IN THE SUPREME COURT FOR THE STATE OF ALASKA

THOMAS J. KNOLMAYER, M.D., ALASKA TRAUMA AND ACUTE CARE SURGERY, LLC, Petitioners, v. CHARINA MCCOLLUM, JASON MCCOLLUM, Respondents.	)	Supreme Court Case No. S-17792

Superior Court Case No. 3AN-16-04601 CI

ON PETITION FOR REVIEW FROM THE SUPERIOR COURT FOR THE STATE OF ALASKA, THIRD JUDICIAL DISTRICT AT ANCHORAGE, HERMAN WALKER, JUDGE

BRIEF OF PETITIONERS THOMAS J. KNOLMAYER, MD, AND ALASKA TRAUMA AND ACUTE CARE SURGERY, LLC

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the STATE OF ALASKA

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Alaska Statutes

Sec. 09.17.010. Noneconomic damages.
(a) In an action to recover damages for personal injury or wrongful death, all damage claims for noneconomic losses shall be limited to compensation for pain, suffering, inconvenience, physical impairment, disfigurement, loss of enjoyment of life, loss of consortium, and other nonpecuniary damage.

(b) Except as provided under (c) of this section, the damages awarded by a court or a jury under (a) of this section for all claims, including a loss of consortium claim, arising out of a single injury or death may not exceed $400,000 or the injured person's life expectancy in years multiplied by $8,000, whichever is greater.

(c) In an action for personal injury, the damages awarded by a court or jury that are described under (b) of this section may not exceed $1,000,000 or the person's life expectancy in years multiplied by $25,000, whichever is greater, when the damages are awarded for severe permanent physical impairment or severe disfigurement.

(d) Multiple injuries sustained by one person as a result of a single incident shall be treated as a single injury for purposes of this section.

Sec. 09.17.070. Collateral benefits.
(a) After the fact finder has rendered an award to a claimant, and after the court has awarded costs and attorney fees, a defendant may introduce evidence of amounts received or to be received by the claimant as compensation for the same injury from collateral sources that do not have a right of subrogation by law or contract.

(b) If the defendant elects to introduce evidence under (a) of this section, the claimant may introduce evidence of

> **(1)** the amount that the actual attorney fees incurred by the claimant in obtaining the award exceed the amount of attorney fees awarded to the claimant by the court; and
>
> **(2)** the amount that the claimant has paid or contributed to secure the right to an insurance benefit introduced by the defendant as evidence.

(c) If the total amount of collateral benefits introduced as evidence under (a) of this section exceeds the total amount that the claimant introduced as evidence under (b) of this section, the court shall deduct from the total award the amount by which the value of the

nonsubrogated sum awarded under (a) of this section exceeds the amount of payments under (b) of this section.

(d) Notwithstanding (a) of this section, the defendant may not introduce evidence of

(1) benefits that under federal law cannot be reduced or offset;

(2) a deceased's life insurance policy; or

(3) gratuitous benefits provided to the claimant.

(e) This section does not apply to a medical malpractice action filed under AS 09.55.

(f) Notwithstanding any other provision of this section, if the teachers' retirement system (AS 14.25) or the public employees' retirement system (AS 39.35) obtains an award of damages or other recovery in compensation for harms caused by the wrongful or negligent conduct of a third party, the award of damages or other recovery is not subject to reduction under this section on account of additional state contributions under AS 14.25.085 or AS 39.35.280.

Sec. 09.55.548. Awards, collateral source.
(a) Damages shall be awarded in accordance with principles of the common law. The fact finder in a malpractice action shall render any award for damages by category of loss. The court may enter a judgment that future damages be paid in whole or in part by periodic payments rather than by a lump-sum payment; the judgment must include, if necessary, other provisions to assure that funds are available as periodic payments become due. Insurance from an authorized insurer as defined in AS 21.97.900 is sufficient assurance that funds will be available. Any part of the award that is paid on a periodic basis shall be adjusted annually according to changes in the consumer price index in the community where the claimant resides. In this subsection, "future damages" includes damages for future medical treatment, care or custody, loss of future earnings, or loss of bodily function of the claimant.

(b) Except when the collateral source is a federal program that by law must seek subrogation and except death benefits paid under life insurance, a claimant may only recover damages from the defendant that exceed amounts received by the claimant as compensation for the injuries from collateral sources, whether private, group, or governmental, and whether contributory or noncontributory. Evidence of collateral sources, other than a federal program that must by law seek subrogation and the death benefit paid under life insurance, is admissible after the fact finder has rendered an award. The court may take into account the value of claimant's rights to coverage exhausted or depleted by payment of these collateral benefits by adding back a reasonable estimate of their probable value, or by earmarking and holding for possible periodic payment under (a)

of this section that amount of the award that would otherwise have been deducted, to see if the impairment of claimant's rights actually takes place in the future.

Sec. 09.55.549. Limitation on damages from health care provider's services.
(a) Notwithstanding AS 09.17.010, noneconomic damages for personal injury or death based on the provision of services by a health care provider may only be awarded as provided in this section.

(b) In an action to recover damages for personal injury or wrongful death based on the provision of services by a health care provider, damages may include both economic and noneconomic damages.

(c) Damage claims for noneconomic losses shall be limited to compensation for pain, suffering, inconvenience, physical impairment, disfigurement, loss of enjoyment of life, loss of consortium, and other nonpecuniary damage, but may not include hedonic damages.

(d) Except as provided in (e) of this section, the damages awarded by a court or a jury under (c) of this section for all claims including a loss of consortium claim or other derivative claim arising out of a single injury may not exceed $250,000 regardless of the number of health care providers against whom the claim is asserted or the number of separate claims or causes of action brought with respect to the injury.

(e) The damages awarded by a court or jury under (c) of this section for all claims including a loss of consortium claim or other derivative claim arising out of a single injury or death may not exceed $400,000 regardless of the number of health care providers against whom the claim is asserted or the number of separate claims or causes of action brought with respect to the injury or death when damages are awarded for wrongful death or severe permanent physical impairment that is more than 70 percent disabling.

(f) The limitation on noneconomic damages in this section does not apply if the damages resulted from an act or omission that constitutes reckless or intentional misconduct.

(g) Multiple injuries sustained by one person as a result of a single course of treatment shall be treated as a single injury for purposes of this section.

(h) In this section,

(1) "economic damages" means objectively verifiable monetary losses incurred as a result of the provision of, use of, or payment for, or failure to provide, use, or pay for health care services or medical products, and includes past and future medical expenses, loss of past and future earnings, cost of obtaining domestic services,

burial expenses, loss of use of property, cost of replacement or repair, loss of employment, and loss of business or employment opportunities;

(2) "health care provider" has the meaning given in AS 09.55.560 and includes a state agency or municipality the health care services of which are the subject of an action that is subject to this section;

(3) "hedonic damages" means damages that attempt to compensate for the pleasure of being alive.

United States Codes

5 U.S.C. § 8902. Contracting authority
(m)
(1) The terms of any contract under this chapter [5 USCS §§ 8901 et seq.] 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.

29 U.S.C. § 1003. Coverage
(a) In general. Except as provided in subsection (b) or (c) and in sections 201, 301, and 401 [29 USCS §§ 1051, 1081, and 1101], this title shall apply to any employee benefit plan if it is established or maintained—

(1) by any employer engaged in commerce or in any industry or activity affecting commerce; or

(2) by any employee organization or organizations representing employees engaged in commerce or in any industry or activity affecting commerce; or

(3) by both.

(b) Exceptions for certain plans. The provisions of this title shall not apply to any employee benefit plan if—

(1) such plan is a governmental plan (as defined in section 3(32) [29 USCS § 1002(32)]);

(2) such plan is a church plan (as defined in section 3(33) [29 USCS § 1002(33)]) with respect to which no election has been made under section 410(d) of the Internal Revenue Code of 1986 [26 USCS § 410(d)];

(3) such plan is maintained solely for the purpose of complying with applicable workmen's compensation laws or unemployment compensation or disability insurance laws;

(4) such plan is maintained outside of the United States primarily for the benefit of persons substantially all of whom are nonresident aliens; or

(5) such plan is an excess benefit plan (as defined in section 3(36) [29 USCS § 1002(36)]) and is unfunded.

The provisions of part 7 of subtitle B [29 USCS §§ 1181 et seq.] shall not apply to a health insurance issuer (as defined in section 733(b)(2) [29 USCS § 1191b(b)(2)]) solely by reason of health insurance coverage (as defined in section 733(b)(1) [29 USCS § 1191b(b)(1)]) provided by such issuer in connection with a group health plan (as defined in section 733(a)(1) [29 USCS § 1191b(a)(1)]) if the provisions of this title do not apply to such group health plan.

(c) Voluntary employee contributions to accounts and annuities. If a pension plan allows an employee to elect to make voluntary employee contributions to accounts and annuities as provided in section 408(q) of the Internal Revenue Code of 1986 [26 USCS § 408(q)], such accounts and annuities (and contributions thereto) shall not be treated as part of such plan (or as a separate pension plan) for purposes of any provision of this title other than section 403(c), 404, or 405 [29 USCS § 1103(c), 1104, or 1105] (relating to exclusive benefit, and fiduciary and co-fiduciary responsibilities) and part 5 (relating to administration and enforcement). Such provisions shall apply to such accounts and annuities in a manner similar to their application to a simplified employee pension under section 408(k) of the Internal Revenue Code of 1986 [26 USCS § 408(k)].

29 U.S.C. § 1144. Other laws

(a) Supersedure; effective date. Except as provided in subsection (b) of this section, the provisions of this title and title IV shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 4(a) [29 USCS § 1003(a)] and not exempt under section 4(b) [29 USCS § 1003(b)]. This section shall take effect on January 1, 1975.

42 U.S.C. § 1396a. State plans for medical assistance.

(a) Contents. A state plan for medical assistance must -

(25) provide—

...

