MEDICARE ADVANTAGE MISCONCEPTIONS ABOUND

D. Gary Reed, Esq.
Humana Inc.
Louisville, KY

There are two distinctly different versions of Medicare Advantage.

The first is the Medicare Advantage in which almost 16 million Medicare beneficiaries – 30 percent of all Medicare beneficiaries – are enrolled.¹ This is the Medicare Advantage option authorized by Part C of Title XVIII of the Social Security Act and administered – down to the finest detail – by the Centers for Medicare & Medicaid Services (“CMS”). Because Medicare Advantage offers more robust benefits and better coordination of medical care than Original fee-for-service Medicare, it is attractive to many beneficiaries.

The second form of Medicare Advantage is the one found in pleadings, briefs, and court decisions. This version finds its mooring not in the Medicare statute, nor in the actual operation of the Medicare Advantage option, but in other court decisions. Because this avatar of the Medicare Advantage program exists only in judicial opinions, no Medicare beneficiaries are enrolled in it – except those who have the misfortune of finding themselves in court.

Medicare’s managed care option – as authorized by Medicare Part C – has been around since 1997. Congress initially called this option “Medicare+ Choice,” but renamed it Medicare Advantage in 2003.² Litigants in a case involving Medicare Advantage may therefore be tempted to offer the court only an abbreviated explanation of the Medicare Advantage option. That temptation may be reinforced by trial court rules that impose page limits on briefs so short as to make addressing any but the simplest issues a challenge.

But many courts have fundamental misconceptions about the Medicare program – and about Medicare Advantage in particular. Therefore, litigation counsel must assume responsibility for educating the court about the basics of the Medicare program and its Medicare Advantage option. This is especially true for counsel for the Medicare Advantage plan, as the existing case law perpetuates several serious misconceptions that usually operate to the disadvantage of the plan.

Medicare Advantage – A Brief Overview

Medicare Advantage is one of Medicare’s two options for hospital and medical benefits.¹ The initial provision in Part C, 42 U.S.C. § 1395w-21(a), makes this clear. It provides that Medicare beneficiaries may obtain

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SLICING THE PIE: PROTECTING HEALTH PLAN SUBROGATION RIGHTS POST McCUTCHEN

John E. B. Gerth, Esq.
Stanley E. Graham, Esq.
Waller Lansden Dortch & Davis, LLP
Nashville, TN

Introduction

When an individual who requires healthcare due to the acts of another secures a settlement or judgment from the responsible party, the amount of the settlement or judgment becomes a “pie.” That pie has to be divided among the individual, his or her counsel, and the entity that paid for the necessary healthcare in the interim. Often the pie is not large enough for everyone to get the slice he or she seeks, and the rules about how the pie should be divided become very important. For many years, health plans have attempted to set out the rules for slicing the pie up front, incorporating subrogation and reimbursement provisions into plan documents. Not surprisingly, health plan participants and the personal injury attorneys representing them have worked to increase the size of their respective slices post settlement/judgment by challenging the enforceability of the relevant terms of the applicable health plan or applying affirmative defenses to reduce the size of health plan liens.

In April 2013, in U.S. Airways v. McCutchen,1 the U.S. Supreme Court reinforced the central importance of plan language to the relationship between parties claiming rights under a health plan governed by the Employee Retirement Income Security Act of 1974 (“ERISA”),2 ruling that when a self-funded ERISA health plan seeks to enforce a subrogation or reimbursement provision, the terms of the plan govern without regard to traditional equitable principles or doctrines, as long as the plan terms are clear, even though the section of ERISA permitting the health plan to enforce its reimbursement rights provides for “appropriate equitable relief.” McCutchen resolved a split in the circuits about whether equitable doctrines, such as the “make whole” and “common-fund” doctrines, might require a reduction of a health plan’s reimbursement rights even where the plan specifically disclaimed the application of such doctrines.3

The immediate take-away from McCutchen for health plan administrators has been repeated frequently in the year since the ruling: make sure that the plan’s subrogation and reimbursement rights are addressed explicitly in the plan document. The practical take-aways from McCutchen, however, are farther reaching. Personal injury lawyers universally view McCutchen as a blow to their efforts at maintaining the greatest portion of settlement proceeds for their clients (and perhaps more cynically, to cover their fees), and since McCutchen, savvy lawyers have looked creatively for other ways of strengthening their hand during negotiations over subrogation liens. In this climate, health plan administrators are wise to be prepared.

