The PAID Act: Providing Much Needed Information to Resolve Injury Claims brought by Medicare Beneficiaries

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I. MEDICARE SECONDARY PAYER STATUE RECEIVES A WELCOMED REVITALIZATION

The reimbursement provision of the Medicare Secondary Payer Statute ("MSP") states:

> [A] primary plan, and an entity that receives payment from a primary plan, shall reimburse the appropriate Trust Fund for any payment made by the Secretary . . . with respect to an item or service if it is demonstrated that such a primary plan has or had a *responsibility to make payment* with respect to such item or service.[2]

The MSP plainly defines "primary plan" to include "tortfeasors and their insurance carriers."[3] Thus, the MSP requires entities or individuals settling or paying injury claims of Medicare beneficiaries to consider whether Medicare paid for the claimant's injury-related medical expenses.[4] When Medicare pays a claim that is ultimately the responsibility of a third party, the Medicare beneficiary and third party must arrange to reimburse Medicare.[5] While a straightforward concept, until recently, defendants, their insurers, and plaintiff's counsel lacked a reliable method of ascertaining if claimants were enrolled in Medicare, thus creating a significant obstacle to repayment. The Provide Accurate Information Directly Act ("PAID"), signed into law on December 11, 2020, is intended to rectify this confusion

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[2] 42 U.S.C. § 1395y(b)(2)(B)(ii) (emphases added).

[3] Taransky v. Sec'y of U.S. Dep't of Health and Hum. Serv., 760 F.3d 307, 314 (3d Cir. 2014); *see also* § 1395y(b)(2)(B)(ii); *Bio-Medical Applications of Tenn., Inc. v. Central States Se. and Sw. Areas Health and Welfare Fund, 656 F.3d 277, 289-90 (6th Cir. 2011)* (explaining Congress' intent to foreclose litigation on the definition of "primary plan" via the 2003 amendments).

[4] § 1395y(b)(8)(A)(i).

[5] Mathis v. Leavitt, 554 F.3d 731, 733 (8th Cir. 2009); Wasson v. Sebelius, No. 11CV46, 2011 WL 2837882, at *3 (E.D. Mo. July 18, 2011).

surrounding a claimant's Medicare status and create a streamlined system to reduce the risk of an unexpected Medicare reimbursement demand.[6] PAID's updates to the Medicare Section 111 Query Process are a significant and needed revision to the MSP reimbursement process.

II. THE HISTORY AND OVERVIEW OF MEDICARE

A. 1965–1980: Primary Payer to Secondary Payer

The Medicare Health Insurance Program ("Medicare") has been transformed significantly since it was first enacted in 1965 under Subchapter XVIII of the Social Security Act.[7] Medicare was designed to provide health insurance coverage for enrollees and was the primary payer for most of their covered medical expenses.[8] This meant that Medicare would pay the covered cost of a beneficiary's treatment even if other insurances or third parties were also responsible for this cost.[9] One of the first major revisions to Medicare came in 1980 with the passage of Medicare Secondary Payer requirements.[10]

The 1980 amendments were significant in that they made Medicare a secondary payer: secondary to every other person or entity also responsible for the cost of a beneficiary's covered medical treatment.[11] The amendments also established reimbursement rights when the identity of a primary payer becomes known after Medicare has paid for the treatment.[12] Therefore, as the secondary payer, Medicare became prohibited from paying for a beneficiary's covered medical treatment when the identity of a primary payer was known.[13] Despite the MSP restrictions, Medicare is permitted to make conditional payments for treatment when it is not reasonably expected that the primary payer will promptly pay.[14] However, Medicare may then seek reimbursement from the primary payer for any conditional payments.[15] Various subsequent statutes and court opinions, described below, have strengthened Medicare's position as the payer of last resort, and the PAID Act is the latest effort to further this goal.

