Is Medicare Advantage Entitled to Bring a Private Cause of Action Under the Medicare Secondary Payer Act?

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IS MEDICARE ADVANTAGE ENTITLED TO BRING A PRIVATE CAUSE OF ACTION UNDER THE MEDICARE SECONDARY PAYER ACT?

Jennifer Jordan†

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I. INTRODUCTION

Medicare Advantage\(^1\) was created in 1997 as a means “to harness the power of private sector competition to stimulate experimentation and innovation to create a more efficient and less expensive Medicare system.”\(^2\) It was intended to “allow beneficiaries to have access to a wide array of private health plan choices in addition to traditional fee-for-service Medicare . . . [and] enable the Medicare program to utilize innovations that have helped the private market contain costs and expand health care delivery options.”\(^3\) But Medicare Advantage is merely an alternative to traditional Medicare Parts A and B.\(^4\) It is still Medicare, governed by the Medicare Act and funded through the Medicare Trust Fund.\(^5\) However, there is a common and prevailing public perception that Medicare Advantage is an “opt-out” or is entirely distinct from Medicare.\(^6\) This misconception has led to much confusion when it comes to applications of the Medicare Secondary Payer Act (the MSP) in federal courts.

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4. See Reed, supra note 2, at 2–3.
5. See id.
6. Id. at 5–6.
The MSP prohibits Medicare from making payments when there is another responsible payer and requires the Secretary of Health and Human Services (the Secretary) to seek reimbursement whenever available. Because Medicare Advantage is in fact still Medicare, the MSP exclusion applies equally to Medicare Advantage Organizations (MAOs). But contradictory language in the Medicare Act makes it unclear if Congress truly intended for MAOs to possess the same reimbursement rights as traditional Medicare. Since about 2010, case law has trickled out of the federal courts with many varying interpretations of MAO reimbursement rights. While the federal courts initially applied a strict statutory interpretation, the opinions have devolved into an extremely liberal interpretation in favor of MAOs with little reliance on explicit congressional intent. And although public policy does favor doing whatever is necessary to safeguard the Medicare Trust Fund, the courts are not the proper forums for legislative reform to ensure Medicare’s sustainability.

Unfortunately, for the time being, the precedent set by the courts will likely control, as the government rarely initiates MSP amendments when the law is being interpreted to its advantage. Medicare currently enjoys a statutory priority right to full reimbursement and is trying to share this privilege with its Medicare Advantage contractors. The last legislative fix to the government’s MSP reimbursement rights came in the late 1990s and early 2000s. As a response to unsuccessfully litigated MSP recoveries by the government, Congress intervened and broadened the definition of “self-insured” to include anyone remotely responsible for medical payments or having touched related insurance payments. Because the courts are currently ruling in favor of Medicare in all forms, there is little incentive for Congress

7. See infra notes 46, 49, 53, 63, 68.

8. See generally Mason v. Am. Tobacco Co., 346 F.3d 36 (2d Cir. 2003); United States v. Baxter Int’l, Inc., 345 F.3d 866 (11th Cir. 2003). Section 301 of the MMA was labeled a “technical amendment” but had the effect of broadening the reach of MSP recoveries to encompass not just situations such as those where corporations paid settlement expenses from operational accounts rather than making formal insurance claims, but also those where insurance should have been purchased and was not for whatever reason and the ability to recover from anyone who received settlement funds prior to Medicare reimbursement or those in possession of settlement funds that could have made reimbursement. See Medicare Advantage in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), Pub. L. No. 108-173, § 301, 117 Stat. 2066, 2221.
to act at this time. Therefore, it is imperative that practitioners take the time to understand the Medicare Act to effectively litigate these issues. Effective litigation would create conflict among the circuits, which could lead the Supreme Court to finally intervene and clarify once and for all exactly what rights MAOs have for MSP recoveries.

This Article proposes to analyze the current state of Medicare Advantage recovery rights and to establish whether or not MAOs were intended to share exactly the same recovery rights as traditional Medicare. Because there is currently no proposed legislation to clear up the inconsistencies in the application of the Medicare Secondary Payer Act to MAOs, this Article will also compare judicial outcomes to identify why the results evolved as they have and to illustrate why those decisions appear to be in error. Ultimately, the Article argues for legislative reform because Medicare Advantage is still a secondary payer under the Medicare Act and, as such, is entitled to reimbursement, through whatever means Congress deems appropriate. Current attempts to avoid reimbursement through exploitation of technicalities are simply a waste of judicial resources, and inconsistent judicial outcomes spur additional litigation. Because it is not proper for judges to legislate from the bench as they have in these Medicare Advantage cases, this is a problem whose resolution lies with Congress.

II. MEDICARE ADVANTAGE AND THE MEDICARE SECONDARY PAYER ACT

A. Medicare Advantage Compared to Medicare

Medicare Advantage was created in the Balanced Budget Act of 1997. Originally named Medicare+Choice, the program was designed to take advantage of private sector efficiencies to better deliver more cost-effective health insurance benefits on behalf of the federal government. To accomplish this, Congress created an arrangement whereby the government would pay private health

10. The program was renamed Medicare Advantage in the MMA. See supra note 1.
11. See supra Part I. Section 238 of the MMA required the Secretary to “conduct an evaluation of leading health care performance measures in the public and private sectors and options to implement policies that align performance with payment under the medicare program.” § 238(a)(2), 117 Stat. at 2213–14.
insurers a flat rate per enrollee, referred to as a capitation rate. Due to provider network arrangements and other efficiencies, private sector insurers could potentially provide care to their enrollees for less money than what the government paid. While some of the surplus funds would find their way back to the beneficiaries in the form of benefits beyond those that Medicare provides, the rest would be profit, making it a win-win situation for the government and MAOs, as well as beneficiaries.

Congress first introduced the Medicare HMO risk-sharing concept in 1972. The Secretary had been authorized to contract with federally qualified HMOs to provide Medicare services on the government’s behalf for over four decades. However, initial participation was low because the “risk sharing” was skewed in the government’s favor. To increase participation, Congress in 1982 established capitated payments to balance the risk sharing. Congress also created competitive medical plans (CMPs) to allow HMOs that were not federally qualified to participate. By 1985, the program finally took off as a result of these earlier interventions but was ultimately replaced by Medicare+Choice in 1997. Under the Medicare Prescription Drug, Improvement, and Modernization (MMA) Act of 2003, the Secretary is prohibited from entering into any new risk-sharing contracts under 42 U.S.C. § 1395mm, essentially nullifying that section of the statute. The Medicare Advantage provisions are codified under 42 U.S.C. §§ 1395w-21 to -28.

14. See 42 U.S.C. § 1395mm(a) (1982). In 2010, Congress reduced “federal payments to Medicare Advantage plans over time, bringing them closer to the average costs of care under the traditional Medicare program.” Medicare Advantage Fact Sheet, HENRY J. KAISER FAMILY FOUND. (May 1, 2014), http://kff.org/medicare/fact-sheet/medicare-advantage-fact-sheet/. Additionally, under the Affordable Care Act of 2010, Medicare Advantage plans must maintain a “medical loss ratio of at least 85%,” thereby limiting their profits. Id. The effects of these policy changes on the health insurance market are yet to be analyzed in detail.
15. For a general list of federal qualifications for CMPs, see 42 C.F.R. § 417.407. See also 42 U.S.C. § 1395mm.
17. See 42 U.S.C. § 1395mm(k). Section 1395mm(k) remains a part of the Medicare Act despite the fact that the Secretary cannot enter into any new contracts and may not renew any such contracts on or after January 1, 1999. See id.
Medicare and Medicare Advantage have some fundamental similarities. The government does not provide any "direct" services even for traditional Medicare; therefore, all Medicare benefits are provided under contract with private sector entities. MAOs "shall provide to members enrolled under this part . . . benefits under the original [M]edicare fee-for-service program option," meaning that they all receive the same basic benefits. Should any beneficiary disagree with a benefit determination, he must exhaust the administrative remedies provided. And both programs are statutorily prohibited from making payments when there is another responsible party.

