No. 11-238

In The
Supreme Court of the United States

STATE FARM MUTUAL
AUTOMOBILE INSURANCE COMPANY,

Petitioner,

v.

HONORABLE THOMAS A. BEDELL, JUDGE OF THE CIRCUIT COURT OF HARRISON COUNTY; LANA S. EDDY LUBY; AND CARLA J. BLANK,

Respondents.

On Petition For A Writ Of Certiorari To The Supreme Court Of Appeals Of West Virginia

MOTION FOR LEAVE TO FILE A BRIEF AS *AMICUS CURIAE* AND BRIEF OF THE WEST VIRGINIA MUTUAL INSURANCE COMPANY AS *AMICUS CURIAE* IN SUPPORT OF PETITIONER

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September 26, 2011

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This case, arising from a denial of a writ of prohibition involving an overly restrictive protective order regarding medical records, presents such an issue. Overly broad protective orders limiting liability insurers' ability to retain and store medical records present unique problems. Each year thousands of medical malpractice claims and lawsuits, like the case below, are asserted against physicians and other healthcare providers insured by the Mutual and other liability insurers to which they devote substantial legal and financial resources. Because protective orders curtailing a liability insurers' legitimate use of medical records present significant obstacles for compliance with state and federal law, the Mutual has a strong interest in assuring that state trial courts do not improperly restrict legitimate use of medical records in the post litigation context.

In what is increasingly becoming commonplace, in state and federal courts, the court below erroneously issued a broad protective order that places a significant impediment to an insurer's ability to act in accordance with state and federal reporting and compliance obligations. These orders are at odds with state and federal statutes as well as needlessly broadening patient privacy protection. This issue is relevant in virtually every medical malpractice lawsuit. State trial courts that issue protective orders, like the one in this case, substantially impact the rights and obligations of liability insurers.

In its brief, the Mutual will urge this Court to grant certiorari in order to clarify the rights and

obligations of an insurer to medical records obtained through litigation. As a liability insurer, the Mutual has an interest in assisting the Petitioner in obtaining relief from an erroneous decision, but also an interest assuring that important federal and state laws are not improperly curtailed by the actions of state trial courts.

Respectfully submitted,

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STATEMENT OF INTEREST OF THE *AMICUS CURIAE*[1]

The interest of *amicus curiae* West Virginia Mutual Insurance Company is set forth in the Motion for Leave to File a Brief as *Amicus Curiae* which is filed along with this brief.

STATEMENT OF THE CASE

The Mutual adopts the Statement of the Case of Petitioner.

SUMMARY OF ARGUMENT

This Court should grant the petition in order to provide clarity and guidance on issues relating to the use and retention of medical records in the before, during and after litigation. Time and again, in

[1] The parties were notified ten days prior to the due date of this brief of the intention to file. The parties have consented to the filing of this brief.

No counsel for a party authored this brief in whole or in part, and no counsel or party made a monetary contribution intended to fund the preparation or submission of this brief. No person other than *amicus curiae*, it members, or its counsel made a monetary contribution to its preparation or submission.

providing discovery orders, ruling on dispositive motions and in reviewing such matters on appeal, some state courts are unnecessarily broadening an individual's privacy rights, thereby curtailing the valid retention of medical records by liability insurers after conclusion of the litigation. These orders demonstrate how state courts can significantly impact not only the course of litigation in an individual case, but also upset a carefully crafted Medicare reporting system under 42 U.S.C. § 1395y(b)(8).

The language and legislative history of 42 U.S.C. § 1395y(b)(8), which is the statutory basis of the Medicare Conditional Payment Recovery Process, imposes detailed reporting requirements on the part of workers compensation, liability, no-fault insurance and employer group health plans. As such, these insurance entities cannot fulfill these reporting requirements without access to a party's medical records well after the conclusion of the litigation. In what is becoming a developing trend, state courts, at the behest of plaintiffs' attorneys, are increasingly issuing orders that significantly impede these insurance entities' ability to comply with these reporting requirements. It is axiomatic that a state court judge issuing orders interpreting state law must do so in a manner that does not usurp applicable federal law. Accordingly, any such order issued in contravention of federal law is preempted in accordance with this Court's jurisprudence under the Supremacy Clause. This case is ideally situated to establish a broad principle as to the preemptive effect of federal law with regards to

access and retention of medical records in the post-litigation context.

