No. 20-1424

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

AMICI CURIAE BRIEF OF AMERICAN PROPERTY CASUALTY INSURANCE ASSOCIATION, DRI, INC., MEDICARE ADVOCACY RECOVERY COALITION, NATIONAL ASSOCIATION OF MUTUAL INSURANCE COMPANIES, AND PERSONAL INSURANCE FEDERATION OF FLORIDA IN SUPPORT OF PETITIONERS

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The American Property Casualty Insurance Association, DRI, Inc., Medicare Advocacy Recovery Coalition, National Association of Mutual Insurance Companies, and Personal Insurance Federation of Florida (collectively, "Amici") support the Petition for Writ of Certiorari ("Petition") filed by ACE American Insurance Company, Auto-Owners Insurance Company, Owners Insurance Company, Southern-Owners Insurance Company, and Travelers Casualty and Surety Company ("Petitioners").[1] The Question Presented in the Petition is of great importance to Amici and their members.

INTEREST OF AMICI CURIAE[2]

Amicus curiae American Property Casualty Insurance Association ("APCIA") is the primary national trade association for home, auto, and business insurers. APCIA promotes and protects the viability of private competition for the benefit of consumers and insurers, with a legacy dating back 150 years. APCIA's member companies write $412 billion in direct written premium and assumed reinsurance premium,

[1] No party or counsel for a party authored this brief in whole or in part and no counsel or party made a monetary contribution intended to fund the preparation or submission of the brief. No person other than the Amici and their members have made such a monetary contribution.

[2] Pursuant to Rule 37.2 of the Rules of the Supreme Court of the United States, Amici provided timely notice to all parties of Amici's intent to file this brief. Petitioners and Respondent consent to the filing.

representing nearly 60 percent of the U.S. property-casualty insurance marketplace.

Amicus curiae DRI, Inc. is an international organization of approximately 16,000 attorneys and corporations involved in the defense of civil litigation. DRI is committed to enhancing the skills, effectiveness, and professionalism of defense attorneys. Because of this commitment, DRI seeks to promote the role of defense attorneys, to address issues germane to defense attorneys and their clients, and to improve the civil justice system. DRI has long participated in the ongoing effort to make the civil justice system fairer, more consistent, and more efficient. To promote these objectives, DRI, through its Center for Law and Public Policy, participates as amicus curiae in cases that raise issues important to its members, their clients, and the judicial system.

Amicus curiae the Medicare Advocacy Recovery Coalition ("MARC Coalition") is a not-for-profit association that was formed in September 2008 to advocate for the improvement of the Medicare Secondary Payer program for beneficiaries and affected companies. MARC's membership is comprised of entities representing virtually every sector of the MSP-regulated community, including attorneys, brokers, insureds, insurers, insurance and trade associations, self-insureds, and third-party administrators. MARC is deeply interested in improving the Medicare Secondary Payer program, and has worked with Congress, the Centers for Medicare and Medicaid Services, and the Courts to

ensure the program is functional and efficient for all stakeholders.

Amicus curiae The National Association of Mutual Insurance Companies ("NAMIC") is the largest property/casualty insurance trade group with a diverse membership of more than 1,400 local, regional, and national member companies, including seven of the top 10 property/casualty insurers in the United States. NAMIC members lead the personal lines sector representing 66 percent of the homeowner's insurance market and 53 percent of the auto market. Through our advocacy programs we promote public policy solutions that benefit NAMIC member companies and the policyholders they serve and foster greater understanding and recognition of the unique alignment of interests between management and policyholders of mutual companies.

Amicus curiae Personal Insurance Federation of Florida ("PIFF") is a leading voice for the personal lines property and casualty insurance industry in Florida. PIFF represents national insurance carriers and their subsidiaries, including many of the state's top writers of private passenger auto and homeowners multiperil insurance. Together, PIFF members write more than $13 billion in premiums in Florida.

