Casualty Actuarial Society

Casualty Loss Reserve Seminar

Reserving for Medicare Set-Asides

September 15–17, 2013

Pharmacy
Critical Care
Settlement Solutions

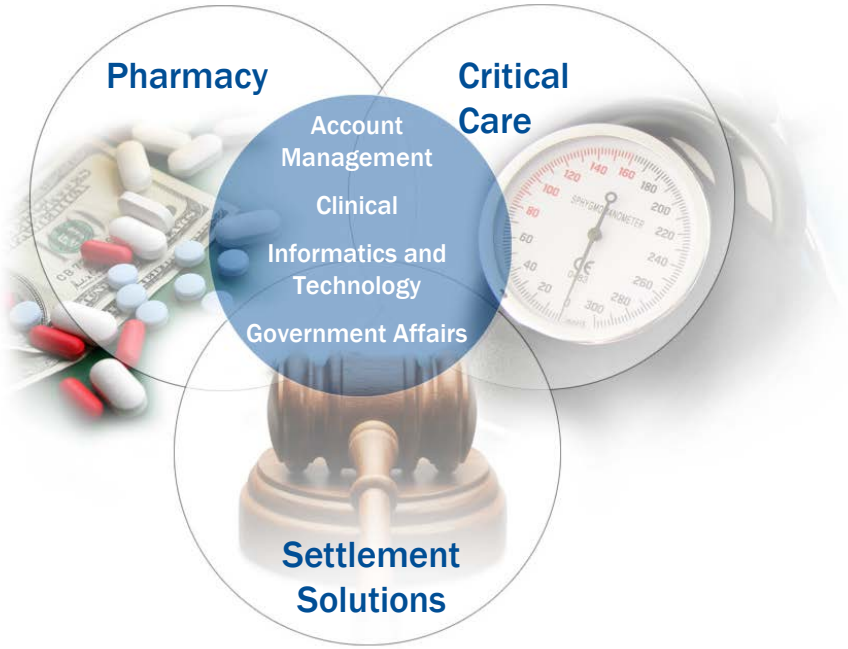
pmsi®
Proven Solutions for Cost Containment

Agenda

- MSP Act & History
- Current Industry Landscape
- Medicare Set-Aside allocations – the data
- Open vs. Settlement
- Solutions – Is MSP driving settlement values?
- The Future & Legislation

Who is PMSI?

PMSI Overview – Company Overview



- Workers' compensation specialty services company
- Largest standalone workers' compensation-focused pharmacy benefit manager
- Only fully integrated Medicare Set-Aside (MSA) and Pharmacy Benefit Management (PBM) vendor
- Headquartered in Tampa, FL
- 700 employees
- $450M in annual revenue
- Three business units supported by integrated account management, clinical, informatics, technology, and government affairs functions
- Serve over 1,200 clients including many of the country's largest payors and TPAs

MSP Act & History

Medicare Secondary Payer (MSP) Act

- The MSP Act (42 USC § 1395y) resides in the Omnibus Budget Resolution Act
  - Workers' Compensation has been primary since the inception of the Medicare program in the 1960's
  - Liability and No-Fault have been primary to Medicare since December 5, 1980
- Provides that Medicare should not pay for medical costs when payment has been made or can reasonably be expected to be made by a primary plan
- **Two methods required to protect Medicare's interest:**
  - *Look to the Past* - Reimbursement to Medicare for any Conditional Payments made (i.e., Medicare liens or past payments made by Medicare)
  - *Look to the Future* - MSA or another form of future medical allocation to avoid shifting the burden of future payments to Medicare and to protect the Plaintiff's future Medicare benefits
- Mandatory Insurer Reporting (MIR) drives compliance with the MSP

Enforcement of the MSP

- CMS communicates with the industry via memoranda which outline procedural changes and/or new guidelines
  - Memoranda are not law, but they are how CMS defines the MSA process
- MSP not enforced until 2001 when CMS issued the “Patel Memo”
  - The government concluded that taxpayers were essentially paying for future medical bills that should have been covered by primary payers and settlements
- From 2001 to present, there are more than 15 memoranda issued by CMS which relate to workers’ compensation cases
- CMS has issued one memorandum regarding liability cases

What is a Medicare Set-Aside Allocation (MSA)?

- Monies set aside in a settlement to satisfy the Medicare Secondary Payer (MSP) Act
- The intent is to avoid the shifting of the burden of past and future medical expenses to Medicare
- MSA is established from a portion of the settlement amount that is used to pay for future medical treatment and prescription drug expenses related to the injury/illness that would otherwise be payable by Medicare

Consequences of Falling Short or Ignoring the MSA Requirement

- Adversely affects the claimant's Medicare benefits
  - The Claimant may lose their Medicare benefits for items related to the injury.
  - CMS will require documentation that the entire settlement amount has been exhausted on Medicare covered items related to the injury before it will provide coverage for the injury.
- If no MSA or future medical amount is established, CMS can require that the entire settlement amount become the future medical amount.
- Litigation
  - Claimant v. Payer
  - Claimant v. Attorney(s)

CMS Memorandums – Prescription Drugs

CMS Memorandum – Dec. 30, 2005

- As of January 1, 2006, CMS requires that pharmacy costs be included in MSA allocations but they are not reviewed by CMS
  - – Average Rx was less than 30% of total allocation

CMS Memorandum – April 3, 2009

- June 1, 2009 – CMS begins reviewing the pharmacy portion of MSAs
  - – Average Rx increased significantly

CMS Memorandum – Off-Label Medications

CMS Memorandum – May 14, 2010

"For a Part D drug to be covered by Medicare, and thus included properly in a WCMSA, the drug should be prescribed for an outpatient use that is approved under the Federal Food, Drug, and Cosmetic Act..."

