Medicare, Medicaid & Private (Employer-Provided) Health Insurance Plans

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IMPORTANT INFORMATION ABOUT HEALTHCARE LIENS IN PERSONAL INJURY SETTLEMENTS

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FEDERAL, STATE AND PRIVATE HEALTHCARE OBLIGATIONS WHEN SETTLING A PERSONAL INJURY CASE

Under the laws of most states, when a plaintiff receives a personal injury settlement, you must use part of that settlement to pay back whoever paid for the medical care needed to treat the injury, whether it's the government, your employee health plan, or your health insurance company. These healthcare "liens" or "reimbursement obligations" are now a part of almost all personal injury settlements. Yet many plaintiffs are not aware that they may have such obligations when they settle their personal injury case. Courts, defendants, and healthcare providers are placing stronger emphasis on satisfying healthcare liens related to a personal injury settlement. Laws and regulations, and the healthcare coverage policies that interpret them, often place the burden on the plaintiff to verify whether or not a healthcare provider has a lien and, if so, to resolve it. Therefore, as a plaintiff, you should take a few moments to make sure you understand your healthcare benefits, your obligations and your rights. Proactively evaluating and resolving any healthcare provider's reimbursement interest before your settlement will help provide for your continued access to quality healthcare after settlement.

What is a Lien?

We often think that healthcare coverage is meant to pay for all of our medical needs, no matter what the cause. However, the concept behind healthcare liens in personal injury settlements is that the responsible/negligent party should pay the medical bills. Therefore, regardless of your past premiums, co-pays or deductibles, if a third party (i.e., a "defendant" in a personal injury claim) is liable for your injury, that third party ultimately should pay for your medical bills, not your healthcare provider. Most healthcare plans, whether provided by the government (federal or state programs) or by your employer, create their right to a claim or lien on any settlements when you originally became entitled and accepted coverage. This right of recovery is disclosed within the plan documents, but many individuals are not be aware of this or even think about it because most never foresee themselves a victim of a personal injury event.

A healthcare provider's lien is typically focused solely on injury-related medical expenses paid for from the date of the injury through the date of settlement.

What are the Different Types of Healthcare Providers?

As mentioned above, any healthcare plan's right of recovery is disclosed in the plan documents. The first order of business is to have a strong grasp of the type(s) of coverage you currently receive or expect to rely upon in the future. Within the U.S., there are numerous ways to obtain healthcare coverage. This document describes three of the most prevalent: Medicare, Medicaid, and private (or employer-provided) health insurance.

Medicare - is the federal government's healthcare program, it provides healthcare for those 65 or older or those under 65 who are disabled, suffering from permanent kidney failure, or diagnosed with Lou Gehrig's disease.

Medicaid - is the state government's needs-based healthcare program. Each state administers its own program; therefore the laws for each program may vary. For all government programs, reimbursement obligations or liens arise from statutes or laws. This occurs as soon as a recipient of government (state or federal) healthcare receives the first dollar of coverage.

Private insurance - is administered by many different insurance companies. Most Americans on private insurance get their coverage through their employer (these are often referred to as ERISA plans). For this type of insurance, lien obligations arise out of a pre-existing contract between the client and health plan.

MEDICARE: WHAT IS IT AND WHAT ARE THE RULES?

Medicare is known as an entitlement program since you are entitled to Medicare if you have a sufficient work history (e.g. you have worked up to 20 out of 40 calendar work quarters, depending on age), and you therefore have paid a sufficient amount of Social Security tax into the system. As stated above, it is the federal government's healthcare program, and it provides healthcare benefits for those individuals age 65 or older or those under age 65 who are disabled, suffering from permanent kidney failure, or diagnosed with Lou Gehrig's disease. Medicare does not pay for long-term care, but does pay for a portion of major medical expenses and hospitalizations and covers many prescription drugs.

For those who are disabled and meet the criteria, they often begin receiving Medicare two years after being approved for any kind of Social Security disability (SSD) benefit (other than Supplemental Security Income discussed below). The SSD system was created to provide disability insurance for injured workers and their families. Once a worker (who has paid a sufficient amount into the Social Security system) is unable to engage in substantial gainful employment for a period of at least 12 months, he or she is eligible for SSD.

