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MSAs the Legal Way:
Why You Overpay for MSAs

Medicare Set-Asides (MSAs) frustrate everyone. Claimants, attorneys and the insurance industry (insurance carriers, self-insureds and third party administrators [TPAs]) find the entire process, from determining when a MSA is "required" to asking Medicare to review/approve the MSA, exasperating.

On its face, the workers' compensation industry suffers from a lack of options in the marketplace to deal with MSA issues. Experienced MSA vendors continue to proclaim that the law requires you to "consider and protect Medicare's interests" without providing common sense solutions and precise citations to that part of the law. They continue to provide MSAs based on medical record review. While those reports have a place in certain situations, they fail to address the MSA issue properly most of the time. Unknowingly, stakeholders in the workers' compensation world rely on medically based MSAs to their detriment, both legally and financially.

This article addresses the "legal" way to calculate MSAs. MSAs address legal obligations under federal law, not medical obligations. It makes sense, then, to review the law and regulations which create that obligation. When you do, you confirm to your chagrin what your CFO might already tell you: you pay too much for your MSAs. If you applied a legal approach to MSAs instead of the medical approach currently used, your MSAs would be cheaper and just as compliant as the medically based MSAs calculated today.

The "Law" About Medicare Set-Asides.

To begin, please grasp this fundamental concept: the law does not require MSAs. The law, the Medicare Secondary Payer (MSP) Act, is silent about MSAs. What the law does prohibit is Medicare making payment for medical expenses where payment has been made under a workers' compensation (WC), auto, liability insurance (including self-insurance) or no-fault insurance. *42 U.S.C. § 1395y(b)(2)(A)(ii)*. When a claim is resolved and the award contains dollars for future medicals (in whole or in part), the law prohibits Medicare from paying those same bills for which dollars were paid to the claimant.

The one exception to this broad prohibition is the conditional payment exception. When Medicare makes a conditional payment, it is made under the condition that Medicare can recover that payment from the party who is actually responsible for the medical bill. Again, nothing in the law mentions MSAs.

Despite this, parties have gravitated to the MSA as the one and only tool to address future medicals in compliance with the law. Why is that? Most likely, it's a response to the Centers for Medicare & Medicaid Services (CMS) stating that MSAs are its preferred compliance vehicle. Over the past 15 years, CMS has provided ample MSA guidance in the form of alerts, memos and even a WCMSA Reference Guide. One can only assume the vast majority nationwide assume what CMS says is the law.

In fact, that's not necessarily the case. We already know the law is silent about MSAs. But so are the regulations supporting the law. This is a critical concept to understand. Regulations are the federal government's way to provide its official statutory interpretation. Entire laws like the Administrative Procedure Act and federal offices like the Office of Management & Budget (OMB) exist so CMS and other federal administrative agencies can provide the public with its official statutory interpretation. As of 2017, CMS has never done that about MSAs.

The law tells us what happens under those circumstances. The Medicare Act provides the Secretary of Health & Human Services (as delegated to CMS) authority to prescribe regulations to administer insurance programs under the Medicare Act. *42 U.S.C. § 1395hh(a)(1)*. This authority extends to the MSP Act, a program administered under the Medicare Act. More importantly, the statute announces the following: "No rule, requirement, or other statement of policy … that establishes or changes a substantive legal standard governing the scope of benefits, the payment for services, or the eligibility of individuals, entities, or organizations to furnish or receive services or benefits under this title shall take effect unless it is promulgated by the Secretary by regulation under paragraph (1)." *42 U.S.C. § 1395hh(a)(2)*. Since no regulations about MSAs exist, there is no substantive legal standard to meet.

The United States Supreme Court has also weighed in. In *Christensen v. Harris County*, it concluded that just because an agency like CMS might say something in a memo, that does not necessarily make it the law. *Christensen v. Harris County*, 529 U.S. 576, 587 (2000). While a federal administrative agency's statutory interpretation, as promulgated in policy memos, handouts, statements on websites, etc., may be persuasive, *Christensen* holds that the agency's statutory interpretation is not accorded the same deference as a regulation interpreting an ambiguous statute. "Interpretations such as those in opinions letters – like interpretations contained in policy statements, agency manuals and enforcement guidelines, all of which lack the force of law – do not warrant Chevron-style deference." *Id*. at 587.

So, while the CMS alerts, memos and reference guides might be nice, they are not binding on the WC industry. Where does that leave us? CMS has the statutory authority to promulgate regulations about MSAs and chooses not to. Why? It must like the current process, right? It must like the insurance industry serving as Medicare's watchdog and collection agent for MSAs. It's the insurance industry doing the heavy lifting on behalf of the federal government. If CMS does not have incentive to provide regulations about MSAs, then why would it ever do so? The insurance industry blindly follows MSA vendors' advice and it has worked out wonderfully for CMS.

