No. 14-__

IN THE
Supreme Court of the United States

THE RAWLINGS COMPANY, LLC, OXFORD HEALTH PLANS (NY), INC., AND UNITEDHEALTH GROUP INCORPORATED,
Petitioners,

v.

MEGAN WURTZ, ET AL.,
Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Second Circuit

PETITION FOR A WRIT OF CERTIORARI

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QUESTION PRESENTED

Section 502(a) of the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1132(a), establishes a comprehensive, integrated, and *exclusive* mechanism for clarifying and enforcing rights under ERISA-governed benefit plans. *See Aetna Health Inc. v. Davila*, 542 U.S. 200, 208-09 (2004).

The plans here provide that if the insurer pays a participant's medical expenses as a benefit under the plan, and the participant later receives compensation for those expenses from a third-party tortfeasor, then the insurer is entitled to be reimbursed by the participant for the payment of medical benefits. Respondents filed a class action seeking relief under a New York state statute that purports to invalidate such plan reimbursement provisions. The district court held that respondents' state-law action was completely preempted by § 502(a)'s exclusive remedial structure. The Second Circuit reversed, expressly rejecting decisions of three other circuits holding materially identical actions to be completely preempted by § 502(a). The question presented is:

Whether a state-law action by ERISA plan participants challenging a plan reimbursement provision is completely preempted by ERISA § 502(a)'s exclusive scheme for enforcing and clarifying plan terms.

PARTIES TO THE PROCEEDING

Petitioners are The Rawlings Company, LLC, Oxford Health Plans (NY), Inc., and UnitedHealth Group Incorporated, defendants below.

Respondents, plaintiffs below, are Megan Wurtz and Mindy Burnovski, individually and on behalf of a class of all others similarly situated.

RULE 29.6 DISCLOSURE

The Rawlings Company, LLC ("Rawlings") has no parent corporation, and no publicly traded company owns more than 10 percent of its stock.

Oxford Health Plans (NY), Inc. ("Oxford") is a wholly owned subsidiary of UnitedHealth Group Incorporated, and no other publicly traded company owns more than 10 percent of its stock.

UnitedHealth Group Incorporated ("United") has no parent corporation, and no publicly traded corporation owns more than 10 percent of its stock.

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PETITION FOR A WRIT OF CERTIORARI

Petitioners respectfully seek a writ of certiorari to review the judgment of the United States Court of Appeals for the Second Circuit.

OPINIONS BELOW

The court of appeals' decision is reported at 761 F.3d 232, and is reprinted in the Petition to the Appendix ("App.") at 1a-23a. The district court's order is reported at 933 F. Supp. 2d 480, and reprinted at App. 24a-78a.

JURISDICTION

The court of appeals entered judgment on July 31, 2014. This Court has jurisdiction under 28 U.S.C. 1254(1).

STATUTES INVOLVED

ERISA § 502(a)(1)(B) provides in relevant part:

> [A] civil action may be brought … by a participant or beneficiary … 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.

29 U.S.C. § 1132(a)(1)(B).

Relevant portions of ERISA, as well as Section 5-335 of the New York General Obligation Law ("GOL"), are reproduced at App. 81a-84a.[1]

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[1] After the district court in this case held that GOL § 5-335 was preempted by ERISA § 514, the New York legislature amended the statute. In reversing the district court's express preemption holding, the court of appeals referred to the pre-

INTRODUCTION

The court of appeals' decision creates a square and acknowledged conflict over an important question of federal law: whether ERISA completely preempts state-law actions by participants in ERISA-governed employee benefit plans seeking to invalidate plan provisions governing reimbursement of plan benefit payments. The Second Circuit held that such actions are not preempted, because (in its view) those claims are "independent" of the plan's terms, and thus cannot be brought under § 502(a)(1)(B). That decision, as the panel expressly acknowledged, directly conflicts with decisions of the Third, Fourth, and Fifth Circuits. *See Arana v. Ochsner Health Plan*, 338 F.3d 433, 438 (5th Cir. 2003) (en banc); *Singh v. Prudential Health Care Plan, Inc.*, 335 F.3d 278, 291-92 (4th Cir. 2003); *Levine v. United Healthcare Corp.*, 402 F.3d 156, 163 (3d Cir. 2005).

That circuit conflict is untenable. One of ERISA's principal purposes is to induce employers to establish welfare benefit plans by guaranteeing that suits implicating the terms of such plans will be brought in federal court, subject to a limited remedial scheme that is uniform nationwide. The circuit conflict cre-

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amendment version of the law, but explained that the "changes enacted by the New York legislature do not affect our analysis." App. 4a n.1. The New York legislature's amendments related only to issues relevant to whether GOL § 5-335 is expressly preempted under ERISA § 514—a question not presented in this petition—and have no effect on the § 502(a) complete preemption question that is presented. The pre-amendment version of the law considered by the Second Circuit is reprinted in the Petition Appendix.

ated by the decision below undermines that fundamental purpose. In three circuits, plaintiffs seeking to invalidate plan reimbursement provisions can bring suit, if at all, only under § 502(a). In the Second Circuit, by contrast, plaintiffs *may not* bring such suits under ERISA, and instead *must* bring them under state law (and in state court, if there is no independent basis for federal jurisdiction). Not only does the Second Circuit's decision subject plans to varying state remedial schemes for actions concerning plan benefits, but the circuit conflict itself creates nationwide disuniformity that is contrary to ERISA's principal objective. And the problem is not limited to the treatment of claims invoking state anti-subrogation laws—under the Second Circuit's decision, actions invoking *any* purportedly "independent" state insurance law to invalidate, modify, or mandate *any* ERISA plan term would fall outside § 502(a) and thus would proceed under state law, with the full panoply of state-law remedies at the court's disposal.

The decision below conflicts not only with other circuit decisions but also with multiple decisions of this Court. In *UNUM Life Ins. Co. of Am. v. Ward*, 526 U.S. 358 (1999), and *Rush Prudential HMO Inc. v. Moran*, 536 U.S. 355 (2002), the Court made clear that an action to invalidate a plan term on the basis of a state insurance regulation necessarily *does* proceed under § 502(a), contrary to the premise of the decision below. And in *U.S. Airways, Inc. v. McCutchen*, 133 S. Ct. 1537 (2013), and *Sereboff v. Mid Atl. Med. Servs., Inc.*, 547 U.S. 356 (2006), the Court held that an action to enforce a plan reimbursement provision proceeds under § 502(a). It follows that a mirror-image action to *resist* enforcement

of the same reimbursement provision must proceed under § 502(a) as well.

Certiorari should be granted, and the decision below should be reversed.

STATEMENT OF THE CASE

A. Statutory Background

1. ERISA was designed to "'protect … the interests of participants in employee benefit plans and their beneficiaries' by setting out substantive regulatory requirements for employee benefit plans and to 'provide for appropriate remedies, sanctions, and ready access to the Federal courts.'" *Aetna Health Inc. v. Davila*, 542 U.S. 200, 208 (2004) (quoting 29 U.S.C. § 1001(b)) (alterations omitted). The statute "places the regulation of private sector employee benefit plans (including health benefits) primarily under federal jurisdiction for about 177 million people." Congressional Res. Serv., *ERISA Regulation of Health Plans: Fact Sheet 1* (2007).

ERISA does not require employers to offer welfare benefit plans. *See Curtiss-Wright Corp. v. Schoonejongen*, 514 U.S. 73, 78 (1995). Congress instead sought 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 v. Frommert*, 130 S. Ct. 1640, 1649 (2010). In other words, ERISA's main objective "is to provide a uniform regulatory regime over employee benefit plans" and "to ensure that employee benefit plan regulation [is] exclusively a federal concern." *Davila*, 542 U.S. at 208 (quotations omitted). In this way, ERISA seeks to "minimize the administrative and financial burden

of complying with conflicting directives" imposed by different jurisdictions. *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 142 (1990). This addresses Congress's concern that "administrative costs" and "litigation expenses" might "unduly discourage employers from offering welfare benefit plans in the first place." *Varity Corp. v. Howe*, 516 U.S. 489, 497 (1996).

2. ERISA accomplishes its goal of federal uniformity in two principal ways—it assures uniform substantive regulation of ERISA plans in most cases, and a uniform remedial scheme to enforce or adjudicate the scope of plan terms in *all* cases.

a. First, ERISA § 514 expressly preempts "any and all State laws insofar as they may now or hereafter relate to any" ERISA-covered plan. 29 U.S.C. § 1144(a). Thus, ERISA precludes the states in most circumstances from regulating the terms of ERISA plans. That provision, however, has one major exception—§ 514 "saves" from express preemption state laws that "regulate[] insurance, banking, or securities." *Id.* § 1144(b)(2)(A). Respondents contended below, and the court of appeals held, that the New York law at issue in this case—GOL § 5-335—is a law that regulates insurance. Petitioners do not seek review of the court of appeals' decision concerning § 514.

b. Second, ERISA § 502(a) separately "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 Ins. Co. v. Dedeaux*, 481 U.S. 41, 54 (1987). That balance is reflected in

limitations Congress imposed on ERISA causes of action. For example, § 502(a)(1)(B)—the provision most relevant here—generally allows a plan participant to bring suit to enforce the terms of his ERISA plan, i.e., "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." 29 U.S.C. § 1132(a)(1)(B). But before asserting a right to relief under § 502(a)(1)(B), the participant first must exhaust internal plan remedies. *See Heimeshoff v. Hartford Life & Accident Ins. Co.*, 134 S. Ct. 604, 610 (2013). And a participant asserting a claim under § 502(a)(1)(B) is prohibited from obtaining "remedies beyond those authorized under ERISA," such as administrative penalties and punitive damages. *Davila*, 542 U.S. at 215.

Section 502's "comprehensive civil enforcement scheme" is also *exclusive*, *Pilot Life*, 481 U.S. at 54, meaning that "any state-law cause of action 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 pre-empted." *Davila*, 542 U.S. at 209. And not just preempted, but *completely* preempted: any state-law claim that, in substance, falls within § 502(a)'s broad compass is deemed a federal § 502(a) action. *See id.* (§ 502(a) is "one of those provisions with such extraordinary pre-emptive power that it converts an ordinary state common law complaint into one stating a federal claim" under that provision (quotations omitted)).

Section 502(a)'s completely preemptive force has two important consequences. *First*, when a state-law action could be brought under § 502(a) and is

thus completely preempted, the defendant can remove the case to federal court, despite the well-pleaded complaint rule. *Davila*, 542 U.S. at 209. *Second*, in those circumstances, the plaintiff can proceed on the merits only if he or she can state a valid ERISA claim under § 502(a), *id.* at 221 n.7, including satisfaction of the exhaustion requirement and taking into account the remedial limitations described above.

c. Unlike express preemption under § 514, there is no carve-out for insurance regulations under § 502(a). To the contrary, this Court has repeatedly explained that if a state law that affects ERISA plan terms is "saved" from preemption because it is a law that regulates insurance, a suit brought to enforce that law against plan terms and rights must nevertheless be brought under § 502(a) as an ERISA claim subject to ERISA's remedial rules and limitations.

In *UNUM Life Ins. Co. of Am. v. Ward*, 526 U.S. 358 (1999), the Court ratified a § 502(a)(1)(B) claim that sought to invalidate an ERISA plan term based on a saved state insurance regulation. The Court held that the case was properly brought as a suit "under § 502(a)(1)(B) 'to recover benefits due ... under the terms of his plan,'" and the state insurance regulation that invalidated a plan term "supplied the relevant rule of decision for this § 502(a) suit." *Id.* at 377.

Similarly, in *Rush Prudential HMO Inc. v. Moran*, 536 U.S. 355 (2002), a suit to enforce a state regulation against a plan term was originally brought in state court, but was successfully removed to federal court on "complete preemption" grounds. *Id.* at 363. This Court explained that because the

saved insurance regulation at issue could be enforced against the plan and thus effectively altered its substantive terms, "a suit to compel compliance with [the saved state law] in the context of an ERISA plan would seem to be akin to a suit to compel compliance with the terms of a plan under 29 U.S.C. § 1132(a)(3)." *Id.* at 362 n.2. "Alternatively, the proper course may have been to bring a suit to recover benefits due, alleging that the denial was improper in the absence of compliance with [the state law]." *Id.* Either way, the Court made clear, the proper mechanism for ensuring that the plan's benefits and rights complied with the state insurance regulation was an action under § 502(a).

In other words, ERISA assures that even when plan terms are subject to *substantive* state regulation, ERISA still "induce[s] employers to offer benefits by assuring a predictable set of liabilities" under "a uniform regime of ultimate remedial orders and awards." *Conkright*, 130 S. Ct. at 1649. As explained, a participant seeking relief under § 502 is generally required to exhaust administrative remedies, and is barred from obtaining remedies not authorized by ERISA, such as punitive damages. And a defendant facing a completely preempted state-law claim filed in state court is entitled to remove it, ensuring that federal courts can enforce the uniform federal remedies governing plan rights and administration.

B. Proceedings Below

1. The material facts at issue in this case are not in dispute. Both respondents are participants in ERISA benefit plans provided by their employers and insured by petitioner Oxford. *E.g.*, App. 16a,

39a, 58a-59a. Those plans permit reimbursement of benefits paid by the plan to an injured member if that member later recovers from a third party responsible for the injury. App. 6a, 26a-27a. Respondents received health benefits under their plans for injuries caused by third parties, and later filed suit against and sought or obtained settlements from those third parties. App. 29a-31a. Oxford (through its vendor Rawlings) asserted an interest in those potential recoveries based on the plans' reimbursement provisions, and requested notification of any potential settlement of respondents' claims. App. 30a-31a.

2. On February 2, 2012, respondents filed a putative class action in New York state court, alleging that they were entitled to retain all of the benefits they received, notwithstanding the contrary terms of their ERISA plans. Respondents asserted that GOL § 5-335—an anti-subrogation law purporting to prohibit the enforcement of reimbursement provisions like the provisions found in respondents' insured ERISA plans, App. 4a-5a, 83a-84a—prohibited petitioners from exercising their ERISA plan-based reimbursement rights.

Respondents asserted claims for relief under New York statutory and common law, seeking, *inter alia*, declaratory relief, compensatory damages, disgorgement, a constructive trust, attorney fees, and punitive damages. App. 115a-116a.

On March 9, 2012, petitioners removed the action to federal district court, asserting that respondents' state-law claims may be pursued, if at all, only as claims for benefits under ERISA § 502(a), and are thus "removable to federal court." *Davila*, 542 U.S.

at 209. Petitioners also removed under the Class Action Fairness Act ("CAFA"), 28 U.S.C. §§ 1332(d), 1453. App. 85a-98a. Respondents did not contest the district court's jurisdiction or seek remand to state court.

3. Once in federal court, petitioners moved to dismiss on multiple grounds, including that respondents' claims are preempted by § 502(a)(1)(B), and that respondents cannot state a claim under that provision for several reasons, including their failure to exhaust their internal plan remedies.[2]

On March 28, 2013, the district court agreed and dismissed the complaint. The district court held that respondents' allegations, "even when read in their favor, directly implicate issues concerning benefits due under the Plans, as well as their right to such benefits." App. 41a. The court reasoned that respondents "effectively seek to cut off defendants' reimbursement rights under the Plans, and to retain benefits that otherwise would be subject to reimbursement." App. 42a. Relying on directly on-point precedent from the Third, Fourth, and Fifth Circuits,

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[2] The plans at issue each set forth an administrative grievance process. C.A. App. A-53-54, A-62-63. Respondents do not dispute that they failed to exhaust those administrative remedies. That failure is critical because the reimbursement provisions at issue here only apply to settlements that expressly allocate a portion of the settlement to medical expenses, and only to the extent of those medical expenses. C.A. App. A-55-56, A-64. Depending on the terms of their settlements, respondents could have either reduced the level of reimbursement required by the plans, or even eliminated reimbursement entirely through the administrative channels provided in the plans. They instead chose to file this state-court, state-law class action.

the district court held that respondents' claims fall within § 502(a) and thus are completely preempted. App. 42a-46a (discussing *Arana v. Ochsner Health Plan*, 338 F.3d 433 (5th Cir. 2003), *Singh v. Prudential Health Care Plan, Inc.*, 335 F.3d 278 (4th Cir. 2003), and *Levine v. United Healthcare Corp.*, 402 F.3d 156 (3d Cir. 2005)).

The district court next addressed whether respondents' claims can proceed on the merits as "restyled" claims under § 502(a)(1)(B). The court held that they could not, for three reasons. *First*, respondents did not allege that they exhausted their administrative remedies. App. 73a-75a. *Second*, respondents in any event could not assert rights under GOL § 5-335 because it was expressly preempted under ERISA § 514—it "relate[d] to" the plan, 29 U.S.C. § 1144(a), and was not saved from express preemption because it was not a law that "regulates insurance," *id.* § 1144(b)(2)(A). App. 71a-72a, 75a-76a. *Third*, respondents failed to allege that petitioners were plan administrators or trustees, as required for § 502(a)(1)(B) claims under Second Circuit precedent. App. 76a-77a.

Rather than attempting to amend their complaint to state § 502(a) ERISA claims that would address the grounds for the district court's dismissal, respondents appealed.

4. On July 31, 2014, a panel of the Second Circuit reversed. The panel first held that CAFA provided federal jurisdiction. App. 10a-12a. Having assured itself of jurisdiction, the panel also held that GOL § 5-335 is an insurance regulation "saved" from preemption under § 514(b) and is thus not expressly preempted. App. 12a-15a. Petitioners do not seek

review of those portions of the court of appeals' ruling.

The panel then considered whether respondents' claims were completely preempted by § 502(a). The panel held that respondents could not have pursued their claims under § 502(a) because they do not seek to keep their "tort settlements 'under the terms of [their] plan[s]'—rather, they contend that they have a right to keep their tort settlement under N.Y. Gen. Oblig. Law § 5-335." App. 16a (alterations in original). According to the panel, "the terms of plaintiffs' ERISA plans are irrelevant to their claims," since GOL § 5-335 is saved from express preemption and categorically bars the enforcement of plan reimbursement provisions. App. 16a-18a.

The court of appeals based its conclusion on its interpretation of this Court's precedents. According to the court of appeals, "the Supreme Court has held that state statutes regulating insurance that nonetheless affect ERISA benefits are not expressly preempted, with no hint that claims under these statutes might still be completely preempted and thus unable to be adjudicated under those state laws when they do not expand the remedies available for beneficiaries for claims based on the terms of their plans." App. 17a-18a (citing *Rush Prudential*, 536 U.S. at 377-79, and *UNUM*, 526 U.S. at 366-67).

The panel also reasoned that an "independent legal duty" "arises from section 5-335, which prohibits defendants from seeking subrogation or reimbursement from settling parties," and that respondents' claims thus "do not derive from their plans or require investigation into the terms of their plans"—i.e., the plan terms respondents alleged to be invalid

under New York law. App. 18a-19a. "[R]ather," the court held, respondents' claims "derive from N.Y. Gen. Oblig. Law § 5-335." App. 19a.

The court of appeals recognized that "this result is in some tension with holdings of the Third, Fourth, and Fifth Circuits in similar antisubrogation cases, albeit decided before *Davila*." App. 19a-20a (citing *Arana*, 338 F.3d at 438; *Singh*, 335 F.3d at 291-92; and *Levine*, 402 F.3d at 163, which in fact was decided after *Davila*). The panel objected to the "logic" of these decisions because they "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)." App. 20a.

REASONS FOR GRANTING THE PETITION

This case satisfies every factor for this Court's exercise of certiorari jurisdiction. The decision below is in acknowledged conflict with decisions of three other circuits, which hold that state-law suits seeking to invalidate ERISA plan reimbursement provisions are completely preempted by § 502(a). The decision also conflicts with precedents of this Court recognizing that suits invoking state law to alter, invalidate, or mandate ERISA plan terms should be brought under § 502(a)(1)(B). In direct opposition to those precedents, the decision below holds that such suits *cannot* be brought under § 502(a)(1)(B), because they are, in the Second Circuit's view, "independent" of the ERISA plan terms they seek to invalidate. If left standing, the decision below will undermine the uniform federal remedial structure that is central to ERISA's regulatory objective. The uniform enforcement of reimbursement provisions is

important to plans nationwide. What is more, there is no principle in the court of appeals' decision that would limit it to challenges of reimbursement provisions. Under the decision below, any claim seeking to invalidate ERISA plan provisions may be pursued in state court (absent a separate basis for federal jurisdiction), with whatever remedies state law affords, so long as the plaintiff can identify some state-law source of authority that is purportedly saved from express § 514 preemption and "independent" of the plan terms. Because this case presents an ideal vehicle through which to resolve the conflict among the circuits, the Court should grant review, and reverse the decision below.

A. The Courts Of Appeals Are Divided On The Question Presented

As the court of appeals recognized, the decision below creates a conflict among the circuits concerning whether suits to enforce state laws prohibiting plan reimbursement provisions must be brought under § 502(a)(1)(B). The Third, Fourth, and Fifth Circuit have held that suits to enforce state-law anti-subrogation provisions like GOL § 5-335 are completely preempted by § 502(a)(1)(B) and thus can be brought only under that ERISA remedial provision. The Second Circuit expressly rejected the approach of those courts, holding instead that such suits *cannot* be brought under ERISA, and can instead only be brought under state law.

1. Fourth Circuit. The Fourth Circuit addressed the question presented in *Singh*. There, as here, a member of an ERISA-governed health plan filed suit in state court asserting that an ERISA plan's reimbursement provision was contrary to the terms of a

state anti-subrogation statute. There, as here, the defendant removed the case to federal court on the ground that plaintiffs' suit was completely preempted by § 502(a)(1)(B). And there, as here, the district court accepted jurisdiction under that rationale.

The Fourth Circuit agreed. Although plaintiff's suit invoked a state anti-subrogation statute, the court explained, the suit's objective was still to obtain plan benefits—i.e., benefits undiminished by the reimbursement provision allegedly invalidated by the state law at issue. *See* 335 F.3d at 291. The suit, in other words, required "a court to determine entitlement to a benefit *under the lawfully applied terms* of an ERISA plan." *Id.* (emphasis in original). And "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)." *Id.* (emphasis in original). The court thus concluded that plaintiff's claims "undoubtedly fall within the scope of § 502(a) and for that reason are 'completely preempted.'" *Id.* at 292.

<u>Fifth Circuit.</u> The *en banc* Fifth Circuit unanimously agreed with the Fourth Circuit in *Arana*. There, an ERISA plan member filed suit in state court asserting that a Louisiana statute barred the enforcement of an ERISA plan's reimbursement provisions. After the case was removed to federal court and appealed, a three-judge panel of the Fifth Circuit held that plaintiffs' claims were not completely preempted, because plaintiff "is not seeking to enforce the plan's terms but rather to declare a portion of the plan illegal under Louisiana law if enforced," 338 F.3d at 436—precisely the same rationale approved by the decision below in this case.

The *en banc* Fifth Circuit reversed the panel decision, holding that although plaintiff invoked a state statute, the claim was completely preempted because it "can 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 plaintiff's action was a claim to recover benefits because "although the benefits have already been paid, [plaintiff] has not fully 'recovered' them because he has not obtained the benefits free and clear of [reimbursement] claims." *Id.* And it was a claim to enforce rights under the plan because the plaintiff sought "to determine his entitlement to retain the benefits based on the terms of the plan." *Id.* Either way, plaintiff could bring his claim only under § 502(a)(1)(B).

The Fifth Circuit in *Arana* flatly rejected the argument—central to the decision below (App. 17a-18a)—that preemption under § 514 is a necessary prerequisite to complete preemption under § 502(a). As the Fifth Circuit pointed out, this Court held the opposite in *UNUM* and *Rush Prudential*. 338 F.3d at 439. In *UNUM*, the court observed, this Court "determined that a California state law was not preempted under § 514 (because it was a law regulating insurance) but acknowledged that the plaintiff properly brought a claim in federal court under ERISA § 502(a)." *Id.* at 440. And in *Rush Prudential*, the court explained, this Court "found that ERISA § 514 did not preempt the Illinois HMO Act (because it too was a law regulating insurance) but nonetheless noted, and did not question the fact that, the Seventh Circuit found federal subject matter jurisdiction over the claim under ERISA § 502(a)." *Id.* *UNUM* and *Rush Prudential* thus

"clearly indicate," the Fifth Circuit concluded in *Arana*, "that there may be complete preemption subject matter jurisdiction over a claim that falls within ERISA § 502(a) even though that claim is not conflict-preempted by ERISA § 514." *Id.*

Third Circuit. Expressly "[a]gree[ing] with the reasoning" of *Singh* and *Arana*, the Third Circuit in *Levine* likewise held completely preempted a claim seeking to enforce a New Jersey statute against ERISA plan reimbursement provisions. 402 F.3d at 163. As the Third Circuit concluded: "Where, as here, plaintiffs claim that their ERISA plan wrongfully sought reimbursement of previously paid health benefits, the claim is for 'benefits due' and federal jurisdiction under section 502(a) of ERISA is appropriate." *Id.*

2. The Second Circuit in this case acknowledged and squarely rejected the foregoing circuit decisions, asserting that their "logic" 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)." App. 20a.

