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Medicare Advantage Plans

Exploring Recovery Rights and Court Decisions

An emerging area of focus on the Medicare Secondary Payer compliance landscape relates to Medicare Advantage (MA) plans. Interest in this topic has been generated by the claim industry's heightened sensitivity to Medicare compliance issues in general, and in light of the fact that MA plans are taking a more aggressive posture in the claims context.

Over the past several months, questions concerning MA plans have also been the subject of three important court opinions, including the recent decision of *In Re Avandia Marketing, Sales Practices and Products Liability Litigation,* Nos. 7-md-01871, 10-6733, 2011 WL 2413488 (D. Pa., June 13, 2011) issued by the United States District Court for the Eastern District of Pennsylvania.

A key question concerns whether or not MA plans have reimbursement rights under the Medicare Secondary Payer Statute (MSP)[1], or other authority, against primary payers and other parties for accident- related medical treatment provided in relation to workers' compensation, liability or other injury-based claim[2].

As the claims industry currently examines this issue, several important questions arise, such as:

- What are MA plans?
- How do MA plans fit into the larger Medicare program?
- What are the differences between "traditional" Medicare and MA plans?
- Do MA plans have reimbursement rights?
- If so, what are the nature and extent of these rights?
- How have the courts ruled?

Through this article, the author aims to address these questions to assist the reader in better placing MA plans into a more clear and workable framework.

What Are Medicare Advantage Plans?

By way of brief background, the Medicare program was enacted into law in 1965 and is currently comprised of four parts: Parts A, B, C and D.[3]

Medicare Parts A and B are commonly referred to as "original" or "traditional" Medicare and are administered by the *federal government*. In general, Part A covers in-patient hospitalization, skilled nursing facility care, certain home health visits (some of which are also covered under Part B), and

hospice; while Part B covers a host of outpatient services, including physician visits, certain preventive services and home health visits.[4]

Medicare Part C was added to the Medicare program in 1997 as part of the Balanced Budget Act of 1997 and was initially known as "Medicare+Choice."[5] Six years later, certain modifications were made to the program and the name was changed to "Medicare Advantage" as part of the Medicare Modernization Act of 2003.[6] The underlying policy goals behind Part C's implementation included providing Medicare beneficiaries with greater options and controlling program costs.[7]

Under Medicare Part C, individuals receive Medicare benefits through *private insurers* via a variety of different arrangements, such as HMOs, PPOs, private fee for service plans (PFFs), and other options.[8]

In general, under Part C Medicare pays MA plans a capitulated amount (per enrollee) to provide benefits to their enrollees.[9] The MA plan does not receive additional funds from the federal government if an individual requires benefits in excess of the capitulated amount; nor must the MA plan return any unused funds back to the Medicare program.[10]

The number of individuals enrolled in MA plans has increased considerably over the past five years. For example, in 2005 about 5.3 million people were enrolled in a MA plan.[11] By 2010, this figure had essentially doubled to approximately 11 million individuals (or about 24% of Medicare beneficiaries).[12] Of this figure, the majority (65%) is enrolled in MA-HMOs, with 19% covered under local or regional preferred provider organizations, 13% enrolled in private fee-for services plans, with the remainder covered through various other MA arrangements.[13]

Medicare Part D provides a limited outpatient prescription drug benefit. This program was started in 2006 and consists of numerous plans and options which are provided through private insurers under both "traditional" Medicare and MA plans.

With this backdrop set, the focus shifts to addressing what rights MA plans may have to be reimbursed for accident related medical treatment. This discussion first starts with a review of applicable federal statutes.

Medicare Advantage Plans: Reimbursement & Recovery Rights

In assessing the nature and extent of a MA plan's secondary payer status, it is important to note that there are key statutory differences in terms of the rights and recourses provided to the federal government and those afforded to private MA plans.

Under 42 U.S.C. § 1395y(b)(2) of the MSP, the federal government is armed with strong and broad reimbursement rights as part of its administration of "traditional" Medicare (Parts A and B).

