

Medicare Secondary Payer: Coordination of Benefits

Updated August 9, 2023

Congressional Research Service

<https://crsreports.congress.gov>

RL33587



RL33587

August 9, 2023

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Medicare is a federal program that covers medical services for qualified beneficiaries. Established in 1965 to provide health insurance to individuals age 65 and older, Medicare has been expanded to include certain disabled individuals under 65. Medicare now consists of four parts (A-D) that cover hospitalizations, physician services, prescription drugs, skilled nursing facility care, home health visits, hospice care, and other treatments. Generally, Medicare is the “primary payer” for medical services, meaning that it pays health claims first. If a beneficiary has other health insurance, that insurance is billed after Medicare has made payments to fill all, or some, of any gaps in Medicare coverage. In certain situations, however, federal Medicare Secondary Payer (MSP) law prohibits Medicare from making payments for an item or service when payment has been made, or can reasonably be expected to be made, by another insurer such as a liability plan. Congress initiated MSP requirements beginning in 1980 to ensure certain insurers met their contractual obligations to beneficiaries and to reduce Medicare expenditures, thus extending the life of the Medicare Trust Fund. MSP laws and regulations reduced Medicare spending by about \$9.7 billion in FY2021, according to the Department of Health and Human Services (HHS).

In general, Medicare is the secondary payer for beneficiaries who are also covered through (1) a group health plan (GHP) based on their own or their spouse’s *current* employment; (2) auto and other liability insurance; (3) no-fault liability insurance; and (4) workers’ compensation programs, including the Federal Black Lung Program. Additionally, Medicare is prohibited from covering items and services paid for directly, or indirectly, by another government entity, such as the Department of Veterans Affairs (subject to certain limitations), although Medicaid is always secondary to Medicare. In cases when Medicare is the secondary payer but primary payment is delayed or in dispute—such as a medical liability lawsuit—Medicare can step in to cover claims to ensure beneficiaries do not experience a gap in coverage that would threaten or delay needed services. Medicare must be reimbursed for these conditional payments when a primary insurer makes payment.

To identify cases where Medicare is the secondary payer and prevent improper Medicare payments, HHS uses a number of information sources including voluntary data sharing agreements with large employers. The Medicare, Medicaid, and SCHIP Extension Act of 2007 (P.L. 110-173) requires private insurers such as GHPs, liability insurers, no-fault insurers, and workers’ compensation plans to regularly submit coverage information to HHS regarding Medicare beneficiaries. The 2018 Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act; P.L. 115-271) requires health plans to report information to HHS on prescription drug benefits to ensure better coordination with the Medicare Part D outpatient prescription drug program.

This report examines the MSP system, reporting requirements, beneficiary responsibility, payer liability issues, and issues for Congress.

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Introduction

Medicare is a federal program that covers medical services for qualified beneficiaries. Established in 1965 as Title XVIII of the Social Security Act to provide health insurance to individuals aged 65 and older, Medicare has been expanded to include qualified disabled individuals under the age of 65, persons with End Stage Renal Disease (ESRD), and persons with Amyotrophic lateral sclerosis (ALS, or Lou Gehrig's Disease).¹ Medicare now consists of four parts (A-D) that cover hospitalizations, physician services, prescription drugs, skilled nursing facility care, home health visits, hospice care, and other treatments.²

Medicare Benefit Structure

Medicare has four distinct parts: Medicare Part A (Hospital Insurance), Part B (Supplementary Medical Insurance), Part C (Medicare Advantage, or MA), and Part D (outpatient prescription drugs). In general, under Medicare,

- Beneficiaries entitled to Part A receive coverage primarily for inpatient hospital services, skilled nursing care, hospice care, and some home health services. Most persons aged 65 or older are automatically entitled to premium-free Part A because they or their spouse paid Medicare payroll taxes for at least 40 quarters (10 years) on earnings covered by either the Social Security or the Railroad Retirement system. Under Part A, individuals pay cost sharing for Medicare inpatient hospital benefits per spell of illness. Additional co-payments and charges apply to stays of more than 60 days.
- Beneficiaries entitled to Part A may enroll in Part B, which covers physician services, hospital outpatient services, some home health services, durable medical equipment, preventive services, and prescription drugs administered by a physician. Medicare beneficiaries generally pay a Part B premium that varies depending on income, and there is generally 20% coinsurance for Part B services. Together, Medicare Parts A and B represent "original" Medicare, or *fee-for-service* Medicare.
- Beneficiaries entitled to Part A and enrolled in Part B may receive these covered services through a Medicare Part C, or MA, private plan. The federal government pays private health plans that choose to participate in Part C a per person, or *capitated*, monthly amount to provide all services covered under Parts A and B (except for hospice care). MA plans may provide additional items or services not covered under Part A or B. Some MA plans charge enrollees an additional premium. In general, cost sharing for enrollees in an MA plan may differ from amounts that would be charged if the beneficiary were in Medicare Part A or B.
- Beneficiaries entitled to Part A and/or enrolled in Part B may enroll in Part D, which covers outpatient prescription drugs through private, stand-alone drug plans (PDP) or through MA plans that include a Part D benefit (MA-PD). Part D premiums and cost sharing vary by plan and by income (i.e., whether an enrollee qualifies for an additional low-income subsidy or must pay an income-based premium surcharge).

When Medicare was created in 1965, it was the primary payer for all beneficiaries except those receiving coverage through workers' compensation programs. When Medicare acts as the primary payer, it assumes responsibility for a beneficiary's medical bills, with coverage not to exceed designated Medicare program limits. If an enrollee has other insurance, the beneficiary, physician, or other supplier can bill that insurance to fill in possible gaps in Medicare coverage only after Medicare is billed.³ Medicare is always primary to Medicaid, the joint federal-state health

¹ The Treasury and General Government Appropriations Act for Fiscal Year (FY) 2001 (P.L. 106-554) amended Social Security Act (SSA) Section 226 to waive the Medicare 24-month waiting period for disabled individuals medically determined to have ALS (Lou Gehrig's disease).

² For more information about Medicare, see CRS Report R40425, *Medicare Primer*.

³ Centers for Medicare & Medicaid Services (CMS), "Medicare & You 2023," p. 21, <https://www.medicare.gov/publications/10050-Medicare-and-You.pdf>.

insurance program for qualifying low-income and certain disabled beneficiaries. Medicaid pays only after Medicare and group health plans (GHP) have paid.⁴

Beginning with the Omnibus Budget Reconciliation Act of 1980 (P.L. 96-499; OBRA), Congress created the Medicare Secondary Payer (MSP) program,⁵ which spells out specific conditions under which other insurers are required to pay first and Medicare is responsible for qualified, secondary payments. MSP is designed to ensure certain insurers make contractually required payments, reduce Medicare expenditures, and thereby extend the life of the Medicare Trust Fund.

The 1980 OBRA made Medicare a secondary payer for medical claims involving what the Centers for Medicare & Medicaid Services (CMS) terms non-group health plans (NGHP) such as liability and no-fault insurance.⁶ In 1981, Congress expanded MSP to cover certain Medicare beneficiaries in employer-sponsored GHPs including individuals eligible for Medicare on the basis of ESRD.⁷ MSP has been further refined in a series of additional statutes. (See **Appendix**.)

In general, Medicare is now the secondary payer for an item or service when payment has been made, or can reasonably be expected to be made, by responsible third-party payers (see shaded text box “Medicare as Secondary Payer,” below).⁸ Medicare also does not cover services paid for by another government entity, such as the Department of Veterans Affairs (VA).

Medicare as Secondary Payer

Medicare is considered a secondary payer when a beneficiary can reasonably be expected to receive payment under

- An employer group plan of 20 or more employees, based on either the beneficiary’s or a spouse’s *current* employment
- A large employer (at least 100 employees) GHP, for disabled current workers
- An employer GHP of any size, for beneficiaries with End Stage Renal Disease
- A Department of Veterans Affairs program (VA pays for VA-authorized services, and Medicare pays for Medicare-covered services)
- A medical, auto, or no-fault liability insurance plan
- The Federal Black Lung Program
- Workers’ Compensation

Source: CMS, “Medicare and Other Health Benefits, Your Guide to Who Pays First.”

MSP sometimes is confused with Medicare supplement, or Medigap, insurance policies, but the two are different. MSP spells out instances where private or other types of health coverage are

⁴ CMS, “Medicare and Other Health Benefits, Your Guide to Who Pays First,” p. 11, <https://www.medicare.gov/sites/default/files/2021-10/02179-Medicare-and-other-health-benefits-your-guide-to-who-pays-first.pdf>.

⁵ SSA §1862(b), 42 U.S.C. §1395y(b). Applicable regulations may be found at 42 C.F.R. Part 411.

⁶ CMS, in regulations and guidance that follow congressional directives, terms workers’ compensation, liability, and no-fault insurance as “non-group health plans” for the purpose of MSP oversight. (See CMS, “Mandatory Insurer Reporting (NGHP),” <https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Mandatory-Insurer-Reporting-For-Non-Group-Health-Plans/Overview>.) The MSP terminology differs from other, more general definitions of health insurance, in which non-group insurance refers to plans purchased by individuals outside of a group insurance setting.

⁷ Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35), §2146.

⁸ Group health plans, third-party administrators, liability and no-fault insurers, and workers’ compensation must ensure benefit payments are made in the proper order and to repay Medicare if mistaken primary payments are made or if there is a settlement, judgment, award, or other payment made for services paid conditionally by Medicare. See “Resolving MSP Mistaken/Conditional Payments” in this report.

primary and Medicare coverage is secondary. Medigap policies, by contrast, are private policies that provide supplemental coverage for individuals who rely on Medicare as their primary payer.⁹

In certain cases where Medicare is the secondary payer but primary payment is delayed, Medicare may step in to pay claims, thereby ensuring that beneficiaries have sufficient coverage. Examples of such so-called conditional payments include cases where medical liability claims are contested in court or where employer plans are slow to make payment.¹⁰ For example, in a situation where a Medicare beneficiary is hit by a car, the driver's insurance may be responsible for covering medical bills related to the collision, but payment could be delayed by legal proceedings. In such a case, Medicare may pay outstanding claims until a legal settlement is reached. Medicare is entitled to recover its conditional payments once a beneficiary has received a settlement, judgment, or other award. (See "MSP Conditional Payments.")

MSP laws and regulations reduced Medicare spending by about \$9.7 billion in FY2021, according to CMS.¹¹ The level of MSP savings has increased over the years as Congress has expanded the scope of the MSP statute. (See **Table 4**.) However, businesses, insurers and beneficiaries have told lawmakers that the resulting paperwork requirements can be onerous and that CMS can be slow to provide a final accounting of conditional payments that must be reimbursed, leading to delays in settling some liability cases.¹²

Congress has attempted to expedite the MSP payment and resolution process in statutes including the 2012 SMART Act (P.L. 112-242), which created a new process for resolving MSP conditional payment claims to speed up resolution of liability insurance, no-fault insurance, and similar cases. Also, the 2020 PAID Act, enacted as part of the Further Continuing Resolution for FY2021 (P.L. 116-215), requires CMS to provide NGHPs, at their request, with the name, address and plan number of each Part C Medicare Advantage (MA)¹³ and Part D outpatient prescription drug plan in which a Medicare beneficiary (who is subject to the NGHP coverage) was enrolled in the prior three years, in order to improve the MSP process. HHS proposed, but withdrew, regulations that would simplify the process for resolving Medicare conditional payments and setting aside funds for future medical bills related to workers' compensation and NGHP (liability) settlements. (See "Workers' Compensation Medicare Set-Aside Accounts (WCMSAs).")

⁹A Medigap policy is a private health insurance policy designed specifically to fill in some of the "gaps" in Medicare's coverage when Medicare is the primary payer. Medicare supplement policies typically pay for expenses that Medicare does not pay because of deductible or coinsurance amounts or other program limits. Medicare.gov, "What's Medicare Supplement Insurance (Medigap)?" <https://www.medicare.gov/supplements-other-insurance/whats-medicare-supplement-insurance-medigap>. See also CRS Report R47552, *Medigap: Background and Statistics*.

¹⁰HHS MSP regulations at 42 C.F.R. §411.21 generally define slow payment for GHPs as claims not paid within 120 days after receipt of a claim. For NGHPs regulations at 42 C.F.R. §411.50 define prompt payment as within 120 days after the earlier of 1) the date a claim was filed with an insurer or a lien was filed against a potential liability settlement or 2) the date the service was furnished or, in the case of inpatient hospital services, the date of discharge.

¹¹CMS, "Medicare Secondary Payer," Medicare Learning Network Booklet, July 2022, p. 4, https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/msp_fact_sheet.pdf. Annual savings going back to FY2015 can be found at CMS, "Medicare and Medicaid Integrity Programs, Reports to Congress," <https://www.cms.gov/about-cms/components/cpi/cpireportsguidance>.

