# MEDICARE SECOND PAYER ACT – WHAT ACTUARIES NEED TO KNOW

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## WHAT IS MEDICARE?

- Medicare is a social health insurance program for an at-risk portion of the population (Age 65+ or disabled)
- Medicare was enacted in 1965 along with Social Security Act
- Unlike Medicaid it is not a social welfare program
- Premiums are partially funded by workers
- As enacted, Medicare was "primary payer" (while always "secondary" to Workers' Comp)

## WHAT IS THE SECOND PAYER ACT?

- Medicare Second Payer Act (MSP) is a Federal law that states Medicare is a "second payer" to everyone else (created December 5, 1980)
- "Second payer" means Medicare pays "secondary" to all other "primary plans" *before* Medicare.
- Under the MSP "primary plans" includes *all* other lines of coverage including: Automobile, No-fault, "Med-pay," General Liability, Professional Liability insurance, *et. al.*
- Medicare has always been secondary to Workers' Comp.
- In 2003 (MMA Act), the government "clarified" the MSP always included "Self-insured" entities (whether as registered self-insureds by intention or omission). Also clarified Medicare could make "conditional payments" if other "primary plans" were not expected to pay "promptly." (120 days by regulation)
- Intent of the MSP is to preserve the Medicare Trust Fund by making Medicare "secondary" to everyone else.

## HISTORICAL REALITY

- The MSP has (until recently) been universally ignored in liability cases.
- Since June 2001, Medicare has been actively engaged in perfecting their rights of recovery for "future medical expenses" in Workers' Comp cases *via a via* Medicare Set-Aside ["MSA"] arrangements.
- Medicare has historically done a poor job of identifying "primary payers" or "primary plans" notwithstanding existing legal tools.
- Medicare's primary philosophy of recovery is it prefers to have primary plans pay first rather than having to chase "conditional payments."

## HISTORICAL REALITY

- Medicare found that WC settlements were often made with the express intent to shift the burden for future items and services to Medicare (i.e. did not provide for proper future medical care)
- Medicare was (and is) getting into greater and greater debt.
- Medicare found it was too often the primary payer and not the second payer, as intended by the December 5, 1980 MSP Act.
- Medicare and Medicaid SCHIP Extension Act of 2007 ("MMSEA") was Medicare's solution to ensuring greater compliance with the MSP.

## EXAMPLE

- Carrier settles a claim with a Medicare beneficiary for $250,000
- The settlement includes "items and services" paid by Medicare in excess of $250,000.
- The plaintiff attorney takes 30% of the settlement ($75,000).
- This is done WITHOUT notification to Medicare.
- Medicare finds out about the settlement (via a via new MMSEA reporting requirement; reports from "medical provider" or social security, *et. al.*).
- Under MSP, Medicare can seek the full $250K from the insurance carrier even though the carrier has already paid $250K and obtained a release from the beneficiary and up to 2 times $250K if Medicare has to file suit against carrier to recover (i.e.$750K).
- Medicare can collect from the plaintiff's attorney (or any "entity") who received a portion of the settlement (see *US v. Harris*).
- Medicare can also cut-off future items and services to beneficiary until $250K has been incurred by the beneficiary.
- If settled after Oct 1, 2011, and not reported to Medicare under MMSEA, $1,000 per day / per claim penalty may be assessed.

## Chief take away

- Medicare beneficiaries, plaintiff's attorneys, insurance carriers and self-insured all need to carefully consider their respective duties to Medicare under the MSP.
- Each party may face severe penalties if they do not dispense their respective duties under the MSP statutes and regulations.
- Each party has significant incentives to cooperate with each other in meeting their obligations to Medicare.
- While Medicare has historically been lacks in asserting their rights under the MSP, extreme pressure is building to increase revenues and decrease expenders of the Medicare Trust Fund.
- Medicare cost $396.5 Billion in 2010 and is expected to increase to $502.8 Billion in 2016. Medicare views the MSP as part of the solution to their revenue shortfall problem.