Apparently seeking to diminish the force of the contrary circuit decisions, the Second Circuit also observed that they were "decided before *Davila*." *Id.* The observation is both wrong and irrelevant. In fact, the Third Circuit decided *Levine* one year *after* *Davila*, and also reaffirmed *Levine* in 2006. *See Wirth v. Aetna U.S. Healthcare*, 469 F.3d 305, 308-09 (3d Cir. 2006). And although the Fifth Circuit decided *Arana* before *Davila*, it has since cited *Arana* and *Davila* together as controlling precedent on § 502(a)

"complete preemption." *Clayton v. ConocoPhillips Co.*, 722 F.3d 279, 285 (5th Cir. 2013).

As to *Singh*, it is irrelevant that *Davila* was decided later, because *Davila* did not undermine *Singh*'s holding or analysis in the slightest. As discussed in greater detail below, *Davila* did not alter settled complete preemption doctrine, and certainly did not impose a newly *narrowed* construct. Rather, *Davila* reaffirmed the same principles underlying *Singh*, as shown by *Levine*'s post-*Davila* finding of complete preemption in reliance on *Singh*.

3. There is, in short, no serious doubt that the circuit conflict over the question presented here is live and concrete. As it stands, the question whether state-law-based challenges to ERISA plan reimbursement provisions must be brought under ERISA § 502(a) turns entirely on the jurisdiction in which suit is filed. Plaintiffs seeking to assert such challenges in the Third, Fourth, and Fifth Circuits *must* bring suit under ERISA, and they are limited to their § 502(a) remedies. Plaintiffs bringing precisely the same type of suits in the Second Circuit, by contrast, *cannot* bring suit under ERISA § 502(a), but instead may and must invoke the causes of action and remedies available under state law.

That differential treatment of prospective plaintiffs and defendants, depending solely on where a suit is filed, would be inappropriate in any context. But it is particularly intolerable here because one of ERISA's principal purposes—and, indeed, the main function of § 502(a)—is federal remedial *uniformity*. Allowing this circuit conflict to persist would self-evidently undermine that purpose. And allowing a circuit conflict that permits state-law suits to pro-

ceed *wholly* outside of ERISA's strictures, and to seek remedies such as punitive damages, would eviscerate that purpose entirely. Certiorari should be granted.

B. The Decision Below Conflicts With This Court's Decisions

The decision below conflicts not only with decisions of three other circuits, but also with the precedents of this Court.

This Court most recently addressed the standard for § 502(a) complete preemption in *Davila*. There, the Court explained that a state-law claim is completely preempted "if an individual, at some point in time, could have brought his claim under ERISA § 502(a)(1)(B)," and "there is no other independent legal duty that is implicated by a defendant's actions." 542 U.S. at 210. This case easily satisfies those conditions.

1. a. Respondents' claim plainly could have been brought under § 502(a)(1)(B). Their complaint is premised fundamentally on their allegation that, because of New York's GOL § 5-335, petitioners "have *no right* to assert and/or collect any liens and/or rights of subrogation and/or rights of reimbursement *under fully funded health insurance plans*." App. 112a (Compl. ¶¶ 39-40) (emphasis added). The complaint seeks a declaration of those rights under respondents' health benefit plans (App. 112a-113a (Compl. ¶ 41)), and seeks recovery of monies already paid "through the assertion and collection of fully insured health plan liens" (App. 115a (Compl. ¶ 51)). The claim on its face thus seeks "to enforce … rights under the terms of the plan," and to "clarify … rights to future benefits under the terms of the plan." 29

U.S.C. § 1132(a)(1)(B). The claim also can be considered a suit to recover the benefits themselves: although the benefits were paid, respondents have "not fully 'recovered' them because [they have] not obtained the benefits free and clear of [reimbursement] claims," *Arana*, 338 F.3d at 438, which is the basis for their compensatory damages claim.

The Second Circuit's conclusion that respondents' claim fell outside § 502(a) was based on a serious misreading of this Court's precedents. The court of appeals read *UNUM* and *Rush Prudential* to stand for the proposition that when a state law regulates insurance and is therefore saved from § 514 preemption, a suit to enforce that law against a plan term proceeds under the state law, rather than § 502(a). App. 17a-18a (citing *UNUM* and *Rush Prudential*). That conclusion is backwards. As explained earlier, and as the Fifth Circuit emphasized in *Arana*, 338 F.3d at 440, both *UNUM* and *Rush Prudential* make clear that a claim challenging plan terms under an allegedly saved state insurance regulation *does* proceed under § 502(a). *See supra* at 7-8.

In *UNUM*, the suit proceeded under § 502(a)(1)(B), and the saved state insurance regulation constituted the "rule of decision" that prohibited enforcement of the challenged ERISA plan term. *UNUM*, 526 U.S. at 377. This Court expressly held that § 502(a) was the proper vehicle for enforcing the plaintiff's state-law rights against the plan. *Id.*

Likewise, in *Rush Prudential*, the state-law challenge was successfully removed under a § 502(a) complete preemption theory. 536 U.S. at 363-64. The Court explained that because the state law, as construed by the Court elsewhere in the opinion, ef-

fectively mandated an additional plan term, "a suit to compel compliance with [the state law] in the context of an ERISA plan would seem to be akin to a suit to compel compliance with the terms of a plan under 29 U.S.C. § 1132(a)(3)." *Id.* at 362 n.2. "Alternatively," the Court observed, the claim could be understood as "a suit to recover benefits due, alleging that the denial was improper in the absence of compliance with [the state law]." *Id.* Either way, the action to enforce the saved state insurance law would proceed exclusively under § 502(a).

The Court reaffirmed the point in *CIGNA Corp. v. Amara*, 131 S. Ct. 1866 (2011). While § 502(a)(1)(B) "speaks of '*enforc[ing]*' the 'terms of the plan,'" *Amara* explains, the "provision allows a court to look outside the plan's written language in deciding what those terms are, *i.e.*, what the language means." *Id.* at 1877. *Amara* describes *UNUM* as a § 502(a) case "permitting the insurance terms of an ERISA-governed plan to be interpreted in light of state insurance rules." *Id.* Cases like *UNUM* and *Amara* thus establish that "when an ERISA plan includes an insurance policy, the requirements imposed by state insurance law become plan terms for purposes of a claim for benefits under [§ 502(a)(1)(B)]." *Larson v. United HealthCare Ins. Co.,* 723 F.3d 905, 912 (7th Cir. 2013).

The Second Circuit thus missed the mark entirely in trying to distinguish respondents' claim from the claim in *Davila* on the ground that in *Davila*, the "wording of the plans" was "material" to the state-law claims. App. 16a (quoting *Davila*, 542 U.S. at 215). Exactly the same is true here: the whole point of respondents' state-law claim is to establish that the plans' reimbursement terms, as "interpreted in

light of state insurance rules," *Amara*, 131 S. Ct. at 1877, cannot be enforced against respondents. This Court's precedents make clear that respondents' challenge to the plans' reimbursement provisions could have been—and, thus, *must* have been—brought under § 502(a).

b. For the same reason, the Second Circuit erred in holding that respondents' claim survives § 502(a) preemption because it is based on an "independent legal duty" that "arises from section 5-335." App. 18a. According to the decision below, because the state law "prohibits defendants from seeking subrogation or reimbursement from settling parties," it is "unrelated to whatever plaintiffs' ERISA plans provide about reimbursement." *Id.* Not so. As *Amara*, *Rush Prudential*, and *UNUM* make clear, the alleged state-law duty effectively *amends* the plan terms, which otherwise unambiguously permit reimbursement. Put differently, the right respondents seek to enforce exists only because of the plan provisions requiring reimbursement—absent those plan provisions, the state law would have no effect on either petitioners or respondents. Moreover, the challenged *conduct* in the case is based entirely on the rights and duties set forth in the terms of respondents' ERISA plans. The state-law duty thus is not independent of those plans' terms in any respect.

In short, respondents seek to invoke state law to alter or invalidate the terms of their ERISA plans, just as the plaintiffs in *UNUM* and *Rush Prudential* did. And the claims in those cases were properly asserted under § 502(a)(1)(B). The Second Circuit's conclusion that the claims here *cannot* be asserted under § 502(a)(1)(B) directly conflicts with those precedents.

2. The decision below is also inconsistent with this Court's recent decisions concerning reimbursement provisions in ERISA plans. *See U.S. Airways, Inc. v. McCutchen*, 133 S. Ct. 1537 (2013); *Sereboff v. Mid Atl. Med. Servs., Inc.*, 547 U.S. 356 (2006). Those decisions hold that ERISA plans, acting as plaintiffs, may rely on such plan provisions to "obtain … appropriate equitable relief … to enforce … the terms of the plan" in federal court, 29 U.S.C. § 1132(a)(3)(B), even when state-law equitable defenses purport to limit such rights, *see McCutchen*, 133 S. Ct. at 1546-48; *Sereboff*, 547 U.S. at 361-65. In response to such a claim, the participant may attempt to invoke a state antisubrogation law such as GOL § 5-335 to preclude enforcement of the reimbursement provision, but the plan's claim is still an action to enforce plan terms and thus must proceed under § 502(a). The claim here is simply the mirror image: rather than asserting GOL § 5-335 as a defense to petitioners' § 502(a)(3) claim, respondents have sought to assert their rights under GOL § 5-335 in the first instance, to end run § 502(a). It makes no sense to say that this mirror-image claim does not—and indeed *cannot*—proceed under § 502(a) merely because respondents filed it first. Whether an action to resolve an ERISA plan's reimbursement rights is a § 502(a) claim should not depend on which party wins the race to the courthouse.

C. The Question Presented Is A Recurring Issue Of National Importance, And This Case Presents An Ideal Vehicle For Resolving It

1. The question whether suits to enforce antisubrogation laws against ERISA plans are completely preempted is a recurring question of national im-

portance. In addition to the four published circuit decisions already discussed, district courts in at least three other circuits have also confronted the question whether a suit to evade enforcement of an ERISA plan's reimbursement provision is completely preempted. *See*, *e.g.*, *Wausau Supply Co. v. Murphy*, 2014 WL 2565555 (W.D. Wis. June 6, 2014); *Cavanagh v. N. New Eng. Benefit Trust*, 2012 WL 5863615 (D.N.H. Nov. 19, 2012); *Osterman v. Smith*, 2011 WL 1343056 (C.D. Ill. Mar. 17, 2011); *Werner v. Primax Recoveries, Inc.*, 2008 WL 4159431 (N.D. Ohio Aug. 6, 2008); *White v. Humana Health Plan, Inc.*, 2007 WL 1297130 (N.D. Ill. May 2, 2007).

The recurring nature of the question bespeaks its importance to plans, participants, and state regulators. ERISA plans and insurers often depend on reimbursement provisions to reduce plan costs. *See*, *e.g.*, *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."). But many states have enacted laws potentially invalidating or limiting such provisions, including states in circuits involved in the conflict.[3] Whether those laws can be enforced through state-law actions subjecting ERISA-governed employee benefit plans to the full range of remedies available under state law is a matter of vital importance to all parties interested in the enforcement, or the restriction, of plan reimbursement provisions.

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[3] *See*, *e.g.*, Conn. Gen. Stat. § 52-225(c); La. Rev. Stat. § 22:663; N.J. Stat. Ann. § 2A:15-97; GOL § 5-335; 11 N.C.A.C. 12.0319; 75 Pa. Cons. Stat. § 1720; Tex. Civ. Prac. & Remedies Code ch. 140; Va. Code Ann. § 38.2-3405(a).

The prospect of litigating cases like this one under state law, with whatever remedies state law affords, is not an academic concern to ERISA plans and insurers. On the contrary, it strikes at the heart of Congress's concern in enacting ERISA that "administrative costs" and "litigation expenses" might "unduly discourage employers from offering welfare benefit plans in the first place." *Varity*, 516 U.S. at 497. Even a one-percent increase in the cost of administering ERISA plans "results in a potential loss of insurance coverage for about 315,000 individuals" nationwide. Health Economics Practice, Barents Group LLC, *Impacts of Four Legislative Provisions on Managed Care Consumers: 1999-2003*, at iii (1998).

The importance of the question presented here also extends beyond the context of reimbursement provisions. The Second Circuit rejected complete preemption by reading this Court's precedents as holding that claims under state insurance laws saved from § 514 preemption are also exempt from complete preemption "when they do not expand the remedies available for beneficiaries for claims based on the terms of their plans." App. 18a. The decision thus would exclude from § 502(a)'s compass *any* suit enforcing *any* state law that a plaintiff alleges is saved from § 514 preemption, even if that law invalidates, modifies, or mandates ERISA plan terms, so long as the law does not also expand the remedies allowed by § 502(a).[4] Yet such state-law claims are routinely adjudicated in federal court under

[4] Respondents' claims actually *do* seek remedies beyond those allowed by § 502(a), including punitive damages and disgorgement. *Supra* at 9.

§ 502(a)—the ERISA cause of action provides the vehicle for suit and defines the permissible remedies, while the saved state law provides the rule of decision for the action.[5] The decision below thus throws now-settled practice under §502(a) into considerable disarray, and not just in the context of plan reimbursement provisions.

2. This case presents an ideal vehicle for resolving the question presented. The material facts are not in dispute. If this case had been filed in the Third, Fourth, or Fifth Circuits, it could only have proceeded under § 502(a). In addition, the answer to the question presented is outcome-determinative here. The Second Circuit held that respondents' suit to enforce New York's anti-subrogation provision is not completely preempted because it could not be

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[5] *See*, *e.g.*, *UNUM*, 526 U.S. at 377 (suit under § 502(a) to enforce California "notice-prejudice rule," which precludes enforcing notice-related plan terms in some circumstances); *Rush Prudential*, 536 U.S. at 363 (suit under § 502(a) challenging Illinois law providing certain recipients of health coverage with a right to independent medical review of benefit denials, notwithstanding contrary plan terms); *Johnson v. Conn. Gen. Life Ins. Co.*, 324 F. App'x 459 (6th Cir. 2009) (suit under § 502(a) to enforce against ERISA plan Ohio law that precludes denying recovery under an insurance policy based on a false statement in an insurance application unless it was willfully false or fraudulent); *Werdehausen v. Benicorp Ins. Co.*, 487 F.3d 660 (8th Cir. 2007) (suit under § 502(a) to enforce Missouri law precluding denial of insurance coverage for preauthorized medical treatment); *Spellman v. UPS*, 540 F. Supp. 2d 237 (D. Me. 2008) (holding that suit to enforce Maine law that requires a disability insurer, in certain circumstances, to award an employee disability benefits without regard to any policy exclusion for work-related injury or disease must be brought under § 502(a), not state law).

brought under § 502(a)(1)(B). If this Court were to reject that approach and adopt the position of Third, Fourth, and Fifth Circuits, respondents' suit would be required to proceed under § 502(a)(1)(B). And that in turn would require dismissal of their complaint, not only because respondents failed to allege that they exhausted administrative remedies, as the district court recognized, but also because respondents failed to seek leave to amend their complaint to allege an ERISA claim. *Davila*, 542 U.S. at 221 n.7. This case thus clearly and cleanly presents the question whether a suit seeking to invalidate an ERISA plan reimbursement provision (or any other provision) under state law must proceed under § 502(a). Now is the right time, and this is the right case, to answer that important question.

CONCLUSION

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

Respectfully submitted,

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October 2014

APPENDIX

APPENDIX A: OPINION OF THE U.S. COURT OF APPEALS FOR THE SECOND CIRCUIT

13-1695-cv

Wurtz v. Rawlings Co.

IN THE

UNITED STATES COURT OF APPEALS

FOR THE SECOND CIRCUIT

AUGUST TERM, 2013

ARGUED: OCTOBER 30, 2013
DECIDED: JULY 31, 2014

No. 13-1695-cv

MEGHAN WURTZ, MINDY BURNOVSKI,
individually and on behalf of
all others similarly situated,
Plaintiffs-Appellants,

v.

THE RAWLINGS COMPANY, LLC, OXFORD HEALTH PLANS (NY), INC., UNITEDHEALTH GROUP INCORPORATED,

Defendants-Appellees.

Before: WALKER, CABRANES, and PARKER, *Circuit Judges*.

Plaintiffs initially filed the complaint in this case in New York state court, seeking, among other

things, to enjoin defendant insurers under N.Y. Gen. Oblig. Law § 5-335 from obtaining reimbursement of medical benefits from plaintiffs' tort settlements. Defendants removed this action to the Eastern District of New York (Joseph F. Bianco, *District Judge*), where the district court granted defendants' motion to dismiss under Rule 12(b)(6) for failure to state a claim on the basis that plaintiffs' claims were subject to both "complete" and "express" preemption under the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 *et seq*.

We hold that plaintiffs' claims do not satisfy the Supreme Court's test for being subject to complete ERISA preemption, which would have conferred federal subject-matter jurisdiction. *See Aetna Health Inc. v. Davila*, 542 U.S. 200, 210 (2004). Such jurisdiction exists, however, under the Class Action Fairness Act ("CAFA"), 28 U.S.C. § 1332(d). We thus reach the merits of the express preemption defense and conclude that N.Y. Gen. Oblig. Law § 5-335 is saved from express preemption under ERISA § 514, 29 U.S.C. § 1144, as a law that "regulates insurance." Accordingly, we VACATE the district court's judgment and REMAND for further proceedings on plaintiffs' claims.

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RICHARD W. COHEN, Lowey Dannenberg Cohen & Hart, P.C., White Plains, NY, and ANTON METLITSKY, O'Melveny & Myers LLP, New York, NY (Uriel Rabinovitz, Lowey Dannenberg Cohen & Hart, P.C., White Plains, NY; Gerald Lawrence, Lowey Dannenberg Cohen & Hart, P.C., West Conshohocken, PA; Brian D. Boyle, Theresa S. Gee, David K. Roberts, O'Melveney & Myers LLP, Washington, DC; Charles E. Bachman, O'Melveny & Myers LLP, New York, NY, *on the brief*), *for Defendants-Appellees.*

David S. Preminger, Keller Rohrback LLP, New York, NY, and Benjamin Gould, Keller Rohrback LLP, Seattle, WA, *for* Amicus Curiae *New York State Trial Lawyers Association*.

JOHN M. WALKER, JR., *Circuit Judge*:

Plaintiffs initially filed the complaint in this case in New York state court, seeking, among other things, to enjoin defendant insurers under N.Y. Gen. Oblig. Law § 5-335 from obtaining reimbursement of medical benefits from plaintiffs' tort settlements. Defendants removed this action to the Eastern District of New York (Joseph F. Bianco, *District Judge*), where the district court granted defendants' motion to dismiss under Rule 12(b)(6) for failure to state a

claim on the basis that plaintiffs' claims were subject to both "complete" and "express" preemption under the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 *et seq*.

We hold that plaintiffs' claims do not satisfy the Supreme Court's test for being subject to complete ERISA preemption, which would have conferred federal subject-matter jurisdiction. *See Aetna Health Inc. v. Davila*, 542 U.S. 200, 210 (2004). Such jurisdiction exists, however, under the Class Action Fairness Act ("CAFA"), 28 U.S.C. § 1332(d). We thus reach the merits of the express preemption defense and conclude that N.Y. Gen. Oblig. Law § 5-335 is saved from express preemption under ERISA § 514, 29 U.S.C. § 1144, as a law that "regulates insurance." Accordingly, we VACATE the district court's judgment and REMAND for further proceedings on plaintiffs' claims.

BACKGROUND

The New York statute at issue in this appeal, N.Y. Gen. Oblig. Law § 5-335,[1] states that a personal injury settlement presumptively "does not include any compensation for the cost of health care ser-

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[1] For purposes of this appeal, we will refer to the version of section 5-335 that was in effect at the time of this action and relied upon by the District Court in reaching its decision as well as the parties in their briefing here. We note, however, that the statute has since been amended on November 13, 2013, primarily by replacing references to "a benefit provider" with "an insurer," and the amendment applies retroactively to claims brought on or after November 12, 2009. *See* 2013 N.Y. Sess. Laws Ch. 516 (codified at N.Y. Gen. Oblig. Law § 5-335). The changes enacted by the New York legislature do not affect our analysis.

vices" or other losses that "are obligated to be paid or reimbursed by a benefit provider" (such as an insurer), and that benefit providers have no "right of subrogation or reimbursement against any such settling party."[2] When section 5-335 was enacted in 2009, it eliminated an asymmetry between jury verdicts and settlements that tended to discourage the settlement of personal injury lawsuits.[3]

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[2] "[S]ubrogation is the principle by which an insurer, having paid losses of its insured, is placed in the position of its insured so that it may recover from the third party legally responsible for the loss." *Teichman ex rel. Teichman v. Cmty. Hosp. of W. Suffolk*, 663 N.E.2d 628, 631 (N.Y. 1996) (internal quotation marks omitted). While the equitable doctrine of subrogation is distinct from the contractual right of reimbursement, *see id.* at 631-32; 16 Steven Plitt et al., *Couch on Insurance 3d* § 222:82, the distinction is not relevant to this appeal.

[3] *See* 2009 N.Y. Sess. Laws 1265 (Ch. 494) (enacting section 5-335). In New York, jury awards in personal injury actions may not include medical expenses for which an insurer has paid. N.Y. C.P.L.R. § 4545(a). However, in 1996 (thirteen years prior to the enactment of section 5-335), the New York Court of Appeals held that after a personal injury settlement, insurers may "seek a refund of any medical expense payments included in the settlement." *Teichman*, 663 N.E.2d at 632. And in 2009, the year of section 5-335's enactment, the New York Court of Appeals held that settlements may not eliminate an insurer's subrogation right, but suggested that "the Legislature may wish to reexamine" this issue. *Fasso v. Doerr*, 903 N.E.2d 1167, 1171-73 (N.Y. 2009). Thus, tortfeasors would be unlikely to include medical expenses in settlement offers (as these would not be included in awards at trial), and yet insurers could use subrogation to extract from tort settlements medical expenses that they had covered. *See generally* Brief of Amicus Curiae New York State Trial Lawyers Association at 5-6.

In February 2012, plaintiffs Meghan Wurtz and Mindy Burnovski filed a class action complaint in New York state court, alleging section 5335 violations by the three defendants, which are related companies in the insurance business: The Rawlings Company, LLC; Oxford Health Plans (NY), Inc.; and UnitedHealth Group, Inc.[4] According to the complaint, both named plaintiffs had received medical benefit payments from defendants for personal injuries. Wurtz also settled her personal injury lawsuit, thereby recovering from the tortfeasor. Defendants had asserted liens under plaintiffs' insurance plans to recover medical expenses that they had paid to plaintiffs, and Wurtz paid a reimbursement sum of $1,316.87 to The Rawlings Company, LLC. In filing their action, plaintiffs sought a declaration that (based on section 5335) defendants did not have a right to seek reimbursement or subrogation of medical benefits against plaintiffs' tort settlements, and they also sought damages for unjust enrichment and deceptive business practices under N.Y. Gen. Bus. Law § 349.

Defendants removed this action to the Eastern District of New York and then moved to dismiss under Federal Rule of Civil Procedure 12(b)(6) for failure to state a claim based on ERISA preemption. The district court granted defendants' motion to dismiss, holding that plaintiffs' claims "are superseded under two parallel and independent principles of preemption: (1) complete preemption under ERISA § 502(a), and (2) express preemption under

[4] The Rawlings Company collects subrogation claims on behalf of insurer Oxford Health (NY), which is a wholly owned subsidiary of insurer UnitedHealth Group.

ERISA § 514." *Wurtz v. Rawlings Co., LLC*, 933 F. Supp. 2d 480, 489 (E.D.N.Y. 2013). The complete preemption holding permitted plaintiffs' claims to be recast as claims under ERISA, but the district court concluded that the claims could not successfully proceed under ERISA because plaintiffs had not exhausted their administrative remedies and because the terms of their plans allow reimbursement. *Id.* at 507-09. The district court also held that plaintiffs' claims for damages were "simply a reassertion of their declaratory judgment claim" and were thus "also expressly preempted." *Id.* at 507 n.10. Plaintiffs timely appealed.

