HCFA Rulings

Department of Health
and Human Services

Health Care Financing
Administration

Ruling No. 94-1 | Date: April 1994

HCFA Rulings are decisions of the Administrator that serve as precedent final opinions and orders and statements of policy and interpretation. They provide clarification and interpretation of complex or ambiguous statutory or regulatory provisions relating to Medicare, Medicaid, Utilization and Quality Control Peer Review, and related matters.

HCFA Rulings are binding on all HCFA components, the Provider Reimbursement Review Board and Administrative Law Judges who hear Medicare appeals. These decisions promote consistency in interpretation of policy and adjudication of disputes.

This Ruling announces the Health Care Financing Administration's policy regarding Medicare payment if an entity required or responsible to pay primary benefits is bankrupt or insolvent. Under these circumstances, HCFA will not make Medicare conditional primary payments. Also, HCFA will not make Medicare secondary payments in advance, but will determine the amount of Medicare secondary payments after the conclusion of the bankruptcy or insolvency proceedings.

HCFAR 94-1-1

MEDICARE PROGRAM

Hospital Insurance Benefits (Part A) Program and Supplementary Medical Insurance (Part B) Program

Policy Regarding Medicare Payments in the Event a Primary Payer Is Bankrupt or Insolvent

Purpose: This Ruling sets forth the Health Care Financing Administration's (HCFA's) policy regarding Medicare payment if an entity required or responsible to pay primary benefits is bankrupt or insolvent and cannot make the contracted primary payment. This Ruling provides notice that Medicare will not make conditional primary payments nor will Medicare make secondary payments in advance in the event that a primary payer fails to pay benefits because of bankruptcy or insolvency. This decision is consistent with section 1862(b)(2)(A) of the Social Security Act (the Act), which states that payment may not be made when payment has been or can reasonably be expected to be made, by a primary payer. In the case of a bankrupt or insolvent primary payer, this provision would apply to the entity or entities (for example, the State guaranty fund, reinsurer, bankruptcy trustee, receiver, or estate) that are responsible for settling and/or paying the

outstanding debts of the bankrupt or insolvent primary payer. Section 1862(b)(2)(B)(i) of the Act authorizes

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conditional payments, with the understanding that the Trust Fund will be reimbursed if it is determined that payment has been made or could reasonably be expected to be made by a third party payer. Therefore, the Medicare program is under no obligation to make conditional payments.

Citations: Section 1862(b)(2) of the Social Security Act (42 U.S.C. 1395y(b)(2)); 42 CFR §§ 411.20, 411.24(e) and 424.44.

Pertinent History: A Medicare beneficiary died after incurring medical expenses of approximately $39,000 in connection with her terminal illness. Before her death, the providers that furnished her services had filed Medicare claims under their Medicare provider agreements, and the physicians and other suppliers that furnished her services had filed Medicare claims on an assignment-related basis. The Medicare contractors denied the Medicare claims of the providers, and physicians and other suppliers because a private health plan, the XYZ Trust, was her primary coverage. The providers, and physicians and other suppliers then filed claims with the Trust. Shortly after the beneficiary's death, however, the Trust became insolvent and was placed in the hands of a receiver, the State Commissioner of Insurance. In this particular State (Georgia), State law requires the receiver to give potential claimants, including those who had already filed claims with the Trust, written notice

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of the right to file claims with the receiver. A period of 6 months must then be allowed for the claims to be filed. Thereafter, it takes a year and a half or more for the receiver to marshal the assets of the Trust and to process the claims. The receiver may then be able to make only a fractional payment, perhaps as little as 10 cents for each dollar value of the claims. During the liquidation process, however, the providers, and physicians and other suppliers have filed claims with the beneficiary's estate and are dunning the beneficiary's husband for payment.

The questions being raised in this case are as follows:

- Will Medicare make a conditional primary payment if a third party payer fails to pay primary benefits in accordance with its contract because the company has become bankrupt or insolvent?
- In bankruptcy or insolvency cases, will Medicare make a secondary payment before the liquidation process is completed?
- After the bankruptcy or insolvency has been resolved, how will Medicare secondary payments, if any, be determined?

