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Developments and Considerations Affecting Resolution of Claims with Plaintiffs Enrolled in Medicare Parts C or Part D

The Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) established a system requiring parties to report certain settlements, judgements, awards or other payments to Medicare beneficiaries. Medicare, Medicaid, and S-CHIP Extension Act of 2007, 42 U.S.C. §1395y (2011). The MMSEA's purpose was to enhance Medicare's opportunities to recover conditional payments it made for injury-related medical treatment of its enrollees for which it is statutorily a secondary payer. The MMSEA and case law interpreting it has led to increased attention to the obligation to reimburse the federal government for payments it made under Medicare Parts A and B. The Centers for Medicare and Medicaid Services (CMS) administers these Parts of Medicare healthcare coverage.

Conversely, Medicare Parts C and D are administered by private health insurance companies, not the federal government. Recent developments have caused greater emphasis to be placed on the secondary payer position of Medicare Parts C and D. Defendants and their insurers can minimize the risk of a secondary payer claim after resolution with a plaintiff through greater attention to the recovery rights of Parts C and D providers. Steps should be taken during the pendency of a case, especially near and at the time of resolution. This article discusses some of the developments affecting Medicare Parts C and D reimbursement and gives strategies to help protect against a subsequent recovery claim through consideration of the secondary payer rights of these providers.

Private Cause of Action with Double Damages Remedy Available to Part C Providers

In a case of first impression, the United States Court of Appeals for the Third Circuit held that a private insurance company could maintain an action for double damages pursuant to the Medicare Secondary Payer Act. The case is *In re Avandia Marketing, Sales Practices and Products Liability Litigation*. *In re Avandia Marketing, Sales Practices and Products Liability Litigation*, 685 F.3d 353 (3d Cir. 2012). The district court had dismissed the case finding the MSP's private cause of action did not extend to Part C health insurance providers such as plaintiff. *Avandia,* 685 F.3d at 355. The appellate court reversed that decision, reinstating the case. *Id.*

The defendant in *Avandia*, GlaxoSmithKline (Glaxo), was sued separately by hundreds of individuals claiming that they were injured as a result of taking one of the drugs Glaxo manufactured. *Id.* Some of the plaintiffs had Medicare Parts A and B health coverage that paid for medical treatment for these alleged injuries. *Id.* As part of the settlements Glaxo reached, it reimbursed Medicare Parts A and B for payments made on behalf of enrollees. *Id.* Some of the plaintiff received medical coverage through Medicare Part C plans. *Id.* Glaxo did not reimburse these private insurance companies, which included Humana Medical Plan, Inc. and Humana Insurance Company (collectively Humana) were two such entities. *In re Avandia Mktg., Sales Practices and Prod. Liab. Litig.*, 685 F.3d 353, 355 (3d Cir. 2012).

The Medicare program was established in 1965 when Subchapter XVIII of the Social Security Act was passed. 42 U.S.C. §1395-1395(kkk) (2011). With few exceptions, Medicare paid for all covered medical costs of those enrolled in the program. Medicare assumed this primary responsibility regardless of whether another source was also responsible for the cost of care. To reduce Medicare expenses borne by the federal government, Congress included what has been referred to as the Medicare Secondary Payer Act (MSP) in the Omnibus Reconciliation Act of 1980, which is codified in 42 U.S.C. §1395y(b)(2)(B)(ii). This statute became effective on December 5, 1980. With its passage, Medicare became the payer of last resort, or secondary payer, for a beneficiary's covered medical treatment whenever another source was obligated to pay.

