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The Sixth Circuit Gives Teeth to the Medicare Secondary Payer Act Private Cause of Action

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In a ruling that should be considered by group health plans ("GHP"s) across the country, the Sixth Circuit recently held that a healthcare provider can impose liability against a GHP for double damages under the Medicare Secondary Payer Act ("MSPA") when the GHP terminates the coverage of a retiree who became eligible for Medicare due to end stage renal disease ("ESRD").[1] Significantly, the Sixth Circuit determined that the private cause of action was viable even though the provider did not satisfy the "demonstrated responsibility" provision prior to bringing the claim.[2] This decision in *Bio-Medical Applications of Tenn., Inc. v. Cent. States Se. & Sw. Areas Health and Welfare Fund* gives private parties the ability to enforce the terms of the MSPA without having to demonstrate that GHPs are responsible for paying for certain services prior to initiating litigation. The MSPA contains "non-discrimination" rules prohibiting GHPs from "taking into account" that individuals who are over 65 or suffer from a disability or ESRD are entitled to Medicare.[3] Prior to the decision, the MSPA's private cause of action had virtually no effect on GHPs, because private plaintiffs who brought claims for damages under the MSPA were almost uniformly met with dismissal based on their inability to satisfy the "demonstrated responsibility" provision of the MSPA.[4] As a result of the application of this provision, private plaintiffs who could show that a GHP impermissibly took into account a beneficiary's Medicare entitlement still could not state a cause of action.[5] After *Bio-Medical*, private plaintiffs will be able to maintain actions to enforce the 'non-discrimination" rules without having to meet the "demonstrated responsibility" provision.

I. MSPA Prevents GHPs from Shifting Healthcare Costs to Medicare

Congress enacted the MSPA to reduce Medicare spending and preserve the fiscal integrity of the Medicare program.[6] In order to prevent GHPs from shifting costs to Medicare, the MSPA delineated certain situations in which GHPs were required to continue making primary payments even when an individual became entitled to coverage under Medicare.[7]

Three sections of the MSPA are relevant to the scheme enacted by Congress. First, paragraph 1 of the MSPA prohibits GHPs from taking into account an individual's Medicare entitlement in certain circumstances:

- GHPs cannot take into account[8] that an individual is entitled to Medicare benefits based on age when that individual is covered by the GHP by virtue of current employment;
- GHPs with over 100 employees[9] cannot take into account that an individual is entitled to Medicare benefits based on disability when that individual is covered by the GHP by virtue

of current employment;
- GHPs cannot take into account that an individual is entitled to or eligible for Medicare benefits based on ESRD[10] during the first 30 months of Medicare entitlement or eligibility.[11]

The MSPA does not prohibit GHPs from considering the age-based or disability-based Medicare entitlement of an individual who is not covered by the GHP by current employment status; however, it does prohibit GHPs from considering the ESRD-based Medicare entitlement or eligibility of an individual who is not covered by virtue of current employment status. In other words, the age and disability prohibitions do not apply to retirees or those covered by COBRA,[12] but the ESRD prohibition does. The failure to recognize this distinction is probably the chief reason that the plan language of many GHPs violates the MSPA.

CMS has issued regulations which provide examples of actions that constitute "taking into account" Medicare entitlement or eligibility.[13] The list of actions that constitute "taking into account" Medicare entitlement includes, (a) failing to pay primary benefits, (b) offering coverage that is secondary to Medicare, (c) terminating coverage, (d) denying coverage, (e) charging higher premiums, (f) imposing longer wait times, (g) and paying less to medical providers for services.[14]

Second, paragraph 2 of the MSPA provides that Medicare will not pay for services that should be covered by a GHP pursuant to the "taking into account" prohibitions of paragraph 1.[15] However, part B of paragraph 2 notes that Medicare may make a *conditional* payment in certain situations.[16] Part B goes on to create an obligation to repay the government for a conditional payment.[17] This obligation ripens when a primary plan's responsibility is demonstrated by a judgment, settlement, or other similar means (the "demonstrated responsibility" provision).[18] If a primary plan fails to pay after its responsibility is demonstrated, the government has a right of action to recover against that primary plan.[19]

Third, paragraph 3 of the MSPA creates "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)."[20]

Through this statutory framework, the MSPA makes it unlawful for GHPs to take into account the Medicare entitlement of the working aged, working disabled, and those with ESRD, thereby requiring GHPs to continue paying primary benefits for its participants in these categories even after they become eligible for Medicare.

II. The "Demonstrated Responsibility" Provision in Private Causes of Action

Although the statutory framework indicates that the "demonstrated responsibility" provision applies to the obligation to repay the government for conditional payments, the provision had been applied universally to private causes of action. This resulted in a scheme in which a private plaintiff would essentially have to bring two suits to succeed on a private cause of action against a GHP: one to demonstrate the defendant's responsibility for payment under the MSPA and a second to recover damages under the private cause of action. Private causes of action were routinely met with dismissal based on the failure to satisfy the "demonstrated responsibility"

requirement.

