MEDICARE SET-ASIDES:

WHERE ARE WE NOW?

PRESENTED AT: 2003 WORKERS' COMPENSATION LAW INSTITUTE

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Medicare's inception as a secondary payer has its basis in § 1862 (b) of the Social Security Act [42 U.S.C. §1395]. With the enactment of the Medicare Secondary Payer Act (MSPA) on July 30, 1965, the Medicare program became effective. Initially Medicare was the primary payer for all beneficiaries except those with workers' compensation and Veterans Administration benefits. In 1980, in response to rising medical costs, § 953 of the Omnibus Budget Reconciliation Act (OBRA) was amended to significantly broaden the scope of the MSPA. Auto medical, no fault, or liability situations also became primary payers to Medicare under OBRA. With the enactment of the Deficit Reduction Act of 1984, Congress created the right to bring direct legislative action against any entity responsible for primary payment. This law also clarified that Medicare is subrogated to "any right of a worker or any other entity to payment". This act also enacted Medicare's right to recover for overpayments from any entity that would be responsible to make a primary payment and to provide a remedy of double damages. The Omnibus Budget Reconciliation Act of 1986 amended §1862(b) of the Social Security Act to create a private cause of action for damages "in law or plan, automobile or liability insurance policy or plan or no-fault insurance plan, group health plan, or large group health plan" which has been deemed primary and "fails to provide from primary payment (or appropriate reimbursement)..." 42U.S.C. §1395(b), 1985 (**Attachment 1**).

The MSPA has received little attention until recently, due in part to the passage of the "Medicare Integrity Program" Act of 1996. The MSPA requires that payment of medical expenses be withheld "to the extent that …payment has been made or can reasonably be expected to be made promptly under a work[ers'] compensation law or plan … or under an automobile or general liability insurance policy or plan or under no fault insurance." 42 U.S.C. § 1395y(b)(2)(A)(ii). The Centers for Medicare and Medicaid Services (CMS), formerly HCFA, have issued three memos that further clarify the CMS policy regarding Medicare and Workers' Compensation settlements. (July 23, 2001 memo published by Deputy Director Patel, Center for Medicare Management and April 22, 2003 and May 23, 2003 All Regional Administrators (ARA) Memos published by Director Thomas Grissom. See **Attachment 2** May 23, 2003 ARA Memo.)

A series of regulations found at 42 C.F.R. §§ 411.20 – 411.52 give effect to the provisions of the MSPA. Tracking the language of the MSPA itself, federal regulations at 42 C.F.R. §411.26(a) state that Medicare is "subrogated to any worker, provider, supplier, physician, private insurer, State agency, attorney, or any other entity entitled to payment by a third party payer." Additionally, 42 C.F.R. § 411.24(g) states that Medicare "has a right of action to recover its payments from any entity, including a beneficiary, provider, supplier, physician, attorney, private insurer, State agency, or private insurer that has received a third party payment." See Colonial Penn Ins. Co. v. Heckler, 721 F. 2d 432 (3rd Cir. 1983) and Abrams v. Heckler, 582 F. Supp 1155 (S.D. New York 1984) for case law decisions that establish Medicare as a residual rather than primary payer, and recognize that any State Law, which would interfere with this intent, would is superseded.

THRESHOLD FOR MEDICARE SECONDARY PAYER STATUTE

The Medicare directives are that a Medicare set-aside allocation **and** approval by the CMS is required with any settlement in which:

1. The claimant is a Medicare recipient at the time of settlement regardless of the amount of the settlement

2. The claimant is not yet receiving Medicare benefits but the following 2 prong test is met:

    a) The total amount of the settlement is over $250,000.00 **and**
    b) It is reasonably expected that the claimant will become a Medicare recipient within 30 months of the settlement

Also see **Attachment 3** CMS notice that a CMS approved Medicare set aside arrangement is unnecessary unless this two prong test is met. What are the situations in which there may be a "reasonable expectation of Medicare enrollment within 30 months"? The April 22, 2003 ARA memo provides clarification. These situations include but are not limited to:

1. Worker is receiving Social Security Disability (SSDI) benefits at time of settlement.

2. Workers has applied for SSDI or has applied and been denied but anticipates appealing the decision.

3. Worker is in the process of appealing and/or re-filing for SSDI benefits.

4. Worker is 62.5 or greater at time of settlement.

5. Worker has End Stage Renal (ESRD) disease but does not qualify for Medicare based on ESRD.

What statutory law, regulations, or federal case law vests CMS with the authority to include for consideration, those injured workers who are not Medicare beneficiaries, but have a reasonable expectation of Medicare enrollment within 30-months of the settlement date and a total settlement amount of greater than $250,000? Section l862(b)(2) of the Social Security Act (“the Act") requires that Medicare payment may not be made for any item or service to the extent that payment has been made under a workers' compensation law or plan. 42 U.S.C. § 1395y(b)(2). Additionally, 42 C.F.R. § 411.46 requires the WC payer to be the primary payer when a worker receives a workers' compensation ("WC") settlement award that is intended to compensate the worker for future medical expenses required because of a work-related injury or disease. That is, Medicare must not pay for a worker's medical services when that worker received a WC settlement award that includes funds for future medical expenses. **Section 1862(b)(2) of the Act and 42 C.F.R. § 411.46 do not explicitly require workers who are not yet Medicare beneficiaries to consult with CMS prior to settling their WC cases**. However, once a worker becomes a Medicare beneficiary, §1862(b)(2) of the act and 42 C.F.R.§ 411.46 prohibit CMS from paying for items and services where a primary payment is available to pay. Medicare, therefore, has promulgated policy that at the time of settlement to give consideration whether the worker may become a Medicare beneficiary in the near future.

