IN THE SUPREME COURT OF THE STATE OF ALASKA

THOMAS J. KNOLMAYER, M.D., and ALASKA TRAUMA AND ACUTE SURGERY, LLC, Petitioners, vs. CHARINA MCCOLLUM and JASON MCCOLLUM, Respondents. Superior Court Case No. 3AN-16-04601 CI	)	Supreme Court No. S-17792

PETITION FOR REVIEW FROM THE SUPERIOR COURT,
THIRD JUDICIAL DISTRICT AT ANCHORAGE,
THE HONORABLE HERMAN G. WALKER, JR., JUDGE

RESPONDENTS' BRIEF

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Filed in the Supreme Court
of the State of Alaska, this
5th day of March 2021.

Meredith Montgomery, Clerk

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29 U.S.C. § 1132(a)(3). Civil Enforcement.

(a) Persons empowered to bring a civil action
A civil action may be brought
(3) by a participant, beneficiary, or fiduciary for appropriate relief under section 1109 of this title.

29 U.S.C. § 1144(a). Other Laws.

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

29 U.S.C. § 1144(b)(2)(A). Other Laws.

(b) Construction and application
(2)(A) Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

ALASKA STATUTES

AS 09.55.530. Declaration of Purpose.

The legislature considers that there is a need in Alaska to codify the law with regard to medical liability in order to establish that the law in Alaska in this regard is the same elsewhere.

AS 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.

JURISDICTIONAL STATEMENT

Dr. Thomas Knolmayer filed a petition for review to the Alaska Supreme Court of the trial court's April 30, 2020 Order that ruled Charina and Jason McCollum's federally governed health benefits plan is "a federal program that by law must seek subrogation" within the meaning of AS 09.55.548(b) ("Section 548(b)" or "§ 548(b)"). [Exc. 283-307] This Court's October 29, 2020 Order granted Dr. Knolmayer's Petition for Review. This Court has jurisdiction pursuant to Appellate Rule 402.

STATEMENT OF THE ISSUES PRESENTED FOR REVIEW

Dr. Thomas Knolmayer's medical negligence injured Charina McCollum compelling significant medical treatment and hospitalization. Lowe's Companies, Inc. Welfare Benefits Plan ("Plan") paid those expenses as part of an employment-related ERISA-regulated medical insurance plan, which requires Charina to reimburse the Plan for "100%" of benefits paid by a tortfeasor "without deduction for attorney's fees and costs" and "without regard to whether the [insured] is fully compensated by his or her recovery from all sources." [Exc. 88-89] Alaska Statute 09.55.548(b) creates a medical malpractice specific collateral source rule aimed at preventing double-recovery by a plaintiff by limiting recovery of benefits paid by other sources. Does AS 09.55.548(b) penalize Charina for the negligent injury caused by Dr. Knolmayer by:

(1) narrowly defining a "federal program" contemplated in AS 09.55.548(b) to exclude federally governed ERISA plans that have the full force of federal law in compelling reimbursement from Charina;

(2) barring Charina from recovering money she is forced by federal law to repay to the Plan;

(3) preventing the Plan from assigning its right to reimbursement to Charina to ensure the Plan's right to reimbursement and subrogation are protected; and

(4) violating the Alaska Constitution's due process and equal protection guarantees by financially and legally obligating a class of insured plaintiffs to pay significant health care costs resulting from an injury inflicted by a negligent health care provider, while others similarly situated are not burdened by such claims.

STATEMENT OF FACTS

Charina McCollum expected to have her gallbladder removed by Dr. Knolmayer. Instead, during the gallbladder removal surgery, Dr. Knolmayer severed her hepatic artery, or bile duct. [Exc. 1] Charina's severed bile duct caused extensive injuries that required medivacing her to Virginia Mason Medical Center in Seattle and a lengthy hospitalization. [Exc. 2-3] Charina and her husband, Jason, filed a medical malpractice case against Dr. Knolmayer alleging he negligently and recklessly violated the applicable standard of care and that his medical negligence caused Charina to suffer economic and non-economic losses. [Exc. 1-3] Dr. Knolmayer admitted that he severed Charina's bile duct. [Exc. 4-5]

Charina's husband, Jason, was employed by Lowe's Companies, Inc., a nationwide home improvement chain at the time of her surgery. Lowe's employees and their spouses receive medical benefits coverage under Lowe's self-funded "Welfare

Benefits Plan." [Exc. 108] The Plan is regulated and administered by Employee Retirement Income Security Act of 1974 ("ERISA"). [Exc. 92, 101, 108]

The Plan paid for most of the medical care Charina needed to treat the injury caused by Dr. Knolmayer, totaling $349,049.87. [Exc. 109-112] But after the lawsuit was filed, the Plan notified the McCollums that it had a "[s]ubrogation, reimbursement, and/or third party recovery provision requiring full reimbursement of all related claims paid by the Plan upon settlement of this claim." [Exc. 259] The notice explained that "[s]ince the Plan is a self-funded plan governed by ERISA, state law is preempted . . . ." [*Id.*]

The Plan includes harsh and comprehensive terms requiring any covered person to protect the Plan's interests in being reimbursed for any injury caused by a tortfeasor, even if it means burdening the injured person with those costs and seizing an entire settlement or verdict.

The Plan terms allowing for reimbursement are standard ERISA Plan terms entitling the Plan to "100% of the benefits paid, without deduction for attorneys' fees" and explicitly rejects legal theory aimed at protecting an injured person's right to compensation. [Exc. 88-89] It does not matter if the covered person cannot and did not recover the costs of the benefits paid from the tortfeasor because benefits still must be repaid even when the "recovery is less than the benefits paid" or when the covered person is not fully compensated. [*Id.*] Failure to reimburse the Plan exposes the covered person to paying "any and all expenses (fees and costs) associated with the Plan's attempt to recover such money." [*Id.*]

The Plan also details a separate but related subrogation right that conditions the receipt of benefits to an agreement by the covered person "[t]o assign to the Plan the right to subrogate any and all claims, causes of action or rights." [Exc. 88] The Plan also includes an "automatic equitable subrogation claim" that "attaches to any claim" a covered person has against a party causing an injury. While the requirement to reimburse is absolute, the Plan has complete discretion to exercise subrogation. [*Id.*]

The Plan details the obligations of a covered person including the obligation to "cooperate with the Plan . . . in protecting its rights" also any action "[t]o facilitate enforcement of its subrogation and reimbursement rights," and the duty to not settle any claim without consent of the Plan. [Exc. 90] Any failure to comply with these terms allows the Plan to stop paying all current and future medical benefits until the covered person "satisfies his or her obligation." [*Id.*] In other words, by filing a lawsuit Charina and Jason McCollum were required to protect the Plan's interest in recovering the $349,049.87 even though Alaska law restricted their ability to recover that amount. Failing to do so without delay (or challenge) jeopardized their current and future health care, as well as an actual attorney's fee award.

The McCollums asked the trial court to find that ERISA preempted AS 09.55.548(b), citing to 29 U.S.C. § 1144(a) and federal cases interpreting ERISA preemption. [Exc. 8-15] Explaining that the broad preemption language in § 1144(a) that provides ERISA plans "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan" empowered the Plan to require Charina to protect the Plan's right to subrogate and/or reimburse the benefits paid for the

treatment of her injuries. The McCollums explained, AS 09.55.548(b) related to the Plan because it attempted to restrict Charina's recovery of those expenses. [*Id.*]

Ignoring the requirement that Charina was required to assist the Plan in obtaining either reimbursement or subrogation, Dr. Knolmayer argued AS 09.55.548(b) did not "relate to" the plan and was not preempted because it limited the recovery of the plaintiff, not the Plan. [Exc. 114-23] To avoid preemption, Dr. Knolmayer asserted that AS 09.55.548(b) did not restrict reimbursement or subrogation by the Plan. [Exc. 119] Conflating reimbursement and subrogation, Dr. Knolmayer also argued that AS 09.55.548(b) "[i]s expressly not an antisubrogation or antireimbursement statute" because it allowed for subrogation "when the collateral source is a federal program that by law must seek subrogation . . . ." [Exc. 121]

Dr. Knolmayer did not acknowledge the impact of the Plan's obligations on Charina to protect and preserve the Plan's right to reimbursement or subrogation. Charina responded explaining that the Plan requires and allows that she represent the interest of the Plan in seeking reimbursement or subrogation. [Exc. 166]

The trial court issued an order adopting Dr. Knolmayer's argument that AS 09.55.548(b) was not preempted because it does not "directly or indirectly prevent a plan from seeking subrogation. To the contrary, it provides a mechanism for the plan to be reimbursed in the post-trial hearing." [Exc. 169-170] The trial court also ignored the Plan's right to reimbursement, but held that Charina could include the subrogation claim in her own claim. [Exc. 170-171] Dr. Knolmayer filed a Motion to Reconsider. [Exc. 173-178]

The Motion to Reconsider abandoned the argument that AS 09.55.548(b) did not directly or indirectly impact the right to subrogation or reimbursement. Now, without citing to any legislative history, Dr. Knolmayer argued that AS 09.55.548(b) was meant to "reduce the liability of a medical malpractice defendant" and the trial court's order would "award damages to plaintiff's insurer that plaintiff herself cannot recover." [Exc. 174]

