No.

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

PETITION FOR A WRIT OF CERTIORARI

MIGUEL A. ESTRADA
Counsel of Record
LUCAS C. TOWNSEND
GIBSON, DUNN & CRUTCHER LLP
1050 Connecticut Avenue, N.W.
Washington, D.C. 20036
(202) 955-8500
mestrada@gibsondunn.com

Counsel for Petitioner

QUESTIONS PRESENTED

The Employee Retirement Income Security Act of 1974 ("ERISA") provides "a uniform regulatory regime over employee benefit plans" through "expansive pre-emption provisions," including ERISA § 502(a)'s "integrated enforcement mechanism." *Aetna Health Inc.* v. *Davila*, 542 U.S. 200, 208 (2004). In this case arising under ERISA § 502, the Second Circuit held that a New York state statute, General Obligations Law § 5-335, "effectively bars an insurer from reducing the benefits owed to an insured by the amounts the insured receives from a personal injury settlement," in conflict with decisions from the Third, Fourth, and Fifth Circuits holding that ERISA preempts such anti-reimbursement laws. Pet. App. 3a. Creating another circuit split, the Second Circuit also held that a contractual choice-of-law provision in the ERISA plan stating that the plan "will be construed" according to Connecticut law incorporated only that state's law of contract interpretation, not state substantive law, in conflict with decisions of the Fifth and Sixth Circuits. Pet. App. 20a.

The questions presented are:

1. Whether ERISA § 502(a) completely preempts state laws that purport to invalidate ERISA plan provisions requiring reimbursement by plan participants who separately receive payment from third-party tortfeasors.

2. Whether an ERISA plan's choice-of-law provision requiring that the plan "will be construed" in accordance with a particular state's laws incorporates state substantive law or only state law governing construction of the plan's terms.

PARTIES TO THE PROCEEDING AND RULE 29.6 STATEMENT

All parties to the proceeding are named in the caption. Pursuant to this Court's Rule 29.6, petitioner Aetna Life Insurance Company is a wholly owned subsidiary of Aetna Inc. Aetna Inc. is a publicly traded corporation that has no parent corporation, and no publicly held corporation owns 10 percent or more of its stock.

TABLE OF CONTENTS

TABLE OF CONTENTS *(continued)*

TABLE OF AUTHORITIES

TABLE OF AUTHORITIES *(continued)*

Page(s)

TABLE OF AUTHORITIES *(continued)*

TABLE OF AUTHORITIES *(continued)*

TABLE OF AUTHORITIES *(continued)*

Statutes

TABLE OF AUTHORITIES *(continued)*

Page(s)

Other Authorities

PETITION FOR A WRIT OF CERTIORARI

Petitioner Aetna Life Insurance Company ("Aetna") respectfully petitions for a writ of certiorari to review the judgment of the United States Court of Appeals for the Second Circuit.

OPINIONS BELOW

The Second Circuit's opinion under review (Pet. App. 1a-27a) is reported at 860 F.3d 97. The opinion and order of the United States District Court for the Eastern District of New York (Pet. App. 28a-49a) is not reported but is available at 2015 WL 3915607.

JURISDICTION

The court of appeals entered judgment on June 22, 2017. This Court has jurisdiction under 28 U.S.C. § 1254(1).

STATUTES INVOLVED

Section 502(a) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1132(a), provides:

> **§ 1132(a). Persons empowered to bring a civil action**
>
> A civil action may be brought—
>
> (1) by a participant or beneficiary—
>
> * * *
>
> (B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan.

* * *

The relevant portion of New York General Obligations Law § 5-335 is reproduced in the Appendix at 50a-51a.

STATEMENT

In enacting the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 *et seq.*, Congress envisioned "a *uniform* regulatory regime over employee benefit plans." *Aetna Health Inc.* v. *Davila*, 542 U.S. 200, 208 (2004) (emphasis added). Congress recognized that employers, insurers, and administrators of benefit plans need uniform standards and duties for "'processing claims and paying benefits.'" *Egelhoff* v. *Egelhoff ex rel. Breiner*, 532 U.S. 141, 150 (2001) (citation omitted). Equally important, employees enrolled in a given ERISA-governed plan are entitled to receive "benefits due" as determined by "the terms of [their] plan," 29 U.S.C. § 1132(a), and not by the varying laws of the states in which each employee happens to reside.

That uniform regulatory regime was upended here. The Second Circuit held in this case that states are free to annul provisions of employee benefits plans that allow ERISA administrators to offset or recoup benefit payments by amounts that beneficiaries have recovered from other sources, including litigation settlements with third parties. Pet. App. 3a-5a, 18a-20a. Such offsets, known as reimbursement and subrogation rights, are critical in protecting ERISA-governed funds when beneficiaries have been made whole by other means. The Second Circuit's holding invites a patchwork of state laws that interfere with the uniform administration of ERISA plans and the uniform payment of benefits to employees in different states. It also conflicts sharply with decisions of the Third, Fourth, and Fifth Circuits, each of which has held that ERISA completely preempts such state anti-subrogation and anti-reimbursement laws.

Compounding its errors, the decision below creates a separate circuit split on whether a contractual choice-of-law provision—here, a provision in the ERISA plan—requiring that the contract be "construed" in accordance with the law of a particular state is limited only to that state's law of contract interpretation, or instead incorporates the state's substantive law governing the parties' rights and obligations. The Second Circuit held, as a matter of federal common law, that a Connecticut choice-of-law provision in the ERISA plan was limited to that state's law of contract interpretation, and therefore did not preclude the application of New York's anti-subrogation and anti-reimbursement law. That holding conflicts sharply with decisions of the Fifth and Sixth Circuits and further frustrates the purposes of ERISA by disrupting ERISA administrators' ability to specify a uniform body of law by which to administer plans efficiently.

The petition should be granted.

1. Most Americans receive health coverage through employer-provided benefit plans. *See* Jessica C. Barnett & Marina S. Vornovitsky, *Health Insurance Coverage in the United States: 2015* at 1 (Sept. 2016). Congress enacted ERISA to "protect … the interests of participants" in these employee benefit plans by establishing nationwide "standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to the Federal courts." 29 U.S.C. § 1001(b). The "systems and procedures" set forth in ERISA "are intended to be uniform" and exclusive. *Gobeille* v. *Liberty Mut. Ins. Co.*, 136 S. Ct. 936, 944 (2016).

ERISA's "comprehensive legislative scheme" includes "an integrated system of procedures for enforcement." *Davila*, 542 U.S. at 208 (citation omitted). After exhausting a statutorily prescribed internal appeals process, ERISA § 502(a), 29 U.S.C. § 1132(a), permits a plan beneficiary to file suit in federal court to ensure compliance with the terms of the plan and to obtain specified forms of relief for any failure to comply. This enforcement mechanism "represents a careful balancing of the need for prompt and fair claims settlement procedures against the public interest in encouraging the formation of employee benefit plans." *Pilot Life Ins. Co.* v. *Dedeaux*, 481 U.S. 41, 54 (1987).

In creating this federal enforcement mechanism, Congress understood that permitting beneficiaries to "obtain remedies under state law" would "completely undermin[e]" ERISA's central purpose of establishing a uniform regime for the administration and payment of employee benefits. *Pilot Life*, 481 U.S. at 54. Indeed, "[r]equiring ERISA administrators to master the relevant laws of 50 States and to contend with litigation would undermine the congressional goal of minimiz[ing] the administrative and financial burden[s] on plan administrators—burdens ultimately borne by the beneficiaries." *Gobeille*, 136 S. Ct. at 944 (citation omitted). To this end, ERISA preempts state laws that purport to interfere with the administration of benefits governed by an ERISA plan in two ways:

First, because Congress "did *not* intend to authorize other remedies" that it did not "incorporate expressly" in ERISA, *Pilot Life*, 481 U.S. at 54 (citation omitted), § 502(a)'s "exclusive" enforcement mechanism completely preempts any state law that

"duplicates, supplements, or supplants the ERISA civil enforcement remedy." *Davila*, 542 U.S. at 209. So "extraordinary" is § 502(a)'s preemptive force that it even "converts an ordinary state common law complaint into one stating a federal claim for purposes of the well-pleaded complaint rule," allowing such causes of action to be removed to federal court. *Ibid.* (citation omitted); *see also Metro. Life Ins. Co.* v. *Taylor*, 481 U.S. 58, 67 (1987).

Second, ERISA's express-preemption provision, § 514, "supersede[s] any and all State laws insofar as they may now or hereafter relate to any [ERISA] employee benefit plan." 29 U.S.C. § 1144(a). At the same time, it saves from preemption state laws that "regulat[e] insurance, banking, or securities." *Id.* § 1144(b)(2)(A). This provision preempts state laws that "ac[t] immediately and exclusively upon ERISA plans … or where the existence of ERISA plans is essential to the law's operation," as well as state laws that "'gover[n] … a central matter of plan administration' or 'interfer[e] with nationally uniform plan administration.'" *Gobeille*, 136 S. Ct. at 943 (citations omitted). Section 514 is ultimately "intended to ensure that employee benefit plan regulation [is] 'exclusively a federal concern.'" *Davila*, 542 U.S. at 208 (citation omitted).

Together, ERISA § 502(a) and § 514 have a broad preemptive effect that is "essential to accomplish Congress' purpose of creating a comprehensive statute for the regulation of employee benefit plans." *Davila*, 542 U.S. at 208.

2. In 2009 Respondent Salvatore Arnone became disabled in an on-the-job accident and claimed benefits under his employer's ERISA-governed long-term disability plan. Pet. App. 5a-8a. Aetna is the plan's

insurer and claims administrator. Pet. App. 4a. Aetna approved Arnone's claim for disability benefits, and Arnone subsequently began collecting benefits under the plan. Pet. App. 7a-8a. Arnone also sued those allegedly responsible for his injuries in New York state court. He eventually settled that suit, executing a general release in exchange for a lump-sum payment of $850,000. Pet. App. 8a-9a.

Arnone's ERISA plan provides that long-term disability benefits are based on a percentage of a claimant's "monthly predisability earnings," reduced by any "Other Income Benefits" received from other sources. Joint Appendix, A-125, A-129, A-145, *Arnone* v. *Aetna Life Ins. Co.*, 860 F.3d 97 (2d Cir. 2017) (15-2322). Under the plan, the term "Other Income Benefits" includes, among other things, "[d]isability payments which result from the act or omission of any person whose action caused your disability." *Id.* at A-128. The plan explains that for purposes of determining "Other Income Benefits," any "lump sum or periodic payment that is *for disability* will be counted, even if it is not specifically apportioned or identified as such," and that "[i]f there is no proof acceptable to Aetna as to what that part reasonably is, 50% will be deemed to be for disability." *Id.* at A-129 (emphasis added). *See generally* Pet. App. 6a-11a.

Following his litigation settlement, Arnone submitted a copy of the settlement agreement to Aetna. *See* Joint Appendix, A-189, *Arnone* v. *Aetna Life Ins. Co.*, 860 F.3d 97 (2d Cir. 2017) (15-2322). Because the settlement information did not designate whether any portion of the lump-sum payment was *not* for lost income due to disability, Aetna offset Arnone's future benefit payments by 50% of his settlement

award pursuant to the plan's terms governing other income benefits. Pet. App. 11a.[1]

3. Arnone contested the settlement offset through Aetna's appeals process, arguing that the settlement only compensated him for his pain and suffering, not lost income. Pet. App. 11a, 26a. After Aetna upheld the offset based on Arnone's failure to submit proof as to what part of the settlement was attributable to pain and suffering damages rather than lost wages, Arnone sued Aetna in New York state court to challenge Aetna's offset determination, asserting a state-law breach-of-contract claim and a claim for benefits allegedly due under ERISA § 502(a)(1)(B). Pet. App. 58a-65a.

Aetna removed the case to federal court. Pet. App. 55a-57a. Aetna then asserted a counterclaim pursuant to ERISA § 502(a)(3) for equitable restitution of overpaid plan benefits that Arnone received from Aetna but failed to return. Pet. App. 12a.

Arnone moved for summary judgment, invoking for the first time New York General Obligations Law § 5-335 ("Section 5-335"). That statute—titled "[l]imitation of reimbursement and subrogation claims in personal injury and wrongful death actions"—provides that "[n]o person entering into … a [personal injury or wrongful death] settlement shall be subject to a subrogation claim or claim for reimbursement by an insurer," and that for purposes of

---

[1] Arnone also began receiving New York workers' compensation benefits and Social Security Disability Income benefits following his accident. Pet. App. 8a. Aetna further offset Arnone's disability benefits by these other income amounts, *ibid.*, and Arnone has not challenged those offsets on appeal.

such settlements, "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 an insurer." N.Y. Gen. Oblig. L. § 5-335(a). Arnone argued that Section 5-335 prohibited Aetna's determination that he failed to show that his settlement proceeds were solely for pain and suffering. Pet. App. 12a-13a.

Aetna opposed Arnone's motion for summary judgment and cross-moved for summary judgment on its ERISA-based counterclaim. With respect to Section 5-335's prohibition on reimbursement, Aetna contended that ERISA preempts such state anti-subrogation and anti-reimbursement laws, and that in any event Section 5-335 is irrelevant because the plan's choice-of-law provision states that the plan "will be construed in line with the law of the jurisdiction in which it is delivered," which the plan identifies as Connecticut. Pet. App. 20a.

4. The district court denied Arnone's motion for summary judgment and granted Aetna's cross-motion for summary judgment. Pet. App. 28a-49a. As relevant here, the court held that "[p]ursuant to the Plan's clear language," Aetna's "deductions were permissible and therefore, not arbitrary or capricious." Pet. App. 46a. As to Arnone's argument, "for the first time in this action, that [Section 5-335] applies to this case," the court explained that the "Plan contains an enforceable choice of law clause, which states that 'this policy will be construed in line with the law of the jurisdiction in which it is delivered.'" Pet. App. 47a-48a n.8 (quoting Joint Appendix, A-91, *Arnone* v. *Aetna Life Ins. Co.*, 860 F.3d 97 (2d Cir.

2017) (15-2322)). Because the "policy was delivered in Connecticut" according to the terms of the plan, "New Yor[k] [law] does not apply to [the] Plan." *Ibid.* Having determined that Section 5-335 did not apply, the district court did not address Aetna's argument that ERISA preempts Section 5-335. *See* Pet. App. 46a-49a.

Arnone appealed, again on the ground that Section 5-335 prohibited Aetna's offset determination. Aetna argued on appeal that "ERISA preempts section 5-335 because giving section 5-335 any effect here would be 'entirely inconsistent with ERISA's core congressional goal of uniformity of plan administration.'" Pet. App. 18a. Aetna also argued that Section 5-335 does not apply because the plan's choice-of-law provision states that it will be "construed in line with the law of [Connecticut]," rather than New York law. Pet. App. 20a.

5. The Second Circuit reversed, concluding that Aetna's argument that ERISA preempts Section 5-335 "is flatly foreclosed" by *Wurtz* v. *Rawlings Co.*, 761 F.3d 232 (2d Cir. 2014). Pet. App. 18a.

In *Wurtz*, which involved claims for benefits brought directly under Section 5-335, the Second Circuit concluded that Section 5-335 was neither expressly preempted under ERISA § 514, ERISA's express-preemption provision, 29 U.S.C. § 1144, nor completely preempted under ERISA § 502, ERISA's cause of action, 29 U.S.C. § 1132. With respect to complete preemption, the court in *Wurtz* expressly disagreed with decisions of the Third, Fourth, and Fifth Circuits, all of which had held that ERISA § 502(a) completely preempts state anti-subrogation and anti-reimbursement laws. 761 F.3d at 243-45 (citing *Levine* v. *United Healthcare Corp.*, 402 F.3d

156 (3d Cir. 2005); *Singh* v. *Prudential Health Care Plan, Inc.*, 335 F.3d 278 (4th Cir. 2003); *Arana* v. *Ochsner Health Plan*, 338 F.3d 433 (5th Cir. 2003) (en banc)). The Second Circuit was not "persuaded" by these other circuits' decisions, believing that "the logic of *Arana*, *Singh*, and *Levine* would expand complete preemption to encompass state laws that regulate insurance and that do not impermissibly expand the exclusive remedies provided by ERISA § 502(a)." *Id.* at 244.

Despite acknowledging that "Arnone relie[d] solely on section 502(a)(1)(B) of ERISA in support of his challenge," Pet. App. 13a n.5, the court did not explicitly address the complete preemptive effect of that provision and declined to "revisit our holding in *Wurtz* in order to find ERISA preemption here," Pet. App. 20a. Instead, after stating that Aetna's preemption arguments were "foreclosed" by *Wurtz*, the court below went on to address only whether ERISA § 514's so-called "savings clause" exempts Section 5-335 from preemption as a law that "regulates insurance." Pet. App. 19a. The court concluded that Section 5-335 was saved from preemption under this provision "as a permissible regulation of New York's insurance markets." Pet. App. 19a.

