No.

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

PETITION FOR WRIT OF CERTIORARI

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QUESTION PRESENTED

Whether the Medicare Secondary Payer Act, 42 U.S.C. § 1395y(b)(2), establishes a cause of action for private insurers operating Medicare Advantage plans to sue tortfeasors for double damages.

CORPORATE DISCLOSURE STATEMENT

Pursuant to this Court's Rule 29.6, petitioner GlaxoSmithKline LLC states that it is owned, through several levels of wholly owned subsidiaries, by petitioner GlaxoSmithKline plc, a public limited company organized under the laws of the United Kingdom. No publicly held company owns 10% or more of the outstanding shares in GlaxoSmithKline plc. The Bank of New York Mellon, however, acts as depositary in respect of Ordinary Share American Depositary Receipts representing shares in GlaxoSmithKline plc. In that capacity, the Bank of New York Mellon is the holder of more than 10% of the outstanding shares of GlaxoSmithKline plc.

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INTRODUCTION

This case presents important questions concerning when, if ever, private insurers have a federal cause of action to sue tortfeasors for double damages. The ability of insurers to recover from tortfeasors is typically governed by state law. Under the venerable doctrine of subrogation, an insurer that pays out a claim is subrogated to the rights of its insured against any tortfeasor who is liable for the insured's injuries. That permits the insurer to recover its costs, while also placing responsibility for the loss on the party that caused it. Each State has its own well-developed law regarding subrogation, and those laws often differ from State to State. None of those laws provides for double damages.

Congress has created an alternative subrogation regime for Medicare. Under the Medicare Secondary Payer Act ("MSP Act"), 42 U.S.C. § 1395y(b)(2), a tortfeasor that settles with, or is found liable for injuring, a Medicare beneficiary must reimburse the United States for the costs Medicare incurred in covering the beneficiary's medical expenses. If the tortfeasor fails to do so—after its responsibility for payment has been demonstrated by a judgment or a settlement—the Act authorizes the United States to sue the tortfeasor for double damages. This federal subrogation regime differs from the typical state-law regime in two important ways: (1) the MSP Act imposes an affirmative obligation on tortfeasors to reimburse Medicare without requiring Medicare to bring a reimbursement action; and (2) the MSP Act authorizes Medicare to recover double damages from tortfeasors that fail to provide such reimbursement.

Most courts have interpreted the federal subrogation regime created by the MSP Act to be limited to recovering payments made by Medicare. In the decision below, however, the Third Circuit held that private insurers operating Medicare Advantage plans can *also* pursue federal subrogation rights under the MSP Act, rather than under state law. The Medicare Advantage program, enacted 17 years after the MSP Act, authorizes private insurers to offer health insurance to Medicare-eligible individuals that replaces traditional Medicare benefits. As the Third Circuit conceded, the Medicare Advantage statute itself does not provide such insurers a federal cause of action against tortfeasors. Nonetheless, that court construed the MSP Act to provide private insurers operating Medicare Advantage plans with the same federal cause of action that it provides Medicare.

The decision below is the latest in a string of cases in which the Courts of Appeals have disagreed over the extent to which the MSP Act authorizes double-damages suits against tortfeasors. Taking the narrowest view, the Sixth Circuit has construed the MSP Act to provide *only* the United States—and not private insurers or Medicare beneficiaries—with a cause of action against tortfeasors. The First and Eighth Circuits, in contrast, have construed the Act also to permit Medicare beneficiaries to sue tortfeasors, but only where Medicare—and not private insurers—covered the beneficiaries' medical costs. In the decision below, the Third Circuit adopted the broadest construction of all by holding that the MSP Act creates a cause of action for private insurers to sue tortfeasors for double damages, even though Medicare did not pay the benefits and

regardless of whether those insurers have adequate subrogation remedies under state law.

The extent, if any, to which the MSP Act permits private insurers to pursue federal double-damages actions against tortfeasors is a matter of significant importance. Today, over *13 million* Americans—over a quarter of the Medicare-eligible population—are enrolled in Medicare Advantage plans. Together, these beneficiaries received at least *$124 billion* in medical care in 2011, as measured by the amount the Federal Government paid to private insurers that operate those plans. Given these staggering numbers, the present state of uncertainty and confusion in the law is intolerable. All affected parties—beneficiaries, insurers, and alleged tortfeasors—would benefit from a clarification of their rights and obligations under the MSP Act. This lawsuit should not be permitted to proceed simply because it was filed in Philadelphia, not Cincinnati.

Accordingly, this Court should grant the petition.

OPINIONS BELOW

The Third Circuit's decision below is reported at 685 F.3d 353 and reprinted in the Appendix (App.) at 1-31a. The District Court's opinion and order is reported at 2011 WL 2413488 and reprinted at App. 34-51a.

JURISDICTION

The Third Circuit rendered its decision on June 28, 2012, App. 2a, and denied a timely petition for rehearing on August 6, 2012, App. 32-33a. On October 19, 2012, Justice Alito extended the time to file a petition for a writ of certiorari to December 5,

2012. This Court has jurisdiction under 28 U.S.C. § 1254(1).

PERTINENT STATUTORY PROVISIONS

The MSP Act provides in pertinent part:

> **(b)(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

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.

(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.

(C) Treatment of questionnaires

The Secretary may not fail to make payment under subparagraph (A) solely on the ground that an individual failed to complete a questionnaire concerning the existence of a primary plan.

(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).

