## Medicare Set-Asides:

# What is the True Cost of Future Medical Care?

*After 15 years of experience with Medicare Set Asides (MSAs), it is time to assess whether workers' compensation claims payers' MSA practices benefit them. Most claims payers voluntarily submit MSA forecast reports to the federal government to limit their exposure for claims that are subject to Medicare Secondary Payer (MSP) regulation. However, these optional reports pose an administrative burden and irrevocably lock claims payers into inflated financial commitments. New data show these commitments are far in excess –roughly double – of what is needed to meet legal obligations. Claims payers have always had a simpler, more realistic and feasible option which involves not submitting MSA reports. Administratively and financially, the non-submit option is a means to comply with the MSP regulation without making a non-refundable overpayment to the Federal government.*

Workers' Compensation Medicare Set Asides (WCMSAs) have become a standard feature in settling workers' compensation claims over the past fifteen years. This year set aside MSA proposals for 26,000 workers' compensation claims might be submitted to the federal government. We present new evidence that strongly suggests that this voluntary process of submission predictably and excessively inflates the cost of claims, leaving the claims payer worse off compared to not submitting a set-aside. A "non-submit" option should be considered by every claims payer.

In 2016 Care Bridge International (CareBridgeInc.com) documented through a survey of 36 workers' compensation primary payers' widespread dissatisfaction with the MSA process, which can seriously delay and disrupt the settling of claims and burden claims adjusters.

In this report, we go beyond our 2016 review to challenge the financial justification for electing to submit these MSA proposals, or reports, to the Centers for Medicare and Medicaid Services (CMS) for review and approval. A strong case can be made for not submitting a MSA report for most settlements. Rather, claims payers can quite feasibly forecast much more realistically future medical spending for a settled claim and use the realistic forecast to resolve its financial exposure. Administratively and financially, this is a better option.

*It is time to step back and ask, do claims payers benefit from submissions? There are some significant financial drawbacks to doing so.*

Our findings draw from analysis of over one billion medical claim transactions and of MSAs reviewed and approved by CMS. We also draw upon a detailed review of the account administration of actual MSAs, post claim settlement.

## What is a Medicare Set-Aside?

Medicare is by law a secondary payer of medical expenses for work-related injuries. Workers' compensation is the primary payer. CMS manages the federal government's right to obtain reimbursement from financially responsible parties for Medicare spending to treat a work-related injury. Extensive rules define which workers' compensation claims are covered and which parties are financially responsible.

According to a recent study by NCCI[1], a large number of claims are settled involving injured workers in their 50s, and/or have already been enrolled in Social Security Disability Insurance (SSDI), which means that the worker is already or may soon be Medicare eligible either due to age or disability.[2] When insurers and self-insured employers ("claims payers") settle with these injured workers the medical obligations of their claim, they or the claimant remain financially exposed to Medicare demands for reimbursement for its outlays to treat the work injury. They can substantially resolve their liability by setting aside funds as a part of the settlement. These set-asides are expensive. The NCCI, in its study, estimates that MSAs represent about 45% of total settlement costs, and that the average settlement that includes an MSA is $200,000.

Many workers' compensation claims payers submit MSA reports as if they were legally required. But submitted reports are not the only way to limit the claims payer's financial liability. It is time to step back and ask, do claims payers benefit from submissions? There are some significant financial drawbacks to doing so.

## The impact of medications

To see how submitted MSAs predictably inflate the costs of claims, we need to dig into the content of submitted MSAs. Per NCCI more than half of MSA costs are for medications. Of special interest is forecasted spending on opioids. This is a costly element in many MSAs. Opioids create unique patient safety risks. They have been subject to special attention by medical providers and regulators. Moreover, studies have noted an association between opioid prescribing and high rates of other medications and medical services such as surgery.

Care Bridge has analyzed the distribution of medical expenses in approved MSA reports and estimates that 68% of these reports contain opioids. Among MSAs including opioids, 79% utilize one opioid, 20% 2 opioids and 1% 3 opioids.

When a claims payer voluntarily submits for approval a MSA report, it commits to complying with MSA's mandatory policies regarding medication forecasts. These policies include lifetime projection of medication use. The average life expectancy for a MSA is 24 years. There is no scientific assurance whatsoever that opioids are effective in providing long term relief from pain, much less being safe to use for 24 years.

