The Governor's Council for Judicial Appointments

State of Tennessee

Application for Nomination to Judicial Office

Name: Eileen Kuo

Office Address: 167 N. Main St. [redacted]
(including county) Memphis, Shelby County, TN 38103

Office Phone: 901-969-2910 Facsimile:

Email Address: [redacted]

Home Address: [redacted]
(including county)

Home Phone: Cellular Phone: [redacted]

INTRODUCTION

The State of Tennessee Executive Order No. 87 (September 17, 2021) hereby charges the Governor's Council for Judicial Appointments with assisting the Governor and the people of Tennessee in finding and appointing the best and most qualified candidates for judicial offices in this State. Please consider the Council's responsibility in answering the questions in this application. For example, when a question asks you to "describe" certain things, please provide a description that contains relevant information about the subject of the question, and, especially, that contains detailed information that demonstrates that you are qualified for the judicial office you seek. In order to properly evaluate your application, the Council needs information about the range of your experience, the depth and breadth of your legal knowledge, and your personal traits such as integrity, fairness, and work habits.

The Council requests that applicants use the Microsoft Word form and respond directly on the form using the boxes provided below each question. (The boxes will expand as you type in the document.) Please read the separate instruction sheet prior to completing this document. Please submit your original hard copy (unbound) completed application (*with ink signature*) and any attachments to the Administrative Office of the Courts as detailed in the application instructions. Additionally, you must submit a digital copy with your electronic or scanned signature. The digital copy may be submitted on a storage device such as a flash drive that is included with your original application, or the digital copy may be submitted via email to laura.blount@tncourts.gov .

THIS APPLICATION IS OPEN TO PUBLIC INSPECTION AFTER YOU SUBMIT IT.

PROFESSIONAL BACKGROUND AND WORK EXPERIENCE

1. State your present employment.

US Attorney's Office for the Western District of Tennessee

2. State the year you were licensed to practice law in Tennessee and give your Tennessee Board of Professional Responsibility number.

2008, 027365

3. List all states in which you have been licensed to practice law and include your bar number or identifying number for each state of admission. Indicate the date of licensure and whether the license is currently active. If not active, explain.

Mississippi, 103152 – I went to inactive status when I began working at the U.S. Attorney's Office because I no longer needed to maintain a practice in Mississippi.

4. Have you ever been denied admission to, suspended or placed on inactive status by the Bar of any state? If so, explain. (This applies even if the denial was temporary).

From August 17-21, 2023, my license was briefly suspended for failure to timely complete continuing legal education requirements. Upon notice, I immediately applied for reinstatement, demonstrating my compliance, and was reinstated two business days later.

5. List your professional or business employment/experience since the completion of your legal education. Also include here a description of any occupation, business, or profession other than the practice of law in which you have ever been engaged (excluding military service, which is covered by a separate question).

April of 2019 to present – U.S. Attorney's Office for the Western District of Tennessee, Assistant U.S. Attorney

- From April 2019 through February 2023, I represented the United States in affirmative civil enforcement cases as well as defensive litigation such as employment claims, tort, and medical malpractice.
- Since February 2023, I have represented the United States in criminal prosecutions, primarily handling violent crime cases.

December of 2014 to March of 2019 – Jackson Lewis, P.C.

- Represented employers in employment discrimination cases in federal and state court as well as administrative charges, as well as provided advice and counseling on employment law issues.
- Handled unionization efforts on behalf of employers.

October of 2010 to November of 2014 – ROS Law Group (f/k/a Lawrence & Russell, PLC)

- Represented employers and benefit plan fiduciaries in health benefits litigation, including ERISA subrogation and Medicare Advantage reimbursement.

July of 2010 to September of 2010 – Counsel on Call, Inc.

- Provided litigation support, including electronic discovery.

August of 2008 to May of 2010 – Littler Mendelson (f/k/a Kiesewetter Wise Kaplan Prather, PLC)

- Defended employers in employment litigation in federal and state court as well as administrative charges.

6. If you have not been employed continuously since completion of your legal education, describe what you did during periods of unemployment in excess of six months.

Not applicable.

7. Describe the nature of your present law practice, listing the major areas of law in which you practice and the percentage each constitutes of your total practice.

Currently, I am fully engaged in criminal prosecution as 100% of my present law practice, with a focus on violent crimes.

8. Describe generally your experience (over your entire time as a licensed attorney) in trial courts, appellate courts, administrative bodies, legislative or regulatory bodies, other forums, and/or transactional matters. In making your description, include information about the types of matters in which you have represented clients (e.g., information about whether you have handled criminal matters, civil matters, transactional matters, regulatory matters, etc.) and your own personal involvement and activities in the matters where you have been involved. In responding to this question, please be guided by the fact that in order to properly evaluate your application, the Council needs information about your

range of experience, your own personal work and work habits, and your work background, as your legal experience is a very important component of the evaluation required of the Council. Please provide detailed information that will allow the Council to evaluate your qualification for the judicial office for which you have applied. The failure to provide detailed information, especially in this question, will hamper the evaluation of your application.

Throughout my career, I have represented clients in a variety of forums on a state and federal level, before administrative agencies, and have extensive experience in both civil and criminal practice.

As an Assistant U.S. Attorney, I have extensive federal trial court experience, including jury trials and a steady volume of cases before the U.S. District Court for the Western District of Tennessee. I also handle appeals to the Sixth Circuit Court of Appeals, including oral argument in May of 2025 in a case in which the United States ultimately prevailed on appeal.

During 2010-2014, when I worked at ROS Law Group (then known as Lawrence & Russell), my practice included health benefits litigation. In this role, I represented clients in state and federal courts in various states due to the nationwide nature of the work, including arguing motion hearings in state and federal courts, and federal appellate practice. At this firm, I handled several cases before the Fifth and Eighth Circuit Courts of Appeals, as well as one case where I petitioned the U.S. Supreme Court for a writ of certiorari.

From 2008 through 2019, my practice was primarily focused on employment litigation. In this capacity, I defended clients against employment claims at the administrative charge stage before the EEOC, unfair labor practice claims before the NLRB, as well as state and federal court litigation.

9. Also separately describe any matters of special note in trial courts, appellate courts, and administrative bodies.

I handled the briefing and oral argument before the Sixth Circuit for a case involving the constitutionality of a federal statute regulating the possession of machineguns: *United States v. Bridges*, 150 F.4th 517 (6th Cir. 2025)

10. If you have served as a mediator, an arbitrator or a judicial officer, describe your experience (including dates and details of the position, the courts or agencies involved, whether elected or appointed, and a description of your duties). Include here detailed description(s) of any noteworthy cases over which you presided or which you heard as a judge, mediator or arbitrator. Please state, as to each case: (1) the date or period of the proceedings; (2) the name of the court or agency; (3) a summary of the substance of each case; and (4) a statement of the significance of the case.

Not applicable.

11. Describe generally any experience you have serving in a fiduciary capacity, such as guardian ad litem, conservator, or trustee other than as a lawyer representing clients.

In 2008, during my third year of law school, I served as a guardian ad litem. In this capacity, I represented the best interests of a child who was suspected to be the victim of abuse.

12. Describe any other legal experience, not stated above, that you would like to bring to the attention of the Council.

Not applicable.

13. List all prior occasions on which you have submitted an application for judgeship to the Governor's Council for Judicial Appointments or any predecessor or similar commission or body. Include the specific position applied for, the date of the meeting at which the body considered your application, and whether or not the body submitted your name to the Governor as a nominee.

This is my first application.

EDUCATION

14. List each college, law school, and other graduate school that you have attended, including dates of attendance, degree awarded, major, any form of recognition or other aspects of your education you believe are relevant, and your reason for leaving each school if no degree was awarded.

Duke University School of Law, JD (2008); LLM, International and Comparative Law (2009)

- Study Abroad: Geneva Institute in Transnational Law (Geneva, Switzerland), July-August of 2006
- Duke Journal of Gender Law and Policy, Senior Research Editor

Duke University, BA (2005). Majors: Political Science, Women's Studies (with high distinction)

- Senior honors thesis: International Trafficking of Women and Children in Thailand and Japan

PERSONAL INFORMATION

15. State your age and date of birth.

42, [redacted] 1982

16. How long have you lived continuously in the State of Tennessee?

17 years

17. How long have you lived continuously in the county where you are now living?

17 years

18. State the county in which you are registered to vote.

Shelby

19. Describe your military service, if applicable, including branch of service, dates of active duty, rank at separation, and decorations, honors, or achievements. Please also state whether you received an honorable discharge and, if not, describe why not.

Not applicable.

20. Have you ever pled guilty or been convicted or placed on diversion for violation of any law, regulation or ordinance other than minor traffic offenses? If so, state the approximate date, charge and disposition of the case.

No.

21. To your knowledge, are you now under federal, state or local investigation for possible violation of a criminal statute or disciplinary rule? If so, give details.

No.

22. Please identify the number of formal complaints you have responded to that were filed against you with any supervisory authority, including but not limited to a court, a board of

professional responsibility, or a board of judicial conduct, alleging any breach of ethics or unprofessional conduct by you. Please provide any relevant details on any such complaint if the complaint was not dismissed by the court or board receiving the complaint.

Not applicable.

23. Has a tax lien or other collection procedure been instituted against you by federal, state, or local authorities or creditors within the last five (5) years? If so, give details.

No.

24. Have you ever filed bankruptcy (including personally or as part of any partnership, LLC, corporation, or other business organization)?

No.

25. Have you ever been a party in any legal proceedings (including divorces, domestic proceedings, and other types of proceedings)? If so, give details including the date, court and docket number and disposition. Provide a brief description of the case. This question does not seek, and you may exclude from your response, any matter where you were involved only as a nominal party, such as if you were the trustee under a deed of trust in a foreclosure proceeding.

CT-3866-23 – Filed 9/18/2023 – Kuo v. Till - Divorce

- Divorce was granted and Final Decree was entered December 6, 2023.

26. List all organizations other than professional associations to which you have belonged within the last five (5) years, including civic, charitable, religious, educational, social and fraternal organizations. Give the titles and dates of any offices that you have held in such organizations.

Not applicable.

27. Have you ever belonged to any organization, association, club or society that limits its membership to those of any particular race, religion, or gender? Do not include in your answer those organizations specifically formed for a religious purpose, such as churches or synagogues.

    a. If so, list such organizations and describe the basis of the membership limitation.

b. If it is not your intention to resign from such organization(s) and withdraw from any participation in their activities should you be nominated and selected for the position for which you are applying, state your reasons.

No.

ACHIEVEMENTS

28. List all bar associations and professional societies of which you have been a member within the last ten years, including dates. Give the titles and dates of any offices that you have held in such groups. List memberships and responsibilities on any committee of professional associations that you consider significant.

Association for Women Attorneys – active since 2015

- 2015 – **CLE Chair** – In this role, I revamped the AWA's CLE program and organized several seminars hosted by the AWA.
- 2016 – **CLE Co-Chair, Vice President**
- 2017 – **CLE Co-Chair, President-Elect** – During this year, I continued to build the AWA's CLE program, including the inception of the AWA's Women in Law & Leadership Conference, an annual day-long CLE featuring topics of interest to young female attorneys.
- 2018 – **President** – In this role, I led the AWA Board in carrying out the mission of the organization, prioritizing community engagement, mentorship, and CLE, focusing on initiatives to aid the professional growth of young attorneys.
- 2024 – **CLE Co-Chair**
- 2025 – I am currently serving on a committee planning the AWA's Annual Banquet

29. List honors, prizes, awards or other forms of recognition which you have received since your graduation from law school that are directly related to professional accomplishments.

2016-2018 Mid-South Rising Star (Super Lawyers)

30. List the citations of any legal articles or books you have published.

Kuo, Eileen, "Medicare Advantage: Medicare or 'Private' Insurance? Developments in Medicare Secondary Payer Law," Health Law Handbook, (2013 Ed., *in press*), WestGroup, a Thomson Company.

Meyers, Robert; **Kuo, Eileen**, "When Does an Employee Return to Work for the Pre-Injury Employer Under Tennessee's Workers' Compensation Law?" Tennessee Bar Journal, August, 2010, Volume 46, No. 8.

31. List law school courses, CLE seminars, or other law related courses for which credit is

given that you have taught within the last five (5) years.

"Calm Your Nerves: Persuasive Public Speaking for Attorneys" (1 general credit), co-presenter

- This CLE was offered as part of the AWA's Women in Law & Leadership Conference on October 26, 2021

32. List any public office you have held or for which you have been candidate or applicant. Include the date, the position, and whether the position was elective or appointive.

Not applicable.

33. Have you ever been a registered lobbyist? If yes, please describe your service fully.

Not applicable.

34. Attach to this application at least two examples of legal articles, books, briefs, or other legal writings that reflect your personal work. Indicate the degree to which each example reflects your own personal effort.

The following are attached to this application:

1. Kuo, Eileen, "Medicare Advantage: Medicare or 'Private' Insurance? Developments in Medicare Secondary Payer Law," Health Law Handbook, (2013 Ed., *in press*), WestGroup, a Thomson Company.

2. A response to an unfair labor practice charge before the NLRB (names of parties changed).

Both writing samples reflect my personal work and were drafted solely by my personal effort.

ESSAYS/PERSONAL STATEMENTS

35. What are your reasons for seeking this position? ***(150 words or less)***

I aspire to serve on the Tennessee Supreme Court to ensure that justice in our state remains principled, fair, and grounded in real-world experience. Having served as both a prosecutor and a civil attorney, I have gained unique insight into how the law affects individuals, businesses, and communities from every angle. It would be an honor to serve by applying the law faithfully and consistently as enacted by our legislators, ensuring that the text and spirit of our laws are upheld and enforced as intended. My background has taught me the importance of accountability, balance, and respect for the rule of law—values that resonate deeply with Tennesseans. I would bring a practical, even-handed perspective to the Court, one informed by

years of service to both the public and private sectors, and guided by a steadfast commitment to justice, integrity, and the Constitution.

36. State any achievements or activities in which you have been involved that demonstrate your commitment to equal justice under the law; include here a discussion of your pro bono service throughout your time as a licensed attorney. ***(150 words or less)***

I am deeply committed to ensuring that access to justice is not limited by income or circumstance. During my tenure on the board of the Association for Women Attorneys, I have helped organize our members' participation in the Second Saturday Legal Advice Clinic at the Memphis Public Library, as well as volunteered at these clinics while in private practice. These experiences gave me the opportunity to help underserved Memphians navigate legal challenges that might otherwise go unanswered and reinforced my belief that every person deserves meaningful access to legal guidance and the protection of their rights.

37. Describe the judgeship you seek (i.e. geographic area, types of cases, number of judges, etc. and explain how your selection would impact the court. ***(150 words or less)***

I am seeking appointment to the Tennessee Supreme Court to be one of the five justices that ensure the consistent and fair interpretation of Tennessee law across all ninety-five counties in both civil and criminal matters. My selection would bring to the Court a breadth of experience from both criminal and civil practice—perspectives that reflect the diverse realities of our justice system. In addition, my appellate experience has strengthened my ability to analyze complex legal issues, apply precedent with precision, and craft reasoned, principled arguments. These skills are essential to the Court's work of providing clear and consistent guidance to the bench and bar. I would bring to the Court a grounded, even-handed approach, rooted in respect for the Constitution, the separation of powers, and respect for the role of the judiciary in preserving stability, fairness, and public confidence in the rule of law.

38. Describe your participation in community services or organizations, and what community involvement you intend to have if you are appointed judge? ***(250 words or less)***

I have been deeply engaged in the legal community through the Association for Women Attorneys, where I have served on the board in various leadership positions since 2015, including as President in 2018. These roles allowed me to help serve the legal profession by expanding CLE opportunities, mentoring young attorneys, and fostering collaboration among lawyers of diverse backgrounds. Members of the AWA have benefited from mentorship and guidance from its judicial members who have generously offered their time and expertise as permitted by the Code of Judicial Conduct—if appointed, I would strive to do the same.

