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Medicare Secondary Payer — Coordination of Benefits

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Hinda Chaikind
Specialist in Health Insurance and Financing
Domestic Social Policy Division

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Medicare Secondary Payer — Coordination of Benefits

Summary

Medicare is the nation's health insurance program for qualifying individuals who are 65 and older, disabled, and those with End Stage Renal Disease (ESRD). Generally, Medicare is the "primary payer" — that is, it pays health claims first, and if a beneficiary has other insurance, that insurance may fill in all or some of Medicare's gaps. However, in some situations the Medicare Secondary Payer (MSP) rules prohibit Medicare from making payments for any item or service when payment has been made or can reasonably be expected to be made by a third-party payer. Under certain conditions, the law makes Medicare the secondary payer to insurance plans and programs for beneficiaries covered through (1) a group health plan based on either their own or a spouse's current employment; (2) auto and other liability insurance; (3) no-fault liability insurance; and (4) workers' compensation situations, including the Black Lung program. The purpose of the MSP program is to shift costs from Medicare to private sources of payment, thus reducing Medicare expenditures. Additionally, the Medicare statutes exclude Medicare coverage for items and services paid for directly or indirectly by a government entity, subject to certain limitations. This includes the Department of Veterans Affairs, among others. The circumstances detailing when Medicare is primary or secondary are discussed in this report.

The law authorizes several methods to identify cases when an insurer other than Medicare is the primary payer and to facilitate recoveries when incorrect Medicare payments have been made. One such method is the data match program, where Medicare recipients are matched against data contained in Social Security Administration and Internal Revenue Service files to identify cases in which a working beneficiary (or working spouse) may have employer-based health insurance coverage. Most recently Congress passed the Medicare, Medicaid, and SCHIP Extension Act of 2007 (P.L. 110-173) expanding information requirements for group health plans, liability insurance (including self-insurance), no fault insurance, and workers' compensation laws and plans. These entities must submit information to the Secretary of HHS to enhance efforts for coordination of benefits and for any applicable recovery claims.

Efforts by both the federal government and private citizens to use the MSP as a vehicle to recover payments made on behalf of beneficiaries for treatment of tobacco-related illnesses to date have not been successful.

This report will be updated as necessary to reflect legislative changes.

Contents

List of Tables

Medicare Secondary Payer — Coordination of Benefits

Generally, Medicare is the "primary payer" — that is, it pays health claims first, and if a beneficiary has other insurance, that insurance may fill in all or some of Medicare's gaps. However, §1862(b) of the Social Security Act authorizes the Medicare Secondary Payer (MSP) program, which identifies specific conditions under which another party pays first and Medicare is only responsible for qualified secondary payments, thereby reducing expenditures under the Medicare program. The law prohibits Medicare payments for any item or service when payment has been made or can reasonably be expected to be made by a third-party payer. Medicare is the secondary payer to insurance plans and programs, under certain conditions, for beneficiaries covered through (1) a group health plan based on either their own or a spouse's current employment; (2) auto and other liability insurance; (3) no-fault liability insurance; and (4) workers' compensation situations, including the Black Lung program. Additionally, under §1862(a) of the Social Security Act, items and services paid for directly or indirectly by a government entity, subject to certain limitations, are excluded from Medicare coverage. This includes the U.S. Department of Veterans Affairs, among others. As a result, Medicare also coordinates benefits for cases involving the Veterans Health Administration. The circumstances detailing when Medicare is primary or secondary are discussed below. In some circumstances, Medicare may make a conditional payment; however, this payment is subject to repayment.

MSP for Employer Group Health Plans

Medicare is the primary payer for services provided to Medicare beneficiaries who are retired, even if they have retiree health insurance coverage through their former employer. However, the rules for secondary coverage are different for Medicare beneficiaries who are working (often referred to as the "working aged") and offered health insurance through their employer. Employer-sponsored group health insurance[1] offered to current workers, regardless of Medicare status,[2] is

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[1] Group health plans include health insurance coverage that is provided by private sector employers, government and self-employed entities, employee organizations such as labor unions, and self-insured plans (i.e., the employer assumes the risk of insurance rather than passing the risk to an insurance company).

[2] Generally, individuals are entitled to Medicare Part A (Hospital Insurance) when they turn 65, and must be enrolled in Part B (Supplementary Medical Insurance) during an initial enrollment period or face a permanent monthly penalty of increased Part B monthly premiums if they chose to enroll at a later date. However, the law waives the Part B late enrollment penalty for current workers as long as the beneficiary has primary coverage

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generally the primary payer for individuals covered through their own or a spouse's *current* employment. A conditional payment may be made in certain situations — for example, if an employer does not pay a properly filed claim. However, Medicare may seek repayment. When the group health plan is primary, but does not pay in full, Medicare may make a secondary payment, as prescribed by law.

