



Medicare Secondary Payer: Coordination of Benefits

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Summary

Medicare is a federal program that covers medical services for qualified beneficiaries. Established in 1965 to provide health insurance to individuals age 65 and older, Medicare has been expanded to include permanently disabled individuals under 65. Medicare now consists of four parts (A-D) that cover hospitalizations, physician services, prescription drugs, skilled nursing facility care, home health visits, hospice care and other treatments. Generally, Medicare is the “primary payer” for medical services, meaning that it pays health claims first. If a beneficiary has other health insurance, that insurance is billed after Medicare has made payments, to fill all, or some, of any gaps in Medicare coverage. In certain situations, however, federal Medicare Secondary Payer (MSP) law prohibits Medicare from making payments for an item or service when payment has been made, or can reasonably be expected to be made, by another insurer such as an employer-sponsored group health plan. Congress initiated MSP in 1980 to ensure that certain insurers met their contractual obligations to beneficiaries and to reduce Medicare expenditures, thus extending the life of the Medicare Trust Fund. According to the Department of Health and Human Services (HHS), private insurers designated legally primary to Medicare now pay about \$8 billion in claims from Medicare recipients each year.

In general, Medicare is the secondary payer for beneficiaries who are also covered through (1) a group health plan based on their own or their spouse’s *current* employment; (2) auto and other liability insurance; (3) no-fault liability insurance; and (4) workers’ compensation programs, including the Federal Black Lung Program. Additionally, Medicare is prohibited from covering items and services paid for directly, or indirectly, by another government entity, such as the Department of Veterans Affairs (subject to certain limitations). In cases when Medicare is the secondary payer but primary payment is delayed or in dispute—for example, a medical liability lawsuit—Medicare can step in to cover claims to ensure that beneficiaries do not experience a gap in coverage. Medicare must be reimbursed for these conditional payments when a primary insurer makes payment.

To identify cases where Medicare is the secondary payer and prevent improper Medicare payments, HHS matches information about Medicare recipients against data from the Social Security Administration and Internal Revenue Service. The Medicare, Medicaid, and SCHIP Extension Act of 2007 (P.L. 110-173) requires private insurers such as group health plans, liability insurers, no-fault insurers, and workers’ compensation plans to regularly submit coverage information to HHS regarding Medicare beneficiaries. In December 2012, Congress approved, and the President signed into law, H.R. 1845 (P.L. 112-242), which includes provisions designed to speed up the process for settling Medicare conditional claims in liability, no-fault, and similar cases. Title II of P.L. 112-242 requires HHS to establish a secure website that beneficiaries and their representatives can access to view information on conditional payments relating to a potential settlement, judgment, or award. The law made additional changes to the MSP statute and current HHS procedures, including data reporting requirements, appeal rights, use of Social Security numbers, and statutes of limitations. Separately, HHS has been attempting to create streamlined processes for settling smaller-dollar liability and workers’ compensation cases involving Medicare beneficiaries. In June 2012, HHS published a proposed rulemaking to expedite certain liability and workers’ compensation settlements that include coverage for future medical bills. This report examines the MSP system, reporting requirements, liability issues, and issues for Congress.

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Introduction

Medicare is a federal program that covers medical services for qualified beneficiaries. Established in 1965 under Title XVIII of the Social Security Act to provide health insurance to individuals age 65 and older, Medicare has been expanded to include permanently disabled individuals under 65. Medicare now consists of four parts (A-D) that cover hospitalizations, physician services, prescription drugs, skilled nursing facility care, home health visits, hospice care, and other treatments. When Medicare was created in 1965, it was the primary payer for all beneficiaries except those receiving coverage through workers' compensation programs. When Medicare acts as the primary payer, it assumes responsibility for a beneficiary's medical bills, up to designated Medicare program limits. If an enrollee has other insurance, the beneficiary, physician, or other supplier can bill that insurance only after Medicare is billed to fill in possible gaps in Medicare coverage.¹ Medicare is always primary to Medicaid, the joint federal-state health insurance program for qualifying low-income and certain disabled beneficiaries. Medicaid pays only after Medicare and group health plans have paid.²

Beginning with the Omnibus Budget Reconciliation Act of 1980 (P.L. 96-499; OBRA), Congress created the Medicare Secondary Payer (MSP) program,³ which spells out specific conditions under which other insurers are required to pay first and Medicare is responsible for qualified, secondary payments. MSP is designed to ensure that certain insurers make contractually required payments, reduce Medicare expenditures, and extend the life of the Medicare Trust Fund.

The 1980 OBRA made Medicare a secondary payer for medical claims involving non-group health insurance such as liability and no-fault insurance.⁴ In 1981, Congress expanded MSP to cover certain Medicare beneficiaries in employer-sponsored group health plans.⁵ MSP was further refined in the Tax Equity and Fiscal Responsibility Act (P.L. 97-248; TEFRA) of 1982 and other statutes. (See **Appendix A**.) In general, Medicare is now the secondary payer for an item or service when payment has been made, or can reasonably be expected to be made, by responsible third-party payers.⁶ (See **Table 1**.) Medicare also does not cover services paid for by another government entity such as the Department of Veterans Affairs.

¹ Centers for Medicare & Medicaid Services, "Medicare & You," <http://www.medicare.gov/Pubs/pdf/10050.pdf>.

² Centers for Medicare & Medicaid Services, "Medicare and Other Health Benefits, Your Guide to Who Pays First," <http://www.medicare.gov/Pubs/pdf/02179.pdf>.

³ §1862(b) of the Social Security Act.

⁴ CMS, in regulations and guidance, terms workers' compensation, liability, and no-fault insurance as "non-group health plans" for the purpose of MSP oversight. (See "MMSEA Section 111 Mandatory Reporting," <http://www.cms.gov/Medicare/Coordination-of-Benefits/MandatoryInsRep/Downloads/NGHPQuickRef.pdf>.) The CMS terminology differs from other, more general definitions of health insurance, in which non-group insurance refers to plans purchased by individuals outside of a group insurance setting.

⁵ Omnibus Budget Reconciliation Act of 1981 (P.L. 97-499), §953.

⁶ 42 USC §1395y(b). A third-party payer is an entity with a legal or contractual agreement to provide health coverage to a Medicare beneficiary.

Table I. Medicare as Secondary Payer

Medicare is considered a secondary payer when a beneficiary can reasonably be expected to receive payment under:

- An employer group plan of a certain size, based on either the beneficiary's or a spouse's *current* employment.
- A large employer group health plan, for disabled workers.
- An employer group health plan, for beneficiaries with End Stage Renal Disease.
- A Department of Veterans Affairs program. (VA pays for VA-authorized services, and Medicare pays for Medicare-covered services.)
- A medical, auto, or no-fault liability program or a workers' compensation program.
- The Federal Black Lung Program.

Source: Department of Health and Human Services.

MSP is sometimes confused with Medicare supplement, or Medigap, insurance policies, but the two are different. MSP spells out instances where private insurance is primary and Medicare coverage is secondary. Medigap policies, by contrast, are private policies that provide supplemental coverage for individuals who rely on Medicare as their primary payer.⁷

In certain cases where Medicare is the secondary payer, but primary payment is delayed, Medicare may step in to pay claims, thereby ensuring that beneficiaries do not have a break in coverage. Examples of such so-called conditional payments include cases where medical liability claims are contested in court or where employer plans are slow to make payment.⁸ For example, in a case where a Medicare beneficiary is hit by a car, the driver's insurance may be responsible for covering medical bills related to the accident, but payment could be delayed by legal proceedings. In such a case, Medicare can pay outstanding claims until a legal settlement is reached. Medicare is entitled to recover its conditional payments once a beneficiary has received a settlement, judgment, or other award.

MSP laws and regulations have reduced Medicare spending by an average of about \$8 billion a year in recent years, including about \$50 billion in savings from FY2006 through FY2012.⁹ (See **Table 5**.) As Congress has expanded the scope of MSP, however, businesses and insurers have told lawmakers that the resulting paperwork requirements are onerous and that HHS has been slow to provide a final accounting of conditional payments that must be reimbursed, leading to delays in settling some liability cases.¹⁰ The American Bar Association has urged Congress to pass legislation to simplify the process for dealing with MSP claims for future medical bills in

⁷ CRS Report R42745, *Medigap: A Primer*, by Carol Rapaport. As noted by CMS in its booklet "Medicare Secondary Payer and You," a Medigap policy is a private health insurance policy designed specifically to fill in some of the "gaps" in Medicare's coverage when Medicare is the primary payer. Medicare supplement policies typically pay for expenses that Medicare does not pay because of deductible or coinsurance amounts or other program limits.

⁸ HHS regulations define slow payment as claims not paid within 120 days after submission.

⁹ Statement of Deborah Taylor, Chief Financial Officer and Director Office of Financial Management, Centers for Medicare & Medicaid Services, House Energy and Commerce Subcommittee on Oversight and Investigations, June 22, 2011, <http://archives.republicans.energycommerce.house.gov/Media/file/Hearings/Oversight/062211/Taylor.pdf>.

¹⁰ House Energy and Commerce Committee, Subcommittee on Oversight and Investigations, "Protecting Medicare with Improvements to the Secondary Payer Regime," June 22, 2011, <http://archives.republicans.energycommerce.house.gov/hearings/hearingdetail.aspx?NewsID=8716>. A group of businesses, law firms, and insurance companies in 2008 formed the Medicare Advocacy Recovery Coalition, to work for changes in the MSP program. See <http://www.marccoalition.com>.

workers' compensation cases.¹¹ HHS has responded by increasing the number of workers processing claims and settlements, reorganizing operations, and creating standardized procedures for resolving smaller claims and some workers' compensation cases. In June 2012, HHS issued a proposed rulemaking to further expedite processing of certain MSP settlements.¹²

On December 19, 2012, the House approved H.R. 1845, the Medicare IVIG Access Act. Title II of the legislation (The SMART Act) creates a new process for resolving MSP conditional payment claims to speed up resolution of liability, no-fault and similar cases. The Senate passed H.R. 1845 by unanimous consent on December 28, 2012, and President Obama signed the measure into law on January 10, 2013, (P.L. 112-242). The law requires HHS to create a special website that beneficiaries and their representatives can access to view information on conditional payments relating to a potential settlement, judgment, or award. The law makes additional changes to the MSP statute and current HHS procedures, including data reporting requirements, appeal rights, use of Social Security numbers, and statutes of limitations.¹³ (See **Appendix B**.)

