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News and Alerts **October 2016**

ALERT: Eleventh Circuit Holds That Medicare Advantage Organization Entitled to Double Damages Under MSP's Private Cause of Action

A number of federal district courts have followed the ruling of the Third Circuit in *In re Avandia Sales Practices and Products Liability Litigation*, 685 F.3d (3rd Cir. 2012), finding that Medicare Advantage Organizations (MAOs) have a private cause of action to recover double damages under the Medicare Secondary Payer Act (MSP). In the present case, *Humana Med. Plan v. W. Heritage Ins. Co.*, (2016 U.S. App. LEXIS 14509), the United States Court of Appeals for the Eleventh Circuit was asked to review the finding of one of those district court decisions. The Eleventh Circuit considered the Defendant's (Western Heritage Insurance Company) appeal of the U.S. District Court decision holding that Plaintiff (Humana) was entitled to reimbursement from Defendant for payments made on behalf of Defendant's insured and should receive double damages for the same under the MSP.

We previously wrote about this case in March 2015 when the U.S. District Court considering Humana's Motion for Summary Judgment held that Western was liable for the charges paid on insured's behalf and Humana was entitled to double damages under the MSP. As you may recall, the insured agreed to be responsible for the Medicare liens as part of the settlement agreement and Western had even attempted to list Humana as a payee on the settlement check. We noted that similar to the reimbursement rights of Medicare, the reimbursement rights of an MAO will not be bound by the terms of a settlement agreement. Western appealed the decision of the District Court to the Eleventh Circuit.

In deciding whether the MSP private cause of action permits an MAO to sue a primary payer...

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...that refuses to reimburse the MAO for a secondary payment, the Eleventh Circuit followed the direction of the Third Circuit's decision in *In re Avandia* and upheld Humana's Motion for Summary Judgment. The Court found that Humana has a private cause of action under the MSP and is entitled to recover double damages as a result of Western Heritage Insurance Company's ("Western") failure to reimburse Humana for medical expenses it advanced on behalf of its insured. In reaching its decision, the Eleventh Circuit considered Defendant's two-part argument that (1) it lacked constructive knowledge that Medicare made a payment and (2) it attempted to make Humana a payee on the settlement check but was ordered instead to pay the amount of the lien into a trust held by the insured's attorney. Western argued that it was unaware that Humana was an MAO in this case. The Court rejected this argument, stating that Western was aware that insured had coverage through Humana and could have easily discovered the nature of that coverage. Likewise, the Court rejected Western's argument that the funds placed into the trust account were appropriate reimbursement looking directly to CMS regulations, which state that if a beneficiary failed to reimburse Medicare within sixty (60) days of receiving a primary payment, the primary plan "must reimburse Medicare even though it has already reimbursed the beneficiary..."

This case specifically highlights the fact that an insurer can still be found responsible for reimbursing a MAO even if there is a contrary agreement of the parties regarding the responsibility for the repayment of liens and even if some efforts were taken toward ensuring that an insured repays liens. As more courts uphold the rights of MAOs under the MSP, the importance of researching and resolving potential liens is growing. We are happy to answer any questions you may have regarding MAOs and help you address and resolve these liens.

Expanded Recognition of MAOs Recovery Rights Under MSP

Courts continue to consider and rule on the rights of Medicare Advantage Organizations (MAOs) under the Medicare Secondary Payer Act (MSP). In the present case, *Mspa v. Co. V.*, No. 16-20531, 2016 U.S. Dist. LEXIS 132592 (U.S Dist. S.D. Fla., September 26, 2016), a woman was injured after suffering burns in an incident which occurred at Sonic. The injured woman was enrolled in a Medicare Advantage Plan with Florida Healthcare Plus, a Medicare Advantage Organization (MAO). The MAO made payments on behalf of the woman for injuries related to her accident at Sonic. Plaintiffs, as assignee of the MAO, filed a complaint under the MSP against the Defendant, National Fire Insurance Company of Hartford, the provider of Sonic's commercial general liability insurance. The complaint alleged a private cause of action seeking double damages under the MSP and requested a declaratory judgment as to the defendant's obligation to reimburse Medicare benefits conditionally paid by the MAO.

