Personal Injury Attorney's Guide to Representing the Aged or Disabled Client

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Martha is a 70 year old nursing home resident. She is on Medicaid. She went to a local store with her daughter. While there, Martha was injured as a result of the store's negligence. She received medical care which was paid for by Medicare and Medicaid. The store wants to settle the litigation. What do you do?

In the United States, health care is a commodity. It is not free.[1] Thus, in our economy, clients who are aged (over 64), blind or disabled, need planning assistance that extends beyond resolving the litigation. Settling or winning a case, by itself, is not enough.

Future health care costs and long-term care costs can quickly consume an entire recovery. Those costs increased 7.9% in 2004. According to CMS's National Health Expenditures report, annual inflation in the health care market exceeded 6.3% each year since 2000; those costs have a projected growth annual rate of 7.1% from 2003 through 2014.[2] This bodes ill for aged, blind and disabled clients who require significant health care expense, but who live on small fixed incomes. In short, winning the case is just the beginning.

Today's disabled plaintiffs present a range of issues that personal injury lawyers historically disregarded. They include reimbursing Medicare, Medicaid and private insurance companies that funded prior medical expenses and planning for life after the lawsuit. If these issues are addressed at the outset of the case, dealing with them at its conclusion may be smooth sailing. Certainly, if you do not deal with them at all, your clients will be dissatisfied when the issues crop up after you close your file. And even if you do address these issues at the close of litigation, failure to raise them early may lead to embarrassing moments (e.g., "What do you mean I just settled my case for $X, but I can't keep any of it?). This outline is for personal injury attorneys who choose to become knowledgeable concerning issues facing disabled clients with a view toward addressing them early.

Top Ten Conditions Requiring Long Term Care for the Aged
1. Alzheimer's disease, related dementia; 2. Cancer; 3. Stroke; 4. Parkinson's disease, other neurological conditions; 5. Arthritis; 6.

[1] The United States spent $2 trillion on health care in 2004. That's a "2" with 12 zeros after it. *See* M. Higgins, Washington Times, January 10, 2006, http://www.washtimes.com/business/20060109-112402-9530r.htm.

[2] Nationally the *average* daily cost for a private room in a nursing home is $192.00 or $70,080 annually. The average hourly rate for a Home Health Aides provided by a home care agency is $18 per hour; assuming an inflation rate of 6% a year, the cost would double in ten years.

Heart Attack; 7. Other injuries (fractures); 8. Emphysema, other respiratory diseases; 9. Diabetes; 10. Mental, nervous, other Alzheimer's related conditions.

PUBLIC BENEFITS

Those who are eligible for public benefits may gain assistance paying for food, clothing, shelter, medical care and long-term care. The primary public benefits program available to meet these needs are Supplemental Security Income, Medicaid and housing assistance (e.g., Section 8 housing).

SSI: An understanding of the SSI eligibility rules is necessary because most of other state and federal benefit programs link their eligibility rules to the SSI[3] eligibility criteria. To be eligible for Supplemental Security Income, an individual must meet medical eligibility criteria, to wit: they must be aged, blind or disabled.[4] The disabling condition must meet the requirements found in Title II of the Social Security Act. Regulations on disability are at Title 20, Code of Federal Regulations, Part 404.

To be found disabled, a person must be unable to engage in any substantial gainful activity by reason of any *medically determinable* physical or mental impairment that is expected to result in death or has lasted, or can be expected to last, for a continuous period of 12 months.

