Academy of
Special Needs Planners

Settlement Planning

for Plaintiffs with Special Needs

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Settlement Planning Attorneys

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I. Introduction to Settlement Planning for Plaintiffs with Special Needs

Settlement planning is the process of ensuring that a plaintiff, who has special needs such as a significant disability, lacks capacity, or has a complex financial situation that deserves extra attention will receive his or her litigation proceeds in such a way that it will meet the client's needs without jeopardizing his or her future. Too often, plaintiffs receive a settlement that will cause harm if a plan has not been implemented that plans for the receipt of the settlement. Settlement planning generally involves larger settlements but can include even modest recoveries especially if the plaintiff is a minor or person with a disability on public benefits.

Settlement planning is accomplished by bringing together experts in several fields, which includes some or all of the following:

- Special Needs Planning Attorney;
- Estate Planning Attorney
- Medicare Set-Aside Specialist
- Lien Resolution Expert
- CPA, and
- Financial Advisor.

The tools at the disposal of the settlement planner include the Special Needs Trust (SNT), the Medicare Set Aside Arrangement (MSA), the Structured Settlement Annuity, and the Qualified Settlement Fund (QSF). These tools can be used independently or together to maximize the litigation recovery for the client.

The end result of the settlement planning process is that the personal injury attorney's client receives the litigation recovery in such a way that:

1. It preserves eligibility for essential public benefits when necessary;

2. Is held by an appropriate entity (such as in a trust, conservatorship/guardianship, or through special bank accounts like UTMA or blocked accounts);

3. Is managed by an appropriate individual with an excellent understanding of his or her duties or responsibilities;

4. It protects the client from his or her own lack of knowledge in money management;

5. It is distributed to the client in the most tax efficient manner; and

6. It will provide the appropriate financial resources throughout the life of the client.

A. Why Should Personal Injury Attorneys Care About Settlement Planning?

Personal injury attorneys should understand the settlement planning process so they can identify those clients who may require settlement planning or who may benefit from the process. Plus, depending on the client's situation, there may be professional liability on the attorney's part when managing the settlement proceeds for a client with special needs if no planning is done and the client is harmed by the receipt of the litigation recovery. Despite whatever liability concerns there are, the personal injury attorney should assist the plaintiff in settlement planning because it is simply the right thing to do.

At a minimum, in order to protect the personal injury attorney, the attorney should inform the client of how settlement planning can assist with the proper management of the litigation recovery, and if the client chooses to not avail himself or herself of this type of planning, the attorney can document the file that such advice was given and was ignored or refused.

B. What Types of Plaintiff Require Settlement Planning

This section will primarily discuss those plaintiffs who require settlement planning. Although as discussed in the next section, all plaintiffs could benefit from some form of planning. Plaintiffs who require settlement planning are:

- Minors;
- Adults who lack capacity; and
- Clients receiving needs-based public benefits.

A minor or adult who lacks capacity will require some type of protected entity to manage the litigation recovery. Depending on the client's circumstances, the litigation recovery may be placed into a trust, guardianship or conservatorship of the estate, blocked account, uniform transfer to minor account, or similar type of arrangement. In many jurisdictions, the type of entity selected can provide much needed flexibility so a firm understanding of the options and their advantages and disadvantages should be explained to the client and his or her legal representative.

Clients receiving public benefits will require an assessment as to how the settlement will interfere with those public benefits, if at all. Public benefit programs have different qualification criteria some of which will be lost if a litigation recovery is provided to them without planning. A more thorough discussion of the public benefit programs is set forth in the sections describing Special Needs Trusts.

C. What Types of Plaintiff Should Consider Settlement Planning

All plaintiffs could benefit from some form of settlement planning. For adults without a disability and without a complicated personal or financial situation, the planning can be as simple as doing a simple financial or estate plan -specifying what happens to the recovery in the event of death or incapacity of the plaintiff. For plaintiffs who may have a more complicated personal or financial

situation, planning can include more advanced forms of estate planning to protect against the estate tax. There may be family issues (child support or spousal support) that need to be resolved, there may be other debts that need to be managed, and there may be concerns with the client's ability to manage a significant sum of money for the first time in their lives. Regardless of the situation, the personal injury attorney cannot know or understand these issues without inquiring as to the plaintiff's situation. A settlement planning professional can assist in identifying and resolving these issues.

II. Effect on Plaintiff's Public Benefits on Receipt of Litigation Proceeds

Plaintiffs can come to the litigation already eligible for public benefits, or may be eligible for public benefits as a result of the injury received as part of the incident giving rise to the lawsuit. It is very important for the future care of the plaintiff to assess whether continued public benefits eligibility is necessary. For some plaintiffs, the recovery is so large and the restrictions of protecting eligibility may be too cumbersome (particularly for an adult with a disability who has capacity) that a reasoned decision is made to forego public benefits.

However, the far greater majority of personal injury clients suffer long-term permanent and severe disabilities which will make it difficult, perhaps impossible, to earn a living, or even perform such basic activities of daily living as eating and drinking, bathing, dressing, walking and grooming. Moreover, the nature and scope of the client's injuries and consequent disabilities may very well cause the client to need a tremendous amount of medical care, possibly even long term care in a skilled nursing facility.

The cost of such medical and long term care can be devastating. When the personal injury attorney took the case, he or she performed an evaluation and estimate of the anticipated costs of such medical and long term care expenses. The attorney may have retained the services of a life care planner to prepare an analysis and report as to what the client's care needs and cost of care would be, as part of determining the amount of damages sought.

Nearly all personal injury cases settle, a settlement is nearly always for some fraction of the total amount of actual damages. It is likely that the amount of the settlement will not completely cover the future cost of the client's needs – such is the nature of compromise. In such cases, the severely permanently disabled client may end up spending most if not all of the settlement amount on care giving expenses, medical expenses, and long term care expenses, leaving little to apply toward quality of life.

Once the money is gone, the client may live a pure welfare existence to pay for medical care, and basic living expenses. This result can be avoided in many cases through proper special needs settlement planning.

A. Settlement Planning and Public Benefits

The main purpose of special needs settlement planning in the context of personal injury / medical malpractice litigation is to ensure that the client is able to avail himself or herself of government benefits programs such as Supplemental Security Income (SSI), Medicaid[2], Medicare and Section 8 housing subsidies.

Without question, public benefits are a complex area of the law. The field of public benefits law is challenging because:

- The statutes, regulations, and policies are difficult to find, are complex, and contain contradictory directives and guidelines;
- Local program administrators cannot be relied on for authoritative advice; and
- The law governing eligibility and administration of public benefits frequently changes.

Justice Powell's often quoted summary of the complexity of the Social Security Act (42 U.S.C. §§401–1397jj), on which many of the programs discussed in this chapter are based, may serve as a warning:

> The Social Security Act is among the most intricate ever drafted by Congress. Its Byzantine construction, as Judge Friendly has observed, makes the Act "almost unintelligible to the uninitiated."[3]

A personal injury attorney should become familiar with the eligibility criteria for the key government benefits programs in order to avoid the pitfalls that could arise when settling a case that could cause a loss of, these important benefits. Because some of these benefits programs are needs based, that is, are only available to persons with limited income and assets, the receipt of a settlement or judgment award could cause a loss of those benefits.

A personal injury attorney should also be conversant with the rights government agencies have to recover from any settlement or judgment ultimately received for the amount of funds the agencies spent on medical care for the client while the case was pending. Failure to comply with these reimbursement rules could result in loss of the benefits, not to mention personal liability on the part of the attorney who disbursed the funds from his escrow account without reimbursing the government.

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[2] May have different names in different states, *e.g.*, in California it is called Medi-Cal.

[3] *Schweiker v Gray Panthers* (1981) 453 U.S. 34, 43, 69 L Ed 2d 460, 469, 101 S. CT. 2633, quoting *Friedman v Berger* (2nd Cir. 1976) 547 F.2d 724, 727 n7

B. Understanding What Public Benefits Are Available

1. Supplemental Security Income (SSI)

SSI is a federal program that provides a modest income stipend to persons who meet certain eligibility criteria. SSI will pay the plaintiff a federal benefit rate in 2010 of $674 per month, plus many States will supplement this amount. For example, California will add $171 per month for those who qualify for SSI.

