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Casualty Insurers And Drug Plans: Medicare Secondary Payer Ties That Bind Under SPARC Act

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It is premature to say whether H.R. 1122, the SPARC Act, will be a constructive catalyst for change in the interactions of casualty insurers and Medicare Part D drug plans, both of which play important insurer roles in the Medicare program. Although this bill is not tied to or dependent upon any health care reform legislation, it could get stalled by initiatives to repeal and replace the Affordable Care Act or be promoted as a bipartisan opportunity to improve the Medicare program without adding to the federal deficit. Before it can become the latter, certain inconsistencies in the bill's provisions need to be addressed.

On February 16, 2017, Representatives Tim Murphy (R-PA) and Ron Kind (D-WI) reintroduced the *Secondary Payer Advancement, Rationalization, and Clarification Act* (the SPARC Act) in the U.S. House of Representatives.[1] They first introduced nearly identical Medicare legislation in the waning months of 2016 that expired at the end of the last congressional term.[2] The bill would amend the Social Security Act provisions that established the Medicare Prescription Drug program (known as Medicare Part D) in 2006 and authorized the offering of Part D drug plans by private entities. Today, more than 40 million Medicare beneficiaries are enrolled in a Part D plan.

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The bill's sponsors state that the SPARC Act would "improve the Medicare Secondary Payer (MSP) statute and clarify its application to the [Part D] program," specifically the secondary payer status of a Part D plan and its right to seek reimbursement of drug payments from primary payers (including casualty insurers) identified by the MSP statute.[3] Armed with this legislation, plans presumably could recover greater amounts of drug expenditures from primary payers than they do today, at a time when skyrocketing drug expenditures are adding to the federal deficit.[4] But as we discuss below, the bill leaves some important questions unanswered, albeit perhaps unintentionally. Before finalizing the bill, lawmakers should consider resolving apparent inconsistences in the legislation that sow confusion and appear to work against the sponsors' bipartisan goal of more efficient administration of an unwieldy MSP regulatory scheme.

Status and Overview of the Bill

H.R. 1122 has been referred to both the Committee on Ways and Means and the Energy and Commerce Committee's Health Subcommittee, with the latter designated as the committee of primary jurisdiction. To date, no companion bill has been introduced in the Senate. Because no further legislative activity is imminent, there is time for Reps. Murphy and Kind to fully consider and address the issues with their bill.

If the bill is enacted, the Centers for Medicare & Medicaid Services (CMS) would be required to share with Part D plans certain settlement and other payment information reported by liability, no-fault, and workers' compensation insurers (all primary payers under the MSP statute) in compliance with Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Section 111).[5] This information would facilitate a Part D plan's recovery of prescription drug payments it made *before* learning of the existence of a primary payer (these payments are referred to as "conditional payments;" *see* 42 U.S.C § 1395y(b)(2)(B)). For example, when a casualty insurer settles a lawsuit and receives a release of liability for the bodily injury or emotional harm alleged by a Medicare beneficiary, and the Part D plan can establish its payment of drugs for the released injury, the plan may pursue reimbursement from the casualty insurer. But the path of that pursuit is not entirely clear, even with assistance from the SPARC Act.

Some say this bill is long overdue. Prescription drug costs now account for approximately 17% of total U.S. personal healthcare spending, and that number is expected to rise in coming years.[6] Part D costs accounted for 14% of all Medicare benefit payments in 2016.[7] The legislation thus may be welcomed by Part D plans — which often do not pursue reimbursement of drug payments due to lack of timely information regarding primary payers and the related high cost of pursuit — but it may not be fully welcomed without amendment. It appears to shut the door on any argument that a Part D plan may file a private right of action against Medicare beneficiaries and casualty insurers for failure to reimburse the plan's conditional payments or accept ongoing responsibility for drug payments. That right is enjoyed today by Medicare Advantage (MA) plans[8] in certain federal circuits when they seek reimbursement of their payment of Medicare Part C medical items and services. Many believe that right also extends under existing law to Part D plans, some of which are sponsored by the same entities that sponsor MA plans.[9]

For casualty insurers and Medicare beneficiaries, enacted legislation would mean that yet another party could be seeking conditional payment reimbursement from a limited pool of insurance funds, with related costs likely to rise. Unlike Part D plans, these insurers are likely to welcome the removal of any threat of Part D private causes of action.

