



# Medicare Secondary Payer:

How Streamlining a Broken Bureaucracy Will Protect Seniors and Taxpayers

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## The Broken System of Medicare Reimbursement

Since 1980, the Medicare Secondary Payer (MSP) system has protected Medicare funds by ensuring that Medicare is reimbursed for costs that other entities have primary responsibility for paying. That system has become a poster child for inefficient bureaucracy. It is plagued with difficulties that range from posing inconveniences to causing genuine economic harm. Insurance companies, small businesses, municipalities and even other federal agencies have to spend millions of dollars to navigate MSP's web of red tape. The system is so dysfunctional that even Medicare is harmed by its own bureaucracy, unable to recoup taxpayer dollars from people who are trying to give money back to the government.

The situation is so bad that it has inspired universal demand for reform from the most disparate of groups — politicians from both sides of the aisle, corporations and consumer groups, and attorneys from both the plaintiff and defense bars. But perhaps the most grievously affected participants are the seniors who Medicare was supposed to protect. These seniors often find themselves left in limbo and unable to pay their bills, or worse, wrongfully pursued for debts they never incurred by the very agency meant to protect them.

## Medicare Secondary Payer (MSP) - An Introduction

It was not meant to be this way. Medicare was created in 1965 to provide health care for America's seniors. Americans pay for this health insurance program through payroll taxes. It is the principal form of health care coverage for everyone over 65 and for millions of disabled Americans.

Generally, Medicare is the "primary payer" — that is, it pays health claims first, and if a beneficiary has other insurance, that insurance may fill in all or some of Medicare's gaps. However, in some instances another party may have a responsibility to pay an individual's medical bills; for instance, an auto insurer in the case of an automobile accident. In these instances, Medicare is a "secondary payer," and has the right to be reimbursed from a primary payer. "Primary payers" are usually hospitals or insurance companies, self-insured businesses, municipalities and even other government agencies.

To better understand the MSP system, imagine this hypothetical scenario. Grandma Rose is injured in a car accident by a driver that runs a red light. She has a broken arm. Medicare pays Grandma Rose's medical bills for the accident. Later, the driver of the car that ran the red light is found liable for the accident. The driver's insurance company — the primary payer — then reimburses Medicare.

## The Problems with MSP

No one questions whether Medicare should be reimbursed for the health care costs it pays for when another entity has primary responsibility for paying the medical bills. The Medicare Secondary Payer system saves taxpayers billions of dollars. However, a mix of bureaucracy and overzealousness has resulted in the system causing a wide array of problems.

The Centers for Medicare and Medicaid Services (CMS) — the entity charged with processing Medicare’s reimbursements — has made the reimbursement process excessively difficult, with frequent mistakes and unreasonably slow resolutions. In 2007, new reporting requirements were introduced that further increased the inefficiency of the system, and placed costly burdens on all parties involved. In fact, the CMS bureaucracy is so complex, inefficient, and riddled with contradictions that it has the ironic result of depriving Medicare of money it is owed.

Critics from across the political spectrum have come together to urge reform of the Medicare Secondary Payer system. Representatives from both political parties, from business and consumer groups, and from plaintiff and defense attorney groups have united to reduce the system’s inefficiency, and to reduce the cost to both public and private sector. Nor is it just businesses that seek the consistency missing from the system — seniors left stranded by the agency meant to protect them also seek the peace of mind Medicare should offer.



## Long, Drawn-Out Resolutions

The chief criticism of the MSP system is that it is a laborious process that can drag on for years. Insurance companies, attorneys and injured consumers are consistently left in limbo, unable to conclude settlements and distribute funds because CMS will not respond to requests for information in a timely fashion.

Insurance companies and attorneys need to know how much they owe Medicare before they can reach agreement on a settlement amount. However, in what some have described as a “chicken and egg situation,” CMS often will not provide the “conditional payment letter” estimating a reimbursement amount until after the parties have entered into a legal settlement agreement. As the House Energy and Commerce Committee Chairman Fred Upton describes the situation:

“[T]here is no requirement for CMS to provide the parties with the amount due, or the amount they should set aside to cover future payments, before settlement so they can appropriately allocate and resolve these Medicare obligations during settlement. The end result is uncertainty for all parties involved. CMS is unsure when it will receive repayment. The primary payer is unsure about its bottom line, and the beneficiary, who Medicare is meant to protect, is unsure if they will receive the coverage they were promised.”<sup>10</sup>

Nor can the parties even be certain precisely what rules they must follow, as local CMS offices vary in their interpretation of the federal reporting rules.<sup>11</sup> This uncertainty is a costly burden for business, and makes it difficult for insurance companies and attorneys to settle legal disputes because the parties cannot know the full value of a claim. This stalls negotiations between insurance companies and attorneys for seniors, who must proceed with negotiations without knowing what Medicare is owed. Even after settlement, it can take years for seniors to learn the amount Medicare is owed. During this lengthy delay, seniors have no access to any settlement funds they may have received.

