What Private and Public Resources Need to be Protected in Settling a Workers Compensation Claim?

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1) **Introduction**
   a) There are many issues involved when a working individual becomes disabled. There are usually multiple attorneys involved (the personal injury attorney, defense attorney, special needs attorney) and a myriad of complex regulations that govern everything from how settlements may be used, tax implications, and public benefits for the disabled individual. This article will explain common scenarios that arise in connection with a disabled individual who receives settlement in his or her favor.
   b) This article assumes that the practitioner is familiar with the basic eligibility requirements for Supplemental Security Income (SSI), Social Security Disability Income (SSDI), and Medicaid.
2) **Structured Settlements**
   a) A structured settlement (SS) is a "settlement in which the defendant agrees to make periodic payments to an injured plaintiff for a specified time. Commonly, such settlement consists of an initial lump-sum payment with future periodic payments funded with an annuity"[1]
      i) "An arrangement which is established by suit or agreement for the periodic payment of damages excludable from gross income of the recipient under section 104(a)(2) or an agreement for the periodic payment of compensation under any workers' compensation law excludable from the gross income of the recipient under section 104(a)(1) and under which the periodic payments are of the character described in subparagraphs (A) and (B) of section 130(c)(2) and payable by a person who is a party to the suit or agreement or to the workers' compensation claim or by a person who has assumed liability for such periodic payments under a qualified assignment in accordance with section 130."[2]
         (1) Qualified assignment means any assignment of liability of periodic payments as damages or workers' compensation if the assignment assumes liability from a person who is a party to the suit or agreement and if payments are fixed and determinable as to time and amount, payments cannot be accelerated, deferred, increased or decreased by recipient, the assignee's obligation is no greater than assignor's and payments are excludable under section 104(a)(1) or (2) then the recipient may have rights greater than a general creditor.[3]

[1] Black's Law Dictionary, 6th Ed.
[2] 26 U.S.C. § 5891(A)(i)-(ii) & (B)(i)-(ii).
[3] IRC § 130(c)(1)-(2).

ii) A SS is an innovative method of compensating injury victims. They have been encouraged since 1982 by the U.S. Congress and are a completely voluntary agreement between the injury victim and the defendant.[4]

iii) Using a SS, an injury victim does not receive compensation for his or her injuries in one lump sum; rather, he will receive a stream of tax-free payments tailored to meet future medical expenses and basic living needs.[5]

iv) A SS may be agreed to privately such as in a pre-trial settlement or it may be required by a court order.[6]

b) Transactions that create a SS include:[7]

i) claims resolved by suit or agreement

ii) a settlement agreement and release

iii) assignment of obligation. Here, the original obligor is released when future payment liability is transferred to the third party.

c) Qualified settlement fund

i) A qualified settlement fund (QSF) allows for immediate payment of proceeds by the defendant while preserving the options of the plaintiff without defense involvement.[8]

(1) A QSF must be established pursuant to an order of the United States or a state or territory.[9]

(2) Taxation issues

(a) The amount transferred is the basis and is not taxed. Earnings are taxed at the highest federal rate and applicable state rate.[10]

(b) Expenses, costs, and fees offset earnings.[11]

(c) Taxation to payee depends on application of IRC § 104(a)(2) or other exclusion such as return of property.[12]

(3) Constructive receipt and economic benefit issues

(a) Constructive receipt can be avoided.[13]

(b) Economic benefit is the theory under which the liability insurance industry seeks to prevent a QSF from making a qualified assignment under IRC § 130 when the QSF was established for a single claimant.[14]

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[4] Richard B. Risk, Jr., *Integrating a Structured Settlement With a Special Needs Trust Through a Qualified Settlement Fund*, Academy of Special Needs Planners Seminar, March 6, 2009.
[5] *Id.*
[6] *Id.*
[7] *Id.*
[8] *Id.* The statutory requirements for establishing a QSF can be found at 26 U.S.C. § 468B and 26 C.F.R. § 1.468B-1(c).
[9] 26 C.F.R. § 1.468B-1(c)(1).
[10] Risk.
[11] *Id.*
[12] *Id.*
[13] *Id.*
[14] *Id.*

(c) Whether or not constructive receipt or economic benefit attaches do not affect the status of the QSF, only whether IRC § 104(a)(2) damages may be structured and assigned.[15]

(d) The defendant receives a tax deduction under IRC § 461(h) whether or not funds are taxed to the claimant or if periodic payment liability is assigned.[16]

(4) QSF sequence of events[17]

(a) Phase one:

(i) Establish QSF

(ii) Appoint administrator

1. The role of the administrator includes submitting to jurisdiction or court or agency, is a party to any proceedings, must exercise independent judgment, may promise future payments and assign liability, sends the 1099s and files taxes

(iii) Obtain employer identification number

(iv) Settlement between claimants and defendants

(v) Receive funds

(b) Phase two:

(i) Settlement between claimant and QSF

(ii) May include periodic payments

(iii) Court approval if necessary, including authorization to distribute

(iv) Issue 1099 and file tax returns

3) **Life Care Plans**

a) A Life Care Plan (LCP) is a rehabilitation and medical needs analysis and has increased in popularity for outlining current and future needs as a method to assist with dispute resolution in the identification of damages associated with catastrophic injuries.[18]

b) The LCP is an organized method of identifying and addressing the comprehensive short and long-term needs of the injured party and his or her family.[19] In essence, it is a blueprint that provides the cost estimates of the injured party's needs.[20]

c) The tort is analyzed and the economic, physical, mental, and consequential damages are identified to defend against or substantiate a compensable injury.[21]

i) LCPs are frequently used by plaintiff's counsel to justify damages in personal injury, medical malpractice, and product liability cases.[22]

4) **Special Needs Trusts**

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[15] *Id.*
[16] *Id.*
[17] *Id.*
[18] Michele Whitmore, *Utilization of the Life Care Plan in Personal Injury Litigation: Case Evaluation and Funding Design in the Catastrophic Needs Case*, NeuroRehabilitation Journal, 1996.
[19] *Id.*
[20] *Id.*
[21] *Id.*
[22] *Id.*

a) The goal of SNTs is to hold funds for a disabled individual while keeping that person eligible for public benefits such as Medicaid and SSI
    i) To accomplish this goal, the SNT must be irrevocable and the trust corpus must not be available to the beneficiary, i.e. the beneficiary cannot direct or control the trust corpus or distributions from the trust.
    ii) These types of trusts can pay for the beneficiary's needs such as additional medical or dental care, vacations, guardian and trustee costs, and personal items
b) Types of SNTs
    i) First party SNT—aka "d4A Trust"
        (1) irrevocable
        (2) this type of SNT is funded with the beneficiary's own funds
        (3) established pursuant to 42 U.S.C. § 1396p(d)(4)(A).
            (a) statutory requirements:
                (i) individual must be under 65
                (ii) must be disabled pursuant to the SSA definition
                (iii) trust must be for the sole benefit of the beneficiary for his or her lifetime
                (iv) trust is established by beneficiary's parent, grandparent, guardian, or court order with the beneficiary's funds
                (v) trust must contain a provision stating that at the death of the grantor/beneficiary, the state has a priority claim against the remaining trust corpus for the value of all medical assistance provided to the beneficiary
    ii) Third party SNT
        (1) Irrevocable
        (2) Settler is not the beneficiary. Generally, this trust is most commonly seen where a parent or grandparent leaves money for the disabled beneficiary
        (3) Not subject to Medicaid liens
    iii) Pooled trusts—aka "d4(C) Trust"[23]
        (1) Irrevocable
        (2) This type of trust contains one master trust which holds all of the beneficiaries' funds for investment purposes, but each beneficiary's account is used solely for his or her own benefit.
            (a) To join a pooled trust, a beneficiary must execute a joinder agreement
            (b) If a beneficiary's sub-account runs out of funds, that beneficiary can draw upon the funds contained in the master trust
        (3) established pursuant to 42 U.S.C. § 1396p(d)(4)(C)
            (a) statutory requirements:
                (i) the master trust must be established by a non-profit organization

[23] The Springhill Housing Corporation Pooled Accounts Trust master trust and sample joinder agreement are attached as Exhibit 1.

(ii) each sub-account for each beneficiary must be managed solely for that beneficiary's benefit

(iii) the sub-account must be established by parent, grandparent, guardian, by court order, or by the beneficiary if competent

(iv) any remaining funds in the sub-account after a beneficiary's death must either be retained in the master trust for the use by other beneficiaries or if it is distributed, the amount distributed is first subject to a Medicaid lien for the amount that the state provided in medical care

5) **Issue to Be Aware of: Medicare Set Aside (MSA)**

a) A topic of concern among workers compensation and personal injury attorneys is the effect of settlements on a worker's Medicare benefits. Like SSDI (and therefore unlike SSI), Medicare is not a means-tested program. The wealthiest citizens may take advantage of this program, whereas its counterpart, Medicaid, is generally only available to the elderly and disabled who have low income and assets. However, due to the current and ongoing crisis with Medicare and concern for its future viability, the Centers for Medicare and Medicaid Services (CMS) has begun to aggressively pursue reimbursement for medical services provided to a worker who receives a large monetary settlement as a result of a work-related injury or personal injury suit. The worker's attorney may also be held liable under the new laws passed.

b) A MSA is an account which contains the first year of anticipated medical expenses in cash, with the remaining years' anticipated expenses paid into the account through the use of a structured settlement. If the MSA account is exhausted during that year, Medicare becomes the primary payer until the next payment is paid into the account.

i) A MSA can be used to pay a provider so long as two criteria are met:

(1) the medical treatment or service must be injury related, and

(2) it must be a Medicare allowable expense.

c) How to set up a MSA

i) There are many private companies that specialize in the calculation of the amount of assets to be segregated and administration of these accounts.

