



Medicare

Set-Aside Arrangements A Combined Effort

by

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Overview:

- **When is Medicare an issue?**
- **What is required when Medicare is an issue?**
- **Dealing with CMS and Medicare.**
- **Problems associated with Medicare in the context of workers' compensation claims.**

When is Medicare an Issue?

- When the **Claimant is a Medicare beneficiary** regardless of whether the claim is *settling or not*:
 - Medicare must be reimbursed for compensable medical treatment within 60 days of notice, settlement or award.
 - Sometimes Claimants and/or doctors submit medical bills for compensable treatment to Medicare along with bills for unrelated treatment.
 - Controverted medical treatment may later be compensable by acceptance, settlement or award.
- When **settlement** provides for future medical treatment for a work-related injury AND certain conditions exist, a Medicare Set-Aside may be necessary.

When is Medicare an issue?

When the claim is NOT being settled:

- When the **Claimant is a Medicare beneficiary** *regardless* of whether the claim is *settling or not*:
 - Medicare must be reimbursed for compensable medical treatment within 60 days of notice, settlement or award.
 - Sometimes Claimants and/or doctors submit medical bills for compensable treatment to Medicare along with bills for unrelated treatment.
 - Controverted medical treatment may later be compensable by acceptance, settlement or award.

When is Medicare an issue?

The Settlement Context:

– Claimant is a **Medicare beneficiary**.

• **OR**

– Lump sum settlement is **\$250,000.00** or greater,

– **AND**

– Claimant is “**reasonably likely**” to become entitled to **Medicare benefits within 30 months** of settlement.

- Claimant has applied for SSDI.
- Claimant has been denied SSDI, but he intends to appeal or re-file.
- Claimant is 62.5 years old or older.
- Claimant has ESRD, but does not yet qualify for Medicare.

What is required when settling?

- **“Adequately consider”** Medicare’s interests when settling a claim.
 - Failure to do so may result in liability for double damages.
- However, the Employer/Insurer is *NOT* required to consider any liability beyond that which is provided in the **Georgia Workers’ Compensation Act!**

What does it mean to "adequately consider" Medicare's interests?

- Lump sum **settlement allocates sufficient funds** to cover the Claimant's future medical expenses.
- A portion of the lump sum must be "set aside" to cover **future Medicare-covered medical expenses**.
- Must include a **"mechanism"** which will ensure the funds will not be misappropriated.

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How do the parties know whether they have “adequately considered” Medicare’s interests?

- **CMS will give a written opinion, upon which the parties can rely.**

What is required to obtain CMS's written approval of a settlement agreement?

- **Claimant and attorney's information.**
- **A social security consent to release information form, signed by the Claimant.**
- **Date and basis for Medicare entitlement.**
- **Employer/Insurer and attorney's information.**
- **Date of Injury and Description of Injury (including ICD-9 codes).**
- **Amount of the lump sum settlement.**
- **Amount of the proposed MSA.**

Additional requirements

- **Life expectancy (CDC Table) / rated age.**
- **Life care plan / cost projection analysis.**
- **Copy of the settlement agreement.**
- **Medical records (last two years) documenting:**
 - **Current medical treatment.**
 - **Future medical treatment.**
 - **Prognosis.**
- **Maximum expected expenses for all of the Claimant's future medical expenses:**
 - **Medicare covered.**
 - **Non-Medicare covered.**

Additional requirements

- **Administration of the MSA – who will control and disburse the funds, and what is the “mechanism” for ensuring the funds are not misappropriated?**
 - Professionally administered.
 - Self-administered.
- **Funding/Structure of the MSA:**
 - Interest bearing checking account.
 - Structured settlement.
 - Trust professionally administered.
 - Combination.
- **Fees:**
 - Attorney’s fees.
 - Administration costs.

Dealing with CMS and Medicare: *Gathering the Information*

- **Much of the information is simple and easy to produce, but obtaining some of the information and materials can be time consuming.**
- **The amount of time and documentation required depends on:**
 - **Cooperation of:**
 - **Medical providers.**
 - **The parties.**
 - **The rehab suppliers, life care planners.**
 - **Complexity of the case and the settlement:**
 - **Intensity and duration of the Claimant's future medical treatment.**
 - **Structured settlements.**

Dealing with CMS and Medicare: *The Medicare Set-Aside Proposal*

- Convincing CMS that **enough of the lump sum is being allocated for future medical benefits** may be tricky:
 - CMS seems to have a hard time understanding why claims do not settle for **full exposure**.
 - CMS will **no longer** consider the **present value** of future medical expenses, but an **annuity** can be used with certain added conditions.
 - In fact, CMS does not require use of an **“inflation factor”** in evaluating the value of future medical expenses.
- Defining the **“mechanism”** in the terms of the settlement agreement which is satisfactory to CMS and the claimant:
 - Claimants want control over *their* money.
 - CMS wants assurance that the Claimant will not misappropriate the funds “set aside” for Medicare covered medical expenses.

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**Problems with Medicare
in the Context of
Workers' Compensation
Settlements**

Why are workers' compensation claims such good "targets" for CMS?

- Injured workers probably account for much of the MSP situations.
- Medicare Secondary Payer Act and Medicare regulations give guidelines for evaluating whether a settlement "adequately considered" Medicare's interests.
- The value of a wc claimant's benefits can be more easily determined than the awards and judgments of other types of liability plaintiffs.
 - Compensation rates.
 - PPD schedule.
 - Fee schedule for medical treatment.
 - Limited types of benefits / "damages."

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However, in settlement, workers' compensation claims have a

“fair market” (compromise) value

- Workers' compensation claims **do NOT settle for the full exposure!**

– **SETTLEMENT** = **COPROMISE and NEGOTIATION**

– **FULL EXPOSURE** = **SURRENDER**

- Paying the full exposure is a surrender and not a settlement because ***full exposure is the worst case scenario.***

- The strength of Employer/Insurer's defenses v. the strength of Claimant's case.
- Different Employer/Insurers have different policies that give different “internal values” to settling claims.
- Claimants do not necessarily undergo all the treatment their doctors think they may need in the future.
- A change of physician can significantly change the Claimant's treatment plan.
- Claimants do not always live out their full life expectancy.
- The Employer/Insurer may find the Claimant a job.
- Many times, Claimants' conditions improve after settlement.
- Claimants want to move on with their lives.
- Employer/Insurers want to resolve the claim.
- Claimants usually want a lump sum.
- Litigation costs.
- Frustration.

Projecting future medical expenses

MUST take into account the “fair market” (compromise) value of the claim!

- A claim might have a **full potential exposure** of \$800,000.00 or more, but it may only have an **actual (“fair market”) value** of \$20,000.00.
 - In these cases, there may be more than \$100,000.00 worth of future Medicare-covered medical expenses projected for the Claimant’s future medical treatment.
- Often times, the **full potential exposure** for **medical benefits** is close to the **actual “fair market” value** of the **entire claim**.

Questions?