No. 17-416

IN THE

Supreme Court of the United States

AETNA LIFE INSURANCE COMPANY,

Petitioner,

—v.—

SALVATORE ARNONE,

Respondent.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

BRIEF IN OPPOSITION

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QUESTIONS PRESENTED

At the core of this matter, Petitioner seeks to use this case to re-litigate issues of federal preemption raised in *Wurtz v. The Rawlings Co., LLC,* 761 F.3d 232 (2d Cir. 2014), a matter in which this Court denied the defendant insurers' Petition for a Writ of Certiorai two years ago. ___ U.S. ___, 135 S.Ct. 1400 (2015). Yet the fundamental question in *Wurtz*—whether ERISA preempted state-law causes of action for fraud and unjust enrichment based on insurers' violation of New York's anti-subrogation law—is found nowhere in the Second Circuit's decision here; quite the opposite, the court below expressly acknowledged that no such state-law claims were even at issue on Respondent's appeal, pointedly noting that the only cause of action being pursued was the civil enforcement remedy provided by ERISA § 502 itself to recover the insurance benefits due to Respondent under the plan. Pet. App. 13a, n 5. To the extent Petitioner argues that New York's anti-subrogation statute is otherwise preempted by ERISA, that issue has long been settled by this Court's explanation of the "saving clause" at ERISA § 514, which specifically saves from preemption state laws regulating insurance provided to ERISA-governed benefits plans; in circumstances such as those presented here, state law supplies the relevant rule of decision for a suit brought under ERISA's enforcement provision. *UNUM Life Ins. Co. of Am. v. Ward,* 526 U.S. 358, 377 (1999). In the context of this case, the application of New York state insurance law as a rule of decision is unaffected by the insurance policy's choice-of-law provision requiring it to be "construed" according to the law of Connecticut, since the New York law does nothing to construe, interpret,

define, modify, or invalidate any part of the policy itself.

Accordingly, the questions presented are:

1. Whether state laws regulating insurance are saved from preemption by ERISA so that they may indirectly regulate ERISA plans by regulating the insurers and insurance contracts through which plan benefits are provided.

2. Whether an insurance policy's choice-of-law provision requiring its terms to be "construed" according a particular state's law allows the insurer to exempt itself from regulation by the insurance law of another state in which it does business.

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STATEMENT OF THE CASE

A. Legal Background

1. The Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. § 1001 *et seq.*, sets minimum standards for pension and health benefit plans. Where private employers choose to establish plans for their employees, ERISA generally governs the provision of benefits. ERISA also charts a course between federal preemption of claims relating to plan benefits and the preservation of state law in traditional areas of state insurance regulation. The Act governs this interplay between federal and state law in two separate sections, which operate to preempt certain causes of action subsumed by the statute's exclusive civil enforcement mechanism while preserving states' rights to regulate insurance.

First, ERISA Section 502, 29 U.S.C. § 1132, ERISA's civil enforcement provision, may operate impliedly to convert state-law causes of action into federal claims to the extent they fall into a "select group" of claims that Congress has rendered "necessarily federal in character." *Metro. Life Ins. Co. v. Taylor,* 481 U.S. 58, 63-64 (1987). Section 502(a) authorizes an ERISA plan participant to bring a suit, among other things, "to recover benefits due to him under the terms of the Plan, to enforce his rights under the terms of his Plan, or to clarify his rights to future benefits under the Plan." 29 U.S.C. § 1132(a)(1)(B). Section 502 is accompanied by its own set of remedies. *See Pilot Life Ins. Co. v. Dedeaux,* 481 U.S. 41, 52-54 (1987). This Court has held that a suit is converted into an ERISA claim only where a state-law claim is (1) the type of claim that could be brought under Section 502(a)(1)(B), and (2) where there is "no other independent legal duty that is implicated by a defendant's actions."

Aetna Health Inc. v. Davila, 542 U.S. 200, 210 (2004). Conversely, where either of these requirements is unsatisfied, the claim is not completely preempted and may remain a state-law claim, rather than one under ERISA Section 502(a).

