Medicare Madness: New Rules, New Risks, and New Realities

October 2, 2025

Disclaimer

Agenda

Quick refresher on the law and regulations

- Who qualifies for Medicare
- Three components: Section 111 reporting, Conditional Payments, Medicare Set-Asides

Section 111 changes and how they may affect you

Conditional Payments – process and practical concerns

- Process
- Possible issues with the CMS setup of their collection models
- Possible pitfalls with Medicare Advantage (Part C) and Prescription Drug Plans (Part D)

Medicare Set-Asides

- Zero MSAs
- Current concerns

MSP Act

Original Medicare Act:

"(b) Payment under this title may not be made with respect to any item or service to the extent that payment has been made, or can reasonably be expected to be made (as determined in accordance with regulations), with respect to such item or service, under a workmen's compensation law or plan of the United States or a State. Any payment under this title with respect to any item or service shall be conditioned on reimbursement to the appropriate Trust Fund established by this title when notice or other information is received that payment for such item or service has been made under such a law or plan.

Congress added liability, no-fault and self-insurance plans to the exclusion

PUBLIC LAW 96-499—DEC. 5, 1980 94 STAT. 2647

MEDICARE LIABILITY SECONDARY WHERE PAYMENT CAN BE MADE UNDER LIABILITY OR NO FAULT INSURANCE

SEC. 953. Section 1862(b) of the Social Security Act is amended— 42 USC 1395y.

(1) by inserting "or under an automobile or liability insurance policy or plan (including a self-insured plan) or under no fault insurance" before the period at the end of the first sentence;

(2) by inserting ", policy, plan, or insurance" before the period at the end of the second sentence; and

(3) by adding at the end the following new sentence: "The Secretary may waive the provisions of this subsection in the case of an individual claim if he determines that the probability of recovery or amount involved in such claim does not warrant the pursuing of the claim.".

MSP amended from time to time

- 1982 – Medicare made secondary to GHPs
- 1987 – Government entities made primary for disabled employees covered by Medicare
- 1989 – Established penalties for noncompliance
- 1990, 1993 & 1997 – added ESRD provisions
- 1997 – Medicare+Choice created / also secondary payer
- 2003 – Medicare Modernization Act redefined self-insured, added Rx
- 2007 – Medicare, Medicare & SCHIP Extension Act created reporting requirement
- 2012 – SMART Act created primary payer appeal & certain conditional payment reimbursement improvements

Medicare's Exclusion from Payment Stems from Underlying State Law

- (2) Medicare secondary payer
- (A) In general
- ***Payment under this subchapter may not be made, except as provided in subparagraph (B)***, with respect to any item or service to the extent that—
- (i) [covered by GHP], or
- (ii) payment has been made or can reasonably be expected to be made under a workmen's compensation law or plan of the United States or a State or under an automobile or liability insurance policy or plan (including a self-insured plan) or under no fault insurance.

[i.e., to the extent that someone else is responsible for payment, therefore exclusion is actually driven by underlying ***state*** tort, WC, contract, etc. laws]

** NO COVERAGE UNDER STATE LAW, NO EXCLUSION

How do I know if someone is a Medicare beneficiary?

- Age 65+
- Social Security Disability award, after 30 month waiting period from date of disability (24 months after first disability check entitlement)
    - Reasonable expectation of Medicare entitlement is a lower bar – application triggers!
- **Can get this information from the beneficiary's local Social Security office – need SSA-3288 release to get the information**

Three Components to MSP Compliance

1. Reporting – Medicare beneficiaries with ORM (accepted medicals) and TPOC ("Total Payment Obligation to Claimant" = Settlement, judgment or award w/closure of medicals

2. Conditional Payments – Payments made by Medicare during pendency of claim must be repaid.[1] Trigger is ORM, settlement, judgment or award.[2] Payment must be made "in full" within 60 days of settlement.