The court of appeals below also concluded that the plan's Connecticut choice-of-law provision did not preclude application of Section 5-335. The court held that "[t]he Plan's choice of law provision, in stating that the Plan will be 'construed' in accordance with Connecticut law, sets forth only which jurisdiction's law of contract interpretation and contract construction will be applied." Pet. App. 20a-21a. "[T]hat provision," the court declared, "is insufficient to bind this court to apply the full breadth of Connecticut

law, to the exclusion of another jurisdiction's law, in fields other than the interpretation of the language in this contract." *Id.* at 21a. Although the court admitted that "Section 5-335 may, of course, affect whether and how certain provisions of benefit plans—such as the Plan's 'other income benefits' offset provision—are ultimately implemented," Pet. App. 23a, it nevertheless reasoned that "[n]othing about section 5-335 'construes' the Plan in the ordinary sense of the verb," Pet. App. 22a.

REASONS FOR GRANTING THE PETITION

The Second Circuit not only reaffirmed its decision in *Wurtz*, but extended it to hold that ERISA does not preempt New York's anti-reimbursement law *even in a case for "benefits due" under ERISA § 502(a)(1)(B)*. 29 U.S.C. § 1132(a)(1)(B) (emphasis added). The Second Circuit has therefore parted ways with all other courts of appeals to consider this question, all of which have concluded, consistent with this Court's precedents, that ERISA § 502 completely preempts such state laws. Compounding its error, the Second Circuit refused to apply the ERISA plan's Connecticut choice-of-law provision, which would have rendered New York's anti-subrogation and anti-reimbursement law inapplicable, and thus split with other courts of appeals that construe such choice-of-law provisions to incorporate state substantive law. Each of those errors warrants this Court's review.

I. THE SECOND CIRCUIT'S DECISION EXACERBATES AN ACKNOWLEDGED CIRCUIT SPLIT ON WHETHER ERISA § 502(a) PREEMPTS STATE ANTI-SUBROGATION LAWS

The decision below squarely implicates, and extends, an acknowledged circuit split over whether state anti-subrogation laws like Section 5-335 are preempted by ERISA's cause of action, § 502(a), 29 U.S.C. § 1132(a).

A. The Circuits Are Split 3–1 On An Important Question Of Federal Law

1. Congress enacted ERISA "to provide a *uniform* regulatory regime over employee benefit plans." *Aetna Health Inc.* v. *Davila*, 542 U.S. 200, 208 (2004) (emphasis added). ERISA achieves this uniformity in two ways. First, § 514 expressly preempts "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." 29 U.S.C. § 1144(a). Section 514 also includes a so-called "savings clause" that saves from express preemption "any law of any State which regulates insurance, banking, or securities," *id.* § 1144(b)(2)(A), thus cabining the effect of ERISA's express preemption provision.

Second, ERISA includes in § 502(a) "'an integrated system of procedures for enforcement,'" *Davila*, 542 U.S. at 208 (citation omitted), that provides a plan participant the right to "bring a civil action … to recover benefits due to him under the terms of his plan [or] to enforce his rights under the terms of the plan." 29 U.S.C. § 1132(a). This Court has cautioned that "[u]nder ordinary principles of conflict preemption, … even a state law that can arguably be characterized as 'regulating insurance' will be preempted if it provides a separate vehicle to assert a

claim for benefits outside of, or in addition to, ERISA's remedial scheme." *Davila*, 542 U.S. at 217-18. Thus, § 514's savings clause cannot be read to override complete preemption under § 502, because the savings clause "must be interpreted in light of the congressional intent to create an exclusive federal remedy in ERISA § 502(a)." *Id.* at 217; *see also Pilot Life Ins. Co.* v. *Dedeaux*, 481 U.S. 41, 52 (1987).

In this manner, § 502(a) "set[s] forth a comprehensive civil enforcement scheme that represents a careful balancing of the need for prompt and fair claims settlement procedures against the public interest in encouraging the formation of employee benefit plans." *Pilot Life*, 481 U.S. at 54. Congress designed § 502(a)'s remedial scheme to be exclusive, free from state-law incursion. *Any* state law that "duplicates, supplements, or supplants the ERISA civil enforcement remedy conflicts with the clear congressional intent to make the ERISA remedy exclusive," and is therefore completely preempted. *Davila*, 542 U.S. at 209.

To determine whether a state law is completely preempted under § 502(a), courts first look to whether the "individual, at some point in time, could have brought his claim under ERISA § 502(a)(1)(B)," and then to whether "there is no other independent legal duty that is implicated by a defendant's actions." *Davila*, 542 U.S. at 210. Where a plaintiff sues "only to rectify a wrongful denial of benefits promised under ERISA-regulated plans," and does not "attempt to remedy any violation of a legal duty independent of ERISA," that plaintiff's state-law claims are "completely pre-empted by ERISA § 502." *Id.* at 214. Consistent with this test, the Third, Fourth, and Fifth Circuits all have correctly concluded that

§ 502(a) completely preempts state laws that purport to disrupt an ERISA plan administrator's reimbursement or subrogation efforts.

In *Levine* v. *United Healthcare Corp.*, 402 F.3d 156 (3d Cir. 2005), the Third Circuit held that where an ERISA plan participant "claim[s] that they were entitled to certain health benefits and that the Providers wrongly sought the return of those benefits," such claims are in essence claims "for benefits due" under ERISA. *Id.* at 163. Because it "is impossible to determine the merits of the [participants'] claims without delving into the provisions of their ERISA-governed plans," the Court explained, § 502(a) is the "appropriate"—and exclusive—mechanism by which such claims must be brought. *Ibid.*

The Third Circuit reaffirmed *Levine*'s reasoning in *Wirth* v. *Aetna U.S. Healthcare*, 469 F.3d 305 (3d Cir. 2006). There, the plan participant argued that his claim to recover money paid to reimburse a plan administrator was not a claim for benefits under the plan. *Id.* at 308. Citing *Levine*, the court of appeals held that the plan participant was in effect seeking "benefits due" to him. *Id.* at 309. "That the bills and coins used to extinguish [the plan administrator's] lien are not literally the same as those used to satisfy its obligation to cover [the plan participant's] injuries," the court explained, "is of no import." *Ibid.*

In *Arana* v. *Ochsner Health Plan*, 338 F.3d 433 (5th Cir. 2003) (en banc), a plan participant sought a declaratory judgment requiring the ERISA plan to release a notice of lien and withdraw its subrogation claims for reimbursement of benefits following the participant's tort claim settlements. *Id.* at 438. The en banc Fifth Circuit held that the plan participant was "seek[ing] benefits" under the terms of the

ERISA plan despite the fact that the participant asked for relief under Louisiana state law. *Ibid.* The Court thus concluded that a claim seeking the return of benefits premised on an ERISA plan read in conjunction with state law is completely preempted by § 502(a). *Id.* at 438-39.

Similarly, in *Singh* v. *Prudential Health Care Plan, Inc.*, 335 F.3d 278 (4th Cir. 2003), a plan participant sought "the return of funds taken pursuant to the plan's subrogation term." *Id.* at 290. The Fourth Circuit explained that the participant's "claim to recover the portion of her benefit that was diminished by her payment to [the plan] under the unlawful subrogation term of the plan is no less a claim for recovery of a plan benefit under § 502(a) than if she were seeking recovery of a plan benefit that was denied in the first instance." *Id.* at 291. "Whether a State law defines the quantum of a plan benefit by negating subrogation terms that would diminish the benefit, … or defines a plan benefit by mandating coverage of certain treatments, … ERISA's complete dominion over a plan participant's claim to recover a benefit due under a lawful application of plan terms is not affected by the fortuity of *when* a plan term was misapplied to diminish the benefit." *Ibid.* Rather, the court held, "when the validity, interpretation or applicability of *a plan term* governs the participant's entitlement to a benefit or its amount, the claim for such a benefit falls within the scope of § 502(a)," and "therefore [is] completely preempted." *Ibid.*

2. In conflict with *Levine*, *Arana*, and *Singh*, the Second Circuit below relied on its prior decision in *Wurtz* v. *Rawlings Co.*, 761 F.3d 232 (2d Cir. 2014), to hold that ERISA does not preempt New York's an-

ti-subrogation law—even where, as here, the plaintiff expressly seeks benefits pursuant to ERISA § 502(a)(1)(B). Pet. App. 5a, 18a-20a.

In *Wurtz*, the Second Circuit held that state-law claims brought under Section 5-335 are not completely preempted by ERISA § 502(a) because Section 5-335 provides a legal duty that is "independent" of ERISA or of the plan's terms. 761 F.3d at 241-43. The court in *Wurtz* reasoned that the plan participants "do not contend that they have a right to keep their tort settlements 'under the terms of [their] plan[s]'—rather, they contend that they have a right to keep their tort settlements" under Section 5-335. 761 F.3d at 242. Nor do the plan participants "seek to 'enforce' or 'clarify' their rights 'under the terms of [their] plan[s],'" the court reasoned, "because the state right they seek to enforce—to be free from subrogation—is not provided by their plans." *Ibid.* Instead, the plan participants "'have already received all the benefits they were due in the form of medical expense coverage, and make no claim for any more.'" *Ibid.*

That holding is flatly inconsistent with *Levine*, *Arana*, and *Singh*, which recognized that a plan participant's claim for benefits under a state's anti-subrogation law is quintessentially a claim "for benefits due" under ERISA. *Levine*, 402 F.3d at 163; *Arana*, 338 F.3d at 438; *Singh*, 335 F.3d at 291. As the en banc Fifth Circuit explained, a beneficiary's action to enforce a state's anti-subrogation law is no different than an action "to enforce his rights under the terms of the plan, for he seeks to determine his entitlement to retain the benefits based on the terms of the plan." *Arana*, 338 F.3d at 438; *accord Levine*, 402 F.3d at 163 ("Where, as here, plaintiffs claim

that their ERISA plan wrongfully sought reimbursement of previously paid health benefits, the claim is for 'benefits' due" under ERISA § 502(a)); *Singh*, 335 F.3d at 291 (similar).

In this case, not only did the Second Circuit reaffirm *Wurtz*'s divergent holding, it extended that holding to cases where, as here, the claim at issue is a *claim for benefits* brought under § 502(a). The panel acknowledged that "Arnone relie[d] solely on section 502(a)(1)(B) of ERISA in support of his challenge" to Aetna's benefits determination, Pet. App. 13a n.5, and that Aetna "contend[ed] that ERISA preempts section 5-335 because giving section 5-335 any effect here would be 'entirely inconsistent with ERISA's core congressional goal of uniformity of plan administration,'" Pet. App. 18a. Yet the Second Circuit ruled that "[t]his argument is flatly foreclosed" by *Wurtz*, *ibid.*, which held that claims brought under Section 5-335 are neither expressly preempted nor completely preempted by ERISA, 761 F.3d at 240-44. In extending *Wurtz*'s preemption holding, the Second Circuit viewed the "only" question as being "whether section 5-335 can be said to 'regulate insurance' such that it falls within ERISA's savings clause" for purposes of express preemption, Pet. App. 19a, and failed even to acknowledge the complete preemptive effect of Arnone's own cause of action.

The decision below therefore widens the rift between the Second Circuit and other circuits that have considered whether ERISA completely preempts state anti-subrogation and anti-reimbursement laws. There is no difference between state laws that "defin[e] the quantum of a plan benefit by negating subrogation terms that would diminish the benefit" and those that "defin[e] a plan bene-

fit by mandating coverage of certain treatments" in the first instance. *Singh*, 335 F.3d at 291. Either way, "ERISA's complete dominion over a plan participant's claim to recover a benefit due under a lawful application of plan terms is not affected by the fortuity of *when* a plan term was misapplied to diminish the benefit." *Ibid.*

Wurtz also concluded that Section 5-335's prohibition on subrogation and reimbursement recoveries creates an "independent" legal duty because it is "unrelated to whatever plaintiffs' ERISA plans provide about reimbursement." 761 F.3d at 243. That conclusion, too, contradicts the holdings of *Levine*, *Arana*, and *Singh*. State-law prohibitions on subrogation and reimbursement are directly related to "whatever plaintiffs' ERISA plans provide about reimbursement," *ibid.*, because, by definition, such prohibitions affect—and effectively amend—the "benefits due" under an ERISA plan. *Levine*, 402 F.3d at 163. Indeed, Section 5-335 is titled "Limitation of reimbursement and subrogation claims in personal injury and wrongful death actions," Pet. App. 50a, leaving no doubt that it operates directly on subrogation and reimbursement terms in ERISA plans. As this Court explained in *FMC Corp.* v. *Holliday*, 498 U.S. 52 (1990), anti-subrogation and anti-reimbursement laws "'relat[e] to' an employee benefit plan" precisely because reimbursement affects how carriers "calculate benefit levels." *Id.* at 60. Laws barring subrogation and reimbursement "requir[e] plan providers to calculate benefit levels in" states that have such laws "based on expected liability conditions that differ from those in States" that do not, changing the net amount carriers are obligated to pay. *Ibid.* That disparity "frustrate[s] plan adminis-

trators' continuing obligation to calculate uniform benefit levels nationwide." *Ibid.*

Indeed, if the Second Circuit's erroneous conception of "independence" were correct, this Court could not have decided *Davila* as it did. There, the Texas statute that supposedly required the payment of certain health benefits created a duty of "ordinary care when making health care treatment decisions"—a duty that the respondents argued arose "independently of ERISA or the terms of the employee benefit plans." 542 U.S. at 205, 212 (citation omitted). Yet this Court disagreed, holding instead that Aetna's duty to cover requested treatment "derives entirely from the particular rights and obligations established by the benefit plans," and not from any legal relationship outside the ERISA context. *Id.* at 213. The same is true here: Any duty that Aetna has to provide disability benefits derives entirely from its relationship with Arnone as the insurer and claims administrator for his employer's ERISA-governed disability benefits plan, and that federally regulated duty is defined by the terms of the plan itself. As in *Davila*, Aetna has no other relationship with Arnone outside the ERISA context, such as a contractual or tort-law relationship, that New York could "independently" regulate. In these circumstances, as in *Davila*, any state-law duties or causes of action that Arnone could assert against Aetna to compel the payment of disability benefits "are not entirely independent of the federally regulated contract itself." *Ibid.* The Second Circuit's contrary position cannot be squared with *Davila* or decisions of other circuits that have found complete preemption in these precise circumstances.

By adhering to *Wurtz* and concluding that ERISA's savings clause applies to Section 5-335 notwithstanding that Arnone brought his claim for benefits under ERISA's cause of action, § 502(a), the decision below necessarily reaffirmed—and extended—*Wurtz*'s holding that ERISA § 502 does not completely preempt Section 5-335. *See* Pet App. 19a (rejecting Aetna's argument that "applying the statute to Arnone's settlement stands in tension with Congress's general goal of uniform administration of ERISA plans in every jurisdiction in which a plan has participants"). The Second Circuit could not have ruled on the express preemption issue otherwise, given that "ERISA § 514(b)(2)(A) must be interpreted in light of the congressional intent to create an exclusive federal remedy in ERISA § 502(a)." *Davila*, 542 U.S. at 217.

3. In *Wurtz*, the Second Circuit insisted that the circuit split it created was with decisions predating *Davila*. 761 F.3d at 243. But *Levine* was decided after *Davila*, and *Wurtz* identified no reason why *Davila* should have changed the outcome in *Levine*, *Arana*, and *Singh*. As the Second Circuit admitted, it simply was not "persuaded" by these cases. 761 F.3d at 244.

In any event, the Third, Fourth, and Fifth Circuits have continued to rely on their precedents in *Levine*, *Arana*, and *Singh* even after *Davila*. *See*, *e.g.*, *Wirth*, 469 F.3d at 308 ("The force of *Levine*'s reasoning has not diminished."); *Casselman* v. *Am. Family Life Assur. Co.*, 143 F. App'x 507, 511 n.2 (4th Cir. 2005) (relying on *Singh* to conclude that, "[t]o the extent the claims seek remedies that fall outside the scope of 29 U.S.C. § 1132(a), … those claims are rejected as preempted"); *Clayton* v. *Cono-*

coPhillips Co., 722 F.3d 279, 285 (5th Cir. 2013) (noting removal to federal court on "complete preemption" grounds pursuant to *Davila* and *Arana*); *Woods* v. *Tex. Aggregates, LLC*, 459 F.3d 600, 603 (5th Cir. 2006) (citing *Arana* for the proposition that "[§] 502(a) may provide for preemption where § 514(a) is inapplicable by operation of one of § 514's exemptions from preemption").

Even in decisions postdating *Wurtz*, the Third Circuit has steadfastly adhered to its prior position. *See*, *e.g.*, *Roche* v. *Aetna, Inc.*, 681 F. App'x 117, 122 (3d Cir. 2017) (noting Third Circuit's "reaffirm[ation]" of "*Levine*'s reasoning in *Wirth*"); *Mallon* v. *Trover Sols. Inc.*, 613 F. App'x 142, 144 (3d Cir. 2015) (similar). The Tenth Circuit has also acknowledged this circuit split and endorsed the majority view, albeit in dictum, in the context of a case concerning preemption under the Federal Employees Health Benefits Act of 1959. *See Helfrich* v. *Blue Cross & Blue Shield Ass'n*, 804 F.3d 1090, 1106 (10th Cir. 2015) ("We note that several circuit courts have interpreted an ERISA provision authorizing civil actions to 'recover benefits due … under the terms of [a] plan,' 29 U.S.C. § 1132(a)(1)(B), as encompassing suits disputing a plan's reimbursement efforts."). In sum, the positions of the respective circuits remain firmly entrenched even in the wake of *Wurtz*.