Beyond the legal community, I have also found fulfillment in supporting Memphis's vibrant

theatre community. I served on the board of Germantown Community Theatre from 2016-17 as well as 2021-22, and have also enjoyed performing in local productions as an actor and musician throughout my years living in Memphis. As time permits, I would continue to support the arts.

If I am appointed, I would strive to honor the privilege of my position by giving back and continuing to serve my community as permitted by my schedule and the Code of Judicial Conduct.

39. Describe life experiences, personal involvements, or talents that you have that you feel will be of assistance to the Council in evaluating and understanding your candidacy for this judicial position. ***(250 words or less)***

My life and career have been grounded in diligence, integrity, and personal responsibility. I was raised in a home where my parents instilled the importance of honest work and using one's abilities in service to others. I have always been inspired by my father, who recently retired as Director of Community Programs with the University Corporation for Atmospheric Research. During his distinguished career in meteorology, he led the deployment of several data-gathering satellites, fostered international collaboration between weather agencies, and strengthened vital operational functions within UCAR. From him, I learned that leadership requires steadiness, humility, and the courage to act according to principle even when doing so is difficult.

In private practice, I had the opportunity to represent businesses defending employment claims, gaining practical insight into how the law affects business and individuals alike. This experience reinforced my belief that a fair and predictable legal system is essential to both economic stability and public confidence.

My experience in both criminal and civil practice, encompassing both plaintiff/prosecution and defense, has given me the ability to analyze cases from multiple perspectives without bias or a propensity to analyze cases from only one side. This background enables me to approach every matter with balance and fairness, guided by the law rather than personal belief.

40. Will you uphold the law even if you disagree with the substance of the law (e.g., statute or rule) at issue? Give an example from your experience as a licensed attorney that supports your response to this question. ***(250 words or less)***

Yes. It is vital to our justice system that all elements work to their fullest in tandem—that all parties receive effective and capable representation, and that a fair and impartial arbiter weigh the positions of each side against the applicable standards of review. The checks and balances vital to our government dictate that as a justice, I would be required to uphold the law even if I disagreed with the substance of the law at issue.

An example from my practice involves representing health insurance carriers in ERISA subrogation claims. These cases often involved recovering funds from accident victims who had received personal injury settlements, and there were moments when it would have been easy to be swayed by sympathy. However, all parties are entitled to an advocate, and when there was a colorable claim and support for my position, I faithfully represented my clients, ensuring that their lawful rights were enforced.

My experiences in my career reinforce my belief that a justice's role is to apply the law as written, without letting personal sympathies dictate outcomes. Upholding the law, even when uncomfortable or unpopular, ensures predictability, fairness, and consistency in the judicial system. This is the commitment I would bring to the Tennessee Supreme Court.

REFERENCES

41. List five (5) persons, and their current positions and contact information, who would recommend you for the judicial position for which you are applying. Please list at least two persons who are not lawyers. Please note that the Council or someone on its behalf may contact these persons regarding your application.

A. Marques Young, Deputy Criminal Chief, US Attorney's Office WDTN, [redacted]
B. Craig Cowart, Assistant District Counsel, US Army Corps of Engineers, [redacted]
C. Michael Detroit, Executive Producer, Playhouse on the Square, [redacted]
D. Adam Remsen, Co-Founder, Quark Theatre, [redacted]
E. Judge Charmiane G. Claxton, Magistrate Judge, Western District of Tennessee, [redacted]

AFFIRMATION CONCERNING APPLICATION

Read, and if you agree to the provisions, sign the following:

I have read the foregoing questions and have answered them in good faith and as completely as my records and recollections permit. I hereby agree to be considered for nomination to the Governor for the office of Justice of the Supreme Court of Tennessee, and if appointed by the Governor and confirmed, if applicable, under Article VI, Section 3 of the Tennessee Constitution, agree to serve that office. In the event any changes occur between the time this application is filed and the public hearing, I hereby agree to file an amended application with the Administrative Office of the Courts for distribution to the Council members.

I understand that the information provided in this application shall be open to public inspection upon filing with the Administrative Office of the Courts and that the Council may publicize the names of persons who apply for nomination and the names of those persons the Council nominates to the Governor for the judicial vacancy in question.

Dated: __October 22_____, 2025___.

____s/Eileen Kuo_____
Signature

When completed, return this application to Laura Blount at the Administrative Office of the Courts, 511 Union Street, Suite 600, Nashville, TN 37219.

*** The names of the parties have been changed.**

August 29, 2014

Linda Mohns
Field Attorney
National Labor Relations Board
Subregion Twenty-six
80 Monroe Ave., Suite 350
Memphis, TN 38103-2416

Re:	Charging Party:	Jane Doe
	Respondent:	Blood Bank, LLC
	NLRB Case No.:	15-CA-132867

Dear Ms. Mohns:

This letter represents the position statement of Respondent, Blood Bank, LLC ("BB" or "Respondent"), regarding the allegations contained in the above-referenced unfair labor practice charge. BB employs the individuals who work at the BB location at 123 Main St. ("BB-Main"), where Charging Party, Jane Doe ("Doe" or "Charging Party") worked. This position statement is submitted without prejudice to additional theories or legal arguments that BB may advance at some subsequent stage of the proceedings.

This response is based on BB's understanding of the facts and the information reviewed thus far. This position statement is submitted for the purpose of aiding the NLRB in its investigation and facilitating the informal resolution of this matter. While believed to be accurate, this position statement does not constitute an affidavit or a binding statement of BB's legal position, nor is it intended to be used as evidence of any kind in any administrative or court proceeding in connection with Doe's allegations. Because additional facts may be uncovered through discovery or following a full investigation, BB in no way waives its right to present new or additional information at a later date for substance or clarification. Moreover, by responding to this charge, BB does not waive, and hereby preserves, any and all substantive and procedural defenses that may exist to the charge and Doe's allegations.

Further, BB requests that any efforts to contact its current managers be directed through its undersigned counsel.

INTRODUCTION

Respondent, BB, operates plasmapheresis centers that provide blood components to the therapeutic, medical, and diagnostic industries. Plasmapheresis is the process of collecting plasma from blood. Plasmapheresis centers such as BB-Main, at which Doe was an employee, collect plasma from donors. The plasma is then used in a variety of life-saving products that treat various medical conditions, such as hemophilia and immune system deficiencies. Plasma is

also used to help treat and prevent diseases such as tetanus, rabies, measles, rubella, and hepatitis B. BB's plasmapheresis centers are licensed by the U.S. Food and Drug Administration ("FDA") and certified by the International Quality Plasma Program. They are subject to strict regulations to ensure the quality of the blood components and the safety of both donors and the recipients of any blood components. BB's affiliated founding corporation, Blood Business, Inc., has been in the whole-blood and plasmapheresis business since 1949.

On July 16, 2014, Doe filed an unfair labor practice charge against BB, Case No. 15-CA-132867. In her Charge, Doe alleged: "Since about May 8, 2014, the Employer has interfered with, restrained, and coerced its employees by terminating employee Jane Doe in retaliation for her protected concerted activities."

BB denies any unlawful actions and avers that Doe's allegations in the Charge lack merit. Doe had multiple disciplinary issues, several of which were grounds for termination. In addition, Doe never engaged in any protected concerted activity within the meaning of the National Labor Relations Act ("NLRA"). BB was never aware of any such activity by Doe. Even if Doe had engaged in a protected concerted activity, BB had a legitimate reason for terminating Doe's employment. As discussed below, BB would have terminated Doe's employment for her violations of the Employee Policy Manual regardless of any engagement in protected concerted activities.

Accordingly, for the reasons set forth below, BB requests that the Board dismiss the instant Charge.

FACTS

I. Jane Doe's employment.

Jane Doe began working for BB at BB-Main on January 23, 2013. She was hired as a Donor Processor and initially worked for BB on a part-time basis. On September 17, 2013, Doe became a full-time employee of BB.

II. Disciplinary issues with Doe's employment.

During her relatively short employment with BB, Doe had multiple performance and disciplinary issues that created problems for BB-Main's donation process and risked the safety of the donors. Throughout her employment, Doe had issues following the directions of her managers and supervisors and performing the duties of her job.

Due to the nature of plasmapheresis and the health and safety implications of the blood components that BB collects and processes, following BB procedure and supervisors' instructions is of paramount importance, including correctly obtaining donors' medical histories. BB is subject to strict FDA regulations for determining the suitability of donors. 21 C.F.R. §§ 640.3 and 640.63. On July 22, 2013, Doe received a verbal reprimand for failure to properly obtain a donor's medical history. Obtaining a complete and thorough medical history from a donor is crucial because a donor's past and present health history may affect whether that donor

is in an acceptable condition to donate plasma. Further, the medical history may reveal whether a donor has had exposure to certain infectious diseases such as HIV and hepatitis, which may affect the quality and safety of the plasma that is collected. As a result of the July 22, 2013 incident, Doe was warned that a further infraction would result in a written reprimand.

On September 20, 2013, Doe was disciplined again for failure to properly obtain a donor's medical history. Doe received a written Disciplinary Action form and was suspended for three days. At this time, Doe was warned that the next infraction would result in the termination of her employment.[1] Thus, Doe was on notice that any subsequent disciplinary issues could result in her termination.

III. April 24, 2014 incident regarding Doe's discipline for refusal to perform her job duties.

On April 24, 2014, towards the end of the day, Operations Supervisor, Maria Hill ("Hill"), one of Doe's supervisors, asked Doe and another Donor Processor, Lois Lane ("Lane"), to process a donor. This task is within the definition and description of the Donor Processor position and is one of Doe and Lane's primary job duties. Both Doe and Lane refused to obey the instructions issued by their supervisor, which pertained to their work and duties assigned. Doe and Lane were insubordinate and disrespectful to Hill, and indicated that another employee could perform the duties that Hill instructed them to do. At that time, the other employee was working for BB-Main as an extern, and it was inappropriate for Doe and Lane, who were Donor Processors, to cause an extern to perform their job duties. Doe was aggressive and antagonistic toward Hill. As a result of Doe and Lane's actions, the donor was forced to wait until the extern became available to perform the Donor Processor job duties. An Assistant Manager, Steve Rogers, advised Hill that both Doe and Lane should receive written disciplinary action forms for their violation of the Work Rules/Appropriate Conduct Policy, Employee Policy 205 ("Conduct Policy"), which provides the standard for Work Rules and Appropriate Conduct for employees of BB.

The Conduct Policy provides:

> 1.0 WORK RULES / APPROPRIATE CONDUCT
>
> As a Company team member, employees are expected to accept certain responsibilities, follow acceptable business principles in matters of conduct, and exhibit a high degree of integrity at all times.
>
> …
>
> Violation of any behavior and/or conduct listed below that the Company considers inappropriate may result in termination. The following list is not all inclusive:

[1] True and correct copies of documents relating to these disciplinary actions are attached along with her personnel file as Exhibit A.

- Violation of any Company rule

…

- Any action that is detrimental to the Company's efforts to operate profitably or affects regulatory compliance

…

- *Insubordination or refusing to obey instructions issued by your Manager pertaining to your work; refusal to perform duties assigned, either routine or special assignment; refusal to work with others as an effective team member*

…

- *Spreading malicious gossip and/or rumors; engaging in behavior which creates discord and lack of harmony; interfering with another employee on the job*; restricting work output or encouraging others to do the same

…

- Leaving work before the end of a workday or not being ready to work at the start of a workday without approval of your Manager; *stopping work before time specified for such purposes*; being absent without authorization or notifying management; or extending break time by leaving early for break or returning late from break

…

- Rude, obscene or abusive language toward any donor, employee, vendor, or customer; or any disorderly/antagonistic conduct on Company premises

Should an employee's performance, work habits, overall attitude, conduct, or demeanor become unsatisfactory based on *violations of any of the above* or of any other Company policies, rules, or regulations, the employee *will be subject to disciplinary action, up to and including termination*.

Employee Policy Manual, EP205 (emphasis added). A true and correct copy of the Employee Policy Manual is attached hereto as Exhibit B.

On April 25, 2014, Doe and Lane were disciplined for their insubordination and refusal to obey instructions issued by a supervisor pertaining to their work and their refusal to perform their assigned duties, pursuant to the Conduct Policy (third bullet point, above). On that day, Melinda May (Doe's direct supervisor), Operations Supervisor Hill, and Assistant Manager Kathy Kane ("Kane") had a meeting with Lane and Doe regarding the April 24, 2014 incident.

They discussed the written Disciplinary Action in an effort to counsel Doe and Lane regarding their misconduct and insubordination, which violated the Conduct Policy.

As required under the Disciplinary Process Policy, Employee Policy 210 ("Disciplinary Policy"), Assistant Manager Kane requested that Lane and Doe sign their respective Disciplinary Action forms. The Disciplinary Policy states:

> You, as the employee, must sign the reprimand. Your signature is an acknowledgment that you received the reprimand. It does not admit guilt. **Refusal to sign the reprimand is grounds for termination.** An employee has the right to respond to any written reprimand before signing but must be aware that management has the right to add additional comments to the document.

Employee Policy Manual, EP210, Exhibit B (emphasis added).

Lane, upon assurance that signing her Disciplinary Action form does not admit guilt, signed her form. However, Doe refused to sign, and instead inquired as to BB's grievance procedure. The Complaint Resolution Procedure is a company complaint procedure by which employees may seek redress for various complaints regarding their employment. A copy of BB's Complaint Resolution Procedure, EP240, is attached with the Employee Policy Manual as Exhibit B. Kane provided to Doe a copy of BB's Complaint Resolution Procedure and encouraged her to use it. She also counseled Doe regarding her professionalism and attitude. To Respondent BB's knowledge, Doe did not initiate any complaint or grievance using the Complaint Resolution Procedure.

IV. Termination of Doe's employment.

According to the Employee Policy Manual, Doe's violations of the Conduct Policy and the Disciplinary Policy were sufficient grounds for termination. Doe had been insubordinate when she refused to obey the instructions of a supervisor and refused to perform the duties of her job. In light of Doe's multiple violations of the Employee Policy Manual, several managers, (her direct supervisor May, Assistant Manager Kane, and Center Manager Clint Barton), sought to evaluate her record and consider whether to terminate her employment. Several days later, while these managers were still considering whether to terminate Doe's employment, Doe was involved in yet another incident that caused a significant disturbance at BB-Main. Another employee, Natasha Romanoff ("Romanoff"), complained to her supervisor that Doe had made various comments that Romanoff found disturbing and offensive. Romanoff became very upset about Doe's attitude.

Doe's pattern of disciplinary issues, insubordination, and aggressive attitude were sufficient grounds to terminate her employment. In addition, she exhibited hostility and combativeness towards BB-Main managers when presented with the Disciplinary Action form, which she refused to sign. Her refusal to sign the form indicated her As stated above, "Refusal to sign the reprimand is grounds for termination." When presented with the additional disturbance and discord caused by Doe's combative attitude and the negative effect it had on her coworker, Respondent BB had no choice but to follow its Employee Policy Manual and

terminate Doe's employment. The Conduct Policy prohibits "engagement in behavior which creates discord and lack of harmony; lack of respect for the feelings of others; and antagonistic conduct." Due to her multiple violations of BB's policies, Doe's employment was terminated. A true and correct copy of Doe's Notice of Termination is attached with her personnel file as Exhibit A.

V. Comparison of Doe's discipline and termination with other employees who have engaged in similar conduct.

Other employees who have violated EP205 by displaying insubordinate behavior, refusing to perform their work duties, and for being disruptive have also been disciplined, suspended, or terminated. For example, on September 3, 2013, an employee of BB-Main was suspended for five days for "insubordination; refusing to obey instructions issued by supervisor and [management]; refusal to work as an effective team member; using rude, disorderly/antagonistic conduct, unprofessional overall attitude, conduct and demeanor during work shift on 08/31/13." Another BB-Main employee was suspended for one week on May 28, 2013 for "Insubordination towards back up supervisor" and issuing an "implied threat and inappropriate behavior." On January 9, 2014, another BB-Main employee was suspended for five days for "insubordination, refusing to obey instruction issued by supervisor and [management]; refusal to work as an effective team member, using rude and disorderly/antagonistic conduct, unprofessional overall attitude, conduct, and demeanor during work shift on January 8, 2014." True and correct copies of the Disciplinary Action forms relating to these three similarly-disciplined employees are attached hereto as Exhibit C. BB is not aware of any efforts by any of these similarly-disciplined employees to engage in any concerted activities protected by the NLRA.

