

Finishing Strong: Protecting the Recovery After Settlement or Verdict

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As everyone knows, it is imperative that each knight shall have a lady – for a knight without a lady is like a body without a soul. To whom would he dedicate his conquests? What vision sustain him when he sallies forth to do battle with ogres and with giants?³

Introduction:⁴

Litigators, as a rule, prefer to focus on slaying the nursing home ogres and giants. After that battle, however, we must continue the fight or we may discover that we have lost the war. As Quixote fought *for* Aldonza, we must fight *for our clients* by minimizing liens after the case is settled or the verdict is taken.⁵ (To put this in familiar terms, it isn't enough to simply reach "Mount Doom;" we must cast the ring into the fire). We do this to ensure that the recovery is paid to the innocent party and, where the victim remains alive, to improve the quality of his or her life.⁶

Initially, lawyers should always discuss potential liens with clients *before* filing suit. This allows the client to consider whether to bring the suit at all and, if suit is brought, what the case must settle for to satisfy potential liens. Some clients may decide to forego litigation if "the government is going to get everything anyway." If litigation goes forward after this conversation, the potential for having an unhappy client when funds are disbursed is diminished.⁷

In nursing home cases (and other injury cases), the injured party's recovery may be reduced if a third party financed the cost of long term care (e.g., the Medicare or

³ D. Wasserman, *Man from La Mancha* 32 (Random House 1966).

⁴ Many of the issues addressed in this paper were also addressed in Kennard Bennett's paper, *Settlement Issues in Nursing Home Cases: Medicare Liens, Medicaid, and Other Complications*, ATLA's Litigating Nursing Home Cases, April 20-21, 2001. Mr. Bennett's paper can be purchased through the ATLA exchange.

⁵ This paper is limited to Medicare, Medicaid and eligibility issues. It does not focus on settlement strategies generally, or on other subrogation issues. For a discussion of settlement strategies in nursing home cases, see S. Horowitz, *Settlement Strategies*, Chapter 13 in *Nursing Home Litigation: Pretrial Practice and Trials* (Lawyers & Judges Publishing Company, Inc. 2001). For a general discussion of subrogation issues, see D. Roberts, *Subrogation* (Ohio Academy of Trial Lawyers, July 2003) (available for online purchase at <http://www.oatlaw.org/>); and see K. Canfield, *The Changing World of Collateral Sources, Subrogation and Reimbursement: Revisited* (Georgia Trial Lawyers Association, August 13, 1999).

⁶ It is worth noting that the principal focus of Elder Law, as opposed to Estate Law, is on improving the quality of life for *living* Elders. See Takacs & McGuffey, *The Elder Centered Law Practice: What it is, How to Attain It*, presented at North Carolina Bar Association, *8th Annual Elder Law Symposium* (Feb. 27, 2004).

⁷ We suggest that you make this disclosure in writing as part of your engagement letter.

Medicaid programs). Under those circumstances, payback issues must be considered. In death cases, liens and estate recovery issues must be considered. In injury cases, the issues requiring consideration are liens and continuity of public benefits. This paper addresses both with a view toward maximizing the client's recovery.

Since the focus of this conference is nursing home litigation, as a starting point, it is worth considering how nursing home care is funded. In 2001, 7% of all U.S. health care expenses related to nursing home care.⁸ \$98.9 billion was paid for nursing home care, with an additional \$33.2 billion on home health care.⁹ Regarding nursing home care, consumers paid \$26.9 billion out of pocket and private insurers paid an additional \$7.5 billion.¹⁰ Federal funds paid \$41.8 billion and State and Local government funds paid \$19 billion.¹¹

In 2001, approximately 11.2% of nursing home care was funded by the Medicare program, while 47% was funded by the Medicaid program.¹² The remainder was funded privately, either with the resident's own funds or with a long term care insurance policy. The following table illustrates the payment trend from 1980 through 2001:

Year	Total ¹³	Out-of-Pocket Payments	Third-Party Payments						Medicare	Medicaid
			Total	Private Health Insurance	Other Private Funds	Public				
						Total	Federal	State and Local		
Amount in Billions										
1980	\$17.7	\$7.1	\$10.6	\$0.2	\$0.8	\$9.6	\$5.7	\$3.9	\$0.3	\$8.9
1988	40.5	15.6	24.9	2.2	2.7	20.1	12.0	8.1	0.7	18.4
1990	52.7	19.8	32.9	3.1	3.9	25.9	15.8	10.2	1.7	23.2
1997	85.1	21.8	63.3	7.1	5.2	51.0	34.0	17.0	9.6	39.6
1998	89.1	24.9	64.2	7.4	4.6	52.3	35.0	17.2	10.2	40.1
1999	89.6	25.4	64.2	7.5	4.5	52.2	34.3	17.9	8.4	41.8
2000	93.8	26.2	67.6	7.3	4.1	56.2	37.7	18.5	9.5	44.6
2001	98.9	26.9	72.0	7.5	3.7	60.9	41.8	19.0	11.6	47.0
Projected										
2002	103.7	27.3	76.4	7.7	3.3	65.3	44.7	20.6	12.1	50.8
2003	108.2	28.3	79.9	8.2	3.3	68.4	46.5	21.9	11.8	54.0
2004	113.3	29.3	83.9	8.9	3.4	71.7	48.6	23.1	12.0	57.0
2012	178.8	41.1	137.6	16.0	3.8	117.8	80.5	37.2	21.2	91.9

⁸ Nationally, in 2001, public funds paid for 46% of all health care costs. See CMS, National Health Accounts.

⁹ See CMS National Health Accounts, Table 1, at <http://www.cms.hhs.gov/statistics/nhe/definitions/sources-methods/>. The figure for nursing home care is projected to reach \$166.4 Billion annually by 2011. See S. Heffler et al., *Health Spending Projections for 2001-2011: The Latest Outlook*, 21 Health Affairs 207, 208 (March/April 2002).

¹⁰ See CMS National Health Accounts, Table 1, *supra*.

¹¹ *Id.*

¹² See CMS, National Health Accounts, Table 7, at <http://www.cms.hhs.gov/statistics/nhe/historical/t7.asp>.

¹³ Table figures represent dollars in "Billions."

Source: excerpts from *CMS National Health Accounts*, historical data at: <http://www.cms.hhs.gov/statistics/nhe/historical/t7.asp>; and projections at <http://www.cms.hhs.gov/statistics/nhe/projections-2002/t13.asp>.

In 2001, approximately 72% of the nursing home care provided was funded by third party payments, with that number climbing each year. Thus, it appears safe to presume that most clients who recover funds through nursing home litigation must address third-party payback issues related to participation in these programs.

Among the issues that must be considered are:

- Medicare Liens;
- Medicaid Liens;
- Medicaid Estate Recovery;
- Continued Eligibility for Benefits; and
- Special Needs Trusts.

Medicare and Medicaid Distinguished

Although Medicare and Medicaid are fundamentally different, few clients (and too few lawyers) understand the differences relating to eligibility, coverage and benefits for these two government programs. Medicare is an entitlement program and provides *little* assistance in funding the cost of long-term care.¹⁴ It is often compared to health insurance and is designed for persons over 65 years of age, or who are disabled.¹⁵ Medicare is funded through payroll deductions and premium payments.¹⁶ Entitlement to Medicare is not affected by the amount of income or assets received or owned by the recipient.¹⁷

Medicare pays for critical care services such as hospitalization (Part A), and for physician services and durable medical equipment (Part B).¹⁸ If during a “spell of illness”¹⁹ a nursing home resident requires *skilled care*²⁰ following a qualifying hospitalization,²¹ then Medicare will pay for 100% of (up to) the first 20 days, and will

¹⁴ Medicare was established in 1965, under Title XVIII of the Social Security Act (42 U.S.C. § 1395), to pay medical expenses for persons who receive Social Security retirement benefits or Social Security disability income.

¹⁵ See, generally, Part A, 42 C.F.R. § 406.10 to 406.13; Part B, 42 C.F.R. § 407.10.

¹⁶ Part A is funded through payroll deductions and Part B is funded through monthly premiums. Part B premiums are generally deducted from the recipient’s monthly Social Security check. In **2004**, the Part B monthly premium is \$66.60.

¹⁷ See J. Stein & A. Chiplin, *2003 Medicare Handbook* § 1.01 (Aspen). The Medicare Prescription Drug, Improvements and Modernization Act of 2003 (P.L. 108-173) (the “Medicare Act of 2003”), signed by President Bush on December 8, 2003, will alter this rule, somewhat, at least with respect to prescription drugs.

¹⁸ Coverage for Parts A and B is summarized in the *2003 Medicare Handbook*, supra, at § 1.05.

¹⁹ The phrase “spell illness” refers to the Medicare benefit period, which is defined at 42 C.F.R. § 409.60. In general terms, a benefit period is 90 days and begins on the first day the beneficiary receives inpatient care and ends 60 days after payments terminate for the condition that initiated the need for care. Thereafter, a new benefit period can begin. See *2003 Medicare Handbook* § 1.05[A][1].

²⁰ 42 C.F.R. § 409.32 to 409.33.

²¹ A qualifying hospitalization is a three day stay, not counting the day of discharge. See 42 U.S.C. § 1395x(i); 42 C.F.R. § 409.30.

pay all but the daily deductible for (up to) the next 80 days.²² In **2004**, the daily deductible is **\$109.50**. After the first 100 days, there is no Medicare coverage for nursing home care (absent a new spell of illness).

Assuming Medicare pays for the first 100 days of nursing home care, when it runs its course, Medicaid is the only government program that will pay the cost of nursing home care.

Unlike Medicare, Medicaid is a public assistance (welfare) program.²³ Medicaid eligibility is “means-tested.” Applicants are eligible only if other criteria are met and **countable** income and **countable** resources (assets) are below the eligibility limits. (“Countable” resources are those resources remaining after certain exclusions are taken into account.)²⁴ A sudden infusion of income or assets (e.g., a tort recovery) can result in a loss of benefits.

Medicaid eligibility rules will vary from State to State because Medicaid is a program jointly funded by the Federal and State governments.²⁵ While Congress establishes the Medicaid eligibility criteria, each state applies the criteria as it sees fit. The general criteria is that one must be **aged, blind, or disabled**,²⁶ have **no more than \$2,000 in countable resources**, and may retain exempt resources including the home place, an automobile, certain life insurance, burial spaces, and limited funds designated for incidental funeral expenses.²⁷ If the Medicaid applicant is married the limits are increased somewhat, depending on the criteria of the specific Medicaid program (in 2004, the Community Spouse Resource Allowance is up to \$92,760).²⁸

Medicaid pays for a broad range of medical services, including hospitalization, prescription drugs, nursing home care and doctor visits. Although the focus here is “nursing home Medicaid,” it is worth noting that there are numerous Medicaid programs available to persons based on variations of income, resources, age, type of disability and institutionalization. In Georgia and Tennessee, applicants who receive Supplemental Security Income (SSI) payments (monthly cash assistance payments from

²² 100 days are not guaranteed. If skilled care is no longer necessary, then Medicare may cover fewer than 100 days.

²³ Medicaid was also established in 1965, under Title XIX of the Social Security Act (42 U.S.C. § 1396 et seq.), as a federal-state partnership designed to provide medical care to low-income persons who are aged, blind or disabled. Every state has voluntarily elected to participate in the Medicaid program, and the various states bear from 50% to 80% of the cost of such medical assistance. Regulations covering the Medicaid program generally appear at 42 C.F.R. Part 430 and at 20 C.F.R. Part 416.

