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A Legislative Solution For Medicare Claims Settlement Delays

By **David Farber and Tim Lee** (January 5, 2021, 4:59 PM EST)

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On Dec. 11, 2020, Congress overwhelmingly passed the Provide Accurate Information Directly Act, a bill designed to fill a crucial gap in the claims-settling process under the Medicare Secondary Payer Act.[1]

In short, the PAID Act will require the Centers for Medicare & Medicaid Services, starting Dec. 11, 2021, to identify Medicare Part C and Part D plans for parties settling claims with Medicare beneficiaries, so that those parties can coordinate benefits and make appropriate repayments to Medicare.

This article reviews the background for the PAID Act, highlights its key provisions and analyzes its potential impact on insurers, benefit providers and other entities that frequently settle claims with Medicare beneficiaries.

Background

The Medicare Secondary Payer Act

The MSP Act designates Medicare as a secondary payer for its beneficiaries' medical expenses. This means that Medicare is only secondarily responsible for paying its beneficiaries' medical costs whenever other sources of payment, including private group health plans, workers' compensation plans, and automobile and liability insurance plans, are available to cover those costs.[2]

The MSP Act makes these other sources of payment, i.e., primary payers, responsible in the first instance for payment of Medicare beneficiaries' medical expenses.

To the extent a primary payer has not made its payment and cannot be reasonably expected to make a prompt payment, Medicare can pay for medical expenses up front, but such payment "is conditioned on Medicare's right to reimbursement in the event that a primary plan later pays or is found responsible for payment of the item or service."[3]

The MSP Act accordingly contemplates the conditional payment of medical expenses by Medicare in some instances and the recovery of those payments by Medicare from primary payers who are subsequently determined to be responsible for beneficiaries' expenses.

The secondary payer framework requires coordination between primary payers and CMS. Suppose, for example, that a Medicare beneficiary is crossing a street and is struck by a car. The beneficiary receives immediate medical treatment and incurs significant medical costs, which Medicare conditionally pays.

Later, the beneficiary files a claim with the driver's automobile insurer, which agrees to settle the beneficiary's claim by covering her medical expenses. At that point, the driver's automobile insurer becomes the settling claimant's primary payer and is required to file a query with CMS to determine if the settling claimant is a Medicare beneficiary.

If the settling claimant is a Medicare beneficiary, the primary payer must report the settlement to CMS via a Section 111 report.[4]

In return, CMS must inform the primary payer whether Medicare has previously conditionally paid the beneficiary's costs, present a claim for reimbursement of its conditional payment, and work with the beneficiary to recover the conditional payment amounts.

If the beneficiary is unable to pay, CMS is then allowed to seek recovery from the primary payer.[5]

The Problem of Medicare Advantage and Part D Plans

This framework functions well in the Medicare fee-for-service programs, Medicare Part A and Part B. But the process has been broken when it comes to the Medicare Advantage, or Part C, and the Medicare Prescription Drug Benefit, or Part D, programs, which allow certain private entities to provide and administer Medicare benefits.

Because private entities administer the benefits for those programs, CMS does not have claim information on medical payments made for beneficiaries enrolled in Medicare Advantage and Part D plans. Accordingly, CMS cannot inform a primary payer of whether a Medicare Advantage or Part D plan has made a payment that requires reimbursement.

And although CMS for years has been providing the Medicare Advantage and Part D plans with Section 111 reports filed by primary payers on a monthly, if not more frequent, basis, the plans have been slow to resolve outstanding claims.[6]

To compound matters, primary payers are unable to contact the relevant Medicare Advantage or Part D plans on their own initiative because CMS does not currently disclose the identity of those plans to primary payers.

As a result, when an insurer becomes a primary payer for a beneficiary enrolled in a Medicare Advantage Plan, the primary payer has no way of knowing whether it is responsible for reimbursing a conditional payment. This information asymmetry prevented insurers and self-insured entities resolving claims with beneficiaries from settling with finality.

The PAID Act

As explained above, upon settling a claim, Section 111 requires a primary payer to file a query with CMS to determine if the claimant is a Medicare beneficiary.

The PAID Act will now require CMS, in response to a query made by a primary payer, to disclose to the

primary payer: (1) whether the claimant "is, or during the preceding three-year period has been, entitled to benefits" under Medicare; and (2) when applicable, the "name and address of any Medicare Advantage plan under Part C and any prescription drug plan under Part D in which the claimant is enrolled or has been enrolled during" the preceding three-year period.

This practical commonsense legislation[7] will likely have a major impact on Medicare, Medicare Advantage and Part D plans, and the insurance industry.

As an initial matter, filling the existing information gap should help Medicare Advantage and Part D plans coordinate benefits with primary payers, which will likely result in a higher rate of recovery of conditional payments. The PAID Act should also make Medicare more efficient.

In rare circumstances, Part D plans are permitted to pass prescription costs directly to the Medicare program for payment. By facilitating a higher rate of recovery, the PAID Act is estimated to save Medicare $23 million on these relatively rare Part D payments alone.[8]

Additionally, primary payers should benefit from being able to settle claims with finality. Primary payers will be able to ask Medicare Advantage and Part D plans directly whether conditional payments have been made for settling claimants and position themselves to settle claims without having to deal with unknown reimbursement claims on the back end.

