No. 12-690

IN THE

Supreme Court of the United States

GLAXOSMITHKLINE LLC, ET AL.,

Petitioners,

v.

HUMANA MEDICAL PLANS, INC., ET AL.,

Respondents.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Third Circuit

BRIEF OF THE MARC COALITION, THE PROPERTY AND CASUALTY INSURERS ASSOCIATION OF AMERICA AND FRANCO SIGNOR AS AMICI CURIAE IN SUPPORT OF PETITIONERS

DAVID J. FARBER
Counsel of Record
CORDELL A. HULL
PATTON BOGGS LLP
2550 M Street, N.W.
Washington, DC 20037
(202) 457-6000
dfarber@pattonboggs.com

Counsel for Amici Curiae

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Page(s)

Cases

Statutes

Regulations and Rules

Other Authorities

INTEREST OF THE AMICI CURIAE[1]

The Medicare Advocacy Recovery Coalition (MARC) is a not-for-profit association that was formed in September 2008 to advocate for the improvement of the Medicare Secondary Payer (MSP) program for beneficiaries and affected companies. Formed by a group of entities in the regulated community, MARC has been collaborating and developing strategic alliances with Congressional leaders and government agencies to focus on broader MSP reform. MARC's membership is comprised of entities representing virtually every sector of the MSP-regulated community, including attorneys, brokers, insureds, insurers, insurance and trade associations, self-insureds, and third-party administrators.

The Property Casualty Insurers Association of America (PCI) is a national trade group representing more than 1000 property/casualty insurers. PCI members are domiciled and transact business in all 50 states as well as the District of Columbia and Puerto Rico. PCI's member companies write $180 billion in direct written premium, or over 38.3% of all the property/casualty insurance written in the United States. PCI members write 44.3% of the nation's auto insur-

---

[1] Pursuant to Rule 37.6, amici affirm that no counsel for a party authored this brief in whole or in part, and no such counsel or any party made a monetary contribution intended to fund the preparation or submission of this brief. No person or entity, other than amici curiae, their members, and their counsel, made a monetary contribution intended to fund its preparation or submission. Counsel of record for all parties have received timely notice of amici curiae's intent to file this brief and have consented to the filing of this brief in letters on file with the Clerk's office.

ance, 31.6% of all homeowners' policies, and 42.6% of the private workers' compensation insurance market. PCI member companies include all types of insurers, including large national insurance companies, mid-size regional writers, insurers doing business in a single state and specialty companies that serve specific niche markets. PCI member companies include stock companies, mutual companies, and companies that write on a non-admitted basis. The PCI membership is literally a cross-section of the United States' property and casualty insurance industry.

Franco Signor is a privately held, 100% employee owned and operated company specializing in compliance with, and settlements under, the Medicare Secondary Payer Act (MSP Act). The company works in MSP risk assessment, MSP compliance, and clinical aspects of a client's claim.

Amici are keenly interested in the proper scope and implementation of the MSP Act and submit this brief to share their experience with application of the statute.

SUMMARY OF THE ARGUMENT

Over the past several years, the regulated community has significantly increased compliance with the MSP Act. Concurrently, the Centers for Medicare and Medicaid Services (CMS) have initiated increased enforcement of the MSP Act's repayment provisions. While increased compliance with the MSP Act is laudable, that compliance has proven that the MSP Act itself is balky, and often times can impede the very settlements from which CMS seeks to recover funds. This case presents another, particularly severe, possible

impediment, which stands to harm both Medicare beneficiaries, whose cases will now be difficult to settle, and Medicare Advantage (MA) plans—not to mention the Medicare Trust Fund in direct actions under the MSP Act—that will now be forced to litigate claims through trial.

The court of appeals' holding in this case departs from the plain language of the MSP Act to give privately run Medicare Advantage Organizations (MAOs) a new cause of action for double damages against primary plans, a group that includes self-insuring entities. The holding ignores the MSP Act's carefully crafted scheme that requires reimbursement to Medicare, not private companies, for payments made on behalf of beneficiaries.

When settling cases, it is often important for a putative tortfeasor to be able to quantify its total obligation, including any potential reimbursement due the Medicare Trust Fund. Toward that end, CMS administers a program that permits settling parties to ascertain any potential reimbursement obligation before a settlement in which Medicare beneficiaries are involved. There is no similar regulatory scheme or program that allows for the same process when applied to beneficiaries enrolled in MA plans.

