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CDLA

The Voice of Connecticut's Civil Defense Trial Lawyers

February 7, 2019

Melissa A. Farley, Esq.
Executive Director
Connecticut Judicial Branch
Division of External Affairs
231 Capitol Avenue
Hartford, CT 06106

RE: Proposed Practice Book §13-12A and New Form 217

Dear Attorney Farley:

At the January 22, 2019 meeting of the Rules Committee of the Superior Court, Judge Stevens requested that the Connecticut Defense Lawyers Association (CDLA) provide the Committee with drafts of proposed Practice Book § 13-12A and Form 217 that reflect the changes suggested by the CDLA in prior comments. Pursuant to that request, enclosed please find copies of the proposed rule and form with the CDLA's suggestions incorporated.

Thank you again for the invitation to comment and participate in the consideration of this matter. A representative of the CDLA will be in attendance at the next meeting of the Rules Committee and available to address any further questions or concerns of the Honorable members of the Committee.

Very Truly Yours,
CONNECTICUT DEFENSE LAWYERS ASSOCIATION

M. Karen Noble
President

Encl.

PRACTICE BOOK § 13-12A AS INITIALLY DRAFTED BY THE RULES COMMITTEE:

Sec. 13-12A. Disclosure of Medicare Enrollment, Eligibility and Payments Received

In any civil action involving allegations of personal injury, information on the claimant's Medicare enrollment status, eligibility or payments received, which is sufficient to allow providers of liability insurance, including self-insurance, no fault insurance, and/or worker's compensation insurance to comply with the federally mandated reporting requirements imposed under 42 U.S.C. § 1395y (b) (8), shall be subject to discovery by any party by interrogatory as provided in Sections 13-6 through 13-8. The interrogatories shall be limited to those set forth in Form 217. Information disclosed pursuant to this rule is not by reason of disclosure admissible in evidence at trial. Such information shall be used only for purposes of complying with 42 U.S.C. § 1395y (b) (8) and shall not be used or disclosed for any other purpose.

PROPOSED CDLA CHANGES TO PRACTICE BOOK § 13-12A:

Sec. 13-12A. Disclosure of Medicare Enrollment, Eligibility and Payments Received

In any civil action involving allegations of personal injury, information on the claimant's Medicare enrollment status, eligibility or payments received, which is sufficient to allow providers of liability insurance, including self-insurance, no fault insurance, and/or worker's compensation insurance to comply with ~~the federally mandated reporting requirements imposed under 42 U.S.C. § 1395y (b) (8)~~ **Medicare Secondary Payer obligations, including those imposed under 42 U.S.C. § 1395y (b) (2) and § 1395y(b)(8), as applied to all Medicare Parts**, shall be subject to **pretrial** discovery by any party by interrogatory as provided in Sections 13-6 through 13-8. The interrogatories shall be limited to those set forth in Form 217. Information disclosed pursuant to this rule is not by reason of disclosure admissible in evidence at trial. Such information shall be used only for purposes of **litigation and for** complying with **reporting and reimbursement obligations under 42 U.S.C. § 1395y (b) (2) and** 42 U.S.C. § 1395y (b) (8) and shall not be used or disclosed for any other purpose.

FORM 217, INTERROGATORY NOS. 2 AND 3, AS INITIALLY DRAFTED BY THE RULES COMMITTEE:

(XX) State whether you have ever been enrolled in Medicare Part A or Part B.

(XX) If the response to the previous interrogatory is affirmative, state:

(a) The effective date(s);

(b) Your Medicare claim number(s);

(c) Your name exactly as it appears on your Medicare card; and

(d) The amount.

(e) Medicare Part A or Part B has paid any bills for treatment of any injuries allegedly sustained as a result of the incident alleged in the complaints.

PROPOSED CDLA CHANGES TO FORM 217, INTERROGATORY NOS. 2 AND 3:

(XX) State whether you have ever been enrolled in **a plan offered pursuant to any** Medicare Part ~~A or Part B~~.

(XX) If the response to the previous interrogatory is affirmative, state:

(a) The effective date(s);

(b) Your Medicare claim number(s);

(c) Your name exactly as it appears on your Medicare card; and

(d) The amount.

(e) Whether a plan offered pursuant to any Medicare Part ~~A or Part B~~ has paid any bills for treatment of any injuries allegedly sustained as a result of the incident alleged in the complaints.

(previous materials)

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Proposal by Judge Bright to include Medicare questions in standard discovery. (These questions were removed from the Form 202 recommendations of Rules Committee on May 15, 2017 prior to Judges' Annual Meeting in June 2017.) On May 15, 2017 based on comments received from Judge Stevens, the Rules Committee referred matter and Judge Stevens's comments to Civil Commission for its consideration. (On 10-18-17, Judge Bright asked that the new CAJ for civil be given an opportunity to weigh in on this issue before presenting it to the Rules Committee. Justice Robinson agreed.) On 11-19-18, RC considered New Sec. 13-12A, Disclosure of Medicare Enrollment, Eligibility and Payments Received and directed Counsel to work with Judges Stevens and Bellis on rule and stand-alone standard interrogatories. Referred matter to CBA, CTLA, CDLA, and Judge Abrams for comment. On 12-18-18, Judges Stevens and Bellis gave status report to RC and RC tabled matter to 1-22-19 RC mtg. Comments from CBA, CTLA, CDLA and Judge Abrams requested by 1-7-19. **Comments received from CBA, CTLA, CDLA and Judge Abrams.**

5/12a
4/2

(New) Sec. 13-12A. Disclosure of Medicare Enrollment, Eligibility and Payments Received

In any civil action involving allegations of personal injury, information on the claimant's Medicare enrollment status, eligibility or payments received, which is sufficient to allow providers of liability insurance, including self-insurance, no fault insurance, and/or worker's compensation insurance to comply with the federally-mandated reporting requirements imposed under 42 U.S.C. § 1395y (b) (8), shall be subject to discovery by any party by interrogatory as provided in Sections 13-6 through 13-8. The interrogatories shall be limited to those set forth in Form 217. Information disclosed pursuant to this rule is not by reason of disclosure admissible in evidence at trial. Such information shall be used only for purposes of complying with 42 U.S.C. § 1395y (b) (8) and shall not be used or disclosed for any other purpose.