On May 22, 2014, an employee was terminated for insubordination and refusal to follow her supervisors' instructions. According to the Notice of Termination, "Employee was informed that her section was to be closed by operations supervisor and she knowingly refused to follow instructions and proceeded to seat donors in her section. This is the third written incident we have on file where she directly refused to follow instruction from supervisors. Employee is constantly in conflict with co-workers/supervisors. (EP205 Work Rules/Appropriate Conduct)." A true and correct copy of the Notice of Termination for this similarly terminated employee is attached hereto as Exhibit D. BB is not aware of any efforts by this employee to engage in any concerted activities protected by the NLRA. Notably, this employee was terminated only for insubordination and refusal to follow a supervisor's instructions. Doe was not only insubordinate in refusing to follow a supervisor's instructions; she was also combative and disruptive. She displayed a disrespectful attitude toward her fellow employees and the managers in further violation of the Conduct Policy.

These facts show that Doe had engaged in conduct that violated several of BB's policies that are terminable offenses under the Employee Policy Manual. Further, other employees who engaged in identical or similar conduct as Doe, and who had violated the Conduct Policy, were disciplined and terminated in similar fashion to Doe. None of these other employees engaged in protected concerted activities. Employees who had engaged in a pattern of disciplinary issues were subject to progressive discipline and eventually terminated, just like Doe. As demonstrated

by the legal analysis below, BB's termination of Doe's employment was lawful and was not a violation of the NLRA.

LEGAL ANALYSIS

I. An employee must act with or on behalf of other employees to seek the protection provided for concerted activities.

To establish that an employer interfered with or coerced its employees in the exercise of their right to engage in protected concerted activities in violation of the National Labor Relations Act, 29 U.S.C. § 158(a)(1), an employee must establish that: 1) she was engaged in a protected concerted activity; 2) that "the employer knew of the activity and its concerted nature"; and 3) "that the employee's protected activity was a motivating factor prompting some adverse action by the employer." *Ajax Paving Industries, Inc. v. NLRB*, 713 F.2d 1214, 1216 (6th Cir. 1983) (citing *Vic Tanny International, Inc. v. NLRB*, 622 F.2d 237 (6th Cir. 1980); *Air Surrey Corp. v. NLRB*, 601 F.2d 256 (6th Cir. 1979); *Jim Causley Pontiac v. NLRB*, 620 F.2d 122 (6th Cir. 1980); *McLean Trucking Co. v. NLRB*, 689 F.2d 605 (6th Cir. 1982)).

A. Jane Doe did not engage in a protected concerted activity.

Though the NLRA does not explicitly define "concerted activity," it is well established that such activity must be pursued on behalf of or with other employees, not on a single employee's own behalf. Absent some form of interaction with other employees, an employee's actions *on her own behalf* do not constitute protected concerted activities. *Meyers Indus., Inc.*, 281 N.L.R.B. No. 118, 123 L.R.R.M. (BNA) 1137, 1138 (1986); *ARO, Inc. v. NLRB*, 596 F.2d 713 (6th Cir. 1979); *Bay-Wood Industries, Inc. v. NLRB*, 666 F.2d 1011 (6th Cir. 1981); *UPS v. NLRB*, 654 F.2d 12 (6th Cir. 1981). One employee's complaints about an employer's company policy are not protected concerted activity if they are pursued only on her own behalf. *See Aro*, 596 F.2d at 717 (An employee complaining about being terminated is not protected concerted activity because it is pursued only on that employee's behalf). Here, the only dissatisfaction that Doe ever expressed, informally or otherwise, was that she was concerned about the fact that discipline was levied against her. Though they were disciplined together, Doe never expressed any concerns about Lane's discipline or anything involving anyone else.

When an employee complains or submits a grievance regarding only her own discipline for failure to perform job duties, the Sixth Circuit has found that such complaints or grievances do not constitute protected concerted activities within the scope of the NLRA. *See UPS*, 654 F.2d at 14-15 (There was evidence that the charging party refused to perform the duties of his job due to personal reasons and that he was disruptive. The Court found that the employer did not violate the Act for disciplining the employee's disruptiveness and refusal to perform his job duties.). This is exactly what happened here—Doe, as a Donor Processor for BB-Main, refused to perform her donor-processing duties in direct violation of the Conduct Policy, which prohibits "[i]nsubordination or refusing to obey instructions issued by your Manager pertaining to your work; refusal to perform duties assigned." Instead, she attempted to push her duties onto an extern. When BB disciplined her for her violation of the Conduct Policy, she inquired about the Complaint Resolution Procedure. Although BB readily provided a copy of the Complaint

Resolution Procedure to her and encouraged her to use it, she did not, and the only dissatisfaction that BB is aware of is her objection to being disciplined. In other words, her concerns related only to her own personal issues.

In both *Bay-Wood Industries* and *Aro*, the Sixth Circuit rejected the Interboro Doctrine as described in *Interboro Contractors, Inc.*, 157 NLRB 1295 (1966). The Interboro Doctrine, which the Sixth Circuit referred to as a "judicial fiction," suggests that an employee is engaging in a protected concerted activity if he seeks to advance the interests of his fellow employees, despite lack of interest by his fellow employees. *Baywood*, 666 F.2d at 1013 (citing *Aro*, 596 F.2d at 718). Thus, in the Sixth Circuit, one individual's complaint or grievance does not necessarily implicate the interests of all employees, even if it is grounded in an agreement (CBA) that involves all employees. *Id*. "For an individual claim or complaint to amount to concerted action under the Act it must not have been made solely on behalf of an individual employee, but it must be made on behalf of other employees or at least be made with the object of inducing or preparing for group action and have some arguable basis in the collective bargaining agreement." *Aro*, 596 F.2d at 718.

Here, BB has no knowledge that Doe submitted a complaint or grievance through the Complaint Resolution Procedure. Even assuming that she did, for argument's sake, Doe acted completely alone, and on behalf of her own interests. BB is aware only of her dissatisfaction with the April 24, 2014 incident and knows of no other complaint, grievance, or concern she may have had. Thus, throughout the events leading up to her termination, she was acting only on her own behalf. With regard to the April 24, 2014 incident, Doe was only looking out for herself when she refused to perform her job duties—she forced someone else to perform those duties. After the incident, Doe did not express any concerns about other employees and never mentioned any objections relating to Lane's discipline. Thus, her objections regarding the April 24, 2014 did not relate to any issues that involved other employees or any particular policy or practice of BB that she felt was unfair or improper. Her concerns regarding the requirement to sign the Disciplinary Action form also related to her alone, and no other employees. Lane, the other Donor Processor who was also disciplined for insubordination and refusal to perform job duties, signed her Disciplinary Action form and did not participate in or express any interest in Doe's objections.

BB is also unaware of any reason for Doe and Lane's resistance to performing the job duties of Donor Processor in connection with the April 24, 2014 incident other than their personal desire not to perform those duties. In fact, they attempted to push those duties onto another employee. Neither Doe nor Lane were asked to perform any tasks that were out of the ordinary or outside the job description of Donor Processor—in fact, they were asked to perform the exact task for their position: process a donor. No employee has raised any concerns to BB regarding any potential safety issues with processing donors.

Accordingly, to the extent Doe pursued a complaint or grievance through BB's Complaint Resolution Procedure, neither her complaint nor her desire to submit one constitutes a protected concerted activity because Doe acted entirely on her own behalf and to advance her own interests.

B. Respondent is unaware that Doe has ever engaged in any protected concerted activity.

If the decision-makers involved with an employer's termination of an employee were unaware of any protected activity by that employee, the employer could not have terminated that employee in retaliation for the protected activity. *See Blizzard v. Marion Tech. College*, 698 F.3d 275, 288 (6th Cir. 2012). "[T]o establish actionable retaliation, the relevant decision maker, not merely some agent of the defendant, must possess knowledge of the plaintiff's protected activity." *Escher v. BWXT Y-12, LLC*, 627 F.3d 1020, 1026 (6th Cir. 2010) (citing *Mulhall v. Ashcroft*, 287 F.3d 543, 551-52 (6th Cir. 2002); *Fenton v. HiSAN, Inc*., 174 F.3d 827, 832 (6th Cir. 1999)).

Here, BB could not have retaliated against Doe for engaging in a protected concerted activity because Doe did not, at any point, submit a grievance or complaint. When Assistant Manager Kane disciplined Doe for the April 24, 2014 incident, Doe asked about the grievance procedure, but did not utilize it, despite it being made available to her. Any dissatisfaction that she expressed to Kane, Center Manager Barton, or her direct supervisor, May, related only to her own interests and concerns. She did not raise any issues that related to other employees, and no other employees expressed any interest in her concerns.

The only managers of BB that participated in the decision to terminate Doe's employment were Kane, Barton, and May. Kane and Barton are aware only that Doe objected to her discipline for the April 24, 2014 incident and requested clarity as to the requirement under the Disciplinary Policy that she sign her Disciplinary Action form. However, Kane, Barton, and May are unaware of Doe initiating any of the steps outlined in the Complaint Resolution Procedure to address any of these issues.

Doe did not submit anything in writing to any manager or regional manager of BB as instructed by the Complaint Resolution Procedure. She also did not submit a written complaint or appeal to the HR Department of the Corporate Office of BB. Although the HR Department of BB was not involved in the decision to terminate Doe's employment, no one in the department is aware of any efforts by Doe to initiate any of the steps outlined in the Complaint Resolution Procedure.

Thus, despite having the Complaint Resolution Procedure available to her, at no time (before, during, or after her termination) did Doe ever complain of a policy or practice that involved other employees or implicated the interests of other employees. She did not complain that a particular policy of BB was generally unfair for any employees other than herself. To the extent she verbally indicated any dissatisfaction with respect to the April 24, 2014 incident, she merely complained that she, Doe, should not have been disciplined for refusal to perform her job duties.

Accordingly, Respondent BB could not have known of any protected concerted activity engaged in by Doe and, thus, could not have retaliated against her for any protected concerted activity.

C. Respondent terminated Doe's employment due to her antagonistic attitude and refusal to perform the duties of her job in violation of company policy—the fact that she inquired as to the grievance procedure was not a motivating factor of her termination.

Doe bears the burden of establishing that her engagement in a protected concerted activity was a motivating factor in her discharge. *Int'l Union, UAW v. NLRB*, 514 F.3d 574, 585 (6th Cir. 2008). As established above, Doe cannot meet this burden because she never submitted any grievance or complaint that BB is aware of. To the extent she expressed any dissatisfaction, she sought only to advance her own interests, not any other employees'. Conversely, her fellow employees did not take any interest in any of her concerns. However, even if Doe were able to show that she had engaged in a protected concerted activity and that it was a motivating factor in her discharge, BB would have terminated her employment regardless of the protected conduct. Many considerations contributed to her managers' decision to terminate her employment—she had a history of performance issues during her short employment, and she continued to engage in conduct that violated the Conduct Policy despite being warned and counseled regarding her conduct. In fact, as detailed in Section V above, BB has similarly disciplined and terminated other employees who have engaged in the same conduct. BB had no choice but to terminate Doe's employment in light of her continued violations of the Conduct Policy. Because BB terminated her employment regardless of her participating in any protected concerted activity, her termination was not a violation of § 8 of the NLRA. *Id*.

In *Int'l Union, UAW v. NLRB*, the Sixth Circuit agreed with the Board's conclusion that the employer met its burden of establishing that it had a legitimate reason for discharging the charging party. The Board's conclusion was based on these findings: "(1) the Company had consistently maintained that it fired Ahern for his actions related to the package; (2) the Company considered Ahern's actions to have violated its rules of conduct; and (3) there was no evidence that the Company had failed to discharge other employees for similar conduct." *Id*. Here, BB maintains that Doe committed numerous violations of the policies listed in the Employee Policy Manual, several of which were terminable. Doe was insubordinate and refused to obey the instructions of a supervisor. Further, she was combative and insubordinate with regard to her discipline, and exhibited disruptive and combative conduct that upset and offended a fellow employee. Doe was ultimately terminated for her violation of the Conduct Policy for her conduct which created "discord and lack of harmony, lack of respect for the feelings of others, and antagonistic conduct." This is consistent with BB's decisions with regard to similarly-disciplined and similarly-terminated employees who had engaged in the same or similar violations of the Conduct Policy. There is no evidence that BB failed to discharge other employees for similar conduct.

When determining whether an employer acted with unlawful motive, one must consider circumstantial evidence such as disparate or inconsistent treatment, expressed hostility toward the protected activity, departure from past practice, and shifting or pretextual reasons being offered for the action. *See, e.g., Jewish Home for the Elderly of Fairfield County*, 343 NLRB 1069, 1099 (2004), *enfd*. 2006 WL 898084 (2d Cir. 2006). Here, there is no disparate or inconsistent treatment, nor is there any hostility toward the alleged protected activity. As discussed above, when Doe requested the grievance procedure, Assistant Manager Kane made

the company's Complaint Resolution Procedure available to her. Thus, BB did not act with any unlawful motive.

An employer has the right to discharge an employee for any reason, whether that decision is just or reasonable, as long as the discharge is not in retaliation for the employee's participation in protected concerted activities. *San Lorenzo Lumber Co*., 238 NLRB 198 (1978). "In considering the propriety of these discharges the question is not whether they were merited or unmerited, just or unjust, nor whether as disciplinary measures they were mild or drastic. These are matters to be determined by the management, the jurisdiction of the Board being limited to whether or not the discharges were for union activities or affiliations of the employees." *Indiana Metal Prods. Corp. v. NLRB*, 202 F.2d 613, 617 (7th Cir. 1953); *see also NLRB v. McGahey*, 233 F.2d 406 (5th Cir. 1956). Here, BB had the right to use its discretion to discipline its employees, including Doe, under its Employee Policy Manual for conduct that was disruptive to the operations of BB-Main, a plasmapheresis center. The process of drawing blood and separating blood components is a heavily regulated process that implicates the health and safety of all involved. Thus, it is of paramount importance that BB ensures that its employees are able to follow directions, obey instructions, and maintain a respectful environment. Doe violated the Conduct Policy on multiple occasions, acted on no one's behalf other than her own, and gave BB no choice but to terminate her employment.

Accordingly, BB has established that it had a legitimate reason for terminating Doe's employment, and has not violated the NLRA.

CONCLUSION

For the foregoing reasons, Respondent BB respectfully requests that the Board find that BB committed no violation of the applicable laws and dismiss the unfair labor practice charge filed by Doe against BB.

Sincerely,

Eileen Kuo

Enclosures

V

OUT OF THE BOX

Chapter 12

Medicare Advantage: Medicare or "Private" Insurance? Developments in Medicare Secondary Payer Law

Eileen Kuo

§ 12:1 Introduction

The Medicare Advantage program, in short, is an option by which Medicare beneficiaries may elect to receive their Medicare benefits through enrollment in a Medicare Advantage plan. Medicare Advantage organizations (MAOs) contract with the government to provide Medicare benefits. They occupy a unique space in the Medicare statutory scheme in that Medicare Advantage is actually a part of the Medicare program—MAOs pay Medicare benefits. Yet, the fact that MAOs are coordinated care organizations rather than the "government" lends the program to confusion, particularly with regard to misconstruing Medicare Advantage plans as "insurance policies" issued by private insurance companies. This dichotomy has proven particularly tricky with regard to the rights of MAOs to seek reimbursement when Medicare benefits are secondary to another source of benefits, such as when Medicare beneficiaries recover from a liable third party after an MAO has already paid Medicare benefits on their behalf. The struggles to define not only what an MAO is but also what its rights and remedies are under the Medicare Act have resulted in a daunting line of conflicting case law, particular with regard to MAOs' right to be reimbursed from third party recoveries under the Medicare Secondary Payer (MSP) provisions. These challenges have resulted in significant roadblocks to an MAO's ability to exercise its statutory right to recover reimbursement under the MSP law. The broad-reaching effect of these challenges is that Medicare Advantage organizations and their enrollees are facing a lot of uncertainty, particularly in settling personal injury actions in which MAOs may assert reimbursement rights. This uncertainty implicates millions of dollars of Medicare benefits, which, if unrecovered by MAOs, would be detrimental to the statutory goal of tempering the rising cost of Medicare.

