The MSA Today

Medicare Set-Aside News/Updates from Cattie - @MSALawyer

Welcome to the MSA Today!

The MSA Today is our law firm's periodic newsletter. It provides readers with updates about Medicare Set-Asides (MSAs) and the issues related to MSAs. It's one of the only places to get MSA updates from the legal perspective.

"**This [MSA] program is caused by a legal requirement for Medicare to not make payment where another entity has responsibility. This can be found in 42 CFR 411, and the Social Security Act 1862(b).**" Anonymous CMS Official

The obligation to determine if Medicare has a right to not pay certain future medical expenses related to a settlement/judgment/award is a legal obligation. While the law does not "require" MSAs, it does require that Medicare not pay when payment has been made under a workers' compensation plan, an automobile plan, a liability insurance plan (including self-insurance) or a no-fault plan.

Too often, folks miss the forest for the trees on MSA issues. They seek a black/white MSA requirement in the liability insurance context, or they strictly follow informal policy memos or reference guides from Medicare in the workers' compensation insurance context. Instead, following what the law says and the regulations say about future medicals leads you to a more compliant (and often cheaper) conclusion. Claims are resolved faster, settlements are approved faster and injured workers get out of the workers' compensation system faster.

The goal here is to be educational and informative. While nothing here is intended to provide you legal advice about a current or previous case, I'd be happy to weigh in on those as well if you engage Cattie, P.L.L.C. for that purpose.

Your feedback is critical to a successful newsletter. Please reach out with your comments, suggestions and constructive criticism. Send that to us in an email at jcattie@cattielaw.com, via Twitter @MSALawyer or by phone at (844) 546-3500. With that, please keep reading to get the latest scoop about MSAs and related issues.

Commutations Vs. Compromises in WC: A Deeper Dive

In previous editions of The MSA Today, you may have read about commutations versus compromises in the MSA context. While MSAs historically have been created and utilized based purely on medical reasons, lawyers look to Medicare's regulations under the MSP Act to determine exactly what steps must be taken to extinguish a client's future medical exposure. In so doing, lawyers can use the legal concepts of commutation and compromise, apply Medicare's regulations and arrive at a conclusion that significantly reduces or completely extinguishes that client's future medical exposure under the MSP Act. For workers compensation attorneys on both sides of the 'v', the distinction between a commutation and a compromise means everything to the final MSA result.

What is a Commutation? In short, a commutation grants a claimant all benefits potentially owed under a state's workers' compensation statute. The notion of a commutation follows the employer or insurance carrier ("E/C") accepting a workers' compensation claim as compensable.

At some point, the parties may wish to resolve the claim. To do so, they would need to agree to close future medicals. The E/C would pay a lump sum to the claimant in exchange for a general release of all claims. That lump sum, if it were a true commutation settlement, would includes all future medicals related to the compensable claim and required to be paid to the claimant as a benefit. The lump sum would also contain payment for all indemnity benefits owed. For a settlement to be a true commutation, it must include all payments owed for both medical and indemnity. If it does not, it cannot be called a true 'commutation' of benefits.

What is a Compromise? In short, a compromise is the opposite of a commutation. In a compromise, the settling parties do not agree that the lump sum payment includes all benefits owed under a state's workers' compensation statute. The claimant is either getting paid less than 100 cents on the dollar for indemnity, medical or perhaps both.

Compromises can arise in a variety of forms. The fact that the parties negotiate back and forth to a final settlement figure can be indicative of a compromise. The fact that a claim is being resolved on a doubtful and disputed basis can be indicative of a compromise. The fact that the E/C denied the claim from the outset can be indicative of a compromise. Even the mere fact that a claimant hires an attorney to represent them could be interpreted as indicative of a compromise. Why would a claimant hire an attorney if the E/C would agree to pay them all benefits required pursuant to a state's workers' compensation statute?

Why is the Difference Significant? When you apply the legal concepts of commutations and compromises to the MSA context, you likely achieve a vastly different result that you see today in your MSAs. It's a difference Medicare understands, and has provided us with its official statutory interpretation.

In 42 C.F.R. Sec. 411.46, Medicare provides its official statutory interpretation about future medical expenses under the MSP Act. There, it discusses the different treatment of future medicals in a commutation settlement versus a compromise settlement.

"If a lump-sum compensation award stipulates that the amount paid is intended to compensate the individual for all future medical expenses required because of the work-

related injury or disease, Medicare payments for such services are excluded until the sum payment." *42 C.F.R. Sec. 411.46(a) Lump-sum commutation of future benefits*. The operative phrase there to pay attention to is "...stipulates that the amount paid is intended to compensate the individual for all future medical expenses required because of the work-related injury or disease..." How often does your settlement release contain that phrase, even in cases where the E/C has accepted responsibility for medicals?