(New)
Form 217

Defendant's Interrogatories-Civil Actions Alleging Personal Injury-Medicare Enrollment, Eligibility and Payments Received

No. CV-	: SUPERIOR COURT
(Plaintiff)	: JUDICIAL DISTRICT OF
VS.	: AT
(Defendant)	: (Date)

The undersigned, on behalf of the Defendant, hereby propounds the following interrogatories to be answered by the Plaintiff, _____, under oath, within sixty (60) days of the filing hereof in compliance with Practice Book Section 13-2.

Definition: "You" shall mean the Plaintiff to whom these interrogatories are directed except that if suit has been instituted by the representative of the estate of a decedent, ward, or incapable person, "you" shall also refer to the Plaintiff's decedent, ward or incapable person unless the context of an interrogatory clearly indicates otherwise.

In answering these interrogatories, the Plaintiff(s) is (are) required to provide all information within their knowledge, possession or power. If an interrogatory has subparts, answer each subpart separately and in full and do not limit the answer to the interrogatory as a whole. If any interrogatories cannot be answered in full, answer to the extent possible.

(1) State the following:

(a) your full name and any other name(s) by which you have been known;

(b) your date of birth;

(c) your motor vehicle operator's license number;

(d) your home address;

(e) your business address;

(2) State whether you have ever been enrolled in Medicare Part A or Part B.

(a) If the response to the previous interrogatory is affirmative, provide:

(i) The effective date(s);
(ii) Your Medicare claim number(s);
(iii) Your name exactly as it appears on your Medicare card; and
(iv) Your date of birth.

(b) State whether Medicare Part A or Part B has paid any bills for treatment of any injuries allegedly sustained as a result of the incident alleged in the complaints.

(c) If the response to the previous interrogatory is affirmative, state the amount Medicare Part A or Part B has paid.

(d) If you are not presently enrolled in Medicare Part A or Part B, state whether you are eligible to enroll in Medicare Part A or Part B.

(e) State whether you plan to apply for Medicare Part A or Part B within the next thirty-six (36) months.

DEFENDANT,

BY_____

I, _____, hereby certify that I have reviewed the above interrogatories and responses thereto and that they are true and accurate to the best of my knowledge and belief.

_____
(Plaintiff)

Subscribed and sworn to before me this _____day of _____, 20____.

_____
Notary Public/
Commissioner of the Superior Court

CERTIFICATION

I certify that a copy of this document was or will immediately be mailed or delivered electronically or non-electronically on (date) _____ to all attorneys and self-represented parties of record and to all parties who have not appeared in this matter and that written consent for electronic delivery was received from all attorneys and self-represented parties receiving electronic delivery.

Name and address of each party and attorney that copy was or will immediately be mailed or delivered to*

*If necessary, attach additional sheet or sheets with the name and address which the copy was or will immediately be mailed or delivered to.

_____
Signed (Signature of filer) Print or type name of person signing Date Signed

_____
Mailing address (Number, street, town, state and zip code) or E-mail address, if applicable Telephone number

COMMENTARY: This new form, established pursuant to (New) Section 13-12A, sets forth a single, six-part question regarding Medicare enrollment status, eligibility or payments received and is to be used in any civil action involving allegations of personal injury. That question is intended to allow defendant providers of liability insurance, including self-insurance, no fault insurance and worker's compensation insurance, to capture the information necessary to satisfy the federal reporting requirements on the Medicare enrollment status of claimants. In the absence of that question, defendants seek permission to file non-standard interrogatories to obtain the required Medicare reporting information.

5-2 b.

Del Ciampo, Joseph

From: Bill Chapman <bchapman@ctbar.org>
Sent: Friday, January 4, 2019 1:33 PM
To: Del Ciampo, Joseph; Jonathan M. Shapiro; lwoodard@walshwoodard.com; knoble@danaherlagnese.com
Subject: RE: Referral from the Rules Committee of the Superior Court Regarding Standard Discovery

Joe:

Thank you for the reminder. There are no CBA sections commenting or taking a position on this referral.

Bill Chapman
Director, Government & Community Relations
Connecticut Bar Association
Mobile: 860-707-3309
Desk: 860-612-2004
bchapman@ctbar.org
Twitter: @CTBarLeg

From: Del Ciampo, Joseph [mailto:Joseph.DelCiampo@jud.ct.gov]
Sent: Monday, December 31, 2018 9:23 AM
To: Jonathan M. Shapiro <jshapiro@shapirolawofficesct.com>; Bill Chapman <bchapman@ctbar.org>; lwoodard@walshwoodard.com; knoble@danaherlagnese.com
Subject: RE: Referral from the Rules Committee of the Superior Court Regarding Standard Discovery

Good Morning,

This is just a reminder that the Rules Committee is expected to consider the proposal noted below at its January meeting. Your comments on the proposal on or about January 7th would be appreciated. Thank you and Happy New Year!

Joseph J. Del Ciampo
Director of Legal Services
Connecticut Judicial Branch
100 Washington Street, 3rd Floor
Hartford, CT 06106

e-mail: Joseph.DelCiampo@jud.ct.gov

Tel: (860) 706-5120

Fax: (860) 566-3449

From: Del Ciampo, Joseph
Sent: Monday, December 17, 2018 5:09 PM
To: Jonathan M. Shapiro <jshapiro@shapirolawofficesct.com>; 'Bill Chapman (bchapman@ctbar.org)' <bchapman@ctbar.org>; 'lwoodard@walshwoodard.com' <lwoodard@walshwoodard.com>; 'knoble@danaherlagnese.com' <knoble@danaherlagnese.com>
Subject: Referral from the Rules Committee of the Superior Court Regarding Standard Discovery

Good Afternoon,

Attached is a referral from the Rules Committee of the Superior Court. Thank you.

