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The impact of new Medicare legislation on liability claim settlements

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Federal legislation effective July 1, 2009, could radically change the ability of insurers to settle liability and workers' compensation claims.

The legislation—contained in the Medicare, Medicaid, and SCHIP Extension Act of 2007—was enacted in part to ensure that Medicare does not pay medical benefits for beneficiaries whose medical treatments arise out of a liability- or work-related accident. In such situations, Medicare has always been a *secondary payer* of these benefits. The primary payers are, generally, liability and workers' compensation insurers and large employers who self-insure. For example, when a Medicare beneficiary seeks payment from Medicare for medical expenses resulting from an auto accident, Medicare, in turn, is entitled to reimbursement from the auto liability insurer.

In theory, Medicare has always had the ability to enforce its lien for reimbursements against primary payers. In practice, however, Medicare's rights to reimbursement have not been frequently exercised. One major reason cited for Medicare's failure to collect reimbursement from primary payers is that Medicare simply has not had the ability to identify those beneficiaries who are also recipients of liability or workers' compensation payments. Because it is difficult for Medicare to identify those situations that involve a primary payer, it is possible that Medicare has been overpaying on these claims. A report generated by the Government Accountability Office (GAO) in 1999 estimated that Medicare had erroneously paid approximately \$43 billion between 1991 and 1998 on claims that should have been paid by a primary payer.

The new legislation, therefore, addresses Medicare's ability to identify these types of claims. The law contains a provision that requires insurers to report all claims to Medicare that could potentially involve Medicare as a secondary payer of benefits. The purpose of the reporting requirements is clear: to enable

Medicare to enforce its liens against primary payers and effectuate the reimbursement process. The law highlights issues that extend beyond simple accountability questions (i.e., "who should pay which medical benefits?").

As a result of this new legislation, the ability of liability and workers' compensation insurers to procure *full and final* medical settlements is likely to be substantially diminished. Medicare will now be able to identify those Medicare recipients who are (or were) also liability or workers' compensation claimants. Medicare can then collect reimbursements for medical payments it made as a secondary payer—regardless of whether the insurer had previously settled the medical portion of the claim with the claimant. This reopening potential could have a chilling effect on the insurers' ability and incentive to settle the medical portion of claims, thereby increasing claim costs.

History of Medicare as a secondary payer

The 2007 legislative focus on protecting Medicare's interests as secondary payer is not unprecedented. After the GAO issued its 1999 report, the Medicare set-aside program was established to reinforce the fact that medical expenses arising out of liability and workers' compensation claims cannot be shifted to Medicare. Under the set-aside program, Medicare recommended that when a claimant receives a workers' compensation settlement for future medical expenses, a portion of those settlement funds should be placed in fund subject to a *Workers' Compensation Medicare Set-aside Arrangement* (MSA). The MSA was mandated for settlements over \$250,000. The amount in the MSA fund is submitted to and approved by Medicare prior to finalization of the settlement. The fund is then to be used for the future medical services related to the workers' compensation claim, so that Medicare's interests as secondary payer are protected.

If the insurer and the claimant settle without obtaining an MSA, and Medicare makes a payment as a secondary payer, Medicare has the right to collect reimbursement from any entity that directly received a portion of or indirectly benefited from the settlement. This entity could be the claimant, the insurer, the attorneys, and even the claimant's medical providers who received the Medicare payment. Moreover, Medicare has the right to seek 100% reimbursement from one party, without regard to comparative or contributory negligence laws. The MSA clarified that no party would have *safe harbor* from future liens if an MSA were not obtained. Consequently, in the years following the 1999 GAO report, there was significant expansion of MSA activity in workers' compensation; liability carriers also procured MSAs prior to settlements greater than \$250,000. Medicare retained contractors to process the increasing number of MSA requests.

Nonetheless, despite the risk involved in not obtaining MSAs, not all insurers routinely procure them when settling claims. The process of obtaining an MSA results in prolonging and complicating the underlying settlement process, which, in turn, results in higher claim costs for several reasons:

- Claim values increase with time.
- Workers' compensation carriers must continue to make indemnity payments.
- Claim-adjusting expenses and legal costs increase.
- Additional expenses related to the MSA approval process must be incurred (e.g., obtaining life care plans).
- Settlement efforts are likely to be significantly delayed or fail entirely.

For these (and other) reasons, insurers did not always procure recommended MSAs prior to settling workers' compensation claims. Typically, the risk of settling without an MSA was minimal, because Medicare did not aggressively pursue reimbursements.

The new reporting requirements

The Medicare, Medicaid, and SCHIP Extension Act of 2007 will now require MSAs for liability and workers' compensation settlements greater than \$250,000. Moreover, the new law will also require primary payers (including liability, no-fault, and workers' compensation insurers and self-insurers) to report data in a specific format to the Secretary of Health and Human Services on claim settlements for Medicare-eligible claimants. The required data elements include identification information, insurance policy details, and claim details. The resulting database of all liability and workers' compensation claims will, presumably, be used to check whether Medicare beneficiaries are seeking payment for treatment that relates back to a liability or workers' compensation claim. If so, Medicare can readily seek reimbursement from the primary payer

(or deny payment altogether). There is no statute of limitations on when Medicare overpayments can be collected from a primary payer.

