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MEDICARE SECONDARY PAYER

Process for Situations Involving Non-Group Health Plans

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Highlights of [GAO-11-726T](#), a testimony before the Subcommittee on Oversight and Investigations, Committee on Energy and Commerce, House of Representatives

Why GAO Did This Study

The Centers for Medicare & Medicaid Services (CMS) is responsible for protecting the Medicare program’s fiscal integrity and ensuring that it pays only for those services that are its responsibility. Medicare Secondary Payer (MSP) provisions make Medicare a secondary payer to certain group health plans (GHP) and non-group health plans (NGHP), which include auto or other liability insurance, no-fault insurance, and workers’ compensation plans. CMS has the right to recover Medicare payments made that should have been the responsibility of another payer, but CMS has not always been aware of these MSP situations. In 2007, Congress added mandatory reporting requirements for GHPs and NGHPs that should enable CMS to be aware of MSP situations. CMS reports that mandatory reporting was pushed back from 2009 to 2011 for some NGHPs and from 2009 to 2012 for others, in part due to concerns raised by the industry.

GAO was asked to present background information about the MSP process as it pertains to NGHPs. To do this work, GAO reviewed relevant CMS documentation, including MSP regulations, manuals, and user guides, and conducted an interview with CMS related to mandatory reporting and the MSP process. GAO shared the information in this statement with CMS. CMS provided technical comments, which GAO incorporated as appropriate. GAO has ongoing work examining challenges related to the MSP process for NGHPs.

View [GAO-11-726T](#) or key components. For more information, contact James C. Cosgrove at (202) 512-7114 or cosgrovej@gao.gov

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What GAO Found

MSP situations involving NGHPs are triggered by unexpected incidents, such as car accidents or work-related injuries, that involve Medicare beneficiaries and result in medical expenses for which an NGHP—rather than Medicare—has primary responsibility for payment. In these situations, Medicare becomes a secondary payer.

Medicare payments for MSP situations involving NGHPs can vary. In most MSP situations involving NGHPs, Medicare will initially pay for related medical expenses in order to ensure that the beneficiary has timely access to needed care, and later seek to recover those payments. Once CMS is notified of an MSP situation involving an NGHP—by the insurer, the beneficiary, or another party—Medicare may start denying claims or may continue to make payments pending a resolution so the beneficiary has continued access to needed medical services. To help prevent Medicare from making future payments for MSP situations involving NGHPs, a Medicare set-aside arrangement may be created when an individual is expected to have future medical expenses related to an MSP situation. This is a voluntary arrangement where funds are set aside by the primary insurer to pay for related future medical expenses.

The MSP process for situations that involve NGHPs generally includes five basic components (see table 1). The process details, and CMS’s administrative tasks, can vary based on when in the process CMS is notified, the type of insurance involved, and the type of resolution reached. CMS contracts with three entities to perform most of its MSP activities.

Table 1: The Basic Components of the MSP Process for Situations Involving NGHPs

Component	Description
Notification	CMS is notified of the MSP situation by the insurer, the beneficiary, or another party. This can occur at any time from the time of the incident through mandatory reporting.
Negotiation	Negotiation takes place between the NGHP and the injured party or his attorney. CMS may provide information to involved parties during the negotiation process.
Resolution	A resolution is reached between the NGHP and the injured party or his attorney.
Mandatory reporting	As required by mandatory reporting requirements, the NGHP reports details of the final resolution to CMS.
Recovery	CMS seeks to recover any MSP payments made.

Source: GAO analysis of CMS documents.

Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today to discuss the Centers for Medicare & Medicaid Services' (CMS) Medicare Secondary Payer (MSP) program. MSP situations arise when other insurers have the primary responsibility to pay for a Medicare beneficiary's medical expenses.¹ In these situations, Medicare is the secondary payer and is only responsible for paying for beneficiaries' Medicare-related health care costs that are not covered by the primary insurer. CMS, the agency within the Department of Health and Human Services (HHS) that administers Medicare, is responsible for protecting the Medicare program's fiscal integrity. To safeguard funds, CMS must take steps to ensure that it pays only for those services that are the responsibility of the Medicare program. Until 1980, Medicare was the primary payer in all situations involving Medicare beneficiaries except those covered by workers' compensation.² In 1980, Congress enacted provisions that made Medicare a secondary payer in all instances to non-group health plans (NGHP)—which include auto or other liability insurance, no-fault insurance, and workers' compensation plans.^{3,4} For example, an NGHP is the primary payer for medical expenses related to injuries that a Medicare beneficiary may sustain in an automobile accident (see figure 1). In 1981 Congress enacted provisions that made Medicare a secondary payer to employer-sponsored group health plans (GHP) in certain situations.⁵

¹Medicare is the federally financed health insurance program for persons age 65 or over, certain individuals with disabilities, and individuals with end-stage renal disease.

²Workers' compensation is a law or plan of the United States, or any state, that compensates employees who get sick or injured on the job.

³Omnibus Budget Reconciliation Act of 1980, Pub. L. No. 96-499, § 953, 94 Stat. 2599, 2647 (codified, as amended, at 42 U.S.C. § 1395y).

⁴Liability insurance is insurance that provides payment based on legal liability for injury or illness or damage to property. It includes, but is not limited to, automobile liability insurance, uninsured motorist insurance, underinsured motorist insurance, homeowners' liability insurance, malpractice insurance, product liability insurance, and general casualty insurance. No-fault insurance is insurance that pays for medical expenses for injuries sustained on the property or premises of the insured, or in the use, occupancy, or operation of an automobile, regardless of who may have been responsible for causing the accident. 42 U.S.C. § 411.50(b).

⁵Omnibus Budget Reconciliation Act of 1981, Pub. L. No. 97-35, § 2146, 95 Stat. 357, 800. Although persons age 65 or older are eligible for Medicare coverage, some are employed and may receive health insurance coverage through an employer-sponsored GHP.

Figure 1: An MSP Situation Involving an Auto Liability Insurer



A Medicare beneficiary is injured in a car accident and goes to the hospital. The hospital bills Medicare, although the auto liability insurance company is responsible for paying for the beneficiary's treatment. Because the beneficiary has not yet reached a resolution with the auto liability insurance company, Medicare makes payments to the hospital for the care provided. Once the resolution is reached and the beneficiary receives a settlement from the auto liability insurance company, CMS attempts to recover the amount of Medicare's payments from the beneficiary.

Source: GAO (text), FEMA/Casey Deshong (photograph).

When MSP situations have occurred, CMS has not always been notified that beneficiaries had other insurance that should be the primary payer. As a result, Medicare has paid for services that were the financial responsibility of another payer. Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007⁶ added mandatory reporting requirements for GHPs and NGHPs with respect to MSP situations that should enable CMS to be aware of MSP situations. With this information, CMS should be able to identify which payments were made by Medicare that should have been the primary responsibility of another payer, and therefore should be recovered, or situations in which CMS should avoid making payments when another payer should be primary. Section 111 also included penalties for non-compliance with the mandatory reporting requirements (\$1,000 fine per day of non-compliance per claim). The Congressional Budget Office estimated that these provisions for GHPs and NGHPs would save Medicare \$1.1 billion over 10 years in improper payments that could be recovered or avoided by Medicare.

CMS reports that while the implementation of Section 111 added reporting rules for GHPs and NGHPs, it did not eliminate or change any existing MSP laws or regulations, or otherwise change CMS's existing MSP process. Specifically, prior to mandatory reporting requirements, GHPs and NGHPs involved in MSP situations had a legal obligation to notify and repay Medicare when they determined that Medicare should not have paid first. Likewise, Medicare beneficiaries had an obligation to take whatever

⁶Pub. L. No. 110-173, § 111, 121 Stat. 2492, 2497, adding 42 U.S.C. §1395y(b)(7-8).

actions were necessary to obtain any payment that could be reasonably expected from an NGHP and to cooperate with CMS in any action CMS takes to recover conditional payments. These obligations remain, although prior to mandatory reporting the parties involved in MSP situations may not have always been aware of these obligations.