As organizations whose members are primary payers or who have a dedicated mission to enhance the functioning of the Medicare Secondary Payer program, Amici have a particular interest in the issue of whether subcontractors of Medicare Advantage Organizations ("MAOs") have standing to sue under the

Medicare Secondary Payer Act (the "Act"). The Eleventh Circuit's decision expanding standing under 42 U.S.C. § 1395y(b)(3)(A) to any entity that happens to have a connection to an MAO is contrary to this Court's precedent, would undermine (rather than support) Congress's intent, and would expose Amicis' members to potential double damages under the Act without any notice of such entities' purported claims, raising serious due process concerns. Respondent MSP Recovery Claims, Series LLC and MSPA Claims 1, LLC or entities associated with them (collectively, "Respondent") have filed hundreds of cases in in federal courts across the country purporting to assert claims under the Act pursuant to alleged assignments from entities that are not MAOs, making this issue one of industry-wide importance to insurers and other primary payers.

SUMMARY OF ARGUMENT

The Eleventh Circuit's decision in this case was wrongly decided and warrants this Court's review now. Most importantly, in determining that Respondent has standing to pursue a statutory cause of action under 42 U.S.C. § 1395y(b)(3)(A), the court below failed to cite, let alone apply, this Court's established precedents for determining statutory standing to sue. Congress did not grant standing to entities who are neither the Secretary of Health and Human Services (the "Secretary") nor Medicare Advantage Plans, also referred to as Medicare Advantage Organizations ("MAOs").

Federal Election Comm'n v. National Conservative Political Action Comm., 470 U.S. 480, 483 (2011) and *Lexmark v. Static Control Components*, 572 U.S. 118, 129 (2014) hold that entities not identified by Congress in the Medicare Secondary Payer Act (the "Act") or which are not within the zone of protected interests by the Act have no standing under the Act's private cause of action.

In addition, the question presented is vitally important to the administration of the Medicare system. Critically, the Eleventh Circuit's decision frustrates the goal of making the Medicare system more efficient. The decision: (a) fails to consider the structure of the Medicare Advantage system; (b) creates a new system in which primary payers under the Act will be faced with demands by multiple parties for reimbursement of the same Medicare benefits without the ability to know which demands are legitimate; (c) delays the prompt resolution of the underlying accident claims; and (d) pushes the Act's reimbursement process into the federal courts instead of the current orderly and efficient reimbursement practice established by statute ad regulations among the Secretary, MAOs, and primary payers.

Finally, the issue is recurring, and delay in obtaining review would generate intolerable waste. Respondent has filed hundreds of similar lawsuits across the United States imposing a substantial burden on the federal courts without any potential benefit to the taxpayers because Respondent is entitled to keep the entire double damages permitted under the Act if it is

successful. Nothing will be returned to the Medicare Trust Funds of the Treasury of the United States (the "Trust Fund"). For these reasons, Amici support Petitioners' request that the Court review the Eleventh Circuit's decision.

ARGUMENT

I. Introduction and Background

Under the Act, the Secretary may make payments for healthcare services provided to a Medicare beneficiary and then seek reimbursement for those so-called "conditional payments" from a "primary payer." 42 U.S.C. § 1395y(b)(2)(B). Petitioners and Amici's members are primary payers when a Medicare beneficiary is injured in an underlying accident that triggers a workers' compensation plan, an automobile or liability insurance policy (including a self-insured plan), or no fault insurance that they have issued. § 1395y(b)(2)(A). If a primary payer refuses to reimburse the Secretary's conditional payment, Congress has provided a private cause of action for the Secretary and permits an award of double damages. § 1395y(b)(2)(B)(iii).

When Congress created Medicare Part C, private insurers were permitted to contract with the Secretary to provide Medicare benefits to people who are Medicare-eligible. These MAOs, like the Secretary, make conditional payments and may seek reimbursement from primary payers. Because MAOs, to some extent, perform the same function as the Secretary, some

courts have concluded that the Act's private right of action can be involved by MAOs.

