Medicare Secondary Payer Reform Bills Distinguished

Two bills impacting workers' compensation related to Medicare Secondary Payer (MSP) provisions of federal law are in the process of review with congressional staff for potential consideration as part of end of year legislation. HR 1063 (SMART) Act introduced by Rep. Tim Murphy (R-PA) was marked up earlier this year and passed out of the House Energy and Commerce Committee by voice vote. Because HR 1063 amends Medicare, it must also be reviewed by the House Ways and Means Committee.

HR 5284, introduced by Rep. Dave Reichert (R-WA), addresses the WC MSA review process, and is also currently in review by House Ways and Means staff with a view to consider both of these bills together, pending scoring by the Congressional Budget Office (CBO).

HR 1063 passed out of the E&C committee with a $45 million positive score over the ten year budget period. The "score" for HR 5284 is pending with CBO. HR 5284 includes provisions that should generate additional revenue for Medicare by permitting the parties to a WC settlement to send WC MSA amounts directly to CMS to satisfy MSP obligations related to the settlement. This is seen as a viable option, particularly in small settlements when injured workers choose not to take on the responsibility of administering set-aside accounts. There is also a "safe harbor" provision in HR 5284 that would provide for direct payment to CMS. Medicare would benefit in these cases from receiving the full set-aside amount up front instead of relying on individuals to spend from set-aside accounts before seeking payment for medical services through Medicare at some future date.

We view HR 1063 and HR 5284 as complementary proposals that address different issues related to Medicare Secondary Payer provisions of federal law.

Attached is a side by side comparison of HR 1063 as it passed out of the Energy and Commerce Committee and HR284 as introduced.

UWC – STRATEGIC SERVICES ON UNEMPLOYMENT & WORKERS' COMPENSATION
910 17th Street, N.W., Suite 315, Washington, D.C. 20006
Phone (202) 223-8902 • Fax (202) 783-1616 • www.UWCstrategy.org

Issue	HR 1063: Strengthening Medicare and Repaying Taxpayers Act of 2011 (SMART Act)	HR 5284: Medicare Secondary Payer and Workers' Compensation Settlement Agreements Act of 2012
Qualified Set-Asides	Does not address	Adds a new subsection (q) to the MSP Act governing "qualified" set-asides. A settlement which includes a "qualified" set-aside satisfies all obligations under the MSP Act, and Medicare has no further recourse against the claimant or payer.
Settlements Subject to Conditional Payments	Not later than November 15 before each year, the Secretary shall calculate and publish a single threshold amount for settlements, judgments, awards or other payments for conditional payment obligations arising from each of liability insurance (including self-insurance) and for alleged physical trauma-based incidents (excluding alleged ingestion, implantation, or exposure cases) subject to this section for that year. Each such annual single threshold amount for a year shall be set such that the expected average amount to be credited to the Medicare trust funds of collections of conditional payments from such settlements, judgments, awards, or other payments for each of liability insurance (including self-insurance), workers' compensation laws or plans, and no fault insurance subject to this section shall equal the expected average cost of collection incurred by the United States (including payments made to contractors) for a conditional payment from each of liability insurance (including self-insurance) and alleged physical trauma-based incidents (excluding alleged ingestion, implantation or exposure cases) subject to this section for the year. At the time of calculating, but before publishing, the single threshold amount for a year, the Secretary shall inform, and seek review of, the Comptroller General of the United States with regard to such amount. The Secretary shall include, as part of such publication for a year— (i) the expected average cost of collection incurred by the United States (including payments made to contractors) for a conditional payment arising from liability insurance (including self-insurance) and from alleged physical trauma-based	Does not address

	incidents (excluding alleged ingestion, implantation or exposure cases; and (ii) a summary of the methodology and data used by the Secretary in computing each such threshold amount and such cost of collection.	
Settlement Subject to Set Aside	Does not address	Amends the Social Security Act by adding a new subsection (p) to the Medicare Secondary Payer (MSP) Act, which creates an exception to Medicare secondary payer requirements for certain workers' compensation settlement agreements. Settlements under threshold for consideration as primary plans subject to the MSP Act, such as: total settlement, including the sum of monetary wage replacement benefits, attorney fees, all future medical expenses, repayment of Medicare conditional payments, payout totals for annuities to fund the expenses listed above, and any previously settled portion of the workers' compensation claim, is $25,000 or less (includes both current and future Medicare beneficiaries); Claimant is not eligible for Medicare on the effective date of the agreement and is unlikely to become eligible within 30 months of the effective date of the agreement; claimant is not eligible for payment of medical expenses after the effective date of the agreement under the workers' compensation law of the jurisdiction; and/or the settlement does not extinguish the employer's responsibility for medical expenses after the effective date of the agreement.
Deadlines for List of Conditional Payments	Amends title XVIII (Medicare) of the Social Security Act with respect to any settlement, judgment, award, or other payment between a Medicare claimant and an applicable plan involving a payment made for items and services by the Secretary of Health and Human Services (HHS). Declares that, in the case of a payment made by the Secretary pursuant to clause (i) for items and services provided to the claimant, the claimant or applicable plan (as defined in paragraph (8)(F)) may at any time beginning 120 days before the	CMS has 90 days after receiving a request from a claimant or payer who is a party to the settlement, to provide documentation of conditional payments requiring repayment to the notifying party. The documentation must be sufficient for the claimant or payer to make a reasonable determination whether Medicare payments were for items or services provided in connection with the claimant's work related injury or illness. The claimant or payer may rely upon the provided documentation of this conditional payment amount. Payment