## WHAT DID MEDICARE DO ABOUT THE PROBLEM?

- Established the Medicare Secondary Payer Center (MSPRC) to oversee collection of Medicare "conditional payments" *et, al*.
- In Workers Compensation cases where there is a "commutation" of future benefits, Medicare is entitled to the full amount of the settlement. Since June 2001, Medicare has allowed the parties to WC settlements to "set aside" funds for future work related items or services so long as there is no attempt to "shift" costs to Medicare (aka Medicare Set-aside arrangements or "MSAs").
- Enactment of the Medicare, Medicaid SCHIP Extension Act of 2007 ["MMSEA"] establishing severe penalties for non-reporting of claims ($1,000 per claim, per day, no caps).

## More on MSAs

- There are no laws requiring MSAs.
- MSAs and the MSA industry are all predicated on an internal Medicare memoranda know as the "Patel Memorandum" (June 2001) that articulated Medicare's "preferred methodology" for "considering Medicare's interests" in workers compensation cases
  (There are no regulations, statutes or internal memorandum requiring MSAs in liability cases).
- While Medicare has repeatedly stated they are willing to consider other methodologies, so far none have replaced MSAs.
- The Medicare Set-aside is the arraignment where there is a "settlement, judgment, award or other payment" and money is "set aside" from the settlement to pay for future medical items or services related to the work related injury.

## Even more on MSAs

- Each MSA amount is determined on an individual case-by-case basis by professionals (lawyers, doctors, nurses and specialists trained in the preparation of MSA documents submitted to Medicare for approval).
- The costs of preparing an MSA generally ranges anywhere between $1,300 to $2,300.
- In 2007, there were 16,320 WC MSAs submitted to Medicare of which 9,215 where approved. Total treatment for approved WCMSAs was approximately $1.386 Billion.
- In 2008, there were 17,507 WCMSAs submitted to Medicare and 10,694 approved. Total treatment for approved WCMSAs was $2.058 Billion.
- No current data. However, passage of MMSEA is expected to increase the frequency and amount of WCMSAs.
- There is a robust MSA industry that has evolved to meet this demand.

## Medicare Set Aside Statistics through 2008

| | Total Submissions | WCMSA Amount (billion) | Total Settlement (billion) | % | Avg RX | Self Admin | Other | % Self Admin |
|---|---|---|---|---|---|---|---|---|
| 2005 | 15817 | 1.8 | 11.9 | 15.11% | | 3847 | 699 | 85.2% |
| 2006 | 14120 | 3.9 | 20.6 | 19.39% | 19,368 | 5467 | 731 | 82.0% |
| 2007 | 16320 | 6.6 | 25.6 | 25.99% | 150,454 | 5294 | 243 | 95.6% |
| 2008 | 17507 | 9.4 | 32.8 | 28.80% | 192,529 | 7593 | 289 | 98.3% |
| TOT | 63764 | 21.7 | 90.9 | 24.08% | 90,588 | 22201 | 1962 | 91.880% |

## HOW DOES THE MEDICARE SET-ASIDE PROGRAM WORK?

- MSA's are currently for Workers Compensation settlements ONLY (even though Medicare will accept review of liability cases on a "voluntary" basis).
- Once established and approved by CMS, medical items and services for the work related injury must be paid out of the MSA fund.
- The MSA fund can be either "self-administered" or "professionally administered." In theory, Medicare requires periodic accounting of MSA funds.
- Structured Settlements can be used as a mechanism for funding the MSA.

## How Do Medicare Set-aside arrangements work? (continued)

- Medicare will only review MSAs for Medicare eligible claimants (or claimants who expect to be Medicare eligible within 30 months of the settlement) where the total settlement is > $25k. Medicare has made it clear that this is an "administrative threshold" only.
- Future medical items and services for Workers Compensation may or may not be subject to state fee schedules, thus increasing the potential costs of MSAs.
- Medicare expects future cost projections to include some estimate of medical cost inflation and higher drug costs.
- MSAs are NOT subject to administrative or judicial appeal or review. The local Medicare District Office has total desecration over the amount required for an MSA.