²⁴ Other circumstances would include citizenship, state of residence and similar matters. In this paper, only financial criteria are considered.

²⁵ Here we consider the Federal rules as well as the Georgia and Tennessee eligibility rules. Counsel should consult an attorney experienced in Medicaid matters in the appropriate jurisdiction.

²⁶ O.C.G.A. §49-4-81.

²⁷ HCFA Transmittal 64 (included in the State Medicaid Manual) § 3257.B.4 (applying the same resource definition used in the SSI regulations); 42 U.S.C. §1382b; 20 C.F.R. §416.1210; O.C.G.A. §49-4-6(a); Volume II/MA, MT 1-01/02 §§2300 et seq.

²⁸ Although a thorough discussion of Medicaid Planning is beyond the scope of this paper, the CSRA is addressed at 42 U.S.C. § 1396r-5.

the Social Security Administration to the low-income disabled to help pay for basic food/clothing/shelter needs) automatically receive Medicaid assistance.²⁹

Ethical Obligations to Creditors

Under Rule 1.15 of the Model Rules of Professional Conduct, the personal injury lawyer has a duty to his or her client's creditor if the creditor has an interest in settlement proceeds.³⁰ The ABA's version of Model Rule 1.15 is as follows:

(a) A lawyer shall hold property of clients or third persons that is in a lawyer's possession in connection with a representation separate from the lawyer's own property. Funds shall be kept in a separate account maintained in the state where the lawyer's office is situated, or elsewhere with the consent of the client or third person. Other property shall be identified as such and appropriately safeguarded. Complete records of such account funds and other property shall be kept by the lawyer and shall be preserved for a period of [five years] after termination of the representation.

(d) Upon receiving funds or other property in which a client or third person has an interest, a lawyer shall promptly notify the client or third person. Except as stated in this rule or otherwise permitted by law or by agreement with the client, a lawyer shall promptly deliver to the client or third person any funds or other property that the client or third person is entitled to receive and, upon request by the client or third person, shall promptly render a full accounting regarding such property.

(e) When in the course of representation a lawyer is in possession of property in which two or more persons (one of whom may be the lawyer) claim interests, the property shall be kept separate by the lawyer until the dispute is resolved. The lawyer shall promptly distribute all portions of the property as to which the interests are not in dispute.³¹

Charles Cork, a Georgia trial lawyer, differentiates between legal claims and equitable claims, concluding that the lawyer has no duty to creditors absent a valid interest in the proceeds (e.g., a perfected lien).³² If there is a valid legal claim, then even if the client objects, the lawyer should disclose the existence of the settlement because Rule 1.15 takes precedence over client confidentiality in that instance.³³ Where there is no valid objection to the claim, the lawyer should pay the creditor even over the client's objection.³⁴ However, where the claim is disputed, several approaches may be considered. First, the lawyer may interplead the opposing claims. Second, the lawyer may hold the funds in trust until the dispute is resolved. Also, the lawyer may seek a declaratory judgment or attempt mediation. However, the lawyer may not unilaterally "settle" the dispute and may not simply sit on the money for a prolonged period of time.

²⁹ 42 U.S.C. §1396a(a)(10)(A)(i)(II); Ga. Medicaid Manual, Volume II/MA, MT 1-01/02 §2111-1; Tenn. Comp. R. & Regs. 1200-13-12-.02(1)(c); 1200-13-13-.02(1)(c).

³⁰ C. Cork, *A Lawyer's Ethical Obligations When the Client's Creditors Claim a Share of the Tort Settlement Proceeds*, 39 *Tort Trial & Insurance Practice* L.J. 121, 123 (2003).

³¹ In Tennessee, see T.R.P.C. Rule 1.15(b); in Georgia, see G.R.P.C. Rule 1.15(I).

³² "The ethics opinions all agree that an interest includes undisputed statutory [e.g., Medicare and Medicaid] liens, ..." *Cork*, at 124.

³³ *Cork*, *supra*, p. 132.

³⁴ *Id.*, at 133, and authority cited at fn. 104.

Recently, in *In re Allen*, 2004 WL 231507 (Ind. 2004), the court disciplined counsel, finding that:

“Beginning in 1998, [attorney Young] represented a client on a claim for injuries she suffered in an automobile accident. During the proceedings, the client received \$4,786 in services from a chiropractor. Young and the client signed a "Doctor's Lien," which provided, *inter alia*, that the respondent would "withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect" the chiropractor. Although \$2,021.29 of the chiropractor's bill was paid, a balance of \$2,764.71 remained when the client's case settled for \$50,000. The client advised Young that she thought the chiropractor had overcharged her for services. She directed Young to pay to the chiropractor only \$1,000 from the settlement proceeds. Pursuant to the client's instruction, Young disbursed only \$1,000 to the chiropractor despite the outstanding "Doctor's Lien" and the fact that the chiropractor claimed he was still owed \$2,764.71. Young then forwarded \$1,764 to the client from the settlement proceeds, which represented the claimed unpaid portion of the chiropractor's bill.”

The court found that Young violated Rule 1.15. “Implicit in [Rule 1.15 is the obligation that] a lawyer hold disputed funds in trust until the dispute is resolved so that the lawyer can effect accurate disbursement. Moreover, as the Comment to Prof. Cond. R. 1.15(b) indicates, a lawyer should not unilaterally settle a dispute between his client and a third party.” For violating the Rule, Young was subjected to public reprimand. A similar result was reached in *State ex rel. Oklahoma Bar Ass'n v. Taylor*, 71 P.3d 18 (Okla. 2003).³⁵

The ethics opinions suggest that statutory liens such as those addressed below are ignored at the lawyer's peril.

Medicare Liens & Medicare Secondary Payer

“In 1980 Congress prohibited Medicare from paying for health services that are also covered by other insurers though its creation of the Medicare Secondary Payer (MSP) program.”³⁶ The legislative history of the MSP provisions reveal that "it is expected that Medicare will ordinarily pay for the beneficiary's care in the usual manner and then seek reimbursement from the private insurance carrier after, and to the extent that, such carrier's liability under the private policy for the services has been determined. H.R. Rep. No. 96-1167 (1980), *reprinted in* 1980 U.S.C.C.A.N. at 5752.”³⁷ The MSP claim springs into being when a liable third party makes payment.³⁸

³⁵ “Where a lawyer knows there is a dispute over funds in his hands **and** he is unaware at the time of disbursement, under applicable law, who is actually entitled to the funds, he violates Rule 1.15(b) and/or (c) when he disburses the disputed funds to a disputant, even though in hindsight under the applicable law it might eventually be judicially decided the funds were disbursed correctly because one or more of the disputants had no valid claim to the funds or a portion thereof.” *Taylor*, at 27.

³⁶ See 2003 Medicare Handbook, *supra*, § 9.01; see also *Fanning v. U.S.*, 346 F.3d 386, 388 (3rd Cir. 2003); see also H. McCormick, *supra*, § 1:67 et seq.

³⁷ *Bird v. Thompson*, 2003 WL 21537748, *2 (S.D. N.Y. 2003).

³⁸ Medicare Intermediary Manual § 3418.6.

This presentation will not address Medicare Secondary Payer issues and the Medicare lien; instead, see, in this conference, Martha Eastman, "Goetzmann and Liens: How to Deal with Them," *Litigating Nursing Home Cases*, ATLA, Ft. Lauderdale, Florida. (March 19-20, 2004). The authors of this paper have prepared a paper on MSP issues which is available on request.

Medicaid Liens

Medicaid liens and Medicaid estate recovery (discussed below) are different. Think of the Medicaid lien as Medicaid's first bite at the apple. Both must be considered when resolving personal injury or malpractice claims.

The Medicaid statute requires States to ascertain the "legal liability" of third parties "to pay for care and services" rendered under the Medicaid program, 42 U.S.C. § 1396a(a)(25)(A), and, to pursue recovery to the full *extent of such legal liability*, 42 U.S.C. § 1396a(a)(25)(B) (emphasis added).³⁹ The purpose of establishing and maintaining effective third party liability programs (Medicaid liens) is to reduce Medicaid expenditures.⁴⁰ Pursuant to 42 U.S.C. § 1396k and 42 C.F.R. § 433.145, a Medicaid recipient must assign to Medicaid any rights to pay medical care paid for by a third party.⁴¹ The Medicaid lien is limited to recovery for services reimbursed by Medicaid for the injury sustained.⁴² Otherwise stated, the claim is limited and should not include any payments Medicaid would have paid *even if* the incident had not occurred. Thus, Medicaid liens are similar in scope to other subrogation liens.⁴³

³⁹ *Ahlborn v. Arkansas Dept. of Human Services*, 280 F.Supp.2d 881, 888 (E.D. Ark. 2003); see also H. McCormick, *Medicare and Medicaid Claims and Procedures*, 3rd Ed. § 27:27 (West 2001, updated annually).

⁴⁰ State Medicaid Manual § 3900.1.

⁴¹ Congress enacted this amendment in Pub. L. No. 95-145, § 1912(a)(1)(A), 91 Stat. 1175, 1196 (1977). One issue that may or may not impact compromise of the claim is "when does the assignment take place." Under Georgia law (and the many other states), a personal injury claim cannot be assigned. See O.C.G.A. § 44-12-24. Thus, a subrogated party could not proceed directly against a third party. See *Government Employees Ins. Co. v. Hirsh*, 211 Ga. App. 374 (1993) (claim for medical expenses cannot be assigned); but see *Department of Corrections v. Barkwell*, 256 Ga. App. 877 (2002) (holding, in the context of a prison case, that once the State fulfills its duty to provide care, ... it may proceed against a third party ... who caused the injuries; whether the government would have a similar direct action in the context of a Medicaid lien is an open question). At Section 3905, the State Medicaid Manual recognizes that the assignment of claims is governed by State law. See, e.g., O.C.G.A. § 44-12-24. This reasoning would not apply in the Medicare context since Medicare has an independent cause of action under Federal law.

⁴² See, e.g., O.C.G.A. § 49-4-149; T.C.A. § 71-5-117(a). Pursuant to 42 U.S.C. § 1396k(b), the State may retain the amount necessary to reimburse it for medical assistance payments made and the remainder must be paid to the individual. See <http://www.cms.hhs.gov/medicaid/tpl/default.asp>. But see A. Bove & M. Langa, *Protecting Personal Injury Awards Through Special Needs Trusts*, Massachusetts Lawyers Weekly (3/11/2002), citing *Whelan v. Division of Medical Assistance*, 694 N.E.2d 10 (1998) for proposition that the Medicaid lien may be enforced against the entire recovery, not just the portion allocated to past medical expenses; and see *Ahlborn v. Arkansas Dept. of Human Services*, supra, for same proposition. See also H. McCormick, supra, § 27:33.

