No. _____

IN THE

Supreme Court of the United States

ACE AMERICAN INSURANCE COMPANY,
AUTO-OWNERS INSURANCE COMPANY,
TRAVELERS CASUALTY AND SURETY COMPANY, *et al.*,

Petitioners,

—v.—

MSP RECOVERY CLAIMS, SERIES LLC,

Respondent.

ON PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT

PETITION FOR WRIT OF CERTIORARI

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QUESTION PRESENTED

When Medicare has made a conditional payment for healthcare services on behalf of a Medicare beneficiary, 42 U.S.C. § 1395y(b)(3)(A) provides a cause of action to recover double damages from certain primary payers who have failed to reimburse Medicare. Respondent is not Medicare, did not make any conditional payment for healthcare services on behalf of a Medicare beneficiary, and does not seek to recover money for reimbursement to Medicare. Nonetheless, the Eleventh Circuit held that Respondent has standing to bring suit under § 1395y(b)(3)(A), reasoning in part on policy grounds that Respondent is "'in a better position,' when incentivized with double damages, 'to recover on behalf of Medicare than the government itself.'" App. 16a (citation omitted). In reaching its conclusion, the Eleventh Circuit neither cited nor applied this Court's precedents for determining when an entity such as Respondent has statutory standing and that establish the standing issue as a matter of statutory interpretation. *See, e.g.*, *Fed. Election Comm'n v. Nat'l Conservative Political Action Comm.*, 470 U.S. 480 (1985); *Lexmark Int'l, Inc. v. Static Control Components, Inc.*, 572 U.S. 118 (2014). The issue is recurring and important. The question presented is:

Should the Court grant certiorari to review and summarily reverse the decision of the Eleventh Circuit holding that Respondent has statutory standing to pursue a cause of action under § 1395y(b)(3)(A), where the court below neither cited nor applied this Court's precedents for determining statutory standing in *Federal Election Commission* and *Lexmark*, and instead based its determination on policy considerations and general concepts of liability allocation?

PARTIES TO THE PROCEEDING

Petitioners are ACE American Insurance Co., Auto-Owners Insurance Co., Owners Insurance Co., Southern-Owners Insurance Co., and Travelers Casualty and Surety Co.

Respondent is MSP Recovery Claims, Series LLC.

CORPORATE DISCLOSURE STATEMENT

Petitioner ACE American Insurance Co. is a wholly owned subsidiary of INA Holdings Corp., which is a wholly owned subsidiary of INA Financial Corp., which is a wholly owned subsidiary of INA Corp., which is a wholly owned subsidiary of Chubb INA Holdings Inc., which is owned 80% by Chubb Group Holdings Inc. and 20% by Chubb Limited. Chubb Group Holdings Inc. is a wholly owned subsidiary of Chubb Limited, a publicly traded corporation. No publicly held company owns 10% or more of Chubb Limited's stock.

Petitioner Auto-Owners Insurance Co. has no parent corporation; it is a mutual insurance company without any stock or shareholders, and no publicly held company owns 10% or more of it. Petitioner Southern-Owners Insurance Co. and Petitioner Owners Insurance Co. are wholly owned subsidiaries of Petitioner Auto-Owners Insurance Co.

Petitioner Travelers Casualty and Surety Co. is a wholly owned subsidiary of Travelers Insurance Group Holdings, Inc., which is a wholly owned subsidiary of Travelers Property Casualty Corp., which is a wholly owned subsidiary of The Travelers Companies, Inc., a publicly traded corporation. No

publicly held company owns 10% or more of The Travelers Companies, Inc.'s stock.

RELATED PROCEEDINGS

United States District Court (S.D. Fla.)

- *MSP Recovery Claims, Series LLC v. ACE Am. Ins. Co.*, No. 1:17-cv-23749 (judgment entered Mar. 9, 2018; reconsideration denied May 18, 2018)
- *MSP Recovery Claims, Series LLC v. Auto-Owners Ins. Co.*, No. 1:17-cv-23841 (judgment entered Apr. 25, 2018)
- *MSP Recovery Claims, Series LLC v. Auto-Owners Ins. Co.*, No. 1:17-cv-24069 (judgment entered Apr. 25, 2018)
- *MSP Recovery Claims, Series LLC v. Owners Ins. Co.*, No. 1:17-cv-24066 (judgment entered Apr. 25, 2018)
- *MSP Recovery Claims, Series LLC v. Southern-Owners Ins. Co.*, No. 1:17-cv-24068 (judgment entered Apr. 25, 2018)
- *MSP Recovery Claims, Series LLC v. Travelers Cas. & Sur. Co.*, No. 1:17-cv-23628 (judgment entered June 21, 2018)

United States Court of Appeals (11th Cir.):

- *MSP Recovery Claims, Series LLC v. ACE Am. Ins. Co.*, 18-12139 (judgment entered Sept. 4, 2020; rehearing denied Nov. 9, 2020)
- *MSP Recovery Claims, Series LLC v. Auto-Owners Ins. Co. et al.*, 18-12149 (judgment entered Sept. 4, 2020; rehearing denied Nov. 9, 2020)

MSP Recovery Claims, Series LLC v. Travelers Cas. & Sur. Co., 18-13049 (judgment entered Sept. 4, 2020; rehearing denied Nov. 9, 2020)

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The Eleventh Circuit's opinion (App. 1a) is reported at 974 F.3d 1305, and its order denying rehearing (App. 89a) is unreported. The district court's decision granting the motion to dismiss filed by Petitioner ACE American Insurance Co. (App. 33a) and its decision denying Respondent's motion for reconsideration (App. 71a) are unpublished but available at 2018 WL 1547600 and 2018 WL 2316647, respectively. The district court's decision granting the motion to dismiss filed by Petitioners Auto-Owners Insurance Co., Owners Insurance Co., and Southern-Owners Insurance Co. (App. 53a) is unpublished but available at 2018 WL 1953861. The district court's decision granting the motion to dismiss filed by Petitioner Travelers Casualty and Surety Co. (App. 76a) is unpublished but available at 2018 WL 3599360.

JURISDICTION

This Court has jurisdiction under 28 U.S.C. § 1254(1). The Eleventh Circuit entered judgment on September 4, 2020. Petitioners timely filed motions for rehearing on September 25, 2020. The petitions for rehearing were denied on November 9, 2020. App. 89a. This petition is timely because on March 19, 2020, this Court extended the deadline to file any petition for a writ of certiorari due to the ongoing public health concerns relating to COVID-19.

RELEVANT STATUTORY PROVISIONS

Title 42, Section 1395y(b)(3)(A), *see* App. 121a, provides:

> 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).

Title 42, Section 1395y(b)(2)(A), *see* App. 109a-10a, provides:

> 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.

Title 42, Section 1395y(b)(2)(B), *see* App. 110a-11a, provides in relevant part at subsection (i):

> 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.

PRELIMINARY STATEMENT

Where the Secretary of Health and Human Services (the "Secretary") makes a conditional "secondary" payment for healthcare services provided to a Medicare beneficiary, 42 U.S.C. § 1395y(b)(3)(A) provides a cause of action to recover that secondary payment from the party "primarily" responsible for the payment, plus double damages in appropriate cases. Respondent is neither the Secretary, nor a Medicare beneficiary, nor a person who directly provided healthcare services to a Medicare beneficiary, nor someone who made a secondary payment, nor someone to whom reimbursement of a secondary payment is due. Likewise, Respondent has not been assigned the interests of any such person. Rather, Respondent is a hedge-fund-backed litigation vehicle created to leverage the double-damages provision of § 1395y(b)(3)(A) to recover money for itself, not Medicare.

There is *no* legitimate basis to conclude that Respondent has standing to assert the private right of action under the governing statutory scheme. Yet the Eleventh Circuit in this case concluded that Respondent does have standing because Congress

intended to confer standing to sue under § 1395y(b)(3)(A) when "the plaintiff has a connection to Medicare's unreimbursed conditional payment." App. 16a. Superimposing its own policy analysis, the court below reasoned that recognizing standing for such litigants places them "'in a better position,' when incentivized with double damages, 'to recover on behalf of Medicare than the government itself.'" *Id.* The only limitation the court below recognized is that the relevant suit must not be purely a *qui tam* action. App. 18a. Critically, in formulating this broad "connection-based" test that no party below advocated, the Eleventh Circuit did not cite or apply this Court's guiding precedents for determining statutory standing set forth in such cases as *Federal Election Commission*, 470 U.S. at 483 (language specifically identifying who may sue governs statutory standing), or *Lexmark*, 572 U.S. at 129 (where language identifies a broad category of persons who may sue, standing is nonetheless limited by the "zone of interest" and "proximate causality" standards, which federal courts must expressly apply).

The Eleventh Circuit's disregard of this Court's clear precedents and guidance on statutory standing has added fuel to a federal litigation explosion. This dramatic expansion of standing extends well beyond what the actual statutory text authorizes or what the available evidence of congressional intent plausibly supports. *See Humana Med. Plan, Inc. v. W. Heritage Ins. Co.*, 832 F.3d 1229, 1241 (11th Cir. 2016) (*W. Heritage I*) (Pryor, J., dissenting) (demonstrating why only private parties seeking reimbursement of the Secretary's payments have statutory standing). In addition to the three cases consolidated below,

Respondent has filed more than 50 other cases in federal court seeking to turn what has historically been a question of the coordination of benefits under Medicare's administrative processes and state-law liability insurance allocation schemes into a federal cause of action for double damages that will, if allowed, effectively turn state insurance law on its head. *Humana Med. Plan, Inc. v. W. Heritage Ins. Co.*, 880 F.3d 1284, 1296 (11th Cir. 2018) (*W. Heritage II*) (Tjoflat, J., dissenting) (describing decision giving Medicare Advantage Organizations statutory standing as "a rewriting of state insurance laws").

The issue is both recurring and vitally important. As discussed *infra*, the decision below threatens to clog the courts with unnecessary and wasteful litigation. That will reduce Medicare efficiency and increase insurance premiums. Further, the decision below jeopardizes the successful and efficient claims-resolution system that has long existed between Medicare and private insurers. If an alternative to that system is desired, that is for Congress to legislate, not the courts to promote through a novel standing analysis. Because the court below disregarded this Court's established precedents for determining statutory standing, and likewise accepted as the basis for its standing determination reasoning this Court has rejected, certiorari and summary reversal are appropriate.

BACKGROUND

I. MEDICARE AND THE INCLUSION OF § 1395Y(B)(3)(A) AS PART OF THE MEDICARE SECONDARY PAYER ACT

Most of the traditional aspects of Medicare are governed by Parts A and B of the Medicare Act. As directed by these provisions, the Department of Health and Human Services ("HHS"), administered by the Secretary, pays providers for covered medical services they offer to eligible Medicare beneficiaries. In turn, Part C of the Medicare Act governs the Medicare Advantage Program. The Medicare Advantage Program permits Medicare enrollees to participate in insurance coverage with a Medicare Advantage Organization ("MAO"). MAOs contract with the Secretary to provide benefits that equal or exceed what Medicare is required to provide. Part E of the Medicare Act contains definitions and exclusions. This matter involves the interpretation of a provision of the Medicare Act—§ 1395y(b)(3)(A), which was added as a part of the Medicare Secondary Payer Act ("MSP Act").

A. Medicare as a Secondary Payer

Enacted in 1980, the MSP Act addressed the allocation of liability between Medicare and non-Medicare insurers when both are at least partially liable for an individual's medical costs. Prior to 1980, Medicare paid in full the portion of medical services for which it was responsible, leaving private insurers, if any, "to pick up whatever expenses remained." *W. Heritage I*, 832 F.3d at 1234 (quoting *Bio–Med. Applications of Tenn., Inc. v. Cent. States Se. & Sw.*

Areas Health & Welfare Fund, 656 F.3d 277, 278 (6th Cir. 2011)). As a result, when both Medicare and a private insurer were liable for the same expense, Medicare satisfied the private insurer's obligation to the extent permitted under the Medicare Act, and the private insurer paid only any remaining covered amount.

In response to rising healthcare costs, Congress enacted the MSP Act to "invert[]" the arrangement described above by making "private insurers covering the same treatment the 'primary' payers and Medicare the 'secondary' payer." *Id.* (quoting *Bio–Med.*, 656 F.3d at 278). As a result, Medicare benefits are now "an entitlement of last resort" available only if and to the extent an insurer is not liable to cover them. *Id.*

Three Paragraphs of the MSP Act are directly implicated here. Paragraph (2)(A) prohibits Medicare from paying for items or services for which a primary plan has already paid or can reasonably be expected to pay. 42 U.S.C. § 1395y(b)(2)(A). The statutory exception to this rule is codified in paragraph (2)(B), entitled "Conditional Payment." *Id.* § 1395y(b)(2)(B). Under this exception, the Secretary may make a "conditional payment" covering an expense for which a primary plan may be liable to pay, but "[a]ny such payment by the Secretary shall be conditioned on reimbursement" by the primary payer (if in fact there is one) "to the appropriate Trust Fund." *Id.* §

1395y(b)(2)(B)(i).[1] Paragraph (3)(A), which was added in 1986 and is the particular subject of this case, provides: "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)." *Id.* § 1395y(b)(3)(A); Pub. L. No. 99–509, § 9319, 100 Stat. 1874. By its terms, § 1395y(b)(3)(A) facilitates the Secretary's ability to recover secondary payments, together with double damages in appropriate cases.

B. The Medicare Advantage Program

Part C of the Medicare Act, which is known as the Medicare Advantage Program, was added in 1997 to "harness the power of private sector competition to stimulate experimentation and innovation that would ultimately create a more efficient and less expensive Medicare system." *W. Heritage I*, 832 F.3d at 1235 (citing H.R. Rep. No. 105-217, at 585 (1997), 1997 U.S.C.C.A.N. 176, 205-06 (Conf. Rep.)). Under this program, a private insurance company operating as an MAO is authorized to provide Medicare benefits under contract with the Secretary. The MAO must offer at least the same benefits that enrollees would be entitled to receive under traditional Medicare, and

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[1] The term "Trust Fund" refers to the Federal Hospital Insurance Trust Fund of the Treasury of the United States. 42 U.S.C. § 1395i(a).

in exchange the Secretary pays the MAO a fixed fee per enrollee.

Part C includes a section entitled "Organization as secondary payer." This section expressly references the MSP Act and provides that an MAO

> may (in the case of the provision of items and services to an individual under a [Medicare Advantage] plan under circumstances in which payment under this subchapter is made secondary pursuant to section 1395y(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).

The effect of § 1395w-22(a)(4) is arguably to place MAOs in essentially the same position as the Secretary with respect to secondary payments. *W. Heritage I*, 832 F.3d at 1238. Like the Secretary, MAOs are permitted to make conditional payments to healthcare providers for expenses that a primary payer is obligated to pay (in whole or in part), subject to reimbursement from the primary payer.

Under the MSP Act, MAOs may also enter into contracts with other entities to perform various

functions (*e.g.*, administrative services). 42 C.F.R. § 422.2 (defining MAO contracting entities); *id.* § 422.504(i) (describing basic requirements for MAO subcontracts).

II. STATEMENT OF THE CASE

Respondent is neither the Secretary nor an MAO. Likewise, Respondent is neither a direct Medicare provider nor a Medicare beneficiary. Further, Respondent has not made any conditional payments, nor does Respondent seek to recover amounts for Medicare. Rather, as detailed below, Respondent is a litigation vehicle created to bring lawsuits against primary payers in order to attempt to access the double damages feature of § 1395y(b)(3)(A).

In the three cases resolved by the ruling below, the district court stated that statutory standing under § 1395y(b)(3)(A) belongs to (i) a Medicare beneficiary, (ii) an MAO, or (iii) a direct healthcare provider. App. 45a; App. 63a; App. 85a-86a. Regardless of whether this list captures precisely the universe of parties with standing to sue under the statute, or is simply a list of those that arguably have standing under a generous reading of the statute—an issue this Court need not decide—it is clear that Respondent is *none* of these entitles. Nor is Respondent the assignee of any of these entities. At best, Respondent asserts merely an exceedingly tenuous "connection" to the Medicare

system. Under this Court's precedents, Respondent clearly lacks statutory standing to bring suit.

A. Respondent Is a Special Purpose Litigation Vehicle

Respondent is a Delaware limited liability company created for the purpose of filing putative class actions against insurance companies under the MSP Act. Like dozens of other cases Respondent has brought against various insurers, Respondent's complaints alleged that it was assigned the litigation claims of entities that are not themselves MAOs, but have entered into various relationships with MAOs. The complaints sought the recovery of supposedly unreimbursed conditional payments or costs incurred by subcontractors, and demanded double damages under § 1395y(b)(3)(A). Critically, Respondent is *not* a debt-collector actively seeking to recover unreimbursed secondary payments for the benefit of Medicare, an MAO, a direct provider of Medicare benefits, or a Medicare beneficiary. Rather, Respondent is an entity created to isolate and recover for its *own* benefit a claim for double damages under § 1395y(b)(3)(A) that Respondent purchased from a subcontractor of an MAO. Because that subcontractor itself is neither the Secretary, an MAO, a direct Medicare provider, nor a Medicare beneficiary holding an unreimbursed right to payment, Respondent's purported right to sue is best described as an arbitrage derivative acquired from an entity that

itself lacks a plausible claim to standing under the governing statutory scheme.

B. Travelers Litigation

On August 10, 2017, Respondent commenced a putative class action in Florida state court, asserting a claim under § 1395y(b)(3)(A) and seeking double damages against Travelers Casualty and Surety Co. ("Travelers") for unspecified conditional payments on behalf of unidentified Medicare beneficiaries. On October 3, 2017, Travelers removed the action to the United States District Court for the Southern District of Florida based on federal question jurisdiction. On November 22, 2017, Respondent filed an Amended Complaint seeking reimbursement for unspecified conditional payments allegedly related to an unidentified entity, which Respondent later identified as Health First Administrative Plans, Inc. ("HFAP"). Respondent identified no purported examples of Travelers' failure to reimburse any payments.

On June 19, 2018, the district court dismissed Respondent's claims against Travelers with prejudice after determining that HFAP is a company that performs administrative functions for an MAO but is not an MAO itself. The district court explained that "[b]ecause HFAP—the entity that allegedly assigned its rights to Plaintiff—is not an MAO, and thus lacks standing to bring a private cause of action under the [MSP Act], Plaintiff also lacks standing to bring a

claim under § 1395y(b)(3)(A) based on the purported assignment of rights from HFAP." App. 86a.

C. ACE Litigation

On August 9, 2017, Respondent commenced a putative class action in Florida state court, alleging a claim under § 1395y(b)(3)(A) and seeking double damages against ACE American Insurance Co. ("ACE") for unspecified conditional payments made on behalf of unidentified Medicare beneficiaries. On October 13, 2017, ACE removed the action to the United States District Court for the Southern District of Florida based on federal question jurisdiction. Respondent amended its complaint three times.

Respondent's Third Amended Complaint asserted the claims of Management Service Organizations ("MSOs") as assignee. MSOs are not MAOs; they provide management and administrative services to MAOs. Respondent alleged that it pursued claims on behalf of MSOs that allegedly "managed" a Medicare Advantage plan, were "charged" for medical services, and (without further explanation) "became financially responsible" for certain services to Medicare Advantage enrollees.

On March 9, 2018, the district court dismissed Respondent's Third Amended Complaint with prejudice. Since neither Respondent nor MSOs are Medicare beneficiaries, MAOs, or direct healthcare providers, the district court dismissed for lack of

statutory standing to pursue claims under § 1395y(b)(3)(A). App. 51a.

D. Auto-Owners Litigation

In August 2017, Respondent commenced four nearly identical putative class actions in Florida state court against Auto-Owners Insurance Co., Owners Insurance Co., and Southern-Owners Insurance Co. (collectively, "Auto-Owners") under § 1395y(b)(3)(A) seeking double damages for unspecified conditional payments purportedly made on behalf of unidentified Medicare beneficiaries. On October 17 and November 3, 2017, Auto-Owners removed all four cases to the United States District Court for the Southern District of Florida based on federal question jurisdiction. On February 16, 2018, the district court consolidated all four cases and permitted Respondent to file a Consolidated Complaint.

In its Consolidated Complaint, Respondent purported to assert claims as assignee of HFAP (the same entity at issue in the Travelers case) and Verimed IPA, LLC ("Verimed"). As discussed above, HFAP is a company that performs administrative functions for an MAO but is not an MAO itself. Verimed is an Independent Physician Association ("IPA"). IPAs are physician-led groups made up of primary care and specialty physicians that enter into contracts with MAOs. Verimed allegedly paid two healthcare providers for one beneficiary's services, and reimbursed an MAO for payments that the MAO

made to other providers on behalf of a second beneficiary.

On April 25, 2018, the district court applied the same three-category test described above and dismissed Respondent's claims against Auto-Owners for lack of statutory standing. Just as in *Travelers*, the district court held that "HFAP is not an MAO." Similarly, though Respondent alleged that Verimed paid for certain benefits, Respondent "failed to allege that Verimed was the direct provider of" those services. App. 69a.

E. Consolidated Appeal to 11th Circuit

Respondent appealed the dismissals to the Eleventh Circuit. Respondent challenged the holding that it did not have statutory standing. The Eleventh Circuit requested an amicus submission from HHS on "its views regarding the appropriate interpretation of 42 U.S.C. § 1395y(b)(3)(A) and whether certain MSOs and IPAs may access the private right of action." HHS filed its submission on June 8, 2020.

The Eleventh Circuit reversed or modified the dismissals of the three complaints on the ground that any entity with a "connection to Medicare's unreimbursed conditional payment[s]" has statutory standing. App. 16a. Neither the government nor any party had sponsored such a broad approach to statutory standing.

The starting point for the Eleventh Circuit's analysis was its prior decision in *Western Heritage I*, 832 F.3d at 1229–31, which held (over the vigorous dissents of Judges Pryor and Tjoflat) that §

1395y(b)(3)(A) confers statutory standing to bring a private right of action on private health insurers that act as MAOs, *id.* at 1240–43 (W. Pryor, J., dissenting); *W. Heritage II*, 880 F.3d at 1290–1300 (Tjoflat, J., dissenting). In *Western Heritage I*, the Eleventh Circuit adopted the policy-based reasoning of the Third Circuit in *In re Avandia Marketing, Sales Practices & Products Liability Litigation*, wherein the Third Circuit found that MAOs are not excluded by the statute and that finding standing for an MAO would promote competition and achieve cost savings for Medicare. 685 F.3d 353, 363–65 (3d Cir. 2012); *W. Heritage I*, 832 F.3d at 1231 ("we agree with the Third Circuit [in *Avandia*] and affirm the order of the district court").

In this case, the Eleventh Circuit found that the same policy reasons for allowing MAOs to pursue a private cause of action also justified permitting other entities "connected to" an unreimbursed conditional payment to pursue a private cause of action. App. 19a (finding that statutory standing promotes competition and cost savings in the Medicare system). According to the Eleventh Circuit, the primary objective of the MSP Act is to reduce the healthcare costs borne by Medicare, which § 1395y(b)(3)(A) accomplishes by incentivizing the recovery of conditional payments from primary payers. App. 16a-17a. The court's textual analysis in this case was limited to the assertion that § 1395y(b)(3)(A) is a "'broadly worded provision' . . . [that] is easily read to cover downstream actors who have borne the cost of a conditional payment and thus have suffered damages." App. 16a, App. 19a (quoting *W. Heritage I*, 832 F.3d at 1238). The "only limitation" the Eleventh Circuit placed on §

1395y(b)(3)(A) is that it may not be treated as a *qui tam* provision permitting a plaintiff with no connection to Medicare to recover double damages from a primary payer. App. 18a.

Applying this form of reasoning, the Eleventh Circuit concluded that "the payment of medical expenses that should have been covered by a primary payer" is what the MSP Act was designed to remedy. App. 22a. Further, the court below observed, any entity "connected to" such a payment is "'in a better position,' when incentivized with double damages, 'to recover on behalf of Medicare than the government itself.'" App. 16a (citation omitted).

In conducting its analysis, the court below neither cited nor applied this Court's established precedents for determining when an entity has standing to pursue a statutory cause of action that Congress has created. *See, e.g.*, *Lexmark*, 572 U.S. at 129; *Fed. Election Comm'n*, 470 U.S. at 483. Likewise, the court below did not mention, let alone evaluate, the textual and contextual statutory references available for discerning the particular parties Congress intended to have standing to pursue the relief set forth in § 1395y(b)(3)(A). Nor did the court below consider these statutory references in light of the history of the relevant legislation. Similarly, the court below did not find any ambiguity in the statute necessitating the consideration of secondary interpretive sources, such as the statute's legislative history. Rather, the court below simply construed the statutory text in light of its own policy evaluation. In doing so, the Eleventh Circuit accepted as a basis for its standing determination arguments this Court has repeatedly

rejected, and thus strayed unacceptably from this Court's established precedents.

REASONS FOR GRANTING THE PETITION

I. THE DECISION BELOW CONFLICTS WITH THIS COURT'S PRECEDENTS.

Section 1395y(b)(3)(A) authorizes a cause of action to recover payments made by the Secretary when a primary plan has failed to make a primary payment as required under the governing statutory scheme. Respondent does not pursue claims on behalf of the Secretary. In holding that a plaintiff pursuing the interests of private parties—not the Secretary—may pursue a cause of action under § 1395y(b)(3)(A), the court below failed to cite or follow this Court's relevant precedents. The Court's relevant precedents consist of two lineages.

The first, exemplified by the Court's decision in *Federal Election Commission*, 470 U.S. at 483, and *Hartford Underwriters Insurance Co. v. Union Planters Bank, N.A.*, 530 U.S. 1, 6 (2000), establishes that, where a statute authorizes a particular named person or official to bring suit (*e.g.*, "the Federal Election Commission" or "the trustee"), those who are not included in the reference are presumptively excluded. The second, exemplified by the Court's decision in *Lexmark*, 572 U.S. at 128, establishes that, where a statute contains a more general and undifferentiated authorization to sue (*e.g.*, "any person"), a court must consider whether the plaintiff falls within the zone of interests Congress intended to protect and whether there is proximate cause. Under both lines of cases, this Court has made clear that the

relevant inquiry is one of statutory construction: "We do not ask whether in our judgment Congress should have authorized [the particular party to bring] suit, but whether Congress in fact did so." *Id.*; *Hartford Underwriters*, 530 U.S. at 6. Rather than cite or apply either form of analysis, the Court below reached its conclusion on policy grounds, reasoning in part that allowing those who are not secondary payers to sue makes sense because "such plaintiffs are presumed to be 'in a better position,' when incentivized with double damages, 'to recover on behalf of Medicare than the government itself.'" App. 16a (citation omitted).

Because this Court has repeatedly rejected the approach followed below in determining statutory standing, certiorari and summary reversal are warranted.

