INTRODUCTION

The Centers for Medicare & Medicaid Services (CMS) approved $1.8 billion of workers compensation (WC) Medicare Set-Asides (MSAs) in FY 2013 [1]. An MSA is a fund established to pay future work-related-injury medical costs that might otherwise be paid by Medicare. CMS will review a proposed MSA if the total settlement meets certain criteria.

Using a sample of proposed workers compensation settlements whose MSAs have been reviewed by CMS, this paper looks at:

- Demographics related to MSAs, such as:
  - The distributions of amounts of MSAs and total settlements that include MSAs
  - The distributions of ages of claimants
- Aspects of the CMS review process, such as:
  - The length of time from submission to CMS approval
  - The relation between submitted and CMS-approved MSA amounts

KEY FINDINGS

- After a period of dramatic lengthening, CMS’s processing time for MSAs has recently declined
- The ratio of CMS-approved MSA amounts to submitted MSA amounts has declined over time
- The differences between proposed and approved MSA settlements have been largely due to prescription drug costs
- Most MSAs are for claimants who are Medicare-eligible at the time of settlement
  - Most of these claimants are Medicare-eligible because they have been on Social Security Disability for at least two years
- MSAs make up about 40% of total proposed settlements
  - Of this 40%, prescription drugs make up half
BACKGROUND

Some workers compensation claimants are eligible for Medicare benefits, or will become eligible in the near future. By law,¹ Medicare is a secondary payer for work-related injuries—workers compensation should pay for medical services for such injuries. Workers compensation insurers (including self-insureds) are therefore required to protect Medicare’s interests when settling claims. Workers compensation Medicare Set-Asides—funds established to pay future work-related-injury medical costs that might otherwise be paid by Medicare—are common mechanisms used to protect Medicare’s interests. An MSA can be funded as a lump sum, an annuity, or some combination of these. An MSA can be “self-administered,” meaning that the claimant administers the MSA, or the MSA can be professionally administered.

For total workers compensation settlements meeting certain criteria, CMS will review the proposed MSA. Having CMS review a proposed MSA is optional—there is no requirement that carriers submit proposed MSAs to CMS for review. However, there is a “safe-harbor” aspect to having CMS review a proposed MSA—if certain conditions are met and the MSA funds are not sufficient to pay for the medical care needed for the work-related injury, then Medicare will pay for any further (otherwise Medicare covered) medical services needed to treat the work-related injury.

CMS has two thresholds for reviewing MSAs, often called the “$25,000 threshold” and the “$250,000 threshold.” Specifically, CMS will review a proposed MSA when:

- The claimant is currently Medicare-eligible and the proposed total settlement is at least $25,000. The claimant might be Medicare-eligible because:
  - They are 65 years old or older
  - They have been on Social Security Disability for at least two years
- The claimant is likely to become Medicare-eligible within 30 months and the proposed total settlement is at least $250,000. The claimant might be likely to become Medicare-eligible within the next 30 months because:
  - They are at least 62½ years old but not yet 65 years old
  - They have been on Social Security Disability for less than two years or are likely to become eligible for Social Security Disability within the next six months

The focus of this report is the CMS review process, which is just one part of the total claims settlement process.

CMS uses a contractor to review proposed MSAs; the agency changed contractors on July 1, 2012. For additional background related to MSAs, see:

- NCCI’s “Workers Compensation and Medicare Set-Asides—Webinar on Demand” on ncci.com
- CMS’s Self-Administration Toolkit for Workers’ Compensation Medicare Set-Aside Arrangements on cms.gov

¹ The 1965 Medicare Amendment to the Social Security Act and the 1980 Medicare Secondary Payer Act (MSP) both state that Medicare is a secondary payer for medical services for work-related injuries.
STUDY DATA

Two WC data sources were used in this study—sample data for MSAs provided by Gould & Lamb and NCCI’s Medical Data Call (MDC).

