IADC COMMITTEE NEWSLETTER

INSURANCE AND REINSURANCE

LIFE, HEALTH AND DISABILITY SUBCOMMITTEE

FEBRUARY 2017

IN THIS ISSUE

The Medicare Secondary Payer Act is a new tool in the arsenal of Medicare Advantage Organizations. Given the increasing pressure on cost containment and an aging population, more claims under the Medicare Secondary Payer Act are anticipated and the risk of double damages presents a significant new exposure for lawyers.

Medicare Secondary Payer Act Claims Present Problems for Claimants Counsel, Insurance Counsel, and Malpractice Counsel

ABOUT THE AUTHOR

Bryan D. Bolton is a founding member of the Baltimore based law firm Funk & Bolton, P.A. He is a frequent speaker and author on health insurance, disability insurance, life insurance, ERISA, FEHBA, and Department of Labor regulations. He regularly represents health insurers, disability insurers, life insurers, managed care companies, plan sponsors, and trustees in federal court, state court, and regulatory proceedings, as well as in arbitration and mediation. Mr. Bolton's extensive appellate experience includes appeals to the United States Courts of Appeals for the Second, Third, Fourth and District of Columbia Circuits, as well as amicus counsel before the Supreme Court of the United States. Mr. Bolton is a member of the Maryland and Pennsylvania bars. Mr. Bolton is included in the Bar Register of Preeminent Lawyers, *Maryland Super Lawyers* and the *Best Lawyers in America*. He can be reached at bbolton@fblaw.com.

ABOUT THE COMMITTEE

The Insurance and Reinsurance Committee members, including U.S. and multinational attorneys, are lawyers who deal on a regular basis with issues of insurance availability, insurance coverage and related litigation at all levels of insurance above the primary level. The Committee offers presentations on these subjects at the Annual and Midyear Meetings. Learn more about the Committee at www.iadclaw.org. To contribute a newsletter article, contact:

Natalie T. Furniss
Vice Chair of Newsletters
Bricker & Eckler LLP
nfurniss@bricker.com

Over the past few years, in response to a litigation strategy apparently developed and pursued by Humana Insurance Company ("Humana"), courts around the country have been called upon to address the scope and application of the Medicare Secondary Payer Act, *see* 42 U.S.C. § 1395y(b), to Medicare Advantage Organizations ("MAOs"). Since the litigation strategy has proven successful for Humana, counsel representing tort claimants, insurance companies, and attorneys in the context of legal malpractice claims need to consider the implications of these decisions and the impact on their respective practices.

The Medicare Secondary Payer Act was adopted in 1980 and essentially provides that Medicare is a secondary payer and will not pay claims whenever a primary plan is expected to pay. *See* 42 U.S.C. § 1395y(b)(2)(A). Prior to 1980, Medicare was a primary payer and the change in the law was motivated by a desire to control Medicare costs. Under certain circumstances, however, Medicare permits "conditional payment" of benefits even if Medicare is a secondary payer. *See* 42 U.S.C. § 1395y(b)(2)(B). The Medicare Secondary Payer Act explicitly created a private cause of action for double the amount of the conditional payment if a primary plan failed to reimburse Medicare based on the primary payment obligation. *See* 42 U.S.C. § 1395y(b)(3)(A).

Seventeen years later, in 1997, Congress created the Medicare Advantage program. The Medicare Advantage program authorized private insurance companies, such as Humana, to operate as an MAO, and administer benefits under contracts with the Centers for Medicare & Medicaid Services ("CMS"). *See* 42 U.S.C. §§ 1395w-22(a) & 1395w-23. Medicare Part C, which created the Medicare Advantage program and regulates MAOs, includes a provision entitled "Organization as secondary payer." This provision provides that when a secondary payment is permitted pursuant to 42 U.S.C. § 1395y(b)(2), then the MAO may "charge or authorize the provider of such services to charge, in accordance with the charges allowed under a law, plan, or policy described in such section—(A) the insurance carrier, employer, or other entity which under such law, plan, or policy is to pay for the provision of such services, or (B) such individual to the extent that the individual has been paid under such law, plan, or policy for such services." 42 U.S.C. § 1395w-22(a)(4).

