GOVERNMENT INSURERS STUDY NOTE
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INTRODUCTION

Nyce [1] provides an excellent introduction to government insurance including the five main reasons for government insurance, which are summarized in this study note.

Both the federal and state governments are involved in insurance as regulators of insurance companies and as insurers. As insurers, they participate in a number of insurance programs either as the sole insurer, in partnership with insurance companies or in competition with insurance companies. Several major programs that are discussed elsewhere in the syllabus include the National Flood Insurance Program, Social Security, Guaranty Funds, FAIR plans, TRIA, and various state Auto Plans. In this study note, we will discuss state and federal involvement in Workers Compensation Insurance, Crop Insurance, and Unemployment Insurance.

Is government participation in insurance necessary? According to Greene and Weining, there are several reasons for government participation in insurance:

- Filling insurance needs unmet by private insurance
- Compulsory purchase of insurance
- Convenience
- Greater efficiency
- Social purposes

Filling Insurance Needs Unmet by Private Insurance

According to Nyce [1] and Greene [2], one justification for government participation in insurance is the residual market philosophy, with governments offering insurance in markets unserved by private insurance; either because of unavailability or affordability. One implication of the residual market philosophy is that government requirements for insurability are different from private insurers' requirements. A government may step into situations in which private insurers do not because the government has the financial capacity to subsidize losses, either by directly taxing taxpayers for the insurance program even those who do not benefit from the program, or indirectly by charging less than the actuarial cost of providing insurance coverage for the exposure and making up the difference through government-provided funds (crop / flood). There are strong arguments, both pro and con, as to whether a government should provide this type of subsidy.

Begun in 1968, the Federal Crime Insurance Program was intended to provide coverage for homeowners and small businesses located in neighborhoods with high crime rates, primarily because private insurance for burglary or robbery was not available at affordable rates for these risks. With proper loss prevention methods, this insurance was available from the private market at rates less than the government rates and the Federal Crime Insurance Program expired in 1995.

Crop insurance and Flood insurance are available and affordable only because of subsidies from the federal government.

Compulsory Purchase of Insurance

Government may require individuals or businesses to obtain insurance to meet social responsibilities. A driver who causes an automobile accident is responsible for repairing the damage or injury caused by the accident. Many people would not have the financial resources to meet this obligation without insurance protection. An employer is deemed responsible for injury to an employee regardless of fault. Again, without insurance protection an employer may not be able to meet this obligation. Without a compulsory insurance requirement, some persons who have suffered injury or loss may not have the costs of repairing the damage to their property or their medical costs covered by the person responsible for these costs.

Since purchase of insurance such as workers compensation or automobile insurance may be compulsory, some state legislatures felt obliged to offer the insurance to individuals who could not find a private market [2]. The workers compensation state funds established in several states and the Maryland Automobile Insurance Fund are examples of this philosophy. Another reason why some federal and state legislators believe that government should provide compulsory insurance is that private companies should make only limited profits, given the government guaranteed market. A government program would operate as a not-for-profit entity and the cost of the compulsory insurance would be lower than if offered by a for-profit insurer. In other non-insurance government mandated programs such as highway construction contracts, private organizations often service the program. Within a purely competitive market excessive profits cannot persist in the long run. Private insurance seems to work for most states in supplying the vast majority of the public with compulsory insurance such as workers compensation and auto insurance.

While workers compensation insurance is administered by a monopolistic state fund in a few states, most states have private companies that offer workers compensation insurance, sometimes in competition with state-run funds that will provide coverage to anyone who applies for coverage to the fund, sometimes referred to as “take all comers.” For those states without a state fund, and some with a state fund, there is usually some other form of residual market that provides coverage to those who are unable to find the required coverage with a private insurer.

For compulsory auto insurance, government insurance is normally not the answer; so provisions are in place to make auto insurance available for those unable to buy insurance on the open market. Sometimes these alternate sources also provide the coverage at costs below the actuarial cost of providing the coverage. In these situations, insurers, other insureds or taxpayers subsidize part of the cost of the coverage for high risk drivers. Hamilton and Ferguson [3] discuss these provisions, which include assigned risk plans, reinsurance facilities, and joint underwriting associations depending on the state. Maryland has the only state-owned auto insurance company.

Convenience

Some government insurance programs are established because it appears to be easier for the government to set up a program quickly as a legislature can appropriate funding for the new program, whereas the private market may take longer to find the necessary funding [3]. A government program may also be already set up to provide certain types of services needed by the insurance program. These services include loss mitigation development and funding, as the Florida legislature did when establishing the Florida Hurricane Catastrophe Fund.

Using government insurance programs only for convenience may not be justified if the private market is willing and able to provide a reasonable market.

Greater Efficiency

One argument in favor of government insurance is that there is greater efficiency than in the private market [2]. Some government insurance programs may be established because of the belief that government can provide the service at a lower cost than the private market. However, the costs of providing insurance, including the costs of keeping records, providing consumer education, issuing policies and paying claims, exist even in government insurance programs. Services such as explaining coverages, keeping records, and handling claims questions are still provided by customer service representatives (who must be compensated). The cost savings claimed for government insurance programs might be overstated because other government departments may perform services on behalf of the government insurance entity that are usually performed by insurance companies, including appraising property, administering claims, or making investments.

