

## MEDICARE SET ASIDE TRUSTS (AM I REQUIRED TO DO ONE?)

**By: A. Kel Long, III**

The phone call goes like this: “I just settled a liability case and the defense lawyer is asking about a Medicare Set Aside Trust. Do I have to do one?” asks the plaintiff attorney on the other end of the line. That is the question I hear frequently now. And the answer is: Probably not.

Before we get into the how’s and why’s, let us first clarify that this article focuses on liability cases and not Workers Compensation cases. In the Workers Compensation area, the rules for establishing a Medicare Set Aside Trust are well established. It is helpful to understand two significant distinctions between a Workers Compensation case and a liability case. First, the Workers Compensation settlement process allows for an allocation of a portion of the award to future Medicare covered medicals; whereas, in a liability case, it is rare to see a verdict or settlement that specifies future medicals, let alone a specific allocation to Medicare covered medicals. Second, the federal government’s Center for Medicaid and Medicare Services (“CMS”) provides guidance on establishing a Medicare Set Aside trust or other arrangement (“MSA”) in the Workers Compensation area, but to date CMS has yet to provide any guidance in the liability area. This article will instead focus on liability cases where the rules and regulations are in flux and unclear at best.

Also, before we begin with the analysis, a few basics should be covered. Medicare is a secondary payor program, meaning that it is to pay only after other insurance. The term “insurance” includes payments from all insurers including self insurers. Medicare considers the allocation for future medicals to be the primary fund for paying Medicare covered expenses compensable to the injury. Once the set aside fund is exhausted, Medicare becomes the primary payor of the Medicare covered expenses for the compensable injury.<sup>1</sup> And, a MSA in a liability case is strictly voluntary – it is not required by CMS. While a MSA for future medicals is voluntary, resolution of a Medicare lien for past medicals is not; the Medicare lien must be resolved at the time of settlement and is unrelated to whether a MSA is established or not. Also, Medicaid, a needs based program, has its own rules for future eligibility, which are entirely different than Medicare. The Medicaid eligibility requirements are not covered by this article.

In order to determine whether a MSA is required in a liability case, I have found it helpful to follow the progression of the following questions.

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<sup>1</sup> 42 C.F.R. Section 411.46.

First question. Is the client receiving or about to receive Medicare?<sup>2</sup> If not, then stop here. If yes, then continue with the analysis. For example, minors generally cannot receive Medicare. Thus, if the client is a minor, then a MSA is not required. Only the following persons are eligible for Medicare: those age sixty-five (65) or over; those receiving Social Security Disability Benefits (SSDI<sup>3</sup>); and those, including children, who are suffering from End Stage Renal Disease or Lou Gehrig's disease.

Second question. Will the client have future Medicare covered medical needs associated with the injury giving rise to the claim? If not, then a MSA is not needed. Note that by the time that many cases are settled or tried, the injuries have stabilized and future Medicare covered medical needs related to the injury are not expected. Also keep in mind that the term “future medicals” may constitute a large part of the litigation claim however those “medicals” may not be the type of medical expenses covered by Medicare. Medicare pays for skilled care, such as surgeries, hospital stays and therapies. For example, in a brain or spinal injury case, much of the future medical expense will be for in-home or nursing care, which is not covered by Medicare.

Third question. Were damages for future injury related Medicare covered medicals allocated in the award or verdict, or otherwise determinable? A MSA obligation is only clear in the unusual case where there is a definitive allocation of future injury-related Medicare covered expenses. Examples would be a verdict or a specific allocation in the settlement agreement. The allocation would also have to differentiate between injury-related Medicare covered future medicals and future medicals in general. For example, the settlement agreement could allocate a specific amount to a scheduled future surgery. That scenario is of course highly unusual, if non-existent.

In the unusual case where future Medicare covered medicals are determinable, but the case settles for less than its full value, it does appear that an Ahlborn<sup>4</sup> type allocation would be appropriate to determine the amount of the settlement allocable to the future medicals. As a simple example, assume the total value of all claims is \$10,000,000 including the cost of future surgeries that Medicare would otherwise pay for of \$500,000. If the case settles for \$1,000,000 gross, being 10% of the total value, then under an Ahlborn type allocation, the amount allocated to future Medicare covered medicals would be \$50,000 ( $\$500,000 \times 10\%$ ). If instead the estimated cost of the surgeries was \$100,000 then the set aside amount would arguably be

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<sup>2</sup> In order for a MSA to have to be considered, either of two conditions must exist: 1) the injured person must be currently eligible for Medicare and the value of the total settlement exceeds \$25,000; or 2) if the injured person is not currently on Medicare, but is reasonably expected to become eligible within 30 months, then the total settlement must exceed \$250,000.

<sup>3</sup> Note that SSDI is not the same as SSI (Supplemental Security Income). SSI is a needs based program, whereas SSDI is part of the social security system and eligibility is not based on financial need.