CMS regulations provide that an MAO "will exercise the same rights to recover from a primary plan, entity, or individual that the Secretary exercises under the MSP regulations in subparts B through D of part 411 of this chapter." 42 C.F.R. § 422.108(f). Part 411, subpart B, of chapter 42, identifies two causes of action available to the Secretary: one against a primary payer and another against any entity (including a beneficiary) receiving a primary payment. 42 C.F.R. §§ 411.24(e) & 411.24(g). CMS regulations, therefore, authorized an MAO

to sue a primary plan or beneficiary under the Medicare Secondary Payer Act.

The Third Circuit Court of Appeals was the first federal circuit court to consider whether an MAO can assert a claim under the Medicare Secondary Payer Act. In that case, Humana filed a class action complaint against GlaxoSmithKline ("Glaxo"), a drug company, on its own behalf and on behalf of other similarly situated MAOs. *In re Avandia Mktg.*, 685 F.3d 353 (3rd Cir. 2012). Humana asserted claims under the Medicare Secondary Payer Act claiming Glaxo was a primary payer and should be compelled to reimburse Humana for the costs of treating Medicare Part C participants for Avandia-related injuries. *Id*. at 355-56. The Third Circuit found in favor of Humana, determining the statutory text unambiguously supported Humana's claim under the Medicare Secondary Payer Act, the legislative history supported Humana's claim, and, finally, the CMS regulations, which were due deference under the Supreme Court's *Chevron* decision, supported Humana's claim under the Medicare Secondary Payer Act. *Id*. at 357-67.

The Eleventh Circuit recently considered the same question and reached the same result, albeit in a slightly different context. *See Humana Med. Plan, Inc. v. Western Heritage Ins. Co.*, 832 F.3d 1229 (11th Cir. 2016). The Eleventh Circuit case originated out of Humana's claims under the Medicare Secondary Payer Act against a condominium insurer. Humana's claim arose from medical care expenses paid for injuries sustained by Mrs. Reale at the Hamptons West condominium property. *Id.* at 1232. Mrs. Reale and her husband filed a lawsuit against Hamptons West. *Id.* While the lawsuit was pending, Humana issued an "organization determination" to Mrs. Reale indicating $19,155.41, was subject to reimbursement. *Id.* Although an appeal process was offered and available from the organization determination, no appeal was filed. *Id.*

The Reales settled with Hamptons West in exchange for payment of $115,000 from the liability insurer, Western Heritage. 832 F.3d at 1232. The Reales released both Hamptons West and Western Heritage. *Id.* The Reales further represented in the settlement agreement that there was no Medicare lien and no right to subrogation. *Id.* Finally, the Reales agreed to indemnify Hamptons West and Western Heritage for any Medicare lien or subrogation. *Id*. Although Western Heritage attempted to add Humana to the settlement check, the Reales objected and the check ultimately was issued without Humana as a payee. *Id*. The Reales, however, agreed to hold $19,155.41 in escrow pending the outcome of the Humana lawsuit. *Id*.

Humana's lawsuit against Western Heritage sought double damages under the Medicare Secondary Payer Act, claiming Western Heritage was a primary payer. 832 F.3d at 1233. Western Heritage moved to dismiss and Humana moved for summary judgment. *Id*. The District Court denied the motion to dismiss and granted summary judgment to

Humana for double damages. *Id*. The Eleventh Circuit affirmed.

The Eleventh Circuit notably rejected several defenses advanced by Western Heritage. The Court first rejected Western Heritage's argument that it discharged its statutory obligation by providing a means for payment to Humana by requiring the Reales to place $19,155.41 from the settlement proceeds in escrow. 832 F.3d at 1239-40. The Court explained the CMS regulations required reimbursement to Humana within sixty days after receipt of the primary payment from Western Heritage. *Id*. at 1239; *see also* 42 C.F.R. § 411.24(i)(1). The Reales failed to remit payment within sixty days of receipt of the primary payment, which obligated Western Heritage to reimburse Humana, regardless of any prior payment by Western Heritage. *Id*. at 1239-40.