But because Medicare Advantage is a risk-sharing proposition rather than fee-for-service arrangement, the similarities stop there. The government pays MAOs a fixed capitation rate using a bidding process under which plan providers submit estimated costs per enrollee to Medicare. If a bid meets the necessary requirements, it is accepted. For plans where the estimated costs exceed the benchmark, the enrollee pays the difference in the form of premiums. By using a fixed capitation rate, MAOs share in the risk that beneficiaries may require treatment in excess of the amount provided by the government. However, the MAO keeps any excess funds as profit should the beneficiary require treatment totaling less than the capitation rate. Because it is the beneficiary's election and the potential for profit is greater with a larger pool of enrollees, MAOs incentivize enrollment by providing benefits in excess of those that traditional Medicare provides, such as dental and vision benefits. The idea is to maximize enrollment to diffuse the cost of people requiring active treatment over a large pool of enrollees.

18. Id. § 1395w-22(a)(1)(A).
19. See 42 C.F.R. § 405.904(a). Note that while the entities that perform the first two steps of the appeal differ slightly, the appeal process is fundamentally the same for both programs.
22. See id. (explaining further the anticipated changes in Medicare's payment policies to Medicare Advantage plans).
As a way to ensure MAO contractors are capable of assuming the financial risk, Congress required that an MAO be licensed in each state in which it offers a plan. An MAO must provide an “explanation of coverage” annually, approved by the Centers for Medicare & Medicaid Services (CMS), to enrollees that explains the terms and conditions of the arrangement with the beneficiary. While many of the benefits provided to enrollees in Medicare Advantage plans parallel those under traditional Medicare, MAOs have some more flexibility in how these services are provided. Each MAO may charge different out-of-pocket costs and develop its own rules for how enrollees get their services. For example, Medicare Advantage HMOs may establish networks of accepted specialists and other providers that may be broader or narrower than the networks under traditional Medicare. As a limiting factor on the power of Medicare Advantage, beneficiaries continue to benefit from the maximum annual limit on out-of-pocket costs that applies to persons enrolled in traditional Medicare.

As the details of program administration demonstrate, the Medicare Advantage program lays out a very different infrastructure than the contracting that occurs to provide services for traditional Medicare Parts A and B. But fundamentally, it is important to recognize that it is still Medicare.

B. Medicare Advantage as a Secondary Payer

Medicare is statutorily prohibited from making payments when there is a primary payer, with the exception of payments made when primary payment is not timely made, conditioned upon reimbursement should primary payment responsibility be

24. 42 U.S.C. § 1395w-25(a)(1). This license can be to operate as an insurance company, as a health maintenance organization, as a provider-sponsored organization, or simply as an MAO. See id. § 1395w-25(a)(1)-(2).

25. While technically not an insurance “policy” per se, the explanation of coverage outlines the contractual obligations between the MAO and beneficiary.

determined. 42 U.S.C. § 1395w-22(a)(4) extends secondary payer status to Medicare Advantage by virtue of reference to payments made pursuant to 42 U.S.C. § 1395y(b)(2). But the statute does not incorporate any of the recovery provisions available at 42 U.S.C. § 1395y(b)(2)(B)(iii) or (iv) expressly granted to the United States. Instead, the statute provides that an MAO “may” charge the responsible party or a beneficiary who has received payment for reimbursement of payments for which Medicare is prohibited from making or had made conditionally. It is interesting to note that this permission given to MAOs to bill for reimbursement appears discretionary, whereas traditional Medicare conditional payments made by the Secretary “shall be” conditioned on reimbursement. If Congress were truly concerned about the recovery of payments made from the capitated payments to MAOs, it could have easily required that an MAO bill the responsible party, but instead, it merely granted MAOs permission to do so.

42 C.F.R. § 422.108 specifically covers MSP procedures for MAOs. It states that CMS does not pay for services when Medicare is not primary and lays out responsibilities of MAOs to identify and coordinate benefits with primary payers, reemphasizing the idea that MAOs are making payments on behalf of CMS. Interestingly,


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.

Id.

30. Id. § 1395y(b)(2)(B)(i).
32. See id. § 422.108(a)–(f) (discussing, inter alia, the responsibilities of
subsection (b) states that the "MA organization must" identify primary payers and amounts owed, thereby demonstrating that Congress is capable of using mandatory language. Yet subsections (c), (d), and (e) employ discretionary language: "[an] MA organization may bill" for covered Medicare services. When used in such close proximity, one cannot help but infer that the word selection was intentional.

It stands to reason that the government can require its contractors to consistently coordinate benefits in the same manner as the traditional program so that all beneficiaries receive the same base-level benefits and exclusions. But federal funds are not in play with regard to the MAO recovery itself since such reimbursements are not returned to the Medicare Trust Fund. Part of the risk sharing is that MAOs are paid a fixed capitation rate, whether beneficiaries seek medical treatment or not, and whether MAOs collect from third parties or not. The manner and extent to which an MAO elects to pursue its third-party recoveries are business expenses that should have factored into its benchmarks when bidding to be an MAO. How MAOs conduct their ordinary course of business determines how much profit they can make contracting as an MAO and is not Congress's concern, so long as Medicare beneficiaries receive the guaranteed benefits provided by law. If the principles of Medicare Advantage were founded on the idea that private sector insurance companies can deliver health care benefits more efficiently than the federal government, one has to assume that they are just as efficient and knowledgeable about recovering liens from responsible third parties.

C. The Practical Problem with MAOs

Beside the statutory and regulatory differences, MAOs simply operate differently than traditional Medicare. Historically, practitioners have always treated MAOs like private sector insurance companies, and MAOs responded in kind by acting as

MAOs, procedures for collecting funds from entities other than the government, and the relationship between MAO rules and state laws.

33. Id. § 422.108(b) (emphasis added).
34. Id. § 422.108(c)-(e) (emphasis added).
35. Note that the capitation rate is reduced in secondary payer situations based solely on the assumption that, with another primary source of insurance, the covered Medicare expenses would be less, and therefore CMS should not have to pay as much for the MAO to assume responsibility for such a beneficiary.
such. Payments made by MAOs were generally treated as liens, and state subrogation laws applied. Medicare conditional payment resolutions were considered reserved for traditional Medicare Part A and B claims, mainly because many people do not consider Medicare Advantage to be the same as traditional Medicare. Under the opt-out perspective described above, Medicare Advantage has typically been treated like, and acted like, any other form of private medical insurance.

But the real source of this problem is that CMS does not treat Medicare Advantage like traditional Medicare. There exists a real lack of communication between CMS and MAOs, a result of the fact that CMS is truly far removed from MAO claims. While it is true that the federal government does not provide direct care in either traditional Medicare or Medicare Advantage, CMS does maintain control of traditional Medicare, whereas MAOs are left to administer their own benefits. Because MAOs maintain their own claim information, CMS has no way of knowing if conditional payments have been made by an MAO. If a practitioner were to contact the proper CMS contractor regarding conditional payments for a Medicare Advantage enrollee, they would simply receive notice that it had no record of any conditional payments in need of reimbursement. The contractor does not elaborate that the reason is because the beneficiary was enrolled in Medicare Advantage and that they do not have access to those records. As a result, many practitioners check the box that they resolved their "Medicare liens," disburse funds and go on with life, leaving an unknown Medicare Advantage plan unknowingly unreimbursed. 36

Even more confusing is the fact that CMS does not share Section 111 Mandatory Insurer Reporting (MIR) information with MAOs to assist in coordination of secondary payer provisions. 37 With nearly 150 data fields provided in MIR reporting, CMS knows everything about an ongoing medical responsibility or insurance settlement, including the nature of the injury and all of the involved parties. But rather than share that information with its Medicare Advantage contractors, CMS instead only puts them on notice of secondary payer situations by reducing its capitation rate.

36. Technically, any improper payment made by Medicare is considered under federal law an "overpayment" and use of the term "lien" is incorrect. The use here is demonstrative of use by practitioners.