Medicare has been the secondary payer for the working aged since the passage of the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982. Secondary payer rules for the disabled were first established in the Omnibus Budget Reconciliation Act (OBRA) of 1986, and Medicare secondary payer rules for persons with End Stage Renal Disease (ESRD) have been in effect since the passage of OBRA 1981. The MSP rules for employer group health plans have been amended in subsequent legislation.

Working Aged. Subject to certain conditions, Medicare payments are secondary to employer-sponsored health insurance offered to employees. An employer with 20 or more employees[3] must offer workers aged 65 and over the same group health insurance coverage offered to other employees. In fact, the statutes prohibit a group health plan from taking into account that an individual or his/her spouse who is covered by the plan, by virtue of the individual's current employment status, is entitled to Medicare benefits. Any individual age 65 or older (and his/her spouse age 65 or older) who has current employment status is entitled to the same benefits under the employer's group health plan, under the same conditions as any such individual (or his/her spouse) under age 65.

Such employees must be in "*current employment status*" — that is, they must be individuals who are (1) actively working as an employee, (2) the employer, or (3) associated with the employer in a business relationship (such as a supplier included on the employer's group health plan). If the employer offers health insurance coverage to spouses, it must also offer the coverage to any employee's spouse, including those who are aged 65 and older.

Working aged employees have the option of accepting or rejecting the employer's coverage. If a working aged individual accepts coverage, the employer plan is the primary payer and Medicare is secondary, for both the employee and the employee's spouse. For Medicare-enrolled employees who reject employer-

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[2] (...continued)
through the individual's or spouse's employer-sponsored plan. These individuals have a special enrollment period, once their employer coverage ends, and as long as they enroll in Part B during this time, they will not be subject to penalty. For a complete discussion of the premium penalty, see CRS Report RS21731, *Medicare: Part B Premium Penalty*, by Jennifer O'Sullivan.

[3] In order to meet this requirement, employers must have 20 or more full and/or part-time employees for each working day in each of 20 or more calendar weeks in the current calendar year or the preceding calendar year. The 20 weeks do not have to be consecutive. The requirement is based on the number of employees, not the number of people covered under the plan. Employers who did not meet the requirement during the previous calendar year may meet it at some point during the new calendar year, and at that point Medicare would become the secondary payer for the remainder of that year and through the next year.

sponsored coverage, Medicare is primary. However, the statutes prohibit the employer from paying for supplemental benefits for Medicare-covered services, so as not to provide any financial incentives for employees to reject the employer-sponsored coverage in favor of less expensive supplemental coverage.

These MSP requirements also apply to multiple employer plans (a plan sponsored by more than one employer) and to multi-employer plans (a plan jointly sponsored by the employers and unions under the Taft-Hartley law). When each of the employers in the group has less than 20 employees, Medicare is primary. When all employers have 20 or more employees, or if at least one employer has 20 or more employees, Medicare is secondary. An employer in the group with fewer than 20 employees may request an exemption for its working aged employees. In that case, Medicare would be primary for the exempted employees, and the employer could offer those individuals coverage that supplements Medicare.

Working Disabled. Similarly, Medicare is the secondary payer for disabled Medicare beneficiaries who have employer-sponsored health insurance based on their own current employment or a spouse's current employment.[4] One difference between the working aged and working disabled requirements is the size of the employee group. For the disabled, the MSP rule applies to a large group health plan — that is, a plan offered by an employer with 100 or more employees on at least 50% or more of its business days during the preceding calendar year. This applies to smaller plans that are part of a multiple or multi-employer plan if at least one of the employers in the plan has 100 or more employees. Unlike the working aged rules that allow for an exemption, a multiple or multi-employer plan may not exempt people enrolled though an employer with less than 100 employees.

Persons with End-Stage Renal Disease (ESRD). For individuals with Medicare entitlement based solely on ESRD,[5] MSP rules apply for those covered by an employer-sponsored group plan, regardless of the employer size or current

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[4] Prior to August 1993, Medicare was the secondary payer for "active individuals" entitled to Medicare on the basis of disability. Active individuals included people who were not actually working, who had employee status as indicated by their relationship to their employer. For example, the employer might have been paying the individual sick or disability pay that was subject to Federal Insurance Contributions Act (FICA) taxes or the individual might have participated in an insurance plan that was available only to employees. The standard for disabled Medicare beneficiaries was changed to "current employment status" in 1993 to be consistent with the standard for the working aged. Those previously covered by the "active individual" standard, whose status changed, have Medicare as their primary payer.

[5] Medicare entitlement based on ESRD usually begins with the third month after the month in which the beneficiary starts a regular course of dialysis, referred to as the three-month waiting period. This waiting period may be waived, in part or entirely, if, during that time (1) the individual takes an approved home dialysis training program in self-dialysis; (2) the individual is admitted to a Medicare-approved hospital for a kidney transplant or for health care services needed before the transplant, if the transplant takes place during that month or the following two months; or (3) the individual is scheduled for a transplant that is delayed more than two months after the beneficiary is admitted to the hospital or for health care services.

employment status. For individuals whose Medicare eligibility is based *solely* on ESRD, any group health plan coverage they receive through their employer or a spouse's employer is the primary payer for the first 30 months of ESRD benefit eligibility, referred to as the 30-month coordination period. After 30 months, Medicare becomes the primary insurer.

