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KAISER FOUNDATION HEALTH
PLAN, INC.

IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF HAWAI'I

KAISER FOUNDATION HEALTH PLAN, INC.,

Plaintiff,

vs.

ISLAND INSURANCE COMPANY, LIMITED,

Defendant.

Civil No. CV13 00511 RLP

COMPLAINT; EXHIBIT "A"; SUMMONS

COMPLAINT

Plaintiff KAISER FOUNDATION HEALTH PLAN, INC. ("Kaiser") brings this action for recovery of benefits extended to a Medicare Advantage Enrollee for which the Defendant, ISLAND INSURANCE COMPANY, LIMITED is a primary payer, pursuant to the Medicare Secondary Payer ("MSP") law, 42 U.S.C § 1395y(b).

OVERVIEW

1. Kaiser is a Medicare Advantage Organization ("MAO"). *See* "Evidence of Coverage" attached hereto as Exhibit A.

2. As an authorized MAO, Kaiser provides Medicare benefits to beneficiaries who elect to enroll in Kaiser's Medicare Advantage ("MA") plans. *See* 42 U.S.C § 1395w-22(a).

3. On information and belief, Kaiser alleges that Defendant Island Insurance Company, Limited provided liability insurance to Chong Hon Kim and Peppa's Korean BBQ at all relevant times between January 1, 2010 and the date this Complaint was filed herein.

4. The Medicare Secondary Payer ("MSP") law, 42 U.S.C. § 1395y(b), makes payments under Title XVIII of the Social Security Act, *i.e.*, under Medicare, "secondary" to liability insurance, meaning that Medicare pays after other available insurance coverage pays (the "primary" coverage).

5. Defendant's liability insurance policy is, as a matter of federal law, "primary," and the benefits under Kaiser's MA plan are "secondary" in situations where Defendant's liability insurance policy and Medicare benefits under an MA plan would otherwise both be available to pay an MA enrollee's medical expenses.

6. If an MA enrollee incurs medical expenses in circumstances in which liability insurance is primary, the MAO has a private cause of action for damages (which shall be in an amount double the amount otherwise provided) in the event the primary payer, *i.e.*, the liability insurer, fails to

provide for primary payment or appropriate reimbursement to the MAO. *See* 42 U.S.C. § 1395y(b)(3)(A).

7. Kaiser brings this action seeking:

(a) Pursuant to 28 U.S.C. § 2201(a), a declaratory judgment that:

i. To the extent Defendant is liable on behalf of its insured for payment of medical expenses covered by Medicare provided to Kaiser's Medicare enrollee, the liability or similar first party coverage issued by Defendant is primary to Medicare, including Medicare benefits provided and/or advanced by Kaiser in its capacity as an MAO;

ii. To the extent Kaiser has provided and/or advanced Medicare benefits to its Medicare enrollee under circumstances in which the coverage afforded by Kaiser's MA plan is secondary to liability coverage or similar first party coverage provided by Defendant pursuant to 42 U.S.C. § 1395y(b)(2) and § 1395w-22(a)(4), then Defendant is obligated to make appropriate reimbursement to Kaiser.

(b) Pursuant to 42 U.S.C.§ 1395y(b)(3)(A), recovery of double damages from Defendant for Defendant's failure to pay as primary or to make appropriate reimbursement to Kaiser; or alternatively,

(c) Pursuant to 42 U.S.C. § 1395w-22(a)(4), recovery from Defendant of charges for the items and services Kaiser's enrollee obtained from

Kaiser or for which Kaiser has advanced payment and for which Defendant's coverage was the primary plan and Defendant the primary payer; and

(d) Restitution to avoid Defendant being unjustly enriched by Kaiser's provision of and/or payment for Medicare benefits for which the liability coverage provided by Defendant was the primary plan under the MSP law.

8. Kaiser files this Complaint based upon its knowledge as to facts pertaining to itself and upon information and belief as to other matters.

PARTIES

9. Kaiser is a California non-profit corporation which is authorized to do business in Hawai'i as a Health Maintenance Organization ("HMO") under Hawai'i Revised Statutes chapter 432D, and has its principal place of business in Hawai'i at 711 Kapi`olani Blvd., Honolulu, Hawai'i 96813.

10. Defendant is an insurer licensed to sell, among other things, property, liability and casualty insurance in Hawai'i, with its principal place of business located at 1022 Bethel Street, Honolulu, Hawai'i 96813.