Commutations Vs. Compromises.

Though unwilling to provide regulations about MSAs, CMS has provided regulations about the broader issue of future medicals in WC. These regulations, found at 42 C.F.R. § 411.46, contemplate two distinct situations found in WC: commutations and compromises.

§ 411.46 Lump-sum payments.

(a) Lump-sum commutation of future benefits. 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 medical expenses related to the injury or disease equal the amount of the lump-sum payment.

(d) Lump-sum compromise settlement: Effect on payment for services furnished after the date of settlement -

(1) Basic rule. 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.

(2) Exception. 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.

Importantly, CMS does not define the terms 'commutation' and 'compromise' by regulation. 42 C.F.R. § 411.21 provides all the definitions for the regulations supporting the MSP Act and those terms are not there. CMS has chosen to not define those for us. Again, like the MSA concept itself, 42 U.S.C. § 1395hh(a)(1) and (2) would apply here. Without a regulation telling us how CMS defines those terms, there is no substantive legal standard to which you must adhere. "Commutation' and 'compromise' may mean something very different than what CMS believes they mean.

Luckily, we can figure out what they mean for ourselves based on common understanding. Compromise is well known to us. It's the negotiation that goes back and forth between the Employer/Carrier (E/C) and the claimant before a WC claim is resolved, right? It's the tit for tat to reach middle ground. In WC, this happens all the time. We see it in a denied claim where the E/C does not accept responsibility for medicals. We also see it on an accepted claim where the parties might dispute how to treat a claimant's condition and the necessity to undergo certain procedures.

Commutation is the opposite of compromise. Commutations occur when the E/C accepts the WC claim and, in fact, pays for everything. This includes all indemnity/wage loss owed under state law, all past medicals and all future medicals. Commutation settlements epitomize the "Grand Bargain" our WC system has represented for over 100 years.

Commutations don't happen nearly as often as you might expect anymore. Here's an example: E/C accepts a WC claim for a back injury and pays medicals. Medical reports indicate that the claimant may need a spinal cord stimulator (SCS). The E/C does not want to pay for the SCS and settles the claim without paying for the SCS. Is this a commutation settlement since the E/C paid past medicals and will

be paying some future medicals? Or is it a compromise settlement because it refuses to pay for the SCS which the claimant may need in the future?

The distinction means everything to the final MSA answer. If you call this a commutation, then you agree to pay for everything medically "required", including the SCS. *42 C.F.R. § 411.46(a)*. If you call this a compromise though, 42 C.F.R. § 411.46(d) would apply since you're not paying for everything. Remember the basic rule and the sole exception under the regulation, Medicare's official statutory interpretation on point. Medicare will pay for future medicals unless there is a specific amount allocated for future medicals. If there is, then the claimant must spend down and exhaust before billing Medicare.

Note again, the regulation does not mention a MSA as the means to calculate the allocated medical figure. Silence from CMS via regulation means that options exist. Note also that the regulation does not speak to penalties for failure to utilize a MSA under those circumstances. It also does not speak to CMS review/approval of the allocated future medical figure.

There is no substantive MSA legal standard. There is, however, a substantive legal standard to meet about classifying the claim as a commutation or a compromise. The E/C spend millions of dollars trying to gain CMS approval of a MSA based on medical documentation. Your goal by doing that is to mitigate your risk in the future on CMS collecting future medical dollars from you. That's what the MSA vendor industry has always told you without providing alternatives. However, alternatives to traditional MSAs exist since there is no substantive legal standard to meet about MSAs. All it takes is an open mind and willingness to listen to reason and common sense.

What About Shifting the Burden to Medicare?

Now, some might point to 42 C.F.R. § 411.46(b)(2) and say you can't shift the burden to Medicare. Does that sound familiar? Let's take a look at that regulation:

(b) Lump-sum compromise settlement.

(2) *If a settlement appears to represent an attempt to shift to Medicare the responsibility for payment of medical expenses for the treatment of a work-related condition, the settlement will not be recognized* (emphasis added). For example, if the parties to a settlement attempt to maximize the amount of disability benefits paid under workers' compensation by releasing the workers' compensation carrier from liability for medical expenses for a particular condition even though the facts show that the condition is work-related, Medicare will not pay for treatment of that condition.

Skeptics point to 42 C.F.R. § 411.46(b)(2) for the proposition that the fully funded MSA based on medicals is the only way to address MSP future medical obligations in a WC settlement. Anything less would shift the burden to Medicare impermissibly. This critique comes from the MSA vendor industry

and lacks any legal foundation. What skeptics fail to realize is how this would play out in reality. In settling a case and letting plaintiff handle the MSA issue, defense does not shift the burden to Medicare. If that occurs, it would be plaintiff doing that post-settlement when he bills Medicare prematurely.