3. Future Medical – Medicare excluded from payment when settlement clos

[1] 42 U.S.C. 1395y(b)(2)(B)
[2] 42 U.S.C. 1395y(b)(2)(B)(iii)

SECTION 111 REPORTING

- Query function:
  - Tells primary payer when someone is a beneficiary (has or had Medicare entitlement, shows in system about 3 months before entitlement)
  - 12/11/2021 – Tells primary payer last 3 years of Medicare Advantage and drug plans
- Online reporting system applicable to Medicare beneficiaries ONLY
  - Primary payer must report all ORM (ongoing responsibility for medical payments) and TPOC (total payment obligation to the claimant)
  - TPOC now includes the MSA amount, even if below Medicare's threshold for review

Practical Concerns with Section 111 Reporting

Medicare knows about your settlement, and how you addressed post-settlement medicals

Section 111 directly impacts both:

- Timing for addressing conditional payments; and
- Which party is the “debtor” in Medicare’s eyes

Benefits denials based on existence of MSA

- Where the treatment sought is unrelated

mln FACT SHEET

KNOWLEDGE • RESOURCES • TRAINING

Medicare Secondary Payer: Don't Deny Services & Bill Correctly

If claim services are unrelated to the MSP NGHP record found in the Medicare eligibility file, but the diagnosis codes match or are related to the diagnosis codes found in the NGHP record:

- Submit these claims to Medicare after you submit them to the appropriate GHP or NGHP insurer.
- The NGHP insurer may deny these claims if they're new claim services that are unrelated to the original accident or injury found on the eligibility response.
- When you get a claim denial from the NGHP, include the denial reason on the primary payer remittance advice on your claim to Medicare. We may pay depending on why the NGHP denied the claim.
- After you submit these claims to us, we may not pay the claim for service because the diagnosis codes are related to the diagnosis codes found on the NGHP MSP record on the eligibility response.
- Appeal the mistakenly denied claim with your MAC. Provide an explanation and relevant reason codes to justify the services aren't related to the accident or injury on record.
- Continue to provide services to your patient.

How to Bill When There's a Workers' Compensation Medicare Set-Aside Agreement

A Workers' Compensation Medicare Set-Aside (WCMSA) is an agreement between CMS and a patient. It determines how much of the settlement funds the WCMSA will spend for care related to all settled WC injuries or illnesses before we become the primary payer.

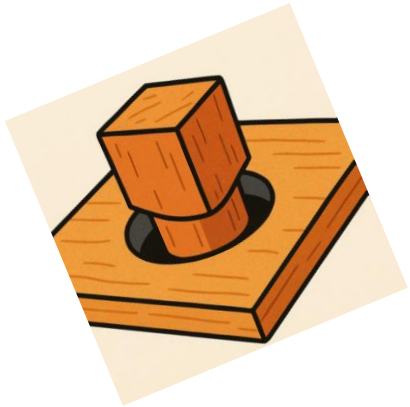
Use the Medicare eligibility transaction if there's an open or closed WCMSA MSP record:

- Ask your patient if they have other insurance that may be primary to Medicare. View the Medicare Questions to learn which questions to ask.
- If the patient has an active WCMSA record that pays for services related to the accident, bill the patient directly. If the remittance advice shows the primary insurer rejected the claim with reason code P3 (Workers' Compensation case settled), the patient is responsible to pay the claim. Contact the WC insurer if this information isn't accurate.
- If the WCMSA pays for some services but doesn't pay for all the services because benefits are exhausted, bill Medicare and show, on the claim, the amount WCMSA paid, and that the residual payment wasn't made because of benefit exhaustion.
- We'll then pay as a primary or secondary payer, depending on the WCMSA status and how much it paid on the claim.

Source: www.cms.gov/files/document/mln7748519-medicare-secondary-payer-dont-deny-services-bill-correctly.pdf