A. The Decision Below Conflicts with this Court's *Federal Election Commission* Line of Decisions.

In *Federal Election Commission*, the FEC challenged the Democratic Party's standing to bring suit under the Presidential Election Campaign Fund Act, which only authorized the FEC, "the national committee of any political party, and individuals eligible to vote for President" to bring causes of actions "as may be appropriate to implement or construe any provisions of the Fund Act." 470 U.S. at 484 (quoting 26 U.S.C. § 9011(b)(1)) (brackets omitted). In concluding that the Democratic Party lacked statutory standing to pursue a cause of action under the Fund Act, the Court reasoned that "[t]he plain language of the Fund Act"—which "[c]learly" omitted the Democratic Party from the list of entities with

standing under section 9011(b)(1)—"suggests quite emphatically that the Democrats do not have standing to bring a private action against another private party." *Id.* at 486. *See also id.* at 502, n.1 (White, J., dissenting) ("I agree with the majority that, under the plain terms of § 9011(b)(1), the Democratic Party has no cause of action.").

Similarly, in *Hartford Underwriters*, the Court construed section 506(c) of the Bankruptcy Code, which specifically authorized "the trustee" to recover certain administrative expenses from the value of property encumbered by a secured creditor's lien, but which was silent as to whether "others" could also "use § 506" to obtain such payments. 530 U.S. at 6 (citing 11 U.S.C. § 506(c)). In holding that "the trustee is the only party empowered to invoke the provision," the Court reasoned that "a situation in which a statute authorizes specific action and designates a particular party empowered to take it is surely among the least appropriate in which to presume nonexclusivity." *Id.* It was of no legal significance that the statute did not expressly state that "only" the trustee had statutory standing, because the idea that "the expression of one thing indicates the inclusion of others unless exclusion is made explicit . . . is contrary to common sense and common usage." *Id.* at 8.

Like the statutory provisions in the above cited cases, § 1395y(b)(3)(A) only confers standing on specific parties. It does so by creating a "private cause of action" only where payments are not made "in accordance with paragraphs (1) and (2)(A) [of the MSP Act]."

Paragraph (1), which is not at issue here, outlines various obligations and requirements of "group health plans," which are plans offered by employers to their employees and family members. *Id.* § 1395y(b)(1)(B) (adopting definition in 26 U.S.C. § 5000). Paragraph (2)(A) is entitled "Medicare secondary payer." It provides that, with the exception of payments made under paragraph (2)(B), Medicare shall not pay for items or services for which a primary plan has paid or can reasonably be expected to pay. *Id.* § 1395y(b)(2)(A). Under the exception created by paragraph (2)(B), the Secretary, who is responsible for administering Medicare, may make a "[c]onditional payment" under certain circumstances. *Id.* § 1395y(b)(2)(B). As noted above, this conditional payment is "conditioned on reimbursement to the appropriate Trust Fund in accordance with the succeeding provisions of this subsection." *Id.* § 1395y(b)(2)(B)(i)–(ii).

As this combination of provisions directs, § 1395y(b)(3)(A) creates a private cause of action when the "Secretary" makes a conditional payment and seeks reimbursement from the primary payer, but the primary payer fails to reimburse "the appropriate Trust Fund" as required by paragraph (2)(A) and (2)(B). Respondent, however, is not the Secretary, does not seek the reimbursement of payments made by the Secretary, and does not seek to protect the Trust Fund, as contemplated by the MSP Act. Rather, Respondent brings suit on account of payments made or "charges" incurred by others as a form of litigation arbitrage, asserting a "connection" to the Medicare system as its basis for doing so. Accordingly, as in the cases cited above, Respondent is excluded from

asserting a cause of action under the MSP Act because Respondent is not among the specifically identified parties permitted to assert the cause of action.

Respondent cannot avoid this result by borrowing the statutory status of MAOs—highly regulated private insurance providers that offer insurance plans to Medicare recipients. Seventeen years after § 1395y(b) took effect, Congress enacted the Medicare Advantage Program—the statutory scheme outlined above that authorizes an MAO to act "as [a] secondary payer" under "section 1395y(b)(2) of this title," including the right to make conditional payments and demand reimbursement from primary payers. *Id.* § 1395w-22(a); *see also W. Heritage I*, 832 F.3d at 1236–38. Among other things, the MAO legislation provides that an MAO "shall provide" its enrollees with the benefits to which they would be entitled under traditional Medicare, 42 U.S.C. § 1395w–22(a)(1)(A), and an MAO only satisfies its payment obligations where it "provides payment in an amount . . . equal to at least the total dollar amount of payment . . . as would otherwise be authorized under parts A and B," *id*. As a result of this statutory scheme, an MAO may make payments in the same amount and under the same circumstances as the Secretary under paragraph (2)(A) and (2)(B), and where a primary payer fails to reimburse the MAO for conditional payments, the MAO has been recognized as having a right to pursue a cause of action under § 1395y(b)(3)(A). *See W. Heritage I*, 832 F.3d at 1236–38.

It is undisputed, however, that Respondent is not an MAO and is not asserting the rights of any MAO in

these cases. There is no statutory framework identifying Respondent as a type of entity that may assert a cause of action under § 1395y(b)(3)(A). Respondent is thus presumptively excluded from doing so under the *Federal Election Commission* line of cases. And regardless of whether Respondent asserts a "connection" to an MAO, an MAO administrator, or some other entity that itself may claim standing under the statutory scheme, the mere assertion of a connection is inadequate. Respondent must demonstrate that it is among the parties Congress intended to have standing under § 1395y(b)(3)(A). The decision below failed to hold Respondent and its purported assignors to this standard and is thus in direct conflict with this Court's precedents.

B. The Decision Below Conflicts with this Court's *Lexmark* Line of Decisions.

In *Lexmark*, the Court examined a provision in the Lanham Act authorizing "any person" aggrieved by false advertising to assert a cause of action against the alleged wrongdoer. 572 U.S. at 122. The parties disputed whether the plaintiff could pursue a cause of action under that broadly worded provision, which the Court described as "a straightforward question of statutory interpretation." *Id.* at 129. Recognizing that Congress rarely confers statutory standing coextensive with Article III standing, the Court presumed as a matter of law "that a statutory cause of action extends only to plaintiffs whose interests 'fall within the zone of interests protected by the law invoked.'" *Id.* (quoting *Allen v. Wright*, 468 U.S. 737, 751 (1984)). *See also Bond v. United States*, 564 U.S.

211, 218–19 (2011) (distinguishing pleading a cause of action from Article III standing). Under the modern zone-of-interests test, a court "do[es] not ask whether in [its] judgment Congress *should* have authorized [plaintiff's] suit, but whether Congress in fact did so." *Lexmark*, 572 U.S. at 128 (emphasis in original). As such, "a court cannot apply its independent policy judgment to recognize a cause of action that Congress has denied." *Id.* (citing *Alexander v. Sandoval*, 532 U.S. 275, 286–87 (2001)).

The Court further presumes that Congress only confers statutory standing on "plaintiffs whose injuries are proximately caused by violations of the statute." *Id.* at 132. Based in common law, this presumption recognizes that "the judicial remedy cannot encompass every conceivable harm that can be traced to alleged wrongdoing." *Id.* (quoting *Associated Gen. Contractors v. Carpenters*, 459 U.S. 519, 536 (1983)). *See also Holmes v. Sec. Inv'r Prot. Corp.*, 503 U.S. 258, 266 (1992) (finding it "very unlikel[y] that Congress meant to allow all factually injured plaintiffs to recover" under RICO). Thus, notwithstanding broad statutory language conferring standing to sue on "any person" aggrieved by certain conduct, a court is required to consider "whether the harm alleged has a sufficiently close connection to the conduct the statute prohibits." *Lexmark*, 572 U.S. at 133.

As this Court's decisions illustrate, proximate cause is most commonly lacking where the plaintiff's harm "is purely derivative of 'misfortunes visited upon a third person by the defendant's acts.'" *Id.* (quoting *Holmes*, 503 U.S. at 268–69). For example,

in the *Illinois Brick* line of cases, the Court has repeatedly held that indirect purchasers lack standing to bring a private cause of action against manufacturers under section 4 of the Clayton Act, which broadly grants statutory standing to "any person who shall be injured in his business . . . by reason of anything forbidden in the antitrust laws." *Ill. Brick Co. v. Ill.*, 431 U.S. 720, 724 n.1 (1977) (quoting 15 U.S.C. § 15). *See also Kansas v. UtiliCorp United, Inc.*, 497 U.S. 199 (1990); *Apple Inc. v. Pepper*, 139 S. Ct. 1514 (2019). Instead, only direct purchasers have a cause of action because they "alone" have suffered an injury within the meaning of section 4. *UtiliCorp*, 497 U.S. at 204.

Under the *Lexmark* line of cases, the court below was required to determine whether Respondent fell within the relevant zone of interests the statute was designed to protect and whether Respondent demonstrated proximate cause. This analysis is entirely absent from the lower court's decision. Instead, the decision was based on policy considerations that are speculative, unsupported by the record, and best left to Congress. Worse, the court below adopted uncritically reasoning this Court has repeatedly rejected as a sufficient basis for finding statutory standing.

For example, citing "cost-reduction and efficiency goals," the court below interpreted § 1395y(b)(3)(A) "to allow recovery when the plaintiff has a *connection* to Medicare's unreimbursed conditional payment" on the theory that "such plaintiffs are presumed to be 'in a better position,' when incentivized with double damages, 'to recover on behalf of Medicare than the

government itself.'" App. 16a (emphasis added). It is difficult to imagine, however, a more expansive interpretation, underscored by the court's elaboration that the "only limitation" placed on "§ 1395y(b)(3)(A)'s breadth is that it cannot be treated as a *qui tam* provision." App. 18a. As the court explained, "[i]n other words, a plaintiff with *no connection* to Medicare or the Medicare Advantage system lacks statutory standing to seek double damages from a primary player." *Id.* (emphasis added). And as the facts of this case aptly illustrate, the kind of connection necessary to satisfy the court's test is slender indeed—one need only assert a connection with an administrative entity that itself has a connection to the Medicare system but need not be the Secretary, an MAO, a direct Medicare provider, or a Medicare beneficiary. At bottom, the court expanded what is necessary to satisfy the requirements of statutory standing under § 1395y(b)(3)(A) to essentially match (and arguably exceed) the outer limits of constitutional standing under Article III. But once again, that is exactly the approach this Court has repeatedly rejected. *See, e.g.*, *Lexmark*, 572 U.S. at 129 (observing that "the 'unlikelihood that Congress meant to allow all factually injured plaintiffs to recover persuades us that [the statute at issue] should not get such an expansive reading'") (quoting *Holmes*, 503 U.S. at 266); *see also Alexander*, 532 U.S. at 286–87 ("[A] cause of action does not exist" without "[s]tatutory intent" and courts cannot "create [a cause of action], no matter how desirable that might be as a policy matter, or how compatible with the statute."); *Nw. Airlines, Inc. v. Transp. Workers*, 451 U.S. 77, 94 (1981); *Transamerica Mortg. Advisors, Inc. v. Lewis*, 444 U.S. 11, 24 (1979) ("[T]he mere fact that the

statute was designed to protect advisers' clients does not require the implication of a private cause of action for damages on their behalf. The dispositive question remains whether Congress intended to create any such remedy. Having answered that question in the negative, our inquiry is at an end.") (internal citations omitted).

Likewise, the court below reasoned that, given the broad wording of § 1395y(b)(3)(A), the statute is "easily read" to include a variety of persons. App. 19a. As noted above, however, the same is true of the wording of many statutory causes of action, including the one at issue in *Lexmark*, authorizing suit for "any person who believes that he or she is likely to be damaged" by the defendant's false advertising. *Lexmark*, 572 U.S. at 129. As the Court explained, "[r]ead literally, that broad language might suggest that an action is available to anyone who can satisfy the minimum requirements of Article III." *Id*. But as the Court also insisted, that is not the test. Rather, when faced with such a broadly worded provision, courts properly apply two "background principles . . . : zone of interests and proximate causality." *Id*.; *see also Bond*, 564 U.S. at 218 (holding it was error to treat "standing" and the right to pursue a "cause of action" as "interchangeable" and noting the difference between "whether there is a legal injury at all and whether the particular litigant is one who may assert it"). Conspicuously absent from the decision below is any reference to these principles, let alone any evidence of their application. On the contrary, it is abundantly clear that they played no part in the Eleventh Circuit's analysis. The decision below thus stands unavoidably at odds with this Court's long-

standing guidance for determining standing to pursue a statutory cause of action.

* * *

The Eleventh Circuit overlooked this Court's *Federal Election Commission* and *Lexmark* lines of cases. It did not cite them, let alone attempt to apply them. This error is so clear that there is no need for full review by this Court. *Wearry v. Cain*, 136 S. Ct. 1002, 1007–08 (2016) (granting summary reversal when the lower court's denial of petitioner's *Brady* claims "egregiously misapplied settled law" and "chances that further briefing or argument would change the outcome [were] vanishingly slim"); *Mullenix v. Luna*, 577 U.S. 7, 12–13 (2015) (granting summary reversal when the Fourth Circuit's formulation of qualified immunity had previously been considered and rejected by the Supreme Court); *Langenkamp v. Culp*, 498 U.S. 42, 45 (1990) (summarily reversing when the "decision by the Court of Appeals overlooked the clear distinction which our cases have drawn" with respect to a creditor's right to a jury trial). Petitioners respectfully request that the Court grant certiorari, summarily reverse the decision below, and remand with the instruction that the Eleventh Circuit apply *Federal Election Commission* and *Lexmark*.

II. THE QUESTION PRESENTED IS OF EXCEPTIONAL IMPORTANCE.

The question presented is one of recurring and vital importance. It is also one likely to recur in a concentrated fashion within the Eleventh Circuit. With the decision below in place, Respondent intends

to seek nationwide class action certifications based on litigation commenced within the Eleventh Circuit and, having now secured a favorable and unprecedented decision in the Eleventh Circuit, Respondent has an incentive to avoid litigating the issue in other circuits. And as expected, Respondent and affiliated litigation vehicles have already filed dozens of similar lawsuits against insurance companies other than Petitioners, on the same theory of statutory standing. Although Petitioners believe that review of the question presented in this Court is likely to be inevitable, the court below has so far departed from this Court's jurisprudence on statutory standing that review at this time is warranted.

Statutory standing under § 1395y(b)(3)(A) is an exceptionally important question, in no small part because recognizing statutory standing in the manner permitted by the court below threatens to destabilize the Medicare reimbursement system. For decades, there has been very little MSP Act litigation because liability insurers (as primary payers) and Medicare have a well-established administrative process to resolve the coordination of benefits among them. *See* 42 U.S.C. § 1395ff; 42 C.F.R. § 405.920 *et seq.* (describing administrative and appeals process). Similarly, disputes among liability insurers and other private payers have been resolved for more than a century under well-settled state-law regimes. *W. Heritage II*, 880 F.3d at 1294–96 (Tjoflat, J., dissenting) ("At common law, once a tortfeasor's liability is established by a judgment for the insured that includes compensation for medical expenses paid by a medical insurer as a secondary payer, or once the tortfeasor agrees to a settlement that includes such

expenses, the medical insurer has the right to seek reimbursement of the sums it expended.").

To interpret § 1395y(b)(3)(A) as affording Respondent statutory standing, though, would upset these well-established procedures. As explained by Judge Tjoflat in *Western Heritage II*, extending a private right of action for double damages to Respondent would "amount[] to a rewriting of state insurance laws," *id.* at 1296; effectively add[] beneficiaries (*e.g.*, litigation vehicles like Respondent) to insurance policies, *id.*; "render releases of liability under state law a nullity," *id.* at 1297; and give plaintiffs a new claim for double recovery, *id.* These realities will combine to incentivize litigation vehicles to file litigation in federal court in unprecedented numbers. *Id.*

Respondent and its hedge-fund affiliates, for example, are trying to turn the MSP Act and its double damages provision into a litigation arbitrage vehicle at the expense of the Medicare system, not to promote or facilitate it. They purchase claims that are normally and efficiently handled through well-settled processes for allocating responsibility among payers and have filed a plethora of similar lawsuits under § 1395y(b)(3)(A) to try to take advantage of the double damages provision of the MSP Act. It would be one thing if an efficient claims-resolution system was not already in place and Respondent was in the business of collecting unreimbursed payments on behalf of Medicare for the benefit of Medicare. But that is not Respondent's practice. Respondent is in the business of preemptively purchasing the rights of others for the sake of recovering double damages—in this case the

purported rights of MAO-affiliates that do not have any standing to sue. To succeed in cases such as this one, Respondent seeks to leverage the kind of flawed standing analysis that this Court has long rejected.

If Respondent's aggressive and expensive litigation alternative to the present claims-resolution system is desirable, that authorization should come from Congress, not the courts. Absent such legislative direction, this Court should address the issue by requiring a statutory analysis under *Federal Election Commission* and *Lexmark*, which will preclude Respondent from clogging the Courts with hundreds of unnecessary lawsuits that will inevitably result in a less-efficient Medicare system and higher insurance premiums for consumers. *Id.* at 1299.

CONCLUSION

For the foregoing reasons, Petitioners respectfully request that the Court grant certiorari to review and summarily reverse the decision below.

Respectfully submitted,

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Dated: April 8, 2021

APPENDIX

Appendix A

UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

No. 18-12139, No. 18-12149,
No. 18-13049, No. 18-13312

September 4, 2020

MSP RECOVERY CLAIMS, SERIES LLC,

Plaintiff-Appellant,

—v.—

ACE AMERICAN INSURANCE COMPANY,

Defendant-Appellee.

MSP RECOVERY CLAIMS, SERIES LLC,
a Delaware entity,

Plaintiff-Appellant,

—v.—

AUTO-OWNERS INSURANCE COMPANY,
a foreign profit corporation,

Defendants-Appellees.

MSP Recovery Claims, Series LLC,
a Delaware entity,

Plaintiff-Appellant,

—v.—

Owners Insurance Company,
a foreign profit corporation,

Defendant-Appellee.

MSP Recovery Claims, Series LLC,
a Delaware entity,

Plaintiff-Appellant,

—v.—

Southern-Owners Insurance Company,
a foreign profit corporation,

Defendant-Appellee.

MSP Recovery Claims, Series LLC,
a Delaware entity,

Plaintiff-Appellant,

—v.—

Auto-Owners Insurance Company,
a foreign profit corporation,

Defendant-Appellee.

MSP Recovery Claims, Series LLC,
a Delaware entity,

Plaintiff-Appellant,

—v.—

Auto-Owners Insurance Company,
a foreign profit corporation,

Defendant-Appellee.

MSP RECOVERY CLAIMS, SERIES LLC,
a Delaware entity,

Plaintiff-Appellant,

—v.—

TRAVELERS CASUALTY AND SURETY COMPANY,
a foreign profit corporation,

Defendant-Appellee.

MSPA CLAIMS 1, LLC,
a Florida profit corporationy,

Plaintiff-Appellant,

—v.—

LIBERTY MUTUAL FIRE INSURANCE COMPANY,
a Foreign profit corporation,

Defendant-Appellee.

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Appeals from the United States District Court for the Southern District of Florida, D.C. Docket No. 1:17-cv-23749-PAS, D.C. Docket No. 1:17-cv-23841-PAS, D.C. Docket No. 1:17-cv-23628-KMW, D.C. Docket No. 1:17-cv-22539-KMW,

Before JORDAN, JILL PRYOR, and WALKER,* Circuit Judges.

Opinion

WALKER, Circuit Judge:

MSP Recovery Claims, Series LLC (MSPRC), and MSPA Claims 1, LLC (MSPA), collection agencies and Plaintiffs here, appeal from

* The Honorable John M. Walker, Jr., Circuit Judge for the United States Court of Appeals for the Second Circuit, sitting by designation.

dismissals with prejudice of their claims against ACE American Insurance Company, Auto-Owners Insurance Company, Southern-Owners Insurance Company, Owners Insurance Company, Travelers Casualty and Surety Company, and Liberty Mutual Fire Insurance Company (collectively, Defendants). Plaintiffs sought double damages against Defendants under the Medicare Secondary Payer Act. Plaintiffs alleged that actors within the Medicare Advantage system, including Medicare Advantage Organizations (MAOs) and various "downstream actors" that contracted with MAOs, had assigned their Medicare Secondary Payer Act claims to Plaintiffs for collection. The district court dismissed Plaintiffs' cases, now consolidated on appeal, after finding that (1) some of Plaintiffs' alleged assignments, including those from MAOs, were invalid and (2) Plaintiffs' downstream-actor assignors fell outside the ambit of the Medicare Secondary Payer Act's private right of action and thus could not confer statutory standing on Plaintiffs through an assignment. On appeal, Plaintiffs primarily argue that their downstream-actor assignors could access the private right of action and had rights to assign under the Medicare Secondary Payer Act. MSPRC individually argues that the district court erred in dismissing its claims based on an alleged assignment from an MAO with prejudice because dismissals based on defects in an assignment are not decisions on the merits and must be entered without prejudice. And MSPA argues that all of its assignments were valid. We agree with Plaintiffs on all issues.

Accordingly, we VACATE the dismissals of Plaintiffs' claims based on assignments from

downstream actors, REMAND those claims for further proceedings consistent with this opinion, and MODIFY the dismissals of MSPRC's claims based on its alleged assignment from an MAO to be without prejudice.

I

Plaintiffs are collection agencies that specialize in recovering funds on behalf of various actors in the Medicare Advantage system. By way of background, the Medicare Advantage system is a public-private health insurance system that runs parallel to Medicare. The Medicare Advantage system allows Medicare beneficiaries to opt into private health insurance plans offered by Medicare Advantage Organizations (MAOs) that provide coverage in excess of the coverage provided by Medicare. To operate more nimbly and to better compete with Medicare, some MAOs contract with smaller organizations, like independent physician associations, that have closer connections to local healthcare providers. These smaller organizations, or "downstream" actors, are also a part of the Medicare Advantage system and are central to the present case.

Plaintiffs' primary tool for recovering funds is the Medicare Secondary Payer Act. Generally speaking, the Act established that Medicare—and, as an extension of Medicare, the Medicare Advantage system—should not bear the costs of medical procedures that are already covered by a "primary payer," or other insurer such as a provider of workers' compensation insurance or automobile insurance. (Plaintiffs allege that

Defendants are all primary payers.) Under the Act, Medicare and MAOs still can, as a stopgap measure, make a "conditional payment" to cover their beneficiaries' medical bills when the primary payer "cannot reasonably be expected to make payment with respect to such item or service promptly." 42 U.S.C. §§ 1395y(b)(2)(B)(i), 1395w-22(a)(4). If Medicare or an MAO has made a conditional payment, and the primary payer's "responsibility for such payment" has been "demonstrated," as by a judgment or settlement agreement, the primary payer is obligated to reimburse Medicare or the MAO within 60 days. 42 U.S.C. §§ 1395y(b)(2)(B)(ii), 1395w-22(a)(4). When a primary payer fails to do so, Medicare can seek "double damages," or twice the amount of the conditional payment, from the primary payer under the Medicare Secondary Payer Act's right of action for the government at 42 U.S.C. § 1395y(b)(2)(B)(iii). In *Humana Med. Plan v. Western Heritage Insurance Co.*, this circuit held that MAOs (and their assignees) likewise can seek double damages under 42 U.S.C. § 1395y(b)(3)(A), the Medicare Secondary Payer Act's private right of action. 832 F.3d 1229 (11th Cir. 2016). *Humana* and this circuit's other case law to date, however, are silent on whether downstream actors that contract with MAOs, and in effect make conditional payments pursuant to those contracts, can seek double damages under the Act's private right of action.

Here, Plaintiff MSPRC alleged that it held an assignment of Medicare Secondary Payer Act claims against several of the defendants from an MAO. And both Plaintiffs alleged that they held assignments of claims against others of the

defendants from various contractors of MAOs. Plaintiffs alleged that these downstream assignors had contracted with MAOs to fully cover beneficiaries' costs in exchange for a set capitation fee. Pursuant to these contracts, Plaintiffs' downstream actors allegedly directly made conditional payments for MAOs or reimbursed MAOs for their conditional payments.

The following took place before the district court:

A. ACE Claims

As is relevant to this appeal, MSPRC presented two representative claims in its case for reimbursement against ACE American Insurance Company (ACE). These claims were for medical expenses that MSPRC alleged were directly charged to and paid by Hygea and Health Care Advisor Services, management services organizations that contract with MAOs to assist in providing health-care and administrative services to beneficiaries. MSPRC's third amended complaint alleged that these downstream actors, pursuant to their contracts with MAOs, "made conditional payments on behalf of [beneficiaries] to cover accident-related expenses" that should have been covered by ACE as the primary payer. *ACE* D.E. 36 at 2.

The district court (Patricia A. Seitz, *J.*) dismissed MSPRC's claims against ACE after concluding that non-MAO downstream actors, like Hygea and Health Care Advisor Services, cannot access the Medicare Secondary Payer Act's private right of action that allows MAOs to seek double damages. *MSP Recovery Claims, Series LLC v. ACE Am. Ins. Co.*, No. 17-cv-23749, 2018 WL 1547600, at *8

(S.D. Fla. Mar. 9, 2018). Having allowed MSPRC to amend its complaint numerous times, the district court entered its dismissal with prejudice.

B. Auto-Owners Claims

MSPRC presented five representative claims for reimbursement in its case against Auto-Owners Insurance Company, Southern-Owners Insurance Company, and Owners Insurance Company (collectively, Auto-Owners). These claims were for medical expenses allegedly paid by Health First Administrative Plans, Inc. (HFAP) and Verimed IPA, LLC (Verimed).

MSPRC alleged that HFAP is an MAO, even though Health First Health Plans, Inc. (Health First), a related company that is not HFAP, contracted directly with Medicare to be a part of the Medicare Advantage system. In support of its allegation, MSPRC submitted an affidavit from Michael Keeler, the Chief Operating Officer of both HFAP and Health First. The Keeler affidavit explained that "HFAP had and continues to have authority to manage and act on behalf of Health First Health Plan, Inc. with respect to all financial assets, including the Assigned Claims." *Auto-Owners* D.E. 60-1 at 1. It further explained that "HFAP, on behalf of Health First Health Plans, Inc., entered into a Recovery Agreement ... whereby HFAP assigned to MSP Recovery all right, title, interest in and ownership of the Assigned Claims." *Id*. The affidavit included an agreement between HFAP and Health First, which shows that the two companies have the same parent company, that HFAP "shall act as the general, administrative and financial manager" of Health First, that HFAP

shall engage in "oversight with respect to the management of the assets of" Health First, that HFAP has the authority to deposit Health First funds and make payments on behalf of Health First, and that HFAP shall provide Health First with "[c]onsultation and assistance with ... legal affairs" and with "risk management and compliance" services, as reasonably required. *Id.* at 4–5.