Reversing course from his argument that AS 09.55.548(b) did not restrict reimbursement or subrogation, Dr. Knolmayer argued that the insurer has no greater rights to subrogation than the insured. [Exc. 175] Dr. Knolmayer asserted that AS 09.55.548(b) restricted the Plan's recovery to Charina's, stating: "subrogation or reimbursement must be satisfied from whatever Plaintiff recovers," without explaining how that interpretation did not "relate to" the Plan. [Exc. 175-176] Ignoring the complete discretion the Plan affords itself in the area of subrogation, Dr. Knolmayer also asserted the only avenue AS 09.55.548(b) allows for the Plan to assert subrogation rights is to bring a direct claim against him, suggesting that the Plan "would become subject to possible Rule 82 attorney's fees." [Exc. 177] This restriction to the Plan's subrogation rights was unsupported by any citation or law. It also ignored the express language of the Plan that makes Charina responsible for any costs associated with seeking reimbursement or subrogation. [Exc. 88-89] Charina pointed out the contradiction between Dr. Knolmayer's new argument and the trial court's ruling that there was no preemption. [Exc. 181-185]

The trial court again adopted Dr. Knolmayer's argument and vacated the previous order that allowed the Plan to collect the subrogated interest at a post-trial hearing, holding that doing so violated the "statutory purpose and legislative history" which "forecloses collection of the Plan's subrogated interest against Defendants *by Plaintiff*."[1] [Exc. 187-190] Instead of analyzing whether this new interpretation meant AS 09.55.548(b) affected, interfered with or restricted the Plan's rights to subrogation or reimbursement as required by the broad "relating to" language in 29 U.S.C. § 1144(a), the trial court re-wrote the test. [Exc. 189] It found preemption was not necessary because AS 09.55.548(b) did not "prevent" subrogation by the Plan and that the "Plan's subrogation right has not been eliminated by the statute." [Exc. 189-190] The trial court also held that the Plan could only enforce subrogation if it was joined as a party, or by bringing its own action. [Exc. 189-190] Dr. Knolmayer did not move to reconsider the trial court's ruling about joinder of the Plan.

Charina filed a notice of assignment from the Plan and her intent to pursue that claim at the trial. [Exc. 204] Dr. Knolmayer opposed the Plan assigning its subrogation right to Charina because doing so violated the trial court's interpretation of AS 09.55.548(b) that required joinder in the action: "[a]ssignment and subrogation are different legal concepts. Therefore, an assignment is not the same as the Plan joining this action to directly pursue its subrogation claim against Defendants." [Exc. 223]

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[1] (Emphasis in original.)

Charina also moved to join the Plan under Alaska R. Civ. P. 19(a). [Exc. 247-248] Dr. Knolmayer opposed that motion arguing that the Plan, as "partially-subrogated insurers," could not be involuntarily joined under Alaska R. Civ. P. 17 or 19 because its interests were protected by Charina's claim. [Exc. 270] Yet, Dr. Knolmayer had consistently and successfully argued Charina was not entitled to claim the Plan's expenses in the case. [Exc. 114-123, 174-175] In dizzying circular reasoning, Dr. Knolmayer asserted that because the Plan had "ratified" Charina's ability to recover the benefits it paid (a point Dr. Knolmayer had repeatedly questioned), that "ratification is the functional equivalent of joinder," and that forcing joinder was an abuse of discretion. [Exc. 273] Dr. Knolmayer did not explain how "ratification" was different than the assignment of rights that he opposed, or how the Plan's interests were protected by ratification when he had successfully foreclosed Charina's ability to claim the subrogation and reimbursement rights as a loss.

In its third substantive order, the trial court reversed parts of its previous orders, but maintained that ERISA did not preempt AS 09.55.548(b). [Exc. 283-307] Abandoning its earlier preemption standard that required a state law to explicitly eliminate the insurers subrogation right in order to "relate to" the Plan, the trial court applied the appropriate standard for preemption, analyzing whether the state law has an impermissible connection with an ERISA plan. [Exc. 293-296]

The trial court then applied that test to Charina's medical malpractice claim ***not the state law at issue in AS 09.55.548*** explaining, "[h]er claim does not have an impermissible connection with an ERISA plan because her state-law claim does not

'govern[] a central matter of plan administration,' 'interfere[] with nationally uniform plan administration,' or 'bear[] on an ERISA-regulated relationship,'" because "[t]he claim that is the basis for her action is a state-law medical malpractice claim." [Exc 295-296] Charina's medical malpractice claim is governed by AS 09.55.540, a different state law than the one at issue. The trial court did not analyze whether AS 09.55.548(b) had an impermissible connection with an ERISA plan using the appropriate standard.

The trial court citing, *City of Valdez v. State*,[2] acknowledged the three factor "sliding scale" approach to statutory interpretation requiring consideration of 1) the language of the statute, 2) the legislative history, and 3) the legislative purpose. [Exc. 297] Concluding that the statute did not define "federal program," the trial court moved on to the legislative history and purpose of the statute. [Exc. 298] But, the trial court did not analyze the legislative history of the omnibus 1976 legislation that resulted in changes to AS 09.55.530-.560 governing Medical Malpractice Actions. Instead, it relied on two Alaska Supreme Court cases *Plumley v. Hale*,[3] and *Reid v. Williams*,[4] where this court made only passing references to the legislative history. [Exc. 299]

The trial court concluded that because the Plan "[i]s also required to seek subrogation and reimbursement" and those requirements have the force of federal law, the Plan was a "federal program that by law must seek subrogation" qualifying for the exception under AS 09.55.548(b) that allowed the plaintiff to recover the money.

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2 372 P.3d 240, 248 (Alaska 2016).

3 594 P.2d 497 (Alaska 1979).

4 964 P.2d 453 (Alaska 1998).

[Exc. 302-304] In a separate order, the trial court also found that the issues of joinder and assignment were mooted since the Plan's right to subrogation and reimbursement are recoverable as a "federal program" under the statute. [Exc. 308-316] The court explained that because of its ruling that the Plan was entitled to recover as a federal program, Charina's joinder motions under Alaska R. Civ. P. 17 and 19 were unnecessary because the Plan's interest in reimbursement or subrogation were protected. [Exc. 314-316]

Dr. Knolmayer moved to reconsider the ruling arguing that the trial court misinterpreted AS 09.55.548(b) because it allowed the Plan to collect without bearing the risk and burden of litigation embodied in Alaska R. Civ. P. 82 loser pays provision. [Exc. 319-321] Dr. Knolmayer ignored the Plan's specific prohibition against sharing in attorney's fees. [Exc. 88-89] He also urged the trial court to adopt the reasoning of a non-binding Fairbanks Superior Court case *French, et al. v. McIntyre, M.D.*, Case No. 4FA-14-01377 CI, where Judge Kauvar found no preemption and no right to recover subrogation or reimbursement.[5] [Exc. 319-321] Dr. Knolmayer did not challenge the trial court's finding that the Plan was a "federal program" under AS 09.55.548(b). The trial court rejected Judge Kauvar's decision that a self-funded ERISA plan was not a

[5] Dr. Knolmayer submitted Judge Kauvar's Order as "supplemental authority". [Exc. 150-161] Originally, the trial court did not allow a substantive response and found the issue was moot since it ruled that the Plan could collect its reimbursement or subrogation interest post-trial. [Exc. 163, 172] Then, after reversing that order and without giving Charina an opportunity to substantively respond, the trial court adopted the reasoning in Judge Kauvar's Order as "persuasive." [Exc. 189-190]

"federal program" that "must seek subrogation" in denying the Motion to Reconsider. [Exc. 325-328]

Dr. Knolmayer petitioned for review of the trial court's order that the Plan was exempt from AS 09.55.548(b) because it was a federal program required by law to seek subrogation. This Court granted expedited interlocutory review of the single issue appealed by Dr. Knolmayer but, *sua sponte*, requested briefing on several related questions.[6]

STANDARD OF REVIEW

This Court applies its independent judgment in interpreting statutes and the Alaska Constitution "according to reason, practicality, and common sense, taking into account the plain meaning and purpose of the law as well as the intent of the drafters."[7]

ARGUMENT

I. THE EXCEPTION IN AS 09.55.548(b) ALLOWING SUBROGATION FOR FEDERAL PROGRAMS SHOULD NOT BE INTERPRETED NARROWLY BECAUSE THE LEGISLATIVE PURPOSE FOR ENACTING THE ANTI-SUBROGATION PROVISION DID NOT INTEND TO PENALIZE THE INJURED.

Before 1976, Alaska followed the common law collateral source rule that aimed at balancing two competing principles 1) the need to hold the tortfeasor accountable for all damages resulting from the tort, and 2) ensuring an injured party should only recover

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6 *See* Supreme Court Order, Sept. 29, 2020 at 3-4.

7 *Native Vill. of Elim v. State*, 990 P.2d 1, 5 (Alaska 1999), *see also Sands ex rel. Sands v. Green*, 156 P.3d 1130, 1132 (Alaska 2007).

what is needed to be made whole.[8] The collateral source rule "[r]esolves this conflict in favor of the injured party" allowing for the possibility of a double recovery to avoid the alternative of allowing the tortfeasor to escape liability.[9] Dr. Knolmayer argues that AS 09.55.548(b) ("the statute" or "Alaska statute") intended to topple this scale of justice in favor of a system that allows the wrongdoer to escape accountability at the price of the injured incurring the debt of health care costs that in any other circumstance would be covered by insurance. This interpretation is not supported by the language, purpose or legislative intent of AS 09.55.548(b) and should be rejected.

