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Recovery Under the Medicare Secondary Payer Act

Impact of Reporting Thresholds

Eric Helland and Fred Kipperman¹

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Effective January 1, 2012, Medicare will require insurers and self-insured companies to report settlements, awards, and judgments that involve a Medicare beneficiary to the Centers for Medicare and Medicaid Services (CMS). This reporting requirement results from amendments to the Medicare Secondary Payer (MSP) Act of 1980, which stipulates that Medicare is the secondary insurer on all claims involving another source of insurance and hence must be reimbursed for any payments it makes that are also covered by another insurer.² In the first year of the new amendment's implementation, claims resolved for less than \$5,000 will be exempt from the reporting requirement. In the second year, the threshold for reporting will fall to \$2,000 and then \$600. In the third year, all claims will have to be reported regardless of payment size.³

Proponents of this new reporting requirement view it as a way for Medicare to obtain funds that it is legally owed by Medicare beneficiaries but has traditionally been unable to collect, and thus as providing a new source of revenue to enhance the program's

fiscal sustainability.⁴ However, some attorneys and insurers have expressed concerns that the compliance costs of the new reporting requirement may be high relative to the amounts collected by Medicare. Unfortunately, the current policy debate occurs against a backdrop of almost no empirical information on the costs of compliance, the amounts likely to be available to Medicare through the collection process, or the effects of different thresholds on these quantities.

As a first step toward informing this discussion, we examined one aspect of the new reporting requirement: the eventual phaseout of the \$5,000 threshold for reporting settlements. Using the Insurance Research Council's (IRC's) *Paying for Auto Injuries: A Consumer Panel Survey of Auto Accident Victims* datasets for the years 1992, 1997, and 2002 (IRC, 1994, 1999, and 2004), we approximated how much Medicare could potentially recover from payments made to auto injury victims under the MSP Act and then examined how much of this recovery would be lost to CMS if it continued its \$5,000 reporting threshold. We found that the amount recovered under the new requirement will not be greatly diminished if claims under \$5,000 are exempt from reporting, even when we assume that beneficiaries will not reimburse Medicare for any payments it is owed for these claims. Although we were unable to directly estimate compliance costs, we were able to glean information about their potential size from interviews with property casualty insurers.

To be clear, we were not able to evaluate the costs and benefits of the new reporting requirement and hence cannot examine whether the policy is beneficial, with or without the threshold. We had no data on non-

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² The MSP Act (42 U.S. Code [USC] 1395y(b)(2)) is itself one of many amendments to the Social Security Act (Public Law [PL] 74-271 (49 Stat. 620), which was approved on August 14, 1935.

³ The thresholds exempt those making payments to a Medicare beneficiary from the reporting requirement but do not represent a safe harbor from other obligations under the provisions of the MSP Act's statutes. Throughout this paper, we assume that without the reporting requirement, Medicare would not recover any money owed to it by beneficiaries who receive payments from liability insurers. Since we cannot determine the fraction of Medicare payments that would be reimbursed without the reporting requirement, our estimates represent an upper bound on possible recovery.

⁴ It is important to note that all health, liability, no-fault, and workers' compensation insurers that make a payment to an eligible Medicare beneficiary will be required to report that payment to CMS. Recovery is distinct from reporting. The beneficiary owes CMS reimbursement for payments he or she receives, but CMS may recover from the primary payer or anyone who receives payment from a primary payer.

auto cases and hence could not estimate what the ratio of benefits to costs is overall. However, as we show below, a substantial number of cases under the \$5,000 reporting threshold are auto cases, which allowed us to estimate what reductions in MSP Act recovery would be if the current threshold were maintained.⁵

Background on the Medicare Reporting Requirement

The Medicare reporting requirement, found in the Medicare, Medicaid, and SCHIP⁶ Extension Act of 2007 (MMSEA),⁷ is being implemented to provide the federal government with a greater ability to enforce the MSP Act provisions requiring that insurance carriers be the primary payer for treatment if a claimant is also eligible for Medicare. Under the 2003 Amendments to the MSP Act,⁸ Medicare treats tortfeasors or their liability insurers that pay either settlements or judgments to a Medicare beneficiary as primary insurers. Thus, the Medicare beneficiary/tortfeasor has a responsibility to reimburse Medicare for any payments to insured parties that are related to the accident in question.⁹ The new requirement will facilitate recovery of Medicare payments when a negligent third party in a tort suit or a workers' com-

pensation claim has also paid compensation (Chaikind et al., 2008).

Although the law has allowed such recovery since 1980, CMS has had difficulty collecting payments, particularly in small cases. Because attorneys and their clients do not always notify CMS of such payments, the new law places the reporting requirement on insurers—or so-called required reporting entities (RREs), which include not only insurers, but any entity making third-party payments in the liability system (such as defendants in class action cases, to name one notably contentious example).¹⁰

The new reporting requirement has generated considerable concern and uncertainty. Proponents point to the financial risks that Medicare will face in the future: The most recent report of the Medicare Trust Fund found that the fund will go bankrupt by 2029 (The Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, 2010).¹¹ They also argue that the new requirement will generate considerable income for Medicare. Opponents, who include insurers and many plaintiff's attorneys, point to the cost of reporting and the considerable fines for failing to file required information and for simple errors in reported information. Critics are also concerned about the administrative burden on insurers, who have never systematically collected the data called for in the new regulation. These competing perceptions of the value and effects of the reporting requirement raise an important policy question: How does the possible recovery generated by the new reporting requirement compare with the administrative costs of compliance?¹²

The most recent report of the Medicare Trust Fund found that the fund will go bankrupt by 2029.