¹²A group of businesses, law firms, and insurance companies in 2008 formed the Medicare Advocacy Recovery Coalition, to work for changes in the MSP program. See <http://www.marccoalition.com>.

¹³Medicare Advantage plans are managed care plans that cover Part A and Part B services. See CRS Report R40425, *Medicare Primer*.

MSP and Employer Group Health Plans

MSP law is not uniform; rather, the determination of whether Medicare is primary or secondary depends on factors including employment status, disability, or a diagnosis of ESRD.¹⁴ **Table 1** outlines the main instances when Medicare is the primary or secondary payer for those covered by group insurance policies.

Retirees

Medicare is the primary payer for beneficiaries with retiree coverage under an employer GHP.¹⁵ In such cases, Medicare is billed first for covered health services, and the retiree plan and any other coverage is billed after Medicare.

Employers are *not* required to provide health care coverage to their retirees but may choose to provide such benefits to attract and retain workers. Employers that offer retiree health care may offer lesser benefits to retirees than to current workers and may require Medicare-eligible retirees to enroll in Medicare as a condition for employer-provided retiree coverage.¹⁶ Employers may design retiree health plans as wrap-around benefits to Medicare, meaning the employer plans fill in gaps in Medicare coverage or offer supplemental benefits not covered by Medicare. Increasingly, employers are offering retirees Medicare Advantage managed care plans.¹⁷

There are exceptions to MSP rules for retiree coverage for individuals with ESRD. (See “Persons with End-Stage Renal Disease.”)

Working Aged

Medicare is the secondary payer for certain beneficiaries who are still working (often referred to as the *working aged*) and who have group health insurance through an employer. Under MSP rules, employer-sponsored health insurance¹⁸ is the primary payer (with some exceptions) for Medicare-eligible individuals who have group coverage due to their own or a spouse’s *current* employment. When a GHP is primary but does not cover a bill in full, Medicare may make a secondary payment, as prescribed by law. (See **Table 1**.)

Medicare is the secondary payer for a beneficiary with group health insurance aged 65 or older who is working, or whose spouse is working, for a company with 20 or more employees (or for a group of employers where at least one has more than 20 workers).

¹⁴ MSP consists of laws amending the Social Security Act, as well as HHS regulations and guidance. See **Appendix** for a list of the main MSP statutes.

¹⁵ See CMS, “Retiree Insurance,” <https://www.medicare.gov/supplements-other-insurance/retiree-insurance>.

¹⁶ U.S. Equal Employment Opportunity Commission (EEOC), “Age Discrimination in Employment Act; Retiree Health Benefits,” 72 *Federal Register*, December 26, 2007, pp. 72938-72945; <https://www.govinfo.gov/content/pkg/FR-2007-12-26/html/E7-24867.htm>. According to the EEOC, the final rule permits the practice of unrestricted coordination of retiree health benefits with Medicare eligibility to continue. Under the rule, for example, employers may offer “carve-out plans” that make Medicare or a comparable State health plan the primary payer of health benefits for retirees eligible for Medicare or the comparable State health plan.

¹⁷ Kaiser Family Foundation, “Medicare Advantage Coverage is Rising for the Declining Share of Medicare Beneficiaries with Retiree Health Benefits,” December 1, 2022, <https://www.kff.org/medicare/issue-brief/medicare-advantage-coverage-is-rising-for-the-declining-share-of-medicare-beneficiaries-with-retiree-health-benefits/>.

¹⁸ Group plans refer to health benefits provided by employers and other entities (e.g., unions and associations) who sponsor such benefits.

Table I. Medicare Secondary Payer Guidelines for Group Health Coverage
(general guidelines for Medicare coverage)

When You:	This Insurer Pays First:
Have retiree insurance coverage ...	Medicare pays first.
Are 65 or older, have group health coverage based on your or your spouse's <i>current</i> employment, and your employer has 20 or more workers ...	GHP pays first.
Are 65 or older, have group health coverage based on your or your spouse's <i>current</i> employment, and your employer has fewer than 20 workers ...	Medicare pays first.
Are under 65 and disabled, have group health coverage based on your or a family member's <i>current</i> employment, and the employer has 100 or more workers ...	GHP pays first.
Are under 65 and disabled, have GHP coverage based on your or a family member's <i>current</i> employment, and the employer has fewer than 100 employees ...	Medicare pays first.
Have Medicare solely because of a diagnosis of End Stage Renal Disease (ESRD) and are enrolled in a GHP ...	GHP pays first for 30 months of ESRD Medicare eligibility. Medicare pays first after the 30-month period ends.
Have Medicare on the basis of simultaneous ESRD and other eligibility and are enrolled in a GHP ...	GHP pays first for 30 months of ESRD Medicare eligibility. Medicare pays first after the 30-month period ends.
Have Medicare on the basis of disability or other entitlement and then have a diagnosis of ESRD and are enrolled in a GHP ...	If Medicare was properly the primary payer at the time of the ESRD entitlement, Medicare continues to be the primary payer.

Source: Centers for Medicare & Medicaid Services (CMS), *Medicare Secondary Payer* and *Medicare ESRD* manuals, available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs>.

Under federal law, an employer with 20 or more employees¹⁹ must offer workers aged 65 and older the same group health insurance coverage offered to other employees. Federal statutes bar most GHPs from taking into account that an individual, or his/her spouse who is covered by the plan, is entitled to Medicare benefits. Any individual aged 65 or older (and his/her spouse aged 65 or older) who has current employment status and is in a group plan with more than 20 workers is entitled to equal benefits, under the same conditions, as any such individual (or his/her spouse) under the age of 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 GHP).²⁰

If a working-aged individual is enrolled in an employer-provided GHP that meets certain federal secondary payer guidelines such as group size, the employer plan is the primary payer and

¹⁹ CMS, *Medicare Secondary Payer (MSP) Manual*, Chapter 1 -General MSP Overview, Rev. December 21, 2022, Section 20.1, <https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/msp105c01.pdf>. 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 group health plan.

²⁰ Ibid.

Medicare is secondary.²¹ For Medicare-enrolled employees who reject employer-sponsored coverage, Medicare is primary. Federal statutes prohibit employers from paying for supplemental benefits for Medicare-covered services for such employees, such as Medigap policies, so as not to provide financial incentives for the employees to reject employer-sponsored coverage.²²

The MSP requirements also apply to multiple-employer plans (plans sponsored by more than one employer) and to multi-employer plans (plans jointly sponsored by the employers and unions under the Taft-Hartley law, P.L. 80-101). When each of the employers in the group has less than 20 employees, Medicare is primary. When at least one employer has 20 or more employees, Medicare is secondary. A multi-employer GHP that includes at least one employer with 20 or more employees may prospectively request to exempt employees (and their spouses) of employers with fewer than 20 employees from the working aged provision. In that case, Medicare would be primary for the exempted employees, and the employer could offer those individuals coverage that supplements Medicare.²³

There are exceptions to MSP policy for the working aged. Medicare is *not* the secondary payer for the working aged who are enrolled only in Medicare Part B, or who are enrolled in Part A based on monthly premiums (rather than qualifying through work history).²⁴

Workers in Group Health Plans with Fewer Than 20 Employees

Medicare is the primary payer for aged workers in employer-sponsored GHPs with fewer than 20 employees (unless such plans choose to offer primary coverage). GHPs with fewer than 20 employees are not required to offer the same coverage to employees over age 65 as to younger workers.²⁵ Some health organizations suggest that aging workers covered under GHPs with fewer than 20 workers should enroll in Medicare when eligible to prevent possible gaps in coverage and higher out-of-pocket costs, and to prevent possible penalties for late Medicare enrollment.²⁶

²¹ Generally, individuals are entitled to Medicare Part A (Hospital Insurance) when they turn 65, and must enroll in Part B (Supplementary Medical Insurance) during an initial enrollment period or face a permanent penalty of increased Part B monthly premiums if instead they enroll at a later date. The law waives the Part B late enrollment penalty for Medicare-eligible individuals who choose not to enroll in Part B because they have primary coverage through their own or a spouse's qualified employer-sponsored plan, based on current employment. Such individuals are eligible for a special Part B enrollment period when their group health coverage (based on current employment) ends. As long as they enroll in Part B during the special enrollment period, they will not be subject to the Part B late enrollment penalty. The size of the group needed to trigger primary workplace coverage differs for disabled beneficiaries under age 65.

²² 42 C.F.R. §411.103. An employer or other entity (for example, an insurer) is prohibited from offering Medicare beneficiaries financial or other benefits as incentives not to enroll in, or to terminate enrollment in, a group health plan that is, or would be, primary to Medicare. This prohibition precludes offering to Medicare beneficiaries an alternative to the employer primary plan (for example, coverage of prescription drugs) unless the beneficiary has primary coverage other than Medicare. An example would be primary coverage through his own or a spouse's employer.

²³ 42 C.F.R. §411.172(b).

²⁴ 42 C.F.R. §411.172. Most persons age 65 or older are automatically entitled to premium-free Part A because they or their spouse paid Medicare payroll taxes for at least 40 quarters (10 years) on earnings covered by either the Social Security or the Railroad Retirement systems. Persons over age 65 who are not automatically entitled to Part A may obtain coverage by paying a monthly premium or, for persons with at least 30 quarters of covered employment, a reduced monthly premium. See CRS Report R40425, *Medicare Primer*.

²⁵ *Ibid*.

²⁶ National Council on Aging, "When is the Best Time to Enroll in Medicare?" November 8, 2022, <https://www.ncoa.org/article/when-is-the-best-time-to-enroll-in-medicare>. UnitedHealthcare, "Should I get Part B if I'm working past 65?," <https://www.uhc.com/news-articles/medicare-articles/should-i-get-part-b-if-im-working-past-65>.

Working Disabled

Medicare is the secondary payer for disabled Medicare beneficiaries who are under age 65 and have employer-sponsored health insurance based on their own current employment, a spouse's current employment, or as a dependent of an employed worker.²⁷

One major difference between the MSP requirements for the working aged and the working disabled is the size of the employee group needed to trigger secondary payer status. The MSP rules apply to disabled beneficiaries enrolled in large GHPs—that is, plans offered by employers that had 100 or more employees on at least 50% or more of their business days during the preceding calendar year. The requirement 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. Another difference from the MSP rules for the working aged is that a multiple or multi-employer plan may not seek an exemption from MSP requirements for a disabled worker who is enrolled via an employer with fewer than 100 employees.²⁸

Persons with End-Stage Renal Disease

Individuals who are under the age of 65 may qualify for Medicare based on a diagnosis of ESRD, a medical condition in which the kidneys are failing and a person cannot live without dialysis or a kidney transplant.²⁹ For individuals with enrollment based solely on ESRD, MSP rules apply for those covered by an employer-sponsored GHP, regardless of the employer size or current employment status.³⁰

²⁷ Prior to the Omnibus Budget Reconciliation Act of 1993 (OBRA 93; P.L. 103-66) 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, but 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. Medicare defines employed in this case as a person whose relationship is indicative of employment status. For background see CMS, “Medicare Program; Medicare Secondary Payer for Individuals,” 60 *Federal Register* August 31, 1995, p. 45346, <https://www.govinfo.gov/content/pkg/FR-1995-08-31/pdf/95-21265.pdf#page=3/>.

²⁸ Medicare entitlement for the disabled begins after Social Security Disability benefits have been paid for 24 months. However, if a beneficiary suffers from ALS (Lou Gehrig's disease) he or she is entitled to Medicare the same month they start receiving Social Security Disability benefits. See CMS, “Secondary Payer Disability Introduction,” <https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Medicare-Secondary-Payer/Downloads/Medicare-Secondary-Payer-Disability.pdf>. For information on qualifying for Social Security Disability Insurance, see CRS In Focus IF10506, *Social Security Disability Insurance (SSDI)*.

²⁹ Not everyone with ESRD is eligible for Medicare. In addition to a diagnosis of the condition, a person must meet work history requirements or receive Social Security or Railroad Retirement benefits, or be the spouse or dependent child of a person who has met work requirements or is receiving Social Security or Railroad Retirement benefits. See CRS Report R45290, *Medicare Coverage of End-Stage Renal Disease (ESRD)*.

³⁰ The ESRD provisions apply to both current and former employees. Medicare entitlement based on ESRD usually begins with the third month after the month in which an ESRD 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; or (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. If a transplant is delayed more than two months after a beneficiary is admitted to the hospital (for the transplant or for health care services needed for the transplant), Medicare coverage can begin two months before the transplant. Medicare.gov, “End-Stage Renal Disease (ESRD),” <https://www.medicare.gov/basics/end-stage-renal-disease>.

For individuals whose Medicare eligibility is based solely on ESRD, any GHP coverage they receive through their employer or their spouse's/parents' employer is the primary payer for the first 30 months that an individual is entitled to enroll in Medicare on the basis of ESRD, which is referred to as the 30-month coordination period.³¹ After 30 months, Medicare becomes primary. (Medicare remains the secondary payer for the full 30 months for a person who was initially covered by Medicare on the basis of ESRD even if that person becomes eligible for Medicare during that time period due to age or other disability.)³² During this 30-month period, the GHP is the primary insurer for all ESRD-related costs.