If you meet these criteria, Medicare may be responsible for providing your primary healthcare coverage. Under certain circumstances, Medicare will pay for your injury-related care when another party is responsible. If you are able to recover from the party responsible for your injury, you must repay Medicare for the injury-related care. (Medicare technically refers to their reimbursement right as a "reimbursement claim" because they have a priority right to reimbursement that is stronger than any other lien. However, for the purposes of this educational booklet we will refer to Medicare's right of recovery generically as a lien). Federal law requires all parties to "consider Medicare's interests" in third party settlements where Medicare has paid "conditionally" for injury-related care.[1]

The term "conditional payments" describes the injury-related payments Medicare made after your injury when another party was responsible for having caused that injury. Because it is a conditional payment, if money is received in a personal injury settlement, Medicare must be paid back from your settlement prior to distributing any settlement proceeds to you.

Enactment of the Medicare Modernization Act of 2003 placed the clear obligation on you and your attorney to inform Medicare of any possible situation where Medicare made a "conditional payment." Medicare is not required to send notice of their lien to you. Rather, you or your attorney will need to request a conditional payment summary and then

[1] Under Section 1862(b)(1) of the Social Security Act (42 U.S.C. §1395y(b)(1)), payment may not be made under Medicare for covered items or services to the extent that payment has been made, or can reasonably be expected to be made promptly, under a liability insurance policy or plan (including a self-insured plan). 42 U.S.C. §1395y(b)(1), *amended by* Pub. L. No. 109-171, 120 Stat. 4 (2006).

analyze, audit and resolve Medicare's claims for reimbursement.

Types of Medicare Programs

Medicare offers several program options. The choices vary from the services covered to the type of service providers. People who are eligible for Medicare commonly choose the Original Medicare Plan or a Medicare Advantage Plan. The Original Medicare Plan is a fee-for-service plan managed by the federal government. Most people on the Original Medicare Plan have a combination of Part A and Part B benefits. Recipients of Original Medicare have the option of adding a Medicare Prescription Drug Plan (Medicare Part D) and purchasing a Medigap (supplemental) policy. Medicare Advantage plans are an HMO (Health Maintenance Organization) or PPO (Preferred Provider Organization) that can provide Parts A, B and D coverage.[2] Below is an overview of the most common plans.

1) Medicare Part A covers inpatient hospital care. Medicare Part A is offered to those who paid Medicare taxes while working. For most, it is not necessary to pay a monthly premium for the coverage. Others who have not paid Medicare taxes can buy Part A coverage. Medicare Part A is available for medically necessary blood, home health services, hospice care, hospital stays and skilled nursing facility care when recipients meet certain conditions.[3]

[2] CMS's booklet, *Medicare & You 2011*, is available at http://www.medicare.gov/Publications/Pubs/pdf/10050.pdf (accessed May 18, 2011).
[3] *Id.* at 7-9.

2) Unlike Medicare Part A, Medicare Part B is optional and requires those people who enroll to pay a monthly premium.[4] Additionally, co-payments and deductibles may apply to these services. Medicare Part B covers services that Medicare Part A does not, such as outpatient care, doctors' services and other medical services. It covers services that are medically necessary and some preventive services.[5]

3) Part C – Medicare Advantage Plans. Medicare Advantage Plans are offered by private companies and approved by Medicare. Members of Part C plans are still on Medicare. Medicare Advantage Plans provide the same coverage as Part A and Part B. Many also provide extra benefits and Part D prescription drug coverage. Types of the Medicare Advantage Plan include: Preferred Provider Organization (PPO) Plans, Health Maintenance Organizations (HMO) Plans, Private Fee for Service Plans (PFFS), Special Needs Plans and Medicare Medical Savings Account (MSA) Plans. Members of Medicare Advantage Plans do not need Medigap and cannot be enrolled on Medicare Part D.[6]

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[4] Effective January 1, 2007, Part B premiums are determined by income. Most people who enroll ("enrollee") will pay the standard monthly premium ($88.50 in 2006). Those with income of $80,000 individually and $160,000 jointly will be required to pay a higher premium. If the enrollee receives Social Security, railroad retirement or federal civil service retirement benefit checks, Part B premiums will be subtracted from those checks. If an enrollee does not receive the above mentioned government benefits, he or she must pay the premiums to the government.