> **CRITICAL PRACTICE POINT:** In most States, a person who receives SSI payments is automatically eligible for and will receive Medicaid coverage. In addition, if a person on SSI receives a settlement or award after trial, the proceeds may put the person over the resource limit, causing a loss of eligibility and consequent loss of SSI and Medicaid. Appropriate special needs settlement planning is required to preserve benefits.

a. General Requirements

The SSI eligibility requirements are described in 20 C.F.R. §§416.200–416.269 and require that the applicant:

- Be aged 65 or older, blind, or disabled (20 C.F.R. §416.202(a)). An applicant is disabled if unable to earn substantial wages (20 C.F.R. §416.972)

- Have no more than the permitted earned and unearned income and resources to pay for food and shelter (20 C.F.R. §416.202(c)–(d)).

- Establish residency and prove citizenship or qualifying alien status (20 C.F.R. §416.202(b)).

b. Defining Disability

Not all persons with a disability are "disabled" for purposes of SSI eligibility. The definition is different if we are talking about an adult or minor.

- Disability for an adult is defined as the inability to engage in any "substantial gainful activity" (SGA)[4], due to any medically determinable physical or mental impairment, or combination of impairments, that has lasted or can be expected to last for a continuous period of at least 12 months, or result in death. 20 C.F.R. §416.905.
- Disability for an individual under the age of 18 is defined as "a medically determinable

[4] Substantial Gainful Activity is "a level of work activity that is both substantial and gainful. Substantial work activity involves performance of significant physical or mental duties, or a combination of both, which are productive in nature. For activity to be substantial it need not necessarily be performed on a full-time basis; work activity performed on a part-time basis may also be substantial. Gainful activity is work performed for pay or profit; or work of a nature generally performed for pay or profit, whether or not a profit is realized. In 2010, the Substantial Gainful Activity limit for the non blind is $1,000 per month, *i.e.,* income below $1,000 is not considered SGA. See http://www.ssa.gov/OACT/COLA/SGA.html.

physical or mental impairment, or combination of impairments, that causes marked and severe functional limitations, and that can be expected to cause death or that has lasted or can be expected to last for a continuous period of not less than 12 months." 20 C.F.R. §416.906.

c. Resource and Income Requirements

As a general rule, only income and resources that can be used for, or be converted into funds to pay for food and shelter are countable for purposes of SSI eligibility.[5]

Resource Limitation. An individual is only allowed to own $2,000, and an eligible couple can own $3,000. 20 C.F.R. §416.1205(c). Certain assets are not counted or are considered exempt. The most valuable assets include a home of any value, a car of any value, home furnishings, clothing and certain other assets that are set forth in 42 U.S.C. §1382b(a).

> **EXAMPLE:** An otherwise eligible SSI recipient unknowingly has a bank account that has $3,500 in it. The SSI recipient is ineligible for SSI until the assets in the bank account are spent down so ALL the person's assets are below $2,000.

Income Limitation. For SSI computational purposes, income is categorized as either earned, unearned, or in-kind income.[6] The first $20 of any income, except in-kind support and public aid, $65 of earned income, and half of the remaining earned income, are not counted as income.[7] Thus, the reduction in a recipient's SSI monthly cash payment due to unearned income is much more severe than it is with earned income.

Unearned income reduces the SSI monthly cash payment dollar-for-dollar, after taking a $20 "any-income" exemption. Earned income only reduces the SSI monthly cash payment by one dollar for each two dollars earned, after taking an earned income exemption of $65.

> **EXAMPLE:** An SSI recipient is given $500 from a friend as a gift. SSI treats this money as unearned income. The SSI check will be reduced by $480 because of the dollar for dollar reduction less the $20 any income exclusion. If instead the SSI recipient were able to earn $500 from employment his SSI check would only be reduced by $207.50 ($500 minus the earned income exemption of $65.00 and the $20 any-income exemption, divided by two).

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[5] For further specifics on what constitutes countable income and resources for purposes of SSI eligibility, see: Social Security Administration Program Operations Manual System (POMS), SI 00810.005 – What is Income and SI 01110.001 Role of Resources. The POMS can be found online at https://secure.ssa.gov/apps10/poms.nsf/partlist!OpenView. The POMS relating to Supplemental Security Income and Medicaid are found in the section: SI–Supplemental Security Income.

[6] 20 C.F.R. §§416.1104, 416.1110–416.1112, 416.1120–416.1124.

[7] 20 C.F.R. §§416.1112(c)(4), (c)(5), (c)(7), 416.1124(c)(12).

A special category of SSI unearned income, "in-kind support and maintenance" (ISM), consists of food or shelter provided directly to the recipient or paid for by a third party. ISM reduces an SSI recipient's SSI benefits, but not dollar for dollar as with unearned cash. Instead, depending on the recipient's living arrangements, the maximum reduction is subject to either the one-third reduction rule (also referred to as the "value of the one-third reduction" (VTR) or the presumed maximum value rule (PMV).[8] In general, the receipt of income will reduce an SSI recipient's check in 2010 by $244.67 or $224.67 depending on living arrangements.

d. Effect of Litigation Recovery on SSI Eligibility

A litigation award is considered SSI "income" in the month of receipt. 20 CFR §§416.1121(e)-(g). In the month after receipt, if retained by the benefits recipient, the asset will be counted as an SSI "resource." 20 CFR §§416.1207(d); POMS SI 01120.005(B)(2). The effect of a litigation recovery nearly always causes the loss of SSI.

> **EXAMPLE:** Plaintiff receives a litigation recovery of $25,000 on August 15 for personal injuries. For August, the SSI recipient loses eligibility for SSI because the cash will cause a dollar for dollar reduction of SSI up to the full amount of the SSI amount as unearned income. On the first day of September, the litigation award is considered a "resource" and if over $2,000 will cause a loss of SSI.

e. SSI Gifting Penalty

Oftentimes, a plaintiff when understanding the he or she will lose eligibility for SSI if a litigation recovery is obtained, decides that he or she will give away the assets to friends or family members. This is not a good idea as these gifts are penalized. Individuals who transfer resources for less than fair market value are ineligible for SSI for up to 36 months.[9] To calculate the period of ineligibility, the amount transferred is divided by the transferor's monthly SSI benefit (including state supplement), rounding the result up or down to the nearest whole number. 42 USC §1382b(c)(1)(A).

> **EXAMPLE:** Eric, who is on SSI benefits ($637/month), receives $30,000 from a litigation recovery. He gives his entire recovery to his brother.
>
> Transferred amount ÷ SSI = ineligibility period (30,000 ÷ 637 = 47 months). Eric is ineligible for SSI for the full 36 months.

[8] 20 CFR §§416.1130-416.1148.
[9] 42 USC §1382b(c); Foster Care Independence Act of 1999 §206 (Pub L 106-169, 113 Stat 1822); POMS SI 01150.110.

f. SSI Income and Resource Deeming

Deeming is an important concept for personal injury attorneys to understand. It is not uncommon for a minor who appears to meet the disability definition for public benefit programs to not be eligible for SSI. The reason is that until the minor reaches age 18 his or her parents' income and resources will be counted as the minor's or "deemed" to be the minor's. See 20 C.F.R. §§416.1160–1169, 416.1202–416.1204a. Thus, if no planning is done because the attorney believes that the minor is not receiving public benefits, on reaching age 18 the client would lose eligibility for SSI that could have been preserved if not for the lack of planning.

Deeming is based on the idea that those who have a legal responsibility for one another share their income and resources. Thus, the income and resources of a person having a duty of support are attributed or "deemed" to the person who is legally entitled to support. See POMS SI 01310.001. Deeming is an irrebuttable presumption: It does not matter if money is actually provided to an eligible individual for deeming to apply. 20 C.F.R. §§416.1160(a), 416.1202. There are three main situations in which income and resources are deemed:

- From an ineligible parent(s) to a minor child;
- From an ineligible spouse to an eligible spouse; and
- From a sponsor to an alien.

2. Medicaid

Medicaid rules, if anything, are more complex and arcane than SSI rules. The Medicaid program is the primary provider of medical benefits for low-income persons with disabilities.

Medicaid was added to the Social Security Act in 1965, as Title XIX, and operates under joint federal and state funding and administration. Medicaid's purpose is to enable each state (42 U.S.C. §1396) to furnish:

(1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and

(2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care.

While the Medicaid program has numerous mandatory requirements, the federal government has also given the states the authority, in establishing their Medicaid state plans, to adopt their own rules, tailoring the plan to the specific needs of their population. For example, while all states must offer certain mandatory medical services (42 U.S.C. §1396a(a)(10)), such as in-patient and out-patient hospital services, there are optional services that states can elect to offer, such as dental care and psychological services.

Medicaid Eligibility. States have three options as to how they treat SSI recipients in relation to Medicaid eligibility.

