UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF TEXAS
GALVESTON DIVISION

HUMANA, INC., UNITED HEALTHCARE SERVICES, INC., and AETNA INC., Plaintiffs, vs. SHRADER & ASSOCIATES, LLP, Defendant.	Civil Action No. 3:16-cv-00354 **JURY TRIAL DEMANDED**

PLAINTIFFS' RESPONSE TO
DEFENDANT'S MOTION FOR SUMMARY JUDGMENT
[Related to ECF No. 116]

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I. Introduction and Summary of Argument

Defendant Shrader & Associates, LLP ("Shrader") specializes in prosecuting asbestos cases and regularly asserts asbestos related claims against solvent asbestos tortfeasors in state court and insolvent asbestos tortfeasors in asbestos trusts on behalf of its clients. In some instances, Shrader deliberately ignores his clients' subrogation and reimbursement obligations. Plaintiffs Humana, Inc. ("Humana"), United HealthCare Services, Inc. ("UHC"), and Aetna Inc. ("Aetna") (collectively, the "Health Plans") have brought this action to enforce those rights, and specifically to seek recovery directly from Shrader from fees it has retained in the course of its representation of its clients that are also the Health Plans' members (the "Matched Claimants").

Shrader filed its Motion for Summary Judgment (Motion),[1] arguing that (i) the Health Plans lack Article III standing to pursue their claims; (ii) Shrader is immune from suit under the Medicare Secondary Payor ("MSP") Act; (iii) the misidentification of one Plan as a Plan governed by the Employee Retirement Income Security Act of 1974 ("ERISA") rather than an MSP Plan in the Supplement to the Complaint requires dismissal of that claim; (iv) dismissal is necessary because the Matched Claimants are required, indispensable parties that cannot be joined; and (v) the Health Plans' claims should be severed into 15 separate actions instead of proceeding as one.[2]

[1] *See* Def.'s Mot. for Summ. J. ("Def.'s Mot."), July 20, 2018, ECF No. 116.

[2] Shrader also argues that UHC's ERISA claim as to Claimant No. 5 fails as a matter of law because it was brought on behalf of a state government plan rather than an ERISA Plan. *See* Def.'s Mot. at 25-26. The Health Plans agree and voluntarily withdraw their ERISA claim on behalf of the ERISA Plan that provided benefits to Claimant No. 5. The Health Plans, however, continue to assert their MSP claims on behalf of the MA Plans that provided benefits to Claimant No. 5.

The Court should deny Shrader's Motion for the following reasons:

- The Health Plans are parent companies to dozens of subsidiary Medicare Advantage Organizations ("MAO"), including the MAOs that administered the Plans to which the Matched Claimants, Shrader's clients, were members. The Supreme Court has ruled that a parent has Article III standing to pursue claims against a defendant that injures its subsidiary. Therefore, Shrader's argument that the Health Plans lack Article III standing to assert their MSP claims fails.

- The Administrative Services Only ("ASO") Agreements governing the relationship between the Health Plans and the ERISA plans they administer give the Health Plans the authority to act as plan fiduciaries under ERISA. Therefore, Shrader's argument that the Health Plans lack Article III standing to assert their ERISA claims fails.

- The express language of the MSP Act provides the Health Plans with a direct, private cause of action against Shrader, which is supported by the clear and unequivocal intent expressed by Congress and the CMS, as well as the case law interpreting the MSP Act. Therefore, Shrader's argument that the Health Plans' MSP claims should be dismissed fails.

- The Health Plans' inadvertent misidentification of the Plan under which Claimant No. 9 received benefits as an ERISA Plan instead of a MA Plan can be cured with an amendment or supplement to the Health Plans' Complaint. Therefore, Shrader's request for dismissal based thereon should be denied, and the Health Plans should be allowed to cure this misidentification.

- The Matched Claimants are not required parties to this action because they do not have an interest in, nor are the prejudiced by the Health Plans' claims or requested relief, nor are they indispensable because a judgment in this action would not be prejudicial, but would be adequate. And, in any event, joinder of the Matched Claimants is feasible because this Court has both subject matter and personal jurisdiction over them.

- The Health Plans' claims should not be severed into individual actions because their claims arise out of the same transaction or occurrence, or series of transactions or occurrences, and at least one common question of law or fact links all of them.

II. Nature and Stage of the Proceedings

The Health Plans filed their Complaint against Shrader and five other law firms on September 6, 2016, asserting, among other things, claims under ERISA and the MSP Act.[3] The claims against Shrader were severed into this action.[4]

Shrader previously filed a Motion to Dismiss, for a More Definite Statement, and to Sever ("Motion to Dismiss"),[5] which was denied with prejudice on all grounds except as to its motion to dismiss for failure to join indispensable parties and motion to sever.[6]

Shrader now files this Motion seeking, among other things, dismissal for failure to join indispensable parties and to sever each of the Health Plans' claims into separate actions.[7]

III. Statement of the Issues

Shrader's Motion presents the following issues:

1. Whether the Health Plans have Article III standing to assert their MSP and ERISA claims;

2. Whether, under the MSP Act, the Health Plans, as MAOs, may recover directly from the group of entities that Congress and CMS intended, which includes more than just "primary plans";

3. Whether a curable, inadvertent misidentification of a Plan requires dismissal of an otherwise valid claim;

4. Whether, under Rule 19, the Matched Claimants are required, indispensable parties that cannot be joined in this action; and

[3] *See* Pls.' Original Compl., Sept. 6, 2016, ECF No. 1.

[4] *See* Pls.' Am. Compl., Feb. 21, 2017, ECF No. 62.

[5] *See* Def.'s Mot. to Dimiss, Mar. 6, 2017, ECF No. 63.

[6] *See* Mem. Op. & Order, Mar. 16, 2018, ECF No. 93.

[7] *See* Def.'s Mot. to Dimiss, Mar. 6, 2017, ECF No. 63.

5. Whether the Health Plans' claims should be severed into separate actions, i.e., whether their claims arise out of the same transaction or occurrence, or series of transactions or occurrences, and at least one common question of law or fact links all of them.

IV. Factual and Procedural Background

The Health Plans filed their Complaint against Shrader and five other law firms on September 6, 2016, asserting, among other things, claims under ERISA and the MSP Act.[8] The claims against Shrader were severed into this action, and the Health Plans filed their Amended Complaint.[9]

Shrader filed a Motion to Dismiss,[10] which was denied with prejudice in all respects, except with respect to Shrader's request for dismissal for failure to join indispensable parties under Rule 19 and its request for severance under Rule 20, which were denied without prejudice because the Court lacked sufficient information, including the operative health plans, to make a ruling on those requests.[11] The Court ordered the Parties to exchange the information it lacked and to file status reports concerning same.[12]

After receiving the status reports, the Court entered a Discovery Confidentiality Order allowing the Parties' to exchange confidential information previously withheld because there were not adequate protections in place,[13] and held a status conference on April 19, 2018. At the conference, the Court ordered the Parties to exchange documents

[8] *See* Pls.' Original Compl., Sept. 6, 2016, ECF No. 1.

[9] *See* Pls.' Am. Compl., Feb. 21, 2017, ECF No. 62.

[10] *See* Def.'s Mot. to Dimiss, Mar. 6, 2017, ECF No. 63.

[11] *See* Mem. Op. & Order, Mar. 16, 2018, ECF No. 93.

[12] *Id*.

[13] *See* Disc. Confidentiality Order, April 5, 2018, ECF No. 98.

relevant to the joinder and severance issues.[14] The Court also ordered the Health Plans to supplement their Complaint to identify each Matched Claimant, his or her plan type, and the amount paid to treat each Matched Claimants' injuries.

Pursuant to the Court's order, on April 30, 2018, the Health Plans filed the Supplement to their Complaint,[15] and the Parties exchanged the documents ordered by the Court.

On June 27, 2018, the Health Plans served their First Requests for Production on Shrader seeking documents reflecting the nature of the relationship between Shrader and the Matched Claimants, including the extent of their communications.[16] This information is highly relevant to the feasibility of joinder issue that Shrader has repeatedly injected into this action and raises in the Motion. In its Responses, however, Shrader refused to produce any of the documents.[17]

On June 29, 2018, Shrader filed a request for a conference before filing his second motion to dismiss.[18] On July 12, 2018, the Court held the requested conference during which it instructed Shrader that rather that filing another motion to dismiss, it had to raise those issues in a motion for summary judgment. Because of the need for evidence to file

[14] *See* Minute Entry Order, Apr. 20, 2018, ECF No. 103.

[15] *See* Pls.' Suppl. to Pls.' Am. Compl., April 30, 2018, ECF No. 108. In the Supplement, the Health Plans inadvertently misidentified UHC Matched Claimant No. 9's Plan funded by The Coca Cola Company ("Coca Cola") as an MAO Plan rather than an ERISA Plan.

[16] The Health Plans, of course, do not insist on obtaining the specific contents of these communications. But their existence – how many there were, how many involved Texas attorneys, etc. – are relevant. They should be produced in redacted form and/or identified on a privilege log.

[17] *See* Def.'s Resps. to 1st Reqs. For Produc., a true and correct copy of which is attached hereto as **Exhibit A.**

[18] *See* Shrader's Request, June 29, 2018, ECF No. 112.

a motion for summary judgment, the Court offered Shrader as long as it needed to file the motion. Despite a substantial amount of discovery remaining to be done and Shrader's continued refusal to produce documents relevant to Shrader's Rule 19 and Rule 20 arguments, however, Shrader insisted on filing its Motion for Summary Judgment by July 20, 2018.

The deadline to complete discovery in this action does not expire until October 4, 2018.[19]

V. Argument

Shrader throws a variety of arguments at the summary judgment wall, hoping one will stick. All of Shrader's arguments are without merit, and Shrader's Motion should be denied.

A. The Health Plans have Article III standing to bring their MSP and ERISA Claims.

1. The Health Plans have Article III standing to bring their MSP claims.

Shrader first argues that the Health Plans lack Article III standing to bring their MSP claims because the relevant plan documents, CMS's list of MA Plans and the Health Plans' SEC filings show that the Health Plans "are not MAOs," and accordingly "neither provided health benefits under MA plans nor suffered injury from any purported failure to reimburse."[20] And Shrader is right on the facts: the Health Plans themselves are not MAOs; they are instead holding companies operating in individual states through

[19] *See* Disc. Confidentiality Order, April 5, 2018, ECF No. 98.

