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ALERT

Section 111 Bulletin: Court Denies Federal Private Right of Action to Medicare Advantage Plan Seeking to Step Into Secondary Payer Shoes of Medicare to Sue Liability Insurer

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The United States District Court for the Eastern District of Pennsylvania joined a small but growing number of federal courts in rejecting a Medicare Advantage organization's (MAO's or MA Plan's) assertion of a private right of action under the Medicare Advantage Program's secondary payer provisions. Judge Cynthia Rufe, in a Memorandum Opinion, dismissed an MA Plan's suit against a primary payer for reimbursement of conditional payments made by the Plan on behalf of Medicare beneficiaries enrolled in its managed care alternative to the traditional, fee-for-service Medicare program. The Court held that the Plan had failed to state a claim upon which relief can be granted, finding that an MA Plan has no private right of action under federal law to assert a direct action against a primary payer, notwithstanding Medicare regulation and guidance to the contrary.

Judge Rufe's ruling in *In re Avandia Marketing Sales Practices and Products Liability Litigation, Humana v. GlaxoSmithKline*, No. 10-6733, 2011 WL 2413488 (E.D. Pa. June 13, 2011), may be the tipping point that compels CMS to seek Congressional amendment of the MA Program's secondary payer provisions. It also raises the likely question of whether CMS may require non-group health plans (NGHPs), under Section 111 of the Medicare and Medicaid SCHIP Extension Act of 2007 (Section 111), to report their payments to MA Plan beneficiaries. NGHPs include liability insurers (including self-insured entities), no-fault carriers and workers' compensation plans.

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The *Humana* case arose out of settlements between GlaxoSmithKline, a self-insured entity, and plaintiffs, some of whom were enrollees in Humana's MA Plan, for injuries allegedly sustained through use of certain diabetes medications. Although the underlying settlements reimbursed Medicare for its conditional payments for medical services rendered to beneficiaries enrolled in the traditional Medicare program (Parts A and B of Medicare), these settlements did not reimburse MA Plans insuring beneficiaries under Part C of Medicare. Humana thus filed suit to enforce its assumed right as a secondary payer under the Medicare Secondary Payer (MSP) statute to obtain reimbursement from GlaxoSmithKline of the conditional payments Humana had made to settling plaintiffs enrolled in its MA Plan.

In asserting a private right of action against GlaxoSmithKline, Humana relied on the statutory provisions that created the Medicare Part C Program, 42 U.S.C. § 1395w-22(a)(4), and its implementing regulations, along with the MSP statute at 42 U.S.C. § 1395y(b)(3). Both these sections of Title 42 amended provisions of the Social Security Act that created the traditional Medicare Program in the 1960s. The MSP statute, enacted in 1980, specifically created a private cause of action to enforce the right to recover conditional payments made by Medicare, including the right to obtain double damages. 42 U.S.C. § 1395y(b)(3)(A). The Medicare Part C provisions refer to the earlier MSP statute in establishing an MA Plan's rights as a secondary payer, stating that where a payment is made secondary pursuant to the MSP statute, an MA Plan "may" seek reimbursement from the primary payer. 42 U.S.C. § 1395w-22(a)(4). Additionally, a Part C Program regulation expressly vests an MA Plan with the same rights of recovery held by the Secretary of the Department of Health and Human Services (HHS) under traditional Medicare under the MSP regulations, including the right to bring "a direct right of action to recover [conditional payments] from any primary payer." 42 C.F.R. § 411.24(e). Guidance from CMS echoes this purported vesting of direct action rights. CMS, Medicare Managed Care Manual, Ch.4, § 130.7 (Rev. 94, Dec. 3, 2010). Thus, Humana argued, relying on both regulation and CMS guidance, an MA Plan stands in the shoes of the Secretary of HHS for purposes of the MSP rules and may assert a federal cause of action to recover from a primary payer.

The court soundly rejected this argument for three reasons. First, it noted that unlike the MSP statute, the Part C Program's statutory provision that gives an MA Plan the right to seek reimbursement of conditional payments from a primary payer is permissive rather than mandatory, and does not incorporate the full remedies of the MSP statute. Second, the court determined that while MA Plans have neither an explicit nor implied federal right of action against a primary payer, they do have a remedy under state contract law, at least with respect to recovery of conditional payments from the Plan member and possibly from a primary payer through rights of subrogation. Slip. Op. at 6-7.

Most significantly, the court held that the Part C implementing regulation, 42 C.F.R. § 422.108(f), is an impermissible construction of the Part C statute to the extent the HHS Secretary attempted to grant a private right of action to MA Plans. Slip Op. at 12-13. Given the court's determination that Congress had decidedly not created such a private right of action, the court concluded that this reticence was intentional and not an oversight resulting in ambiguity. It rationalized that because the Part C statutory provisions contain an express right to demand payment from primary payers but are silent as to enforcement mechanisms, Congress's silence "indicates its intent not to create a private right of action for [MA Plans], instead leaving [MA Plan's] to

enforce their rights as secondary payers under the common law of contract." Moreover, the Court reasoned, even if Congress's intent was ambiguous, "the Secretary cannot create a right Congress has not created". Slip Op. at 13.