The Bill Up Close

Medicare Secondary Payer law applies to the Medicare Part D program "in the same manner" as it applies to the Part C Medicare Advantage program. *See* 42 U.S.C. § 1395w-102(a)(4). This short statutory clause has engendered much debate over how Part D plans may enforce their secondary payer status and collect their prior drug payments from group and non-group health plans with primary payer status. Today, if Part D plans even learn of the existence of a potential primary payer (typically from their insureds), the cost of collection efforts often exceeds collections. The bill's sponsors believe they are providing the clarity that will end the debate.[10]

Subrogation Rights

The SPARC Act specifies that a "a prescription drug plan shall be subrogated . . . to any right of an individual [a Medicare beneficiary] or any other entity to payment, with respect to such covered part D drug, under a primary drug plan." A "primary drug plan" is defined elsewhere in the SPARC Act, consistent with the MSP statute, to include both "group health plans" and "non-group health plans," the latter of which includes liability, no-fault, and workers' compensation carriers. The bill then states that a "subrogation claim shall be the *exclusive legal remedy* of the PDP sponsor of the plan ...." (Emphasis added.) Intentionally or unintentionally, this language appears to reduce rights that some Part D plans believe they have today.

As we noted earlier, existing Part D legislation provides that MSP laws apply to the Medicare Part D program "in the same manner as they apply under Part C of this subchapter."[11] In a December 5, 2011 memorandum, CMS confirmed that PDP sponsors have the same Medicare Secondary Payer rights and responsibilities as MA plans.[12] Accordingly, one could conclude that if MSP law, specifically 42 U.S.C. § 1395y(b)(3)(A), allows MA plans under Part C to file private actions against both Medicare beneficiaries and casualty insurers to recover conditional payments (with a possible award of double damages), as two federal circuit Courts of Appeals have to date held, then MA plans under Part D also may file suit against primary payers. Certainly, the circuit court opinions in *In re Avandia* and *Humana* support this conclusion.[13]

But contrary to this conclusion, as quoted above, the SPARC Act directs that a subrogation claim shall be the *exclusive* legal remedy of the Part D plan. That language, on its face, would amend the above-cited MSP provision that affords Part D plans the same rights and remedies as Part C plans. Part C plans today are not limited to filing subrogation claims to recover conditional payments as would Part D plans moving forward under the SPARC Act. But perhaps that was not the intended clarity of the SPARC Act.

Subrogation is the act of one party claiming the legal rights of another for whom it has reimbursed losses. Stated another way, it is the act of one party stepping into the legal shoes of another to pursue a legal claim. That understanding leads to two conclusions when interpreting the SPARC Act. First, if a Medicare beneficiary

has already settled his or her claim with (or otherwise received insurance payment from) a primary payer—which is the event that triggers both the primary payer's obligation to report payment information to CMS under Section 111 and CMS's corresponding obligation, under the SPARC Act, to convey that information to the Part D plan[14]—then the Part D plan has no subrogation claim to pursue. There simply are no beneficiary shoes into which the Part D plan can step. Second, unlike an MA plan, the Part D plan would not have further recourse against the casualty insurer in federal court, which it would have if the court followed the legal reasoning of *In re Avandia* and *Humana Medical Plan, Inc.* The Part D plan's sole remedy would appear to be to seek reimbursement from the beneficiary if permitted under its insurance policy. In sum, the only time subrogation would appear to be a valid option for a Part D plan under the SPARC Act would be if (i) the Medicare beneficiary had, on his or her own, informed the Part D plan of the existence of a *pending* claim against a casualty insurer, or (ii) the beneficiary, not the casualty insurer, had informed CMS of this information and CMS then passed that information to the Part D plan *before* the beneficiary received payment form the insurer. Of note, the SPARC Act does not require CMS to share that information at that time with the Part D plan. One must ask if this was the intended clarity sought by the bill's sponsors.

