

Report to Congress

**Computation of Annual Liability Insurance (Including Self-Insurance)
Settlement Recovery Threshold**

**As Required by Section 202 of the Medicare IVIG Access and Strengthening Medicare and
Repaying Taxpayers Act of 2012**

(SMART Act)

From the

Department of Health and Human Services

Office of the Secretary

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Executive Summary

Section 202 of the Medicare IVIG Access and Strengthening Medicare and Repaying Taxpayers Act of 2012 (the SMART Act) amended section 1862(b) of the Social Security Act (the Act) , in part by adding a section (b)(9), which requires the Secretary of the Department of Health and Human Services (the Secretary) to calculate and publish each year a single threshold amount for settlements, judgments, awards or other payments (hereafter referred to as settlements) for obligations arising from liability insurance (including self-insurance) and for alleged physical trauma-based incidents (excluding alleged ingestion, implantation, or exposure cases). The single threshold amount for a year is to be set so that the average cost of collecting conditional payments is equal to the amount credited to the Medicare Trust Fund. This requirement ensures that Centers for Medicare & Medicaid Services (CMS) is not spending more to recover funds than it is collecting. Section 202 also requires the Secretary to evaluate whether similar thresholds should be established for obligations arising from workers' compensation and no-fault insurance.

The average cost of collecting conditional payments for liability settlements was approximately \$420 for fiscal year (FY) 2014. The average demand was calculated for various settlement ranges to find a point where the cost of collecting approximated the amount Medicare would likely recover. Through our analysis, we concluded for settlements of \$1000 or less, the cost of collecting conditional payments would most closely approximate the amount Medicare would recover. As a result, CMS will maintain the current \$1000 threshold, established on January 1, 2014, for physical trauma-based liability insurance cases in 2015. We believe the established threshold promotes fiscal efficiency and revenue neutrality.

The recommended single liability settlement reporting threshold amount for 2015 and the methodology used to calculate the cost of collection was forwarded to the Comptroller General of the United States in **June 2015**. CMS is still evaluating workers' compensation and no-fault insurance data to determine if similar thresholds should be established.

Background

In 1980, the Congress enacted the Medicare Secondary Payer (MSP) provisions of the Act, which established Medicare as the secondary payer to certain primary plans. Please see Appendix A for an overview of the Medicare Secondary Payer provisions.

As part of these provisions, section 1862(b)(9) of the Act requires an annual evaluation of costs of collection in determining a threshold to ensure CMS does not spend more money pursuing a secondary payer claim than it could recover from the settlement.

There are costs associated with recovering conditional payments. These costs include compiling related claims, calculating conditional payments, applying reductions, sending demands, and providing customer service, among others. In addition to CMS' costs associated with pursuing recovery, Medicare does not usually recover the full amount of the conditional payments. For example, there may be reductions to the demand to account for procurement costs borne by the

beneficiary (attorney fees and/or costs) or for full or partial waiver of recovery if certain criteria are met. Implementing a threshold allows CMS to use its resources wisely.

In evaluating whether to change the settlement threshold for liability insurance for 2015, CMS reviewed the cost of collection for settlements, the average recovery from settlements at targeted settlement amounts; and the point at which the cost of collection approximated the amount recovered.

Conclusion

Comparing the results of cost of collection to recovery amounts, we identified a liability insurance settlement threshold where the estimated cost of collection approximates the amount of expected recovery. See Appendix B for the methodology and results.

Based on the analysis performed, CMS will maintain the settlement threshold amount for physical trauma-based liability insurance settlements (excluding alleged ingestion, implantation or exposure cases) at \$1000. In such situations where the liability insurance settlement is \$1000 or less, CMS will not require reporting of the settlement and CMS will not assert a recovery claim.

Unlike liability insurance, cases involving no-fault insurance and workers' compensation require Medicare beneficiaries to take action to obtain payments from the workers' compensation plan and no-fault insurance and, as a result, these entities are frequently billed directly by the provider. Currently, CMS has a reporting threshold of \$750, where in certain situations workers' compensation entities are not required to report until the costs paid on behalf of a beneficiary have exceeded \$750. CMS is in the process of reviewing workers' compensation and no fault insurance data to determine if the workers' compensation threshold needs to be increased or if additional thresholds should be established.

