Nos. 18-12139, 18-12149, 18-13049, 18-13312 (consolidated)

IN THE UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT

MSP RECOVERY CLAIMS, SERIES LLC, et al.,

Plaintiffs-Appellants,

v.

ACE AMERICAN INSURANCE COMPANY, et al.,

Defendants-Appellees.

On Appeal from the United States District Court for the Southern District of Florida

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BRIEF FOR THE UNITED STATES AS AMICUS CURIAE

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INTRODUCTION AND INTEREST OF UNITED STATES

This amicus brief is in response to the Court's December 23, 2019 letter inviting the Department of Health and Human Services (HHS) to submit an amicus brief regarding "the appropriate interpretation of 42 U.S.C. § 1395y(b)(3)(A) and whether certain [management service organizations] and [independent physician associations] may access the private right of action." Letter from David J. Smith, Clerk of Court for the Eleventh Circuit, to Robert P. Charrow, General Counsel, U.S. Dep't of Health and Human Servs. 2 (Dec. 23, 2019) (Letter). HHS administers the Medicare program and, therefore, has a significant interest in the interpretation of the statute at issue in this case.

Under the Medicare Secondary Payer Act, a Medicare plan—whether traditional Medicare or a Medicare Advantage plan—is generally not responsible for any medical expense that is also covered by another insurance policy or plan. Responsible insurance carriers, or "primary plans," generally have an obligation to reimburse Medicare if they turn out to be responsible for medical items or services for which Medicare has paid. The Medicare Secondary Payer Act creates a private right of action for double damages against primary payers that fail to reimburse Medicare or a Medicare Advantage plan for such expenses.

The Medicare Secondary Payer Act does not specify who may access the private cause of action. This Court has already held that while the private cause of

action "is not a *qui tam* statute," it is available "when the plaintiff has suffered an injury in fact." *Humana Med. Plan, Inc. v. Western Heritage Ins. Co*., 832 F.3d 1229, 1238 (11th Cir. 2016). Thus, Medicare Advantage plans that have made payments that are subject to reimbursement may avail themselves of the private cause of action. *Id.* For similar reasons, other entities that have paid for or provided coverage and for that reason suffer injuries in fact based on the failure to provide reimbursement may avail themselves of the cause of action.

Here, plaintiffs themselves have not suffered an injury in fact, and thus may not take direct advantage of the cause of action. Instead, plaintiffs assert that the cause of action would be available to entities—known as management service organizations (MSOs) and independent physician associations (IPAs)—that have contracted with the Medicare Advantage plan. MSOs and IPAs may avail themselves of the private right of action if and only if these organizations have paid for or provided medical care and would have been entitled to the reimbursement had it been made. We take no position on whether the particular MSOs or IPAs involved in this case could take advantage of the private right of action, nor do we opine on the validity of any purported assignment on which plaintiffs rely.

STATEMENT

A. Statutory Background

1. Medicare beneficiaries may "choose to receive Medicare benefits through either the traditional, government-run Medicare program or a Medicare Advantage plan." *MSPA Claims 1, LLC v. Kingsway Amigo Ins. Co.*, 950 F.3d 764, 768 (11th Cir. 2020). Under the Medicare Advantage program, private health insurers provide Medicare coverage to beneficiaries under contract with CMS. *See* 42 U.S.C. §§ 1395w-22(a), 1395w-23. "Medicare pays the [Medicare Advantage organization] a fixed fee per enrollee, and, in exchange, the [Medicare Advantage organization] must provide at least the same benefits to the enrollee that she would receive under traditional Medicare." *MSPA Claims 1, LLC v. Tenet Fla., Inc.*, 918 F.3d 1312, 1316 (11th Cir. 2019).