Second, ERISA Section 514 expressly preempts state laws that "relate to" an ERISA-governed employee benefit plan. 29 U.S.C. § 1144. However, Section 514 also contains a "saving" clause that exempts any state law from ERISA's preemptive force if that law "regulates insurance." 29 U.S.C. § 1144(b)(2)(A). This provision is designed to prevent ERISA from preempting "areas of traditional state regulation," including state laws regarding subrogation, which are "return[ed] . . . to state law." *FMC Corp. v. Holliday,* 498 U.S. 52, 61-62 (1990). ERISA's preemptive scheme thus recognizes that some state-by-state "disuniformities . . . are the inevitable result of the congressional decision to 'save' local insurance regulation." *Rush Prudential HMO, Inc. v. Moran,* 536 U.S. 355, 381 (2002) (quoting *Metro. Life Ins. Co. v. Massachusetts,* 471 U.S. 724, 747 (1984)).

2. As this case comes to this Court, the parties agree that the state insurance law at issue here—New York General Obligations Law (GOL) § 5-335—is "saved" from preemption under Section 514. Enacted in 2009, GOL § 5-335 provides that when a person enters into a personal injury settlement, "it shall be conclusively presumed" that "the settlement does not include any compensation for the cost of health care services, loss of earnings or other economic loss to the extent those losses or expenses have been or are obligated to be paid or reimbursed by a benefit provider." N.Y. GOL § 5-335. The New York legislature found that this law was needed to protect settling insureds from being subjected to "a

subrogation claim or claim for reimbursement by a benefit provider." *Id.* With the enactment of Section 5-335, the legislature "eliminated an asymmetry between jury verdicts and settlements that tended to discourage the settlement of personal injury lawsuits." *Wurtz v. The Rawlings Co., LLC,* 761 F.3d 232, 236 (2d Cir. 2014); *see* n.3 (describing the New York legislature's purpose in more detail). In 2013, in response to the district court's decision *Wurtz* finding N.Y. GOL § 5-335 preempted by Section 514, the New York legislature made amendments, retroactive to the original 2009 enactment, "to make clear" that the purpose of the statute was to prevent insurers from subrogating against settlements "so that the burden of payment for health care services, disability payments, lost wage payments or any other benefits for the victims of torts will be borne by the insurer and not any party to a settlement of such a victim's tort claim." 2013 N.Y. Sess. Laws Ch. 516.

B. Factual And Procedural Background

1. Respondent Salvatore Arnone, a New York resident, is a former employee of Konica Minolta Business Solutions U.S.A., Inc., who worked out of the company's office in Melville, New York. Pet. App. 4a-5a. In June 2009, Arnone was working at a customer's site in Hauppauge, New York, when he slipped in a puddle of water and fell about four feet, hitting his head, lower back, and neck on a cinder block wall, sustaining serious injuries. *Id.* He filed for, and received, long-term disability benefits related to the injury through his employer's benefit plan, which was governed by the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 *et seq.* Petitioner Aetna Life Insurance Company, a Connecticut company and national insurer that is registered to do business

in New York, is both the Plan's insurer and its claims administrator. Pet. App. 4a.

2. Arnone brought a personal injury suit in New York state court against his employer's customer and settled the suit for $850,000. As a result of his obtaining the settlement, Aetna deemed half of Arnone's net recovery to be duplicative of its disability plan benefits; citing a plan provision regarding offsetting payments from other sources, the insurer then reduced its obligation for Arnone's disability benefits by $275,550, granting itself a credit as reimbursement in respect of his personal injury settlement. Pet. App. 4a, 11a.

3. Arnone sued Aetna to recover the benefits it had "offset" as reimbursement. In moving for summary judgment, he invoked N.Y. GOL § 5-335. The district court denied Arnone's motion, reasoning that section 5-335 had no bearing on the amount of Arnone's benefit entitlement in light of the plan's choice of law provision, which designated Connecticut law as controlling the plan's construction. Pet. App. 4a.

