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

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

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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.

INTRODUCTION

Petitioners Dr. Knolmayer and Alaska Trauma and Acute Care Surgery, LLC (collectively Dr. Knolmayer) submit this brief in response to Respondent Ms. McCollum's brief as well as the briefs of amici curiae, Alaska Association for Justice ("AAJ") and Premera Blue Cross ("Premera").

ARGUMENT

One thing is clear from the briefing of the parties and amici: the Plan is a contract between Ms. McCollum and her insurer. Contracts have benefits, and contracts have burdens. Ms. McCollum seeks to derive the benefits of the contract, and shift her burdens to Dr. Knolmayer by avoiding application of AS 09.55.548(b) ("subsection 548(b)" or "the statute"). Nothing in the caselaw, legislative history or plain language of the statute support the notion that a tortfeasor's liability should be governed by a contract to which he is a stranger instead of state law.

I. MS. MCCOLLUM HAS WAIVED SEVERAL ARGUMENTS.

Ms. McCollum has waived several arguments in her brief. These arguments include: the medical expenses paid by the plan are a "federal program that by law must seek subrogation"; the medical expenses are recoverable under AS 09.55.548(b) even if the statute is not preempted; and AS 09.55.548(b) is unconstitutional. Ms. McCollum did not make any of these arguments before the trial court.

Additionally, while Ms. McCollum did argue issues regarding joinder and ERISA preemption before the trial court, the trial court ruled against her, and she has not cross-petitioned for interim review any issues.

A party may not raise an issue for the first time on appeal.[1] Ms. McCollum does not dispute that the sole issue argued by the parties was whether ERISA preempted AS 09.55.548(b), that neither party argued the Plan was a federal program that by law must seek subrogation, and, most importantly, that the parties assumed and understood that the Plan was not a federal program that by law must seek subrogation.[2] She also does not dispute that she failed to challenge the constitutionality of the statute in the trial court.[3]

Ms. McCollum has also waived any challenge regarding the correct interpretation of AS 09.55.548(b). Although Ms. McCollum does not clearly offer her own interpretation, she seems to argue that subsection 548(b) allows her to recover the medical expenses paid by the Plan, even if the statute is not preempted or unconstitutional.[4] She claims "[t]he legislative history cannot mean that the Legislature intended the injured plaintiff to bear the burden of these collateral sources…" and that "…it would punish the injured patient for bringing the lawsuit by forcing her to pay for the costs of her medical care, … Nothing in the language of the statute, or purpose and legislative history of the statute support this interpretation."[5] This is totally inconsistent with the arguments she made in the trial court. Quite the opposite, that was precisely the interpretation offered by Ms. McCollum in the trial court. Notably, this change in legal strategy (abandoning certain arguments and raising

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[1] *Brandon v. Corrections Corp. of America*, 28 P.3d 269 (Alaska 2001).
[2] Petitioners' Br. at 5.
[3] *Id.* at 28.
[4] Respondent's Br. at 22-24 & 29.
[5] *Id.* at 23.

new ones) followed new counsel having entered an appearance on behalf of Ms. McCollum.

First, in her underlying motion for ruling of law, Ms. McCollum argued "[t]he 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] Ms. McCollum then consistently maintained that if AS 09.55.548(b) applies, she would be left with very little recovery if she prevails because there would be an offset under subsection 548(b), and she would have to reimburse the plan. [Exc. 132, 182, 237, 241] Therefore, it was understood at all times in the trial court that the correct interpretation of subsection 548(b) was that the medical expenses paid by the Plan were subject to an offset if the statute was not preempted by ERISA.

Finally, Ms. McCollum has waived any challenges to the trial court's orders regarding joinder and assignment because she never filed a petition for review or cross-petition. Appellate Rule 403(a)(1)(A) requires a petition for review to be filed within ten days after the date of notice the order or decision of which review is sought. Or, if a motion for reconsideration is filed, the running of the time for filing a petition for review is terminated, and the ten-day period begins to run again on the date of notice of a judgment of the date of denial of the motion for reconsideration.[6] Appellate Rule 403(a)(2) governs Cross-Petitions for Review and provides: "When a petition is filed under this rule, any

[6] Appellate Rule 403(a)(1)(B).

other party may file a cross-petition for review ***of the same order***. Cross-petitions must be filed within ***ten days*** from service of the petition for review." (emphasis added)

In *Hagen v. Strobel*, 353 P.3d 799 (Alaska 2015), a medical malpractice case, this court affirmed the trial court's grant of summary judgment where the defendant offered expert affidavits, and the plaintiff failed to oppose within timeframe allowed. The plaintiff had moved for reconsideration and to amend the complaint. The trial court denied the motion for reconsideration and entered final judgment. This court affirmed, concluding the plaintiff waived the argument that the superior court erred in denying his motion for reconsideration and motion to amend the complaint by omitting the issue from the brief's statement of points on appeal and then giving only cursory treatment to the issue.

On August 27, 2019, the trial court denied Ms. McCollum's motion for clarification as to whether she could obtain an assignment from the Plan to pursue their medical costs. [Exc. 202-03] Ms. McCollum never petitioned for review of that order, which would have been due ten days later. Instead, Ms. McCollum strategically continued to litigate in the trial court by filing several other motions, including a motion to join PHIA.[7] The trial court denied that motion on May 6, 2020. [Exc. 315] Ms. McCollum never petitioned for review of that order, either.

Dr. Knolmayer filed a petition for review on May 26, 2020. The question presented for review was whether the trial court erred in holding that Ms. McCollum's health insurance plan is a "federal program that by law must seek subrogation" under AS

[7] Petitioners' Br. at 8-10.

09.55.548(b).[8] Ms. McCollum did not file a cross-petition, and her response brief did not suggest that she intended to challenge the trial court's orders regarding joinder and assignment, or raise new arguments, such as the constitutionality of AS 09.55.548.

II. THE LOWE'S HEALTH PLAN IS NOT "A FEDERAL PROGRAM THAT BY LAW MUST SEEK SUBROGATION."

Despite ERISA having been passed over forty-five years ago in 1976, neither Ms. McCollum nor amici cite any federal law or interpreting caselaw for the proposition that the Plan is a "federal program that by law must seek subrogation." Instead, Ms. McCollum and amici claim the Lowe's Companies Inc's Health Plan is a federal program simply because it is governed by ERISA, and, therefore, has the "force of federal law." The fallacy of this argument is illustrated by the fact that there are several other federal laws that implement standards upon private employers. For example, The Fair Labor Standards Act (FLSA) is a federal law commonly known for minimum wage, overtime pay, child labor and other standards applicable to most private and public employees. The FLSA imposes standards on employers for the benefit and protection of employees, and is administered and enforced by the Wage and Hour Division of the U.S. Department of Labor. Does that mean that the wages paid by every private employer who must abide by the FLSA's minimum standards are a "federal program"? Of course not. The same analogy can be made with the FMLA or OSHA.