(1) Medivest is a full-service company that will handle both, in addition to preparing a MSA allocation report which must be submitted to CMS for approval. If the MSA is depleted, they will contact CMS to ensure that Medicare becomes the primary payer for future medical expenses.

d) What is a Medical Custodial Account (MCA)?

i) A MCA is an account which contains funds that are not required to be set-aside in a MSA and is designed to meet an individual's needs which to not meet the criteria for a MSA. This makes MCAs more flexible than MSAs. A MCA can be set up at the same time as a MSA and can be administered by a private company such as Medivest.[24]

[24] A sample MCA from Medivest with supporting materials is attached at Exhibit 2.

ii) Concerns that should be addressed relating to MCAs
    (1) Can payment terns be changed or amended?
    (2) What happens if there is a marriage or divorce?
    (3) Is it insulated from creditors?
    (4) What are the fees for using private companies to administer a MCA or MSA?

e) How to identify potential MSA issues:
    i) You should always be on alert for this issue when an individual who requires extensive medical care due to an accident receives a settlement, either from worker's compensation or a personal injury suit and becomes eligible for Medicare.
    ii) Example: You have a client who is disabled as a result of a vehicle accident. Assume that the SSA has determined her permanently disabled. She receives $1 million in subsequent personal injury settlement. The ad litem attorney asks you if the cash settlement will jeopardize the client's eligibility for Medicare benefits. Client is now eligible for both SSDI and Medicare. The client does not have any private health insurance coverage and due to the client's resources is not eligible for Medicaid or other means-tested programs, so it is crucial that the client maintains Medicare coverage for future medical expenses. Based upon the foregoing facts, you quickly advise the ad litem that since SSDI and Medicare are entitlement programs, there is absolutely no problem with the client accepting the $1 million cash settlement amount and the client may spend or invest the funds as the client pleases.[25]
        (1) If that is your advice, you have just given some bad advice that may give rise to the loss of Medicare benefits for the disabled individual.[26]
        (2) It is the position of the CMS is that a portion of the personal injury recovery is awarded for future medical expenses of the disabled plaintiff. In the example above, if a reasonable determination of the amount awarded for future medical services (including prescriptions, doctors' bills, hospital costs, and other items normally paid by Medicare) is not made and set aside in a separate MSA account, then the entire settlement must be expended on medical costs for the client, even though such expenses are normally covered by Medicare, before Medicare benefits will again be available to the client.[27]

f) When to be concerned and what to do
    i) Whenever a client receives a large settlement from worker's compensation or personal injury suit and it is foreseeable that the client will require ongoing medical treatment, this issue may come into play.[28]
    ii) You should do the following:[29]

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[25] Ronald R. Cresswell, *What You Need to Know About the New Medicare Set Aside Rules and their Impact on SNTs*, February 2009, University of Texas Law School.
[26] *Id.*
[27] *Id.*
[28] *Id.*
[29] *Id.*

(1) Gather the facts as to the client's medical condition and public benefit eligibility,
(2) Analyze whether client needs to maintain eligibility for either Medicare or Medicaid
(3) If Medicare is necessary, determine if a MSA is required
    (a) Does the recover encompass payment for future medical services and has Medicare paid in the past (or be expected in the future to pay) for medical expenses for injuries related to the incident that gave rise to the lawsuit? If so, advise to pay any Medicare subrogation claim from the settlement proceeds. Also, establish a MSA.
(4) Determine if client is Medicaid eligible and if so, consider using a standard SNT and forgo Medicare altogether. This will eliminate the MSA worry.
(5) If both Medicare and Medicaid are needed, then draft a MSA into the SNT, as will be discussed below.
(6) If MSA is needed but there is insufficient time to make a reasonable determination as to the allocation of amount of future recovery, it may be necessary to utilize 468B qualified settlement fund.
(7) Discourage the personal injury attorney and/or client to use a self-administered MSA. Also, recommend that an independent consultant, such as Medivest, be used to analyze the proper MSA amount. This should also be recommended to the trustee of either the SNT or MSA, whichever is applicable.
(8) Consider whether a structured settlement would be beneficial based on the first few years of treatment.
(9) Recommend annual accounting of expenses to the CMS.
(10) Document all advice given to client or attorney in writing.

