme Court decision addressing an ERISA plan's right of reimbursement is *US Airways v. McCutchen*, 133 S.Ct. 1537 (2013). While disagreeing on the law as applied to the specific facts at issue, the Court was unanimous in its holding that equitable arguments do not overrule the clear terms of an ERISA plan. The ERISA plan provided for an equitable lien by agreement in its requirement that plan members reimburse it upon receipt of third party settlement funds. Again relying upon *Barnes*, the Court stated that "enforcing the lien means holding the parties to their mutual promises…. Conversely, it means declining to apply rules…at odds with the parties' expressed commitments." *McCutchen*, p. 1746. Under *McCutchen*, the clear terms of an ERISA plan are to be enforced as written, yet the Second Circuit decision prevents the ERISA plans from enforcing their clear terms of reimbursement from third party settlements.

If the underlying appellate decision is allowed to stand, ERISA plans in the Third, Fourth and Fifth Circuits are allowed to enforce their reimbursement provisions under *Knudson*, *Sereboff*, and *McCutchen*, but those ERISA plans in the Second Circuit cannot. Such a result sets up a disagreement among the

circuits, which this Court should address by granting certiorari.

CONCLUSION

For these reasons stated herein, petition for a writ of certiorari should be granted.

Respectfully submitted,

Laura D. Schmidt
Counsel of Record
DOWNS STANFORD, P.C.
2001 Bryan St.,Suite 4000
Dallas, TX 75093
(214) 748-7900
lschmidt@downsstanford.com

John D. Kolb
GIBSON & SHARPS, PSC
9420 Bunsen Parkway
Suite 250
Louisville, KY 40220

Daran P. Kiefer
KREINER & PETERS CO., L.P.A.
2570 Superior Avenue
Suite 401
Cleveland, OH 44114

Bryan B. Davenport
LAW OFFICES OF BRYAN B.
DAVENPORT, P.C.
160 Fairway Lakes Drive
Franklin, IN 46131

Counsel for Amici Curiae