THE BEGLEY REPORT

USING MEDICARE SET-ASIDE ARRANGEMENTS IN THIRD PARTY LIABILITY CASES

By: Thomas D. Begley, Jr.

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Thomas D. Begley, Jr

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Medicare Set-Aside Arrangements (MSA) have long been used in the Workers' Compensation (WC) arena. Because of the enactment of the Medicare, Medicaid, and SCHIP Extension Act of 2007,[1] it appears that MSAs are now going to be required in third party liability cases. In some cases special needs trusts will be required in order to protect the injured plaintiff's public benefits, and an MSA will need to be incorporated in the trust.

THE LEGAL AUTHORITY FOR REQUIRING A MEDICARE SET-ASIDE ARRANGEMENT

♦ **Medicare Secondary Payer Act.** [2] The Medicare Secondary Payer Act (MSPA) gives the Centers for Medicare and Medicaid Services (CMS) the authority to require an MSA. Under the MSPA, Medicare is generally precluded from paying the beneficiary's medical expenses when "payment has been made or can reasonably be expected to be made under a workmens' compensation law or plan of the United States or a State or under an automobile or *liability* insurance policy or plan (including a self-insured plan) or under no-fault insurance."[3] For many years, WC insurers would settle a claim resulting in a burden to Medicare for future payments. Parties would calculate a dollar amount that would cover expected future medical costs and expenses related to the injured worker's claim. The settlement proceeds would then be conveyed to the claimant, who then turned to Medicare to pay for the on-going cost of injury-related care. The MSPA was enacted in 1980, but enforcement did not begin until 2001 with the issuance of the Patel memorandum on July 23, 2001.[4] Enforcement began and to date has largely, but not exclusively, been confined to WC cases.

Medicare payments are conditional on reimbursement from the primary payer.[5]

♦ **The Medicare Prescription Drug, Improvement, and Modernization Act 42 USC § 1395y(b)(2)(A) and (B).** The Medicare Prescription Drug, Improvement, and Modernization Act (MMA) amended the MSPA. The law expanded the definition of an insurance plan to include uninsured businesses and clarified when a primary plan's responsibility for reimbursement to Medicare begins. This amendment ensured that persons responsible for an insured to pay for medical care that Medicare would otherwise cover.

[1] 42 U.S.C. §1305, Medicare, Medicaid and SCHIP Extension Act of 2007.
[2] 42 U.S.C.§1395y(b)(2).
[3] 42 U.S.C. §1395y(b)(2)(A)(ii).
[4] Medicare Set-Aside Arrangements Transmittal (Patel Memo), July 23, 2001.
[5] 42 U.S.C. §1395y(b)(2)(B).

♦ **Medicare, Medicaid and SCHIP Extension Act of 2007.** Historically, CMS has primarily enforced the provisions of the MSPA only in WC cases. However, the passage of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA) requires all insurers, third party administrators for group health plans, self-insured plans, and self-administered plans to identify situations where the plan is or has been a primary plan to the Medicare program. There is a civil penalty of $1,000 per day for non-compliance. The plan shall determine whether a claimant is entitled to benefits under the Medicare program. If the claimant is determined to be so entitled, the plan must submit a report including the identity of the claimant and such other information as the secretary shall specify.

The report includes the contact information for the personal injury attorney. MMSEA clearly signals the intention of CMS to increase its enforcement in the liability settlement arena. It is likely that reporting enforcement activities for third party liability cases will be similar to those in WC settlements.

