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I. INTRODUCTION

This Article serves as a review of significant healthcare developments in the United States Court of Appeals for the Eleventh Circuit over the last two years and builds upon *Mercer Law Review*'s last Healthcare Article[1] in Volume 65. Specifically, this Article will cover cases dealing with physician speech, the False Claims Act,[2] and the Medicare Secondary Payer Act.[3]

II. LIMITATIONS ON PHYSICIAN SPEECH

Wollschlaeger v. Governor[4] arose from a challenge of Florida's Firearm Owners' Privacy Act (FOPA)[5] enacted in 2011.[6] The plaintiffs' claims, grounded in the Free Speech Clause of the First Amendment,[7] challenged the constitutionality of FOPA as some portions regulated the content of physician speech.[8] Practically, FOPA restricted medical professionals on what they could ask patients regarding firearm ownership.[9]

Doctors and medical organizations filed suit in the United States District Court of the Southern District of Florida against Florida officials.[10] The district court permanently enjoined the law's provisions

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1. Terri K. Benton, *Healthcare, Eleventh Circuit Survey*, 65 MERCER L. REV. 1027 (2014).

2. 31 U.S.C. § 3729 (2018).

3. 42 U.S.C. § 1395y(b) (2018).

4. 848 F.3d 1293 (11th Cir. 2017).

5. FLA. STAT. ANN. § 790.338 (2018) (subsections (1), (2), and (6) held unconstitutional by *Wollschlaeger*, 848 F.3d at 1319).

6. *Wollschlaeger*, 848 F.3d at 1300.

7. U.S. CONST. amend. I.

8. *Wollschlaeger*, 848 F.3d at 1300.

9. *Id.*

10. *Id.*

regarding "record-keeping, inquiry, anti-discrimination, and anti-harassment" because those provisions violated the Fourteenth Amendment[11] and First Amendment.[12] The Florida officials subsequently appealed, and the Eleventh Circuit issued three different opinions upholding FOPA.[13] In June 2016, the court voted to rehear the case en banc.[14] Applying heightened scrutiny, the Eleventh Circuit ultimately held that FOPA's record-keeping, inquiry, and anti-harassment provisions violated the First Amendment but that the anti-discrimination provision may stand.[15]

The court first characterized FOPA's record-keeping, inquiry, and anti-harassment provisions as speaker-focused and content-based restrictions on speech because "[t]hey apply only to the speech of doctors and medical professionals, and only on the topic of firearm ownership."[16] As such, it rejected rational basis review and applied heightened scrutiny.[17] The standard, as established by *Sorrell v. IMS Health Inc.*,[18] requires a showing by state officials that the provisions "directly advance[] a substantial governmental interest and that the measure[s] [are] drawn to achieve that interest. There must be a 'fit between the legislature's ends and the means chosen to accomplish those ends.'"[19] The court, therefore, looked to the empirical evidence relied upon by the legislature, which amounted to six anecdotes.[20]

The court explained that doctors typically ask patients about health and safety risks such as household chemicals, swimming pools, and firearms.[21] Per the opinion, the American Medical Association promotes physician inquiry about household firearms so that patients may be educated as to their dangers, especially regarding children.[22] The six anecdotes suggested that medical providers began asking Florida patients "unwelcome questions or made purportedly improper comments regarding their ownership of firearms."[23] The court noted that a National Rifle Association representative even recounted a scenario where a

11. U.S. CONST. amend. XIV.
12. *Wollschlaeger*, 848 F.3d at 1300–01.
13. *Id.* at 1301.
14. *Id.*
15. *Id.*
16. *Id.* at 1307.
17. *Id.* at 1311.
18. 564 U.S. 552 (2011).
19. *Wollschlaeger*, 848 F.3d at 1312 (quoting *Sorrell*, 564 U.S. at 572).
20. *Id.*
21. *Id.* at 1301.
22. *Id.*
23. *Id.* at 1302.