- "1634 States" - Section 1634 of SSI law allows SSA to enter into agreements with States to cover all SSI recipients with Medicaid eligibility. SSI recipients are not required to make a separate application for Medicaid under this arrangement. 32 States and the District of Columbia chose this option.

- "SSI Criteria States" - Under the second option, States elect to provide Medicaid eligibility for all SSI recipients, but only if the recipient completes a separate application with the State agency which administers the Medicaid Program. The "SSI Criteria States" are Alaska, Idaho, Kansas, Nebraska, Nevada, Oregon, and Utah and the Commonwealth of the Northern Mariana Islands.

- "209b States" - The third and most restrictive option allows States –to impose Medicaid eligibility criteria which are more restrictive than SSI criteria, so long as the criteria chosen are not more restrictive than the State's approved Medicaid State plan in January 1972. The 209(b) States may be more restrictive in defining blindness or disability, or more restrictive in their financial requirements for eligibility, and require a Medicaid application with the State. However, aged, blind, and disabled SSI recipients who are Medicaid applicants must be allowed to "spend down" in 209(b) States, if the State uses more restrictive income criteria, regardless of whether the State has a medically needy program. Currently 11 States use the 209(b) option for Medicaid coverage of aged, blind, and disabled SSI recipients. The 11 States that use this option are Connecticut, Hawaii, Illinois, Indiana, Minnesota, Missouri, New Hampshire, North Dakota, Ohio, Oklahoma, and Virginia.

3. SSDI and Medicare

In addition to the needs-based public benefits, many persons with disabilities are also eligible for entitlement benefits under the Old Age, Survivors, and Disability Insurance Program (OASDI), found in the Social Security Act. Under this program, the Social Security Administration (SSA) provides certain benefits for workers or their families when the worker retires, becomes disabled, or dies, including (42 U.S.C. §§401–434; 20 C.F.R. §§404.1–404.2127):

- Social Security retirement benefits; (not covered in this article)
- Social Security Disability Insurance (SSDI); and
- Social Security family member and survivor benefits. Social Security provides benefits for a disabled adult child of a covered worker. When a covered worker dies, becomes disabled before age 65, or retires, his or her disabled child is eligible for benefits if the child became disabled before age 22. 42 U.S.C. §§402(d)(1); 20 C.F.R. §404.350(a).

Unlike SSI and Medicaid, SSDI, Social Security Family Member benefits, and Medicare have no income or resource requirements. That is because entitlement to these programs, like Social Security retirement, is based on earnings previously paid into the Social Security system rather than on need.

The prior earnings may have been those of the beneficiary, the beneficiary's parents, or the beneficiary's spouse or former spouse.

> **CRITICAL PRACTICE POINT**: Many confuse Social Security with SSI benefits because the cash payments are almost the same and both checks come from the Social Security Administration at the beginning of the month. It is important to know precisely what benefits an individual is receiving. If the only government benefits involved are Social Security Disability and Medicare, planning may be unnecessary because these programs do not have restrictions on unearned income and resources. On the other hand, planning may nevertheless be necessary to preserve the disabled person's future eligibility for Medicaid, possibly through other eligibility programs.

a. Social Security Disability Insurance (SSDI)

SSDI payments are made to persons who have become disabled and who have worked and contributed to the Social Security system for a certain period of time. The Social Security standard of disability is identical to that of SSI: a person is considered disabled if he or she is either (1) blind or (2) unable to engage in any substantial gainful activity due to a physical or mental impairment that is expected to last (or has lasted) one year or result in death. 42 U.S.C. §423(d); cp. 42 U.S.C. §2382c(a)(1).

Social Security work credits are based on the individual's total yearly wages or self-employment income. Generally, in addition to qualifying as "disabled" a person must have 40 "work credits," 20 of which were earned within the last 10 years ending with the year the person became disabled.[10] A person can earn up to four credits each year. Each year the amount of annual earnings required for a credit changes. In 2009, you will earn one credit for each $1,090.00 of wages or self-employment income. Once the individual's earnings reach $4,360.00, they earn four credits for 2009. Social Security Disability payments begin 5 months after a determination of eligibility.

b. Medicare

Medicare is a federal program with no income or resource requirements. It provides health insurance for individuals who are age 65 or over, disabled, or have end stage kidney disease or amyotrophic lateral sclerosis (ALS; also known as Lou Gehrig's disease). Medicare is also known as the "Health Insurance Act for the Aged and Disabled" under Title XVII of the Social Security Act. 42 U.S.C. §§1395–1395hhh.

Medicare is linked to Social Security Disability much as Medicaid is to SSI.

[10] In some cases, a younger worker may qualify for SSD even though he has not received 40 credits. *See, Disability Planner: How Many Credits do you Need. Social Security Online. Retrieved from*: http://www.ssa.gov/dibplan/dqualify3.htm

CRITICAL PRACTICE POINT: The person receiving SSDI will automatically be enrolled in Medicare 24 months after he or she begins to receive SSDI payments.

Medicare provides health care coverage to eligible disabled or elderly participants. It does not cover all health care needs or cover all costs of care received. Medicare does not cover any service that is not medically "reasonable and necessary." 42 U.S.C. §1395y(a)(1); 42 C.F.R. §411.15(k). It specifically excludes coverage of, among other things, routine physical examinations, custodial care, and some preventive care. 42 U.S.C. §1395y; 42 C.F.R. §411.15.

4. Other Public Benefits

a. Veterans Administration.

VA benefits can include compensation (for service-connected disabilities), pensions (for nonservice-connected disabilities), and medical and other benefits. Depending on the type of benefit, it may be available to veterans of military service, their dependents, and their survivors.[11] The eligibility requirements for each benefit are different and complex. It far exceeds the scope of these materials.

b. Section 8[12]

The federal Section 8 Housing Program began in 1975, with the goal of providing safe and affordable housing to persons of limited means.[13] In general, persons who have incomes that are less than 50% of their area median income can qualify for Section 8 Housing supplements, given in the form of rent vouchers. Under Section 8, the household pays a portion of monthly housing costs based on the income of the household. This portion is usually equal to 30 percent of the household's monthly adjusted income. The Section 8 voucher will cover the remainder of the rent.

Lump-sum amounts received by a Section 8 recipient, such as a litigation settlement, are considered assets not income. 24 C.F.R. §§5.609(c), 982.316Voucher Guidebook §5.2, Exhibit 5-2, Income Exclusions (3). The receipt of these types of assets alone should not interfere with Section 8 benefits, although the income earned from these assets will be counted. Moreover, if the Section 8 recipient transfers the assets to an SNT, it is treated the same as a transfer of assets for less than fair market value.

EXAMPLE: Julie Daniels, a long-time Section 8 recipient, was injured in a car accident. She received a settlement of $300,000 to compensate her for her personal injuries and an additional $5000 to compensate her for 12 months of past wage loss. A (d)(4)(A) SNT, funded with all the settlement proceeds, was established for Julie's benefit. Julie will have to pay around $275 more per month

[11] A guide to all VA benefits is available on the website of the VA Office of Public Affairs at http://www1.va.gov/opa/publications/benefits_book.asp.

[12] For a relatively user-friendly treatment of a very complex area, see: Section 8 Made Simple, Using The Housing Choice Voucher Program To Assist People With Disabilities, and Published By: The Technical Assistance Collaborative, Inc., Boston, MA. It can be found at: http://www.tacinc.org/Docs/HH/Sect8_2ndEd.pdf

[13] The name of the program has since been changed to the Housing Choice Voucher Program. However, it is still commonly referred to as the Section 8 Housing Program.

for her share of the total tenant payment. First, she must count the $5000 as income prorated over the 12-month period because it is payment in place of earnings. This will result in an additional monthly payment of $125. She also must include the $300,000 under the transfer of assets for less than fair market rules. This means that her rent will increase by $150. This portion is calculated as follows: $300,000 (settlement) times 2 percent (HUD-determined passbook rate) / 12 (monthly rate) times 0.30 (tenant portion of payment). The calculations are more complicated than indicated in this example, but this provides a general summary of the program's requirements.

III. Preserving SSI and Medicaid Eligibility with the Special Needs Trust (SNT)

A personal injury client who receives a litigation recovery must provide some plan to preserve eligibility for public benefits. Good planning is essential because either having assets or the receipt of assets will cause the person with a disability to lose his or her SSI and Medicaid until the assets are spent to below $2,000 for an individual or $3,000 for a couple (*i.e.*, the resource limits for SSI and Medicaid).