MSP mandatory reporting requirements have not been fully implemented. GHPs began mandatory reporting in January 2009. While NGHPs were scheduled to begin mandatory reporting in July 2009, CMS reports that this timeline has been pushed back several times, in part due to concerns raised by the industry. Mandatory reporting requirements began in January 2011 for certain NGHPs, including workers' compensation and no-fault insurers. Other NGHPs, including most liability insurers, are required to begin reporting in January 2012. GAO has ongoing work related to mandatory reporting and the MSP process for situations involving NGHPs.

You expressed interest in obtaining information about the MSP process, particularly as it pertains to NGHPs. My statement today will provide an overview of Medicare payments for MSP situations involving NGHPs and the MSP process for those situations, and will also provide illustrations of that process.

For this statement, we reviewed relevant CMS documentation including MSP regulations, manuals, user guides, and information found on the CMS Web site and a contractor's Web site related to the MSP process. We also conducted an interview with CMS officials concerning mandatory reporting and the MSP process. We shared the information in this statement with CMS. CMS provided technical comments, which we incorporated as appropriate. We conducted our work from May 2011 to June 2011 in accordance with all sections of GAO's Quality Assurance Framework that are relevant to our objectives. The framework requires that we plan and perform the engagement to obtain sufficient and appropriate evidence to meet our stated objectives and to discuss any limitations in our work. We believe that the information and data obtained, and the analysis conducted, provide a reasonable basis for any findings and conclusions.

Medicare Payments and the MSP Process for Situations Involving NGHPs

Medicare payments for MSP situations involving NGHPs can vary, depending in part on when CMS is notified that an MSP situation exists. Generally, the MSP process for situations that involve NGHPs includes five basic components—notification, negotiation, resolution, mandatory reporting, and recovery—but the details of the process can differ depending on the particular situation.

Medicare Payments

Medicare payments can vary in different MSP situations. In most MSP situations involving NGHPs, Medicare will initially pay for medical treatment related to the incident, and later seek to recover those payments. These initial payments sometimes occur because medical treatment is provided before CMS is notified of the NGHP MSP situation.⁷ Once CMS is notified that an MSP situation exists and an NGHP should be the primary payer, Medicare may start denying claims. However, according to CMS, in most NGHP MSP situations, even after CMS becomes aware that Medicare is the secondary payer, Medicare will continue to make payments while the situation is pending resolution so that the beneficiary has access to needed medical services in a timely manner. CMS refers to any payments made by Medicare for services where another payer has primary responsibility for payment as “conditional payments.”⁸ For example, an NGHP could dispute that it is responsible for a Medicare beneficiary’s medical expenses and refuse to pay any claims until the matter is investigated and resolved. In those types of situations, Medicare would continue to make conditional payments for the beneficiary’s medical expenses until a resolution can be reached between the beneficiary and the NGHP. Once a resolution is reached between the beneficiary and the NGHP, Medicare will seek to recover any conditional payments made.⁹

⁷This differs from the MSP process for GHPs, in which CMS primarily seeks to prevent mistaken payments by determining whether a Medicare beneficiary has other insurance through a GHP that should be primary to Medicare before any payments are made. This is because, unlike NGHPs, GHPs have an established and ongoing obligation to pay for health care as a primary payer.

⁸The payment is “conditional” because it must be repaid to Medicare when the Medicare beneficiary receives a settlement, judgment, award, or other payment from the NGHP.

⁹This assumes a resolution in which the Medicare beneficiary or someone on his behalf receives a settlement, judgment, award or other payment from the NGHP.

Additionally, to help Medicare prevent making any future payments related to MSP situations involving NGHPs, when a beneficiary is expected to have future medical expenses related to their accident, injury, or illness, CMS states that all parties involved in negotiating a resolution of those situations have responsibilities to protect Medicare's interests. CMS does not require that this be done in any specific way, but one way to accomplish this is through a Medicare set-aside arrangement—a voluntary arrangement where a portion of the proceeds from a settlement are set aside to pay for all related future medical expenses that would otherwise be reimbursable by Medicare.¹⁰ In cases where a Medicare set-aside arrangement is created, Medicare will not make payments for medical expenses related to the MSP situation until the Medicare set-aside arrangement is exhausted.