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6 Mark Popolizio & Kate Riordan, *The PAID Act is Now Law*, VISUALIZE (Dec. 14, 2020), https://www.verisk.com/insurance/visualize/paid-act-now-law/.
7 §§ 1395-1395lll.
8 *Id.*
9 *Id.*
10 *Id.* § 1395y(b)(2)(b)(ii).
11 *Id.* § 1395y.
12 *Id.* § 1395y(b)(8).
13 § 1395y(b)(2)(A).
14 *Id.* § 1395y(b)(2)(B).
15 *Id.*

B. 1997–2003: Expansion of Medicare through Creation of Part C and D Plans

When Medicare was created, it was composed of two parts:[16] Part A, which today covers the cost of inpatient hospital care, skilled nursing, hospice, and some home health care services; and Part B, which covers the cost of outpatient doctors, preventative services, and medical supplies.[17] As part of the 1997 Balanced Budget Act,[18] Part C was first established as the Medicare + Choice ("M+C") program.[19] Under the M+C program, the Centers for Medicare and Medicaid Services ("CMS")[20] can contract with third parties to offer different health plan coverage options for Medicare beneficiaries.[21] In 2003, Congress went further by passing the Medicare Prescription Drug Improvement and Modernization Act,[22] which renamed M+C plans as Part C plans and created prescription drug coverage with Part D plans.[23] Part C became known as "Medicare Advantage," which combines the coverages of Parts A and B, as well as Part D prescription coverage and often includes additional coverages (e.g., dental and hearing).[24] Part C coverage gives an alternative to traditional Medicare coverage, while Part D covers the cost of prescription drugs, shots, or vaccines.[25]

The key difference between public Medicare (Parts A and B) and the 1997 and 2003 amendments (Parts C and D) is that the former is provided by the federal government through CMS and the latter is provided by approved commercial insurance companies contracting with the federal government—often referred to as "private Medicare."[26]

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16 These two parts are now commonly referred to as "original" or "public" Medicare. *History*, CMS.GOV (Dec. 1, 2021, 7:02 PM), https://www.cms.gov/About-CMS/Agency-Information/History.

17 *Id.*; *What's Medicare?*, MEDICARE.GOV, www.medicare.gov/what-medicare-covers/your-medicare-coverage-choices/whats-medicare (last visited Nov. 1, 2021).

18 Balanced Budget Act of 1997, Pub. L. No. 105-33, 111 Stat. 251.

19 *Health Plans - General Information*, CMS.GOV (Dec. 1, 2021, 8:00 PM), https://www.cms.gov/Medicare/Health-Plans/HealthPlansGenInfo.

20 This agency falls under the U.S. Department of Health and Human Services, the administrator. *About CMS*, CMS.GOV, https://www.cms.gov/About-CMS/About-CMS (last visited Mar. 15, 2022).

21 *Health Plans - General Information*, *supra* note 19.

22 Medicare Prescription Drug Improvement and Modernization Act of 2003, Pub. L. No. 108-173, 117 Stat. 2065.

23 *Health Plans - General Information*, *supra* note 19.

24 *What is Medicare Part C?*, HHS.GOV, https://www.hhs.gov/answers/medicare-and-medicaid/what-is-medicare-part-c/index.html (last visited Nov. 1, 2021).

25 *What's Medicare?*, *supra* note 17.

26 *Id.*

C. 2007: Reporting Requirements and Civil Money Penalties for Not Reporting Established

1. Reporting Requirements under MMSEA

Despite Medicare's role as a secondary payer, prior to 2007, there was no requirement to report the settlement of personal injury claims to CMS. To provide visibility of settlements and payments for the personal injury claims of Medicare beneficiaries, Congress passed the Medicare, Medicaid, and SCHIP Extension Act of 2007 ("MMSEA").[27] This law provides a check and balance system for the secondary payer reimbursement process.[28] Among other things, it requires defendants, their insurers, and even counsel for the claimant to report to CMS any settlements, judgments, awards, or other payments to Medicare beneficiaries when certain criteria are met (these criteria are outside the scope of this article).[29] CMS uses this information to coordinate its recovery efforts and ensure proper reimbursement by primary payers.[30]

To enforce the reporting requirements, the Act also instituted a considerable penalty of $1,000 per day for each day a party fails to timely report when required under MMSEA.[31] Imposition of this civil money penalty ("CMP"), as named by the statute, was originally mandatory.[32] This provision created a significant incentive for defendants and their insurers to report resolution of personal injury and wrongful death claims involving Medicare beneficiaries. Likewise, the capability of CMS to cross-reference its payment records with these reports provided motivation for parties to ensure Medicare's conditional payments were reimbursed. Some of the statutory penalties for failing to reimburse Medicare are described more fully below.