42 U.S.C. § 1395y (b)(2)(B)(ii) states:

> A primary plan, and an entity that receives payment from a primary plan, shall reimburse the appropriate Trust Fund for any payment made by the Secretary under this subchapter with respect to an item or service if it is demonstrated that such primary plan has or had a responsibility to make payment with respect to such item or service. A primary plan's 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.[14]

The MSP provides "the United States" with wide latitude in terms of who it may pursue for conditional payments, and how it may do so. For example, 42 U.S.C. § 1395y (b)(2)(B)(iii) states that "the United States" may bring an action against *"any and all entities that are or were required or responsible"* for making payment, and against any entity that *received* primary payment.[15] Against primary payers, the government can seek double damages in certain circumstances.[16] In addition, the government also has rights of subrogation and intervention.[17]

With respect to Medicare Part C (MA plans), the federal statutes contain specific and separate provisions related to the secondary payer status and rights of MA plans.

Significantly, while the statutory provisions pertaining to MA plans make general reference to the MSP, they do not incorporate the provisions of 42 U.S.C. 1395y(b)(2) of the MSP. In general, the MA statutes, unlike the provisions contained in 42 U.S.C. §1395y(b)(2), permit, but do not mandate, recovery in MSP situations.

The main statutes addressing a MA plan's secondary payer rights are 42 U.S.C. § 1395w-22(a)(4) and 42 .S.C. § 1395mm(4) (pertaining to MA-HMOs).

Both of these statutes essentially provide that MA plans "*may … charge or authorize the provider of such services to charge…(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 member to the extent that the member has been paid under such law, plan, or policy for such services."*[18]

For those readers interested in viewing the full statutory texts of these statutes, same is provided in the endnote to this sentence.[19]

Similar provisions are contained in 42 C.F.R. § 422.108 (d) and 42 C.F.R. § 417.528(b) (pertaining to MA-HMOs).

For example, 42 C.F.R. § 417.528(b) provides that:

> (b) Charge to other insurers or the enrollee. If a Medicare enrollee receives from an HMO or CMP covered services that are also covered under State or Federal worker's compensation, automobile medical, or any no-fault insurance, or any liability insurance policy or plan, including a self-insured plan, the HMO or CMP may charge, or authorize a provider that furnished the service to charge-
>
> 1) The insurance carrier, employer, or other entity that is liable to pay for these services; or
> (2) The Medicare enrollee, to the extent that he or she has been paid by the carrier, employer, or other entity.[20]

The MA regulations preclude states from infringing upon the recovery rights of MA plans. On this point, 42 C.F.R. § 422.108 (f) states:

> (f) MSP rules and State laws. Consistent with § 422.402 concerning the Federal preemption of State law, 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. (Emphasis Added).

With this basic understanding of the MA statutory and regulatory landscape, the focus now shifts to reviewing how the courts have interpreted these statutes and regulations.

Court Decisions Addressing MA Plans

Over the past few months, issues concerning the secondary payer rights of MA plans have come before various federal courts.

In brief overview, the MA plans in these cases basically attempted to assert their recovery claims in federal court under the MSP. However, for the reasons discussed more fully below, these courts ruled that the federal courts did *not* have proper jurisdiction to address the merits of a MA plan's recovery action.

The courts ruled that while the federal statutes grant MA plans recovery rights, these statutes do *not* create a federal right for MA plans to enforce its recovery actions in federal court. These rulings in essence indicate that the secondary payer rights and recourses granted the government under the MSP, are different and inapplicable in relation to the recovery rights afforded MA plans under federal statute. As part of its analysis, the courts indicated that MA recovery actions essentially sound in contract, with state courts being the more appropriate adjudicatory forum to address the issue.

These cases can be summarized as follows:

Humana Medical Plan, Inc. v. Reale

A case from earlier this year which addressed this issue is ***Humana Medical Plan, Inc. v. Reale***, No. 10-21493-Civ., 2011 WL 335341 (D.Fla., Jan. 31, 2011). In this case, the MA provider filed a recovery claim against the plaintiff and her attorneys in federal court per 42 U.S.C. § 1395y(b)(2).

The defendants filed a motion to dismiss Humana's complaint on grounds that the court lacked subject matter jurisdiction. The defendants asserted that 42 U.S.C. § 1395y(b)(2) did not provide Humana with a private cause of action to bring its recovery claim in federal court. Humana countered that jurisdiction was proper under a conjunctive reading of 42 U.S.C. § 1395y(b)(2) and 42 C.F.R. § 422.108(f).

