MEDICARE SET ASIDES

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Medicare Set Asides (MSA) have proven a significant roadblock for parties who are desirous of settling a workers' compensation claim. When a set aside is submitted to the Centers for Medicare and Medicaid Services (CMS) for review, it frequently takes months, sometimes over a year, for a response to be issued. Further, the amount CMS demands necessary to protect its future interest sometimes has little connection with the status of the case, and there is no ability to appeal this determination. This lack of accountability leads to results that force the parties to leave a case open when both sides would be happier with a settlement. No one disputes that the parties to a settlement have an obligation to protect Medicare's future interest. However, the manner in which CMS has handled the MSA process is in need of significant reform.

However, change is on the way. On May 15, Congressman Dave Reichert (R-WA) and Congressman Mike Thompson (D-CA) introduced the Medicare Secondary Payer and Workers' Compensation Settlement Agreement Act of 2013, marked as H.R. 1982. Congressman Todd Young (R-IN) has recently signed on as a co-sponsor. This proposed legislation would have tremendous benefits for all stakeholders in workers' compensation practice, and, I would submit, for the Centers for Medicare and Medicaid Services as well. H.R. 1982 aims to resolve these problems, in a manner that works for the claimants, the carriers and employers, the workers' compensation boards, and even for CMS.

As it stands, the criteria for when a MSA may be reviewed by CMS create a problem for the parties to a settlement. CMS will review an MSA in any case in which a claimant either: (a.) is Medicare enrolled as of the date of settlement, with a settlement of $25,000 or more, or (b.) anticipates Medicare enrollment within 30 months, with a settlement of $250,000 or more. Cases that fall outside these criteria will not be reviewed for approval by CMS, but that does not exempt the parties from having to consider Medicare's future interest. In H.R. 1982, the $250,000 distinction is done away with; any case in which the claimant has no reasonable expectation of Medicare enrollment within 30 months is exempted from the MSA approval process, as is any settlement below $25,000. Further, this legislation proposes a safe harbor for any set aside that constitutes 15% of the total settlement amount, where the settlement amount is less than $250,000. As it stands, the parties have no assurance that CMS will not later file suit against them for failure to protect Medicare's interest other than the MSA approval letter. Once again, this legislation aims to give the parties to settlement certainty.

H.R. 1982 proposes two significant, and beneficial, changes to the process of CMS approval. First, it requires that any MSA application be acted upon within 60 days. Failure to act on an application within 60 days will mean the application is deemed approved. While CMS has, to its credit, improved response times of late, this is still a significant sore point for parties to settlement. Every week that an application for approval remains pending is an additional week that the carrier must continue making payments on a claim that it has already earmarked for closure. Every week that an application for approval remains pending is an additional week that a claimant has to wait for a settlement payment that they have often earmarked for significant expenditures.

The second major process change is that the parties may request reconsideration of CMS' response within 60 days of the determination, with CMS' response to that request due within 30 days. An appeal to an ALJ could be filed 30 days thereafter, if CMS does not reconsider to the parties' satisfaction. The determinations made by CMS can often be mystifying; for instance, I have submitted hundreds of applications for CMS approval over the years, and have seen numerous examples of treatment being added into the MSA for an unrelated site of injury. Similarly, treatment that has been ruled out by treating physicians makes its way into the MSA, even though there are no plans to go forward. Opening up CMS' opaque approval process would surely decrease, if not eliminate, these instances.

Finally, and perhaps best of all, H.R. 1982 would allow for direct payment of the MSA to CMS. Rather than put the burden on a claimant to account for their annual medical expenses and ensure that the appropriate fee schedule is being utilized, something that perhaps one claimant in a thousand is both willing and capable of doing, the MSA could just be paid upfront to CMS, and Medicare would pick up treatment. Once a claim

is settled, claimants tend to decrease treatment, often significantly; the direct payment option could thus potentially be a revenue generator for CMS. To date, CMS has been unwilling to allow the parties to a settlement to simply pay the amount of the MSA. This is a baffling decision, coming as it does from an entity that is facing $34 trillion in unfunded liabilities.

My colleagues and I in the Torts and Insurance Practice Section had the opportunity to speak to a number of Congressmen and their staffers recently, and the reaction to this proposed legislation was very receptive. An identical piece of legislation was proposed last year, but was brought forth too late in the year for action. No one disputes that the parties to a settlement have an obligation to protect Medicare's future interest. However, the manner in which CMS has handled the MSA process is in need of significant reform. Ultimately, H.R. 1982 provides needed clarity to the MSA approval process, gives the parties certainty to govern their actions moving forward, and likely without additional cost to CMS. ⚖