UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF LOUISIANA

HUMANA HEALTH BENEFIT PLAN OF LOUISIANA, INC.	*	**CIVIL ACTION NO.**
Plaintiff	*	**SECTION:**
v.	*	
FLOYD J. FALCON, JR., and AVANT AND FALCON, A LAW CORPORATION	*	**JUDGE:**
	*	**MAG. JUDGE:**
Defendants	*	

* *

COMPLAINT FOR DECLARATORY JUDGMENT

Plaintiff, Humana Health Benefit Plan of Louisiana. Inc. ("Humana"), brings this action for declaratory judgment and monetary damages to recover amounts due and owing to Humana, a Medicare Advantage Organization ("MAO"), by virtue of third party payments made on behalf of "Enrollee,"[1] a Medicare beneficiary who elected Medicare Advantage coverage from Humana.

PARTIES

1. Plaintiff, Humana Health Benefit Plan of Louisiana, Inc., is a Louisiana corporation with its principal place of business at One Galleria Boulevard, Suite 850, Metairie, Louisiana 70001. Plaintiff, Humana, contracts with the Center for Medicare and Medicaid Services ("CMS") to administer Medicare benefits for Medicare beneficiaries who elect to enroll in Medicare Advantage ("MA" or "Medicare Part C"). Plaintiff is part of the Humana family of companies.

[1] Enrollee's name is known to Defendants but is not being pled in this Complaint to protect Enrollee's privacy.

2. Defendant, Floyd J. Falcon, Jr. ("Falcon"), is an attorney licensed in the State of Louisiana. Falcon practices law in the State of Louisiana with the law firm Avant and Falcon, a law corporation incorporated under the laws of the State of Louisiana ("Avant & Falcon"). Falcon and Avant & Falcon (collectively, "Defendants") may both be served care of Floyd J. Falcon, Jr. at 429 Government Street, Baton Rouge, Louisiana 70802. Falcon and Avant & Falcon provided legal services to Enrollee.

JURISDICTION AND VENUE

3. This action arises under the laws of the United States and involves federal questions. The Court therefore has jurisdiction over the subject matter of this action under 28 U.S.C. § 1331.

4. Venue is proper in the Middle District of Louisiana because (1) Defendants do business in, and thus reside in, this judicial district and (2) a substantial part of the events or omissions giving rise to this action occurred in this judicial district. 28 U.S.C. § 1391(b) and (c).

LEGAL BACKGROUND

5. Medicare is a system of federally funded health insurance for people 65 and older, certain disabled persons, and persons with End Stage Renal Disease. Congress enacted the Medicare Program as Title XVIII of the Social Security Act ("Medicare Act"). 42 U.S.C. § 1395, *et seq.* Medicare is an enormous and complex federal program that insured over 55.3 million Americans in 2015 with total expenditures of $647.6 billion, compared to total income of $644.4 billion, a deficit of $3.2 billion.[2]

6. As set forth below, in response to the rising cost of healthcare paid for by the Medicare program, Congress created the Medicare Advantage program "to harness the power of

[2] *See* 2016 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, p. 7.

private sector competition to stimulate experimentation and innovation that would ultimately create a more efficient and less expensive Medicare system." *In re Avandia Mktg., Sales Practices & Prod. Liab. Litig.*, 685 F.3d 353, 363 (3d Cir. 2012) (citing H.R.Rep. No. 105–217, at 585 (1997), 1997 U.S.C.C.A.N. 176, 205–06 (Conf. Rep.)).

7. Moreover, and in response to the same concern, Congress determined that, in the event of a bodily injury such as an automobile accident, liability and no-fault insurance policies were to provide the primary source of recovery, with Medicare to be the secondary source of recovery. *See, e.g.*, 42 U.S.C. § 1395y(b)(2).

8. However, personal injury settlements frequently occur well after medical expenses have been incurred, meaning that the existence of primary payers is often not known until after Medicare Advantage Organizations ("MAOs") have issued payments to providers that treated Medicare beneficiaries. MAOs must then seek reimbursement from that parties responsible for paying for this medical care.