The court ruled against Humana and dismissed its complaint finding that it failed to bring a proper claim arising under federal law. In reaching its decision, the court disagreed with Humana's interpretation of 42 C.F.R. § 422.108(f) noting that while the language of this section permitted MA plans to exercise the same rights to recover "that the Secretary exercises under the MSP regulations," it found that the Secretary's authority was limited to making payments *"conditioned upon reimbursement to the appropriate Trust Fund,"* and that United States, and not the Secretary, was vested with full authority to bring a reimbursement action per 42 U.S.C. § 1395y (b)(2)(B)(iii).[21]

Parra v. PacifiCare of Arizona, Inc.

Approximately two months following the *Humana* decision, this issue surfaced again in ***Parra v. Pacifi- Care of Arizona, Inc.***, No. CV 10-008-TUC-DCB, 2011 WL 1119736 (D. Ariz., March 28, 2011). In this case, the MA provider, PacifiCare, sought reimbursement for treatment it provided in relation to an underlying wrongful death claim. The plaintiff moved to dismiss the action asserting that the federal court did not have proper jurisdiction to hear the case.

The court ruled that PacifiCare did *not* have a private cause of action under the MSP, or other Medicare statutes, to assert its reimbursement claim in federal court. Accordingly, the court stated that it lacked jurisdiction to address PacifiCare's recovery action. While the court in *Parra* recognized that the federal statutes granted MA plans recovery rights, it concluded that the statutes did *not* create a federal right to enforce those rights.[22]

In reaching its decision, the court stated:

> The Court agrees with the Magistrate's Judge's analysis that the Medicare statutory and regulatory scheme does not reflect any congressional intent to create a private cause of action…
>
> The Court finds that the Medicare statutes at issue, here, do no more than create a federal right. They stop short of creating a federal private right of action to enforce that right and do not contain any jurisdictional provision granting the federal courts exclusive jurisdiction over Medicare reimbursement claims. The Court finds the same in respect to 42 U.S.C. § 1395w–26(b)(3) (2003) and 42 C.F.R. § 422.108(f).
>
> Congress and the Secretary did no more than protect PacifiCare's right to charge and/or bill a beneficiary for reimbursement, notwithstanding and state law or regulation to the contrary.[23]

Concluding that it lacked proper jurisdiction, the court stated that PacifiCare would need to have its action addressed in *state court* stating as follows:

> There being no jurisdiction in this Court for PacifiCare's claim, it must proceed in state court. This is the better approach because the parties dispute the breadth of the settlement agreement between Plaintiffs and the third-party insurer… The Court agrees with the Magistrate Judge that the state courts are better suited to consider that which is essentially a contract claim, pursuant to Arizona law, and are as capable as this Court to address the preemption questions relevant to resolving the merits of the claim for reimbursement.[24]

Based on the foregoing, the court dismissed PacifiCare's complaint on grounds that same failed to state a federal claim for relief.

In Re Avandia Marketing

The issue was most recently addressed in the case ***In Re Avandia Marketing, Sales Practices and Products Liability Litigation,*** Nos. 7-md-01871, 10-6733, 2011 WL 2413488 (D. Pa., June 13, 2011). This case relates to the *Humana v. GlaxoSmith-Kline* (GSK) litigation which involved a large personal injury case settlement arising from injuries allegedly caused by several diabetes medications collectively referred to by the court under the name "Avandia."

In relation to this settlement, GSK addressed its conditional payment obligations in relation to "traditional" Medicare; but *not* in relation to the reimbursement claims asserted by the MA plan, Humana, or the other Part C providers. Humana then filed a reimbursement claim against GSK in federal court.[25] In response, GSK filed a motion to dismiss Humana's case arguing that that the MSP did *not* provide Humana (or the other Part C providers involved in the case) with a private cause of action to assert its reimbursement action in federal court.