Gould & Lamb is a Medicare Secondary Payer (MSP) and Mandatory Insurer Reporting (MIR) compliance service provider. The sample data provided by Gould & Lamb is based on approximately 2,200 MSAs submitted to CMS between September 2009 and November 2013, and completed between January 2010 and November 2013. Data for each submission to CMS includes the proposed total settlement, the proposed MSA amount, and the final MSA amount. Both the proposed and approved MSAs include separate amounts for medical services that might otherwise be covered under:

- Medicare Parts A & B—hospital, office visits, and related services
- Medicare Part D—prescription drugs

Although NCCI cannot conclusively determine that the data provided by Gould & Lamb is representative of all MSAs, the distribution of MSAs by state was in line with the general state population for states that allow settlements for workers compensation medical benefits. Furthermore, the sample used in this study is generally comparable to data for other published studies on MSAs.

The MDC data that was used captures transaction-level detail on medical services provided during 2012 and evaluated as of March 2013. NCCI collects the MDC for the 35 jurisdictions where NCCI provides ratemaking services and for 8 additional states on behalf of the independent state rating organizations. The MDC was used to compare MSA claimant demographics to the general WC claimant population.

TERMINOLOGY

Terms used throughout this study include:

- WC Medicare Set-Aside (MSA)—a fund established to pay medical costs to treat a work-related injury that might otherwise be paid by Medicare
- Centers for Medicare & Medicaid Services (CMS)—US federal agency responsible for the administration of the Medicare and Medicaid programs, among other services
- Medicare—federal health insurance program mainly for people who are 65 years of age or older and for younger individuals with certain disabilities
- Medicare Parts A & B—hospital, office visits, and related services
- Medicare Part D—prescription drugs

---

2 The 35 jurisdictions for which NCCI provides ratemaking services are AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, KS, KY, LA, MD, ME, MO, MS, MT, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, and WV; the 8 independent bureau states for which NCCI collects the Medical Data Call are IN, MA, MI, MN, NC, NJ, NY, and WI.
MSA DEMOGRAPHICS

Here we look at some of the general characteristics of MSA claims. Analyses in this section are based on submissions to CMS, not the MSAs approved by CMS.

Most MSAs submitted to CMS are for claimants who are Medicare-eligible. Exhibit 1 shows the distribution of submissions by claimant Medicare eligibility at the time the MSA is submitted to CMS for review. Over 90% of submissions are for claimants who are Medicare-eligible. In turn, the majority of these submissions are for claimants under 65 years of age. In comparison, according to CMS [2], for the general Medicare population, less than 20% of Calendar Year 2012’s enrollments were for individuals under 65 years of age.

![Most MSAs Are for Claimants Who Are Medicare-Eligible at the Time of Settlement](chart)

Source: Gould & Lamb’s Medicare Set-Aside Sample Data—MSAs submitted to CMS between September 2009 and November 2013, and completed between January 2010 and November 2013
The majority of MSAs reviewed by CMS are for claimants between ages 50 and 70. Exhibit 2 displays the distribution of claimant age at the time of CMS submission. This exhibit also shows that more than half of the claimants are younger than 60.

The Majority of MSAs Reviewed by CMS Are for Claimants Between Ages 50 and 70

Distribution of Claimant Age at CMS Submission

Source: Gould & Lamb’s Medicare Set-Aside Sample Data—MSAs submitted to CMS between September 2009 and November 2013, and completed between January 2010 and November 2013

Exhibit 2
MSAs are often associated with large claim settlements, as shown in Exhibit 3. This exhibit examines the distribution of proposed total settlements. The proposed total settlement includes the MSA amount as well as indemnity costs, other medical costs not covered by Medicare, and attorney fees, when applicable. Approximately 60% of these settlements are greater than $100K. For the submissions in this sample data, the average total settlement size is approximately $175K.

