In the Commonwealth Court of Pennsylvania

Nos. 103 & 128 CD 2012

DALLAS SCHOOL DISTRICT, as Fiduciary and Trustee of Its Employees Who are Members of the Class, FRANK GALICKI, On His Own Behalf and On Behalf Of All Other Persons Similarly Situated Within The Dallas School District, PITTSTON AREA SCHOOL DISTRICT, as Fiduciary and Trustee Of Its Employees Who Are Members of the Class, GEORGE COSGROVE, On His Own Behalf Of All Other Persons Similarly Situated Within The Pittston Area School District,
Plaintiffs/Appellees/Cross–Appellants,

v.

NORTHEAST PENNSYLVANIA SCHOOL DISTRICTS (HEALTH) TRUST,
Defendant/Appellant/Cross–Appellee.

REPLY BRIEF FOR APPELLANT/
RESPONSE BRIEF FOR CROSS–APPELLEE

On Appeal from the Judgment of the Court of Common Pleas of Luzerne County, Pennsylvania, Civil Division, No. 1404–08, entered January 18, 2012

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I. INTRODUCTION

If the Brief for Appellees/Cross–Appellants that plaintiffs Dallas School District and Pittston Area School District have filed demonstrates anything, it's that the only way the trial court's conclusion that defendant Northeast Pennsylvania School Districts (Health) Trust was designed to operate and in fact operated as a segregated trust — whereby each school district had its own individual account balance — can be upheld is by distorting the trial court record in this case beyond recognition.

At most, the plaintiffs' appellate brief merely establishes that it was possible to calculate, for certain Plan years, the annual total of health insurance claims and expenses paid from the Trust Fund on behalf of those school districts' employees and their beneficiaries and then to compare that total against the total in health insurance premiums that those school districts paid into the Trust for those same years. But the raw ability to perform such calculations proves nothing, and it assuredly fails to establish that the Trust operated as a segregated, rather than a pooled, Trust.

The entire lengthy presentation contained in the Trust's Brief for Appellant establishing that the Trust was established as a pooled trust and has operated in that manner — based on the language of the Trust Agreement, the language of the duly adopted pooled rating methodology and Scoda resolution, the language of the Trust's duly authorized IRS filing to obtain tax–exempt status, the testimony of the Trust's founding trustees, and perhaps most importantly the actual undisputed

operation of the Trust, whereby the Trust did not maintain or report to school district members individual surplus or deficit balances — emerges entirely unscathed from challenge in the plaintiffs' Brief for Appellee.

What the plaintiff school districts' Brief for Appellee does make clear is that this case involves nothing more than unjustified buyer's remorse, translated into an all–out assault on the business fundamentals that necessarily undergird the entire insurance industry. The only way that insurance can work is that most insureds pay too much for the benefits that they actually end up receiving so that the unfortunate insureds who suffer extreme forms of the risk being insured against can have their claims covered even though they (in retrospect) paid too little. The healthy subsidize the sick. The living subsidize the dying. Those fortunate to be spared disasters and mishaps subsidize those plagued by disasters and mishaps.

What is clear, however, is that someone who annually pays tens of thousands of dollars for health insurance coverage for himself and his family is not entitled to a refund, or even a discount on next year's coverage, because last year the family was fortunate to remain healthy. Term life insurance may purchase peace of mind while in effect, but in retrospect last year's term life insurance premiums represented a total waste of money for someone who did not die last year. Malpractice insurance premiums for lawyers and doctors seem to increase every year, regardless of whether the particular lawyer or doctor has ever been sued.

The very type of recovery that the trial court allowed plaintiffs to achieve here is simply anathema to the entire concept of insurance risk spreading. The

plaintiff school districts in fact received the benefit of the bargain for which they contracted — namely, spreading the risk that their employees and their beneficiaries would experience worse than expected health care claims across a pool of insurance premiums covering the employees and beneficiaries of a dozen similarly situated school district employers and the certainty of knowing in advance what they would have to pay regardless of their actual claims experience. Suffering now from a severe case of *ex post facto* buyer's remorse, the plaintiff school districts are asking this Court to affirm a trial court decision that would divest the other similarly situated school districts of the benefit of *their* bargain, depriving those school districts of the cost certainty and spreading of their risk across that very same pool of insurance premiums as the Trust has done since its inception.

The result that plaintiffs seek is neither fair nor lawful. Plaintiffs knew that the Trust operated as a pooled trust; indeed, plaintiffs' Trustees participated in the decisions adopting the rating methodology that spread the risk of high claims among other members and the Scoda resolution, which confirmed the Trust's operation as a pooled trust. Plaintiffs never received any statements from the Trust showing their individual school district's surplus or deficit balance, because no such information was maintained by the Trust for any participating school district. With appropriate advance notice, the plaintiff school districts could have withdrawn from the Trust at any time if they had received or could have obtained a better bargain on health insurance elsewhere. While plaintiffs assert that they paid too much for their employees' and beneficiaries' health insurance, the record is utterly bereft of

any evidence that these school districts could have obtained less expensive insurance elsewhere in advance — before they knew what their claims were going to be.

For all of these reasons, and as explained in more detail below, the trial court's conclusion that the Health Trust was intended to operate, and in fact operated, as a segregated trust and the trial court's award of relief on that basis must be reversed.

II. ARGUMENT IN REPLY

A. The Health Trust At All Relevant Times Operated With The Essential Attributes Of A Pooled Trust, And None Of The Plaintiff School Districts' Contentions To The Contrary Disproves Or Undermines That Conclusion

1. None of the plaintiff school districts' arguments based on the record in this case suffices to uphold the trial court's obviously erroneous conclusion that the Trust in fact operated as a segregated trust

Often the simplest explanation also turns out to be the most convincing, and that is certainly the case here. If, as the trial court concluded and as the plaintiff school districts urge, the Health Trust in fact operated as a segregated trust rather than as a pooled trust, then the Health Trust did a remarkably poor job of conducting its internal business operations in the manner of a segregated trust.

The record in this case is undisputed that the Health Trust did not calculate the individual account balances of its school district members to ascertain whether those members' individual balances reflected a surplus or a deficit. R.976a–81a,

897a–98a, 1050a–54a, 1351a–52a, 1378a. This Court can appreciate that if the Health Trust in fact operated as a segregated trust, then the individual school districts would both want and need to know their particular, individual account balances on at least an annual basis.

Moreover, and equally as important, the Health Trust never sought to recover additional payments from an individual school district based on any calculation of whether in a given Plan year the health insurance claims paid out on account of that school district's employees and their beneficiaries plus expenses exceeded the health insurance contributions made by that same particular school district into the Health Trust. R.1360a–61a, 908a–09a, 911a–12a. Here, the trial court has concluded that a Trust that lacked every necessary indicia of a segregated trust, but rather possessed every necessary indicia of a pooled trust, in fact operated as a segregated trust. It is inconceivable that the trial court's conclusion in this regard can survive appellate review.

After reading the opposing parties' opening briefs, this Court may very well be asking itself one extremely important question: What is the single essential attribute of a pooled trust that distinguishes a pooled trust from a segregated trust? The answer to that question, it should now be clear, is that a pooled trust does not maintain or track its members' individual account balances or perform any retrospective reconciliation or settlement with respect to any such balance, because those members do not in fact maintain individual accounts. Rather, all premium contributions are pooled to pay for all members' claims and expenses, and thus risk

is shared. The record could not be more clear that the Health Trust did not maintain or track its members' individual account balances, because those districts did not maintain individual accounts. The question is not whether the Trust *could have* tracked and reconciled its school district members' supposed individual account balances; rather, the issue is whether or not the Trust *did so*, and here the record is unambiguous that the Trust did not do so.

It may be helpful to contrast a pooled trust with an example of a segregated trust with which the judges of this Court are no doubt familiar: an attorney's trust account, often commonly referred to in Pennsylvania as an IOLTA account (the abbreviation standing for Interest on Lawyers Trust Accounts). An attorney is permitted to combine money belonging to different clients in a single IOLTA account, but the lawyer must track and account for each client's money separately.

If a client has deposited a retainer with the lawyer to pay for work to be performed, the attorney is authorized to deduct the client's money as bills are presented to the client, but the attorney must keep the client apprised concerning how much of the retainer remains and refund any balance that may remain when the work is completed. Moreover, if the amount of work performed exceeds the client's retainer, the attorney is not authorized to continue to pay himself for that work from the attorney's IOLTA account, because the additional money that remains in that account belongs to other clients rather than to the client for whom the work is being performed.