MSP and Employer Group Health Plans

Medicare is the primary payer for Medicare beneficiaries who are retired, even if they have retiree health insurance coverage through a former employer. Medicare is the secondary payer for certain beneficiaries who are still working (often referred to as the “working aged”) and who are eligible for group health insurance through an employer. **Table 2** outlines the main instances when Medicare is the primary or secondary payer for those covered by group insurance policies.

Working Aged

Under MSP rules, employer-sponsored health insurance¹⁴ is the primary payer (with some exceptions) for Medicare-eligible individuals who have group coverage due to their own or a spouse's *current* employment. When a group health plan is primary, but does not cover a bill in full, Medicare may make a secondary payment, as prescribed by law.¹⁵

¹¹ American Bar Association, “ABA Supports Medicare Secondary Payer Legislation,” May 2012, http://www.americanbar.org/publications/governmental_affairs_periodicals/washingtonletter/2012/may/medicaresecondpayeract.html.

¹² Centers for Medicare & Medicaid Services, “Medicare Program: Medicare Secondary Payer and Future Medicals,” 42 CFR Parts 405 and 411, *Federal Register*, June 15, 2012, p. 35917, <https://www.federalregister.gov/articles/2012/06/15/2012-14678/medicare-program-medicare-secondary-payer-and-future-medicals>.

¹³ The three-year period begins at the date of a judgment, settlement or other award.

¹⁴ Group health plans include health insurance coverage that is provided by private sector employers, government and self-employed entities, employee organizations such as labor unions, and self-insured plans (i.e., the employer assumes the risk of insurance rather than passing the risk to an insurance company).

¹⁵ The MSP consists of laws amending the Social Security Act, as well as HHS guidance and regulations. For example, legal requirements for persons with End Stage Renal Disease (ESRD) have been in effect since the passage of OBRA 1981. Medicare has been the secondary payer for the working aged since the passage of the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982. Secondary payer rules for the disabled were first established in the Omnibus Budget Reconciliation Act (OBRA) of 1986. MSP rules for employer group health plans have been amended in subsequent legislation. See **Appendix A** for a list of the main MSP statutes.

Medicare is the secondary payer for a beneficiary with group health insurance who is age 65 or older, who is working, or whose spouse is working, for a company with 20 or more employees (or for a group of employers where at least one has more than 20 workers).

Table 2. Medicare Secondary Payer Guidelines for Group Health Coverage

General Guidelines for Medicare Coverage

When You:	This Insurer Pays First:
Have retiree insurance coverage ...	Medicare pays first.
Are 65 or older, have group health coverage based on your or your spouse's <i>current</i> employment, and your employer has 20 or more workers ...	Group health plan pays first.
Are 65 or older, have group health coverage based on your or your spouse's <i>current</i> employment, and your employer has less than 20 workers ...	Medicare pays first.
Are under 65 and disabled, have group health coverage based on your or a family member's <i>current</i> employment, and the employer has 100 or more workers...	Group health plan pays first.
Are under 65 and disabled, have group health plan coverage based on your or a family member's <i>current</i> employment, and the employer has less than 100 employees ...	Medicare pays first.
Have Medicare solely because of a diagnosis of End Stage Renal Disease (ESRD) ...	Group health plan pays first for 30 months of ESRD Medicare eligibility. Medicare pays first after the 30-month period ends.

Source: Department of Health and Human Services.

Under federal law, an employer with 20 or more employees¹⁶ must offer workers age 65 and older the same group health insurance coverage offered to other employees. Federal statutes prohibit a group health plan from taking into account the fact that an individual, or his/her spouse who is covered by the plan, is entitled to Medicare benefits. Any individual age 65 or older (and his/her spouse age 65 or older) who has current employment status and is in a group plan with more than 20 workers is entitled to the same benefits, under the same conditions, as any such individual (or his/her spouse) under age 65. Such employees must be in *current employment status*—that is, they must be individuals who are (1) actively working as an employee, (2) the employer, or (3) associated with the employer in a business relationship (such as a supplier included on the employer's group health plan).

All working-aged employees have the option of accepting or rejecting employer group health coverage. If a working-aged individual accepts coverage that meets certain federal secondary payer guidelines such as group size, the employer plan is the primary payer and Medicare is

¹⁶ In order to meet this requirement, employers must have 20 or more full and/or part-time employees for each working day in each of 20 or more calendar weeks in the current calendar year or the preceding calendar year. The 20 weeks do not have to be consecutive. The requirement is based on the number of employees, not the number of people covered under the group health plan. Employers who did not meet the requirement during the previous calendar year may meet it at some point during the new calendar year, and at that point Medicare would become the secondary payer for the remainder of that year and through the next year.

secondary.¹⁷ For Medicare-enrolled employees who reject employer-sponsored coverage, Medicare is primary. However, federal statutes prohibit employers from paying for supplemental benefits for Medicare-covered services, such as Medigap policies, so as not to provide financial incentives for employees to reject employer-sponsored coverage.¹⁸

The MSP requirements also apply to multiple-employer plans (plans sponsored by more than one employer) and to multi-employer plans (plans jointly sponsored by the employers and unions under the Taft-Hartley law, P.L. 80-101). When each of the employers in the group has less than 20 employees, Medicare is primary. When at least one employer has 20 or more employees, Medicare is secondary. An employer in a group with less than 20 employees may request an exemption for its working-aged employees. In that case, Medicare would be primary for the exempted employees, and the employer could offer those individuals coverage that supplements Medicare.

There are exceptions to MSP policy for the working aged. Medicare is *not* the secondary payer for the working aged who:

- Are enrolled only in Medicare Part B, or who are enrolled in Part A based on monthly premiums (rather than qualifying through work history).¹⁹
- Are covered by an individual, rather than a group, health plan.
- Are former spouses who have Federal Employee Health Benefit coverage under the Spouse Equity Act.²⁰
- Are on a temporary leave of absence from their place of employment.²¹

¹⁷ Generally, individuals are entitled to Medicare Part A (Hospital Insurance) when they turn 65, and must enroll in Part B (Supplementary Medical Insurance) during an initial enrollment period or face a permanent monthly penalty of increased Part B monthly premiums if they choose to enroll at a later date. However, the law waives the Part B late enrollment penalty for individuals, so long as the beneficiary has primary coverage through the individual's or a spouse's qualified employer-sponsored plan based on current employment. These individuals have a special enrollment period, once the employer coverage ends, and as long as they enroll in Part B during this time, they will not be subject to penalty. The size of the group needed to trigger primary workplace coverage differs for disabled vs. non-disabled Medicare beneficiaries.

¹⁸ Novitas, *Medicare A/B Reference Manual*, Chapter 11, <https://www.novitas-solutions.com/refman/chapter-11.html>.

¹⁹ Most persons age 65 or older are automatically entitled to premium-free Part A because they or their spouse paid Medicare payroll taxes for at least 40 quarters (10 years) on earnings covered by either the Social Security or the Railroad Retirement systems. Persons over age 65 who are not automatically entitled to Part A may obtain coverage by paying a monthly premium (\$441 in 2013) or, for persons with at least 30 quarters of covered employment, a reduced monthly premium (\$243 in 2012). See CRS Report R40425, *Medicare Primer*, coordinated by Patricia A. Davis and Scott R. Talaga. See Novitas, *Medicare A/B Reference Manual*, Chapter 11, <https://www.novitas-solutions.com/refman/chapter-11.html>.

²⁰ Spouse Equity Act of 1984, (P.L. 98-615).

²¹ There are conditions where an employee may be absent from the workplace, but still retain employment rights. Examples include sick leave, an approved leave of absence, or employment as a seasonal worker, such as teachers, who do not work throughout the year. See Centers for Medicare & Medicaid Services, *Medicare Secondary Payer (MSP) Manual*, Chapter 1, (Revision 87), August 3, 2012, <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/msp105c01.pdf>.

Workers in Group Health Plans with Less than 20 Employees

Medicare is the primary payer for aged workers in employer-sponsored group health plans with less than 20 employees (unless such plans choose to offer primary coverage). Only employers offering group health plans with more than 20 employees are required to offer the same coverage to employees over age 65 as to younger workers.²² Health benefits experts suggest that aging workers in group health plans with less than 20 workers should enroll in Medicare when eligible to prevent possible gaps in coverage and higher out-of-pocket costs, and to prevent possible penalties for late Medicare enrollment.²³

Working Disabled

Medicare is the secondary payer for disabled Medicare beneficiaries (other than those with ESRD) who are under age 65 and have employer-sponsored health insurance based on their own current employment, a spouse's current employment, or as a dependent of an employed worker.²⁴

One major difference between the MSP requirements for the working aged and the working disabled is the size of the employee group needed to trigger secondary payer status. The MSP rules apply to disabled beneficiaries enrolled in large group health plans—that is, plans offered by employers that had 100 or more employees on at least 50% or more of their business days during the preceding calendar year. The requirement applies to smaller plans that are part of a multiple or multi-employer plan if at least one of the employers in the plan has 100 or more employees. Another difference from the MSP rules for the working aged is that a multiple or multi-employer plan may not seek an exemption from MSP requirements for a disabled worker who is enrolled via an employer with fewer than 100 employees.

The MSP provisions do *not* apply to:

- Disabled individuals enrolled in Medicare Part A on the basis of monthly premiums or individuals enrolled in Part B only.
- Disabled individuals covered by a health plan other than a large group plan, such as an individual plan bought outside of a place of employment.

Persons with End-Stage Renal Disease (ESRD)

Individuals who are under the age of 65 can qualify for Medicare based on a diagnosis of ESRD, a medical condition in which the kidneys are failing and a person cannot live without dialysis or a

²² Centers for Medicare & Medicaid Services, *Medicare Secondary Payer (MSP) Manual*, Chapter 1, (Revision 87), August 3, 2012, <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/msp105c01.pdf>.

²³ Society for Human Resource Management, "It's Complicated: Coordinating Medicare, Employer Health Plans," April 15, 2011, <http://www.shrm.org/hrdisciplines/benefits/articles/pages/medicarechoices.aspx>.