[20] Shrader's Mot. at 17.

wholly-owned subsidiary MAOs.[21] These subsidiaries include every MAO identified in the plan documents. The same subsidiaries are identified as such on CMS's website, which lists all MAO plans as well as their parent corporations.[22]

But, Shrader is wrong on the law. the MAO plans' status as subsidiaries of the Health Plans, and their absence as named plaintiffs in this case, is no basis for dismissal of the Health Plans' claims, because the Supreme Court has held that parent companies have Article III standing to bring claims for injuries borne directly by their subsidiaries.[23] In that case, a California tax on subsidiary corporations "threaten[ed] to cause actual financial injury" to their parent corporations "by illegally reducing the return on their investments" in their subsidiaries and "by lowering the value of their stockholdings."[24] Because a subsequent ruling in the parents' favor "would prevent such injuries," the parent corporations had Article III standing to sue.[25]

Shrader's reliance on cases involving MSP Recovery Claims, MSPA Recovery Claims, and the like (the "MSP Recovery Entities") is misplaced, because all of these

[21] *See id.* ("The [Health Plans'] public filings indicate that they are holding companies that operate through subsidiaries . . . .").

[22] *See* CMS MA Plan Directory at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/MA-Plan-Directory-Items/MA-Plan-Directory.html (last visited Aug. 7, 2018).

[23] *Franchise Tax Bd. of Calif. v. Alcan Aluminium Ltd.*, 493 U.S. 331, 335-36, 110 S. Ct. 661, 107 L. Ed. 2d 696 (1990); *BCC Merch. Sols., Inc. v. Jet Pay, LLC*, 129 F. Supp. 3d 440, 449 (N.D. Tex. 2015) ("The Supreme Court has held . . . that a parent company does have Article III standing on the basis of injury to a subsidiary."); *In re Neurontin Mktg. & Sales Practices Litig.*, 810 F. Supp. 2d 366, 369 (D. Mass. 2011) ("The Supreme Court's most authoritative statement on Article III standing of shareholders and the prudential doctrine of shareholder standing came in *Franchise Tax Board of California v. Alcan Aluminium Ltd*. There, a wholly-owned subsidiary was taxed by the state of California. The subsidiary's parent companies, rather than the subsidiary itself, sued for relief. The Supreme Court concluded that the parent companies clearly had standing.").

[24] *Alcan Aluminium*, 493 U.S. 331 at 336.

[25] *Id.*

plaintiffs lacked Article III standing for reasons entirely unrelated to the artificial distinction between a parent corporation and its subsidiaries that Shrader would have the court adopt.

The MSP Recovery Entities derived their purported right to sue by dint of an assignment from, among others, an MAO called Florida Healthcare Plus, Inc. ("FHCP"), which ceased doing business in Florida in 2015.[26] In its two-year existence, FHCP claimed to have provided coverage as an MAO to approximately 10,000 Floridians.[27] In November 2014, eleven FHCP employees, including their CEO, were indicted for participating in a scheme to defraud Medicare and Medicaid by submitting false and fraudulent enrollment applications which claimed that FHCP beneficiaries resided in Florida when, in fact, they resided in Nicaragua and the Dominican Republic.[28] The Florida Department of Financial Services (the "FDFS") took over the company the following month, liquidating it in January 2015.[29] At some point before that, the MSP Recovery Entities acquired or claimed to have acquired by assignment FHCP's rights of recovery under the MSP Act.

The MSP Recovery Entities' only apparent function is to serve as class representatives in hundreds of lawsuits filed across the country by the MSP Recovery Law Firms, using its assignment from FHCP and other MAOs as the basis for asserting

[26] Bob Herman, "Florida Medicare HMO to Shut Down," MODERN HEALTHCARE, Dec. 16, 2014, available at http://www.modernhealthcare.com/article/20141216/NEWS/312169967.

[27] *See* ATLANTIC INFORMATION SERVICES, INC., AIS'S DIRECTORY OF HEALTH PLANS: 2014 at 152 (Susan Namovicz-Peat et al., eds.), a true and correct copy of which is attached hereto as **Exhibit B**.

[28] *See* Herman, *supra* note 23.

[29] *Id.*

Article III standing to bring their class claims. However, because FHCP's recovery rights were never better than dubious, and the MSP Recovery Entities lacked a valid assignment either from FHCP or the FDFS, courts have routinely dismissed their cases for lack of Article III standing.[30] Other suits brought by the MSP Recovery Entities involving purported assignments from other MAO plans have faced similar difficulties.[31]

Unlike the MSP Recovery Entities, the Health Plans are parents of dozens of fully-owned subsidiary MAO plans. The Health Plans and their subsidiaries are identified as such on the Medicare website's list of MAOs.[32] And unlike the MSP Recovery Entities, all have Article III standing not by dint of a legally deficient assignment from a fly-by-night MAO, but because of their direct ownership of the MAOs.

Of course, if the Court has any concerns in this regard, it is, at worst, a pleading defect that the Health Plans can correct by either amending their Complaint under Rule 15(a)(2) to add a handful of paragraphs elucidating the relationships between the Health

[30] *See, e.g.*, *MSPA Claims 1, LLC v. Kingsway Amigo Ins. Co.*, No. 16-20212-CIV, 2016 U.S. Dist. LEXIS 105571, at *5 (S.D. Fla. July 27, 2016); *MSPA Claims 1, LLC v. United Auto. Ins. Co.*, 204 F. Supp. 3d 1342, 1345 (S.D. Fla. 2016); *MSPA Claims 1, LLC v. Infinity Auto Ins. Co.*, 204 F. Supp. 3d 1346, No. 16-20320-Civ, 2016 U.S. Dist. LEXIS 116445, 2016 WL 4531943, at *2 (S.D. Fla. Aug. 30, 2016); *MSPA Claims 1, LLC v. First Acceptance Ins. Co.*, No. 16-20314-CIV, 2016 U.S. Dist. LEXIS 116628, 2016 WL 4523850, at *2 (S.D. Fla. Aug. 29, 2016); *MSPA Claims 1, LLC v. Nat'l Specialty Ins. Co.*, No. 16-20401-Civ, 2016 U.S. Dist. LEXIS 113936, 2016 WL 4479372, at *2 (S.D. Fla. Aug. 25, 2016); *MSPA Claims 1, LLC. v. Tower Hill Prime Ins. Co.*, No. 1:16-cv-20460-KMM, 2016 U.S. Dist. LEXIS 119710, 2016 WL 4157593, at *1 (S.D. Fla. Aug. 3, 2016).

[31] *See, e.g.*, *MSP Recovery, LLC v. Allstate Ins. Co.*, No. 15-20788-CIV, 2015 U.S. Dist. LEXIS 178181, at *7 (S.D. Fla. June 24, 2015) (dismissing MSP Act claim against no-fault insurer because plaintiff had failed to plead that an insured's injuries were related to a car accident); *MSP Recovery Claims, Series LLC v. ACE Am. Ins. Co.*, No. 17-CV-23749, 2018 U.S. Dist. LEXIS 40371, at *20-21 (S.D. Fla. Mar. 9, 2018) (dismissing with prejudice plaintiff's amended complaint when it failed to plead that it had an assignment from an MAO); *MSP Recovery Claims, Series LLC v. Travelers Cas. & Sur. Co.*, No. 17-23628-CIV-WILLIAMS, 2018 U.S. Dist. LEXIS 105078, at *11-12 (S.D. Fla. June 21, 2018) (same).

[32] *See* CMS MA Plan Directory at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/MA-Plan-Directory-Items/MA-Plan-Directory.html (last visited Aug. 7, 2018).

Plans and their wholly-owned subsidiaries and/or by moving to join their subsidiaries under Rule 20(a). Either is a more sensible outcome than dismissal, given the strong presumption in favor of joinder, even for proceedings that have advanced much further than the present one.[33] Accordingly, there is no basis to grant summary judgment for Shrader on ground that the Health Plans do not have Article III standing to sue under the MSP Act.

2. Aetna has standing as a plan fiduciary to bring an ERISA claim as to Claimant No. 4.[34]

Shrader next argues that Aetna and United's claims for equitable relief under ERISA must fail because both plans lack Article III standing to bring their claims. Shrader makes this contention because (i) the Health Plans have produced SPDs rather than the "actual Plan Documents," which "alone entitles Shrader to judgment as a matter of law"; (ii) the SPDs that Aetna produced show that a "separate corporate entity" rather than Aetna is the claims administrator for the plan; and (iii) the plan documents do not identify Aetna and United as "claims administrators," and even if they did, it would be insufficient to show that they are plan fiduciaries because the Health plans "have produced no evidence establishing that they exercise discretionary authority concerning the ERISA plans on which they sue sufficient to render them plan fiduciaries."

[33] *See, e.g.*, *Broadstar Wind Sys. Grp. Ltd. Liab. Co. v. Stephens*, 459 F. App'x 351, 358 (5th Cir. 2012) (affirming district court's decision to join a subsidiary *sua sponte* after the conclusion of a bench trial); *Kaiser Found. Health Plan, Inc. v. Pfizer, Inc. (In re Neurontin Mktg. & Sales Practices Litig.)*, 810 F. Supp. 2d 366, 373 (D. Mass. 2011) (allowing plaintiff health plan to join six subsidiaries after it prevailed in a six-week jury trial).

[34] Aetna hereby waives its ERISA claim as to Claimant No. 14. The Health Plans also waive their ERISA claim as to Claimant No. 5. *See supra* note 2.