⁴³ In *Martin ex rel. Hoff v. City of Rochester*, 642 N.W.2d 1 (Minn. 2002), the court explained the limited scope of the Medicaid lien as follows: "The anti-lien provision protects the personal property of a medical assistance recipient--here, Hoff's cause of action--from a state's effort to recover for medical expenses. The assignment transfers to the state the recipient's right to recover medical expenses, and

The rights assigned are described in 42 U.S.C. § 1396k(a)(1)(A) and in 42 C.F.R. § 433.146.⁴⁴ The recipient's duty of cooperation is outlined at 42 U.S.C. § 1396k(a)(1)(B), (C), (a)(2) and at 42 C.F.R. § 433.147. If the recipient fails to make the assignment and cooperate with Medicaid in securing the recovery, future benefits must be denied. 42 C.F.R. § 433.148.⁴⁵

As noted above, Medicaid is funded by both the Federal and State governments. Thus, arguably, both Federal and State interests are at stake in estate recovery. Recently, an Arizona court ruled that a State agency may not waive the Federal portion of the Estate recovery claim.⁴⁶ Arguably, the State places its receipt of Federal funds in jeopardy if it fails to seek reimbursement from liable third parties.⁴⁷

The Medicaid lien is statutory.⁴⁸ Further, each State Plan identifies its position concerning liens and estate recovery.⁴⁹ In Georgia, prior to filing an action, counsel should give notice to the Department of Community Health pursuant to O.C.G.A. § 9-2-21(c). This (or other notice) initiates the recovery process which, in Georgia, is contracted out to Public Consulting Group.⁵⁰

An example of an initial letter to Medicaid is as follows:

Re: [Name of Medicaid Beneficiary and Medicaid Number/Claim Number]

Dear Sirs:

Please be advised that this firm represents the above-named Medicaid Beneficiary who [has filed suit against (or who has settled a claim against)] the following potentially responsible third-party: [identify third party]. The claim relates to injuries alleged to have occurred between [dates]. Please forward to me a written notice of the amount necessary to satisfy any Medicaid claim related to this injury.

therefore the ability to pursue directly potentially liable third parties for medical assistance expenses paid. The anti-lien provision protects all of a recipient's nonassigned rights to recover." *But see Grey Bear v. North Dakota Dept. of Human Services*, 651 N.W.2d 611 (N.D. 2002).

⁴⁴ See, generally, 42 C.F.R. § 433.135 to § 433.148.

⁴⁵ Interestingly, nowhere is cooperation defined as filing suit or pursuing litigation against a third party. If State law precludes the assignment of personal injury claims, this may give the beneficiary limited leverage in compromising a claim prior to litigation since the beneficiary (or heirs) may decline to proceed where the State would take the entire recovery. As a practical matter, taking this position may be more useful in death cases. See State Medicaid Manual § 3905.4 (requiring termination of benefits where assignment and cooperation are refused). Note, however, that even where Medicaid cannot directly pursue a third party, the landscape may change since CMS has instructed States to amend their subrogation laws to permit collection in tort and non-tort situations. State Medicaid Manual § 3910.15

⁴⁶ *Eaton v. Arizona Health Care Cost Containment System*, 79 P.3d 1044 (Ariz. App. 2nd Div. 2003).

⁴⁷ See 42 C.F.R. § 433.140; State Medicaid Manual § 3904.6.

⁴⁸ Claims of insurance carriers, in contrast, are contractual.

⁴⁹ See, e.g., Georgia, http://cms.hhs.gov/medicaid/stateplans/State_Data/GA/4.17/X_001.pdf; Tennessee, http://cms.hhs.gov/medicaid/stateplans/State_Data/TN/4.17/X_001.pdf.

⁵⁰ <http://www.pcgus.com/default.html>. Public Consulting Group also handles claims for other states including West Virginia.

I am enclosing a self-addressed stamped envelope.

Thank you for your cooperation. If you have any questions, please do not hesitate to contact me.⁵¹

Georgia's subrogation rights are codified at O.C.G.A. § 49-4-148 and its lien rights are codified at O.C.G.A. § 49-4-149. Some States have formalized the lien review process. For example, a paper reviewing Virginia's Lien Compromise Guidelines is available online.⁵² In Georgia, the process works as follows: "Upon contact by an attorney, the [Recovery Unit] will establish the client's Medicaid eligibility status at the time of the accident, determine whether the Medicaid program incurred any medical expenses as a result of the accident or injury, and generate a complete medical history of Medicaid claims filed on behalf of the client."⁵³ The State must establish procedures to identify legally liable third parties and must incorporate that information into its eligibility file.⁵⁴ Among other procedures, the recovery unit audits trauma codes to identify potential claims.⁵⁵ For example, Georgia's State Medicaid Plan provides: "Diagnosis and trauma code edits are conducted in each weekly claims processing cycle to identify those paid claims for Medicaid recipients that contain diagnosis codes 800 through 999 (ICD 9-CM) except for diagnosis code 994.6."⁵⁶ While the case is pending, Medicaid may file a lien with the clerk of court in both the county where the Medicaid beneficiary resides and in Fulton County, Georgia.⁵⁷ If the claim is ignored, the claim is forwarded to the Attorney General's Office.

Some states will reduce their Medicaid lien to absorb a pro-rata share of attorney fees and litigation expenses.⁵⁸ Others do not.⁵⁹ There is a divergence of opinion regarding whether the "made-whole" rule applies."⁶⁰

In Georgia, O.C.G.A. § 49-4-148 provides that "the commissioner of community health may compromise, settle, and execute a release of any such claim or waive, expressly, any such claim, in whole or in part, for the convenience of the Department of Community Health." In practice, claims are reduced where "there are insufficient funds from the

⁵¹ T. Begley & J. Jeffreys, *Medicare Set-Aside Arrangements*, Appendix 19J, in *Representing the Elderly Client* (Aspen Publishers, 2003 Supplement).

⁵² See R. Majette, *Medicaid and Medicare Issues in Tort and Worker Compensation Settlements*, <http://www.geocities.com/hana+zushi/strucset.pdf>; for West Virginia, see <http://wvrecovery.com/Trauma%20Recovery%20Unit.htm>.

⁵³ Georgia's recovery practice is summarized in R. Singh & L. McMillion, *Dealing with Georgia Medicaid and the Recovery Unit*, copy on file with authors.

⁵⁴ 42 C.F.R. § 433.138(g)(4).

⁵⁵ "The purpose of reviewing trauma codes is to detect potential casualty and liability claims and determine if another party is at fault." State Medicaid Manual § 3903.3.

⁵⁶ http://cms.hhs.gov/medicaid/stateplans/State_Data/GA/4.22/Attachments/A/A_001.pdf; 42 C.F.R. § 433.138(e); State Medicaid Manual § 3902.

⁵⁷ Singh & McMillion, *supra*.

⁵⁸ *Holland v. State Farm Mut. Auto. Ins. Co.*, 236 Ga. App. 832 (1999); *but see Padgett v. Toal*, 261 Ga. App. 154 (2003), distinguishing *Holland* and holding that Georgia's Medicaid lien is reduced by the attorney lien only where the settlement is insufficient to satisfy both liens.

⁵⁹ *State, Agency for Health Care Admin. v. Wilson*, 782 So.2d 977 (Fla. App. 1st Dist. 2001).

⁶⁰ See cases cited at H. McCormick, *supra*, § 27:30.

settlement to pay the attorney for fees and expenses and satisfy all other lien holders.”⁶¹ Documentation is required.

In some states, the Department may be bound by a statute of limitations. For example, in *Department of Medical Assistance v. Hallman*, 203 Ga. App. 615 (1992), the Department failed to comply with O.C.G.A. § 49-4-148 and pursue its claim within one year.⁶² Thus, collection was foreclosed. Elder Law Attorney Tim Takacs suggests a similar result in Tennessee, *citing* T.C.A. § 30-2-310(b) and *In re Key*, 1999 Tenn. App. Lexis 201, 1999 WL 172675 (March 24, 1999). *See* T. Takacs, *Elder Law Practice in Tennessee* § 5-12(a) (Lexis, 2003 Cumulative Supp.).

Where there are conflicting claims between Medicare and Medicaid, Medicare’s claim has priority.⁶³

Medicaid Estate Recovery

“When Medi-Cal recipient Jane Longshore died in August 1995, she was survived by four children, two of whom suffer from multiple sclerosis and have been classified under state and federal law as “permanently and totally disabled.” Nevertheless, in March 1996, the California Department of Health Services filed a creditor's claim for more than \$157,000 against Longshore's estate.”⁶⁴

⁶¹ Singh & McMillion, *supra*. Documentation must include the amount and date of the settlement, a list of all creditors and the amount of their claim, an itemized list of attorney’s fees and expenses, documentation of any reductions from other creditors and/or the attorney, and the reason for the requested reduction. The Singh & McMillion paper indicates that the recovery unit will respond (in Georgia) within 48 hours.

⁶² In Georgia, the Department of Medical Assistance “shall have one year from the date the last item of medical care was furnished to file its verified lien statement” (O.C.G.A. § 49-4-149). The lien must be enforced by following the procedures applicable to hospital liens (O.C.G.A. § 44-14-470 et seq.). O.C.G.A. § 44-14-474(a) provides that the action to enforce the lien “shall be commenced against the person liable for the damages or such person's insurer **within one year** after the date the liability is finally determined by a settlement, by a release, by a covenant not to bring an action, or by the judgment of a court of competent jurisdiction.” Whether statutes of limitations may be expanded, or disregarded altogether is a subject of speculation as budget crises continue. *See, e.g., State, Dept. Trans. v. Sullivan*, 527 N.E.2d 798, 799 (Ohio 1998) (“Federal and state courts throughout the United States seem to have uniformly held that the federal government and state governments are not bound by the terms of a general statute of limitations. *In Guaranty Trust Co. v. United States* (1938), 304 U.S. 126, 58 S.Ct. 785, 82 L.Ed. 1224, the United States Supreme Court stated at 132 that this rule “ * * * appears to be a vestigial survival of the prerogative of the Crown.”).

⁶³ State Medicaid Manual § 3908.

⁶⁴ N. Siegal, *One last dig: Medicaid collects at the grave (US requires estates to pay Medicaid back under 1993 Omnibus Budget Reconciliation Act)*, *The Progressive*, April, 1998.

Estate recovery is mandated by federal law.⁶⁵ It is a potential “second-bite at the apple” that can follow satisfaction of the Medicaid lien. Because most tangible assets are spent down to achieve eligibility, estate recovery focuses on assets that were exempt during the eligibility process (e.g., real property, personal property or income producing assets).⁶⁶ Further, because tort recoveries may flow through an estate, those assets are also targeted. “The basic premise of estate recovery is that the receipt of public assistance constitutes a debt of the recipient (amounts paid unrelated to the incident that caused the settlement) which is enforceable only after the death of the recipient.”⁶⁷

An example of how estate recovery works is as follows:

Ms. Jones, age 79, received a settlement of \$600,000 in connection with a claim against a nursing home. She pays attorney’s fees (40% contingent fee), litigation expenses (\$35,000), and pays her Medicare and Medicaid liens (\$25,000 and \$70,000 respectively) in full. Her net recovery was \$230,000. Thereafter, she is now over-resourced and, thus ineligible for Medicaid. Her nursing home bill is \$5,000 per month. She dies six months later, leaving an estate of \$200,000.

Ms. Jones was originally admitted to the nursing home at age 74 and was on Medicaid during her entire residency, except for her final 6 months. The State may now seek recovery of the other \$130,000 it paid for Ms. Jones’ care from the date of admission.