**Over Half of Submissions Reviewed by CMS Are for Settlements Greater Than $100K**

Distribution of Submissions by Proposed Total Settlement Size

![Distribution of Submissions](chart)

Source: Gould & Lamb’s Medicare Set-Aside Sample Data—MSAs submitted to CMS between September 2009 and November 2013, and completed between January 2010 and November 2013

Exhibit 3
While more than half of the submissions reviewed by CMS are for proposed total settlements that are more than $100K (Exhibit 3), approximately half of the submissions reviewed by CMS have proposed MSA amounts less than $25K. Exhibit 4 shows the distribution of submissions by proposed MSA size. In some cases, the proposed total settlement can be quite large, while the MSA component of the total settlement is small.

Almost Half of Submissions Reviewed by CMS Have MSA Amounts Less Than $25K

Distribution of Submissions by Proposed MSA Size

<table>
<thead>
<tr>
<th>Proposed MSA</th>
<th>Share of MSA Submissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under $25K</td>
<td>45%</td>
</tr>
<tr>
<td>$25K-$50K</td>
<td>16%</td>
</tr>
<tr>
<td>$50K-$100K</td>
<td>18%</td>
</tr>
<tr>
<td>$100K-$150K</td>
<td>8%</td>
</tr>
<tr>
<td>$150K-$200K</td>
<td>4%</td>
</tr>
<tr>
<td>Over $200K</td>
<td>8%</td>
</tr>
</tbody>
</table>

Source: Gould & Lamb's Medicare Set-Aside Sample Data—MSAs submitted to CMS between September 2009 and November 2013, and completed between January 2010 and November 2013

Exhibit 4
Exhibit 5-a gives the distribution of proposed settlement costs for MSAs submitted to CMS. This exhibit shows that MSAs represent about 40% of proposed total settlement costs. These proposed MSA amounts are split evenly between prescription drugs (Medicare Part D) and other medical services (Medicare Parts A & B). Further detail is given in Exhibit 5-b, which breaks down the cost distribution by size of settlement, showing that prescription drugs are about half of proposed MSAs across most settlement sizes.

**Other than MSA** includes indemnity, medical not covered by Medicare, and other expenses such as attorney fees.

Source: Gould & Lamb’s Medicare Set-Aside Sample Data—MSAs submitted to CMS between September 2009 and November 2013, and completed between January 2010 and November 2013

Exhibit 5-a
Prescription Drugs Are Half of MSAs Across Most Proposed Settlement Sizes

**Other than MSA** includes indemnity, medical not covered by Medicare, and other expenses such as attorney fees.

Source: Gould & Lamb's Medicare Set-Aside Sample Data—MSAs submitted to CMS between September 2009 and November 2013, and completed between January 2010 and November 2013

Exhibit 5-b
Exhibit 6 shows the distribution of types of injuries for MSAs and for WC countrywide, where type of injury is determined from the primary ICD-9 diagnosis code. This comparison is restricted to states in common between NCCI’s Medical Data Call and the MSA sample.

The most common type of injury in the MSA sample was disease of the musculoskeletal system and connective tissue, which accounted for more than half of the MSA claims. In contrast, for the countrywide WC claim distribution only one-third of the claims involve this type of injury. Conversely, only 1% of the MSAs are open-wound claims, whereas 11% of the countrywide WC claims are open-wound claims.

Half of MSAs Reviewed by CMS Involve Musculoskeletal Impairments

<table>
<thead>
<tr>
<th>Injury Description</th>
<th>MSAs Share</th>
<th>Countrywide WC Claims Share</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disease of the Musculoskeletal System and Connective Tissue</td>
<td>54%</td>
<td>34%</td>
</tr>
<tr>
<td>Sprains and Strains of Joints and Adjacent Muscles</td>
<td>18%</td>
<td>34%</td>
</tr>
<tr>
<td>Fractures</td>
<td>17%</td>
<td>11%</td>
</tr>
<tr>
<td>Open Wound</td>
<td>11%</td>
<td>1%</td>
</tr>
<tr>
<td>All Others</td>
<td>16%</td>
<td>34%</td>
</tr>
</tbody>
</table>

Injury—Based on Primary ICD9 Diagnosis Code

*Comparison restricted to states in common between NCCI’s Medical Data Call and the MSA sample—AK, AL, AR, AZ, CO, CT, DC, FL, GA, IA, ID, IL, IN, KS, KY, LA, MA, MD, ME, MN, MO, MS, NC, NE, NJ, NM, NY, OK, RI, SC, SD, TN, TX, UT, VA, VT, WI, and WV.