The primary planning tool is transferring the assets into a qualified first party special needs trust (SNT), but it is not the only option. The available options are:

- Doing nothing and losing needs-based public benefits until assets are spent to below $2,000 for an individual or $3,000 for a couple;
- Placing assets in a first party SNT authorized under 42 U.S.C. §1396p(d)(4)(A) (commonly called a (d)(4)(A) SNT) as described below
- Joining a pooled SNT authorized under 42 U.S.C. §1396p(d)(4)(C) and preserving both assets and needs-based public benefits as described below
- Spending the assets on exempt assets such as a personal residence or automobile or other qualified expenditures until assets are below $2,000 for an individual or $3,000 for a couple. This is commonly called a spend-down;
- Gifting, transferring, or disclaiming assets, which results in the loss of needs-based public benefits for a period of time. Generally not favorable due to loss of benefits; or
- Some combination of the above.

The primary way to preserve needs-based public benefits like SSI or Medicaid for a litigation recovery is to transfer it into a qualifying first- party SNT. [14] An SNT is a trust into which assets are

[14] There are two federal statutes that carve out these "safe harbor" trusts. Medicaid allows such trusts under the

placed to be used for the benefit of a person with special needs. In the context of a personal injury case, the assets that are placed into the trust are the proceeds of a settlement or award (including structured settlement payments) given to the plaintiff who will require needs-based government benefits.

The two types of first party SNT are the (d)(4)(A) SNT and the Pooled SNT whose requirements are:

A. (d)(4)(A) SNT

The (d)(4)(A) SNT (sometimes called a Payback Trust) is a creature of statute, specifically, 42 U.S.C. §1396p(d)(4)(A). Assets in the trust are not "countable resources" for SSI and Medicaid eligibility purposes. The d4a trust is used for only one beneficiary. A trustee is appointed to manage the trust and make disbursements. Following are some conditions and limitations relating to the d4A trust:

- The trust can only be established for someone under age 65 and funded while the person is under 65 (although the trust can continue in effect after age 65)

- The trust must be established by a parent, grandparent, legal guardian or a court (but ***not*** by the beneficiary)

- The trust can hold assets owned by the beneficiary, including awards obtained in litigation and structured settlement payments

- If the trust is to be funded with proceeds from a personal injury settlement or award, any existing Medicare or Medicaid "liens" must be paid first before transferring the funds to the trust

- Any amount remaining in the trust on the death of the beneficiary must be used first to reimburse any medical benefits provided by the government, and if anything is left it can pass to the estate of the beneficiary.

B. Pooled SNT

The Pooled Trust is also a creature of statute, specifically, 42 U.S.C. § 1396p(d)(4)(C). There is a master trust created by a non-profit organization. Persons who wish to transfer their funds to the Pooled SNT in order to qualify for, or continue to receive; needs-based government benefits do so by signing a joinder agreement and transferring the funds to the trustee.

Omnibus Budget Reconciliation Act of 1993 (OBRA 1993) (42 U.S.C., §1396p(d)(4)). The SSI program allows the same trusts under the Foster Care Independence Act of 1999 (FCIA) (42 U.S.C., §1382b), which incorporates the Medicaid safe harbor provisions of OBRA 1993 into SSI law.

The funds transferred by the beneficiary are pooled with other assets held by the trust. A sub-account is set up for the beneficiary. The sub-account is administered for the benefit of the beneficiary in the same way and subject to the same distributions as a (d)(4)(A) SNT. Following are some conditions and limitations relating to the d4C trust:

- The trust is created and managed by a nonprofit organization [15]
- The account can be set up by the individual, a parent, grandparent, legal guardian or a court
- There is no age restriction on a d4C trust, so it can also be used for the individual age 65 or older
- An individual's funds are transferred to the trust, which creates a separate bookkeeping sub account for the individual, but pools several persons' funds into one investment trust account for purposes of investment and administration
- Upon the death of the beneficiary, any amount in the trust that is not retained by the charity establishing the trust must be used to reimburse any medical benefits provided by Medicaid
- If the trust is to be funded with proceeds from a personal injury settlement or award, any existing Medicare or Medicaid "liens" should be paid first before transferring the funds to the trust

C. Establishing the Special Needs Trust

Because a person with a disability is not allowed to establish his or her own (d)(4)(A) SNT, determining the correct procedure to establish the trust is often a very difficult task. The choice of the proper procedure depends on a number of variables, the most critical of which are whether:

- There is a parent, grandparent or legal guardian willing to assist, or, if not, whether a court order can be obtained;
- The person has capacity; and
- The person is a minor, age 18 or over but under age 65, or age 65 or over.

[15] A list of Pooled SNTs throughout the country is located at http://www.specialneedsanswers.com/resources/directory_of_pooled_trusts.asp.

Each State has different requirements in establishing an SNT. For example, establishment of a (d)(4)(A) SNT can be difficult if the personal injury attorney's client lacks capacity. The trust must be established by a Court because the beneficiary lacks the capacity to consent to the funding of the trust.

> **PRACTICE POINTER**: Oftentimes, if a court petition is required, to establish the (d)(4)(A) SNT, the process can take weeks. Thus, it is important for personal injury attorneys to engage special needs planning attorneys as early as possible so the trust can be established in a timely manner.

If a court is needed to establish the (d)(4)(A) SNT, the petitioning attorney typically asks the court to enter an order establishing the trust and incorporating proposed draft language of the trust into the order by reference, thus avoiding the court having to perform the physical act of signing the trust. Many States will require a brief with the court, showing support for the proposition that the court is authorized to establish the trust under the Social Security Act and under applicable State law, if available. This will often give the judge comfort that he or she is not exceeding judicial authority.

If the client has capacity and a parent or grandparent willing to assist, then the trust can be set up by the parent, grandparent or legal guardian. This is commonly called a "seed trust" after the POMS that authorizes the procedure. POMS SI 01120.203(B)(1)(f) and (g).

In all cases involving minors or adults who lack capacity, the best practice is to seek court approval to transfer the balance of the settlement proceeds (after payment of the Medicare and Medicaid reimbursement and the personal injury attorney's fees) to the (d)(4)(A) SNT.

If the settlement involves structured settlement payments, the payments should be made directly to the (d)(4)(A) SNT. This can be done by making the appropriate motion to the court, or including this relief as part of the paperwork seeking approval of the settlement. If the personal injury attorney obtains an award after judgment, he or she may have to petition the court separately for permission to fund the (d)(4)(A) SNT and, if necessary, have the court establish the (d)(4)(A) SNT.

If the client has no parent, grandparent or legal guardian, or if the amount of funds to be transferred is too small for a (d)(4)(A) SNT, the personal injury attorney can consider transferring the funds to a Pooled SNT. As noted, the mechanism for participating in a Pooled SNT is simply to sign a joinder agreement with the chosen Pooled SNT.

> **PRACTICE POINTER**. For a plaintiff who is 65 years of age or older, it is not possible to establish a (d)(4)(A) SNT due to its age requirement. For these plaintiffs, it is required that SNT alternatives be considered or they join a Pooled SNT. However, it is important to understand that some States may penalize the joining of a Pooled SNT by a person age 65 or older.

D. Ongoing Administration of a Special Needs Trust

Once the SNT is established, the assets held in the trust will not disqualify the plaintiff from his or her public benefits. However, the plaintiff must understand the limitations of an SNT. The hardest thing about this planning is describing the limitations placed on the funds in an SNT.

The primary purpose of any SNT is to improve the overall quality of life of the person with a disability. The trustee, in many cases, is asked to perform a balancing act between making distributions that do not violate the "income" or "resource" rules of the applicable benefit program (typically SSI and Medicaid) and providing the beneficiary goods and services so he or she does not have to live at the poverty level. The most difficult balancing task an SNT trustee is required to perform is deciding whether a distribution that will reduce (or even eliminate) a beneficiary's government benefits is in the beneficiary's best interest.

For example, a first-party SNT must only be used for the “sole benefit” of the primary beneficiary during his or her lifetime. It is very difficult to explain to an SNT beneficiary or his or her immediate family that assets in a first-party SNT cannot be used to support a minor child or spouse. Even a simple gift of $100 to a child is forbidden. In addition, another limitation is that the SNT cannot give cash directly to an SNT beneficiary. Under the SSI program, beneficiaries must report all income received each month and lose a dollar of benefit for every dollar of income over $20 a month. This includes distributions from his or her SNT. There are numerous other limitations, so it is prudent that the practitioner understand and guide the plaintiff through these issues before he or she consents to the establishment of a first-party SNT.