Estate recovery applies to individuals who were age 55 or older when they received Medicaid or to permanently institutionalized adults under 55.⁶⁸ The federal statute mandating estate recovery is as follows:

42 U.S.C. 1396p(b)

(b) Adjustment or recovery of medical assistance correctly paid under a State plan

(1) No adjustment or recovery of any medical assistance correctly paid on behalf of an individual under the State plan may be made, **except that the State shall seek adjustment or recovery of any medical assistance correctly paid on behalf of an individual under the State plan in the case of the following individuals:**

(A) In the case of an individual described in subsection (a)(1)(B) of this section, the State **shall seek adjustment or recovery from the individual's estate or upon sale of**

⁶⁵ *West Virginia v. U.S. Dept. of Health and Human Services*, 289 F.3d 281 (4th Cir. 2002). See <http://www.cms.hhs.gov/medicaid/estaterec.asp>. Estate recovery may be limited to the probate estate or, at the State’s option, may be expanded to include any other property in which the beneficiary had a legal or equitable interest. See State Medicaid Manual § 3810(B). Until recently, Texas, Michigan and Georgia were the only States without a Medicaid Estate Recovery Program. Now, it appears as though Georgia is the only holdout. There is talk that estate recovery will be in Georgia soon. At least one Georgia State website claims it already program exists, see <http://www2.state.ga.us/Departments/DHR/facmed.html>, but in practice, it does not exist. See <http://www.tn-elderlaw.com/prior/020408.html>; and <http://www.elderlawanswers.com/news/xcnewsplus.asp?cmd=view&articleid=162>.

⁶⁶ *Id.*, at 284-285.

⁶⁷ See J. Hefren & S. Schneider, *How to Satisfy the Liens and Preserve the Client’s Public Assistance*, 75 Fla. B. J. 42, 46 (April 2001).

⁶⁸ “You must seek adjustment or recovery from the estate of an individual who was age 55 or older when that person received medical assistance. You must recover up to the total amount spent by Medicaid on the person's behalf....” State Medicaid Manual § 3810(A)(2).

the property subject to a lien imposed on account of medical assistance paid on behalf of the individual.

(B) In the case of an individual who was **55 years of age or older** when the individual received such medical assistance, the State shall seek adjustment or recovery from the individual's estate, but only for medical assistance consisting of--

(i) **nursing facility services**, home and community-based services, and related **hospital and prescription drug services**, or

(ii) at the option of the State, any items or services under the State plan.

(C)(i) In the case of an individual who has received (or is entitled to receive) benefits under a long-term care insurance policy in connection with which assets or resources are disregarded in the manner described in clause (ii), except as provided in such clause, the State **shall seek adjustment or recovery from the individual's estate** on account of medical assistance paid on behalf of the individual **for nursing facility and other long-term care services**.

(ii) Clause (i) shall not apply in the case of an individual who received medical assistance under a State plan of a State which had a State plan amendment approved as of May 14, 1993, which provided for the disregard of any assets or resources--

(I) to the extent that payments are made under a long-term care insurance policy; or

(II) because an individual has received (or is entitled to receive) benefits under a long-term care insurance policy.

(2) Any adjustment or recovery under paragraph (1) may be made **only after the death** of the individual's surviving spouse, if any, and only at a time--

(A) when he has no surviving child who is under age 21, or (with respect to States eligible to participate in the State program established under subchapter XVI of this chapter) is blind or permanently and totally disabled, or (with respect to States which are not eligible to participate in such program) is blind or disabled as defined in section 1382c of this title; and

(B) in the case of a lien on an individual's home under subsection (a)(1)(B) of this section, when--

(i) no sibling of the individual (who was residing in the individual's home for a period of at least one year immediately before the date of the individual's admission to the medical institution), and

(ii) no son or daughter of the individual (who was residing in the individual's home for a period of at least two years immediately before the date of the individual's admission to the medical institution, and who establishes to the satisfaction of the State that he or she provided care to such individual which permitted such individual to reside at home rather than in an institution), is lawfully residing in such home who has lawfully resided in such home on a continuous basis since the date of the individual's admission to the medical institution.

States, at their option, may limit estate recovery to the probate estate or may expand it to other interests in property owned at the time of death.⁶⁹ Expanded estate recovery would reach assets such as life estates in realty, annuities, structured settlements, etc.

⁶⁹ “Probate Definition.--At a minimum, you must include all real and personal property and other assets included within the individual's estate as provided in your State probate law. Optional Definition.--In addition to property and assets under the probate definition, you may include any other real and personal property and other assets in which the individual had any legal title or interest at the time of death (to the extent of such interest). This includes assets conveyed to a survivor, heir, or assign of the deceased through joint tenancy, tenancy in common survivorship, life estate, living trust, or other arrangement.” State Medicaid Manual § 3810.

Some States, such as West Virginia, contend that “the estate recovery program is bad public policy that yields little in terms of dollars actually recovered but creates substantial non-financial problems, such as “widespread clinical depression in aged and disabled nursing home residents.”⁷⁰ That conclusion appears to be justified in view of a 1997 survey conducted by the State of North Carolina reference the various estate recovery programs and including their effectiveness. The overall finding was that estate recovery, as a percentage of total Medicaid expenditures, was less .026%. *See* Appendix E. However, reality is that every State budget is strained and in the current “no new taxes” environment, state governments will continue to review estate recovery. If estate recovery has not been an issue in your state, you should anticipate changes designed to enhance estate recovery collection efforts.

An example of one such change appears in the Tennessee Code Annotated. As of 2002, a Tennessee estate cannot be closed until the personal representative secures a TennCare release.⁷¹

T.C.A. § 71-5-116

(a) No applicant shall be required to execute an agreement for a lien on real property occupied as such applicant's residence on account of medical assistance paid or to be paid on such applicant's behalf under this part.

(b) No lien may be imposed against the real property of any individual prior to such individual's death on account of medical assistance paid or to be paid on such individual's behalf under this part, except pursuant to a court judgment for recovery of benefits incorrectly paid on behalf of such individual.

(c) There shall be no adjustment or recovery of any payment for medical assistance correctly paid on behalf of any individual under this part, except in the case of an individual who was fifty-five (55) years of age or older when such individual received such medical assistance or services, from such individual's estate, and then only after the death of such individual's surviving spouse, if any, and only at a time when such individual has no surviving child who is under eighteen (18) years of age or who is blind or permanently and totally disabled.

(1) To facilitate and enhance compliance with this subsection (c), the department of health shall promptly notify the bureau of TennCare, in a format to be specified by the bureau, of the death of any individual fifty- five (55) years of age or older. Such notification shall include the decedent's name, date of birth, and social security number. It is the legislative intent of this subsection (c) that the bureau of TennCare strive vigorously to recoup any TennCare funds expended for a decedent after the date of death.

⁷⁰ *West Virginia, supra*, 289 F.3d at 285. In fact, West Virginia’s Attorney General has posted a memo on his website that explains how estate recovery can be avoided. *See* D. McGraw, *Medicaid Estate Recovery: What Seniors Should Know*, at <http://www.wvs.state.wv.us/wvag/press/2002/oct/01.htm>. Georgia, at least under the former Democratic administration, took a similar position. On September 18, 1998, Laura Marshall, spokesperson for the Department of Medical Assistance, was quoted as saying: “We are not going to do [estate recovery]. For the emotional impact, it was probably not worth the cost.” *See* I. Leff, *Georgia Nursing Home Medicare and Medicaid* (updated annually for the Institute of Continuing Legal Education in Georgia). The new Republican administration has indicated that Georgia may be implementing estate recovery in the near future.

⁷¹ The TennCare release form is available at: <http://www.state.tn.us/tenncare/rel-form.pdf>.

(2) Before any probate estate may be closed pursuant to title 30, with respect to a decedent who, at the time of death,⁷² was enrolled in the TennCare program, the personal representative of the estate shall file with the clerk of the court exercising probate jurisdiction a release from the bureau of TennCare evidencing payment of all medical assistance benefits, premiums, or other such costs due from the estate under law, unless waived by the bureau.⁷³

(d) Recoveries shall be prorated among the federal government, the state, and the county involved, if any, in proportion to the amounts which each contributed to the assistance and services.

In Tennessee, estate recovery is handled through the Program Integrity Unit, 11th Floor, Andrew Johnson Tower, 710 James Robertson Parkway, Nashville, TN 37247-0110 Telephone: (615) 253-4004, or 1-800-433-3982, Fax: (615) 532-7509. At this time, there is no estate recovery in Georgia.

Where estate recovery would work an undue hardship, adjustment or recovery is waived.⁷⁴ Among those factors considered in evaluating hardship are: (1) whether the asset is the sole income-producing asset of survivors (where such income is limited), such as a family farm or other family business; (2) whether it is a homestead of modest value; or (3) other compelling circumstances.⁷⁵ States must adopt procedures under which individuals who will be affected by estate recovery will have the right to apply for an undue hardship waiver. These procedures must, at a minimum, provide for advance notice of any proposed recovery. They must also specify the method for applying for a waiver, the hearing and appeal rights, and the time frames involved.⁷⁶

Medicaid Eligibility:

Basic Medicaid Eligibility Criteria

Why must tort lawyers consider Medicaid eligibility?⁷⁷ The reason, as shown in the table in the Introduction, is that nursing home care is expensive and *living* clients will continue to need assistance paying for nursing home care.⁷⁸ If eligibility is lost, then the

⁷² The authors question whether the statute, as drafted, applies to estates where the TennCare beneficiary is not receiving Medicaid at the time of death.

⁷³ Although substantiating facts have not been received, the authors understand that TennCare's Program Integrity Unit may be prosecuting two attorneys who filed false reports that TennCare had no claim against the estate. (E-mail from Kelly Guyton Frere, Certified Elder Law Attorney, January 23, 2004, on file with the authors).

⁷⁴ State Medicaid Manual § 3810.

⁷⁵ *Id.* "A homestead of "modest value" can be defined as fifty percent (50%) or less of the average price of homes in the county where the homestead is located, as of the date of the beneficiary's death." *Id.* Applying for the hardship exception can be problematic since some States (*e.g.*, Tennessee) have not established procedures outlining how to apply for the waiver.

⁷⁶ *Id.*

⁷⁷ See also Attorney Liability, *infra*.

⁷⁸ In 2000, the average daily rate in a U.S. skilled nursing facility was \$145. See *10th Annual CNA Cost of Nursing Care Study*, http://www.cna.com/group/gltc/gltcper_nursestudy.pdf. The cost is rising. A 2002 study prepared by the Metlife Mature Markets Institute indicates that average annual cost of

client's hard won recovery will likely be repaid to the nursing home. Thus, where possible, the recovery should be structured to preserve eligibility.⁷⁹

Medicaid is a cost-sharing arraignment. The basic rule is that nursing home residents must pay all of their income, less certain permitted deductions, to the nursing home. Medicaid then picks up the balance due.

In general terms, there are three pathways to income eligibility for nursing home residents who otherwise eligible for nursing home Medicaid.⁸⁰ First, SSI recipients are almost always eligible.⁸¹ Second, in most States, if the resident's income does not exceed 300% of the federal poverty level (\$1,692 in 2004), then she qualifies for Medicaid under a "special income level." Third, medically needy residents who are 65 or older, blind or disabled receive Medicaid.⁸² Medically needy residents achieve eligibility by spending down (paying medical bills) until their net monthly income falls below \$1,692 (2004).⁸³ Since the monthly cost of nursing home care almost always exceeds the resident's income, most nursing home residents either meet the income criteria for Medicaid eligibility, or can spend down to meet that criteria.⁸⁴

An infusion of cash (e.g., a malpractice recovery) is income during the month when it is received.⁸⁵ However, funds retained until the first moment of the second calendar month following its receipt will be treated a resource.⁸⁶ In general terms, a nursing home resident may not have more than \$2,000 in countable assets and may not have regular income which exceeds the monthly cost of nursing home care.⁸⁷

nursing home care is now \$61,000. *See MetLife Market Survey on Nursing Home and Home Care Costs 2002*; *see also Businesswire, GE Financial Survey Finds Nursing Home Care Now Costs over \$85,000 in Top Markets* (August 34, 2003), reporting that the average cost of nursing home care rose 7%, with costs ranging from \$35,900 to \$166,700. The average in the nation's five most expensive markets exceeded \$85,000 annually.

