Back to Basics: MSAs What's In an MSA and How to Use One

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Let's pretend you have never heard of Medicare Set-Asides. Life was pretty good without the MSA. Now wake up and come back to reality.

MSAs are complex and you are not a medical professional. And, while they are here to stay, MSAs need not be part of your nightmares. Let's get back to basics to simplify how you look at and how you use MSAs.

Why do we need MSAs?

The Medicare Secondary Payer Statute[1] ("MSP") states that Medicare may obtain *secondary payer status* "if payment has been made or can reasonably be expected to be made under a workmen's compensation law or plan of the United States or a state…"[2] all of which are defined in the statute as a "primary plan."

These terms are relatively clear: a primary plan pays first and a secondary plan pays second. But, what makes Medicare secondary after your settlements? That settlement fund of course. Medicare *reasonably expects* payment to be made for bills because you created a settlement fund for, among other things, future medical bills.

Post-settlement, Federal Regulations specifically forbid Medicare from paying for case related care: "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."[3] We know what you're thinking, if you don't allocate anything for future medicals you are free and clear. Nope. 42 C.F.R. § 411.46(b) states that Medicare will not recognize a settlement if it attempts to shift the burden of medical payments to Medicare.[4]

Let's get this out of the way: an MSA is not required by law. Nevertheless, something is needed to prevent Medicare from paying for the future care. Medicare is comfortable with the MSA system. Medicare understands the MSA system. You can create a separate way to prevent Medicare's payments; however, that method might cause greater headaches if Medicare inadvertently pays a bill and attempts to recoup its payment (its favorite method is to garnish Social Security payments).

[1] 42 U.S.C. § 1395y(b)(2)
[2] 42 U.S.C. § 1395y(b)(2)(A)(ii)
[3] 42 C.F.R. § 411.46(d)(2)

Perhaps Medicare says it best, "the parties to a [Workers' Compensation] settlement choose to pursue a CMS-approved [MSA] in order to establish certainty with respect to the amount that must be appropriately exhausted before Medicare begins to pay…"[5]

The short answer is that you need an MSA because the law forbids Medicare from paying for case-related future medical care.[6]

When do we need MSAs?

MSAs are needed where your case closes future medical benefits from the employer. As discussed, this portion of settlement creates a "primary" payment fund causing Medicare to become the secondary payer. It is at this point that the law forbids Medicare to pay for case-related medical care pursuant to 42 C.F.R. § 411.46(d)(2).

As part of the "when" you need an MSA, confusion arises as some may point out the Centers for Medicare & Medicaid Services ("CMS") has published review thresholds for MSAs.

> CMS will only review new WCMSA proposals that meet the following criteria:
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> - The claimant is a **Medicare beneficiary** and the total settlement amount **is greater than $25,000.00**; or
> - The claimant has a reasonable expectation of Medicare enrollment within 30 months of the settlement date and the anticipated total settlement amount for future medical expenses and disability/lost wages over the life or duration of the settlement agreement is expected to be **greater than $250,000.00**[7]

These thresholds are helpful to the MSA *review* process, but these thresholds do not state when you need an MSA. Settlements outside of these thresholds do not mean the law is different. The law still states that Medicare is forbidden from paying until the primary fund has been exhausted. Settlements outside of these thresholds still may need an MSA or other device to prevent Medicare from paying *if* future care is required.

What kind of treatment is included in an MSA?

We've establish why you may need an MSA, but, what's in one? MSAs are a very specific device. Consider the full name: Medicare Set-Aside. That name

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[5] *Workers' Compensation Medicare Set-Aside Arrangement (WCMSA) Reference Guide,* v 2.9, p.4, para. 4.1.

[6] 42 USC 1395y(b)(2)(A)(ii) ("In general Payment under this subchapter may not be made… with respect to any item or service to the extent that –… payment has been made or can reasonably be expected to be made under a workman's compensation law…")

[7] https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Workers-Compensation-Medicare-Set-Aside-Arrangements/WCMSA-Overview.html

should be enough to tell even the newest legal professional that this device is meant to pay only what Medicare would normally cover. It's *not a Medical Set-Aside*. It's a Medicare Set-Aside.

