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ALERT

Section 111 Bulletin: Summer Round Up On Notable Medicare Reporting And Reimbursement Developments For Property And Casualty Insurers

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It has been a slow year overall for guidance from the courts and the Centers for Medicare & Medicaid Services (CMS) on the reporting and reimbursement obligations of property and casualty insurers under the Medicare Secondary Payer (MSP) statute. Long awaited regulations that will define civil money penalties (CMPs) under Section 111 and how Medicare enrollees may "protect Medicare's interests" and meet their MSP obligations related to "future medical care" remain lost in the bureaucratic queue. User Guide updates now issue infrequently, and Town Hall calls seem to be a thing of the past, but last month CMS made a little progress when it published an Alert that should reduce the number of reports that insurers must file when they compensate Medicare beneficiaries for pre-December 1980 losses. Further, on the litigation front, two federal Circuit Courts of Appeals recently issued decisions addressing and arguably expanding the rights of the Government or private entities to hold Medicare beneficiaries and non-group health plans (NGHPs) responsible for the primary payment of beneficiary medical expenses.

CMS Revises Prior Guidance on Settlements of Exposure, Ingestion, and Implantation Claims with Dates of Incidence Prior to December 5, 1980

On August 19, 2014, CMS issued an Alert reflecting a change in application of the December 5, 1980 effective date of the MSP statute. Whereas CMS previously explained that it looks to *all*

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Section 111 Insurer Reporting and MSP Reimbursement

pleadings to determine whether MSP reporting obligations are triggered by a settlement, judgment, award, or other payment, CMS's Alert explains that Responsible Reporting Entities (RREs) may rely on the "most recent amended complaint or comparable supplemental pleading" to determine qualification for a reporting exemption. The effect of this change thus should be to lessen Section 111 reporting to instances in which the operative pleading, and not simply any pleading, asserts exposure, ingestion, or implantation on or after December 5, 1980, the effective date of the MSP statute.

As we previously reported, CMS's prior position was that it would not assert an MSP recovery claim where the date of incident was prior to December 5, 1980. For exposure, ingestion, and implantation claims, this meant that Section 111 reporting was not required where *all* of the following criteria were met:

- All exposure or ingestion ended, or the implant was removed, before December 5, 1980; and
- Exposure, ingestion, or an implant on or after December 5, 1980 had not been claimed and/or specifically released; and
- There was either no release for exposure, ingestion, or implant on or after December 5, 1980; or where there was such a release, it was a broad general release (rather than a specific release), which effectively released exposure or ingestion on or after December 5, 1980. The rule also applied if the broad general release involved an implant.

CMS's new guidance added language to the second prong of this test, which now reads as follows (Emphasis added):

- Exposure, ingestion or an implant on or after December 5, 1980, has not been claimed **in the most recently amended complaint (or comparable supplemental pleading)**and/or specifically released.

The CMS Alert also states:

Any operative amended complaint (or comparable supplemental pleading) must occur prior to the date of settlement, judgment, award, or other payment and must not have the effect of improperly shifting the burden to Medicare by amending the prior complaint(s) to remove any claim for medical damages, care, items and/or services, etc.

Where a complaint is amended by Court Order and that Order limits Medicare's recovery claim based on the criteria contained in this alert, CMS will defer to the Order. CMS will not defer to Orders that contradict governing MSP policy, law, or regulation.

Although questions remain on specific claims scenarios involving pre-MSP statute exposures, the effect of the new CMS guidance should lessen reporting obligations on RREs.

Federal Courts Address the Reach of Medicare's Reimbursement Rights and the Ability of Private Entities To Lend CMS a Hand Under the MSP Private Right of Action

In July, the Third Circuit Court of Appeals afforded deference to longstanding CMS guidance in holding that the MSP statute authorizes CMS (or its contractors) to seek reimbursement of conditional payments from a court approved settlement between a Medicare beneficiary and a tortfeasor that apportions no funds to medical expenses. *See Taransky v. Sec'y of U.S. Dep't of Health & Human Servs.*, No. 13-3483, 2014 WL 3719158 (3d Cir. July 29, 2014). In perhaps a more noteworthy opinion from this summer, the Sixth Circuit held that a health care provider may bring a private cause of action against an NGHP under the MSP statute for failure to pay a patient's medical services even though that primary plan arguably declined to pay the services for reasons other than the patient's eligibility for Medicare benefits. *See Michigan Spine & Brain Surgeons, PLLC v. State Farm Mut. Auto. Ins. Co.*, 13-2430, 2014 WL 3440644 (6th Cir. July 16, 2014).