JURISDICTION AND VENUE

11. This action arises under the laws of the United States and involves a federal question. The Court therefore has jurisdiction over the subject-matter of this action under 28 U.S.C. § 1331.

12. Venue is proper in this Court pursuant to 28 U.S.C. § 1391(b) and (c).

THE MEDICARE PROGRAM

13. Medicare is a system of federally funded health insurance for people 65 and older, certain disabled persons, and persons with End Stage Renal Disease. Congress enacted the Medicare Program as Title XVIII of the Social Security Act ("Medicare Act"). 42 U.S.C. § 1395, *et seq.* Medicare is an enormous and complex federal program. As of 2012, Medicare insured over 50 million Americans, including 42.1 million individuals aged 65 and older, and 8.5 million disabled, with total expenditures of $574.2 billion.

14. The Secretary ("Secretary") of the U.S. Department of Health and Human Services ("HHS") is the federal officer responsible for administration of the Medicare program. *See* 42 U.S.C. § 1395hh(a)(1) and § 1395kk(a). Medicare Parts A and B comprise the traditional, fee-for-service, government-administered Medicare ("Original Medicare"). Medicare Part C creates a program now known as Medicare Advantage, which allows for the creation of MA plans such as Kaiser's.[1] The Secretary regulates the Medicare Part C program in great detail through regulations, the Medicare manuals and other sub-regulatory guidance. For most purposes, the Secretary has delegated authority over the Medicare program to a subunit of HHS, the Centers for Medicare and Medicaid Services ("CMS").

[1] Medicare Part C contractors are allowed somewhat more flexibility than exists under Parts A and B, but are required to compete against each other and to assume a certain amount of financial risk. *See* 42 U.S.C. §§ 1395w-21 to 1395w-29.

15. CMS in turn frequently acts through contractors. By law, "[t]he Secretary may perform any of his functions under this subchapter directly, or by contract providing for payment in advance or by way of reimbursement, and in such installments, as the Secretary may deem necessary." *See* 42 U.S.C. § 1395kk(a). Importantly, the Secretary (through CMS) contracts with MAOs, 42 U.S.C. § 1395w-27, and pays them "in advance." *See* 42 U.S.C. § 1395w-23(a)(1)(A). Thus, the Secretary (through CMS) may perform any of her functions under Medicare Part C "directly" or "by contract" through contractors, including MAOs.

16. In the context of the Medicare Advantage or Medicare Part C program, the Secretary (through CMS) contracts with and delegates to MAOs the right and responsibility to collect from primary payers using the same procedures as in the Original Medicare fee-for-service option. *See* 42 C.F.R. § 422.108(f); CMS, Memorandum: Medicare Secondary Payment Subrogation Rights (Dec. 5, 2011).[2]

17. Congress enacted Medicare Part C in the hope that it would lead to a more efficient and less expensive Medicare program. *See, e.g.,* H.R. Rep. No. 105-217, at 585 (1997) (Conf. Rep.) (stating that MA program was intended to "enable the Medicare program to utilize innovations that have helped the private market contain costs and expand health care delivery options").

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[2] http://www.cms.gov/Medicare/Health-Plans/HealthPlansGenInfo/downloads/21_MedicareSecondaryPayment.pdf

18. The Medicare Act guarantees eligible Medicare beneficiaries the right to elect to receive Medicare benefits either through the Original Medicare fee-for-service program option or through an MA plan. *See* 42 U.S.C. § 1395w-21(a). About 27% of Medicare beneficiaries chose to enroll in MA plans in 2012.

19. The funds for MA benefits come from the Medicare Trust Funds. *See* 42 U.S.C. § 1395w-23(f). The Medicare Trust Funds expended approximately $123.6 billion to provide Parts A and B Medicare benefits through the MA program in 2011, and expended approximately $137 billion to provide Parts A and B Medicare benefits through the MA program in 2012.

20. The Conference Committee which finalized the legislation that became Medicare Part C reported:

> The Conferees believe that the Medicare+Choice [now referred to as MA] program will continue to grow and eventually eclipse original fee-for-service Medicare as the predominant form of enrollment under the Medicare program. Under original fee-for-service, the Federal government alone set legislative requirements regarding reimbursement, covered providers, covered benefits and services, and mechanisms for resolving coverage disputes. Therefore, the Conferees intend that this legislation provide a clear statement extending the same treatment to private [MA] plans providing Medicare benefits to Medicare beneficiaries.