medical provider refused to examine a child if the parent did not answer questions regarding household firearms.[24] Thus, FOPA was enacted.[25]

The purported interests that state officials sought to protect through FOPA included: protecting "the Second Amendment right of Floridians to own and bear firearms" from private encumbrances,[26] protection of patient privacy,[27] "ensuring access to health care without discrimination or harassment,"[28] and "the need to regulate the medical profession in order to protect the public."[29] The State further argued that "the First Amendment is not implicated because any effect on speech is merely incidental to the regulation of professional conduct."[30] However, the court held that the state's interests did not meet *Sorrell*'s heightened scrutiny test.[31] It analogized the facts at hand to *Conant v. Walters*,[32] a United States Court of Appeals for the Ninth Circuit case that "struck down . . . a federal policy which threatened doctors with revocation of their DEA prescription authority if they recommended the medicinal use of marijuana to their patients."[33] There, the Ninth Circuit categorized the speech as content and viewpoint based and invalidated it on First Amendment grounds.[34] Thus, the Eleventh Circuit struck down all the challenged provisions except for the anti-discrimination section.[35]

In *Wollschlaeger*, the court gave deference to physicians and medical providers as an authority. There is value given to what information they believe necessary for treatment. Indeed, the Eleventh Circuit stated that "[i]n 'the fields of medicine and public health . . . information can save

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24. *Id.*

25. *Id.*

26. *Id.* at 1312.

27. *Id.* at 1314.

28. *Id.*

29. *Id.* at 1316.

30. *Id.* at 1308. The State supported this argument by relying upon a concurrence written by United States Supreme Court Justice White in 1985. *Id.* The Eleventh Circuit summarized Justice White's analysis: "when a person is exercising judgment with respect to a particular client, he is 'engaging in the practice of a profession' and his speech is 'incidental to the conduct of the profession,' such that his First Amendment interests are diminished." *Id.* (quoting Lowe v. S.E.C., 472 U.S. 181, 232 (1985) (White, J., concurring in the judgment)). The Eleventh Circuit, however, distinguished *Lowe* and its progeny. *Id.* at 1309. It explained that "The Supreme Court has never adopted or applied Justice White's rational basis standard to regulations which limit the speech of professionals to clients based on content." *Id.* at 1310.

31. *Id.* at 1311.

32. 309 F.3d 629 (9th Cir. 2002).

33. *Wollschlaeger*, 848 F.3d at 1310.

34. *Id.*

35. *Id.* at 1318.

lives.'"[36] The court held that restricting physician speech is an inappropriate methodology to change the way household firearms are discussed in the medical context.[37] With that being said, FOPA's anti-discrimination provision still stands, and any discrimination against a patient based solely on the ownership of a firearm will not be tolerated.[38]

III. THE FALSE CLAIMS ACT: "CONTRADICTION IS NOT A SIGN OF FALSITY, NOR THE LACK OF CONTRADICTION THE SIGN OF TRUTH."[39]

In *United States v. AseraCare, Inc.*,[40] the United States brought an action under the False Claims Act (FCA)[41] against AseraCare, Inc. (AseraCare),[42] alleging that AseraCare submitted false claims to Medicare on behalf of 123 hospice patients claiming that the patients' medical records did not support the medical prognosis.[43] The FCA provides, in relevant part, that if a person:

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36. *Id.* at 1313 (quoting *Sorrell*, 564 U.S. at 566). While the Eleventh Circuit acknowledged that information can save lives, Florida is not unique in its attempt to limit the medical community's access to patient health risk information in terms of gun ownership. By the enactment of the Dickey Amendment in 1996 (which has been reauthorized each year since), the United States Congress prevents the Centers for Disease Control and Prevention (CDC) from using its funding "to advocate or promote gun control." Department of Health and Human Services Appropriations Act of 1997, Pub. L. No. 104-208, 110 Stat. 3009-242–44 (1996). Many medical organizations have opposed the amendment in recent years because of its stifling effect on research. Letter from the Academic Consortium for Integrative Medicine & Health, et al., to the U.S. Senate and U.S. House of Representative's Appropriations Committees (Apr. 6, 2016), http://files.www.drsforamerica.org/blog/blogs-from-dc-climate-change-and-health-at-the-white-house/CDC_letter_4-6_FINAL.pdf. In 2016, the American Medical Association, along with over one hundred other organizations like the American Psychological Association, American Association for the Advancement of Science, Doctors for America, the American College of Preventative Medicine, and the American Academy of Pediatrics, wrote to the U.S. Senate and U.S. House of Representatives "urg[ing]" them to provide the CDC with funding to research gun violence because of the health risks guns present. *Id.*

37. *Wollschlaeger*, 848 F.3d at 1313–14.

38. *Id.* at 1317 (quoting FLA. STAT. ANN. § 790.338(5) (2018)).

39. Blaise Pascal, *quoted in* GEORGE ENGLEBRETSEN, BARE FACTS AND NAKED TRUTHS: A NEW CORRESPONDENCE THEORY OF TRUTH 153 (2006).

40. 176 F. Supp. 3d 1282, 1283 (N.D. Ala. 2016), *argued*, No. 16-13004 (11th Cir. Mar. 16, 2017).

41. 31 U.S.C. § 3729(a)(1)–(2) (2018).

42. The United States also brought an action against Golden Gate National Senior Care, LLC, an entity providing billing services for AseraCare, among others. Complaint in Intervention at ¶ 10, United States v. AseraCare, Inc., 176 F. Supp. 3d 1282 (N.D. Ala. 2016) (No. 2:12-CV-0245-KOB).

43. *AseraCare, Inc.*, 176 F. Supp. 3d at 1283. The Federal Regulation governing hospice Medicare eligibility requires certification of the person's illness. 42 C.F.R. § 418.22 (2018). "The certification must specify that the individual's prognosis is for a life expectancy of 6

> (A) knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval; [or] (B) knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim . . . is liable to the United States Government for [civil penalties].[44]

In 2015, the United States District Court for the Northern District of Alabama bifurcated the trial into phases one and two, with the "falsity element" to be tried in phase one.[45] The court subsequently granted AseraCare's motion for new trial because the court did not instruct the jury that a difference of opinion is not enough to prove falsity.[46] The court also put the parties on notice that it would consider summary judgment *sua sponte* in light of its concern over whether or not the United States "[had] sufficient admissible evidence of more than just a difference of opinion to show that the claims at issue are objectively false as a matter of law."[47] The court explained that the United States had "to point to objective evidence in the Phase One record that the court may have overlooked that shows a particular claim was false, other than [the expert's] testimony."[48]

In 2016, the court granted, *sua sponte*, summary judgment in favor of AseraCare.[49] The court noted that the litigation in *AseraCare, Inc.* "has always been about whether AseraCare knowingly submitted *false* claims to Medicare by certifying patients as eligible for hospice who did not have a prognosis of 'a life expectancy of 6 months or less *if* the terminal illness runs its normal course.'"[50] It is well established in the Eleventh Circuit that "the submission of a false claim is the *sine qua non* of a False Claims Act violation."[51] The United States must provide "proof of an objective falsehood" in prosecuting a claim.[52] When a healthcare entity uses

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months or less if the terminal illness runs its normal course." 42 C.F.R. § 418.22(b)(1) (2018).

44. 31 U.S.C. § 3729(a)(1)–(2). The FCA provides that "knowing" and "knowingly" "(A) mean that a person, with respect to information—(i) has actual knowledge of the information; (ii) acts in deliberate ignorance of the truth or falsity of the information; or (iii) acts in reckless disregard of the truth or falsity of the information; and (B) require no proof of specific intent to defraud." 31 U.S.C. § 3729(b) (2018).

45. United States v. AseraCare, Inc., 153 F. Supp. 3d 1372, 1377 (N.D. Ala. 2015).

46. *Id.* at 1382–85.