<sup>4</sup> *Arkansas Dept. of Health and Human Services v. Ahlborn*, 547 U.S. 268 (2006).

\$10,000 (\$100,000 x 10%), which is probably too low an amount to justify the cost and expense of a third party administered MSA.<sup>5</sup>

Fourth Question. What if the defense counsel insists on a MSA regardless of the above factors? One response is that CMS has confirmed again recently that in the liability arena, a MSA is voluntary.<sup>6</sup> Another response is that there is no liability to third parties (i.e., the defendant) for failing to establish a MSA. Unlike payment of past medicals (e.g., a Medicare lien) there is no third party liability for future medical expenses. Instead, the regulations provide that any liability for future medicals lies with the Medicare beneficiary in the form of loss of coverage.<sup>7</sup> In other words, the defendant cannot be held liable for failing to establish a MSA. If defense counsel continues to require a MSA, then another alternative is to provide indemnification language in the settlement agreement providing that plaintiff will indemnify defendants from any and all injury-related obligations to Medicare.

Fifth question. What if the unusual case exists where there are to be significant future Medicare covered expenses that are injury related and the client is also Medicare eligible? In that case, there are consulting firms that can assist with establishing a set aside amount based on a “reasonable person” standard. The MSA may also be submitted to a CMS regional office, however, there is no guarantee that CMS will elect to review and approve the MSA. The general understanding is that CMS is not staffed sufficiently to handle the number of MSA’s submitted and thus frequently declines to review them.

Sixth Question. What happens if a MSA is not established, but it is later determined that a MSA was required? As noted above, there is no liability to a third party. The result would instead be loss of Medicare benefits until a MSA is established. One solution, where a special needs trust (“SNT”) is otherwise being used (which is often the case), is to later create a MSA subtrust. Under this method, the SNT could allow the trustee to establish a subtrust in the future to hold the MSA amount if and when the MSA amount is ever determined to be required by Medicare. In this way, the decision to create a MSA could be deferred until the facts are clearer or CMS guidance is provided. It should also be noted that this author has had such language approved by the Georgia Department of Community Health for use in a SNT.

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<sup>5</sup> Where a third party administered MSA would be cost ineffective, two other options exist. One is for the client to set aside the funds in a self administered MSA. The second is for the client to not use an MSA at all, but rather understand the risk and set up a savings fund to pay for the future Medicare covered costs.

<sup>6</sup> CMS conference call transcript from March 24, 2009.

<sup>7</sup> 42 C.F.R. §411.24(e).

Seventh Question. Do the new reporting requirements for insurers affect the need for a MSA? The answer is: No. Beginning January 1, 2010<sup>8</sup>, new rules apply regarding who must notify CMS regarding liability claimants. These rules were established by the Medicare, Medicaid and SCHIP Extension Act of 2007 (“MMSEA”). It should be clearly noted that MMSEA does nothing more than place a notice provision on defendants when a case involves a Medicare beneficiary. The MMSEA notification requirements have nothing to do with Medicare Set Asides.

The purpose of the MMSEA notification requirements is to ensure Medicare liens (for past medicals) are satisfied. The information obtained may also be used as statistical information as to whether CMS should require MSA’s in liability cases in the future.

The MMSEA rules govern only insurers, however the definition of “insurers” is liberally defined to include not only liability insurers, no-fault insurers, and workers compensation insurers, but also self-insurers. The insurer must determine whether any claimant who files a claim against the insurer is entitled to Medicare benefits.<sup>9</sup> Failure to comply results in a \$1,000 per day penalty imposed against the insurer. Regulations are expected to be issued describing what information is required to be provided and when.<sup>10</sup> Note that all defendants are required to report – as compared to plaintiffs and their attorneys who are not required to report.

Conclusion: As one can see from the analysis above, the circumstances where a MSA is needed in a liability case are very narrow. And where a special needs trust is otherwise used, the decision can be deferred by allowing the creation of a MSA subtrust under the special needs trust if later required by Medicare.

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<sup>8</sup> The original start date of July 1, 2009 was extended by CMS memorandum on May 11, 2009. The link to the memorandum is:

[http://www.cms.hhs.gov/MandatoryInsRep/03\\_Liability\\_Self\\_No\\_Fault\\_Insurance\\_and\\_Workers\\_Compensation.asp#TopOfPage](http://www.cms.hhs.gov/MandatoryInsRep/03_Liability_Self_No_Fault_Insurance_and_Workers_Compensation.asp#TopOfPage)

<sup>9</sup> To be directed to the "Mandatory Insurer Reporting" web page, go to:

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

<sup>10</sup> Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (PL 110-173) which amends the Medicare Secondary Payer (MSP) provisions of the Social Security Act (Section 1862(b) of the Social Security Act; 42 U.S.C. 1395y(b)).