♦ **CMS Regional Coordinator Pronouncement.** According to Sally Stalcup, Region VI, MSP Regional Coordinator, CMS, "At this time, the Centers for Medicare and Medicaid Services (CMS) is not soliciting cases solely because of the language provided in the general Release. CMS does not review or sign-off on counsel's determination of the amount to be held to protect the Trust Fund in most cases. If we do, however, urge counsel to consider this issue in settling the case and recommend that their determination as to whether or not the case provided recovery funds for *future medicals* (emphasis added) be documented in their records. Should they determine that future services are funded, these dollars must be used to pay for future otherwise Medicare covered case-related services. There is generally no formal CMS review process in the liability arena as there is for WC. On rare occasions, when the liability is large enough or other unusual facts exist within the case, the CMS Regional Office will review the settlement and help make a determination on the amount to be available for future services."[6]

♦ **Anticipated Impact of the Medicare, Medicaid and SCHIP Extension Act of 2007.** The likely outcome of the reporting requirements of the MMSEA is that insurance companies will begin to require MSAs in third party liability cases. There is no reason for insurance companies to run the risk of failing to establish an MSA. In fact, in most instances, companies have already begun to do so.

THE THEORY BEHIND A MEDICARE SET-ASIDE ARRANGEMENT

♦ **Contrived Shift.** Under the MSPA, Medicare makes conditional payment for medical expenses for beneficiaries with the understanding that Medicare will be paid when the beneficiary receives payment from a third party. Medicare is opposed to any settlement that results in a contrived shift to Medicare of responsibilities of a claimant's future medical care. In settling claims, Medicare's interest must be considered. The solution to the problem of burden shifting is to establish an MSA. It is not fair for the plaintiff to collect for future medicals, pocket that money, and then send the bill for future medicals to Medicare.

♦ **Past and Future Medical Bills.** Medicare has a right of recovery for *past* medical bills up to the date of the settlement[7]. The MSPA also applies to third party liability situations in which the settlement or award includes payment for *future* medical expenses. Medicare is not bound by the Release with respect to an allocation for future medical expenses. If Medicare determines that the injured party will have future medical expenses then an MSA is expected.

LIABILITY FOR NON-COMPLIANCE

If a Medicare beneficiary fails to comply with the terms of the MPSEA, then Medicare will not pay for future treatment related to the

[6] Sally Stalcup, Region 6 MSP Regional Coordinator
[7] 42 U.S.C. §1395y(b)(2)(B)(ii); 42 CFR §411.24

injury. CMS may also elect to make payment, but to reduce the cost from the beneficiary's future SSDI or Railroad Retirement Disability (RRD) benefits. Either of these actions could result in a malpractice claim against the personal injury attorney.

Medicare has a right of action against a primary payer, and any entity that receives payment from a primary payer, if it has demonstrated that the primary payer has or had a responsibility to make payment.[8] Medicare is entitled to recover the amount of the Medicare primary payment.[9] If it is necessary for CMS to take legal action against the primary payer, CMS may recover twice the amount. The Regulation imposing double damages has been upheld.[10] The amount of the recovery is not limited to cases where the settlement proceeds, or part thereof, can be identified as being for items or services for which Medicare payment may be made. The Court noted that when a judgment is entered or an arbitration award is rendered and amounts are identified as being for medical expenses and/or pain and suffering, Medicare seeks reimbursement only from that portion of the judgment or award identified as for medical expenses. But, the Court also reasoned that nothing in the statute prohibits Medicare from recovering the full amount it has paid for any item or service. The Court concluded that Medicare beneficiaries who had received settlement payments from third-party payers, without any part of the settlements being identified as being for medical care, had failed to show that the government's practice of seeking recovery of such settlements violates the MSPA.[11]Recovery may be made from parties that receive primary payment including "a beneficiary, provider, supplier, physician, *attorney*, State agency or private insurer that has received a primary payment."[12]

[8] 42 CFR §411.22(a).
[9] 42 CFR §411.22(c).
[10] *Health Ins. Ass'n of Am v. Shalaa*, 23 F.3d 412, 306 U.S. App D.C. 104 (1994).
[11] *Id*.
[12] 42 CFR §411.24(g) (emphasis added).

WHEN IS AN MSA APPROPRIATE?