Verimed is an independent physician association that serves as an intermediary between an MAO and medical service providers. MSPRC alleged that Verimed, under its contract with its MAO, "is required to completely pay for whatever accident-related medical expenses are incurred" by a beneficiary. *Auto-Owners* D.E. 48 at 11. As described, Verimed reimbursed its MAO for conditional payments. *Id.* at 22 ("[The MAO] paid $155.68 for the accident-related expenses and, pursuant to their arrangement, required Verimed to fully reimburse and pay for those medical expenses.").

The district court (Patricia A. Seitz, *J.*) dismissed MSPRC's claims against Auto-Owners after determining that HFAP was not an MAO, that MSPRC did not hold any assignments from an MAO, and that non-MAOs like HFAP and Verimed cannot access or assign a claim under the Medicare Secondary Payer Act's private right of action. *MSP Recovery Claims, Series LLC v. Auto-Owners Ins. Co.*, Nos. 17-cv-23841, 17-cv-24069, 17-cv-24066, & 17-cv-24068, 2018 WL 1953861, at *6 (S.D. Fla. Apr. 25, 2018). Having allowed MSPRC to amend its complaint numerous times, the district court entered its dismissal with prejudice.

C. Travelers Claims

MSPRC did not present any representative claims in its case for reimbursement against Travelers Casualty and Surety Company (Travelers). Instead, it alleged that it "holds, and otherwise owns the rights and interests to, claims that have been processed for items and/or services pertaining to Medicare Beneficiaries for which the Defendant is the primary payer." *Travelers* D.E. 20 at 12. MSPRC made this allegation on the basis that Travelers had "reported some or all of [its] cases to [an agency within the Department of Health and Human Services] admitting it has primary payer responsibility." *Id.* MSPRC asserted that, pursuant to the Health Insurance Portability and Accountability Act (HIPAA), the names of the beneficiaries and their corresponding MAOs could be provided to Travelers "upon execution of a qualified protective order." *Id.* at 11 n.8.

MSPRC later indicated that its claims regarded medical expenses paid by HFAP, which it alleged was an MAO. *See MSP Recovery Claims, Series LLC v. Travelers Cas. and Sur. Co.,* No. 17-23628, 2018 WL 3599360, at *3 (S.D. Fla. June 21, 2018). MSPRC submitted the same Keeler affidavit that was submitted in the Auto-Owners case. Citing the opinion dismissing MSPRC's claim against Auto-Owners, the district court (Kathleen M. Williams, *J.*) found that HFAP was not an MAO, that MSPRC did not hold any assignments from an MAO, and that HFAP categorically could not access the Medicare Secondary Payer Act's private right of action. *Id.* at *4. Here, too, the district court dismissed MSPRC' claims against Travelers with prejudice.

D. Liberty Claims

As is relevant on appeal, MSPA presented two representative claims in its case against Liberty Mutual Fire Insurance Company (Liberty). These claims regarded medical expenses allegedly paid by Florida Healthcare Plus (FHCP) and the Interamerican Medical Center Group, LLC (IMC).

In its third amended complaint, MSPA alleged that FHCP "made conditional payments" that should have been reimbursed by Liberty. *Liberty* D.E. 49 at 5. MSPA dropped its allegation that FHCP was an MAO, instead arguing that, "[i]n addition to MAOs, first-tier and downstream entities also suffer damages." *Id.* at 21. On April 15, 2014, FHCP executed a contract with La Ley Recovery that conveyed to the latter FHCP's right "to recover costs already paid" for beneficiaries from the appropriate primary payers. *Liberty* D.E. 49-8 at 2. In exchange, La Ley Recovery would provide FHCP with 50% of the claims collected. The term of the contract was for one year, with an automatic renewal for an additional year. The contract empowered La Ley Recovery to "assign the Agreement in whole or in part but the assignee must be approved by [FHCP]." *Id.* at 3. La Ley Recovery then assigned the rights it had acquired to MSPA. In its third amended complaint, MSPA alleged that FHCP approved the assignment. *Liberty* D.E. 49 at 11. On December 10, 2014, the Florida Department of Financial Services was appointed FHCP's receiver. As FHCP's receiver, the Department of Financial Services wrote to La Ley Recovery to cancel its contract and subsequently filed a petition to enjoin La Ley Recovery and MSPA from pursuing their recovery

rights. After MSPA had filed the present litigation, however, the Department of Financial Services recognized the validity of FHCP's contract with La Ley Recovery pursuant to a settlement agreement.

MSPA also alleged that IMC, a management services organization, contracted with MAOs "to manage and provide healthcare services and absorb the risk of [financial] loss" for a defined population of beneficiaries. *Liberty* D.E. 58-2 at 3. IMC "irrevocably assign[ed] all of [its] rights" to seek double damages from primary payers to MSPRC, *Liberty* D.E. 49-14 at 9, which in turn assigned those rights to MSPA, *id.* at 2. In its third amended complaint, MSPA alleged that MSPRC's assignment to MSPA was "ministerial in nature" and thus did not require IMC's approval under the terms of IMC's contract with MSPRC, *id.* at 12, and that, in any event, IMC "consented to any subsequent assignment from [MSPRC] to any then-existing or future MSP Company, which include[d] MSPA," *Liberty* D.E. 49 at 14.

The district court (Kathleen M. Williams, *J.*) dismissed MSPA's claims. The district court determined that MSPA's claim derived from the FHCP assignment was legally deficient because the contract on which it was predicated was invalid at the time of filing, in the period between when the Department of Financial Services canceled FHCP's assignment to La Ley Recovery and when the Department concluded the settlement agreement. *MSPA Claims 1, LLC v. Liberty Mut. Fire Ins. Co.*, 322 F. Supp. 3d 1273, 1280–81 (S.D. Fla. 2018). The district court also found that the FHCP and IMC assignments were legally deficient

because MSPA had failed to allege that FHCP and IMC consented to the assignments. *Id.* at 1280, 1282. Additionally, the district court concluded that, even if the assignments were valid, MSPA's non-MAO assignors were categorically unable to access the Medicare Secondary Payer Act's private right of action. *Id.* at 1283. Having allowed MSPA to amend its complaint numerous times, the district court entered its dismissal with prejudice.

* * *

On appeal, we must address a series of issues raised by the following arguments: Plaintiffs argue (1) that the district court misapprehended the scope of the Medicare Secondary Payer Act's private right of action and therefore erroneously dismissed their claims on the basis that the assignments supporting those claims were not from MAOs but were from downstream actors. MSPRC additionally argues (2) that the district court erred in ordering that the dismissals of its HFAP claims be with prejudice. And MSPA argues (3) that the district court erred in dismissing its claims after incorrectly concluding that the assignments to MSPA were invalid. In response, Defendants present (4) a bevy of alternative bases for affirmance, including that (a) Plaintiffs' contracts with the downstream actors were "mere contingency agreements" rather than assignments; (b) Plaintiffs failed to comply with their supposed pre-suit notice requirements; and (c) there were defects with MSPRC's chain of assignments. We consider each of these arguments in turn, reviewing the district court's dismissals *de novo* and accepting Plaintiffs' well-pled factual allegations as true. *See MSPA Claims 1, LLC v.*

Tenet Fla., Inc., 918 F.3d 1312, 1317 (11th Cir. 2019).

IIA

Because Plaintiffs' claims (setting aside the HFAP claims) involve assignments from non-MAOs in the Medicare Advantage system, they would be properly dismissed if such non-MAOs are categorically barred from seeking damages under the Medicare Secondary Payer Act. In dismissing each of Plaintiffs' claims, the district court so interpreted the Act, concluding that only MAOs, not downstream actors in the Medicare Advantage system, may access its private right of action at § 1395y(b)(3)(A). On appeal, Plaintiffs argue that the district court adopted a crabbed reading of § 1395y(b)(3)(A) and thus erred in dismissing their claims on the basis that their assignors were non-MAOs. We agree with Plaintiffs' interpretation of § 1395y(b)(3)(A) and conclude that the district court erred by narrowly construing this provision to categorically exclude claims by downstream actors.

The language establishing the private right of action reads:

> 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)(3)(A). We have previously recognized that this is a "broadly worded provision that enables a plaintiff to vindicate harm caused by a primary plan's failure to meet its [Medicare Secondary Payer] primary payment or reimbursement obligations." *Humana*, 832 F.3d at 1238. And courts have generally understood the underlying objective of § 1395y(b)(3)(A) to be "help[ing] the government recover conditional payments from insurers or other primary payers" or otherwise reducing the healthcare costs borne by Medicare. *Stalley v. Cath. Health Initiatives*, 509 F.3d 517, 524 (8th Cir. 2007); *see also Manning v. Utils. Mut. Ins. Co., Inc.*, 254 F.3d 387, 397 n.8 (2d Cir. 2001) ("[W]hen Senator David Durenberger, Republican of Minnesota, introduced President Reagan's Medicare proposals for 1986, which included adding a private right of action to enforce the [Medicare Secondary Payer Act], it was introduced as the President's 'health care cost reduction proposals.'").

Consistent with the breadth of § 1395y(b)(3)(A)'s text and its cost-reduction and efficiency goals, this circuit and others have interpreted this section to allow recovery when the plaintiff has a connection to Medicare's unreimbursed conditional payment; such plaintiffs are presumed to be "in a better position," when incentivized with double damages, "to recover on behalf of Medicare than the government itself." *Netro v. Greater Baltimore Med. Ctr., Inc.*, 891 F.3d 522, 527 (4th Cir. 2018). In *Catholic Health Initiatives*, the Eighth Circuit allowed Medicare beneficiaries to access § 1395y(b)(3)(A)'s private right of action, even when those beneficiaries' medical bills had already been paid

by Medicare. 509 F.3d at 524–25. The Eighth Circuit explained that affording beneficiaries access to the private right of action would incentivize them to seek damages and "pay back the government for its outlay," thus reducing the cost of Medicare. *Id.* at 525. We endorsed that holding in *Stalley ex rel. U.S. v. Orlando Regional Healthcare System*, 524 F.3d 1229, 1234 (11th Cir. 2008); *accord Netro*, 891 F.3d at 528. And the Sixth Circuit, in *Michigan Spine & Brain Surgeons, PLLC v. State Farm Mutual Automobile Insurance Co.*, interpreted § 1395y(b)(3)(A) to allow medical care providers who have already received conditional payments from Medicare to bring a claim for double damages against primary payers. 758 F.3d 787, 790 (6th Cir. 2014). The Sixth Circuit implied that providers would repay Medicare with the damages from the primary payer, thereby advancing Congress's intent to "curb skyrocketing health costs and preserve the fiscal integrity of the Medicare system." *Id.* at 793. We endorsed that holding in *Humana.* 832 F.3d at 1234–35.

More recently, both the Third Circuit and this circuit interpreted § 1395y(b)(3)(A) to apply to MAOs in the Medicare Advantage system. They found that denying MAOs access to the private right of action would "hamstring" them by putting them at a "competitive disadvantage" relative to Medicare. *In re Avandia Mktg., Sales Practices & Prods. Liab. Litig.*, 685 F.3d 353, 364 (3d Cir. 2012); *Humana*, 832 F.3d at 1235–38. This would thwart congressional intent with respect to the Medicare Advantage system. In reaching their holdings, neither circuit concluded that access to § 1395y(b)(3)(A) was limited to MAOs or otherwise

addressed downstream actors' access to the private right of action. To the contrary, and as we further explain below, the Third Circuit's reasoning and our reasoning in *Humana* fully support downstream actors having access.

The only limitation that circuit courts have placed on § 1395y(b)(3)(A)'s breadth is that it cannot be treated as a *qui tam* provision. In other words, a plaintiff with no connection to Medicare or the Medicare Advantage system lacks statutory standing to seek double damages from a primary payer. This circuit, like others, *see, e.g., Catholic Health Initiatives*, 509 F.3d at 527; *Stalley v. Methodist Healthcare*, 517 F.3d 911, 919 (6th Cir. 2008), has foreclosed *qui tam* suits because plaintiffs with no connection to a conditional payment likely would not reimburse Medicare or an MAO and thus would not advance the Medicare Secondary Payer Act's aim of reducing costs for Medicare or the Medicare Advantage system. Distinguishing § 1395y(b)(3)(A) from the *qui tam* provision in the False Claims Act (FCA), we reasoned that "[t]he private plaintiff in an action under the [Medicare Secondary Payer Act] is entitled to the entire recovery if he or she is successful, unlike under the FCA, which apportions the recovery between the relator and the government." *Orlando Reg'l Healthcare Sys., Inc.*, 524 F.3d at 1234. We further explained that the Medicare Secondary Payer Act "provides to the government none of the procedural safeguards to manage or direct an action which are granted to it under the FCA." *Id.*

The central issue in our case is whether actors downstream from MAOs, who directly make

conditional payments or fully reimburse MAOs for their conditional payments, may themselves seek double damages from primary payers under § 1395y(b)(3)(A). In the wake of *Humana*'s holding that § 1395y(b)(3)(A) is a tool not only for preserving the solvency of the Medicare Trust Funds but also for reducing costs in the Medicare Advantage system, we believe this to be a straightforward inquiry.

The language of § 1395y(b)(3)(A), which has been interpreted to apply to plaintiffs with a connection to a conditional payment, is easily read to cover downstream actors who have borne the cost of a conditional payment and thus have suffered damages. Furthermore, allowing downstream actors who have directly paid beneficiaries' medical bills or reimbursed an MAO to recoup damages would plainly benefit the Medicare Advantage system. It would enable downstream actors to avoid costs that, under the Medicare Secondary Payer Act, should be borne by primary payers, not actors within the Medicare Advantage system. This, in turn, would enable downstream actors to continue presenting attractive contracts to MAOs. Ultimately, these attractive contracts are what enable MAOs to compete with Medicare. Rejecting downstream actors' access to § 1395y(b)(3)(A)'s private right of action would jeopardize MAOs' ability to negotiate favorable contract terms and would pass primary payers' statutorily-established risks and costs into the Medicare Advantage system. Finally, rejecting downstream actors' ability to seek double damages would incentivize primary payers to delay making primary payments and reimbursing conditional

payments, in the hope that these costs would be permanently passed from an MAO to a downstream actor with no recourse. Both the text and the objective of § 1395y(b)(3)(A) support allowing downstream actors to bring suit, or assign their right to bring suit, against primary payers.

The Department of Health and Human Services's interpretation of § 1395y(b)(3)(A) further supports allowing downstream actors like Plaintiffs' alleged assignors to bring suit, or assign their right to bring suit, against primary payers. At our request, the Department of Health and Human Services (HHS), which administers Medicare, oversees the Medicare Advantage system, and promulgates regulations regarding the Medicare Secondary Payer Act, submitted an *amicus* brief (to which all parties were given an opportunity to respond) on the scope of § 1395y(b)(3)(A). In its briefing, which considered the relevant cases, statutes, regulatory scheme, and legislative history, HHS urged that any downstream actor that has "actually suffered an injury because it provided or paid for care from its own coffers and was harmed by a primary plan's failure to provide reimbursement" should be able to access the private right of action. HHS *amicus* br. at 12. We afford HHS's well-reasoned and considered interpretation of § 1395y(b)(3)(A) *Skidmore* deference, under which "an agency's interpretation may merit some deference depending upon the 'thoroughness evident in its consideration, the validity of its reasoning, its consistency with earlier and later pronouncements, and all those factors which give it power to persuade, if lacking power to control.'" *Buckner v. Fla. Habilitation Network, Inc.*, 489

F.3d 1151, 1155 (11th Cir. 2007) (quoting *Skidmore v. Swift & Co.*, 323 U.S. 134, 140, 65 S.Ct. 161, 89 L.Ed. 124 (1944)); *see also Pugliese v. Pukka Dev., Inc.*, 550 F.3d 1299, 1305 (11th Cir. 2008) (affording *Skidmore* deference to agency *amicus* brief where "[t]he brief is thoroughly reasoned and demonstrates a high level of consideration given to the issue; the brief thoroughly and rationally analyzes the statute, the legislative history, and the policy implications of the statutory interpretation").

In response to Plaintiffs and HHS, Defendants advance two main arguments to counter the textual and purposive arguments in favor of affording MAOs access to § 1395y(b)(3)(A)'s private right of action. But neither of these arguments is persuasive. First, Defendants emphasize that § 1395y(b)(3)(A) is not a *qui tam* provision. Of course this is so, but it has little bearing on whether downstream actors that have suffered financial losses in the amount of their MAOs' unreimbursed conditional payments can bring suit. Such downstream actors cannot be equated to *qui tam* plaintiffs who sue on behalf of the government and have no personal financial losses.

Second, Defendants assert that downstream actors cannot suffer injuries under the Medicare Secondary Payer Act because they make conditional payments or reimburse MAOs' conditional payments pursuant to their contractual obligations, rather than "mak[ing] *statutory* conditional payments on behalf of Medicare or the MAO." Auto-Owners br. at 20 (emphasis added). Defendants reason that downstream actors "accepted [MAOs'] risk under private sub-contracts" and are trying to "push that

risk on to insurers," who are primary payers. ACE br. at 35. Defendants' argument is a sleight of hand; the primary payers already have that risk. The downstream actors' alleged injury—the payment of medical expenses that should have been covered by a primary payer—is precisely the kind of injury that the Medicare Secondary Payer Act was meant to remove from the Medicare and Medicare Advantage systems. Under the Act, the risk that Defendants assert downstream actors accept from MAOs is in fact borne by primary payers and covered by the insurance policies they issue, not by MAOs or any party with which they contract.

In an attempt to bolster their argument that downstream actors' status as contractors of MAOs precludes their access to § 1395y(b)(3)(A)'s private right of action, Defendants cite several cases in which various courts found that a plaintiff's contractual relationship was insufficient to sustain statutory standing. These cases bear no resemblance to this case. In *American Federation of Government Employees, Local 2119 v. Cohen*, the Seventh Circuit denied statutory standing to federal employees who challenged a procurement process based on how the resulting award would negatively affect their job security. The Seventh Circuit found that the employees' asserted injury fell within the province of their job contracts, not within that of the procurement statute, which was designed to ensure fair bid processes for potential government contractors. 171 F.3d 460, 472 (7th Cir. 1999). In *Benjamin v. Aroostook Medical Center*, the First Circuit denied statutory standing to patients of a black doctor who alleged that a

medical center's racial discrimination against the doctor had prevented them from contracting for and receiving their desired medical procedures. Although the doctor had statutory standing under the anti-discrimination statute, his patients, whose interest in contracting for and receiving medical treatment fell outside the ambit of the anti-discrimination statute, could not sue under the statute. 57 F.3d 101, 104 (1st Cir. 1995). In both cases, the plaintiffs' injury was far removed from the interests protected by the statute at issue. As we have discussed, when a downstream actor bears the cost of an MAO's conditional payments, that downstream actor suffers an injury squarely within the ambit of the Medicare Secondary Payer Act.

Defendants have presented no persuasive rationale for limiting downstream actors' access to § 1395y(b)(3)(A)'s private right of action. The *amici* writing in support of Defendants have similarly failed to persuade us that downstream actors that fully cover MAOs' conditional payments are situated differently from MAOs in any material way. Therefore, and in light of the text, purpose, and persuasive agency interpretation of § 1395y(b)(3)(A), we hold that downstream actors that have made conditional payments in an MAO's stead or that have reimbursed an MAO for its conditional payment can bring suit for double damages against the primary payer. The district court erred in dismissing Plaintiffs' claims on the theory that, as a threshold matter, non-MAOs are categorically barred from accessing the Medicare Secondary Payer Act's private right of action no matter the circumstances.

IIB

MSPRC also appeals the district court's dismissals of its HFAP claims, insofar as those dismissals were entered with prejudice. MSPRC br. at 27. The district court dismissed with prejudice MSPRC's HFAP claims against Auto-Owners and Travelers on the basis that HFAP lacked an assignment from Health First—a recognized MAO that is tightly bound up and shares corporate executives with HFAP. Explaining that "HFAP is not an MAO" and has "not been assigned any rights by Health First Health Plans, Inc.," the district court held that HFAP, and therefore its assignee MSPRC, "lacks standing under § 1395y(b)(3)(A)." *Auto-Owners Ins. Co.*, 2018 WL 1953861, at *5. MSPRC argues that dismissals based on a party's lack of an assignment are dismissals for want of Article III standing, not statutory standing, and that dismissal with prejudice was therefore inappropriate. We agree with MSPRC.

As the Seventh Circuit explained in *MAO-MSO Recovery II v. State Farm Mutual Automobile Insurance Co.*, a case analogous to this one, if an assignment from HFAP "conveyed nothing" from Health First, "plaintiffs had no rights to enforce" at all. 935 F.3d 573, 581 (7th Cir. 2019). If MSPRC had no rights to enforce because the HFAP assignment conveyed nothing, MSPRC had no injury in fact and thus no Article III standing. *See Sprint Commc'ns Co., L.P. v. APCC Servs., Inc.*, 554 U.S. 269, 289, 128 S.Ct. 2531, 171 L.Ed.2d 424 (2008) (treating the presence or absence of a valid assignment as an issue of Article III standing). In

the absence of Article III standing, the district court lacked jurisdiction to resolve MSPRC's claims on the merits. *See MAO-MSO Recovery II*, 935 F.3d at 581. The district court therefore could not have dismissed MSPRC's claims with prejudice. *See id.*; *see also MSP Recovery Claims, Series LLC v. QBE Holdings*, 965 F.3d 1210 (11th Cir. 2020) (vacating district court order dismissing similar claim with prejudice and directing that the dismissal be entered without prejudice).

Auto-Owners and Travelers contend that, even if the district court lacked jurisdiction to resolve MSPRC's case on the merits, the district court still had the authority to dismiss MSPRC's claims with prejudice because such claims were frivolous and made in bad faith. In support of this contention, Auto-Owners and Travelers marshal a plethora of unpublished, non-precedential Eleventh Circuit cases affirming, as an example, a district court's dismissal with prejudice of a complaint that alleged "wild accusations and incredible stories" after the district court "conclud[ed] that it did not have subject matter jurisdiction." *Gibbs v. United States*, 517 F. App'x 664, 667, 670 (11th Cir. 2013). We need not consider whether this practice set forth in unpublished opinions is consistent with district courts' lack of jurisdiction because we conclude, like the Seventh Circuit, that MSPRC did not bring frivolous or bad-faith claims.

As the Seventh Circuit noted in *MAO-MSO Recovery II*, the "corporate arrangement [between HFAP and Health First] was not just complex, but ... freighted with overlapping names and functions." 935 F.3d at 585. In support of its claims here, MSPRC submitted a contract between HFAP

and Health First showing that HFAP "manage[d]" the MAO's general, administrative, and financial affairs. The same contract shows that HFAP was tasked, in particular, with handling the MAO's "legal affairs." Michael Keeler, the Chief Operating Officer of both HFAP and Health First, signed the assignment between HFAP and MSPRC and stated in an affidavit that he intended for "HFAP, on behalf of Health First Health Plans, Inc., ... [to] assign[ ] to MSP Recovery all right, title, interest in and ownership of" any claims against primary payers. *Auto-Owners* D.E. 60-1 at 1. As MSPRC argues on appeal, it was eminently reasonable for MSPRC to plead that it had a valid assignment of claims from an MAO. Moreover, if MSPRC in fact had a defective assignment, MSPRC was well positioned to cure the technical defect and refile its case with the same claims. Like the Seventh Circuit, because we find that the district court erred insofar as it dismissed MSPRC's HFAP claims with prejudice, we order that the district court's dismissal be without prejudice.

III

In addition to dismissing MSPA's claims because MSPA's assignors were non-MAOs, the district court dismissed the claims after finding that MSPA's assignments were invalid. Specifically, the district court found that (1) FHCP's assignment was canceled when FHCP went into receivership and (2) MSPA failed to allege, with respect to both its FHCP and IMC claims, that FHCP and IMC approved the assignment of their rights to MSPA. On appeal, MSPA argues that the district court

erred because (1) the purported cancellation of FHCP's assignment did not extinguish MSPA's vested rights and (2) MSPA's third amended complaint did in fact allege that FHCP and IMC had approved the assignment of their rights to MSPA. We agree with MSPA.

With respect to the purported cancellation of FHCP's assignment, FHCP executed a contract "assign[ing] all of [its] rights" under the Medicare Secondary Payer Act to La Ley Recovery on April 15, 2014. *Liberty* D.E. 49-8 at 2. Because nothing in this contract suggested that FHCP would retain an interest in its rights with respect to these claims that were assigned under the contract or that its rights with respect to these claims would revert to FHCP, the contract fully divested FHCP of such rights. On February 20, 2015, La Ley Recovery executed a contract "irrevocably assign[ing]" to MSPA "any and all" of La Ley Recovery's "claims, rights and causes of action set forth" in its contract with FHCP. *Liberty* D.E. 49-9 at 1. This agreement transferred the claims under the Act that La Ley Recovery then possessed to MSPA. That FHCP went into receivership after concluding its contract with La Ley Recovery, and that FHCP's receiver sought to cancel the contract, had no effect on the chain of assignments. FHCP's receiver had no authority to claw back what FHCP had already irrevocably transferred. *See State of Florida, ex rel. Dep't of Fin. Servs. v. Florida Healthcare Plus, Inc.*, No. 2014-CA-2762, Order Dated Dec. 10, 2014, at 13 (Fla. 2d Cir. Ct. 2014) (giving FHCP's receiver the authority to "cancel[ ]," but not rescind, contracts); Samuel Williston & Richard A. Lord, *Williston on Contracts* § 49:129 (4th ed.

1990) ("A rescission avoids the contract *ab initio*, while cancellation merely terminates the policy prospectively, as of the time the cancellation became effective."). At most, FHCP's receiver could prevent La Ley Recovery, and subsequently MSPA, from acquiring new rights that FHCP acquired after the date of the purported cancellation.

The district court's finding that MSPA failed to allege that it had received consent from FHCP and IMC for its assignments is belied by the record. MSPA's third amended complaint plainly alleged that FHCP had approved La Ley Recovery's assignment to MSPA. *Liberty* D.E. 49 at 11. The complaint also plainly alleged that IMC had "accepted, acknowledged, approved, and consented to" MSPRC's assignment to MSPA. *Id.* at 14. Moreover, MSPA submitted an affidavit from a manager of IMC stating that "IMC was aware of the subsequent assignment from [MSPRC] to MSPA" and that "[n]o prior written consent was needed to effectuate that subsequent assignment because it was ministerial in nature" under the terms of IMC's contract with MSPRC. *Liberty* D.E. 58-2 at 3. Accordingly, we find that the district court erred in dismissing MSPA's FHCP and IMC claims based on the purported cancellation and validity of MSPA's assignments.

IV

Defendants advance several alternative bases for affirmance. Across claims, Defendants argue that (1) Plaintiffs' contracts are "mere contingency agreements" rather than assignments; (2) Plaintiffs failed to comply with their supposed pre-suit

notice requirements; and (3) there exist potential defects with MSPRC's chain of assignments. These arguments are without merit.