Thus, where a segregated trust is involved, the trustee/lawyer must: (1) maintain records showing deposits into and deductions from each segregated account; (2) keep the entity to whom the money in the account belongs apprised of the amount of money remaining in the account; (3) ensure that sufficient funds exist in the account before paying out more than the amount of money that a specific client possesses in the account; and (4) obtain additional funds from the owner of the segregated account to pay claims that exceed the amount remaining in that specific account. These four items are all essential attributes of a segregated account.

It was not by accident that the Health Trust did none of these four things, because the Health Trust intentionally operated as a pooled trust rather than a segregated trust. Moreover, the evidence discussed in the plaintiff school districts' Brief for Appellees fails to establish that the Health Trust did any of these four things that represent the essential attributes of a segregated trust.

The plaintiff school districts argue in their brief that the Health Trust had the information necessary to track the claims and expenses of each school district member on a district–by–district basis. Blue Cross, for example, provided such information when it processed the claims of school district employees and their beneficiaries, so that the Health Trust could ensure that it was only paying the claims of those who were entitled to have their health care claims reimbursed from

the Trust.[1] But the record unambiguously makes clear that the Health Trust *did not* use that information to determine whether any particular school district's claims exceeded that school district's contributions into the Trust. At most, this evidence establishes only that the Trust possessed information that might have enabled the Trust to operate as a segregated Trust. The evidence does not establish that the Health Trust in fact operated as a segregated trust, and indeed all of the evidence is to the contrary.

Next, the plaintiff school districts argue that during the Trust's early years, when the Trust had an operating deficit, the Trust obtained an additional payment from the school districts participating in the Trust to restore needed funds and liquidity back into the Trust (referred to as a "cash call," made in 2001). The plaintiff school districts, regrettably, misrepresent the details of what actually happened and would happen in the future if the Trust found itself in a deficit position: each participating school district and other school entity in the past was

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[1] Plaintiffs cite to testimony by the Trust bookkeeper, Danielle Savitsky, that she entered into the Trust's QuickBooks program certain claims and expense information which Blue Cross provided on its invoices to the Trust, listed by member school district. During trial, plaintiffs' counsel used a computer to show the Trust's QuickBooks software (which the Trust had produced to the plaintiffs during discovery in electronic form) on a screen. These screens were printed out and marked as exhibits P–511 and P–652 (R.2537a & 2991a–3000a). Significantly, in presenting this information to the trial court, plaintiffs omitted key information from the trial court's view — namely, the column of information titled "Account" cuts off the account code number where this claims information was entered. Ms. Savitsky unequivocally testified, however, that she entered all of the Blue Cross claims information for every district into the same account code — number 5010 — even though the numbers for each district are listed separately. R.958a, 1360a. The Trust's auditor, Thomas Rainey, confirmed that claims and expenses were never posted in the Trust's records using separate account codes by member district. R.1378a–82a.

and in the future would be required to make supplemental payments to the Trust in proportion to the premium contribution payments that the school districts and other school entities made to the Trust for the year in question. R.1277a–80a (Scoda testimony); R.3221a–22a (Def. Exh. 8). Thus, supplemental payments into the Trust to erase deficits never were and never would be based on any particular school district's deficit or surplus position (because no such thing exists or is measured). Rather each member school district would feel the pain equally based on the proportion of its annual contribution payment to the annual contributions of the other member school districts, regardless of whether a school district's own claims experience did or did not contribute to the Trust's overall deficit.

The plaintiff school districts' next riposte is to point out that the Trust has required them to pay their "run–off" balances after these school districts withdrew from the Trust. The school districts, however, expect this Court to overlook that the Trust Agreement itself provides that withdrawing school districts such as these plaintiffs will be responsible for paying for their run–off claims upon leaving the Trust. R.3202a (Trust Agreement §5.4(a)(2)). There is nothing inconsistent between the Health Trust's operation as a pooled trust and the Trust Agreement's requirement that withdrawing school districts will remain liable to pay for those school districts' own run–off claims. Run–off claims are claims that are incurred–but–not–reported during the existence of a health insurance policy, so that the insurer (here, the Health Trust) remains liable to pay those claims even though additional premiums from the employer/school district are ordinarily no longer

being received to offset those liabilities. While school districts remain as members in the Health Trust, they have the benefit of pooled trust treatment of their claims, but following the effective date of their withdrawal (as the Trust Agreement clearly provides), the withdrawing school district remains individually liable to reimburse the Trust for run–off claims pertaining to that school district's employees and beneficiaries.

This distinction between actual members in the Health Trust and non–members also demonstrates the irrelevant nature of the Trust's distinct treatment of Crestwood School District, which the plaintiff school districts in their Brief for Appellees concede never became a member of the Trust. It was thus necessary for the Trust to ensure that Crestwood properly reimbursed the Trust for the benefits that Crestwood's employees and beneficiaries received from the Trust, because, having failed to sign and become subject to the Trust Agreement, Crestwood was not entitled to benefit from the pooled nature of the Trust.

As further support for their position, plaintiffs repeatedly point to a document prepared in 2002 that the Trust never received or acted upon as having some significance in this case, yet argue that the rating methodology and Scoda resolutions actually voted on and approved by the Trustees have no significance. Specifically, plaintiffs cite to exhibits P–116 (R.1785a–88a), P–421 (R.2364a–66a), and P–489 (filed under seal). All of these exhibits are versions of the same information — the Withdrawal Liability spreadsheets that the Trust's actuarial firm, Conrad Siegel, prepared in 2002. Significantly, the record establishes, through

the testimony of Robert Glus of Conrad Siegel, that these spreadsheets are incomplete because there was insufficient breakdown of claims information by district to complete them (for example, no breakdown of prescription drug claims by member district), that Conrad Siegel had to force the calculations to tie into the Trust's Audited Financial Statements, and, most critically, that they were never given to the Health Trust and never presented at any Trust meeting or acted on by the Trust. R.841a–42a, 859a–60a, 863a–64a, 875a–76a, 890a–94a. More importantly, as previously noted, what the Trustees did act upon and approve in 2002 was the pooled rating methodology (Exh. D–6, R.3216a–18a) and the Scoda resolution (Exh. D–8, R.3221a–22a), both of which operate to pool the risk of high claims. At the same time, in 2002, the Trustees rejected the segregated approach of Robert Eyet (Exh. P–95, R.1731a–32a), which the plaintiffs are advancing in this case. R.1277a–78a, 1289a–90a, 1293a (Scoda testimony); R.899a–900a, 906a (Glus testimony). Accordingly, the spreadsheets constituting plaintiff exhibits P–116 (R.1785a–88a), P–421 (R.2364a–66a), and P–489 (filed under seal) are simply a red herring and are absolutely irrelevant to any issue in this case.

The plaintiff school districts further observe that each school district participating in the Trust is entitled to offer its own menu of benefits to employees and their dependents as a reason for concluding that the Trust must be considered segregated rather than pooled. What the districts are able to negotiate with their unions is one or more of the programs offered through the Trust's Plan of Benefits — i.e., the Traditional, Access Care II (the PPO), or First Priority Health (the HMO)

medical programs, the dental program, the vision program, and the prescription drug program. R.1196a–97a, 1200a–01a. The Trust's actuary, Robert Glus, in calculating the premium (contribution) rates for a Plan year, comes up with a Trust–wide base rate for each program, and for each district, applies a factor to the rate that appropriately takes into account the differences in benefits, co–pays, and deductibles that that district has negotiated with its union. R.826a, 900a–07a, 1422a–23a. Mr. Glus testified that, within each program, the benefits are extremely similar and the differences have been very minor (R.826a), but he does account for negotiated benefit changes and give a district proper credit for them in a district's rates (R.1422a–23a).

Moreover, as reflected in the contribution rate sheets approved by the Trustees in advance for each Plan year (see approved contribution rates sheets attached to the Trust's Answer and New Matter as Exh's 5, 8, 11, 14, and 17 and ¶¶131 to 164 thereof, R.200a–08a, 244a–49a, 256a–60a, 268a–75a, 284a–91a, 301a–08a), there is a different rate within programs depending on whether it is for an individual, a family, and so on, and a district's overall contribution rate reflects the base rate for each program multiplied by the number of employees enrolled in that program, as well as a component for the overhead expenses of the Trust. Thus, for example, if a district through collective bargaining negotiates dental coverage, then that district's overall contribution rate will include payment of the Trust rate for dental coverage times the number of employees in that district enrolled in dental

coverage, but if that district does not negotiate dental coverage with the union, then that district pays nothing for dental coverage.