[5] Specifically, those services include but are not limited to: ambulance services, clinical laboratory services, diabetic supplies, doctor services (not routine physical exams, with the exception of the Medicare enrollment physical), emergency room services, eyeglasses, flu shots, hearing and balance exam, kidney dialysis services & supplies, mammograms, physical therapy, prosthetic/orthotic items, tests, transplant services and urgently needed care.

[6] *Id.* at. 33-40

4) Part D – Prescription Drug Coverage. Medicare Part D offers prescription drug plans from private companies which are approved by Medicare. Prescription Drug Coverage is optional and members who wish to receive the benefits are required to pay a monthly premium. Prescription Drug Coverage is available through Medicare Part D or through Medicare Advantage Plans. Different plans have different options based on cost, drug coverage and convenience.[7]

5) Medigap Policy or Medicare Supplemental Insurance. A Medigap policy, or Medicare Supplemental Insurance, is health insurance sold by private companies to fill in the gaps of the Original Medicare Plan. Medigap policies only apply to Original Medicare Plans. Some Medigap plans include prescription drug coverage. Recipients cannot have Medigap prescription drug coverage and Medicare prescription drug coverage at the same time. Twelve plans, subject to federal and state laws, are available.[8]

Do All of These Medicare Plans Have Liens?

Part A & B coverage is managed through the federal government's Medicare Secondary Payer (MSP) Department's Tort Recovery Division. Part C is handled by private, independent providers. Part D tort recovery is yet to be defined however will be plan-specific as all Part D coverage is managed by private, independent Prescription Drug Plans (PDP). While these Part C, Part D, and supplemental plans are created under some authority through Medicare, they are nonetheless supplemental or replacement plans offered through a variety of private health insurance companies, each

[7] *Id.* at. 43-46
[8] *Id.* at 29-30

with their own policies. While these plans may have a right of recovery from a settlement, they do not follow the same procedures for indentifying and resolving potential reimbursement claims/liens.

The balance of this section on Medicare only addresses the reimbursement of original Medicare (Part A and Part B).

What is my Reimbursement Obligation to Medicare in a Liability Settlement?

In a liability settlement, original Medicare (hereafter just referred to as "Medicare") seeks recovery for all injury-related care expenditures from your date of injury to date of settlement.

How Long Does it Normally Take to Resolve a Medicare Lien?

The entire process can take as long as six months. The first task is to establish a case with Medicare's tort recovery department and seek a listing of all expenditures. This listing will assist in determining which charges are related to your injury. When the process is begun early in the litigation (before settlement), Medicare's claim can be satisfied within 45 days after the date of settlement.

Why Does it Take So Long?

There are several reasons it takes a long time to resolve Medicare liens. First, the private contractor that handles the lien recovery for Medicare must go out and find all the medical expenses that have been paid on your behalf by the Part A and Part B medical service providers. Complicating matters, in certain situations your medical providers have up to 25 months to bill Medicare after providing medical services to

you. Then, someone must review all of the expenses for which Medicare is claiming a right of reimbursement to make sure that a) they occurred sometime between your date of injury and date of settlement and b) that they are truly related to the injury for which you have settled your case. All this means that it can take a great deal of time to get a lien resolved with Medicare.

What Can I Do to Speed Up the Process?

Provide your attorney all of the information he/she requests to manage the resolution process. Do not duplicate efforts by contacting Medicare directly as this will lead to significant delays.

You should sign up for and access your Explanation of Benefit (EOB) through MyMedicare.gov. Keep an accurate journal of all the medical treatment you receive that is related to your injury, including the name of the provider and the date and type of service. Then, monitor to make sure your treatment history is accurately reported on the EOB.

Can I Challenge or Appeal Medicare's Lien?

Plaintiffs who are Medicare beneficiaries have the right to appeal Medicare's lien amount. Any appeal request must be made in writing on special forms. Appeal decisions are generally based on the financial hardship that repayment would cause the plaintiff / beneficiary (such as the impact of unforeseen severe financial circumstances as well as the impact of out-of-pocket medical expenses not covered by Medicare and your ability to meet those obligations). In order to make the determination, a "waiver" form is sent to the beneficiary, requesting information on monthly income and expenses.

Does Medicare Have to Pay Any of the Attorney Fees and Costs Associated with My Settlement?

Medicare will offset its lien by a proportionate share of the necessary "procurement costs" incurred in obtaining your settlement. Procurement costs refer to those costs typically incurred pursuing a personal injury claims (e.g., court costs, attorney's fees, other case expenses). This procurement offset is only applicable if you recover from a liable third party. If you receive payment from your own automobile, medical, or no-fault insurer, this offset will not apply.