§ 12:2 A brief history of Medicare

The Medicare program was enacted under Title XVIII of the Social Security Act as the Social Security Amendments of 1965 as a hospital insurance and medical benefits program

for the elderly.[1] Medicare Parts A and B, often referred to as Original Medicare, were created at this time. Part A provides benefits for hospital and posthospital care, home health services, and hospice care,[2] and Part B provides supplementary medical insurance benefits such as physicians' services, home health services, outpatient services, and other health services.[3] The Social Security Amendments of 1972 expanded the Medicare program to include higher or expanded benefits, such as extending Medicare benefits to disability insurance beneficiaries who have been on the Social Security disability benefit rolls for at least two years, and to individuals under the age of 65 who suffer from chronic kidney disease (or "end-stage renal disease").[4] Thus, Medicare benefits are available to individuals aged 65 or older or individuals who receive Social Security Disability Benefits or who have end-stage renal disease.[5]

In addition to extending Medicare benefits, the Social Security Amendments of 1972 also enacted an option for Medicare beneficiaries to receive benefits through a Health Maintenance Organization, which would then receive payment from the federal medical insurance trust fund on a capitation basis.[6] This amendment, which enacted the Medicare health maintenance organization (HMO) provisions at 42 U.S.C. § 1395mm, introduced the concept of risk-sharing contracts with HMOs to provide Medicare benefits.

In 1982, the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) amended the Medicare risk-sharing provisions with HMOs as part of the effort to address the budget

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[Section 12:2]

[1]Social Security Amendments of 1965, Pub. L. 89-97, 79 Stat. 286, 89th Congress, H.R. 6675, July 30, 1965.

[2]42 U.S.C. §§ 1395c to 1395i-5.

[3]42 U.S.C. §§ 1395j to 1395w-5.

[4]Social Security Amendments of 1972, Pub. L. 92-603, 86 Stat. 1329, Oct. 30, 1972; *see also* Ball, Robert, *Social Security Amendments of 1972: Summary and Legislative History*, Social Security Bulletin, Vol. 36 No. 3, available at http://www.ssaonline.us/policy/docs/ssb/v36n3/v36n3p3.pdf (last visited Nov. 19, 2012).

[5]42 U.S.C. § 1395c.

[6]Social Security Amendments of 1972, Pub. L. 92-603, 86 Stat. 1329, Oct. 30, 1972.

deficit during the 1980's recession.[7] TEFRA added several changes, including a provision codified at 42 U.S.C. § 1395mm(e)(4) permitting Medicare HMOs to seek reimbursement for benefits paid that the covered beneficiary was entitled to receive from another source:

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

Thus, even in the early incarnations of the relationship between Medicare and managed care, the recovery of funds that could or should have been paid from another insurance plan or policy already played an important role. Any additional funds that a Medicare HMO recovered would be used either to provide additional or future health benefits for its members or would revert back to the trust funds.[8]

§ 12:3 Overview of the Medicare Secondary Payer law and its evolution

When the Medicare program began, Medicare paid benefits first unless a beneficiary was entitled to workers' compensation benefits.[1] It was not until 1980, when Congress enacted the Medicare Secondary Payer provisions as part of the Omnibus Budget Reconciliation Act of 1980, that Medicare

[7] *See* Tax Equity and Fiscal Responsibility Act of 1982, § 114(a), Pub. L. 97-248, 96 Stat. 324, Sep. 3, 1982.

[8] 42 U.S.C. § 1395mm(g)(2) to (5).

[Section 12:3]

[1] *See* Medicare Secondary Payer (MSP) Manual, § 10, *available at* http://www.cms.gov/Regulations-and-Guidance/ Guidance/Manuals/downloads/msp105c01.pdf (last visited Nov. 20, 2012).

became secondary to automobile, no-fault, and other liability insurance.[2] Congress further amended the Medicare Secondary Payer provisions with the enactment of the Omnibus Budget Reconciliation Act of 1986, which added a paragraph at § 1862(b)(4), making Medicare secondary to "large group health plans."[3]

The Medicare Secondary Payer law, codified at 42 U.S.C. § 1395y(b), provides that payment "under this subchapter" (in other words, under Title XVIII of the Social Security Act, which encompasses all Medicare benefits) may not be made with respect to any item or service to the extent that primary "payment has been made, or can reasonably be expected to be made." Primary payment may be made by a group health plan under 42 U.S.C. § 1395y(b)(1), or under "a workmen's compensation law or plan . . . or under an automobile or liability insurance policy or plan (including a self-insured plan) or under no fault insurance."[4] For purposes of the Medicare Secondary Payer law, "primary plan" or primary payer means a group health plan or large group health plan, to the extent that clause 42 U.S.C. § 1395y(b)(2)(A)(i) applies, or "an automobile or liability insurance policy or plan (including a self-insured plan) or no fault insurance," to the extent that 42 U.S.C. § 1395y(b)(2)(A)(ii) applies.[5]

If benefits are paid under Title XVIII of the Social Security Act despite anticipated payment by a primary payer, payment of those Medicare benefits is conditioned on reimbursement by either the primary payer or the Medicare beneficiary. These benefits are commonly referred to as "conditional" Medicare benefits. Subparagraph (B) of the

[2] Omnibus Budget Reconciliation Act of 1980, Pub. L. 96-499, 94 Stat. 2599; codified as 42 U.S.C. § 1395y(b)(2) as amended; *see also* Chaikind, Hinda, *Medicare Secondary Payer—Coordination of Benefits*, Congressional Research Service, July 10, 2008, *available at* http://aging.senate.gov/crs/medicare11.pdf (last visited Nov. 20, 2012).

[3] Omnibus Budget Reconciliation Act of 1986, § 9319, Pub. L. 99-509, 100 Stat. 2010; *see also* 42 U.S.C. § 1395y(b)(1)(B) as amended. The Omnibus Budget Reconciliation Act of 1989 clarified the Medicare Secondary Payer provisions and transferred the provisions codified at § 1862(b)(4) to 42 U.S.C. 1395y(b)(1)(B). Omnibus Budget Reconciliation Act of 1989, § 5302, Pub. L. 101-239, 103 Stat. 2106.

[4] 42 U.S.C. § 1395y(b)(2)(A).

[5] 42 U.S.C. § 1395y(b)(2)(A).

Medicare Secondary Payer provisions at 42 U.S.C. § 1395y(b)(2) provides:[6]

> The Secretary may make payment under this subchapter with respect to an item or service if a primary plan described in subparagraph (A)(ii) has not made or cannot reasonably be expected to make payment with respect to such item or service promptly . . . Any such payment by the Secretary shall be conditioned on reimbursement to the appropriate Trust Fund in accordance with the succeeding provisions of this subsection.

A primary payer's responsibility to pay for certain items or services is demonstrated by "a judgment, a payment conditioned upon the recipient's compromise, waiver, or release (whether or not there is a determination or admission of liability) or payment for items or services included in a claim against the primary plan or the primary plan's insured, or by other means."[7]

The amendments to the Medicare Secondary Payer law in the Omnibus Budget Reconciliation Act of 1986 also established a private cause of action where Medicare is secondary:[8]

> There is hereby created a private cause of action for damages (which shall be in an amount double the amount otherwise provided) in the case of a workmen's compensation law or plan, automobile or liability insurance policy or plan or no fault insurance plan, group health plan, or large group health plan which is made a primary payer under paragraph (1), (2), (3), or (4), respectively, and which fails to provide for primary payment (or appropriate reimbursement) in accordance with such respective paragraphs.

The private right of action is codified at 42 U.S.C. § 1395y(b)(3), which provides: "There 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)."

[6]42 U.S.C. § 1395y(b)(2)(B)(i).

[7]42 U.S.C. § 1395y(b)(2)(B)(ii).

[8]Omnibus Budget Reconciliation Act of 1986, § 9319, Pub. L. 99-509, 100 Stat. 2010; codified at 42 U.S.C. § 1395y(b)(3)(A) as amended; *see also* U.S. v. Baxter Intern., Inc., 345 F.3d 866, 878, Prod. Liab. Rep. (CCH) P 16742, 57 Fed. R. Serv. 3d 410 (11th Cir. 2003) (citing H. Res. 5300, 99th Cong., 2d Sess., 100 Stat. 1874 (1986) at § 9319) ("In OBRA 1986, Congress added the private right of action for double damages codified at 42 U.S.C. § 1395y(b)(3)(A). It also added the cross-reference to that section in § 1395y(b)(2)(B)(ii), which enables the Government to collect double damages 'in accordance with' the new private right of action.").

Separately, the Medicare Secondary Payer law provides that the United States "may bring an action against any or all entities that are or were required or responsible . . . to make payment with respect to the same item or service (or any portion thereof) under a primary plan. The United States may, in accordance with paragraph (3)(A) collect double damages against any such entity."[9] With respect to the United States, the Medicare Secondary Payer law further provides that "[t]he United States shall be subrogated (to the extent of payment made under this subchapter for such an item or service) to any right under this subsection of an individual or any other entity to payment with respect to such item or service under a primary plan."[10]

Courts have recognized that the overarching statutory purpose of the Medicare Secondary Payer provisions, which shift costs from Medicare to other responsible sources of payment, is to reduce the cost of Medicare.[11] However, enforcing this principle, particularly outside the context of traditional Original Medicare, has proven challenging.

§ 12:4 Medicare Part C: the Medicare Advantage program

The Balanced Budget Act of 1997 again amended Title XVIII of the Social Security Act by creating the Medicare+Choice program. The Medicare+Choice program was an option by which Medicare beneficiaries could elect to receive their Medicare benefits from managed care organiza-

[9]42 U.S.C. § 1395y(b)(2)(B)(iii).

[10]42 U.S.C. § 1395y(b)(2)(B)(iv).

[11]*See, e.g.,* Zinman v. Shalala, 67 F.3d 841, 845, 49 Soc. Sec. Rep. Serv. 128 (9th Cir. 1995) ("The transformation of Medicare from the primary payer to the secondary payer with a right of reimbursement reflects the overarching statutory purpose of reducing Medicare costs."); Bio-Medical Applications of Tennessee, Inc. v. Central States Southeast and Southwest Areas Health and Welfare Fund, 656 F.3d 277, 278, 52 Employee Benefits Cas. (BNA) 1234 (6th Cir. 2011), cert. dismissed, 132 S. Ct. 1087, 181 L. Ed. 2d 805 (2012) ("Medicare costs are rising. In 1980, Congress enacted the Medicare Secondary Payer Act (the 'Act') to counteract the growth of these costs.").

tions that contracted with the Secretary of Health and Human Services to offer Medicare+Choice plans.[1] The provisions governing the Medicare+Choice program provide:[2]

> The Secretary [of the U.S. Department of Health and Human Services] shall not permit the election under section 1851 of a Medicare+Choice plan offered by a Medicare+Choice organization under this part, and no payment shall be made under section 1853 to an organization, unless the Secretary has entered into a contract under this section with the organization with respect to the offering of such plan . . . . Such contract shall provide that the organization agrees to comply with the applicable requirements and standards of this part and the terms and conditions of payment as provided for in this part.

A Medicare+Choice plan may be a coordinated care plan "which provide[s] health care services, including but not limited to health maintenance organization plans."[3]

In 2003, the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) changed the name of the Medicare+Choice program to Medicare Advantage and amended various aspects of the program, including the calculation of payments by the Department of Health and Human Services under 42 U.S.C. § 1395w-23 to private organizations that offer Medicare Advantage plans pursuant to contracts under 42 U.S.C. § 1395w-27.[4] The MMA provided that "[t]he Medicare Advantage program shall consist of the

[Section 12:4]

[1]42 U.S.C. § 1395w-21 ("(a) Choice of Medicare benefits through Medicare+Choice plans. (a) In general.—Subject to the provisions of this section, each Medicare+Choice eligible individual (as defined in paragraph (3)) is entitled to elect to receive benefits (other than qualified prescription drug benefits) under this title—(A) through the original Medicare fee-for-service program under parts A and B, or (B) through enrollment in a Medicare+Choice plan under this part . . ..").

[2]42 U.S.C. § 1395w-27(a) (emphasis added); *see also* 42 U.S.C. § 1395kk(a) ("Except as otherwise provided in this subchapter [Title XVIII of the Social Security Act] . . . the insurance programs established by this subchapter shall be administered by the Secretary. The Secretary may perform any of his functions under this subchapter directly, or by contract . . ..").

[3]42 U.S.C. § 1395w-21(a)(2).

[4]Pub. L. 108-173, Title II, Sec. 201, Dec. 8, 2003, 117 Stat. 2176 ("any reference to 'Medicare+Choice' is deemed a reference to 'Medicare Advantage' and 'MA' " and vice versa).

program under part C of Title XVIII of the Social Security Act."[5] In other words, under Medicare Part C, the government contracts with MAOs to provide Medicare benefits. The Centers for Medicare and Medicaid Services (CMS) is the agency within the United States Department of Health and Human Services that administers the Medicare program and enters into Medicare Advantage contracts.[6]

A Medicare Advantage plan must offer all the benefits provided under the "original Medicare fee for service program option"—in other words, all benefits covered by Medicare Parts A and B.[7] However, it may offer additional supplemental benefits subject to approval by the Secretary of Health and Human Services, with additional benefits generally approved unless they would discourage enrollment in the Medicare Advantage plan.[8] Thus, as far as providing benefits, MAOs perform the same role as traditional Medicare, with an added advantage to the beneficiary in that supplemental benefits may be offered. Courts have recognized that the benefits provided under Original Medicare (Medicare Parts A and B) and Medicare Advantage (Part C) are both Medicare benefits.[9]

Notably, both Original Medicare and Medicare Advantage are funded from the same source. Medicare Part C does not have separate financing or an associated trust fund—rather, the trust funds that provide funding for Medicare Parts A

[5]Pub. L. 108-173, Title II, Sec. 201, Dec. 8, 2003, 117 Stat. 2176 ("any reference to 'Medicare+Choice' is deemed a reference to 'Medicare Advantage' and 'MA' " and vice versa).

[6]Medicare Managed Care Manual, Chapter 11—Medicare Advantage Application Procedures and Contract Requirements, § 20, *available at* http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads /mc86c11.pdf (last visited Nov. 21, 2012).

[7]42 U.S.C. § 1395w-22(a)(1).

[8]42 U.S.C. § 1395w-22(a)(3).

[9]Shah v. Secretary, Medicare & Medicaid P 303350, 2010 WL 1489984 (D. Ariz. 2010); Phillips v. Kaiser Foundation Health Plan, Inc., Medicare & Medicaid P 303831, 2011 WL 3047475 (N.D. Cal. 2011) ("The Medicare Advantage ('MA') program permits eligible individuals to elect to receive Medicare benefits from a private health insurer like Kaiser. *See* 42 U.S.C. § 1395w-21, 22."); United HealthCare Ins. Co. v. Sebelius, 774 F. Supp. 2d 1014, 1019 (D. Minn. 2011) ("Part C, formerly known as Medicare+Choice, allows beneficiaries to receive their Part A and Part B benefits through a MA organization, ...").

and B are also the source of payments to Medicare Advantage plans.[10] Pursuant to 42 U.S.C. § 1395w-23, which governs payments to MAOs, the Medicare Trust Funds spent $98.2 billion for benefits for enrollees of private health plans that provide benefits under Medicare Part C in the calendar year 2008 and $112.7 billion in 2009.[11] Part C expenditures continue rising—in 2010, the Medicare Trust Funds spent $115.9 billion for Medicare Part C benefits and, in 2011, $123.7 billion.[12] Enrollment in Medicare Advantage plans rose rapidly following the passage of the MMA and is projected to continue rising through 2013.[13]

Like the former Medicare HMO statute, the provisions governing the Medicare Advantage program also allow MAOs to "charge or authorize the provider of such services to charge for payment when the MAO is secondary to a primary payer:[14]

> (4) Organization as secondary payer
>
> Notwithstanding any other provision of law, a Medicare Choice organization may (in the case of the provision of items and services to an individual under a Medicare Choice plan under circumstances in which payment under this subchapter

[10]The 2009 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, 170, available at http://www.cms.hhs.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2009.pdf (last visited Nov. 21, 2012).