²⁴ Prior to August 1993, Medicare was the secondary payer for "active individuals" entitled to Medicare on the basis of disability. Active individuals included people who were not actually working, who had employee status as indicated by their relationship to their employer. For example, the employer might have been paying the individual sick or disability pay that was subject to Federal Insurance Contributions Act (FICA) taxes or the individual might have participated in an insurance plan that was available only to employees. The standard for disabled Medicare beneficiaries was changed to "current employment status" in 1993 to be consistent with the standard for the working aged. Medicare defines employed in this case as a person whose relationship is indicative of employment status.

kidney transplant.²⁵ For individuals with enrollment based solely on ESRD, MSP rules apply for those covered by an employer-sponsored group health plan, regardless of the employer size or current employment status.²⁶

For individuals whose Medicare eligibility is based *solely* on ESRD, any group health plan coverage they receive through their employer or their spouse's employer is the primary payer for the first 30 months of ESRD benefit eligibility, which is referred to as the 30-month coordination period. After 30 months, Medicare becomes the primary insurer. (Medicare remains the secondary payer for the full 30 months for a person initially covered due to ESRD even if that person becomes eligible for Medicare during that time due to age or other disability.)²⁷ During this 30-month period, the group health plan is the primary insurer for all ESRD-related costs.

Similarly, for working individuals (or spouses) who qualify for and remain eligible for Medicare based on *both* ESRD and age or disability, any group health plan coverage they had been receiving through their employer or a spouse's employer remains the primary payer during the 30-month coordination period. After 30 months, Medicare becomes primary, even if the individual has employer-sponsored health insurance based on current employment status.

There is an exception to the MSP rules for beneficiaries with ESRD. Medicare would *immediately* become the primary payer if *both* following conditions were met: (1) an individual was first entitled to Medicare on the basis of age or disability and then also became eligible on the basis of ESRD, and (2) the MSP provisions for age or disability did not apply because the plan coverage was not "by virtue of current employment status," or the employer did not meet the test of size for either the aged or disabled.

For retirees, rather than current workers, who first qualify for Medicare based on ESRD and then turn 65 during the 30-month coordination period, their retiree health insurance remains primary for the entire 30-month period. For retirees with group health insurance who simultaneously become eligible for Medicare based on age and ESRD, the group health plan is primary for 30 months.

Medicare coverage for those who qualify based solely on a diagnosis of ESRD ends 12 months after the month in which a beneficiary stops dialysis treatment, or 36 months after the month a beneficiary has a successful kidney transplant. However, if Medicare coverage ends, and then begins again based on ESRD, the 30-month coordination period also starts again.

²⁵ Not everyone with ESRD is eligible for Medicare. In addition to a diagnosis of the condition, a person must meet work history requirements, receive Social Security or Railroad Retirement benefits, or be the spouse or dependent child of a person who has met the requirements or is receiving Social Security or Railroad Retirement benefits.

²⁶ The ESRD provisions apply to both current and former employees. Medicare entitlement based on ESRD usually begins with the third month after the month in which the beneficiary starts a regular course of dialysis, referred to as the three-month waiting period. This waiting period may be waived, in part or entirely, if, during that time (1) the individual takes an approved home dialysis training program in self-dialysis; (2) the individual is admitted to a Medicare-approved hospital for a kidney transplant or for health care services needed before the transplant, if the transplant takes place during that month or the following two months; or (3) the individual is scheduled for a transplant that is delayed more than two months after the beneficiary is admitted to the hospital or for health care services.

²⁷ Centers for Medicare & Medicaid Services, *Medicare Secondary Payer (MSP) Manual*, Chapter 1, (Revision 87), p. 11, August 3, 2012, <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/msp105c01.pdf>.

COBRA

Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA; P.L. 99-272) requires that certain group health plans allow beneficiaries to continue existing employer-sponsored coverage if they are laid off, work fewer hours, or lose insurance due to a change in family circumstance, such as a divorce or the death of a spouse enrolled in a plan. Group health plans offered by employers that have 20 or more employees are subject to COBRA.²⁸ COBRA benefits typically last for 18 months, but can run for 36 months, depending on the nature of the triggering event.²⁹ Though enrollees must pay as much as 102% of the group health plan premium for COBRA coverage, it is often less expensive than the cost of an individual insurance plan on the private market.³⁰

Table 3. Medicare Secondary Payer Rules and COBRA

When You:	This Insurer Pays First:
Have Medicare based on ESRD and then qualify for COBRA coverage ...	Group health plan continues to pay first to the extent coverage overlaps with the 30-month coordination period.
Are eligible for Medicare and COBRA and are currently working, though on reduced hours ...	Medicare pays first, because COBRA coverage is due to provisions of law rather than employment status.
Have Medicare due to age or disability before becoming eligible for COBRA and are not currently employed ...	Medicare pays first, COBRA is secondary.
Have COBRA benefits first and then become entitled to Medicare ...	Employer may terminate COBRA. Medicare would become payer.

Source: Department of Health and Human Services, Department of Labor.

In general, COBRA is secondary to Medicare when an individual’s insurance coverage is based on COBRA eligibility, rather than on current employment status. (See **Table 3.**) Employers may terminate COBRA benefits if a person who has first elected COBRA coverage subsequently becomes entitled to Medicare (with some exceptions).³¹ In cases where a person loses retiree coverage due to Medicare entitlement, however, his or her spouse and children still may be eligible for COBRA benefits.³²

If an individual is entitled³³ to Medicare due to ESRD, rather than age or disability, COBRA continuation depends on when he or she becomes eligible for COBRA. If an individual becomes entitled to Medicare because of ESRD prior to becoming eligible for COBRA benefits, COBRA

²⁸ U.S. Department of Labor, “FAQs for Employers about COBRA Continuation Health Coverage,” http://www.dol.gov/ebsa/faqs/faq_compliance_cobra.html.

²⁹ If an employer files for Chapter 11 bankruptcy, certain affected retirees may be eligible for COBRA coverage beyond the 36-month period. See I.M. Golub and Roberta Chevlowe, *2012 COBRA Handbook*, Wolters Kluwer Law & Business, New York.

³⁰ CRS Report R40142, *Health Insurance Continuation Coverage Under COBRA*, by Janet Kinzer.

³¹ Centers for Medicare & Medicaid Services, *Medicare Secondary Payer (MSP) Manual*, Chapter 1, (Revision 87), p. 12 August 3, 2012, <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/msp105c01.pdf>. However, if a person is entitled to COBRA coverage because a firm has declared bankruptcy, COBRA coverage cannot be terminated based on Medicare eligibility.

³² U.S. Department of Labor, “Eligible for Medicare,” <http://www.dol.gov/elaws/ebsa/health/68.asp>.

³³ An individual is entitled to Medicare in general when he or she enrolls in Medicare Part A or B.

will remain primary to the extent it overlaps the 30-month coordination period. If a person still has COBRA coverage remaining when the 30-month coordination period ends, Medicare will pay first and COBRA coverage will end.³⁴

Individuals who become eligible for Medicare, based on age, while receiving COBRA benefits may face a financial penalty and a delay in coverage if they do not sign up for Medicare during the initial program enrollment period. Federal law allows workers to postpone signing up for Medicare, without penalty, if they are covered by insurance from a company where they or a spouse are currently working. But COBRA recipients who are not currently employed are not entitled to the special enrollment period for Medicare Part B. If those individuals do not enroll during the initial eight-month period, they may be subject to a late enrollment penalty and may have to wait until the next open enrollment period, which runs from January to March each year, for coverage beginning that July.³⁵

MSP and Non-Group Insurance

No-Fault and Liability Insurance

Medicare is the secondary payer when payment has been made, or can reasonably be expected to be made, under automobile medical insurance, and other forms of no-fault and liability insurance.³⁶ Medicare may make conditional payments for services when payment from these primary payers has been delayed, subject to later reimbursement. If a beneficiary is also covered by a group health plan, the group health plan, as well as the liability plan, is to be billed first before Medicare conditional payment is requested. In cases where Medicare has made a conditional payment in a medical liability case, HHS has a *priority right of recovery* from the primary payer, as well as from any other parties that have received part of a settlement including a provider, beneficiary, supplier, or insurer. In addition, Medicare has other recovery rights. (See “Subrogation.”) The MSP provisions governing automobile, medical, no-fault, and other liability insurance initially were included in OBRA 1980, effective December 5, 1980.

Workers’ Compensation

Medicare is the secondary payer for items or services covered under a workers’ compensation law or plan of the United States or a state.³⁷ In the case of a contested claim, a workers’ compensation

³⁴ Medicare Rights Center, “Can I Have Both COBRA and Medicare?” http://www.medicareinteractive.org/page2.php?topic=counselor&page=script&slide_id=127; Centers for Medicare & Medicaid Services, *Medicare Secondary Payer (MSP) Manual*, Chapter One, (Revision 87), p. 13 August 3, 2012, <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/msp105c01.pdf>.

³⁵ Social Security Administration, “Medicare Information,” <http://www.socialsecurity.gov/disabilityresearch/wi/medicare.htm#cobra>.

³⁶ *Ibid.* Liability insurance can include homeowner’s insurance, malpractice insurance, product liability insurance and general casualty insurance, among others. It also includes payment under state wrongful death statutes that provide payment for medical damages.

³⁷ The MSP provisions also apply to workers’ compensation plans of the District of Columbia, American Samoa, Guam, Puerto Rico, and the Virgin Islands. MSP also applies to federal workers’ compensation provided under the Federal Employees’ Compensation Act, the U.S. Longshoremen’s and Harbor Workers’ Compensation Act and its extensions, and the Black Lung Program. The Federal Employers’ Liability Act (FELA), which covers employees of interstate railroads, and the Merchant Marine Act of 1920 (Jones Act), which covers merchant seamen, do not fall (continued...)

board must notify a beneficiary, and pending a decision, Medicare may be billed. A Medicare conditional primary payment may be made if the compensation carrier will not pay promptly, but follow-up action must be taken to recover the payment. If a beneficiary exhausts all appeals under workers' compensation, Medicare would be the primary payer.

Beneficiaries who receive workers' compensation settlements or other payments designed to cover future or lifetime medical costs must protect the Medicare program from unnecessary expenses. Medicare does not pay for workers' compensation-related medical and prescription drug benefits when an individual receives a payment or settlement designed to cover future medical expenses. In such cases, the CMS recommends that individuals set up a Workers' Compensation Medicare Set-aside Arrangement (WCMSA), which allocates a portion of any workers' compensation settlement for future medical expenses. The amount of the set-aside is determined on a case-by-case basis and is reviewed by CMS, when appropriate. (See "Medicare Set-Aside Accounts.")