The assumption is that if a primary payer exists, then the MAO is not required to provide as many benefits and therefore its payment should be reduced accordingly. But the question remains, if Medicare Advantage is in fact supposed to be the same as Medicare, then why does CMS not share sufficient data with its Medicare Advantage contractors to help facilitate secondary payer recoveries?

Between MAOs not behaving like Medicare and CMS leaving MAOs to fend for themselves, it is not hard to see why the perception that Medicare Advantage is different from Medicare exists. Unfortunately, that misunderstanding has filtered its way into the judicial system. The resulting case law stems from either bad legislation or a judicial attempt to read something into the Medicare statute that just is not there. The next sections will explore the situation.

III. STATUTORY CONSTRUCTION AND APPLICATION OF MEDICARE ADVANTAGE SECONDARY PAYER PROVISIONS

A. Express Statutory Provisions as Provided by Congress

The Medicare Act has been described as "one of 'the most completely impenetrable texts within human experience.'"\(^\text{38}\) Originally codified in 1965, the Medicare Act has been routinely amended throughout the years, primarily through budget bills.\(^\text{39}\) But several inconsistencies were created in the statute along the way. None has proven more challenging than identifying the reimbursement rights of Medicare Advantage plans.

Statutorily, MAOs only have the right to bill primary payers or beneficiaries in receipt of insurance payments. The regulations

\(^{38}\) Parra v. PacifiCare of Ariz., Inc., 715 F.3d 1146, 1149–50 (9th Cir. 2013) (quoting Cooper Univ. Hosp. v. Sebelius, 636 F.3d 44, 45 (3d Cir. 2010)).

\(^{39}\) See, e.g., Balanced Budget Act of 1997, Pub. L. No. 105-33, 111 Stat. 251. The Act instituted a 30-month period after the start of dialysis during which Medicare is secondary for ESRD with respect to Medicare beneficiaries with group health coverage. It also extended the time period during which CMS may seek recovery of conditional Medicare payments from liable primary payers to three years from the date when the service was rendered. It clarified that beneficiaries are generally not liable for MSP overpayments unless Medicare issued payment directly to the beneficiary. Finally, Medicare was permitted to recover from third-party administrators of primary plans as long as the third-party administrator has the ability to recover from the employer or group health plan and is either employed by or under contract with the employer.
permit MAOs to "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." The MSP states that the Secretary may make a conditional payment, may waive reimbursement obligations when in the best interest of the program, shall provide access to claim information, and shall perform many other collection functions. However, subrogation rights and the right to bring a private cause of action in federal court to recover Medicare overpayments are reserved for the United States.

So while an MAO cannot bring a private cause of action under 42 U.S.C. § 1395y(b)(2)(B)(iii), the MSP contains a second private cause of action provision under § 1395y(b)(3)(A), totally separate from the rights reserved for the United States. It provides that "[t]here 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)."

Paragraph (1) is titled "Requirements of group health plans" and lays out several scenarios where group health plans may not take eligibility for Medicare benefits into consideration for purposes of denying benefits. Paragraph (2)(A) establishes situations where Medicare is prohibited from making payments due to the existence of other primary payment options, in which group health plans are expressly noted. Due to use of the

41. See Parra, 715 F.3d at 1154.
43. Id. § 1395y(b)(1)(A)(i). The paragraph states:

A group health plan—(I) may not take into account that an individual (or the individual’s spouse) who is covered under the plan byvirtue of the individual’s current employment status with an employer is entitled tobenefits under this subchapter under section 426(a) of this title, and (II) shallprovide that any individual age 65 or older (and the spouse age 65 or older of any individual) who has current employment status with an employer shall be entitled to the same benefits under the plan under the same conditions as any such individual (or spouse) under age 65.

Id.

44. Id. § 1395y(b)(2)(A). The paragraph states:

Payment under this subchapter may not be made, except as provided in subparagraph (B), with respect to any item or service to the extent
conjunctive "and" and the reference to group health plans in each condition, it would be easy to assume that this private cause of action was intended to apply in situations in which a group health plan refused to make payment due to Medicare eligibility causing Medicare to pay. But that is not the case today.

While paragraph (2)(A) has non-group health plan (NGHP) applications, paragraph (1) only applies to group health plans. Therefore the intentional use of the conjunction "and" makes applications of § 1395y(b)(3)(A) impossible in non-group health situations if the statute is to be strictly construed. This result, while implausible, may be explained by the fact that CMS did not turn its attention to NGHP situations until the turn of the century. There is no documented proof of congressional intent regarding § 1395y(b)(3)(A) in the congressional record, or anywhere else for that matter. Unfortunately, this lack of evidence caused the courts to resort to the *Chevron* analysis and adopt public policy arguments aimed at preserving the Medicare program to reach conclusions in favor of MAOs. These conclusions essentially rewrite the MSP.

that—(i) payment has been made, or can reasonably be expected to be made, with respect to the item or service as required under paragraph (1), or (ii) payment has been made or can reasonably be expected to be made under a workmen's compensation law or plan of the United States or a State or under an automobile or liability insurance policy or plan (including a self-insured plan) or under no fault insurance. In this subsection, the term "primary plan" means a group health plan or large group health plan, to the extent that clause (i) applies, and a workmen's compensation law or plan, an automobile or liability insurance policy or plan (including a self-insured plan) or no fault insurance, to the extent that clause (ii) applies. An entity that engages in a business, trade, or profession shall be deemed to have a self-insured plan if it carries its own risk (whether by a failure to obtain insurance, or otherwise) in whole or in part.

Id.

B. Judicial Interpretations of MAO Rights

1. Strict Statutory Construction Originally Prevented MAOs from Suing Under the MSP

Although there were a few reported earlier cases, the recovery rights of MAOs truly came into question starting in January 2011, when the U.S. District Court for the Southern District of Florida dismissed a suit filed by Humana seeking recovery from a Medicare beneficiary who settled a slip-and-fall claim against a condominium association. The court found that, because the MSP only permits the United States to bring a private cause of action, Humana lacked standing to do so as MAOs possess only the rights of the Secretary. Therefore, the court concluded that an MAO lacked standing to pursue such a claim for recovery of Medicare payments in federal court.

Shortly thereafter, the U.S. District Court for the District of Arizona provided some additional analysis in Parra v. Pacificare of Arizona, Inc. In a wrongful death action involving a Medicare Advantage enrollee, the court dismissed the action for lack of subject matter jurisdiction. The court found that the statute provided no private cause of action for MAOs and found no congressional intent to infer such a right. Due to express statutory and regulatory provisions regarding billing rights, the court found

47. See id. at *5 (citing 42 U.S.C. § 1395y(b)(2)(B)(iii) (2006); 42 C.F.R. § 422.108(f) (2010)).
48. Id. The court took this conclusion one step further, noting that "[e]ven if this action had been brought under 1395mm(e)(4), however, a dismissal would still be warranted because 1395mm(e)(4) does not confer a private right of action." Id. at *5 n.2.
50. Id.
51. Id. at *3-5 ("The Magistrate Judge found that the Medicare statutes allow PacifiCare to include subrogation and reimbursement rights in its agreement with its members, 'but it did not create a federal right to enforce that contract.' This Court agrees with the Magistrate Judge . . . . 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.").
that the proper place for MAO reimbursement claims lay in state court under contract theories.  

Then the U.S. District Court for the Eastern District of Pennsylvania ruled against Humana in its efforts to recover from GlaxoSmithKline in the In re Avandia multidistrict litigation. While Humana argued that § 1395y(b)(3)(A) unambiguously granted a private cause of action to MAOs, the court found that it did not. The court supported this conclusion in several steps. First, it discussed the permissive versus mandatory language of the statute. Next, the court performed the four-part test set forth in Cort v. Ash to examine whether an implied right could be established. The court even performed the two-part Chevron analysis and found 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."  