g) Background
    i) Pursuant to 42 U.S.C.§ 1395y[30], Medicare is a secondary payer for any medical services for which payments have been made or which can reasonably expected to be made under a workmen's compensation law or a federal or state plan or under another plan such as automobile or liability insurance policy or insured or self-insured plan or under no-fault insurance.
        (1) 42 U.S.C. § 1395y(2)(A) provides that "[p]ayment under this subchapter may not be made, except as provided in subparagraph (B), with respect to any item or service to the extent that . . . payment has been made or can be reasonably be expected to be 'made under a workmen's compensation law or plan of the United States or a State or under an automobile or liability insurance policy or plan (including self-insured plan) or under no fault insurance . . ."
    ii) CMS is the federal agency which administers the Medicare program. Historically, CMS focused its efforts to protect Medicare's secondary payer status in the

[30] See Exhibit 3.

workmen's compensation arena.[31] For example, in connection with a worker's compensation claim, CMS considers the worker's compensation carrier as the primary payer with respect to the injured worker's future medical expenses.[32] Consequently, CMS requires that once a worker's compensation award is determined, then a calculation must be made as to the portion of the award that is attributable to the future medical expenses of the injured worker.[33] In order to protect Medicare's interest as a secondary payer, CMS requires that the portion of the award which constitutes payment by the worker's compensation carrier (as the primary payer) for future medical expenses must be set aside in a separate MSA trust or account.[34] The funds segregated in the MSA must be exhausted in payment of Medicare covered medical expenses for the injured worker that are related to what was claimed or released in the worker's compensation settlement before Medicare will be responsible for payment of the injured worker's medical expenses.[35]

iii) The CMS position with respect to the MSA concept is expressed in the Medicare regulations and Medicare manuals as follows:

(1) Medicare regulations at 42 CFR § 411.46 states that "[i]f a lump-sum compensation award stipulates that the amount paid is intended to compensate the individual for all future medical expenses required because of the work related inquiry or disease, Medicare payments for such services are excluded until medical expenses related to the injury or disease equal the amount of the lump sum payment."[36]

(2) Medicare Manuals, § 3407.8 of the MIM, § 2370.8 of the MCM states that "[w]hen a beneficiary accepts a lump-sum payment that represents a commutation of all future medical expenses and disability benefits, and the lump-sum amount is reasonable considering the future medical services that can be anticipated for the condition, Medicare does not pay for any items or services directly related to the injury or illness for which the commutation lump-sum is made until the beneficiary presents medical bills related to the injury equal to the amount of the lump sum settlement allocated to medical treatment."

g) MSAs outside of the worker compensation arena

i) Application of MSAs to personal injury cases

(1) CMS now takes the position that the Medicare Secondary Payer Act requires that a MSA be established in the case of judgments and settlement awards in personal injury cases which do not involve worker's compensation claims.[37] The specific

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[31] Cresswell.
[32] *Id.*
[33] *Id.*
[34] *Id.*
[35] *Id.*
[36] See Exhibit 4 for the Medicare Secondary Payer Regulations.
[37] Cresswell.

statutory authority which CMS relies upon for its position is the following language found in 42 U.S.C. § 1395y(b)(2)(A):[38]

(a) "Payment under this subchapter may not be made, . . . , with respect to any item or service to the extent that . . . (ii) payment has been made or can reasonably be expected to be made under a workmen's 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**." Emphasis added.

(2) Sally Stalcup, MSP Regional Coordinator for Region 6 in Dallas, Texas stated on page 14 of this Special Needs Trust Conference held on February 15-16, 2007, the following CMS position:[39]

(a) "Any time a settlement, judgment or award provides funds for future medical services, it can reasonably be expected that those funds are available to pay for **Medicare covered** future services **related to what was claimed and/or released in the settlement, judgment, or award."** Emphasis added.

(3) Thus, when a liability carrier in a traditional personal injury case pays a judgment amount or a settlement amount to the plaintiff in a personal injury case, CMS requires that a calculation be made as to the portion of the award which constitutes payment of the future medical expenses of the insured plaintiff.[40] The MSA must then be funded with the amount of future medical expenses that Medicare would normally cover to the extent that the award for future medical services is related to the claims released in the personal injury case.[41]

ii) CMS memoranda

(1) CMS has issued ten memoranda since July 23, 2001 giving guidance to its Medicare Regional Offices pertaining to various issues relating to Medicare set-aside arrangements.[42] Unfortunately, the existing CMS memoranda only address MSAs in the context of workmen's compensation cases.[43] CMS intends to issue a new memorandum dealing with the implementation of MSA's in personal injury cases.[44] The CMS memoranda do not constitute law; however, Medicare employees do rely on the CMS memoranda as authoritative as to the agency's policies much as Social Security employees rely heavily on the POMS. From the standpoint of the practitioner, the CMS memoranda are helpful in understanding the position of CMS as to various MSA issues.[45]

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[38] *Id.*
[39] *Id.*
[40] *Id.*
[41] *Id.*
[42] *Id.*
[43] *Id.*
[44] *Id.*
[45] See Exhibit 5.

