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PROGRAM MATERIALS

DOUBLE DAMAGES:

Resolving Medicare & Medicare Advantage Plan Liens

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MEDICARE ADVANTAGE PLANS (MAPS)

A. MEDICARE ADVANTAGE GENERALLY—PART C OF THE MEDICARE ACT.

In 1997, the Medicare Advantage Program (hereinafter "MA"), Part C of the Medicare Act, was created as an alternative to the government Medicare program. Under the Medicare Advantage Program, enrollees have the option of receiving their Medicare insurance from private insurers instead of direct benefits from the federal government.

B. STATUTES AND REGULATIONS

The Medicare Secondary Payer (MSP) Act provides that Medicare is secondary to other insurers, called primary plans: group health plans, workers compensation plans, liability insurance policies and plans, and no-fault insurance. See 42 U.S.C. § 1395y(b)(2)(A). Medicare makes conditional payments, i.e., it pays for services and if it later learns that those services are covered by a primary plan, the primary plan (or an entity that receives payment from a primary plan) must reimburse Medicare for those services. See 42 U.S.C. § 1395y(b)(2)(B).

1. The Medicare Advantage Secondary Payer Statute

The Medicare Advantage (MA or Part C) statute includes its own provision regarding the role of an MA plan as secondary payer. The MA statute's secondary payer provision, at 42 U.S.C. § 1395w-22(a)(4), states that:

> Notwithstanding any other provision of law, a Medicare+Choice organization may (in the case of the provision of items and services to an individual under a Medicare+Choice plan under circumstances in which payment under this subchapter is made secondary pursuant to section 1395y(b)(2) of this title) 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.

2. The Medicare Advantage Secondary Payer Regulations

On January 28, 2005, the Medicare Advantage regulations were amended. The Secretary of Health and Human Services, in respect for the basic rule that Medicare does not pay for services to the extent that Medicare is not the primary payer, adopted 42 CFR § 422.108 which provides for the secondary payer responsibilities of a MA plan:

(a) Basic rule. CMS does not pay for services to the extent that Medicare is not the primary payer under section 1825(b) of the Act and part 411 of this chapter.

(b) Responsibilities of the MA organization. The MA organization must, for each MA plan—

(1) Identify payers that are primary to Medicare . . . ;

(2) Identify the amounts payable by those payers; and

(3) Coordinate its benefits to Medicare enrollees with the benefits of the primary payers, including reporting, on an ongoing basis, information obtained related to requirements in paragraphs (b)(1) and (b)(2) of this section in accordance with CMS instructions.

(c) Collecting from other entities. The MA organization may bill, or authorize a provider to bill, other individuals or entities for covered Medicare services for which Medicare is not the primary payer, as specified in paragraphs (d) and (e) of this section.

(d) Collecting from other insurers or the enrollee. If a Medicare enrollee receives from an MA organization covered services that are also covered under State or Federal workers' compensation, any no-fault insurance, or any liability insurance policy or plan, including a self-insured plan, the MA organization may bill, or authorize a provider to bill any of the following—

(1) The insurance carrier, the employer, or any other entity that is liable for payment for the services under section 1862(b) of the Act and part 411 of this chapter.

(2) The Medicare enrollee, to the extent that he or she has been paid by the carrier, employer, or entity for covered medical expenses.

Finally, 42 CFR § 422.108(f) states that:

The rules established under this section supersede any State laws, regulations, contract requirements, or other standards that would otherwise apply to MA plans. A State cannot take away an MA organization's right under Federal law and the MSP regulations to bill, or to authorize providers and suppliers to bill, for services for which Medicare is not the primary payer. The MA organization 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 CFR § 422.108(f).

3. MSP Private Cause of Action for Double Damages

There have been a number of cases in both state and federal courts that have considered the issue of whether there is a federal cause of action providing for MA plans to enforce their rights under the Medicare Advantage statutes, the MSP Act, and the accompanying regulations.

