

MEDICARE SET-ASIDES

Co-Presenters

Pi-Yi Mayo
Sally Stalcup

2007 Changes and Trends Affecting
Special Needs Trusts

February 15 - 16, 2007
Radisson Hotel & Suites
Austin, Texas

TABLE OF CONTENTS

I.	Introduction	page 3
II.	What is a WCMSA and What does it do?	page 4
III.	MSA's as SNT's	page 6
IV.	Unresolved Issues	page 7
Exhibit "A"	E-mail from Sally Stalcup addressing the position of CMS on Medicare Set aside trusts	
Exhibit "B"	Sample Submission of a Proposal to WCMSA	

I. Introduction

Several years ago the Center for Medicare and Medicaid Services (CMS) published a memo outlining the policies and procedures for dealing with something they referred to as Workers' Compensation Medicare Set-Aside Arrangements (WCMSA). The first memo was published in July of 2001, and has been followed since that time by eight more memoranda that include various types of information and guidance for both agency personnel and attorneys in handling claims stemming from Workers' Compensation (WC) claim matters. These memos can be found on the CMS website at [http://www.cms.hhs.gov/WorkersCompAgencyServices/01_overview.asp#TopOf Page](http://www.cms.hhs.gov/WorkersCompAgencyServices/01_overview.asp#TopOfPage).

The basic premise behind the idea of WCMSA is an extension of the policy that Medicare is not allowed to pay for medical expenses for which payment has been made, or can reasonably be expected to be made under a workers' 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.¹ The Medicare Secondary Payer (MSP) statute sets forth Medicare's status as secondary payer to any claim covered by a workers' compensation carrier or a self-insured employer.² If a workers' compensation claim is settled and the settlement includes compensation for future medical expenses, the case is referred to as a "WC commutation case" by Medicare. Medicare takes the position that by releasing the workers' compensation carrier from liability for future medical expenses, the plaintiff in reality is transferring the liability for coverage of such future medical expenses to the Medicare program. Further, Medicare requires that any money paid to settle the liability for future medical must be spent on medical expenses related to the injury before Medicare will cover any expenses. This fulfills Medicare's mandate by statute under the MSP.

Most personal injury attorneys are aware that if a nonworkers' compensation case is settled for a Medicare beneficiary and Medicare has paid for medical care that was required as a result of a tort, then Medicare will have a claim to be reimbursed for any past medical bills that are part of a recovery from the tortfeasor. This once again is a requirement of the MSP statute. In the past however, Medicare has never asserted a claim for payment of future medical expenses outside the context of a WC commutation case. This is no longer the case. Medicare has adopted a policy that it retains its secondary payer status after the settlement of any personal injury claim where payment is made for future medical expenses.³ John Campbell in his article *Preserving Public Benefits in Physical Injury Settlements: Special-Needs Trusts and Beyond* quotes Medicare Secondary Payer Coordinators from two CMS Regional offices:

CMS' position is that we expect any funds that are allocated for future medicals to be spent before any claims are submitted to Medicare for payment and the beneficiary will probably be asked about it on the initial enrollment questionnaire that is systems generated, but we are not asking that MSA's be established in these cases, nor are we reviewing/approving/denying them.

CMS has no current plans for a formal process for reviewing and approving liability Medicare set-aside arrangements. However, even though no formal process exists, there is an obligation to inform CMS when future medicals were a consideration in reaching the liability settlement, judgement or award as well as any instances where a settlement, judgement or award specifically provides for medicals in general or future medicals.⁴

This position is supported by Sally Stalcup the Secondary Payer Regional Coordinator Dallas for CMS in her email that is attached as Exhibit A.

Although there is no official policy or regulation explaining what is required in a liability case CMS, has mandated that the parties “reasonably consider Medicare’s interest”. In the settlement of such cases the correct procedure to follow is hard to ascertain.⁵ Until such time as CMS promulgates some regulations, the best indication of how to properly consider Medicare’s interest is to examine the process that is currently in place for the settlement of a Workers’ Compensation Medicare Set-Aside Agreement or WCMSA.

II. What is a WCMSA and what does it do?

Since July of 2001, and the publication of the aforementioned memos, the methodology to deal with Medicare’s interest has been through the creation of a Medicare Set-Aside Agreement. For the first several years the only way such an agreement could be reached involved the creation of a formal trust with a professional trustee to manage the assets in the trust and to handle the disbursements of proceeds for medical expenses. The procedure included negotiation with CMS to determine the amount of money to fund such a trust so that Medicare would be assured that there were sufficient assets to pay for potential Medicare covered medical expenses for the life of the beneficiary. The determination of how much money to place in the trust is a complicated issue that requires consideration of factors such as, life care plans, the “rated age” of the beneficiary, and evaluation of the documentation that gives the basis for the amounts of projected expenses for Medicare covered services and services not covered by Medicare.

