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Designing a Solution to the Problems of Medicare Set-aside Arrangements in Workers' Compensation

Summary

Issue: Workers' Compensation Medicare Set-asides (WCMSAs) have become an increasingly costly component of the workers' compensation system. Between 2004 and 2008 The dollar amount of WCMSAs increased (+525%) to about 4% of workers' compensation paid medical and they could reach 12-15% of workers' compensation paid medical by 2025. This trend has made WCMSAs a major concern of insurers, policyholders, self-insured employers, attorneys, workers involved in potential settlements, and policymakers trying to improve system efficiency.

Medicare's problem: Despite the large increase in set-aside total dollars, preliminary research finds that Medicare remains substantially underfunded by the primary payers. Even when all parties act in good faith and set-aside the appropriate amount, we estimate that Medicare will be underfunded by 40%--60% of Medicare's ultimate liability. In addition, Medicare certainly has substantial additional administrative costs connected with tracking claims, determining liability, recovering conditional payments, and accounting for WCMSAs.

Solution: Medicare would be responsible for all medical treatment, both occupational and non-occupational, when a person is Medicare eligible. We use a simulation to make a preliminary, single-state estimate of the fair assessment on workers' compensation insurance policies for treatment related to occupational injuries of Medicare beneficiaries. This assessment would be paid directly to the Medicare Trust Fund (assuming implementing legislation).

Gains: For California, an assessment of 1.3% of workers' compensation premiums (and the equivalent for self-insured employers) would reimburse 100% of Medicare's liability for the occupational conditions of Medicare beneficiaries. Assuming all states participate, this approach would eliminate Medicare's current \$400 million to \$600 million shortfall. Because Medicare's unit costs are lower and administrative costs much lower, employers' premium costs in California, after the 1.3% assessment, would be 4.8% lower.

Continuing research: The simulation is constructed with California specific parameters for the current time period. Substantial improvements could include 1) broadening the range of parameters to include other individual states and national averages; 2) developing 10 year simulations for budget savings estimates; 3) refining estimates by developing medical cost distributions for important conditions; 4) including in the simulation consideration of cases that qualify to Medicare through SSDI & SSI; 5)

broadening the modeling to include other forms of insurance such as auto and product liability where Medicare likely recovers even a smaller fraction of liabilities; and 6) bringing together stakeholders to discuss the practical challenges of implementation.

Introduction

Workers' Compensation Medicare Set-asides (WCMSAs) have become an increasingly costly component of the workers' compensation system. The attached background paper (Attachment A) highlights the growth of dollars under WCMSAs between 2004 and 2008 (+525%) to about 4% of workers' compensation paid medical, the likely substantial increases between 2008 and 2010, and the potential for large future increases that could take WCMSAs to 12-15% of workers' compensation paid medical.¹ This trend has made WCMSAs a major concern of insurers, self-insured employers, workers involved in potential settlements, and policymakers trying to improve system efficiency.

Besides the escalating cost, a number of other concerns have been raised, for example, the Centers for Medicare and Medicaid Services' (CMS) approach to administering the Medicare Secondary Payer (MSP) provisions, the high administrative and litigation costs related to WCMSAs, delays, and the fairness and adequacy of many settlements for both the insurers and Medicare.

The focus of this research has been the development of efficient alternatives to the current WCMSA approach. We believe that the alternative outlined in this paper could both increase Medicare's recoveries and reduce employers' cost. Absent alternatives, states may react to the rising costs of WCMSAs by restricting the compensability of "long-tail" or long-latency conditions or even changing state statutes to end employer responsibility for occupational medical treatment when a worker is eligible for Medicare.² Medicare may react to the underfunding by raising the target amounts of individual set-asides making them even more costly and less predictable for employers/insurers.

If several states adopt restrictions that limit insurer/employer liability affecting Medicare's recovery, more states may feel forced to adopt similar statutes to remain competitive. Medicare may react with increased demands. Insurers, employers, and Medicare may get trapped in a downward spiral of confrontation with workers trapped in the middle.

¹ See Neuhauser, Frank, Anita Mather, and Joshua Pines, "Working Safer or Just Working Longer? The Impact of an Aging Workforce on Occupational Injury and Illness costs." Report for the Commission on Health and Safety and Workers' Compensation. January, 2011.

² LC0305 introduced January 2011 in the Montana Legislature would terminate employer liability at 5 years from date of injury, substantially limiting possible recoveries by Medicare.

The alternative we discuss in this draft paper includes the following provisions:

Once a person becomes Medicare eligible, Medicare would pay for all treatment for the beneficiary, regardless of original cause of the condition or party originally liable for treatment. This draft paper discusses workers' compensation insurance, but all similar insurance products could be included, (auto, product liability, etc.).

Insurers/self-insurers would pay an assessment to the Medicare Trust Fund equal to the present value of the future expected cost of treatment supplied by Medicare that would otherwise have been the responsibility of the insurer or self-insured entity.

