



## *Risk Financing*<sup>®</sup> **PERSPECTIVES**

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### **THE ADDITIONAL CLAIM COSTS IMPOSED BY THE MEDICARE SECONDARY PAYER LAW AND MEDICARE, MEDICAID AND SCHIP EXTENSION ACT**

By John V. D'Alusio

Medicare is one of two great federal entitlement programs. In an effort to provide it with a small degree of fiscal protection and financial viability, Congress afforded it secondary payer protection under the Omnibus Budget Reconciliation Act of 1981 and Title 42 of the Social Security Act.

The secondary payer protection due Medicare has practical cost implication for payers such as insurance companies, self-insureds, and companies with high SIRs/deductibles. Claims adjusters are to take Medicare's interest into consideration when:

1. Bodily injury cases (workers compensation *and* liability) are being settled;
2. The settlement includes irrevocable closure of future medical benefits; and

3. The injured claimant is already Medicare entitled or has potential Medicare entitlement within 30 months of the date of settlement.

In this case, "taking Medicare's interest into consideration" equates to a financial burden. Medicare is due protection in two directions: past protection via a statutory right of recovery for any "conditional payments" that Medicare made for treatment of the condition for which the claim is being settled, and future protection in the form of a Medicare Set-Aside Allocation (MSA) that shields Medicare from future payments post-settlement.

It goes without saying that there are more costs involved in the settlement of a claim where Medicare's interest must be taken into consideration than one where no such protection for Medicare is due. What are these costs? How can they be estimated and budgeted? Are there methods of risk mitigation that can be applied? This issue of *Risk Financing Perspectives* addresses these questions and other issues arising from the Medicare Secondary Payer (MSP) law.

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### Enumerating the Added Costs

There are several obvious cost components involved with the disposition of all workers compensation and bodily injury liability claims. These include:

- Loss costs (medical and indemnity payments in workers compensation, and general and special damages in bodily injury liability claims)
- Legal costs (from claims involving attorney participation)
- Other allocated expense costs (e.g., medical evaluations to determine disability or causal connection)



### Risk Financing PERSPECTIVES

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- Unallocated costs (general overhead expenses from claims handling services)

So in cases where Medicare's interests must be taken into consideration when a claim is being resolved, what is added and how can the additional costs to settlements be determined?

### Entitlement Status Verification

The first step is to determine if the injured party is Medicare entitled, or has potential Medicare entitlement within 30 months of the date of settlement. If the claimant's age does not make it obvious, a Social Security release (SSA-3288) should be secured from the injured party. There are three ways of accessing Medicare: age, via catastrophic injury or mortal condition, or by collecting SSDI (Social Security Disability Income) for 24 consecutive months. If an injured person files for SSDI, the individual is considered to have potential Medicare entitlement within 30 months of settlement.

MSA service providers typically charge between \$150 and \$175 to have an SSA-3288 release processed. It can be done in-house, but this would entail sending a person to the local Social Security office and perhaps waiting there for several hours to have the form processed. If the Social Security office verifies that the injured person has not filed for SSDI, and is not Medicare entitled, an MSA would not be required. However, there is a cost to determine the injured person's Medicare entitlement status.

### Medicare Statutory Right of Recovery

Insurers and self-insureds have an affirmative legal obligation to determine if Medicare has made any conditional payments relating to treatment for an injury, and to make Medicare whole, usually at time of disposition. To help with this, a service has been established by the

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Centers for Medicare & Medicaid Services (CMS) referred to as the Coordination of Benefits contractor (COB). However, this service generally is not quick to respond to inquiries. In some instances it has taken the COB contractor months to verify the amount of money they believe is owed to Medicare. This can create an impediment to a timely resolution, and can result in additional loss costs while a claim remains open awaiting settlement.