The balance of the regulation contemplates future medicals in a compromise settlement. Importantly, Medicare provides us with 42 C.F.R. Sec. 411(d) *Lump-sum compromise settlement: Effect on payment for services furnished after the date of settlement*. There, subpart 1 gives us Medicare's basic rule in those situations. "Except as specified in paragraph (d)(2) of this section, if a lump-sum compromise settlement forecloses the possibility of future payment of workers' compensation benefits, **medical expenses incurred after the date of the settlement are payable under Medicare**." *42 C.F.R. Sec. 411.46(d)(1)*(Emphasis added). Medicare's basic rule in a workers' compensation case being settled on a compromise basis is that it will pay for a claimant's future medical care.

There is one exception to that basic rule. "If the settlement agreement allocates certain amounts for specific future medical services, Medicare does not pay for those services until medical expenses related to the injury or disease equal the amount of the lump-sum settlement allocated to future medical expenses." *42 C.F.R. Sec. 411.46(d)(2).*

Conclusion. The historical use of MSAs misses the mark in a compromise settlement. Calculating the MSA based on medical records for a compromise settlement necessarily will overfund the MSA every single time. MSAs should account for how many dollars are being paid by a E/C to a claimant for future medicals. The MSA allocation based on medicals is a good tool for that in a commutation case, but a poor one in a compromise case.

For any compromise case, a MSA Legal Opinion represents a better option. The MSA Legal Opinion utilizes the MSP statute and regulations to address, identify and minimize a client's future medical exposure under the MSP Act. A MSA Legal Opinion should discuss the differences between a commutation case and a compromise case. It should then apply those concepts to your case-specific facts. Assuming the case can be positioned as a compromise instead of a commutation, the MSA Legal Opinion should then conclude that Medicare will pay for future medical care post-settlement unless the parties specifically allocate something to future medicals in the release. This process provides a more accurate and realistic conclusion for the client.

For more information about MSA Legal Opinions, click here.

Medicare Begins Issuing New Medicare Cards

Fraud and data breach concerns are everywhere these days. Starting April 2018, Medicare begins issuing new Medicare cards to its beneficiaries. The significant change to the new

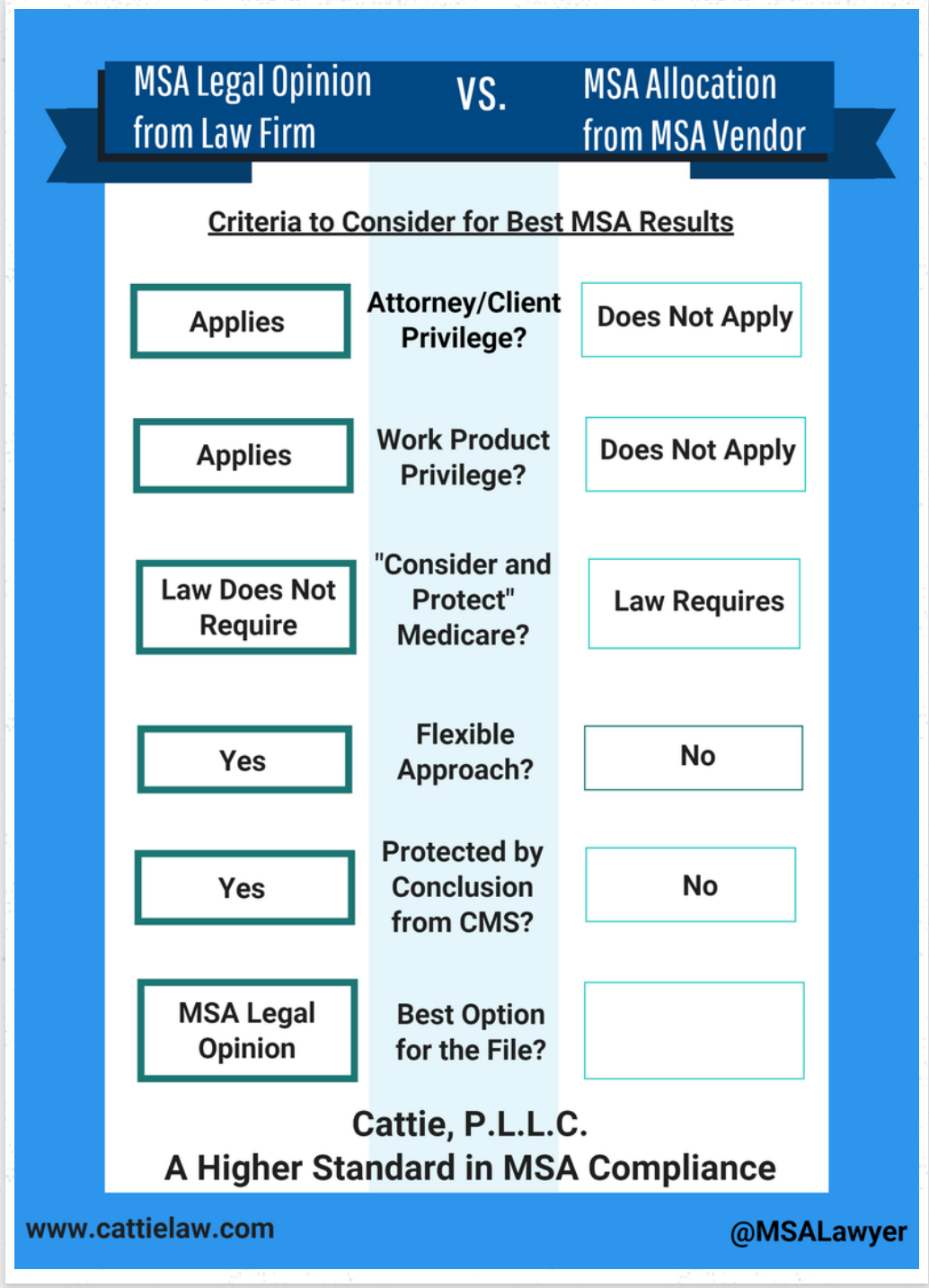
card lies in the fact that it will no longer contain a beneficiary's Social Security number.