In the wake of the court of appeals' conclusion in this case, settling parties will have difficulty settling cases involving MA members. The result will lead to increasingly crowded courthouses. That crowding will only increase with the significant number of people reaching Medicare-eligible age every day.

At a minimum, the court of appeals' decision, if left unreviewed, will disparately impact primary plans seeking to settle litigation with MA beneficiaries. With their new double damages cause of action, MAOs are able to play a game of "gotcha," subjecting primary plans acting in the utmost good faith to double damages when they could not know of their reimbursement obligation, assuming it exists to MAOs in the first place.

Amici urge the Court to grant review of this case.

ARGUMENT

THE COURT OF APPEALS' INFERRING A PRIVATE FEDERAL CAUSE OF ACTION FOR MEDICARE ADVANTAGE ORGANIZATIONS FRUSTRATES PRIMARY PLANS' ABILITY TO SETTLE CASES.

Before the court of appeals' holding in this case, settling parties had predictability in cases involving Medicare beneficiaries. Now, apart from having a new federal cause of action with double damages wielded against them, primary payers will be unable to quantify their potential exposure and arrive at efficient and fair settlements. This new cause of action exists because of the court of appeals' decision and is devoid of statutory support. The result of the court of appeals' rule will slow resolution of claims, mire parties in litigation, and subject primary plans to a federal cause of action posing the risk of double damages in cases with MAO members, depending solely on which side of the Ohio/Pennsylvania border that MAO member lives.

A. When Settling Cases Under The MSP Act, Primary Plans Are Able To Quantify Their Exposure, But They Cannot When Settling With MAO Beneficiaries.

In arriving at its conclusion that respondents are able to pursue a claim against petitioners under the MSP Act's double damages provision, the court of appeals failed to grasp the distinction between the regulations governing the MSP Act and those applicable to MAOs. The MSP Act permits the government to pursue payment from a primary plan—including self-insured entities[2]—when the government has made a conditional payment on behalf of a beneficiary. *See* 42 U.S.C. § 1395y(b)(2)(B)(iii)-(iv) (providing the ability for the "United States to pursue" direct and subrogation actions to recoup a primary payment). The regulations promulgated under the MSP Act provide a litany of mechanisms for the government to obtain reimbursement for a payment made on behalf of a beneficiary.

The regulations permit CMS to initiate recovery proceedings "as soon as it learns that payment has

---

[2] The relevant regulation, 42 C.F.R. § 411.21, defines a "primary plan" to include "a group health plan or large group health plan, a workers' compensation law or plan, an automobile or liability insurance policy or plan (including a self-insured plan), or no-fault insurance." *Id.*; *see also* 42 U.S.C. § 1395y(b)(2)(A) ("In this subsection, the term 'primary plan' means a group health plan or large group health plan . . . 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 . . . . 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.").

been made or could be made under workers' compensation, any liability or no-fault insurance, or an employer group health plan." 42 C.F.R. § 411.24(b). CMS's recovery can be through an offset of monies CMS otherwise owes to the primary plan, *see id.* § 411.24(d), or it may pursue litigation to recover the outlay. *Id.* § 411.24(e) ("CMS has a direct right of action to recover from any primary payer."). Should CMS pursue litigation to recover a primary payment, "CMS may recover twice the amount" of the primary payment. *Id.* § 411.24(c)(2). The MSP Act's implementing regulations thus provide a clear structure for recovery by the Medicare Trust Fund after it makes a primary payment.

To assist primary plans in efficiently settling their obligations to beneficiaries and the Medicare Trust Fund, CMS recently implemented a program that permits settling parties to determine their reimbursement obligation to Medicare.[3] The Medicare Secondary

---

[3] On December 21, 2012, Congress passed H.R. 1845, which further enhances the ability of settling parties to receive "conditional payment" information from the government before settlement. *See* Section 202, H.R. 1845 (passed by the House of Representatives Dec. 19, 2012, and by the Senate Dec. 21, 2012). The information exchange provisions require only the Secretary of the Department of Health and Human Services to provide information to "applicable plans" (liability, workers compensation, no-fault and self-insurers), and nowhere reference MAOs. Surely if Congress believed that MAOs had a cause of action to recover payments they previously had made for health care, MAOs would have been included in the legislation as well. Indeed, there was no reason for Congress to disadvantage settlements involving MAO beneficiaries from fee-for-service beneficiaries if MAOs had such a cause of action. The fact that Congress did not do so clearly reflects its understanding that only the Secretary, and not MAO plans, have

Payer Recovery Contractor (MSPRC) allows these entities to learn with certainty their reimbursement obligation to the Medicare Trust Fund.[4] Among the functions of the program are provisions allowing settling parties to "[r]equest conditional payment information," "[d]ispute claims included in a conditional payment letter," and "[s]ubmit case settlement information." The program allows the settling parties direct insight into their obligation to reimburse the Medicare Trust Fund.