With respect to their first argument, Defendants, despite claiming to do so, *see, e.g.*, Liberty br. at 29–30, point to no cases in which a court characterized Plaintiffs' contracts as contingency arrangements or collection-only agreements rather than assignments. The one district court to consider this question was "not persuaded" that Plaintiffs' contracts were anything other than assignments. *MSP Recovery Claims, Series LLC v. Farmers Ins. Exchange*, Nos. 17-cv-02522 & 17-cv-02559, 2018 WL 5086623, at *12 (C.D. Cal. Aug. 13, 2018). Defendants contend that Plaintiffs must have contingency arrangements or collection-only agreements rather than assignments because their contracts grant the supposed assignors a contingency interest, and because the clear purpose of the contracts is to provide the supposed assignors with recovered payments. But the Supreme Court has held that contracts that include recovery-sharing provisions, even if they require the assignee to "remit all litigation proceeds" to the assignor, are still properly construed as assignments. *Sprint Commc'ns*, 554 U.S. at 273–85, 128 S.Ct. 2531 (outlining the history of "assignees for collection"). Defendants also argue that the fact that Plaintiffs' contracts have termination provisions cuts against the contracts being assignments. Although the termination provisions are curious in this context, given that an assignor's transferred rights would not revert after termination, this oddity alone does not override the plain text of Plaintiffs' contracts.

Plaintiffs' contracts repeatedly refer to themselves as "Assignment[s] of Claims," *see, e.g., Liberty* D.E. 49-9 at 2, and include language such as, "Client hereby irrevocably assigns, transfers, conveys, sets over and delivers to [MSPRC], or its assigns, any and all of Client's ... rights and entitlements ... to pursue and/or recover monies" from primary payers, see, e.g., *Ace* D.E. 28-1 at 2. We find this language dispositive of the fact that Plaintiffs hold assignments from various downstream actors.

With respect to their second argument, that Plaintiffs failed to comply with alleged pre-suit notice requirements, Defendants point to no law that obligated Plaintiffs to submit "recovery demand letters" or otherwise provide advance notice of their intent to bring a claim. The regulation that Defendants cite to support their argument contemplates that primary payers' liability arises not only after the primary payer receives a recovery demand letter but also in cases in which "the demonstration of primary payer responsibilities is other than receipt of a recovery demand letter." 42 C.F.R. § 411.22. Although primary payers must have knowledge that they owed a primary payment before a party can claim double damages under the Medicare Secondary Payer Act, *see Glover v. Liggett Grp., Inc.*, 459 F.3d 1304, 1309 (11th Cir. 2006); see also 42 C.F.R. § 411.24(i)(2), Plaintiffs plausibly alleged that Defendants had such knowledge.

Plaintiffs alleged that they chose which claims to bring by comparing their assignors' claims data against two sets of documents: Defendants' filings with HHS under 42 U.S.C. § 1395y(b)(7)–(9), which obligates insurers like Defendants to report

the claims for which they are primary payers, and certain of Defendants' settlement agreements to which MSPRC had access. The filings with HHS evidence Defendants' knowledge that they owed primary payments, including the primary payments for which Plaintiffs seek reimbursement. For the remaining claims, Defendants' settlement agreements with beneficiaries show, at minimum, that Defendants had constructive knowledge that they owed the primary payments. *See United States v. Baxter Int'l, Inc.*, 345 F.3d 866, 903 (11th Cir. 2003) (finding that a complaint "sufficiently alleges constructive knowledge" on behalf of the primary payer based on the primary payer's entry into a settlement agreement with beneficiaries). Because Plaintiffs have plausibly alleged Defendants' actual or constructive knowledge, we decline to adopt Defendants' second alternative basis for affirmance.

Third and finally, Defendants argue that MSPRC "asserts defective (or incomplete) assignment chains" because its proffered contracts are between purported assignors and "series LLCs" that are affiliated with but are not themselves MSPRC. ACE br. at 39–40. Defendants liken MSPRC to a parent corporation with subsidiaries and note that parent corporations cannot sue on behalf of their subsidiaries. But Delaware law, under which MSPRC is incorporated, uses permissive language that provides that "series *may* have"—but are not required to have—"separate rights, powers or duties with respect to specified property or obligations of [its affiliated] limited liability company." 6 Del. C. § 18-215 (emphasis added). Depending on how MSPRC's

relationships with its affiliated series LLCs are structured, MSPRC may have the same rights as or rights separate from the series LLCs with respect to the assignments. Nothing in the record suggests that MSPRC's relationships with its series LLCs preclude MSPRC from asserting those series LLCs' rights. At the pleading stage, we accept as true MSPRC's allegation that it has the right to bring claims under the proffered contracts. As with the previous alternative bases for affirmance, we find this third basis meritless.

V

We have considered Defendants' remaining arguments for affirmance and find them to be without merit. For the reasons stated above, in case numbers 18-12139 (ACE) and 18-13312 (Liberty), we **VACATE** the dismissals of Plaintiffs' claims based on assignments from downstream actors and **REMAND** those cases for further proceedings consistent with this opinion. In case number 18-12149 (Auto-Owners), we **AFFIRM IN PART** the dismissal of the Plaintiffs' claims in this action to the extent that they involve claims for medical expenses allegedly paid by Health First Administrative Plans, Inc. (HFAP). We **MODIFY** the dismissal of these claims to be without prejudice. We **VACATE** the dismissal of the plaintiffs' remaining claims in case number 18-12149. In case number 18-13049 (Travelers), we **AFFIRM** the dismissal of the Plaintiffs' claims but **MODIFY** the dismissal of these claims to be without prejudice.

Appendix B

UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF FLORIDA
MIAMI DIVISION

CASE NO. 17-CV-23749

CLASS ACTION

March 9, 2018

MSP RECOVERY CLAIMS, SERIES LLC,

Plaintiff,

—v.—

ACE AMERICAN INSURANCE COMPANY,
a foreign profit corporation,

Defendant.

ORDER GRANTING MOTION TO DISMISS WITH PREJUDICE

THIS MATTER came before the Court for hearing on Defendant's Motion to Dismiss Plaintiff's Third Amended Complaint [DE 38]. In the Third Amended Complaint [DE 36], pursuant to the Medicare Secondary Payer Act (MSPA), 42 U.S.C. § 1395y, Plaintiff alleges it is entitled to reimbursement from Defendant for payments made on behalf of Medicare beneficiaries. Defendant seeks to dismiss the complaint for lack of standing and for failing to state a claim pursuant to Federal Rule of Civil Procedure 12(b)(6). Plaintiff filed a response [DE 39] and Defendant filed a reply [DE 40].

Standing is a threshold question that the Court must address to ensure it has subject-matter jurisdiction over the claim. While the Third Amended Complaint pleads additional facts compared to the original complaint, the allegations still fail to establish Plaintiff has standing as recognized under the MSPA. Therefore, because Plaintiff fails to allege standing to sue and the Court has already provided Plaintiff with four opportunities[1] to cure its defective complaint, the Motion to Dismiss is granted with prejudice.

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[1] After a motion to dismiss was filed in response to Plaintiff's original Complaint [DE 1], Plaintiff filed its First Amended Complaint [DE 12]. Pursuant to the Court's Order to plead facts rather than a formulaic recitation of the elements [DE 26], Plaintiff submitted a Second Amended Complaint (SAC) [DE 28]. Pursuant to another Order regarding the deficiencies in the SAC [DE 35], Plaintiff submitted its Third Amended Complaint on January 19, 2018.

I. RELEVANT BACKGROUND

Plaintiff is an entity whose business model involves obtaining assignments from various entities, including Medicare Advantage Organizations, first-tier entities and downstream entities, to recover reimbursement for payments made for the medical expenses of Medicare beneficiaries that should have been made by a private insurer pursuant to the Medicare Secondary Payer Act (MSPA), 42 U.S.C. § 1395y(B)(3)(A). [DE 36 ¶ 1, 3]. Plaintiff filed this class action as the assignee of three representative entities—Hygea Holdings Corp., MMM Holdings, LLC, and Health Care Advisor Services—to seek reimbursement from Defendant pursuant to the MSPA. [DE 36 ¶ 5, 6]. Because Plaintiff stands in the shoes of its original assignors, the Court must consider whether the original assignors have standing. Because this claim is brought under the private cause of action in the MSPA, § 1395y(B)(3)(A), the Court must consider the statutory framework of the MSPA in its analysis.

A. The Medicare Secondary Payer Act (MSPA)

In 1965, Congress enacted the Medicare Act to establish a federally subsidized health insurance program for the elderly and disabled. [DE 36 ¶ 64]. At the time, Medicare provided payment for medical expenses even when Medicare beneficiaries were also enrolled in third party insurance policies that covered those same costs. *See MSP Recovery, LLC v. Allstate Ins.Co.,* 835 F.3d 1351 (11th Cir. 2016).

In an effort to reduce costs, Congress passed the MSPA in 1980. The MSPA provides that Medicare will be the secondary payer, rather than the primary

payer, for medical services provided to its beneficiaries when they are also covered for the same services by a private insurer. 42 U.S.C. § 1395y. Under the MSPA, the private insurer becomes the primary payer, as defined by the terms in the statute,[2] for medical services. However, Medicare may make conditional payments when a primary payer cannot be expected to make a payment for a service promptly. *Id*. Once notified of its responsibility for a payment, a primary payer must reimburseMedicare for any payment made within 60 days. *Id.* In an effort to enforce this scheme, the MSPA created a private cause of action for double damages when a primary plan fails to provide for primary payment. *See* § 1395y(B)(3)(A).

B. Medicare Advantage Organizations, First-Tier Entities and Downstream Entities

In 1997, Congress created the Medicare Part C option to allow Medicare beneficiaries the option of receiving Medicare benefits through private insurers known as Medicare Advantage Organizations (MAOs). *See* 42 U.S.C. §§ 1395w-21-w-23. To become an MAO, an insurer must meet certain requirements set by Medicare. *See* § 1395w-21. Medicare strictly construes and regulates MAOs to ensure equivalence in all respects with the traditional Medicare program.[3] *See*

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[2] Primary payers are generally defined as a group health plan, a workmen's compensation plan, an automobile or liability insurance plan, or no-fault insurance plan. *See* § 1395y(B)(2)(A).

[3] An MAO has to abide by coverage determinations provided by Medicare and all disputes go through the traditional Medicare process. [DE 36 ¶ 73]. MAOs receive a fixed fee per beneficiary directly from Medicare to provide services to each Medicare beneficiary. [DE 36 ¶ 72].

§ 1395w-23(c). MAOs contract directly with Medicare to administer benefits for a Medicare beneficiary. *Humana Medical Plan Inc., v. Western Heritage Ins. Co.,* 832 F.3d 1229, 1235 (11th Cir. 2016).

An MAO may then subcontract directly with third-party providers, known as first-tier entities and downstream entities, to provide health care or administrative services to the Medicare beneficiaries in the MAO's plan. *See* 42 C.F.R. § 422.2. First-tier entities and downstream entities include Management Service Organizations (MSOs) and Independent Physician Associations (IPAs). [DE 36 ¶ 95]. The MAO pays providers by either: (1) entering into a written contract as described above where the MAO agrees to pay certain rates for certain categories of treatments, or (2) reimbursing a provider that is outside the MAO's network of contracted providers for providing treatment to the beneficiary. *Tenet Healthsystem GB, Inc. v. Care Improvement Plus South Central Ins. Co.,* 875 F.3d 584, 586 (11th Cir. 2017). These first-tier entities and downstream entities "bear the full risk of loss pursuant to their contractual obligations with MAOs." [DE 36 ¶ 94]. Regardless of any relationship an MAO may have with a first-tier entity or downstream entity, the MAO maintains the ultimate responsibility for fully complying with all terms and conditions of its contract with Medicare. *See* 42 C.F.R. § 422.504.

C. Relevant Allegations of the Third Amended Complaint

Plaintiff as assignee of three representative entities—Hygea, MMM Holdings, and Health Care Advisor Services—alleges Defendant, a private

liability insurer, is a primary payer[4] which failed to perform its statutory obligation to reimburse Plaintiff's assignors for medical expense payments made on behalf of Medicare beneficiaries. *See* § 1395y(2); [DE 36 ¶ 5, 6]. The relevant facts that are alleged in Plaintiff's three representative claims are:

1. R.C. and Hygea Holdings Corp. ("Hygea"): R.C. was enrolled in a Medicare Advantage plan managed by Hygea. [DE 36 ¶ 32]. R.C.'s medical expenses were "subsequently paid" by Hygea. *Id.* Hygea was "charged" $1,227.48. [DE 36 ¶ 36]. Two assignments were subsequently made: (1) Hygea assigned its rights to recover conditional payments to MSP Recovery, LLC on September 15, 2015; and later (2) MSP Recovery, LLC assigned the rights acquired from Hygea to Series 15-08-19, LLC on June 12, 2017. [DE 36 ¶ 59, 60].
2. D.G. and MMM Holdings, LLC ("MMM Holdings"): D.G. was enrolled in a Medicare Advantage plan managed by MMM Holdings. [DE 36 ¶ 25]. D.G.'s medical expenses were "subsequently paid" by MMM Holdings. *Id.* MMM Holdings was "charged" $1,892.84. [DE 36 ¶ 29]. Two assignments were subsequently made: (1) MMM Holdings assigned its rights to recover conditional payments to MSP Recovery, LLC on June 12, 2017; and later (2) MSP Recovery, LLC further assigned the rights

[4] Plaintiff alleges Defendant is a primary payer by virtue of settlements it entered into with Medicare beneficiaries, as well as contractual obligations under its insurance policies to provide coverage to its insureds. [DE 36 ¶ 4, 5].

acquired from MMM Holdings to Series 17-02-554, LLC on June 12, 2017. [DE 36 ¶ 56, 57].

3. E.F. ("E.F.") and Health Care Advisor Services: E.F. was enrolled in a Medicare Advantage plan managed by Health Care Advisor Services. [DE 36 ¶ 17]. E.F.'s medical expenses were "subsequently charged" to Health Care Advisor Services in the amount of $29,883.14. [DE 36 ¶ 17, 22.] Two assignments were subsequently made: (1) Health Care Advisor Services assigned its rights to recover its conditional payments to MSP Recovery, LLC, a different entity than the Plaintiff, on August 28, 2015; and later (2) MSP Recovery, LLC further assigned the rights acquired from Health Care Advisor Services to Series 15-08-27 LLC on June 12, 2017.[5] [DE 36 ¶ 53, 54].

Plaintiff does not specifically allege if its original assignors are either MAOs or non-MAOs, or first-tier entities or downstream entities in the Third Amended Complaint. The three assignment agreements contain identical broad language describing the assignors as entities that "operate a Health Maintenance Organization, MSO, IPA, Medical Center, and/or is a Physician and/or otherwise … provides or arranges for the provision of care, services, and/or supplies including medications, treatments or other procedures to persons covered under [Medicare] and other third party." [DE 36-7; 36-9; 36-11]. In response to the present motion to

[5] Defendant challenges the legitimacy of the assignments. The Court will not reach that issue, and for the purposes of this motion accepts and refers to the Plaintiff's alleged assignors as the "Plaintiff's assignors."

dismiss, Plaintiff first asserts Hygea and Health Care Advisor Services are MSOs and MMM Holdings is an MAO [DE 39 at 6].

For each representative claim, Plaintiff contends its assignors conditionally paid for medical services that Defendant should have paid as a primary payer under the MSPA. Plaintiff seeks double damages under § 1395y(B)(3)(A) because of Defendant's alleged failure to properly reimburse Plaintiff's assignors. Plaintiff also seeks reimbursement for the amount "billed"[6] to the assignors and class members for medical treatment provided to the Medicare beneficiaries during the time period which Defendant was a primary payer. [DE 36 ¶ 14].

II. STANDARD OF REVIEW

Standing is a threshold question that must be addressed prior to, and independent of, the merits of a party's claim because it addresses the Court's jurisdiction to adjudicate the claim. *DiMaio v. Democratic Nat'l Comm.,* 520 F.3d 1299, 1301 (11th Cir. 2008). The party invoking federal jurisdiction bears the burden of establishing standing. *Lujan v. Defs. of Wildlife,* 504 U.S. 555, 561 (1992). To establish standing, the plaintiff has the burden to show: (1) that it suffered an injury-in-fact that is (a) concrete and particularized, and (b) actual or imminent; (2) a causal connection between the injury and the conduct complained of (and not the result of the independent action of some third party not before the court); and (3) that it is likely, not merely speculative, that the injury will be redressed by a

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[6] Defendant contends the Complaint should set forth the amount that was paid, not billed.

favorable decision. *Id.* at 560 (citations omitted). Plaintiff must support each element of standing in the same way as any other matter on which the plaintiff bears the burden of proof, with the manner and degree of evidence required at the successive stages of litigation. *See id.*

Standing requires a careful judicial examination of a complaint's allegations to ascertain whether the particular plaintiff is entitled to an adjudication of the particular claims asserted. *DiMaio,* 520 F.3d at 1301. A plaintiff lacks standing if the complaint merely sets forth facts from which courts could imagine an injury. *Id.* (citations omitted). The Court should not speculate concerning the existence of standing; if the plaintiff fails to meet his burden, the Court cannot create jurisdiction by embellishing a deficient allegation of injury. *Id.* (citations omitted).

In evaluating a standing challenge, the Court must first determine if a factual or facial challenge has been raised. *Lawrence v. Dunbar,* 919 F.2d 1525, 1529 (11th Cir. 1990). A facial attack requires the court to determine if the plaintiff has sufficiently alleged a factual basis of subject matter jurisdiction, and the allegations in the complaint are taken as true for the purposes of the motion. *See McElmurray v. Consol. Gov't of August-Richmond Cnty.,* 501 F.3d 1244, 1251 (11th Cir. 2017) (citations omitted). A factual attack, on the other hand, challenges the existence of jurisdiction irrespective of the pleadings, and matters outside of the pleadings such as testimony and affidavits are considered. *Id.* (citations omitted).

Here, the Court will address each representative claim separately either as a factual or facial attack based on the motion to dismiss. Generally, Defendant facially attacks the Third Amended Complaint,

arguing a dearth of facts as to each representative claim, including: the name of the MAO; the name of the medical provider; and the relationship between the assignor, the beneficiary, and the provider. [DE 38 at 3-5]. Defendant also makes a factual attack that the assignors are non-MAOs. [DE 38 at 6]. Plaintiff concedes that two assignors are non-MAOs, but asserts that assignor MMM Holdings is an MAO. [DE 39]. Defendant maintains that MMMHoldings is a non-MAO. [DE 40 at 5]. Therefore, the Court's analysis of the claim involving D.G. and MMM Holdings will be on the basis of a factual attack. For the claims involving R.C. and Hygea, and E.F. and Health Care Advisor Services, the Court will proceed on the basis of afacial attack.

III. ANALYSIS

Because the Plaintiff asserts standing pursuant to the private cause of action in the MSPA, the Court must first determine who can bring a claim under § 1395y(B)(3)(A). The language creating the private cause of action states:

> 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)(3)(A). The Plaintiff's theory is that § 1395y(B)(3)(A) allows for *any private party* to bring a claim. [DE 36 ¶ 86]. Because the statute is silent regarding who may file a claim, courts have interpreted the meaning of "private cause of action" to identify who may assert a claim. The Eleventh

Circuit has determined that § 1395y(B)(3)(A) is not a *qui tam* statute that authorizes any private person to sue on behalf of the government. *See MSP Recovery LLC, v. Allstate Ins. Co.,* 835 F.3d 1351, 1363 at n.3 (11th Cir. 2016) (citations omitted). Rather, § 1395y(B)(3)(A) allows a private party to sue only where that party itself has suffered an injury under the statute. *Id.* Therefore, the Court must first consider which persons and entities meet this standard and can bring a claim under § 1395y(B)(3)(A).

Courts have held that Medicare beneficiaries may bring claims under § 1395y(B)(3)(A). *See Stalley v. Orlando Regional Healthcare System,* 524 F.3d 1229, 1234 (11th Cir. 2008); *Glover v. Liggett Group, Inc.,* 459 F.3d 1304 (11th Cir. 2006). While not directly examining standing,[7] *Glover* involved two Medicare beneficiaries who sought reimbursement from a cigarette manufacturer for health care services attributable to smoking. *See Glover,* 459 F.3d at 1305. In dicta, the court noted that the MSPA created a private right of action to "encourage *private parties"* who are aware of non-payment by primary plans to bring actions to enforce Medicare's rights. *See id.* Here, relying on *Glover,* Plaintiff argues that its assignors, which are not Medicare beneficiaries, are encompassed under the term "private parties" and thus may bring a claim.[8] [DE 39 at 7]. However,

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[7] The issue in *Glover* was whether the individuals could sue the manufacturer without first establishing liability.

[8] Plaintiff similarly relies on *O'Connor v. Mayor and City Council of Baltimore*, 494 F. Supp. 2d 372 (D. Md. 2007) to illustrate its assignors have standing. As in Glover, the plaintiff in *O'Connor* was a Medicare beneficiary. Here, Plaintiff's assignors are not Medicare beneficiaries.

because *Glover* was not directly dealing with standing and the plaintiffs there were Medicare beneficiaries, the Court can at most read *Glover* as allowing Medicare beneficiaries to bring a claim under § 1395y(B)(3)(A).[9]

Additionally, healthcare providers that initially treated the Medicare beneficiary have been found by the Sixth Circuit Court of Appeals to have standing under § 1395y(B)(3)(A). *See Mich. Spine & Brain Surgeons, PLLC v. State Farm Mut. Auto. Ins. Co.,* 758 F. 3d 787, 790 (6th Cir. 2014). The plaintiff in *Michigan Spine* was an independent health provider that treated the Medicare beneficiary directly, was paid a reduced amount by Medicare, and filed a lawsuit against the beneficiary's insurer seeking damages under the MSPA. *See id.* While standing was not directly at issue in the case,[10] the Court can at most read *Michigan Spine* as allowing a health-care provider that initially treated the Medicare beneficiary to bring a claim under § 1395y(B)(3)(A).

Finally, MAOs may have standing under § 1395y(B)(3)(A). *See Humana Medical Plan, Inc., v.*

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[9] In *Stalley v. Catholic Health Initiatives*, 509 F.3d 517, 526 (8th Cir. 2007), the court found the congressional intent behind the private cause of action was to provide Medicare beneficiaries standing to sue their primary insurers for expenses Medicare had already paid and to allow beneficiaries to vindicate their own contractual or tort interests. The court also noted that beneficiaries suffer an injury because a conditional payment made by Medicare leaves the beneficiary with a less than final settlement of their liability to the provider. *Id.*

[10] In *Michigan Spine*, the court was determining whether the provider could sue a primary insurer that had denied coverage because of a pre-existing condition, not on the basis of Medicare eligibility.

Western Heritage Ins. Co., 832 F.3d 1229 (11th Cir. 2016). In *Humana,* the court held that MAOs have standing under § 1395y(B)(3)(A) because other areas in the MSPA appeared to treat MAOs similarly as Medicare. *Humana,* 832 F.3d at 1233. In dicta, the *Humana* court referenced *Michigan Spine* to support the proposition that direct health care providers who have not been paid by a primary plan have standing to bring a claim. *Id*. at 1235 (citations omitted). Plaintiff relies on *Humana* to support its theory that non-MAOs and, in particular, "private parties" generally have standing.[11] [DE 39 at 7]. However, *Humana* only held that the private cause of action was available to MAOs. *See Humana,* 832 F.3d at 1233. Even considering the court's dicta, *Humana* at most allows direct providers of medical services to bring claims.[12]

Therefore, based on the Court's review of the statute and precedent, there is a two-prong test to establish standing to bring a claim under § 1395y(B)(3)(A). First, the plaintiff must be either: (1) a Medicare beneficiary; (2) an MAO; or a (3) direct healthcare provider to the Medicare beneficiary. Second, the plaintiff must show: (1) that it suffered an injury-in-fact; (2) a causal connection between the

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[11] Plaintiff disappointingly misquotes *Humana* to suggest that decision supports the theory that the cause of action was available to any "private parties." [DE 39 at 7]. Plaintiff ignores that the Eleventh Circuit was implicitly supporting the proposition that direct providers had standing under § 1395y(B)(3)(A). *Humana*, 832 F.3d at 1235.

[12] To demonstrate that it has standing, Plaintiff also relies on *In re Avandia*, 685 F.3d 353 (3d Cir. 2012). However, that decision, like *Humana*, only held that MAOs had a private right of action under the MSPA.

injury and the conduct complained of; and (3) that it is likely that the injury will be redressed by a favorable decision. *See, e.g., Lujan v. Defs. of Wildlife,* 504 U.S. 555, 561 (1992); *Humana Medical Plan, Inc., v. Western Heritage Ins. Co.,* 832 F.3d 1229 (11th Cir. 2016); *Glover v. Liggett Group, Inc.,* 459 F.3d 1304 (11th Cir. 2006); *Mich. Spine & Brain Surgeons PLLC v. State Farm Mut. Auto. Ins. Co.,* 758 F.3d 787 (6th Cir. 2014).

In this case, because Plaintiff is the assignee of various claims, the Court must first determine whether Plaintiff's original assignor in each representative claim is: (1) a Medicare beneficiary; (2) an MAO; or (3) a direct healthcare provider to the Medicare beneficiary in order to have standing under § 1395y(B)(3)(A). If not, the Plaintiff's assignors are not within the established entities that courts have found have standing and the inquiry ends there.

A. CLAIM 1: HYGEA AND R.C.

In this claim, Hygea is Plaintiff's original assignor. Defendant contends the Third Amended Complaint fails to allege the relationship between R.C., Hygea, and the medical provider which treated R.C. Because this constitutes a facial attack on Hygea's standing, it is only necessary to look to the Third Amended Complaint to see if Plaintiff has sufficiently alleged whether Hygea is an MAO or was the direct health-care provider to R.C. in this claim. *See McElmurray,* 501 F.3d at 1251 (explaining that facial attacks require the court to merely look at the complaint and see if the plaintiff has sufficiently alleged a basis of subject matter jurisdiction).

In the Third Amended Complaint, Plaintiff alleges that R.C. was enrolled in a Medicare Advantage plan

"managed by Hygea." R.C.'s medical expenses were "subsequently paid by Hygea" and Hygea was "financially responsible" for R.C. Hygea was charged $1,227.48. Plaintiff's assignment agreement describes Hygea expansively as operating "a Health Maintenance Organization, MSO, IPA, Medical Center, and/or is a Physician and/or otherwise ... provides or arranges for the provision of care, services, and/or supplies including medications, treatments or other procedures to persons covered under [Medicare] and other third party."