Respondent here, however, is not the Secretary or an MAO. Respondent also has no assignment of rights from the Secretary or an MAO. Rather, Respondent is a venture capital-backed litigation vehicle that obtains assignments from subcontractors of MAOs.[3] Respondent will not send any of the damages it recovers to the federal government or the MAO. Yet, the Eleventh Circuit decided to extend standing under the Act to Respondent without any action by Congress and contrary to this Court's precedents. *See*, *e.g.*, *Stalley ex rel. United States v. Orlando Reg'l Healthcare Sys., Inc.*, 524 F.3d 1229, 1234 (11th Cir. 2008) (the Act is not a *qui tam* statute); *see also Stalley v. Methodist Healthcare*, 517 F.3d 911, 918–19 (6th Cir. 2008) ("[T]he [Act] does not contemplate that the plaintiff share a monetary judgment with the government" but instead "authorizes the private plaintiff to recover the entire bounty."); *United Seniors Ass'n, Inc. v. Philip Morris USA*, 500 F.3d 19, 25 (1st Cir. 2007) ("the plaintiff is entitled to the entire recovery").

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[3] *See*, *e.g.*, https://coralgablesthemagazine.com/the-commissioner-comes-home/ (stating MSP received venture capital funding); *MAO-MSO Recovery II, LLC v. State Farm Mut. Ins. Automobile Ins. Co.*, 1:17-cv-1537, ECF #106-3, p.4 (Interrogatory 2) (C.D. Ill. Dec. 10, 2018) (admission that RD Legal Finance and Virage Capital Mgmt. are managers of Respondent and affiliated entities); https://www.claimsjournal.com/news/national/2020/09/09/299226.htm (Respondent's principal stating that Respondent has spent $150m in investors' money to fund Respondent's efforts in hundreds of lawsuits).

The Eleventh Circuit's decision is not only wrong, it is wrong for reasons that warrant this Court's review now. In addition to the Eleventh Circuit's failure to follow precedent for determining statutory standing, the decision below upsets the current orderly and efficient process established between primary payers and the Secretary or MAOs for resolving conditional-payment reimbursement claims under the Act and, instead, encourages the filing of massive class actions with no benefit to the taxpayer. As a result, the decision encourages Amici's members to stop settling claims with Medicare beneficiaries, resulting in fewer, rather than more, recoveries for the Trust Fund and MAOs.

II. The Eleventh Circuit's decision finding that Respondent has standing to sue under § 1395y(b)(3)(A) departs from this Court's precedents.

Congress did not grant standing to Respondent or Respondent's assignors to invoke the Act's private cause of action. This Court has held that when a statute authorizes a named person or official to bring suit, those who are not named in the statute do not have standing. *Federal Election Comm'n*, 470 U.S. at 483. The Act expressly grants standing to the Secretary to pursue claims for the reimbursement of conditional payments to reimburse the Trust Fund. § 1395y(b)(2)(B)(iii). Part C of the Act, which created MAOs, authorized MAOs (like the Secretary) to make conditional payments and seek reimbursement from primary payers. 42 U.S.C. § 1395w-22(a)(4)(A). The

Secretary and MAOs are the only entities that are discussed in the Act as having a right of reimbursement from primary payers.[4] Neither Respondent nor Respondent's non-MAO assignors are named in the Act as entities who have standing to seek reimbursement of conditional payments. Likewise, no amount that Respondent would collect under these actions would go to reimburse the Trust Fund. Thus, whether by name or by purpose, *i.e.*, to reimburse the Trust Fund, Congress did not intend to give standing to Respondent or its assignors.

Instead, the Eleventh Circuit's decision gave standing to Respondent not because Congress authorized the subcontractors of MAOs to bring suit under the Act, but merely because the subcontractors have a "connection" to the Medicare program. A16a. Nothing in *Federal Election Commission* says that anyone who merely had a "connection" to the Presidential Election Campaign Fund Act had standing. There, the Democratic Party asserted it had standing under that statute as one of the two major political parties in the United States and the Court held that it did not. The Democratic Party certainly had some "connection" to the Presidential election system. Had this Court held that some "connection" was all that was required to

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[4] The Secretary is expressly authorized to pursue a private right of action for double damages. 42 U.S.C. § 1395y(b)(2)(B)(iii). While Part C expressly provides that MAOs have reimbursement rights, it does not expressly reference a right to double damages, 42 U.S.C. § 1395w-22(a)(4)(A), and that issue is not before the Court.

establish standing, the result in *Federal Election Commission* would have been different.