(B) that in any case where such a legal liability is found to exist after medical assistance has been made available on behalf of the individual and where the amount

of reimbursement the State can reasonably expect to recover exceeds the costs of such recovery, the State or local agency will seek reimbursement for such assistance to the extent of such legal liability;

Constitutional Provisions

Alaska Const. art. I
Section 1. Inherent Rights.
This constitution is dedicated to the principles that all persons have a natural right to life, liberty, the pursuit of happiness, and the enjoyment of the rewards of their own industry; that all persons are equal and entitled to equal rights, opportunities, and protection under the law; and that all persons have corresponding obligations to the people and to the State.

Section 7. Due Process.
No person shall be deprived of life, liberty, or property, without due process of law. The right of all persons to fair and just treatment in the course of legislative and executive investigations shall not be infringed.

JURISDICTIONAL STATEMENT

This is a petition for review of the trial court's April 30, 2020 order regarding application of AS 09.55.548(b) to this medical malpractice case. [Exc. 283-307] Because the April 30 order vacated prior orders (dated October 1, 2018 and June 25, 2019) on the same issue, those orders are called into question as well. [Exc. 162-72 & 193-96] This Court has jurisdiction pursuant to Appellate Rule 402 for interim review of an order that is not appealable under Rule 202.

STATEMENT OF THE ISSUES PRESENTED FOR REVIEW

1. Whether the trial court erred in holding that Ms. McCollum's health insurance plan obtained through and funded by a private employer is a "federal program that by law must seek subrogation" under AS 09.55.548(b)?

2. Whether AS 09.55.548(b) bars a medical malpractice plaintiff from seeking recovery of an insurer's contractually subrogated claim for medical payments made on behalf of the plaintiff?

3. Whether an insurer can assign a contractually subrogated claim to a plaintiff for collection purposes in a medical malpractice lawsuit, and whether such an assignment was made here?

4. Whether AS 09.55.548(b) violates the Alaska Constitution's due process or equal protection guarantees if applied to a plaintiff whose insurer has contractual subrogation rights to collect from the plaintiff's recovery against a medical malpractice defendant? Or does applying AS 09.55.548(b) to a plaintiff whose insurer has contractual

subrogation rights to collect from the plaintiff's recovery require that such subrogation rights be invalidated?

5. Whether the Employee Retirement Income Security Act of 1974 preempts AS 09.55.548(b)?

STATEMENT OF THE CASE

A. Substantive Facts

This case arises out of the emergent removal of Charina McCollum's very diseased gallbladder by Thomas Knolmayer, MD, at Providence Alaska Medical Center on May 9, 2015. Dr. Knolmayer discovered at surgery that Ms. McCollum's anatomy (with extensive inflammation, dense adhesions, pus and necrotic tissue) presented a more difficult case than was shown on the prior ultrasound. Nevertheless, Dr. Knolmayer believed the surgery was successful upon its completion. Unfortunately, it was later discovered that the wrong duct had been cut.

Ms. McCollum filed this medical malpractice action on February 3, 2016, alleging Dr. Knolmayer fell below the standard of care in removing her gallbladder. [Exc. 1-3] Dr. Knolmayer admits he mistakenly cut the wrong duct, but denies the allegations of negligence and that he fell below the standard of care, maintaining that the error occurred because of a misperception of Ms. McCollum's difficult anatomy, a recognized complication of gallbladder surgery. [Exc. 4-5]

Ms. McCollum seeks to recover economic damages (including past medical expenses, future medical expenses, and past lost wages), noneconomic damages for pain and suffering, punitive damages, prejudgment interest, costs and attorney's fees. [Exc. 2-

3] She also alleges Dr. Knolmayer acted recklessly, which, if proven, would allow Ms. McCollum to recover unlimited noneconomic damages. [Exc. 2-3] [1]

Ms. McCollum alleges her past medical expenses total $554,212,08. [Exc. 206] This includes $349,049.87 paid by health insurance obtained through Ms. McCollum's (then) husband's employer, Lowe's Companies, Inc. pursuant to a benefits plan entitled "The Lowe's Companies, Inc. Welfare Benefits Plan" (hereafter "the Plan"). [Exc. 8] The Plan is a self-funded health benefits plan that is sponsored and administered by Lowe's Companies, Inc., meaning, all benefits are paid from the general assets of Lowe's. [Exc. 108] The Plan is administered by Meritain Health, Inc. in accordance with the Employee Retirement Income Security Act of 1974. [Exc. 92, 101 & 108]

The Plan contains a "Subrogation, Third-Party Recovery and Reimbursement" clause that provides in relevant part:

> **Payment Condition**
>
> .....
>
> (3) In the event a Covered Person settles, recovers or is reimbursed by any coverage, the Covered Person agrees to reimburse the Plan for all benefits paid by the Plan on behalf of the Covered Person. ...
>
> .....
>
> **Subrogation**
>
> (1) As a condition to participation in and receiving benefits under this Plan, the Covered Person agrees to assign to the Plan the right to subrogate any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and

[1] *See* AS 09.55.549(f)("The limitation on noneconomic damages in this section does not apply if the damages resulted from an act or omission that constitutes reckless or intentional misconduct.").

to any coverage to which the Covered Person is entitled, regardless of how classified or characterized, at the Plan's discretion.

(2) If a Covered Person receives or becomes entitled to receive benefits, an automatic equitable subrogation lien attaches in favor of the Plan to any claim, which any Covered Person may have against any coverage and/or party causing the Illness or Injury to the extent of such conditional payment by the Plan plus reasonable costs of collection.

(3) The Plan ***may, at its discretion***, in its own name or in the name of the Covered Person, commence a proceeding or pursue a claim against any party or coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.

.....

Right of Reimbursement

(1) The Plan shall be entitled to recover 100% of the benefits paid, without deduction for attorneys' fees and costs or application of the common fund doctrine, make whole doctrine or any other similar legal theory, without regard to whether the Covered Person is fully compensated by his or her recovery from all sources. ... If the Covered Persons' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved.

[Exc. 88-89 (bold italics added)] The Plan also has a "Conformity with Applicable Laws" provision that states: "It is intended that the Plan will conform to the requirements of any applicable federal or state law." [Exc. 102]

The PHIA Group represents the Plan and its claims administrator with respect to its reimbursement and subrogation matters. [Exc. 277] Shortly after Ms. McCollum initiated this action, the PHIA Group sent a letter to Ms. McCollum's attorney, advising that at the time of settlement or resolution of this case, it would seek "full reimbursement" of medical expenses paid by the Plan:

> The Plan has a subrogation, reimbursement, and/or third party recovery provision requiring full ***reimbursement*** of all related claims paid by the Plan upon settlement of this claim. … In accordance with the Plan's rights, ***at the time of settlement or resolution of any underlying claims, we will seek full reimbursement*** of all related claims paid by the Plan.

[Exc. 277 (emphasis added)]

B. Procedural History

Ms. McCollum filed a "Motion for Ruling of Law on Recoverability of Medical Expenses Paid by ERISA Plan," asserting that the terms of the Plan require her to assert the Plan's claim in this action, and she sought a ruling that AS 09.55.548 was preempted by ERISA. [Exc. 8-15] Dr. Knolmayer opposed and cross-moved for a ruling of law that ERISA does *not* preempt AS 09.55.548. [Exc. 114-23] The sole issue argued by the parties was whether ERISA preempted AS 09.55.548.[2] Neither party argued that the Plan was a federal program that by law must seek subrogation. Instead, by virtue of litigating whether ERISA preempts AS 09.55.548, the parties assumed and understood that the Plan was ***not*** a federal program that by law must seek subrogation.[3] Additionally, Dr. Knolmayer argued that the statute was constitutional, which was not challenged by Ms. McCollum. [Exc. 117]

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[2] Ms. McCollum argued "The issue for the Court to decide is not what is the correct interpretation of AS 09.55.548(b), but rather whether that statute is pre-empted by the federal ERISA statutes… [Exc. 14]

[3] If the Plan was such a "federal program," then AS 09.55.548(b) would not apply, mooting any preemption issue.

In support of his opposition and cross-motion, Dr. Knolmayer submitted an order by Judge Kauvar in *French, et al. v. McIntyre, M.D.*, Case No. 4FA-14-01377 CI, another medical malpractice case similarly involving payment of a plaintiff's medical expenses by an ERISA plan. [Exc. 150-61] The trial court in *French* held that AS 09.55.548(b) applies to the plaintiff's ERISA health plan, ERISA does not preempt AS 09.55.548(b), and the plaintiff cannot recover the expenses paid by his plan. In so holding, the Judge Kauvar explained in part:

> This is a medical malpractice action, and neither party claims that Plaintiff's health plan is a federal program which by law must seek subrogation. Although Plaintiff's Plan is regulated by ERISA, ERISA by definition applies only to some private sector employee benefit plans, not to plans established or maintained by government entities. [ ] Therefore, Plaintiff's plan is not a federal program which by law must seek subrogation, and the damages in this case are governed by AS 09.55.548(b).

[Exc. 156-57] Judge Kauvar held further that ERISA did not preempt AS 09.55.548(b) because the statute did "not directly prohibit ERISA plans from seeking subrogation; it only limits the amount plaintiffs can recover in medical malpractice actions." [Exc. 158]

Oral argument was held on Ms. McCollum's motion and Dr. Knolmayer's cross-motion on July 24, 2018. Consistent with the parties' briefing, both parties argued with the understanding that the Plan was not a federal program that by law must seek subrogation, and that the statute applied unless it was preempted by ERISA. [Tr. 7/24/18 Oral Arg. at 29:8-39:23] Dr. Knolmayer expressly argued that the Plan is "not a federal program that by law must seek subrogation… And the constitutionality of the statute was upheld by the Alaska Supreme Court in Reid versus Williams." [*Id.* at 38:12-20] Ms.