[11]The 2009 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, 5, *supra* n. 29; 2010 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, 10, available at http://www.cms.hhs.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2010.pdf (last visited Nov. 21, 2012).

[12]The 2011 Annual report of the Boards of Trustees of the Federal Hospital Insurance and federal Supplementary Medical Insurance Trust Funds, 9, available at http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2011.pdf (last visited Nov. 21, 2012); The 2012 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, 10, available at http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2012.pdf (last visited Nov. 20, 2012).

[13]*See id.* at 137.

[14]42 U.S.C. § 1395w-22(a).

> 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.

This provision is almost identical to the right-to-charge provision codified at 42 U.S.C. § 1395mm(e)(4) for the Medicare HMO risk-sharing program except that the Medicare Advantage right-to-charge provision specifically references the Medicare Secondary Payer law at 42 U.S.C. § 1395y(b)(2). Arguably, this would seem to suggest that Congress meant to arm MAOs with more teeth than its Medicare HMO predecessors to recover reimbursement of Medicare benefits in situations where the MAO is a secondary payer. The legislative history of the Omnibus Budget Reconciliation Act of 1986 suggests two ways to enforce the Medicare Secondary Payer provisions: "The secondary payer provisions are enforceable through private action *or* action brought by the Federal Government (with double damages payable)."[15] The statute does not limit the entities that may be involved in a dispute regarding payments for services where Medicare benefits are secondary. In fact, the Medicare Advantage right-to-charge provision specifically refers to the Medicare Secondary Payer law, incorporating the parameters in which a Medicare Advantage plan would be a secondary payer. While the statute does not specifically limit the scope of the "private" cause of action under 42 U.S.C. § 1395y(b)(3)(A), the statute does specifically anticipate that an MAO may be a secondary payer as defined by 42 U.S.C. § 1395y(b)(2).

The regulations promulgated by CMS relating to MAOs and the Medicare Secondary Payer law directly and unequivocally support the argument that MAOs should have all the same rights as Medicare when it comes to recovering reimbursement for conditional Medicare benefits. The regulations governing Medicare Secondary Payer procedures for

[15]House Conference Report, No. 99-1012, Joint Explanatory Statement of the Committee of the Conference, 320 [3965] (emphasis added).

the Medicare Advantage program provide, as a basic rule, that "CMS does not pay for services to the extent that Medicare is not the primary payer under section 1862(b) [42 U.S.C. § 1395y(b)] of the Act and part 411 of this chapter"—again, referring directly to the Medicare Secondary Payer law.[16] These regulations reflect the statute in providing that MAOs are secondary to "workers' compensation, any no-fault insurance, or any liability insurance policy or plan, including a self-insured plan" and may bill ("or authorize a provider to bill") a primary payer or Medicare enrollee when the MAO is secondary.[17] But the regulations take MAOs' rights with respect to Medicare Secondary Payer laws even farther, providing:[18]

> Consistent with § 422.402 concerning the Federal preemption of State law, the rules established under this section supersede any State laws, regulations, contract requirements, or other standards that would otherwise apply to MA plans. A State cannot take away an MA organization's right under Federal law and the MSP regulations to bill, or to authorize providers and suppliers to bill, for services for which Medicare is not the primary payer. *The MA organization will exercise the same rights to recover from a primary plan, entity, or individual that the Secretary exercises under the MSP regulations in subparts B through D of part 411 of this chapter.*

"Subparts B through D of part 411 of this chapter" refers to the regulations at 42 C.F.R. §§ 411.20 to 411.37 (subpart B), 42 C.F.R. §§ 411.40 to 411.47 (subpart C), and 42 C.F.R. §§ 411.50 to 411.54 (subpart D). The Secretary's or CMS's rights under these MSP regulations include those described in 42 C.F.R. § 411.24, which provides, in relevant part:

> (b) **Right to initiate recovery.** CMS may initiate recovery as soon as it learns that payment has been made or could be made under workers' compensation, any liability or no-fault insurance, or an employer group health plan.
>
> . . .
>
> (e) **Recovery from primary payers.** *CMS has a direct right of action to recover from any primary payer.*
>
> . . .

[16]42 C.F.R. § 422.108(a).

[17]42 C.F.R. § 422.108(d).

[18]42 C.F.R. § 422.108(f) (emphasis added).

> (g) **Recovery from parties that receive primary payments.** *CMS has a right of action to recover its payments from any entity*, including a beneficiary, provider, supplier, physician, attorney, State agency or private insurer that has received a primary payment.

Presumably, given that 42 C.F.R. § 411.24 falls under "subparts B through D of part 411 of this chapter," the right of action against any primary payer or other entity for recovery of conditional Medicare benefits extends to MAOs as well, at least in the eyes of CMS.

Indeed, CMS expects that MAOs will "avoid" paying benefits when Medicare is secondary by identifying primary payers and coordinating the benefits the MAOs offer with the other payers. In addition, MAOs must "[r]ecover from liable third parties; [a]void Part C costs by directing providers to bill liable third parties directly; or [a]ccount for Part B costs that could have been recovered or avoided, but that were not actually recovered or avoided, by not including them in Part C base period costs."[19] Thus, as far as CMS is concerned, the right to charge or direct providers to bill third parties directly is not the only way that MAOs may seek to "recover" or "avoid" Part C costs. CMS assumes that MAOs will be able to accomplish comparable "savings" through these mechanisms, including recovering from liable third parties. Therefore, CMS projected Medicare Secondary Payer savings of $1.5 billion in 2007 and $2 billion by 2010.[20]

Though CMS assumes MAOs will achieve comparable Medicare Secondary Payer cost savings, recent judicial challenges to MAOs' reimbursement rights have set up obstacles to MAOs' ability to achieve the savings that CMS expects.

[19]Medicare Program; Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs; Proposed Rule, 74 FR 54634, 54690 to 54691 (Oct. 22, 2009).

[20]Medicare Program; Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs, Final Rule, 75 FR 19678 to 19797 (Apr. 15, 2010) ("Regarding the Medicare Secondary Payer (MSP) Procedures (§ 422.108), in 2007 original Medicare estimated total savings due to MSP at $6.5 billion . . . . We assume a similar MSP rate for MA enrollees as obtains in original Medicare, and therefore project total savings from MSP in the MA program in 2007 as close to $1.5 billion and by 2010 at approximately $2 billion.").

§ 12:5 Medicare Advantage as secondary payer: efforts by MAOs to seek reimbursement under the Medicare Secondary Payer law—Private cause of action—Confusion between the old and the new with Medicare and managed care

The Balanced Budget Act replaced the former Medicare HMO risk-sharing program, codified at 42 U.S.C. § 1395mm, with what is now known as the Medicare Advantage program, codified at 42 U.S.C. §§ 1395w-21 to 1395w-28. However, the old provisions continue to provide a great source of confusion in the development of case law regarding whether MAOs have a private cause of action under the Medicare Secondary Payer law. Many believe that MAOs are limited to a right to "charge" for reimbursement through its plan language.

In *Care Choices HMO v. Engstrom*, a Medicare HMO under the risk-sharing program of 42 U.S.C. § 1395mm filed suit in federal district court seeking a declaration that it was entitled to reimbursement of medical expenses it paid on behalf of a covered enrollee, after the enrollee recovered funds from a third party.[1] Care Choices HMO brought its action under 42 U.S.C. § 1395mm(e)(4), arguing that the right-to-charge provisions, which authorized Medicare HMOs to seek reimbursement where they are secondary, also provided a private right of action to enforce its reimbursement rights.[2] In affirming the district court's order dismissing Care Choices HMO's claims, the Sixth Circuit found that 42 U.S.C. § 1395mm(e)(4) provided neither an express nor implied right of action.[3] In reaching this conclusion, the court compared § 1395mm(e)(4) to the Medicare Secondary Payer law and found that where 42 U.S.C. § 1395y(b)(2) utilizes mandatory language, requiring that Medicare payments "shall" be conditioned on reimbursement by the primary insurer, § 1395mm(e)(4) utilized permissive language, providing that the Medicare HMO "may" seek

[Section 12:5]

[1]Care Choices HMO v. Engstrom, 330 F.3d 786, 787, 2003 FED App. 0162P (6th Cir. 2003).

[2]330 F.3d 786, 787.

[3]330 F.3d at 789.

reimbursement.[4] This decision, though it specifically relates only to the former Medicare risk-sharing HMO program and even distinguished its analysis from the Medicare Secondary Payer law, has become the sword by which Medicare beneficiaries and primary payers alike challenge MAOs' reimbursement rights under the Medicare Secondary Payer law.

Both 42 U.S.C. §§ 1395mm(e)(4) and 1395w-22(a)(4) were cited in *Nott v. Aetna U.S. Healthcare, Inc.*, in which the plaintiff challenged the right of Aetna U.S. Healthcare, Inc. ("Aetna") to seek reimbursement of Medicare benefits out of the plaintiff's tort recovery.[5] The plaintiff raised her claim under the Pennsylvania Motor Vehicle Financial Responsibility Law, which bars "subrogation," and Aetna argued that the state law was completely preempted by the Medicare Act.[6] Though the court analyzed the claims at least in part under 42 U.S.C. § 1395w-22, which is part of Medicare Part C, the court treated *Aetna* as if it were "private Medicare-substitute HMO insurance," "providing replacement coverage for Medicare-eligible persons,"[7] rather than an entity that contracted with the government to pay Medicare benefits. The procedural posture of *Nott* centered around whether federal courts have jurisdiction but turned on whether 42 U.S.C. § 1395w-22(a)(4) and § 1395mm(e)(4) provide an enforcement scheme such that these provisions would completely preempt state laws.[8] Citing *Engstrom*, the court compared these right-to-charge provisions with the MSP law at 42 U.S.C. § 1395y(b)(2)(B)(ii), and found that there is no similar provision creating a cause of action for HMOs to "pursue their private contract rights," and thus, "Congress did not create a mechanism for the private enforcement of subrogation rights of Medicare substitute HMOs."[9] Without a remedial scheme, the court found that

[4]330 F.3d at 790.

[5]Nott v. Aetna U.S. Healthcare, Inc., 303 F. Supp. 2d 565, 566 (E.D. Pa. 2004).

[6]303 F. Supp. 2d 565, 566.

[7]303 F. Supp. 2d at 566–67.

[8]303 F. Supp. 2d at 570–71.

[9]303 F. Supp. 2d at 571.

the federal statutes were not completely preempted, and thus remanded the case to state court.[10]

A common thread between *Engstrom* and *Nott* is the concept of the Medicare "insurance contract" as if these private organizations issue insurance policies to its insured members. In *Engstrom*, the court reasoned that 42 U.S.C. § 1395mm governs the composition of Medicare "insurance contracts," and thus, § 1395mm(e)(4) permits "Medicare-substitute HMOs" to "include a provision in their own policies making them a secondary insurer."[11] The court in *Nott* took this analysis a step further and applied it not only to 42 U.S.C. § 1395mm(e)(4) but also § 1395w-22(a)(4): "The Medicare Act allows a health insurer providing replacement coverage for Medicare-eligible persons to include in its insurance contract a right of subrogation against an insured's recovery from a third party for money previously paid for the insured's medical care. 42 U.S.C. §§ 1395w-22(a)(4), 1395mm(e)(4)."[12]

The idea that Medicare HMOs (in the past) or MAOs (currently) can include "subrogation" rights in their "insurance contracts" focuses on a misconception that there is such thing as a Medicare insurance "policy" that governs the provision of "replacement" benefits to Medicare beneficiaries. However, this was not the case for the former Medicare risk-sharing HMOs.[13] Neither is it the case now, for MAOs—as discussed above, MAOs provide the same benefits as would be provided under Medicare Parts A and B[14] and provides them pursuant to their contracts with CMS.[15] MAOs must provide their enrollees copies of their Evidence of Coverage describing, among other items, the benefits provided under Original

[10]303 F. Supp. 2d at 573.

[11]*Engstrom*, 330 F.3d at 790.

[12]*Nott*, 303 F. Supp. 2d at 567.

[13]42 U.S.C. § 1395mm(g) governs contracts between the Medicare HMOs and the Secretary, not a contract with enrollees. Further, 42 U.S.C. § 1395mm provides that Medicare HMOs must provide to its members the same benefits they would be entitled to under Medicare Parts A and B and would be funded by the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund. *See* 42 U.S.C. § 1395mm(a) to (c).

[14]42 U.S.C. § 1395w-22(a)(1).

[15]42 U.S.C. § 1395w-27.

Medicare as well as any supplemental benefits offered by the MAO and the grievance and appeal procedures.[16] Any changes to the Evidence of Coverage must be approved by CMS.[17] Thus, MAOs do not issue a Medicare "insurance policy" but, rather, send out a document describing the Medicare benefits that enrollees receive. They do not pay benefits pursuant to a "policy" but rather under a statutory framework. By the same token, MAOs do not exercise the power to include "subrogation rights" in their policies—rather, MAOs' rights as secondary payers are statutory.

A state court in New York followed the same line of reasoning as in *Engstrom* and *Nott* in *Ferlazzo v. 18th Ave. Hardware, Inc.*[18] In *Ferlazzo*, a Medicare beneficiary sought an order extinguishing the "lien" of a Medicare Advantage plan, which the court characterized as a "private insurer authorized under federal law to provide benefits to Medicare recipients."[19] The court cited both *Engstrom* and *Nott* and, in similar fashion, found that MAOs do not have a private right of action to recover payments when they are secondary but, rather, "allows the private insurer to include in its insurance contract a right of subrogation against an insured's recovery from a third party for money previously paid for the insured's medical care" under 42 U.S.C. § 1395w-22(a)(4) and § 1395mm(e)(4).[20] The court found that MAOs had no statutory right of reimbursement but rather "statutory permission" to include recovery provisions in their contracts.[21]

§ 12:6 Medicare Advantage as secondary payer: efforts by MAOs to seek reimbursement under the Medicare Secondary Payer law—Private cause of action—The private cause of action under Medicare Secondary Payer law

Aside from seeking reimbursement under the right-to-charge provisions, MAOs have also sought enforcement of

[16]*See* 42 C.F.R. § 422.111.

[17]42 C.F.R. § 422.111(d).

[18]Ferlazzo v. 18th Ave. Hardware, Inc., 33 Misc. 3d 421, 929 N.Y.S.2d 690 (Sup 2011).

[19]33 Misc. 3d 421 at 422.

[20]33 Misc. 3d 421 at 424.

[21]33 Misc. 3d 421 at 425-26.

their reimbursement rights through various theories regarding a private cause of action provided under the Medicare Secondary Payer laws. In *Primax Recoveries v. Yarmosh*, the plaintiff filed an action seeking reimbursement of Medicare benefits on behalf of CIGNA Healthcare (CIGNA), naming as defendants the Medicare beneficiaries and the insurer of the tortfeasor.[1] The plaintiff cited to the old Medicare HMO risk-sharing statute instead of Medicare Part C, arguing that "it is entitled to recovery under 42 U.S.C. § 1395mm(e)(4), a subsection of the statute that creates and governs the Medicare+Choice program."[2] The court declined to recognize an implied cause of action in § 1395mm(e)(4), citing *Engstrom* as well as the Sixth Circuit's opinion in *Empire HealthChoice Assur., Inc. v. McVeigh*, where a private insurance carrier's right to seek reimbursement did not translate to an implied federal cause of action to sue for reimbursement.[3] *McVeigh*, however, involved the Federal Employees Health Benefits Act of 1959 (FEHBA), 5 U.S.C.S. §§ 8901 et seq., and thus relates to an entirely different statutory scheme.