The Third Amended Complaint fails to allege facts that Hygea is either an MAO or a direct healthcare provider to R.C. in this claim. The Third Amended Complaint simply states Hygea managed the plan in which R.C. was enrolled and was also financially responsible for R.C. In the Third Amended Complaint's attached exhibits regarding R.C.'s services, Hygea is not listed anywhere as the provider of medical services to R.C. In fact, only an urgent care center appears as an apparent provider. [DE 46-3]. Additionally, Plaintiff's own assignment agreement does not describe Hygea as either an MAO or the direct healthcare provider of services to R.C. in this claim. A court may not speculate concerning the existence of standing; a plaintiff lacks standing if the complaint merely sets forth facts from which courts could imagine an injury. *See DiMaio,* 520 F.3d at 1301. Therefore, because Plaintiff has failed to allege Hygea is either an MAO or a direct healthcare provider to R.C. for this claim, Hygea has no standing to bring a claim under § 1395y(B)(3)(A).[13]

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[13] Based on the parties' filings, Hygea seeks reimbursement for an amount charged due to the terms of its private contract with an MAO called Wellcare. Thus, it

B. CLAIM 2: MMM HOLDINGS AND D.G.

In this claim, MMM Holdings is Plaintiff's original assignor. In addition to the lack of facts alleged in the Third Amended Complaint, Defendant contends that MMM Holdings is not an MAO. Because this is a factual attack on MMM Holdings' standing, the Court may consider matters outside of the pleadings to determine if MMM Holdings is in fact an MAO. *See McElmurray,* 501 F. 3d at 1251 (explaining that factual attacks allow the court to consider matters outside the pleadings, such as testimony and affidavits).

In the Third Amended Complaint, Plaintiff alleges that D.G. was enrolled in a Medicare Advantage plan "managed by" MMM Holdings. D.G.'s medical expenses were "subsequently paid" by MMM Holdings. MMM Holdings was "charged" $1,892.84. Plaintiff's assignment agreement broadly describes MMM Holdings as operating "a Health Maintenance Organization, MSO, IPA, Medical Center, and/or is a Physician and/or otherwise … provides or arranges for the provision of care, services, and/or supplies; including medications, treatments or other procedures to persons covered under [Medicare] and other third party."

The Third Amended Complaint fails to allege MMM Holdings is an MAO. Plaintiff first states

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appears Hygea was not directly injured under the MSPA but because of its relationship with Wellcare. Its claim must instead be determined by reference to the written contract. *See Provident Care Mgmt., LLC v. Wellcare Health Plans Inc.*, Case No. 16-cv-61873-BB, (S.D. Fla. Feb. 1, 2018) ("A contract provider's claims are determined entirely by reference to the written contract, not the Medicare Act.")

MMM Holdings is an MAO based in Puerto Rico in its response to the second motion to dismiss. [DE 39 at 6]. In resolving this factual issue, the Court reviewed the Centers for Medicare & Medicaid Services website, which provides an updated list of MAOs.[14] The list was most recently updated in February 2018 and MMM Holdings is not listed. However, an entity with a similar name "MMM Healthcare LLC" is listed. At the hearing on the motion, Plaintiff represented that MMM Holdings is the same entity as "MMM Healthcare." However, despite various opportunities to defeat this factual attack, Plaintiff's Third Amended Complaint fails to allege any facts or provide evidence to show that the two entities are one and the same. As previously stated, the court cannot speculate concerning the existence of standing. *See DiMaio,* 520 F.3d at 1301. Based on the Court's review, it is unclear what type of entity MMM Holdings is and whether it has any relationship to this claim or Medicare. Therefore, because MMM Holdings is not listed on the website as an MAO and the Medicare website is a source which cannot be reasonably questioned, the Court takes judicial notice that MMM Holdings is not an MAO and thus lacks standing under § 1395y(B)(3)(A). *See* Fed. R. Evid. 201.

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[14] Centers for Medicare & Medicaid Services, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/MA-Plan-Directory-Items/MA-Plan-Directory.html (last visited March 5, 2018).

C. CLAIM 3: HEALTH CARE ADVISOR SERVICES AND E.F.

In this claim, Health Care Advisor Services is Plaintiff's original assignor. Defendant contends the Third Amended Complaint fails to allege the relationship between E.F., Health Care Advisor Services, and the medical provider which treated E.F. Because this constitutes a facial attack on Health Care Advisor Services' standing, the Court will merely look to the pleadings to see if Plaintiff has sufficiently alleged whether Health Care Advisor Services is an MAO or was the direct healthcare provider to E.F. in this claim. *See McElmurray,* 501 F. 3d at 125.

In the Third Amended Complaint, Plaintiff alleges that E.F. was enrolled in a Medicare Advantage plan "managed by" Health Care Advisor Services. E.F.'s medical expenses were "subsequently charged" to Health Care Advisor Services. Health Care Advisor Services was charged $29,883.14. Plaintiff's assignment agreement describes Health Care Advisor Servicesas operating "a Health Maintenance Organization, MSO, IPA, Medical Center, and/or is a Physician and/or otherwise … provides or arranges for the provision of care, services, and/or supplies including medications, treatments or other procedures to persons covered under [Medicare] and other third party."

The Third Amended Complaint fails to allege Health Care Advisor Services is either an MAO or a direct healthcare provider to E.F. in this claim. The Third Amended Complaint simply states Health Care Advisor Services managed the plan in which E.F. was enrolled and that E.F.'s medical expenses were

charged to Health Care Advisor Services. In the attached exhibits regarding E.F.'s medical services, Health Care Advisor Services is not listed and only various hospitals, clinics, and doctors appear as providers. Additionally, Plaintiff's own assignment agreement does not describe Health Care Advisor Services as either an MAO or the direct healthcare provider of services to E.F. in this claim. Again, the Court may not speculate regarding standing. *See DiMaio,* 520 F.3d at 1301. Therefore, because Plaintiff has failed to allege Health Care Advisor Services is either an MAO or a direct healthcare provider to E.F. for this claim, Health Care Advisor Services lacks standing to bring a claim under § 1395y(B)(3)(A).

IV. CONCLUSION

Plaintiff has failed to allege that its original assignors have standing under § 1395y(B)(3)(A). Plaintiff's theory is that § 1395y(B)(3)(A), by virtue of providing a private cause of action, provides standing to "*all private parties*." However, courts have determined that § 1395y(B)(3)(A) is not a *qui tam* statute; only Medicare beneficiaries, MAOs, and providers that directly treated the Medicare beneficiaries have standing under § 1395y(B)(3)(A).

Despite four attempts to plead, and even after standing was challenged in the first motionto dismiss [DE 10], Plaintiff has still failed to allege that any of its assignors are Medicare beneficiaries, MAOs, or medical providers that directly treated the alleged Medicare beneficiaries. In fact, the four template complaints are all-encompassing and overly broad. Each complaint is saddled with an overabundance of conclusory statements obscuring any facts to support

them. The Court's role is to adjudicate the claim with which it is presented; it is not to put a complaint in a colander, shake out the excess, and see if what remains is a potential claim for a plaintiff.

Therefore, because Plaintiff has failed four times to allege facts to show standing, the Court can only assume the facts do not exist and the assignors do not have standing under § 1395y(B)(3)(A), As a result, the Court lacks subject-matter jurisdiction to hear this case. The Court need not allow an amendment when there has been "repeated failures to cure deficiencies" by amendments previously allowed. *Corsello v. Lincare, Inc.,* 428 F.3d 1008, 1014 (11th Cir. 2005) (citations omitted). Therefore, because Plaintiff has failed four times to demonstrate standing, the Court finds it is in the best interest of judicial economy to grant the motion with prejudice. Accordingly, it is

ORDERED THAT

(1) The Motion to Dismiss [DE 38] is **GRANTED WITH PREJUDICE.**

(2) All pending motions are **DENIED AS MOOT.**

(3) This case is **CLOSED.**

DONE and ORDERED in Miami, Florida, this 9th day of March, 2018.

/s/ Patricia A. Seitz
PATRICIA A. SEITZ
UNITED STATES DISTRICT JUDGE

CC: Counsel of Record

Appendix C

UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF FLORIDA
MIAMI DIVISION

CASE NO. 1:17-cv-23841-PAS

CONSOLIDATED CLASS ACTION

April 24, 2018

MSP RECOVERY CLAIMS, SERIES LLC,
a Delaware entity,
Plaintiff,

—v.—

AUTO-OWNERS INSURANCE COMPANY,
a foreign profit corporation,
Defendant.

Case No. 1:17-cv-24069-PAS

MSP RECOVERY CLAIMS, SERIES LLC,
a Delaware entity,
Plaintiff,

—v.—

AUTO-OWNERS INSURANCE COMPANY,
a foreign profit corporation,
Defendant.

Case No. 1:17-cv-24066-PAS

MSP RECOVERY CLAIMS, SERIES LLC,
a Delaware entity,
Plaintiff,

—v.—

OWNERS INSURANCE COMPANY,
a foreign profit corporation,
Defendant.

Case No. 1:17-cv-24068-PAS

MSP RECOVERY CLAIMS, SERIES LLC,
a Delaware entity,

Plaintiff,

—v.—

SOUTHERN-OWNERS INSURANCE COMPANY,
a foreign profit corporation,

Defendant.

ORDER GRANTING MOTION TO DISMISS WITH PREJUDICE

THIS MATTER is before the Court on Defendants' Motion to Dismiss Plaintiff's Consolidated Complaint. [DE 54]. In the Consolidated Complaint [DE 48], Plaintiff alleges it is entitled to reimbursement from Defendants for payments made on behalf of Medicare beneficiaries pursuant to the Medicare Secondary Payer Act (MSPA), 42 U.S.C. § 1395y(b). Defendants move to dismiss for lack of standing and for failing to state a claim. Fed. R. Civ. P. 12(b)(l), 12(b)(6). Plaintiff filed a response [DE 57] to which Defendants replied [DE 58]. Plaintiff also filed an Affidavit of Michael Keeler [DE 60] which Defendants moved to strike as an unauthorized sur-reply [DE 62].

Standing is a threshold question that the Court must address to ensure it has subject-matter jurisdiction over the claim. While the Consolidated Complaint pleads additional facts compared to the original complaints, the allegations still fail to establish Plaintiff has standing as recognized under the MSPA. Therefore, because Plaintiff fails to allege standing to sue and the Court has already provided Plaintiff with numerous opportunities[1] to properly plead its claims, the Motion to Dismiss is granted with prejudice.

I. RELEVANT BACKGROUND

Plaintiff is an entity whose business model involves obtaining assignments from Medicare Advantage Organizations, first-tier entities and downstream entities to recover reimbursement for payments made for the medical expenses of Medicare beneficiaries that should have been made by a private insurer pursuant to the Medicare Secondary Payer Act (MSPA), 42 U.S.C. § 1395y(b). [DE 48 ¶ 89]. Plaintiff filed this class action as the assignee of two entities-Health First Administrative Plans, Inc. and Verimed IPA, LLC—to seek reimbursement from Defendants pursuant to the MSPA. [DE 48 ¶¶ 14, 29]. Therefore, the Court must consider whether Health First Administrative Plans, Inc. and Verimed IPA, LLC have standing under the private cause of action in the MSPA, § 1395y(b)(3)(A).

[1] This matter involves the consolidation of four separate cases filed by Plaintiff. The operative, consolidated complaint represents Plaintiff's fourteenth attempt at pleading its claims.

A. The Medicare Secondary Payer Act (MSPA)

Congress enacted the Medicare Act in 1965 to establish a health insurance program for the elderly and disabled. At that time, Medicare paid for medical expenses even when Medicare beneficiaries were also enrolled in third-party insurance policies that covered those same costs. *See MSP Recovery, LLC v. Allstate Ins. Co.*, 835 F.3d 1351, 1354 (11th Cir. 2016). In an effort to reduce costs, Congress passed the MSPA in 1980 which made Medicare the secondary payer, rather than the primary payer, for medical services provided to its beneficiaries when they are covered for the same services by a private insurer. *See* § 1395y(b)(2). Thus, the private insurer becomes the primary payer, as defined by the statute,[2] for medical services. However, when a primary payer cannot be expected to make a payment for a service promptly, Medicare may make conditional payments. § 1395y(b)(2)(B)(i). Once notified of its responsibility for a payment, a primary payer must reimburse Medicare for any payment made within 60 days. § 1395y(b)(2)(B)(ii). In an effort to enforce this scheme, the MSPA created a private cause of action for double damages when a primary plan fails to provide payment. *See* § 1395y(b)(3)(A).

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[2] Primary payers are generally defined as a group health plan, a workmen's compensation plan, an automobile or liability insurance plan, or no-fault insurance plan. *See* § 1395y(b)(2)(A).

B. Medicare Advantage Organizations, First-Tier Entities and Downstream Entities

In 1997, Congress created Medicare Part C to give Medicare beneficiaries the option of receiving Medicare benefits through private insurers known as Medicare Advantage Organizations (MAOs). *See* 42 U.S.C. § 1395w-21. MAOs contract directly with Medicare to administer benefits for a Medicare beneficiary. *See Humana Medical Plan Inc., v. Western Heritage Ins. Co.,* 832 F.3d 1229, 1235 (11th Cir. 2016).

An MAO may then separately contract with third-parties, known as first-tier entities and downstream entities, to provide health care or administrative services to the Medicare beneficiaries in the MAO's plan.[3] *See* 42 C.F.R. § 422.2. The MAO pays first-tier entities and downstream entities certain rates for certain categories of treatments. *Tenet Healthsystem GB, Inc. v. Care Improvement Plus South Central Ins. Co.,* 875 F.3d 584, 586 (11th Cir. 2017). Plaintiff alleges these first-tier entities and downstream entities take on the "full risk" for a Medicare beneficiary's medical care. [DE 48 ¶¶ 85, 87].

C. Relevant Allegations of the Consolidated Complaint

Plaintiff as assignee[4] of two entities—Health First Administrative Plans, Inc. ("HFAP") and Verimed

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[3] First-tier entities and downstream entities include Independent Physician Associations (IPAs). [DE 48 ¶¶ 83, 87].

[4] Defendants contest the assignments made to Plaintiff. For this Order, the Court will refer to the alleged assignors as "assignors" but does not reach the issue of the legitimacy of Plaintiff's assignments.

IPA, LLC ("Verimed")—alleges Defendants are primary payers[5] which failed to perform their statutory obligation pursuant to the MSPA to reimburse Plaintiff's assignors for medical payments made on behalf of Medicare beneficiaries. [DE 48 ¶¶ 2, 4]. The relevant alleged facts as to Plaintiff's HFAP and Verimed claims are:

1. **HFAP:** As assignee of HFAP, Plaintiff brings three representative claims. Medicare beneficiaries J.L, J.W and P.G. were each enrolled in a Medicare Advantage plan issued and managed by HFAP, an MAO. [DE 48 ¶¶ 8, 35, 45]. The medical providers issued bills to HFAP for the medical expenses of J.L, J.W. and P.G. which HFAP paid. [DE 48 ¶¶ 11, 39, 49].

2. **Verimed:** As assignee of Verimed, Plaintiff brings two representative claims. Medicare beneficiaries S.H. and P.L. were each enrolled in a Medicare Advantage plan issued and managed by Optimum HealthCare, Inc. ("Optimum"), an MAO. [DE 48 ¶¶ 19, 55]. Optimum contracted with a first-tier entity, Verimed, to provide services to S.H. and P.L., in exchange for a fixed fee. [DE 48 ¶¶ 20, 56]. Under its contract with Optimum, Verimed: (1) incurred the cost of S.H.'s medical services provided by Springhill Regional Hospital and SDI Diagnostic Imaging; and (2) reimbursed Optimum for services P.L. received at Polk

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5 Defendants are allegedly primary payers because they: (1) issued no-fault insurance policies to the beneficiaries; or (2) entered into settlements with the beneficiaries. [DE 48 ¶¶ 2, 4].

County, Central Florida Imaging Associates, and Publix. [DE 48 ¶¶ 20, 26, 60; DE 48-7; DE 48-18].

Plaintiff alleges HFAP and Verimed assigned their rights to recover conditional payments made on behalf of Medicare beneficiaries. [DE 48 ¶¶ 14, 15, 29, 30]. Both assignment agreements contain identical boilerplate language describing HFAP and Verimed broadly as a "Health Maintenance Organization, Maintenance Service Organization, Independent Practice Association, Medical Center, and/or other health care organization and/or provider . . ." [DE 48-4; DE 48-8].

For each representative claim, Plaintiff contends HFAP and Verimed conditionally paid for medical services that Defendants should have paid as primary payers under the MSPA. Plaintiff seeks double damages under § 1395y(b)(3)(A), as well as a reimbursement of damages under 42 C.F.R. § 411.24(e)[6] because of Defendants' alleged failure to properly reimburse Plaintiff's assignors.

II. STANDARD OF REVIEW

Standing is the threshold question that must be addressed prior to, and independent of, the merits of a party's claim because it addresses the Court's jurisdiction to adjudicate the claim. *DiMaio v. Democratic Nat'l Comm.,* 520 F.3d 1299, 1301

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[6] Plaintiff argues that HFAP, as an MAO, has a separate right of recovery under the MSPA regulations, specifically 42 C.F.R. § 411.24(e). [DE 57 at 22]. As discussed in this Order, HFAP is not an MAO. Therefore, even if § 411.24(e) allows for a separate right of recovery for MAOs, Plaintiff does not have standing.

(11th Cir. 2008). The party invoking federal jurisdiction bears the burden of establishing standing by showing: (1) that it suffered an injury-in-fact that is (a) concrete and particularized, and (b) actual or imminent; (2) a causal connection between the injury and the conduct complained of (and not the result of the independent action of some third party not before the court); and (3) that it is likely, not merely speculative, that the injury will be redressed by a favorable decision. *Lujan v. Defs. of Wildlife,* 504 U.S. 555, 560 (1992). Plaintiff must support each element of standing in the same way as any other matter on which the plaintiff bears the burden of proof, with the manner and degree of evidence required at the successive stages of litigation. *Id.*

The Court is required to carefully examine the allegations to ascertain whether a plaintiff is entitled to an adjudication of the claims asserted. *DiMaio,* 520 F.3d at 1301. There is no standing where the Court can only imagine an injury from the facts in the complaint. *Id.* The Court should not speculate concerning standing; if a plaintiff fails to meet his burden, the Court cannot embellish a deficient allegation of injury. *Id.*

In evaluating a standing challenge, the Court must first determine if a factual or facial challenge has been raised. *Lawrence v. Dunbar,* 919 F.2d 1525, 1529 (11th Cir. 1990). A factual attack challenges the existence of jurisdiction irrespective of the pleadings, and matters outside of the pleadings such as testimony and affidavits are considered. *See McElmurray v. Consol. Gov't of August-Richmond Cnty.,* 501 F.3d 1244, 1251 (llthCir.2017). Here, Defendants make two factual attacks that: (1) HFAP is not an MAO; and (2)

Verimed was not the direct provider of medical services to the beneficiaries in these claims. [DE 55 at 5, 7]. Plaintiff maintains that HFAP is an MAO, and that Verimed was the direct provider of medical services to the beneficiaries. [DE 57 at 7, 8]. Therefore, in light of the factual attacks, the Court will examine the standing of HFAP and Verimed.

III. ANALYSIS

While Plaintiff's theory is that § 1395y(b)(3)(A) allows *any private entity* to bring a claim, the Eleventh Circuit has determined that § 1395y(b)(3)(A) is not a *qui tam* statute that authorizes any private person to sue on behalf of the government. *See Allstate,* 835 F.3d at 1363 at n.3; *see also* [DE 48 ¶ 5]. Rather, § 1395y(b)(3)(A) allows a private party to sue only where that party itself has suffered an injury under the statute. *Id.*

The statutory language creating the private cause of action states:

> 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).

§ 1395y(b)(3)(A). Because the statute is silent, courts have interpreted the meaning of "private cause of action" to identify who may assert a claim. Thus, this Court recently examined this issue in another of Plaintiff's cases. *MSP Recovery Claims, Series LLC v. ACE Am. Ins. Co.,* No. 17-CV-23749, 2018 WL 1547600, at *6 (S.D. Fl. Mar. 9, 2018).

In the Eleventh Circuit, MAOs have standing because the MSPA treats MAOs similarly as Medicare. *Humana,* 832 F.3d at 1233. Plaintiff misreads *Humana* to say MAOs have standing under the statute simply because they suffer an injury, just like any private party; thus, any private party may bring a claim. [DE 57 at 4]. However, MAOs suffer an injury because they make conditional payments, just like traditional Medicare. *Humana,* 832 F.3d at 1238. Additionally, § 1395y(b)(3)(A) is not a *qui tam* statute. *Id.* The Eleventh Circuit underscores standing is limited by indicating that MAOs are included within the *purview of parties* who may bring a private cause of action. *Humana,* 832 F.3d at 1236.

The Eleventh Circuit has also recognized that Medicare beneficiaries can bring a claim under § 1395y(b)(3)(A) for their medical costs paid by Medicare, and that health care providers that directly treated the Medicare beneficiary and were paid a reduced amount by Medicare can also sue under the statute. *See Humana,* 832 F.3d at 1229 (citing *Mich. Spine & Brain Surgeons*, *PLLC v. State Farm Mut. Auto. Ins. Co.,* 758 F.3d 787, 790 (6th Cir. 2014)); *Glover v. Liggett Group, Inc.,* 459 F.3d 1304 (11th Cir. 2006). Therefore, under § 1395y(b)(3)(A), a plaintiff must be: (1) an MAO who has made a conditional payment for health care services to a Medicare beneficiary; (2) a Medicare beneficiary whose healthcare services were paid by Medicare; or (3) a direct health care provider who has not been fully paid for services provided to a Medicare beneficiary. If a plaintiff falls into one of these categories, it then must show: (1) an injury-in-fact; (2) a causal connection between the injury and the conduct complained of;

and (3) that it is likely that the injury will be redressed favorably. *See, e.g., Lujan,* 504 U.S. at 561; *Humana,* 832 F.3d 1229; *Glover,* 459 F.3d 1304; *Mich. Spine & Brain Surgeons,* 758 F.3d 787.

In this case, Plaintiff contends HFAP is an MAO and Verimed served as the direct healthcare provider in these claims. [DE 48 ¶¶ 8, 25]. Given this is a factual attack, if Plaintiff's assignors are not within the established entities that have standing, the inquiry ends there.

A. ASSIGNOR 1: HFAP

The Consolidated Complaint alleges HFAP is an MAO that issued and administered Medicare Advantage plans to J.L, P.G., and J.W. and paid for their medical expenses. *See supra*: at 5. Defendants, on the other hand, contend HFAP is not an MAO. [DE 54 at 5]. Plaintiff's assignment agreement is unclear, broadly describing HFAP as one of many possible types of entities. *See supra* at 5-6. Because this is a factual attack, the Court may consider matters outside of the pleadings to determine if HFAP is an MAO. *See McElmurray,* 501 F.3d at 1251 (factual attacks allow the court to consider matters outside the pleadings, such as affidavits).

The Court reviewed the Centers for Medicare & Medicaid Services website, which provides an updated list of MAOs.[7] The list was most recently updated in April 2018 and HFAP is not listed. Therefore, because the Medicare website is a

[7] Centers for Medicare & Medicaid Services, https://www.cms.gov/Research-Statistics-Data-and-Systems/StatisticsTrends-and-Reports/MCRAdvPartDEnrolData/MA-Plan-Directory-Items/MA-Plan-Directory.html (last visited April 24, 2018).

source which cannot be reasonably questioned, the Court takes judicial notice that HFAP is not an MAO. *See* Fed. R. Evid. 201.

Despite Plaintiff's unauthorized sur-reply, the Court reviewed the affidavit of Michael Keeler, the Chief Operating Officer of HFAP. [DE 60-1]. Keeler states that HFAP is an entity that performs administrative functions on behalf of another entity, "Health First Health Plans, Inc." It is Health First Health Plans, Inc. that contracts directly with Medicare and is an MAO.[8] Thus, Plaintiff's sworn affidavit contradicts its own repeated allegations that HFAP "is an MAO"—an argument it belabored in its response.[9] [DE 57 at 8].

Through Keeler's affidavit, Plaintiff appears to argue that HFAP can step in the shoes of Health First Health Plans, Inc., an MAO, to bring this claim because HFAP has the "authority to manage and act on behalf of Health First Health Plans, Inc." [DE 60-1]. The Court's review of the attached "Administrative and Financial Management Agreement" shows that HFAP only provides "administrative, management, network access, and financial services."[10] HFAP is simply a contractor

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[8] *Id.*

[9] The status of HFAP is easily ascertainable on the Medicare website. Plaintiff's counsel is to remember its professional duty of candor to the Court to avoid future disciplinary issues.

[10] Services provided by HFAP include: strategic planning, consultation, coordination of benefits, financial consultation and oversight of the assets, booking, information systems support, access to HFAP's networks, and other services that may be reasonably required. [DE 60-1].

to provide administrative and financial management services. Nothing in the agreement demonstrates that HFAP is contracted to pursue claims under § 1395y(b)(3)(A).

However, *even if* HFAP contracted with Health First Health Plans, Inc. to pursue claims under § 1395y(b)(3)(A), a contract for services is not an assignment of rights. HFAP cannot assign rights to Plaintiff that were not assigned to it in the first place. An assignment requires a transfer of all the interests and rights to the "thing" assigned. *MDS Inc. v. Rad Source Technologies, Inc.,* 720 F.3d 833 (11th Cir. 2013) (citations omitted). Here, the agreement Keeler provided is simply a contract for services, not an assignment. Thus, HFAP cannot assign any rights Health First Health Plans, Inc. may have under § 1395y(b)(3)(A) to Plaintiff.

Therefore, based on the Medicare website and the record evidence, the Court finds that HFAP is not an MAO. HFAP has also not been assigned any rights by Health First Health Plans, Inc., to pursue claims under § 1395y(b)(3)(A). Therefore, HFAP lacks standing under § 1395y(b)(3)(A).

A. ASSIGNOR 2: VERIMED

Plaintiff asserts that Verimed served as the direct healthcare provider to S.H. and P.L. by paying for their medical expenses. [DE 48 ¶¶ 21, 57]. On the contrary, Defendants contend that Verimed was not the direct provider of S.H.'s and P.L.'s medical services in these claims. [DE 54 at 4]. Plaintiff's assignment agreement describes Verimed broadly and does not clarify whether Verimed was the direct healthcare provider to S.H.

and P.L. *See supra* at 5-6. Because this is a factual attack on Verimed's standing, the Court will resolve the dispute and determine if Verimed was the direct medical provider of S.H.'s and P.L.'s medical services. *See McElmurray,* 501 F.3d at 1251.

1. Verimed and S.H.

The Consolidated Complaint alleges that medical expenses for S.H. were "incurred" by Verimed. [DE 48 ¶ 26]. Plaintiff's exhibit shows that S.H. received services at Springhill Regional Hospital and SDI Diagnostic. [DE 48-7]. Verimed is not listed as a provider and the Consolidated Complaint does not allege whether there is any relationship between Verimed and the providers in the exhibit. Thus, it is clear Verimed did not provide any treatment to S.H.

