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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. Actna Life Ins. Co. v. Guerrero, 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 Actna Life Ins. Co. v. Guerrero, 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



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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 subrogation 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. Guerrero, 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



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The
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January 10, 2019

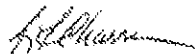
JAKE KOCIENDA
DANAHER LAGNESE, PC
CAPITAL PLACE 21 OAK STREET
Hartford, CT 06106

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
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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 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 21244-1830



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.