Similarly, for working individuals (or spouses) who qualify for and remain eligible for Medicare based on *both* ESRD and age or disability, any group health plan coverage they receive through their employer or a spouse's employer is the primary payer during the 30-month coordination period. After 30 months, Medicare becomes primary, even if the individual has employer-sponsored health insurance based on current employment status. However, there is one exception to the MSP rules for this group. Medicare would be primary **immediately** for these individuals if **both** of the following conditions were met: (1) the individual was first entitled to Medicare on the basis of age or disability and then also became eligible on the basis of ESRD, and (2) the MSP provisions for age or disability did not apply because the plan coverage was not "by virtue of current employment status," or the employer did not meet the test of size for either the aged or disabled.

For retirees, rather than workers, who first qualify for Medicare based on ESRD and then turn 65 during the 30-month coordination period, their retiree health insurance would remain primary for the entire 30-month period.

Medicare coverage ends 12 months after the month the beneficiary stops dialysis treatment or 36 months after the month the beneficiary has a successful kidney transplant. However, if Medicare coverage ends, and then begins again, based on ESRD, the 30-month coordination period will also begin again.

MSP and Workers' Compensation, No-Fault, Automobile, and Liability Insurance

Medicare is the secondary payer when payment has been or can reasonably be expected to be made under workers' compensation, automobile medical insurance, and all forms of no-fault and liability insurance. Medicare has been secondary for workers' compensation since the beginning of Medicare on July 1, 1966, while the MSP rules for automobile medical or no-fault and other liability insurance were included in OBRA1980, effective December 5, 1980.

Workers' Compensation. Medicare is the secondary payer for items or services covered under a workers' compensation law or plan of the United States or a state. In the case of a contested claim, the workers' compensation board must notify the beneficiary, and pending the decision, Medicare may be billed. A Medicare conditional primary payment may be made if the compensation carrier will not pay promptly, but follow-up action must be taken to recover the payment. If a beneficiary exhausts all appeals under workers' compensation, Medicare would be the primary payer.

According to CMS, a Workers' Compensation Medicare Set-aside Arrangement (WCMSA) is used to allocate a portion of a worker's compensation settlement for

future medical expenses. The amount of the set aside is determined on a case-by-case basis and should be reviewed by CMS, when appropriate.

Additionally, Medicare coordinates benefits with the Federal Black Lung Program, which is considered to be a federal workers' compensation program. Medicare does not pay for services covered under the Federal Black Lung Program for Medicare beneficiaries entitled to Black Lung medical benefits in accordance with the Federal Coal Mine Act. Medicare can be billed for Medicare-covered services not covered by the Federal Black Lung Program. If the services are solely for a non-Black Lung condition, Medicare would be billed as primary.

Automobile Medical or No-Fault Insurance. Medicare is the secondary payer of claims for medical items and services to the extent that payment has been made, or can reasonably be expected to be made for items or services under automobile liability insurance, uninsured motorist insurance, or under-insured motorist insurance. Conditional payments may be made in a case where the insurer will not pay promptly. Conditional payments are subject to recovery if the individual later receives payment from the automobile or no-fault insurer.

Other Liability Insurance. Similarly, Medicare is the secondary payer for medical items and services under homeowner's liability insurance, malpractice insurance, product liability insurance, and general casualty insurance. Conditional payments may be made if a proper claim has been filled. This payment is also subject to recovery if the individual later receives payment from the liability carrier.

Medicare Coordination of Benefits with Other Federal Programs

Items and services furnished by federal providers, a federal agency, or under a federal law or contract are excluded from Medicare coverage. This includes U.S. military hospitals, the U.S. Department of Veterans Affairs, and research grants, among others. This exclusion from Medicare coverage does not include health benefits offered to employees of federal entities, rural health clinic services, federally qualified health centers, and other exemptions that may be specified by the Secretary of Health and Human Services.

Medicare and the Department of Veterans Affairs (VA). Medicare coordinates benefits with VA health benefits, effective July 1, 1966. In general, Medicare does not pay for the same services covered by VA benefits for its Medicare beneficiaries who are also entitled to VA benefits.[6] The VA, at its expense, may

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[6] Another health insurance option available to certain uniformed service Medicare-eligible retirees, their spouses, and survivors, entitled to Medicare Part A and enrolled in Medicare Part B is TRICARE for Life (TFL), a program option of TRICARE (the Department of Defense's medical entitlement program). The rules for primary and secondary coverage of this group are not included in the Medicare statutes, but rather are included under Title 10 of the U.S. Code §1095. For beneficiaries who have both Medicare and TFL coverage, Medicare is the primary payer for services covered by both programs. Medicare pays the

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authorize private physicians and other suppliers to provide services to certain veterans with service-connected disabilities and, in certain circumstances, with non-service-connected disabilities. Medicare can reimburse veterans for (or credit toward the Medicare deductible or coinsurance amounts) VA copayment amounts charged for VA-authorized services furnished by non-VA sources.