Beyond the medical criteria, an individual seeking SSI must also meet the financial criteria (income and assets) outlined at 42 U.S.C.A. Section 1382(a). Basically, an aged, blind or disabled person is eligible for SSI benefits if (and only if) that individual has limited income and has countable resources of less than $2,000 "available" to him or her when applying for benefits. Some assets, described at 42 U.S.C.A. 1382(b), are excluded when determining eligibility (non-countable assets). It is useful to know these exclusions when planning because countable assets can be used to purchase exempt assets. One such exclusion is the home; applicants can keep their home (or buy one).[5] Other exempt assets include a vehicle (subject to value limitations in certain circumstances), household goods and personal effects up to a value that the Secretary of the Social Security Administration determines is reasonable, a burial space or plot, and property necessary for self support or money to be used for a plan to become self-supporting, with the plan subject to the approval of the Secretary.

SSI provides a cash stipend to pay for food, clothing and shelter. In 2006, the maximum pay rate is $603 per month. A married couple can receive $904 in SSI benefits during 2006.

2006 Federal Benefit Rate
Individual: $603.00
Couple: $904.00

[3] Title XVI of the Social Security Act; codified at 42 USC §§ 1381 et seq..

[4] There are also technical eligibility requirements, such as U.S. citizenship, but they are not discussed in this article.

[5] Purchasing a home may, or may not be a good idea. Although the home is exempt, home ownership typically carries with it certain maintenance costs, such as payment of property taxes. A person on SSI may not be able to meet these expenses. Also, you should not assume another person can pay these expenses for the SSI beneficiary because those payments may be treated as income and may render the SSI beneficiary ineligible for benefits. Thus, the operative word is “planning.”

SSI Resource Standard
Individual: $2,000.00
Couple: $3,000.00[6]

SSI is particularly useful when planning for disabled children (or adults who were disabled prior to age 22). It can help low-income parents meet the added financial costs of caring for a child with a disability. Caring for disabled children frequently imposes financial burdens on low-income families. SSI helps these families meet some of the added, disability-related costs of care and can ensure that parents are able to care for their disabled children at home. While the cost of care varies from family to family, and needs are individualized, these costs routinely include loss of wages resulting from a parent remaining at home to care for the child, higher child care costs, higher utility bills (such as increased use of electricity needed for medical equipment), specially-adapted shoes, tools to facilitate communication (e.g., hearing aides), alternative foods for restricted diets, and home modifications.

As stated previously, most other income, medical, and service programs link financial eligibility to the SSI eligibility criteria. Thus, the SSI eligibility criteria often set the eligibility standard for other benefits programs. Medicaid, arguably the most important for disabled persons because it pays health care costs, is linked to SSI eligibility in Georgia and Tennessee.[7]

Meeting the eligibility criteria for these programs would, in many cases, result in a meager, pitiful existence. The SSI standard of living (e.g., having food, clothing, shelter and medical care) is not what most of us recognize as a quality life. In the United States, we typically think there is more to life than living indoors and paying our doctor. These other "needs" we consider important for a quality life are known as supplemental needs. One of the issues discussed below is how we identify, get and pay for supplemental needs.

Medicaid is a joint federal and state government program covering extraordinary health care costs.[8] The federal agency that oversees Medicaid is the Center for Medicare and Medicaid Services (CMS) of the US Department of Health and Human Services. The Medicaid law is codified at 42 U.S.C. § 1396 et seq. (Title XIX of the Social Security Act). Medicaid is a "needs based" program requiring qualification based on medical, income and resource criteria. In Georgia, the Medicaid program is administered county by county through the Department of Family and Children's Services (DFCS); in Tennessee, there is a Department of Human Services office in each county. Since medical care could virtually bankrupt an aged or disabled person, public *medical* benefits are a valuable resource. Even large settlements and recoveries quickly vanish if benefits planning is overlooked. The focus of planning, however, is on either

6 http://www.cms.hhs.gov/MedicaidEligibility/downloads/2006SSIFBR.pdf.

7 Georgia and Tennessee are "SSI" states, meaning that if you qualify for SSI, then Medicaid eligibility is automatic. Some States elected to use other criteria and those States are known as 209(b) States. *See* 42 U.S.C. 1396a(f).