Social Purposes

The use of government insurance to achieve social purposes may be the main reason for government insurance programs [3]. Some feel that these social purposes can only be fully achieved within government-owned insurance programs. For example, rehabilitation and vocational training of injured workers are important goals of a workers compensation system and requirements for loss mitigation in catastrophe insurance plans may be more easily accomplished under government insurance programs. Can private insurance programs accomplish the same goals? If Social Security benefits were made available

through a welfare program for the truly needy elderly and disabled while pension plans, 401(k)s, life insurance and disability insurance were to be used to fill the needs of others, would adequate protection for retirement and the disabled be available? If building codes and zoning requirements could be altered to prevent construction in flood-prone areas would private insurers be willing to provide flood coverage? In this scenario, government flood insurance would still be needed for existing buildings in the flood zones, but the need for government flood insurance on new construction would be reduced.

Level of Government

The government (either state or federal) can be involved in three levels as either exclusive insurer, partner with private insurers or as a competitor to private insurers. As an exclusive insurer the government functions as a primary insurer by collecting premiums, providing coverage and paying all claims and expenses. An example of this at the federal level is Social Security and at the state level with some state government-run workers compensation programs.

In partnership with private insurers the government offers reinsurance coverage on specific loss exposures for which the private insurer may retain only a portion of the loss. Examples of this at the federal level are National Flood insurance program, Terrorism Risk Insurance Program and Federal Crop insurance. On the state level this includes several programs to address residual markets where the insured cannot find coverage on the open market. Examples of this are Fair Access to Insurance Requirements (FAIR) plan, Workers Compensation, Windstorm plans and Residual Auto Plans.

In some cases the states operate in direct competition to private insurers such as in the Workers Compensation market in some states.

Detail of the various government insurance plans are provided in this document or in other readings on the Syllabus.

Evaluation of Government Insurance Programs

How well have the federal and state governments performed in providing insurance? According to Greene [2] the questions to be asked are:

- Is the provision of the insurance by the government necessary or does it achieve a social purpose that cannot be provided by private insurance?
- Is it insurance or a social welfare program? Social welfare is designed to provide benefits to qualified people based on demonstrable need for assistance without any payment or contribution by those receiving assistance. These benefits are usually financed by general tax resources. The public welfare programs are an example of social welfare.
- Is the program efficient, is it accepted by the public?

Based on experience in 2004, 2005 and 2012 how is the Federal Flood Insurance Program performing? The rates don't seem to be actuarially sound; insurance is usually only purchased if required by law or mortgage companies; people who do not buy flood insurance seem to be getting federal disaster assistance. With appropriate rates, enforceable building codes, up-to-date flood maps, and available reinsurance could private insurance companies provide flood insurance?

In the following sections, we will discuss several government insurance programs, how they work, their origin and purpose, and their effectiveness.

CROP INSURANCE

The Federal Crop Insurance Program is operated by the Federal Crop Insurance Corporation (FCIC), a wholly owned corporation of the U.S. Department of Agriculture (USDA). In 1996 the USDA created the Risk Management Agency (RMA) to operate and manage the FCIC [4]. The RMA subsidizes the cost of the insurance program that provides protection to farmers against losses to their crops caused by natural disasters such as drought, hail and flood, as well as against market risks. Insurance policies are sold and serviced by private insurers and the losses are reinsured by the federal government. According to the Congressional Budget Office [5], because the risks are not shared proportionally, the private insurers generally have realized underwriting gains while the federal government has realized underwriting losses. Eldon Gould [6], Administrator of the RMA and manager of the FCIC, estimated that insurers would have an underwriting gain of $850 - $900 million in 2005, a return on retained premium of approximately 30%. This would follow gains of $700 million in 2004 and $380 million in 2003 and an underwriting loss of $46 million in 2002.

In addition to reinsuring the losses, the RMA subsidizes the premium paid by the participating farmers and reimburses the participating insurers for their administrative costs. The RMA hopes that the subsidies will induce large numbers of people to buy the insurance and thus protect themselves and thereby protect society from the loss of their vital contribution should disaster strike.

In spite of the existence of some form of federal crop insurance since 1938, the federal government has periodically had to pass disaster bills. From 1994 – 1999, the federal government spent an average of $1.5 billion per year in crop subsidies. Farmer participation in the crop insurance program increased during these years, but not enough to reduce the need for disaster assistance. Many farm groups felt that the crop insurance program did not provide adequate coverage when natural disasters occurred. Opponents of the federal crop insurance program felt that the subsidies provided by the government encourage overproduction [7]. In 2000, the Agricultural Risk Protection Act (ARPA) overhauled the federal crop insurance program to address these concerns. ARPA increased the portion of the premium paid by the federal government and improved the coverage available to farmers affected by multiple years of natural disasters.