All of these arguments are without merit. First, to the extent that Shrader is arguing that dismissal is appropriate because the Health Plans produced SPDs rather than "actual Plan Documents," the majority of courts to have ruled on the issue have held that this is a distinction without a difference.[35]

Second, while Shrader is correct that Aetna's SPDs with respect to Claimant No. 4 identify "Aetna Life Insurance Company," not "Aetna, Inc." as the claims administrator, the former is a wholly-owned Aetna subsidiary, and Aetna has Article III standing as its parent to bring these claims.[36]

Third, the Health Plans are not aware of a single case holding that an ERISA defendant is entitled to summary judgment as a matter of law when a plaintiff is unable to "establish standing under the actual Plan Documents" rather than by showing its status as a plan fiduciary through other means. Nor, for that matter, are the Health Plans required to prove that they are plan fiduciaries through SPDs, which, like ERISA plan documents,

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[35] *See Horn v. Berdon, Inc. Defined Benefit Pension Plan*, 938 F.2d 125, 127 (9th Cir. 1991) ("(T)here is no requirement that documents claimed to collectively form the employee benefit plan be formally labeled as such."); *Fontaine v. Metro. Life Ins. Co.*, 800 F.3d 883, 888 (7th Cir. 2015) ("[T]he artificial distinction that [defendant] draws between ERISA Plan documents and insurance policies, which are linked together so closely, has no basis in either law or common sense") (citing *UNUM Life Ins. Co. of Am. v. Ward*, 526 U.S. 358, 376 (1999)); *Sterio v. HM Life*, 369 F. App'x 801, 803 (9th Cir. 2010) ("The insurance policy is the plan document in this case.") (citation omitted); *Cinelli v. Sec. Pac. Corp.*, 61 F.3d 1437, 1441 (9th Cir. 1995) ("[I]t is clear that an insurance policy may constitute the 'written instrument' of an ERISA Plan.") (citing *Musto v. Am. Gen. Corp.*, 861 F.2d 897, 900-01 (6th Cir. 1988); *Montoya v. Reliance Std. Life Ins. Co.*, No. 14-cv-2740-WHO, 2015 WL 884643, at *3 (N.D. Cal. Mar. 2, 2015) (finding the insurance policy was the operative ERISA Plan document for purposes of determining whether the plaintiff had to exhaust remedies); *Frazier v. Life Ins. Co. of N. Am.*, 725 F.3d 560, 566 (6th Cir. 2013) (finding that an insurance policy is the ERISA Plan document); *Gable v. Sweetheart Cup Co.*, 35 F.3d 851, 856 (4th Cir. 1994) ("An insurance policy may constitute the 'written instrument' of an ERISA Plan"); *Campo v. Oxford Health Plans, Inc.*, No. 06-cv-4332 (JBS), 2007 WL 1827220, at *3 (D.N.J. June 26, 2007) (referring to the "Certificate [that] sets out the terms and conditions of Oxford's health benefits policy (the ERISA plan)" when deciding Oxford's motion).

[36] *See supra* Section A.1.

are created to explain to *plan members* the benefits and obligations that they and their health plan assume by participating in a self-funded ERISA plan, rather than to set forth the benefits and obligations assumed by the plan administrator and the *entity funding the plan* when it enters a contract with a plan administrator. Information of this sort is found in the ASO Agreements governing the relationship between the Health Plans and the entities whose plans they administer. The analysis in *Humana v. Nguyen*, cited extensively in Shrader's brief, focused on the Plan Management Agreement ("PMA") between Humana and the plan's sponsor.[37] The PMA was an ASO agreement, not the ERISA Plan Documents or SPDs distributed to members under the plan, and analysis of the PMA was central to resolving the issue of Humana's status as a fiduciary. This is because ASO agreements need to assign fiduciary responsibilities, both as a practical and legal matter.

Plaintiff 4 received health benefits through an ERISA plan funded by Industrial Piping Specialists, Inc. ("IPS") and administered by Aetna. Among other things, the ASO agreement between Aetna and IPS expressly names Aetna as an ERISA fiduciary:

> **Claim Determinations; ERISA Claim Fiduciary.** For the purpose of section 503 of Title 1 of the Employee Retirement Income Security Act of 1974, as amended (ERISA), [Aetna is] a fiduciary with complete authority to review all denied claims for benefits under this Policy. . . . [Aetna] shall have discretionary authority to determine whether and to what extent eligible employees and beneficiaries are entitled to benefits and to construe any disputed or doubtful terms under this Policy, the Certificate or any other document incorporated herein. [Aetna] shall be deemed to have properly exercised such authority unless [it] abuse[s] [its] discretion by

[37] *See Humana Health Plan, Inc. v. Nguyen*, 785 F.3d 1023, 1025 (5th Cir. 2015) ("API entered into a Plan Management Agreement ("PMA") with Humana, through which Humana agreed to serve as "Plan Manager" and to provide various administrative services to the Plan.").

> acting arbitrarily and capriciously. [Aetna has] the right to adopt reasonable policies, procedures, rules, and interpretations of this Policy to promote orderly and efficient administration.[38]

Because the ASO between IPS and Aetna unambiguously states that Aetna is the Plan's fiduciary, Shrader's motion as to Claimant No. 4 should be denied.

B. The Health Plans are entitled to bring an action under the MSP Act against Shrader.

1. The MSP Act allows the Health Plans to bring this suit.

There is no longer any serious question concerning an MAO's ability to bring an action under the MSP Act.[39] In its motion, Shrader appears to finally concede this and instead focuses its argument on the scope of the rights afforded to MAOs.[40]

An MAO's cause of action arises whenever a primary plan fails to provide for primary payment as required by the statute.[41] When an MAO does not get reimbursed, that MAO suffers an injury for which it can recover damages.

This Court has already held that "asbestos trusts can constitute primary plans under the MSP, and the settlements paid by asbestos trusts to Shrader on behalf of Shrader's clients can be a source of reimbursement under the MSP."[42] Shrader does not

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[38] *See* Aetna ASO at 18, a true and correct copy of which is attached hereto as **Exhibit C**.

[39] *See, e.g., Medical Plan, Inc. v. W. Heritage Ins. Co.*, 832 F.3d 1229, 1238 (11th Cir. 2016); *In re Avandia Mktg. Sales Practices & Prod. Liab. Litig.*, 685 F.3d 353, 367 (3d Cir. 2012) (MSP allows private right of action); *Humana, Inc. v. Shrader & Associates, LLP*, 584 B.R. 658, 677 (S.D. Tex. 2018) (same); *Guerrera*, 300 F. Supp.3d at 379 (citing cases in support of the conclusion that "the Second Circuit has clearly concluded that suit may be brought against the primary plan itself").

[40] *See* Shrader Mem. at 22-24 (arguing that Shrader is not a "primary plan" and thus not a proper defendant). Shrader's citation to "the manner in which appellate courts have described" the MSP. *See* Shrader Mem. at 22, n.13, rips general statements from those decisions out of context. The general background those courts discussed did not take place in the context of facts anywhere close to analogous here.

[41] 42 U.S.C. § 1395y(b)(3)(A).

[42] *Humana, Inc. v. Shrader & Associates, LLP*, 584 B.R 658, 681 (S.D. Tex. 2018).

challenge either of those holdings. Nor does Shrader contest that it and the Matched Claimants received settlement payments and that Health Plans were not reimbursed. With no challenge to the existence of, or factual basis for, the Health Plans' asserted claims, the only remaining question is whether the Health Plans may assert their claims against Shrader.

In contravention of the express intent of Congress and CMS, Shrader asks this Court to curtail MAO's rights and limit the universe of potential defendants strictly to "primary payers." The Health Plans counter that the better-reasoned result is to allow MAOs to bring their cause of action against one of the broad group of entities that Congress and CMS intended. The Health Plans' position not only comports with the clear intent of Congress and the CMS, but it also avoids the perverse incentives that would exist if parties were able to avoid their repayment obligations by hiding their recoveries from the companies that provide them with medical care.

2. Congressional intent, CMS regulations, and the language and purpose of the MSP all support a claim against Shrader.

To begin with, there is no express limitation in the MSP Act concerning the types of entities that MAOs may pursue. "Much like who may bring an action pursuant to the statute, the plain language fails to limit the parties against whom suit may be maintained."[43]

[43] *Humana Ins. Co. v. Paris Blank LLP*, 187 F. Supp.3d 676, 681 (E.D. Va. 2016); *see also Guerrera*, 300 F. Supp.3d at 379 ("[T]he express language of the Private Cause of Action provision does not specify who may be sued" and "the language of the provision itself does not clarify against whom suit is proper"); *see also Avandia*, 685 F.3d at 361 ("[T]here is nothing in the text or legislative history of the MA secondary payer provision that demonstrates a congressional intent to deny MAOs access to the MSP private cause of action.").

To determine the universe of defendants Congress and CMS intended for such suits, it is necessary to examine legislative intent and relevant pronouncements of CMS, the federal agency overseeing the Medicare program.[44] Both show a clear intent to provide MAOs with broad rights of recovery against not only a primary plan, but also against any entity or individual that receives payment from a primary plan, including attorneys such as Shrader.[45]

The *Avandia* court's discussion of legislative intent, while addressing the threshold question of whether an MAO could bring suit, is instructive here:

> Congress's goal in creating the Medicare Advantage program was to harness the power of private sector competition to stimulate experimentation and innovation that would ultimately create a more efficient and less expensive Medicare system. . . . It was the belief of Congress that the MA program would "continue to grow and eventually eclipse original fee-for-service Medicare as the predominant form of enrollment under the and Medicare program.". . . The MA program was thus, like the MSP statute, 'designed to curb skyrocketing health costs and preserve the fiscal integrity of the Medicare system. . . .
>
> It would be impossible for MAOs to stimulate innovation through competition if they began at a competitive disadvantage, and as CMS has noted, MAOs compete best when they recover consistently from primary payers. . . . When they "faithfully pursue and recover from liable third parties," MAOs will have lower medical expenses and will therefore be able to provide additional benefits to their enrollees. . . . If Medicare could threaten recalcitrant primary payers with double damages, and MAOs could not, MAOs would be at a competitive disadvantage, unable to exert the

[44] *See, e.g., Chevron U.S.A., Inc. v. Natural Res. Def. Council, Inc.*, 467 U.S. 837, 844 ("We have long recognized that considerable weight should be accorded to an executive department's construction of a statutory scheme it is entrusted to administer."); *see also Collins v. WellCare Healthcare Plans, Inc.*, 73 F.Supp.3d 653, 682 (E.D. La. 2014) (a finding of ambiguity compels the Court to apply *Chevron* deference). The Supreme Court has also recognized that *Chevron* deference is especially strong where, as here, the agency has been consistent in its view. *Decker v. Nw. Envtl. Def. Crt.*, 568 U.S. 597, 614 (2013).

[45] *See, e.g., MSPA Claims 1, LLC v. Bayfront HMA Med. Ct., LLC.*, 2018 WL 1400465, *6 (S.D. Fla. Mar. 20, 2018) ("deferring to CMS's regulations" and finding "that Plaintiff may bring a private cause of action for double damages if [the health care provider defendant] received a primary payment that should have been reimbursed to Plaintiff").