As it stood in 2011, the courts had established that MAOs could not sue for recovery under the MSP and were instead relegated to state court to pursue claims under a contract theory. CMS, however, did not care for those outcomes and, in December 2011, issued a memorandum to its Part C and Part D contractors stating that "[n]otwithstanding these recent court decisions, CMS maintains that the existing MSP regulations are legally valid and an integral part of the Medicare Part C and D programs." But what is

52. Id. at *5.
55. Id. at *10-14.
interesting about its interpretation of the regulations is that CMS states that 42 C.F.R. § 422.108 is an assignment of the rights and responsibilities to collect for Medicare services for which Medicare is not the primary payer. If CMS is saying that Medicare is prohibited from making payments in secondary payer situations and MAOs are required to seek reimbursement just as the Secretary would be, then why the permissive statutory language?

2. Liberal Interpretation by the Third Circuit Broadened MAO Rights

Starting in 2012, the story went awry and courts began allowing more and more broad interpretations of who the private cause of action under 42 U.S.C. § 1395y(b)(3)(A) was intended for. In June of 2012, the Third Circuit Court of Appeals overturned the district court’s decision in the In re Avandia case, finding that 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.” Rather than be persuaded by the fact that there is no record of congressional intent, the court instead relied on the absence of congressional intent to deny MAOs access to the MSP private cause of action. The court used unrelated information in the Federal Register concerning changes to the Beneficiary Rebate Rule to infer that MAOs required the right to file private causes of action to “faithfully pursue and recover from liable third parties.” Only through these actions, the court concluded, could MAOs lower medical expenses so that rebates go up and enrollees receive more non-Medicare benefits funded by those rebates. In reality, these same savings could be achieved

Data Grp., to Medicare Advantage Orgs. & Prescription Drug Plan Sponsors (Dec. 5, 2011), available at http://www.pmsionline.com/pdf/CMS%20Memo-%20MAOs-%2012-05-11.pdf. While MAOs have “the same rights . . . as the Secretary . . . under the Original Medicare MSP regulations,” Prescription Drug Plans (PDPs) have all the same rights as MAOs, and therefore all of these same issues exist for PDPs as well. Id.

62. Id.
64. Id. at 361.
65. Id. at 363, 363 n.17 (citing policy and technical changes to the Medicare Advantage and the Medicare Prescription Drug Benefits Program, 74 Fed. Reg. 54,634, 54,711 (proposed Oct. 22, 2009)).
66. Id.
through diligent coordination of benefits and pursuit of recoveries rather than costly litigation.

Therefore, it is unclear as to how the court jumped to the conclusion that a private cause of action is necessary from the text provided. While it is feasible to agree with the court that "nothing in the text or legislative history of the statute . . . impl[ies] that Congress did not intend to facilitate recovery for MAOs in the same fashion" as traditional Medicare, there is also nothing that does demonstrate such intent. In fact, there is no support for the contention that Congress, at the time the legislation was written, even remotely considered an MAO's ability to sue in federal court for recovery in secondary payer situations.

Springboarding off of this success, Humana filed four separate cases in different circuits almost simultaneously, possibly in an attempt to see where each circuit would stand on the issue. All of the cases were filed against Farmers Insurance (Farms), or a subsidiary thereof, likely due to its unilateral adoption of the position that MAOs do not have any right under federal law to recover from insurance companies like Farmers. Nor did Farmers believe that MAOs had a right to bring a private cause of action for double damages, or that, in these cases, the MAO complied with the Medicare Act's requirements for making a "conditional payment" which would trigger its reimbursement rights under the MSP. All but one case was voluntarily withdrawn, and, in February 2014, a magistrate judge for the U.S. District Court for the Western

67. Id. at 364.


69. See, e.g., Humana Health Ins. Co. v. Farmers Ins. Co., A-13-CA-611 LY, 2014 U.S. Dist. LEXIS 167143, at *7 (W.D. Tex. Feb. 26, 2014). Farmers contends that a proper conditional payment requires that Humana investigate and determine whether the primary plan "cannot reasonably be expected to make payment," whereas it paid without any investigation. Id. at *15 (quoting 42 U.S.C. § 1395y(b)(2)(B) (2012)). However, 42 C.F.R. § 411.21 (2014) defines a conditional payment as "a Medicare payment for services for which another payer is responsible, made either on the bases set forth in subparts C through H of this part, or because the intermediary or carrier did not know that the other coverage existed." See also Humana Health Ins. Co., 2014 U.S. Dist. LEXIS 167143, at *16 (quoting 42 U.S.C. § 411.21 (2014)). Therefore, Humana's payments were made conditionally despite the lack of knowledge of the primary plan. Id. at *16.
District of Texas noted that the Third Circuit Court of Appeals precedent was not binding. This allowed the judge to thoroughly review the record and legal claims as a matter of first impression for the Fifth Circuit.

In his recommendation to the district court, the magistrate judge noted that "nothing in the [Medicare] statute specifically grants an MAO a private cause of action to recover against a primary payer" and that "if Congress intended for MAOs to recover payments . . . via a federal cause of action, it could have incorporated the private right of action into the [Medicare] statute." The magistrate judge also noted that "different language is used in setting forth the two structures" for recovery of conditional payments. "[A]n MAO is permitted to, that is 'may,' charge a primary payer," while "a primary payer is required to, that is 'shall,' reimburse Medicare for a conditional payment." This gives MAOs the right to bill but mandates that primary payers make reimbursement to Medicare. Under Fifth Circuit precedent, the magistrate judge concluded that variation from mandatory to permissive language is a "fairly clear indication that Congress intended the Medicare program to have more extensive rights" than its private sector counterparts. Lastly, the magistrate judge, citing a House report, explained that the Medicare Advantage program was intended to "harness the power of private sector competition to stimulate experimentation and innovation."

71. Ultimately, the presiding judge did not follow the magistrate's recommendation and followed the Third Circuit's conclusions. See id. at *2.
72. See id. at *13 (quoting Gozlon-Peretz v. United States, 498 U.S. 395, 404 (1991) ("[W]here Congress includes particular language in one section of a statute but omits it in another section of the same Act, it is generally presumed that Congress acts intentionally and purposely in the disparate inclusion or exclusions.").
73. See id. at *13–14.
74. Id. at *13 (citing 42 U.S.C. §§ 1395w-22(a)(4), 1395y(b)(2)(B)(ii)).
75. Id. at *14 ("[W]hen Congress uses different terms, each term [is] to have a particular, nonsuperfluous meaning." (quoting Silva-Trevino v. Holder, 742 F.3d 197, 203 (5th Cir. 2014)) (internal quotation marks omitted)).
76. Id. at *14 n.5 (quoting Care Choices HMO v. Engstrom, 330 F.3d 786, 790 (6th Cir. 2003)) (internal quotation marks omitted).
77. Id. at *15 (quoting In re Avandia Mktg., Sales Practices & Prods. Liab. Litig., 685 F.3d 353, 363 (3d Cir. 2012), cert. denied, 133 S. Ct. 1800 (2013)).
Therefore, creating something that occupied the same space as traditional Medicare would not be innovative. 78 “[T]he fact that a federal statute has been violated and some person harmed does not automatically give rise to a private cause of action in favor of that person,” 79 “no matter how desirable that might be as a policy matter, or how compatible with the statute.” 80 The magistrate recommended that the court dismiss all of Humana’s claims; 81 however, in September 2014, the district court issued its order on the report and recommendation, siding with the Third Circuit and rejecting the magistrate judge’s recommendation. 82

3. Disguising Suits as State Law Claims Not Sufficient to Subvert MAO Recoveries

The remaining private cause of action cases reported in 2014 involved beneficiaries suing their MAOs in an attempt to avoid reimbursement. In Einhorn v. Careplus Health Plans, Inc., 83 the plaintiff attempted to cleverly disguise her MSP issues as violations of the Florida Consumer Collection Practices Act, 84 claiming her MAO was attempting to “collect on debts . . . not owed and/or by misrepresenting the amount due.” 85 The court determined that the MSP was fundamentally at issue here because “seeking compensation for actions that violated the Florida consumer protection laws . . . [is] an untimely collateral attack on CarePlus’ determination of the amount of its lien under the Medicare statutes.” 86 Since the plaintiff’s claims arose under the Medicare

78. Id. ("Occupying the same position as Medicare is not, on its face, innovation. Nor is the mere fact that an MAO would benefit from a private right of action a sufficient basis for concluding one exists." (citing California v. Sierra Club, 451 U.S. 287, 294 (1981))).
79. Id. at *16 (quoting Touche Ross & Co. v. Redington, 442 U.S. 560, 568 (1979)).
80. Id. (quoting Alexander v. Sandoval, 532 U.S. 275, 287 (2001)).
81. Id. at *20.
82. Id. at *3–4
86. Id. at *2 (citing Bodimetric Health Servs., Inc. v. Actna Life & Cas., 903 F.2d 480, 487 (7th Cir. 1990)) ("A party cannot avoid the Medicare Act’s jurisdictional bar simply by styling its attack as a claim for collateral damages instead of a challenge to the underlying denial of benefits. If litigants who have
Act, she was required to exhaust the administrative remedy provided therein before turning to the federal courts. The plaintiff had not exhausted these administrative processes, so her claim was dismissed.