Under the terms of the MSPA, "Medicare's interest must be considered." An MSA is simply a safe harbor for considering Medicare's interest. There is an issue as to whether an MSA is required in third party liability cases. Both the New York and Philadelphia regions take the position that Medicare's interest must be considered in third party liability cases, but both acknowledge that neither region has the manpower to enforce the MSPA except on a random basis. With the advent of mandatory reporting in third party liability cases, which is already underway, it may become more stringent.

While the MSPA clearly establishes a requirement that Medicare's interest be considered in liability cases, there are no rules or regulations under the MSPA. There are rules in WC cases,[13] and the prudent course of action might be to follow those in liability cases. That would mean that an MSA is required if:[14]

- the settlement exceeds $25,000 and the claimant is currently eligible for Medicare; or
- the settlement is for more than $250,000, and the plaintiff can reasonably be expected to become eligible for Medicaid within 30 months.

[13] Medicare Set Aside Arrangements Transmittal (Patel Memo), July 23, 2001; Medicare Secondary Payer – Workers' Compensation (WC) Frequently Asked Questions; (undated) Thomas L. Grissom; Medicare Secondary Payer-Workers' Compensation (WC) Information May 7, 2004; Medicare Secondary Payer (MSP)-Workers' Compensation (WC) Additional Frequently Asked Questions, May 23, 2003; Medicare Secondary Payer (MSP) Workers' Compensation (WC) Additional Frequently Asked Questions, Oct. 15, 2004; Medicare Secondary Payer (MSP) Workers' Compensation (WC) Additional Frequently Asked Questions July 11, 2005; Part D and Workers' Compensation Medicare Set-Aside Arrangements Questions and Answers, Dec. 30, 2005; Workers' Compensation Medicare Set-Aside Arrangements (WCMSAs) and Revision of the Low Dollar Threshold for Medicare Beneficiaries, Oct. 25, 2006; Questions and Answers for Part D and Workers' Compensation Medicare-Set Aside Arrangements, July 24, 2006.
[14] Medicare Set Aside Arrangements Transmittal (Patel Memo), July 23, 2001.

If an individual is in the process of filing, appealing or re-filing for SSDI, that person is included in the 30-month window notwithstanding the fact that a previous application may have been denied and not appealed. An individual who is 62 years and 6 months of age could be eligible within 30 months, and an individual suffering from End-Stage Renal Disease (ESRD), but who does not yet qualify for Medicare based on ESRD, would also be considered a person having a "reasonable expectation" of Medicare enrollment within 30 months.[15]

In determining whether the $250,000 threshold is met, if there is a structured settlement the value of the structure rather than the cost is used. Also, in determining whether the $250,000 threshold is met, past medicals, future medicals, and attorneys' fees and costs are included.[16]

If none of these criteria are met, there is no need for an MSA. If it is absolutely clear that there will be no future medicals as a result of the injury subject to the litigation, then no MSA is required.

WHEN IS AN MSA NOT APPROPRIATE?

Even if an individual meets all of the criteria above, an MSA is not appropriate if all of the following three elements exist:

1. Settlement is only for past medicals; and
2. Settlement has not been manipulated to Medicare's detriment with respect to allocation; and
3. The treating physician issues a letter that no further treatment is required in connection with its claim.

[15] Medicare Secondary Payer-Workers' Compensation (WC) Frequently Asked Questions (2).
[16] Medicare Secondary Payer (MSP) Workers' Compensation (WC) Additional Frequently Asked Questions, May 23, 2003.

HOW IS THE SET-ASIDE AMOUNT DETERMINED?

There are companies that will calculate the set-aside amount. The amount is determined by evaluating past medical treatment, current medical condition, and the probability of future medical needs, as well as other factors. Future medicals are limited only to those expenses that Medicare would pay that are related to the injury. Medicare does not pay all medical expenses. There are some services that are not covered, including deductibles, copayments, and maximums per spell of illness. The MSA does not need to contain monies for those services that would not be covered by Medicare. In calculating the set-aside amount the plaintiff's life expectancy is considered. It is often useful to obtain a rated age as a part of this process. The rated age shows that a person's actual life expectancy may be considerably shorter than his or her actuarial life expectancy, thus less money is required to be set aside. The cost of future prescription drugs must also be considered in calculating the set-aside amount.