MSP and Other Federal Programs

Items and services furnished by federal providers, a federal agency, or under a federal law or contract are excluded from Medicare coverage. (See **Table 4.**) This includes U.S. military hospitals, the Department of Veterans Affairs (with some exceptions), and research grants, among others. This exclusion from Medicare coverage does not include health benefits offered to employees of federal entities, rural health clinic services, federally qualified health centers, and other exemptions that may be specified by the Secretary of HHS.

The federal-state Medicaid program, which covers services for low-income and some disabled elderly beneficiaries, is always secondary to Medicare.

Table 4. Medicare Secondary Payer and Other Government Programs

When You:	This Insurer Pays First:
Are a veteran and are entitled to veteran's benefits ...	The Veterans Administration pays for VA-authorized services. Medicare pays for Medicare-covered services.
Are covered under TRICARE ...	Medicare pays for Medicare-covered services. TRICARE pays for services at a veteran's hospital or other federal provider. TRICARE may provide secondary coverage for beneficiaries in Tricare for Life.
Have black lung disease and are covered by the Federal Black Lung Program ...	The Federal Black Lung Program pays for services related to Black Lung. Medicare pays for non-Black Lung Conditions.

Source: Department of Health and Human Services.

Federal Black Lung Program

Medicare coordinates benefits with the Federal Black Lung Program. Medicare does not pay for services covered under the Federal Black Lung Program for Medicare beneficiaries who are

(...continued)
under the MSP law.

entitled to Black Lung medical benefits, in accordance with the Federal Coal Mine Act (P.L. 91-173). Medicare may be billed for Medicare-covered services not covered by the Federal Black Lung Program. If the services are solely for a non-Black Lung condition, Medicare would be billed as primary.

Department of Veterans Affairs (VA)

Medicare coverage has been coordinated with VA health benefits since 1965, when the Medicare program was created. In general, Medicare does not pay for the same services covered under VA benefits, in a case where a Medicare beneficiary is also entitled to VA benefits. The VA, at its expense, may authorize private physicians and other suppliers to provide services to certain veterans with service-connected disabilities, and, in specific cases, with non-service-connected disabilities. Medicare may reimburse veterans for VA co-payment amounts charged for VA-authorized services furnished by non-VA sources. (Medicare may also provide credit toward the Medicare deductible or coinsurance amounts for such services.)

If a physician accepts a veteran as a patient and bills the VA, the physician must accept the VA reimbursement as payment in full. But Medicare may supplement VA payments when a VA claim is for physician services and is filed by the veteran, not the physician. When the Medicare claim is submitted, it must indicate which services were billed to the VA and whether or not the beneficiary submitted a claim to the VA for payment.³⁸

In another case, if the VA authorizes hospital services in a non-VA hospital, Medicare may pay for covered services that fall outside of the VA authorization. For example, if the VA authorizes a five-day hospital stay in a non-VA hospital, but a patient remains in the hospital two more days, Medicare may cover the two additional days, subject to its payment rules.³⁹

TRICARE

TRICARE provides health care coverage for active duty military, National Guard and reserve members, retirees and their families, survivors and certain former spouses. The rules for primary and secondary coverage of this group are not included in the Medicare statutes, but rather are included under Title 10 of the U.S. Code §1095. In general, Medicare pays for Medicare services and TRICARE pays for services from a military hospital or federal provider.

TRICARE for Life (TFL) is a form of Medigap program under which TRICARE offers secondary coverage to beneficiaries age 65 and older enrolled in both Medicare Part A and Part B.⁴⁰ For TFL beneficiaries, Medicare is the primary payer for services covered by both programs and TRICARE is secondary. For services covered under Medicare but not by TRICARE, TFL beneficiaries must pay Medicare cost-sharing amounts and the deductible. For health care

³⁸ Centers for Medicare & Medicaid Services and CGS, "Medicare Billing and Adjustments," 2012, http://www.cgsmedicare.com/hhh/education/materials/pdf/MSP_Billing.pdf.

³⁹ Centers for Medicare & Medicaid Services, "Medicare Secondary Payer & You," p. 19, <http://www.cms.gov/Medicare/Coordination-of-Benefits/MedicareSecondPayerandYou/index.html>; Medicare Secondary Payer Manual, Chapter 5, (Rev. 89) <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/msp105c05.pdf>.

⁴⁰ Individuals may also be enrolled in TRICARE and Medicare due to ESRD or disability. Centers for Medicare & Medicaid Services, "Medicare and Other Health Benefits: Your Guide to Who Pays First," <http://www.medicare.gov/Pubs/pdf/02179.pdf>.

services covered under TRICARE, but not by Medicare, beneficiaries must pay the TRICARE cost-sharing amounts or deductibles. For TFL beneficiaries serving overseas, TRICARE is primary and they must pay TRICARE's annual deductible and cost sharing.⁴¹

A TRICARE beneficiary entitled to Medicare on the basis of age, disability, or ESRD must enroll and pay the monthly Medicare Part B premium to remain TFL-eligible. There are some exceptions for active duty military.⁴²

Federal MSP Oversight and Administration

Since 2006, MSP reporting and administrative functions have been carried out by three HHS subcontractors. HHS is in the process of revamping its contractors and administrative processes to make the system more efficient.

Coordination of Benefits Contractor (COBC)

CMS established a centralized Coordination of Benefits operation, consolidating data collection in a single entity known as the Coordination of Benefits Contractor (COBC). The COBC is responsible for activities that support the collection, management, and reporting of other insurance coverage for Medicare beneficiaries. The COBC focuses on ensuring that Medicare makes proper payments by identifying primary and secondary payers before Medicare pays any submitted bills.

The COBC is primarily an information-gathering entity, and does not process claims, nor handle mistaken payment recoveries or claim-specific inquiries. The COBC has responsibility for establishing individual beneficiary MSP records on the Common Working File (CWF), the official source of Medicare beneficiary information.

As described later in this report, the COBC is also responsible for the Initial Enrollment Questionnaire and data match. It also carries out all activities necessary to ensure that the primary payer, whether or not it is Medicare, pays first and then makes arrangements for transferring the claims automatically to the secondary payer for further processing.

Medicare Secondary Payer Recovery Contractor (MSRPC)

The CMS has used a contractor known as the Medicare Secondary Payer Recovery Contractor (MSRPC) to identify mistaken MSP payments for recovery; make conditional payments and determine the amounts potentially subject to recovery; provide support to CMS during litigation or negotiations regarding MSP payments; refer delinquent MSP debt to the Department of the Treasury for collection; and track overall MSP debt.⁴³

The MSRPC identifies and recovers Medicare payments that should have been paid by a group health plan or by liability insurers, no-fault insurers, and workers' compensation plans. In

⁴¹ U.S. Department of Defense, "TRICARE for Life," <http://www.tricare.mil/tfl>.

⁴² TRICARE, "Frequently Asked Questions," <http://www.tricare.mil/faqs/question.aspx?ID=1741>.

⁴³ The MSRPC does not pursue supplier, physician, or other provider recovery.

addition to its responsibility for issuing new MSP recovery demand letters and subsequent CMS actions, the MSPRC is responsible for work on all pending recovery cases.

Workers' Compensation Review Contractor (WCRC)

The Workers' Compensation Review Contractor (WCRC) is responsible for overseeing creation and execution of Workers' Compensation Medicare Set-Aside Arrangements (WCMSA). The set-aside accounts are designed to cover future medical expenses relating to workers' compensation cases, thereby ensuring that medical services to treat the underlying disability or illness are not billed to Medicare. Proposed set-aside accounts are reviewed by CMS before final approval, if they meet certain guidelines.

Contractor Reorganization

Lawmakers, HHS officials, and business executives have raised concerns about the efficiency of MSP contractors. Several recent studies, including reviews by the HHS ombudsman,⁴⁴ the Government Accountability Office (GAO),⁴⁵ and the Senate Homeland Security & Governmental Affairs Subcommittee on Contracting Oversight,⁴⁶ have identified issues in the administration of the MSP program. The CMS has replaced some contractors and is creating a Coordination of Benefits and Medicare Secondary Payer Recovery operation to consolidate activities supporting the collection, management and reporting of other insurance coverage of Medicare beneficiaries, as well as the collection of mistaken primary payments.⁴⁷ Reorganization is intended to speed up response to requests for determinations of repayment, provide more information for beneficiaries and attorneys, and improve internal controls.

General Data Reporting Requirements

MSP contractors receive and review information from a variety of sources, including beneficiary questionnaires, Social Security and Internal Revenue Service (IRS) databases, and mandatory industry reports.

Initial Enrollment Questionnaire (IEQ)

Medicare beneficiaries are mailed a voluntary Initial Enrollment Questionnaire (IEQ) about three months before their Medicare entitlement begins. The COBC questionnaire asks about employment status and spouse's employment status; health insurance coverage such as Black

⁴⁴ Office of the Medicare Ombudsman, *2011 Report to Congress*, p. 31, <http://www.cms.gov/Outreach-and-Education/Outreach/OpenDoorForums/Downloads/2011OmbudsmanReporttoCongress.pdf>.

⁴⁵ Government Accountability Office, *Medicare Secondary Payer: Additional Steps are needed to Improve Program Effectiveness for Non-Group Health Plans*, March 2012, <http://gao.gov/assets/590/589158.pdf>.

⁴⁶ Senator Claire McCaskill, "New Information about the Medicare Secondary Payer Recovery Contractor," <http://mccaskill.senate.gov/files/documents/pdf/SecondaryPaymentsFactSheet.pdf>. The subcommittee held a hearing on the issue on April 28, 2010, <http://mccaskill.senate.gov/files/documents/pdf/BensonTestimony4.28.2010.pdf>.

⁴⁷ Centers for Medicare & Medicaid Services, "Medicare Secondary Payer Business Program Operations Contract (BPOC) Solicitation," September 28, 2012, https://www.fbo.gov/?s=opportunity&mode=form&id=e78933bbf30d0d75c1a0792d7714befd&tab=core&_cview=0.

Lung, workers' compensation or liability coverage; and any health insurance purchased through an employer. If the questionnaire is not returned within 45 days, a follow-up survey is sent to the beneficiary. Beneficiaries are asked, but not required to respond to the IEQ.⁴⁸

IRS/SSA/CMS Data Match Program

The Social Security Act authorizes a data match program to identify cases where an insurer other than Medicare is the primary payer.⁴⁹ Each October, the Social Security Administration (SSA) sends a file to the IRS. The IRS has 40 business days to match this file against its tax records. The file is returned to SSA, which has another 40 business days to process the "Data Match Employer-Employee File" for CMS. The COBC reviews and analyzes these data in preparation for use in contacting employers concerning possible other insurance coverage that is primary to Medicare. The purpose of the data match is to identify secondary payer situations before Medicare makes payment, and to facilitate recoveries when incorrect Medicare payments have been made.