2. Penalties for Failing to Reimburse Medicare

To complicate matters while the MSP utilizes the CMP as an enforcement provision for primary payers who fail to report settlements, judgments, awards, or other payments in a timely manner, Medicare law

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27 42 U.S.C. § 1395y(b)(7)-(8).

28 Steven Raffaele, *The Medicare, Medicaid, and SCHIP Extension Act of 2007: Medicare Gets Serious About Reimbursement in Personal Injury Liability Claims*, HOLLAND & KNIGHT (May 2010), https://www.hklaw.com/en/insights/publications/2010/05/the-medicare-medicaid-and schip-extension-act-of-2.

29 §1395y(b)(8)(A)(ii).

30 Raffaele, *supra* note 28.

31 § 1395y(b)(8)(E)(i).

32 *Id.*

includes other enforcement mechanisms to compel reimbursement. One such provision is the private right of action.[33] In particular, the MSP states:

> There 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) [the Act's secondary payer provisions].[34]

Pursuant to this statute, the federal government has aggressively sought double damages against a variety of entities including Medicare beneficiaries, their attorneys, and primary payers.[35] This private right of action did not exist prior to enactment of the MSP in 1980.

After Medicare Parts C and D were established years later, the question arose whether this private right of action extended to private Medicare providers or if it was reserved for the federal government's public Medicare only. In an issue of first impression, the U.S. Court of Appeals for the Third Circuit decided this question in *In re Avandia Marketing* ("*Avandia*").[36] The Court held that the plain text of the statute creating this cause of action did not limit its application only to recovery suits by traditional, government Medicare.[37] *Avandia* held that Medicare Advantage Plans ("MAP") could seek double damages under this provision from primary payers who failed to reimburse them.[38] The U.S. Court of Appeals for the Eleventh Circuit adopted similar reasoning and reached the same conclusion.[39] While not all circuits have ruled on this matter, the trend is moving towards the recognition of the application of the private right of action to Part C and D providers.[40]

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33 *Id.* § 1395y(b)(3)(A).

34 *Id.*

35 Heather Sanderson, *The Different Paths to Protect the Medicare Trust Fund*, CLM MAG., Mar. 2020, at 38-39.

36 *In re* Avandia Mktg., Sales Pracs. and Prods. Liab. Litig., 685 F.3d 353 (3d Cir. 2012).

37 *Id.*

38 *Id.*

39 Humana Med. Plan, Inc. v. W. Heritage Ins. Co., 832 F.3d 1229 (11th Cir. 2016).

40 The following United States district courts have ruled (or strongly indicated) that MAPs can sue claims payers for double damages: MAO-MSO Recovery II, L.L.C. v. Mercury Gen., No. CV 17-025025, 2018 WL 3357493 (C.D. Cal. May 23, 2018); MAO-MSO Recovery II, L.L.C. v. Farmers Ins. Exch., No. 17-cv-02522-CAS(PLAx), 2018 WL 2106467 (C.D. Cal. May 7, 2018); Aetna Life Ins. Co. v. Guerrera, 300 F. Supp. 3d 367 (D. Conn. 2018); MAO-MSO Recovery II, L.L.C. v. State Farm Mut. Auto. Ins. Co., No. 17-cv-01541, 2018 WL 340021 (C.D. Ill. Jan. 9, 2018); Collins v. Wellcare Healthcare Plans, Inc., 73 F. Supp. 3d 653 (E.D. La. 2014); MSP Recovery Claims, Series L.L.C. v. Plymouth Rock Assurance Corp., 404 F. Supp. 3d 470 (D. Mass. 2019); MSP Recovery Claims, Series L.L.C. v. Phoenix Ins. Co., 426 F. Supp. 3d 458 (N.D. Ohio 2019); MSP Recovery Claims, Series L.L.C. v. Grange Ins. Co., No. 19cv00219, 2019 WL 6770729 (N.D. Ohio Dec. 12, 2019); MSP Recovery Claims, Series L.L.C. v. Progressive Corp., No. 19CV2273, 2019 WL 5448356 (N.D. Ohio Sept. 17, 2019); Humana Ins. Co. v. Bi-Lo, L.L.C., No. 18-cv-2151, 2019 WL 4643582 (D.S.C. Sept. 24, 2019); Cariten Health Plan, Inc. v. Mid-Century Ins. Co., No. 14-CV-