- All applicable off-label reductions should be properly applied to MSAs
- Up to 70% of the pharmacy costs in an allocation are impacted by off-label guidelines*
- Off-label reductions affect approximately 65% of the 240 most common drugs in workers' compensation*

**Based on PMSI's data analysis*

Breaking It Down- CMS Submission

Based on CMS memos in effect as of today

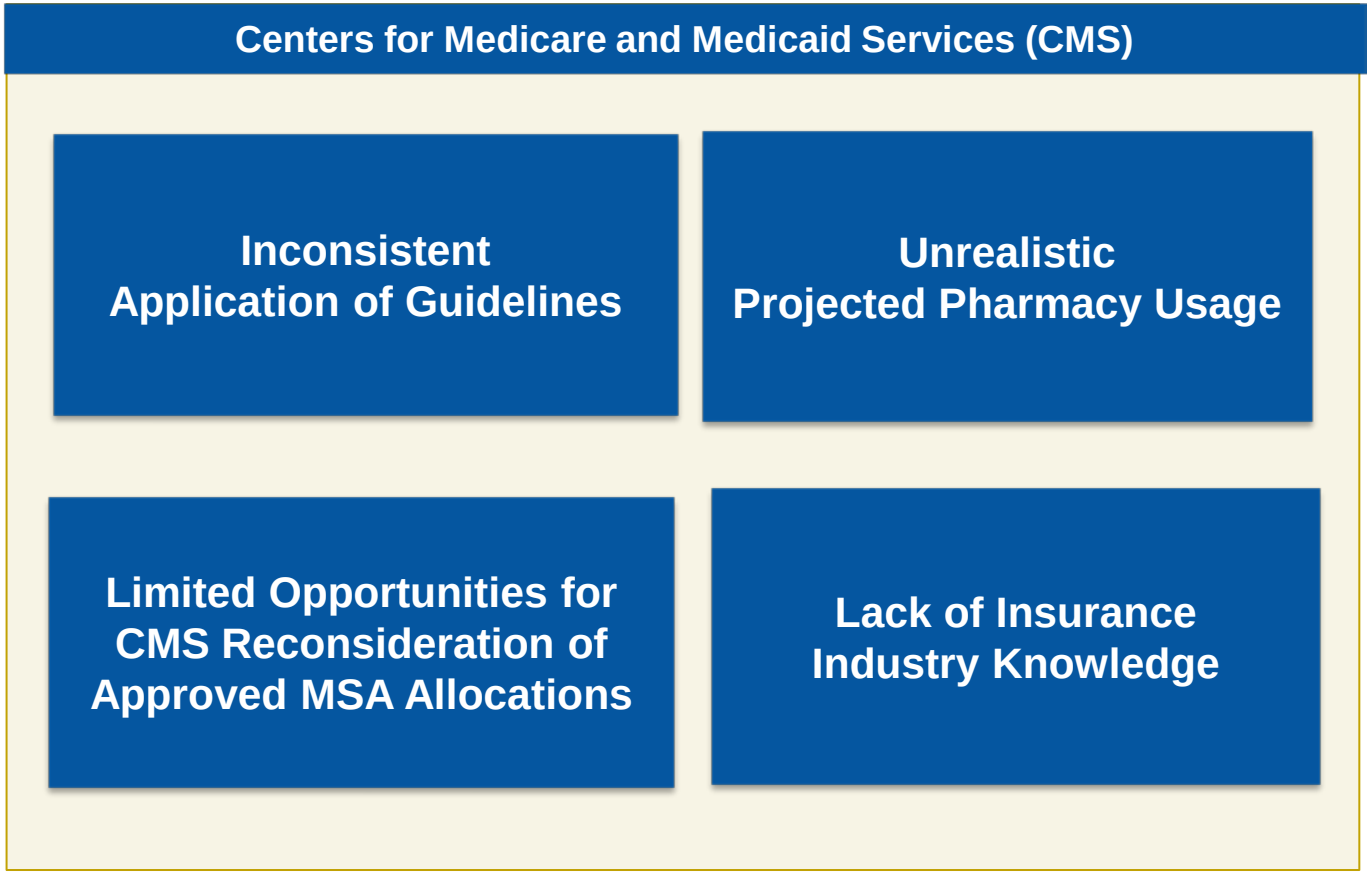
Medicare Status at Time of Settlement	Total Settlement Amount	MSA ?	CMS Threshold Met?
Medicare Beneficiary	$25k or Less	**Yes**	No
Medicare Beneficiary	Greater than $25k	**Yes**	**Yes**
Not entitled to Medicare in next 30 months	$250k or Less	No	No
Not entitled to Medicare in next 30 months	Greater than $250k	No*	No
Will be entitled to Medicare in next 30 months	$250k or Less	**Yes**	No
Will be entitled to Medicare in next 30 months	Greater than $250k	**Yes**	**Yes**

* *If the case is catastrophic, payers may want to still consider an MSA due to the increased likelihood that the claimant will apply for SSDI.*

There are no statutory or regulatory provisions requiring a WCMSA to be submitted to CMS for review

Current Industry Landscape

Current Industry Landscape



CMS Issue – High Allocations

Inconsistency	WCRC approvals can be dependent on reviewer
Determination of Off-Label	CMS is inconsistent as to which compendia* is used to allocate **PMSI recommends FDA*
Acute Usage	CMS is unclear and inconsistent on acute prescription duration
Lack of Appeals Process	Medical and prescription cost-drivers must be addressed prior to MSA submission to CMS
Generic Conversions	Reductions are not currently taken for drugs with a documented patent life — generic conversion could result in savings up to 70%