Sources: NCCI’s Medical Data Call and Gould & Lamb’s Medicare Set-Aside Sample Data—MSAs submitted to CMS between September 2009 and November 2013, and completed between January 2010 and November 2013

Exhibit 6
MSAs can be funded by a lump-sum payment, by an annuity, or by some combination. Exhibit 7-a shows that most proposed MSAs use only lump-sum payments and do not involve annuities. In contrast, about three-quarters of MSA costs are for MSAs that involve annuities, as shown in Exhibit 7-b. Larger settlements are more likely to use an annuity than are smaller settlements.

For lump-sum settlements, Medicare does not make any payments for medical expenses related to the work injury until the fund is exhausted. On the other hand, when an annuity is used, if the fund is exhausted between the scheduled payments, Medicare will pay for otherwise covered services until the next annuity payment.

*Settlement includes at least one annuity in addition to any lump-sum payments.

Source: Gould & Lamb’s Medicare Set-Aside Sample Data—MSAs submitted to CMS between September 2009 and November 2013, and completed between January 2010 and November 2013

Exhibit 7-a

Most MSA Settlements Are Paid as a Lump Sum

MSAs That Include Annuities Are More Than Three-Quarters of MSA Costs

*Settlement includes at least one annuity in addition to any lump-sum payments.

Source: Gould & Lamb’s Medicare Set-Aside Sample Data—MSAs submitted to CMS between September 2009 and November 2013, and completed between January 2010 and November 2013

Exhibit 7-b
RECENT MSA TRENDS

An event that seems to have affected CMS’s MSA processing is that on July 1, 2012, CMS changed the contractor used to review MSAs. We will see some of those effects in this section.

In 4th Quarter 2012, CMS provided determination letters for an unusually large number of MSAs, and almost all of these determination letters were sent in December. Exhibit 8 shows the share of MSAs in the sample data provided by Gould & Lamb by the quarter Gould & Lamb received the determination letter giving CMS’s value for the MSA. CMS’s issuance of the determination letter generally ends the CMS review process. The surge in determination letters in December 2012 appears to be part of a process to reduce a backlog that had built up. Very few of the MSAs that were returned in December had been submitted in the previous six months. The average time from submission to determination letter for these MSAs was about nine months, and some had been submitted more than a year prior.

The lower shares of MSAs in the sample data for 1st Quarter 2010 and 4th Quarter 2013 are due to the cutoff of the data, which excludes submissions prior to September 2009 and subsequent to November 2013. For 3rd Quarter 2012, the lower share of MSAs may be related to the transition from the previous to the current CMS MSA review contractor.

CMS Letters of Determination Surged in December 2012

Source: Gould & Lamb’s Medicare Set-Aside Sample Data—MSAs submitted to CMS between September 2009 and November 2013, and completed between January 2010 and November 2013

Exhibit 8

Generally, the time from CMS issuance of a determination letter to receipt by Gould & Lamb is a few days. Our statistics are based on the dates that Gould & Lamb actually received the determination letter.
While from 2nd Quarter 2010 through 2nd Quarter 2012 a little less than half of the MSAs submitted to CMS were approved as submitted, more than 90% of those completed during December 2012 were approved as submitted—see Exhibit 9. This exhibit shows the shares of MSAs approved as submitted by the quarter in which the review was completed. The spike in the share of approved as submitted in December 2012 appears to be a one-time event related to clearing the backlog. In 2013, approved as submitted shares were slightly lower than most such shares prior to mid-2012.