AS 09.55.548(b) intended to eliminate double recoveries by ensuring that injured patients do not receive compensation that had already been paid on their behalf. Dr. Knolmayer concedes that the Legislature did not intend the statute to eliminate subrogation claims,[10] and that the Plan is entitled to subrogation (albeit only a direct subrogation right), but he fails to identify the language in the statute that allows this interpretation.[11] The trial court agreed that the statute did not eliminate subrogation, eventually settling on the exception that an ERISA plan is a "federal program which must

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8 *Ridgeway v. N. Star Terminal & Stevedoring Co.*, 378 P.2d 647, 650 (Alaska 1963) (Adopting the collateral source rule that "a tort-feasor is not entitled to have his liability reduced merely because plaintiff was fortunate enough to have received compensation for his injuries or expenses from a collateral source"); *see also Chenega Corp. v. Exxon Corp.*, 991 P.2d 769, 790 (Alaska 1999).

9 *Chenega Corp.*, 991 P.2d at 790-91.

10 Dr. Knolmayer's concession is self-serving. Admitting that the statute eliminates subrogation rights concedes that it is preempted by ERISA. It is this tightwire act resulted in the trial court's confusion.

11 Pet'rs' Br., Dec. 17, 2020 at 15, 26-27.

seek subrogation." [Exc. 283-307] Interpreting the statute is necessary to understand the meaning of the law.

This Court considers a statute's language, purpose, and legislative history when interpreting it to "give effect to the legislature's intent, with due regard for the meaning the statutory language conveys to others."[12] This starts with the text and its plain meaning by applying a "sliding-scale approach" to interpret the language.[13] "[T]he plainer the statutory language is, the more convincing the evidence of contrary legislative purpose or intent must be."[38] When "a statute's meaning appears clear and unambiguous, . . . the party asserting a different meaning bears a correspondingly heavy burden of demonstrating contrary legislative intent."[39]

A. Federal Programs Encompass ERISA Plans Because of the Comprehensive Federal Structure that ERISA Established and the Force of Federal Law Behind the Language in the Plan.

It is not clear what the Legislature meant by a "federal program which, by law, must seek subrogation" or "must seek subrogation." The statute does not define federal program. This Court gives "[p]opular or common words their ordinary meaning, if the words are not otherwise defined in the statute."[14] If it intended to limit subrogation to Medicare and Medicaid as Dr. Knolmayer suggests, it would have said so, as it was aware of those programs at the time. It chose broader language like "by law" instead of

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12 *State v. Planned Parenthood of the Great Northwest*, 436 P.3d 984, 992 (Alaska 2019) (citations omitted).

13 *Id.*

14 *Wilson v. State, Dep't of Corr.*, 127 P.3d 826, 829 (Alaska 2006).

by statute, and "federal program" instead of more restrictive terms like a federal health insurance program. The term "federal programs" is broadly used in the Alaska Constitution dedicated funds clause.[15] Alaska courts have used "federal program" to refer to programs in a broader sense.[16] The narrow definition encouraged by Dr. Knolmayer is not supported.

There is significant support for treating ERISA plans like a federal program. The Plan is not simply a private employer who contracts with its employees to provide insurance as Dr. Knolmayer asserts.[17] Dr. Knolmayer argues that "the Plan is a contract, not law," but this ignores the comprehensive federal regulation that ERISA imposes, including controlling the administration of benefit plans,[18] imposing reporting and

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15 Alaska Const. art. IX, § 7.

16 *Stanek v. Kenai Peninsula Borough*, 81 P.3d 268, 271 (Alaska 2003) (Using "federal program" to refer to programs that encourage home ownership); *Alaska Inter-Tribal Council v. State*, 110 P.3d 947, 960 (Alaska 2005) (referring to a pre-statehood race based system of law enforcement as a "federal program"); *Kraus v. State*, 604 P.2d 12, 13 (Alaska 1979) (Referring to the Young Adults Conservation as a "federal program); *Totemoff v. State*, 905 P.2d 954, 960 (Alaska 1995) (citing to a federal regulation that uses "federal program" to refer to the federal management of subsistence hunting on public land).

17 Pet'rs' Br. at 15-16.

18 *See New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 651 (1995); 29 U.S.C. § 1001(b) ("It is hereby declared to be the policy of this chapter to protect interstate commerce and the interests of participants in employee benefit plans and their beneficiaries, by requiring the disclosures and reporting to participants and beneficiaries of financial and other information with respect thereto, by establishing standards of conduct, responsibility and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to the Federal courts.").

disclosure mandates,[19] participation and vesting requirements,[20] funding standards,[21] and fiduciary responsibilities for plan administrators.[22] The law requires administrative oversight, establishes a comprehensive civil enforcement scheme and includes criminal sanctions for a failure to comply.[23]

It is true that ERISA does not require mandatory benefits, but it does give the force of federal law to the Plan once it is written. As the U.S. Supreme Court explained, "The plan, in short, is at the center of ERISA."[24] ERISA authorizes suits against fiduciaries, plan administrators and beneficiaries including lack of compliance with benefit plans.[25] ERISA allows a lawsuit commenced by the insurer (or any plan fiduciary) against the insured to enforce the obligations imposed by the statute or "to enforce the terms of the [health insurance] plan."[26] In *Serboff v. Mid Atlantic Medical Services, Inc*., the U.S. Supreme Court held that the right to reimbursement in an ERISA plan was enforceable as an "equitable lien by agreement" (the same language in

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19 §§ 101-111, 29 U.S.C. §§ 1021-1031.

20 §§ 201-211, 29 U.S.C. §§ 1051-1061.

21 §§ 301-308, 29 U.S.C. §§ 1081-1086.

22 §§ 401-414, 29 U.S.C. §§ 1101-1114.

23 §§ 501-515, 29 U.S.C. §§ 1131-1145.

24 *U.S. Airways, Inc. v. McCutchen*, 569 U.S. 88, 101 (2013).

25 29 U.S.C. § 1132(a)(3); *see also Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 110 (1989).

26 29 U.S.C. § 1132(a)(3) ("A civil action may be brought . . . by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan.").

Charina's plan).[27] Because the language of the Plan has the force of federal law, the mandatory language about subrogation and reimbursement at issue here are required by federal law. Dr. Knolmayer confuses the different *options* for reimbursement or subrogation in the Plan as making *optional* the requirement to recover the money.[28] The Plan's language is not optional as it relates to subrogation or reimbursement.

Dr. Knolmayer misleadingly plucks out a single "may" from one sentence in the subrogation section of the Plan to assert "permissive authority" that "does not require the Plan to seek subrogation."[29] In proper context the Plan states: "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 value of any such benefits or conditional payments advanced by the Plan." [Exc. 88] The "may" cited by Dr. Knolmayer does not make recovery of the paid benefits permissive. It merely gives the Plan the discretion to choose any avenue for recovery that it wants. Conversely, it preempts any state law that tries to limit these avenues.

The Plan establishes unequivocally that it "shall be entitled to recover 100% of the benefits paid, without deduction for attorneys' fees and costs, or . . ." the application of any common law equity principle. [Exc. 89] By requiring recovery of the benefits and providing comprehensive and draconian terms, the Plan can claim as a motive its

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27 574 U.S. 356, 364-65 (2006).

28 Pet'rs' Br. at 9-10.

29 *Id.* at 17-18.

fiduciary duty to preserve the fund for the good of the Plan. Given the comprehensive regulatory structure that establishes ERISA plans, and the force of federal law that supports the language in the Plan, it is reasonable to refer to it as a federal program. The next steps in the analysis of interpretation, purpose and legislative history, also support applying a broader meaning to "federal program."

B. Dr. Knolmayer's Interpretation of AS 09.55.548(b) does the Opposite of What the Legislative History Suggests Because It Would Force Injured Patients to Pay for Medical Care Out-of-Pocket While Restricting the Right to Claim the Damage.

Dr. Knolmayer overstates the impetus of the Commission[30] and omits its goal to balance and protect the interests of Alaskan's injured by medical negligence.[31] The Commission was established after Governor Hammond vetoed a bill that would have established a mandatory Joint Underwriting Association in Alaska that was widely opposed by doctors.[32] While the Commission acknowledged national growing malpractice rate increases, litigation, and verdicts, Dr. Knolmayer omitted the Commission's candid finding that this was not the situation in Alaska, where it explained "[i]t should be noted that Alaska has not had a high frequency of suits, few if any judgments and no extraordinary awards. Taking only the past fifteen years experience, it appears that no significant problem exists in Alaska . . . ."[33]

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30 The "Commission" is "The Governor's Medical Malpractice Insurance Commission." Pet'rs' Br. at App. A-1.

31 *Id.* at App. 12-13.

32 *Id.* at App. A-73-74.

33 *Id.* at App. A-24-25.

The Commission also acknowledged that the shortage in medical malpractice insurance in the Lower-48 was caused by the insurance industry that had "suffered an under-writing loss of heretofore unmatched proportions" that caused insurers to eliminate books of business to increase profits and absorb the complete financial collapse of Argonaut.[34] The Commission found "[t]hese matters related little to the results on the malpractice business sold in Alaska," and that "Alaska's malpractice experience indicates a lowering of rates."[35] The struggle at that time was getting reliable information about rates charged by private carriers, the small number (only 315) of doctors in Alaska limiting pooling options, and some higher risk specialists.[36]

One area of concern "was the method for distributing the costs of medical malpractice loss among the classes of persons available to pay the costs."[37] The Commission recognized that when a person is injured by a medical professional "a loss of immeasurable amount was established."[38] The Commission "struggled hardest" on "the equities of who should bear the loss," seeking to avoid policy that found "the injured

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34 *Id.* at App. A-44-45.

