UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF NORTH CAROLINA

CATHY MONROE SIMS,

Plaintiffs,

vs.

THE PMA INSURANCE COMPANY d/b/a
THE PMA INSURANCE GROUP,

Defendant.

INDEX NO. _______

COMPLAINT

Plaintiff Cathy Monroe Sims, individually and on behalf of all persons similarly situated, alleges:

INTRODUCTORY STATEMENT

1. Medicare provides federal healthcare funds for three groups of individuals: (1) the aged, (2) the disabled, and (3) persons with end stage renal disease. Many Medicare recipients are also covered by private health care plans and, as relevant to this case, workers' compensation for workplace injuries and occupational diseases. Prior to 1981, Medicare generally acted as the "primary" payer in situations where there was double coverage for the Medicare recipient – in other words, Medicare paid for Medicare beneficiaries' medical expenses even when the beneficiaries carried other insurance that covered the same expenses.

2. In 1980, however, in the face of skyrocketing Medicare costs, Congress passed the Medicare Secondary Payer Act (the "MSPA"), intending to reduce federal spending and to protect the financial wellbeing of the Medicare program by making Medicare coverage "secondary" to any private coverage. Congress designed the MSPA to ensure that medical costs more properly paid by primary insurance and private plans are not shifted to Medicare, which is

now a secondary payer. Despite this legislation, Defendant and other insurers have failed to comply with the law and have continued to shift workers' compensation medical expenses to Medicare and federal taxpayers.

3. In this case, on June 6, 2011, Plaintiff, a certified nursing assistant, was working in a nursing home for her employer Century Care Management when she seriously injured her back while attempting to move a patient.

4. When Defendant refused to pay for some of the medical care Plaintiff received for her injury, Medicare paid the health care providers. Subsequently, after the North Carolina Industrial Commission ruled that Defendant was required to pay for that care, Defendant failed to reimburse Medicare, choosing instead to allow the cost for that care to be shifted to federal taxpayers.

5. One of the mechanisms Congress enacted to prevent such cost-shifting was a private right of action allowing Medicare beneficiaries to sue for double damages when an insurer like Defendant has failed to timely reimburse Medicare for payments Medicare made that were actually the primary responsibility of the insurer. Plaintiff brings this class action pursuant to the private right of action authorized by Congress to ensure that Defendant complies with its statutorily-mandated responsibilities and ceases to work to maximize its profits by wrongfully shifting costs to Medicare.

PARTIES

6. Plaintiff Cathy Monroe Sims resides in Marston, North Carolina.

7. The PMA Insurance Company d/b/a as the PMA Insurance Group is a subsidiary of The PMA Companies, Inc. and is organized under the laws of Pennsylvania with its headquarters in Blue Bell, Pennsylvania.

8. Defendant was the carrier and administrator responsible for Plaintiff's compensable workers' compensation injury and was the primary payer within the meaning of the MSPA with respect to Plaintiff's injury.

JURISDICTION AND VENUE

9. This Court has federal question jurisdiction over this action under 28 U.S.C. § 1331 and 42 U.S.C. § 1395y(b)(3)(A).

10. Venue is proper in this District because Plaintiff is located in this District.

FACTUAL ALLEGATIONS

A. Statutory Background

11. The MSPA prohibits Medicare from paying for medical expenses if "payment has been made or can reasonably be expected to be made *under a workmen's compensation law or plan* of the United States or a State or under an automobile or liability insurance policy or plan (including a self-insured plan) or under no fault insurance." 42 U.S.C. § 1395y(b)(2)(A)(ii) (emphasis added). If, however, a primary payer "has not made or cannot reasonably be expected to make payment with respect to the item or service promptly," then Medicare may make a payment on the Medicare beneficiary's behalf, *conditioned on* reimbursement from the primary payer. *Id.* § 1395y(b)(2)(B)(i) (emphasis added).