Still further, the Eleventh Circuit rejected the argument by Western Heritage that the damages claimed by Humana were disputed. 832 F.3d at 1240. The Court explained that Humana issued an organization determination of liability in the amount of $19,155.41, and Mrs. Reale was entitled to an administrative appeal. *Id*. Since Mrs. Reale never appealed, the reimbursement amount became fixed and could not now be disputed by Western Heritage. *Id*.

Finally, the Eleventh Circuit concurred with the District Court that double damages were required by the Medicare Secondary Payer Act. 832 F.3d at 1240. The Court explained the statutory private cause of action language "shall" is mandatory, and, therefore, the District Court properly granted summary judgment and ordered Western Heritage to reimburse Humana in the amount of $38,310.82. *Id*.

Humana further extended potential liability for Medicare Secondary Payer Act claims to lawyers and law firms in the relatively recent case of *Humana Ins. Co. v. Paris Blank, LLP*, No. 3:16CV79-HEH, 2016 U.S. Dist. LEXIS 61814 (E.D. Va. May 10, 2016). This dispute arose out of an automobile accident involving a Humana Medicare Advantage enrollee. *Id.* at *3. Humana made conditional payments for the benefit of the enrollee in the total amount of $191,612.09. *Id.* at *4. The law firm was engaged to represent the enrollee in a lawsuit related to the automobile accident. The settlement of the lawsuit filed on behalf of the enrollee resulted in various insurance companies remitting payments totaling $497,600. *Id*. at *3-4. The settlement checks were made payable in various ways, but at least one included Humana as a co-payee. The law firm typically was at least a co-payee on all the settlement checks. *Id*. at *4-5.

After the settlement, Humana wrote to the enrollee claiming reimbursement for the conditional payments totaling $191,612.09. 2016 U.S. Dist. LEXIS 61814, at *5. The letter requested reimbursement within sixty days, but also provided information on how to appeal or request a waiver. *Id.* The law firm, on behalf of the enrollee, requested a waiver. *Id.* The law firm appeared to seek a waiver based on correspondence with CMS

showing the enrollee did not owe any Medicare obligations under Medicare Parts A and B. *Id.* The CMS correspondence, however, said nothing about Medicare Part C, which was the predicate for Humana's request for reimbursement. *Id.* Perhaps not surprisingly, Humana denied the waiver request. *Id*.

After Humana filed a lawsuit against the law firm, the law firm again argued Humana could not maintain a claim under the Medicare Secondary Payer Act, but the Court, consistent with the Third Circuit's decision in *In re Avandia*, rejected that argument. 2016 U.S. Dist. LEXIS 61814, at *12-13. The law firm further argued Humana could not pursue claims against a law firm or lawyers representing a Medicare Advantage enrollee. *Id*. at *13. The argument that law firms and lawyers cannot be held liable under the Medicare Secondary Payer Act got little traction. *Id.* The Court found no attorneys exception to liability under the Medicare Secondary Payer Act and refused to create one. *Id*. Moreover, the Court explained, even assuming any ambiguity as to the extent of attorney liability under the Medicare Secondary Payer Act, the Court would still recognize claims against attorneys based on the CMS regulations identifying attorneys as an entity from whom recovery may be sought. *Id*. at *12-14; *see also* 42 C.F.R. §§ 422.108 & 411.24(g). For all these reasons, the Court denied the law firm's motion to dismiss and authorized Humana to proceed with claims against the law firm under the Medicare Secondary Payer Act.

As the above discussion illuminates, the Medicare Secondary Payer Act has become a powerful tool for Medicare Part C MAOs. Humana first established the right of MAOs to pursue claims under the Medicare Secondary Payer Act. *See In re Avandia*, 685 F.3d 353. Subsequent decisions affirmed MAOs right to pursue claims under the Medicare Secondary Payer Act and further extended claims to other parties and for additional damages.

