

Nos. 04-1224 and 04-1225

**UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT**

JEAN LEVINE,
Plaintiff – Appellee,

v.

UNITED HEALTHCARE CORPORATION,
Defendant – Appellant.

NOREEN BOGURSKI,
Plaintiff – Appellee,

v.

HORIZON BLUE CROSS BLUE SHIELD OF NEW JERSEY,
Defendant – Appellant.

BENJAMIN EDMONDSON,
Plaintiff – Appellee,

v.

HORIZON BLUE CROSS BLUE SHIELD OF NEW JERSEY,
Defendant – Appellant.

Appeal under 28 U.S.C. § 1292(b) from the Order of the United States District Court for the District of New Jersey, Entered on March 4, 2003, in Civil Action Nos. 01-4964 (JBS), 01-5339 (JBS) and 01-5812 (JBS), Denying Appellants' Motion to Dismiss Appellees' Complaints

**REPLY BRIEF OF APPELLANTS/CROSS APPELLEES
UNITED HEALTHCARE CORPORATION AND
HORIZON BLUE CROSS BLUE SHIELD OF NEW JERSEY**

Edward A. Scallet
William F. Hanrahan
Jason H. Ehrenberg
GROOM LAW GROUP, CHARTERED
1701 Pennsylvania Avenue, N.W., Suite 1200
Washington, DC 20006
(202) 857-0620

Counsel for United Healthcare Corporation

Edward S. Wardell
Kelley, Wardell & Craig, LLP
41 Grove Street
Haddonfield, NJ 08033
(856) 795-2220

Counsel for Horizon Blue Cross Blue Shield
of New Jersey

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JURISDICTIONAL STATEMENT

In its May 28, 2002 decision denying the motion to remand of plaintiffs-appellees-cross-appellants Jean Levine, Noreen Bogurski, and Benjamin Edmonson (collectively, "plaintiffs"),¹ the district court determined that it had original jurisdiction over plaintiffs' state-law claims pursuant to section 502(e) of the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1132(e). Plaintiffs moved to certify this ruling for interlocutory appeal pursuant to 28 U.S.C. § 1292(b), and the district court granted this motion by order dated October 6, 2003. By order dated January 14, 2004, this Court granted plaintiffs' petition, which was filed as a cross-petition to defendants' petition for interlocutory appeal, also granted on January 14, 2004. The Court of Appeals has jurisdiction pursuant to 28 U.S.C. § 1292(b).

¹ The parties have agreed to file a Stipulation of Dismissal pursuant to Fed. R. App. P. 42(b), requesting that the Court dismiss without prejudice the portion of Appeal No. 04-1225 captioned *Benjamin Edmonson v. Horizon Healthcare Services, Inc. d/b/a Horizon Blue Cross Blue Shield of New Jersey*, Civ. Action No. 01-5812 (JBS). However, until the Court issues any order pursuant to Rule 42(b) – and for purposes of the present brief – it will be assumed that Mr. Edmonson is still an active participant in this case.

STATEMENT OF THE ISSUES

The sole issue raised on plaintiffs' cross-appeal in Case No. 04-1225 is whether the district court erred as a matter of law when it denied plaintiffs' motion to remand and concluded that "plaintiffs' unjust enrichment claims for monies taken pursuant to subrogation and reimbursement provisions in their ERISA health plans are claims for benefits due within the meaning of ERISA section 502(a)." Appellants' Appendix ("A") at 95.

As noted in defendants' opening brief, the two issues presented in defendants' appeal in Case No. 04-1224 are:

1. Whether the district court erred as a matter of law when it denied defendants' motion to dismiss and found that the New Jersey collateral source statute, N.J.S.A. 2A:15-97, is not conflict preempted by ERISA section 514(a) because it is "saved" as a state law that regulates insurance under ERISA section 514(b)(2)(A). A 1, 63, 97.

2. Whether the district court erred as a matter of law when it denied defendants' motion to dismiss on the ground that *Perreira v. Rediger*, 169 N.J. 399 (2001) ("*Perreira*"), applies retroactively to invalidate claims determinations and settlements between ERISA plans and their participants that were made before that decision. A 1, 63, 97.

COUNTER-STATEMENT OF THE CASE

Pursuant to Federal Rule of Appellate Procedure 28(h), defendants are satisfied with plaintiffs' statement of the case on their cross-appeal, except as follows:

STATEMENT OF FACTS

Plaintiffs assert in their "Statement of Facts" that they were – in their actions against the tortfeasors that allegedly caused their injuries – "barred by New Jersey's collateral source statute, N.J.S.A. 2A:15-97, from recovering any loss by a third party, such as healthcare expenses covered by her insurance plan." Plf. Brief at 3, 4 and 5. Plaintiffs also assert that New Jersey's collateral source statute acted as a "statutory bar to [their] own recovery of healthcare expenses." *Id.*

These statements are without foundation in the record. The decision below denied the defendants' motion pursuant to Fed. R. Civ. P. 12(b)(6) to dismiss the complaints for failure to state a claim on which relief could be granted. Before the court were the complaints, the health insurance policies that contained the terms of the plaintiffs' health benefit plans, A 237 ff and A 283 ff, and a few letters between the insurance company defendants and plaintiffs' personal injury counsel memorializing the settlements of the subrogation claims at issue. A 230-36. In her complaint, Jean Levine alleged

nothing more than that she brought suit against the various entities responsible for her injuries and then settled the case. A 137, ¶¶ 11-12. Benjamin Edmondson made the same brief allegations of filing suit and settling. A 169, ¶¶ 11-12. Noreen Bogurski alleged only that defendant Horizon Blue Cross Blue Shield required "that its insureds must reimburse it . . . when the insured receive recoveries in the form of third party settlements or paid judgments from third party tortfeasors." A 147, ¶ 1.

The policy issued by The Travelers Insurance Company (United HealthCare Corporation's predecessor in interest) contained the following relevant provisions regarding the company's right to recover benefits that it had paid and which the insured recovers from a third party:

The Company shall require the return of health benefits paid for an Illness or Injury, up to the amount a Covered Person receives for that Illness or Injury through:

- a third party settlement;
- a satisfied judgment; or
- other means.

The Company will only require such payment when the amounts received through such settlement, judgment or otherwise, are specifically identified as amounts paid for health benefits for which the Company has paid benefits.

The repayment will be equal to the amount of benefits paid by the Company. However, the Covered Person may deduct the reasonable pro-rata expenses, incurred in effecting the third party payment from the repayment to the Company.

A 283.

The policy issued by Horizon Blue Cross Blue Shield of New Jersey contain these same provisions in virtually identical language. A 388.