There is further support for the conclusion that the sponsors did not intend to use the term "subrogation" in its full legal sense. The Act states that a subrogation claim "shall be reduced to take into account the [beneficiary's] cost of procuring the judgment or settlement with respect to such claim if an individual's liability, workers' compensation, or no-fault claim is disputed." If the beneficiary has incurred costs to procure a judgment or settlement, then the Part D plan would not be in a true subrogation posture; there would be no unclaimed legal rights left for the plan (or its sponsor) to pursue. Given the growing divide among courts as to the proper use of the *Chevron* doctrine to interpret ambiguous legislation, we strongly encourage the bill's sponsors to more carefully articulate their intent – exactly what rights will a Part D plan have to recover conditional payments? Both Part D plans and casualty insurers have a real interest in that answer.

Coordination of Benefits

The bill's sponsors also highlight the imposition of coordination of benefits (COB) requirements on CMS and Part D plans. As noted above, CMS would be required to share the Section 111 payment information it receives with Part D plans, as it does today with MA plans, within fifteen days of receipt. In turn, Part D plans would be required to instruct pharmacies or other entities providing prescription drugs to bill directly any entities, like no-fault and workers' compensation carriers, that have accepted an ongoing responsibility to pay a beneficiary's prescription drug benefits, thus avoiding the need to pay and chase.

Expedited Repayment Process

The SPARC Act would offer Part D plans aware of a pending casualty claim[15] the opportunity to join in the optional expedited repayment process for conditional payments heralded by the SMART Act of 2012.[16] Under that process, the parties settling a liability claim may request a *final* conditional payment demand from CMS *before* reaching settlement. Prior to issuance of the SMART Act regulations, CMS would only provide *tentative* repayment numbers before settlement of its Part A and Part B reimbursement demands.[17]

HHS as Bill Collector

Finally, under certain identified circumstances, the bill would permit the Secretary of Health and Human Services (HHS), on behalf of Part D plans, to collect from primary payers any outstanding reimbursement for conditional payments. It is not clear from the legislation how this process would work, or whether it might apply to situations where Part D plans have no subrogation rights and cannot pursue reimbursement on their own. Whether CMS would even have the necessary resources to play this role is a question for Congress and administration officials involved in authorizing and appropriating the agency's budget.

Industry Comments

The Medicare Advocacy Recovery Coalition (MARC), a diverse group of organizations with business interests in the secondary payer community, has been an active supporter of the SMART Act and now the SPARC Act. MARC has commented that the SPARC Act will "significantly improve the efficiency of the current MSP system and speed repayment of amounts owed from Medicare beneficiary claims directly to [Part D plans]."[18] We fail to understand how such efficiency will be gained if CMS is not required to share primary payer information it may have with Part D plans until after casualty insurers report under Section 111, by which time most insurers will have settled or paid beneficiary claims. At that time, subrogation rights will not be helpful to Part D plans. That leaves only CMS's invitation for Part D plans to join in the optional expedited repayment process, but that is an efficiency dependent upon the beneficiary choosing to commence the process.[19]

We do note MARC's comment that the new Part D "subrogation right is the same as that Congress has given to the federal government in the Part A/B statute, 42 U.S.C. § 1395(y)(b)(2)(B)(iv), clarified to apply specifically to prescription drugs."[20] That is true, but Congress gave CMS additional statutory rights of far greater value, including the right to sue a primary plan directly for reimbursement of conditional payments. 42 U.S.C. § 1395 (y)(b)(2)(B)(iii).