D. 2012: Easing the strict CMP requirements

While the CMP helped to improve compliance with MSP, it was considered draconian as it made the penalty mandatory even where primary payers had limited visibility to whether an individual was a Medicare beneficiary.[41] The Medicare IVIG Access and Strengthening Medicare and Repaying Taxpayers Act of 2012 ("SMART") eased the harsh nature of the CMP by making it discretionary in some cases.[42] It modified the statutory language to state that CMPs *may* be imposed for failure to report when the primary payers are "liability insurers (including self-insured entities), no-fault insurers, and workers' compensation laws or plans."[43] This revision was embraced by well-intentioned parties who in good faith attempted to report but failed to do so due to technical or ministerial errors.[44] Although imposing a CMP is now discretionary under certain circumstances, it continues to act as a strong compliance mechanism.

E. 2012: Medicare Enrollment Status Query System

The SMART Act also placed other obligations on CMS designed to facilitate the Medicare recovery process. A critical component of the SMART Act was the requirement that CMS create an electronic query system for parties to determine the Medicare enrollment status of a claimant.[45] This query system makes it easier for primary payers to discern if an individual is or was a Medicare beneficiary and if repayment to Medicare from settlement funds is required.[46] To run a query, a primary payer must have the claimant's social security or health identification claim number, first initial of their first name and first six characters of their last name, their birthday, and gender.[47]

The query process is straightforward for Medicare Parts A and B enrollees; however, when the SMART Act was enacted, CMS did not report

476, 2015 WL 5449221 (E.D. Tenn. Sept. 1, 2015); Humana Ins. Co. v. Farmers Tex. Cnty. Mut. Ins. Co., 95 F. Supp. 3d 983 (W.D. Tex. 2014); Humana, Inc. v. Shrader & Assocs., 584 B.R. 658 (S.D. Tex. 2018); Humana Ins. Co. v. Paris Blank L.L.P., 187 F. Supp. 3d 676 (E.D. Va. 2016).

41 Renee D. Faried & Carrie Roane, *SMART Act Brings Welcome Changes to Medicare Reporting and Reimbursement Requirements*, 32 TRIAL ADVOC. 26 (2013).

42 42 USC § 1395y(b)(8)(E).

43 *Id.*

44 Jennifer C. Jordan, *Medicare Secondary Payer: The Shape of Things to Come*, LEXISNEXIS (Mar. 3, 2013), https://www.lexisnexis.com/legalnewsroom/workers-compensation/b/medicare-secondary-payer/posts/medicare-secondary-payer-the-shape-of-things-to-come.

45 §1395y(b)(2)(B)(vii)(II).

46 *The Smart Act January 10, 2013*, MEDICARE ADVOC. RECOVERY COAL., https://www.marccoalition.com/smart-act---11013.html (last visited Feb. 24, 2022).

47 Mark Popolizio, *Determining Medicare Status - Assessing CMS' Query Process System in the Bigger Picture of MSP Compliance*, LEXISNEXIS (Jan. 24, 2012), https://www.lexisnexis.com/legalnewsroom/workers-compensation/b/workers-compensation-law-blog/posts/determining-medicare-status-assessing-cms-query-process-system-in-the-bigger-picture-of-msp-compliance.

if a beneficiary was covered under a Part C or D plan.[48] Due to the lack of centralized information regarding Part C and D beneficiaries, identifying if an individual was an enrollee in these plans was next to impossible. Therefore, despite the SMART Act's intent to increase visibility through the query system, the problem of incomplete information remained, and primary payers were at the mercy of an imperfect query system. This lack of visibility continued to put well-intentioned primary payers at risk of paying steep penalties due to a lack of information about individuals' Medicare status.