McCollum did not dispute those propositions. [*Id.* at 41:8-47:22] Her counsel clearly asserted twice that he represented the Plan as well as Ms. McCollum. [*Id.* at 6:21-23 & 17:22-23]

On October 1, 2018, Judge Walker entered an "Order Holding That ERISA Does Not Preempt AS 09.55.548." [Exc. 162-72] The trial court reasoned that the statute "does not address plan structure, and does not either directly or indirectly prevent a plan from seeking subrogation." [Exc. 170] The trial court further held that "[t]he statute does not prevent plaintiffs from presenting the evidence of the medical expenses to the jury." [*Id.*] However, instead of reducing Dr. Knolmayer's liability for those medical expenses, the Court would set aside that money to reimburse the Plan in a post-trial hearing. [Exc. 171] Dr. Knolmayer moved for reconsideration of the second part of the order. [Exc. 173-78]

After granting partial reconsideration, the trial court entered an order on June 25, 2019 vacating the portion of its prior order that would set aside medical expenses awarded by the jury in a post-trial procedure to award them directly to the non-party Plan. [Exc. 187-90] The trial court explained that AS 09.55.548(b) forecloses *Plaintiff* from recovering the amounts paid by the Plan, but that AS 09.55.548(b) did not prevent the Plan from recovering as a party itself:

> ...nothing in AS 09.55.548(b) prevents the Plan from recovering on its subrogated interest as a party itself; the statute bars recovery by Plaintiff, not collateral sources. The Plan may thus recover against Defendants by joining this action or, as Defendants suggested in their briefing, by bringing its own action against Defendants.

[Exc. 189]

Ms. McCollum then moved for clarification as to whether she could obtain an assignment from the Plan to pursue their medical costs. [Exc. 191] For her proposed order, Ms. McCollum sought the following relief:

> (1) Plaintiff can obtain an Assignment and proceed as Assignee of the Plan (Assignor) to recover medical cost or alternatively,
>
> (2) The Plan can join the action. The statute of limitations will not apply to the Plan in joining the action.
>
> (3) If the Plan, plaintiff and counsel agree, plaintiff counsel can represent the Plan and plaintiff.

[Exc. 197]

Dr. Knolmayer opposed, arguing the relief Ms. McCollum sought amounted to an advisory opinion. [Exc. 198-200] The trial court agreed with Dr. Knolmayer and denied Ms. McCollum's motion on August 27, 2019. [Exc. 202-03]

On October 7, 2019, Ms. McCollum filed a "Notice to Court" advising that she had agreed to an assignment from the Plan, but that "[t]he actual assignment will be completed in the near future." [Exc. 204] Ms. McCollum did not identify what she was going to be assigned or any of the terms of the assignment, and she conceded she was "not interested in finalizing an assignment which will have no legal effect." [Exc. 236] She again sought a ruling as to whether an assignment would be valid; if not, she would seek an involuntary joinder of the Plan, PHIA. [*Id.*] Dr. Knolmayer responded, arguing that an assignment would have no impact on the court's application AS 09.55.548(b). [Exc. 222-23]

Ms. McCollum also filed a motion on October 7, 2019 seeking a ruling that she could recover the difference between the amount of medical expenses billed ($554,212.08) and the amount paid ($349,049.87). [Exc. 206] Relying on *Weston v. AKHappytime, LLC,* 445 P.3d 1015, 1019 (Alaska 2019), Ms. McCollum argued that the total amount of medical expenses billed is recoverable, even if that amount exceeds the amount ultimately paid in satisfaction of those bills. [Exc. 206-07] Dr. Knolmayer opposed, arguing this court held in *Weston* that the amount billed is admissible, but not necessarily recoverable. [Exc. 225-28]

On November 4, 2019, Ms. McCollum moved for a stay and continuance, claiming there was still "uncertainty" as to whether the ERISA lien can be assigned, and that she intended to file a declaratory judgment action in federal court within the next ten days. [Exc. 237-38] Ms. McCollum's counsel stated in an affidavit: "it is the understanding of the plaintiff that the Plan does not want to voluntarily join the action." [Exc. 242] She also sought expedited consideration of the motion. [Exc. 245] On the same date, however, Ms. McCollum moved for an order involuntarily joining PHIA as a co-plaintiff in this case. [Exc. 247]

Dr. Knolmayer opposed the motions, arguing there was not good cause to continue trial (then scheduled to begin in less than one month), and that a partially-subrogated insurer such as PHIA cannot be forced to bring a direct claim against Defendants. [Exc. 255 & 270-75]

At a pretrial conference on November 20, 2019, counsel represented that he has "been preparing a declaratory judgment action that [he was] going to file next week in –

federal court. ... Because [he] was hoping to have a decision on...the preemption issue out of federal court one way or the other before we go to trial." [Tr. 11/20/19 Hrg. at 6:3-13]

On April 30, 2020, the trial court denied Ms. McCollum's motion for recoverability of medical expenses not paid by ERISA, reserving the right to address the question of recoverability *if* the jury finds for Ms. McCollum. [Exc. 283-307] Believing there to be confusion regarding the court's earlier orders, however, the trial court found "that it misstated the procedural applicability of AS 09.55.548" and vacated its prior orders. [Exc. 283 & 289] In sum, the trial court held that AS 09.55.548 applies to this action and is not preempted by ERISA (as it had before). [Exc. 290-305] However, the trial court found that the amounts paid by the Plan are exempt from AS 09.55.548 because "Ms. McCollum's federally-governed self-funded insurance plan is a 'federal program that by law must seek subrogation' under AS 09.55.548." [Exc. 302-03] The trial court did not cite any legal authority for its finding, and instead relied only on the letter from the Plan's administrator and the language in the Plan. [*Id.*]

On May 6, 2020, the trial court denied Ms. McCollum's motion to join PHIA as well as her motion for a stay and continuance, reasoning in part:

> Ms. McCollum and the insurance plan have a contractual relationship that is distinct and separate for this law suit. While the amount of McCollum's obligation to the insurance plan will be impacted by the outcome of this case, it would be a conflation of issues for the Court to say that disposition of this action in the insurance plan's absence would impair the insurance plan's ability to protect its contractual interest. That is simply untrue.

[Exc. 315]

Ms. McCollum never completed the purported assignment, nor did she file a declaratory judgment action in the federal court. The Plan – whether through the Lowe's Companies, Inc., PHIA or otherwise – has never appeared in this litigation in order to comment on its reimbursement or subrogation rights, even though this court invited it to file a brief as an amicus curiae.

STANDARD OF REVIEW

The interpretation of a statute is a question of law that is reviewed de novo.[4] Issues of constitutional interpretation are also questions of law that are reviewed de novo.[5] Under this standard, the supreme court independently reviews the matter and adopts the rule that is most persuasive in light of precedent, policy, and reason.[6]

ARGUMENT

At common law, the collateral source rule "prohibits the reduction of a plaintiff's damages when he has received compensation from another source."[7] This allowed plaintiffs to recover damages from a defendant even if those injuries have already been compensated by health insurance.[8] However, the Alaska legislature has modified the common law collateral source rule (in nonmedical malpractice cases) by enacting AS

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[4] *Kodiak Island Borough v. Roe*, 63 P.3d 1009, 1012 n.6 (Alaska 2003)(citing *Guin v. Ha*, 591 P.2d 1281, 1284 n.6 (Alaska 1979)).

[5] *Andrews v. Alaska Operating Engineers-Employers Training Trust Fund*, 871 P.2d 1142, 144 (Alaska 1994)(citation omitted).

[6] *Id; see also,* n.4, *supra.*

[7] *Tolan v. ERA Helicopters, Inc.*, 699 P.2d 1265, 1267 (Alaska 1985).

[8] *Id.*

09.17.070, which "allows the court to reduce an injured party's jury award to reflect unsubrogated collateral source payments in some circumstances."[9]

The legislature enacted a separate collateral source statute for medical malpractice actions such as this one, AS 09.55.548(b).[10] AS 09.55.548(b) (hereafter "the statute" or "the Alaska statute") precludes a medical malpractice plaintiff from recovering damages that were paid by certain collateral sources. The statute provides:

> ***(b) Except when the collateral source is a federal program that by law must seek subrogation*** and except death benefits paid under life insurance, ***a claimant may only recover damages from the defendant that exceed amounts received by the claimant as compensation for the injuries from collateral sources, whether private,*** group or governmental, and whether contributory or noncontributory. ***Evidence of collateral sources, other than a federal program that must by law seek subrogation*** and the death benefit paid under life insurance, ***is admissible after the fact finder has rendered an award.*** The court may take into account the value of claimant's rights to coverage exhausted or depleted by payment of these collateral benefits by adding back a reasonable estimate of their probable value, or by earmarking and holding for possible periodic payment under (a) of this section that amount of the award that would otherwise have been deducted, to see if the impairment of claimant's rights actually takes place in the future.

(emphasis added).

The statute "was enacted in 1976 as part of a comprehensive medical malpractice reform package intended to alleviate a perceived crisis in medical malpractice insurance costs."[11] [T]hroughout the whole country, malpractice insolvency, retrenching insurance markets, extraordinary rate increases, growing malpractice judgments and rapidly

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[9] *Chenega Corp. v. Exxon Corp.*, 991 P.2d 769, 791 (Alaska 1999).

[10] AS 09.17.070(e) expressly states that AS 09.17.070 "does not apply to a medical malpractice action filed under AS 09.55."

[11] *Reid*, 964 P.2d at 456.

increasing frequency of litigation was precipitating crises and legislative review at the federal level and in all states." [Appx. A-12] "[I]ndividual medical practitioners were expressing concern over the economic impact of the higher rates and restricted coverage on their own personal estates and making public announcements of discontinuing medical service unless relief was obtained." [*Id.*] "[P]hysicians, surgeons and hospitals of the State of Alaska [were] experiencing growing difficulties in procuring adequate insurance coverage for their malpractice exposures." [Appx. A-11] By January of 1975, "it became apparent to the medical community in this State that legislative relief was required." [Appx. A-12] "Several surgeons and anesthesiologists had ceased performing routine surgery...and public concern was growing." [Appx. A-17] In July 1975, Governor Hammond appointed a representative group of Alaska citizens to serve on a Commission to address the issue. [Appx. A-13 & A-1] The Commission ultimately decided to create a "permanent plan for improving the whole method of controlling, determining and indemnifying medical negligence." [*Id.*] The Commission held at least twenty-four meetings (totaling 162 hours over 64 days), took oral testimony from fifty persons, and received substantial written material. [Appx. A-16]

On October 1, 1975, the Commission issued a report containing twenty-seven recommendations governing the substantive law and procedures for medical malpractice actions. [Appx. A] These recommendations included, *inter alia*, limiting the discovery period for the purpose of the statute of limitations, reducing jury awards, controlling legal fees, precluding certain liability, defining the standard of care, modifying the burden of proof, using an expert medical panel, and so on. [*Id.*] The second recommendation –

reducing ultimate awards - eventually became AS 09.55.548(b). [Appx. A-28-30] In making its recommendation, the Commission studied several proposals that would reduce the size of awards, including "limits on total awards, limits on general damages, scheduled benefits and several variations of each of these concepts." [Appx. A-28] However, the Commission rejected arbitrary limits on awards, reasoning that the amount of the reduction would be "speculative at best," and seriously injured persons may not be adequately compensated. [Appx. A-28-29] Instead, the Commission chose to reduce jury awards by the amount of collateral sources. [Appx. A-29] In so doing, the Commission considered how compensation from collateral sources allows a plaintiff a double recovery and presents "additional complications of subrogation and collateral source liens." [*Id.*] Thus, the Commission was mindful of "how to approach eliminating the double recovery or subrogation problem" when it recommended:

> Any award to which the injured patient is entitled should be reduced by all available collateral sources such as private, group or governmental medical or disability benefits whether contributory or noncontributory, except life insurance, by precluding the introduction into evidence of the items of damage compensated by collateral sources, except federal programs which by law must seek subrogation.