If the VA authorizes hospital services in a non-VA hospital, Medicare can pay for any covered services that fall outside of the VA authorization. For example, if the VA authorizes a five-day hospital stay, but the patient remains in the hospital two more days, Medicare can pay for the services received during the two additional days, subject to its payment rules.

Furthermore, when a physician accepts a veteran as a patient and bills the VA, the physician must accept the VA charge determination as payment in full. Medicare may supplement VA payments when a VA claim is for physician services and is filed by the veteran, not the physician. When the Medicare claim is submitted, it must indicate which services were billed to the VA and whether or not the beneficiary submitted a claim to the VA for payment.

Resources for Determining Primary Payer Status

Coordination of Benefits Contractor. The Centers for Medicare and Medicaid Services (CMS) established a centralized Coordination of Benefits operation, which consolidates activities under a single contractor entity, the Coordination of Benefits Contractor (COBC). The COBC is responsible for the performance of activities that support the collection, management, and reporting of other insurance coverage for Medicare beneficiaries. Its duties focus on activities to ensure that Medicare makes proper payments by identifying the correct payer before payments are made. It is primarily an information-gathering entity. The prepayment activities carried out by the COBC were previously the responsibility of the Medicare Fiscal Intermediaries (FIs) and Carriers.

The COBC does not process any claims, nor does it handle any mistaken payment recoveries or claim-specific inquiries. The COBC has responsibility for establishing individual beneficiary MSP records on the Common Working File (CWF), the official source of beneficiary information for Medicare.

As described below, the COBC is also responsible for the Initial Enrollment Questionnaire (IEQ) and the data match. It also carries out all activities necessary to ensure that the primary payer, whether or not it is Medicare, pays first and then makes arrangements for transferring the claims automatically to the secondary payer for further processing.

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[6] (...continued)
allowable amount for the care, and TRICARE pays the Medicare cost-sharing amounts and Medicare deductible. For services covered under Medicare but not TRICARE, beneficiaries must pay the Medicare cost-sharing amounts and the deductible. For health care services covered under TRICARE but not Medicare, beneficiaries must pay the TRICARE cost-sharing amounts or deductibles.

Initial Enrollment Questionnaire (IEQ). A voluntary IEQ, approved by the Office of Management and Budget (OMB), is mailed to beneficiaries three months before their Medicare entitlement begins. The questionnaire asks about employment status and spouse's employment status, health insurance coverage such as Black Lung, workers compensation, liability coverage, and any health insurance purchased through an employer. If the questionnaire is not returned within 45 days, a follow-up survey is sent to the beneficiary.

IRS/SSA/CMS Data Match Program. The Social Security Act authorizes a data match program intended to identify cases where an insurer other than Medicare is the primary payer. Each October, the Social Security Administration (SSA) sends a file to the Internal Revenue Service (IRS). The IRS has 40 business days to match this file against its tax records. The file is returned to SSA, which has another 40 business days to process the "Data Match Employer-Employee File" for CMS. The COBC reviews and analyzes these data in preparation for use in contacting employers concerning possible other insurance coverage that is primary to Medicare. The purpose of the data match is to identify secondary payer situations before Medicare makes a payment, and to facilitate recoveries when incorrect Medicare payments have been made. Each year, the COBC receives information on about 350,000 employers and 1 million workers. Certain employers are removed from the file, including those who do not meet the employer-size requirements. The current year data match only includes new Medicare beneficiaries, workers, or those who were not in the prior data match.

The COBC sends selected employers a questionnaire to determine which employers offer health insurance, and to determine the insurance status of specific beneficiaries. The information becomes part of the CWF. CMS may impose civil monetary penalties on employers who do not respond to the questionnaire. FIs and carriers use this information to identify claims on an ongoing basis for which Medicare should not be the primary payer.

Voluntary Data Sharing Agreement (VDSA). Alternatively, employers and insurers may enter into a Voluntary Data Sharing Agreement (VDSA) with CMS, electronically providing group health insurance information and Medicare entitlement data on a scheduled basis. The VDSA partner agrees to provide group health plan quarterly information about employees and dependents to the COBC. The CMS provides the VDSA partner with Medicare entitlement information for those employees and dependents entitled to Medicare.

Expanded MSP Requirements for Medicare Part D Prescription Drug Coverage. The establishment of the Medicare Part D prescription drug program resulted in additional requirements for MSP. Coordination between CMS, state programs, insurers, employers, and other payers of prescription drug coverage is necessary to ensure that the benefits provided to Part D beneficiaries are paid for correctly. CMS and the COBC have responsibility for providing the True Out of Pocket (TrOOP) facilitation contractor and Part D plans with the secondary non-Medicare prescription drug coverage information that they must have to facilitate payer determinations and the accurate calculation of the TrOOP expenses for beneficiaries.