Balanced Budget Act of 1997, P.L. 105-33, H.R. Conf. Rep. 105-217 (July 30, 1997).

21. The Secretary controls MAOs through the bid process, through its contracts with the organization, through audits, and through the threat of intermediate sanctions and contract termination. The Secretary (through CMS) provides direction and instructions to MAOs on a nearly daily

basis. As one court aptly summarized the situation, "[i]n order to accomplish the legislative goals, it was necessary for CMS to contract with private companies to provide the new health plan choices under the new provisions of Medicare Part C. The government pays private companies like Humana to provide these new health plan choices. As part of the contract and pursuant to federal law, these Medicare Advantage plans are regulated, monitored, and directly controlled by CMS, including the disenrollment procedures and premium adjustments." *Mann v. Reeder,* 2010 U.S. Dist. LEXIS 134821 (W.D. Ky. 2010).

22. Eligible Medicare beneficiaries elect to enroll in an MA plan by making an election during the annual, year-end open enrollment period or during individual-specific special enrollment periods (*e.g.*, as when an individual first becomes eligible for Medicare). Medicare beneficiaries elect to enroll in an MA plan by completing an election form and giving it to the MAO, which the organization then transmits to CMS. *See* 42 U.S.C. § 1395w-21(c). Medicare Part C requires the Secretary to provide information concerning options to Medicare beneficiaries, and it requires MAOs to provide detailed information to enrollees. *See* 42 U.S.C. § 1395w-21(d). The Secretary (through CMS) requires MAOs to provide that detailed information in a disclosure document, written by CMS, which CMS calls the "Evidence of Coverage." *See* Exhibit "A" hereto.

23. CMS pays MAOs and delegates to them the obligation to administer, pay, and assume Medicare's economic risk for the Medicare benefits provided to MA enrollees, all pursuant to the requirements of Medicare

Part C and CMS regulations. The amount paid to the MAO is carefully calibrated, taking into account such factors as the geographic location, age, disability status, gender, institutional status, and health status of each MA enrollee, so as to ensure actuarial equivalence with the Original Medicare fee-for-service program option. *See* 42 U.S.C. § 1395w-23(c). The amount paid to the MAO is reduced if the enrollee is covered by an employer group health plan that is primary pursuant to 42 U.S.C. § 1395y(b)(1) and (2).

24. Currently, there are over 14 million persons enrolled in MA plans nationally.

25. The size and expense of the MA program makes it important that liability and casualty insurers like Defendant do not deflect their financial obligations under the Medicare Secondary Payer law onto MAOs and ultimately onto the Medicare Trust Funds.

MEDICARE ADVANTAGE ORGANIZATIONS AND THE MEDICARE SECONDARY PAYER LAW

26. In 1980, Congress began enacting the provisions that now comprise the MSP law, 42 U.S.C. § 1395y(b). The primary intent underlying the MSP provisions is to shift the financial burden of health care from the Medicare program to private insurers like Defendant, and thereby lower the cost of the Medicare program. *See, e.g., Bio-Medical Applications of Tennessee, Inc. v. Central States,* 656 F.3d 277 (6th Cir. 2011), *cert. denied, Central States v. Bio-Medical in re Tenn.,* 132 S.Ct. 1087 (2012); *Farmers Ins. Exch. v. Forkey,* 764 F. Supp. 2d 1205 (D. Nev. 2010); *Smith v. Farmers Ins. Exch. and Mid-Century Insurance Company,* 9 P.3d 335, 341 (Colo. 2000).

27. By its terms, as enacted in § 1862(b)(2) of the Social Security Act, the MSP law applies to all payments made "under this title," referring to Title XVIII of the Social Security Act, *i.e.* to the whole Medicare program. In fact, § 1862(b) is codified as 42 U.S.C. § 1395y(b) in Part E of Title XVIII, the Part that contains definitions and other general provisions pertaining to the Medicare program as a whole. When § 1862(b)(2) of the Social Security Act was codified as § 1395y(b)(2) in the United States Code Annotated, the words "under this title" were changed to "under this subchapter," referring to Chapter 7, Subchapter K of Title 42 of the United States Code. There is no substantive difference.