[Appx. A-29-30] On October 31, 1975, the Commission submitted a supplement with draft proposed legislation. [Appx. B] The collateral source rule read:

> Except when the collateral source is a federal program which, by law, must seek subrogation, an award to which a claimant is entitled may only cover damages which exceed any amounts received by the claimant, as compensation for his injuries, from collateral sources, whether private, group, or governmental, and whether contributory or non-contributory, except life insurance. Evidence of damages compensated by a collateral source, other than a federal program which must seek subrogation, is not admissible. **Notwithstanding**

> **other provisions of state law, and except as provided in this subsection, a collateral source does not have a right of subrogation.**

[Appx. B-22-23 (emphasis added)]. However, when the legislature enacted AS 09.55.548(b), it did not include the Commission's proposal to eliminate subrogation rights.

The trial court recognized that the legislative history of the bill indicates that elimination of subrogation rights was considered but ultimately rejected. [Exc. 189] The court correctly ruled that that the statute was not preempted by ERISA because the statute did not eliminate the Plan's subrogation rights. [*Id.*] However, the trial court erred when it held that the Plan is a federal program that by law must seek subrogation. This court should find that the statute is constitutional, not preempted by ERISA, and applies to the benefits paid by the Plan.

I. THE TRIAL COURT ERRED BY FINDING THAT THE PLAN IS A "FEDERAL PROGRAM THAT BY LAW MUST SEEK SUBROGATION"

Without citing any legal or evidentiary support whatsoever, the trial court concluded that the Plan is a "federal program" merely because it is governed by ERISA. [Exc. 302-03] While the Plan is governed by a federal *law* (ERISA), that does not mean the Plan is a federal *program*. Rather, the Plan itself is a private, not federal, program. The Lowe's Companies, Inc. Welfare Benefits Plan is a health insurance plan obtained through Mr. McCollum's employer, Lowe's Companies, Inc., which is a private employer,[12] and all benefits paid under the Plan are from the general assets of Lowe's.

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[12] *EEOC v. Lowe's Cos.*, 1982 U.S. Dist. LEXIS 15041, *4 (W.D.N.C. May 28, 1982)(finding that Lowe's Companies, Inc. was a private employer subject to Title VII of the Civil Rights Act of 1964).

Citing ERISA, Judge Kauvar in *French v. McIntyre* recognized that although the plan in that case was "regulated by ERISA, ERISA by definition applies only to some private sector employee benefit plans, not to plans established or maintained by government entities." [Exc. 156-57]. Several other Courts have routinely recognized that ERISA plans are private health care plans.[13] Even the United States Department of Law's website defines ERISA as applying to health plans in the private industry: "The Employee Retirement Income Security Act of 1974 (ERISA) is a federal law that sets minimum standards for most voluntarily established pension and **health plans in private industry…**"[14] Accordingly, the Plan is not a "federal program."

Nor is the Plan "required by law to seek subrogation." The trial court did not cite any legal authority whatsoever in finding that the Plan is required to seek subrogation, and instead erroneously relied on the Plan language and a hearsay letter from the Plan administrator. [Exc. 302-03] The Plan is a contract, not a law. AS 09.55.548(b) only excludes a federal program that *by law* must seek subrogation. AS 09.17.070(a), Alaska's collateral source statute for non-medical malpractice civil actions, on the other hand, allows the court to reduce a plaintiff's

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[13] *Scudder v. Colgate Palmolive Co.*, 2017 U.S. Dist. LEXIS 83445, *13, 2017 WL 2367054 (D.N.J. May 31, 2017)("ERISA is a federal law that regulates private industry pension plans, retirement plans, profit-sharing plans, and health insurance coverage. For such plans, ERISA establishes rules and minimum standards that are meant to protect plan participants"); *Kennedy v. Lilly Extended Disability Plan*, 856 F.3d 1136, 1138 (7th Cir. 2017)(ERISA governs "voluntarily established health and pension plans in private industry"); *DB Healthcare, LLC v. Blue Cross Blue Shield of Ariz., Inc.*, 852 F.3d 868, 872, (9th Cir. 2017)(recognizing that ERISA "governs private employer plans"); *Botsford v. Blue Cross & Blue Shield of Mont., Inc.*, 314 F.3d 390, 398 (9th Cir. 2002)(citing 29 U.S.C. § 1003 (2002) for the proposition that "ERISA governs health plans meeting certain characteristics provided by any number of private employers").

[14] https://www.dol.gov/general/topic/health-plans/erisa (emphasis added).

jury award in certain situations by "collateral sources that do not have a right of subrogation by law *or contract*." (emphasis added). AS 09.17.070 was enacted in 1986 and amended in 2008 to add subsection (f).[15] AS 09.55.548 was enacted in 1976, and subsection (a) was amended in 1992 to make minor textual corrections.[16] The plain language of section 548(b) coupled with the fact that the legislature did not amend section 548(b) to include subrogation "by law *or contract*" when it amended section 548(a) or enacted AS 09.17.070 reflects a legislative intent for section 548(b) to apply only to a program that *by law* must seek subrogation. Therefore, a provision of ERISA itself must require plans to seek subrogation to fall under section 548(b)'s exception. However, nothing in ERISA requires plans to seek subrogation or reimbursement. Courts have recognized that ERISA is silent on these issues.[17]

Moreover, even if section 548(b) included subrogation "by contract" – as opposed to simply subrogation "by law" – the contract does not mandate subrogation. The subrogation clause in the Plan provides that it "may, at its discretion, … commence a proceeding or pursue a claim…" [Exc. 88] The term "may" denotes permissive authority and does not require the

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[15] *See* SLA 2008, ch. 13 § 2, eff. Apr. 9, 2008.

[16] *See* SLA 1992, ch. 30 § 7 (S.B. 399).

[17] *Hotel Employees & Restaurant Employees Int'l Union Welfare Fund v. Gentner,* 815 F.Supp. 1354, 1357 (D.Nev. 1993)("ERISA itself is silent on the issue of subrogation agreements"); *see also, Admin. Comm. v. Salazar*, 525 F.Supp.2d 1103, 1113 (D.Ariz. 2007)("It is true that ERISA does not address reimbursement of medical expenses paid out by a plan"); *see also, Member Servs. Life Ins. Co. v. Am. Nat'l. Bank & Trust Co. of Sapupla*, 130 F.3d 950, 958 (10th Cir. 1997)(quoting *Ryan v. Fed. Express Corp.*, 78 F.3d 123, 127 (3rd Cir. 1996) for the proposition that "ERISA says nothing about subrogation provisions. ERISA neither requires a welfare plan to contain a subrogation clause nor does it bar such clauses or otherwise regulate their content.").

Plan to seek subrogation.[18] If the contract intended a mandatory duty to seek subrogation, then it could have used the term "shall" or "will." Had the legislature intended the exception under AS 09.55.548(b) to apply to permissive rights as opposed to mandatory duties, it would have used the language "right of subrogation" as it did in AS 09.17.070, rather than "must seek subrogation" as used in AS 09.55.548(b). Exercising its permissive right, the Plan here has chosen to seek reimbursement from Ms. McCollum, rather than pursue a direct subrogation claim against Dr. Knolmayer.

A collateral source that would be considered "a federal program that by law must seek subrogation" would be Medicare or Medicaid.[19] For example, "[F]ederal law requires every [state participating in the Medicaid program] to implement a 'third party liability' provision which requires the state to seek reimbursement for Medicaid expenditures from third parties who are liable for medical treatment provided to a Medicaid recipient."[20] 42 U.S.C. § 1396(a)(25)(B) requires states or local agencies administering Medicaid plans to seek reimbursement:

> **(B)** that in any case where such a legal liability is found to exist after medical assistance has been made available on behalf of the individual and where the amount of reimbursement the State can reasonably expect to recover exceeds the costs of such recovery, the State or local agency

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[18] *See, e.g., Gerber v. Juneau Bartlett Mem. Hosp.*, 2 P.3d 74, 76 (Alaska 2000)("In contrast to the term 'shall,' the term 'may' generally denotes permissive or discretionary authority and not a mandatory duty.").

[19] *Waskey v. United States*, 2007 U.S.Dist. LEXIS 100190, *5, 2007 WL 898888 (D.Alaska March 23, 2007)(recognizing that AS 09.55.548(b) would not apply "if payment were made from a program like Medicare because it is a 'federal program that by law must seek subrogation.'").

[20] *Caremark, Inc. v. Goetz*, 395 F.Supp.2d 683, 686 (M.D.Tenn. 2005)(citing 42 U.S.C. § 1396a(a)(25)).

> ***will seek reimbursement*** for such assistance to the extent of such legal liability;[21]

The term "will" denotes mandatory action. Unlike Medicare and Medicaid laws, there is no provision in ERISA that addresses subrogation or reimbursement, let alone mandates it.[22] Based on the foregoing, the Plan is not a "federal program that by law must seek subrogation" as that phrase is used in AS 09.55.548(b).