> same pressure and thus forced to expend more resources collecting from such payers. It is difficult to believe that it would have been the intent of Congress to hamstring MAOs in this manner.[46]

CMS has also explained how the recovery from liable third parties by MAOs helps achieve these congressional goals:

> We note that MAOs claim expenses related to MSP recoveries as part of their administrative overhead. MA organizations that faithfully pursue and recover from liable third parties will have lower medical expenses. Lower medical expenses make such plans more attractive to enrollees. The lower the medical expenses in an MA plan, the higher the potential rebate. The rebate is calculated as the difference between the cost of Medicare benefits and the benchmark for that plan. The benchmark is a fixed amount. Therefore, as the cost of Medicare benefits go down (with the benchmark remaining constant), the larger the rebate. Therefore, as more MSP dollars are collected or avoided, medical expense go down and rebates go up, allowing the sponsoring MA organization to offer potential enrollees additional non-Medicare benefits funded by rebate dollars. Such non-Medicare benefits include reductions in cost sharing. Since cost sharing is generally expressed as a percentage of medical costs, such cost sharing will also be proportionally lower as overall medical costs go down—providing MA organizations offering such plans with an additional competitive edge.[47]

The language of the MSP makes clear that Congress intended for the Medicare program to be entitled to reimbursement from "a primary plan, and an entity that receives payment from a primary plan."[48] CMS regulations dictate that MAOs be permitted to "exercise the same rights to recovery from a primary plan, entity, or individual that the

[46] *Avandia*, 685 F.3d 353.

[47] Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs, 74 Fed. Reg. 54634, 54711 (proposed Oct. 22, 2009); *see also Avandia*, 685 F.3d at 364 (explaining why, when MAOs recover their initial payments in an efficient manner, the Medicare Trust Fund achieves overall cost savings).

[48] 42 U.S.C. § 1395y(b)(2)(B)(ii) ("Repayment Required" section, discussing who must reimburse Medicare).

Secretary exercises under the MSP regulations in subparts B through D of part 411 of this Chapter."[49]

Finally, when predicting "the savings expected to be generated for MAOs as a result of their secondary payer status, CMS 'assume[d] a similar MSP rate for MA enrollees as obtains in original Medicare.'. . . If MAOs lacked the recovery mechanism available to 'original' Medicare, this assumption would be facially invalid."[50]

In the face of all this, not even Shrader disputes that both Congress and CMS intended to give MAOs broad rights to recovery. Multiple courts that have assessed this intent have found such broad rights warranted in order to achieve the overall goals of Congress in enacting the Medicare statute, and CMS in ensuring those goals are achieved.

The *Collins* court, noting "a distinction in the statutory language" regarding the government's recovery rights and those of MAOs, examined the nature and purpose of the statute, concluding that the clear intention was to allow for broad recovery from settlement funds.[51] The fact that settlement funds may have changed hands from the tortfeasor to the injured party (or their attorney) should not alter this intent; and to find

[49] *Id.* § 422.108(f); *see also* H.R. Rep. No. 105-217 at 638 (Congress intended MAOs to enjoy a status parallel to that of traditional Medicare).

[50] *Avandia*, 685 F.3d at 366 (citing Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs, 74 Fed. Reg. 54634, 54711 (proposed Oct. 22, 2009)).

[51] *Collins*, 73 F.Supp.3d at 666-67 (discussing *Brown v. Thompson*, 374 F.3d 253, 261 (4th Cir. 2005)).

otherwise would "encourage beneficiaries to hide their settlements from the MAOs and provide no recourse to the MAOs against the beneficiaries for such action."[52]

These same concepts underlie the decision in *Paris Blank*, where the court rejected the same argument put forth by Shrader here, noting

> the law does not carve out exceptions for attorneys and law firms. The statute generally establishes a private cause of action 'in the case of a primary plan which fails to provide for primary payment.' Much like who may bring an action pursuant to the statute, the plan language fails to limit the parties against whom suit may be maintained.
>
> To the extent the language is ambiguous, regulation dictates that MAOs 'exercise the same rights to recovery from a primary plan, entity, or individual that the Secretary exercises under the MSP regulations in subparts B through D of this chapter.' CMS has promulgated regulations identifying attorneys as an entity from which recovery may be brought under the MSP law by the Secretary. Accordingly, Plaintiff may maintain suit against Defendants for recovery of conditional premiums.[53]

More recently, a district court in the Southern District of Florida specifically examined CMS's pronouncements and found "the CMS regulations to be a permissible construction of the MSP."[54] Indeed, the *Bayfront* court found the "statutory scheme does not make sense if MAOs are required to provide certain benefits in the same manner as the Government but then are limited, in ways the Government is not, from pursuing reimbursement."[55] The *Bayfront* court concluded that the plaintiff was entitled to pursue a

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[52] *Id.* at 667.

[53] *Paris Blank*, 187 F.Supp.3d at 681-82 (internal citations omitted); *see also United States v. Harris*, No. 08-cv-102, 2009 WL 891931, at *3 (N.D. W. Va. Mar. 26, 2009) (holding personal injury attorney individually liable for failing to reimburse Medicare), *aff'd* 334 F. App'x 569 (4th Cir. 2009).

[54] *Bayfront*, 2018 WL 1400465, at *5-6. Shrader's failure to cite *Bayfront*, despite it being specifically referenced in a case Shrader cites in support of its position, is curious.

[55] *Id.*, 2018 WL 1400465, at *5.

private right of action against a health care provider who received a primary payment that should have been reimbursed.[56]

In contrast to these decisions, the *Guerrera* court simply held that MAOs have no right of recovery whatsoever against any entity that receives payment from a primary plan.[57] That holding flies in the face of the clearly expressed intentions of both Congress and CMS.[58] Indeed, the *Guerrera* court itself acknowledged that its "interpretation of the Private Cause of Action provision . . . conflicts with the intention of CMS that MAOs be accorded the same rights to recover as the government."[59] The court not only did not afford that intent any deference, it simply ignored it. The *Guerrera* court's conclusion that MAO's have only very limited recovery rights, and its refusal to provide CMS's regulations with the deference they warrant are not sound law or policy. Its holding should not be adopted here.[60]

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[56] *Id.*, 2018 WL 1400465, at *6.

[57] *Guerrera*, 300 F.Supp.3d at 382 ("Thus, to conclude that beneficiaries and their attorneys may be sued under the Private Cause of Action provision would mean that MAOs would not have rights equal to those of the government, but rather rights greater than those of the government, because the Private Cause of Action provision only provides for double damages.").

[58] *Cf.* 42 U.S.C. § 1395y(b)(2)(B)(ii) (Medicare entitled to recover from "a primary plan, and an entity that receives payment from a primary plan"); 42 C.F.R. § 422.108(f) (CMS intended MAOs to "exercise the same rights to recovery 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."); H.R. Rep. No. 105-217, at 638 (Congress intended MAOs to enjoy a status parallel to that of traditional Medicare).

[59] *Guerrera*, 300. F.Supp.3d at

[60] The only other case cited (but not discussed) by Shrader, *MSPA Claims 1, LLC v. Halifax Health, Inc.*, 2018 WL 3458298 (M.D. Fla. July 18, 2018), offers little guidance here. The court rejected an attempt, in a purported class action brought by the assignee of an MAO against a health care provider that had received a partial payment from the injured parties' no-fault PIP insurer, to pursue a claim against the provider. In so doing, the court never discussed the MSP's legislative history or CMS' intent. More persuasive is *Bayfront*, 2018 WL 1400465, at *5-6 (discussing legislative history, CMS intent, and *Chevron* deference in upholding a claim for double damages against a provider who received a primary payment (and rejecting the rationale of the *Halifax* court)).

Not only does the result reached by the *Guerrera* court contradict the purpose and intent of the MSP and related CMS pronouncements, but it would exacerbate the same perverse incentives identified by the *Collins* court. Beneficiaries and their attorneys would be incentivized to resolve their claims and collect their money without notifying the MAO, so that they could "receive a windfall from artfully concealing any cases or settlements with third party tortfeasors' and their insurance companies."[61] It could not have been the intent of Congress or CMS to leave MAOs with no remedy whatsoever while incentivizing tortfeasors, injured parties, and their attorneys to conduct their dealings in secret.

C. One of UHC's ERISA claims was inadvertently labeled an MSP Act claim.

Shrader is correct that one of UHC's ERISA claim as to Claimant No. 9 was inadvertently labeled an MSP claim in the supplement to the Health Plans' Complaint. The Health Plans intend to amend the Supplement to correct this mistake.

Shrader also maintains, on grounds identical to those forwarded elsewhere in its motion, that summary judgment for lack of standing would still be appropriate even if the Health Plans' Complaint had correctly identified it as an ERISA claim.[62] That argument fails for the reasons set forth in Section A.2. Specifically, UHC is the parent corporation of the subsidiary that administers Coca Cola's Plan and therefore has Article III standing under settled Supreme Court jurisprudence to bring claims on its own behalf.[63] Moreover,

[61] *Collins*, 73 F. Supp. 3d at 667.

[62] *See* Def.'s Mot. at 25 n. 15..

[63] *See supra* note 20.

UHC's ASO contract with Coca Cola expressly gives UHC the discretionary authority to pursue claims such as this one:

> We will also provide services to recover Plan benefits that were paid and are recoverable by the Plan because payment was or should have been made by a third party for the same medical expense (other than in connection with coordination of benefits, Medicare, or other Overpayments). This is referred to as "Third Party Liability Recovery" (or "subrogation"). You will not engage any entity except Us to provide Third Party Liability Recovery services without prior notice to Us. If You desire to apportion Third Party Liability Recovery services, such as having another entity handling a category of Third Party Liability Recoveries such as auto accident, workers' compensation or general liability recoveries, You will obtain Our agreement that We can coordinate such services prior to engaging any entity to provide a portion of the Third Party Liability Recovery services. You may terminate Our subrogation services at any time after thirty (30) days advance written notice to Us.
>
> You will be charged fees when any of the services described herein are provided by Us through a subcontractor or affiliate. The fees are deducted from the actual recoveries. You will be credited with the net amount of the recovery.
>
> You delegate to Us the discretion and authority to develop and use standards and procedures for any recovery, including but not limited to, whether or not to seek recovery, what steps to take if We decide to seek recovery, and the circumstances under which a claim may be compromised or settled for less than the full amount of the claim. You acknowledge that use of Our standards and procedures may not result in full or partial recovery for any particular case. We will not pursue any recovery if it is not permitted by any applicable law, or if recovery would be impractical. We may initiate litigation to recover payments, but We have no obligation to do so. If We initiate litigation, You will cooperate with Us in the litigation.[64]

The same contract also expressly names UHC the claims fiduciary for the plan:

> **Section 5.1 ERISA Claim Procedures.** You appoint Us a named ERISA fiduciary under the Plan with respect to (i) performing initial benefit determinations and payment, (ii) performing the fair and impartial review of first level internal appeals, and (iii) performing the fair and impartial

[64] *See* Coca Cola ASO at 6, a true and correct copy of which is attached hereto as **Exhibit D**.