In response to the Plaintiff's amended complaint, the Defendant filed a motion to dismiss. In support of its motion, the Defendant argued in part that the MSP does not provide a private cause of action for MAOs. Further, Defendants argued that the Plaintiff's complaint failed to provide factual allegations showing that Defendant is responsible for the medical bills in question, that Defendant had actual or constructive knowledge that Plaintiff had made payments on behalf of the member when Defendant issued funds to the member, or that Defendant failed to reimburse liens.

In considering the Defendant's motion, the district court looked to two recent Eleventh Circuit decisions—*Humana Med. Plan, Inc. v. W. Heritage Ins. Co.,* No. 15-11436, 2016 WL 4169120 (11th Cir. August 8, 2016) and *MSP Recovery, LLC v. Allstate Ins. Co.*, 2016 WL 4525222 (11th Cir. August 30, 2016). Based upon these cases, the court opined that several of the issues raised by the Defendant were already resolved by the Eleventh Circuit. The court found that the cases established that (1) an MAO may assert a cause of action against a primary payer that fails to reimburse an MAO's secondary payment under the MSP, (2) the private cause of action under the MSP is assignable and (3) a contractual obligation without more may satisfy the condition precedent to suit under the MSP that requires the demonstration of responsibility for payment.

In this particular liability case, the Court found that the demonstration of responsibility for primary payment was established through the parties' settlement agreement, much like the *Western Heritage* case. Additionally, the Court found that the Plaintiff's allegations concerning the Defendant's knowledge of the lien was sufficient to survive the motion to dismiss. The Court looked to the *United States v. Baxter Int'l, Inc.,* 345 F.3d 866 (11th Cir. 2003) decision which found that willful blindness, which is what the Plaintiff's alleged in the present case, could constitute constructive knowledge. Reviewing this particular case in light of all of the recent Eleventh Circuit precedent, the Court found the Plaintiff's complaint sufficient to survive the motion to dismiss and denied the Defendant's motion. We will continue to monitor this case as litigation continues.

Alert! Eleventh Circuit: Contractual Obligation Sufficient to Establish "Demonstrated Responsibility"

What qualifies as a "demonstrated responsibility" sufficient to proceed under the private cause of action provision of the Medicare Secondary Payer Act has been a recent hot topic of discussion. Following the Eleventh Circuit's decision in *Glover v. Liggett Group*, several courts found that a contractual relationship alone would not suffice. Recently, however, the Eleventh Circuit Court of Appeals issued a decision that will change the way that we think about this requirement when it comes to no-fault or personal injury protection (PIP) cases.

This case, *MSP Recovery, LLC v. Allstate Ins. Co.*, 2016 U.S. App. Lexis 15984, involves seven consolidated cases that all presented the question of whether a contractual obligation alone can satisfy the "demonstrated responsibility" requirement of the private cause of action provision of the MSPA. Defendants are all insurance companies that provide personal injury protection (PIP)/ no-fault insurance in Florida. All cases involve a Medicare Advantage Plan enrollee who was injured in an automobile accident. The Advantage Plan provider, Florida Healthcare Plus (FHCP), made conditional payments on behalf of the injured enrollees to cover medical expenses in each of the accidents. FHCP assigned its claims to Plaintiffs. Plaintiffs argue that Defendants were primary plans under the Medicare Secondary Payer Act (MSPA) and that Defendants were obligated to pay some of their insureds' medical costs. According to Plaintiffs, Defendants' responsibility to pay is demonstrated by the insurance contracts the injured persons entered into with Defendants.

In each of the cases, the District Court for the Southern District of Florida dismissed the case based on the Eleventh Circuit's decision in *Glover v. Liggett Group, Inc.*, 459 F.3d 1304 (11th Cir. 2006). Glover held that when the primary plan's responsibility to pay arises from tort liability, the responsibility to pay must be demonstrated through a judgment or agreement that is separate from the MSP claim. Accordingly, the district courts dismissed Plaintiffs' suits because Plaintiffs did not obtain a judgment on the insurance contracts prior to bringing the MSP claims. On appeal, Plaintiffs argue that Glover applies only when the responsibility to pay arises from tort and that the existence of a contractual obligation to pay is sufficient to demonstrate a primary payer's responsibility under the MSPA private cause of action provision. Defendants, on the other hand, continue to assert that Glover's requirement for a separate adjudication or agreement applies whether the responsibility is derived from contract or tort.