Decision Guide

Type of Claim	***Worker's Status at Time of Settlement***	***MSPA Directive***
Class I Claim	Any settlement amount Medicare beneficiary at time of settlement	Yes CMS approval
Class II Claim	Settlement over $250,000 Yes to reasonable expectation of Medicare within 30 months of settlement	Yes CMS approval
Class III claim	Settlement equals or less than $250,000* Not a Medicare beneficiary at time of settlement Yes to reasonable expectation of Medicare within 30 months of settlement. See **Attachment 4**	No CMS approval
	Settlement equals or less than $250,000* Not a Medicare beneficiary at time of settlement No reasonable expectation of Medicare within 30 months of settlement	No CMS approval
	Settlement over $250,000* No Reasonable expectation of Medicare within 30 months of settlement	No CMS approval
	*(Note $250,000 is for disability/lost wages & future medical expenses)	

If an injured worker who is not a Medicare beneficiary at the time of settlement meets the review thresholds (i.e., the 30-month and $250,000 figures) and fails to consider Medicare's interests, then Medicare may preclude its payments pursuant to 42 C.F.R. § 411.46 once the injured worker actually becomes a Medicare beneficiary. Medicare must not pay for a worker's medical services when that worker received a WC settlement award that includes funds for future medical expenses. If Medicare's

interests are not reasonably considered, Medicare may refuse to pay for services related to the WC injury that otherwise would be covered by Medicare until such time that the medical expenses related to the WC injury equal the amount of the entire WC settlement (not simply the stipulated future medical expenses portion of the settlement). CMS has a direct right of action to recover from any entity responsible for making primary payment. This includes an employer, an insurance carrier, plan, or program., and a third party administrator. CMS is subrogated to any right of a worker or any other entity to payment made under an insurance plan or policy. Refer to 42 U.S.C. § 1395y(b)(2)(B)(iii).CMS has a direct right of action and may collect double damages against a third party insurance policy or plan that fails to provide primary payment. See 42 U.S.C. § 1395y(b) and 42 CFR § 411.24(e).

REASONABLE CONSIDERATON OF MEDICARE'S INTERESTS

Although 42 CFR 411.46 requires that WC settlements must adequately consider Medicare's interests, the regulation does not mandate what type of arrangement must be used to set aside funds for Medicare. If an arrangement is self-administered, then the injured worker/beneficiary **must** adhere to the same rules/requirements as any other administrator of a set-aside arrangement.

In accord with 20 C.F.R. §404.408(d), the funds allocated to a set aside arrangement must be consonant with the applicable law or plan and reflect either the actual amount of expenses already incurred (based on a fee schedule) or a reasonable estimate of future expenses. Thus, the amounts to be set aside for future medical expenses may be based on the applicable WC fee schedule amounts, rather than on actual dollar amounts. However, the WC settlement must clarify that the amount

allocated to future medical expenses was calculated based upon applicable WC medical fee schedule amounts. The agreement creating the set-aside arrangement must also contain terms that address the provider's agreement to abide by the WC fee schedule reimbursement level.(e.g., providers will be reimbursed out of the set aside arrangement at the WC rate for medical services rather than the physicians regular full rate or the Medicare rate for covered services).(**Attachment 5**.)

The Patel memo outlines two methods for medical providers to obtain payment for WC covered services when funds are held in a set-aside arrangement. The memo clarifies that the payment method depends on two factors: 1.) How the set-aside arrangement is constructed and 2.) Whether the arrangement was constructed by contemplating full actual charge estimates or WC medical fee schedule.

The memo further states that there must be specific provisions in the settlement agreement that clarify the set aside arrangement will reimburse medical providers in accordance with the WC medical fee schedule. Once the CMS regional office has reviewed and approved the sufficiency of the arrangement based on the WC medical fee schedule, then medical providers will be paid based on what would normally be payable under the WC plan (i.e., under the WC medical fee schedule).

After the set aside funds are depleted, there must be a complete accounting to the Medicare contractor to ensure that the funds were used for medical services that would have been reimbursable by Medicare. Based on the acceptance by the Medicare contractor of documentation that justifies the depletion of the set aside funds, then Medicare can be billed for future medical services. Note that § 3416 "Effect of Lump Sum Compromise Payment" of the CMS Intermediary Manual directs the Medicare

contractor to retain a copy of the lump-sum agreement and flag any new claims for the condition for which the beneficiary received the lump-sum payment in order to assure accuracy of the payment on claims.

The Patel Memo states at pages 9, 14 and footnote 2 that there must be some reasonable and verifiable additional sources outside the agreement of the basis for arriving at the allocation amount. Reasonableness can be demonstrated by a provider report documenting necessity of future care, injured worker's claims history in the 2 to 2 year period after the condition has stabilized, and/or a life care plan. Note that a life care plan that is completed for litigation purposes is very different from one that establishes a realistic MSA cost allocation of future medical expenses for purposes of settling a claim. In fact, when litigating a claim, there are usually life care plans completed by each side. Life care plans completed for litigation purposes may project twice as much cost allocations that are completed for purposes of settling a claim. CMS has addressed this inconsistency in its April 21, 2003 ARA memo that states on page 6 that a "life care plan" or similar evaluation is not automatically conclusive. That is, if there is contrary evidence, internal conflicts or if the plan is not credible on its face, then CMS will not accept the plan.

Practice Tips: See Barrett v. Massanari,, 2001 WL 1193716, 2001 U. S. Dist. LEXIS 16232. Reasonableness can be demonstrated by a treating provider report and prognosis documenting frequency and duration of future care, an independent medical exam, and/or a functional capacity evaluation. See **Attachment 6** for sample medical provider questionnaire (MPQ). When future care recommendations from treating providers can be obtained, that is the most defensible and consistent approach with life

care planning methodology to be followed in the calculation of the set aside allocation. Retrospective reviews of the past medical records and medical billing summary may be used to establish the future MSA cost allocation. CMS accepts this type of analysis. But see the decision in Norwest Bank and Kenneth Frick vs. K-Mart Corporation, U. S. District Court, Northern District of Indiana, Case No. 3:94-CV-78RM, found at 1997 U. S. Dist LEXIS 3426, decided January 29, 1997 (**Attachment 7**), that excluded a life care plan with an analysis of future medical needs based upon a retrospective review of medical records as inadmissible under Federal Rules of Evidence 702.

As an example of how the provider recommendations can impact the set aside amount, the following case study illustrates this point. A cost projection completed by a Medicare health care consultant using a rated age of 54 and a retrospective review of the medical records and billing summary recommended a set aside allocation of $101,396.00. Using the same medical records, same medical billing summary, and same rated age but obtaining treating provider recommendations, the recommendation for the set aside allocation was $55,735.00. The cost savings came from the provider recommendations. In response to treating provider questionnaires, the psychologist recommended only two years of psychotherapy and the physical therapist recommended a gym membership and in home therapy exercises with no further treatment at the clinic. The psychiatrist recommended a total of 9 office visits for first two years and semiannually thereafter for medication management. See chart below for details of comparison.