### **Medicare Set-Aside Allocation**

If the injured party is Medicare entitled (or has potential Medicare entitlement within 30 months of the date of resolution) and is projected to require medical treatment and services post-settlement, and those items are Medicare covered and related to the injury or condition for which the case is being resolved, a Medicare Set-Aside (MSA) allocation will be necessary. Firms that offer MSA allocation services typically charge anywhere from \$1,500 to \$3,500 to produce an MSA report. It is a multiple-page document outlining anticipated future Medicare covered treatment and services over the life expectancy of the injured party. Formulating an MSA report requires examining all prior medical records and projecting future treatment (post-settlement) predicated on sound medical evidence. The better reports also include non-Medicare covered future treatment, thus giving the recipient an estimate of total future medical exposures. The report must be able to stand up to presettlement and possibly post-settlement scrutiny from the government enforcement agency, the Centers for Medicare and Medicaid Services (CMS).

Of course, the person writing the report must also know which future treatments and services are Medicare covered, and which ones are not. Otherwise, the MSA report will be flawed.

Because an MSA amount is an annual figure multiplied by the life expectancy of the injured person, co-morbidity factors must be taken into consideration, as the claimant may have a shortened actuarial life expectancy. Therefore, a "rated age" is often a necessity. The rated age may mean an additional expense of \$100-\$200.

### **Presettlement MSA Submission to CMS**

In *workers compensation* settlements, CMS has prescribed certain instances when it wishes to review the MSA for accuracy and adequacy prior to final disposition. Thus far, there are no such written submission requirements for *bodily injury liability* claims.

Workers compensation claims are reviewed prior to settlement if the claimant is Medicare entitled at the time of resolution, and the total amount of settlement (indemnity, medical, and claimant attorney fees) is \$25,000 or more. In cases where the claimant has potential Medicare entitlement within 30 months of the proposed settlement, CMS reviews the workers compensation MSA if the total settlement is \$250,000 or more. Note that these are submission thresholds. Settlements under these amounts must still protect Medicare, but the MSAs are not required to be preapproved. CMS has elected to waive right of presettlement review, but it may still request post-settlement review if it has any questions.

The cost of submitting an MSA to CMS is in addition to the MSA itself. The average cost MSA service providers charge for this service is \$750-\$1,000. Any organization that performs CMS submissions of MSAs "in-house," must be prepared to justify the future Medicare-covered treatment cost estimate if CMS has any questions, or outright rejects the allocation. This can take a lot time and energy on the part of the submitting entity/person.

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### **Tangential Loss Costs**

CMS typically takes approximately 75–90 days to respond to a submission. While awaiting a formal response (which can be acceptance, rejection, or inquiries for additional information), insurers and self-insureds could be paying additional TTD (Temporary Total Disability) benefits. If medical treatment is continuing while waiting for CMS to make a decision, the costs of this benefit is also adding up. The longer it takes CMS to respond, the more costly the result in terms of indemnity and medical loss expense.

Additionally, when an MSA is required, future Medicare covered treatment and services cannot be discounted as otherwise allowed for settlements where Medicare is not involved. CMS will require 100 percent of the estimated future Medicare covered treatment in the MSA. Often, a significant amount of an injured claimant's treatment relates to prescription drug needs. This means that the present value of the medical component of settlements where Medicare must be extended secondary payer protection is greater than in cases where Medicare is not involved.

### **The SCHIP Extension Act Claim Reporting Requirements**

Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (State Children's Health Insurance Program) states that claims adjustors must electronically report details to CMS on open workers compensation, bodily injury liability, and auto no-fault claims where the injured party is Medicare entitled. The Congressional intent behind this law is to preclude Medicare from making any payments where a primary payer exists.

For liability insurance and workers compensation claims, the electronic reports are due quarterly starting July 1, 2009. There are 36 mandatory

data elements that must be included for each file in the report. Files reported late will be fined at the rate of \$1,000 per day per file for as long as the case is not reported. This is a staggering financial liability for insurers who, by acts of omission or commission, do not comply with the reporting mandates. The fines may be levied on self-insured organizations themselves, even if claims are handled by a third-party administrator.

### **Risk Identification**

For self-insureds and insurers in the realm of workers compensation, it should be fairly easy to identify a heightened exposure to the additional cost burdens of the Medicare Secondary Payer (MSP) Law and SCHIP Extension Act reporting mandates. The key to identification of risk in this area is the age of the workforce. The older the employee population, the greater the exposure to the additional costs of the Medicare Secondary Payer law at time of settlement. An injury to a worker 55–62 years of age is more likely to result in involvement with the Medicare Secondary Payer law on injuries of even moderate severity than it would be for an injury suffered by a younger employee.