SUMMARY OF ARGUMENT

I. Argument on Plaintiffs' Cross-Appeal

The district court denied plaintiffs' motion to remand because plaintiffs' state law claims for unjust enrichment were claims for "benefits due" under their ERISA plans, and therefore were claims within the scope of section 502(a)(1)(B) of ERISA, which authorizes a participant to sue "to recover benefits due under the terms of his plan." Claims that fall within the scope of ERISA § 502(a) are completely preempted, and the federal courts have jurisdiction over them, regardless of a plaintiff's attempt to characterize the claim as arising solely under state law. *Metropolitan Life Insurance Co. v. Taylor*, 481 U.S. 58, 63-64 (1987).

The district court's determination that plaintiffs' claims for unjust enrichment are completely preempted under ERISA § 502(a)(1)(B) is fully consistent with the authority in both this and other circuits. In *Pryzbowski v.*

U.S. Healthcare, Inc., 245 F.3d 266, 271 (3rd Cir. 2001), this Court stated that the test for determining whether a state law claim is completely preempted under ERISA § 502(a) "is whether the claim challenges the administration of or eligibility for benefits. . . ." Here, plaintiffs seek the recovery of the portion of the health benefits that defendants initially paid on their behalf and which plaintiffs refunded in satisfaction of the subrogation provisions contained in the health benefit plans and policies that covered plaintiffs. Plaintiffs allege that these subrogation provisions are unenforceable, and that they are therefore entitled to receive the full unreduced benefits that would be payable in the absence of the subrogation provisions. These are clearly claims for "benefits due" under section 502(a)(1)(B).

Since the district court rendered its decision, the Fifth Circuit, sitting *en banc*, and the Fourth Circuit have each addressed the precise question answered by the district court, and have agreed that state law claims virtually identical to the ones advanced here are claims for benefits due that are completely preempted and properly removed to federal court. *Arana v. Ochsner Health Plan*, 338 F.3d 433, 438 (5th Cir. 2003) (*en banc*), *cert. denied*, 124 S. Ct. 1044 (2004); *Singh v. Prudential Health Care Plan, Inc.*, 335 F.3d 278, 291 (4th Cir. 2003), *cert. denied*, 124 S. Ct. 924 (2003).

II. Argument on Defendants' Appeal

Plaintiffs have failed to demonstrate that New Jersey's collateral source statute, N.J.S.A. 2A:15-97, is saved from preemption under ERISA's insurance savings clause because the statute is "specifically directed" at the insurance industry. The New Jersey collateral source statute does not by its terms specifically impose any prohibitions on insurers. Rather, the statute is a law of general application that may be transgressed not only by insurers, but by insurers and non-insurers alike. The statute applies whenever a plaintiff receives a payment from any of a wide variety of sources and operates even where there is no insurance or insurance company on the horizon. *Kentucky Association of Health Plans, Inc. v. Miller*, 538 U.S. 329, 355 (2003). Consequently, N.J.S.A. 2A:15-97 is not "saved" from ERISA's provision preempting state laws that relate to employee benefit plans.

Plaintiffs have also failed to demonstrate that the *Perreira* decision should apply retroactively in these cases to invalidate claims determinations and settlements between ERISA plans and their participants that occurred before the decision. Plaintiffs' first argument in favor of retroactivity, that the *Perreira* decision did not establish a new rule of law or decide an issue of first impression, is simply wrong. The New Jersey Supreme Court considered an issue of first impression in *Perreira* when it decided whether health insurers

can enforce contractual subrogation provisions contained in policies issued to health plans.

Plaintiffs' second argument, that the equities in this case favor retroactive application, similarly misses the mark as utterly unsupported by any allegations of fact. Nothing in the record supports plaintiffs' wholly speculative claims that their tort recoveries were reduced by the operation of the New Jersey collateral source statute. New Jersey case law, as well as the limitations on subrogation rights contained in the insurance policies at issue, demonstrate that plaintiffs' speculations about receiving less than full recovery unless *Perreira* is applied retroactively are groundless.

The actual equities in this case strongly favor prospective application of *Perreira*. Retroactive application of *Perreira* would require the undoing of thousands of settled transactions spanning a nine-year period, and would undermine New Jersey's strong policy in favor of the final settlement of legal disputes. In like circumstances, the New Jersey Supreme Court has declined to apply its decisions retroactively.

ARGUMENT

I. Plaintiffs' claims to recover amounts they refunded to their employee benefit plans in satisfaction of their subrogation obligations are claims for "benefits due" under ERISA § 502(a)(1)(B). These claims are within the original jurisdiction of the district court, and the court properly retained jurisdiction over them.

In their cross-appeal, plaintiffs challenge the district court's May 28, 2002 Opinion and Order denying their motion to remand. The district court concluded that plaintiffs' state law claims for unjust enrichment were claims for "benefits due" under their ERISA plans, and therefore their "state law claims are claims within Section 502(a)(1)(B) of ERISA and were properly removed to federal court." A 180. Significantly, in arguing that removal was improper, plaintiffs have failed to address the substance of the district court's decision.

As the district court noted, the propriety of removal in this case turns on "whether the case falls within the original 'federal question' jurisdiction of the United States District Courts." A 182 (citing *Pryzbowski v. U.S. Healthcare, Inc.*, 245 F.3d 266, 271 (3rd Cir. 2001)). The court also correctly noted that, under the "well-pleaded complaint" rule, federal question jurisdiction exists only when an issue of federal law appears on the face of the complaint. *Id.* (citing *Pryzbowski*, 245 F.3d at 271). However, the court recognized that there is an exception to the well-pleaded complaint rule – "complete preemption."

Complete preemption occurs when Congress so pervasively occupies a particular field (here, enforcement of claims under ERISA) that any complaint that comes within the scope of a federal cause of action necessarily arises under federal law and is completely preempted. *Id.* at A 182-183. Complete preemption functions to recharacterize plaintiffs' state law claims as federal claims for purposes of removal, thereby creating federal removal jurisdiction. *Id.* at A 183. A claim that has been completely preempted is removable regardless of whether a federal claim appears from a reading of the complaint. *Metropolitan Life Insurance Co. v. Taylor*, 481 U.S. 58, 63-64 (1987).

In *Taylor*, the Supreme Court applied these principles to claims of breach of contract and retaliatory discharge arising out of an employer's alleged wrongful denial of disability benefits. The Supreme Court concluded that the breadth of ERISA's express preemption clause, coupled with ERISA's legislative history, confirmed that Congress intended that ERISA's civil enforcement scheme completely preempts all state law "causes of action within the scope of the civil enforcement provisions of § 502(a). . . ." Consequently, all such claims are removable to federal court. *Id.* at 66.