Case Study Comparison of IW Debbie

Chronological age 44 Rated age 54 LE 27.22 years

Using Provider Questionnaires		Retrospective Review Using Medical Records & Payout Screens	
Office visits(Pain mgment; Drug mgment)	$14,361.	Office visits(annual neurological & ortho)	2,156
Therapeutic intervention	$2,286.	Pain Mgment (monthly)	$25,872.
Diagnostic &Lab work	$14,318.	Psychiatric-Drug mgment	$8,400.
TENS unit & supplies	$14,127.	Psychotherapy (monthly)	$37,968.
Orthopedic needs	$6,533.	Lab work	$2,800.
One time trial spinal cord stimulator	$4,110.	Diagnostic x-rays & MRI	$7,000.
		TENS unit & supplies	$17,200.
TOTAL	**$55,735.**	TOTAL	**$101,396.**

DETERMINATION OF LIFE EXPECTANCY

The life expectancy of the injured worker for whom the need for a Medicare Set-aside Arrangement is being evaluated, will impact components of the settlement process in addition to the period of time into the future for which provision must be made for medical care costs related to the compensable work injury which are subject to reimbursement/payment by Medicare. For example, in the "case study" of "Debbie," a 45-year-old while female, born 12/08/58, the adjuster requested a "rated age" to be provided to a Florida company that was employed to prepare a proposed MSA allocation using the "retrospective review of utilization costs" methodology. The letter

from the annuity broker communicating to the adjuster the "rated age" of 54 states: "we received the rated age information from our life markets, and the *best* rated ages from [the workers' compensation insurer's] approved life companies are . . . ." **Attachment 8,** obtained nearly one year later contains the "rated" ages provided by seventeen (17) different life companies. The "rated age" to which "Debbie's" chronological age was advanced, with the sole exception of a "rated age" of forty-six (46), provided a "rated age" for every year between " Debbie's" chronological age of forty-five (45) and the "rated age" which advanced "Debbie's" chronological age by the most years!

Life expectancy will impact how the Social Security "offset" of workers' compensation periodic income benefits will be determined and will be a factor in settlement negotiations concerning the amount of income benefits and medical care costs not subject to Medicare reimbursement/payment would be paid by the Employer/Insurer in the years between the true chronological age and the "rated age."

Sources For Life Expectancy Tables

For some, the inquiry both begins and ends with O.C.G.A. 24-4-44 and 45 and the Appendix to Title 24, Evidence. At pages 729 - 734, the American Experience Mortality Table, The Commissioner's 1958 Standard Ordinary Mortality Table and The Annuity Mortality Table for 1949, Ultimate, are appended. Contrary to the belief of many, determination of life expectancy in Georgia Courts or State or Federal Agencies in which Georgia Workers' Compensation claims, causes of action, or various benefit systems are subject to review, other mortality tables can be used in many circumstances. O.C.G.A. Title 24-4-45 states:

> "(a) *In addition to any other lawful methods of computing* the value of the life of a decedent in wrongful death cases or of determining the present

> value of future due earnings or amounts in cases involving permanent personal injuries, there shall be admissible in evidence, as competent evidence in such cases, either or both of the following mortality tables:
>
> (1) The Commissioner's 1958 Standard Ordinary Mortality Table;
>
> (2) Annuity Mortality Table for 1949, Ultimate."

And, subsection (c) goes even further:

> "(c) The admissible evidence provided for in subsections (a) and (b) of this Code section shall not be the exclusive method which the jury or court hereafter is required to use in such cases but shall be supplementary to other lawful and allowable evidence and method for such purpose otherwise obtaining in this state." (Emphasis supplied).

Life expectancy can be determined from numerous sources;[1] for example:

> Social Security Administration Period Life Table, 1999 (by gender)
>
> HCFA Medicaid Life Expectancy Tables (by gender)
>
> June, 2002, publication 590 Internal Revenue Service (composite)

There are other sources which contain life tables such as The National Center for Health Statistics, Centers for Disease Control and Prevention. The United States Life Tables, 1997, reported in the December 13, 1999, National Vital Statistics Reports, Volume 47, Number 28, contains separate life tables for the total population; males; females; white population; white males; white females; black population; black males and black females. A number of different tables and mortality statistical studies may be found at www.aoa.gov/NAIC/Notes/lifeepectancy.html.

The 2001 Commissioner's Standard Ordinary Mortality Table, in particular, justifies special comment. That table, the latest revision of the 1958 edition specifically approved for use in evidence in Georgia by O.C.G.A. §24-4-45(a)(1) will have far-

[1] See O.C.G.A. §§24-3-1; 33-10-13; 33-15-65; 33-15-100,101; 33-25-3,4,5; 33-26-2; 33-28-3; 44-12-198; 47-2-1; 47-3-1; 47-3-122; 47-4-2; 47-5-23; 47-16-101; 47-17-80; 47-22-11; 51-1-9,10; 51-4-1; 51-12-13.

reaching implications, affecting reserves, product design, state filings and administrative systems. The 2001 CSO Mortality Table was adopted by the National Association of Insurance Commissioners in December, 2002. Texas appears to be the first state that has officially adopted the 2001 CSO. Following public hearing held in Texas on March 12, 2003, the Texas Commissioner of Insurance formally adopted the 2001 CSO on April 14, 2003. By Regulation, the State of Texas permits the use of 2001 CSO Mortality Table only for new policies issued after May 1, 2003. Insurers marketing any insurance products in the State of Texas will be required to use the table for all products issued after January 1, 2009. The new table is expected to lower reserve levels for a number of products which use the new table compared to reserve levels produced by the 1980 CSO Mortality Table, which Insurers in the State of Texas are currently required to use.[2] The Texas Insurance Commissioner estimated that reserves for term insurance could be lowered by thirty (30%) percent and that whole life insurance reserves were likely to be reduced by ten to fifteen (10-15%) percent. Obviously, the determination of increased life expectancy in the 2001 CSO over the 1980 CSO would result in lower premium cost for consumers.

Other states have followed Texas' lead in the adoption of the 2001 CSO. The increased life expectancies can be used by practitioners in the settlement of workers' compensation claims in Georgia. Attached to this paper with the express written permission of Jack Luff, an actuary that participated in the compilation of the statistics upon which the 2001 CSO is based, is **Attachment 9(a); 9(b)** a copy of the draft of the

[2] Curiously, the State of Georgia never legislatively "updated" its approved Commissioner's Mortality Table from the 1958 version to the 1980 version and one wonders whether the 2001 CSO will be adopted in Georgia by O.C.G.A. §24-4-45(a)(1).

composite LE table for males and females that has been created from the voluminous statistical data available at the website of the American Academy of Actuaries, www.actuary.org/life/cso.

