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

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

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

BRIEF OF AMICUS CURIAE PREMERA BLUE CROSS

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TABLE OF CONTENTS

TABLE OF AUTHORITIES

State Cases

Federal Cases

State Statutes

Federal Statutes

Rules

Other Authorities

LEGAL AUTHORITIES PRINCIPALLY RELIED UPON

Alaska Statutes

§ 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.

§ 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.

Federal Statutes

29 U.S.C. § 1102. Establishment of plan

(a) Named fiduciaries

(1) Every employee benefit plan shall be established and maintained pursuant to a written instrument. Such instrument shall provide for one or more named fiduciaries who jointly or severally shall have authority to control and manage the operation and administration of the plan.

(2) For purposes of this subchapter, the term "named fiduciary" means a fiduciary who is named in the plan instrument, or who, pursuant to a procedure specified in the plan, is identified as a fiduciary (A) by a person who is an employer or employee organization with respect to the plan or (B) by such an employer and such an employee organization acting jointly.

(b) Requisite features of plan

Every employee benefit plan shall--

(1) provide a procedure for establishing and carrying out a funding policy and method consistent with the objectives of the plan and the requirements of this subchapter,

(2) describe any procedure under the plan for the allocation of responsibilities for the operation and administration of the plan (including any procedure described in section 1105(c)(1) of this title),

(3) provide a procedure for amending such plan, and for identifying the persons who have authority to amend the plan, and

(4) specify the basis on which payments are made to and from the plan.

(c) Optional features of plan

Any employee benefit plan may provide--

(1) that any person or group of persons may serve in more than one fiduciary capacity with respect to the plan (including service both as trustee and administrator);

(2) that a named fiduciary, or a fiduciary designated by a named fiduciary pursuant to a plan procedure described in section 1105(c)(1) of this title, may employ one or more persons to render advice with regard to any responsibility such fiduciary has under the plan; or

(3) that a person who is a named fiduciary with respect to control or management of the assets of the plan may appoint an investment manager or managers to manage (including the power to acquire and dispose of) any assets of a plan.

29 U.S.C. § 1144. Other laws

(a) Supersedure; effective date

Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III shall supersede any and all State laws insofar as they may now or 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.

(b) Construction and application

(1) This section shall not apply with respect to any cause of action which arose, or any act or omission which occurred, before January 1, 1975.

(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.

(B) Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

(3) Nothing in this section shall be construed to prohibit use by the Secretary of services or facilities of a State agency as permitted under section 1136 of this title.

(4) Subsection (a) shall not apply to any generally applicable criminal law of a State.

(5)(A) Except as provided in subparagraph (B), subsection (a) shall not apply to the Hawaii Prepaid Health Care Act (Haw.Rev.Stat. §§ 393-1 through 393-51).

(B) Nothing in subparagraph (A) shall be construed to exempt from subsection (a)--

(i) any State tax law relating to employee benefit plans, or

(ii) any amendment of the Hawaii Prepaid Health Care Act enacted after September 2, 1974, to the extent it provides for more than the effective administration of such Act as in effect on such date.

(C) Notwithstanding subparagraph (A), parts 1 and 4 of this subtitle, and the preceding sections of this part to the extent they govern matters which are governed by the provisions of such parts 1 and 4, shall supersede the Hawaii Prepaid Health Care Act (as in effect on or after January 14, 1983), but the Secretary may enter into cooperative arrangements under this paragraph and section 1136 of this title with officials of the State of Hawaii to assist them in effectuating the policies of provisions of such Act which are superseded by such parts 1 and 4 and the preceding sections of this part.

(6)(A) Notwithstanding any other provision of this section--

(i) in the case of an employee welfare benefit plan which is a multiple employer welfare arrangement and is fully insured (or which is a multiple employer welfare arrangement subject to an exemption under subparagraph (B)), any law of any State which regulates insurance may apply to such arrangement to the extent that such law provides--

(I) standards, requiring the maintenance of specified levels of reserves and specified levels of contributions, which any such plan, or any trust established under such a plan, must meet in order to be considered under such law able to pay benefits in full when due, and

(II) provisions to enforce such standards, and

(ii) in the case of any other employee welfare benefit plan which is a multiple employer welfare arrangement, in addition to this subchapter, any law of any State which regulates insurance may apply to the extent not inconsistent with the preceding sections of this subchapter.

(B) The Secretary may, under regulations which may be prescribed by the Secretary, exempt from subparagraph (A)(ii), individually or by class, multiple employer welfare arrangements which are not fully insured. Any such exemption may be granted with respect to any arrangement or class of arrangements only if such arrangement or each arrangement which is a member of such class meets the requirements of section 1002(1) and section 1003 of this title necessary to be considered an employee welfare benefit plan to which this subchapter applies.

(C) Nothing in subparagraph (A) shall affect the manner or extent to which the provisions of this subchapter apply to an employee welfare benefit plan which is not a multiple employer welfare arrangement and

which is a plan, fund, or program participating in, subscribing to, or otherwise using a multiple employer welfare arrangement to fund or administer benefits to such plan's participants and beneficiaries.

(D) For purposes of this paragraph, a multiple employer welfare arrangement shall be considered fully insured only if the terms of the arrangement provide for benefits the amount of all of which the Secretary determines are guaranteed under a contract, or policy of insurance, issued by an insurance company, insurance service, or insurance organization, qualified to conduct business in a State.