The district court's determination that plaintiffs' claims for unjust enrichment are completely preempted is fully consistent with the authority in both this and other circuits. As this Court explained in *Pryzbowski*, "the

ultimate distinction to make for purposes of complete preemption is whether the claim challenges the administration of or eligibility for benefits, which falls within the scope of § 502(a) and is completely preempted, or the quality of the medical treatment performed, which may be the subject of a state action." 245 F.3d at 273. The district court determined that under this test plaintiffs' claims were completely preempted because they "seek to recoup a benefit due under the plan. . . ." A 193. In so concluding, the district court noted that plaintiffs had conceded that "the monies plaintiffs now seek had their genesis as benefits," and that "when asked by the Court, plaintiffs' counsel was unable to give a clear statement of what the monies they sought were if not benefits." *Id.* at A 188.

Nevertheless, plaintiffs suggest that their state-law unjust enrichment claims are not within the scope of section 502(a)(1)(B) because the claims are not actually claims "for benefits due under the terms of [a] plan," but rather are claims for "damages resulting from the defendant insurers' unlawful conduct." Plf. Brief at 35. Plaintiffs argue that their claims directly relate to their tort recoveries from third parties and, therefore, are only remotely related to the health care benefits previously granted them by the plans with which defendants contract. This argument ignores the inextricable connection between plaintiffs' claims and their employee benefit plans.

Indeed, the claim set-offs that are at the heart of plaintiffs' complaints arise directly from the design of the plans. Specifically, the plans promised to pay benefits at a stated level to cover the medical costs of illnesses and injuries that plan participants might incur, but also provided that if a participant recovered all or a part of the costs of care from a third party, the quantum of benefits payable on account of the illness or injury would be reduced by the third-party recovery. Hence, the benefits promised under the plan were always contingent as to amount – the plans would pay the full cost of care, subject to reduction upon the satisfaction of the contingency of a third-party recovery. Clearly, if the plans withheld all payments until the completion of proceedings on the third party claim, and then paid only the net amount of benefits due when the participant obtained a recovery, there would be no serious doubt that the process of determining the final amount payable was a pure decision on a claim for benefits and that the net amount paid represents the quantum of benefits due under the terms of the plan.

Here, the defendants paid the full amount of the benefits apparently due and waited for the occurrence of the contingency of a third-party recovery. Defendants' subsequent enforcement of the subrogation and reimbursement provisions in the plans had the effect of reducing the total amount of the benefits plaintiffs received from those plans. That the process of determining

the final amount due occurred in two separate steps does nothing to change the nature of the amounts now in dispute. In essence, plaintiffs are seeking to recover the additional portion of the benefits that would be payable on account of their injuries if the plans' subrogation provisions are unenforceable. Consequently, the district court's refusal to remand these actions is right in line with the test set out in *Pryzbowski*.²

Case law from other circuits also supports the district court's denial of remand. For example, in *Singh v. Prudential Health Care Plan, Inc.*, 335 F.3d 278 (4th Cir. 2003), a health plan participant commenced an action in state court against her insurer alleging unjust enrichment and seeking primarily reimbursement of monies paid to the insurer pursuant to a subrogation provision in her health plan. The participant's complaint relied on the application of a state statute prohibiting subrogation. *Id.* at 289. The Fourth Circuit held that:

² Plaintiffs cite *Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350, 354 (3d Cir. 1995) for the proposition that, "it is clear that claims falling outside the specific remedies set out in § 502 do not give rise to federal jurisdiction." Plf. Brief at 36. This is a misreading of this court's statement that "[t]he Supreme Court has determined that Congress intended the complete-preemption doctrine to apply to state law causes of action which fit within the scope of ERISA's civil enforcement provisions." 57 F.3d at 354. As this court made clear in *Wood v. Prudential Ins. Co. of America*, 207 F.3d 674, 678 (3d Cir. 2000), "a state law claim may fall within Section 502(a) and thus be completely preempted even if the plaintiff asks for relief that is not available under section 502(a)."

Because Prudential successfully pursued a subrogation claim against [plaintiff's] recovery from a third party, the benefit sought is the return of funds taken pursuant to the plan's subrogation term that was negated by the Maryland HMO Act. At least this portion of the remedies sought falls within the scope of those provided by § 502(a). . . . [Plaintiff's] claim to recover the portion of her benefit that was diminished by her payment to Prudential 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. . . . Thus, for purposes of complete preemption under § 502(a), a claimant who is denied a benefit is no different than a customer who is faced with an invoice from the insurer for the return of a benefit paid or a claimant who has paid such an invoice, because resolution in each case requires a court to determine entitlement to a benefit *under the lawfully applied terms of an ERISA plan*. The jurisdictional aspect of ERISA's remedial scheme, which overpowers even the well-pleaded complaint rule, cannot itself be overpowered by clever or fortuitous maneuvers.

Id. at 291 (emphasis in original) (citing with approval the district court's May 28, 2002 Opinion and Order - *Carducci v. Aetna U.S. Healthcare*, 204 F. Supp.2d 796, 803 (D.N.J. 2002)).

A recent decision from the Fifth Circuit is also instructive. In *Arana v. Ochsner Health Plan*, 338 F.3d 433 (5th Cir. 2003) (*en banc*), *cert. denied*, 124 S. Ct. 1044 (2004), the plaintiff sued in state court for a declaratory judgment requiring his health insurer to release subrogation, reimbursement, and assignment claims on compensation the insured received from a third party

tortfeasor because such claims allegedly violated a Louisiana statute. 338 F.3d at 437. The Fifth Circuit held that the state law claim was completely preempted as falling within the scope of ERISA § 502(a)(1)(B). *Id.* In response to the plaintiff's argument that he did not seek relief under ERISA section 502(a)(1)(B) because he claimed entitlement to relief under Louisiana law, and not under the terms of his ERISA plan, the court stated that the plaintiff's claim could "fairly be characterized either as a claim 'to recover benefits due to him under the terms of his plan' or as a claim 'to enforce his rights under the terms of the plan.'" *Id.* at 438. The court explained that:

As it stands, [plaintiff's] benefits are under something of a cloud, for [defendant] is asserting a right to be reimbursed for the benefits it has paid for his account. It could be said then, that although the benefits have already been paid, [plaintiff] has not fully 'recovered' them because he has not obtained the benefits free and clear of [defendant's] claims. Alternatively, one could say that [plaintiff] seeks 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.