Medicare Advantage organizations may provide health coverage and services through subcontractors, such as independent physician associations. HHS reviews certain contract provisions, but "[Medicare Advantage organizations] and providers are generally free to 'define the terms of their own agreements without reference to the Medicare [statute]" so long as those agreements do not conflict with the statute." *MSPA Claims 1*, 918 F.3d at 1320 (quoting *Tenet Healthsystem*

GB, Inc. v. Care Improvement Plus S. Cent. Ins. Co., 875 F.3d 584, 591 (11th Cir. 2017)); *see also King v. Allstate Ins. Co.*, 906 F.2d 1537, 1540 (11th Cir. 1990).[1]

2. The Medicare Secondary Payer provisions are designed, as the name suggests, to ensure that Medicare is a "secondary" payer in certain situations: if an insurance company has a responsibility to make payment for a particular item or service, Medicare will not bear financial responsibility for that item or service. The Medicare Secondary Payer provisions, which are codified at 42 U.S.C. § 1395y(b)(2), accomplish this goal by limiting the payment of Medicare benefits in the first instance and by providing for reimbursement by insurance carriers. In particular, Medicare may not pay benefits when payment has been made or can reasonably be expected to be made promptly under an insurance policy or plan. *See* 42 U.S.C. § 1395y(b)(2)(A). But in order to accommodate Medicare beneficiaries and providers, Medicare may make conditional payments if the primary plan cannot be expected to make prompt payments. 42 U.S.C. § 1395y(b)(2)(B)(i). Such payments are "intended to minimize patient anxiety about the source of payment and to avoid delays in reimbursement for" medical expenses. *United States v. Baxter Int'l, Inc.*, 345 F.3d 866, 892 (11th Cir. 2003) (quoting H.R. Rep. No. 97-208, pt. 2, at 956 (1981)).

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[1] Medicare Advantage organizations' ability to pass on their risk to other entities is limited by 42 U.S.C. § 1395w-25(b).

When Medicare makes a conditional payment, the primary insurer is required to reimburse Medicare for that payment. 42 U.S.C. § 1395y(b)(2)(B)(ii). That way "the beneficiary gets the health care she needs, but Medicare is entitled to reimbursement." *Cochran v. U.S. Health Care Fin. Admin.*, 291 F.3d 775, 777 (11th Cir. 2002). If the primary plan fails to repay Medicare for the cost of this care, the United States can bring suit and collect double damages. 42 U.S.C. § 1395y(b)(2)(B)(i).

Private parties can also bring suit to enforce this provision. The statute provides that "[t]here is established a private cause of action for damages (which shall be in an amount double the amount otherwise provided) in the case of a primary plan which fails to provide for primary payment (or appropriate reimbursement) in accordance with paragraphs (1) and (2)(A)." 42 U.S.C. § 1395y(b)(3)(A). The statute is silent on the question of who may access this cause of action.

3. This case involves the intersection of the Medicare Secondary Payer Act with the Medicare Advantage program. Medicare Advantage plans, like traditional Medicare plans, may make conditional payments and seek reimbursement from the primary plan. *MSPA Claims 1*, 918 F.3d at 1317 (citing *Humana Med.*, 832 F.3d at 1235). The statute provides that, "under circumstances in which payment under this subchapter is made secondary pursuant to section 1395y(b)(2)"—that is, the

Medicare Secondary Payer provision—the Medicare Advantage organization "may" "charge or authorize the provider" to charge the primary insurance. 42 U.S.C. § 1395w-22(a)(4).

By regulation, Medicare Advantage organizations must identify primary insurance companies covering their enrollees and amounts payable by primary insurance, and may bill the primary insurance. 42 C.F.R. § 422.108(b), (c). The regulation provides that Medicare Advantage organizations "will exercise the same rights to recover from a primary plan, entity, or individual that the Secretary exercises under the [Medicare Secondary Payer] regulations" and "supersede[s] any State laws, regulations, contract requirements, or other standards." 42 C.F.R. § 422.108(f).

B. Facts and Prior Proceedings

These consolidated appeals arise from claims brought by entities that purport to have received assignments of causes of action under the Medicare Secondary Payer private right of action. Plaintiffs assert, in particular, that certain MSOs and IPAs have "assume[d] the risk of Medicare Advantage organizations ('MAOs')" in the sense that they are compelled to "reimburse their respective MAOs for, *inter alia*, conditional payments made pursuant to the Medicare Secondary Payer Act." Letter 1. The claims were dismissed on the ground "that only MAOs, providers, and beneficiaries—and not plaintiffs' alleged assignors—can access the private

right of action." *Id.* This Court invited HHS to "advis[e] the panel of its views regarding the appropriate interpretation of 42 U.S.C. § 1395y(b)(3)(A) and whether certain MSOs and IPAs may access the private right of action." *Id.* at 2.