(7) Subsection (a) shall not apply to qualified domestic relations orders (within the meaning of section 1056(d)(3)(B)(i) of this title), qualified medical child support orders (within the meaning of section 1169(a)(2)(A) of this title), and the provisions of law referred to in section 1169(a)(2)(B)(ii) of this title to the extent they apply to qualified medical child support orders.

(8) Subsection (a) of this section shall not be construed to preclude any State cause of action--

(A) with respect to which the State exercises its acquired rights under section 1169(b)(3) of this title with respect to a group health plan (as defined in section 1167(1) of this title), or

(B) for recoupment of payment with respect to items or services pursuant to a State plan for medical assistance approved under title XIX of the Social Security Act which would not have been payable if such acquired rights had been executed before payment with respect to such items or services by the group health plan.

(9) For additional provisions relating to group health plans, see section 1191 of this title.

(c) Definitions

For purposes of this section:

(1) The term "State law" includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State. A law of the United States applicable only to the District of Columbia shall be treated as a State law rather than a law of the United States.

(2) The term "State" includes a State, any political subdivisions thereof, or any agency or instrumentality of either, which purports to regulate, directly or

indirectly, the terms and conditions of employee benefit plans covered by this subchapter.

(d) Alteration, amendment, modification, invalidation, impairment, or supersedure of any law of the United States prohibited

Nothing in this subchapter shall be construed to alter, amend, modify, invalidate, impair, or supersede any law of the United States (except as provided in sections 1031 and 1137(b) of this title) or any rule or regulation issued under any such law.

(e) Automatic contribution arrangements

(1) Notwithstanding any other provision of this section, this subchapter shall supersede any law of a State which would directly or indirectly prohibit or restrict the inclusion in any plan of an automatic contribution arrangement. The Secretary may prescribe regulations which would establish minimum standards that such an arrangement would be required to satisfy in order for this subsection to apply in the case of such arrangement.

(2) For purposes of this subsection, the term "automatic contribution arrangement" means an arrangement--

(A) under which a participant may elect to have the plan sponsor make payments as contributions under the plan on behalf of the participant, or to the participant directly in cash,

(B) under which a participant is treated as having elected to have the plan sponsor make such contributions in an amount equal to a uniform percentage of compensation provided under the plan until the participant specifically elects not to have such contributions made (or specifically elects to have such contributions made at a different percentage), and

(C) under which such contributions are invested in accordance with regulations prescribed by the Secretary under section 1104(c)(5) of this title.

(3)(A) The plan administrator of an automatic contribution arrangement shall, within a reasonable period before such plan year, provide to each participant to whom the arrangement applies for such plan year notice of the participant's rights and obligations under the arrangement which--

(i) is sufficiently accurate and comprehensive to apprise the participant of such rights and obligations, and

(ii) is written in a manner calculated to be understood by the average participant to whom the arrangement applies.

(B) A notice shall not be treated as meeting the requirements of subparagraph (A) with respect to a participant unless--

(i) the notice includes an explanation of the participant's right under the arrangement not to have elective contributions made on the participant's behalf (or to elect to have such contributions made at a different percentage),

(ii) the participant has a reasonable period of time, after receipt of the notice described in clause (i) and before the first elective contribution is made, to make such election, and

(iii) the notice explains how contributions made under the arrangement will be invested in the absence of any investment election by the participant.

JURISDICTIONAL STATEMENT

By Order dated September 29, 2020, this Court granted review of the trial court's April 30, 2020 ruling that 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)"). This Court has jurisdiction pursuant to Appellate Rule 402.

STATEMENT OF THE ISSUES PRESENTED FOR REVIEW

1. The McCollums assert medical malpractice claims against Thomas J. Knolmayer, M.D., and Alaska Trauma and Acute Care Surgery, LLC (collectively, "Dr. Knolmayer"). They claim they incurred medical expenses because of negligence by Dr. Knolmayer, which were paid by the Lowe's Companies, Inc. Welfare Benefits Plan ("the Plan") provided to Mr. McCollum by his employer, national hardware chain Lowe's Companies, Inc. ("Lowe's"). The Plan requires the McCollums to reimburse the Plan out of any recovery they obtain on a first-dollar basis, without deduction for attorney fees or other legal expenses, and without regard to whether they have been fully compensated. Under the Employee Retirement Income Security Act of 1974 (ERISA), 88 Stat. 829, 29 U.S.C. § 1001 *et seq.*, this obligation is enforceable and a party administering the Plan must follow its terms. Is the Plan, together with the federal law enforcing it, "a federal program that by law must seek subrogation" within the meaning § 548(b)?

2. Is § 548(b) preempted by ERISA to the extent that it would uniquely in Alaska require the Plan, as Dr. Knolmayer argues, "to assign its claims to Ms. McCollum

or pursue a direct right of action against defendants," Pet'rs. Br. at p. 27, as a condition of realizing its federally enforceable subrogation and reimbursement rights?

3. Is Dr. Knolmayer's interpretation of § 548(b) unconstitutional, because it would arbitrarily allow beneficiaries of *some* federally-governed benefits plans to recover damages covering their reimbursement obligations, but disallow that recovery to beneficiaries of other such plans, forcing *these* beneficiaries to cover their reimbursement obligations using any recovery they obtain for their other, personal damages? *See* Pet'rs. Br. at p. 26 ("any recovery by Ms. McCollum in this action is subject to a reduction under the statute . . . , and the Plan can obtain reimbursement from Ms. McCollum's recovery, if any, after this litigation.").

STATEMENT OF THE CASE

A. *Amicus Curiae* Premera Blue Cross administers federally-governed benefit plans covering beneficiaries in Alaska, among other states.