DISCUSSION

"We review a district court's ERISA preemption ruling and 12(b)(6) dismissal for failure to state a claim de novo." *Arditi v. Lighthouse Int'l*, 676 F.3d 294, 298 (2d Cir. 2012). "The purpose of ERISA is to provide a uniform regulatory regime over employee benefit plans." *Davila*, 542 U.S. at 208. However, "because the States are independent sovereigns in our federal system, we have long presumed that Congress does not cavalierly preempt state-law causes of action." *Medtronic, Inc. v. Lohr*, 518 U.S. 470, 485 (1996). Thus, "analysis of ERISA preemption must start with the presumption that 'Congress does not intend to supplant state law.'" *Stevenson v. Bank of N.Y. Co.*, 609 F.3d 56, 59 (2d Cir. 2010) (quoting *Gerosa v. Savasta & Co.*, 329 F.3d 317, 323 (2d Cir. 2003)).

I. Federal Subject-Matter Jurisdiction

We begin by addressing our "special obligation to satisfy [ourselves] ... of [our] own jurisdiction." *Arnold v. Lucks*, 392 F.3d 512, 517 (2d Cir. 2004) (in-

ternal quotation mark omitted) (quoting *Bender v. Williamsport Area Sch. Dist.*, 475 U.S. 534, 541 (1986)). The district court held that plaintiffs' claims were subject to both "complete" preemption and "express" preemption. As explained below, complete preemption can be the basis for federal subject-matter jurisdiction, but express preemption cannot. Because we hold below that the district court erred in finding N.Y. Gen. Oblig. Law § 5-335 to be completely preempted by ERISA, we normally would decline to reach the merits of the express preemption defense. In this case, however, there is another basis for federal subject-matter jurisdiction under CAFA, 28 U.S.C. § 1332(d).

A. Preemption and Federal Jurisdiction

Express preemption is one of the "three familiar forms" of ordinary defensive preemption (along with conflict and field preemption). *Sullivan v. Am. Airlines, Inc.*, 424 F.3d 267, 273 (2d Cir. 2005). It occurs when "Congress ... withdraw[s] specified powers from the States by enacting a statute containing an express preemption provision." *Arizona v. United States*, 132 S. Ct. 2492, 2500-01 (2012). As an ordinary defensive preemption claim, express preemption cannot support federal jurisdiction because it would not appear on the face of a well-pleaded complaint. *See Metro. Life Ins. Co. v. Taylor*, 481 U.S. 58, 63 (1987); *Sullivan*, 424 F.3d at 272 ("The well-pleaded complaint rule mandates that in assessing subject-matter jurisdiction, a federal court must disregard allegations that a well-pleaded complaint would not include—e.g., allegations about anticipated defenses.").

In contrast, under the "so-called 'complete preemption doctrine,'" which is distinct from the three forms of defensive preemption, "a plaintiff's 'state cause of action [may be recast] as a federal claim for relief, making [its] removal [by the defendant] proper on the basis of federal question jurisdiction.'" *Vaden v. Discover Bank*, 556 U.S. 49, 61 (2009) (alterations in original) (quoting Wright & Miller, 14B *Fed. Prac. & Proc. Juris.* § 3722.2); *see also Metro. Life*, 481 U.S. at 63-67 (extending complete preemption doctrine to the ERISA context and stating that complete preemption, unlike ordinary defensive preemption, supports federal subject-matter jurisdiction). "In concluding that a claim is completely preempted, a federal court finds that Congress desired not just to provide a federal defense to a state law claim but also to replace the state law claim with a federal law claim and thereby give the defendant the ability to seek adjudication of the claim in federal court." 14B *Fed. Prac. & Proc. Juris* § 3722.2. This does not mean simply that Congress intended the federal court to adjudicate a state law claim; rather, when a claim is completely preempted, "the law governing the complaint is exclusively federal." *Vaden*, 556 U.S. at 61; *see also Arditi*, 676 F.3d at 298.

Thus, in a case such as this, complete preemption may be "crucial to the existence of federal subject-matter jurisdiction." *Sullivan*, 424 F.3d at 274. Below, we hold that plaintiffs' claims were not completely preempted. Thus, in the absence of an alternative basis for subject-matter jurisdiction, it would be inappropriate to reach the merits of the ordinary express preemption defense. *See id.* at 277 ("Because it follows from our holding [of no complete

preemption] that the district court lacked subject-matter jurisdiction over this case, we have no occasion to consider the merits of [defendant's] argument that the plaintiffs' ... claims ... are subject to ordinary preemption.").

B. Class Action Fairness Act

In this case, defendants have asserted an alternative basis to justify removal to federal court. Under CAFA, federal courts have jurisdiction over a class action filed under Fed. R. Civ. P. 23 or a "similar State statute or rule of judicial procedure authorizing an action to be brought by 1 or more representative persons as a class action" if "the matter in controversy exceeds the sum or value of $5,000,000, exclusive of interest and costs" and the parties are minimally diverse. 28 U.S.C. § 1332(d)(1)(2). CAFA does not apply when "the number of members of all proposed plaintiff classes in the aggregate is less than 100." *Id.* § 1332(d)(5)(B).

"We generally evaluate jurisdictional facts, such as the amount in controversy, on the basis of the pleadings, viewed at the time when defendant files the notice of removal. With this in mind, a court must assess the three prerequisites for CAFA jurisdiction: no fewer than 100 members of the plaintiff class, minimal diversity, and $5 million in controversy." *Blockbuster, Inc. v. Galeno*, 472 F.3d 53, 56-57 (2d Cir. 2006) (internal citation omitted). "[The] defendant bears the burden of establishing federal subject matter jurisdiction" by showing that there is a "reasonable probability" that each of the jurisdictional prerequisites is satisfied. *Id.* at 58 (internal quotation marks omitted).

Defendants have satisfied this burden. Plaintiffs filed this action as a class action under Article 9 of the New York Civil Practice Law and Rules. With regard to the number of class members, the complaint states that "[p]laintiffs reasonably believe[] that there are hundreds of members in the proposed Class." With regard to minimal diversity, the complaint states that the named plaintiffs are residents of Arkansas and New York but makes no declaration as to citizenship. As defendants state in their notice of removal, however, "[e]ven if both were citizens of New York, minimal diversity exists since UnitedHealth is both incorporated and has its principal place of business in Minnesota." *See Blockbuster*, 472 F.3d at 59 ("[I]t seems plain to us that [defendant] is able to meet its burden of showing there is a reasonable probability that at least one of these class members is a citizen of New York and thus is 'a citizen of a State different from ... defendant.'" (quoting 28 U.S.C. § 1332(d)(2)(A))). Finally, with regard to the requirement of $5 million in controversy, the complaint states that defendants have "collect[ed] hundreds of millions of dollars in fully insured health insurance liens that they were not entitled to enforce or collect following the enactment of NY GOL 5335." In their notice of removal, defendants confirm that "[d]efendant Rawlings has handled subrogation and reimbursement claims totaling more than $5 million with respect to New York insureds covered by fully insured plans since the adoption of NY GOL § 5-335."

CAFA also contains express exceptions to jurisdiction. For example, federal jurisdiction would not exist here if (1) over two-thirds of the proposed plaintiffs were citizens of New York; (2) at least one

defendant from whom "significant relief is sought" was a citizen of New York; (3) "principal injuries resulting from the alleged conduct ... were incurred in" New York; and (4) "during the 3year period preceding the filing of that class action, no other class action has been filed asserting the same or similar factual allegations against any of the defendants on behalf of the same or other persons." 28 U.S.C. § 1332(d)(4). The Second Circuit has declined to reach the issue of who bears the burden with regard to CAFA exceptions. *See Blockbuster*, 472 F.3d at 58. Here, plaintiffs have not claimed that any CAFA exceptions apply (or contested CAFA jurisdiction at all), so as in *Blockbuster*, these "exceptions are not before us, and therefore we need not comment" further. *Id.*

Because CAFA supplies a basis for federal subject-matter jurisdiction, we reach defendants' express preemption defense in addition to their complete preemption argument. We discuss both forms of preemption below.

II. Express Preemption

ERISA expressly preempts any state law that "relate[s] to any employee benefit plan," but not if that law "regulates insurance." ERISA § 514(a)-(b), 29 U.S.C. § 1144(a)-(b). It is undisputed that N.Y. Gen. Oblig. Law § 5-335 "relate[s] to" ERISA plans, but we conclude that it is "saved" from express preemption as a law that "regulates insurance." A law "regulates insurance" under this savings clause if it (1) is "specifically directed toward entities engaged in insurance," and (2) "substantially affect[s] the risk pooling arrangement between the insurer

and the insured." *Kentucky Ass'n of Health Plans, Inc. v. Miller*, 538 U.S. 329, 342 (2003).

The district court's holding that N.Y. Gen. Oblig. Law § 5-335 does not fall within this savings clause is contrary to the Supreme Court's decision in *FMC Corp. v. Holliday*, 498 U.S. 52 (1990). *FMC* concerned a Pennsylvania antisubrogation statute similar in relevant respects to the one at issue here, and the Supreme Court stated that "[t]here is *no dispute* that the Pennsylvania law falls within ERISA's insurance saving clause" and that such laws "are 'saved'" from express preemption. *Id.* at 60-61 (emphasis added).

Here, the district court concluded that section 5-335 is not "specifically directed" at insurance because it regulates not only insurers but also all other "benefit provider[s]," "including self-funded employer plans."[5] *Wurtz*, 933 F. Supp. 2d at 503. But the antisubrogation statute at issue in *FMC* was also broadly addressed to "[a]ny program, group contract or other arrangement" for benefit payments, not just insurance companies. 498 U.S. at 55. Indeed, the specific issue in *FMC* related to the law's application to a self-funded plan.[6] Nonetheless, the Supreme

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[5] Under N.Y. Gen. Oblig. Law § 5-101, "'benefit provider' means any insurer, health maintenance organization, health benefit plan, preferred provider organization, employee benefit plan or other entity which provides for payment or reimbursement of health care expenses, health care services, disability payments, lost wage payments or any other benefits under a policy of insurance or contract with an individual or group."

[6] The issue in *FMC* was the effect of the so-called "deemer clause" of ERISA § 514(b)(2)(B), which exempts self-funded plans from the savings clause. The Supreme Court held that

Court recognized that the law "does not merely have an impact on the insurance industry; it is aimed at it." *Id.* at 61.

The district court also concluded that section 5-335 does not "substantially affect the risk pooling arrangement between the insurer and the insured" because the law "only applies to a subset of benefit providers, specifically, those without a statutory right of reimbursement and who do not intervene in underlying third party actions in which the third party settles." *Wurtz*, 933 F. Supp. 2d at 505. But the test is not whether the law substantially affects the whole insurance market—the test is whether the law substantially affects how risk is shared when it applies. For example, even though only a subset of insureds suffer from mental illness, the Supreme Court has held that a law requiring minimum mental health care benefits regulates insurance and is thus saved from preemption. *Metro. Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 743 (1985). Section 5-335 requires that insurers bear the risk of medical expenses whether or not the insured settles or goes to trial, and it thus substantially affects risk pooling between insurers and insureds.

Because N.Y. Gen. Oblig. Law § 5-335 is specifically directed toward insurers and substantially affects risk pooling between insurers and insureds, we

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the deemer clause did not cause preemption of the entire statute in all cases, but only as applied to self-funded plans. 498 U.S. at 61. Under *FMC*, the applicability of N.Y. Gen. Oblig. Law § 5-335 to self-funded plans would only mean that the law is preempted as applied to those plans (which is not the case here because the plans at issue are insured), not that the law is not "specifically directed" at insurance.

conclude that it is saved from express preemption under ERISA § 514 as a law that regulates insurance.

III. Complete Preemption

The district court held that plaintiffs' claims are completely preempted under ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B), which allows an ERISA participant to bring an action to receive or to clarify his plan benefits. In *Davila*, 542 U.S. at 210, the Supreme Court established a two-part test for determining whether a claim is completely preempted by § 502(a)(1)(B). As we have explained,

> [under *Davila*], claims are completely preempted by ERISA if they are brought (i) by "an individual [who] at some point in time, could have brought his claim under ERISA § 502(a)(1)(B)," and (ii) under circumstances in which "there is no other independent legal duty that is implicated by a defendant's actions."

Montefiore Med. Ctr. v. Teamsters Local 272, 642 F.3d 321, 328 (2d Cir. 2011) (footnote omitted) (quoting *Davila*, 542 U.S. at 210). State law claims are completely preempted only if both parts of this test are satisfied. *Id.* In this case, plaintiffs' claims under N.Y. Gen. Oblig. Law § 5-335 satisfy neither part of the *Davila* test.

A. *Davila* Part One

In *Montefiore*, we "expressly disaggregate[ed] the first prong of *Davila*": "First, we consider whether the plaintiff is the *type* of party that can bring a claim pursuant to § 502(a)(1)(B); and second, we con-

sider whether the *actual claim* that the plaintiff asserts can be construed as a colorable claim for benefits pursuant to § 502(a)(1)(B)." *Montefiore*, 642 F.3d at 328. In this case, it is undisputed that the plaintiffs are the type of party that can bring a claim pursuant to § 502(a)(1)(B). The only issue under the first part of the *Davila* test is thus whether plaintiffs' claims—to prevent defendants from asserting subrogation claims against plaintiffs' tort recoveries in settlement—can be construed as colorable claims for benefits under § 502(a)(1)(B). We conclude that they cannot.

ERISA § 502(a)(1)(B) allows a plaintiff "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 claims in plaintiffs' complaint seek to do none of these things. Plaintiffs 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 N.Y. Gen. Oblig. Law § 5-335. They also do not seek to "enforce" or "clarify" their rights "under the terms of [their] plan[s]" because the state right they seek to enforce—to be free from subrogation—is not provided by their plans. Indeed, the terms of plaintiffs' ERISA plans are irrelevant to their claims. Plaintiffs' claims are thus unlike the claims for benefits that were held completely preempted in *Davila*, for which "the wording of the plans [was] certainly material to [the] state causes of action." 542 U.S. at 215.[7] As plaintiffs explain, they

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[7] The *Davila* plaintiffs "complain[ed] only about denials of coverage promised under the terms of ERISA-regulated em-

"have already received all the benefits they were due in the form of medical expense coverage, and make no claim for any more." Pls.' Reply Br. 6.

The district court held that plaintiffs' claims can be construed as claims for benefits under ERISA § 502(a)(1)(B) because they "effectively seek to cut off defendants' reimbursement rights under the Plans." *Wurtz*, 933 F. Supp. 2d at 493. The district court reasoned that the claims are "really about [plaintiffs'] right to *keep* the monetary benefits received from defendants under their ERISA governed plans; this triggers issues concerning their rights and ability to recover (and/or retain) benefits under the Plans, and accordingly, brings ERISA § 502(a)(1)(B) directly into play." *Id.* at 495.

This expansive interpretation of complete preemption ignores the fact that plaintiffs' claims are based on a state law that regulates insurance and are not based on the terms of their plans. As a result, state law does not impermissibly expand the exclusive remedies provided by ERISA § 502(a). Under ERISA § 514(a)(b), state laws that "relate to" ERISA plans are expressly preempted, but not if they "regulate[] insurance." 29 U.S.C. § 1144(a)(b). Based on this "insurance saving clause," the Su-

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ployee benefit plans," arguing that they were entitled to additional benefits under a state law that imposed a duty to "exercise ordinary care when making health treatment decisions." 542 U.S. at 211-12. However, the state law made clear that "a managed care entity could not be subject to liability under the [state law] if it denied coverage for any treatment not covered by the health care plan that it was administering," so "interpretation of the terms of [plaintiffs'] benefit plans form[ed] an essential part of their [state law] claim." *Id.* at 213.

preme Court has held that state statutes regulating insurance that nonetheless affect ERISA benefits are not expressly preempted, with no hint that claims under these statutes might still be completely preempted and thus unable to be adjudicated under those state laws when they do not expand the remedies available for beneficiaries for claims based on the terms of their plans. *See Rush Prudential HMO Inc. v. Moran*, 536 U.S. 355, 377-79 (2002); *UNUM Life Ins. Co. of Am. v. Ward*, 526 U.S. 358, 366-67 (1999).

B. *Davila* Part 2

Plaintiffs' claims under N.Y. Gen. Oblig. Law § 5-335 also do not satisfy the second part of the *Davila* test—that there be "no other independent legal duty that is implicated by [the] defendant[s'] actions." *Davila*, 542 U.S. at 210. The district court held that plaintiffs' claims implicate no independent legal duty because their claims are "inextricably intertwined with the interpretation of Plan coverage and benefits." *Wurtz*, 933 F. Supp. 2d at 498 (quoting *Montefiore*, 642 F.3d at 332) (internal quotation marks omitted). But the independent legal duty arises from section 5-335, which prohibits defendants from seeking subrogation or reimbursement from settling parties. The duty is independent because it is unrelated to whatever plaintiffs' ERISA plans provide about reimbursement.

In *Stevenson*, 609 F.3d at 60-61, this court held that the plaintiff's state law contract and unjust enrichment claims that "reference[d] various benefit plans" were not completely preempted because they arose from a "separate promise" that did "not require a court to review the propriety of an administrator's

or employer's determination of benefits." Similarly here, while defendants' reimbursement claims relate to plaintiffs' plans, this is not the test for complete preemption. Plaintiffs' claims do not derive from their plans or require investigation into the terms of their plans; rather, they derive from N.Y. Gen. Oblig. Law § 5-335.

The district court also stated that section 5-335 could not be the basis of an independent legal duty because it does not apply "where there is a statutory right of reimbursement," N.Y. Gen. Oblig. Law § 5-335(a), and plaintiffs' plans contain a right of reimbursement that "is enforced by means of ERISA." *Wurtz*, 933 F. Supp. 2d at 499-500. However, "ERISA says nothing about subrogation provisions. ERISA neither requires a welfare plan to contain a subrogation clause nor does it bar such clauses or otherwise regulate their content." *Member Servs. Life Ins. Co. v. Am. Nat'l Bank & Trust Co. of Sapulpa*, 130 F.3d 950, 958 (10th Cir. 1997) (quoting *Ryan ex rel. Capria-Ryan v. Fed. Express Corp.*, 78 F.3d 123, 127 (3d Cir. 1996)) (internal quotation marks omitted). Under the district court's reasoning, all contract language enforced by statute would become "statutory" language.

"The [*Davila*] test is conjunctive; a state-law cause of action is [completely] preempted only if both prongs of the test are satisfied." *Montefiore*, 642 F.3d at 328. Because plaintiffs' claims do not satisfy either part of the *Davila* test, we hold that they are not completely preempted by ERISA.

C. Other Circuits

We recognize that this result is in some tension with holdings of the Third, Fourth, and Fifth Cir-

cuits in similar antisubrogation cases, albeit decided before *Davila*. *See Arana v. Ochsner Health Plan*, 338 F.3d 433, 438 (5th Cir. 2003) (en banc) (holding that a claim under a Louisiana antisubrogation statute could be characterized as a claim under ERISA § 502(a)(1)(B) because the plaintiff's "benefits are under something of a cloud, for [the insurer] is asserting a right to be reimbursed for the benefits it has paid to his account"); *Singh v. Prudential Health Care Plan, Inc.*, 335 F.3d 278, 291-92 (4th Cir. 2003) (holding a claim under a Maryland antisubrogation statute to be completely preempted)[8]; *see also Levine v. United Healthcare Corp.*, 402 F.3d 156, 163 (3d Cir. 2005) (following *Arana* and *Singh*).

As we have explained, however, 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).

We are more persuaded by the reasoning of the Ninth Circuit in *Marin General Hospital v. Modesto & Empire Traction Co.*, 581 F.3d 941 (9th Cir. 2009), which was decided after *Davila*. In that case, a hospital sued an ERISA plan administrator in state court based on breach of an oral contract to cover 90% of an ERISA participant's expenses, and the administrator removed to federal court, arguing that the claims were completely preempted. *Id.* at 944.

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[8] The *Singh* Court did, however, conclude that the antisubrogation statute was *not* expressly preempted, noting that "[i]n *FMC Corp. v. Holliday*, the Supreme Court dealt precisely with the question of whether a State antisubrogation law was saved from preemption under § 514(b)(2)(A), and held that it was." 335 F.3d at 286. As explained above, we agree.

The Ninth Circuit disagreed. The claims failed the first part of the *Davila* test: "The Hospital does not contend that it is owed this additional amount because it is owed under the patient's ERISA plan. Quite the opposite. The Hospital is claiming this amount precisely because it is not owed under the patient's ERISA plan." *Id.* at 947. And the claims additionally failed the second part of the *Davila* test in that they implicated the independent legal duty of state contract law. *Id.* at 950. The Ninth Circuit directed that the case be remanded to state court for lack of federal jurisdiction. *Id.* at 951.

Other circuits have similarly declined to expand complete preemption doctrine to allow removal of state law claims into federal court simply because they implicate ERISA benefits. *See, e.g.*, *Gardner v. Heartland Indus. Partners, LP*, 715 F.3d 609, 614 (6th Cir. 2013) (concluding that a state law claim for tortious interference with an ERISA plan is not completely preempted because "[n]obody needs to interpret the plan to determine whether th[e] duty [to not interfere] exists"); *Lone Star OB/GYN Assocs. v. Aetna Health Inc.*, 579 F.3d 525, 531–32 (5th Cir. 2009) (concluding that claims implicating the *rate* of payment under the Texas Pay Prompt Act are not completely preempted because they do not duplicate ERISA claims); *Franciscan Skemp Healthcare, Inc. v. Cent. States Joint Bd. Health & Welfare Trust Fund*, 538 F.3d 594, 597 (7th Cir. 2008) (concluding that claims by an ERISA beneficiary's assignee to recover plan benefits are not completely preempted because they "arise not from the plan or its terms, but from the alleged oral representations made by" the plan provider).

In the same vein, in this case plaintiffs are not claiming that they have a right to enjoin defendants from seeking reimbursement because of the terms of their ERISA plans. Rather, they claim that they have this right under N.Y. Gen. Oblig. Law § 5-335, which imposes an independent legal duty on defendants not to seek reimbursement of medical expenses from plaintiffs' tort settlements, regardless of what plaintiffs' ERISA plans say about reimbursement.

Allowing plaintiffs' statelaw claims under section 5-335 to proceed will not disturb ERISA's goal of providing national uniformity. ERISA has strong preemptive provisions, the purpose of which are "to provide a uniform regulatory regime over employee benefit plans." *Davila*, 542 U.S. at 208. But "ERISA says nothing about subrogation provisions. ERISA neither requires a welfare plan to contain a subrogation clause nor does it bar such clauses or otherwise regulate their content." *Member Servs. Life Ins. Co.*, 130 F.3d at 958 (internal quotation marks omitted). *Cf. La. Health Serv. & Indem. Co. v. Rapides Healthcare Sys.*, 461 F.3d 529, 535 (5th Cir. 2006) (concluding, in the face of ERISA's "silen[ce] on the assignability of employee welfare benefits," that a Louisiana assignment statute—which gave hospitals a cause of action against insurers that did not honor benefit assignments made by patients to hospitals—was not preempted by ERISA § 502(a)(1)(B)). Because ERISA is silent on subrogation, our decision does nothing to disturb ERISA's goal of national uniformity in employee benefit plan regulation.

CONCLUSION

For the reasons stated above, we conclude that CAFA supplies a basis for federal subject-matter ju-

risdiction and that plaintiffs' claims are neither expressly nor completely preempted by ERISA. We VACATE the district court's judgment and REMAND for further proceedings on plaintiffs' claims.

APPENDIX B: OPINION OF THE U.S. DISTRICT COURT FOR THE EASTERN DISTRICT OF NEW YORK

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF NEW YORK

№ 12-CV-1182 (JFB) (ETB)

MEGHAN WURTZ AND MINDY BURNOVSKI, INDIVIDUALLY AND ON BEHALF OF ALL OTHERS SIMILARLY SITUATED,

Plaintiffs,

VERSUS

THE RAWLINGS COMPANY, LLC, OXFORD HEALTH PLANS (NY), INC., AND UNITEDHEALTH GROUP, INC.

Defendants.