What Happens If I Ignore Medicare's Lien?

Once a final lien amount is agreed upon, it must be paid within 60 days. If Medicare's demand for payment is ignored, it will be referred to the U.S. Treasury Department for collection. If you do not respond to the U.S. Treasury's collection request, your government checks (benefits) will be offset (i.e., the government will recover its lien by deducting the amount of the lien from your checks until the lien is satisfied).

What, If Anything, Must I Do to Preserve My Medicare Coverage After a Settlement?

Because SSD and Medicare are entitlement programs, the money you personally receive after paying any lien generally should not affect your eligibility for these programs. Appendix 1, however, contains some information about Medicare Set Asides that may apply in limited circumstances. These considerations are especially important if you are settling a workers' compensation claim.

What Can Be Done to Ensure the Most Favorable Result?

Your attorney and his or her firm dedicate their time to maximizing any settlement you may receive. However, the rules surrounding healthcare liens concern a different area of the law requiring a different focus. Both private and governmental healthcare liens constitute a complex field with potential impact on future healthcare coverage for you and your family.

The Garretson Resolution Group's (GRG) dedicated staff has a sound knowledge of these developing laws and legal processes and can help resolve these matters for you and your attorney. GRG's experience helps to provide you with the best result, maximizing your recovery and protecting your health benefits.

Conclusion

1) Your attorney has taken all the above mentioned issues into account and is committed to securing the most favorable results for you. These efforts include having the resources with the appropriate experience and knowledge to both evaluate your healthcare provider's right of recovery and satisfy Medicare's interest in the most efficient and favorable fashion. By providing you with these materials, your attorney is making sure you are aware of the obligations associated with your healthcare plan. Please be aware your attorney's firm has a formalized means of addressing these issues, and we ask that you do not duplicate the efforts as it could lead to significant delays.

2) We trust you find this guide beneficial and that it provides you a peace of mind that your attorney has taken into consideration your best interest in both securing the best results in your settlement and your continued access to quality healthcare.

3) If you do not already utilize all of the tools available online, you may want to consider logging on to MyMedicare.gov.

THE FUTURE COST OF CARE: EXPANDED MEDICARE OBLIGATION

How to account for shifting the burden of Future Cost of Care to Medicare after a settlement

Medicare "Set Aside" Requirements

This section contains the following checklist designed to help assure that you are fully informed about potential Medicare Set Aside requirements.

- The Medicare Secondary Payer regulations say Medicare is always secondary to workers' compensation and other insurance, including no-fault and liability insurance. Under the Social Security Act, payment "may not be made under Medicare for covered items or services to the extent that payment has been made, or can reasonably be expected to be made, under a liability insurance policy or plan."

- While Medicare's authority to scrutinize liability settlements (to determine if some portion must be "set aside" and spent down on future injury-related care) arises under the same statute as does its authority to scrutinize worker compensation settlements, currently no formal set-aside process exists for liability settlements. It is an "honor system," based upon standards of "good faith" and the "reasonable person." However, the lack of a formal

review process for liability MSAs does not mean the issue should not be examined.

- Medicare will not pay for any medical expenses related to the injury after settlement until any portion of the settlement that is allocated to future medical expenses covered by Medicare has been fully exhausted. While such allocation is common in workers' compensation cases, allocation may or may not be part of a liability settlement based on confounding factors to full recovery.

- If any portion of your settlement has been allocated to future medical expenses, some portion of the settlement may need to be set aside into an account as an adequate representation of Medicare's interest in your future cost of care.

- A Medicare Set Aside allocation amount is determined through the detailed analysis of each particular case. Once this "set aside" amount is exhausted, Medicare becomes the primary payer of Medicare covered expenses for those settlement-related injuries.

- If an allocation of damages (to future medical expenses) is part of your settlement, Medicare's future interest is properly considered by generating an injury-specific estimate of the future course (and cost) of treatment. Further protection is available if you obtain approval from the Centers for Medicare and Medicaid Services (CMS) of the proposed Set Aside amount. Only when these funds have been exhausted will you be able to utilize your Medicare card for all injury-related healthcare needs. Again, while such allocation is generally part of every workers' compensation settlement, it may or may not be part of a liability settlement.