The MSP Process

The process for MSP situations that involve NGHPs generally includes five basic components—notification, negotiation, resolution, mandatory reporting, and recovery. However, the details of the process, and the administrative tasks that CMS must conduct, can vary depending on when in the process CMS is notified, the type of insurance involved (liability, no-fault, or workers' compensation), and the type of resolution reached. CMS contracts with three entities to perform most of its administrative activities within the MSP process: the Coordination of Benefits Contractor (COBC); the Workers' Compensation Review Contractor (WCRC); and the Medicare Secondary Payer Recovery Contractor (MSPRC) (see app. I).

While the details vary by situation, in general, the roles of these CMS contractors within the MSP process are as follows:

- *Notification:* The COBC is notified that a beneficiary's accident, injury, or illness is an MSP situation and creates a record. Notification can come from various sources—including the beneficiary, an attorney, a physician, or the NGHP—and can occur at various times during the MSP process. While mandatory reporting requires NGHPs to report MSP resolutions to CMS through the COBC, NGHPs or other involved parties may also provide notification to CMS earlier in the process. For example, a beneficiary's attorney could notify CMS of the MSP

¹⁰In situations where a Medicare set-aside arrangement is used, the responsibility for managing the Medicare set-aside funds is not established by CMS and instead can fall to various parties, including the beneficiary themselves or a third-party administrator, such as an attorney.

situation involving an NGHP shortly after an accident occurs. After the COBC receives notification of the MSP situation, Medicare may begin denying claims, or it may continue to make conditional payments.

- *Negotiation:* Negotiation takes place between the NGHP and the injured beneficiary or his representative, such as an attorney. The point in the MSP process at which CMS receives notification can affect the number and amount of conditional payments made by Medicare and whether, and the extent to which, CMS can make information available during the negotiation.¹¹ For example, if CMS has been notified of the situation early in the process, the MSPRC can provide information that may be used during negotiations, informing the beneficiary or his representative, about related claims paid by Medicare. For workers' compensation situations that involve future medical expenses, the WCRC may be involved in reviewing proposed Workers' Compensation Medicare Set-Aside Arrangement (WCMSA) amounts.
- *Resolution:* The resolution is reached between the beneficiary or the beneficiary's attorney and the NGHP.¹² The type of resolution varies and can include the insurer assuming ongoing responsibility for payment of medical claims related to the injury or illness, a lump-sum payment, a Medicare set-aside arrangement, or a combination of any of these. For resolutions that include a WCMSA, no future payments are made by Medicare for medical expenses related to the workers' compensation injury or illness until the set-aside is exhausted. Additionally, CMS requires the administrator of the WCMSA to submit an annual accounting of the set-aside funds to the MSPRC.
- *Mandatory Reporting:* CMS requires the NGHP to report the resolution to CMS through the COBC. Regardless of whether CMS was notified of the MSP situation earlier in the process, after a resolution is reached in which the Medicare beneficiary or someone on his behalf receives a settlement, judgment, award or other payment from the NGHP, NGHPs

¹¹If an NGHP immediately agrees to assume ongoing responsibility for a beneficiary's medical expenses, current and future, then there may not be a negotiation component to the MSP process.

¹²Resolution may also be reached by trial.

are required to report information about the MSP situation and its resolution to the COBC¹³ under mandatory reporting requirements.

- *Recovery*: CMS seeks to recover payments made. After reviewing the resolution, the MSPRC calculates the total amount owed to Medicare and issues a demand for payment—referred to as a demand letter. This letter is typically issued to the beneficiary or his representative, but in certain situations may also be issued to the NGHP. Payment is due to the MSPRC within 60 days of the date of the demand letter. Either payment is received and the case closed, a response is received challenging all or part of the demand, or no response is received. Debt delinquent more than 180 days is referred to the Department of the Treasury for collection action. The beneficiary has the right to question, appeal,¹⁴ or request a waiver of the amount CMS demanded.¹⁵