Similarly, for working individuals (or spouses) who qualify for, and remain eligible for Medicare, based on *both* ESRD and age or disability, any GHP coverage they had been receiving through their employer or a spouse's employer remains 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.

During the 30-month coordination period, a GHP may not take into account that an individual is entitled to benefits solely by reason of ESRD eligibility, and may not differentiate in the benefits provided between individuals with ESRD and other individuals covered by the plan on the basis of the existence of ESRD, the need for renal dialysis, or in any other manner.³³

There is an exception to the MSP rules for certain beneficiaries with ESRD. Medicare would *immediately* become the primary payer if *both* following conditions were met: (1) an 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.³⁴

³¹ If an individual does not apply for Medicare in a timely fashion and coverage under Medicare is delayed, or if the individual chooses not to apply for Medicare, the 30-month period begins on the date the individual was first eligible to enroll in Medicare. CMS, "MSP End Stage Renal Disease," Electronic Correspondence Referral System, April 4, 2022, <https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Medicare-Secondary-Payer/Downloads/MSP-End-Stage-Renal-Disease-ESRD.pdf>.

³² CMS, *Medicare Secondary Payer (MSP) Manual*, Chapter 1: General MSP Overview, Rev. December 21, 2022, Section 20.2, <https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/msp105c01.pdf>.

³³ A 2022 Supreme Court ruling found that an employment-based GHP did not violate the MSP statute's ESRD anti-differentiation and take-into-account requirements by making all dialysis coverage out-of-network and setting low provider reimbursement rates for outpatient dialysis services. According to the Court, because the plan's terms uniformly applied to all plan participants (i.e., those with and without ESRD), there was no violation of the MSP statute. See CRS Legal Sidebar LSB10819, *Supreme Court Allows Health Plans to Limit Dialysis Benefits*.

³⁴ There has been litigation and rulemaking over the years regarding the meaning of a GHP "taking into account" that an individual is eligible for Medicare ESRD benefits, particularly after a provision in the Omnibus Budget Reconciliation Act of 1993 (OBRA 93; P.L. 103-66), expanded the MSP provisions to cover GHP enrollees with ESRD who were eligible for Medicare based on more than one condition. For a broader discussion, see 60 Federal Register, August 31, 1995, <https://www.govinfo.gov/content/pkg/FR-1995-08-31/pdf/95-21265.pdf#page=14>, starting on p. 45357. Under current law and guidance, the term "taking into account" can come into play in determining whether Medicare is the primary or secondary payer for an individual with ESRD. For example, if Medicare was properly the secondary payer for an individual under working aged/disability guidelines immediately prior to the individual's eligibility based on ESRD, Medicare remains secondary. If Medicare was properly the primary payer under MSP working aged/disability guidelines immediately prior to the individual's eligibility based on ESRD, Medicare remains primary. If ESRD and disability/working age eligibility are simultaneous, Medicare is secondary. In short, if a GHP continues to implement a Medicare requirement that it pay for an individual in the secondary position after that individual also becomes eligible for Medicare based on ESRD, that does not "take into account" the later ESRD eligibility. CMS, "MSP End Stage Renal Disease," Electronic Correspondence Referral System, April 4, 2022, <https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Medicare-Secondary-Payer/Downloads/MSP-End-Stage-Renal-Disease-ESRD.pdf>.

Medicare coverage for those who qualify based solely on a diagnosis of ESRD ends 12 months after the month in which a beneficiary stops dialysis treatment, or 36 months after the month a beneficiary has a successful kidney transplant. However, if Medicare coverage ends, and then begins again based on ESRD, the 30-month coordination period also starts again.

COBRA Continuation Coverage

Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA; P.L. 99-272) requires that certain GHPs allow qualified beneficiaries to continue existing employer-sponsored coverage if coverage would otherwise be lost as a result of an employee being laid off or working fewer hours, or there is a change in family circumstance, such as divorce from or the death of a covered employee enrolled in a plan. Most GHPs offered by employers that have 20 or more employees are subject to COBRA.³⁵ COBRA coverage typically lasts for 18 months, but can run for 36 months, depending on the nature of the triggering event.³⁶ Enrollees may be required to pay as much as 100% of the premium, plus an additional 2% for the administrative costs incurred for COBRA coverage.³⁷

Table 2. Medicare Secondary Payer Rules and COBRA Continuation Coverage

When You:	This Insurer Pays First:
Have Medicare due to age or disability and are then enrolled in COBRA coverage ...	The individual's entitlement to Medicare benefits cannot be a basis for the employer to terminate the COBRA continuation coverage, Medicare pays first, because COBRA coverage is due to provisions of law rather than employment status.
Have COBRA coverage first and then become entitled to Medicare ...	Employer may terminate COBRA based on Medicare entitlement. Medicare would become payer.
Have Medicare based on ESRD and are then enrolled in COBRA coverage ...	COBRA coverage pays first to the extent coverage overlaps with the 30-month coordination period.

Source: U.S. Department of Health and Human Services, U.S. Department of Labor.

In general, COBRA is secondary to Medicare because an individual's insurance coverage is based on COBRA law, rather than on current employment status. (See **Table 2.**) Employers may not terminate COBRA coverage due to Medicare entitlement if an individual who is first entitled to Medicare, then enrolls in COBRA. However, employers may terminate COBRA coverage if a person who has first elected COBRA coverage subsequently becomes entitled to Medicare (with

³⁵ U.S. Department of Labor, "An Employee's Guide to Health Benefits Under COBRA," <https://www.dol.gov/sites/dolgov/files/legacy-files/ebsa/about-ebsa/our-activities/resource-center/publications/an-employees-guide-to-health-benefits-under-cobra.pdf>.

³⁶ If the employer files for Chapter 11 bankruptcy, the employer is required to offer COBRA coverage to retirees who lost their retiree health insurance due to the bankruptcy filing. In this case, the coverage can continue until the death of the retiree. The retiree's spouse and dependent children may purchase COBRA coverage from the former employer for 36 months after the retiree's death. See CRS Report R40142, *Health Insurance Continuation Coverage Under COBRA*.

³⁷ Ibid.

limited exceptions).³⁸ In cases where a person loses COBRA coverage due to Medicare entitlement, however, his or her spouse and children still may be eligible for COBRA coverage.³⁹

If an individual is entitled to Medicare due to ESRD, rather than age or disability, and then enrolls in COBRA, COBRA continuation may pay first depending on when he or she became eligible for Medicare.⁴⁰ If an individual who is already entitled to Medicare enrolls in COBRA coverage prior to the end of the Medicare ESRD coordination period, COBRA would be primary to the extent it overlaps the 30-month coordination period. If a person still has COBRA coverage when the 30-month coordination period ends, Medicare would pay first and COBRA coverage would pay second.⁴¹

Individuals who are enrolled in COBRA coverage and have Medicare Part A may face a financial penalty and a delay in coverage if they did not sign up for Medicare Part B when their non-COBRA employer-sponsored insurance ended. Federal law allows workers to postpone signing up for Medicare Part B, without penalty, if they are covered by insurance from a company where they or a spouse are currently working.⁴² But COBRA recipients who are not currently employed are not entitled to the special enrollment period for Medicare Part B. If those individuals do not enroll in Part B during the initial special election period following loss of employer coverage, they may be subject to a late enrollment penalty and may have to wait until the next open enrollment period, from January to March each year, for coverage beginning that July.⁴³

In addition, some individuals who are eligible for but not enrolled in Medicare Part B and have COBRA may discover that their COBRA insurer still assumes Medicare coverage is primary.⁴⁴

³⁸ CMS, *Medicare Secondary Payer (MSP) Manual*, Chapter 1 -General MSP Overview, Rev. December 21, 2022, Section 10, <https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/msp105c01.pdf>. See 42 C.F.R. §§411.161(a)(3) and 162(a)(3). COBRA requires that certain GHPs offer continuation of plan coverage for 18 to 36 months after the occurrence of certain “qualifying events,” including loss of employment or reduction of employment hours. With one exception, the COBRA amendments expressly permit termination of continuation coverage upon entitlement to Medicare. The exception is that the plan may not terminate continuation coverage of an individual (and his or her qualified dependents) if the individual retires on or before the date the employer substantially eliminates regular plan coverage by filing for Chapter 11 bankruptcy (26 U.S.C. 4980B(g)(1)(D) and 29 U.S.C. 1167.(3)(C)).

³⁹ U.S. Department of Labor, “Eligible for Medicare,” <https://webapps.dol.gov/elaws/ebsa/health/68.asp>. According to the DOL, a qualified beneficiary becomes entitled to Medicare benefits upon the effective date of enrollment in either part A or B, whichever occurs earlier.

⁴⁰ In general, an individual is considered entitled, rather than eligible, for Medicare when he or she enrolls in Part A or B. While most eligibility is based on age, an individual with ESRD under age 65 is eligible for Medicare if the individual requires regular dialysis or a kidney transplant to maintain life. The ESRD 30-month coordination period begins on the date the individual is first eligible to enroll in Medicare due to ESRD. 42 C.F.R. §411.161(a)(3) specifies that if an employer terminates COBRA coverage for individuals who have Medicare on the basis of ESRD when they become entitled to Medicare benefits, such action does not violate MSP requirements that GHPs not (1) take into account Medicare eligibility or (2) differentiate in benefits between ESRD and other Medicare beneficiaries.

⁴¹ Medicare Rights Center, “Can I Have Both COBRA and Medicare?” <https://www.medicarerights.org/PartB-Enrollment-Toolkit/Part-4-QA-COBRA.pdf>; and “The 30-month coordination period for people with ESRD,” <https://assets-us-01.kc-usercontent.com/ffacf7d-10b6-0083-2632-604077fd4eca/060baf26-c4fc-47d4-be66-03461f5db560/CBA-ESRD-Toolkit-Handout-30-month.pdf>.

⁴² See CRS Report R40082, *Medicare Part B: Enrollment and Premiums*. Individuals who qualify for Medicare based on age may sign up during the eight-month period after retirement or the ending of GHP coverage, whichever happens first. (If an individual’s GHP coverage, or the employment on which it is based, ends during the initial enrollment period, that individual would not qualify for a special election period.)

⁴³ Social Security Administration (SSA), “Medicare Coverage,” <https://www.ssa.gov/disabilityresearch/wi/medicare.htm#cobra>. Also SSA, “How to Apply for Medicare Part B (Medical Insurance) During Your Special Enrollment Period,” <https://www.ssa.gov/pubs/EN-05-10012.pdf>.

⁴⁴ According to Medicare, “If you have COBRA and you’re eligible for Medicare, COBRA may only pay a small (continued...)”

For example, many state laws contain coordination of benefit provisions that allow insurers to reduce benefits on the assumption that an individual could be enrolled in Medicare Part B.⁴⁵ This *implied coverage* means that COBRA could pay only a small portion of certain services that would be covered under Medicare Part B, with the individual having to pay for most of the costs for such services unless he or she enrolls in Part B.

No-Fault and Liability Insurance

Medicare is the secondary payer when payment has been made, or can reasonably be expected to be made, by NGHPs including automobile insurance, and other forms of no-fault and liability insurance.⁴⁶ Medicare may make conditional payments for services when payment from these primary payers has been delayed, subject to later reimbursement. If a beneficiary is also covered by a GHP, the GHP, as well as the liability plan, is to be billed first before Medicare conditional payment is requested. In cases where Medicare has made a conditional payment in a medical liability case, HHS has a *priority right of recovery* from the primary payer, as well as from any other parties that have received part of a settlement including a provider, beneficiary, supplier, or insurer. In addition, Medicare has other recovery rights. (See “Subrogation.”)

The MSP provisions governing automobile, no-fault, and other liability insurance initially were included in OBRA 1980, effective December 5, 1980. In general, NGHP coverage is usually limited to care related to the underlying illness or injury at question.

Workers’ Compensation

Nearly all workers and employers in the United States are covered by workers’ compensation. When a covered worker is injured, becomes sick, or dies as a result of his or her employment, that worker is entitled to full medical coverage for the injury, cash benefits to replace a portion of wages lost due to inability to work, and benefits for surviving family members in case of death. Employers are responsible for providing workers’ compensation benefits to their workers and generally purchase insurance to cover these costs. The federal government has only a limited role in the provision of workers’ compensation because most workers are covered by state law. Federal programs cover federal employees, longshore and harbor workers, and selected other groups.⁴⁷

portion of your medical costs, and you may have to pay most of the costs yourself. Contact your COBRA plan and ask what percent they pay.” See Medicare.gov, “COBRA: 7 Important Facts,” <https://www.medicare.gov/basics/get-started-with-medicare/medicare-basics/working-past-65/cobra-facts>.