⁷⁹ Eligibility issues should also be considered where the settlement proceeds will go to someone other than the nursing home resident, but who is receiving government benefits.

⁸⁰ Medicaid benefits are not paid unless the applicant meets categorical, medical and financial criteria. Here, medical eligibility is presumed due to the nursing home admission. Regarding categorical eligibility, the federal Medicaid statute identifies over 25 different eligibility categories for which federal matching funds are available. These statutory categories can be classified into five broad coverage groups: children; pregnant women; adults in families with dependent children; individuals with disabilities; and the elderly.

⁸¹ Some States, known as "209(b) States", do not link Medicaid eligibility to SSI eligibility. There, the eligibility analysis may be different.

⁸² A nursing home resident is medically needy if her monthly income is less than the cost of nursing home care.

⁸³ Here, for discussion purposes, the author has blended the "medically needy" and special income level eligibility rules. As a practical matter, in most instances, the distinction is illusory.

⁸⁴ Georgia, *see* ABD Manual §§ 2150 and 2151. Tennessee, *see* Medicaid Manual §

⁸⁵ 20 C.F.R. § 416.1123(a). Interestingly, a failure to accept or access an injury settlement is a transfer that could result in ineligibility. *See* State Medicaid Manual § 3257.B.3.

⁸⁶ 20 C.F.R. § 416.1201(c).

⁸⁷ Special eligibility rules apply where the Medicaid applicant is a nursing home resident. If she is an SSI recipient, in most States, she receives Medicaid. Even if a nursing home resident does not qualify for SSI, in most States she is still be eligible for Medicaid if (i) her monthly income is less than 300% of the SSI rate (\$1,692 in 2004), or (ii) the cost of her nursing home care exceeds her income each month.

Assets:⁸⁸

As a general rule, all countable assets owned by the Institutionalized Spouse are considered available to pay his nursing home bills. A Medicaid applicant cannot have more than \$2,000 in countable assets (or resources).⁸⁹ An asset is countable, unless it falls within an exempt category, if it can be converted to cash to pay bills.⁹⁰

Caution: Medicaid beneficiaries cannot “fix” eligibility by giving away their assets. A transfer of assets without receipt of equivalent consideration will result in a penalty. “The penalty for an institutionalized individual consists of ineligibility for certain services for a period or periods of ineligibility that equal the number of months calculated by taking the total, cumulative uncompensated value of all assets transferred by the individual or spouse on or after the look-back date discussed in §3258.4, divided by the average monthly cost to a private patient of nursing facility services in the State at the time of application” See *HCFA Transmittal 64*, § 3258.5.D. **In plain English, the penalty is roughly equivalent to the amount of nursing home care the beneficiary could have purchased with the funds that were given away.** For this reason, Medicaid Planning should not be attempted by anyone who is not intimately familiar with the Medicaid program.

Medicaid Planning

An applicant can plan to structure her estate for Medicaid eligibility. Doing so shifts the cost of nursing home care to someone else, either a third party or Medicaid and protects the applicant’s assets.

Medicaid Planning is a process. First, the attorney gathers information about the applicant. We use that information to help the applicant analyze options and develop possible strategies for meeting eligibility within the framework of the program. There are a number of Medicaid Planning strategies that are summarized as follows:

- The conversion of Countable Assets to Exempt Assets;
- Transfer of Assets;
- Spend Down of Countable Assets;
- Reducing the Value of Countable Assets; and
- Converting Assets to Income.

⁸⁸ “Resources available to the client include those for which he has the right, authority, ability, or power to liquidate including those deemed available to him from a financially responsible relative and the uncompensated value of a transferred asset.” Tennessee Medicaid Manual, Ch. 15, Part I, § (A)(4). Countable resources include (i) resources not excluded by law; (ii) the client owns individually and jointly with another; (iii) deemed to him from his spouse; (iv) considered available to the individual; (v) the uncompensated value of any transfer within the look back period. Tennessee Medicaid Manual, Ch. 15, Part I, § B(4)(a) and (b). For a general discussion of exempt and countable assets, see H. McCormick, *supra*, Chapter 27.

⁸⁹ Tennessee Medicaid Manual, Ch. 15, Part I, § B(1)(a). This includes patient funds held by a nursing home. Georgia ABD Manual § 2325; Tennessee Medicaid Manual, Ch. 15, Part V, § I. Resources are evaluated according to their equity value, which is the current market value less any encumbrance. Tennessee Medicaid Manual, Ch. 15, Part I, § B(3).

⁹⁰ Georgia ABD Manual § 2300; Tennessee Medicaid Manual, Ch. 15, Part I, § A(1).

Because the focus here is on protecting the recovery, an extended discussion of Medicaid Planning is omitted. For further reading on that subject, *see* R. Fleming, *Elder Law Answers 2nd Ed.* (Aspen 2003); T. Takacs, *Elder Law Practice in Tennessee* (Lexis-Nexis 1998, supplemented annually).

SSI Eligibility

Eligibility for Supplemental Security Income (SSI) is often linked to Medicaid. Thus, losing SSI eligibility can result in the loss of health care benefits.

Initially, both Georgia and Tennessee are “SSI States.” This means that if you qualify for Supplemental Security Income (a federal benefits program), then you also qualify for Medicaid.⁹¹ In SSI states, a single dollar of SSI will result in Medicaid coverage. Thus, planning begins by determining whether you qualify (or can become qualified) for SSI.

SSI is a federal welfare program established under Title XVI of the Social Security Act⁹² to provide cash assistance to financially needy individuals who are age 65 or older, or blind, or disabled,⁹³ to assure such individuals a minimum level of income (**\$564** per month in **2004**).

An individual is considered financially needy if he has “countable assets” of no more than \$2,000 (or \$3,000 for a married couple),⁹⁴ and has limited income. Assets that are not considered when determining this valuation include the individual’s home place, limited household goods, an automobile, certain life insurance, burial spaces, and a Certificate of Deposit of up to \$1,500 designated for funeral expenses.⁹⁵

The Social Security Administration defines income as “anything you receive in cash or in kind that you can use to meet your needs for food, clothing, and shelter.”⁹⁶ This includes gifts, inheritances,⁹⁷ in-kind assistance, earned, unearned, cash, and non-cash income.⁹⁸ To be eligible for SSI benefits in 2004 an individual’s countable monthly income cannot exceed \$564 (or \$846 for a couple). However, because many kinds of income are not counted in determining SSI eligibility, an individual may be eligible for SSI even though his income is somewhat higher.

To get SSI, you must be age 65 or older or blind or disabled. As with Medicaid, there are

⁹¹ 42 C.F.R. § 435.120. *See* Georgia ABD Manual § 2111-1; *See* Tennessee Medicaid Manual

⁹² Title XVI of the Social Security Act, 42 U.S.C. §§1381 *et seq.*; 20 CFR §416.101 *et seq.*; governed by operational guidelines contained in the Social Security *Program Operation Manual System* (POMS) (available at <http://policy.ssa.gov/poms.nsf/poms?OpenView>).

⁹³ Disabled is defined as “unable to engage in any substantial gainful activity because of a medically determinable physical or mental impairment that can be expected to result in death or that has lasted or can be expected to last for a continuous period of at least 12 months.” 42 U.S.C. §1382c (a)(3)(A).

⁹⁴ 20 C.F.R. § 416.1205. *See also* 20 CFR § 416.1201 (defining resources).

⁹⁵ 20 C.F.R. § 416.1210.

⁹⁶ 20 C.F.R. § 416.1102.

⁹⁷ 42 U.S.C. § 1382a(a)(2)(D).

⁹⁸ 20 C.F.R. § 416.1102.

financial criteria. If you are single, in 2004, you cannot earn more than \$564 per month. If you are married, in 2004, your combined income cannot exceed \$846. Certain categories of income are counted differently so a lawyer experienced in SSI matters should be consulted when seeking benefits.

SSI also looks at your assets. You cannot have assets worth more than \$2,000. However, not all assets are counted.⁹⁹

If you meet the SSI criteria, then in an “SSI State,” Medicaid eligibility is “automatic” (assuming you apply for Medicaid).¹⁰⁰ If you do not qualify for SSI, it is possible that your estate can be re-structured to make you eligible.

Special Needs Trusts

Why should we consider Special Needs Trusts (SNTs)? Simply put, we must consider SNTs because Medicare and Medicaid benefits are never paid to the beneficiary and are always limited to medical expenses. To borrow a phrase from the OBRA regulations, our clients have other needs that must be met to ensure their “highest practicable” social and emotional well-being. Special needs trusts can be used to fund a variety of supplemental needs ranging from:

- A home, including adjacent land, if the beneficiary lives there or intends to return to it;¹⁰¹
- Health and dental treatment and equipment for which there are not funds otherwise available;
- Rehabilitative expenses and occupational therapy services;
- Medical and diagnostic treatment beyond Medicaid benefits, even though not medically necessary or lifesaving;
- Medical insurance premiums;
- Supplemental nursing care;
- Supplemental dietary needs;
- Eyeglasses;
- Travel;
- Entertainment;
- Companionship;
- Private case management;
- Cultural experiences;

⁹⁹ See POMS SI 01110.210 for list of excluded resources.

¹⁰⁰ 42 U.S.C. § 1396a(a)(10)(A)(i)(II).

¹⁰¹ Note, however, that disbursements for food, clothing and shelter may reduce SSI income. See *Hecht v. Barnhart*, 68 Fed.Appx. 244 (2nd Cir. 2003).

- Expenses associated with bringing relatives or friends to visit with the beneficiary;
- Vacations;
- Movies;
- Telephone service and answering machines;
- Television and cable equipment and services;
- Radios, stereos and musical instruments;
- Training and education programs;
- Caretaker Expenses;
- Recreation, entertainment and travel for the beneficiary and a caretaker;
- Purchase of furniture for the beneficiary;
- Purchase of an automobile for transportation to medical treatment;
- Renovations to a house to adapt to the needs of the beneficiary;
- Cost of adapting a car or van to the needs of the beneficiary;
- Reading and educational materials;
- A burial plot and pre-paid burial expenses.¹⁰²

There are two varieties of Special Needs Trusts: those created with the beneficiary's money (self-settled) and those created with someone else's money (third-party). This paper is limited to self-settled SNTs. Federal and state law recognize two versions of the self-settled SNT. First, some individuals may establish individual trusts pursuant to 42 U.S.C. § 1396p(d)(4)(A) (referred to as a "d4A trust"). Second, those who do not meet the criteria necessary to establish a d4A Trust are usually eligible to fund a pooled trust pursuant to 42 U.S.C. § 1396p(d)(4)(C) (referred to as a "d4C Trust" or "pooled trust").