Plaintiff artfully expands the term "provider" to include anyone who pays for services. [DE 48 125]. By doing so, Plaintiff attempts to shoehorn Verimed to fit the *Ace* test where direct providers that *treated* the Medicare beneficiary have standing under § 1395y(b)(3)(A). *See Ace,* 2018 WL 1547600, at *5 (citing *Mich. Spine & Brain Surgeons,* 758 F. 3d at 790). In *Ace,* the Court relied on *Michigan Spine & Brain Surgeons,* 758 F.3d at 790, where the plaintiff was a provider who directly treated a Medicare beneficiary and received a reduced payment from Medicare. Here, that is not the case. Verimed did not provide any treatment services to S.H. and no facts demonstrate any relationship between Verimed and Springhill Regional Hospital and SDI Diagnostic. [DE 48 ¶ 26].

Therefore, the Court finds that Verimed was not the direct healthcare provider that treated S.H. and lacks standing under § 1395y(b)(3)(A).

2. Verimed and P.L.

Plaintiff alleges that Verimed served as a medical provider and reimbursed Optimum for P.L.'s medical expenses pursuant to its agreement.[11] [DE 48 ¶¶ 60, 61]. However, a review of Plaintiff's exhibit shows that P.L. received services at Polk County, Central Florida Imaging Associates, and Publix Pharmacy. [DE 48-18]. Verimed is not listed as a provider to P.L. and there are no facts alleged to illustrate if there is any relationship between the providers listed and Verimed. Thus, because Plaintiff has failed to allege that Verimed was the direct provider of treatment services to P.L., Verimed lacks standing to bring this claim under § 1395y(b)(3)(A).

IV. CONCLUSION

Plaintiff has failed to allege its original assignors have standing under § 1395y(b)(3)(A). Plaintiff's theory is that § 1395y(b)(3)(A), by virtue of providing a private cause of action,

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[11] Verimed apparently seeks reimbursement for a payment made pursuant to Optimum under the terms of its private capitation contract. Thus, if Verimed suffered a loss, it was a result of its contractual relationship with Optimum. Its claim must instead be determined by reference to the written contract. *See Provident Care Mgmt., LLC v. WellCare Health Plans Inc.*, Case No. 16-CV-61873-BB, (S.D. Fla. Feb. 1, 2018) ("A contract provider's claims are determined entirely by reference to the written contract, not the Medicare Act.")

provides standing to all private parties. However, § 1395y(b)(3)(A) is not a *qui tam* statute; only Medicare beneficiaries, MAOs, and providers that directly treated the Medicare beneficiaries have standing to bring a claim under § 1395y(b)(3)(A).

Despite its fourteenth attempt at pleading its claims, Plaintiff has still failed to allege that any of its assignors are Medicare beneficiaries, MAOs or medical providers that directly treated the Medicare beneficiaries in these claims. As the evidence shows, this fatal defect cannot be cured. Plaintiff's assignors simply are not within the purview of parties who can bring a claim under § 1395y(b)(3)(A).

Therefore, because Plaintiff's own evidence confirms that it cannot allege facts to show standing, the Court lacks subject-matter jurisdiction to hear this case. The Court need not allow an amendment when there has been "repeated failures to cure deficiencies" by previously allowed amendments. *Corsello v. Lincare, Inc.,* 428 F.3d 1008, 1014 (11th Cir. 2005) (citations omitted). Therefore, the Court finds it is in the best interest of judicial economy to grant the motion with prejudice. Accordingly, it is

ORDERED THAT

(1) The Motion to Dismiss [DE 54] is **GRANTED WITH PREJUDICE.**

(2) All pending motions are **DENIED AS MOOT.**

(3) This case is **CLOSED.**

DONE and ORDERED in Miami, Florida, this 24th day of April, 2018.

/s/ Patricia A. Seitz
PATRICIA A. SEITZ
UNITED STATES DISTRICT JUDGE

CC: Counsel of Record

Appendix D

UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF FLORIDA
MIAMI DIVISION

CASE NO. 17-CV-23749

May 18, 2018

CLASS ACTION

MSP RECOVERY CLAIMS, SERIES LLC,
a Delaware entity,
Plaintiff,

—v.—

ACE AMERICAN INSURANCE COMPANY,
a foreign profit corporation,
Defendant.

ORDER DENYING MOTION FOR RECONSIDERATION

THIS MATTER is before the Court on Plaintiff's Motion for Rehearing of the Court's Order Granting Motion to Dismiss [DE 56], arguing that it seeks to correct a clear error of law and fact. Plaintiff seeks reconsideration of the Court's Order on behalf of two of its assignors, Hygea Holding Corps ("Hygea") and Health Care Advisor Services ("HCAS").[1] Defendant responded [DE 58] and Plaintiff replied [DE 61]. The Court will deny the motion because: (1) Plaintiff is rearguing its earlier position that misreads and misquotes binding precedent as to the private parties that have standing under 42 U.S.C. § 1395y(b)(3)(A); and (2) Plaintiff's assignors are neither Medicare Advantage Organizations (MAOs) or direct healthcare providers to the Medicare beneficiaries in this claim.

I. Reconsideration Standard

Reconsideration of an order "is an extraordinary remedy to be employed sparingly." *Burger King Corp. v. Ashland Equities, Inc.*, 181 F. Supp. 2d 1366, 1370 (S.D. Fla. 2002). There are three grounds for reconsideration: (1) an intervening change in controlling law; (2) the availability of new evidence; and (3) the need to correct clear error or prevent manifest injustice. *Id.* at 1369. In order to demonstrate clear error, a plaintiff must do more than simply restate previous arguments.

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[1] Plaintiff filed a Notice [DE 57] withdrawing the representative claim about a third assignor, MMM Holdings LLC.

Bautista v. Cruise Ships Catering & Service Intern'l, NV, 350 F. Supp. 2d 987,992 (S.D. Fla. 2003).

> It is an improper use of the motion to reconsider to ask the Court to rethink what the Court … already thought through—rightly or wrongly … The motion to reconsider would be appropriate where, for example, the Court has patently misunderstood a party, or has made a decision outside the adversarial issues presented to the Court by the parties, or has made an error not of reasoning but of apprehension.

Z.K. Marine Inc. v. MIV Archigetis, 808 F. Supp. 1561, 1563 (S.D. Fla. 1992) (citations omitted and brackets omitted). Thus, a "motion for reconsideration cannot be used to re-litigate old matters, raise argument or present evidence that could have been raised prior to the entry of the [challenged order]. This prohibition includes new arguments that were previously available, but not pressed." *Wilchombe v. Teevee Toons, Inc.*, 555 F.3d 949, 957 (11th Cir. 2009) (internal quotations and citations omitted). Finally, when a litigant simply thinks a district court's ruling is wrong, the proper remedy is to appeal the ruling, not to seek reconsideration. *Jacobs v. Tempur-Pedic International, Inc.*, 626 F.3d 1327, 1344 (11th Cir. 2010).

II. Discussion

The principal thrust of Plaintiff's argument is that the Court did not adopt its interpretation of *Humana Medical Plan Inc., v. Western Heritage Ins. Co.*, 832 F.3d 1229, 1235 (11th Cir. 2016).

However, Plaintiff previously raised this argument and the Court did not find it had legal merit. [DE 39 at 9]. If Plaintiff thinks the Court's ruling is wrong, the proper course of action is to appeal the ruling.

As to the factual error prong of its argument, Plaintiff's Reply contradicts both the Motion and the Third Amended Complaint which admit that Hygea and HCAS reimbursed MAOs for treatment given to these Medicare beneficiaries. [DE 56 at 13]. Although Hygea and HCAS generally serve as medical providers, they did not provide medical services to the Medicare beneficiaries in this case.[2] [DE 46-1; DE 46-3]. Now, in an effort to get around its own alleged facts, Plaintiff's Reply claims that HCAS directly provided treatment services and refers to unclear statements made by counsel at a hearing.[3] [DE 61 at 5]. Overlooking this factual flip-flop, the Court is only required to look at the allegations in the Third Amended Complaint when standing is under a facial attack. *See McElmurray v. Consol. Gov't of Augusta-Richmond Cty.*, 501 F.3d 1244, 1251 (11th Cir. 2007). There are no allegations that HCAS directly treated the Medicare beneficiary in this claim and thus no factual error was made.

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[2] In its Order [DE 54], the Court relied on *Michigan Spine & Brain Surgeons, PLLC v. State Farm Mut. Auto. Ins. Co.*, 758 F.3d 787, 790 (6th Cir. 2014), where the plaintiff was a provider that directly treated a Medicare beneficiary. Here, that is not the case.

[3] Even if the Court could consider evidence outside the Third Amended Complaint, arguments made by counsel are not evidence. *See United States v. Granville*, 716 F .2d 819, 822 (11th Cir. 1983).

Therefore, because Plaintiff is attempting to re-litigate matters that have already been raised prior to the entry of the Court's Order, and because the only factual error is one that Plaintiff is inappropriately trying to create, it is ORDERED THAT Plaintiff's Motion for Reconsideration [DE 56] is **DENIED**.

DONE and ORDERED in Miami, Florida, this 18th day of May, 2018.

/s/ Patricia A. Seitz
PATRICIA A. SEITZ
UNITED STATES DISTRICT JUDGE

CC: Counsel of Record

Appendix E

UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF FLORIDA

CASE NO. 17-23628-CIV-WILLIAMS

June 19, 2018

MSP RECOVERY CLAIMS, SERIES LLC,

Plaintiff,

—v.—

TRAVELERS CASUALTY AND SURETY CO.,

Defendant.

ORDER

THIS MATTER is before the Court on Defendant Travelers Casualty and Surety, Company's ("Defendant") motion to dismiss Plaintiff MSP Recovery Claims, Series LLC's ("Plaintiff") amended complaint for lack of subject matter jurisdiction and failure to state a claim (DE 26), to which Plaintiff filed a response in opposition (DE 35), and to which Defendant filed a reply (DE 38). For the reasons set

forth below, Defendant's motion to dismiss (DE 26) is **GRANTED WITH PREJUDICE**[1] and this case is **DISMISSED** for lack of subject matter jurisdiction.

I. BACKGROUND

This lawsuit arises under the Medicare Secondary Payer ("MSP") provisions of the Medicare Act, 42 U.S.C. § 1395y *et seq*. Plaintiff's class action complaint against Defendant is one of numerous similar actions filed by Plaintiff, and other related entities, in courts across the country.[2] Plaintiff is

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[1] As the Court in *MSP Recovery Claims, Series LLC v. Auto-Owners Ins. Co.*, No. 17-23841-PAS, 2018 WL 1953861 (S.D. Fla. Apr. 25, 2018) noted, "[s]tanding is a threshold question that the Court must address to ensure it has subject-matter jurisdiction over the claim. While the Consolidated Complaint pleads additional facts compared to the original complaints, the allegations still fail to establish Plaintiff has standing as recognized under the MSPA." *Auto Owners*, 2018 WL 1953861, at *1. The facts of this case are nearly identical to those in *Auto-Owners*, including the fact that Plaintiff—which was one of the plaintiffs in *Auto-Owners*—has had multiple opportunities to mend its complaint. Therefore, because Plaintiff fails to allege standing to sue and this Court—and other courts in this District—has already provided Plaintiff with multiple opportunities to properly plead its claims, the motion to dismiss is granted with prejudice.

[2] *See, e.g., MAO-MSO Recovery II, LLC v. Am. Family Mut. Ins.* Co., No. 17-CV-175-JDP, 2018 WL 835160, at *1 (W.D. Wis. Feb. 12, 2018); *MAO-MSO Recovery II, LLC v. Gov't Employees Ins.* Co., No. PWG-17-711, 2018 WL 999920, at *7 (D. Md. Feb. 21, 2018); *MAO-MSO Recovery II, LLC v. USAA Gas. Insurance Co.*, No. 17-20946-CIV, 2018 WL 295527, at *1 (S.D. Fla. Jan. 3, 2018); *MAO-MSO Recovery II, LLC v. Boehringer Ingelheim Pharm., Inc.,* 281 F. Supp. 3d 1309 (S.D. Fla. 2017); *MAO-MSO Recovery II, LLC v. Mercury Gen.,* No. CV 17-25q7-AB (FFMX), 2017 WL 5086293, at *1 (C.D. Cal. Nov. 2, 2017);

"an entity whose business model involves obtaining assignments from Medicare Advantage Organizations [("MAOs")], first-tier entities, and downstream entities to recover reimbursement for payments made for the medical expenses of Medicare beneficiaries that should have been made by a private insurer pursuant to the Medicare Secondary Payer Act (MSPA)." *Auto-Owners,* 2018 WL 1953861, at *1 (citing 42 U.S.C. § 1395y(b)). Plaintiff filed this class action as the assignee of Health First Administrative Plans, Inc. to seek reimbursement from Defendant pursuant to the MSPA.[3] Thus, as the Court in *Auto-Owners* noted, the threshold issue this Court must consider is "whether Health First Administrative Plans, Inc. has standing under the private cause of action in the MSPA,

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MAO-MSO Recovery II, LLC v. Farmers Ins. Exch., No. 217CV02522CASPLAX, 2017 WL 5634097, at *1 (C.D. Cal. Nov. 20, 2017); *MSPA Claims 1, LLC v. Covington Specialty Ins. Co.*, 212 F. Supp. 3d 1250 (S.D. Fla. 2016), *appeal dismissed*, No.17-11273-JJ, 2017 WL 4386453 (11th Cir. Sept.19, 2017); *MSPA Claims 1, LLC v. Tower Hill Prime Ins. Co.*, No. 1:16-CV-20459-KMM, 2016 WL 4157592, at *1 (S.D. Fla. Aug. 3, 2016), *reconsideration denied*, No. 1:16-CV-20459-KMM, 2017 WL 1289321 (S.D. Fla. Mar. 31, 2017), *appeal dismissed* (Sept. 19, 2017); *MSPA Claims 1, LLC v. Liberty Mut. Fire Ins. Co.*, No. 16-20271-CIV, 2016 WL 3751481, at *1 (S.D. Fla. July 14, 2016); *MSP Recovery, LLC v. Progressive Select Ins. Co.*, 96 F. Supp. 3d 1356 (S.D. Fla. 2015).

[3] Although, as Defendant notes in its motion to dismiss, Plaintiff's amended complaint references only "unidentified Medicare Advantage Organizations," the Recovery Agreement submitted by Plaintiff (DE 31, at 1) makes it clear that the purported MAO that assigned its rights to Plaintiff is Health First Administrative Plans, Inc., a Florida corporation that was also the purported MAO assignor in *MSP Recovery Claims, Series LLC v. Auto-Owners Ins. Co.*, No. 17-23841-PAS, 2018 WL 1953861 (S.D. Fla. Apr. 25, 2018).

§ 1395y(b)(3)(A)." *Auto-Owners,* 2018 WL 1953861, at *1. Here, Defendant argues that Plaintiff lacks standing to bring this case because Plaintiff has not adequately pied, or actually suffered, an injury in fact. To support this argument, Defendant contends that Plaintiff has not pied a valid assignment of claims against Defendant by an MAO to Plaintiff. (DE 26, at 4). Defendant also presents several other arguments as to why Plaintiff has failed to state a claim under Fed. R. Civ. P. 12(b)(6) but, because this case must be dismissed for, lack of subject matter jurisdiction, we need not address the merits of Defendant's other arguments.

II. LEGAL STANDARD

a. Subject Matter Jurisdiction

A challenge to subject matter jurisdiction under Rule 12(b)(1) of the Federal Rules of Civil Procedure may be presented as either a facial or factual attack. *McElmurray v. Consol. Gov't of August-Richmond Cty.,* 501 F.3d 1244, 1251 (11th Cir. 2007). Facial attacks challenge subject matter jurisdiction based on the allegations in the complaint, which the district court takes as true when considering the motion. *Lawrence v. Dunbar,* 919 F.2d 1525, 1529 (11th Cir. 1990). In contrast, factual attacks challenge the existence of subject matter jurisdiction in fact, and in such cases "no presumptive truthfulness attaches to plaintiff's allegations." *Id.* The Eleventh Circuit has held that "the party invoking the court's jurisdiction bears the burden of proving, by a preponderance of the evidence, facts supporting the existence of federal jurisdiction." *McCormick v. Aderholt,* 293 F.3d 1254, 1257 (11th Cir. 2002). Because standing is "not [a] mere

pleading requirement[ ] but rather an indispensable part of the plaintiff's case, [it] must be supported in the same way as any other matter on which the plaintiff bears the burden of proof, *i.e.,* with the manner and degree of evidence required at the successive stages of the litigation." *Lujan v. Defs. of Wildlife,* 504 U.S. 555, 559-60 (1992).

Article III standing has three elements: "[t]he plaintiff must have (1) suffered an injury in fact, (2) that is fairly traceable to the challenged conduct of the defendant, and (3) that is likely to be redressed by a favorable judicial decision." *Spokeo, Inc. v. Robins,* 136 S. Ct. 1540, 1547 (2016), *as revised* (May 24, 2016) (citing *Lujan,* 504 U.S. at 560-61)). To satisfy the first "injury" element, the plaintiff must demonstrate that the injury affects the plaintiff in a personal and individual way. *Id.* at 1548; *Valley Forge Christian College v. Americans United for Separation of Church and State, Inc.,* 454 U.S. 464, 472 (1982) (standing requires that the plaintiff "personally has suffered some actual or threatened injury"). Here, to demonstrate injury in fact, Plaintiff must plead facts showing (1) that the MAO itself suffered an injury in fact *(i.e.,* the MAO was not reimbursed for its enrollees' medical expenses by defendant who was responsible for primary payment under the MSPA); and (2) that an MAO validly assigned its rights of recovery to Plaintiff. *See MAO-MSO Recovery II, LLC v. Boehringer Ingelheim Pharm., Inc.,* No. 1:17-CV-21996-UU, 2017 WL 4682335, at *4 (S.D. Fla. Oct. 10, 2017).

b.The Medicare Secondary Payer Act ("MSPA") and Medicare Advantage Organizations

The Court in *Auto-Owners* set forth a thorough history of the MSPA:

> Congress enacted the Medicare Act in 1965 to establish a health insurance program for the elderly and disabled. At that time, Medicare paid for medical expenses even when Medicare beneficiaries were also enrolled in third-party insurance policies that covered those same costs. *See MSP Recovery, LLC v. Allstate Ins. Co.*, 835 F.3d 1351, 1354 (11th Cir. 2016). In an effort to reduce costs, Congress passed the MSPA in 1980 which made Medicare the secondary payer, rather than the primary payer, for medical services provided to its beneficiaries when they are covered for the same services by a private insurer. See § 1395y(b)(2). Thus, the private insurer becomes the primary payer, as defined by the statute, for medical services. However, when a primary payer cannot be expected to make a payment for a service promptly, Medicare may make conditional payments. § 1395y(b)(2)(B)(i). Once notified of its responsibility for a payment, a primary payer must reimburse Medicare for any payment made within 60 days. § 1395y(b)(2)(B)(ii). In an effort to enforce this scheme, the MSPA created a private cause of action for double damages when a primary plan fails to provide payment. See § 1395y(b)(3)(A).

Auto-Owners, 2018 WL 1953861, at *1. Further, Part C of the Medicare Act allows Medicare enrollees to obtain their Medicare benefits through private insurers, called Medicare Advantage Organizations ("MAOs"), instead of receiving direct benefits from the government under Parts A and B. 42 U.S.C. § 1395w-21(a); *see also MAO-MSO Recovery II, LLC, et al., v. State Farm Mutual Automobile Ins. Co.*, No. 1:17-CV-01541-JBM-JEH, 2018 WL 2392827, at *2 (C.D. Ill. May 25, 2018). "The MSP makes Medicare insurance secondary to any 'primary plan' obligated to pay a Medicare recipient's medical expenses, including a third-party tortfeasor's automobile insurance." *State Farm,* 2018 WL 2392827, at *2 (quoting *Parra v. PacifiCare of Ariz., Inc.,* 715 F.3d 1146, 1152 (9th Cir. 2013) (citing § 1395y(b)(2)(A))). "In other words, Medicare serves as a back-up insurance plan to cover that which is not paid for by a primary insurance plan." *State Farm,* 2018 WL 2392827, at *2 (quoting *Caldera v. Ins. Co. of the State of Pa.,* 716 F.3d 861, 863 (5th Cir. 2013)). The Medicare Act provides that Medicare cannot pay medical expenses when "payment has been made or can reasonably be expected to be made under … an automobile or liability insurance policy or plan … or no fault insurance." *Id.* (quoting § 1395y(b)(2)(A)(ii)). Section 1395y(b)(3)(A) of the MSPA provides a private cause of action against primary payers who do not reimburse secondary payers for conditional payments made to Medicare beneficiaries. *State Farm,* 2018 WL 2392827, at *3. The Eleventh and Third Circuits have held that subsection (3)(A) permits an MAO to sue a primary plan that fails to reimburse an MAO's secondary payment. *See Humana Med. Plan, Inc. v. W. Heritage Ins. Co.*, 832

F.3d 1229, 1238 (11th Cir. 2016); *In re Avandia Mktg., Sales Practices & Prods. Liab. Litig.,* 685 F.3d 353, 355 (3d Cir. 2012). In the wake of those decisions, "district courts around the country have followed suit." *State Farm,* 2018 WL 2392827, at *3 (citing *Humana Ins. Co. v. Paris Blank LLP,* 187 F. Supp. 3d 676, 681 (E.D. Va. 2016); *Humana Med. Plan, Inc. v. W. Heritage Ins. Co.*, 94 F. Supp. 3d 1285, 1290-91 (S.D. Fla. 2015); *Cariten Health Plan, Inc. v. MidCentury Ins. Co.*, No. 14-476, 2015 WL 5449221, *5-6 (E.D. Tenn. Sept. 1, 2015); *Collins v. Wellcare Healthcare Plans, Inc.,* 73 F. Supp. 3d 653, 664-65 (E.D. La. 2014); *Humana Ins. Co. v. Farmers Tex. Cnty. Mut. Ins. Co.*, 95 F. Supp. 3d 983, 986 (W.D. Tex. 2014)).

III. ANALYSIS

Plaintiff is not an MAO. Rather, as in other cases involving the same Plaintiff and the same cause of action, Plaintiff alleges that it has obtained claims for reimbursement via assignment from an MAO, Health First Administrative Plans, Inc. ("HFAP"). Plaintiff alleges that Defendant is a primary payer that failed to perform its statutory obligation pursuant to the MSPA to reimburse Plaintiff's assignor for medical payments made on behalf of Medicare beneficiaries. (DE 20, at 4). In order to demonstrate a valid assignment, and therefore a valid right to pursue these claims, Plaintiff provided the Court with two documents: a "Recovery Agreement," dated April 28, 2016, between "Health First Administrative Plans" ("HFAP") and "MSP Recovery, LLC." (DE 31, at 1). These documents are similar, if not identical, to the documents provided in

similar cases, including *Auto-Owners,* 2018 WL 1953861 and *State Farm,* 2018 WL 2392827.

Defendant argues that this case should be dismissed because "Plaintiff, who claims to be the alleged assignee of HFAP pursuant to the exact same assignment agreement analyzed by the Courts in *Auto-Owners* and *State Farm,* has similarly not demonstrated that HFAP is an MAO, [thus,] Plaintiff does not have standing to maintain a cause of action under the MSPA." (DE 53, at 2). The Court agrees with Defendant.

In *State Farm,* the Court noted that the "Plaintiffs have led the Court to believe ... that HFAP is an MAO" and that the "Recovery Agreement purports to assign all of HFAP's rights of recovery under the MSP provisions to Plaintiff." *State Farm,* 2018 WL 2392827, at *3. As in *State Farm,* Plaintiff here has provided the Court with a document titled "Assignment," dated June 12, 2017, wherein an entity called MSP Recovery, LLC assigns all of its rights from HFAP to "Series 16-05-456 LLC, a series of MSP Recovery Claims, Series LLC." (DE 31, at 14). The *State Farm* Court went on to explain that "MSP Recovery Claims, Series, LLC is the only Plaintiff that has any alleged 'rights' to vindicate to support standing in this case." *State Farm,* 2018 WL 2392827, at *3. Plaintiff in this case is, in fact, MSP Recovery Claims, Series, LLC. Further, Plaintiff's amended complaint is nearly identical to the consolidated complaint that was dismissed in *Auto-Owners,* a similar action by Plaintiff and its affiliated entities in this District. In *Auto-Owners,* the Court held that HFAP is not in fact an MAO and therefore had no rights under the MSP provisions to assign

MSP Recovery Claims, Series, LLC. (the same Plaintiff in this case). *Auto-Owners,* 2018 WL 1953861, at *5.

In *Auto-Owners,* the Court stated that "[w]hile Plaintiff's theory is that § 1395y(b)(3)(A) allows *any private entity* to bring a claim, the Eleventh Circuit has determined that § 1395y(b)(3)(A) is not a *qui tam* statute that authorizes any private person to sue on behalf of the government." *Auto-Owners,* 2018 WL 1953861, at *3 (citing *Allstate,* 835 F.3d at 1363 at n.3). "Rather, § 1395y(b)(3)(A) allows a private party to sue only where that party itself has suffered an injury under the statute." *Id.* The statutory language creating the private cause of action states:

> 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).

§ 1395y(b)(3)(A). "Because the statute is silent, courts have interpreted the meaning of "private cause of action" to identify who may assert a claim. *Auto-Owners,* 2018 WL 1953861, at *4. The *Auto-Owners* Court interpreted applicable Eleventh Circuit precedent and held that to have standing to bring a claim under Section 1395y(b)(3)(A) of the MSPA, "a plaintiff must be: (1) an MAO who has made a conditional payment for health care services to a Medicare beneficiary; (2) a Medicare beneficiary whose healthcare services were paid by Medicare; or (3) a direct health care provider who has not been

fully paid for services provided to a Medicare beneficiary." *Id.* Further, "[i]f a plaintiff falls into one of these categories, it then must show: (1) an injury-in-fact; (2) a causal connection between the injury and the conduct complained of; and (3) that it is likely that the injury will be redressed favorably." *Auto-Owners,* 2018 WL 1953861, at .*4 (citing *Lujan,* 504 U.S. at 561; *Humana,* 832 F.3d 1229; *Glover v. Liggett Group, Inc.*, 459 F.3d 1304 (11th Cir. 2006); *Mich. Spine & Brain Surgeons, PLLC v. State Farm Mut. Auto. Ins. Co.*, 758 F.3d 787, 790 (6th Cir. 2014)). The *State Farm* Court relied on the reasoning from *Auto-Owners* to find, as the Court in *Auto-Owners* found, that "because HFAP has not been assigned any rights from [a separate MAO] to pursue claims under § 1395y(b)(3)(A), Plaintiff MSP Recovery Claims, Series, LLC also has no rights to pursue claims under § 1395y(b)(3)(A)." *State Farm,* 2018 WL 2392827, at *6.

