National Alliance of Medicare Set-Aside Professionals

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President's Letter to NAMSAP

Wow, what a year of change in the country and our industry. As your new President, I wanted to update you on several things that have occurred over the last few months that you may have missed if you were not at the annual meeting on October. I will try to keep this short, but there are a lot of highlights and coming attractions from NAMSAP!

- In 2008, the Board of Directors was approached by Ringler and Associates to provide specific NAMSAP training to their brokers. Ringler is the largest of the structured settlement firms. We were able to provide a day long training for Ringler in February of 2009. Our thanks to Mark Popolizio, Robert Lewis, Rafael Gonzalez and Robert Sagrillo for their faculty roles.
- We are actively working with the National Structured Settlement Association on many issues , including providing NAMSAP training in coordination with their meetings.
- Mark Popolizio and crew, just hosted our first Webinar of the year.
- We continue to reach out to the broad spectrum of the MSA world. NAMSAP made a substantial contribution to the MARC Coalition, as a founding member. A NAMSAP representative now sits on the steering committee of MARC.
- We continue in many and varied ways to deal with CMS on a variety of issues. Over the years NAMSAP has met with CMS, provided them with documentation on a variety of issues and continues in our efforts to speak for all of you with CMS.
- In January of this year, the Board of Directors approved two significant meeting dates: "Go to Washington" will be a meeting to expand our member's contacts with the legislature. Our Annual Meeting is scheduled for September 30th -October 1st in Las Vegas.
- Rob Brown our good friend and Board Member was called to active duty in the Mid East. The BOD agreed that we should support Rob by ensuring his return to the BOD on completion of his active duty.
- Patty Meifert who worked so tirelessly to help found and run this organization in its' infancy ; left the BOD to have more time for the many other things in her life.
- We have added two new board members to replace our friends; they are Barbara Bate and Jon Gice. Please see their biographies and information on the NAMSAP website.
- Our committees all continue to function and we encourage you to become actively involved with any of the committees that are of interest to you.

But first and foremost; the BOD has made an active commitment to increase communication within NAMSAP. This newsletter is the first of many you will see in the Members section of the NAMSAP website. We encourage you to share information on the 'listserv' and directly with any member of the BOD.

We are looking forward to a great 2009 at NAMSAP!

Michael E. Westcott
President, NAMSAP

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Special Points of Interest:

- "Go to Washington Day": May 7th and 8th
- 2009 Meeting: September 30th through October 1st, Las Vegas
- Welcome our new Board members: Barb Bate and Jon Gice

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NAMSAP "Goes to Washington" Day

By: Benjamin M. Basista, Esq., Burns, White and Hickton, LLC

The NAMSAP Board of Directors began working to establish "NAMSAP Goes to Washington" in December 2008, as part of their ongoing "global" effort to address issues and concerns over recent CMS legislation. On May 7, 2009, and May 8, 2009, the members of NAMSAP are invited to converge on Washington to meet with members of Congress. Each interested NAMSAP member is asked to reach out to the members of Congress in their district as a constituent and a member of the business community to secure a brief meeting with the Senator/ Representative and/or a member of their staff.

As part of "Go To Washington Day", there will a pre-meeting to discuss how to get information to your Congressional members. Following the meeting with your Congressional members will be a debriefing session to report on how the information was received and what proposed actions were discussed. The purpose of each meeting with the members of Congress will be to discuss NAMSAP, its members and goals.

A great source to find out who represents you and your state is http://www.govtrack.us/Congress/findyourreps.xpd. Once you locate your Senator/ Representative, it is suggested that you fax or email them, and them call them. Mike Westcott, has advocated that emails sent to your Representative be sent through http://capwiz.com/pickensplan/utr/2/?a=13047601&i=92726410&c= . A sample letter for use can be found at www.NAMSAP.org. It is requested that you use the draft letter, or a similar version, so that the message from NAMSAP members will be consistent. It is also recommended that letters from each constituent member be faxed or emailed so that the receiving Congress member is aware of the volume of people who are NAMSAP members in their district, and the range of backgrounds and professions represented in NAMSAP membership. When making the follow up call to your fax or email, it is recommended that you wait an appropriate amount of time. When you call, let the staffer that you speak with know that you are calling as a follow up to your letter regarding NAMSAP. Explain the nationwide effort going into organizing the group "Go to Washington Day", the number of faxes and emails going to other members of Congress, and your desire to speak with your Congress person and/or their staffer about scheduling a brief meeting on May 7th or May 8th to discuss the group, its members and goals.