According to CMS Administrator Seema Verma, "We're taking this step to protect our seniors from fradulent use of Social Security numbers which can lead to identity theft and illegal use of Medicare benefits... We want to be sure that Medicare beneficiaries and healthcare providers know about these changes well in advance and have the information they need to make a seamless transition."

The change in Medicare numbers is a response to the Medicare Access and CHIP Reauthorization Act of 2015. The process of removing Social Security Numbers from the card began in 2018 with Medicare generating approximately 150 million Medicare Beneficiary Identifiers (MBIs), 60 million for active beneficiaries and 90 million for deceased or archived beneficiaries.

The MBIs are eleven characters long, randomly generated and will have no link to a beneficiary's identification like HICNs in the past. The characters used in the MBI will be both numbers (0-9) and all letters from A-Z except for the letters S, L, O, I, and B. MBIs will take the format of 4 characters, 3 characters, 4 characters. As an example, it could look like this: 4PN2-WM3-JC98.

There will be a 21 month roll out period during which time Medicare will mail out new cards for active beneficiaries. During this transition (from April 2018 to December 2019), either the HICN or the MBI may be used. For more information from Medicare about this important development, click here.



CMS Issues Version 2.7 of its WCMSA Reference Guide

Since our last newsletter, CMS issued version 2.7 of its Workers' Compensation Medicare Set-aside Arrangement ("WCMSA") Reference Guide (the "Guide"). On the surface, changes made in version 2.7 appear minor. Digging a little deeper may reveal a different answer.

Medicare made two (2) changes in the Guide. First, it changed the phone number for its Workers' Compensation Review Contractor ("WCRC") to reflect its new contractor, Capital Bridge (see above for details). Second, it changed its Confidentiality Statement. Now, that statement reads as follows: "The collection of this information is authorized by Section 1862(b) of the Social Security Act (codified at 42 U.S.C. Sec. 1395y(b)) (see also 42 C.F.R. 411.24). The information collected will be used to identify and recover past conditional and mistaken Medicare primary payments and to prevent Medicare from making mistaken payments in the future for those Medicare Secondary Payer situations that continue to exist. The Privacy Act (5 U.S.C. 552a(b)), as amended, prohibits the disclosure of

information maintained by the Centers for Medicare & Medicaid Services (CMS) in a system of records to third parties, unless the beneficiary provides a written request or explicit written consent/authorization for a party to receive such information. Where the beneficiary provides written consent/proof of representation, CMS will permit authorized parties to access requisite information."

Is this a minor change or major shift? We believe this signals a major shift in how CMS intends to use information gathered via the WCMSA review process going forward. The previous version of the Confidentiality Statement focused on disclosure of information. Now, Medicare is advising that it intends to use information gathered in this process to identify/recover conditional payments made as well as prevent mistaken payments in the future when another responsible party exists.

Cattie believes this is the next step in CMS' enhanced compliance efforts to better preserve the Medicare Trust Funds. Remember that Medicare spent the bulk of 2017 advising medical providers about its enhanced compliance efforts and the real chance that providers would see Medicare rejecting more reimbursement claims, directing the provider to collect from the patient's WCMSA or LMSA. For examples of that, see here and here.

