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Making Good Better: How To Improve Medicare Part D

By **David Farber**

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Law360, New York (August 8, 2017, 12:21 PM EDT) -- It is hard to imagine that in 2003, when Congress enacted the Medicare Modernization Act (MMA) and created the Medicare Prescription Drug Program (the "Part D" program), nobody really knew whether beneficiaries would actually sign up. Nor did Congress know whether, or how, the law would actually work.

The CMS administrator at the time, Tom Scully, famously noted that a prescription drug program "does not exist in nature."[1] In fact, at the time no model existed for a federally subsidized private insurance program, and there was nothing the Congress could use as a template. At best, Congress looked to the Medicare Advantage program as a guide for several of the operational aspects of the new Part D program. But even that was a poor analog.

Today, of course, we know what Congress could not know then: the Part D program is a success, with over 90 percent of all Medicare beneficiaries participating and receiving prescription medications at heavily subsidized rates. Importantly, the model itself has proven a success, with patient participant satisfaction rates over 90 percent on average.

However, while beneficiary premiums remain low, the federal government spends over 50 billion dollars per year in subsidies paid to the Part D plans to keep costs down for beneficiaries. And even less discussed is the reality that several of the operational parts of the law simply have never worked, to the frustration of beneficiaries, Part D plans (PDPs) and third parties alike.

Most prominent among these operational failures, and one that could save the federal government tens of million dollars each year, is the Part D Secondary Payer Program. Fortunately, Congress has begun to take action to fix this problem.

Most recently, Representatives Tim Murphy, R-Pa., and Ron Kind D-Wis., have introduced bipartisan legislation — the SPARC Act (H.R. 1122) — to turn today's "lose-lose-lose" for beneficiaries, Medicare and companies small and large into a "win-win-win."

Secondary Payer — The Issue

What is secondary payer? The principle, embodied in the Medicare A/B program since 1980, is simple —

Medicare should not pay claims if another party is responsible for paying; and if another party is not available to pay, Medicare can pay "conditionally" subject to later recovery if funds become available.

For example, if a beneficiary is still working and has group health coverage, the coverage pays first, and Medicare pays whatever the group health does not. Similarly, if a beneficiary is involved in an accident and can recover from a workers compensation insurance, no fault (auto) insurance or a third party claim, Medicare should not pay first. If Medicare pays when another party should have, under certain conditions Medicare is permitted to bring a later recovery action against the settling parties.

While Medicare struggles to run this program for the Part A and Part B programs, secondary payer in the Part D program does not work at all. Why has Part D secondary payer failed? Because unlike Parts A and B, parties settling a disputed case with a Medicare beneficiary have no ability to identify which Part D plan that beneficiary uses, much less if the Part D Plan paid for any drugs related to the accident or injury.

Similarly, PDPs have no ability to identify settling parties from which they can recover. This uncertainty puts at risk beneficiaries' ability to settle legitimate claims in the first instance, and can often tie up recoveries in escrow for months or years. And everyone is at risk of litigation.

Who is to blame for this mess? No one. In 2003, Congress simply had no idea how to address this very complex issue. As a result, Congress included a single line in the MMA to try to create a Part D secondary payer program providing that: "[t]he provisions of section 1852(a)(4) shall apply under this part in the same manner as they apply under part C." Social Security Act, Sec. 1860D-2(a)(4); 42 U.S.C. 1395w-102.

The provisions of "section 1852(a)(4)" are the Medicare Advantage secondary payer provisions, which technically (with certain very limited exceptions) legally do not fit,[2] and at best are completely vague and uncertain. In fact, the courts cannot even agree what secondary payer rights Medicare Advantage plans actually have. As a result, the Part D secondary payer program has failed everyone — the PDPs, beneficiaries, the government and taxpayers.

H.R. 1122 — The Solution

Fortunately Reps. Murphy and Kind, the lead authors on the SMART Act of 2013, which overhauled and greatly improved the Part A/B secondary payer system, have taken the initiative to develop a functional program for Part D. Their legislation, called the SPARC Act, embodies three core elements — transparency, efficiency and fairness — and proposes to rebuild the Part D secondary payer process so that it works.

Appropriately harnessing existing private sector practices and incentives, the legislation "rebuilds" the secondary payer process that will save money and restore certainty to the government, taxpayers, and both beneficiaries and those companies with whom they are settling claims.

How does the SPARC Act propose to do so? First, the legislation makes clear that insurers may not make themselves secondary to the Part D program — a fundamental building block that is simply missing in the statute. Second, the law increases transparency by requiring Medicare to share with Part D plans information reported by settling parties to Medicare about the settlements, so that Part D plans can actually recover in the right circumstances.

