No. 16-149

In The
Supreme Court of the United States

COVENTRY HEALTH CARE OF MISSOURI, INC.,

Petitioner,

v.

JODIE NEVILS,

Respondent.

On Writ Of Certiorari To The Supreme Court Of Missouri

BRIEF FOR *AMICI CURIAE* AMERICA'S HEALTH INSURANCE PLANS AND ASSOCIATION OF FEDERAL HEALTH ORGANIZATIONS IN SUPPORT OF PETITIONER

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BRIEF FOR *AMICI CURIAE* AMERICA'S HEALTH INSURANCE PLANS AND ASSOCIATION OF FEDERAL HEALTH ORGANIZATIONS IN SUPPORT OF PETITIONER

America's Health Insurance Plans ("AHIP") and Association of Federal Health Organizations ("AFHO") respectfully submit this brief as *amici curiae* in support of petitioner, with the written consent of the parties.[1]

STATEMENT OF INTEREST OF *AMICI CURIAE*

America's Health Insurance Plans ("AHIP") is the national trade association representing the health insurance community. AHIP advocates for public policies that expand access to affordable healthcare coverage to all Americans through a competitive marketplace that fosters choice, quality, and innovation. Along with its predecessors, AHIP has over 50 years' experience in the industry. AHIP's members provide health and supplemental benefits through employer-sponsored coverage, the individual insurance market, and public programs such as Medicare, Medicaid, and – as relevant here – the Federal Employees Health Benefit

[1] Counsel for *amici* has filed the requisite consent letters with the Clerk. No party or counsel for a party authored this brief in whole or in part, and no counsel or party, or any person other than *amici*, their members, and counsel, made a monetary contribution intended to fund the brief's preparation or submission.

("FEHB") Program. As a result, AHIP's members have broad experience working with hospitals, physicians, patients, employers, state governments, the federal government, pharmaceutical and device companies, and other healthcare stakeholders to ensure that patients have access to needed treatments and medical services. That experience gives AHIP extensive first-hand and historical knowledge about the Nation's healthcare and health insurance systems and a unique understanding of how those systems work.

The Association of Federal Health Organizations ("AFHO") is an organization of entities that serve as carriers of health benefit plans under the FEHB Program. Collectively, the plans of AFHO member carriers provide health benefits to over 3 million federal and postal employees and annuitants who receive health coverage under the FEHB Program.

Amici and their members have a demonstrated interest in ensuring that courts correctly interpret and apply federal health benefit statutes, including the Federal Employees Health Benefits Act ("FEHBA"). *See, e.g.*, *Health Care Serv. Corp. v. Pollitt*, 559 U.S. 965 (2010) (AHIP and AFHO participated as *amici* in FEHBA case dismissed pursuant to Supreme Court Rule 46.1); *see also Hillman v. Maretta*, 133 S. Ct. 1943 (2013) (AFHO filed *amicus* brief in preemption case arising under Federal Employees' Group Life Insurance Act, which contains a preemption provision similar to FEHBA's); *Metropolitan Life Ins. Co. v. Glenn*, 554 U.S. 105 (2008) (AHIP participated as *amici* in

ERISA case); *Sereboff v. Mid Atl. Med. Servs.*, 547 U.S. 356 (2006) (same).

This case is of significant importance to *amici*, whose members contract with the Office of Personnel Management under 5 U.S.C. § 8902 to offer a significant percentage of all FEHBA health plans offered across the United States. As explained below, the Missouri Supreme Court's rulings on preemption, and the concurrence's reasoning concerning the Supremacy Clause, could make the design and administration of FEHBA health plans exceedingly complex and expensive for carriers, federal employees, and taxpayers, who shoulder the burden of those costs each year.

SUMMARY OF ARGUMENT

Congress enacted the Federal Employee Health Benefits Act to ensure that federal employees have access to affordable, high quality healthcare plans offering uniform benefits and rates regardless of where the employee happens to live and work. To make the Act's promise a reality, Congress charged the Office of Personnel Management ("OPM") with regulating the terms, conditions, and administration of FEHBA plans.

OPM engages in detailed oversight and regulation of every aspect of the program, demonstrating both the importance of the program to the federal government and its careful consideration of the impact of various provisions on enrollees. OPM has issued regulations and guidance governing a wide range of plan activities,

including what and how they communicate about plan provisions with enrollees. Among other things, the federal government: specifies benefits that FEHBA plans must offer; drafts the standard form contract that carriers must execute when agreeing to participate in the FEHBA program; and approves each and every page of the plan benefit brochures FEHBA enrollees receive. This includes the subrogation language at issue in this case, which, like all terms of FEHBA contracts or benefits brochures, is authorized by federal statute and/or regulation, and has been reviewed and approved by the federal government, through OPM.