Premera Blue Cross ("Premera") provides services which embrace pursuing subrogation and reimbursement from personal-injury recoveries to employer self-funded benefit plans. In a "self-funded" plan like the Lowe's plan covering the McCollums, the employer pays benefits according to the Plan with its own funds, but may hire a third-party administrator such as Premera to provide administrative services, as well as pursue subrogation and reimbursement.

A third-party administrator servicing a self-funded ERISA plan generally is subject to federally-enforceable obligations in carrying out its administrative tasks. The administrator must follow the plan terms. It must do so throughout the different states in

which the employer may employ workers. Lowe's is a national brand and employs workers in many states. A third-party administrator of the Lowe's company benefits plan must administer benefits in all those states. One of the overriding purposes of ERISA was to allow these plans to be administered consistently in different states. When the established plan terms require pursuit of subrogation and reimbursement, the third-party administrator must follow those plan terms like any others. For the administrator, seeking subrogation and reimbursement is not optional, but required by the plan and therefore required by federal law.

Premera has provided and continues to provide administrative services to benefit plans covering beneficiaries in Alaska. Premera has processed payment for medical services resulting from injuries actionable in subsequent tort claims, including medical malpractice claims. When required by the plan terms, pursuant to federal law, Premera has indicated to the beneficiaries and their Alaska injury counsel that Premera will require reimbursement from their recoveries. Premera has done this in medical malpractice cases subject to § 548(b), pursuant to federally-enforceable plan terms under ERISA. Accordingly, Premera has a direct interest in the proper interpretation of § 548(b).

B. The Plan requires the McCollums to pursue and protect the Plan's interests.

Premera has sought to enforce plan terms substantially similar to those appearing in the Lowe's plan covering the McCollums. As Dr. Knolmayer observes, the Plan makes payments conditional on the McCollums' duty to reimburse the Plan; the McCollums assigned their rights of recovery to the Plan to the extent of its payments; the Plan is

entitled to enforce its subrogation and reimbursement rights through a lien on any recovery, no matter how that recovery is characterized as compensating medical expenses or other losses; and the Plan's right to recovery is not reduced by the common fund doctrine, sharing of attorney fees or costs, the made-whole doctrine, or other theory. *See* Pet'rs. Br. at pp. 3-4.

In addition, however, this Plan imposes on the McCollums additional duties to protect the Plan's rights. Although the Plan retains the discretion to pursue claims on its own behalf, the Plan contemplates that this will occur "if the Covered Person fails to file a claim or pursue damages against" a responsible party. [Exc. 88] In the first instance, it is the "Covered Person's obligation," here the McCollums', to "cooperate with the Plan . . . in protecting its rights," to "take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights," and to "not settle or release, without the prior consent of the Plan, any claim . . . ." [Exc. 90] Together, the obligations of first-dollar reimbursement, cooperation, protecting the Plan's rights, and not settling without the Plan's consent, require the McCollums to protect and pursue the Plan's interests in any claim that they bring, including their claim against Dr. Knolmayer.

If the McCollums breach these obligations, or obtain a recovery and fail to reimburse the Plan, the Plan may declare "a forfeiture of payment by the Plan of medical benefits," and "any funds or payments due" under the Plan "may be withheld until the Covered Person satisfies his or her obligation." [Exc. 90] Pursuant to these Plan terms, the administrator in Braintree, Massachusetts, advised the McCollums' counsel that the

Plan would require full reimbursement from any recovery, regardless of state law. [Exc. 143]

These Plan terms are enforceable under federal law. Premera asks that this Court conclude that a federally-governed benefit plan requiring reimbursement or subrogation is "a federal program that by law must seek subrogation" within the meaning § 548(b). This carries out legislative intent that recovery be allowed when the claimant is under federal mandate to make reimbursement; avoids a direct clash with the intent of ERISA to promote consistent implementation of benefit plans across state lines; and avoids an arbitrary and unconstitutional distinction between claimants who are able to make recoveries covering their federally imposed reimbursement obligations and those who are not.

STANDARD OF REVIEW

This matter turns on the intended meaning of § 548(b)'s exception for a "a federal program that by law must seek subrogation," and, if that law sets up a statutory classification between ERISA plan participants and other claimants, the constitutionality of that classification. Each issue is subject to de novo review in this Court. *Alaskans For Efficient Gov't, Inc. v. Knowles*, 91 P.3d 273, 275 (Alaska 2004) ("We review de novo questions of law, including the interpretation of a statute, adopting the rule of law most persuasive in light of precedent, reason, and policy."); *L.D.G., Inc. v. Brown*, 211 P.3d 1110, 1118 (Alaska 2009) ("Issues regarding the constitutionality of statutes are questions of law that we review de novo.").

I. ARGUMENT

A. The Plan is a "Federal Program that by Law Must Seek Subrogation" Within the Meaning of § 548(b).

1. Section 548(b) was Intended to Allow Claimants to Make Recoveries Necessary to Cover Federally-Mandated Reimbursement Obligations.

Section 548(b) was enacted as "a reasonable legislative response to a perceived medical malpractice insurance crisis." *Reid v. Williams*, 964 P.2d 453, 455 (Alaska 1998). The law abrogates the common-law collateral source rule in medical malpractice cases, providing that, "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." AS 09.55.548(b). In other words, the claimant may not recover amounts that were paid by collateral sources, such as health insurance. In *Reid*, this Court held that § 548(b) survived constitutional challenge, because "It is reasonable to conclude that reducing damage awards would help reduce the cost of medical malpractice insurance," and "alleviating a perceived medical malpractice insurance crisis was a legitimate public purpose for enacting AS 09.55.548(b), and [] the statute was reasonably related to that goal." 964 P.2d at 457.