As part of the planning for the event, a Medicare and MSA 101 guide will be disseminated. The information will be geared to the true basics of Medicare and MSA's. Any member who has information specific to the MSA industry that they would like to share as leverage to get a meeting or to be used in a meeting, please advise or pass it along. Information can include the amount of MSA's you handle per year, the amount of MSA's that you get approved, your approval rate, the estimated dollar amount that your clients "set aside" per year, etc.

The success of "Go to Washington" will sink or swim based on the efforts put forth by each individual NAMSAP member. As a group of professionals, we have dedicated our careers to providing our clients with the absolute best Medicare based services that each of our entities can provide. It is imperative that members of Congress know the time, efforts and dedication that the members of NAMSAP have put into protecting the Medicare trust fund. It is urged that every member take an active role in participating in this event.

Links to Medicare Web Pages or Helpful Sites:

http://msprc.info/

https://www.cms.hhs.gov/

https://www.cms.hhs.gov/MandatoryInsRep/

https://www.cms.hhs.gov/WorkersCompAgencyServices/

https://www.cms.hhs.gov/COBGeneralInformation/

http://mymedicare.gov/

About NAMSAP:

NAMSAP is the only non-profit association exclusively addressing the issues and challenges of the Medicare Secondary Payer Statute and its impact on workers' compensation and liability settlements. Its members are comprised of attorneys, nurses, settlement planners, claims professionals and others professionals who tackle the issues of Medicare compliance in an informed and professional manner.

NAMSAP was formed to help individuals and organizations address claims impacted by the Medicare Secondary Payer Statute (MSP). The MSP is federal legislation designed to prevent the shifting of responsibility from a primary payer to the federal government in liability and workers' compensation claims.

NAMSAP Mission Statement:

The mission of NAMSAP is to foster the highest standards of integrity and competence among Medicare Set-Aside professionals and those they serve.

Purposes of NAMSAP:

- Develop standards and define best practices for the industry;
- Promote a multidisciplinary approach to the Medicare Set-Aside practice;
- Provide a forum for learning and shared knowledge between all associated disciplines;
- Provide a unified voice to affect change and improve the Medicare Set-Aside process; and
- Protect the interests of all partied in settlements involving Medicare Set-Aside related issues.

Members of NAMSAP are invited to converge on Washington.

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Average Wholesale Price (AWP) for WCMSA Proposals

By: Matt Larkin, MSCC, Vice President of New Business Development, Experea Pharmacy Services, Inc.

This article briefly explores the history of AWP used in the pricing of prescription drugs, highlights some of the changes that have emerged through its evolution today, and looks at the Centers for Medicare & Medicaid Services (CMS) new policy as it relates to WCMSA proposals.

Recently CMS has elected to use AWP as the cornerstone of prescription drug pricing but it is a dynamic standard and one that is undergoing current growing pains and threats from recent regulatory changes. There seems to be an emerging pattern when one looks at how the AWP standard has evolved to its current status.

Definition

According to the Red Book, published by Thomson Medical Economics, the AWP information is "based on data obtained from manufacturers, distributors, and other suppliers" [1]. This pricing information is then sold to government entities, private insurance companies, and other purchasers of prescription drugs.

- Average Wholesale Price (AWP) - The average list price that a manufacturer suggests wholesalers charge pharmacies. AWP is typically less than the retail price, which will include the pharmacy's own price markup. AWP is referred to as a sticker price because it is not the actual price that large purchasers normally pay [2].
- Average Sales Price (ASP) - The weighted average of a manufacturer's sales to all purchasers in a given quarter, after certain pricing adjustments such as discounts and rebates, and excluding certain government and other purchasers. In the Medicare Modernization Act, Congress adopted the ASP to replace the average wholesale price (AWP) for reimbursing outpatient drugs under Medicare Part B begin-ning in 2005 [2].
- Wholesale Acquisition Cost (WAC) - The price paid by a wholesaler for drugs purchased from the wholesaler's supplier, typically the manufacturer of the drug. On financial statements, the total of these amounts equals the wholesaler's cost of goods sold. Publicly disclosed or listed WAC amounts may not reflect all available discounts [3].
- Estimated Acquisition Cost (EAC) - EAC is often determined by subtracting a percentage discount from a drug's AWP.

History

Reimbursement for Medicare prescription drugs has undergone significant change over the years. Prior to use of the AWP as a pricing benchmark, Medicare drugs were reimbursed on the basis of the physician's acquisition cost. That system was eventually replaced with one based on 100 percent of the AWP, and then to the lower of the estimated acquisition cost (EAC) or 95 percent of the AWP. EAC is often determined by subtracting a percentage discount from a drug's AWP. Every employer-PBM contract uses AWP as the basis of cost. Until recently it has been the most stable measure in drug pricing.