The Missouri Supreme Court's holding, if affirmed, would undermine Congress and OPM's goals by adding significant cost and complexity to the FEHBA Program and paving the way for the cross-state subsidization of health benefits (which Congress expressly sought to avoid). OPM and FEHBA carriers would be required to adjust organizational structures, and possibly even re-price premiums, to account for the uncertainty and administrative burden that would result from carriers' need to comply with state laws regulating reimbursement and/or subrogation. The increased complexity, and therefore cost, are compounded by the range of such laws, which include not only outright prohibitions on subrogation (as in Missouri) but more subtle distinctions, such as: limitations on the specific kinds of benefits that may be subject to reimbursement and/or subrogation; the "make-whole" doctrine; and the "common-fund" rule.

Affirming the decision below also would put FEHBA carriers to an untenable choice: comply with their contractual obligations to pursue subrogation recoveries or risk lawsuits alleging improper subrogation activities in states that do not permit it in some or all circumstances. As shown by the class action complaint filed in this very case, which seeks compensatory and punitive damages, that kind of litigation can be protracted and expensive.

The reasoning of the concurrence below threatens to compound exponentially the problems portended by the majority's decision. If the Supremacy Clause cannot accomplish preemption in these circumstances, then a whole range of state substantive and procedural rules that Congress clearly meant to override would apply to FEHBA plans. These requirements range from minimum-benefits rules mandating that certain types of care be covered by all policies sold within a state, to detailed claims-handling requirements, to rules for contesting benefits determinations. Compliance with all such state requirements – which often conflict with one another – would add substantial cost and complexity to the administration of FEHBA plans and endanger the viability of the multi-state and national plans Congress sought to create for the federal workforce.

This Court should reverse the judgment below.

ARGUMENT

I. Congress And OPM Exercise Substantial Control Over The Content Of FEHBA Contracts And Benefits Brochures, Including Subrogation Clauses, Lending Support To The Argument That FEHBA Preempts State Anti-Subrogation Laws.

In choosing to go into direct conflict with the U.S. Court of Appeals for the Tenth Circuit, *see Helfrich v. Blue Cross & Blue Shield Ass'n*, 804 F.3d 1090 (10th Cir. 2015), as well as the Arizona Court of Appeals, *see Kobold v. Aetna Life Ins. Co.*, 370 P.3d 128 (Az. Ct. App. 2016), the Missouri Supreme Court expressed great reluctance to "permit[] contract terms to preempt state law." Pet. App. 12a. This reasoning fundamentally misunderstands the "contracts" at issue here.

FEHBA plans are not mere private health insurance contracts negotiated between insurance companies and their customers. Rather, they are federal plans whose every detail is controlled by the Office of Personnel Management ("OPM"). This is the way it *must* be for OPM to achieve Congress' express goal of "offer[ing] uniform benefits and rates to [FEHB] enrollees regardless of where they may live." H.R. Rep. No. 105-374, at 9 (1997).

1. Congress enacted FEHBA to establish "a comprehensive program of health insurance for federal employees." *Empire HealthChoice Assur., Inc. v. McVeigh*, 547 U.S. 677, 682 (2006). Under the Act, the Office of Personnel Management contracts with

private insurance companies, known as FEHBA "carriers," to "offer federal employees an array of health-care plans." *Id.* Over 8 million federal employees, retirees, and their dependents receive coverage through the FEHB Program each year. *See Federal Employees Health Benefits Program; Subrogation and Reimbursement Recovery*, 80 Fed. Reg. 29203, 29203 (May 21, 2015); *see also* Kirstin B. Blom and Ada S. Cornell, Congressional Research Service, *Federal Employees Health Benefits (FEHB) Program: An Overview*, at 1 (Feb. 3, 2016) ("CRS Report").[2]

FEHBA plans are funded by premiums paid by the federal government and plan enrollees. The lion's share of these premiums – generally 72% – is paid by the federal government, with the remainder coming from enrollees. *See* 5 U.S.C. § 8906(b)(1). The premiums are paid into a special fund in the U.S. Treasury, established by Congress and administered by OPM, known as the Employee Health Benefits Fund ("Treasury Fund"). *Id.* § 8909. Any money left in the Treasury Fund at the end of the year is used, in OPM's discretion, to reduce premium rates or to "increase the benefits provided by[ ] the plan." 5 U.S.C. § 8909(b); *see also* 5 C.F.R. § 890.503(c)(2).

FEHBA plans come in two basic varieties: "community-rated" and "experience-rated." A community-rated plan, like the one at issue here, receives a "per member per month capitation rate" for each member

[2] Available at https://fas.org/sgp/crs/misc/R43922.pdf (last visited Dec. 18, 2016).

enrolled in the plan. 42 C.F.R. § 1602.170-2. Community-rated carriers receive these payments up front from the Treasury Fund and use those premiums to pay claims consistent with OPM guidelines. *Id.* § 1632.170(a). Community-rated plans tend to cover specific metropolitan areas; however, as shown by the plan at issue here, they often operate across state lines.

Experience-rated plans, by contrast, receive premiums based on "actual paid claims" (subject to certain adjustments). 48 C.F.R. § 1602.170-7. Experience-rated carriers may access these funds on a "letter of credit" basis, drawing down the funds necessary to pay claims made from the Treasury Fund set up to administer the FEHB Program. *Id.* § 1632.170(b). The carriers' profit comes not from premiums charged or the efficient management of healthcare utilization, but from a "service charge" they negotiate with OPM. *See* 48 C.F.R. § 1615.404-4. Experience-rated plans are generally open to federal employees nationwide.