The COBC sends selected employers a questionnaire to determine which employers offer health insurance, and to determine the insurance status of specific beneficiaries. The information becomes part of the Common Working File. CMS may impose civil monetary penalties on employers who do not respond to the questionnaire. This information is used on an ongoing basis to identify claims for which Medicare should not be the primary payer.

Provider Notification

Medicare providers, including hospitals, physicians, and outpatient hospital departments, among others, must ask beneficiaries a series of standardized questions before providing services to ascertain whether another insurer is primary to Medicare. For recurring outpatient hospital services, the MSP information needs to be verified once every 90 days. While the information is not required to be collected for every visit, incorrect Medicare payments are still subject to repayment. Health care providers must bill other primary payers before billing Medicare.

A health care provider must notify the COBC promptly if an attorney or insurance company requests a copy of a medical record or bill concerning a Medicare patient. Further, if a provider receives a primary payment from both Medicare and a third-party payer, as well as any deductible or coinsurance amounts from the beneficiary, the provider must refund the beneficiary up to the full amount that he or she paid. Any amount paid by the third-party payer that is greater than the deductible and coinsurance amount is considered to be a debt to Medicare, because it duplicates payment made by Medicare. Medicare must be reimbursed within 60 days of the provider's receipt of the duplicate payment.

⁴⁸ In addition to responding to the survey, beneficiaries receiving health care services should tell their physician, other providers, and the COBC about any changes in health insurance. They (or their lawyers, if applicable) should also contact the COBC if (1) they take legal action or an attorney takes legal action on their behalf for a medical claim, (2) they are involved in an automobile or other accident, or (3) they are involved in a workers' compensation case.

⁴⁹ Centers for Medicare & Medicaid Services, "IRS-SSA-CMS Data Match," <http://www.cms.gov/Medicare/Coordination-of-Benefits/IRSSACMSDataMatch/index.html>.

2007 MMSEA Mandatory Reporting

In addition to the general data reporting requirements, Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007, (P.L. 110-173, MMSEA) requires Responsible Reporting Entities (RRE) that include group health plans and what CMS calls non-group health plans such as liability, no-fault, and workers' compensation insurers, to provide information to HHS regarding health insurance status of employees, as well as judgments, payments, or settlements involving Medicare beneficiaries. The information is used prospectively to determine whether Medicare is a primary or a secondary payer and retrospectively to collect reimbursement for erroneous payments and conditional payments. The 2007 requirements were phased in gradually, in response to concerns from businesses and insurers about the possible burden of the law.⁵⁰

The SMART Act (P.L. 112-242) makes additional changes to Section 111 that are intended to speed up the process for estimating conditional payments that must be reimbursed. (See **Appendix B**.) The SMART Act also eases some requirements that businesses found onerous. For example, RREs that did not comply with the Section 111 reporting requirements were subject to fines of up to \$1,000 per day per violation. The SMART Act gives HHS discretion to relax those penalties.

Group Health Plans

The MMSEA instituted mandatory reporting for group health plans,⁵¹ which include insurers, third-party administrators or insurance plans, and in the case of self-insured and self-administered plans, an administrator or fiduciary. Plans may also use third parties such as data firms to submit their information. Under Section 111, group health plans provide information to the COBC on a quarterly basis regarding active, covered individuals in their plans. Active, covered individuals are people who may be Medicare-eligible and are currently employed, or who are spouses or dependents of workers who are covered by a group health plan and may be Medicare-eligible.⁵² The COBC, after receiving the data, provides insurers with information about primary and secondary coverage for individuals that it can identify as Medicare beneficiaries.⁵³ The Secretary of HHS is entitled to share this enrollment information with other government entities in order to coordinate benefits.

⁵⁰ While the MMSEA instituted mandatory reporting, insurers already had an obligation to pay Medicare in cases where their policies were deemed primary.

⁵¹ Prior to enactment of the MMSEA, employers were mainly responsible for collecting information about health insurance coverage other than Medicare. Group health providers had been allowed to enter into a Voluntary Data Sharing Agreements (VDSA) with CMS, electronically providing group health insurance information and Medicare entitlement data on a scheduled basis. In return, the CMS provided its VDSA partners with information about employees and dependents entitled to Medicare. Section 111 of the MMSEA replaced these data sharing agreements, though VDSAs are still allowed for non-group health plans such as liability insurers.

⁵² For a fuller description see, Centers for Medicare & Medicaid Services, *MMSEA Section 111 MSP Mandatory Reporting GHP User Guide*, Version 3.2, April 20, 2011, <http://www.cms.gov/Medicare/Coordination-of-Benefits/MandatoryInsRep/Downloads/GHPUserGuideV32.pdf>.

⁵³ *Ibid.* Insurers that choose to file an expanded report can also provide and receive information about Medicare Part D prescription drug benefits.

Liability, No-Fault and Workers' Compensation Reporting

The MMSEA Section 111 quarterly reporting requirements apply to non-group health plans such as auto, homeowners, no-fault, and workers' compensation insurance.⁵⁴ These plans are required to supply CMS with information regarding Medicare beneficiaries or dependent spouses of Medicare-eligible beneficiaries for whom they assume responsibility for ongoing medical payments, or who receive a settlement, judgment, or award from liability insurance, no-fault insurance, or a workers' compensation plan.⁵⁵ This group of insurers and related entities may also enter into voluntary data sharing agreements with the COBC.⁵⁶

The 2007 law requires these RREs to report information including diagnosis codes for injuries or illnesses, the amount of any settlement, judgment or other financial awards, and information about any other claimants.⁵⁷ Section 111 initially required RREs to submit a beneficiary's Medicare identification number (HICN) or Social Security number. Reporting entities also have been required to provide an Employer Identification Number (EIN). Congress altered these requirements in the SMART Act. The law requires the Secretary of HHS to modify reporting requirements, within 18 months of enactment, so that plans complying with MSP laws are permitted, but not required, to access or report Social Security or HICN numbers.⁵⁸ (See **Appendix B.**)

Increased Industry Reporting Volume

CMS phased in implementation of the MMSEA Section 111 requirements in response to concerns from business and insurance interests. Group health plans began data reporting in 2009 and were phased in by 2011. Workers' compensation and other liability insurance reporting requirements, based on set, dollar-level thresholds, are being phased in through 2015. Even with the staggered requirements, the HHS noted in its *2011 Financial Report* that the volume of reports regarding MSP liability and other payment situations had doubled since the MMSEA was passed.⁵⁹ Most of

⁵⁴ Centers for Medicare & Medicaid Services, *MMSEA Section 111 MSP Mandatory Reporting Liability Insurance (Including Self-Insurance), No-Fault Insurance, and Workers' Compensation User Guide Chapter III Policy Guidance*, Version 3.4, July 3, 2012, <http://www.cms.gov/Medicare/Coordination-of-Benefits/MandatoryInsRep/Downloads/NGHPUserGuideVer34Ch3Policy.pdf>. The requirement also applies to self-insured plans. According to CMS, the Section 111 requirements do not eliminate existing processes, including CMS's process for self-identifying pending liability insurance, no-fault insurance, or workers' compensation claims to the COBC.

⁵⁵ There are additional considerations for entities that insure insurers, such as companies providing stop-loss or re-insurance coverage. Crystal Fraser, "The Complexity of the Mandatory Medicare Section 111 Reporting Rules and Its Practical Legal Affects – Is There a Break in Sight?," *Connecticut Insurance Law Journal*, Volume 17:2, 2011, <http://insurancejournal.org/wp-content/uploads/2011/12/Fraser.pdf>.

⁵⁶ Centers for Medicare & Medicaid Services, "Employer Voluntary Data Sharing Agreements," <http://www.cms.gov/Medicare/Coordination-of-Benefits/EmployerServices/employervdsa.html>.

⁵⁷ Centers for Medicare & Medicaid Services, "Collection of Medicare Health Insurance Claim Numbers (HICNs), Social Security Numbers (SSNs) and Employer Identification Numbers (EINs) (Tax Identification Numbers) – ALERT," April 6, 2010. Centers for Medicare & Medicaid Services, *MMSEA Section 111 MSP Mandatory Reporting Liability Insurance (Including Self-Insurance), No-Fault Insurance, and Workers' Compensation User Guide Chapter III Policy Guidance*, Version 3.4, p. 31, July 3, 2012, <http://www.cms.gov/Medicare/Coordination-of-Benefits/MandatoryInsRep/Downloads/NGHPUserGuideVer34Ch3Policy.pdf>.

⁵⁸ However, the law allows the Secretary of HHS to extend the deadline each year if the Secretary certifies that the changes threaten the privacy of individuals or the integrity of the MSP system.

⁵⁹ Centers for Medicare & Medicaid Services, *CMS Financial Report: Fiscal Year 2011*, p. 22, http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CFORreport/Downloads/2011_CMS_Financial_Report.pdf.

the increased reporting has been from group health plans. (More than 1,500 group health insurers provide data under Section 111.)

The GAO in a March 2012 report to Congress noted that the number of reported MSP cases involving liability and no-fault plans rose by 176% from FY2008 to FY2011, while the number of workers' compensation set-aside proposals submitted to the CMS contractor rose by 42% during that period.⁶⁰ However, the GAO noted that a number of workers' compensation cases that were submitted did not meet certain financial thresholds required for CMS review. (See "Medicare Set-Aside Accounts.")

Determining MSP Reimbursement for Claims

When Medicare is the secondary payer, a health care provider must first submit a claim to a beneficiary's primary payer, who processes the claim according to terms of the coverage contract. If the primary payer does not pay the full charges for the service, Medicare secondary payments may be made *if the service is covered by Medicare*. In no case can the actual amount paid by Medicare exceed the amount it would pay as primary payer. Any primary payments from a third-party payer for Medicare-covered services are credited toward the beneficiary's Medicare Part A and Part B deductibles and, if applicable, coinsurance amounts. However, if the primary payment is less than the deductible, the beneficiary may be responsible for paying his/her unmet Medicare deductibles and coinsurance amounts.