35 *Id.* at App. A-45-47.

36 *Id.* at App. A-48. It is worth noting that in 2020 there were 7,254 licensed doctors in Alaska. https://www.commerce.alaska.gov/web/portals/5/pub/PL_Licensing_Stats_AnnualReport.pdf.

37 Pet'rs' Br. at App. A-20.

38 *Id.*

person should bear the loss," while also making changes that provided "physicians with adequate insurance."[39]

Throughout its report, the Commission rejected recommendations that shifted the cost burden to the injured patient because of "some reason beyond the patient's control"[40] to avoid an "extreme loss that would only be adequately compensated by an award"[41] by creating "arbitrary roadblocks that would preclude the legitimate claimant from having recourse to counsel and the courts for redress,"[42] and a higher standard of proof that "would make it more difficult for the legitimate cases to be adjudicated."[43] The Commission's goal was to "harmonize the desire to reduce the contingent exposure of the physicians without arbitrarily terminating legitimate rights . . . ."[44] It concluded that the recommendations do "no violence to the legitimate rights of persons injured as a result of negligent conduct."[45]

The Commission's recommendation on collateral sources echoed this reluctance to shift the burden of actual damages to the injured patient. The intent of the Commission was to prevent a double recovery based on the assumption that the burden would be shifted to a first party payor, not the injured patient. In fact, it rejected limits on "the

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39 *Id.* at App. A-20-21.

40 *Id.* at App. A-27.

41 *Id.* at App. A-28-29.

42 *Id.* at App. A-29.

43 *Id.* at App. A-34.

44 *Id.* at App. A-27.

45 *Id.* at App. A-63.

portion of the awards which is in excess of the patient's actual out-of-pocket losses," because it would disincentivize patients and lawyers from bringing lawsuits.[46] In this context, it is not reasonable to assume that the Commission chose instead an alternative that would require injured patients to repay their health care costs from those out-of-pocket losses or pain and suffering.

Noting "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 Commission sought to prevent the "potential for double recovery, and the presentation of the additional complications of subrogation and collateral source liens."[47] The Commission believed that by limiting collateral source damage claims at trial the "overall cost would be reduced if the patient was required to first utilize the first party coverages to which he is entitled, which are much more efficient forms of distribution than allowing the full measure of damages in an expensive third party proceeding . . . ."[48] It did not foresee that the injured patient would be forced by federal law to pay back those conditional benefit payments without being able to recover the damages. It also assumed that the injured party had an absolute right to the "the first party coverages," not a conditional right.

The original omnibus legislation, House Bill 574 ("HB 574") adopted the recommendations by the Commission, which included a provision that altered the

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46 *Id.* at App. A-29.

47 *Id.*

48 *Id.*

"Declaration of Purpose" that existed in AS 09.55.530. HB 574 proposed changing the existing purpose that stated: "[t]he legislature considers that there is a need in Alaska to codify the law with regard to medical liability in order to establish that the law in Alaska in this regard is the same as elsewhere," to read:

> The legislature finds that the health of the people is threatened by curtailment of health-care services due to the difficulty in obtaining adequate malpractice insurance at a reasonable cost to the health-care provider. It is the purpose of secs. 530-560 of this chapter to protect the health and safety of the people of this state by establishing a procedure for handling malpractice claims which will help ensure the ready availability of adequate insurance at reasonable cost and which will be fair to all parties concerned.[49]

This declaration of purpose did not pass.[50] There is no legislative history that describes why the Legislature removed the declaration.[51] Its removal supports a finding that the Legislature did not intend the purpose behind the changes to AS 09.55.530-.560 to be so lopsided in description. Instead, it is reasonable to interpret this removal as a more balanced approach to ensure the physician's low-cost medical malpractice insurance was not at the expense of the injured party.

HB 574 also included a provision that shifted the burden for paying the loss to the collateral source, stating: "Notwithstanding other provisions of state law, and except as provided in this subsection, a collateral source does not have a right of subrogation."[52]

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49 App. C-10-11.

50 App. C-97.

51 The declaration of purpose passed the House but was removed in the Senate Commerce Committee. There are no Senate Commerce Committee Minutes available.

52 App. C-17.

The Senate Commerce Committee removed this sentence and the declaration of purpose in CSHBam 574, heard one day after being transmitted to the Senate.[53] It passed out of Committee the next day.[54] The Senate Commerce Committee removed the last sentence that barred subrogation, but replaced it with a new sentence that protected the injured patient from suffering depleted or exhausted collateral sources:

> Evidence of collateral sources, other than a federal program which by law must seek subrogation and the death benefit paid under life insurance, is admissible after the fact finder has rendered an award, but the court shall also take into account the value of the claimant's rights to coverage exhausted or depleted by payment of these collateral benefits. It may do so 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.[55]

This version passed the Senate and was referred to a Conference Committee after the House failed to concur.[56] The Conference Committee version of the bill that became law changed this last sentence, breaking it into two, removed the "shall" and replaced it with "may" (instead of requiring it) allowing the trial court the option of replacing collateral sources "exhausted or depleted" in the post-trial offset hearing if it is established that the "claimant's rights" were actually "impaired" by either reimbursement or subrogation.[57] This serves the legislation's goal of preventing double recovery, while

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53 App. C-1.

54 *Id.*

55 App. C-59.

56 App. C-1.

57 App. C-104.

also ensuring the injured patient was not burdened with the expense. Importantly, it reveals the Legislature intended to hold the physician/tortfeasor responsible for collateral sources within the claim, a point Dr. Knolmayer has repeatedly fought.

This legislative history cannot mean that the Legislature intended the injured plaintiff to bear the burden of these collateral sources unless the collateral source chose to seek subrogation in a direct action against the physician, as Dr. Knolmayer insists. This is especially true when coupled with the change in the declaration of purpose that removed any reference that established the physician's interest in insurance should be elevated above the injured plaintiff's actual damages.

The Legislature never expressed an intent to force the injured patient to pay the actual costs of the injury. Importantly, such intent is not related to the goal of preventing double recovery. Instead, it would punish the injured patient for bringing the lawsuit by forcing her to pay for the costs of her medical care, triggered only by filing a lawsuit for malpractice. Nothing in the language of the statute, or purpose and legislative history of the statute support this interpretation.

The Legislature included protections to avoid unfairly deducting benefits that it knew would deprive an injured plaintiff of their compensation, like subrogation forced by federal law, "death benefits," or depletion or exhaustion of other benefits. There is no evidence the Legislature made a choice to leave out injured patients who were contractually obligated to repay the costs the statute restricted. In 1976, ERISA (which passed in 1974), had not been interpreted to give the mandatory subrogation and

reimbursement provisions in the Plan the full force of federal law.[58] The Legislature could not have understood that a health insurer or an ERISA Plan would have the force of federal law to require reimbursement or subrogation. Had it known this, the threat of double recovery that it intended to address would have been much less troubling.

Dr. Knolmayer's interpretation means the Legislature specifically allowed for an injured plaintiff to be compensated for any out-of-pocket costs related to their health care before trial, but also intended that an injured plaintiff pay the out-of-pocket costs associated with their health care after the verdict and before judgment. This is not supported by the purpose or legislative history. The opposite is true as the Legislature intended to ensure the injured plaintiff was compensated for damages in a way that did not serve to disincentivize going to court or over-compensating with a double recovery. Dr. Knolmayer's interpretation eviscerates this purpose.

Taken as a whole, the legislative intent and purpose supports either a broad meaning of "federal program" or a broader allowance for a post-trial proceeding to allow the compensation to the injured patient for collateral sources. Either way, this Court's remaining questions require briefing.

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[58] *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 106 (1983); *see also* Daniel W. Sherrick, *ERISA Preemption: An Introduction*, Mich. B.J., October 1985, at 1074-75 (Describing the seminal and sweeping holding that an ERISA Plan preempted state law that prohibited discrimination by private employers on the basis of sex); Roger M. Baron & Anthony P. Lamb, *The Revictimization of Personal Injury Victims by ERISA Subrogation Claims*, 45 Creighton L. Rev. 325, 330 (2012) ("There were no efforts by health insurers to seek subrogation on personal injury claims until the 1980s.").

II. DR. KNOLMAYER'S INTERPRETATION OF AS 09.55.548(b) FORCES AN INJURED PATIENT WHO WAS AWARDED COMPENSATION FOR THE ACTUAL COSTS OF THE INJURY TO SHOULDER THAT BURDEN.

Dr. Knolmayer's interpretation of AS 09.55.548(b) bars the injured patient from recovering for any actual damages that were conditionally covered by collateral sources.[59] It is not merely a "limitation" when the injured patient is forced to use the money the jury provided to compensate for other losses like future health care costs, lost wages or pain and suffering to pay for the health care costs already paid and caused by the injury. There is no evidence suggesting the Legislature considered this.

The injured patients in *Weston v. AK Happytime*,[60] and *Reid v. Williams*,[61] were not faced with this bar as Dr. Knolmayer asserts.[62] Neither case involved injured patients who were forced to offset medical costs related to their injury post-verdict from the remaining verdict meant to compensate for other losses. Dr. Knolmayer asks this Court to find that the statute requires this result.[63] Dr. Knolmayer's interpretation of AS 09.55.548 thwarts the purpose of finding a balance between the need to hold the tortfeasor responsible, while preventing double recoveries. It is also not supported by any case law.

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59 Pet'rs' Br. at 19-20.

60 445 P.3d 1015 (Alaska 2019).

61 964 P.2d 453 (Alaska 1998).