In addition to defying common sense, Ms. McCollum's interpretation is not supported by the plain language of the statute. "Interpretation of a statute begins with its

[8] *See* Petition for Review at 7.

text."[9] The Court also considers the legislative history and purpose of the statute.[10] Under this court's sliding scale approach, "the plainer the statutory language is, the more convincing the evidence of contrary legislative purpose or intent must be."[11] Here, the exception under AS 09.55.548(b) for collateral sources from a "federal program that by law must seek subrogation" is clear and unambiguous. Ms. McCollum has failed to offer any convincing evidence that the legislature considers ERISA benefits a "federal program," let alone that the Plan terms have the force of federal law. As discussed below, her position adopts an overly expansive reading that would swallow the rule and disregard the legislature's intent.

The Plan is not a "federal program" because the Lowes Companies, Inc. is a private employer who fully funds the plan, and the Plan is not sponsored, administered, or funded by the United States.[12] Ms. McCollum ignores several decisions recognizing that ERISA plans are private.[13] The Ninth Circuit explained "ERISA governs health plans meeting certain characteristics provided by any number of private employers... Moreover, no agency of the United States administers ERISA plans; private employers may administer their own ERISA plans or may contract for administration of plans from an independent

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[9] *Mat-Su Valley Med. Ctr. v. Bolinder*, 427 P.3d 754, 763 (Alaska 2018)(concluding that the plain language of Alaska's peer review statute supported a broader construction of the privilege even though evidentiary privileges are generally construed narrowly, reasoning that the text of the statute did not support a narrower interpretation).
[10] *Id.*
[11] *Id.*
[12] Petitioners' Br. at 3 & 15.
[13] Petitioners' Br. at 16 & n.13.

company."[14] Similarly, a Ninth Circuit dissenting opinion recognized that "federal programs" are those which use federal money, and the United States Supreme Court has specifically distinguished such federal programs from ERISA:

> The cases cited by the majority in support of this proposition, however, all involve federal programs, which are based on considerably different statutory schemes, and which use federal money. In *Hisquierdo v. Hisquierdo*, 439 U.S. 572, 59 L. Ed. 2d 1, 99 S. Ct. 802, the Supreme Court specifically distinguished such federal programs from ERISA:
>
> > In this case [involving a federal program], Congress has granted a separate spouse's benefit, and has terminated that benefit upon absolute divorce. Different considerations might well apply where Congress has remained silent on the subject of benefits for spouses, particularly where the [ ] pension program is a private one which federal law merely regulates. See Employment Retirement Income Security Act of 1974, 88 Stat. 829, 29 U.S.C. § 101 *et seq.* Our holding intimates no view concerning the application of community property principles to benefits payable under programs that possess these distinctive characteristics.[15]

The Alaska cases Ms. McCollum cites involving "federal programs" are distinguishable because the United States Government funded or administered those programs. For example, *Stanek v. Kenai Peninsula Borough*, 81 P.3d 268 (Alaska 2003) cited 12 U.S.C.S. § 1715I, which involves federally subsidized housing projects and the United States Government as the insurer of mortgages. Similarly, the reference to "federal

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[14] *Botsford v. Blue Cross & Blue Shield of Mont., Inc.*, 314 F.3d 390, 398 (9th Cir. 2002).
[15] *Ablamis v. Roper*, 937 F.2d 1450, 1467 (9th Cir. 1991)(Fletcher, J., dissenting)(brackets original)(quoting *Hisquierdo v. Hisquierdo*, 439 U.S. 572, 590 n.24, 59 L.Ed.2d 1, 99 S.Ct. 802 (1979), *superseded by statute*, 45 U.S.C.S. § 231m(b)(2)).

programs" in *Alaska Inter-Tribal Council v. State*, 110 P.3d 947, 960 (Alaska 2005) involved the Indian Police program operated by the federal government before statehood. *Kraus v. State*, 604 P.2d 12, 13 (Alaska 1979) referred to the Young Adults Conservation Corp. as a federal program, which provides jobs for unemployed young adults. That program was administered jointly by the United States Departments of Labor, Interior and Agriculture. Finally, the reference to a federal program in *Totemoff v. State*, 905 P.2d 954, 960 (Alaska 1995) involved a citation to Title VIII of the Alaska National Interest Lands Conservation ACT (ANILCA), which required the Secretary of the Interior and the Secretary of Agriculture to implement a joint program regarding subsistence uses of fish and wildlife resources on public lands unless the State of Alaska implemented a subsistence program consistent with ANILCA's requirements. Therefore, once again, the "federal program" was administered by the United States.

Here, no agency of the United States administers or funds the Lowe's Plan. There is no dispute that Lowe's is a private employer, that the plan is fully self-funded, meaning, all benefits are paid from Lowe's general assets, and the Plan is administered by Meritain Health, Inc. By definition, ERISA only applies to private employers.[16] The United States Supreme Court characterized an ERISA pension program as a "private one which federal law merely regulates."[17] The Court should readily conclude that the Lowe's Plan is not a "federal program."

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[16] Petitioners' Br. at 16.
[17] *Hisquierdo*, 439 U.S. at 590 n.24.

In addition, no federal law requires the Plan to seek subrogation or reimbursement. Ms. McCollum does not dispute that ERISA itself does not require reimbursement or subrogation, and instead argues, without any legal support whatsoever, that the Plan has "the force of federal law."[18] However, no court has held that an ERISA plan has the force of federal law. And the decisions Ms. McCollum cites involve analysis of ERISA's jurisdictional provisions, 29 USC § 1132, in suits against fiduciaries, plan administrators or beneficiaries, or suits commenced by the insurer against the insured.[19] None of those decisions involve ERISA's preemption provision or the third-party tortfeasor. In fact, the United States District Court for the District of Alaska held that 29 USC § 1132 does not confer subject matter jurisdiction in a medical malpractice case involving an ERISA collateral source benefit.[20] The Court explained that the underlying medical malpractice claims arise independently of ERISA and the terms of the Plan.[21] The Ninth Circuit affirmed, agreeing that "the duties implicated in Blakney's state law medical malpractice claims do not derive from ERISA. [ ] The tort duties at issue in the state law claims would exist regardless of whether an ERISA plan existed."[22] By logical extension, if ERISA has no impact on Dr. Knolmayer's duties to Ms. McCollum vis-à-vis her medical malpractice claim, ERISA likewise has no impact on Dr. Knolmayer's liability to Ms. McCollum.