ARGUMENT

THE PRIVATE RIGHT OF ACTION IS AVAILABLE TO PARTIES THAT HAVE ASSUMED RESPONSIBILITY FOR MEDICAL CARE FOR WHICH A PRIMARY PLAN HAS FAILED TO REIMBURSE MEDICARE

1. The Medicare Secondary Payer provisions were designed to ensure that the Medicare program does not assume responsibility for costs that could be borne by an insurance policy or plan. Accordingly, Medicare is instructed not to make payment in the first instance if an insurance company is expected to pay promptly. 42 U.S.C. § 1395y(b)(2)(A). Medicare may make payments to accommodate its beneficiaries if prompt payment from another entity is not expected, but those payments are conditional and subject to reimbursement once the primary plan's obligation to make payment has been demonstrated. *Id.* § 1395y(b)(2)(B)(i)-(ii).

If a primary plan fails to reimburse Medicare in the traditional Medicare program, the government can file a cause of action. 42 U.S.C. § 1395y(b)(2)(B)(iii). Likewise, a failure to reimburse a Medicare Advantage organization gives rise to a cause of action. *See Humana Med. Plan, Inc. v. Western Heritage Inc. Co.*, 832 F.3d 1229, 1236 (11th Cir. 2016) (discussing the private right of action's applicability when a primary plan has "'fail[ed] to provide

for primary payment (or appropriate reimbursement) in accordance with paragraphs (1) and (2)(A)'" (quoting 42 U.S.C. § 1395y(b)(3)(A)). The Medicare Secondary Payer Act does not specify who may access that cause of action. The statute simply states that "[t]here is established a private cause of action for damages." 42 U.S.C. § 1395y(b)(3)(A).

"Not just anyone can wander in off the street and avail themselves of the . . . Act's private cause of action." *Netro v. Greater Balt. Med. Ctr., Inc.*, 891 F.3d 522, 528 (4th Cir. 2018). Plaintiffs must have suffered an Article III injury from the primary plan's failure to make payment or provide reimbursement to bring suit. *Stalley ex rel. U.S. v. Orlando Reg'l Healthcare Sys.,Inc.*, 524 F.3d 1229, 1232 (11th Cir. 2008) (*Orlando*). As this Court has explained, "every plaintiff must show that it (1) suffered an injury-in-fact (2) that is fairly traceable to the defendant's conduct and (3) is redressable by a favorable judicial decision." *MSPA Claims 1, LLC v. Tenet Fla., Inc.*, 918 F.3d 1312, 1317 (11th Cir. 2019) (citing *Gill v. Whitford*, 138 S. Ct. 1916, 1929 (2018)). Thus, the party bringing suit must have "itself suffered an injury because a primary plan has failed to make a required payment to or on behalf of it." *MSP Recovery, LLC v. Allstate Ins. Co.*, 835 F.3d 1351, 1356 n.3 (11th Cir. 2016) (quoting *Woods v. Empire Health Choice, Inc.*, 574 F.3d 92, 101 (2d Cir. 2009)). And because the cause of action is for "damages," 42 U.S.C. § 1395y(b)(3)(A), only an entity that has suffered harm from

the failure to provide reimbursement may file suit. Consistent with these principles, this Court, along with every other court of appeals to have considered the issue, has uniformly rejected attempts to treat this provision as a *qui tam* statute. *Orlando*, 524 F.3d at 1233.[2]

Medicare Advantage organizations can access the private cause of action because they suffer Article III injury when they have paid for medical items or services and a primary plan has failed to reimburse them. *See Humana*, 832 F.3d at 1237; *see also In re Avandia Mktg., Sales Practices & Prods. Liab. Litig.*, 685 F.3d 353, 356, 367 (3d Cir. 2012); 42 C.F.R. § 422.108(f) (providing that the Medicare Advantage organization "will exercise the same rights to recover from a primary plan, entity, or individual that the Secretary exercises under the [Medicare Secondary Payer] regulations"). In addressing Medicare Advantage organizations' ability to sue, this Court reasoned that, other than the requirements of Article III standing, "[n]either the [statute] nor our case law places any other restriction on the class of plaintiffs to whom the [Medicare Secondary Payer] private cause of action is available." *Humana*, 832 F.3d at 1238; *see also MSPA Claims 1, LLC v. Kingsway Amigo Ins. Co.*, 950 F.3d 764, 771 (11th Cir. 2020) (reasoning that the