Unlike the regulations promulgated under the MSP Act and the MSPRC program, the regulations pertaining to MAOs do not provide any clarity regarding a potential reimbursement obligation, nor do they provide a direct cause of action. The MAO secondary payer regulations comprise a single section that is silent on information sharing for primary plans. The regulations place information-collecting obligations on the MAOs, including "[i]dentify[ing] payers that are primary to Medicare," "[i]dentify[ing] the amounts payable by those payers," and "[c]oordinat[ing] its benefits to Medicare enrollees with the benefits of the primary payers." 42 C.F.R. § 422.108(b)(1)-(3). The regulation is silent on information sharing with primary payers, however. And more importantly, there is simply no way for settling primary payers to know whether an MAO is involved, or equally important, how much the reimbursement obligation may be. Even if a primary plan is able to determine that an MAO is likely involved, with many dozens of such

---

a direct cause of action under the MSP Act.

[4] *See* http://www.msprc.info (last visited Jan. 3, 2013).

plans, it will prove to be a difficult task to determine which one to contact.

The creation of such a right in MAOs to bring direct claims against primary payers, much less claims for double damages, would turn the litigation and settlement process on its head. Apart from creating a problem not contemplated by—and incompatible with—the regulations, the court's holding was created out of whole cloth.

B. The Court Of Appeals' Holding Impermissibly Creates A New Cause Of Action Unsupported By The Statute.

The decision below is troubling because the court of appeals is the first to hold that MAOs have a federal private right of action against primary plans, and more troubling that such a right of action includes claims for double damages. This holding is all the more remarkable because the secondary provision specifically applicable to MAOs, 42 U.S.C. § 1395w-22(a)(4), does not contain any direct action provision against a primary plan, or any double damages provision. Furthermore, the court of appeals explicitly recognized that "the legislative history is nowhere explicit that MAOs may bring suit for double damages under the MSP [Act's] private cause of action or using any other provision." Pet. App. at 23a-24a (citing H.R. REP. NO. 105-217, at 638 (1997) (Conf. Rep.)).

The regulations applicable to MAOs set out how an MAO may obtain reimbursement, but they provide only that an MAO may bill a primary plan, not institute a cause of action in federal district court. *See* 42 C.F.R. § 422.108. As under the MSP Act, the MAO

regulations make clear that Medicare must be a secondary payer in all circumstances. *See id.* § 422.108(a). That is fine, so far as it goes, but it is hardly the basis for a direct cause of action. The relevant regulation simply permits an MAO to "*bill*, or authorize a provider to bill, other individuals or entities for covered Medicare services for which Medicare is not the primary payer." 42 C.F.R. § 422.108(c) (emphasis added). The regulations then lay out specific collection procedures an MAO may use to obtain reimbursement from a primary plan. *Id.* § 422.108(d)-(e).

There is a second reason that review is appropriate here: the court's holding is further unmoored from the MSP Act's text, which explicitly requires reimbursement only for "item[s] or service[s]" paid for by Medicare, not private parties. In fact, both the MSP Act's secondary payer provision and the secondary payer provision applicable to MAOs contain this language. *Compare* 42 U.S.C. § 1395y(b)(2)(A) ("Payment under this subchapter may not be made, except as provided in subparagraph (B), with respect to any *item or service* . . . .") (emphasis added) (MSP Act), *with* 42 U.S.C. § 1395w-22(a)(4) ("Notwithstanding any other provision of law, a Medicare+Choice[5] organization may (in the case of the provision of *items and services* to an individual under a Medicare+Choice plan under circum-

---

[5] As noted in the petition, the Medicare+Choice plans have been renamed Medicare Advantage plans. Pet. at 12 (citing Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4001 et seq., 111 Stat. 251 (creating Medicare+Choice); Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, § 201, 117 Stat. 2066, 2176 (renaming "Medicare+Choice" the "Medicare Advantage" program)).

stances in which payment under this subchapter is made secondary pursuant to section 1395(b)(2) of this title) . . . .") (emphasis added) (MAO provision).