But there is an exception "when the collateral source is a federal program that by law must seek subrogation." AS 09.55.548(b). Both the 1975 Commission appointed by the Governor and Dr. Knolmayer's own analysis make it clear that the purpose of abrogating the collateral source rule was to eliminate any possibility of "'double recovery.'" Pet'rs. Br. at p. 14 (quoting [Appx. A at p. 29]). But the Commission wished

to maintain the claimant's right to recover "actual out-of-pocket losses." [Appx. A at pp. 29-30] This recognized that when a claimant received only *conditional* payments from the collateral source, and was subject to a federal repayment requirement beyond the state's power to eliminate, the balance intended to be struck was to allow recovery.

When construing a statute de novo, this Court considers three factors: "the language of the statute, the legislative history, and the legislative purpose behind the statute." *City of Valdez v. State*, 372 P.3d 240, 248 (Alaska 2016) (quotation omitted). This Court has rejected "a mechanical application" of the plain meaning rule. *Peninsula Mktg. Ass'n v. State*, 817 P.2d 917, 922 (Alaska 1991). The Court's goal is "to give effect to the legislature's intent, with due regard for the meaning the statutory language conveys to others." *Alyeska Pipeline Serv. Co. v. State, Dep't of Envtl. Conservation*, 145 P.3d 561, 566 (Alaska 2006)

Each factor this Court relies on to construe a statute supports the conclusion that the Lowe's ERISA plan was "a federal program that by law must seek subrogation" under § 548(b).

First, the *language* of the statute is broader than merely covering specifically Medicare and Medicaid, which the parties agree fall into the exception. By making the exception cover any federal "program," the Legislature contemplated that it could not anticipate exactly how Congress might fashion a federal reimbursement right, let alone Congress and the federal courts working in tandem over many years. The Legislature passed § 548(b) in 1976, only two years after Congress passed ERISA and long before the federal courts interpreting ERISA clearly established strong, federally enforceable

subrogation and reimbursement rights. By using general language, the Legislature indicated an intent to embrace the array of schemes Congress might use to establish federally enforceable rights.

Second, the *legislative history* shows that the law did intend to allow at least a single recovery to medical malpractice claimants for their loss, but was concerned primarily with preventing a "'double recovery.'" Pet'rs. Br. at p. 14 (quoting [Appx. A at p. 29]). Where Congress has created a regulatory scheme that requires the first dollars of recovery to pay back an ERISA plan, it would go against the Legislature's intent to leave claimants with no recovery to make that required reimbursement apart from damages they can claim for other losses different from the medical expenses the plan paid. In fact, the legislative history says so in so many words: "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." [Appx. A at p. 20] The Legislature did *not* adopt a policy of leaving the claimant "no remedies."

Finally, the *legislative purpose* of the law, again, is to prevent double recovery. But that purpose is not served when the abrogation of the collateral source rule does not yield to a federally-enforceable, first-dollar reimbursement right. Significantly, when the Legislature enacted Section 548(b) in 1976, subrogation in health insurance was not as commonplace as it is today. "Historically, courts did not allow equitable subrogation of personal injury claims." Adam G. Todd, *An Enduring Oddity: The Collateral Source Rule in the Face of Tort Reform, the Affordable Care Act, and Increased Subrogation*, 43 McGeorge L. Rev. 965, 989 (2012). In that setting, the risk of double recovery was also

more common, and thus the basis for legislative attention. In contrast, today, "most health insurance contracts now provide for subrogation and reimbursement." *Id.* at 990. While the risk of double recovery may be less prevalent today, it remains the guide for the legislative intent behind Section 548(b), and it is not served by preventing the McCollums from recovery when they must repay the Plan.

2. The Plan and Federal ERISA Law Amount to a "Federal Program" within the Meaning of § 548(b).

The conclusion that Section 548(b) allows recovery in the case of an ERISA plan mandating reimbursement is consistent with Congress' federalization of employee benefits law. ERISA authorizes employers to craft benefit plans that require reimbursement, and commands plan administrators to seek reimbursement once an employer has done so.

a. ERISA comprehensively regulates benefits plans such as the Lowe's plan.

Congress enacted ERISA to establish a uniform federal law of employee benefits, so that employers providing employee benefit plans would not be subject to varying requirements in different states. As the U.S. Supreme Court has explained:

> ERISA was enacted "to make the benefits promised by an employer more secure by mandating certain oversight systems and other standard procedures." *Gobeille v. Liberty Mut. Ins. Co.*, 577 U. S. 312, 320–321, 136 S. Ct. 936, 194 L.Ed.2d 20 (2016). In pursuit of that goal, Congress sought "to ensure that plans and plan sponsors would be subject to a uniform body of benefits law," thereby "minimiz[ing] the administrative and financial burden of complying with conflicting directives" and ensuring that plans do not have to tailor substantive benefits to the particularities of multiple jurisdictions. *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 142, 111 S. Ct. 478, 112 L.Ed.2d 474 (1990).

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

ERISA establishes an "extensive" set of "reporting, disclosure, and recordkeeping requirements for welfare benefit plans." *Gobeille v. Liberty Mut. Ins. Co.*, 136 S. Ct. 936, 944, 194 L. Ed. 2d 20 (2016). In addition to mandating certain disclosures to plan participants, ERISA requires employers to submit financial data to the Secretary of Labor, and empowers the Secretary to demand that the plan submit additional financial data supporting required filings. *Id.* These functions are overseen by the Employee Benefits Security Administration established within the U.S. Department of Labor.

