Oregon State Bar Elder Law Newsletter

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Personal-injury settlements may require Medicare set-asides

By Donna R. Meyer, Attorney at Law

Elder law and disability-planning attorneys are sometimes involved in cases in which a plaintiff eligible for government benefits receives a personal-injury settlement. In these settlement planning cases, numerous issues may arise, including the need to preserve eligibility for SSI and/or Medicaid and establish a special needs trust. Many of these plaintiffs also receive Medicare or are reasonably expected to become eligible for Medicare within the next 30 months. If so, then the provisions of the Medicare Secondary Payer Act (MSPA)—including "set asides"—must be considered.[1]

Medicare Secondary Payer Act

As its name implies, the MSPA's purpose is to have Medicare pay for injury-related claims only secondarily, after payments made under "workmen's compensation law or plan of the United States or a State or under an automobile or liability insurance policy or plan (including a self-insured plan) or under no fault insurance."[2]

The MSPA addresses two time frames. First, there are Medicare payments made on behalf of the plaintiff for injury-related medical expenses prior to the date of settlement. These are called "conditional payments," because Medicare makes the payments conditional on recovery once the personal-injury case is resolved.[3] Typically the plaintiff's trial attorney takes responsibility for notifying and reimbursing Medicare for the conditional payments, as well as paying liens to third-party insurers and Medicaid, if applicable.

A second time frame begins after the settlement or award. Does Medicare have a right under the MSPA to deny claims for future injury-related medical expenses, or to recover for payments made for post-settlement medical expenses?[4] Is the plaintiff required to "set aside" funds from the settlement to pay for these expenses directly? (This type of arrangement is called a Medicare set-aside or MSA).

Workers' compensation cases

Formal procedures exist to enforce the MSPA with respect to workers' compensation cases, which can be found in federal regulations and in policy memoranda issued by the Centers for Medicare and Medicaid Services.[5] These provide a detailed framework for establishing MSAs when a workers' compensation settlement includes recovery for future medical expenses and the plaintiff is a current Medicare beneficiary (or is reasonably expected to become eligible for Medicare within 30 months). Essentially, when an amount from a workers' compensation settlement is allocated for future injury-related medical expenses, an amount is set aside to pay those expenses directly. In certain cases MSA proposals must be submitted to CMS for approval, providing a safe harbor for the plaintiff and the attorneys. Injury-related claims are not submitted to Medicare until the amount set aside is exhausted.

Third-party liability cases

No formal procedure has been established for third-party liability cases, and MSAs are

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Medicare set-asides

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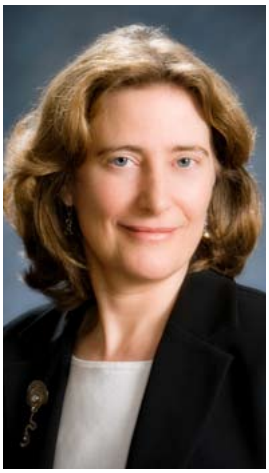

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not required by the MSPA or by CMS. Rather, an MSA is a mechanism for complying with the general language in the MSPA that states Medicare should pay injury-related claims only secondarily. In the absence of clear procedures, each attorney must take special care to analyze the law and evaluate the risks before advising the client.

One factor to consider is actual CMS practice in our region. The Seattle Region repeatedly states that clients who receive settlements must "consider Medicare's interests." In response to written questions in connection with a national publication, the Seattle Region answered as follows:[6]

1. The MSPA does apply to third-party liability cases.
2. The region will not review an MSA submission and approve or give other responses.
3. CMS may enforce the MSPA in third-party liability cases, even in nonsubstantial cases (some other regions indicated "no" to enforcement).
4. Workers' compensation guidelines should be followed in third-party liability cases.

What is the risk for our clients? If an MSA is not established and approved, Medicare could deny claims for all injury-related medical expenses up to the entire amount of the settlement. The likelihood of this is unclear. The answers set out above were intended as informal guidance only. Actual enforcement of the provisions of the MSPA against clients in the Seattle Region who are enrolled in traditional Medicare is currently virtually non-existent. Conversely, some Medicare Advantage plans in Oregon are now aggressively denying claims, and asking for reimbursement for claims paid for injury-related medical expenses.

Predictably, opinions about the appropriate response to the absence of enacted regulations and formal procedures to enforce the MSPA for third-party liability cases vary widely among lawyers around the country. Some very knowledgeable and well-respected attorneys think an MSA should be done in every case. Some think it should not be done, because neither Congress nor CMS have enacted regulations and rules. Others believe it should only be done in cases in which there has been a definitive allocation in the settlement for future injury-related medical expenses. Still other attorneys offer a larger range of options to the client.[7]

Although review of all the options and considerations is beyond the scope of this article, here are a few of the options.