A "significant proportion of" the FEHB Program's more than 8 million enrollees "are covered through nationwide fee-for-service plans with uniform rates," 80 Fed. Reg. at 29203, which are experience-rated, CRS Report at 9 n.48. Community-rated plans, like the one at issue in this case, cover the remainder of the FEHB Program's enrollees and account for the rest of its expenses.

2. OPM negotiates the terms of the federal health benefit contracts with all FEHBA carriers. 5 U.S.C. § 8902(a). Congress specified the types of coverage that FEHBA plans must offer. 5 U.S.C. § 8904. It further directed OPM to "prescribe reasonable minimum standards for health benefits plans" offered under FEHBA. *Id.* § 8902(e); *see also* 42 C.F.R. § 890.201 (setting forth those standards). Congress also specified that the rates charged by FEHBA carriers "shall reasonably and equitably reflect the cost of the benefits provided," *id.* § 8902(i), which necessarily implicates the ability of carriers to reduce those costs through subrogation and/or reimbursement.

As with other government insurance programs administered by private companies (such as the National Flood Insurance Program), OPM created a standard form contract it uses when contracting with FEHBA carriers. *See, e.g.*, FEHB 2012 Standard Contract for Community-Rated Health Maintenance Organizations (Jan. 27, 2012);[3] FEHB 2012 Standard Contract for Experience-Rated Health Maintenance Organizations (Jan. 1, 2012).[4] Each year, OPM also issues proposed amendments to those standard contracts, showing the changes OPM has made from the prior year. *See, e.g.*, Proposed Changes to Standard 2016 Community-Rated HMO Health Benefits

[3] Available at http://www.opm.gov/healthcare-insurance/healthcare/carriers/community-rated.doc (last visited Dec. 18, 2016).

[4] Available at http://www.opm.gov/healthcare-insurance/healthcare/carriers/experience-rated.doc (last visited Dec. 18, 2016).

Contract;[5] Proposed Changes to Standard 2016 Experience-Rated HMO Health Benefits Contract.[6]

Congress also required OPM to "make available to each individual eligible to enroll in a health benefits plan under this chapter such information, in a form acceptable to [OPM] after consultation with the carrier, as may be necessary to enable the individual to exercise an informed choice among the types of plans. . . ." 5 U.S.C. § 8907(a). Congress similarly required that each person who enrolls in a FEHBA plan receives "an appropriate document setting forth or summarizing the – (1) services or benefits, including maximums, limitations, and exclusions, to which the enrollee or the enrollee and any eligible family members are entitled thereunder; (2) procedure for obtaining benefits; and (3) principal provisions of the plan affecting the enrollee and any eligible family members." *Id.* § 8907(b). OPM meets this requirement by requiring carriers to send each enrollee a document commonly known as the FEHB "benefits brochure."

However, it is OPM, and not the FEHBA carriers, that ultimately is responsible for the content of these brochures. 42 C.F.R. § 1603.7001. That brochure also serves another function required by Congress; it constitutes the contractual "detailed statement of benefits offered," including "such maximums, limitations,

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[5] Available at https://www.opm.gov/healthcare-insurance/healthcare/carriers/2015/2015-17a1.pdf (last visited Dec. 18, 2016).

[6] Available at https://www.opm.gov/healthcare-insurance/healthcare/carriers/2015/2015-17a2b.pdf (last visited Dec. 18, 2016).

exclusions, and other definitions of benefits as [OPM] considers necessary or desirable." 5 U.S.C. § 8902(d); *see also* J.A. 80, 113 (contract provisions requiring Petitioner to provide all services specified in benefits brochure attached to contract). The brochure is typically attached to each contract between the FEHBA carrier and OPM. *See* J.A. 235 (brochure attached to contract as Appendix A); *see also McVeigh*, 547 U.S. at 684 (noting benefits brochure is appended to OPM-carrier contract).[7]

These statutes and regulations ensure that OPM exercises nearly complete control over the contents of its contracts with carriers, including the benefits brochure that describes enrollees' rights and responsibilities under the FEHBA plan. Thus, no carrier could insert subrogation language in its brochure unless that is precisely what the federal government intended for it to do. With Congress having explicitly given OPM authority over the contract terms (including the benefits brochure), and with Congress intending that those

[7] OPM uses a multi-step, months-long process to ensure uniformity in the benefits brochures that go out to FEHBA enrollees. That process starts with OPM sending the carrier its latest "brochure handbook"; proceeds with OPM giving carriers access to an online brochure-creation tool and training them how to use it; continues with OPM reviewing and approving any proposed deviations from the standard brochure language; and ends with OPM telling the carrier how many brochures are needed and may be charged to the FEHBA contract. *See, e.g.*, FEHB Program Carrier Letter No. 2015-03(b), Attachment II ("Preparing Your 2016 Brochure"), available at https://www.opm.gov/healthcare-insurance/healthcare/carriers/2015/2015-03b.pdf (last visited December 12, 2016).

terms – not state insurance laws – govern issues relating to coverage or benefits, there is no place for the Missouri Supreme Court's restrictive reading of FEHBA's preemption provision. That is particularly true here, where the subrogation activities OPM requires save federal employees and taxpayers significant money each year, as we address next.