Even once a settlement is negotiated, attorneys trying to reimburse Medicare are frequently unable to do so. Attorneys are forced to withhold settlement funds intended for their clients because CMS will not respond to attempts to reimburse Medicare. That bears repeating: attorneys trying to repay Medicare cannot get Medicare’s attention.

This problem caught the eye of Missouri Democratic Senator Claire McCaskill, who said, “clearly with our health care costs where they are and the amount taxpayers are spending on Medicare, the notion that someone is trying to give them money and no one is home is pretty offensive.”<sup>12</sup>

In many cases, CMS will make multiple requests for different amounts. Insurance companies and attorneys report that the agency will request additional reimbursement even after settlements have been negotiated, funds distributed, and Medicare repaid. This can result in CMS coming after individuals for thousands of dollars years after they were told everything had been correctly settled.

Kansas City, Missouri, attorney Stephen Bough had to withhold his client's \$60,000 settlement check for more than six months because CMS failed to respond to his attempts to pay them. He sent five letters without response. Eventually, his client died without receiving any of his settlement.

For Kansas City lawyer John Kurtz, the wait was 16 months. Kurtz's client was paralyzed in a car accident. Kurtz contacted Medicare in September 2007, but by the time Medicare told him how much he should apportion to Medicare, his client was dead. "The agony for these families who have to go through this hassle is tragic," says Kurtz.

Washington State Attorney Patrick LePley settled a case with Medicare, soon after which his client died. Then, Medicare decided it was owed more money, and because the client was dead, went after his widow and began docking her Social Security checks.<sup>13</sup>

## No Finality

The Medicare Secondary Payer process may be the most muddled maze the government has to offer, but even after Medicare is repaid, seniors are not out of the woods. CMS will often come after them for more money, sometimes years later. Though it is official Medicare policy to go after insurance companies first, in reality it is Medicare seniors who are targeted.<sup>14</sup>

Seniors in this situation are presented with collection letters from CMS demanding thousands of dollars immediately. When they are unable to pay, often their Social Security checks are docked.

Seniors also face consequences when Medicare begins denying coverage for needed medical care years after unrelated injuries. Insurance executives have testified before Congress that they see hundreds of cases where Medicare has denied coverage for a senior because of a past, unrelated closed claim. In one case, a senior with breast cancer was denied coverage by Medicare because of a prior, unrelated car accident that happened many years before. In many cases Medicare has denied coverage for seniors that the insurance companies have no record of at all.<sup>15</sup>

In early 2011, attorneys for a 78-year-old woman, who died in a hospital after being given a lethal overdose of pain and anxiety medications, entered into settlement negotiations with the hospital and physician responsible. The woman's attorneys contacted CMS to identify what Medicare was owed, because the agency had paid the medical costs for the two days the woman lay in a vegetative state. However, CMS had accidentally closed the file, and had to begin the process anew.

The case was then settled and the settlement reported to Medicare. The attorneys requested a final demand for payment from CMS. The agency did not respond. The attorneys submitted another request, and then continued to contact Medicare again and again. In June 2011, CMS finally sent a Conditional Payment Notice. Within two days the attorneys submitted the requested payment to Medicare.

A few days later, CMS wrote to say that it was investigating whether Medicare was owed additional payments. Despite having received the payment, CMS said it planned to keep the file on the case open, and would submit any subsequent demand not to the attorneys or hospital, but to the beneficiary – who had died five years earlier. CMS also stated that the file on the case would stay open as long as they wanted, and that the parties would not be informed if it was closed.<sup>16</sup>

## Administrative Bureaucracy

The value of some of these claims does not merit the cost of administering them. CMS originally exempted claims with a value of less than \$5,000, but under new reporting requirements, the agency intends to collect any claim, even those under a dollar. That decision will result in a mass of new claims. The Rand Institute's analysis of these sub-\$5,000 claims found that the average amount recouped would be \$195. That would pay for about one hour of a paralegal's time to identify and process a claim.<sup>1</sup> In one notorious case in 2009, Medicare demanded \$1.59 out of a \$4,500 settlement — a reimbursement far smaller than the cost of collecting it.<sup>2</sup> The current system already generates more than a million pieces of correspondence a year, and those handling the claims say that mistakes are an everyday occurrence. It is anticipated that mistakes associated with the new wave of sub-\$5,000 claims will add \$30 million a year in unnecessary administrative costs to an already bloated bureaucracy.<sup>3</sup>

This administrative burden goes two ways. The CMS decision to go after every claim, no matter how small, greatly increases the private sector administrative demand in addition to the government bureaucracy it creates. In fact, eliminating the sub-\$5,000 exemption nearly doubles the number of claims in the system (43 percent), adding to the bureaucracy.<sup>4</sup>