Revenue Ruling 2001-38 was issued for the purpose of clarifying Section 807(d)(5) of the Internal Revenue Code and part one of Rev. Rul. 92-19 regarding the use of Commissioner's Standard Tables by insurance companies in computing reserves for life insurance and total and permanent disability benefits, individual and group annuities. Interestingly. Revenue Ruling 2001-38 also states that annuity contracts based on settlements of various forms of claims, including tort actions and workers' compensations claims, should be based upon the 1983 table (a) of the Annuity Mortality Table. That reference suggests that Georgia is also "behind the times" in having failed to update from the presently approved Annuity Mortality Table for 1949, Ultimate.

Life Expectancy And "The Pro-ration" Formula

Obviously, a Medicare Set-aside Arrangement only becomes a factor to be considered in settlement of a claim because the injured worker is receiving either Social Security Disability Insurance Benefits or Social Security Retirement Benefits. If the injured worker is receiving Social Security Disability Insurance Benefits (DIB) and is receiving workers' compensation income benefits there is a good chance that the DIB will be reduced by an offset. A simple rule of thumb is this: Social Security Disability Insurance Benefits will be reduced by the amount by which those benefits, when added to the workers' compensation income benefits, exceeds eighty (80%) percent of the average current earnings of the injured worker. 20 CFR §404.1500 et seq. In the case study of "Debbie," her average current earnings were $783.00. Her ACEH; that is, the

sum which represents eighty (80%) percent of the greatest sum that "Debbie" earned in a year during the five-year period preceding her date of onset of disability is $626.40.[3]

Since "Debbie's" workers' compensation weekly income benefit is $147.67, her monthly workers' compensation income benefit of $630.28 ($147.67 x 4.3) results in "Debbie" being totally offset, meaning that she receives no Social Security Disability Insurance Benefits. However, because the cost of living adjustments awarded annually apply to the full monthly SSDIB benefits to which "Debbie" was entitled - but for the total offset - "Debbie" does receive a Social Security DIB check in the amount of $128.00 per month which represents only COLA increases.

Until "Debbie's" claim is settled, she will continue to experience a total offset until she reaches the age of sixty-two (62). 42 U.S.C.A. §424(a). However, if "Debbie" does not settle her claim and elects "early retirement" at age sixty-two (62) in order to eliminate the affect of the offset, she will be forced to accept a twenty (20%) percent reduction in retirement benefits. 42 U.S.C.A. §402(q). Note that recent changes to 20 CFR §404.317 provide that the "penalty" for early retirement at age sixty-two (62) will be gradually increased to thirty (30%) percent for retirees and thirty-five (35%) for spouses.

Thus, in settling "Debbie's" case, effort should be made to reduce to the greatest extent possible, the affect of the offset. Since "Debbie" is currently forty-five (45), if her offset could be completely eliminated, she stands to recover $133,368.00 in SSDIB by

[3] To avoid confusing the issue - and the reasons for which "Debbie's" case was selected, mention must be made of primary insurance amount (PIA). Suffice it to say that PIA is based on an individual's taxable earnings averaged over the working lifetime to yield a monthly benefit that partially replaces the earned income lost because of retirement, disability, or death. There are two methods of averaging earnings. In "Debbie's" case, the second method of determining her "first eligibility" would be used; that is, her period of disability began before she attained the age of sixty-two (62) and "first eligibility" occurred after 1979. Thus, "Debbie's" PIA is based on average indexed monthly earnings for years following 1951 and are indexed, ie. adjusted to put them in proportion to the earnings level of all workers for those years.

the time she is eligible to retire with "full" retirement benefits at age sixty-six (66) years and eight (8) months when her "retirement" benefit will be $555.70 - the same as her "PIA."[4] But, note that even though "Debbie" would not be eligible for a full Social Security retirement benefit until she reaches sixty-six (66) years and eight (8) months; nevertheless her offset still ends the day she becomes sixty-five (65). See 20 CFR §404.317, 68 Fed. Reg. 4700.

Thus, in settlement of "Debbie's" claim, care must be given to the life expectancy used. The 7/23/01 ("Patel memo") permits, but not require, that a "rated age" be used for determining the length of time an injured worker would continue to live and require medical care for the work-related injury. In response to question No. 5, regarding the criteria that Medicare uses to determine whether the amount of a lump sum or structured settlement has sufficiently taken the interest of Medicare into account, one of the criteria stated is "age of beneficiary - Acquire an evaluation of whether his/her condition would shorten the life span." Question 10 and its answer is even more specific:

> "**Question 10:** **Are there documentation requirements that must be satisfied before the RO can provide a written opinion on the sufficiency of a Set-aside Arrangement?**
>
> **Answer:** Yes. At a minimum, the following documentation must be obtained by the RO prior to the approval of any arrangement:
>
> > A copy of the settlement agreement, or proposed settlement agreement, a copy of the life care plan (if there is one), and, *if a life care plan does not contain an estimate of the injured individual's estimated life span, then a "rated age" may be obtainable from life insurance companies for injuries/illnesses sustained by other similarly situated individuals."* (Emphasis supplied).

[4]The $133,368 is based upon the monthly PIA of $555.70 x 12 x 20 rather than the ACE of $626.40.

If a "rated age" which advances an injured workers' chronological age is used resulting in a reduced MSA, one should not assume that Social Security would accept that same "rated age" for the purpose of calculating the offset. For example, if use of a "rated age" advanced the chronological age of an injured worker from fifty-eight (58) to sixty-five (65), resulting in the potential elimination of seven (7) years of medical care costs that would have been included in an MSA, one should not assume that Social Security would accept that "rated age" of sixty-five (65) and upon receiving a copy of the settlement agreement would simply eliminate the application of the offset.