CMS will continue to review any established thresholds, and the potential for new thresholds, annually. At the end of each fiscal year, we will review the settlement demand amounts and compare them to the costs of collection. Based on the findings and any other relevant factors, CMS will determine the annual threshold amounts for the upcoming calendar year. Before publishing any threshold, CMS will seek review by the Comptroller General. CMS will submit a Report to Congress on an annual basis.

Appendix A: Medicare Secondary Payer Overview

When the Medicare program was enacted in 1965, Medicare was the primary payer for all medically necessary items and services for Medicare beneficiaries, with the exception of those items and services covered and payable by workers' compensation. In 1980, the Congress enacted the Medicare Secondary Payer provisions of the Act, which added section 1862(b) to the Act and established Medicare as the secondary payer to certain primary plans. Primary plan, as defined in the Act, means a group health plan or large group health plan, workers' compensation law or plan, automobile or liability insurance (including self-insurance) policy or plan, or no-fault insurance.

Section 1862(b)(2) of the Act, in part, prohibits Medicare from making payment where payment has been made or can reasonably be expected to be made by a primary plan. If payment has not been made, or cannot reasonably be expected to be made promptly by a primary plan, Medicare may make conditional payments with the expectation that the payments would be reimbursed by the primary plan to the appropriate Trust Fund. That is, Medicare may pay for medical claims with the expectation that it will be repaid if the beneficiary obtains a settlement, judgment, award, or other payment (hereafter referred to as "settlement"). Section 1862(b)(2)(B) provides authority for Medicare to make conditional payments and requires the primary plan, if it is responsible for the payment, to reimburse Medicare. A primary plan, and any entity that receives payment from a primary plan, shall reimburse the appropriate Trust Fund for Medicare's payments for items and services if it is demonstrated that such primary plan has or had responsibility to make payment with respect to such items and services (whether or not there is a determination or admission of liability).

The responsibility for payment on the part of liability insurance (including self-insurance) is generally demonstrated by settlements. When a settlement occurs, the settlement is subject to the MSP provisions because a payment has been made with respect to medical care of a beneficiary related to that settlement. Section 1862(b)(2)(B)(iv) provides the Federal government subrogation rights to any right under MSP of an individual (or any other entity) to payment for items or services under a primary plan, to the extent that Medicare payments were made for such medical items and services. Moreover, section 1862(b)(2)(B)(iii) of the Act provides the Federal government a direct right of action to recover conditional payments made by Medicare. This direct right of action, which is separate and independent from Medicare's statutory subrogation rights, may be brought to recover conditional payments against any or all entities that are or were responsible for making payment for the items and services under a primary plan. Under the direct right of action, the Federal government may also recover payment from any entity that has received payment from a primary plan or the proceeds of a primary plan's payment to any entity.

More information about the Medicare Secondary Payer process is available at <http://go.cms.gov/cobro>.

Appendix B: FY 2015 Computation of a Liability Recovery Threshold

For Fiscal Year (FY) 2015, per 1862(b)(9) of the Act, CMS performed an analysis of cases involving liability insurance (which always includes self-insurance) settlements, judgments, awards, or other payments.

Below are the methodology used and the results.

Step 1: Cost of Collection

To determine the cost of collection, CMS obtained the FY 2014 costs of our contractors that perform MSP work related to identifying and recovering conditional payments for liability insurance cases. In FY 2014, CMS completed a contractor restructuring process so costs were gathered from both the incumbent contractors and the new sole contractor. During the first three months of FY 2014, the following contractors performed this work:

- The Coordination of Benefits Contractor (COBC) – This contractor collected information on Group Health Plan (GHP) and Non-Group Health Plan (NGHP) coverage. The GHP coverage information collected generally relates to other primary insurance offered through a beneficiary’s employer. The NGHP coverage information collected generally relates to other primary payment responsibility of liability insurance, no-fault insurance, and workers’ compensation laws or plans.
- The Medicare Secondary Payer Recovery Contractor (MSPRC) - This contractor used the information obtained by the COBC to compile paid claims data for both GHP and NGHP situations to identify the amount of Medicare’s recovery claim. When Medicare had a recovery claim, this contractor was responsible for issuing a demand and collecting the amount owed.