The court of appeals' holding on this point uses a sledgehammer where a scalpel is appropriate because the "item[s]" and "service[s]" reimbursed under the MSP Act is limited to Part A (hospital insurance) and Part B (non-hospital medical insurance).[6] It certainly does not cover payments outside the statutory confines, including under Part D for prescription drugs. *See* 42 U.S.C. § 1395y(a) ("Notwithstanding any other provision of this subchapter, no payment may be made under part A or part B of this subchapter for any expenses incurred for items or services" and listing several conditions regarding medical necessity); *see also* CRS MEDICARE PRIMER at 1 ("Part C . . . is a private plan option for beneficiaries that covers all Part A and B services, except hospice."). If an MA plan member wants prescription drug coverage, he must enroll in a specified MA plan that includes such coverage. *See id.* at 5 & n.11 ("Generally, beneficiaries enrolled in an MA plan providing qualified prescription drug coverage (MA-PD plan) must obtain their prescription drug coverage through that plan.").

The court of appeals further errs in its analysis because the funds at issue in this case are not those of the Medicare Trust Fund; they are instead the funds of

---

[6] For an overview of the various services covered by Medicare, see Patricia A. Davis, CONGRESSIONAL RESEARCH SERVICE, MEDICARE PRIMER (2010) (CRS MEDICARE PRIMER); *see also id.* at 6-8 (discussing benefits covered by Part A), 8-15 (Part B), 15-16 (Part C Medicare Advantage), and 16-17 (Part D).

private companies. *See* Pet. App. at 13a-14a. The court's conclusion is at odds with the text of the MSP Act, the terms of which restrict payment to reimbursement of "*the appropriate Trust Fund* for any payment made *by the Secretary*" of the Department of Health and Human Services (HHS). 42 U.S.C. § 1395y(b)(2)(B)(ii) (emphasis added). To support its extra-textual holding, the court went on to conclude that MAOs would be at a competitive disadvantage vis-à-vis Medicare without a federal cause of action and that MAOs should have the right to a federal forum, even in the absence of a statutory grant. Pet. App. at 24a (collecting court of appeals cases providing that Medicare has a right of action). Put simply, adjusting any perceived competitive disadvantage is a matter for Congress, not a federal court.

The court of appeals' creation of an implied statutory cause of action is troubling enough, but the result will hamper settlement and lead to protracted litigation.

C. The Court Of Appeals' Holding Will Frustrate Settlement In Cases Large And Small.

Because primary plans will not be able to effectively quantify their liability to Medicare, many cases will be required to proceed through litigation, including trial and potentially appeal—and many other cases may never be brought due to the complexity associated with a claimant being a Medicare beneficiary. *See, e.g.*, Norma S. Schmidt, *The King Kong Contingent: Should the Medicare Secondary Payer Statute Reach to Future Medical Expenses in Personal Injury Settlements?*, 68 U. PITT. L. REV. 469, 469-70 (2006) (describ-

ing generally how settlements with Medicare beneficiaries are more difficult because of the MSP Act). The court of appeals' decision upsets the settled expectations of parties that, before now, were able to effectively settle cases short of full-blown litigation. Taking GSK as an example, many companies "set[] aside reserves to reimburse the Medicare Trust Fund for payments [the settling company] made to cover the costs of treatment for the claimants' . . . injuries." Pet. App. at 4a. Many of MARC's members, as well as property and casualty insurers, operate in similar fashion. Under the court of appeals' holding, however, these companies cannot ascertain their MAO liability or assess the reasonableness of settlement terms.

The result of the court of appeals' holding leaves primary plans with a great deal of uncertainty in their dealings with members of MAOs and inhibits the well-recognized policies favoring settlement. *See, e.g.*, *McDermott, Inc. v. AmClyde*, 511 U.S. 202, 215 (1994) (Parties settle cases "to reduce uncertainty" and recognizing that "public policy wisely encourages settlements."); *Delta Airlines, Inc. v. August*, 450 U.S. 346, 352 (1981) (noting that an offer of judgment "is to encourage the settlement of litigation" because "[i]n all litigation, the adverse consequences of potential defeat provide both parties with an incentive to settle in advance of trial"); Stephen McG. Bundy, *The Policy in Favor of Settlement in an Adversary System*, 44 HASTINGS L.J. 1, 3 (1992) ("It is a truism that the law favors a policy of settlement and compromise."). The inability to settle will also negatively impact court dockets. *See, e.g.*, *Marek v. Chesny*, 473 U.S. 1, 10 (1985) ("Congress made clear its concern that civil

rights plaintiffs not be penalized for helping to lessen docket congestion by settling their cases out of court . . . . [S]ettlements rather than litigation will serve the interests of plaintiffs as well as defendants.") (internal quotation and citation omitted).