4. Arnone appealed the district court's determination and the Second Circuit reversed, finding that N.Y. GOL § 5-335 prohibited Aetna's offset action as a matter of law. Pet. App. 15a. The court ruled that the state statute prohibits insurers from treating settlement amounts as compensation for the cost of healthcare services, loss of earnings or other economic loss, and that Aetna's offset against Arnone's disability benefits denied him sums to which he was entitled under the benefits plan. Pet. App. 17a.

The court of appeals expressly rejected Aetna's argument that N.Y. GOL § 5-335 was prempted by ERISA § 514, ruling that it was saved as a law regulating insurance. Pet. App. 19a. The court further rejected Aetna's argument that its contractual choice-

of-law provision precluded application of N.Y. GOL § 5-335 to its "offset" reimbursement claim, noting that nothing about the statute "construes" any plan provisions; state laws may limit an insurer's rights without necessarily relating to a contract's construction. Pet. App. 22a. Aetna' petition to this Court followed.

REASONS FOR DENYING THE WRIT

I. There Is No Genuine Split In Authority.

Review should be denied because the Second Circuit's decision in this case is entirely consistent with this Court's precedent and the relevant decisions of other Circuits. It is readily apparent that Petitioner does not actually seek review of the Second Circuit's decision in this case, but instead plainly seeks to re-litigate the rulings of *Wurtz v. The Rawlings Co., LLC,* 761 F.3d 232 (2d Cir. 2014), *cert. denied,* ___ U.S. ___, 135 S.Ct. 1400 (2015). To the extent Petitioner claims to find a split in authority with three other court of appeals decisions on preemption of claims under ERISA § 502(a), the Second Circuit did not even have occasion to address that issue in this case, and in any event those earlier decisions did not apply this Court's test for Section 502(a) complete preemption, announced in *Aetna Health, Inc. v. Davila,* 542 U.S. 200 (2004). Two of the decisions pre-date *Davila*; the third, although decided shortly after *Davila*, did not mention it or apply its two-part test. Moreover, to the extent they even touch on issues relevant to the instant matter, the decisions are actually in accord with the Second Circuit's ruling.

1. In explaining the operation of ERISA's express preemption provision, this Court ruled that the Section 514 "saving clause" directs that insured employee

benefit plans are subject to state insurance regulation. "An insurance company that insures a plan remains an insurer for purposes of state laws 'purporting to regulate insurance'. . . . The insurance company is therefore not relieved from state insurance regulation. The ERISA plan is consequently bound by state insurance regulations insofar as they apply to the plan's insurer." *FMC Corp. v. Holliday*, 498 U.S. 52, 61 (1990). This "saving" of state insurance law is justified by "the presumption that Congress does not intend to pre-empt areas of traditional state regulation." *Id.* at 62., citing *Jones v. Rath Packing Co.,* 430 U.S. 519, 525 (1977). The Court noted that the McCarran-Ferguson Act, 15 U.S.C. § 1011 *et seq.,* provides that the "business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business," 15 U.S.C. § 1012(a), and that "[b]y recognizing a distinction between insurers of plans and the contracts of those insurers, which are subject to direct state regulation, and self-insured employee benefit plans governed by ERISA, which are not, we observe Congress' presumed desire to reserve to the States the regulation of the '"business of insurance."' *Id.* at 62-63.

Subsequently, in a case highly analogous to the instant matter, this Court ruled that state insurance law saved under Section 514 "supplied the relevant rule of decision" in a suit to recover long-term disability benefits brought pursuant to the civil enforcement provision of Section 502(a). *UNUM Life Ins. Co. of Am. v. Ward,* 526 U.S. 358, 377 (1999). In that case, disability insurer UNUM had denied benefits due to a plan participant under his employer's long-term disability plan because submission of his claim for benefits was untimely according to the insurance

contract. *Id.* at 364-65. However, under California's "notice-prejudice" rule, an insurer could not deny an untimely claim unless it showed it had suffered actual prejudice from the delay. *Id.* at 366. This Court held that the state notice-prejudice rule was a law regulating insurance and therefore escaped preemption under Section 514, and further held that Section 502 did not preempt use of the rule to determine the insurer's liability for benefits. *Id.* at 373, 376-77. Observing that the Court had "repeatedly held that state laws mandating insurance contract terms are saved from preemption under [Section 514]," it made "scant sense" to find them preempted by other sections of the Act: "States would be powerless to alter the terms of the insurance relationship in ERISA plans; insurers could displace any state regulation simply by inserting a contrary term in plan documents. This interpretation would virtually read the saving clause out of ERISA." *Id.* at 375-76 (citations and quotations omitted).