12. Although under the MSPA workers' compensation policies and plans are primarily responsible for payment of medical expenses incurred for workplace injuries covered by workers' compensation, Medicare will conditionally pay for medical expenses when a workers' compensation claim is denied or when a primary payer does not pay a medical expense promptly. *See* 42 U.S.C. § 1395y(b)(2)(i); 42 C.F.R. § 411.21. As the Center for Medicare and Medicaid Services ("CMS") has explained: "A conditional payment is a payment Medicare

makes for services another payer may be responsible for. Medicare makes this conditional payment so that the beneficiary won't have to use his own money to pay the bill. The payment is 'conditional' because it must be repaid to Medicare when a settlement, judgment, award or other payment is made."[1]

13. In 1986, in a further attempt to ensure that health costs would not be shifted from primary payers to Medicare, Congress amended the MSPA to grant Medicare beneficiaries and others a "private cause of action for damages (which shall be in an amount double the amount otherwise provided) in the case of a primary plan" that fails to reimburse Medicare for its conditional payments. Omnibus Rec. Act of 1986, Pub. L. No. 99-509, 100 Stat. 1874 (codified at 42 U.S.C. § 1395y(b)(3)(A)).

14. However, in 2015, the Occupational Safety & Health Administration issued a report finding that, despite the MSPA and the enactment of a private right of action, "through Medicare and Medicaid alone, taxpayers pay almost 19 percent of the medical costs of [occupational injuries and illnesses]." See D. Michaels, PhD, MPH, "Adding Inequality to Injury: The Costs of Failing to Protect Workers on the Job," OSHA p. 10 (June 2015).[2] The National Safety Council has estimated that medical expenses for workers' compensation injuries totaled $34.3 billion in 2017.[3] These two reports suggest that more than $6 billion in work-related medical costs are being shifted to Medicare and Medicaid each year.

15. Primary payers in workers' compensation cases, such as Defendant, have historically had a practice of attempting to shift to Medicare the cost of medical care for

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[1] *See* https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Medicare-Secondary-Payer/Medicare-Secondary-Payer.html.

[2] Published at https://www.osha.gov/Publications/inequality_michaels_june2015.pdf.

[3] *See* https://injuryfacts.nsc.org/work/costs/work-injury-costs/.

Medicare beneficiaries. Rather than act as a primary payer and pay medical expenses as they come due, insurers and third party administrators can refuse to pay certain medical expenses or they can just delay paying the health care providers with the result that Medicare will then go ahead and conditionally pay the medical bills. Then, the insurers and administrators will often either wait until the settlement of the case and at that point reimburse Medicare for its conditional payments or they make no attempt to reimburse Medicare at all.

16. The workers' compensation primary payers have a strong incentive to reimburse Medicare instead of paying medical expenses as they are incurred. Rather than pay the fully-billed amount for the medical expenses, primary payers can, through the reimbursement strategy, pay medical expenses based on the Medicare fee schedule as opposed to the higher fee schedules set by state workers' compensation systems. And, if Medicare makes no demand for reimbursement, the primary payers can avoid paying medical expenses at all.

17. Primary payers can avoid or at least delay receiving any demand from Medicare by failing to properly comply with statutory reporting requirements that require primary payers to notify Medicare of their responsibility for ongoing medical expenses.

B. <u>Defendant's Failure to Comply with the MSPA</u>

18. In 2011, Plaintiff was employed as a certified nursing assistant by Century Care Management and was working in a nursing home in North Carolina. On June 16, 2011, Plaintiff was attempting to move a patient when she sustained an injury to her lower back.

19. Defendant was the insurance company bearing the risk and providing insurance coverage for workers' compensation claims for Century Care Management during the period of time in which Plaintiff's workers' compensation claim arose.

20. Initially, Defendant failed to accept or deny Plaintiff's claim, although on January 13, 2012, it filed an N.C. Industrial Commission Form 63, which stated that Defendant would pay Plaintiff's medical expenses connected with her work-related injury without prejudice to denying the compensability of Plaintiff's workers' compensation claim. This form was signed by Jackie Holland, a Senior Account Claims Representative.