What happens if Medicare does not recognize the settlement? Let's say the claimant funds the MSA insufficiently (whether it is underfunded or not funded at all). Here's the fact pattern. Parties settle a WC claim, closing future medicals in the process. When this happens, the claimant gives the E/C a general release of all claims while the E/C pay claimant a certain sum of money. The state WC board/commission approves settlement as submitted by the parties. Post-settlement, the claimant treats for his work-related condition and pays those bills from his underfunded MSA. At some point, the MSA is exhausted. The claimant continues to treat and now instructs his medical provider to bill Medicare for that treatment. Medicare receives the bill and either: 1) rejects the bill, telling the hospital to collect from the patient/claimant; or 2) pays the bill, then recognizes overpayment and seeks recovery from the party responsible to pay for the bill.

If Medicare rejects the bill and tells the hospital to collect from the patient/claimant, then the matter is between the provider and the claimant. In essence, this is a hospital lien. Under those facts, Medicare has not been harmed and would not have standing to bring legal action against anyone with respect to the underfunded MSA. But what happens when Medicare does pay by mistake and an overpayment situation is created for which Medicare seeks recovery?

At this point, the question becomes, "**From whom can Medicare pursue recovery successfully**?" Obviously, Medicare can pursue the claimant and will do so, either by collection directly from the claimant or by referring the matter to the Department of the Treasury for the IRS to garnish tax refunds to recoup the debt. Medicare might be able to make a claim against the claimant's attorney as he was a party that "received payment" as part of the settlement. Such a result would be consistent with Medicare's own guidance in its WCMSA Reference Guide:

> "Any claimant who receives a WC settlement, judgment, or award that includes an amount for future medical expense must take Medicare's interest with respect to future medicals into account. If Medicare's interests are not considered, CMS has a priority right of recovery against any entity that received any portion of a third-party payment either directly or indirectly – a right to recover, or take back, that payment." *CMS WCMSA Reference Guide, v2.5, section 3.0*.

That section indicates that Medicare pursues plaintiffs and parties receiving payment from a third-party, as opposed to parties making those third-party payments. Payment in this context refers to satisfaction of a judgment or payment under the terms of a settlement agreement. The E/C would not be in the position to receive payment of a judgment or settlement; they always make those payments.

Medicare would not bring a right of subrogation against the E/C for an MSA issue. Subrogation regulations as they pertain to the E/C do not apply here because there is nothing to subrogate once the case is closed. At this point, the E/C has received its release and is no longer a primary payer. That distinction is transferred to the claimant under the terms of the settlement agreement, a distinction which the E/C has paid valid consideration. The claimant is the primary payer under the MSP Act post-settlement until the claimant can prove the MSA proceeds were exhausted properly. After that, Medicare becomes primary payer for all medical care, injury-related or otherwise. While the insurance industry has long feared being in the government's crosshairs on MSA issues as the proverbial "deep pocket", the law simply does not allow that to occur with any success in and of itself. It is this type of legal analysis which MSA vendors fail to provide their clients.

MSA Legal Opinions – The Stronger Alternative.

The medical record review approach to calculating MSAs works for some claims. Claims accepted in full by the E/C with no dispute or settlement negotiation. Claims that are true commutations. However, if a claim is in any way a "compromise" situation, the traditional MSA approach and the industry created specifically for that purpose fails its clients. MSAs are overfunded, obligations are exaggerated and MSA myths are perpetuated, lining the pockets of the MSA vendors themselves.

For a moment, imagine another approach allowing you to calculate lower MSAs. An approach letting you avoid the federal government completely. An approach that extinguishes all MSA risk. Handling MSAs the legal way instead of the medical way empowers you to do all that and more.

For years, MSA vendors have led the WC industry astray by focusing only on medical expenses in all claims, commutations and compromises alike. Perhaps this was done unknowingly since MSA vendors are not lawyers and cannot provide legal advice. Perhaps it was done knowingly to build a cottage industry. We may never know. Here's what we do know. By relying on CMS' official statutory interpretation about future medicals in the regulations instead of its unofficial statutory interpretation in alerts, policy memos and the WCMSA Reference Guide, your MSA position is more firmly rooted in the law itself. Putting legal opinions in the file allow for the seamless risk transfer you seek.

MSAs are legal obligations, demanding legal solutions from lawyers using the law to their client's advantage. Instead of obtaining MSA allocations, you should be obtaining MSA legal opinions. For those of you who rely on MSA vendors, that vendor should be well-versed in these legal arguments and can provide you with a MSA legal opinion instead of a mere MSA allocation. If you have a MSA vendor panel, make sure it includes at least one law firm well-versed in these issues. Having that firm on your panel provides your team the ability to select the right tool for the right claim. MSAs have been a thorn in your side for far too long, with far too few options presented by the self-professed experts working for MSA vendors. It's time to give MSA lawyers a chance to help close those troubling claims.