The parties did not dispute that MA plans may have contractual rights to charge a primary payer, but disagreed regarding whether MA plans had a private right of action to enforce those rights in federal court under the MSP.[26] Humana argued that the private cause of action provision of 42 U.S.C. 1395y(b)(3) (A) of the MSP "unambiguously applied" to its action. This section establishes *"a private cause of ac*tion 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 ruled that the federal statutes did *not* provide MA plans with an express or implied private right of action to assert its recovery action in federal court.

In reaching its decision, the court noted that:

> The MA statute is not silent as to an MAO's secondary payer status; in fact, it contains its own (permissive) secondary payer provision. The statute references and incorporates the definition provision of the MSP but does not expressly or impliedly incorporate any other provisions. The statute unambiguously gives the MAO the right to charge primary payers, but is silent as to any enforcement rights. Given Congress's reference to the MSP, it is clear that it was considering the interaction between the two statutes when drafting the MA act and yet did not reference or incorporate the private right of action provision. The Court finds that the silence of Congress regarding private remedies does not create ambiguity, but rather indicates its intent not to create a private right of action for MAOs, instead leaving

> MAOs to enforce their rights as secondary payers under the common law of contract. However, even if the Court found that Congress's intent was ambiguous, the regulation is not a permissible construction of the statute, as the Secretary cannot create a right that Congress has not created. Accordingly, the Court will not defer to the regulation in deciding this matter.[27]

Accordingly, the court concluded that the federal statutes did not provide an express private right of action stating:

> [T]his Court finds, upon examination of § 1395w, that no explicit grant of a private right of action to MAOs is found therein. Although the MA statute does reference the MSP, that reference is limited to the MSP's description of the 'circumstances in which payment... is made secondary pursuant to section 1395y(b) (2).' The secondary payer provision applicable to MAOs does not reference or expressly incorporate the remedy the MSP provides to the United States in 42 U.S.C. § 1395y(b) (2) (B)(iii), nor does it reference or incorporate § 1395y(b)(3), which creates a private right of action for damages when a primary plan fails to provide for primary payment or reimbursement.[28]

However, the court noted that the MA plan was not left without recourse to pursue its recovery claim. Similar to *Parra*, the court noted that MA plans could bring their actions in *state court* indicating as follows:

> [E]ven assuming that some or all of the settlement funds from GSK to Humana enrollees were provided to compensate them for the cost of medical treatment for Avandia-related injuries, Humana is not left without a remedy. *Rather than seeking payment directly from GSK under the Medicare Act, it can bring its claims in the state courts against its enrollees to enforce its secondary payer status under the terms of their insurance contacts.* State courts are well suited to interpret insurance contracts and determine whether the enrollees recovered medical damages against which Humana can seek reimbursement or assert subrogation rights under the terms of its enrollees' contracts. (Emphasis Added).[29]

Practical Considerations

As the dust settles, an interesting state of affairs appears to emerge. While federal statutes grant MA plans recovery rights, the courts have found that MA plans do not enjoy the same enforcement rights as those provided to the federal government under the MSP.

From a practical claims perspective, primary payers and practitioners should assure that MA

plans are included as part of their overall MSP compliance protocols and that due consideration is afforded regarding how best to address the MA issue when applicable. The logical starting point would involve confirming the *type* of Medicare coverage at issue. That is, is the claimant a beneficiary under a "traditional" Medicare or under a MA plan?

It is important to remember that since most beneficiaries are permitted to change Medicare plans at certain times, it is possible that an individual may have been covered under *both* "traditional" Medicare and a MA plan at different times during the course of a claim. Discerning these facts could be important in making sure that *all* potential compliance obligations are being addressed.

If it is determined that the claimant is a beneficiary under "traditional" Medicare (or was at any point during the claim), steps should be taken to obtain conditional payment information from the Centers for Medicare and Medicaid Services (CMS) in order to determine applicable reimbursement obligations.
Under CMS' current process, this involves contacting the Coordination of Benefits Contactor (COBC) which will then notify the Medicare Secondary Payer Recovery Contractor (MSPRC). The MSPRC then provides the parties with Medicare's conditional payment information. The MSPRC is also the contractor with which the parties interact to address any questions or disputes it may have with CMS' conditional payment claim.[30]

If, on the other hand, the claimant is determined to be a MA beneficiary (or was at any point during the claim), the parties will need to assess their respective reimbursement obligations related to the specific MA plan at issue and determine how best to proceed.