- AWP was developed in 1969 by George Pennebaker to provide a standardized method of reimbursing pharmacies providing services to the California Medicaid population.
- Since inception in 1969 it has expanded to serve as the primary basis of cost for all prescription drug transactions between payers, PBM's and government agencies.
- Historically AWP was equal to WAC +20%
- In 2002 AWP was artificially inflated to equal WAC +25%
- The inflated prices effected 95% of all brand name drugs on the market

On January 1, 1998, as a result of the Balanced Budget Act of 1997 and in an effort to bring down costs, Medicare Part B began to reimburse covered brand-name drugs at 95 percent of the AWP. For multisource drugs—drugs with generic equivalents or brand-name drugs with at least one competing product—reimbursement is 95 percent of the lower of (a) the median AWP of all generic forms of the drug and (b) the lowest brand-name product's AWP [4] .

In December 2003, President Bush signed into law the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA), which replaced the AWP methodology with a new pricing scheme based primarily on Average Sales Price (ASP). In keeping with the provisions in the MMA, the CMS issued an interim final rule establishing the ASP data reporting requirements for pharmaceutical manufacturers in April 2004, followed by a proposed rule implementing the ASP payment system on August 5, 2004. For 2004, the MMA mandated that the percentage variable of AWP reimbursement be decreased to 85%. New drugs that were not available before April 1, 2003 were paid at 95% of AWP in 2004. Beginning January 1, 2005, CMS has replaced the AWP methodology with the ASP payment system.

According to the U.S. General Accounting Office (GAO), the AWP may be neither "average" nor "wholesale" [4]. In addition, an investigation by the U.S. Department of Justice (DOJ) and the National Association of Medicaid Fraud Control Units (NAMFCU), which involved the collection of actual wholesale pricing information, indi-

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cated that some drug manufacturers report inflated average wholesale pricing information [5].

Some manufacturers argue that they do not set the AWP for their drugs and are therefore not in a position to inflate these prices. They maintain that the commercial publishers of drug pricing data independently assess and report a drug's AWP. Despite these claims, it is clear that the manufacturers must provide some level of pricing data to commercial publishers to enable them to publish AWP lists. Inflating the AWP has led to litigation against two major benchmark pricing resources, MediSpan and First Data Bank (FDB).

AWP Litigation

- June 2005 class action complaint filed
- October 2006 preliminary settlement from FDB
- November 2006 court grants preliminary approval to FDB settlement
- May 2007 MediSpan settlement
- August 2007 court grants preliminary approval for MediSpan settlement
- August 2007 court certifies class
- January 22, 2008 final approval hearing took place
- As of today the status of AWP has not been finalized.

Potential Outcomes from Class Action

- Prices will roll back by a margin of 5%
- FDB & MediSpan will discontinue publishing AWP within 2 years
- Industry may seek alternatives to AWP i.e. AMP, ASP, or WAC
- PBM's will likely renegotiate all contracts with pharmacies and payers.

CMS Memo

On April 3, 2009, The Director with the Financial Services Group Office of Financial Management Centers for Medicare & Medicaid Services (CMS) set forth changes to the pricing methodology used for future prescription drug treatment costs in Workers' Compensation Medicare Set-Aside Arrangement (WCMSA) proposals [6].

The changes were limited to those prescription drugs covered by Medicare for the treatment of the Workers' Compensation (WC) related injury(ies) and/or illness (es)/disease(s) [6].

The CMS will begin independently pricing future prescription drug treatment costs/expenses in WCMSA proposals beginning June 1, 2009. Effective with complete WCMSA submissions received by CMS' Coordination of Benefits (COB) Contractor on or after June 1, 2009, where the WC related injury warrants the need of prescription drugs for the ongoing treatment of the WC related injury, CMS' independent pricing of the prescription drug amount will be calculated and priced using average wholesale price (AWP). The CMS will not use or recognize any other pricing, discounting, or calculation methods when determining the adequacy of the prescription drug amounts in WCMSA proposals [6].

The CMS will apply the following procedures to all WCMSA proposals received on or after June 1, 2009. This procedure will also apply to all closed WCMSA cases that reopen on or after June 1, 2009, as noted below [6].

If an entity submits a WCMSA proposal to CMS' COB contractor that does not contain an amount for prescription drugs for the treatment of a WC related injury and if, upon further review, CMS deems that the WCMSA warranted the need for prescription drugs for the treatment of the WC related injury, CMS will default to pricing using a pricing strategy of AWP for brand name drugs in determining the adequacy of the prescription drug amount [6].