II. FEHBA Reimbursement And Subrogation Saves The Federal Treasury Substantial Amounts Of Money Each Year.

OPM requires FEHBA carriers to pursue subrogation activities. As noted above, OPM publishes standard contracts for both experience-rated and community-rated carriers. The relevant subrogation section of each of those Standard Contracts requires all FEHBA carriers to "subrogate FEHB claims in the same manner in which it subrogates claims for non-FEHB members," according to a series of rules that apply depending on whether the state(s) in which the carrier is doing business permit subrogation. *See* Standard Contract for Community-Rated HMOs, *supra* n.3, § 2.5; Standard Contract for Experience-Rated HMOs, *supra* n.4, § 2.5. Of relevance to this case, "[t]he Carrier shall subrogate FEHB claims if it is doing business in a State in which subrogation is prohibited, but in which the Carrier subrogates for at least one plan covered under the Employee Retirement Income Security Act of 1974 (ERISA)." *Id.* § 2.5(a)(2). The subrogation clause of the

OPM-Carrier contract at issue in this case contains this very same language. *See* Pet. App. 147a.[8]

FEHB benefits brochures typically contain subrogation and/or reimbursement language required by these federal regulations and contracts. For example, the benefits brochure for the FEHBA plan at issue in this case, known as the Group Health Plan, states: "If you do not seek damages you must let us try. This is called subrogation. If you need more information, contact us for subrogation procedures." Pet. App. 147a.

As explained below, the Government has a compelling reason to require Carriers to pursue these recoveries: FEHBA reimbursement and subrogation saves the FEHBA Program, and thus the U.S. Treasury, substantial amounts of money each year.

Both community-rated and experience-rated carriers save the government money by pursuing subrogation, albeit in different ways. Experience-rated plans, who insure the largest percentage of federal employees, must return all reimbursement and subrogation recoveries (net of the expenses in obtaining the recoveries) directly to the Treasury Fund set up to finance the FEHB Program. *See* 48 C.F.R. §§ 31.201-5, 1631.201-70(a) & (g), 1652.216-71(b)(2)(i); *see also*

[8] OPM later promulgated a new regulation requiring that all FEHBA contracts contain such a provision: "All health benefit plan contracts shall provide that the Federal Employees Health Benefits (FEHB) carrier is entitled to pursue subrogation and reimbursement recoveries, and shall have a policy to pursue such recoveries in accordance with the terms of this section." 5 C.F.R. § 890.106(a) (emphasis added).

McVeigh, 547 U.S. at 685 ("Pursuant to the OPM-BCBSA master contract, reimbursements obtained by the carrier must be returned to the Treasury Fund."). Thus, subrogation by experience-rated carriers saves the federal government money on an almost dollar-for-dollar basis.

Community-rated carriers also save money for the Treasury Fund when they pursue subrogation activities. As the United States explained in the *amicus* brief it filed in the court below, "[s]ubrogation recoveries by community-rated carriers also lower subscription charges for enrollees and the federal government." Pet. App. 170a. "The premiums that community-rated carriers charge generally depend on the expected cost of providing benefits." Pet. App. 171a. "Subrogation recoveries by community-rated carriers tend to reduce those expected costs, and thus the premiums," *id.* – over 70% of which are paid by the federal government. Federal employees benefit as well, of course, as they pay the remainder of these premium costs.

The total effect of these subrogation recoveries is substantial. OPM estimates that reimbursement and subrogation recoveries save the FEHB Program – and the enrollees and taxpayers who fund it – over $125 million per year. *See* Pet. App. 151a.

III. Exempting Anti-Subrogation Laws From Federal Preemption Would Add Substantial Complexity, Uncertainty, And Cost To The Administration Of FEHBA Plans.

Congress enacted FEHBA to create a uniform, national program for federal employee health benefits, with plans "offer[ing] uniform benefits and rates to [FEHB] enrollees regardless of where they may live." H.R. Rep. No. 105-374, at 9 (1997). For that system to work, federal – and not state – law must govern every aspect of FEHBA benefit administration.

A FEHBA program where states set the ground rules with respect to reimbursement and subrogation would lead to a system that is neither uniform nor national. "Disuniform application of FEHB contract terms as they apply to enrollees in different states is administratively burdensome, gives rise to uncertainty and litigation, and results in treating enrollees differently, although enrolled in the same plan and paying the same premiums." *Federal Employees Health Benefits Program; Subrogation and Reimbursement*, 80 Fed. Reg. 931, 932 (Jan. 7, 2015). That is precisely what would happen if this Court affirms the decision below.