Also, CMS approves MSAs only when the price of Medicare Part D prescription drugs is set at Redbook® "average wholesale price" or AWP. The AWP is not a transparent price subject to competitive probing. Rather, AWP is an artifact, like other often-cited indexes, such as the sticker price of an auto, or factory price for household appliances, whose prices are subject to obscure manipulation. Pharmacy benefit managers typically charge their claims payer clients using a reference benchmark that is almost invariably a discount off AWP. Our analysis of a large sample of actual MSAs reveals that MSA drug pricing is 36% higher than actual drug outlays. CMS is significantly inflating the costs of MSAs. The only way to avoid this price inflation is to not be bound by a submitted MSA – meaning, not to submit a report.

## Actual drug use patterns conflict with MSA forecasts

Until now, long term patterns in medication use by injured workers have been poorly understood. It has been speculated that over time many injured workers gradually reduce or otherwise change their medication regime. We now have evidence of the actual tapering by injured workers of their use of opioids over time.

Care Bridge analyzed the medical claims data for approximately eight million workers' compensation claimants without settlements, with dates of injury between 2005 and 2013. For most of these claimants, the database captured claims lifetime data for at least five years of claims history and for some upwards of 11 years. We isolated those claims for which there was more than a one-time use of opioids. We documented the average pattern of opioid use month by month in the first-year post injury and for subsequent years.

We expected to see a fairly rapid termination of use in the first few months, and then a gradual decline over years with perhaps a plateauing, that is to say no more significant decline, after some years. Indeed, the data showed a rapid early decline. For instance, 77% of the number of claimants who used opioids in the first month did not use opioids at all in the second year. But the data strikingly showed that the decline in use never ceased. Year over year, ever fewer claimants used opioids.

This declining pattern persisted well after the 4th and 5th years after the date of injury, by which time according to NCCI most MSAs are approved. For every 100 claimants who were actively using opioids in the fourth-year post injury, only 50% were using opioids in the 7th year and 25% were using opioids in the 10th year.

Again, submitted MSA reports must assume that medication continues unchanged through the future lifetime of the claimant. The actual pattern of opioid tapering dramatically conflicts with mandatory MSA forecasts.

Care Bridge undertook another, more in-depth analysis of a very large national sample of submitted and approved MSA reports. We believe this sample fairly represents the entire population of submitted and approved MSAs. (One confirmation is that the sample's average morphine daily dose equivalent (MED) per claimant is 58, very close to the 54.7 MED in a sample of MSAs in California as reported by the California Workers' Compensation Institute[3].) Our MSA sample contained actual medical spend data for the first five years of the MSA's life.

We found a generally declining use of medical resources by the claimants over these five years. In the fifth year, total medication spending was 64% of the level forecasted in the MSA report and other medical spending was 55% of the forecasted level. This is strong evidence that MSA mandated forecasts far over-estimate actual medical spend.

We have focused on opioids due to their importance in costs, patient safety, and industry attention. The evidence of drug tapering over the course of years matches up well with the emergence of a broad pattern of changes in prescribing and popular expectations regarding opioids. Whatever tapering has been naturally occurring in the past, is it reasonable to expect that it is becoming more frequent.

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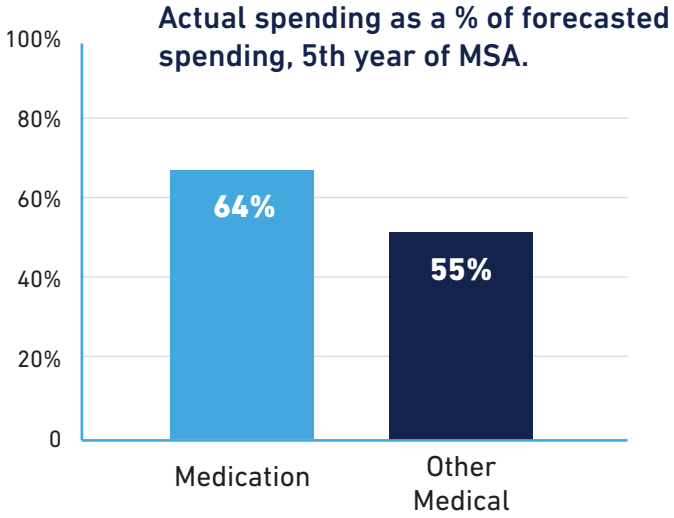