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[18] Respondent's Br. at 15.
[19] *Id.* at 15 nn.24-26.
[20] *Blakney v. Prasad*, 2019 U.S.Dist. LEXIS 34472, *15-18 (D.Alaska, Feb. 5, 2019).
[21] *Id.* at *17-18.
[22] *Blakney v. Prasad*, 817 Fed. Appx. 504, 2020 U.S.App. LEXIS 26682, 2020 WL 4917610 (9th Cir. Aug. 11, 2020)(unpublished opinion)(citing *Depot, Inc. v. Caring for Montanans, Inc.*, 915 F.3d 643, 665-67 (9th Cir. 2019)).

Ms. McCollum's assumption that the Plan has the force of law is further belied by the plain language of ERISA's preemption provision, which states:

> **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…

29 USC § 1144(a)(emphasis added).

By contrast, FEHBA's preemption provision declares:

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

5 USC § 8902(m)(1)(emphasis added). In *Empire*, the Supreme Court explained that FEHBA's preemption prescription "is unusual in that it renders preemptive contract terms in health insurance plans, not provisions enacted by Congress."[23] However, unlike FEHBA, ERISA does not give preemptive force to contract terms and instead provides that the provisions of ERISA supersede state laws that relate to plans. This distinction between contract terms superseding and preempting state laws under FEBHA, and federal laws preempting state law under ERISA was recognized by the Second Circuit in *Empire*:

> Though courts generally decide FEHBA cases as if § 8902(m)(1) were a preemption provision like any other….., the provision is in fact quite unusual, because it provides that certain types of *contract terms* will "supersede and preempt" state laws in a particular field. 5 U.S.C. § 8902(m)(1). **Normally, preemption clauses provide that federal *law* will preempt state law. A typical provision might provide for preemption, for example, by expressly stating that the statute's provisions preempt state law, *see, e.g.*, Employee Retirement**

[23] *Empire HealthChoice Assur., Inc. v. McVeigh*, 547 U.S. 677, 697126 S.Ct. 2121, 165 L.Ed.2d 131 (2006).

> **Income Security Act (ERISA) [ ] § 514(a), 29 U.S.C. § 1144(a)**; 1976 Copyright Act § 301, 17 U.S.C. § 301(a), or by prohibiting state law from interfering with a policy established in federal law, *see, e.g.*, Communications Act § 253, 47 U.S.C. § 253. Regardless of a given provision's structure or wording, however, we generally take for granted that **it is *law*, and not a mere contract term, that carries the preemptive force**.[24]

If Congress intended to give preemptive effect to the contract terms of an ERISA plan, it would have written ERISA's preemption provision similar to FEHBA's. It did not. As such, ERISA does not give the Lowe's Plan contract the force of federal law.

Ms. McCollum's assertion to the contrary is not supported by the plain language of AS 09.55.548(b). If the legislature intended the construction advanced by Ms. McCollum, it would have stated "by law *or contract*" when it enacted subsection 548(b) in 1976, as it did when it enacted AS 09.17.070 in 1986. The legislature could have added "or contract" when it amended AS 09.55.548(a) in 1992. It did not. This court presumes "that the legislature intended every word, sentence, or provision of a statute to have some purpose, [ ] force, and effect, and that no words or provisions are superfluous."[25] Ms. McCollum and AAJ completely ignore the legislature's decision to omit the words "or contract" from the collateral source statute appliable to medical malpractice cases, while including "or contract" in the collateral source statute applicable to other civil cases.[26]

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[24] *Empire HealthChoice Assur., Inc., v. McVeigh*, 396 F.3d 136, 143 (2nd Cir. 2005)(italics original, bold added), *affirmed, Empire*, 547 U.S. 677.

[25] *Rydwell v. Anchorage Sch. Dist.*, 864 P.2d 526, 530-31 (Alaska 1993)(citation omitted).

[26] Premera is the only other litigant who addresses this argument, but their argument is completely unavailing because they fail to apply basic statutory construction principles. *See*, n.25, *supra*.

Ms. McCollum also ignores that ERISA is silent on reimbursement and subrogation. "ERISA does not regulate the substantive content of employee benefit plans. Thus, it neither requires nor bars subrogation or reimbursement clauses, and it does not otherwise regulate the content of these clauses."[27] Even if the Plan were a federal program (it is not), there is no question that ERISA does not require reimbursement or subrogation. While the terms of the Plan may require Ms. McCollum to reimburse the Plan, the exemption under subsection 548(b) only applies to federal programs that by law must seek *subrogation*, not programs that must seek *reimbursement*. The parties concede that the Plan's subrogation rights are discretionary.[28] This is consistent with Alaska law that defines an insurer's subrogation rights as optional.[29]

III. DR. KNOLMAYER'S INTERPRETATION OF AS 09.55.548(b) IS SUPPORTED BY THE PLAIN LANGUAGE OF THE STATUTE, LEGISLATIVE HISTORY AND CASELAW.[30]

It was understood at all times in the trial court that unless ERISA preempted AS 09.55.548(b), the medical expenses paid by the Plan were a collateral source subject to reduction under section 548(b). Although Ms. McCollum ostensibly challenges this interpretation, the plain language, legislative history, and this court's precedent all support

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[27] *Wood v. Prosser*, 1997 Tenn. App. LEXIS 418 (Ct. App. Tenn. June 11, 1997)(citations omitted).

[28] AAJ's Br. at 11; Premera's Br. at 4; Respondent's Br. at 4.

[29] *See* Petitioners' Br. at 24 & n.34 (quoting *Ruggles v. Grow*, 984 P.2d 509, 512 (Alaska 1999)("...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.")).

[30] This section responds to Ms. McCollum's argument sections I.B. and II. (pages 17-29 of her brief), as they both relate to the proper interpretation of AS 09.55.548(b).

the conclusion that, unless preempted, subsection 548(b) applies to the benefits paid by the Plan. Ms. McCollum certainly never argued for any other interpretation before the trial court, and she should be estopped from doing so now. As discussed below, her new interpretation lacks merit.

A. The Legislative History And Plain Language Of The Statute Support Reducing Ms. McCollum's Damages (If Any) By The Amount Of Medical Expenses Paid By The Plan.