Plaintiffs must also understand that while there are limitations, an SNT can also have great flexibility. A short list of permissible distributions that will not interfere with public benefits eligibility are:

- Automobile/van;
- Accounting services;
- Acupuncture/acupressure;
- Appliances (TV, VCR, DVD player, stereo, microwave, stove, refrigerator, washer/dryer);
- Bottled water or water service;
- Bus pass/public transportation costs;
- Camera, film, recorder and tapes, development of film;
- Clothing;
- Clubs and club dues (record clubs, book clubs, health clubs, service clubs, zoo, advocacy groups, museums);
- Computer hardware, software, programs, and Internet service;
- Conferences;
- Courses or classes (academic or recreational), including books and supplies;
- Curtains, blinds, and drapes;
- Dental work not covered by Medicaid, including anesthesia;
- Down payment on home or security deposit on apartment;
- Dry cleaning and/or laundry services;
- Elective surgery;

- Fitness equipment;
- Funeral expenses;
- Furniture, home furnishings;
- Gasoline and/or maintenance for automobile;
- Haircuts/salon services;
- Hobby supplies;
- Holiday decorations, parties, dinner dances, holiday cards;
- Home alarm and/or monitoring/response system;
- Home improvements, repairs, and maintenance (not covered by Medi-Cal), including tools to perform home improvements, repairs, and maintenance by homeowner;
- Home purchase (to the extent not covered by benefits);
- House cleaning/maid services;
- Insurance (automobile, home and/or possessions);
- Legal fees/advocacy (may need court approval of legal fees if court-supervised);
- Linens and towels;
- Magazine and newspaper subscriptions;
- Massage;
- Musical instruments (including lessons and music);
- Nonfood grocery items (laundry soap, bleach, fabric softener, deodorant, dish soap, hand and body soap, personal hygiene products, paper towels, napkins, Kleenex, toilet paper, and household cleaning products);
- Over-the-counter medications (including vitamins and herbs);
- Personal assistance services not covered by Medi-Cal;
- Pet and pet supplies, veterinary services;
- Physician specialists if not covered by Medi-Cal;
- Private counseling if not covered by Medi-Cal;
- Repair services (*e.g.*, for appliances, automobile, bicycle, household, or fitness equipment);
- Snow removal/landscaping/gardening (lawn) services;
- Sporting goods/equipment/uniforms/team pictures;
- Stationery, stamps, and cards;
- Storage units;
- Taxicab;
- Telephone service and equipment, including cell phone, pager;
- Therapy (physical, occupational, speech) not covered by Medicaid;
- Tickets to concerts or sporting events (for beneficiary and an accompanying companion, if necessary);
- Transportation (automobile, motorcycle, bicycle, moped, gas, bus passes, insurance, vehicle license fees, gas, car repairs);
- Utility bills (satellite TV, cable TV, telephone—but not gas, water, or electricity);
- Vacation (including paying for a personal assistant to accompany the beneficiary if necessary).

IV. Resolving Medicare's Future Interest by Utilizing a Medicare Set Aside Arrangement (MSA)

Many injury victims are Medicare beneficiaries, which implicates the Medicare Secondary Payer Act (MSP). The MSP is a series of statutory provisions enacted in 1980 as part of the Omnibus Reconciliation Act with the goal of reducing federal health care costs.[16] The MSP provides that if a primary payer exists, Medicare only pays for medical treatment relating to an injury to the extent that the primary payer does not pay. 42 C.F.R. § 411.20(2) Part 411, Subpart B, (2007).

There are two issues that the MSP deals with: (1) Medicare payments made prior to the date of settlement ("conditional payments"), and (2) future Medicare payments for covered services.

> **NOTE**: The discussion in this article only discusses Medicare's right to recover against future medical bills paid for a Medicare recipient and not for those payments Medicare made during the pendency of the lawsuit.

A Medicare set-aside arrangement (MSA) describes a mechanism developed in the context of workers' compensation settlements and approved by the Centers for Medicare and Medicaid Services (CMS) (the federal agency responsible for administering Medicare) to protect Medicare's interest as a secondary payer under 42 U.S.C. §1395y(b)(2). At the present time, CMS has only promulgated policies for its post-settlement status as secondary payer in workers' compensation cases. However, CMS has taken the position that Medicare's "future interests" must also be considered in liability settlements. CMS interprets 42 U.S.C. §1395y(b)(2)(A) to include a personal injury settlement as a situation in which "payment has been made" for an item or service otherwise covered by Medicare "under an automobile or liability insurance policy or plan (including a self-insured plan) or under no fault insurance."

An MSA can be defined as an arrangement through which an amount of a settlement is allocated (or "set-aside") to cover future anticipated medical expenses related to a claimant's compensable injuries that would otherwise be covered under Medicare. No Medicare payments are made until the lump sum settlement amount that is intended to compensate for future medical expenses is spent to cover medical expenses that would otherwise be covered by Medicare. 42 C.F.R. §411.46. The set aside may or may not be approved by CMS, it is voluntary whether to submit it for approval. This will be discussed in greater detail herein.

Planning in this area consists of four primary areas:

- Understanding which settlements require an MSA analysis;
- Determining the amount of the settlement that must be set-aside to protect Medicare's future interest in the appropriate case;
- Establishing the appropriate vehicle (*e.g.* Medicare set-aside trust/custodial agreement) to

[16] (The provisions of the MSP can be found at Section 1862(b) of the Social Security Act. 42 U.S.C. § 1395y(b)(6) (2007).)

hold the set-aside amount; and
- Properly administering the Medicare set-aside arrangement so it complies with CMS policies and procedures regarding exhaustion.

A. Basic Concepts

1. When an MSA is Not Required

An MSA is not necessary if:

- The client is not a Medicare beneficiary and isn't reasonably likely to become one within 30 months of settlement.
- The settlement is only for past medical expenses;
- There is no evidence that the individual is attempting to maximize the other aspects of the settlement to Medicare's detriment; or
- The treating physician, in writing, determines within a reasonable degree of medical certainty the individual will not need future Medicare covered services related to the injury

2. Effect of Ignoring Medicare's Future Interest

The failure to address Medicare's future interest creates two primary issues:

1. Medicare may refuse to pay for injury related care until entire settlement is exhausted.
2. There could be malpractice risk, ethical and legal considerations for parties to settlement.

In the written memos that CMS issues concerning MSAs, it states:

> "When an attorney's client effectively ignores Medicare's interests in a WC case, the attorney should consult their national, state, and local bar associations for information regarding their ethical and legal obligations. Additionally, attorneys should review applicable statutes and regulations, including, but not limited to, 42 C.F.R. 411.24 (COA to recover) and 411.26 (subro)."[17]

3. Notice and Reporting Requirement

Effective January 1, 2011, liability insurance plans (including self-insured plans), no-fault insurance, and workers' compensation will have an affirmative obligation to determine if a claimant is entitled to Medicare and, if so, to place Medicare on notice of the entitlement and to submit certain information. Pursuant to CMS's Mandatory Insurer Reporting guidelines, the party responsible for putting Medicare on notice and for submitting the required information is known as the "responsible reporting entity" (RRE), who will be required to do all of the following (42 U.S.C. §1395y(b)(8)):

[17] Workers' Compensation Medicare Set-aside Arrangements Ethical and Legal Considerations (Ref: 4/21/03 Memo Q12)

- Determine whether a claimant (including an individual whose claim is unresolved) is entitled to Medicare benefits; and

- If the claimant is determined to be so entitled, submit information regarding the identity of the claimant, and other information regarding coordination of benefits, and applicable recovery claims as provided in regulations to be developed by the Secretary of Health and Human Services in a form and manner (including frequency) specified by the Secretary.

Failure to file the required information to CMS within the time parameters to be established by CMS will result in a civil penalty of $1000 per day per claimant. This penalty is in addition to any other applicable penalties at law under the MSP. 42 U.S.C. §1395y(b)(8)(E).