Approaches in this regard may include, but may not necessarily be limited to, understanding the MA statutes, regulations and related case law, reviewing the applicable contract language contained in the MA plan, and evaluating any governing state law which may have addressed the issue of MA plan recovery rights, as well as any other authority germane to the issue. The subject MA plan should be able to provide the parties with documentation and information related to its recovery claim. In relation to this process, the parties may wish to consider requesting conditional payment information from the MSPRC to determine if "traditional" Medicare may have issued payments for any reason.

Conclusion

Considering the secondary payer status of MA plans should be included as part of a primary payer's and practitioner's MSP compliance protocols. In addressing this issue, it is important to recognize the important statutory distinctions between the secondary payer recovery rights and recourses granted the federal government and those afforded to MA plans. Notwithstanding these distinctions, the fact remains that the issue of MA plan reimbursement will need to be addressed as part of claims handling and settlement practice when applicable.

END NOTES

[1] The Medicare Secondary Payer Statute (MSP) is codified at 42 U.S.C. § 1395y, et. seq. In addition, pertinent MSP provisions are contained in Subparts B, C and D of Title 42 of the Code of Federal Regulations (42 C.F.R. §§ 411.20 through 411.50, et. seq.)

[2] The scope and focus of this article is limited to the issue of MA reimbursement and recovery rights with respect to payments made by MA plans for accident related medical treatment. This article does not address issues pertaining to MA plans in regard to Medicare Set Asides or Section 111 of the Medicare, Medicaid & SCHIP Extension Act (42 U.S.C. § 1395y(b)(8)).

[3] The Medicare program was enacted into law in 1965 as a federal health insurance program designed to provide medical benefits to individuals age 65 years or older. In 1972, the program was expanded to provide coverage for individuals under 65 who were awarded social security disability (SSD) benefits. Coverage is also currently provided for individuals with end-stage renal disease (ESRD) and amyotrophic lateral sclerosis (ALS). Presently, Medicare covers approximately 47 million people, with eight (8) million of these individuals (or about 17% of Medicare beneficiaries) on Medicare through disability.

In addition to Parts A, B and C discussed *supra*, Part D of the Medicare program provides a limited outpatient prescription drug benefit program which started in 2006. Part D is voluntary for most beneficiaries and the program is offered through numerous private insurer plans for beneficiaries enrolled in both traditional Medicare and MA plans. As of 2010, approximately 28 million Medicare beneficiaries were enrolled in a Part D plan.

Note: The information presented in this endnote was obtained from, and is hereby cited and accredited to, the following excellent sources from The Henry J. Kaiser Family Foundation: *Medicare Fact Sheet-Medicare At a Glance, September 2010*, p.1; *Medicare Fact Sheet-Medicare and Non-Elderly People With Disabilities, September 2010*, p.1; and *Medicare Fact Sheet- Medicare Advantage, September 2010*, p.1. These documents can be obtained from The Henry J. Kaiser Family Foundation website at www.kff.org.

[4] The Henry J. Kaiser Family Foundation, *Medicare Fact Sheet- Medicare At a Glance, September 2010*, p.1. This document can be obtained from The Henry J. Kaiser Family Foundation website at www.kff.org.

[5] The Henry J. Kaiser Family Foundation, *Medicare Fact Sheet- Medicare Advantage, September 2010*, p.1.

[6] *Id.*

[7] Timothy D. McBride, *Medicare Advantage: What Are We Trying to Achieve Anyway?,* 1 St. Louis U.J. Health L. & Pol'y, 1 (2008).

[8] The Henry J. Kaiser Family Foundation, *Medicare Fact Sheet- Medicare Advantage, September 2010*, p.1. In this article, the author refers to the various Part C plans collectively using the term "Medicare Advantage (MA)" and makes limited references to a specific *type* of MA plan (i.e. MA-HMO) only as may be required.