*Id.*³

³ Plaintiffs cite three district court decisions for the proposition that "federal courts in similar cases have found that analogous claims are not preempted by ERISA and that defendants' removal was therefore improper." *See* Plf. Brief at 39. Two of the cases are from the District of Maryland, and they relied on the subsequently vacated panel decision in *Arana v. Ochsner Health Plan, Inc.*, 302 F.3d 462 (5th Cir. 2002). *McKandes v. Blue Cross and* (continued...)

As in *Singh* and *Arana*, plaintiffs' attempts here to frame their claims as claims arising only under state law are unavailing. Plaintiffs now claim that defendants had no right to reduce the maximum benefits due plaintiffs under the terms of their employee benefit plans because of N.J.S.A. 2A:15-97, the New Jersey collateral source statute. Plaintiffs could have made that argument at the time defendants sought reimbursement of these benefits, and if the defendants did not agree, there is no doubt that plaintiffs could have brought claims under section 502(a)(1)(B) to determine whether the quantum of benefits owed by the plans should be determined with reference to the reimbursement provisions of the plans. As the Fourth Circuit noted in *Singh*, the only difference between that hypothetical case and the one at bar is that plaintiffs want the opportunity to argue that the plan reimbursement provisions

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Blue Shield Assoc., 243 F. Supp.2d 380, 384-85 (D.Md. 2003); *Popoola v. MD-Individual Practice Assoc., Inc.*, 244 F. Supp.2d 577, 581 (D. Md. 2003). Moreover, the holdings in these cases have since been directly overruled by *Singh*. Plaintiffs' reliance on *Serraiocco v. Seba*, 286 F. Supp.2d 860 (E.D. Mich. 2003) is similarly misplaced. There, the court believed that the case before it was distinguishable from both the district court's decision in this case and the comparable district court decision in *Arana* (subsequently affirmed by the full Fifth Circuit) because the case removed to federal court was the plan participant's state law lawsuit against his tortfeasor, in which the insurer was joined as an additional party defendant. The district court believed that this different procedural posture made the case before it unremovable. *Id.* at 865.

(continued...)

are unenforceable many years after they reached settlements of their disputes with defendants. 335 F.3d at 291-92.

In sum, these cases at heart ask the court to determine the ultimate quantum of benefits owed by the plans to participants. As the district court below found, "[i]n order to award plaintiffs the relief they seek, this Court must determine the content of the ERISA plan." A 193. If this case does not involve the "various mechanisms and institutions involved in the . . . payment of plan benefits," *Dukes*, 57 F.3d at 356, then it is difficult to conceive of a case that does.

II. New Jersey's collateral source statute is a law of general applicability that is not saved from preemption by ERISA's "insurance savings clause."

Plaintiffs have failed to demonstrate that New Jersey's collateral source statute, N.J.S.A. 2A:15-97, is saved from preemption under ERISA's insurance savings clause because the statute is "specifically directed" at the insurance industry.⁴ As noted in the opening brief, defendants do not disagree with the

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Whatever the merits of this procedural distinction, it is clear the *Serraiocco* court's analysis has no bearing on the present case.

⁴ Although they admit that the district court below did not certify the question whether N.J.S.A. 2A:15-97 "relates to" plaintiffs' employee benefit plans, plaintiffs nevertheless expend a great deal of energy arguing that the New Jersey statute does not "relate to" their plans. There are at least two

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district court's observation that the "primary purpose" of the New Jersey collateral source statute was to disallow double recovery to plaintiffs, or the court's observation that, because insurers are often involved in tort cases and health plans, the statute's "secondary goal was clearly the containment of spiraling [liability] insurance costs." Def. Brief at 11. But the fact that N.J.S.A. 2A:15-97 applies to insurers in certain circumstances does not mean that the statute is "specifically directed" towards insurers or insurance.

Plaintiffs place great reliance on the Supreme Court's recent decision in *Kentucky Association of Health Plans, Inc. v. Miller*, 538 U.S. 329 (2003).

That case, however, demonstrates why the New Jersey statute at issue in this

(...continued)

reasons why plaintiffs did not pursue certification on this question. First, in the district court plaintiffs conceded that N.J.S.A. 2A:15-97 "relates to" employee benefit plans. Plaintiffs' Memorandum of Law In Support of Motion To Remand Action To State Court, filed November 13, 2001, at 6 ("The first prong of the three pronged ERISA preemption test is whether or not the New Jersey statute and regulations 'relate to' an employee benefit plan. No one could seriously doubt that this test is satisfied"). Second, the very cases that plaintiffs cite in support of their argument that antisubrogation laws are saved from preemption by the savings clause hold that these laws "relate to" employee benefit plans. *See, e.g., Singh*, 335 F.3d at 284 ("Indeed, both the Supreme Court and this court, recognizing the expansive sweep of § 514(a) preemption, have held that State antisubrogation laws 'relate to' an employee benefit plan.") (citing *FMC Corp. v. Holliday*, 498 U.S. 52, 58 (1990) and *Hampton Indus., Inc. v. Sparrow*, 981 F.2d 726, 729 (4th Cir. 1992)).

case is *not* "specifically directed" at insurance and, therefore, not saved from preemption as a state law regulating insurance.⁵

The petitioners in the *Miller* case included several health maintenance organizations ("HMOs") and a Kentucky-based association of HMOs. *Miller*, 538 U.S. at 332. The petitioners sued the Commissioner of Kentucky's Department of Insurance, asserting that ERISA preempted Kentucky's "any willing provider" ("AWP") laws, which allegedly impaired the petitioners' right to limit the number of providers with access to their networks, and thus their ability to use the assurance of high patient volume as the *quid pro quo* for the discounted rates that network membership entails. *Id.* The specific Kentucky laws at issue in *Miller* were contained in the Kentucky Insurance Code, and provided in relevant part that:

⁵ As plaintiffs note, the Supreme Court in *Miller* identified two factors that must be met in order for a state law to be considered a law that regulates insurance for purposes of the savings clause. First, the "state law must be specifically directed toward entities engaged in insurance." Second, the "state law must substantially affect the risk pooling arrangement between the insurer and the insured." *Miller*, 538 U.S. 341-42. A state law is only saved from preemption under the savings clause when both factors are satisfied. *Id.* As defendants have demonstrated here, and in our opening brief, N.J.S.A. 2A:15-97 is clearly not "specifically directed toward" insurance and, therefore, is not saved from preemption. Thus, there is no need for the Court to consider whether the statute affects the insurance practices or risk pooling arrangements of insurers.

A health insurer shall not discriminate against any provider who is located within the geographic coverage area of the health benefit plan and who is willing to meet the terms and conditions for participation established by the health insurer, including the Kentucky state Medicaid program and Medicaid partnerships.