1. Do nothing. This is the riskiest option. After all, the MSPA does say Medicare is secondary payer.
2. Create a trust for the Medicare beneficiary to hold the settlement and write language in the trust that anticipates the possibility of an MSA in the future when and if Congress, CMS, or the courts provide clarity about the requirements.
3. Obtain a Medicare allocation report and set aside the amount in the report, reduced to a percentage of the settlement in relation to the total damages, arguing that liability cases can be distinguished from workers' compensation cases and should be treated differently.
4. Obtain a Medicare allocation report, ask for approval from CMS to show due diligence, and set aside the entire amount.

The best practice is to advise the client of Medicare's possible interest and the lack of legal clarity, and explain the options to the client. Be aware that arguably the attorneys involved can be financially responsible for failure to comply with the MSPA.[8] Whatever the decision, the attorney should have the client sign a document showing that he or she has been fully advised of the state of the law and of the risks, and has made an informed decision. ■

Footnotes

1. 42 U.S.C. §1395y(b)
2. 42 U.S.C. §1395y(b)(2)
3. This article addresses these complex issues in very general terms.
4. In this article "medical expenses" means future injury-related medical goods, services, and prescription drugs that would be normally covered by Medicare, in the context of a liability case.
5. 42 C.F.R. §411.40; www.cms.hhs.gov
6. Angela Canellos and Thomas D. Begley Jr., Chapter 12, Medicare Set-Aside Arrangements, Special Needs Trusts Handbook, Aspen Publishers
7. A NAELA report recently approved by the Medicare Task Force provides NAELA's position regarding MSAs. **www.NAELA.org**
8. 42 U.S.C. §1395y(b)(2)

Are your conservator-trustee clients properly bonded?

By Jenny Tuomi, Certified Insurance Counselor

Jenny Tuomi has been the head of Court Bonds, a division of JD Fulwiler & Co. Insurance, since 2002 and has been in the insurance industry since 1979. Jenny is a licensed insurance agent and obtained her CIC (Certified Insurance Counselor) designation in 2005.

As a surety agent who provides fiduciary bonding, I have noted a misconception about the bonding of fiduciaries who serve in dual capacities of conservator and trustee.

Contrary to what some believe, conservator bonds will not automatically pick up the bonded person's actions in any role other than conservator unless the bond is specifically broadened to do so.

When a conservatorship is established, it is common practice to provide a bond to satisfy the governing statute. For whatever reason, at some point a trust may be established with the conservator serving as trustee and most or all assets of the protected person moved into the trust. This process makes the conservatorship a pass-through station or a "shell" devoid of holdings.

The conservator's bond effectively provides security for the assets until such time the assets are transferred to the trust. The result when the bond is not broadened to include a trustee: a well bonded shell conservatorship with few or no assets and a well- funded trust and no applicable bond.

The main message

A conservator's bond specifies that the principal (the person bonded) has been appointed as conservator and provides for faithful performance in his or her appointed role. The action of creating a separate entity—a trust—by the conservator does not impose any change to the bond. For example:

> A bond is written in the matter of the conservatorship for John Doe with Betty Smith as the conservator. The bond will only respond to matters pertaining solely to actions of Betty Smith in her role as conservator. If Betty Smith as conservator creates a trust and Betty's conservator's bond is not amended to include Betty as trustee, the bond will not apply to any actions of Betty in her role as trustee.

Broadening a conservator's bond to include a trust and the trustee

An underwriting process considers the extension of a bond to include a trust (revocable, irrevocable, special needs, or otherwise).

Generally speaking the focus is on four key points:

1. The same person is appointed to fill both roles as conservator and trustee.
2. There must be a call for the bond—meaning that the trust document or a court order or limited judgment must specifically state that the trustee is required to be bonded and that the bond is set for a specific dollar amount. That dollar amount must be the aggregate of all unrestricted assets held in both the conservatorship and trust.
3. There must be some form of an annual accounting and approval of those accountings through the court. This can be accomplished by stating that trust assets will be accounted for in accordance with the statutes for conservatorships. This actually works quite well.
4. A complete copy of the trust document and all amendments (or a restating of the trust) are to be provided to the surety.

Items 2 and 3 need to be plainly stated within a motion or petition and then included with an order or limited judgment. What will not work is the mere statement: "… and the bond now applies to both the conservatorship and the trust."

Finally, a surety will not agree to pick up risk for prior actions. Orders or limited judgments that seek to add a trust retroactively or by way of a nunc pro tunc order will not be honored.