1. State reimbursement and subrogation laws are varied and complicated. *See generally* AFHO State Survey of Reimbursement Laws in The Health Insurance Context ("AFHO State Survey") (Feb. 2014).[9] Several states, including Missouri, generally prohibit

[9] Available at http://ermerlaw.com/PDFs/Feb2014%20FHOState SurveyWithMap.pdf (last visited Dec. 18, 2016).

reimbursement and/or subrogation altogether. *See, e.g.*, Ariz. Rev. Stat. § 12-565; Conn. Gen. Stat. Ann. § 52-225a; N.J. Stat. Ann. § 2A:15-97; N.Y. Gen. Oblig. Law § 5-335(a); 11 N.C. Admin. Code § 12.0319; Va. Stat. § 38.2-3405; *Travelers Indem. Co. v. Chumbley*, 394 S.W.2d 418, 419 (Mo. Ct. App. 1965); Kan. Admin. Regs. § 40-1-20.

Other states take a more nuanced approach. Michigan, for example, generally allows subrogation if a health insurance plan contains a reimbursement or subrogation provision. *See Foremost Life Ins. Co. v. Waters*, 329 N.W.2d 688, 689 (Mich. 1982). However, it prohibits subrogation in automobile accidents governed by its No-Fault Act, *Great Lakes Am. Life Ins. Co. v. Citizens Ins. Co.*, 479 N.W.2d 20, 21 (Mich. Ct. App. 1991).

The patchwork of state reimbursement and subrogation laws is not limited to the question of whether subrogation is allowed and/or in what contexts. States also employ numerous legal and equitable doctrines that can prevent a health insurer from obtaining reimbursement even in jurisdictions where seeking reimbursement and/or subrogation are permissible. For example, many states apply a version of the "make-whole" doctrine. *See generally* AFHO State Survey, *supra* n.9, at 1 (map identifying approximately 20 "make-whole" states). Under this doctrine, an insurer may not subrogate until its insured receives full compensation for his or her loss. *See, e.g.*, *Dufour v. Progressive Classic Ins. Co.*, 881 N.W.2d 678, 683 (Wis. 2016). But, of course, states do not entirely agree on what it means to be "made whole." Some, such as Wisconsin, hold that

an insured is made whole only when the insured is compensated for *all* of his or her injuries, *see Rimes v. State Farm Mutual Auto Insurance Co.*, 316 N.W.2d 348, 355 (Wis. 1982). Other states, such as Iowa, hold that carriers are allowed to subrogate when the insured is compensated for the element of damages that the carrier has already paid, *see Ludwig v. Farm Bureau Mutual Insurance Co.*, 393 N.W.2d 143, 145 (Iowa 1986). Further, many states will apply the make-whole doctrine even when the insurance plan contains language that expressly rejects it.

Many states also apply the "common-fund" rule in reimbursement and/or subrogation cases. *See generally* AFHO State Survey, *supra* n.9, at 1 (map identifying nearly 40 "common-fund" states). Under this rule, "a litigant or lawyer who recovers a common fund for the benefit of persons other than himself or his client is entitled to a reasonable attorney's fee from the fund as a whole." *US Airways, Inc. v. McCutchen*, 133 S. Ct. 1537, 1545 (2013) (internal quotation marks and citation omitted). In practice, this rule requires FEHBA carriers that do not actively participate in litigation to reduce their reimbursement and/or subrogation demands to absorb a portion of the plaintiff's attorney's fees. Like the "make-whole" doctrine, the rule therefore operates to limit what FEHBA carriers might recover even in states where subrogation and/or reimbursement is available.

2. Against this backdrop, it is easy to see how the Missouri Supreme Court's ruling with respect to subrogation would undercut Congress' goal of having a single, nationwide system for federal employee health

benefits. The effect on those paying for such plans – the federal government and enrollees – is amplified because of the resulting, significant increase in the administrative difficulty, burden, and expense of administering FEHBA plans in an environment of fifty separate approaches to subrogation. These increased costs to the government and to individual federal employees is felt both directly (through lost recoveries that would otherwise benefit the Treasury Fund) and indirectly (through higher administrative costs that make the program more expensive to administer).

A few hypothetical scenarios drive home how quickly uniformity is lost, and the government and federal employees are harmed, when fifty approaches to subrogation are substituted for OPM's. Although these examples are drawn from specific plans that cover particular regional markets, the problems are equally – if not more – acute for those plans available to federal employees nationwide; if the decision below were affirmed, they would be required to account for similar nuances in state subrogation and reimbursement across all 50 states.

Scenario 1: St. Louis. In the absence of preemption, a federal employee's choice of where to live within a given metropolitan area could determine whether reimbursement and/or subrogation are even available to the FEHBA carrier. Imagine that Jack and Jill are two federal employees working in the St. Louis Field Office of the FBI. Jack lives in suburban St. Louis, just west of downtown. Jill, on the other hand, lives just across the river in southern Illinois. Both elected to enroll in

the same plan offered to federal employees living in the greater St. Louis area (which extends into Illinois) – like the Coventry Group Health Plan at issue here, *see* Pet. App. 145a (noting service area). As co-workers enrolled in the same plan, they pay the same premium for their coverage.