Joseph J. Del Ciampo
Director of Legal Services
Connecticut Judicial Branch
100 Washington Street, 3rd Floor
Hartford, CT 06106

e-mail: Joseph.DelCiampo@jud.ct.gov

Tel: (860) 706-5120
Fax: (860) 566-3449

CONNECTICUT
TRIAL LAWYERS
ASSOCIATION

D. LINCOLN WOODARD
President

5-2c.

January 10, 2019

Rules Committee of the Superior Court
State of Connecticut Judicial Branch
100 Washington Street, Third Floor
Hartford, CT 06106

Re: Proposed Practice Book Rule Section 13-12A and Form 217

Dear Justice McDonald and Committee members:

The Connecticut Trial Lawyers Association appreciates the opportunity to comment on the proposed rule changes involving Medicare information in personal injury matters. In general, we believe that the addition of this new form as a separate set of discovery requiring additional certification would unnecessarily duplicate most of the information provided through the existing form discovery and result in undue burden on the plaintiffs as we anticipate that plaintiffs would soon receive the request in every case involving personal injuries. While CTLA recognizes that there are mandatory reporting requirements on the part of liability and other insurers who pay these claims under 42 U.S.C. §1395y(b)(8), the necessary information for disclosure purposes could more efficiently be discovered if the following interrogatory, taken from the proposed form 217, was inserted to existing form 202:

(#) State whether you have ever been enrolled in Medicare Part A or Part B.

If the response to the previous interrogatory is affirmative, state:

(a) The effective date(s);
(b) Your Medicare claim number(s);
(c) Your name exactly as it appears on your Medicare card; and
(d) Whether Medicare Part A or Part B has paid any bills for treatment of any injuries allegedly sustained as a result of the incident alleged in the complaint.

(#) If you are not presently enrolled in Medicare Part A or Part B, state:

(a) Whether you are eligible to enroll in Medicare Part A or Part B;

(b) Whether you plan to apply for Medicare Part A or Part B within the next thirty-six (36) months.

By adding these interrogatories to the existing standard forms, any liability insurer would have all the necessary information to submit to Medicare for purposes of their reporting requirements. For example, in interrogatory form 202 all identifying information is contained in interrogatory number 1; all expenses/medical bills are requested in interrogatory 17; interrogatory 18 requires the identity of Medicare as a payor; and in form 205, request for production 8 requires disclosure of all "documentation of claims of right to reimbursement...and all documentation of payments made by third parties."

The Committee's proposed form Interrogatory 2(a)(iv) contains a subpart requesting "amount," which would be unnecessary for several reasons. First, the amount Medicare pays is not required as part of the reporting requirements under 42 U.S.C. §1395y(b)(8); second, to the extent "amount" means the amount paid by Medicare, the information is already included in response to Interrogatory 17, 18 of Form 202 and request 8 of Form 205; and third, the amount Medicare is claiming it paid often differs from the amount the plaintiff claims as related payments and will sometimes result in an entirely separate administrative appeal process within Medicare in order to resolve. Further, Medicare's final claimed amount due at the end of a case is typically reduced to reflect the costs of procurement or even waived in limited circumstances. *See* 42 C.F.R. §411.37(procurement reduction); 42 CFR §411.28 (waiver).

CTLA believes that the addition of the interrogatories above would better balance the interests of insurers' need for Medicare/Social Security numbers for their reporting obligations against injured plaintiffs' privacy concerns. CTLA requests that if these additions are made to form 202 that the commentary contain language similar to the proposed Rule 13-12A and the proposed commentary, which makes clear that the only purpose of this disclosure is to allow insurers to comply with 42 U.S.C. §1395y(b)(8).

Lastly, the Connecticut Defense Lawyers Association provided a copy of its comments that asks the Rules Committee to expand the scope of this disclosure far beyond its intended purpose -- something CTLA would ardently oppose. This Committee's proposal was never intended to expand the use of this information, which includes social security numbers, for use in litigation as CDLA requests. Further, the

Medicare reporting requirements for liability insurers have nothing to do with Medicare Part C/Medicare Advantage Plans.

Part C plans are private medical insurance that have different lien and subrogation rights from Medicare Parts A and B. The law surrounding the lien rights of Part C plans is entirely unsettled at present both in Connecticut and nationally. The lower court case cited by CDLA merely denied a motion to dismiss, and any final judgment in that case is going to be appealed according to the plaintiff's counsel in that case. The rights of Part C insurers to be reimbursed should simply not be included as any part of the discussion on whether there should be form discovery to allow insurers to comply with their reporting obligations to traditional Medicare. The reporting obligations contained in 42 U.S.C. §1395y(b)(8) and the related regulations require reporting, in particular form, to the federal government. Those requirements do not extend to private health insurers contracting with Medicare participants to provide alternate insurance plans. Anyone enrolled in Medicare Part C is required first to obtain a Medicare number by registering with traditional Medicare and only then can that person opt to purchase a Part C plan. This discovery along the lines proposed by CDLA extends far beyond this proposed rule change and CTLA would request the opportunity to comment further if anything related to disclosures to the private, Part C insurers or other expansions suggested by CDLA are being considered by the Committee.

Thank you again for allowing us to participate in this process. Please feel free to contact me should you have any questions or concerns.

Sincerely,

D. Lincoln Woodard

DLW:cmm

CONNECTICUT
TRIAL LAWYERS
ASSOCIATION

5-2c
1/18/19

LINCOLN WOODARD
President

January 17, 2019

Rules Committee of the Superior Court
State of Connecticut Judicial Branch
100 Washington Street, Third Floor
Hartford, CT 06106

Re: Reply to CDLA letter on Proposed Practice Book Rule Section 13-12A and Form 217

Dear Justice McDonald and Committee members:

CTLA supplements its original response only to address the comments from CDLA regarding Medicare Advantage Organizations (MAO) in its January 14, 2019 correspondence. These plans and the concerns expressed by CDLA simply have nothing to do 42 U.S.C. §1395y(b)(8). We believe that it would be imprudent to adopt form discovery to include Part C plans at this time, where there has been no Second Circuit opinion on the issue; a split of authority among the other Circuits and District Courts regarding the private right of actions by MAOs; and where existing form discovery requires plaintiffs to identify all insurers paying related medical expenses, including MAOs.

