



A State of Confusion and Ambiguity

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It is not just Parts A and B; Medicare Advantage and Medicare Part D plans also involve secondary payer recovery rights, but what are they?

The Current Background of Medicare Advantage and Part D Litigation



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Medicare Advantage Plans (MAPs), also known as Medicare “Part C,” are private insurance plans that provide a Medicare beneficiary’s “Part A” and “Part B” benefits. A Medicare beneficiary can choose to enroll in a MAP rather

than traditional Medicare. Part D plans provide benefits for a Medicare beneficiary’s prescription drugs. It is important to note that traditional Medicare generally does not provide prescription coverage directly; a beneficiary must enroll in a Part D plan to receive Part D benefits.

MAPs and Part D plans have undefined recovery rights for conditional payments under the Medicare Secondary Payer Act (MSP). When Congress created the Part D program in 2003, it failed to address secondary payer issues beyond simply stating that Part D plans’ secondary payer rights operated “in the same manner” as the MAPs’ secondary payer rights. 42 U.S.C. §1860D-2(a)(4). The Centers for Medicare and Medicaid Services (CMS) Prescription Drug Benefit Manual adds little more direction or guidance to Part D plans’ obligations under the MSP. In fact, it only goes as far as stating: “The MMA extended MSP laws applicable to MA organizations to Part D sponsors. Accordingly, Part D sponsors will have the same responsibilities under MSP laws as do MA plans...” See CMS Medicare Prescription Drug Benefit Manual, Chapter 14, Coordination of Benefits, Section 50.13. The case law across the country is scattered on the degree of recovery rights that MAPs and thereby Part D plans have for payments covered by other insurance or a settlement, a judgment, or an award. It is clear, however, that at the very least they have rights to recover the payments that they have made just as they would for any other medical lien, and in some jurisdictions, they have the right to recover double damages for payments that are not reimbursed. This article will explore the current state of confusion and ambiguity pertaining to the recovery rights for conditional payments that MAPs and Part D plans have.

MAP and Part D Recovery Rights Case Law History

Exploring the history of MAP and Part D recovery rights case law is fundamental to

understanding what brought us to this confusion today. On February 4, 2011, a wrongful death action involving a MAP enrollee in the U.S. District Court for the District of Arizona titled *Parra v. Pacificare of Arizona*, 715 F.3d 1146 (9th Cir. Ariz. 2013), found that the MSP did not provide a private cause of action for MAPs and Part D plans similar to that provided for Part A and B plans under 42 U.S.C. §1395y(b)(3)(A). Additionally, the *Parra* decision found no congressional intent to infer such a right. Due to express statutory and regulatory provisions regarding billing rights, the court found that the proper place for a MAP reimbursement claim lies in the state courts under traditional contract theories.

Subsequently, the U.S. District Court for the Eastern District of Pennsylvania ruled against Humana in its efforts to recover from GlaxoSmithKline in a case titled *In Re Avandia v. GSK. In re Avandia Mktg., Sales Practices & Prods. Liab. Litig.*, 685 F.3d 353(3d Cir. Pa. 2012), *cert. denied*, 133 S. Ct. 1800 (2013). While Humana argued that the MSP, 42 U.S.C. §1395y(b)(3)(A), unambiguously granted a private cause of action to MAPs, the court found that it did not. Rather, the court held that Humana only had a lien right under state law to recover such payments.

On December 5, 2011, in response to the *Parra* and *In Re Avandia* decisions, the CMS issued a memorandum in support of MAPs and Part D plans having the right to collect for payment of services when Medicare is not the primary payer. In the memorandum, CMS went so far as to state that MAPs and Part D plans can exercise the same rights of recovery that the Secretary of Health and Human Services exercises under the existing MSP regulations. While the CMS memo was very clear on CMS’ position on MAP and Part D recovery rights, a memorandum issued by an administrative agency is not binding, and therefore litigation continued. Even so, the CMS memo arguably could carry *some*

weight through *Chevron* deference. *Chevron* deference is a well-known, two-part test established by the U.S. Supreme Court for determining when a federal court ought to defer to the interpretation of a statute by the federal agency charged with implementing that statute. See *Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984).