C. MEDICARE ADVANTAGE REIMBURSEMENT: CASE LAW

1. *Care Choices HMO v. Engstrom*, 330 F.3d 786 (6th Cir. 2003)

In this case, the private insurer was not a Medicare Advantage plan, but rather a Medicare-substitute HMO. The HMO sought reimbursement from a plaintiff who recovered a settlement in a third-party liability action. The U.S. Court of Appeals for the Sixth Circuit considered whether the applicable statute, 42 U.S.C. § 1395mm(e)(4), contains a private right of action in federal court. The court found no such right and held:

> Reading the statute as a whole, it is clear that Section 1395mm(e)(4) is intended to permit Medicare-substitute HMOs to create a right of reimbursement for themselves in the context of their own insurance agreements with Medicare beneficiaries. The statute does not confer any affirmative rights to reimbursement, much less contain an implied right of action. . . . If an HMO chooses to include such a provision in its insurance policy, its remedy would be based on a standard insurance contract claim and not on any federal statutory right.

Care Choices is frequently cited in cases deciding the issue of a private right of action for MA plans. Although the plan in *Care Choices* was not an MA plan, the issues raised and the statutory language in 42 U.S.C. § 1395mm(e)(4) are essentially the same as the issues raised in the context of MA plans and the statutory language in the MA statute, 42 U.S.C. § 1395w-22(a)(4). Thus, *Care Choices* continues to be favorably cited.

2. *Nott v. Aetna U.S. Healthcare, Inc.*, 303 F. Supp. 2d 565 (E.D. Pa. 2004)

Here, the Federal District Court for the Eastern District of Pennsylvania considered whether a Medicare Advantage plan's right to assert subrogation against an enrollee's tort recovery arose under the Medicare Advantage statute. The court noted that the language of the statutory provision, 42 U.S.C. § 1395w-22(a)(4), does not create a federal scheme for the civil enforcement of an MA plan's subrogation rights.

Rather, the Act only authorizes, but does not require, the private insurer to include subrogation provisions in the insurance contract. This permissive language, along with the absence of an express remedial provision, is evidence of Congress's intent not to create an explicit right of action for private MA plans. Thus, if the MA plan includes a subrogation provision in the insurance policy, the right to subrogation remains a private contractual right which may be enforced in state court.

NOTE: It is important to note that this case may have been rendered irrelevant by the recent Third Circuit decision in *In re Avandia* that is discussed below. *Nott*, along with *Care Choices*, is frequently cited in cases holding that there is no express or implied federal right of action for Medicare Advantage plans to enforce their rights of subrogation and/or reimbursement. *In re Avandia* held that an MA plan may bring an action under 42 U.S.C. §1395y(b)(3)(A) of the MSP Act. *In re Avandia* concluded that *Nott* only considered 42 U.S.C. Sections 1395mm(e)(4) and 1395w-22(a)(4), and did not consider 1395y(b)(3)(A). Therefore, *Nott* was irrelevant to its decision. Although not explicitly overruled, *Nott* has no real impact in the Third Circuit because *In re Avandia* held that there is another federal avenue of relief for MA plans, through the private cause of action under 42 U.S.C. § 1395y(b)(3)(A).

3. *Primax Recoveries, Inc. v. Yarmosh*, Case No. 3: 03CV01931, 2006 U.S. Dist. LEXIS 98858 (D. Conn. 2006)

In this case, Primax, as the subrogation and collection agent for a Medicare Advantage plan, sued in federal court to enforce its right of subrogation and reimbursement. Here, the Federal District Court for the District of Connecticut agreed with the reasoning in *Care Choices* and concluded that there was no express or implied private right of action in the statutes to allow a Medicare Advantage plan to sue in federal court. It noted that the Second Circuit had not addressed the issue, but the *Care Choices* decision relied on the same standard to determine whether there is an implied cause of action that is applicable in the Second Circuit. "This court agrees with the *Care Choices* court that there is no private cause of action for a Medicare+ Choice HMO under the Medicare+ Choice statute, 42 U.S.C. § 1395mm(e)(4)." Primax, 2006 U.S. Dist. LEXIS 98858 at *13.