Next, and returning to the "case study" of "Debbie," utilizing a "rated age" of fifty-four (54), a Florida company recommended that a Set-aside allocation be established in the amount of $101,396.00. Experience teaches that the Insurer would also attempt to reduce its settlement "exposure" by insisting that certain health conditions "documented" in "Debbie's" medical records amply support the Insurer's contention that "Debbie" has a nine-year shorter life expectancy;[5] therefore, income benefits and medical care expenses, not reimbursable by Medicare, that would have been incurred during the nine-year period between "Debbie's" actual chronological age of forty-five (45) and the "rated age" of fifty-four (54) should not be considered for settlement purposes. But, acceptance of the validity of the basis for the "rated age" of fifty-four (54) would result in "factoring out" of settlement value $57,094.48 in income benefits for temporary total disability at $147.67 per week reduced to present value for that nine-

[5] In fact, the "consulting" group that examined the medical records stated in its report: "there is mention in the medical reports of a cervical (?!) uterine cancer - treated in 1993, scoliosis, diabetes and hypercholesterolemia (sic)." Yes, there were "mentions" of all these conditions; but only diagnoses of scoliosis (resulting from the work-related back injury) and uterine cancer successfully treated years ago exist.

year period and $136,132.00 in medical care costs not reimbursed/covered by Medicare. But, in using "Debbie's" chronological age life expectancy, determined from the Annuity Mortality Table for 1949, Ultimate, the MSA calculated by Beverly Manley only increased from $55,735 to $74, 430. Thus, use of the "rated age" of fifty-four (54) in "Debbie's" case would have "taken off the table" exposure totaling $174,531.48. (Income benefit of $57,094.48 plus medical care costs not reimbursed by Medicare of $136,132.00 less $18,695.00 - the difference between the chronological age MSA of $74,430 and the "rated age" MSA of $55,735.)

So, in "Debbie's" case study, not using a "rated age" is not only consistent with the medical "facts" in her case; but also allows her to argue that her claim has much greater settlement value by including the income benefit and medical care costs not reimbursed by Medicare in the exposure of the Employer/Insurer.

SETTLEMENT METHODOLOGY

"Debbie" is experiencing a complete offset. Although the amount allocated to the MSA is not subject to the offset, the settlement combining the Employer/Insurer's future exposure for any form of income benefits and un-segregated future medical care costs not subject to reimbursement/payment by Medicare is subject to the offset. Thus, in "Debbie's" case could her claim be settled - exclusive of the amount to be allocated to an MSA - in a way that recovers all or most of the Social Security Disability Benefits that she is currently losing to the offset? If "Debbie" chooses to settle her claim, the principal settlement sum, exclusive of the amount to be set-aside in an MSA, is to be reduced for offset purposes by the amount of legal expenses; rehabilitation expenses; past and future medical expenses; payments to dependents and payments for specific

loss such as permanent partial anatomical loss. Davidson v. Sullivan, 942 F. 2d 90. After deducting for the foregoing expenses, the "net" sum due the injured worker may still be subject to offset if the injured worker was already experiencing an offset. In order to reduce as much as possible the amount of workers' compensation benefits against which the offset will be applied, the lump sum settlement is pro-rated. There are three different methods for pro-rating the lump sum:

1. The excludable expenses are first totaled and then divided by the weekly income benefit rate. This method delays the application of the offset until the number of weeks produced by the division of the total excludable expenses by the weekly income benefit has been consumed. This pro-ration method is particularly useful if the injured worker is approaching sixty-five (65) when the offset would end, anyway.

2. The second method involves dividing the net amount of benefits, after deducting excludable expenses, by the gross amount of benefits (gross settlement before deduction of expenses) and then the resulting percentage is multiplied by the weekly rate to get a reduced weekly rate to apply in computing the offset.

3. The third method is what is commonly called "the Hartman method." This method involves dividing the Claimant's portion of the settlement, after having deducted all excludable expenses, by the number of weeks (or months) remaining in the injured worker's life expectancy. If this pro-ration method is selected, the mortality table that produces the longest life expectancy should be used.

Lump Sum Or Structured Settlement?

If the injured worker was already subject to an offset, a lump sum or structure such as an annuity is likely to result in continuation of the offset; albeit at a reduced rate. Social Security Ruling 81-32 considers the applicability of the offset provisions of Section 224 of the Act when annuities are used in a workers' compensation settlement. The Ruling:

> "it is the position of the Social Security Administration (SSA) that where the W/C award gives the worker an option of receiving a cash lump-sum payment or having the employer or insurer purchase an annuity, the worker's exercise of that option constitutes his or her receipt of the lump-sum or purchase price. Thus, a worker who chooses to receive a lump-sum amount is considered to have been paid that amount regardless of whether he or she uses it to purchase an annuity. Where the worker exercises an option to have an employer or insurer purchase an annuity, it is the purchase price of the annuity which he or she is considered to have been 'paid' within the meaning of Section 224(a) of the Act."
>
> The following example is used in SSR 81-32:
>
> "A workers' W/C award consisted of a lump-sum of $10,000.00 and an annuity to be purchased by the employer and insurer to provide the worker a lifetime income of $500.00 per month for the first year with an increase in the monthly amount after that under a 5% compounded interest escalator schedule . . . . the insurer advised that the lump-sum settlement and the annuity are completely separate; the worker did not have the option to receive the lump-sum settlement only; the worker did not determine the amount of the monthly payment from the annuity; and the monthly payment from the annuity was payable immediately. Although the annuity was part of the W/C settlement award agreed to by the worker, he did not have the option of converting the purchase price of the annuity into a lump sum."

Thus, in the example given by Social Security, because the worker did not have the option of taking a lump sum in lieu of the annuity, the worker did not have the dominion and control over the time and manner of the annuity payments. Assuming there was no option and the annuity created a stream of periodic payments, Social Security would

determine whether receipt of the annuity payments would cause an offset, applying the offset computation at the time the annuity payments are actually paid to the worker. In applying the offset, if the worker did not have the option to elect an annuity and it was a mandatory term of the agreement, Social Security will use the monthly payment amount received at the time it is paid for the purposes of offset calculations. On the other hand, if the worker was given an option which was elected, the Social Security Administration will consider the amount paid up-front which will allow the application of the lifetime pro-ration method for offset calculations to be used so long as those provisions are contained within the Settlement Agreement.

Because "Debbie" is completely "offset," a settlement method that restores as much of her Social Security Disability Benefit award as possible should be explored. Examples are furnished in the "slides" which accompany this presentation.

Some Thoughts About Use Of Annuities "To Fund" An MSA

At the point in time that an MSA is established, it could be "funded" in a number of ways. If the Set-aside Arrangement is to be self-administered, there is no need to "build in" additional sums for administration of the Arrangement by a third party. Moreover, if the Arrangement is based upon the employee having attained maximum medical improvement with future medical costs generally limited to periodic office visits, occasional diagnostic testing and issuance of prescriptions for medication, the arrangement can be calculated very accurately. **Attachment 10** is a sample Medicare Questionnaire and report upon which specific calculations were based in a claim that required use of an "IME" physician. This "sample" questionnaire combines the questions that would be propounded to the treating physician and the "special"

questions that must be propounded to an "IME" physician in order to comply with the directive of Q & A 15, page 6 of the 4/22/03 ARA Memo. **Attachment 11** is a sample stipulation which contains a self-administered Arrangement.