It is undisputed that the long-term disability plan at issue in this case is insured by Petitioner Aetna Life Insurance Company, and therefore Aetna and its insurance policies remain regulated by state insurance law even though they may insure ERISA-governed employee benefit plans. It is likewise beyond any serious contention that New York's anti-subrogation statute, General Obligations Law § 5-335, is a law regulating insurance. *Wurtz v. The Rawlings Co., LLC,* 761 F.3d 232, 241 ("Because N.Y. Gen. Oblig. Law § 5–335 is specifically directed toward insurers and substantially affects risk pooling between insurers and insureds, we conclude that it is saved from express preemption under ERISA § 514 as a law that regulates insurance"); *see also* Legislative Intent, New York State Assembly Bill A7828A (June 5, 2013), https://

www.nysenate.gov/legislation/bills/2013/a7828/amendment/a ("This law is specifically directed toward entities engaged in providing health insurance, thus falling under the 'savings' clause contained in ERISA, which reserves to the states the right and the ability to regulate insurance."). Under these circumstances, and pursuant to this Court's precedent, Respondent Arnone's claim for long-term disability benefits due him under his employee benefit plan was properly brought pursuant to ERISA § 502, with state insurance law supplying the rule of decision determining the insurer's liability.

2. Petitioner erroneously claims that the Second Circuit's decision in *Wurtz* contradicts decisions of the Third, Fourth and Fifth Circuits, "all of which had held that ERISA § 502 completely preempts state anti-subrogation and anti-reimbursement laws." Pet. 10. Petitioner's contention at best obscures the nature of the claims presented in those cases and elides the actual bases for the rulings. For example, the Third Circuit's preemption ruling in *Levine v. United Healthcare Corp.,* 402 F.3d 156 (3d Cir 2005) was not based on the fact that the New Jersey collateral source statute incorporated an anti-subrogation rule, but on the panel majority's view that the statute swept too broadly to be "specifically directed toward the insurance industry," and was therefore not saved from preemption under Section 514 as a law regulating insurance. *Id.* at 164-66. In fact, the only portion of the Third Circuit's ruling that touched on complete preemption under Section 502(a) held that the plan participants' state-law claims alleging unjust enrichment were more properly characterized as claims for benefits due under their plans, and were therefore re-cast as claims under ERISA, thus supporting federal jurisdiction. *Id.* at 163.

Likewise, in *Singh v. Prudential Health Care Plan Inc.,* 335 F.3d 278 (4th Cir. 2003) the Fourth Circuit did not find the anti-subrogation rule of Maryland's HMO Act to be preempted by Section 502. Instead, it found that the plan participant's claims for unjust enrichment and negligent misrepresentation "must be taken as ERISA claims and resolved under § 502(a) of ERISA," and that the state-law anti-subrogation provision "remains saved and therefore supplies the relevant rule of decision in a § 502(a) claim to enforce the provision of State law." *Id.* at 281, 289 (citations and quotations omitted).

Finally, in *Arana v. Ochsner Health Plan,* 338 F.3d 433 (5th Cir. 2003) (en banc), a plan beneficiary sought a declaratory judgment in state court pursuant to a Louisiana insurance statute that his health plan was prohibited from seeking reimbursement from him. In a ruling that addressed only the propriety of federal removal jurisdiction, the Fifth Circuit held that the state-law claim was preempted by ERISA § 502(a) because the relief sought was within the scope of the federal civil enforcement provision, and federal jurisdiction was therefore established. *Id.* at 440. The court expressly declined to rule on whether or in what manner the state regulation might be treated under ERISA § 514. *Id.* However, the Fifth Circuit specifically took note of this Court's rulings allowing state insurance law to provide the rule of decision in claims brought under ERISA, observing that Section 502 did not preempt its application: "These cases clearly indicate, then, that there may be complete preemption subject matter jurisdiction over a claim that falls within ERISA § 502(a) even though that claim is not conflict-preempted by ERISA 514." *Id.*