*These trends strongly suggest that many injured workers once on opioid treatment later reduce or dispense with treatment.*

Pharmacy benefit managers (PBMs) in workers' compensation have been noting a reduction in the rate of opioid prescribing for some years. These downward trends in opioid prescribing match the rise in recent years of public dismay over opioid-related deaths and of greater activity of public agencies and healthcare professions to better control the prescribing of opioids. These trends strongly suggest that many injured workers once on opioid treatment later reduce or dispense with treatment.

These trends are no doubt abetted by the increasing realization that opioids are largely ineffective for long term relief from musculoskeletal pain, the most common type of pain experienced by injured workers. In addition, evidence is mounting that opioids may be no more effective than less dangerous and less expensive medications. In March of this year, the Journal of the American Medical Association reported a study in which non-opioid medications provided more pain relief and less adverse effects than did opioids.[4]

## Why is overall medical spend lower than in MSA forecasts?

As noted above, there has been widespread speculation that actual use of medical resources post MSA approval is often below the MSA forecast mandated for submitted reports. Now we have strong evidence of that by analyzing actual use. This leads to the question of why there is lower use. There are five credible influencers:

First, the clear majority (98%, according to NCCI) of MSA accounts are self-administered by the injured worker, post settlement. This means that when the worker elects not to obtain forecasted medical care, the worker may choose to release funds from the MSA for personal use. This is despite the CMS requirement to spend those dollars on any injury related care that Medicare would cover and to provide an annual self-attestation to the proper use of those funds until the funds are depleted.

Second, CMS guidelines as noted above require submitted reports to use artificially inflated medication prices. Actual drug spend, when managed by a PBM as it has been on the sampled set-aside claims, is at the PBM pricing.

Third, as noted above, the entire medical community is more alert to the dangers of opioids. Our sample of MSA reports reveal that one fifth contain opioid regimes of at least 100 MEDs, which is extremely high per today's standards. There is a concerted effort, nationally, among all stakeholders to decrease opioid use and abuse. We expect that many workers with an MSA consider terminating their use of opioids.

Fourth, many MSAs include overall medication regimes that, in the light of evidence-based medicine, are inappropriate, flawed, and thereby subject to improvement. In a close analysis of a few randomly selected MSAs, which we sent for a drug utilization review, we found that by applying evidence-based medicine standards, the medication regimes would be adjusted resulting in 68% savings in medication costs.

Lastly, claims which could have been managed with more scrutiny or evidence-based medical decision -making may sometimes derail in the presence of claim file transfer, in the hands of less experienced claims handlers, or through the impact of litigation and/ or secondary gain mentality, often becoming overinflated with cost. These claims may be remedied using a data driven approach to calculating future care, whereas, under the existing CMS review paradigm, future care is forecast based upon historical utilization of treatment and costs. In other words, if a payer has unknowingly paid for care that is unrelated to the compensable injury, the payer will continue to do so over the claimant's life expectancy through the MSA vehicle. CMS does not make corrections or accommodations for lost claims management opportunities.

## Risks of non-submission of MSA reports

There is risk associated with the non-submission of MSAs to CMS for review and approval. If the MSA account is depleted faster than anticipated either due to unforeseen issues in medication or treatment or through the improper spending of MSA funds by the Medicare beneficiary, Medicare could deny payments for injury related care. CMS may assert that there were simply not enough funds set aside to protect Medicare's interests or require the beneficiary to provide an accounting of the depletion of the set aside funds. Alternatively, if Medicare does make payments, CMS may assert its recovery rights up to the value of the total settlement amount or total amount paid by Medicare. To date, however, there is no such statutory authority, case law or examples of CMS having made this type of argument.

The claims payer must demonstrate that it has prudently taken Medicare's interest in account. It stands to reason that if a statistically valid, reliable data set is used to calculate future care based upon the aggregate of millions and millions of claims nationwide then paired with the safeguard of post settlement account administration, the funds set aside to protect Medicare is strong evidence that Medicare's interests were considered. In fact, the basis for a data-driven calculation is objective, as opposed to the subjective calculation by an individual, based upon some level of clinical or legal experience and less easily defended.