62 Pet'rs' Br. at 20.

63 *Id.* at 27 ("[A]s long as the Plan merely chose to seek reimbursement [as opposed to a direct action against the tortfeasor], as it did here, then AS 09.55.548(b) precludes Ms. McCollum from recovering the expenses paid by the Plan.").

Other states have laws that modify collateral sources, but it appears that only Alaska's statute and those of two other states, Iowa and New York, do not expressly address how the statute effects the subrogation rights of the collateral source.[64] The remaining states that have enacted statutes modifying the collateral source rule either expressly permit recovery of ***subrogated*** collateral source benefits[65] or, expressly prohibit the collateral source from enforcing subrogation against its insured.[66] In some cases, courts have struck statutes modifying the collateral source rule as violating constitutional protections.[67]

Like AS 09.55.548, New York's Legislature enacted a statute limiting recovery of collateral source benefits without addressing whether subrogated collateral benefits were

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64 Absent legislative action, states have generally rejected judicially imposed modifications to the common law collateral source rule. *See, e.g.*, *Dedmon v. Steelman*, 535 S.W.3d 431, 466 (Tenn. 2017).

65 *See, e.g.*, Colo. Rev. Stat. Ann. § 13-21-111.6 (West 1997); Conn. Gen. Stat. § 52.225a (1991); Fla. Stat. Ann. § 768.76 (West 1999); Haw. Rev. Stat. § 663-22 (1999); 735 Ill. Comp. Stat. Ann. § 5/2-1205 (West 1999); Iowa Code § 147.136 (1997); Mich. Comp. Laws Ann. § 600.6303 (West 1999); Minn. Stat. Ann. § 548.36 (West 1999); Mont. Code Ann. § 27-1-308 (1999); N.Y. C.P.L.R. § 4545(A) (Mckinney 1992); N.D. Cent. Code § 32-03.2-06 (1999); 40 Pa. Cons. Stat. Ann. § 1301.602 (West 1999) (repealed).

66 *See, e.g.*, Ala. Code § 12-21-45(A) (1999); Ariz. Rev. Stat. Ann. § 12-565 (West 1999); Cal. Civ. Code § 3333.1 (West 1997); Del. Code Ann. Tit. 18, § 6862 (1998); Ga. Code Ann. § 51-12-1(B) (1999); Ind. Code Ann. § 34-44-1-2 (West 1999); Md. Code Ann., Cts. & Jud. Proc. § 3-2a-06(F) (1998); Mo. Rev. Stat. § 490.715 (1996); Or. Rev. Stat. § 18.580 (1998); R.I. Gen. Laws § 9-19-34.1 (1998); S.D. Codified Laws § 21-3-12 (Michie 1999); Wash. Rev. Code Ann. § 7.70.080.

67 *Johnson v. Rockwell Automation, Inc.*, 308 S.W.3d 135, 142 (2009); *O'Bryan v. Hedgespeth*, 892 S.W.2d 571, 576 (Ky. 1995); *see also Denton v. Con-Way S. Exp., Inc*, 402 S.E.2d 269, 272 (1991), *abrogated on other grounds by Grissom v. Gleason*, 418 S.E.2d 27 (1992).

recoverable.[68] New York courts determined that its Legislature did not intend to impair recovery of subrogated collateral source benefits:

> Section 4545 prevents double recoveries; it was not intended to deprive insurers of their basic subrogation rights, provided by equity for fairness, and also by law through the assignment clauses typical of insurance contracts, which require the insured to assign its rights against the tortfeasor in consideration for receiving the insurance proceeds that allay its injury. Certainly, § 4545 was not intended to create a windfall for the tortfeasor, granting it the benefit of the injured party's insurance, for which it did not pay, as a reward, in effect, for committing a tort and injuring another.[69]
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> . . . [T]he rule of law, now established by three decisions of New York's highest court, is that § 4545 does not affect the subrogation rights of plaintiffs' insurers. The principle of subrogation is so embedded in the common law, and would be so radically affected, that a very clear legislative intent to disrupt it is required . . . . The statute contains absolutely no language that effects the disruption for which the moving parties argue. It eliminated a well-established feature of the common law, the collateral source rule, with clarity. In the absence of any similar clarity, and in light of the consistent holdings of the Court of Appeals . . . the statute did not also eliminate the subrogation rights of plaintiffs' insurers.[70]

Here, there is no clear legislative intent to disrupt this right and Dr. Knolmayer provides no contrary evidence. It is possible that the Plan will be unable to recover its total subrogated or reimbursement right, because of Charina's limited damages. Unless the jury finds Dr. Knolmayer was reckless, any pain and suffering award will be limited to $250,000. The Plan's subrogated interest exceeds that amount. The Plan's first-dollar right to recovery is disrupted by Dr. Knolmayer's interpretation.

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68 *See*, NY § 4545.

69 *In re September 11 Litigation*, 649 F.Supp.2d 171, 180 (2009) (citations omitted).

70 *Id.* at 183 (citations omitted).

The Iowa courts have addressed the absence of its statute to clarify subrogation rights both by barring subrogation and allowing the subrogated claim.[71] In *Toomey v. Surgical Servs.*, Iowa's Supreme Court interpreted its statute to eliminate both the right to recover collateral source benefits as well the collateral source's right to seek subrogation from its insured so that the plaintiff is not penalized with a "double deduction:"

> Giving effect to section 147.136 in this case and ***disallowing United Fire's lien*** promotes the legislature's desire that malpractice claims be limited in order to reduce malpractice insurance premiums and assure availability of health care. This is the more recent pronouncement of the legislature. In addition, plaintiff Toomey will not receive a double recovery. Indeed, allowing a lien under section 85.22(1) would lead to a double reduction for Toomey, a result which clearly would be unfair. *See Schonberger v. Roberts*, 456 N.W.2d 201, 203 (Iowa 1990) (declining to apply statute literally because such application would lead to the "absurd result" of a double reduction). (emphasis added). [72]

Given the impact of ERISA and the Plan's absolute right to first-dollar recovery regardless of whether it is "unfair," this interpretation applied here is an "absurd result" because it requires the injured patient to pay the wrongdoer for the injury he caused.[73]

In *Loftsgard v. Dorrian*, the court took a different view interpreting the statute to allow recovery of subrogated benefits because "[w]here collateral benefits are paid subject to the right of subrogation, there can be no double dipping because the subrogee will recover collateral benefits out of plaintiff's tort recovery from defendant."[74] Again,

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71 *See* IA ST § 147.136.

72 *Toomey v. Surgical Servs., P.C.*, 558 N.W.2d 166, 170 (Iowa 1997) (emphasis supplied).

73 *Id.*

74 *Loftsgard v. Dorrian*, 476 N.W.2d 730, 734 n.4, 735 (Iowa Ct. App. 1991).

under either approach, double recoveries are eliminated without penalizing the plaintiff with a "double reduction." Likewise, the lack of clarity in AS 09.55.548(b) about subrogation claims should not be interpreted to mean Charina suffers a "double reduction" for having paid for medical benefits that were only conditional if she sought to seek court intervention to compensate for the other injuries she suffered.

No 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. As this Court has repeatedly made clear, a statute cannot be interpreted in a manner that would lead to an absurd result.[75] Significantly, the purpose of AS 09.55.530 as it currently reads requires that AS 09.55.548(b) should be "the same as elsewhere." Dr. Knolmayer's interpretation would make Alaska unique, not similar to other state's navigating antisubrogation.

It is simply untenable that in seeking to prevent a double recovery, the Legislature intended to allow the physician/nurse/physician's assistant to pocket part of the verdict that the injured patient is forced to repay. This Court should interpret AS 09.55.548(b) in a manner that permits recovery of subrogated collateral source benefits, irrespective of the way those benefits are recovered (direct action subrogation or reimbursement from the insured).

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[75] *Nash v. State, Commercial Fisheries Entry Comm'n*, 679 P.2d 477, 479 (Alaska 1984).

III. DR. KNOLMAYER'S CONCESSION THAT THE PLAN HAS A RIGHT TO SUBROGATE NECESSARILY REQUIRES THAT CHARINA COLLECT THAT RIGHT IN THE CASE BECAUSE THE SUBROGATION AND REIMBURSEMENT RIGHTS IN THE PLAN ALLOW CHARINA TO STAND IN THE SHOES OF THE PLAN.

Dr. Knolmayer concedes that the Plan has a right to subrogate its interest against him directly, yet he ignores the plain language of the Plan that confers both the right and the obligation on Charina to protect and ensure the Plan's right to first-dollar recovery through both reimbursement or subrogation.[76] It is also undisputed that AS 09.55.548 does not expressly limit subrogation to a direct claim to be filed after the verdict. Since Dr. Knolmayer concedes that the Plan has a direct right to sue him for the damages he caused, it does not matter how that right is exercised. At the very least, neither the language of AS 09.55.548, nor the legislative history support his argument that the Plan is restricted to subrogation through a direct cause of action.

Subrogation "simply means substitution of one person for another; that is, one person is allowed to stand in the shoes of another and assert that person's rights against the defendant."[77] Subrogation can come from 1) common law, 2) contract, or 3) statute.[78] The language of the Plan here does not distinguish between the two in assigning the right to Charina, and there is no legal distinction between her ability and obligation to pursue both on behalf of the Plan providing that "[t]hese rights of ***subrogation and***

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[76] Pet'rs' Br. at 21-22.

[77] 1 DAN B. DOBBS, LAW OF REMEDIES § 4.3(4) (2 ed. 1993).