42 U.S.C. § 1395y(b).

The Medicare Advantage statute provides in relevant part:

> **(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 is made secondary pursuant to section 1395(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.

42 U.S.C. § 1395w-22(a)(4).

STATEMENT OF THE CASE

A. Statutory Background

1. The Medicare Secondary Payer Act

Medicare is a federally funded insurance program that provides health-insurance benefits to persons 65 or older and persons under 65 who suffer from certain specified diseases. For various reasons, many individuals covered by Medicare are also covered by a separate, private health insurer. It is therefore not uncommon for both Medicare and a

private insurer to provide overlapping coverage for the same medical expense.

For the first 15 years of its existence, Medicare paid benefits without regard to whether a private health insurer also provided coverage. That changed in 1980, when Congress enacted an amendment to the Medicare laws that has come to be known as the MSP Act. *See* Medicare & Medicaid Amendments of 1980, Pub. L. No. 96-499, § 953, 94 Stat. 2599, 2647 (codified as amended at 42 U.S.C. § 1395y(b)(2)). The MSP Act makes Medicare's liability secondary to other sources of payment—*i.e.*, if both Medicare and a private insurance plan provide coverage, the private plan is deemed the "primary plan" and must pay the Medicare beneficiaries' medical costs. *See* 42 U.S.C. § 1395y(b)(2)(A). The Act thus saves Medicare dollars by shifting medical costs to private sources of payment whenever possible.

The Act contains a number of detailed provisions designed to enforce Medicare's status as a "secondary" payer. The Act, to begin, forbids Medicare from making any payment when a primary plan provides coverage. *Id.* In order to ensure that needed medical care is not withheld, however, the Act authorizes Medicare to make a "conditional payment" if a primary plan "cannot reasonably be expected to make payment … promptly." *Id.* § 1395y(b)(2)(B)(i). Primary plans are then obligated to reimburse Medicare for the amount of that conditional payment "if it is demonstrated that such primary plan has or had a responsibility to make payment with respect to such item or service." *Id.* § 1395y(b)(2)(B)(ii).

The Act provides two remedies for instances in which a primary plan fails to reimburse Medicare as required by the Act. *First*, the Act authorizes "the United States" to sue a primary plan and to "collect double damages against any such entity." *Id.* § 1395y(b)(2)(B)(iii). *Second*, in 1986 Congress added a private cause of action to the MSP Act:

> 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).

Omnibus Budget Reconciliation Act of 1986, Pub. L. No. 99-509 § 9319(b), 100 Stat. 1874, 2011 (codified at 42 U.S.C. § 1395y(b)(3)(A)). Although no legislative history explains how the private right of action in section 1395y(b)(3)(A) was meant to operate, courts have "generally agreed" that it was intended to provide a cause of action for Medicare beneficiaries to sue primary plans:

> The thinking behind the statute is apparently that (1) the beneficiary can be expected to be more aware than the government of whether other entities may be responsible to pay his expenses; (2) without the double damages, the beneficiary might not be motivated to take arms against a recalcitrant insurer because Medicare may have already paid the expenses and the beneficiary would have nothing to gain by pursuing the primary payer; and (3) with the private right of action and the double

> damages, the beneficiary can pay back the government for its outlay and still have money left over to reward him for his efforts.

Stalley v. Catholic Health Initiatives, 509 F.3d 517, 524-25 (8th Cir. 2007).

2. The Medicare Advantage Program

In 1997, Congress created the Medicare+Choice program, which was subsequently renamed the Medicare Advantage program. *See* 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). Under Medicare Advantage, Medicare-eligible individuals who would otherwise receive medical benefits from the Government can elect to enroll in a private health-insurance plan (known as a "Medicare Advantage" plan) from an insurance carrier authorized to offer such plans (known as a "Medicare Advantage Organization" or "MAO"). *See* 42 U.S.C. § 1395w-21. These private insurers have contracted with the Federal Government to provide their enrollees the same benefits as would otherwise be provided by Medicare, as well as any additional or supplemental benefits the MAO elects to provide. *See id*. § 1395w-22. In return, the Government pays MAOs a set amount per enrollee, which is calculated annually pursuant to a statutory formula. *See id*. § 1395w-23.

Once an individual enrolls in a Medicare Advantage plan, the plan operates in all respects like a private health insurance plan. Eligible beneficiaries enroll in Medicare Advantage plans

directly with an MAO and, as with other private insurance plans, the enrollee enters into an insurance agreement with the MAO that describes the terms and conditions of the coverage. *See id.* § 1395w-21(c)–(h). Once enrolled, beneficiaries make premium payments to the MAO, including monthly premiums for basic, prescription-drug, and supplemental coverages, *id.* § 1395w-24(d), and the MAO retains for itself the entire amount of those premiums. Beneficiaries also submit claims directly to the MAO, and the amounts necessary to pay claims come from the MAO, not the Government. *See id.* § 1395w-22.

Significantly, the Medicare Advantage statute does not include a federal cause of action for MAOs to seek reimbursement from primary payers. Instead, the statute authorizes (but does not require) MAOs to assume "secondary payer" status in relation to other private insurers, and thus preempts state anti-subrogation laws that might otherwise prevent MAOs from assuming that status. The Medicare Advantage statute thus states that "[n]otwithstanding any other provision of law, a Medicare+Choice organization may … charge" a primary plan for medical costs in any case "in which payment under this subchapter is made secondary [for Medicare] pursuant to section 1395y(b)(2)." *Id.* § 1395w-22(a)(4).

