Report to Congress

Computation of Annual Liability Insurance (Including Self-Insurance), No-Fault Insurance, and Workers' Compensation 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) 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 at least equal to the amount credited to the Medicare Trust Fund. This requirement ensures that the Centers for Medicare & Medicaid Services (CMS) is not spending more to recover funds than it is collecting.

The average cost of collecting conditional payments for liability insurance (including self-insurance), no-fault insurance, and workers' compensation settlements was approximately $421 for fiscal year (FY) 2015. We compared the estimated cost of collection per case (approximately $421) to the average demand amount per settlement range for liability insurance, no-fault insurance, and workers' compensation, to set settlement thresholds so that the average cost of collecting conditional payments is at least equal to the amount credited to the Medicare Trust Fund.

Although the calculated cost of collection for liability insurance settlements most closely aligns with the average demand amount for settlements of $750 or less, CMS will maintain the threshold of $1,000 for physical trauma-based liability insurance settlements because the cost of collection for FY 2015 remains consistent with the cost of collection for FY 2014. That is, physical trauma-based liability insurance settlements of $1,000 or less do not need to be reported and Medicare's conditional payment amount for these settlements does not need to be repaid. Furthermore, the cost to implement a change to reduce the threshold to $750 would likely exceed any estimated recoveries.

Section 202 of the SMART Act also requires the Secretary to evaluate whether similar thresholds should be established for obligations arising from workers' compensation and no-fault insurance. Through its evaluation of available data related to no-fault insurance and workers' compensation, CMS has determined that it will establish for the first time a threshold for no-fault insurance and workers' compensation settlements. Based on the analysis performed, 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 where the no-fault insurer or workers' compensation entity does not otherwise have ongoing responsibility for medicals.

The threshold amounts for Calendar Year (CY) 2016 and the methodology used to calculate the cost of collection was forwarded to the Comptroller General of the United States in May 2016.

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. Appendix A contains 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.

CMS has relied on fiscal year data to calculate the applicable threshold for the next calendar year. At the end of each fiscal year, CMS's MSP systems contractor runs queries to pull relevant data from the Recovery Management Accounting System. CMS simultaneously solicits cost-related information from MSP contractors that perform coordination of benefits and recovery work. CMS then compiles and analyzes the data, develops its recommendation, and solicits review by the Comptroller General.

In evaluating whether to change the settlement threshold for liability insurance and implement thresholds for no-fault insurance and workers' compensation for CY 2016, 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

Physical Trauma-Based Liability Insurance

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 **$1,000**. In such situations where the liability insurance settlement is $1,000 or less, CMS will not require reporting of the settlement and CMS will not assert a recovery claim.

No-Fault and Workers' Compensation

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 limited situations, workers' compensation entities are not required to report until the costs paid on behalf of a beneficiary have exceeded $750. This threshold is not the same as the threshold for workers' compensation and no-fault insurance described under Section 202 of the SMART Act.

CMS reviewed workers' compensation and no-fault insurance data from FY 2015 to determine if the workers compensation threshold (currently applicable only in limited circumstances) should be updated, or if additional thresholds should be established, including for no-fault insurance for CY 2016. Based on cost of recovery data obtained in FY 2015, CMS will establish a settlement threshold of **$750** for workers' compensation and no-fault insurance, where the no-fault insurer or workers' compensation entity does not otherwise have ongoing responsibility for medical expenses coverage. 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 settlement cases will not need to be repaid. CMS will continue to pursue recoveries of all claims when the insurer has accepted ongoing responsibility for medical expenses.

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. For no-fault and workers' compensation insurance, Medicare is always the secondary payer. However, there are situations where the no-fault or workers' compensation insurer will dispute the claim and settlement occurs. 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 https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Overview.html.

Appendix B: 2016 Computation of Recovery Thresholds

For CY 2016, per 1862(b)(9) of the Act, CMS performed an analysis of FY 2015 cases involving liability insurance (which always includes self-insurance), no-fault insurance, and workers' compensation 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 2015 costs of the contractor that performs MSP work related to identifying and recovering conditional payments for liability insurance, no-fault insurance and workers' compensation settlements. In FY 2015, the CMS Benefit Coordination & Recovery Center (BCRC) performed this work.