On July 12, 2012, the Third Circuit Court of Appeals reversed the U.S. district court decision in *In Re Avandia*. The Third Circuit found that MAPs have the same rights to recovery as Medicare and additionally that MAPs have a right to pursue a private cause of action for double damages under the MSP for conditional payments that are not reimbursed. Presumably the court would have found the same for Part D plans, although no such claims were present in the case.

On April 15, 2013, the U.S. Supreme Court denied certiorari to review the *In Re Avandia* case; therefore, the decision of the Third Circuit remained in place. Just four days later, on April 19, 2013, the Ninth Circuit affirmed the initial decision in the *Parra* case, which found that MAPs do not have the same rights to recovery as Medicare does and can recover conditional payments by way of their contract with the beneficiary.

Then on September 24, 2014, the U.S. District Court for the Western District of Texas (Austin Division) overturned an earlier U.S. magistrate judge’s recommendation in *Humana v. Farmers Texas County Mutual Insurance Company*, 95 F. Supp. 3d 983 (D. Tex. 2014), which rejected a private cause of action for MAPs. The decision is the first in the Fifth Circuit to follow the line of reasoning from the Third Circuit’s *In Re Avandia* decision.

The most recent major decision on this issue is *Collins v. Wellcare Health Plans*, 73 F. Supp. 3d 653 (D. La. 2014), on December 16, 2014. There, the U.S. District Court for the Eastern District of Louisiana decided that the MAP had a private cause of action under the MSP to secure reimbursement from its insured to recover conditional payments that it had made related to an automobile accident. This is the second decision from the Fifth Circuit to follow *In Re Avandia*.

The resulting question is, where do we stand today? Currently, we have two cir-

cuits, the Ninth and Third Circuit, which have differing views on MAP recovery rights. Both circuits agree that MAPs and Part D plans have the right to recover conditional payments; however, they disagree as to the extent to which MAPs and Part D plans can use that right. We cannot read anything from the U.S. Supreme Court's denial of review in the *In Re Avandia* case.

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That denial first was too close in time to the decision in the Ninth Circuit (*Parra*); but more importantly, legally, the U.S. Supreme Court had the right to deny certiorari, and not hearing the case has no precedential value.

Each circuit court can still interpret the law based on legal authority that exists across the country. With two conflicting circuit opinions, the law should be viewed as unsettled and unclear.

Best Practices for Payers Regarding Medicare Advantage and Part D Payments

Until Congress clarifies the MSP law, or the U.S. Supreme Court rules on this issue, more litigation is expected. Insurance carriers should therefore consider MAPs and Part D plans as generating potential claims for recovery when resolving a workers' compensation or liability claim with a Medicare beneficiary claimant.

The best way to reduce risk by MAPs and Part D plans is to adopt good practices consistent with the law in the applicable jurisdiction today. Defense lawyers should become familiar with these practices and consider them when approaching a settle-

ment involving a Medicare beneficiary. As always, the threshold question that must be asked is whether or not the case involves a Medicare beneficiary. Timing is crucial to this analysis because it is the claimant's status on the date of settlement or judgment and not the date of the injury or the accident that is relevant.

Medicare beneficiary status can be based on a number of factors, principally age, illness, or disability. Recall that a claimant's right to Medicare is not based on need, as with state Medicaid programs, but on eligibility. Once eligibility tests are met, then Medicare status is established. Thus, if your claimant is 65 years or older, has contracted Lou Gehrig's, suffers from kidney disease, or is entitled to Social Security disability income, he or she is more likely than not a Medicare beneficiary. If the claimant does not meet any of these entitlement requirements, then there is no MAP or Part D plan claim, and the case can proceed to settlement or judgment without regard to these plans' interests. However, if any of these factors exists, then these plans could have paid for care related to the claim that could subject your client to exposure. Therefore, you must address it.