- If in good faith, a reasonable person would surmise that if an allocation to future medical expenses is part of a liability settlement, two options exist – i) identify the appropriate allocation and ensure that those proceeds are spent down on future injury-related care (for which Medicare would otherwise pay); or ii) your attorney or the consultant he/she retained may contact the appropriate Medicare regional office, share the fact pattern of the case and see if they would like to review and approve the allocation (see discussion below).

- Medicare must be notified of any workers' compensation claim settlement if you have received, currently are receiving, or will be receiving Medicare benefits within the next 30 months. Medicare only will formally review and approve set asides for workers' compensation settlements that are greater than $25,000 for a current beneficiary or greater than $250,000 for an individual who has a reasonable expectation of becoming a Medicare beneficiary within 30 months. Although CMS approval of the set-aside calculation is not mandatory, it helps avoid problems with future Medicare coverage. It also ensures that only a predefined portion of the settlement-rather than the entire settlement-must be spent before Medicare takes over payment again.

- Set Aside money must be used only for *injury-specific medical expenses* which *Medicare would have paid.* Compliance with *all* Medicare rules and regulations is mandatory, including showing Medicare that money in the set aside account was spent properly. You may opt to either self-administer your own set-aside funds or may purchase a plan through a Medicare set-aside administration company to ensure that your funds are properly disbursed. If you choose to self-administer the

funds, it is your obligation to ensure that the funds are used properly. Improper administration of the funds could result in the loss of Medicare eligibility.

- If a Medicare Set Aside is required, you must keep and submit to CMS all of the medical bills and receipts associated with the payment of injury-related, Medicare-approved medical expenses.

- In a situation where there is a death before the Medicare Set Aside is exhausted, the money will go back to your family or your designated beneficiary.

This section focuses on clients who are settling a personal injury case and who are receiving **Medicaid**.

MEDICAID: WHAT IS IT AND WHAT ARE THE RULES?

Supplemental Security Income ("SSI") and Medicaid are *needs-based programs.* Many individuals receive SSI due to poverty and others receive SSI due to disability. In most states, disabled people who qualify for SSI automatically become eligible for Medicaid, which is the joint federal and state program for medical coverage for the needy. Medicaid benefits can cover items like prescription medication, transportation, and home-based care.

Under certain circumstances, Medicaid will pay for either all or a portion of your injury-related care when another party is responsible. If you are able to recover from the party responsible for your injury, you must repay Medicaid. When a person receives Medicaid benefits from the state, that person agrees, by accepting those benefits, to reimburse the state for injury-related care if that person recovers from the party that is responsible for causing his/her injury.

Medicaid generates a "lien" only where a Medicaid beneficiary's injuries are associated with third-party liability. In almost all states, there is no similar "lien" in the case of maintaining SSI benefits. This Medicaid lien always runs from the date of your injury and ends on the date of your settlement because that is the only period for which the third party is

liable. Further, the Medicaid lien is limited to injury-related medical expenses and does *not* include any payments Medicaid would have paid *if* the incident (giving rise to liability) had not occurred.

What Does "Needs-Based" Mean?

The term "Needs-Based" refers to fact that Medicaid is only available to people who are under certain income and/or asset thresholds. For example, in 2010, a single individual who qualifies for SSI can receive up to $674, and a married person up to $1,011, not including state additions to those benefits. And, a single person with income of more than $674 (or other amounts, depending on the state he or she lives in) and countable assets of more than $2,000 may not be eligible for SSI and/or state Medicaid, depending on the circumstances. Married persons typically can own up to $2,250 or $3,000 in countable assets.

What are the Different Types of Medicaid Programs

Typical Medicaid recipients are children and their parents, the elderly, and people with disabilities. According to federal guidelines, the states must offer Medicaid eligibility to low-income pregnant women, low-income families with children, and SSI recipients. State also may choose to cover other groups of people under Medicaid. For instance, states may choose to have Medically Needy (MN) programs which allow people who do not meet the Medicaid income requirements to be eligible for Medicaid if their income minus their medical expenses falls below a certain limit. States also may allow "Categorically Needy" people to receive Medicaid benefits. "Categorically Needy" people are working individuals with disabilities who do not qualify for Medicaid because their income exceeds the eligibility requirements. Furthermore,

recipients of Medicaid can be "dual eligibles." "Dual eligibles" are individuals who are eligible for Medicare Part A and/or Medicare Part B and for some form of Medicaid benefits.[9]

Finally, most if not all states have Waiver Programs (also called home and community-based services (HCBS) waivers). For the most part, these programs were created to serve as an alternative to institution-based care. "Waivers" are generally used to enable states to provide community based healthcare, which is healthcare in the recipient's own home or community, instead of institutional services. Waiver Programs typically allow receipts to have more income and assets (and still be eligible) than other Medicaid programs.