Ms. McCollum downplays the circumstances that led to enacting subsection 548(b). While it is true the Commission noted Alaska's legal system did not have any significant problems *in the prior fifteen years*, the Commission determined that "[t]rends in law of judicial practice identified in the other states...eventually become the law or the practice in Alaska" and that "[t]here is a striking spread of malpractice litigation in the other states and frequent large judgments. The awareness of this phenomena is beginning to manifest a claims consciousness among patients in Alaska which is evident in a *recent increased frequency of actually filed or threatened new law suits against Alaska doctors*."[31] Although the medical malpractice insurance crisis was only a "perceived" crisis when the statute was enacted in 1976, there was nevertheless an "urgency" for the legislation to encourage doctors who had stopped practicing to return to work.[32] Moreover, this court has repeatedly recognized that the medical malpractice reform package enacted in 1976 was intended to alleviate a medical malpractice insurance crisis.[33]

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[31] Appx. A-24-25 (emphasis added).
[32] Appx. A-17-18; *see also,* Petitioners' Br. at 12-13.
[33] *Reid v. Williams*, 964 P.2d 453 (Alaska 1998); *see also, Keyes v. Humana Hosp. Alaska*, 750 P.2d 343, 352 (Alaska 1988). In holding that "[i]t is virtually beyond dispute that the

Ms. McCollum's brief also suggests that the conditions which justified enacting AS 09.55.548(b) in 1976 no longer exist or have been ameliorated.[34] This court rejected such an argument in *Reid v. Williams* as a basis for invalidating the statute.[35] To the extent the conditions that justified the statute have been ameliorated, the simple explanation could be that the statute is working as intended. Certainly, the record before this court contains no evidence contradicting the evidence before the Commission and the Legislature.

Ms. McCollum incorrectly claims that the legislature did not intend for plaintiffs to bear the loss. The Commission recognized:

> To permit no remedies to an injured person does not eliminate the loss; it only implements the policy that the injured person should bear the loss. To permit no change in the tort law and fail to provide physicians with adequate insurance only implements the policy to shift the burden completely to the negligent physician. To create a wholly State funded insurance mechanism only implements the policy that the taxpayers should bear the burden of the loss.[36]

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purpose of the numerous panel review procedures (including Alaska's) enacted during the early and mid-1970's was to alleviate the effects of the malpractice insurance crisis, the Court in *Keyes* cited *Attorney Gen v. Johnson,* 282 Md. 274, 385 A.2d 57 (Md. 1978), *appeal dismissed,* 439 U.S. 805, 58 L. Ed. 2d 97, 99 S. Ct. 60 (1978), for the proposition that "One would, in fact, have to be an ostrich to suggest that no medical malpractice insurance problems existed which the legislature could appropriately attempt to resolve.". *Keyes*, 750 P.2d at 352.

[34] *See* Respondent's Br. at 18 & n.36; *see also*, AAJ's Br. at 2-3.

[35] 964 P.2d 453, 460 (Alaska 1998)("We must also assume that the statute helped to alleviate the conditions perceived by the legislature in 1976; to abrogate the statute would potentially restore conditions that convinced the legislature to adopt the statute in the first place.").

[36] Appx. A-20.

By enacting AS 09.55.548(b), the Legislature made the policy decision that the injured person should bear the loss. Contrary to Ms. McCollum's assertion,[37] the Commission was well-aware of subrogation and collateral source liens:

> On the other hand, it was discovered that frequently a person would be allowed an award predicated upon out-of-pocket losses which, in fact, were wholly or partially compensated from other or collateral sources. The result is potential for double recovery, and the presentation of the additional complications of subrogation and collateral source liens.[38]

As Ms. McCollum concedes, HB 574 proposed: "...Notwithstanding other provisions of state law, and except as provided in this subsection, a collateral source does not have a right of subrogation."[39] By eliminating this sentence from the final version of AS 09.55.548(b), the legislature made the policy decision that the injured person would not be able to recover certain collateral sources, while preserving the collateral sources' subrogation rights and lien. This further demonstrates the legislature's intent to put the burden of loss on the plaintiff.

Although Ms. McCollum suggests that the trial court can simply add back the value of the collateral sources if the claimant's rights were impaired "by either reimbursement or subrogation,"[40] this interpretation is not supported by the plain language of the statute or

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[37] AAJ argues that health insurers did not begin seeking subrogation until the 1980s. AAJ Br. at 3 & nn.4-5. This fact supports upholding subsection 548(b). 1980 was forty years ago. Insurers have been seeking subrogation and/or reimbursement for forty years and yet this court has upheld medical malpractice reform statutes, and our legislature has not substantively amended subsection 548(b).

[38] Appx. A-29.

[39] Appx. B-1. Respondent's Br. at 21.

[40] Respondent's Br. at 22.

legislative history. The actual language of the statute is "...the value of claimant's rights to coverage exhausted or depleted..." There is no mention of reimbursement or subrogation, as Ms. McCollum suggests. Moreover, Ms. McCollum never claimed her rights to coverage have been exhausted or depleted. At oral argument, Dr. Knolmayer pointed out that Ms. McCollum conceded she would continue to receive whatever benefits she has under the plan, regardless of whether or not the statute applies.[41] She did not dispute this fact.

In any event, Ms. McCollum's interpretation is overbroad and illogical. If the Court were to add back collateral sources simply because they have a right to subrogation or reimbursement, that would swallow the rule. As mentioned above, the legislature decided not to include such language.[42] If the legislature intended the meaning advanced by Ms. McCollum, then it would have written subsection 548(b) similar to AS 09.17.070, which does not allow an offset for collateral sources that have a right of subrogation.[43] The Court cannot adopt Ms. McCollum's interpretation because it would render subsection 548(b) entirely superfluous.[44]

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[41] Tr. July 24, 2018 Oral Argument at 34:11-15.

[42] *See*, n.39, *supra.*

[43] AS 09.17.070(a) provides: "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."

[44] *See, e.g., FDIC v. Laidlaw Transit*, 21 P.3d 344, 353 (Alaska 2001)("to apply FDIC's plain meaning of subsection .822(a), then, would nullify the section .823 defense, rendering the provision entirely superfluous. This, in turn would clash with the rule of construction holding that, as a general rule, a 'statute should be construed so that effect is given to all its provisions, so that no part will be inoperative or superfluous, void or insignificant.'")(citations omitted).

Ms. McCollum points out that the Commission rejected various recommendations.[45] In deciding how to recommend reducing the size of awards, the Commission studied several proposals and rejected arbitrary limits on awards.[46] This shows that the Commission's process and decision to recommend what ultimately became AS 09.55.548 was thoughtful, well-informed, and not arbitrary, further supporting the constitutionality of the statute.