Medicare Set-asides and conditional payments would be entirely eliminated.

Employer savings would be from the reduction in premium less the additional cost of the assessment.

Medicare would get fair reimbursement without the administrative cost of WCMSA and the related recovery of conditional payments. The fair reimbursement, by itself, would be substantially higher than current Medicare recovery for the same conditions, even when insurers set aside what Medicare and/or Medicare's contractor think is fair.

Current Medicare approach to workers' compensation

The current Medicare approach to WCMSAs requires certain special considerations from parties to settlements that involve future medical treatment and a claimant that is eligible or likely to become eligible for Medicare. The parties are also required to notify Medicare if there is a chance that Medicare has or will make "conditional" payments on a claim even when there is no settlement. When a settlement involves a set-aside, these are set-up and administered individually.

The advantages of the alternative proposed here arise from two sources, 1) savings to employers from administrative simplification and lower unit prices under Medicare and 2) 100% recovery by Medicare of Medicare's cost instead of the current much lower percent recovery.

The current approach leads to a number of administrative complexities that are costly to workers, insurers, policyholders and Medicare. These can be broken into two areas:

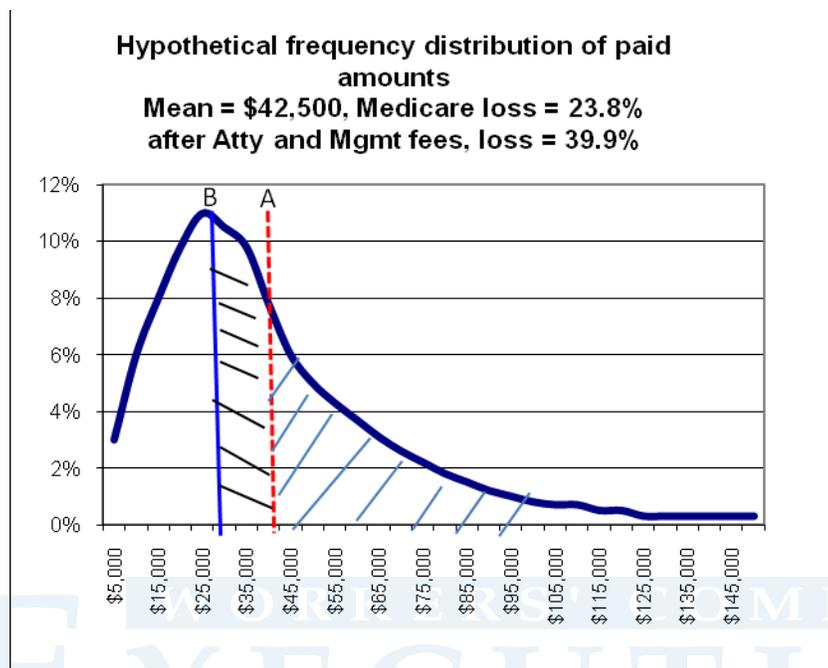
Conditional payments—when a worker is Medicare eligible, Medicare may make payments "conditionally" while CMS, the insurer, and/or the worker resolve whether the condition is the responsibility of the insurer, the worker (in case of a prior settlement) or CMS. CMS may also make payments because it is unaware that another payer has responsibility and fail to recover or have to litigate the issue later along with fines and penalties.

Medicare set-asides—When insurers settle a case meeting certain criteria that put Medicare at risk for future medical treatment, Medicare requires that insurers fund Medicare set-asides, essentially trusts set up to pay all medical bills connected with a condition. If the trust is exhausted, CMS is responsible for future payments. If funds remain in the trust when medical treatment concludes, the funds return to the worker or her estate.

This discussion will focus on Medicare Set-asides, but virtually every issue is mirrored in the area of conditional payments.

Example of why Medicare will be consistently underfunded with WCMSAs

The chart below shows a hypothetical distribution of ultimate paid medical costs on a set of conditions that have an estimated mean ultimate cost of \$42,500.



In this example, WCMSAs were theoretically calculated using all available data at the time of settlement. The parties (and Medicare) conclude that expected future medical treatment is \$42,500, which we will assume was accurate. However, as we know, ultimate medical has a high variance. Most claims will have costs under the average, some cases will be above the average, and a few will have very high costs. If WCMSAs are funded at the average, most workers' WCMSAs (those with ultimate costs to the left of the mean—vertical line-A) will be over-funded. On the other hand, many WCMSAs will be under-funded. This portion is to the right of the vertical red line-A (the area with positively sloped hash marks). For these claims, Medicare spends substantially amounts after the WCMSA is exhausted. In this example, if Medicare gets the accurate mean value, the WCMSAs will under-fund Medicare by 23.8%, because Medicare pays when the WCMSAs are under-funded but does not recover the extra from the majority of cases that are over-funded.