The VDSA agreements and the Coordination of Benefits Agreement data exchange processes have been expanded to include Part D information. CMS is also allowing employers, insurers, and other entities with a VDSA, who are also participating in the Retiree Drug Subsidy (RDS)[7] program, to use the VDSA process to submit subsidy enrollment files to the RDS contractor. CMS has also developed data exchanges for entities that have not coordinated benefits with Medicare before, including Pharmaceutical Benefit Manager (PBMs), State Pharmaceutical Assistance Program (SPAPs), and other drug payers.

Recent Legislative Action

Most recently, Congress passed the Medicare, Medicaid, and SCHIP Extension Act of 2007 (P.L. 110-173), which requires group health plans to provide the Secretary of HHS with information identifying situations where the plan is or has been primary to Medicare. This requirement, which would be effective January, 2009, would affect all group health plans, while currently, most of the emphasis on collecting information about health insurance coverage other than Medicare focuses on employers. Insurers can currently enter in the voluntary data sharing agreement, with CMS, but this change will require that they provide information to CMS. Additionally, effective June 2009, in the case of liability insurance (including self-insurance), no fault insurance, and workers' compensation laws and plans, these entities must also submit information to the Secretary, including (1) the claimant's identity and (2) other information specified by the Secretary to enable an appropriate determination concerning coordination of benefits and any applicable recovery claims. The Secretary must share information on Medicare Part A entitlement and Part B enrollment with entities, plan administrators, and fiduciaries. The Secretary may share this information with other entities for the proper coordination of benefits.

MSP Postpayment Recoveries

As of October 2, 2006, CMS consolidated all functions and workloads related to MSP postpayment recoveries into a single MSP recovery contract (MSPRC). The MSPRC responsibilities include, but are not limited to, the following (1) identifying mistaken MSP payments for recovery, (2) providing interim conditional payment amounts and determining amounts that are potentially subject to recovery, (3) issuing recovery demand letters, (4) making beneficiary waiver determinations, (5) providing MSP litigation/negotiation support to CMS, (6) referring delinquent MSP debt to the Department of the Treasury, and (7) tracking MSP debt.

In addition to its responsibility for all *new* MSP recovery demand letters and subsequent CMS actions, the MSPRC is responsible for work on all *pending* recovery cases, if a recovery demand letter had not been issued by October 2, 2006. There are a few exceptions when the MSPRC will not be responsible for the new or pending postpayment activities: (1) when the recovery demand letter is issued by the MSP recovery Audit contractors (RACs) implemented as a demonstration under the Medicare Moderation Act of 2003; and (2) when the MSP recovery demand letters

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[7] For more information on the retiree drug subsidy, see CRS Report RL33041, *Medicare Drug Benefit: Retiree Provisions*, by Jennifer O'Sullivan.

is issued by the claims processing contractors to providers, physicians, and other suppliers. Further, the MSPRC is responsible for all *further* CMS collection actions for MSP recovery demand letters issued before October 2, 2006, unless the demand letter was issued by one of a few contractors.[8]

MSP Savings

CMS's annual MSP savings report shows total MSP savings of $6.5 billion for 2007, increasing from $3.6 billion in 2001.[9] As shown in **Table 1**, most of the increase over time in MSP savings is for the working aged and the disabled. Looking at total savings each year, about half of the savings were for the working aged. The second-largest category is for working disabled individuals, accounting for about another one-third of the savings. The numbers in the table include both prepayment and post-payment savings, but do not include any associated administrative costs. CMS estimates that for 2007, total MSP expenditures for administrative costs were $115.9 million.

Table 1. MSP Savings for 2001-2007
(dollars in millions)

MSP category	2001	2002	2003	2004	2005	2006	2007
Working aged	$1,626	$1,943	$2,147	$2,297	$2,781	$2,981	$2,919
ESRD	172	200	206	233	281	299	278
Working disabled	1,278	1,509	1,604	1,640	1,921	2,034	1,939
Worker's compensation[a]	96	106	122	113	102	93	877
Auto/No Fault	252	297	274	265	245	244	233
Liability	220	224	240	281	325	410	232
Veterans Admin./Other	N/A	N/A	N/A	N/A	17	29	26
Total	$3,644	$4,279	$4,593	$4,829	$5,671	$6,089	$6,505

Source: CMS unpublished data — MSP Savings Report (Crowd System).

Note: Totals may not add due to rounding.

a. The 2007 savings for Worker's Compensation includes $770 million for Worker's Compensation Medicare Set-aside Arrangements (WCMSA), which is not reported in other years.