More Than 90% of MSAs Completed During December 2012 Were Approved as Submitted

*Excluding December 2012; 4Q2012 approved as submitted share including December 2012 is 84%.

Source: Gould & Lamb's Medicare Set-Aside Sample Data—MSAs submitted to CMS between September 2009 and November 2013, and completed between January 2010 and November 2013

Exhibit 9
The change in review contractor seems to have reduced the average CMS processing time for MSAs. Exhibit 10 displays the average and median processing\(^6\) times for MSAs completed between 3rd Quarter 2010 and 4th Quarter 2013. Processing time is the number of days from submission of an MSA to CMS to receipt of the determination letter. The processing times shown for 1st and 2nd Quarter 2010 may be understated because the sample data used does not include submissions made before September 2009. Therefore, the first two quarters of 2010 are not shown. This possible distortion is discussed in Appendix A.

Average processing time nearly tripled from 3rd Quarter 2010 to 2nd Quarter 2012. The average and median processing times progressively increased at similar rates over this period. The similarities in these two measures indicate a narrow distribution of processing times. It appears that, during this period, CMS was mostly working on the oldest submissions, and the age of these oldest submissions kept increasing. We found no evidence that the size of the proposed MSA affected the processing time or that the distribution of sizes of proposed MSAs changed significantly over this period.

A 2012 US Government Accountability Office (GAO) report\(^7\) noted this increase and discussed actions by CMS to reduce MSA processing time—see Appendix B for excerpts from the GAO report.

Subsequent to the change in contractor and the substantial clearing of the backlog in the second half of 2012, average processing times for MSAs completed in 2013 are generally shorter than average processing times for MSAs completed in 2011 or the first half of 2012.

---

\(^6\) The median processing time is the number of days for which half of MSAs are processed in less time and half take longer.

\(^7\) The average processing times given in the GAO report [3] are generally lower than those given here. The GAO study excludes MSAs that required rereview, while such MSAs are included here. Also, the GAO study might include settlements that do not meet the CMS review thresholds, and these might have a short processing time. Our study only looks at settlements that meet the review thresholds.
Although the processing time has changed considerably over the period considered, there is no apparent trend in approved MSA amounts, which are shown in Exhibit 11. This exhibit shows the median and the average approved MSAs for the quarter in which the CMS review was completed. While the average approved amounts tend to vary more than the median, there is no apparent upward or downward trend.

The difference between the average and the median is due to the distribution of MSA sizes. Exhibit 4 shows that almost half of MSAs are less than $25K. The spike in the average for 4th Quarter 2013 is due to a few large claims and not a general increase in MSA size.

There Is No Apparent Trend in Average Approved MSAs

Approved MSA Amounts

Quarter in Which Determination Letter Was Received

Source: Gould & Lamb's Medicare Set-Aside Sample Data—MSAs submitted to CMS between September 2009 and November 2013, and completed between January 2010 and November 2013

Exhibit 11
While many MSAs have been approved by CMS as submitted, CMS often requires that the MSA be increased. Exhibits 12 through 17 compare the average CMS approved MSA amount to the average submitted by the year that the review was completed, and show that the average CMS approved amount has been greater than the average submitted amount. Due to the impact of the large number of December 2012 determination letters that, for the most part, approved submissions as filed (see Exhibit 9), these exhibits compare the approved and submitted values including and excluding submissions completed during that month.

The gap between average submitted and approved MSA amounts has been shrinking, as Exhibits 12 and 13 show. Exhibit 12-b, which excludes the December 2012 completed submissions, suggests that there is no significant trend in the average value of approved MSAs. On the other hand, there has been an upward trend in the average submitted MSA since 2011. Vendors and carriers may now understand CMS procedures better and, as a result, submitted values may be more in line with what CMS is likely to require. In addition, CMS has published improved guidelines and appears to have become more consistent in its valuation of MSAs. The result is that the ratio of approved to submitted MSA has dropped from 1.60 to 1.10 for submissions completed between 2010 and 2013, as shown in Exhibit 13.