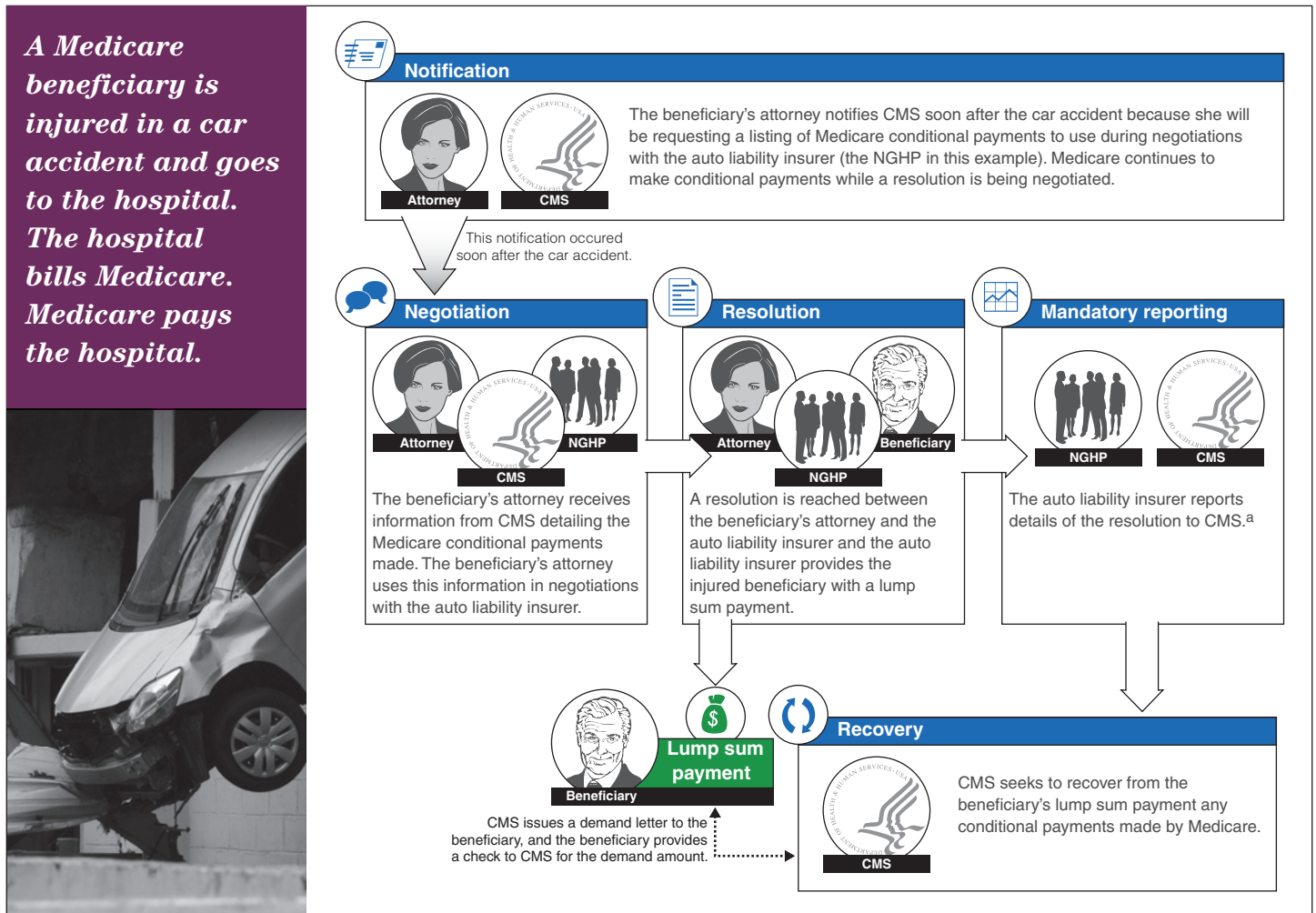
The following figures illustrate the MSP process for situations that involve an auto liability insurer, a no-fault insurer, and a workers' compensation plan:

¹³The data NGHPs are required to submit includes information to identify the beneficiary; information about the injury, accident, or illness; information concerning the policy or insurer; information about the injured party's representative or attorney; and settlement or payment information.