Ky. Rev. Stat. Ann. § 304.17A-270 (emphasis added).

Notwithstanding the statute's facial limitation to health insurers, the petitioners argued that the laws were not "specifically directed" toward insurers because they regulated not only the insurance industry, but also health-care providers who seek to form and maintain limited provider networks with HMOs. *Miller*, 538 U.S. at 334. The Supreme Court disagreed. The Court concluded that the AWP laws did not, *by their terms*, impose any prohibitions on health-care providers. *Id.* at 335. Rather, the laws were only transgressed when a "health insurer" excluded from its network a provider who was willing and able to meet its terms. Obviously, a consequence of the AWP laws was that health-care providers, who themselves were not insurers, could not enter into certain agreements with Kentucky insurers. But this did not mean that the laws were not "specifically directed" at insurers. As the Court observed, laws specifically directed toward certain entities will almost always disable other entities from doing what the regulations forbid. For example, a state law specifically directed at health insurers that prohibits the inclusion of a

subrogation provision in the policies they issue also prevents inhabitants in the state from obtaining reduced insurance premiums by entering into an enforceable insurance contract that includes subrogation. *Id.*

Given the Court's analysis in *Miller*, one cannot reasonably argue that N.J.S.A. 2A:15-97 is "specifically directed" at insurers. Unlike the AWP laws at issue in *Miller*, the New Jersey collateral source statute does not *by its very terms* specifically impose any prohibitions on insurers. And, unlike the AWP laws in *Miller*, N.J.S.A. 2A:15-97 is a law of general application that may be transgressed not only by insurers, but by insurers and non-insurers alike. As we point out in our opening brief, the statute applies whenever a plaintiff receives a payment from any of a wide variety of sources. *See* Def. Brief at 15. Thus, whereas the AWP laws in *Miller* could not operate in the absence of insurers, N.J.S.A. 2A:15-97 applies with equal force whenever a plaintiff obtains reimbursement from a third-party source of any kind, and regardless of whether the defendant has liability insurance to cover his exposure. Consequently, New Jersey's collateral source rule operates even where no party to the "civil action" governed by the rule has an insurance policy.

Of course, New Jersey's collateral source statute, as now interpreted by *Perreira*, does apply when the plaintiff's collateral source is a health insurance policy, and it may even be true that the majority of cases where the statute is

invoked involves health insurance as the collateral source. But even though the statute may have more of an effect on insurance companies than others does not mean that the law is "specifically directed" at insurers.

The Supreme Court made this clear in *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987), where the Court examined whether Mississippi's common law of bad faith was saved from preemption as a law regulating insurance. The Court noted that, "[e]ven though the Mississippi Supreme Court has identified its law of bad faith with the insurance industry, the roots of this law are firmly planted in the general principles of Mississippi tort and contract law." 481 U.S. at 50 (emphasis added). The Court went on to note that "[a]ny breach of contract, and not merely breach of an insurance contract, may lead to liability for punitive damages under Mississippi law." *Id.* The Court therefore held that the law of bad faith was not specifically directed at the insurance industry and was not saved from preemption as a law regulating insurance. *Id.*

Likewise here, even if the New Jersey Supreme Court has, as plaintiffs contend, identified N.J.S.A. 2A:15-97 with the insurance industry, *see* Plf. Brief at 14, that does not change the actual terms of the statute, which is silent about its impact on insurers.⁶ Nor does this "identification" with the insurance

⁶ Indeed, the plain language of the statute demonstrates that it is not specifically directed towards insurers. The statute says that any benefits
(continued...)

industry mean that the statute will not be given full effect in every case to which it applies, even where no policy of insurance is involved in any fashion. Instead, just like the Mississippi law of bad faith, the collateral source statute is one of general applicability with its roots firmly planted in general principles of New Jersey evidence and tort law. Even plaintiffs have conceded this point:

[T]he New Jersey collateral source statute was not designed to prohibit or mandate any specific insurance coverages nor to require any particular plan structure. Instead, it was a tort reform effort, aimed at eliminating "double recoveries" to plaintiffs. . . .

Plf. Brief at 10 n.1.

Notwithstanding their concession about New Jersey's rule, plaintiffs cite several cases involving other states' antisubrogation laws in support of the proposition that "courts examining statutes limiting subrogation recoveries

(...continued)

received by a plaintiff "for the injuries allegedly incurred from *any other source other than a joint tortfeasor*" will be reduced. *See* N.J.S.A. 2A:15-97 (emphasis added). The statute excludes two categories of benefits from being reduced – "workers compensation benefits" and "proceeds from a life insurance policy". *Id.* Clearly, the terms "benefits received" were meant to encompass more than just insurance proceeds. Moreover, the use of the phrase "proceeds from a life insurance policy" demonstrates that the New Jersey legislature knew how to make specific reference to insurance. If the provision was to be specifically directed at insurance, it likely would have read "if a plaintiff receives or is entitled to receive proceeds from any other source other than a joint tortfeasor, including proceeds from an insurance policy, for the injuries allegedly incurred. . . ."

have consistently found them to be specifically directed towards the insurance industry and therefore saved from preemption." Plf. Brief at 14-17. These cases provide little comfort to plaintiffs. For example, the Pennsylvania antisubrogation rule at issue in both *FMC Corp. v. Holliday*, 498 U.S. 52 (1990) and *Bill Gray Enterprises, Inc. Employee Health & Welfare Plan v. Gourley*, 248 F.3d 206 (3d Cir. 2001), is contained in Pennsylvania's motor vehicle liability insurance laws and "prohibits insurance providers from obtaining reimbursement payments from recoveries an insured receives from third parties in a motor vehicle accident." *Bill Gray Enterprises, Inc.*, 248 F.3d 213 n.4. Similarly, in *Singh v. Prudential Health Care Plan, Inc.*, 335 F.3d 278 (4th Cir. 2003), the court concluded that the antisubrogation rule in the Maryland HMO Act regulated insurance because it applied only to HMOs, which are treated as insurers for some purposes under Maryland law. *Id.* at 284-85. Likewise, the Virginia law at issue in *Health Cost Controls v. Whalen*, No. Civ. 1:96-66A, 1996 WL 787163 (E.D. Va. Aug. 14, 1996), applied only to "insurance contracts," *Id.* at *1. These laws, by their very terms, were directed solely at the insurance industry and were applicable only to insurance contracts. None of the cases that plaintiffs cite involve a statute like N.J.S.A. 2A:15-97,

which does not even mention insurers and which operates regardless of the existence of insurance.⁷