Now imagine that one day, Jack and Jill each get into an accident as soon as they have pulled out of their driveways on the way to work. Because each sustained the very same injuries, the Coventry paid identical sums (say, $5,000) for care related to each accident. However, the Coventry's rights would be different in each case, by virtue of the fact that Jack lives in and was injured in Missouri, whereas Jill lives in and was injured in Illinois.

Coventry would be able to bring suit in Illinois to recover from the liable third party for Jill's injury there, or to seek reimbursement from any settlement proceeds she obtains. However, under the reasoning of the court below, Coventry could *not* pursue recovery for Jack's identical injuries in Missouri. Hence, two participants in the same plan paying the same premium will, in effect, receive different benefits simply because they lived in different states. This is antithetical to the purposes of the FEHB Program. *See* 80 Fed. Reg. at 932 ("Congress enacted the preemption provision to avoid such disparities, and to enhance the ability of the Federal Government to offer its employees a program of health benefits governed by a uniform set of legal rules.").

Scenario 2: Road Trip. An employee's state of residence is not the only factor that would undermine the uniformity of plan benefits under the ruling below. Imagine that Jack and Jill were traveling together on a road trip to Chicago when they got in an accident. If that accident happened in Missouri just after they left the office, Coventry still would not be entitled to reimbursement and/or subrogation for Jack's injuries.

In Jill's case, however, the issue is not as cut-and-dried. Does the law of Missouri (the *lex loci delicti*) or the law of Illinois (the *lex loci contractus*) apply? The same questions would remain, though in reverse, if the accident happened after Jack and Jill crossed over the Mississippi River into Illinois. In either instance, Coventry would likely be required to conduct a detailed investigation of the facts of the case, and possibly even to litigate its rights to recover the expenses it advanced on Jack and/or Jill's behalf.

Moreover, because Illinois applies both a version of the make-whole doctrine and the common-fund rule, *see* 770 Ill. Comp. Stat. 23/50-2; *Bishop v. Burgard*, 764 N.E.2d 24 (Ill. 2002), Coventry will have additional hurdles to clear even if it is able to recover in Illinois for the injuries one or both sustained there. This, too, exacerbates the differences between the benefits that Jack and Jill are entitled to keep under the very same plan.

Scenario 3: Washington, D.C. These variations in state law become more problematic for FEHBA plans as they expand to cover more jurisdictions. For

example, there are numerous plans in the Washington, D.C. area that cover federal employees and annuitants residing in the District, Maryland, and Virginia (such as Aetna's Open Access HMO[10]).Under the court's decision below, these enrollees' choices about where to reside within the Beltway has meaningful consequences for carriers and the enrollees alike.

Imagine that Jack and Jill are selected for positions in the FBI's headquarters in Washington, D.C. Jack moves to Alexandria, VA, while Jill chooses to live in the District. Both elect the same Aetna plan discussed above and pay the same premiums. If they each are injured near their homes, Virginia law would prohibit Aetna from seeking subrogation or reimbursement for Jack's injuries. *See* Va. Stat. § 38.2-3405. The District of Columbia, by contrast, would permit that kind of recovery. *See Murrell v. Criterion Ins. Co.*, 551 A.2d 95, 96 (D.C. 1988); *see also* D.C. Code § 31-3407(a)(2)(P) (allowing HMOs to provide for subrogation in their contracts).

It is *not* clear, however, whether Virginia law would bar Aetna from subrogating if Jill were injured after crossing the Potomac on her way to visit Jack in Alexandria. Virginia's anti-subrogation provision only extends to insurance contracts "delivered or issued for delivery or providing for payment of benefits to or on behalf of persons residing in or employed in this

[10] The Benefits Brochure for that plan is available at https://www.opm.gov/healthcare-insurance/healthcare/plan-information/plan-codes/2017/brochures/73-052.pdf (last visited Dec. 18, 2016).

Commonwealth." Va. Code Ann. § 38.2-3405. Because Jill does not live or work in Virginia, that statute arguably would allow Aetna to enforce its subrogation clause in connection with injuries sustained by a D.C. resident. There is no case law directly answering this question, however, meaning that Aetna could have to undertake (or risk) expensive litigation to find out whether it could recover in those circumstances.

Maryland likely would allow subrogation and/or reimbursement as well, if Jill had happened to move to Silver Spring instead of the District. *See, e.g.*, Md. Code Ann., Health-Gen. § 19-713.1(d) (allowing HMOs to provide for subrogation in their contracts). However, Maryland would *not* permit the carrier to be subrogated to any PIP benefits. *See id.* § 19-713.1(e).

The consequences of Jill's decision to move to Maryland instead of D.C. extend beyond the mere availability of subrogation in the first instance. As in the St. Louis example discussed above, this choice also implicates issues related to the make-whole doctrine. Unlike the District of Columbia, *Pac. Coast Dist., Marine Eng'rs' Ben. Ass'n v. Travelers Cas. & Sur. Co.*, 782 A.2d 269 (D.C. 2001), Maryland does not apply the make-whole doctrine, *Stancil v. Erie Ins. Co.*, 740 A.2d 46, 46 (Md. Ct. Spec. App. 1999). Thus, whether the carrier is entitled to subrogate at all could depend on how much Jill recovers from the liable third party, relative to the injuries she sustained.