It is noted that Medicare beneficiaries have had the option to receive their Medicare benefits as part of private HMO arrangements dating back to the 1970's as part of the Medicare risk contract program. This program was essentially modified and expanded through the formal introduction and implementation of Part C in 1997. *See*, The Henry J. Kaiser Family Foundation, *Medicare Fact Sheet- Medicare Advantage, September 2010*, p.1 and Timothy D. McBride, *Medicare Advantage: What Are We Trying to Achieve Anyway?,* 1 St. Louis U.J. Health L. & Pol'y, 1 (2008).

[9] The Henry J. Kaiser Family Foundation, *Medicare Fact Sheet- Medicare Advantage, September 2010*, p.2.

[10] *See*, *In Re Avandia Marketing, Sales Practices and Products Liability Litigation,* Nos. 7-md-01871, 10-6733, 2011 WL 2413488 (D. Pa., June 13, 2011).

[11] The Henry J. Kaiser Family Foundation, *Medicare Fact Sheet- Medicare Advantage, September 2010*, p.1. This document can be obtained from The Henry J. Kaiser Family Foundation website at www.kff.org.

[12] *Id*.

[13] The Henry J. Kaiser Family Foundation, *Medicare Chart Book (4th Edition), September 2010*, p.2. This document can be obtained from The Henry J. Kaiser Family Foundation website at www.kff.org.

[14] 42 U.S.C. § 1395y (b)(2)(B)(ii). In addition to the items referenced in 42 U.S.C. § 1395y (b)(2)(B)(ii), a *"settlement"* or *"contractual obligation"* demonstrate "responsibility" under the MSP. *See*, 42 C.F.R. § 411.22(a)(3).

[15] *See also*, 42 C.F.R. § 411.24(g) which states that CMS has a right of action to recover its payments from any entity, including a beneficiary, provider, supplier, physician, attorney, State agency or private insurer that has received a primary payment. It is also noted that 42 C.F.R. § 411.24(i)(1) provides that if a beneficiary or other party fails to reimburse Medicare, than *"the primary payer must reimburse Medicare even though it has already reimbursed the beneficiary or other party."*

[16] 42 U.S.C. § 1395y (b)(2)(B)(iii).

[17] *See*, 42 U.S.C. § 1395y (b)(2)(B)(iv) and 42 C.F.R. § 411.26.

[18] 42 U.S.C. § 1395mm(4).

[19] **42 U.S.C. § 1395mm(4) states:**

> (4) Notwithstanding any other provision of law, the eligible organization may (in the case of the provision of services to a member enrolled under this section for an illness or injury for which the member is entitled to benefits under a workmen's compensation law or plan of the United States or a State, under an automobile or liability insurance policy or plan, including a self-insured plan, or under no fault insurance) charge or authorize the provider of such services to charge, in accordance with the charges allowed under such law or policy--
>
> **(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 member to the extent that the member has been paid under such law, plan, or policy for such services.

42 U.S.C. § 1395W-22(a)(4) states:

(4) Organization as Secondary Payer

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 title 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.

[20] 42 C.F.R. § 422.108 (d) contains a similar provision as that found in 42 C.F.R. § 417.528(b). This regulation states as follows:

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.

[21] *Humana Medical Plan, Inc.,* 2011 WL 33534, at *2.

[22] *Parra,* 2011 WL 1119736, at *3.

[23] *Id.* at *4-5.

[24] *Id.* at *5.

[25] It is noted that Humana also sought equitable relief from the court asking that it compel GSK to provide Humana with a listing of all settling plaintiffs who were also Humana MA enrollees. GSK argued that it would not be able to provide this information as it did not gather insurance coverage information in relation to its cases.

In regard to this claim, the court noted that Humana knew the identities of its enrollees, had access to their medical information, and could communicate with beneficiaries who may have used Avandia thereby allowing Humana to inquire as to whether its enrollees had filed claims against GSK. Furthermore, the court noted that Humana's contracts may also contain pertinent disclosure clauses. Accordingly, the court ruled that Humana's request was inappropriate finding that Humana *"was in a better position to gather the information it seeks, and the Medicare Act currently puts the reporting requirement on the MAO enrollee and not the liable payer." Humana Medical Plan, Inc.,* 2011 WL 33534, at *6. As part of this discussion, the court expressly declined to address whether Section 111 of the Medicare, Medicaid and SCHIP Extension Act required GSK to release this information.