In sum, plaintiffs have offered no convincing reason to believe that New Jersey's collateral source statute is saved from preemption under the insurance savings clause. While it is certainly possible for a state to devise an antisubrogation statute specifically directed towards insurers, as Pennsylvania has done in its motor vehicle liability insurance law, the New Jersey legislature

⁷ Plaintiffs also cite *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355 (2002), for the proposition that "the fact that a statute mandating external review was drawn to encompass entities other than insurers [does] not take it out of the reach of the savings clause." Plf. Brief at 18. Plaintiffs' characterization of this decision, at best, vastly overstates what the Court actually said. *Rush Prudential* involved a state external review law that required HMOs, and only HMOs, to provide a mechanism for the independent review of disputes between a primary care physician and an HMO by a physician unaffiliated with the HMO. *Id.* at 359. The petitioners argued that the law was not specifically directed at insurance because it swept too broadly with definitions capturing organizations that provide no insurance. The Supreme Court rejected this argument, finding that the argument was "based on unsound assumptions" and that it was "far from clear" that the terms of the statute would even theoretically apply to entities other than HMOs acting as insurers. *Id.* at 371. Moreover, the Court observed, "[e]ven on the most generous reading of the petitioners' argument, it boiled down to the bare possibility (not likelihood) of some overbreadth in the application of the statute beyond HMOs . . ." In the Court's view this "bare possibility" was insufficient to take the statute out of the scope of ERISA's insurance savings clause. *Id.* Here, there is far more than a possibility or even a likelihood of application of the New Jersey statute beyond insurers – the statute has actually been applied to reduce tort plaintiffs' awards by amounts received from sources other than insurance. *See, e.g.*, cases cited in defendants' opening brief at 15-16.

chose a different path, and enacted a general antisubrogation rule that applies in "any civil action." New Jersey's statute is therefore not saved from ERISA preemption.

III. The district court erred when it denied defendants' motion to dismiss on the ground that *Perreira* applies retroactively to invalidate subrogation rights contained in Plaintiffs' pre-*Perreira* ERISA plans.

Plaintiffs make two principal arguments in support of their assertion that the *Perreira* decision should be applied retrospectively in this case. First, they argue that the New Jersey Supreme Court concluded in *Perreira* that "health insurers" have never had a common law right to equitable subrogation. Plf. Brief at 22, 24. Thus, plaintiffs contend, "*Perreira* did not establish a new rule of law by overruling precedent." *Id.* at 26. Second, plaintiffs argue that equitable considerations also require retroactive application of *Perreira* in this case. *Id.* at 28-34.

Plaintiffs' first argument is contradicted by the very authorities on which they rely. In *Perreira*, the health insurance company argued that the interpretation of the New Jersey collateral source statute must take into account "a common-law equitable right to subrogation that pre-dated N.J.A.S. 2A: 15-97. . . ." After examining the authorities, the New Jersey Supreme Court concluded that "[w]e are satisfied that no *equitable* remedy of subrogation was available to health insurers in 1987, at the time N.J.S.A. 2A:15-97 was

enacted." *Perreira*, 169 N.J. at 414 (emphasis added). Plaintiffs jump from this statement to the wholly unwarranted conclusion that "[t]here were no prior reported decisions establishing that health insurers had any fundamental right to subrogation and/or reimbursement. . . ." Plf. Brief at 26.

Plaintiffs have confused the doctrine of equitable subrogation, which is not dependent on a consensual, contractual right of subrogation, with a right of contractual subrogation, which exists only if the underlying contract specifically so provides. Compare *Perreira*, 169 N.J. at 414 ("courts typically have not implied a *non-contractual* or non-statutory right to subrogation in health insurance") (emphasis added) with *Camden Fire Ins. Ass'n v. Prezioso*, 93 N.J. Eq. 318, 319 (Ch. Div. 1922) ("The policy contains the usual clause subrogating the insurance company to the rights of the insured against tortfeasors."); see *Providence Washington Ins. Co. v. Hogges*, 67 N.J. Super. 475 (App. Div. 1961) (recognizing an insurer's right of contractual subrogation and stating that an insurer's rights of equitable subrogation can be altered by contract).

Both types of subrogation were at issue in *Perreira*. The court concluded that there was no right to equitable subrogation in response to the insurers' argument that the doctrine had to be taken into account in analyzing the meaning of the New Jersey collateral source statute. *Perreira*, 169 N.J. at

411, 414. The Court then went on to consider explicit contractual subrogation and concluded, based on other considerations, that the statute invalidated the explicit contractual provisions permitting health insurers to seek subrogation which had existed since the Department of Insurance had first adopted a regulation permitting them in 1993. *Id.* at 415-16.

Thus, while the New Jersey Supreme Court did not break new ground in its brief discussion of equitable subrogation, it most certainly considered a question of first impression when it decided whether contractual subrogation provisions such as those at issue here were enforceable. Up until *Perreira*, no court in New Jersey had addressed the precise question. The only legal authority directly on point was the Department of Insurance regulations, and defendants certainly acted reasonably in relying on this authority, especially when the New Jersey courts had long recognized the enforceability of such contractual provisions in other types of insurance policies. *See, e.g., Hartford Fire Ins. Co. v. Riefolo Const. Co., Inc.*, 81 N.J. 514, 523 (1980) (stating that it is "well settled" in New Jersey that subrogation based on contractual obligations of an insured to an insurer exists in favor of the insurer) (citing *Standard Accident Ins. Co. v. Pellicchia*, 15 N.J. 162, 178 (1954)).

Whether the *Perreira* decision is characterized as establishing a new rule of law by overruling the Department of Insurance's regulations or by deciding a

question of first impression on contractual subrogation under the collateral source statute, or both, the result remains the same. "Prospective application is appropriate where a decision establishes a principle of law by overruling past precedent or by deciding an issue of first impression." *Henderson v. Camden County Municipal Utility Authority*, 176 N.J. 554, 561-62 (2003) (quoting *Montells v. Haynes*, 133 N.J. 282, 295 (1993)).

Plaintiffs' second argument in favor of retroactivity essentially asks the Court to ignore the equities at issue in this case. In determining whether to apply a rule prospectively, the court "must weigh, among other things, whether retroactive application could produce substantial inequitable results." *Id.* at 563. *See also A.B. v. S.E.W.*, 175 N.J. 588, 596 (2003); *Cox v. RKA Corp.*, 164 N.J. 487, 514 (2000).