⁵ Determining the relative costs and benefits of the overall reporting requirement would require examining the MSP Act's 2003 amendments that made liability insurers a first-party insurer with respect to Medicare. Evaluating those amendments is more difficult than examining the reporting threshold because, as discussed extensively by Swedloff (2008), they generally have a greater impact on the functioning of the civil justice system. If enforced completely, the amendments would likely alter the composition of cases in the civil justice system. In particular, because plaintiff's attorneys often cannot identify the extent to which Medicare may have paid for a client's injuries resulting from an accident and because Medicare is reportedly slow to respond to inquiries, the MSP Act likely delays payments and/or the resolution of claims and may make some smaller claims uneconomical. Although retaining the threshold would eliminate this issue for cases resolved for less than \$5,000, it would do nothing in larger cases. The threshold will also not alter the need for plaintiffs (and their attorneys) and liability insurers to resolve Medicare liens, so delay will remain an issue even if the threshold is retained. It should also be noted that the 11th Circuit has recently taken up these issues. In *Bradley v. Sebelius*, 2010 WL 3769132 (11th Cir. Sept. 29, 2010), the court ruled against Medicare's interpretation of the 2003 amendments. The decision appears to put Medicare in a position closer to the subrogation standards that exist for other secondary insurers with regard to the liability system. The court found that Medicare was entitled to a proportionate share of a settlement rather than to a dollar-for-dollar reimbursement, in effect requiring Medicare to share the risk associated with litigation. The court suggested that Medicare's current approach to recovery could have the unintended consequence of reducing its ultimate recovery under the MSP Act because potential plaintiffs would simply not find it worthwhile to pursue a claim.

⁶ SCHIP is the State Children's Health Insurance Program, which provides matching funds to states to provide health care for children.

⁷ Section 111 of MMSEA (PL 110-173) adds the reporting requirements for health and liability insurance, no-fault insurance, and Workers' Compensation (42 USC 1395y(b)(7) and (8)).

⁸ Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (PL 108-173, para. 301).

⁹ Note that this is not tort litigation as commonly considered and is perhaps better thought of as tort disputes given that the MSP Act applies even if no lawsuit has been filed prior to settlement.

¹⁰ In fact, the MSP Act is quite broad with respect to recovery, as well. Although the Medicare recipient who receives a payment from a primary payer is responsible for any liens under 42 USC 1395y(b)(2)(B)(iii) of the statute, the government may initiate recovery against anyone involved in a claim: (1) primary payers (i.e., workers' compensation law or plan, liability insurance, no-fault insurance, self-insurance); 42 Code of Federal Regulations (CFR) 411.24(e): "CMS has a direct right of action to recover from any primary payer . . ."; or (2) attorneys, beneficiaries, and other entities that receive payment from a primary plan: 42 CFR 411.24(g): "Recovery from parties that receive primary payments. CMS has a right of action to recover its payments from any entity, including a beneficiary, provider, supplier, physician, attorney, State agency or private insurer that has received a primary payment." It is thus possible that the law will facilitate recovery from a variety of sources.

¹¹ In a letter accompanying the report, CMS's chief actuary was harshly critical of the report's assumptions, claiming that those made in connection with future payment cuts "do not represent a reasonable expectation" of Medicare's finances (Goldstein, 2010).

¹² As mentioned above, the costs of the new law are, of course, much broader than the administrative costs and potential fines. The new reporting requirement also affects the ability and willingness of potential plaintiffs to file claims in the presence of potentially reduced recovery; the ability to settle claims when the size of Medicare's claim remains undetermined until after the claim is resolved; and the role of the new reporting requirement in mass and class action litigation, where plaintiff's attorneys and defendants often do not know who the clients are until the case is resolved.

Previous Research

Essentially no research has been done on either the benefits or the costs of the new reporting requirement, and no research has examined the impact of retaining the requirement that only payments over \$5,000 be reported. The reason why analysis has been scarce is the decentralized nature of the tort system. There are relatively few databases containing information on injury payments from different forms of insurance. Estimating Medicare's potential recovery from the tort system would require information on whether an accident victim had been compensated by a property-casualty insurer (from either a judgment or a settlement), whether that victim had received a payment from Medicare, and, if so, what the amount of the payment was.

Several attempts have been made to estimate the potential recovery from the liability system by examining parallel recovery efforts in the workers' compensation system. Workers' compensation has more-comprehensive datasets, so researchers are able to match Medicare eligibility to payments from the workers' compensation system. Generalizing from potential recovery in workers' compensation to potential recovery in the liability system is problematic, however. The workers' compensation system involves injuries and payments different from those in the liability system, does not require a finding of fault for payment, and does not allow for noneconomic damages. Even more problematic is the fact that the workers' compensation study used for these comparisons seems to have been fundamentally misunderstood.

Most commentary on the reporting scheme's impact on Medicare's recovery from workers' compensation refers to an influential study by the Government Accountability Office (GAO) that was based on workers' compensation data (GAO, 2001). Unfortunately, even though the study provides no estimate of the size of the potential recovery available from this source, it has been widely misquoted as claiming that Medicare has lost more than \$40 billion because of uncollected secondary payments in workers' compensation.¹³ For example, Briscoe, Fleming, and Taylor (2009, p. 1) state: "A report generated by the Government Accountability Office (GAO) in 1999 [sic] estimated that Medicare had erroneously paid approximately \$43 billion between 1991 and 1998 on claims that should have been paid by a primary payer."

In actuality, the GAO report, which reviewed workers' compensation claims in Virginia between 1991 and 1998 for 10,000 individuals, found that 26 percent of those individuals had received payment from Medicare, and that a much smaller percentage had received benefits for more than a month. The \$43 billion noted by Briscoe, Fleming, and Taylor refers to the amount that workers received each year in medical benefits through workers' compensation programs. Thus, the claim some have made—that uncollected payments over this period totaled \$40 billion—seems quite high, since it would represent 20 to 30 percent of total workers' compensation medical payments between 1991 and 1998. Unfortunately, misunderstandings regarding the GAO study's findings have generated considerable confusion in the public debate about the potential recovery available to Medicare from improved reporting.

To summarize, no one has a good idea of the magnitude of recovery possible under the new provisions for workers' compensation or other lines of insurance, and no existing study has examined the potential impact on liability payments.

Research Approach

As noted earlier, an analysis of potential recovery requires data on both recovery from the RREs and payments from the government. The IRC consumer panel survey on auto injury claims is one of the few databases that contain this information.