## WHAT IS WRONG WITH THE MSA PROGRAM?

- Inconsistent rules on what creates a sufficient MSA amount.
- No consistency between Medicare District Offices on what constitutes sufficient MSA fund.
- No statutes or regulations govern MSAs; only internal Medicare memoranda (beginning with the June 2001 *Patel Memorandum*).
- WC cases may not settle if Medicare does not approve MSA (over 7,000 cases in 2007 and 2008).
- Severe penalties if CMS does not feel the law was complied with (double damages).
- No guarantees MSA funds will be used as intended.
- No guarantees WC claims are truly "closed" in MSAs claims not reviewed and approved by Medicare.

## DIFFICULTIES IN MSA TRANSACTIONS

- Uncertainty and lack of timeliness in getting MSA approved by Medicare (now + or - 140 days)
- Attorney's may be liable for failing to reimburse Medicare's conditional payments.
- With exponential medical cost increases in the future, can Medicare come back to primary payers? Open question.
- No certainty MSA funds will be used as intended.
- Social security numbers are required to determine Medicare status. Privacy issues remain.
- Compliance issues lengthen settlement timelines and creates complexity for all parties.

## SETTLEMENT PROBLEMS

- Private/Insurance settlements are discouraged with Medicare beneficiaries.
- Cost of "conditional payments" may be greater than settlement value of the case.
- In WC cases, costs of MSA may be greater than the settlement value of the case making it impossible to "compromise and release" claim.
- Most adjusters and attorneys still don't fully understand Medicare's protocols for resolving claims.

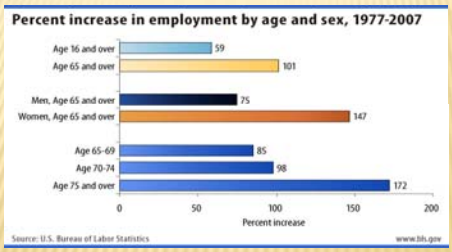
## Settlement Problems (continued)

- Under MSP, Resolution of Medicare 'conditional payment" occurs only *AFTER* the settlement without parties knowing the amount.
- Extinguishing Medicare contingent liabilities in settlement still a work in progress. No firm rules or "safe harbors" in MSP statutes or regulations (though MSP Manual *may* provide some guidance).
- Primary payer may be exposed to "Double-damages" if Medicare's "60 day demand letter" is not satisfied even if settlement documents transfer responsibility for reimbursing Medicare to beneficiary and/or their attorney.
- MSP statute does not contain any rights of appeal for Primary Payer; only Medicare beneficiaries. "Due process" absent in the MSP remains *big* issue.

## WHAT'S COMING?

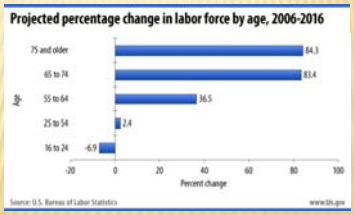
- "MMSEA 2007" "MIR" or "Section 111"
  - Mandates quarterly electronic reporting by all "primary payers" under MSP (defined as "Responsible Reporting Entities" or RREs).
  - Reporting now required for WC; Liability claim reporting delay until first quart 2012 for liability claims settled on or after October 1, 2011.
  - $1k per day, per claim (no limit) for non-compliance. "RRE" cannot contract away responsibility for penalties under MMSEA to a third party.
  - Initially some liability claims excluded (claim settled < $5k for 10/2011, 2012; < $2000 for 2013; <$600 2014).
  - MMSEA Section 111 did not change prior MSP statutes or regulations.

## Percentage increase in employment by age and sex 1977-2007




## Percentage change in labor force by age 2006-2016

- With the baby-boom generation about to start joining the ranks of those age 65 and over, the graying of the American workforce is only just beginning. By 2016, workers age 65 and over are expected to account for 6.1 percent of the total labor force, up sharply from their 2006 share of 3.6 percent.




## WHAT DOES THIS MEAN FOR WC RESERVES?

- For WC reserves, some studies have estimated 10-20+% impact on historical reserves due to new reporting requirements (this reflects impact of greater awareness from Medicare on these claims).
- Actuaries need to be ready for potential prior year development, which will be upward biased for an older workforce. (note limited safe harbors for WC claims administratively closed prior to 1/1/2009).
- Claims will continue to take longer to reach settlement and ***may create more re-openings*** as Medicare seeks reimbursement.