The differences between original Medicare's lien rights and the MAOs' were generally described by Judge Tjoflat's recent 39 page dissenting opinion out of the Eleventh Circuit Court of Appeals:

> The statutory right of action cited by Humana, the District Court, and the panel majority was not intended to protect MAOs. The policy reasons behind the right of action differ starkly from those which motivated the creation of the Medicare Advantage program. Moreover, the statutory text of the right of action never references Medicare Advantage insurers at all. Nor could it: the right of action predated the Medicare Advantage program, and the statute that codified Medicare Advantage insurers' common law subrogation rights, by seventeen years.

Humana Med. Plan, Inc. v. W. Heritage Ins. Co., 880 F.3d 1284, 1286 (11th Cir. 2018). Eventually, we will hear from the Second Circuit and probably the United States Supreme Court on the issue, but it is currently unresolved. While it is true, as CDLA suggests, that collection companies like Rawlings assert lien rights against plaintiffs and sometimes liability insurers, that does not mean their claims are legally enforceable in Connecticut or anywhere in the Second Circuit. The claims are usually contested by

plaintiffs. Negotiated resolutions of the liens may occur, but none of this relates to the insurers' disclosure requirements under Medicare.

Medicare, through the Center for Medicare Services (CMS) has issued a form last updated in April 2018, that liability insurers are encouraged to use to gain the required information for reporting purposes.[1] The form begins by asking essentially the same question as contained in the proposed interrogatory: "Are you presently, or have you ever been, enrolled in Medicare Part A or B?" The form allows plaintiffs to refuse to provide the information for stated reasons, which are typically due privacy concerns and because they are not Medicare eligible and will not be eligible within 36 months. Answering yes to this question would encompass all MAO participants since they must first enroll in original Medicare to be eligible.
See, e.g., https://www.medicare.gov/pubs/pdf/11219-understanding-medicare-part-c-d.pdf at p. 2 ("You must have Medicare Part A and Part B to join a Medicare Advantage Plan").

The morass associated with the Part C plans' lien rights falls well beyond the liability insurers' disclosure requirements. If the Committee decides this additional form discovery is necessary, CTLA maintains that the Part C plans should not be part the proposed changes.

Thank you again for your consideration of our position.

Sincerely,

D. Lincoln Woodard

DLW:cmm

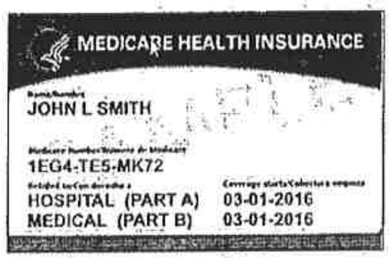
[1] https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Mandatory-Insurer-Reporting-For-Non-Group-Health-Plans/Overview.html; MMSEA 111 – MBI, SSN Collection – NGHP Model Language, attached.

The Centers for Medicare & Medicaid Services (CMS) is the federal agency that oversees the Medicare program. Many Medicare beneficiaries have other insurance in addition to their Medicare benefits. Sometimes, Medicare is supposed to pay after the other insurance. However, if certain other insurance delays payment, Medicare may make a "conditional payment" so as to not inconvenience the beneficiary, and then recover after the other insurance pays.

Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA), a federal law that became effective January 1, 2009, requires that liability insurers (including self-insurers), no-fault insurers, and workers' compensation plans report specific information about Medicare beneficiaries who have other insurance coverage. This reporting is to assist CMS and other insurance plans to properly coordinate payment of benefits among plans so that your claims are paid promptly and correctly.

We are asking you to answer the questions below so that we may comply with this law.

Please review this picture of the Medicare card to determine if you have, or have ever had, a similar Medicare card.



Section I

Are you presently, or have you ever been, enrolled in Medicare Part A or Part B?	☐ Yes	☐ No
If yes, please complete the following. If no, proceed to Section II.		
Full Name: (Please print the name exactly as it appears on your SSN or Medicare card if available.)		
Medicare Number:	**Date of Birth (Mo/Day/Year)** / /	
****Social Security Number:** (If Medicare Number is Unavailable) - -	**Sex** ☐ Female	☐ Male

** Note: If you are uncomfortable with providing your full Social Security Number (SSN), you have the option to provide the last 5 digits of your SSN in the section above.

Section II

I understand that the information requested is to assist the requesting insurance arrangement to accurately coordinate benefits with Medicare and to meet its mandatory reporting obligations under Medicare law.

Claimant Name (Please Print) _____ Medicare Number _____

Name of Person Completing This Form If Claimant is Unable (Please Print) _____

Signature of Person Completing This Form _____ Date _____

If you have completed Sections I and II above, stop here. If you are refusing to provide the information requested in Sections I and II, proceed to Section III.

Section III

Claimant Name (Please Print) _____ Medicare Number _____

For the reason(s) listed below, I have not provided the information requested. I understand that if I am a Medicare beneficiary and I do not provide the requested information, I may be violating obligations as a beneficiary to assist Medicare in coordinating benefits to pay my claims correctly and promptly.

Reason(s) for Refusal to Provide Requested Information:

_____

_____

_____

_____

Signature of Person Completing This Form _____ Date _____

5-2d.

CDLA

The Voice of Connecticut's Civil Defense Trial Lawyers

January 8, 2019

Joseph DelCampo
Director of Legal Services
Connecticut Judicial Branch
100 Washington Street, 3rd Floor
Hartford, CT 06106

RE: Proposed Rule §13-12A and New Form 217

Dear Mr. DelCampo:

The CDLA appreciates the invitation of the Rules Committee to provide input as to Proposed Rule §13-12A and New Form 217. In general, the CDLA is in favor of the changes proposed as it will alleviate some of the current cumbersome procedures that are required to obtain this necessary information. As the Rules Committee is probably aware, the Medicare reporting requirement noted in proposed Rule 13-12A is designed as part of the Medicare Secondary Payer statute to require a liability insurer, as a primary payer, to notify Medicare and Medicare Advantage Plans that a Medicare beneficiary is making a liability claim. Ultimately, should a beneficiary's claims against a liability insurer or insured reach settlement, all Medicare liens must be satisfied within sixty days of tendering settlement to the beneficiary. In seeking to recover an unpaid Medicare lien, the administrator of a Medicare plan can recover directly from the beneficiary, the defendant being sued by a beneficiary, or the defendant's liability insurer. A recent Connecticut Federal District Court decision has found that the lienholder can sue the defendant or the liability insurer—but not the plaintiff-beneficiary—for double damages if the lien is not timely satisfied. Aetna Life Ins. Co. v. Guerrera, 300 F. Supp. 3d 367, 383 (D. Conn. 2018). Accordingly, the defendant and liability insurer have a heightened interest in assuring the lien is timely satisfied. This interest is hampered significantly if early notice of a lien's existence is withheld.