By January 2015, all NGHP coordination of benefit and recovery activities were consolidated to the following single contractor:

- The Benefits Coordination & Recovery Center (BCRC) - This contractor collects information on GHP and NGHP coverage. The GHP coverage information collected generally relates to other primary insurance offered through a beneficiary’s employer. The NGHP coverage information collected generally relates to other primary payment responsibility of liability insurance, no-fault insurance, and workers’ compensation laws or plans. The BCRC compiles paid claims data for NGHP situations to identify the amount of Medicare’s recovery claim. When Medicare has a recovery claim, this contractor issues a demand and collects the amount owed.

The CMS asked the incumbent COBC and MSPRC, and the new BCRC, to split their FY 2014 costs between GHP and NGHP activities. These contractors reported the following NGHP costs for FY 2014:

- The COBC reported it spent \$3,025,588 on NGHP activities.

- The MSPRC reported it spent \$17,547,444 on NGHP activities.
- The BCRC reported it spent \$52,436,427 on NGHP activities.

Based on this data, the total amount spent on NGHP benefit coordination and recovery was \$73,009,459 in 2014.

Liability Insurance MSP Case Recovery Unit Cost

To calculate an average cost per NGHP demand issued for liability insurance cases only, the total NGHP costs were allocated between liability insurance, no-fault insurance and workers' compensation MSP cases based upon the percentage distribution of contractor estimated costs reported by MSP type.

The reported costs for liability insurance represented 84.5% of the total \$73,009,459 spent on NGHP benefit coordination (.845 x \$73,009,459 = \$61,692,993). The cost of \$61,692,993 for liability insurance cases was divided by the total number of liability insurance final demand letters. There were 146,999 final liability insurance demands issued in FY 2014. This results in an average cost per liability insurance case of approximately \$420 (\$61,692,993/146,999=\$419.68).

Step 2: Estimated Recovery Amount

An analysis of amount demanded (recovery amount) was performed for liability insurance settlements in FY 2014. The projected recovery amount was calculated for five threshold ranges -- three hundred dollars (\$300) or less, greater than \$300 to five hundred dollars (\$500), greater than \$500 to seven hundred and fifty dollars (\$750), greater than \$750 to one thousand dollars (\$1000) (the current threshold), and greater than \$1000 to fifteen hundred dollars (\$1500).

Methodology

To determine the liability insurance threshold amount, we compared the estimated \$420 cost of collection per liability insurance case to the average liability insurance demand amount per settlement range. The chart below identifies the number of final demands and the average amount demanded for the various ranges.

| Settlement Range | # of Demands | Average Demand Amount |
|--------------------------------|--------------|-----------------------|
| ≤ \$300 | 1099 | \$136 |
| > \$300 to ≤ \$500 | 1151 | \$269 |
| > \$500 to ≤ \$750 | 824 | \$403 |
| > \$750 to ≤ \$1,000 | 1,190 | \$436 |
| > \$1,000 to ≤ \$1,500 | 2,008 | \$473 |

Step 3: Estimated Cost of Collection Equal to Estimated Recovery Amount

Based on this information, CMS determined it should maintain the \$1000 threshold established on January 1, 2014, so that physical trauma-based liability insurance settlements of \$1000 or less do not need to be reported and Medicare's conditional payment amount for these settlements does not need to be repaid. We arrived at this conclusion because the average amount demanded for the highlighted settlement range is \$436, which is closest to the estimated cost of collection of \$420. Because the liability insurance threshold for physical trauma based settlements remains at \$1,000 and it is revenue neutral, where cost of collection approximates the expected recovery amount, there are no additional expected savings in FY 2015.