Prior to the passage of the ARPA, many agricultural producers maintained crop insurance coverage only at the catastrophic level or coverage that would indemnify a farmer for only 27.5% of the value of a total loss. To encourage higher levels of coverage, the ARPA increased premium subsidies. The level of crop insurance coverage purchased is a percent of the expected crop production, as determined by the RMA. For example, if a farmer purchases insurance at the 70% coverage level and the actual crop production is less than 70% of the expected level, the farmer receives an indemnity payment. At this level of coverage, the premium subsidy under ARPA is 59%. Prior to ARPA, the premium subsidy was 24%.

The increase in subsidies appeared to accomplish one of the goals of increasing participation in the program at higher levels of coverage. In 2002, over 50% of the insurable acreage was insured at 70% or higher compared to 9% coverage in 1998 [7]. The increase in subsidies contributed to better coverage as catastrophic coverage, which accounted for 21% of the crop insurance program's liability in 2000, and was down to 16% of the program's liability in 2005. Catastrophic coverage is available to farmers at no premium charge, just an administrative fee. During this same period, from 2000 to 2005, the number of in-force policies dropped but the number of covered acres increased.

The experience of the crop insurance program has improved in recent years. The program's average loss ratio for 1981 to 1990 was 153% and has fallen to 93% from 2001 to 2005.

In 2005, RMA revised the reinsurance agreements to lower the reimbursement rate to insurers for administrative and operating expenses and a rebalancing of the risk shared by the government and private insurers. Whether the lower reimbursement rate will affect the financial results of private insurers or if they will simply decide to write less crop insurance remains to be seen.

While there has been improvement in the experience of the crop insurance program, the RMA continues to look for ways to make the program more efficient and less reliant on disaster payments. According to March 2006 testimony provided by Eldon Gould [6] before the House Agriculture Subcommittee on General Farm Commodities and Risk Management, in recent years congress appropriated $10 billion in disaster assistance covering six crop years. Therefore, the 2007 budget includes a proposal to link the purchase of crop insurance to other farm program benefits. Under this proposal, in order to receive farm program benefits a participant would need to purchase crop insurance protection for at least 50% of the expected market value.

WORKERS COMPENSATION INSURANCE

With the advent of the industrial revolution, new technology and machinery resulted in more industrial accidents. The only recourse an injured worker had was to sue their employer; a long, expensive process with an uncertain outcome. Workers compensation benefits evolved as a means by which employees injured on the job would be certain to

have their injuries adequately taken care of by their employer without having to sue. Employers, as well as employees, benefited from the new system as the employer also exchanged an uncertain, potentially large payment, for a certain guaranteed benefit system.

Governments, both state and federal, participate in workers compensation insurance programs in a variety of ways. In some states, workers compensation insurance is only available through private insurance companies, while in other states it is only available from a state fund, an entity established by law to provide workers compensation insurance. In some states, a state fund may compete with private insurers. In all states, government and private insurers cooperate in providing workers compensation insurance as the benefits are defined by law, either state or federal, and unless there is an exclusive state fund, private insurers provide the insurance coverage.

Workers compensation programs covering most employees are enacted and administered at the state level in all fifty states, the District of Columbia and the five U.S. territories. Federal government employees and certain categories of workers, such as longshoremen or railroad workers, are covered by federal workers compensation programs.

A) Federal Workers Compensation Programs

Various federal programs compensate certain categories of workers for disabilities caused on the job and provide benefits to dependents of workers who die of work-related causes. The federal government works to ensure these programs perform well under the U.S. Office of Management and Budget and Federal Agencies. The following are some major federal programs:

1) The **Federal Employee Compensation Act (FECA)** provides compensation benefits to non-military, federal employees for disability due to personal injury sustained while in the performance of duty and for employment-related disease. It is administered by the Office of Workers' Compensation Programs (OWCP) in the U.S. Department of Labor.

The Act is the exclusive remedy for federal civilian employees who suffer occupational injury or illness. There is some claimant overlap with other federal programs, however, regulations generally bar the receipt of dual benefits for the same injury/illness and mandate the reduction in benefits to offset other sources of compensation.

The program's purpose is to return individuals to work while containing the costs of the system. Designed as a non-adversarial system (i.e., no judicial review and limited employer ability to contest claims) the program limits administrative and litigation costs, which may account for a substantial share of payout in some systems.
The program is efficient relative to comparable state-administered systems in that administrative costs were about 4.6% of total program obligations in FY 2002. In contrast, administrative costs in comparable state systems were as much as 16.6%. Administrative cost per claim filed ($698) is also low [25], but the average benefits paid within the FECA system are substantially higher than state workers compensation systems, leading to a relatively low administrative percentage.

2) The **Longshore and Harbor Workers' Compensation Act of 1927 [30]** requires employers to provide workers compensation protection for longshore, harbor, and other maritime workers who are injured or suffer occupational diseases while working on or near navigable water in the United States. These benefits are provided by employers by either procuring insurance coverage from private insurers or by qualifying to self-insure. In some special circumstances, such as second injuries or default in payment of claims by insurers or employers, benefits are paid by a special fund administered by the Department of Labor Employment Standards Administration, Division of Longshore and Harbor Workers' Compensation (DLHWC). The DLHWC [8] is responsible for adjudicating disputed claims and ensuring that employers and carriers pay benefits.