The Medicare secondary payment amount is subject to certain limits. For some services, such as inpatient hospital care, the *combined* payment by the primary payer and Medicare cannot exceed Medicare's recognized payment amount (without regard to beneficiary cost-sharing charges). As one example of how Medicare would decide its secondary payment amount for inpatient hospital services, assume that an individual received inpatient hospital services costing \$6,800. The primary payer paid \$4,360 for the Medicare-covered services. No part of the inpatient hospital deductible (\$1,183 for 2013) had previously been met. Medicare's gross payment amount, without regard to the deductible, is \$4,700. As the secondary payer, Medicare would pay the lowest of

- Medicare's gross payment amount, without regard to deductible, minus the primary payer's payment— $\$4,700 - \$4,360 = \$340$;
- Medicare's gross payment amount minus the Medicare inpatient deductible— $\$4,700 - \$1,183 = \$3,517$;
- the hospital charge minus the primary payer's payment— $\$6,800 - \$4,360 = \$2,440$;
- the hospital charge minus the Medicare inpatient deductible— $\$6,800 - \$1,183 = \$5,617$.

In this case, Medicare would pay \$340. The combined payment made by the primary payer and Medicare is \$4,700. The beneficiary has no liability for Medicare-covered services, since the

⁶⁰ Government Accountability Office, Medicare Secondary Payer: Additional Steps are Needed to Improve Program Effectiveness for Non-Group Health Plans, GAO- 12-333, p. 15, March 2012; <http://gao.gov/assets/590/589158.pdf>.

primary payer's payment satisfied the \$1,183 inpatient deductible. If Medicare's payment amount had been lower than the primary payer's amount, it would not have made a secondary payment.

In other cases, such as physicians' services, the Medicare secondary payment amount cannot exceed the lowest of the calculation of the following three options. For example, assume that a physician charges \$175 for a service; the primary payer's allowable charge is \$150, of which it pays 80%, or \$120; and Medicare's recognized payment amount for the service is \$125, of which it pays 80%, or \$100. The options⁶¹ are described below:

- actual provider charge minus the primary payer's allowable charge, adjusted for copayment: $\$175 - \$120 = \$55$;
- Medicare's payment amount, adjusted for copayment: $.80 \times \$125 = \100 ;
- primary payer's allowable charge of \$150 is compared to the Medicare recognized payment amount of \$125, and the higher of the two (which in this case is the primary payer's charge of \$150) minus the primary payer's payment of \$120: $150 - \$120 = \30 .

Because Medicare's secondary payment is based on the lowest of these three options, Medicare would pay \$30.

MSP Conditional Payments

In some cases, Medicare may pay first for a medical claim, and then the COBC may receive notification or otherwise determine that Medicare was actually the secondary payer. In other instances, Medicare will make conditional payments for medical treatment even when it is the recognized secondary payer. Examples include cases when (1) Medicare could reasonably expect payment to be made under a workers' compensation or no-fault insurance claim, but Medicare determines the payment will not be paid or will not be made promptly (within 120 days); (2) a beneficiary's employer-sponsored plan denies a properly filed claim, in some cases; or (3) a properly filed claim is not made due to physical or mental incapacity of the beneficiary.⁶² Medicare can also make payments in cases where Medicare benefits have been claimed for an injury that allegedly was caused by another person.

Medicare will *not* make conditional payments under the following conditions: (1) a third-party payer plan alleges that it is secondary to Medicare; (2) a plan limits payment when the individual is entitled to Medicare; (3) a plan provides covered services for younger employees and spouses, but not for employees and spouses who are 65 and older; (4) a proper claim is not filed, or is not filed in a timely manner, for any reason other than the physical or mental incapacity of the beneficiary; or (5) a group health plan fails to furnish needed information to CMS to determine whether or not an employer plan is primary to Medicare.

Medicare must be repaid for conditional payments by the primary payer or anyone who has received the primary payment, if it is demonstrated that another payer, such as a liability insurer,

⁶¹ Centers for Medicare & Medicaid Services, "Medicare University – Medicare Secondary Payer (MSP) Payment for Part B Providers," May 18, 2011.

⁶² 42 C.F.R., §411.52.

had a responsibility to make a payment. Repayment is expected when a beneficiary receives a settlement or other payment.

Subrogation

In addition to statutory authority to collect reimbursement for conditional payments, CMS has the right of subrogation in liability or other cases that involve Medicare beneficiaries. Typically, subrogation occurs when an insurance company that pays its insured client for injuries, losses, or medical expenses, seeks to recover its payment. The insurer, in this case Medicare, may reserve the “right of subrogation” in the event of a loss. This means that the insurer may choose to take action to recover the amount of a claim paid for services provided to a beneficiary if the loss was caused by a third party. For example, if a beneficiary is injured in a car accident, Medicare may seek to recover its payment from any money collected by the beneficiary, or it may sue on behalf of the beneficiary to recover its payment, from automobile liability insurance, uninsured motorist insurance, or under-insured motorist insurance.

CMS is subrogated to any individual, provider, supplier, physician, private insurer, state agency, attorney, or any other entity entitled to payment by a primary payer. Medicare will reduce its recovery to take account of the beneficiary’s cost of procuring a judgment or settlement. If the Medicare payment is less than the judgment or settlement amount, Medicare will prorate the procurement costs. If the payment equals the judgment or settlement, it may recover the total amount minus total procurement costs.⁶³

Current Conditional Payment Resolution System

One of the more challenging aspects of the MSP program has been to develop an expeditious system to process and resolve conditional payment claims arising from liability and workers’ compensation cases.

Under current regulations, in the case of a group health plan, when Medicare finds evidence of a mistaken payment, the MSPRC issues a Primary Payment Notice to the insurer or plan sponsor, seeking verification of enrollment and beneficiary information. The employer or plan sponsor has 45 days to respond. If the issue is not resolved, a demand letter is issued for the claims at question. The employer or plan sponsor can then pay the claim or contest the claim. If the claim is neither paid nor contested, interest will begin to accrue and if CMS efforts are unsuccessful, the claim may be turned over to the Department of the Treasury.⁶⁴ The actual time for resolving claims may vary from the timeline, depending on factors involved in the cases.

In a case of accident or illness involving liability and other insurers, where the COBC has been notified and Medicare has stepped in to make conditional payments, the MSPRC follows up with a letter to the affected parties laying out their rights and responsibilities. The MSPRC contractor then begins to review bills and other documents relevant to the underlying illness or injury, and

⁶³ Eugene Podesta, Jr. “Issues Arising out of the Medicare Secondary Payer Act,” Baker, Donelson, Bearman, Caldwell & Berkowitz, https://marketcenter.bakerdonelson.com/files/Uploads/Documents/Podesta_Medicare-Medicare_for_Lawyers_Journal_Club.pdf.

⁶⁴ MSPRC, “Overview of the Recovery Process: Group Health Plans,” November 11, 2010, <http://www.msprc.info/processes/GHP%20flowchart.pdf>. Claims cannot be sent to Treasury earlier than 120 days after a demand letter or later than 240 days from a demand letter.

calculates the amount owed to Medicare.⁶⁵ The MSPRC next issues a conditional payment notification that summarizes Medicare payments made. In an effort to speed up the process, CMS has created an automated phone line and a web-based portal where beneficiaries, attorneys, insurers, and select other parties can request updates of the amount of conditional payments outstanding, submit case settlement information, dispute conditional payment letters, and take other actions.⁶⁶

When a settlement, judgment or payment is reached, the parties submit information to the MSRPC, including total payments and costs, as well as attorney's fees. CMS determines total repayment after deducting allowable expenses such as legal bills, and issues a demand letter, with payment due within 60 days. Beneficiaries can pay, appeal, or request a waiver of repayments. Interest begins to accrue on any outstanding balance from the date of demand, and is assessed beginning after the 60-day timeframe. If full payment is not received in 120 days, (assuming all correspondence regarding the conditional payments has been reviewed and resolved) the MSPRC may issue a letter saying it will refer the issue to the Department of the Treasury for collection. CMS will not refer debt to Treasury any earlier than 120 days from the date of the demand letter, nor any later than 240 days from the demand letter. As is the case with conditional payment claims involving group health plans, the actual time it takes to resolve a claim can vary significantly.

The MMSEA Section 111 reporting requirements prompted an increase in number of conditional payment cases reported to CMS, but also led to complaints from beneficiaries, insurers, and businesses about what they said were delays in CMS response time to their requests for information needed to settle claims or lawsuits or process awards.⁶⁷ A number of beneficiaries and other interested parties have filed lawsuits challenging CMS decisions regarding reimbursement of conditional payments.⁶⁸

On June 22, 2011, the House Energy and Commerce Subcommittee on Oversight and Investigations held a hearing on issues related to MSP reporting requirements and response time by CMS contractors.⁶⁹ The House hearing followed a 2010 investigation by the Senate Homeland Security and Governmental Affairs Select Subcommittee on Contracting Oversight.⁷⁰ The Subcommittee, citing reports by CMS auditors, identified performance problems with the contractors. The GAO in a March 2012 report to Congress identified areas for improvement in MSP administration, noting that average wait times for telephone calls to contractors regarding MSP cases had increased substantially from FY2008 to FY2011, as had the time for the contractors to process claims.⁷¹ The GAO noted that the rising delays were due partly to the fact

⁶⁵ MSRPC, Conditional Payment Flow Chart, <http://www.msprc.info/processes/nghp%20flowchart.pdf>.

⁶⁶ MSRPC, "The Medicare Secondary Payer Recovery Portal is Live!" <http://www.msprc.info/>.

⁶⁷ The Medicare Advocacy Recovery Coalition, a group that includes insurers, pharmaceutical companies, retailers, and other businesses, has advocated for changes to the Section 111 reporting requirements since its 2008 founding. See Medicare Advocacy Recovery Coalition, <http://www.marccoalition.com/index.html>.

⁶⁸ As an example, see *Haro vs. Sebelius*, CV 09-134, TUC DCB (D. AZ.) May 5, 2011; and *Hadden v. United States*, 132 F. Supp. 202 – 1955.

⁶⁹ House Energy and Commerce Committee, Subcommittee on Oversight and Investigations, "Protecting Medicare with Improvements to the Secondary Payer Regime," June 22, 2011, <http://archives.republicans.energycommerce.house.gov/hearings/hearingdetail.aspx?NewsID=8716>.