Curiously, no trends of surcharges from workers compensation underwriters to offset the additional costs of claims involving Medicare protection when the prospective insured has an older workforce have emerged yet. This could change in the near future.

Identification of MSP risks in non-workers compensation insurance coverage is much more problematic. Clearly, one cannot accurately predict the demographic of injured claimants in a liability insurance risk environment, as one never knows who will be injured. However, sensitivity to the exposure and additional cost burden should be kept in mind.

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### Conclusion

There is little in the way of specific MSP risk avoidance or risk transfer that can be suggested. The fact of the matter is that injuries of moderate severity involving older individuals, or severe/catastrophic injuries to any age group, are likely to involve the MSP Law at time of settlement. The good news is that only 5–10 percent of cases settled involve the MSP Law. However, on those claims that do meet the criteria for extending secondary payer protection to Medicare, insurers and self-insureds need to recognize that there is most definitely an added “cost of doing business” when it comes to claim settlements.

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### **IRMI’s RISK FINANCING MARKET CORNER**

Despite the combination of an economic recession, severe turmoil in the financial markets, and the fourth highest year in the past ten for catastrophe losses, the U.S. property and casualty insurance market displayed strong resiliency during the fourth quarter of 2008. Other than a few specific exceptions, year-end renewals across most lines of coverage and most industries show little or no signs of rating increases or coverage restrictions. In order to retain good accounts, insurers are still offering rate reductions and even multiyear programs. However, even though certain areas are benefiting from intense competition, the days during which most insureds could expect significant pricing decreases have likely come to an end. The industry will

post an underwriting profit in 2008, but overall net income will show the effects of substantial reductions in investment returns. The prevailing opinion is that while the market is not yet hardening, the soft market appears to be near the bottom of the curve.

Underwriters across all lines of business are looking very closely at the business activities and loss control efforts of insureds. They are scrutinizing operations, cash flow and investment policies, personnel issues, contractual risk transfer practices, and any areas in which insureds have had claims activity. Underwriters are also looking closely at overall financial strength, especially for programs requiring collateral. Competition among surety bond issuers is expected to be sufficient to keep premiums stable in the short term, but underwriters are exercising additional discipline there as well.

The market segments experiencing the most difficulty include directors and officers (D&O) liability for financial institutions, coastal property risks, and property and casualty reinsurance. Underwriters for financial institution D&O liability insurance are bracing for shareholder suits and other claims driven by banks’ poor performances and even bankruptcies that have resulted in billions of dollars in investor losses. Some D&O underwriters are cutting capacity for financial institutions, and adding prior acts exclusions as well as exclusions for claims related to subprime lending. They also have concerns over the possibilities of bankruptcies spreading to other industries due to the credit crunch. When an insured goes bankrupt, the insurer can be on the hook for the first dollar in a program even if it was underwritten with a sizeable deductible.

2008 property losses from weather-related claims in the southern United States and storms in the Midwest, coupled with poor investment

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results are driving some insurers to take funds out of policyholders surplus. This creates an increase in demand for reinsurance and is expected to result in higher reinsurance pricing. However, industry professionals contend that in the event of a major catastrophe triggering a severe capacity crunch, private equity funds still have plenty of cash to invest in new start-ups.

Chubb and Travelers each sent letters of protest to Treasury Secretary Henry Paulson to voice their opposition to extending federal aid to the insurance industry. They contend that participating insurers would gain access to cheap capital

and an unfair advantage over those that were not included. In their opinion, the industry would be better served by exploring private market solutions to address the current conditions, preserving federal financial assistance for more acute circumstances. The American Insurance Association reported that most of its members do not support inclusion of property/casualty insurers in the U.S. Treasury Department's Capital Purchase Program (CPP). However, Hartford Financial Services Group is pressing forward with its plans to acquire a Florida savings bank so that it will be eligible to receive up to \$3.4 billion in federal funds under the CPP. The growing debate over this issue threatens to divide the industry.