Significantly, the plaintiffs have failed to explain or point to any testimony as to why these minor differences in negotiated benefits, which are accounted for in the pre–determined contribution rates, is evidence that this Trust must be deemed to be segregated. This fact does not change the undisputed evidence that the school districts are pooling risk and that there has been no retrospective reconciliation or settlement process performed to assign individual account balances. R.908a–11a.

Plaintiffs also observe that a school district's recent claims experience may slightly reduce that school district's overall premiums for the following year as an actuarial consideration in the rate–setting process. This also does not change the fact that these districts are pooling risk. Mr. Glus, who established the approved rating methodology and prepared the proposed contribution rates for each Plan year, explained how the rating methodology acts to pool claims risk (R.898a–912a, 1420a, 1423a, 3216a–18a), which advances the stated goal of the Trustees to achieve stability in their rates over time. R.899a–900a, 1425a–26a. Mr. Glus further testified that what makes this Trust pooled is not only the pooled rating methodology, but also the fact that the nature of the risk relationship is determined at the outset of the Plan year in question. In other words, once the contribution rates are set for a Plan year, the individual districts are not then responsible for their own district–specific claims experience. R.1423–24, 1427a–28a, 1434a–35a.

The fact that there is a small component of the contribution rate for the Traditional program that considers the specific district's historical claims experience does not change any of this. As Mr. Glus explained, once that component is applied, a district's final contribution rate for the Traditional program cannot be more than plus or minus 5% of the Trust's overall average rate for that program. R.901a–04a, 1420a–21a, 3216a–18a. Also, as Mr. Glus testified, the district–specific claims experience component of the Traditional program rate is used only to set the future rate — and the rating methodology does not include a look back to compare a district's contributions paid in with what its actual claims were to determine a district–specific balance or to try to recoup that or factor it into the rating methodology. R.1441a–42a.

In any event, the mere fact that each school district can negotiate a somewhat different program of benefits, or that a school district's recent experience can factor into the upcoming year's rates for the Traditional program, fails to disprove or contradict that the Health Trust operates and has at all relevant times operated as a pooled trust that spreads risk. R.1423a–24a, 1428a (Glus testimony).

At the end of the day, the plaintiff school districts' claims boil down to the fact that their employees and beneficiaries ended up needing health care services that were less expensive than the Trust's actuaries originally estimated in good faith based on the rating methodology that their Trustees voted on and approved. These school districts should view it as a blessing that their employees and their beneficiaries ended up being healthier than expected. But now, after the fact, the

school districts are blaming the Heath Trust for having supposedly made them pay too much for their health insurance coverage, despite these school districts' failure to introduce any evidence whatsoever that they could have obtained equivalent or better coverage on the open market for less money. Now, with the benefit of perfect 20–20 hindsight, the plaintiff school districts know that if they had instead stashed their health care contributions in the proverbial mattress instead of entering into the pooled insurance arrangement that the Health Trust represents, the school districts would have ended up with a district–specific surplus. Even if relevant, that still does not prove that these school districts received a bad deal or establish entitlement to relief in this lawsuit.

Rather, as the Health Trust explained at the outset of this Reply Brief, whether or not insurance is a good deal cannot be evaluated after–the–fact when it is known that the risk being insured against has been avoided (or the potential full extent of the risk has failed to manifest itself). Here, these school districts achieved the goals they set out to achieve in participating in the Trust, which was not only rate stability but also the knowledge that the proceeds of the entire pooled trust would be available as necessary if the health claims of the school districts' employees and their beneficiaries turned out to be worse than expected.

As further explained at the outset of this Reply Brief, insurance only works if many pay too much so that the few who experience the risk being insured against can pay too little. Here, these plaintiff school districts say, after the fact, based on health claim information that was not available in advance when the decision

concerning what type of health insurance to obtain was being made, that they paid too much for their health insurance coverage. That's too bad. But it's not a reason for this Court to endorse what the trial court did in this case, which is to undermine the entire predicate on which both this particular Trust and the insurance industry as a whole operate.

If entities that insure against a risk can force the insurer to give them their money back (contrary to the contract between the parties) if the hazard fails to manifest itself, then the entire insurance industry will be destroyed. The plaintiff school districts' victory in this case wipes out this Trust's risk–sharing method of operation for the past 11 years and, if upheld, threatens to destroy this Trust. Thus, if this Trust has to calculate district–specific "balances" starting from the inception of the Trust over 11 years ago, those districts who happen to have district–specific surpluses (the "haves") will have incentive to withdraw from the Trust and demand payment just as the plaintiffs in this case did. How does this Trust now recover money from those districts that have district–specific deficits (the "have–nots") to pay the "haves," especially when such a recovery is contrary to the approved rating methodology that all Trustees agreed upon in 2002? If the destruction of this Trust as a consequence of the trial court's ruling is not reason enough to overturn that ruling, it is difficult to conceive of what would be.

Before concluding this discussion of plaintiffs' distortion of the evidence contained in the record, the Trust wishes to address the plaintiffs' citation to the trial court's comment that "to stop the bleeding, you have to leave." R.1479a. As

noted above, the plaintiffs could have left the Trust, with appropriate notice, at any time. Moreover, even if relevant, there is absolutely no evidence in the record that these plaintiff school districts could have obtained equivalent or better health care coverage on the open market for less money than what they paid while in the Health Trust. In fact, there is record evidence to the contrary, from the Trust's actuary, that indicates that the members of this Health Trust had likely saved a minimum of between $10 million and $16 million in health care costs from inception in 1999 through May of 2007 by joining together in this Trust (through administrative cost savings, premium savings for catastrophic claims coverage, and savings through negotiated vendor contracts as one large entity). Def. Exh. 42 (R.3327a–31a) and D–43 (R.3332a–33a); R.1421a, 1423a (Glus testimony).

Plaintiffs did not introduce into evidence any comparison of what they could have paid outside the Health Trust for the years that they were members of the Trust. Rather, they compared what they paid in contributions to the Trust versus what their actual claims and pro rata share of expenses were, learned after the fact. R.1078a–79a, 2546a–655a. That latter comparison does not in any way establish that these plaintiffs received a bad deal while participating in this Health Trust, especially given the fact that they also received reduced risk for all of those years.

The plaintiffs' citation to the analysis performed by the Hartz brokerage firm does not advance this argument either. First, the Hartz analysis (R.1968a–72a) addressed ways to potentially save on costs for health care for the plaintiffs in the future, not the past, and plaintiffs presented no information on actual cost savings.

Moreover, the plaintiffs did not even retain the Hartz firm after they left the Trust. Rather, the plaintiffs retained Elite Brokerage. R.2676a–79a. Keith McNeil of Elite Brokerage testified at his deposition that he did not understand that Dallas was withdrawing from the Trust to save money, but rather to be in a stand–alone program and be independent. Mr. McNeil further testified that the only way Dallas could have experienced a cost savings was to change carriers or change plan design. R.6202a, 6204a, 6216a. Neither Dallas School District nor Pittston Area School District changed carriers or plan design after they left the Trust. R.736a, 1037a; *see also* Brief for Appellees/Cross–Appellants at 48.

The plaintiffs, in their brief, also point to testimony from Al Melone related to the contribution rates for the member districts for the first three Plan years, before the Trustees adopted the rating methodology prepared by the actuarial firm of Conrad Siegel. Setting aside the fact that Plan 3 established those rates early on and that Mr. Melone acknowledged that he did not actually know how Plan 3 came up with those rates (R.1005a, 1064a–65a, 1068a–69a, 5950a), this testimony in no way supports plaintiffs' position that this Trust was a segregated trust. In fact, the evidence is undisputed that during Plan 3's administration of the Trust, the Trust accumulated a $4.2 million overall deficit by June of 2002 and that the Trustees fired Plan 3 and then hired Conrad Siegel, which prepared the pooled rating methodology that the Trustees voted on and adopted for future Plan years. Thus, whatever Plan 3 did obviously did not work, and the Trustees acted accordingly.

Above, the Health Trust has demonstrated that none of the reasons that the plaintiff school districts have offered in their Brief for Appellee for affirming the trial court's decision that the Trust operated as a segregated trust has merit.