By arguing the statute benefits tortfeasors and "punishes" the plaintiff, Ms. McCollum attacks the statute on equity and policy grounds.[47] The plaintiff in *Reid* made a similar argument, which was rejected by this court.[48] This court has routinely recognized that "[i]t 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."[49] Moreover, the statute does not "punish" the plaintiff. If

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[45] Respondent's Br. at 19.

[46] Appx. A-28-29.

[47] Ms. McCollum claims her contract contains "harsh" terms requiring her to reimburse her insurer even if she is not made whole. Respondent's Br. at 3. Yet, the parties concede this is a standard, enforceable term. *Id.*; *see also* AAJ Br. at 5; Premera Br. at 3 & 11.

[48] *Reid*, 964 P.2d at 458. Although Ms. McCollum and amici urge a "narrow" interpretation of subsection 548(b), there is no reason why this case should be treated any different than *Reid*.

[49] *Concerned Citizens v. Kenai Peninsula Borough*, 527 P.2d 447, 452 (Alaska 1974); *Evans v. State*, 56 P.3d 1046, 1051 (Alaska 2002)(agreeing with several other decisions that have held that damages caps do not violate the constitutional right to a trial by jury because "[t]he decision to place a cap on damages awarded is a policy choice and not a re-examination of the factual question of damages determined by the jury"); *North Kenai Peninsula Rd. Maintenance Serv. Area v. Kenai Peninsula Borough*, 850 P.2d 636, 640 (Alaska 1993); *Anchorage v. Leigh*, 823 P.2d 1241, 1244 (Alaska 1992); *Dunn v. Municipality of Anchorage*, 100 P.3d 905, 908 (Alaska Ct. App. 2004); *Ward v. State*, 288 P.3d 94, 106 (Alaska 2012)("When a statute unambiguously requires a certain result, policy arguments advocating for a different result are better addressed to the legislature.");

the end result is that Ms. McCollum bears the costs of her medical expenses, that is because her insurance contract requires it after this lawsuit is over, not because there was an offset for the collateral source under subsection 548(b). But what happens after this lawsuit is a matter between Ms. McCollum and her insurer.[50] The crux of Ms. McCollum's argument is that her contract is inequitable. This argument is misplaced as her potential contractual defenses have no bearing on an ambiguous statute.[51]

B. Caselaw Supports Dr. Knolmayer's Interpretation of AS 09.55.548(b).

Ms. McCollum asks the Court to read an exception into subsection 548(b) for benefits that were provided on the condition that they are subject to reimbursement. Neither the legislative history, caselaw, nor plain language of the statute support this interpretation.

Ms. McCollum misunderstands Dr. Knolmayer's reliance on *Weston v. AK Happytime, LLC*, 445 P.3d 1015 (Alaska 2019) and *Reid* to argue that subsection 548(b) does not bar any claims. These cases identify the correct post-trial procedure for reducing a damage award under Alaska's collateral source statutes.[52] Ms. McCollum does not dispute this procedure. Instead, she attempts to draw factual distinctions between these

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Benavides v. State, 151 P.3d 332, 336 (Alaska 2006)("The fairness or wisdom of [legislative] policy, however, is not for a court to determine; we consider only compliance with the statute.")

[50] Ms. McCollum argued before the trial court that there is an "intrinsic unfairness" by the operation of subsection 548(b) and the terms of her Plan. Tr. July 24, 2018 Oral Argument at 21:16-22:5 & 23:18-24. As Dr. Knolmayer pointed out, Ms. McCollum is asking the Court to make assumptions about what the insurer will do after this case is over. *Id.* at 35:11-36:5. She claims the insurer will exercise its permissive right to reimbursement and seek the full amount of benefits it paid, but it is not uncommon for an insurer to discount and accept less than the amount it paid. *Id.*

[51] *See* n.49, *supra.*

[52] *See* Petitioners' Br. at 19-21.

cases, arguing those plaintiffs did not have to reimburse their insurer from an award meant to compensate losses other than past medical expenses. It is true that *Weston* and *Reid* do not discuss resolution of the insurer's lien to the Plaintiff's recovery, but that does not mean that the plaintiffs were not faced with such liens.[53] Rather, it simply demonstrates that the trial court need not concern itself how liens are resolved between the plaintiff and her insurer at the conclusion of the lawsuit when applying Alaska's collateral source statutes. These cases support Dr. Knolmayer's arguments, not Ms. McCollum's.

Ms. McCollum's reliance on other states' collateral source statutes to support the legislative intent behind subsection 548(b) is misplaced. Other state statutes are no indication as to what our legislature intended. *In re September 11 Litigation*, is particularly unhelpful to Ms. McCollum's position.[54] That decision supports Dr. Knolmayer's argument that subsection 548(b) is not the type of anti-subrogation statute typically found to be preempted by ERISA because it does not prevent the plan from pursuing a direct action against Dr. Knolmayer. Unlike this case, *In re September 11 Litigation* involved direct subrogation claims brought by insurers.[55] The court concluded that New York's collateral source statute did not bar the insurers from pursuing direct subrogation claims.[56] However, the Court recognized that the statute "denies tort plaintiffs the right to recover

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[53] *Weston* involved Medicare benefits. Under both AS 09.17.070 and AS 09.55.548(b), there would not be a reduction for the Medicare benefits. *Reid* involved payments by the plaintiff's "insurer." While the court did not expound any further upon the collateral source, nothing suggests that the insurer would not have a had at least an equitable lien by agreement with its insured.

[54] 649 F.Supp.2d 171 (N.Y.D.C. 2009).

[55] *Id.* at 172.