The overall IRC consumer panel study is a series of surveys sponsored by the IRC in which consumers injured in auto accidents are queried about medical losses and sources of payment for those losses. We drew on three waves of the survey—conducted in 1992, 1997, and 2002 (IRC, 1994, 1999, and 2004)—to create a sample of 2,294 third-party payments. The full dataset contained 14,749 surveys, 407 of which involved individuals who received payments from Medicare, Medicaid, or Social Security Disability. When we excluded all individuals not receiving a payment from a third-party insurance source, the remaining sample was 2,294 individuals, 77 of whom received a payment from both the government and a third-party insurer (see Table 1).¹⁴

The principal drawbacks of this data source, which are apparent in the table, are that the last survey was done in 2002 and that the sample of

Essentially no research has been done on either the benefits or the costs of the new reporting requirement, and no research has examined the impact of retaining the requirement that only payments over \$5,000 be reported. The reason why analysis has been scarce is the decentralized nature of the tort system.

¹³ This rampant misquotation has been noted by others. For example, Alex Swedlow, executive vice president of the California Workers' Compensation Institute, pointed this problem out at a 2010 Medicare Session at the Annual Issues Symposium of the National Council on Compensation Insurance.

¹⁴ We excluded payments from "medical payment" (med pay) coverage afforded under personal and commercial auto policies for no-fault. Med pay plans are typically offered on no-fault auto insurance programs, but payments come directly from an individual's own auto insurer. These claims are covered under a different reporting requirement, and coordination of benefits is, at least anecdotally, considered to be better.

Table 1
Distribution of Observations in the IRC Consumer Panel Survey

Survey Year	Total Individuals Surveyed	Number Receiving Settlements Over \$0	Number Receiving Government Payment	Number Receiving Both Settlement and Government Payment
1992	5,503	803	150	22
1997	5,768	701	161	24
2002	3,478	790	96	31
Total	14,749	2,294	407	77

SOURCE: IRC 1992, 1997, and 2002 consumer panel surveys (IRC, 1994, 1999, and 2004).

Clearly, auto cases constitute the largest number of trials, making up over 50 percent of likely bodily injury trials, and result in the smallest average award, consistent with the view that auto cases are the majority of small claims in the civil justice system.

individuals with third-party payments is small. To determine the extent to which we could generalize from these survey results, we examined a second auto-claims database, the IRC’s Auto Injury Insurance Claims: Countrywide Patterns in Treatment, Cost, and Compensation, 2008. These data, which allowed us to better understand the implications of relying on self-reports, rely on payment information provided directly from insurance companies. They are also more recent (they are from claims closed in 2007) than the survey data and are based on a much larger sample. The principal drawback with this database is that it contains no information on payments from other insurance sources, so we could not determine the government’s potential recovery from the claims.

Although the IRC closed claim data are both more recent and not self-reported, they do, like the IRC survey data, contain information only on auto accidents. The reporting requirement, however, applies to all types of bodily injury cases, including, for example, mass torts with a bodily injury component (such as asbestos cases). However, we know of no data covering both third-party payments and Medicare payments for types of bodily injury cases other than auto claims. Fortunately, auto claims make up the largest proportion of claims in the civil justice system. According to one study (Cohen, 2009), over 35 percent of trials are auto torts.¹⁵ In fact, this percentage likely understates auto claims’ importance, since a number of tort trials, such as false imprisonment, are unlikely to involve bodily

injury of a Medicare recipient and hence are unlikely to be covered by the MSP Act. Table 2 provides some evidence on the potential size of the omission. The data in the table are from Cohen (2009), whose sample covers trials in the 45 largest counties in 2005. The breakdown of trials in tort cases is shown, with only those case types that commonly involve bodily injury being retained.

This is by no means a random sample of all claims, since very few claims result in trials. Given that less-valuable claims are more likely to be resolved earlier in the process that moves from claim to filing to trial, trials are likely to be far less frequent for auto claims than for other claim types. The difficulty is that no recent dataset provides a random sample of claims that would allow us to determine the relative importance of different claim types. Our aim was simply to provide some indication of the relative size of the different claim types likely to be affected by the reporting requirement.¹⁶ Clearly, auto cases constitute the largest number of trials, making up over 50 percent of likely bodily injury trials, and result in the smallest average award, consistent with the view that auto cases are the majority of small claims in the civil justice system. The next largest claim type is medical malpractice, which has a significantly higher average award. The only other large claim type is premises liability, which is almost as common as medical malpractice but has slightly smaller average awards. Table 2 likely understates the auto claims percentage of overall claims, since the small dollar value of these claims makes them more likely to settle than other types of cases.

¹⁵ An earlier study, which included filings rather than just litigated cases, found that auto cases are also the largest case type in terms of number of filings (DeFrances et al., 1995). Researchers using National Center for State Courts data, which covers 35 states, found that auto accident cases represent between 18 and 69 percent of all cases (LaFountain et al., 2010). We know of no study examining claims that do not result in filed cases, but we have no reason to think that auto claims do not represent the majority of all claims, as well as filings and trials.

¹⁶ In fact, the number of cases likely does not track the impact of the reporting requirement for non-auto cases. Asbestos and product liability cases are far more likely than auto cases to have multiple plaintiffs, and state courts vary widely in whether these multiple-plaintiff cases are listed as one case or several. The reporting requirement, however, is specific to the individual, not the case.

Table 2
Breakdown of Trials for Common Torts with Bodily Injury, 2005

Case Type	Number of Cases	Fraction of All Cases (%)	Average Award (\$)
Motor vehicle tort	2,963	52.76	189,446.32
Medical malpractice	994	17.70	411,957.18
Premises liability	874	15.56	270,047.80
Intentional tort	272	4.84	311,074.50
Unknown tort	207	3.69	1,030,589.44
Product liability (not asbestos)	125	2.23	1,520,429.47
Professional malpractice (not medical)	79	1.41	733,308.94
Asbestos	53	0.94	1,504,099.51
Animal attack	49	0.87	50,951.69
Total cases	5,616		

SOURCE: Cohen, 2009.