47. *Id.* at 1385.

48. *Id.* at 1387.

49. *AseraCare, Inc.*, 176 F. Supp. 3d at 1286.

50. *Id.* at 1283 (quoting 42 C.F.R. § 418.22(b)(1)) (emphasis in original).

51. *Id.* (quoting Urquilla-Diaz v. Kaplan Univ., 780 F.3d 1039, 1052 (11th Cir. 2015)).

52. *Id.* (quoting United States *ex rel.* Parato v. Unadilla Health Care Ctr. Inc., 787 F. Supp. 2d 1329, 1339 (M.D. Ga. 2011)).

improper practices, those practices alone "are insufficient to show falsity without proof that specific claims were, in fact, false when submitted to Medicare."[53]

In its ruling on the "falsity" requirement, the court disagreed with the United States' argument that the lack of "clinical information" in the patients' medical records supporting their hospice eligibility warranted the claims for those patients as "false."[54] The court explained that "[w]hen hospice certifying physicians and medical experts look at the very *same* medical records and disagree about whether the medical records support hospice eligibility, the opinion of one medical expert *alone* cannot prove falsity without further evidence of an objective falsehood."[55] The court cautioned that if

> [A]ll the Government needed to prove falsity in a hospice provider case was one medical expert who reviewed the medical records and disagreed with the certifying physician, hospice providers would be subject to potential FCA liability any time the Government could find a medical expert who disagreed with the certifying physician's clinical judgment. The [C]ourt refuses to go down that road.[56]

The court held that the United States failed to prove falsity as a matter of law and granted summary judgment for AseraCare.[57]

The United States subsequently appealed, and oral arguments took place on March 16, 2017.[58] The court has not yet issued an opinion. The ruling on this matter will significantly impact the prosecution of false claims moving forward. As the 2015 Memorandum Opinion stated in the underlying litigation: "One of the undecided areas of law in the Eleventh Circuit is the legal standard for falsity in a case like this one, where the Government alleges that the hospice provider's medical records do not support its hospice eligibility certifications, and, therefore, the certifications are false."[59] If the Eleventh Circuit agrees with the Northern District of Alabama, the United States will not be able to merely rely upon expert testimony to provide "proof of an objective

53. *Id.* at 1283–84 (quoting *Urquilla-Diaz*, 780 F.3d at 1045).

54. *Id.* at 1283.

55. *Id.*

56. *Id.* at 1285.

57. *Id.* at 1286. In its 2015 Memorandum Opinion, the court suggested that the outcome may be different if the United States "offered [] evidence that AseraCare billed for phantom patients, that it submitted Certificates of Terminal Illness with forged signatures, or that any AseraCare employees lied to or withheld critical information from the certifying doctors about any specific patients." *AseraCare, Inc.*, 153 F. Supp. 3d at 1375.

58. *AseraCare, Inc.*, 176 F. Supp. 3d at 1283.

59. *AseraCare, Inc.*, 153 F. Supp. 3d at 1375.

falsehood" in these hospice cases. According to one healthcare expert, this would constitute "a stunning development in the often clinically murky area of complex medical practice, with major implications for health care fraud enforcement."[60]

IV. MEDICARE ADVANTAGE ORGANIZATIONS' ACCESS TO DOUBLE DAMAGES

The Eleventh Circuit recently held in *Humana Medical Plan, Inc. v. Western Heritage Insurance Co.*[61] that, as a matter of first impression, a private cause of action is available to Medicare Advantage Organizations (MAOs)[62] under the Medicare Secondary Payer Act (MSP).[63] MAOs are now officially entitled to bring claims against a tortfeasor's liability insurer when seeking reimbursement for secondary payments.[64] This is significant because the private cause of action allows for double damages.[65]