Are The Medicaid Lien Rules the Same In Every State?

It is important to evaluate the Medicaid agency's recovery procedures and case law that affects the agency's right of recovery in your state. One state may require the Medicaid beneficiary to put the state on notice that there is a possible third party recovery. Another state may not require notice, but may still pursue the beneficiary for payment of a lien. Additionally, if you have received Medicaid benefits in multiple states for the injury-related care, you may be obligated to reimburse each state.

What Happens If I Ignore Medicaid's Lien?

The Medicaid recipient – and often his/her attorney as well - has a duty to cooperate in the Medicaid lien recovery process. Failure to cooperate may result in the *denial* of *future* benefits.

[9] *Id.* at 122-129.

How Long Does it Normally Take to Resolve a Medicaid Lien?

In many states, Medicaid liens can be resolved rather quickly. Also, in many states you cannot settle your personal injury case unless Medicaid consents to the settlement, and you first agree with Medicaid on the amount of the lien. Therefore, often these liens are resolved at the time of settlement. However, if you and your attorney are unable to reach an agreement with your state's Medicaid agency regarding the amount of the lien, a court hearing may be necessary, resulting in some delay.

What Can I Do to Speed Up the Process?

Keep an accurate journal of all the medical treatment you receive that is related to your injury, including the name of the provider and the date and type of service. Typically, Medicaid has up to 90 days to process a medical expense claim. Oftentimes, this process takes longer because the medical care provider does not bill on a timely basis. Review your medical records and if there are discrepancies in billing, follow up with the medical care provider to ensure that it has billed Medicaid on a timely and accurate basis. If you are still receiving care at the time of settlement, work with your medical care providers to determine the last injury-related medical expense that is to be submitted to Medicaid.

This process can take a long time, but failing to follow these tips often results in a longer lien resolution process.

Can I Challenge or Appeal Medicaid's Lien?

As mentioned above, it may be necessary to involve the court if you and your attorney are unable to come to agreement with Medicaid about the amount of its lien at the time of settlement. A 2006U.S. Supreme Court decision makes it clear that states

do not have a priority right to your entire settlement – they only can be reimbursed from the portion of your settlement that represents payment by the third party (defendant) for your medical expenses (as opposed to payment for your lost wages, pain and suffering, and your other non-medical losses). Oftentimes, it is necessary to involve the court to determine what part of a settlement actually represented payment by the defendant for your medical losses. Some states will compromise their lien amount based upon hardship or other criteria without requiring court involvement.

Does Medicaid Have to Pay Any of the Attorney Fees and Costs Associated with My Settlement?

Under some state laws, the Medicaid lien amount is reduced by the same percentage that your settlement proceeds were reduced by your attorney fees and case expenses. Under other state laws, the Medicaid lien amount is reduced by a preset percentage found in the statutes.

What Can Be Done To Ensure the Most Favorable Result?

Your attorney and his or her firm dedicate their time to maximizing any settlement you may receive. However, the rules surrounding healthcare liens concern a different area of the law requiring a different focus. Both private and governmental healthcare liens constitute a complex field with potential impact on future healthcare coverage for you and your family.

The Garretson Resolution Group's (GRG) dedicated staff has a sound knowledge of these developing laws and legal processes and can help resolve these matters for you and your attorney in your best interest. GRG's experience helps to provide you

with the best result, maximizing your recovery and protecting your health benefits.

What Can I Do to Protect my SSI and Medicaid Benefits After the Settlement?

As discussed above, "Needs-Based" government programs like SSI and Medicaid that provide you with monthly income or payments for medical services have strict financial eligibility limits. Without careful planning, a settlement award may cause you to lose your eligibility for those programs.

Certain items, such as your home, one automobile (if used for travel to and from the doctor's office or your employer), a Special Needs Trust, and a limited amount of home furnishings and jewelry may not be counted as available resources for purposes of determining eligibility. In this regard, if you are currently receiving needs-based benefits, it may be wise for you to use the settlement proceeds to purchase and/or be placed in "exempt" items within the same month that you receive your settlement proceeds.