Medicare again helps in its WCMSA Reference Guide where it writes, "[the] goal of establishing a WCMSA is to estimate, as accurately as possible, the total cost that will be incurred for all **medical expenses otherwise reimbursable by Medicare** for work-injury related conditions during the course of the claimant's life."[8]

A simple way to determine what is generally in an MSA is to ask:

- Does Medicare normally pay for this service?
- Is the service reasonable, necessary and directly related to the claimant's work injury?

Medicare covers a good amount of medical payments for its beneficiaries. Rather than listing everything that Medicare *does* cover, perhaps it is easier to build an understanding of what an MSA will *not include*.

What kind of treatment is left out of MSAs?

It is extremely important to understand what an MSA will *not* include. If you skimmed this article and found one line to read, this is it: **MSAs are incomplete pictures**. Each injured person may have a significant amount of care that is left out of the MSA because *Medicare doesn't pay for everything*. Do not allow your opponents to fool you. The MSA is just part of the future medical picture. In fact, Medicare's own website has a full page dedicated to "What's not covered by Part A & Part B."[9]

First, note there are different types of Medicare coverage. Medicare Part A provides inpatient/hospital coverage. Medicare Part B provides outpatient/medical coverage. Medicare Part C acts as an alternative way to receive benefits through either private supplemental insurance or private replacement insurance. Medicare Part D provides prescription drug coverage through a private insurance organization.

Medicare Parts A&B do not cover:

a. Long-term care;
b. Long-term skilled nursing facility care;
c. Blood transfusions (Medicare does not cover the first three per year)[10]
d. Many prescription drugs;
e. Over-the-counter drugs;
f. Inpatient hospital days after 150 days in a lifetime;
g. Incontinence supplies;
h. Eastern medicine/holistic medicine like acupuncture, massage therapy, and biofeedback;
i. Chiropractic care (Medicare only covers 80% cost of

[8] *WCMSA Reference Guide,* v. 2.9, p. 3, Para. 3.0 (*Emphasis Added)*

[9] https://www.medicare.gov/what-medicare-covers/whats-not-covered-by-part-a-part-b
[10] https://www.medicare.gov/coverage/blood

manipulation for subluxation and no other services);
j. Psychiatric care (which is often overlooked in critically disabled individuals);
k. *Common* medical supplies;
l. TENS units;
m. Dental care;
n. Certain Durable Medical Equipment;
o. Emergency care;
p. Routine eye care;
q. Routine foot care;
r. Transportation;
s. Gym memberships;
t. Home modification or repairs/maintenance; and,
u. Certain other care[11]

Current trends have led to adversarial MSAs that attempt to underfund the future care. As a result, even where CMS approves a defense-created MSA, you should remain concerned about deductibles, coinsurance, and copays for an MSA that is underfunded.

Even the above list is incomplete. For example, what is long-term care? It can include bathing, dressing, feeding, and helping the injured-person move around[12]. The Administration on Aging defines long-term care in more detail, citing Instrumental Activities of Daily Living (IADLs) that include housework, medication assistance, the preparation of and cleaning up after meals, etc.

For the gravely injured, have you considered Medicare's maximum on hospital admissions days – just 150 days? That 150 includes an individual's 60 "lifetime reserve days." Admittedly, days 1-60 are fully covered by Medicare. Though before that 150 day limit there are *shared* costs that a Medicare beneficiary must pay:

1. $1,364 annual Medicare Part A Deductible;
2. Days 61-90: Coinsurance of $341/day;
3. Days 91-150: Coinsurance of $682/day;
4. Days 151+: All costs.

The above are 2019 rates only. These rates generally increase yearly.[13]

There are other allocations available to fill this gap created by the underfunded MSA. Non-Medicare Cost Projections (NMCPs) are designed to show future medical expenses covered by the Workers' Compensation carrier, but not included in an MSA. If an injured person settles without taking those costs into account, the injured person would be forced to pay for those charges out-of-pocket, putting him into a potentially worse position than if the case had not settled.