Conditional Payments

Collection Models

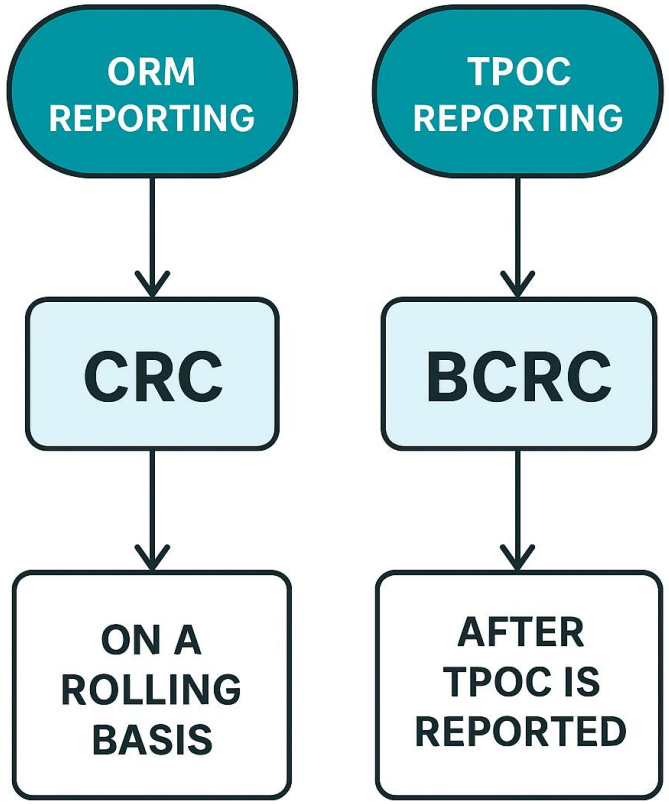


Repayment triggered by ORM or TPOC report

- ORM triggers recovery throughout pendency of claim *from primary payer*
- TPOC triggers payment after settlement/award *from beneficiary*

Two contractors

- CRC works ORM cases, collects from primary payer
- BCRC works TPOC cases, collects from beneficiary

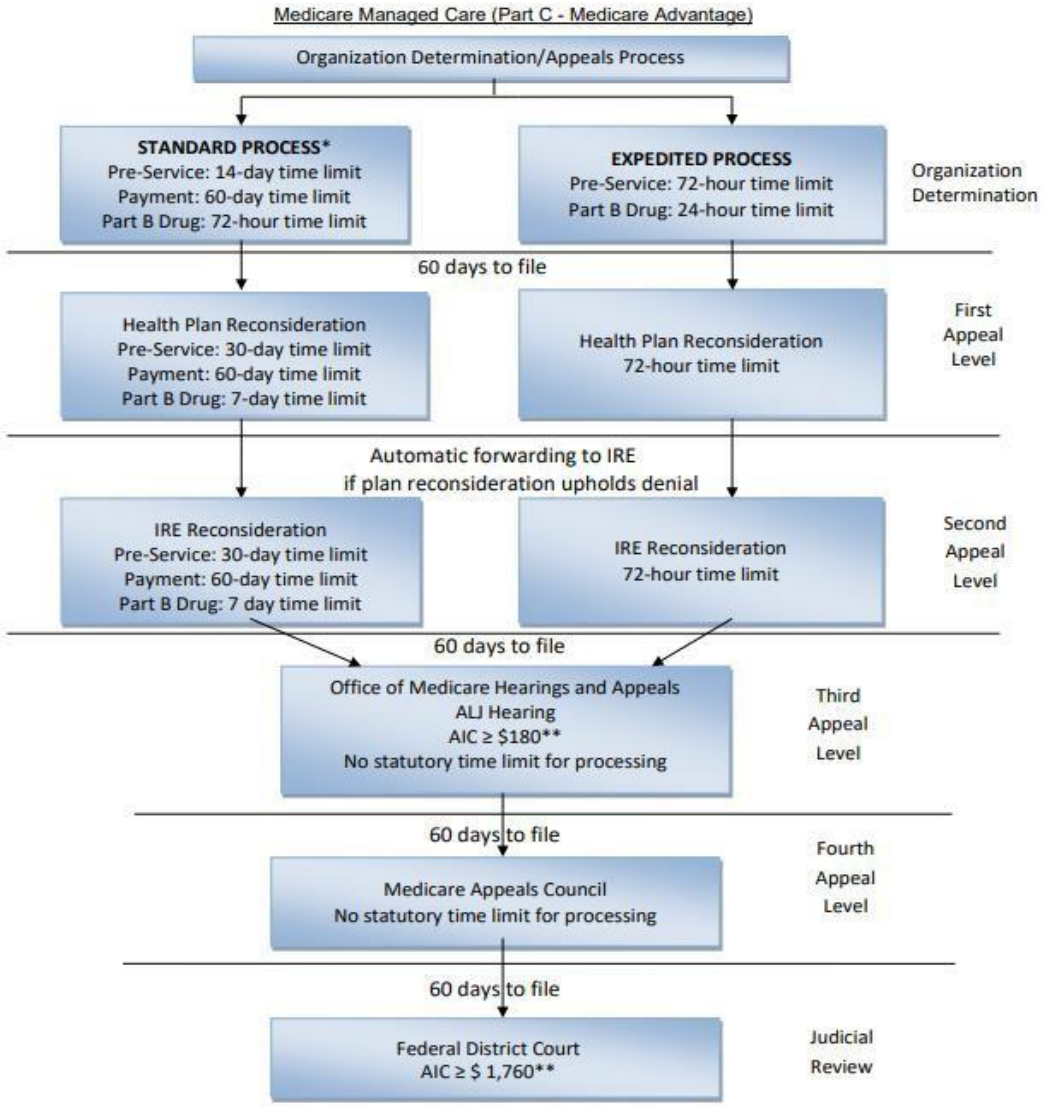


TRADITIONAL MEDICARE

CONDITIONAL PAYMENTS (CPs)

