12. (2.75 points)

On December 29, 2007, the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA) was signed into law.

a. (0.75 point)

Describe the process mandated by the law and briefly describe how the law benefits Medicare.

b. (1 point)

Describe two features of existing Medicare law that may reduce Medicare's payment responsibility when it overlaps with other insurance programs.

c. (1 point)

A workers compensation insurance company has implemented the requirements of the MMSEA. Evaluate the impact MMSEA may have on the frequency and severity of the insurer's claims.

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a. FDIC
b. No interaction; exclusively provided by federal gov't
c. To stabilize financial market, prevent bank run in the event of rumored insolvency, give protection to depositors
d. Successful as bank run hasn't occurred in US for many decades

Guaranty Funds
a. Guaranty funds
b. Insurers pay assessments to the fund
c. Protect policyholders when insolvent companies can't pay claims
d. Yes, it pays claims (although subject to limitations) to policyholders

11. Examiner's Report

For property-casualty insurance plans, this was a fairly straightforward question. It was more difficult to discuss the social insurance plans and the financial insurance plans. Part d was the most challenging part of this question, as it required candidates to evaluate the success of the various programs.

a. There were several acceptable answers under each category. The property-casualty insurance plans were the most straightforward. For social insurance plans and financial insurance plans, Nyce lists unemployment insurance, social security, FDIC, and PBGC. Among these, the social insurance plans are unemployment insurance, social security, and PBGC. It was also acceptable to categorize guaranty funds as a financial insurance plan as they protect an insured's unearned premium.

b. The question asked candidates to describe the interaction between government and private insurers. Some candidates failed to describe the interaction and instead described how the program operates.

c. Some candidates stated inaccurate information or did not understand the program referenced in part a. However, most programs have multiple objectives that could be argued as a primary objective, and the papers referenced several objectives for government programs (eg fulfill unmet needs, compel insurance purchase, achieve social collateral purpose, etc.). It was acceptable to discuss the category or accurate examples of the category. For example, for Social Security the primary objective is to achieve a social collateral purpose, but it's also acceptable to state "provide a minimum floor of income to retired or disabled people".

d. Some candidates stated inaccurate information or failed to communicate that they understood the performance of the program. Candidates needed to provide more than just "successful", "not successful", or "this program met its primary objective" by providing a very brief example of how it was a good or bad program as shown in the sample answers.

12. Sample Answers

a.

Sample 1

Requires claim payers (Liability/NF/WC insurers) to report claim data to CMS (Center for Medicare & Medicaid Services) and determine Medicare enrollment status of claimants.

Assist in coordinating benefits & uncover reimbursable claims (paid by Liability/NF/WC insurance)

Sample 2

Claim payer must submit claim data to CMS. Insurer must determine if claimant is Medicare eligible. Both of these benefit Medicare because determining status prevents benefit overlaps (saves costs)

Sample 3

Responsible Reporting Entities (RREs) are required to determine the Medicare enrollment status of all claimants and submit certain information of the claims to the Center of Medicare and Medicaid Services (CMS). The law benefits Medicare as the responsibility of payment can be clearly determined.

b. Any two of the following:

- Medicare is secondary to both WC and liability insurance and pays only if/when benefits are exhausted.
- Medicare is secondary to workers compensation or liability insurance coverages.
- Medicare makes conditional payments (on medical costs that may be incurred before eligibility to collect insurance is determined) to medical providers which can be reimbursed by an insurer determined to be the primary
- Conditional payments allow Medicare to be reimbursed for payments it made while liability was being determined.
- Conditional payments – if Medicare begins paying bills early in a case before liability is determined, it gives them the ability to recover these conditional payments from the responsible party.
- All parties to a settlement agree to set aside a portion to be primary over Medicare for future treatment after injured party becomes Medicare eligible
- Medicare set asides require that settlements include a portion of funds for the time period when Medicare would apply. This prevents settlements from escaping their primary duty to pay.
- Medicare set aside requirements ensure that part of the settlements from other insurance will be set aside and be primary to Medicare in the future when the worker becomes Medicare eligible.

c.

Sample 1

Could increase frequency and severity of medical claims. Previously, if a claim had both medical and indemnity component, it was sometimes coded as indemnity only. With new reporting requirements, it is more important to correctly code as medical, so medical frequency will increase. Also, because they now have to better make sure settlements account for future medical costs (and don't incorrectly expect Medicare to pay), severity will increase – Medicare must approve that amount in MSA is adequate.