The RRE's are defined below as:

- **INSURER.** For purposes of the reporting requirements for 42 U.S.C. 1395y**(**b)(8), a liability insurer (except for self-insurance) or a no-fault insurer is an entity that, in return for the receipt of a premium, assumes the obligation to pay claims described in the insurance contract and assumes the financial risk associated with such payments. The insurer may or may not assume responsibility for claims processing; however, the insurer has the responsibility for the reporting requirements at 42 U.S.C. 1395y(b)(8) regardless of whether it uses another entity for claim processing.
- **CLAIMANT.** For purposes of the reporting requirements at 42 U.S.C. 1395y(b)(8), "claimant" includes: 1) an individual filing a claim directly against the applicable plan, 2) an individual filing a claim against an individual or entity insured or covered by the applicable plan, or 3) an individual whose illness, injury, incident, or accident is/was at issue in "1)" or "2)".
- **APPLICABLE PLAN.** For purposes of the reporting requirements at 42 U.S.C. 1395y(b)(8), the "applicable plan" as defined in subsection (8)((F) has the responsibility for the reporting requirements at 42 U.S.C. 1395y(b)(8). For workers' compensation information this would be the Federal agency, the State agency, or self-insured employer or the employer's insurer.
- **NO-FAULT INSURANCE.** Trade associations for liability insurance, no-fault insurance and workers' compensation have indicated that the industry's definition of no-fault insurance is narrower than CMS' definition. For purposes of the reporting requirements at 42 U.S.C. §1395y(b)(8), the definition of no-fault insurance found at 42 C.F.R. §411.50 is controlling.
- **LIABILITY SELF-INSURANCE.** 42 U.S.C. §1395y(b)(2)(A) provides that an entity that engages in a business, trade or profession shall be deemed to have a self-insured plan if it carries its own risk (whether by a failure to obtain insurance, or otherwise) in whole or in part. Self-insurance or deemed self-insurance can be demonstrated by a settlement, judgment, award, or other payment to satisfy an alleged claim (including any deductible or co-pay on a liability insurance, no-fault insurance, or workers' compensation law or plan) for a business, trade or profession. See also 42 C.F.R. §411.50.

These guidelines and procedures are referred to by CMS as the agency's Mandatory Insurer Guidelines (MIR), which consist of very detailed reporting requirements concerning the nature of the data to be reported and the frequency and timing of filing. Under the MIR, reporting will be done

electronically and the RRE must comply with a detailed registration and testing process regarding electronic filing. While the RRE may use an agent to report the required data, the RRE (and not the agent) must complete the registration process and remains ultimately responsible for liability purposes under 42 U.S.C. §1395y(b)(8). On February 22, 2010, CMS published its updated User Guide for MIR Compliance, which provides detailed instructions on the submission of required data by non-GHP RREs. Additional alerts continue to refine CMS's reporting requirements.

B. What is the Responsibility of Personal Injury Attorney?

There has been a lot of recent discussion in legal circles regarding just what attorneys and their clients who receive Medicare are supposed to do in order to "reasonably protect" Medicare's future interest in the context of a personal injury settlement. The confusion is understandable because of the lack of direction from the CMS.

Currently, there are no set procedures for "reasonably protecting" Medicare's future interest for personal injury cases. Thus, attorneys have attempted to utilize procedures that were established for "reasonably protecting" Medicare's future interest in Workers Compensation settlements. However, this has been difficult because even those procedures established for Workers Compensation cases are voluntary, they do not always work with personal injury matters, and generally will not receive a blessing from CMS.

However because of the potential loss of Medicare benefits for clients, the prudent thing is to undertake an MSA analysis to demonstrate that Medicare's interests were considered. The primary way to address Medicare's interests is to use a Medicare Set Aside Arrangement (MSA) which is CMS's approved method to address their interests under the MSP. There are Medicare set-aside professionals who can prepare an estimate of the amount to be set aside, the "allocation".

C. How to Establish an MSA

A personal injury attorney should consider retaining the services of a Medicare set aside professional who can evaluate the estimated future injury-related medical expenses, determine what portion of those expenses would otherwise be covered by Medicare, and provide the appropriate number for the set-aside amount. Having an independent assessment of the set-aside amount will make it easier to argue in the future that Medicare's interests were protected.

Once the set-aside amount is calculated, the settlement planning professional must then set up a mechanism to hold the funds and have them applied to future injury-related medical expenses. There are a number of ways this can be accomplished:

1. The MSA Trust

A Medicare set-aside trust (MSAT) is an MSA in the form of a formal trust agreement, administered by a trustee. Consequently, such trusts are subject to state and federal fiduciary laws applicable to trusts and trustees. These laws provide significant protections, both for the claimant, who is the beneficiary of the trust, and for Medicare. The funds in an MSAT should be placed in FDIC insured

investments to ensure continued growth of the funds and to ensure that funds will be available when needed to cover medical costs.

Although a properly and carefully drafted MSAT administered by an experienced trustee provides a formal and safe means for the settling claimant to reasonably consider Medicare's interest with the "blessing" of CMS, MSATs have two significant drawbacks:

- Often, medical claims administrators with sufficient expertise in Medicare to ensure proper trust distributions for Medicare-covered services are not licensed as professional trustees. Thus, proper MSAT administration requires both a trustee and a professional medical claims administrator, which results in increased costs.

- Professional trustees typically charge fees based on a minimum annual amount, plus a percentage of the value of the money in the trust. The fees may seem disproportionately large compared to the size of the fund being administered. Further, it may be difficult to find a professional trustee willing to serve if the Medicare set-aside amount is less than $100,000 because many professional trustees will only agree to administer trusts with at least that amount in assets. Finally, the funds in the MSA can't be used to pay the trustee so a 3rd party source would have to pay those fees.

2. MSA Custodial Agreement

Medicare set-aside custodial agreements contain guidelines and protections similar to those found in trust agreements to ensure proper administration of the set-aside funds, but because custodial agreements are not trusts, a medical claims administrator can administer the funds without being licensed as a professional trustee. Moreover, the medical claims administrator/custodian charges significantly smaller fees than a professional trustee. Medicare set-aside custodial agreements are routinely accepted by CMS in lieu of a formal trust**.**

3. Self-Administered Medicare Set-Aside Arrangements

CMS allows self-administration of MSAs (if it is permitted under state law, i.e. no competency issues) and requires adherence to the same guidelines for administration as arrangements being administered professionally.[18]

When formal Medicare set-aside custodial agreements become disproportionately expensive, a self-administered Medicare set-aside arrangement may be the solution to administer a smaller settlement. The vast majority of workers' compensation claims for future medical expenses settle for less than $50,000; most will settle for under $20,000. In these cases, even the fees of professional medical claims administrators can be cost prohibitive. Claimants are increasingly using self-administered arrangements, especially since the ban on payment of administrative and attorney fees from Medicare set-aside arrangements went into effect on May 7, 2004.[19]

[18] CMS Memorandum (Apr. 23, 2003) Q9.
[19] CMS Memorandum (May 7, 2004).

Even though self-administration is permitted, it is not always advisable. Many claimants will simply not make appropriate administrators due to lack of sophistication or poor money-management skills. Because CMS guidelines regarding self-administration do not contain specific provisions regarding administration, a formal trust or custodial agreement (or terms in the settlement agreement) should be used to memorialize the following points, even though CMS does not require a formal agreement for self-administered Medicare set-aside arrangements:

- The claimant must apply the portion of his or her settlement allocated to future medical expenses solely to payment of injury-related future medical expenses otherwise covered by Medicare before Medicare will cover those items;
- The claimant must determine which of his or her medical expenses are of the type normally covered by Medicare and what the proper payment amounts would be;
- The claimant should submit an annual self-attestation form when monies have been exhausted; and
- The claimant must keep meticulous records, receipts, and other related documents needed to verify proper application of their settlement funds, especially if it will take several years to exhaust those funds.

4. Dual Eligibility - MSA/Special Needs Trust

Some injury victims are "dual eligible," meaning they qualify for both Medicaid and Medicare. In certain cases, a Medicare set-aside/special needs trust or pooled trust sub-account may be necessary to preserve the client's dual eligibility. An MSA without an SNT can pose problems for plaintiffs or claimants who may also need to preserve eligibility for Medicaid or SSI. MSAs are not subject to any special treatment under Medicaid resource rules.[20] Because Medicare set-aside trusts, custodial agreements, and self-administered arrangements are all funded with property belonging to the plaintiff or claimant, each will be subject to SSI and Medicaid restrictions applicable to self-settled trusts. As a result, funds held in such MSAs will generally be considered available resources for purposes of determining Medicaid or SSI eligibility; or the funding of such arrangements will be treated as transfers without fair consideration, resulting in the imposition of a period of ineligibility, unless the MSA also meets the Medicaid special needs trust rules.[21]

If the plaintiff must preserve Medicaid or SSI eligibility, a formal Medicare set-aside trust must be created that also complies with the Medicaid or SSI criteria applicable to a first party SNT—in other words, a Medicare set-aside/SNT. There are two types of SNTs that can be used in the case where the personal injury attorney's client is also on needs-based benefits, such as SSI or Medicaid, or is expected to need needs-based government benefits in the future. These two options are a special needs trust and a pooled special needs trust.

[20] CMS Memorandum (July 1, 2005) Q13.
[21] CMS Memorandum (July 1, 2005) Q13.