The Law on Health Plan Reimbursement Rights Pre-McCutchen

In several key cases since 1993, the U.S. Supreme Court has addressed both the scope and contours of “appropriate equitable relief” under ERISA, particularly as applicable to health plans seeking to enforce plan subrogation or reimbursement rights. In 1993 in Mertens v. Hewitt Associates, the Court held that ERISA § 502(a)(3)4 permits “those categories of relief that were typically available in equity,” distinguishing this from relief typically available at law.5 This was, and continues to be, an important distinction under ERISA, since a common form of relief sought – monetary damages – has traditionally been considered legal and not equitable, and thus not available under ERISA § 502(a)(3).6

In 2002 in Great-West Life & Annuity Insurance Company, et al. v. Knudson,7 a divided Court held that Great-West, an insurer under an ERISA-governed health plan, could not pursue a reimbursement claim against an individual participant who had received a sizeable personal injury settlement because the relief sought – money damages equal to the amount of the plan’s subrogation lien – was legal and not equitable. The Court further rejected Great-West’s argument that it was in fact seeking equitable restitution because the settlement funds were no longer identifiable (they had been paid into a special needs trust for the severely-injured beneficiary) and were thus not subject to an equitable lien.8 For health plans, Knudson is a case about remedies, reminding health plans that the relief sought under a subrogation or reimbursement provision must be equitable in nature, not legal, to be enforceable under ERISA. The more a claim looks like money damages, the less likely it will be enforced by court order.

Four years later, the U.S. Supreme Court confirmed that ERISA permits self-funded health plans to seek subrogation or reimbursement under ERISA § 502(a)(3) where the relief sought is enforcement of an equitable lien against settlement proceeds. In Sereboff v. Mid Atlantic Medical Services, Inc.,9 the Court held unanimously that the health plan could pursue reimbursement from a third party settlement where the settlement funds were identifiable and the plan created an “equitable lien [on those settlement funds] by agreement.”10 The Court mentioned in dicta Sereboff’s argument that the subrogation lien should
be reduced to account for equitable doctrines, such as the “make whole” doctrine.\textsuperscript{11} The Court opined that equitable doctrines are “beside the point” when an equitable lien is established by agreement, but otherwise dodged the issue, stating that it had not been raised in the district court or court of appeals, and thus would not be addressed by the Supreme Court.\textsuperscript{12} This dicta, however, did not prevent a circuit split on the applicability of equitable doctrines to health plan reimbursement claims.

**McCUTCHEN AND THE IMPORTANCE OF PLAN LANGUAGE**

In 2013, the U.S. Supreme Court picked up where its dicta left off in Sereboff, holding that neither the make whole nor common-fund doctrines “can override the clear terms of a plan.”\textsuperscript{13} James McCutchen participated in a self-funded health plan established by his employer, U.S. Airways, pursuant to ERISA. McCutchen was seriously injured in a car accident in 2007. The health plan paid a total of $66,866 in medical expenses on McCutchen’s behalf. McCutchen retained counsel, agreeing to a 40 percent contingency fee, to seek recovery of damages, estimated in excess of $1 million.\textsuperscript{14} McCutchen received $100,000 from his own automobile insurer, the policy maximum, and he settled against the responsible driver for $10,000 because of limited insurance coverage and others seeking recovery from the same insurance policy (the accident in which McCutchen was injured resulted in serious injury or death to three other people). Out of the total $110,000 recovered, after the 40 percent contingency fee, McCutchen received $66,000.\textsuperscript{15} When U.S. Airways learned of McCutchen’s recovery, it demanded reimbursement in the amount of $66,866. When McCutchen refused, U.S. Airways sued him under ERISA § 502(a)(3) seeking full reimbursement without any reduction under the make whole or common-fund doctrines.\textsuperscript{16}

Picking up on its prior analysis in Sereboff, the U.S. Supreme Court identified U.S. Airways’ right to reimbursement as an “equitable lien by agreement,” arising out of the terms of the health plan.\textsuperscript{17} As such, it “both arises from and serves to carry out a contract’s provisions.” In the case of an “equitable lien by agreement,” “[t]he agreement itself becomes the measure of the parties’ equities; so if a contract abrogates the common-fund doctrine, the insurer is not unjustly enriched by claiming the benefit of its bargain.”\textsuperscript{18} In short, “if the agreement governs, the agreement governs.”\textsuperscript{19} Where the plan document is silent or ambiguous, however, the Court held that equitable doctrines are appropriate interpretive tools to establish the parties’ intent. Applying this analysis to U.S. Airways’ reimbursement claim, the Court held that the make whole doctrine was inapplicable because it was expressly disclaimed in the plan,\textsuperscript{20} but concluded that the common-fund doctrine applied because the plan was silent as to a reduction for attorneys’ fees.

