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Medicare Set Asides & Special Needs Settlement Planning

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1. INTRODUCTION

a. When representing a disabled plaintiff in a personal injury or worker compensation case, attorneys must be sensitive to ethical issues.

  i. The attorney must determine whether plaintiff has capacity to settle and may want to ask the Court to appoint a guardian ad litem where there is no plenary guardian and virtual representation (such as parent for a child) doesn't apply. RPC 1.14 governs the lawyer's obligations where client has disabilities and RPC 4:26-3 permits virtual representation in certain situations.

  ii. Conflicts of interest frequently arise between a disabled plaintiff and family that feel they should benefit from a recovery. In case of major conflicts, an independent court appointed guardian *ad litem* may be essential.

  iii. While ethical issues are crucial, detailed discussion of ethics when representing a disabled person is beyond

the scope of this program.

b. My presentation will address government disability benefits, lawyer obligations to Medicaid and Medicare when resolving claims for a disabled person, and techniques to keep a recovery from disqualifying a disabled person for Medicaid, Medicare, and other benefits with particular emphasis on special needs and Medicare set-aside considerations.

2. GOVERNMENT DISABILITY PROGRAMS

a. Disabled people potentially can qualify for several government benefits such as cash assistance, health care, housing, vocational training, and various other programs.

b. Many programs apply the Social Security Act definition of disabled, which essentially is inability to work due to a medically determinable impairment expected to last at least a year or result in death. 42 U.S.C. §423(d)(1)(A). While work is defined quite broadly, an individual's age, work experience, and condition are factored in so that a sixty year old college professor who suffers a serious brain injury probably wouldn't fail to be considered disabled merely because he theoretically could sweep floors 42 C.F.R. §404.1505

c. Some programs use other definitions of disability. For instance, a person may be considered developmentally disabled due to substantial functional impairments in three major life activities (i.e. self-care, receptive and expressive language, learning, mobility, self-direction, and capacity for

independent living or economic self-sufficiency) even though he isn't Social Security disabled and, in fact, earns $1,500 a month working at a corporate fitness center. States provide various benefits such as supported housing (e.g. group home or supervised apartment) and day programs to people with developmental disabilities.

d. Many key government disability programs are limited to individuals whose finances are modest or charge a financially secure individual for benefits that would be provided at little or no cost to an individual of nominal means. These include Supplemental Security Income (SSI), Medicaid, housing aid, group homes and other programs for people with developmental disabilities and mental illness, and state pharmaceutical assistance programs for elderly and disabled people.

   i. SSI is cash aid limited to people with minimal resources and income. A recovery that pays plaintiff outright (as opposed to payments in a qualifying special needs trust– discussed below) is disqualifying. SSI automatically brings with it Medicaid in New Jersey and most other states.

   ii. Medicaid can cover most medical care and long term care but is limited to people with minimal resources and income. As with SSI, outright settlement payments count against Medicaid income and resource qualification limits.

   iii. DDD (New Jersey Department of Human Services Division of Developmental Disabilities) provides group homes and other disabilities housing and day programs

(such as workshops and job assistance) to people with developmental disabilities.

(1) While developmental disabilities must manifest before age 22, they need not arise at birth. A 20 year old Harvard student who is badly injured in a motorcycle accident can be considered developmentally disabled.

(2) Participants with more than minimal resources and income may have to pay for future benefits and repay prior benefits. Thus settlements should be designed to minimize DDD exposure.

e. Gifts, devises, inheritances, recoveries (settlements, awards, trial judgments, Etc.), equitable distributions, alimony, child support, and most other kinds of receipts can disqualify a recipient and family members for above programs or require them to pay for benefits that otherwise would be free.

f. Most government disability programs are limited to individuals whose finances are modest or charge a financially secure individual for benefits that would be provided at little or no cost to an individual of nominal means. Recoveries (settlements, awards, trial judgments, Etc.) for nearly everyone who is disabled or has disabled loved ones should be designed to preserve eligibility for means tested programs because even an individual who currently receives only benefits that aren’t limited based on finances such as Social Security Disability and Medicare, may need programs like Medicaid down the road.