In *Glover v. Liggett Group, Inc.*,[21] the plaintiffs brought a private cause of action against tobacco companies to recover the cost of healthcare services that were attributable to cigarette smoking.[22] In order to determine whether the defendants failed to pay within the meaning of the MSPA, the court looked to whether the defendant's responsibility was demonstrated prior to the filing of the private cause of action.[23] The Eleventh Circuit concluded that an alleged tortfeasor's responsibility for payment of the medical services must be demonstrated before the private cause of action can be brought.[24]

While *Glover* involved a private party acting as a private attorney general to recover costs for the Medicare program, its holding was applied in all contexts. Notably, in *Nat'l Renal Alliance LLC v. Blue Cross & Blue Shield of Ga., Inc.*,[25] the court applied the "demonstrated responsibility" provision to a healthcare provider's private cause of action against a GHP.[26] The court held that a GHP's responsibility must be demonstrated by a judgment, settlement, or other means prior to bringing the private cause of action.[27] The court further concluded that for "demonstrated responsibility" purposes there was no distinction between the claim at issue and the claim in *Glover*.[28] Other courts followed suit, and the "demonstrated responsibility" provision was applied to all private causes of action, which led to dismissals.

III. The Sixth Circuit Changes Course

In *Bio-Medical Applications of Tennessee, Inc. v. Cent. States Se. & Sw. Areas Health & Welfare Fund*,[29] the plaintiff was a healthcare provider who had rendered services to a patient whose GHP coverage was terminated because she was entitled to Medicare benefits based on having ESRD.[30] The patient was covered under a retiree plan; thus, she was not covered by current employment.[31] The provider brought a private action seeking double damages against the GHP for failing to pay for the medical services provided to the patient. Looking to the plain language of the statute, the Sixth Circuit determined that the termination of coverage based on Medicare eligibility violated paragraph 1 of the MSPA.[32]

After a long, detailed look at the case law, legislative history, and statutory structure, the Sixth Circuit concluded that the "demonstrated responsibility" provision only applies to actions brought by the government to recover conditional Medicare payments where a tortfeasor was responsible for making the primary payment.[33] The "demonstrated responsibility" provision does not apply to private causes of action against GHPs.[34] The Sixth Circuit reasoned that the provision was added as a direct response to cases that limited *tortfeasor* liability and there was no reason to believe Congress intended to affect the liability of *non-tortfeasors*, like GHPs.[35] In fact, the provision only makes sense in the context of tort, where liability must be established, as opposed to GHPs, whose responsibility is mandated by the statute.[36] Finally, the provision's text only places the requirement on the obligation to repay Medicare for a conditional payment, but in the context of a private action against a GHP the obligation to reimburse Medicare for a conditional payment is not at issue.[37]

Thus, the provider stated a valid private cause of action for double damages against the GHP. Presumably recognizing the import of its decision, the Sixth Circuit took the unusual step of

identifying many district court cases that "applied the 'demonstrated responsibility' provision beyond its proper scope."[38]

Finally, the Sixth Circuit turned to the damages issue. The MSPA clearly provides that the damages are doubled, but the reference point for double damages is not clear.[39] The court briefly discusses two possibilities: (1) the amount the GHP should have paid to the provider or (2) the amount of conditional payments by Medicare. Ultimately, the court remanded to the district court for briefing on the question of the proper measure of damages.[40] The case remains at this stage at present. Because of the disparity in Medicare rates and GHP rates, the question of the reference point for damages is extremely important.

The rationale for the Sixth Circuit's departure from other courts' application of the "demonstrated responsibility" provision is persuasive. The Court convincingly explains that when district courts applied *Glover* against non-tortfeasor defendants, they extended *Glover* beyond its purpose and contorted the MSPA.[41] After a series of courts reflexively applied *Glover* to non-tortfeasor cases,[42] the Sixth Circuit was the first to step back and analyze whether such extension made sense. According to the Court, it does not.

IV. Implications for GHPs and Providers

With the threat of double damages now a real concern for GHPs that violate the MSPA, plans and their advisors should take a close look at plan language. Almost every plan imposes restrictions on individuals with Medicare. Since virtually any type of change tied to Medicare will constitute "taking into account" of the Medicare entitlement, it is essential to ensure that the terms of the plan are consistent with paragraph 1 of the MSPA. Consistency requires adherence to the different rules that apply on the basis of the reason an individual is entitled to Medicare. While the MSPA does not prohibit considering the age-based or disability-based Medicare entitlement of a retiree or COBRA participant, it does prohibit taking into account the ESRD-based Medicare eligibility or entitlement of a retiree or COBRA participant.[43] Plan provisions that affect changes in coverage or benefits upon Medicare entitlement must be mindful of the MSPA's varied requirements tied to the basis of the Medicare entitlement.

On the other hand, providers are likely to benefit from the decision. While some may ultimately receive damages awards stemming from private causes of action, most providers are likely to benefit from changes in GHP terms that bring the GHPs into compliance with the MSPA. In this way, providers will receive payments from GHPs, which typically offer higher rates of payment, rather than from Medicare, which often reimburses at a lower rate.