It is no surprise, then, that district courts and litigants must routinely grapple with this hardened circuit split. In *Roche* v. *Aetna Inc.*, 167 F. Supp. 3d 700 (D.N.J. 2016), for example, plaintiffs "urge[d] th[e] Court to follow the reasoning of *Wurtz* rather than the decision in *Levine*." *Id.* at 710 n.10. The district court, however, said that it "cannot" because "[t]he Third Circuit has specifically reaffirmed its

holding from *Levine* when invited to depart from it." *Ibid.* "Unless the Third Circuit determines to overrule its earlier ruling in *Levine* or is overruled by the Supreme Court," the district court explained, "the law of this circuit is that claims under anti-subrogation laws are claims for 'benefits due' under ERISA § 502(a)(1)(B)." *Ibid.*

In *Noetzel* v. *Hawaii Medical Service Association*, 183 F. Supp. 3d 1094 (D. Haw. 2016), the district court likewise explained that "*Wurtz* represents the minority view that a challenge to an ERISA plan administrator's right to subrogation or reimbursement falls outside the scope of ERISA § 502(a)." *Id.* at 1106. The court then rejected *Wurtz* because it "flouts the direction in *Davila* to examine the essence of a claim in determining whether it is completely preempted by ERISA § 502(a)." *Id.* at 1107. "*Davila* counsels the court not to accept claims at face value," yet *Wurtz* "'[d]istinguish[es] between pre-empted and non-pre-empted claims based on the particular label affixed to them'" in a way that "'elevate[s] form over substance and allow[s] parties to evade the pre-emptive scope of ERISA simply by relabeling their contract claims as [state law] claims.'" *Ibid.* (quoting *Davila*, 542 U.S. at 214). In that court's view, *Wurtz*'s "analysis … conflicts directly with governing Ninth Circuit precedent" holding that "'[p]reemption under ERISA section 502(a) is not affected by [section 514(b)(2)(A) as a state regulation of insurance].'" *Id.* at 1108 (citing *Cleghorn* v. *Blue Shield of Cal.*, 408 F.3d 1222, 1225-27 (9th Cir. 2005)); *see also Rudel* v. *Haw. Mgmt. All. Ass'n*, No. CV 15-00539 JMS-RLP, 2016 WL 4083320, at *2 (D. Haw. Aug. 1, 2016) (similarly rejecting *Wurtz*).

B. The Second Circuit's Decision Conflicts With This Court's Decisions

The Second Circuit's artificial distinction between state laws that restrict receipt of benefits and those that restrict retention of benefits is irreconcilable with this Court's precedents as well. As this Court explained in *Davila*, a state-law claim for damages arising from the denial of ERISA benefits is no different than a claim for benefits due under ERISA, because any liability "derives entirely from the particular rights and obligations established by the benefit plans." 542 U.S. at 213. Here, Arnone's claim for benefits is expressly based on the terms of his ERISA plan, *see* 29 U.S.C. § 1132(a)(1)(B), and his belated resort to Section 5-335 is premised on "the failure of the plan itself to cover the requested [benefits]" by dint of the plan's subrogation rights, 542 U.S. at 213. Section 5-335 therefore plainly "duplicates, supplements, or supplants [Arnone's] ERISA civil enforcement remedy" and is completely preempted. *Id.* at 209. *Davila* forecloses the Second Circuit's contrary holding.

This Court has applied similar reasoning in related contexts. In *Hillman* v. *Maretta*, 133 S. Ct. 1943 (2013), for example, the Court held that a federal law prescribing who receives life-insurance payments impliedly preempted a state law directing recipients of life-insurance payments to *transfer* them to someone else. *Id.* at 1952. It "makes no difference," *Hillman* explained, whether a state law withholds benefits in the first instance or takes them away after they have been paid; "[i]n either case, state law displaces the beneficiary selected" by federal law, and so is preempted. *Ibid.*

Wurtz also asserted that the plan participants' "claims are based on a state law that regulates insurance and are not based on the terms of their plans," and so the savings clause of ERISA's express preemption provision places a thumb on the scale against complete preemption. 761 F.3d at 242. The Second Circuit feared that the Third, Fourth, and Fifth Circuits' contrary approach "would expand complete preemption to encompass state laws that regulate insurance and that do not impermissibly expand the exclusive remedies provided by ERISA § 502(a)." *Id.* at 244. This Court, however, rejected that very argument in *Davila*. ERISA's savings clause, this Court explained, "must be interpreted in light of the congressional intent to create an exclusive federal remedy in ERISA § 502(a)." 542 U.S. at 217. That holding reflects the commonsense view that a statute cannot be read to destroy itself, and it is fundamentally at odds with the decision below.

Not only does *Wurtz* disrupt national uniformity in plan administration, but its holding, as reaffirmed by the decision below, creates an untenable anomaly in federal law governing health benefits. In *Coventry Health Care of Missouri, Inc.* v. *Nevils*, 137 S. Ct. 1190 (2017), this Court held—drawing on its ERISA preemption jurisprudence—that the Federal Employees Health Benefits Act of 1959 ("FEHBA") preempts state anti-subrogation laws pursuant to FEHBA's express-preemption provision. *Id.* at 1198-99. Under the Second Circuit's view, however, even though FEHBA preempts state anti-subrogation laws as applied to federal employees' benefit plans, those same laws may interfere with private-sector ERISA plans. There is no sound reason to believe that Congress wanted a different scope of preemption of state anti-subrogation laws under ERISA than

FEHBA. Left uncorrected, the Second Circuit's decision would sow disuniformity of benefits administration for ERISA plans despite contrary precedent under FEHBA's analogous benefits scheme.

*****

The Second Circuit has repeatedly applied or extended *Wurtz* in the three years since it was decided. *E.g.*, *McCulloch Orthopaedic Surgical Servs., PLLC* v. *Aetna Inc.*, 857 F.3d 141, 149-50 (2d Cir. 2017) (applying *Wurtz* to conclude that ERISA did not preempt a beneficiary's state promissory-estoppel claim). It will continue to do so in the face of mounting disagreement from other circuits unless this Court grants review and brings the court back in line with its sister circuits and this Court's precedent. Only this Court can restore uniformity and certainty to this critically important area of federal law.

II. THE SECOND CIRCUIT'S DECISION CREATES A CIRCUIT SPLIT ON WHETHER CHOICE-OF-LAW PROVISIONS REQUIRING THAT CONTRACTS BE "CONSTRUED" IN ACCORDANCE WITH A STATE'S LAWS INCORPORATE STATE SUBSTANTIVE LAW

"Courts construe ERISA plans, as they do other contracts, by 'looking to the terms of the plan' as well as to 'other manifestations of the parties' intent.'" *US Airways, Inc.* v. *McCutchen*, 569 U.S. 88, 102 (2013) (quoting *Firestone Tire & Rubber Co.* v. *Bruch*, 489 U.S. 101, 113 (1989)); *see also Heimeshoff* v. *Hartford Life & Acc. Ins. Co.*, 134 S. Ct. 604, 611-12 (2013) ("The principle that contractual limitations provisions ordinarily should be enforced as written is especially appropriate when enforcing an ERISA plan."). The ERISA plan at issue in this case pro-

vides that it "'will be construed in line with the law of the jurisdiction in which it is delivered,' which the Plan identifies as Connecticut." Pet. App. 20a. The Second Circuit held that this provision, "in stating that the Plan will be 'construed' in accordance with Connecticut law," refers only to "which jurisdiction's law of contract interpretation and contract construction will be applied." Pet. App. 20a-21a. The provision, the court concluded, "is insufficient to bind this court to apply the full breadth of Connecticut law … in fields other than the interpretation of the language in this contract." Pet. App. 21a.

The Second Circuit's choice-of-law holding conflicts with the holdings of the Fifth and Sixth Circuits, which have held that the word "construed" in choice-of-law provisions means "governed by" the substantive law of that jurisdiction, not simply "interpreted" under that jurisdiction's contract-interpretation principles.

In *Kipin Industries, Inc.* v. *Van Deilen International, Inc.*, 182 F.3d 490 (6th Cir. 1999), the Sixth Circuit analyzed a contractual choice-of-law provision stating that the contract "'should be construed according to Michigan Law.'" *Id.* at 493. The Sixth Circuit explained that "[r]ead literally," this provision may not "indicate that the parties wished to have their contract regulated under Michigan law" because "[t]o construe a contract is merely '[t]o ascertain the meaning of language by a process of arrangement, interpretation and inference.'" *Id.* at 493-94 (citation omitted). But the court explained that it had previously rejected this overly formalistic argument, "holding that the same contract language … evidenced the parties' intention to be bound by the substantive law of the chosen state," not merely the

state's contract-interpretation laws. *Id.* at 494 (citing *Boatland, Inc.* v. *Brunswick Corp.*, 558 F.2d 818 (6th Cir. 1977)).

In *Boatland*, the parties disputed the significance of a choice-of-law provision stating that the contract shall "be interpreted and construed according to the laws of the State of Wisconsin." 558 F.2d at 821. The defendant argued that the provision "means only that Wisconsin law was to give 'meaning and effect' to the terms of the contract, rather than to be 'governed' by the laws of Wisconsin"—the same argument the Second Circuit adopted in this case. *Ibid.*; *cf.* Pet. App. 23a-24a. The Sixth Circuit rejected that "strained and narrow construction of the language." 558 F.2d at 821-22. Absent evidence to the contrary, the court held, a choice-of-law provision requiring the contract to be "construed" in accordance with a state's law demonstrates an "inten[t] … that the substantive law of [that state] should determine their rights and obligations." *Id.* at 822.

The Fifth Circuit reached the same conclusion in *C. A. May Marine Supply Co.* v. *Brunswick Corp.*, 557 F.2d 1163 (5th Cir. 1977), which addressed a contractual provision entitled "'Interpretation'" that stated that "'[t]his agreement and all of its provisions are to be interpreted and construed according to the laws of the State of Wisconsin.'" *Id.* at 1164. The defendant argued that "the words 'interpreted and construed according to [Wisconsin law]' are not meant to imply that the rights and duties of the parties under the contract are to be governed by Wisconsin law," but only that "the meaning of ambiguous contract terms is to be resolved 'by looking to the law of Wisconsin'"—again, the same argument that the Second Circuit adopted here. *Id.* at 1165. The Fifth Circuit,

like the Sixth, rejected this argument. Although the court recognized that "the term 'construe in accordance with' is technically distinguishable from the term 'governed by,'" the court found no reason to assume "such a fine distinction was intended by the parties." *Ibid.*[2]

In reaching its conflicting judgment, the Second Circuit ignored the ordinary meaning of contractual choice-of-law provisions specifying the law under which a contract shall be "construed." Indeed, "[c]ommon sense tells us that the process of construing an agreement includes, in addition to the definition of possible ambiguous terms, the *application* of the terms to the case in question." *Hammel* v. *Ziegler Fin. Corp.*, 113 Wis. 2d 73, 77 (Ct. App. 1983) (emphasis added). This application "may require resort to extrinsic sources such as the substantive law." *Ibid.* It would make little sense to "look to the law of a specific state to define contractual terms but to the law of a second jurisdiction to ascertain the legal effect of the agreement," because "the meaning associated with a term by one jurisdiction might not mesh with the statutory and common-law scheme of another." *Id.* at 78.

Not only does the Second Circuit's judgment conflict with ordinary principles of contract interpretation, it establishes a federal common-law rule that is fundamentally at odds with a core purpose of ERISA: to provide uniformity in the administration of ERISA

---

[2] That holding is also precedent in the Eleventh Circuit. *See Bonner* v. *City of Prichard, Ala.*, 661 F.2d 1206, 1207 (11th Cir. 1981) (en banc) (decisions of the former Fifth Circuit issued before October 1, 1981 are "binding as precedent in the Eleventh Circuit").

benefits. *See Conkright* v. *Frommert*, 559 U.S. 506, 516 (2010) (noting that courts must ask whether "the language of the statute, its structure, or its purposes require departing from common-law trust requirements" when reviewing the interpretation of ERISA plans (citation omitted)). The Second Circuit acknowledged its precedent for "'developing federal common law,'" Pet. App. 21a (quoting *Critchlow* v. *First UNUM Life Ins. Co.*, 378 F.3d 246, 256 (2d Cir. 2004)), yet it ignored its own guidance that courts "may use state common law as the basis of the federal common law only if the state law is consistent with the policies underlying the federal statute in question," *Critchlow*, 378 F.3d at 256 (citation omitted). Here, ERISA's expansive preemptive provisions are designed to ensure that the construction of ERISA plans does not turn on state-law variations—a policy at odds with the Second Circuit's narrow construction of the plan's choice-of-law provision.

The court below further contended that Section 5-335 provides "a legal rule of proof … regarding personal injury settlements" that "applies irrespective of any language that may appear in the parties' contract or benefit plan and around which the parties cannot contract." Pet. App. 23a. But the fact that Section 5-335 does not expressly refer to the terms of an ERISA plan does not mean that it does not dictate the legal effect of those terms. Elsewhere, the Second Circuit acknowledged that Section 5-335 is "New York's directive" that Aetna may not "reduce Arnone's benefits by amounts he received from the settlement of his personal injury suit." Pet. App. 22a. That "directive" is quintessentially a matter of plan construction because it nullifies the standard subrogation provisions in most ERISA plans. If parties cannot effectively specify which states' laws govern

the construction of plan terms, it will lead to greater disuniformity in the construction of plan terms.

*****

As a result of the Second Circuit's decision, any contract that uses the familiar phrase "construed" in its choice-of-law provision will now be subject to circuit-by-circuit variation regarding the provision's reach. The consequences of this circuit split are especially harmful for ERISA plans, which Congress intended to be governed by a set of predictable, uniform rules. This Court should grant review on this additional question and restore the uniformity that ERISA guarantees.

III. THIS CASE IS A PRIME VEHICLE TO RESOLVE THESE RECURRING QUESTIONS OF NATIONAL SIGNIFICANCE

A. The questions presented are recurring issues of immense national importance to ERISA plan administrators and participants alike. Congress enacted ERISA to "'induc[e] employers to offer benefits 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.'" *Conkright*, 559 U.S. at 517 (quoting *Rush Prudential HMO, Inc.* v. *Moran*, 536 U.S. 355, 379 (2002)). Such "[u]niformity is impossible, however, if plans are subject to different legal obligations in different States." *Egelhoff* v. *Egelhoff ex rel. Breiner*, 532 U.S. 141, 148 (2001). The holding and conflict created by *Wurtz* and exacerbated by the decision below threatens ERISA's uniform scheme of benefits administration.

The skyrocketing costs of health and disability benefits demand a disciplined and consistent ap-

proach to benefits administration. For this reason, ERISA plans typically include subrogation and reimbursement provisions to reduce plan costs and to lower premiums for all plan participants. *See Zurich Am. Ins. Co.* v. *O'Hara*, 604 F.3d 1232, 1237-38 (11th Cir. 2010) ("Reimbursement inures to the benefit of all participants and beneficiaries by reducing the total cost of the Plan."); *Cutting* v. *Jerome Foods, Inc.*, 993 F.2d 1293, 1297 (7th Cir. 1993) ("Without subrogation, … [the insured] pays more for the insurance."). Indeed, the ubiquity of these subrogation and reimbursement provisions is precisely why many states, such as New York, have taken aim at the practice by enacting statutes such as Section 5-335.

Laws governing subrogation and reimbursement rights vary widely by state. Some states permit both rights, some permit neither, and some permit one but not the other, subject to myriad exceptions and qualifications. *See* Ass'n of Fed. Health Orgs., *State Laws Restricting Subrogation and Reimbursement* (2014), http://tinyurl.com/podatzj. The Second Circuit's decision means that ERISA plan administrators will be subjected to this patchwork of state-specific laws and conflicting obligations. The result will be a balkanization of ERISA benefits, making uniform plan administration impossible.

Worse still, similarly situated employees who receive benefits through the same multi-state ERISA plan may be entitled to receive vastly different "benefits due," depending solely on the laws of their home states. Under the existing circuit split, suits brought in the Second Circuit for benefits under an ERISA plan will be subject to the state anti-subrogation laws that apply to the plan, while suits brought in the Third, Fourth, and Fifth Circuits for benefits un-

der that same ERISA plan will not be. That result is directly at odds with the system Congress envisioned in enacting ERISA—one "'that is [not] so complex that administrative costs, or litigation expenses, unduly discourage employers from offering [ERISA] plans in the first place.'" *Conkright*, 559 U.S. at 517 (citation omitted). As this Court has recognized, "differing state regulations affecting an ERISA plan's 'system for processing claims and paying benefits' impose 'precisely the burden that ERISA preemption was intended to avoid.'" *Egelhoff*, 532 U.S. at 150 (citation omitted). This Court regularly grants review to eradicate such circuit-by-circuit and state-by-state distortions in the administration and payment of ERISA benefits. *E.g.*, *McCutchen*, 569 U.S. at 94; *Cigna Corp.* v. *Amara*, 563 U.S. 421, 435 (2011); *Conkright*, 559 U.S. at 517-21; *Sereboff* v. *Mid Atl. Med. Servs., Inc.*, 547 U.S. 356, 361 (2006).