- Repayment required by statute within 60 days
- Collection options available – direct right of action (double damages), US Treasury garnishments, Private collection agents
- Very specific appeals process. If not followed, could mean defenses are lost.
- 3-year Statute of Limitations (SOL) for CPs after notice for traditional Medicare plans. No enumerated SOL for Medicare Advantage Plans.

Traditional Medicare Conditional Payment Recovery Process



AIC = Amount in Controversy / ALJ = Administrative Law Judge / IRE = Independent Review Entity
*Plans must process 95% of all clean claims from out of network providers within 30 days. All other claims must be processed within 60 days.
**The AIC requirement for an ALJ hearing and Federal District Court is adjusted annually in accordance with the medical care component of the consumer price index. The chart reflects the amounts for calendar year (CY) 2021.

Process

Sent to the Responsible Reporting Entity!!!

(Sometimes) Conditional Payment Letter (just explains how much is owed, can't pay off this)

Conditional Payment Notice

- Must be appealed within 30 days or a Demand issues

Demand

- Can be appealed, see flowchart
- 60 days to pay, else collections and high interest
- Sent to Treasury to collect if not disputed

US Treasury Collections

- Direct right of action, TOPS (offsets), Private Collection Agencies

Practical Concerns

Unrelated charges on the conditional payment listing

When the payer takes responsibility for conditional payments in settlement agreement (TPOC) - BCRC collection model

Post- settlement conditional payment demand

- Where ORM is not correctly reported
- Where ORM is not timely reported
- Where TPOC report is delayed (whether at next scheduled 3-month reporting, or later if accidentally delayed)
- Conditional payment “waiver” by Medicare - cannot be addressed until *after* settlement

Practical Concerns

Letters going to the claimant – Setting expectations

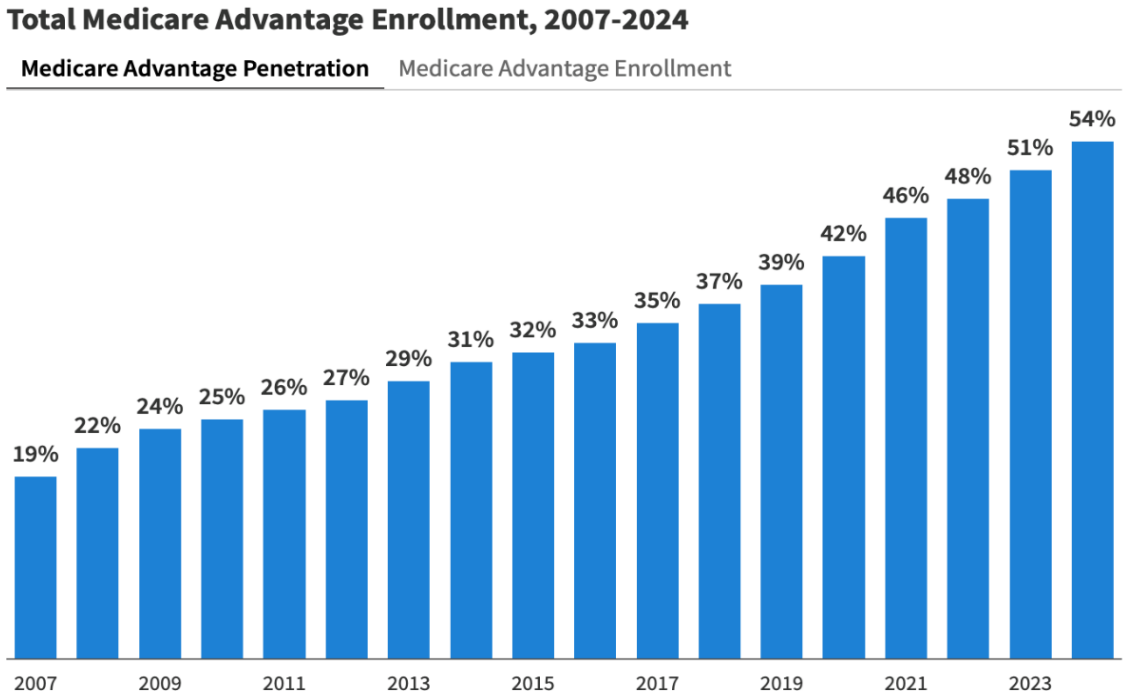
- At Section 111 termination
- Post-settlement ("My lawyer told me the insurance carrier was taking care of this!"