The MSPA requires a primary plan to reimburse Medicare if it demonstrates that the primary plan has or had responsibility to pay for the item or service. Responsibility for such payment may be demonstrated by a judgment, a payment conditioned upon the recipient's compromise, waiver, or release (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary plan or the primary plan's insured, or by other means.

Here, the question before the court is whether the phrase "by other means" allows demonstration of responsibility under contractual obligation.

In its analysis, the Court outlined the important difference between tort liability and contractual liability. Obligations created by the contract exist as soon as it is executed, whereas an alleged tortfeasor has no obligations until he is adjudged liable. Further, the Court reasoned, if the Defendants were correct that a judgment or settlement agreement must always preempt suit under the MSPA, then there are no "other means" that may demonstrate responsibility, therefore rendering that part of the statute superfluous.

Based on the reasoning above, the Court held that a plaintiff suing a primary plan under the private cause of action provision of the MSPA may satisfy the "demonstrated responsibility" prerequisite by alleging the existence of a contractual obligation to pay. The Court went on to vacate the judgments of the district courts and remand the cases for further proceedings not inconsistent with this opinion.

This decision clearly evidences the expanding recovery efforts of Medicare Advantage Organizations. Timely discovery and resolution of all Medicare Advantage liens is an important aspect of settlement in each case involving an enrollee. If you have any questions about Medicare Advantage or Medicare Part D liens, please do not hesitate to let us know.

New Fee Schedule Set for MSAs in Mississippi

Paragraph XIV of Mississippi's proposed fee schedule provides that in the event that a claimant settles his or her workers' compensation claim and the terms of settlement include a Medicare Set-aside (MSA), the fees and charges for reimbursement set forth in the fee schedule shall remain applicable to all treatment and services provided in the exact same manner as if the claim had not been settled. Mississippi's new fee schedule will take effect November 1, 2016.

US District Court grants Defendant's Motion to Dismiss in Sexton vs. Medicare

In *Sexton v. Medicare,* 2016 U.S. Dist. LEXIS 89818, Medicare made conditional payments for Plaintiff's treatment after Plaintiff was injured in a motor vehicle accident. After the conditional payments were made, Medicare issued a conditional payment letter to Plaintiff notifying him that Medicare had paid $678.80 for treatment of his accident-related injuries and that he may be required to reimburse Medicare for medical expenses related to his liability claim in the future. The conditional payment letter clearly stated, in bold type: "THIS IS NOT A BILL. DO NOT SEND PAYMENT AT THIS TIME."

Following receipt of the conditional payment letter, Plaintiff filed an action seeking to compel Medicare to recover funds from the insurer for the driver of the other vehicle involved in the accident or the providers that "Medicare knowingly paid by mistake". Defendant, U.S. Department of Health and Human Services' (HHS), filed a motion to dismiss, arguing that Plaintiff's claim was not ripe for judicial review because Plaintiff had not suffered an actual or imminent injury and that Plaintiff failed to avail himself and exhaust the administrative remedies.

The Court granted Defendant's motion to dismiss, finding that the Plaintiff did not have standing to sue because he alleged "only a potential for injury that has not yet occurred," as Medicare had not sought reimbursement for the conditional payments. Plaintiff had only been notified that Medicare could seek recovery in the future. Because the Court found that the Plaintiff lacked standing to sue, the Court did not consider Defendant's second argument that Plaintiff failed to avail himself and exhaust the administrative remedies.

Importantly, the Plaintiff had not received a primary payment at the time that the conditional payment letter was issued. As such, if Medicare had been seeking recovery from the Plaintiff, instead of just providing notice that recovery could be sought in the future, the outcome of this case may have been different, as a primary payment is required before CMS's right of action against a beneficiary can arise. Of course, this is unlike CMS's right of recovery against a primary insurer, which accrues as soon as CMS learns that payment has been made or could be made under workers' compensation, any liability or no-fault insurance, or an employer group health plan.