The Act was created to provide workers' compensation coverage for categories of workers who were not seamen and were injured while working on or near navigable water in the United States and for which no state act coverage applied. Since the enactment of the Act, there have been questions regarding when coverage under the Act ends and state act coverage begins, particularly when the injury occurs "near" navigable water. In 1984 the scope of the program was amended in an attempt to clarify the extent to which shoreside coverage applied. However, about 40 states allow concurrent receipt of state and longshore benefits. The Act provides for the offset of compensation paid to individuals under any other workers compensation law for the same disability or death. The possibility of an injured worker pursuing either longshore benefits or state act benefits is an issue that employers need to be aware of so that they have adequate insurance protection for their exposure.

Because the claims handling process is the responsibility of the insurer or the self-insured employer, the DLHWC does not collect data to monitor the efficiency of the service provided by insurers and employers. However, the DLHWC does monitor its own dispute resolution process and they have exceeded their performance goals for quickly and efficiently resolving disputed claims every year since 2003 when the long-term goals were established. [9]

3) The **Black Lung Benefits Act** provides wage-replacement and medical benefits to coal miners who are totally disabled due to pneumoconiosis (black lung disease) and to eligible survivors.

The program was established in 1969 because state workers compensation systems rarely assisted victims of black lung disease. While Federal respirable dust control standards and advances in dust suppression technology have helped to reduce the prevalence of occupational black lung disease, it remains a problem. There are anecdotal data suggesting that state coverage of black lung disease remains inadequate. In cases where an individual receives both state and federal benefits, the federal benefit is reduced by the full amount of the state benefit.

The program is financed partly by federal general revenues and partly by the Black Lung Trust Fund which is financed by coal mine operators through a federal excise tax. While

excise tax revenue is now sufficient to cover the current cost of benefits and administration, the Black Lung Disability Trust Fund must borrow more each year to service its debt from prior years [10].

The 2010 Patient Protection and Affordable Care Act included a provision which made it easier for long-time coal mine workers and their dependent to obtain benefits. The "Byrd Amendment" mandates a presumption that disability or death due to black lung is work related and compensable if the injured workers were employed for at least fifteen years in coal mining. This presumption was retroactive to 2005. The second change allowed surviving dependents to be automatically receive survivors benefits if the miner was receiving lifetime benefits at the time of death. Both of these changes is expected to significantly increase the number of compensable claims under the Act. [11]

B) State Workers Compensation Programs

The state government can act as a partner with private insurers, a competitor of private insurers, or an exclusive insurer.

Partnership with Private Insurers

State programs vary concerning who is allowed to provide insurance, which injuries or illnesses are compensable, and the level of benefits. State laws prescribe workers compensation benefits, but these laws assign to employers the responsibility for providing benefits. Employers can obtain workers compensation coverage to provide benefits to their employees by purchasing insurance from a private carrier or a state workers compensation fund, depending upon the options available in their state. They can also use self-insurance in almost every state if they demonstrate the financial capacity to do so by meeting certain requirements.

Private insurers are allowed to sell workers compensation insurance in all but a few states and territories that have exclusive state funds. Where private insurers may sell workers compensation, a public-private partnership exists since the benefits are established by state law, but insuring those benefits is the role of private insurers.

State Funds

With enactment of state workers compensation laws, the need for workers compensation insurance created its own set of problems, while solving others. Employers feared they would be forced out of business if refused coverage by insurance companies. They were also fearful that insurance carriers might impose excessive premium rates that would be a financial burden. High premium rates could negatively affect a state's economy and ultimately limit opportunities for employment. Another fear was that because the mandatory nature of the coverage reduces elasticity of demand, insurance rates might soar, enabling insurers to reap unfair profits. Some state legislators addressed these concerns by establishing state workers compensation insurance funds to provide a stable source of affordable insurance coverage.

Washington was the first state to adopt the state fund approach in 1911 and by the end of 1916, thirteen states had established state funds [12]. As of 2013, a total of twenty-five states have state funds that provide workers compensation insurance.

In general, state funds are established by an act of the state legislature, have at least part of their board appointed by the governor, are usually exempt from federal taxes, and typically serve as the insurer of last resort – that is, they do not deny insurance coverage to employers who have difficulty purchasing it privately.

Among the twenty-five states that have state workers compensation funds, four have exclusive state funds and twenty have competitive state funds. South Carolina state fund is neither an exclusive fund nor a competitive fund, because it is the required insurer for state employees and is available to cities and counties to insure their employees, but it does not insure private employers. Sources for this include papers by Lencsis [13], a paper by the National Academy of Social Insurance [14], and the American Association of State Compensation Insurance Funds [15].

Competitive State Funds

In states with competitive state funds [16] state funds sell workers compensation insurance, at least theoretically, in competition with private insurers in insuring and administrating the workers compensation laws. In some states, Oklahoma is one example, the state fund is not permitted to refuse coverage to an employer, no matter how undesirable the risk, so long as past and current premiums are paid. In this regard they are referred to as "insurers of last resort". In other states such as Oregon, the state fund does not operate as the insurer of last resort. The mission of the state fund is set out in the Oregon statute that authorizes the existence of the state fund. This mission is to "make insurance available to as many Oregon employers as inexpensively as may be consistent" with protecting the integrity of the Industrial Accident Fund and sound principle of insurance [17].