ERISA does not specify the terms that benefit plans must use. This is by design. "The statutory scheme [] 'is built around reliance on the face of written plan documents.'" *US Airways, Inc. v. McCutchen*, 569 U.S. 88, 100–01, 133 S. Ct. 1537, 1548, 185 L. Ed. 2d 654 (2013) (quoting *Curtiss–Wright Corp. v. Schoonejongen*, 514 U.S. 73, 83, 115 S.Ct. 1223, 131 L.Ed.2d 94 (1995)). Congress intended to make employee benefits more secure "by mandating certain oversight systems and other standard procedures." *Gobeille*, 136 S. Ct. at 943. ERISA seeks to encourage employers to provide benefit plans by "assuring a predictable set of liabilities, under uniform standards of primary conduct and a uniform regime of ultimate remedial orders and awards when a violation has occurred." *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 379, 122 S.Ct. 2151, 153 L.Ed.2d 375 (2002). As a result, "employers have large leeway to design disability and other welfare plans as they see fit." *Black & Decker Disability Plan v. Nord*, 538 U.S. 822, 833, 123 S. Ct. 1965, 1971, 155 L. Ed. 2d 1034 (2003).

However, "once a plan is established, the administrator's duty is to see that the plan is 'maintained pursuant to [that] written instrument.'" *Heimeshoff v. Hartford Life & Acc. Ins. Co.*, 571 U.S. 99, 108, 134 S. Ct. 604, 612, 187 L. Ed. 2d 529 (2013) (quoting 29 U.S.C. § 1102(a)(1)). The administrator's duty to follow the plan terms is essential to the proper functioning of ERISA. The U.S. Supreme Court has described ERISA's "focus on the written terms of the plan" as "the linchpin" of "a system that is [not] so complex that administrative costs, or litigation expenses, unduly discourage employers from offering [ERISA] plans in the first place." *Id.* (quoting *Varity Corp. v. Howe*, 516 U.S. 489, 497, 116 S.Ct. 1065, 134 L.Ed.2d 130 (1996)). The administrator's duty to follow the plan terms is mandatory. *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 110, 109 S. Ct. 948, 954, 103 L. Ed. 2d 80 (1989).

In the present case, the terms of the Lowe's plan requiring the McCollums to reimburse the Plan are enforceable. *Sereboff v. Mid Atl. Med. Servs., Inc.*, 547 U.S. 356, 364, 126 S. Ct. 1869, 1875, 164 L. Ed. 2d 612 (2006). The reimbursement provisions of the Plan are mandatory, not optional as Dr. Knolmayer argues. Looking at one provision out of context, Dr. Knolmayer argues that reimbursement under the Lowe's plan is not mandatory because the Plan says it "may, at its discretion" bring an action to recover its payments. Pet'rs. Br. at 17. But this confuses two different things. The Plan reserves discretion on whether it will secure reimbursement through sharing in the McCollums' recovery or through pursuing a recovery on its own. But reimbursement in the event of recovery through one mechanism or another is mandatory under the Plan terms requiring first-dollar reimbursement. The assumption that the Plan would be entitled to that

reimbursement is built into the employer's financial reporting to the Department of Labor, *Gobeille*, 136 S. Ct. at 944; once this requirement has been "established" in the written Plan, it is the administrator's "duty" to "see that the plan is maintained pursuant to [that] written instrument," *Heimeshoff*, 571 U.S. at 108 (quotation omitted); and the administrator's faithful adherence to the written plan is the "linchpin" of the system Congress devised, *id.*

b. ERISA's regulation of employee benefits is a "federal program" within the meaning of § 548(b).

Ignoring ERISA's deliberate balancing of allowing employers freedom to craft their own benefit plans within a defined regulatory framework, Dr. Knolmayer argues that ERISA and the Plan do not form a "federal program" based on the fact that Lowe's is a private employer. But this argument ignores that Congress's decision to federalize employee benefits, create a uniform system of administration of employee benefits, require employers to submit their plans to the financial and regulatory oversight of the U.S. Department of Labor, and, as a policy matter, allow employers to define their own benefit terms within that framework, is a "federal program" under the ordinary meaning of those terms.

There is no question that the ERISA regulatory framework differs from Medicare or Medicaid. Under those federal benefit schemes, Congress has established statutory benefits together with statutory reimbursement requirements. *See* 42 U.S.C. § 1395y(b) (Medicare) & 42 U.S.C. § 1396(a)(25)(B) (Medicaid). The parties appear to agree that under these federally-enforceable reimbursement obligations, Alaska medical malpractice

claimants are entitled to recover medical expenses as damages under the exception in § 548(b) for "a federal program that by law must seek subrogation." But the fact that Medicare and Medicaid *do* fall into the exception does not define the intended scope of § 548(b), nor compel the conclusion that a federally-enforceable ERISA Plan does *not* fall into its terms.[1] In ERISA, Congress adopted a different, but no less enforceable, regulatory scheme. This federal law grants employers the right to craft benefit plans requiring reimbursement, *Sereboff*, 547 U.S. at 364, and commands administrators to carry out plan terms that do, *Heimeshoff*, 571 U.S. at 108.