¹⁴Medicare beneficiaries have administrative appeal rights with respect to a MSP recovery claim against them that include five levels. The first level of appeal is to a CMS contractor. The second level of appeal is to an independent contractor to review the decision made at the first level of appeal. The third level of appeal is to an administrative law judge and must meet a minimum monetary threshold. The fourth level of appeal is with the Departmental Appeals Board before the Medicare Appeals Council. The fifth level is with the federal district court and has a minimum monetary threshold.

¹⁵The debt is not referred to Treasury if there is open correspondence related to the debt or if there is a pending appeal or waiver request.

Figure 2: Illustration of the MSP Process for a Situation Involving an Auto Liability Insurer

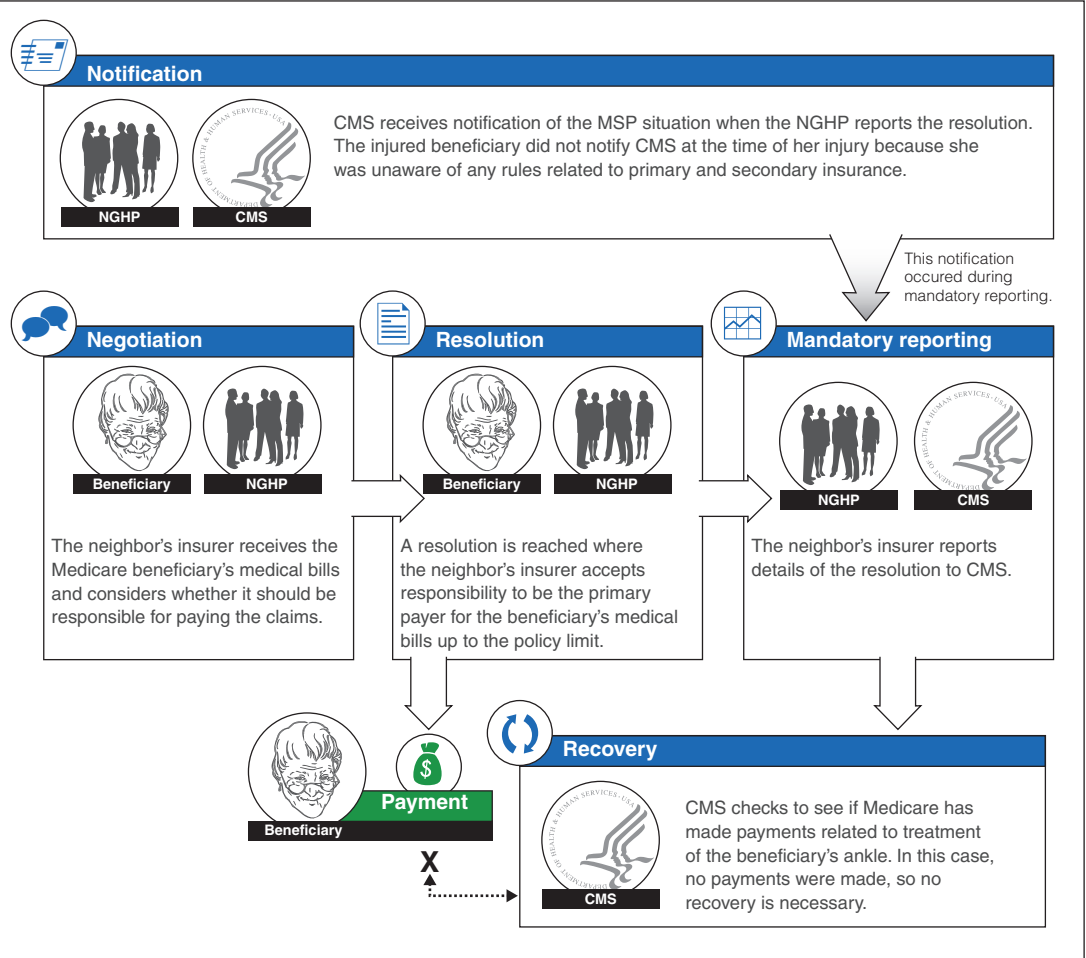


Source: GAO (process), FEMA/Casey Deshong (photograph), Art Explosion (illustrations).