**PLACES WHERE MCCUTCHEN DOES NOT TREAD – HEALTH PLAN REIMBURSEMENT RIGHTS OUTSIDE OF ERISA OR SUBJECT TO STATE INSURANCE LAW**

McCutchen is important because it clarifies the subrogation and reimbursement rights of self-funded health plans governed by ERISA. It is also important, however, to keep in mind that McCutchen does not necessarily impact the reimbursement rights of all health plans. Some health plans are not governed by ERISA at all, and fully-insured ERISA health plans are still subject to state insurance laws, including state anti-subrogation statutes.

In addition to individual policies for health insurance, governmental health plans are not governed by ERISA, and church plans are often not covered by ERISA.\textsuperscript{21} Without ERISA’s preemptive effect, state laws, including both statutory insurance laws and common law doctrines of unjust enrichment, such as the make whole and common-fund doctrines, are not affected by McCutchen. Additionally, insured health plans that are otherwise governed by ERISA are still subject to state insurance laws that are specifically directed toward insurance companies and “substantially affect the risk pooling arrangement between insurer and insured,” an express limitation on ERISA preemption under ERISA’s savings clause.\textsuperscript{22}

Multiple states have attempted to limit the extent to which health plans, and perhaps more directly, insurance companies can enforce plan subrogation or reimbursement provisions to recoup benefit payments from subsequent tort recoveries by plan beneficiaries.\textsuperscript{23} A recent example is New York General Obligation Law § 5-335, which provided that a benefit provider had to have a statutory right, not just a contractual or plan-based right, to assert and enforce a subrogation lien. In March 2013, however, a federal court in New York held that the statute was preempted by ERISA even as to fully-insured health plans because it was neither specifically directed toward insurance companies nor did it “substantially affect the risk pooling arrangement between the insurer and the insured.”\textsuperscript{24} The New York legislature responded quickly to revise the statute to track ERISA’s savings clause. The upshot is that state legislatures in New York and elsewhere are interested in protecting individuals from subrogation or reimbursement claims to the extent possible within the confines of ERISA and federal preemption.

Are these exclusions from ERISA preemption important? Yes, and perhaps counter-intuitively, even for self-insured ERISA health plans. Why? Because McCutchen has taken away many of the arrows in the quiver of personal injury attorneys to challenge the amount of health plan reimbursement claims. The result of this is that, post-McCutchen, personal injury attorneys are taking a harder

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look at whether plans fall within ERISA’s ambit on the front end, looking for any toehold to assert common law equitable defenses to reduce an otherwise explicit plan right to full reimbursement. As discussed below, savvy plaintiff’s attorneys’ are exploiting every pressure point possible to avoid McCutchen’s effect.

Proactive Steps for Health Plan Administrators

Following McCutchen, what should prudent health plan administrators be doing to effectively protect plan assets in light of both the current state of the law and renewed efforts by personal injury attorneys to maximize their recoveries?

Confirm that subrogation and reimbursement rights are explicitly stated in the plan

The obvious take-away from McCutchen bears reinforcing. Under ERISA and as confirmed by McCutchen, the terms of the plan control the rights of the parties, generally without respect to state or federal equitable doctrines. Plan documents should be reviewed carefully to confirm that subrogation and reimbursement rights are laid out clearly and explicitly. Attention should be paid to where in the plan documents subrogation and reimbursement provisions arise, remembering the U.S. Supreme Court’s guidance in Cigna v. Amara that, in the event of inconsistency or conflict between the underlying plan document and the summary plan description, the plan document controls.25

Be prepared for plan document requests

Plan participants have a right to certain plan documents upon written request, and thorough personal injury lawyers are increasingly requesting plan documents to confirm what the plan says about subrogation and reimbursement, and whether the plan is indeed covered by ERISA. Those same lawyers also know that a request for plan documents raises the specter of statutory penalties, up to $110 per day,26 if the plan administrator does not strictly comply with ERISA’s requirements, and use document requests as leverage in negotiating a subrogation lien.

Plan administrators should already have a reliable system for receiving plan document requests, calendaring the 30-day deadline to respond,27 evaluating the scope of the request, and drafting a response that demonstrates good faith compliance with ERISA’s requirements.

Consider whether to leave “negotiating room” in plan documents

Many health plans as a matter of practice effectively follow the common-fund doctrine by making a reduction to reimbursement claims to account for a pro rata portion of attorneys’ fees, even in circumstances where the plan expressly disclaims any such requirement. The reasons for doing so run the gamut, from a sense that it is fair for the health plan to share in the cost of the recovery to the economic reality that negotiating for full reimbursement for every claim increases administrative expenses for plan administrators. Consider whether incorporating common-fund language into a subrogation and reimbursement provision makes it simpler for the plan administrator to process reimbursement claims, or whether keeping more plan-friendly language gives the administrator “negotiating room” during negotiations over a subrogation lien. For example, a health plan administrator might consider agreeing to a reduction in reimbursement to account for a portion of attorneys’ fees in exchange for agreed limitations on plan documents requested by plaintiff’s counsel.