28. Moreover, when Congress enacted Medicare Part C, Congress indicated that when payment by the MAO "is made secondary pursuant to section 1395y(b)(2)," the MAO may avoid MSP expense by charging, or authorizing the actual provider to charge, for the items and services covered by the primary plan. 42 U.S.C. § 1395w-22(a)(4). In doing so, Congress expressed its understanding and intention that the MSP law applied to Medicare Part C.

29. The MSP law creates a federal coordination of benefits scheme, in which worker's compensation, liability insurance (and self-insurance), and no fault insurance are primary, and Medicare benefits are secondary. *See* 42 U.S.C. § 1395y(b)(2); 42 C.F.R. § 422.108(b)(3). *Appalachian Regional Healthcare, Inc. v. Shalala,* 131 F.3d 1050 (D.C. Cir., 1997).

30. A primary plan includes a "liability insurance policy or plan (including a self-insured plan)." 42 U.S.C § 1395y(b)(2)(A).

31. Under the MSP regulations, "Medicare benefits are secondary to benefits payable by a primary payer even if State law or the primary payer states that its benefits are secondary to Medicare benefits or otherwise limits its payments to Medicare beneficiaries." 42 C.F.R. § 411.32(a)(1).

32. As with any system of coordination of benefits, the MSP regime involves both avoidance and recovery. Optimally, when items and services are covered by both a primary plan and by Medicare benefits, Medicare beneficiaries inform their providers of the existence of the primary plan, and the providers submit their charges to the primary payer. If the primary payer pays as required by its insurance contract, Medicare avoids the expense of paying those charges.

33. Sometimes, however, Medicare beneficiaries do not inform their providers of the primary coverage. Even when beneficiaries do inform their providers of the primary plan, the circumstances may be such that the primary plan may not be expected to pay promptly. In such cases, as in the case at hand, Medicare may pay and seek to recover its payments from the primary plan. *See* 42 U.S.C. §§ 1395y(b)(2) and 1395y(b)(3)(A).

34. Because MA is simply another way in which Medicare beneficiaries may receive Medicare benefits, CMS requires MAOs such as Kaiser to advance Medicare benefits under these circumstances. *See* Medicare Managed Care Manual § 130.3 (Rev. 107, June 22, 2012).

35. CMS has interpreted the MSP law as it applies to MAOs in a formal regulation, 42 C.F.R. § 422.108, which states that MAOs may exercise the same rights to recover from a primary plan, entity or individual, as the

Secretary exercises under the relevant MSP regulations. Specifically, in § 422.108(f), CMS states:

> (f) MSP rules and State laws. Consistent with § 422.402 concerning the Federal preemption of State law, the rules established under this section supersede any State laws, regulations, contract requirements, or other standards that would otherwise apply to MA plans. A State cannot take away an MA organization's right under Federal law and the MSP regulations to bill, or to authorize providers and suppliers to bill, for services for which Medicare is not the primary payer. 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 of part 411 of this chapter.

36. CMS understands this regulation "to assign MAOs 'the right (and responsibility) to collect' from primary payers using the same procedures available to traditional Medicare." CMS, Memorandum: Medicare Secondary Payment Subrogation Rights (Dec. 5, 2011).

37. If Congress has not "directly addressed the precise question at issue," the agency's reading is controlling, unless it is "arbitrary or capricious in substance, or manifestly contrary to the statute." *Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984); *Sebelius v. Auburn Reg'l Med. Ctr.*, 133 S.Ct. 817, 826 (2013) ("A court lacks authority to undermine the regime established by the Secretary unless her regulation is 'arbitrary, capricious, or manifestly contrary to the statute.'").

Avoidance

38. Under the original Medicare fee-for-service program option, when a primary plan, such as worker's compensation or no fault insurance, is available and may be expected to pay promptly, providers generally bill the

primary plan. *See* 42 C.F.R. § 411.40 and § 411.50(c). When they do, Medicare avoids paying the expenses covered by the primary plan.

39. To encourage providers to bill primary plans, federal regulations make clear that, when Medicare is secondary, providers are not limited by Medicare rates and may charge the primary plan their usual charges; absent other legal or contractual restraints, the providers may expect to be paid their full charges. *See* 42 C.F.R. § 411.31(b) ("With respect to workers' compensation plans, no-fault insurers, and employer group health plans, a provider or supplier may bill its full charges and expect those charges to be paid unless there are limits imposed by laws other than Title XVIII of the Act or by agreements with the primary payer."). *See, e.g., Smith v. Farmers Ins. Exch. and Mid-Century Insurance Company,* 9 P.3d 335, 341 (Colo. 2000).

