Traub Lieberman Team Obtains Summary Judgment in Favor of Insurer in Class Action Lawsuit Involving Medicare Secondary Payer Act

In *MSPA Claims 1, LLC v. Covington Specialty Ins. Co.*, 19-21583-CIV, 2021 WL 2915097 (S.D. Fla. July 12, 2021), the United States District Court Judge affirmed and adopted the Magistrate's Report and Recommendation granting summary judgment in favor of an insurer. The summary judgment was entered in a purported class action lawsuit alleging claims under the Medicare Secondary Payer Act ("MSP Act"). The plaintiff sued the insurer on behalf of a putative class of Medicare Advantage Organizations (or their assignees) that allegedly paid accident-related medical expenses on behalf of claimants who had also asserted claims against the insurer's insureds. The plaintiff sought double damages under the MSP Act private cause of action. In support of its claims, and to demonstrate standing to sue, the plaintiff pled a single "representative claim" of a Medicare beneficiary who filed suit against the insurer's insured as a result of a slip and fall incident. The plaintiff contended that it was an assignee of a now defunct Medicare Advantage Organization that allegedly paid for the claimant's accident related medical expenses that should have been paid by the insurer. In order to establish the insurer's responsibility to pay under the MSP Act, the plaintiff relied on the medical payments coverage included in commercial general liability policies issued by the insurer

On summary judgment, the insurer successfully argued that the plaintiff could not point to any evidence demonstrating that the insurer had any responsibility to pay any sums of money with respect to the representative claim. In doing so, the Court rejected the plaintiff's proffered legal theories and arguments that Section 111 reporting rendered the insurer a primary payer, that the MSP Act preempted the conditions of the insurance policy and that the insurer failed to exhaust administrative remedies.

Instead, the Court applied a straight forward coverage analysis to determine whether the medical payments coverage was implicated in the first place. The policy's medical payments coverage included a one-year time requirement that required medical expenses to be incurred and reported to the insurer within one year from the date of the accident. The Court likened this requirement to a claims-made-and-reported policy, explaining "when an insurance policy requires the reporting of a claim within a specific time period and that condition is not met – coverage does not exist." Ultimately, the Court concluded that the plaintiff failed to present any testimony or evidence that it complied with this reporting requirement. As a result, the medical payments coverage was never implicated and, thus, the insurer was not a "primary payer" as contemplated by the MSP Act. In light of these findings, the Court entered summary judgment in favor of the insurer on the plaintiff's MSP Act private cause of action and breach of contract claim. The plaintiff has since appealed Magistrate and District Court Orders to the United States Court of Appeals for the Eleventh Circuit.