The obligation of all others also required to pay for a beneficiary's treatment became primary to Medicare's obligation. 42 U.S.C. §1395y(b)(2)(B)(ii) (2011). The MSP also allows Medicare to pay first for a covered treatment on a conditional basis to ensure beneficiaries can timely receive needed medical care. 42 U.S.C. §1395y(b)(2)(B)(i). Subsequently, identified primary payers are required to reimburse Medicare for the conditional payments it makes. 42 U.S.C. §1395y(b)(2)(B)(ii). Turning back to the Avandia case, Humana eventually sued in the United States District Court for the Eastern District of Pennsylvania alleging that Glaxo, as the primary payer under the MSP, had to reimburse it when settlements with the individual claimants were reached. *See In re Avandia Mktg., Sales Practices and Prod. Liab. Lit*, 2011 WL 2413488, (E.D.Pa. June 13, 2011). Humana claimed damages were twice the amount of conditional payments it paid for its insureds' Avandia-related care.

The court looked at the MSP provision that created a private cause of action for failure to reimburse conditional payments and that allows secondary payers to seek double damages. The issue in *Avandia* was whether this provision afforded Part C providers the double damages remedy. The pertinent section of the MSP states:

> Private cause of action. There is established a private cause of action for damages (which shall be in an amount double the amount otherwise provided) in the case of a primary plan which fails to provide for primary payment (or appropriate reimbursement) in accordance with paragraphs (1) and 2(A) [the secondary payer requirements of the Act]. 42 U.S.C. §1395y(b)(3)(A).

The court found that this portion of the MSP is unambiguous. *Avandia*, 685 F.3d at 359. It unequivocally creates a private cause of action without limitation as to the party that can assert it or seek its damages. The court saw no language suggesting Congress intended to block the ability of any private entity, Part C provider or otherwise, to seek this remedy. *Id.* at 359. After reaching this holding, the court then analyzed and rejected Glaxo's defenses.

Congress established Medicare Part C as part of the Balanced Budget Act of 1997. *Id.* at 357. The MSP provisions and the private cause of action was enacted in 1980, before Part C was established. Part C provisions state these providers are secondary payers. 42 U.S.C. §1395w-22(a)(4) (2011). However, the Part C provisions do not include the double damages remedy passed in 1980.

Glaxo argued that if Congress intended to extend the federal private cause of action to Part C providers, it would have mirrored this provision in the 1997 law. *Avandia*, 685 F.3d at 360-361. Because this right was not included, Glaxo argued that Congress did not intend to extend it to these entities. This reasoning prevailed in the district court. However, in rejecting this argument, the appellate court noted Congress established Medicare risk plans administered by private (e.g. non-governmental) companies in 1972. The court determined Congress already knew in 1980 private entities may

provide Medicare coverage but still drafted the private cause of action section without explicitly limiting who could seek it. *Id.* at 360.

After receiving this favorable ruling, Humana brought a similar suit against another primary payer for failure to reimburse it when funding a settlement with a Part C beneficiary. The United States Court of Appeals for the Eleventh Circuit ruled on this issue in *Humana Medical Plan, Inc. v. Western Heritage Insurance Company*. *Humana Med. Plan, Inc. v. W. Heritage Ins. Co.*, 832 F.3d 1229 (11th Cir. 2016). Western Heritage Insurance Company provided liability insurance to a defendant in an underlying personal injury case. *W. Heritage,* 832 F.3d at 1232. Humana provided health insurance to the plaintiff under Medicare Part C. *Id.* Humana alleged Western Heritage failed to reimburse it for injury-related medical expenses when Western Heritage paid a settlement to that plaintiff. It sought double damages from Western Heritage under the private cause of action pursued in *Avandia*.

The Eleventh Circuit adopted the *Avandia* reasoning and reached the same decision. *Id.* at 1233. It affirmed the district court's grant of summary judgment in Humana's favor. *Id. Avandia* and *Western Heritage* illustrate the importance of determining from the time of alleged injury to the time a case is resolved the Part C enrollment status of a plaintiff and whether that health insurance provider paid for plaintiff's injury-related treatment.

Review of Medicare Part D Secondary Payer Status

Public health coverage under Medicare Parts A and B do not pay for an enrollee's outpatient prescription drug expenses. The federal government authorized this type of Medicare coverage beginning January 1, 2006 with enactment of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. Medicare Prescription Drug, Improvement, and Modernization Act of 2003, 42 U.S.C. §1395w-102 (2011). This law, also known as the Medicare Modernization Act (MMA), was the start of insurance coverage for outpatient drug expenses through Medicare Part D. These insurance policies, like those under Medicare Part C, are provided by private health insurance companies.