Historically I've not seen any change in the bond premium when broadening a conservator's bond to include a trust, and I have no expectation of a change in that regard. One of the requirements to include a trust is to bond for all unrestricted assets. If that requires an increase in bond amount then we would certainly have an increase in premium.

With this information I hope to have provided you with enough information to identify if your conservator-trustees are properly bonded and if not how to go about getting it done. ■

Legislature considers bills that affect elder law

By Erin M. Evers, Attorney at Law

The Legislative Process

After a bill's first reading, the Speaker refers it to a committee. The bill is also forwarded to the Legislative Fiscal Officer and Legislative Revenue Officer for determination of its fiscal seffect.

The committee reviews the bill and holds public hearings and work sessions.

Any amendments to the bill are printed and the bill may be reprinted to include the amendments.

The bill, now back in the house of origin, has its second and third readings.

The body debates the measure. To pass, the bill must receive aye votes of a majority of members (31 in the House, 16 in the Senate).

If the bill is passed by a majority of the members, it is sent to the other house, where it undergoes a similar process.

After the bill has passed both houses in identical form, it is sent to the Governor.

If the Governor chooses to sign the bill, it will become law on the prescribed effective date. ■

Several bills of interest to the elder law community are before the Oregon State Legislature this year. The following is a brief summary of legislation the Elder Law Section Executive Committee has identified as worthy of attention.

HB 2683 amends the procedure outlined in ORS 125.012 for requesting confidential information in protective proceedings. The bill has been introduced in the House and referred to the Judiciary Committee. It is expected to be heard early in the session and if passed is effective immediately. The amendment adds definitions and clarification of when and how to obtain a protective order and use confidential information obtained from DHS or the Oregon Health Authority.

HB 2684 modifies calculations of the elective share of a surviving spouse and provides that the surviving spouse's estate includes 50 percent of the corpus of a trust or portion of a trust established by a decedent for special or supplemental needs of the surviving spouse who is disabled or incapable. The bill applies only to the surviving spouse of a decedent who dies on or after the effective date of the act. The bill has been introduced into the House and referred to the Judiciary Committee. It is expected to be heard early in the session and if passed is effective immediately.

SB 51 and SB 221 remove the sunset provision and makes permanent the provisions in ORS 127.535 that allow a health care representative to hospitalize the principal for up to 18 days for treatment of behavior caused by dementia. These bills have been introduced and referred to the Health Care Committee. Theyare expected to be heard early in the session.

HB 2375 removes the current prohibition in ORS 127.540 that prevents a health care representative from admitting a person in a health care facility for treatment of mental illness. This bill has also been introduced and referred to the Human Services Committee.

SB 413 substantially modifies the responsibility of DHS when responding to complaints regarding residential facilities licensed by the department. It removes the definition of abuse of residents in facilities and places limits on the duration of disqualification from direct care services due to certain criminal convictions.

It allows employment following disqualification if found fit for the position.

It removes the right of the complainant to accompany the investigator to the site of the alleged abuse and removes the authority of the investigator to photograph the victim of abuse for purposes of preserving evidence.

It removes immunity from civil and criminal liability for the person reporting the alleged abuse in good faith and authorizes civil penalties against facilities for certain substantiated claims of resident abuse or neglect. This bill has been introduced and referred to the Health Care Committee.

Although not yet introduced, **LC 2202** is in draft form and provides for a form of deed to be used to transfer property to a beneficiary via a beneficiary designation deed.

The full text of all bills can be found on the legislature's website:
www.leg.state.or.us/bills_laws. ■

New Rules speed Social Security disability benefits

The Social Security Administration (SSA) has published final rules that will reduce the time it takes to decide applications for disability benefits from those persons with the most severe disabilities—including leukemia, amyotrophic lateral sclerosis (ALS), many cancers, and early-onset Alzheimer's disease.

The new rules allow disability examiners to make fully favorable determinations for adult cases under the agency's Quick Disability Determination (QDD) and Compassionate Allowance (CAL) processes without medical or psychological consultant approval.

The changes are expected to help the agency process cases more efficiently, because they will give medical and psychological consultants more time to work on complex cases where their expertise is most needed.

Under Social Security's QDD process, a predictive computer model analyzes specific data within the electronic disability file to identify cases where there is a high likelihood that the claimant is disabled and SSA can quickly obtain medical evidence. The CAL process identifies 88 specific diseases and conditions that clearly qualify for Social Security and Supplemental Security Income disability benefits and can be fast-tracked.

The final rules, 20 CFR Parts 404 and 416, were effective on November 12, 2010.