II. AS 09.55.548(b) DOES NOT BAR A MEDICAL MALPRACTICE PLAINTIFF FROM SEEKING RECOVERY OF AN INSURER'S CONTRACTUALLY SUBROGATED CLAIM FOR MEDICAL PAYMENTS MADE ON BEHALF OF THE PLAINTIFF

AS 09.55.548(b) does not ***bar*** a medical malpractice plaintiff from seeking recovery of past medical expenses paid by collateral sources or obtaining a jury verdict including those amounts. Instead, the statute merely ***limits*** the total amount of the plaintiff's recovery by reducing certain collateral sources from a jury's award.

Subsection (a) of the statute provides that "Damages shall be awarded in accordance with principles of the common law. The fact finder in a malpractice action shall render any award for damages by category of loss." Subsection (b) provides that "Evidence of collateral sources, other than a federal program that must by law seek subrogation and the death benefit paid under life insurance, is admissible *after the fact finder has rendered an award*." (emphasis added). Reading subsections (a) and (b) together, a medical malpractice plaintiff may seek recovery of collateral sources, and a jury may award those expenses (if

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[21] 42 U.S.C. § 1396a(a)(25)(B)(emphasis added).

[22] *See* n.17, *supra*.

proven), but plaintiff's recovery is generally reduced by the amount of collateral sources subject to subsection (b), in a post-verdict proceeding after the jury rendered its award.

This was the procedure recently explained by this court in *Weston, supra*, in evaluating the collateral source statute applicable to nonmedical malpractice cases.[23]

This was also the procedure followed in *Reid v. Williams*, 964 P.2d 453 (Alaska 1998). Reid sued Dr. Williams for medical malpractice and prevailed at trial.[24] The jury awarded Reid damages of $25,000, including $6,553 for past medical expenses.[25] Williams argued that Reid's jury award for past medical expenses should be reduced under AS 09.55.548(b) by the amount of medical expenses paid by Reid's insurer.[26] "The superior court reduced the award for past medical expenses from $6,553 to $507.10, the amount of medical expenses not paid for by Reid's insurer."[27] This court affirmed.[28]

This is also the procedure that the trial court should follow had it not concluded that the Plan is a "federal program that by law must seek subrogation." The trial court summarized the rule as follows:

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[23] *Weston*, 445 P.3d at 1019 (concluding that the amounts billed by providers are relevant evidence of the medical services' reasonable value for the purpose of establishing plaintiff's past medical expenses, and that evidence of the amounts paid is a collateral source "excluded from the jury's consideration but is subject to post-trial proceedings under AS 09.17.070 for possible reduction of the damages award.").

[24] 964 P.2d. at 454.

[25] *Id.* at 455.

[26] *Id.*

[27] *Id.*

[28] *Id.* at 463.

> ...First, the amount of Ms. McCollum's total medical expenses is admissible during trial if there is a clear linkage between the expenses and Ms. McCollum's alleged damages. However, who paid for the medical expenses is not admissible during trial and is only admissible during the administration of the award in accordance with AS 09.55.548.

[Exc. 284] The trial court then explained application of AS 09.55.548 in more detail:

> ...the rule that emerges is as follows: First, AS 09.55.548 applies if, and after, the jury finds for the plaintiff. Second, any contributions from collateral sources are evaluated under the statute. If the plaintiff received compensation from a collateral source that is "a "federal program that by law must seek subrogation" or "death benefits paid under life insurance," the collateral source rule remains intact. This means, evidence of compensation from federal programs that by law must seek subrogation is not admissible and the plaintiff's damages may not be reduced based on payments received by plaintiff from those sources.
>
> In contrast, if the plaintiff received compensation from a collateral source that is not a "federal program that by law must seek subrogation" or "death benefits paid under life insurance," the statute abrogates the collateral source rule. This means evidence of compensation from those sources is admissible and damages may be reduced based on payments received by plaintiff from those sources.

[Exc. 301-02]

Finally, the parties understood this was the correct procedure that would be followed unless the trial court found that ERISA preempted AS 09.55.548(b).

III. AN INSURER COULD ASSIGN A CONTRACTUALLY SUBROGATED CLAIM TO A PLAINTIFF FOR COLLECTION PURPOSES IN A MEDICAL MALPRACTICE LAWSUIT, BUT NO EFFECTIVE ASSIGNMENT WAS MADE HERE

As discussed below, subrogation is by definition an assignment from the insured to the insurer. "A subrogated insurer stands in the shoes of the insured, inheriting the rights

of the insured and subject to any defenses a third party would have against the insured."[29] The Plan acknowledged this principal by including in its subrogation provision: "...the Covered Person agrees to assign to the Plan the right to subrogate any and all claims..." [Exc. 88] Therefore, if the insurer were to assign its subrogation claim to the insured, it would simply be assigning the insured's claim back to the insured. In any event, the Plan never assigned its subrogation claim to Ms. McCollum. As such, the Court need not reach this issue.

Although both reimbursement and subrogation allow an insurer to recover expenses it paid, they are distinct concepts.[30] Subrogation allows an insurer to pursue recovery directly from a tortfeasor, whereas reimbursement occurs when the insured recovers from the tortfeasor, and then in turn reimburses the insurer.[31] "Subrogation" is defined as:

> The substitution of one creditor for another. Subrogation is the substitution of one claimant by another claimant for the same claim, brought about when the new claimant pays the earlier claimant's claim in a circumstance in which the earlier claimant then assigns the claim to the later claimant. The most common form of subrogation occurs when an insurer pays an insured for an injury caused by a third party, and the insured assigns the insured's underlying claim to the insurer, who then pursues the third party on the subrogated claim. ***Subrogation thus requires both payment to the original claimant and assignment by that claimant.*** Assignment may occur as a result

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[29] *Ace Am. Ins. Co. v. Sandberg*, 900 F.Supp.2d 887, 892 (S.D.Ill. 2012)(citing 16 Couch on Insurance § 222.5 (3rd edition)).

[30] *See generally, Maynard v. State Farm Mut. Auto. Ins. Co.*, 902 P.2d 1328 (Alaska 1995)(evaluating propriety of insurer switching its theory to "reimbursement" after it "realized the limits of subrogation").

[31] *See, Masters v. State Farm Mut. Auto. Ins. Co.,* 840 So.2d 665 (La.Ct.App.2d Cir. 2003)(explaining that reimbursement gives the insurer only the right to be repaid by the insured, whereas subrogation gives the insurer the right to assert the actions and rights of the insured and places the insurer in the shoes of the insured.).

of the insurance agreement or as a result of an assignment particular to the settlement of the claim.[32]

Couch on Insurance expanded on this definition of subrogation:

> **§ 222:5. Definition and Nature of Subrogation**
>
> References
>
> "Subrogation" is the substitution of another person in place of the creditor to whose rights he or she succeeds in relation to the debt, and gives to the substitute all the rights, priorities, remedies, liens, and securities of the person for whom he or she is substituted.
>
> Observation:
>
> In fact, subrogation has sometimes been referred to as "substitution." In other words, a subrogated insurer stands in shoes of an insured, and has no greater rights than the insured, for one cannot acquire by subrogation what another, whose rights he or she claims, did not have.
>
> Observation:
>
> The insurer not only inherits the right to sue the third party, *but is subject to any defenses the third party would have against the insured. Similarly, an insurance subrogee is subject to all the limitations applicable to the original claim of the subrogor.*
>
> Accordingly, on paying a loss, an insurer is subrogated in a corresponding amount to the insured's right of action against any other person responsible for the loss, such that the insurer is entitled to bring an action against this third party whose negligent or other tortious or wrongful conduct caused the loss, regardless of whether the insurer would have been entitled to bring such an action in its own right.[33]

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[32] Wolters Kluwer Bouvier Law Dictionary Desk Edition (emphasis added); *see also, Rice v. Denley,* 944 P.2d 497, 500-501 (Alaska 1997)(explaining that "when Colonial paid Denley's medical expenses, it in effect received an assignment by operation of contract and law of Denley's claim (to the extent of payment) against Rice.")

[33] 16 Couch on Insurance § 222.5.

This court has likewise recognized that subrogation includes an assignment from the insured to the insurer, explaining the rights of a subrogated insurer in *Ruggles v. Grow*, *infra*, as follows:

> When an insurer pays expenses on behalf of an insured it is subrogated to the insured's claim. ***The insurer effectively receives an assignment of its expenditure by operation of law and contract.*** If the insurer does not object, the insured may include the subrogated claim in its claim against a third-party tortfeasor. Any proceeds recovered must be paid to the insurer, less pro rata costs and fees incurred by the insured in prosecuting and collecting the claim. But the subrogated claim belongs to the insurer. The insurer may pursue a direct action against the tortfeasor, discount and settle its claim, or determine that the claim should not be pursued.[34]

Under the foregoing authority, the Plan has (or had) multiple options. It may seek reimbursement from Ms. McCollum after she recovers an award against Dr. Knolmayer (if any), pursue a direct action against Dr. Knolmayer, settle the claim, or decide the claim should not be pursued at all.

Here, the Plan chose to seek reimbursement from Ms. McCollum, and not pursue a direct action against Dr. Knolmayer. By ratifying Ms. McCollum's action, the Plan has chosen to be bound by the result of this lawsuit.[35] In fact, while Ms. McCollum ostensibly received an assignment from the Plan, the assignment was never "finalized," and it appears

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[34] 984 P.2d 509, 512 (Alaska 1999)(emphasis added).

[35] *Municipality of Anchorage v. Baugh Constr. & Engineering Co.*, 722 P.2d 919, 924 (Alaska 1986)(recognizing that "[a]s a general proposition a partially subrogated insurer who is clearly bound by the result of the lawsuit should not be joined under Rule 19(a)" and holding that the superior court erred in ordering insurer joined as a party plaintiff because the insurer ratified the plaintiff's bringing of the action, and the trial court "does not have the discretion to generally disregard the choice of the real party in interest").

that idea was abandoned. Although Ms. McCollum's counsel initially argued that he represented both Ms. McCollum and the Plan, Ms. McCollum later sought an order belying that proposition, seeking a ruling that "[i]f the Plan, plaintiff and counsel agree, plaintiff counsel can represent the Plan and plaintiff." [*Compare* Tr. 7/24/18 Oral Arg. at 6:21-23 & 17:22-23 *with* Exc. 197] Ms. McCollum also filed a motion to join PHIA, further suggesting joinder would be involuntary on PHIA's part. Therefore, this court need not reach the hypothetical issue as to whether Ms. McCollum could receive an assignment from the Plan since that scenario has decidedly not come to fruition.