Although the *Humana* case is consistent with earlier federal decisions, such as those reached in *Nott v. Aetna U.S. Healthcare, Inc.*, 303 F. Supp. 2d 565 (E.D. Pa. 2004), [1] and *Care Choices HMO v. Engstrom*, 330 F.3d 786 (6th Cir. 2003), both of which rejected implied private rights of action for MA Plans, it is the first case to declare 42 C.F.R. § 422.108(f) an improper exercise of the Secretary's rulemaking authority to the extent it purports to authorize a private right of action. Two recent district court opinions rejecting implied private rights of action for MA Plans did not find it necessary to invalidate 42 C.F.R. § 422.108(f). In *Humana Medical Plan, Inc. v. Mary Reale*, No. 10-21493 2011 WL 335341 (S.D. Fla. Jan. 31, 2011), the court held that the United States, not the Secretary, is vested with authority to bring an action for private payer reimbursement of conditional payments, and thus stepping into the Secretary's shoes does not grant an MA Plan a private right of action. Similarly, in *Parra v. Pacificare of Arizona*, No. 10-008 2011 WL 1119736 (D. Ariz. Mar. 28, 2011), the court held that the statutes at issue stop short of creating a private right of action, as "Congress and the Secretary did no more than protect [an MA Plan's] right to charge and/or bill a beneficiary for reimbursement . . . ." 2011 WL 1119736 at *5.

As the result of the recent holdings either narrowing the interpretation of the Part C regulation or outright rejecting it, CMS may face pressure from MA Plans to provide them the same rights and protections afforded to Medicare under Parts A and B if Medicare wants private entities to continue to underwrite the managed care side of the Medicare Program. These federal contractors will argue that they relied upon Medicare regulation and guidance when they entered into their Part C contracts with CMS, and their capitation rates per enrollee assume full MSP rights of recovery and enforcement. Such a remedy, however, would require Congressional action, action which is unlikely in the current political environment.

From a practical perspective, the recent federal decisions may embolden decisions by non-group health plans (NGHPs) to decline to respond to demand letters from MA Plans if settlement funds or liability payments already have been disbursed to the claimant/enrollee. If such funds have not been paid out, MA Plans could still bill primary payers but would lack any enforcement option in federal court under Medicare law if other courts follow in *Humana*'s footsteps. Rather, an MA Plan must be content to resort to bringing state law or common law contract claims against its enrollees, or a subrogation action against NGHPs, to recover its conditional payments. Because Medicare has had limited success in pursuing Medicare beneficiaries for conditional payments, this remedy alone is also unlikely to be satisfactory to MA Plans.

Given the partial invalidation of the Part C regulation by the *Humana* Court, 42 C.F.R. § 422.108(f), we also question whether additional judicial challenges to the Part C regulations are soon to follow. The Part C statutory provisions permit an MA Plan to seek recovery of conditional payments from the provider or authorize the provider to bill the primary payer or the claimant for its services (to the extent the claimant has been paid by the primary payer)-they say nothing about the MA Plan billing a primary payer directly for the conditional payments. *See* 42 U.S.C. § 1395w-22(a)(4). Could a challenge to the regulation that authorizes

MA Plans to bill or seek collection *directly* from primary payers in court be far behind?

Another question that follows logically from the *Humana* decision is whether CMS has authority under Section 111 to require NGHPs to report payments to MA Plan enrollees in addition to enrollees in traditional Medicare. CMS has answered this question during several Section 111 town hall conference calls, as recently as March 9, 2011, instructing NGHPs to report payments they make to all Medicare beneficiary claimants, regardless of the Medicare program (managed care or traditional fee-for-service) in which they are enrolled. Without addressing whether Congress intended Section 111 to sweep this broadly, CMS has explained that it is not uncommon for Medicare beneficiaries to switch their enrollment from time to time between MA Plans and traditional Medicare. For this reason, CMS believes an individual enrolled in an MA Plan at the time of settlement may have been enrolled previously in traditional Medicare and thus a portion of the settlement funds may be compensation for medical expenses incurred during that earlier time and thus reportable under Section 111. This scenario could arise, for example, during extended class-action periods. The question avoided by CMS and perhaps headed for judicial review is whether an NGHP must report a settlement to a claimant who has only received Medicare benefits under an MA Plan. An argument might be advanced that if the MA Plan has no right of recovery against the NGHP, then the NGHP should not bear the cost of Section 111 reporting. Indeed, the settling MA Plan beneficiary will owe an obligation under its Plan policy to report the settlement to the Plan and, if appropriate, reimburse the Plan for any conditional payments.

As shown by the *Humana* decision and its possible implications, there are many issues that intersect both MSP situations and Section 111 reporting that will continue to evolve and demand our attention in the coming months.

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[1] The *Nott* court reasoned that no private right of action exists because the Medicare statute contains no provision creating a cause of action for MA Plans to pursue their recovery rights against primary payers in litigation. *Nott,* 303 F. Supp. 2d at 570. But unlike *Humana, Nott* was decided before 42 C.F.R. § 422.108(f) was amended in 2005 to include the statement that "[t]he 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" which the *Humana* court partially invalidated.