In this case, the trial court was presented with a Trust Agreement whose express language was designed to create and authorize a pooled trust. R.3032a, 3025a, 3020a (Trust Agreement §§6.6, 5.1(b), 4.4(u)). Soon after its creation, the Trust formally represented to the Internal Revenue Service that it operated as a pooled trust when applying for and obtaining tax–exempt status. R.3057a–58a. The trustees of the Trust, shortly after the Trust's creation, officially adopted a rating methodology (Def. Exh. 6, R.3216a–18a) that provided for pooling contributions and spreading risk and a resolution (Def. Exh. 8, R.3221a–22a) governing the treatment of Trust deficits or surplus, further confirming the Trust's status as a pooled trust, while simultaneously rejecting a competing resolution to operate the Trust as a segregated trust (R.1289a–90a, 1301a). Finally, the Trust presented a massive amount of uncontradicted evidence establishing both that the Trust has in fact operated as a pooled trust and that it was the intention of the Trust's founding trustees to create a pooled trust that shared risk.

This is simply not a case where the trial court confronted conflicting evidence and conflicting inferences and was required to decide which competing view of the evidence was more believable. Rather, here the evidence permits only one conclusion: the Health Trust is and at all relevant times operated as a pooled trust.

2. The plaintiff school districts' legal arguments in favor of upholding the trial court's conclusion that the Health Trust operated as a segregated trust are likewise bereft of merit

The school districts' Brief for Appellee denounces the Health Trust's opening brief on appeal for having ignored a supposedly "controlling case" that consists of a Brooklyn–based federal district court's opinion in *Head Start Child Devel. Servs., Inc.* v. *Kearse*, 86 F. Supp. 2d 143 (E.D.N.Y. 2000). According to Westlaw's KeyCite feature, that federal district court decision has only been cited once in a published opinion issued in an entirely separate case by any court located anywhere. *See Harju* v. *Olson*, 709 F. Supp. 2d 699, 729–30 (D. Minn. 2010) (declining to follow *Head Start*).

To begin with, the plaintiff school districts' assertion that the federal district court's decision in the *Head Start* case is somehow "controlling" is demonstrably incorrect. Federal appellate courts, including the U.S. Supreme Court, have recognized that a federal district (trial) court's opinion does not constitute precedent but rather fact binds no one beyond the parties to the particular case being decided. *See*, *e.g.*, *Camreta* v. *Greene*, 131 S. Ct. 2020, 2033 n. 7 (2011) ("A decision of a federal district court judge is not binding precedent in either a different judicial district, the same judicial district, or even upon the same judge in a different case.") (quoting 18 J. Moore, *et al.*, *Moore's Federal Practice* §134.02[1][d], p.134–26 (3d ed. 2011)); *Flying J, Inc.* v. *J.B. Van Hollen*, 578 F.3d 569, 573 (7th Cir. 2009) (recognizing that "the decision of a district court has no authority as precedent"); *United States* v. *One TRW, Model M14, 7.62 Caliber Rifle*, 441 F.3d 416, 423 n.10

(6th Cir. 2006) ("a district court opinion * * * is not binding precedent on any court").

Beyond the plaintiff school districts' misbegotten effort to elevate a single federal district judge's ruling into something unusually meaningful, the plaintiffs' reliance on the *Head Start* decision must fail, because that opinion is easily distinguished on its facts. The decision in *Head Start* merely concludes that if a particular trust is operated as a segregated trust, as the trust at issue in *Head Start* was operated, then a departing employer is entitled to withdraw any surplus when departing from the segregated trust to be deposited into whatever successor trust the employer chooses to join next. The rationale that the federal district court employed in *Head Start* lacks any force here, by contrast, because in this case the trial judge's decision that the Health Trust operated as a segregated trust cannot survive appellate review. Moreover, the district court in the *Head Start* case *did not* hold that an employer withdrawing from a pooled trust (which most accurately describes the two plaintiff school districts in this case) was entitled to withdraw some supposed "surplus" attributable to the withdrawing employer.

As noted above, in *Head Start* the district court ruled that that particular trust involved in that case operated in a segregated manner. In reaching that conclusion, the court in *Head Start* relied on: (1) the annual financial reports of that trust, which disclosed a direct allocation of benefits paid and the proportionate administrative expenses from each segregated portion of the fund, *see* 86 F. Supp. 2d at 146; (2) the testimony of the accountant for that trust, who testified that he

calculated a reserve at the end of each fiscal year for each agency–member of that trust, *see id.* at 146–47; (3) a Schedule of Reserves included in the annual financial reports for that trust that segregated, by employer, the contributions and income and expenses, *see id.* at 147; and (4) testimony by a trustee and administrator of that trust that if the trust was terminated, each of the employers would receive its share of the remaining reserves, *see id.*

In stark contrast to this evidence from the *Head Start* case, the evidence in the instant case establishes unequivocally that: (1) this Health Trust's annual financial reports (and monthly reports to the Trustees) show only Trust–wide accounting and no breakdown by member school district (R.1370a–75a, R.3593, R.1350a–52a, R.4671a); (2) there was no retrospective settlement process performed to determine or assign district–specific "balances" or "reserves" (R.898a, 908a–09a, 1464a, 976a–79a, 1378a–82a); and (3) the Trustees here understood that once they paid their pre–determined contribution rate for a Plan year, they would be asked to pay no more, and would receive no refund, based on what their district's actual claims and expenses were (R.1337a–38a, 911a–12a, 1257a, 6033a, 1192a, 1204a–05a, 1308a–09a, 1275a–76a, 1412a–13a).

Additionally, unlike in the *Head Start* case, the Trustees here adopted a pooled rating methodology that spreads risk among the other districts and specifically rejected the segregated approach of Trustee Robert Eyet. R.898a–907a, 1289a–91a, 1301a. Moreover, the Trust Agreement here makes contributions irrevocable (Sections 6.6 and 5.1(b), R.3025a, 3032a) and gives the Trustees

exclusive title to all the assets held in the Trust Fund and the sole responsibility to determine all rights and interest of the parties in the assets held in the Trust Fund (Sec. 1.1(b) and 2.1(c), R.3008a, 3010a).

Next, the school district plaintiffs launch into an extensive and complex discussion of ERISA principles, arguing that only ERISA, but not the federal LMRA (Labor Management Relations Act), should apply here. As the Health Trust explained in its opening brief on appeal, ERISA in general does not have any application to the Health Trust, because the Trust is classified as a government trust exempt from ERISA. The Trust Agreement, however, did opt to incorporate several of ERISA's fiduciary principles into the Trust's own self–governance to govern the Trust's relationship with its actual beneficiaries — namely, the employees of the member school districts and those employees' dependents.

The Health Trust further demonstrated in its opening brief that the Trust's operation as a pooled trust violates neither Pennsylvania nor federal law. There is simply no case law to support the plaintiff school districts' argument that governmental employers who decide to operate a pooled trust for the benefit of themselves and their employees in doing so somehow transgress the requirements of the federal ERISA law.

The plaintiff school districts' argument that not permitting them to abscond with their supposed "surplus" would violate ERISA's so–called exclusive benefit rule likewise lacks merit. As we have just explained, there are no cases holding that public employers such as the school districts who formed the Health Trust violate

ERISA by operating as a pooled trust. Here, the Trust Agreement contains its own version of ERISA's exclusive benefit rule, providing in pertinent part that "All contributions made by public school entities to the Trust Fund shall be irrevocable, and no part of the corpus of the Trust Fund nor any income therefrom shall revert to any public school entity or be used for or diverted to purposes other than for the exclusive benefit of the Participants and their Beneficiaries." R. 3032a (Trust Agreement §6.6).

The capitalized terms "Participants" and "Beneficiaries" refer to the employees and their dependents who work for the school districts that are members of the Trust at the relevant time. Once the plaintiff school districts voluntarily withdrew from the Trust, their employees and their dependents no longer qualified as "Participants" or "Beneficiaries" of the Trust, and therefore the trial court's order mandating the transfer of the Trust's reserves for the benefit of those who then were non–participants and non–beneficiaries of the Trust violated the Trust's own exclusive benefit provision, instead of complying with it. Moreover, the trial court's order violates Section 403(c)(1) of ERISA, 29 U.S.C. §1103(c)(1), which provides that the assets of a plan should be held for the exclusive purpose of providing benefits to the participants *in the plan* and their beneficiaries.

