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Medicare Set-Asides: Are You Paying Too Much?

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Background

Medicare came into being in 1935 as part of the original Social Security Act enacted by Congress. It was described as "a federally funded health insurance program for the elderly and the disabled." Over the years, its cost became problematic and in the late 1970s, a General Accounting Office study suggested that forty-one billion dollars of Medicare benefits were being used to subsidize other insurance programs such as workers' compensation and liability insurance. Consequently, in 1980, Congress passed the Medicare Secondary Payor Act which required beneficiaries to exhaust all other health insurance options before Medicare would pay benefits. Those other options include insurance for workers' compensation, liability, auto etc. The Act provided that Medicare would make "conditional payments" and provide benefits if the other carriers initially denied liability, but it is required that Medicare be repaid if other benefits are found to be applicable.

In the workers' compensation arena, a Medicare set-aside arrangement (MSA) is necessary to account for the future medical component of the primary payor's responsibility. MSAs are the tool used to account for the future medical expense associated with injuries, in order to avoid shifting responsibility for future medical from the primary payor to the Medicare system. This article will briefly touch on two separate issues. The first will be to describe the appeal process for dealing with contested conditional payments. The second will deal with the question of whether too much is being set-aside in providing for Medicare's future interests.

Conditional Payments

Conditional payments are made by Medicare based upon diagnosis codes. The Centers for Medicare and Medicaid Services (CMS) will attribute certain diagnosis codes to an injury. In workers' compensation, it will depend upon the diagnosis of the injury, but will also include any payments for any diagnoses that are made voluntarily and without prejudice. These potentially unrelated codes/conditions become part of the liability for the work injury in Medicare's point of view.

Once liability for a primary payor is "demonstrated" by either an acceptance of liability or by settlement of the claim, conditional payments must be addressed. The parties should request that the case be put into the "final conditional payment process" which notifies the CMS Benefit Coordination and Recovery Center that the case is within 120 days of settlement. A request may be made for a final conditional payment amount within three business days of settlement via the Medicare Secondary Recovery portal. Once you have that amount, the question becomes whether it is an accurate description of the medical costs of the consequences of the actual injury, or whether it includes other treatment for which there should be no liability, either in a liability case or in the workers' compensation arena.

Appeal Process

The law is now clear that workers' compensation administrative bodies and state courts lack subject matter jurisdiction over Medicare Secondary Payor (MSP) reimbursement disputes that have not been fully exhausted

through the mandatory Medicare appeal process. Any challenge to MSP's entitlement "arises under the Medicare Act" and the appellant, or the Medicare enrollee, must first proceed with an administrative appeal prior to any judicial review. *See, e.g., 42 U.S.C. §405(g-h) §1395w-22g5; 42 C.F.R. §422.560-422.612.* That appeals process has five steps:

1. The parties must appeal the conditional payment demand letter within thirty days.
2. The appealing party will receive an independent outside entity review (qualified independent contractor) that contracts with CMS to do this work.
3. If the result from the independent qualified contract review is unfavorable, an Administrative Law Judge hearing may be requested.
4. If the Administrative Law Judge hearing produces an adverse result, the party may appeal to a Medicare Appeal Council, if the ruling is adverse to the appellant and exceeds a threshold amount ($1,000).
5. Finally, if the ruling is still adverse, an appeal may be made for federal judicial review, to the Federal District Court in the appropriate jurisdiction. From there, an appeal can be taken to the Circuit Court of Appeals and possibly to the United States Supreme Court.

The important point is that absent a timely utilization of this appeal process, there is no possibility of attacking the issue of whether a conditional payment was, in fact, for the workers' compensation injury or automobile accident in question in any state proceeding, or whether other defenses such as the statute of limitations are available. Any factual issues will be resolved either through the initial administrative steps of the appeal process, or before the Administrative Law Judge.

Are You Paying Too Much?

Accounting for Medicare's interests for future medical expense for an injury is a well-developed process in workers' compensation. CMS has established work review thresholds of $25,000 for a current Medicare beneficiary, or $250,000 and the potential that the Medicare beneficiary is likely to become enrolled in Medicare within thirty months, for workers' compensation cases. If those thresholds are met, CMS will review a future MSA proposal and will provide an opinion that the parties can rely upon in settling their case. This conventional practice of submitting an MSA proposal to CMS for review and approval, which is entirely voluntary, predictably inflates costs and over burdens claim payors. In 2017 alone, some 26,000 claims had an average of about $93,000 each set aside as funds to reimburse Medicare for future medical treatment. Care Bridge International, a vendor that does work on MSAs recently did a study focusing on the actual spending on behalf of an injured worker for the first five years post MSA report approval. Their finding was that in the fifth year post settlement, the pace of medication spending was 64% of the forecast and 55% for all other medical care. In another study, they analyzed a huge database of eight million non-settled workers' compensation claims noting the medical spending for up to eleven years after injury.

Why the inflated numbers?

1. Medicare requires that medications be priced unrealistically high at RED BOOK average wholesale price. Most claims payors pay for drugs with pharmacy benefit managers and arrange for prices that are up to 35% lower.
2. Medicare unrealistically requires that medications be budgeted unaltered for the projected life of the worker. There is no scientific assurance that this will be the case.
3. Medicare requires that treatment the worker is receiving or has planned, as of the time of settlement, will continue but, in reality, treatment evolves as patients adapt.

MSA vendors are learning this and using it to their advantage. There are several vendors who now will produce an MSA proposal and recommend that it not be submitted to CMS regardless of whether it falls within the work-review threshold. Those vendors offer to stand behind their proposal and take over and pay if CMS rejects their analytics and if, in fact, payment exceeds the amount proposed. It is my understanding that they are developing or utilizing an insurance product for this purpose. Moreover, in some states, MSAs that are structured are being negotiated with consideration given to making the beneficiary the insurance carrier or the self-insured employer, rather than the claimant's estate. These products are new to the market, but should be considered as potential cost savings can be significant.