Similarly, Respondent is not within the zone of interests contemplated by the Act. *See Lexmark*, 572 U.S. at 129. The purpose of the Secretary's private cause of action is to return funds to the Trust Fund. § 1395y(b)(3)(A). That will not happen here if Respondent ultimately prevails on the merits of its claims. Instead, Respondent will keep the full double damages recovery that it seeks. Because the Eleventh Circuit did not consider this Court's precedent in creating the new "connection" rule for standing, and because the Eleventh Circuit's "connection" standard is one this Court has repeatedly rejected, certiorari is warranted.

III. The Court should take up this case, which will upend the Medicare reimbursement system and impose significant burdens on federal-court dockets, and to resolve a recurring problem.

A. The Eleventh Circuit's decision upsets the current orderly practice for making and resolving conditional-payment demands.

The Eleventh Circuit's expansive interpretation of the Act's private right of action risks throwing the current conditional-payment resolution process between Medicare or MAOs and primary payers into turmoil, with perverse ancillary results for consumers. The only parties who gain from the Eleventh Circuit's decision

are hedge-fund-backed litigation vehicles like Respondent.

The Medicare Advantage Program was intended to make the Medicare system "more efficient and less expensive." *Humana Med. Plan, Inc. v. W. Heritage Ins. Co.*, 832 F.3d 1229, 1235 (11th Cir. 2016) (citing H.R. Rep. No. 105-217, at 585 (1997), U.S.C.C.A.N. 176, 205-06 (Conf. Rep.)). Expanding the Act's private right of action to entities that merely happen to have a contract with an MAO would do the opposite. The expansion would not, in fact, incentivize cost-reduction and efficiency within the Medicare Advantage system, as the Eleventh Circuit predicts. Rather, it would force primary payers to restructure their operations, and force the federal government to set up a system to track every subcontractor and sub-subcontractor of every MAO.

First, the decision to expand the Act's private right of action to ***any*** party with "a connection to a conditional payment," A16a, fails to consider the structure of the Medicare Advantage system and the severely adverse consequences that the decision below will have for that system.

MAOs contract with the Secretary and, in exchange for a fixed fee per enrollee, are obligated to provide at least the same benefits that enrollees would be entitled to receive under traditional Medicare. In turn, an MAO may enter into subcontracts with other private parties for those other parties to perform various functions for the MAO related to the Medicare

beneficiaries' care. 42 C.F.R §§ 422.2; 422.504(i). Unlike MAOs, those subcontractors have no contractual or other direct relationship with the Secretary. Their obligations and rights are exclusively contractual between them and the MAOs. There is no obligation for the MAOs or the subcontractors to disclose the subcontractors' identities or contract terms to the Secretary or the Medicare beneficiaries.[5] Indeed, the fact that a Medicare beneficiary's MAO has even entered into these subcontracts is unknown to the beneficiary. Likewise, primary payers have no practical ability to identify these subcontractors, let alone the even more expansive universe of potential private plaintiffs with a "connection" to the Medicare system.

When primary payers receive a claim that a Medicare beneficiary has been injured in an accident, they report their primary payer status to the Secretary under a system maintained by the Center for Medicare and Medicaid Services ("CMS"). § 1395y(b)(8). By reporting their primary payer status, all that is being accomplished (and all the current CMS system is designed to do) is to tell the Secretary that the insurer may be primary to Medicare for the beneficiary's health care expenses related to the underlying accident. Should CMS choose to demand reimbursement for a conditional payment it made for the Medicare beneficiary's health treatment, CMS notifies the

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[5] Medicare Managed Care Manual, Ch. 11, § 110 (rev. 83, 04-25-2007) https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/mc86c11.pdf.

primary payer of the reimbursement amount. Indeed, the Act contains detailed requirements and procedures for making conditional payments and seeking reimbursement. *See generally* § 1395y(b).