⁴⁵ States are the main regulators of commercial health insurance. A number of states have adopted model insurance coordination of benefits (COB) legislation developed by the National Association of Insurance Commissioners (NAIC) which states in part that “A COB provision may not be used that permits a plan to reduce its benefits on the basis that.... (2) A person is or could have been covered under another plan, except with respect to Part B of Medicare. The NAIC Coordination of Benefits Model Legislation can be viewed at <https://content.naic.org/sites/default/files/inline-files/MDL-120.pdf>. As of the summer of 2020, 11 states have adopted the current NAIC model in a substantially similar manner and 37 states have enacted some COB rules or adopted the previous NAIC model. NAIC, “Coordination of Benefits Model Legislation,” MDL-120 (naic.org).

⁴⁶ CMS, “Non-Group Health Plan Recovery,” <https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Non-Group-Health-Plan-Recovery/Non-Group-Health-Plan-Recovery>. Liability insurance can include homeowner’s insurance, malpractice insurance, product liability insurance and general casualty insurance, among others. It also includes payment under state wrongful death statutes that provide payment for medical damages.

⁴⁷ CRS In Focus IF10308, *Workers’ Compensation: Overview and Issues*.

Medicare has been the secondary payer for items or services covered under a workers' compensation law or plan of the United States or a state since Medicare was created in 1965.⁴⁸ In the case of a contested claim for benefits, a workers' compensation agency or board must notify the beneficiary, and pending a decision, Medicare may be billed for medical costs. 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 and the claim is ultimately not approved, Medicare would be the primary payer.

In most states, a workers' compensation claim may be settled through a negotiated agreement between the payer (the employer or the insurer) and the worker. Settlements can provide lump sum or periodic payments for disability and future medical costs in exchange for a release of the payer from all future liability. Workers' compensation settlements generally must be approved by a state agency or court. Settlements are not permitted under the Federal Employees' Compensation Act (FECA), the federal workers' compensation system for federal employees.

Beneficiaries who receive workers' compensation settlements or other payments designed to cover future or lifetime medical costs must, by Medicare practice, protect the Medicare program from unnecessary expenses. Medicare does not pay for workers' compensation-related medical and prescription drug benefits when an individual receives a payment or settlement designed to cover future medical expenses. In such cases, the CMS recommends that individuals set up a Workers' Compensation Medicare Set-aside Arrangement (WCMSA), which allocates a portion of any workers' compensation settlement for future medical expenses.⁴⁹ The amount of the set-aside is determined on a case-by-case basis and is reviewed by CMS, when appropriate. (See "Workers' Compensation Medicare Set-Aside Accounts.")

MSP and Other Federal Health Programs

Items and services furnished by federal providers, a federal agency, or under a federal law or contract are excluded from Medicare coverage. (See **Table 3**.) This includes U.S. military hospitals, the Department of Veterans Affairs (with some exceptions), and research grants, among others. The exclusion of these items or services from Medicare coverage does not include health benefits offered to employees of federal entities, services made available to members of Indian Tribes funded by or provided through the Indian Health Service, rural health clinic services, federally qualified health centers, and other exemptions that may be specified by the Secretary of HHS.

The federal-state Medicaid program, which covers services for some low-income and disabled elderly beneficiaries, is always secondary to Medicare.

⁴⁸ The MSP provisions also apply to workers' compensation plans of the District of Columbia, American Samoa, Guam, Puerto Rico, and the Virgin Islands. MSP also applies to federal workers' compensation provided under the Federal Employees' Compensation Act, the U.S. Longshoremen's and Harbor Workers' Compensation Act and its extensions, and the Black Lung Program. The Federal Employers' Liability Act (FELA), which covers employees of interstate railroads, and the Merchant Marine Act of 1920 (Jones Act), which covers merchant seamen, do not fall under the MSP law.

⁴⁹ CMS, "Workers Compensation Medicare Set Aside Arrangements," <https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Workers-Compensation-Medicare-Set-Aside-Arrangements/WCMSA-Overview>.

Table 3. Medicare Secondary Payer and Other Government Programs

When You:	This Program Pays First:
Have black lung disease and are covered by the Federal Black Lung Program ...	The Federal Black Lung Program pays for services related to Black Lung. Medicare pays for items and services that are non-Black Lung related.
Have Medicare and are a veteran entitled to veteran's benefits ...	The Department of Veterans Affairs (VA) pays for VA-authorized services. Medicare does not pay for services paid or provided through the VA health system, but may pay for Medicare-covered services outside the VA system.
Are covered under TRICARE ...	TRICARE pays for services at a veteran's hospital or other federal provider. Medicare pays for other Medicare-covered services. TRICARE may provide secondary coverage for Medicare beneficiaries through Tricare for Life.

Source: Department of Health and Human Services.

Federal Black Lung Program

Medicare coordinates benefits with the Federal Black Lung Program. Medicare does not pay for services covered under the Federal Black Lung Program for Medicare beneficiaries who are entitled to Black Lung medical benefits, in accordance with the Federal Coal Mine Act (P.L. 91-173). Medicare may 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.⁵⁰

Department of Veterans Affairs

Medicare coverage has been coordinated with Department of Veterans Affairs (VA) health benefits since 1965, when the Medicare program was created. Even though a veteran may have both VA and Medicare coverage, the two health programs are not supplementary. In general, Medicare is prohibited from making payments to any federal health care provider who is obligated by law or contract to render services at public expense;⁵¹ therefore, Medicare does not pay for services provided through the VA medical system.⁵² VA is also statutorily prohibited from receiving Medicare payments for services provided to Medicare-covered veterans.⁵³

Medicare may pay for Medicare covered services provided to a VA beneficiary who chooses not to use VA medical services and instead uses outside, Medicare-certified providers or where VA determines that it does not have responsibility for a claim for care that was not previously authorized.

⁵⁰ CMS, *Medicare Secondary Payer (MSP) Manual*, "Chapter 3: MSP Provider, Physician, and Other Supplier Billing Requirements," Section 30.2.3, Rev. March 22, 2019, <https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/msp105c03.pdf>.

⁵¹ 42 U.S.C. §§1395f(c), 1395n(d), and 1395f(a).

⁵² Veterans may have additional health care coverage (e.g., TRICARE private health insurance, Medicaid, Medicare, among others). See CRS In Focus IF10418, *Do Veterans Have Choices in How They Access Health Care?*

⁵³ 42 U.S.C. §1395f(c), and 38 U.S.C. §1729(i)(1)(B)(i).

VA Facility

If an eligible veteran receives care at a VA medical facility and the service is covered by VA, Medicare cannot be billed.⁵⁴ Under current law, some veterans are required to pay co-payments for medical services⁵⁵ and outpatient medications⁵⁶ related to the treatment of a *non-service-connected condition*.⁵⁷ Any health service or medication provided in connection to the treatment of a *service-connected condition*⁵⁸ or disability is provided at no cost to the veteran. Additionally, VA does not charge co-payments for preventive screenings such as for infectious diseases; cancers; heart and vascular diseases; mental health conditions and substance abuse; metabolic, obstetric, and gynecological conditions; and vision disorders, as well as regular recommended immunizations.⁵⁹

The VA may collect appropriate Medicare cost sharing and deductible amounts from Medicare supplement insurance (Medigap) held by a VA beneficiary for health care services ordinarily covered by Medicare, if such care is (1) furnished at VA facilities and (2) provided to veterans covered by both VA and Medicare who also have supplemental coverage. CMS and the VA have an interagency data sharing agreement to expedite such claims. Under the agreement, CMS provides the VA with information about how much Medicare would have paid if it had covered a particular service (including deductibles and coinsurance). The VA then sends the CMS Medicare information to the Medicare supplemental insurer so the insurer can determine the amounts, if any, owed to the VA.⁶⁰

Non-VA Facility

The VA has authority under its Veterans Community Care Program (VCCP) and other statutory authorities to pay for medical services for eligible veterans, for care provided in a non-VA facility or a VA-contracted facility.⁶¹ In such cases, the VA pays for the entire episode of authorized care and Medicare may be billed for Medicare-covered services that were not authorized by the VA.⁶²

⁵⁴ 38 U.S.C. §1729(i)(1)(B)(i).

⁵⁵ 38 U.S.C. §1710(f) and 38 C.F.R. §17.108.

⁵⁶ 38 U.S.C. §1722A and 38 C.F.R. §17.110.

⁵⁷ “The term “non-service-connected” means, with respect to disability or death, that such disability was not incurred or aggravated, or that the death did not result from a disability incurred or aggravated, in line of duty in the active military, naval, air or space service.” (38 U.S.C. §101(17)).

⁵⁸ “The term “service-connected” means, with respect to disability or death, that such disability was incurred or aggravated, or that the death resulted from a disability incurred or aggravated, in line of duty in the active military, naval, air or space service.” (38 U.S.C. §101(16)).

⁵⁹ 38 C.F.R. Parts 17.108 and 17.110.

⁶⁰ CMS, *Medicare Claims Processing Manual*, Chapter 37: Department of Veterans Affairs (VA) Claims Adjudication Services Project, Rev. April 20, 2022, <https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c37.pdf>. Section 1.3 “While the VA is entitled by law to collect the coinsurance and deductible amounts that would have been payable had the claim been a true Medicare claim, it is generally permitted to do so only to the extent that there are no true Medicare claims for coinsurance and deductible submitted to the insurer for the same beneficiary for the same year.”

⁶¹ VA, “Community Care,” https://www.va.gov/COMMUNITYCARE/programs/veterans/General_Care.asp.

⁶² CMS, “Centers for Medicare & Medicaid Services, “Medicare and Other Health Benefits: Your Guide to Who Pays First,” September 2021, p. 26, <https://www.medicare.gov/sites/default/files/2021-10/02179-Medicare-and-other-health-benefits-your-guide-to-who-pays-first.pdf>.

For Medicare to be billed for such care, the services must be provided in a Medicare-certified facility.⁶³

If the VA authorizes care from a physician outside a VA facility, the physician must accept the VA reimbursement as payment in full and cannot bill Medicare.⁶⁴

TRICARE

The Department of Defense (DOD) administers statutory health entitlements and benefits to active-duty military, National Guard and reserve members, retirees and their families, survivors, and certain former spouses through the TRICARE program.⁶⁵ The rules for primary and secondary coverage of TRICARE beneficiaries are not included in the Medicare statutes, but rather are included under 10 U.S.C. §1095. In general, Medicare pays for Medicare services and TRICARE pays for services from a military hospital or clinic, or civilian health care providers participating in the TRICARE program.

TRICARE for Life (TFL) is a form of supplemental insurance under which TRICARE offers secondary coverage to beneficiaries age 65 and older enrolled in both Medicare Parts A and B.⁶⁶ For TFL beneficiaries, Medicare is the primary payer for services covered by both programs and TRICARE is secondary. For services covered under Medicare but not by TRICARE, TFL beneficiaries must pay Medicare cost-sharing amounts and the deductible. For health care services covered under TRICARE, but not by Medicare, beneficiaries must pay the TRICARE cost-sharing amounts or deductibles. For TFL beneficiaries residing overseas, TRICARE is primary and they must pay TRICARE's annual deductible and cost sharing.⁶⁷

A TRICARE beneficiary entitled to Medicare on the basis of age, disability, or ESRD must enroll and pay the monthly Medicare Part B premium to remain TFL-eligible. However, TRICARE does not require a premium to participate in TFL.

MSP and Medicare Advantage (Part C)/Part D Plans

A growing share of Medicare enrollees obtain Medicare medical and prescription drug benefits by purchasing MA and/or Part D plans from commercial insurers. (See textbox on Medicare MA and Part D Bidding and Medicare Payment.) Although MA and Part D plans provide Medicare benefit coverage, for MSP purposes they are considered to be commercial insurance products; albeit products subject to specific MSP coordination, reporting, and payment requirements that do not apply to other commercial insurance products.⁶⁸

⁶³ CMS, *Medicare Claims Processing Manual*, Chapter 3: Inpatient Hospital Billing, Section 100.9, Rev. February 2, 2023, <https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c03.pdf>.

⁶⁴ CMS, *Medicare Secondary Payer (MSP) Manual*, Chapter 5: Contractor MSP Claims Prepayment Processing Requirements, (Rev. 11550), Section 20.3, Rev. January 19, 2023, <https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/msp105c05.pdf>.

⁶⁵ For more on TRICARE, see CRS Report R45399, *Military Medical Care: Frequently Asked Questions*.

⁶⁶ Individuals may also be enrolled in TRICARE and Medicare on the basis of ESRD or disability. CMS, "Medicare and Other Health Benefits: Your Guide to Who Pays First," September 2021, <https://www.medicare.gov/sites/default/files/2021-10/02179-Medicare-and-other-health-benefits-your-guide-to-who-pays-first.pdf>.