In addition, Medicare allows for trust management and attorneys fees to be deducted from the set-aside amounts. So, Medicare does not receive the expected amount, but rather something less in most cases. Attorney fees are often 15% (workers' compensation) to 40% (liability insurance) and trust management is likely around 15% of any WCMSA. If we chose 30% as a conservative estimate of attorney fees and trust management, then in the above example, Medicare will receive about \$29,000 against a "fair" amount of \$42,500. Using the distribution of costs in the

example above, Medicare would be underfunded by about 40%. This area is to the right of the vertical line-B.

Thus, for a very reasonable example, Medicare will be underfunded by 40% of the correct amount. And we assume in this example that the parties act in good faith, calculated accurately the future expected cost of a condition, and do not cherry-pick the claims subject to set-asides, and have no incentives to shift costs to Medicare. If any of these assumptions is violated, we would expect Medicare to be even more severely under-funded. If trust administration cost is higher or attorney fees take a larger slice (as in many property casualty lines), the recovery by Medicare will be substantially less.

In addition, Medicare will spend an unknown, but possibly substantial, amount to track claims, determine whether treatment is the responsibility of Medicare or a primary payer, recover conditional payments, determine appropriate WCMSA amounts and audit accounting of WCMSAs. This will add to the underfunding of Medicare's direct liabilities.

Alternative to current WCMSA design:

A straight-forward and efficient solution is to estimate the expected value of future medical treatment for occupational injuries and illnesses that would be paid on claims after workers become Medicare eligible. This estimated amount would be distributed across insurers and self-insured employers in the form of an assessment paid directly to the Medicare Trust Fund (this is similar to assessments to support Second Injury Funds or high-risk pools). Medicare would pay for all care, regardless of cause, once a worker is Medicare eligible.

The advantages to this approach are numerous. BY THE WORKERS' COMP EXECUTIVE

Medicare's is fully and fairly reimbursed.

Employers/insurers will pay no more than their appropriate share. This will be substantially less than they currently pay in for the combination of treatment under workers' compensation, conditional payments to Medicare, and Medicare set-aside arrangements.

Administratively costly set-aside arrangements are avoided. This saves workers extensive hassle with paying their own bills or paying to have professional management of the set-aside.

Instead of paying at the applicable state's workers' compensation fee schedule, as conditional payments and WCMSAs are currently set up to do, the payments would be at Medicare's fee schedule rate. This rate is typically 50% to 75% of states' workers' compensation fee schedules.

All parties avoid the administrative expense and hassle of handling the payments and adjudication of a single condition separate from all other medical conditions a worker (patient) experiences.

All parties avoid the costly disputes that arise over whether a condition should be paid under a workers' compensation policy, a WCMSA, or would be Medicare's responsibility under current law.

The very high administrative costs associated with the delivery of workers' compensation medical benefits would be entirely avoided on the treatment covered by Medicare. There is no "gaming" of Medicare arrangements by any party.

Preliminary estimate of savings to employers and gains to Medicare

We have done preliminary modeling of the costs and benefits of the assessment alternative and have identified substantial savings to employers and increased recoveries for Medicare. The simulation involves the following steps:

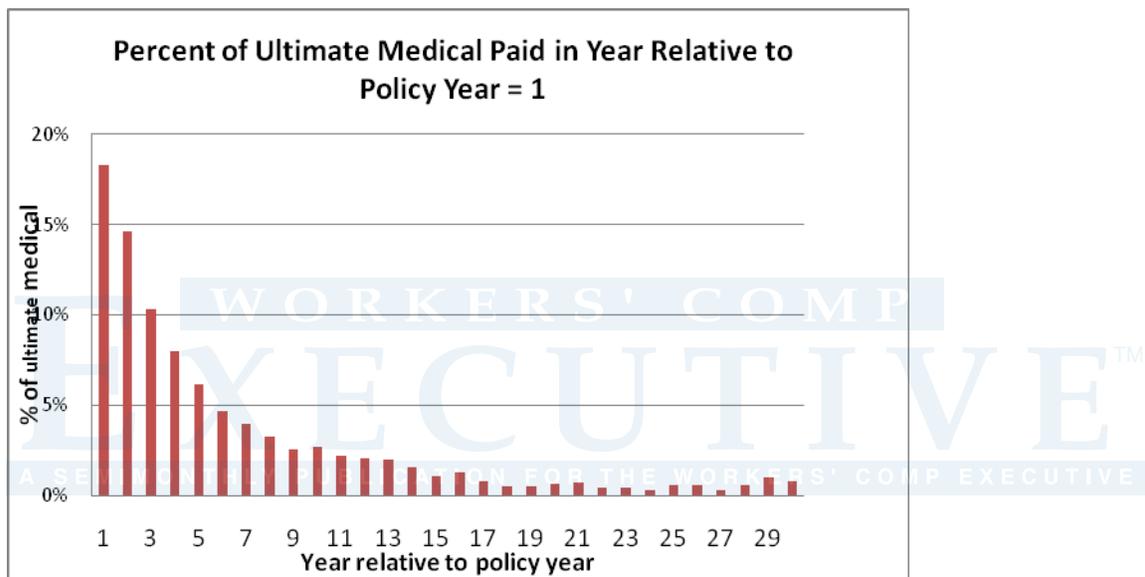
1. Calculate the undiscounted value of the workers' compensation medical that is delivered after a worker becomes "Medicare eligible" (ME). Calculate this as a fraction of undiscounted ultimate medical. (Workers' compensation insurers report ultimate medical costs as the sum of all, undiscounted, medical payments over the life of the claim.)
2. Calculate the discounted value of the ME medical costs as a fraction of discounted ultimate medical costs.
3. Use the current estimated split between medical and indemnity benefits to determine the discounted ME as a fraction of all discounted benefit costs. And,
4. Use estimates for benefits/premium (43% to 48%) that was calculated for the paper on the administrative cost of workers' compensation medical treatment.³
5. Discount Medicare's ultimate payments to reflect the lower unit cost faced by Medicare relative to workers' compensation systems' typical fee schedule
6. Calculate cost savings due to Medicare's lower unit price
7. Calculate Medicare's cost including average administrative cost.

