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COMPUTATION OF ANNUAL LIABILITY INSURANCE (INCLUDING SELF-INSURANCE) SETTLEMENT RECOVERY THRESHOLD

BACKGROUND:

The Medicare Secondary Payer (MSP) provisions, found at section 1862(b) of the Social Security Act, prohibit 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 pay conditionally, with the expectation that the conditional payments would be reimbursed, once primary payment responsibility is demonstrated.

In liability insurance (which always includes self-insurance) situations, the primary plan has demonstrated primary payment responsibility when a settlement, judgment, award, or other payment (hereinafter, "settlement") occurs. Accordingly, Medicare is obligated by statute to recover conditional payments it made for medical care related to the settlement. Medicare's recovery is limited to the amount of the settlement less any attorney fees or costs the beneficiary incurred to obtain the settlement.

Medicare beneficiaries, their attorneys, and applicable plans report settlements to Medicare. Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) requires that an applicable plan making an insurance or workers' compensation settlement payment report that payment to Medicare. This reporting is required so Medicare is able to determine if it made any conditional payments related to that settlement. Once reported, Medicare calculates its conditional payment amount, reduces that amount for attorney fees and costs, and issues a demand letter requiring reimbursement.

Medicare incurs costs to perform these activities. These costs include compiling related claims, calculating conditional payments, applying reductions, sending demands, providing customer service, etc. 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 (attorney fees and 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 2013, as an annual requirement of section 202 of the Act, CMS reviewed all of the costs related to collecting data and determining the amount of Medicare's recovery claim. As a result of this analysis, CMS calculated a revised threshold for physical trauma-based liability insurance

settlements. Effective January 1, 2014, CMS established a single threshold for these cases, where settlements of $1000 or less do not need to be reported and Medicare's conditional payment amount related to these cases did not need to be repaid. In 2014, CMS reviewed current costs related to collecting data and determining the amount of Medicare's recovery claim. For 2015, CMS has determined that it will maintain the current single threshold for these cases, where settlements of $1000 or less do not need to be reported and Medicare's conditional payment amount related to these cases does not need to be repaid.

COST OF COLLECTION:

The CMS estimated the average cost of collection for Non-Group Health Plan (NGHP) cases as approximately $420 a case. This cost of collection was based on the amount paid (invoices) to our Benefits Coordination and Recovery Contractors for work related to identifying and recovering NGHP conditional payments (this data includes liability insurance, no-fault insurance and workers' compensation). The data used were for the fiscal year 2014. The total dollar amount paid to our contractors was divided by the number of final NGHP demand letters issued in 2014. The average cost of collection per NGHP case was calculated to be approximately $420.

The CMS then examined the amounts demanded for liability insurance cases for FY 2014. Different settlement amount ranges were examined. The settlement amount range that had the demand amount closest to the $420 cost of collection was for settlements above $750 and less than or equal to $1000. The average demand amount for this range of settlements was $436. Based on this information, CMS determined it should maintain the threshold of $1000, so that physical trauma-based liability insurance (including self-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.

As required by section 1862(b)(9) of the Act, CMS will maintain the single threshold for physical trauma-based liability insurance settlements of $1000 or less. Medicare will not require reporting and Medicare will not assert a recovery claim against physical trauma-based liability insurance settlements that are $1000 or less.