⁶⁷ U.S. Department of Defense, "TRICARE for Life," <https://www.tricare.mil/Plans/HealthPlans/TFL>. Medicare benefits are not available to individuals overseas.

⁶⁸ Most MA and Part D plans are sold to individuals. However, private employers that offer retiree health benefits to their former employers may do so by offering special group MA and Part D plans that are known as Employer Group (continued...)

MA (Part C) and Part D Bidding and Medicare Payment

Medicare Advantage (MA) is an alternative way for beneficiaries to receive Medicare-covered benefits. In general, private insurers contract with Medicare on an annual basis to offer MA plans in areas of their choosing, generally consisting of counties or groups of counties or, in the case of MA regional preferred provider organization (PPO) plans, states or groups of states, as defined by the Secretary. All items and services covered under original Medicare Parts A and B are covered by MA plans (except hospice care which is covered by original Medicare).

Medicare Part D plans provide coverage for retail prescription drugs. Private insurers contract with CMS on an annual basis for the right to offer Part D plans in one or all of 34 specified regions of the country. Part D can be offered as a standalone plan (PDP) or as part of an MA plan (MA-PD).

Medicare payments to MA and Part D plans are based on annual contract bids that plan sponsors (insurers) submit to CMS. The bids outline the insurer's projected annual cost for providing Medicare benefits that meet at least minimum standards specified in law. Unlike original or fee-for-service Medicare, in which CMS pays medical providers and facilities for each covered item, procedure, episode, or spell of illness, CMS pays MA and Part D plans a risk-adjusted, per-capita monthly amount to provide required benefits, regardless of the number of services an enrollee uses. The capitated payments are based on statutory formulas.

CMS requires MA and Part D insurers to adjust their annual contract bids to account for enrollees who have other, primary insurance and/or Medicare as a secondary payer, such as aged/disabled workers or ESRD enrollees. Medicare payments to MA and Part D plans are reduced in cases where enrollees have other primary coverage because the plans' costs are lower.

See CMS, "Instructions for Completing the Medicare Advantage Bid Pricing Tools for Contract Year 2023," and CMS, "Instructions for Completing the Prescription Drug Plan Bid Pricing Tool for Contract Year 2023."

MA and Part D plans are secondary payers in cases where an enrollee has other commercial GHP or NGHP coverage that meets the MSP statutory requirements to be a primary payer to Medicare. One example would be an MA enrollee who is a current worker with coverage under an employer GHP of 20 or more employees. (See "MSP and Employer Group Health Plans.")

Medicare Advantage MSP Requirements

Federal regulations⁶⁹ require that MA plan sponsors identify payers, including GHPs and NGHPs, that are primary to Medicare for specific plan enrollees, and coordinate MA plan benefits for such enrollees with the benefits offered by the primary payers. As part of this process, MA plans must report any amounts payable by other insurers to CMS on an ongoing basis. MA organizations must account for the MSP payment responsibilities of other primary GHPs and NGHPs in one of three ways.

MA organizations must

- Recover from liable third parties;
- Avoid Medicare costs by directing medical providers to bill liable third parties directly; or
- Account for Medicare costs that could have been recovered or avoided, but that were actually not recovered or avoided, by subtracting them from allowable costs when submitting annual contract bids to CMS.⁷⁰

Waiver Plans (EGWPs). For more information see the EGWP section in CRS Report R40611, *Medicare Part D Prescription Drug Benefit*.

⁶⁹ 42 C.F.R. §422.108; <https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-422/subpart-C/section-422.108>.

⁷⁰ CMS, "Medicare Program; Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs, Final rule," 75 *Federal Register*, vol. 72, April 15, 2010, p. 19770.

Part D Medicare Secondary Payer Requirements

Medicare Part D and MA-PD plans are subject to the same MSP regulations as MA plans.⁷¹ In addition, Part D plan sponsors must coordinate payment and coverage with certain state programs that provide prescription drug assistance; other prescription drug plans, including Medicaid, GHPs, Federal Employee Health Benefits (FEHB), military coverage; and other plans or programs providing prescription drug coverage. To support the required benefit coordination, Part D sponsors may request information on third-party insurance from beneficiaries.

Recent court cases have established that MSP statutes give MA plan sponsors, as private entities, the right to sue other GHPs or NGHPs for double damages in cases where those GHPs and NGHPs were primary payers to the MA plans, but did not make required payments or appropriate reimbursements for Medicare-covered services. (See “Private Right of Action”).

Determining MSP Reimbursement for Claims

When Medicare is the secondary payer, a health care provider must first submit a claim to a beneficiary’s primary payer, which processes the claim according to terms of the coverage contract. If the primary payer does not pay the full charges for the service, Medicare may be billed as secondary, and Medicare may make payments *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 deductibles/coinsurance, 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.⁷² For services, such as inpatient hospital care or outpatient dialysis, the *combined* payment by the primary payer and Medicare cannot exceed Medicare’s recognized payment amount (without regard to beneficiary cost-sharing charges).

⁷¹ 42 C.F.R. §423.462. The provisions of 42 C.F.R. §422.108 apply to Part D sponsors and Part D plans (with respect to the offering of qualified prescription drug coverage) in the same way as they apply to MA organizations and MA plans. A Part D sponsor must report credible new or changed primary payer information to the CMS Coordination of Benefits Contractor in accordance with processes and timeframes specified by CMS.

⁷² MSP payment formulas are at 42 C.F.R. §411.33. In general, for medical services paid on a basis other than fee schedule, reasonable charge, or monthly capitation rate (such as hospital or dialysis services), Medicare will not pay more than the Medicare-allowable amount for a service – based on the primary insurer’s payment plus the Medicare payment. MSP only comes into effect if a primary payer has paid less than the allowable Medicare amount. However, if a provider has agreed to accept reimbursement that is below the full Medicare-allowed amount, Medicare does not have to pay up to the full Medicare-allowed amount, under §411.33(e). According to 54 *Federal Register*, October 11, 1989, p. 41729, <https://www.federalregister.gov/citation/54-FR-41734>: “As was pointed out in the Notice of Proposed Rulemaking published on June 15, 1988 (53 FR 22340), §1862(b)(3)(B) of the Act permits Medicare secondary payments only if the employer GHP pays less than the charges. We therefore feel that the intent of the law is for Medicare to supplement the amount paid by a primary payer up to the provider’s charges... For instance, if a provider charged \$10,000 for services for which the Medicare PPS rate is \$18,000, and the primary payer paid \$10,000, Medicare would make no payment, since the statute does not permit Medicare secondary payments where a third-party payer pays the charges in full. Yet, if the third-party payer paid one dollar less than the charges (\$9,999), Medicare would have to pay \$8,001 (the difference between the \$18,000 PPS amount and the \$9,999 paid by the third-party payer). We have chosen a policy that does not lead to this anomalous result.”

As one example⁷³ 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 Medicare Part A inpatient hospital deductible (\$1,600 for 2023) had previously been met. Medicare's gross payment amount, without regard to the deductible, is \$4,700. As the secondary payer and per the formula in regulation, 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— $\$4,700 - \$1,600 = \$3,100$;
- the hospital charge minus the primary payer's payment— $\$6,800 - \$4,360 = \$2,440$; or
- the hospital charge minus the Medicare inpatient deductible— $\$6,800 - \$1,600 = \$5,200$.

In this case, Medicare would pay \$340. The combined payment made by the primary payer and Medicare is \$4,700, the Medicare-recognized payment amount. The beneficiary has no liability for Medicare-covered services, since the primary payer's payment satisfied the \$1,600 inpatient deductible and, in this example, there is no applicable coinsurance for this service. If Medicare's payment amount had been lower than the primary payer's amount, it would not have made a secondary payment.⁷⁴

In other cases, for services for which CMS pays on a Medicare fee schedule or reasonable charge basis, such as physicians' services, the Medicare secondary-payment amount cannot exceed the lowest of the calculation of the three options described in the following example.

Assume that a physician charges a beneficiary \$175 for a service. The primary payer's allowable charge is \$150, of which it pays 80%, or \$120 (the remaining 20% would be beneficiary coinsurance). Medicare's Part B-recognized payment amount for the service is \$125, of which it pays 80%, or \$100. The beneficiary's Part B deductible had been met. The three options⁷⁵ for determining payment are described below:

- excess of the actual provider charge minus the primary payer's payment: $\$175 - \$120 = \$55$;
- Medicare's payment amount if the services were not covered by a primary payer: $.80 \times \$125 = \100 ; and
- the higher of the primary payer's allowable charge (\$150) or the Medicare-recognized payment amount (\$125), minus the primary payer's (\$120) payment: $\$150 - \$120 = \$30$.⁷⁶

⁷³ Examples are based on examples in regulations at 42 C.F.R. §411.33.

⁷⁴ If the beneficiary had primary insurance that also had a deductible, the example would only apply if the beneficiary had already met the deductible of the primary coverage.

⁷⁵ 42 C.F.R. §411.33.

⁷⁶ 42 C.F.R. §411.33(a)(3) The higher of the Medicare fee schedule, Medicare reasonable charge, or other amount which would be payable under Medicare (without regard to any applicable Medicare deductible or coinsurance amounts) or the primary payer's allowable charge (without regard to any deductible or coinsurance imposed by the policy or plan) minus the amount actually paid by the primary payer.

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

MSP Conditional Payments

In some cases, Medicare will make conditional payments for medical treatment even when it is the recognized secondary payer. Examples include cases when (1) Medicare could reasonably expect payment to be made under a workers' compensation or no-fault insurance claim, but Medicare determines the payment will not be paid or will not be made promptly (within 120 days); and (2) a beneficiary's GHP denies a properly filed claim, in some cases, or a properly filed claim is not made due to physical or mental incapacity of the beneficiary.⁷⁷ Medicare can also make payments in cases where Medicare benefits have been claimed for an injury that allegedly was caused by another person.

Medicare will not make conditional payments under the following conditions: (1) it is alleged that a GHP is secondary to Medicare; (2) a GHP limits payment when the individual is entitled to Medicare; (3) a GHP provides covered services for younger employees and spouses, but not for employees and spouses who are 65 and older; (4) a proper claim is not filed, or is not filed in a timely manner, for any reason other than the physical or mental incapacity of the beneficiary; or (5) a GHP asserts it is secondary to the liability, no-fault, or workers' compensation insurer.⁷⁸

Medicare must be repaid for 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. Repayment is expected when a beneficiary receives a settlement or other payment. In general, NGHP coverage is usually limited to care related to the underlying illness or injury at question.

Subrogation

In addition to statutory authority to collect reimbursement for conditional payments, CMS has the right of subrogation in liability or other cases that involve Medicare beneficiaries. Typically, subrogation occurs when an insurance company that pays its insured client for injuries, losses, or medical expenses, seeks to recover its payment. The insurer, in this case Medicare, may reserve the "right of subrogation" in the event of a loss. This means that the insurer 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 subrogated 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.

⁷⁷ 42 C.F.R. §411.52 and CMS, *Medicare Secondary Payer (MSP) Manual*, Chapter 1: General MSP Overview, Rev. December 21, 2022, Sections 20.7 through 20.7.2, <https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/msp105c01.pdf>.

⁷⁸ Ibid.

Private Right of Action

Medicare secondary payer law⁷⁹ provides a private cause of action under which insurers or other responsible parties may sue for double damages in cases where a primary plan fails to provide for primary payment (or appropriate reimbursement) in accordance with MSP requirements. The law also allows the United States⁸⁰ to collect up to double damages against any such entities, as well as from any entity that has received payment from a primary plan or from the proceeds of a primary plan's payment to any entity.

In recent years, courts have held in lawsuits brought by MA plans that the plans have the right to sue for double damages under the private right of action.⁸¹ (See “MSP and Medicare Advantage (Part C)/Part D Plans” and “Section 111 and MA and Part D plans.”)

Federal MSP Oversight and Administration

CMS works through outside contractors to coordinate payment of Medicare benefits with other types of health coverage. The process is designed to identify insurers and other entities that are primary to Medicare; to collect necessary information to prevent mistaken or unnecessary payment of Medicare benefits; and to recoup Medicare payments, including conditional payments, in cases where other insurance is found to be primary.

Benefits Coordination and Recovery Center

The Benefits Coordination & Recovery Center (BCRC) oversees collection, management, and reporting of information regarding coverage of Medicare beneficiaries by GHPs and NGHPs including workers' compensation programs, in order to recover mistaken Medicare payments through post-payment review.⁸² (See “MSP Data Reporting Sources.”)

The BCRC updates the Medicare systems and databases used in the claims payment and recovery processes including information on Medicare claims from beneficiaries, providers, employers, insurers, workers' compensation plans, and attorneys.⁸³

In cases where a Medicare beneficiary has other coverage, the BCRC initiates an investigation to determine whether Medicare or the other insurer has primary responsibility for payment. The BCRC is responsible for recovering payments in NGHP cases where a beneficiary must reimburse Medicare for mistaken liability, no-fault, and workers' compensation claims. (See “NGHP Conditional Payment Recovery from Beneficiaries.”)