[78] 73 AM. JUR. 2D SUBROGATION § 43 (2007) (classifying subrogation as legal, conventional and statutory).

reimbursement shall apply without regard to whether any separate written acknowledgement of these rights is required by the Plan and signed by the Covered Person."[79] [Exc. 89]

Dr. Knolmayer argues there is a distinction between the two, but does not explain or provide any support that the Plan's assignment of its reimbursement right has any less force than the assignment of its subrogation right.

Dr. Knolmayer's circular argument that the Plan is both a partially subrogated insurer and barred by the statute of limitations is unpersuasive.[80] He acknowledges the Plan ratified the lawsuit, but also asserts it was not a proper assignment. The Plan's language ratified the lawsuit, not the notice. *Ruggles v. Grow* allows ratification or assignment through the "operation of law and contract."[81]

Next, he argues that because the Plan ratified the lawsuit, the Plan is bound to the outcome of the lawsuit and limited to the avenue of reimbursement. The preemption problem with this argument is addressed below. But, regardless of the preemption issue, ratification of the lawsuit does not limit the Plan's options to either reimbursement or subrogation. Both are still available to the Plan and by extension to Charina in this lawsuit. The language of the Plan does not limit the Plan to choose one avenue and be bound by it as Dr. Knolmayer asserts.

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79 Emphasis added.

80 Pet'rs' Br. at 25.

81 948 P.2d 509, 512 (Alaska 1999).

Joinder is not necessary if the Court agrees that Charina is permitted to pursue the Plan's reimbursement and subrogation rights standing in the shoes of the Plan. If the Court rules that this is prohibited, than joinder is necessary and appropriate under Alaska R. Civ. P. 19 because the Plan would not be "clearly bound by the result of the lawsuit."[82] *Baugh*,[83] does not support Dr. Knolmayer's argument otherwise because there the court found that joining the insurer was not necessary because 1) complete relief could have been afforded to all parties in the absence of the insurer, and 2) joinder did not avoid multiple litigation or liability.[84] Neither is true here if the Court adopts Dr. Knolmayer's interpretation of AS 09.55.548(b). If Charina is barred from recovering the reimbursement or subrogated amount, then complete relief could not be afforded in the absence of the Plan. Dr. Knolmayer concedes that his interpretation creates the exposure of a direct lawsuit by the Plan.

Similarly, joinder is unnecessary under Alaska R. Civ. P. 17(a) because the Plan ratified suit for both the reimbursement and subrogation rights. As the court in *Baugh* explained, when ratification has the same effect as joinder, then joinder should not occur.[85] But here, if Charina is prohibited from pursuing the claim for subrogation or reimbursement on behalf of the Plan, the ratification cannot bind the plan because it is not

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82 *Municipality of Anchorage v. Baugh Constr. & Engineering Co.*, 722 P.2d 919, 924 (Alaska 1986).

83 *Id.*

84 *Id*.

85 *Id*. at 926.

"subject to any orders the court may make concerning discovery or attorney's fees," nor does it "bear the burden of claims litigated on their behalf . . . ."[86]

Dr. Knolmayer's statute of limitation argument is also unpersuasive. Charina, upon filing suit and making a claim for the past medical expenses paid, preserved the Plan's subrogation and reimbursement rights as she was obligated to do. And, if AS 09.55.548(b) is interpreted to bar that right of the Plan, it should not be governed by state law. The subrogation claim by the Plan is authorized by federal statute and has federal jurisdiction. ERISA allows a lawsuit commenced by the insurer (or any plan fiduciary) against the insured to enforce the obligations imposed by the statute or "to enforce the terms of the [health insurance] plan."[87] It is unclear when such a claim would accrue.

Dr. Knolmayer argues that because the Plan stands in Charina's shoes it is subject to Alaska law asserting "Ms. McCollum cannot transfer rights she does not have," and this is not subject to preemption.[88] Dr. Knolmayer cites to *Qualchoice, Inc. v. Nationwide Ins. Co.*, an unpublished opinion from Ohio Court of Appeals, that does not include the language Dr. Knolmayer quoted.[89] Instead, that court rejected the

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86 *Id*.

87 29 U.S.C. § 1132(a)(3) ("A civil action may be brought . . . by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan.").

88 Pet'rs' Br. at 25-26.

89 *Id.* at 25 n.37; WL 2008-Ohio-6979 *6 (Ct. App. Ohio 2008).

defendant/insurer's argument that the trial court lacked jurisdiction to hear the subrogation claim explaining "[w]e do not reach the question of whether the subject QualChoice plan is an ERISA plan . . . ." There is no legal support for Dr. Knolmayer's assertion that state law prohibiting a Plan's right to recovery survives preemption.

Dr. Knolmayer also misleadingly quotes *Rudel v. Hawai'i Mgmt. All. Ass'n* to assert that ERISA preemption does not apply to state antisubrogation laws.[90] That is not the law. The Ninth Circuit in *Rudel* determined that two Hawaii statutes one explicitly dealing with insurance that referred to that other general civil statute limiting subrogation had to be read together.[91] Because one statute was directed at insurance both statutes were exempted from preemption by the savings clause in ERISA "§ 514 because they are directed at insurance practices and impact risk pooling."[92]

The Ninth Circuit explained that "[a] state statute may provide a relevant rule of decision in an ERISA action if: (1) it is saved from preemption under § 514; and (2) it does not impermissibly expand the scope of liability outlined in § 502(a)," in finding in *Rudel* both criteria were met.[93] Here, there is only one statute at issue – AS 09.55.548(b) – and Dr. Knolmayer does not argue, nor could he, that it is directed at insurance

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90 Pet'rs' Br. at 26 n.39; 937 F.3d 1262, 1268 (9th Cir. 2019), *cert. denied sub nom. Hawaii Mgmt. All. Ass'n v. Rudel*, 140 S. Ct. 1114 (2020).

91 *Rudel*, 937 F.3d at 1273.

92 *Id.* at 1274.

93 *Id.* at 1275-76.

practices. ERISA plans preempt state anti-subrogation laws aimed at shifting the burden from liability insurers to the ERISA plan collateral sources.[94]

IV. ERISA PREEMPTS AS 09.55.548(b) AS DR. KNOLMAYER INTERPRETS IT BECAUSE HE ASSERTS THE STATUTE SHOULD BE READ TO LIMIT THE PLAN'S ABILITY TO RECOVER REIMBURSEMENT OR SUBROGATION.

Originally, Dr. Knolmayer convinced the trial court that ERISA did not preempt AS 09.55.548(b) because it was not an anti-subrogation statute. Even so, Dr. Knolmayer is arguing exactly that. ERISA pre-empts "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan" covered by ERISA.[95] "[A] state law relates to an ERISA plan if it has a connection with or reference to such a plan."[96] The ERISA "[p]re-emption clause is conspicuous for its breadth," establishing as an "area of exclusive federal concern the subject of every state law that "relate[s] to" an employee benefit plan governed by ERISA."[97] A state law "relates to" an employee welfare plan if it has "a connection with or reference to such a plan."[98] But the connection and reference need not be literal. The state law does not need to be "specially designed to affect" the plan.[99] The law also does not need to deal with "subject matters

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94 *See Levine v. United Healthcare Corp.*, 402 F.3d 156, 165 (3d Cir. 2005).

95 29 U.S.C. § 1144(a).

96 *Egelhoff v. Egelhoff*, 532 U.S. 141, 147 (2001) (internal quotation marks omitted).

97 *FMC Corp. v. Holliday*, 498 U.S. 52, 58 (1990).

98 *Id.*

99 *Id.*

covered by ERISA such as reporting, disclosure, and fiduciary duties . . ."[100] A state law has an "impermissible connection" with an ERISA plan when it either governs a central matter of plan administration or it interferes with nationally uniform plan administration.[101]

In *FMC Corp. v. Holliday*, the U.S. Supreme Court found that the Pennsylvania anti-subrogation law "[h]as a 'reference' to benefit plans governed by ERISA" because it identified the collateral sources as "any program, group contract or other arrangement . . . [and] hospital plan corporation or professional health service corporation" that pays benefits.[102] This language is indistinguishable from the "collateral sources, whether private, group or governmental, and whether contributory or noncontributory" found in AS 09.55.558(b).

Like AS 09.55.548(b), Pennsylvania law had an "impermissible connection" to the ERISA plan because it restricted subrogation rights forcing the Plan to "calculate benefit levels in Pennsylvania based on expected liability conditions that differ from those in states that have not enacted similar antisubrogation legislation."[103] Dr. Knolmayer's interpretation of AS 09.55.548(b) will create an atmosphere of uncertainty for the Plan because it restricts the Plan's ability to choose subrogation over reimbursement. Similarly, requiring the Plan to only exercise its subrogation right directly against

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100 *Id.* at 59.

101 *Rutledge v. Pharm. Care Mgmt. Ass'n*, 141 S. Ct. 474, 480 (2020).

102 498 U.S. at 59.

103 *Id.* at 60.

Dr. Knolmayer is restrictive. Both interfere with the central purpose of ERISA to create a uniform administrative scheme. The trial court erred in its analysis because it applied this test to Charina's medical malpractice claim instead of AS 09.55.548(b). [Exc 295-296]

This led the trial court to skip analyzing the remaining steps in preemption. Those steps also support a finding that AS 09.55.548(b) should be preempted. Pennsylvania's law in *FMC Corp*., is like AS 09.55.548(b), because it also applies to insurance contracts under the "savings clause" in 29 U.S.C. § 1144(b)(2)(A).[104] But, it is still preempted because the "deemer clause" in (B) establishes that a self-funded ERISA plan, like the Plan here, is always "deemed" to fall outside the scope of state insurance regulations for purposes of preemption.[105] For these reasons, preemption was appropriate.