To provide perspective on the size of the omission caused by examining only auto cases and its possible implications for our findings on the threshold’s costs and benefits, we examined the size of medical malpractice payments, the second most-frequent type of case in the tort system. Our reasoning was that if very few cases of this type would fall under the 2012 reporting threshold, our estimates using auto cases alone may provide a reasonable approximation of the impact of retaining the \$5,000 threshold. We used 2006 data from the National Practitioner Data Bank (NPDB) Public Use Data File (various dates) to check the payment distribution of medical malpractice claims. Under the Health Care Quality Improvement Act of 1986, insurers must report to the Department of Health and Human Services (HHS) all medical malpractice payments made on behalf of individual practitioners to resolve claims, and HHS then publishes that information on a quarterly basis in the NPDB.

Because the IRC consumer panel survey data provide claims information from a random sample of auto accident victims, we were able to estimate the average potential recovery available to Medicare per claimant by simply averaging government payments to accident victims when the victim had also recovered from another person or his/her insurance (either via a judgment or settlement) across our sample. We were also able to estimate the upper bound of the potential reduction in this recovery if the \$5,000 reporting threshold were retained. We assumed that the government would recover none of its payments of less than \$5,000 to individuals who received payments from both the government and another party, and we then deducted the total potential government

recovery in these cases from the total government recovery without the exemption. This allowed us to calculate the potential loss in recovery from the reporting threshold. Clearly this will be an overestimate of the loss if, contrary to our assumption, some of the payments owed to Medicare in claims under the threshold were recovered, even if the threshold were retained. This estimate understates potential losses from the reporting threshold to the extent that premises liability payments, which are not present in any of our data sources, mirror the distribution of auto cases.

Results

We now turn to the central question of our study: How much is likely to be owed to CMS for auto cases under the MSP Act, and what percentage of this recovery would be lost to CMS if it continued its \$5,000 reporting threshold? To answer this question, we examined the total payments made by government sources (excluding workers’ compensation payments) and the total payments made by third-party insurance sources. Note that our estimates are likely to represent an upper bound on the potential recovery of Medicare because we have assumed that all government payments reported in the IRC survey were Medicare payments, even though some of them likely came from other government programs, such as Medicaid. Unfortunately, the survey does not ask respondents to specify the precise source of each payment, and includes all government payers other than workers’ compensation in a single category.¹⁷

How much is likely to be owed to CMS for auto cases under the MSP Act, and what percentage of this recovery would be lost to CMS if it continued its \$5,000 reporting threshold?

¹⁷ Even if respondents were asked about specific sources, they may be unable to reliably report this information.

How Much Is the Government Likely to Recover?

A Small Number of Claims Make Up the Bulk of the Government’s Potential Reimbursement

Table 3 summarizes information on claim amounts from the IRC consumer panel survey. We categorized injured individuals into eight groups based on the value of payments by a third-party insurer. For each group, we report the number of injuries, the mean payment made by insurers per injury, and the mean potential government recovery from primary payers per injury. Potential government recovery, as calculated in the final column of Table 3, is not identical to the amount paid by the government for the individual’s injury. Although it is thought that the government will not attempt to recover more from a plaintiff than he or she receives from defendants, Medicare is entitled under the law to require that the minimum settlement amount be the amount it is owed under the MSP Act. Given the difficulties in determining how Medicare’s subrogation right would have altered settlement negotiations, we defined the government recovery as the smaller of the amounts paid by government insurance or third-party insur-

ance. For the 2,294 claims in which the parties received a payment from a third-party insurer, the government also paid a total of \$1,246,935 to the same injured parties. There were, however, only 77 cases in which both the government and a third-party insurer made a payment (i.e., in 3.35 percent of the cases in which third-party payments were made, the government also made a payment). The government could recover only \$880,963.80 from third parties, however, since the third parties’ total payments were in some cases less than the government’s payment.¹⁸ The most salient feature of Table 3 is that 43 percent of the injuries involved payments under \$5,000 (990 claims out of 2,294). As can be seen, government payments are present in all payment ranges but are most common in smaller claims (up to \$5,000) and larger claims (over \$25,000).

Exempting nearly half of all third-party payments from the reporting requirement would lead to a 2.4 percent reduction in the total recovery.

Exempting Nearly Half of All Third-Party Payments from the Reporting Requirement Would Lead to a 2.4 Percent Reduction in the Total Recovery

Under the assumption that the government could not recover more money from a third-party insurer

**Table 3
Distribution of Claim Amounts and Government Recovery**

Payment Range (\$)	Number of Claims	Mean Payment per Claim (\$) (standard deviations)	Mean Government Recovery per Claim (\$) (standard deviations)
1–500	83	293.92 (127.49)	13.09 (64.36)
501–1,000	113	749.17 (135.63)	16.32 (110.77)
1,001–2,000	218	1,488.38 (279.01)	21.12 (165.42)
2,001–5,000	576	3,407.06 (842.82)	23.84 (248.20)
5,001–10,000	566	7,172.21 (1,361.46)	44.61 (492.55)
10,001–25,000	441	15,347.26 (4,010.43)	189.79 (1,284.62)
25,001–50,000	147	36,132.82 (6,663.80)	1,151.28 (5,712.81)
>50,000	150	177,524.16 (496,586.03)	3,876.80 (20,537.37)
Total	2,294		

SOURCE: IRC 1992, 1997, and 2002 consumer panel surveys (IRC, 1994, 1999, and 2004).

¹⁸ We refer to this as potential recovery because, during all of the survey periods, the MSP Act would have required plaintiffs or their attorneys to reimburse Medicare for their treatment. Because the survey does not contain information on reimbursements, we simply assumed that none of the cases in question reimbursed Medicare.

than the amount of the payment, the total possible recovery from the 2,294 auto injuries receiving a third-party insurance payment is \$880,963.80 (see Table 4).¹⁹ We arrived at this number by totaling the smaller of the government payment or the amount received from the third-party insurer in all 77 cases in which the individual received payment from both the government and a third-party insurer. The vast majority of this money was, not surprisingly, recovered from the handful of very large cases. Again, using the \$5,000 threshold limit as an example, *only 2.4 percent of the government’s potential recovery would be lost by exempting 43 percent of the cases from reporting.*