Although you have a potential for Medicare status, there is no need to protect a MAP or a Part D plan if the claimant is *not* a Medicare beneficiary. Thus always corroborate claimant's Medicare status, before taking any other steps.

Assuming that Medicare status has been determined, defense attorneys should take every step to identify all healthcare plans that a claimant may have through discovery. This information is critical in those jurisdictions that currently recognize a MSP private cause of action claim against your client. In those jurisdictions that do not, you should include the information in the settlement documentation because it is relevant, at a minimum, to how these liens should be addressed. In those jurisdictions that have not yet addressed the question, it is best to err on the side of caution.

The Third Circuit case of *In Re Avandia* is the only U.S. circuit court of appeals decision to date that has established the private cause of action against primary plans (insurance carriers and self-insurers) that handle workers' compensation and liability cases. The Third Circuit includes the

states of Pennsylvania, New Jersey, and Delaware. In these jurisdictions, the best practice for a defense lawyer is to identify immediately the MAP and prescription drug plans for a claimant and have a strategy in place to address these liens and reimbursement obligations at the time of settlement. Since workers' compensation insurers and self-insurers and the payers in these jurisdictions can presently be subject to double damages, it may make sense to notify your court immediately of this concern and how it should be addressed. Additional care must be taken in these jurisdictions because the liability is strict. It is easy for the unknowing defense practitioner to become entangled in this trap because a claimant could also individually bring the private cause of action on behalf of the MAP and Part D plans. Hence, it may make sense for the insurance carrier or the self-insured, or both, to pay directly. If that is not feasible, involving your court should be considered. Should court involvement not be an option, then carefully draft the release with the proper indemnity provisions for the MSP private cause of action, including a waiver from the claimant to prevent the claimant from presenting a cause of action him- or herself. If the plan is for the claimant to pay, always ask for confirmation of payment.

Always check to see if the venue of your case has a U.S. district court opinion that has addressed the MSP question discussed in this article. If it has, and it follows *In Re Avandia*, you should consider paying the reimbursement directly as you would in Pennsylvania, New Jersey, or Delaware. If it has not, then you should still consider using discovery to identify whether MAP or Part D plans are involved. If a claimant is a Medicare beneficiary, then the release should specify how those liens or reimbursement obligations will be addressed. At a minimum, having proof that the liens or the reimbursement obligations were satisfied would be helpful.

While *In Re Avandia* is the only current circuit court of appeal decision, it certainly won't be the last. One case to watch is *Humana v. Western Heritage Insurance Co.* This case involves an insurance carrier that settled a liability matter and learned after the settlement that the claimant was a Medicare beneficiary. In an attempt to

mitigate its risk, the carrier attempted to add conditions to the release. The plaintiff's attorney resisted, and the state court required Western Heritage to pay the funds, allowing the claimant and his attorney to deal with the Medicare issues. Regrettably, the claim involved a MAP, and as the matter progressed with regard to the lien, Humana did not receive a favorable ruling on its lien and filed an appeal. It also filed a lawsuit against Western Heritage in the U.S. district court requesting the full value.

Despite the pending state court appeal, the U.S. district court in the action brought by Humana awarded Humana double damages because Western Heritage was required (in the court's interpretation of the MSP law) to pay Humana when the case settled. Western Heritage appealed, and the case is presently pending in the Eleventh Circuit. Oral argument was held in mid-April of this year with a decision expected sometime late summer or early fall. A ruling for Humana would more than likely result in widespread application across the country. If that should occur, counsel will need to be prepared to address reimbursement obligations under MAPs and Part D plans as well as Part A and Part B plans or risk exposure to double damages. However, a ruling for Western Heritage would lead to the opposite conclusion.