III. THE PAID ACT

MSP reporting and reimbursement obligations, penalties for not complying, and no comprehensive query system to determine a claimant's Medicare enrollment status provided an ample backdrop for the support the PAID Act received in a polarized Congress.

A. Legislative History: From Introduction to Enactment

The PAID Act followed a lengthy road from introduction in 2018 to final passage and signature by former President Donald Trump in 2020.[49] A bipartisan group of U.S. Representatives first introduced the PAID Act bill in the House of Representatives (the "House") on May 18, 2018.[50] During this second session of the 115th Congress, the bill was referred to both the Ways and Means Committee and the Energy and Commerce Committee for consideration.[51] Neither committee advanced the bill during this session of Congress, stalling the enactment efforts.[52] However, the bill was re-introduced in the House as a stand-alone measure in February 2019, near the beginning of the 116th Congress.[53] It was later introduced as a provision in multiple other bills. Throughout this process, the bill continued to enjoy bipartisan sponsorship, with even more co-sponsors supporting it after it was re-introduced.[54] More than a year after the bill was first introduced in the House, it was introduced in the Senate in June 2019.[55]

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48 *Provide Accurate Information Directly (PAID) Act S. 1989 - Section by Section*, MEDICARE ADVOC. RECOVERY COAL., http://www.marccoalition.com/uploads/8/4/2/1/8421729/s1989_paid_act_--_section_by_section_final.pdf_ (last visited Sept. 6, 2021).

49 Provide Accurate Information Directly Act, H.R. 5881, 115th Cong. (2018).

50 *Id.*

51 *Id.*

52 *Id.*

53 Provide Accurate Information Directly Act, H.R. 1375, 116th Cong. (2019).

54 *Id.*

55 Provide Accurate Information Directly Act, S. 1989, 116th Cong. (2019).

In December 2020, with just a few days remaining in the 116th Congress, the PAID Act quickly advanced through a flurry of legislation.[56] On December 8, 2020, the stand-alone bill moved to the House floor, passed with a voice vote, and was sent to the Senate.[57] The bill was also added as a provision of the Beneficiary Enrollment Notification and Eligibility Simplification Act of 2019 ("BENES").[58] This bill moved to the House floor the same day, passed with a voice vote, and was sent to the Senate.[59]

The PAID Act was added as Section 1301 ("Transparency of Medicare Secondary Payer Reporting Information") of the Further Continuing Appropriations Act, 2021, and Other Extensions Act that was also introduced in the House on December 8, 2020.[60] The House approved this government funding bill with the PAID Act provision the following day by a vote of 343 to 67.[61] The bill was then forwarded to the Senate for approval.[62] The Senate passed the Further Continuing Appropriations Act, 2021, and Other Extensions Act by a voice vote on December 11, 2020.[63] The enrolled bill was presented to the President that same day, and it was signed it into law later that evening.[64]

B. PAID Act Requirements

The PAID Act instituted the much-needed changes to the Medicare query system. Most importantly, it changed the system to require CMS to report enhanced information in response to enrollment inquiries from providers of "liability insurance (including self-insurance), no fault insurance, and workers' compensation laws or plans."[65] CMS refers to these entities collectively as Non-Group Health Plans.[66] It is an important note that the Act's requirements do not apply to enrollment inquiries made by Group Health Plans.

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56 Mark Popolizio & Kate Riordan, *The PAID Act Is Now Law*, VERISK (Dec. 14, 2020), https://www.verisk.com/insurance/visualize/paid-act-now-law/.