At lease one MSP industry veteran agrees that the change is significant. In a response to a LinkedIn posting about this, Brian Bargender from Humana noted, "Whether or not the changes to the "confidentiality statement" have any impact on MSAs they are significant and have broader implications for MSP enforcement. This is the clearest indication I've seen that CMS believes its ability to share data with settling parties is constrained by the Privacy Act. When CMS doesn't believe that sharing data housed on government systems is vital to either recovering conditional payments or avoiding payments that should be covered by primary payers, CMS maintains that it doesn't have the authority to release that data to any parties that are not under contract with CMS.

This might explain the rationale for why CMS does not readily identify Medicare Advantage (Part C) and Medicare Prescription Drug (Part D) plans to primary payers. Since primary payers can't get that information from CMS, they should be proactive in identifying Part C and D plans prior to settling claims. At the same time, of course, Part C and D plans should also have proactive efforts to identify potential primary payers."

If you typically use the WCMSA review process and have concerns about how CMS may use the information it gathers, remember that you have a choice. Submitting MSAs to CMS for review and approval is always voluntary. It's only mandatory if the parties have made that a condition of settlement. Instead of feeding into those concerns, call Cattie and ask for a MSA Legal Opinion instead. You can still manage the risk of the MSA issue fully while not subjecting yourself to the information concerns that may now arise given CMS' revised Confidentiality Statement. For more information about MSA Legal Opinions, please click here.

Webcast - MSP Act Case Law Update

For those of you who enjoy staying up-to-date with the most recent federal and state court decisions involving MSP issues from the comfort of your own office, I highly encourage you to circle Tuesday, April 24th on your calendar. On that day, the DRI MSP Task Force will present what I believe to be the most comprehensive MSP Case Law update you can find. The webcast begins at 2PM EDT, 1PM CDT and will last for 60 minutes.

For more information, please click here.

Attn. WC Plaintiff Attorneys - Can You Collect Fees on Future Medicals in Your State?

Cattie plans to prepare an article which discusses attorney fees in workers' compensation cases, and we'd like your help. In advance of that article, we'd like feedback from WC plaintiff attorneys around the country. Please answer the following two questions:

1) Does your state permit you to collect fees on the future medical portion of a WC award?
2) What is your state's statutory provision which grants or bars you from doing so?

Please submit your feedback to us at jcattie@cattielaw.com and look out for an article later this year about attorney fees in WC and the MSP Act. Thanks in advance for the feedback.

NCCI Releases MSA Research Brief

Earlier this year, the National Council on Compensation Insurance ("NCCI") released a new research brief (the "Brief") which provides important data to those in the MSA world. The Brief updated NCCI's most recent study from 2014. Importantly, the data presented for analysis relates to performance under the old WCMSA review contractor. What will interest Cattie is how the new contractor performs as compared to the metrics and findings detailed in the Brief.

Here are some of key findings detailed in the Brief:

- CMS processing times have declined since 2012;
- Median CMS processing time appears to be longer for the largest MSA submissions than for smaller MSA submissions;
- The ratio of approved to submitted MSA amounts declined from 2010 to 2013 and increased slightly from 2013 to 2015;
- Overall, prescriptions drugs account for about 1/2 of MSA amounts, though for more than 1/3 of all MSAs, drugs are less than 10% of the MSA value;
- Larger MSAs have larger drug shares;
- The largest number of MSAs are submitted approximately four years from the year of accident;

- MSAs comprise about 45% of total submitted settlements; and
- Over 1/2 of MSAs involve an attorney.

The Brief presents some thought provoking analytic details which The MSA Today will present in its next edition. Needless to say, the data reveals ways to both put more money from a settlement into the injured worker's pocket as well as significantly reduce an employer/carrier's future medical exposure under the MSP Act.

To read the Brief in its entirety, click here.

Extinguish Future Medical Exposure with Cattie

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Talk to Cattie at a Future Event

Cattie will be at the following events in the next few months. If you're attending, please come find us, say hello and ask how Cattie can extinguish your future medical exposure under the Medicare Secondary Payer Act.

- April 26-27, GTLA 2018 Annual Convention, Atlanta, GA
- May 8-10, ARLA 2018 Annual Convention, Asheville, NC
- May 17-19, TTLA 2018 MidYear Conference, Houston, TX
- May 22-24, CLM 2018 WC Conference, Chicago, IL
- June 10-13, NCSI 2018 Annual Conference, Ft. Lauderdale, FL
- June 20-23, FJA 2018 Annual Conference, West Palm Beach, FL