It is equally important to note what the PAID Act does not do.

First, it does not eliminate any of the parties' existing responsibilities under the law. Medicare Advantage and Part D plans are responsible for ensuring that payment is not available, or is not reasonably expected to be available, from a primary payer before making a conditional payment.[9]

Second, in appropriate cases where Medicare Advantage and Part D plans have made conditional payments, the burden remains on those entities to seek recovery of their conditional payments by presenting demands for reimbursement to the parties to the settlements, e.g., beneficiaries, the beneficiaries' attorneys and insurers.

Nothing in the PAID Act creates an obligation on primary payers to affirmatively contact Medicare Advantage and Part D plans. Instead, they may do so if they so choose.[10]

Medicare will continue to provide the Section 111 reports to the plans so that they can pursue these recoveries, and they will need to do so and be denied payment from a beneficiary of insurer before bringing suit for recovery in court. Given the frustration settling parties have encountered with the process, we expect many to voluntarily coordinate benefits with Medicare Advantage and Part D plans to so that everyone can settle with finality.

Key Takeaways for Primary Payers

The PAID Act will likely change the dynamics of the claims-settling process, and primary payers will need to plan accordingly.

First, primary payers should ensure their continued compliance with the MSP Act's query requirement. Because CMS' obligation to provide information to a primary payer is triggered by the primary payer's query as to whether a settling claimant is a Medicare beneficiary, to benefit from the PAID Act, primary

payers will need to continue submitting queries to CMS.

Second, Medicare Advantage and Part D plans will need to be prepared to respond to primary payers seeking to resolve reimbursement claims relating to conditional payments.

While the MSP Act already requires Medicare Advantage and Part D plans timely present claims for reimbursement to primary payers,[11] Medicare Advantage and Part D plans have often failed to do so. If the Medicare Advantage or Part D plan does not timely respond to coordination of benefits requests, they should be deemed to have waived their recovery.[12]

Third, primary payers may be in a position to better manage their liabilities. At present, hundreds of insurers are defendants in pending putative class actions alleging that they failed to reimburse conditional payments made by Medicare Advantage plans that the insurers did not — and could not — have even known existed.

The PAID Act should allow primary payers, like insurers, to ascertain whether they are subject to a Medicare Advantage or Part D reimbursement claim and decide whether they want to exercise their option to coordinate benefits on the front end.

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Disclosure: King & Spalding represents the MARC Coalition, an organization of retailers, insurers, attorneys, brokers, insureds, trade associations, self-insureds and third-party administrators that was a key advocate of the PAID Act.

[1] H.R. 1375, incorporated into H.R. 8900, Section 1301 (116th Congress).

[2] 42 U.S.C. § 1395y(b)(2).

[3] United Seniors Ass'n, Inc. v. Philip Morris USA, 500 F.3d 19, 21 (1st Cir. 2007) (citing 42 U.S.C. § 1395y(b)(2)(B)).

[4] See 42 U.S.C. § 1395y(b)(7) and (b)(8), for group health plans and non-group health plans, respectively.

[5] 42 C.F.R. 411.24.

[6] 2015-2018 private data collected by the authors suggest that Medicare Advantage Plans pursued collection in approximately 5% of eligible cases.

[7] Statement of Rep. Gus Bilirakis (R-Fla.), PAID Act, Congressional Record, H6993 (Dec. 8, 2020).

[8] Federal government savings are relevant only when Part D Plan prescription drugs are sold to "Low Income Subsidy" eligible individuals, for which Plan costs are passed through to the Medicare Trust

Fund. 42 U.S.C. 1395w-114. For this reason, when "scoring" the impact of the PAID Act to the federal government, the Congressional Budget Office only identified $23 million of savings over five years and no budgetary impact when measured over 10 years. Congressional Budget Office, Estimate of the Statutory Pay-As-You-Go Effects of H.R. 1375, the Provide Accurate Information Directly Act, available at https://www.cbo.gov/system/files/2020-12/HR1375PAYGO.pdf. It is this savings that Representative Estes referred to when identifying the benefits of the PAID Act for the "American Taxpayer." Statement of Rep. Ron Estes (R-Kan.), PAID Act, Congressional Record, H6992 (Dec. 8, 2020).

[9] 42 U.S.C. 1395y(b)(2)(A); see also 42 C.F.R. 411.50-54.

[10] Statement of Sen. Tim Scott (R-S.C.), PAID Act, Congressional Record, S7324 (Dec. 9, 2020).

[11] Congressional Record at S7324 ("Congress expects Part C and Part D Plans to continue to seek recovery of claims by timely notifying settling parties when a payment has been made that should be reimbursed.").

[12] 42 U.S.C. 1395y(b)(2)(B)(iv). To the extent that Medicare Advantage and Part D Plans stand in the shoes of the Secretary, as they allege when pursuing recovery, they should have the same rights and obligations as the Secretary, including the right to waive claims if such waiver is in the best interests of the program.