⁷⁹ SSA §1862(b)(3)(A) (42 U.S.C. 1395y(b)(3)(A)).

⁸⁰ SSA §1862(b)(2)(B)(iii).

⁸¹ See *Aetna Life Ins. Co. v. Big Y Foods*, 52 F. 4th 66 (2nd Cir. 2022).

⁸² CMS, “Coordination of Benefits & Recovery Overview,” <https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Overview>.

⁸³ CMS, “MMSEA Section 111 MSP Mandatory Reporting GHP User Guide,” Version 6.7, Section 50.4 January 2023. Available at <https://www.cms.gov/medicare/coordination-of-benefits-and-recovery/mandatory-insurer-reporting-for-group-health-plans/ghp-user-guide/ghp-user-guide>.

Commercial Repayment Center

The Commercial Repayment Center (CRC)⁸⁴ initiates recovery in mistaken payment cases where Medicare has paid first, but a GHP is determined to be the primary payer rather than Medicare. Since FY2016, the CRC also has been responsible for the recovery of conditional payments where a liability insurer (including a self-insured entity), no-fault insurer or workers' compensation entity has assumed responsibility for ongoing medical payments and is the identified debtor.⁸⁵

For GHPs, the CRC recovers mistaken primary payments from the entity with main payment responsibility, such as the employer or other plan sponsor, insurer, or claims-processing third-party administrator (TPA). These entities do not have formal rights to appeal the CRC actions, but may challenge the debt repayment through a set process.⁸⁶

For NGHPs, the CRC initiates recovery of Medicare conditional payments that an applicable plan should have paid. CMS granted NGHP applicable plans formal administrative appeal rights for debts established on or after April 28, 2015. (See "NGHP Conditional Recovery from Payers.")

During FY2021, the CRC identified \$500 million in mistaken and conditional payments for both GHPs and NGHPs. The CRC processed collections of \$327.93 million, refunded excess collections of \$41.10 million, and posted \$286.83 million in net collections.⁸⁷ (See **Table 4**.)

Medicare MACs

Medicare Administrative Contractors (MACs) are private health care insurers in set geographic areas of the country that process Medicare Fee-For-Service (FFS) claims (Part A and Part B (A/B) medical claims and Durable Medical Equipment (DME) claims) for Medicare FFS beneficiaries.⁸⁸ MACs handle claims submitted for primary or secondary payment.

Medicare MACs forward relevant MSP information obtained from insurers, providers, and suppliers to the BCRC. The MACs generate much of the correspondence/inquiries related to NGHP, and workers' compensation MSP cases, although the MACs do not resolve MSP outstanding cases.⁸⁹

Workers' Compensation Review Contractor

The Workers' Compensation Review Contractor (WCRC) oversees creation and execution of Workers' Compensation Medicare Set-Aside Arrangements (WCMSA). The set-aside accounts are designed to cover future medical expenses relating to workers' compensation cases, thereby

⁸⁴ As is the case with other Medicare integrity auditors, under SSA §1893(h), the CRC is paid on a contingency-fee basis. The amount of the contingency fee is a percentage of the mistaken payment that the identified debtor has returned to the Medicare program.

⁸⁵ CMS, "The Medicare Secondary Payer Commercial Repayment Center in Fiscal Year 2021," October 2022, p. 3, <https://www.cms.gov/medicare/coordination-of-benefits-and-recovery/coordination-of-benefits-and-recovery-overview/reports/reports-page>.

⁸⁶ Ibid.

⁸⁷ Ibid, p. 7.

⁸⁸ CMS, "What's a MAC?," <https://www.cms.gov/Medicare/Medicare-Contracting/Medicare-Administrative-Contractors/What-is-a-MAC>.

⁸⁹ CMS, *Medicare Secondary Payer (MSP) Manual*, Chapter 5: Contractor MSP Claims Prepayment Processing Requirements, Rev. August 12, 2022, <https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/msp105c05.pdf>.

ensuring that medical services to treat the underlying disability or illness are not billed to Medicare. Proposed set-aside accounts are reviewed by CMS before final approval, if they meet certain guidelines.⁹⁰

Workers' compensation is a primary payer for Medicare beneficiaries' work-related illnesses or injuries. Medicare beneficiaries are required to apply for all applicable workers' compensation benefits in cases of employment-related injuries and illnesses. If a Medicare beneficiary has a condition that is approved for coverage through workers' compensation, providers, physicians, and other suppliers must bill workers' compensation before billing Medicare.⁹¹ Workers' compensation pays all medical costs associated with covered conditions without any co-payments, coinsurance, or other cost sharing by the worker. In addition, workers' compensation frequently provides coverage for certain additional expenses related to an injury such as transportation to medical appointments.

MSP Data Reporting Sources

The BCRC, CRC, and related review entities obtain information from a variety of sources, including the following:⁹²

- **Voluntary Data Sharing Agreement (VDSA):** These agreements between payers and CMS allow for the exchange of information regarding GHP eligibility and Medicare, including prescription drug coverage in commercial plans and Medicare Part D.⁹³
- **Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA):** Section 111 imposes mandatory MSP data sharing requirements for GHP and NGHPs. (See "Section 111 Mandatory Reporting" below.)
- **MSP Claims Investigation:** Investigations conducted by the BCRC involve collecting other health insurance or coverage information that may be primary to Medicare based on information submitted on a medical claim or other sources like correspondence, accident and injury cases, or phone calls.⁹⁴

⁹⁰ CMS, "Workers' Compensation Medicare Set Aside Arrangements," <https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Workers-Compensation-Medicare-Set-Aside-Arrangements/WCMSA-Overview>. See link to WCMSA Reference Guide Version 3.8 (PDF).

⁹¹ CMS, "Workers' Compensation Medicare Set-Aside Arrangement (WCMSA) Reference Guide," Version 3.5 January 10, 2022.

⁹² Medicare Learning Network, "Medicare Secondary Payer," Rev. July 2022, p. 13, https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/msp_fact_sheet.pdf.

⁹³ CMS, "Voluntary Data Sharing Agreement," <https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/EmployerServices/Voluntary-Data-Sharing-Agreement>. "A VDSA authorizes CMS and an employer, or agent on behalf of an employer, to electronically exchange health insurance benefit entitlement information. On a quarterly basis, a VDSA partner agrees to submit GHP entitlement information about employees and dependents to CMS's Benefits Coordination & Recovery Center (BCRC). In exchange, CMS agrees to provide the VDSA partner with Medicare entitlement information for those individuals in a GHP that can be identified as Medicare beneficiaries. This mutual data exchange helps to assure that claims will be paid by the appropriate organization at first billing."

⁹⁴ Providers are required to ask Medicare patients for information on other potential GHP, NGHP, or government health coverage. The model questionnaire for inpatient and outpatient admissions can be found at *Medicare Secondary Payer (MSP) Manual*, Chapter 3: MSP Provider, Physician, and Other Supplier Billing Requirements, Section 20.2.1, Rev. September 15, 2020, available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/msp105c03.pdf>.

- **Questionnaires:** Three months before prospective enrollees are first entitled to Medicare, they fill out an initial enrollment questionnaire asking for information about other existing medical coverage.

Section 111 Mandatory Reporting

Section 111 of the MMSEA requires Responsible Reporting Entities (RRE), which include GHPs and NGHPs, to provide information regarding the health insurance status of their enrollees or any judgments, payments, or settlements involving Medicare beneficiaries.⁹⁵ The information is used prospectively to determine whether Medicare is a primary or a secondary payer and retrospectively to collect reimbursement in the case of erroneous payments or conditional payments.⁹⁶ Section 111 reporting requirements are the primary source of MSP information reported to CMS.

Group Health Plan Section 111 Reporting

MMSEA Section 111 provisions require GHPs to report plan information to the BCRC each calendar quarter regarding medical and drug coverage for workers who may be Medicare-eligible. Reporting may be carried out by the insurers, third-party administrators, and in the case of self-insured and self-administered plans, an administrator or fiduciary. Insurance plans also may use third parties such as data firms to submit their information.

Each quarter, GHPs electronically submit information about active, covered individuals, defined generally as people who may be Medicare-eligible and are currently employed, or who are the spouses or dependents of workers covered by a GHP who may be Medicare-eligible.⁹⁷

The BCRC processes the Section 111 data, then adds the information to the Medicare Common Working File (CWF) and the Medicare Beneficiary Database (MBD), for use by other Medicare contractors in claims processing and payment recovery. When the BCRC has finished processing, or the allotted time for a response (45 days) ends, the BCRC transmits a response file to the GHP RRE. The response file includes information about any errors in the original data and information about primary or secondary coverage for individuals the BCRC identifies as Medicare beneficiaries. Section 111 allows CMS to share information with reporting GHPs regarding a beneficiary's Medicare Part A, Part B, Part C, and Part D coverage. The HHS Secretary may share this enrollment information with other government entities in order to coordinate benefits.⁹⁸

⁹⁵ CMS.gov, "Mandatory Insurer Reporting (NGHP)," <https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Mandatory-Insurer-Reporting-For-Non-Group-Health-Plans/Overview>; and CMS.gov, "Mandatory Insurer Reporting for Group Health Plans (GHP)," <https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Mandatory-Insurer-Reporting-For-Group-Health-Plans/Overview>. CMS, MMSEA Section 111 MSP Mandatory Reporting GHP User Guide," Version 6.7, January 2023, available at <https://www.cms.gov/medicare/coordination-of-benefits-and-recovery/mandatory-insurer-reporting-for-group-health-plans/ghp-user-guide/ghp-user-guide>.

⁹⁶ While the MMSEA instituted mandatory reporting, insurers already had an obligation to pay Medicare in cases where their policies were deemed primary.

⁹⁷ 42 U.S.C. §1395y(b)(7). For a fuller description, see CMS, "MMSEA Section 111 MSP Mandatory Reporting GHP User Guide," Version 6.7, Section 7.3.1, January 2023. Available at <https://www.cms.gov/medicare/coordination-of-benefits-and-recovery/mandatory-insurer-reporting-for-group-health-plans/ghp-user-guide/ghp-user-guide>. Plans are required to report if they meet the specifications to be subject to MSP for plan payments.

⁹⁸ The 2018 SUPPORT Act provided for exchanging GHP prescription drug coverage information to coordinate coverage with Medicare Part D. As required by the SUPPORT Act, GHPs must submit primary prescription drug coverage information using the Section 111 process.

Non-Group Health Plan Section 111 Reporting

Section 111 quarterly reporting requirements also apply to NGHP applicable plans such as auto, homeowners, no-fault insurance, and workers' compensation plans.⁹⁹ NGHP RREs must supply information to the BCRC regarding Medicare beneficiaries or dependent spouses of Medicare-eligible beneficiaries for whom they have assumed responsibility for ongoing medical payments (known as ongoing responsibility for medicals or ORM), or who receive a settlement, judgment, or award from liability insurance, no-fault insurance, or a workers' compensation plan.¹⁰⁰

The NGHPs report the names of all Medicare beneficiaries whose illness, injury, incident, or accident is at issue in a claim, as well as any other information required by the HHS Secretary.¹⁰¹ (NGHP RREs may contract with outside entities to act as their agents for Section 111 reporting, such as data service or consulting companies.)

NGHPs must report information to the BCRC in cases where they have assumed ORM. According to CMS, ORM means the NGHP has continuing responsibility to pay for a Medicare beneficiary's medical costs associated with a claim.

The trigger for reporting ORM is the assumption of ORM by the RRE—when the RRE has made a determination to assume responsibility for ORM, or is otherwise required to assume ORM—not when (or after) the first payment for medicals under ORM has actually been made. Medical payments do not actually have to be paid for ORM reporting to be required.¹⁰²

When a NGHP's responsibility for payments ends, it reports an ORM termination date.¹⁰³ When there is a NGHP settlement, judgment, award or other payment in an outstanding case, the NGHP must report a Total Payment Obligation to Claimant (TPOC) to the BCRC.¹⁰⁴

⁹⁹ CMS, "MMSEA Section 111 MSP Mandatory Reporting Liability Insurance (Including Self-Insurance), No-Fault Insurance, and Workers' Compensation User Guide Chapter III Policy Guidance," Chapter 1, Version 7, January 2023, <https://www.cms.gov/medicare/coordination-of-benefits-and-recovery/mandatory-insurer-reporting-for-non-group-health-plans/nghp-user-guide/nghp-user-guide>. The requirement also applies to self-insured plans. According to CMS, the Section 111 requirements do not eliminate existing processes, including CMS's process for self-identifying pending liability insurance, no-fault insurance, or workers' compensation claims to the BCRC.