Exclusive State Funds

In states with exclusive state funds, North Dakota, Ohio, Washington, and Wyoming, private insurers are not permitted to provide workers compensation insurance and state funds enjoy the exclusive right to sell workers compensation insurance. All employers are required to procure their workers compensation insurance from the state fund, or, in some jurisdictions, an employer may also self-insure.

Residual Markets

In states without a state fund, or with a state fund that does not serve as an "insurer of last resort", it will sometimes happen that an applicant for workers compensation insurance is unable to obtain coverage. Private carriers are limited by regulation in the rates that they can charge. If they believe that the maximum rate will be inadequate for a particular insured, they simply decline to write the policy. This may be because the prospective insured has an inherently hazardous business model, or poor safety practices, or a poor or inadequate loss record.

If states took no action on behalf of such applicants, the applicants would have little choice but to go out of business. This would increase unemployment and impair tax revenues. As a result states without state funds have set up residual market mechanisms to act as insurers of last resort.

The details of this mechanism vary from state to state. Applicants generally enter the residual market after being declined by at least two private carriers. In some states such applicants are assigned to carriers based on their workers compensation market share, with the carriers writing policies and collecting premium and paying claims just as if they were serving the applicants voluntarily.

In other states, carriers reinsure undesirable applicants via a reinsurance pool, and profits or losses from the pool are shared among carriers in proportion to market share. In still other states, the state authorizes a Joint Underwriting Association to serve the residual market, and with carriers sharing on a pro-rata basis profit or loss. Note that these residual market mechanisms closely parallel the automobile liability residual market mechanisms described by Hamilton and Ferguson [3].

The market share within the residual market varies from state to state and year to year, depending on filed rate adequacy and the risk appetites of insurers. In 2011 the aggregate residual market share was about 5% within the states for which the National Council on Compensation Insurance (NCCI) collects data. The combined ratio for residual market business was about 120% [18]. As one would expect, residual market business is generally written at a loss despite generally higher rate levels for residual market risks (carriers are correct to eschew it in the voluntary market). This results in a higher combined ratio for workers compensation insurers, either directly as residual risks are assigned to carriers, or indirectly as reinsurance or JUA losses are pro-rated. The voluntary market effectively subsidizes the higher-risk residual market, despite higher rate levels for residual market risks.

C) Evaluation of Workers Compensation Insurance

Private carriers remain the largest source of workers compensation benefits. In 2010, they accounted for 56.7% of benefits paid in the nation. Yet, the state funds have created significant competition in the workers compensation insurance business in the states where they operate. State funds have a significant market share in virtually every state where they are located. The share of benefits provided by state funds accounted for 18.5% of benefits paid in 2010 in the nation. Exhibit 1 shows that the benefits paid by the twenty state funds and various federal agencies have been slightly lower in more recent years, falling below 25% of the total.

Exhibit 1

Workers Compensation Benefits Paid, by Type of Insurer, 2004-2011
(From Table 4 of "Workers Compensation: Benefits, Coverage, and Costs, 2010" [34]

Year	Private Insurers	State Fund	Self Insured	Federal Program
2004	51.0%	19.9%	23.4%	5.8%
2005	50.9%	19.5%	24.0%	5.7%
2006	50.9%	19.2%	23.9%	6.0%
2007	52.2%	18.0%	23.9%	5.9%
2008	52.8%	17.6%	23.7%	5.9%
2009	53.1%	17.0%	23.9%	6.1%
2010	53.0%	16.8%	23.3%	6.3%
2011	53.5%	16.2%	23.9%	6.3%

Exhibit 2 provides information for 2011 on the ratio of benefits paid by state workers compensation funds to total workers compensation benefits paid to workers from all sources. The data shows that state funds pay a third or more of the total in six states – Arizona, Colorado, Idaho, Montana, Oregon, Rhode Island, and Utah. Funds were less important in other states.

Exhibit 2

Workers Compensation Benefits Paid by Type of Insurer, 2011, for States with Competitive Funds
(From Table 8 of "Workers Compensation: Benefits, Coverage, and Costs, 2011",[34]

State with Competitive Funds	Private Insurers	State Funds	Self-Insured
Arizona	46.4%	33.9%	19.7%
California	54.7%	14.0%	31.4%
Colorado	31.4%	52.1%	16.6%
Hawaii	53.3%	11.7%	35.0%
Idaho	40.9%	56.2%	3.0%
Kentucky	56.0%	12.8%	31.3%
Louisiana	55.1%	11.8%	33.1%
Maryland	54.0%	17.2%	28.8%
Missouri	65.2%	10.5%	24.3%
Montana	33.2%	52.9%	16.2%
New Mexico	57.7%	9.3%	33.1%
New York	43.0%	26.6%	30.4%
Oklahoma	50.1%	30.5%	19.4%
Oregon	34.0%	46.0%	19.9%
Pennsylvania	71.4%	7.5%	21.1%
Rhode Island	35.8%	49.4%	14.8%
Texas	55.9%	24.2%	19.9%
Utah	36.9%%	45.9%	17.2%
West Virginia	37.4%	50.9%	11.7%
Non-Federal Total All States	56.7%	18.5%	24.9%

Proponents of state funds argue that because the state funds are specialists in workers compensation they can be expected to offer more intensive levels of rehabilitation and other services than some private insurers whose workers compensation plan is only one of several types of coverage offered. However, there are private insurers who also specialize in providing only workers compensation coverage and may offer the same level of service and expertise as the state funds.