21. On September 11, 2012, Plaintiff filed a motion to compel Defendant to either accept or deny Plaintiff's workers' compensation claim, as statutorily required. Two days later, Defendant signed a Form 60 in which Defendant admitted Plaintiff's right to compensation for her injury that occurred on June 16, 2011. This Form 60 was also signed by Ms. Holland, the Senior Account Claims Representative. Under North Carolina law, a Form 60 is the equivalent of an award entered by the North Carolina Industrial Commission. N.C. Gen. Stat. § 97-82(b).

22. Plaintiff was found disabled for purposes of Social Security Disability Insurance on September 1, 2011. She became eligible to receive Medicare on February 1, 2014.

23. Subsequently, Defendant refused to pay for treatment that Plaintiff needed for her back injury, forcing Plaintiff to file a motion to compel Defendant to provide that treatment. Because of Defendant's refusal to pay for her medical treatment, Medicare was required to pay for it.

24. On May 15, 2015, the Full Commission of the North Carolina Industrial Commission entered an Opinion and Award finding that Plaintiff had sustained a compensable injury by accident to her back on June 16, 2011 and that Defendant had accepted it by a Form 60. The Full Commission concluded that Plaintiff was entitled to "ongoing [medical] care, related to her back injury and that said care is causally related to her workplace accident of 16 June 2011." The Full Commission further concluded that Defendant had failed to meet its burden of proving

that the treatment Plaintiff was requesting was not related to her compensable workers' compensation claim. The Full Commission therefore ordered Defendant to provide treatment for Plaintiff's back as recommended by her treating physician. Defendant did not appeal the Full Commission's Opinion and Award and the time to appeal has long since passed.

25. Upon information and belief, Defendant failed to notify the Center for Medicare and Medicaid Services ("CMS") of its responsibility for Plaintiff's medical expenses arising out of her compensable workers' compensation injury as established by their Form 60 and the Industrial Commission's May 15, 2015 Opinion and Award. On July 16, 2015, Plaintiff's workers' compensation attorney sent CMS a copy of the Opinion and Award and notified CMS that Defendant was the carrier responsible for Plaintiff's medical treatment arising out of her workers' compensation injury. On August 18, 2015, Plaintiff's workers' compensation attorney again sent the Opinion and Award to CMS notifying it that Defendant was liable for Plaintiff's treatment after March 20, 2013.

26. On August 11, 2015 and September 3, 2015, CMS issued conditional payment letters showing the conditional payments due by Defendant. CMS sent the letters to Manufacturers Alliance Insurance Company ("MAICO"), a sister company of Defendant. Upon information and belief, Defendant received copies of those letters.

27. The September 3, 2015 letter stated: "As of the date of this letter, Medicare has identified $2,391.39 in conditional payments that we believe are associated with your claim, based upon the available information. You/your attorney will find a listing of claims that comprise this total as an attachment to this letter. Please review this listing and inform us if you/your attorney disagree with the inclusion of any claim, along with an explanation of why

you/your attorney disagree." Upon information and belief, Defendant neither repaid the conditional payments nor challenged any of the conditional payment claims.

28. On November 17, 2016 and November 21, 2016, Plaintiff's attorney asked Defendant's workers' compensation attorney why Medicare was still having to pay for Plaintiff's medical treatment after the Full Commission's Opinion and Award. He received no response.

29. On March 7, 2017, Plaintiff's workers' compensation attorney, after discovering on the Medicare Secondary Payer internet portal that Defendant still had not reimbursed Medicare for the conditional payments, emailed Defendant's workers' compensation attorney. He emphasized to Defendant's counsel that Defendant had the obligation to prove that the conditional payments were not owed and noted that "Plaintiff's only involvement will be through 42 U.S.C. § 1395y(b)(3)(A)" – the statutory provision authorizing Medicare beneficiaries to sue carriers for double damages.

30. On March 15, 2017, CMS issued another conditional payment letter showing that Defendant owed $6,166.31 in conditional payments. On March 21, 2017, Plaintiff's attorney emailed the conditional payment letter to Defendant's workers' compensation attorney who said he would transmit the letter to Defendant.