(2) Brief highlights of the memoranda are as follows:[46]

(a) In workmen's compensation cases, Medicare will consider a review of the proposed MSA arrangement provided that the following minimum review criteria are satisfied:

(i) As to injured claimants who are not yet eligible for Medicare, the CMS minimum review standard requires that the claimant must have a "reasonable expectation" of Medicare enrollment within 30 months of the settlement date and the total settlement amount must be greater than $250,000.00. CMS Memorandum dated July 23, 2001.

(ii) As to injured claimants who are currently Medicare eligible, the CMS minimum review standard requires that the total settlement amount is in excess of $25,000.00. CMS Memorandum dated April 25, 2006.

(b) Settlements which make an express allocation of the gross settlement amount for various categories (such as, lost wages, pre-settlement medical expenses, pain and suffering, future medical expenses, etc.) are not binding upon the Medicare agency. If the settlement designations do not protect Medicare's interests, Medicare may require that the entire gross settlement amount be exhausted in payment of the claimant's future medical expenses before the claimant will again be eligible for Medicare benefits. CMS Memorandum dated April 22, 2003.

(c) The estimated time period for a MSA review determination is 45 to 60 days from the time all necessary documentation is submitted. CMS Memorandum dated April 22, 2003.

(d) The funds set aside in the MSA arrangement must be used exclusively for the claimant's future Medicare covered medical expenses. Attorneys' fees, administrative fees and other expenses cannot be paid from the MSA. CMS Memorandum dated April 22, 2003.

(e) A claimant may self administer the claimant's own MSA arrangement. CMS Memorandum dated April 22, 2003.

(f) CMS has no formal appeals process for rejection of a MSA proposal. However, CMS will consider additional information and documentation submitted by the claimant whose MSA has been denied to determine if such additional information justifies the MSA proposal. The only remedy available to a claimant following a final rejection of a MSA proposal is an appeal from a rejection of a particular claim. CMS Memoranda dated April 22, 2003 and July 11, 2005.

(g) In determining the funding of the MSA, the MSA amount does not need to be indexed for inflation and such amount may not be discounted to present day value. CMS Memorandum dated October 15, 2004.

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[46] Cresswell.

(h) A MSA may be funded in part with a structured settlement annuity. The seed money for the MSA must consist of a cash sum equal to the claimant's first surgery and two years of annual payments. The remaining amount of the approved funds for the MSA should be divided by the number of years of claimant's life expectancy. Annual periodic payments may then be made in an amount equal to each annual MSA funding amount. For example, if a structured MSA annual periodic payment is scheduled to pay $20,000 per year for ten years, then Medicare would pay covered expenses in any given year after the $20,000 is exhausted. On the other hand, if the entire $20,000 is not fully spent on covered expenses in any given year, the unused annual payment amount is carried forward into the next year and added to the annual MSA amount for such subsequent year. CMS Memoranda dated April 22, 2003 and October 15, 2004.

(i) A MSA account which is not embedded in a special needs trust ("SNT") is a countable nonexempt resource for Medicaid purposes. Thus, if it is important to maintain the claimant's Medicaid eligibility, the MSA account should be a separate subaccount of a SNT. CMS Memorandum dated July 11, 2005.

h) Enforcing Medicare's rights

i) Enforcement provisions to protect Medicare's interests

(1) Example[47]: Plaintiff A was severely injured in a vehicular rollover accident and files suit against the manufacturer of his vehicle and others. The Social Security Administration determines that Plaintiff A is permanently disabled. Plaintiff A begins receiving SSDI payments and Plaintiff A becomes eligible for Medicare 24 months after receiving his first SSDI payment. Four years after the lawsuit was filed, Plaintiff A receives a very sizable lump sum cash settlement. Issue: Is there a duty to reimburse Medicare for the medical expenses paid by Medicare for the benefit of Plaintiff A prior to the receipt by Plaintiff A of the cash settlement?

(a) The answer is yes.[48] Medicare is entitled to recover from Plaintiff A the amount of the medical expenses which Medicare furnished to the extent that such Medicare payments relate to injuries arising from the incident that gave rise to the personal injury lawsuit.[49] This statutory right of subrogation is also sometimes referred to as the Medicare "Super Lien" since Medicare's statutory subrogation rights are superior to and take priority over other common law rights of subrogation.[50] The Medicare Prescription Drug, Improvement and Modernization Act of 2003 expanded the group of individuals and entities who have an obligation to reimburse Medicare for conditional payments to include a primary plan (group health plan, liability insurance policy, self-

[47] *Id.*
[48] *Id.*
[49] 42 U.S.C. § 1395v.(b)(2)(B)(I), §1396K(a)(l)(C), § 2651; 42 C.F.R. § 411.24(2)(h).
[50] Zinman v. Shalala, 67 F.3d 841, 844 (9th Cir. 1993).