Under the terms of the Trust Agreement and its duly adopted rating methodology and resolutions, any surplus or reserve that develops in the Trust as the result of a school district's better than expected claims experience belongs to the Trust and may be used on behalf of all of the Trust's employee–participants, rather

than belonging only to a particular school district and only that school district's employees and beneficiaries. *See* Trust Agreement §1.1(b) (R.3008a); *Ganton Technologies, Inc.* v. *National Indus. Group Pension Plan*, 76 F.3d 462, 464 n.1 (2d Cir. 1996) (ERISA provides that ordinarily participating employers have no interest in plan assets).

As the Health Trust has repeatedly explained, the plaintiff school districts received from the Trust all that those school districts and their employees and dependents were entitled to receive during the years in which those school districts' claims experience was better than expected. Holding the plaintiff school districts to the actual terms of the Trust Agreement, which prohibits any money contributed to the Trust from reverting to those school districts, will not cause any cognizable harm to either the plaintiff school districts or their employees and their beneficiaries.

Focusing first on those school districts' employees and beneficiaries, they are contractually entitled to receive from their employer school districts, under the terms of these employees' collective bargaining agreements, health insurance benefits paid for by these school districts each year. If the plaintiff school districts are denied recovery here, as they should be since the Trust is a pooled irrevocable trust, their employees and their dependents will still receive all of the health insurance to which those employees are entitled under the terms of their collective bargaining agreement with the school districts. In other words, if the plaintiff school districts are denied recovery here, they will need to pay for their employees'

and their dependents' health insurance in the same manner that those school districts have funded those health insurance benefits in prior years.

The fact that it is the school districts' contractual obligation to pay for those health insurance benefits each year makes clear that the school districts' contention that the funds contributed to the Trust are not in actuality reverting back to the school districts as a result of the trial court's decision elevates form over substance. Whatever money that the plaintiff school districts abscond with from the Trust is money that those school districts can keep in their own treasuries instead of having to pay the full current cost of obtaining health insurance coverage. Thus, it improperly ignores economic reality for the trial court to reason that its imposition of a constructive trust on the money awarded from the Trust to the plaintiffs does not constitute property contributed to the Trust that would now be reverting back to plaintiffs in contravention of the express terms of the Trust Agreement.

The plaintiffs' attempt to distinguish defendant's citations to federal cases addressing the sole and exclusive benefit rule must also be rejected. In *Ganton*, 76 F.3d 462, the Second Circuit addressed and rejected a claim that the trustees acted unreasonably and contrary to Section 404(a)(1) of ERISA (which requires that they act "solely in the interest of the participants and beneficiaries") by denying Ganton Technologies the benefit of "surplus" payments that the company made into the trust fund at issue when the company elected to withdraw from the plan. This is the

very argument that the plaintiffs here have advanced in this case, and it was soundly rejected in *Ganton*.[2]

The plaintiffs here attempt to distinguish *Ganton* because it involved a pension plan rather than a health care plan. Plaintiffs overlook, however, that the fiduciary duty provision of Section 404 of ERISA, 29 U.S.C. §1104, applies to employee benefit plans whether they are employee pension benefit plans or employee welfare benefit plans (which include health care plans). *See* 29 U.S.C. §§1101(a), 1002(1), 1002(2), 1003(3), and 1003(a). Moreover, plaintiffs have offered no reason why the same conclusion that was reached in *Ganton* should not follow with respect to this Trust's health care plan. Just as with the pension plan in *Ganton*, the Plan here utilized actuarial assumptions and projections to determine contribution rates. Similarly, as in *Ganton*, several employers contribute to the Plan, the assets are not segregated into accounts, and the common assets are used to pay benefits (in that case, pensions) to those employees of the participating employers who had a right to them. Moreover, as the Court noted in *Ganton*, there is no guaranteed tie between the amount contributed on behalf of a particular employee and the amount the employee actually will receive, and "[t]he pooling aspect of these plans provides security to all participants at the risk of receiving less than maximum possible benefits" and "[s]uch is the risk inherent in joining a multiemployer plan." *Ganton*, 76 F.3d at 468.

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[2] It is worth noting that the analysis of the sole and exclusive benefit rule in the *Head Start* case, which plaintiffs extensively cite in this case, is directly contrary to the analysis of that rule in *Ganton*, a Second Circuit ruling whose precedential effect the district court improperly ignored in the *Head Start* decision.

Similarly, the pooling aspect of this Trust provides a stabilized cost for health care so that no employer pays more than its designated contribution rate for that Plan year at the risk, for the Trust, that the employer's actual claims experience may ultimately show that its claims exceeded actuarial projections and at the risk, for the employer, that its claims would be less than actuarial projections. Accordingly, the particular facts that the Second Circuit in *Ganton* found to be material are strikingly similar to the facts of this case.

The plaintiffs also contend that *Ganton* is distinguishable because there was a rule adopted by that Board of Trustees stating that the Board may approve a transfer to another qualified plan of a portion of Plan Assets if that action is deemed by the Board to be in the best interests of the Plan. However, here there is language actually precluding a transfer of assets, in Section 6.6 and 5.1(b) of the Trust Agreement, providing that contributions made to the Trust Fund by the public school entities are irrevocable. R.3025a, 3032a. Furthermore, the Trustees here adopted the Scoda resolution, which addressed what could be done with Trust–wide surpluses and did not include a provision for transferring any portion to a withdrawing employer. R.3221a–22a.

There is one more point about the *Ganton* case that is worthy of mention but that is conspicuously absent from the plaintiffs' discussion of that case — the appropriate standard of review applied in determining whether to reverse the trustees' decision not to agree to transfer a portion of surplus to the withdrawing employer. Specifically, the court in *Ganton* gave deference to the decision of the

trustees in that case, stating that when the plan documents give the trustees the discretion to interpret plan terms, a court should not substitute its judgment unless the trustees' interpretation was arbitrary and capricious. *See Ganton*, 76 F.3d at 466. Here, that same standard should apply, given that the Trust Agreement here provides that the Trustees have the sole responsibility to determine the existence, non–existence, nature, and extent of the rights and interest of all parties in the Trust Fund (Sec. 2.1(c)). R.3010a. Applying that standard, one cannot possibly conclude that the Trustees in this case acted arbitrarily or capriciously in denying plaintiffs' request for a transfer of monies out of the Trust Fund, given the irrevocability language of Section 6.6 and 5.1(b) of the Trust Agreement (R.3025a, 3032a), the operation of the Trust by pooling contributions and spreading risk since inception, and the understanding of the Trustees that once a district paid its pre–determined contribution rate for a Plan year, it would pay no more and would receive no refund based on its actual claims experience and expenses for that Plan year.

For the same reason, to the extent that the Trust Agreement is deemed to be ambiguous, the Trustees of this Trust cannot be deemed to have breached their fiduciary duty under Section 404(a)(1)(B) of ERISA unless a court concludes that their interpretation of the contract in question was not a reasonable interpretation of that contract. *See Keegan* v. *Steamfitters Local Union No. 420 Pension Fund*, 174 F. Supp. 2d 332, 339 (E.D. Pa. 2001) (noting that ERISA employs the "prudent man" standard of care with regard to fiduciary duties, *see* 29 U.S.C. §1104). The trial

court made no such finding, and, indeed, the evidence could not support such a finding.

Contrary to plaintiffs' assertion, defendant has not "abandoned" its argument that federal cases which interpret LMRA Section 302(c)(5) are relevant to interpreting the sole and exclusive benefit rule of ERISA. Here, the founding public school entities and labor unions that created this Trust's Plan incorporated the sole and exclusive benefit rule set forth in Section 302(c)(5) of the LMRA (also known as the Taft–Hartley Act), 29 U.S.C. §186(c)(5), by the language included in this Trust Agreement's preamble at pp. 4–5 (and the procedure for arbitration at Sec. 4.2(c) of the Trust Agreement) that essentially matches the language of LMRA Section 302(c)(5). R.3004a–05a, 3013a–14a. Moreover, the U.S. Supreme Court itself has recognized that LMRA Section 302(c)(5) and ERISA Section 404(a)(1), relied on by the plaintiffs in this case, establish the same duty of loyalty. *See NLRB* v. *Amax Coal*, 453 U.S. 322, 331 (1981) ("ERISA essentially codified the strict fiduciary standards that a section 302(c)(5) trustee must meet. Section 404(a)(1) requires a trustee to 'discharge his duties * * * solely in the interest of the participants and beneficiaries'"); *Concrete Pipe and Products of California, Inc.* v. *Construction Laborers Pension Trust*, 508 U.S. 602, 616 (1993). To the extent that this Court even reaches this issue, cases decided under the sole and exclusive benefit rule of the LMRA are unquestionably relevant.