31. The March 15, 2017 conditional payment letter notified Defendant: "Medicare has identified a claim or number of claims for which you have primary payment responsibility and Medicare has made primary payment. Medicare must recover these payments from the entity responsible for payment or when payment has been made, from the entity/individual who has received payment for those claims (see 42 U.S.C. 1395y(b)(2)). As of the date of this letter, based upon the information available, Medicare has identified $6,166.31 in conditional payments . . . . Please be advised, this case file is still being investigated to obtain any other outstanding

Medicare conditional payments; therefore, the enclosed listing of current conditional payments is not final. If you believe the enclosed itemization of conditional payments is incomplete, inaccurate, or that you are not responsible for repaying Medicare for these payments, please provide documentation along with an explanation to support your dispute. Please include a description of the illness/injury with your response."

32. Defendant did not immediately respond to the March 15, 2017 letter and did not reimburse Medicare for the conditional payments.

33. On March 1, 2018, CMS sent Plaintiff a letter indicating that a conditional payment claim dispute had been submitted. The letter stated that CMS' Benefits Coordination & Recovery Center had received a request for claims to be removed or added with respect to the conditional payments associated with Plaintiff's workers' compensation injury. CMS had partially agreed with the dispute and adjusted the amount due. Because also on March 1, 2018, CMS sent a new conditional payment letter stating that $4,779.73 in conditional payments were due – a figure less than in the prior conditional payment letter – it appeared that CMS had removed some claims in response to the claim dispute.

34. On March 8, 2018, Plaintiff's workers' compensation attorney sent Defendant's workers' compensation attorney a copy of the March 1, 2018 conditional payment letter. That letter stated: "If you believe the enclosed itemization of conditional payments is incomplete, inaccurate, or that you are not responsible for repaying Medicare for these payments, please provide documentation along with an explanation to support your dispute. Please include a description of the illness/injury with your response."

35. Defendant has not reimbursed Medicare for the $4,779.73 in conditional payments that are due.

36. Plaintiff has found no indication that Defendant has notified Medicare with respect to the March 1, 2018 conditional payment letter of any dispute that it has with the charges or that it has made any attempt to administratively challenge Medicare's determination that the payments set out in the letter are conditional payments for which Defendant must reimburse Medicare. Because Plaintiff's workers' compensation case has not settled and is still open, Plaintiff believes that there may be additional payments by Medicare for which Defendant is responsible, as Medicare suggested in its conditional payment letter. Defendant has not, however, contacted Plaintiff and does not appear to have contacted Medicare to determine whether there are additional charges.

37. CMS has not sent a final demand letter.

38. Defendant does not have in place policies and procedures that ensure it properly notifies Medicare when it has become a primary payer with respect to workers' compensation cases and that it timely and fully reimburses Medicare for any conditional payments it makes in workers' compensation cases once Defendant has demonstrated responsibility for ongoing medical expenses in a workers' compensation case.

39. By failing to reimburse Medicare for conditional payments Medicare made, Defendant has shifted the cost of medical expenses for workplace injuries and diseases to Medicare and federal taxpayers even though Defendant, under state workers' compensation systems and according to the MSPA, has primary and full responsibility for those expenses. Additionally, Defendant has (a) subjected Plaintiff and the Class members to co-payments and other out-of-pocket expenses under the Medicare system that would not have been owed under the workers' compensation system, and (b) forced medical providers to accept lesser payments

through the Medicare system than the amounts otherwise payable by Defendant under state workers' compensation systems.

CLASS ACTION ALLEGATIONS

40. Plaintiff brings this action on behalf of herself and as a class action pursuant to Federal Rules of Civil Procedure, Rule 23 (a) and (b)(3), on behalf of a similarly situated Class, which is defined as follows:

> A class of all individuals who have incurred medical expenses as a result of an injury or an occupational disease covered by workers' compensation that were conditionally paid by Medicare and (a) for which Defendant has a demonstrated responsibility established at least 135 days prior to the filing of this lawsuit by virtue of a final judgment or award of a state workers' compensation tribunal, a binding admission of responsibility for medical expenses, or a settlement agreement and (b) for which Defendant has not prior to the filing of this lawsuit reimbursed Medicare or formally administratively challenged its responsibility for those conditional payments.