8 For example, the State of Georgia spent $1,269,886,217 on long-term care in 2002. With federal matching funds (approximately 60% in Georgia), the actual amount spent on Medicaid in Georgia during 2002 would be over $3 billion.

maintaining the assets necessary to ensure non-institutionalized care or to provide for supplemental needs; in the United Sates, everyone (should) qualify for Medicaid nursing home benefits after they are broke. Since few clients (in fact, none we are aware of) have the stated goal of giving away all their money so they can qualify for Medicaid and go to a nursing home, we should aim somewhat higher in our planning.

Public Housing. If a client is receiving housing assistance, then receipt of funds from a settlement or other recovery may cause a loss of benefits. Assets placed in a special needs trust (discussed infra) will not be deemed available to the beneficiary if they were procured through settlement or judgment.[9] However, payments made from the trust may be considered income. Because most litigation clients (in our part of the country, anyway) will not getting public housing assistance, for additional information on the HUD rules, see *Occupancy Requirements of Subsidized Multifamily Housing Programs, Chapter 5. Determining Income and Calculating Rent.*[10] *See also B. Isenhour & S. Bleck, Special Needs Trusts and Subsidized Housing Benefits.*[11]

[9] "Assets placed in non-revocable trusts are considered as assets disposed of for less than fair market value except when the assets placed in trust were received through settlements or judgments." *Occupancy Requirements of Subsidized Multifamily Housing Programs*, 5-7.G

[10] http://www.hudclips.org/sub_nonhud/cgi/nph-brs.cgi?d=HSGH&s1=@docn&l=100&SECT1=TXTHLB&SECT5=HEHB&u=./hudclips.cgi&p=11&r=1032&f=G.

[11] http://www.isenbleck.com/articles/SNT1.PDF.

Applying for, or Advising Clients regarding, Public Benefits: Some commentators argue that it is the personal injury lawyer's *duty* to preserve public benefits or to engage separate counsel who can preserve those benefits. Those commentators argue that failure to do one or the other is malpractice. Of course, only time will tell whether that becomes the accepted standard of care. On a more practical note, you have not done your client any favors if you recover a verdict that is not used in a way that enhances your client's quality of life. Public benefits planning is a value-added service because it structures the recovery so that your client's funds are preserved for quality of life (supplemental) needs *after* public benefits pay for basic life needs.

Members of the National Academy of Elder Law Attorneys (www.naela.org) are typically acquainted with public benefits planning.

The case you handle may be your client's first experience with public benefits planning. Perhaps your client had no disability prior to being injured. Prior to the recovery, the client may not have had any resources, so eligibility planning was not an issue. It may be an issue now. Thus, a nursing home resident who was on Medicaid prior to injury may find, without planning, that the entire recovery is spent down paying nursing home bills before she gets back on Medicaid. A minor child may become ineligible because his parent's income or resources are "deemed" to him. Clients cannot make informed settlement decisions without knowing what life will be like after the settlement. If you cannot address these issues, then your client is best served by involving a public benefits expert.

SPECIAL NEEDS TRUSTS

What is a Trust? A trust is a legal arrangement regulated by state law in which one party (the grantor) transfers property to a second party (the trustee) who holds the property for the benefit of one or more the beneficiaries. A trust can contain cash or other liquid assets or real or personal property that could be turned into cash. Frequently, liquid assets are invested for the benefit of the beneficiaries.