Result: Inability to settle claims

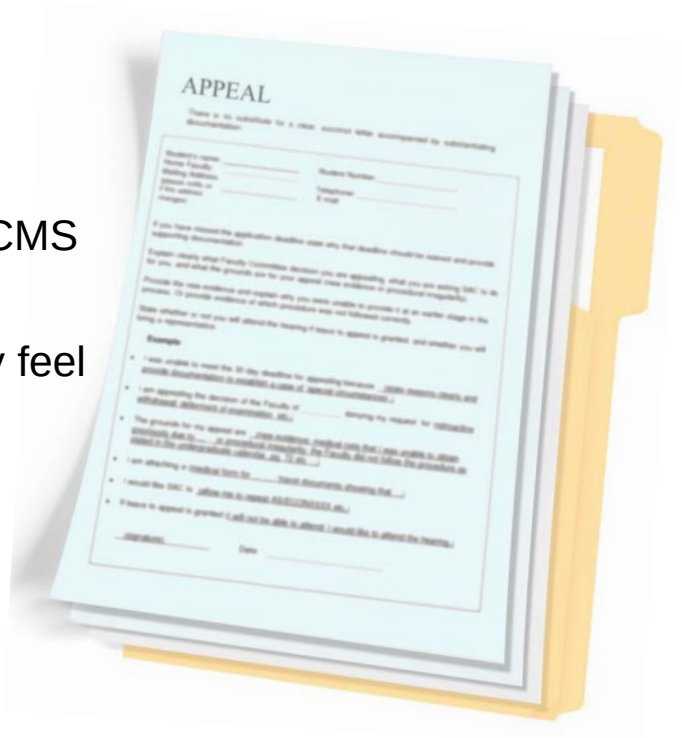
MSA Pricing When Submitting to CMS

- Redbook Average Wholesale Price (AWP) for prescription drugs
- State Workers' Compensation Fee schedule or actual charges (carrier payment history) for states in which there is no WC Fee Schedule.
- CMS mandated pricing for certain items (when applicable)

Pharmacy Issues

It is important to address any issues prior to CMS submission due to the lack of a formal appeals process

- CMS has no formal appeals process for rejection of an MSA
- The parties may provide the CMS Regional Office with additional information/documentation in order to justify their proposal (CMS Memo 4/22/03)
- Due to the lack of a formal appeals process the only recourse is the re-submission (reconsideration) process
  - Adds additional time to the MSA review process (if CMS will agree to reconsider the case)
  - CMS is normally reluctant to re-review a case if they feel their initial determination was without error



Pharmacy Issues

- CMS does not always adhere to the May 14, 2010 Memo (removal of off-label prescriptions) and inclusion varies depending on the reviewer at WCRC
  - Provigil and Nuvigil should only be allowed for shift work sleep disorder, narcolepsy, or obstructive sleep apnea. CMS will include it if the claimant is taking medications that are causing drowsiness.
    - Provigil 100mg is $24.46 per pill ($8,930 annually)
    - Nuvigil 150mg is $11.64 per pill ($4,250 annually)
- Allocation of acute medications is inconsistent
  - Some cases are allocated over life expectancy with no reduction
  - Range of CMS reductions is from 25 – 75%
  - Most of the time CMS will reduce acute medications to half the current life expectancy
- CMS' allocation of medications is inconsistent
  - Appears to be arbitrarily decided on a case by case basis rather than based on a medical standard of care (based on PMSI's analysis of recent submission

MMSEA Section 111

- Medicare Medicaid SCHIP Extension Act (MMSEA)
  - Former President George W. Bush signed the bill into law on December 29, 2007
  - Applicable to Group Health Plans and Workers' Compensation, Liability, and No-Fault Auto plans (collectively referred to as non-GHP)
  - Claims involving Medicare eligible injured parties must be submitted to the Centers for Medicare Medicaid Services, in the form and format specified by the Secretary
    - Reporting began in 2010
  - $1,000 per day, per claim fine (now discretionary) for non-compliance
  - Drive compliance with the MSP:
    - Discover billions in unresolved Medicare liens (conditional payments) and seek immediate recovery and cease making ongoing conditional payments in the future
    - Ensure that all settlements "adequately consider" (allocate) Medicare's interests as required by law

The Data

Conditional Payments

Conditional Payments (CP)	2010	2011	2012
Average Initial CP	$5,375	$13,149	$5,136
Conditional Payment (CP) Analysis	**2010**	**2011**	**2012**
Average CP Before Analysis	N/A	$23,838	$14,676
Average CP After Analysis	N/A	$3,909	$5,904
Average Reduction		98.3%	56.9%

When are MSAs Secured?

Age of Claim	Percentage
24 to 47 months	28%
48 to 71 months	17%
0 to 23 months	16%
72 to 95 months	10%
96 to 119 months	7%

MSA Values – Year Completed

All Original MSAs	2010	2011	2012
Average MSA Total	$91,319	$78,089	$100,472
Median MSA Total	$38,391	$36,369	$40,891
Average % Part A/B	68%	64%	62%
Average % Part D	31%	36%	39%

Accident Year Data Valued 6/30/2013

Accident Year	Average MSA	Median MSA	Average Part A/B	Average Part D
2001	$116,744	$51,803	59%	41%
2002	$115,777	$51,699	58%	42%
2003	$138,858	$53,671	59%	41%
2004	$107,337	$47,824	62%	38%
2005	$105,536	$48,400	62%	38%
2006	$89,603	$42,820	64%	36%
2007	$86,675	$41,833	66%	34%
2008	$71,795	$33,620	67%	33%
2009	$60,777	$25,925	69%	31%
2010	$55,528	$22,054	70%	30%
2011	$46,027	$12,377	77%	23%
2012	$26,640	$13,399	77%	23%

MSA Value vs. Age of Claim

	0 to 23 months	24 to 47 months	48 to 71 months	72 to 95 months	96 to 119 months
< $25k	57.4%	39.6%	31.7%	28.8%	29.4%
$25 - $50k	18.0%	20.7%	20.9%	20.9%	19.3%
$50 - $75k	8.7%	11.7%	12.8%	11.1%	10.8%
$75 - 100k	5.3%	6.6%	7.2%	7.7%	6.4%
$100 - 125k	2.5%	4.2%	5.4%	6.0%	5.2%
$125 - 150k	1.9%	3.2%	4.7%	3.7%	5.2%
$150 -$175k	1.6%	2.8%	2.3%	3.0%	3.4%
$175 -$200k	1.1%	1.9%	3.1%	2.6%	2.6%
> $200k	3.5%	9.3%	11.9%	16.2%	17.7%