In *Primax Recoveries*, the plaintiff also argued that the right of action provided to the United States under 42 U.S.C. § 1395y(b)(2)(B)(ii) also created a cause of action to recover the medical expenses that CIGNA paid, alleging that the term "United States" could be read broadly to include a Medicare+Choice organization.[4] The court found that the language of the statute was "clear and unambiguous"—that neither CIGNA nor Primax Recoveries are included within the meaning of "United States" and that CIGNA's only remedy is under state contract law.[5]

Along the same lines of a close reading of the MSP statute, another federal district court came to a similar conclu-

[Section 12:6]

[1]Primax Recoveries v. Yarmosh, No. 3:03-CV-01931, at *2 (D. Conn. Sept. 7, 2006). The plaintiff also named a law firm, claiming that the law firm advised the Medicare beneficiaries not to reimburse the medical benefits.

[2]Primax Recoveries v. Yarmosh, at *9.

[3]Primax Recoveries v. Yarmosh, at *12–13 (citing Empire Healthchoice Assur., Inc. v. McVeigh, 547 U.S. 677, 126 S. Ct. 2121, 165 L. Ed. 2d 131, 37 Employee Benefits Cas. (BNA) 2729 (2006)).

[4]*Primax Recoveries*, at *13–14.

[5]*Primax Recoveries*, at *15.

sion in *Humana Med. Plan, Inc. v. Reale*, finding that even if an MAO may exercise the same rights of reimbursement as the Secretary pursuant to the CMS regulations,[6] the Medicare Secondary Payer law at 42 U.S.C. § 1395y(b)(2)(B)(iii) creates a cause of action for the "United States," *not* the "Secretary."[7] Even though the court later vacated this decision, personal injury attorneys nonetheless frequently rely on this opinion in their efforts to argue that MAOs are not entitled to reimbursement at all.

In *Reale*, a Medicare beneficiary named Mary Reale had enrolled in the Humana Gold Plus Medicare Advantage Plan, which Humana Medical Plan, Inc. ("Humana") administered pursuant to a contract with CMS.[8] Reale sustained injuries as a result of a slip-and-fall incident, and Humana paid Medicare benefits for the treatment of these injuries.[9] Humana took the position that, as a MAO, its payment of benefits was conditioned on reimbursement if Reale recovered for her injuries from a primary payer as defined under 42 U.S.C. § 1395y(b)(2)(A).

Reale and her husband, August Reale, filed a personal injury action against various defendants, including Hamptons West Condominium Association, Inc. ("Hamptons West"), the owner of the premises on which she was injured.[10] The Reales eventually settled their personal injury action and received settlement funds from the insurer of Hamptons West.[11] Pursuant to the regulations at 42 C.F.R. § 422.108(f) and 42 C.F.R. § 411.37, Humana asserted a right of reimbursement against these settlement funds pursuant to the

[6]*See* 42 C.F.R. § 422.108(f).

[7]Humana Medical Plan, Inc. v. Reale, Medicare & Medicaid P 303661, 2011 WL 335341 (S.D. Fla. 2011), order vacated, (Sept. 26, 2011) ("The United States is vested with full authority to bring an action for reimbursement, not the Secretary. 42 U.S.C. § 1395y(b)(2)(B)(iii).").

[8]*See* Statement of Undisputed Material Facts in Support of Plaintiff's Motion for Summary Judgment at 1, Humana Medical Plan, Inc. v. Mary Reale, et al., No. 1:10-cv-21493 (S.D. Fla. Jan. 28, 2011).

[9]*See* Statement of Undisputed Material Facts in Support of Plaintiff's Motion for Summary Judgment at 2.

[10]*Reale*, 2011 WL 335341 at *1–2; *see also* Mary Reale and August Reale v. Hamptons West Condo. Assoc., Inc., No. 09-42330 CA 09 (Fla. 11th Jud. Cir. Ct.).

[11]*See* Defendant Humana Medical Plan, Inc.'s Motion for Summary Judgment on Affirmative Defenses at 3, Mary Reale, et al. v. Humana

reimbursement formula provided under 42 C.F.R. § 411.37(c), but Reale refused to remit reimbursement pursuant to the regulations.[12] At the time, it was believed that Humana had paid a total of $19,155.41 in conditional Medicare benefits on Reale's behalf.[13]

The identity of the primary payer, the insurer who paid the settlement funds to the Reales, was not known at the time that Humana learned of the settlement and was attempting to enforce its reimbursement right. Thus, Humana filed suit against Mary Reale and her attorney in federal district court, seeking a declaratory judgment that Humana was entitled to reimbursement of the conditional Medicare benefits it paid pursuant to the Medicare Secondary Payer law and seeking reimbursement pursuant to the rights provided to MAOs under 42 U.S.C. § 1395y(b)(2)(B)(iii) and 42 C.F.R. § 422.108(f).[14] In the alternative, Humana sought enforcement of its "contractual" reimbursement rights as set forth in the Evidence of Coverage.

Reale and her attorney moved to dismiss Humana's suit, arguing that 42 U.S.C. § 1395y(b)(2) does not grant MAOs a private cause of action, and thus, the court lacked subject matter jurisdiction.[15] The court, in granting their Motion to Dismiss, seemed to recognize the validity of the CMS regulations at 42 C.F.R. § 422.108, which provides in subparagraph (f) that an MAO will exercise "the same rights to recover from a primary plan, entity, or individual that the Secretary exercises under the MSP regulations . . .."[16] However, the MSP statute at 42 U.S.C. § 1395y(b)(2)(B)(iii) provides only that the "United States" may file suit—thus, the court

Medical Plan, Inc., No. 10-31906-CA-30 (Fla. 11th Jud. Cir. Ct. May 29, 2012).

[12]*See* Statement of Undisputed Material Facts in Support of Plaintiff's Motion for Summary Judgment at 3, Humana Medical Plan, Inc. v. Mary Reale, et al., No. 1:10-cv-21493 (S.D. Fla. Jan. 28, 2011).

[13]*See* Defendant Humana Medical Plan, Inc.'s Motion for Summary Judgment on Affirmative Defenses at 4, Mary Reale, et al. v. Humana Medical Plan, Inc., No. 10-31906-CA-30 (Fla. 11th Jud. Cir. Ct. May 29, 2012).

[14]*See* Complaint, Humana Medical Plan, Inc. v. Mary Reale, et al., No. 1:10-cv-21493 (S.D. Fla. May 17, 2010).

[15]*Reale*, 2011 WL 335341 at *2.

[16]2011 WL 335341 at *4–5.

reasoned that the Secretary may not, and if the Secretary could not bring an action for reimbursement, neither could Humana.[17] Humana filed a Motion for Amendment, Clarification, or Reconsideration of the court's order dismissing the case, and the court vacated the order.[18]

Meanwhile, another federal district court considering a similar issue also found that the Medicare Act does not create a private cause of action under which MAOs could file suit to enforce their reimbursement rights against beneficiaries. In *Parra v. PacifiCare of Ariz., Inc.*, the U.S. District Court for the District of Arizona considered an MAO's right of reimbursement under 42 U.S.C. § 1395w-22(a)(4), § 1395y(b)(2), as well as § 1395mm(e)(4), and found that the Medicare Advantage statutory scheme provides no more than a federal right, not a private cause of action.[19] The court considered the provision in 42 C.F.R. § 422.108(f) that an MAO exercises the "same rights to recover from a primary plan, entity, or individual that the Secretary exercises under the MSPA regulations in subparts B through D of part 411 of this chapter" but found that even though the Secretary may take legal action for reimbursement, actions by the Secretary involve administrative procedures that must be exhausted before judicial action.[20] This reasoning would seem to suggest that an MAO could also bring a Medicare Secondary Payer claim to federal court as long as it exhausted the administrative remedies first. *Parra* created even more confusion regarding the validity and application of the CMS regulations in that the Court seemed to recognize that the Secretary *could* bring an action under the Medicare Secondary Payer law whereas, in contrast, the court in *Reale* found that the Secretary was not the "United States" and thus could not file suit to enforce Medicare Secondary Payer rights.

In the wake of this decision, and before the court in *Reale* entered an order on Humana's Motion for Amendment,

[17]2011 WL 335341 at *5.

[18]*See* Humana Medical Plan, Inc.'s Motion for Amendment, Clarification, or Reconsideration, Humana Medical Plan, Inc. v. Mary Reale, et al., No. 1:10-cv-21493 (S.D. Fla. Feb. 28, 2011).

[19]Parra v. PacifiCare of Arizona, Inc., 2011 WL 1119736, *12–13 (D. Ariz. 2011).

[20]2011 WL 1119736, at 11 (citing 42 C.F.R. § 422.108(f)).

Clarification, or Reconsideration, Humana determined that its claims would be more proper if brought against the primary payer, whose identity Humana had learned. Thus, Humana voluntarily dismissed its claims against Reale and filed suit against Western Heritage Insurance Company ("Western Heritage") under the private cause of action provided under 42 U.S.C. § 1395y(b)(3)(A).[21]

Pursuant to the regulations governing recovery of conditional Medicare benefits, a beneficiary who recovers from a primary payer after Medicare benefits had already been paid on her behalf must reimburse the conditional Medicare benefits within 60 days.[22] The regulations also provide:[23]

> (i) Special rules.
>
> (1) In the case of *liability insurance settlements* and disputed claims under employer group health plans, workers' compensation insurance or plan, and no-fault insurance, the following rule applies: *If Medicare is not reimbursed as required by paragraph (h) of this section, the primary payer must reimburse Medicare even though it has already reimbursed the beneficiary or other party.*
>
> (2) The provisions of paragraph (i)(1) of this section also apply if a primary payer makes its payment to an entity other than Medicare when it is, or should be, aware that Medicare has made a conditional primary payment.

Far more than 60 days had passed since the Reales received settlement funds from Western Heritage. Thus, pursuant to the regulations, Western Heritage is obligated to reimburse the Medicare benefits Humana paid even though it had already sent payment to the Reales. Western Heritage filed a Motion to Dismiss Humana's complaint, and the motion is currently pending in the U.S. District Court for the Southern District of Florida.[24]

If Humana's claims against Western Heritage survive the Motion to Dismiss, this case could potentially resolve the issue of how the phrase "double damages" is to be interpreted in the context of Medicare Advantage and the private cause of action under Medicare Secondary Payer law.[25] This is a question that has yet to be answered by the courts. Humana paid at least $19,155.41 in conditional Medicare benefits on Reale's behalf, but these payments reflect the reduced amounts that MAOs pay—the health care providers' full, billed charges are actually much higher. With regard to Reale's treatments that Humana paid Medicare benefits for, the full, billed charges totaled $74,636.17.[26] Thus, calculation of double damages could be either double the conditional Medicare benefits that Humana paid, totaling $38,310.82 (2 x $19,155.41), or double the providers' full, billed charges: $149,272.34 (two x $74,636.17). The private cause of action provision does not expressly provide one way or the other:[27]

> There 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).

Recall that the Medicare Advantage right-to-charge provision allows MAOs to charge (or authorize providers to charge) primary payers "in accordance with the charges allowed under a law, plan, or policy" when the MAO is secondary.[28] The phrase "charges allowed under a law, plan, or policy" refers to payments the primary payer would have made pursuant to its governing law, plan, or policy. Subparagraph (A) of 42 U.S.C. § 1395w-22(a)(4) provides that the MAO may charge a primary payer which would be obligated to pay for the provision of treatments or services "under

[21] *See* Complaint, Humana Medical Plan, Inc. v. Western Heritage Insurance Company, No. 1:12-cv-20123 (S.D. Fla. Jan. 11, 2012).

[22] 42 C.F.R. § 411.24(h).

[23] 42 C.F.R. § 411.24(i) (emphasis added).

[24] *See* Defendant Western Heritage Insurance Company's Motion to Dismiss Complaint, Humana Medical Plan, Inc. v. Western Heritage Insurance Company, No. 1:12-cv-20123 (S.D. Fla. May 9, 2012). The motion is still pending as of March 29, 2013.

[25] See 42 U.S.C. § 1395y(b)(3)(A) ("There 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 [42 U.S.C. § 1395y(b)(1)] and [42 U.S.C. § 1395y(b)(2)(A)].") (emphasis added).

[26] *See* Complaint at 8, 10, Humana Medical Plan, Inc. v. Western Heritage Insurance Company, No. 1:12-cv-20123 (S.D. Fla. Jan. 11, 2012).

[27] 42 U.S.C. § 1395y(b)(3)(A) (emphasis added).

[28] 42 U.S.C. § 1395w-22(a)(4).

such law, plan, or policy."[29] If 42 U.S.C. § 1395w-22(a)(4) provides the amount that an MAO may charge a primary payer, it would be reasonable to extrapolate that this is the "amount otherwise provided" for purposes of calculating double damages under § 1395y(b)(3)(A). Assuming that such a law, plan, or policy would pay the providers' actual charges rather than the reduced Medicare payments, double damages would be calculated as double the providers' full, billed charges.

The purpose of double damages is to deter the undesirable act of shifting costs from responsible primary payers to the Medicare trust funds, so calculating double damages as double the providers' full, billed charges would be consistent with this goal.[30] Though courts have not yet ruled on the proper calculation of double damages, the Sixth Circuit has recognized the possibility that double damages may be twice the providers' full, billed charges. In *Bio-Medical Applications of Tenn., Inc. v. Cent. States Southeast & Southwest Areas Health & Welfare Fund*, a health care provider filed suit under 42 U.S.C. § 1395y(b)(3)(A) for double damages against a group plan for terminating coverage upon learning of a member's eligibility for Medicare benefits, in violation the Medicare Secondary Payer law.[31] The Sixth Circuit reversed the district court's dismissal of plaintiff Bio-Medical's claim under § 1395y(b)(3)(A), finding that the defendant group plan failed to make the primary payments required under the Medicare Secondary Payer law by taking into account the member's eligibility for Medicare benefits.[32] With regard to the calculation of double damages under the private cause of action provision, the Sixth Circuit remanded

[29]This phrasing is consistent with the definition of primary payer under the Medicare Secondary Payer law at 42 U.S.C. § 1395y(b)(2)(A)(ii): "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." (emphasis added).

[30]Harris Corp. v. Humana Health Ins. Co. of Florida, Inc., 253 F.3d 598, 606 (11th Cir. 2001) ("A private cause of action for double damages in these contexts serves Congress' interest in the fiscal integrity of the Medicare program by deterring private insurers primary to Medicare under the statute from attempting to lay medical costs at the government's doorstep.").

[31]*Bio-Medical*, 656 F.3d at 280.

[32]656 F.3d at 287.

the issue to the district court for a determination.[33] However, the parties settled without briefing the issue of double damages, and no determination was ever made.[34]

In analyzing the reference point for double damages under 42 U.S.C. § 1395y(b)(3)(A), the Sixth Circuit in *Bio-Medical* considered the possibility that the reference point could be double the amount of damages incurred by the health care provider—in other words, twice the amount of the outstanding bills to the defendant private insurer.[35] The other possibility is that the reference point is double the damages incurred by Medicare or twice the amount of the conditional Medicare benefits that Medicare had to pay in light of the primary payer's failure to pay.[36] Again, because Medicare typically pays lower rates than private insurers, double the Medicare conditional payments will usually be less than the amount double the outstanding providers' bills to a private insurer.[37] Determining which method of calculation is proper requires analyzing why the statute provides for double damages in the first place—punishing private insurers that violate the prohibition against shifting costs to Medicare would certainly have a deterrent effect, much like treble damages in antitrust laws.[38] Violations of the Medicare Secondary Payer law do not so much hurt the general marketplace but damage Medicare's fiscal integrity—thus, the Medicare Secondary Payer cost-shifting protects the fiscal integrity of the Medicare program.[39]

[33]656 F.3d at 297.

[34]Stipulation of Dismissal with Prejudice, Bio-Medical Applications of Tenn., Inc. v. Cent. States Southeast & Southwest Areas Health & Welfare Fund, No. 2:08-cv-00228 (E.D. Tenn. Jan. 13, 2012).

[35]*Bio-Medical*, 656 F.3d at 295.

[36]656 F.3d at 297.

[37]656 F.3d at 297.

[38]656 F.3d at 297.

[39]656 F.3d at 297.