40. When Congress enacted Medicare Part C, Congress provided that, when Medicare benefits are secondary, MAOs and their providers may similarly avoid MSP expense by charging, or authorizing the provider to charge, the primary plan. *See* 42 U.S.C. § 1395w- 22(a)(4); 42 C.F.R. § 422.108(f).

41. Congress also provided that, when Medicare benefits are secondary, MAOs may charge, or authorize providers to charge, primary plans in accordance with the rates paid by the primary plan, *i.e.*, without regard to the usual Medicare rates. Specifically, Congress provided that, when Medicare benefits are "made secondary pursuant to section 1395(y)(b)(2)," the MAO may "charge or authorize the provider of such services to charge" the insurer, "in accordance with the charges allowed under [its] policy." 42 U.S.C. § 1395w-22(a)(4).

42. As more fully alleged below, Kaiser provided or arranged for the provision of items and services for its enrollee, for which Defendant's policy was the primary plan. Kaiser is therefore entitled, notwithstanding any other provision of law, to charge Defendant in accordance with the charges generally allowed under its policy without regard to the Medicare fee schedule. *See* 42 U.S.C. § 1395w-22(a)(4); 42 C.F.R. § 422.108(f).

43. Kaiser has asserted its claim against Defendant for those services in a notice of lien properly filed in the pending State court litigation between its MA enrollee and Defendant, but Defendant has failed and refused to make appropriate reimbursement to Kaiser and instead has entered into a tentative "general damages only," policy-limit settlement with the plaintiffs in that litigation which, if upheld by the State court, may result in Kaiser being deprived of payment for the Medicare services provided out of Defendant's liability insurance policy.

Recovery

44. In the event a primary plan fails to pay as primary or make appropriate reimbursement, 42 U.S.C. § 1395y(b)(3)(A) authorizes a "private" cause of action to recover double damages from the primary plan. An MAO that has advanced Medicare benefits has standing to bring the private cause of action. *In re Avandia Mktg.*, 685 F.3d 353 (3d Cir. 2012).

45. To bring the private cause of action for double damages, a private party must have injury sufficient to confer Article III standing. Kaiser has standing because it has provided and/or made payments for Medicare benefits on behalf of its MA enrollee (referred to herein as "the Enrollee") for

which Defendant was primarily liable and for which it did not reimburse Kaiser.

46. When MA plans recover reimbursement from primary plans or other liable parties pursuant to the MSP law, those recoveries help reduce Medicare expenditures by the Medicare Trust Funds. *See* HHS, Medicare Program; Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs, 75 Fed. Reg. 19678, 19797 (April 15, 2010) ("MA organizations that faithfully pursue and recover from liable third parties will have lower medical expenses."). *See also* HHS, Medicare Program; Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs, 74 Fed. Reg. 54634, 54711 (October 22, 2009).

47. Thus, MSP recoveries by MAOs fulfill the essential purpose of the MSP law – shifting expense from the Medicare program to primary payers. *See In re Avandia Mktg.*, 685 F.3d 353, 363 (3d Cir. 2012).

MAOs May Exercise the Same Rights as the Secretary

48. Alternatively, 42 U.S.C. § 1395y(b)(2)(B)(iii) allows the federal government to bring the otherwise private cause of action for double damages created by 42 U.S.C. § 1395y(b)(3)(A). Consistent with this, 42 C.F.R. § 411.24(c)(2) provides that, "[i]f it is necessary for CMS to take legal action to recover from the primary payer, CMS may recover twice the amount specified in paragraph (c)(1)(i) of this section."

49. Under 42 C.F.R. § 422.108(f), an MAO "will exercise the same rights to recover from a primary plan, entity, or individual that the Secretary [*i.e.*, CMS] exercises under the MSP regulations . . . ."

50. Thus, Kaiser has standing to assert its claims under 42 U.S.C. §§ 1395y(b)(2)(B)(iii) and 1395y(b)(3) because the federal government has delegated responsibility for coordination of benefits with respect to Medicare benefits under the MA option to MAOs, such as Kaiser. *See* 42 C.F.R. § 422.108(f). *See also* CMS, Memorandum: Medicare Secondary Payment Subrogation Rights (Dec. 5, 2011).