## WHAT DOES THIS MEAN FOR GL RESERVES?

- New reporting process and monitoring may lead to the "Swedloff paradox" where Medicare beneficiaries are disenfranchised due to increased settlement costs of liability claims. This may off-set increased costs of claim due to MSP compliance. (see "Can't Settle, Can't Sue")
- So called "Liability MSAs"or LMSAs remain an uncertain issue. While currently "voluntary" some carriers are demanding them thus increasing the overall cost of a claim and the "Swedloff paradox" affect.
- *US v. Stricker* [US 11th District Court of Appeals] established 3 year statute for "Primary Payers." Is currently on appeal to US Supreme Court. Is will decide what constitutes "notice" to Medicare under the MSP. Actuaries need to be ready for prior year development, which will be upward biased upon an older workforce.
- Major issues with limits of liability and relationship to Medicare as second payer. New "SMART" Act [HR 1063] if passed could have positive impact.
- Concerns on determining Medicare status for third party claimants.
- RAND study focuses on collateral source rule as guide for future litigation behavior.

## FUTURE STUDIES?

- Little actuarial information is available on the subject
  - What are the current Medicare approval rates?
  - Are the rates changing?
  - Is Medicare reviewing/approving more or less cases?
  - Will Medicare look backward to <$25K settled without Medicare approval after MMSEA fully implemented?
  - How will Medicare respond to Liability claims and limits of liability?
  - Will Medicare seek changes to MSP allowing Liability MSAs?
  - How often will double-damages and $1k per day fines apply? (Prediction: look to MMSEA enforcement actions after 5 years)
  - How does the settlement behavior change with these moving parameters (i.e. "Swedloff paradox" )
- RAND continues to review information available to understand the impact of these little known policy issues.

## MEDICARE TIMELINE

- 1965 – Medicare becomes law.
- 1980 – Second payer act (MSP) becomes law.
- 2001 – Medicare Set-asides become "required" for Workers Compensation under Petal Memo.
- 2003 – Medicare Modernization Act (MMA) - Self Insurance is included in second payer act; allowed Medicare to make "conditional payments."
- 2007 – (MMSEA Sect 111) Reporting requirements become law; $1k per day per claim penalty; WC reporting required Now. Q1 2012 for GL claims settled on or after Oct 1, 2011.

## Important Web-sites

MARC (Medicare Advocacy Recovery Coalition):

www.marccoalition.com

Center for Medicare and Medicaid Services (CMS):

www.cms.hhs.gov/MandatoryInsRep/01_Overview.asp

## *Useful Medicare Acronyms*

| | |
|---|---|
| CMS | Center for Medicare and Medicaid Services (Medicare) |
| COBC | Coordination of Benefits Contractor |
| HICN | Health Insurance Claim Number |
| MIR | Mandatory Insurer Reporting |
| MMSEA | Medicare, Medicaid and SCHIP Extension Act of 2007 |
| MSA | Medicare Set-aside |
| MSP | Medicare Secondary Payer Act |
| MSPRC | Medicare Secondary Payer Recovery Contractor |
| NGHP | Non-group Health Plan (i.e. liability, auto, workers' comp, no-fault) |
| GHP | Group Health Plan |
| ORM | Ongoing Responsibility for Medical Payments (workers' comp, no-fault) |
| RRE | Responsible Reporting Entity |
| RRE ID | Responsible Reporting Entity Identification Number |
| SSN | Social Security Number |
| TPOC | Total Payment Obligation to Claimant (liability, insured and self-insured) |

## Disclaimers that Keep our Lawyers Happy!

- We are not attorneys.
- Nothing in this presentation should be considered as legal advise or constituting the practice of law.
- Any specific questions regarding how your claims administration should be reviewed with your legal counsel and consultants. We encourage you to seek advise from your attorney and/or insurance/risk management advisors and consultants.