Consider thresholds below which reimbursement claims may not be worth pursuing

Finally, consider whether the administrative costs associated with pursuing subrogation or reimbursement are justified by the amount of the claim at issue. For example, a threshold below which the plan administrator will not pursue reimbursement would prevent scenarios where more is spent seeking reimbursement than what is ultimately recovered. Doing so would also help avoid a scenario where pursuit of a $50 reimbursement claim leads to an expansive request for plan documents requiring hours of administrative time to process. A potential exception, and a right worth protecting, would be mass torts giving rise to relatively small claims that might nevertheless add up when aggregated. For instance, if a negligent third party caused a fire that resulted in smoke inhalation by a large number of employees, a class action against the responsible party is reasonably foreseeable. Were that to occur, the total amount paid for the aggregate health claims could very well be large enough to pursue. When developing guidelines, health plan administrators should consider both foreseeable circumstances as well as the actual past claims experience of the health plan. A great time to review this would be during a periodic audit of health claim reimbursements.

Conclusion

With the substantial publicity surrounding the enactment of the Patient Protection and Affordable Care Act, the costs of healthcare and how those costs are spread are at the front of the minds of healthcare consumers, providers, insurance companies, and health plans alike. When a third party is responsible for the incurred costs, all parties understandably want their fair share of the pie. McCutchen clarifies
the rules for dividing the pie, at least for ERISA-governed health plans, and the most important lesson from McCutchen remains the importance of incorporating clear reimbursement and subrogation provisions into plan documents. In addition, and recognizing that efforts by all interested parties to maximize their respective shares of the pie will no doubt continue, health plan administrators should remain vigilant against encroachments on reimbursement and subrogation rights.

John “Jeb” E.B. Gerth is a partner with Waller Lansden Dortch & Davis, LLP. Clients from a wide range of industries collaborate with him to address ongoing employment issues, develop litigation strategies, defend at trial or in arbitration proceedings, or achieve an early resolution to labor and employment and employee benefit matters. Clients also seek Mr. Gerth’s services to help implement effective employment policies and reduce the legal exposure of day-to-day employment decisions. He has authored articles on employment law issues, and has been published in American Health Lawyers Association Labor & Employment Magazine and Journal of Health & Life Sciences Law. Mr. Gerth may be reached at jeb.gerth@wallerlaw.com.

Stanley “Stan” E. Graham is a partner with Waller Lansden Dortch & Davis, LLP. Major employers in the retail, hospitality, automotive, information services, and manufacturing industries turn to him for answers when dealing with complex employment issues. An accomplished trial lawyer, Mr. Graham provides immediate access, risk mitigation advice, and strategic planning that serve clients’ specific goals in litigation and daily advice and counsel.

His practice includes extensive experience with the defense of litigation and arbitrations. He also has broad experience in non-compete disputes, medical peer review actions, drug testing and medical inquiries, and business disputes.

A former assistant attorney general, for several years Mr. Graham has served on the Steering Committee and was elected to serve as Program Chair for the 2015 Annual Seminar for the Labor and Employment Section of DRI, an international organization of attorneys defending the interests of business in civil litigation. He also formerly served as Chair of the Tennessee Bar Labor and Employment Law Section. Mr. Graham may be reached at stan.graham@wallerlaw.com.

Endnotes
2. 29 U.S.C. § 1001, et seq. See, e.g., Wal-Mart Stores, Inc. v. Assoc’s Health & Welfare Plan v. Wells, 213 F.3d 398, 402 (7th Cir. 2000) (plan language controls without regard to equitable doctrines); U.S. Airways, Inc. v. McCutchen, 663 F.3d 671 (3d Cir. 2011) (reimbursement claims are subject to equitable defenses regardless of plan terms to the contrary); CGI Tech. & Solutions v. Rose, 683 F.3d 1113 (9th Cir. 2013) (same). Under the “make whole” doctrine, a health plan’s right to reimbursement is limited to the amount of the of the participant’s potential double recovery, meaning the participant should be “made whole” before any right to reimbursement arises. Under the “commonfund” doctrine, the health plan is required to pay a proportional share of the attorneys’ fees incurred in securing the settlement or judgment against the third party. See McCutchen, 133 S. Ct. at 1545–46.

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