FACTUAL ALLEGATIONS

51. The Enrollee is a Medicare beneficiary who resides in, and at the time of the events giving rise to this action resided in, the City and County of Honolulu, State of Hawai'i. The name of the Enrollee is known to Defendant, but is not pled in this Complaint to protect her privacy.

52. The Enrollee elected to obtain her Medicare benefits through participation in an MA plan administered by Kaiser, commencing at some point prior to March 15, 2010, and continuing through all times relevant to this Complaint.

53. Kaiser operates as an HMO, and therefore directly provides most covered services to its Medicare enrollees through its affiliated and contracted providers, including Kaiser Foundation Hospital ("KFH") and Hawaii Permanente Medical Group ("HPMG").

54. On or about March 9, 2010 the Enrollee ate take-out food purchased from and prepared by Peppa's Korean BBQ, the entity for which Defendant provided liability insurance coverage.

55. The Enrollee experienced severe cramping and diarrhea on or about March 13, 2010 and was taken to a Kaiser medical clinic for an initial assessment of the symptoms.

56. On or about March 16, 2010, the Enrollee was admitted to a Kaiser hospital with complaints of bloody diarrhea, severe abdominal pain, extreme dizziness, and debilitating weakness.

57. The Enrollee's stool culture tested positive for an enterohemorrhagic Escherichia coli 0157:H7 infection. This is a foodborne disease causing pathogen that can result in serious illness or death in the young and the elderly.

58. On or about March 19, 2010, the Enrollee was diagnosed with hemolytic-uremic syndrome (HUS), a complication of Escherichia coli 0157:H7 infection and required a prolonged and costly hospital stay.

59. The Department of Health ("DOH") for the State of Hawai'i was investigating six recent reports of Escherichia coli 0157:H7 infections which occurred on Oahu between March 2, 2010 and March 23, 2010, in which four individuals, including the Enrollee, had to be hospitalized.

60. On March 19, 2010, the DOH reported that a sanitarian who inspected Peppa's Korean BBQ reported three (3) violations: "(1) inaccessible hand washing sinks; (2) knives stored between wall and sink; and (3) an employee reporting the use of a mixing bowl used to mix raw hamburger meat

was also used to mix cooked vegetables without being properly sanitized between uses."

61. On March 25, 2010, the DOH reported that its "[f]oodborne Disease Surveillance and Response Coordinator observed that the tongs to place raw meat on the grill were also used to plate cooked products into the clam shell containers (styrofoam take-out container). Additionally, the sanitarian and the Epidemiological Specialist noted that the raw hamburger meat normally stored in the walk-in refrigerator was stored next to fresh produce."

62. In a memorandum dated April 1, 2010, Rebecca Kanenaka, M.S., a Foodborne Disease Surveillance and Response Coordinator at the DOH, stated that the DOH had determined that the Enrollee's case shared, in common with four additional infection cases, consumption of food products from Peppa's Korean BBQ.

63. Defendant provided liability insurance for Peppa's Korean BBQ.

64. With respect to the medical care resulting from the Enrollee's injury, the first party coverage issued by Defendant was the primary plan and the MA plan administered by Kaiser was the secondary plan.

65. Aside from coinsurance and copayment amounts, Kaiser provided and incurred the cost of and/or otherwise fully discharged the Enrollee's payment obligation for the items and services provided to the Enrollee and/or for which the Enrollee's providers charged Kaiser.

66. The first party coverage issued by Defendant was the primary plan and the MA plan administered by Kaiser was the secondary plan with respect to the medical expenses resulting from the Enrollee's injuries caused by consumption of food purchased from and prepared by Peppa's Korean BBQ on or about March 9, 2010.

67. Defendant did not make primary payment for the services provided the Enrollee in connection with the injuries caused by and resulting from consumption of food purchased from and prepared by Peppa's Korean BBQ on or about March 9, 2010.

68. Defendant has not made appropriate reimbursement for the provision of and/or payment for Medicare benefits advanced by Kaiser for the services provided the Enrollee in connection with the injuries caused by and resulting from consumption of food purchased from and prepared by Peppa's Korean BBQ on or about March 9, 2010.

69. Kaiser has not been reimbursed for its provision of and/or payment for Medicare services provided to the Enrollee by any other payment source.