Once an MSA amount is calculated in a WC case, it is submitted to Medicare for approval. While CMS maintains that a set-aside is necessary in liability cases, there is no mechanism for approval at this time.

CMS is not bound by an allocation for future medicals made by the parties in the settlement agreement. CMS may disregard any such allocation and make its own calculation as to the cost of future medicals.

ADMINISTERING THE MSA

There are four possibilities for administering an MSA:

♦ **Self-Administered Accounts.** These accounts are usually small accounts and are administered by the claimant. No formal agreement is necessary. The claimant must follow the same accounting rules as a professional administrator, but it is likely that most claimants will not comply; however, the liability of the personal injury lawyer should terminate when the MSA is established.

♦ **Custodial Account.** A larger account is usually administered by a custodian. These are professional organizations that have expertise in medical claims administration. They charge a fee and are recommended where financially justified.

♦ **Special Needs Trusts.** A special needs trust is required if the plaintiff is receiving means-tested public benefits, such as SSI, Medicaid, food stamps, veterans' benefits, or Section 8 housing. In these cases, the MSA is wrapped in the special needs trust.

♦ **Pooled Trusts.** In smaller cases where the plaintiff is receiving any of these means-tested public benefits, a pooled trust may be considered. A pooled trust is operated by a non-profit organization. The plaintiff's money is pooled with other persons' money for investment purposes, but each member has an individual sub-account. Whenever a trust or a pooled trust is used, a sub-trust is established for the MSA funds.

	No Public Benefits	Public Benefits*
Small Settlement	Self-Administered	Pooled Trust
Large Settlement	Custodial Agreement/ Professional Administrator	Stand Alone Special Needs Trust

*NOTE: *As used above the term "public benefits" applies only to means-tested public benefits where there are financial eligibility rules pertaining to income and/or assets of the beneficiary and/or his or her family/ household. These benefits typically include SSI, Medicaid, veterans' benefits, Section 8 housing, and food stamps. For purposes of this chart, public benefits do not include SSDI and Medicare, but an MSA will always be required if the plaintiff is receiving or will receive these benefits.*

Typically, the custodian of the MSA issues a medical card, which the client uses to obtain medical services much like a private medical insurance or Medicare card. In pooled trusts or stand alone special needs trusts, the trustee generally retains the services of a professional administrator to administer the MSA subtrust. In this case, the professional administrator issues the medical insurance card.

♦ **Fees and Expenses.** Administrative fees/expenses for administration of the MSA and/or attorneys' costs specifically associated with establishing the MSA cannot be charged to the MSA. CMS will no longer evaluate the reasonableness of any of these costs because the payment of these costs must come from some other payment source, which is completely separate from the MSA funds.[17]

The All Regional Administrators (ARA) memorandum, which states that these costs cannot be include, replaces the policy that was outlined in the ARA memorandum issued July 23, 2001, commonly referred to as the Patel Memorandum, as well as the answer to question 7 from the April 21, 2003 publication of frequently asked questions.

The additional income tax due by virtue of interest income earned on an MSA account may be paid from the MSA assuming that there is adequate documentation for the amount of the incremental tax. Payment may be made as a "cost that is directly related to the account" to cover the additional tax liability.[18]

♦ **Presumption of Medicare Payments.** Medicare will not make any payments for any services related to the work-related injury or disease until the funds in the MSA have been exhausted.[19] The MSA is designed to pay all of the work-related injury expenses over the remaining lifetime of the injured claimant. Medicare will continue to pay for medical services on behalf of the injured claimant that are not related to the work-related injury or

[17] All Regional Administrators Memorandum dated May 7, 2004.
[18] Medicare Secondary Payer (MSP)—Workers' Compensation (WC) Additional Frequently Asked Questions, A6, July 11, 2005.
[19] CMS Memorandum, Medicare Secondary Payer - Workers' Compensation, Aug. 25, 2008.

disease. These expenses should not be paid from the MSA.