We are grateful to the Rules Committee for their hard work in crafting the Proposed Rule and Form 217. We do, however, have a few proposed modifications and suggestions for consideration by the Rules Committee:

1. We ask that Form 217, Interrogatory 3(ii) include Medicare Part C plans as part of the request. The current wording of the proposed Form 217 would require the disclosure of Medicare Part A and Part B plans, but does not extend to Medicare Part C plans (also known as Medicare Advantage Plans). However, the Medicare Secondary Payer regime, which includes Medicare reporting obligations and related obligations to satisfy Medicare liens, applies equally to Part C plans. See Aetna Life Ins. Co. v. Guerrera, *supra*. By

omitting Part C from information in discovery, plaintiffs who are Part C beneficiaries and with liens asserted by the Part C secondary payor may, inadvertently or intentionally, not inquire of or use the absence of discovery requests as an excuse to avoid investigating the existence of Medicare Advantage Plan liens. Under such a scenario, a defendant's liability insurer could pay a settlement without the plaintiff-beneficiary's Medicare lien being satisfied, which is a requirement under the Medicare Secondary Payer rules. Based on a current interpretation of the Medicare Secondary Payer rules in Connecticut, the defendant and the liability insurer are potentially liable for the satisfaction of the plaintiff-beneficiary's obligations under such a lien. Moreover, the Medicare Advantage Plan, as lienholder, may have the right to recover double damages and steep interest costs from the defendant and liability insurer if the lien is not timely satisfied.

2. In the Proposed Rule, we ask that the word "pretrial" be added before the word "discovery:"

> In any civil action involving allegations of personal injury, information on the claimant's Medicare enrollment status, eligibility or payments received, which is sufficient to allow providers of liability insurance, including self-insurance, no fault insurance, and/or worker's compensation insurance to comply with the federally mandated reporting requirements imposed under 42 U.S.C. § 1395y (b) (8), shall be subject to pretrial discovery by any party by interrogatory as provided in Sections 13-6 through 13-8.

This addition is requested to avoid confusion as to whether this information may be disclosed after a verdict or during pretrial discovery.

3. In the last sentence of the Proposed rule, we ask that the sentence be amended as follows:

> Such information shall be used only for purposes of litigation and for complying with 42 U.S.C. §1395y (b) (8) and shall not be used or disclosed for any other purpose.

There are some circumstances where Medicare information may be admissible and/or may lead to the discovery of admissible evidence, and therefore, limiting the use of this information for only compliance with the federal regulation would seem unnecessarily prohibitive.

We appreciate consideration by the Rules Committee of these suggestions, and welcome questions or discussion as they deem necessary. We believe that amending Proposed Rule §13-12A and Form 217 as requested above is consistent with the stated intent of the proposed Practice Book § 13-12A, will avoid unnecessary disputes among litigants and reduce the need for court involvement.

Very Truly Yours,

CONNECTICUT DEFENSE LAWYERS ASSOCIATION

M. Karen Noble
President

cc: Jonathan Shapiro, President CBA
jshapiro@shapirolawofficesct.com

William Chapman, Government & Community Relations CBA
bchapman@ctbar.org

Lincoln Woodard, President CTLA
lwoodard@walshwoodard.com

5-2d.

CDLA

The Voice of Connecticut's Civil Defense Trial Lawyers

January 14, 2019

Joseph Del Ciampo
Director of Legal Services
Connecticut Judicial Branch
100 Washington Street, 3rd Floor
Hartford, CT 06106

RE: Proposed Practice Book §13-12A and New Form 217

Dear Mr. Del Ciampo:

We write to address certain contentions regarding Medicare Part C raised by the Connecticut Trial Lawyer's Association in their comments on proposed Practice Book §13-12A and Form 217; namely, the lien and subrogation rights of Medicare Advantage Organizations (MAO) and the law surrounding those liens in Connecticut. The reporting requirements are a means to achieving the ends of the Medicare Secondary Payer scheme; namely, reimbursement for conditional payments made by Medicare or the MAO. The proposed section 13-12A and Form 217 should be designed to help meet that overarching purpose, particularly in light of the expansive rights held by the MAO seeking recovery from a liability insurer. Moreover, including Part C information in the proposed revision would help ensure that settling entities can efficiently resolve any outstanding Medicare Advantage liens without seeking judicial intervention and without concern that they could be exposed to future actions by the MAO.

First, it is important to clarify the relationship between Medicare and the MAO. Contrary to the CTLA's assertion, an MAO offering Medicare Advantage plans carries the same rights of recovery and subrogation rights as Medicare. This has been recognized by no less than the Centers for Medicare and Medicaid Services (CMS), the Federal agency that administers Medicare. In a 2011 memorandum that CMS sent to MAOs, the agency formalized its position that its regulations under 42 CFR § 422.108 give "Medicare Advantage organizations (MAOs) and Prescription Drug Plan (PDP) sponsors the right, under existing Federal law, to collect for services for which Medicare is not the primary payer." (See Letter from The Rawlings Co. to defense counsel regarding subrogration rights arising from underlying tort action, attached as Exhibit A, at *6.) MAOs have embraced their full right of recovery and subrogation and are using that national regulatory guidance from CMS to put liability insurers on notice of possible action for any outstanding liens. (See, e.g., Exhibit A, at *1)

Second, these proposed changes will help to promote judicial economy. While some jurisdictions have adopted a minority position, precluding the private right of action, Connecticut has not, and liability insurers and their counsel work to protect their interests based on the

current state of the law. The law providing MAOs with a private right of action is very clear, as reflected by Judge Hall's decision in Aetna Life Ins. Co. v. Guerrera, 300 F. Supp. 3d 367 (D. Conn. 2018) and the decisions of numerous other Courts nationally. There is no contrary authority in Connecticut limiting the private right of action, and litigants and liability insurers in Connecticut must be expected to act accordingly.