9. Attorneys have the financial ability and ethical obligation to ensure that no-fault and bodily injury settlement proceeds are used to reimburse the medical expenses paid by Medicare Advantage plans. Therefore, Congress has authorized Medicare Advantage plan providers to seek recovery of unreimbursed Medicare Advantage plan expenditures and seek double damages directly from any party that is responsible for such payments ("primary plan"), and any person that received payment from a primary plan, including a plaintiff's attorney.

10. Here, the Defendants, counsel for Enrollee, chose to ignore this legal and ethical obligation to see that Humana was reimbursed for its plan payments on behalf of Enrollee.

11. This suit and others like it challenge these and similar practices that drain money from the Medicare Trust Funds and increase the costs borne by elderly and disabled beneficiaries who enroll in Medicare Advantage plans.

The Medicare Act

12. Subchapter XVIII of the Social Security Act – commonly called the Medicare Act – is divided into five "Parts."

13. Part A is automatic and provides hospital and certain other facility benefits. *See* 42 U.S.C. §§ 1395c to 1395i-5. Part B provides medical benefits, and although heavily subsidized by the federal government, is a voluntary program that requires a small premium from the beneficiary. *See* 42 U.S.C. §§ 1395j to 1395w-4. Parts A and B are often collectively referred to as the "original Medicare fee-for-service program option."

14. Medicare Part C creates an alternative option for Medicare benefits provided by private contractors. *See* 42 U.S.C. §§ 1395w-21 to 1395w-29. Congress enacted Medicare Part C to "enable the Medicare program to utilize innovations that have helped the private market contain costs and expand health care delivery options." H.R. Rep. No. 105-217, at 585 (1997) (Conf. Rep.). Congress initially called this program "Medicare + Choice." *See* Balanced Budget Act of 1997, Pub. L. No. 105-33, Title IV, §§ 4001-4006, 111 Stat. 251, 275-334 (Aug. 5, 1997). In 2003, Congress strengthened the program and renamed it "Medicare Advantage." *See* Medicare Prescription Drug, Improvement, and Modernization Act of 2003 ("MMA"), Pub. L. No. 108-173, Title II, §§ 201-241, 117 Stat. at 2176-221.

15. Medicare Part D is the voluntary prescription drug benefit, added in 2003. *See* Title I, §§ 101-111, 117 Stat. 2066, 2071-176 (Dec. 8, 2003) (codified at 42 U.S.C. §§ 1395w-101 to 1395w-152).

16. The final "Part" of Title XVIII is Medicare Part E, which contains definitions and general provisions applicable to the whole of the Medicare program. *See* 42 U.S.C. §§ 1395x - 1395y. The Medicare Secondary Payer law, 42 U.S.C. 1395y(b), is codified in Part E.

The Medicare Advantage (Medicare Part C) Program

17. The Medicare Act guarantees eligible beneficiaries the right to elect to receive Medicare benefits either through the Original Medicare fee-for-service option or through a Medicare Advantage plan. *See* 42 U.S.C. § 1395w-21(a). Approximately 30% of all Medicare beneficiaries chose to enroll in Medicare Advantage plans.

18. Medicare Advantage is a federal program, operated under federal rules, funded by federal dollars.

19. The funds for Medicare Advantage benefits come from the Medicare Trust Funds. *See* 42 U.S.C. § 1395w-23(f). The Medicare Trust Funds expend more than one hundred billion dollars annually to provide Medicare benefits through the Medicare Advantage program.

20. The Conference Committee which finalized the legislation that became Medicare Part C believed that Medicare Advantage would "eventually eclipse original fee for service Medicare as the predominant form of enrollment under the Medicare program." Balanced Budget Act of 1997, P.L. 105-33, H.R. Conf. Rep. 105- 217 (July 30, 1997).

Medicare Advantage Organizations
And the Medicare Secondary Payer Law

21. In 1980, in response to skyrocketing costs, Congress began enacting the provisions that now comprise the Medicare Secondary Payer Law ("MSP Law"), 42 U.S.C. § 1395y(b). The primary intent underlying the MSP law is to shift the financial burden of health care from the Medicare program to private insurers and thereby lower the cost of the Medicare program.