They can be found through the Federal Register online at **www.regulations.gov.**

Additional information about Social Security's Compassionate Allowances process and the list of conditions it covers is available at **www.socialsecurity.gov/compassionateallowances**. ■

No Social Security cost-of-living adjustment for 2011

Because there is no Social Security COLA for 2011, there are no changes to the income figures for the OSIP standard or the room and board rate.

Also, a "hold harmless" provision says that in order to avoid reducing their net Social Security benefit when there is no COLA, most Social Security beneficiaries will not pay a higher Part B Medicare premium. This does not apply, however, to higher-income beneficiaries and beneficiaries newly entitled to Part B in 2011.

Monthly Social Security and Supplemental Security Income (SSI) benefits for more than 58 million Americans did not increase in 2011.

The Social Security Act provides for an automatic increase in Social Security and SSI benefits if there is an increase in the Consumer Price Index for Urban Wage Earners and Clerical Workers (CPI-W) from the third quarter of the last year a cost-of-living adjustment (COLA) was determined to the third quarter of the current year.

The Bureau of Labor Statistics determined there was no increase in the CPI-W from the third quarter of 2008—the last year a COLA was determined—to the third quarter of 2010. Therefore, under existing law there could be no COLA in 2011.

The CPI-W is one of four consumer price indexes available to the government. The population represented is restricted to households that derive more than half of their income from clerical or wage occupations and where at least one earner has been employed for 37 weeks in the previous year. The CPI-W by definition excludes families and individuals whose income comes primarily from pensions or Social Security benefits. It represents the spending of 32 percent of the population.

Other indexes have been suggested as alternatives to indexing benefits to the CPI-W. The Consumer Price Index for All Urban Consumers (CPI-U), for example, represents the spending of roughly 87 percent of the population, including the self-employed, the unemployed, professionals, the poor, and retired people

The Consumer Price Index: How It Impacts the Federal Budget and Social Security Benefits by Selena Caldera of AARP's Public Policy Institute Economics team describes the four price indexes published by the Bureau of Labor Statistics, discusses differences in the methodology used to derive them, and explains how they affect government benefits, revenues, and expenditures. It can be downloaded at **www.aarp.org/work/social-security/info-09-2009/fs160_cpi.html.** ■

Popular Elder Law Section unCLE program returns

By Mark M. Williams, unCLE Program Chair

For the eighth year, the Elder Law Section is sponsoring a unique program that gives elder law practitioners the opportunity to get together for a day-long session of brainstorming, networking, an exchange of forms, and discussion of topics ranging from estate planning to guardianship to Medicaid to office management.

Elder law attorneys willing to share their experiences will moderate the small group discussions. There will be no formal speakers, but there will be time to question and learn from our peers. The program is modeled on the highly successful NAELA UnProgram, has received very high ratings from attendees, and may be the best educational opportunity available to us. Despite its title, the Oregon State Bar has granted 5 general CLE credits for the program.

Don't miss this chance to mix and mingle with your peers in the elder law community and discuss substantive issues as well as nuts and bolts practice issues. The intent is to get us away from our practices for a full day and to allow colleagues from all parts of the state to have reasonable access.

This year's program will be held on Friday, May 6, 2011, from 8:00 a.m. to 5:00 p.m. at the Valley River Inn, 1000 Valley River Way, Eugene, Oregon.

Attendance is limited to 75 Elder Law Section members, so register early. The program usually sells out more than a week in advance.

The program fee is $100 and includes a full buffet breakfast, lunch, and a post-program reception. (Add $25 for dues if you are not already an Elder Law Section member.)

Registration for the program is available by contacting the Oregon State Bar order desk at 800.452.8260, ext. 413, or 503.684.7413.

Valley River Inn special room rates are $99 for reservations made before April 5, 2011. Phone: 541.743.1000.
Website: **www.valleyriverinn.com**. ■

Resources for elder law attorneys

CLE seminars

2011 Ethics Update
OSB "Quick Call" Program
Part 1: February 1, 2011
Part 2: February 2, 2011
10:00 to 11:00 a.m. both days
Via telephone
www.osbar.org

Elder Financial Abuse Litigation
Multnomah Bar Association seminar
February 1, 2011; 3:00 - 5:00 p.m.
World Trade Center
Portland, Oregon
www.mbabar.org

Ethical Issues in Client Representation Agreementss
OSB "Quick Call" Program
February 11, 2011; 10:00 to 11:00 a.m.
Via telephone
www.osbar.org

Attorney Ethics in Billing and Collecting Fees from Clients
OSB "Quick Call" Program
February 18, 2011; 10:00 to 11:00 a.m.
Via telephone
www.osbar.org