> review of second level internal appeals. As such, You delegate to Us the discretionary authority to (i) construe and interpret the terms of the Plan, (ii) determine the validity of charges submitted to Us under the Plan, and (iii) make final, binding determinations concerning the availability of Plan benefits under the Plan's internal appeal process.[65]

D. The Matched Claimants are not required, nor indispensable under Rule 19.

The purpose of a motion under Federal Rule of Civil Procedure 12(b)(7) is to challenge a plaintiff's failure to join a required party under Rule 19.[66] Resolving such a motion requires a two-step inquiry. First, Rule 19(a) is applied to determine whether an absent person is required and his joinder is feasible.[67] If the person is required and joinder is feasible, the Court must order the absent person be made a party.[68] If joinder is required, but is not feasible, the Court must then determine "whether, in equity and good conscience, the action should proceed among the existing parties or should be dismissed," i.e., whether the person is indispensable.[69]

If the Court determines in equity and good conscience that the person is dispensable, the action may continue without joinder. If the Court, however, determines in equity and good conscience that the person is indispensable and thus, the action cannot proceed without said person, the Court must dismiss the action.[70]

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[65] *Id.* at 7.

[66] *See* FED. R. CIV. P. 12(b)(7).

[67] *See id.* 19(a).

[68] *Id.* 19(a)(2).

[69] *Id.* 19(b). *United States v. Rutherford Oil Corp.*, No. 08-CV-0231, 2009 WL 1351794, at *1 (S.D. Tex. May 13, 2009) (citations omitted).

[70] *Hood ex rel. Miss. v. City of Memphis, TN*, 570 F.3d 625, 629 (5th Cir. 2009).

Courts are reluctant to grant motions under Rule 12(b)(7).[71] When evaluating whether a required person is indispensable, courts have "substantial discretion," but in exercising said discretion they should bear in mind that "very few cases should be terminated due to the absence of nondiverse parties unless there has been a reasoned determination that their nonjoinder makes just resolution of the action *impossible.*"[72] When assessing such a motion, courts must also accept all factual allegations of the complaint as true and draw any inferences in favor of the non-moving party.[73] Finally, courts may consider extrinsic evidence.[74]

1. The Matched Claimants are not required parties under Rule 19(a). [75]

The party advocating joinder has the initial burden of demonstrating that a missing person is required.[76] Under Rule 19(a)(1)(B), a person is a required party if "that person claims an interest relating to the subject matter of the action *and* is so situated that disposing of the action in the person's absence may:

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[71] *Dozier v. Sygma Network, Inc.*, No. 3:15-CV-2783-B, 2016 U.S. Dist. LEXIS 32164, at *3 (N.D. Tex. Mar. 14, 2016) (quoting 5C Charles Alan Wright & Arthur R. Miller, Federal Practice & Procedure § 1359 (3d ed. 2004)).

[72] *Travelers Indemnity Co. v. Household Int'l, Inc.*, 775 F. Supp. 518, 527 (D. Conn. 1991) (citing *Jaser v. New York Property Ins. Underwriting Ass'n*, 815 F.2d 240, 242 (2d Cir. 1987)) (emphasis added).

[73] *Dozier*, 2016 U.S. Dist. LEXIS 32164, at *4.

[74] *Timberlake v. Synthesis Spine, Inc.*, No. V-08-4, 2011 U.S. Dist. LEXIS 70894, 2011 WL 2607044, at *2 (S.D. Tex. June 30, 2011).

[75] The Health Plans recognize that in the Court's March 16 Opinion, it concluded that the Matched Claimants were required parties. *See* Mem. Op. & Order, Mar. 16, 2018, ECF No. 93. However, this conclusion was based on the Court's determination that it did not have "information sufficient to distinguish the Matched Claimants that have no interest in settlement proceeds in Shrader's possession from that that do." Mem. Op. & Order at 61. The Health Plans have since supplemented their complaint to clarify that they are only seeking to recover from the portion of any recovery that Shrader itself has retained after distributing the remainder to the Matched Claimants. *See* Pls.' Suppl. to Pls.' Am. Compl. at 2, April 30, 2018, ECF No. 108. Thus, the reason why the Court made that initial determination is no longer applicable.

[76] *Hood ex rel. Miss.*, 570 F. 3d at 628.

i. as a practical matter impair or impede the person's ability to protect the interest; or

ii. leave an existing party subject to a substantial risk of incurring double, multiple, or otherwise inconsistent obligations because of the absent person's interest."[77]

The Matched Claimants do not satisfy this definition.

Shrader asserts that the Matched Claimants claim an interest in the subject matter of this lawsuit because (a) the Health Plans are allegedly seeking to litigate the Matched Claimants' contractual obligations, (b) the Health Plans are allegedly seeking to recover funds that belong to the Matched Claimants, (c) proceeding without the Matched Claimants would allegedly impair their ability to protect their interests in the settlement funds they have been awarded (in separate legal actions), and (d) proceeding without the Matched Claimants would allegedly subject Shrader to a substantial risk of incurring inconsistent obligations.[78] Shrader is wrong.

a) The Health Plans are not seeking to litigate the Matched Claimants' contractual obligations.

Shrader misstates the basis of the Health Plans' claims for reimbursement of benefits provided under MA Plans. Specifically, litigation of the Health Plans' MSP Act

[77] FED. R. CIV. P. 19(a)(1)(B) (emphasis added). A person may also be a required party if "in that person's absence, the court cannot accord complete relief among existing parties." *Id.* 19(a)(1)(A). Shrader does not argue that the Matched Claimants must be joined in order for the Court to accord complete relief. *See* Shrader's Mot. at 27-32. Nor could it; this analysis hinges on whether, in the absence of the Matched Claimants, the Court could order relief that would achieve the objective of this action. The objective of this action—to determine Shrader's liability under the MSP and ERISA can be fully adjudicated—can be fully achieved with the existing parties. Any potential effect on the Matched Claimants is not part of this analysis. *See Niven v. E-Care Emergency McKinney, LP*, No. 14-CV-00494, 2015 WL 1951811, at *1 (E.D. Tex. Apr. 10, 2015) ("The definition of 'complete relief' under Rule 19(a)(1) refers to relief as between the persons already parties, not as between a party and the absent person whose joinder is sought." It "does not concern 'any subsequent relief via contribution or indemnification for which the absent party might later be responsible.'") (citations omitted).

[78] *See* Shrader's Mot. at 27-32, ECF No. 116.

claims does not require any interpretation or analysis of the Matched Claimants' contractual obligations. Indeed, the only analysis of the MA Plans that is required to litigate these claims is determining whether the Health Plans are MAOs as to the MA Plans.[79] The other issues necessary to resolve these claims—i.e., Shrader's receipt of funds in connection with a Matched Claimant's asbestos recovery and Shrader's failure to remit any portion of that to the Health Plans—do not require any interpretation or analysis of the Matched Claimants' contractual obligations.[80]

b) The Matched Claimants do not have an interest in the funds sought to be recovered by the Health Plans.

As clarified in the Health Plans complaint supplement, the Health Plans do not seek funds that belong to or in which the Matched Claimants have any interest. The MSP gives the Health Plans a direct, private claim against Shrader for its mishandling of the settlement funds.[81] And, damages awarded on these claims is not tied to, limited by, or required to be paid out of the mishandled settlement funds. Shrader, however, conveniently ignores this because it proves that the Matched Claimants have no interest in the subject matter of the MSP claims asserted against Shrader. Instead, Shrader focuses entirely on the Health Plans' ERISA claims.

But even there, Shrader again completely ignores cases that directly contradict its position. Specifically, to the extent the Health Plans seek recovery on their ERISA claims from settlement funds that Shrader has already disbursed (although it surely retains at

[79] *See* Pls.' Am. Compl. ¶¶ 2, 54-62, ECF No. 62; *see supra* Section A.1.

[80] *See* Pls.' Am. Compl. ¶¶ 2, 54-62, ECF No. 62; *see supra* Section B.

[81] *See supra* Section B.

least a portion, namely the percentage it kept as a fee), the Matched Claimants have no current, direct interest in those funds.[82] To the extent they seek recovery from "current" settlement funds actually (or soon to be) in Shrader's possession, the Court can consider whether the Matched Claimants covered by ERISA plans have an interest in those funds sufficient to warrant their inclusion in this litigation.

c) Proceeding without the Matched Claimants would not impair their ability to protect their alleged interest in settlement funds they have been awarded because, as stated above, they do not have any interest in the funds the Health Plans are seeking to recover.

Arguing that proceeding without the Matched Claimants would impair the Matched Claimants' ability to protect their alleged interests in the damages sought by the Health Plans ignores reality. As explained above, the Matched Claimants do not have any interest in the subject matter of the Health Plans' MSP Act claims, nor do they have any interest in the damages the Health Plans seek for their ERISA claims to the extent they relate to asbestos recoveries on which Shrader has already distributed the Matched Claimants their portion of the settlement funds to the Matched Claimants. In these instances, the Health Plans are only seeking to recover damages out of that portion of the settlement funds that Shrader has retained as a fee, and the Matched Claimants certainly have no interest in those funds.

[82] *See, e.g., Longaberger Co. v. Kolt*, 586 F.3d 459 (6th Cir. 2009) (upholding equitable restitution claim against personal injury attorney who received, but disbursed, settlement on behalf of client who had received medical benefits from an ERISA plan), *abrogated on other grounds*, *Montanile*, 136 S. Ct. 651 (2016); *cf. ACS Recovery Servs., Inc. v. Griffin*, 723 F.3d 518, 526 (5th Cir. 2013) (constructive trust imposed to enforce ERISA plan's equitable lien on settlement proceeds held by beneficiary's tort lawyer).

d) Shrader will not be subjected to inconsistent obligations if the case proceeds without the Matched Claimants.