The Legislature intended to make an exception for when federal law intervened to require reimbursement out of a tort recovery. The reason for doing so is obvious. The Legislature has no power to countermand a federally-enforceable reimbursement obligation. But if it eliminated recoveries for medical expenses even where claimants had to repay health plans under federal law, it would eliminate the claimants' ability to obtain even a single recovery for loss. But the legislative history shows that the Legislature intended to allow at least that much. Accordingly, the McCollums' federally-enforceable reimbursement obligation falls within the exception the Legislature intended in § 548(b) for "a federal program that by law must seek subrogation."

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[1] Dr. Knolmayer cites *Waskey v. United States*, 3:04-CV-110 JWS, 2007 WL 898888, at *2 (D. Alaska Mar. 23, 2007), but that case merely acknowledges that Medicare is a "federal program" within the meaning of § 548(b), without any analysis of the intended scope of the exception.

B. Dr. Knolmayer's Interpretation of § 548(b) Would be Preempted by ERISA.

Dr. Knolmayer's interpretation of § 548(b) creates draconian results for claimants such as the McCollums. Dr. Knolmayer argues that the McCollums cannot recover medical expenses paid by the Plan, and can recover only other damages such as, presumably, wage loss, pain and suffering, or other out-of-pocket expenses. At the same time, Dr. Knolmayer concedes that the Plan terms require the McCollums to reimburse the Plan out of *any* recovery they obtain, no matter how that recovery is characterized. In other words, Dr. Knolmayer is arguing that the Legislature intended that claimants in the McCollums' position who proved their claims would have repay the Plan out of any damages they obtain for wage loss, pain and suffering, or other out-of-pocket expenses.

Recognizing that this outcome is contrary to the legislative intent disclosed in the history of § 548(b), Dr. Knolmayer attempts to chart an alternate course in which full damages can be recovered, but only if the Plan makes its discretionary election to bring an action on its own, rather than share in the McCollums' recovery. Dr. Knolmayer argues that § 548(b) "does not apply to insurers who pursue direct subrogation claims, and thereby subject themselves to potential costs and fees." Pet'rs. Br. at 27. Of course, as Dr. Knolmayer has elsewhere emphasized, there is no insurer involved in this case. This Plan consists of Lowe's assets as a self-funded plan, so it would be Lowe's assets put at risk in Dr. Knolmayer's proposal. This would be a rule unique to Lowe's employees in Alaska and is precisely what ERISA preempts.

1. Dr. Knolmayer's Interpretation of § 584(b) Has an Impermissible Connection with ERISA Plans.

"ERISA pre-empts 'any and all State laws insofar as they may now or hereafter relate to any employee benefit plan' covered by ERISA." *Rutledge*, 141 S. Ct. at 479 (quoting 29 U.S.C. § 1144(a)). A state law "relates to" an ERISA plan and is preempted if it "has a connection with" such a plan. *Id.* (quotation omitted). "To determine whether a state law has an 'impermissible connection' with an ERISA plan, this Court considers ERISA's objectives as a guide to the scope of the state law that Congress understood would survive." *Rutledge*, 141 S. Ct. at 480 (quotation omitted). The U.S. Supreme Court explained this test late last year:

> ERISA is therefore primarily concerned with pre-empting laws that require providers to structure benefit plans in particular ways, such as by requiring payment of specific benefits, *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 103 S. Ct. 2890, 77 L.Ed.2d 490 (1983), or by binding plan administrators to specific rules for determining beneficiary status, *Egelhoff*, 532 U.S. 141, 121 S. Ct. 1322, 149 L.Ed.2d 264. A state law may also be subject to pre-emption if "acute, albeit indirect, economic effects of the state law force an ERISA plan to adopt a certain scheme of substantive coverage." *Gobeille*, 577 U.S. at 320, 136 S. Ct. 936 (internal quotation marks omitted). As a shorthand for these considerations, this Court asks whether a state law "governs a central matter of plan administration or interferes with nationally uniform plan administration." *Ibid.* (internal quotation marks and ellipsis omitted). If it does, it is pre-empted.

Id. In *Rutledge*, the court held an Arkansas law was not preempted, where that law did not touch on ERISA plan management, but required pharmacy benefit managers to provide certain minimum levels of reimbursement to pharmacies for prescription drugs. The court has cleared state laws having only "indirect economic influence" on plans, because "ERISA does not pre-empt state rate regulations that merely increase costs or

alter incentives for ERISA plans without forcing plans to adopt any particular scheme of substantive coverage." *Id.*

But Dr. Knolmayer's proposed interpretation of § 548(b) would impermissibly "require providers to structure benefit plans in particular ways," "govern[] a central matter of plan administration," and "interfere[] with nationally uniform plan administration." This is because it would attach a requirement to enforcing reimbursement in Alaska that the Plan would not have to meet in any other state: forcing the Plan to sue in its own name in this state but not any other. Far from regulating some aspect of the market in which ERISA plans participate such as the prescription drug market in Arkansas, Dr. Knolmayer's interpretation of § 548(b) would impose a specific *administrative* choice on plans. This is the precise thing states may *not* do.

2. Section 548(b) Is Not Saved as a Law Regulating Insurance.

In a footnote, Dr. Knolmayer seeks to rely on federal law holding that state anti-subrogation laws are not preempted by ERISA, citing *Rudel v. Hawai'i Mgmt. All. Ass'n*, 937 F.3d 1262, 1276 (9th Cir. 2019), *cert. denied sub nom. Hawaii Mgmt. All. Ass'n v. Rudel*, 140 S. Ct. 1114, 206 L. Ed. 2d 183 (2020). But *Rudel* does not apply, and cannot save an impermissible interpretation of § 548(b), because this case arises from a plan self-funded with the employer's own assets, and does not involve any insurance contracts.