If an entity submits a WCMSA proposal to CMS' COB Contractor and the submitter priced the future prescription drug treatment costs/expenses as being "Generic" and there is no "Generic" available, CMS will default to the AWP pricing for brand name drugs in determining the adequacy of the prescription drug amount [6].

NOTE: With regard to closed cases, when the CMS' COB contractor receives the previously requested necessary documentation, the case is considered a new WCMSA submission and the requirements included in all of CMS' current published policy memorandums related to: (1) future medical treatment; and (2) future prescription drug treatment will be applied to the new WCMSA submission [6].

Employers and Payers

- If a drug had a WAC cost of $100 in 2002 the AWP would be equal to $120
- Assuming no price increase that same $100 drug would now cost a payer $125
- The average retail brand discount prior to 2002 was AWP -13%
- Using the 13% discount the cost of that product in 2002 would be $104.40
- The average retail brand discount in today's market is AWP -16%

Some manufacturers argue that they do not set the AWP for their drugs and are therefore not in a position to inflate these prices.

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- Using a 16% discount the cost of the same drug today with the inflated AWP would be $105.00
- Although brand discounts improved significantly they fell slightly short of keeping up with the inflated mark up.

Prior to the recent CMS policy change there were many different methods being used to reduce allocation amounts such as the Donut Hole, using Patent Expiration Dates, and performing Drug Utilization Reviews. If CMS is going to accept only AWP after June 1, 2009 the array of methods that can be used to reduce allocation amounts are dwindling.

Did you know there can be multiple AWP's for a single drug description and strength?

Multiple AWP's for the Same Drug

- Example: Oxycodone HCL-Acetaminophen 10MG-352MG

NDC	Description	Strength	AWP
53746020401	Oxycodone HCL-Acetaminophen	10mg-325mg	$1.78
54868502405	Oxycodone HCL-Acetaminophen	10mg-325mg	$1.87
54868502407	Oxycodone HCL-Acetaminophen	10mg-325mg	$2.30
57866416505	Oxycodone HCL-Acetaminophen	10mg-325mg	$2.82
57866416502	Oxycodone HCL-Acetaminophen	10mg-325mg	$3.50
54868502402	Oxycodone HCL-Acetaminophen	10mg-325mg	$4.00
54868502400	Oxycodone HCL-Acetaminophen	10mg-325mg	$4.23

Keep in mind that if an item is too far below the average amount there is a reasonable level of expectation that CMS will send back the report with a re-priced value for that item and more than likely not tell you how the pricing was derived.

Conclusion

Because the AWP is part of the reimbursement formula used in Medicare and by many state Medicaid programs, any increase in the published AWP can increase the billions of dollars that federal and state governments pay for prescription drugs.

Medicare Part D benefits provide reimbursement coverage for the majority of prescription costs outside the surgical or physician's office setting. The WCMSA may be considered as 100% co-insurance because it pays 100% for items that are compensable to the settled WCMSA. Anything not compensable to the settled WCMSA case is typically the responsibility of the beneficiary. Regardless of who is paying the bill it has a direct impact on everyone involved.

There is vastly more exposure to the economy when using AWP as the benchmark for pricing WCMSA proposals due to outside influences that can affect how an AWP price is derived. With the release of the recent CMS Memo, CMS has given the industry a substantial road block to being more competitive while also seizing the ability for those within the WC settlement arena to utilize its negotiated buying power.

Where does that leave the allocator, claimant, attorney and such? Now more than ever is the time to consider having back-end cost-containment solutions in place that provide the injured party access to pricing discounts which surpass regulated benchmarks, helps prevent the shifting of financial burden to Medicare, and mitigates concern about exposure to post-settlement risk.

There can be multiple AWP's for a single drug description and strength.

"There is vastly more exposure to the economy when using AWP as a benchmark for pricing WCMSA proposals due to outside influences that can affect how an AWP is derived."

References:

1. Medical Economics Staff, Red Book, 106th ed. (Montvale, NJ: Thompson Medical Economics, 2002), 169
2. National Health Policy Forum Website: http://www.nhpf.org/library/other/AcronymGlossary_MMBriefingBook09.pdf
3. National Association of Public Hospitals and Health Systems Website: http://www.naph.org/Content/ContentGroups/Advocacy_Issues/Glossary1/Wholesale_Acquisition_Price.htm
4. William J. Scanlon, "Medicare Part B Drugs: Program Payments Should Reflect Market Prices," testimony before the Subcommittee on Health and the Subcommittee on Oversight and Investigations, U.S. House Committee on Energy and Commerce, September 21, 2001 (GAO-01-1142T), U.S. General Accounting Office, Washington, D.C., 4; accessed May 20, 2002, at http://www.gao.gov/new.items/d011142t.pdf
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6. The Centers for Medicare & Medicaid Services Website: http://www.cms.hhs.gov/WorkersCompAgencyServices/Downloads/April2009WCMSARXProcedureMemorandum.pdf

