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Section 111 Bulletin: Summer 2016 Round Up of Section 111 and Medicare Secondary Payer Developments for Liability Insurers

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11th Circuit *Humana* Decision Adopts 3rd Circuit *Avandia* Reasoning and Bestows MSP Private Right of Action on MAO

The United States Court of Appeals for the Eleventh Circuit recently held that a Medicare Advantage Organization (MAO) may bring suit against a "primary plan" under the Medicare Secondary Payer (MSP) statute for failure to reimburse the MAO for its payment of Medicare beneficiary services. *See Humana Medical Plan, Inc. v. Western Heritage Ins. Co.*, No. 15-11436 (11th Cir. August 8, 2016). In the absence of Eleventh Circuit precedent on the issue, the court looked to the Third Circuit's reasoning in *In re Avandia Mktg., Sales Practices & Prods. Liab. Litig.*, 685 F.3d 353 (3d Cir. 2012), to hold that Humana, an MAO that insures Medicare beneficiaries under the Medicare Advantage Program—a managed health care alternative to Original Medicare benefits—could assert a private cause of action for double damages against one type of primary plan, a liability insurer, also known as a non-group health plan (NGHP). In*Avandia*, the Third Circuit was the first circuit court to hand this private right of action to an MAO. We previously reported on the *Avandia* decision and other MAO-related cases *here* and *here*.

Specifically, the court reasoned that there was no language in the MSP statute that would "exclude MAOs from a broadly worded provision that enables a plaintiff to vindicate harm caused by a primary plan's failure to meet its MSP primary payment or reimbursement obligations." Slip op. at 18. The court observed that

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the MSP statute provides a private cause of action under 42 U.S.C. § 1395y(b)(3)(A) "in the case of a primary plan which fails to provide for primary payment." Slip op. at 14. The court also noted that paragraph 2(A) defines a "primary plan" to include a liability insurer and bars any Medicare payment—including an MAO payment—when there is a primary plan with a legal obligation to pay benefits before Medicare. *Id.* The court explained that the defined term "primary plan" presupposes that there is an obligation, whether statutory or contractual, to pay for covered items or services. *Id.* Thus, the court held that these statutory paragraphs "work together to establish a comprehensive MSP scheme" that ultimately "grants private actors a federal remedy when a primary plan fails to fulfill its obligation." *Id.* at 14-15.

The court rejected the NGHP's argument that the MSP statute governs only the rights of the Department of Health and Human Services as a secondary payer and not MAOs; rather, the court pointed out that Paragraph 2(A) "unambiguously refers to all Medicare payments, which include both traditional Medicare and Medicare Advantage plans." *Id.* at 15. The court was not able to discern any limitations on the right of a secondary payer to bring a suit against a primary plan "regardless of whether the secondary payer is the Secretary or an MAO." *Id.* at 16.

The *Humana* decision is noteworthy as the Eleventh Circuit is the first circuit court to weigh in on the Third Circuit's four-year-old holding in *Avandia* extending the MSP statute's private cause of action to MAOs. While the majority in *Humana* unequivocally endorsed the Third Circuit's view, Circuit Judge William Pryor authored a dissent, suggesting that other circuits might reach a different conclusion after studying the relevant MSP regulatory history.

CMS Renews Long-Tabled Public Discussion of Liability MSAs

The Centers for Medicare & Medicaid Services (CMS) announced in June that it is considering expanding its voluntary Medicare Set-Aside Arrangement (MSA) "amount review process," now offered exclusively to those parties settling workers' compensation claims, to include the review and approval of proposed liability insurance (including self-insurance) and no-fault insurance MSA amounts. MSA arrangements expressly identify how much of a settlement is to be put aside to cover future medical expenses related to the compensated injury. CMS promised to work closely with the stakeholder community to identify how best to implement this potential expansion, noting it expects to provide additional details through web announcements and yet-to-be-scheduled town hall meetings. There have been no updates since the announcement.

Déjà Vu? The June announcement was the first agency action to touch on MSAs since October 8, 2014, when CMS withdrew, without comment and prior to publication, its draft Notice of Proposed Rulemaking (NPRM) for the handling of future medical costs in liability claim settlements. As we discussed in our June 2012 Bulletin and again in our February 2015 Bulletin, the 2012 Advance NPRM had proposed options available to Medicare beneficiaries for "protect[ing] Medicare's interests" when they receive settlements, judgments, awards or other payments from insurers related, at least in part, to claims for "future medical care" delivered after the date of settlement. CMS, *Medicare Program; Medicare Secondary Payer and "Future Medicals"*, 77 Fed. Reg. 35917 (June 15, 2012). Option 1 required the beneficiary to pay for all related future medical care

until his/her settlement was exhausted. Option 4 required certain beneficiaries to submit an MSA to CMS. CMS then solicited comments on "how a liability MSA amount review process could be structured, including whether it should be the same as or similar to the process used in the workers' compensation arena, whether review thresholds should be imposed, etc."

The MSP community expected CMS to reissue the NPRM, but one never came and CMS never publicly offered an explanation for its withdrawal. Presumably, CMS will build upon the unpublished comments it received in 2012 when it reengages with the community, but it also may be that after four years of public silence, we are again back at square one.

For many years following the passage of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA), certain vendors of MSA services perpetuated the erroneous belief that Medicare law required Medicare beneficiaries and insurers—workers' compensation, liability, and no-fault alike (NGHPs)—to set up MSAs. Although most of the initial vendor hype died down with CMS's acknowledgement a number of years back that MSAs are not, and have never been, required by law for any settling parties, those same vendors remain, not surprisingly, the biggest proponents of the expansion of CMS's MSA review process to cover liability and no-fault MSAs. In contrast, many insurers fail to see any benefit bestowed upon them from MSAs.

As we have advised over the years, the largest benefactor of an MSA is the settling Medicare beneficiary plaintiff, who stands to gain CMS's assurance that Medicare will not require settlement funds, beyond the amount identified in the MSA, be used to pay for future (post-settlement) medical expenses. With such an agreement, the plaintiff avoids the risk of Medicare cutting off future benefits until all settlement funds are exhausted on future medical care.

But what does the insurer gain? CMS has no statutory authority to look to an NGHP for payment or Agency reimbursement of medical expenses incurred post-settlement. Again, CMS has acknowledged that fact clearly. For that reason we typically counsel a liability insurer not to get involved in setting up or administering an MSA. If there is any insurer benefit to identify, it may arise from the plaintiff's greater willingness to settle if he or she has a clear understanding of what monies CMS will expect to be set aside to pay for future medicals and what monies can safely be spent on other expenses. But whether that benefit will be sufficient to offset the certain increase in time and cost that will come with both the set-up and administration of the MSA and CMS's subsequent review of that arrangement, remains to be seen.

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Our Section 111 Team routinely covers CMS's Section 111 NGHP Town Hall Teleconferences, and we send periodic Section 111 Bulletins to our clients addressing notable Town Hall discussions and other Section 111 and Medicare Secondary Payer developments. We also maintain a searchable electronic database of Town Hall transcripts back to October 2008. Please let us know if you would like more information about any of the topics discussed in this Section 111 Bulletin. You also may access our Section 111 webpage and other Section 111 Bulletins and articles we have published at www.wileyrein.com/section111.