Under the CMS reporting system, CMS does not provide the primary payer with any information concerning whether the Medicare beneficiary has elected to receive Medicare benefits through an MAO. Indeed, CMS is currently incapable of providing that information to putative primary payers under liability insurance, no fault insurance, or workers' compensation. CMS maintains a database of all MAOs, but its reporting system is incapable of informing primary payers of which MAO, if any, the Medicare beneficiary is an enrollee.

Thus, when the primary payer is paying or resolving the underlying claim with the injured person, there is no place for it to look to see if an MAO is seeking reimbursement for a conditional payment it made on behalf of the injured Medicare beneficiary. Moreover, the primary payer has no knowledge of which of the hundreds of MAOs has accepted the responsibility to provide the injured party's Medicare benefits. The primary payers are reliant on the beneficiary's MAO making itself known and providing notice that it has made a conditional payment and expects reimbursement under the Act.

Similar in some ways to how Congress established procedures for the Secretary to make conditional payments and seek reimbursement from primary payers,

it provided payment and reimbursement procedures for MAOs. To assist MAOs and primary payers with this process, Congress recently passed the PAID Act, H.R. 8900, Sec. 1301 (116th Cong.), which amends 42 U.S.C. § 1395y(b)(8)(G) and directs CMS to put in place a system under which a primary payer can learn which MAO, if any, is providing Medicare services for a beneficiary. When it is implemented, primary payers will have some opportunity to resolve underlying claims quickly (without the concern that a previously unknown MAO will surface after the claim is closed to seek reimbursement for conditional payments) because, under coming system, primary payers will be able to identify who the relevant MAO is and affirmatively ask if it made any conditional payments.

In contrast, Congress has created no payment/reimbursement process naming anyone other than the Secretary or MAOs. Moreover, neither the current reporting system nor the new system CMS is creating will inform the primary payers who the MAO's subcontractors are. If Congress intended downstream entities to have claims under the Act, surely Congress would have addressed those entities in the PAID Act. It did not because downstream entities do not have such claims. But, under the Eleventh Circuit's decision, those unknown subcontractors would have standing to sue for double damages after the underlying injury claim is resolved if they allege that they made conditional payments or incurred costs under the Act. While Congress remedied the problem of unknown MAOs with the PAID Act, a separate action by Congress to

create yet another massive database and reporting system for all of the downstream entities would be required to solve the problem of Respondent (or another downstream entity) from suing for double damages under the Act.

From a practical perspective, the Eleventh Circuit's decision foists tremendous costs on the federal government and primary payers by requiring the creation and maintenance of a massive new federal infrastructure for the tracking of subcontractors, and sub-subcontractors, and tying those entities to specific Medicare beneficiaries. Such a system is not contemplated by CMS, but without such a system, primary payers cannot resolve claims without the persistent concern that a subcontractor may show up years later and demand reimbursement, exposing the primary payer to a potential lawsuit seeking double damages for a reimbursement claim for which it previously had no knowledge. This is completely antithetical to the certainty and finality claims paying entities require to close their books on past obligations. Additional costs to CMS to establish this new reporting and tracking system creates a burden on taxpayers, on top of the increased costs to insurers that will inevitably be passed along to policyholders.[6] Meanwhile, the downstream

[6] Indeed, the Eleventh Circuit's decision grants greater rights to Respondent and its assignors than the Secretary or MAOs. Under *Humana Medical Plan, Inc. v. Western Heritage Insurance Co.*, 832 F.3d 1229, 1236 (11th Cir. 2016), MAOs (and presumably now downstream entities) that are permitted to sue primary payers have "the same rights" (not greater rights) than the federal government. But, the decision below held that

entities, like Respondent's assignors, can remain unknown to primary payers and Medicare beneficiaries but still sue for double damages without prior notice to the primary payers of their alleged liens.