The Gap Between Submitted and Approved MSAs Is Shrinking

Source: Gould & Lamb’s Medicare Set-Aside Sample Data—MSAs submitted to CMS between September 2009 and November 2013, and completed between January 2010 and November 2013
The Gap Between Submitted and Approved MSAs Is Shrinking

Excluding December 2012

Source: Gould & Lamb’s Medicare Set-Aside Sample Data—MSAs submitted to CMS between September 2009 and November 2013, and completed between January 2010 and November 2013

Exhibit 12-b

The Ratio of Overall Approved to Submitted MSAs Has Declined Over Time

Source: Gould & Lamb’s Medicare Set-Aside Sample Data—MSAs submitted to CMS between September 2009 and November 2013, and completed between January 2010 and November 2013

Exhibit 13
Exhibits 14 through 17 are similar to Exhibits 12 and 13, but look separately at the components of the MSA for Medicare Parts A & B (Exhibits 14 and 15) and Medicare Part D (Exhibits 16 and 17). Note that a few of the MSAs in the sample dataset have only the reported total approved amount and not the separate approved amounts for Parts A & B or Part D. Because of this, the sum of the approved averages for Parts A & B and Part D is not precisely the total average approved shown earlier.

The gap between approved and submitted MSAs for Parts A & B has been stable, as Exhibits 14 and 15 show. Although the average approved MSA for Parts A & B has been fairly stable, Exhibit 15 shows that the average approved amounts have been approximately 10% higher than the submitted.

During 2012 and 2013, the approved to submitted ratio increased slightly. We are told that CMS has recently been adding some medical services not included in the submission, such as visits to some types of specialists that the claimant has not used in the past. Also, in some cases, CMS appears to be estimating a higher future frequency of certain medical services than are reflected in the claimant’s history, especially for regular office visits.

The Gap Between Approved and Submitted MSAs for Parts A & B Has Been Fairly Stable

![Graph showing the gap between approved and submitted MSAs for Parts A & B]

Source: Gould & Lamb’s Medicare Set-Aside Sample Data—MSAs submitted to CMS between September 2009 and November 2013, and completed between January 2010 and November 2013

Exhibit 14-a
The Gap Between Approved andSubmitted MSAs for Parts A & B Has Been Fairly Stable

Excluding December 2012

Year Determination Letter Was Received

Source: Gould & Lamb’s Medicare Set-Aside Sample Data—MSAs submitted to CMS between September 2009 and November 2013, and completed between January 2010 and November 2013

Exhibit 14-b

The Ratio of Overall Approved to Submitted MSAs for Parts A & B Has Been Fairly Stable

Year Determination Letter Was Received

Source: Gould & Lamb’s Medicare Set-Aside Sample Data—MSAs submitted to CMS between September 2009 and November 2013, and completed between January 2010 and November 2013

Exhibit 15
The gap between average submitted and approved MSA amounts for prescription drugs, which are covered under Medicare Part D, declined between 2010 and 2013, as Exhibits 16 and 17 show. In 2009, CMS increased its scrutiny of prescription drug provisions in proposed MSAs and generally began to require increases over the amounts proposed for prescription drugs in the submitted MSAs. For example:

- CMS typically assumed that for the rest of their life the claimant would continue to take whatever drugs the claimant had been taking recently and at that same rate. Submissions often assumed that use of certain drugs would stop at some time or that the rate of use of certain drugs would decline.
- CMS used average wholesale prices for some medications, while submitters would use the workers compensation fee schedule amount or another negotiated price that was lower than the average wholesale price.

We have been told that recently CMS has been more open to considering MSA proposals that price drugs using WC fee schedules or other discounted prices, and to considering whether use of certain drugs can reasonably be expected to taper off.