MEMORANDUM AND ORDER
March 28, 2013

JOSEPH F. BIANCO, District Judge:

Plaintiffs Meghan Wurtz ("Wurtz") and Mindy Burnovski ("Burnovski") bring this class action on behalf of themselves and all others similarly situated (collectively, "plaintiffs")[1] against The Rawlings

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[1] Plaintiffs seek to represent a class of, *inter alia*, "all persons who have paid monies to Defendants and/or their agents pursuant to fully insured health insurance plans in violation of New York State General Obligation Law § 5-335 . . ., all persons against who Defendants and/or their agents have, pursu-

Company, LLC ("Rawlings"), Oxford Health Plans (NY), Inc. ("Oxford Health"), and UnitedHealth Group, Inc. ("UnitedHealth") (collectively, "defendants"). Plaintiffs seek compensatory and punitive damages, restitution, attorneys' fees, and declaratory relief arising from defendants' allegedly improper enforcement of claims/liens for reimbursement following Oxford Health's payment of plaintiffs' medical expenses pursuant to its health benefit plans with plaintiffs' employers. In particular, plaintiffs assert that New York General Obligations Law § 5-335 ("NY GOL § 5-335") trumps any reimbursement rights that defendants might have under the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001, *et seq.*, and/or the terms of their health benefit plans, and furthermore, that defendants are in violation of NY GOL § 5-335 by virtue of their assertion of such rights. Plaintiffs accordingly argue that (1) declaratory judgment is warranted because NY GOL § 5-335 bars reimbursement or subrogation under defendants' health benefit plans; (2) defendants' actions constitute deceptive acts and practices pursuant to Section 349 of New York's General Business Law ("NY GBL § 349"); and (3) defendants wrongfully benefited from their unlawful acts, misrepresentations, and omissions, and accordingly, have been unjustly enriched at plaintiffs' expense.

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ant to their fully insured health insurance plans, wrongfully asserted and continue to assert liens and/or rights of subrogation and/or reimbursement from settled cases and/or claims covered by NY GOL § 5-335, and . . . all persons covered by a fully insured health insurance policy with respect to any personal injury . . . or similar cases or claims arising and/or pending in New York." (Compl. ¶ 29.)

Defendants move to dismiss pursuant to Rule 12(b)(6) of the Federal Rules of Civil Procedure on the following grounds: (1) plaintiffs' claims are completely preempted pursuant to Section 502 of ERISA, as they directly concern rights under their ERISA-governed benefit plans and do not implicate a legal duty independent of the plans; (2) plaintiffs' claims are expressly preempted pursuant to Section 514 of ERISA; (3) even if plaintiffs were to try and bring their claims under ERISA § 502(a)(1)(B), their claims would be deficient, thereby requiring dismissal; and (4) plaintiffs' state law claims fail on their own terms.

After careful consideration of the parties' arguments, and for the reasons set forth herein, the Court grants defendants' motion to dismiss.

I. Facts

The following facts are taken from the complaint and are not findings of fact by the Court. The Court assumes these facts to be true for purposes of deciding the pending motion to dismiss. The Court construes the facts in the light most favorable to plaintiffs, the non-moving party.

A. Accidents, Legal Actions, Liens, and State Laws

Both Wurtz and Burnovski are participants in health benefit plans ("Plans" or "Oxford Health Plans") that are provided by their employers and insured by Oxford Health. Pursuant to the express terms of these Plans, Oxford Health is entitled to be reimbursed for health benefits provided to a member if he or she recovers the cost of those benefits from a third party. (Pls.' Opp'n to Defs.' Mot. to Dismiss ("Pls.' Opp'n") at 2.) As discussed in greater detail

supra, Wurtz and Burnovski suffered injuries arising from separate accidents; each then received medical benefits from Oxford Health and brought suit against those parties allegedly responsible for their injuries. (Compl. ¶¶ 6-7.) Because of this, Rawlings, acting as Oxford Health's subrogation claims recovery vendor, corresponded with plaintiffs and/or their counsel, asserting "claims/liens" for reimbursement of Oxford Health's coverage of such expenses, and requesting notification prior to any settlement of their claims. (*Id.* ¶¶ 18-19, 21.)

1. Background on the Health Care Entities

UnitedHealth is a self-described "leader in the health benefits and services industry," offering various services in the health care field. (*Id.* ¶ 10.) Oxford Health is a health insurance company that provides health insurance benefit plans. (*Id.* ¶ 11.) In 2004, Oxford Health and UnitedHealthcare (an operating division of defendant UnitedHealth) joined forces and merged. (*Id.*)[2]

Rawlings is a self-described "recognized leader in the healthcare subrogation services field." (*Id.* ¶ 8.) The company acts as a collection agent, or subrogation claims recovery vendor, on behalf of Oxford

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[2] Although plaintiffs' pleadings make clear that Oxford Health and UnitedHealth merged in 2004, it is not clear if the companies subsequently became one company with a single name. The complaint repeatedly refers to each company as a seemingly separate entity, despite the alleged 2004 merger, and it is unclear how the respective entities' merger affected each company's business status or division of responsibilities.

Health,[3] helping it to process claims and recover money for debts owed for prior healthcare services. (*Id.*) For purposes of the underlying dispute, these companies' respective roles in the healthcare industry all became intertwined following events involving Wurtz, Burnovski, and incidents leading to their individual personal injuries and damages. Before addressing the events leading to the underlying dispute, the Court addresses NY GOL § 5-335.

2. New York Statutory Law

On November 10, 2009, Senate Bill S66002 was passed by both the New York State Senate and Assembly; it became effective on November 12, 2009. (*Id.* ¶ 13.) Senate Bill S66002, in effect, amended New York's General Obligations Law by adding a new section, Section 5-335, around which this dispute centers. The relevant portions of Section 5-335, at least for purposes of this dispute, are as follows:

> § 5-335. Limitation of Non-Statutory Reimbursement and Subrogation Claims in Personal Injury and Wrongful Death Actions.
>
> (a) When a plaintiff settles with one or more defendants in an action 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 earn-

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[3] The Court assumes that any subrogation actions that Rawlings takes on behalf of Oxford Health are, following the latter's merger with UnitedHealth, also taken on behalf of UnitedHealth.

> ings or other economic loss to the extent those losses or expenses have been or are obligated to be paid or reimbursed by a benefit provider, *except for those payments as to which there is a statutory right of reimbursement*. By entering into any such settlement, a plaintiff shall not be deemed to have taken an action in derogation of any nonstatutory right of any benefit provider that paid or is obligated to pay those losses or expenses; nor shall a plaintiff's entry into such settlement constitute a violation of any contract between the plaintiff and such benefit provider.
>
> *Except where there is a statutory right of reimbursement*, no party entering into such a settlement shall be subject to a subrogation claim or claim for reimbursement by a benefit provider and a benefit provider shall have no lien or right of subrogation or reimbursement against any such settling party, with respect to those losses or expenses that have been or are obligated to be paid or reimbursed by said benefit provider.

(*Id.* ¶ 14 (emphasis added).)

3. Wurtz and Burnovski

Wurtz is a resident of Little Rock, Arkansas who, on April 4, 2008, sustained personal injuries and damages in an accident. (Compl. ¶ 6.)[4] Due to her

[4] The nature of Wurtz's accident is unclear from the pleadings.

injuries, Wurtz received medical benefits from her Oxford Health Plan, entitled "Freedom Plan Metro Access." (*Id.*) Similarly, Burnovski is a resident of Long Beach, New York who was in a motor vehicle accident on July 5, 2008. (*Id.* ¶ 7). Burnovski sustained both personal injuries and damages from the accident, for which she received medical benefits from her fully insured Oxford Health Plan, entitled the "Oxford Exclusive Plan Metro," or the "Oxford Freedom EPO Plan." (*Id.*)

On December 9, 2008, Wurtz filed a lawsuit in the Supreme Court of the State of New York, seeking to recover for the injuries and damages she suffered from the April 2008 accident. (*Id.* ¶ 6.) She later settled this action on October 28, 2011. (*Id.*)

Although the chronological nature of events is unclear from the pleadings, it appears that sometime between the enactment of NY GOL § 5-335 and Wurtz's settlement, Rawlings, pursuant to its subrogation responsibilities with Oxford Health, contacted both Wurtz and Burnovski (via mail or fax) asserting a claim/lien that sought reimbursement for Oxford Health's coverage of Wurtz and Burnovski's respective medical expenses, the former of which totaled $1,316.87 (*id.* ¶¶ 6, 18-19), and the latter of which totaled $78,991.48 (*id.* ¶ 7).[5]

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[5] The complaint confusingly states that Rawlings sought to recover medical expenses from "Plaintiff Sylvia Potts." (Compl. ¶ 6.) The Court understands the Complaint's reference to a "Sylvia Potts" to be a typographical error, given that the entire paragraph discusses Wurtz's accident, subsequent medical expenses, settlement, and her paying off the lien asserted by Rawlings.

On receiving notice from Wurtz that her personal injury action settled on October 28, 2011, Rawlings again sent Wurtz a letter informing her that its lien on behalf of Oxford Health remained in effect. (*Id.* ¶ 19.) Rawlings included with this letter the Company's November 2009 position statement. (*Id.*) In addition, Rawlings also stated:

> This letter shall serve as notice that our client has a claim/lien for medical benefits paid on behalf of the patient for the above-referenced loss. These medical expenses were paid pursuant to an ERISA plan governed by federal law. There are differing legal viewpoints regarding the application of New York law CPLR § 4545 and General Obligations Law 5-335 as amended by Governor's Program Bill 95/S66002 effective November 12, 2009. This claim/lien applies to any amount now due or which may hereafter become payable out of a recovery collected or to be collected, whether by judgment, settlement, or compromise, from any party hereby notified. No settlement of any claim should be made prior to notifying our office of the potential settlement and reaching an agreement for satisfaction of our client's interest.

(*Id.*) Rawlings sent Burnovski a letter containing this same language on November 30, 2011. (*Id.* ¶ 21.)

On January 10, 2012, Wurtz paid Rawlings $1,316.87 to release its lien under the Oxford Health

Plan. (*Id.* ¶¶ 6, 20.) Burnovski does not allege that she has settled her personal injury lawsuit or satisfied the reimbursement claim.

II. Procedural History

On February 2, 2012, plaintiffs filed the instant action against defendants in the Supreme Court of the State of New York for the County of Nassau. Defendants removed the action to this Court on March 9, 2012. On May 30, 2012, defendants submitted a motion to dismiss. On June 29, 2012, plaintiffs filed their opposition to defendants' motion to dismiss. Defendants submitted their reply on July 16, 2012. On December 26, 2012, the case was reassigned to the undersigned, and oral argument was subsequently held on January 22, 2013. On January 29, 2013 and February 6, 2013, the parties submitted letters addressing issues raised during oral argument. This matter is fully submitted and the Court has considered all of the party's submissions.

III. Standard of Review

A. Motion to Dismiss

Motions to dismiss under Rule 12(b)(6) of the Federal Rules of Civil Procedure probe the legal, not the factual, sufficiency of a complaint. *See, e.g., Sims v. Artuz*, 230 F.3d 14, 20 (2d Cir. 2000). Stated differently, when assessing the viability of a complaint's pleadings at the Rule 12(b)(6) stage, "the issue is not whether a plaintiff is likely to prevail ultimately, but whether the claimant is entitled to offer evidence to support the claims." *Chance v. Armstrong*, 143 F.3d 698, 701 (2d Cir. 1998) (internal alternation omitted). Thus, when reviewing a motion to dismiss, "the [c]ourt must accept the factual allegations set forth in the complaint as true and draw

all reasonable inferences in favor of the plaintiff." *Volpe v. Nassau Cnty.*, 12-CV-2416 (JFB)(AKT), 2013 WL 28561, at *5 (E.D.N.Y. Jan. 3, 2013); *see also Erickson v. Pardus*, 551 U.S. 89, 93-94 (2007) (per curiam). However, "the tenet that a court must accept as true all of the allegations contained in a complaint is inapplicable to legal conclusions." *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009).

To survive a motion to dismiss, a complaint must set forth "a plausible set of facts sufficient 'to raise a right to relief above the speculative level.'" *Operating Local 649 Annuity Trust Fund v. Smith Barney Fund Mgmt. LLC*, 595 F.3d 86, 91 (2d Cir. 2010) (quoting *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 555 (2007)). Generally, this standard for survival does not require "heightened fact pleading of specifics, but only enough facts to state a claim to relief that is plausible on its face." *Twombly*, 550 U.S. at 570.

Where a motion to dismiss presents itself before the court, a court may examine the following: "(1) facts alleged in the complaint and documents attached to it or incorporated in it by reference, (2) documents 'integral' to the complaint and relied upon in it, even if not attached or incorporated by reference, (3) documents or information contained in defendant's motion papers if plaintiff has knowledge or possession of the material and relied on it in framing the complaint, (4) public disclosure documents required by law to be, and that have been, filed with the Securities and Exchange Commission, and (5) facts of which judicial notice may properly be taken under Rule 201 of the Federal Rules of Evidence." *Nasso v. Bio Reference Labs., Inc.*, No. 11-cv-3480(JFB)(ETB), 2012 WL 4336429, at *3 (quoting

In re Merrill Lynch & Co., 273 F. Supp. 2d 351, 356-57 (S.D.N.Y. 2003)) (internal citations omitted).

IV. Discussion

Defendants contend that plaintiffs are attempting to use state law to negate their obligations to reimburse their respective employers' benefit Plans from proceeds recovered from third party tortfeasors. Defendants argue that plaintiffs' claims, grounded in NY GOL § 5-335, are superseded under two parallel and independent principles of preemption: (1) complete preemption under ERISA § 502(a), and (2) express preemption under ERISA § 514.[6] For this reason, defendants assert that this Court should dismiss plaintiffs' claims, even if NY GOL § 5-335 may be deemed applicable to the governing ERISA regulated plans (which defendants claim it cannot). As set forth below, the Court agrees with defendants.

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[6] Complete preemption applies where Congress has so "completely pre-empt[ed] a particular area that any civil complaint raising this select group of claims is necessarily federal in character." *Bloomfield v. MacShane*, 522 F. Supp. 2d 616, 620 (S.D.N.Y. 2007) (quoting *Metro. Life Ins. Co. v. Taylor*, 481 U.S. 58, 63-64 (1987)) (internal quotation marks omitted). In contrast, express preemption applies where a federal law "contains an express preemption clause," requiring the court to "'focus on the plain wording of the clause, which necessarily contains the best evidence of Congress' preemptive intent.'" *Chamber of Commerce of U.S. v. Whiting*, 131 S. Ct. 1968, 1977 (2011) (quoting *CSX Transp., Inc. v. Easterwood*, 507 U.S. 658, 664 (1993)). As set forth *infra*, the Court concludes that plaintiffs' claims (including their declaratory judgment, unjust enrichment, and NY GBL § 349 claims) are both completely and expressly preempted pursuant to ERISA's expansive scope regarding employment benefit plans. *See Metro. Life*, 481 U.S. at 63-64.

A. Complete Preemption

1. Legal Standard

ERISA was enacted to "'protect . . . the interests of participants in employee benefit plans and their beneficiaries' by setting out substantive regulatory requirements for employee benefit plans and to 'provid[e] for appropriate remedies, sanctions, and ready access to the Federal courts.'" *Aetna Health Inc. v. Davila*, 542 U.S. 200, 208 (2004) (quoting 29 U.S.C. § 1001(b)) (alteration in original). Its main objective "is to provide a uniform regulatory regime over employee benefit plans." *Id.; see also also N.V. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 656-57 (1995) ("Congress intended 'to ensure that plans and plan sponsors would be subject to a uniform body of benefits law; the goal was to minimize the administrative and financial burden of complying with conflicting directives among States or between States and the Federal Government . . . , [and to prevent] the potential for conflict in substantive law . . . requiring the tailoring of plans and employer conduct to the peculiarities of the law of each jurisdiction.'" (alterations in original) (quoting *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 142 (1990))).

To provide such uniformity, the statute contains broad preemption provisions, which safeguard the exclusive federal domain of employee benefit plan regulation. *See Davila*, 542 U.S. at 208; *see also Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 523 (1981). One such source of preemption under ERISA is Section 502(a)(1)(B), which serves as ERISA's main enforcement tool in ensuring a uni-

form federal scheme. Section 502(a)(1)(B) of ERISA provides:

> 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.

29 U.S.C. § 1132(a)(1)(B).

The Supreme Court has explained that "the detailed provisions of § 502(a) set 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 Ins. Co. v. Dedeaux*, 481 U.S. 41, 54 (1987). The Supreme Court has noted how "the inclusion of certain remedies and the exclusion of others under [§ 502's] federal scheme . . . 'provide[s] strong evidence that Congress did *not* intend to authorize other remedies that it simply forgot to incorporate expressly.'" *Id.* (quoting *Mass. Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 146 (1985)). It likewise has acknowledged that "the federal scheme would be completely undermined if ERISA-plan participants and beneficiaries were free to obtain remedies under state law that Congress rejected in ERISA." *Id.*

For this reason, where a plaintiff brings a state law claim that is in reality an ERISA-claim cloaked in state-law language, ERISA's preemption power will take effect. *See Davila*, 542 U.S. at 207 (stating that "[w]hen a federal statute wholly displaces the state-law cause of action through complete pre-

emption, the state claim can be removed" to federal court (quoting *Beneficial Nat'l Bank v. Anderson*, 539 U.S. 1, 8 (2003)) (alterations and internal quotation marks omitted)); *id.* at 207-08 ("[W]hen the federal statute completely preempts the state-law cause of action, . . . even if pleaded in terms of state law, [it] is in reality based on federal law." (citation and internal quotation marks omitted)); *id.* at 208 (describing ERISA as "one of these statutes" that holds complete preemption power). The effect of this preemptive power cannot be understated: it "prevents plaintiffs from 'avoid[ing] removal' to federal court 'by declining to plead necessary federal questions.'" *Arditi v. Lighthouse Int'l*, 676 F.3d 294, 298-99 (2d Cir. 2012) (quoting *Romano v. Kazacos*, 609 F.3d 512, 519 (2d Cir. 2010)) (alteration in original).

The relevant test for assessing whether a claim is completely preempted under ERISA consists of two parts:

> claims are completely preempted by ERISA if they are (i) brought by "an individual [who] at some point in time, could have brought his claim under ERISA § 502(1)(B)," and (ii) under circumstances in which "there is no other independent legal duty that is implicated by a defendant's actions."

Montefiore Med. Ctr. v. Teamsters Local 272, 642 F.3d 321, 328 (2d Cir. 2011) (quoting *Davila*, 542 U.S. at 210); *see also Davila*, 542 U.S. at 210 ("[I]f an individual . . . could have brought his claim under ERISA § 502(a)(1)(B), and where there is no other independent legal duty that is implicated by defendant's actions, then the individual's cause of action is

completely pre-empted by ERISA § 502(a)(1)(B)."); *Metro. Life*, 481 U.S. at 65-66 (noting that section 502(a)(1)(B) of ERISA contains "extraordinary pre-emptive power" that "converts an ordinary state common law complaint into one stating a federal claim," making "causes of action within the scope of . . . § 502(a) . . . removable to federal court"). Additionally, "[t]o avoid potential confusion under the first prong of *Davila*, [the Second Circuit] has further clarified that the plaintiff must show that: (a) he is the type of party who can bring a claim pursuant to § 502(a)(1)(B) of ERISA; and (b) the actual claim asserted can be construed as a colorable claim for benefits pursuant to § 502(a)(1)(B)." *Arditi*, 676 F.3d at 299. Where both of *Davila*'s factors are satisfied—including the two sub-parts to *Davila*'s first prong—ERISA will preempt the state law claim. *Id.* (citing cases).

2. Application

a. *Davila* Prong One

The Court first addresses whether plaintiffs are "the *type* of party that can bring a claim" under Section 502(a)(1)(B); it then considers "whether the *actual claim*" at issue constitutes a "colorable claim" for benefits under Section 502(a)(1)(B). *Montefiore*, 642 F.3d at 328; *see also Josephson v. United Healthcare Corp.*, No. 11-cv-3665(JS)(ETB), 2012 WL 4511365, at *3 (E.D.N.Y. Sept. 28, 2012) (acknowledging the Second Circuit's interpretation of *Davila*'s two-pronged test as consisting of two inquiries under the first prong).

i. Type of Party

As previously set forth, Section 502(a)(1)(B) clearly provides that a civil action may be brought

(1) "by a participant or beneficiary" of (2) an ERISA employee benefit plan. 29 U.S.C. § 1132(A)(1)(B). Examining each in turn, it is clear that both of these factors is satisfied in this case.

To begin with, Oxford Health's fully insured Plans constitute an employee welfare benefit plan within the meaning of Section 3(1) of ERISA, 29 U.S.C. § 1002(1).[7] Further, plaintiffs each qualify as a "participant or beneficiary" of their employers' health Plans, as they were eligible for benefits (which they received) under the Plans. (*See* Compl. ¶¶ 6-7); *see also* 29 U.S.C. § 1002(7) (defining "participant" as "any employee or former employee of an employer . . . who is or may become eligible to receive a benefit of any type from an employee benefit plan which covers employees of such employer or members of such organization, or whose beneficiaries may be eligible to receive any such benefit").) Thus, plaintiffs meet at least the initial standing requirements to bring a civil action under Section 502(a)(1)(B). *See* 29 U.S.C. § 1132(a)(1)(B); *see also Arditi*, 676 F.3d at 299 (finding that plaintiff "is the type of party who can bring an ERISA claim because he is a Plan participant and he is seeking benefits under the Plan").

ii. Colorable Claim

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[7] Section 3(1) of ERISA defines an employee welfare benefit plan as "any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries . . . benefits." 29 U.S.C. § 1002(1).

Defendants assert that plaintiffs' cause of action here—seeking a judgment concluding that the Plans' reimbursement provisions are not applicable to them by virtue of NY GOL § 5-335—is in fact a claim under Section 502(a)(1)(B) of ERISA. (*See* Defs.' Mem. of Law in Supp. of Mot. to Dismiss ("Defs.' Mot. to Dismiss") at 7; Defs.' Reply at 2.)

Plaintiffs first argue that the medical benefits they received under their Plans are not subject to the latter's subrogation and/or reimbursement provisions because NY GOL § 5-335 nullifies any such lien power; ergo, plaintiffs are entitled to hold onto the previously received benefits. (Compl. ¶ 41.) Second, plaintiffs argue that their claims are not for a "right to payment," which would implicate ERISA's provisions, but rather, solely concern an "amount to payment" under the Plans. (Pls.' Opp'n at 4-6.) The Court addresses each of these arguments in turn.

a) **Whether Plaintiffs' Claims Sound in Benefits**

As to their benefits argument, it is not enough for plaintiffs to simply assert that their claims as to benefit entitlement are dictated by state law so as to shield their claims from ERISA's preemptive force. Instead, reading the pleadings in the light most favorable to plaintiffs and drawing all inferences in their favor, it must be reasonable and appropriate for the Court to conclude that the underlying allegations here are not ones that, for all intents and purposes, fall under Section 502(a)(1)(B) of ERISA. *See Davila*, 542 U.S. at 210 (noting that Section 502(a) will preempt a state law claim where two conditions are met, the first of which is that a plaintiff "could have brought his or her claim under ERISA

§ 502(a)(1)(B)"); *Harrison v. Metro. Life Ins. Co.*, 417 F. Supp. 2d 424, 434 (S.D.N.Y. 2006).

Section 502(a)(1)(B)'s language is clear: it provides an exclusive civil remedy to "participants or beneficiaries" of an ERISA-governed plan "to *recover benefits due under their plans*, to *enforce rights under their plans*, or to *clarify rights to future benefits under their plans*." *Arditi*, 676 F.3d at 299 (emphasis added) (citing 29 U.S.C. § 1132(a)). Plaintiffs' allegations in this case, even when read in their favor, directly implicate issues concerning benefits due under the Plans, as well as their right to such benefits. (*See* Compl. ¶ 6 ("Defendant Rawlings, as agent for Defendant Oxford Health Plans (NY), has asserted . . . a lien under Defendant Oxford Health (NY) fully insured Freedom Plan Metro Access insurance plan to recover from Plaintiff . . . medical expenses in the sum of $1,316.87 . . . . The lien [c]laimed by the Defendant The Rawlings Company, LLC and United Healthcare Oxford Health Care Plan (NY) is invalid as a matter of law in violation of NY GOL § 5-335."); *id.* ¶ 7 ("As a result of the personal injuries that Plaintiff Burnovski sustained in [her] accident, Ms. Burnovski received medical benefits through her fully insured United Healthcare Oxford Insurance plan . . . . Defendant Rawlings . . . has asserted and continues to assert a lien under Defendant Oxford Health Plans' fully insured [] Plan, and presently seeks to recover from Plaintiff [Burnovski] medical expenses in the sum of $78,991.48 in violation of NY GOL § 5-335.").)