It is important to note that if CMS rejects the proposed settlement, there is no formal appeal process to contest the rejection. The only alternative is to submit a bill to Medicare and have the bill denied and then pursue the appeals process through the regular administrative appeals process that exists for the denial of any “regular” Medicare billing denial. This is hardly a reasonable solution as the time required to pursue such an appeal can easily be more than 14 months. It is not practical to wait 14 months to determine if necessary medical care will be covered by Medicare or not. The lack of a reasonable appeal process makes the negotiation with CMS basically a take it or leave it proposition. If CMS rejects the proposal, then counsel for the beneficiary has little choice but to offer a settlement agreement that is dictated by CMS.

Because of this situation it is very important to understand the requirements of MSA that will be acceptable to CMS. An excellent source for obtaining Medicare's position and policies is the information that is provided to Medicare Contractors in the various manuals that CMS publishes to instruct its Contractors in how to process claims for benefits. The Medicare Secondary Payer (MSP) Manual at Chapter 7 §§40.3.4 through 40.3.5 contains an explanation of CMS's evaluation of a proposal as well as questions and answers concerning processing claims involving WCMSA. This manual is CMS's explanation to its Contractors of many of the factors that its Regional Offices will use in dealing with WCMSA cases. Because of the complexity and the expertise required to negotiate the proper settlement amount with CMS it is difficult for counsel to effectively deal with these issues unless they have a significant number of cases to make it worthwhile to become knowledgeable in the myriad of issues involved. Because of the complexity there are some lawyers in the country that have developed a specialty in handling these cases. Additionally, there are nonlawyer companies that will handle the negotiation with CMS for a fee.

Attached as Exhibit B is a sample submission of a proposal of a WCMSA. Even a cursory review of this document will show that the preparation of such a proposal is a very complex and detailed task.

Once an agreement is reached on the funding of the trust, the administration of the trust must be handled such that only medical expenses that would be covered by Medicare will be paid from the trust. The expertise to supervise the disbursements of the funds for Medicare covered medical expenses requires the knowledge of a medical claims administrator that is experienced in Medicare billing and the codes that Medicare uses to delineate different medical procedures and claims. It is difficult to find a professional fiduciary that has the experience and qualifications as a money manager to handle the investment side of the trust duties that also has the knowledge to manage the administration of the trust and to sort out the issues of what medical claims to pay. This problem often requires that the two duties be split between different entities, a professional trustee to manage the money and a medical claims administrator to handle the day to day decisions on what bills to pay.

Early on in the history of these cases (remember they were compensation cases) it became clear that most of these type of compensation cases only received a small amount of money as payment for future medical expenses. Because these settlements were small it was not practical to have a corporate fiduciary to manage money and a claims administrator to pay the bills.⁶ After repeated requests CMS in a memorandum published on April 22, 2003, approved self-administration of a set-aside arrangement by a beneficiary. The memorandum makes it clear that any self-administered MSA must comply with all of the rules and requirements just as any other MSA.

A practical solution to the problem of professional fiduciary management of the money was to invest the money in an annuity.⁷ The annuity would pay into the MSA according to a schedule that had been approved by CMS. The structures could pay

monthly or annually and any money not used to pay expense in a certain year would have to be accumulated and paid out in a later year before Medicare would cover any medical expenses related to the specific injury. This solved several problems, first the money to fund future payments from the trust was guaranteed by a large insurance company and no money needed to be managed by a corporate fiduciary. Secondly, and very importantly if the person were to receive a "rated age" by the insurance company it is possible that an MSA could be funded with a discounted cash purchase. The use of annuities to fund the MSA's took care of the first issue but the administration of the trust was and still is, a very difficult job. Unless the individual has experience and knowledge of Medicare's billing and payment systems it would be very difficult for such an individual to comply with Medicare's rules for paying medical expenses related to the specific injury that the future medical payments were intended to fund.

The goal in preparing a WCMSA is to create and fund a trust or agreement with an amount of money that will be used to pay for Medicare covered medical care that is related to the injury that the beneficiary received in settlement of a claim against a tortfeasor. Once the money that is awarded to the beneficiary for future medical expenses is spent on expenses that Medicare would normally pick up then Medicare will cover other medical expenses related to the injury. There are many practical problems with the system set up by Medicare to deal MSA's. There are many reports of Medicare Contractors refusing payment of all medical bills of a beneficiary including payment of medical bills for treatment that has no connection to the injury for which the beneficiary has received a settlement based on future medical liability. This should not be the case. Medicare has no basis to refuse payment of bills that have no relation to the injury caused by a settling tortfeasor. Because of the precarious position that a Medicare beneficiary may be placed in if Medicare refuses payment for emergency medical care or other vital treatment, it is extremely important that counsel for any settling beneficiary make sure that these issues are dealt with carefully.