Even if the Plan were to assign its claim to Ms. McCollum or pursue a direct right of action against defendants (it has not), the claim would be barred by the applicable statute of limitations at this point.[36] And even if the claim were not barred, the claim would be governed by state law anyway, including AS 09.55.548(b).[37] As mentioned above, a subrogated insurer is subject to any defenses a third party has against the insured.[38] Because the Plan stands in the shoes of Ms. McCollum, the Plan has no greater rights against Dr. Knolmayer than Ms. McCollum does. In other words, because subrogation is an assignment

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[36] *See, e.g., St. Paul Fire & Marine Ins. Co. v. Glassing,* 887 P.2d 218, 221 (Mont. 1994)(quoting 16 Couch on Insurance 2d § 61:234 (1983) for the general principle of subrogation that: "Since the insurer's claim by subrogation is derivative from that of the insured, it is subject to the same statute of limitations as though the cause of action were sue[d] upon by the insured. Consequently, the insurer's action is barred if it sues after expiration of the period allowed for the suing out of tort claims.")

[37] *Qualchoice, Inc. v. Nationwide Ins. Co.*, 2009 WL 943538, 2009 Ohio App. LEXIS 1426, *12 (Ohio April 9, 2009)("Ohio courts have concluded that subrogation claims by ERISA benefit plans are governed by state law and are not preempted.").

[38] 16 Couch on Insurance § 222.5.

from the subrogor-insured to the subrogee-insurer, Ms. McCollum cannot transfer rights she does not have. Additionally, the Plan stated an intent to be bound by "any applicable federal or state law." [Exc. 102] Therefore, the Plan is subject to AS 09.55.548(b). ERISA is silent on reimbursement and subrogation. As discussed in Section V below, ERISA does not preempt AS 09.55.548(b). Because there are no statutory provisions of ERISA that address reimbursement or subrogation, there is no conflict between the Alaska statute and ERISA.[39] Both can be complied with because any recovery by Ms. McCollum in this action is subject to a reduction under the statute by the amount paid by the Plan (among other collateral sources), and the Plan can obtain reimbursement from Ms. McCollum's recovery, if any, after this litigation.

Moreover, the United States Supreme Court has held that where an insurer seeks to recover directly from a third party, the tortfeasor's liability is governed by state law, not the contract between the insurer and insured or the federal law that governs said contract:

> The BCBSA Plan's statement of benefits links together the carrier's right to reimbursement from the insured and its right to subrogation. Empire's subrogation right allows it, once it has paid an insured's medical expenses, to recover directly from a third party responsible for the insured's injury or illness. Had Empire taken that course, no access to a federal forum could have been predicated on the OPM–BCBSA contract right. The tortfeasors' liability, whether to the insured or the insurer, would be governed not by an agreement to

[39] *Rudel v. Hawai'i Mgmt. Alliance Assoc.*, 937 F.3d 1262, 1275 (9th Cir. 2019)("The Hawai'i Statutes only impact the insurer's subrogation rights against a third party tort settlement fund. There are no statutory provisions of ERISA that address reimbursement limitations. Thus, no conflict exists between the Hawai'i Statutes and ERISA"), *cert. denied*, 140 S.Ct. 1114, 206 L.Ed.2d 183 (2020).

> which the tortfeasors are strangers, but by state law, and § 8902(m)(1) would have no sway.[40]

Alternatively, if this court disagrees for whatever reason that the traditional concept of subjecting a subrogated insurer to the defenses a third-party tortfeasor has against its insured apply (for example if the Court were to conclude that concept would render the statute unconstitutional), then the Court should conclude that AS 09.55.548(b) does not apply to insurers who pursue direct subrogation claims, and thereby subject themselves to potential costs and fees. In enacting the statute, the legislature was mindful not to eliminate the subrogation rights of insurers.[41] But as long as the Plan merely chose to seek reimbursement, as it did here, then AS 09.55.548(b) precludes Ms. McCollum from recovering the expenses paid by the Plan.

IV. AS 09.55.548(b) DOES NOT VIOLATE THE ALASKA CONSTITUTION'S SUBSTANTIVE DUE PROCESS OR EQUAL PROTECTION GUARANTEES

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[40] *Empire Healthchoice Assur., Inc. v. McVeigh*, 547 U.S. 677, 680, 165 L.Ed.2d 131, 126 S.Ct. 2121, 2122 (2006). 5 U.S.C. § 8902(m)(1) is the preemption provision in the Federal Employees Health Benefits Act, which is the counterpart to ERISA for federal employers and employees' health benefits plans. *See* p.41 & nn.78-79, *infra.* Both ERISA and FEHBA preempt state laws that "relate to" health plans. If FEHBA's preemption provision does not apply to a tortfeasor's liability, then neither does ERISA.

[41] *See* p.14-15, *supra,* & Appx. B-22-23. The trial court recognized:

> "The legislative history of the bill indicates that elimination of subrogation rights was considered but ultimately rejected. A draft by the House Judiciary Committee included language that would have done so: "Notwithstanding other provision of state law and except as provided in this subsection, a collateral source does not have a right of subrogation." H. Judiciary Comm., C.S.H.B. 574 Bill File, Third Draft of Committee Substitute for House Bill 574, 9th Leg., 2d Sess. at 99 (Feb. 18, 1976) …

[Exc. 189]

In *Reid v. Williams,* 964 P.2d 453 (Alaska 1998), this court upheld the constitutionality of AS 09.55.548(b) on both due process and equal protection grounds. Now the Court asks the parties to address whether those conclusions change when the statute is applied to an injured party subject to contractual subrogation. It does not.

A. McCollum Waived Any Challenge To AS 09.55.548(b) On Constitutional Grounds.

A party may not raise an issue for the first time on appeal.[42] Ms. McCollum never challenged the constitutionality of AS 09.55.548(b) in the trial court, even though she filed a slew of motions and other briefs relating to her recovery of benefits paid by the Plan. Dr. Knolmayer argued in his cross-motion and at oral argument that the statute was constitutional. By failing to challenge the constitutionality of AS 09.55.548(b) in the trial court despite multiple opportunities to do so, Ms. McCollum has waived that issue. Ms. McCollum's silence on the issue should be regarded as a concession that the statute ***is*** constitutional.

B. Reducing Ms. McCollum's Damages Under AS 09.55.548(b) Does Not Violate Her Substantive Due Process Rights Because The Statute Bears A Reasonable Relationship To A Legitimate Governmental Purpose.

The due process clause of the Alaska Constitution provides that "No person shall be deprived of life, liberty, or property, without due process of law."[43] This clause "requires

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[42] *Brandon v. Corrections Corp. of America*, 28 P.3d 269 (Alaska 2001); *Padgett v. Theus*, 484 P.2d 697, 700 (Alaska 1971)("Ordinarily an issue which was not raised in the trial court will not be treated on appeal."); *see also Crittell v. Bingo*, 83 P.3d 532, 536 n.19 (Alaska 2004)(concluding that an argument was waived where appellants failed to raise it in the trial court and cursorily raised the argument in the reply brief on appeal).

[43] Alaska Const. art. I, § 7.

that legislation be 'at least minimally rational.' 'If any conceivable legitimate public policy for the enactment is either apparent or offered,' the enactment will survive due process scrutiny so long as the factual basis for the justification is not disproved."[44] "The party asserting a substantive due process challenge must demonstrate that the statute bears ***no*** reasonable relationship to a legitimate governmental purpose."[45]

This court analyzes a substantive due process claim as follows:

> Substantive due process is denied when a legislative enactment has no reasonable relationship to a legitimate governmental purpose. It is not a court's role to decide whether a particular statute or ordinance is a wise one; the choice between competing notions of public policy is to be made by elected representatives of the people. The constitutional guarantee of substantive due process assures only that a legislative body's decision is not arbitrary but instead based on some rational policy.
>
> A court's inquiry into arbitrariness begins with the presumption that the action of the legislature is proper. The party claiming a denial of substantive due process has the burden of demonstrating that no rational basis for the challenged legislation exists. This burden is a heavy one, for if any conceivable legitimate public policy for enactment is apparent on its face or is offered by those defending the enactment, the opponents of the measure must disprove the factual basis for such a justification.[46]

The statute bears a reasonable relationship to a legitimate governmental purpose for the reasons set forth in *Reid*. That analysis does not change based on the presence of a subrogation claim.

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[44] *Chokwak v. Worley*, 912 P.2d 1248, 1255 (Alaska 1996)(quoting *Gonzales v. Safeway Stores, Inc.*, 882 P.2d 389, 397-98 (Alaska 1994)(other citations omitted)).

[45] *Reid*, 964 P.2d at 456 (emphasis added).

[46] *Id.* at 456 n.5 (quoting *Concerned Citizens v. Kenai Peninsula Borough*, 527 P.2d 447, 452 (Alaska 1974)).

First, ensuring that citizens have proper health care is a legitimate government purpose. This court recognized that AS 09.55.548(b) "was enacted in 1976 as part of a comprehensive medical malpractice reform package intended to alleviate a perceived crisis in medical malpractice insurance costs."[47] This crisis has been described as follows:

> In response to the recent vast increase in the number of medical malpractice actions brought against physicians, hospitals, and related personnel, the necessary costs of defense, and high damage awards, many malpractice liability insurers have either greatly raised their premiums or declined to offer coverage. As a result, some physicians and other health care providers have threatened to limit or curtail their practices and services, creating what has been referred to as a medical malpractice insurance "crisis."
>
> In order to meet this challenge and to continue to provide proper health care for their citizens, a number of states have enacted remedial legislation. In general, the expressed purposes of these statutes are to make professional health care insurance available at a reasonable cost, and to establish a system through which a victim who has sustained injury or death caused by a health care provider can be assured of a prompt adjudication of the claim and a fair and reasonable recovery.[48]

Thus, the statute was "a comprehensive system to furnish hospitals and individual health care providers with medical malpractice insurance."[49]

This court has held on multiple occasions that "the desire to alleviate the medical malpractice insurance crisis was a legitimate governmental purpose behind the medical

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[47] *Reid*, 964 P.2d at 456.