A recent Kaiser Family Foundation report estimated 70% of Medicare beneficiaries, or more than 42 million people, are enrolled in a Part D plan. The Henry J. Kaiser Family Foundation*, The Medicare Part D Prescription Drug Benefit* (Oct. 2, 2017), https://www.kff.org/medicare/fact-sheet/the-medicare-prescription-drug-benefit-fact-sheet/ (last visited Feb. 6, 2018). Though Medicare Part D was created independently from the other Medicare Parts, these private companies also enjoy secondary payer status. 42 U.S.C. §1395 w-102(a)(4) (2011). However, because of differences in the language of the enacting statutes, Part D has a different jurisprudential and legislative history defining this status. The number of people enrolled in a Part D plan makes consideration of these providers' secondary payer status a significant factor in case resolution.

The MMA is relatively silent about the secondary payer rights of Part D providers. It merely provides, "The provisions of section 1395w-22(a)(4) [Part C secondary payer provision] of this title shall apply under this part in the same manner as they apply under part C of this subchapter." *Id.* Further, CMS added scant clarity to the parameters of these rights. Its regulations state:

> The provisions of §422.108 of this chapter regarding Medicare secondary payer procedures apply to Part D sponsors and Part D plans (with respect to the offering of qualified prescription drug coverage) in the same way as they apply to [insurance providers] under Part C of Title XVIII of the Act, except all references to [Part C insurance providers] are considered references to Part D sponsors or Part D plans. 42 C.F.R. §423.462 (2010).

The provisions of 42 CFR §422.108 reiterate that CMS will not pay for covered services when there is a primary payer responsible for them. It also details the responsibilities of Part C providers to enforce these secondary payer rights. 42 C.F.R. §422.108(a) (2010). Further, in a December 5, 2011 memo regarding the above-referenced regulations and the subrogation rights of Part C and Part D providers, CMS stated:

> Additionally, the MSP regulations at 42 CFR §422.108 are extended to [Part D] sponsors at 42 CFR §423.462. Accordingly, [Part D] sponsors have the same MSP rights and responsibilities as [Part C plans]. Danielle R. Moon (Dec. 5, 2011), https://www.cms.gov/Medicare/Health-Plans/HealthPlansGenInfo/downloads/21_MedicareSecondaryPayment.pdf (last visited Feb. 5, 2018).

Finally, Chapter 14, §50.12 of CMS' Medicare Prescription Drug Benefit Manual states:

> The MMA (1860§D-2(a)(4)) extended MSP requirements that are applicable to [Part C plans] to include Part D sponsors. Accordingly, Part D sponsors will have the same responsibilities under MSP requirements as [Part C] plans, including the collection of mistaken primary payment from insurers, group health plans, employer sponsors, enrollees, and other entities …. Centers for Medicare Medicaid Services, *Medicare Prescription Drug Benefit Manual*, Chapter 14, §50.12, https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pub100_18.pdf (last visited Feb. 6, 2018).

As the *Avandia* case and its progeny highlight, the secondary payer rights of Part C providers are in flux and under development across the country. Through the MMA and CMS guidelines, secondary payer rights of Part D providers are also developing. The trend is toward recognizing greater recovery rights for these private insurers.