III. MSA's as SNT's

The funds used to establish an MSA belong to the plaintiff/beneficiary. The funds in a Medicare set-aside arrangement are not entitled to any special treatment under Medicaid or SSI resource rules.⁸ Therefore the funds in the trust will be considered an available resource to the beneficiary under Medicaid rules. If the plaintiff/beneficiary needs to maintain eligibility for Medicaid benefits then the MSA should meet the requirements of the OBRA '93 law for D4a trust so that the money in the MSA would not be considered a countable resource. The disbursement provisions would limit the use of the money in the trust to the payment of medical expenses covered by Medicare per the set-aside agreement. The trust must contain the required payback provision concerning any funds remaining in the trust at the death of the beneficiary.

IV. Unresolved issues

At the time of the publication of this paper there are a lot more issues concerning these Medicare set-aside agreements in liability cases that are unresolved than issues that are clearly defined. The area of the WCMSA,s has some history upon which to draw when dealing with issues in the third party liability realm. However, there are some very important areas that although unsettled at this time are very basic to any decisions about how to deal with one of these cases.

One of the issues that is basic to the establishment of a MSA is the calculation of how much of a settlement is allocated for the payment of future medical damages. It is clear from the statute that Medicare only has a claim for reimbursement based on the part of damages that were meant to compensate the plaintiff/beneficiary for the cost of future medical expenses related to the accident or injury caused by the defendant. In most of these cases a settlement is reached wherein the defendant agrees to pay a lump sum amount to compensate the plaintiff for all of his or her claims including pain and suffering, lost earning capacity as well as past and future medical bills. Under the existing statues Medicare has a formula for calculating the amount of a settlement that they consider to be for future medical. *However, that statute appears to only apply to workers' compensation cases.*⁹

At least one commentator has opined that Medicare does not have statutory authority to determine the portion of a personal injury settlement that is an award for future medical expenses:

CMS appears to have no authority in a PI settlement to determine the reasonableness of the settlements allocation to future medical expenses or to calculate its own allocation.¹⁰

Another area of the law that appears to be unsettled is the obligation that an attorney has when settling a personal injury case that includes damages for future medical expenses. CMS takes the position that attorneys have statutory duties to affirmatively assist Medicare in its efforts to obtain reimbursement for conditional payment under the MSP law. Some commentators maintain the position that attorneys own no duty to Medicare to assist them in any manner in the collection of such claims:

First, an attorney does not owe Medicare the duty to protect its recovery claim against his or her client. The Medicare regulations do impose a duty on the beneficiary, a duty to cooperation and on the other insurance company a duty to notify Medicare. In 1998 CMS proposed regulations that would require the beneficiary *or the beneficiary's representative* to give Medicare notice of an insurance claim within 60 days and notice of settlement within 30 days, but these proposed regulations have never been finalized.¹¹

The author's position goes on to explain that contrary to popular belief, if an attorney advises his or her client of the MSP recovery program and the client chooses

to take their recovery and deal directly with CMS, then the statutes and regulations impose no penalty on the attorney. The statute does give CMS the right to recover against any liability proceeds *in the possession of an attorney*.¹²

Most important to handling of cases in this area is the refusal of CMS to approve a MSA in a nonworkers' compensation case. The literature published by CMS and the representations of its personnel such as the position asserted by Ms. Stalcup in her email, absolutely maintain that Medicare's interest must be protected and considered when settling a third party liability case. But if CMS will not review, approve, or deny MSA in third party liability cases then the correct procedure for an attorney to follow in these types of cases is unclear.

1. 42 U.S.C. § 1395y(b)(2)(A)(ii)(2005).
2. Section 1862(b)(2) of the Social Security Act; 42 U.S.C. 1395y(b)(2).
3. Campbell, John J., CELA, MSCC, *Preserving Public Benefits in Physical Injury Settlements: Special-Needs Trusts and Beyond*, NAELA Journal Vol. II 2006. Footnote 26.
4. *Id. at p. 376.*
5. *Id. at p. 377.*
6. *Id. at p. 379.*
7. CMS All Regional Administrators Memo dated October 15, 2004; Question 5.
8. CMS All Regional Administrators Memo dated December 30, 2005; Question 13.
9. 42 CFR §411.47
10. Campbell, *supra at 377.*
11. Stein, Judith and Chiplin, Alfred, *2007 Medicare Handbook*, Wolters Kluwer 2007, at page 9-15.
12. 42 CFR §411.24(g)