United States' Amicus Brief Argues Medicare Act Preempts Statutory Consumer Protection and State Common Law Claims

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Since January 1, 2006, Part D of the Medicare Act has provided Medicare beneficiaries with an elective prescription drug benefit option. Under Part D, benefits are administered to beneficiaries through private health insurance companies, known as "sponsors," which contract with the Centers for Medicare & Medicaid Services (CMS).

In late 2005, Do Sung Uhm and Eun Sook Uhm (the "Uhms"), Medicare beneficiaries, applied for the prescription drug benefit plan offered by Humana (the "Plan"). In accordance with the Uhms' election to receive benefits under Part D, the Social Security Administration withheld monthly premiums from their social security benefits.

Pursuant to the Plan, the Uhms' benefits were to begin on January 1, 2006; however, as of February 6, 2006, the Uhms had not received any information from Humana regarding how to obtain their benefits. As a result, the Uhms had to pay out-of-pocket for their prescription medications.

A little over a month after their benefits were supposed to begin, the Uhms filed a class action lawsuit in the United States District Court for the Western District of Washington against Humana Health Plan, Inc., and its parent company, Humana Inc., ("Humana") entitled *Uhm v. Humana*, alleging that they failed to receive the prescription drug benefits promised. They alleged claims for violation of several state consumer protection statutes as well as state common law claims of fraud, breach of contract and unjust enrichment.

The United States Court of Appeals for the Ninth Circuit initially affirmed the district court's conclusion that the Medicare Act's express preemption clause barred each of the Uhms' claims. See *Uhm v. Humana*, 540 F.3d 980 (9th Cir. 2008). However, the Ninth Circuit later withdrew its opinion and issued an order on July 22, 2009 requesting the opinion of the United States as to whether the claims were preempted by the Medicare Act. As demonstrated by the amicus brief filed by the United States on October 29, 2009 in support of Humana, the United States' position is that all of the claims asserted by the Uhms are either expressly or impliedly preempted by the Medicare Act.

First, the United States argues that the Uhms' statutory consumer protection claim is preempted under the Medicare Act's express preemption provision pertaining to state statutes or regulations which endeavor to govern the same subject matter regulated by, in this case, Part D standards. Specifically, the Uhms' state consumer protection claim is premised upon the allegation that Humana's marketing materials contained fraudulent misrepresentations. However, under the Act, CMS is charged with reviewing and determining whether the marketing materials produced by the sponsors are inaccurate or misleading.

Second, although the Uhms' fraud claim is not barred by the Act's express preemption provision because the statute preempts only state laws and regulations, the United States contends it is

impliedly preempted because it actually conflicts with federal law. That is, like their consumer protection claim, the Uhms' fraud claim is premised upon the assertion that the sponsor made fraudulent representations in its marketing materials. As stated above, CMS is charged with reviewing and determining whether the marketing materials produced by the sponsors are inaccurate or misleading. Therefore, according to the United States, whether the marketing materials determined by CMS to be truthful under federal law were also determined to be *misleading* under state law creates a conflict between federal and state law resulting in the preemption of the Uhms' fraud claim.

Third, the United States asserts that the Uhms' breach of contract and unjust enrichment claims are also precluded, either because they are preempted, or because the Uhms lack standing to assert such claims. That is, if the Uhms' claims are based upon Humana's alleged failure to confer benefits notwithstanding the Uhms' enrollment in its Plan, then they are preempted by Medicare's review structure for benefits and coverage disputes. Under the Act, if coverage is denied, the sponsor must first provide the beneficiary with a written explanation detailing the reasons for the denial, as well as the available appeal procedures. Next, the plan participant may request that the sponsor reconsider its denial. If the sponsor again denies the claim, the participant may appeal the decision to an independent review entity contracted by CMS. After that point, further review is limited. The Uhms did not engage in this dispute process to try to obtain benefits before filing suit.

If, on the other hand, the Uhms' claims are based upon Humana's alleged failure to enroll the Uhms in the Plan, the Uhms arguably lack standing to bring such a claim since they were retroactively enrolled in the Plan. As a result, their damages would have been limited to their out-of-pocket costs incurred during the pendency of their application, for which they could have sought reimbursement under Medicare's benefits and coverage dispute review process outlined above.

The Ninth Circuit is expected to issue a new decision shortly taking into account the United States' position as discussed above.