### The Gap Between Approved and Submitted MSAs for Drugs Has Declined Significantly

Source: Gould & Lamb’s Medicare Set-Aside Sample Data—MSAs submitted to CMS between September 2009 and November 2013, and completed between January 2010 and November 2013

**Exhibit 16-a**
### The Gap Between Approved and Submitted MSAs for Drugs Has Declined Significantly

Excluding December 2012

Source: Gould & Lamb’s Medicare Set-Aside Sample Data—MSAs submitted to CMS between September 2009 and November 2013, and completed between January 2010 and November 2013

### Exhibit 16-b

The Ratio of Overall Approved to Submitted MSAs for Drugs Has Declined Sharply

Source: Gould & Lamb’s Medicare Set-Aside Sample Data—MSAs submitted to CMS between September 2009 and November 2013, and completed between January 2010 and November 2013

### Exhibit 17
Exhibits 18 to 21 use box plots to show the overall distribution of ratios of approved to submitted MSA amounts. These boxplots illustrate the range of approved to submitted ratios. The shaded boxes indicate the 25th to 75th percentiles of the distribution, while the “whiskers” above and below the box show the broader ranges of results represented by the 95th and the 5th percentiles respectively. A wider box indicates more spread in the observed ratios than a narrower box. Long whiskers indicate that there are some ratios that differ substantially from the majority of the observations. In these exhibits, the box-and-whiskers denoted “2012*” excludes submissions completed in December 2012.

The spread of MSA approved to submitted ratios has been fairly consistent over time when December 2012 is excluded, as shown in Exhibit 18. For all years, when December 2012 is excluded:

- The 25th percentile is 1.0
- The 75th percentile is about 1.2 to 1.6
- The 5th percentile ranges from about 0.7 to about 0.8
- The 95th percentile ranges from about 3.2 to about 4.4

While it is not shown in Exhibit 18, the median ratio for all years, whether or not December 2012 is included, is 1.00.

*Excluding December 2012.

Source: Gould & Lamb’s Medicare Set-Aside Sample Data—MSAs submitted to CMS between September 2009 and November 2013, and completed between January 2010 and November 2013

Exhibit 18

---

8 For example, the 25th percentile is the value for which 25% of ratios are that value or smaller. In general, the $p$th percentile is the value for which $p$ percent of ratios are that value or smaller. The median is the 50th percentile.
For Medicare Parts A & B, the spread of MSA approved to submitted ratios has increased, as Exhibit 19 shows. While in all years the 25th percentile ratio is 1.0, the 75th percentile ratio grew from 1.04 in 2010 to almost 1.5 in 2013. The spread between the 5th and 95th percentiles also increased over this period. Possible reasons for this increase in spread were given in the discussion of Exhibits 14 and 15.

The median ratio is 1.00 for all years except 2013, where the median increased to 1.07.

The Spread of Approved to Submitted Ratios for Parts A & B Has Grown

Source: Gould & Lamb’s Medicare Set-Aside Sample Data—MSAs submitted to CMS between September 2009 and November 2013, and completed between January 2010 and November 2013

Exhibit 19
Most of the spread in MSA approved to submitted ratios is due to provisions for drugs, Medicare Part D, as displayed in Exhibit 20. For 2010, the spread from the 25th to the 75th percentile is considerably greater for Medicare Part D than for Medicare Parts A & B (cf. Exhibit 19). By 2013, the Medicare Part D spread between the 25th and 75th percentiles is actually smaller than that for Parts A & B. Note that the 95th percentiles are greater than 5.0 for all years, suggesting that there have been some number of submissions where the approved amount is substantially greater than the amount proposed in the submission. This is more evident in Exhibit 21, which shows the same information as Exhibit 20, but uses a wider scale for the approved to submitted ratios. The median ratio is 1.00 in all years.