Scenario 4: National Plans. These discrete hypotheticals, based on plans covering specific metropolitan areas, illustrate the complexity that would result from affirming the decision below. Multi-state and national plans that offer uniform benefits and rates to enrollees across a number of jurisdictions would face even greater challenges. As discussed above, each state has a different permutation of anti-subrogation rules, the make-whole doctrine, and the common-fund rule. *See generally* AFHO State Survey, *supra* n.9. And as described below, the burdens of administering a plan against that backdrop will make it difficult – if not impossible – to fulfill Congress' purposes in enacting the FEHB Program.

3. These hypotheticals illustrate the obvious: the FEHB Program cannot exist as it does now, with national and multi-state plans offering uniform rates and benefits to all enrollees, if state subrogation laws override OPM's regulations and contract provisions.

The consequences of the Missouri Supreme Court's holding would be particularly acute for the nationwide and multi-state FEHBA plans. Those plans – which insure a significant percentage of all FEHBA enrollees – would be faced with two distinct kinds of challenges, both of which are likely to reduce options and increase costs for federal employees and taxpayers.

First, these multi-state plans will be required to structure their systems and train their employees to take account of the patchwork of state subrogation and reimbursement laws. Among other things, plans

will need to constantly monitor: prohibitions on subrogation and/or reimbursement; limitations on the kinds of coverage for which carriers may pursue subrogation and/or reimbursement; legal and equitable "make-whole" rules that can prohibit recovery in certain cases; and common-fund rules that work to reduce the amounts to which the carrier is entitled, even in states where recovery is permitted.

Moreover, because OPM continues to require carriers to pursue subrogation, *see* 5 C.F.R. § 890.106(a), carriers will have no choice but to conduct expensive and time-consuming investigations of each case to determine where reimbursement and/or subrogation is available under these varying state rules. If there is any question about which state's laws apply in a given circumstance, carriers may need to consult legal counsel on choice-of-law questions in routine subrogation investigations. After all, the costs of getting that question wrong can be immense: an expensive and time consuming class action alleging improper subrogation activities, as this case itself illustrates. Moreover, as is also illustrated by this case (*see* J.A. 64, 74), such litigation is likely to include claims for punitive damages and/or other damages multipliers available under state law. In a world where FEHBA does not preempt anti-subrogation laws, the prospect of enhanced damages can only serve to deter plans from taking steps in an uncertain legal landscape to comply with their contractual obligations to OPM.

Second, OPM and multi-state carriers would have to grapple with the difficult question of accurately setting premiums when operating across a patchwork of states with widely varying subrogation and/or reimbursement rules. Premiums for national plans, which tend to be experience-rated plans, are to be determined using a "cost analysis" methodology. *See* 42 C.F.R. § 1615.402(b). Calculating that prospective "cost" will be extremely difficult where OPM and the carriers have to price into their plans a significant amount of uncertainty concerning the carriers' ability to pursue reimbursement and/or subrogation in many of the states where they operate. The additional costs, of course, are borne by the federal government and by federal employees in the form of higher premiums.

All of this will harm federal employees and the federal government, because it substantially increases the complexity (and thus cost) of administering FEHBA plans, particularly nationwide plans. That increased complexity, in turn, could drive premiums higher – especially when coupled with the loss of subrogation revenue that would otherwise flow back to the Treasury Fund. Federal taxpayers will bear the brunt of any premium increase – 72%, *see* 5 U.S.C. § 8906(b)(1) – with FEHBA enrollees picking up the rest.

Similar harms will be felt by federal employees enrolled in regional and multi-state HMOs as well, like aforementioned plans serving the greater St. Louis and Washington, D.C. areas. Such plans, too, will need to design complex systems to conduct recovery

activities within the bounds of the myriad subtle distinctions drawn by the jurisdictions they cover. They also will need to work with OPM to set premiums that account for that complexity, as well as the variability in state subrogation and reimbursement laws.

4. In the end, consumers may find themselves with fewer health plan choices. Given the logistical and operational challenges of designing a FEHBA plan that complies with multiple states' subrogation laws – let alone 50 states' subrogation laws – one likely effect of affirming the Missouri Supreme Court's ruling would be to encourage carriers to offer more state-specific plans instead of the national and multi-state plans Congress chose to promote. After all, in the hypotheticals discussed above, it is likely that residents of Illinois, D.C., and Maryland would bristle at the thought of paying higher premiums to be in a pool with their colleagues living in Missouri and Virginia, where carriers now will have to absorb greater losses. Those consumers may opt to join cheaper, single-state plans based in jurisdictions that allow reimbursement and subrogation, leaving their federal counterparts in neighboring jurisdictions with higher cost plans and/or plans that offer different benefits.

That result would unquestionably frustrate Congress' aim in enacting FEHBA. Single-state plans composed of only federal employees (and their dependents) are unlikely to have sufficient scale to offer the same kind of benefits and rates that multi-state and national FEHBA plans can. And, it goes without saying, those plans will not offer the kind of multi-state

uniform benefits Congress intended to provide the federal workforce.