The MA plan in this case also argued that the MSP Act itself, in 42 U.S.C. §1395y(b)(2)(B)(ii) entitled it to sue in federal court. That provision, however, only authorizes the United States to bring a lawsuit in federal court. The statute does not expressly grant a cause of action to any entity other than the United States. The court found the language of the statute clear and unambiguous, dismissed the MAO's federal action, and allowed them to replead in state court under a state contract law claim.

4. *Konig v. Yeshiva*, 12-CV-467, (E.D. N.Y. March 30, 2012)

Here, the District Court in the Eastern District of New York found that MA plans do not have a right of action under the Medicare laws. "Although the Medicare statute clearly authorizes the government to bring an action to enforce its subrogation rights under its own Medicare insurance

contracts, see 42 U.S.C. § 1395y(b)(2)(B)(iii), the statute does not expressly accord private MAP providers the same right." Konig, 12-CV-467, at 5. The court noted that "every court" to address the issue has found that the laws also fail to create an implied cause of action.

In *Konig*, the MA plan argued that the corresponding regulation, at 42 CFR § 422.108(f), provides that Medicare Advantage Plan organizations (MAO) exercise the same right to recover as the Secretary, and therefore this places them in the same shoes as the government, thereby granting them the power to bring a private right of action. The court disagreed, stating that the reasoning is faulty. The court reasoned that "[l]anguage in a regulation may invoke a private right of action that Congress through statutory text created, but it may not create a right that Congress has not." Id. at 5, fn. 2 (citing *Alexander v. Sandoval*, 532 U.S. 275, 291 (2001)). Since there is nothing in the Medicare statutes that creates a cause of action, then the parties cannot fashion one by invoking the regulations. The Medicare laws offer no private right of action—express or implied—to MA plans to enforce any claimed subrogation rights.

5. *In re Avandia Marketing, Sales Practices and Products Liability Litigation*, 685 F.3d 353 (3d Cir. 2012)

The U.S. Court of Appeals for the Third Circuit, in *In Re Avandia*, came to a different conclusion than every previous decision. The lower court decision in this case, in U.S. District Court for the Eastern District of Pennsylvania, ruled in line with previous decisions that an MA plan does not have a private right of action in federal court, and the MA plan is limited to state court to enforce the subrogation terms in the insurance contract.

The plan argued that the MSP Act itself, even without reference to the Medicare Advantage statutes, is broad enough to include a Medicare Advantage plan within the parties that may bring a private right of action for double damages under 42 U.S.C. § 1395y(b)(3)(A). The private cause of action statute states:

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 Court here agreed, and reversed the lower court's ruling. The Third Circuit concluded that an MAO has the same right to recover as the Medicare Trust Fund. The Medicare statute has two separate causes of action. When the Medicare Trust Fund makes a conditional payment and the primary payer does not reimburse it, the United States may bring suit pursuant to § 1395y(b)(2)(B)(iii). Also, there is a private right of action with no particular plaintiff specified under § 1395y(b)(3)(A) any time a primary payer fails to make required payments.

Even though the MSP Act was enacted before Part C, private Medicare risk plans were authorized at the time. The Court felt that Congress was aware that private Medicare providers existed; and had Congress intended to prevent them from suing under the private cause of action provision, Congress could have done so explicitly.

The MA plan here did not argue that the MA secondary payer provision provides a cause of action through its reference to the MSP Act, but it argued that the language of the MSP Act itself is broad enough to encompass an MA plan, regardless of the existence of 42 U.S.C. §1395w-22(a)(4). The Court concluded that there is nothing in the text or legislative history of the MA secondary payer provision that demonstrates a congressional intent to deny MA plans access to the MSP private cause of action.