Similarly, in Collins v. Wellcare Healthcare Plans, the plaintiff alleged her claims did not arise under the Medicare Act because she brought only state law claims under her “contract” with Wellcare and did “not seek any Medicare benefits or services.” Furthermore, she argued that Wellcare was not entitled to subrogation because the right was not articulated in her contract and that Wellcare “does not have a private right of action under the MSP because . . . [Collins was not] a group health plan.” As in Einhorn, the court found that a private cause of action did exist under the MSP and that the plaintiff failed to exhaust her administrative remedies, ultimately dismissing her claims. Notably, however, this court did not find that Wellcare had a right to double damages in this instance. The statute states that “a primary plan must fail to provide reimbursement”; therefore, the punitive effect is intended for those “who intentionally withhold payment.” The plaintiff placed funds in escrow upon receipt pending the outcome of this litigation, therefore clearly not refusing payment.

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87. Id. at *2-3.
88. Id. ("Subsection 405(h) prevents beneficiaries and potential beneficiaries from evading administrative review by creatively styling their benefits and eligibility claims as constitutional or statutory challenges to Medicare statutes and regulations." (quoting United States v. Blue Cross & Blue Shield of Ala., 156 F.3d 1098, 1104 (11th Cir. 1998))).
90. Id.
91. Id. at *5-7.
92. Id. at *16.
93. Id. at *15 ("Failure connotes an active dereliction of a duty, and the award of double damages is intended to have a punitive effect on plans who intentionally withhold payment.").
94. See id. at *16. ("A failure to provide reimbursement does not describe the situation in the instant case, and the intended punitive remedy of double damages is therefore not appropriate. Collins’ duty to reimburse Wellcare only arose once she received her tort settlement, and when this occurred, Collins placed the money claimed by Wellcare into a trust. Collins therefore did not conceal the
C. Other Applications of 42 U.S.C. § 1395y(b)(3)(A)

At this point it is evident that the federal courts have fully adopted the Third Circuit’s broad interpretation of the MSP in favor of Medicare Advantage plans, despite the express statutory language to the contrary. But the debate as to who may bring a private cause of action under 42 U.S.C. § 1395y(b)(3)(A) is not limited to Medicare Advantage cases. In fact, MAOs originally attempted to use 42 U.S.C. § 1395y(b)(2)(B)(iii), assuming that they sat in the Secretary’s shoes. It was not until the district court in In re Avandia emphasized this and other possibilities95 that a noticeable increase of cases arose under § 1395y(b)(3)(A). Unfortunately, the possible use of § 1395y(b)(3)(A) by MAOs suffers from the district courts’ application of Chevron deference, since there is no known record of express congressional intent regarding § 1395y(b)(3)(A). In practice, then, this permits the active application of a policy built on the overwhelming sentiment to protect the Medicare program and results in absurdities that Congress could not have intended.

1. Standing Imperative

Once CMS started drawing attention to the MSP in 2001, many tried to profit from the private cause of action in § 1395y(b)(3)(A). In 2004, a workers’ compensation claimant sued her carrier, on behalf of all similarly situated claimants, because she did not receive a Medicare set-aside96 when she settled her claim in what she perceived was a violation of the MSP.97 Regardless of the fact that she did not allege that she was a Medicare beneficiary or ever would be, she failed to demonstrate any actual damages as Medicare had made no payments and the MSP is a recoupment money or spend the money...".


provision and totally ineffective for claiming future inchoate damages. Therefore, the case was dismissed for lack of standing. 98

2. Demonstration of Responsibility Is Not Necessary

In 2006, the Eleventh Circuit Court of Appeals upheld the dismissal of a claim attempting to recover from certain tobacco manufacturers the cost of health care services attributable to cigarette smoking that were paid by Medicare. 99 Rather than argue standing, given that the MSP is not a qui tam statute, the defendants argued for dismissal based on collateral estoppel or the ground that the claim was duplicative of claims brought by the United States in another court. 100 Additionally, the defendants moved for dismissal on the ground of failure to state a claim because the defendants' responsibility for payment had not been established. 101 While the court did not agree with the defendants' first two arguments, it was not persuaded by the plaintiff's argument that responsibility for primary payment could be established by litigating the state tort claim during the MSP action. 102 The court thus found that one could not fail to make payment when responsibility has not been established. 103 In addition, the court said that its conclusion was supported by the fact that such a decision would drastically expand federal jurisdiction by creating a forum to litigate any state tort claim without regard to diversity or amount in controversy, and that this would contravene class action requirements.

Despite not being a qui tam statute, several suits were also filed by Douglas Stalley, a known associate of Erin Brokovich, famous for her class action claims against Pacific Gas and Electric. All of these suits were dismissed for lack of standing and Mr. Stalley was

98. Id. at 1078–83.
100. Id. at 1307.
101. Id.
102. Id. at 1309 (“When Plaintiffs filed their MSP claim, Defendants’ responsibility to pay for items or services had not yet been ‘demonstrated,’ which is a condition precedent to Defendants’ obligation to reimburse Medicare under section 1395y(b)(2)(B)(ii). Until Defendants’ responsibility to pay for a Medicare beneficiary’s expenses has been demonstrated . . . Defendants’ obligation to reimburse Medicare does not exist under the relevant provisions.”).
103. Id.
104. See id.
sanctioned in 2008 for his frivolous waste of judicial resources. In Wood v. Empire Health Choice, the plaintiff nearly achieved standing by alleging injury as a taxpayer; however, the court ultimately found his injury "too generalized and attenuated" to constitute personal injury. In fact, only one reported opinion during this period actually proceeded to the merits. O'Connor v. Mayor & City Council of Baltimore involved a plaintiff denied benefits under workers' compensation, which caused Medicare to pay despite orders by the Maryland Workers' Compensation Commission. The plaintiff achieved standing because he filed as a Medicare beneficiary suing on behalf of himself as a workers' compensation claimant wrongfully denied state benefits, which caused Medicare to make payments, rather than on behalf of Medicare. The court felt that the rights under the statute were intended to be vindicated by involved citizens with knowledge of the debt.

The next case addressing the scope of § 1395y(b)(3)(A) was Bio-Medical Applications of Tennessee, Inc. v. Central States Southeast & Southwest Areas Health & Welfare Fund in 2011. Like O'Connor, this suit was one of the few initiated by a Medicare beneficiary denied medical benefits due to Medicare entitlement. In this case, an Employee Retirement Income Security Act (ERISA) group health plan denied benefits on the basis of the patient's eligibility for Medicare due to end-stage renal disease, causing Medicare to make payments. Bio-Medical's motion for summary judgment on the ERISA claim was granted; however, Bio-Medical's MSP claim for


106. Woods v. Empire Health Choice, 574 F.3d 92, 96 (2d Cir. 2009) ("[T]he complaint asserts only that the Government has suffered substantial pecuniary injury as a result of Empire's actions, depriving taxpayers of savings to which they are rightfully entitled. The alleged injury suffered by the Government, however, was not inflicted on Woods.").

107. O'Connor v. Mayor & City Council of Balt., 494 F. Supp. 2d. 372, 373 (D. Md. 2007). Note that this court did not even question claimant's standing in a non-group health situation despite the express terms of the legislation.