Special Needs Trusts are an exception to the transfer penalty rules discussed above.¹⁰³ A Special Needs Trust is a discretionary spendthrift trust created for a disabled beneficiary which supplements but does not supplant public benefits for which the beneficiary may be eligible. It must be carefully drafted and implemented to conform with statutory and regulatory requirements to assure the ongoing SSI and Medicaid eligibility of the

¹⁰² List compiled from: The Georgia Community Trust, *Disbursements for the Benefit of the Beneficiary*, <http://www.georgiacommunitytrust.com/disbursementsofbenefit.html>; T. Takacs, *Administration of a Supplemental Needs Trust (Vista Points, Tennessee Pooled Trust)*, <http://www.tn-elderlaw.com/sntadmin.html>; The Arc of Texas Master Pooled Trust, *What are "Supplemental Needs?"*, at http://www.thearcoftexas.org/Master%20Pooled%20Trust/more_about_supplemental_needs.htm. "[T]here is no 'hornbook law' concerning the types of expenditures which may be made from a supplemental needs trust and not be objectionable to a particular county's office of the Department of Social Services." *In re Felice*, 2004 WL 94049, *4 (N.Y. Sup. 2004).

¹⁰³ 42 U.S.C. §1382b (c)(1)(C)(ii)(IV); 42 U.S.C. §1396p (d)(4); State Medicaid Manual §§ 3256 to 3259.8; POMS SI 01120.203 B.; POMS SI 01150.121 A.3. *But see Parkhurst v. Wilson-Coker*, 2003 WL 1995720 (Conn. Super. 2003) (holding that transfer was prohibited under State law).

disabled person.¹⁰⁴ The SSI and Medicaid rules regarding SNTs are similar though not identical.

Attorneys who draft, implement and administer SNTs should be familiar with Federal benefits laws and regulations, as well as State trust law, guardianship law and, to a lesser extent, tax law.¹⁰⁵ For example, an improperly drafted trust is an available asset, meaning that the beneficiary may be over-resourced and Medicaid eligibility may be lost.¹⁰⁶ Technical rules, particularly those protecting incapacitated persons must be adhered to; in that regard, it goes (almost) without saying, but “a settlement agreement is not enforceable if it does not also satisfy the requirements of any relevant court rule.”¹⁰⁷

Do you need a Special Needs Trust?

One issue you should address early on is whether your client needs an SNT. Do adequately consider that issue, you need to understand what the client needs, what an SNT does, and the alternatives to an SNT. In most cases, this will require the assistance of Special Needs Counsel.

Client needs must be assessed on a one-on-one basis. The assessment can be done informally, or by a life care planner. As discussed above, the function of an SNT is to preserve assets to meet quality of life needs beyond those funded by benefits programs. Among the alternatives to an SNT is Medicaid Planning. An alternative to an individual SNT would be placement of the assets in a d4C pooled trust. The costs associated with a pooled trust are generally lower because they are spread among the pool participants.

The cost of creating and funding a d4A SNT frequently reaches or exceeds \$5,000. Thereafter, the trust will incur administration expenses, including trustee's fees, investment fees, and tax return preparation fees. These costs may be excessive in relation to the amount in question.¹⁰⁸

Medicare and Medicaid Liens Must Be Paid Prior to Funding

¹⁰⁴ A properly drafted SNT preserves SSI benefits, *see, e.g., In re Estate of Del Castillo*, 2004 WL 100548, *21 (Cal. App. 4th Dist. 2004); and Medicaid benefits. *See, e.g., In re Estates of Esterbrook*, 80 P.3d 419, 422 (Mont. 2003); *In re Daniel J. Rosenbaum Trust*, 2003 WL 1849141 (Ohio App. 8th Dist. 2003). An improperly drafted trust, or one that is not drafted as a d4A or d4C trust, will be considered available if there are any circumstances under which the trust could be used to benefit the Medicaid applicant. *See* 1396p(d)(3)(b)(i); *Gayan v. Illinois Dept. of Human Services*, 796 N.E.2d 657 (Ill. App. 3rd Dist. 2003); *Horowitz v. Barnhart*, 29 Fed. Appx. 749 2nd Cir. 2002) (SSI eligibility denied for period between receipt of settlement proceeds and establishment of SNT, but granted after SNT established and funded).

¹⁰⁵ *See, e.g., In re Examination of Annual Inventory and Account of Susan Felice & Bank of New York*, 2003 WL 21815970 (N.Y. Sup. 2003) (SNT cannot be structured to circumvent guardianship law).

¹⁰⁶ *See* 42 U.S.C. § 1396p(d)(3).

¹⁰⁷ *Bowden v. Hutzler Hosp.*, 652 N.W.2d 529 (Mich. App. 2002).

¹⁰⁸ *See* A. Hook, *What the Trusts and Estates Lawyer Needs to Know About d(4)(A) Special Needs Trusts* (2003), http://www.oast-hook.com/legal_information/SNT_for_lawyers.pdf.

Before an SNT may be funded, pre-existing liens must be discharged. In *Norwest Bank of North Dakota, N.A. v. Doth*, 159 F.3d 328 (8th Cir. 1998), the trustee argued that lien repayments are, essentially, deferred until the death of the SNT beneficiary. The Court ruled against the trustee holding that its position would allow the Medicaid beneficiary to evade an existing lien by placing settlement proceeds in an SNT. Other courts reaching the same or a similar conclusion include: *Barnes v. Lawrence Nursing Care Center, Inc.*, 2003 WL 22849648, *2 (N.Y. Sup. 2003); *Sullivan v. County of Suffolk*, 174 F.3d 282 (2nd Cir 1999); *Waldman v. Candia*, 722 A.2d 581 (N.J. App. Div. 1999), cert. granted, 731 A.2d 45 (1999); *Cuello v. Valley Farm Workers Clinic*, 937 P.2d 1258 (Wash. App. Div. 3 1998). See also cases cited in C. Kruse, *Third-Party and Self-Created Trusts: Planning for the Elderly and Disabled Client 3rd Ed*, Chapter 4 (ABA 2002). At least one court, consistent with 42 U.S.C. § 1396k(b) would limit the lien to that portion of the recovery attributable to Medicaid funded medical expenses. See *Martin ex rel. Hoff v. City of Rochester*, 642 N.W.2d 1 (Minn. 2002); but see *In re Kietur*, 752 A.2d 799 (N.J. Super. A.D. 2000) (holding that all of the settlement proceeds, regardless of how they are characterized, are available to the State for its Medicaid reimbursement claim before the SNT is funded). Thus, SNTs are funded with *excess* funds, *after* liens are satisfied, to continue Medicaid eligibility.

ERISA liens, on the other hand, may be avoided in certain instances. In *Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204 (2002), the liable third party was ordered to pay funds directly to a special needs trust rather than to the plaintiff. Great Western (the ERISA Plan) filed suit to enjoin that payment pursuant to Section 502(a)(3) of the ERISA statute.¹⁰⁹ The Supreme Court held that because funds were never paid to the plan beneficiary and, therefore, were not under her control, she could not be compelled to reimburse the plan pursuant to Section 502(a)(3). The result is different, however, where funds are under the plaintiff's control, either personally or in an attorney trust account, when the plan files suit. See *Wellmark, Inc. v. Deguara*, 257 F.Supp.2d 1209 (S.D.Iowa, 2003) (holding that funds in attorney trust account were subject to § 502(a)(3) ERISA claim).¹¹⁰

Individual (“d4A”) Self-Settled Special Needs Trusts

A SNT created under 42 U.S.C. §1396p (d)(4)(A) (commonly called as a “d4A trust”) must be “established” for a disabled beneficiary who is under age 65 by a parent, grandparent, legal guardian, or court, and must be irrevocable.¹¹¹ It can continue in

¹⁰⁹ Section 502(a)(3) authorizes a civil action: "by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates ... the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of ... the terms of the plan." 29 U.S.C. § 1132(a)(3) (1994 ed.).

¹¹⁰ See J. Grist, *ERISA Reimbursement Claims: Life After Great-West v. Knudson*, in *Handling Long-Term Disability/ERISA Claims* (ICLE of Georgia March 27, 2003). Mr. Grist, arguing from Justice Scalia's discussion in *Knudson*, says that where an ERISA plan fails to intervene, it may "have a very short amount of time, perhaps only minutes, to file a lawsuit seeking equitable relief."

¹¹¹ See *In re Gillette*, 756 N.Y.S.2d 835 (N.Y. Sur. 2003) (where SSI determined that trust was countable asset because it was set up by an attorney-in-fact and, thus, deemed established by the beneficiary himself; the court declined to "create" the trust *nunc pro tunc*; the court did, however, create a

effect after the beneficiary becomes 65, but assets cannot be added to it after that time. In the context of nursing home litigation, d4A Trusts are rarely used because most nursing home residents are 65 or older. In Georgia, a d4A trust is not a Medicaid resource and a transfer to a d4A is not a disqualifying transfer.¹¹²

A d4A trust is funded with assets belonging to the beneficiary. A self-settled SNT can be created with proceeds from the settlement of a lawsuit (often times the lawsuit initiated to recover for injuries that caused the disability which now causes the individual to become eligible for benefits), or with the proceeds of an inheritance that was left outright to the disabled individual. The trust can be funded with one lump sum or over time with a structured settlement, after existing Medicaid, Medicare, and private insurance liens have been negotiated and paid.¹¹³

For both SSI and Medicaid purposes, the trust document must state that the trust is “for the sole benefit” of the beneficiary,¹¹⁴ and must provide for Medicaid (but not SSI) to be reimbursed at the death of the beneficiary for the medical care provided during his lifetime.¹¹⁵ Remainder beneficiaries should be named to take any assets not reimbursed to Medicaid.¹¹⁶

new trust and presumably the assets were then transferred into it creating eligibility); 42 U.S.C. §1382b(c)(1)(C)(ii)(IV); 42 U.S.C. §1396p(d)(4)(A) – “A trust containing the assets of an individual under age 65 who is disabled (as defined in §1614(a)(3)) and which is established for the benefit of such individual by a parent, grandparent, legal guardian of the individual, or a court if the State will receive all amounts remaining in the trust upon the death of such individual up to an amount equal to the total medical assistance paid on behalf of the individual under a State plan under this title.” POMS SI 01120.203 B.1.; Volume II/MA, MT (07/03) §2337-2. The d4A trust is discussed in Bove & Langa, *Protecting Personal Injury Awards, supra*.

¹¹² See Volume II/MA, MT 7 (07/03) § 2337-1, providing: “The following trusts will NOT be counted as a resource or considered a transfer of assets: a trust containing the assets (income and resources) of an individual under age 65 who is disabled, and which is established for the sole benefit of the individual by a parent, grandparent, legal guardian of the individual, or a court, if the state will receive all amounts remaining in the trust upon the death of the individual up to an amount equal to the total medical assistance paid on behalf of the individual. In addition to the assets of the individual, the trust may also contain the assets of individuals other than the disabled individual. Any pay out could be countable income if given to the A/R. This type of trust is often referred to as a *Special Needs Trust*.”

¹¹³ 42 U.S.C. §1396a(a)(25)(A) and (B); *Cricchio v. Pennisi*, and *Link v. Town of Smithtown*, 683 N.E.2d 301 (N.Y. 1997); O.C.G.A. §49-4-149(a).

¹¹⁴ 42 U.S.C. §1382b(c)(1)(C)(ii)(IV); 42 U.S.C. §1396p(c)(2)(B); SI ATL01120.201. HCFA Transmittal 64 (§3257.B.6) provides that transfer is *for the sole benefit* of another if it is “arranged in such a way that no individual or entity except the spouse, blind or disabled child, or disabled individual can benefit from the assets transferred in any way, whether at the time of the transfer or at any time in the future.”