insured plan, etc.) such as an individual or entity that receives payment from a primary plan (e.g., an attorney who receives funds from an automobile policy or other liability insurance policy).[51] If the Medicare subrogation claim is not paid following a case settlement or judgment, Medicare has a statutory right to recover double its claim.[52] Medicare has authority to waive its subrogation claim if waiver is in the best interest of the Medicare secondary payer program or in the case of financial hardship.[53]

ii) Medicare's enforcement powers pertaining to recoveries for future medical expenses

(1) Based upon the provisions of the Medicare Secondary Payer statute, CMS takes the position that in liability cases such as personal injury cases involving claims against tortfeasors who are covered by an automobile policy, a liability insurance carrier, no-fault insurance, or a self-insured plan, a MSA must be established and funded with a "reasonable allocation" of the gross settlement or judgment amount for future medical expenses.[54] CMS has not established a formal review procedure for MSA funding determinations outside of the workmen's compensation arena.[55] Moreover, the only published guidance promulgated by CMS as to MSA issues consists of the workmen's compensation MSA guidelines found in the CMS memorandum attached as Exhibit 5.

(2) The CMS position is that there is a duty to establish a MSA to protect Medicare's secondary payer status whenever a settlement or judgment involving a recovery for future medical expenses occurs.[56] Thus, there is an obligation on the part of attorneys and other advisors involved in personal injury recoveries to advise clients of the MSA requirements.[57] The consequences of failure to establish and fund a MSA arrangement are clearly undesirable:

(a) If the plaintiff in a liability case obtains a recovery and fails to establish a MSA, Medicare will consider the entire settlement or judgment amount (after deduction for payment of Medicare's subrogation claim for pre-settlement or pre-judgment conditional payments made by Medicare for plaintiff's injury related medical expenses) to be entirely for future medical expenses.[58] Therefore, where no MSA is established, Medicare will not pay any medical expenses until the entire settlement amount is exhausted by payment for Medicare covered future medical expenses.[59] It is therefore advisable to establish a MSA arrangement to reduce the amount of future medical

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[51] Cresswell. See also Medicare Modification Act, Pub. L. No. 108-173, 117 Stat. 2066 (2003).
[52] Cresswell. See also 42 U.S.C. § 1395y(b)(3)(A); 42 C.F.R. § 441.24(c)(2).
[53] Cresswell. See also 42 U.S.C. § 1395y(b)(2)(B)(iv); 42 U.S.C. § 3404(b); 20 C.F.R. § 404.507.
[54] Cresswell. See also 42 C.F.R. § 411.46(d)(2).
[55] Cresswell.
[56] *Id.*
[57] *Id.*
[58] *Id.*
[59] *Id.*

expenses required to be paid before Medicare benefits are again available.[60] Even in cases where the settlement documents allocate the plaintiff's recovery among lost wages, pain and suffering, attorneys' fees and future medical expenses, if the allocation does not adequately consider and protect Medicare's interests, the allocation will not be binding upon CMS.[61] .

(b) As discussed above, the Medicare Prescription Drug Improvement Act enacted in 2003 expanded Medicare's recovery rights and clarified its enforcement powers by amending the Medicare Secondary Payer Act.[62] CMS has a right to seek recovery "against any entity, including a beneficiary, provider, supplier, physician, attorney, state agency, or private insurer that has received any portion of the third-party payment directly or indirectly" if such third party funds (as opposed to Medicare) should have covered injury related medical expenses.[63] .

(i) Previously, there was a question as to whether the plaintiff, his legal counsel and other advisors are exposed to liability under this statute for failure to establish a MSA account to protect Medicare's interest as a secondary payer with respect to the future medical expenses of the plaintiff.[64]

(ii) However, recently the Northern District for West Virginia decided that an attorney was liable.[65]

(iii) This issue requires careful consideration since CMS has the power under the statute to seek double damages plus interest and prosecution by the Department of Justice.[66]

iii) How will Medicare know?

(1) Section III of the Medicare, Medicaid and SCHIP Extension Act of 2007 amends the Medicare Secondary Payer Act to provide for mandatory reporting of payments made after a claim is resolved through a settlement, judgment, award or other payment[67]. The obligation to report is imposed upon group health plan arrangements, liability insurance (including self insurance), no fault insurance and

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[60] *Id.*

[61] Cresswell However, compare this to the U.S. Court's decision in *Ahlborn v. Arkansas Department of Health and Human Services, et al.*, 547 U.S. 268 (2006) which upheld the need to attempt to obtain CMS approval of the amount allocated to the MSA for future medical expenses.

[62] Cresswell.

[63] Cresswell. See also 42 U.S.C. §1395y(b)(2)(ii). Compare *Thompson v. Goetzmann*, 337 F.3d 489 (C.A 5, 2003) where the government did sue an attorney under the Medicare Secondary Payer Statute. It is clear that liability arises under this statute with respect to individuals and entities who fail to arrange for payment of Medicare's subrogation claims for conditional payments made by Medicare prior to the plaintiff's recovery.