Next Steps in Clarifying Medicare Advantage and Part D Recovery Rights

As described above, the secondary payer laws for MAPs are themselves conflicting and unclear. Moreover, they often do not make sense in the prescription drug context. Without clear direction or guidance, Part D plans have been left to guess what their obligations are under the MSP and how to implement them. In the end, Part D plans are unsure what rights and obligations they have and how those rights and obligations may affect beneficiaries and payers or the insurers that are involved in resolving claims with beneficiaries. The limited guidance available creates a process in which it appears that Part D plans pay for a beneficiary's prescription drugs but then later are forced to seek reimbursement for those payments. This process is inefficient and costly to enforce. Further, pursuit of secondary payer recovery for Part D often costs more than can be recovered and thus

The Medicare Advocacy Recovery Coalition (MARC) is a national coalition advocating for the improvement of the MSP programs. The coalition collaborates and develops strategic alliances with beneficiaries, affected companies, and a wide range of other stakeholders to work with the Congress and government agencies to implement MSP reforms that will improve the process for all. DRI is a steering committee member.

is a waste of government and Part D plan resources. Finally, even though Section 111 of the Medicare Medicaid S-CHIP Extension Act (MMSEA) requires payers that settle claims with Medicare beneficiaries to report those settlements to Medicare, this process is not linked to Part D plans, meaning that the data about a settlement is not shared with Part D plans, leaving these plans with no opportunity to identify a recovery or a coordination of benefits opportunity at the time; the plans only learn about a settlement long after the case is resolved.

In an attempt to solve these issues, the Medicare Advocacy Recovery Coalition (MARC) is working on proposed legislation—the SPARC Act—similar to the SMART Act, which was signed into law in January 2013 as part of the Medicare IVIG Access and Strengthening Medicare and Repaying Taxpayers Act of 2012 and helped improve the processes for MSP recovery and reporting under Parts A and B for all stakeholders. The SPARC Act (the Secondary Payer Advancement, Rationalization and Clarification Act) would make clear who is responsible for prescription drug costs and when they must be reimbursed. It would also make clear when that responsibility begins, how a prescription drug plan can recover for past payments, and when, and how CMS must share data to help facilitate the secondary payer process and recovery. The end result should be savings for the federal government as well for prescription drug plans.

The proposed legislation would repeal the vague language described above that grants prescription drug plans secondary payer rights “in the same manner” as MAPs and instead provides a clear, five-part secondary payer process. This process includes granting permission to a prescription drug plan to be subrogated against a beneficiary or a party in a liability action to recover past payments made for prescription drugs that should have been included in the settlement, the judgment, or the

award. Similar to the recovery process for Part A and Part B plans, there would be a three-year statute of limitations, and the final recovery would be reduced by procurement costs associated with pursuing the claim. The SPARC Act also proposes to permit a Part D plan to waive the secondary payer provisions if the plan determines that a waiver is in the best interest of the Medicare program, similar to existing federal law. This would allow plans to pursue recovery only when the recovery would exceed the cost of collection. The SPARC Act would also require CMS to pass along to a Part D plan the information included in a report under Section 111 of the MMSEA, which would bring the case resolution to the attention of the Part D plan and thus to allow the Part D plan to coordinate benefits. Further, when an entity has the ongoing responsibility to pay for medical benefits, the SPARC Act would require a Part D plan to ensure that the pharmacy or the entity providing the prescription drugs sends the bills to the entity with the ongoing responsibility instead of billing the Part D plan.

Resolving questions about Part D plans' obligations to pursue reimbursement and payers obligations to make reimbursement to Part D plans is needed to fill the guidance void and to provide certainty in the handling of claims in the liability and the workers' compensation context. The SPARC Act will do just that.

MARC is currently working with legislators in the U.S. House and the U.S. Senate to introduce the SPARC Act as a bill. MARC could use your help supporting this proposed legislation. To learn more about the SPARC Act and how you can help support it becoming law, please see <http://marccoalition.com/>. At the same time, you or your organization can join MARC as a member to stay abreast of the progress of the SPARC Act, as well as of the status of implementation of the SMART Act and other MSP program issues. 