Because the number of cases with payments from both sources was small—only 77 cases—we bootstrapped the standard errors to provide a confidence interval on our recovery and proportion of cases under \$5,000.²⁰ The estimate of the proportion of cases under the threshold was quite precise, with a 95 percent confidence interval, suggesting that the threshold would exempt between 41 percent and 45 percent of the claims. The estimates of the government’s reduction in recovery were less precise, although still significant at the 10 percent level. The upper bound of the 95 percent confidence interval on our estimate of the reduction of recovery is 4.8 percent.²¹

The intuition for this finding is seen in Figure 1, which plots the cumulative potential recovery of government payments from individuals who have received payments from RREs. The area under the curve represents the amount of recovery from all cases to the left of that point. The graph was constructed by ordering all cases from lowest claim payment to highest and then summing the government’s potential recovery. Thus, the green area is the recovery from the 990 cases with claim payments less than \$5,000 (i.e., \$21,263.80). For reference, the red area represents the potential recovery from cases with payments greater than \$5,000 but less than \$50,000. The red area under the curve in this case is \$278,197.70, suggesting that much of the government’s potential recovery comes from large cases. If the \$5,000 threshold were retained, the government’s overall recovery in the IRC sample would drop from \$880,963.80 to \$859,700.00, which is a 2.4 percent reduction in total recovery.

The results have implications for MSP Act reporting policy in that they allow us to estimate the government’s potential recovery from auto claims. First, for our sample of auto claims, CMS could expect to receive about 2 percent of total bodily injury payments made by auto insurers: \$45,163,663.03 in total

CMS could expect to receive about 2 percent of total bodily injury payments made by auto insurers: \$45,163,663.03 in total payments by third-party insurers to individuals in our sample—i.e., 2,294 people—and \$880,963.80 in possibly recoverable government payments, or 1.95 percent.

Table 4
Distribution of Government Recovery from Automobile Claims

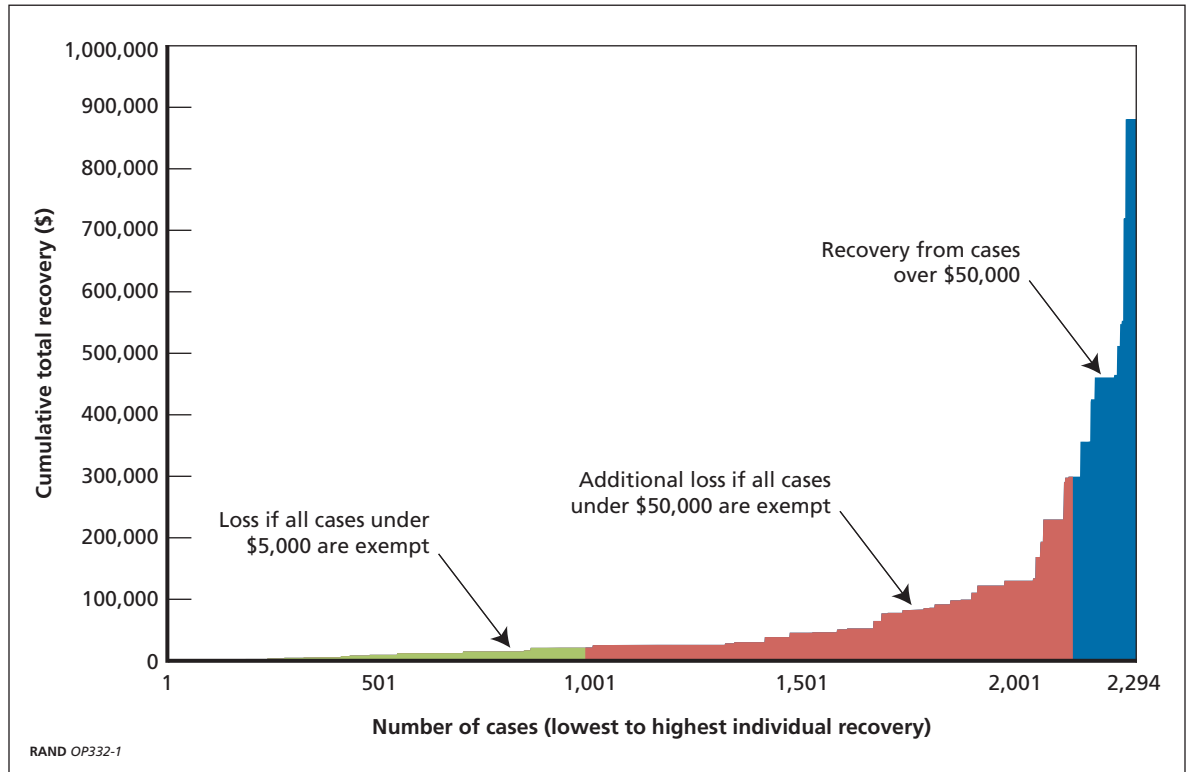
	Percent Reduction [Bootstrap Standard Error]
Total cases: 2,294	
Number of cases with payments under \$5,000: 900	43%*** [.98163]
Total possible recovery from all claims: \$880,963.80	
Loss in recovery by exempting claims under \$5,000: \$21,263.80	2.4%** [1.23491]
SOURCE: Calculations based on data from IRC 1992, 1997, and 2002 consumer panel surveys (IRC, 1994, 1999, and 2004). ***significant at the 5 percent level, **significant at the 10 percent level.	

¹⁹ One important assumption in our calculation is that the presence of the reporting requirement would not change the negotiated claim payment. Because Medicare could theoretically demand that the claim only be resolved for at least its lien, it is possible that the claims in question could be resolved for more than the current settlement. Of course, the alternative is also possible. Potential plaintiffs may decide not to file their claim in the first place if the majority of payment, or all of the payment, is used to pay off the lien.

²⁰ Bootstrapping is a statistical method of measuring the accuracy of sample estimates by resampling from the observed distribution. In our case, this involved drawing a sample of cases, with replacement so that a case could be represented multiple times in the resampled data. The degree to which this resample distribution mirrors the observed distribution provides an estimate of the precision of the estimates.

²¹ A confidence interval is the range of estimated values for a given level of certainty. Thus, our estimates assign only a 2.5 percent chance that the true value of the reduction in recovery is greater than the upper value of a 95 percent confidence interval.