Adding further uncertainty to the secondary payer rights of Part D providers, the SPARC Act bill was re-introduced in this session (115th Congress 2017-2018) of the U. S. House of Representatives on February 16, 2017 as H.R. 1122. The official title of this Act is the Secondary Payer Advancement, Rationalization, and Clarification Act. H.R. 1122, 115th Cong. §1 (2017). This bill was originally introduced during the last session of Congress by Rep. Tim Murphy [R-PA-18] and Rep. Ron Kind [D-WI-3]. That bill expired at the end of the congressional term while still in committee. In addition to Reps. Murphy and Kind, the current bill is co-sponsored by Rep. Patrick Meehan [R-PA-7], Rep. David Rouzer [R-NC-7], Rep. Harold Rogers [R-KY-5], and Rep. Steve Chabot [R-OH-1]. It is assigned to the House Energy and Commerce Committee and the House Ways and Means Committee. https://www.congress.gov/bill/115th-congress/house-bill/1122/committees. The bill is currently assigned to each Committee's Subcommittee on Health.

The SPARC Act is designed to amend Title XVIII of the Social Security Act. 42 U.S.C. §§1395-1395(kkk) (2011). It makes several significant changes to Part D providers' recovery rights and to the infrastructure under which they exercise those rights. Its stated purpose is "to provide for clarification and rationalization of Medicare prescription drug plan recovery rules for certain claims." H.R. 1122, 115th Cong. Preamble (2017). The SPARC Act repeals the current statutory standard stating Part D providers' rights apply "in the same manner as they apply under part C." It then institutes a much more detailed structure of the rights and responsibilities of Part D providers.

The SPARC Act states Part D providers "shall be secondary payor to any valid and collectible payment from a primary drug plan." H.R. 1122, 115th Cong. §2(a)(4)(A)(i) (2017). This status shall continue until "such time as such

primary drug plan pays a final settlement, judgment, or award" to the insured or "otherwise terminates its ongoing responsibility for medical payments with respect to the individual." *Id.* Primary drug plans are defined in the Act as certain group health plans, workers' compensation laws or plans, automobile or liability insurance policies or plans (including self-insured plans), or no fault plans if such coverage would be treated as a primary plan under Parts A and B. H.R. 1122, 115th Cong. §2(a)(4)(A)(iv) (2017).

The SPARC Act states subrogation is the exclusive remedy available to Part D providers that are not reimbursed by a primary payer. H.R. 1122, 115th Cong. §2(a)(4)(C) (2017). This provision eliminates Part D providers' access to the private cause of action and double damages remedy Part C providers obtained in *Avandia*. The Act imposes a 3-year statute of limitations for recovery beginning when a Part D provider receives notice of a payment by a primary drug plan for a covered drug. *Id.* The Part D provider's recovery claim shall be reduced by the insured's procurement costs to prosecute the claim for which payment from the primary payer was made. *Id.*

Within 15 days of receiving information a potential primary payer is involved in a claim with a Part D beneficiary, CMS must provide this information to Part D coverage providers. H.R. 1122, 115th Cong. §2(a)(4)(D) (2017). When the Part D provider receives notice that a primary payer has assumed ongoing responsibility for an insured's prescription drug costs, it can authorize the drug provider to bill that primary payer directly. H.R. 1122, 115th Cong. §2(a)(4)(E) (2017). A Part D provider has the option to waive its recovery claim if it determines waiver "is in the best interests of the program." H.R. 1122, 115th Cong. §2(a)(4)(B) (2017). Finally, CMS is authorized to collect recovery payments directly from a primary plan and forward them to the Part D provider. H.R. 1122, 115th Cong. §2(a)(4)(F)(iv) (2017).

The SPARC Act may not become law. In the meantime, Part D providers can assert their recovery claims against primary payers "in the same manner" as Part C providers. Part C providers can bring a private cause of action recovery claim seeking double damages in both the Third and Eleventh Circuits. Additionally, the plaintiffs in *Avandia* and *Western Heritage* continue to aggressively assert double damages claims in federal courts throughout the country.