What makes a Special Needs Trust so special? Special Needs Trusts are specialized trusts used to protect assets that would otherwise have to be spent prior to achieving benefits eligibility. Here, the purpose of asset protection is to use funds for special needs. In the context of litigation, we generally deal with first-party special needs trusts. The federal statute authorizing individual first-party special needs trusts is codified at 42 U.S.C. 1396p(d)(4)(A). This law, adopted as part of OBRA 93, is used for disabled clients under the age of 65 who recovery funds through personal injury litigation.[12] Funds placed in these trusts can be used to purchase supplement needs such as:

- *Medicines and Devices*. experimental therapies, prescription and nonprescription medicines, eyeglasses, hearing aids, prosthetic devices and expenses for maintenance of those devices.
- *Medical Services*. A private room, private nurses, private care management, home health care, physical therapy, rehabilitation, hospice care, medical transportation, wheelchairs, modified scooters, supplemental dietary needs, eyeglasses, psychological counseling, respite care and room and board during a medical confinement.
- *Dental Care*. dental check-ups and all related needs.
- *Education*. vocational, athletic training and educational expenses such as tuition, books, supplies, computer and software and training in their use.
- *Recreation*. hobbies, attendance at cultural and athletic events and vacation travel (including the cost of a companion if needed) for visits with relatives and friends, Radios, stereos and musical instruments, Cultural experiences.
- *Transportation*. The purchase of a car, including insurance, gasoline and maintenance, are provided if a car is necessary for the beneficiary to perform essential daily activities, or for a specially equipped vehicle such as a van.
- *Insurance*. premiums for term life insurance for caregivers. Insurance may be a vehicle for providing future security for beneficiaries. Also, supplemental health insurance may be paid for from the trust.
- *Certain Housing Items*. Goods and services that add pleasure and quality to life: audio and video equipment, videos, CD's, DVD's, furniture, gardening expenses, home insulation, home improvements such as ramps and rails to accommodate the

[12] The law can also be used when a client under age 65 has or receives assets other than through litigation.

beneficiary's physical condition and similar items.

A d4A trust must be properly structured to accomplish its goals. The client must be under age 65. The beneficiary must have a condition that meets the definition of disability under the Social Security Act. The trust must be irrevocable and must be established by a parent, grandparent, legal guardian or the court. The trust must include a “payback” provision meaning that, at the death of the beneficiary, the State Medicaid program is repaid any funds spent on the beneficiary’s care. The trust must not require the trustee to support the beneficiary; instead, the trustee has discretion to meet the beneficiary’s supplemental needs. Under these circumstances, the corpus of a special needs trust is not under the beneficiary’s control and the beneficiary has no right or power to withdraw funds.

Sometimes a Special Needs Trust is useful even when public benefits eligibility is not the principal goal. A trust provides continuity of financial management over a long period of time. Often, using a trust dispenses with the necessity of a conservatorship.

The **primary disadvantage** to establishing a Special Needs Trust is that the individual no longer has unrestricted use of the assets. However, with good planning and under the appropriate circumstances, the settlement proceeds can be used to substantially improve the life of the disabled person and his family, provide for future security, protect access to Medicaid, and manage the money in an efficient and secure manner.

Other Types of Special Needs Trusts

There are four types of special needs trusts, all of which will preserve crucial public benefit programs if properly drafted and managed. The first (a d4A trust) has been described above.

Pooled or "c" special needs trusts. Federal law allows disabled persons to “band together” in an investment pool. The statutory authority is 42 USC 1396p(d)(4)(c), thus they are often called "d4C" trusts. They are most often called "pooled" trusts though, because trust assets are pooled for investment purposes. This type of trust is the only trust that will preserve SSI and Medicaid benefits for disabled individuals over age 65 and who want to fund an SNT with their own money.[13] There are times when d4C trusts are appropriate for younger persons, such as when the corpus is so small that trust fees would be prohibitive.

The pooled trust’s Trustee must be a nonprofit organization, so these trusts are often managed through an organization such as The ARC. The trust assets are accounted for separately, but are pooled for investment management. Each beneficiary joins the trust by executing a joinder agreement. After joining the trust, the individual uses his or her sub-account to fund special needs during his or her lifetime.

Pooling assets for investment management costs less for smaller accounts than it would in an individually

[13] In Georgia and Tennessee, there is no transfer penalty associated with funding a pooled trust sub-account. This rule varies from State to State due to a divergence in interpretation of 42 U.S.C. § 1396p.

managed SNT of the same size. For smaller estates and settlement awards (under $100,000), a pooled trust is often more cost effective for the trust beneficiary.

