Medicare Reporting Requirements and the Impact on Workers Compensation Losses

Presented by:

Christine M. Fleming, Moderator
Raymond Blanchfield
Dave Bellusci

2010 CAS Spring Meeting
San Diego, California
May 23-26, 2010

Introduction

- Panelists
  - Christine Fleming, Milliman
  - Raymond Blanchfield, Munich Re
  - Dave Bellusci, WCIRB of California
- Section 111 – Background and Impact
- Medicare and the Future of Workers Compensation
- Medicare Requirements and the Impact on Workers Compensation - A Rating Organization Perspective

Section 111 - Agenda

- Definitions and background
- Medicare as a Secondary Payer Statute (MSP)
- Section 111 of the Medicare, Medicaid, and State Children's Health Insurance Program Extension Act of 2007 (MMSEA)
- Medicare Set Asides (MSA) for WC
- Potential Impact on Claim Closures and Settlements
- Potential Impact on Actuarial Analyses

Terms Used in this Presentation

- Centers for Medicare and Medicaid Services (CMS)
- Medicare as a Secondary Payer Statute (MSP)
- The Medicare, Medicaid, and State Children's Health Insurance Program Extension Act of 2007 (MMSEA)
- Section 111 of the MMSEA (Section 111)
- Mandatory Insurer Reporting Requirements (MIR)
- Medicare Set Asides (MSA)
- Primary Plan Provider (PPP)
- Total Payment Obligation to the Claimant (TPOC)
- Ongoing Responsibility for Medical (ORM)

Chronology

- Medicare established in 1965; Centers for Medicare and Medicaid Services (CMS) administers program
- Medicare as Secondary Payer (MSP) Statute - 1980
- Medicare Set-Aside (MSA) - late 1990's
- The Medicare, Medicaid, and State Children's Health Insurance Program Extension Act (MMSEA) – 2007
  - Section 111 Mandatory Insurer Reporting Requirements

Background - MSP

- Medicare as Secondary Payer Statute
  - Established in 1980
  - Reduce costs; shift costs
  - Applies to claims involving liability or workers compensation (WC)
  - May not make payment on behalf of a beneficiary if payment should be made by a primary plan provider (PPP)
- Relied upon others to determine secondary status
- Result of voluntary reporting system: Payments made for which PPP responsible

Secondary Payer Protection

- Decisions
  - Protect Medicare's interests
  - Recoup past payments made ("conditional" payments)
  - Prevent shifting from PPP to Medicare going forward
- Actions
  - MSA approval procedures
  - Section 111 of MMSEA

MMSEA

- Section 111 of MMSEA includes Mandatory Insurer Reporting Requirements (MIR)
- Signed into law December 29, 2007; effective July 1, 2009*
- Applicable to liability, self-insured, no-fault, and WC claims (non-group health insurers)
- $1,000 per day/per claimant penalty for failure to report

* There are some implementation timeline adjustments; currently, reporting is expected to begin 1/1/11

Claims Subject to Section 111 MIR

- Claims involving Medicare beneficiaries
- Upon assumption of ongoing responsibility for medical payments (ORM)
  - Report when assume ORM
  - Report when terminate ORM
- When there is an award, judgment, settlement, or compromise finalizing future monetary exposure for the primary plan provider (total payment obligation to the claimant, or "TPOC")

Medicare "Beneficiaries"

- CMS refers to "Beneficiaries"
- Section 111 refers to "entitled" to Medicare benefits "on any basis"
- Determination of "entitlement" to Medicare benefits unclear:
  - Age 65 or older?
  - Received SSDI benefits? Is reasonably expected to?
  - Pays FICA?

ORM Trigger (WC) - Report Twice

- When ORM is assumed
  - For open claims (in WC, if payment made or claim accepted)
  - For closed claims (unless "actively closed" prior to 1/1/10)
- When ORM terminated
  - Obligation must be terminated; not just administratively closed

Termination of ORM

- Identify, investigate, resolve conditional payments made by Medicare (past)
- MSA approval or process (future)

Medicare Set-Aside Program

- Procedures developed by CMS in late 1990's for WC
- Protect Medicare's interests - set aside funds in a trust to pay for future medical services stemming from the WC injury
- Required for current Medicare beneficiary if settlement amount over $25,000
- Required for settlements over $250,000 if "reasonable expectation" of Medicare enrollment in 30 months

Medicare Set-Aside Program

- If less than $25,000 (when the claimant is a Medicare beneficiary) or under $250,000 (when the claimant is not a Medicare beneficiary), or not WC
  - CMS will not review/approve MSA
  - MSA may still be needed?
- "Safe Harbor" – evidence of protecting Medicare's interests

MSA Program - Impact

- MSAs integral to WC settlements, because:
  - Settlements often occur on larger claims
  - Settlements often include provisions for future medical payments
  - Larger claims often associated with older claimants or more serious injuries indicating potential for SSDI
  - PPPs wanted "safe harbor" even prior to MIR

MSA Program - Impact

- BUT . . .MSAs increase costs
  - Prolonged time to settlement; increased complexity of settlement process
  - Increased settlement cost
    - Additional time claim remains open
    - "Cushion" required by claimant
  - Increased expenses
    - approval process
    - expert medical projections
    - life care plans
    - other claims activity

Summary

- Enforcement of Secondary Payer status was limited
  - Voluntary identification of MSP claims – voluntary
  - Claims closed without anticipating future Medicare involvement
- Section 111 requires mandatory reporting of ORM claims

Section 111 – Potential Impacts

- Barriers to settlement
- Higher settlement values, change in case reserving
- Increased administrative costs
- Claims staffing expertise and workloads
- Increased litigation costs
- Claim reopenings
- Increased lag between report and close date