State funds are, by law, designed to be self-supporting from their premium and investment revenue. Overhead expense ratios of both exclusive and competitive funds may be lower than expense factors for private carriers in part because of absence of some administrative costs such as agency commissions and other marketing costs. As nonprofit departments of the state, or as independent nonprofit companies, they are able to return dividends or safety refunds to their policyholders, just as some private insurers do. This further reduces the overall cost of workers compensation insurance both for the state fund as well as the private insurer that offers these types of programs [2] [3]. While lower administrative costs for state funds may reduce the cost of providing workers compensation coverage, the fact that more states have not created state funds, and some state funds have been privatized recently, suggests that private insurers are also able to provide this coverage in an efficient manner.

The evidence suggests that both state funds and private insurers are able to provide workers compensation coverage in an efficient manner.

D) Interaction of Workers Compensation Insurance with Medicare

Background

In 1965, Congress created the Medicare program to provide health insurance for elderly Americans. The mechanics of Medicare are addressed elsewhere in the syllabus [3]. The authors of the law creating Medicare recognized that it might overlap with other private or government insurance programs—especially workers compensation insurance.

For example, a 67-year-old worker might be injured in a job accident. That worker would be entitled to have his or her medical costs reimbursed by his or her employer's workers compensation insurer. However, that worker, being more than 65 years of age, might also be eligible for Medicare. To save Medicare costs, Congress therefore stipulated that workers compensation insurance would be primary in such a case. Medicare would be secondary and would begin to pay only if and when workers compensation benefits were exhausted.

In 1980, Congress passed the Medicare Secondary Payer Act, which stipulated that Medicare was also secondary to liability insurance. For example, if an elderly American were injured by another driver in an auto accident, the responsible driver's insurance would be primary and Medicare secondary.

The 1980 act also introduced the notion of a "conditional payment". In many cases persons begin incurring medical costs before eligibility to collect insurance has been determined. In such cases Medicare will make "conditional payments" to medical providers, subject to later reimbursement by an insurer subsequently determined to be primary.

In some cases workers compensation claims are closed via a settlement which provides compensation to the injured worker for anticipated *future* medical payments. These payments can also overlap with Medicare. For example, a 63-year-old worker may be injured on the job. That worker is not eligible for Medicare. However, the worker's claim may be closed with a settlement that allows for medical treatment anticipated to last five years. By the end of that time the worker will be Medicare-eligible.

Federal regulators therefore introduced (1989) the Medicare Set-Aside Allocation (MSA), in which all parties to a settlement would agree to "set aside" a portion to be primary over Medicare for future treatment after the injured party became Medicare eligible.

Despite these laws and regulations, the status of Medicare as secondary insurer remained mostly notional through the Twentieth Century. Medicare administrators simply did not know when Medicare eligible (or soon to be eligible) parties were collecting workers compensation or liability payments. In the absence of aggressive collection, parties had little incentive to agree to MSA's.

Medicare Set-Aside Allocations since 2001

This became increasingly untenable as Medicare costs rose due to medical cost inflation and longer life expectancy. In 2001 the Center for Medicare and Medicaid Services (CMS), which administers Medicare, established its first guidelines for the review and approval of MSA's. The implied threat was that, where MSA's were not submitted, or not approved, Medicare would refuse payment for future care, and be more aggressive in seeking reimbursement for past conditional payments.

Since 2001, the submission and approval process for MSAs has changed several times. The changes have generally been in the direction of making MSA approval more difficult. A new sub-industry of MSA consultants has emerged to assist Third Party Administrators and insurers to evaluate settlements for MSA requirements and gain the approval of CMS.

As of 2012, CMS will review all workers compensation MSA's where:

- The claimant is either a Medicare beneficiary and the settlement is greater than $25,000 or
- The claimant is expected to be Medicare eligible within 30 months of the settlement and the settlement or expected future medical costs and lost wages of the injury exceeds $250,000.

The CMS thresholds do not create a safe-harbor, so even smaller medical settlements should consider Medicare's interests.

After an MSA is approved, the injured worker must comply with reporting requirements and use the MSA appropriately. Claimants must agree to pay their workers compensation-related medical bills, using an interest-bearing account, and to complete reporting of their payments before Medicare will make any payments for claim-related conditions.

CMS can reject or revise MSA proposals, increasing the estimated lifetime medical need, to assure that Medicare rarely become liable for claim-related expenses throughout the claimant's life. Two specific issues – pharmacy costs and life expectancy – are often cited as areas of concern. With Medicare Part D, pharmacy costs were added to Medicare. In 2009, CMS issued pharmacy guidelines for MSAs, which essentially priced drugs at the retail cost level without regard to negotiated price arrangements that the insurer may have. However, many drugs commonly used for pain management are not included in Medicare Part D.