♦ **Non-Recognition of Waiver.** A claimant cannot waive his or her right to specific services related to a WC case in order to reduce the amount of the MSA.[20]

♦ **The Interplay Between MSA and Medicaid.** In the elder and disability law world, there is a significant issue as to the interplay between the MSA and Medicaid. Generally, the funds in the MSA are available and counted as resources for Medicaid eligibility purposes. In cases where Medicaid is important, the MSA must be wrapped in a self-settled special needs trust.[21]

PRESCRIPTION DRUGS

All WC and third party liability settlements must consider and protect Medicare's interest when future treatment includes prescription drugs along with future medical services that would otherwise be reimbursable by Medicare.[22] The submission for MSA approval must include separate amounts for (1) future medical treatments, and (2) future prescription drug treatment. In addition, the cover letter must include an explanation as to how the submitter calculated the future prescription drug treatment amount (e.g., actual costs, average wholesale price, etc.).[23]

In computing the total settlement amount, prescription drugs must be included if future treatment indicates the claimant has been prescribed drugs and/or may need drugs in the future. The total settlement amount includes, but is not limited to, wages, attorneys' fees, all future medical expenses, and repayment of any Medicare conditional payments. Payout totals for all annuities to fund the above expenses should be used instead of cost or present values of any annuities.

Claimants who have not enrolled in Part D need to include future prescription drug expenses in their MSA proposals, if the current treatment records indicate that the claimant has been prescribed drugs and/or may need future prescription drug treatment related to the injury.[24]

The administrator of the MSA must forward an annual accounting separately identifying the expenditures for medical treatment and prescription drug treatment to the Medicare contractor.[25]

SPECIAL NEEDS TRUSTS

If the plaintiff in a third party liability case is receiving means-tested public benefits, the existence of assets held in an MSA would disqualify the plaintiff from receiving those benefits. Assets in an MSA are available to the plaintiff. In order to protect the plaintiff's public benefits, a self-settled special needs trust must be established to include not only the settlement proceeds being paid to the plaintiff with disabilities, but also the amount of the set-aside arrangement. The trustee of the special needs trust typically retains the services of outside providers with expertise in the administration of MSAs. The trust document must contain language sufficient to satisfy CMS that the MSA is being properly administered. This includes language prohibiting the payment of fees and expenses from the MSA amount, a requirement that the proceeds of the MSA be invested, provisions for accounts to CMS for distributions, and limitations on the distributions that can be made from the MSA. In most cases involving an MSA of any size, it is funded in part by a structured settlement. It is important that

[20] Medicare Secondary Payer (MSP) - Workers' Compensation (WC) Additional Frequently Asked Questions, May 23, 2003.
[21] Medicare Secondary Payer (MSP) - Workers' Compensation (WC) Additional Frequently Asked Questions, Q13, July 11, 2005.
[22] CMS Memorandum Part D and Workers' Compensation Medicare Set-Aside Arrangements (WCMSAs) Questions and Answers (Dec. 30, 2005), Answer 1.
[23] CMS Memorandum Part D and Workers' Compensation Medicare Set-Aside Arrangements (WCMSAs) Questions and Answers (Dec. 30, 2005), Answer 2.
[24] CMS Memorandum: Questions and Answers for Part D and Workers' Compensation Medicare Set-Aside Arrangements (July 24, 2006), Answer 7.
[25] CMS Memorandum: Questions and Answers for Part D and Workers' Compensation Medicare Set-Aside Arrangements (July 24, 2006), Answer 8.

sufficient assets be set aside as seed money to cover the first two years of anticipated medical bills and/or the first surgery.[26]

In cases where the total recovery or settlements are small, it is more difficult to find a trustee with the expertise and the willingness to administer the MSA. In smaller settlements, a pooled trust is usually the best way to protect the plaintiff's means-tested public benefits, but most non-profit operators of pooled trusts lack the expertise to administer the MSA.