Self-funded plans are not subject to state insurance law. In *Rudel*, an ERISA-governed benefit plan obtained funding to provide plan benefits by acquiring a state-law insurance contract from the Hawai'i Medical Alliance Association. 937 F.3d at 1267.

Although ERISA has a strong express preemption clause, there is an exception for "'any law of any State which regulates insurance, banking, or securities.'" *Id.* at 1269 (quoting 29 U.S.C. § 1144(b)(2)(A)). But there is an exception-to-the-exception for self-funded plans. Under ERISA's "deemer clause," an ERISA plan itself is not "deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies." 29 U.S.C.A. § 1144(b)(2)(B). The "deemer clause" "exempt[s] self-funded ERISA plans from state laws that regulat[e] insurance within the meaning of the saving clause." *FMC Corp. v. Holliday*, 498 U.S. 52, 61, 111 S. Ct. 403, 409, 112 L. Ed. 2d 356 (1990) (quotation omitted).

Because the McCollums' Lowe's plan is a self-funded plan that uses the employer's own assets to fund benefits, it is not governed by state insurance law and *Rudel* does not apply.

C. Dr. Knolmayer's Interpretation of § 548(b) is an Unconstitutional Equal Protection Violation.

By the exception for a "federal program" in § 548(b), the Legislature meant to allow recovery of medical expenses when the claimant would have to repay those out of any recovery. But if the Court concludes either that § 548(b) sets up a distinction between contractual subrogation and a statutory reimbursement requirement, or that it sets up a distinction between ERISA reimbursement and Medicare and Medicaid reimbursement, then the law would create arbitrary distinctions having no basis in the legislative history

at all, let alone a rational basis. The illogic of either distinction is only more evidence that the Legislature never intended the regime Dr. Knolmayer suggests.

Under Alaska's Equal Protection Clause, when the Legislature imposes disparate treatment on similarly situated persons, this Court requires, under minimum scrutiny for economic interests, a "substantial relationship between means and ends." *Harris v. Millenium Hotel*, 330 P.3d 330, 336 (Alaska 2014). In *Harris*, the Court found an equal protection violation where the workers' compensation law allowed married spouses to receive death benefits but not unmarried same-sex partners. Finding that the purposes of the law included both compensating dependents and administrative efficiency in determining eligibility, denying same-sex couples access to death benefits did not "bear a fair and substantial relationship to the purposes of the act." *Id.* at 338. Denying medical expense recovery to medical malpractice claimants who must repay federal ERISA plans—if that is what the Legislature intended—would fail the same test.

1. Neither this Court's Decision in *Reid v. Williams*, Nor Dr. Knolmayer's Brief, Addresses the Classifications Dr. Knolmayer's Interpretation Would Create.

An equal protection challenge "involves resolution of several questions." *Id.* at 332. The Court's first task is to determine whether a law sets up a statutory distinction subject to equal protection review by having a "discriminatory purpose" or being "facially discriminatory," and whether it "treats similarly situated persons differently." *Id.* at 333–34 (quotations omitted).

In *Reid*, this Court explained that § 548(b) survived equal-protection scrutiny based on its rationally distinguishing between "between malpractice plaintiffs and

defendants and other tort plaintiffs and defendants." 964 P.2d at 460. The legislature's decision to treat medical malpractice plaintiffs and defendants differently from others was "reasonably related to the legislative objectives of lowering the costs of medical malpractice actions, and ensuring the continued availability of health care for the public." *Id.*

But Dr. Knolmayer's interpretation of § 548(b) sets up two more, completely different statutory distinctions. First, based on a review of a different and unrelated statute, Dr. Knolmayer attempts to set up a distinction between subrogation required by "law" as contrasted with subrogation required merely by "contract." But this is an artificial distinction where the baseline rule is that a valid contractual term is enforceable under law. Second, Dr. Knolmayer's narrow interpretation of the term "federal program" sets up a distinction between claimants with reimbursement obligations under *certain kinds* of federal programs and those with the same obligations under *other kinds* of federal programs. Dr. Knolmayer argues that patients covered by Medicare or Medicaid may recover medical expenses when they bring claims over poor care, but patients covered by ERSIA plans may not. Whether a distinction between persons having reimbursement obligations imposed by "law" versus by "contract," or one between persons having reimbursement obligations imposed by a "federal program" versus an ERISA plan, there is no question Dr. Knolmayer's interpretation of § 548(b) sets up distinctions which "treat[] similarly situated persons differently." *Harris*, 330 P.3d at 334 (quotation omitted).

2. The Classifications Created by Dr. Knolmayer's Interpretation of § 548(b) Have No Rational Basis.

a. A distinction between "contractual" subrogation and subrogation required "by law" does not exist, and would lack rational basis as to federally enforceable rights that state law cannot invalidate.

Dr. Knolmayer constructs an argument that the Legislature had a specific intent that § 548(b) would not cover any subrogation arising "by contract," because it specifically refers to federal programs requiring subrogation "by law." This is based on a different statute, AS 09.17.070, which was enacted 10 years later. In AS 09.17.070, the Legislature allowed for reduction of recoveries in cases other than medical malpractice cases when the claimant has been compensated "from collateral sources that do *not* have a right of subrogation *by law or contract*." AS 09.17.070(a) (emphasis added).