The Court disregarded the decisions of *Care Choices HMO v. Engstrom*, and *Nott v. Aetna U.S. Healthcare, Inc*. In both decisions, the Court noted that the question of whether a Medicare Advantage plan could have brought suit as a private actor directly under the MSP Act under 42 U.S.C. 1395y(b)(3)(A) was neither raised nor addressed. Therefore, those decisions were irrelevant.

The Court found nothing in the text or the legislative history of the statute to imply that Congress did not intend to facilitate recovery for MA plans in the same fashion as that of traditional Medicare, and found the text of the statute to be clear and unambiguous.

Even if the statute was ambiguous as to whether an MA plan has the same rights as traditional Medicare in the MSP Act, the Chevron defense would apply to reach the same conclusion. The Supreme Court in Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc., 467 U.S. 837 (1984) established a test to determine when a court should defer to the interpretation of a statute embodied in a regulation enacted by the federal agency charged with implementing the statute.

CMS regulations state that an "MA organization 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). The court found that the plain language of the regulation suggests that the Medicare Act treats MA plans the same way it treats the Medicare Trust Fund for purposes of recovery from any primary payer. So, deference to the agency's interpretation in the regulations suggests that there is a private cause of action under the MSP Act for MA plans:

The language of the MSP private cause of action is broad and unrestricted and therefore allows any private plaintiff with standing to bring an action. Since private health plans delivered Medicare services prior to the 1980 passage of the MSP Act, Congress was certainly aware that private health plans might be interested private parties when it drafted the cause of action, and it did not exclude them from that provision's ambit. That decision is logically consistent because affording MAOs access to the private cause of action for double damages comports with the broader policy goals of the MA program. Further, even if we were to find the statutory text to be ambiguous on the issue, Chevron deference to CMS regulations, which grant MAOs parity with traditional Medicare, would require us to find in favor of [the MAO] here.

6. *Potts v. Rawlings Company, LLC*, No. 11 Civ. 9071 (S.D.N.Y. September 25, 2012).

In this case, a class of Medicare Part C beneficiaries challenged the collection activities of various collection agents who had worked on behalf of MA Plans. They argued that the plans' claims arise under state contract law and the New York anti-subrogation statute (General Obligations Law § 5-335), and not under the Medicare Act.

Here, the court held that the issue of whether a MA plan has a private cause of action to pursue reimbursement is irrelevant. The issue is that the Medicare Act expressly pre-empts state law, and thus General Obligations Law § 5-335 does not apply:

> First, that the Medicare Act does not create a private right of action for MA organizations is not at all clear, as there is a split of authority on the issue. Second, given the broad express preemption clause in the Medicare Act, whether there is a private right of action for MA organizations is immaterial to the question whether GOL § 5-335 is preempted.
> . . .
> Because Plaintiffs' claims, in essence, are claims seeking the retention of benefits, they arise under the Medicare Act, and Plaintiffs were obligated to exhaust their administrative remedies before bringing this action. Thus, the Court is without subject matter jurisdiction to consider those claims.

7. *Trezza v. Trezza*, 2012 N.Y. Slip. Op. 09048 (N.Y. App. Div. 2d Dept. 2012)

In a reversal of arguments as to the enforceability of claims for reimbursement of Medicare Advantage Plans, on December 26, 2012 [*argued September 21, 2012*] the New York State Appellate Division, Second Judicial Department has reversed the lower court's decision in the appeal of the matter of the Kings County Supreme Court decision of *Trezza v. Trezza*, 32 Misc 3d 1209[A], 2011 NY Slip Op 51237[U] (Sup Ct, Kings County).

The Second Department held that: "General Obligations Law §5-335, insofar as applied to Medicare Advantage organizations under Part C, is preempted by federal law since it would impermissibly constrain contractual reimbursement rights authorized under the "Organization as secondary payer" provisions of the Medicare Act."

By way of relevant background, Janine Trezza was injured in a motor vehicle accident while riding in a vehicle operated by her husband. Oxford Health Plus, the Medicare Advantage plan, paid $37,787.64 in medical expenses for plaintiff's accident-related injuries. Plaintiff received a settlement of $75,000.00 out of which Oxford Health Plus claimed entitlement to reimbursement of $37,787.64.