These steps are described in more detail below.

³ Neuhauser, et al., "Integration of Occupational Medical Care into Health Insurance: An Answer to Financing Universal Coverage?"

1. We built a simulation to model the portion of workers' compensation costs that would be paid during the period when workers are Medicare eligible (ME). In this simulation we define Medicare eligibility as age 65+. Alternative definitions of ME could be inserted. The main components of this simulation are:

Medical development over the first 30 years for workers compensation claims: For this initial simulation we used the 30-year development numbers for California that are published by the Workers' Compensation Insurance Rating Bureau of California (WCIRB). Medical development numbers can be translated into the fraction of "ultimate medical" cost that is paid in each accident year from the initial accident year through the 30th year. The simulation allows any set of development numbers to be substituted for the California numbers.

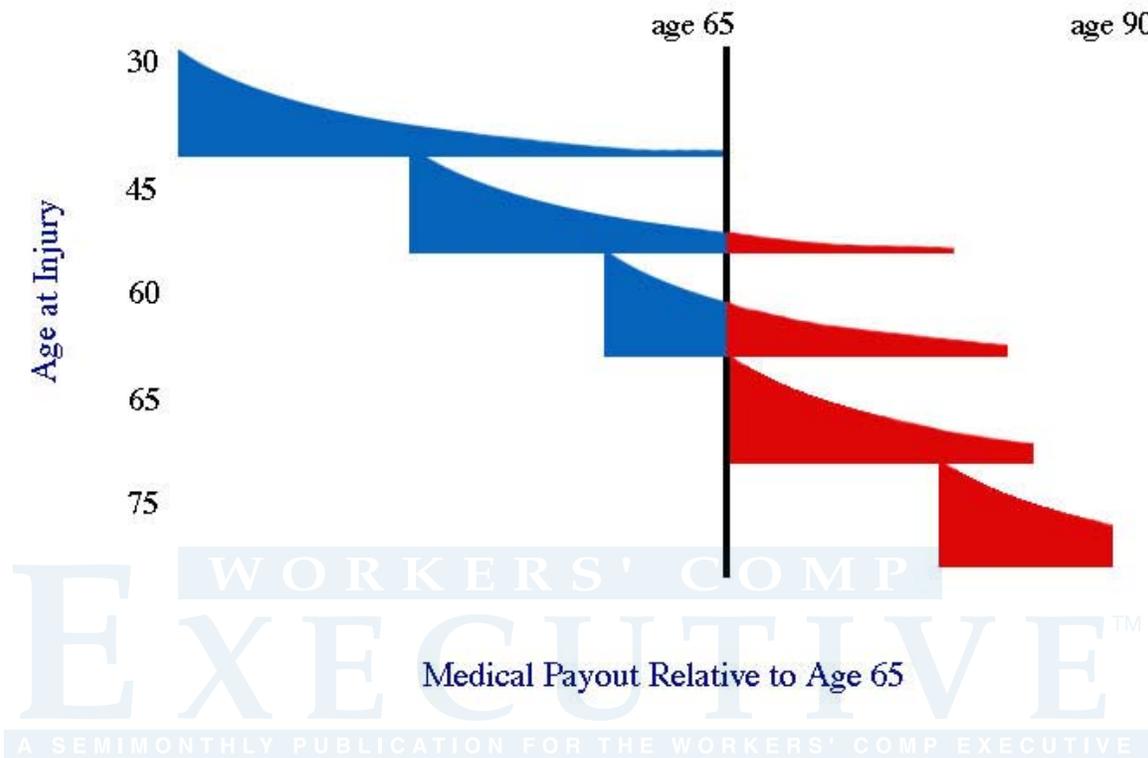


This “development” distribution is then arrayed in a spreadsheet for workers at each year of age. A stylized version of this is shown in the figure below.

Each worker is given a life expectancy based on the most recent life tables.