Dr. Knolmayer cites to cases that do not address Charina's arguments.[106] For example, in *Bui v. American Telephone Co. Inc*., the Ninth Circuit held, "ERISA does not preempt claims of medical malpractice against medical service providers for decisions made in the course of treatment or . . . evaluation."[107] Unlike the beneficiaries in *Bui* whose estate sued the employer and its independent contractor for negligent medical advice,[108] Charina is not alleging malpractice against the Plan. No one is arguing that her

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104 *Id.*

105 *Id.*at 60-61.

106 Pet'rs' Br. at 40-41.

107 310 F.3d 1143, 1150-52 (9th Cir. 2002).

108 *Id.* at 1146-47.

medical malpractice claim governed by AS 09.55.540 is preempted by ERISA. *Bui* does not establish or support that a state statute that interferes with the Plan's right to reimbursement and subrogation is controlled by state law if the underlying claim is for medical malpractice.

Similarly, *Empire Healthchoice Assur., Inc. v. McVeigh*,[109] does not evaluate preemption over state law under FEHBA as Dr. Knolmayer asserts.[110] Instead, *Empire* addresses whether there is federal jurisdiction over such a dispute since FEHBA only authorizes lawsuits against the United States.[111] Dr. Knolmayer urges this Court to treat ERISA preemption the same as FEHBA preemption, while omitting Justice Ginsberg's key point that explains why FEHBA and ERISA are different:

> While this regulation channels disputes over coverage or benefits into federal court by designating a United States agency (OPM) sole defendant, no law opens federal courts to carriers seeking reimbursement from beneficiaries or recovery from tortfeasors. Cf. 29 U.S.C. § 1132(e)(1) (provision of the Employee Retirement Income Security Act (ERISA) vesting in federal district courts "exclusive jurisdiction of civil actions under this subchapter").[112]

Had the supreme court intended for *Empire* to wipe-out decades of ERISA preemption precedent it would have said so, instead of distinguishing the two different statutory schemes.

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109 547 U.S. 677 (2006).

110 Pet'rs' Br. at 27.

111 *Empire*, 547 U.S. at 680-81; Pet'rs' Br. at 41.

112 *Empire*, 547 U.S. at 687.

V. AS 09.55.548(b) VIOLATES SUBSTANTIVE DUE PROCESS RIGHTS WHEN AN INJURED PATIENT IS FORCED TO REIMBURSE A COLLATERAL SOURCE FOR THE INJURY CAUSED BY THE DEFENDANT BECAUSE IT BEARS NO REASONABLE RELATIONSHIP TO THE GOVERNMENTAL PURPOSE OF PREVENTING DOUBLE RECOVERY.

Substantive due process is guaranteed by article I, section 7 of the Alaska Constitution, ensuring that "[n]o person shall be deprived of life, liberty or property without due process of law." AS 09.55.548(b) "bears no reasonable relationship to a legitimate government purpose" of preventing double recovery because the evidence establishes the Legislature in 1976 did not intend to require the insured injured patient to shoulder the financial burden of the medical care that a defendant's negligence caused.

Reid v. Williams found that Reid's due process challenge failed because he did not disprove the factual justification for the statute.[113] But, the court in *Reid* did not consider the specific purpose (explained above) for which the Legislature enacted AS 09.55.548(b).[114] It also appears the court in *Reid* adopted findings in law review articles and the American Law Report's to support the purpose of changing the law[115] without considering the Commission's own findings that Alaska did not suffer from the same problems.

The court in *Reid* was not presented with evidence that the Commission and Legislature's intent for AS 09.55.548(b) was to avoid double recovery in a balanced way:

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113 *Reid*, 964 P.2d at 457.

114 *Supra* I. B. at 17-23.

115 *Reid*, 964 P.2d at 457, n.7.

"overall cost would be reduced if the patient was required to first utilize the first party coverages to which he is *entitled*, which are much more efficient forms of distribution than allowing the full measure of damages in expensive third party proceeding . . . ."[116] The entitlement to the collateral source was presumed. The cost-savings was not shifted to the injured patient, but instead to the first party coverages. The Legislature did not intend, foresee or expect that a first party collateral source could force an injured patient to pay back money that she did not receive in compensation.

The Commission and the Legislature sought to balance the need to reduce costs while protecting the legitimate interests of injured patients. This is reinforced by the Legislature's removal of the amendment to the section "Declaration of Purpose" that existed in AS 09.55.530, by removing a stated purpose that appeared to prioritize the interest in affordable medical malpractice insurance above interests of injured patients. The Legislature actively rejected adopting this narrative. The Declaration of Purpose is the policy statement about the Legislature's changes to AS 09.55, so it cannot be assumed that the statute was created solely to protect medical malpractice insurance premiums as Dr. Knolmayer argues.[117] Further, the court in *Reid* was not aware of the legislative history behind AS 09.55.548(b) that establishes the Legislature's intent to ensure a process existed post-trial for a patient to recover collateral sources that were depleted or

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116 Pet'rs' Br. at App. A-29 (emphasis added).

117 *Id.* at App. A-30.

exhausted. Collectively, there is evidence that the Legislature sought to balance protecting injured patients with the need to bring down costs.

Given this purpose, this Court must next consider if interpreting AS 09.55.548(b) to require Charina to shoulder the punitive financial burden of her medical care caused by Dr. Knolmayer's injury is "reasonably related to this purpose."[118] While it is true this Court has recognized the overarching goal of alleviating the medical malpractice insurance crisis as a legitimate government purpose, it has never analyzed the specific purpose of preventing a double recovery behind AS 09.55.548(b) as legitimate when it is applied unfairly to insured patients who are not receiving a double recovery.

The court in *Reid* was not faced with this issue because that plaintiff actually received a double recovery. There is no evidence Reid was forced to pay back the amount deducted post-trial through a contractual obligation of reimbursement or subrogation. Even with the deduction for his double recovery, Reid maintained a significant portion of his compensation. *Reid* challenged the policy decision that chose to prevent double recoveries, not the unintended punitive consequences of AS 09.55.548(b) when there was no double recovery.

It is not reasonably related to the purpose of preventing a double recovery to require a deduction when the evidence post-trial establishes there will not be a double recovery. There is no evidence the Legislature intentionally cast this double recovery net

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118 *Reid*, 964 P.2d at 457.

too wide catching legitimate damages too. In fact, the legislative history establishes the Legislature intended to protect legitimate damages.

Similarly, it is not reasonably related to the goal of preventing a double recovery to deduct the entire legitimate recovery. The legislative history suggests the Legislature was concerned about and afforded injured patient's a post-trial method for ensuring that their collateral sources were not "depleted or exhausted" by the injury. It is not reasonably related to avoiding double recoveries to force compensation that is similar to these categories to be deducted at the expense of the injured patient.

The availability and cost of health care is a significant crisis in our country, as Dr. Knolmayer concedes.[119] It is an important governmental purpose. But, AS 09.55.548(b) undermines that legitimate governmental purpose. Finding a way to provide affordable health care coverage for people has dominated the political debate for over a decade and formed the impetus behind ERISA. The statute as Dr. Knolmayer interprets it punishes the injured plaintiff who has health care insurance with contractual reimbursement or subrogation requirements. Charina could collect the losses for past-medical care if she did not have insurance. It does not serve the purpose of encouraging affordable health insurance if the cost of that insurance includes giving up your right to be compensated for injuries caused by negligence. Since AS 09.55.548(b) does not serve a legitimate government purpose, it violates Charina's substantive due process rights.

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[119] Pet'rs' Br. at 31.

VI. EQUAL PROTECTION UNDER THE ALASKA CONSTITUTION IS VIOLATED BECAUSE AS 09.55.548(b) AND AS 09.17.010 WORK TOGETHER TO DEPRIVE CHARINA OF HER CONSTITUTIONAL RIGHT TO A JURY TRIAL.

Alaska's equal protection clause in article 1, section 1 of the Constitution provides that "all persons are equal and entitled to equal rights, opportunities, and protection under the law."[120] A classification is only valid under Alaska's equal protection test, if it is reasonable, not arbitrary, and must also bear a fair and substantial relation to a legitimate governmental objective.[121] "Depending on the importance of the individual's interest involved, a greater or lesser burden will be placed on the state to show this fair and substantial relationship."[122] This Court must determine the appropriate level of scrutiny by analyzing the nature of the individual's interest.[123]

Deciding which classes to compare is the first step in an equal protection question. Here, AS 09.17.010 and AS 09.55.548(b) discriminate against medical malpractice plaintiffs with a contractual obligation for reimbursement of past health care costs and medical malpractice plaintiffs who either did not have insurance or do not have that contractual obligation.

Applying the following three-step sliding scale approach, the Court must decide if the rationale for AS 09.55.548(b) justifies treating these two similarly situated groups of medical malpractice plaintiffs differently considering: 1) the weight to afford the

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121 *Wilson v. Municipality of Anchorage*, 669 P.2d 569, 572 (Alaska 1983).

122 *State v. Ostrosky*, 667 P.2d 1184, 1193 (Alaska 1983).