ARGUMENT

STATE ACTION THAT CURTAILS THE RETENTION OF MEDICAL RECORDS BY LIABILITY INSURERS AFTER LITIGATION IS PREEMPTED BY THE MEDICARE SECONDARY PAYER PROVISIONS

A. The Medicare Secondary Payer Provisions

The "Medicare Conditional Payment Recovery Process" was established through a series of amendments to the Social Security Act, known as the "Medicare Secondary Payer provisions," (MSP Provisions) now codified in 42 U.S.C. § 1395y. These provisions provide in general terms that health care services under the Medicare Provisions of the Social Security Act shall be secondary to coverage for such services available from other sources. These sources, known as primary payers, have later been defined as workers compensation, liability, no-fault insurance and employer group health plans. 42 U.S.C. § 1395y(b)(2). Medicare can refuse to pay for a beneficiary's covered expenses where payment has been made or can reasonably be expected to be made by a primary payer. 42 U.S.C. § 1395y(b)(2)(A)(ii). The MSP Provisions allow Medicare to make conditional payments if the primary payer will not pay or will not pay promptly. 42 U.S.C. § 1395y(b)(2)(B)(i). The primary payer becomes liable

to Medicare, and it is responsible for reimbursing Medicare upon proof by a judgment, a payment conditioned upon recipient's compromise, waiver or release of payment for items or services in a claim against the primary payer or the primary payer's insured, or by other means. 42 U.S.C. § 1395y(b)(2)(B)(ii). These provisions have been routinely upheld upon challenge on grounds ranging from violation of the McCarran-Ferguson Act to the Employee Retirement Income Security Act. *United States v. Blue Cross & Blue Shield*, 726 F. Supp. 1517 (E.D. Mich. 1989); *Provident Life & Acci. Ins. Co. v. United States*, 740 F. Supp. 492 (E.D. Tenn. 1990); *Varacalli v. State Farm Mut. Auto. Ins. Co.*, 763 F. Supp. 205 (E.D. Mich. 1990).

In 2007, Congress passed the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA), which modified the MSP Provisions to shift the burden of reporting settlements/judgments subject to the secondary payer provisions from Medicare Beneficiaries to primary payers. 42 U.S.C. § 1395y. Under 42 U.S.C. § 1395y(b)(8)(B), if a primary payer entity fails to comply with its reporting requirements it is subject to a civil money penalty of $1,000.00 for each day of noncompliance. Under MMSEA, self-insured employers, group health plans, liability insurers, no-fault insurers, and workers compensation plans, known as "Responsible Reporting Entities," (RREs) are required to submit to the CMS on a quarterly basis, all claims that involve a Medicare beneficiary where (on or after July 1, 2009) there is a settlement, judgment,

award or other payment that constitutes payment or reimbursement for medical costs, regardless of whether there was a determination of liability. Importantly, the United States may file suit and recover from liability insurers any sums conditionally paid even if the Medicare beneficiary or other party has already been reimbursed.

Since its enactment in 2007, the Department of Health and Human Services has promulgated regulations detailing the reporting requirements of RREs, when Medicare becomes a secondary payer. 42 C.F.R. § 411.25. This is of importance to this case because in order to discharge its duties under the MSP Provisions, RREs must be in possession of the required information. Once a RRE identifies an individual as a Medicare Beneficiary, they must identify and report one hundred thirty-one (131) distinct data points after settlement or final judgment. These include, among other things, the date of injury, the cause of injury and injury information. Centers for Medicare and Medicaid, Medicare Secondary Payer Manual, Chapter 3 (10-27-2006), https://www.cms.gov/manuals/downloads/msp105c03.pdf. Thus, it is necessary for RREs to possess the medical records of the Medicare Beneficiary in order to determine both the accuracy and sufficiency of their reporting to the Centers for Medicare and Medicaid Services (CMS). In addition, 42 C.F.R. § 411.25(c) leaves the door open for CMS to require the reporting of additional information stating, "[t]he primary payer must provide additional information to the designated entity or entities as the designated entity or entities may require this information to update the CMS's system of records. Because

of the open ended nature of this regulation, it is unclear what additional information may be required to "update CMS system of records," with regard to cases already settled or that have achieved final judgment. Accordingly, it will be necessary for an RRE to possess at the time of reporting not only the information currently required by CMS, but such information as should be required in the future. In order for an RRE to meet these undefined obligations, it must be in possession of a Beneficiary's medical records for a substantial period of time after the conclusion of the litigation.