The SNT requirements outlined above must be met, except that the individual may be over age 65 and any funds remaining in the individual trust account at the trust beneficiary's death may be retained by the Trustee for charitable purposes (e.g., to benefit other individuals with disabilities).

Third-party special needs trusts. Interested parties may create a special needs trust to benefit a disabled individual. Remember, persons applying for public benefits are limited by the eligibility criteria so giving them assets may simply switch them from public benefits to private pay status. Instead, if gifts are placed into an SNT, public benefits can be maintained AND special needs can be funded with the gifted funds. Like the pooled trust, a third-party trust must meet the provisions outlined above, except there is no age restriction and there is no duty to reimburse Medicaid when the trust terminates.

Family special needs trusts. There is a role for SNTs in traditional estate planning for families where families include disabled individuals. Any assets given directly to the disabled family member or included in a guardianship will disqualify the individual from receiving SSI, Medicaid and housing assistance if the assets exceed $2,000 (with some exemptions for exempt assets). The use of an SNT allows family members who are not disabled to give assets to disabled family members to supply supplemental needs and, at the same time, preserve benefit eligibility. The trust may be established during the lifetime of the family member/grantor via a "living SNT" or through an individual's Will that funds the SNT at death. SNTs may be funded through outright gifts or through gifts used to purchase life insurance on the grantor. It is possible to coordinate the special needs aspects of these trusts with traditional estate tax planning, but such planning is extremely complex. Traditional *Crummey* power trusts are difficult to structure in a manner that does not eliminate benefits eligibility because the right to withdraw funds would over-resource the disabled person. Family SNTs must meet the general SNT provisions outlined above except there are no age restrictions and no Medicaid lien provisions are required.

The four SNTs may be referred to as supplemental needs trusts or special needs trusts. Other names include settlement SNTs, disability trusts, Dussault trusts, "d(4)(A)" trusts (referring to the federal statute), or simply by the name of the disabled individual (for example, John Doe irrevocable trust). Regardless of how the trust document is named, a trust properly drafted under the above criteria will preserve various public benefits for individuals with disabilities.

Structured Settlements and SNTs. In general terms, structured settlements and SNTs are usually (but not always) incompatible. Let's consider why someone structures a settlement:

1. To protect the recipient from wasting the funds. However, the SNT would probably name a professional fiduciary to manage the funds, and that fact alone

ought to provide good protection.[14]

2. Favorable income tax treatment. But in most cases where an SNT is used, there are significant medical expenses. Often, the SNT beneficiary pays either no tax or pays at the lowest rate--reducing the tax value (but not necessarily eliminating it) of a structure.

3. Proper investment diversification. A fixed annuity can provide diversification similar to the fixed-income portion of an investment portfolio. However, the annuity will be a relative static value (shrinking slowly over time), and the value of non-annuity assets may both fluctuate wildly and adjust significantly as the SNT purchases or sells a home, pays for major rehabilitative services, etc. Further, if viewed strictly as an investment choice, the annuity's return will probably be unattractive. A structure may be a reasonable investment IF income taxation is an important consideration AND the portion of the total settlement structured is relatively small.

The major drawback to a structure will be lack of flexibility. SNT beneficiaries tend to be variable in their needs over time. For that reason alone, SNTs and structures are generally incompatible.

Even so, structures may have a positive effect when used with SNTs, especially with young plaintiffs who may not need Medicaid in the foreseeable future. For example, you can arrange for a structure to make payments directly to the beneficiary (NOT to the SNT) once every five years, with no monthly or annual payments between those anniversaries. The logic is that once every five years the beneficiary can decide whether to (1) transfer the annuity payment to the SNT and lose one month's SSI, or (2) purchase a new vehicle, pay down the home mortgage or do repairs, and put whatever is left after a rapid spend-down into the SNT, or (3) accept the structure payment, let SSI/Medicaid slide, and not subject the primary asset to a Medicaid payback. This strategy requires you to be pretty comfortable that the SSI/Medicaid rules will not change radically over the life of the annuity, or that the beneficiary really is likely to improve, or both. This strategy requires long-term management and is not for the faint of heart.