The BCRC collects information on both Group Health Plan (GHP) and Non-Group Health Plan (NGHP) coverage. The GHP coverage information collected relates to other insurance a beneficiary obtains through his or her employer or the employer of his or her spouse. The NGHP coverage information collected relates to liability insurance, no-fault insurance and workers' compensation situations. 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 letter and collects the amount owed.

CMS asked the BCRC to split their FY 2015 costs between GHP and NGHP activities. CMS spent $74,671,682 on NGHP benefit coordination and recovery activities in FY 2015. This includes costs incurred by other CMS contractors that directly support the BCRC's NGHP activities. To calculate an average cost per NGHP demand letter, the total NGHP costs were divided by the total number of NGHP demand letters. CMS determined that there was no difference between the work performed on liability insurance, no-fault insurance and workers' compensation MSP recovery cases. Therefore, the same unit cost applied to all NGHP case types. This results in an average cost of collection per NGHP case of approximately $421 ($74,671,682 / 177,511 cases = $421).

Step 2: Estimated Recovery Amount

An analysis of amount demanded (recovery amount) was performed for liability insurance, no-fault insurance and workers' compensation settlements in FY 2015. The projected recovery amount was calculated for six threshold ranges – greater than zero dollars ($0) to three hundred dollars ($300), 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 ($1,000) (the current threshold), greater than $1,000 to fifteen hundred dollars ($1,500) and greater than fifteen hundred dollars to two thousand dollars ($2,000).

Methodology

To determine settlement thresholds, we compared the estimated cost of collection per NGHP case of approximately $421 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. The charts below identify the number of demand letters and the average amount demanded for the settlement ranges listed.

Liability Insurance:

Settlement Range	# of Demands	Average Demand Amount
Over $0, less than or equal to $300	963	$131.80
Over $300, less than or equal to $500	652	$298.49
Over $500, less than or equal to $750	628	$451.18
Over $750, less than or equal to $1,000	771	$486.11
Over $1000, less than or equal to $1500	2216	$477.32
Over $1500, less than or equal to $2000	2336	$515.25

No-Fault Insurance:

Settlement Range	# of Demands	Average Demand Amount
Over $0, less than or equal to $300	1257	$119.11
Over $300, less than or equal to $500	496	$333.06
Over $500, less than or equal to $750	437	$499.72
Over $750 less than or equal to $1000	1005	$740.99
Over $1000, less than or equal to $1500	419	$863.21
Over $1500, less than or equal to $2000	517	$1,126.19

Workers' Compensation:

Settlement Range	# of Demands	Average Demand Amount
Over $0, less than or equal to $300	172	$111.19
Over $300, less than or equal to $500	52	$349.78
Over $500, less than or equal to $750	53	$516.09
Over $750, less than or equal to $1000	48	$696.35
Over $1000, less than or equal to $1500	60	$929.02
Over $1500, less than or equal to $2000	100	$1,020.98

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

Based on this information, CMS determined it should maintain the $1,000 threshold first established on January 1, 2014, so that physical trauma-based settlements of $1,000 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 demand amount for settlements of $750 or less. However, CMS will maintain the threshold of $1,000 for physical trauma-based liability insurance settlements because the average cost of collection per case for FY 2015 remains consistent with the average cost of collection for FY 2014, which was $420. While the average cost of collection per case has not changed dramatically, the number of liability insurance cases with settlements of $1,000 or less decreased by almost 30% between FY 2014 and FY 2015. Where parties negotiating settlements recognize that a case may fall under the threshold, they do not report them. Therefore, liability insurance settlement demand data available to compare to cost of collection decreased. Keeping the threshold at $1,000 versus adjusting it to $750 does decrease potential additional recoveries by approximately $50,000. The expected cost that CMS would incur by lowering the threshold would likely exceed these estimated recoveries.

For workers' compensation and no-fault insurance settlements, CMS will establish a threshold of $750, where the no-fault insurer or workers' compensation entity does not otherwise have ongoing responsibility for medical expenses. We arrived at this conclusion because the average amount demanded for the settlement range of $500 - $750 for no-fault insurance and workers' compensation are $499 and $516 respectively, which are closest to the estimated cost of collection of $421. In recognizing that some demand amounts in the $500 - $750 settlement range were for less than $421, we choose to set the threshold at the upper end of the $500 - $750 settlement range. This will ensure that no demands will be sent for amounts that exceed the average cost of collection.