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[8] Empire - Syracuse, New York or Harrisburg, Pennsylvania; First Coast Service Options - Jacksonville, Florida; Mutual of Omaha - Omaha, Nebraska; Palmetto - Augusta, Georgia, or Columbia, South Carolina or Columbus, Ohio; and Trailblazer - Denison, Texas.

[9] The 2007 savings include $770 million for the Workers' Compensation Medicare Set-aside Arrangement (WCMSA) which was not included in previous years.

Provider, Beneficiary, and Employer Responsibilities

Provider Responsibilities. Medicare providers, including hospitals, physicians, and outpatient hospital departments, among others, must ask beneficiaries a series of standardized questions before providing services to ascertain whether another insurer should be primary to Medicare. For recurring outpatient hospital services, the MSP information needs to be verified once every 90 days. While the information is not required to be collected for every visit, but rather only every 90 days, incorrect Medicare payments are still subject to repayment. Providers must agree to bill other primary payers before billing Medicare.

The provider must notify the COBC promptly if an attorney or insurance company requests a copy of a medical record or bill concerning a Medicare patient. Further, if a provider receives a primary payment from both Medicare and a third-party payer, as well as any deductible or coinsurance amounts from the beneficiary, the provider must refund the beneficiary up to the full amount that he or she paid. Any amount paid by the third-party payer greater than the deductible and coinsurance amount is considered to be a debt to Medicare, because it duplicates any payment made by Medicare. Medicare must be reimbursed within 60 days of the provider's receipt of the duplicate payment.

Beneficiary Responsibilities. Beneficiaries are asked, but not required to respond to, the Initial Enrollment Questionnaire (IEQ). Beneficiaries receiving health care services should tell their physician, other providers, and the COBC about any changes in health insurance. They (or their lawyers, if applicable) should also contact the COBC if (1) they take legal action or an attorney takes legal action on their behalf for a medical claim, (2) they are involved in an automobile accident, or (3) they are involved in a workers' compensation case.

Employer Responsibilities. Employers must (1) assure that their health plans identify those individuals to whom the MSP requirements apply; (2) assure that their plans provide for proper primary payments where, by law, Medicare is the secondary payer; (3) assure that their plans do not discriminate against employees and their spouses age 65 or over, people who suffer from permanent kidney failure, and disabled Medicare beneficiaries for whom Medicare is the secondary payer; and (4) accurately complete and submit timely Data Match reports on identified employees or a VDSA.

Determining Medicare Secondary Payment Amounts

When Medicare is the secondary payer, the health care provider first submits a claim to the beneficiary's primary payer, who processes the claim according to terms of the coverage contract. If the primary payer does not pay the full charges for the service, Medicare secondary payments may be made *if the service is covered by Medicare*. In no case can the actual amount paid by Medicare exceed the amount it would pay as primary payer. Any primary payments from a third-party payer for Medicare-covered services are credited toward the beneficiary's Medicare Part A and Part B deductibles and, if applicable, coinsurance amounts. However, if the primary

payment is less than the deductible, the beneficiary may be responsible for paying his/her unmet Medicare deductibles and coinsurance amounts.

The Medicare secondary payment amount is subject to certain limits. For some services, such as inpatient hospital care, the *combined* payment by the primary payer and Medicare cannot exceed Medicare's recognized payment amount (without regard to beneficiary cost-sharing charges). As one example of how Medicare would decide its secondary payment amount for inpatient hospital services, assume that an individual received inpatient hospital services costing $6,800. The primary payer paid $4,360 for the Medicare-covered services. No part of the inpatient hospital deductible ($1,024 in 2008) had previously been met. Medicare's gross payment amount, without regard to the deductible, is $4,700. As the secondary payer, Medicare would pay the lowest of

- Medicare's gross payment amount, without regard to deductible, minus the primary payer's payment — $4,700-$4,360 = $340;
- Medicare's gross payment amount minus the Medicare inpatient deductible — $4,700-$1,024 = $3,676;
- the hospital charge minus the primary payer's payment — $6,800-$4,360 = $2,440;
- the hospital charge minus the Medicare inpatient deductible — $6,800-$1,024 = $5,776.

In this case, Medicare would pay $340. The combined payment made by the primary payer and Medicare is $4,700. The beneficiary has no liability for Medicare-covered services, since the primary payer's payment satisfied the $1,024 inpatient deductible. If Medicare's payment amount had been lower than the primary payer's amount, it would not have made a secondary payment.

In other cases, such as physicians' services, the Medicare secondary payment amount cannot exceed the lowest of the calculation of the following three options. For example, assume that a physician charges $175 for a service; the primary payer's allowable charge is $150, of which it pays 80%, or $120; and Medicare's recognized payment amount for the service is $125, of which it pays 80%, or $100. The options are described below:

- actual provider charge minus the primary payer's allowable charge, adjusted for copayment: $175-$120 = $55;
- Medicare's payment amount, adjusted for copayment: .80 x $125 = $100;
- primary payer's allowable charge of $150 is compared to the Medicare recognized payment amount of $125, and the higher of the two (which in this case is the primary payer's charge of $150) minus the employer plan's payment of $120: 150-$120 = $30.