A. The Underlying Litigation

The litigation began in 2009 when a Humana Medicare Advantage Plan enrollee and her husband brought an action against Hamptons West Condominiums for personal injuries. In 2010, while the parties negotiated settlement, Humana issued an "Organization Determination" to the plaintiffs for $19,155.41.[66] Meaning, Humana made a claim to that payment.[67] In terms of background, "Humana operates as an MAO, providing Medicare Part C coverage (also known as a Medicare Advantage [P]lan) to Medicare-eligible enrollees and receiving in return a per capita fee from the Centers for Medicare & Medicaid Services (CMS)."[68] Humana sought to be reimbursed for said amount because the MSP provides that "Medicare payments are secondary and reimbursable

60. Zack Buck, *Keeping an Eye on the Eleventh*, HARV. L. BLOG: BILL OF HEALTH (June 29, 2017), http://blogs.harvard.edu/billofhealth/2017/06/29/keeping-an-eye-on-the-eleventh/#more-22892.

61. 832 F.3d 1229 (11th Cir. 2016).

62. *Id.* at 1231–40.

63. 42 U.S.C. § 1395y(b) (2018).

64. *Humana Med. Plan, Inc.*, 832 F.3d at 1239–40.

65. *Id.* at 1240; 42 U.S.C. § 1395y(b)(3)(A) (2018).

66. *Humana Med. Plan, Inc.*, 832 F.3d at 1232.

67. An "Organization Determination" is a term of art meaning the Medicare Advantage Organization's "original claim for payment." *See* CENTERS FOR MEDICARE AND MEDICAID SERVICES, PAYMENT DISPUTE RESOLUTION CONTRACTOR (PDRC) PROCESS MANUAL 5 (2010), https://www.cms.gov/Medicare/Health-Plans/HealthPlansGenInfo/Downloads/PDRC_Process_Manual-.pdf.

68. *Humana Med. Plan, Inc.*, 832 F.3d at 1231–32.

if any other insurer—even a tortfeasor's liability insurer—is liable."[69] Despite the option for the plaintiffs to appeal Humana's Organization Determination, no administrative appeal was taken.[70]

The parties in the underlying personal injury action settled for $115,000, releasing Hamptons West Condominiums and its insurer, Western. Notably, the plaintiffs did not mention a Medicare lien, any other liens, or any rights to subrogation in the settlement agreement. By signing the settlement agreement, the plaintiffs also agreed to indemnify the defendant and Western against said liens or rights to subrogation.[71]

B. Humana's Attempts to Obtain Reimbursement

Humana then sought to recover the $19,155.41 by filing an action against the original plaintiffs, and procedural havoc ensued, resulting in the original plaintiffs bringing a declaratory action in state court to determine the amount owed to Humana. After Humana appealed the state court decision, a Florida District Court of Appeal held that Florida courts did not have jurisdiction over the matter on the basis that once the administrative process under the Medicare Act is exhausted, the act requires federal judicial review.[72]

Humana subsequently brought an action in federal court against Western, the original defendant's liability insurer, seeking reimbursement for Humana's secondary payment. Humana alleged that it was entitled to the following: (1) double damages under the MSP's private cause of action; (2) declaratory relief under Medicare's statutory and regulatory schemes; and (3) damages under state law theories such as unjust enrichment. Upon motion, the district court dismissed the state-law claims. In 2014, when Humana moved for summary judgment, the district court found that the private cause of action under the MSP is available to a Medicare Advantage Organization and entered a judgment, leading to Western's appeal.[73]

69. *Id.* at 1232 (citing 42 U.S.C. § 1395y(b)(2) (2015); 42 U.S.C. § 1395w-22(a)(4) (2010)).

70. *Id.*

71. *Id.*

72. *Id.* (citing Humana Med. Plan, Inc. v. Reale, 180 So. 3d 195 (Fla. Dist. Ct. App. 2015)).

73. *Id.* at 1233.