In fact, not only is there no actual conflict between the Second Circuit's rulings and the three cases

mentioned above, but the Third, Fourth, Sixth and Ninth Circuits have all held that state anti-subrogation laws are generally saved from preemption. In *Medical Mutual of Ohio v. DeSoto,* 245 F.3d 561, 573 (6th Cir. 2001), the Sixth Circuit held that a California anti-subrogation statute prohibiting a health insurer from recouping payments made on a participant's behalf—incorporating features similar to New York's law—regulated insurance and thus was not preempted by ERISA. In addition to its ruling in *Singh* concerning the anti-subrogation provision of the Maryland HMO Act, outlined above, the Fourth Circuit has also found that a North Carolina statute limiting subrogation was within ERISA's saving clause. *Hampton Indus. v. Sparrow,* 981 F.2d 726, 729-30 (4th Cir. 1991). The Ninth Circuit has also found that state anti-subrogation rules are saved from ERISA preemption. *United Food & Commercial Workers & Employers Health & Welfare Trust v. Pacyga,* 801 F.2d 1157, 1161 (9th Cir. 1986) (Arizona common law disallowing subrogation is law regulating insurance and within the protection of ERISA's saving clause). The Third Circuit has found that state law limitations on subrogation recoveries appear to be directly aimed at the insurance industry and therefore fall within the saving clause of ERISA § 514. *Bill Gray Enterprises, Inc. Employee Health & Welfare Plan v. Gourley,* 248 F.3d 206 (3d Cir. 2001) (Pennsylvania anti-subrogation statute regulates insurance and is thus within saving clause).

Furthermore, District Courts have regularly found both common law and statutory anti-subrogation provisions to be within the scope of the ERISA saving clause. *See, e.g., Donlan v. Greater Cleveland Reg'l Transit Auth.*, 2000 WL 485268 (N.D. Ohio 2000) (Ohio antisubrogation statute is within ERISA's savings clause); *Blue Cross and Blue Shield of Alabama v.*

Fondren, 966 F.Supp. 1093, 1097 (M.D. Ala. 1997) (Alabama law of subrogation is saved from pre-emption); *Health Cost Controls v. Ross,* 1997 WL 222877 at *6 (N.D. Ill. 1997) ("consensus in this jurisdiction is . . . that Illinois' anti-subrogation law is saved from preemption by the savings clause"); *Health Cost Controls v. Whalen,* 1996 WL 787163, *2 (E.D. Va. 1996) (group insurance plan is subject to direct state law regulation by Virginia anti-subrogation statute); *Blue Cross and Blue Shield of Alabama v. Lewis,* 754 F.Supp. 849 (N.D. Ala. 1991); *Board of Trustees of Montana Teamsters Employers v. Coyne,* 628 F.Supp. 561 (D. Mont. 1986) (Montana common law voiding subrogation clause in group health policy is saved from preemption).

3. Even if Petitioner were correct in its assertion of a conflict between *Wurtz* on one hand and *Levine, Singh* and *Arana* on the other, this Court's unanimous decision in *Davila* announced a new test for complete preemption under ERISA Section 502(a) that was not applied in the three earlier cases. Under this test, a state-law claim is completely preempted only where two requirements are met. First, the state-law claim must be brought by "an individual [who] at some point in time, could have brought his claim under ERISA § 502(a)(1)(B)," and second, there must be "no other independent legal duty that is implicated by a defendant's actions." *Davila,* 542 U.S. at 210. Given this new articulation of the complete-preemption doctrine, "pre-*Davila* case law should be evaluated in light of the *Davila* test." Lee T. Polk, 2 ERISA Practice and Litigation § 11:46 (West 2014).