The Second Circuit's erroneous choice-of-law holding only makes matters worse. Now, countless ERISA plans employing the term "construe" in their choice-of-law provisions will be subject to an assortment of state and federal laws. A dispute over such a plan in the Second Circuit will be subject to one set of state substantive law (but perhaps different state laws of contract interpretation), while a dispute over the *same* ERISA plan between the *same* parties in the Sixth Circuit may be subject to an entirely *different* set of state substantive law. If the ERISA claim at issue in this case were brought in the Sixth Circuit, there is no doubt the outcome would have been different: Connecticut substantive law would have applied, and Arnone's claim for benefits would have been adjudicated without regard to Section 5-335.

B. This case is an ideal vehicle to address these important questions. The Second Circuit decided the ERISA preemption issue by reaffirming its prior holding in *Wurtz* that a claim under Section 5-335 is neither expressly nor completely preempted by ERISA. But the court here went even further, extending *Wurtz* to allow Section 5-335 to determine the outcome of a claim for "benefits due" under ERISA § 502(a)(1)(B). This aspect of the Second Circuit's ruling—along with the choice-of-law holding—makes this case a far stronger candidate for this Court's review than the petition for a writ of certiorari that the Court considered in *Wurtz*. *See Rawlings Co., LLC* v. *Wurtz*, 135 S. Ct. 1400 (2015).

Moreover, the issues presented in this case, unlike in *Wurtz*, are outcome-determinative. The Second Circuit's mandate to reverse the grant of summary judgment in Aetna's favor and enter summary judgment for Arnone rested on the determination that ERISA did not preempt Section 5-335 and that New York substantive law applies. If this Court reverses that determination, Aetna will be entitled to judgment. In *Wurtz*, by contrast, other issues that were being litigated on remand could have rendered the preemption question irrelevant to the ultimate outcome of the case. Specifically, the applicability of a voluntary-payment defense would have made the question whether § 502(a) preempted Section 5-335 immaterial. No such infirmity exists here.

The Second Circuit in *Wurtz* also never addressed whether respondents' claims could be dismissed for failure to exhaust administrative remedies—an issue that would have determined the appropriateness of dismissal. Again, this case suffers from no similar flaw. On the contrary, the Second

Circuit expressly excused Arnone's failure to raise his Section 5-335 argument during the claims administration process, thus ensuring that the preemption and choice-of-law issues are cleanly and squarely presented for this Court's review.

CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted.

MIGUEL A. ESTRADA
Counsel of Record
LUCAS C. TOWNSEND
GIBSON, DUNN & CRUTCHER LLP
1050 Connecticut Avenue, N.W.
Washington, D.C. 20036
(202) 955-8500
mestrada@gibsondunn.com

Counsel for Petitioner

September 19, 2017

APPENDIX

APPENDIX A

15-2322-cv
Arnone v. Aetna Life Ins. Co.

United States Court of Appeals
FOR THE SECOND CIRCUIT

August Term, 2016

(Argued: August 15, 2016 Decided: June 22, 2017)

Docket No. 15-2322

SALVATORE ARNONE,

Plaintiff-Counter-Defendant-Appellant,

–v.–

AETNA LIFE INSURANCE COMPANY,

Defendant-Counter-Claimant-Appellee.

B e f o r e :

POOLER, LYNCH, and CARNEY, *Circuit Judges*.

Appellant Salvatore Arnone, a New York resident, appeals from part of a June 30, 2015 judgment of the United States District Court for the Eastern District of New York (Feuerstein, *J.*), denying his motion for summary judgment and granting the summary judgment motion filed by Appellee Aetna Life Insurance Company, an insurer registered to do business in New

York. After an accident, Arnone became disabled, entitling him to long-term disability benefits under a benefit plan created by his employer, administered and insured by Aetna, and governed by the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001 *et seq*. (the "Plan"). Arnone began collecting disability benefits after the accident; he also sued in New York state court those allegedly responsible for his injuries and settled that suit. Following the settlement, Aetna reduced Arnone's Plan benefits, on the theory that the settlement payment duplicated sums otherwise due Arnone under the Plan. We conclude that Aetna's determination contravened New York General Obligations Law § 5-335, which provides, "When a person settles a claim . . . for personal injuries . . . it shall be onclusively presumed that the settlement does not include any compensation for . . .cost[s] . . . obligated to be paid or reimbursed by an insurer." N.Y. Gen. Oblig. Law § 5-335(a). We also conclude that neither ERISA nor the Plan's choice of law provision (which identifies Connecticut law as controlling the Plan's construction) blocks application of section 5-335. Thus, as to the issue of Arnone's entitlement to the past and ongoing benefits that Aetna has not paid on the ground that they are duplicative of Arnone's personal injury settlement, the District Court erred in granting Aetna's motion for summary judgment and denying Arnone's motion for summary judgment. Arnone is entitled to the unpaid benefits. For these reasons, the District Court's judgment is REVERSED IN PART, as to that issue, and the cause is REMANDED for the entry of a revised judgment consistent with this opinion.

REVERSED IN PART AND REMANDED.

FRANKLIN P. SOLOMON, Solomon Law Firm, LLC,
Cherry Hill, NJ, *for Salvatore Arnone*.

MICHAEL H. BERNSTEIN (Matthew P. Mazzola, *on the brief*),
Sedgwick LLP, New York, NY, *for Aetna Life Insurance Company*.

SUSAN L. CARNEY, *Circuit Judge*:

Section 5-335 of the New York General Obligations Law provides that personal injury settlements "shall be conclusively presumed" not to include "any compensation for the cost of health care services, loss of earnings or other economic loss[es]" that "have been or are obligated to be paid or reimbursed by an insurer." N.Y. Gen. Oblig. Law § 5-335(a). When section 5-335 is applied, it effectively bars an insurer from reducing the benefits owed to an insured by the amounts the insured receives from a personal injury settlement.[1] In this appeal, we consider whether section 5-335 applies to payments made in settlement of a personal injury suit brought in a New York court by a New York resident injured in New York, even though the governing benefit plan provides that the law of a state other than New York controls the plan's construction.

---

[1] We note that throughout this opinion we do not use the terms "insured" and "insurer" broadly to refer to *all* kinds of insureds and insurers. Rather, we use those terms with reference to the positions functionally occupied by Arnone and Aetna in this case.

In brief summary, appellant Salvatore Arnone, a New York resident, sustained serious injuries while working in New York at the site of a customer of his employer. He filed for, and received, long-term disability benefits related to the injury through his employer's benefit plan (the "Plan"), which was governed by the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 *et seq*. Aetna Life Insurance Company ("Aetna"), 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.

Arnone brought a personal injury suit in New York state court against his employer's customer and settled the suit for $850,000. In light of the settlement, Aetna reduced Arnone's disability benefits by a portion of the settlement proceeds. Taking the position that the settlement included compensation duplicative of Arnone's disability benefits and citing a Plan provision regarding offsetting payments from other sources, Aetna maintained that the Plan permitted it to reduce its benefit payment obligation.

Arnone sued Aetna to recover the offset benefits. In moving for summary judgment, he invoked section 5-335. The District Court (Feuerstein, *J*.) 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 designating Connecticut law as controlling the Plan's construction. Arnone appeals this determination. Aetna defends the District Court's reasoning, and further argues that ERISA preempts section 5-335 as an impermissible state regulation of the Plan. Aetna also contends that Arnone forfeited his right to invoke section

5-335 in this lawsuit by failing to rely on it during Aetna's claims administration process.

We conclude that, when applied, section 5-335 prohibits Aetna's reduction in Arnone's disability benefits. We further decide that neither ERISA's preemptive force nor the Plan's choice of law provision compels a different conclusion. We also reject Aetna's issue forfeiture argument. Thus, as to Arnone's entitlement to the past and ongoing benefits that Aetna has withheld on the ground that they are duplicative of Arnone's personal injury settlement, the District Court erred in granting Aetna's motion for summary judgment and denying Arnone's motion for summary judgment. Arnone is entitled to the unpaid benefits. For these reasons, the District Court's judgment is REVERSED IN PART, as to that issue, and the cause is REMANDED for the entry of a revised judgment consistent with this opinion.

BACKGROUND

The facts set forth here are undisputed. Arnone is a former account executive for Konica Minolta Business Solutions U.S.A., Inc. ("Konica") who worked out of Konica's office in Melville, New York. In June 2009, Arnone was working at the site of one of Konica's customers, Meopta U.S.A., Inc. ("Meopta"), 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. Arnone reported that, as a result of the fall, he experienced pain, limitations in the range of motion in his cervical

and lumbar spine, radiculopathy,[2] and difficulty sitting or standing for prolonged periods. Several months after the fall, Arnone returned to work, but in December 2009 he stopped working—this time permanently—because of his injuries.

Konica had established for its employees a group long-term disability plan (the "Plan") that qualified as an employee welfare benefit plan under ERISA. Konica had also purchased from Aetna a group insurance policy designed to allow Konica to fund benefits under the Plan and engaged Aetna as the Plan's claims administrator. Arnone was a Plan participant.

Under ERISA, "benefits plans must be 'established and maintained pursuant to a written instrument.'" *M & G Polymers USA, LLC v. Tackett*, 135 S. Ct. 926, 933 (2015) (quoting 29 U.S.C. § 1102 (a)(1)). We understand the parties to agree that the written terms of the Plan comprise the insurance policy issued by Aetna to Konica, Joint App'x ("J.A.") 91-123, the "Booklet" apparently issued to employees as their "Certificate of Coverage," J.A. 124-42, and the "Summary of Coverage" document accompanying it, J.A. 143-52. We accept the parties' characterization for present purposes. *See, e.g.*, *Gibbs ex rel. Estate of Gibbs v. CIGNA Corp.*, 440 F.3d 571, 573 (2d Cir. 2006) (determining that the terms of a plan were expressed in an employer's plan description and an insurer's policy materials); *Ruiz v. Cont'l Cas. Co.*, 400 F.3d 986, 990-91 (7th Cir. 2005) (collecting cases and holding that an employer's disability insurance policy,

---

[2] Radiculopathy is a disorder of the spinal nerve roots. *See* Stedman's Medical Dictionary (28th ed. 2006).

together with certificates issued to employees, constituted ERISA plan documents).

The Plan provides that the amount of a participant's long-term disability benefit payment is a function of, among other factors, the number that is 60 percent of the individual's "monthly predisability earnings," reduced by "other income benefits" due from other sources. J.A. 125, 145. It defines "other income benefits" to include "[d]isability, retirement, or unemployment benefits required or provided for under any law of a government." J.A. 127. This category encompasses, for example:

> disability benefits under any state or federal workers' compensation law or any other like law, which are meant to compensate the worker for any one or more of the following: loss of past and future wages; impaired earning capacity; lessened ability to compete in the open labor market; any degree of permanent impairment; and any degree of loss of bodily function or capacity.

J.A. 127-28. The list of "other income benefits" also includes "[d]isability payments which result from the act or omission of any person whose action caused [the Plan participant's] disability." J.A. 128. In contrast, the term "other income benefits" does *not* include disability benefits being received from particular enumerated sources before the date of disability under the Plan, or from "individual disability income policies" or "severance pay." J.A. 129.

In August 2009, following his injury, Arnone filed a request for disability benefits with Aetna. In De-

cember, he submitted additional paperwork in support of his request. By letter dated March 12, 2010, Aetna approved Arnone's claim for disability benefits effective retroactively to December 2009 (when Arnone became eligible for benefits). It calculated 60 percent of his monthly pre-disability earnings to be $4,881. (In discussing dollar amounts, we round to the nearest dollar.)

Aetna reduced Arnone's disability benefits, however, in accordance with the Plan's "other income benefits" provision. By the time Aetna approved Arnone's claim, Arnone had already begun to receive New York workers' compensation benefits in the amount of $2,383 per month. As of March 12, 2010, then, Aetna calculated that Arnone was due disability benefits of $2,498 per month—$4,881 (60 percent of his pre-disability earnings) less $2,383 (his monthly workers' compensation benefits).

An additional reduction for "other income benefits" followed. In April 2011, the Social Security Administration awarded Arnone Social Security Disability Income ("SSDI") benefits totaling $2,414 per month. After offsetting these benefits as well, Aetna informed Arnone that he was due $114 per month under the Plan. This sum represented the Plan's guaranteed floor—its minimum monthly disability benefit for Plan participants.

Meanwhile, in November 2009, Arnone filed a personal injury suit against Meopta in New York state court, seeking compensation for his injuries. Roughly three years later, in late 2012, Arnone settled that suit for a lump-sum payment of $850,000. In return

for the payment, he executed a sweeping general release of his claims against Meopta (the "Release").

After Arnone executed the Release, Konica's workers' compensation insurance carrier exercised its statutory right to impose a lien against the proceeds of the settlement, requiring Arnone to reimburse the carrier for the workers' compensation benefits paid him. *See* N.Y. Workers' Comp. Law § 29(1); N.Y. Gen. Oblig. Law § 5-335(c) (excepting workers' compensation benefits from the general rule that a personal injury settlement "shall be conclusively presumed" not to include "any compensation for the cost of health care services, loss of earnings or other economic loss[es]" that "have been or are obligated to be paid or reimbursed by an insurer"). Arnone then wrote to Aetna to obtain a redetermination of his disability benefits. He requested that Aetna pay him the sums Aetna had previously withheld as "other income benefits" on the understanding that Arnone was receiving those sums in the form of workers' compensation benefits.[3]

In response, Aetna requested an "itemized list of liens that were paid out of [Arnone's] settlement for

---

[3] In October 2012, Arnone also notified Aetna that his workers' compensation benefits had been discontinued in August 2012. Aetna responded with an estimate that, once the workers' compensation offset was removed, it would pay Arnone monthly disability benefits of $1261, but it requested further documentation of the discontinuation. The record is unclear as to whether Arnone ever provided sufficient documentation of the discontinuation or received any monthly payments of $1261, because soon after this exchange, Aetna and Arnone began disputing the impact of Arnone's personal injury settlement on his disability benefits.

medical bills, income replacement, attorney fees, etc." J.A. 205. During the ensuing back-and-forth with Aetna, Arnone's counsel made no mention of New York General Obligations Law § 5-335, but represented (according to an Aetna employee's notes) that the remaining portion of the settlement was "all for pain and suffering" and that "no wage replacement was included" because "[a]ll wage replacement that was paid by [the workers' compensation] carrier was repaid to [the workers' compensation] carrier." J.A. 182. In April 2013, Aetna requested a copy of the settlement agreement, cautioning in internal correspondence that it could not "go by what [Arnone's] attorney is telling [it] . . . regarding the pain and suffering." J.A. 181.

In May 2013, Aetna issued its recalculation of Arnone's benefits. Aetna determined that Arnone netted $551,100 from the personal injury suit: the settlement amount of $850,000, less attorney's fees and litigation costs and a portion of the funds repaid to the workers' compensation insurance carrier. Because the Release was general and did not designate whether or how the settlement sum reflected compensation for pain and suffering, medical expenses, lost income, or other considerations, Aetna applied the Plan's so-called "50% Provision" in its recalculation. That provision reads:

> That part of the lump sum or periodic payment that is *for disability* will be counted [as an "other income benefit" offsetting benefits otherwise due], even if it is not specifically apportioned or identified as such. If there is no proof

> acceptable to Aetna as to what that part reasonably is, 50% will be deemed to be for disability.

J.A. 129 (emphasis added).

Relying on this language, Aetna concluded that the personal injury settlement reduced its obligation to Arnone by $275,550 (50 percent of the $551,100 net settlement amount paid by Meopta to Arnone). It prorated this sum, offsetting $1,791 per month retroactively from November 2012 (the date of the settlement, as Aetna determined it) to May 2013 (the date of Aetna's recalculation), and prospectively until August 2025 (the date when Arnone's disability benefit period under the Plan would end). Combined with the existing offsets, Arnone's disability benefits going forward from May 2013 were thus again, in Aetna's estimation, reduced to the $114 monthly minimum.

Arnone's counsel turned to Aetna's internal appeal process to challenge Aetna's recalculation. In a June 2013 letter, he argued that, because the remainder of the lump-sum settlement "was not for disability, but for pain and suffering only, no such portion should be deducted from [Arnone's] monthly benefit." J.A. 184. In a July 2013 letter, Aetna notified Arnone that, after an internal administrative review, it had upheld its original decision.

In August 2013, Arnone filed the instant action against Aetna in New York state court, seeking, among other relief, an award of the disability benefits that Aetna withheld in light of the settlement. As relevant to this appeal, Arnone asserted his entitlement to those unpaid benefits under section 502(a)(1)(B) of ERISA, which empowers a plan participant to sue "to

recover benefits due to him under the terms of his plan" and "to enforce his rights under the terms of the plan." 29 U.S.C. § 1132(a)(1)(B).