[48] *Id.* at 465 n.6 (quoting Davis W. Louisell & Harold Williams, 2 Medical Malpractice P18.02, at 18-10 to 18-11 (1992 & Supp. 1993)).

[49] *Reid*, 964 P.2d at 457 (quoting *Plumley v. Hale*, 594 P.2d 497, 498-99 n.3 (Alaska 1979)(citing Chapter 102 SLA 1976)).

malpractice reform statutes."[50] The government has a legitimate interest in ensuring that proper health care is available for its citizens. This is true now more than ever as the availability and cost of healthcare is a prominent issue in our nation, which is currently grappling with a global pandemic.

Second, the statute is reasonably related to the goal of reducing medical malpractice insurance rates. The availability and cost of health care was jeopardized by the lack of medical malpractice insurance due to the increased costs of defending medical malpractice cases and paying high damage awards. Reducing a medical malpractice plaintiff's award of damages reduces malpractice liability insurers' payments of such damage awards, which in turn affects premiums and coverage. The goal of lowering premiums and offering coverage was to furnish hospitals and health care providers with medical malpractice insurance so they could keep practicing. The Commission considered several proposals that would reduce the size of jury awards, and rejected arbitrary limits in favor of a reduction based on the amount of collateral sources. [Appx. A-28-30] Therefore, the statute does not violate substantive due process because it is based on rational policy and is not arbitrary.

C. AS 09.55.548(b) Does Not Violate Alaska's Equal Protection Clause Because There Is A Fair And Substantial Relationship To The Legitimate Reason For Alleviating The Medical Malpractice Insurance Crisis.

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[50] *Reid*, 964 P.2d at 457 (citing *Keyes v. Humana Hosp. Alaska, Inc.*, 750 P.2d 343 (Alaska 1988).

The equal protection clause of the Alaska Constitution provides that "all persons are equal and entitled to equal rights, opportunities, and protection under the law; and that all persons have corresponding obligations to the people and to the State."[51] "The common question in equal protection cases is whether two groups of people who are treated differently are similarly situated and thus entitled to equal treatment."[52] However, equal protection does not broadly prohibit any or all differential treatment; instead, "[e]qual protection jurisprudence concerns itself largely with ***the reasons for*** treating one group differently from another."[53] As such, this court ordinarily reviews "a classification under Alaska's equal rights clause by asking whether a legitimate reason for disparate treatment exists, and, given a legitimate reason, whether the enactment creating the classification bears a fair and substantial relationship to that reason."[54] A "sliding scale" approach is used to evaluate equal protection claims:

> First, it must be determined . . . what weight should be afforded the constitutional interest impaired by the challenged enactment. The nature of this interest is the most important variable in fixing the appropriate level of review . . . .
>
> Second, an examination must be undertaken of the purposes served by a challenged statute. Depending on the level of review determined, the state may be required to show only that its objectives were legitimate, at the low end of the continuum, or, at the high end of the scale, that the legislation was motivated by a compelling state interest.
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> Third, an evaluation of the state's interest in the particular means employed to further its goals must be undertaken. . . . At the low end

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[51] Alaska Const. art. I, § 1.

[52] *Gonzales v. Safeway Stores*, 882 P.2d 389, 396 (Alaska 1994).

[53] *Id.* (emphasis added).

[54] *Id.* (citing *State, Dept's of Revenue v. Cosio*, 858 P.2d 621, 629 (Alaska 1993)).

> of the sliding scale, we have held that a substantial relationship between [ ] means and ends is constitutionally adequate. At the higher end [ ] of the scale, the fit between the means and ends must be much closer. If the purpose can be accomplished by a less restrictive alternative, the classification will be invalidated.[55]

As explained in *Reid, supra*, "[a] medical malpractice plaintiff's right to damages is an economic interest, which traditionally receives only minimum protection under our equal protection analysis."[56] Under this low end of the scale, the state's objectives in enacting AS 09.55.548(b) "need only be legitimate."[57] The statute "will pass constitutional muster if the classifications it creates bear a fair and substantial relationship to the purposes of [the statute]."[58]

Here, the statute applies to all medical malpractice plaintiffs with collateral sources unless those collateral sources are from a federal program that by law must seek subrogation or death benefits paid under life insurance; the statute does not distinguish specifically between plaintiffs with contractual subrogation claims and those without. Nor is the statute limited to insurance benefits as the statute broadly applies to all collateral sources other than those that fall under the exception. For example, as recognized in

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[55] *Williams, v. Dep't of Revenue*, 895 P.2d 99, 103-104 (Alaska 1995)(citations omitted).

[56] *Reid*, 964. P.2d at 458; *see also, Williams*, 895 P.2d at 104 (classifications relating to an economic interest are entitled only to minimum protection, reviewed at the low end of the sliding scale); *see also, Gonzales*, 882 P.2d at 396 n.7 (collecting cases for the proposition that classifications relating merely to economic interests are consistently reviewed using the "relaxed scrutiny" test).

[57] *Williams*, 895 P.2d at 104.

[58] *Gilmore v. Alaska Workers' Compensation Bd.,* 882 P.2d 922, 927 (Alaska 1994); *see also, Reid*, 964 P.2d at 458 (explaining that "the legislative classification must bear only a 'fair and substantial relation' to attaining 'legitimate' government objectives.")

Weston, *supra*, when the amount billed is greater than the amount accepted as full and final payment of the medical expenses, the difference is a collateral source.[59] Here, Ms. McCollum claims $554,212.08 of past medical expenses was billed, while the amount paid by the Plan was only $349,049.87. The difference could also be a collateral source subject to AS 09.55.548(b).

In any event, regardless of whether the collateral source involves a contractual subrogation claim or not, the interest affected is merely economic. The legislature's objectives in enacting the statute are legitimate for the same reasons set forth above with respect to due process – namely, the government has a legitimate interest in ensuring the availability of healthcare by reducing jury verdict awards, and, in turn, a reduction in insurance premiums. There is a substantial relationship between the means and the ends of the statute. As explained in *Reid*, the statutory purpose is to control medical malpractice insurance costs and increase the availability of health care.[60] "Reducing medical malpractice damage awards by the amount received by a malpractice victim's insurer lessens the liability of health care providers. This in turn reduces the cost of insuring the health care providers."[61]

It should also be noted that the classification between medical malpractice plaintiffs with certain collateral sources and those without is a classification that is the result of a

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[59] *Weston*, 445 P.3d at 1028 ("to the extent the negotiated rate differential represents a collateral benefit for which the collateral source has no 'right of subrogation by law or contract,' it is subject to the post-verdict procedure set out in AS 09.17.070.").

[60] 964 P.2d at 459.

[61] *Id.*

series of choices made by Ms. McCollum. First, she agreed to a contract with her insurer that contains express provisions regarding reimbursement and subrogation. Second, and with full knowledge of the foregoing, Ms. McCollum accepted benefits from her insurer and chose to seek recovery of those expenses in this litigation. She could have foregone accepting those medical benefits, seeking the entire amount from defendant, thereby avoiding the statute in its entirety.

Several Alaska Statutes distinguish between various classes of plaintiffs or defendants for the purpose of assessing damages. AS 09.17.010 provides a cap on noneconomic damages in civil personal injury cases other than medical malpractice cases, allowing more or less damages depending on whether the plaintiff has a "severe permanent physical impairment or severe disfigurement" or not. AS 09.17.010 also imposes a single cap for all claims arising out of the same injury regardless of the number of claimants, thereby distinguishing between classes of plaintiffs with individual beneficiaries or spouses. Similarly, AS 09.55.549 provides a cap on noneconomic damages in medical malpractice cases unless the damages resulted from an act or omission that constitutes reckless or intentional misconduct. This court has routinely upheld limitations on damages against constitutional challenges, and should do so again here.[62]

V. ERISA DOES NOT PREEMPT AS 09.55.548(b) BECAUSE THE STATUTE DOES NOT "RELATE TO" MS. MCCOLLUM'S COVERAGE OR BENEFITS

[62] *Reid, supra; Evans v. State*, 56 P.3d 1046 (Alaska 2002); *L.D.G., Inc. v. Brown*, 211 P.3d 1110 (Alaska 2009); *C.J. v. Dep't of Corr.*, 151 P.3d 373 (Alaska 2006).

The central dispute between the parties in the trial court was whether ERISA, 29 U.S.C. § 1001 *et seq.*, preempted AS 09.55.548(b). Although the trial court issued multiple orders on the issue, it routinely held that ERISA did not preempt AS 09.55.548(b). Dr. Knolmayer's petition for review only sought interim review of the portion of Judge Walker's order that the Plan was a "federal program that by law must seek subrogation." Should this court reach the separate issue of preemption, then the Court should conclude that ERISA does not preempt AS 09.55.548(b).

The Supremacy Clause of the United States Constitution preempts state laws that are in conflict with federal laws.[63] ERISA has a preemption provision superseding state laws that "relate to" any employee benefit plan governed by ERISA.[64] Although the preemption clause is broad, the United States Supreme Court has observed that "[i]f 'relate to' were taken to extent to the furthest stretch of its indeterminacy, then for all practical purposes preemption would never run its course. That is a result 'no sensible person could

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[63] *Cipollone v. Liggett Group, Inc.*, 505 U.S. 504, 516, 112 S.Ct. 2608, 120 L.Ed.2d 407 (1997).