Second, the Eleventh Circuit's decision creates utter chaos with respect to primary payers' obligations under the Act. Indeed, under the Eleventh Circuit's interpretation, primary payers theoretically could face claims from ***any*** entity that asserts it has been affected by a conditional payment, even if the primary payer already has paid the MAO for the Medicare beneficiary's care. A primary payer could be presented with reimbursement demands in connection with the same accident-related medical expenses from: an MAO, which has ultimate responsibility to the Secretary for the beneficiary's care; a medical services organization ("MSO," an administrator of health care providers), which has taken on contractual obligations vis-à-vis the MAO for some aspect of the beneficiary's care; and the MSO's independent physician's association, or other subcontractors, who have taken on contractual obligations vis-à-vis the MSO for some aspect of the beneficiary's care. Each of these entities, after all, "has a connection to Medicare's unreimbursed conditional payment." App. 16a. For example, the MAO could send a reimbursement demand for the whole amount of a beneficiary's medical treatment and recovery costs due to an accident. And, a subcontractor that provided a

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Respondent, unlike the Secretary and MAOs, is not required to send primary payers any notice of the reimbursement claim, and may instead immediately sue for double damages.

portion of that care under a subcontract with the MAO, such as physical therapy after the injury, could demand direct reimbursement for its portion of the care regardless of whether the MAO had already been reimbursed for the same therapy costs and even if the MAO has sent the reimbursement to the MSO. The Medicare Advantage system lacks any infrastructure that would permit for coordination amongst these various actors. The Eleventh Circuit's decision supplies no guidance about how to prioritize among competing claims and provides no safe-harbor for a primary payer that reimburses one entity in good faith.

Such a system is untenable for primary payers and invites even further litigation. Primary payers will be unsure about whom to pay, rightly concerned about the prospect of paying for the same medical treatment several times over, and unable to determine which reimbursement demands to prioritize – all at the risk of double damages under the Act. If the downstream entities have standing under the Act, and if primary payers are potentially liable for double damages to every contractor who claims it incurred costs for the claimant, every accident claim that primary payers wish to resolve would instead devolve into a lengthy investigation to determine the identity of the MAO; the terms of the MAO's subcontracts (including whether the MAO retained the exclusive right to seek reimbursements under the Act); what entity paid the medical providers for the enrollee's care; how much was paid; and whether medical services were related to the underlying accident. This process would have to be repeated if

the subcontractors, in turn, contract with entities further downstream, delaying every settlement until the primary payers can confirm each entity in this chain has been identified and made whole. These are needless hurdles to the prompt settlement of claims, which is in the interests of all stakeholders – except those whose business models are based on leveraging the double damages provision of the Act. Recognizing the limitation Congress placed on who has standing under the Act avoids these problems.

Downstream vendors are not without recourse. For example, their subcontracts with MAOs could require that the MAOs pursue conditional-payment reimbursements for amounts the subcontractor incurred under their agreement and share those recoveries with the subcontractor. Under that system, the primary payers would have only one entity from which to obtain assurance that no medical cost liens exist – the Secretary or the identified MAO – enabling the claim process to conclude efficiently and with assurance that some third party will not later sue under an allegation that the primary payer reimbursed the wrong party. Similarly, the MAOs would be incentivized to ensure their subcontractors report any amounts incurred promptly and to assert those reimbursement demands when contacted by the primary payers once CMS has the PAID Act reporting system in place.

Third, the Eleventh Circuit's decision disincentivizes the prompt resolution of claims through settlement, and thus, increases the cost primary payers must expend in defense of claims. In a typical

settlement of an underlying claim, a primary payer reimburses Medicare, if Medicare has asserted a lien on the recovery, or any known MAO, if it has asserted a lien. In this settlement process, the Medicare beneficiary agrees that he or she has disclosed to the primary payer whether he or she received Medicare benefits through an MAO and that no MAO or other liens exist. To assure finality of the claim, the beneficiary also agrees to reimburse the MAO, or any other entity that made a conditional payment on behalf of the beneficiary or has a lien on the beneficiary's recovery, that has not been disclosed to the primary payer.