The Supreme Court, Kings County, granted the plaintiff's motion to extinguish the purported lien and/or claim for reimbursement based upon the following reasoning:

> Courts have held that because the Medicare Act did not establish a federal scheme for the civil enforcement of HMO subrogation rights, it did not create a private cause of action (*Nott, 303 F.Supp.2d at 570*; *See also Care Choices HMO v. Engstrom, 330 F.3d 786, 789 [6th Cir. 2003])*. The Medicare Act therefore does not create a statutory right of reimbursement; instead, it allows HMOs to include subrogation rights in its contracts with beneficiaries (*Nott, 303 F.Supp.2d at 570*). Because "the Medicare Act permits, but does not mandate, HMO insurers to contract for subrogation rights" (*id. at 571*), subrogation in this context remains a state contract law issue (*id. at 572*; *Care Choices, 330 F.3d at 790*).

In a matter of first impression before the Appellate Division, the Court further examined the preemptive effect the Medicare Act may have on General Obligation Law §5-335.

In its analysis, the Appellate Division observed:

> Thus, the Medicare Act provides that Medicare Advantage organizations may create a right of reimbursement for themselves in their insurance agreements with Medicare insureds. Moreover, "[t]he standards established under [Part C] shall supersede any State law or regulation (other than State licensing laws or State laws relating to plan solvency) with respect to [Medicare Advantage] plans which are offered by [Medicare Advantage] organizations under [Part C]" (42 USC § 1395w-26[b][3]), and "[a] State cannot take away [a Medicare Advantage] organization's right under Federal law and the MSP regulations to bill, or to authorize providers and suppliers to bill, for services for which Medicare is not the primary payer" (42 CFR 422.108[f]).
>
> Yet General Obligations Law § 5-335 would prohibit Medicare Advantage organizations from exercising the contractual right to reimbursement in that it would constrain contractual reimbursement rights where the insured entered into a personal injury settlement. In other words, General Obligations Law § 5-335, which, insofar as at issue here, clearly does not constitute a licensing law or a law relating to plan solvency, would, in the context of such personal injury settlements, "take away [a Medicare Advantage] organization's right under Federal law and the MSP regulations to bill, or to authorize providers and suppliers to bill, for services for which Medicare is not the primary payer" in contravention of the federal regulations enabled by 42 USC § 1395w-26(b)(1) (42 CFR 422.108[f]).

The Court noted that although Medicare Advantage plans had no "statutory right of reimbursement" as used in General Obligations Law § 5-335, the Medicare Act expressly pre-empted the application of § 5-335.

The Court concluded that "because General Obligations Law § 5-335 is expressly preempted by the Medicare Act, the Supreme Court erred in granting the plaintiff's motion to extinguish the purported lien and/or claim for reimbursement based on that section."

Although the decision reinstated the claim of reimbursement of the Medicare Advantage Plan against the settlement proceeds, it did not preclude other arguments to attack the validity and amount of the purported claim.

As such, this case should not be considered a windfall for Medicare Advantage-type Plans in asserting liens and/or claims for reimbursement from personal injury settlements. As in cases involving ERISA self-insured type plans, the language in the plan should be examined in each particular case to ascertain grounds to attack the amounts claimed in addition to other arguments and defenses.

8. *Parra v. Pacificare of Arizona, Inc.*, 715 F.3d 1146 (9th Cir. 2013)

The Ninth Circuit recently issued a similar opinion. In this case, the Ninth Circuit held that the Medicare Advantage statute itself does not create a cause of action for MA plans and the MSP Act's private cause of action did not apply to MA plans.

Regarding the MA statute, the court held that: "On its face, the MAO Statute does not purport to create a cause of action. Rather, it simply describes when MAO coverage is secondary to other insurance, and permits (but does not require) a MAO to include in its plan provisions allowing recovery against a primary plan."