^aMandatory reporting for liability insurers who settle with injured beneficiaries with lump sum payments, such as the auto liability insurer in this figure, will be required beginning January 1, 2012.

Figure 3: Illustration of the MSP Process for a Situation Involving No-Fault Insurance

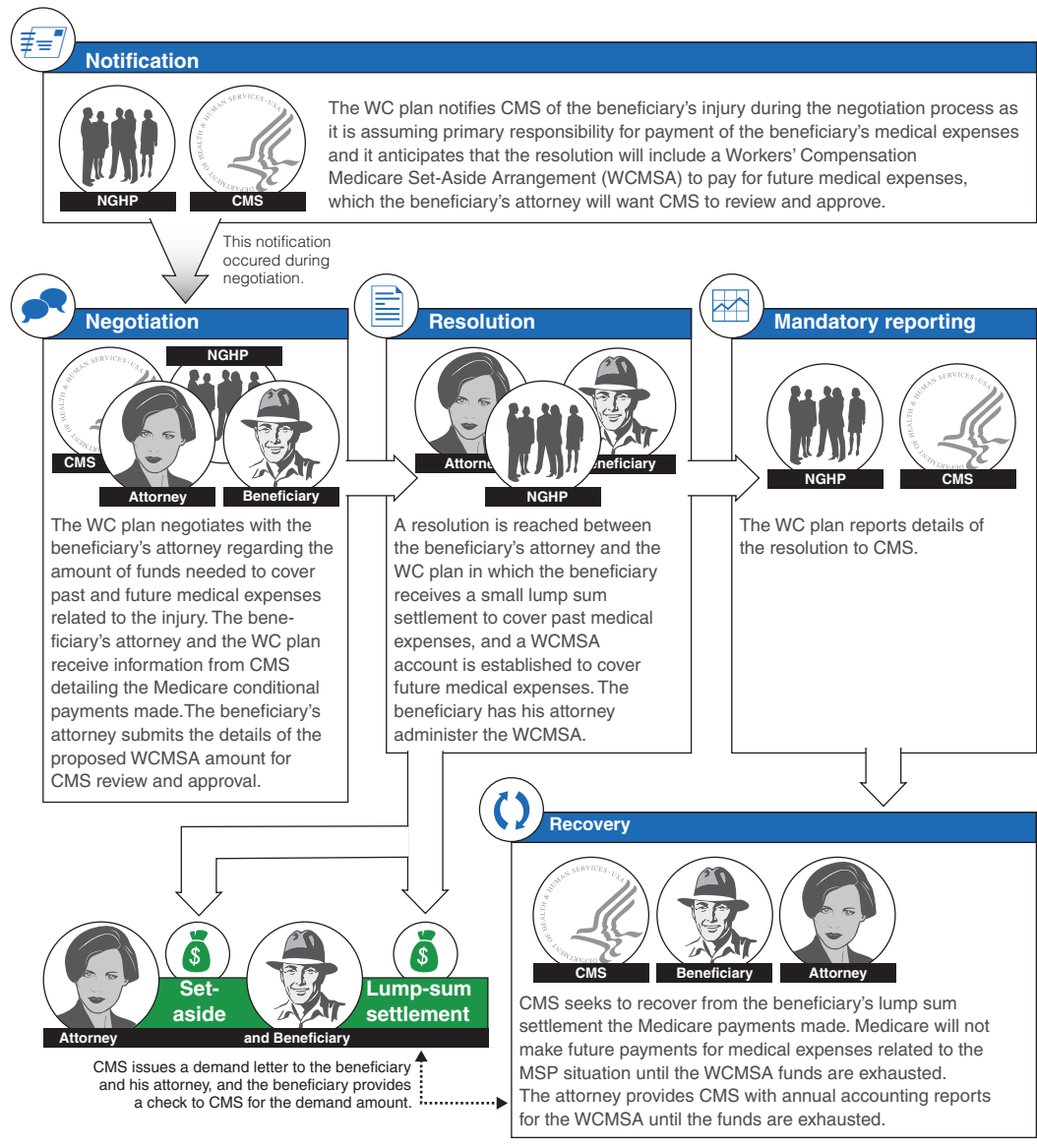
A Medicare beneficiary falls down and twists her ankle while visiting a neighbor's yard sale. The neighbor's homeowner's insurance policy includes no-fault medical coverage and the Medicare beneficiary submits her medical bills to the neighbor's insurer.