Social Security, Medicare Benefits and Medicare Set-Aside Arrangements for Minor Children

By: John C. Campbell, CELA, MSCC

Ever since the first Medicare Set-Aside Arrangement (MSA) was submitted and approved in a workers' compensation (WC) settlement in 1995, MSA professionals have been aware that a seriously disabled worker may be able to qualify for Medicare before age 65. However, this is only considered likely where the injured worker is over age 21 and has sufficient work credits to qualify for Social Security Disability Insurance Benefits (SSDIB).

Now that the use of MSA's in liability settlements is becoming more common, MSA professionals are increasingly facing the scenario where the injured plaintiff is actually a minor child. It is important in this context to understand that certain disabled children may be likely to become eligible for Medicare, even before reaching age 21, without ever having worked at all. When a liability claim for such a child is settled, failure to reasonably consider Medicare's interests as secondary payer following the settlement could have disastrous consequences.

This article will discuss the eligibility requirements and basic workings of SSDIB and the Social Security's Childrens' Disability Benefit (CDB) program; the relationship of CDB to Medicare; and when to consider a Medicare Set-Aside Arrangement in the context of a liability settlement involving a disabled child.

SSDIB:

The Social Security Disability Insurance Benefit (SSDIB) is an income benefit from Social Security available to blind or disabled persons under age 65 who have earned a sufficient number of work credits.

Disability is determined according to the criteria in §1382c(a)(3) of the Social Security Act. To be considered "disabled", an individual must have a diagnosed medical condition (including mental illness) that has lasted or is expected to last at least 12 months or to result in death. Further, the individual must be unable to engage in substantially gainful activity due to his or her medical condition. Generally, a person is deemed to be engaging in substantially gainful activity if he or she is able to earn at least $980 per month in 2009 ($1,640 for a blind individual).

There is a 5-month waiting period from the date of eligibility before payment of SSDIB benefits begins. The date of eligibility can be no earlier than the date of the onset of disability. However, it can be later if the individual delays in filing an application for benefits. While benefits can be awarded retroactively, the date of eligibility can be no earlier than 17 months prior to the application date, meaning that retroactive benefits may not begin earlier than 12 months prior to application, after the 5-month waiting period has expired.

To qualify, a disabled individual must also have sufficient work credits (formerly referred to as "qualifying quarters") under the Social Security system. An individual earns one work credit for each calendar quarter in which he or she earned sufficient income to qualify for the credit. In 2009, one must earn $1,090 in any calendar quarter to earn a work credit for that quarter.

There are actually two tests for sufficient work credits. First, the individual must be "fully insured" in the first month of the SSDIB waiting period, meaning that the individual must have at least one work credit for each year from the year after attaining age 21 until the date of disability.

Further, the individual must have sufficient work credits in the years immediately preceding the date of disability. The number of qualifying quarters needed to qualify for SSDIB benefits depends upon the age of the person when he or she becomes disabled. If the person is age 31 or older, he or she will need at least 20 qualifying quarters within the 10 year period immediately preceding his or her application for SSDIB. Persons under age 24 will need only 6 qualifying quarters; and persons between the ages of 24 and 31 will need enough qualifying quarters to account for having worked half of the time between age 21 and their age at the onset of disability.

SSDIB does not pay for medical care. However, after an individual has maintained SSDIB eligibility for at least 24 consecutive months, the individual will automatically become eligible for Medicare. For SSDIB beneficiaries with amyotrophic lateral sclerosis (ALS), this 24 month waiting period is waived.

CDB:

The Chidrens' Disability Benefit (CDB) program is similar to SSDIB, but is designed for those who are disabled in childhood and cannot attain sufficient work credits to qualify for SSDIB. Qualification for CDB requires that the beneficiary be considered disabled under the Social Security Act, as with SSDIB. Further, the beneficiary must be age 18 or older and he or she must have become disabled prior to age 22.

CDB beneficiaries must qualify based upon the work credits of a parent. That is, the child must have a parent who qualifies for Social Security Retirement Insurance Benefits (RIB) or SSDIB; or who is deceased and was either fully or currently insured as of the date of death. Fully insured status requires that the deceased parent had at least one work credit for every year from the year after attaining age 21 until the year of death. Currently insured status requires that the decease parent have at least 6 work credits during the 39-month period immediately preceding the date of death.