Because Medicare's secondary payment is based on the lowest of these three options, Medicare would pay $30.

Conditional Payments. As previously discussed, in some MSP instances, Medicare will make a conditional primary payment if (1) Medicare could reasonably

expect payment to be made under a workers' compensation or no-fault insurance claim, and Medicare determines that the payment will not be paid or will not be made promptly (within 120 days); (2) a beneficiary's employer-sponsored plan denies a properly filed claim, in some cases; or (3) a properly filed claim is not made due to the physical or mental incapacity of the beneficiary.

Medicare must be repaid for these conditional payments by the primary payer or anyone who has received the primary payment, if it is demonstrated that another payer, such as a liability insurer, had a responsibility to make a payment. Recovery efforts can begin as soon as Medicare becomes aware that a payment has been or could be made. The program may recover the lower of the Medicare payment or the primary payer's payment amount.

Conditional payments may not be made if the claim is denied for one of the following reasons (1) the third-party payer plan alleges that it is secondary to Medicare; (2) the plan limits payment when the individual is entitled to Medicare; (3) the services are covered for younger employees and spouses, but not for employees and spouses who are 65 and older; (4) a proper claim is not filed, or not filed in a timely manor, for any reason other than the physical or mental incapacity of the beneficiary; and (5) the group health plan fails to furnish information requested by CMS as necessary to determine whether or not the employer plan is primary to Medicare.

Subrogation. Typically, subrogation occurs when an insurance company which pays its insured client for injuries, losses, or medical expenses, seeks to recover its payment. An insurer, in this case Medicare, may reserve the "right of subrogation" in the event of a loss. This means that they may choose to take action to recover the amount of a claim paid for services provided to a beneficiary if the loss was caused by a third party. For example, if a beneficiary is injured in a car accident, Medicare may seek to recover its payment from any money collected by the beneficiary, or it may sue on behalf of the beneficiary to recover its payment, from automobile liability insurance, uninsured motorist insurance, or under-insured motorist insurance.

CMS is subrograted to any individual, provider, supplier, physician, private insurer, state agency, attorney, or any other entity entitled to payment by a primary payer. Medicare will reduce its recovery to take account of the beneficiary's cost of procuring a judgment or settlement. If the Medicare payment is less than the judgment or settlement amount, Medicare will prorate the procurement costs. If the payment equals the judgment or settlement, it may recover the total amount minus total procurement costs.

MSP and Tobacco Industry Lawsuits[10]

In 1999 the federal government brought a massive civil action against the tobacco industry to recover health care expenditures incurred by all federal health

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[10] This section was written by Kathleen S. Swendiman, legislative attorney in the American Law Division, Congressional Research Service.

programs except Medicaid (which was addressed in the state tobacco settlement) in treating tobacco-related illnesses such as lung cancer, emphysema, and heart disease. The federal government's claims against the tobacco industry were premised upon the defendant tobacco companies' alleged fraudulent conduct involving a conspiracy to deceive and mislead the American public about the harmful nature of tobacco products and the addictive nature of nicotine. One of the government's claims was that the Medicare program had made conditional payments for treatment of tobacco-related illnesses, and that the tobacco industry must reimburse Medicare for these payments under the MSP provisions. In *United States v. Philip Morris, Inc.*,[11] Judge Gladys Kessler dismissed the government's MSP claim, stating that the MSP provisions only allow suits to be brought against insurance entities, and that the government had not shown that the defendant tobacco companies, against whom the suit was brought, were either insurance companies or entities that had established "self-insured plans." Since the MSP provisions only allow recovery of conditional Medicare payments from an insurance entity responsible for making health care payments, the government could not directly sue the tobacco industry. The court also stated that "it is clear that Congress did not intend MSP to be used as an across-the-board procedural vehicle for suing tortfeasors, which is precisely how the Government attempts to use the statute in this case."[12]

In 2003 Congress enacted P.L. 108-173, the Medicare Prescription Drug, Improvement, and Modernization Act (MMA), and included several amendments to the MSP provisions, one of which provided for a broader definition of "primary plan." Prior to that time the MSP did not define "self-insured plan," and the courts had split over what constituted a self-insurance plan under the statute.[13] Congress, in MMA, provided that an entity that "engages in a business, trade, or profession shall be deemed to have a self-insured plan if it carries its own risk (whether by a failure to obtain insurance, or otherwise), in whole or in part."[14] This clarification was added to address those court cases that allowed "firms that self-insure for product liability ... to avoid paying Medicare for past medical payments related to the claim."[15] Congress also clarified the means available for demonstrating a primary plan's responsibility to reimburse Medicare. Such a responsibility "may be demonstrated by a judgement, a payment conditioned upon the recipient's

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[11] 116 F.Supp.2d 131 (D.D.C. 2000). The federal government amended its MSP claim to allege that the companies were self-insured plans that carried their own risks, but the court held that there was no showing that there was a "plan" with arrangements for reserves or claims-handling procedures. *United States v. Philip Morris Inc.*, 156 F.Supp. 2d 1 (D.D.C. 2001).