Shrader identifies two sets of inconsistent obligations that it allegedly would be subject to if this case proceeds without the Matched Claimants:

i. adjudication by this Court that the Health Plans are entitled to reimbursement from funds recovered on behalf of the Matched Claimants versus adjudication in a separate action between Shrader and the Matched Claimants that no such reimbursement right exists;[83] and

ii. the risk that the Matched Claimants may sue Shrader in a separate legal proceeding if it were to distribute part of the Matched Claimants' settlement funds to the Health Plans in this case.[84]

Again, however, Shrader either completely misunderstands the basis of the Health Plans' claims and the relief they are seeking, or it is intentionally trying to confuse the issues and the Court.

First, the Health Plans' MSP claims against Shrader are direct, private claims. That is, damages awarded on these claims are not tied to or required to be paid out of any assets, including settlement funds, in which the Matched Claimants have an interest. As a result, Shrader's payment of any damages will not create a colorable legal claim by the Matched Claimants against Shrader in which the Health Plans' reimbursement rights would be adjudicated. For these same reasons, proceeding without the Matched Claimants on the Health Plans' MSP Act claims does not create any risk that the Matched

[83] *See* Shrader's Mot. at 28.

[84] *See id.* at 29.

Claimants will sue Shrader in a separate proceeding for distributing settlement funds to the Health Plans in this case.

Second, the Health Plans are only seeking reimbursement related to funds recovered on behalf of the Matched Claimants on two ERISA claims.[85] To the extent these claims arise from settlement funds that Shrader has already distributed to the Matched Claimants, the Health Plans are only seeking recovery out of the portion of the funds that Shrader retained as its fee.[86] Accordingly, there is no risk that the Matched Claimants will sue Shrader in a separate proceeding related thereto. And, although it is hard to believe that Shrader would sue its own clients—the Matched Claimants under these circumstances, if it does, the court in that lawsuit would be adjudicating the contractual rights between the parties arising under the agreement between them.

To the extent these claims arise from settlement funds that Shrader has not yet distributed to the Matched Claimants, there is no legal basis for the Matched Claimants to sue Shrader. Shrader, pursuant to its agreement with the Matched Claimants, has the contractual right to deduct from settlement funds "any third party's rights or interests provided for by . . . right of reimbursement, subrogation, . . . or other binding agreements" before disbursing the remaining funds to the Matched Claimants.[87] The agreement between Shrader and the Matched Claimants also contains the following:[88]

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[85] Those three ERISA claims relate to Claimant No. 4 and Claimant No. 9.

[86] *See* Pls.' Suppl. to Pls.' Am. Compl. at 2.

[87] *See, e.g.*, Attorney-Fee Contract and Power of Attorney at 1, a true and correct copy of which is attached hereto as **Exhibit E.**

[88] *Id.* at 3.

> Client understands and agrees that it is expressly and solely his/her financial responsibility to fully satisfy any and all liens (specifically including, but not limited to liens asserted by Medicare, Medicaid, or any other State or Federal agency) asserted on any proceeds from this lawsuit that exist now or in the future, and agrees to indemnify and hold harmless its attorneys in any actions, lawsuits, or attempts to recover proceeds from this lawsuit in satisfaction of any liens asserted on those proceeds by any person or entity.

Most importantly, both Shrader and the Matched Claimants have contractual and/or statutorily mandated obligations to reimburse the Health Plans out of the settlement funds.

In summary, the Health Plans are not seeking to litigate the Matched Claimants' contractual obligations; nor are they seeking to recover funds that belong to the Matched Claimants or in which the Matched Claimants otherwise have any interest. Proceeding without the Matched Claimants will not impair their ability to protect their interest in their asbestos recoveries. Nor will proceeding without the Matched Claimants subject Shrader to a substantial risk of incurring inconsistent obligations.[89] For these reasons, the Matched Claimants are not required parties under Rule 19(a), and the Health Plans respectfully request the Court deny Shrader's Motion accordingly.

2. To the extent the Matched Claimants are required parties under Rule 19(a), which the Health Plans dispute, the limited evidence produced to date indicates that it is feasible to join them in this case.

If the Matched Claimants are required under Rule 19(a), which the Health Plans dispute, the Court must determine whether it is feasible to join them in this case.[90] It is not feasible to join the Matched Claimants if (i) they are not subject to service of process

[89] What Shrader implies (but never admits) is that it would sue its own clients to recoup any monies it is forced to pay to the Health Plans. Indeed, the attorneys' fee contract entered into with many Matched Claimants expressly gives Shrader the right to do so. However, a defendant's intention to implead an absent non-party for purposes of asserting an indemnity or contribution claim does not make that non-party a "required" party as to the plaintiffs' initial claim. *See, e.g., Nottingham v. Gen. Am. Comms. Corp.*, 811 F.2d 873, 880-81 (5th Cir. 1987).

[90] *See Janney Montgomery Scott, Inc. v. Shepard Niles, Inc.*, 11 F.3d 399, 404 (3d Cir. 1993).

(i.e., beyond the personal jurisdiction of the court), (ii) their presence would deprive the Court of subject-matter jurisdiction, or (iii) they have a valid objection to venue.[91]

The Health Plans' claims arise under ERISA and the MSP, both of which are federal laws. Therefore, the Court has federal-question jurisdiction over the Health Plans claims even if the Matched Claimants are joined, and their presence would not deprive the Court of subject-matter jurisdiction.

ERISA provides for nationwide service of process on Matched Claimants[92] that received benefits under ERISA plans.[93] Binding Fifth Circuit precedent also establishes personal jurisdiction over these Matched Claimants.[94] Shrader is aware of this Fifth Circuit precedent[95] but fails to bring that precedent to this Court's attention, let alone try to distinguish it.[96] Indeed, Shrader erroneously claims that the Court does not have jurisdiction over Claimant No. 9 solely because he is a Pennsylvania resident, thereby failing to give any consideration to ERISA's statutory grant of personal jurisdiction.[97] Because the Health Plans' claims concerning Shrader's recovery of settlement funds on

[91] *See* FED. R. CIV. P. 19(a)(1), (a)(3).

[92] Claimant No. 4, Claimant No. 5, Claimant No. 9, and Claimant No. 14 were covered by ERISA plans. The Health Plans have waived their claim against Claimants Nos. 5 and 14. Claimant No. 4 is also a Texas resident. Therefore, in addition to ERISA's statutory grant of personal jurisdiction, this Court also has personal jurisdiction over Claimant No. 4 as a result of his Texas residency.

[93] *See* 29 U.S.C. § 1132(e)(1).

[94] *See Bellaire Gen. Hosp. v. Blue Cross Blue Shield*, 97 F. 3d 822, 825-26 (5th Cir. 1996).

[95] *See, e.g.*, Pls.' Reply in Supp. of Pls.' Mot. for Prelim. Inj., 7-8 [Doc. 41]. The fact that this binding Fifth Circuit precedent was specifically brought to Shrader's attention in November, and yet is completely ignored in Shrader's Motion is telling.

[96] *See* Decl. of Justin Hyde Shrader, ¶ 2[Doc. 37-2].

[97] *See* Shrader's Mot. at 29.

behalf of Claimant Nos. 4 and 9 arise under ERISA,[98] this Court has personal jurisdiction over these Claimants.

This Court unquestionably has personal jurisdiction over any Matched Claimants that are residents of the State of Texas.

With regard to non-resident Matched Claimants that received benefits under MA plans, the relevant inquiry is whether they have minimum contacts with Texas, and whether the due process concerns of the Fifth Amendment are satisfied and traditional notions of fair play and substantial justice are not offended if the Court exercises personal jurisdiction over them.[99] When examining the jurisdictional evidence presented by the parties, "the Court must draw all reasonable inferences and construe and conflicts in favor of plaintiffs."[100]

"Minimum contacts can give rise to either specific jurisdiction or general jurisdiction."[101] General personal jurisdiction exists when a nonresident's affiliations with the forum state are so continuous and systematic as to render the nonresident essentially at home in the forum state.[102] That is, general jurisdiction requires "extensive contacts between a [nonresident] and a forum [state]."[103] Specific personal jurisdiction exists "when a nonresident . . . has purposefully directed its activities at the forum state

[98] *Verizon Emp. Benefits Comm. v. Adams*, No. 3:05-CV-1793-M, 2006 WL 66711, at *3 (N.D. Tex. Jan. 11, 2006).

[99] *Trois v. Apple Tree Auction Ctr., Inc.*, 882 F.3d 485, 488-89 (5th Cir. 2018).

[100] *Schmidt v. JPS Indus.*, No. 1:09-CV-3584-JEC, 2011 U.S. Dist. LEXIS 35284, at *4 (N.D. Ga. Mar. 31, 2011) (quoting *Morris v. SSE, Inc.*, 843 F.2d 489, 492 (11th Cir. 1988)).

[101] *Sangha v. Nagiv8 Shipmanagement Private Ltd.*, 882 F.3d 96, 101 (5th Cir. 2018) (citations omitted).

[102] *Id*.

[103] *Id*. at 101-102 (citations omitted).

and the litigation results from alleged injuries that arise out of or relate to those activities."[104] Indeed, "[s]pecific jurisdiction is confined to adjudication of issues deriving from, or connected with, the very controversy that establishes jurisdiction."[105]

Contrary to Shrader's contention,[106] the Health Plans are not relying solely on the fact that the non-resident Matched Claimants retained Shrader—a Texas law firm—to represent them in non-Texas litigation to establish personal jurisdiction over them in Texas. Instead, the Health Plans are relying on the totality of the circumstances surrounding each Matched Claimant's contacts with the State of Texas, including, *inter alia*, the following:

- The forum in which the Matched Claimants initiated contact with or retained Shrader (Texas);[107]
- Whether the Matched Claimants requested Shrader to perform services in Texas (almost all certainly did);[108]
- Whether the engagement agreement with Shrader contains a Texas choice of law provision or other provision consenting to suit in Texas (almost all of them do);[109]
- Whether the Matched Claimants are parties to the engagement agreement with Shrader (they are);[110]

[104] *Id*. at 101.