In September 2013, Aetna removed the action to the United States District Court for the Eastern District of New York. It also brought a counterclaim against Arnone for $40,125, representing the amount of disability benefits that, in its view, it had overpaid to Arnone from December 2009 through April 2011.[4]

Both Arnone and Aetna moved for summary judgment. Arnone argued that section 5-335 precluded Aetna from offsetting half of his net settlement amount against his disability benefits. The Plan's 50% Provision, by its text, allows offset only of the portion of the settlement that is "for disability," Arnone contended. He pointed out the 50% Provision's qualification: that only "[i]f there is no proof acceptable to Aetna as to what part reasonably is . . . for disability," will 50 percent of the total sum be "deemed" to be such compensation. J.A. 129. New York law as stated in section 5-335 provides, however, that personal injury settlements "shall be conclusively presumed" not to include "any compensation for the cost of health care

[4] Aetna originally counterclaimed for an alleged over-payment of $61,540, but in its motion for summary judgment, Aetna clarified that the actual amount of overpayment was $40,125. These calculations were premised on the federal government's 2011 payment of Social Security benefits to Arnone—a retroactive payment representing the total Social Security bene-fits he should have been receiving since December 2009. Because the start of Aetna's disability payments predated the start of the retroactive Social Security period, Aetna had already paid him this amount without offset. Aetna thus treated the retroactive Social Security award as "other income benefits" and offset this award against its payment obligation.

services, loss of earnings or other economic loss[es]" that "have been or are obligated to be paid or reimbursed by an insurer." N.Y. Gen. Oblig. Law § 5-335. Accordingly, Arnone argued, Aetna could not lawfully treat any part of his otherwise undifferentiated settlement amount as a payment "for disability" as required to apply the 50% Provision, and Aetna erred by reducing his disability benefits as it did. For its part, Aetna defended its application of the Plan's provisions.

The District Court denied Arnone's motion for summary judgment and granted Aetna's motion for summary judgment, dismissing Arnone's complaint in its entirety and also entering judgment for Aetna on its counterclaim for $40,125. *See Arnone v. Aetna Life Ins. Co.*, No. 13-cv-5168, 2015 WL 3915607, at *10 (E.D.N.Y. June 25, 2015). The District Court addressed New York law and section 5-335 only briefly. After observing that Arnone invoked the statute "for the first time in the action" in his motion for summary judgment, it concluded that section 5-335 was irrelevant to the reconciliation of amounts due Arnone because the Plan both specified that it would "be construed in line with the law of the jurisdiction in which it is delivered" and identified that jurisdiction as the state of Connecticut. *Id.* at *9 n.8.

This appeal followed. On appeal, Arnone seeks reversal of the District Court's judgment in Aetna's favor as to the personal injury settlement offset. He has not challenged the judgment as to other offsets made by Aetna or as to Aetna's counterclaim.[5]

---

[5] We note further that, on appeal, Arnone relies solely on section 502(a)(1)(B) of ERISA in support of his challenge and has

DISCUSSION

Arnone takes the position that, because he is a New York resident who was employed in New York and injured in New York, section 5-335 applies to his settlement and prohibits Aetna from applying the 50% Provision and thereby reducing his Plan benefits. Aetna counters that New York law has no bearing on the Plan, which, by its terms, is to be construed under Connecticut law. Aetna further contends that, even if section 5-335 has some relevance to Arnone's entitlements under the Plan, ERISA preempts the statute's application. Finally, Aetna urges us to conclude that Arnone forfeited his argument under section 5-335. We address each argument in turn.

I. Standard of review

We review a district court's grant of summary judgment *de novo*. *Fay v. Oxford Health Plan*, 287 F.3d 96, 103 (2d Cir. 2002). "When there exist no genuine issues of material fact in dispute, as is the case here, our task is to determine whether the district court correctly applied the law." *Pagan v. NYNEX Pension Plan*, 52 F.3d 438, 441 (2d Cir. 1995) (internal quotation marks omitted).

Arnone and Aetna agree that Aetna, as claims administrator, has discretionary authority to determine a participant's eligibility for benefits under the Plan. When a plan gives an administrator such discretion,

---

abandoned the theory—rejected by the District Court as preempted by ERISA—that Aetna's offset also constituted a breach of contract. *Arnone v. Aetna Life Ins. Co.*, No. 13-cv-5168, 2015 WL 3915607, at *9 (E.D.N.Y. June 25, 2015). We express no view as to the merits of either the latter theory or the District Court's rejection of it.

"a court may not overturn the administrator's denial of benefits unless its actions are found to be arbitrary and capricious." *McCauley v. First Unum Life Ins. Co.*, 551 F.3d 126, 132 (2d Cir. 2008). In the ERISA context, an administrator's decision is arbitrary and capricious if it is made "without reason," if it is "unsupported by substantial evidence," or, most relevant here, if it is "erroneous as a matter of law." *Id.*

II. The effect of section 5-335

We begin by addressing the straightforward question whether section 5-335, if applicable to this dispute, would prohibit Aetna's offset action—putting aside for a moment the arguments that section 5-335 should not apply. For the reasons set out below, we conclude that section 5-335 would prohibit Aetna's offset action as a matter of law and, for that reason, would render its decision arbitrary and capricious.

The current version of section 5-335 provides in relevant part:

> When a person settles a claim, whether in litigation or otherwise, against one or more other persons for personal injuries, . . . 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 an insurer. . . .
>
> No person entering into such a settlement shall be subject to a subrogation claim or claim for reimbursement by an insurer and an insurer

> shall have no lien or right of subrogation or reimbursement against any such settling person or any other party to such a settlement, with respect to those losses or expenses that have been or are obligated to be paid or reimbursed by said insurer.

N.Y. Gen. Oblig. Law § 5-335(a).[6]

Aetna, emphasizing the statute's "subrogation or reimbursement" language and the absence of any reference to offsets, argues that section 5-335, by its terms, does not apply here because Aetna has not filed a reimbursement or subrogation claim to recover portions of the settlement proceeds. We reject this argument. Notwithstanding the statute's lack of a reference to offsets, we think that, by referring to "losses or expenses that have been *or are obligated to be* paid or reimbursed by said insurer," *id.* (emphasis added), it contemplates protecting an insured's entitlement to ongoing benefits. Even clearer still, the applicability

---

[6] In November 2013, about four months after Arnone filed this action against Aetna in New York state court, section 5-335 was amended. The amendment "primarily . . . replac[ed] references to a 'benefit provider' with 'an insurer.'" *Wurtz v. Rawlings Co.*, 761 F.3d 232, 236 n.1 (2d Cir. 2014). As we noted in *Wurtz*, the amendment applies retroactively to the period between November 12, 2009, and November 13, 2013 (the date of the amendment's enactment). *See id.*; 2013 N.Y. Sess. Laws Ch. 516 (A. 7828-A) ("This act shall take effect immediately and shall apply to all settlements entered into on or after November 12, 2009."). Because Arnone settled his personal injury suit in 2012, we conduct our analysis under the amended version of section 5¬335. In any event, the amendment has no bearing on the issue before us, and we would reach the same result applying the earlier version.

of the first quoted paragraph, which creates a conclusive presumption that a settlement does *not* include amounts that an insurer *could* recover, is not, by its terms, limited to reimbursement and subrogation actions.

If applied to this dispute, section 5-335's conclusive presumption would bar Aetna from offsetting portions of Arnone's settlement against his ongoing disability benefits. The statute prohibits insurers from treating settlement amounts as "compensation for the cost of health care services, loss of earnings or other economic loss." N.Y. Gen. Oblig. Law § 5-335(a). There is no dispute that Aetna's offset falls within the reach of that statutory language. The offset is based on Aetna's conclusion that the settlement is an "other income benefit[]," 50 percent of which is deemed "for disability." J.A. 127-29. While payments "for disability" might not always be limited to compensation for "loss of earnings," the phrase "other economic loss" in section 5-335 is quite broad. Further, the record in this case reflects that the parties understood Aetna's offset to apply to wage replacement, and Aetna has not argued otherwise on appeal.

It therefore follows that Aetna's decision to offset half of the net settlement amount against Arnone's disability benefits would, under New York law, unlawfully deny him sums to which he is entitled under the Plan. Although our review of the claims determinations made by Aetna as claims administrator is "highly deferential," *Zervos v. Verizon N.Y., Inc.*, 277 F.3d 635, 646 (2d Cir. 2002), such a denial would be "erroneous as a matter of law" under section 5-335 and, accordingly, arbitrary and capricious, *McCauley*, 551 F.3d at 132 (internal quotation marks omitted).

The outcome of this appeal therefore depends on whether we apply section 5-335. If we do not apply the statute, then the judgment must be affirmed: Arnone has raised no other basis for reversal. If we do apply the statute, then the judgment must be reversed as to the issue of Arnone's entitlement to the past and ongoing benefits that Aetna has withheld on the ground that they are duplicative of amounts received from his personal injury settlement.

III. The applicability of section 5-335

Having determined that, if applied, section 5-335 would prohibit Aetna's offset action, we turn now to Aetna's arguments as to why section 5-335 does not apply to this dispute. For the reasons set out below, we find them unpersuasive.

A. ERISA preemption

Aetna contends that ERISA preempts section 5-335 because giving section 5-335 any effect here would be "entirely inconsistent with ERISA's core congressional goal of uniformity of plan administration." Appellee's Br. at 35. This argument is flatly foreclosed, however, by our recent holding in *Wurtz v. Rawlings Co.*, 761 F.3d 232 (2d Cir. 2014).

ERISA contains a broadly worded preemption clause declaring that the statute "supersede[s] any and all State laws" that "*relate to* any employee benefit plan." 29 U.S.C. § 1144(a) (emphasis added). The "basic thrust" of this preemption provision is to "avoid a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans." *Concerned Home Care Providers, Inc. v. Cuomo*, 783 F.3d 77, 88 (2d Cir. 2015).

But ERISA does not preempt *all* state laws that "relate to" an ERISA plan. ERISA's so-called "savings clause" exempts from preemption, as relevant here, "any law of any State which regulates insurance." 29 U.S.C. § 1144(b)(2)(A). The Supreme Court has left no doubt that "[a]n insurance company that insures a plan"—such as Aetna does for Konica—"remains an insurer for purposes of state laws purporting to regulate insurance" and "is therefore not relieved from state insurance regulation." *FMC Corp. v. Holliday*, 498 U.S. 52, 61 (1990) (internal quotation marks omitted). An ERISA plan is "bound by state insurance regulations insofar as they apply to the plan's insurer." *Id*.

Because Aetna acts as an insurer here as well as the claims administrator, the only remaining question with respect to its preemption argument is whether section 5-335 can be said to "regulate insurance" such that it falls within ERISA's savings clause. In *Wurtz*, we left no doubt that it does: "N.Y. Gen. Oblig. Law § 5-335 is saved from express preemption under ERISA . . . as a law that 'regulates insurance.'" 761 F.3d at 236. Thus, even if Aetna is correct that section 5-335 "relate[s] to" the Plan in some sense—a question we need not decide here—our precedent calls for us to treat it, notwithstanding ERISA, as a permissible regulation of New York's insurance markets, in which Aetna is an established participant.

Aetna also objects that applying the statute to Arnone's settlement stands in tension with Congress's general goal of uniform administration of ERISA plans in every jurisdiction in which a plan has participants. This is not, however, a novel, avoidable, ordispositive concern: "Such disuniformit[y] . . . [is]

the inevitable result of the congressional decision to 'save' local insurance regulation." *Metro. Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 747 (1985); *see also Wurtz*, 761 F.3d at 244 ("Allowing plaintiffs' state-law claims under section 5-335 to proceed will not disturb ERISA's goal of providing national uniformity.").

Aetna's argument is especially unconvincing because the structure of Konica's Plan invites the very disuniformity Aetna warns of: the Plan requires offset of "[d]isability, retirement, or unemployment benefits required or provided for under any law of a government," including state governments. J.A. 127. These benefits can be expected to vary considerably by jurisdiction. The Plan, then, by its design, embraces the same sort of "dissimilar outcomes on identical claims submitted by claimants from different states," Appellee's Br. at 37-38, that Aetna contends warrant disregarding section 5-335. Aetna's resort to the specter of disuniformity thus fails to persuade us to revisit our holding in *Wurtz* in order to find ERISA preemption here.

B. The Plan's choice of law provision

Aetna next argues that New York's section 5-335 has no purchase here because the Plan provides that it "will be construed in line with the law of the jurisdiction in which it is delivered," which the Plan identifies as Connecticut. J.A. 91. We reject Aetna's argument because, in our view, the Plan's choice of law provision does not encompass the matter at issue in this case. The Plan's choice of law provision, in stating that the Plan will be "construed" in accordance

with Connecticut law, sets forth only which jurisdiction's law of contract interpretation and contract construction will be applied. In the context presented here, that provision is insufficient to bind this court to apply the full breadth of Connecticut law, to the exclusion of another jurisdiction's law, in fields other than the interpretation of the language in this contract.

Contractual choice of law provisions are generally enforceable under both New York law and federal common law.[7] *See Fireman's Fund Ins. Co. v. Great Am. Ins. Co. of N.Y.*, 822 F.3d 620, 641 (2d Cir. 2016); *Buce v. Allianz Life Ins. Co.*, 247 F.3d 1133, 1149 (11th Cir. 2001); *Wang Labs., Inc. v. Kagan*, 990 F.2d 1126, 1128-29 (9th Cir. 1993). But as we have previously observed, "[t]he effect of [a] choice-of-law clause depends on . . . its scope," and New York courts are "reluctan[t] to read choice-of-law clauses broadly." *Fin. One Pub. Co. v. Lehman Bros. Special Fin., Inc.*, 414 F.3d 325, 332, 335 (2d Cir. 2005); *see also Critchlow v. First UNUM Life Ins. Co. of Am.*, 378 F.3d 246, 256 (2d Cir. 2004) ("In developing federal common law in an area, the courts may look to state law . . . ."). We may apply Connecticut law to issues within the scope of the Plan's choice of law provision and another jurisdiction's law to issues outside the provision's scope. *See Fieger v. Pitney Bowes Credit Corp.*, 251 F.3d 386, 397 (2d Cir. 2001).

---

[7] We think it unnecessary in this case to decide whether it is New York law or federal common law that determines the effect of the Plan's choice of law provision.

We are not convinced that the Plan's declaration that it will be "construed" in accordance with Connecticut law requires application of Connecticut law to the specific question posed by this litigation: whether Aetna may reduce Arnone's benefits by amounts he received from the settlement of his personal injury suit, notwithstanding New York's directive to the contrary. Nothing about section 5-335 "construes" the Plan in the ordinary sense of the verb. For example, Webster's New World College Dictionary (5th ed. 2014), offers the following as its first definition of "construe": "to analyze (a sentence, clause, etc.) so as to show its syntactic construction and its meaning." The New York statute does not "analyze" any Plan provision. 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. *See* N.Y. Gen. Oblig. Law § 5-335 ("When a person settles a claim . . . for personal injuries . . . it shall be conclusively presumed that *the settlement* does not include any compensation for [losses] . . . to be paid or reimbursed by an insurer." (emphasis added)). It curtails insurers' rights following an insured's settlement, irrespective of any language that may appear in the parties' contract or benefit plan.

State laws governing contracts do not necessarily relate to the contracts' construction. We think it plain, for example, that Connecticut's usury statute prohibiting "agreement[s] to receive . . . interest at a rate greater than twelve per cent per annum" governs contracts without saying anything about their construction. Conn. Gen. Stat. § 37-4. In contrast, it is clearly

a rule of construction under Connecticut law that ambiguities in insurance contracts are resolved in favor of the insured "only when all other avenues to determining the parties' intent have been exhausted." *R.T. Vanderbilt Co., Inc. v. Hartford Accident & Indem. Co.*, 156 A.3d 539, 556 (Conn. App. Ct. 2017).

Since section 5-335 is not a statute of contract construction or of contract interpretation, it does not fall under the express terms of the Plan's choice of law provision. Section 5-335 may, of course, affect whether and how certain provisions of benefit plans—such as the Plan's "other income benefits" offset provision—are ultimately implemented. In that general respect, it perhaps might be said to "govern" the Plan's application, although even that proposition could be debated. But the Plan's choice of law provision refers only to how the Plan is "construed." Section 5-335 does not, as we read it, modify how benefit plans are "construed." Rather, section 5-335 is, by its terms, a "[l]imitation of reimbursement and subrogation claims." N.Y. Gen. Oblig. Law § 5-335. It provides a rule to which all contracts between an insurer and an insured must adhere. Section 5-335, like Connecticut's usury statute, says nothing about the construction of the language in a contract or plan. Instead, section 5-335 provides a legal rule of proof, external to any plan documents, regarding personal injury settlements. This legal rule of proof applies irrespective of any language that may appear in the parties' contract or benefit plan and around which the parties cannot contract. In effect, section 5-335 calls for Aetna to abide by this external limitation in making benefits calculations under the Plan.