ALTERNATIVES AVAILABLE TO THE PERSONAL INJURY ATTORNEY

1. Do Nothing. Simply assume the risk that the MSPA will not be enforced.
2. Obtain an Indemnification from the Plaintiff and a Release. The Plaintiff's indemnification may have little value.
3. Buy a policy. Buy a private medical insurance policy to cover the Plaintiff's future medical requirements, if possible.
4. Calculate, but don't submit. Calculate the amount of the Medicare Set-Aside Arrangements, but do not submit it to CMS. This is the usual procedure in third party liability cases. The reason for not submitting is that CMS does not have the manpower to review it. If the case is ever audited, the personal injury attorney can point to the calculation and to the fact that CMS is not reviewing MSA submissions in third party liability cases.
5. Calculate and submit. Calculate the MSA amount and submit to CMS for approval. This seems to be a wasted step, since it simply generates a form letter indicating that CMS will not review the submission.

THE PROCESS

The process for calculating an MSA is to submit past medicals to a firm that does these calculations. The firm doing the calculation will obtain a rated age. Then, you should determine whether or not to submit the calculation to CMS.

FUNDING

Once the amount of the MSA has been determined, it must be funded by a lump sum equal to the first two years' medicals plus the first surgery and a set-up fee for the custodian. Thereafter, it makes sense to obtain a structured settlement for future medical payments and for annual administration fees to the professional custodian. On a typical case, the utilization of a structured settlement will reduce the cost of the MSA by roughly 50 percent.

CONCLUSION

Most plaintiffs in third party liability cases involving MSAs will not be receiving means-tested public benefits; however, there will be some plaintiffs who do receive public benefits. WC cases tend to result in smaller settlements, so a higher percentage of those cases are self-administered MSAs. Settlements in third party liability cases tend to be larger. It is likely that a higher percentage of third party liability cases will result in stand-alone special needs trusts.

Insurance companies are already beginning to require MSAs as a condition of settlement of a third party liability case. In most instances, the personal injury attorney agrees to the MSA if the conditions so warrant. In cases where the insurance company does not demand an MSA, the personal injury attorney must determine his or her tolerance for risk.

[26] Medicare Secondary Payer Act (MSP)-Workers Compensation (WC) Additionally Frequently Asked Questions, A-5, Oct. 15, 2004.

Quick Screen
Is a Medicare Set-Aside Arrangement (MSA) Required?

1. Is it anticipated that there will be future medical expenses relating to my client's injury?
   ☐ Yes ☐ No
2. Is my client a Medicare beneficiary?
   ☐ Yes ☐ No
3. Is my client receiving SSDI?
   ☐ Yes ☐ No
4. Is my client receiving RRD?
   ☐ Yes ☐ No
5. Has my client applied for SSDI or has my client applied and been denied, but anticipates appealing the decision?
   ☐ Yes ☐ No
6. Is my client in the process of appealing and/or refiling for SSDI benefits?
   ☐ Yes ☐ No
7. Is my client age 62.5 years or older?
   ☐ Yes ☐ No
8. Does my client have End State Renal Disease (ESRD) but does not yet qualify for Medicare based on ESRD?
   ☐ Yes ☐ No
9. Does my client have Amyotrophic Lateral Sclerosis (ALS or Lou Gehrig's disease) but does not yet qualify for Medicare based on ALS?
   ☐ Yes ☐ No

If the answer to question 1 is YES, and then the answer to any one of questions 2 through 9 is YES, then an MSA is required.

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