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Vermont Supreme Court Upholds Finding that MSA Vendor's Undervaluation of MSA Caused No Economic Harm to Plaintiff When MSA Was Approved by CMS

In *Bindrum v. Am. Home Assur. Co.,* 2016 Vt. Unpub. LEXIS 150 (Vt. Aug. 19, 2016), the Supreme Court of Vermont recently affirmed the superior court's granting of summary judgment to Defendant NuQuest Bridge Pointe with respect to Plaintiff's lawsuit alleging that defendant NuQuest and the workers' compensation carrier, AIG, undervalued the MSA and unnecessarily delayed sending it to the Vermont Department of Labor for approval.

Plaintiff, who was injured in a work-related accident in 2003, reached an agreement with Defendant AIG to settle his workers' compensation claim. According to the terms of the agreement, AIG would create a Medicare Set-aside to pay for Plaintiff's future medical expenses to be funded "only to the amount required for CMS approval up to a limit of $750,000."

The parties further agreed that the agreement would be submitted for approval once the MSA had been approved by CMS. AIG contracted with Defendant NuQuest to set up the MSA. After considering NuQuest's proposed MSA of $223,693.00, CMS issued approval of an MSA in the amount of $282,179.00. AIG agreed to fund the MSA as approved by CMS and the Department of Labor subsequently approved the settlement agreement.

Plaintiff filed an action against AIG alleging that AIG undervalued the MSA and delayed sending it to the DOL. In dismissing the action, the federal district court noted: 1) the difference between AIG's MSA valuation and the valuation done by the Plaintiff's consultant had no bearing on the actual damages that Plaintiff alleged, and 2) any damages caused by AIG's delay in sending the MSA to the DOL did not meet the federal jurisdictional threshold amount.

After the dismissal, Plaintiff filed an action against both AIG and NuQuest. The superior court dismissed several counts of the complaint, but allowed Plaintiff's third party beneficiary claim against NuQuest to move forward. NuQuest responded by filing a motion for summary judgment. In granting NuQuest's motion, the court found that Plaintiff had no cause of action with respect to the agreement between AIG and NuQuest as long as the MSA was approved by CMS.

According to the court, the Plaintiff couldn't point to any economic damage sustained due to the alleged undervaluation of the MSA because any inadequacy in the MSA would harm only Medicare, as Medicare would be the one to cover any shortfall.

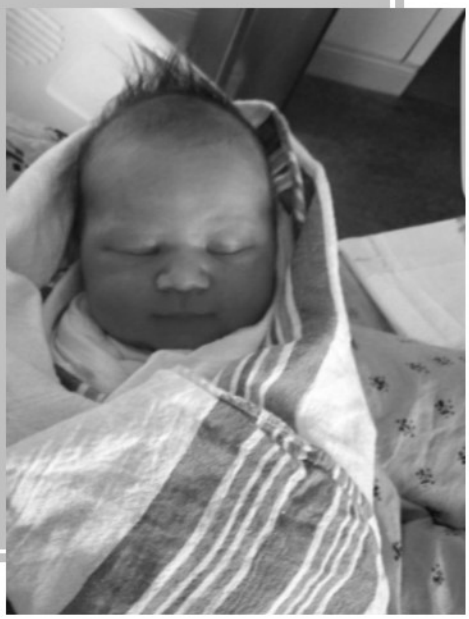
Plaintiff appealed to the Vermont Supreme Court, who, in affirming the superior court's ruling, pointed to Federal regulations, the Form 15 settlement agreement approved by the Department of Labor, and Plaintiff's own acknowledgment as evidence that Plaintiff's interest as a thirty party beneficiary of the agreement between AIG and NuQuest was limited to his interest in an MSA that met with CMS approval. AIG's obligation was to submit an MSA that would be approved by CMS and they fulfilled that obligation through NuQuest.

On a Personal Note

We are so thankful to work with a wonderful group of individuals who bring a special touch of community to our office. We love to welcome new additions to our Carr Allison family!

Evelyn Wesley Holland

Daughter of Caylan Holland



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