The contrary position—that any law resulting in a change in a plan participant's benefit level necessarily "construes" that plan—stretches the definition of "construe" to the breaking point. Accordingly, we conclude that section 5-335 does not bear on how the Plan is "construed," and therefore that the Plan's choice of law provision presents no obstacle to applying section 5-335 to Arnone's settlement.[8]

C. Asserted forfeiture of the section 5-335 argument

In a final effort to resist application of section 5-335, Aetna seizes on the fact that Arnone did not alert it to section 5-335 during the claims administration process. It appears to be accurate, as the District Court also noted, that it was in his motion for summary judgment in that court that Arnone "for the first time" made express mention of section 5-335. *See Arnone*, 2015 WL 3915607, at *9 n.8. But we are not persuaded that Arnone has therefore forfeited his right to rely on the statute in making his arguments against offset.[9]

---

[8] Aetna makes no argument independent of the Plan's choice of law provision that any law other than New York's should govern the insurance consequences of a settlement agreement resolving a New York lawsuit between two New York parties. Nor do we perceive any reason why New York law should not apply here. We therefore see no cause to engage in further choice of law analysis.

[9] At points in its brief, Aetna frames its forfeiture argument in terms of our standard of review: it contends that its offset action cannot be deemed arbitrary and capricious on the basis of an argument—Arnone's invocation of section 5-335—that was not raised during the claims administration process. Fundamentally, though, Aetna is simply making a forfeiture argument.

We have previously outlined a few principles concerning issue forfeiture in ERISA cases, albeit in the context of plan administrators that failed to preserve arguments for denying coverage, rather than plan participants who failed to preserve arguments in support of coverage. In *Lauder v. First Unum Life Insurance Co.*, we concluded that a proposed forfeiture finding against a plan administrator called for a "case-specific analysis." 284 F.3d 375, 381 (2d Cir. 2002). That individualized analysis, we reasoned, should be informed by whether such a finding would encourage "meaningful dialogue between plan administrators and plan members" during the claims administration process. *Id.* at 382 (alterations omitted). We deemed the *Lauder* administrator's defense forfeited after we concluded that the dialogue would have benefited from the administrator's assertion of the defense, given that it was aware at the time of all the circumstances relevant to the defense. *Id.* As relevant here, we distinguished *Lauder*'s circumstances from those of *Juliano v. Health Maintenance Organization of New Jersey, Inc.*, in which we expressed concern that requiring administrators to raise *every* possible defense during the claims administration process would turn ERISA notices into "meaningless catalogs of every conceivable reason that the cost in question might not be reimbursable, instead of candid statements as to why the administrator . . .thinks reimbursement is unwarranted." 221 F.3d 279, 288 (2d Cir. 2000). In *Lauder*, we also justified applying a forfeiture rule as discouraging "manipulative strategies" by the administrator in the claims administration process, concerned that, absent forfeiture rulings, "plan administrators . . . will try the easiest and least ex-

pensive means of denying a claim while holding in reserve another, perhaps stronger, defense should the first one fail." 284 F.3d at 382.

Permitting Arnone to raise the section 5-335 issue here does not implicate the concerns we identified in *Lauder*. We are not worried, for example, that absent a forfeiture rule for someone in Arnone's position, the claims administration process will be undermined. Arnone has not strategically saved his best argument for last or otherwise ambushed Aetna. Even though Arnone did not expressly flag the statute during Aetna's claims process, he certainly made to Aetna in substance the same argument that he now makes in court: he repeatedly informed Aetna that the settlement amounts it sought to offset were for "pain and suffering" and "not for disability," J.A. 182, 308, and that "no wage replacement was included," J.A. 182. In citing section 5-335 later, Arnone supplemented a consistently held position with legal authority, which seems to us to be permissible in this context.

Moreover, Aetna can hardly have been surprised by the emergence of section 5-335 in its dispute with a New York resident who settled a personal injury claim arising in New York. Although we are mindful of Aetna's concern regarding the administrative burdens involved in becoming familiar with the anti-subrogation laws of each state, we do not deal here with a local business tripped up by an unusual law from another state on an obscure topic. Aetna is a well-established and sophisticated insurer that operates nationwide, is subject to varying state laws in other aspects of its business, and cannot but be aware that anti-subrogation laws are a subject of division among the states. It is registered to conduct business in, and

is regulated as an insurer by, the state of New York and doubtless many other jurisdictions. It is not entitled to insulate itself from the application of relevant state law by hoping that during the claims process its insureds— generally less knowledgeable and with fewer resources—fail to invoke by number a state law with which Aetna should already be quite familiar.

CONCLUSION

The plain text of section 5-335 controls the outcome of this appeal, and all of Aetna's efforts to avoid section 5-335's application fall short. Aetna erroneously overlooked the law's provisions when it acted on its conclusion that 50 percent of the net proceeds from Arnone's personal injury settlement were "for disability" such that Aetna was permitted to reduce Arnone's disability benefits in offset. As a matter of New York statutory law, the personal injury settlement could not be so applied. Aetna has identified no persuasive reason for treating the statute as inapplicable or ignoring it: in particular, the statute is not preempted by ERISA, nor does the Plan's choice of law clause preclude this application of New York law.

For these reasons, we conclude that the District Court erred in granting Aetna's motion for summary judgment and denying Arnone's motion for summary judgment as to the issue of Arnone's entitlement to the past and ongoing benefits that Aetna has not paid on the ground that they are duplicative of Arnone's personal injury settlement. Arnone is entitled to the unpaid benefits. Accordingly, the District Court's judgment is REVERSED IN PART, as to that issue, and the cause is REMANDED for the entry of a revised judgment consistent with this opinion.

APPENDIX B

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF NEW YORK

---------- X

SALVATORE ARNONE,

Plaintiff,

-against-

AETNA LIFE INSURANCE COMPANY,

Defendant.

---------- X

OPINION AND ORDER
13-CV-5168 (SJF)

FEUERSTEIN, District Judge:

Before the Court are cross-motions for summary judgment pursuant to Federal Rule of Civil Procedure ("FRCP") 56. Plaintiff also seeks a declaratory judgment pursuant to FRCP 57. For the following reasons, Salvatore Arnone's ("plaintiff") motion is **DENIED** and Aetna Life Insurance Company's ("defendant") motion is **GRANTED**. Defendant's counterclaim for reimbursement of its overpayment of LTD benefits to plaintiff is **GRANTED**.

I. Introduction

A. Facts

1. Parties

Plaintiff was employed by Konica Minolta Business Solutions U.S.A., Inc. ("Konica") as a Traveling Account Executive.[1] Def. 56.1(a) Stmt. 1. Konica established and maintained a Group Long Term Disability Plan ("the Plan") for Konica employees and Aetna issued a group insurance policy identified as number GP-877115, effective July 1, 2004, to fund benefits under the Plan. *Id.* at ¶¶ 2, 3. The Plan is an employee welfare benefit plan governed by the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001, *et seq*. *Id.* at ¶ 4. Plaintiff, who last worked for Konica on December 3, 2009, was a participant in the Plan; defendant was the claim administrator. *Id*. at ¶¶ 5, 6, 7.

2. Pertinent Plan Provisions

The Plan's "Test of Disability" states: "From the date that you first become disabled and until Monthly Benefits are payable for 36 months, you will be deemed to be disabled on any day if: you are not able to perform the material duties of your own occupation solely because of: disease or injury; and your work earnings are

---

[1] Pursuant to EDNY/SDNY Local Rule 56.1(d), "[e]ach statement by the movant or opponent . . . including each statement controverting any statement of material fact, must be followed by citation to evidence. Portions of plaintiff's 56.1(a) statement of material facts, however, fail to identify the location of the evidence in the record and/or do not cite to an exhibit. Where there is no citation or the Court cannot locate the evidence, those statements shall not be considered.

80% or less of your adjusted predisability earnings. After the first 36 months that any Monthly Benefit is payable during a period of disability, you will be deemed to be disabled on any day if you are not able to work at any reasonable occupation solely because of: disease; or injury. If your own occupation requires a professional or occupational license or certification of any kind, you will not be deemed to be disabled solely because of the loss of that license or certification." *Id*. at ¶ 8.

A participant's monthly LTD benefit is based upon monthly predisability earnings and other income benefits. *Id*. at ¶ 9. "If other income benefits are payable for a given month: the monthly benefit payable under this Plan for that month will be the lesser of: the Scheduled Monthly LTD Benefit minus all other income benefits; and the Maximum Monthly Benefit, but not less than the Minimum Monthly Benefit." *Id*. at ¶ 10.

Under the terms of the Plan, "Other Income Benefits" includes: "disability, retirement, or unemployment benefits required or provided for under any law of a government. Examples are: Unemployment compensation benefits. Temporary or permanent, partial or total disability benefits under any state or federal workers' compensation law or any other like law, which are meant to compensate the worker for any one or more of the following: loss of past and future wages; impaired earning capacity; lessened ability to compete in the open labor market; any degree of permanent impairment; and any degree of loss of bodily function or capacity. . . . Disability payments which result from the act or omission of any person whose

action caused your disability. These payments may be from insurance or other sources." *Id.* at ¶ 11.

The Plan also states that "Other Income Benefits include those, due to your disability or retirement, which are payable to: you; your spouse; your children; your dependents." *Id*. at ¶ 12. Additionally, under the section entitled "Lump Sum and Periodic Payments from Any Other Income Benefits," the Plan states:

> Any lump sum or periodic other income payments that you receive will be prorated on a monthly basis over the period of time for which the payment was made. If a period of time is not indicated, Aetna will prorate the payments over a reasonable period of time, taking into account the expected length of disability payments and other relevant factors.
>
> That part of the lump sum or periodic payment that is for disability will be counted, even if it is not specifically apportioned or identified as such. If there is no proof acceptable to Aetna as to what that part reasonably is, 50% will be deemed to be for disability.

Id. at ¶ 13.

3. Plaintiff's Claim for LTD Benefits

On June 26, 2009, plaintiff was injured when he slipped in a puddle of water and fell, hitting his head, lower back and neck on a cinder block wall while

at a customer's facility[2] visiting, delivering parts and checking existing equipment. *Id.* at ¶¶ 14, 15. During an initial interview on January 6, 2010, plaintiff advised Aetna that as a result of his injuries, he experienced significant pain, a limited range of motion in his cervical and lumbar spine and radiculopathy. *Id*. at ¶ 16. He also advised that due to his injuries, he was unable to sit, drive and stand for prolonged periods. *Id*. at ¶ 17. Aetna Analyst Christine Coen ("Coen") advised Arnone that if he were to file a personal injury lawsuit against the customer, it might be entitled to apply an offset to any monthly long term disability ("LTD") benefit award because the lawsuit would be for damages arising from the same injury that caused his alleged disability. *Id.* at ¶ 18. On December 2, 2009, plaintiff executed a reimbursement agreement wherein he agreed that if his claim for LTD benefits was approved, he would reimburse Aetna for any overpayments received due to his or his dependent's receipt of income from any other sources, including but not limited to Social Security. *Id.* at ¶ 23.

By letter dated March 12, 2010, Aetna approved plaintiff's claim for LTD benefits effective December 7, 2009 and advised that he was entitled to a monthly LTD benefit in the sum of four-thousand, eight-hundred and eighty-one dollars and four cents ($4,881.04) minus offsets due to his receipt of "other income benefits," as defined by the Plan. *Id.* at ¶ 21. Aetna also advised that because plaintiff had been awarded worker's compensation disability benefits effective December 2009 in the sum of one-thousand and one-hundred dollars ($1,100.00) every two (2)

---

[2] The company's name is MEOPTA U.S.A., Inc.

weeks, i.e., two-thousand, three-hundred and eighty-three dollars and thirty-three cents ($2,383.33) per month, his monthly LTD benefit would be reduced to two-thousand, four-hundred, ninety-seven dollars and sixty-eight cents ($2,497.68) per month. *Id.* at ¶ 22.

4. Aetna's Review of Plaintiff's Claim for Continuing LTD Benefits

On March 25, 2010, Aetna analyst Coen received a call from a representative of One Beacon Insurance Company, the insurance carrier for the client at whose worksite plaintiff was injured, who advised that plaintiff had filed a personal injury lawsuit based upon his accident. *Id.* at ¶ 24. By letter dated March 25, 2010, Coen notified plaintiff that his monthly LTD benefits were subject to offsets for his receipt of other income benefits, which specifically included any award of Social Security Disability Income ("SSDI") benefits and "[d]isability payments which result from the act or omission of any person whose action caused your disability," such as proceeds from a personal injury lawsuit. *Id.* at ¶ 25. Coen also advised plaintiff of the Plan's provision for other income benefits and his receipt of any lump sum or periodic payments. *Id.* at ¶ 26.

a. Plaintiff is Awarded SSDI Benefits

On or around April 29, 2010, Aetna contacted plaintiff to inquire as to whether he had applied for primary and dependent SSDI benefits. *Id*. at ¶ 27. Plaintiff responded that he had not applied for primary SSDI benefits and inquired whether there would be an offset if his children received dependent SSDI ("DSSDI") benefits based upon his disability.

Id. at ¶ 28. Aetna advised that DSSDI benefits, to the extent they arose from plaintiff's disability, were considered "other income benefits" under the Plan and, consequently, Aetna would be entitled to an offset for plaintiff's monthly LTD benefit in the amount of the DSSDI. *Id*. at ¶ 29.

On April 30, 2011, Aetna was advised by Allsup, Inc., a company that provides SSDI claim services, that plaintiff was awarded retroactive SSDI benefits in the sum of two-thousand, four-hundred and fourteen dollars ($2,414.00) per month, effective December 2009. *Id*. at ¶ 30. Plaintiff also received a retroactive award of SSDI benefits in the sum of forty-thousand, one-hundred and twenty-five dollars and twenty-eight cents ($40,125.28) for the period of December 2009 through April 20, 2011. *Id*. at ¶ 31. By letter dated April 22, 2011, Aetna informed plaintiff that having paid LTD benefits during the relevant time period, it was entitled to recover the full amount of overpayments that resulted from the retroactive award of SSDI benefits. *Id*. at ¶¶ 32, 33. Aetna also advised that plaintiff's monthly LTD benefit would be reduced by the amount of his award of monthly SSDI benefits and that it was still entitled to apply an offset of two-thousand, three-hundred, eighty-three dollars and thirty-three cents ($2,383.33) per month for workers' compensation ("W/C") disability benefits. *Id*. at ¶¶ 34, 35. Thus, based upon the SSDI and W/C monthly benefits, plaintiff was receiving other income benefits in the sum of four-thousand, seven-hundred, ninety-seven dollars and thirty-three cents ($4,797.33) per month. *Id*. at ¶ 36. Aetna requested that plaintiff reimburse it for the forty-thousand, one-hundred, twenty-five dollar and twenty-eight cents ($40,125.28)

overpayment in a lump sum, which plaintiff refused to do until after his personal injury lawsuit was settled. To date, defendant has not been reimbursed. *Id*. at ¶¶ 37-39.

b. Plaintiff's Children Are Awarded Dependent SSDI Benefits

On May 9, 2011, Aetna was advised that plaintiff's two (2) children were awarded DSSDI benefits, based upon plaintiff's disability, in the sum of six-hundred and three dollars ($603.00) each for a total monthly benefit of one-thousand, two hundred and six dollars ($1,206.00). *Id*. at ¶¶ 40, 41. The Social Security Administration ("SSA") also approved plaintiff's claim for DSSDI retroactive benefits in the sum of twenty-thousand, five-hundred and two dollars ($20,502.00) for the period December 2009 through April 30, 2011. *Id*. at ¶ 42.

c. Plaintiff's Workers' Compensation Benefits are Discontinued

On October 23, 2012, plaintiff advised Aetna that his W/C compensation disability benefits had been discontinued. *Id*. at ¶ 43. By letter dated October 23, 2012, Aetna requested documentation demonstrating that his W/C disability benefits had been discontinued so it could adjust his monthly LTD benefits accordingly. *Id*. at ¶ 44.

d. Plaintiff's Personal Injury Lawsuit is Settled

By letter January 9, 2013, plaintiff's attorney requested that Aetna reimburse plaintiff for the W/C offsets it had applied to his monthly LTD benefits be-

cause plaintiff had reimbursed the W/C insurance carrier from the proceeds he received from settling his personal injury lawsuit. *Id*. at ¶ 45. As proof, plaintiff attached a letter from counsel for the W/C insurance carrier approving plaintiff's settlement in the sum of eight-hundred, fifty-thousand dollars[3] ($850,000.00) and noting that as part of the settlement, plaintiff agreed to settle the W/C lien in the sum of two-hundred, thirty-two thousand, eight-hundred, forty-eight dollars and fifty-nine cents ($232,848.59). *Id*. at ¶ 46.

On January 23, 2013, during a telephone call with Aetna, plaintiff confirmed that he had settled his personal injury lawsuit and inquired as to whether the settlement would result in any further offset of his monthly LTD benefit. *Id*. at ¶ 47. By facsimile to plaintiff's counsel dated February 11, 2013, Aetna stated that it required more information to determine the effect of the settlement on plaintiff's LTD benefits and requested that plaintiff provide "an itemized list of the liens that were paid out of his settlement for medical bills, income replacement, attorney's fees, etc." and that information be provided regarding that portion of the settlement designated as income replacement. *Id*. at ¶¶ 48-50.