Moreover, plaintiffs' particular causes of action—for declaratory judgment, unjust enrichment, and deceptive conduct under NY GBL § 349—while not pled as claims for benefits under Section 502(a)(1)(B)

of ERISA, may fairly be characterized as such, only masked in state law guise. That is, plaintiffs effectively seek to cut off defendants' reimbursement rights under the Plans, and to retain benefits that otherwise would be subject to reimbursement. These actions directly fall within the scope of Section 502(a)(1)(B), which includes actions "to recover benefits due . . . under the terms of [an employer benefit] plan, [or] to enforce his rights under the terms of the plan." 29 U.S.C. § 1132.

Turning first to the declaratory judgment cause of action, the Fifth Circuit addressed a similar claim in *Arana v. Ochsner Health Plan*, 338 F.3d 433 (5th Cir. 2003) (en banc). In that case, the plaintiff sought declaratory judgment requiring a health insurer to release its lien, as well as its subrogation, reimbursement, and assignment claims, that targeted compensation previously received by the insured following injuries suffered in an automobile accident. *Id.* at 435-36. Plaintiff argued that a Louisiana state law statute, which prohibited a reduction in health insurance benefits, barred the health insurer from asserting a right of subrogation to the plaintiff's personal injury cause of action, and moreover, from its right to reimbursement of any tort settlement funds that the insured received. *Id.* The panel held that plaintiff's claim was a claim for benefits under the terms of the governing plan, and therefore, was preempted by ERISA. *Id.* at 437-38. Of particular relevance here is the following language:

> [Plaintiff's] benefits are under something of a cloud, for [the health insurer] is asserting a right to be reimbursed for the benefits it has paid for [plaintiff's] 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 [the health insurer'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. at 438. For these reasons, the Fifth Circuit concluded that plaintiff's declaratory judgment claim was completely preempted under ERISA § 502(a)(1)(B), as plaintiff—despite couching his claims in Louisiana law and claiming that such nullified the plan's reimbursement power—essentially sought to "recover" or "enforce" his rights under the terms of his health insurance benefit plan. *Id.* at 440. The same logic may be applied here, where plaintiffs, for all intents and purposes, seek to determine their right to retain or recover benefits available under the Plans free of Oxford Health's (by means of Rawlings) reimbursement or subrogation lien.

Turning next to plaintiffs' unjust enrichment cause of action, both the Third and the Fourth Circuit Courts of Appeal offer useful guidance in this area. In *Singh v. Prudential Health Care Plan, Inc.*, 335 F.3d 278 (4th Cir. 2003), the Fourth Circuit considered whether claims of unjust enrichment and negligent misrepresentation, raised against an insurer's subrogation and reimbursement actions, were actually claims for "benefits due." The Fourth Circuit concluded that plaintiffs' claims were preempted by ERISA, stating:

> [Plaintiff's] claim to recover the portion of her benefit that was diminished by her payment to [the health insurer] 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. Whether a State law defines the quantum of a benefit by negating subrogation terms that would diminish the benefit . . . 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.

Id. at 291.

The Third Circuit addressed a similar claim of unjust enrichment in *Levine v. United Healthcare Corp.*, 402 F.3d 156 (3d Cir. 2005). In that case, the Third Circuit concluded that plaintiffs' unjust enrichment claim—that plaintiffs were entitled to certain health benefits and that the providers wrongly sought reimbursement of the same—was "[e]ven more than in *Arana*, . . . [a claim] for benefits due." *Id.* at 163. This was so, even though plaintiffs argued that New Jersey law nullified the insurance policies' subrogation and reimbursement provisions, and even though plaintiffs already had paid a portion of their received benefits back to the insurer. *Id.* The Third Circuit, agreeing with both the Fifth Circuit's reasoning in *Arana* and the Fourth Circuit's in *Singh*, concluded that where "plaintiffs claim that their ERISA plan wrongfully sought reimbursement

of previously paid health benefits, the claim is for 'benefits due' and federal jurisdiction under section 502(a) of ERISA is appropriate." *Id.*

The Court finds the Third, Fourth, and Fifth Circuit Courts of Appeals' holdings regarding other plaintiffs' declaratory judgment and unjust enrichment actions relevant and persuasive here. Try as they might, plaintiffs' argument that they are not making a claim for benefits, but simply seeking a determination as to defendants' right (or lack thereof, by virtue of state law) to reimbursement under the Plans, cannot save their arguments from ERISA's preemptive force. Plaintiffs do not dispute that they received their medical benefits under health plans that conditioned the receipt of such benefits upon potential reimbursement. (*See* Pls.' Opp'n at 2 (stating "the boilerplate terms of the insurance health plans entitled Defendant Oxford to seek reimbursement for health benefits if a plan participant recovers the cost of those benefits from a responsible third party").) Instead, their sole point of contention is that NY GOL § 5-335 voids the Plans' reimbursement clause. (*Id.*) However, plaintiffs' claim, although characterized as one looking only at state law, is really about their right to *keep* the monetary benefits received from defendants under their ERISA-governed plans; this triggers issues concerning their rights and ability to recover (and/or retain) benefits under the Plans, and accordingly, brings ERISA § 502(a)(1)(B) directly into play.

As to plaintiffs' deceptive conduct under NY GBL § 349 cause of action, the Court similarly concludes that the crux of this claim is one for benefits under ERISA § 502(a)(1)(B). In stating their cause of action, plaintiffs again point to the Plans' reimburse-

ment provisions and identify as the alleged deceptive acts at issue defendants' conduct of asserting liens on tort settlements following the provision of medical benefits to plaintiffs. (*See* Compl. ¶¶ 44-48.) The relief sought under this claim is the amount of reimbursement paid (or to be paid) under plaintiffs' interpretation of the Plans' reimbursement provisions (which they assert is modified by NY GOL § 5- 335). Thus, plaintiffs' NY GBL § 349 claim, while cloaked in NY GOL § 5-335 argumentation, is again one for benefits under the ERISA-governed Plans. This is ERISA, and not state law, governed territory. *See Lupo v. Human Affairs Int'l, Inc.*, 28 F.3d 269, 272 (2d Cir. 1994) (stating that ERISA preempts state law causes of action that seek "to recover benefits due to [the plaintiff under the terms of the] 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" (alterations in original) (quoting 29 U.S.C. § 1132(a)(1)(B))).

In sum, no matter how reasonably the Court reads plaintiffs' allegations (of unjust enrichment, declaratory judgment, or deceptive conduct under NY GBL § 349) in their favor, the essence of plaintiffs' claims directly concerns the issue of benefits under ERISA § 502(a)(1)(B), thereby prompting preemption. *See, e.g., Coughlin v. Health Care Serv. Corp.*, 244 F. Supp. 2d 883, 885-89 (N.D. Ill. 2002) (holding that insureds' declaratory judgment class action claims, seeking to retain tort settlements following their insurers' claims for reimbursement, were claims to "enforce [their] rights under the terms of the plan" and to "clarify [their] rights to future benefits under the terms of the plan" under ERISA); *Carducci v. Aetna U.S. Healthcare*, 204 F.

Supp. 2d 796, 799 - 804 (D.N.J. 2002) (finding that insureds' suit to recover funds that their ERISA plans had obtained from subrogation liens on tort settlement proceeds were in fact suits for "benefits due" under their plans); *Franks v. Prudential Health Care Plan, Inc.*, 164 F. Supp. 2d 865, 873 (W.D. Tex. 2001) (concluding that an insured's suit to recover money paid to reimburse his ERISA plan from tort settlement proceeds was a suit "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").

b) **Whether Plaintiffs' Claims Concern a Right versus an Amount to Payment**

Moving to plaintiffs' second argument concerning *Davila* prong one — that their claims concern an "amount of payment" under the Plans, as opposed to a "right to payment," thereby weighing against ERISA preemption — the Court does not find plaintiffs' position persuasive. The Second Circuit has noted a distinction between claims concerning a "*right* to payment" versus claims involving an "*amount* of payment." *See Monetfiore*, 642 F.3d at 331 (emphasis added). Whereas the former class of claims "implicate[s] coverage and benefits established by the terms of the ERISA benefit plan," which may be brought under § 502(a)(1)(B), the latter are "typically construed as independent contractual obligations between the provider and . . . the benefit plan." *Id.*

Plaintiffs take the position that ERISA cannot preempt their claims because the terms of the ERISA Plans are not implicated here. Instead, so their argument goes, their claims solely concern NY GOL § 5-335's impact on defendants' reimbursement obligations. (*See* Pls.' Opp'n at 1, 4-6.) However, this view of plaintiffs' claims is overly narrow. Furthermore, it overlooks the fact that the whole source of contention here is the benefits that plaintiffs received under the Plans, as well as the conditions imposed on such benefits under the Plans, the latter of which gave rise to defendants' currently-contested liens on the benefits. Thus, the matter goes beyond a simple dispute concerning a quantity of payment; instead, it concerns issues regarding benefit eligibility and conditions to the receipt of such coverage under ERISA-governed Plans. In particular, it concerns the effect of third party settlements upon such benefits (following plaintiffs' receipt of coverage) under the Plans. *See Neuroaxis Neurosurgical Assocs., PC v. Cigna Healthcare of N.Y., Inc.*, No. 11 Civ. 8517 BSJ AJP, 2012 WL 4840807, at *3-4 (S.D.N.Y. Oct. 4, 2012) (noting that only "right to payment" claims "are considered actual claims for benefits and can be preempted"; further clarifying that "'[r]ight to payment' claims involve challenges to benefits determinations, depend on the interpretation of plan language, and often become an issue when benefits have been denied," whereas "'[a]mount of payment' claims involve the calculation and execution of reimbursement payments, depend on the extrinsic sources used for the calculation, and are commonly tied to the rate schedules and arrangements included in provider agreements"); *Josephson*, 2012 WL 4511365, at *3 (noting distinction between claims for plan benefits that turn on a "right to payment" as

opposed to an "amount of payment," and concluding that because some of the reimbursement claims at issue "were denied for reasons that would implicate coverage determinations under the terms of the United benefit plans," federal subject matter jurisdiction applied).

Although the Court need not (and does not) consider the merits of the case at this stage, even if it were to substantively pass on plaintiffs' challenges to defendants' reimbursement rights, this would require it to look at the terms of the health benefit Plans. Although plaintiffs contend this is not so, saying the Court could simply look to NY GOL § 5-335, which (so they argue) negates defendants' reimbursement power under the Plans, this would not stop the Court from having to examine the Plans. Indeed, plaintiffs concede that they were participants in their employers' health benefit Plans, that they received benefits under the Plans, and that conditions applied to these benefits, once received. Their only argument is to the applicability of some of these conditions, along with their effect on plaintiffs' ability to retain or recover their benefits under the Plans. It would be impossible for the Court to effectively consider any such arguments regarding plaintiffs' rights to benefits without examining, *inter alia*, the Plans' benefit provisions and/or provisions addressing participants' rights and enforceability of the same.

Indeed, if defendants' reimbursement power is knocked out by virtue of state law, there still remains, at the very least, questions concerning what amount plaintiffs were entitled to receive under the ERISA-governed Plans, what amount they did in fact receive under the Plans, and whether any of the

Plans' conditions (with the exception of those concerning reimbursement, in theory voided under state law) affect the amount to which they are now entitled. Stated differently, claiming that NY GOL § 5-335 knocks out the reimbursement provisions from the Plans does not thereby remove plaintiffs' arguments concerning their rights to benefits from the governing terms of the Plans, nor, for that matter, from the sweeping scope of ERISA. *See Montefiore*, 642 F.3d at 331 (describing "right to payment" as "claims that implicate coverage and benefits established by the terms of the ERISA benefit plan" and "amount of payment" as "claims regarding the computation of contract payments or the correct execution of such payments"); *Olchovy v. Michelin N. Am., Inc.*, No. CV 11-1733(ADS)(ETB), 2011 WL 4916891, at *4 (E.D.N.Y. Sept. 30, 2011) (Report and Recommendation) (stating that *Montefiore* "teaches that a dispute is a colorable claim for benefits under ERISA when its resolution depends on an interpretation of the terms of an ERISA-governed employee benefit plan; that is, when, in order to determine whether the plaintiff is entitled to relief, the court must look to the terms of employee benefit plan, itself").

Plaintiffs' reliance on *Olchovy*, 2011 WL 4916891, to support their "amount of payment" argument does not advance their position. (*See* Pls.' Opp'n at 5-6.) In that case, the plaintiffs alleged that they were entitled to family medical coverage pursuant to a medical agreement with defendants' predecessor, *not* pursuant to an ERISA-governed plan. *Id.* at *5. The Court concluded that this did not constitute a "colorable claim" under ERISA because it was "not a case in which plaintiffs seek benefits under [an ERISA-governed] Plan, or seek to clarify or en-

force their rights under the Plan[;] [r]ather, plaintiffs assert that, notwithstanding what the Plan states, they are entitled to . . . coverage . . . pursuant to a separate court-ordered settlement." *Id.* Thus, because the dispute did not concern payment under the ERISA plan, but instead, under the separate, court-ordered settlement agreement, it was not an ERISA "colorable claim." *Id.* Of particular relevance to the *Olchovy* court was the fact that it did not have to examine the terms of the ERISA-governed plans in order to consider plaintiffs' claims. *See id.* at *4-5.

The same cannot be said here. Plaintiffs do not dispute that the challenged payments here consist of benefits they received *under their employers' health benefit Plans*. (*See* Compl. ¶¶ 6-7; Pls.' Opp'n at 2.) There is no separate, court-ordered document dictating the terms to which plaintiffs are entitled. Although plaintiffs claim "the Court need not look further than the New York statute to conclude that this matter does not involve claims for benefits and does not fall within ERISA" (Pls. Opp'n at 6), this is not true: as previously set forth, turning solely to NY GOL § 5-335 will not assist either plaintiffs or this Court in determining the rights plaintiffs hold, the benefits they are entitled to, and any conditions attached to such benefits under the Plans. Indeed, the allegations here stand in contrast to those cases in which a court has held that the plaintiff's claim was better categorized as an "amount of payment" dispute, as opposed to a "right to payment" matter. *Compare Marin Gen. Hosp. v. Modesto & Empire Traction Co.*, 581 F.3d 941, 943-44 (9th Cir. 2009) (holding that action against an ERISA plan administrator based on his alleged oral promise to pay for the majority of beneficiary's medical expenses was

not a colorable claim under § 502(a)(1)(B) because dispute concerned the terms of the alleged oral promise, not of the ERISA plan itself), *with Zummo v. Zummo*, No. 11 CV 6256(DRH)(WDW), 2012 WL 3113813, at *4 (E.D.N.Y. July 31, 2012) (because plaintiff's breach-of-contract claim required an examination of an employee benefit plan's language and essentially sought enforcement of a right to payment under the terms of that plan, plaintiff's "claim [fell] squarely within the enforcement provision of ERISA").

For these reasons, plaintiffs' claims are "colorable" under ERISA. Accordingly, they satisfy both facets of the first prong of the *Davila* test.

b. ***Davila*** **Prong Two**

The second prong of *Davila* addresses whether any other legal duty, independent of ERISA or the Plans' terms, is implicated. *Davila*, 542 U.S. at 210. The Second Circuit has made clear that the "key words" in conducting this analysis are "other" and "independent." *See Montefiore*, 642 F.3d at 332 (internal quotation marks omitted).

Here, plaintiffs contend that their claims sound separately and independently in state law, namely, NY GOL § 5-335. (*See* Compl. ¶¶ 1, 2, 15, 25-28; *see also* Pls.' Opp'n at 1- 2, 6-7.) Plaintiffs assert that NY GOL § 5-335 creates an independent legal duty between plaintiffs and Rawlings/Oxford Health, as "the interpretation of the benefits plans themselves has no relevance whatsoever," given that Section 5-335 "eliminate[es] [the] contractual rights [of the parties] under [the] benefit plan, [and] arise[s] irrespective of the terms of the relevant employee benefit plan(s)." (Pls.' Opp'n at 6-7.)

The Court is not persuaded. First, *Montefiore* explained that where an entity's conduct is "inextricably intertwined with the interpretation of Plan coverage and benefits," there is no separate or independent duty. 642 F.3d at 332. This is the case here. Specifically, plaintiffs argue against defendants' conduct of exercising their reimbursement rights — *i.e.*, asserting a lien on medical benefits distributed under the Plans — following the trigger of one of the Plans' reimbursement conditions (here, entry into settlement with a third party tortfeasor).

However, defendants' conduct of inquiring about third party suits and seeking reimbursement under the Plans was done solely on account of their expressly stated reimbursement rights in the ERISA-governed Plans, not because of any independent duty under state law. This is a compelling point. The Second Circuit has explained that a court's focus in this context should not be on the *source* of the law *per se* when considering preemption, but rather, on the targeted ERISA entity's *conduct*, and assessing whether the same better triggered ERISA or a different, independent legal duty. *See*, *e.g.*, *Arditi*, 676 F.3d at 300-01 (concluding that ERISA entity's issued employment agreement did not provide separate duty to support a breach of contract claim because the agreement "merely described the benefits [an employee] would receive as a Plan member; it made no promises of benefits separate and independent from the benefits under the Plan"); *Montefiore*, 642 F.3d at 332 (phone conversations between insurer and provider as to patient coverage did not create a separate duty because the plan required such a pre-approval process).

Here, to assess how defendants allegedly should have acted, the Court still would need to review the terms of the Plans. NY GOL § 5-335 — allegedly voiding any of the Plans' reimbursement rights — would simply become part of the equation, but it would not singularly answer the question as to plaintiffs' rights and entitlement to benefits under the Plans. *See Davila*, 542 U.S. at 213 ("Petitioners' potential liability under the [state law] in these cases, then, derives entirely from the particular rights and obligations established by the benefit plans. So . . . respondents' [state law] causes of action are not entirely independent of the federally regulated contract itself."). Therefore, even if NY GOL § 5-335's applies here (addressed *infra*), plaintiffs cannot get around the fact that their claims (concerning their right to benefits and defendants' rights of reimbursement) derive directly from the Plans.

In short, the Plan remains part and parcel of any state law claims plaintiffs raise here, and the Supreme Court has made clear that an independent duty cannot arise where the "interpretation of the terms of [plaintiffs'] benefit plans forms an essential part of their [state law] claim and [state] liability would exist here only because of [defendants'] administration of ERISA-regulated benefit plans." *Id.* at 213; *Montefiore*, 642 F.3d at 332; *see also Riemer v. Columbia Med. Plan, Inc.*, No. Civ. L-96-2544, 1997 WL 33126252, at *2 (D. Md. Mar. 28, 1997) ("Plaintiffs' claims, in essence, rely on the [state] statute to challenge [defendant's] subrogation provision. Whether the Court characterizes these claims as arising under the [state] statute or under the plan, their resolution requires construing [defendant's] reimbursement provision to determine wheth-

er it violates the statute. . . . [B]ecause the resolution of plaintiffs' claims requires plan interpretation as governed by ERISA § 502(a), plaintiffs' claims are 'completely preempted' and recharacterized as federal claims."). Thus, because "no legal duty (state or federal) *independent of ERISA or the [P]lan[s'] terms*" is implicated here, ERISA preemption applies. *Davila*, 542 U.S. at 210 (emphasis added); *see also Rice v. Panchal*, 65 F.3d 637, 644-45 (7th Cir. 1995) (stating that "a suit brought by an ERISA plan participant is an action to 'enforce his rights under the terms of the plan' within the scope of § 502(a)(1)(B) where the claim rests upon the terms of the plan or the 'resolution of the [plaintiff's] state law claim . . . require[s] construing [the ERISA plan]'" (alterations in original) (quoting *Lingle v. Norge Div. of Magic Chef, Inc.*, 486 U.S. 399, 407 (1988))).

Additionally, the Court is not convinced that the law to which plaintiffs direct the court to establish a separate and independent legal duty offers them assistance. Section 5-335 specifically addresses the "[l]imitation of non-statutory reimbursement and subrogation claims in personal injury . . . actions." N.Y. G.O.L. § 5-335. Although the statute explicitly states that "no party entering into [] a settlement [with one or more defendants in tort actions] shall be subject to a subrogation claim or claim for reimbursement by a benefit provider," as well as that "a benefit provider shall have no lien or right of subrogation or reimbursement against any such settling party," the statute also contains a clear and highly relevant exception: "*except where there is a statutory right of reimbursement*." *Id.* In other words, where

there is such a statutory right of reimbursement, then Section 5-335's limitations will not apply.

Here, there is a right of reimbursement expressly stated in the ERISA-governed plans. Although plaintiffs challenge this point, taking the position at oral argument that any such right arises under the contract between plaintiffs and defendants, and not under ERISA, the Court disagrees. (*See* Oral Arg. Jan. 22, 2013.)[8] The right of reimbursement con-

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[8] Following oral argument, the Court allowed the parties to submit supplemental briefing regarding matters raised at oral argument, including this notion of the rights at issue here arising under contract, and not ERISA. In their letter, defendants note that "the same enactment that created GOL § 5-335 amended New York Civil Practice Law and Rules ("CPLR") § 4545 to include the phrase 'statutory right of reimbursement.' *See* Act of November 12, 2009, ch. 494, 2009 N.Y. Sess. Laws 1265, 1278-80 (McKinney)." (Defs.' Letter of Jan. 29, 2013, at 1, Docket No. 25.). Defendants argue that this confirms that the phrase, "statutory right of reimbursement," should have the same meaning in both statutes.

To support this argument, defendants note that, prior to amendment, Section 4545 permitted evidence of "'any collateral source such as insurance (except for life insurance), social security (except those benefits provided under [the Medicare Act]), workers' compensation or employee benefit programs (except such collateral sources entitled by law to liens against any recovery of the plaintiff.'" (*Id.* at 1-2 (quoting N.Y. C.P.L.R. § 4545(c) (2008)).) The 2009 amendment allowed evidence of collateral sources "'except for life insurance and those payments as to which there is a statutory right of reimbursement.'" (*Id.* (quoting N.Y. C.L.P.R. § 4545(a) (2012)).) Defendants assert that "[t]here is no indication that this change in formulation was intended to narrow the exceptions in the previous iteration of CPLR § 4545." (*Id.* at 2.) Instead, defendants argue that the amendment simply removed from collateral source treatment those payments "'as to which there is a statutory right of reimbursement,'" including employee benefit plans en-

tained in the ERISA governed Plans is enforced by means of ERISA. *See Mittenthal v. N.V. Univ. Sch. of Med.*, No. 106332/09, 2012 N.Y. Misc. LEXIS 1358, at *6 (Sup. Ct. Mar. 26, 2012) (holding that NY GOL § 5-335 does not apply to ERISA plans because of "ERISA's statutory right of reimbursement"). Thus, because the exception applies, NY GOL § 5-335 cannot even serve as the independent source of law here.

* * *

For these reasons, the Court concludes that both prongs of *Davila* are satisfied. Accordingly, plaintiffs' claims are completely preempted under ERISA.

B. Express Preemption

In addition to being completely preempted, defendants argue, in the alternative, that plaintiffs' claims also are expressly preempted under ERISA. The Court agrees.

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titled by law to liens. (*Id.* (citing David D. Siegel, *New Law on Settlement and Collateral Source Rule*, 216 Siegel's Prac. Rev. 1, at *2 (Dec. 2009)).) For this reason, defendants assert that ERISA plans with reimbursement language that are subject to enforcement under ERISA § 502(a)(3) have a "statutory right of reimbursement" within the meaning of the statutes. (*Id.* (quoting 9 Weinstein, Korn & Miller, New York Civil Practice: CPLR ¶ 4545.01, at *3 (David L. Ferstendig ed., LexisNexis Matthew Bender 2d ed. 2012) (referring to ERISA plans, Medicare, and other programs as "statutory providers" that, under CPLR § 4545, "may have a right to be reimbursed out of the [judgment] for their past and anticipated future obligations").) The Court finds this persuasive as to underlying rights here arising under ERISA and not the Plans, in and of themselves.

There are two focal points upon which the Court must direct its attention in examining the issue of express preemption. The first is ERISA's "preemption" clause, set forth in Section 514(a). *See* 29 U.S.C. 1144(a). The second is the "savings" clause, set forth in Section 514(b). *See* 29 U.S.C. § 1144(b)(2)(A). The Court addresses each in turn.