Unlike SSDIB, there is no 5-month waiting period for CDB. Once a disabled child reaches age 18 (or becomes disabled between age 18 and 22), he or she can begin receiving benefits immediately if an application is filed at that time. If the application is delayed, benefits can be awarded retroactively for up to 6 months (where the child is qualifying on the work record of a decease parent or a parent on RIB) or up to 12 months (where the child is qualifying on the work record of a parent on SSDIB).

As with SSDIB, a CDB beneficiary will become eligible for Medicare after 24 months of continuing eligibility (but no earlier than age 20), unless the beneficiary is diagnosed with ALS, in which case the beneficiary will qualify for Medicare at the same time as he or she qualifies for CDB. Medicare eligibility includes eligibility for Medicare Part A (hospital insurance), and for enrollment in Medicare Part B (medical insurance) and Medicare Part D (prescription drug coverage). Thus, an individual qualifying for Medicare as the result of CDB eligibility will have the same coverage, co-pays and deductibles as an adult

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age 65 or an adult qualifying through SSDIB.

Medicare Set-Asides for Minor Plaintiffs:

Since 1980, the Medicare Secondary Payer (MSP) Statute (42 U.S.C. §1395y) has provided that Medicare will not pay for items or services that have been paid or can reasonably be expected to be paid by a WC plan or by automobile, liability or no-fault insurance (including self-insured plans). There is no difference in treatment under the statute between WC and liability plans.

The Centers for Medicare & Medicaid Services, the federal agency which administers Medicare, has encouraged the use of MSA's in WC settlements for more than 12 years, although CMS' first policy memorandum on this issue was not published until July, 2001. To date, CMS still has not published policies or procedures for the use of MSA's in liability settlements, but representatives from CMS have indicated that Medicare's interests as secondary payer must always be reasonably considered. Further, several of the CMS Regional Offices have been reviewing MSA proposals in liability settlements on a discretionary basis since at least 2007 (which would not be the case unless CMS' Central Office in Baltimore granted the Regional Offices authority to do so).

With CMS increasing its ability to enforce its powers and protect its interests under the MSP Statute through mandatory insurer reporting, there can be little doubt that policies and procedures for the use of MSA's in liability settlements are being developed and that these policies and procedures, representing CMS' official position on the issue, will be published in the foreseeable future. In the mean time, cautious practitioners, plaintiffs, insurance carriers and their counsel have begun to recognize that they are in the same situation as existed in the WC industry immediately prior to July, 2001: the MSP statute's provisions apply whenever there is a payment, such as a settlement of a claim, and they have done so for over 20 years, but CMS has not yet spoken officially on how it expects its interests to be considered in liability settlements.

In this situation, these entities have been increasingly looking to MSA professionals to assist them in ensuring that their liability settlements are completed properly so as to prevent future liability and loss of benefits under the MSP provisions. As with the WC situation pre-2001, the most effective way to ensure an MSP-compliant settlement is through the funding of an MSA.

As MSA professionals have found themselves dealing with more liability settlements, they have also found themselves dealing with issues that rarely, if ever, arise in the context of a WC settlement. One of these issues involves the phenomenon of dealing with large settlements of catastrophic liability cases for severely disabled children. In these cases, MSA professionals must be able to recognize the signs of impending Medicare eligibility as well as they have learned to recognize these signs as they pertain to disabled, working adult WC claimants and liability plaintiffs.

Where a liability settlement involves a disabled minor child, MSA professionals will need to consider whether either of the child's parents may currently qualify for RIB or SSDIB through Social Security. They should also consider whether either parent may have severe disability or health issues that may result in a premature death. Finally, they should consider whether amount of the settlement reasonably allocated to the plaintiff's future injury-related medical care and prescription drugs of the type normally covered by Medicare will be significant enough that the settlement may not be completely exhausted on these expenses before the child reaches the age where he or she may qualify for Medicare through CDB eligibility.

All of these factors weigh in the decision to recommend for or against the creation and funding of an MSA in the context of the settlement. It will be more likely that an MSA will be advisable where: the settlement is large; the child is closer to age 18; or one of the child's parents has died or qualifies for RIB or SSDIB benefits or is likely to in the foreseeable future. The weight to be give to each of these factors will depend upon the overall circumstances of each individual case. Therefore, the MSA practitioner will need to develop the ability to effectively and thoughtfully analyze these issues independently and in context each time.