Third, recognizing that the cost of recovery may exceed the amount recovered,[3] the legislation allows

Part D plans to waive recoveries if they so choose. Fourth, in the event a responsible party refuses to reimburse a Part D plan, the law explicitly allows Part D plans the same "subrogation" recovery rights as other private insurers.

And finally, the law includes Part D plans in the "expedited claims resolution" process that Representatives Murphy and Kind in 2012 created for Medicare Parts A and B through their "SMART Act," so that the Part D plans can be repaid at the settlement table when parties are actually settling claims.

Some have argued that the subrogation provisions are only relevant to those cases before a settlement is reached and would not give Part D plans a right to sue "in the shoes of" the beneficiary after a responsible party paid the settlement to the beneficiary.[4]

But that is exactly how the process works in the private sector today — especially because the Part D plans themselves are private insurers, and the program was intended to harness private insurance principles using a federally-subsidized private sector model. The legislation thus is in harmony both with the objectives and operational realities of Part D.

Questions also have been raised about whether PDPs may lose certain recovery rights. But assuming they have any in the first place (and the law is, at best, unclear today), this question misses the reality that today uncertainty prevents settlements, and if there are no settlements, there is nothing from which PDPs can recover.

Moreover, the PDP "recovery right" question glosses over two more fundamental issues: first, whether Part D plans may have any recovery rights today, which is itself unclear and has only been hinted at in one of the conflicting Medicare Advantage court cases,[5] and second, if Part D is secondary to other available coverage by which PDPs manage the claims they submit to Medicare today.

Because there is no clarity on any of these issues, the legislation addresses them all, giving PDPs an expedited recovery right, making clear that PDPs are "secondary" in the first instance, clarifying "who can sue whom" after the fact, and giving PDPs a clear waiver right in the proper circumstances to avoid seeking recovery rather than tendering the claim to the government for payment through the "PDE" process.

Most importantly, the legislation eliminates uncertainty that plagues today's settlement environment and the risk of litigation years after the fact — allowing parties to settle and PDPs to be repaid faster.

Conclusion

The Medicare secondary payer laws have been built upon two core principles: that Medicare should not pay if another source of payment is available, and that reimbursement can be accomplished quickly and efficiently if sources of payment become available after Medicare has paid.

Although both are missing in the Part D program today, the SPARC Act fixes this problem by taking an ambiguous and ineffective law and turning it into a functional program.

And by doing so, H.R. 1122 will create the "win-win-win" for beneficiaries who will be able to settle their claims timely, for settling parties who will be able to repay the Part D plans at the time of settlement,

and for the plans (and the federal government) who will be able to recover in the right cases and avoid wasting funds on chasing recoveries in the wrong cases.

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[1] R. Pear, Medicare Aide Voices Doubts On Adding Drug Benefits; New York Times (June 7, 2003), available at http://www.nytimes.com/2003/06/07/us/medicare-aide-voices-doubts-on-adding-drug-benefits.html

[2] This is because both Medicare Part A and B and the Part C statute create secondary payer rights for payment of "items and services," a term of art generally defined as treatments. In contrast, the Part D program only addresses "covered outpatient drugs" — a different term of art covering prescription medications only, which by definition exclude any drugs covered under the B statute (drugs are not separately covered under the Part A statute). Thus, to the extent that Part D plans are limited by the plain statutory language to the rights afforded to Part C plans) and those plans are limited to recovering only for "items or services" which exclude all prescription drugs covered by Part D plans, it follows that Part D plans have no recovery rights for anything other than the limited set of drugs covered by both the Part B and D statutes (such as certain nursing drugs used in nursing homes).

[3] The average prescription drugs dispensed costs a Part D Plan $60. Although average costs of recovery are not available for private plans, the Medicare program estimates its own costs of recovery for a single claim to be $320. Thus, if only one or two drugs are subject to recovery, it makes no sense to spend over $300 to recover $120. Particularly since the government is charged the costs of recovery through the Part D Plan's "bid" as "administrative costs," it would save the Medicare program and taxpayers, as well as properly align incentives, to let make Part D plans responsible for their recovery costs and allow them to waive recovery when they will be "underwater" on the claim.

[4] See Medicare Ties that Bind Casualty Insurers and Drug Plans, Law360, May 18, 2017.

[5] Compare 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, 367 (3d Cir. 2012); Parra v. PacificCare of Arizona Inc., 715 F. 3d 1146 (9th Cir. 2013).

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