D. Submission of MSA for approval by CMS

Liability Cases

There is uncertainty whether to seek CMS approval of a MSA arrangement in a personal injury matter. Technically, there is no requirement for seeking CMS approval of an MSA arrangement in any case.

> **CRITICAL PRACTICE POINT.** Even though there is no absolute statutory requirement that the personal injury attorney seek CMS review of MSAs, the personal injury attorney is taking a significant risk if the client meets the CMS review thresholds in a WC case and nothing is done to seek CMS approval. Because as discussed below, the trend appears to be heading in the direction of MSA reviews for Liability MSAs (LMSA), the personal injury attorney should give serious consideration to seeking CMS approval of the MSA in a personal injury case.

In addition, at a recent Town Hall Telephone Conference on March 24, 2009, involving reporting requirements under Section 111 of the Medicare, Medicaid & SCHIP Extension Act OF 2007, 42 U.S.C. 1395y(b)(8) **(MMSEA)**, Ms. Barbara Wright, CMS' Acting Director of the Division of Medicare Debt Management, made several comments respecting MSAs in the context of WC and personal injury cases:

> "John's question about worker's comp set-asides and liability set-asides, ***we'll repeat what we said over and over is that the worker's compensation set-aside process first of all that is not a required process; it's a voluntary process that's highly recommended***. Secondly CMS for liability set-asides does not have the same formal review process although our regional offices will consider review of proposed liability set-aside amounts depending on their particular work load and whether or not they believe significant dollars are at issue. . .Well the point is the set-aside process is totally separate from the Section 111 reporting process. As we've said in more than one call we don't anticipate changing our routine recovery processes. When there is a TPOC (third party obligation to claimant - RJF) amount typically what we're doing is pursuing recovery against the beneficiary's settlement, judgment award or other payment; we are not - the fact that you're reporting to us doesn't change any other obligations or eliminate any other obligations.[22] (Emph. added).

[22] Transcript: Town Hall Teleconference – Section 111 of the Medicare, Medicaid & SCHIP Extension Act of 2007, 42 U.S.C. 1395y(b)(8), Date of Call: March 24, 2009, PAGES 23-24, retrieved at http://www.cms.hhs.gov/MandatoryInsRep/Downloads/MMSEA111March24NGHPTranscript.pdf

Ms. Wright went on to add:

> ***Liability set-asides; both of them, worker's comp and liability neither one of them has ever been required to participate in a CMS review process***. . .Nonetheless they're based on the same underlying statutory language which is that Medicare is not supposed to pay if payment has been made. And to the extent a settlement, judgment award or other payment takes into consideration future medicals then that settlement, judgment or award should be appropriately expended for those future medicals. The fact that we don't have a formal review process never did and does not create any type of safe harbor if it's not reviewed by CMS. The threshold for review for worker's compensation, Medicare set-asides is just that. It's a workload threshold that doesn't create any type of substantive safe harbor for instances where the worker's compensation settlement is below that threshold.[23] (Emph. added)

CMS does not have a formal review criteria/approval process for liability MSAs. Nonetheless, certain CMS Regional Offices (ROs) are electing to review liability MSAs. It should be noted that there is no guarantee that the RO will agree to review each submitted proposal—this decision lies solely in the discretion of the RO.

If the personal injury attorney wishes to seek CMS approval for the LMSA, then the procedures for MSAs in the worker's compensation regulations can be utilized. The procedures set out for Workers Compensation Medicare Set-Asides can be found on the CMS website.[24]

It should also be noted that there is no appellate procedure regarding MSA determinations by CMS and if submission is made to CMS, it could impair an injury victim's rights with no remedy. The decision of whether to submit a proposed LMSA or not should be carefully considered.

Worker's Compensation Cases Review Thresholds

While the CMS review process is voluntary, CMS will review an MSA in a Workers' Compensation case when either:

1. The claimant is currently a Medicare beneficiary and the total settlement amount is greater than $25,000; or
2. The claimant has a "reasonable expectation" of Medicare enrollment within 30 months of the settlement date and the anticipated total settlement amount for future medical expenses and disability/lost wages over the life or duration of the settlement agreement is expected to be greater than $250,000.[25]

> **CRITCAL PRACTICE POINT.** *Reasonable expectation* is defined as someone age 62 ½; currently receiving Social Security Disability (SSD); has applied for SSD; appealing denial of SSD or diagnosis of end stage renal disease/ALS.

[23] *Ibid*, at p. 61
[24] The basic procedures can be found at the CMS website. See Fn. 22, *supra*.
[25] *See* CMS, *Workers Compensation Medicare Set-aside Arrangements (WCMSAs)*, Fn. 22, *supra*.

How and Where to Submit

Once the documentation in support of the MSA allocation is gathered, it must be organized and submitted with a cover letter to CMS for review. CMS has very specific requirements for the submission of workers' compensation MSA (WCMSA) proposals. See http://www.cms.hhs.gov/WorkersCompAgencyServices/05_wcmsasubmission.asp#TopOfPage.

All liability MSA proposals submitted for CMS review must be sent to the appropriate Regional Office. All WCMSA proposals must be submitted to: CMS, Coordination of Benefits Contractor, Attention: WCMSA Proposal, P.O. Box 33849, Detroit, MI 48232.

V. Taking a Deep Breath - The Qualified Settlement Fund (QSF)

A Qualified Settlement Fund or (QSF or 468B Trust) is a relatively unknown tool that can provide a great benefit for a plaintiff or plaintiffs who require settlement planning.

A QSF can be used for a variety of reasons. One example is when a case is settled for John Doe who is married to Jane. John has a significant brain injury and there are questions of competency. John was injured on the job but had a products liability claim which is the part of the case that was settled. He receives both Medicaid and Medicare benefits. Medicare and Medicaid both have substantial liens along with the Workers' Compensation carrier. Jane has a loss of consortium claim and there are issues of allocation of the settlement that have yet to be handled. A Medicare Set Aside may be necessary to preserve Medicare and a Special Needs Trust is a must to preserve his Medicaid eligibility. A structured settlement is also being considered for part of the settlement proceeds. In addition, the defendant's insurance carrier has stopped taking new business and is only paying off claims indicating that it is in financial distress.

How can all of these issues be handled? How can the attorney get the money from the defendant immediately without ruining the client's available settlement planning options? The answer to all of these questions is to use a QSF.

A. What is a QSF and Why Use One?

A QSF is a temporary trust established to receive settlement proceeds from a defendant or group of defendants. Its primary purpose is to allocate the monies deposited into it amongst various claimants and disburse the funds based upon agreement of the parties or court order, if required. Upon disbursing all of the monies the QSF ends.

There are many reasons to use a QSF in a settlement. First and foremost, they are quite easy to establish. There are only three requirements for establishing a QSF.

1. It must be created by a court order with continuing jurisdiction over the QSF.[26]

[26] Treas. Reg. §1.468B-1(c)(1).

2. The trust is set up to resolve tort or other legal claims prescribed by the Treasury regulations.[27]
3. Finally, it must be a trust under applicable state law.[28]

Any court, with or without jurisdiction over the matter, may sign the order creating the QSF and exert continuing jurisdiction over the trust.

The QSF is a temporary holding tank for the litigation settlement proceeds. It does not exist in perpetuity and is not meant to be a support trust for claimants. Instead, it exists for as long as there are allocation issues between the parties or planning that needs to be done prior to disbursement. It can exist for weeks, months or even years.

A QSF may hold benefits for all parties as it relates to taxes, timing of income and settlement planning needs. A tax-free structured settlement and a tax-deferred attorney fee structure can be properly created through the use of a QSF. The parties can influence timing of income through the use of a QSF. QSF claimants are typically not taxed on funds in the QSF until those funds are distributed (assuming the damages are taxable). A QSF also gives some extra time and flexibility for claimants to make decisions related to settlement planning issues.

The defendant receives an immediate tax deduction upon contributing the agreed upon amount to the QSF and is typically permanently released.[29] This is a large benefit to the defendant as normally a defendant cannot claim a deduction until the funds are received by the claimant which can be delayed in a complicated settlement. An important point is that the tax deduction for the defendant is not impacted by when distributions actually flow out of the QSF.

The tax treatment of QSFs is uncomplicated. A QSF is assigned its own Employer Identification Number from the IRS. A QSF is taxed on its modified gross income[30] (which does not include the initial deposit of money), at a maximum rate of 35%. Thus, it is taxed on accumulations to the principal from interest or dividends less deductions[31] available which include administrative expenses.