¹⁰⁰ CMS, "MMSEA Section 111 MSP Mandatory Reporting Liability Insurance (Including Self-Insurance), No-Fault Insurance, and Workers' Compensation User Guide Chapter III Policy Guidance," Chapter 3, Version 7, Section 6.3, January 2023, <https://www.cms.gov/medicare/coordination-of-benefits-and-recovery/mandatory-insurer-reporting-for-non-group-health-plans/nghp-user-guide/nghp-user-guide>.

¹⁰¹ CMS, "MMSEA Section 111 MSP Mandatory Reporting Liability Insurance (Including Self-Insurance), No-Fault Insurance, and Workers' Compensation User Guide Chapter III Policy Guidance," Chapter 1, Version 7, January 2023, <https://www.cms.gov/medicare/coordination-of-benefits-and-recovery/mandatory-insurer-reporting-for-non-group-health-plans/nghp-user-guide/nghp-user-guide>.

¹⁰² CMS, "MMSEA Section 111 MSP Mandatory Reporting Liability Insurance (Including Self-Insurance), No-Fault Insurance, and Workers' Compensation User Guide Chapter III Policy Guidance," Chapter 3, Version 7, Section 6.3, January 2023, <https://www.cms.gov/medicare/coordination-of-benefits-and-recovery/mandatory-insurer-reporting-for-non-group-health-plans/nghp-user-guide/nghp-user-guide>.

¹⁰³ *Ibid.* The reference to "ongoing" is not related to "ongoing reporting" or repeated reporting of claims under Section 111, but rather to the RRE's responsibility to pay, on an ongoing basis, for the injured party's (Medicare beneficiary's) medicals associated with the claim.

¹⁰⁴ *Ibid.* The TPOC amount refers to the dollar amount of a settlement, judgment, award, or other payment in addition to or apart from ORM. The computation of the TPOC amount includes, but is not limited to, all Medicare covered and non-covered medical expenses related to the claim(s), indemnity (lost wages, property damages, etc.), attorney fees, set-aside amount (if applicable), payout totals for all annuities rather than cost or present values, settlement advances, lien payments (including repayment of Medicare conditional payments), and amounts forgiven by the carrier/insurer.

Section 111 and MA and Part D plans

Under the PAID Act, effective in December 2021, the BCRC provides requesting NGHPs with plan enrollment information for Medicare beneficiaries, as part of any Section 111 query response file. The information includes MA and Part D plan contract names, plan numbers, and entitlement dates for the prior three years (up to 12 instances) of coverage, as well as the most recent Part A and Part B entitlement dates.¹⁰⁵ According to industry groups that lobbied for the PAID Act, the law was a response to lawsuits filed by MA and Part D plans under Medicare's private right of action seeking to recover MSP payments, including double damages. The additional Section 111 Medicare enrollment information is designed to help NGHPs make more accurate payments to the appropriate parties and forestall such lawsuits.¹⁰⁶

Resolving MSP Mistaken/Conditional Payments

Resolving Mistaken GHP Payments

The CRC resolves MSP GHP cases where Medicare mistakenly paid in the primary, rather than the secondary position.

If the CRC identifies an erroneous claim, it sends a payment notice to the GHP insurer/payer for the mistaken amount. After receiving the notice, the payer has 45 days to respond. If payment is submitted, the case is closed.

If a payer makes no response or valid defense to a CRC finding after 45 days, the CRC issues a demand letter to the employer/plan sponsor and the insurer:

- If the employer pays the outstanding amount in the demand letter, the case is resolved.
- If a payer challenges the demand letter, the case is considered through a review process that is not a formal Medicare appeals process.¹⁰⁷ (GHPs do not have the same appeal rights as providers or beneficiaries, but may challenge a demand letter.) If a challenge is successful, the debt is adjusted accordingly. If the challenge is not successful, the CRC sends a notice to that effect, and the case continues.

If a payer does not respond or has an invalid defense

- Interest on the outstanding payment begins accruing from the date the CRC demand letter was issued, but is not assessed unless a debt is not paid in 60 days.
- If a case is not resolved 120 days after receipt of a demand letter, the CRC provides notification that it intends to refer the case to the Department of the Treasury.

¹⁰⁵ CMS, "Paid Act Webinar," June 23, 2021, <https://www.cms.gov/files/document/june-23-2021-provide-accurate-information-directly-paid-act-webinar-presentation.pdf>.

¹⁰⁶ The Omnibus Budget Reconciliation Act of 1986 (OBRA 86), Section 9319, added a private cause of action to MSP allowing for double damages in cases in which a primary plan fails to pay. Verisk, "The PAID Act is now live – 5 things you need to know (and how we can help!)," December 31, 2021, <https://www.verisk.com/insurance/visualize/the-paid-act-is-now-live—5-things-you-need-to-know-and-how-we-can-help/>.

¹⁰⁷ CMS, "The Medicare Secondary Payer Commercial Repayment Center in Fiscal Year 2021," October 2022, p. 5, <https://www.cms.gov/medicare/coordination-of-benefits-and-recovery/coordination-of-benefits-and-recovery-overview/reports/reports-page>.

- If the case is not resolved within 60 days of an intent to refer notice (180 days after receipt of the original demand letter), the outstanding debt is referred to Treasury.¹⁰⁸

Resolving MSP Conditional Payments

CMS operates a two-part system to process and resolve NGHP conditional payment claims.

NGHP Conditional Payment Recovery from Beneficiaries

The BCRC is responsible for recovering conditional payments in cases where there is a settlement, judgment, award, or other payment to a Medicare beneficiary and the beneficiary has an obligation to repay the Medicare program. All pending liability, no-fault, or workers' compensation cases must be reported to the BCRC, including by beneficiaries.¹⁰⁹ In general, the BCRC Medicare recovery period runs from the date of an incident subject to NGHP coverage, through the date of any settlement/judgment/award.¹¹⁰

If the BCRC finds evidence (from its data sources) that a NGHP is primary to Medicare in a reported case, it creates an MSP "occurrence" which is posted in Medicare records and used to begin the recovery process. If the MSP occurrence involves a NGHP, the BCRC creates a Rights and Responsibilities (RAR) letter that spells out information needed from the beneficiary/insurer to resolve the issue, and explains the process for Medicare recovery.¹¹¹ The letter may be sent to a beneficiary or, if the BCRC is pursuing recovery directly from an insurer/workers' compensation entity, the correspondence is sent directly to that entity.

Within 65 days of an RAR letter, the BCRC sends a conditional payment letter (CPL) providing an accounting of items or services covered by Medicare on a conditional basis, including an interim total conditional payment amount. The CPL also provides instructions for disputing claims. (The payment amount is considered interim because Medicare might have to keep covering expenses while a beneficiary's claim from a proper primary payer is pending.)

If a settlement, judgment, award, or other payment had already occurred before a beneficiary first reported a case, and the beneficiary must repay Medicare, the BCRC sends the beneficiary a conditional payment notice (CPN) spelling out the required payment amount.¹¹² The BCRC also sends a CPN when a NGHP notifies it of a settlement of judgment. After receiving the CPN

¹⁰⁸ CMS, "Overview of the Group Health Plan (GHP) Recovery Process," <https://www.cms.gov/medicare/coordination-of-benefits-and-recovery/coordination-of-benefits-and-recovery-overview/downloads/ghp-recovery-process-flowchart.pdf>.

¹⁰⁹ CMS, "Liability, No-Fault and Workers' Compensation Reporting," <https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Beneficiary-Services/Liability-No-Fault-and-Workers-Compensation-Reporting/Liability-No-Fault-and-Workers-Compensation-Reporting>. Also, see CMS, "Medicare's Recovery Process," <https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Beneficiary-Services/Medicare's-Recovery-Process/Medicare's-Recovery-Process>.

¹¹⁰ *Ibid.* If an "incident" involves exposure to or ingestion of a substance over time, the date of incident is the date of first exposure/ingestion.

¹¹¹ If Medicare is pursuing recovery directly from the insurer/workers' compensation entity, a beneficiary and his/her attorney or other representative will receive correspondence sent to the insurer/workers' compensation entity.

¹¹² Parties to a conditional payment case can use the Medicare Secondary Payer Recovery Portal to report a case and manage cases reported to the BCRC. The Portal lets users obtain updated conditional payment amounts, request a copy of a current conditional payment letter, or make an electronic payment. If the BCRC has already sent a CPL prior to a settlement, the BCRC will identify any new, related claims that have been paid since the last time the CPL was issued up to and including the settlement/judgment/award date. Once the process is complete, the BCRC will issue a formal recovery demand letter advising of the amount owed to the Medicare program. The amount of money owed is called the demand amount.

- A beneficiary has 30 days to respond to a CPN/CPL and may file a dispute, with documentation, challenging the payment amounts. The BCRC must respond to the dispute filing within 45 calendar days and may recalculate the conditional payment amount if warranted. If the BCRC finds that the dispute documentation is not sufficient, the dispute is denied.
- If a response to the CPN is not received in 30 calendar days, a demand letter is issued requesting repayment of all conditional payments, without any reduction for fees or costs.¹¹³ Interest on the amount due accrues from the date of the demand letter. If the debt is not repaid or otherwise resolved within the time period specified in the recovery demand letter, interest is assessed for each 30-day period the debt remains outstanding.

If there is no response within the specified time frame, the BCRC may refer the debt to the Department of Justice for legal action and/or the Department of the Treasury for collection:

- If the debt is referred to Treasury, the beneficiary will be notified through an Intent to Refer letter, which is sent 90 days after the original demand letter.
- If full payment or valid documented defense is not provided within 60 days of the Intent to Refer Letter (150 days after the demand letter), the debt is referred to Treasury once any outstanding correspondence is worked out by the BCRC.
- The BCRC may also refer debts to the Department of Justice for legal action. The federal government is authorized to collect double damages from any party that is responsible for resolving the matter but which fails to do so.

If a beneficiary is settling a liability case, he or she may be eligible to obtain Medicare's demand amount prior to settlement, or to pay Medicare a flat percentage of the total settlement. (See "Expedited Repayment Options.")

NGHP Conditional Recovery from Payers

The CRC is responsible for recovering conditional payments from NGHPs that have or had Ongoing Responsibility for Medicals (ORM). In such cases, the BCRC first collects data related to a Medicare beneficiary's coverage under liability insurance, no-fault insurance, or workers' compensation plans (known as an occurrence).

In the case of an accident or illness involving a NGHP where the BCRC has been notified and Medicare has stepped in to make conditional payments, the BCRC follows up with a letter to the affected parties laying out their rights and responsibilities. The CRC then reviews cases where NGHPs have primary responsibility for ORM.¹¹⁴

¹¹³ If the beneficiary or his/her attorney or other representative believes any claims included on a CPL or CPN should be removed from Medicare's conditional payment amount, they must provide the BCRC with documents supporting their position. The BCRC has 45 days for review, and may adjust the conditional payment amount depending on the review. In cases where the BCRC has been notified of a settlement, judgment, or award after issuing its initial CPL, it will apply a termination date (generally the date of settlement) to the case. The BCRC will identify any relevant claims Medicare has paid since the last CPL was issued up to and including the settlement/judgment/award date, and will then then issue a formal recovery demand letter specifying the amount owed to the Medicare program, called the demand amount.

¹¹⁴ CMS, "Insurer NGHP Recovery," <https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/InsurerServices/Insurer-NGHP-Recovery>.

In such cases,

- If a payer owes an outstanding amount to Medicare, the CRC issues a conditional payment notice (CPN) summarizing the Medicare payments that have been made.¹¹⁵ The CPN lists conditional payments identified by the CRC, and provides 30 days to dispute responsibility for repayment before the recovery case proceeds to the demand stage.
- The CRC next issues a demand letter, which is a formal notification of the debt, including claim-specific information. The demand letter provides instructions on how to repay or appeal the debt, and the penalties for failure to resolve the debt by the set deadline.
- In response to the demand letter, debtors may pay the CRC. If payment is not made within 60 days from the date of the demand letter, interest is assessed. Interest accrues from the date of the demand letter, but is assessed only if there is an outstanding balance after 60 days. Interest is assessed for each 30-day period the debt is unresolved.
- If any part of the debt remains unresolved after 60 days, the CRC will provide a referral notice to notify the debtor that the case will be referred to Treasury for collection. Unless an appeal is filed, failure to resolve the debt after the referral notice will result in referral of the debt to Treasury.

A NGHP debtor has 120 days from the time a demand letter is received to file an appeal. NGHP entities have formal administrative appeal rights specified in statute:¹¹⁶

- The CRC processes the first-level appeal, called a request for redetermination. Documentation is required for an appeal. If an appeal is successful, the debt is adjusted.
- If an appeal is not successful, a debtor may seek additional appeals. Higher-level appeals are: reconsideration by the CMS Qualified Independent Contractor, a hearing by an Administrative Law Judge within the Office of Medicare Hearings and Appeals, and a review by the Departmental Appeals Board's Medicare Appeals Council.
- Outstanding debt will not be referred to Treasury for collection while an appeal is under consideration, but interest will continue to accrue.¹¹⁷

¹¹⁵ CMS, "The Medicare Secondary Payer Commercial Repayment Center in Fiscal Year 2021," October 2022, p. 6, <https://www.cms.gov/medicare/coordination-of-benefits-and-recovery/coordination-of-benefits-and-recovery-overview/reports/reports-page>.