108. Id. at 374.

109. See id.

110. 656 F.3d 277 (6th Cir. 2011).

111. 494 F. Supp. 2d. 372.

112. See Bio-Med. Applications of Tenn., Inc., 656 F.3d at 280.
double damages was dismissed on the basis that Bio-Medical failed to demonstrate that Central States bore responsibility for payment. On appeal, the Sixth Circuit Court of Appeals found that “the ‘demonstrated responsibility’ provision limits only lawsuits against tortfeasors, not lawsuits against private insurers.”

The phrase “demonstrated responsibility” is found in the United States’ private cause of action found at 42 U.S.C. § 1395y(b)(2)(B)(iii), whereas Bio-Medical used the private cause of action found at 42 U.S.C. § 1395y(b)(3)(A), which only requires that the primary payer fail to pay. The court was particularly persuaded by a regulatory change adopted in 2006 which clarified that the demonstration of liability could be accomplished with a settlement, judgment, or other means, such as an insurance contract, indicating tort situations.

The thorough legal analysis of § 1395y(b)(3)(A) found in the Bio-Medical case was truly the first of its kind. The court questioned when a primary plan fails to make payment in accordance with both conditions and looked at each in great detail. Satisfying paragraph (1) was easy in the case because the ERISA plan expressly required participants to enroll in Medicare immediately upon attaining eligibility. Denying the patient coverage because of her eligibility for Medicare was the kind of act the statute expressly intended to prevent. Paragraph (2)(a) however, proved to be more of a challenge as the provision is directed at Medicare, instructing it not to pay when there is another available primary payer. Because a primary plan cannot violate an order addressed

113. Id. at 281. Although Bio-Medical is actually the provider, it filed suit on behalf of the Medicare beneficiary through assignment of her rights. Id. at 280–81.
114. Id. at 291.
115. See id. (“This interpretation is now fully supported by a federal regulation adopted in February 2006 . . . . This regulation interprets the ambiguous statutory phrase ‘other means’ and is reasonable because it implicitly acknowledges that while a tortfeasor’s responsibility must be determined ex post, the nature of insurance is the assumption of responsibility ex ante.” (citing 42 U.S.C. § 1395y(b)(2)(B)(ii) (2006))). For a copy of the regulation referred to in the decision, see Medicare Program; Medicare Secondary Payer Amendments, 71 Fed. Reg. 9466 (Feb. 24, 2006) (codified at 42 C.F.R. § 411.22 (2014)). The clarification provided via the new regulation was introduced to prevent clever attorneys from not making a claim for medical damages or engaging in other legal maneuvers to avoid triggering the MSP.
117. See id. at 284–86.
to Medicare, it is impossible to meet both conditions of this private cause of action. To avoid this legal gridlock, the Third Circuit Court of Appeals suggested that the paragraphs be read separately rather than together. This permitted the important conclusion that "a primary plan fails to pay 'in accordance with paragraphs (1) and (2) (A)' when it terminates a plan holder's coverage and thereby induces Medicare to make a conditional payment on its behalf." 

3. **Compensability Under State Law Is Necessary**

Following *Bio-Medical*, there began to be a more limited application of the private cause of action provision under § 1395y(b)(3)(A). In *Caldera v. Insurance Company of the State of Pennsylvania*, a Medicare beneficiary sued his workers' compensation carrier for reimbursement of Medicare payments made between 2002, when his Texas compensation claim was administratively closed, and 2009, when an agreed judgment was entered in which his benefits were reinstated and the carrier stipulated that all medical treatment received to date related back to the claimant's original date of loss. While the insurer compensated the beneficiary for all missed indemnity payments, the carrier refused to reimburse any medical expenses. According to the carrier, the claimant failed to obtain proper authorization from the carrier pursuant to Texas law at the time the services were rendered. The courts at all levels agreed that the carrier was not responsible under state workers' compensation law, even though Medicare was entitled to reimbursement under the pure spirit of the MSP.

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120. See id. (citing United States v. At. Research Corp., 551 U.S. 128, 137 (2008) (concluding that statutes should not be interpreted so as to "render [an] entire provision a nullity").
121. Id.
122. 716 F.3d 861 (5th Cir. 2013).
124. Caldera, 716 F.3d at 863.
125. See id. at 862-63.
126. See id. at 864-65 ("The MSP and its implementing regulations do not,
Caldera is a glaring example of how the misunderstanding of the MSP is rampant in the federal court system. This was a model case for which Congress likely intended individuals to bring a private cause of action—a Medicare beneficiary sought reimbursement from his workers’ compensation carrier who questionably terminated his benefits, the carrier then later reversed its decision, causing Medicare to make payments in the interim.\textsuperscript{127} The parties’ actions prior to the agreed judgment should have been irrelevant for purposes of the MSP as the MSP was not even triggered until the agreed judgment was entered.\textsuperscript{128} Thus, the focus on federal preemption was misplaced. At the time the services were rendered, Medicare was Caldera’s primary payer\textsuperscript{129} and it was not until the agreed judgment that the MSP came into play. Despite acceptance by the defendant that the injury was compensable, it did not agree to pay past medical damages.\textsuperscript{130} And because it was not conceded to in the settlement agreement, the carrier’s liability for payment was determined purely on the basis of workers’ compensation law.\textsuperscript{131} While the significance of the agreed judgment in the context of the MSP should have at least been discussed, Caldera does represent good precedent that Medicare recovery rights are limited by the underlying state law.\textsuperscript{132} However, extend so far as to eviscerate all state-law limitations on payment . . . To the contrary, the plain language of the MSP illustrates its harmonious relationship with state workers’ compensation law: a workers’ compensation carrier is ‘primary’ only if ‘payment has been made or can reasonably be expected to be made under a workmen’s compensation law or plan of the United States or a State.’\textsuperscript{133} Additionally, the Fifth Circuit concluded, “Medicare generally ‘does not pay until the beneficiary has exhausted his or her remedies under workers’ compensation.’”\textsuperscript{134} Id. The Supreme Court denied Caldera’s petition for certiorari on October 15, 2013. See Caldera, 134 S. Ct. 436.

\textsuperscript{127} Caldera, 716 F.3d at 862–63.

\textsuperscript{128} See Caldera, 2012 WL 360183, at *1 (“On April 12, 2011, the parties entered into an Agreed Judgment in state court holding that the condition requiring back surgery was, in fact, related to the initial 1995 workers compensation injury.” (citation omitted)).

\textsuperscript{129} Although a moot point, recall that at the time of the services, the claimant was denied workers’ compensation benefits. See id. Therefore, intuitively, the question remains why he would have sought authorization.

\textsuperscript{130} Id. at *3.

\textsuperscript{131} Id.

\textsuperscript{132} See Caldera, 716 F.3d at 867.
4. Race to File for Double Damages

But what happens when one takes Bio-Medica's lack of demonstrated liability and uses it in conjunction with In re Avandia's liberal interpretation of standing under 42 U.S.C. § 1395y(b)(3)(A)? The answer is found in Michigan Spine & Brain Surgeons, PLLC v. State Farm Mutual Automobile Insurance Co. In the most convoluted of all MSP applications, the U.S. District Court for the Eastern District of Michigan originally granted standing to a medical provider that had already billed and accepted a conditional payment from Medicare and therefore had no damages. The claim stemmed from an auto accident with coverage denied on the basis of the beneficiary's preexisting condition. Upon denial of payment, the provider made the election to accept a conditional payment from Medicare and then sued the auto insurer, State Farm, for double its original bill. Following Bio-Medical, the court found that the provider did not need to prove State Farm's liability for the payments, only that it did not make them, and the court granted the provider standing to pursue a claim under the MSP. On reconsideration, the court dismissed the MSP claim as further statutory analysis found that the private cause of action could only be brought against a group health plan due to the use of the conjunctive "and" in the statute.