When Medicare a denied (or partially denied) case does not appear in the portal and you are at settlement

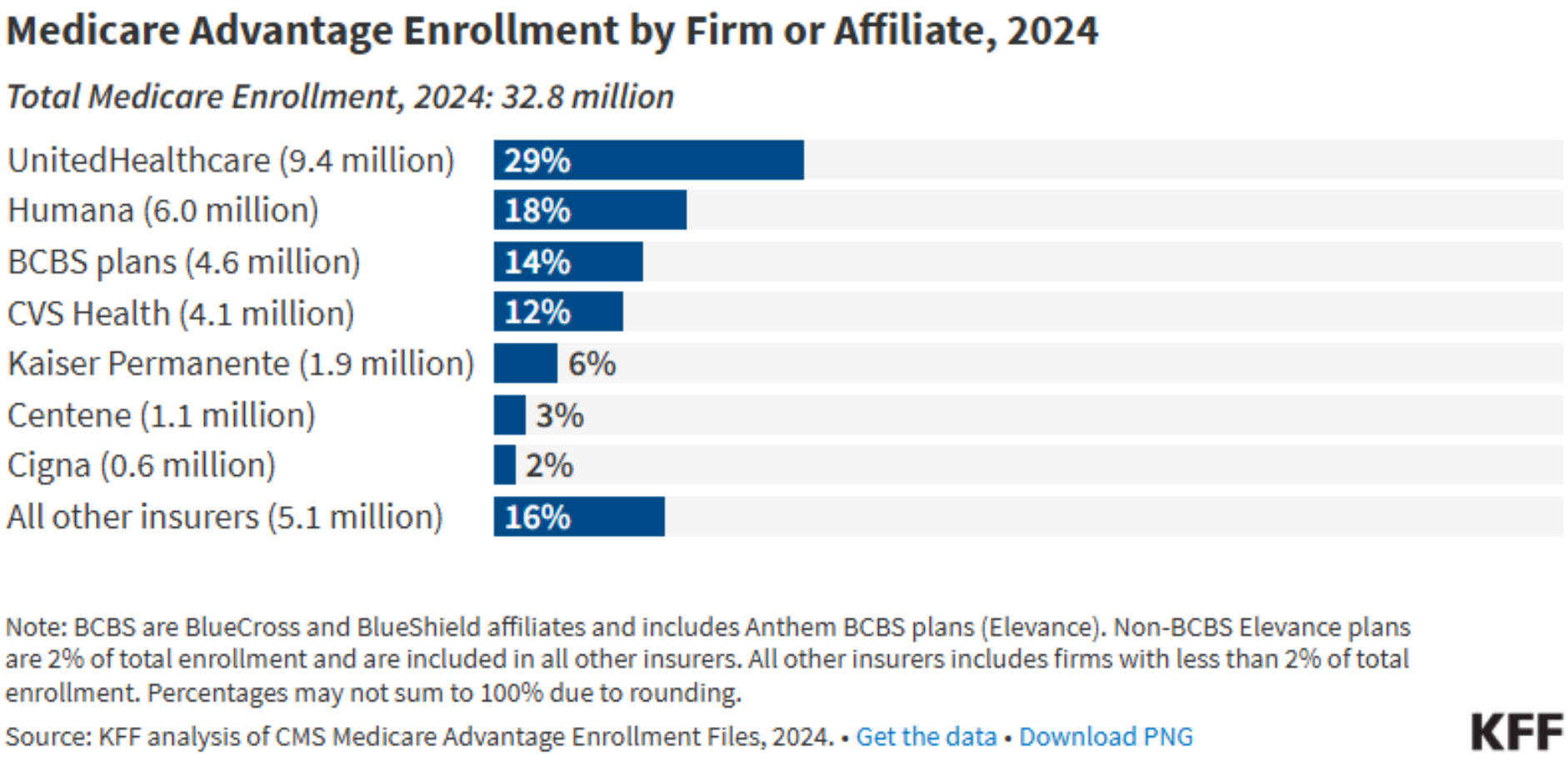
- "Beneficiary self-report":
  - Representatives: https://www.cob.cms.hhs.gov/MSPRP/ (can only be used for totally denied claims
  - Beneficiaries can access via Medicare.gov
  - Partially accepted case w/ORM – denied body parts must be reported to BCRC by phone: 855-798-2627