Humana brought a private cause of action in the U.S. District Court for the Eastern District of Virginia against a personal injury law firm that represented a Medicare beneficiary in *Humana v. Paris Blank LLP*. Heather Sanderson, *Humana's MSP Private Cause of Action for Double Damages Against Plaintiff Attorney Law Firm Survives Motion to Dismiss* (May 11, 2016), https://www.francosignor.com/humanas-msp-private-cause-of-action-for-double-damages-against-plaintiff-attorney-law-firm-survives-motion-to-dismiss/ (last visited Feb. 6. 2018). The defendant moved for dismissal, arguing that the MSP private cause of action was not available to Part C providers and it was not a "primary payer" under the MSP. *Id.* The court rejected these arguments, denied the motion, and allowed the suit to proceed. *Id.* Humana sued other plaintiff personal injury firms in the United States District Courts for the Middle District of Louisiana and the Northern District of Florida. Heather Sanderson, *Plaintiff Attorneys Targeted by Medicare Advantage Plans Lawsuits Seeking Double Damages Under MSP Private Cause of Action Theory* (Sept. 14, 2017), https://www.francosignor.com/plaintiff-attorneys-targeted-medicare-advantage-plans-lawsuits-seeking-double-damages-msp-private-cause-action-theory/ (last visited Feb. 6, 2018). Humana and two other Medicare Part C providers also sued a group of six asbestos plaintiff injury firms in the United States District Courts for the Southern District of Texas. *Humana, Inc., United Healthcare Services, Inc., and Aetna, Inc. v. Brent W. Coon, P.C. a/k/a Brent Coon & Associates, Reaud Morgan & Quinn, LLP, The Bogdan Law Firm, Foster & Sear, LLP, Hissey Kientz, LLP and Shrader & Associates, LLP*, No. 3:2016-cv-00240 (S.D. Tex. filed on Sept. 6, 2016). Additionally, Humana sued an automobile insurer in the Western District of Washington. Heather Sanderson, *Humana Medicare Advantage Seeking to Establish*

Right to an MSP Double Damages Recovery on the West Coast (Oct. 3, 2017), https://www.francosignor.com/humana-medicare-advantage-seeking-establish-right-msp-double-damages-recovery-west-coast/ (last visited Feb. 6, 2018).

The plaintiffs in all of these cases are seeking double damages pursuant to the private cause of action. It is clear that Part C providers have become very assertive with their secondary payer recovery rights. If recognition of Part C providers' private cause of action recovery rights continues to extend, so will recognition of Part D providers' recovery rights.

Defense Strategies

Insurance carriers and defendants alike must use extra caution to ensure providers of coverage under all parts of Medicare – public and private—are reimbursed for conditional payments they make. This task is difficult because CMS does not have a system to inform of a beneficiary's Part D enrollment status or claim settlement with a primary payer. It is also complicated because multiple companies offer Part D health insurance policies and beneficiaries can change their provider over time. There are, though, several tools available to defendants and their insurers to help minimize the risk that a Part D provider will seek post-settlement recovery of conditional payments.

Effective discovery requests are one tool. Initial discovery to plaintiff should explore the details of her or his Medicare enrollment status with specificity as to every Part. This information should be obtained from the date of the alleged injury to when a case is filed. Many jurisdictions impose a duty to timely supplement discovery responses with new information. Throughout the pendency of the case, and especially as resolution becomes imminent, defense counsel should press for supplemental responses or get confirmation that the information in the original responses is still accurate and complete.

Next, plaintiff's medical bills and statements should indicate the entity that has paid for the treatment and related medications. Defense counsel should review these documents carefully. This information could signal that plaintiff may be enrolled in a Medicare Part C or Part D plan. Based on this information, defense counsel could investigate further whether Medicare coverage under these Parts is at issue. Finally, plaintiff's assertions in a release or related resolution documents can add one more layer of due diligence on defendant's part to pin down this vitally important but potentially elusive piece of information.

About the Author

Sean P. Sheehan is an associate in the Edwardsville office of *HeplerBroom LLC*. He focuses his practice on civil litigation defense of toxic tort personal injury and wrongful death cases. He has extensive experience in asbestos product, premises, supplier, distributor, contractor, and employer liability matters. As part of this role, Mr. Sheehan advises his clients on issues related to Medicare reporting and recovery. Mr. Sheehan received his J.D., M.B.A., and undergraduate degrees from St. Louis University.

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