Likewise, it found that the regulation at 42 CFR § 422.108(f) adds nothing to a MAO's claim to a private right of action because language in a regulation cannot create a right that Congress has not created by statute. The Private Cause of Action statute was intended to allow private parties to vindicate wrongs occasioned by the failure of primary plans to make payments, not plaintiff beneficiaries. The court went on to distinguish the Third Circuit's *In re Avandia* case (discussed below), as there the plan sought recovery directly against the third-party tortfeasors and not the Plaintiffs.

9. *Collins v. Wellcare Healthcare Plans, Inc.,* No. 13-6759 L(3) (E.D. LA 2014).

Wellcare, a MAO, made payments for Collins' medical bills as a result of a motor vehicle accident. Collins seeks declaratory judgment as to Wellcare's subrogation and reimbursement rights in regards to Collins' personal injury settlement. Wellcare then removed the case to federal court on diversity jurisdiction.

Wellcare first argued that Collins was required to exhaust administrative remedies before seeking declaratory judgment, and thus the court should dismiss Collins' claim. The court determined

that Collins' claim did "arise under" Medicare because it was essentially a claim to retain benefits by arguing that MSP did not apply. *See Eihnorn*, 2014 WL 4385912. Therefore, Collins' case did arise under Medicare, and exhaustion was required.

Wellcare also argued that as a MAO, it was entitled to reimbursement through the MAO or MSP statutes. The court failed to make a determination on whether the MAO statute created a specific right of reimbursement, or only created the right to charge such reimbursement in their contracts, but did acknowledge the circuit split. The Court did, however, determine that the MSP statute was broad enough to include MAOs.

After it was determined that MAOs had a private right of action generally, the court decided whether Wellcare's claim satisfied the requirements of the MSP to enforce a private cause of action. The main issue was whether tort settlements were considered primary plans for purposes of paragraph (1) and (2)(A) of 42 U.S.C. §1395(y)(3)(A). The court deferred to other circuit holdings that this cause of action included tort settlements, and not just group health plans as set out in paragraph (1). Furthermore, the court held that Wellcare was indeed making conditional payments even though it did not know of any other primary payers. *See* 42 C.F.R. §411.21.

Lastly, assessing double damages was inappropriate for this case because Collins placed the settlement funds into a trust account pending a determination of Wellcare's rights.

10. *Humana Med. Plan, Inc. v. W. Heritage Ins. Co.*, No. 15-11436, 1:12-cv-20123-MCG (11th Cir. Aug. 8, 2016).

Ms. Reale was the injured plaintiff in a personal injury case against Hamptons West Condominium Association. Hamptons West was insured by Western Heritage Insurance Company. Humana paid medical bills for Ms. Reale's injuries, as a Medicare Advantage plan; it paid $19,155.41 in expenses. Humana requested reimbursement while the personal injury suit was still pending.

Ms. Reale and Western Heritage agreed to settle the personal injury claim for $115,000.00. Ms. Reale represented in the Release that there was no Medicare lien, and she also agreed to indemnify and hold harmless defendant and its insurance company.

Humana first attempted to sue Ms. Reale and her attorney in federal district court seeking reimbursement. The district court initially dismissed Humana's complaint for lack of subject matter jurisdiction, but it later vacated that order after Humana moved to correct the order. However, prior to the hearing to consider Humana's motion, Humana voluntarily dismissed its action against Ms. Reale and her attorney.

At this time, Western Heritage had still not tendered the settlement check to plaintiff because Western Heritage demanded that Humana be included as a payee on the settlement check. The state court ordered that Western Heritage tender the check without Humana as payee, but also ordered Ms. Reale's attorney to hold $19,155.41 in trust, pending resolution of the dispute on the claimed lien. Ms. Reale then sued Humana in state court seeking a declaration as to the amount

owed. The state court applied Florida law regarding collateral indemnity and subrogation and concluded that Humana was only entitled to $3,685.03. On appeal by Humana, Ms. Reale's case was dismissed for lack of jurisdiction by the Florida appellate court, determining that only upon exhaustion of the administrative process does the Medicare Act provide for federal judicial review, and it expressly preempts state law. *See* 42 U.S.C. §§ 1395w-22(g)(5) and 1395w-26(b)(3), respectively.