22. The MSP law is codified as 42 U.S.C. § 1395y(b), in Part E of the Medicare Act, which contains definitions and other general provisions pertaining to the Medicare program as a whole. The terms of the MSP law make clear that it is applicable to all payments "under this Subchapter," 42 U.S.C. § 1395y(b)(2)(A), which includes payments made by MAOs under Part C of the Act.

23. Moreover, Part C of the Medicare Act expressly incorporates the MSP law into the Medicare Advantage program; authorizing an MAO to charge a primary plan or an individual that has been paid by a primary plan "under circumstances in which payment under this title is made secondary pursuant to" the MSP law (§ 1395y(b)(2)). 42 U.S.C. §1395w- 22(a)(4). In doing so, Congress expressed its understanding and intention that the MSP law applied to Medicare Part C.

24. The MSP law creates a federal coordination of benefits scheme, in which worker's compensation, liability insurance, and no-fault insurance are primary, and Medicare benefits are secondary. *See* 42 U.S.C. § 1395y(b)(2); 42 C.F.R. § 422.108(b)(3).

25. When an MAO makes a payment for medical services that are the responsibility of a primary plan under the MSP law, those payments are conditional, whether the primary plan's liability was established at the time of the conditional payment or not. Federal regulations define the term "conditional payment" under the MSP law to mean "a Medicare payment for services for which another payer is responsible, made either on the bases set forth in subparts C through H of this part, or because the intermediary or carrier did not know that the other coverage existed." 42 C.F.R. § 411.21.

26. As with any system of coordination of benefits, the Medicare Secondary Payer regime involves both avoidance and recovery. Optimally, when items and services are covered by both a primary plan and by Medicare benefits, the providers submit their charges to the primary payer, and Medicare ***avoids*** the expense of paying those charges. Alternatively, when Medicare makes a conditional payment for medical services that have a primary payer, regardless of the reason, Medicare may seek to ***recover*** those conditional payments. *See* 42 U.S.C. § 1395y(b)(2); § 1395y(b)(3)(A).

27. Because Medicare Advantage is simply another way in which Medicare beneficiaries may receive Medicare benefits, the same MSP rules apply. *See* CMS, Medicare Managed Care Manual, Chap. 4, § 130.3 (Rev. 107, 06-22-12) ("In the case of the presence of workers compensation, no-fault and liability insurance (including self-insurance), Medicare makes conditional payments if the other insurance does not pay promptly. These conditional payments are subject to recovery when and if the other insurance does make payment.").

28. CMS has interpreted the MSP Law as it applies to MAOs in a formal regulation, which states that "[t]he MAO will exercise the same rights to recover from a primary plan, entity or individual, that the Secretary exercises under the MSP regulations." 42 C.F.R. § 422.108(f). An entity that receives payment from a primary plan shall therefore be required to reimburse an MAO for conditional Medicare payments.

29. CMS has further explained that the regulation assigns MAOs "the right, under existing Federal law, to collect for services for which Medicare is not the primary payer" using "the same rights of recovery that the Secretary exercises under the Original Medicare MSP regulations." CMS, Memorandum: Medicare Secondary Payment Subrogation Rights (Dec. 5, 2011).

30. The MSP Law makes clear that "a primary plan, and an entity that receives payment from a primary plan, shall reimburse" any conditional Medicare payments. 42 U.S.C. § 1395y(b)(2)(B)(ii).

31. The MSP regulations further clarify that Medicare payers may recover "recover its payments from any entity, including a beneficiary, provider, supplier, physician, *attorney*, State agency or private insurer that has received a primary payment." 42 C.F.R. § 411.24(g) (emphasis added).

32. Applying this regulation, numerous courts have held that an attorney who receives a tort settlement or other primary payment on behalf of a Medicare beneficiary is an entity that receives payment from a primary plan under the MSP law and may be sued personally in an action to recover conditional payments. *Humana Insurance Co. v. Paris Blank LLP*, 187 F. Supp. 3d 676 (E.D. Va. 2016); *United States v. Harris,* 2009 U.S. Dist. LEXIS 23956 (N.D. W. Va. 2009) *aff'd*, 2009 U.S. App. LEXIS 23394 (4th Cir. Oct. 23, 2009); *United States v. Weinberg,* 2002 U.S. Dist. LEXIS 12289 (E.D. Pa. 2002); *Denekas v. Shalala*, 943 F. Supp. 1073, 1080 (S.D. Iowa 1996); *US. v. Sosnowski,* 822 F. Supp. 570, 573 (W.D. Wis. 1993).