¹¹⁵ 42 U.S.C. §1396p(d)(4)(A); POMS SI 01120.203 B.1.f.; POMS SI 01120.203 B.2.g. For purposes of SSI eligibility, an eight step evaluation checklist is used in evaluating SNTs, which appears in the POMS at POMS SI 01120.203 D.1.

¹¹⁶ 42 U.S.C. §1396p(d)(4)(A); POMS SI 01120.203 B.1.f.; POMS SI 01120.203 B.2.g. Where no remainder beneficiary is named, or where the remaindermen are simply the grantor’s “heirs,” the doctrine of “worthier title” may rear its head. This doctrine, which has been abolished in many States, has been revived by the Social Security Administration in its review of SNTs in the context of SSI eligibility. Black’s Law Dictionary 5th Ed. (West) states that the “Doctrine of worthier title provides that conveyance by grantor with limitation over to grantor’s heirs creates reversion in grantor, not remainder interest in heirs, and to take by descent rather than by purchase, is said to create a worthier title.” Pursuing various

Some see the requirement that Medicaid be reimbursed as a potential down-side to a d4A trust. However, because Medicaid pays less for health services than the beneficiary would pay in the open market, the expense is not as large as it would have been had the trust assets instead been spent to provide medical care during the beneficiary's lifetime; further, this is an equitable way to provide for the beneficiary during his lifetime while alleviating some of the burden on the state's Medicaid programs.

Although the statute is silent as to provisions for distributions to or for the beneficiary, such trusts usually require either that such distributions be entirely discretionary with the trustee, or be limited to distributions that will "supplement and not supplant" public benefits. Another option is to provide for absolute discretion, with a statement of intent that the distributions be used to "supplement and not supplant" public benefits. Yet another possibility, to avoid ambiguity, is to provide expressly that the trustee may make distributions that disqualify the beneficiary for benefits, if the trustee in its discretion determines that to do so is in the beneficiary's best interests.

Be wary of allowing family members to serve as trustee. Improper trust administration can disqualify the Medicaid and/or SSI beneficiary.

Pooled Special Needs Trusts

An irrevocable pooled SNT account (commonly called as a "d4C trust") can be established for a beneficiary of any age by that individual, a parent, grandparent, legal guardian, or a court.¹¹⁷ In Georgia, a pooled SNT can be created under the Georgia Community Trust Act¹¹⁸ and transfers to a d4C do not render the beneficiary ineligible for Medicaid.¹¹⁹ Tim Takacs was instrumental in establishing a pooled trust in Tennessee.¹²⁰

theories, the Social Security Administration continues attacking these trusts. *See, e.g., Lanoue v. Commissioner, Social Sec. Admin.*, 774 A.2d 1236 (N.H. 2001) (rejecting government's argument).

¹¹⁷ *See e.g., Griffith ex rel. Estate of Butler v. Nance*, 2003 WL 21246068 (N.D. Tex. 2003) (includes the text of the Arc of Texas Pooled Trust); 42 U.S.C. §1382b(c)(1)(C)(ii)(IV); 42 U.S.C. §1396p(d)(4)(C) – "A trust containing the assets of an individual who is disabled (as defined in §1614(a)(3)) that meets the following conditions: (i) The trust is established and managed by a non-profit association; (ii) A separate account is maintained for each beneficiary of the trust, but, for purposes of investment and management of funds, the trust pools these accounts; (iii) Accounts in the trust are established solely for the benefit of the individuals who are disabled (as defined in §1614(a)(3)) by the parent, grandparent, or legal guardian of such individuals, by such individuals, or by a court; (iv) To the extent that amounts remaining in the beneficiary's account upon the death of the beneficiary are not retained by the trust, the trust pays to the State from such remaining amounts in the account an amount equal to the total amount of medical assistance paid on behalf of the beneficiary under the State plan under this title."

¹¹⁸ 42 U.S.C. §1382b(c)(1)(C)(ii)(IV); 42 U.S.C. §1396p(d)(4)(C); O.C.G.A. §§30-10-1 through 30-10-9; Volume II/MA, MT 1-01/02 §2337-2.

¹¹⁹ *See* Volume II/MA, MT 7 (07/03) § 2337-1, providing: The following trusts will NOT be counted as a resource or considered a transfer of assets: A trust, generally referred to as a *Pooled Trust*, containing the assets of an individual who is disabled that meets the following conditions:

- The trust is established and managed by a non-profit organization
- Separate accounts are maintained for each beneficiary, even if pooled for purposes of investment and management

The pooled SNT can be a self settled trust (if funded with assets belonging to the beneficiary), or a third party trust (if funded with third party funds). It is managed by a non-profit association such as the Georgia Community Trust¹²¹ where each sub-account is tracked separately while the funds are pooled for investment purposes. The assets in the trust can be used to supplement the public benefits the beneficiary receives.

Assuming the fund is self-settled, then funds remaining after the death of the beneficiary must first be used to reimburse the state for Medicaid payments made on behalf of the beneficiary; the remainder can then be distributed via the Joinder Agreement, or the balance can be retained by the trust for the benefit of indigent individuals with a disability. In that event there is no requirement to reimburse the state.¹²²

Among the benefits of a pooled SNT are the fact that a disabled person can establish his own account, and can be over age 65 at the time¹²³ (though there is no provision waiving a transfer penalty for SSI purposes for contributions to a self-settled pooled trust by persons age 65 and over, and there is not agreement among elder law attorneys regarding the existence of a transfer penalty for Medicaid purposes). Further, if the pooled trust already exists (E.g., the Georgia Community Trust and Vista Points), there are no lengthy documents to draft; completing a Joinder Agreement is all that is required to open an account, and the costs are nominal for professional management and trustee services. A pooled-account trust is often a good option when the size of the trust estate is not sufficient to make it economically feasible to engage a corporate trustee for purposes of managing the trust estate.

Structured Settlements

The pros and cons of structures, in financial terms, should be weighed on a case-by-case basis and numerous articles address whether they should be used and when to use them.¹²⁴ Among those considerations addressed when considering a structure or lump sum are:

- **Income tax treatment:** With a structured settlement annuity, both the initial award and the internal growth of the annuity policy are excluded from gross income under IRC §

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- The trust was established by the disabled individual, their parents, grandparents, legal guardian or the court

Amounts remaining upon the beneficiary's death are paid to the State by the trust in an amount equal to the total amount of medical assistance paid on his/her behalf."

¹²⁰ The name of the pooled trust is Vista Points. See <http://www.vistapoints.org>.

¹²¹ www.georgiacommunitytrust.com.

¹²² 42 U.S.C. §1396p(d)(4)(C)(iv); POMS SI 01120.203 B.2.g.

¹²³ 42 U.S.C. §1382b(e)(5); 42 U.S.C. §1396p(d)(4)(C); POMS SI 01120.203 B.2.

¹²⁴ See, e.g., H. Margolis and J. Bloom, *Supplemental Needs Trusts vs. Structured Settlements: What is the Best Form of Settlement for Disabled Clients?* (2003), presented at Advanced Elder Law Forum, Atlanta, Georgia; and see R. Bernstein, *Structured Settlements*, presented at Special Needs Trust V (Stetson University College of Law October 24, 2003).

104, as long as the client has no control over the funds while they grow. Once the client receives the funds, future growth is taxable. With a lump sum cash settlement, all future growth after the initial award is taxable. However, the investments can be managed to minimize tax consequences and maximize yields.

- **Spendthrift protection:** Structured settlement annuities afford spendthrift protection as the income is payable periodically. The annuity is exempt from seizure by creditors and can be an exempt asset in bankruptcy. A lump sum can potentially be dissipated by a spendthrift client if not placed in a conservatorship or a trust.
- **Flexibility:** With a structured settlement annuity, income needs cannot be accurately determined many years in advance and the structure may not accommodate unforeseen future needs, such as medical expenses or a financial emergency. With a lump sum settlement, the client retains the control and flexibility to protect against unforeseen needs. Options available to the client include liquidating assets, reallocating assets, and cash reserves.
- **Protection against inflation:** The typical structured settlement annuity locks in interest rates at the time of settlement. This could result in low returns over time if settlement occurs during a period of historically low interest rates such as at present, and leave the claimant defenseless against inflation. The flexibility of a cash settlement allows an asset allocation with equity growth to protect future income. For a portfolio under the stress of regular withdrawals, substantial yet prudent investment in equities is vital to its long-term success. According to a recent study, a portfolio of 100% bonds has only a 20% probability of lasting 30 years at a 4% withdrawal rate, rising with inflation. A portfolio of 50% bonds and 50% stocks, on the other hand, will have a 95% probability of survival. With certain limitations and restrictions, variable annuities have entered the market to provide equity based growth inside the structured settlement.
- **Security:** When considering a structured settlement annuity, it may be difficult to ascertain the financial strength of the obligor. Since these settlements extend for decades, it is vital to accurately assess the financial strength of the entity ultimately responsible for making the payments. The actual obligor may not be the issuing insurance company, but an assignment company which may be a “shell” subsidiary of the insurance company. A key factor in the security of lump sum settlements is the quality and prudence of the investment management. The implementation and ongoing asset management is typically best done by an experienced and prudent professional.
- **Estate Tax Liability:** In the event of premature death, either the annuity provider will assume the remaining assets or the individual’s estate will receive future payments if the annuity is guaranteed for a period certain. The present value of future payments will be used to calculate the estate value. Funds may not be available to pay the estate taxes. Lump sum proceeds will be available for payment of estate taxes. In the case of premature death, lump sum proceeds will be available to client’s estate or legatees.¹²⁵

Here, however, our focus is not on whether to structure or take a lump sum. Instead we look at how a structure impacts Medicaid and SSI eligibility.

¹²⁵ P. Bertenshaw and B. Swartz, *Preparing Your Client for Life After Personal Injury Settlement*, <http://www.maricopabar.org/maricopa-lawyer/personalinjurysettlement.pdf>. See also *General Advantages of a Structure*, http://www.structuredsettlements.org/artman/publish/cat_index_22.shtml.

42 U.S.C. § 1396p(d)(d) provides that the term "trust"¹²⁶ includes an annuity to the extent and in such manner as the Secretary specifies. CMS recognizes that annuities (which is what structures are) may be used "to shelter assets so that individuals purchasing them can become eligible for Medicaid." See HCFA Transmittal 64, § 3258.9.B. Accordingly, they are closely examined and are acceptable only where they are actuarially sound. *Id.* An actuarially sound annuity is one where the expected return on the annuity is commensurate with a reasonable estimate of the life expectancy of the beneficiary. *Id.* Life expectancy is measured consistent with Life Table published in HCFA Transmittal 64. CMS provides the following example:

For example, if a male at age 65 purchases a \$10,000 annuity to be paid over the course of 10 years, his life expectancy according to the table is 14.96 years. Thus, the annuity is actuarially sound. However, if a male at age 80 purchases the same annuity for \$10,000 to be paid over the course of 10 years, his life expectancy is only 6.98 years. Thus, a payout of the annuity for approximately 3 years is considered a transfer of assets for less than fair market value and that amount is subject to penalty.

Id. This CMS position makes it clear, at least to these authors, that structures cannot be used to transfer assets from living Medicaid beneficiaries to their heirs and, at the same time, maintain Medicaid eligibility. The result, then, is a shorter payout period with higher income. Higher income, however, will almost certainly terminate SSI eligibility and in many cases will terminate Medicaid eligibility.

Another alternative might be to place the annuity in the SNT. This would shield the asset and, in many cases, preserve eligibility.¹²⁷ However, other than favorable income tax treatment, many of the purposes for creating the structure are lost once the decision is made to place the asset in the trust.