Humana successfully extended liability under the Medicare Secondary Payer Act to a condominium insurer that settled with a claimant without discharging Humana's conditional payment. As a result, not only was the insurer responsible for paying the costs of settling the lawsuit in the first instance, but also liable for double damages to Humana. *See Western Heritage*, 832 F.3d 1229. Another way to look at it is the property insurer was essentially liable for treble damages. Caveat insurer!

Lawyers representing and advising insurers in connection with the settlement of lawsuits involving a Medicare Part C enrollee should take heed and protect their insurance company clients. Consider, for example, adding a requirement to the settlement agreement that the MAO will be included as an additional payee on the settlement check. Counsel should keep in mind a letter from CMS denying liability under Medicare Parts A and B is not likely to offer much solace in response to an MAO claim under Medicare Part C. Counsel also needs to take note of

any appeal rights offered in connection with a request for MAO reimbursement—the failure to appeal is often fatal to any attempt to dispute the amount claimed by an MAO.

Finally, Humana extended liability under the Medicare Secondary Payer Act to lawyers involved in representing Medicare Advantage Part C enrollees. *See Paris Blank*, 2016 U.S. Dist. LEXIS 61814. As a threshold matter, lawyers involved in representing tort claimants need to ascertain whether their client was at any relevant time enrolled in an MAO. If so, then the lawyer needs to be careful in reimbursing the MAO. Indeed, counsel should consider contacting the MAO to ascertain the status of any conditional payments and whether the MAO might agree to some reduction before discussing settlement of the underlying tort action.

Legal malpractice insurers need to consider the additional risk and exposure created for lawyers and law firms representing tort claimants under the Medicare Secondary Payer Act. The potential exposure is not limited to tort claimants' counsel, but extends to counsel advising insurers in connection with the settlement of claims involving conditional payments by an MAO. Moreover, the exposure is not limited to the reimbursement amount sought by the MAO, but includes the risk of "mandatory" double damages, which might exceed the settlement or payment amount.

In sum, with an aging population increasingly enrolled in Medicare, lawyers, law firms, and insurers, need to carefully consider the implications of potential MAO claims under the Medicare Secondary Payer Act. Although the risk is manageable, failure to understand and appreciate the process and how to manage the risk can create significant financial consequences for lawyers, law firms, and insurers.

Past Committee Newsletters

Visit the Committee's newsletter archive online at www.iadclaw.org to read other articles published by the Committee. Prior articles include:

DECEMBER 2016
Expanding "Best Practices" to all Aspects of the Insuring Process so as to Avoid Bad Faith Claims
Michael Cawley

JUNE 2016
It's all Change, all Change here in Great Britain
Tanguy Le Gouëllec de Schwarz

MAY 2016
Welcome to my Nightmare! The Second Circuit Determines De Novo Review is Warranted for Failure to Strictly Comply with ERISA Claim Regulations
Bryan D. Bolton

The Number of "Occurrences" Dilemma
John T. Harding

APRIL 2016
Fracking and Concussion Claims Continue to Impact the Legal Landscape
Jay Barry Harris and Andrew P. Rosen

MARCH 2016
Federal Court in Pennsylvania Issues Ruling Modifying Test for Duty to Defend in Cases Involving Named Insured's Employee's Claim against Additional Insured
David J. Rosenberg and Kenneth M. Portner

FEBRUARY 2016
Supreme Court Grants Review in Health Care False Claims Act
Bryan D. Bolton

JANUARY 2016
Vacating Arbitration Awards Due to "Evident Partiality" Under the Federal Arbitration Act
Timothy W. Stalker, David J. Rosenberg and Ryan A. Nolan

DECEMBER 2015
Delaying Tactics: How Delayed Flights Became Such a Burden to Airlines — and What They Can Do About It
Tanguy Le Gouëllec de Schwarz