## Criteria for CMS non-submit MSAs

How does one decide which types of claims are best suited for submission vs. non-submission to CMS for review and approval? The answer is to use a conventional MSA report for the relatively few medically complex claims and rely on a data-driven predictive system for the great majority of claims covered by Medicare regulation.

Claims of a catastrophic/ complex nature such as traumatic brain injury, spinal cord injury, extensive electrical or thermal burns, amputations, or individuals with multiple trauma injuries or chronic, progressive conditions are better suited for a professional life care planning evaluation and forecast, as these types of claims exhibit a high degree of variability and very high costs of care over the life time. These individuals decline with advancing age, representing a significant financial burden to the Medicare Trust fund, and often the Medicaid system as well. These claims are best managed using a professional administrator for both the medical and Medicare Set Aside accounts to maximize and manage the funds for their highest and most efficient use for the benefit of the injured person.

These claims typically represent at most 10% of the claims subject to Medicare regulation. The remaining 90%-plus of injury claims subject to Medicare regulation can be forecasted and settled without CMS submission with minimal to no risk, using predictive models and post settlement account administration or support. This strategy cuts costs and administrative headaches while remaining in compliance.

## Conclusion: the non-submit option

According to NCCI, reports approved by CMS in 2015 averaged about $93,000. With about 26,000 reports likely to be submitted this year the total annual dollar value of new MSAs will be over two and a half billion dollars. Care Bridge is confident in making this conclusion: for most claims being brought to settlement, it is not in the financial interest to the claims payer to submit a MSA to CMS for review and approval.

Rather than submit a MSA, which locks the claims payer into an inflated and unalterable fixed set-aside, the claims payer can prepare a plan for the large majority of claims using realistic forecasts, fund it, and enjoy a cap on its financial liability – without submitting a report. CMS has always recognized a non-submitted, funded plan as sufficient to satisfy its secondary payer rights so long as certain compliance steps are taken.

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One way to create a non-submitted plan that meets CMS standards is to use Care Bridge's predictive, analytic – powered Medicare Set Aside Allocation generator, which projects medical costs over a life expectancy according to actual medical spend patterns of millions of actual workers' compensation claims. The plan can be generated in minutes, rather than days or weeks. The plan can lead to structuring a settlement that will allocate funds for realistically forecasted spend. The settlement would include post-settlement support to the injured worker to help manage the funds and stay in compliance. So long as the participating parties adhere to some basic procedural steps, CMS will consider the plan as satisfying its rights. For the claims payer, its financial liability is capped. Administratively and financially, this is a better option.

CMS is transitioning to a data driven culture. In June, CMS announced its new Office of Information Products and Data Analytics (OIPDA), created for driving the use and dissemination of big data. The department functions to deploy advanced analytics, generate and expand upon new policies and programs that support the use of CMS data.

As InsurTech is adopted in the insurance industry, the digitization of claims is our new reality. Based upon this paradigm shift, John Leonard, former CEO of MEMIC, ranked the top workers' compensation company in the U.S. by the Association for Cooperative Operations Research and Development (ACORD), offers this advice to primary payers, "Adapt a contemporary way of thinking rather than falling into a model that is now about 15 years old. We learned a lot during those past 15 years, but it's time we put that knowledge to work in today's environment."



**End Notes**

[1] NCCI, Medicare Set-asides and Workers' Compensation: 2018 Update. February 2018

[2] CMS review and approval of a MSA is not only voluntary under the MSP statute, but CMS has a workload capacity and is unable to review each and every consideration for Medicare's future interests and has established a review threshold. The review contractor will only review WCMSAs that exceed $25K total settlement amount involving a Medicare beneficiary or $250K total settlement for an injured worker with a reasonable expectation of Medicare eligibility within 30 months, or age 62 ½ years.

[3] CWCI, Opioids in Workers' Compensation Set-Asides. October 2017

[4] Krebs EE et al. Effect of Opioid vs Nonopioid Medications on Pain-Related Function in Patients With Chronic Back Pain or Hip or Knee Osteoarthritis Pain: The SPACE Randomized Clinical Trial. JAMA. 2018 Mar 6;319(9):872-882