Medicare Set-Asides (MSAs) Are Not the Enemy to Medicare Beneficiary Settlement: How to Finalize Cost Efficient Settlements with Medicare Beneficiaries

Workers Compensation Medicare Set-Asides (WCMSAs): Submitted and Non-Submitted

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A Medicare Set-Aside (MSA) is a financial agreement that reserves a portion of a workers' compensation settlement to cover future treatment and prescription costs of an injury, illness, or disease. MSAs were designed to protect Medicare from paying for post-settlement treatment related to the underlying injury for which the employer/workers' compensation carrier would remain liable for if the claim was not settled. Utilized when an injured worker is or will soon be a Medicare beneficiary, MSAs project future injury-related medical costs over the person's life expectancy.

MSAs became commonplace in workers' compensation settlements in 2001 when the Centers for Medicare & Medicaid Services (CMS) issued the Patel Memorandum, which now provided monetary submission thresholds in which CMS would review a proposed WCMSA. The two thresholds which exist today in which CMS will review an MSA are: 1) The claimant is a Medicare beneficiary and the total proposed settlement amount is $25,000 or greater; or 2) The claimant has "reasonable expectation" of Medicare entitlement within 30 months of the settlement and the total proposed settlement amount is $250,000 or greater. It is important to note that CMS' WCMSA Reference Guide notes that there are no statutory or regulatory requirements requiring parties to submit an MSA to CMS for review; the process is recommended but voluntary.

In January 2022, there was quite the commotion in the workers' compensation industry when the Centers for Medicare & Medicaid Services (CMS) released an update to the WCMSA Reference Guide (Reference Guide) which included new information as it pertains to Workers' Compensation Medicare Set-Asides (WCMSAs). Of significance was the inclusion of Section 4.3, which, for the first time, addressed CMS' position on Non-Submit/Evidence-Based Medicare Set-Asides (EBMSAs).

The initial Reference Guide update on Non-Submit MSA's occurred on January 13, 2022, wherein Section 4.3 was added to address Non-Submit/EBMSAs. This update provided that unless the CMS program has reviewed the MSA, it cannot be certain that its interests have been protected. Word of this update traveled fast, and the workers' compensation/Medicare Secondary Payer (MSP) industry had numerous questions/noteworthy concerns about the language chosen for inclusion in the updated Reference Guide Section 4.3. It almost appeared like CMS was trying to mandate submission of MSAs to CMS, which is currently a voluntary process/procedure.

Subsequently about a month later, CMS hosted a WCMSA webinar. During the webinar, CMS acknowledged that in submitted MSAs, the Workers' Compensation Review Contractor (WCRC)

reviews proposed WCMSAs with a "worst case scenario" allocation philosophy. CMS additionally acknowledged that the CMS submission process is a wholly voluntary process. Additionally, regarding Non-Submitted/EBMSAs, CMS softened its stance on the webinar from its initial messaging in the January Reference Guide to comment that Non-Submitted MSAs would not automatically be assumed a burden shift to Medicare, and that nothing had changed from a legal, regulatory, or legislative standpoint with the Section 4.3 update. Thus, non-submit MSAs are still recognized, legitimate, and not automatically deemed a burden shift so long as the beneficiary and his/her representatives can prove appropriate allocation and exhaustion of the Non-Submit MSA/EBMSA funds.

Next, in March of 2022, CMS issued a revised Section 4.3 for the Reference Guide and softened the language. CMS now utilized soft and permissive language ("may deny" rather than "will deny") to describe its ability to deny payment. Thus, this language change clearly signaled that parties may prove that the Non-Submit MSA was appropriately allocated for and a protection of Medicare's interests.

The million-dollar question that is being asked quite often, is what is the status on Non-Submit/EBMSAs now, nearly 18 months since the initial inclusion of 4.3 in the Reference Guide? While there have been no known challenges/benefit denials in settlements with Non-Submit MSAs to date, and no additional guidance updates on this matter since March 2022, there have been some resulting changes/impact to settlements in which parties desire to incorporate a Non-Submit MSA into workers' compensation settlements with Medicare beneficiaries in some jurisdictions.

It appears that there is a lack of awareness around the March 21, 2022, Reference Guide update/change to 4.3. Unfortunately, despite the update/clarification, some claimant attorneys and even Judges have misinterpreted CMS' WCMSA Reference Guide update from January to now mean that submission of MSAs to CMS is mandatory where review threshold is met.

However, as mentioned above, the March 2022 update to the WCMSA Reference Guide makes clear that submission of MSAs to CMS remains a voluntary process, and that Non-Submit MSAs would not automatically be deemed a burden shift to Medicare. Parties may demonstrate to CMS that the Non-Submit/EBMSA allocation/exhaustion was appropriate. Further, on the February 2022 webinar, CMS made clear that nothing from a legal, regulatory, or legislative standpoint has changed with the Section 4.3 update.

Additionally, Non-Submit MSAs are permissible pursuant to 42 CFR 411.46(d)(2), and so long as the MSA provider/vendor can appropriately stand behind the methodology of calculation of the Non-Submit/EBMSA, the MSA will be recognized, and the rest of the settlement dollars will be protected.

Thus, the industry is currently in a position today where Non-Submit/EBMSAs are still being utilized in many settlements for those that understand the legal backing of 42 CFR 411.46(d)(2) to Non-Submit MSAs and that CMS is no longer taking the position that a Non-Submit/EBMSA would be deemed automatically to be a burden shift to Medicare. Parties seeking to continue to utilize Non-Submit MSAs should take solace in knowing that a well-documented/allocated EBMSA will withstand any potential future CMS scrutiny, and all parties, including the

beneficiary, will be protected. Only the Non-Submit MSA/EBMSA will need to be exhausted before Medicare resumes primary coverage and the rest of the settlement dollars will be protected from CMS recovery.

Liability Medicare Set-Asides (LMSAs): What's the Status?

In October of 2022, the Office of Information and Regulatory Affairs (OIRA) at the White House's Office of Management and Budget (OMB) issued notice that the Center for Medicare and Medicaid Services' (CMS) proposed rule titled "Medicare Secondary Payer and Future Medicals" has been withdrawn. The abstract of the withdrawn Proposed Rule had indicated that it would provide legislative guidance on the protection of Medicare's future interest in liability (LMSAs), No-Fault (No-Fault MSAs), and even was potentially going to impact workers' compensation (WCMSAs).

This notice being withdrawn indicates that the Proposed Rule is no longer pending, and it provides no indication as to whether the Proposed Rule will be re-filed. If this feels reminiscent to some, back in 2012 CMS released a future medicals advanced notice of proposed rulemaking which was also ultimately withdrawn without explanation.

What does this mean for LMSAs, and will CMS attempt to file another Proposed Rule regulating the protection of Medicare's interest in liability claims? This remains unknown. Perhaps rather than taking the regulatory/legislative route in providing guidance on LMSAs, CMS will issue administrative guidance through memoranda/Reference Guide instead, but this is merely speculation. It is unknown what the future may hold, and in the interim, parties settling liability claims with Medicare beneficiaries are currently without clear guidance on future medical obligations in liability claims.

The potential need to protect Medicare's interest in liability claims (LMSAs) is certainly a tough issue due to the nature of liability claims (i.e., comparative negligence, acceptance of liability, and policy limits). Each individual claim is unique and blanket rules would be hard to apply, unlike in workers' compensation where claims are more often clearly delineated as accepted or denied. While it appears that the liability industry will continue without formal guidance for now on LMSAs and when they might be appropriate to be included in liability settlements, this lack of formal guidance does not negate the underlying MSP Act requirements to protect Medicare's interest.