3. The 2003 Amendment To The MSP Act

One final legislative enactment completes the statutory picture. Beginning in the early 2000s, the United States began invoking its cause of action in the MSP Act against the settlements in certain mass tort cases. *See Bio-Medical Applications of Tenn.,*

Inc. v. Central States S.E. & S.W. Areas Health & Welfare Fund, 656 F.3d 277, 289 (6th Cir. 2011). The Government's theory was that the putative tortfeasors in those cases—mainly tobacco companies and drug manufacturers—qualified as "primary plans" under the MSP Act because they carried their own risk and thus were "self insured" for their tortious conduct. *Id.* As primary plans, the Government argued, those putative tortfeasors were liable for double damages because they had not reimbursed Medicare for the costs it incurred in treating the injured plaintiffs. *Id.*

Citing an unwillingness to "apply [the MSP Act's] heavy remedy of double damages to the context of tort litigation," the Courts of Appeals uniformly rejected the Government's argument. *Mason v. American Tobacco Co.*, 346 F.3d 36, 42 (2d Cir. 2003); *see also, e.g.*, *Thompson v. Goetzmann*, 337 F.3d 489, 496-501 (5th Cir. 2003) (*per curiam*). In 2003, however, Congress explicitly overruled those decisions by amending the MSP Act to make clear that putative tortfeasors may qualify as "primary plans" under the Act. *See* Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108–173, § 301(b)(1), 117 Stat. 2066, 2222 ("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."); *see also* H.R. Rep. No. 108-178, pt. 2 at 189–190 (2003) (explaining that the purpose of the amendment was to address "recent court decisions" that allowed "firms that self-insure for product liability … to avoid paying Medicare for past medical payments related to the claim"). As a result,

businesses that settle with a tort plaintiff (or that are found liable in court) are obligated to reimburse Medicare for its costs. *See* 42 U.S.C. § 1395y(b)(2)(B)(ii). If they fail to do so, Medicare can sue those putative tortfeasors for double damages. *Id*. § 1395y(b)(2)(B)(iii).

B. Factual Background & Proceedings Below

This case arises out of thousands of personal-injury claims brought by individuals who used the diabetes drug Avandia® manufactured by petitioner GlaxoSmithKline LLC ("GSK"). The claimants maintain that they were injured by the drug and incurred medical costs to treat their injuries. App. 36a. GSK has settled many of those claims. *Id*. The settlement agreements include provisions requiring that third party liens—such as liens possessed by health insurers—be satisfied. *Id*. For those plaintiffs covered by Medicare, such liens include GSK's obligation under the MSP Act to reimburse Medicare for any "conditional payment[s]" made by the government to cover a plaintiff's medical costs. *Id*; *see also* 42 U.S.C. § 1395y(b)(2)(B). For claimants covered by private insurance plans, such liens include liens perfected by insurance carriers with contractual subrogation rights under state law. App. 36a.

Respondents Humana Medical Plans, Inc. and Humana Insurance Co. (collectively "Humana") are insurance companies that operate Medicare Advantage plans. App. 52-53a. In November 2010, Humana brought this lawsuit against GSK in the United States District Court for the Eastern District of Pennsylvania on behalf of itself and a putative

class of similarly situated MAOs. *Id.* The complaint alleged that many of the plaintiffs with whom GSK had settled were covered by Medicare Advantage plans offered by Humana and other MAOs, and that Humana and other insurers had therefore paid medical costs for those plaintiffs. App. 57-62a. Because settling tortfeasors qualify as "primary plans" under the MSP Act, the complaint alleged that GSK was obligated to reimburse Humana and other MAOs for the costs they incurred in paying the medical costs for Avandia plaintiffs. App. 61-62a. Instead of seeking to recover those amounts under state law, however, Humana purported to sue GSK for double damages under the private cause of action included in the MSP Act. App. 68-69a.

1. District Court

The district court (Rufe, J., E.D. Pa.) dismissed Humana's complaint for failure to state a claim, holding that the private cause of action in the MSP Act did not authorize MAOs to sue putative tortfeasors for double damages. App. 34-51a. The Medicare Advantage program, the court emphasized, was enacted more than a decade after the MSP Act. App. 46a. And although the Medicare Advantage statute contains "its own secondary payer provision regarding the role of an MAO as a secondary payer," App. 41a, that provision:

> does not reference or expressly incorporate the remedy the MSP [Act] provides to the United States in 42 U.S.C. § 1395y(b)(2)(B)(iii), nor does it reference or incorporate § 1395(b)(3), which creates a private right of action for damages when a

> primary plan fails to provide for primary payment or reimbursement.

App. 45a. The court viewed that omission as strong evidence that Congress did not intend to afford MAOs a federal cause of action to sue tortfeasors for double damages.

The district court made clear, however, that its holding did not leave MAOs without a remedy. MAOs still had "a widely recognized alternative avenue for enforcement: a standard insurance contract claim brought in state court." App. 44a (quotations omitted); *see also* App. 47a. The Medicare Advantage statute, the court noted, paved the way for that remedy by explicitly authorizing MAOs to include subrogation or secondary-payer provisions in insurance contacts with their enrollees. App. 41a, 47a. In short, "Congress intended [MAOs] to recover the reimbursement through its contract with the enrollee, rather than through a federal court action against the tortfeasor/primary payer." App. 46-47a n.39.