[105] *Id.* (citations omitted).

[106] Shrader's Mot. at 35.

[107] *Id*. at *8.

[108] *Id*. at *9.

[109] *Id*. at *10; *Thompson Hine, LLP v. Taieb*, 734 F.3d 1187, 1190, 1192 (D.C. 2013).

[110] *Schmidt, 2*011 U.S. Dist. LEXIS 35284, at *10.

- The duration of the relationship between the Matched Claimants and Shrader;[111]
- The nature of Shrader's control from Texas over the relationship with the Matched Claimants (discovery pending);[112]
- The extent of the Matched Claimants' communications with attorneys in Texas (discovery pending);[113]
- The Matched Claimants' relationship with any Texas lawyers in Shrader's office;[114]
- Whether a Texas attorney appears on the engagement agreement between Shrader and the Matched Claimants;[115] and
- Whether payments were to be received by Shrader in Texas.[116]

The limited discovery conducted to date reveals that each Match Claimant is subject to personal jurisdiction in the State of Texas.

By Shrader's own admission, it asserted claims against as asbestos trust located in Texas on behalf of Matched Claimants Nos. 3, 6, 7, 10, 11, and 12.[117] This trust arose out of multiple bankruptcy cases filed under chapter 11 of the Bankruptcy Code that were jointly administered in the United States Bankruptcy Court for the *Southern District of Texas*.[118] The purpose of this particular trust was to "provide fair, equitable and

[111] *Thompson Hine, LLP*, 734 F.3d at 1190, 1192.

[112] *Id*. at 1190 (citing *Burger King Corp. v. Rudzewicz*, 471 U.S. 462, 465 (1985)).

[113] *Id*.

[114] *Id*. at 1191.

[115] *Id*.

[116] *Id*. at 1192.

[117] *See* Shrader's Texas trust claim chart, a true and correct copy of which is attached hereto as **Exhibit F**.

[118] *See* the Asbestos Personal Injury Settlement Trust Distribution Procedures ("ASARCO Distribution Procedures") at 2 (emphasis added), a true and correct copy of which is attached hereto as **Exhibit G.**

substantially similar treatment for all Asbestos Personal Injury Claims" that were being or could be asserted against the debtors in the underlying bankruptcy.[119] Presumably, Shrader had its clients' permission and its clients instructed it to file claims on their behalves against this trust. That is, these non-resident Matched Claimants instructed Shrader to perform work in Texas on their behalves and Shrader admits that it performed the requested work. Considering the purpose of the Trust, it can be reasonably inferred that the non-resident Matched Claimants' claims asserted therein related to the very injuries that the Health Plans provided health benefits to treat and thus, the Health Plans' claims in this case arise, at least in part, out of those activities.

The limited evidence produced to date also reveals that each Matched Claimant has either signed a contract in Texas, agreed to be subjected to Texas law, and/or agreed that recoveries can be sent to (and distributed from) Texas banks. All of them have interacted with attorneys in Texas concerning their claims. The following chart summarizes some of this evidence:[120]

[119] *Id*.

[120] *See* Exs. E, F, and H for the sources of this information.

Claimant No.	Reside in Texas?	Filed claim in Texas?	Represented by Houston attorney?	Texas choice of law clause?	Funds payable in Texas?
1	Yes	Yes	Yes	Yes	Maybe
2	Yes	Yes	Yes	Yes	Maybe
3		Yes	Yes		
4	Yes	Yes	Yes	Yes	Maybe
5			Yes	Unknown	Unknown
6		Yes	Yes	Yes	Maybe
7		Yes	Yes	Unknown	Unknown
8	Yes	Yes	Yes	Yes	Maybe
9		Yes	Yes	Unknown	Unknown
10		Yes	Yes	Yes	Maybe
11		Yes	Yes	Yes	
12		Yes	Yes	Yes	Yes
13			Yes	Unknown	Unknown
14	Yes	Yes	Yes	Yes	Maybe
15			Yes	Unknown	Unknown

Regardless, however, the non-resident Matched Claimants' contacts with Texas serve as the very basis for the Health Plans' claims against Shrader—the Matched Claimants' engagement of and communication with Shrader, a Texas law firm, and its employees, Texas attorneys, to assert asbestos-related claims, both in Texas and other jurisdictions, for asbestos injuries the Health Plans paid to treat, and obtain asbestos-recoveries from which the Health Plans should have been reimbursed. Indeed, but for the Matched Claimants' contacts with Texas, the Health Plans would not even be making its

claims against Shrader because Shrader would not have acted on the Matched Claimants' behalves to recover the settlement funds.

For these reasons, joinder of the Matched Claimants is feasible, and the Health Plans respectfully request the Court deny Shrader's Motion accordingly.

3. The Matched Claimants are not indispensable under Rule 19(b).

If the Court finds that the Matched Claimants are required, but cannot be joined, the Court "must determine whether, in equity and good conscience, the action should proceed among the existing parties or should be dismissed."[121] That is, the Court must decide whether the Matched Claimants that cannot be joined are "indispensable." The factors to be considered by the Court include:

1. to what extent a judgment rendered in the Matched Claimants' absence might be prejudicial to them or to the Health Plans or Shrader;

2. the extent to which, by protective provisions in the judgment, by the shaping of relief, or other measures, the prejudice can be lessened or avoided;

3. whether a judgment rendered in the Matched Claimants' absence will be adequate; and

4. whether the Health Plans will have an adequate remedy if the action is dismissed for nonjoinder.[122]

These factors are nonexclusive and are not intended to exclude other considerations which may be applicable in particular situations.[123]

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[121] FED. R. CIV. P. 19(b). Of course, if Shrader fails to establish the Matched Claimants are required, no inquiry under Rule 19(b) is necessary. *Temple v. Synthes Corp.*, 498 U.S. 5, 8 (1990).

[122] FED. R. CIV. P. 19(b).

[123] *See* FED. R. CIV. P. 19, Advisory Committee's Notes; *see also Republic of Phil. v. Pimentel*, 553 U.S. 851, 862-63 (2008).

Shrader alleges that a judgment rendered in the Matched Claimants' absence would be prejudicial to the Matched Claimants because the Health Plans' claims are directly antagonistic to the Matched Claimants' interest in the settlement funds and they would not be present to protect those interests. As explained in detail above, however, the Health Plans' MSP Act claims do not have any effect on the Matched Claimants' interest in the settlement funds, as those claims are direct against Shrader and the resulting damages are not tied to or to be paid out of the settlement funds.[124] And, on their ERISA claims, the Health Plans are seeking a constructive trust over only that portion of the settlement funds that Shrader has previously retained or is entitled to retain as payment for its fees, and thus, the Matched Claimants have do not have an interest in those fees. For these reasons, the Matched Claimants' interest in the settlement funds is not prejudiced by a judgment rendered in this lawsuit.

Shrader further alleges that it would be fundamentally unfair and prejudicial to the Matched Claimants' privacy rights to permit the Health Plans to seek disclosure of the Matched Claimants' confidential healthcare information in the Matched Claimants' absence. Shrader does not explain, however, how rendering a judgment in the Matched Claimants' absence has any effect on this alleged issue. Indeed, taking this argument to its logical conclusion, parties in every lawsuit in which non-party confidential information is exchanged would have to join those non-parties or the court would be prevented from rendering a judgment. That is absurd. Also, the parties' have briefed and

[124] *See supra* Sections B and D.

this Court has entered a protective order to, in part, address this very concern.[125] To the extent Shrader wishes to further protect future information requested by the Health Plans, it may file a motion with the Court seeking such protection.

Shrader also argues that a judgment rendered in the Matched Claimants' absence would be prejudicial to it because of the alleged risk it creates that the Matched Claimants' will assert a claim against Shrader for the same funds the Health Plans are seeking to recover. Regarding the damages sought on the MSP Act claims, they are to be paid directly by Shrader, not out of the settlement funds. Therefore, the Matched Claimants have no interest in, and thus, no claim to assert for, the funds that the Health Plans are seeking to recover on their MSP claims. Regarding the Health Plans' ERISA claims, they are seeking a constructive trust only on that portion of the settlement funds that Shrader has previously retained or is entitled to retain as payment for its fees, and thus, the Matched Claimants have no interest in, and thus, no claim to assert for, the funds over which the Health Plans are seeking a constructive trust. For these reasons, the alleged risk Shrader raises does not exist.

For these reasons, protective provisions are not necessary because there is neither the Matched Claimants nor Shrader will suffer prejudice if this action proceeds in the Matched Claimants' absence. Also, a judgment rendered in the Matched Claimants' absence will be adequate. Specifically, all of the Health Plans' claims, as well as

[125] *See* Disc. Confidentiality Order, April 5. 2018. ECF No. 98.

Shrader's defenses, if any, will be fully and finally resolved upon entry of a judgment in this action.

For these reasons, the Matched Claimants are not "indispensable" under Rule 19 and thus, in equity and good conscience, this action should proceed without them.

E. Severance is not required because the Health Plans' claims arise out of the same transaction, occurrence, or series of transactions or occurrences and there is at least one common question of law or fact linking all of the claims.

The purpose of Rule 20 is to promote convenience and efficiency to expedite the final determination of disputes and prevent multiple lawsuits.[126] The Supreme Court has noted that the "impulse" of the Rule "is toward entertaining the broadest possible scope of action consistent with fairness to the parties; joinder of claims, parties, and remedies is strongly encouraged."[127] Rule 20 sets out a two part test: (i) do the claims arise out of the same transaction, occurrence, or series of transactions or occurrences; and (ii) is there at least one common question of law or fact linking all claims.[128] As long as both prongs are met, joinder is generally at the option of the plaintiffs.[129]

Shrader argues that the Health Plans' claims should be severed because they do not arise out of the same transaction or occurrence. Although, the Fifth Circuit has not endorsed a specific test for what constitutes "the same transaction or occurrence" under

[126] *See, e.g., Jackson v. Tex. Park & Wildlife Dept.*, No. 14-cv-748, 2015 WL 12862879, at *2 (W.D. Tex. Oct. 2, 2015) (citation omitted).

[127] *United Mine Workers of Am. v. Gibbs*, 383 U.S. 715, 724 (1966).

[128] FED. R. CIV. P. 20.

[129] *Jackson*, 2015 WL 12862879 at *2 (quoting *Applewhite v. Reichhold Chem., Inc.*, 67 F.3d 571, 574 (5th Cir. 1995)).