Finally, for clients who are expected to receive annuity payments after age 65, you should know that the prohibition on creating a d4A is also interpreted as a prohibition on funding a d4A after age 65. A recent letter from the Social Security Administration, to Roger Bernstein, dated January 31, 2006, indicates that where payments would be made after age 65, the assignment to the trust must be irrevocable.

LIENS ON THE RECOVERY

Frequently, the decedent or injured party will have incurred medical expenses for treatment of the injury giving rise to the claim. A variety of sources including, but not limited to, Medicaid, Medicare, health insurance policies, and auto insurance policies may have made payments to medical providers on behalf of the injured or

[14] Sometimes a family member is appointed as the Trustee, but this rarely happens in States where the Trustee must be bonded because bonding companies frequently refuse to bond non-professionals. In Georgia and Tennessee, the bond requirement can be waived. In those cases, this negates this reason for avoiding a structure.

decedent. Medical payments from these sources may result in liens that attach to the recovery. These liens may attach regardless of whether there has been compliance with creditors' claim requirements. The legal basis and method for calculating the lien differs depending on the identity of the payor.

Georgia Medicaid Claims: In Georgia, the statutory authority for Medicaid to recover moneys advanced is found at O.C.G.A. § 49-4-148.[15]

It is the responsibility of the Medicaid recipient, his or her legal representative, or any person representing or acting as agent for Medicaid recipient, to pay the Department of Community Health, within 60 days after receipt of settlement proceeds, the full amount of any third-party benefits, not in excess of the total medical assistance provided by Medicaid.

The function has been privatized and all Medicaid third-party liability files are now being by an outside concern:

Department of Community Health
The Subrogation Unit
5660 New Northside Drive , Suite 750
Atlanta , GA 30328
Fax: (770) 937-0180
Phone: (770)980-9777
http://web.pcgus.com/garecovery/

In the case of a wrongful death claim, the Medicaid recipient, or the recipient's legal representative, must notify the agency of the wrongful death action within 30 days of the filing suit. The notice must provide all information specified by the statute. The agency may file suit on its own behalf, or intervene in or join an existing proceeding in order to enforce its lien rights

The Medicaid lien is only for benefits resulting from the injury for which the beneficiary received recovery. It is possible, but difficult, to argue that a portion of the recovery is for other injuries for which the beneficiary did not receive Medicaid benefits. A more successful argument can often be made where there are multiple plaintiffs, that a portion of the settlement amount should be attributed to plaintiffs who did not receive Medicaid benefits. Finally, it is important to review the Medicaid claim carefully to make sure that it is submitting claim only for benefits paid as a result of the injury that gave rise to the personal injury action.

There is another type of Medicaid lien which is mandated by Federal law and which is new to Georgia (and which has been around in Tennessee for several years). It is called the Medicaid Estate Recovery Lien. This is the lien that must be satisfied at the death of the Medicaid beneficiary. Whether you are advising a personal representative settling a claim, or the Trustee of the Special Needs Trust, you must take steps necessary to ascertain the amount of this lien and resolve it.

Medicare Claims: If a tort case is settled for an injured person who has been receiving Medicare, there is a repayment obligation to Medicare the full amount the Medicare program spent as a result of the injury. Medicare has an absolute statutory right of recovery based on 42 U.S.C. §1395y of Social Security Act. The Center for Medicaid and Medicare Services (CMS) has a

[15] http://www.legis.state.ga.us/cgi-bin/gl_codes_detail.pl?code=49-4-148.

direct right of reimbursement from any recipient of third party payments, including any attorney who has failed to protect a Medicare lien. Repayment to Medicare is due within 60 days of receipt of the third party payment.