3. GOVERNMENT LIENS

a. State programs may have liens independent of Medicaid and Medicare. Thus, recipients of certain benefits such as group homes, public hospital care, and state psychiatric hospitalizations must address potential claims by New Jersey Department of Human Services when settling claims. The Department has threatened to bring claims against attorneys who ignore its interests. Liens may arise for prior benefits, but compromises may be possible. Experience in compromising Department claims can be very useful in crafting compromise proposal.

b. When an individual is in a public psychiatric or other hospitalization, the Department may recover care costs from the individual. If the individual comes into money after discharge, limitations apply to recovery claims. Once the individual dies the Department may claim against the estate.

c. Medicaid & Medicare Claims

   i. Personal injury and worker compensation recoveries must repay Medicaid, Medicare, and sometimes other benefits.

   ii. Plaintiff and defense counsel, defendants, insurers, and others may have personal liability if a settlement is disbursed without satisfying Medicaid, Medicare, and other government claims. It is both unethical and stupid to ignore Medicare, Medicaid and other repayment obligations. Because it can take several months to obtain lien amounts, make lien requests early.

iii. Despite prior contrary state court rulings in New York and New Jersey, in *Arkansas Department of Health and Human Services, et al. v. Ahlborn*, 547 U.S. 268 (2006), a unanimous United States Supreme Court ruled that Medicaid can recover only from the portion of a settlement intended to compensate plaintiff for medicals. However, collusive settlement allocations that artificially diminish the medicals portion of a recovery will not necessarily bind Medicaid. Therefore, parties should negotiate a reasonable allocation with Medicaid or make Medicaid a party to a judicial allocation hearing.

iv. Where government repayment obligations are large relative to amount of settlement, it may be possible to compromise a repayment claim if negotiations commence before settlement is reached.

4. ORDINARY SETTLEMENTS RISK GOVERNMENT AID

a. Nearly any settlement paid outright to a disabled person, certain relatives, or a trust that isn't exempt would be disqualifying for SSI Medicaid and other programs that base eligibility on financial need.

b. Setting aside a litigation recovery in a qualifying special needs trust can make funds available to supplement rather than supplant a disabled person's government aid. In New Jersey and other states, a personal injury settlement can provide for payments into a qualifying special needs trust (called supplemental needs trust in New York State).

c. It may be more difficult to arrange to pay a worker compensation recovery directly into trust.

d. Recent Supreme Court ruling holds that child support can be paid into special needs trust where proponent shows that same is in the child's best interests. *J.B. v. W.B., __ N.J. __* (Aug. 20, 2013)
www.judiciary.state.nj.us/opinions/supreme/A11111JBvWB.pdf

e. When a settlement will fund a special needs trust, settlement documents should call for payment into trust rather than outright to the plaintiff. If plaintiff receives a settlement, it can be difficult to get into a special needs trust and can lead to otherwise avoidable loss of benefits.

5. SPECIAL NEEDS TRUSTS TO PROTECT GOVERNMENT AID

a. To qualify as a special needs trust, a trust must be drawn in accordance with rules governing the various government benefit programs at issue. For instance, a trust that satisfies 42 U.S.C. §1396p(d)(4)(A and (C) is not countable against SSI and Medicaid eligibility but may count against eligibility for some programs.

b. Of at least equal importance to avoiding disqualification, a special needs trust must be compatible with the beneficiary's individual needs. While a special needs trust must be drafted in a manner that won't disqualify the beneficiary for crucial government aid, the trust must not be so restrictive that it

can't buy needed goods and services. For instance, a trust for a person with mental illness may be of little benefit if it can't pay for his housing in the community.

c. Well drafted special needs trust are much more than mere forms drawn primarily to preserve Medicaid eligibility.
   i. For instance, form trusts often prohibit a trust from funding support to ensure the trust isn't Medicaid disqualifying. That kind of prohibition isn't necessary and may prevent a huge settlement from meeting a seriously disabled individual's goal to live in a nice condominium.

   ii. A better approach is to draft a special needs trust to clearly say the trust has no obligation to pay for support but not prohibit desirable expenditures. However, the drafting must be is very tight to ensure the trust isn't obligated to pay for support, which would result in disqualification.

d. A special needs trust funded with a litigation recovery, worker compensation award, or other amount attributable to the beneficiary (such as certain divorce payments) is SSI and Medicaid disqualifying unless it complies with 42 U.S.C. §1396p(d)(4)(A) or (C).
   i. A 42 U.S.C. 1396p(d)(4)(A) SNT is a traditional trust with just one disabled beneficiary while a (d)(4)(C) SNT is a pooled trust sponsored by a non-profit organization.