In the decade intervening between *Davila* and *Wurtz*, courts of appeals generally have recognized that Davila established that two-part test for determining complete preemption under Section 502. *See, e.g.,*

Montefiore Med. Ctr. v. Teamsters Local 272, 642 F.3d 321, 328 (2d Cir. 2011); *Pascack Valley Hosp. v. Local 464A UFCW Welfare Reimbursement Plan,* 388 F.3d 393, 400 (3d Cir. 2004); *Kuthy v. Mansheim,* 124 Fed. Appx. 756, 757 (4th Cir. 2004) (*per curiam*) (unpublished); *Lone Star OB/GYN Assocs. v. Aetna Health Inc.,* 579 F.3d 525, 529 (5th Cir. 2009); *Gardner v. Heartland Indus. Partners,* 715 F.3d 609, 613 (6th Cir. 2013) (cited in opinion below); *Franciscan Skemp Healthcare, Inc. v. Cent. States Joint Bd. Health & Welfare Trust Fund,* 538 F.3d 594, 597 (7th Cir. 2008); *Marin Gen. Hosp. v. Modesto & Empire Traction Co.,* 581 F.3d 941, 946-47 (9th Cir. 2009); *Salzer v. SSM Health Care of Oklahoma Inc.,* 762 F.3d 1130, 1134-35 (10th Cir. 2014); *Ehlen Floor Covering, Inc. v. Lamb,* 660 F.3d 1283, 1287 (11th Cir. 2011). No new standard has been articulated by this Court since *Davila*.

4. In its pre-*Davila* decision in *Singh v. Prudential Health Care Plan, Inc.,* 335 F.3d 278 (4th Cir.), *cert. denied,* 540 U.S. 1073 (2003), the Fourth Circuit determined that a claim under a Maryland statute prohibiting subrogation was completely preempted under Section 502(a) because the plaintiff was "seeking recovery of a plan benefit" under the insurer's health plan. *Id.* at 291. The court did not determine, as *Davila* would require a year later, whether the plaintiff's claims arose from a legal duty independent of any obligations under the ERISA plan.

In its pre-*Davila* decision in *Arana v. Ochsner Health Plan,* 338 F.3d 433 (5th Cir. 2003) (en banc), *cert. denied,* 540 U.S. 1104 (2004), the Fifth Circuit also did not apply the necessary independent-duty prong. The court reasoned only that the plaintiff was making a claim for benefits under the plan. *Id.* at 438. Although

this reasoning resembles the inquiry required by the first prong of *Davila,* it does not address the second.

Contrary to petitioners' assertion that the Fifth Circuit has remained committed to *Arana*'s approach to complete preemption, Pet. 21-22, in cases decided after *Davila,* the Fifth Circuit faithfully has applied the *Davila* framework. In *Lone Star OB/GYN Associates v. Aetna Health Inc.,* 579 F.3d 525, the court determined that state-law claims against an ERISA plan administrator for failure to promptly pay benefits due under an ERISA plan were not completely preempted, relying on *Davila*'s second, "independent duty" prong. *Id.* at 530-31. The court observed that "[w]hile Aetna is correct that any determination of benefits under the terms of a plan—i.e., what is 'medically necessary' or a 'Covered Service'—does fall within ERISA, [appellant's state-law] claims are entirely separate from coverage and arise out of the independent legal duty contained in the contract." *Id.* (citation omitted); *see also McAteer v. Silverleaf Resorts, Inc.,* 514 F.3d 411, 418 (5th Cir. 2008) (recognizing *Davila* as the controlling test and finding no preemption of state tort claim).

The Third Circuit's decision in *Levine v. United Healthcare Corp.,* 402 F.3d 156 (3d Cir.), *cert. denied,* 546 U.S. 1054 (2005), came less than a year after *Davila* and does not cite *Davila*, let alone apply the *Davila* test. Rather, *Levine*'s complete-preemption holding is sparsely reasoned, relying on the pre-*Davila* decisions in *Arana* and *Singh* to determine that claims asserting that state law barred subrogation were claims for "benefits due" under the plan. Like the pre-*Davila* cases, then, *Levine* failed to consider *Davila*'s second prong.