1. The Preemption Clause

Section 514(a) provides that "the provisions of [ERISA] shall supersede any and all State laws insofar as they now or hereafter *relate to* any employee benefit plan." 29 U.S.C. § 1144(a) (emphasis added). The Court breaks these elements down.

First, "ERISA applies to employee benefit *plans*, not employee benefits." *Howard v. Gleason Corp.*, 901 F.2d 1154, 1156 (2d Cir. 1990) (emphasis added). An employee benefit plan under ERISA is defined as "any plan . . . established or maintained by an employer . . . for the purpose of providing . . . participants or their beneficiaries, through the purchase of insurance . . . benefits." 29 U.S.C. §1002(1)(A). In plaintiffs' own words, the contested liens here are "for medical benefits paid by them *pursuant to employee benefits plans*." (Pls.' Opp'n at 1 (emphasis added); *see also id.* at 2 (stating that plaintiffs "are participants in partially and fully-funded insured health plans who had received medical benefits through Defendant Oxford" (emphasis omitted)).) The Oxford Health Plans, therefore, meet the definition of an employee benefit plan under ERISA. The Court next considers NY GOL § 5-335's effect on the Plans.

Section 5-101(4) of New York General Obligations Law sets forth definitions for terms contained

in Section 5-335. In this section, it defines a "benefit provider"—one of the principal terms of import in NY GOL § 5-335—as "*any* . . . health benefit plan . . . employee benefit plan *or any other entity* which provides for payment or reimbursement of health care expenses, health care services, . . . or any other benefits under a policy of insurance or contract with an individual or group." N.Y. Gen. Oblig. L. § 5-101 (emphasis added). Under the plain language of the statute, it is clear that a health benefit plan covered by ERISA would fall within the scope of this statute, as such "provides for payment or reimbursement of health care expenses, health care services, . . . or any other benefits." *Id.* Thus, the New York statute upon which plaintiffs rely affects an ERISA-covered employee benefit plan. The question is whether this state law is preempted, which turns on whether the law "relates to" an ERISA plan. As set forth below, the Court concludes that the state law "relates to" an ERISA plan and is expressly preempted.

ERISA mandates preemption where a state law relates to an employee benefit plan. "A claim under state law relates to an employee benefit plan if that law 'has a connection with or reference to such a plan.'" *Franklin H. Williams Ins. Trust v. Travelers Ins. Co.*, 50 F.3d 144, 148 (2d Cir. 1995) (quoting *Metro. Life Ins. Co. v. Mass.*, 471 U.S. 724, 739 (1985)); *see also Paneccasio v. Unisource Worldwide, Inc.*, 532 F.3d 101, 114 (2d Cir. 2008) (same). A state law also may "relate to" a benefit plan, "even if the law is not specifically designed to affect such plans, or the effect is only indirect." *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 139 (1990). Thus, ERISA "preempts all state laws that *relate* to employee benefit plans and not just state laws which purport to

regulate an area expressly covered by ERISA." *Howard v. Gleason Corp.*, 901 F.2d 1154, 1156 (2d Cir. 1990) (alteration, citation, and internal quotation marks omitted).

Section 5-335's express language seeks to impose on a benefit provider—which, under Section 5-101(4)'s plain language, includes Oxford Health (as it constitutes an entity that provides, *inter alia*, for payment or reimbursement of health care expenses or services)—reimbursement or subrogation obligations of the same type as those imposed by ERISA via its employee benefit Plans. This means that Section 5-335's reimbursement/subrogation obligations (if read according to plaintiffs' interpretation) would intrude upon an area that Congress intended to be fully occupied by federal statutory law. This cannot be.

Indeed, if NY GOL § 5-335 were not preempted by ERISA here, then federal and state laws would be creating the very conflict that Congress sought to prevent in enacting ERISA's broad preemption power. *See* 29 U.S.C. § 1132(a)(1)(B). Where such statutory conflict presents itself, the question arises: which law should govern? Congress has answered, and quite clearly: ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan . . . ." 29 U.S.C. § 1144. In short, if NY GOL § 5-335 were permitted to eclipse ERISA's preemptive force in the manner suggested by plaintiffs, it would severely undercut ERISA's "extraordinary pre-emptive power" that "converts an ordinary state common law complaint into one stating a federal claim." *Davila*, 542 U.S. at 209 (quoting *Metro. Life*, 481 U.S. at 65-66).

Perhaps the most compelling point here against plaintiffs' reading of § 5-335, and in favor of preemption, is that such conflict of federal and state laws is not what seems to have been intended by NY GOL § 5-335's express language. As set forth *supra*, Section 5-335 specifically states "no party entering into [] a settlement shall be subject to a subrogation claim or claim for reimbursement by a benefit provider and a benefit provider shall have no lien or right of subrogation or reimbursement against any such settling party," with one principal exception: "[*e*]*xcept where there is a statutory right of reimbursement*." N.Y. G.O.L. § 5-335 (emphasis added). In this case, there is. The ERISA-covered Plans explicitly provide for such a right, and therefore, Section 5-335 must cede to it by its own language.

In sum, NY GOL § 5-335 is expressly preempted. However, the Court's express preemption analysis does not end here. Even where Section 514(a)'s broad preemption provision is applicable, *see Ingersoll-Rand Co.*, 498 U.S. at 139; *Howard*, 901 F.2d at 1156, it is not without limits: it "excepts from preemption laws that 'regulate insurance.'" *Howard*, 901 F.2d at 1156. It is this exception upon which plaintiffs rely to salvage their claims from ERISA's sweeping effect. (*See* Pls.' Opp'n at 7-13.) Thus, the Court next examines whether the savings clause here can salvage plaintiffs' claims from preemption, *see Franklin H. Williams Trust*, 50 F.3d at 148 (where it is established that a state law relates to an employee benefit plan, "ERISA preemption follows *unless* the saving clause precludes preemption" (emphasis added)), and concludes it does not.

2. The Savings Clause

Section 514(b)(2)(A) enables a state law, that sufficiently "relate[s] to" a benefit plan, to be "saved" from preemption if it "regulates insurance, banking, or securities." 29 U.S.C. § 1144(b)(2)(A) (stating "[e]xcept as provided in [the deemer clause], nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance"); *Ky. Ass'n of Health Plans, Inc. v. Miller*, 538 U.S. 329, 333 (2003). There are two requirements that a state law must satisfy in order to be deemed a law that regulates insurance under ERISA § 514(b)(2)(A). "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. at 341-42 (citations omitted).

a. **Whether NY GOL § 5-335 is Specifically Directed at Insurance Entities**

Turning to *Miller*'s first prong, NY GOL § 5-335 is not specifically directed at entities engaged in insurance. By its own terms, Section 5-335 expressly limits a benefit provider's ability to enforce a subrogation claim, claim for reimbursement, or lien against a party entering into a settlement, unless a statutory right of reimbursement applies. N.Y. G.O.L. § 5-335. The statute, however, contains a broad definition of what constitutes a "benefit provider" under Section 5-335. Specifically, the term is defined as including "any insurer, health maintenance organization, health benefit plan, preferred provider organization, employee benefit plan or other entity which provides for payment or reimbursement of health care expenses, health care services,

disability payments, lost wage payments or any other benefits under a policy of insurance or contract with an individual or group." N.Y. G.O.L. § 5-101(4). Thus, Section 5-335's restriction on an entity's subrogation and reimbursement rights as to a beneficiary's settlement with a third party will apply, regardless of whether the entity asserting such rights is an insurer, and regardless of whether the benefits at issue constitute insurance.

Supreme Court precedent is clear: in determining whether a law regulates insurance within the meaning of the savings clause, "a law must not just have an *impact* on the insurance industry, but must be *specifically directed* toward that industry." *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 50 (1987) (emphasis added). Although plaintiffs are correct (and defendants do not dispute) that Section 5-335 applies to entities in the insurance field, it stretches the statute's plain language far too far to claim that its sweeping scope—encapsulating numerous entities falling outside of the insurance industry, and applying to benefits beyond the insurance field—is "*specifically* directed" at the insurance industry. In fact, the statute covers employers, including self-funded employer plans, from which many employees often receive their health benefits. *See* N.Y. G.O.L. § 5-335.

The Second Circuit has found the applicability of a statute's terms to employers to be a sufficient reason for concluding that a state law (in that instance, New York Insurance Law § 4216(d)) was not saved from ERISA preemption. *See Howard*, 901 F.2d at 1158 (where statute provided that a certificate holder of a group life insurance policy "shall be notified" of any right that arises to convert the group policy to

an individual one, the court held that because "the notice requirement may be fulfilled *either* by the group insurance policyholder—here, the employer—*or* by the insurer," this shows that the law's regulation of notice, including in the employer context, "is not directed toward the insurance industry at all, much less 'specifically'" (emphasis added)).[9]

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[9] In *Howard*, the Second Circuit also addressed whether the contested notice practices constituted "the business of insurance" under the McCarran-Ferguson Act, 15 U.S.C. § 1011 et seq. 901 F.2d at 1168 (citing *Pilot Life*, 481 U.S. at 48). The three factors of this test include: "first, whether the practice has the effect of transferring or spreading a policyholder's risk; second, whether the practice is an integral part of the policy relationship between the insurer and the insured; and third, whether the practice is limited to entities within the insurance industry." *Pilot Life*, 481 U.S. at 48-49 (alterations, citation, emphasis, and internal quotation marks omitted). The Supreme Court has made clear that "the McCarran-Ferguson factors are considerations to be weighed in determining whether a state law regulates insurance and that none of these criteria is necessarily determinative in itself." *UNUM Life Ins. Co. of Am. v. Ward*, 526 U.S. 358, 373 (1999) (alterations and internal citations and quotation marks omitted). That is, while they are "relevant," they are not "required." *Id.* (internal quotation marks omitted). Here, it is clear that NY GOL § 5-335, by its plain language, cannot satisfy at least the third factor to this test (i.e., whether the state law's practice is limited to insurance entities). See N.Y. G.O.L. §§ 5-101(4); 5-335. It is also clear that it cannot satisfy the first factor (regarding transfer of a policyholder's risk), as Section 5-335 does not address a transfer of *risk*, but simply one of benefits in the context of third-party settlements. The Court does not believe the second factor (focusing on the policy relationship between an insurer and insured) is applicable to the facts at issue. The fact that Section 5-335 cannot satisfy any of the three factors supports the conclusion that Section 5-335 is not directed at insurance.

Other courts, including the Supreme Court, have held similarly. *See, e.g., Pilot Life*, 481 U.S. at 49-51 (where state law of bad faith was based in general contract and tort law, not insurance law, and where it could apply in any breach of contract case—as opposed to exclusively in breach of insurance contract cases—the law did not fall within the savings clause); *Levine*, 402 F.3d at 164-66 (where state law "require[ed] a plaintiff who receives benefits from *any* source other than a joint tortfeasor to deduct that amount from his or her recovery in *any* civil action," the Third Circuit concluded that such did not show that the state statute is "'specifically directed toward the insurance industry,'" even though the statute's legislative history "indicate[s] an intent to lighten the burden on the liability insurance industry," because an "examination of the driving intent behind the statute shows that . . . the law here is a general law of civil procedure" that "governs all civil actions, not merely those involving insurance entities," and the statute's plain language shows its "general applicability" to both "non-insurance parties as well as insurance entities," the sum of which weighs against saving from ERISA preemption); *Blue Cross & Blue Shield of Ala. v. Sanders*, 138 F.3d 1347, 1356 n.6 (11th Cir. 1998) ("The law of subrogation, while generally applicable to insurance contracts, is not specifically directed toward the insurance industry." (alteration and internal citations omitted)).

In addition to the fact that the statute covers employers and other non-insurance entities (and further undercutting plaintiffs' position that NY GOL § 5-335 is "specifically directed" at the insurance industry), the New York State Assembly codified NY

GOL § 5-335 in the section of the state code "cover[ing] the creation, definition, enforcement, transfer, modification, discharge and revival of various civil obligations," N.Y. C.L.S. Gen. Oblig. Note (2012), *not* in the code's insurance section. This further illustrates the statute's "general applicability," *Levine*, 402 F.3d at 165-66, weighing against its preservation from preemption.

b. Whether NY GOL § 5-335 Substantially Affects Risk Pooling Arrangements

Turning to *Miller*'s second requirement, the Court must consider whether NY GOL § 5-335 "substantially affect[s] the risk pooling arrangement between the insurer and the insured." *Miller*, 538 U.S. at 342. In short, it does not.

As stated *supra*, the statute expressly removes from its reach claims for subrogation or reimbursement that derive from a "statutory right of reimbursement." N.Y. G.O.L. § 5-335. As defendants note in their motion to dismiss, such a "statutory right of reimbursement" may include claims arising under such government mandated benefits and insurance as, *inter alia*, workers compensation, Medicaid, Medicare, or uninsured or underinsured motorist coverage. (Defs.' Mot. to Dismiss at 15 (citing Joseph D. Jean et al., 5-49 Appleman on Insurance Law and Practice § 49.02 (2012)).) Moreover, Section 5-335's plain terms make clear that it *only* applies to filed settlements of tort actions. *See* N.Y. G.O.L. § 5-335 (describing settlement with "one or more defendants in an action for personal injuries, medical, dental, or podiatric malpractice, or wrongful death"). This means that there is a wide array of reimburse-

ment and subrogation rights—falling outside of the filed tort settlement realm—that are not implicated under the statute. In other words, and as defendants state in their briefs, the law, for all intents and purposes, only applies to a subset of benefit providers, specifically, those without a statutory right of reimbursement and who do not intervene in underlying third party actions in which the third party settles. (*See* Defs.' Mot. to Dismiss at 15.) Thus, the Court is hard-pressed to accept that the law's effect on risk-pooling arrangements is "substantial[]," where only a slice of certain types of settlements in certain types of cases involving certain types of benefit providers are actually implicated. *Miller*, 538 U.S. at 342.

Plaintiffs attempt to counter this point by directing the Court to two cases, *FMC Corp. v. Holliday*, 498 U.S. 52 (1990) and *Singh*, 335 F.3d 278, which plaintiffs contend support their position against Section 514's preemptive power. However, their reliance on *FMC Corp.* or *Singh* for purposes of establishing a substantial effect on a risk pooling arrangement here is similarly unavailing.

FMC Corp. concerned a statute which undisputedly regulated insurance (in fact, by the statute's express language, it *only* applied to insurance policies), and it did not contain any exception similar to that present in NY GOL § 5-335. *See FMC Corp.*, 498 U.S. at 55; *see also Sanders*, 138 F.3d at 1356 n.6 (noting that *FMC Corp.* "applied ERISA's saving clause because the state subrogation law was directly related to insurance," and concluding that in the underlying case, because the subrogation law "covers *all* subrogation actions, including those arising *outside* of the insurance context," *FMC Corp.*'s reason-

ing was not applicable (first emphasis added)). Similarly, in *Singh*, the statute only applied to HMOs (which the Fourth Circuit concluded constituted insurers), and contained no express exceptions. *Singh,* 335 F.3d at 284-85. These cases' discussion of risk pooling arrangements between actual insurers and insureds under statutes directly concerning insurance are inapposite and distinguishable from the facts and statute at issue here. Stated differently, these cases—with statutes containing no exceptions like those present here, and with language solely directed at insurers, unlike here—are not persuasive to the Court's analysis as to risk pooling arrangements.

3. The Deemer Clause

Alternatively, plaintiffs argue that ERISA's "deemer" clause further supports Section 5-335's applicability to, and regulation of, Oxford Health's Plans. (*See* Pls.' Opp'n at 8-9.) In particular, plaintiffs state that Supreme Court precedent makes clear that a State may regulate a benefit plan (either directly or indirectly), so long as it is insured; if the plan is uninsured or self-funded, however, the State may not regulate it. (*See id.* (quoting *FMC Corp.*, 498 U.S. at 64 (stating "if a plan is insured, a State may regulate it indirectly through regulation of its insurer and its insurer's insurance contracts," but "if the plan is uninsured, the State may not regulate it")).) Because Section 5-335 does not regulate self-funded or uninsured benefit providers, but rather, applies, at least indirectly, to insured benefit plans, plaintiffs argue that it applies to Oxford Health's insured benefit plans.

To best understand plaintiffs' argument, background on the "deemer" clause is necessary. Section 514(b)(2)(B) provides that an employee benefit plan shall not "be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies." 29 U.S.C. § 1144(b)(2)(B). The Supreme Court has explained the deemer clause as follows:

> We read the deemer clause to exempt self-funded ERISA plans from state laws that "regulat[e] insurance" within the meaning of the saving clause. By forbidding States to deem employee benefit plans "to be an insurance company or other insurer . . . or to be engaged in the business of insurance," the deemer clause relieves plans from state laws "purporting to regulate insurance." As a result, self-funded ERISA plans are exempt from state regulation insofar as that regulation "relate[s] to" the plans. State laws directed toward the plans are preempted because they relate to an employee benefit plan but are not "saved" because they do not regulate insurance. State laws that directly regulate insurance are "saved" but do not reach self-funded employee benefit plans because the plans may not be deemed to be insurance companies, other insurers, or engaged in the business

> of insurance for purposes of such state laws. On the other hand, employee benefit plans that are insured are subject to indirect state insurance regulation. An insurance company that insures a plan remains an insurer for purposes of state laws "purporting to regulate insurance" after application of the deemer clause. The insurance company is therefore not relieved from state insurance regulation. The ERISA plan is consequently bound by state insurance regulations insofar as they apply to the plan's insurer.

FMC Corp., 498 U.S. at 61 (alterations in original).

The purpose of the deemer clause, in effect, is to ensure that a state does not "deem" an employee benefit plan an insurance plan in order to avoid preemption, thereby restricting applicability of the savings clause to conventionally insured employee benefit plans. In other words, "ERISA's 'deemer' clause provides an exception to its saving clause that prohibits States from regulating self-funded plans as insurers. Therefore, [a state law] [will] not be 'saved' as an insurance law to the extent it applie[s] to self-funded plans." *Rush Prudential HMO, Inc. v. Moran*, 536 U.S 355, 371 n.6 (2002) (internal citations omitted).

Breaking this down to basic form, the deemer clause only comes into play once it is determined that a state law is saved from preemption, which, as previously explained, occurs once it is determined that a state law regulates insurance. *See Miller*, 538 U.S. at 336 n.1 (noting that ERISA's saving clause,

in order to be applicable, requires that a law regulate insurance). Here, the Court already has determined that NY GOL § 5-335 does not regulate insurance, as the Supreme Court has so interpreted that phrase, because the state law is not "specifically directed toward entities engaged in insurance," nor does the statute "substantially affect the risk pooling arrangement between the insurer and the insured." *Miller*, 538 U.S. at 341-42. Thus, the deemer clause, under the facts presented, is irrelevant. Section 5-335 remains preempted because it is not saved by the savings clause, the conclusion of which bypasses any need to address the deemer clause, which simply distinguishes between insured and uninsured plans that are subject to State laws regulating insurance, with the former subject to indirect State regulation and the latter, not. *See FMC Corp.*, 498 U.S. at 62; *see also Metro. Life Ins. Co.*, 471 U.S. at 734-35.

* * *

In sum, Section 5-335 "relates to" an employee benefit plan, here, the Oxford Health Plans, and therefore, it is expressly preempted. Section 5-335 is not saved from preemption under the savings clause because it is not specifically directed at the insurance industry, nor does it substantially affect the risk pooling arrangement between an insurer and insured. Because it is not saved from preemption, ERISA's deemer clause (distinguishing between permissible State regulation of insured plans as opposed to uninsured or self-funded plans) does not apply. For these reasons, the court concludes that

ERISA expressly preempts NY GOL § 5-335, and accordingly, plaintiffs' claims arising thereunder.[10]

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[10] Although the majority of this analysis addresses plaintiffs' declaratory judgment claim, plaintiffs' unjust enrichment and NY GBL § 349 claim are similarly preempted. Plaintiffs' unjust enrichment claim is simply a reassertion of their declaratory judgment claim, *i.e.*, that defendants may not assert their reimbursement rights on account of NY GOL § 5-335, and accordingly, plaintiffs are entitled to keep benefits under the Plans. (*See* Compl. ¶¶ 49-54.) Because the Court already has concluded that ERISA § 514 preempts any such claim, and because plaintiffs' unjust enrichment lies on the same grounds (as to benefits and reimbursement rights), it likewise is preempted. *See Neidich v. Estate of Neidich*, 222 F. Supp. 2d 357, 375 (S.D.N.Y. 2002). ("Section 514(a) of ERISA explicitly provides that ERISA preempts [unjust enrichment] claims.").

The same applies for plaintiffs' NY GBL § 349 claims. This state law claim relates to the ERISA-covered Plans, as the alleged deceptive acts are defendants' reimbursement actions (taken pursuant to the Plans' express provisions) for portions of tort settlement recoveries based on the medical benefits that plaintiffs received under the Plans. (*See id.* ¶¶ 44-46.) Consideration of the ERISA-covered Plans is, again, necessary to determine whether defendants' reimbursement practices were deceptive and/or plaintiffs' entitlement to the Plans' benefits. Accordingly, plaintiffs' NY GBL § 349 claim is preempted. It also is not saved from preemption, because Section 349, targeting deceptive business acts or practices, "clearly do[es] not 'regulate insurance'" under the Supreme Court's two-part meaning to that phrase, explained *supra*. *Shackelton v. Conn. Gen. Life Ins. Co.*, 817 F. Supp. 277, 282 (N.D.N.Y. 1993) (also stating that "claims that are completely unrelated to the insurance industry often arise under" NY GBL § 349); *see also Berry v. MVP Health Plan, Inc.*, 06-cv-120 (NAM/RFT), 2006 WL 4401478, at *6 (N.D.N.Y. Sept. 30, 2006) (finding that, because NY GBL § 349 claim related to an employee benefit plan covered by ERISA, preemption was warranted).

For these reasons, plaintiffs' unjust enrichment and NY GBL § 349 claims are also expressly preempted.

c. **Plaintiffs' State-Law Claims Restyled as ERISA Claims**

Having concluded that plaintiffs bring an ERISA benefit claim and/or that their claims are preempted by ERISA, the Court next addresses whether such claims may proceed under ERISA § 502(a)(1)(B). For the following reasons, the Court concludes that they cannot.

To begin with, it not clear whether plaintiffs in fact exhausted their ERISA claims. They do not allege as such in their complaint, nor do they challenge (in their opposition papers or at oral argument) defendants' contentions that they have failed to exhaust. Their only position is that an exhaustion analysis is not applicable here because state statutory law governs. (*See* Pls.' Opp'n at 14; Oral Arg. Jan. 22, 2013.) Despite plaintiffs' contentions to the contrary, establishing exhaustion is generally considered a prerequisite to pursuing an ERISA action. *See, e.g.*, *Novella v. Westchester Cnty.*, 661 F.3d 128, 135 n.10 (2d Cir. 2011) (stating that "[a]lthough 'ERISA does not contain an explicit exhaustion[-]of[-]remedies requirement . . . this Circuit has inferred [one]'" (quoting *Burke v. PricewaterHouseCoopers LLP Long Term Disability Plan*, 572 F.3d 76, 79 n.3 (2d Cir. 2009))); *Burke*, 572 F.3d at 79 (stating that "an ERISA action may not be brought in federal court until administrative remedies are exhausted"); *De-Silva v. North Shore-Long Island Jewish Health Sys., Inc.*, 770 F. Supp. 2d 497, 538 (E.D.N.Y. 2011) (dismissing plaintiffs' Section 502(a)(1)(B) claim with prejudice for failure to plead exhaustion of administrative remedies under the plan); *Kesselman v. The Rawlings Co., LLC*, 668 F. Supp. 2d 604, 608 (S.D.N.Y. 2009) ("[Defendants] argue that [plaintiff]

has not stated a viable claim for relief against them because she has not sufficiently pled exhaustion of administrative remedies, a prerequisite to bringing an ERISA action. The Court agrees."). Thus, plaintiffs' failure to plead any exhaustion of administrative remedies here typically would require dismissal of their claims on this ground. *See, e.g., Davenport v. Harry N. Abrams, Inc.*, 249 F.3d 130, 133-34 (2d Cir. 2001) (per curiam) (affirming dismissal for failure to exhaust); *Kennedy v. Empire Blue Cross and Blue Shield*, 989 F.2d 588, 595 (2d Cir. 1993) (same); *Thomas v. Verizon*, No. 02 Civ. 3083(RCC)(THK), 2004 WL 1948753, at *4 (S.D.N.Y. Sept. 2, 2004) (citing cases in which a failure to exhaust administrative remedies under an ERISA plan led to dismissal).