33. The enforcement provision of the MSP law authorizes a private cause of action to recover primary payments or reimbursements owed under the MSP law. 42 U.S.C. § 1395y(b)(3)(A). The provision further provides that damages "shall be in an amount double the amount otherwise provided." *Id.*

34. An MAO that has advanced Medicare benefits has standing to bring the MSP private cause of action. *Humana Med. Plan, Inc. v. Western Heritage Ins. Co.*, 832 F.3d 1229 (11th Cir. 2016); *In re Avandia Mktg.*, 685 F.3d 353 (3d Cir. 2012); *Cariten Health Plan, Inc. v. Mid-Century Ins. Co.*, 2015 U.S. Dist. LEXIS 126887, at *14 (E.D. Tenn. Sep. 1, 2015); *Collins*

v. Wellcare Healthcare Plans, Inc., 73 F. Supp. 3d 653, 665 (E.D. La. 2014); *Humana Ins. Co. v. Farmers Tex. Cnty. Mut. Ins. Co.*, 95 F. Supp. 3d 983, 986 (W.D. Tex. 2014).

35. Plaintiff, Humana, has standing under 42 U.S.C. § 1395y(b)(3)(A) to bring this private cause of action to recover double damages from Defendants because (1) Humana made payments of Medicare benefits on behalf of its MA Enrollee, for which Humana was not primarily liable and (2) Defendants received payments from plans that were primarily liable but failed to reimburse Humana.

36. When Medicare Advantage plans recover reimbursement from primary plans or other liable parties pursuant to the MSP law, those recoveries help reduce Medicare expenditures by the Medicare Trust Funds. *See* HHS, *Medicare Program; Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs,* 75 Fed. Reg. 19678, 19797 (April 15, 2010) ("MAOs that faithfully pursue and recover from liable third parties will have lower medical expenses.").

37. Thus, MSP recoveries by MAOs fulfill the essential purpose of the MSP law and Medicare Part C – creating a more efficient and less expensive Medicare program.

FACTUAL BACKGROUND

38. On or about December 31, 2013, Enrollee was a passenger in a vehicle that was involved in a serious collision.

39. At the time of the collision Enrollee was eligible for Medicare and had elected Medicare Part C coverage through Humana.

40. Enrollee received Medicare benefits for injuries sustained in the collision. Specifically, Humana has expended at least $182,198.35 in conditional payments on Medicare claims submitted on behalf of Enrollee for medical services rendered as a result of the collision.

41. After retaining counsel to represent her interests, Enrollee received settlement payments from one or more insurance companies totaling at least $24,000.00.

42. Enrollee and Defendants failed to timely notify Humana of the accident claim and liability settlement.

43. After learning that Enrollee may have been injured in a car accident, and that Enrollee was represented by Defendants, Humana placed Defendants on notice of Humana's lien.

44. Defendants failed or refused to ensure that Enrollee satisfied Humana's lien.

45. Counsel for Humana sent Defendants a letter on February 17, 2017 that advised them of their non-delegable duty to ensure that Humana is appropriately reimbursed for its conditional payments on behalf of Enrollee. That letter informed Defendants that they could personally be sued for double damages under the controlling law, including the Eleventh Circuit's recent decision in *Humana Med. Plan, Inc. v. Western Heritage Ins. Co.*, 832 F.3d 1229 (11th Cir. 2016), if they refused Humana's reimbursement request.

46. Defendants have refused to honor Humana's request for reimbursement.

47. Plaintiff, Humana, has not received any reimbursement to date for the conditional payments it made on behalf of Enrollee.

COUNT I

DECLARATORY JUDGMENT AS TO DEFENDANTS' OBLIGATION TO REIMBURSE MEDICARE BENEFITS

48. Plaintiff, Humana, incorporates by reference the allegations of paragraphs 1 through 47 of the Complaint as if set forth herein.

49. Pursuant to 28 U.S.C. § 2201, and Fed. R. Civ. P. 57, Plaintiff, Humana, is entitled to a Declaration as follows:

(a) The insurance policies providing liability, no fault, collision, and underinsured motorist coverage to Enrollee are primary to Medicare, including Medicare benefits advanced by MA organizations such as Plaintiff, Humana.