§ 12:7 Medicare Advantage as secondary payer: efforts by MAOs to seek reimbursement under the Medicare Secondary Payer law—Private cause of action—The Third Circuit finds that MAOs do have a private cause of action against primary payers

In a promising turn for MAOs, the Third Circuit recognized in *In re Avandia Mktg.*[1] that the Medicare Secondary Payer law does authorize a private cause of action by MAOs to enforce their reimbursement rights. GlaxoSmithKline was the defendant in multidistrict litigation brought by individuals who claimed personal injury damages from use of GlaxoSmithKline's diabetes medication, "Avandia."[2] When GlaxoSmithKline began settling with many of the plaintiffs and releasing settlement funds, GlaxoSmithKline honored the reimbursement rights of Medicare Parts A and B but not the claims for reimbursement by MAOs, such as Humana.[3] Humana, which had paid Medicare Part C benefits to many of the *Avandia* plaintiffs, filed a complaint to seek reimbursement of its conditional Medicare benefits against GlaxoSmithKline under the private cause of action provided by 42 U.S.C. § 1395y(b)(3)(A).[4] The district court, in dismissing Humana's Complaint, perplexingly found that the Medicare Secondary Payer law as a whole does not apply to the Medicare Advantage program. Though the Medicare Advantage right-to-charge provision references the MSP law at 42 U.S.C. § 1395y(b)(2), the district court held that this reference "is clearly limited to the statutory language explaining when a Medicare provider is a secondary insurer, and does not incorporate the remedies of the MSP Act."[5] The district court reasoned that the Medicare Act permitted MAOs to

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[1]In re Avandia Marketing, Sales Practices and Products Liability Litigation, 685 F.3d 353 (3d Cir. 2012), petition for cert. filed, 81 U.S.L.W. 3340 (U.S. Dec. 5, 2012).

[2]In re Avandia Marketing, Sales Practices and Products Liability Litigation, Medicare & Medicaid P 303801, 2011 WL 2413488 (E.D. Pa. 2011), rev'd, 685 F.3d 353 (3d Cir. 2012), petition for cert. filed, 81 U.S.L.W. 3340 (U.S. Dec. 5, 2012).

[3]2011 WL 2413488, at *4–5.

[4]2011 WL 2413488, at *8.

[5]2011 WL 2413488, at *9–10.

charge primary payers for conditional Medicare benefits as a contractual right, but the federal statute does not obligate primary payers to pay MAOs or create a federal right of action against primary payers.[6]

The Third Circuit, in reversing the district court's decision, found that 42 U.S.C. § 1395y(b)(3)(A) *does* authorize a private right of action by MAOs to file suit to enforce its reimbursement rights under the MSP provisions. In doing so, the Third Circuit thoroughly rejected GlaxoSmithKline's and the district court's reliance on the cases finding no private right of action under 42 U.S.C. § 1395mm(e)(4) and § 1395w-22(a)(4). These cases, *Engstrom*, *Nott*, and *Parra,* are the same cases that others have relied on to challenge MAOs' reimbursement rights, including Western Heritage in defense of Humana's lawsuit under the same private cause of action.[7] As discussed above, these cases are often cited in support of the argument that an MAO does not have a private right of action under 42 U.S.C. § 1395y(b)(3)(A) because 42 U.S.C. § 1395mm(e)(4) and § 1395w-22(a)(4) do not authorize a private right of action to enforce reimbursement. In *In re Avandia Mktg.*, the Third Circuit found that these cases provide no guidance on the issue of whether MAOs could file suit under 42 U.S.C. § 1395y(b)(3)(A) as these cases did not involve claims raised under that provision. *Engstrom* concerned § 1395mm(e)(4), and thus, the Sixth Circuit decision did not address whether an MAO could bring suit under the MSP private cause of action under § 1395y(b)(3)(A)—thus, the Third Circuit found its analysis irrelevant to the issues raised in Humana's suit against GlaxoSmithKline.[8] Similarly, *Nott* concerned § 1395mm(e)(4) and § 1395w-22(a)(4) and "nowhere mentioned the § 1395y(b)(3)(A) private cause of action . . . . Once again, because the decision does not discuss whether a private insurer providing Medicare services can bring suit under the MSP private cause of action, it is of limited

[6]2011 WL 2413488, at *11.

[7]Defendant Western Heritage Insurance Company's Motion to Dismiss Complaint at 5–8, Humana Medical Plan, Inc. v. Western Heritage Insurance Company, No. 1:12-cv-20123 (S.D. Fla. Mar. 9, 2012).

[8]*In re Avandia Mktg.*, 685 F.3d at 362.

relevance here."[9] "For the same reasons, *Parra v. PacifiCare of Arizona, Inc.*, cited by Glaxo and the District Court, is also inapposite."[10] Thus, the Third Circuit declined to follow the logic that no private right of action is authorized under 42 U.S.C. § 1395y(b)(3)(A) based on cases in which courts found no right of action under § 1395mm(e)(4) or § 1395w-22(a)(4).

The Third Circuit also rejected the argument that the Medicare Secondary Payer law does not apply to MAOs. The right of action created under 42 U.S.C. § 1395y(b)(3)(A) authorizes a private cause of action when a primary payer fails to make payments "in accordance with paragraphs (1) and (2)(A)." In turn, paragraph (2)(A) (or 42 U.S.C. § 1395y(b)(2)(A)) refers consistently to "payments under this subchapter."[11] GlaxoSmithKline contended that "subchapter" refers only to Medicare benefits paid under Parts A and B while Humana argued that "subchapter" refers to the Medicare Act as a whole, and not in particular to Parts A and B, pointing to other provisions in the Medicare Act where Congress specifically limited the applicability of those provisions to certain parts of the Act.[12] The Third Circuit agreed with Humana:[13]

> This language makes clear that "subchapter" refers to the Medicare Act as a whole. Since the MSP Act and its private cause of action provision do not attach any narrowing language to "payments made under this subchapter," that phrase applies to payments made under Part C as well as those made under Parts A and B. Accordingly, that language cannot be read to exclude MAOs from the ambit of the private cause of action provision.

The Third Circuit also analyzed the legislative history, considering conference reports discussing Congress's goals in creating the Medicare Advantage program, and found that although the text of the statute is not ambiguous, legislative

[9] *In re Avandia Mktg.*, 685 F.3d at 362.

[10] *In re Avandia Mktg.*, 685 F.3d at 362 n. 14.

[11] 42 U.S.C. § 1395y(b)(2)(A); *In re Avandia Mktg.*, 685 F.3d at 359–60.

[12] *In re Avandia Mktg.*, 685 F.3d at 359.

[13] *In re Avandia Mktg.*, 685 F.3d at 360.

history and policy rationales support its conclusion.[14] Congress's intention in creating the Medicare Advantage program was to "ultimately create a more efficient and less expensive Medicare system," a goal that would be impossible if MAOs began at a "competitive disadvantage" of being unable to consistently recover conditional benefits from primary payers.[15] If Medicare could threaten a lawsuit for double damages, but MAOs could not, MAOs would be unable to collect from primary payers, and the Third Circuit found it "difficult to believe that it would have been the intent of Congress to hamstring MAOs in this manner."[16] In fact, the legislative history directly supports Humana's argument that Congress intended MAOs to "enjoy a status parallel to that of traditional Medicare":[17]

> Under original fee for service, the Federal government alone set legislative requirements regarding reimbursement, covered providers, covered benefits and services, and mechanisms for resolving coverage disputes. Therefore, the Conferees intend that this legislation provide a clear statement extending the same treatment to private [MA] plans providing Medicare benefits to Medicare beneficiaries.

Thus, the Third Circuit recognizes that the goals of the Medicare Advantage program are directly served by allowing MAOs the same rights, including the right to file suit to enforce its MSP reimbursement rights, as the federal government has for traditional Medicare.

Finally, the Third Circuit also rejected the district court's determination that providing MAOs a private right of action would not serve the program's cost-savings aim as the district court believed that the economic risks are shifted from the government to the MAO.[18] Pursuant to the statute, 25% of any savings that an MAO is able to achieve covering Medicare beneficiaries is retained by the Medicare Trust Fund—"Accordingly, when MAOs spend less on providing coverage for their enrollees, as they will if they recover ef-

[14] *In re Avandia Mktg.*, 685 F.3d at 363.

[15] *In re Avandia Mktg.*, 685 F.3d at 363–64.

[16] *In re Avandia Mktg.*, 685 F.3d at 364.

[17] *In re Avandia Mktg.*, 685 F.3d (citing H.R. Rep. No. 105-217 at 638 (1997) (Conf. Rep.)).

[18] *In re Avandia Mktg.*, 685 F.3d at 364–65.

ficiently from primary payers, the Medicare Trust Fund does achieve cost savings."[19] In other words, when MAOs are able to reduce costs by avoiding payment or collecting reimbursement when MAOs are secondary to a primary payer, the resulting savings do return to the Medicare Trust Fund and result in reduced costs for Medicare.

Going forward in light of the Third Circuit's game-changing decision, MAOs have more clout in seeking reimbursement under the Medicare Secondary Payer provisions, but at this time, its power is limited to the private cause of action against primary payers recognized in *In re Avandia*. Logistically, in handling enrollees' personal injury settlements, MAOs are not always working directly with the primary payer. Staying involved with the settlement process and making sure the primary payer is on notice of the MAO's reimbursement right is paramount to ensuring payment.

§ 12:8 The Medicare appeal process, a jurisdictional requirement

Though MAOs may be making headway in enforcing their right of reimbursement against primary payers under the MSP private cause of action, they face a different set of challenges if enrollees seek to challenge reimbursement in state court, under the respective state subrogation laws. One area of uncertainty is whether Medicare Advantage enrollees seeking to challenge MAOs' reimbursement rights under the Medicare Secondary Payer law must exhaust the appeal process under 42 U.S.C. § 1395w-22(g) before they may file suit in a federal district court.

§ 12:9 The Medicare appeal process, a jurisdictional requirement—Overview of the appeal process

As discussed above, Congress enacted Medicare in 1965 as an amendment to the Social Security Act, specifically, as Title XVIII of the Social Security Act. The Social Security Act contains a provision that directs appeals by Social Security recipients through an administrative process, with further judicial review permitted only in the federal courts.[1] When Congress enacted Medicare, it adopted the Social Security appeals process, with only slight modifications, for the Medicare program.[2] The Supreme Court has recognized the applicability of the appeal process to Medicare claims: "A related Social Security Act provision, 42 U.S.C. § 405(h), channels most, if not all, Medicare claims, through this special review system."[3]

The Medicare Advantage program, codified at 42 U.S.C. §§ 1395w-21 to 1395w-28, also incorporates this appeal process, at § 1395w-22(g). These provisions set forth the detailed requirements of the appeals process for Medicare beneficiaries to challenge benefit determinations by MAOs. Specifically, the statute provides for review of Medicare Advantage determinations by the Secretary of Health and Human Services ("Secretary") and for judicial review in federal court pursuant to 42 U.S.C. § 405(g) of the Social Security Act. Under 42 U.S.C. § 1395w-22(g), every MAO must have a procedure for making benefit determinations for enrollees and must also provide for reconsideration of any such determinations.[4] "If the amount in controversy is $1,000 or more, the individual or organization shall, upon notifying the other party, be entitled to judicial review of the Secretary's final decision as provided in section 205(g) [42 U.S.C. § 405(g)]."[5] When Congress established Medicare Part D, for Medicare prescription drug coverage under Prescription

[19] *In re Avandia Mktg.*, 685 F.3d at 365 (citing 42 U.S.C. §§ 1395w-24 (b)(1)(C)(i), (b)(3)(C), (b)(4)(C)).

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[1] 42 U.S.C. § 405(g).

[2] *See* 42 U.S.C. § 1395ii (adopting 42 U.S.C. § 405(g): "The provisions of sections 406 and 416 (j) of this title, and of subsections (a), (d), (e), (h), (i), (j), (k), and (l) of section 405 of this title, shall also apply with respect to this subchapter [Title XVIII].").

[3] Shalala v. Illinois Council on Long Term Care, Inc., 529 U.S. 1, 120 S. Ct. 1084, 146 L. Ed. 2d 1, 67 Soc. Sec. Rep. Serv. 1 (2000); *see also* Heckler v. Ringer, 466 U.S. 602, 614-15, 104 S. Ct. 2013, 80 L. Ed. 2d 622, 5 Soc. Sec. Rep. Serv. 3 (1984).

[4] 42 U.S.C. § 1395w-22(g)(1) to (2).

[5] 42 U.S.C. § 1395w-22(g)(5).

Drug Plans (PDP), it required Part D enrollees to utilize the same appeals process as codified in Medicare Part C.[6]

Consistent with the statute, the CMS adopted formal regulations for the Medicare Advantage program in Title 42, Part 422. The regulations regarding the appeals process are coded in Subpart M: 42 C.F.R. §§ 422.560 to 422.626. These regulations addressed many of the concerns raised in a 1993 lawsuit, *Grijalva v. Shalala,* brought by Medicare beneficiaries against the Secretary, alleging that the Secretary had failed to "enforce due process requirements" and failed to "monitor HMO denials of medical services to enrolled Medicare beneficiaries."[7] The U.S. District Court for the District of Arizona and the Ninth Circuit recognized that private, nongovernmental entities are involved with the administration of Medicare benefits and that these private entities were required to provide meaningful appeal procedures for Medicare beneficiaries in accordance with the requirements established by the federal government.[8]

[6]42 U.S.C. § 1395w-104(g)(1) ("A PDP sponsor shall meet the requirements of paragraphs (1) through (3) of section 1852(g) [42 U.S.C. § 1395w-22(g)] with respect to covered benefits under the prescription drug plan it offers under this part in the same manner as such requirements apply to an MA organization with respect to benefits it offers under an MA plan under part C.").

[7]Grijalva v. Shalala, 152 F.3d 1115, 1117, 58 Soc. Sec. Rep. Serv. 27 (9th Cir. 1998), cert. granted, judgment vacated, 526 U.S. 1096, 119 S. Ct. 1573, 143 L. Ed. 2d 669 (1999).

[8]Grijalva v. Shalala, 946 F. Supp. 747, 752–53, 52 Soc. Sec. Rep. Serv. 384 (D. Ariz. 1996), aff'd, 152 F.3d 1115, 58 Soc. Sec. Rep. Serv. 27 (9th Cir. 1998), cert. granted, judgment vacated, 526 U.S. 1096, 119 S. Ct. 1573, 143 L. Ed. 2d 669 (1999) ("There is really nothing new about a private, non-governmental entity being involved in the administrative arena of Medicare . . . . HMOs 'must provide meaningful procedures for hearing and resolving grievances between the organization . . . and members enrolled with the organization under [the Medicare program].' ") (citing 42 U.S.C. § 1395mm(c)(5)(A)); *see also* Grijalva v. Shalala, 152 F.3d 1115, 1120, 58 Soc. Sec. Rep. Serv. 27 (9th Cir. 1998), cert. granted, judgment vacated, 526 U.S. 1096, 119 S. Ct. 1573, 143 L. Ed. 2d 669 (1999) ("We find that HMOs and the federal government are essentially engaged as joint participants to provide Medicare services such that the actions of HMOs in denying medical services to Medicare beneficiaries and in failing to provide adequate notice may fairly be attributed to the federal government. The Secretary extensively regulates the provision of Medicare services by HMOs. HMOs are required, by the Medicare statute and their contracts with the Secretary, to comply with all federal laws and regulations. The Secretary is required to ensure, inter alia, that HMOs provide adequate notice and meaningful appeal procedures to beneficiaries."). In light of the Balanced Budget Act of 1997 and the CMS regulations implementing the appeals process, the United States Supreme Court and then later the Ninth Circuit vacated and remanded the case for further consideration. Shalala v. Grijalva, 526 U.S. 1096, 119 S. Ct. 1573, 143 L. Ed. 2d 669 (1999); Grijalva v. Shalala, 185 F.3d 1075 (9th Cir. 1999).