B. Brief Legislative History

Qualified Settlement Funds grew out of Internal Revenue Code ("IRC") Section 468B. IRC Section 468B was added to the Code by Congress as part of the Tax Reform Act of 1986[32] and created Designated Settlement Funds ("DSF"). A DSF can be funded by or more defendants to make settlement payments to tort claimants. The DSF was fairly limited in the way it could be utilized and in 1993 passed regulations creating a new type of fund, Qualified Settlement Funds. There are fewer

[27] Treas. Reg. §1.468B-1(c)(2).
[28] Treas. Reg. §1.468B-1(c)(3).
[29] See Treas. Reg. §1.468B-3(c).
[30] Treas. Reg. §1.468B-2(b)(1).
[31] Treas. Reg. §1.468B-2(b)(2).
[32] Tax Reform Act of 1986, Pub. L. No. 99-514; I.R.C. §1087(a)(7)(A), 100 Stat. 2085 (1986); I.R.C. §468B.

requirements to create a QSF than DSF and a QSF can address a broader range of legal claims with increased flexibility.

The DSF and QSF were originally created for use in mass tort litigation enabling a defendant to settle a claim by depositing money into a central fund that could then settle the claims with each individual plaintiff. The defendant could walk away from the settlement fund after its creation and funding, taking a deduction for the entire settlement amount in the year it was deposited.

However, the QSF is not limited to situations involving mass torts. A Qualified Settlement Fund can be used to settle cases of any value involving multiple plaintiffs including cases involving the personal injury victim with a derivatively injured spouse, child or parent. It can arguably be used in single plaintiff cases based upon the plain language of the Treasury Regulations implementing QSFs.

C. How it Works

Using a 468B Qualified Settlement Fund settlement proceeds can be placed into a QSF trust preserving the right to do a structured settlement and protecting public benefit eligibility temporarily. While the money is in the QSF, a financial settlement plan can be designed and liens can be negotiated. Additionally, if the settlement recipient is on public benefits the QSF avoids issues with receipt of the settlement, which could trigger a loss of public benefits. While the funds are in the QSF, there is time to create public benefit preservation trusts for the settlement recipient. A structured settlement or other financial products can then be set up to work in concert with a special needs trust or Medicare Set Aside so that the injured victim does not lose their public benefits.

IRS Code § 468B and Income Tax Regulations found at § 1.468B control the use of a QSF. These provisions provide that a defendant can make a qualifying payment to the QSF and economic performance would be accomplished, crucial for tax reasons to the defendant. Thus, the QSF trustee can receive settlement proceeds allowing the defendant a current year deduction releasing them from the case. The QSF trustee can, after receiving the settlement proceeds, agree to pay a plaintiff future periodic payments, assign that obligation to a third party, and allow the plaintiff to receive tax-free payments under IRC § 104(a) (the provision excluding from gross income periodic payments from a structure).[33] The transaction works exactly the same as it normally would when you have the defendant involved in the structured settlement transaction.

There are only three requirements under 468B to establish a QSF trust. First, the fund must be established pursuant to an order of a court and is subject to the continuing jurisdiction of the court. Second, it must be established to resolve **one or more** contested claims arising out of a tort. Third, the fund, account, or trust must be a trust under applicable state law.

[33] I.R.C. §104(a). Section 104(a) excludes from gross income personal physical injury recoveries paid in a lump sum or via future periodic payments. It excludes personal injury recoveries under 104(a)(2); Workers' Compensation recoveries at 104(a)(1) and disability recoveries under 104(a)(3).

As for the first requirement, any court may create a QSF by court order and exercise continuing jurisdiction. It can be the court that the underlying litigation is being heard by, but it does not have to be that court. The court does not have to have jurisdiction over the tort action to establish the QSF. A QSF is "established" once a court signs the order creating it and not before. Thus a QSF can't be funded until it is properly established.

The Treasury Regulations implementing 468B require a QSF to be established to satisfy *one or* more claims arising out of a tort[34.] However, Workers' Compensation claims are specifically excluded from being the basis for establishing a QSF. As long as the QSF is established to resolve a claim involving a physical injury, other than a Workers' Compensation claim, this requirement is easily established. The last requirement of the fund being a trust under applicable state law is simply satisfied by proper drafting of a trust and approval by the court.

In terms of the mechanics, it is easy to establish a QSF. First, a court must be petitioned to establish the QSF. The court is provided with the QSF trust document and an order to establish the trust. Once the order is signed, the defendant is instructed to make a check payable to the QSF and the defendant is given a cash release in return for the payment. The consideration for the release with the defendant is payment into the QSF thus the consideration recital should reflect payment to the QSF and not the injury victim.

In terms of timing of distributions from a QSF, that is dependent on the agreement amongst claimants or as ordered by a court. For example, if the case involves minor or incompetents the necessary court approvals would need to be obtained prior to disbursement of fund from the QSF just like they would if no QSF was involved. The QSF can provide a lump sum payment to the claimant(s); fund a SNT or MSA, pay liens and fund a structured settlement. If a structured settlement or an attorney fee structure is funded, the QSF replaces the defendant and the transaction is consummated just as any other structured settlement would be if a defendant were involved. Upon distribution of funds from the QSF, the trustee will obtain a release from the claimants for the distributions from the QSF evidencing the fact that the distribution resolved or satisfied the claimant's claims against the QSF.

Once all funds have been distributed, the QSF ceases to exist. A court order is obtained closing the QSF and terminating the court's jurisdiction over the QSF.

D. The Single Claimant QSF Question

QSF for single claimant cases has become commonplace today. However, there is some question of doubt whether a QSF can be used in a single claimant case. The basis for the controversy is the assertion by some that money placed into a QSF for a single claimant triggers constructive receipt or economic benefit. If either of these income tax concepts are triggered, the monies would be attributed to the claimant from a tax perspective defeating one of the main purposes of establishing

[34] Treas. Reg. §1.468B-1(c)(2). There are other claims besides torts that a QSF may be used to resolve. According to the Treasury regulations, it can be used for CERCLA claims, breach of contract, violation of law or any other claims the Commissioner of the Internal Revenue service designates in a Revenue ruling or Revenue procedure. *Id.*

the QSF (timing of income and funding future periodic payments). The IRS, despite requests, has refused to comment or clarify this issue.

We are therefore left with the plain meaning of "one or more contested or uncontested claims" in the Treasure regulations relating to IRC 468B. The regulations say one or more. The only logical interpretation based upon the meaning of these words would be that it is permissible to establish a QSF for a single claimant.

Nevertheless, defendants may raise this issue in an attempt to prevent the creation of a QSF. This typically happens when future periodic payments will be funded from a QSF and relates frequently to issues over control of structured settlement funding. The bottom line is that if the defendant refuses to cooperate with funding a single claimant QSF for these reasons, it will be impossible to create the QSF unless a court orders a defendant to fund the QSF.

E. Advantages of a QSF from the Plaintiff's Perspective

There are several advantages to utilizing a QSF from the plaintiff's perspective. First, funding the QSF removes the defendant and defense counsel from the settlement process. It is very much like an all cash settlement in the eyes of the defendant. Once the Trustee receives the settlement money, economic performance has occurred and the defendant is out of the case. Second, the attorney's fees and other expenses can be paid immediately from the 468B fund. Third, the 468B trust removes the defendant from process of allocating the settlement amounts between the various plaintiffs. Finally and probably most importantly, the time crunch is alleviated with regards to the lien negotiations, allocations, and probate proceedings. The plaintiffs can take their time, carefully considering the various financial decisions they must make and addressing public benefit preservation issues.

VI. Conclusion

There is enormous pressure to wrap up a personal injury case quickly so the client can be compensated for their injuries and the personal injury attorney can be compensated and reimbursed for costs incurred. However, in the rush to finalize the settlement things may be overlooked or important settlement planning issues may be missed. This is why an experienced settlement planning specialist should be contacted as soon as possible when it appears there is a realistic chance of settlement. The settlement planning attorney can assist with the minor or adult who lacks capacity, address issues concerning public benefit eligibility, negotiate lien resolution, provide a solid financial plan for the future, handle any taxation issues that arise, and can do so utilizing the most up to date techniques and strategies developed.

For example, a Qualified Settlement Fund can be created to receive the settlement proceeds thereby giving everyone the time necessary to carefully plan for the future. Plaintiff counsel can get his or her fees and costs quickly. The funds are obtained from the defendant, they are released and the client's settlement dollars can be procured quickly. The liens can be negotiated, allocation decisions can be made, public benefit preservation trusts can be implemented and settlement planning issues, including structured settlements, can be considered. The attorney's option to structure his or her attorney fees is also preserved.

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The Academy of Special Needs Planners

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