At the time of this article, Medicare's position is that it will not actively seek to collect past reimbursements; rather, it will use the database to enforce liens going forward on future medical benefit payments. However, Medicare's pronouncements are communicated in the form of informal agency directives, and Medicare is not bound by law or regulation to adhere to them. Thus, Medicare retains the right to change its position and stated intentions. Moreover, Medicare has announced that, unlike the period following the 1999 GAO report (when an insurer or self-insurer was free to seek an MSA for any settlement amount), Medicare will no longer process any MSAs for settlements under \$25,000.

Imagine, therefore, a worker who sustains a back injury on the job and files a claim for benefits with the employer's workers' compensation insurer. The claim includes benefits for ongoing future medical treatment resulting from the injured back. The insurer and the claimant agree to settle the claim without first obtaining an MSA. The insurer pays the claimant an agreed-upon sum of money to cover past and future benefits, and the claimant agrees no more benefits will be paid under the claim. Ten years after the settlement is paid and the claim is closed, the worker, now retired, requires back surgery and submits the claim to Medicare. Prior to the mandatory data reporting legislation, Medicare would have had difficulty identifying this beneficiary as a workers' compensation claimant who had received funds to cover medical treatment for a back injury. After implementation of the new reporting requirements, however, Medicare will easily be able to identify the primary payer/insurer. Despite the settlement 10 years prior, Medicare will have the basic right and the ability to seek reimbursement from the insurer for treatment related to the prior back injury.

Noncompliance not an option

Failure of the insurer to report the required data carries a fine of \$1,000 per claim per day. Thus, insurers have a compelling incentive to report every claim that meets the criteria, and perhaps err on the side of overreporting. Indeed, some insurers may find it easier and more efficient to simply include every open claim in its reports.

Big ripples

The most obvious potential impact of the new legislation is that it will do precisely what it was designed to do: ensure that millions, perhaps billions, of dollars paid by Medicare as a secondary payer will be reimbursed by primary payers. Certainly, this result is fair in that it upholds and protects Medicare's legal interests. However, because these reimbursement rights have not been consistently or frequently enforced in the past, insurers may find themselves ill-equipped to ascertain and prepare for the potential financial impact.

For example:

If a claim settles without an MSA, will that claim need to remain open longer, even indefinitely? Because of the unlimited time horizon in which Medicare can seek reimbursement, as well as the financial and legal consequences of failing to report claims, the uncertainty surrounding insurers' decisions to close claims will be magnified.

- Will there be changes to the reserving process? If inactive claims will now remain open, what will be the appropriate case reserve? Will the incurred-but-not-reported (IBNR) reserve, which accounts in part for the potential reopening of claims, need to be changed to recognize the additional exposure or the higher case reserves being held for longer periods of time? What actuarial methods and assumptions will be used to estimate IBNR, when there is no historical precedent for this phenomenon? It may take years or decades to understand and incorporate the effects the new Medicare reimbursement efforts.
- Will additional costs be passed on to the employer? Will there be affordability issues associated with increased premiums? Will there be availability issues associated with increased uncertainty and financial stress?

Of lesser significance, insurers will also face direct and immediate financial consequences, including:

- additional claims and actuarial resources devoted to understanding the new requirements and educating the reporting entity on how best to address them
- additional and more experienced staff to analyze and identify every claim with potential Medicare issues
- deterioration in the quality of claim handling as resources are stretched beyond capabilities
- additional and more experienced claim staff and lawyers to effectuate settlements that are increasingly difficult to obtain because of Medicare-related obstacles
- increased expenses for consulting and data-reporting service providers related to the new regulations

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Additional issues

Apart from the financial impact, there are a multitude of other unanswered questions, each of which potentially affects claim-handling practices and financial outcomes:

- How will Medicare reimbursements be allocated among insurers, claimants, claimants' attorneys, and treating physicians? How often will Medicare seek reimbursement directly from insurers versus from these other parties?
- Are MSAs truly a *safe harbor* and, if so, will they be required on all claims prior to settlement? How would such a requirement apply to verdicts rendered by juries, who have the constitutional obligation to determine the amount to be paid to a plaintiff without Medicare *approval*?
- Insurers have the obligation and right to deny payment for invalid claims—for example, a workers' compensation carrier would and should deny payment for medical treatment that does not arise out of the work-related injury. In such a situation, who is financially responsible if Medicare later pays the expenses without questioning their validity? Can Medicare still demand reimbursement from the insured? Will litigation between Medicare and the insurer be the likely result? Would such a dispute be futile in the mind of the insurer, thereby undermining the entire basis for claim adjusting?

Conclusion

There are many unresolved issues and unanswered questions surrounding Medicare's new reporting requirements. What seems clear, however, is that Medicare will soon be actively pursuing its rights to reimbursement. The impact on insurers could be significant as settlement efforts fail, claim-closure rates drop, and claim costs increase. The primary questions are whether, when, and how insurers will quantify this impact.

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