The Sixth Circuit Court of Appeals again reversed and granted Michigan Spine & Brain Surgeons standing to pursue

133. 758 F.3d 787 (6th Cir. 2014).
136. Id. at *1-3.
137. Id. at *5-6.
reimbursement under the MSP. The court found Bio-Medical distinguishable as it did not address non-group health plans, as was the case here, and instead turned to Chevron deference. The court looked at numerous regulations all addressing group health plans and inferred that the paragraph (1) requirement only applied to group health plans and that non-group health plans only needed to satisfy paragraph (2) (a). Any other interpretation "would eviscerate the private cause of action as it relate[d] to non-group health plans." The court also relied upon dicta taken from In re Avandia about how Congress intended to "curb skyrocketing health costs and preserve the fiscal integrity of the Medicare system" to conclude that this was Congress’s plan all along. As noted above, evidence of this congressional intent does not exist in the legislative history or congressional records. In the end, we are left with precedent that a medical service provider, who had already been paid, can then sue on behalf of Medicare for double damages without any need to prove that the defendant was even responsible for the payment.

Finally, we reach the apex of absurd. Estate of Clinton McDonald v. Indemnity Insurance Co. of North America involved Medicare reimbursements that were agreed to during a workers’ compensation dispute but remained unpaid following resolution of that issue. Claimant’s estate filed suit under the MSP after the defendant contacted CMS to obtain the amount owed but before the agency’s response. The conditional payments were immediately resolved once demand was made; however, the court still awarded the estate its full share of the double damages. The court found that the estate’s suit compelled the insurer to pay Medicare as the statute intended and, as such, it was still entitled to its bounty. The court stated that “[o]nce a private cause of action claim has been lodged against a defendant, a defendant cannot

140. Id. at 792–93.
141. See id.
142. Id. at 793.
143. Id. (quoting In re Avandia Mktg., Sales Practices & Prods. Liab. Litig., 685 F.3d 353, 363 (3d Cir. 2012), cert. denied, 133 S. Ct. 1800 (2013)).
145. See id. at *1–2.
146. Id. at *5.
147. Id.
escape the double damages provided for in that provision by paying single damages to Medicare.”

For those who have never attempted to resolve a Medicare conditional payment obligation, the absurdity of this outcome may be lost. Although some procedural improvements have been made by CMS, the procedures that applied when this case was developing are likely to blame for this outcome. At that time, an insurer had to request a conditional payment search be conducted by a certain CMS contractor, the Medicare Secondary Payer Recovery Contractor (MSPRC). Unfortunately, had the insurer not first opened a case file with the Coordination of Benefits Contractor (COBC), requested said information from any other CMS affiliate, or failed to submit the proper release signed by the Medicare beneficiary, the request would have been ignored without notice. Had the request been successful, the insurer very likely would have received a laundry list of every medical service performed since the date of loss at a minimum of forty-five days later but generally more like sixty to ninety days later. Even if the insurer successfully argued what items were unrelated and they were removed, the letters would continue to arrive with new additions until a demand letter was finally issued; however, a final demand would not be issued until the settlement was finalized as the MSP is not actually triggered until settlement, judgment, award, or other payment, even though it would be very helpful to know what is owed prior to that moment. If the insurer sent a payment to the government prior to a demand, that check would have been cashed but the insurer’s reimbursement obligations not necessarily credited. And if the insurer happened to tender the funds to the Medicare beneficiary in hopes that they would find their way to Medicare and they did not, then under 42 C.F.R. § 411.26, the insurer may just have to satisfy that reimbursement obligation again. So it is ridiculous for a federal court to penalize an insurer-defendant to the tune of $184,514.24 for not being able to satisfy the reimbursement obligations before the plaintiff, knowledgeable of the defendant’s efforts, is able to run to the courthouse and file suit.

148. Id.
150. See Estate of McDonald, 2014 WL 4365209, at *1.
IV. PURSUING CLARIFICATION

A. Courts Must Understand CMS Practices and Policies to Make Informed Rulings

Right or wrong, this precedent is controlling, and so long as the MSP is being interpreted to the advantage of the Medicare program, there is little hope of congressional intervention to clean up the inconsistencies in the statute. Due to this lack of clarity and because the courts' conclusions support the strong public policy of preserving the Medicare program, the opinions are wrong per se. However, the problem is that it is not proper for the courts to legislate from the bench and that is exactly what they are currently doing. The statute clearly states that MAOs may bill for reimbursement, yet the courts are finding congressional intent for much greater reimbursement rights despite the lack of tangible proof. Whether Congress purposefully did not grant an express private cause of action for MAOs or it was merely an oversight, the fact of the matter is that the express statutory language and lack of proof of congressional intent both point to the fact that the Third Circuit precedent is overreaching. Of course MAOs would want the same recovery rights as traditional Medicare, but if Congress did not provide them, then it is not for the courts to grant them.

The best hope for resolution of this issue will have to come from the Supreme Court. For it to reach that stage, there will need to be more conflict among the circuits. Unfortunately, that is no easy feat. The Supreme Court has been extremely reluctant to take up an MSP case, having denied both cases that petitioned for certiorari in recent years. The first involved a challenge to the amount of reimbursement owed, as CMS refused to compromise and the reimbursement nearly exhausted the entire settlement amount, leaving the beneficiary with next to nothing. The second was the In re Avandia case referenced above. Unfortunately, due to the fact that administrative procedures must be exhausted, it takes a very long time to get to court. While the process varies slightly for Medicare Advantage, its appeals process merges with

153. See In re Avandia, 685 F.3d 353.
traditional Medicare in adjudication before an administrative law judge, for which there is currently a seven-year backlog of cases. Therefore, it could be a decade before today’s Medicare Advantage issues will be heard before a court and be in the pipeline nearing the judicial review stage.

To create the needed conflict, the cases will have to articulate why the Third Circuit decision is misinformed and overreaching. One of the primary reasons that the courts reach such conclusions is their lack of personal expertise in dealing with the Medicare program. Interpreting Medicare statutes and regulations in a vacuum is idealistic when the realities of the government bureaucracy are unknown. It is impossible to hold someone accountable for violating the statute or regulation when it is the agency that caused the delay or frustrated the process. But that is exactly what the courts are being asked to do.

Take, for example, Estate of Clinton McDonald v. Indemnity Insurance Co. of North America, referenced above.154 While there is nothing wrong with the court’s strict interpretation of the MSP permitting double damages, the fact of matter was that the plaintiff took advantage of the situation by filing suit in the middle of the process with CMS. It was not as if the defendant was not trying to resolve the issue and reimbursement was made as soon as demand was received, but the court still awarded the estate double damages.155 The court concluded that it was the suit that compelled payment and also that double damages cannot be avoided after suit is filed by only paying single damages to Medicare.156 But for the CMS process being so convoluted and time consuming, the defendant could likely have resolved the issue long before the private cause of action was filed and no such damages would have been owed. So one can only conclude that the plaintiff filed purely to profit and not to obtain reimbursement for Medicare, as that process was already underway at the time of filing. The amount of $184,514.24 is certainly punitive, but perhaps an award of attorney’s fees may have been more appropriate.

155. Id. at *5.
156. Id.
B. Courts Must Understand What MAOs Are and How They Operate Before Assuming Congressional Intent

1. MAOs Offer the Same Benefits but Operate Very Differently and Totally Independently of CMS

With regard to MAOs, to affect better outcomes, the courts need a better understanding of the MAOs' relationship with CMS before assuming that Congress intended them to operate the same as traditional Medicare. MAOs operate somewhat autonomously of the federal government. While CMS does not provide any direct Medicare benefits and even contracts out its fee-for-service traditional Part A and B benefits, it maintains a certain amount of oversight. On a day-to-day basis, the federal government has no actual knowledge of benefits provided by the MAOs. The MAOs and the government do not regularly share claim data. If an insurer requests conditional payment information from the government and it turns out the beneficiary is enrolled in a Medicare Advantage plan, the results will be zero, even if benefits were paid by the MAO. If an enrollee has a problem with a benefit determination, he must first seek reconsideration from the MAO before he enters the Medicare appeal process. Even the Third Circuit noted the distinction between the permissive language used when establishing rules for the independent MAOs compared to the mandatory language used when creating rules for the Secretary, over whom Congress exercises control.\footnote{157} With so many differences in the infrastructure of the two delivery models, there is little justification for the courts to arrive at the conclusion that Congress intended them to both have the same recovery rights.