Of growing concern to entities designated as RREs under the MSP Provisions, such as the Petitioner and this *Amicus Curiae*, are the issuance of court orders that curtail a RREs ability to retain medical records after the conclusion of the underlying litigation. As was laid out above, RREs have a manifest interest in retaining these records to discharge their responsibilities under the MSP Provisions. These court orders are in contravention to federal law, as set out herein, and as such are preempted in accordance with Article VI, Clause 2 of the United States Constitution.

B. Preemptive Effect of the Medicare Secondary Payer Provisions

There is no express preemption provided in the MSP Provisions. However, there is a strong circumstantial evidence of Congress's intent to preempt state law to the extent necessary to enable RREs to comply with their reporting requirements required

under the MSP Provisions. This is further supported by the express language within the provisions related to the Medicare Advantage Program, which establishes that state law is preempted to the extent that it poses an obstacle to recovery under the MSP Provisions by Medicare Advantage organizations. 42 C.F.R. § 422.108(f). This provision under the Medicare Advantage Program provides strong circumstantial evidence of Congress's intent to preempt state law when the actor is CMS instead of Medicare Advantage organizations. Furthermore, it would seem illogical of Congress to provide express preemption for Medicare Advantage organizations under the MSP Provisions, while not implying that state law is preempted to the extent that it poses an obstacle for CMS to recover. Obviously, an inability of a primary payer to report under the MSP Provisions presents an obstacle to recovery.

Despite the absence of an express preemption provision, any state law that poses a barrier to an RRE's ability to fulfill its reporting requirements is clearly one that violates the Supremacy Clause under the well established principles of implied preemption. Traditionally, this court has recognized two instances under which the doctrine of implied preemption applies. In the first instance, commonly referred to as field preemption, "congressional intent to pre-empt state law in a particular area may be inferred where the scheme of federal regulation is sufficiently comprehensive to make reasonable the inference that Congress 'left no room' for supplementary state

regulation." *California Federal Sav. and Loan Ass'n v. Guerra*, 479 U.S. 272, 281 (1987) (citing *Santa Fe Elevator Corp.*, 331 U.S. 218, 230 (1947)). In the second instance, commonly known as conflict preemption, state law is preempted to the extent it actually conflicts with federal law. *Hillsborough County, Fla. v. Automated Medical Laboratories, Inc.*, 471 U.S. 707 (1985). The Supremacy Clause, under the doctrine of implied conflict preemption has been further defined to exist "where it is impossible for private party to comply with both state and federal requirements, or where state law stands as obstacle to accomplishment and execution of full purposes and objectives of Congress." *Freightliner Corp. v. Myrick*, 514 U.S. 280 (1995).

Congress has recognized the importance of privacy in medical records in a variety of contexts, as a prominent example the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). *U.S. v. Comprehensive Drug Testing, Inc.*, 513 F.3d 1085, 1138 (9th Cir. 2008). In promulgating regulations pursuant to HIPAA, the Department for Health and Human Services has emphasized that "[t]he need for privacy of health information ... has long been recognized as critical to the delivery of needed medical care. More than anything else, the relationship between a patient and a clinician is based on trust." 65 Fed.Reg. at 82,467. While HIPAA regulations are pervasive in the field of privacy of medical records

and contain an express preemption provision, by its own terms it does not completely occupy the field of medical record privacy. Title 45, Section 160.203 of the Code of Federal Regulations provides express preemption of state law to the extent that is contrary to HIPAA. Additionally, 45 C.F.R. § 160.203 provides a savings provision, that allow contrary state laws to stand provided they meet certain conditions. Among them, subsection (b) allows states to adopt medical record privacy laws that are more stringent than those imposed under HIPAA. As such, intent to pre-empt state law by federal occupation of the field of medical record privacy is not so pervasive as to say that Congress has "left no room" for supplementary state regulation. HIPAA by its own terms leaves room for the states to regulate the area of medical record privacy.