Thank you again for providing us with the opportunity to comment on the proposed Practice Book §13-12A and New Form 217. We hope these letters have been of assistance to the Rules Committee and would be happy to add any additional comment, as requested.

Very Truly Yours,
CONNECTICUT DEFENSE LAWYERS ASSOCIATION

M. Karen Noble
President

cc: Jonathan Shapiro, President CBA
jshapiro@shapirolawofficesct.com

William Chapman, Government & Community Relations CBA
bchapman@ctbar.org

Lincoln Woodard, President CTLA
lwoodard@walshwoodard.com

The Rawlings Company LLC
Subrogation Division

Post Office Box 2000
LaGrange, Kentucky 40031-2000

One Eden Parkway
LaGrange, Kentucky 40031-8100

January 10, 2019

JAKE KOCIENDA
DANAHER LAGNESE, PC
CAPITAL PLACE 21 OAK STREET
Hartford, CT 06106

Re: Our Client: TUFTS Health Plan Medicare Preferred
Member/Patient: [redacted]
Date of Injury: [redacted]
Our Reference No.: 63505407

Dear Mr. KOCIENDA:

As you may know, the Center for Medicare and Medicaid Services ("CMS"), the agency charged with administering Medicare and Medicaid, released a 2011 Position Memorandum commenting upon the recovery rights of Medicare Advantage health plans. In regards to the above-referenced incident, Norman Miltimore was provided medical benefits from such a plan. Enclosed is a Memorandum from our legal department discussing CMS's position and court cases that have addressed Medicare Advantage health plan recovery rights. It is important that you, your client and/or insured, and the other parties involved in this matter understand the position of CMS and The Rawlings Company LLC as early as possible. Please contact me if you have any questions, and I look forward to working with you to resolve this case.

Sincerely,

Ken F. Charron | Subrogation Recovery Analyst
PH: 502-814-2672 | FAX: 502-753-7355
kfc@rawlingscompany.com

MEMORANDUM

FROM: The Rawlings Company, LLC

DATE: October 2016

RE: Recovery Rights of Medicare Advantage Organizations

The purpose of this document is to communicate the position of The Rawlings Company, LLC, after consultation with legal counsel, regarding the subrogation and reimbursement rights of Medicare Advantage organizations ("MAOs") under the Medicare Secondary Payer Act ("MSP Act"). As outlined in more detail below, the majority of courts that have reviewed this issue have held that (1) state laws limiting subrogation and reimbursement rights of MAOs are preempted under the Medicare Act, and (2) MAO's recovery rights under the MSP Act are identical to the recovery rights of traditional Medicare, including specifically the ability to pursue subrogation and reimbursement rights through a private cause of action.

1. Preemption:

42 U.S.C. § 1395w-26(b)(3)

Medicare Part C contains an express preemption provision: "[t]he standards established under [Part C] shall supersede any State law or regulation . . . with respect to MA plans which are offered by MA organizations under this part." *See also* 42 C.F.R. § 422.108(f).

***Meek-Horton v. Trover Solutions, Inc.*, 910 F. Supp. 2d 690 (S.D.N.Y. 2012)**

This matter involved a class action lawsuit against 40 Medicare Advantage plans alleging various violations of New York law by seeking and obtaining reimbursement out of the proceeds of settlements. Following *Potts v. The Rawlings Co., LLC*, the U.S. District Court for the Southern District of New York granted the defendants' motion to dismiss after determining that the basis of plaintiffs' claims—New York's anti-subrogation statute—was "expressly preempted by the 'plain wording' of federal law [42 U.S.C. § 1395w-26(b)(3), and 42 C.F.R. § 422.108(f)]", and dismissed the case. *Id.* at 696.

***Potts v. Rawlings Co., LLC*, 897 F. Supp. 2d 185 (S.D.N.Y. 2012)**

Three months prior to *Meek-Horton*, the U.S. District Court for the Southern District of New York held that New York's anti-subrogation statute (GOL § 5-335) was preempted by the Medicare Act: "to whatever extent the New York statute applies to Medicare or MA organizations, it is expressly preempted by the Medicare Act." *Id.* at 196. In reaching its conclusion, the court held that applicable statutory and regulatory preemption, exhaustion of remedies, and reimbursement provisions apply equally to traditional Medicare and MAOs. The court also distinguished the issue of whether a MAO has a private cause of action from the issue of preemption of state law: "given the broad express preemption clause in the Medicare Act, whether there is a private right of action for MA organizations is immaterial to the question whether GOL § 5-335 is preempted." *Id.*

***Trezza v. Trezza*, 104 A.D.3d 37 (N.Y. App. Div. 2d Dep't 2012)**

The New York Supreme Court, Appellate Division, held that New York's anti-subrogation statute, as applied to MAOs, was preempted by federal law because it restricted reimbursement rights provided by the Medicare Act and applicable regulations. In reversing the trial court's order extinguishing a MAO's reimbursement claim, the appellate court held that the express preemption provisions in 42 USC 1395w-26(b)(3) and as explained in 42 CFR 422.108(f), prohibited a state from limiting MAOs' ability to obtain reimbursement under the MSP Act.

2. **Private Cause of Action:**

***In re Avandia Mktg.*, 685 F.3d 353 (3d Cir. 2012)**

In *Avandia*, the U.S. Court of Appeals for the Third Circuit held that 42 U.S.C. § 1395y(b)(3)(A) provides MAOs with "a private cause of action for damages . . . placing no limitations upon which private (i.e., non-governmental) actors can bring suit for double damages when a primary payer plan fails to appropriately reimburse" the MAO. *Id.* at 359. The Third Circuit further held that even if 42 U.S.C. § 1395y(b)(3)(A) were deemed ambiguous in this regard, courts must to defer to CMS regulations—specifically 42 C.F.R. § 108—which states: "The MA organization will exercise the same rights to recover from a primary plan, entity, or individual that the Secretary exercises under the MSP regulations in subparts B through D or part 411 of this chapter." *Id.* at 365-66.