Medicare Advantage Plans

- Must cover at least what Medicare covers and may cover additional items and services
- 2024: >33 million Medicare beneficiaries had MAP plans
- MA enrollment more than doubled since 2007 (19% to 54%)
- CBO predicts that 74 million will be enrolled in MAP plans by 2034
- Expected transition of individuals from Medicaid to Medicare due to age
- Illinois has 157 MAP plans available to its residents



Medicare Advantage Plans



Do Medicare Advantage Plans (MAP) have the same rights of recovery as traditional Medicare?

- Essentially, yes.[3] There is a right to recover payments made:

> "a Medicare Choice organization may (in the case of the provision of items and services to an individual under a Medicare Choice plan under circumstances in which payment under this subchapter is made secondary pursuant to section 1395y (b)(2) of this title) charge or authorize the provider of such services to charge, in accordance with the charges allowed under a law, plan, or policy described in such section—
>
> > (A) the insurance carrier, employer, or other entity which under such law, plan, or policy is to pay for the provision of such services, or
> >
> > (B) such individual to the extent that the individual has been paid under such law, plan, or policy for such services.

[3] 42 U.S.C. 1395w-22(a)(4)

MAP Recovery (cont.)

- No published Statute of Limitations
- No formal appeals process for these plans
- Handled through the individual plan – no centralization
- Some plans have no recovery programs
- *Humana* then *MSP Recovery* cases – trend toward plans seeking double damages where MAP plan not notified of the settlement and/or repaid
- THIS IS CURRENTLY THE AREA WITH THE MOST LITIGATION

How do I know whether someone has a Medicare Advantage or prescription drug plan?

- As of 12/11/2021, query function the claim handler has access to will show us the last 3 years of plans

**** Practice point:*** **Get updated info every 2-3 years on "old dog" claims**

**** Practice point:*** **Put plan on notice – query gives plan's address but keep in mind this is not likely to be the subrogation address for the plan**

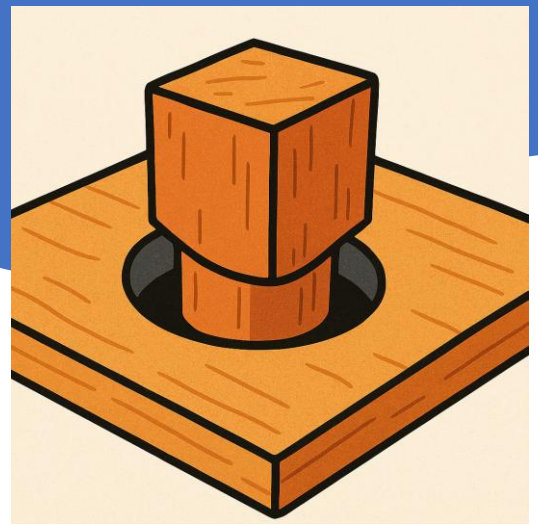
Practical Concerns with Non-Traditional Medicare Plans

Identify Medicare plan(s)	Identify if any MA Plan existed during course of case	Settlement –	Trial -
• Query will show last 3 years of plans	• Request conditional payment information from each plan • Section 111 report does not necessarily trigger the plan to collect • Dispute any unrelated charges • These plans will negotiate	• Who reimburses? • Section 111 report does not necessarily mean you will get an itemization • Settlement contract language to cover all contingencies	• DWD's decision is effectively binding on Medicare Advantage, but you may need to explain that to the plan

Future Medical – Medicare Set-Asides

- Applies only when medicals are closed
- For now, MSA review process only applies to WC cases
- Should cover Medicare-covered expenses reasonably anticipated post-settlement which would be covered under state law

Zero (unfunded) MSAs



Source: WCMSA Reference Guide, version 4.4, July 14, 2025

4.2 Indications That Medicare's Interests Are Protected

Submitting a WCMSA proposed amount for review is never required. But WC claimants must always protect Medicare's interests. A WCMSA is not necessary under the following conditions because when they are true, they indicate that Medicare's interests are already protected:

a) The facts of the case demonstrate that the injured individual is only being compensated for past medical expenses (i.e., for services furnished prior to the settlement); and

b) There is no evidence that the individual is attempting to maximize the other aspects of the settlement (e.g., the lost wages and disability portions of the settlement) to Medicare's detriment.