HCFA's policy in bankruptcy and insolvency situations is that -- (1) Medicare will not make any payment until the liquidation process is completed; and (2) Medicare will not make a secondary

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payment in advance of a determination of the appropriate primary payment. HCFA's policy is consistent with the provisions in section 1862(b)(2)(A) of the Act and 42 CFR §411.20, which provide that Medicare payment may not be made to the extent that payment has been made, or can reasonably be expected to be made, by a primary payer. Section 1862(b)(2)(A) defines a "primary plan" (that is, the primary payer) to mean a group health plan or large group health plan.

When an entity required or responsible to pay primary benefits becomes bankrupt or insolvent, Medicare payment may not be made to the extent that payment can reasonably be expected to be made by-- (1) the bankrupt or insolvent entity required or responsible to pay; or (2) the entity or entities responsible for settling and/or paying the outstanding debts of the bankrupt or insolvent entity, as determined in the liquidation process. (Entities required to pay or responsible for paying primary benefits include employers, insurance carriers, plans, or programs, and third party administrators (42 CFR § 411.24(e)).) Whether the entity is able to make a primary payment, and the amount of the primary payment, is not determined until the end of the liquidation process.

Section 1862(b)(2)(B)(i) of the Act provides that all Medicare payments are conditioned on reimbursement to the appropriate

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Medicare Trust Fund when notice or other information is received that payment for the item or service has been or could be made by a primary payer. The law, however, does not obligate Medicare to make conditional payments. We have determined that conditional primary payments shall not be made in cases involving bankrupt or insolvent entities required or responsible to pay primary benefits. The administrative procedures that would be involved in tracking bankruptcy or insolvency cases through the lengthy liquidation process would be extremely costly, burdensome, and time-consuming. Further, there is no certainty that Medicare would be able to recover any payment that may be due it at the end of the process. Thus, it would not be appropriate for Medicare to make conditional payments in cases involving bankrupt or insolvent entities that are required or responsible to pay primary.

Participating providers, and physicians and other suppliers that have accepted assignment, may not during the liquidation process collect or seek to collect from the beneficiary, or the beneficiary's estate, charges for Medicare-covered services. Under the terms of the Medicare provider agreement and the terms of the Medicare assignment, the providers, and physicians and other suppliers may bill the beneficiary (or the beneficiary's estate) only to establish a legal claim for future collection of

charges, and not for purposes of currently collecting charges from the beneficiary or the beneficiary's estate.

Regarding Medicare secondary payments before the conclusion of the liquidation process, there is no way to determine the proper amount of the secondary payment since there would not be a determination of what funds are available from the bankrupt or insolvent entity. Also, there would be no Explanation of Benefits or similar statement available upon which to base a Medicare secondary payment. Therefore, any estimates for payment made in advance would be speculative.

A Medicare secondary payment may be made after the conclusion of the liquidation process if-- (1) the payment made on behalf of the bankrupt or insolvent entity responsible for paying primary benefits is less than the amount of the charge and less than the amount Medicare would have paid as the primary payer; and (2) the provider, and physician or other supplier is not required to accept that payment as full discharge of the liability of the beneficiary (or the estate) for the bill.

At the conclusion of the liquidation process, the amount of the Medicare secondary payment will be computed by the Medicare contractor based on the amount of the primary payer's liability, as determined by the receiver. To determine the amount of

Medicare secondary payment, the Medicare contractor must obtain specific information from the receiver regarding the terms of the payments made by the receiver on behalf of the primary payer.

One possibility is that the Medicare secondary payment may be computed based on the amount the receiver pays on behalf of the bankrupt or insolvent entity as partial satisfaction of the entity's liability for primary payment. In effect, this would mean that the Medicare secondary payment would make up for the liability of the primary payer that was not satisfied because of lack of funds.