In sum, none of the plaintiff school districts' legal arguments suffices to allow affirmance of the trial court's erroneous conclusion that the Health Trust operated as a segregated trust rather than as a pooled trust.

3. The plaintiff school districts do not even attempt to defend the trial court's holding that pooled trusts somehow violate public policy, thereby leaving this Court with no basis on which to uphold the trial court's ruling

Unable to establish that either the record of this case or the law supports the affirmance of the trial court's plainly incorrect ruling that the Health Trust operated as a segregated trust, all that the plaintiff school districts are left with is the trial court's holding that pooled trusts violate public policy.

The Health Trust's opening brief on appeal, at pages 51–56, and the amicus briefs filed in support of the Health Trust's appeal demonstrated that the trial court's public policy holding was entirely without merit and that, in fact, pooled governmental trusts operate throughout Pennsylvania and the United States. Instead of directly responding to those convincing arguments, the Brief for Appellees that the plaintiff school districts have filed attempts to minimize the trial court's public policy holding to the point of insignificance and fails to offer any grounds for affirming that aspect of the trial court's ruling.

The plaintiff school districts' precise understanding of the trial court's public policy holding is difficult to glean from the Brief for Appellees. On the one hand, the plaintiff school districts assert that the trial court did not intend to hold that pooled trusts are contrary to public policy as a sweeping, categorical matter in all cases. On

the other hand, however, the plaintiff school districts in their Brief for Appellees fail to offer any explanation for why the use of a pooled trust in this case is somehow distinguishable from other cases in which the use of a pooled trust would not violate public policy.

In particular, the plaintiff school districts' Brief for Appellees does not argue that it is the use of a pooled trust by public employers that violates public policy. Nor do the plaintiff school districts argue that the self–insured nature of the Health Trust is what causes this particular pooled trust to violate public policy. Rather, it seems that the plaintiff school districts are asserting that a trial court may permissibly invoke public policy to invalidate a contract based on an *ad hoc*, gestalt, "know it when I see it" approach that is based on nothing more than an individual judicial officer's personal reaction to the overall fairness of the circumstances.

Here, according to the plaintiff school districts, due to their employees' and their dependents' far less expensive than expected health care utilization, gleaned after the fact, these two school districts' contribution to the surplus/reserves of the Health Trust was so large and disproportionate to the contributions of the other school districts participating in the Health Trust as to be unfair. The plaintiff school districts' proposed legal standard, however, is so imprecise and uncertain that it is simply impossible to ascertain before the fact where the line exists between lawfully disproportionate contributions to surplus/reserves and unlawfully disproportionate contributions.

Even more importantly, as the Health Trust has repeatedly observed in its appellate briefing in this appeal, the existence and proper continued operation of the entire insurance industry is predicated on the very same, and often even worse, "unfairness" about which the school districts now complain. Take term life insurance, for example. Every year that a policyholder does not die, the premiums paid for term life insurance, in retrospect, purchased nothing of value and instead could have been put toward some useful purpose or have been donated to charity. If these school districts had instead combined to form a self–insured term accidental death insurance pooled trust, and Dallas and Pittston Area had several years in which none of its employees died from accidental causes while on the job, assuredly those two school districts would not be entitled to a return of their premium payments, which perhaps may have been necessary to cover greater than expected losses sustained by other employers who belonged to this hypothetical trust.

The only proper way to evaluate the fairness of an insurance premium is in advance of knowing what the actual risk experience ended up being during the policy period. The Trust Agreement permitted all school district members to present notices of withdrawal sufficiently in advance (which later could be rescinded, allowing the school district to remain in the Trust) so that if the school district believed that it could obtain less expensive health insurance elsewhere outside of the Trust, the school district could leave the Trust and purchase elsewhere. The record in this case, however, contains no evidence whatsoever that either Dallas or

Pittston Area School District could have obtained less expensive health insurance elsewhere for any of the years at issue.

Neither the trial court's sweeping public policy holding, which the plaintiff school districts wisely now disclaim, nor the plaintiff school districts' own specific claims of supposed unfairness can suffice to uphold the trial court's decision that pooled trusts in general, or this pooled trust in particular, violate public policy.

B. As A Matter Of Law, Plaintiffs' Claim For Unjust Enrichment Fails To Provide An Alternate Basis For Affirmance Of The Trial Court's Ruling In Favor Of The Plaintiff School Districts

Neither the trial court nor the plaintiff school districts have identified any way in which the Health Trust has breached its contract with the plaintiffs. Accordingly, as shown above, the trial court's ruling in favor of the plaintiff school districts on their breach of contract claim against the Health Trust should be reversed. That result, however, does not entitle the plaintiffs to relief on their unjust enrichment claim.

The issue is not, at this late juncture, whether the plaintiff school districts had the ability to plead a claim for unjust enrichment in the alternative to their claim for breach of contract. *Cf.* Brief for Appellees at 55. Rather, now that the trial of this case is over and an express contract (namely, the Trust Agreement) has indisputably been found to exist governing the relationship between the Health Trust and the plaintiff school districts, the question is simply whether the plaintiff

school districts' claim for unjust enrichment can at this juncture provide an alternate basis for upholding the trial court's decision.

As the Health Trust explained in its opening brief, at pages 49–51, the Trust Agreement is a written contract that clearly and unequivocally exists to define the parameters of the parties' respective rights, duties, obligations, and responsibilities. As continually recognized by Pennsylvania courts, "the doctrine of quasi contract, or unjust enrichment, is inapplicable where a written or express contract exists." *Northeast Fence & Iron Works, Inc.* v. *Murphy Quigley Co.*, 933 A.2d 664, 669 (Pa. Super. Ct. 2007). Here, the existence of the Trust Agreement simply precludes plaintiffs' unjust enrichment claim as a matter of law.

Moreover, as the facts of this case reveal, there was simply nothing "unjust" about the outcome as to the Dallas and Pittston Area School Districts. Those school districts' employees and their dependents received the health care coverage that they expected the Health Trust to provide, in exchange for the premium payments that those school districts had contractually committed themselves to make. If the plaintiff school districts believed that they could have received a better health care bargain elsewhere (keeping in mind that the record in this case contains no evidence that any such belief would have been correct), those school districts were free to leave the Health Trust at any time after having given the contractually required advance notice. What those school districts could not do, without violating the Trust Agreement, was to force the Health Trust to pay out any portion of the

Trust's surplus/reserves to those school districts when those school districts withdrew from the Trust.

As the Health Trust has explained, the plaintiff school districts' claim of injustice cannot succeed, because they have no one other than themselves to blame. Plaintiffs participated in and were aware of the Health Trust's decisions to operate as a pooled trust by spreading risk. Plaintiffs were willing to accept the benefits of the Health Trust's operation as a pooled trust, and consequently plaintiffs must also be required to bear the corresponding burdens (including the possibility of paying more for insurance benefits than the value of the benefits actually received). Finally, by withdrawing from the Health Trust when they did, plaintiffs voluntarily and knowingly agreed to forgo obtaining the benefits of the Trust's surplus/reserve, which the school districts and other school entities remaining in the Trust were able to experience in later years in the form of reduced rate increases and premium payment forgiveness.

Here, the uncontradicted evidence of record establishes that the parties' relationship is governed by the written Trust Agreement. Accordingly, the existence of the Trust Agreement confines the plaintiffs to a contractual remedy, and the trial court's award in favor of the plaintiffs cannot be upheld on the basis of unjust enrichment.

C. Plaintiffs' Argument That The Trust Can Only Recover On Its Counterclaims If The Trial Court's Decision Is Affirmed, But Not If The Trial Court's Decision Is Reversed, Is Entirely Without Merit

In a mere three paragraphs (*see* Brief for Appellees/Cross–Appellants at 62–64), the plaintiff school districts advance the confounding argument that although the judgment that the trial court awarded was reduced with plaintiffs' consent to reflect credit in full for the Trust's counterclaims, if the judgment is reversed then the Trust should be denied any recovery for those same counterclaims.