Plaintiffs are correct that where a party makes a "clear and positive showing" that pursuit of administrative remedies would have been futile, the exhaustion doctrine will not be held against that party. (*See* Pls.' Opp'n at 15); *see also Thomas*, 2004 WL 1948753, at *4 ("Courts will waive the exhaustion requirement if the Plaintiff makes a 'clear and positive showing' that pursuing available administrative remedies would be futile."). However, plaintiffs make no such showing here, either in their pleadings or their opposition papers. At most, they argue that exhaustion would have been futile because had they informed defendants of NY GOL § 5-335's applicability, defendants would have ignored it. (Pls.' Opp'n at 16.) This is not sufficient for purposes of establishing futility. *Cf. Preston v. Am. Federation of Television & Radio Artists*, No. 90 Civ. 7094 (RJW), 2002 WL 1009458, at *4 (S.D.N.Y. May 16, 2002) (finding plaintiffs had failed to make a "clear and positive

showing" of futility where they argued that any efforts to exhaust would have been futile because defendants "will merely do what they have always done;" noting that past denials of similar claims does not establish futility (internal quotation marks omitted)).

However, even assuming *arguendo* that plaintiffs have exhausted their claims, their action still fails. Section 502(a)(1)(B) of ERISA provides relief based on the terms of the plan. *See* 29 U.S.C. § 1132(a)(1)(B). Indeed, one of ERISA's "core functional requirements" is that "'[e]very employee benefit plan shall be established and maintained *pursuant to a written instrument*.'" *Curtiss-Wright Corp. v. Schoonejongen*, 514 U.S. 73, 83 (1995) (emphasis added) (quoting 29 U.S.C. § 1102(a)(1)). As previously stated, ERISA's entire purpose is to "'establish a uniform administrative scheme, [with] a set of standard procedures to guide processing of claims and disbursement of benefits," *Kennedy v. Plan Adm'r for DuPont Sav. & Inv. Plan*, 555 U.S. 285, 300 (2009) (quoting *Egelhoff v. Egelhoff*, 532 U.S. 141, 148 (2001)), and it does so by requiring that claims concerning benefits "stand[] or fall[] by 'the terms of the plan,'" *id.* (quoting 29 U.S.C. § 1132(a)(1)(B)).

Here, plaintiffs do not dispute that they received their benefits pursuant to the express terms of their employers' health benefit Plans, nor do they challenge the fact that the Plans explicitly state that receipt of such benefits is conditioned on plaintiffs reimbursing the Plans should they recover the cost of such benefits from third parties. (*See* Pls.' Opp'n at 2 (stating that plaintiffs "are participants in partially and full-funded [] health plans who had received

medical benefits through Defendant Oxford," and noting that "the boilerplate terms of the insurance health plans entitled Defendant Oxford to seek reimbursement for health benefits if a plan participant recovers the cost of those benefits from a responsible third party").) Stated differently, plaintiffs do not contest the express terms of the Plans, which make clear as to what benefits plaintiffs are entitled, as well as the strings attached to such benefits. Plaintiffs cannot now try to cut such strings by asserting that the explicit terms of the Plans (by which plaintiffs received such benefits in the first place) are not applicable. *See Curtiss-Wright*, 514 U.S. at 83 (stating that "ERISA already *has* an elaborate scheme in place for enabling beneficiaries to learn their rights and obligations at any time, a scheme that is built around reliance on the face of written plan documents"). Moreover, NY GOL § 5-335 may not serve as the scissors by which plaintiffs may extrapolate their benefit claims from the Plans' explicit conditions for the reasons set forth *supra*.

Not only do plaintiffs' claims fail if restyled as claims under ERISA § 502(a)(1)(B) because the plain language of the Oxford Health Plans expressly conditions their claims to the type of lien at issue here, but they also fail for another reason. The Second Circuit has held that a claim for benefits pursuant to ERISA § 502(a)(1)(B) may only be asserted against the plan itself or particular plan representatives, specifically, the plan administrator and the plan trustees. *See Crocco v. Xerox Corp.*, 137 F.3d 105, 107 (2d Cir. 1998) ("[O]nly the plan and the administrators and trustees of the plan in their capacity as such may be held liable." (quoting *Leonelli v. Pennwalt Corp.*, 887 F.2d 1195, 1199 (2d Cir. 1989)) (in-

ternal quotation marks omitted)); *see also Chapman v. Choicecare Long Island Disability Plan*, 288 F.3d 506, 509-10 (2d Cir. 2002); *Chapro v. SSR Realty Advisors, Inc. Severance Plan*, 351 F. Supp. 2d 152, 155 (S.D.N.Y. 2004). Plaintiffs proffer no allegations establishing that defendants here qualify as any of these types of entities. Further, their only argument against this point on opposition is that, in all of the cases in which the Second Circuit has required that a claim be brought against the plan administrator and the plan trustees, such cases have specifically concerned a recovery-of-benefits claim. (Pls.' Opp'n at 16.) However, this is a recovery-of-benefits claim matter, and plaintiffs' allegations are bereft of any pleadings establishing any of these requisite entities.

Therefore, dismissal of plaintiffs' claims is also warranted on the ground that even if they were re-styled as ERISA claims, they would fail.

d. **State Law Claims On Their Own**

Because the Court has determined that plaintiffs' claims are both completely preempted and expressly preempted under ERISA's two separate preemption doctrines, it does not address whether — if the state law claims were not so preempted — plaintiffs' state law claims would prevail on their own terms.

CONCLUSION

For the reasons set forth herein, the Court grants defendant's motion to dismiss in full and dismisses plaintiff's Complaint. The Clerk of the Court shall enter judgment accordingly and close the case.

SO ORDERED.

JOSEPH F. BIANCO
United States District
Judge

Dated: March 28, 2013
Central Islip, New York

* * *

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APPENDIX C: JUDGMENT OF THE U.S. COURT OF APPEALS FOR THE SECOND CIRCUIT

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

At a Stated Term of the United States Court of Appeals for the Second Circuit, held at the Thurgood Marshall United States Courthouse, 40 Foley Square, in the City of New York, on the 31st day of July, two thousand and fourteen.

Before: John M. Walker, Jr.,
José A. Cabranes,
Barrington D. Parker,
*Circuit Judge*s.

Meghan Wurtz, Mindy Burnovski, individually and on behalf of all others similarly situated,

Plaintiffs - Appellants,

JUDGMENT
Docket No. 13-1695

v.

The Rawlings Company, LLC, Oxford Health Plans (NY), Inc., UnitedHealth Group Incorporated,

Defendants - Appellees.

The appeal in the above captioned case from a judgment of the United States District Court for the Eastern District of New York was argued on the district court record and the parties' briefs. Upon consideration thereof,

IT IS HEREBY ORDERED, ADJUDGED and DECREED that the judgment of the district court is VACATED and the case REMANDED for further proceedings on plaintiffs' claims.

For The Court:

Catherine O'Hagan Wolfe,
Clerk of Court

APPENDIX D: RELEVANT STATUTORY PROVISIONS

ERISA § 502, 29 U.S.C. § 1132

(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;

* * *

(3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this title or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this title or the terms of the plan[.]

* * *

ERISA § 514, 29 U.S.C. § 1144

(a) Supersedure; effective date. Except as provided in subsection (b) of this section, the provisions of this title and title IV shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 4(a) [29 U.S.C. § 1003(a)] and not exempt under section 4(b) [29 U.S.C. § 1003(b)]. This section shall take effect on January 1, 1975.

(b) Construction and application.

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

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

(B) Neither an employee benefit plan described in section 4(a) [29 USCS § 1003(a)], which is not exempt under section 4(b) [29 USCS § 1003(b)] (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

* * *

N.Y. Gen. Oblig. L. § 5-101

*** * ***

4. As used in section 5-335 of this article, the term "benefit provider" means any insurer, health maintenance organization, health benefit plan, preferred provider organization, employee benefit plan or other entity which provides for payment or reimbursement of health care expenses, health care services, disability payments, lost wage payments or any other benefits under a policy of insurance or contract with an individual or group.

N.Y. Gen. Oblig. L. § 5-335

Limitation of non-statutory reimbursement and subrogation claims in personal injury and wrongful death actions

(a) When a plaintiff settles with one or more defendants in an action 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 a benefit provider, except for those payments as to which there is a statutory right of reimbursement. By entering into any such settlement, a plaintiff shall not be deemed to have taken an action in derogation of any nonstatutory right of any benefit provider that paid or is obligated to pay those losses or expenses; nor shall a plaintiff's entry into such settlement constitute a violation of any contract between the plaintiff and such benefit provider.

Except where there is a statutory right of reimbursement, no party entering into such a settlement shall be subject to a subrogation claim or claim for reimbursement by a benefit provider and a benefit provider shall have no lien or right of subrogation or reimbursement against any such settling party, with respect to those losses or expenses that have been or are obligated to be paid or reimbursed by said benefit provider.

* * *

APPENDIX E: NOTICE OF REMOVAL AND COMPLAINT

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF NEW YORK

MEGHAN WURTZ and MINDY BURNOVSKI, individually and on behalf of all others similarly situated, Plaintiff, - vs. - THE RAWLINGS COMPANY, LLC; OXFORD HEALTH PLANS (NY), INC.; UNITEDHEALTH GROUP, INCORPORATED, Defendants.	Case No. _________ ECF CASE

NOTICE OF REMOVAL

Defendants The Rawlings Company, LLC ("Rawlings"); Oxford Health Plans (NY), Inc. ("Oxford"); UnitedHealth Group, Incorporated ("UnitedHealth"), collectively referred to as "Defendants", hereby give notice of the removal of this action from the Supreme Court of the State of New York, County

of Nassau, Index No. 12-001459, to the United States District Court, Eastern District of New York, pursuant to 28 U.S.C. §§ 1331, 1332(d), 1441(a) and (b), 1446 and 1453. Defendants state as follows:

I. Procedural Background and Nature of the Action

1. On February 3, 2012, Plaintiffs Meghan Wurtz ("Wurtz") and Mindy Burnovski ("Burnovski") filed a putative class action complaint (the "Complaint" or "Compl.") in the Supreme Court of the State of New York, Nassau County, Index No. 12-001459, (the "Action") against Defendants. A true and correct copy of the Summons and Complaint, constituting all pleadings, process and orders served upon Defendants in this action, is annexed hereto as Exhibit 1.

2. Defendants have filed this Notice of Removal within 30 days of February 10, 2012, the date on which the first defendant received the initial pleading setting forth the claims for relief upon which the Action is based.

3. Plaintiffs allege that they suffered personal injuries at the hands of third parties and, as a result, received medical benefits from their fully insured health plans through Oxford ("Plans"). (Compl., ¶¶ 6, 7.) Plaintiffs' complaint incorporates language describing their insurance plans as "ERISA plans", or Plans within the scope of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). (*Id.* at 19, 21.)

4. ERISA applies broadly to employee benefit plans established or maintained by employers or employee organizations, including insurance plans to provide medical, surgical, or hospital care or bene-

fits, or benefits in the event of sickness, accident, disability, or death. *See* ERISA §§ 3(1), 4(a), 29 U.S.C. § 1002(1), 1003(a); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 44 (1987); *Borden v. Blue Cross and Blue Shield of W. N.Y.*, 418 F.Supp.2d 266, 271 (W.D.N.Y. 2006).

5. Plaintiffs filed lawsuits against their respective tortfeasors to recover for their personal injuries and damages. (Compl. ¶¶ 6, 7).

6. Rawlings, as Oxford's alleged collection agent, notified Plaintiffs of its "claim/ lien for medical benefits paid", advised that the medical benefits paid to them were paid "pursuant to an ERISA plan governed by federal law," and informed them Plaintiffs that, while legal viewpoints differ as to the application of NY GOL § 5-335, the "claim/lien applies to any amount" due or payable in connection with the personal injury lawsuits. (Compl., ¶¶ 19, 21.) Rawlings advised that "No settlement of any claim should be made prior to notifying our office of the potential settlement and reaching an agreement for satisfaction of our client's interest." (*Id.*)

7. According to the Complaint, Wurtz settled her personal injury action and paid Rawlings $1,316.87, the amount of the claim or lien for the medical benefits provided by Oxford. (Compl., ¶¶ 6, 19.)

8. Burnovski does not allege a settlement of her personal injury lawsuit and contends that Rawlings, as Oxford's alleged agent, asserts a claim or lien in the amount of $78,991.48, representing the amount of medical benefits provided by Oxford. (Compl., ¶¶ 7, 21.)

9. Plaintiffs assert that Defendants' assertion or collection of reimbursement and/or present and future efforts to collect reimbursement from persons insured under fully insured health insurance plans violates NY GOL § 5-335. The Complaint's First Cause of Action seeks a Declaratory Judgment that the New York law prohibits the enforcement of contractual liens; the Second Cause of Action alleges that Defendants' assertion of a lien is a deceptive act or practice, in violation of New York General Business Law § 349; and the Third Cause of Action contends that Defendants have been unjustly enriched at Plaintiffs' expense. (Compl., ¶¶ 37-54.) For relief, Plaintiffs seek a constructive trust, disgorgement, restitution and compensatory and punitive damages against Defendants for reimbursement paid by Wurtz and putative class members, and permanent injunctive relief on behalf of Burnovski and putative class members persons against pending and future assertions of claims or liens for reimbursement. (Compl., prayer for relief .)

10. Plaintiffs purport to bring the Action on behalf of: "(i) all persons who have paid monies to Defendants and/or their agents pursuant to fully insured health insurance plans in violation of New York State General Obligations Law Section 5-335 ('NY GOL § 5-335'), (ii) all persons against who[m] Defendants and/or their agents have, pursuant to fully insured health insurance plans, wrongfully asserted and continue to assert liens and/or rights of subrogation and/or reimbursement from settled cases and/or claims covered by NY GOL § 5-335, and (iii) "all persons covered by a fully insured health insurance policy with respect to any personal injury, medical, dental, or podiatric malpractice, wrongful

death or other similar cases or claims arising and/or pending in New York." (Compl. ¶ 29.)

II. This Action Arises Under the Laws of the United States

11. Federal district courts have original jurisdiction of all civil actions arising under the laws of the United States, including ERISA. 28 U.S.C. § 1331; ERISA § 502(f), 29 U.S.C. § 1132(f). Moreover, removal of a case from state to federal court is proper if the case could have been brought originally in federal court. *See* 28 U.S.C. § 1441(a); *Aetna Health Inc. v. Davila*, 542 U.S. 200, 207 (2004); *Arditi v. Lighthouse Int'l,* ---F.3d---, No. 11-423, 2012 WL 400706 at *2 (2d Cir. Feb. 9, 2012).

12. As explained below, this Action could have been brought in federal court as an action for benefits due under ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B); *see Levine v. United HealthCare Corp.*, 402 F.3d 156, 162 (3d Cir. 2005); *Arditi,* 2012 WL 400706 at *3 (§ 502(a)(1)(B) "provides participants or beneficiaries with a civil remedy to recover benefits due under their plans, to enforce rights under their plans, or to clarify rights to future benefits under their plans").

13. ERISA's civil enforcement mechanism, which includes § 502(a)(1)(B), "is one of those provisions with such 'extraordinary pre-emptive power' that it 'converts an ordinary state common law complaint into one stating a federal claim", making it removable to federal court. *Davila,* 541 U.S. at 209.

14. Accordingly, the Action arises under the laws of the United States, specifically ERISA, 29 U.S.C. §§ 1001, *et. seq.*, and may be removed to this Court pursuant to 28 U.S.C. §§ 1441, *et. seq.*

A. <u>Complete Preemption Under ERISA</u>

15. A federal court has original jurisdiction where Congress has "so completely pre-empt[ed] a particular area that any civil complaint raising this select group of claims is necessarily federal in character." *Met. Life Ins. Co. v. Taylor,* 481 U.S. 58, 63-64 (1987). A plaintiff may not avoid removal "by declining to plead necessary federal questions." *Arditi,* 2012 WL 400706 at *3.

16. "Certain federal laws, . . . including ERISA, so sweepingly occupy a field of regulatory interest that any claim brought within that field, however stated in the complaint, is in essence a federal claim. In such cases, the doctrine of complete preemption provides federal jurisdiction and allows removal to federal court." *Levine*, 402 F.3d at 162, *citing Taylor*, 481 U.S. at 63-64.

17. "Congress enacted ERISA to 'protect . . . the interests of participants in employee benefit plans and their beneficiaries' by setting out substantive regulatory requirements for employee benefit plans and to 'provide for appropriate remedies, sanctions, and ready access to the Federal courts." *Davila*, 542 U.S. at 208.

18. ERISA's "comprehensive legislative scheme" and "integrated enforcement mechanism, in ERISA § 502(a), 29 U.S.C. 1132(a), is a distinctive feature of ERISA, and essential to accomplish Congress' purpose of creating a comprehensive statute for the regulation of employee benefit plans." *Davila,* 541 U.S. at 208.

19. Under ERISA's civil enforcement provisions, a plan participant or beneficiary may sue to recover benefits due and seek relief in "the form of accrued

benefits due, a declaratory judgment on entitlement to benefits, or an injunction against a plan administrator's improper refusal to pay benefits." *Pilot Life,* 481 U.S. at 53; ERISA § 502(a)(1)(B), (a)(3), 29 U.S.C. § 1132(a)(1)(B), (a)(3). ERISA also provides a right of action for fiduciary breaches, recovery of losses to plans, removal of breaching fiduciaries and injunctive and other equitable relief. *Pilot Life,* 481 U.S. at 53; ERISA § 502(a)(2), (a)(3), 29 U.S.C. § 1132(a)(2), (a)(3).

20. "In sum, the detailed provisions of § 502(a) set 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. The policy choices reflected in the inclusion of certain remedies and the exclusion of others under the federal scheme would be completely undermined if ERISA-plan participants and beneficiaries were free to obtain remedies under state law that Congress rejected in ERISA." *Pilot Life,* 481 U.S. at 54.

21. Congress' intent in crafting ERISA's comprehensive framework for providing rights, remedies and access to federal courts "would make little sense if the remedies available to ERISA participants and beneficiaries under § 502(a) could be supplemented or supplanted by varying state laws." *Pilot Life,* 481 U.S. at 56.

22. Thus, "any state-law cause of action 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 pre-empted." *Davila,* 542

U.S. at 209.

B. <u>Plaintiffs' Claims Arise Under ERISA and Are Completely Preempted</u>

23. Under ERISA, "[a] civil action may be brought -- (1) by a participant or beneficiary -- (B) to recover benefits due to him [or her] under the terms of his [or her] plan, to enforce his [or her] rights under the terms of the plan, or to clarify his [or her] rights to future benefits under the terms of the plan. ERISA § 502(a)(1)(B); 29 U.S.C. § 1132(a)(1)(B).

24. Plaintiffs' state law claims, which seek to nullify Defendants' rights to reimbursement for medical benefits from Plaintiffs' tort recoveries, are claims to determine their benefits under ERISA § 502(a)(1)(B). In particular, through their causes of action for a declaratory judgment and unjust enrichment, Plaintiffs seek to use New York GOL 5-335 to invalidate the reimbursement and subrogation provisions of their ERISA Plans and retain the full amount of the medical benefits provided to them, notwithstanding their tort recoveries.

25. The Third Circuit's decision in *Levine v. United HealthCare Corporation*, 402 F.3d 156 (3d Cir. 2005), is particularly instructive on this issue.

26. In *Levine*, the plaintiff insureds paid the defendant insurers certain amounts received from third party recoveries to satisfy the insureds' claims for reimbursement. *Levine,* 402 F.3d at 159-60. The plaintiffs then brought unjust enrichment claims in a series of state court lawsuits, including ; *Carducci v. Aetna U.S. Healthcare*, 204 F.Supp.2d 796 (D.N.J. 2002), alleging that the insurers violated New Jersey's anti-subrogation statute. *Levine,* 402 F.3d at 160. The insurers, after consolidating *Carducci* and

the other actions, removed them to federal court. *Id.*

27. The *Levine/Carducci* insureds moved to remand and the question before the district court was "whether the monies plaintiffs now seek, that is the monies paid back to the defendants from plaintiffs' tort recoveries pursuant to the subrogation provisions in their ERISA plans, are 'benefits due' under those plans, within the meaning of [ERISA] Section 502(a)(1)(B) [29 U.S.C. 1132(a)(1)(B)." *Carducci*, 204 F.Supp.2d at 797. The district court denied remand and found removal was proper: "Because this Court finds that plaintiffs' claims seek to recoup a benefit due under the plan (that is the entire benefit amount paid as opposed to the benefit minus the subrogation loan), the Court holds that plaintiffs' claims are completely preempted under Section 502(a)(1)(B), and that removal was proper." *Id.* at 803-04.

28. The Third Circuit affirmed the district court's decision, concluding that "[w]here, as here, plaintiffs claim that their ERISA plan wrongfully sought reimbursement of previously paid health benefits, the claim is for 'benefits due' and federal jurisdiction under section 502(a) of ERISA is appropriate." *Levine,* 402 F.3d at 163; *see also Singh v. Prudential Health Care Plan, Inc.,* 335 F.3d 278, 291 (4th Cir. 2003) ("for purposes of complete preemption under § 502(a), a claimant who is denied a benefit is no different than a claimant 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").

29. The fact that Burnovski has not yet paid the claim or lien does nothing to diminish the ERISA nature of her claims. Courts addressing similar circumstances have reached the same conclusion as

Levine. *See Arana v. Ochsner Health Plan,* 338 F.3d 433, 438 (5th Cir. 2003) (insured's action for declaratory judgment that insurer could not obtain reimbursement was completely preempted and properly removed); *Borden,* 418 F.Supp.2d at 272 (claim that New York common law prohibits insurer's subrogation claim is completely preempted by ERISA).

30. The claims asserted in the present Action, like those in *Levine*, *Singh, Arana,* and *Borden*, are completely preempted under ERISA and properly removed to this Court.

III. The Action is a Removable Class Action

31. The Judiciary Code, at 28 U.S.C. § 1453(b) provides:

> **(b) In general.**—A class action may be removed to a district court of the United States in accordance with section 1446 (except that the 1-year limitation under section 1446(b) shall not apply), without regard to whether any defendant is a citizen of the State in which the action is brought, except that such action may be removed by any defendant without the consent of all defendants.

32. 28 U.S.C. § 1332(d)(1)(B) provides: "[T]he term 'class action' means any civil action filed under rule 23 of the Federal Rules of Civil Procedure or similar state statute or rule of judicial procedure authorizing an action to be brought by 1 or more representative persons as a class action."

33. The Action is a civil action filed as a class action under Article 9 of the New York Civil Practice

Laws and Rules, the New York class action statute, which authorizes an action to be brought by one or more representative persons as a class action.

34. The Class Action Fairness Act ("CAFA") applies to class actions with more than 100 proposed class members, minimal diversity between the parties, and at least $5 million in controversy. *See* 28 U.S.C. § 1332(d)(2), (d)(2)(A) and (d)(5)(B).

35. Minimal diversity exists between the parties as Plaintiffs are citizens of a state different from a Defendant. Wurtz is a resident of Arkansas and Burnovski, a resident of New York. (Compl., ¶¶ 6, 7.) Even if both were citizens of New York, minimal diversity exists since UnitedHealth is both incorporated and has its principal place of business in Minnesota. (*Id.* at ¶ 10.)

36. The proposed class consists of more than 100 members. Plaintiffs "reasonably believe[] that there are hundreds of members in the proposed Class" and assert that the class members "are so numerous that joinder of all members is impracticable." (Compl., ¶ 30.)

37. The amount in controversy exceeds $5 million, exclusive of interest and costs. Plaintiffs seek to represent not only Oxford's insureds, but "all persons covered by a fully insured health insurance policy with respect to any personal injury, medical, dental, or podiatric malpractice, wrongful death or other similar cases or claims arising and/or pending in New York." (Compl., ¶ 29.) This proposed class includes not only New York residents, but also individuals, like Wurtz, who live outside the state but were injured in New York or who were injured elsewhere and sue a defendant located in New York.

38. Defendant Rawlings has handled subrogation and reimbursement claims totaling more than $5 million with respect to New York insureds covered by fully insured plans since the adoption of NY GOL § 5-335.