The Eleventh Circuit's decision disrupts this orderly process. If the injured party fails to reimburse each entity in the chain, or even if some entity in the chain merely alleges it was not paid, the ***primary payer*** will be subject to a lawsuit and a threat of double damages.[7] In other words, the primary payers cannot achieve finality when settling with the beneficiary. But, if standing is confined to the Secretary, as intended by Congress, or MAOs, the underlying claims can be resolved quickly and without the concern that a previously unknown downstream entity will sue for double damages because the primary payer can investigate and pay any Medicare and MAO liens under the current CMS reporting system or the upcoming system under the PAID Act.

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[7] The plaintiff in such an action may seek compensation from the primary payer even if the underlying Medicare beneficiary had agreed to pay all outstanding liens, *i.e.*, the Act provides no safe-harbor. § 1395y(b)(2)(B)(iii); 42 C.F.R. § 411.24.

To achieve finality, either the injured party or the primary payer will have to obtain and review every contract between the MAO and all its downstream entities before making any payment. Put simply, the practical effect of the Eleventh Circuit's decision fosters a system in which primary payers cannot quickly or efficiently obtain critical facts due to the opaque collection of subcontractors – and this system would undoubtedly elongate the process of settlement and reimbursement under the Act while providing fertile ground for unnecessary and costly litigation.

Fourth, the confusing new paradigm created by the Eleventh Circuit's decision will be exacerbated by the fact that the process of satisfying payment obligations arising under the Act will now take place in courts – as opposed to the current industry practice between MAOs and primary payers in which an MAO sends a reimbursement demand to a primary payer and the two entities resolve the issue, usually with no court involvement. This is evidenced by the dearth of litigation under the Act until Respondent began filing hundreds of class actions a few years ago. *See* Section III B. The change of forum from routine industry communication among conditional and primary payers to the federal courts, in which previously unknown subcontractors seek double damages in a class action, is not a theoretical concern, but a real one demonstrated by the facts of this case. The Eleventh Circuit may not have envisioned it, but its ruling sets the stage for a free-for-all in which entities unknown to primary payers (or even the injured parties) will assert claims for

double damages in court without first providing the primary payers with notice of the reimbursement claim.

B. Absent this Court's review, Respondent and related entities will continue to pursue *in terrorem* litigation in the federal courts.

At the time that the parties' merits briefing was completed in the Eleventh Circuit proceeding from which Petitioners now seek a Writ of Certiorari, Respondent has filed at least 273 suits in federal courts nationally seeking to represent a nationwide and/or statewide class of similarly situated entities.

The imposition on the courts cannot be measured simply by the sheer number of nearly identical suits that Respondent files. Respondent's practice is to file an initial deficient complaint, wait for a motion to dismiss, file an amended complaint that tries to remedy some of the deficiencies, wait for a motion to dismiss that amended pleading, file a second amended complaint, and so on. With each serial pleading, Petitioners and Amici's members must respond to the flawed allegations. As the Seventh Circuit remarked in recently affirming (for the second time in two years) a district court's dismissal of an action brought by Respondent, "[t]his lawsuit mirrors scores like it filed in federal courts throughout the country that have all the earmarks of abusive litigation and indeed have drawn intense criticism from many a federal judge." *MAO-MSO*

Recovery II, LLC v. State Farm Mut. Auto. Ins. Co., ___ F.3d ___, No. 20-1268, 2021 WL 1538233, at *1 (7th Cir. April 20, 2021).

Worse, Respondent tends to sue first and ask questions later, relying on "the litigation process itself (in particular, discovery) as [its] pathway to identifying" whether a secondary payer actually owes reimbursement for conditional payments made. *Id.* at *2. This practice left the Seventh Circuit "with the unmistakable impression that these debt collector plaintiffs pull the litigation trigger before doing their homework. They sue to collect on receivables they paid little or nothing for and then rely on the discovery process to show they acquired something of value." *Id.* at *7.