The fraction of expenditures (if any) expected to be after a worker becomes Medicare eligible is then calculated for each age.

30-year Paid Medical Development Relative to Medicare Eligibility



The distribution of injuries by age for workers compensation claims: This distribution was generated by Martha Jones, Research Manager, for the California Division of Workers' Compensation from the Workers' Compensation Information System (WCIS). Any alternative distribution can be easily substituted for the California specific distribution.

The relative average medical cost by age. Medical costs may differ by age: If average medical costs differ by age, then it is important to build in factors for the relative cost of claims by age. We do this using the average medical cost for workers at each year increment of age relative to the average for all workers. This allows us weight the values in the simulation to reflect higher or lower costs for workers of different ages. The average medical cost by age was generated by Martha Jones from WCIS data on claims with between \$50 and \$250,000 in paid medical for accident year 2009, evaluated at 1/1/2011. Any alternative set of relative values can be substituted in the simulation including a baseline set that is neutral relative to age. We ran a simulation using constant

medical costs by age, which was consistent with data on incurred medical available from the WCIRB PD Survey.

Discount rate: The ultimate medical costs calculated by the WCIRB are not discounted to reflect the time value of money. Consequently, the simulation allows the user to insert any specific discount rate. For our basic estimate we used 5%.

The simulation has places for each of these inputs. The outputs are the “undiscounted” and “discounted” fraction of ultimate medical that would be paid by workers’ compensation after a worker reaches age 65. For this discussion we use 9.3% as the undiscounted fraction and 6.1% as the discounted fraction, consistent with the age and medical cost distribution from WCIS, a discount rate of 5%, 30-year California medical development from the WCIRB, and life expectancy set at most recent available data.

2. Medical benefits constitute only a portion of all benefits paid. For California, on a policy year basis, the WCIRB estimates that medical benefits constitute 66.7% of ultimate benefits. Consequently, as a fraction of all benefits the medical benefits paid on the ME workers’ will be $2/3^{\text{rd}}$ of the values estimated in the simulation. In the example, we get undiscounted benefits of 6.2% and discounted benefits of 4.1%. One can easily substitute alternative splits to simulate other state’s numbers or a national number.
3. Administrative costs in workers compensation are much higher than they are under Medicare. The reasons for this are detailed in a separate paper comparing workers’ compensation administration to group health (Neuhauser et al. 2010). That paper estimates that administration in workers’ compensation constitutes 52% to 57% of every premium dollar. Consequently, the actual medical payments made for MEs will be 43%-48% of the estimated fraction of benefit costs. In this exposition we will use 45% as a middle estimate. The discounted value will be $.45 * 4.1\% = 1.8\%$, which represent the fraction of premium that would be paid for the medical treatment on ME workers.
4. Medicare usually pays a substantial discount to workers’ compensation for each unit of service. The discount varies by type of service and the state’s schedule under which it is paid. We will use the simplification that workers’ compensation schedules are, on average, 150% of Medicare, or that Medicare pays 66.7% of workers’ compensation for the same unit of treatment. Consequently, the present value of the payments Medicare would make on MEs will be $.667 * 1.8\% = 1.2\%$ of workers’ compensation premiums.
5. Medicare does face administrative costs on its medical payments. Most estimates put this at 3%-5% of medical costs (Mathews, 2006). Consequently, the appropriate assessment on a workers’ compensation insurance premium in California that could be paid, up-front, to CMS to cover all future medical care for workers once they become Medicare eligible, would be $(1.05 * 1.2\%)/.933 =$ or 1.3% of premium. [Note: the .933 factor reflects the smaller premium level after eliminating the payment for Medicare eligible workers, but the requirement that we generate the equivalent of 1.2% of the current premium.]

The reduction in premium is difficult to calculate because there are different ways to interpret how insurers construct premiums from underlying costs. The approach we use mirrors the approach used by the Workers' Compensation Insurance Rating Bureau of California (WCIRB) and the National Council of Compensation Insurers for estimating the impact of legislative changes on employers' premiums.

The insurers build base rates using the formula (Ultimate Medical + Ultimate Indemnity) * LAE*Rate Deviation*Underwriting Expense. Then the reduction on the ultimate cost of medical treatment, because it is shifted to Medicare, is the undiscounted percent of medical that is paid on ME workers times the fraction of benefits represented by medical. In the example used here, undiscounted medical on ME workers is 9.3% and medical is 66.7% of benefits. So the appropriate starting point for premium reduction is 6.2%. While this is a simplification of a complex calculation, this is the basic method that would be used by WCIRB to evaluate a legislative proposal that involved a reduction in medical costs.

Employer savings: Employers would pay premiums that in this example would be 6.2% less, but also pay an assessment that is 1.4% of premium. Employer savings will then be roughly $6.2\% - 1.3\% = 4.9\%$ of premium.