Unique Issues in Estate Planning for Gay Clients
Multnomah Bar Association seminar
March 1, 2011; 3:00 - 5:00 p.m.
World Trade Center
Portland, Oregon
www.mbabar.org

ABCs of Decedents' Estate Administration
Oregon Law Institute seminar
March 11, 2011; 8:00 a.m. to 4:30 p.m.
Oregon Convention Center
777 NE Martin Luther King Jr. Blvd.
Portland, Oregon
www.lclark.edu/law/continuing_education/upcoming_seminars

Elder Law Section unCLE Program
May 6, 2010; 8:00 a.m. to 5:00 p.m.
Valley River Inn; Eugene, Oregon
See page 6 for details.

Elder and Special Needs Law Annual National Conference
May 19-21, 2011
Las Vegas, NV
www.naela.org

NAELA Telephonic Training Programs

- **PEME – Pre-eligibility Medical Expense & Medicaid & Long-Term Care**
  February 10, 2011; 11:00 a.m. to 12:30 p.m.
- **The Ins & Out of Reverse Rule of Halves Planning**
  March 3, 2011; 11:00 a.m. to 12:30 p.m.
- **Staff Training - Document Drafting Tips for 10 Elder Law & Special Needs Planning Documents**
  March 15, 2011; 11:00 a.m. to 12:30 p.m.
- **Special Needs Trusts - When a SNT is not the Only or Best Choice**
  April 7, 2011; 11:00 a.m. to 12:30 p.m.
- **Top 10 Things you can do to Generate Revenue in your Elder Law & Special Needs Planning Practice**
  Aprl 28, 2011; 11:00 a.m. to 12:30 p.m.

www.naela.org

Elder Law Section Web site

www.osbar.org/sections/elder/elderlaw.html

The Web site has useful links for elder law practitioners, past issues of the *Elder Law Newsletter,* and current elder law numbers.

Elder Law Section electronic discussion list

All members of the Elder Law Section are automatically signed up on the list, but your participation is not mandatory.

How to use the discussion list

Send a message to all members of the Elder Law Section distribution list by addressing it to: **eldlaw@lists.osbar.org**. Replies are directed by default to the sender of the message *only*. If you wish to send a reply to the entire list, you must change the address to: **eldlaw@lists.osbar.org**—or you can choose "Reply to all." ■

Important elder law numbers

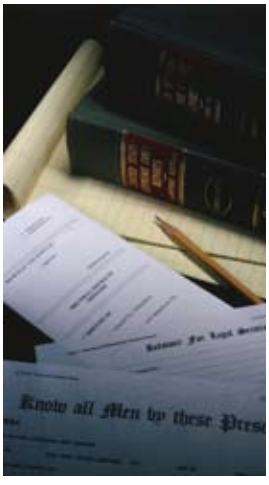
as of
January 1, 2011

Supplemental Security Income (SSI) Benefit Standards	
Eligible individual	$674/month
Eligible couple	$1,011/month
Medicaid (Oregon)	
Long term care income cap	$2,022/month
Community spouse minimum resource standard	$21,912
Community spouse maximum resource standard	$109,560
Community spouse minimum and maximum monthly allowance standards	$1,822/month; $2,739/month
Excess shelter allowance	Amount above $547/month
Food stamp utility allowance used to figure excess shelter allowance	$397/month
Personal needs allowance in nursing home	$30/month
Personal needs allowance in community-based care	$152/month
Room & board rate for community-based care facilities	$523.70/month
OSIP maintenance standard for person receiving in-home services	$675.70
Average private pay rate for calculating ineligibility for applications made on or after October 1, 2008	$7,663/month
Medicare	
Part B premium for those enrolled in 2011	$115.40/month*
Part B deductible	$162/year
Part A hospital deductible per spell of illness	$1,132
Part D premium:	Varies according to plan chosen
Skilled nursing facility co-insurance for days 21-100	$141.50/day

* For those enrolled in 2010, the premium is $110.50. For those enrolled in 2009, the premium is $96.50. For those enrolled prior to 2009, the premium is $96.40. Premiums are higher if annual income is more than $85,000 (single filer) or $170,000 (married couple filing jointly).

Save the date

Elder Law Section unCLE program



Friday, May 6, 2011
Eugene

See page 6 for details

Newsletter Board

The *Elder Law Newsletter* is published quarterly by the Oregon State Bar's Elder Law Section, Brian Haggerty, Chair. Statements of fact are the responsibility of the authors, and the opinions expressed do not imply endorsement by the Section.