Here, as in *Auto-Owners* and *State Farm,* Plaintiff has failed to allege that its original assignor, HFAP, has standing under § 1395y(b)(3)(A). Plaintiff has also failed to allege that HFAP, or any other unidentified assignors, are Medicare beneficiaries, MAOs or medical providers that directly treated the Medicare beneficiaries in these claims. As noted in *Auto-Owners,* this is a "fatal defect" because "Plaintiff's assignors simply are not within the purview of parties who can bring a claim under § 1395y(b)(3)(A)." *AutoOwners,* 2018 WL 1953861, at *6. Because HFAP—the entity that allegedly assigned its rights to Plaintiff—is not an MAO, and thus lacks standing to bring a private cause of action under the MSPA, Plaintiff also lacks standing to bring a claim

under Section 1395y(b)(3)(A) based on the purported assignment of rights from HFAP.[4]

IV. CONCLUSION

For the reasons set forth above, the Court finds that Plaintiff has failed to establish subject matter jurisdiction. Federal Rule of Civil Procedure 12(h)(3) requires that "[i]f the court determines at any time that it lacks subject-matter jurisdiction, the court must dismiss the action." Fed. R. Civ. P. 12(h)(3). Accordingly, it is **ORDERED AND ADJUDGED** that Defendant's motion to dismiss (DE 26) is **GRANTED** and this action is **DISMISSED WITH PREJUDICE** for lack of subject matter jurisdiction.[5]

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[4] The Court notes that, while it will not *sua sponte* order Plaintiff to show cause regarding the imposition of sanctions in this matter at this time, the Court in *State Farm* ordered that because plaintiffs' amended complaint was "knowingly inaccurate," and "there is absolutely no basis in law to support the argument that HFAP is an MAO," plaintiffs were required to show cause as to why sanctions should not be imposed under Fed. R. Civ. P. 11. *State Farm*, 2018 WL 2392827, at *7. Instead, Plaintiff here is reminded of its duty of candor to the court and its obligation to comply with the requirements of Rule 11.

[5] As the Court in *State Farm* noted, "typically, when cases are dismissed for lack of subject matter jurisdiction, dismissal is without prejudice." *State Farm*, 2018 WL 2392827, at *8, n.7. However, as in *State Farm*, the Court here cannot "perceive how Plaintiffs could amend their allegations in good faith to overcome the lack of subject matter jurisdiction." *Id.* Further, the Eleventh Circuit has held that courts "need not allow an amendment when there has been 'repeated failures to cure deficiencies' by previously allowed amendments." See *Auto-Owners*, 2018 WL 1953861, at *6 (quoting *Corsello v. Lincare, Inc.*, 428 F.3d 1008, 1014 (11th Cir. 2005)).

All pending motions are **DENIED AS MOOT.** The Clerk is directed to **CLOSE** this case.

DONE AND ORDERED in Chambers in Miami, Florida, this 19th day of June, 2018.

/s/ Kathleen M. Williams
KATHLEEN M. WILLIAMS
UNITED STATES DISTRICT JUDGE

Appendix F

UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

Filed November 9, 2020

No. 18-12139-GG

D.C. Docket No. 1:17-cv-23749-PAS

MSP RECOVERY CLAIMS, SERIES LLC,

Plaintiff-Appellant,

—versus—

ACE AMERICAN INSURANCE COMPANY,

Defendant-Appellee.

No. 18-12149-GG

D.C. Docket No. 1:17-cv-23841-PAS

1:17-cv-23841-PAS

MSP RECOVERY CLAIMS, SERIES LLC,
a Delaware entity,

Plaintiff-Appellant,

—versus—

AUTO-OWNERS INSURANCE COMPANY,
a foreign profit corporation,

Defendant-Appellee.

1:17-cv-24066-PAS

MSP RECOVERY CLAIMS, SERIES LLC,
a Delaware entity,

Plaintiff-Appellant,

—versus—

OWNERS INSURANCE COMPANY,
a foreign profit corporation,

Defendant-Appellee.

1:17-cv-24068-PAS

MSP RECOVERY CLAIMS, SERIES LLC,
a Delaware entity,

Plaintiff-Appellant,

—versus—

SOUTHERN-OWNERS INSURANCE COMPANY,
a foreign profit corporation,

Defendant-Appellee.

1:17-cv-24069-PAS

MSP RECOVERY CLAIMS, SERIES LLC,
a Delaware entity,

Plaintiff-Appellant,

—versus—

AUTO-OWNERS INSURANCE COMPANY,
a foreign profit corporation,

Defendant-Appellee.

No. 18-13049-GG

D.C. Docket No. 1:17-cv-23628-KMW

MSP RECOVERY CLAIMS, SERIES LLC,
a Delaware entity,

Plaintiff-Appellant,

—versus—

TRAVELERS CASUALTY AND SURETY COMPANY,
a foreign profit corporation,

Defendant-Appellee.

No. 18-13312-GG

D.C. Docket No. 1:17-cv-22539-KMW

MSP CLAIMS 1, LLC,
a Florida profit corporation,

Plaintiff-Appellant,

—versus—

LIBERTY MUTUAL FIRE INSURANCE COMPANY,
a Foreign profit corporation,

Defendant-Appellee.

Appeals from the United States District Court
for the Southern District of Florida

ON PETITION(S) FOR REHEARING AND PETITION(S) FOR REHEARING EN BANC

BEFORE: JORDAN, JILL PRYOR, and WALKER,* Circuit Judges.

PER CURIAM:

The Petitions for Rehearing En Banc are DENIED, no judge in regular active service on the Court having requested that the Court be polled on rehearing en banc. (FRAP 35) The Petitions for Rehearing En Banc are also treated as Petitions for Rehearing before the panel and are DENIED. (FRAP 35, IOP2)

ORD-42

* The Honorable John M. Walker, Jr., Circuit Judge for the United States Court of Appeals for the Second Circuit, sitting by designation.

Appendix G

42 U.S.C.A. § 1395y

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

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Effective: December 11, 2020

(a) Items or services specifically excluded

Notwithstanding any other provision of this subchapter, no payment may be made under part A or part B for any expenses incurred for items or services—

(1)(A) which, except for items and services described in a succeeding subparagraph or additional preventive services (as described in section 1395x(ddd)(1) of this title), are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member,

(B) in the case of items and services described in section 1395x(s)(10) of this title, which are not reasonable and necessary for the prevention of illness,

(C) in the case of hospice care, which are not reasonable and necessary for the palliation or management of terminal illness,

(D) in the case of clinical care items and services provided with the concurrence of the Secretary and with respect to research and experimentation conducted by, or under contract with, the Medicare Payment Advisory Commission or the Secretary, which are not reasonable and necessary to carry out the purposes of section 1395ww(e)(6) of this title,

(E) in the case of research conducted pursuant to section 1320b-12 of this title, which is not reasonable and necessary to carry out the purposes of that section,

(F) in the case of screening mammography, which is performed more frequently than is covered under section 1395m(c)(2) of this title or which is not conducted by a facility described in section 1395m(c)(1)(B) of this title, in the case of screening pap smear and screening pelvic exam, which is performed more frequently than is provided under section 1395x(nn) of this title, and, in the case of screening for glaucoma, which is performed more frequently than is provided under section 1395x(uu) of this title,

(G) in the case of prostate cancer screening tests (as defined in section 1395x(oo) of this title), which are performed more frequently than is covered under such section,

(H) in the case of colorectal cancer screening tests, which are performed more frequently than is covered under section 1395m(d) of this title,

(I) the frequency and duration of home health services which are in excess of normative guidelines that the Secretary shall establish by regulation,

(J) in the case of a drug or biological specified in section 1395w-3a(c)(6)(C) of this title for which payment is made under part B that is furnished in a competitive area under section 1395w-3b of this title, that is not furnished by an entity under a contract under such section,

(K) in the case of an initial preventive physical examination, which is performed more than 1 year after the date the individual's first coverage period begins under part B,

(L) in the case of cardiovascular screening blood tests (as defined in section 1395x(xx)(1) of this title), which are performed more frequently than is covered under section 1395x(xx)(2) of this title,

(M) in the case of a diabetes screening test (as defined in section 1395x(yy)(1) of this title), which is performed more frequently than is covered under section 1395x(yy)(3) of this title,

(N) in the case of ultrasound screening for abdominal aortic aneurysm which is performed

more frequently than is provided for under section 1395x(s)(2)(AA) of this title,

(O) in the case of kidney disease education services (as defined in paragraph (1) of section 1395x(ggg) of this title), which are furnished in excess of the number of sessions covered under paragraph (4) of such section, and

(P) in the case of personalized prevention plan services (as defined in section 1395x(hhh)(1) of this title), which are performed more frequently than is covered under such section;

(2) for which the individual furnished such items or services has no legal obligation to pay, and which no other person (by reason of such individual's membership in a prepayment plan or otherwise) has a legal obligation to provide or pay for, except in the case of Federally qualified health center services;

(3) which are paid for directly or indirectly by a governmental entity (other than under this chapter and other than under a health benefits or insurance plan established for employees of such an entity), except in the case of rural health clinic services, as defined in section 1395x(aa)(1) of this title, in the case of Federally qualified health center services, as defined in section 1395x(aa)(3) of this title, in the case of services for which payment may be made under section 1395qq(e) of this title, and in such other cases as the Secretary may specify;

(4) which are not provided within the United States (except for inpatient hospital services furnished outside the United States under the conditions described in section 1395f(f) of this title and, subject to such conditions, limitations, and requirements as are provided under or pursuant to this subchapter, physicians' services and ambulance services furnished an individual in conjunction with such inpatient hospital services but only for the period during which such inpatient hospital services were furnished);

(5) which are required as a result of war, or of an act of war, occurring after the effective date of such individual's current coverage under such part;

(6) which constitute personal comfort items (except, in the case of hospice care, as is otherwise permitted under paragraph (1)(C));

(7) where such expenses are for routine physical checkups, eyeglasses (other than eyewear described in section 1395x(s)(8) of this title) or eye examinations for the purpose of prescribing, fitting, or changing eyeglasses, procedures performed (during the course of any eye examination) to determine the refractive state of the eyes, hearing aids or examinations therefor, or immunizations (except as otherwise allowed under section 1395x(s)(10) of this title and subparagraph (B), (F), (G), (H), (K), or (P) of paragraph (1));

(8) where such expenses are for orthopedic shoes or other supportive devices for the feet, other than shoes furnished pursuant to section 1395x(s)(12) of this title;

(9) where such expenses are for custodial care (except, in the case of hospice care, as is otherwise permitted under paragraph(1)(C));

(10) where such expenses are for cosmetic surgery or are incurred in connection therewith, except as required for the prompt repair of accidental injury or for improvement of the functioning of a malformed body member;

(11) where such expenses constitute charges imposed by immediate relatives of such individual or members of his household;

(12) where such expenses are for services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth, except that payment may be made under part A in the case of inpatient hospital services in connection with the provision of such dental services if the individual, because of his underlying medical condition and clinical status or because of the severity of the dental procedure, requires hospitalization in connection with the provision of such services;

(13) where such expenses are for—

(A) the treatment of flat foot conditions and the prescription of supportive devices therefor,

(B) the treatment of subluxations of the foot, or

(C) routine foot care (including the cutting or removal of corns or calluses, the trimming of nails, and other routine hygienic care);

(14) which are other than physicians' services (as defined in regulations promulgated specifically for purposes of this paragraph), services described by section 1395x(s)(2)(K) of this title, certified nurse-midwife services, qualified psychologist services, and services of a certified registered nurse anesthetist, and which are furnished to an individual who is a patient of a hospital or critical access hospital by an entity other than the hospital or critical access hospital, unless the services are furnished under arrangements (as defined in section 1395x(w)(1) of this title) with the entity made by the hospital or critical access hospital;

(15)(A) which are for services of an assistant at surgery in a cataract operation (including subsequent insertion of an intraocular lens) unless, before the surgery is performed, the appropriate quality improvement organization (under part B of subchapter XI) or a carrier under section 1395u of this title has approved of the use of such an assistant in the surgical procedure based on the existence of a complicating medical condition, or

(B) which are for services of an assistant at surgery to which section 1395w-4(i)(2)(B) of this title applies;

(16) in the case in which funds may not be used for such items and services under the Assisted Suicide Funding Restriction Act of 1997;

(17) where the expenses are for an item or service furnished in a competitive acquisition area (as established by the Secretary under section 1395w-3(a) of this title) by an entity

other than an entity with which the Secretary has entered into a contract under section 1395w-3(b) of this title for the furnishing of such an item or service in that area, unless the Secretary finds that the expenses were incurred in a case of urgent need, or in other circumstances specified by the Secretary;

(18) which are covered skilled nursing facility services described in section 1395yy(e)(2)(A)(i) of this title and which are furnished to an individual who is a resident of a skilled nursing facility during a period in which the resident is provided covered post-hospital extended care services (or, for services described in section 1395x(s)(2)(D) of this title, which are furnished to such an individual without regard to such period), by an entity other than the skilled nursing facility, unless the services are furnished under arrangements (as defined in section 1395x(w)(1) of this title) with the entity made by the skilled nursing facility;

(19) which are for items or services which are furnished pursuant to a private contract described in section 1395a(b) of this title;

(20) in the case of outpatient physical therapy services, outpatient speech-language pathology services, or outpatient occupational therapy services furnished as an incident to a physician's professional services (as described in section 1395x(s)(2)(A) of this title), that do not meet the standards and conditions (other than any licensing requirement specified by the Secretary) under the second sentence of section 1395x(p) of this title (or under such sentence through the

operation of subsection (g) or (*ll*)(2) of section 1395x of this title) as such standards and conditions would apply to such therapy services if furnished by a therapist;

(21) where such expenses are for home health services (including medical supplies described in section 1395x(m)(5) of this title, but excluding durable medical equipment to the extent provided for in such section) furnished to an individual who is under a plan of care of the home health agency if the claim for payment for such services is not submitted by the agency;

(22) subject to subsection (h), for which a claim is submitted other than in an electronic form specified by the Secretary;

(23) which are the technical component of advanced diagnostic imaging services described in section 1395m(e)(1)(B) of this title for which payment is made under the fee schedule established under section 1395w-4(b) of this title and that are furnished by a supplier (as defined in section 1395x(d) of this title), if such supplier is not accredited by an accreditation organization designated by the Secretary under section 1395m(e)(2)(B) of this title;

(24) where such expenses are for renal dialysis services (as defined in subparagraph (B) of section 1395rr(b)(14) of this title) for which payment is made under such section unless such payment is made under such section to a provider of services or a renal dialysis facility for such services; or

(25) not later than January 1, 2014, for which the payment is other than by electronic funds

transfer (EFT) or an electronic remittance in a form as specified in ASC X12 835 Health Care Payment and Remittance Advice or subsequent standard.

Paragraph (7) shall not apply to Federally qualified health center services described in section 1395x(aa)(3)(B) of this title.

In making a national coverage determination (as defined in paragraph (1)(B) of section 1395ff(f) of this title) the Secretary shall ensure consistent with subsection (l) that the public is afforded notice and opportunity to comment prior to implementation by the Secretary of the determination; meetings of advisory committees with respect to the determination are made on the record; in making the determination, the Secretary has considered applicable information (including clinical experience and medical, technical, and scientific evidence) with respect to the subject matter of the determination; and in the determination, provide a clear statement of the basis for the determination (including responses to comments received from the public), the assumptions underlying that basis, and make available to the public the data (other than proprietary data) considered in making the determination.

(b) Medicare as secondary payer

(1) Requirements of group health plans

(A) Working aged under group health plans

(i) In general

A group health plan—

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

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

(ii) Exclusion of group health plan of a small employer

Clause (i) shall not apply to a group health plan unless the plan is a plan of, or contributed to by, an employer that has 20 or more employees for each working day in each of 20 or more calendar weeks in the current calendar year or the preceding calendar year.

(iii) Exception for small employers in multiemployer or multiple employer group health plans

Clause (i) also shall not apply with respect to individuals enrolled in a multiemployer or multiple employer group health plan if the coverage of the individuals under the plan is by virtue of current employment status with an

employer that does not have 20 or more individuals in current employment status for each working day in each of 20 or more calendar weeks in the current calendar year and the preceding calendar year; except that the exception provided in this clause shall only apply if the plan elects treatment under this clause.

(iv) Exception for individuals with end stage renal disease

Subparagraph (C) shall apply instead of clause (i) to an item or service furnished in a month to an individual if for the month the individual is, or (without regard to entitlement under section 426 of this title) would upon application be, entitled to benefits under section 426-1 of this title.

(v) "Group health plan" defined

In this subparagraph, and subparagraph (C), the term "group health plan" has the meaning given such term in section 5000(b)(1) of the Internal Revenue Code of 1986, without regard to section 5000(d) of such Code.

(B) Disabled individuals in large group health plans

(i) In general

A large group health plan (as defined in clause (iii)) may not take into account that an individual (or a member of the

individual's family) who is covered under the plan by virtue of the individual's current employment status with an employer is entitled to benefits under this subchapter under section 426(b) of this title.

(ii) Exception for individuals with end stage renal disease

Subparagraph (C) shall apply instead of clause (i) to an item or service furnished in a month to an individual if for the month the individual is, or (without regard to entitlement under section 426 of this title) would upon application be, entitled to benefits under section 426-1 of this title.

(iii) "Large group health plan" defined

In this subparagraph, the term "large group health plan" has the meaning given such term in section 5000(b)(2) of the Internal Revenue Code of 1986, without regard to section 5000(d) of such Code.

(C) Individuals with end stage renal disease

A group health plan (as defined in subparagraph (A)(v))—

(i) may not take into account that an individual is entitled to or eligible for benefits under this subchapter under section 426-1 of this title during the 12-month period which begins with the first

month in which the individual becomes entitled to benefits under part A under the provisions of section 426-1 of this title, or, if earlier, the first month in which the individual would have been entitled to benefits under such part under the provisions of section 426-1 of this title if the individual had filed an application for such benefits; and

(ii) may not differentiate in the benefits it provides between individuals having end stage renal disease and other individuals covered by such plan on the basis of the existence of end stage renal disease, the need for renal dialysis, or in any other manner;

except that clause (ii) shall not prohibit a plan from paying benefits secondary to this subchapter when an individual is entitled to or eligible for benefits under this subchapter under section 426-1 of this title after the end of the 12-month period described in clause (i). Effective for items and services furnished on or after February 1, 1991, and before August 5, 1997,[1] (with respect to periods beginning on or after February 1, 1990), this subparagraph shall be applied by substituting "18-month" for "12-month" each place it appears. Effective for items and services furnished on or after August 5, 1997, (with respect to

[1] So in original. The comma probably should not appear.

periods beginning on or after the date that is 18 months prior to August 5, 1997), clauses (i) and (ii) shall be applied by substituting "30-month" for "12-month" each place it appears.

(D) Treatment of certain members of religious orders

In this subsection, an individual shall not be considered to be employed, or an employee, with respect to the performance of services as a member of a religious order which are considered employment only by virtue of an election made by the religious order under section 3121(r) of the Internal Revenue Code of 1986.

(E) General provisions

For purposes of this subsection:

(i) Aggregation rules

(I) All employers treated as a single employer under subsection (a) or (b) of section 52 of the Internal Revenue Code of 1986 shall be treated as a single employer.

(II) All employees of the members of an affiliated service group (as defined in section 414(m) of such Code) shall be treated as employed by a single employer.

(III) Leased employees (as defined in section 414(n)(2) of such Code) shall be treated as employees of the person for whom they perform

services to the extent they are so treated under section 414(n) of such Code.

In applying sections of the Internal Revenue Code of 1986 under this clause, the Secretary shall rely upon regulations and decisions of the Secretary of the Treasury respecting such sections.

(ii) "Current employment status" defined

An individual has "current employment status" with an employer if the individual is an employee, is the employer, or is associated with the employer in a business relationship.

(iii) Treatment of self-employed persons as employers

The term "employer" includes a self-employed person.

(F) Limitation on beneficiary liability

An individual who is entitled to benefits under this subchapter and is furnished an item or service for which such benefits are incorrectly paid is not liable for repayment of such benefits under this paragraph unless payment of such benefits was made to the individual.

(2) Medicare secondary payer

(A) In general

Payment under this subchapter may not be made, except as provided in subpara-

graph (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[2] or can reasonably be expected to be made[2] 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

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[2] So in original. Probably should be "made,".

or service if a primary plan described in subparagraph (A)(ii)[3] has not made or cannot reasonably be expected to make payment with respect to such item or service promptly (as determined in accordance with regulations). Any such payment by the Secretary shall be conditioned on reimbursement to the appropriate Trust Fund in accordance with the succeeding provisions of this subsection.

(ii) Repayment required

Subject to paragraph (9), a primary plan, and an entity that receives payment from a primary plan, shall reimburse the appropriate Trust Fund for any payment made by the Secretary under this subchapter with respect to an item or service if it is demonstrated that such primary plan has or had a responsibility to make payment with respect to such item or service. A primary plan's responsibility for such payment may be demonstrated by a judgment, a payment conditioned upon the recipient's compromise, waiver, or release (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary plan or the primary plan's insured, or by other means. If reimbursement is not made to the appropriate Trust Fund before the expiration of the 60-day period

[3] So in original. Probably should be "subparagraph (A)".

that begins on the date notice of, or information related to, a primary plan's responsibility for such payment or other information is received, the Secretary may charge interest (beginning with the date on which the notice or other information is received) on the amount of the reimbursement until reimbursement is made (at a rate determined by the Secretary in accordance with regulations of the Secretary of the Treasury applicable to charges for late payments).

(iii) Action by United States

In order to recover payment made under this subchapter for an item or service, the United States may bring an action against any or all entities that are or were required or responsible (directly, as an insurer or self-insurer, as a third-party administrator, as an employer that sponsors or contributes to a group health plan, or large group health plan, or otherwise) to make payment with respect to the same item or service (or any portion thereof) under a primary plan. The United States may, in accordance with paragraph (3)(A) collect double damages against any such entity. In addition, the United States may recover under this clause from any entity that has received payment from a primary plan or from the proceeds of a primary plan's payment to any entity. The United States may not recover from a third-party administrator under this clause in

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

(iv) Subrogation rights

The United States shall be subrogated (to the extent of payment made under this subchapter for such an item or service) to any right under this subsection of an individual or any other entity to payment with respect to such item or service under a primary plan.

(v) Waiver of rights

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

(vi) Claims-filing period

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

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

(I) Notice to Secretary of expected date of a settlement, judgment, etc.

In the case of a payment made by the Secretary pursuant to clause (i) for items and services provided to the claimant, the claimant or applicable plan (as defined in paragraph (8)(F)) may at any time beginning 120 days before the reasonably expected date of a settlement, judgment, award, or other payment, notify the Secretary that a payment is reasonably expected and the expected date of such payment.

(II) Secretarial[4] providing access to claims information through a website

The Secretary shall maintain and make available to individuals to whom items and services are furnished under this subchapter (and to authorized family or other representatives recognized under regulations and to an applicable plan which has obtained the consent of the individual) access to information on the claims for such items and services (including payment amounts for such claims), including those claims that relate to a potential settlement, judgment, award, or other payment. Such access shall be provided to an individual, representative, or plan through a website that requires a password to gain access to the information. The Secretary shall update the information on claims and payments on such website in as timely a manner as possible but not later than 15 days after the date that payment is made. Information related to claims and payments subject to the notice under subclause (I) shall be maintained and made available consistent with the following:

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[4] So in original.

(aa) The information shall be as complete as possible and shall include provider or supplier name, diagnosis codes (if any), dates of service, and conditional payment amounts.

(bb) The information accurately identifies those claims and payments that are related to a potential settlement, judgment, award, or other payment to which the provisions of this subsection apply.

(cc) The website provides a method for the receipt of secure electronic communications with the individual, representative, or plan involved.

(dd) The website provides that information is transmitted from the website in a form that includes an official time and date that the information is transmitted.

(ee) The website shall permit the individual, representative, or plan to download a statement of reimbursement amounts (in this clause referred to as a "statement of reimbursement amount") on payments for claims under this subchapter relating to a potential settle-

ment, judgment, award, or other payment.

(III) Use of timely web download as basis for final conditional amount

If an individual (or other claimant or applicable plan with the consent of the individual) obtains a statement of reimbursement amount from the website during the protected period as defined in subclause (V) and the related settlement, judgment, award or other payment is made during such period, then the last statement of reimbursement amount that is downloaded during such period and within 3 business days before the date of the settlement, judgment, award, or other payment shall constitute the final conditional amount subject to recovery under clause (ii) related to such settlement, judgment, award, or other payment.

(IV) Resolution of discrepancies

If the individual (or authorized representative) believes there is a discrepancy with the statement of reimbursement amount, the Secretary shall provide a timely process to resolve the discrepancy. Under such process the individual (or representative) must provide documentation explaining the discrepancy and a proposal to

resolve such discrepancy. Within 11 business days after the date of receipt of such documentation, the Secretary shall determine whether there is a reasonable basis to include or remove claims on the statement of reimbursement. If the Secretary does not make such determination within the 11 business-day period, then the proposal to resolve the discrepancy shall be accepted. If the Secretary determines within such period that there is not a reasonable basis to include or remove claims on the statement of reimbursement, the proposal shall be rejected. If the Secretary determines within such period that there is a reasonable basis to conclude there is a discrepancy, the Secretary must respond in a timely manner by agreeing to the proposal to resolve the discrepancy or by providing documentation showing with good cause why the Secretary is not agreeing to such proposal and establishing an alternate discrepancy resolution. In no case shall the process under this subclause be treated as an appeals process or as establishing a right of appeal for a statement of reimbursement amount and there shall be no administrative or judicial review of the Secretary's determinations under this subclause.

(V) Protected period

In subclause (III), the term "protected period" means, with respect to a settlement, judgment, award or other payment relating to an injury or incident, the portion (if any) of the period beginning on the date of notice under subclause (I) with respect to such settlement, judgment, award, or other payment that is after the end of a Secretarial response period beginning on the date of such notice to the Secretary. Such Secretarial response period shall be a period of 65 days, except that such period may be extended by the Secretary for a period of an additional 30 days if the Secretary determines that additional time is required to address claims for which payment has been made. Such Secretarial response period shall be extended and shall not include any days for any part of which the Secretary determines (in accordance with regulations) that there was a failure in the claims and payment posting system and the failure was justified due to exceptional circumstances (as defined in such regulations). Such regulations shall define exceptionalcircumstances in a manner so that not more than 1 percent of the repayment obligations

under this subclause would qualify as exceptional circumstances.

(VI) Effective date

The Secretary shall promulgate final regulations to carry out this clause not later than 9 months after January 10, 2013.