Medicare's gain: Medicare is very likely getting reimbursed 40% to 60% of actual expenditures on cases with set-asides. Since Medicare is likely facing some cost shifting on conditional payments, missing some cases, and spending substantial administrative resources to monitor both set-asides and conditional payments, we expect that Medicare will more than double the fraction of expenditures it currently recovers. With WCMSAs in 2008 at \$1 billion, Medicare's underfunding would be \$400 million to \$600 million annually. This underfunding is likely to become much worse. The dollar value of WCMSAs has almost surely risen substantially through 2010 and the aging workforce will continue to increase liabilities for Medicare through at least 2025.

References

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Neuhauser, Frank, Anita Mather, and Joshua Pines, “Working Safer or Just Working Longer? The Impact of an Aging Workforce on Occupational Injury and Illness costs.” Report for the Commission on Health and Safety and Workers’ Compensation. January, 2011.



ATTACHMENT A

Background

Recent Trends in Workers' Compensation Medicare Set-asides

Beginning in the early 2000s, Medicare has taken a more aggressive stance on the responsibility of insurers and self-insured employers when they settle the future medical liabilities in a workers' compensation case. Starting in 2001, the Centers for Medicare and Medicaid Services (CMS) began issuing a series of directives clarifying the responsibilities of parties and defining the cases on which Medicare's interests must be considered. CMS also made clear that in the absence of adequate consideration of Medicare's interests, CMS reserved the right to go back to the insurer or self-insured employer to recover medical treatment costs. More recently, CMS has issued instructions on how its contractor will handle estimation of future prescription drug costs.

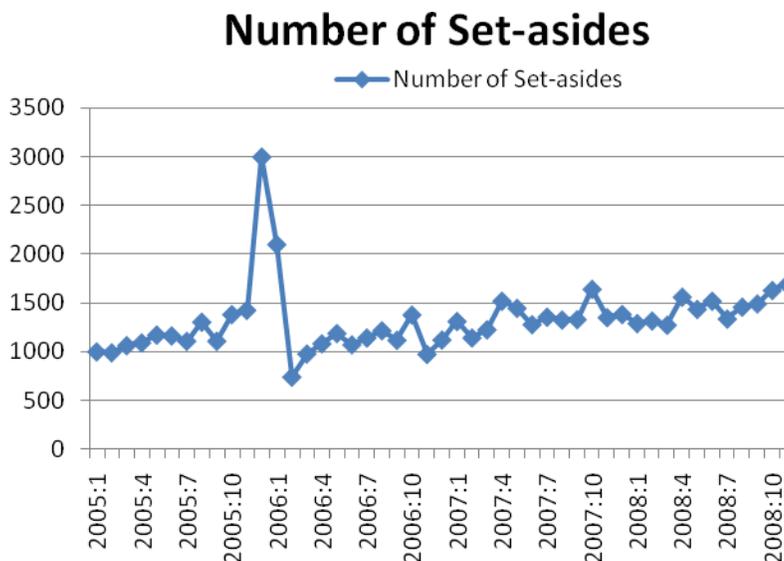
The impact of CMS policies has been to raise concerns by workers' compensation insurers and self-insured employers about the extent of the liabilities they face, which can include liabilities on cases for which premiums have already been paid and reserves already set. In California, insurers' concerns have been raised in discussion about premium rate setting both in the workers' Compensation Insurance Rating Bureau (WCIRB) Claims Subcommittee and Actuarial Committee. However, there have been almost no data available to evaluate the actual impact of CMS's actions.

Because CMS refused to release information on WCMSAs, I filed a Freedom of Information Act (FOIA) request in December of 2009. Recently, CMS responded to the request with a limited set of data on WCMSAs approved in calendar years 2005 through 2008. This brief presents these data. Unfortunately, CMS claims that data prior to 2005 is not available because the WCMSA process was decentralized. CMS stated they were not required to respond to a FOIA request for data for the period after 2008 because they do not customarily prepare these data. The 2004-2008 data are only available ("FOIA-able") because these data were prepared in response to a direct request by Senator Lautenberg (D-New Jersey).⁴

Number of WCMSAs

While we cannot observe the number of WCMSAs filed prior to 2005, the trend since the beginning of 2005 has been positive, with the number of WCMSAs increasing approximately 55%-70% over this period. Figure 1 presents the monthly number of WCMSAs filed nationally.

⁴ I plan to ask Senator Feinstein (D-CA) to request data for 2009 and 2010.