As the amount "set aside" increases as annual medical care costs expected to be incurred increase, the funding mechanism becomes more complex with greater potential for error when the Arrangement is established. An annuity can be purchased to fund the MSA provided that it has escalator provisions to account for increases in inflation, as well as possible periodic "bubbles" to provide funding for unexpected medical care costs. Provision must be made for disposition of any sums remaining in the MSA arrangement if the employee dies before the MSA has been exhausted. In the July 23, 2001, "Patel memo," CMS points out that structured set-aside arrangements generally apportion settlement money over fixed or defined periods of time. For example, a structured arrangement may be designed to disburse $20,000 per year over the next ten (10) years for an employee's Medicare covered services. If the $20,000 allocated on January 1, for Year One was exhausted by August 31, of that year, Medicare may make payments for the services performed after August 31, once the contractor responsible for monitoring the employee's case verifies that the entire $20,000 (plus interest, if applicable) was exhausted. However, when the structured arrangement allocates money for the start of Year Two (i.e. on January 1) Medicare would not make any payments for services performed until year two's allocation was completely exhausted. Another approach to consider would be to use sequential annuities that are limited in the amount and duration to five-year increments. This approach would allow adjustment for unexpected medical care costs in later years that

could not have been reasonably anticipated when the Arrangement was initially established. This approach might involve the purchase of annuities sequentially in the fourth year of each five-year incremental period which would allow adjustments to be made periodically if medical care costs increased or decreased over the original projections. Another funding method that is worthy of exploration would be the use of U.S. Treasury "strips" or zero coupon Treasury Bonds that are purchased at a steep discount and can be purchased to mature annually on a specific date. If using this approach, it might be wise to consider "blending" an annuity or even a one-time "cash" payment in the early years with Treasury "strips" that accumulate interest for at least ten years before maturity, since U. S. Treasury "strips" or zero coupon Treasury Bonds can be purchased at a significant "discount."

OTHER ISSUES TO CONSIDER

Inclusion Of Prescription Medication Cost In The MSA

Currently, Medicare does not reimburse for outpatient prescription drugs; therefore, there appears to be no valid basis for including in an MSA a sum for future prescription medication costs. However, the answer to question 7 in the "Patel memo" states, in part:

> "provision should also be made in the Settlement and Agreement to provide for a mechanism so that items or services that were not covered by Medicare at the time, but later become covered, are transferred from the commutation specified for non-Medicare covered items and services to the Set-aside Arrangement. (For example, if outpatient prescription drugs become more widely covered.)"

Presently pending in both the U.S. Senate and House are bills designed to create for the first time some form of reimbursement. Under both the House and Senate bills, Medicare eligible persons would be required to pay an estimated $420 annual premium

and a deductible before receiving benefits. Examples of the impact of each plan on costs to Medicare eligible persons:

House Plan

How much Medicare eligible persons would pay out-of-pocket under the private prescription drug benefit plan approved by the House will be based on each individual's current spending on drugs. Benefits apply to Medicare eligible persons with adjusted gross income of $60,000 or less. Those with higher incomes would pay more.

Current Costs	Estimated premium	Deductible	Co-payment (1)	Additional costs to beneficiary (2)	Total out of pocket costs
$1,000	$420	$250	$150	$0	$820
$3,000	$420	$250	$350	$1,000	$2,020
$5,000	$420	$250	$350	$2,900	$3,920
$10,000	$420	$250	$350	$2,900	$3,920

Senate plan

How much Medicare eligible persons would pay out-of-pocket under the private prescription drug benefit plan approved by the Senate will be based on each individual's current spending on drugs. Benefits would apply regardless of personal income.

Current costs	Estimated premium	Deductible	Co-payment (1)	Additional costs to beneficiary (2)	Total out of pocket costs
$1,000	$420	$275	$363	$0	$1,058
$3,000	$420	$275	$1,363	$0	$2,058
$5,000	$420	$275	$2,113	$500	$3,308
$10,000	$420	$275	$2,113	$1,732	$4,540

1 - House bill includes 20% co-payment on spending from $151 to $2,000. Senate bill includes 50% co-payment on spending from$276 to $4,500.

2 - House bill calls for beneficiaries to pay all costs from $2,001 to $4,900. Senate bill calls for beneficiaries to pay all costs from $4,501 to $5,813, and 10% of costs above $5,813.

Many see the battle over creation of a Medicare reimbursement program for prescription medications as a game of political "chicken." Lobbyists for American Pharmaceutical Manufacturers were deeply involved in drafting and shaping both the House and Senate versions of the prescription medication "reimbursement" program. Both the House and Senate versions of the bill bar the government from getting involved in price negotiations. The absence of government regulation - price controls - is likely to result in whatever version of the bill passes and is signed into law exceeding the 400 billion dollar limit that the President proposed should be the maximum cost. But, even then, the foregoing chart supports the analysis that less than 25% of Medicare eligible persons' drug costs would be covered. Health care analysts project non-Medicare covered drug costs at 1.8 trillion dollars over the same ten (10) year period that the President proposed spending 400 billion dollars. And, the proposals (assuming they weren't designed to fail in the first place) have created a potential political problem since a USA Today/CNN/Gallop Poll reported on September 3, 2003, indicates that an overwhelming majority of "seniors" believe that what Congress is offering would not do nearly enough to help the elderly pay for prescription drug costs. Of those responding to the Poll, more thought that the plans would make things worse than those that thought that the current bills would make things better. The fact that the

effective date of the bill is not until 2006, long after the 2004 presidential election, is also troubling many. There is also a significant ideological conflict since Democrats generally favor adding prescription drug coverage as an integral part of the Medicare program to be administered along side Medicare parts A and B. Republicans, on the other hand, propose that an increased role for private insurers would help control costs.