**Exhibit 20**

*Excluding December 2012.*

Source: Gould & Lamb’s Medicare Set-Aside Sample Data—MSAs submitted to CMS between September 2009 and November 2013, and completed between January 2010 and November 2013
CLOSING REMARKS

For many years, MSAs have been a significant share of workers compensation claims costs. Most MSAs are for claimants under the age of 65 who are Social Security Disability beneficiaries, and about half of MSA amounts are for prescription drugs. Also, largely due to the prescription drug component of MSAs, the ratio of CMS-approved MSA amounts to submitted MSA amounts has declined over time. Another positive recent development is that after a period of dramatic lengthening, CMS’s processing time for MSAs has recently declined.

ACKNOWLEDGMENTS

The authors are grateful to Gould & Lamb for providing the sample MSA data and for many helpful discussions. Thanks also to Patrick O’Brien, who contributed to this study.
APPENDIX A
Possible Processing Time Distortion Discussion—1Q2010–2Q2010

The average processing time computed from the sample data for MSAs completed in the first two quarters of 2010 might understate the average CMS processing times during these two quarters. However, the average processing times computed from the sample data for MSAs in 3rd Quarter 2010 and subsequent are likely to be representative of average CMS processing times.

Exhibit 22 shows the distribution of MSA processing time by the quarter in which the determination letter was received. The sample data contains MSAs submitted to CMS in or after September 2009. Any MSA submitted prior to September 2009 and completed 3rd Quarter 2010 or later would increase the average processing time shown in Exhibit 10 for the quarter in which the determination letter was received.

- 1st Quarter 2010—Exhibit 8 shows a lower share of completed MSAs for 1st Quarter 2010 than for subsequent quarters. This suggests that some MSAs may not be included due to the cutoff of the data extract. We believe that the potential missing observations could be for submissions prior to September 2009.
- 2nd Quarter 2010—Exhibit 8 shows that the share of completed MSAs for 2nd Quarter 2010 is comparable to subsequent quarters. Thus, the data cutoff might not impact the average processing times for MSAs completed in 2nd Quarter 2010 as for those completed in 1st Quarter 2010. However, some MSAs processed in 2nd Quarter 2010 were submitted during 4th Quarter 2009. As such, there is a potential that some MSAs submitted prior to September 2009 could have been completed during 2nd Quarter 2010.
- 3rd Quarter 2010 and subsequent—it is unlikely that the data cutoff affected the average processing times shown in Exhibit 10. The gap between the dashed line and the 95th percentile whiskers in Exhibit 22 shows that the 95th percentile processing time for these quarters is much less than what the processing time would be for any MSA submitted before September 2009.
- We have elected to restrict Exhibit 10 to 3rd Quarter 2010 and subsequent in order to address this.

Source: Gould & Lamb’s Medicare Set-Aside Sample Data—MSAs submitted to CMS between September 2009 and November 2013, and completed between January 2010 and November 2013

Exhibit 22
APPENDIX B

Page 16—Ineligible submissions increased by about 148 percent from 2008 through 2011, growing from about 4,500 ineligible submissions in 2008 to about 11,200 ineligible submissions in 2011. Although mandatory reporting did not add any new WCMSA requirements, a CMS official told us the NGHP [Non-Group Health Plan] industry may be submitting more WCMSA proposals that are not eligible for WCRC [Workers’ Compensation Review Contractor] review because it wants documentation from CMS stating that a WCMSA did not meet CMS’s review thresholds.

Page 16—WCRC officials said that they have also seen an increase in $0 WCMSA proposals. A workers’ compensation plan may submit these proposals when a settlement amount meets the minimum thresholds and is eligible for WCRC review, but the plan is asserting that it does not have responsibility for paying the beneficiary’s future medical expenses. WCRC officials told us that when an NGHP submits a $0 WCMSA proposal, it may be seeking CMS confirmation that it does not have responsibility for paying the beneficiary’s future medical expenses.

Page 24—Also, CMS reported that a change made to the data system used by the WCRC to process WCMSAs resulted in a decrease in system performance, which significantly increased review time from September 2010 through January 2011, adding to the backlog of WCMSA proposals to be reviewed.
REFERENCES


ADDITIONAL SOURCES