PMSI Top 12 Jurisdictions (Volume) – 2012

Jurisdiction	Average MSA	Average Part A/B	Average Part D
California	$105,648	59%	41%
New York	$83,135	63%	37%
Florida	$108,286	58%	42%
Illinois	$69,942	74%	26%
Pennsylvania	$117,167	63%	37%
Georgia	$95,351	61%	39%
North Carolina	$115,965	63%	37%
Louisiana	$121,908	60%	40%
Michigan	$36,567	76%	24%
Alabama	$122,603	50%	50%
Oklahoma	$70,605	63%	37%
Connecticut	$89,486	71%	29%

Accident Year Data- Top PMSI Jurisdictions

- Illinois was typically the lowest MSA cost
  - Has some of the lowest overall Part D percentages
  - Has a higher fee schedule than other states which could affect the A/B to D ratio

- Part D prescription drug costs are lowest in the first 2-3 years of the claim
  - Increases thereafter
  - Levels off around year 6

Average MSA Values by Year Completed

MSA Values for Different Primary Injuries

	2010	2011	2012
Back Injury	$103,198	$90,969	$114,738
Ankle Injury	$55,206	$60,322	$63,801
Elbow Injury	$30,933	$25,728	$50,620
Knee Injury	$53,902	$53,308	$46,262
Shoulder Injury	$44,487	$31,025	$35,018
Spinal Cord Injury	$361,321	$141,971	$684,190
Chronic Pain Injury	$293,856	$238,562	$333,361

MSA Data by Injury Type

- Data based on accident years 2010 - 2012
- Back, spinal cord and chronic pain cases yield the highest MSA allocations
- Highest Part D costs are associated with chronic pain cases
- Joint injuries (ankle, elbow, knee shoulder) all had very similar Part A/B to Part D ratios

Open vs. Settle

Settle When Brand Medication Dispensed?

Brand Medication – AWP=$200; Discount 10%; Dispense fee = $2; 12 Refills per Year; 20 Year L.E

- CMS allocation methodology would allow $2,400 per year be included in the MSA for Part D covered drugs
  - Over a 20 year life expectancy = $48,000

- At 2% inflation the cost for the Brand medication will exceed the CMS required amount ($2,400 per year) in 9 years

- At 7% inflation the cost for the Brand medication will exceed the CMS required amount ($2,400 per year) in 2 years

Settle When Generic Medication Dispensed?

Generic Medication – AWP=$75; Discount 25%; Dispense Fee = $2; 12 Refills per Year; 20 Year L.E

- CMS allocation methodology would allow $900 per year be included in the MSA for Part D covered drugs
  - Over a 20 year life expectancy = $18,000

- At 2% inflation the cost for the Generic medication will never exceed the CMS required amount

- At 7% inflation the cost for the Generic medication will exceed the CMS required amount ($900 per year) in 7 years

Rated Ages

- CMS allows the use of rated ages
- Rated ages take into account medical conditions and may decrease overall life expectancy
- How are your lifetime cases reserved? Biological age life expectancy, or rated age life expectancy?
- On average, rated ages reduce life expectancy by 3.4 years

Rated Age vs. Actual Age

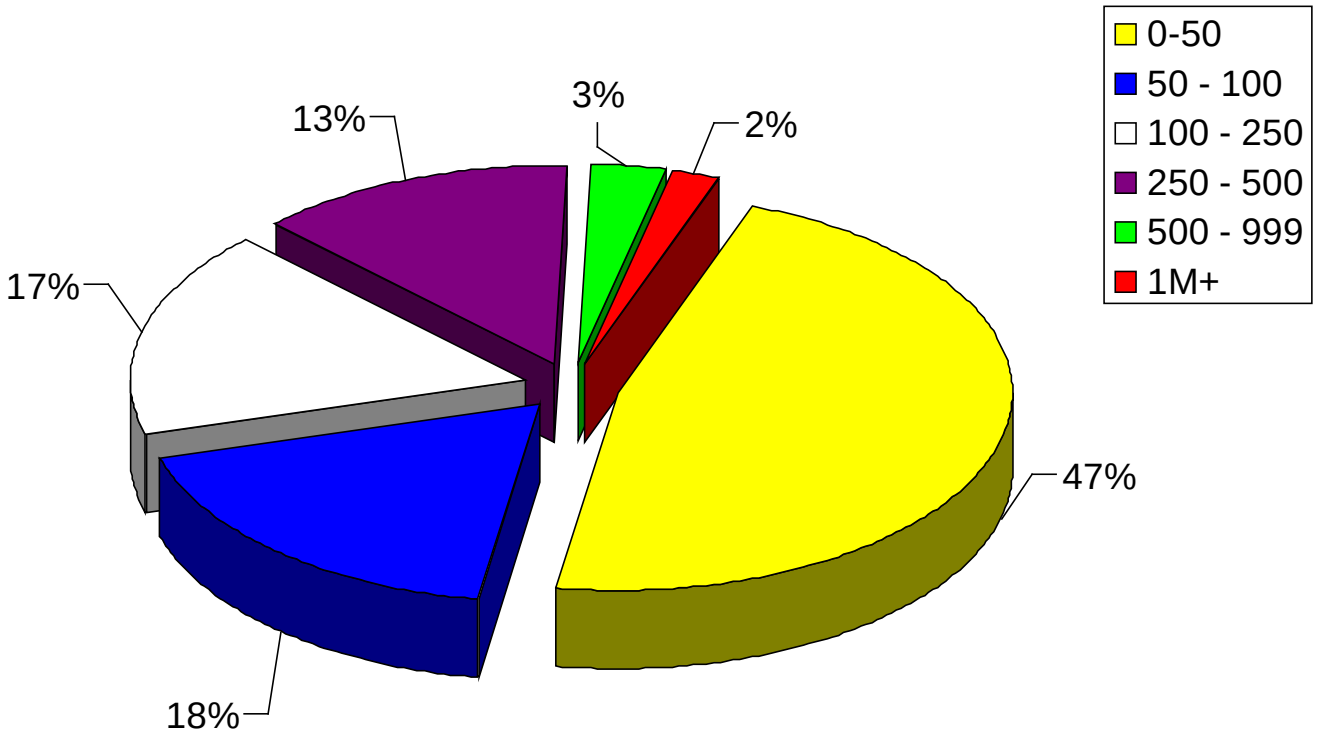
- Actual Age
  - Age according to birth date = 35
  - Life expectancy = 45 years
  - Allocation will be based on annual cost times 45
- Rated Age
  - Age according to birth date = 35
  - Age according to medical condition(s) = 45
  - Life expectancy = 35 years
- Difference in 10 years of life expectancy if annual costs are $5,000 = $50,000

Rated Ages effectively reduce the amount of the MSA by reducing the life expectancy.