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[2] *See also Netro*, 891 F.3d at 527; *In re Avandia Mktg., Sales Practices & Prods. Liab. Litig.*, 685 F.3d 353 (3d Cir. 2012); *Woods*, 574 F.3d at 100; *Stalley v. Methodist Healthcare*, 517 F.3d 911 (6th Cir. 2008); *Stalley ex rel. U.S. v. Catholic Health Initiatives*, 509 F.3d 517 (8th Cir. 2007); *United Seniors Ass'n v. Philip Morris USA*, 500 F.3d 19 (1st Cir. 2007).

cause of action "is broadly available" where Article III is satisfied) (quotation marks omitted). Accordingly, other entities that have paid for medical items or services—whether by providing those items or services themselves or by paying others to do so—and would be entitled to receive the proceeds of a reimbursement if one were made have suffered a cognizable injury and can file suit.

To the extent that subcontractors have taken on the health care risk of the Medicare Advantage organization, they can suffer injury if not reimbursed by the primary insurer and thus can take advantage of the private right of action. If their contracts with the Medicare Advantage organization are structured so that the subcontractor has taken responsibility for providing health care items or services, and reimbursement from a primary plan would have gone to the subcontractor, the subcontractor suffers the same injury that the Medicare Advantage organization suffered in *Humana*.

Thus, for example, if a subcontractor is required by its contract with the Medicare Advantage organization to pay for medical care that a beneficiary receives at an emergency room in the absence of other coverage, and any reimbursement from the primary plan would go to the subcontractor, the subcontractor is injured by the primary payer's failure to pay. The subcontractor is also injured if its own employees provide the care and its contract with the Medicare Advantage organization provides that the subcontractor can keep any

payment from the primary plan, but the primary plan fails to pay. In this circumstance, the subcontractor experiences the same injury that a doctor experiences if he or she provided care and was not paid. *See Bio-Medical Applications of Tenn., Inc. v. Central States Se. & Sw. Areas Health & Welfare Fund*, 656 F.3d 277, 295-96 (6th Cir. 2011) (holding that doctors are injured if not paid by the primary plan and can access the private right of action).

This sort of harm plainly qualifies as Article III injury. In addition, allowing the subcontractor to recover in these circumstances advances the goals of the Medicare Secondary Payer statute. The purpose of those provisions is to protect the fiscal integrity of the Medicare program by ensuring that Medicare will not be required to pay for items or services for which a primary plan should be responsible. *Kingsway Amigo*, 950 F.3d at 767; *Glover v. Liggett Grp.*, *Inc.*, 459 F.3d 1304, 1307 (11th Cir. 2006). While payments do not go to Medicare directly in Medicare Advantage cases, payment by primary payers reduces costs, and some of those savings are passed on to Medicare through reduced costs or to the beneficiaries through expanded services. *See* 42 U.S.C. § 1395w-23. It is entirely natural that the entity that actually paid for the services, and that assumed the risk that reimbursement would not be made as required by the statute, would have a right of action to compel payment. Additionally, a subcontractor that pays for the care or provides the care through its employees will often be in the best position to

enforce the repayment obligation through the private cause of action. *Kingsway Amigo*, 950 F.3d at 767 (explaining that cause of action "is available to Medicare beneficiaries and other private entities, who 'are often in a better position than the government to know'" that another plan should pay for the care) (quoting *MSPA Claims 1*, 918 F.3d at 1316).

The possibility that some subcontractors can access the private right of action does not mean that every subcontractor can do so. Medicare Advantage organizations may have relationships with many types of subcontractors. Some of these subcontractors perform discrete tasks, such as billing or administrative functions, without assuming any of the risks of providing care or coverage for that care. It is not the organization's designation as an independent physician organization or management service organization that is significant for determining whether the organization can bring suit, but whether it actually suffered an injury because it provided or paid for care from its own coffers and was harmed by a primary plan's failure to provide reimbursement.