2. Third Circuit

The Third Circuit reversed, holding that the "Medicare Secondary Payer Act, in 42 U.S.C. § 1395y(b)(3)(A), provides Humana with a private cause of action against [GSK]." App. 3a. According to the Third Circuit, "[t]he plain text of the MSP [Act's] private cause of action" is broad enough to include double-damages suits by MAOs, because it "plac[es] no limitations upon which private (i.e., non-governmental) actors can bring suit for double damages when a primary plan fails to appropriately reimburse any secondary payer." App. 13a. If Congress had wanted to exclude private insurers

from the scope of the Act, the court declared, it "could have done so explicitly." App. 15a.

To buttress that textual argument, the Court of Appeals looked to the "legislative history and policy rationales" underlying the Medicare Advantage program. App. 21a. The Third Circuit reasoned that "MAOs would be at a competitive disadvantage" with Medicare if they lacked the ability to "threaten recalcitrant primary payers with double damages." App. 22-23a. While conceding that "the legislative history is nowhere explicit that MAOs may bring suit for double damages under the MSP [Act's]private cause of action," App. 23-24a, the Third Circuit believed that implying such a remedy was necessary "to facilitate recovery of conditional payments." App. 24a (quotations omitted).

Although it believed that the MSP Act "unambiguously" provided MAOs with a cause of action to bring double-damages suits against putative tortfeasors, the Third Circuit explained that *Chevron* deference would have required it to reach the same conclusion "even if the statute's text were deemed to be ambiguous." App. 27a; *see also* 6a (citing *Chevron, USA, Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 842-43 (1984)). The Centers for Medicare & Medicaid Services ("CMS")—the federal agency charged with administering Medicare—has issued a regulation stating that MAOs can "exercise the same rights to recover from a primary plan … that the Secretary exercises." App. 28a. In the Third Circuit's view, that regulation authorized MAOs to invoke the private cause of action in the MSP Act. App. 27-30a.

This petition follows.

REASONS FOR GRANTING THE WRIT

The Third Circuit Erred, And Deepened A Conflict Among the Courts Of Appeals, By Holding That The MSP Act Establishes A Cause Of Action For Private Insurers To Sue Putative Tortfeasors For Double Damages.

This Court should grant certiorari to clarify the extent to which the MSP Act authorizes double-damages suits against putative tortfeasors. The decision below—which extended the MSP Act's remedies beyond government-provided Medicare to privately provided Medicare Advantage plans—conflicts with the decisions of other Court of Appeals concerning what private parties, if any, can sue tortfeasors under the Act. Without clarity from this Court, entities or individuals that settle tort actions (or that are found liable in court) will face inconsistent liabilities based on the regional Court of Appeals in which they find themselves litigating—and a double-damages penalty if they erroneously evaluate those liabilities.

The Third Circuit's decision to extend the remedies in the MSP Act to MAOs, moreover, will have significant consequences. By providing MAOs with a federal cause of action for double damages, the Third Circuit's ruling overrides the well-developed state-law remedies that private insurers typically invoke in these circumstances. Without a clear statement of legislative intent, courts should not lightly presume that Congress intended to effect such a sweeping and significant change in the law.

Nor can the Third Circuit's decision be justified on the merits. The plain text of the MSP Act limits the private cause of action to instances in which the

plaintiff is seeking to recover a conditional payment made by Medicare. That is simply impossible when an MAO brings suit under the MSP Act: because the MAO itself is responsible for paying its enrollees' medical costs, the MAO by necessity seeks to recover the amounts that *it* paid out, not amounts that Medicare paid out. And were there any ambiguity on that score, Congress surely resolved any such ambiguity when it authorized MAOs to charge primary payers but did not include any express federal remedy for MAOs in enacting the Medicare Advantage statute.

A. The Decision Below Deepens A Circuit Conflict Over The Scope Of The Private Cause Of Action In The MSP Act.

The Third Circuit's holding that private insurers operating Medicare Advantage plans can pursue a federal cause of action against tortfeasors under the MSP Act cannot be reconciled with other Circuits' interpretations of the Act. The resulting confusion warrants this Court's review.

As a threshold matter, the decision below conflicts with *Bio-Medical Applications of Tenn., Inc. v. Central States S.E. & S.W. Areas Health & Welfare Fund*, 656 F.3d 277 (6th Cir. 2011). In that case, a healthcare provider sued a health insurer under the private cause of action in section 1395y(b)(3)(A) of the MSP Act, arguing that the health insurer had violated the Act by terminating benefits when a beneficiary became eligible for Medicare. *See id.* at 280-81; *see also* 42 U.S.C. § 1395y(b)(1) (forbidding insurers from "tak[ing] into account" a beneficiary's eligibility for Medicare when providing coverage). In resolving that claim, the Sixth Circuit conducted an

exhaustive analysis of how the causes of action in the MSP Act should be construed in light of the 2003 legislation authorizing Medicare to seek reimbursement from putative tortfeasors. *See* 656 F.3d at 284-93.

After closely parsing the statutory text and legislative history, the Sixth Circuit concluded that the MSP Act gives *only* the Federal Government—not private parties—a cause of action against tortfeasors: "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*." *Id.* at 292-93 (emphasis in original). According to the Sixth Circuit, "*the Act does not permit a private cause of action (as opposed to one brought by Medicare) in tort*." *Id.* at 293 (emphasis added).

