



Financial Services Group

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Centers for Medicare & Medicaid Services Computation of Annual Recovery Thresholds for Certain Liability Insurance, No-Fault Insurance, and Workers' Compensation Settlements, Judgments, Awards or Other Payments

BACKGROUND:

The Medicare Secondary Payer (MSP) provisions 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.

The primary plan, such as liability insurance, no-fault insurance, or workers' compensation, often demonstrates primary payment responsibility through a settlement, judgment, award, or other payment (hereinafter, "settlement"). 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 primary plans report settlements to Medicare. 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, for example, compiling related claims, calculating conditional payments, applying reductions, sending demands, and providing customer service. 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 facilitates CMS' efficient use of its resources.

To fulfill the requirements of Section 202 of the SMART Act, in 2017, 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, 2017, CMS will establish a single threshold for these cases, where settlements of \$750 or less do not need to be reported and Medicare's conditional payment amount related to these cases did not need to be repaid.

CMS also evaluated available data related to no-fault insurance and workers' compensation settlements. Based on this data, CMS determined that it will maintain a \$750 threshold for no-fault insurance and workers compensation settlements first established in 2016. For 2017, settlements of \$750 or less for no-

fault insurance and workers' compensation will not need to be reported and Medicare's conditional payment amount related to these cases will not need to be repaid.

COST OF COLLECTION:

The CMS estimated the average cost of collection for Non-Group Health Plan (NGHP) cases (which includes liability insurance (including self-insurance), no-fault insurance, and workers' compensation) as approximately \$323 per 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. CMS relied on data between August 2016 and July 2017. The total dollar amount paid to CMS' contractors was divided by the number of final NGHP demand letters issued during the aforementioned date range.

To determine settlement thresholds, CMS compared the estimated cost of collection per NGHP case of approximately \$323 to the average liability insurance demand amount per settlement range. We then did the same comparison of the estimated cost of collection to the average no-fault insurance and workers' compensation demand amounts per settlement range.

CONCLUSION:

Based on this information, CMS determined that it should maintain a \$750 threshold for 2018 so that physical trauma-based settlements of \$750 or less do not need to be reported and Medicare's conditional payment amount for these settlements does not need to be repaid. For liability insurance settlements, the calculated cost of collection most closely aligns with the average highlighted demand amount of \$417.79 for settlements of \$750 or less.

For no-fault and workers' compensation insurance, CMS will also maintain a threshold of \$750 where the insurer or workers' compensation entity does not otherwise have ongoing responsibility for medicals. Although the cost of collection of \$323, most closely aligns with the average demand for settlement of \$300 - \$500, the limited number of demands for no-fault and workers' compensation within this range represents a minimal amount of missed potential recoveries. The total demand amount missed by not lowering these thresholds would represent \$56,792 (No-Fault - \$40,336, workers' compensation \$16,456). The cost for CMS and external stakeholders to lower the threshold to \$500 for these two insurance types would far exceed potential recoveries for this range.