[56] *Id.* at 172 & 183-84.

damages that duplicate insurance recoveries," requiring a reduction of damages for a plaintiff's medical expenses.[57]

Toomey v. Surgical Services, P.C., is even more inapposite as that decision involved a conflict between two Ohio state laws – one collateral source statute applicable to medical malpractice cases, and a separate statute that allowed an employer's worker's compensation lien on a third-party recovery.[58] The insurer intervened in the employee's medical malpractice action to assert a subrogation lien.[59] The Court declined to allow the employer's worker's compensation lien, concluding it would be more equitable for the insurer, which has been paid a premium for the workers' compensation coverage, to bear the loss.[60] Importantly, the Court concluded that the collateral source statute applied and limited the plaintiff's recovery in his medical malpractice case.[61]

Loftsgard v. Dorrian, was another Iowa case.[62] Instead of applying Iowa's collateral source statute applicable to medical malpractice cases, Iowa Code § 147.136 (which was at issue in *Toomey*), this decision involved Iowa's other collateral source statute, Iowa Code § 668.14, which applies to nonmedical malpractice civil cases.[63] This statute allowed

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[57] *Id.* at 179 & 182 (quoting *Omiatek v. Marine Midland Bank, N.A.*, 9 A.D.3d 831, 781 N.Y.S.2d, 389, 391 (N.Y. App. Div. 2004) for the proposition that "[A]lthough CPLR 4545(c) requires a reduction of the damages for medical expenses with respect to plaintiff, defendant still may be held responsible in subrogation to . . . [plaintiff's health care] insurer.")(brackets original).
[58] 558 N.W.2d 166 (Iowa 1997).
[59] *Id.* at 167.
[60] *Id.* at 169-70.
[61] *Id.*
[62] 476 N.W.2d 730 (Iowa Ct. App. 1991).
[63] *Id.* at 733.

a plaintiff to introduce evidence concerning existing rights of indemnification or subrogation.[64] The analogue to Iowa Code § 668.14 in Alaska would be AS 09.17.070, which similarly applies to civil actions other than medical malpractice actions, and does not apply to "collateral sources that do not have a right of subrogation by law or contract." AS 09.55.548(b) is broader and applies regardless of whether a mere right to subrogation exists.

Unlike both *In re Sept. 11 Litigation* and *Toomey*, the insurer here has not pursued a direct subrogation claim against Dr. Knolmayer. This case only concerns Ms. McCollum's recoverable damages in a medical malpractice case. Even under New York's and Ohio's collateral source statutes, Ms. McCollum would not be able to recover the benefits paid by the Plan.[65] Therefore, applying subsection 548(b) to this case does not lead to an "absurd" result.

Ms. McCollum argues "[n]o state courts interpret statutes in a manner that imposes on the insured plaintiff the obligation to repay collateral source benefits (ERISA or otherwise) when prevented from recovering from the tortfeasor."[66] This is wrong,[67] and

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[64] *Id.*

[65] Ms. McCollum disingenuously suggests her damages would be limited to $250,000. Respondent's Br. at 27. She has alleged recklessness and punitive damages, and she does not account for other alleged economic damages such as lost wages or judgment add-ons, *i.e.*, prejudgment interest, costs and attorney's fees. Additionally, an inherent risk exists in any litigation that a plaintiff may not recover any damages, let alone damages that make them whole.

[66] Respondent's Br. at 29.

[67] Ms. McCollum relied on *Electro-Mechanical Corp. v. L Ogan E,* 9 F.3d 445 (6th Cir. 1993) in her briefing before the trial court. [Exc. 130] Dr. Knolmayer distinguished *Electro-Mechanical Corp.*, as that case involved an action by the plan administrator against plan participants who refused to reimburse the plan after they settled their medical

confuses the issues. Subsection 548(b) does not impose any obligation on Ms. McCollum to repay the Plan – her health insurance contract with Lowe's imposes that obligation, and that contract is separate and apart from Dr. Knolmayer's liability to Ms. McCollum.[68] Essentially, Ms. McCollum wants Dr. Knolmayer to pay the price for her bad contract decision. In *U.S. Airways v. McCutchen*, the United States Supreme Court held a beneficiary to the reimbursement terms of its ERISA health benefits plan, rejecting the insured's equitable defenses.[69] The Court recognized that a beneficiary may be made worse off by pursuing a third-party action, but the terms of a plan nevertheless apply because enforcing the lien means holding the insurer and insured to their mutual promises.[70]

In sum, Dr. Knolmayer's interpretation of subsection 548(b) is consistent with this Court's prior interpretation and application of subsection 548(b) to reduce medical malpractice damages by the amount of their collateral sources in *Reid*. Other states have similarly applied their medical malpractice collateral source statutes regardless of the presence of any potential lien, when the insurer is not pursuing a direct subrogation claim.[71] This court should find that while subsection 548(b) does not bar Ms. McCollum from

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malpractice claim. The issue was whether the statute precluded the plan administrator from asserting its subrogation rights against its plan participants *after* the medical malpractice action had settled. Notably, the participants in *Electro-Mechanical Corp.* conceded that, under state statute, they would be precluded in their underlying medical malpractice action from recovering medical expenses from the tortfeasor that were paid for by collateral sources. [Exc. 145-46]

[68] *Empire*, 547 U.S. at 680.

[69] 569 U.S. 88, 133 S.Ct. 1537, 185 L.Ed.2d 654 (2013).

[70] 133 S.Ct. at 1546-48 & 1550-51.

[71] *See, e.g., Toomey, supra.*

seeking an award of medical expenses paid by the plan, such an award is subject to reduction under the statute in a post-trial proceeding.

IV. LOWE'S HAS CHOSEN TO SEEK REIMBURSEMENT FROM MS. MCCOLLUM INSTEAD OF PURSUING A DIRECT SUBROGATION CLAIM AGAINST DR. KNOLMAYER.

The relevant question posed by this court was whether an insurer can assign a contractually subrogated claim to a plaintiff, and whether there was an effective assignment in this case. Ms. McCollum does not answer that question, and instead misconstrues both Dr. Knolmayer's arguments and the terms of the Plan.

Ms. McCollum claims that subrogation allows her to stand in the shoes of the Plan.[72] Quite the opposite, it is the subrogated insurer who stands in the shoes of its insured.[73] This is important because the subrogated insurer is subject to any defenses a third party would have against the insured, and has no greater rights than the insured.[74]

This court has characterized an insurer's subrogation claim as an assignment.[75] The United States Supreme Court called it an "equitable lien by agreement."[76] Ms. McCollum attempted an assignment of the Plan's claim, but never finalized one. Regardless of how the Court characterizes the Plan's claim, the Plan has chosen to obtain reimbursement from any recovery Ms. McCollum receives, not pursue a direct subrogation claim against Dr. Knolmayer.

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[72] Respondent's Br. at 30.
[73] Petitioners' Br. at 21.
[74] *Id.* at 21-23.
[75] *See* Petitioners' Br. at 24 & n.34 (quoting *Ruggles v. Grow*, 984 P.2d 509, 512 (Alaska 1999)).
[76] *U.S. Airways v. McCutchen*, 569 U.S. at 95.