Buying Time: 468B Trusts (the Qualified Settlement Fund)

In many cases, additional time may be necessary to involve Special Needs Counsel. If a settlement is reached and more time is necessary to attend to the issues described above, Section 468B provides a mechanism to buy that time. Section 468B (Title 26 of the U.S. Code) was originally enacted to benefit Defendants (providing an immediate tax deduction where funds are not immediately disbursed to the Plaintiff). Now, it is used by Plaintiff's counsel to "control the settlement funds while negotiating medical liens, determining appropriate distribution amounts to their clients (in cash and in structured settlements), in Supplemental Needs Trusts to preserve Medicaid and Supplemental Security Income (SSI), structuring attorney fees, and planning for estate needs."¹²⁸

¹²⁶ Recall that trusts are available assets when determining eligibility. 42 U.S.C. § 1396p(d)(3).

¹²⁷ *But see Matter of LaBarbera*, N.Y.L.J., April 26, 1996 (Sup. Ct. Suffolk), p. 36, col. 6, described in C. Kruse, *supra*, p. 12, as a case where a Medicaid-exempt trust was not authorized because a disabled child's income from a tort settlement exceeded her monthly care needs.

¹²⁸ <http://www.davissettlementpartners.com/sp1.html>. "The QSF removes settlement funds from the custody and control of the defendant while settlement funds are allocated, the terms of structured settlements are determined, or special needs trusts are created. A QSF is created by filing a petition with the court. The petition is accompanied by a copy of the trust instrument that governs the QSF and an order to be entered by the court authorizing the establishment of the trust." Oast & Hook, *Report From*

Although the practice is not without controversy, Section 468B can be used in single plaintiff cases.¹²⁹

Advantages in using a Section 468B trust include removing the defendant (and counsel) from the litigation and the allocation process, permitting immediate payment of plaintiff's attorney's fees, and that Special Needs Counsel now has additional time to address liens, structure the SNT and address other matters (e.g., probate court approval).¹³⁰ Where guardians *ad litem* in the probate court might object to allocations among plaintiffs (e.g., the injury claim versus loss of consortium), those issues may be dealt with by the trial court administering the trust.

Under Section 486B, a QSF must have certain characteristics, which are:¹³¹

A "designated settlement fund" means any fund –

(A) which is **established pursuant to a court order** and which **extinguishes completely the [defendant]'s tort liability** with respect to claims described in subparagraph (D),¹³²

(B) with respect to which no amounts may be transferred other than in the form of qualified payments,

(C) which is **administered by persons** a majority of whom are **independent** of the [defendant],

(D) which is established for the principal purpose of resolving and satisfying present and future claims against the [defendant] (or any related person or formerly related person) arising out of personal injury, death, or property damage,

(E) under the terms of which the [defendant] (or any related person) may not hold any beneficial interest in the income or corpus of the fund, and

(F) with respect to which an election is made under this section by the [defendant].

In structuring the 468B trust, initially, an escrow account or fund is set up and the defendant is released from liability. The plaintiff is not considered to be in "constructive receipt" of the settlement funds.¹³³ Thus, Medicaid and SSI eligibility are not lost while Special Needs Counsel structures the final arraignments. A fund administrator, on behalf of the qualified settlement fund, settles claims against the defendant and the defendant pays the agreed upon settlement amount into the fund, which then extinguishes any alleged liability of the defendant. When the settlement funds are paid out to plaintiffs, lien holders, the attorneys, or to a third party assignee, the fund then closes, and the administrator files a final tax return. Usually the qualified settlement fund exists for only a short duration.¹³⁴

the Special Needs Alliance Seminar, Elder Law News (March 14, 2003), at <http://www.oast-hook.com/el03/newsltr11.pdf>.

¹²⁹ See J. Kearns, ¶ 468B Trusts, p. 3, presented at Special Needs Trusts V (Stetson University College of Law 2003); Oast & Hook, *Report From the Special Needs Alliance Seminar*, *supra*.

¹³⁰ Kearns, *supra*, at 7.

¹³¹ 26 U.S.C. ¶ 468B(d), available at <http://www4.law.cornell.edu/uscode/26/468B.html>.

¹³² This strategy does not work with partial settlements. The tax benefit is lost where the agreement fails to extinguish the entire claim. See *United States v. Brown*, No. 2:95-CR 245 B (D. Utah May 23, 2001).

¹³³ S. Laird, *Mediation and Settlement* (ATLA December 2002), available at <http://www.texlawyers.com/CM/Library/stevenlaird.pdf>.

¹³⁴ *Id.*

Where you chose to use a 468B trust, the following is an example of a letter that could be sent to defense counsel informing them of your decision.

Dear [defense counsel]:

On behalf of your client, [the tortfeasor], we have agreed that his [her] insurer will pay in present-value dollars the amount of \$X,XXX,XXX.XX for the benefit of my client. We negotiated in terms of a cash settlement, payable in full at the time the settlement documents are signed. You agreed that the funds would be available not later than [date].

In this regard, my client directs that the entire settlement amount be paid to the [plaintiff's surname] Qualified Settlement Fund (QSF), which my client will petition the court to create and oversee. I will provide you with the applicable federal employer identification number for this entity, which must be obtained from the Internal Revenue Service. Please advise me as soon as possible when this number is needed so as not to cause any delay in the availability of the funds.

Upon payment of this amount to the administrator of the QSF, once the court creates the QSF and appoints an administrator, your client and his [her] insurer will be released and dismissed with prejudice. Any tort liability of your client that might exist will be transferred to the QSF through a substitution of parties called a novation. This assignment of liability away from your client is absolute and irrevocable.

Additionally, the transferor will be deemed to have made "economic performance" for purposes of section 461(h) of the Internal Revenue Code of 1986, as amended, which authorizes the entire payment to be deducted in the current tax year. See 26 C.F.R. § 1.468B-3(c)(2).

I will cause to be drafted for your approval the appropriate release of all liability, and other documents pertaining to the creation of the QSF. You will be responsible for preparing a dismissal with prejudice of all claims.¹³⁵

Very truly,
[your name]

Attorney Liability

Courts have held attorneys liable for malpractice for failing to identify and address issues relative to settling litigation and establishing Special Needs Trusts. It is critical for attorneys to be aware of claims by health and workers compensation insurers and governmental agencies based on subrogation in personal injury actions. Most personal injury cases involve such claims; if they are ignored, they may come back to haunt both the parties and attorneys. See *Hotel Employees & Restaurant Employees Int'l Union Welfare Fund v. Gentner*, 50 F.3d 719 (9th Cir. 1995) (attorney is liable for distributing settlement proceeds to a client without reimbursing an ERISA fund). A Maine court recently sanctioned an attorney for not including a SNT in a testator's Will so the primary beneficiary of the Will would not lose her Medicaid eligibility. See *Board of Overseers of the Bar v. Brown*, Me., No. BAR-01-6, Oct. 25, 2002). Other cases involving claims that SNT planning was overlooked include: *French v. Glorioso*, 94 S.W.3d 739 (Tex. App.-San Antonio, 2002).

¹³⁵ http://www.structuredsettlements.org/artman/publish/article_38.shtml.

Engaging Special Needs Counsel

Although some attorneys attempt to engage in “the general practice of law,” for most it is impossible to be all things to all people. Specialization is the result.¹³⁶ Attorneys who specialize in government benefits planning are often associated to ensure that settlements are properly structured to continue eligibility. Our advice is associate them early.

Special needs counsel (and trial counsel) should understand that the special needs “specialist” is jumping onto a moving train.¹³⁷ The trial lawyer has been working with the client longer than anyone else and is generally driving the train. The role of special needs counsel is to navigate closure of the case in a way that benefits the disabled victim. Among those issues special needs counsel could be called upon to address are the following: identify and resolved (or negotiate) Medicare liens, Medicaid liens, and subrogation claims of private health insurers, review (and sometime commission) life care plans, draft court documents associated with implementation of a special needs trust, review settlement agreements, releases, and structured settlement proposals, identify potential trustees, prepare funding instructions, staff the trust, review government benefit eligibility issues, defend the trust, provide on-going advice to family members who must deal with the trust, and advise the trustee concerning issues related to termination of the trust following the beneficiary’s death.¹³⁸

Special needs counsel must get up to speed quickly to avoid derailing the settlement. In doing so, they should: meet with the client, assess the client’s needs, determine what benefits the client is receiving, determine the client’s assets and income, meet with the client’s family, develop a plan for protecting the recovery, work with the client and family to be certain public benefits are preserved, and notify applicable government agencies of receipt of the settlement and the options selected by the client.¹³⁹ At times, this may include initiation of guardianship or conservatorship proceedings, or probate proceedings. The role (and fees) of special needs counsel will vary depending on the scope of the representation.

Elder law attorneys are familiar with government benefits program that impact elderly and disabled individuals. Elder law is defined by the client to be served, and the practice of elder law encompasses many different areas of law.¹⁴⁰ For this reason, Elder Law

¹³⁶ For example, “[a]sset transfer strategies should only be attempted by attorneys who are totally familiar with the federal law, the law of their state, the tax consequences of specific strategies, and their client’s circumstances.” H. McCormick, *Medicare and Medicaid Claims and Procedures 3rd Ed.* § 27:8 (West 2001, updated annually).

¹³⁷ M. Bernstein, *Ethical Issues: Settling Injury Cases for Persons on Public Benefits, Using Special Needs Trusts*, 13 NAELA Quarterly 13 (2000).

¹³⁸ *Id.*, at 14.

¹³⁹ R. Berg, CELA, *Medicaid and Medicare Liens: Potential Effects on Recovery*, in *Nursing Home Negligence: Asserting Claims & Defending Nursing Homes, Conference II* (PESI 2000).

¹⁴⁰ A principal concern for clients who seek advice from Elder law attorneys is financing the cost of long-term care. Other issues that may be of concern include surrogate decision-making, fiduciary representation, access to programs such as SSI, Veteran’s benefits and food stamps, insurance advice, housing rights and resident rights. The National Academy of Elder Law Attorneys defines thirteen elder

Attorneys are often engaged as special needs counsel when closing a litigation file for a Medicare or Medicaid beneficiary.

Conclusion

The Medicare and Medicaid programs, potentially, may make claims against large portions of the recovery. This may reduce the payment of proceeds to the client and, as a result, you can win the battle but lose the war by failing to protect the recovery. The lesson here is that when the settlement check arrives, the work may have just begun.

Appendix A: State Statutes & Regulations Relating to Nursing Homes

Available online at: www.mcguffey.net/ATLAappendix.pdf.

Appendix B: State Statutes and Regulations Relating to Medicaid Liens

Available online at: www.mcguffey.net/ATLAappendix.pdf.

Appendix C: State Statutes and Regulations Relating to Medicaid Estate Recovery

Available online at: www.mcguffey.net/ATLAappendix.pdf.

Appendix D: Results from 1997 North Carolina Survey: Comparing State Medicaid Recovery Efforts

Available online at: www.mcguffey.net/ATLAappendix.pdf.

Appendix E: Special Needs Alliance Members

Available online at: http://www.specialneedsalliance.com/menu_members.asp.

Appendix F: National Academy of Elder Law Attorneys, Members

Available online at:
<http://www.naela.org/Applications/ConsumerDirectory/index.cfm>.

law practice categories, many of which are listed in NAELA, *Questions and Answers When Looking for an Elder Law Attorney*, <http://www.naela.org/public/QA.htm>.