The different language in the later statute is not a reliable guide to the Legislature's intent in enacting § 548(b). Dr. Knolmayer's argument is precisely the sort of "mechanical application" of statutory law that this Court rejects. *Peninsula Mktg. Ass'n*, 817 P.2d at 922. Moreover, the statutes are worded differently, and the addition of the clarifying "*or contract*" serves a purpose in the later-enacted law. The later law is phrased in the negative, referring to cases in which collateral sources do "not" have subrogation rights. If the later statute had referred to collateral sources that do "not" have subrogation rights "by law," then it would have been ambiguous as to whether it meant for a court to determine the *merit* of the subrogation right, as opposed to the *existence* of one. By adding the clarifying language to refer to collateral sources that do "not" have subrogation rights "by law or contract," the statute demonstrates that the Legislature

means for a court determining the applicability of the statute simply to ascertain whether the controlling terms of the claimant's collateral source *contain* a subrogation right. Because the additional reference to "contract" serves a clarifying purpose in the later law, it is not a reliable guide to the intent of § 548(b).

In addition, however, if the Legislature had intended a distinction between subrogation arising "by law" versus "by contract" in Section 548(b), there still would be ambiguity about its treatment of *federally* enforceable ERISA plans. "When an insurer pays expenses on behalf of an insured it is subrogated to the insured's claim. The insurer effectively receives an assignment of its expenditure by operation of law and contract." *Ruggles ex rel. Estate of Mayer v. Grow*, 984 P.2d 509, 512 (Alaska 1999). Under Alaska law, when an insurer seeks recoupment of its subrogation interest out of the insured's recovery, it must bear "pro rata costs and fees incurred by the insured in prosecuting and collecting the claim." *Id.* And the insured's claim is reduced by the subrogated amount if the insurer instructs the insured not to pursue it. *Id.*

Alaska law may also require application of the made-whole rule. "The made-whole doctrine recognizes that there may be situations in which a defendant's policy would be exhausted and the injured party would be left without being fully compensated for her own loss if her insurer collected the subrogation lien before she was herself compensated for her separate damages." *O'Donnell v. Johnson*, 209 P.3d 128, 135 (Alaska 2009). Thus, if the Legislature eliminated the McCollums' ability to recover medical expenses in their claims against Dr. Knolmayer, the made-whole rule would support a conclusion that an insurer paying medical expenses would not be entitled to

subrogation, because enforcement of subrogation as to damages the McCollums never collected would prevent them being "compensated for [their] separate damages." *Id.* The made-whole rule provides the doctrinal basis for answering the Court's question posed to the parties in this case: "does applying AS 09.55.548(b) to a plaintiff whose insurer has contractual subrogation rights to collect from the plaintiff's recovery require that such subrogation rights be invalidated?" Order of 9/29/2020 at 4. The existence of the made-whole rule supports a conclusion that the Legislature intended this Court to apply it in cases governed by § 548(b) where the claimant was prevented from recovering medical expenses, "invalidat[ing]" an insurer's contractual subrogation rights.

But the analysis breaks down for a federally-enforceable ERISA plan that Alaska law does not govern. Indeed, if this Court concludes that § 548(b) impliedly intends that an insurer's contractual subrogation rights are invalidated in cases under § 548(b) so that the claimant is allowed to recover and retain their own separate damages, that would imply a Legislative intent not to follow the same course where federally enforceable subrogation rights cannot be invalidated. This shows that there would be no rational connection between the purposes of § 548(b) and disallowing medical expense recovery by the McCollums because they still would have to repay the Lowe's plan. The Legislative history shows an intent to reduce recoveries by *balancing* the danger of a double recovery while preserving the claimant's right to recover their own "out-of-pocket" loss. [Appx. A at pp. 29-30] Adopting a regime in which recovery for that out-of-pocket loss is transferred to a federal ERISA plan leaving the claimant without any compensation would *thwart* that balancing, and so would not "bear a fair and substantial

relationship to the purposes" of § 548(b). *Harris*, 330 P.3d at 338. Accordingly, if § 548(b) were truly intended to eliminate the McCollums' ability to recovery medical expenses despite their obligation to use any separate recovery to repay the Lowe's plan, it would violate Alaska's Equal Protection Clause.

b. A distinction between certain kinds of federal programs and other federal programs does not exist, and would lack rational basis.

The same conclusion follows if the relevant statutory distinction is viewed as patients enrolled in Medicaid or Medicare versus a federal ERISA plan. The different regimes represent Congress's different approaches to different issues. Medicaid and Medicare are established as statutory benefit programs, in which all the terms are set by statute, including the benefits to be paid and the subrogation and reimbursement rules. ERISA is established as a mandatory, uniform framework within which employers are granted latitude to form their own benefit plans, notwithstanding that once formed, the plans are binding and must be followed. But each regime is equally beyond the power of any state to countermand. To arbitrarily allow participants in one of these federal programs to recover, while forcing participants in the other to use recovery for their "out-of-pocket" loss to repay the program, would just as much thwart the documented intent of § 548(b) and create an equal protection violation.

II. CONCLUSION

The intent of § 548(b) is to allow a claimant to recover medical expenses when the claimant is subject to a federally enforceable obligation to repay those expenses to another party out of any recovery. If § 548(b) is construed to disallow that recovery, in

spite of the federal repayment obligation, then it would both violate the documented legislative intent of § 548(b) and violate Alaska's Equal Protection Clause. The Court should hold that the McCollums may recover medical expenses in their claims against Dr. Knolmayer.

CERTIFICATE OF SERVICE AND TYPEFACE

The undersigned hereby certifies that a true and correct copy of the foregoing document was emailed on the 22nd day of February, 2021, to:

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