Section 5.4 of the Agreement and Declaration of Trust provides, in Subsections (a)(l) and (a)(2), as follows:

> Any public school entity party to this Agreement and Declaration of Trust may withdraw from the Trust Fund provided:
>
> (1) on or before June 30 (the 'Notice Date'), it provides written notice to the Trustees of its intention to withdraw from the Trust Fund, which withdrawal shall become effective no earlier than twelve (12) months after the aforesaid June 30 'Notice date';
>
> (2) within thirty (30) days after the effective date of withdrawal, the withdrawing public school entity pays to the Trust Fund all required contributions for claims incurred on behalf of Participants and Beneficiaries in the Trust Fund who are the employees of the withdrawing public school entity or dependent or Beneficiaries of those employees, which though incurred prior to the public school entity's withdrawal from the Trust Fund, have not been or will not be charged for, billed or paid until after the public school entity's effective date of withdrawal; . . . .

R.3026a–27a.

Accordingly, both the Dallas and Pittston Area School Districts, as withdrawing public school entities, are required by Section 5.4 of the Trust Agreement, quoted above, to pay to the Trust all required contributions for claims

incurred by the Trust on behalf of participants and beneficiaries in the Trust Fund who are the employees of either the Dallas or Pittston Area School Districts or a dependent or beneficiary of those employees which claims were incurred by the employee or employee's dependent of either School District before the School Districts' withdrawal from the Trust Fund, which were not charged for or billed until after the School Districts' withdrawal from the Trust Fund. This liability is referred to as either the "incurred but not reported IBNR liability" or the "run–off" liability of each withdrawing School District.

At trial, the Trust did present evidence of these counterclaims through the testimony (R.1352a–54a) of the Trust's office manager, Danielle Savitsky (formerly Kampas), and exhibits D–50, D–51, and D–52 (R.3358a–73a). This evidence established that the total of the run–off claims for Dallas School District, which Dallas has never paid and still owes to the Trust, is $209,242.74, and the total of the run–off claims for Pittston Area School District, which Pittston has never paid and still owes to the Trust, is $259,203.78. Moreover, the plaintiffs' expert, Richard Kipp, testified that he considered that these amounts were liabilities of the plaintiff school districts. R.1108a–09a.

It is undisputed that the Dallas and Pittston Area School Districts have not paid the amounts demanded of them by the Trust. Section 5.4 of the Trust Agreement imposes strict liability on withdrawing public school districts to pay the IBNR or run–off liability incurred by the Trust as a consequence of the withdrawal of the departing public school entity.

Based on the language of Section 5.4, the calculation of the amount owing thereunder by Dallas and Pittston, and the failure of Dallas and Pittston to pay the amounts owing, judgment should be entered in favor of the Defendant Trust on its counterclaims against Dallas and Pittston in the amounts of $209,242.74 and $259,203.78, respectively, together with pre–judgment interest, when this Court reverses the trial court's entry of judgment in favor of the plaintiff school districts.

D. Plaintiffs Are Not Entitled To Any Recovery Of Attorneys' Fees As Prevailing Parties

This issue is relevant only in the unlikely event that this Court were to uphold the trial court's ruling in favor of the plaintiff school districts on the merits.

The plaintiffs, in their Brief for Appellees, acknowledge that the Trust Agreement does not expressly incorporate ERISA's attorneys' fee provision. That, of course, should be the end of this Court's inquiry, because the Trust Agreement incorporated those provisions of ERISA that the Trust voluntarily wished to apply and did not incorporate those provisions of ERISA that the Trust did not select to apply.

The plaintiff school districts, however, maintain that the Trust's express decisions concerning which particular provisions of ERISA would apply to the Trust (keeping in mind that ERISA had no independent application, because ERISA does not apply to government plans such as that of the Health Trust, *see* 29 U.S.C. §1003(b)) should be disregarded because the Trust's express incorporation of particular fiduciary principles from ERISA "would be rendered meaningless" in the

absence of any incorporation of ERISA's attorneys' fee remedy. *See* Brief for Appellees at 65.

The plaintiff school districts' argument strains credulity. Plaintiffs sought and have achieved a recovery in this case of far in excess of $5 million; an award of attorneys' fees in addition to those amounts is surely unnecessary to make this lawsuit worthwhile. But, if plaintiffs wish to characterize their recovery thus far in this lawsuit as "meaningless," then this Court need not have any reluctance in setting that award aside due to the utter absence of any support either in the record or in the law.

As the Health Trust explained in its opening brief, Pennsylvania law makes clear that litigants cannot recover their attorneys' fees from an opposing party unless otherwise permitted by express statutory authority, a clear agreement of the parties, or some other established exception to the general rule against recovery. *See Mosaika Acad. Charter Sch.* v. *Commonwealth, Dep't of Educ.*, 572 Pa. 191, 206–07, 813 A.2d 813, 822 (2002); *Merlino* v. *Delaware County*, 556 Pa. 422, 425, 728 A.2d 949, 951 (1999). As Pennsylvania's highest court has explained:

> This Court has consistently followed the general, American rule that there can be no recovery of attorneys' fees from an adverse party, absent an express statutory authorization, a clear agreement by the parties or some other established exception.

Merlino, 556 Pa. at 425, 728 A.2d at 951 (citations omitted). In this case, the evidence at trial was clearly insufficient to overcome the general prohibition against an award of attorneys' fees. As a result, the trial court's award of attorneys' fees should be reversed.

Although Section 6.2 of the Trust Agreement (R.3030a) incorporates the fiduciary standards of ERISA codified at 29 U.S.C. §§1101–1114, the Trust Agreement does not incorporate the provisions of ERISA which either allow attorneys' fees (29 U.S.C. §1132(g)) or which mandate attorneys' fees (29 U.S.C. §1145). R.3029a–30a. Further, Section 1132(g) of ERISA provides that:

> In any action brought under this subchapter (other than an action described in paragraph (2)) by a participant, beneficiary or fiduciary, the Court in its discretion may allow a reasonable attorney's fee and costs of action to either party.

29 U.S.C. §1132(g)(1).

As noted above, this section of ERISA was not incorporated into the Trust Agreement. Moreover, plaintiffs do not have the status of a "participant, beneficiary or fiduciary" of the Health Trust as those terms are defined in ERISA. *See* 29 U.S.C. §1002(7) (defining "participant"); 29 U.S.C. §1002(8) (defining "beneficiary"); 29 U.S.C. §1002(21)(A) (defining "fiduciary"). None of the plaintiffs are employees or former employees eligible to receive benefits under the Trust's Plan of Benefits. The plaintiff districts no longer participate in the Trust, and their employees received all of the healthcare benefits to which they were entitled while they were still in the Trust. Nor are the plaintiffs fiduciaries of this Trust, as they no longer participate in the Trust, and, even while participating in the Trust, they did not have the power, acting alone, to make fiduciary decisions. *See Eureka Paper Box Co.* v. *WBMA, Inc.*, 767 F. Supp. 642, 651 (M.D. Pa. 1991). Nor does plaintiffs' action arise under the jurisdiction granted to the state and federal courts under Section 1132 of ERISA, since the Health Trust is a "governmental plan" exempt from ERISA, has

only incorporated the fiduciary standards of ERISA set forth in Sections 1101–1114 as operating principles for the administration of the Health Trust, and the claims in this action are not the type allowed or even contemplated by any of those fiduciary provisions of ERISA.

Lastly, even if §1132(g)(1) were to apply, there is no presumption that a successful plaintiff should receive an attorney's fee award absent exceptional circumstances. *See McPherson* v. *Employees' Pension Plan of Am. Re–Insurance Co.*, 33 F.3d 253, 254 (3d Cir. 1994). Moreover, a trial court must analyze the five factors set forth in *Ursic* v. *Bethlehem Mines*, 719 F.2d 670, 673 (3d Cir. 1983), before awarding fees. Neither Judge Muroski, as part of his July 1, 2008 order disposing of preliminary objections, nor Judge Wetzel, as part of his November 28, 2011 order concluding summarily that attorneys' fees will be awarded based on Judge Muroski's order, undertook any analysis of the required factors. In fact, it would have been impossible for Judge Muroski to evaluate the five factors set out in the *Ursic* case because the litigation was only at the preliminary objection stage when Judge Muroski issued his order. For this reason as well, the trial court's award of attorneys' fees was erroneous and should be reversed.