Figure 1
Cumulative Distribution of Government Payments



We found that the more-recent, closed claim data are more heavily skewed toward smaller and midsized payments than are the older, survey data: The \$5,000 cutoff would eliminate 56 percent of the total number of claims rather than the 43.1 percent arrived at using the earlier data.

payments by third-party insurers to individuals in our sample—i.e., 2,294 people—and \$880,963.80 in possibly recoverable government payments, or 1.95 percent. If auto insurers pay about \$50 billion per year for medical care nationwide, the reporting requirement would result in payments to CMS of about \$1 billion a year from auto claims: \$50 billion \times 0.0195 = \$975 million, or approximately \$1 billion.

Distribution of More-Recent Auto Closed Claims Appears to Be Similar to That of Earlier Survey Data

The data on which we based our analysis came from the most-recent IRC consumer panel surveys available, the last of which was conducted in 2002. Since then, the distribution of auto claims might have changed, with recent years showing a larger number of high-value real payments. This is potentially a concern, since our estimates of the recovery lost from retaining the \$5,000 threshold depend on the distribution of payments not shifting so as to reduce the proportion of claims under \$5,000. To allay this concern, we examined a more recent IRC database, the Auto Injury Insurance Claims: Countrywide Patterns in Treatment, Cost, and Compensation (IRC, 2008), which contains closed claims from 2007 but does not contain information on payments from other sources. We restricted the sample to claims with a payment

by a third party and to bodily injury, personal injury protection, and uninsured motorist claims in order to approximate the payments by RREs covered by the new reporting requirement.

Table 5 presents the number of payments in each of the eight payment bins used to analyze the IRC consumer panel survey data. We found that the more-recent, closed claim data are more heavily skewed toward smaller and midsized payments than are the older, survey data: The \$5,000 cutoff would eliminate 56 percent of the total number of claims rather than the 43.1 percent arrived at using the earlier data.

The reason for the difference can be seen in Figure 2. The survey data simply have fewer small claims than do the closed claim data. There are a number of potential reasons for this difference; one plausible explanation is that people do not recall small claims when surveyed about them.

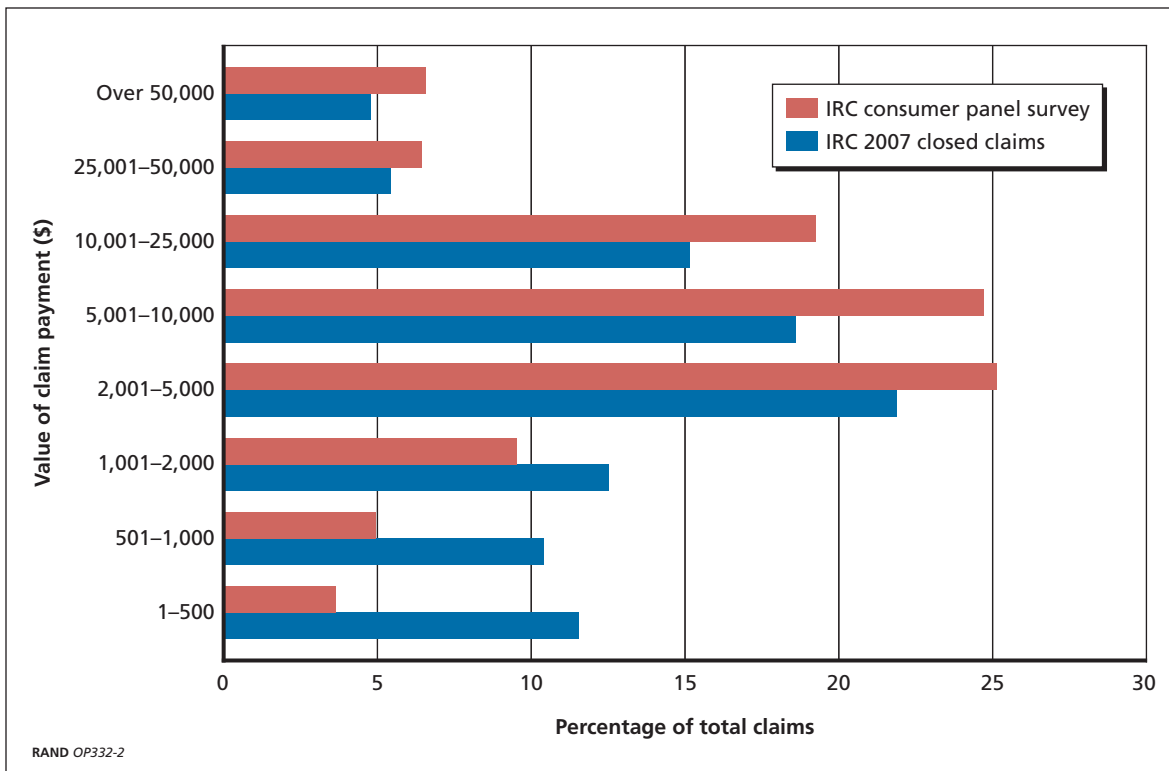
Because the 2007 IRC closed claim data do not contain information on payments from the government, there is no way to determine whether the reductions in Medicare recovery resulting from retaining the threshold are consistent across the survey and closed claim samples. Regardless, both samples suggest that for auto claims, a \$5,000 threshold for reporting would exempt a number of cases.

Table 5
Distribution of the 2007 IRC Closed Claim Data

Amount Paid in Auto Closed Claims (\$)	Number of Payments	Mean Payment (\$)
1-500	3,616	252
501-1,000	3,266	705
1,001-2,000	3,928	1,426
2,001-5,000	6,868	3,289
5,001-10,000	5,844	7,042
10,001-25,000	4,752	14,735
25,001-50,000	1,694	32,115
Over 50,000	1,489	100,825

SOURCE: IRC, 2008.

Figure 2
Comparison of the 2007 Closed Claim Data and the 1992, 1997, and 2002 Consumer Panel Survey Data



For Medical Malpractice Claims, Exempting Claims Under \$5,000 Would Have Almost No Effect on Recovery

Although auto cases represent a substantial portion of all cases in the tort system and an even larger portion of claims paid by third-party insurers, it is possible that the \$5,000 reporting threshold would substantially reduce Medicare recovery in other types of cases. To investigate this possibility, we examined the second most-common type of case in the tort

system: medical malpractice. We found that the \$5,000 threshold would affect very few payments for medical malpractice and hence would have very little effect on Medicare’s potential recovery from the reporting requirement.