C. The Eleventh Circuit Analysis

In its discussion, the Eleventh Circuit covered the background of the MSP, the Medicare Advantage Program,[74] and analyzed an MAO's rights under the MSP.[75]

1. The MSP

The MSP, specifically 42 U.S.C. § 1395y(b)(2), makes Medicare the "secondary payer" to certain primary plans.[76] Congress passed this legislation "in an effort to shift costs from Medicare to the appropriate private sources of payment."[77] The MSP prevents the Medicare trust fund from becoming depleted by requiring that primary plans—for instance, other forms of health insurance—pay claims before Medicare does so.[78] While the Secretary of Health and Human Services can make a payment through Medicare to a beneficiary before a primary plan, that payment is "conditioned on the reimbursement" of the Medicare trust fund.[79] Notably, as the court pointed out, the MSP "does not mention MAOs and refers almost exclusively to the Secretary, the United States, and the Medicare trust fund."[80] The MSP also contains a provision regarding a private cause of action that allows for the recovery of payment from primary plans who fail to reimburse for primary payment.[81] This provision allows for double damages.[82] In the past, the Eleventh Circuit has held "that the MSP private cause of action is available 'against a primary plan that pays a judgment or settlement to a Medicare beneficiary, but fails to pay Medicare its share.'"[83] However, until the

74. 42 U.S.C. §§ 1395w-21–1395ww-28 (2018). This program is also known as Medicare "Part C." 832 F.3d at 1235.

75. *Humana Med. Plan, Inc.*, 832 F.3d at 1233–36.

76. *Id.* at 1234.

77. *Medicare Secondary Payer*, CENTERS FOR MEDICARE & MEDICAID SERVICES, https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Medicare-Secondary-Payer/Medicare-Secondary-Payer.html (last visited Feb. 4, 2018).

78. *Id.*

79. *Humana Med. Plan, Inc.*, 832 F.3d at 1234 (citing 42 U.S.C. § 1395y(b)(2)(B)(i) (2018)).

80. *Id.*

81. *Id.* (citing 42 U.S.C. § 1395y(b)(3)(A), which states "[t]here 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).").

82. *Id.*

83. *Id.* (quoting Glover v. Liggett Grp., Inc., 459 F.3d 1304, 1310 (11th Cir. 2006)).

case at hand, the Eleventh Circuit had not directly addressed if the MSP's private cause of action is available to an MAO.[84]

2. The Medicare Advantage Program

The court next explained that Congress enacted the Medicare Advantage Program 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."[85] Practically, the private sector's power is "harnessed" by allowing private insurance companies to administer Medicare benefits per an agreement with CMS.[86] Although MAOs are actually private companies, they function like the government and "provide[] at least the same benefits as an enrollee would receive under traditional Medicare."[87] Section 1395w-22(a)(4)[88] of the Medicare Advantage Program, or the MAO right-to-charge provision, allows MAOs as a secondary payer to recover against a primary plan.[89] Notably, the Medicare Advantage Program and right-to-charge provision are separate from the provisions in the MSP, as explained above.

3. MAO Rights Under the MSP

The Eleventh Circuit ultimately agreed with Humana's argument that, as an MAO, it can avail itself of the MSP's private cause of action and sue a primary plan.[90] In forming this opinion, the court relied upon its own statutory interpretation of the MSP,[91] the MAO right-to-charge provision,[92] CMS regulations,[93] and Third Circuit precedent.[94] The court rejected Western's argument that MAOs are governed by the MAO right-to-charge provision and do not gain secondary payer status from the MSP.[95] To the contrary, the court held that the MSP applies to MAOs, stating "[w]e see no basis to exclude MAOs from a broadly worded

84. *Id.* at 1235.

85. *Id.* (quoting *In re* Avandia Mktg., Sales Practices & Prods. Liab. Litig., 685 F.3d 353, 363 (3d Cir. 2012)).

86. *Id.*

87. *Id.*

88. 42 U.S.C. § 1395w-22(a)(4) (2018).

89. *Humana Med. Plan, Inc.*, 832 F.3d at 1235–36.