Petitioner argues that the Third Circuit reaffirmed *Levine* in 2006 in *Wirth v. Aetna U.S. Healthcare,* 469 F.3d 305 (3rd Cir. 2006). Pet. 15. But this argument does not provide a basis for concluding that Third Circuit law genuinely conflicts with Second Circuit law. *Wirth* viewed *Levine* as controlling and did not cite *Davila*. Instead, it summarily determined that the state-law claim was one for benefits due under the plan because "the actions undertaken by the insurer resulted in diminished benefits provided to the plaintiff insureds." *Wirth,* 469 F.3d at 309. Thus, like *Levine, Wirth* did not address Davila's second prong.

At bottom, however, Petitioner's argument here conflates plan participants' state-law *claims* against their benefit plans—which may or may not be preempted, according to the *Davila* test—with state-law *rules of decision* supplied by laws regulating insurance, which remain applicable to insurers of ERISA-governed plans regardless of whether the claim is ultimately characterized as one solely for benefits due and implicating no other independent duty. But more to the point, this sort of claim preemption analysis is simply not part of the Second Circuit's decision in this case, because Respondent Arnone's claim proceeded solely as a claim for benefits due under Section 502(a). Pet. App. 13a, n. 5. As a result, whether or not there may be some other state-law claim that survives complete preemption by Section 502 is wholly irrelevant to an issue actually presented by this case.

II. Aetna's Contractual Choice-Of-Law Provision Is Irrelevant To Whether The Insurer May Be Regulated By New York Law And Does Not Indicate Any Split In Authority Among The Circuits.

1. Petitioner's argument that its insurance policy's choice-of-law clause precludes the application of any New York law in this case misapprehends the nature and function of such clauses, neglecting to articulate how either Connecticut or New York state law would "construe" its policy provisions in any differing manner. The choice-of-law clause in the Petitioner's long-term disability policy provides only that "this policy will be construed in line with the law of the jurisdiction in which it is delivered." Pet. App. 20a. Yet Petitioner fails to identify any specific manner in which its policy provisions would have to be construed, interpreted, defined, modified, or invalidated by the application of New York rather than Connecticut law.

2. The issue here is not whether N.Y. GOL § 5-335 somehow alters the construction of a Connecticut insurance policy; it is whether New York can prohibit an insurer authorized and licensed to do insurance business in New York from interfering in a personal injury matter between New York litigants brought and settled in a New York court, with the parameters of their settlement defined by New York law. It would be unreasonable to suggest that Aetna could exempt itself from New York's regulation of the disposition of New York tort recoveries through an insurance policy clause that pertains only to construing its policy terms. As the Second Circuit recognized in its decision below, "Nothing about section 5-335 'construes' the plan in the ordinary sense of the verb. . . . It does not define any term of art or provide any principle for resolving textual ambiguities in this or other benefit

plans or contracts. Instead, it addresses personal injury settlements like Arnone's and limits the insurance consequences of such settlements." Pet. App. 22a. In rendering its decision the court pointed out that the effect of a choice-of-law clause depends on its scope, and that in looking to state law to develop federal common law, New York courts are reluctant to read such clauses broadly. Pet. App. 21a, citing *Fin. One Pub. Co. v. Lehman Bros. Special Fin., Inc.,* 414 F.3d 325, 332, 335 (2d Cir. 2005) and *Critchlow v. First UNUM Life Ins. Co. of Am.,* 378 F.3d 246, 256 (2d Cir. 2004).

The court below noted that, rather than modifying how benefit plans are "construed," N.Y. GOL § 5-335 by its terms acts as a "[l]imitation of reimbursement and subrogation claims," providing a rule to which all contracts between an insurer and an insured must adhere. Pet. App. 23a. The statute "provides a legal rule of proof, external to any plan documents, regarding personal injury settlements," which "applies irrespective of any language that may appear in the parties' contract or benefit plan and around which the parties cannot contract." *Id.*