Medical malpractice cases typically have much higher payments than do auto cases. Table 6, which presents medical malpractice closed claims from the NPDB Public Use Data File, confirms this observation: Very few of the 15,843 claims paid in 2006 had

For medical malpractice claims, exempting claims under \$5,000 would have almost no effect on recovery.

Table 6
Closed Claims for Medical Malpractice

Amount Paid for Medical Malpractice (2010 \$)	Number of Claims	Mean Payment (2010 \$)
1-500	64	237.59
501-1,000	57	817.50
1,001-2,000	129	1,635.00
2,001-5,000	470	4,077.06
5,001-10,000	713	8,467.37
10,001-25,000	1,504	19,281.55
25,001-50,000	1,294	36,360.01
Over 50,000	11,612	416,800.86
SOURCE: NPDB Public Use Data File, 2006 data.		

payments below \$5,000. Of the \$4,920,000,000 paid out to compensate medical malpractice claims in 2006, payments below \$5,000 constitute about 0.02 percent of total payments and only about 3 percent of the number of payments. Therefore, exempting these claims will have little effect on cumulative payments.

Because the NPDB provides no information on Medicare’s payments to the plaintiff for medical malpractice claims, we could not estimate CMS’s potential recovery from such claims. These results suggest that our estimates of the lost revenue from retaining the \$5,000 threshold would not be materially altered if we could include medical malpractice cases in our analysis.

What Is the Likely Effect on Administrative Costs?

Thus far, our findings indicate that for auto claims, the \$5,000 reporting threshold exempts a sizable fraction of payments from the reporting requirement while having a small effect on the government’s potential recovery. They also indicate that the second largest type of case—medical malpractice—will be largely unaffected by the threshold because most payments for this case type are far in excess of the reporting requirement. We now consider the potential reductions in administrative costs that might result if the threshold were retained. Perhaps the largest potential benefit of the threshold for RREs, however, is not administrative cost savings but the elimination of the threat of fines for a sizable fraction of claims. Currently, the law contains a penalty of \$1,000 per day per claim for late or flawed reporting and does not contain a good faith exemption for unintentional errors. Although the error rate in reporting will not be known until the requirement goes into effect, removing almost half of the auto claim payments from the requirement would reduce potential fines.

It is possible that the threshold will have no impact on administrative costs. If the costs are largely

fixed—that is, they are for installing new data capacity and programs to deal with the new fields—then once firms are able to report payments above the threshold, there may be no incremental cost to also reporting cases below the threshold. There are reasons to believe that more direct administrative cost savings would result from retaining the threshold. Under the new reporting requirement, an insurer will need to query all bodily injury claims to determine Medicare eligibility at the time of settlement, judgment, or award (and preferably earlier), or upon assumption of responsibility for ongoing medical care. The penalty for late or flawed reporting is \$1,000 per day per claim. Our estimates suggest that the reporting threshold would exempt almost 123,000 cases, and we can hypothetically assume that the error rate in reporting will be 5 percent (a number representing a high degree of accuracy in reporting) and that Medicare will not allow for good faith exemptions. Then, if we further assume that all errors take an average of a week to correct (at the penalty rate of \$1,000 per day), Medicare would be collecting \$30,750,000 (123,000 × 0.05 × 5,000) in fines from auto claim payments under \$5,000, which is equal to about 3 percent of our estimated recovery from all auto claims.

Although no one knows what the ultimate compliance costs will be, there are reasons to believe they will not be merely incremental once the reporting systems are operational. First, insurance companies typically have not collected such information, and it will be costly for them to put into place the means to do so.²² For litigated cases, such data collection

²² In fact, liability insurers that provide workers’ compensation coverage are now collecting this information and, as mentioned above, have collected it for no-fault claims. However, given that the insurer is making a payment to a beneficiary and not a third-party in these cases, it is not unreasonable to conclude that collecting this information in the context of the liability system will be more expensive.

Perhaps the largest potential benefit of the threshold for RREs, however, is not administrative cost savings but the elimination of the threat of fines for a sizable fraction of claims.

would necessarily involve attorneys' time (never an inexpensive proposition); but even for non-litigated cases, information collection still involves costs not previously incurred. Second, the data are necessarily organized around social security numbers, which require a high level of security and confidentiality.²³ It seems probable that data on social security numbers were not previously collected precisely because of the additional costs of utilizing such data. Finally, these costs must be paid either by consumers of insurance or owners of insurance companies. If we think of the reporting requirement as a tax on property casualty insurance, basic economic theory suggests that some portion of this tax will be passed on to consumers.

Another issue is that the time to resolve an auto claim is often quite brief. One major insurer notes that a claim is typically resolved in about 14 days. During that period, an injury may not present itself, but resolution does not end the reporting requirement. Although there is a reporting requirement for cases that do not involve bodily injury, since it would be impossible to generate a Medicare payment solely for property damage, Medicare is theoretically allowed to seek reimbursement from non-bodily injury claims if the accident generates a subsequent Medicare payment after the claim is resolved. Since the insurer is often unable to tell even for small claims whether a future Medicare payment will result, the amendment would theoretically require that all fender benders be reported, even if they are resolved for very small sums of money.

Although we do not know the cost of gathering the required information, insurers told us that they do not collect such information as social security numbers from individuals receiving payment in the liability system.²⁴ While compliance costs may rise with payment size, it seems unlikely that they will rise as rapidly as payments do. Put another way, the compliance costs for the top 10 percent of claim payments are likely to be much closer to those for the bottom 10 percent than are the relative values of the payments. A similar logic applies to CMS cost of recovery. The cost of pursuing recovery from a large claim is likely similar to the cost of pursuing recovery from a small claim. For these reasons, reporting is

simply not worth the money for some claims. One major property casualty insurer reported CMS making claims for \$.50 when the cost of processing the claim was clearly greater than the eventual recovery.²⁵ Although this claim is surely not typical, it does indicate the problems with a comprehensive reporting requirement.