Structured Settlements

- Medicare Set-Aside allocations can be structured/annuitized
- Advantage – Lower initial cost for a long periodic payment tail
- Helps protect the Medicare Trust Fund and the beneficiary

Ringler Associates Data – 2010 MSA Size



Structured Savings Example

Ringler Associates: Medicare Set-Aside Savings

Here are the results for a year, where an MSA allocation was prepared for 806 Medicare Set-Asides:

TOTAL Allocation
$85.7M

427 Annuity Purchases
(funded MSAs)

TOTAL Allocation
(for funded MSAs)
$50.6M

TOTAL Amount (purchased annuities for funded MSAs)
$31.2M

Direct Savings: $18.9M
37.28% saved by using Structured Settlement Annuities to fund MSA Allocations

Is MSP Driving Settlements Higher?

Are MSAs Broken or the Underlying Claim (Handling)?

- Do you have a mechanism to identify off label medications?
- Do you have a mechanism to identify Medicare Part D covered drugs pre-MSA?
- Do you have a mechanism to identify high cost medications without a generic equivalent?
- Do you have a mechanism to identify brand medications that have a generic equivalent?
- Do you have intervention programs that target cases pre-MSA to assure allocations are reasonable?
- Do your adjusters have a tool to predict MSA values; especially the Part D component?

Most medical case managers focus on short term therapeutic issues and don't focus on long term/lifetime exposures if treatment or medication patterns perpetuate

The Future & Legislation

HR1845 – SMART Act

Background and Development

- **Medicare Advocacy Recovery Coalition** (MARC)
  - Formed in September of 2008
  - **Purpose**: To advocate for beneficiaries and affected companies to improve the Medicare Secondary Payer (MSP) program
- **March 14, 2011**: Presentation of SMART Act to the House of Representatives
  - MARC's efforts are key to introduction
  - Bi-partisan support won through lobby efforts of MARC supporters

H.R. 1845
Strengthening Medicare and Repaying Taxpayers Act of 2012 (SMART Act)

To provide a demonstration project providing Medicare coverage for in-home administration of intravenous immune globulin (IVIG) and to amend title XVIII of the Social Security Act with respect to the application of Medicare secondary payer rules for certain claims.

- **December 19, 2012**: U.S. House of Representatives passes the SMART Act
  - Attached to a Medicare IVIG Access bill (H.R. 1845)
  - Cost savings of the SMART Act enables attachment to other legislation in order to achieve an overall cost savings for the Bill
  - Congressional Budget Office estimates the SMART Act will save the Medicare program over $45 million over the next 10 years.
- **December 21, 2012**: U.S. Senate passes H.R. 1845
- **January 10, 2013**: President Obama signs the SMART Act into law.

Summary of Timelines for Items Within SMART Act

- **March 10, 2013; (deadline has passed and CMS has not yet issued a rulemaking)**
  - New rules around the discretion for MIR fines to go through a rulemaking in the Federal Register
    - CMS has 60 days to first publish a notice
    - Another 60 days after that to publish proposed rules
    - After that, CMS gets to review comments to the proposed rules
    - No time limit in which they have to finalize their guidelines on that—unclear when this will be finalized
- **July 10, 2013**
  - New statute of limitations for conditional payment recovery of 3 years begins
- **October 10, 2013**
  - CMS implementation deadline for new conditional payment process with website and timelines
- **January 1, 2014**
  - Threshold to not report a claim or have to pay back conditional payments to begin
  - November 15th (annually)–Congress to publish threshold
- **July 10, 2014 or later**
  - SSNs and HICNs not required in reporting
  - CMS has 18 months after enactment of the SMART act to implement
    - One year extensions may be filed if it is creating problems or hardship

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PMSI—THE ONLY SOLUTION YOU NEED

Founded in 1976, PMSI is a leader in developing solutions to control the growth of medical costs in workers' compensation while achieving maximum health outcomes. As one of the nation's largest and most experienced companies focused solely on workers' compensation, we deliver proven solutions for injured worker care across the claims lifecycle. PMSI's Pharmacy, Critical Care, and Settlement Solutions products deliver quantifiable results and improve the quality of care for injured workers. We provide our customers with the innovation, focus, expertise, analytics and technology needed to successfully and cost effectively deliver workers' compensation benefits.

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Appendix

MSA Data

Accident Year – Top PMSI Jurisdictions

	CA	NY	FL	IL	PA	GA	NC	LA	MI	AL	OK	CT
2001	$99.0	$110.80	$148.60	$12.10	$163.40	$206.90	$57.60	$158.90	182.60	$196.10	$357.40	$58.90
Part A/B	58%	57%	57%	93%	52%	61%	83%	59%	46%	65%	56%	86%
Part D	42%	43%	43%	7%	48%	39%	17%	41%	54%	35%	44%	14%
2002	$109.90	$73.10	$152.10	$90.90	$150.40	$142.80	$128.30	$125.60	$91.50	$112.10	$129.70	$135.40
Part A/B	57%	71%	46%	61%	60%	50%	58%	57%	61%	26%	40%	64%
Part D	42%	29%	54%	39%	40%	49%	42%	43%	39%	74%	60%	36%
2003	$90.80	$85.60	$105.60	$85.10	$241.30	$159.50	$95.40	$121.10	$168.90	N/A	$181.30	$217.70
Part A/B	60%	66%	48%	72%	56%	52%	55%	51%	81%	N/A	62%	47%
Part D	40%	33%	52%	28%	44%	48%	45%	49%	19%	N/A	38%	53%
2004	$84.20	$83.40	$188.20	$138.40	$105.50	$100.90	$98.30	$131.70	$112.20	$134.70	$98.70	$62.40
Part A/B	62%	63%	62%	62%	63%	68%	55%	49%	62%	48%	41%	62%
Part D	38%	37%	38%	38%	37%	32%	45%	51%	38%	52%	59%	37%