Contractors that did not pay for or provide unreimbursed medical expenses, regardless of how they are described, are not entitled to access the private cause of action. *See MAO-MSO Recovery II, LLC v. State Farm Mut. Auto. Ins. Co.*, 935 F.3d 573, 580-81 (7th Cir. 2019). This is true even if the subcontractor fills a role, such as billing, that gives it particular awareness regarding instances in which a

primary plan has failed to reimburse the Medicare Advantage organization, and even if the subcontractor might, in some indirect way, benefit from the primary payment. For example, if an entity merely provides administrative services to a physician, it may not avail itself of the private right of action even if its compensation for providing those services might be affected by the primary insurer's failure to pay the physician (such as when the compensation is calculated as a percentage of the physician's revenue). As noted above, this Court's cases have been limited to circumstances in which the party bringing suit has "itself suffered an injury because a primary plan has failed to make a required payment to or on behalf of it." *MSP Recovery*, 835 F.3d at 1356 n.3 (quoting *Woods*, 574 F.3d at 101). This Court's cases have not addressed other types of consequential damages that might arise for entities that would not receive primary payment themselves (either directly or through an intermediary), and the statute should not be read to encompass such damages. In particular, the statute refers to the amount of damages "otherwise provided," 42 U.S.C. § 1395y(b)(3)(A), which is naturally read to refer to the amount of primary payment owed rather than a more complex and indeterminate damages calculation.

The government takes no position on whether any particular MSO or IPA involved in this litigation has suffered the requisite injury, or whether the allegations of any of the complaints are sufficient. In making that determination,

as noted, this Court (or the district court in the first instance) should analyze whether a particular MSO or IPA has assumed the relevant health insurance risk by paying for or providing care and assuming the risk of nonpayment by a primary plan.

We note, however, that it is clear that plaintiffs are not entitled to avail themselves of the private right of action in their own right, as they do not allege that they have provided or paid for care. *MSPA Claims 1*, 918 F.3d at 1318; *see also MSP Recovery*, 835 F.3d at 1358. The government expresses no view on the validity of the assignments at issue in this case.

2. In seeking a categorical rule that MSOs and IPAs may never avail themselves of the private right of action, defendants seek to analogize this case to disputes between two private insurance companies outside of Medicare. *See* Travelers Br. 42-43 (No. 18-13049). But the cases on which defendants rely do not involve a failure to reimburse Medicare. Instead, they involve the question of which of two private plans is responsible for payment for medical care that was received by someone who happens to be a Medicare beneficiary but for which Medicare is unquestionably not responsible, such that "Medicare has never been asked to pay anything." *Baptist Mem'l Hosp. v. Pan Am. Life Ins. Co.*, 45 F.3d 992, 998 (6th Cir. 1995); *Perry v. United Food & Commercial Workers Dist. Unions 405 & 442*, 64 F.3d 238, 244 (6th Cir. 1995). These cases arise if, for

example, a Medicare beneficiary is also insured by both his own employer plan and his spouse's plan, as was the case in *Harris Corp. v. Humana Health Ins. Co. of Fla., Inc.*, 253 F.3d 598, 605-06 (11th Cir. 2001). It may also occur if a Medicare beneficiary covered by an employer plan is injured in an automobile accident, as was the case in *Baptist Mem'l*, 45 F.3d at 994, 998. Under these circumstances, "[t]he [Medicare Secondary Payer] statute simply d[oes] not apply to the question of which private insurance carrier was the primary payer." *Perry*, 64 F.3d at 244; *Harris*, 253 F.3d at 605.[3]

Here, by contrast, payment has been made under the Medicare Advantage plan, and the dispute concerns whether a private insurer is compelled to reimburse the Medicare Advantage plan as required under the Medicare Secondary Payer provisions. This Court reasoned in *Harris* that the private cause of action is available when a private insurance company attempts to make Medicare the primary payer, even if the dispute is between two private companies. *Harris*, 253 F.3d at 606. That same reasoning compels the conclusion that an entity that has

[3] Travelers also relies on *Brooks v. Blue Cross & Blue Shield of Fla., Inc.*, 116 F.3d 1364 (11th Cir. 1997). Travelers Br. 43 (No. 18-13049). That case also did not involve liability for a Medicare or Medicare Advantage plan. In any event, defendants cite the district court opinion, which was attached as an addendum to this Court's opinion. This Court stated that it "ha[d] no occasion to reach" standing under the Medicare Secondary Payer Act and "impl[ied] no view concerning" it. 116 F.3d at 1365.

assumed responsibility for paying for or providing items and services under the Medicare program may file suit to compel a primary plan to satisfy its reimbursement obligation.