Ms. McCollum ignores that her Plan defines subrogation and reimbursement separately. The Plan clearly contemplates that the Plan has the right (but not the obligation) to pursue a subrogation claim in its own name against a third party. [Exc. 88-89] Separate and apart from this right of subrogation, the Plan provides that it has a right to reimbursement from any recovery Ms. McCollum receives in this case. [*Id.*] Nothing in the Plan contemplates Ms. McCollum having a subrogation right.

This court should reject Ms. McCollum's arguments regarding joinder of the Plan. The trial court denied Ms. McCollum's motion for joinder, and she never petitioned for review of that order. Nor is joinder warranted because the Plan is a partially subrogated insurer. This court has routinely held that partially subrogated insurers who are clearly bound by the result of the lawsuit should *not* be joined.[77] The Plan did not join as a plaintiff in the trial court, or on interim review, despite this court's invitation. By its actions, the Plan has chosen to be bound by the trial court's and this court's orders. Multiple terms in the Plan further demonstrate an intent to be bound by state law. The Plan has a broad "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 Plan also subjects itself to state laws regarding subrogation: "Notwithstanding anything contained herein to the contrary, to the extent this Plan is not governed by ERISA, the Plan's right to subrogation and reimbursement may be subject to applicable State subrogation laws." [Exc. 90]

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[77] *Municipality of Anchorage v. Baugh Constr. & Eng. Co.*, 722 P.2d 919, 924 (Alaska 1986)(collecting cases)).

The Court should also reject Ms. McCollum's suggestion that a direct subrogation claim by the Plan would not be time-barred. Although Ms. McCollum now claims it is unclear when such a claim would accrue, she sought relief in the trial court that if the Plan joined the action, the statute of limitations would not apply. [Exc. 197] She does not dispute the legal authority cited by Dr. Knolmayer that an insurer' subrogation claim is subject to the same statute of limitations its insured has in tort.[78]

Finally, Ms. McCollum fails to meaningfully distinguish *Qualchoice, Inc. v. Nationwide Ins. Co.*, 2009 WL 943538, 2009 Ohio App. LEXIS 1426 (Ohio April 9, 2009) or *Rudel v. Hawai'i Mgmt. Alliance Assoc.*, 937 F.3d 1262 (9th Cir. 2019) as Dr. Knolmayer correctly quoted those cases. Namely, the Court in *Qualchoice* concluded that "subrogation claims by ERISA benefit plans are governed by state law and are not preempted."[79] Similarly, *Rudel* recognized there is no conflict between a Hawaii statute that impacts the insurer's subrogation rights because ERISA is silent on such rights.[80]

There is no ambiguity in the terms of the Plan, Alaska caselaw, or the Plan's actions that suggest anything other than the fact that the Plan has chosen to seek reimbursement from Ms. McCollum rather than pursue a direct subrogation action against Dr. Knolmayer.

V. THERE IS NO CONFLICT BETWEEN ERISA AND AS 09.55.548(b) BECAUSE BOTH LAWS CAN BE COMPLIED WITH.

Although tangential issues of joinder and assignment arose, the primary issue before the trial court was whether ERISA preempted AS 09.55.548(b). The trial court consistently

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[78] *See* Petitioners' Br. at 25 n.36.
[79] *Id.* at 25 n.37.
[80] *Id.* at 26 n.39.

ruled that ERISA did not preempt subsection 548(b). Ms. McCollum never sought interim review of that issue, and she only devotes four pages of her fifty-page brief to this issue. Her arguments are just as unavailing now as they were in the trial court.

Ms. McCollum relies heavily on *FMC Corp. v. Holliday*.[81] The Pennsylvania statute at issue in that case is readily distinguishable because it provides "there shall be no right of subrogation or reimbursement from a claimant's tort recovery with respect to [benefit payments by any program, group contract or other arrangement]."[82] *FMC Corp.* involved an action by the insurer against its insured who refused to reimburse the insurer after settling a personal injury case arising from a motor vehicle accident. The issue was whether the Pennsylvania law precluded the insurer from asserting its subrogation rights against its insured after settlement of the personal injury claim. The Court held that Pennsylvania's anti-subrogation law "relate[s] to" an ERISA plan because it "prohibits plans from being structured in a manner requiring reimbursement in the event of recovery from a third party."[83]

Unlike Pennsylvania's law, AS 09.55.548 does not have any impact on how health plans are structured, or preclude plans from seeking reimbursement or subrogation. Subsection 548(b) is not an anti-subrogation statute because the legislature did not include the phrase "…a collateral source does not have a right of subrogation."[84] Nothing prevents

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[81] 498 U.S. 52, 58-61, 111 S.Ct. 403, 112 L.Ed.2d 356 (1990).
[82] *Id.* at 55.
[83] *Id.* at 60.
[84] *See* n.39, *supra*.

the plan from seeking reimbursement from Ms. McCollum after this lawsuit is over. Subsection 548(b) merely governs Dr. Knolmayer's liability to Ms. McCollum.

Ms. McCollum concedes that under *Bui v. American Telephone Co. Inc.*, 310 F.3d 1143 (9th Cir. 2002), her medical malpractice claim is governed by state law and is not preempted by ERISA. Since her claim is governed by state law and not ERISA, it follows that Dr. Knolmayer's defenses should also be governed by state law and not ERISA. The distinction in the relationships between an insured and insurer, and the insured and tortfeasor finds support in this court's precedent as well as the United States Supreme Court.[85] Ms. McCollum does not dispute the basic premise that a tortfeasor's liability should be governed by state law, not a contract to which it is not a party.

Finally, Ms. McCollum does not challenge the well-reasoned analysis of Judge Kauvar in *French v. McIntyre*, Case No. 4FA-14-01377 CI, which relied on *Alaska State Council of Carpenters v. United Brotherhood of Carpenters & Joiners of America, Local 1281*,[86] to conclude that ERISA does not preempt subsection 548(b). [Exc. 152-161] In *Alaska State Council of Carpenters*, this court explained that ERISA preempted state laws that "had a substantial impact on the terms of the benefit plans," and "either affected the benefits or terms of ERISA plans; created reporting disclosure, funding, or vesting requirements for ERISA plans; dictated rules for calculating benefits under ERISA plans;

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[85] *See* Petitioners' Br. at 38-39.
[86] 727 P.2d 306 (Alaska 1986).

or provided remedies for the maladministration of ERISA plans."[87] Judge Kauvar correctly concluded that subsection 548(b) does none of these things. [Exc. 159]

Alaska State Council of Carpenters also held that "no conflict exist[ed] because ERISA contains no provisions which govern trustee selection. Nor does state organizational law frustrate ERISA's main objective: to ensure that works will receive their promised benefit if they fulfill the conditions for obtaining those benefits."[88] Since ERISA is silent regarding reimbursement or subrogation, there is no conflict between subsection 548(b) and ERISA. This is especially true here since the Plan specifically subjects its subrogation and reimbursement rights to State subrogation laws. [Exc. 90] By so doing, the Plan has subjected its subrogation and reimbursement rights to subsection 548(b). The Plan here provides that Ms. McCollum's benefits are conditional and that the Plan is entitled to recover even if she is not made full. [Exc. 88-89][89] Thus, like the plan in *French,* "full recovery is not a 'promised benefit' of the health plan which Plaintiff can obtain upon fulfilling the plan's conditions, so Alaska Statute 09.55.548(b) does not frustrate ERISA's objective." [Exc. 159-60] In other words, subsection 548(b) does not relate to the Plan because the Plan contemplates the possibility that Ms. McCollum may not be made whole.