As explained by CMS in these regulations, the appeals process consists of five steps:

1. For the first level appeal, described in 42 C.F.R. § 422.578, the enrollee must ask the Medicare Advantage organization to reconsider its decision, and the organization must make a prompt decision.
2. If the Medicare Advantage organization does not resolve the matter entirely in favor of the enrollee, the organization must forward the file to the external review entity, currently, Maximus Federal Services, contracted by CMS to perform an independent review pursuant to 42 C.F.R. § 422.592.
3. If the enrollee is not satisfied with the external review decision, he or she may request a hearing before an Administrative Law Judge, pursuant to 42 C.F.R. § 422.602. The enrollee may be represented by an attorney and present evidence.
4. An enrollee who is not satisfied with the decision of the Administrative Law Judge may appeal to the Medicare Appeals Council (MAC), pursuant to 42 C.F.R. § 422.608. The decision by the MAC constitutes the final decision of the Secretary.
5. *Only* after completing all of the above levels of review may a Medicare beneficiary seek judicial review of determinations of the Medicare Appeals Council (*i.e.*, Secretary's final decision) in an action brought in a federal district court, as set forth in 42 U.S.C. § 405(g) and 42 C.F.R. § 422.612. Thus, at no point is review of decisions subject to the appeal process appropriate in state court. "The sole avenue for judicial review for all claims arising under the Medicare Act is through the exhaustion of administrative remedies before the Secretary."[9]

Federal courts have recognized that the administrative

[9]Heckler v. Ringer, 466 U.S. 602, 614–15, 104 S. Ct. 2013, 80 L. Ed. 2d 622, 5 Soc. Sec. Rep. Serv. 3 (1984).

appeal process is a jurisdictional requirement and have dismissed lawsuits brought by Medicare beneficiaries under state law against MAOs for failure to exhaust the administrative remedies as required by 42 U.S.C. § 1395w-22(g) and § 405(g) to (h). For example, in *Masey v. Humana, Inc.*, a Medicare Advantage enrollee brought claims against a Humana MAO alleging that certain benefits should have been covered as under Medicare Part B where the MAO had categorized them as Medicare Part D.[10] The federal district court found that the plaintiff's claims were " 'inextricably intertwined' with a claim for Medicare benefits, and therefore, Plaintiff was required to exhaust her administrative remedies before seeking judicial review. Because Plaintiff did not exhaust her administrative remedies, these claims too must be dismissed."[11]

Courts have also found the mandatory appeal process to be a jurisdictional requirement in the context of Medicare Secondary Payer issues with MAOs. In a recent case in a federal district court in New York, *Potts v. Rawlings Co., LLC,* Medicare Advantage enrollees sought a declaratory judgment that the defendant MAOs do not have a right of reimbursement pursuant to the New York deceptive business practices statute, N.Y. Gen. Bus. L. § 349.[12] The plaintiff originally brought the case in the New York State Supreme Court for New York County, but the defendant MAOs removed it to federal court before moving to dismiss the case for lack of subject matter jurisdiction and failure to state a claim.[13] Recognizing that § 405(g) of the Social Security Act is made applicable to Medicare Part C Medicare Advantage plans by 42 U.S.C. § 1395w-22(g), the court found that claims relating to Medicare Secondary Payer issues do in fact arise under the Medicare Act and, thus, are subject to the requirement to exhaust administrative remedies.[14] "[T]he fact that a plaintiff 'is using state law as the vehicle to press her assertion' that the MA organization is not entitled to reimbursement 'does not matter' "—exhaustion is nonetheless a jurisdictional requirement, including the "nonwaivable and nonexcusable" requirement that an individual present a claim for a final decision by the Secretary of Health and Human Services.[15]

Another example of a federal court that recognizes the requirement to exhaust administrative remedies in MSP cases is *Phillips v. Kaiser Found. Health Plan, Inc.*, in which the court also found that the plaintiff's claims arose under the Medicare Act and was thus subject to the appeal process.[16] Even though the plaintiff alleged "unfair and unlawful creditor actions," beyond just resisting reimbursement pursuant to the MSP law, the court nonetheless found that the MAO's actions would only be unfair if they went beyond the MAO's rights under the MSP, and thus, the plaintiff could not bring those claims without exhausting the administrative remedies.[17]

In contrast, if sued in state court by a Medicare Advantage enrollee, MAOs have not had the same luck convincing state court judges that the appeal process and jurisdictional requirement to exhaust it apply to MAOs the same as it would to Original Medicare.[18] Notwithstanding any of the above cases finding that claims against MAOs challenging their rights under the Medicare Secondary Payer law, a state court judge in Florida recently found that an enrollee's

[10]Masey v. Humana, Inc., Medicare & Medicaid P 302206, 2007 WL 2788612, *4–5 (M.D. Fla. 2007).

[11]2007 WL 2788612, at *5.

[12]Potts v. Rawlings Co., LLC, 2012 WL 4364451, *2 (S.D. N.Y. 2012).

[13]2012 WL 4364451, at *2.

[14]2012 WL 4364451, at *22-23; *see also* 2012 WL 4364451, at *19 (citing cases holding that lawsuits concerning MSP reimbursement must be exhausted at the administrative level before adjudication in a federal district court: Fanning v. U.S., 346 F.3d 386, 400 (3d Cir. 2003); Nygren v. U.S., 268 F. Supp. 2d 1275, 1279 (W.D. Wash. 2003); Truett v. Bowman, 288 F. Supp. 2d 909, 911-12 (W.D. Tenn. 2003)).

[15]*Potts*, 2012 WL 4364451 at *15, 21 (citing Shalala v. Illinois Council on Long Term Care, Inc., 529 U.S. 1, 15, 120 S. Ct. 1084, 146 L. Ed. 2d 1, 67 Soc. Sec. Rep. Serv. 1 (2000); Mathews v. Eldridge, 424 U.S. 319, 328, 96 S. Ct. 893, 47 L. Ed. 2d 18 (1976); quoting Phillips v. Kaiser Foundation Health Plan, Inc., Medicare & Medicaid P 303831, 2011 WL 3047475 (N.D. Cal. 2011)).

[16]Phillips v. Kaiser Foundation Health Plan, Inc., Medicare & Medicaid P 303831, 2011 WL 3047475 (N.D. Cal. 2011).

[17]*Potts*, 2012 WL 4364451 at *30–31.

[18]Though, the Supreme Court of Alabama has held that claims against MAOs that are inextricably intertwined with claims for benefits do not belong in court until exhaustion of the administrative remedies. Ex parte Blue Cross and Blue Shield of Alabama, 90 So. 3d 158, 160 (Ala. 2012).

claims challenging reimbursement belonged in state court and should be adjudicated under Florida law.

After Humana filed its federal action against Reale in Humana Med. Plan, Inc. v. Reale, Case No. 10-21493 in the U.S. District Court for the Southern District of Florida to enforce its reimbursement rights under the MSP law, Reale and her husband filed a concurrent action against Humana in state court, seeking a declaratory judgment as to the amount the Reales should reimburse pursuant to the Florida Collateral Source law, Fla. Stat. § 768.76.[19]

Humana moved to dismiss the Reales' action, arguing that the Reales were not entitled to bring their claims without having exhausted the administrative remedies. Mary Reale's rights and responsibilities with respect to Humana's Medicare Advantage plan were set forth in the Evidence of Coverage that Humana mailed to her every year. As required, the Evidence of Coverage contained a detailed description of the Medicare administrative appeal process, including that the process must be exhausted before an enrollee may seek judicial review.[20] Reale did not appeal Humana's determination of her obligation to reimburse Humana the conditional benefits Humana advanced on her behalf according to the Medicare regulations at 42 C.F.R. § 411.37. Further, the sole basis for the Reales' relief that they asserted in their Complaint was under Fla. Stat. § 768.76, the Florida Collateral Sources law. By its terms, the definition of "collateral sources" under Fla. Stat. § 768.76 does not include payments made pursuant to Title XVIII of the Social Security Act—in other words, payments of Medicare benefits.[21] Medicare Part C is a part of Title XVIII of the Social Security Act; thus, payments by MAOs should not be considered a collateral source under Fla. Stat. § 768.76. Even if the Florida Collateral Sources law did not exclude Medicare Part C benefits, it is preempted by the

[19]*See* Complaint to Determine Humana Medical Plan Inc.'s Right of Reimbursement, Mary Reale, et al. v. Humana Medical Plan, Inc., No. 10-31906-CA-30 (Fla. 11th Jud. Cir. Ct. June 4, 2010).

[20]Defendant Humana Medical Plan, Inc.'s Motion for Summary Judgment on Affirmative Defenses at 2-3, Mary Reale, et al. v. Humana Medical Plan, Inc., No. 10-31906-CA-30 (Fla. 11th Jud. Cir. Ct. May 29, 2012).

[21]Fla. Stat. § 768.76(2)(a)(1).

Medicare Part C provisions pursuant to the statute's broad preemption provisions. Medicare Part C, which establishes the Medicare Advantage program, supersedes *any* state laws that may otherwise apply to Medicare Advantage organizations.[22] The regulations governing the Medicare Advantage program, Title 42, Part 422, similarly supersede all state laws that may otherwise apply to Medicare Advantage organizations.[23]

Nonetheless, explaining only that Humana is a "private" entity and therefore "not Medicare," the state court judge denied Humana's Motion to Dismiss.[24] Humana then moved for summary judgment, presenting overwhelming evidence regarding the Medicare appeal process and its application to MAOs such as itself, but the court again denied Humana's motion.[25] The fact that the state court declined to follow the federal statutes and case law requiring dismissal of the Reales' claims makes the state court an outlier. However, the state court's decisions demonstrate some courts' reluctance to consider Medicare Advantage plans a part of the Medicare program rather than "private," for-profit insurance.

This dichotomy poses potential problems for the ability of MAOs to consistently seek reimbursement under the Medicare Secondary Payer law. If the MAO is able to identify primary payers and pursue payment from them pursuant to the private cause of action at 42 U.S.C. § 1395y(b)(3)(A), they may be able to recover funds and achieve the desired cost savings for Medicare. However, if Medicare Advantage enrollees are able to circumvent the mandatory appeal process and obtain declaratory judgments in state court defeat-

[22]42 U.S.C. § 1395w-26(b)(3); *see also Potts*, 2012 WL 4364451 at *24–37.

[23]42 C.F.R. § 422.108(f) ("[T]he rules established under this section supersede any State laws, regulations, contract requirements, or other standards that would otherwise apply to MA plans . . . . The MA organization will exercise the same rights to recover from a primary plan, entity, or individual that the Secretary exercises under the MSP regulations in subparts B through D of part 411 of this chapter."); 42 C.F.R. § 422.402.

[24]Transcript, Hearing on Humana's Motion to Dismiss at 29–30, Reale v. Humana Medical Plan, Inc., No. 10-31906-CA-30 (Fla. 11th Jud. Cir. Ct. Mar. 28, 2012).

[25]Order Denying Humana's Motion for Summary Judgment, Reale v. Humana Medical Plan, Inc., No. 10-31906-CA-30 (Fla. 11th Jud. Cir. Ct. July 30, 2012).

ing MAOs' reimbursement rights, recovery will be widely inconsistent and dependent on various states' laws. In the *Reale* state court action, Humana's recovery under the Florida Collateral Sources law was decimated by a calculation based on the alleged true value of Reale's case against the personal injury defendants. In New York, courts have considered whether to extinguish MAOs' reimbursement rights under the New York General Obligations Law § 5-335.[26]

§ 12:10 Looking forward

Given the potential to have these issues heard in state court and under state law despite the Medicare Act's broad preemption, it is understandable why some personal injury attorneys would advocate that their clients forego the appeal process and file their claims challenging MAOs' "subrogation rights" in state court. At the immediate outset, this strategy would appear to give Medicare beneficiaries a way to avoid reimbursing Medicare conditional benefits in the amounts provided by the CMS regulations. The regulations require, at the very least, reimbursement of the full amount of the conditional Medicare benefits paid on the beneficiary's behalf, less a pro rata reduction for attorney's fees and costs.[1] However, given the breakthrough in the *In re Avandia* decision in the Third Circuit, finding that MAOs *do* have a private cause of action against primary payers where MAOs are secondary, beneficiaries may not be off the hook. The result may be that Medicare beneficiaries may find themselves responsible for double the amount of conditional Medicare benefits paid on their behalf—or worse, double the amount of their health care providers' full billed charges, depending on how courts interpret the double damages provision in the future. It is not unusual for settlement agreements in personal injury actions to contain indemnity clauses whereby the plaintiff agrees to indemnify the defendant and its insurer against any future liability for payments arising from the accident or incident at issue in the action. In such circumstances, if an MAO successfully brings an action against a primary payer who paid settlement funds to a Medicare Advantage enrollee, and is able to obtain an award for double damages as provided under 42 U.S.C. § 1395y(b)(3)(A), the beneficiary may end up on the hook for those damages if the primary payer turns around and enforces the indemnity clause.

Despite the recent case law giving conflicting analysis regarding MAOs' rights to collect reimbursement under the Medicare Secondary Payer law, CMS nonetheless maintains the position that despite any case law questioning whether MAOs may exercise the same recovery rights as the Secretary under Original Medicare, 42 C.F.R. § 422.108(f) remains legally valid and an integral part of Medicare Part C.[2] Thus, CMS will still expect MAOs to recover reimbursement or avoid paying benefits when payment of Medicare benefits is secondary.

However, looking forward, MAOs face additional, conflicting pressures. To limit MAOs' administrative costs, the Health Care and Education Reconciliation Act of 2010 added a paragraph to Medicare Part C at 42 U.S.C. § 1395w-27(e) requiring MAOs to maintain a medical loss ratio of at least 0.85, and imposing steep penalties for failure to maintain it.[3] Obtaining reimbursement under the MSP reduces medical expenses, and MAOs' expenses incurred in seeking reimbursement increase administrative costs. If reimbursement is difficult to obtain, particularly if MAOs face opposition at every turn and must navigate different states' laws, efforts to obtain reimbursement would be expensive and have the opposite effect on the medical loss ratio. If seeking recovery under the MSP law is expensive and yields inconsistent results, which in turn jeopardizes MAOs' contracts under 42 U.S.C. § 1395w-27(e)(4), MAOs may not have much incentive to pursue reimbursement. This, in turn, does nothing to

[26] *See, e.g.*, Trezza v. Trezza, 32 Misc. 3d 1209(A), 934 N.Y.S.2d 37 (Sup 2011), order revd, 957 N.Y.S.2d 380 (App. Div. 2d Dep't 2012).

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[1] 42 C.F.R. § 411.37(c). If the conditional Medicare benefits equal or exceed the total settlement or judgment, the reimbursement amount is the full amount of the settlement or judgment, less procurement costs. 42 C.F.R. § 411.47(d).

[2] Moon, Danielle R., Tudor, Cynthia, *Medicare Secondary Payment Subrogation Rights*, Centers for Medicare and Medicaid Services Memorandum, Dec. 5, 2011, *available at* http://www.cms.gov/Medicare/Health-Plans/HealthPlansGenInfo/Downloads/21_MedicareSecondaryPayment.pdf (last visited Nov. 21, 2012).

[3] 42 U.S.C. § 1395w-27(e)(4) (beginning 2014).

serve the goal of Congress for the Medicare Advantage program to reduce the cost of Medicare.

MAOs might spend less seeking reimbursement if their rights under the MSP become clearer, though at this point, case law on these issues is far from settled. The Arizona District Court's decision in *Parra* is currently on appeal before the Ninth Circuit,[4] and GlaxoSmithKline is seeking review of the Third Circuit's decision in *In re Avandia* before the United States Supreme Court. It remains to be seen what exactly MAOs' rights and remedies are, under the Medicare Secondary Payer law.

[4]Guillermina Parra, et al v. Pacificare of Arizona, Inc., No. 11-16069 (9th Cir. Apr. 27, 2011).

Chapter 13

Ten Core Concepts for Health Care Lease Provisions

Gregory G. Gosfield

§ 13:1 Introduction

The poet says: "A fool sees not the same tree that a wise man sees."[1] The purpose of this chapter is to help illuminate and show latent but fundamental components of the lease that can have serious consequences for the health care facil-

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[1]William Blake, The Marriage of Heaven and Hell, Plate 7, Line 8.