Michigan Spine

The Sixth Circuit's opinion in *Michigan Spine* is noteworthy because the Court departed from its narrower reading of the MSP statute's private cause of action in a 2011 opinion in which it held that a precursor to suit is a primary plan's denial of payment in contravention of MSP rules that forces Medicare to "step in" and pay for medical services as a primary payer. *Bio-Medical Applications of Tennessee, Inc. v. Central States Southeast & Southwest Areas Health & Welfare Fund*, 656 F.3d 277 (6th Cir. 2011).

The relevant provision of the MSP statute states: "[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)" of Section 1395y(b). 42 U.S.C. § 1395y(b)(3)(A) (emphasis added). The *Bio-Medical* Court strictly construed these paragraphs, explaining that a private party can recover damages from a "primary plan" (which, by statutory definition, includes both group health plans and non-group health plans) *only* when it "[1] discriminates against plan holders on the basis of their Medicare eligibility *and* [2] therefore causes Medicare to step in and (temporarily) foot the bill." Id. at 285 (emphasis added). Although *Bio-Medical* was a case brought by a provider against a group health plan, many – including the NGHP in *Michigan Spine* – interpreted the Court's reasoning to apply equally to group health plans and NGHPs The Sixth Circuit panel in *Michigan Spine* disagreed, holding that a health care provider was entitled to bring a private cause of action against an NGHP even if it had denied payment of medical expenses for reasons other than the patient's eligibility for Medicare benefits. *Michigan Spine*, 13-2430, 2014 WL 3440644 (6th Cir. July 16, 2014).

Michigan Spine had provided neurological treatment to a State Farm insured and Medicare beneficiary who was injured in an automobile accident. State Farm, a no-fault carrier or NGHP, denied payment of the provider's services on the basis that the insured's medical condition was the result of a preexisting condition for which there was no coverage. The provider responded by bringing a private cause of action against State Farm to recover damages under the MSP statute for the insurer's alleged refusal to pay primary to Medicare. The district court dismissed the action, holding that the provider's claim was foreclosed by the Sixth Circuit's

decision in *Bio-Medical* because State Farm had not taken the insured's Medicare status into account when it had denied payment.

On appeal, the Sixth Court disagreed, explaining that the particular language quoted above from *Bio-Medical* was dictum as applied to NGHPs, and thus the provider should not have been required to prove that State Farm had discriminated against its insured by taking the insured's Medicare eligibility into account. Although the Court conceded that the MSP provisions in issue were comprised of "convoluted and tortuous text," it also noted that, in providing a private cause of action, Congress intended to reduce health costs and preserve the financial integrity of the Medicare system. *Id.* at *5. To adopt State Farm's interpretation of the MSP statute would, the Court explained, "eviscerate the private cause of action as it relates to non-group health plans." *Id.*

In sum, these two appellate opinions by different Sixth Circuit panels appear to have reached divergent conclusions regarding the reach of the MSP private right of action. To date, at least one district court in another circuit has agreed with a stricter construction of the provision, as set forth in the *Bio-Medical* decision. *See, e.g.*, *Hapeville Dialysis Ctr., LLC v. City of Atlanta, Ga.*, 2013 WL 831635 (N.D. Ga. 2013). Whether a split among the circuits will develop remains to be seen.

Taransky

In this Third Circuit case, the Court held that Medicare could recover its conditional payment of medical services from funds received by a Medicare beneficiary in settlement of her bodily injury claims with a primary plan. Giving deference to longstanding CMS guidance, the Court reasoned that the state court's apportionment order did not prevent Medicare from seeking reimbursement where the order was not decided "on the merits." *Taransky v. Sec'y of U.S. Dep't of Health & Human Servs.*, No. 13-3483, 2014 WL 3719158 (3d Cir. July 29, 2014).

At issue was whether a Medicare contractor could, on behalf of Medicare, demand reimbursement from a Medicare beneficiary for the conditional payments she had received after tripping and falling at a shopping center. After reaching a settlement with the shopping center, the beneficiary had secured a state court order holding that the settlement had not compensated her for medical expenses. Appealing from both federal district court and administrative appeal findings against her, the beneficiary had argued that the MSP statute did not authorize reimbursement and that reimbursement in any event was barred by the New Jersey Collateral Source Statute (NJCCS). That statute provides that a tort plaintiff that has already received payment from another source cannot recover damages from the defendant.