⁷⁰ Senator Claire McCaskill, "New Information about the Medicare Secondary Payer Recovery Contractor," <http://mccaskill.senate.gov/files/documents/pdf/SecondaryPaymentsFactSheet.pdf>.

⁷¹ Government Accountability Office, *Medicare Secondary Payer: Additional Steps are Needed to Improve Program* (continued...)

that a larger number of cases were submitted to CMS.⁷² In recent months, CMS has made progress in reducing its backlog.⁷³

Current Expedited Repayment Options

CMS has created several options for speeding conditional payment claims⁷⁴ in certain cases – both for past medical bills and for some cases that involve future medical payments. Examples of cases where expedited options are in place include:

- \$300 Threshold—if a beneficiary has suffered a physical trauma-type injury, obtains a liability settlement of \$300 or less, and does not receive nor expect to receive additional “settlements” related to the incident, Medicare will not pursue recovery.⁷⁵
- Fixed Payment Option—if a beneficiary suffers a physical trauma-based injury, obtains a liability settlement of \$5,000 or less, and does not receive nor expect to receive additional settlements related to the incident, the beneficiary may resolve Medicare’s recovery claim by paying 25% of the gross settlement.
- Self-Calculated Conditional Payment Option—if a beneficiary suffers a physical trauma-based injury at least six months prior to selecting this option, anticipates obtaining a settlement of \$25,000 or less, proves that medical care has been completed, and has not received nor expects to receive additional settlements related to the incident, the beneficiary may self-calculate Medicare’s recovery claim. Medicare then reviews the beneficiary’s calculations and provides Medicare’s final, conditional payment amount.⁷⁶

SMART Act Changes

Congress in 2012 acted to streamline the process for resolving outstanding conditional payments involving non-group health plans in the SMART Act. (For a full section-by-section explanation of the SMART Act, see **Appendix A.**)

In one of the most significant changes in the new law, a Medicare beneficiary or insurer may notify CMS at any time beginning 120 days before the reasonably expected date of a settlement, judgment, award, or other payment that a payment is reasonably expected. Medicare then will have 65 days to post conditional payment amounts on a special website. At the conclusion of that

(...continued)

Effectiveness for Non-Group Health Plans, p. 21, March 2012, <http://gao.gov/assets/590/589158.pdf>. The time for issuing demand letters averaged 76 days in FY2011, according to the GAO.

⁷² CMS has subsequently reduced its backlog of cases.

⁷³ PR Web, “Broad Approval of Workers’ Compensation MSA Submissions Helps With Backlog, Allsup Reports,” December 7, 2012, <http://www.prweb.com/releases/2012/12/prweb10217288.htm>.

⁷⁴ Centers for Medicare & Medicaid Services, “Medicare Program: Medicare Secondary Payer and Future Medicals,” 42 CFR Parts 405 and 411, *Federal Register*, June 15, 2012, p. 35917, <https://www.federalregister.gov/articles/2012/06/15/2012-14678/medicare-program-medicare-secondary-payer-and-future-medicals>.

⁷⁵ The SMART Act contains provisions that require HHS to set annual thresholds for reporting conditional payment claims.

⁷⁶ *Ibid.*

time period, a Medicare beneficiary/claimant or applicable plan may download a “statement of reimbursement amount” that will constitute the final conditional payment amount recoverable by CMS, if certain conditions are met. (CMS may use its current, online portal to create the conditional payment website required in the law.)

HHS is to implement the SMART Act timelines for issuing conditional payment amounts within nine months of the law’s enactment, though other changes may not be in place for 18 months. Even after the law takes full effect, some beneficiaries will have the flexibility to continue using existing CMS procedures for resolving small-dollar claims and no-fault claims, rather than the new system.⁷⁷ Further, the SMART Act does not address issues regarding creating set-aside accounts to cover future medical bills in workers’ compensation and other cases.

Medicare Set-Aside Accounts

In addition to reimbursing CMS for past, conditional payments, individuals must protect Medicare’s interest with respect to future medical bills if they have received, reasonably anticipate receiving, or should have reasonably anticipated receiving, Medicare-covered items and services for a medical condition after the date of a settlement or payment based on that condition.⁷⁸ CMS suggests, though MSP law does not require, that individuals who receive workers’ compensation settlements that include payments for future medical expenses create set-aside accounts. The accounts allocate a share of a settlement to cover future medical bills, thus ensuring that Medicare does not pay for services related to a disability or illness that triggered a settlement (and where workers’ compensation or liability insurance would otherwise be primary.)⁷⁹ Set-aside accounts are becoming more common in other liability settlements as well.

CMS does not review workers’ compensation settlements for current Medicare beneficiaries when an award is less than \$25,000 in total payments. However, CMS cautions that this threshold is not considered a safe harbor for such accounts and that individuals remain obliged to protect Medicare’s interests.

CMS generally reviews workers’ compensation set-asides in cases where an individual is within 30 months of becoming eligible for Medicare and the payment over the life of the settlement is more than \$250,000. For example, a person who is age 63 and is awarded a settlement equal to \$25,000 per year to cover medical payments would qualify for review of a set-aside account, based on the fact that he or she would be eligible for Medicare at age 65 (within 30 months) and would have a life expectancy of more than ten years (exceeding the \$250,000 threshold).⁸⁰

⁷⁷ Some of the procedures could be affected by CMS regulations to implement the SMART Act. For example, the SMART Act requires that CMS set an annual minimum threshold for review of conditional payments, which could mean a change to the current \$300 threshold.

⁷⁸ Centers for Medicare & Medicaid Services, “Medicare Program: Medicare Secondary Payer and Future Medicals,” 42 CFR Parts 405 and 411, *Federal Register*, June 15, 2012, p. 35917, <https://www.federalregister.gov/articles/2012/06/15/2012-14678/medicare-program-medicare-secondary-payer-and-future-medicals>.

⁷⁹ Centers for Medicare & Medicaid Services, “Workers’ Compensation: Commutation of Future Benefits,” July 23, 2001, <http://www.cms.gov/Medicare/Coordination-of-Benefits/WorkersCompAgencyServices/Downloads/72301Memo.pdf>.

⁸⁰ Applying for disability or ESRD benefits could also be considered by CMS to mean an individual is likely to be eligible for Medicare within 30 months.

In reviewing the adequacy of set-aside accounts, the Workers Compensation Review Contractor (WCRC) considers a number of factors including the severity of the underlying illness, life expectancy, and the cost of expected medical procedures. Once a set-aside account has been approved, Medicare will not pay for items or services related to the injury or illness until the account has been exhausted. (Medicare will cover other, unrelated medical services.) Set-aside accounts are not mandatory, and individuals can use other means to ensure that Medicare's interests regarding future medical bills are protected. However, the ABA and other lawyers and beneficiaries say that even though the set-asides are not required, they are the best way to receive assurance from CMS that Medicare's interests have been met and that Medicare will not withhold payment for future medical services.⁸¹

The ABA and other businesses and attorneys have criticized CMS for not developing formal regulations to guide the set-aside process, instead relying on more informal guidance documents. In June 2012 CMS issued a proposed rulemaking that would provide new options for set-aside accounts.⁸² (See "Expedited Set-Aside Accounts.") In addition, lawmakers have introduced legislation to impose formal requirements for handling set-aside accounts, which would remain voluntary. (See "Issues for Congress.")

The number of workers' compensation set-aside accounts submitted to the WCRC has risen since the Section 111 reporting requirements took effect. The average time for processing an account rose from 22 days in April 2010 to 95 days in September 2011, according to the GAO, though the WCRC has since made progress in clearing up its backlog.⁸³

Expedited Set-Aside Accounts

In June 2012, CMS issued an advance notice of proposed rulemaking⁸⁴ that spells out options for creating a standardized system for Medicare set-aside accounts in cases involving automobile and liability insurance (including self-insurance) and no-fault insurance cases, in addition to workers' compensation set-asides.

The CMS proposed a series of options to streamline the process for set-aside accounts, including:

- Setting out specific conditions under which Medicare would not pursue future medical claims.
- Satisfying future claims by providing documentation that a course of care has been completed and reimbursing Medicare for any conditional payments.

⁸¹ American Bar Association, "Medicare Set-Aside Process in Workers' Compensation," http://www.americanbar.org/advocacy/governmental_legislative_work/priorities_policy/health_care_law/medicare_set_aside_process_in_workers_compensation.html.

⁸² Ibid.

⁸³ Government Accountability Office, *Medicare Secondary Payer: Additional Steps are Needed to Improve Program Effectiveness for Non-Group Health Plans*, p. 21, March 2012, <http://gao.gov/assets/590/589158.pdf>; PRWeb, "Broad Approval of Workers' Compensation MSA Submissions Helps With Backlog, Allsup Reports," December 7, 2012, <http://www.prweb.com/releases/2012/12/prweb10217288.htm>.

⁸⁴ Centers for Medicare & Medicaid Services, "Medicare Program: Medicare Secondary Payer and Future Medicals," 42 CFR Parts 405 and 411, *Federal Register*, June 15, 2012, p. 35917, <https://www.federalregister.gov/articles/2012/06/15/2012-14678/medicare-program-medicare-secondary-payer-and-future-medicals>. Some of the proposals would apply to current Medicare beneficiaries and some for those expected to soon become eligible for Medicare.

- Expanding the current workers’ compensation set-aside review system.
- Expanding or amending Medicare’s existing three expedited payment options.
- Allowing for some type of up-front payment to satisfy MSP requirements.
- Waiving some payments if a beneficiary has a compromise settlement or a waiver or recovery.
- Having a beneficiary administer his or her own settlement account until it is exhausted.

MSP Savings

According to CMS, MSP laws and regulations have reduced Medicare expenditures by about \$50 billion from FY2006 through FY2012. The largest savings came from situations where group health plans acted as primary payers, leaving Medicare in the secondary position. However, CMS is processing a growing volume of claims regarding liability, no-fault, and workers’ compensation cases.⁸⁵

Table 5. MSP Savings for FY2006-FY2012

(dollars in millions)

MSP category	2006	2007	2008	2009	2010	2011	2012 ^a
Working aged	\$2,981	\$2,919	\$3,033	\$3,583	\$3,259	\$3,567	\$3,283
ESRD	299	278	316	376	344	343	\$314
Working disabled	2,034	1,939	1,982	2,232	2,021	2,184	\$2,008
Workers’ compensation	93	877	1,053	1,233	1,613	1,245	\$1,215
Auto/No Fault	244	233	293	248	325	271	\$253
Liability	410	232	82	324	424	448	\$400
Veterans Admin./Other	29	26	27	28	20	21	\$18
Total	\$6,089	\$6,505	\$6,788	\$8,023	\$8,007	\$8,080	\$7,491

Source: CMS unpublished data—MSP Savings Report (Crowd System).