This is not the first time that Congress or a sitting Republican President has proposed some form of assistance to those experiencing high drug costs. In 1988, President Reagan signed bipartisan legislation designed to protect seniors against catastrophic medical expenses, including high drug bills. The provision had been passed with great fanfare; however, once middle and upper income seniors studied the details, they revolted at the prospect of paying a surtax of up to $800 a year for benefits that many already were provided through private insurance. The next year, the law was repealed. The House and Senate versions presently in Conference Committee both contain a gap in coverage where no benefit will be offered. This "gap" is referred to as the "donut hole." The foregoing chart demonstrates that under the House version Medicare eligible persons would pay all their own drug expenses from $2,001 to $4,900 a year; and then would pay nothing above that amount and Medicare eligible persons with annual incomes of more than $60,000 would have higher costs. Under the Senate version, however, Medicare eligible persons would pay all their own drug cost from $4,500 to $5,813, then would pay ten (10%) percent of all additional spending.

It would be difficult to project costs for the purpose of establishing a Medicare Set-aside it either version of the bill with the present "gap" is enacted into law. Since the cost of medications have increased dramatically and would be expected to continue

to do so, some employees might not initially be required to set aside for future medicine costs since they were not eligible for reimbursement when the MSA was first established - depending upon what version emerges - but might subsequently become eligible for reimbursement if the cost of prescription medication continued to increase or consumption increased and the employee finally met reimbursement qualification level. But, if the "gap" is retained in the final version of the bill that is signed into law, consumption and expenditure by any Employee could result in the anomalous situation is which an Employee could initially be eligible for reimbursement to some extent and as prices and/or consumption increases could fall into the "gap" and even re-emerge on "the other side" of the "gap"; once again becoming entitled to reimbursement. Would Medicare simply refuse to reimburse medication costs even though there had been no requirement to set aside for prescription mediations when the MSA was first established?

These questions become even more complicated when it is realized that in early June, 2003, regulations to limit the ability of major drug manufacturers to keep low-cost generic competitors out of the market were announced. The proposal will allow name-brand drug companies just one thirty-month extension of patent protection to settle disputes with generic manufacturers rather than the multiple extensions now possible. Pharmaceutical companies will also be prohibited from obtaining extensions based on meaningless "innovations" such as new packaging. The Federal Food and Drug Administration (FDA) has also announced that it will shorten the time it takes to approve generics for sale to the public. The introduction of more generic medications which are often priced at a fraction of the "patent" equivalent, would impact a Medicare Set-aside

Arrangement since it would require far less money to fund an MSA based upon generic medication costs than patent costs. Currently, nearly fifty (50%) percent of all prescriptions are filled with generic drugs; yet, more than ninety (90%) percent of money spent on prescription medications goes to the purchase of the remaining fifty (50%) percent, which are filled by name-brand medications.

And, the drug re-importation provision in the Medicare prescription benefit provision which passed the House will also affect Medicare Set-asides. The House version would allow Americans to buy medications from foreign suppliers in twenty-five (25) countries where the Food and Drug Administration has approved facilities to manufacture the drugs. The Senate version contains no such provision; however, in the week of August 2, 2003, Senator Charles Grassley (R-Iowa) signaled a change in his attitude by saying that he supports allowing Americans to buy medicines from Canada without the Health and Human Services safety certification. It appears that if a bill emerges from Conference Committee it is likely to include both a provision limiting patent protection, increasing the availability of generic equivalents and probably limited re-importation of medications; but, only from Canada.

At this point in time, it would be reckless to offer any advice concerning what form a prescription medication reimbursement/payment provision may take and how medications should be dealt with in establishing a Medicare Set-aside Arrangement.

Full Disclosure

Some Employers and Insurers have refused to share with an attorney representing an Employee all of the report containing a Medicare Set-aside allocation recommendation made by the consultant hired by the Employer or Insurer. In some

instances, Employers or Insurers have apparently instructed consultants to evaluate only the cost of medical care that is subject to Medicare reimbursement/payment, omitting from the report the medical care costs which are not reimbursed by Medicare. There are also reports of instances in which an Employer, Insurer or defense attorney have refused to share with an Employee's attorney any part of the report except the MSA "bottom line." Yet, these same Employers and Insurers, recognizing their own potential liability, have insisted that the Employee execute a Social Security Release so that determination can be made whether any conditional payments have been made by Medicare. Recognizing that the goal should be the determination whether an MSA in any amount is necessary; and, if so, in what amount, and recognizing that the parties to the claim, their attorneys and even the medical providers have potential liability, these factors would seem to suggest that full disclosure of the reports containing cost projection for Medicare and non-Medicare covered future medical expenses should be made by both sides. The Employee seeks to establish an MSA that is sufficient "to consider the interests of Medicare"; but not a penny more. Employers and Insurers, on the other hand, recognize that the larger the MSA the less likely it will ever be that any "downstream" liability would attach. Moreover, both the Employer and the Employee want to be certain that the Stipulation and Agreement is approved by the State Board of Workers' Compensation, either before "approval" by CMS or after. Because all of the parties to the claim, their attorneys and the medical providers - usually "panel" physicians - have a vested interest in the calculation of an accurate MSA, full disclosure increases the likelihood of the establishment of an MSA that would be reviewed and approved by CMS whether or not the Stipulation and Agreement had been first sent to

and approved by the State Board of Workers' Compensation. If all parties are "working off" the same information, neither "side" will be making decisions, will be negotiating "in the dark."

LIFE CARE PLANNING

Introduction

Life Care Plans, originally introduced in a legal publication, *Damages in Tort Actions (Deutsch & Raffa, 1981),* establish guidelines for determining damages in civil litigation cases, and have developed into the standard by which catastrophic impairments are now measured. Life care planning has become recognized as an advanced practice with evolving standards that are influenced by external forces such as accrediting bodies and courts of law. Life care planners have developed a standard of practice and documented methodology that shall be presented in this overview.

The International Academy of Life Care Planners defines a life care plan as “A dynamic document based upon published standards of practice, comprehensive assessment, data analysis and research which provides an organized concise plan for current and future needs, with associated costs, for individuals who have experienced catastrophic injury or have chronic care needs.” Although life care plans are now utilized in many industries, they are particularly useful in complex medical cases. Life care plans are recognized as dynamic documents because they are multi-dimensional documents subject to continuous change based on the nature of the population for which they are intended to serve. Specific examples of disabilities or diagnosis that may benefit from a life care plan include:- spinal cord injuries, traumatic brain injuries, burn injuries, amputations, birth injuries, some complex orthopaedic and complex chronic

pain patients, anoxic/hypoxic brain injuries, HIV/AIDS, visual impairments and blindness, transplant patients, and children or adults with unusual and complex medical care needs.