On appeal, the Third Circuit affirmed the ruling for the Government. First, to the argument that a tortfeasor cannot be a "primary plan" under the MSP statute, the Court found that *Mason v. American Tobacco Co.*, 346 F.3d 36 (2d Cir. 2003), the sole decision supporting that proposition, was abrogated by the December 2003 amendments to the MSP statute. The Court reasoned that the amendments explicitly expanded the definition of "primary plan" to include certain tortfeasors, which we note is consistent with the statute's recognition that entities that choose to self-insure, or by default self-insure because they fail to secure commercial insurance, are primary plans under the MSP statute.[1] Because the Court found that the shopping center was an "entity

[presumably self-insured] that engages in a business, trade, or profession," it concluded that it was a primary plan from which the Government (via the Medicare contractor) could obtain reimbursement, despite the fact that the shopping center had no preexisting obligation to pay for the beneficiary's medical expenses. The Court also rejected the beneficiary's argument that the Government should have pursued reimbursement directly from the shopping center. Instead, because the MSP Statute explicitly provides that CMS can recover from the "primary plan" *or* "an entity [including a beneficiary] that receives payment from a primary plan," the Court concluded that Medicare's right of recovery from the beneficiary was distinct from its right of subrogation. 42 U.S.C. § 1395y(b)(2)(B)(ii).

Next, the Court rejected the beneficiary's argument that the provider could not demand reimbursement without first showing that the tortfeasor had an express duty to pay for the beneficiary's medical expenses. The Court pointed to the explicit language of the statute, which provides that "[a] primary plan's responsibility for such payment may be demonstrated by . . . release (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary plan or the primary plan's insured . . . ." *Id.* In further support, the Court noted that the Medicare Manual provides that "Medicare policy requires recovering payments from liability awards or settlements . . . without regard to how the settlement agreement stipulates disbursements should be made." MSP Manual, Ch. 7, § 50.4.4. And, in accord with the Sixth and Eighth Circuit Courts of Appeals, the Court also found that the fact that a settlement releases a tortfeasor from claims for medical expenses is enough on its own to trigger the beneficiary's obligation to reimburse Medicare.

After concluding that the settlement did compensate the beneficiary for her medical expenses and thus she could not deprive Medicare of reimbursement, the Court considered whether the NJCCS could prevent reimbursement. The Court predicted that the New Jersey Supreme Court would hold that, due to their conditional nature, Medicare payments do not constitute a collateral source of benefits under the statute. The Court supported that result by noting: (1) that the MSP statute clearly was intended to obligate beneficiaries to reimburse conditional payments made by Medicare once a primary plan is identified; and (2) that the purpose of the state statute "is not served when a beneficiary shifts the burden of payment from a tortfeasor to the Government."

Finally, the Third Circuit rejected the argument that Medicare and the Government must defer to the state court's apportionment order because the Court found that the settlement order had not been decided "on the merits." In support of its conclusion, the Court cited the MSP Manual, which states that "[t]he only situation in which Medicare recognizes allocations of liability payments to nonmedical losses is when payment is based on a court order on the merits of the case." MSP Manual, Ch. 7, § 50.4.4. In *Taransky*, the Court found that the apportionment order was the "antithesis of one made on the merits" because the state court did not adjudicate any substantive issues in the negligence suit; it simply "rubber stamped" the Medicare beneficiary's request. In short, the order deserved no deference.

Our Section 111 Team routinely covers CMS's Section 111 NGHP Town Hall Teleconferences, and we send periodic Section 111 Bulletins to our clients addressing notable Town Hall discussions and other Section 111 developments. We also maintain a searchable electronic database of Town Hall transcripts back to October 2008. Please let us know if you would like more information about any of the Section 111 topics discussed in this Section 111 Bulletin. You also may access our Section 111 webpage and other Section 111 Bulletins and articles we have published at www.wileyrein.com/section111.

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[1] While the court did not expressly offer this reasoning, it cited to that section of the MSP statute that provides in relevant part:

[t]he 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.*

42 U.S.C. § 1395y(b)(2)(A)(ii) (emphasis added).