41. Plaintiff believes that there are numerous Class members located throughout the United States, the exact number and their identities being known by Defendant, making the Class so numerous and geographically dispersed that joinder of all members is impracticable.

42. There are questions of law and fact raised by the named Plaintiff's claims common to those raised by the Class she seeks to represent. Such common questions predominate over questions affecting only individual members of the Class.

43. Plaintiff's claims are typical of the claims of the Class members, and Plaintiff will fairly and adequately protect the interests of the Class. Plaintiff and all members of the Class are similarly affected by Defendant's wrongful conduct in violation of the MSPA, and Plaintiff's claims arise out of the same common course of conduct giving rise to the claims of the other Class members. Plaintiff's interests are coincident with, and not antagonistic to, those of the other Class members.

44. Plaintiff's counsel is unaware of any conflicts of interest between the Class representative and absent Class members with respect to the matters at issue in this litigation. The Class representative will vigorously prosecute the suit on behalf of the Class.

45. Plaintiff is represented by counsel who have substantial experience in complex and class action litigation, including litigation of claims under the MSPA. Plaintiff's attorneys have committed sufficient resources to vigorously represent the Class.

46. The maintenance of the action as a class action will be superior to other available methods of adjudication and will promote the convenient administration of justice. Moreover, the prosecution of separate actions by individual members of the Class could result in inconsistent or varying adjudications with respect to individual members of the Class.

47. Defendant has acted or failed to act on grounds generally applicable to Class members, necessitating declaratory and injunctive relief for the Class.

CLAIM FOR RELIEF

48. Plaintiff repeats and realleges the allegations set forth in the preceding paragraphs as if fully restated here.

49. Medicare made conditional payments on behalf of Plaintiff and the Class members for injuries and occupational diseases covered by workers' compensation.

50. Defendant is a primary plan or payer under the MSPA with respect to conditional payments made by Medicare on behalf of Plaintiff and the Class for medical expenses that should have been covered by workers' compensation because Defendant provided workers' compensation insurance coverage to Plaintiff's and the Class members' employers.

51. By virtue of a judgment, award, formal admission of responsibility, or settlement agreement, Defendant has a demonstrated responsibility under 42 U.S.C. § 1395y(b)(2)(B)(ii)

and 42 C.F.R. § 411.22 to reimburse Medicare for conditional payments made on behalf of Plaintiff and the Class Members.

52. Defendant has failed to reimburse Medicare for conditional payments Medicare made on behalf of Plaintiff and the Class members even though the medical expenses were ones for which Defendant should have made primary payments or were expenses with respect to which Defendant has failed to exhaust its administrative remedies.

53. Defendant is, therefore, liable under 42 U.S.C. § 1395(b)(3)(A) for double damages.

PRAYER FOR RELIEF

WHEREFORE, Plaintiff respectfully requests the following relief from the Court:

1. An order certifying this action as a class action and appointing Plaintiff's counsel to serve as Class Counsel;
2. Double damages under 42 U.S.C. § 1395(b)(3)(A);
3. Statutory and common law interest;
4. Injunctive relief requiring Defendant in the future (a) to comply with the MSPA, (b) to promptly reimburse Medicare for any conditional payments upon demonstration of its responsibility under the MSPA for medical expenses incurred in workers' compensation cases, and (c) to promptly begin paying all medical expenses due when billed by medical providers;
5. An award of reasonable attorneys' fees and litigation expenses; and
6. Such other and further relief as the Court deems just and proper.

DEMAND FOR JURY TRIAL

Plaintiff hereby requests a jury trial, pursuant to Federal Rule of Civil Procedure 38, on any and all issues so triable.

Click here to enter a date.

Respectfully submitted,

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