Accident Year – Top PMSI Jurisdictions

	CA	NY	FL	IL	PA	GA	NC	LA	MI	AL	OK	CT
2005	$103.90	$77.30	$135.30	$127.20	$77.50	$107.70	$116.10	$102.00	$106.70	$139.20	$68.60	$199.80
Part A/B	59%	65%	50%	69%	71%	59%	48%	72%	56%	50%	70%	69%
Part D	41%	36%	50%	30%	29%	41%	52%	28%	44%	50%	30%	31%
2006	$72.90	$69.80	$112.30	$66.40	$64.80	$124.20	$159.80	$117.90	$77.10	$125.10	$107.30	$142.00
Part A/B	61%	65%	55%	73%	71%	51%	65%	65%	68%	58%	65%	64%
Part D	38%	35%	45%	27%	29%	49%	35%	35%	32%	42%	35%	36%
2007	$82.90	$71.80	$88.30	$65.70	$117.40	$63.90	$166.80	$94.30	$101.80	$80.80	$73.80	$51.50
Part A/B	62%	67%	58%	75%	72%	69%	61%	69%	65%	48%	62%	82%
Part D	38%	33%	42%	25%	27%	31%	39%	31%	35%	52%	38%	18%
2008	$66.00	$68.40	$91.60	$44.10	$78.20	$110.30	$94.40	$111.50	$62.80	$60.20	$80.40	$81.40
Part A/B	66%	68%	57%	75%	68%	68%	63%	63%	64%	63%	64%	77%
Part D	34%	32%	42%	25%	32%	32%	37%	37%	36%	37%	36%	23%

Accident Year – Top PMSI Jurisdictions

	CA	NY	FL	IL	PA	GA	NC	LA	MI	AL	OK	CT
2009	$61.80	$77.90	$62.00	$39.30	$64.30	$52.30	$70.10	$78.20	$33.00	$51.80	$36.60	$48.70
Part A/B	66%	64%	67%	80%	66%	70%	68%	67%	77%	60%	74%	84%
Part D	34%	35%	33%	20%	34%	30%	32%	33%	23%	40%	26%	16%
2010	$41.20	$78.90	$58.90	$21.30	$51.40	$47.50	$63.00	$57.80	$13.60	$78.10	$31.20	$42.10
Part A/B	72%	61%	66%	82%	66%	68%	65%	66%	82%	61%	71%	72%
Part D	28%	39%	34%	18%	34%	32%	35%	34%	18%	39%	29%	28%
2011	$33.80	$53.30	$95.40	$17.60	$54.60	$33.40	$40.60	$35.00	$14.40	$64.80	$35.80	$119.60
Part A/B	78%	63%	72%	90%	67%	80%	78%	75%	93%	55%	79%	74%
Part D	22%	37%	28%	10%	33%	20%	22%	25%	7%	45%	21%	26%

Back Injuries

Back Injury MSAs	2010	2011	2012
Average MSA Total	$103,198	$90,969	$114,738
Median MSA Total	$ 53,551	$46,578	$51,075
Average % Part A/B	60%	58%	55%
Average % Part D	39%	42%	45%

Back Injuries by Accident Year

Back Injury MSAs	Average MSA Total	Median MSA Total	Average % Part A/B	Average % Part D
2001	$135,381	$59,890	53%	47%
2002	$101,718	$49,245	59%	40%
2003	$127,407	$67,595	50%	50%
2004	$130,824	$86,675	52%	48%
2005	$168,040	$71,268	52%	47%
2006	$118,444	$70,583	57%	43%
2007	$85,358	$45,794	57%	43%
2008	$89,117	$45,087	59%	40%
2009	$78,780	$43,398	62%	38%
2010	$69,503	$33,200	61%	39%
2011	$48,456	$29,200	67%	33%
2012	$55,184	$42,838	52%	48%

Back Injuries vs. All Injuries by Accident Year

	Average Back	Average All Injuries	Median Back	Median All Injuries
2001	$135,381	$116,744	$59,890	$51,803
2002	$101,718	$115,777	$49,245	$51,699
2003	$127,407	$138,858	$67,595	$53,671
2004	$130,824	$107,337	$86,675	$47,824
2005	$168,040	$105,536	$71,268	$48,400
2006	$118,444	$89,603	$70,583	$42,820
2007	$85,358	$86,675	$45,794	$41,833
2008	$89,117	$71,795	$45,087	$33,620
2009	$78,780	$60,777	$43,398	$25,925
2010	$69,503	$55,528	$33,200	$22,054
2011	$48,456	$46,027	$29,200	$12,377
2012	$55,184	$26,640	$42,838	$13,399

Ankle Injuries

Ankle Injury MSAs	2010	2011	2012
Average MSA Total	$55,206	$60,322	$63,801
Median MSA Total	$25,283	$35,479	$17,489
Average % Part A/B	64%	64%	67%
Average % Part D	36%	36%	33%

Elbow Injuries

Elbow Injury MSAs	2010	2011	2012
Average MSA Total	$30,933	$25,728	$50,620
Median MSA Total	$14,557	$15,859	$21,264
Average % Part A/B	75%	82%	67%
Average % Part D	25%	18%	33%

Knee Injuries

Knee Injury MSAs	2010	2011	2012
Average MSA Total	$53,902	$53,308	$46,262
Median MSA Total	$35,268	$34,332	$30,164
Average % Part A/B	84%	78%	77%
Average % Part D	15%	22%	23%

Shoulder Injuries

Shoulder Injury MSAs	2010	2011	2012
Average MSA Total	$44,487	$31,025	$35,018
Median MSA Total	$23,576	$14,515	$14,616
Average % Part A/B	76%	76%	79%
Average % Part D	23%	24%	21%

Spinal Cord Injuries

Spine Injury MSAs	2010	2011	2012
Average MSA Total	$361,321	$141,971	$684,190
Median MSA Total	$361,321	$155,045	$513,562
Average % Part A/B	73%	54%	74%
Average % Part D	27%	46%	26%

Chronic Pain Cases

Chronic Pain MSAs	2010	2011	2012
Average MSA Total	$293,856	$238,562	$333,361
Median MSA Total	$237,331	$233,993	$263,342
Average % Part A/B	64%	52%	52%
Average % Part D	36%	48%	48%

Open vs. Settle

Is CMS Part D Guidance Unrealistic?