123 *Id*.

constitutional interest impaired by the challenged enactment, 2) the purposes served by the challenged statute, including if it was motivated by a compelling state interest under heightened scrutiny or a legitimate purpose under the lower end scrutiny, and 3) evaluating the particular means employed by the state to further its goals.[124] "At the higher end of the scale, the fit between means and ends must be much closer. If the purpose can be accomplished by a less restrictive alternative, the classification will be invalidated."[125]

Judicial scrutiny of state action is heightened where the Legislature, by selectively denying a benefit to those who exercise a constitutional right, effectively deters the exercise of that right.[126] Heightened scrutiny is applied to this type of case.[127] If AS 09.55.548(b) is interpreted to abolish an entire legitimate recovery, it violates an individual's access to the courts and trial by jury. Heightened scrutiny is appropriate because unlike *Reid*, the issues are not merely an economic interest in a double recovery.

The plurality *Evans ex. rel. Kutch v. State* opinion explained that the damage caps to non-economic damages do not limit access to the courts, but instead limit recovery and a "plaintiff's interests in unlimited damages are merely economic."[128] The *Evans* court

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124 *Planned Parenthood of The Great Northwest v. State*, 375 P.3d 1122, 1137 (Alaska 2016).

125 *Id.*

126 *State, Dep't of Health & Soc. Servs. v. Planned Parenthood of Alaska, Inc.*, 28 P.3d 904, 909 (Alaska 2001).

127 *Id.*

128 56 P.3d 1046, 1052 (Alaska 2002).

did not address a statute that, as applied, served to eliminate all economic and non-economic damages, without any other avenue for relief. That is the situation here.

Importantly, *Evans* was a facial challenge where the court was required to uphold the statute "even if it might occasionally create constitutional problems in its application, as long as it 'has a plainly legitimate sweep.'"[129] In *Evans*, the plurality court recognized that "[t]he right of access to the courts is an important interest requiring enhanced scrutiny; however, that right is impaired only by state action that actually limits or blocks access to the courts."[130] As this Court noted in *Sands ex rel. Sands*: "[t]hat our *Evans* decision did not reach this particular constitutional issue merely reinforces the wisdom of the rule that courts should generally avoid deciding abstract cases."[131]

If Charina is restricted from claiming the economic loss related to her medical care totaling $349,049.87, and she is limited to $250,000 for non-economic loss by virtue of AS 09.17.010, in combination with AS 09.55.548(b), the statutes will serve to eviscerate her entire recovery, not just limit her unlimited damages. Statutes that serve to remove both economic and non-economic damages do not allow an insured medical malpractice claimant any avenue for addressing wrongs through the judicial process.

In *Wilson v. Municipality of Anchorage*, the court found that "interest in redressing wrongs through the judicial process is significant," but because the immunity statute still

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129 *Planned Parenthood of the Great Northwest*, 375 P.3d at 1133 (discussing the *Evans* decision).

130 56 P.3d at 1052.

131 156 P.3d at 1133.

allowed a claim against a private party it did "not completely bar access to the courts."[132] Here that is not case. The trial court's ruling violates Charina's article I, section 16 right to a jury trial as well because it does intrude on the jury's fact-finding function.[133] The statute is not just limiting a category of damages based on "policy." It is instead eliminating actual damages that the injured patient is required to pay back and forcing that reimbursement to come from other damages categories.

In *Smith v. Dep't of Ins.*,[134] the Florida Supreme Court held limiting access to courts by restricting recovery is unconstitutional without providing a reasonable alternative to redress the injury. The Missouri Supreme Court in *Watts v. Lester E. Cox Medical Centers*,[135] overruled a previous supreme court decision upholding a non-economic cap limit because it found the prior court misconstrued the jury right in the Missouri constitution.

Like the plurality *Evans* court, the *Watts* court found that the jury's primary function was to find facts, and the application of the cap was a matter of law outside the purview of the jury.[136] The *Watts* decision explains that this analysis misses the point "[b]ecause the constitutional right to a civil jury trial is contingent upon there being an action for damages, statutory limits on those damages directly curtail the individual right

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132 *Wilson v. Municipality of Anchorage*, 669 P.2d at 572.

133 *Evans*, 56 P.3d at 1051.

134 507 So.2d 1080, 1088 (Fla. 1987).

135 376 S.W.3d 633, 642 (Mis. 2012).

136 *Id.* at 641-42.

to one of the most significant constitutional roles performed by the jury—the determination of damages."[137] That is especially true where the two statutes work together to prevent any compensation. The plurality facial challenge addressed in *Evans* is not controlling on this challenge to the right to a jury trial when AS 09.17.010 and AS 09.55.548(b) work together to deprive a plaintiff like Charina from compensation for the medical error caused by Dr. Knolmayer.

This is not just a hypothetical loss of compensation. Charina might be awarded her out-of-pocket expenses for the medical care she received, but she is legally obligated to pay that money to the Plan for reimbursement. This effectively closes the door to the courthouse to any injured patient whose past medical expenses eclipse the other categories of damages. Importantly, the statue also exposes Charina to the possibility of losing her health benefits if she pursues a claim and fails to reimburse or sufficiently cooperate. [Exc. 90] The Plan requirement for paying the full costs of the Plans effort's to obtain reimbursement, conceivably expose a plaintiff to an actual attorney's fee award. [Exc. 90]. These are impediments that are only triggered by filing the lawsuit and failing to reimburse. The threat of depriving the Plan from reimbursement or subrogation has more than just an economic consequence for insureds. Given this important interest the fit between the means and the end must be much closer.

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[137] *Id.* at 642. The *Watts* Court also found the prior decision failed to analyze the constitutional challenge as a statutory limit on the Legislature's role to impermissibly alter the constitution's right to jury protection. *Id*. at 642-43. The *Evans* court also did not consider this challenge.

Under heightened scrutiny or even a lower level of review, the state's purpose in preventing a double recovery is not either compelling or legitimate when AS 09.55.548(b) fails to accomplish that goal. The Commission considered restricting collateral sources in lieu of any recommendation to limit non-economic damages. Specifically, the Commission rejected damage awards because they created "arbitrary roadblocks that would preclude the legitimate claimant from having recourse to counsel and the courts for redress."[138] Instead the Legislature chose to address double recoveries as a cost shifting measure. It did not want to or intend to limit overall awards on non-economic damages, as Dr. Knolmayer concedes.[139] It cannot be argued that the means chosen for that purpose (eliminating actual damages) was close to the end goal of preventing double recoveries, when there was no double recovery to be reduced.

The third step requires the Court to assess whether the State's interest in controlling medical malpractice insurance costs through preventing a double recovery is the least restrictive means available to accomplish the State's goals. Here it is not.

Dr. Knolmayer concedes the Legislature did not intend AS 09.55.548(b) to bar collateral sources. Allowing collateral sources to be collected after the jury's verdict when it is a federal program, for depletion or exhaustion of collateral sources, or a death benefit establishes that the Legislature wanted to ensure the statute was limited to double recoveries. Forcing the injured patient to shoulder the burden of past medical expenses

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138 *Id.* at App. A-29.

139 Pet'rs' Br. at 14-15.

does far more than prevent a double recovery. It depletes damages the jury awarded for other purposes.

The goal of preventing a double recovery can be accomplished within the statute as written. At the post-trial hearing the trial court can consider whether the plaintiff is going to be forced to pay back the reimbursement or subrogation and allow damages for those costs. This is a less restrictive way to ensure that both goals are met reducing cost by limiting double recoveries, but also ensuring that the injured patient is not penalized for exercising her right to a jury trial. There is not a substantial relationship between the means and the ends of applying this statute when its aim is to prevent a double recovery yet its reach restrictive reach obliterates entire recoveries aimed at actual damages. The statue essentially becomes a cap on actual damages when it was never intended to have this impact.

Dr. Knolmayer's argument that Charina chose this fate because she chose to be insured is stunning.[140] Alaskan's should not be forced to choose between insuring their family's health care and their access to the courts. And, it was certainly not the goal of the legislature to encourage citizens to forgo the more "efficient" first party coverages of health insurance to protect themselves and their children to preserve their right to a jury trial. Dr. Knolmayer's analogy between this and legislative limits for categories of non-economic damages based on severity of the injury is also misplaced. Those

[140] Pet'rs' Br. at 34-35.

classifications do not limit all recovery for a certain category of injured plaintiffs.[141] Those limits also do not require forgoing a category of actual loss.

This Court has not before been asked to address a situation where the medical malpractice statutes work together to eliminate the recovery of an injured patient. Because this infringes on important constitutional rights to access the court and trial by jury it violates the equal protection guarantee.

CONCLUSION

There are many avenues for this Court to ensure that AS 09.55.548(b) is not applied to deprive Charina of a right to access the courts and jury trial. It could rule that ERISA plans are included in "federal programs," that the legislature did not intend for the statute to be applied to injured patients who establish that it is not a double recovery, that the Plans right to subrogation is assigned by ratification to her and can be pursued, or that ERISA preempts the statute. It also has strong constitutional grounds under both due process and equal protection to correct the injustice Dr. Knolmayer has doggedly pursued. On each of these grounds individually, or all of them together, the Court should attempt to ensure that injured patients with a contractual obligation for reimbursement are not forced to pay out-of-pocket for the medical care that was caused by a negligent health care provider.

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[141] Dr. Knolmayer's waiver argument mocks interlocutory review. There has not been a trial in this case, so failure to waive an issue at trial is not the standard. The trial court never accepted Dr. Knolmayer's argument that the Plan's only subrogation right was through a direct action against him. Since Charina still had the possibility of collecting the reimbursement or subrogation amounts at trial, no constitutional violation arose.

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