The plaintiff school districts' Brief for Appellees fails to offer any convincing response in opposition to any of these reasons necessitating the reversal of the trial court's award of attorneys' fees. Accordingly, this Court should hold that the trial court erred in holding that plaintiffs were entitled to recover their attorneys' fees.

III. SUMMARY OF THE ARGUMENT

For essentially the same reasons explained above and in the Health Trust's opening brief on the issue of attorneys' fees, this Court should also reject the plaintiff school districts' cross–appeal, in which the plaintiffs seek recovery of their litigation costs in the form of actuarial fees.

Under Pennsylvania law, litigation costs are not recoverable by the prevailing party in the absence of a statutory or contractual provision expressly allowing them. Here, no such statutory or contractual provision exists, and therefore the trial court was correct in ruling that the plaintiff school districts were not entitled to recover their litigation costs in the form of actuarial fees from the Health Trust.

Moreover, the trial court early in the litigation required the Health Trust to provide the plaintiff school districts with the actuarial information that the trial court viewed as pertinent to the plaintiffs' lawsuit, at the expense of the Health Trust. The trial court, however, did not view the additional actuarial work that the plaintiff school districts opted to perform at their own expense as integral to the school districts' lawsuit. The plaintiffs have not challenged those rulings directly, but rather now the plaintiffs are seeking to circumvent the trial court's earlier unchallenged rulings concerning what actuarial work the Health Trust had to provide to plaintiffs at the Health Trust's own expense by seeking an award from this Court on appeal of all of the plaintiffs' own actuarial expenses.

For these reasons, this Court should reject the plaintiff school districts' cross–appeal and should affirm the trial court's order declining to award actuarial fees to the plaintiffs.

IV. ARGUMENT ON THE CROSS–APPEAL

A. The Trial Court Correctly Rejected The Plaintiff School Districts' Claim For Recovery Of Litigation Costs Consisting Of Actuarial Fees

As is the case with regard to attorneys' fees, *see supra*, Pennsylvania likewise adheres to the "American rule" with respect to litigation costs. As the Supreme Court of Pennsylvania recently explained in *In re Nomination Petition of Farnese*, 17 A.3d 357, 370 (Pa. 2011), "litigants are responsible for their own litigation costs and may not recover them from an adverse party 'unless there is express statutory authorization, a clear agreement of the parties, or some other established exception.'" (quoting *Trizechahn Gateway LLC* v. *Titus*, 601 Pa. 637, 652, 976 A.2d 474, 482–83 (2009)).

Here, the Trust Agreement governing the relationship of the parties does not provide for the recovery of litigation costs. Nor is there any express statutory authorization or other established exception to the "American rule" that would allow their recovery. Accordingly, the trial court did not err or otherwise abuse its discretion in declining to award as litigation costs the actuarial fees that plaintiffs are now seeking to recover by means of their cross–appeal.

Plaintiffs' cross–appeal should also be rejected because it improperly seeks to overturn earlier trial court rulings the correctness of which the plaintiffs are not directly challenging by means of their cross–appeal. More specifically, on August 2, 2010, the trial court issued an order rejecting plaintiffs' request for an accounting by the Health Trust covering the period from July 1, 1999 through June 30, 2007. Instead, the trial court ordered the Trust to provide an accounting at the Trust's own expense covering the period from July 1, 2004 through June 30, 2007. Although the Trust disagreed with the trial court's order even to that extent, the Trust nonetheless complied with the order and provided plaintiffs with the accounting that the trial court had ordered.

Thereafter, the plaintiffs unsuccessfully sought to have the trial court reconsider its order and expand the accounting period back to what the plaintiffs had originally requested, so that it would also include from July 1, 1999 through June 30, 2004. The trial court, however, again denied plaintiffs' request. Now, the plaintiffs are asking this Court to overturn the trial court's decision refusing to award to plaintiffs their actuarial costs without simultaneously and directly challenging the trial court's series of orders that repeatedly refused the plaintiffs' requests to order the Health Trust to provide an accounting for the period between July 1, 1999 and June 30, 2004 as unnecessary to the plaintiffs' claims. Because plaintiffs are not challenging those underlying orders, the plaintiffs' cross–appeal cannot succeed.

In any event, although the Trust complied with Judge Muroski's order requiring the Trust to provide an accounting for the period July 1, 2004 through June 30, 2007, that ruling was erroneous as a matter of law. The Trust Agreement in this case sets forth the specific accounting requirements for the defendant Trust at Sections 4.7 and 4.8. Section 4.7 requires the Trustees to "cause to be prepared a written statement of account with respect to the Plan Year for which contributions were made setting forth: (a) the net income, or loss, of the Trust Fund; (b) the gains, or losses, realized by the Trust Fund upon sale or other disposition of its assets; (c) the increase, or decrease, in the value of the Trust Fund; and (d) all payments and distributions made from the Trust Fund." R.3021a–22a. Section 4.8 requires that the Trustees audit the Plan's records no less than once each Plan Year and provides that "the Trustees shall engage on behalf of all participants and their beneficiaries an independent certified public accountant for that purpose." R.3022a.

At trial, the Trust's auditor Thomas Rainey testified, without dispute, that his firm was retained by the Trust to perform the audits of the Trust's financial records, that he and his firm did so based on the instructions from the Trustees and that they prepared those audit reports on the basis of Trust–wide numbers without breakdown of any assets, liabilities, income or expenses by member school district (with the exception of Crestwood School District in the initial Plan year of July 1, 1999 to June 30, 2000, before the Trust began formal operations, in that Crestwood never became a member of the Trust). R.1370a–77a. Mr. Rainey further confirmed that this Trust–wide presentation of the audits was consistent with the internal

financial records of the Trust, which did not reflect any district–specific balances or any reconciliation or comparison of amounts paid in by a member district versus the actual claims and share of expenses paid out on that district's behalf. R.1378a–82a.

This Trust–wide accounting is in accordance with Pennsylvania law, which provides that where an instrument is explicit as to the duty owed by the Trustee, those terms should govern because "[t]he nature and extent of the duties of a corporate trustee are primarily to be ascertained from the trust agreement." *In re Estate of Niessen*, 489 Pa. 135, 139, 413 A.2d 1050, 1052 (1980) (citing Restatement (Second) of Trust §164 (1959)); *In re Scheidmantel*, 868 A.2d 464, 483 (Pa. Super. Ct. 2005).

For these reasons as well, the plaintiffs' cross–appeal requesting that defendant pay for plaintiffs' expert to perform the accounting that supported plaintiffs' claim for relief in this case must fail.

Unable to succeed on the merits of their claims, the plaintiff school districts and their counsel have regrettably resorted to improperly accusing counsel for the Trust of trying to conceal evidence during discovery and from the Reproduced Record. The actual facts show that counsel for the Trust agreed to include the one particular document (P–489) filed under seal in the trial court as part of the Reproduced Record but understood that a joint motion was needed to file that document separately. That document is now in the Reproduced Record and has not been concealed from this Court, even though it in no way supports the affirmance of the trial court's decision in favor of the plaintiff school districts. The school district's

other supposed claim of misconduct involves a redaction in a document whose disclosure the trial court refused to compel on motion of the plaintiffs, sustaining the Health Trust's assertion of privilege. R.4a (trial court docket entries 76, 81, and 86). Thus, the plaintiffs' disagreement is not with the Health Trust, but with the trial court. Now, however, even that document is found in the Reproduced Record, as plaintiffs managed to obtain it independently of discovery from the Health Trust.

The record in this case contains everything that the plaintiff school districts wished for it to contain. What it does not contain, unfortunately for them, is anything that suffices to allow the affirmance of the trial court's decision awarding a portion of the Health Trust's surplus/reserves to the plaintiffs based on the trial court's clearly incorrect decision holding that the Trust at all relevant times operated as a segregated, rather than a pooled, trust.

For the foregoing reasons, this Court should reject plaintiffs' cross–appeal and affirm the trial court's ruling that denied the plaintiffs' claim for litigation costs.

V. CONCLUSION

For all of the foregoing reasons, this Court should reverse the trial court's judgment and direct the entry of judgment in favor of defendant Northeast Pennsylvania School Districts (Health) Trust. This Court should further specify that the judgment in the Trust's favor should include an award in full for the "run–off" sought in the Trust's counterclaims in accordance with Section 5.4 of the Trust Agreement.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that I am this day serving a true and correct copy of the foregoing document upon the persons and in the manner indicated below which service satisfies the requirements of Pa. R. App. P. 121:

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