(b) When an MAO, such as Humana, has advanced conditional Medicare benefits in circumstances in which its payments are made secondary pursuant to 42 U.S.C. §§ 1395y(b)(2) and 1395w-22(a)(4), it is entitled to pursue reimbursement from a primary plan or entity that received payment from a primary plan under 42 U.S.C. § 1395y(b)(3)(A).

(c) Defendants, as entities that received payment from a primary plan, are individually obligated to appropriately reimburse Humana.

50. Declaratory relief is necessary and appropriate because Defendants have refused to recognize their obligations under the MSP law.

COUNT II

PRIVATE CAUSE OF ACTION UNDER 42 U.S.C. § 1395y(b)(3)(A)

51. Plaintiff, Humana, incorporates by reference the allegations of paragraphs 1 through 50 of the Complaint as if set forth herein.

52. Plaintiff, Humana, made payments of Medicare benefits for items and services required by Enrollee as a result of the injuries Enrollee sustained in the collision.

53. Insurers that provided liability, no fault, collision, and underinsured motorist coverage to Enrollee (collectively "the Primary Payers") were primary payers, as defined in 42 U.S.C. § 1395y(b)(2) and § 1395w-22(a)(4), with respect to medical expenses incurred by Enrollee but paid by Humana. See also Brown v. Thompson, 374 F.3d 253 (4th Cir. 2004) (discussing tort settlements as "primary plans" under the MSP law.).

54. At the time it made payment for Enrollee's medical treatment, Humana did not know that primary coverage provided by the Primary Payers existed or that any primary payer could be expected to pay promptly for Enrollee's care. These payments were, therefore, conditional. See 42 C.F.R. §411.21.

55. Defendants negotiated settlements, on behalf of Enrollee, with the Primary Payers and directly received settlement funds related to the medical services provided to Enrollee after the collision.

56. Defendants are entities that received payment from a primary payer, and are required to reimburse Humana pursuant to 42 U.S.C. § 1395y(b)(2)(B)(ii) and 42 C.F.R. §§ 411.24(g), 422.108(f).

57. Defendants did not make or ensure appropriate reimbursements to Humana for the items and services for which Humana advanced conditional payments.

58. Congress established a private cause of action under 42 U.S.C. § 1395y(b)(3)(A), permitting the recovery of double damages for a failure to make appropriate reimbursement in accordance with the MSP law.

59. Under the private cause of action established by 42 U.S.C. § 1395y(b)(3)(A), Plaintiff, Humana, is entitled to recover "an amount double the amount otherwise provided." Humana made payments of Medicare benefits of at least $13,388.02 and is entitled to recover double that amount, or at least $26,776.04, from Defendants.

Based on the above claims, Plaintiff, Humana, seeks the following relief:

(1) An order declaring:

(a) The insurance policies providing liability, no fault, collision, and underinsured motorist coverage to Enrollee are primary to Medicare, including Medicare benefits advanced by MA organizations such as Plaintiff, Humana;

(b) When an MA organization, such as Humana, has advanced conditional Medicare benefits in circumstances in which its payments are made secondary pursuant to 42 U.S.C. §§ 1395y(b)(2) and 1395w-22(a)(4), it is entitled to pursue reimbursement from a primary plan or entity that received payment from a primary plan under 42 U.S.C. § 1395y(b)(3)(A); and

(c) Defendants, as entities that received payment from a primary plan, are individually obligated to appropriately reimburse Humana.

(2) Double damages under 42 U.S.C. § 1395y(b)(3)(A);

(3) Pre- and post-judgment interest;

(4) Attorneys' fees and costs; and

(5) Such other relief the Court deems proper.

WHEREFORE, Plaintiff, Humana, prays that the Court enter judgment on behalf of Plaintiff, Humana, and against Defendants, Floyd J. Falcon, Jr. and Avant and Falcon, a law corporation, and award Plaintiff, Humana all requested relief.

Respectfully submitted this 30th day of August, 2017.

MATTHIESEN, WICKERT & LEHRER, S.C.

/s/ James T. Busenlener

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