Still unpaid, and perhaps motivated by double damages, Humana then sued the liability carrier, Western Heritage, for failure to reimburse, arguing that the Medicare Secondary Payer Act's private cause of action provision allows a suit for double damages when an insurance company fails to reimburse a Medicare Advantage plan. (Note that this double damages provision is found nowhere within the wording of the Medicare Advantage statute, 42 U.S.C. §§ 1395w-21, et.seq.)

The district court agreed with Humana, and followed the Third Circuit's decision in *In re Avandia Mktg., Sales Practices & Prods. Liab. Litig.,* 685 F.3d 353 (3rd Cir. 2012).

Circuit Judge William Pryor authored a brief but thoughtful and logical dissent which concluded that the majority ignored key words in the statutes, such as "Secretary" and "Trust Fund." Under the Medicare Secondary Payer Act, only the Secretary of Health and Human Services may make conditional payments, which are conditioned on reimbursement to the Medicare Trust Fund.

However, the majority decision is now controlling in the Eleventh Circuit, which will no doubt further embolden collection agents in their attempts to collect on behalf of private insurance companies providing Medicare Advantage coverage.

11. *Aetna Life Ins. Co. v. Guerrera*

The court awarded Aetna double damages against Big Y grocery store; however, the far more interesting question in this decision is: Who May Be Sued:

Here the Court held that the intent of Congress in enacting the Private Cause of Action provision, was to only allow suit against a Primary Plan, i.e., an insurance company or self-insured entity.

“The plain language of the Private Cause of Action provision, while admittedly vague, suggests that Congress intended suit against only primary plans. The provision is triggered when ‘a primary plan . . . fails to provide for primary payment (or appropriate reimbursement).’ Had Congress intended to create a cause of action for double damages against beneficiaries who received payment from a primary plan, Congress could simply have created a cause of action when ‘any entity or person’ failed to reimburse an MAO.”

The double damages claims against Ms. Guerrera and her attorneys were therefore dismissed, while the double damages claim against Big Y was allowed to continue. While the holding is significant and limits the application of the Private Cause of Action provision, it is important to note that plaintiff s and plaintiff s’ attorneys are not off the hook.

Upon remand, the court dismissed the contract claim against the law firm but allowed it to proceed against the plaintiff and fact-finding was to take place. But on Oct 8, 2020, the parties stipulated dismissal of all the claims by Aetna against everyone except Big Y under the private cause of action provision. So the claim against Ms. Guerrera was dropped.

D. Liability of Plaintiff's Attorney

The case law cited above clearly establishes that various courts throughout the country have held plaintiff Medicare beneficiaries and primary plans liable for double damages.

Medicare Advantage plans have also sued the plaintiff's attorney in these cases where the plan is not reimbursed. The Eastern District of Virginia, in *Humana v. Paris Blank, LLP*, 187 F.Supp.3d 676 (E.D. Va. 2016), held that "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 part 411 of this chapter.' 42 C.F.R. § 422.108(f). CMS has promulgated regulations identifying attorneys as an entity from which recovery may be sought under the MSP law by the Secretary. See id. § 411.24(g). Accordingly, Plaintiff may maintain suit against Defendants for recovery of conditional payments." Paris Blank, 187 F.Supp.3d at 682-83.

In this case's aftermath, plaintiff's attorney has been sued by Medicare Advantage plans in cases throughout the country, in addition to plaintiffs themselves. See, e.g., *Humana Health Benefit Plan of Louisiana, Inc. v. Falcon*, 3:17-cv-00596-JWD-EWD (M.D. La., Complaint filed August 30, 2017); *Humana Ins. Co. v. Pelham*, 4:17-cv-00374-RH-CAS (N.D. Fla., Complaint filed August 18, 2017); *United Healthcare Ins. Co. v. Kardoulis*, 1:16-cv-735 (E.D.N.Y., Complain filed February 11, 2016).