Nor is this just a problem for insurance companies. Any entity potentially involved in paying individuals through liability insurance, no-fault insurance, or workers' compensation, including companies that self-insure, are subject to mandatory reporting rules that take up time and money to comply with. That would include companies that self-insure, municipalities and even other federal government agencies – all of whom may be charged with making Medicare whole. Failure to follow the dense rules of the MSP process can result in fines of up to a \$1,000 per day.<sup>5</sup>

The new reporting requirements and legal questions raised by the changes will also result in a tsunami of litigation.<sup>6</sup> Some courts have ruled that CMS has overstepped its bounds in instituting a draconian and overreaching collection process.<sup>7</sup> But the legality of the MSP process is far from settled, and insurance companies have already reported a backlog in claims as they struggle to settle complicated recovery questions that even Medicare officials are unsure of.<sup>8</sup>

**In 1995, 81-year-old Mollie Coury was a passenger in a car driven by her daughter when she was involved in a car accident with a drunk driver. Mollie spent several weeks in the hospital with serious leg injuries, but eventually was able to make a full recovery. Ultimately, her daughter's auto insurer paid Mollie approximately \$20,000 for the injuries she had suffered in the accident.**

**Seven years later, in 2002, CMS demanded she repay them for treatment paid by Medicare. When she could not pay in full, the agency took her monthly \$498 Social Security check – her only income – for three years.**

**Then in 2008, 13 years after the accident, Medicare demanded she pay an additional \$66,000. The agency gave her 60 days to pay. The agency had made an administrative error and mistakenly believed Mollie owed more money. But no amount of calls and letters to the agency could sort out the mistake. When Mollie did not pay, Medicare stopped paying her medical bills.<sup>9</sup>**

## Fixing the Medicare Secondary Payer System

Unusually for Washington, the move to reform MSP has broad support across a variety of disparate interests. Reform is supported by representatives of both parties, corporations from Allstate to Walmart, and both plaintiff and defense attorney groups. It is not often that the American Association for Justice finds itself on the same side of the table as the Defense Research Institute and the U.S. Chamber of Commerce. It is a recognition of the fact that under the current system, everyone is a loser — insurance companies and other businesses with unpredictable reporting requirements, Medicare seniors who risk having needed funds withheld, and even the government itself, which has created an expensive administrative bureaucracy depriving itself of the money it is owed. All affected have appealed for reform.

One such reform is H.R. 1063, “The Strengthening Medicare and Repaying Taxpayers (SMART) Act introduced by Rep. Tim Murphy (R-PA) and Rep. Ron Kind (D-WI). Amongst other provisions, H.R. 1063 provides that Medicare must respond to a demand for a final payment amount within 65 days. Additionally, reimbursement requests would be subject to a statute of limitations of three years, to prevent seniors being hounded for money years after resolution.

These solutions seek to place some consistency on a system that is currently an unpredictable maze of red tape. For businesses, consistency is important because it allows them to handle the administration associated with Medicare repayments in a systematic way. Having a consistent system and a protocol for repayment will make the process more efficient and less costly than the prospect of decrypting each and every claim, and potential claim, one at a time, with the necessary personnel time that entails.

For seniors, the improved speed of resolution these reforms would provide can be a financial lifeline. Currently seniors, many on fixed incomes, may find themselves waiting for years for insurance payments. For a business, such a timeframe is an inconvenience; but for an individual, it can be devastating.

Dorothy Brar’s 87-year-old mother broke her hip in a fall, and after successful surgery and rehab, moved to an assisted living facility in Madison, Wisconsin. But Medicare refused to pay her medical bills because they mistakenly thought they were related to a minor fender bender eight years earlier. The agency had her former auto insurer, Allstate, listed as her current health care carrier.

Because her mother had advanced Alzheimer’s and Parkinson’s disease, Dorothy found herself spending countless hours on the phone trying to clear up the problem. Allstate and her mother’s doctors all helped to try to persuade Medicare workers that Allstate was not her health insurer and that her injuries were not related to the auto accident.

It took 18 months and the intervention of the Wisconsin State Journal to ensure Dorothy Brar’s mother could get her medical bills paid by Medicare.<sup>17</sup>

## Conclusion

The Medicare Secondary Payer system is unique in that it is the one government institution that is so obviously and painfully broken that it has done what was previously thought impossible – united all sides in Washington. Everyone with a vested interest in the Medicare Secondary Payer system has been affected by its breakdowns. The calls for reform are not calls to change what the system is supposed to do or somehow eliminate the reimbursement program altogether. They are a collective expression that everyone involved wants the system to simply work as intended. No party has a problem with the way the system is supposed to work, but unfortunately, it currently does not work at all.

## Endnotes

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