Rule 20,[130] courts have recognized, at least at the pleading stage, that it is sufficient for the plaintiff to allege a pattern or practice of conduct related to the various claims.[131] The Health Plans have alleged and the evidence shows that Shrader has continually, over a period of years, collected and disbursed tort settlements without first accounting for the Health Plans' rights. The evidence also shows that Shrader has made substantially similar claims on behalf of 12 Matched Claimants in the ASARCO Trust,[132] as well as substantially similar claims on behalf of numerous Matched Claimants against the same set of defendants in the same Circuit Court in Madison County, Illinois.[133] Accordingly, there is sufficient evidence to establish that the Health Plans' claims arise out of the same transaction or occurrence—Shrader's prolonged, continuous collection and distribution of tort settlements without first accounting for the Health Plans' rights, and thus, the first prong of Rule 20 has been met.

Further, common questions of law concerning the reach and scope of the MSP (e.g., whether Shrader, as an entity that received payments from a primary payer, is liable under the MSP, and whether the Health Plans are MAOs) and ERISA (e.g., _____) underlie all of the asserted claims. Several common questions of fact also underlie all of the asserted claims, including, among other things, the general procedure for asserting asbestos-related claims and Shrader's knowledge of and continued refusal to recognize

[130] *Jackson*, 2015 WL 12862879 at *3 (citations omitted).

[131] *Pouncie v. Dlorah, Inc.*, No. 15-cv-511, 2015 WL 5178401, at *2 (N.D. Tex. Sept. 4, 2015) (citations omitted).

[132] *See* Exs. F and G.

[133] *See, e.g.*, Charles Curtis's Complaint and Eddie Fisher's Complaint filed by Shrader, true and correct copies of which are attached collectively hereto as **Exhibit I**.

the Health Plans' reimbursement rights. For these reasons, the second prong of Rule 20 has been met.[134]

The primary case relied upon by Shrader—*In re Vioxx Products Liability Litigation*[135]—to refute this point is readily distinguishable. First, the two actions under consideration in *Vioxx* were brought on behalf of far more plaintiffs and sought enforcement of far more health plans than the three plaintiffs and 21 health plans in this case. Indeed, there were 48 AvMed plaintiffs seeking to enforce as many as 1.1 million distinct health benefit plans, and there were "hundreds, and likely thousands" Greater New York plaintiffs all consisting of distinct ERISA plans.[136]

Second, the claim being pursued in that case did not purport to rely upon any common course of conduct by the named defendants; rather, it was simply directed to the settlement fund itself.[137] Because the plaintiffs' claims were not attributable to the settlement (but rather to the individual determination as to whether each beneficiary *would* receive a settlement award), the *Vioxx* court found they were improperly joined. Here, each Matched Claimant has already received one or more Asbestos Recoveries,[138]

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[134] Although Rule 20's second prong requires some common question of law or fact in the claims, there is no requirement that all issues be common to all plaintiffs. *Jackson*, 2015 WL 12862879 at *3 (citation omitted).

[135] 2008 WL 4681368 (E.D. La. Oct. 21, 2008).

[136] *Vioxx*, 2008 WL 4681368 at *3-5. Likewise, in *Acevedo v. Allsup's Convenience Stores, Inc.*, 600 F.3d 516 (5th Cir. 2010), the Fifth Circuit, after denying class certification, rejected an attempt to allow 800 plaintiffs to join together.

[137] *Vioxx* 2008 WL 4681368 at *8.

[138] *See* Ex. H.

and the claims being asserted are based upon Shrader's common course of conduct in (mis)handling the proceeds of those recoveries.[139]

Shrader further argues that the Health Plans' claims should be severed because joinder of the Health Plans in one case would prejudice it and would not facilitate judicial economy.[140] Specifically, Shrader complains that proceeding on all claims in one lawsuit "would prejudice [it] because the [Health Plans] must prove the particulars of each claim," including a determination of the following as to each Matched Claimant:

- the contents of the applicable health benefit plan (to determine whether the plan is an MA plan or ERISA plan);
- the injuries suffered as a result of exposure to asbestos;
- identification of the asbestos-related medical benefits received under the applicable health plan, as opposed to non-asbestos related medical benefits received under the same health plan; and
- the amounts each medical provider billed the applicable health plan, and the amount the applicable health plan paid each provider in response.[141]

Shrader further alleges, without any factual support of explanation, that such individual analysis would require presentation of different witnesses, documentary proof, and health plan language as to each Matched Claimant. As a result, Shrader concludes that "any practical benefits accrued through the conservation of judicial resources are likely

[139] The other case relied upon by Shrader – *Campo v. State Farm Fire and Cas. Co.*, No. 06-cv-2611, 2007 WL 2155792 (E.D. La. July 26, 2007) stands for the unremarkable proposition that the decision on joinder is a highly discretionary one, and where the court finds true disparities in the underlying facts it has the power to deny joinder.

[140] *See* Shrader's Mot. at 47-48.

[141] *Id*.

outweighed by the burden imposed on Shrader in defending multiple claims, with different factual scenarios, in one trial." Shrader's analysis, however, fails in several respects.

First, the total number of documents, including the number of health plans, and pages of medical records that the Parties will produce, review, and potentially present at trial will the same whether the Health Plans' claims are severed or proceed in one case. Indeed, Shrader did not present any argument to the contrary. Shrader also did not present any other argument concerning how the presentation of different documentary proof in one case versus separate cases causes any prejudice. Accordingly, there is no basis for Shrader's assertion that the fact that each claim requires different documentary proof causes it prejudice.

Second, the number of witnesses the Health Plans anticipate calling is affected very little based on the number of cases. Specifically, the Health Plans anticipate calling the following witnesses: (i) one witness for each of the Health Plans—to, among other things, prove up each of their business records and to provide any other necessary testimony about same, including, for example, explaining medical coding or providing information about the amounts charged to and paid by the Health Plans for treatment of asbestos-related injuries, and (ii) an expert witness—to, among other things, identify the asbestos related injuries each Matched Claimant suffered, to the extent the medical benefits related to said injury were provided by one of the Health Plans, and to differentiate between the benefits each Matched Claimant received that were attributable to asbestos related injuries versus non-asbestos related injuries.

If the Health Plans claims proceed in one case, the representatives for the Health Plans could prove up *all* of the Health Plans' business records at the same time, and they would only be required to explain medical coding one time. Although it is true that they would have to identify the specific provision in each health benefit plan proving the type of plan, the burden that exercise places on Shrader, if any, is de minimis. Similarly, the Health Plans' expert would only have to provide testimony concerning his qualifications and means and methods one time, and a substantial portion of his testimony concerning identification of asbestos related injuries and differentiation of asbestos related benefits versus non-asbestos related benefits would only have to be given once.

Shrader would have to elicit much of the same testimony from the Health Plans' representatives and expert if the Health Plans' claims are severed into individual cases. Therefore, judicial economy is achieved by avoiding duplication of that portion of these witnesses' testimony that will be the same in every case, and that benefit clearly outweighs the alleged burden, if any, Shrader may suffer if these witnesses appear in one case. Indeed, Shrader did not provide any factual basis or other explanation to the contrary. Moreover, it would be an extreme waste of judicial resources and well as a substantial burden on the Health Plans' anticipated witnesses to have to appear for 15 depositions and at 15 different trials when a majority of their testimony would be an exact duplicate of the testimony provided at each deposition and each trial.

There are additional reasons why the interests of judicial efficiency favor continuing in one case as well, including the Health Plans' discovery into Shrader's business practices and Shrader's representation of the Matched Claimants and other asbestos claimants.

Shrader's sole reason for seeking severance is that a single trial *may* be unwieldy. For the reasons stated above, however, it is clear that the interests of judicial efficiency outweigh any alleged prejudice that Shrader may suffer as a result of a potential unwieldy trial, and dictate that, at a minimum, all discovery and pretrial matters continue in a single proceeding. Accordingly, the Health Plans respectfully request that Shrader's Rule 20 Motion be denied in its entirety.

Alternatively, the Health Plans request that the Court postpone ruling on the merits of Shrader's request for severance until after the conclusion of discovery and if deemed appropriate at that time, order separate trials under Rule 42(b). Or, if the Court prefers to grant Shrader's request for severance at that time, the Health Plans can re-file separate complaints, along with a contemporaneous motion under Rule 42(a) to consolidate the separate actions for pretrial proceedings.

VI. Conclusion

For the reasons stated above, Shrader's motion should be denied.

Respectfully submitted,

/s/ John B. Thomas

John B. Thomas, *Attorney-in-Charge*
Texas Bar No. 19856150
Southern District Bar No. 10675
Abbie G. Sprague
Texas Bar No. 24074244
Southern District Bar No. 1125904
HICKS THOMAS LLP
700 Louisiana Street, Suite 2000
Houston, Texas 77002
Tel: (713) 547-9106
Fax: (713) 547-9150
jthomas@hicks-thomas.com
asprague@hicks-thomas.com

Gerald Lawrence, *admitted pro hac vice*
New York Bar No. 69079
LOWEY DANNENBERG COHEN & HART, PC
Four Tower Bridge
200 Barr Harbor Drive, Suite 400
West Conshohocken, Pennsylvania 19428
Tel: (610) 941-2760
Fax: (610) 862-9777
glawrence@lowey.com

-and-

Mark D. Fischer, *admitted pro hac vice*
Kentucky Bar No. 83672
Robert Griffith, *admitted pro hac vice*
Illinois Bar No. 6277573
RAWLINGS & ASSOCIATES, PLLC
1 Eden Parkway
LaGrange, Kentucky 40031
Tel: (502) 587-1279
Fax: (502) 584-8580
mdf@rawlingsandassociates.com
rg1@rawlingsandassociates.com

CERTIFICATE OF SERVICE

I certify that on August 10, 2018, a copy of the foregoing was served pursuant to the Federal Rules of Civil Procedure upon the following counsel of record as follows:

BY E-SERVICE:
Justin M. Waggoner
jwaggoner@skv.com
Razvan Ungureanu
rungureanu@skv.com
SMYSER KAPLAN & VESELKA, LLP
700 Louisiana Street, Suite 2000
Houston, Texas 77002

Counsel for Defendant
Shrader & Associates, LLP

/s/ Abbie G. Sprague
ABBIE G. SPRAGUE