E. Where Do We Stand In New York?

Take advantage of the unsettled nature of the law while you still can. In New York State, the most problematic case law regarding MAP reimbursement rights is from the Third and Eleventh Circuits and not binding authority. In fact, the cases closest to home do have some favorable elements. *Konig v. Yeshiva* is an obvious one. *Potts* and *Trezza* have held that New York's anti-subrogation statute, NY General Obligations Law § 5-335 is preempted by the Medicare Act. However, even *Trezza* states that the reimbursement right itself is limited, i.e., there must be language in the contract giving it such rights.

Keep in mind that MAP reimbursement is not a matter of settled law in the State of New York. Barring that, a Medicare Advantage plan's best case scenario for recovery is only that which traditional Medicare has, and nothing more. Therefore, all applicable challenges that might have been made in the regular Medicare context, including an automatic reduction for the costs of litigation, must be applied in the Medicare Advantage context.

The PAID Act

On December 11th, 2020 the Provide Accurate Information Directly (PAID) Act as part of H.R 8900 was signed into law.

Under the PAID Act, if the claimant is a Medicare Advantage and/or Part D beneficiary(or was one or during the preceding 3-year period), then CMS must provide the applicable plan with the names and addresses of any such Medicare plans through the Section 111 Query.

In pertinent part, the text of the PAID Act reads as follows:

(ii) SPECIFIED INFORMATION.— In responding to any query made on or after the date that is 1 year after the date of the enactment of this clause from an applicable plan related to a determination described in subparagraph (A)(i), the Secretary, notwithstanding any other provision of law, shall provide to such applicable plan—

(I) whether a claimant subject to the query is, or during the preceding 3-year period has been, entitled to benefits under the program under this title on any basis; and

(II) to the extent applicable, the plan name and address of any Medicare Advantage plan under part C and any prescription drug plan under part D in which the claimant is enrolled or has been enrolled during such period."

H.R. 8900, Further Continuing Appropriations Act, 2021, and Other Extensions Act, Title III, Offsets, Sec. 1301, (ii), Transparency of Medicare Secondary Payer Reporting Information.

- The PAID Act, which amends 42 U.S.C. § 1395y(b)(8)(G), requires that CMS expand its Section 111 Query Process to identify whether a claimant is currently entitled to, or during the preceding 3-year period has been entitled to, Medicare Part C (Medicare Advantage), and Medicare Part D (prescription drug) benefits. If so, CMS is then required to provide the names and addresses of any such Medicare plans through the Section 111 Query Process.

- Prior to this Act, after a Section 111 Query, Medicare would only inform a RRE (Responsible Reporting Entity) if a claimant was enrolled in Medicare (Parts A/B) without indicating the "type" of Medicare program in which the claimant was enrolled.

- This Act was created as a result of MAPs asserting rights against insurers for double recovery - *In re Avandia* (3rd Cir.) and *Humana v. Western Heritage Insurance Co.* (11th Cir.). This will allow insurers to better identify the claimant's Medicare plans and avoid unnecessary litigation.

- It will allow RRE's to coordinate with MAPs and Part D Plans to resolve any outstanding claims that such Plans might assert for payments related to an accident or injury subject to a settlement, judgment or award paid by the RRE.

- CMS must implement the PAID Act by December 11, 2021. Currently, there is no mechanism.

- RRE's have no new legal obligation to coordinate benefits and reach out to Part C or D plans, but, they may if they so choose, at their option.

- RRE's will be able to notify the MAP and Prescription Drug plans of the presence of a primary payment source, either: (1) the RRE themselves, by opening up a medical claim, or (2) a settlement, judgment or award that releases a medical claim.

- Prior to this act, the only way to obtain this information was from the injured party directly.

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