[64] *Id.* 29 U.S.C. § 1144(a) provides that ERISA pre-empts "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan."

have intended."[65] As such, the Court rejects "uncritical literalism" in applying the clause.[66] A law "relates to" an employee benefit plan if it has a "connection with" or "reference to" such a plan."[67] The United States Supreme Court has described these two categories in more detail as follows:

> First, ERISA pre-empts a state law if it has a "'reference to'" ERISA plans. [ ] To be more precise, "[w]here a State's law acts immediately and exclusively upon ERISA plans . . . or where the existence of ERISA plans is essential to the law's operation . . ., that 'reference' will result in pre-emption." [ ] Second, ERISA pre-empts a state law that has an impermissible "connection with" ERISA plans, meaning a state law that "governs . . . a central matter of plan administration" or "interferes with nationally [ ] uniform plan administration." [ ] A state law also [ ] might have an impermissible connection with ERISA plans if "acute, albeit indirect, economic effects" of the state law

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[65] *Gobeille v. Liberty Mut. Ins. Co.*, 136 S.Ct. 936, 943, 194 L.Ed.2d 20 (2016)(citations omitted). Notably, Justice Thomas suggested in a concurring opinion that perhaps ERISA's preemption provision is unconstitutional:

> Read according to its plain terms, §1144 raises constitutional concerns. [ ] "[T]he Supremacy Clause gives 'supreme' status only to those [federal laws] that are 'made in Pursuance'" of the Constitution. .... But I question whether any provision of Article I authorizes Congress to prohibit States from applying a host of generally applicable civil laws to ERISA plans. "The Constitution requires a distinction between what is truly national and what is truly local." ... If the Federal Government were "to take over the regulation of entire areas of traditional state concern," including "areas having nothing to do with the regulation of commercial activities," then "the boundaries between the spheres of federal and state authority would blur and political responsibility would become illusory." ... Just because Congress can regulate some aspects of ERISA plans pursuant [ ] to the Commerce Clause does not mean that Congress can exempt ERISA plans from state regulations that have nothing to do with interstate commerce.

Id. at 947-48 (internal citations omitted).

[66] *Id.* at 943.

[67] *Cipollone*, 505 U.S. at 656 (citation omitted).

> "force an ERISA plan to adopt a certain scheme of substantive coverage or effectively restrict its choice of insurers."[68]

For example, pre-emption has been found where state laws "attempted to limit or restrict ERISA plan administrators' subrogation rights or to mandate that certain features be incorporated into ERISA plans[.]"[69] However, state laws that do not affect coverage or impose requirements upon ERISA plans themselves are not preempted.[70] The supreme court of Minnesota aptly recognized this distinction when it held that ERISA did not preempt Minnesota's collateral source statute:

> The cases cited by Gilhousen are inapposite because they analyze statutes that attempted to limit or restrict ERISA plan administrators' subrogation rights or to mandate that certain features be incorporated into ERISA plans; these statutes rightfully were found to be preempted by ERISA. *See, e.g., FMC Corp. v. Holliday,* 498 U.S. 52, 58-61, 111 S.Ct. 403, 112 L.Ed.2d 356 (1990) (holding that ERISA preempted application of a statute prohibiting reimbursement to an employer's self-funded health care plan from a employee-plaintiff's tort recovery; noting that the "antisubrogation law prohibit[ed] plans from being structured in a manner requiring reimbursement in the event of recovery from a third party"). In contrast to these cases, and in contrast to the cases in which the Supreme Court has found preemption, **Minnesota's statute does not impose any administrative or operational requirements upon ERISA plans.** Its aim is merely to prevent plaintiffs from "double-dipping," by collecting damages from defendants for which they already have been

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[68] *Id.* (citations omitted).

[69] *Gilhousen v. Illinois Farmers Ins. Co.*, 582 N.W.2d 571, 574-75 (Minn. 1998)(collecting cases).

[70] *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 649 & 664, 115 S.Ct. 1671, 131 L.Ed.2d 695 (1995)(New York statute providing for surcharges did not impose the kind of substantive coverage requirement binding plan administrators that were preempted by ERISA); *see also, Gilhousen,* 582 N.W.2d at 575 ("Minnesota statute did not impose any administrative or operational requirements upon ERISA plans).

compensated.[71]

There is a presumption against preemption. It is presumed that the historic police powers of the States are not superseded by Federal Act unless it is "the clear and manifest purpose of Congress."[72] "In the interest of avoiding unintended encroachment on the authority of the States, however, a court interpreting a federal statute pertaining to a subject traditionally governed by state law will be reluctant to find pre-emption."[73] This principle applies to ERISA preemption cases,[74] and the United States Supreme Court has further pronounced that "pre-emption does not occur . . . if the state law has only a tenuous, remote, or peripheral connection with covered plans, as is the case with many laws of general applicability."[75]

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[71] *Gilhousen,* 582 N.W.2d at 575 (brackets original)(emphasis added).

[72] *Cipollone v. Liggett Group, Inc.*, 505 U.S. 504, 516, 112 S.Ct. 2608, 120 L.Ed.2d 407 (1997)(quoting *Rice v. Santa Fe Elevator Corp.*, 331 U.S. 218, 230, 67 S.Ct. 1146, 1152, 91 L.Ed. 1447 (1947)).

[73] *CSX Transp., Inc. v. Easterwood*, 507 U.S. 658, 664, 113 S.Ct. 1732, 123 L.Ed.2d 387 (1993).

[74] The supreme court in *Travelers* explained:

> ...we have never assumed lightly that Congress has derogated state regulation, but instead have addressed claims of pre-emption with the starting presumption that Congress does not intend to supplant state law. [ ]. Indeed, in cases like this one, where federal law is said to bar state action in fields of traditional state regulation, ..., we have worked on the "assumption that the historic police powers of the States were not to be superseded by the Federal Act unless that was the clear and manifest purpose of Congress."

514 U.S. at 654.

[75] *Id.* at 661.

Here, AS 09.55.548(b) does not relate to the Plan. There is no "reference to" or "connection with" the ERISA plan in the statute. The statute does not impose any administrative requirements on the Plan, or prohibit the Plan from seeking subrogation or reimbursement. In fact, the legislature was mindful of not broadly eliminating collateral source's subrogation rights. Instead, the statute relates solely to Dr. Knolmayer's liability to Ms. McCollum in tort, not the plan's contractual rights to reimbursement or subrogation. The terms and conditions of the Plan are unaffected by an offset under AS 09.55.548. Nor is there any indication that Ms. McCollum's receipt of benefits or coverage is impacted in any way by the statute. There is a fundamental difference between the amount Ms. McCollum may recover in tort against a third party, and the extent to which Ms. McCollum is contractually obligated to reimburse the plan after recovering any amount in tort.

The statute is a law of general applicability in an area of traditional state regulation and concern. "[I]n Alaska, medical malpractice actions are governed entirely by statute."[76] The Ninth Circuit specifically held that "[m]edical malpractice is one traditional field of state regulation that several circuits have concluded Congress did not intend to preempt."[77] In holding that ERISA does not preempt claims alleging medical malpractice and that state law governs, the Ninth Circuit in *Bui* reasoned, in part:

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[76] *D.P. v. Wrangell General Hosp.*, 5 P.3d 225, 229 (Alaska 2000); *see also, Southern Alaska Carpenters Health & Sec. Trust Fund v. Jones,* 177 P.3d 844, 854 (Alaska 2008)(holding that ERISA did not preempt plaintiffs' common law claims for misrepresentation because, *inter alia,* "the common law of negligent misrepresentation is an area of traditional state concern.").

[77] *Bui v. American Telephone & Telegraph Co. Inc.*, 310 F.3d 1143, 1147 (9th Cir. 2002).

> First, under any of the tests applied by this court, it is clear that state medical malpractice standards should not be preempted. They do not mandate employee benefit structures or their administration, do not preclude uniform administrative practices, and do not provide alternative enforcement mechanisms for employees to obtain ERISA benefits. In addition, they are state standards of general application that do not depend upon ERISA. Finally, they will not affect the relationships between principal ERISA participants when acting in their roles as principal ERISA participants. In short, they do not impinge upon Congress's stated goal for ERISA: to ensure uniform administrative enforcement.[78]

Moreover, in evaluating preemption under the "federal analogue to ERISA," the Federal Employees Health Benefits Act of 1959 (FEHBA),[79] the United States Supreme Court held that a tortfeasor's liability is "governed not by an agreement to which the tortfeasors are strangers, but by state law, and [FEHBA's preemption provision] would have no sway."[80] If FEHBA does not apply to a tortfeasor's liability, then neither does ERISA.

The distinction between an insurance plan and a tortfeasor's liability recognized by the United States Supreme Court in *Empire, supra,* has support in Alaska. For instance, in evaluating Alaska's collateral source statute applicable to non-medical malpractice personal injury suits, our supreme court has held that the rule (AS 09.17.010) "speaks to

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[78] *Id.* at 1148 (citations omitted).

[79] *Id.* at 1147 (citing *Roach v. Mail Handlers Benefit Plan,* 298 F.3d 847 (9th Cir. 2002)). ERISA and FEHBA both govern health benefit plans for employees. FEHBA governs health benefits plans for federal employees. ERISA governs health benefit plans for private sector employees. Both Acts preempt state laws that "relate to" an employee benefit plan, or coverage or benefits.

[80] *Empire Healthchoice Assur., Inc. v. McVeigh*, 547 U.S. 677, 680, 165 L.Ed.2d 131, 126 S.Ct. 2121, 2122 (2006).

the relationship between insureds and tortfeasors, not to that between insureds and their insurers."[81]

Although this is an issue of first impression for the Alaska Supreme Court, Alaska trial courts addressing this issue have upheld AS 09.55.548(b) against preemption. The trial court in *French* held that AS 09.55.548(b) applies to plaintiff's ERISA health plan, ERISA does not preempt AS 09.55.548(b), and plaintiff cannot recover the expenses paid by his ERISA plan. [Exc. 152-161] Although the trial court here erred in holding that the Plan is a federal program, the trial court correctly concluded in all of its orders that "ERISA does not preempt Alaska Statute 09.55.548 because the statu[t]e does not interfere, either directly or indirectly, with the reimbursement of the plan." [Exc. 171, 190 & 295-96]

CONCLUSION

This court should once again uphold the constitutionality of AS 09.55.548(b) and conclude that the statute applies to the benefits paid by the Plan, thereby vacating the portion of the trial court's April 30, 2020 order holding that the Plan is a "federal program that by law must seek subrogation," and affirming the remainder of that order, *i.e.,* that ERISA does not preempt AS 09.55.548(b).

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[81] *Ruggles,* 984 P.2d at 512.