3. The cases Petitioner cites as principal authority for its argument in favor of some broader meaning of its choice-of-law provision—and for the existence of a circuit split—simply do not support its assertions. For example, in *Kiplin Industries, Inc. v. Van Deilien International, Inc.,* 182 F.3d 490 (6th Cir. 1999), the Sixth Circuit in fact noted that such provisions may be ignored where "the application of the chosen state's law would violate a fundamental policy of a state which has a materially greater interest in the disputed issue and which would have supplied the governing law in the absence of the parties' selection." *Id.* at 493, citing Restatement (Second) of Conflict of Laws

§ 187(2) (1988 Revision). It is beyond dispute that New York has a materially greater interest in the management of tort litigation in its courts and protection of its litigants from over-reaching claims by insurers than Connecticut has in "construing" private contract provisions generally.

Likewise, the Fifth Circuit's decision in *C.A. May Marine Supply Company v. Brunswick Corporation,* 557 F.2d 1163 (5th Cir. 1977) sets out no immutable rule of federal law. That case involved termination of a dealership relationship between a Wisconsin manufacturer and a Georgia outboard motor dealer. *Id.* at 1164. In finding that Wisconsin law "governed" the dealer's termination under the dealership agreement's choice-of-law clause, the Fifth Circuit candidly noted that it had come to the opposite conclusion reached in a case decided two years earlier on identical contract language. *Id.* at 1166, citing *Boatland, Inc. v. Brunswick Corp.,* C.A. No. C75-298-NA-CV (M.D. Tenn. 1975). Moreover, rather than adopting a hard-and-fast rule for the meaning of contract terms, the court acknowledged the "cardinal rule of construction that ambiguous terms of a contract are to be interpreted against the party which drafted them." *Id.* at 1165.

In the context presented here, there is no significant question of federal law or national labor policy that attaches to a particular court's reading of a particular disability insurance plan. It is simply of no moment that different courts may reach different results when reading different insurance policies using different contract language in different contexts against the backdrop of different state insurance laws. Any "disuniformity" occasioned by the construction or interpretation of insurance contracts is a necessary function of differences in the language of individual

contract clauses, the intention of the parties, the drafter of the contract and applicable state rules.

III. This Case Is A Poor Vehicle For Review Because The Decision Below Does Not Involve The Primary Issues Of Preemption That Petitioner Seeks To Address.

1. The Court should deny review because, at the most fundamental level, Petitioner seeks "review" of an issue that was never raised and a ruling that was never made in the Second Circuit's decision in this case. The object of the Petition here quite obviously is to re-litigate the issues of claim preemption under ERISA § 502(a) that were raised and decided in *Wurtz v. The Rawlings Co., LLC,* 761 F.3d 232 (2d Cir. 2014), *cert. denied,* ___ U.S. ___, 135 S.Ct. 1400 (2015). But the Second Circuit's decision in this case involved no such preemption analysis and indeed could not, since Respondent Arnone did not pursue any state law claims that might have survived the preemptive effect of Section 502 by means of the *Davila* test.

2. The Second Circuit's decision in this matter effected no change in the law, nor did it involve any novel legal issue. There has been no alteration or modification of the standard for claim preemption under ERISA § 502(a) in more than a decade since this court's decision in *Davila*, and the various circuit courts all apply its two-part test.

3. The application of state law in this case results in no "balkanization of ERISA benefits" according to the anti-subrogation law of various states. Pet. 32. As this Court has acknowledged, any state-by-state "disuniformities . . . are the inevitable result of the congressional decision to 'save' local insurance

regulation." *Rush Prudential HMO, Inc. v. Moran,* 536 U.S. 355, 381 (2002) (quoting *Metro. Life Ins. Co. v. Massachusetts,* 471 U.S. 724, 747 (1984)). It hardly constitutes a labor law crisis that an insurer such as Aetna might be expected to comply with the insurance laws of the states in which it does business. Moreover, ERISA-governed plans are free to avoid state insurance regulation altogether if they so choose by self-insuring plan benefits, thereby gaining preemption of all state laws that "relate to" the plan, pursuant to ERISA § 514.

CONCLUSION

For the foregoing reasons, the petition for a writ of certiorari should be denied.

Respectfully submitted,

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Dated: November 6, 2017