To be sure, *Bio-Medical* did not involve a suit by an MAO. Nonetheless, the Sixth Circuit's recognition that only "*Medicare*" can sue tortfeasors under the Act forecloses the possibility that MAOs—which are private insurers—can invoke the MSP Act's private cause of action against putative tortfeasors. Indeed, under the Sixth Circuit's interpretation of the statute, Congress's 2003 amendment authorizing Medicare to recover against tortfeasors had no effect at all on the scope of section 1395y(b)(3)(A): Although private parties can invoke that cause of action to sue *other* health insurers that qualify as "primary plans," they cannot use it to sue putative tortfeasors. *See id.* at 293 (the Act "does not permit a private cause of action … in tort"). At least in the Sixth Circuit, therefore, MAOs cannot invoke

the private cause of action in section 1395y(b)(3)(A) to sue putative tortfeasors.

A second Sixth Circuit decision only confirms that understanding. In *Care Choices HMO v. Engstrom*, 330 F.3d 786 (6th Cir. 2003), the court rejected the argument that private insurers operating as Medicare substitutes have a federal cause of action against tortfeasors. *Id.* at 788 (declining to find "an implied private right of action in federal court for Medicare-substitute HMOs"). Instead, the Sixth Circuit read the Medicare laws to permit Medicare-substitute insurers "to create a right of reimbursement for themselves in the context of their own insurance agreements with Medicare beneficiaries." *Id.* at 789. If a private insurer "chooses to include such a provision in its insurance policy, its remedy would be based on a standard insurance contract claim and not on any federal statutory right." *Id.* at 790.

The First and Eighth Circuits have construed the MSP Act differently. In particular, the Eighth Circuit has held that the private cause of action in section 1395y(b)(3)(A) was intended to permit Medicare *beneficiaries* to sue tortfeasors and other primary payers where *Medicare* had made a conditional payment. *See Stalley*, 509 F.3d at 526 ("Congress must have intended that a Medicare beneficiary could sue its primary insurer for expenses Medicare had already paid."). "The thinking behind the statute," according to that court, was that "with the private right of action and the double damages, the beneficiary can pay back the government for its outlay and still have money left over to reward him for his efforts." *Id.* at 524-25.

The First Circuit articulated the same understanding of the MSP Act in *United Seniors Association, Inc. v. Philip Morris USA*, 500 F.3d 19 (1st Cir. 2007). In a case in which uninjured plaintiffs purported to sue tortfeasors for failing to reimburse Medicare, the First Circuit also construed the Act to mean that "Medicare beneficiaries can prosecute a private § 1395y(b)(3)(A) cause of action," which in turn would "discourage[] primary insurers from failing to reimburse *Medicare* and prevent[] depletion of the Medicare trust fund." *Id.* at 25 (emphasis added).

Thus, in terms of how they interpret the remedies in the MSP Act to apply to putative tortfeasors, the Courts of Appeals are arrayed on a spectrum. The Sixth Circuit has taken the most restrictive view by interpreting the Act to provide only Medicare with a cause of action to recover from putative tortfeasors. The First and Eighth Circuits have gone the extra step of permitting Medicare beneficiaries to sue putative tortfeasors under the MSP Act, but only to the extent Medicare has made a conditional payment that the tortfeasor should reimburse. The Third Circuit's view is the most expansive of all: In that Circuit, private insurance companies offering Medicare Advantage plans can also invoke the Act's double-damages remedy, even though that recovery flows directly to the MAO and not Medicare.

Resolving this conflict is of paramount importance to Medicare beneficiaries, private health insurers, and the business entities and liability insurers that often find themselves as defendants in tort actions. As things currently stand, MAOs and Medicare beneficiaries in some Circuits are free to

invoke MSP Act remedies that are expressly foreclosed to MAOs and Medicare beneficiaries in other Circuits. Conversely, businesses and liability insurers now face inconsistent liabilities based on the regional Court of Appeals in which they are litigating. Those inconsistencies are all the more significant given the MSP Act's double-damages penalty.

B. The Implications Of The Third Circuit's Ruling Are Significant And Warrant This Court's Review

Whether MAOs and other private parties can invoke the MSP Act's double-damages remedy to sue putative tortfeasors is a question of significant importance. It deserves this Court's review.

To begin, if taken to its logical extent, the Third Circuit's ruling could be argued to create a powerful new tort remedy for plaintiffs in personal-injury cases. The Third Circuit interpreted § 1395y(b)(3)(A) to impose "*no limitations* upon which private (*i.e.*, non-governmental) actors can bring suit for double damages" when a putative tortfeasor fails to reimburse Medicare or an MAO. App. 13a (emphasis added). Instead of pursuing state-law actions, therefore, the Third Circuit's opinion could encourage tort *plaintiffs* who receive benefits from Medicare or MAOs to directly sue putative tortfeasors for double damages under the MSP Act. It is thus possible that the Third Circuit's ruling could be used in an effort to create a lucrative new federal tort remedy for all manner of personal-injury actions—something Congress plainly could not have intended when it amended the MSP Act in 2003 to

permit *Medicare* to bring suit against putative tortfeasors.

Even setting aside the broader implications of the Third Circuit's ruling for tort plaintiffs generally, permitting MAOs to sue under section 1395y(b)(3)(A) would fundamentally rework the regime under which private insurance plans have long operated in seeking reimbursement from tortfeasors or other primary insurers. The regulation of insurance "has traditionally been under the control of the States," *SEC v. VALIC*, 359 U.S. 65, 69 (1959), and thus private health insurers generally must rely on state-law remedies when seeking reimbursement from tortfeasors or primary insurers. That is true even when those private insurance companies offer Medicare Advantage plans or other coverages that substitute for or supplement Medicare: in those instances, private insurers typically obtain relief through state-law tort or contract actions, not through any federal remedy. *See, e.g.*, *Engstrom*, 330 F.3d at 790 (remedy for private insurer operating as Medicare substitute is "based on a standard insurance contract claim … not on any federal statutory right"); App 44a, 46-47a & n. 39.