39. In addition to the money damages sought from Defendants, Plaintiffs also seek permanent injunctive relief against pending and future efforts by Defendants. The requested relief therefore extends into the future and encompasses future claims of potentially hundreds of thousands of New Yorkers and other insureds covered by fully insured health insurance policies. The Complaint further demands punitive damages and attorneys' fees. (Compl., prayer for relief.)

40. The value of all such relief demanded can reasonably be expected to exceed $5 million, exclusive of interest and costs. *See Scherer v. Equitable Life Assurance Soc.*, 347 F.3d 394, 397 (2d Cir. 2003) (defendants' "hardly onerous" burden is to show that "it appears to a 'reasonable probability' that the claim is in excess of the statutory jurisdictional amount").

41. No exception to CAFA removal is applicable.

PROCEDURAL MATTERS

42. This Notice of Removal is timely filed with this Court pursuant to 28 U.S.C. § 1446(b), having been filed within 30 days of the commencement of the Action.

43. The venue of this removal action is proper pursuant to 28 U.S.C. § 1441(a) because the United States District Court for the Eastern District of New York embraces the judicial circuit which includes the

New York County Supreme Court, Nassau County, where the state court action has been pending.

44. No Act of Congress prohibits the removal of this cause, and the cause is removable under 28 U.S.C. §§ 1441-1453.

45. Immediately upon the filing of this Notice of Removal, Defendants will give written notice to Plaintiffs' attorneys of the removal of this case and will file a copy of this Notice of Removal with the Clerk of the Supreme Court of the State of New York, County of Nassau, pursuant to 28 U.S.C. § 1446(d).

46. Counsel for all Defendants confirm that they consent to removal.

47. Defendants have served by mail a copy of this notice on Plaintiffs' counsel.

48. This notice has been signed pursuant to Rule 11 of the Federal Rules of Civil Procedure.

CONCLUSION

WHEREFORE, Defendants file this notice to remove the action, now pending in the Supreme Court of the State of New York for the County of Nassau, Case No. 12-001459, from that court to this Court, and request that this action proceed in this Court as an action properly removed to it.

Dated: March 9, 2012
New York, New York

O'MELVENY & MYERS LLP

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Attorneys for Defendants The Rawlings Company LLC

* * *

SUPREME COURT OF THE STATE
OF NEW YORK
COUNTY OF NASSAU

------------------------------------- x	
MEGHAN WURTZ and MINDY BURNOVSKI, individually and on behalf of all others similarly situated,	**Index No.**
Plaintiffs,	**CLASS ACTION**
v.	**COMPLAINT**
THE RAWLINGS COMPANY, LLC, OXFORD HEALTH PLANS (NY), INC., UNITEDHEALTH GROUP, INCORPORATED,	**JURY TRIAL DEMANDED**
Defendants.	
------------------------------------- x	

Plaintiffs, Meghan Wurtz and Mindy Burnovski, individually and on behalf of all other persons similarly situated, by their attorneys, Hach Rose Schirripa & Cheverie LLP and Friedman Harfenist Kraut & Perlstein LLP, allege the following for their class action complaint against Defendants.

PRELIMINARY STATEMENT

1. The instant class action, seeking declaratory and monetary relief as a result of the Defendants' improper enforcement of invalid contractu-

al liens on personal injury settlements, is brought on behalf of (i) all persons who have paid monies to Defendants and/or their agents pursuant to fully insured health plans in violation of New York State General Obligation Law §5-335 ("NY GOL §5-335"), (ii) all persons against who Defendants and/or their agents have, pursuant to their fully insured health plans wrongfully asserted and continue to assert liens and/or rights of subrogation and/or reimbursement from settled cases and/or claims covered by NY GOL §5-335, and (iii) all persons covered by a fully insured health plan with respect to any personal injury, medical dental or podiatric malpractice, wrongful death cases or claims arising and/or pending in New York.

2. Because the Defendants' enforcement and attempted enforcement of the liens violates New York General Obligations Law § 5-335, the plaintiff is entitled to a judgment declaring the contractual liens invalid and a monetary award reimbursing all payments.

JURISDICTION AND VENUE

3. This Court has personal jurisdiction over this motion because all defendants conduct and transact business within this county and the state of New York.

4. This Court has subject matter of this action because the claims arise under and pursuant to alleged violations of New York statutory law, *i.e.*, NY GOL §5-335, and NY GBL §349.

5. Venue is proper in this county because many of the events or omissions giving rise to the claims alleged herein occurred in this county. In ad-

dition, Plaintiff Burnovski is a resident of this county.

PARTIES

6. Plaintiff Meghan Wurtz is a resident of Little Rock, Arkansas. On or about December 9, 2008, Meghan Wurtz commenced a lawsuit in the Supreme Court of the State of New York, County of New York, under Index Number 117091/08 which sought to recover for personal injuries and damages sustained as a result of a April 4, 2008 accident. As a result of the personal injuries that Plaintiff Wurtz sustained in her accident, Ms. Wurtz received medical benefits through her fully insured United Healthcare Oxford Insurance health plan called freedom Plan Metro Access. While litigation was pending, on or about October 28, 2011, Plaintiff Meghan Wurtz settled her personal injury notion. Defendant Rawlings, as agent for Defendant Oxford Health Plans (NY), has asserted a assert a lien under Defendant Oxford Health Plans (NY) fully insured Freedom Plan Metro Access insurance plan to recover from Plaintiff Sylvia Potts, medical expenses in the sum of $1,316.87, In violation of NY GOL §5-335. On or about January 10, 2012, Plaintiff Meghan Wurtz paid Defendant The Rawlings Company, LLC, as an agent for Defendant United Healthcare Oxford Health Plan (NY), $1,316.87 to release its lien. The lien Claimed by the Defendant The Rawlings Company, LLC and United Healthcare Oxford Health Care Plan (NY) is invalid as a matter of law in violation of NY GOL §5-335.

7. Plaintiff Mindy Burnovski is a resident of Long Beach, New York, On or about July 23, 2009, Mindy Burnovski commenced a lawsuit in the Su-

preme Court of the State of New York, County of Nassau, under Index Number 16939/09 which sought to recover for personal injuries and damages sustained as a result of a July 5, 2008 motor vehicle accident. As a result of the personal injuries that Plaintiff Burnovski sustained in his accident, Ms. Burnovski received medical benefits through her fully insured United Healthcare Oxford Insurance plan called Oxford Exclusive Plan Metro, also called the Oxford Freedom EPO Plan. Defendant Rawlings, as agent for Defendant Oxford Health Plans (NY), Inc., has asserted and continues to assert a lien under Defendant Oxford Health Plans' fully insured Freedom EPO Plan, and presently seeks to recover from Plaintiff Mindy Burnovski medical expenses In the sum of $78,991.48 in violation of NY GOL §5-335.

8. Defendant The Rawlings Company, LLC ("Rawlings") is, according to their website, a "recognized leader in the healthcare subrogation services field." The Rawlings Company claims to be "the first," "the largest," and to have "process[ed] more claims and recovered] more money for [Its] clients than any other company in this field." Defendant Rawlings's subrogation division maintains its principal place of business at One Eden Parkway, LaGrange, Kentucky 40031.

9. Defendants enumerated in paragraph 15 above is referred to as the "Collection Agency Defendants"

10. Defendant UnitedHealth Group Incorporated ("UnitedHealth Group") is, according to its website, "a leader in the health benefits and services industry" and through its "six businesses — UnitedHealthcare Employer & Individual, UnitedH-

ealthcare Medicare & Retirement, UnitedHealthcare Community & State, OptumHealth, OptumInsight, and OptumRx — offer exceptional service, broad capabilities and enduring value in creating a modern health care system." Defendant UnitedHealth Group is incorporated in the State of Minnesota with its headquarters and principal place of business is located at UnitedHealth Group Center, 9900 Bren Road East, Minnetonka, MN 55343.

11. Defendant Oxford Health Plans (NY), Inc. ("Oxford") is a health insurance company that provides health insurance benefit plans. In 2004 Oxford merged with UnitedHealthcare. UnitedHealthcare is an operating division of Defendant UnitedHealth Group. Defendant Oxford is a "benefit provider" as defined by NY GOL §5-101(4). Defendant Oxford is incorporated in the State of New York with its headquarters and principal place of business is located at 48 Monroe Turnpike, Trumbull, Connecticut 06611, Defendant Oxford maintains offices in this county at One Penn Plaza, 8th Floor, New York, New York 10119.

12. Defendants enumerated in paragraphs 17 and 18 above are collectively referred to as the "Health Insurance Company Defendants."

FACTUAL BACKGROUND

A. New York's Anti-Subrogation Statute

13. On November 10, 2009, both the New York State Senate and Assembly passed Senate Bill S66002 — commonly referred to as the Anti-Subrogation Law. The Bill was signed by Governor Paterson, and became effective, on November 12, 2009.

14. Specifically, Senate Bill S66002 amended New York's General Obligations Law by adding a new section, §5-335, which states as follows:

> §5-335 Limitation of Non-statutory Reimbursement and Subrogation Claims in Personal Injury and Wrongful Death Actions.
>
> (a) When a plaintiff settles with one or more defendants in an action for personal injuries, medical, dental, or pediatric 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 a benefit provider, except for those payments as to which there is a statutory right of reimbursement. By entering into any such settlement, a plaintiff shall not be deemed to have taken an action in derogation of any nonstatutory right of any benefit provider that paid or is obligated to pay those losses or expenses; nor shall a plaintiff's entry into such settlement constitute a violation of any contract between the plaintiff and such benefit provider.
>
> Except where there is a statutory right of reimbursement, no party entering into such a settlement shall be subject to a subrogation claim or claim for reimbursement by a benefit provider and a benefit provider shall have no lien or right of subrogation or reimbursement against any such settling party, with respect to those losses or expenses that have been or

are obligated to be paid or reimbursed by said benefit provider.

15. Pursuant to NY GOL §5-335, any clause in any health insurance policy or contract which gave the benefit provider a lien or right of subrogation or reimbursement against the settling party, with respect to medical expenses that have been paid or that were obligated to be paid/reimbursed by the benefit provider was now void.

16. NY GOL §5-335 is limited to non-statutory reimbursement and subrogation claims in personal injury, medical, dental, or podiatric malpractice, and wrongful death actions, and, as to such actions, only insurers or entities qualifying as a "benefit provider" are affected.

17. A "benefit provider" is defined by NY GOL §5-101(4) as "any insurers, health maintenance organization, health benefit plan, preferred provider organization, employee benefit plan or other entity which provides for payment or reimbursement of health care expenses, health care services, disability payments, lost wage payments or any other entity which provides for payment or reimbursement of health care expenses, health care services, disability payments, lost wage payments or any other benefits under a policy of insurance or contract with an individual or group."

B. Defendants' Blatant Disregard for New York's Anti-Subrogation Law

18. Since the enactment of NY GOL §5-335, Defendant Rawlings has mailed and/or faxed no less than two letters to Plaintiff Wurtz' counsel representing her in her personal injury action asserting and seeking to collect on lien and/or right of subroga-

tion and/or right of reimbursement as an agent for a fully insured private health insurance company Defendant United Healthcare Oxford Health Plan (NY).

19. On October 28, 2011, Plaintiff Wurtz notified Defendant Rawlings by letter that Plaintiff Wurtz's personal injury action had been settled. On October 28, 2011, Defendant Rawlings replied by letter to Plaintiff Wurtz letter maintaining its position that the lien was valid and annexed Rawlings company-wide November 2009 position statement. Approximately one year and 13 months *after* NY GOL §5-335 took effect, Defendant Rawlings continued to assert a lien on medical benefits Plaintiff Meghan Wurtz received under a fully insured Oxford Health Plan. In a letter to Plaintiff Potts' counsel representing her in her personal injury action, Defendant Rawlings stated in addition to the position statement as follows:

> This letter shall serve as notice that our client has a claim/lien for medical benefits paid on behalf of the patient for the above-referenced loss. These medical expenses were paid pursuant to an ERISA plan governed by federal law. There are differing legal viewpoints regarding the application of New York law CPLR§4545 and General Obligations Law 5-335 as amended by Governor's Program Bill 95/S66002 effective November 12, 2009. This claim/lien applies to any amount now due or which may hereafter become payable our of a recovery collected or to be collected, whether by judgment, settlement, or compromise, from any party hereby notified, No settlement of any claim should be made prior to notifying our office of the potential settlement and

reaching an agreement for satisfaction of our client's interest.

20. On or about January 10, 2012, Plaintiff Meghan Wurtz paid Defendant The Rawlings Company, LLC, as an agent for Defendant United Healthcare Oxford Health Plan (NY), $1,316.87 to release its lien.

21. On November 30, 2011, Defendant Rawlings sent the identical letter referenced in paragraph 28 to Plaintiff Mindy Burnovski.

22. Defendant Rawlings' statements regarding the enforcement of the lien were false and misleading, and indeed contrary to the plain language of NY GOL 5-335, which expressly provides that "no party entering into such a settlement shall be subject to a subrogation claim or claim for reimbursement by a benefit provider and a benefit provider shall have no lien or right of subrogation or reimbursement against any such settling party...."

23. The lien asserted by Defendant Rawlings, as agent for a fully insured health plan Defendant Oxford, against Plaintiff Meghan Wurtz and Mindy Burnovski is immaterial as a matter of law. As such, any payment made by Plaintiff Wurtz, Plaintiff Burnovski, or any other Class members to Defendants Rawlings or Oxford is without consideration.

24. Contrary NY GOL §5-335, Defendant Rawlings issued a company-wide statement in or about November 2009 that maintained the company's position that lien and/or right of subrogation for all insurance health plans is valid and enforceable against Plaintiffs and other similarly situated Class members,

25. The Collection Agency Defendants have asserted and continue to assert liens against other plaintiffs and/or claimants that have settled New York lawsuits and/or claims, by wrongfully alleging liens and/or rights of subrogation and/or rights of reimbursement of fully insured health plans in violation of NY GOL §5-335.

26. The Collection Agency Defendants have fraudulently, deceptively, unlawfully and wrongfully collected monies from plaintiffs and/or claimants that have settled New York lawsuits and/or claims, by wrongfully alleging liens and/or rights of subrogation and/or rights of reimbursement in violation of NY GOL 45-335.

27. The fully insured Health Insurance Company Defendants have asserted and continue to assert liens against other plaintiffs and/or claimants that have settled New York lawsuits and/or claims, by wrongfully alleging liens and/or rights of subrogation and/or rights of reimbursement in violation of NY GOL §5-335.

28. The fully insured Health Insurance Company Defendants have fraudulently, deceptively, unlawfully and wrongfully collected monies from plaintiffs and/or claimants that have settled New York lawsuits and/or claims, by wrongfully alleging liens and/or rights of subrogation and/or rights of reimbursement in violation of NY GOL §5-335.

CLASS ACTION ALLEGATIONS

29. Plaintiffs bring this action as a class action pursuant to Article 9 of the New York Civil Practice Law and Rules ("CPLR") on behalf (i) all persons who have paid monies to Defendants and/or their agents pursuant to fully insured health insur-

ance plans in violation of New York State General Obligation Law §5-335 ("NY GOL §5-335"), (ii) all persons against who Defendants and/or their agents have, pursuant to their fully insured health insurance plans, wrongfully asserted and continue to assert liens and/or rights of subrogation and/or reimbursement from settled cases and/or claims covered by NY GOL §5-335, and (iii) all persons covered by a fully insured health insurance policy with respect to any personal injury, medical, dental, or podiatric malpractice, wrongful death or similar cases or claims arising and/or pending in New York. Excluded from the Class are Defendants, the officers and directors of the Defendants, at all relevant times, members of their immediate families, their legal representatives, heirs, successors or assigns and any entity in which Defendants have or had a controlling interest.

30. The members of the Class are so numerous that joinder of all members is impracticable. While the exact number of Class members is presently unknown to Plaintiffs at this time and can only be ascertained through appropriate discovery, Plaintiff reasonably believes that there are hundreds of members in the proposed Class. Record owners and other members of the Class may be identified from records maintained by Defendants and may be notified of the pendency of this action by mail, or the internet or publication using the form of notice similar to that customarily used in class actions.

31. Plaintiff's claims are typical of the claims of the members of the Class as all members of the Class are similarly affected by Defendants' wrongful conduct in violation of statutory and common law complained of herein.

32. Common questions of law and fact exist as to all members of the Class and predominate over any questions solely affecting individual members of the Class. Among the questions of law and fact common to the Class are:

(a) whether New York General Obligations Law §5-335 was violated by Defendants practice of collecting and/or asserting liens and/or rights of subrogation and/or reimbursement from pending cases, claims and/or settlements;

(b) whether New York General Business Law §349 was violated by Defendants' practice of collecting and/or asserting liens and/or rights of subrogation and/or reimbursement from pending cases, claims and/or settlements in violation of New York General Obligation Law §5-335;

(c) whether Defendants' acts complained of herein unjustly enriched Defendants;

(d) whether the Class is entitled to injunctive or declaratory relief; and

(e) whether Plaintiff and other Class members have sustained monetary damages as a result of Defendants' actions alleged herein, and if so what is the proper measure of damages.

33. A class action is superior to all other available methods for the fair and efficient adjudication of this controversy since joinder of all members is impracticable. Furthermore, as the damages suffered by individual Class members may be relatively small, the expense and burden of individual litigation make it impossible for members of the Class to individually redress the wrongs done to them. There

will be no difficulty in the management of this action as a class action.

34. Plaintiffs will fairly and adequately protect the interests of the members of the Class. Plaintiffs are willing and prepared to serve the proposed Class in a representative capacity with all the obligations and duties material thereto.

35. Plaintiffs have no interests adverse to or which directly and irrevocably conflict with the interests of other members of the Class. Plaintiffs' interests are co-extensive with, and not antagonistic to, those of the absent Class members. Plaintiffs will undertake to represent and protect the interests of absent class members.

36. Plaintiffs have engaged the services of the undersigned counsel, Hach Rose Schirripa & Cheverle LLP and Friedman Harfenist Kraut & Perlstein LLP. Counsel are competent and experienced in complex class action litigation, will adequately prosecute this action, and will assert and protect the rights of, and otherwise represent, the named Plaintiffs and absent Class members.

AS AND FOR A FIRST CAUSE OF ACTION
(Declaratory Judgment)

37. Plaintiffs, individually and on behalf of all others similarly situated, repeat, reiterate and reallege each and every allegation in this Complaint in each of the foregoing paragraphs inclusive, with the same force and effects as if fully set forth herein.

38. Under New York GOL §5-335 prohibits the enforcement of contractual liens against personal injury settlements, In contravention to such prohibi-

tion, the Defendants have attempted to enforce such liens.

39. The Health Insurance Company Defendants have no right to assert and/or collect any liens and/or rights of subrogation and/or rights of reimbursement under fully funded health insurance plans against other plaintiffs and/or claimants that have settled personal injury, medical, dental, podiatric malpractice, or wrongful death cases or claims arising and/or pending in New York.

40. The Collection Agency Defendant, as agents for the Health insurance Company Defendants, have no right to assert and/or collect any liens and/or rights of subrogation and/or rights of reimbursement under fully funded health insurance plans against other plaintiffs and/or claimants that have settled personal injury, medical, dental, podiatric malpractice, or wrongful death cases or claims arising and/or pending in New York.

41. Accordingly, Plaintiffs request a judgment pursuant to the Declaratory Judgment provisions of NY CPLR Section 3001, declaring that:

(a) The Health Insurance Company Defendants, “benefit providers” as defined by NY GOL §5-101(4), do not have a right to assert and/or collect on any lien end/or right of subrogation and/or right of reimbursement under fully insured health insurance plans against other plaintiffs and/or claimants that have settled personal injury, medical, dental, podiatric malpractice, or wrongful death cases or claims arising and/or pending in New York; and

(b) the Collection Agency Defendants, as agents for the Health Insurance Company Defendants, "benefit providers" as defined by NY GOL §5-101(4), do not have a right to assert and/or collect on any lien and/or right of subrogation and/or right of reimbursement under fully insured health insurance plans against other plaintiff and/or claimants that have settled personal injury, medical, dental, podiatric malpractice, or wrongful death cases or claims arising and/or pending in New York.

AS AND FOR A SECOND CAUSE OF ACTION (Violation of the New York General Business Law § 349)

42. Plaintiffs, individually and on behalf of all others similarly situated, repeat, reiterate and reallege each and every allegation in this Complaint in each of the foregoing paragraphs inclusive, with the same force and effect as if fully set forth herein.

43. Section 349 of the New York's General Business Law states:

> Deceptive acts or practices in the conduct of any business, trade or commerce or in the furnishing of any service in this state are hereby declared unlawful.

44. Defendants' deceptive acts and practices whereby Defendants falsely represented to Plaintiffs and similarly situated Class members that, Plaintiffs and other Class members were obligated to pay liens under fully insured health insurance plans. Defendants disseminated false and misleading statements to Plaintiffs and other Class members in

furtherance of Defendants' scheme to assert and collect liens under fully insured health insurance plans against other plaintiffs and/or claimants that have settled New York lawsuits and/or claims in violation of NY GOL §5-335.

45. Defendants' deceptive acts and practices have enabled Defendants to collect hundreds of millions of dollars in fully insured health insurance liens that they were not entitled to enforce or collect following the enactment of NY GOL 5-335,

46. Defendants' conduct and actions, as described above, constitute deceptive business practices in violation of the GBL.

47. The damages sustained by Plaintiffs and the other Class members were a direct and foreseeable result of, and were proximately caused by Defendants' deceptive business practices.

48. As a result of Defendants' actions, Plaintiffs and other Class members have been injured and damaged in an amount to be determined at trial.

AS AND FOR A THIRD CAUSE OF ACTION
(Unjust Enrichment)

49. Plaintiffs, individually and on behalf of all others similarly situated, repeat, reiterate and reallege each and every allegation in this Complaint in each of the foregoing paragraphs inclusive, with the same force and effects as if fully set forth herein.

50. Defendants benefited from its unlawful acts, misrepresentations and omissions to Plaintiffs and the other Class members as alleged herein. These unlawful acts, misrepresentations and omis-

sions caused Plaintiffs and other Class members to suffer injury and monetary loss.

51. Defendants have been, and continue to be, unjustly enriched at the expense of and to the detriment of Plaintiffs and each member of the Class through the assertion and collection of fully insured health plan liens which are invalid as a matter of law.

52. Equity and good conscience require that Defendants disgorge all such unjust gains and that Defendants should pay amounts by which it was unjustly enriched to Plaintiffs and the Class in an amount to be determined at trial.

53. Plaintiffs and the Class seek restitution from Defendants, and seek an order of this Court disgorging all profits, benefits and other such compensation obtained by Defendants through its wrongful conduct,

54. Plaintiffs and the Class are entitled to the establishment of a constructive trust impressed upon the benefits derived by Defendants from its unjust enrichment and inequitable conduct.

WHEREFORE, Plaintiffs pray for relief and judgment, as follows:

A. Determining that this action is a proper class action, certifying the named Plaintiffs as class representatives for the specified class alleged herein under CPLR Article 9 and Plaintiffs' counsel as Class Counsel;

B. Granting such preliminary and permanent equitable relief, including enjoining Defendants' actions complained of herein, the imposition of a constructive trust, as is appropriate to pre-

serve the assets wrongfully taken from Plaintiffs and the Class;

C. Awarding, on Plaintiffs' and the Class' NY GBL §349 claims, compensatory damages, and enhancement of damages Plaintiffs and Class members have sustained as a result of Defendants' conduct as may be permitted under the relevant statutes, such amount to be determined at trial, plus Plaintiffs' cost in this suit, including reasonable attorney's fees;

D. Awarding, on Plaintiffs' and the Class' claims for unjust enrichment, recovery In the amount of that Defendants' collected from fully insured health plan liens that were unlawfully enforced and collected upon in violation of NY GOL §5-335, such amounts to be determined at trial, plus Plaintiffs' cost in this suit, including reasonable attorney's fees;

E. Seeking disgorgement and restitution of all of any and all monies Defendants realized as a result of its unlawful acts, omissions and practices;

F. Awarding punitive damages for each claim to the maximum extent available under the law on account of the outrageous nature of Defendants' willful and wanton disregard for the rights of the Plaintiffs and the Class;

G. Awarding Plaintiffs and the Class their reasonable costs and expenses Incurred in this action, including interest, counsel fees and expert fees; and

H. Such other and further relief as the Court may deem just and proper.

JURY TRIAL DEMANDED

Plaintiffs hereby demand a trial by jury.

DATED: New York, New York
February 2, 2012

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