DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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Financial Services Group

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COMPUTATION OF ANNUAL LIABILITY INSURANCE SETTLEMENT REPORTING AND RECOVERY THRESHOLD

REQUIREMENT:

Section 202 of the Medicare IVIG Access and Strengthening Medicare and Repaying Taxpayers Act of 2012 (the SMART Act) states:

> "IN GENERAL.—Not later than November 15 before each year, the Secretary shall calculate and publish a single threshold amount for settlements, judgments, awards, or other payments for obligations arising from liability insurance (including self-insurance) and for alleged physical trauma-based incidents (excluding alleged ingestion, implantation, or exposure) subject to this section for that year. The annual single threshold amount for a year shall be set such that the estimated average amount to be credited to the Medicare trust funds of collections of conditional payments from such settlements, judgments, awards, or other payments arising from liability insurance (including self-insurance) and for such alleged incidents subject to this section shall equal the estimated cost of collection incurred by the United States (including payments made to contractors) for a conditional payment arising from liability insurance (including self-insurance) and for such alleged incidents subject to this section for the year. At the time of calculating, but before publishing, the single threshold amount for a year, the Secretary shall inform, and seek review of, the Comptroller General of the United States with regard to such amount."

Under Section 202 of the SMART Act, publication of the threshold mandated (as set forth above) shall include:

> "(I) the estimated cost of collection incurred by the United States (including payments made to contractors) for a conditional payment arising from liability insurance (including self-insurance) and for such alleged incidents; and (II) a summary of the methodology and data used by the Secretary in computing such threshold amount and cost of collection."

BACKGROUND:

The Medicare Secondary Payer 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 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. As a result, in August, 2011 the Centers for Medicare &Medicaid Services (CMS) established a single threshold where physical trauma-based liability insurance settlements of $300 or less do not need to be reported and Medicare's conditional payment amount related to these settlements does not need to be reimbursed. The CMS established this single threshold because it estimated that the cost incurred by its Medicare Secondary Payer Recovery Contractor (MSPRC) associated with determining and collecting Medicare's recovery claim would be more than the amount Medicare would recover.

COST OF COLLECTION:

The CMS estimated the average cost of collection for Non-Group Health Plan (NGHP) cases as approximately $335 a case. This cost of collection was based on the amount paid (invoices) to our Coordination of Benefits and Medicare Secondary Payer 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 2012, since these were the most up to date numbers available. Based on our current budget estimates, we expect the costs to be similar in 2013 and 2014. The total dollar amount paid to our contractors was divided by the number of final NGHP demand letters issued in 2013. The average cost of collection per NGHP case was calculated to be approximately $335.

The CMS then examined the amounts demanded for liability insurance cases for FY 2013. Different settlement amount ranges were examined. The settlement amount range that had the demand amount closest to the $335 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 $354. Based on this information, CMS determined it could establish a threshold of $1000, so that physical trauma-based 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.