States thus have well-developed legal regimes governing the circumstances in which insurers can recover costs from tortfeasors. Those regimes can and do vary from State to State. Thus, States have different rules concerning when insurance companies can recover from tortfeasors, the amounts they can seek to recover, and the conditions and procedures with which they must comply to obtain recovery. *See, e.g.*, Johnny C. Parker, *The Made Whole Doctrine: Unraveling The Enigma Wrapped In The*

Mystery of Insurance Subrogation, 70 Mo. L. Rev. 723 (2005) (discussing differences in state subrogation laws); Roger M. Baron, *Subrogation: A Pandora's Box Awaiting Closure*, 41 S.D. L. Rev. 237 (1996) (same). Insurers and putative tortfeasors alike have become accustomed to operating within those frameworks.

The decision below, however, replaces those traditional state-law remedies with a new (and powerful) federal cause of action. If the decision below is allowed to stand, MAOs and other private insurance companies offering Medicare-substitute plans could directly sue tortfeasors and other primary plans under the MSP Act. And because the MSP Act authorizes the recovery of double damages, undoubtedly these insurers will forgo their traditional state-law remedies in favor of the more lucrative federal cause of action that the Third Circuit has created.

This is no small matter. Humana alleges that there over 400 Medicare Advantage Organizations operating in the United States, and that together those MAOs offer more than 2,800 different Medicare Advantage plans. *See* App. 57a (Compl. ¶ 21). Today, over 13 million people are enrolled in such plans, a number that accounts for 27% of the entire Medicare-eligible population. *See* Kaiser Family Foundation, *Medicare Policy, Medicare Advantage 2012 Data Spotlight* at 1 (2012), *available at* http://www.kff.org/medicare/upload/8323.pdf ("Kaiser 2012 Data Spotlight"). Such plans thus account for a significant and growing portion of federal health care spending. "In 2011, payments to MA plans [from the Federal Government] totaled approximately $124

billion." MedPac, *Report to Congress: Medicare Payment Policy* at 317 (March 2012), available at http://www.medpac.gov/chapters/Mar12_Ch12.pdf; *see also* Kaiser 2012 Data Spotlight at 1 ("Medicare Advantage enrollment has more than doubled since 2005.").

The implications of the Third Circuit's decision, moreover, are not limited to MAOs. Prescription drug plans offered under Medicare Part D have the same recovery rights as MAOs under Medicare Part C. *See* 42 U.S.C. § 1395w-102(a)(4) ("The provisions of section 1395w-22(a)(4) of this title shall apply under [Part D of the Medicare Act] in the same manner as they apply under part C of [the Medicare Act.]"); *id.* § 1395w-22(a)(4) (providing that MAOs "may … charge" primary plans or insured individuals for covered medical expenses). The Third Circuit's reasoning thus may open the door for companies offering prescription drug plans under Medicare Part D to invoke the private cause of action in the MSP Act and obtain double-damages recoveries.

That fact only adds to the significance of the decision below. Around 31.5 million Medicare beneficiaries are enrolled in Medicare prescription drug plans under Part D of the Medicare Act. *See* Kaiser Family Foundation, *Medicare Policy, Analysis of Medicare Prescription Drug Plans in 2012 and Key Trends Since 2006* at 1 (2012), *available at* http://www.kff.org/medicare/upload/8357.pdf. Those individuals are covered by more than 1,040 stand-alone Medicare prescription drug plans, which are supplemented by an additional 1,541 Medicare Advantage drug plans. *Id.* at 2. In 2010 alone, the

Federal Government paid out $56.1 billion to those plans to subsidize prescription drug benefits for Medicare enrollees. *See* MedPac, *Report to Congress: Medicare Payment Policy* at 353 (March 2012), available at http://www. medpac.gov/documents /Mar12_EntireReport.pdf. Under the Third Circuit's reasoning, all of those Part D prescription drug plans might well now be able to invoke the double-damages cause of action in the MSP Act.

Finally, the decision below threatens to significantly hamper settlement efforts in mass tort cases. Like the Avandia settlement process from which this case arises, putative tortfeasors settling mass tort claims typically make arrangements to satisfy any government liens arising from Medicare's status as a secondary payer. To facilitate that process, the Federal Government has established clear Medicare-reimbursement procedures with which settling defendants must comply. *See, e.g.*, 42 C.F.R. § 411.20 *et seq*. Those procedures enable identification, from data made available by CMS, of settling claimants to whom Medicare made conditional payments so appropriate reimbursement to the Government may be remitted. At least with respect to Medicare, therefore, defendants can safely enter into settlement agreements without fear that they will be subject to double-damages lawsuits.

In contrast, putative tortfeasors willing to enter settlements do not have an independent and reliable source of information (such as CMS) available to identify which MAO covered which settling claimant at what point in time, which is needed to permit resolution of all MAO reimbursement claims. Neither the Government nor MAOs publish lists of

Medicare Advantage enrollees matched to their carriers. Without this information, a settling putative tortfeasor cannot identify with any assurance the MAOs with which to engage in discussions regarding reimbursement. The problems become particularly acute for those Medicare Advantage enrollees who switch carriers or move onto a spouse's plan. Thus, under the decision below, a settling putative tortfeasor is placed in the untenable position of being exposed to double damages for having failed to resolve a lien claim about which it is not aware. At a minimum, this uncertainty would deter if not defeat some settlements that litigating parties wish to enter.