Imagine the injured person is single and unable to drive to physician visits, the pharmacy, and physical therapy. Even if that injured person utilized non-emergency medical transportation just once per month, it could cost $37,500.00 over 25 years. Medicare is not paying

[11] See Medicare and You 2019, https://www.medicare.gov/sites/default/files/2018-09/10050-medicare-and-you.pdf

[12] https://longtermcare.acl.gov/the-basics/what-is-long-term-care.html

for that transportation. The injured person is paying – most likely - out-of-pocket.

Current Trends in MSAs

As practioners representing injured workers, understanding the function of the MSA is priority one. But, a close second is understating the nuance of the MSA, and how adversaries may attempt to circumvent the future health of your client in favor of cost savings. Recently, many insurance companies shifted to using the services of companies that prepare MSAs almost exclusively for the defense industry. They will generate reports that appear official, purporting to pay for the future care of the injured worked; but, this is where an insightful counselor should be most wary.

A typical defense MSA report will include most of the items that Medicare would pay for, but none of the items that Medicare does not pay for, as identified above. Your adjuster or defense attorney will pleasantly submit the report to you, at no cost to your client, using it as an example of how the defense is operating in good faith and proactively for your client. And yet, there is a relatively decent chance that the MSA, not to be confused with a full medical cost projection, is underfunded. Remember, most of these reports are not submitted to CMS for approval. Even when they are submitted and receive CMS approval, CMS is protecting Medicare, not your client. That is the job of the injured worker's representative.

If CMS approves an MSA, you do not need to worry if Medicare will later pay, after the MSA is exhausted, for your client's Medicare covered expenses. You do need to worry at that point who is paying for the deductibles, co-insurance and non-Medicare covered medical expenses. So, CMS approval is only half the battle. As lawyers, we know the law. I doubt many know all of the medical costs associated with a particular injury or which ones are covered by Medicare and which ones are not. For that reason, it is essential for injured worker representatives to obtain a full medical cost projection to determine where an MSA-only projection has failed to appropriately provide for your client's future needs.

Another cost savings tactic employed by the insurance industry is to add reversionary language to the future medical care agreement. Essentially, if the corpus of the future medical care trust out lasts the injured worker's life, the remaining funds *revert* to the insurance company funding the trust. This prevents the family of the injured worker from receiving those funds. When is a deal not a deal? When it can be altered later to the detriment of your client and their family. Workers' compensation lawyers can prevent this from occurring by not agreeing to it, and leaving the medical open, as required by law. You can also negotiate a better term.

The insurance industry promotes itself and seeks greater market share to increase profitability. As it does so, it

increases case load for its infrastructure and employees. This will continue to rise provided cases are not closed. Leaving the medical open for an indefinite period on exponentially increasing number of claims prevents long range planning for the industry and a company's staffing needs. It also drains resources. What if all lawyers refused to close the medical unless trust language states the remaining corpus transfers to the claimant's estate, do you think the insurance industry would eventually need to re-evaluate its position on reversionary language?

Professional vs. Self-Administration

How is an MSA or future medical care trust administered? CMS allows for self-administration and provides a "toolkit" to advise and instruct your client on the administration of an MSA arrangement.[14] In reading the toolkit, it is readily apparent that an accounting degree, law degree and experience in medical care pricing are necessary. Though the preceding sentence is an exaggeration, the point of emphasis remains. You should be greatly concerned when allowing your client to manage significant dollars, and the temptation those dollars can create, without the necessary education, understanding and training, necessary to properly protect their future medical care. When is it acceptable to allow your client to self-administer the trust? Ultimately the times should be exceedingly rare. You may consider self-administration if the value of the arrangement is small, the client did not suffer a head injury, and the client is relatively educated with reading, comprehension and math skills.

Professional administration is the preferred method for helping protect you and your client with an MSA. The insurance company resolving the work comp claim rarely objects to paying the up-front costs of administering the MSA. Keep in mind that the company receives the benefit of closing its case file and gains a level of assurance that Medicare and CMS will not bother them thereafter because the administration of the trust was improperly administered. There is a significant chance that clients will call you for advice and questions about the administration of the MSA, if they self-administer. If professionally done, those same clients will call the administrator instead. Not only are they better equipped to deal with those issues, you have more time to deal with the issues that you were trained to do.