[12] 116 F.Supp 2d at 135.

[13] Some courts held that a primary plan of self-insurance had to have a specific arrangement for a source of funds and procedures for disbursing those funds when claims were made against the entity (*see Brown v. Thompson*, 374 F.3d 253, 261 (4th Cir. 2004)), while others found that a self-insured plan merely had to have some kind of "arrangement," which did not need to involve any setting aside of funds or formal procedures (*see United States v. Baxter Int'l. Inc.*, 345 F.3d 866, 895-98 (11th Cir. 2003)).

[14] Section 301(b)(1) of P.L. 108-173.

[15] H.Rept. 108-178 (II) at 189-90 (2003).

compromise, waiver, or release (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary plan or the primary plan's insured, or by other means."[16]

In the wake of the federal government's unsuccessful attempt to use the MSP provisions to recover Medicare payments relating to tobacco illnesses, a number of suits were brought under the MSP's private cause of action provision by individuals and private sector entities to recover Medicare payments and obtain damages.[17] This provision gives private citizens an incentive, in the form of double damages, to assist the government in recovering funds "in the case of a primary plan which fails to provide for primary payment."

In one case, *Glover v. Philip Morris,*[18] individual Medicare beneficiaries filed suit as private attorneys general under the MSP statute to recover expenditures Medicare made in Florida after May 26, 1998, for the treatment of illnesses attributable to cigarette smoking. The plaintiff Medicare beneficiaries alleged that defendant tobacco companies were tortfeasors in that they had "battered" Medicare beneficiaries by exposing them to the addictive properties of nicotine, and that, as such, the tobacco companies were liable for the victims' smoking-related medical expenses to the extent that Medicare had made payment for such costs. Defendant tobacco companies argued that the MSP does not provide a private cause of action against an *alleged* tortfeasor, only against an entity that has been shown to be responsible to pay for medical expenses under a primary plan, and that as accused tortfeasors they had not yet been found liable for any medical payments, so they could not be said to have "failed" to make payments to Medicare under their insurance plans. The court in *Glover* held that while the tobacco companies might meet the expanded definition of a "self-insured plan" following the 2003 amendments to the MSP, they had not yet been shown to be responsible for any Medicare payments for smoking-related illnesses, so an MSP lawsuit to recover Medicare payments was premature.[19] In other words, the MSP only provides a private cause of action to recoup Medicare payments from an insurance plan after the tortfeasor's liability has been established in a previous legal action, by agreement, or otherwise. The Court of Appeals for the Eleventh Circuit affirmed the district court's dismissal of the plaintiff's case on August 14, 2006.[20]

In another case, *United Seniors Association, Inc. v. Philip Morris USA,*[21] a nationwide non-profit "taxpayer protection" association sued several tobacco companies as a private attorney general on behalf of the Medicare program to recover medical payments made by Medicare to treat Medicare recipients for illnesses attributable to cigarette smoking. The United Seniors Association alleged that the

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[16] Section 301(b)(2)(A) of P.L. 108-173.

[17] Section 1862(b)(3)(A) of the Social Security Act, 42 U.S.C. § 1395y(b)(3)(A).

[18] 380 F.Supp.2d 1279 (M.D. Fla. 2005).

[19] Id. at 1295.

[20] *Glover v. Liggett Group, Inc.*, 459 F.3d 1304 (11th Cir. 2006) (*per curiam*).

[21] 2006 U.S. Dist. LEXIS 60729 (D. Mass., August 28, 2006).

defendant tobacco companies were tortfeasors in that " they have 'battered' Medicare beneficiaries by exposing them to the addictive evils of nicotine" without their consent, and so should be held liable for the resultant injuries and Medicare medical payments.[22] Here again the court held that an established obligation to pay medical expenses is a condition precedent to bringing an MSP claim to recoup Medicare payments that another insurance entity should have paid for as a primary plan.[23] Since the tobacco companies' liability to pay for smoking-related illnesses had not yet been determined, the district court dismissed plaintiff's MSP claims to recover Medicare payments. On August 20, 2007, the First Circuit Court of Appeals affirmed the lower court's ruling, stating that the United Seniors Association lacked standing to sue the various tobacco companies on behalf of the Medicare program.[24] An appeal to the U.S. Supreme Court by United Seniors Association, Inc. was denied on January 22, 2008.[25]

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[22] Id. at 1.

[23] Id. at 4, citing the *Glover* decision.

[24] *United Seniors Association, Inc. v. Philip Morris USA*, 500 F.3d 19 (2007).

[25] United Seniors Association, Inc. v. Philip Morris USA, 128 S. Ct. 1125, 169 L. Ed. 2d 950 (2008), petition for writ of certiorari denied.