This inhibition of settlements problem is particularly acute in the MSP context, as several courts and commentators have recognized. *See, e.g.*, *Bradley v. Sebelius*, 621 F.3d 1330, 1339 (11th Cir. 2010) ("The Secretary's position [of full reimbursement] would have a chilling effect on settlement. The Secretary's position compels plaintiffs to force their tort claims to trial, burdening the court system. It is a financial disincentive to accept otherwise reasonable settlement offers. It would allow tortfeasors to escape responsibility."); *In re Zyprexa Prods. Liab. Litig.*, 451 F. Supp. 2d 458, 469-70 (E.D.N.Y. 2006) ("[T]he full reimbursement approach gives many beneficiaries little incentive to pursue valid claims or, if they do, to accept otherwise reasonable settlement offers, thereby tending to push them into uncertain litigation that burdens the courts and may result in little or no recovery for either the beneficiaries or for Medicare and Medicaid."); Nicole Miklos, *Giving an Inch, Then Taking a Mile: How the Government's Unrestricted Recovery of Conditional Medicare Payments Destroys Plaintiffs' Chances at Compensation Through the Tort System*, 84 ST. JOHN'S L. REV. 305, 318 (2010) (noting that the MSP Act discourages settlement); Rick Swedloff, *Can't Settle, Can't Sue: How Congress Stole Tort Remedies From Medicare Beneficiaries*, 41 AKRON L. REV. 557, 600 (2008) (same); Christopher C. Yearout, *Big Brother Is Not Just Watching, He's Suing: Medicare's Secondary Pay-*

er Statute Evolves in Aggressive Pursuit of Fiscal Integrity, 41 CUMB. L. REV. 117, 141-42, 155-56 (2011) (Recent amendments to the MSP Act "encourage[] adjudication of any matter that potentially involves Medicare beneficiaries," which is "a waste of judicial economy."). Given the similar concerns raised by Trust Fund recoveries or MAO plan recoveries, the risks of impeding settlements created by the court of appeals' decision require review here.

The most recent statistics compiled by the U.S. Department of Justice demonstrate that, on average, about 97% of civil cases are resolved by settlement. Lynn Langston & Thomas H. Cohen, U.S. Dep't of Justice, *Special Report: Civil Bench and Jury Trials in State Courts*, 2005 (Rev. 2009), at 1, *available at* http://bjs.ojp.usdoj.gov/content/pub/pdf/cbjtsc05.pdf. Yet, if this case is not reviewed, a two-tier system could exist in Pennsylvania, New Jersey, and Delaware as beneficiary cases become extremely difficult to settle because no insurer or self-insured defendant wants to pay three times (once to the beneficiary and double damages to the MAO).

The increase in litigation is troubling enough, but the rule laid down by the court of appeals also requires primary plans—including some of the country's largest companies, but also small businesses and insurers—to act inconsistently with similarly situated segments of the population.

D. The Circuit Conflict Puts Primary Plans In The Position Of Potentially Being Subjected To Double Damages In One Circuit But Not Others.

Given the sheer number of beneficiaries enrolled in MA plans, the court of appeals' decision works an immediate harm on primary plans and subjects beneficiaries in different circuits to different results in analogous situations. Primary plans are now subject to double damages by more than 1.1 million beneficiaries enrolled in MA plans in Pennsylvania, New Jersey, and Delaware, even if the primary plan acts in good faith.

As discussed in the petition (at 20-24), the Circuits are divided whether a private right of action exists under the MSP Act. The petition accurately points out that the Sixth Circuit recognizes a right of action only for the Federal Government. *See, e.g.*, *Bio-Medical Applications of Tenn., Inc. v. Cent. States Se. & Sw. Areas Health & Welfare Fund*, 656 F.3d 277, 292-93 (6th Cir. 2011) ("We believe that when Congress amended the Act in 2003 to permit lawsuits against tortfeasors . . . Congress intended to permit lawsuits against tortfeasors only by *Medicare*, and not lawsuits against tortfeasors by *private parties*."); *Care Choices HMO v. Engstrom*, 330 F.3d 786, 789-90 (6th Cir. 2003). The First and Eighth Circuits permit beneficiaries, but not other private parties, to sue. *See Stalley v. Catholic Health Initiatives*, 509 F.3d 517, 524-26 (8th Cir. 2007); *United Seniors Ass'n, Inc. v. Philip Morris USA*, 500 F.3d 19, 25 (1st Cir. 2007). In contrast, the court of appeals here concluded that any private party has a cause of action for double damages

under the MSP Act. That result affects millions of beneficiaries, as well as companies doing business across the Circuits.