The trend in the number of WCMSAs is likely affected by four factors:

Declining occupational injury and illness rates, which should reduce WCMSA frequency and dollar amounts

Increasing average age of injured workers at time of injury

Response by insurers and self-insured employers to changes in CMS's position

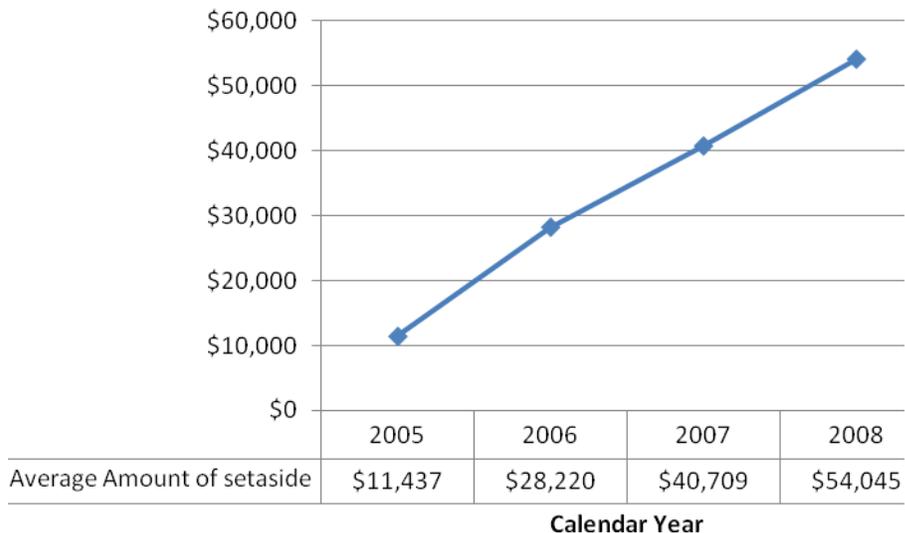
Medical inflation rates that, given fixed thresholds defined by CMS, will generally drive a larger fraction of claims above the threshold.

Average Amount of WCMSAs

The biggest change observed in the WCMSAs over this period is the dramatic increase in the average dollar amount of the set-asides. This is almost surely a response by insurers and self-insured employers to the more aggressive stance by CMS and also likely a response to review by a single national contractor (Life Care Management Partners) with different criteria than the several regional contractors previously used by CMS.

Figure 2 presents the data on the average value of WCMSAs. These data were only made available by calendar year. The average dollar amount increased by 470% from \$11,400 in 2005 to over \$54,000 in 2008. While the absolute dollar value of the year to year changes is nearly linear, the percent increase, year-to-year, is declining.

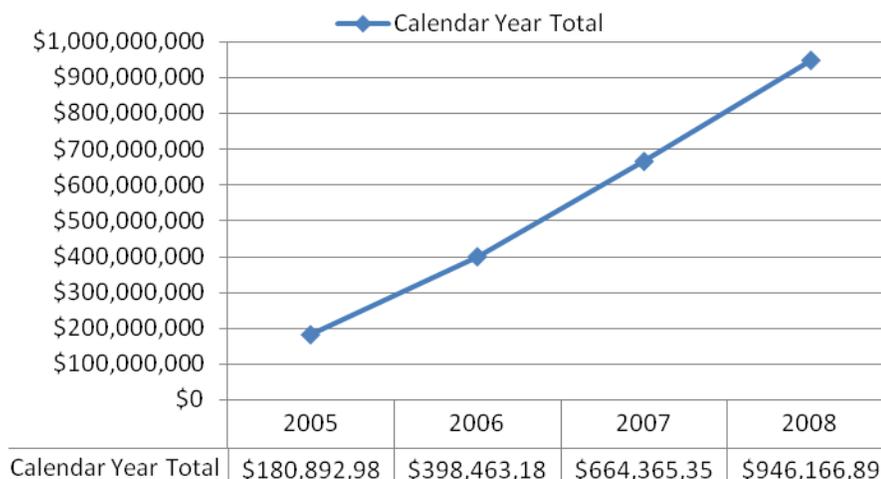
Average Amount of WC Set-aside



Total amount of WCMSAs

The combination of the increasing frequency and increasing average value means that the growth in the total annual WCMSA amount has been very large. The total value of WCMSAs in calendar year 2005 was \$180 million. In 2008 the value had risen to over \$956 million, an increase of 525%. Again, while the absolute dollar increase has been relatively constant, year-to-year, the percentage increase has been decline, but was still in excess of 40% between 2007 and 2008.

Calendar Year Total



Discussion

These data highlight the importance of WCMSAs both as an issue driving workers' compensation costs and a window on the impact of government regulation on private agreements that affect third-parties.

On the cost side, the concerns voiced by insurers and employers about the impact of CMS's more aggressive position are certainly real. The cost of set-asides continues to increase rapidly, even if the pace of growth is moderating. In addition, I had discussions with CMS about these data and they acknowledged that the directives concerning pricing the future liabilities for prescription drugs that were developed in 2008 had a very dramatic effect on 2009 set-aside amounts. This is consistent with concern voiced by insurers and employers. Consequently, we should expect that if and when data becomes available on calendar year 2009, the growth in WCMSA dollar amounts will have accelerated relative to 2007-2008.