A "Back of the Envelope" Cost-Benefit Analysis of the Reporting Threshold

In considering the cost of complying with the new reporting requirement, thinking about the tradeoff between the requirement and eventual recovery is useful. If our analysis is correct, Medicare can recover about \$1 billion from auto cases. If the \$5,000 reporting threshold is left in place, the cost to CMS in terms of lost recovery will be about \$24 million (the estimated \$1 billion in recovery from auto bodily injury claims \times 2.4 percent).²⁶ Currently, there are 190 million insured vehicles in the United States and about one injury claim per 100 insured vehicles, producing 1.9 million claims per year (Insurance Information Institute, 2009). If we assume that about 15 percent of these injury claims involve individuals who are eligible for Medicare and have received some payment that is owed to CMS under the new act, then 285,000 claims would have to be reported. The \$5,000 threshold would remove the need to process 43 percent of these cases, or about 123,000 claims.²⁷ Thus, Medicare is recovering about \$195 for each of these small claims (\$24 million in lost recovery divided by 123,000 claims falling below the threshold). The cost-benefit analysis hinges on whether the average administrative cost of these claims—both to the RREs (for reporting) and CMS (for processing and collecting)—is greater than \$195.

We cannot estimate this tradeoff without more data, but we can approximate the amount of labor required to keep compliance costs below \$195. The Laffey Matrix, used in lodestar-method calculations of attorney's fees, lists the costs of a paralegal with four or fewer years of experience as \$105 per hour (United States Attorneys' Office, 2010). Hourly rates for other legal professionals are higher. Our back-of-the-envelope calculation shows that the reporting costs can be kept under \$195 only if the least-expensive legal professional takes less than 111 minutes to collect and process the necessary information.

Since the insurer is often unable to tell even for small claims whether a future Medicare payment will result, the amendment would theoretically require that all fender benders be reported, even if they are resolved for very small sums of money.

²³ In a recent case, *Seger v. Tank Connection, LLC*, No. 8:08CV 75, 2010 WL 1665253 (D. Neb. April 22, 2010), the plaintiff refused to provide a social security number on the grounds that it was not material.

²⁴ To be clear, such information might be collected on policyholders, but payments made to a third party on behalf of a negligent policyholder typically require relatively little information on the third party. This is particularly true for small claims, which do not generally involve a structured settlement.

²⁵ Personal correspondence on file with the authors.

²⁶ This assumes that CMS would have pursued these small claims in the first place.

²⁷ This assumes that settlement amounts would not be altered to fall under the threshold requirements.

Our analysis suggests that collecting on low-value claims provides Medicare with relatively little revenue and that such claims represent a substantial fraction of the reporting burden. Reducing this burden might generate compliance cost savings that could accrue to consumers in the form of lower premiums or to owners of insurance companies in the form of higher margins.

Conclusion and Implications

Our analysis suggests that CMS could recover approximately \$1 billion per year for the most-common type of claims, those involving auto accidents; and that retaining the \$5,000 reporting threshold would reduce recoveries by 2.4 percent, or \$24 million, while reducing the number of claims that must be reported by 43 percent. For the second most-common type of claim, medical malpractice, the same threshold would have a far smaller impact on reporting costs and almost no impact on the government's recovery.

These results, small as they are, may actually overstate the amounts likely to be recovered by CMS, because payments are often reduced. In the workers' compensation system, where the reporting requirement is already in effect, RREs pay independent firms known as service providers to review claims to ensure compliance. As part of this review, service providers look at the amount requested in a Conditional Payment Notice or a Medicare lien from CMS. According to Crowe Paradis Services Corporation, a leading service provider for workers' compensation, the average reduction of a conditional payment claim is 85 percent.²⁸ Most of the reduction in conditional payment demands comes from Crowe Paradis reducing the requested payments to zero because the RRE is actually not responsible for the treatment costs that Medicare is alleging require reimbursement under the MSP Act.²⁹ This suggests

that a sizable portion of Medicare's requests are for reimbursement for treatment that does not result from the injury at issue in the claim. It should also be pointed out that such claims, despite the eventual reductions, are not without cost to RREs or their clients. Service providers are paid for their ability to reduce CMS claims, so the cost of securing the reduction is likely to be passed on to customers. In the case of small claims, the RRE may forgo potential reductions because the fee charged is too high relative to the size of the initial claim. Although this might be good news for CMS's recovery efforts, it does come at a cost.

Another reason why we may be overestimating the recovery to CMS from small claims is that under the new regulation, plaintiffs may decide not to file the case. It is unclear how these behavioral changes would alter the outcomes, but if fewer people pursue smaller claims, it is likely that both recovery amounts and compliance costs would decrease.

We recommend that policymakers carefully consider whether to retain a reporting exemption for low-value claims. Our analysis suggests that collecting on low-value claims provides Medicare with relatively little revenue and that such claims represent a substantial fraction of the reporting burden. Reducing this burden might generate compliance cost savings that could accrue to consumers in the form of lower premiums or to owners of insurance companies in the form of higher margins. Maintaining the reporting threshold would also provide some barrier to over-claiming. Procedures are in place to reduce CMS's demand in the event that the RRE's client is not responsible for the requested payment. But for small claims, there is no incentive for the RREs to request a reduction if the cost of securing the reduction is higher than the savings. Retaining a threshold would eliminate those cases in which CMS incentives to over-claim are strongest, because such claims are unlikely to be contested. ■

²⁸ From correspondence from Martin Cassavoy, Vice President, Legal Policy, Crowe Paradis Services Corporation, on file with the authors.

²⁹ The reductions appear to result from CMS's method of determining what it is owed. Like most first-party insurers, CMS organizes its data by ICD-9 codes. It does not attempt to determine potential liability for specific injuries. Thus, when requesting repayment, CMS typically claims all treatments during the time period of the injury, regardless of whether the RRE's client is responsible for all of the treatments received. Our data may be more accurate than the typical CMS Conditional Payment Notice because the IRC consumer panel survey specifically asks respondents about payments made by government insurers related to a specific injury. Nevertheless, the experience from workers' compensation suggests that considerable reductions are typical.

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