[64] Cresswell.

[65] *US v. Harris*, Case No. 5:08CV102 (N.D.W.V. Nov. 13, 2008).

[66] John J. Campbell, *Medicare Set-Aside Arrangements in Workers' Compensation & Liability Settlements*, 2009.

[67] Cresswell.

worker's compensation plans.[68] If one of those insurers determines that a claimant is entitled to Medicare benefits "on any basis," the insurer is required to submit to the Secretary of Health and Human Services the identity of the claimant and such other information as Medicare deems necessary in order to enable a determination of coordination of benefits, including any Medicare recovery claim.[69] Insurers who fail to comply with this reporting requirement are subject to a civil penalty of $1,000 per day for each day of noncompliance.[70] Congress has authorized $35 million in funding from the Federal Hospital and Supplementary Medical Insurance Trust Funds for CMS to implement these provisions.[71] The reporting requirements went into effect on January 1, 2009.[72]

i) MSAs and SNTs

i) The impact of MSAs on SNTs

(1) MSA outside of an SNT is a countable resource for SSI and Medicaid

(a) A MSA arrangement outside of a special needs trust is a countable nonexempt resource for Medicaid eligibility purposes.[73] Consequently, establishing a separate account or a Medicare set-aside trust will likely disqualify the claimant from Medicaid benefits unless a MSA subaccount is included in the governing trust agreement for the SNT.[74] In view of this issue, it is important for the claimant's legal counsel and other advisors to analyze whether it is important for the claimant to maintain Medicaid eligibility.[75] If so, the SNT provisions should include a MSA subaccount.[76]

(2) Suggestions for drafting a MSA provision into a SNT

(a) The SNT draftsperson should consider the inclusion of the following MSA subaccount provisions in the governing trust document for the SNT:

(i) Instruct the Trustee to establish a separate MSA subaccount, which subaccount will be considered to be a part of the SNT assets.[77]

(ii) The Trustee should be required to make "authorized MSA payments" from the net income and/or corpus of the MSA subaccount directly to the third party providers of goods and services for the beneficiary.[78] The term "authorized MSA payments" should be carefully defined to include only medical expenses of the beneficiary which (a) ordinarily would be covered and paid by Medicare; and (b) relate to the medical needs of the

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[68] *Id.*
[69] Cresswell. See also 42 U.S.C. § 1395y(b)(8).
[70] Cresswell.
[71] *Id.*
[72] *Id.*
[73] *Id.*
[74] *Id.*
[75] *Id.*
[76] *Id.*
[77] *Id.*
[78] *Id.*

beneficiary resulting from the incident that gave rise to the personal injury claim and/or lawsuit.[79]

(iii) Authorize the Trustee to employ an outside firm that specializes in reviewing medical bills to determine whether the medical expenses of the beneficiary submitted to the Trustee ordinarily qualify for Medicare coverage and are related to the injury which gave rise to the beneficiary's personal injury recovery; corporate trustees will not want the responsibility of making this determination and will likely employ an outside expert consulting firm for this expertise.[80]

(iv) Require the Trustee to invest the funds held in the MSA subaccount in investments which have no risk of loss of value.[81]

(v) Expressly prohibit the Trustee from making any distributions from the assets held in the MSA subaccount other than the Medicare covered injury related medical expenses which come within the definition of "authorized MSA payments."[82] For example, trustee fees and other administrative expenses of the MSA (including the cost of an outside consulting firm) must be paid from the non-MSA portion of the SNT assets.[83]

(vi) Provide that the Trustee shall keep accurate records of all payments from the MSA subaccount and shall provide annual accountings of the activity of the MSA subaccount to Medicare.[84] This reporting requirement should also include a report by the Trustee to Medicare in any particular year when the MSA allocation for that year has been exhausted and when the entire MSA subaccount has been exhausted so that Medicare can commence payment of covered medical expenses of the beneficiary.[85]

(vii) The MSA subaccount provisions should contain broad exculpatory provisions to protect the Trustee because the Trustee cannot be expected to be an expert in making an appropriate allocation as to the portion of a recovery that constitutes payment for future medical expenses.[86] Moreover, the Trustee may not be an expert in items that Medicare normally covers and the Trustee should be able to rely upon outside experts for these determinations.[87]

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[79] *Id.*
[80] *Id.*
[81] *Id.*
[82] *Id.*
[83] *Id.*
[84] *Id.*
[85] *Id.*
[86] *Id.*
[87] *Id.*

(viii) Upon the death of the SNT beneficiary, the funds remaining in the MSA subaccount must expressly be subject to the payback provision.[88] However, care providers have 27 months following the death of the Beneficiary to submit their claims against the MSA subaccount.[89] Consequently, the payback from the remaining MSA subaccount funds should be made following the expiration of 27 months.[90]