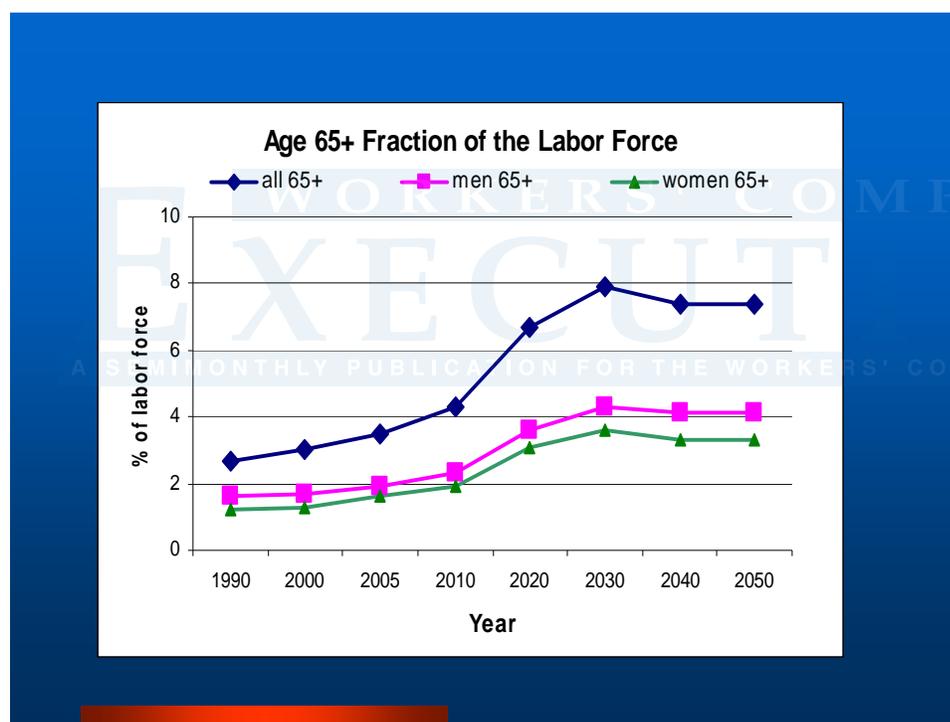
It is a bit difficult to put the value of WCMSAs into perspective with total medical costs in workers' compensation. Total medical benefits paid under workers' compensation in 2007 were a little over \$27 billion according to the National Academy of Social Insurance (NASI, 2009). This rose slightly in 2008 (data not yet published). However, the value placed on WCMSAs by Medicare is the undiscounted value of the expected stream of future payments, so in terms of direct paid amounts, insurers and employers funded the WCMSAs with less than the \$946 million counted by CMS. This makes direct comparisons between workers' compensation costs and WCMSAs more difficult.

There are reasons the medium to long-term expectations for the annual cost of WCMSAs, if unaddressed will become several times the current approximately 4% of medical. First, CMS acknowledges that the cost of WCMSAs increased dramatically between 2008 and 2009. I expect we will see WCMSAs at 5% of total costs in 2009 and probably continuing to increase, maybe to 6% in 2010 or 2011.

Second, the number of older workers is projected to increase substantially between 2010 and 2030. Estimates I made for the Commission on Health and Safety and Workers' Compensation (CHSWC), shown below, find that the working population over 65+ will triple as a fraction of the work force. This alone would triple the cost of WCMSAs to 15% - 18% of all workers' compensation medical payments.

Third, the CHSWC study on the aging workforce also found strong evidence that occupational conditions are substantial under reported for workers 65 and older. This under-reporting is an increase over any under reporting that occurs for workers 18-64. While I did not yet estimate the incremental impact of under reporting that occurs after workers become eligible for Medicare, it is large and will likely draw the attention of Medicare when the results are published.

Finally, the current WCMSA calculation methods leave occupational medical treatment liabilities transferred to Medicare significantly under-funded. Absent another option, Medicare might increase the cost of WCMSAs to offset some of this under payment. I will address this issue along with the solution in the section on solutions.



On a longer-term basis, changes in medical knowledge could lead to changes in the frequency and dollar cost of set-asides. For example, there is a growing literature on the under-reporting of occupational disease. If medical knowledge on the causation of disease improves and parties more aggressively report occupational disease claims, or push for others to more aggressively report, then these costs could escalate substantially. In addition, if the latency period separates the exposure and onset insurers by a substantial period, employers may find themselves subject to liabilities on past policies for which they have under-reserved.

The increasing cost of WCMSAs could also be seen as highlighting a dramatic under-reporting of past liabilities to Medicare. There is very little indication that the recognized liabilities for occupational injuries and illnesses have changed very much over the period of these data. NASI's paid data has shown only moderate change and injury frequency is down. The work force is aging, but this is a very gradual change. Medical inflation is certainly a factor, but likely only explains a small minority of the increase. A likely reason for much of the dramatic growth in WCMSAs is that the parties, prior to the change in CMS's position, regularly and substantially underreported the impact on Medicare when reaching settlements in workers' compensation cases. Both parties may have been advantaged by this, workers' may have retained more settlement dollars and insurers could settle for less, overall.

I suspect that the degree of under-funding of settlements that affected private health insurance for those well under 65 have been and continue to be substantial.