> Example: A participating physician furnishes a service for which the approved charges of the primary payer and of Medicare are $100 and $90, respectively. The primary payer would normally pay 80 percent of $100, or $80, and Medicare would make a secondary payment of $100 minus $80, or $20. However, the primary payer is bankrupt and, after a long delay, its receiver pays the physician only $32. Medicare pays the physician $100 minus $32, or $68, which is $48 more than its normal liability (that is, $68 minus $20).

A second possibility is that the fractional payment made by the receiver must be accepted as full discharge of the amount the primary payer would have been obligated to pay were it not bankrupt or insolvent. In the above example, the receiver might

determine that the $32 it pays fully discharges the liability of the primary payer for the $80 the primary payer would have paid if it were solvent. In this situation, the Medicare secondary payment amount may be the amount payable had the receiver paid the full primary payment, that is, Medicare would pay only $100 minus $80, or $20.

The third possibility is that the provider, and physician or other supplier may be required to accept the fractional payment as full discharge of the entire bill. In the above example, the receiver might determine that the physician must accept the $32 it pays as full discharge of the liability of the estate for $100. In this case, Medicare would make no secondary payment.

Once the liquidation process has been completed, the providers, and physicians or other suppliers can file Medicare secondary claims. The time limit on filing the claims will be the later of the following: (1) the usual time limit specified in regulations for filing Medicare claims (that is, on or before December 31 of the calendar year following the year in which the services were furnished if the services were furnished during the first 9 months of a calendar year, or on or before December 31 of the second calendar year following the year in which the services were furnished if the services were furnished during the last 3 months of the calendar year (42 CFR § 424.44(a))); or (2) the

last day of the 6th calendar month following the month of the written notice by the bankrupt or insolvent entity to the provider, and physician or other supplier of the primary benefits payable. After the claims have been filed, the Medicare contractor will make the appropriate Medicare secondary payment.

Participating providers, and physicians and other suppliers that have accepted assignment should file claims with a receiver as soon as possible. The receiver will determine the payments that can be made on behalf of the bankrupt or insolvent entity. The providers, and physicians and other suppliers will receive any available primary payment from the receiver, and can then file Medicare claims to obtain the appropriate secondary payments, if any. After the Medicare secondary claims have been processed, any remaining liability (for example, deductibles, coinsurance, and payment for non-covered services) of the beneficiary (or of a deceased beneficiary's estate) can be determined and pursued by the providers, and physicians and other suppliers. However, remaining liability, if any, cannot be pursued if a receiver orders that the allocated fractional payment must be accepted as full discharge of the entire bill.

Although the factual situations described in this Ruling have involved only claims from providers, and physicians and other suppliers who accepted assignment, this Ruling also applies to

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claims from beneficiaries and their estates. HCFA will not make Medicare conditional primary payments or Medicare secondary payments to any entity in advance of the conclusion of the applicable bankruptcy or insolvency proceedings.

Ruling: It is HCFA's determination that if an entity required or responsible to pay primary benefits becomes bankrupt or insolvent, Medicare will not make conditional primary payments. Further, Medicare will not make a secondary payment in advance of a determination of the appropriate primary payment. A secondary payment may be made after the conclusion of the liquidation process if the payment made on behalf of the bankrupt or insolvent entity responsible for paying primary benefits is less than the amount of the charge and less than the amount Medicare would have paid as the primary payer, and the provider, and physician or other supplier is not required to accept that payment as full discharge of the liability of the beneficiary (or the estate) for the bill. This Ruling is applicable to any entity filing a claim for Medicare benefits, including providers, and physicians and other suppliers, and beneficiaries.

Participating providers, and physicians and other suppliers that have accepted assignment, may not during the liquidation process collect or seek to collect from the beneficiary, or the beneficiary's estate, charges for Medicare-covered services.

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Under the terms of the Medicare provider agreement and the terms of the Medicare assignment, providers, and physicians and other suppliers may bill the beneficiary (or the beneficiary's estate) only to establish a legal claim for future collection of charges, and not for purposes of currently collecting charges from the beneficiary or the beneficiary's estate.

EFFECTIVE DATE

This Ruling is effective April 18, 1994.

Dated: April 18, 1994

Bruce C. Vladeck,
Administrator, Health Care
Financing Administration.