It is the obligation of counsel to notify the Medicare Coordinator of Benefits to ascertain the existence and amount of any repayment obligation. Again, all parties, including plaintiff counsel, defense counsel, insurers, and any one handling the settlement funds, are personally responsible for the repayment of the Medicare claim. Including up to 100% penalty. There is no statute of limitations.

Address general written inquiries to:

MEDICARE - Coordination of Benefits
P.O. Box 5041
New York, NY 10274-5041

BCBS Georgia Part A	Attn: MSP Unit PO Box 9048 Columbus, GA. 31908	706-571-9586	706-571-5431
Cahaba Medicare Part B	Attn: MSP Unit PO Box 3018 Savannah, GA. 31402	800-727-0827	912-921-3066
Riverbend GBA Part A	Attn: MSP Unit 730 Chestnut St. Chattanooga, TN. 37402	423-752-6521 423-755-6244	423-752-8314
Cigna Medicare Part B	Attn: MSP Unit PO Box 671 Nashville, TN.	800-899-7095	615-782-4477

You can expect as much as a **six-month delay** from the time that the information is requested until you receive the information. It may also be possible to seek a waiver or compromise of the Medicare claim. Procurement costs (costs of collecting the judgment) such as legal fees and expenses can be deducted against the Medicare claim on a pro rata basis. If the liens are extremely high, requesting an "equitable reduction" can be a good idea.

There may be criminal penalties if Medicaid or Medicare liens are not properly satisfied.

After settlement (or recovery), the personal representative should send to Medicare a written copy of the settlement statement or a letter indicating the total settlement amount, and an itemized statement of attorneys' fees and costs incurred to obtain the recovery. This information is used by Medicare to determine whether a reduction of the total lien is warranted.

Medicare does provide for a reduction of the lien in instances in which attorneys' fees and costs have been incurred by the personal representative to obtain the recovery. The reduction, however, is not dollar for dollar and is calculated by Medicare after the total settlement or recovery is made known to Medicare.

No reimbursement is final unless it is calculated by Medicare or confirmed in writing as a correct balance. As a practical matter, it is best to have Medicare make the initial calculation. If Medicare payments are less than judgment or settlement amount allocated to the estate, the lien amount is calculated as follows:

1. The cost ration is determined by taking procurement costs (attorneys' fees and costs) and dividing them by the total recovery.
2. The cost ratio is multiplied by the total Medicare payments. The product is Medicare's share of the procurement costs.
3. Medicare's share of procurement costs is subtracted from the total Medicare payments and the remainder is the Medicare lien amount.

If Medicare payments equal or exceed the estate's award, the lien amount is the estate's award minus the total recovery coats.

Other Liens

If the health insurance of the plaintiff has paid for the care of the injured worker who, thereafter, recovers an award, the health contract may entitle the health insured to a dollar for dollar payback. Again, the plaintiff's attorney should examine the policy to see if such repayment is required.

In dealing with a health insurance carrier who asserts a claim against the judgment of settlement proceeds, it is important to know whether state law affects its right of recovery. Even with favorable state law, if the health insurance is part of an ERISA plan, the health insurance carrier will assert that the state law is not effective because of this supervising federal law.

Private Liens and Loans. When the case is being settled, you should try to identify the amount of any other claims against the recovery and their validity.

Conclusion

Stretching a disabled individual's dollars to meet quality of life needs is serious business and is not something you should leave to chance. Many dangers to a settlement or recovery survive the litigation and, if not addressed, can leave the client wondering why they bothered with the litigation in the first place. Since our job is to improve the client's position, we need a plan to help them. A proper plan takes these dangers into account and helps the client navigate them as they carry on after the litigation file is closed.