Note: Totals may not add due to rounding.

a. Figures are for first 11 months of FY2012. Assuming a continuous trend, this would result in about \$8 billion for 2012.

CMS’s annual MSP report shows total MSP savings of more than \$8 billion for FY2011, increasing from \$6 billion in FY2006.⁸⁶ Payments are expected to reach about \$8 billion in 2012 as well. As shown in **Table 5**, about half of total savings each year came in cases where group health plans were the primary payers for the working aged and the working disabled. Workers’ compensation payments have been the fastest growing part of MSP payments. CMS payments to

⁸⁵ Government Accountability Office, Medicare Secondary Payer: Additional Steps are Needed To Improve Program Effectiveness for Non-Group Health Plans, March 2012, <http://gao.gov/assets/590/589158.pdf>.

⁸⁶ The 2007 savings include \$770 million for the Workers’ Compensation Medicare Set-aside Arrangement (WCMSA) which was not included in previous years.

contractors have also increased since the Section 111 payments took effect. According to the GAO, payments to the CMS contractors were \$21 million higher in FY2011 than in FY2008. During this time the workload for the COBC rose 176%, the MSPRC by 102% and the WCRC by 42%.⁸⁷ While overall savings to Medicare appear to have increased, it could take years to determine final dollar amounts given the lag time between filing claims and collecting payments, according to the GAO.

Issues for Congress

During the past several decades, Congress has expanded the scope of the MSP program in order to ensure that other insurers make contractually required payments, reduce Medicare expenditures, and extend the life of the Medicare Trust Fund. The changes have succeeded in increasing the volume and dollar amount of MSP payments reported to CMS, but have also resulted in a backlog for MSP contractors and created a backlash among businesses, insurers, and attorneys concerned about the time and expense of reporting, delay in CMS response and potential fines.

Congress in the 2012 SMART Act addressed these issues, by creating a centralized website for conditional claim information and setting tighter timelines for CMS action. (See **Appendix B**.) The SMART Act did not address other issues related to MSP that have raised concerns among beneficiaries and industry officials, such as the process for creating set-aside accounts to cover future medical bills. Now that the SMART Act is law, there could be a new focus on legislation setting out a formal process for creating and reviewing workers' compensation set-aside accounts. Legislation introduced in the 112th Congress, H.R. 528, would have imposed thresholds for review of set-aside accounts (which would remain voluntary); imposed timelines for review, as well as an appeals process; and allowed beneficiaries to set aside a set percentage of certain settlements, or make direct payments to Medicare, to cover future medical bills.

In addition, Congress will be overseeing implementation of the SMART Act. The Congressional Budget Office has estimated that the SMART Act will result in modest budget savings to Medicare.⁸⁸ It remains unclear, whether CMS will be able to comply with the law's timelines for calculating and issuing final conditional payments. During House debate on the measure, lawmakers noted that Congress did not provide CMS with additional funding to create the required website, or to implement other features of the measure.

⁸⁷ Government Accountability Office, Medicare Secondary Payer: Additional Steps are Needed To Improve Program Effectiveness for Non-Group Health Plans, Table 3, March 2012, <http://gao.gov/assets/590/589158.pdf>.

⁸⁸ Congressional Budget Office, "H.R. 1063 Strengthening Medicare and Repaying Taxpayers Act of 2011," November 9, 2012, <http://www.cbo.gov/sites/default/files/cbofiles/attachments/hr1063.pdf>. The SMART Act was originally H.R. 1063 before it was folded into another bill for passage.

Appendix A. Selected MSP Legislation

Table A-1. Medicare Secondary Payer Legislation
Federal laws that have shaped the Medicare Secondary Payer program

Legislation	Implication
Omnibus Budget Reconciliation Act of 1980 (P.L. 96-499)	Set MSP rules for non-group health plans.
Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35)	Set MSP rules for group health plans, individuals with End Stage Renal Disease.
Tax Equity and Fiscal Responsibility Act of 1982 (P.L. 97-248)	Set coverage of working aged.
Deficit Reduction Act of 1984 (P.L. 98-369)	Expanded definition of working spouse.
Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272)	Eliminated upper age limit of 69 for the working aged.
Omnibus Budget Reconciliation Act of 1986 (P.L. 99-509)	Made changes in disabled workers provisions.
Omnibus Budget Reconciliation Act of 1987 (P.L. 100-203)	Clarified provisions relating to disabled workers, as well as some COBRA provisions.
Omnibus Budget Reconciliation Act of 1990 (P.L. 101-508)	Modified MSP provisions for beneficiaries with ESRD.
Omnibus Budget Reconciliation Act of 1993 (P.L. 103-66)	Modified MSP provisions for ESRD and disabled beneficiaries.
Balanced Budget Act of 1997 (P.L. 105-33)	Extended time for Medicare to recoup conditional payments, further clarified ESRD provisions.
Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. 108-173)	Expanded government's ability to collect repayment of conditional payments, applied MSP to Medicare Part D.
Medicare, Medicaid & SCHIP Extension Act of 2007 (P.L. 110-173)	Section 111 reporting requirements.
Medicare IVIG Access Act, Title II (The SMART Act) (P.L. 112-242)	Instituted new requirements and timelines for resolving conditional payment claims.

Source: *The Complete Guide to Medicare Secondary Payer Compliance*, Lexis-Nexis, and HHS.

Appendix B. SMART Act

During the 112th Congress, lawmakers approved additional changes to the process for resolving outstanding MSP conditional payments. Title II of P.L. 112-242, signed into law on January 10, 2013, is entitled “Strengthening Medicare Secondary Payer Rules” (also known as the SMART Act).⁸⁹ The statutory provisions make substantive and procedural changes to the MSP statute and current CMS procedures, including provisions relating to Medicare conditional payments, MMSEA Section 111 reporting requirements, appeal rights, use of Social Security numbers, and statutes of limitations. The new provisions apply to what CMS calls non-group health plans such as workers’ compensation, no-fault and liability insurance (including self-insurance) plans, but not to employer group health plans.

Section 201 of P.L. 112-242 directs CMS to make a password-protected website available to Medicare beneficiaries, authorized representatives and “applicable plans” with information on the items and services claimed that relate to a specific injury or incident that forms the basis of a potential settlement, judgment, award, or other payment. CMS must update the conditional payment information (including provider or supplier name(s), diagnosis codes, date of service and conditional payment amounts) on the website in as timely a manner as possible, but not later than 15 days after the date Medicare pays a claim.

CMS is also required to provide a “timely process” for Medicare beneficiaries/claimants and their authorized representatives to resolve discrepancies in downloaded statements of conditional payments from the website. No administrative or judicial review of this dispute resolution process is provided; however, beneficiaries would still be able to exercise formal administrative or judicial appeals to contest final conditional payment demands from CMS.

A Medicare beneficiary or applicable plan may notify CMS at any time beginning 120 days before the reasonably expected date of a settlement, judgment, award, or other payment that a payment is reasonably expected and the expected date of payment. Medicare then has a 65-day response period (95 days in some circumstances) in which to post conditional payments on the website. After the response period, during a prescribed “protected period,” a Medicare beneficiary/claimant or applicable plan may download a “statement of reimbursement amount” that will constitute the final conditional payment amount recoverable by CMS, if certain conditions are met. Regulations implementing the website and dispute resolution requirements of Section 201 must be promulgated within nine months of enactment of this statute.

This section also requires the Secretary to promulgate regulations (no specified deadline) establishing a right of appeal and an appeal process for non-group health plans and their attorneys, agents, or third-party administrators to appeal Medicare final conditional payment determinations for which CMS seeks to recover from such plans. An applicable plan must provide notice to Medicare beneficiaries of its intent to appeal. Under current MSP law, only Medicare beneficiaries can file an administrative appeal or federal court action to challenge Medicare conditional payment demand amounts.

Section 202 requires the Secretary of HHS to annually calculate and publish a single threshold amount below which MSP re-payment and Section 111 of MMSEA reporting obligations will not

⁸⁹ This section was written by Kathleen Swendiman, Legislative Attorney, Congressional Research Service.

apply. The threshold amount will apply to settlements, judgments, awards, or other payments arising from liability insurance (including self-insurance), and for alleged physical trauma-based incidents (excluding alleged ingestion, implantation, or exposure cases), and will apply to years beginning with 2014.

Section 203 changes current law under which Responsible Reporting Entities (RREs) that fail to report certain information regarding Medicare claimants to CMS “shall be subject to a civil monetary penalty of \$1,000 for each day of non-compliance with respect to each claimant” to provide that an RRE “may” be subject to a fine “of up to” \$1,000 per day. In addition, the Secretary must publish a notice within sixty days of enactment soliciting proposals “for the specification of practices for which sanctions will and will not be imposed ... including not imposing sanctions for good faith efforts to identify a beneficiary ...” After consideration of submitted proposals the Secretary is directed to publish proposed safe harbor practices, and thereafter issue final regulations.

Section 204 requires that, no later than 18 months after the date of enactment, the Secretary shall modify the reporting requirements for non-group health plans so that such plans are permitted, but not required, to report to CMS the Social Security Numbers or Health Insurance Claim Numbers of Medicare beneficiaries. The deadline for implementing this modification may be extended by the Secretary upon notice to Congress that compliance with current deadline would threaten patient privacy or the integrity of the secondary payer program.

Section 205 requires that CMS file suit for recovery of Medicare conditional payments in the non-group health plan context within three years after the date CMS receives notice of a settlement, judgment, award, or other payment under Section 111 of MMSEA. This provision applies to actions brought and penalties sought on or after 6 months after the date of the enactment of this Act.

The Congressional Budget Office (CBO) has estimated that the SMART Act will reduce federal outlays by \$45 million from FY2013 to 2022.⁹⁰ According to the CBO, the bill would allow some liability and other legal settlements to take place more quickly. At the same time, some settlements might be less than they would have been under previous law because of the tighter timeframe for estimating conditional payments.

⁹⁰ Congressional Budget Office, H.R. 1063, “Strengthening Medicare and Repaying Taxpayers Act of 2011, Cost Estimate,” November 9, 2012.

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