Due to industry concerns [19], in May 2010 Medicare issued clarifying language that drugs which were not included in Medicare Part D did not need to be considered in a MSA. This reduced the prescription costs in MSAs and was hailed as a significant victory in the insurance industry. Another issue which can raise the costs of a MSA is use of a "rated age" or impaired life expectancy versus the claimant's actual age. If CMS protocols for rated ages are not followed, CMS will recalculate the MSA using the claimant's actual age rather than the impaired life expectancy. Due to the nuances of CMS approval, many insurers use specialists to review their MSA proposals prior to submission to CMS and to shepherd the claim through the process. Use of specialists increases the administrative costs of settling such claims.

New Reporting Requirements since 2007

On December 29, 2007, President George W. Bush signed the "Medicare, Medicaid and SCHIP Extension Act of 2007" (MMSEA). This law sought to address the problem of CMS being unaware of primary payer responsibilities, whether or not a claim involved an MSA. The law requires claim payers, known as Responsible Reporting Entities (RREs), to report claim data to the CMS. Specifically, Section 111 of the act requires the providers of liability insurance (including self-insurers), no fault insurance and workers' compensation insurance (hereinafter "insurers") to determine the Medicare-enrollment status of all claimants and report certain information about those claims to the Secretary of Health and Human Services, through the CMS.

The implementation of the reporting requirement was delayed, as regulations and technology issues were ironed out, but reporting became mandatory on January 1, 2011 for insurers with workers' compensation claims. Reporting of liability claims was phased in (with the largest claims first) beginning on January 1, 2012.

CMS uses the Section 111 data to assist Medicare in coordinating benefits and uncover potentially reimbursable claims. There are substantial penalties for non-compliance with the required reporting of claims - $1,000 per day per beneficiary for each day the insurer is out of compliance. This penalty is in addition to a "Double Damages Plus Interest" penalty that defendants (as primary payers) can be fined if Medicare's right to reimbursement is ignored in any settlement. This rule applies to settlements on or after October 1, 2010.

Property/Casualty Actuarial Implications of the Recent Changes

From 2008 through 2010 there may have been an increase in claim closings, lump-sum payments or settlement in advance of the Section 111 reporting deadline. Some RREs may have taken the opportunity to decrease the volume of relatively minor claims that would otherwise need to have the Medicare eligibility status of the claimant determined and reports made to CMS. For actuaries reviewing both insurers' and self-insurers' loss data, such claim activity can distort both paid and reported losses.

A slowdown in the claim settlement rates is often attributed by Workers Compensation claims professionals to the CMS changes in procedures and increased emphasis on MSAs. CMS approval of MSAs generally takes 60 to 90 days, which can contribute to a slowdown in settlements. It is possible that some portion of increasing WC medical trends is due to MSAs. In the past, claim settlements may not have specifically identified medical vs. indemnity components and the settlement costs may have been entirely attributed to indemnity. With MSAs, a clear portion of the settlement is identified as medical cost, and the CMS procedures may also have increased the average size of the settlements due to future medical considerations. However, to date there are no publically available studies to quantify the impact on overall costs or severity trends.

In addition, for some entities, a significant risk factor could be injured workers currently receiving Medicare payments which should be classified as workers compensation claims. The Section 111 reporting could uncover Medicare payments that should shift to workers compensation claims, causing actuarial estimates to increase as CMS files liens to recover payments. Over the last three years *before* claim reporting was required, the number of recovery demands from CMS increased significantly to 74,000 in 2010 from 43,000 in 2007 [20]. The number is may continue increasing after 2011, or it may spike and then settle down as CMS catches up. Note that recovery can affect claims that were open in prior years, even if they are closed now.

Successful recoveries naturally increase claim severity to an insurer. The General Accounting Office (GAO) estimates total saving due to Medicare claim denials and recovery of payments of $737 million in 2008, rising to $861 million in 2011. These are costs that are borne by insurers instead of Medicare. Furthermore the GAO notes that "(A)n accurate estimate of savings could take years to determine because of the time lag between initial notification of Medicare Secondary Payer situations and recovery, the fact that not all situations result in recoveries, and the fact that mandatory reporting is still being phased in." [21]

The CMS approved 29,000 workers compensation MSA's in 2011, up from 20,000 in 2008. Claim settlements with MSAs would be expected to be predominantly for older workers and those with more severe injuries requiring ongoing medical treatment. The California workers compensation rating bureau, WCIRB, reported the results of a survey of accident year 2007 settlements. [22] The survey included 3,357 settlements of which 59 (1.7%) included MSAs. While there were relatively few MSAs, the percentage was much higher for both older workers and more serious claims. For claims with disability ratings above 60%, about 15-25% included MSAs. Also there was a strong correlation between the age of the worker at the time of injury and MSAs. For claims with MSAs, the MSA was 37% of the total medical cost of the settlement, averaging $45,000 per claim.