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[87] *Id.* at 309; *see also*, Exc. 158, Judge Kauvar's Order at 7 & n.23.
[88] *Id.* at 311; *see also*, Exc. 159, Judge Kauvar's Order at 8 & n.28; *see also, Brazil v. OPM*, 35 F.Supp.3d 1101, 1111 (N.D.Cal. 2014)(Conflict preemption only occurs where it would be "impossible for a private party to comply with both state and federal requirements or where the state law stands as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress.") (internal quotation omitted).
[89] Petitioners' Br. at 3-4.

VI. MS. MCCOLLUM FAILED TO ESTABLISH THAT AS 09.55.548(b) IS UNCONSTITUTIONAL.

A. AS 09.55.548(b) Does Not Violate Substantive Due Process.

Ms. McCollum has failed to establish that subsection 548(b) bears no reasonable relationship to a legitimate governmental purpose. The legislative history as well as this court's precedent establish that the legislature's decision is based on rational policy and not arbitrary.

Ms. McCollum suggests this Court did not have enough evidence in *Reid* to evaluate the legislature's objectives in enacting subsection 548(b). The Court relied on the House and Senate committee files for the 1976 medical malpractice reform legislation as well as its prior decisions, *Plumley v. Hale*, 594 P.2d 497 (Alaska 1979) and *Keyes v. Humana Hospital Alaska, Inc.*, 750 P.2d 343 (Alaska 1988).[90]

Ms. McCollum confuses eliminating "double recovery" as an objective of subsection 548(b).[91] The objectives of the statute were to address a perceived medical malpractice insurance crisis, to furnish health care providers with medical malpractice insurance, and ensure the availability of health care.[92] Reducing a plaintiff's damages by the amount of collateral sources is one of the ways those objectives are served. In making its recommendation, the Commission considered several proposals and rejected arbitrary

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[90] *Reid*, 964 P.2d at 457.
[91] Respondent's Br. at 19; *see also*, AAJ Br. at 2 & 4-5; Premera Br. at 6-7.
[92] Petitioners' Br. at 12-14 & 30-31.

limits on awards.[93] The legislature's decision was based on rational policy, and Ms. McCollum failed to disprove the factual justification for the statute.

Although Ms. McCollum maintains the legislature did not foresee collateral sources seeking reimbursement, this position is not supported by the legislative history. The Commission was aware of subrogation and liens, and the legislature removed language that would have made subsection 548(b) an anti-subrogation statute. While Ms. McCollum complains that subsection 548(b) shifts medical expenses to plaintiffs, this is exactly the same policy argument advanced by the plaintiff in *Reid* that was rejected by this court.[94] The court should conclude that Ms. McCollum has not met the burden of establishing that there is no conceivable legitimate public policy for the enactment of subsection 548(b).

B. AS 09.55.548(b) Does Not Violate Equal Protection.

Ms. McCollum argues a heightened scrutiny should be applied because subsection 548(b) violates her right to a trial by jury, relying on *Evans v. State*, 56 P.3d 1046 (Alaska 2002) for support. *Evans* does not support Ms. McCollum's argument. *Evans* evaluated the constitutionality of caps on noneconomic and punitive damages. The Court held that the damages caps did not limit access to the courts or infringe on the right to a jury trial. The court reasoned that the cap was a "policy choice and not a re-examination of the factual question of damages determined by the jury."[95] The Court also concluded that the damages caps do not constitute a denial of equal protection, reasoning that the damages caps "do not

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[93] *See* n.46, *supra*.
[94] *Reid,* 964 P.2d at 457-58.
[95] 56 P.3d at 1051.

actually limit access to the courts; rather, they simply limit a plaintiff's recovery in civil court."[96]

Here, Ms. McCollum does not dispute that subsection 548(b) applies, if at all, in a post-trial procedure after the jury had rendered its award. Therefore, the statute does not impair Ms. McCollum's right to a jury trial or access to the courts.

Evans and *Reid* both held that restrictions on the types or amount of damages that a plaintiff can pursue in court only infringe upon economic interests, which require only that the State's objective be "legitimate" and not "compelling" for the purpose of an equal protection analysis.[97] As in *Reid*, the Court in *Evans* again declined the plaintiff's invitation to "second-guess the legislature's factual findings" and "delve into question of policy formulation that are best left to the legislature."[98] Here, 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.[99] 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."[100] The Commission made twenty-seven recommendations regarding medical malpractice actions, one of which eventually became subsection 548(b). The record establishes that subsection 548(b) bears a fair and substantial

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[96] *Id.* at 1052.
[97] *Id.* at 1052-53.
[98] *Id.* at 1053-54.
[99] Appx. A-16.
[100] Appx. A-28.

relation to attaining legitimate governmental objectives. This court should not second guess or weigh the evidence before the legislature.

CONCLUSION

There is no question that in enacting Alaska Statute 09.55.548(b), the legislature implemented a policy that shifts the loss to the plaintiff, regardless of whether a right to subrogation exists. The plaintiffs' bar and Premera ask this Court to interpret Alaska Statute 09.55.548(b) in a way that would erode the statute and render it meaningless. Their position is contrary to this Court's precedent, as well as the decisions of other courts. Although some cases have found ERISA preemption of state statutes, courts have only done so in cases between insurers and their insureds. Not one case cited by any party stands for the proposition that ERISA preemption extends to a tortfeasor's liability to a personal injury plaintiff under a state's collateral source statute. Ms. McCollum essentially argues it would be absurd and unfair for subsection 548(b) to apply to her given the promises she made to her insurer, but it would be far more absurd and inequitable for a tortfeasor's liability to be governed by a contract to which he is a stranger or to allow such a contract to undermine clear legislative intent.