¹¹⁶ SSA §1862(b)(2)(B)(viii).

¹¹⁷ CMS, "Insurer NGHP Recovery," <https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/InsurerServices/Insurer-NGHP-Recovery>. Interest on the debt accrues from date of the demand letter and, if the debt is not resolved within 60 days, is assessed for each 30-day period the debt remains unresolved. Payment is applied to interest first and principal second. Interest continues to accrue on the outstanding principal portion of the debt. If an applicable plan requests an appeal, the debt will not be referred to the Department of Treasury while the appeal is being processed, but interest will continue to accrue. The applicable plan may choose to pay the demand amount while appealing the overpayment in order to avoid the accrual and assessment of interest. (An appropriate refund is made if the appeal is favorable to the applicable plan.)

Expedited Repayment Options for Conditional Claims

CMS has created options for speeding conditional payment claims¹¹⁸ in certain cases—both for past medical bills and for some cases that involve future medical payments. Examples of cases where expedited options are in place include the following:

- **\$750 Threshold**—If a beneficiary has suffered a physical trauma-type injury, obtains a liability settlement of \$750 or less, and does not receive or expect to receive additional settlements related to the incident, Medicare will not pursue recovery.¹¹⁹ CMS maintains a single threshold for liability and no-fault insurance plans and workers' compensation. In such cases, settlements of \$750 or less do not need to be reported and Medicare's conditional payment amounts related to these cases does not need to be repaid.
- **Fixed Payment Option**—If a beneficiary suffers a physical trauma-based injury, obtains a liability settlement of \$5,000 or less, and does not receive or expect to receive additional settlements related to the incident, the beneficiary may resolve Medicare's recovery claim by paying 25% of the gross settlement.¹²⁰
- **Self-Calculated Conditional Payment Option**—If a beneficiary suffers a physical trauma-based injury at least six months prior to selecting this option, anticipates a settlement of \$25,000 or less, proves that medical care was completed at least 90 days prior to submitting for the payment option, and has neither received nor expects to receive additional settlements related to the incident, the beneficiary may self-calculate Medicare's recovery claim. Medicare then reviews the beneficiary's calculations and provides Medicare's final, conditional payment amount.¹²¹

Workers' Compensation Medicare Set-Aside Accounts (WCMSAs)

In addition to reimbursing CMS for past conditional payments, individuals must protect Medicare's interest with respect to future medical bills if they have received, reasonably anticipate receiving, or should have reasonably anticipated receiving, Medicare-covered items and services for a medical condition after the date of a settlement or payment based on that condition.

In the case of a workers' compensation settlement in which a portion of settlement is designed to pay for future medical costs, it can be difficult to ensure Medicare does not end up paying for medical costs related to the work injury that should have been covered by the settlement. CMS

¹¹⁸ CMS, "Medicare Program: Medicare Secondary Payer and Future Medicals," 42 C.F.R. Parts 405 and 411, 77 *Federal Register*, June 15, 2012, p. 35917, <https://www.federalregister.gov/articles/2012/06/15/2012-14678/medicare-program-medicare-secondary-payer-and-future-medicals>.

¹¹⁹ Threshold is the amount for 2023. See CMS, "Computation of Annual Recovery Thresholds for Certain Liability Insurance, No-Fault Insurance, and Workers' Compensation Settlements, Judgments, Awards, or Other Payments for 2023," December 13, 2022, <https://www.cms.gov/files/document/computation-annual-recovery-thresholds-nghp-2023.pdf>. As part of the calculation, CMS determined that the cost of collection in such cases would be approximately \$306.

¹²⁰ CMS, "Demand Calculation Options," <https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Beneficiary-Services/Demand-Calculation-Options/Demand-Calculation-Options-page>.

¹²¹ *Ibid.*

suggests that individuals who receive workers' compensation settlements that include payments for future medical expenses create workers' compensation set-aside accounts (WCMSAs) to protect Medicare from paying for medical expenses covered by the settlement. Federal law does not require the establishment of a WCMSA when there is a workers' compensation settlement.

A WCMSA is a voluntary financial agreement in which a portion of the amount of the workers' compensation settlement is dedicated to the payment of future medical expenses covered by workers' compensation. The amount of the settlement that should be placed in the WCMSA is the estimated amount of future medical expenses that would otherwise be paid by Medicare, but that should be covered by workers' compensation, for the life of the person. The amount in the WCMSA must be exhausted before Medicare will pay any medical expenses related to a workers' compensation claim, thus ensuring that Medicare does not pay medical expenses that should be paid by workers' compensation and ensuring that Medicare's remains a secondary payer in workers' compensation cases.

CMS recommends, but does not require, that WCMSAs are submitted to CMS for review to ensure adequate amounts are set aside to protect Medicare's status as a secondary payer to worker's compensation. In reviewing the adequacy of set-aside accounts for CMS, the Workers' Compensation Review Contractor (WCRC) considers a number of factors including the severity of the underlying illness, age, and the cost of expected medical procedures.

CMS will only review WCMSAs that meet one of the following conditions:

- The claimant is a Medicare beneficiary and the total amount of the settlement is greater than \$25,000; or
- The claimant has a reasonable expectation of Medicare enrollment within 30 months of the settlement date and the anticipated settlement amount is greater than \$250,000.¹²²

CMS cautions that even if a workers' compensation settlement does not meet these conditions, or a WCMSA is not submitted for review, an individual is still required to protect Medicare's interests and ensure Medicare remains a secondary payer for expenses covered by workers' compensation.¹²³

Rulemaking on Expedited Set-Aside Accounts

In 2012, CMS issued an advance notice of proposed rulemaking¹²⁴ that spelled out options for creating a standardized system for Medicare set-aside accounts in cases involving automobile and liability insurance (including self-insurance) and no-fault insurance cases, in addition to workers' compensation set-asides.

¹²² CMS, *Workers' Compensation Medicare Set-Aside Agreement (WCMSA) Reference Guide*, Version 3.5, November 14, 2022, p. 9, <https://www.cms.gov/files/document/wcmsa-reference-guide-version-38.pdf>.

¹²³ *Ibid.*, p. 10.

¹²⁴ CMS, "Medicare Program: Medicare Secondary Payer and Future Medicals," 42 C.F.R. Parts 405 and 411, 77 *Federal Register*, June 15, 2012, p. 35917, <https://www.federalregister.gov/articles/2012/06/15/2012-14678/medicare-program-medicare-secondary-payer-and-future-medicals>. Some of the proposals would apply to current Medicare beneficiaries and some for those expected to soon become eligible for Medicare.

CMS proposed a series of options to streamline the process for set-aside accounts, including

- Setting out specific conditions under which Medicare would not pursue future medical claims.
- Satisfying future claims by providing documentation that a course of care has been completed and reimbursing Medicare for any conditional payments.
- Expanding the current workers' compensation set-aside review system.
- Expanding or amending Medicare's existing three expedited payment options.
- Allowing for some type of up-front payment to satisfy MSP requirements.
- Waiving some payments if a beneficiary has a compromise settlement or a waiver or recovery.
- Having a beneficiary administer his or her own settlement account until it is exhausted.

In 2014, this notice of proposed rulemaking was withdrawn by CMS.¹²⁵

CMS published its intent to begin new rulemaking to provide guidance for set-aside accounts in the Fall 2018 Unified Regulatory Agenda.¹²⁶ A formal notice of proposed rulemaking was never published. In March 2022, CMS held a meeting with the Medicare Advocacy Recovery Coalition and other stakeholders pursuant to the requirements of Executive Order 12866.¹²⁷ In October 2022, CMS withdrew its latest attempt at providing guidance for set-aside accounts through rulemaking.¹²⁸

WCMSA Legislation

In the 117th Congress, legislation introduced as the Coordination of Medicare Payments and Worker's Compensation Act (COMP Act; H.R. 3124 and S. 653) would have formalized the WCMSA process.¹²⁹ Under this legislation, a WCMSA that met certain requirements would have been deemed to have satisfied the claimant's responsibilities to protect Medicare's status as a secondary payer to workers' compensation. Any party to a workers' compensation settlement would have the option of submitting a WCMSA to CMS for formal approval, with a right to appeal a denial of approval.

MSP Savings

According to CMS, MSP laws and regulations reduced Medicare spending by about \$63 billion from FY2015 through FY2021. (See **Table 4**.)

¹²⁵ CMS, *Medicare Secondary Payer and "Future Medicals,"* RIN 0938-AR43, October 8, 2014, <https://www.regulations.gov/docket/CMS-2012-0073/unified-agenda>.

¹²⁶ Office of Management and Budget, Office of Information and Regulatory Affairs, *Unified Agenda of Federal Regulatory and Deregulatory Actions*, Fall 2018, 2018, <https://www.reginfo.gov/public/do/eAgendaViewRule?pubId=201810&RIN=0938-AT85>.

¹²⁷ For additional information on the federal agency rulemaking process and Executive Order 12866, see CRS Report RL32240, *The Federal Rulemaking Process: An Overview*.

¹²⁸ Office of Management and Budget, Office of Information and Regulatory Affairs, *OIRA Conclusion of EO 12866 Regulatory Review*, October 13, 2022, <https://www.reginfo.gov/public/do/eoDetails?rrid=229561>.

¹²⁹ Similar legislation was introduced in previous Congresses.

Table 4. MSP Savings for FY2015-FY2021

(dollars in millions)

MSP Savings	2015	2016	2017	2018	2019	2020	2021
Pre-payment Review	\$7,317	\$7,354	\$7,372	\$7,667	\$6,398	\$6,035	
Post-Payment Recovery	\$1,174	\$1,307	\$1,145	\$1,182	\$3,087	\$2,896	
TOTAL	\$8,491	\$8,661	\$8,517	\$8,848	\$9,476	\$8,931	\$9,700

Source: CMS, “Medicare and Medicaid Integrity Program Report to Congress.” Annual reports dating back to 2015 can be found at <https://www.cms.gov/about-cms/components/cpi/cpireportsguidance>.

Note: Totals may not add due to rounding. Figure for 2021 is from CMS, “Medicare Secondary Payer,” Medicare Learning Network Booklet, July 2022, p. 4, National program savings: MSP provisions saved the Medicare Program about \$9.7 billion in fiscal year (FY) 2021. The booklet does not provide a breakdown of the savings, https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/msp_fact_sheet.pdf.

Appendix. Selected MSP Legislation

Table A-1. Medicare Secondary Payer (MSP) Legislation

(federal laws that have shaped the Medicare Secondary Payer program)

Legislation	Implication
Omnibus Budget Reconciliation Act of 1980 (P.L. 96-499)	Set MSP rules for non-group health plans.
Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35)	Set MSP rules for group health plans covering individuals with End Stage Renal Disease (ESRD).
Tax Equity and Fiscal Responsibility Act of 1982 (P.L. 97-248)	Set coverage of working aged.
Deficit Reduction Act of 1984 (P.L. 98-369)	Expanded definition of working spouse.
Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272)	Eliminated upper age limit of 69 for the working aged.
Omnibus Budget Reconciliation Act of 1986 (P.L. 99-509)	Made changes in disabled workers provisions. Created a private right of action allowing for double damages where a primary plan fails to pay in accordance with MSP requirements.
Omnibus Budget Reconciliation Act of 1987 (P.L. 100-203)	Clarified provisions relating to disabled workers, as well as some COBRA provisions.
Omnibus Budget Reconciliation Act of 1990 (P.L. 101-508)	Modified MSP provisions for beneficiaries with ESRD.
Omnibus Budget Reconciliation Act of 1993 (P.L. 103-66)	Modified MSP provisions for ESRD and disabled beneficiaries.
Balanced Budget Act of 1997 (P.L. 105-33)	Extended time for Medicare to recoup conditional payments, further clarified ESRD provisions.
Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. 108-173)	Expanded government's ability to collect repayment of conditional payments, applied MSP to Medicare Part D.
Medicare, Medicaid & SCHIP Extension Act of 2007 (P.L. 110-173)	Created Section III reporting requirements.
Medicare IVIG Access Act, Title II (The SMART Act) (P.L. 112-242)	Instituted new requirements and timelines for resolving conditional payment claims.
Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act (P.L. 115-271)	Required all group health plans that offer primary prescription drug coverage to report this coverage each calendar quarter as part of the Section III reporting process.
PAID Act/Further Continuing Resolution for FY2021 (P.L. 116-215)	Required CMS to provide requesting NGHPs with information on specific plan enrollment for Medicare beneficiaries as part of the Section III reporting process.

Source: *The Complete Guide to Medicare Secondary Payer Compliance*, Lexis-Nexis, and HHS and CRS legislative searches.

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