5) **Other Issues**

a) ERISA Plan Care can recover benefits from special needs trusts

i) Federal courts are permitting ERISA plans to recover the benefits they paid on account of injuries arising through the fault of some third party from tort settlement or judgment proceeds that are set up in special needs trusts.[91] Those are usually designed to provide resources to pay for ongoing care when an individual's injuries are so severe that he or she will need professional care either for the remainder of his or her life or for an indefinite period.[92]

ii) In the absence of such a resource, individuals will be cared for through state programs such as Medicaid in most cases. When a tort settlement or judgment is substantial, the SNT can provide some or all of the required care. Or, a SNT might be used to provide some amenities such as TV, movies, clothing, private insurance or caregivers, or other respites for the injured party.

iii) However, with well-drafted subrogation and reimbursement provisions, self-funded ERISA plans can obtain what amounts to a first lien against the tort settlement proceeds, thereby reimbursing the plan for the benefits it advanced before the resolution of a tort settlement or judgment, but leaving the individual with no resources except for what the state or charity will provide.[93]

(1) In *Mutual of Omaha Insurance Co. v. Estate of Arachikavitz,*[94] Anthony Arachikavitz was seriously injured while he treated in a hospital. He was covered under a group health plan subject to ERISA administered by Mutual of Omaha, which paid about $1 million on account of his medical expenses arising from his injuries before his death in 2005. His lawsuit for damages on account of his injuries exceeded the $1 million paid, but not by much. After his death, but before the proceeds were distributed, Mutual of Omaha brought an action to recover the benefits it paid and moved for summary judgment. The plan clearly provided for reimbursement of benefits from tort settlement or judgment proceeds, and specifically stated that it was entitled to reimbursement regardless of whether or

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[88] *Id.*
[89] *Id.*
[90] *Id.*
[91] Adam V. Russo, a*vailable at* http://www.passionforsubro.com/federal-circuits/9th/erisa-plan-can-recover-benefits-from-special-needs-trust/
[92] *Id.*
[93] *Id.*
[94] 2007 WL 2788604 (Nev., Sept. 21, 2007).

not the plan participant was made whole by the settlement, and without regard to sharing of attorney's fees.[95]

(2) The Court granted the motion for summary judgment. It ruled that the assets in question were specifically identifiable as related to the matter for which Mutual of Omaha paid health benefits, and thus the claim was for equitable relief.[96] The 9th U.S. Circuit Court of Appeals had previously held that such recoveries were not available because it viewed such actions to be legal rather than equitable, but the U.S. Supreme Court overruled that doctrine in its *Sereboff*[97] decision.[98] Although the district court had no guidance on the law from the 9th Circuit, it had guidance from decisions in other circuits, and so upheld the right of the plan to recover the almost $1 million it paid from those proceeds regardless of the fact that they would have been held by the special needs trust had there been no right of recovery for the plan.[99]

(3) Having reimbursed the plan, there was approximately $50,000 available to the special needs trust.[100] However, the attorneys for the SNT that paid the settlement sought reimbursement of its legal fees amounting to about $21,580.[101] The court ruled that the SNT simply was required to bring an action for interpleader, the appropriate remedy for a stakeholder that held money or assets claimed by rival parties, in this case, Mutual and the SNT.[102] The court noted that in such cases, attorneys have relatively little to do other than bring the rival claimants together in court, deposit the money it has into a court trust and seek a discharge of its liability to all claimants. In this case, the entity supported the arguments of the special needs trust and was involved in a state court action before the filing of the lawsuit by Mutual in federal court.[103] The court ruled that the entity was entitled only to fees related to the interpleader in federal court, and reduced the award of attorney's fees to $5,000.[104]

(4) This decision is consistent with previous court decisions in other circuits and there is no reason to believe that the 9th Circuit will disagree with it.[105] Medical plans with well-drafted reimbursement provisions are entitled to full reimbursement of the benefits paid regardless of the insufficiency of tort settlement proceeds to fully compensate the plan participant for all consequences of the injuries incurred.[106]

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[95] Russo.
[96] *Id.*
[97] *Sereboff v. Mid Atlantic Medical Services, Inc.*, 547 U.S. 356 (2006).
[98] Russo.
[99] *Id.*
[100] *Id.*
[101] *Id.*
[102] *Id.*
[103] *Id.*
[104] *Id.*
[105] *Id.*
[106] *Id.*

Until the law is changed, the issue appears to be settled.[107] The *Arachikavitz* decision reached the same result as *Administrative Committee of the Wal-Mart Stores, Inc. Associates' Health and Welfare Plan v. Shank*, 2007 WL 2457664, (8th Cir., 2007), namely, that under the terms of well-drafted plan subrogation and reimbursement provisions, the plan's right to reimbursement reaches funds deposited in special purpose trusts, even if that leaves a plan participant without funds for future medical or custodial care.[108]

[107] *Id.*
[108] *Id.*