   ii. A 42 U.S.C. 1396p(d)(4)(A) SNT can be more flexible and allows the beneficiary to choose his own trustee but

it may be more expensive to establish.

iii. Both 42 U.S.C. 1396p(d)(4)(A) and (C) special needs trusts also must comply with applicable state requirements. For instance, New Jersey Medicaid regulations require special needs trusts to include numerous technical record keeping, reporting, and other requirements while Pennsylvania limits special needs trust expenditures. New York's Estates, Powers, and Trusts Law's supplemental needs trusts provisions nearly always should be included in New York supplemental needs trusts but would not be appropriate for a New Jersey trust. Similarly, New Jersey Medicaid regulation requirements shouldn't be included in New York trusts.

e. While structuring a settlement for a disabled plaintiff can provide tax and other benefits, it is almost never desirable to entirely structure a settlement. While a case is pending, families often are forced to defer expensive purchase they greatly desire for lack of funds. Therefore, it is important to keep liquid sufficient settlement proceeds to meet pent up demand for such big ticket items as a disability modified van, disability modified bathroom, computers, adaptive technology, disabilities camps, etc..

f. When a settlement will fund a special needs trust, settlement documents should call for payment into trust rather than outright to the plaintiff.

6. MEDICARE SECONDARY PAYER ACT

a. The Medicare Secondary Payer Act (MSP) says Medicare is secondary to tortfeasors and worker compensation carriers. Therefore, the MSP requires injured clients to look to personal injury and worker compensation recoveries rather than Medicare to fund care necessitated by a tort or workplace injury.

b. MSP has two separate prongs of importance to lawyers when resolving a claim–

   i. Medicare claims for pre-recovery spending and

   ii. Medicare Set-asides to protect future Medicare.

7. MEDICARE PRE-RECOVERY CLAIMS

a. When a personal injury or worker compensation case is resolved by settlement or verdict, the recovery must repay pre-recovery Medicare expenditures necessitated by the tort or work place injury.

b. Lawyers and defendants have personal liability to ensure that any recovery repays Medicare. If plaintiff's attorney pays a recovery to plaintiff without first repaying Medicare, Medicare may recover from **plaintiff's lawyer**!

c. The amount due is calculated by Medicare's contractor when requested by the lawyers, but the process can take months so it is best to request Medicare's claim early in the settlement process.

d. Medicare's claim must be paid within 60 days of settlement payment or Medicare will seek interest. As no counterpart to *Ahlborn* applies to Medicare, Medicare does not limit its claim to the medicals portion of a recovery.

8. MEDICARE SET-ASIDES (MSA)

a. A personal injury or work accident victim can qualify for Medicaid despite a large settlement where the settlement is paid into a qualifying special needs trust. To protect against windfalls to the Medicaid recipient's family, federal law requires any trust balance when the Medicaid recipient dies to repay Medicaid.

b. To prevent similar windfalls, the MSP provides Medicare isn't responsible for post recovery treatments until medical damages are exhausted. In other words, MSP requires a Medicare recipient to protect Medicare's interests by using damages that compensate for future medicals to pay for medical care related to the injury rather than asking Medicare tod do so.

c. Where a plaintiff ignores the obligation to protect Medicare's interests, Medicare can refuse to fund future accident related care until Medicare determines the plaintiff has met his obligations.
   i. If the plaintiff has already spent the settlement/award money, plaintiff may be unable to afford needed accident related care but Medicare will refuse to pay.

   ii. *This can lead to malpractice claims against plaintiff's*

counsel for not resolving this obligation upon settlement.

d. Where a plaintiff makes a good faith effort to apply a reasonable share of a settlement/judgment to accident related care, Medicare probably will give plaintiff the benefit of the doubt. Conversely, it stands to reason that Medicare probably will construe plaintiff's obligations more harshly where plaintiff ignores plaintiff's MSP obligation to protect Medicare's interests by using medicals damages to fund accident related care.

e. CMS (the federal Medicare agency) guidelines state that MSA is the preferred way to protect Medicare's interests in worker compensation settlements. CMS has provided only minimal informal guidance for personal injury MSAs, but they did issue an Advance Notice of Proposed Rule Making 2012 and appear poised to issue a proposed rule in the fairly near term.