	reasonably expected date of a settlement, judgment, award, or other payment, notify the Secretary that a payment is reasonably expected, and the expected date of such payment. If the individual (or authorized representative) believes there is a discrepancy with the statement of reimbursement amount, the Secretary shall provide a timely process to resolve the discrepancy. Under such process the individual (or representative) must provide an alternate final conditional payment amount and documentation of the basis for such alternate amount. Within 15 days after the date of receipt of such documentation, the Secretary shall determine whether there is a reasonable basis for such alternate final conditional payment amount. If the Secretary does not make such determination within the 15-day period, then the alternate final conditional payment amount shall become the final conditional payment amount. If the Secretary determines within such period that there is not a reasonable basis for the alternate amount, the original final conditional payment amount is reconfirmed. If the Secretary determines within such period that there is a reasonable basis for an alternate final conditional payment amount, the Secretary must respond in a timely manner by agreeing to the alternative final conditional payment amount or by providing documentation showing with good cause why the Secretary is not agreeing to such amount and either reconfirming the original final conditional payment amount or establishing another alternative final conditional payment amount. In no case shall the process under this subclause be treated as an appeals process or as establishing a right of appeal for a statement of reimbursement amount and there shall be no administrative or judicial review of the Secretary's determinations under this subclause.	of the conditional payment amount, after a deduction for procurement costs and removal of unrelated and inappropriate items or services, completely discharges further liability regarding any conditional payments. If CMS fails to provide information within 90 days, neither the claimant nor the payer shall be liable for reimbursement.
Appeals of Conditional Payments	The Secretary shall promulgate regulations establishing a right of appeal and appeals process, with respect to any determination under this subsection for a payment made	Does not address

	under this title for an item or service for which the Secretary is seeking to recover funds from an applicable plan (as defined in paragraph (8)(F)) that is a primary plan under subsection (A)(ii), under which the applicable plan involved, or an attorney, agent, or third party administrator on behalf of such plan, may appeal such determination. The individual furnished such an item or service shall be notified of the plan's intent to appeal such determination.	
Appeals of Set Aside Determination	Does not address	The submitter may file a request for reconsideration within 60 days after the notice of determination. The steps are reconsideration by the Secretary, appeal to ALJ, and then appeal to federal district court. The Secretary must notify the parties to a reconsideration request of the Secretary's determination within 30 days of the request for reconsideration. The parties may appeal the determination on reconsideration within 30 days of receipt. If the Secretary fails to provide timely notice of the reconsideration determination the submission is deemed approved. An ALJ shall conduct and conclude a hearing on appeal and render a decision not later than 90 days after the request for hearing. A decision of an ALJ is appealable as a final administrative decision to federal court. If the ALJ fails to render a decision within the 90 days, the party requesting the hearing may seek judicial review.
Proportionality in Set Asides	Does not address	In the case of a compromise settlement agreement, a claimant or payer who is party to the agreement may elect (but is not required) to calculate the Medicare set-aside amount of the agreement by applying a percentage reduction to the Medicare set-aside amount for the total settlement amount that could have been payable under the applicable workers' compensation law or similar plan involved had the denied or contested portion of the claim not been subject to a compromise agreement. The percentage reduction would be equal to the denied or contested percentage of such total settlement. Such election

		may be made by a party to the agreement only with the written consent of the other party to the agreement. If the workers' compensation claimant or workers' compensation payer elects to calculate the Medicare set-aside amount under this clause, the Medicare set-aside shall be deemed a qualified Medicare set-aside.
Safe Harbor for Conditional Payments	Not later than 60 days after the date of the enactment of this subparagraph, the Secretary shall publish a notice in the Federal Register soliciting proposals, which will be accepted during a 60-day period, for the specification of practices for which sanctions will and will not be imposed under subparagraph (E), including not imposing sanctions for good faith efforts to identify a beneficiary pursuant to this paragraph under an applicable entity responsible for reporting information. After considering any public comments received during such period, the Secretary shall issue final rules specifying such practices.	Does not address
Safe Harbor for Set Asides	Does not address	A Medicare set-aside in the case of a compensation settlement agreement shall be deemed a qualified set-aside if the set-aside amount is a safe harbor amount of 15% of the total settlement amount and the agreed total settlement amount does not exceed $250,000. For purposes of the safe harbor provision, the total settlement amount shall exclude the repayment of conditional payments and previously settled portions of the claim. If such agreement includes an annuity, the cost (but not the payout of the annuity) shall be included in determining the total settlement amount. A Medicare set-aside under the safe harbor provision may not be treated as qualified unless the set aside amount is paid directly to the Secretary of HHS.
Civil Penalties for Conditional Payments	Makes discretionary rather than mandatory the current civil money penalty ($1,000) for an applicable plan's noncompliance with requirements to submit insurance information about a claimant.	Does not address

Statute of Limitations for Conditional Payments	Sets a three-year statute of limitations after notice of settlement or judgment on a Medicare secondary payer claim by the Secretary for reimbursement against an applicable plan that becomes a Medicare primary payer pursuant to a settlement, judgment, award, or other judicial action.	Does not address
Statute of Limitations for Set Asides	Does not address	The parties to a workers' compensation settlement agreement which met the provisions of section 1862(b) of the Social Security Act (42 U.S.C. 1395y (b)) on the effective date of settlement shall be accepted as meeting the requirements of such section notwithstanding changes in law, regulations, or administrative interpretation of such provisions after the effective date of such settlement. Nothing in section 1862(b) of the Social Security Act (42 U.S.C. 1395y (b)) shall authorize the Secretary of Health and Human Services to impose liability that is additional to the liability in effect on the date of the enactment of this Act with respect to a workers' compensation settlement agreement the effective date of which is before such date of enactment, except in the case of fraud.