(VII) Website including successor technology

In this clause, the term "website" includes any successor technology.

(viii) Right of appeal for secondary payer determinations relating to liability insurance (including self-insurance), no fault insurance, and workers' compensation laws and plans

The Secretary shall promulgate regulations establishing a right of appeal and appeals process, with respect to any determination under this subsection for a payment made under this subchapter for an item or service for which the Secretary is seeking to recover conditional payments from an applicable plan (as defined in paragraph (8)(F)) that is a primary plan under subsection (A)(ii),[5] under which the applicable plan involved, or an attorney, agent, or third party administrator on behalf of such plan, may appeal such determination. The

[5] So in original. Probably should be "subparagraph (A)".

individual furnished such an item or service shall be notified of the plan's intent to appeal such determination.[6]

(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).

(B) Reference to excise tax with respect to nonconforming group health plans

For provision imposing an excise tax with respect to nonconforming group health plans, see section 5000 of the Internal Revenue Code of 1986.

(C) Prohibition of financial incentives not to enroll in a group health plan or a large group health plan

It is unlawful for an employer or other entity to offer any financial or other incentive for an individual entitled to benefits under this

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[6] So in original. Probably should be followed by a period.

subchapter not to enroll (or to terminate enrollment) under a group health plan or a large group health plan which would (in the case of such enrollment) be a primary plan (as defined in paragraph (2)(A)). Any entity that violates the previous sentence is subject to a civil money penalty of not to exceed $5,000 for each such violation. The provisions of section 1320a-7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a-7a(a) of this title.

(4) Coordination of benefits

Where payment for an item or service by a primary plan is less than the amount of the charge for such item or service and is not payment in full, payment may be made under this subchapter (without regard to deductibles and coinsurance under this subchapter) for the remainder of such charge, but—

(A) payment under this subchapter may not exceed an amount which would be payable under this subchapter for such item or service if paragraph (2)(A) did not apply; and

(B) payment under this subchapter, when combined with the amount payable under the primary plan, may not exceed—

(i) in the case of an item or service payment for which is determined under this subchapter on the basis of reasonable cost (or other cost-related basis) or under section 1395ww of this title, the

amount which would be payable under this subchapter on such basis, and

(ii) in the case of an item or service for which payment is authorized under this subchapter on another basis—

(I) the amount which would be payable under the primary plan (without regard to deductibles and coinsurance undersuch plan), or

(II) the reasonable charge or other amount which would be payable under this subchapter (without regard to deductibles and coinsurance under this subchapter),

whichever is greater.

(5) Identification of secondary payer situations

(A) Requesting matching information

(i) Commissioner of Social Security

The Commissioner of Social Security shall, not less often than annually, transmit to the Secretary of the Treasury a list of the names and TINs of medicare beneficiaries (as defined in section 6103(l)(12) of the Internal Revenue Code of 1986) and request that the Secretary disclose to the Commissioner the information described in subparagraph (A) of such section.

(ii) Administrator

The Administrator of the Centers for Medicare & Medicaid Services shall request, not less often than annually, the Commissioner of the Social Security Administration to disclose to the Administrator the information described in subparagraph (B) of section 6103(l)(12) of the Internal Revenue Code of 1986.

(B) Disclosure to fiscal intermediaries and carriers

In addition to any other information provided under this subchapter to fiscal intermediaries and carriers, the Administrator shall disclose to such intermediaries and carriers (or to such a single intermediary or carrier as the Secretary may designate) the information received under subparagraph (A) for purposes of carrying out this subsection.

(C) Contacting employers

(i) In general

With respect to each individual (in this subparagraph referred to as an "employee") who was furnished a written statement under section 6051 of the Internal Revenue Code of 1986 by a qualified employer (as defined in section 6103(l)(12)(E)(iii) of such Code), as disclosed under subparagraph (B), the appropriate fiscal intermediary or carrier shall contact the employer in order to determine during what period the employee or employee's spouse may be

(or have been) covered under a group health plan of the employer and the nature of the coverage that is or was provided under the plan (including the name, address, and identifying number of the plan).

(ii) Employer response

Within 30 days of the date of receipt of the inquiry, the employer shall notify the intermediary or carrier making the inquiry as to the determinations described in clause (i). An employer (other than a Federal or other governmental entity) who willfully or repeatedly fails to provide timely and accurate notice in accordance with the previous sentence shall be subject to a civil money penalty of not to exceed $1,000 for each individual with respect to which such an inquiry is made. The provisions of section 1320a-7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a-7a(a) of this title.

(D) Obtaining information from beneficiaries

Before an individual applies for benefits under part A or enrolls under part B, the Administrator shall mail the individual a questionnaire to obtain information on whether the individual is covered under a primary plan and the nature of the coverage

provided under the plan, including the name, address, and identifying number of the plan.

(E) End date

The provisions of this paragraph shall not apply to information required to be provided on or after July 1, 2016.

(6) Screening requirements for providers and suppliers

(A) In general

Notwithstanding any other provision of this subchapter, no payment may be made for any item or service furnished under part B unless the entity furnishing such item or service completes (to the best of its knowledge and on the basis of information obtained from the individual to whom the item or service is furnished) the portion of the claim form relating to the availability of other health benefit plans.

(B) Penalties

An entity that knowingly, willfully, and repeatedly fails to complete a claim form in accordance with subparagraph (A) or provides inaccurate information relating to the availability of other health benefit plans on a claim form under such subparagraph shall be subject to a civil money penalty of not to exceed $2,000 for each such incident. The provisions of section 1320a-7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or

proceeding under section 1320a-7a(a) of this title.

(7) Required submission of information by group health plans

(A) Requirement

On and after the first day of the first calendar quarter beginning after the date that is 1 year after December 29, 2007, an entity serving as an insurer or third party administrator for a group health plan, as defined in paragraph (1)(A)(v), and, in the case of a group health plan that is self-insured and self-administered, a plan administrator or fiduciary, shall—

(i) secure from the plan sponsor and plan participants such information as the Secretary shall specify for the purpose of identifying situations where the group health plan is or has been—

(I) a primary plan to the program under this subchapter; or

(II) for calendar quarters beginning on or after January 1, 2020, a primary payer with respect to benefits relating to prescription drug coverage under part D; and

(ii) submit such information to the Secretary in a form and manner (including frequency) specified by the Secretary.

(B) Enforcement

(i) In general

An entity, a plan administrator, or a fiduciary described in subparagraph (A) that fails to comply with the requirements under such subparagraph shall be subject to a civil money penalty of $1,000 for each day of noncompliance for each individual for which the information under such subparagraph should have been submitted. The provisions of subsections (e) and (k) of section 1320a-7a of this title shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a-7a(a) of this title. A civil money penalty under this clause shall be in addition to any other penalties prescribed by law and in addition to any Medicare secondary payer claim under this subchapter with respect to an individual.

(ii) Deposit of amounts collected

Any amounts collected pursuant to clause (i) shall be deposited in the Federal Hospital Insurance Trust Fund under section 1395i of this title.

(C) Sharing of information

Notwithstanding any other provision of law, under terms and conditions established by the Secretary, the Secretary—

(i) shall share information on entitlement under part A and enrollment under

part B under this subchapter with entities, plan administrators, and fiduciaries described in subparagraph (A);

(ii) may share the entitlement and enrollment information described in clause (i) with entities and persons not describedin such clause; and

(iii) may share information collected under this paragraph as necessary for purposes of the proper coordination of benefits.

(D) Implementation

Notwithstanding any other provision of law, the Secretary may implement this paragraph by program instruction orotherwise.

(8) Required submission of information by or on behalf of liability insurance (including self-insurance), no fault insurance, and workers' compensation laws and plans

(A) Requirement

On and after the first day of the first calendar quarter beginning after the date that is 18 months after December 29, 2007, an applicable plan shall—

(i) determine whether a claimant (including an individual whose claim is unresolved) is entitled to benefits under the program under this subchapter on any basis; and

(ii) if the claimant is determined to be so entitled, submit the information described in subparagraph (B) with respect to the

claimant to the Secretary in a form and manner (including frequency) specified by the Secretary.

(B) Required information

The information described in this subparagraph is—

(i) the identity of the claimant for which the determination under subparagraph (A) was made; and

(ii) such other information as the Secretary shall specify in order to enable the Secretary to make an appropriate determination concerning coordination of benefits, including any applicable recovery claim.

Not later than 18 months after January 10, 2013, the Secretary shall modify the reporting requirements under this paragraph so that an applicable plan in complying with such requirements is permitted but not required to access or report to the Secretary beneficiary social security account numbers or health identification claim numbers, except that the deadline for such modification shall be extended by one or more periods (specified by the Secretary) of up to 1 year each if the Secretary notifies the committees of jurisdiction of the House of Representatives and of the Senate that the prior deadline for such modification, without such extension, threatens patient privacy or the integrity of the secondary payer program under this

subsection. Any such deadline extension notice shall include information on the progress being made in implementing such modification and the anticipated implementation date for such modification.

(C) Timing

Information shall be submitted under subparagraph (A)(ii) within a time specified by the Secretary after the claim is resolved through a settlement, judgment, award, or other payment (regardless of whether or not there is a determination or admission of liability).

(D) Claimant

For purposes of subparagraph (A), the term "claimant" includes—

(i) an individual filing a claim directly against the applicable plan; and

(ii) an individual filing a claim against an individual or entity insured or covered by the applicable plan.

(E) Enforcement

(i) In general

An applicable plan that fails to comply with the requirements under subparagraph (A) with respect to any claimant may be subject to a civil money penalty of up to $1,000 for each day of noncompliance with respect to each claimant. The provisions of subsections (e) and (k) of section 1320a-7a of this title shall apply to a civil money penalty under the

previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a-7a(a) of this title. A civil money penalty under this clause shall be in addition to any other penalties prescribed by law and in addition to any Medicare secondary payer claim under this subchapter with respect to an individual.

(ii) Deposit of amounts collected

Any amounts collected pursuant to clause (i) shall be deposited in the Federal Hospital Insurance Trust Fund.

(F) Applicable plan

In this paragraph, the term "applicable plan" means the following laws, plans, or other arrangements, including the fiduciary or administrator for such law, plan, or arrangement:

(i) Liability insurance (including self-insurance).

(ii) No fault insurance.

(iii) Workers' compensation laws or plans.

(G) Sharing of information

(i) In general

The Secretary may share information collected under this paragraph as necessary for purposes of the proper coordination of benefits.

(ii) Specified information

In responding to any query made on or after the date that is 1 year after December 11, 2020 from an applicable plan related to a determination described in subparagraph (A)(i), the Secretary, notwithstanding any other provision of law, shall provide to such applicable plan—

(I) whether a claimant subject to the query is, or during the preceding 3-year period has been, entitled to benefits under the program under this title on any basis; and

(II) to the extent applicable, the plan name and address of any Medicare Advantage plan under part C and any prescription drug plan under part D in which the claimant is enrolled or has been enrolled during such period.

(H) Implementation

Notwithstanding any other provision of law, the Secretary may implement this paragraph by program instruction or otherwise.

(I) Regulations

Not later than 60 days after January 10, 2013, the Secretary shall publish a notice in the Federal Register soliciting proposals, which will be accepted during a 60-day period, for the specification of practices for which sanctions will and will not be imposed under subparagraph (E), including not

imposing sanctions for good faith efforts to identify a beneficiary pursuant to this paragraph under an applicable entity responsible for reporting information. After considering the proposals so submitted, the Secretary, in consultation with the Attorney General, shall publish in the Federal Register, including a 60-day period for comment, proposed specified practices for which such sanctions will and will not be imposed. After considering any public comments received during such period, the Secretary shall issue final rules specifying such practices.

(9) Exception

(A) In general

Clause (ii) of paragraph (2)(B) and any reporting required by paragraph (8) shall not apply with respect to any settlement, judgment, award, or other payment by an applicable plan arising from liability insurance (including self-insurance) and from alleged physical trauma-based incidents (excluding alleged ingestion, implantation, or exposure cases) constituting a total payment obligation to a claimant of not more than the single threshold amount calculated by the Secretary under subparagraph (B) for the year involved.

(B) Annual computation of threshold

(i) In general

Not later than November 15 before each year, the Secretary shall calculate

and publish a single threshold amount for settlements, judgments, awards, or other payments for obligations arising from liability insurance (including self-insurance) and for alleged physical trauma-based incidents (excluding alleged ingestion, implantation, or exposure cases) subject to this section for that year. The annual single threshold amount for a year shall be set such that the estimated average amount to be credited to the Medicare trust funds of collections of conditional payments from such settlements, judgments, awards, or other payments arising from liability insurance (including self-insurance) and for such alleged incidents subject to this section shall equal the estimated cost of collection incurred by the United States (including payments made to contractors) for a conditional payment arising from liability insurance (including self-insurance) and for such alleged incidents subject to this section for the year. At the time of calculating, but before publishing, the single threshold amount for 2014, the Secretary shall inform, and seek review of, the Comptroller General of the United States with regard to such amount.

(ii) Publication

The Secretary shall include, as part of such publication for a year—

> **(I)** the estimated cost of collection incurred by the United States

(including payments made to contractors) for a conditional payment arising from liability insurance (including self-insurance) and for such alleged incidents; and

(II) a summary of the methodology and data used by the Secretary in computing such threshold amount and such cost of collection.

(C) Exclusion of ongoing expenses

For purposes of this paragraph and with respect to a settlement, judgment, award, or other payment not otherwise addressed in clause (ii) of paragraph (2)(B) that includes ongoing responsibility for medical payments (excluding settlements, judgments, awards, or other payments made by a workers' compensation law or plan or no fault insurance), the amount utilized for calculation of the threshold described in subparagraph (A) shall include only the cumulative value of the medical payments made under this subchapter.

(D) Report to Congress

Not later than November 15 before each year, the Secretary shall submit to the Congress a report on the single threshold amount for settlements, judgments, awards, or other payments for conditional payment obligations arising from liability insurance (including self-insurance) and alleged incidents described in subparagraph (A) for that year and on the establishment and application of similar thresholds for such

payments for conditional payment obligations arising from worker compensation cases and from no fault insurance cases subject to this section for the year. For each such report, the Secretary shall—

(i) calculate the threshold amount by using the methodology applicable to certain liability claims described in subparagraph (B); and

(ii) include a summary of the methodology and data used in calculating each threshold amount and the amount of estimated savings under this subchapter achieved by the Secretary implementing each such threshold.

(c) Drug products

No payment may be made under part B for any expenses incurred for—

(1) a drug product—

(A) which is described in section 107(c)(3) of the Drug Amendments of 1962,

(B) which may be dispensed only upon prescription,

(C) for which the Secretary has issued a notice of an opportunity for a hearing under subsection (e) of section 355 of Title 21 on a proposed order of the Secretary to withdraw approval of an application for such drug product under such section because the Secretary has determined that the drug is less than effective for all conditions of use prescribed, recommended, or suggested in its labeling, and

(D) for which the Secretary has not determined there is a compelling justification for its medical need; and

(2) any other drug product—

(A) which is identical, related, or similar (as determined in accordance with section 310.6 of title 21 of the Code of Federal Regulations) to a drug product described in paragraph (1), and

(B) for which the Secretary has not determined there is a compelling justification for its medical need,

until such time as the Secretary withdraws such proposed order.

(d) Items or services provided for emergency medical conditions

For purposes of subsection (a)(1)(A), in the case of any item or service that is required to be provided pursuant to section 1395dd of this title to an individual who is entitled to benefits under this subchapter, determinations as to whether the item or service is reasonable and necessary shall be made on the basis of the information available to the treating physician or practitioner (including the patient's presenting symptoms or complaint) at the time the item or service was ordered or furnished by the physician or practitioner (and not on the patient's principal diagnosis). When making such determinations with respect to such an item or service, the Secretary shall not consider the frequency with which the item or service was provided to the patient before or after the time of the admission or visit.

(e) Item or service by excluded individual or entity or at direction of excluded physician; limitation of liability of beneficiaries with respect to services furnished by excluded individuals and entities

(1) No payment may be made under this subchapter with respect to any item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) furnished—

(A) by an individual or entity during the period when such individual or entity is excluded pursuant to section 1320a-7, 1320a-7a, 1320c-5 or 1395u(j)(2) of this title from participation in the program under this subchapter; or

(B) at the medical direction or on the prescription of a physician during the period when he is excluded pursuant to section 1320a-7, 1320a-7a, 1320c-5 or 1395u(j)(2) of this title from participation in the program under this subchapter and when the person furnishing such item or service knew or had reason to know of the exclusion (after a reasonable time period after reasonable notice has been furnished to the person).

(2) Where an individual eligible for benefits under this subchapter submits a claim for payment for items or services furnished by an individual or entity excluded from participation in the programs under this subchapter, pursuant to section 1320a-7, 1320a-7a, 1320c-5, 1320c-9 (as in effect on September 2, 1982), 1395u(j)(2), 1395y(d) (as in effect on August 18, 1987), or

1395cc of this title, and such beneficiary did not know or have reason to know that such individual or entity was so excluded, then, to the extent permitted by this subchapter, and notwithstanding such exclusion, payment shall be made for such items or services. In each such case the Secretary shall notify the beneficiary of the exclusion of the individual or entity furnishing the items or services. Payment shall not be made for items or services furnished by an excluded individual or entity to a beneficiary after a reasonable time (as determined by the Secretary in regulations) after the Secretary has notified the beneficiary of the exclusion of that individual or entity.

(f) Utilization guidelines for provision of home health services

The Secretary shall establish utilization guidelines for the determination of whether or not payment may be made, consistent with paragraph (1)(A) of subsection (a), under part A or part B for expenses incurred with respect to the provision of home health services, and shall provide for the implementation of such guidelines through a process of selective postpayment coverage review by intermediaries or otherwise.

(g) Contracts with quality improvement organizations

The Secretary shall, in making the determinations under paragraphs (1) and (9) of subsection (a), and for the purposes of promoting the effective, efficient, and economical delivery of health care services, and of promoting the quality of services of the type for which payment may be made

under this subchapter, enter into contracts with quality improvement organizations pursuant to part B of subchapter XI of this chapter.

(h) Waiver of electronic form requirement

(1) The Secretary—

(A) shall waive the application of subsection (a)(22) in cases in which—

(i) there is no method available for the submission of claims in an electronic form; or

(ii) the entity submitting the claim is a small provider of services or supplier; and

(B) may waive the application of such subsection in such unusual cases as the Secretary finds appropriate.

(2) For purposes of this subsection, the term "small provider of services or supplier" means—

(A) a provider of services with fewer than 25 full-time equivalent employees; or

(B) a physician, practitioner, facility, or supplier (other than provider of services) with fewer than 10 full-time equivalent employees.

(i) Awards and contracts for original research and experimentation of new and existing medical procedures; conditions

In order to supplement the activities of the Medicare Payment Advisory Commission under section 1395ww(e) of this title in assessing the safety, efficacy, and cost-effectiveness of new and

existing medical procedures, the Secretary may carry out, or award grants or contracts for, original research and experimentation of the type described in clause (ii) of section 1395ww(e)(6)(E) of this title with respect to such a procedure if the Secretary finds that—

(1) such procedure is not of sufficient commercial value to justify research and experimentation by a commercial organization;

(2) research and experimentation with respect to such procedure is not of a type that may appropriately be carried out by an institute, division, or bureau of the National Institutes of Health; and

(3) such procedure has the potential to be more cost-effective in the treatment of a condition than procedures currently in use with respect to such condition.

(j) Nonvoting members and experts

(1) Any advisory committee appointed to advise the Secretary on matters relating to the interpretation, application, or implementation of subsection (a)(1) shall assure the full participation of a nonvoting member in the deliberations of the advisory committee, and shall provide such nonvoting member access to all information and data made available to voting members of the advisory committee, other than information that—

(A) is exempt from disclosure pursuant to subsection (a) of section 552 of Title 5 by reason of subsection (b)(4) of such section (relating to trade secrets); or

(B) the Secretary determines would present a conflict of interest relating to such nonvoting member.

(2) If an advisory committee described in paragraph (1) organizes into panels of experts according to types of items or services considered by the advisory committee, any such panel of experts may report any recommendation with respect to such items or services directly to the Secretary without the prior approval of the advisory committee or an executive committee thereof.

(k) Dental benefits under group health plans

(1) Subject to paragraph (2), a group health plan (as defined in subsection (a)(1)(A)(v)[7]) providing supplemental or secondary coverage to individuals also entitled to services under this subchapter shall not require a medicare claims determination under this subchapter for dental benefits specifically excluded under subsection (a)(12) as a condition of making a claims determination for such benefits under the group health plan.

(2) A group health plan may require a claims determination under this subchapter in cases involving or appearing to involve inpatient dental hospital services or dental services expressly covered under this subchapter pursuant to actions taken by the Secretary.

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[7] So in original. Probably should be "(b)(1)(A)(v)".

(l) National and local coverage determination process

(1) Factors and evidence used in making national coverage determinations

The Secretary shall make available to the public the factors considered in making national coverage determinations of whether an item or service is reasonable and necessary. The Secretary shall develop guidance documents to carry out this paragraph in a manner similar to the development of guidance documents under section 371(h) of Title 21.

(2) Timeframe for decisions on requests for national coverage determinations

In the case of a request for a national coverage determination that—

(A) does not require a technology assessment from an outside entity or deliberation from the Medicare Coverage Advisory Committee, the decision on the request shall be made not later than 6 months after the date of the request; or

(B) requires such an assessment or deliberation and in which a clinical trial is not requested, the decision on the request shall be made not later than 9 months after the date of the request.

(3) Process for public comment in national coverage determinations

(A) Period for proposed decision

Not later than the end of the 6-month period (or 9-month period for requests described in

paragraph (2)(B)) that begins on the date a request for a national coverage determination is made, the Secretary shall make a draft of proposed decision on the request available to the public through the Internet website of the Centers for Medicare & Medicaid Services or other appropriate means.

(B) 30-day period for public comment

Beginning on the date the Secretary makes a draft of the proposed decision available under subparagraph (A), the Secretary shall provide a 30-day period for public comment on such draft.

(C) 60-day period for final decision

Not later than 60 days after the conclusion of the 30-day period referred to under subparagraph (B), the Secretary shall—

(i) make a final decision on the request;

(ii) include in such final decision summaries of the public comments received and responses to such comments;

(iii) make available to the public the clinical evidence and other data used in making such a decision when the decision differs from the recommendations of the Medicare Coverage Advisory Committee; and

(iv) in the case of a final decision under clause (i) to grant the request for the national coverage determination, the Secretary shall assign a temporary or

permanent code (whether existing or unclassified) and implement the coding change.

(4) Consultation with outside experts in certain national coverage determinations

With respect to a request for a national coverage determination for which there is not a review by the Medicare Coverage Advisory Committee, the Secretary shall consult with appropriate outside clinical experts.

(5) Local coverage determination process

(A) Plan to promote consistency of coverage determinations

The Secretary shall develop a plan to evaluate new local coverage determinations to determine which determinations should be adopted nationally and to what extent greater consistency can be achieved among local coverage determinations.

(B) Consultation

The Secretary shall require the fiscal intermediaries or carriers providing services within the same area to consult on all new local coverage determinations within the area.

(C) Dissemination of information

The Secretary should serve as a center to disseminate information on local coverage determinations among fiscal intermediaries and carriers to reduce duplication of effort.

(D) Local coverage determinations

The Secretary shall require each Medicare administrative contractor that develops a local coverage determination to make available on the Internet website of such contractor and on the Medicare Internet website, at least 45 days before the effective date of such determination, the following information:

(i) Such determination in its entirety.

(ii) Where and when the proposed determination was first made public.

(iii) Hyperlinks to the proposed determination and a response to comments submitted to the contractor with respect to such proposed determination.

(iv) A summary of evidence that was considered by the contractor during the development of such determination and a list of the sources of such evidence.

(v) An explanation of the rationale that supports such determination.

(6) National and local coverage determination defined

For purposes of this subsection—

(A) National coverage determination

The term "national coverage determination" means a determination by the Secretary with respect to whether or not a particular item or service is covered nationally under this subchapter.

(B) Local coverage determination

The term "local coverage determination" has the meaning given that in section 1395ff(f)(2)(B) of this title.

(m) Coverage of routine costs associated with certain clinical trials of category A devices

(1) In general

In the case of an individual entitled to benefits under part A, or enrolled under part B, or both who participates in a category A clinical trial, the Secretary shall not exclude under subsection (a)(1) payment for coverage of routine costs of care (as defined by the Secretary) furnished to such individual in the trial.

(2) Category A clinical trial

For purposes of paragraph (1), a "category A clinical trial" means a trial of a medical device if—

(A) the trial is of an experimental/investigational (category A) medical device (as defined in regulations under section 405.201(b) of title 42, Code of Federal Regulations (as in effect as of September 1, 2003));

(B) the trial meets criteria established by the Secretary to ensure that the trial conforms to appropriate scientific and ethical standards; and

(C) in the case of a trial initiated before January 1, 2010, the device involved in the trial has been determined by the Secretary to be intended for use in the diagnosis,

monitoring, or treatment of an immediately life-threatening disease or condition.

(n) Requirement of a surety bond for certain providers of services and suppliers

(1) In general

The Secretary may require a provider of services or supplier described in paragraph (2) to provide the Secretary on a continuing basis with a surety bond in a form specified by the Secretary in an amount (not less than $50,000) that the Secretary determines is commensurate with the volume of the billing of the provider of services or supplier. The Secretary may waive the requirement of a bond under the preceding sentence in the case of a provider of services or supplier that provides a comparable surety bond under State law.

(2) Provider of services or supplier described

A provider of services or supplier described in this paragraph is a provider of services or supplier the Secretary determines appropriate based on the level of risk involved with respect to the provider of services or supplier, and consistent with the surety bond requirements under sections 1395m(a)(16)(B) and 1395x(o)(7)(C) of this title.

(o) Suspension of payments pending investigation of credible allegations of fraud

(1) In general

The Secretary may suspend payments to a provider of services or supplier under this subchapter pending an investigation of a

credible allegation of fraud against the provider of services or supplier, unless the Secretary determines there is good cause not to suspend such payments.

(2) Consultation

The Secretary shall consult with the Inspector General of the Department of Health and Human Services in determining whether there is a credible allegation of fraud against a provider of services or supplier.

(3) Promulgation of regulations

The Secretary shall promulgate regulations to carry out this subsection, section 1395w-112(b)(7) of this title (including as applied pursuant to section 1395w-27(f)(3)(D) of this title), and section 1396b(i)(2)(C) of this title.

(4) Credible allegation of fraud

In carrying out this subsection, section 1395w-112(b)(7) of this title (including as applied pursuant to section 1395w-27(f)(3)(D) of this title), and section 1396b(i)(2)(C) of this title, a fraud hotline tip (as defined by the Secretary) without further evidence shall not be treated as sufficient evidence for a credible allegation of fraud.