Brand Medication – AWP=$200; Discount 10%; Dispense fee = $2; 12 Refills per Year; 20 Year L.E.

Annual Inflation	Year	1	2	3	4	5	6	7	8	9
MSA Cost	AWP Cumulative Cost	$2,400.00	$4,800.00	$7,200.00	$9,600.00	$12,000.00	$14,400.00	$16,800.00	$19,200.00	$21,600.00
2	Cumulative Cost	$2,227.20	$4,498.46	$6,814.67	$9,176.73	$11,585.54	$14,042.05	$16,547.21	$19,102.00	$21,707.40
3	Cumulative Cost	$2,248.80	$4,564.34	$6,948.63	$9,403.73	$11,931.77	$14,534.92	$17,215.45	$19,975.67	$22,817.98
4	Cumulative Cost	$2,270.40	$4,630.66	$7,084.36	$9,635.26	$12,287.23	$15,044.32	$17,910.73	$20,890.84	$23,989.19
5	Cumulative Cost	$2,292.00	$4,697.40	$7,221.87	$9,871.36	$12,652.13	$15,570.74	$18,634.08	$21,849.38	$25,224.25
6	Cumulative Cost	$2,313.60	$4,764.58	$7,361.17	$10,112.12	$13,026.69	$16,114.69	$19,386.53	$22,853.24	$26,526.52
7	Cumulative Cost	$2,335.20	$4,832.18	$7,502.28	$10,357.60	$13,411.11	$16,676.69	$20,169.17	$23,904.46	$27,899.53

Is CMS Part D Guidance Unrealistic?

Generic Medication – AWP=$75; Discount 25%; Dispense Fee = $2; 12 Refills per Year; 20 Year L.E.

Annual Inflation	Year	7	8	9	10	11	12	13	14	15	16
MSA Cost	AWP Cumulative Cost	$6,300.00	$7,200.00	$8,100.00	$9,000.00	$9,900.00	$10,800.00	$11,700.00	$12,600.00	$13,500.00	$14,400.00
2	Cumulative Cost	$5,286.50	$6,101.37	$6,932.06	$7,778.88	$8,642.16	$9,522.22	$10,419.41	$11,334.06	$12,266.52	$13,217.15
3	Cumulative Cost	$5,495.33	$6,374.40	$7,279.12	$8,210.26	$9,168.62	$10,155.01	$11,170.27	$12,215.27	$13,290.89	$14,398.07
4	Cumulative Cost	$5,712.60	$6,660.39	$7,645.12	$8,668.29	$9,731.42	$10,836.12	$11,984.04	$13,176.92	$14,416.56	$15,704.82
5	Cumulative Cost	$5,938.65	$6,959.93	$8,031.08	$9,154.58	$10,333.06	$11,569.26	$12,866.08	$14,226.53	$15,653.81	$17,151.25
6	Cumulative Cost	$6,173.79	$7,273.64	$8,438.04	$9,670.86	$10,976.21	$12,358.44	$13,822.17	$15,372.28	$17,013.96	$18,752.69
7	Cumulative Cost	$6,418.37	$7,602.14	$8,867.10	$10,218.93	$11,663.70	$13,207.93	$14,858.58	$16,623.09	$18,509.44	$20,526.15

Cost Containment for MSAs

Off-Label Application

	Original Rx Amount	Off-Label Reduction Amount	Rx after PMSI Application	Percentage Savings	Off-Label Rx
Claimant A	$212,550	$24,057	$188,493	11.32%	Lyrica
Claimant B	$230,254	$108,992	$121,262	52.67%	Lyrica
Claimant C	$100,571	$100,571	$0	100%	Lidoderm
Claimant D	$94,670	$92,631	$2,039	97.85%	Lidoderm

Brand vs. Generic

Medication	Brand Cost per Pill	Generic Status	Generic Cost per Pill	Savings per Pill
Celebrex 200 mg	$5.26	None 5/1/2014	-	-
Cymbalta 60 mg	$6.64	None 3/1/2014	-	-
OxyContin 60 mg	$11.98	None 2023	-	-
Opana ER 40 mg	$14.49	None 7/1/2022	-	-
Opana 10 mg	$6.53	Available	$5.34	$1.19
Ambien CR 12.5 mg	$7.41	Available	$6.11	$1.30