COUNT ONE

DECLARATORY JUDGMENT AS TO DEFENDANT'S OBLGATION TO REIMBURSE MEDICARE BENEFITS

70. Kaiser incorporates by reference the allegations of paragraphs 1 through 69 of the Complaint as if set forth herein.

71. An actual controversy exists between the parties, in that CMS requires MAOs, including Kaiser, to faithfully pursue MSP savings, but

Defendant has taken the position that Kaiser's right to recover the amounts it has incurred and/or paid for the services provided to the Enrollee is limited to a lien against the tentative settlement under State law in the pending State court litigation, and has failed and refused to honor its obligations under the MSP to pay as primary or to make appropriate reimbursement.

72. Although Defendant's insureds have asserted that "the lien issue is akin to an interpleader action, in which competing parties to the same funds . . . stake their claim," that position cannot and does not satisfy Defendant's obligations under the MSP law because Defendant's agreement to the tentative settlement for "general damages only" greatly prejudices Kaiser's right and ability to recover the amounts owed by Defendant under State law.

73. Kaiser gave Island Insurance the opportunity to enter into a settlement with Kaiser that would have avoided this litigation, but Island Insurance has failed and refused to engage in settlement negotiations directly with Kaiser as of the date of filing.

74. Kaiser requests a declaratory judgment that:

(a) To the extent Defendant is liable on behalf of its insured for payment of medical expenses covered by Medicare provided to the Enrollee, the liability coverage issued by Defendant is primary to Medicare, including with respect to Medicare benefits provided and/or advanced by Kaiser in its capacity as an MAO; and

(b) To the extent Kaiser has provided and/or advanced Medicare benefits on behalf of the Enrollee under circumstances in which the coverage afforded by the Kaiser MA plan is secondary to Defendant's liability insurance

pursuant to 42 U.S.C. §§ 1395y(b)(2) and 1395w-22(a)(4), then Defendant is obligated to make appropriate reimbursement to Kaiser.

COUNT TWO

PRIVATE CAUSE OF ACTION FOR DOUBLE DAMAGES

75. Kaiser incorporates by reference the allegations of paragraphs 1 through 73 of the Complaint as if set forth herein.

76. Kaiser provided and/or made payment for Medicare benefits for items and services required by the Enrollee caused by and resulting from consumption of food purchased from and prepared by Peppa's Korean BBQ on or about March 9, 2010, currently totaling $448,368.84.

77. Defendant was the primary payer under 42 U.S.C. §§ 1395y(b)(2) and 1395w-22(a)(4) with respect to the medical expenses incurred by the Enrollee as a result of the above injuries, which benefits were provided and/or paid for by Kaiser.

78. Congress has "established 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 which fails to provide for primary payment (or appropriate reimbursement) in accordance with [the MSP law]." 42 U.S.C. § 1395y(b)(3)(A).

79. Defendant did not make primary payment to Kaiser or the Enrollee's other providers for the items and services which were provided and/or paid for by Kaiser.

80. Defendant did not make appropriate reimbursement to Kaiser for the items and services which were provided and/or paid for by Kaiser.

81. Kaiser brings this action under the private cause of action established by 42 U.S.C. § 1395y(b)(3)(A) to recover from Defendant double damages for its failure to pay as primary or to make appropriate reimbursement.

82. Under the private cause of action established by 42 U.S.C. § 1395y(b)(3)(A), Kaiser is entitled to recover "an amount double the amount otherwise provided." Kaiser provided and/or made payment for Medicare benefits in the current amount of $448,368.84 and is entitled to recover double that amount, currently $896,737.68, or such other amount as may be established at trial, from Defendant.

PRAYER FOR RELIEF

Based on the above allegations, Kaiser seeks the following relief:

1. Declaratory relief as set forth above;

2. Double damages under 42 U.S.C. § 1395y(b)(3)(A); or, alternatively,

3. Its charges (notwithstanding any other provision of law, as provided in 42 U.S.C. § 1395w-22(a)(4) and 42 C.F.R. § 422.108(f));

4. Pre- and post-judgment interest; and

5. Such other relief as the Court deems proper.

WHEREFORE, Plaintiff, Kaiser Foundation Health Plan, Inc. prays that the Court enter judgment in favor of Kaiser and against Defendant, Island Insurance Company, Limited and award Kaiser the relief requested herein.

Respectfully submitted this 7th day of October, 2013.

DIANNE WINTER BROOKINS
MELISSA M. UHL
Attorneys for Plaintiff
KAISER FOUNDATION HEALTH PLAN, INC.