These results are not surprising, since only current Medicare beneficiaries or those expected to become beneficiaries soon should include an MSA in a settlement. It has long been noted that older injured workers tend to have higher average medical costs, with or without settlements. Due to the survey results WCIRB plans to begin collecting information on MSAs and Medicare lien payments, but it will be some time before sufficient information is available for analysis.

In addition, it should be noted that other lines of insurance coverage will be impacted. Automobile liability claims, particularly Personal Injury Protection & Medical Payments claims, must also be reported. All such claims involving potential beneficiaries, open January 1, 2010 and after, must be reported to Medicare. In summary, actuaries and insurance professionals need to be cognizant of the MMSEA and how it may impact property/casualty insurance results.

In 2012, new legislation affecting the interaction of Medicare and private property-casualty insurance was passed. A key provision of the Strengthening Medicare and Repaying Taxpayers Act, or SMART Act, was the implementation of a 3-year statute of limitations on Medicare conditional payment recovery. This provision became effective on July 10, 2013 and provides that an action by the federal government for recovery must be filed no later than 3 years after the date of the receipt of notice of a settlement, judgment, award, or other payment.

While the statute does not define how notice of the settlement, judgment, award or other payment is to be made to Medicare, the provision was put in place with the understanding that notice would be through Section 111 Mandatory Insurer Reporting. It is unclear then whether other types of "non-Section 111 Mandatory insurer Reporting" to Medicare will trigger the limitations period, or whether the statute of limitations will be effective in curtailing increased workers compensation claims should Medicare not cover certain claims.

Changes in the Future?

Section 111 reporting is in its infancy. It is uncertain how CMS will use the huge volume of data that it is collecting, whether this will lead to a significant further increase in set-asides or recovery demands, and whether the statute of limitations will temper claim

volume. It may take years for changes to be fully apparent, especially for liability lines for which mandatory reporting didn't begin until 2012 and will be phased in.

Many would like to see more clarity in the handling of Medicare's interests in insurance claims. In 2011 the American Bar Association (ABA) passed a resolution calling on Congress to enact legislation that would establish a statute of limitations for Medicare liens and provide other consistency [23]. The issues surrounding Medicare and insurance settlements are far from resolved and we expect this area to continue to expand and evolve.

UNEMPLOYMENT INSURANCE

Unemployment insurance is a government insurance program that has no private insurance counterpart. The insurance industry considers unemployment insurance to be uninsurable because of the catastrophic nature of the exposure. Depressions or a less robust economy can put large numbers of employees out of work, and this exposure to loss cannot easily be predicted.

The Federal-State Unemployment Insurance Program provides unemployment benefits to eligible workers who are unemployed through no fault of their own and meet other eligibility requirements as determined under state law. The system was established by the Social Security Act of 1935. The benefits are intended to provide temporary financial assistance to unemployed workers. Each state administers a separate program within guidelines established by federal law. Benefit amounts and durations are determined by state law. Premiums are paid in advance through employer taxes on wages earned in the prior year.

In most states, funding is based solely on a tax imposed on employers. A federal tax is levied and 90% of the revenue returned to the states; the remaining 10% is used to finance program administration through grants to states and to make loans to states when liquidity problems arise. A key federal requirement is that taxes must be experience-rated, meaning that the tax rates move in tandem with a firm's layoffs and unemployment insurance benefit charges. When experience rating operates without restriction it acts to stabilize employment. However, tax rate maximums, minimums, and time lags in tax adjustments weaken the response.

To become eligible for unemployment insurance, a worker must earn a certain amount of wages or have worked a certain amount of time during a one-year time period. Workers must be unemployed through no fault of their own and must be actively seeking work.

To continue eligibility for unemployment insurance, the worker generally files weekly claims and reports any earnings from work during the week and any job offers or refusals of work during the week. States have increasingly viewed the administration of unemployment insurance as simply a disbursement function and have increasingly failed to satisfy the "actively seeking work" requirement, which results in payment errors in

which unemployment insurance benefits are paid to people who do not meet the criteria to receive them.

Generally, benefits are based on a percentage (usually 50%) of an individual's earnings over a 52-week period subject to a state maximum amount and a state minimum amount. During times of high unemployment, additional weeks of benefits may be available in the form of temporary federal programs. Unemployment insurance benefits are subject to federal income taxes.

There are four factors to consider in evaluating the results of unemployment insurance, which intends to partially replace lost earnings for workers who meet certain criteria. First, in the second half of the twentieth century, unemployment insurance replaced one-third of lost wages, on average, among those who qualified for benefits. Second, research has suggested that unemployment insurance payments slightly prolong unemployment spells and has prompted strategies to improve reemployment incentives with job search workshops and self-employment assistance. Third, since the focus of the unemployment insurance system has been on prime-age, full-time workers, proposals have been made to permit payment of benefits to parents who have chosen to take parental family leave and to part-time, contingent, and self-employed workers. Lastly, even among those eligible for benefits, only about two-thirds bother to collect, which raises questions about social adequacy and weakens the counter-cyclical potential of the federal-state unemployment insurance system.

This study note is an update of the original study note of May 2006 prepared by Jennifer Caulder, Howard Eagelfield, Wendy Germani, Sarah McNair-Grove, Chris Throckmorton and Jennifer Wu.

Notes:

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