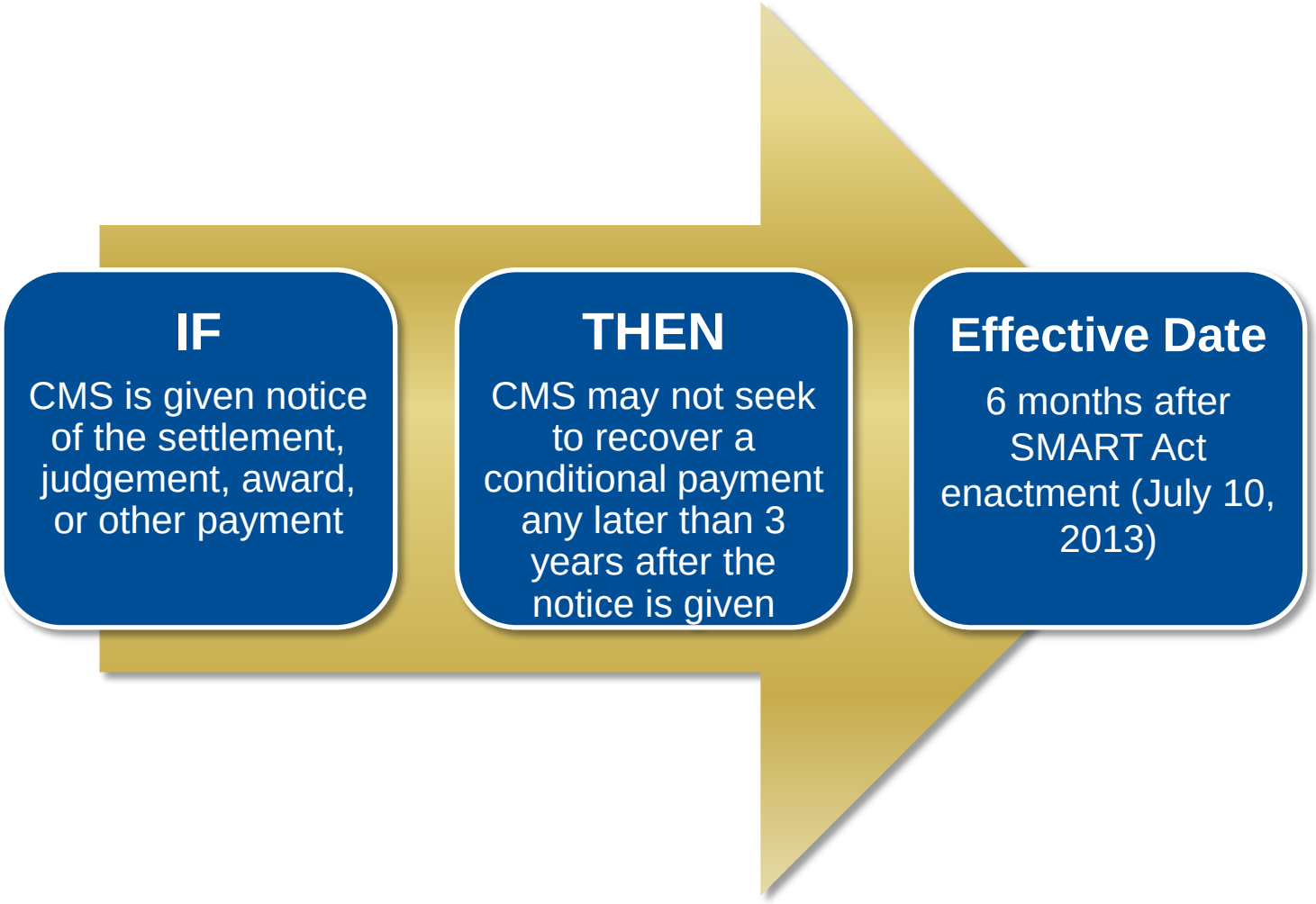
- Costly medications frequently prescribed in workers' compensation claims/MSAs
- Brand medication prescribed rather than generic equivalent

Legislation- SMART Act

Discretionary Fines for Noncompliance With MIR

- SMART Act strikes the portion of the MMSEA law that says a Responsible Reporting Entity (RRE) “shall be subject. . .” (to a $1000 per day/per claim fine if a reportable claim is not reported)
  - The language now says they **“may be subject”**
- Makes fines for noncompliance with MIR discretionary instead of mandatory
- CMS must now solicit comments from the industry on which practices should be considered sanctionable.
- Within 60 days of the enactment of the SMART Act, a notice will be published in the Federal Register seeking commentary
  - After proposal consideration – proposed practices for which sanctions will and will not be imposed will be published
  - After comment consideration – Secretary will publish final rules regarding which practices will be subject to sanctions

New Statute of Limitations for Conditional Payments



New Conditional Payment Resolution Process

- What is new?
  - Payers able to obtain a final demand prior to finalizing settlement
  - Stricter timelines for CMS to provide the demand amount
  - New appeals process if the amount is disputed
- When will the new process take effect?
  - CMS has 9 months from the SMART Act's enactment to implement this process (on or around October 10, 2013)
- Why was this needed?
  - Absence of a final demand prior to settlement can make costs difficult to estimate
  - CMS taking too long in responding to conditional payment requests
  - A formal appeals process was needed

New Conditional Payment Process – How Will It Work?

- A claimant or “applicable plan” (insurance carrier) notifies the Secretary (CMS) any time 120 days prior to the settlement, judgment, or award
  - Expected date and amount
- Within 65 days from the time CMS receives notice of the upcoming settlement, judgment, or award, the last statement downloaded from the website can be considered the “final demand”
  - You must be within three days of settlement
  - CMS may extend the 65 day period for an additional 30 days
  - CMS must allege that exceptional circumstances exist to justify the extension and may not be more than one percent of cases
- A website will help claimants and payers navigate the conditional payment process
  - View conditional payments made by CMS
  - **SMART Act**: Payments made by CMS must be posted to website no later than 15 days from the payment date

How Will It Work? (Continued)

- Dispute over the conditional payment amount
  - Secretary must respond/resolve the dispute within 11 days or the proposed resolution by the claimant/applicable plan will be deemed accepted
  - If not accepted, CMS must provide an alternate discrepancy resolution
- A formal appeals process will be created

Threshold for Exemption From Conditional Payment Reimbursement and Reporting

- Beginning 2014 – Secretary of the Department of Health & Human Services (DHHS) will have to calculate and publish a single threshold amount for settlements, judgments, awards, or other payments.
  - Amount published will be a threshold wherein there will be no conditional payment reimbursement or MIR obligation.
  - The threshold does not apply to future medical obligations

Use of SSNs/HICNs in MIR

- A Responsible Reporting Entity (RRE) will no longer be required to report SSNs and/or HICNs
- Implementation timeline is unclear
  - CMS has 18 months after the date of the enactment of the SMART Act to publish rules
  - CMS may seek one or more periods of up to 1 year in extensions if certain criteria are met
- Will not take effect until July 10, 2014 or later, depending upon whether CMS files for an extension

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