While Congress has chosen not to occupy the field of medical record privacy in a manner that preempts all state regulation, the MSP Provisions provide ample evidence of Congress's intent to preempt state regulation of medical record privacy that conflicts with federal law and regulations. In instances where states restrict the retention and access of medical records to RRE, there is actual conflict between state and federal law. As such, physical compliance with both state and federal law is impossible. *Florida Lime & Avocado Growers, Inc. v. Paul,* 373 U.S. 132, 143 (1963). In the underlying case, the Harrison County Circuit Court, in its second protective order, ordered the Petitioner to return or destroy any nonpublic medical information after the time period supplied by

West Virginia insurance regulation for retention along with a certificate of compliance. West Virginia Insurance Commission, Informational Letter No. 172 (citing W. Va. Code § 33-2-9 and 114 CSR 15). As was discussed above, if the Plaintiff in the underlying suit were a Medicare Beneficiary, the Petitioner, as an RRE, will have to report any settlement or judgment. While currently, RREs are required to report this information in the quarter after the settlement or judgment occurred, 42 C.F.R. § 422.108(f) imposes an open ended obligation on primary payers/RREs to, "provide additional information to the designated entity or entities as the designated entity or entities may require this information to update the CMS system of records." Because the initial reporting obligations require a primary payer/RRE to possess the medical records of a party in order to provide accurate information to CMS, it stands to reason that they will need to retain these records should CMS decide that additional information will be required in the future. State Regulation that curtails the length that a primary payer/RRE can retain medical records of Medicare Beneficiaries place the primary payer/RRE in the unfortunate position where it cannot physically comply with state and federal law at the same time. Consequently, under the doctrine of implied conflict preemption, the state regulation is preempted under the Supremacy Clause.

In addition to producing a scenario where physical compliance with state and federal law is impossible, state regulations that curtail the retention of medical records by primary payers/RREs, "stands as

an obstacle to the accomplishment and execution of the full purposes and objectives of Congress." *Hines v. Davidowitz*, 312 U.S. 52, 67 (1941). Congress's purpose in enacting the MSP Provisions was to provide a mechanism whereby CMS could ensure that funds from the Medicare Trust Fund are not being expended for services and items that are the responsibility of primary payers. Medicare Secondary Payer Manual Centers for Medicare and Medicaid, Medicare Secondary Payer Manual, Chapter 3 (10-27-2006), https://www.cms.gov/manuals/downloads/msp105c03.pdf. When the MSP Provisions were modified by the MMSEA, Congress shifted the burden of reporting when Medicare is a secondary payer from the Medicare Beneficiary to primary payers. 42 U.S.C. § 1395y. As was established, the MMSEA and the regulations promulgated since, primary payers/RREs must report instances where Medicare is a secondary payer or face a penalty of a $1000.00 for each day of noncompliance. 42 U.S.C. § 1395(y)(8)(B). As was established in this brief, in order to fulfill its reporting requirements, RREs must have access to a Medicare Beneficiary's medical records. As was further established in this brief, there is an affirmative obligation on the part of RREs to provide additional information as may be required to update CMS's system of records. An inability to provide this information poses an obstacle to the fulfillment of the purposes and objectives of Congress in enacting the MSP Provisions. As a consequence, any state regulation that curtails the retention and access to

medical records poses such an obstacle and therefore conflicts with federal law.

While the principles of preemption have been traditionally applied to state laws and regulations, the fact that the Court is being asked to extend its preemptive principles to a state trial court order is of no consequence. Federal Courts have considered the preemptive effect of federal law on validly issued state court orders in several different contexts. *Dean v. Johnson*, 881 F.2d 948 (10th Cir. 1989) (considering the preemptive effect of the Federal Employees' Group Life Insurance Act on state court orders in divorce proceedings). *Central States, Southeast & Southwest Areas Pension Fund v. Howell*, 227 F.3d 672, 676 (6th Cir. 2000) (stating, "The law of ERISA expressly preempts all state laws which "relate to" an ERISA plan. . . . This preemption applies to all state law, whether legislative or judge-made."). *Stone v. Stone*, 632 F.2d 740 (9th Cir. 1980) (considering the preemptive effect of Employee Retirement Income Security Act on state court orders in a divorce context). Because it is axiomatic that a state judge's order construing state law must be preempted to the same extent as state law or regulation, the order in the Petitioner's case and any similar order must be preempted as well.

The Mutual urges this Court to grant the Petitioner's certiorari because of the importance of this issue to those entities that are primary payers under the MSP Provisions. The Mutual further urges that this Court not only adopt the Petitioner's reasoning,

but also establish a broad rule that preempts any State regulation that curtails the retention of medical records by RREs for the reasons discussed herein. The Mutual believes that this issue is in its infancy and in order to avoid future controversy action, should be taken by this Court.

CONCLUSION

For the foregoing reasons the Mutual respectfully urges the Court to grant the petition for a writ of certiorari.

Respectfully submitted,

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