2. Recovery Practices Can Never Be the Same, as MAOs Do Not Have Access to Other Federal Agencies

One of the most telling facts suggesting that the courts' assumptions are misguided is that the MAO recoveries are not subject to federal debt collection laws. Any payment made by Medicare in contravention to the MSP is by definition an overpayment, and no different from any other payment made by the U.S. government that should not have been made. While the MSP contains some very specific recovery rights, at all times they

\footnote{157. \textit{In re Avandia}, 685 F.3d at 361.}
are overpayments subject to standard federal debt recovery laws. If a conditional payment reimbursement demand by CMS goes unanswered for 180 days, it must be referred to the Department of Treasury pursuant to the Debt Collection Improvement Act of 1996. If Treasury is unsuccessful in obtaining reimbursement, the claim is referred back to CMS or to the Department of Justice if it believes that litigation under the MSP would be successful in recovering the debt.

In contrast, MAOs are responsible for their own debt collections, as they do not have access to the Departments of Treasury or Justice. In practice, most MAOs utilize ordinary collection agencies allegedly specializing in health care recoveries. And like most collection agencies, they are unrelenting in their demands for payment with little regard to the legalities that give rise to the claim. They send generic letters seeking claim data that someone seeking reimbursement would have, making it obvious that the MAO has not been given sufficient information by CMS about the injury or illness subject to secondary payer provisions. The letters also generally cite a number of statutory and regulatory provisions that look intimidating; however many do not even apply to the situation.

To make matters worse, some MAOs have taken a recovery position that exceeds that of the federal government. Aetna, for example, includes a provision in its evidence of coverage stating that it shall be entitled to full reimbursement on a first-dollar basis from any payments, regardless of the effect on the beneficiary, and that the plan is not required to participate in or pay any costs or attorney’s fees incurred in pursuit of the recovery. Even if Medicare proper is entitled to full reimbursement regardless of any other facts, CMS is required to reduce Medicare recoveries by procurement costs. How can an MAO contractually establish an

159. See id. § 3711(g)(4)(A), (C).
exemption from a regulation to which Medicare proper is obligated? If Medicare Advantage is in fact Medicare and governed by the Medicare Act, federal preemption would negate the MAO’s own “contract” provisions with its enrollees. So which is it, are MAO rights the same as or greater than those of the Secretary?

3. **Harboring Private Sector Efficiencies Should Include Collections Practices**

It makes little sense for courts to assume that private health insurers need the threat of double damages to effectively obtain reimbursements. Part of the rationale for using the private sector to administer Medicare benefits is to harness its efficiencies, meaning that a smaller provider should be able to effectively coordinate benefits for its limited number of enrollees and not make as many improper overpayments. The federal government serviced nearly 38 million Medicare beneficiaries in 2014, whereas all Medicare Advantage plans collectively only serviced 15.7 million beneficiaries. In that year, six insurers serviced 72% of that total: United Healthcare (20%), Humana (17%), Blue Cross Blue Shield (BCBS) affiliated plans (17%), Kaiser Permanente (8%), Aetna (7%), and Cigna (3%). So of all Medicare Advantage enrollees, Aetna serviced only about 1.12 million. While still a considerable number of people, it is certainly not 38 million. The United States needs to encourage involved parties to initiate recoveries on its behalf because it does not have the resources to actively monitor and take action in the claims of 38 million people. It is not rational to believe that Congress intended to provide a private insurer—which has entire departments devoted to all recoveries (not just secondary payer recoveries) and services such a limited number of Medicare beneficiaries—with exactly the same provisions intended to assist the government’s vast recovery efforts. As the magistrate in *McDonald* noted, the idea was to capture the efficiencies of the private sector, not duplicate the government program. And that included utilizing their efficient subrogation practices.

There remains one other fundamental problem courts will soon have trouble reconciling when assuming congressional intent regarding MAOs. Pursuant to the Saving Medicare and Repaying Taxpayers (SMART) Act of 2012, the “Secretary shall maintain and

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164. *Id.*
make available to individuals to whom items and services are furnished under this title . . . access to information on claims for such items and services (including payment amounts for such claims) . . . . Such access shall be provided . . . through a website . . . .”

The statute goes on to outline a process through which parties can self-determine conditional payment reimbursement amounts that can be relied upon at settlement. As stated above, because MAOs and Medicare proper do not share claim data, the Medicare Secondary Payer Recovery Portal (MSPRP) created by CMS will not be helpful in self-determining Medicare Advantage conditional payments. So on January 2, 2016, when the first suit is filed against an MAO for violating the Medicare Act by not providing web access to conditional payment information, what will the courts’ position on congressional intent be then?

It is not disputed that Medicare Advantage is in fact Medicare. Medicare Advantage plans are created by Part C of the Medicare Act and, as such, should be viewed as fundamentally the same as traditional Medicare from a base benefits standpoint. MAOs must provide exactly the same benefits as the government but may provide benefits in excess of what the government-run program provides. The idea of capturing the efficiencies of the private sector is that private health insurers have networks and pharmacy and durable medical equipment plans that cost less and provide better services than the government program; therefore, if the government can pay those insurers to provide benefits for those beneficiaries that elect to participate, everyone wins. If an MAO can incentivize more enrollments through enhanced benefits, the chances of it profiting from beneficiaries who underutilize benefits will likely increase. It is important to never lose sight that these are private health insurance companies in the business of making money.

The courts have generally agreed that the purpose of the MSP is to help the government recover conditional payments, with the idea being that the beneficiary is more aware of who may be responsible for his expenses and, without the double damages provision, may not be motivated to pursue the primary payer on

165. 42 U.S.C. § 1395y(b) (2) (B) (vii) (II) (2012); see also 42 C.F.R. § 411.39(b).
the government's behalf. But an MAO does not require the same incentive, as its profitability should serve as sufficient motivation to spur its recovery actions. Because the MAO has the same powers as the Secretary, it is completely within an MAO's power to elect to waive or compromise recoveries, again affecting nothing but its own bottom line. With the capitation rate fixed, how an MAO elects to make business decisions should be irrelevant to Congress so long as it provides at least the same benefits as traditional Medicare.

V. CONCLUSION

Not only is there no evidence of congressional intent to provide MAOs a private cause of action in federal court under the MSP, there was no reason for it given their total autonomy from the federal government. The Third Circuit in In re Avandia actually relied upon the absence of express congressional intent to arrive at its conclusion that, had Congress wanted to deprive MAOs of the right to bring a private cause of action, it could have done so. Clever as that argument may be, it is not for the courts to legislate from the bench and the law only expressly provides MAOs with the right to bill for reimbursement. Medicare HMOs, Medicare Advantage's predecessor, operating under nearly identical statutory provisions, were held by the Sixth Circuit in 2003 to have only a contractual right of reimbursement. Yet some courts use the existence of Medicare HMOs prior to the enactment of the MSP to show that Congress was aware of such private entities providing Medicare benefits and obviously intended MSP recovery rights to include them. The courts have resorted to disregarding the express group health plan condition in the private cause of action because reading it otherwise would exclude non-group health applications. However, when the MSP was revised in 1986, Congress did expressly itemize all forms of non-group health plans, and it was when Congress subsequently renumbered the MSP sections that the conflicting language was created. Without evidence of congressional intent to the contrary, how can one know that

168. See, e.g., Stalley v. Catholic Health Initiatives, 509 F.3d 517, 524–25 (8th Cir. 2007).

169. Care Choices HMO v. Engstrom, 330 F.3d 786 (6th Cir. 2003). Although the court cites 42 U.S.C. § 1395mm(e)(4), the provisions found in § 1395w-22(a)(4) are nearly identical and the conclusions should be the same.
Congress did not purposefully change the application to only group health plans? Right or wrong, the statute unambiguously says what it says. It is up to Congress, not the courts, to change the law.