Auto-Owners Insurance Company asserts that subcontractors cannot bring suit because the Medicare Advantage organization, not the subcontractor, makes conditional payments under the Medicare Secondary Payer Act and the subcontractor's payments are made pursuant to its contract with the Medicare Advantage organization. Auto-Owners Br. 20-21 (No. 18-12149). It is unclear why these distinctions should be relevant. The statute provides a cause of action for damages "in the case of a primary plan which fails to provide for primary payment (or appropriate reimbursement) in accordance with" the Medicare Secondary Payer provisions. 42 U.S.C. § 1395y(b)(3)(A). If a primary plan fails to make a payment or to provide reimbursement, the entity that was forced to pay for the medical care itself or that should have received the proceeds of the reimbursement has suffered damages and is entitled to file suit. There is no indication that Congress would have wished to prohibit the entity that has actually provided the coverage and borne the risk of nonpayment—and thus has been harmed—from filing suit based on a characterization of which entity made a conditional payment to which the cause-of-action provision does not even refer.

There is no sound reason for the availability of the private right of action to hinge on the corporate structure of the Medicare Advantage organization and its affiliates. If the Medicare Advantage organization or its affiliate has made payment, then reimbursement should be made and should flow to the entity within that corporate family that actually bore responsibility for paying for the items or services. If reimbursement is not made, that entity has been injured and should be able to take advantage of the private right of action to remedy that harm.

3. Defendants' amici raise the specter that primary payers will not be able to determine which entity is entitled to payment, and that there may be multiple attempts at collection by different entities. American Property Casualty Insurance Br. 14, 18-20. But this reflects a misunderstanding of the statute. The cause of action is available only if the primary plan "fails to provide for primary payment (or appropriate reimbursement)." 42 U.S.C. § 1395y(b)(3)(A). "There cannot be a failure to pay when there has been payment." *Netro*, 891 F.3d at 525, 528 (discussing a payment made to a beneficiary as part of a medical malpractice settlement). If a primary payer reimbursed the Medicare Advantage organization, as it is legally required to do, it has not "fail[ed] to provide for primary payment

(or appropriate reimbursement)," and the prerequisites for the cause of action are not satisfied. *See* 42 U.S.C. § 1395y(b)(3)(A).[4]

CONCLUSION

For the foregoing reasons, the Court should hold that MSOs and IPAs may avail themselves of the cause of action under 42 U.S.C. § 1395y(b)(3)(A) to the extent that they have paid for or provided medical care for which they would have been reimbursed if a primary plan had not failed to meet its statutory obligations.

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[4] Some of the defendants appear to misunderstand the regulations governing their payment obligations, asserting that the requirement to reimburse Medicare is not triggered unless Medicare sends a demand letter. *See* Auto-Owners Br. 27 (No. 18-12149). This is incorrect. *Bio-Medical Applications of Tenn., Inc.*, 656 F.3d at 294. The requirement is triggered whenever the primary plan has constructive knowledge of a payment. *United States v. Baxter Int'l, Inc.*, 345 F.3d 866, 901-02 (11th Cir. 2003). Constructive knowledge is established when a defendant "has in its possession information necessary to draw the conclusion that Medicare has made such a payment" or "willfully blinds itself" to such information. *Id.*

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CERTIFICATE OF COMPLIANCE

This brief complies with the type-volume limit of this Court's letter of December 23, 2019, because it contains 4,224 words. This brief also complies with the typeface and type-style requirements of Federal Rule of Appellate Procedure 32(a)(5)-(6) because it was prepared using Microsoft Word 2016 in Times New Roman 14-point font, a proportionally spaced typeface.

s/ Dana Kaersvang
Dana Kaersvang

CERTIFICATE OF SERVICE

I hereby certify that on June 8, 2020, I electronically filed the foregoing brief with the Clerk of the Court for the United States Court of Appeals for the Eleventh Circuit by using the appellate CM/ECF system. Participants in the case are registered CM/ECF users, and service will be accomplished by the appellate CM/ECF system.