Respondent's abusive litigation practices do more than annoy the primary payers they sue. They demand the time and attention of the courts. As the Seventh Circuit remarked, "[f]ederal courts do not possess infinite patience, nor are the discovery tools of litigation meant to substitute for some modicum of pre-suit diligence. The plaintiffs' approach is not sitting well with many judges, and multiple district courts have already commented on what they perceive as MAO-MSO's rush to file litigation in the hope that discovery will show whether an actual case or controversy exists." *Id* at *7 (citing *MSP Recovery Claims, Series LLC v. AIG Property Casualty, Inc.*, 2021 WL 1164091, at *1 (S.D.N.Y. Mar. 26, 2021)); *MSP Recovery Claims, Series LLC v. New York Cent. Mut. Fire Ins. Co.*, 2019 WL 4222654, at *6 (N.D.N.Y. Sept. 5, 2019) ("Plaintiffs' tactics are a flagrant abuse of the legal system."); *MSP Recovery*

Claims, Series LLC v. USAA Gen. Indem. Co., 2018 WL 5112998, at *13 (S.D. Fla. Oct. 19, 2018) ("In light of the ever-shifting allegations Plaintiff has presented in its four versions of its pleading, it is evident Plaintiff has played fast and loose with facts, corporate entities, and adverse judicial rulings."); *see also*, *e.g.*, *MSP Recovery Claims, Series, LLC v. Zurich Am. Ins. Co.*, Case No. 18 C 7849, 2019 WL 6893007, at *3 (N.D. Ill. Dec. 12, 2019) ("Nine attempts to establish standing and plead a cause of action is enough.").

Until a few years ago, litigation had been rare under the Act. In most instances, the Secretary or an MAO would send notice to primary payers that they have made a conditional payment for a Medicare beneficiary, and the primary payer would send back to the Secretary or the MAO the requested reimbursement or an explanation of why it is not responsible under the insurance policy it had issued, *e.g.*, the medical care was not related to the insured accident or the insurance policy limits had already been exhausted. Only rarely did this industry practice escalate to litigation.

Respondent, however, has developed a new strategy that requires the use of the federal courts as its collection tool. Like it did here, Respondent acquires raw data from an MAO's subcontractors and then sues alleged primary payers for double damages without doing its homework or providing notice of the alleged debt owed. This new tactic confuses who has the right to seek reimbursement from primary payers and it slows the process of primary payers reimbursing the Secretary or MAOs while the primary payers

investigate the varying reimbursement claims for the same medical services.

Unless the Eleventh Circuit's decision to expand the type of litigants who have standing under the Act beyond the bounds set by Congress is reversed, MSP Recovery will not be alone in this double-damage-collection-via-the-courts business model. It is reasonable to anticipate that if any person or entity with some "connection" to a Medicare beneficiary's medical care can use the Act as an investment/litigation opportunity to seek double damage, similar litigation vehicles will be created and funded by third-parties. Insurers and self-insured will be incentivized to stop settling cases with Medicare beneficiaries simply to avoid the onslaught of litigation that will follow. And everyone loses.

A decision by the Court that recognizes that Respondent and other non-MAOs lack standing under the Act will provide clarity to the trial courts before judicial resources are expended in repeated motion practice and discovery disputes over the myriad factual and legal deficiencies of Respondent's claims. The costs of these deficient lawsuits are undoubtedly borne by Petitioner's and Amici's members and clients and eventually passed on to consumers and taxpayers. But they also impact the courts that must oversee the oncoming flood of litigation. Accordingly, this decision involves questions of exceptional importance and impacts the outcome of hundreds of similar cases across the country.

CONCLUSION

The Eleventh Circuit's decision expands standing beyond what Congress authorized in the Act and does not advance any important public policy. Instead, it creates unnecessary confusion, prolongs the litigation process, imposes a burden on the courts, delays reimbursement to the Medicare system, and drives up costs that are ultimately borne by consumers. Amici respectfully urge the Court to grant the Petition for a Writ of Certiorari.

Respectfully submitted,

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