C. The Third Circuit Erred In Interpreting The Scope Of The MSP Act's Private Cause of Action.

For these reasons, the Court should grant review to resolve the conflict that has arisen in the Courts of Appeals concerning the scope of tortfeasor liability under the MSP Act and to address the significant implications the Third Circuit's decision has for health insurers, beneficiaries, and putative tortfeasors alike. But review is all the more justified given that the Third Circuit's ruling is plainly wrong on the merits. The text, structure, and history of the MSP Act make it abundantly clear that Congress did not authorize MAOs to forgo their traditional state-law remedies in favor of a federal cause of action for double damages.

To begin, the plain text of the statute cannot be read to authorize double-damages suits by MAOs. As relevant here, section 1395y(b)(3)(A) provides a private cause of action only where a primary plan

has failed to provide for "appropriate reimbursement … in accordance with paragraph[] … (2)(A)."[1] Paragraph 2(A), in turn, does not directly speak to the issue of "appropriate reimbursement," but instead directs readers to paragraph (2)(B) to determine when "appropriate reimbursement" is required. *Id.* § 1395y(b)(2)(A) ("Payment under this subchapter may not be made, *except as provided in subparagraph (B)*") (emphasis added). The only reimbursement obligation mentioned in paragraph 2(B), however, is a primary plan's obligation to reimburse the *Government* for a conditional payment made by *Medicare*. *See id.* § 1395y(b)(2)(B)(ii) ("A primary plan … shall reimburse the appropriate *Trust Fund* for any payment *made by the Secretary*.") (emphasis added). Nothing in paragraph (2)(B) requires primary plans to reimburse MAOs, and, indeed, those requirements are spelled out elsewhere in the Code. *See id.* § 1395w-22(a)(4).

Once unraveled, that chain of statutory cross-references precludes MAOs from suing under the MSP Act's private cause of action. An action can be brought under section 1395y(b)(3)(A) only when a

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[1] Section 1395y(b)(3)(A) also authorizes a private cause of action for a primary plan that has failed to provide for "primary payment … in accordance with paragraph[] … (2)(A)." That language presumably embraces circumstances in which Medicare has not yet made a conditional payment and a private party is seeking to enforce a primary plan's obligation to make primary payment. Humana's complaint in this case makes clear that Humana is seeking "reimbursement" under section 1395y(b)(3)(A). *See, e.g.*, App. 53a ¶ 1 ("Plaintiffs … are suing … to recover … *reimbursement* of the money [MAOs] paid on behalf of their enrollees for medical treatment.") (emphasis added).

primary plan—*e.g.*, a putative tortfeasor—has an obligation to reimburse the Medicare "Trust Fund" for a conditional payment that has been "made by the Secretary." *Id.* § 1395y(b)(2)(B)(ii). That is simply impossible when an MAO is bringing suit. By necessity, an MAO is *always* seeking reimbursement for amounts that the MAO itself paid to cover a beneficiary's medical costs and is *never* seeking to recover conditional payments made by Medicare. The text of section 1395y(b)(3)(A) does not authorize recovery in that circumstance.

The statutory context confirms that the private cause of action in the MSP Act was intended to be invoked only in instances in which the Federal Government—not an MAO—was entitled to reimbursement from primary payers. The private right of action in the MSP Act is included in subsection (b) of section 1395y, which is titled "*Medicare* as Secondary Payer." All of the relevant provisions in subsection (b) pertain to *Medicare*. *See, e.g.*, § 1395y(b)(2)(B)(i) (authorizing "*the Secretary*" to make conditional payments and noting that any payment "by *the Secretary*" is conditioned on reimbursement); § 1395y(b)(2)(B)(ii) (requiring primary plans to reimburse "the appropriate Trust Fund" for payments "made by *the Secretary*" and stating that "*the Secretary* may charge interest" if reimbursement is not made); § 1395y(b)(2)(B)(iii) (authorizing "*the United States*" to sue primary payers); § 1395y(b)(2)(B)(iv) (affording "*[t]he United States*" subrogation rights); § 1395y(b)(2)(B)(v) (providing "*[t]he Secretary*" waiver rights); § 1395y(b)(2)(B)(vi) (affording "*the United States*" a three-year window in which to seek reimbursement); § 1395y(b)(2)(C) (stating that "*[t]he Secretary* may

not fail to make a payment … solely on the ground that an individual failed to complete a questionnaire") (all emphases added).

MAOs, in contrast, are addressed elsewhere in the Code and are consistently distinguished from government "Medicare" by the title "Medicare+Choice" organizations. *See id.* § 1395w-21 *et seq*. It is implausible, to say the least, that Congress would have buried a double-damages cause of action for MAOs in a statutory subsection directed to government-provided Medicare. *See, e.g.*, *Whitman v. American Trucking Ass'ns, Inc.*, 531 U.S. 457, 468 (2001) ("Congress ... does not … hide elephants in mouseholes."); *cf. FDA v. Brown & Williamson Tobacco Corp.*, 529 U.S. 120, 160 (2000) ("[W]e are confident that Congress could not have intended to delegate a decision of such economic and political significance to an agency in so cryptic a fashion.").

