CAS Study Note

Medicare, Workers Compensation, and Liability Insurance

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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[1]. 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.

[1] See Hamilton and Ferguson, Personal Risk Management and Property-Liability Insurance, 9.36-9.40

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[2], 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.

[2] http://blog.reduceyourworkerscomp.com/2010/05/medicare-set-aside-changes-regarding-prescription-medications/#axzz1S0UzJ8Da
http://www.medallocators.com/MSA%20Insider/MSA%20INSIDER%20May%202010-V4.pdf
http://www.pmsionline.com/pdf/PMSI-Applauds-CMS-Changes-to-Drug-Pricing-Methodology-in-MSAs-5.17.10.pdf

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.[3] 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."[4]

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,

[3] Per testimony from Deborah Taylor, CFO and Director, Office of Financial Management, CMS on June 22, 2011 http://republicans.energycommerce.house.gov/Media/file/Hearings/Oversight/062211/Taylor.pdf
[4] GAO report, "Medicare Secondary Payer", March 2012, http://www.gao.gov/products/GAO-12-333

WCIRB, reported the results of a survey of accident year 2007 settlements.[5] 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.

Changes in the Future?

Section 111 reporting is in its infancy. We can't be certain how CMS will use the huge volume of data that it is collecting, or whether this will lead to a significant further increase in set-asides or recovery demands. 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[6]. The issues surrounding Medicare and insurance settlements are far from resolved and we expect this area to continue to expand and evolve.

[5] WCIRB Actuarial Committee Agenda of June 11, 2010 meeting; data used with permission
[6] http://www.settlementlawfirm.com/post-detail.php?id=161