When dealing with disabled children under age 18, it is also more likely than that the MSA practitioner will encounter eligibility issues regarding Supplemental Security Income (SSI) or Medicaid, simply because the rules governing these programs tend to make it easier for children to qualify than it does for adults. Both SSI and Medicaid are means tested benefit programs, so the receipt of a large liability settlement without proper planning could result in a loss of benefits. In such cases, it may be necessary for the MSA to be in the form of a Medicare Set-Aside Special Needs Trust to properly preserve all of the benefits to which the minor plaintiff may be entitled.

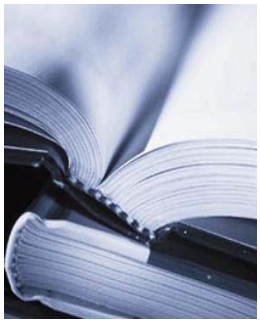
Conclusion:

As the MSA industry expands into the area of liability settlements, MSA professionals will find that they will encounter many new issues due to differences between WC and tort law, as well as differences in the demographics of the plaintiffs involved. How to properly deal with the unique public benefit issues arising in settlements involving disabled minors, as well as other issues unique to the liability area, such as comparative fault, tort damage caps and insurance policy limits, will be of vital importance.

The professionals who learn to understand and recognize these issues will be the leaders in the MSA field. They, in turn, will be the ones most instrumental in influencing CMS' development of policies and procedures governing the use of MSA's in liability settlements; and will likely be the ones that the settling parties turn to first to ensure that Medicare's interests, as well as those of the settling parties, are reasonably considered and properly protected. These will be the professionals who, when CMS finally does release official memoranda on policies and procedures for liability MSA's, will be able to say: "That's what I have been advising my clients to do all along."

Medicare will not pay for items or services that have been paid or can reasonably be expected to be paid by a WC plan or by automobile, liability or no-fault insurance plan.

"Both SSI and Medicaid are means tested benefit programs, so the receipt of a large liability settlement without proper planning could result in a loss of benefits."



Professionals who learn and recognize the issues will be the ones most instrumental in influencing CMS' development of policies and procedures.

Welcome New Members of the NAMSAP Board of Directors

Jon Gice

Jon Gice is the 2nd VP of the workers compensation major case unit at Travelers. An insurance executive with 30 years' experience, Gice previously held senior leadership positions at Royal & Sun Alliance, Managed Comp, Orion Capital, and the St. Paul Companies. In addition to having built and managed workers compensation claims and managed care programs, he has lead workplace health, safety, and underwriting efforts. He holds a Masters Degree in Rehabilitation Counseling from Southern Illinois University where he graduated cum laude. He holds insurance designations as a Chartered Property & Casualty Underwriter (CPCU), Associate in Risk Management (ARM, and Senior Claim Law Associate (SCLA). He also holds medical management related designations as a Certified Rehabilitation Counselor (CRC), Certified Disability Management Specialists (CDMS) and Medicare Set Aside Certified Consultant (MSCC). He is a frequent author in the Journal of Workers Compensation and other insurance publications. He is also a speaker on industry trends and topics such as Medicare, Chronic Pain, and Catastrophic Case Management at regional and national conferences.

Barbara Bate

Barbara Bate, RN, CCM, CNLCP, LNCC, MSCC is co-founder of Northeast Life Care Planning and specializes in the development of Life Care Plans, Medicare Set-Asides, Medical Cost Projections and Case Management. Barbara has over 25 years experience as a licensed registered nurse and holds national certifications in Nurse Life Care Planning, Legal Nurse Consulting, Case Management, and Medicare Set-Aside Consulting. Her experience includes providing medical case management services for patients with severe injuries such as traumatic brain injury, spinal cord injury, amputations, and orthopedic injuries for the past 14 years in addition to clinical work in the Operating Room, Pediatrics and Obstetrics.

Barbara is a graduate of Lankenau Hospital School of Nursing in Philadelphia, PA and is a member of the American Association of Nurse Life Care Planners (President-Elect 2009-AANLCP, Editorial Board for *Journal of Nurse Life Care Planning*), Case Management Society of America (CMSA), American Association of Legal Nurse Consultants (AALNC), American Nurse's Association (ANA), North American Nursing Diagnosis Association (Nanda-I), and a charter member of the National Alliance of Medicare Set-Aside Professionals (NAMSAP). She has been published and has presented at several conferences geared towards the medical-legal and insurance industry.

Barbara and her family reside in Holden, Maine and can be reached at (877) 854-5729 or bbate@nlcp.net.

NAMSAP Committee Meeting Updates

Ethics and Standards Committee:

The Ethics/Standards Committee is currently inactive, having accomplished their task of establishing a document on Ethics which was accepted by the Board of Directors. They have also completed a proposed document on Standards which has been submitted to the current board for review.