90. *Id.* at 1236.

91. 42 U.S.C. §§ 1395y(b)(2)(A), 1395y(b)(3)(A).

92. 42 U.S.C. § 1395w-22(a)(4).

93. 42 C.F.R. § 422.108(f) (2018); 42 C.F.R. §§ 411.24(e), (g) (2018).

94. *Humana Med. Plan, Inc.*, 832 F.3d at 1236–38 (relying on *In re Avandia*, 685 F.3d at 360).

95. *Id.* at 1237.

provision that enables a plaintiff to vindicate harm caused by a primary plan's failure to meet its MSP primary payment or reimbursement obligations."[96] The court explained that the MAO right-to-charge provision's parenthetical reference to the MSP suggests that MAO secondary payments are made "pursuant to the MSP, [and] not the MAO right-to-charge provision."[97] The court further noted that some "aspects of the Medicare Act indicate an MAO *must* make a secondary payment any time the Secretary would do so."[98] Thus, the court concluded that Congress intended MAOs to function as secondary payers in the same manner as the Secretary.[99] The court affirmed the district court's order granting Humana's motion for summary judgment, awarding double damages.[100]

4. Judge Pryor's Dissent

Judge Pryor grounded his dissent in statutory interpretation. He argued that Humana failed to state a claim because the private cause of action in Paragraph (3) of the MSP must be construed in accordance with Paragraphs (1) and (2).[101] As noted above, those provisions do not mention MAOs.[102] Judge Pryor emphasized that § 1395w-22(a)(4), or the right-to-charge provision, states that an MAO "may" seek reimbursement from the liability insurer and only references Paragraph (2) insofar as MAOs are secondary to primary plans.[103] According to Judge Pryor, this provision:

> [D]oes not subject [MAOs] to all of the parts of section 1395y(b)(2). Instead it establishes a different regulatory regime—one that does not require [MAOs] to be secondary payers, impose time limits on reimbursement, require demonstrated responsibility, establish an extensive administrative process, give the Secretary a cause of action, or subrogate the United States to any right to payment by a primary plan. A [MAO] charges primary plans in accordance with section 1395w-22(a)(4), not section 1395y(b)(2)(A).[104]

96. *Id.* at 1238.
97. *Id.* at 1237.
98. *Id.* at 1238.
99. *Id.*
100. *Id.* at 1240 (majority opinion).
101. *Id.* (Pryor, J., dissenting).
102. *Id.* at 1234 (majority opinion).
103. *Id.* at 1242 (Pryor, J., dissenting).
104. *Id.*

Judge Pryor then corrected the majority in that an MAO is not required to make a secondary payment, but "remains free to be the primary payer."[105] He further critiqued the majority on determining that Humana's arguments "appeared" to comply with CMS regulations without explaining how they do so.[106] Judge Pryor concluded that "[b]ecause a Medicare Advantage Organization is not the Secretary and its treasury is not the Trust Funds, [he] respectfully dissent[s]."[107]

5. Judge Tjoflat's Caution

Notably, on December 31, 2017, a majority of the active judges on the Eleventh Circuit voted against rehearing this matter en banc and filed the order on January 25, 2018.[108] Circuit Judge Tjoflat authored an impassioned dissent, building upon Judge Pryor's dissent in the original opinion issued by the Eleventh Circuit.[109] Judge Tjoflat expressed concern over the holding for a number of different reasons. He argued, as the majority acknowledged[110] and Judge Pryor emphasized,[111] that the MSP's language is silent as to MAOs, and does not explicitly extend them the private right of action.[112] This is further exemplified by the fact that while the debt collection process for the government in this regard is "cumbersome,"[113] MAOs are not subject to the same procedure.[114] He further explained that the Medicare Advantage Program protects the "common law reimbursement right[s] for private insurers acting as MAOs."[115] This common law principle is grounded in state law—Alabama, Florida, and Georgia "[a]ll . . . recognize the rights of medical insurers to seek reimbursement under both contract law and under the doctrine of equitable subrogation."[116] Judge Tjoflat argued that on this basis, there is no need to allow additional recovery under the MSP.[117]

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105. *Id.*

106. *Id.*

107. *Id.* at 1243.