s/ Dana Kaersvang
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ADDENDUM

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42 U.S.C. § 1395y A1

42 U.S.C. § 1395y

§ 1395y. Exclusions from coverage and medicare as secondary payer

(b) Medicare as secondary payer

(1) Requirements of group health plans

(A) Working aged under group health plans

(i) In general

A group health plan--

(I) may not take into account that an individual (or the individual's spouse) who is covered under the plan by virtue of the individual's current employment status with an employer is entitled to benefits under this subchapter under section 426(a) of this title, and

(II) shall provide that any individual age 65 or older (and the spouse age 65 or older of any individual) who has current employment status with an employer shall be entitled to the same benefits under the plan under the same conditions as any such individual (or spouse) under age 65.

* * *

(2) Medicare secondary payer

(A) In general

Payment under this subchapter may not be made, except as provided in subparagraph (B), with respect to any item or service to the extent that--

(i) payment has been made, or can reasonably be expected to be made, with respect to the item or service as required under paragraph (1), or

(ii) payment has been made or can reasonably be expected to be made under a workmen's compensation law or plan of the United States or a State or under an automobile or liability insurance policy or plan (including a self-insured plan) or under no fault insurance.

In this subsection, the term “primary plan” means a group health plan or large group health plan, to the extent that clause (i) applies, and a workmen's compensation law or plan, an automobile or liability insurance policy or plan (including a self-insured plan) or no fault insurance, to the extent that clause (ii) applies. An entity that engages in a business, trade, or profession shall be deemed to have a self-insured plan if it carries its own risk (whether by a failure to obtain insurance, or otherwise) in whole or in part.

(B) Conditional payment

(i) Authority to make conditional payment

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 (as determined in accordance with regulations). 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.

(ii) Repayment required

Subject to paragraph (9), a primary plan, and an entity that receives payment from a primary plan, shall reimburse the appropriate Trust Fund for any payment made by the Secretary under this subchapter with respect to an item or service if it is demonstrated that such primary plan has or had a responsibility to make payment with respect to such item or service. A primary plan's responsibility for such payment may be 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) of payment for items or services included in a claim against the primary plan or the primary plan's insured, or by other means. If reimbursement is not made to the appropriate Trust Fund before the expiration of the 60-day period that begins on the date notice of, or information related to, a primary plan's responsibility for such payment or other information is received, the Secretary may charge interest (beginning with the date on which the notice or other information is received) on the amount of the reimbursement until reimbursement is made (at a rate determined by the Secretary in accordance with regulations of the Secretary of the Treasury applicable to charges for late payments).

(iii) Action by United States

In order to recover payment made under this subchapter for an item or service, the United States may bring an action against any or all entities that are or were required or responsible (directly, as an insurer or self-insurer, as a third-party administrator, as an employer that sponsors or contributes to a group health plan, or large group health plan, or otherwise) 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. In addition, the United States may recover under this clause from any entity that has received payment from a primary plan or from the proceeds of a primary plan's payment to any entity. The United States may not recover from a third-party administrator under this clause in cases where the third-party administrator would

not be able to recover the amount at issue from the employer or group health plan and is not employed by or under contract with the employer or group health plan at the time the action for recovery is initiated by the United States or for whom it provides administrative services due to the insolvency or bankruptcy of the employer or plan. An action may not be brought by the United States under this clause with respect to payment owed unless the complaint is filed not later than 3 years after the date of the receipt of notice of a settlement, judgment, award, or other payment made pursuant to paragraph (8) relating to such payment owed.

(iv) Subrogation rights

The 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.

(v) Waiver of rights

The Secretary may waive (in whole or in part) the provisions of this subparagraph in the case of an individual claim if the Secretary determines that the waiver is in the best interests of the program established under this subchapter.

(vi) Claims-filing period

Notwithstanding any other time limits that may exist for filing a claim under an employer group health plan, the United States may seek to recover conditional payments in accordance with this subparagraph where the request for payment is submitted to the entity required or responsible under this subsection to pay with respect to the item or service (or any portion thereof) under a primary plan within the 3-year period beginning on the date on which the item or service was furnished.

(vii) Use of website to determine final conditional reimbursement amount

* * *

(3) Enforcement

(A) Private cause of action

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).

* * *