The legislative history behind the Medicare Advantage program also confirms that Congress did not intend for MAOs to invoke the private cause of action in the MSP Act. The Medicare Advantage statute was enacted into law over a decade after Congress enacted the MSP Act. *See* Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4001 *et seq*., 111 Stat. 251. Nonetheless, Congress did not include an explicit cause of action in the Medicare Advantage statute authorizing MAOs to sue primary plans. And although the Medicare Advantage statute does cross-reference certain provisions of the MSP Act for specific purposes, *see, e.g.*, 42 U.S.C. § 1395w-22(a)(4) (referencing portions of the MSP Act to define the circumstances in which MAOs can

charge beneficiaries or primary payers), it tellingly does not incorporate any of the *remedies* included in the MSP Act.

Congress' actions surrounding the 2003 amendment to the MSP Act are also telling. In amending the Act to make putative tortfeasors liable as secondary payers, Congress made clear that it intended only to overrule certain Courts of Appeals decisions that had barred *Medicare* from suing putative tortfeasors for double damages. *See* H.R. Rep. No. 108-178, pt. 2 at 189–190 (2003) (explaining that the purpose of the amendment was to address "recent court decisions" that allowed "firms that self-insure for product liability … to avoid paying Medicare for past medical payments related to the claim."). Congress gave no indication that it intended to extend a similar cause of action to MAOs. Given the significant implications of providing private insurers with a federal cause of action to sue putative tortfeasors for double damages, it is simply implausible that Congress would have changed the law in such a significant fashion *sub silentio*.

Recognizing that MAOs cannot sue putative tortfeasors under section 1395y(b)(3)(A)—the MSP Act's private cause of action—does not mean that provision has no role to play. Private parties such as Medicare beneficiaries and healthcare providers can sue under section 1395y(b)(3)(A) to recover a conditional payment made by *Medicare*. *See, e.g.*, *Bio-Medical Applications*, 656 F.3d at 280-281; *Stalley*, 509 F.3d at 536. But because MAOs, by necessity, do not seek to recover conditional payments made by Medicare, but instead seek to

recover their *own* payments, section 1395y(b)(3)(A) does not grant them a federal cause of action.

All of this is not to say that MAOs have no remedy at all for a primary plan that fails to provide for primary payment. To the contrary, MAOs have longstanding and well-recognized remedies under state law: MAOs can include subrogation or secondary-payer rights in their private insurance contracts with their enrollees and then enforce those rights through state-law tort and contract actions. *See, e.g.*, *Engstrom*, 330 F.3d at 790; App 46-47a & n. 39. Indeed, to facilitate those recoveries, the Medicare Advantage statute expressly preempts antisubrogation laws or other restrictions that states might impose on an MAO's ability to recover from primary payers or their own beneficiaries. *See* 42 U.S.C. § 1395w-22(a)(4) ("Notwithstanding any other provision of law, a Medicare+Choice organization may … charge" primary plans or insured individuals for covered medical expenses). Congress thus plainly intended that MAOs would pursue traditional state-law subrogation claims, not the federal double-damages cause of action available to Medicare.

Without a stronger expression of congressional intent, courts should not lightly assume that Congress intended the private right of action in the MSP Act to override that state-law regime. Because states have a "long tradition" of regulating insurance, courts are typically "reluctan[t] to disturb the state regulatory schemes that are in actual effect." *VALIC*, 359 U.S. at 68. Although Congress clearly indicated its intent to preempt those state insurance regulations that might limit an MAO's *right* to recover from primary payers, Congress's

silence with respect to the proper *remedies* MAOs should exercise suggests that it intended traditional state-law remedies to remain in place.

Finally, the Third Circuit's decision in this case cannot be sustained under a *Chevron* analysis. CMS, it is true, has promulgated a regulation stating that MAOs "will exercise the same rights to recover from a primary plan, entity, or individual that the Secretary exercises under the MSP regulations." 42 C.F.R. § 422.108(f). But it is unclear exactly what the Court of Appeals understood that language to do. To the extent the Third Circuit believed that this regulation itself created a cause of action authorizing MAOs to sue tortfeasors, that is plainly wrong. It is axiomatic that a regulation may not "conjure up a private cause of action that has not been authorized by Congress," *Alexander v. Sandoval*, 532 U.S. 275, 291 (2001), and, as explained, neither the MSP Act nor the Medicare Advantage statute affords MAOs a federal cause of action to sue tortfeasors.

Nor could this regulation pass muster as an agency interpretation of the language of the private right of action in the MSP Act. As explained above, the necessary precondition of any party invoking the private right of action in section 1395y(b)(3)(A) is that a primary plan have failed to "reimburse the appropriate Trust Fund for any payment made by *the Secretary*." *Id.* § 1395y(b)(2)(B)(ii) (emphasis added). But when an MAO sues under the Act, it is necessarily seeking reimbursement for itself for its *own* payments, and it has no obligation to reimburse Medicare. No MAO, in other words, would be using the private right of action in the MSP Act to recover a conditional payment "made by the Secretary."

Thus, to the extent 42 C.F.R. § 422.108 can be read to authorize MAOs to sue putative tortfeasors under the private right of action in the MSP Act, the regulation would be manifestly contrary to the statutory text and hence not entitled to deference. *See, e.g.*, *Brown v. Gardner*, 513 U.S. 115, 122 (1994) (the fact that a regulation "flies against the plain language of the statutory text exempts courts from any obligation to defer to it").

CONCLUSION

For the foregoing reasons, this Court should grant the petition for writ of certiorari.

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