Plaintiffs argue, without any foundation in the record, that retroactive application of *Perreira* is necessary because plaintiffs were "barred by . . . N.J.S.A. 2A:15-97, from recovering any loss insured by a third party, such as healthcare expenses covered by her insured plan." Plf. Brief at 3, 4, and 5. Thus, they argue, retroactive application is necessary "to ensure that the plaintiffs were fully compensated," Plf. Brief at 31, and because "the departure from the existing law, purportedly authorized by the Commissioner's rule, resulted in reducing recoveries of insureds, who by virtue of N.J.S.A. 2A:15-97

already had their recoveries offset by the medical payments received from the insurers." Plf. Brief at 30.

These recitals of the "equities" weighing in favor of retroactive application are utterly unsupported by any allegations of fact in the complaints. Plaintiffs have never alleged that the collateral source statute has hampered or prohibited them from making a full recovery for their health care costs from their tortfeasors. Ms. Levine alleged nothing more than that she filed suit against her tortfeasor and then settled the case. A 137, ¶¶ 11-12. Mr. Edmonson made the same bare-bones allegations of filing suit and settling. A 169, ¶¶ 11-12. Ms. Bogurski's complaint is totally silent on the circumstances of her own recovery against any third party. At most, she alleges that defendant Horizon Blue Cross Blue Shield required "that its insureds must reimburse it . . . when the insured receive recoveries in the form of third party settlements or paid judgments from third party tortfeasors." A 147, ¶ 1.

Nothing in the three complaints even hints that the plaintiffs' tort recoveries were diminished as a result of the collateral source statute. Instead of alleging any facts showing that plaintiffs have suffered the double whammy of a reduced recovery from their tortfeasors based on the collateral source rule, followed by payments to defendants in satisfaction of claims for subrogation to

funds that the plaintiffs never actually received, plaintiffs have simply hypothesized that "if the liability insurers did in fact deduct amounts that the plaintiffs received from health insurers, and the health insurers took the amounts they paid, retroactive application [is] needed to ensure that the plaintiffs were fully compensated." Plf. Brief. at 31. In short, plaintiffs' entire "equitable" argument for retroactive application of *Perreira* is grounded on nothing more than rank speculation.

Even worse, plaintiffs' speculations that the collateral source statute somehow reduced their tort recoveries is belied by the manner in which the New Jersey courts have actually applied the collateral source statute in cases where there was a facially valid claim for subrogation. By its terms, and as interpreted by the New Jersey courts, the statute does not prohibit a plaintiff from submitting evidence of his or her medical expenses arising from an injury, even where those expenses have been covered in whole or in part by a third party health insurer. The plaintiff presents evidence of his medical expenses to the jury, and the jury is entitled to render a verdict based on the full expenses that the plaintiff has incurred. After the jury verdict, the defendant tortfeasor may present to the judge evidence of the third party reimbursement that the plaintiff received to cover all or a part of his medical expenses, and the judge then reduces the verdict by the amount of the third party payment. *Dias v. A.J.*

Seabra's Supermarket, 310 N.J. Super. 99, 102 (App. Div. 1998) ("The Legislature chose when it enacted N.J.S.A. 2A:15-97 to adopt the procedure of post-verdict modification, rather than simply declaring that evidence of such reimbursed expenses would be inadmissible . . . We are not free to disregard the distinction the Legislature has so clearly drawn.").

The New Jersey courts also made it absolutely clear that where the collateral source statute did *not* prohibit the third party from seeking subrogation of medical expenses that a jury awarded against the tortfeasor, the judge could *not* reduce the judgment by the amount that the third party paid to cover the plaintiff's medical expenses. For example, in *Lusby v. Hitchner*, 273 N.J. Super. 578 (App. Div. 1994), plaintiff's medical expenses were paid under the federal Medicaid program. The federal program provided for a right of subrogation, which preempted the collateral source statute. Because the plaintiff would not receive a "double recovery" where Medicaid had an enforceable subrogation right, the trial court could not reduce the verdict against the tortfeasor by the amount that Medicaid had paid. *Id.* at 591 (collateral source statute cannot be applied to reduce the verdict against the tortfeasor "where, as here, a plaintiff could not in any case pocket a double recovery for medical expenses for the reasons that his entire recovery is subject to Medicaid's reimbursement rights.").

The New Jersey courts applied this same limitation on the operation of the collateral source statute in cases where, before *Perreira*, health insurers sought to enforce their contractual subrogations rights. In *Werner v. Latham*, 332 N.J. Super. 76 (App. Div. 2000), the health insurance company covered the plaintiff's \$510,000 in medical expenses. The plaintiff settled his claim against the tortfeasors for about \$580,000, but only because the tortfeasors' combined insurance coverage was \$600,000, and a judgment in excess of that amount was uncollectable. *Id.* at 80-81. Relying on the appellate division's decision in *Perreira*, which upheld the right of a health insurer to pursue a subrogation claim under the terms of its policy notwithstanding the collateral source statute, the *Werner* court upheld the insurer's right to seek subrogation of the medical expenses that it paid, but limited that right under the "make whole" doctrine to ensure that the health insurer could not recover amounts that the plaintiff did not himself recover from the tortfeasor. *Id.* at 82 ("[W]hether by judgment or settlement a plaintiff is not entitled to retain payment of medical expenses by the tortfeasor that his carrier has already covered. By the same token, the health carrier's right of reimbursement is limited to that portion of the judgment or settlement reasonably attributable to medical expenses only.").

As these cases make clear, when the plaintiffs in this case sued their tortfeasors and then settled their claims, they were in a position to argue that

the tortfeasors could not rely on the collateral source statute to reduce the tortfeasors' exposure to damages claims for medical benefits. Plaintiffs have certainly not alleged in their complaints here that their tort settlements were *in fact* diminished by concerns over the operation of the collateral source statute. And plaintiffs have not alleged that when they settled their subrogation claims with their health insurers – after settling with the tortfeasors – that they paid amounts to the insurers that they never in fact received from the tortfeasors.

Any remaining doubt about this is resolved by the terms of the policies at issue here. Both policies make it clear that the insurance company "will only require such payment when the amounts received through such settlement, judgment or otherwise, are specifically identified as amounts paid for health benefits for which the Company has paid benefits." A 283, 388. In the face of that direct limitation, there is no reason to believe that plaintiffs reimbursed (or agreed to reimburse) defendants for health payments that they never in fact received from their tortfeasors.

In short, plaintiffs' appeal to the "equities" is wholly unsupported. Instead, what the New Jersey case law and the terms of plaintiffs' policies reveal is that plaintiffs are now, through this lawsuit, hoping to secure the double recoveries on medical expenses that the New Jersey legislature and the New Jersey courts have said they should not receive.