By letter dated February 12, 2013, plaintiff's counsel advised Aetna that his employer's W/C insurance carrier had a three-hundred, forty-two thousand and seventy-two dollars and twenty-five cents ($342,072.25) lien on the settlement proceeds. *Id*. at ¶ 51. Plaintiff's counsel also informed Aetna that due to an automatic statutory reduction of 32.9% for attorney's fees, plaintiff was required to repay 67.1% of the

---

[3] Hereinafter "$850,000."

worker's compensation lien out of the settlement award received from the personal injury lawsuit. *Id*. at ¶ 52. On March 15, 2013, plaintiff's counsel contacted Aetna and again stated that plaintiff was required to satisfy the lien held by his employer's W/C insurance carrier and that he was also required to pay two-hundred, seventy-one thousand, seven-hundred, eight-five dollars and seventy-three cents ($271,785.73) in litigation fees and expenses related to his personal injury lawsuit, and that the entire amount of the settlement was for "pain and suffering, and no wage replacement was included." *Id*. at ¶¶ 53-55.

e. Aetna's Financial Triage Unit Receives Plaintiff's Settlement Information

On March 18, 2013, Aetna forwarded plaintiff's claim file to its Financial Triage Unit ("FTU") to determine whether it was entitled to any further offsets with respect to plaintiff's settlement. *Id*. at ¶ 56. The FTU responded that it required the actual settlement agreement to determine how or if the settlement proceeds were earmarked for, e.g., pain and suffering/lost income. *Id*. at ¶¶ 57, 58. On April 11, 2013, Aetna requested a copy of the signed settlement agreement, which demonstrated that plaintiff agreed to settle any and all claims against MEOPTA U.S.A., Inc., for $850,000, but did not categorize or specifically designate a portion of the proceeds for pain and suffering, lost income due to disability, attorney's fees, etcetera. *Id*. at ¶¶ 59-63.

On April 18, 2013, Aetna's FTU issued a financial review, which determined that based upon the settlement agreement and the terms of the Plan,

Aetna's offset against plaintiff's future LTD benefit payments was two-hundred, seventy-five, five-hundred, fifty dollars and seven cents ($275,550.07). *Id*. at ¶ 65. To determine this amount, the FTU relied upon the following Plan terms:

> Lump Sum and Periodic Payments From Any Other Income Benefits- Any lump sum or periodic other income payments that you receive will be prorated on a monthly basis over the period of time for which the payment was made. If a period of time is not indicated, Aetna will prorate the payments over a reasonable period of time, taking into account the expected length of disability benefits and other relevant factors.
>
> That part of the lump sum or periodic payment that is for disability will be counted, even if it is not specifically apportioned or identified as such. If there is no proof acceptable to Aetna as to what part reasonably is, 50% will be deemed for disability.

Id. at ¶ 66. Before applying the offset, the FTU reduced the settlement amount by the amount of attorney's fees and expenses incurred during the personal injury litigation, i.e., two-hundred, seventy-one thousand, seven-hundred, eight-five dollars and seventy-three cents ($271,785.73), and by a portion of the W/C benefits Aetna previously offset from plaintiff's monthly LTD disability benefit, i.e., twenty-seven thousand, four-hundred, seventy-one dollars and thirty-two cents ($27,471.32), which was based upon

the specific percentage of W/C benefits plaintiff was required to reimburse the employer's W/C insurance carrier. *Id*. at ¶ 67. Based upon these deductions, the FTU determined that plaintiff netted five-hundred and fifty-one thousand, one- hundred dollars and fourteen cents ($551,100.14) from the personal injury lawsuit. *Id*. at ¶ 68.

The terms of the Plan required Aetna to apply an offset of 50% of the total net settlement amount, i.e., two-hundred, seventy-five thousand, five-hundred and fifty dollars and seven cents ($275,550.07), and thus, the FTU determined that Aetna had to offset that amount from any future benefit payments to plaintiff in accordance with the Plan's terms. *Id*. at ¶¶ 69, 70.

5. Aetna's Determination of the Appropriate Offset Amount for Plaintiff's Personal Injury Settlement

By letter dated May 1, 2013, Aetna Senior LTD Benefit Manager Angela Hobbs ("Hobbs") advised plaintiff that pursuant to the terms of the Plan, it was required to offset his LTD benefits in the sum of two-hundred, seventy-five thousand, five-hundred and fifty dollars and seven cents ($275,550.07) as a result of the settlement of his personal injury lawsuit. *Id*. at ¶ 71. Hobbs broke down plaintiff's future benefit payments as follows:

Pre-disability earnings:	$8,135.02
60% Monthly Benefit Allowance:	$4,810.01
Less Primary SSDI offset:	$2,414.00
Less DSSDI offset:	$1,206.00

Less W/C Settlement (Personal injury lawsuit offset):	$1,791.23
Gross Minimum Monthly Benefit Allowance:	$114.00

Id. at ¶ 72. Hobbs also informed plaintiff that his monthly LTD benefit would be one-hundred, fourteen dollars ($114.00), the minimum benefit amount required by the Plan. *Id*. at ¶ 73. Hobbs advised plaintiff that pursuant to ERISA, he was entitled to file an administrative appeal of Aetna's offset determination and that to perfect the appeal, he should submit "pertinent identifying information, comments, documents, records and other information [he] would like to have considered." *Id*. at ¶ 74. Finally, Hobbs advised that there was still an outstanding overpayment of his claim in the sum of forty-thousand, one-hundred, twenty-five dollars and twenty-eight cents ($40,125.28), resulting from his retroactive primary SSDI award. *Id*. at ¶ 75.

6. Plaintiff's Appeal of Aetna's Offset Determination

By letter dated June 12, 2013, plaintiff's counsel appealed Aetna's offset determination of his settlement award. *Id*. at ¶ 76. Plaintiff argued that (1) Aetna should credit him with an amount equal to the W/C disability benefits that it previously offset from his monthly LTD benefits because he was required to reimburse the worker's compensation insurance carrier for the amount of those benefits; (2) Aetna was not entitled to offset any amount of benefits from the settlement proceeds because the settlement was limited to damages for pain and suffering and for loss of

income, but not for disability; and (3) the dependent SSDI benefits should not have been offset pursuant to the terms of the Plan.[4] *Id*. at ¶¶ 77-79.

7. Aetna's Final Determination

By letter dated July 24, 2013, Aetna Senior Technical Specialist Kaz Takashima ("Takashima") advised plaintiff that Aetna had decided to uphold its determination regarding the appropriate offset amount for his personal injury settlement. *Id.* at ¶¶ 81, 82. Takashima explained that it had not offset plaintiff's monthly LTD benefits based upon his receipt of W/C benefits; rather, it had reduced plaintiff's monthly LTD benefit award by the exact amount he received from W/C for disability, i.e., two-thousand, three-hundred, eighty-three dollars and thirty-three cents ($2,383.33) per month for a total of eighty-three thousand, four-hundred, sixteen dollars and sixty-seven cents ($83,416.67), during the period December 7, 2009 through November 12, 2012. *Id.* at ¶ 83. Takashima further advised that because plaintiff only repaid the portion of his W/C lien that was not attributed to attorney's fees, 32.9% of the total lien amount, Aetna had credited plaintiff with an amount equal to all but 32.9% of the amount it had previously offset, i.e., twenty-seven thousand, four-hundred and seventy-one dollars and thirty-two cents ($27,471.32). *Id.* at ¶ 84.

In addition, Takashima's letter advised that the settlement agreement submitted by plaintiff did not

[4] Aetna received no documentation from plaintiff to support his arguments. Def. 56.1 Stmt. ¶ 80.

explain the basis for the settlement or indicate its allocation, e.g., pain and suffering/lost income due to disability/attorney's fees and thus, pursuant to the Plan's terms, Aetna was required to offset 50% of the settlement amount against his LTD benefits and that the appropriate monthly offset of the settlement proceeds was determined to be one-thousand, seven-hundred, ninety-one dollars and twenty-three cents ($1,791.23) per month for the remaining period that plaintiff was entitled to LTD benefits. *Id.* at ¶¶ 85, 86. Last, as per the Plan's express terms, Aetna was required to offset plaintiff's monthly benefits by the amount of "other income" received by his family as a result of his disability, including dependent SSDI benefits. *Id.* at ¶ 87.

B. Plaintiff's Complaint and Defendant's Counterclaim

Plaintiff's first and third claims seek to recover LTD benefits pursuant to ERISA, 502(a)(1)(B), 29 U.S.C. § 1132, and allege that: plaintiff is entitled to reimbursement of the amount by which defendant offset his LTD benefits with W/C benefits; plaintiff's future LTD benefits should not be offset by his settlement award; and DSSDI should not be considered in calculating his LTD benefits.[5] Plaintiff's second claim alleges breach of contract and requests a declaratory judgment that defendant is obligated to pay plaintiff a sum certain until he reaches age sixty-five (65).

Defendant's counterclaim seeks reimbursement for overpayment of Plan LTD benefits in the sum of

---

[5] The complaint does not expressly state a first cause of action, however, the wherefore clause demands judgment on the "first cause of action in the sum of $514,566.54."

forty-thousand, one-hundred, twenty-five dollars and twenty-eight cents ($40,125.28).

II. Discussion

A. Legal Standard for Summary Judgment

A motion for summary judgment shall not be granted unless a court determines that there is "no genuine issue as to any material fact and that the movant is entitled to judgment as a matter of law." *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248 (1986) (quoting FRCP 56(a)). Thus, where the pleadings, depositions, answers to interrogatories, affidavits and admissions on file show that there is no genuine issue as to any material fact, the moving party is entitled to judgment. *Williams v. R.H. Donnelly Corp.*, 368 F.3d 123, 126 (2d Cir. 2004). The court must resolve all ambiguities and draw all inferences in favor of the non-moving party. *Id.*; *Castle Rock Entm't, Inc. v. Carol Publ'g Grp.*, 150 F.3d 132, 137 (2d Cir. 1998). "A party opposing a properly brought motion for summary judgment bears the burden of going beyond the [specific] pleadings, and 'designating specific facts showing that there is a genuine issue for trial.' " *Amnesty Am. v. Town of West Hartford*, 288 F.3d 467, 470 (2d Cir. 2002) (quoting *Celotex Corp. v. Catrett*, 477 U.S. 317, 324 (1986)). If there is any evidence in the record from which a reasonable inference may be drawn in favor of the non-moving party on a material issue of fact, summary judgment is improper. *Chambers v. TRM Copy Ctrs. Corp.*, 43 F.3d 29, 37 (2d Cir. 1994).

There is a "genuine" issue of fact only if the "evidence [presented] is such that a reasonable jury could

return a verdict for the nonmoving party." *Giodano v. City of New York*, 274 F.3d 740, 746-47 (2d Cir. 2001). "[A]ttempts to twist the record do not create a genuine issue of material fact for a jury." *Kim v. Son*, No. 05 Civ. 1262, 2007 WL 1989473, at *6 (E.D.N.Y. July 9, 2007). Therefore, "where the cited materials do not support the factual assertions in the Statements, the Court is free to disregard the assertion." *Holtz v. Rockefeller & Co.*, 258 F.3d 62, 73 (2d Cir. 2001). In addition, "conclusory statements, conjecture, or speculation by the party resisting the motion will not defeat summary judgment." *Kulak v. City of New York*, 88 F.3d 63, 71 (2d Cir. 1996). Finally, FRCP 56(c) mandates that all facts under consideration in a motion for summary judgment be directly supported by proof in admissible form.

B. ERISA Standard

With respect to claims challenging a denial of benefits under an employee benefit plan, "[t]he Supreme Court has explained that where the plan 'grants the administrator discretionary authority to determine eligibility benefits, a deferential standard of review is appropriate.' " *Fortune v. Grp. Long Term Disability Plan for Emp. of Keyspan Corp.*, 637 F. Supp. 2d 132, 141 (E.D.N.Y. 2009) (quoting *McCauley v. First Unum Life Ins. Co.*, 551 F.3d 126, 132 (2d Cir. 2008)). " 'Under the deferential standard, a court may not overturn the administrator's denial of benefits unless its actions are found to be arbitrary and capricious, meaning 'without reason, unsupported by substantial evidence or erroneous as a matter of law.' " *Id.* (quoting *McCauley*, 551 F.3d at 132). " 'Substantial evidence is 'such evidence that a reasonable mind might accept as adequate to support the conclusion

reached by the [administrator and] . . . requires more than a scintilla but less than a preponderance.' " *Id.* (quoting *Celardo v. GNY Auto. Dealers Health and Welfare Trust*, 318 F.3d 142, 146 (2d Cir. 2003)).

C. The Cross Motions for Summary Judgment

1. Aetna's W/C and DSSDI Benefits Offsets

Pursuant to 29 U.S.C. § 1132, "A civil action may be brought . . . (1) by a participant or beneficiary . . . (B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan." "Importantly, ERISA does not mandate particular benefits but instead 'governs plan operations, provides rules of fiduciary responsibility and sets forth disclosure requirements to further ERISA's policy of protecting the interests of plan participants in the benefits that employers do elect to provide.' " *Rommel v. First Unum Life Ins. Co.*, No. 94 Civ. 019, 1995 WL 390011, at *4 (N.D.N.Y. June 28, 1995) (quoting *Howard v. Gleason Corp.*, 901 F.2d 1154, 1156 (2d Cir. 1990)).

Plaintiff alleges that his W/C benefits were repaid in full from the settlement and therefore, his LTD benefits should not have been offset by W/C benefits from June 26, 2009 to August 10, 2012 and, in addition, his future LTD benefits should not be offset based upon the settlement. Furthermore, the DSSDI payments for his children should not have been deducted. Compl. ¶¶ 10-21. As a result of these allegedly improper deductions, plaintiff contends he is

owed five hundred and fourteen thousand, five-hundred sixty-six dollars and fifty-four cents ($514,566.54). *Id.* at ¶ 27. Plaintiff's third claim seeks attorney's fees in the sum of fifty-thousand dollars ($50,000). *Id.* at ¶ 28.

Pursuant to the Plan's clear language, however, these deductions were permissible and therefore, not arbitrary or capricious. Dec. Takashima, Exh. A, 000035-38 (LTD plan terms including calculation of the LTD monthly benefit and the effect of other income benefits). Moreover, there is no provision in the Plan requiring that plaintiff be reimbursed for these offsets and thus, defendant's actions did not violate the Plan's terms. Accordingly, plaintiff's motion for summary judgment on his first and third claims is denied, defendant's motion is granted and these claims, including the request for attorney's fees, are dismissed.

2. Breach of Contract

Plaintiff claims that defendant breached its contract to provide LTD payments pursuant to the policy and requests a declaration that defendant is obligated to pay him the sum of two-thousand, four-hundred, sixty-seven dollars and two cents ($2,467.02) per month beginning May 1, 2011 until plaintiff attains the age of sixty-five (65) on August 9, 2025. Compl. at ¶¶ 19-22.

Under 29 U.S.C. §1144(a),[6] however, "ERISA preempts state law regarding any matters that 'relate

[6] Title 29 U.S.C. §1144(a) provides, in pertinent part, that "the provisions of this subchapter and subchapter III of this chapter

to' employee benefit plans." *Westphal v. Eastman Kodak Co.*, No. 05 Civ. 6120, 2006 WL 1720380, at *6 (W.D.N.Y. June 21, 2006). "Moreover, 'ERISA . . . sets forth a 'comprehensive civil enforcement scheme that represents a careful balancing of the need for prompt and fair claims settlement procedures against the public interest in encouraging the formation of employee benefit plans.' This balancing 'would be completely undermined if ERISA-plan participants and beneficiaries were free to obtain remedies under state law that Congress has rejected in ERISA.' " *Id.* (quoting *Romney v. Lin*, 94 F.3d 74, 80-81 (2d Cir. 1996).

It is undisputed that plaintiff seeks to recover other income benefits which were deducted from his LTD benefits pursuant to the Plan and that the Plan is governed by ERISA.[7] Therefore, plaintiff's state law breach of contract claim is preempted by ERISA and plaintiff's motion for summary judgment on this claim is denied as is his request for a declaration of defendant's obligations, defendant's motion is granted and this claim is dismissed.[8]

---

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."

[7] Indeed, plaintiff's complaint seeks relief under ERISA, 502(a)(1)(B), 29 U.S.C. § 1132(a) and defendant removed this case from New York Supreme Court on the basis of ERISA federal question jurisdiction (DE 1-2), which plaintiff did not contest.

[8] Insofar as plaintiff's motion for summary judgment alleges, for the first time in this action, that New York General Obligation Law ("GOL") § 5-335 applies to this case, defendant's LTD Plan contains an enforceable choice of law clause, which states

3. Defendant's Counterclaim

On April 29, 2010, defendant was advised that plaintiff had been awarded retroactive SSDI benefits in the sum of two-thousand, four-hundred and fourteen dollars ($2,414.00) per month, effective December 2009 and received a lump sum retroactive award in the sum of forty-thousand, one-hundred and twenty-five dollars and twenty-eight cents ($40,125.28) for the same disability for which he receives LTD benefits. On December 2, 2009 and prior to the SSDI award, plaintiff had executed an agreement to reimburse defendant "for any and all overpayments made to [plaintiff] under the LTD policy." Dec. Takashima, Exh. B 000766. Based upon the Plan's terms regarding "other benefits," defendant overpaid plaintiff LTD benefits in the lump sum amount. In light of the foregoing and based upon the Plan's terms, defendant's motion for summary judgment on its counterclaim seeking reimbursement of the overpayment to plaintiff in the sum of $40,125.28, is granted.