Sample 2

Frequency may not change much as reporting requirement mainly affects size of the claim but looking at frequency of medical itself, may increase due to reclassification of claim lumped into indemnity to indemnity and medical.
Severity may increase due to additional payment over Medicare not previously paid, and higher LAE due to reporting requirement procedures.

Sample 3

Frequency may increase if claimants were previously getting benefits from Medicare instead of the insurer.

Severity will increase due to increased cost of complying with new reporting law.

Sample 4

Frequency will increase for medical workers compensation since medical portion is clearly identified and in the past, it may have been entirely coded as indemnity.

Decrease in indemnity severity since now medical portion is clearly identified and split out rather than all coded as indemnity

Sample 5

The impact of MMSEA should have little effect on frequency, but may see claims remain open longer as approval is needed for settlement amounts. Severity may see an increase as the company now must set aside any amounts that previously would have been covered by Medicare. Also, the company may need to reimburse Medicare for amounts Medicare paid historically that should have been paid by the company. This would also increase severity.

Sample 6

The frequency won't be affected assuming accidents are always initially reported to the WC carrier.

Severity may go down if insurer now covers more small claims.

Sample 7

The impact of MMSEA will increase the frequency of claims. It will force insureds to look to the workers comp insurer first, when previously they may have erroneously used Medicare first.

It should have little effect on the severity as it does not change the nature of the claim.

12. Examiner's Report

Parts a and b were straightforward questions drawn from the syllabus readings. Part c involved some synthesizing of the potential impacts on a insurer with properly-stated assumptions to support the impacts.

a. Some candidates knew the law requirements while others answered with anything they may remember about the papers (MSAs, secondary payer, etc…). Common errors included:
   - Assuming the 2007 law was about Medicare Set Aside Act or Medicare Secondary Payer Act, rather than the new reporting requirements
   - Mention of reporting requirement in the law without discussing benefit

b. Generally, most candidates were able to identify at least 1 feature when there was an overlap. Common errors included:
   - Not understanding how an MSA works (provision for insurer to set aside portion of settlements for when claimant is Medicare eligible) and how conditional payments work

c. Generally, candidates were able to identify one of the impacts (frequency or severity) MMSEA had on claims. Common errors included:
   - Describing from the viewpoint of Medicare

- Discussing historical statistics, settlement rates
- Discussing settlement/closure rates rather than claim frequency
- Thinking that the insurer may not report claims due to costs of reporting from the new requirement – frequency going down (but insurer is incentivized to report since there are heavy penalties for not reporting)

13. Sample Answers

a.

Principle 1 (any one of the following):

- Rate is estimate of expected future costs for full risk rates in NFIP. However pre-FIRM risks are subsidized and pay less than actuarially fair.
- Satisfy for full-risk premium. Not satisfy for subsidized risk.
- Yes, the full-risk rates satisfied this principle.
- No, the NFIP rates underestimated the expected value of future costs.
- The subsidized rates under the NFIP do not reflect the expected future costs. The risk rated policies do.
- Rates are suppressed in order to make affordable.
- No – some insureds were grandfathered in when the flood maps changed.
- The NFIP rates for some do provide for this, however those in the SFHAs are not in compliance.
- NFIP rates are based on expected value of costs, but they are inadequate in aggregate so doesn't satisfy.

Principle 2 (any one of the following):

- Cost of capital is not included in the rate determination for NFIP, so the rates do not provide for all costs. However cost of capital may not be necessary since federal government can borrow and tax to fund.
- Not satisfy – not include cost of capital
- Yes they meet this. NFIP doesn't charge cost of capital unlike private insurers but this isn't necessary since they have the backing of the US government.
- Does not satisfy because it doesn't have any profit load.
- No, no investment income is considered, doesn't cover all expenses in settling claims.
- No. NFIP rates do not have a risk load. A risk load is not necessary because the federal government backs the program.
- NFIP rates do not include a risk margin so not all costs are included.

Principle 3 (any one of the following):

- Individual risk transfer is also not true, due to subsidies. However, the subsidies encourage participation via some premium paid in and help fulfill NFIP's social objectives.
- Subsidized properties are way below the actuarially sound price, so because of the grandfathered properties, this is not satisfied.
- The broad class plan creates subsidies so this is not satisfied.
- Not satisfied as there is a subsidized part in the NFIP rates.
- Not satisfied because certain risk characteristics are not allowed to be considered in the rates.