f. An MSA is a trust or less formal arrangement whereby amounts from a tort or worker compensation settlement or judgment are earmarked to satisfy the plaintiff's obligation to protect Medicare's interests. The MSA may be spent only for post-settlement care of a kind Medicare normally would fund if the care need weren't occasioned by a tort or work injury. The plaintiff must provide additional MSA funding to cover MSA administration.

g. Because MSA administration requires understanding of Medicare, professional administration is preferable. Professional administrators also often can negotiate

substantial reductions in medical costs.

h. Medicare worker compensation MSA guidelines provide that the MSA should be based on projected care costs over the Medicare participant's life expectancy based on medical and pharmaceutical records.

i. There are significant differences between personal injury and worker compensation settlements in that PI settlements usually compensate only a fraction of damages due to insurance limitations and/or doubtful liability whereas worker compensation normally covers full medical damages. Thus, it seems reasonable to adjust future medicals damage calculations per worker compensation guidelines to take account of these differences. Nevertheless, the recent case of *Hadden v. U.S.*, 661 *F.3d* 298 (6th Cir. 2011) held that when settling a personal injury tort claim, a Participant must repay the full amount of Medicare conditional payments even if the Participant receives less than full damages. However, the 11th Circuit opinion in *Bradley v. Sebelius*, 2010 WL 3769132, (11th Cir. 2010) while not exactly on point has conflicting reasoning. These cases relate to repayment of Medicare pre-settlement conditional payments rather than Future Medicals that must be paid from a personal injury tort settlement to satisfy COB obligations.

j. If an MSA acceptable to Medicare authorities isn't employed, future Medicare benefits will be impaired unless other acceptable arrangements to protect Medicare's interests are in place or the Medicare participant simply falls through the cracks. However, with new insurance reporting requirements, it seems likely that Medicare authorities will

enhance enforcement of MSP requirements.

k. Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (PL 110-173) amends the MSP provisions of the Social Security Act (Section 1862(b) of the Social Security Act; 42 U.S.C. 1395y(b)) to provide for mandatory reporting to Medicare of personal injury and other payments. While section 111 doesn't address MSAs or the obligation to protect Medicare's interests by ensuring personal injury recoveries pay accident related medicals, what other purpose could there be for mandatory reporting?

l. Medicare set-aside arrangements benefit lawyers as well as clients. Where a worker compensation or personal injury recovery is fully spent without reserving anything for future medicals and Medicare refuses to fund costly injury related care, it is easy to envision a failure to warn type legal malpractice claim even though the worker compensation or personal injury attorney may have achieved a very favorable recovery. An MSA may help avoid a malpractice suit.

m. For instance, assume that in 2009, $3,000,000 is paid due to a 2006 catastrophic fall at work.
    i. While $3,000,000 may be more than enough to cover any future medicals with ease, the plaintiff may lack funds to pay medical costs if worker compensation counsel doesn't provide for a Medicare set-aside arrangement. If legal fees and spouse's per quod claim cover $1,200,000, that leaves $1.8 million for the injured worker. However, if $1 million is structured, plaintiff only has $800,000 liquid. Assume counsel doesn't warn plaintiff about Medicare coordination of

benefits and plaintiff spends several hundred thousand dollars to pay off loans and buy a house. When Medicare later refuses to pay for the first $500,000 of costs for post-settlement rehabilitation, back surgery, and traumatic brain injury treatments because Medicare determines that damages for future medicals total $500,000, how will plaintiff fund them?

ii. To ensure plaintiff has funds for future treatment, my firm (FriedmanLaw www.SpecialNeedsNJ.com) would determine a Medicare set-aside amount based on Medicare guidelines and advise plaintiff of options which probably would involve establishing a professionally administered Medicare set-aside trust that ensures seamless coordination of Medicare and MSA. If the plaintiff also receives Medicaid, the set-aside trust would be designed in concert with a Medicaid qualifying special needs trust to avoid Medicaid inclusion of the set-aside. While an MSA takes away from the discretionary amounts available to the plaintiff, it's a trade well worth making to avoid issues with Medicare.

n. Nurse analysis typically is essential to determine a baseline Medicare set-aside amount, but a special needs attorney may have insight to bases to reduce the baseline MSA. Therefore, legal counsel as well as MSA nurses should be involved in designing an MSA.

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