Source: GAO (process), Art Explosion (illustrations).

Figure 4: Illustration of the MSP Process for a Situation Involving Workers' Compensation

A Medicare beneficiary slips at work and sustains a head injury. While Medicare pays the beneficiary's initial medical expenses, soon thereafter the employer's workers' compensation (WC) plan assumes primary responsibility for payment while a resolution is negotiated.



Source: GAO (process), Art Explosion (illustrations).

In addition to the steps outlined in the MSP process description, CMS provides oversight of the MSP activities completed by each of the MSP contractors, such as by reviewing regular reports produced by the contractors on their workload and performance. CMS is also responsible for administering the MSP program and establishing the MSP process, and officials do so through activities such as developing program policy and guidance. CMS also maintains Web sites related to parts of the MSP process, from which NGHPs and beneficiaries can obtain information about their responsibilities in MSP situations involving NGHPs.

Mandatory reporting should enable CMS to be aware of MSP situations involving NGHPs and better ensure that it only pays for medical care that is the responsibility of the Medicare program. As noted earlier, GAO has ongoing work related to mandatory reporting and the MSP process for situations involving NGHPs. Specifically, we are examining what aspects of the MSP process for situations involving NGHPs are presenting challenges for CMS and NGHPs, and how mandatory reporting is expected to affect CMS's MSP workload, costs, and Medicare savings associated with NGHP situations.

Mr. Chairman, this concludes my prepared statement. I would be happy to answer any questions you or other members of the subcommittee may have.

Contacts and Acknowledgments

For further information about this statement, please contact James C. Cosgrove at (202) 512-7114 or CosgroveJ@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement. Kathleen M. King, Director; Gerardine Brennan, Assistant Director; Laurie Pachter; Christina Ritchie; Lisa Rogers; Jessica C. Smith; and Jennifer Whitworth were key contributors to this statement.

Appendix I: CMS MSP Contractors

The Centers for Medicare & Medicaid Services (CMS) contracts with three entities to perform most of the activities within the MSP process:

- *Coordination of Benefits Contractor (COBC)*: The COBC collects, manages, and maintains information in the CMS data systems about other health insurance coverage for Medicare beneficiaries and initiates MSP claims investigations. The COBC processes information submitted by various parties, including beneficiaries, their attorneys, physicians, and NGHPs. The information the COBC collects is available to other CMS contractors, and it also maintains a national database, the Workers' Compensation Case Control System (WCCCS), to store claimant data about submitted Workers' Compensation Medicare Set-Aside Arrangement (WCMSA) proposals.
- *Workers' Compensation Review Contractor (WCRC)*: The WCRC evaluates proposed WCMSA amounts and projects future medical expenses related to workers' compensation accident, injury, or illness situations that would otherwise be payable by Medicare. The WCRC generally only reviews proposed WCMSA amounts for current Medicare beneficiaries in excess of \$25,000.¹
- *Medicare Secondary Payer Recovery Contractor (MSPRC)*: The MSPRC uses information updated by the COBC as well as information from CMS' systems to identify and recover Medicare payments that should have been paid by another entity as primary payer. Once a resolution has been reached between the beneficiary and the NGHP, the MSPRC calculates the final amount owed to Medicare and issues a demand letter to the beneficiary or other individual authorized by the beneficiary.²

¹The WCRC also reviews proposed WCMSA amounts for injured individuals whose total settlement amounts are valued greater than \$250,000 and where there is a reasonable expectation that the injured individuals will become Medicare beneficiaries within 30 months of the date of the settlement.

²This assumes a resolution in which the Medicare beneficiary or someone on his behalf receives a settlement, judgment, award or other payment from the NGHP.

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