These conditions may be demonstrated through one of the following:

- The individual's treating physician documents in medical records that to a reasonable degree of medical certainty the individual will no longer require any treatments or medications related to the settling WC injury or illness; or
- The workers' compensation insurer or self-insured employer denied responsibility for benefits under the state workers' compensation law and the insurer or self-insured employer has made no payments for medical treatment or indemnity (except for investigational purposes) prior to settlement, medical and indemnity benefits are not actively being paid, and the settlement agreement does not allocate certain amounts for specific future or past medical or pharmacy services as a condition of settlement; or
- A Court/Commission/Board of competent jurisdiction has determined, by a ruling on the merits, that the workers' compensation insurer or self-insured employer does not owe any additional medical or indemnity benefits, medical and indemnity benefits are not actively being paid, and the settlement agreement does not allocate certain amounts for specific future medical services; or
- The workers' compensation claim was denied by the insurer/self-insured employer within the state statutory timeframe allowed to pay without prejudice (if allowed in that state) during investigation period, benefits are not actively being paid, and the settlement agreement does not allocate certain amounts for specific future medical services.

How can I get a zero MSA?

(1) Letter from the treating doctor certifying that treatment for the alleged injury related to the settlement has been completed as of the date of the settlement, and that future medical items and/or services for that injury will not be required. (Sometimes works)

(2) Disputed claim where ALL the following are true:

- no medical or indemnity payments made prior to settlement (no advances!);
- medical and indemnity are not actively being paid;
- settlement contract not yet approved; AND
- no allocation or agreement to pay medical bills or allocate future medical money in the settlement.

Do these “non-submit” / “certified” MSAs protect employers? Employees?

- Medicare must exclude payment for items and services where payments have been made
- MSA review process is a “voluntary” one BUT…

4.3 The Use of Non-CMS-Approved Products to Address Future Medical Care

A number of industry products exist with the intent of indemnifying insurance carriers and CMS beneficiaries against future recovery for conditional payments made by CMS for settled injuries. Although not inclusive of all products covered under this section, these products are most commonly termed “evidence-based” or “non-submit.” 42 C.F.R. 411.46 specifically allows CMS to deny payment for treatment of work-related conditions if a settlement does not adequately protect the Medicare program’s interest. Unless a proposed amount is submitted, reviewed, and approved using the process described in this reference guide prior to settlement, CMS cannot be certain that the Medicare program’s interests are adequately protected. As such, CMS treats the use of non-CMS-approved products as a potential attempt to shift financial burden by improperly giving reasonable recognition to both medical expenses and income replacement.

As a matter of policy and practice, CMS will deny payment for medical services related to the WC injuries or illness requiring attestation of appropriate exhaustion equal to the total settlement less procurement costs before CMS will resume primary payment obligation for settled injuries or illnesses. This will result in the claimant needing to demonstrate complete exhaustion of the net settlement amount, rather than a CMS-approved WCMSA amount.

Practical Concerns with MSAs

Initially accepted cases, later denied

MSA submission process is voluntary, not mandatory

MSA Development Letters

Last two years of treatment records, when last two years are not related

Statute of Limitations for medical payments (WI: 6 or 12 years)

Pay without prejudice arguments

Expense ledgers

Non-submit MSAs

Voluntary process

What protection is really offered?

Post-settlement treatment denials by medical providers

For related treatment

For unrelated treatment

Correction of reported Section 111 codes

Settlement language

Private Cause of Action language –

- In the event that Medicare is not timely reimbursed, the private cause of action mechanism allows actions for federal suit for ***double*** the amount initially paid by Medicare against the primary payer. 42 USC §1395(y)(b)(3)(A).
- Beneficiaries and personal representatives of a beneficiary's estate have been determined to have POCA standing under the MSP Act. *See, e.g., Stalley v. Catholic Health Initiatives,*
- Waiver of rights under *42 USC* §1395(y)(b)(3)(A) included in settlement terms

Conditional payments

- Who is responsible for payment?
- How will that work in practice?
- Cooperation of beneficiary for releases, obtaining medical records (esp. those not related to the claim), sending letter to carrier/attorneys in timely fashion


Questions?