Future Non-Medicare Medical Expenses

The primary focus of this article is how a claim can run afoul of Medicare and CMS. Yet, lawyers need to understand that this is not the end of the discussion for settling future medical care. As noted, MSAs are particularly about the

[14] Self-Administration Toolkit for Workers' Compensation Medicare Set-Aside Arrangements; https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Workers-Compensation-Medicare-Set-Aside-Arrangements/Downloads/Self-Administration-Toolkit-for-WCMSAs.pdf

expenses that Medicare pays, not what Medicare does not pay. There is need for a second trust, one that will fully compensate an injured worker for the future medical expenses that are not included within the MSA. Eluded to earlier is that the defense will provide a cost projection for which it is willing to seek CMS approval. The defense will ask that your client sign an authorization for it to communicate with CMS to obtain that approval. Do not provide that signed authorization to the defense unless and until you have a solid settlement, and one that includes non-Medicare expenses.

To be sure that non-Medicare expenses are included in any resolution, seek a cost projection that specifically includes them. Even if you are satisfied with the proposed MSA projection, in order to obtain the entire picture, it is necessary to seek a non-Medicare cost projection. Indeed, failing to do so can result in negative financial implications for your client down the road. That is not the type of call a lawyer wishes to receive when the client realizes that those expenses could have been included, but were not.

Why Would an Injured Worker Settle Future Medical Expenses?

Given the difficulties described in this article, along with the complexities of Medicare, CMS and MSAs, it is difficult to understand why closing medical would be a good idea for the injured worker. Nonetheless, there is significant benefit to the injured worker to settle on the medical benefits, especially in directed care states such as Indiana. In a directed care state, the employer or its representative (TPA or Insurance Company) chooses the physicians that an injured worker may see. Regardless if the claimant does not like the care givers, that is who they get.

Even when a claimant is free to choose their own care givers, getting approval for the care ordered can be onerous and tricky. Getting approval may also delay care. To avoid the employer's choice of physician, delays and denials, a claimant's lawyer looks to settle on the future medical care expenses. The freedom that ensues frequently results in better healing outcomes for the claimant. Maybe it is more anecdotal, but once the injured worker is free to choose their own physicians, they tend to improve physically and mentally. Much of the frustration for claimants throughout a work comp claim stems from dealing with the insurance company to receive necessary medical care. It is akin to a stress reliever: eliminate the insurance company, eliminate stress.

Attorney Fees on Future Medical Expenses

How an attorney is paid on future medical expenses can vary by jurisdiction. In Indiana, the fees are paid by the defense and are calculated as 10% of the future medical expenses reduced to present day value. To calculate present day value, the best method is to obtain a structured settlement quote

from a reputable company. The structure company will provide today's costs to fund a trust that will pay the necessary funds when necessary to provide the future care. As a practice point, a motion for attorney fees on contested and future medical expenses should be filed with the Work Comp Board to preserve the issue of fees. In Indiana, the Board has jurisdiction over all attorney fees. Do not allow the defense to convince you that such fees should come from either the MSA (resulting in underfunding) or from the injured worker's indemnity (compensation) benefits. It is the employer's responsibility to pay if they wish to settle the medical.

Conclusion – Best Practices Tips

Before agreeing to close and settle any future medical expenses for a client, or even provide authority to the defense to consult CMS on behalf of the client, the following should be confirmed.

a. Any MSA and non-Medicare future medical expense trust shall be professionally administered;
b. The employer or its insurer shall pay the professional administration fee and reporting;
c. The MSA may be limited to those expenses actually covered by Medicare but a second trust must include expenses that are not covered by Medicare but nonetheless are medically necessary for the injured worker;
d. To determine the appropriate amount for non-Medicare future expenses, obtain a full medical cost projection or at least a non-Medicare cost projection of your own. Do not rely upon the defense's vendor; and,
e. There will be no reversionary language in the agreement allowing any funds available at the injured worker's time of death to be paid to decedent's estate.