Process

The life care planning process begins with the referral. The, assumingly qualified, life care planner should then set about to gather all current pertinent information available for the case from the initial referral source. This may not be all the information "out there" so it is important that a "Release of Information" is obtained from the client. (*Client is referring to the individual whom the plan is being developed about).* The release of information is useful for gathering additional information not otherwise presented by the referral party, but also to access current treatment providers and obtain the most up-to-date accurate information considered necessary for current and future treatment planning.

Examples of useful information include medical notes, hospital notes, depositions, and school, tax and employment records should vocational issues be addressed. **Note:** future planning can not be accurately delineated solely from past medical records.

Review of the obtained records should be completed prior to the initial meeting with the client, so the planner has a working knowledge of who they are meeting and what needs to address. The initial meeting with the client is best completed at the client's residence so a survey of the social and environmental factors can be conducted. If the client is considered a poor historian a family member or caregiver should be available.

Following this assessment, and after obtaining the release of information, contact should be made with the client's treatment team members. The life care planner may wish to recommend additional assessments or service providers based upon their survey. This would be the time to coordinate those contacts, if given appropriate authority.

As life care plans are procured for individuals' with special needs the communication and/ or correspondence with treatment providers can not be standardized. Each catastrophic injury or illness comes with its' own set of complications and each individual comes with their own special set of circumstances. Life care planners have special training that help them recognize, access and obtain specific information relating to a specific set of circumstances. Typically in complex medical cases there are multiple physicians involved and the planner has to coordinate all of the information and compare it to documented established standards of practice. Life care planners guide the treatment team into looking at the long term care needs. Fortunately, due to medical and technological advances individuals with serious illness and injuries are surviving longer and participating in research that is helpful to the life care planner when identifying new age related needs.

Life care plans assess future needs in the areas of projected evaluations, projected therapeutic modalities, diagnostic testing/ educational assessment, wheelchair needs, maintenance and accessories, aids for independent functioning, durable medical items, orthotics/prosthetics, medications prescribed and over the counter, supplies, home accessibility needs, home care, facility care, routine future medical care, transportation, health and strength maintenance, environmental

renovations, future surgical care, aggressive medical or rehabilitation, orthopaedic equipment needs, vocational and / or educational plan and potential complications.

Preliminary life care plan opinions can be formulated after the initial assessment and should include items or services recommended, beginning and ending dates of service, frequency and duration of treatment or service, costs associated with recommendations, explanation of the purpose of each recommendation and optimally the plan should include the source of each recommendation, its service provider and vendor. Increased creditability is given to those plans that can document they have appropriately qualified providers imparting the recommendations presented.

The ending date of service may be the client's life expectancy. Life care planners are not credentialed to deduce the life expectancy of an individual. There are, however, many resource materials that can provide estimated suggestions and are often utilized if an economist is not available. It is incumbent on the life care planner to disclose the source from which any life expectancy is estimated and suggest its use is for informational purposes only.

The life care planner or planning team should then move to fill in the holes that likely remain in the plan. Communication with related vendors and treatment team members will procure final clarity in the planning process. Costs of items and services need to be included, and this is the appropriate time to complete this step. Costs are an integral part of the life care planning process. Costs can be obtained from a variety of resources, the key is to reference where specific costs are obtained. Life care plans are utilized in many jurisdictions and it is incumbent for them to comply with any special requirements associated with the jurisdiction within which they are being used.

Finalization of the plan usually involves reviewing it with the client or client's family, primary treating physician and the development of a narrative report to explain the contents and recommendations. Distribution of the final product may depend on the rules of the industry. In workers compensation where agreement of parties is typically obtained prior to commencement, distribution of the final product should not be in question, especially as the parties usually want to mediate a suitable resolution on these high dollar, complex, catastrophic cases.

Complications

It is usual and customary for life care plans to include potential complications associated with the disability. Life care planners are encouraged to research and include all possible complications associated with the specific disability or illness. Twenty years since the inception of life care planning this process is still considered vital. The challenge with complications has always been that you cannot project their actual occurrence or frequency therefore, they can not be "costed" into a plan. History has revealed that survivors may or may not encounter one, or any number of the complications, associated with their condition.

Caution should be given when assuming complications associated with cases being presented for Medicare-set-a-side arrangements. Medicare requests diagnostic codes and a list of related complications when submitting the set-a-side request, to assure their interest is thoroughly protected. The dilemma arises in assessing what complications realistically can be anticipated to prevent unnecessary inflation of a claim thereby preventing suitable resolution.

Other quandaries to address in our situation are 1) will the provider agree to charge current rates; 2) what cost is acceptable if there is not a fee schedule code; 3) what costs will be accepted on items that are not Medicare eligible; 4) what to do when provided a range of costs; 5) Medicare requires diagnostic codes for current and anticipated procedures and diagnosis, presumably for future computer generated cost containment measures. What will happen if a new injury or illness presents with the same or similar codes? How can we assure the patients medical costs are not left to future treatment providers having to present unnecessary letters for justification of payments? 6) Lastly inaccurate age limitations can impair funding either by providing too little or too much into a set-a-side or other designated accounts.

Medicare Set-a Side Arrangement

Medicare set-a-side arrangements can be procured directly from a life care plan in catastrophic and complex medical cases(if one is available). The life care plan should include all facets of future needs and those items currently accepted by Medicare can be extracted from said plan. In these cases CMS prefers to see both products to assure they are fully protected. Costs may need to be adjusted dependant upon the jurisdiction within which the plan falls.

Qualified Life Care Planners

If your case meets requirements for a life care plan what should you look for when deciding upon a life care planner?

There are many professionals qualified to complete competent plans. There are approximately 300 certified life care planners in the United States. While being certified is not a requirement to author a life care plan, obtaining the national certification does

demonstrate a commitment to the profession. Life care planners are typically experienced in catastrophic care management, are educated and experienced within the field they are employed, hold licensees or other certifications in addition to the CLCP (Certified Life Care Planner), show a commitment to their profession by maintaining their credentials with continued training, publishing, and utilizing established published and researched materials.

In workers compensations cases it is advisable to utilize a life care planner familiar with the jurisdiction and that all parties can agree upon. Life care planning is not inexpensive; therefore, it seems reasonable to only have to finance one document.

References

Life Care Planning and Case Management Handbook, Edited by Roger O. Weed.

"The Life Care Planning Site", the Web site for the International Academy of Life Care Planners.

Journal of Life Care Planning, Elliot & Fitzpatrick, Inc.,

Aging with Spinal Cord Injury, Gale G. Whiteneck, Ph.D., et al. Craig Hospital, Colorado