[26] *In Re Avandia Marketing*, 2011 WL 2413488, at *3.

[27] *Id.* at *5.

[28] *Id.* at *4. In reaching its decision that the statutes did not provide an *express* private right of action, the court agreed with the court's analysis and decisions in *Nott v. Aetna U.S. Healthcare, Inc*, 303 F.Supp.2d (E.D. Pa. 2004) and *Care Choices HMO v. Engstrom,* 330 F.3d 786 (6th Cir.2003).

It was noted in *Nott* that the court concluded that Congress did not intend to create an explicit right of action for MA plans, but rather, that a MA plan's right of subrogation was a contractual right which, as with *"any contractual disputes between the insurer and the insured, can be resolved in state court." Nott*, 303 F.Supp.2d at 571-73.

Likewise, the Sixth Circuit in *Engstrom* found no express or implied private right of action providing MA plans with a federal cause of action to enforce its subrogation right. As part of its analysis, the court in *Engstrom* also noted important textual differences between the MSP and MA statues. Specifically, the court noted that the statutory language under the MSP is *mandatory* (using the word *"shall"* in relation to the obligation to reimburse conditional payments), while the language in the MA statutes was *permissive* (using the word "*may*"). The court concluded that MA plans reimbursement claims more appropriately sounded in contract to be heard in state court.

The court *In Re Avandia Marketing* also found that an *implied* private right of action did not exist per the four part test set forth in *Cort v. Ash*, 422 U.S. 66 (1975). Under *Cort*, determining whether an *implied* right of action may exist involves examining the issue via the following test factors: (1) Is the plaintiff a member of the class the statute was enacted to benefit; (2) was there legislative intent to create or deny a remedy; (3) is it consistent with the legislative scheme to imply a remedy; and (4) is the cause of action one traditionally litigated under state law. In assessing these factors the court concluded that an implied private of action did *not* exist in the matter before it.

[29] *In Re Avandia Marketing*, 2011 WL 2413488, at *4.

[30] In general, this process is initiated by notifying the Coordination of Benefits Contractor (COBC) and providing this contractor with certain identifying information related to the claimant and claim. Reporting to COBC is made via phone, mail or fax. Once COBC is placed on notice, it in turn notifies the Medicare Secondary Payer Recovery Contractor (MSPRC). The MSPRC then issues a *Rights and Responsibilities Letter* to the parties advising of Medicare's reimbursement rights.

The MSPRC states that within 65 days of the date of the *Rights and Responsibilities Letter* a *Conditional Payment Letter (CPL)* will be issued. The CPL is a significant document as it provides the parties with an *initial* listing of CMS' alleged conditional payment amount related to the claim. Typical information contained

in a CPL includes, but is not limited to, provider information, diagnosis/ICD codes, service dates, total charges, claimed conditional payment amount. Since conditional payments can continue to accrue as the case progresses, it is often necessary to request updated conditional payment information at subsequent points during the claim in order to properly assess potential exposure.

Under CMS' current process, the parties generally *cannot* obtain the exact reimbursable conditional payment amount until *after* the claim settles and the executed settlement agreement is sent to the MSPRC. At that point, the MSRPC will issue CMS' "final demand" reflecting the conditional payment amount that needs to be repaid. CMS typically demands full reimbursement of the claimed amount within 60 days. Depending on potential facts and circumstances, if this amount is not paid within 60 days interest will be, or could be, assessed on the underlying amount. *See*, *Haro v. Sebelius*, No. CV 09-134 TUC DCB, 2011 WL 2040219 (D. Ariz., May 9, 2011). If the claimed amount is not paid within 180 days, the matter could be referred to the United States Department of Treasury for further collection action.

The author notes that there are current efforts aimed at reforming CMS' conditional payment process as more specifically contained in the *Strengthening Medicare and Repaying Taxpayers Act of 2011 (SMART Act) (H.R. 1063)* recently introduced in Congress. To learn more about these reform proposals, the reader may wish to review the author's article as contained in NuQuest/Bridge Pointe's ***Settlement News, March 2011 Edition*** which can be obtained at:
http://www.nqbp.com/sites/default/files/March2011SettlementNews.pdf.