Just the mention of an MSA can have a chilling effect on a potential workers’ compensation settlement. There is concern about the increased costs associated with evaluating the claimant’s future medical exposure in the manner established by the Centers for Medicare and Medicaid Services (CMS), and the delays caused by waiting for the agency’s approval; and then there is the perceived threat that if you don’t do these two things the claimant could be left without medical treatment or, even worse, that CMS will someday show up looking for more money from those involved in the original settlement. More than likely, these concerns are due to misunderstanding of the Medicare Secondary Payer (MSP) laws, exacerbated by misinformation disseminated over several years by both CMS and the burgeoning MSP compliance industry.

Starting with the Patel Memo in July 2001, CMS informally established policy by releasing to the public instructions intended for its Regional Offices regarding how to evaluate requests for written opinions regarding the adequacy of a future medical allocation in a workers’ compensation settlement. Through very liberal use of the word “must,” the contents of that memo were perceived as a legal requirement that MSAs not only be created, but be approved by CMS when they met certain dollar thresholds. Because the Patel Memo was poorly worded, many interpreted it to require MSAs only when the thresholds were met. A clarifying memo was released in October 2002 in Q&A format further fleshing out the WCMSA approval program; that practice continued, with CMS releasing 16 memos in all. Those memos were consolidated into a “user guide” in 2012, but CMS has never formalized any aspect of the program through creation of regulations.

By 2006, CMS MSA policies had been challenged by an MSA vendor under the Administrative Procedures Act. In its defense, CMS filed an affidavit establishing the fact that the program was voluntary – meaning that no one was obligated to seek the agency’s opinion – so the fact that anyone
disagreed with the agency’s policies was irrelevant. CMS’ position is that the appropriate time to challenge its opinion is after a benefit determination is made, so in the case of an MSA, after it is exhausted and benefits continue to be denied or additional reimbursements are being sought. Predictably, very few want that potential exposure hanging over their heads, so they continue to subject themselves to the time-consuming and costly MSA approval process.

Today the WCMSA approval program is more challenging than ever. There is a significant back log of cases that have been submitted for CMS approval, requiring CMS to authorize “expedited reviews” to alleviate the problem. However, the subjective nature of the medical review itself is the major cost driver as CMS evaluates every claim with the worst case medical outcome assumed, and grants unwavering deference to the treating physician despite all commonly accepted medical principles and peer reviews to the contrary, frequently in direct contradiction to the state workers’ compensation law. Compound this approach with funding projected services at rates higher than Medicare’s, and carriers are often forced to settle out their claims for more than they were obligated to pay under state law. For example, CMS mandates that pharmaceuticals be priced at average wholesale price (AWP), a benchmark from which pricing is generally determined, not actually paid. (In fact, Medicare uses average sales price (ASP) when determining Part B drug pricing.) As a result, there is an inherent cost associated with CMS approval.

So, the WCMSA industry has been faced with a dilemma. On the one hand, the workers’ compensation carriers and self insured employers can seek CMS approval of MSAs – which is not required by statute or regulation but is the only currently available assurance that an MSA is adequate – and accept the additional time and cost CMS approval brings to the process. On the other hand, those carriers and self insured employers can skip the CMS approval process, thereby saving time and money, but assuming the risk that an MSA is adequately funded. Most carriers and self insured employers choose the “safe harbor” of CMS approval.

But this dilemma that has faced the WCMSA industry for years is about to change. Ironshore, an A rated P&C insurance company, recently launched an insurance product designed to cover the risks associated with not seeking CMS approval of an MSA. With that insurance policy as a “back-stop,” parties to a workers’ compensation settlement can project future medical expenses without applying the CMS preferences, and without fear of CMS countering with a higher amount, while saving the time and expense associated with the CMS approval process. Ironshore’s product offers an innovating alternative to the choices – or lack of choices – the WCMSA industry has embraced for the past 15 years.