108. Order Denying Rehearing En Banc, Humana Med. Plan, Inc. v. W. Heritage Ins. Co., No. 15-11436, at *2 (11th Cir. Jan. 25, 2018), http://media.ca11.uscourts.gov/opinions/pub/files/201511436.ord.pdf.

109. *Id.* at *3–39 (Tjoflat, J., dissenting).

110. *Humana Med. Plan, Inc.*, 832 F.3d at 1234.

111. *Id.* at 1240.

112. *Humana Med. Plan, Inc.*, No. 15-11436, at *16–17; *see* 42 U.S.C. §§ 1395y(b)(2)(A)–(B); *see also* 42 U.S.C. § 1395y(b)(3)(A).

113. *Humana Med. Plan, Inc.*, No. 15-11436, at *22.

114. *Id.* at *20, *22.

115. *Id.* at *26.

116. *Id.* at *24–25 n.8.

117. *Id.* at *29.

Indeed, he concluded, "this Court's opinion amounts to a rewriting of state insurance laws."[118] Judge Tjoflat then outlined the two models he believed the Eleventh Circuit created as a result of its decision:

> So now we have two models. Under one model, the § 1395w-22(a)(4) model, an MAO can recover its outlay by standing in the shoes of its insured and suing a liability insurer *as part of* its insured's tort action. If it follows this model, the MAO is subject to a number of rules designed to ensure justice is done in the case, including the rule barring recovery by the MAO unless and until the insured has been made whole and the requirement that the court apportion the insured's recovery as the equities dictate. This model has worked for many years and in many contexts; indeed, MAOs use this model all the time to recover their outlays when they make secondary payments to insureds who don't have Medicare Advantage.
>
> Under the other model, the model created by the Court's interpretation of the private right of action, 42 U.S.C. § 1395y(b)(3)(A), an MAO can recover its outlay from the liability insurer directly. It may do so not on the basis of rights derivative of the insured, but by its own rights and at its own option. And it may do so notwithstanding the tortfeasor's denial of liability and regardless of whether the insurer has already paid the MAO's outlays to the insured. And there are no equitable restrictions on this new model: the MAO need not submit to court apportionment. Moreover, double recovery by the MAO's insured is just fine. On top of all that, if the liability insurer balks for any reason, the MAO may recover *double* its outlays.[119]

Thus, Judge Tjoflat argued that the matter should have been subjected to rehearing en banc.[120]

As explained above, the Eleventh Circuit's holding in *Humana Medical Plan, Inc.* leaves MAOs with expanded reimbursement rights. Moving forward, as Judge Tjoflat cautioned, liability insurers and their attorneys will need to spend additional time and effort during discovery uncovering whether any of the claimant's expenses have been paid by an MAO in order to avoid the potential payment of double damages.[121]

V. CONCLUSION

From 2016 through the present, the Eleventh Circuit produced many noteworthy decisions with strong implications moving forward. In

118. *Id.*
119. *Id.* at *37.
120. *Id.* at *39.
121. *Id.* at *35.

Wollschlaeger v. Governor, the Eleventh Circuit held that Florida's efforts to regulate professional conduct created unconstitutional restrictions on physician speech.[122] With the pending outcome of *United States v. AseraCare Inc.*, the Eleventh Circuit will shape how "falsity" is determined under the FCA and will permanently change the prosecution of hospice claims in the future. Finally, in *Humana Medical Plan, Inc. v. Western Heritage Insurance Co.*, the Eleventh Circuit provided private insurance companies expanded reimbursement rights under the MSP, essentially allowing them the same rights of recovery as the United States government with less procedural safeguards.

122. 848 F.3d at 1319.