Conclusion

When he introduced the original bill in the fall of 2016, Congressman Murphy promised that the SPARC Act would "work to ensure that Medicare beneficiaries, entities settling claims with beneficiaries, and the Part D Plans providing medications to beneficiaries can all come out ahead."[21] Whether casualty insurers and Part D plans will really "come out ahead" is not yet clear.

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[1] See https://www.congress.gov/115/bills/hr1122/BILLS-115hr1122ih.pdf.

[2] See https://www.congress.gov/114/bills/hr6120/BILLS-114hr6120ih.pdf.

[3] See https://murphy.house.gov/latest-news/reps-murphy-kind-continue-advancing-common-sense-medicare-reforms2.

[4] See https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/reports/51129-2016outlookonecol-2.pdf.

[5] See https://www.cms.gov/medicare/coordination-of-benefits-and-recovery/mandatory-insurer-reporting-for-non-group-health-plans/overview.html.

[6] *See* https://aspe.hhs.gov/sites/default/files/pdf/187586/Drugspending.pdf.

[7] *See* https://www.cbo.gov/sites/default/files/recurringdata/51302-2017-01-medicare.pdf.

[8] MA plans offer Medicare beneficiaries a managed care alternative to original Medicare benefits under Parts A and B.

[9] That extension follows logically from the decisions of the Third Circuit Court of Appeals in *In re Avandia Marketing*, 685 F.3d 353 (3d Cir. 2012), and the Eleventh Circuit in *Humana Medical Plan, Inc. v. Western Heritage Ins. Co.*, No. 15-11436 (11th Cir. August 8, 2016). *See also* http://www.wileyrein.com/newsroom-articles-11th-Circuit-Humana-Decision-Adopts-3rd-Circuit-Avandia-Approach.html.

[10] *See* https://murphy.house.gov/latest-news/reps-murphy-kind-continue-advancing-common-sense-medicare-reforms2/.

[11] 42 U.S.C. § 1395w-102(a)(4) (citing 1395w-22(a)(4), the secondary payer provision for Part C). *See also* 42 C.F.R. § 422.108(f).

[12] *See* https://www.cms.gov/Medicare/Health-Plans/HealthPlansGenInfo/downloads/21_MedicareSecondaryPayment.pdf.

[13] *In re Avandia Marketing*, 685 F.3d 353 (3d Cir. 2012); *Humana Med. Plan, Inc. v. W. Heritage Ins. Co.*, 832 F.3d 1229, 1231 (11th Cir. 2016). Read our analysis of these two decisions at http://www.wileyrein.com/newsroom-articles-11th-Circuit-Humana-Decision-Adopts-3rd-Circuit-Avandia-Approach.html and http://www.wileyrein.com/newsroom-articles-11th-Circuit-Humana-Decision-Adopts-3rd-Circuit-Avandia-Approach.html.

[14] See https://www.congress.gov/115/bills/hr1122/BILLS-115hr1122ih.pdf.

[15] As discussed above, the SPARC Act does not require CMS to give Part D plans notice of any pending group or non-group health plan claims.

[16] MEDICARE IVIG ACCESS AND STRENGTHENING MEDICARE AND REPAYING TAXPAYERS ACT OF 2012, PL 112-242, January 10, 2013, 126 Stat 2374.

[17] CMS explains the Demand Calculation Options at https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Beneficiary-Services/Demand-Calculation-Options/Demand-Calculation-Options-page.html; read our Section 111 Bulletin covering the SMART Act's passage at http://www.wileyrein.com/newsroom-articles-2564.html.

[18] See http://www.marccoalition.com/newsroom/marc-coalition-supports-introduction-of-the-secondary-payer-advancement-rationalization-and-clarification-act-sparc-act-hr-6120.

[19] See http://www.marccoalition.com/uploads/8/4/2/1/8421729/sparc-act.pdf.

[20] See note 19.

[21] See https://murphy.house.gov/latest-news/murphy-kind-introduce-bipartisan-bill-to-bring-common-sense-to-medicare-help-seniors1/.

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