57 Provide Accurate Information Directly Act, H.R. 1375, 116th Cong. (2020).

58 Beneficiary Enrollment Notification and Eligibility Simplification Act of 2020, H.R. 2477, 116th Cong. (2020).

59 *Id.*

60 Further Continuing Appropriations Act, 2021, and Other Extensions Act, H.R. 8900, 116th Cong. (2020).

61 *Id.*

62 *Id.*

63 *Id.*

64 *Id.*

65 42 U.S.C. § 1395y(b)(8)(G)(ii).

66 *Insurer NGHP Recovery*, CMS.GOV (Mar. 10, 2022, 12:40 PM), https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/InsurerServices/Insurer-NGHP-Recovery.

CMS must report if the claimant is currently, or has previously been, enrolled in Medicare "on any basis."[67] Therefore, CMS must report if a claimant receives or received Medicare coverage under any of its four parts.[68] Further, if the coverage was through a Part C or Part D plan, CMS must disclose that plan's name and address.[69] CMS must report if the claimant received Medicare coverage for the three-year period immediately preceding the inquiry.[70] Finally, CMS must begin providing the additional information in response to queries made one year after the law is enacted, or, in other words, beginning December 11, 2021.[71]

C. CMS Implementation and Timeline

CMS requires all enrollment inquiries to be made electronically through its Benefits Coordination & Recovery Center, which reports the results of its searches electronically.[72] To accommodate the PAID Act's revised process, CMS introduced updated software in September 2021.[73] Beginning then, CMS allowed parties to install and test the new software to ensure a seamless transition.[74] CMS encouraged parties to perform advanced testing, but it was not a requirement.[75]

Between October and December, CMS phased in implementation of the Act and began reporting the additional required information.[76] In response to all inquiries received on or after December 11, 2021, CMS must fully implement the Act and report information pertaining to coverage in all Parts of Medicare.[77] As enrollment in Part C and Part D plans can be fluid since beneficiaries can change these providers over time, CMS also announced it will provide information for up to twelve providers of both Part C and Part D during the preceding three-year period.[78] Finally, CMS will report the most

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67 § 1395y(b)(8)(G)(ii)(I).

68 *Id.* § 1395y(b)(8)(G)(ii).

69 *Id.* § 1395y(b)(8)(G)(ii)(II).

70 Beneficiary Enrollment Notification and Eligibility Simplification Act of 2020, H.R. 2477, 116th Cong. (2020).

71 *Id.*

72 CTRS. FOR MEDICARE & MEDICAID SERVS., LIABILITY INSURANCE (INCLUDING SELF-INSURANCE), NO-FAULT INSURANCE, AND WORKERS' COMPENSATION USER GUIDE ch.1, at 5-1 to -2 (2021), https://www.cms.gov/files/document/mmsea-111-june-11-2021-nghp-user-guide-version-64-chapter-i-introduction-and-overview.pdf.

73 Webinar, Ctrs. for Medicare & Medicaid Servs., Provide Accurate Information Directly (PAID) Act Webinar (June 23, 2021) (on file at https://www.cms.gov/files/document/june-23-2021-provide-accurate-information-directly-paid-act-webinar-presentation.pdf.).

74 *Id.*

75 *Id.*

76 *Id.*

77 *Id.*

78 *Id.*

recent effective and termination dates for a beneficiary's coverage under Parts A and B.[79]

D. PAID Act's Impact on MSP Reporting and Reimbursement Landscape

Before the PAID Act was put into place, entities defending personal injury claims were at a severe disadvantage. Inability to conclusively determine a claimant's Medicare enrollment status coupled with hefty penalties for not complying with MSP provisions often left these parties in a lurch. This hampered resolution of these claims and stymied the process of reimbursing Medicare when required. The interplay between these factors provided the impetus to enact this legislation. Query results indicating the enrollment status under every Part of Medicare will provide critical information for those navigating this process. Satisfying MSP requirements will be even more important following removal of this significant obstacle. The PAID Act spells welcomed relief to those who need to know the Medicare enrollment status of a claimant for MSP compliance purposes.

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[79] Ctrs. for Medicare & Medicaid Servs., *supra* note 73.