In addition to relying on statutory analysis and the CMS-issued regulations, the Third Circuit also used a December 5, 2011 memorandum issued by CMS—the federal agency that administers Medicare—to support its holding. The CMS memorandum reiterated that MAOs exercise the same recovery rights as traditional Medicare under the MSP Act, including preemption of state law under 42 C.F.R. § 422.108, and the ability to file a private cause of action in federal court.

Avandia is the first court of appeals decision to specifically analyze a MAO's recovery rights under the Medicare Secondary Payer Act, 42 U.S.C. § 1395y(b)(2). The Third Circuit distinguished prior cases—including *Care Choices HMO v. Engstrom*, and *Nott v. Aetna*—as those cases did not address the issue of whether a MAO could bring suit under the MSP private cause of action provision. *Id.* at 362.

In sum, pursuant to the *Avandia* decision, MAOs' recovery rights under the MSP Act are identical to the recovery rights of Medicare. Practically speaking, that means MAOs can pursue a claim directly against any source of benefits defined as primary under the statutes and regulations, even if it has already reimbursed the beneficiary. *See* 42 U.S.C. § 1395w-22(a)(4); 42 C.F.R. § 422.108(f). Additionally, by virtue of exercising the same rights to recover from a primary plan, entity, or individual that Medicare exercises under the MSP regulations, MAOs have a direct cause of action against any entity who made payment and any beneficiary or attorney who received payment and failed to reimburse the plan. *See* 42 C.F.R. § 411.24(g).

***Mich. Spine & Brain Surgeons, PLLC v. State Farm Mut. Auto. Ins. Co.*, 758 F.3d 787 (6th Cir. 2014)**

The U.S. Court of Appeals for the Sixth Circuit held that a provider could pursue a private cause of action under the Medicare Secondary Payer Act against an automobile no-fault carrier. Although this case involved a provider, the holding would justify a similar cause of action by a MAO, should a primary payer—whether it be a no-fault or liability carrier—refuse to reimburse the plan.

***Humana Medical Plan, Inc. v. W. Heritage Ins. Co.*, Case No. 15-11436, 2016 U.S. App. LEXIS 14509 (11th Cir. Aug. 8, 2016)**

The U.S. Court of Appeals for the 11th Circuit followed the 3rd Circuit in *Avandia* and held that a Medicare Advantage Organization had private cause of action to sue a primary payer third party carrier under the Medicare Secondary Payer Act, 42 U.S.C. § 1395y(b)(3)(A). The court held the Medicare Advantage plan's rights under the MSP Act included a mandatory right to claim double damages. The Court gave *Chevron* deference to CMS regulation 42 C.F.R. § 411.24(i)(1) which requires a primary payer like the tortfeasor's carrier in the present case to "reimburse Medicare even though it has already reimbursed the beneficiary or other party" if such beneficiary or party fails to reimburse Medicare within 60 days of receiving a primary payment from a carrier.

***MSP Recovery, LLC v. Allstate Ins. Co.*, 2016 U.S. App. LEXIS 15984 (11th Cir. August 30, 2016)**

The U.S. Court of Appeals for the 11th Circuit, following its decision in *Humana Medical Plan, Inc. v. W. Heritage Ins. Co.*, vacated and remanded seven district court opinions which held Medicare Advantage Organizations must demonstrate first party personal injury protection insurers' responsibility to pay primary to the MA plan through a state court action before bringing a claim in federal court under the Medicare Secondary Payer Act. Instead, the 11th Circuit held that demonstrating responsibility in a tort scenario with a third party primary payer was different than establishing primary payment responsibility in first party contracts between Medicare Advantage beneficiaries and the their auto carriers. The 11th Circuit held that the contract between a beneficiary and his or her auto insurer is enough to demonstrate responsibility to pay for purposes of maintaining a private cause of action under the MSP against PIP carriers.

***Collins v. Wellcare Healthcare Plans, Inc.*, 2014 U.S. Dist. LEXIS 174420 (E.D. La. Dec. 16, 2014)**

In *Collins*, the plaintiff received medical benefits from a MAO after being involved in an automobile accident. She obtained a settlement from the tortfeasor, which she deposited into a trust account, and then filed a declaratory judgment action in state court against the MAO, arguing that the MAO was not entitled to subrogation or reimbursement. The MAO removed the case to the U.S. District Court for the Eastern District of Louisiana, and filed a counterclaim against the plaintiff seeking to recover the benefits it incurred out of the plaintiff's settlement with the tortfeasor.

The district court dismissed the plaintiff's declaratory judgment action for lack of subject matter jurisdiction, as it inherently demanded an interpretation of the Medicare Act, even though it was fashioned as a state law claim. Claims that arise under the Medicare Act must exhaust their administrative remedies prior to judicial review under 42 U.S.C. § 405(h). *Id.* at *17.

The district court then granted the MAO's counterclaim, in part. Citing to *Avandia* and the CMS regulations in support, it held that an MAO could pursue a private cause of action in federal court against the plaintiff to obtain reimbursement out of the proceeds of her settlement under 42 U.S.C. § 1395y(b)(3)(A) ("There is established a private cause of action for damages. . .in the case of a primary plan which fails to provide for primary payment . . . ."). *Id.* at *30. The court reasoned there was "no real distinction between a claim against a tortfeasor or his insurer to obtain reimbursement and a claim against a beneficiary to obtain reimbursement from a settlement funded by a tortfeasor or his insurer" for the purposes of a MAO's cause of action under 42 U.S.C. § 1395y(b)(3)(A). *Id.* at *31.