IV. The Missouri Supreme Court's Alternative Holding That FEHBA's Preemption Clause Violates The Supremacy Clause Has the Potential to Make FEHBA Plan Administration Untenable.

Six concurring judges also concluded that Section 8902(m)(1)'s "attempt to give preclusive effect to the provisions of a contract between the federal government and a private party is not a valid application of the Supremacy Clause in Article VI of the U.S. Constitution." Pet. App. 14a. If correct, this holding would create tremendous uncertainty and complexity for FEHBA carriers well beyond the reimbursement and/or subrogation rules noted above. A FEHBA program where states set the ground rules is likely to be untenable.

State regulation of health insurance takes many different forms. Many state regulations prescribe the minimum benefits health insurers must cover under contracts sold within their borders. If these state laws were not preempted, then FEHBA carriers would be left with two choices: either negotiate separate plans for federal employees in each state or negotiate a nationwide plan that satisfies the mandated-benefit laws of all 50 states. Neither option is desirable and neither serves the purposes of the FEHB Program.

Having to negotiate state-by-state contracts would prevent carriers from being able to offer uniform benefits to all enrollees in a given plan regardless of where they live. And the significant administrative costs associated with negotiating multiple contracts on a state-by-state basis could result in higher premium rates for all enrollees in those plans, as well as for the federal government, which pays the majority of those premium costs.

Negotiating a single nationwide plan that covered all of the various benefits required by the 50 states would be no better. That would leave control of federal employee health benefits to 50 individual state regulators, in direct contravention of Congress' goal of making federal employee benefits a matter of federal law. Moreover, a 50-state plan covering the furthest reaches of state requirements in each state would force plan enrollees in most states to cross-subsidize benefits for plan enrollees in whichever state has the most stringent mandated-benefit laws.

The effects of the concurrence's reasoning would not be limited to mandated-benefit requirements, however. There are myriad other requirements that states impose on health plans that "relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits)." 5 U.S.C. § 8902(m)(1). States regulate numerous other aspects of health insurance, including: which family members must be covered; the age limits for covered family members; extension of coverage; and informational material that

must be provided to plan enrollees, including the specific language that must be used in plan brochures.

The variation and conflict among state laws also extends to procedural requirements imposed on insurers. States regulate when the claim must be acknowledged by the insurance provider; when the insurance provider must begin its investigation; when the insurance provider must make its determination; when, and the manner in which, the plan member must be notified of a delay in the payment of the claim; when a claim must be finally paid out; and the interest that must be paid in the event the claim is delayed. To make matters worse, states' time frames often conflict with one another, making carriers' compliance in the absence of federal preemption more expensive and burdensome.

To date, courts have found such laws to be preempted by FEHBA's preemption clause. *See, e.g.*, *Health Care Service Corp. v. Methodist Hospitals of Dallas*, 814 F.3d 242, 253-55 (5th Cir. 2016) (FEHBA preempts Texas law regulating time frame in which health insurers must make coverage determinations and pay providers); *Zipperer v. Premera Blue Cross Blue Shield of Alaska*, 2016 U.S. Dist. LEXIS 109531, *11-18 (D. Alaska Aug. 16, 2016) (FEHBA preempts Alaska "prompt pay" statute). If this Court were to hold that FEHBA's preemption clause is unconstitutional, however, such laws would presumably apply to all FEHBA carriers.

The need to comply with all of these myriad substantive and procedural requirements would create an especially heavy burden for multi-state and national FEHBA plans that operate across many jurisdictions. Moreover, it would directly conflict with the will of Congress, which sought to avoid this very state of affairs. *See McVeigh*, 547 U.S. at 686 (noting that Congress enacted the FEHBA preemption provision to override "'State laws or regulations which specify types of medical care, providers of care, extent of benefits, coverage of family members, age limits for family members, or other matters relating to health benefits or coverage'" (quoting H.R. Rep. No. 95-282, pp. 4-5 (1977)).

When Congress enacted the FEHBA preemption clause in 1977, it noted that "States are becoming more active in establishing and enforcing health insurance requirements which conflict with provisions of the FEHB contracts." H.R. Rep. No. 95-282, at 4 (1977). "These conflicting requirements can be expected to result in: Increased premium costs to both the Government and enrollees[] and [a] lack of uniformity of benefits for enrollees in the same plan which would result in enrollees in some states paying a premium based, in part, on the cost of benefits provided only to enrollees in other states." *Id.* This would directly conflict with "One of the most beneficial features of our FEHB plans" – "the requirement that they provide the same uniform benefits for the same premium for all enrollees in a plan." H.R. Rep. No. 94-1211, at 6 (1976).

Like the court's subrogation holding, the consequences of the concurrence's reasoning are easy to discern: disparate benefits across state lines; more complex plan administration that leads to higher costs for taxpayers and enrollees; and fewer national and multi-state plans. This Court should emphatically reject reasoning that would undermine these core goals of the FEHB Program.

CONCLUSION

For the foregoing reasons, the Court should reverse the judgment of the Missouri Supreme Court.

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