Membership Committee:

The Membership Committee reported that current membership for NAMSAP is 658 members, with 101 new members. Recently, the committee sent NAMSAP fliers to MSA training courses, contacted non-renewed members, and hand-carried NAMSAP brochures to a University of Florida continuing education conference. The Membership Committee is currently looking for NAMSAP members who plan on attending conferences and who are willing to hand-carry NAMSAP brochures to that conference. Please contact the NAMSAP office at (407)647-8839 to obtain the brochures.

Education Committee:

The Education Committee has announced that the Annual Conference will be held in Las Vegas, Nevada, on September 30, 2009, and October 1, 2009. Details have been released via the listserv and will be posted at www.namsap.org. In addition, the March 31, 2009, webinar was a great success. Additional webinars are in the planning stages and will be released in the near future.

Legislative Committee:

Henry M. Kohnlein has stepped down from the Legislative Committee. Benjamin M. Basista has been appointed the new Chairperson. Thank you both for your service!

Sponsorship and Partner Information

Platinum Sponsors

Crowe Paradis Services Corporation (CPSC) - CPSC is a national Medicare compliance company founded by a group of entrepreneurial attorneys with extensive experience in the group disability, liability, workers' compensation and health insurance markets. By combining a best practices legal and medical approach to the Medicare Secondary Payer compliance challenge, CPSC has become a trusted consultant and provider to many of the leading insurance carriers, TPA's, self-insured's and attorneys nationwide.

Gould & Lamb - At Gould & Lamb, our MSA team has extensive experience in legal, medical or workers' compensation disciplines. This experience allows us to consistently deliver the lowest defensible allocation that CMS will accept.

Medivest - Medivest professionally administers medical custodial accounts, provides premier MSA Allocations and other innovative solutions to preserve, protect and stretch settlement dollars in workers' compensation and liability disputes. www.medivest.com

PMSI - PMSI MSA services blend knowledge from in-house clinical, pharmacy and regulatory experts to deliver the lowest defendable MSA allocations. PMSI is an industry pioneer in best practices and new requirements impacting MSAs.

Protocols - Protocols is a multidisciplinary consulting firm that specializes in medical settlement planning for all parties involved in workers' compensation and personal injury liability cases -- from the simple to the complex. The Protocols team of experts - medical, benefits and legal - works together with clients to create a comprehensive plan for the projected medical care of an injured person. We also advise on the best and most cost-effective way to finance this care. Among Protocols specialty services are medical cost projections, life care planning and Medicare set-aside analysis, allocation and administration.

Gold Sponsors:
Experea Healthcare
MedAllocators, Inc.

Silver Sponsors:
The Center for Lien Resolution
The Center for Medicare Set-Aside Administration
The Center for Special Needs Trust
CompEx
MEDVAL, LLC
NuQuest/Bridge Pointe
Procura Management Inc.
Rising Medical Solutions

Announcements

Call for Articles:

Thank you to all who contributed to our first newsletter of 2009! The Communications Committee would like to extend an offering to all interested authors. We are currently receiving articles for the second quarter 2009 newsletter to be published in June. We currently have three categories for articles: Legal, Legislative, and Medical. If you are interested in contributing to one of these categories, or have an idea for a new category, please contact April Pettengill, Chairperson for the Communications Committee. You can contact April by email at april@alpmedicalconsultants.com, or call her at (802) 849-2956.

"Letters to the Editor":

In addition to contributing authors, every interested member is invited to send their "Letters to the Editor", or provide comments on articles that are published in the newsletter.

Educational Opportunities:

The NAMSAP Annual Conference is scheduled for September 30th through October 1st in Las Vegas, Nevada. This is always a great time to join other members and discuss updates and changes in the MSA industry.

If you know of other educational opportunities, please email April so we can provide those to the members of NAMSAP.

CMS Updates:

One of the primary goals of the Communications Committee is to provide updates on each CMS regional office. If you have an experience with a particular regional office of CMS, please submit those to April so we can share those with other members of NAMSAP.

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The mission of NAMSAP is to foster the highest standards of integrity and competence among Medicare Set-Aside Professionals and those they serve.

NAMSAP is the only non-profit association exclusively addressing the issues and challenges of the Medicare Secondary Payer Statute and its impact on workers' compensation and liability settlements. Through the voluntary efforts of our members, NAMSAP is a forum for the exchange of ideas and is a leading resource for information and news in this constantly evolving area of practice. The collective knowledge of our members and NAMSAP's resources will provide you with the ingredients essential to your success!