***Humana Ins. Co. v. Farmers Tex. County Mut. Ins. Co.*, 2014 U.S. Dist. LEXIS 166654 (W.D. Tex. Sept. 24, 2014)**

In this matter, Humana – the MAO – made conditional payments to several enrollees who were injured as a result of an automobile accident. Each individual also had an automobile insurance policy with Farmers, who the MAO argued was the primary payer. Farmers refused the MAO's request for reimbursement, and the MAO filed suit in the U.S. District Court for the Western District of Texas. In response, Farmers filed a motion to dismiss, arguing that a MAO did not have a private cause of action under the MSP Act. The district court agreed with the Third Circuit's analysis in *Avandia*, and denied Farmer's motion to dismiss, finding that "any private plaintiff with standing may bring an action [under 42 U.S.C. 1395(b)(3)(A)]." *Id.* at *4.

***Humana Ins. Co. v. Paris Blank, LLP*, 2015 U.S. Dist. LEXIS 61814 (E.D. Va. May 10, 2016)**

Addressing MAO recovery rights for the first time in the 4th Circuit, the U.S. District Court for the Eastern District of Virginia held MAOs have a private cause of action under the MSP statute. The Court adopted the reasoning of the 3rd Circuit in *Avandia*. The MSP statute is "broad and unambiguous" and places "no limitations upon which private (i.e., non-governmental) actors can bring suit for double damages when a primary plan fails to appropriately reimburse any secondary payer." Like in *Avandia*, the Court held that even if the statute had been construed to be ambiguous, the CMS regulations reiterating these rights would be given *Chevron* deference. Again relying on *Avandia*'s reasoning, the Court went on to hold that the MSP private cause of action permitted MAOs to pursue members' attorneys and their law firms.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicare
7500 Security Boulevard, Mail Stop C4-21-26
Baltimore, Maryland 21244-1850

CENTER FOR MEDICARE

DATE: December 5, 2011

TO: Medicare Advantage Organizations and Prescription Drug Plan Sponsors

FROM: Danielle R. Moon, J.D., M.P.A.
Director, Medicare Drug & Health Plan Contract Administration Group

Cynthia Tudor, Ph.D.
Director, Medicare Drug Benefit and C&D Data Group

SUBJECT: Medicare Secondary Payment Subrogation Rights

The purpose of this memorandum is to summarize and convey our support for our regulations giving Medicare Advantage organizations (MAOs) and Prescription Drug Plan (PDP) sponsors the right, under existing Federal law, to collect for services for which Medicare is not the primary payer. In recent decisions, several courts have challenged Federal regulations governing these collections. Specifically, several MAOs have not been able to take private action to collect for Medicare Secondary Payer (MSP) services under Federal law because they have been limited to seeking remedy in State court.

CMS regulations at 42 CFR § 422.108 describes MSP procedures for MAOs to follow when billing for covered Medicare services for which Medicare is not the primary payer. These regulations also assign the right (and responsibility) to collect for these services to MAOs. Specifically, §422.108(f) stipulates that MAOs will exercise the same rights of recovery that the Secretary exercises under the Original Medicare MSP regulations in subparts B through D of part 411 of 42 CFR and that the rules established in this section supersede any State laws. Additionally, the MSP regulations at 42 CFR §422.108 are extended to Prescription Drug Plan (PDP) sponsors at 42 CFR §423.462. Accordingly, PDP sponsors have the same MSP rights and responsibilities as MAOs.

Notwithstanding these recent court decisions, CMS maintains that the existing MSP regulations are legally valid and an integral part of the Medicare Part C and D programs.

5-2 e.

Del Ciampo, Joseph

From: Abrams, James
Sent: Monday, December 31, 2018 2:16 PM
To: Del Ciampo, Joseph
Cc: Stevens, Barry; Bellis, Barbara
Subject: RE: Referral from the Rules Committee

Follow Up Flag: Follow up
Flag Status: Flagged

Joe,

First, allow me to express enthusiastic support for adding the Rule and the Form Interrogatory. Based on my review of the materials you provided, with an able assist from Judge Pierson, what follows are my specific comments;

Proposed Rule:

A little wordsmithing on the second to last line, which I find a bit confusing:

"Information disclosed shall not be admissible in evidence at trial solely by virtue of its disclosure pursuant to this section."

Form Interrogatory

My concerns are limited to clarity issues involving Interrogatory 2. First, I suggest separating 2 and 2(a) into separate interrogatories; essentially making subsection (a) Interrogatory 3. Second, I suggest reversing the order of subsections (iv) and (v). I would also change (iv) to read: ""The amount of any payments made" and insert the word "Whether" at the beginning of (v). As a result, that part of the Form Interrogatory would now read as follows:

(2) State whether you have been enrolled in Medicare Part A or Part B.

(3) If your response to Interrogatory 2 is in the affirmative, state:

- *(i) The effective date(s) of coverage;*
- *(ii) Your Medicare claim number(s);*
- *(iii) Your name (exactly as it appears on your Medicare card);*
- *(iv) Whether Medicare Part or Part B has paid any bills for treatment of any injuries allegedly sustained as a result of the incident alleged in the complaint; and*
- *(v) The amount of any such payments.*

(4) If you are not presently . . .

Thank you for the opportunity to comment.

Jim Abrams

From: Del Ciampo, Joseph
Sent: Monday, December 17, 2018 5:09 PM
To: Abrams, James

Cc: Stevens, Barry; Bellis, Barbara
Subject: Referral from the Rules Committee

Dear Judge Abrams,

The Rules Committee of the Superior Court is considering the attached new rule and standard interrogatories regarding Medicare information. The Rules Committee has asked that you review and comment on the proposed new rule and form. The Committee has also requested comments on the rule and form from the CBA, CTLA, and CDLA.

The next meeting during which the Rules Committee may discuss the merits of this matter is scheduled for Monday, January 14, 2019. It would be appreciated if you would send any comments you have on the attached rule and form to me by January 7, 2019.

Thank you very much.

Joseph J. Del Ciampo
Director of Legal Services
Connecticut Judicial Branch
100 Washington Street, 3rd Floor
Hartford, CT 06106

e-mail: Joseph.DelCiampo@jud.ct.gov

Tel: (860) 706-5120
Fax: (860) 566-3449