In the opening brief, defendants argued that giving retroactive effect to *Perreira* would manifestly have an adverse impact on the administration of justice because it would allow Plaintiffs to undo voluntary settlements that were concluded long before the decision in *Perreira*. Plaintiffs have completely failed to answer this point. New Jersey has a "strong public policy favoring the settlement of litigation," and absent fraud or other compelling circumstances, "a subsequent change in the law is not a sufficient reason to rescind a settlement agreement." *Zuccarelli v. Dep't.*, 326 N.J. Super 372, 380-381 (App. Div. 1999). Applying these principals in a similar context, the New Jersey Appellate Division has noted that, because plaintiffs in the overwhelming majority of third-party lien actions are represented by counsel who either negotiated or accepted the liens without question, to suggest that these voluntary settlements can or should be undone is to suggest "a process that, on balance, will be more disruptive than productive." *Kuhnel v. CNA Insurance Companies*, 322 N.J. Super 568, 580 (1999). The same is true here.

Defendants also argued in the opening brief that the equities weighed strongly against giving *Perreira* retroactive application, relying principally on the recent decision in *Henderson v. Camden County Municipal Utility Authority*, 176 N.J. 554 (2003). Plaintiffs' attempt to distinguish this case from *Henderson* are completely unavailing. *See* Plf. Brief at 29-30.

The relevant aspects of *Henderson* are readily apparent:

- The plaintiff filed a class action complaint alleging that her municipal and county utilities' assessment of compound interest on her delinquent utilities account was unlawful because a New Jersey statute allegedly authorized only simple interest. 176 N.J. at 588.
- The plaintiff sought declaratory judgments declaring null and void all previously assessed compound interest charges and enjoining utilities from charging any further interest. *Id.*
- The New Jersey Supreme Court agreed that the New Jersey statute at issue did not authorize the utilities to charge compound interest. 176 N.J. at 561.

All one need do is substitute "health insurers" for "utilities" and "subrogation claims" for "compound interest charges," and the description of the *Henderson* decision becomes the description of *Perreira*. However, in *Henderson*, the court went on to consider the propriety of applying its new rule of law retroactively, an issue that was squarely presented because the plaintiff and the class she represented explicitly sought the unraveling of nine years of compound interest charges for thousands of class members. In contrast, the *Perreira* court was not asked to consider the question of retroactive application; the plaintiffs sought nothing more than a judgment prohibiting

their health insurers from pursuing pending subrogation claims. *Perreira*, 169 N.J. at 403-04.

The *Henderson* court, faced with the question of retroactivity, determined that its ruling established a new rule of law by deciding an issue of first impression. The court explained that "an issue of statutory construction that implicates an established practice and that courts have not yet addressed presents an issue of first impression." *Id.* at 562. *Perreira*, of course, did exactly the same thing.

Most significantly, in deciding whether retroactive application of its decision could lead to "substantial inequitable results," the *Henderson* court noted that a refund of the previously collected compound interest would engage the utilities in an "exhaustive review" of bills that spanned a period of almost nine years. *Id.* Moreover, the court concluded, retroactive application of its decision likely would cause other utilities authorities throughout New Jersey to incur "considerable expense and administrative hardship in the process of computing and issuing potential refunds." *Id.* In view of these difficulties, the court determined that retroactive application of its decision could produce substantial inequitable results. *Id.* Thus, the court decided to apply its decision

prospectively and declined to require refunds of compound interest charges that the plaintiff and other customers already had paid. *Id.* at 563.⁸

The same concerns are present in this case. A refund of the amounts defendants previously collected from plaintiffs and the classes they purport to represent would engage defendants in an "exhaustive review" of records that span a period of almost nine years, and cause defendants and other New Jersey health insurers to incur "considerable expense and administrative hardship in the process of computing and issuing potential refunds." *Id.* Notably, in their class action allegations, plaintiffs have asserted that they "reasonably believe[] there are *thousands* of persons" in each class. A 138, A 148, A 170.

Plaintiffs' attempt to distinguish *Henderson* from the present case fails for the simple reason that in all material respects, the utilities' situation is identical to the situation of New Jersey health insurers, who would be faced with unraveling thousands of settled transactions. Giving *Perreira* retroactive application would produce exactly the same "substantial inequitable results"

⁸ For substantially the same reasons, plaintiffs' attempts to distinguish *SASCO 1997 NI, LLC v. Zudkewich*, 166 N.J. 579 (2001), are unavailing. Here, as in that case, (1) the New Jersey Supreme Court announced a new rule of law, and (2) the evidence demonstrated that the commercial lender seeking prospective application had reasonably relied on a practice apparently dominant throughout the industry. *Id.* The court held that, in light of that practice, retroactive application would greatly prejudice the entire commercial
(continued...)

that the New Jersey Supreme Court wisely avoided in *Henderson*. This court should do the same.

(...continued)

lending industry. Therefore, the court concluded that pure prospectivity was warranted. The same is true here.

CONCLUSION

Based on the foregoing, appellants respectfully request that this court reverse the district court's denial of their motion to dismiss the complaints and uphold the district court's denial of plaintiffs' motion to remand.

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Respectfully submitted,

Edward A. Scallet
William F. Hanrahan
Jason H. Ehrenberg
Groom Law Group, Chartered
1701 Pennsylvania Avenue, N.W.
Washington, D.C. 20006
(202) 857-0620

Counsel for United HealthCare Company

Edward S. Wardell
Kelley, Wardell & Craig, LLP
41 Grove Street
Haddonfield, NJ 08033
(856) 795-2220

Counsel for Horizon Blue Cross Blue Shield of
New Jersey

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Date

William F. Hanrahan

CERTIFICATE OF SERVICE

The undersigned hereby certifies that on this 1st day of June, 2004, two copies of the foregoing Reply Brief of Appellants/Cross-Appellees United Healthcare Corporation and Horizon Blue Cross Blue Shield of New were sent via first class mail, postage prepaid, to the following:

Frank P. Solomon
Weitz & Luxenberg, PC
210 Lake Drive East, Suite 101
Woodland Falls Corporate Park
Cherry Hill, NJ 08002

Natalie Finkelman Bennett
Shepherd, Finkelman, Miller & Shah, LLC
Washington Professional Campus
900 Route 168, Suite B4
Turnersville, NJ 08012

Donna Siegel Moffa
Trujillo, Rodriguez &
Richards, LLC
8 Kings Highway West
Haddonfield, NJ 08033

John W. Trimble, Jr.
Trimble & Associates
Washington Professional Campus
900 Route 16B, Suite B1-B2
Turnersville, NJ 08102

William F. Hanrahan