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1 *Bio-Medical Applications of Tenn., Inc. v. Cent. States Se. & Sw. Areas Health & Welfare Fund*, Nos. 09-6121/6129, slip op. (6th Cir. Sept. 2, 2011).

2 *Id.* at 20.

3 42 U.S.C. § 1395y(b)(1); *see alsoNat'l Renal Alliance LLC v. Blue Cross & Blue Shield of Ga., Inc.*, 598 F. Supp. 2d 1344, 1352 (N.D. Ga. 2009).

4 *E.g.*, *Glover v. Liggett Group, Inc.*, 459 F.3d 1304 (11th Cir. 2006); *Bio-Medical Applications of Ga., Inc. v. City of Dalton, Ga.*, 685 F. Supp. 2d 1321 (N.D. Ga. 2009); *Nat'l*

Renal Alliance, LLC, 598 F. Supp. 2d at 1354 n.5.

5 *Bio-Medical Applications of Tenn., Inc. v. Cent. States Se. & Sw. Areas Health & Welfare Fund*, 648 F. Supp. 2d 988 (E.D. Tenn. 2009).

6 *Provident Life & Accident Co. v. United States*, 740 F. Supp. 492 (E.D. Tenn. 1990); *United States v. Travelers Ins. Co.*, 815 F. Supp. 521, 522 (D. Conn. 1992).

7 Prior to the enactment of the MSPA, GHPs typically provided only secondary benefits after a participant became entitled to Medicare benefits. *United States v. Baxter International, Inc.*, 345 F.3d 866 (11th Cir. 2003); *Baptist Memorial Hosp. v. Pan Am. Life Ins. Co.*, 45 F.3d 992, 996 (3d Cir. 1995).

8 The phrase "take into account" means to consider that a person is entitled to Medicare coverage. *Bio-Medical Applications of Tennessee, Inc. v. Cent. States Se. & Sw. Areas Health & Welfare Fund*, Nos. 09-6121/6129, slip op. at 7(6th Cir. Sept. 2, 2011).

9 The MSPA uses the term "large group health plan" and borrows the definition of that term from the Internal Revenue Code.

10 The MSPA also provides that a GHP "may not differentiate in benefits it provides between individuals having [ESRD] and other individuals covered by such plan on the basis of the existence of [ESRD], the need for renal dialysis, or in any other manner." 42 U.S.C. § 1395y (b)(1)(C)(ii). The Sixth Circuit did not reach the issue of whether Central States violated the differentiation clause of the MSPA. *Bio-Medical*, slip op. at 7.

11 42 U.S.C. § 1395y(b)(1).

12 The Consolidated Omnibus Budget Reconciliation Act of 1986 ("COBRA") contains a provision that requires most GHPs to allow employees and their dependents who lose coverage under the GHP to continue their coverage temporarily by electing to pay the premiums themselves.

13 42 C.F.R. § 411.108(a).

14 *Id*

15 42 U.S.C. § 1395y(b)(2)(A).

16 42 U.S.C. § 1395y(b)(2)(B)(i).

17 42 U.S.C. § 1395y(b)(2)(B)(ii).

18 *Id.*

19 42 U.S.C. § 1395y(b)(2)(B)(iii).

20 42 U.S.C. § 1395y(b)(3)(A).

21 459 F.3d 1304 (11th Cir. 2006).

22 *Id.* at 1306.

23 *Id.* at 1308–09.

24 *Id.* at 1309.

25 598 F. Supp. 2d 1344 (N.D. Ga. 2009).

26 *Id.* at 1354, n.5.

27 *Id.*

28 *Id.*

29 Nos. 09-6121/6129, slip op. (6th Cir. Sept. 2, 2011).

30 *Id.* at 5.

31 Accordingly, if the patient's Medicare entitlement had been due to age or disability, the GHP's action would not have violated the MSPA.

32 *Id.* at 10.

33 *Id.* at 20, 22.

34 *Id.* at 20.

35 *Id.* at 20.

36 *Id.* at 21.

37 *Id.* at 22.

38 *Id.* at 23–24.

39 *Id.* at 26–27.

40 *Id.* at 30.

41 *Id.* at 20–24.

42 *See, e.g.*, *Bio-Meidcal Applications of Tenn., inc. v. Central States, Se. & Sw. Areas Health & Welfare Fund*, No. 2:08-CV-228, 2008 U.S. Dist. LEXIS 97748, at *4 (E.D. Tenn. Dec. 1, 2008); *Nat'l Renal Alliance LLC v. Blue Cross & Blue Shield of Ga., Inc.*, 598 F. Supp. 2d 1344, 1354 n.5 (N.D. Ga. 2009).

43 GHPs remain free to terminate COBRA continuation coverage when the COBRA statute permits termination. Thus, a participant who first becomes entitled to Medicare after electing COBRA may be terminated without running afoul of the MSPA. However, if a participant is entitled to ESRD-based Medicare prior to electing COBRA coverage, cannot be terminated under COBRA laws and the GHP is also prohibited from considering the ESRD-based Medicare entitlement by MSPA. Under the same circumstances, the GHP could consider age-based or disability-based Medicare entitlement.