III. Conclusion

For the foregoing reasons, plaintiff's motion for summary judgment is **DENIED** and the complaint is dismissed in its entirety. Defendant's motion for summary judgment is **GRANTED** and its counterclaim

---

that "this policy will be construed in line with the law of the jurisdiction in which it is delivered." Plaintiff's policy was delivered in Connecticut and, accordingly, New York's GOL does not apply to defendant's Plan. *See Barnes v. Am. Int'l Life Assurance Co. of New York*, 681 F. Supp. 2d 513, 520 (S.D.N.Y. 2010) ("In ERISA cases in which an insurance contract contained a choice of law provision dictating that state law would govern, courts have held that the choice of law provision controls, unless it would be unreasonable and unfair to apply state law.").

for reimbursement of its LTD benefit overpayment to plaintiff in the sum of $40,125.28 is **GRANTED**. The pretrial conference set for August 3, 2015 is canceled and the Clerk of the Court shall close this case.

SO ORDERED.

Dated: June 25, 2015

Central Islip, New York

/s/

Sandra J. Feuerstein, U.S.D.J.

APPENDIX C

29 U.S.C. § 1132. Civil enforcement (*excerpt*)

(a) Persons empowered to bring a civil action

A civil action may be brought—

(1) by a participant or beneficiary—

(A) for the relief provided for in subsection

(c) of this section, or

(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;

* * *

N.Y. Gen. Oblig. Law § 5-335. Limitation of reimbursement and subrogation claims in personal injury and wrongful death actions (*excerpt*)

(a) When a person settles a claim, whether in litigation or otherwise, against one or more other persons for personal injuries, medical, dental, or podiatric malpractice, or wrongful death, 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 an insurer. By entering into any such settlement, a person shall not be deemed to have taken an action in derogation of any right of any

insurer that paid or is obligated to pay those losses or expenses; nor shall a person's entry into such settlement constitute a violation of any contract between the person and such insurer.

No person entering into such a settlement shall be subject to a subrogation claim or claim for reimbursement by an insurer and an insurer shall have no lien or right of subrogation or reimbursement against any such settling person or any other party to such a settlement, with respect to those losses or expenses that have been or are obligated to be paid or reimbursed by said insurer.

* * *

APPENDIX D

UNITED STATES DISTRICT COURT

EASTERN DISTRICT OF NEW YORK

----------X

SALVATORE ARNONE,

Plaintiff,

-against-

AETNA, INC. d/b/a AETNA LIFE INSURANCE COMPANY

Defendant.

Civil Action No.

NOTICE OF REMOVAL

TO THE HONORABLE JUDGES OF THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF NEW YORK:

The defendant herein, Aetna Life Insurance Company s/h/a Aetna, Inc. d/b/a Aetna Life Insurance Company ("Aetna"), by its attorneys, Sedgwick LLP, respectfully represents as follows:

1. On or about August 15, 2013 an action was commenced against Aetna, in the Supreme Court of the State of New York, County of Suffolk, by plaintiff Salvatore Arnone ("plaintiff"). The suit is identified in the Supreme Court of the State of New York, County of Suffolk, as *Salvatore Arnone v. Aetna, Inc.*

d/b/a Aetna Life Insurance Company, Index No. 62304/2013.

2. The Summons and Verified Complaint is the initial pleading served upon Aetna which this action is based. The Plaintiff's process server served a copy of the Summons and Verified Complaint on the New York Department of Financial Services on August 15, 2013. The Verified Complaint alleges that the nature of this action is the wrongful denial of disability benefits under section 502(a)(1)(B) of the Employee Retirement Income Security Act of 1974("ERISA"). A copy of the Summons with Notice attached as **Exhibit "A."**

3. The Summons and Verified Complaint are the first papers received by Aetna in which plaintiff alleges a claim establishing the existence of federal question jurisdiction and consequently, this action is removable to this Court pursuant to 28 U.S.C. §1446(b).

4. The filing of this petition for removal is timely because it is within thirty (30) days of the date the defendant Aetna first received notice that this action became removable on the basis of federal question jurisdiction under 28 U.S.C. §1331. *See Whitaker* v. *American Telecasting, Inc.*, 261 F.3d 196 (2d Cir. 2001).[1]

---

[1] While 30 days after August 15, 2013 is actually September 14, 2013, that day falls on a Saturday and pursuant to Fed. R. Civ. P. 6(a)(3)(A), when a party's time to file its Notice of Removal is scheduled to expire on a weekend, that time is extended until the first accessible business day, which in this case was September 16, 2013. Therefore, Aetna timely filed its Notice of Removal in this case.

THIS ACTION IS REMOVABLE ON THE BASIS OF FEDERAL QUESTION JURISDICTION UNDER 28 U.S.C.§1441(A)

5. The basis for federal question jurisdiction is that plaintiff's claims relate to an employee welfare benefit plan (29 U.S.C. §1002(1)) because the above named plaintiff was allegedly eligible for disability benefits through his enrollment in the Konica Minolta Business Solutions, USA, Inc Long-Term Disability ("LTD") Plan ("Plan"). (Exhibit "A" at ¶¶ 5-6). The Plan is an employee welfare benefit plan established and maintained by an employer for the benefit of its employees. As a result, plaintiff's state law causes of action are completely preempted under ERISA. Pursuant to ERISA §502(a)(1); 29 U.S.C. §1132(e)(1), federal courts have primary jurisdiction over such claims. All of plaintiff's claims as articulated in its Summons and Verified Complaint are either preempted and/or removable to Federal Court. *See Aetna Health, Inc. v. Davila,* 542 U.S. 200 (2004); *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58 (1987).

6. The above-referenced action between plaintiff and Aetna is therefore one in which this Court has original jurisdiction under Title 28, United States Code, Section 1331 and is one that may be removed to this Court by Aetna, pursuant to the provisions of Title 28, United States Code, Section 1441(a) in that it is a civil action where the Complaint alleges a federal question.

THIS ACTION IS ALSO REMOVABLE ON THE BASIS OF DIVERSITY OF CITIZENSHIP JURISDICTION UNDER 28 U.S.C. §1332

7. 28 U.S.C. §1332(a)(1) provides in pertinent part that, "[t]he district courts shall have original jurisdiction of all civil actions where the matter in controversy exceeds the sum or value of $75,000, exclusive of interest and costs, and is between . . . citizens of different States." The party seeking removal bears the burden of establishing diversity jurisdiction. *Hertz Corp. v. Friend*, 130 S.Ct. 1181, 1194 (2010); *Frederico v. Home Depot*, 507 F.3d 188 (3d Cir. 2007).

A) This Action is Between Citizens of Different States

8. Plaintiff alleges he is a resident of the State of New York. (Exhibit "A" at ¶1). Plaintiff commenced this action against Aetna.

9. In determining diversity of the parties, "a corporation shall be deemed to be a citizen of any State by which it has been incorporated and of the State where it has its principal place of business." 28 U.S.C. §1332(c)(1); *see also Hertz Corp. v. Friend*, 130 S.Ct. 1181 (2010).

10. Defendant Aetna is a corporation organized under the laws of the State of Connecticut with its principal place of business located in the City of Hartford in the State of Connecticut.

11. Since the Defendant is not a citizen of New York, there is complete diversity of citizenship sufficient for removal.

B) <u>Plaintiff's Matter in Controversy Exceeds $75,000, Exclusive of Interest and Costs.</u>

12. Plaintiff's Complaint alleges a claim for breach of contract and for LTD benefits under ERISA §502(a)(1)(B) pursuant to the terms of the Plan, which was allegedly issued by Aetna. (Exhibit "A").

13. Plaintiff's Verified Complaint seeks an award of total damages in the amount of $564,566.54. (Exhibit "A" at ¶28).

14. Accordingly, based on plaintiff's alleged claims, the amount in controversy exceeds the monetary threshold of $75,000.00. (Exhibit "A" at ¶28).

15. By filing this Notice, Aetna does not waive its right to object to service, service of process, the sufficiency of process, venue, or jurisdiction, and specifically reserves the right to assert any defenses and/or objections to which it may be entitled.

WHEREFORE, petitioner Aetna, the defendant in this action described herein currently pending in the Suffolk County District Court as *Salvatore Arnone v. Aetna, Inc. d/b/a Aetna Life Insurance Company*, Index No. 62304/2013, prays that this action be removed from there to this Honorable Court.

Dated: New York, New York
September 16, 2013

Yours, etc.
SEDGWICK LLP

By: s/_____
Michael H. Bernstein (MB 0579)
Matthew P. Mazzola (MM 7427)
Attorneys for Defendant
AETNA LIFE INSURANCE COMPANY
225 Liberty Street – 28th Floor
New York, New York 10281-1004
(212) 422-0202

TO:

SIBEN & SIBEN, LLP
Michael P. DeNoto
Attorneys for Plaintiff
Office & P.O. Address
90 East Main Street
Bay Shore, NY 11706
(631) 665-3400

SUPREME COURT: STATE OF NEW YORK

COUNTY OF SUFFOLK

----------X

SALVATORE ARNONE,

Plaintiff,

-against-

AETNA, INC. d/b/a AETNA LIFE INSURANCE COMPANY

Defendant.

----------X

VERIFIED COMPLAINT

Index # 062304/2013

Plaintiff, SALVATORE ARNONE, by his attorneys Siben & Siben, LLP, complains of the defendant as follows:

1. That at all times hereinafter mentioned plaintiff is and was a resident of the County of Suffolk, State of New York.

2. Upon information and belief, that at all times hereinafter mentioned, defendant AETNA, INC., d/b/a AETNA LIFE INSURANCE COMPANY was and is a foreign corporation duly licensed to do insurance business in the State of New York.

3. Upon information and belief, that at all times hereinafter mentioned, defendant, AETNA, INC., d/b/a AETNA LIFE INSURANCE

COMPANY was a domestic corporation duly authorized to do insurance business in the State of New York.

4. Upon information and belief that at all times hereinafter mentioned the aforesaid defendant was and is an insurance company authorized by the New York State Insurance Department to issue disability insurance policies in the State of New York.

5. Plaintiff is 52 years of age, having been born on August 9, 1960, and prior to his disability had worked as a sales account executive for Konica Minolta Business Solutions, USA, Inc.

6. That through his employment as aforesaid, plaintiff applied for and was granted a disability insurance policy on or about August 20, 2007, by the defendant insurer under Group Policy #GP-877115, Employer Identification Number 13-1921089, Employee Identification #00411141.

7. That pursuant to said disability insurance policy, the plaintiff was to receive payments of Four Thousand Eight Hundred Eight One Dollars and Two cents ($4,881.02) from the date of his disability until he reaches sixty five (65) years of age.

8. That on June 26, 2009, the plaintiff sustained an injury and was unable to work and disabled from employment from June 26, 2009 through September 28, 2009.

9. That during said time plaintiff received workman's compensation benefits of Five Hun-

dred Fifty Dollars ($550.00) a week, except for the period of July 27, 2009 through July 31, 2009, which was considered vacation time.

10. That thereafter plaintiff attempted to return to work and worked until December 2, 2009, when the pain from his injuries forced him to cease working and again to collect his Five Hundred Fifty Dollars ($550.00) workman's compensation benefits.

11. That on or about December 2, 2009, the plaintiff applied for disability benefits through the policy maintained through his employer with the defendant insurer under Claim Number 2420001 and on or about March 31, 2010 the defendant insurer approved his claim and advised plaintiff that he was due Eighteen Thousand Seven Hundred Ten Dollars and Fifty Four cents ($18,710.54) for six (6) months payments commencing from the June 26, 2009 date of injury to March 31, 2010. However, defendant deducted Nine thousand One hundred Thirty Six Dollars and Ten Cents ($9,136.10) for Workman's Compensation Benefits plaintiff had received and on or about March 31, 2010 paid to plaintiff only Nine Thousand five hundred seventy four dollars and forty four cents ($9,574.44).

12. Commencing on April 30, 2010, and thereafter, defendant deducted the amount of plaintiffs workman's compensation payments in the amount of $2,383.33 from plaintiffs $4,881.01 disability benefit leaving the plaintiff a monthly benefit of $2,497.68 a month.

13. Thereafter, at the insistence of the defendant, plaintiff applied for Social Security Disability and was granted Two Thousand Four Hundred Fourteen Dollars ($2,414.00) a month in Social Security Disability Benefits. Plaintiff was also granted $1,206.00 in Social Security benefits for his daughter, Ariana Arnone and Michael Arnone.

14. Commencing on or about May 1, 2011, defendant discontinued paying plaintiff claiming that they had over paid him to that date.

15. Plaintiff does not dispute the deduction of his $2,414.00 Social Security payment from his Aetna disability payment, however, the $1,206.00 Social Security payment which was for his children should not be deducted from his benefits.

16. Plaintiff had commenced on November 23, 2009, a lawsuit in Supreme Court of the State of New York in Suffolk County against Meopta USA, Inc., claiming their negligence in causing his June 26, 2009, personal injury.

17. On or about August 10, 2012, and thereafter plaintiff no longer received the Five Hundred Fifty Dollars ($550.00) a week payment in Workman's Compensation Benefits.

18. On or about December of 2012, said suit against Meopta USA, Inc., was settled for $850,000.00 in payment of plaintiff's pain and suffering only.

19. From the aforesaid sum the Workman's Compensation Insurance carrier was repaid in

full and thereafter all sums deducted by the defendant, Aetna should have been reimbursed to plaintiff.

20. That by reason of the forgoing, plaintiff should be reimbursed $2,383.33 a month from June 26, 2009 to August 10, 2012, for a total reimbursement of $90,568.54.

21. That by reason of the forgoing after May 1, 2011, plaintiff should have been paid the sum of $2,467.00.02 per month until his 65th birthday on August 9, 2025, less any increases plaintiff may receive in Social Security Benefits in an amount presently unknown but believed to be in excess of a total of $424,000.00 plus the $90,566.54 as alleged in paragraph 20 herein.

22. That by reason of the forgoing, the plaintiff calculated his damages to be in a sum in excess of $514,566.54.

23. That plaintiff is in full compliance with all of the terms and conditions of the said disability insurance policy.

AS AND FOR A SECOND CAUSE OF ACTION

24. Plaintiff repeats, realleges and reiterates the allegations contained in Paragraphs 1 through and including 23 as if set forth at length herein.

25. Due to the defendant insurers breach of its contract to provide disability payments to plaintiff in the proper amount due under the terms

of the disability policy, plaintiff requests this Court to declare that the defendant insurer is obligated to pay plaintiff the sum of $2,467.02 a month from May 1, 2011 until plaintiff reaches the age of sixty five (65) on August 9, 2025.

AS AND FOR A THIRD CAUSE OF ACTION

26. Plaintiff repeats, realleges and reiterates each and every allegation contained in Paragraphs 1 through 23 as if set forth at length herein.

27. That be reason of the forgoing the defendant is in violation of 29 U.S.C. 1132 (Erisa Section 502) and plaintiff as a beneficiary of the Disability Insurance Policy through his employer brings this action pursuant to Section 502(a) of Erisa to recover benefits due him under the terms of the Disability Insurance Policy and to enforce his rights thereunder.

28. That by reason of the forgoing, plaintiff calculates his damages to be in the sum of $514,566.54 plus reasonable attorney's fees to be awarded pursuant to ERISA 502(a) estimated to be Fifty Thousand ($50,000.00) Dollars for total damages of $564,566.54.

WHEREFORE, the plaintiff demands judgment as follows:

A) On the first cause of action in the sum of $514,566.54;

B) On the second cause of action that the Court direct the defendant to pay monthly benefits of $2,467.02 retroactive to May 1, 2011 until plaintiff attains the age of sixty five (65) and otherwise directs defendant to perform according to the terms of the Insurance Contract;

C) On the third cause of action in the sum of $564,566.54 and

D) For interest, costs and disbursements and such other and further relief as to the Court may be just and proper.

Dated: Bay Shore, New York
August 1st, 2013

Yours etc.,

SIBEN & SIBEN, LLP
BY

s/

MICHAEL P. DeNOTO
Attorneys for Plaintiff
Office & P.O. Address
90 East Main Street
Bay Shore, NY 11706
(631) 665-3400

INDIVIDUAL VERIFICATION

STATE OF NEW YORK)

ss.:

COUNTY OF SUFFOLK)

The undersigned, being duly sworn, deposes and says: that deponent is one of the parties in the within action; that deponent has read the attached and knows the contents thereof; that the same is true to deponent's own knowledge, except as to those matters therein stated to be alleged on information and belief, and that as to those matters deponent believes it to be true.

Dated: Bay Shore, New York
August 1st 2013

s/_____
SALVATORE ARNONE

Sworn to before me this
1st, day of August, 2013.

s/_____

NOTARY PUBLIC

[Seal]