Medicare currently covers about 15% of all Americans. *See* 2011 ANNUAL REPORT OF THE BOARDS OF TRUSTEES OF THE FEDERAL HOSPITAL INSURANCE AND FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUNDS 4 (2011), *available at* http://www.cms.gov/reportsTrustFunds/downloads/tr2011.pdf (last visited Jan. 3, 2013) ("In 2010, 47.5 million people were covered by Medicare. . . ."). Providing for its current membership, Medicare handles more than one billion claims per year. *See HHS: What We Do, U.S. Department of Health & Human Services*, http://www.hhs.gov/about/whatwedo.html (last visited Jan. 3, 2013).

Using the most recently available statistics, the total number of MA members nationwide is approximately 13 million Americans, representing 27% of the Medicare population. *See Medicare Advantage 2012 Data Spotlight: Enrollment Market Update*, Kaiser Family Foundation, at 1 (2012), *available at* http://www.kff.org/medicare/upload/8323.pdf (last visited Jan. 3, 2013) (listing MA enrollment of approximately 13.1 million and 27% of the Medicare population); *Total Medicare Advantage Enrollment*, Kaiser Family Foundation (2012) (Kaiser 2012 Medicare Advantage Enrollment), *available at* http://www.statehealthfacts.org/comparetable.jsp?ind=327&cat=6 (last visited Jan. 3, 2013).

Of the total number of MA beneficiaries, there are approximately 1,104,981 in the Third Circuit,[7] and there are approximately 1,575,311 MA beneficiaries in the Sixth Circuit.[8] *See* Kaiser 2012 Medicare Advantage Enrollment. Given the circuit conflict, primary plans are able to settle with some of those beneficiaries, but cannot feasibly settle with the more than 1.1 million beneficiaries in the Third Circuit. The MAOs in that Circuit now wield a double damages federal cause of action that does not exist elsewhere, should a primary plan inadvertently fail to calculate its reimbursement obligation that it cannot guess.

While those numbers of MAO enrollees are indisputably significant, HHS estimates that MA enrollment will continue to grow: "Enrollment in Medicare Advantage is on the rise and is exceeding insurance company expectations. In fact, from 2010 to 2011, enrollment in Medicare Advantage increased by 6%." *Medicare Advantage & the Affordable Care Act, U.S. Dep't of Health & Human Services*, *available at* http://www.healthcare.gov/news/factsheets/2011/02/medicare02102011a.html (last visited Jan. 3, 2013). That rate accelerated in 2012 with an additional 10% increase. *See* Kaiser 2012 Data Spotlight (noting that Medicare Advantage enrollment "grew by 10 percent in

---

[7] According to the most recent data, Delaware has approximately 7456 such enrollees, New Jersey has approximately 197,190, and Pennsylvania has approximately 900,335. *See* Kaiser 2012 Medicare Advantage Enrollment.

[8] According to the most recent data, Kentucky has approximately 129,165 such enrollees, Michigan has approximately 436,057, Ohio has approximately 709,313, and Tennessee has approximately 129,165. *See* Kaiser 2012 Medicare Advantage Enrollment.

2012"). HHS's expectation of further growth has some basis in history. Between 2004 and 2012, MA enrollment has seen more than 100% growth. *See Medicare Advantage Fact Sheet*, Kaiser Family Foundation (Dec. 2012), *available at* http://www.kff.org /medicare/upload/2052-16.pdf (last visited Jan. 3, 2013) ("Since 2004, the number of beneficiaries enrolled in private plans has more than doubled from 5.3 million to 13.1 million in 2012."). There is no reason to think that growth will abate.

Primary plans now face the potential exposure to double damages actions by MAOs on behalf of their more than 1.1 million customers in the Third Circuit. With the baby boomer population reaching Medicare-eligible age in staggering numbers, and many of those beneficiaries enrolling in MA plans, the depth of the problem will only increase in the absence of this Court's review.

CONCLUSION

For the foregoing reasons, the petition for writ of certiorari should be granted.

Respectfully submitted,

DAVID J. FARBER
Counsel of Record
CORDELL A. HULL
PATTON BOGGS LLP
2550 M Street, N.W.
Washington, DC 20037
(202) 457-6000
dfarber@pattonboggs.com

Counsel for Amici Curiae

January 4, 2013