A Special Needs Trust is a special type of trust that allows a disabled person to maintain financial eligibility for some "needs-based" public assistance benefits while preserving his or her settlement award (and/or other assets) in trust for supplemental needs. While not appropriate for everyone, the end result of establishing a Special Needs Trust is that qualified beneficiaries can receive certain "needs-based" public benefits that meet their essential needs (such as Medicaid, food stamps, and subsidized housing) while maintaining a supplemental fund that is available to meet their special or supplemental needs (which are not provided by public benefits).

Whether a private Special Needs Trust [(d)(4)(A)] or a public Pooled Trust [(d)(4)(C)], there are guidelines for using the money in the trust. It is generally best for an independent, third party trustee to use the trust funds to directly purchase from providers "supplemental" goods and services, rather than to purchase food, shelter, or clothing items that government programs are intended to cover. Despite this restriction, these trusts are rather flexible and can be used in a manner that greatly improves an injured person's quality of life.

In some cases, it *does* make sense for the trust to pay for basic items, such as housing costs. It is important to consider the effect of these expenditures on your benefits prior to making such payments, as they may cause a decrease in your SSI benefits or an increase in your Medicaid "spend-down" requirements.

Because these trusts best achieve individuals' benefit preservation goals when the trusts are <u>not</u> changeable (i.e., they are "irrevocable"), individuals generally cannot change their minds and take all their money out of the trust. If they recover and are no longer disabled, they may take steps to terminate the trust.

As an alternative to placing your proceeds in "exempt" items or in a traditional Special Needs Trust or Pooled Special Needs Trust, you (especially with small settlements) might consider spending down your settlement proceeds on existing debt (such as credit cards or utility bills). If you do not have such debt, perhaps you can call your utilities providers to see if you can pay, for instance, four or five months of your gas bill in advance. Again, you should accomplish this in the same month in which you receive your settlement check.

You should know, however, that there is a chance that you will lose at least one month of your SSI eligibility even if you use one of the strategies mentioned above. This often occurs because many Social Security case workers interpret the receipt of settlement proceeds to be the equivalent of receiving income in the month of settlement, which in turn, triggers a one month period of ineligibility, despite the "spending down" or transferring assets to a Special Needs Trust.

You should know that NOT disclosing the settlement to your Medicaid/government agency case worker within 10 days of the receipt of settlement proceeds can result in a loss of benefits. All recipients of benefits have a duty to notify the agency that is responsible for administering their Medicaid program whenever there is a material change in their circumstances. Becoming a beneficiary of any trust is a material change in circumstances, and the individual must provide the agency with a copy of the trust document. Local legal counsel for the agency will review the trust to determine whether it meets all of the technical and legal requirements for being treated as a valid Special Needs Trust.

Also you should be aware that giving away your settlement proceeds to a family member can result in disqualification of your benefits.

Please note that these are just suggestions based upon some general rules regarding needs-based government benefits. These rules may or may not apply to the specific program benefits that you are receiving. If you have concerns about your eligibility, you should contact a qualified disability planner or case worker.

Conclusion

1) Your attorney has taken all the above mentioned issues into account and is committed to securing the most favorable results for you. These efforts include having the resources with the appropriate experience and knowledge to both evaluate your healthcare provider's right of recovery and satisfy Medicaid's interest in the most efficient and favorable fashion. By providing you with these materials, your attorney is making sure you are aware of the obligations associated with your healthcare plan. Please be aware your attorney's firm has a formalized means of addressing these issues and we ask that you do not duplicate the efforts by directly contacting the Medicaid office as it could lead to significant delays.

2) We trust you find this guide beneficial and that it provides you a peace of mind that your attorney has taken into consideration your best interests in both securing the best results in your settlement and your continued access to quality healthcare.

This section focuses on individuals who are settling a personal injury case and who are receiving health insurance coverage through a **private (employer-based) healthcare plan**.

EMPLOYEE HEALTH COVERAGE: WHAT IS IT AND WHAT ARE THE RULES?

You may receive health and medical insurance coverage through your employment. If, as a result of your injuries, you have received medical care paid for by your employee health plan, the health plan may be entitled to reimbursement for those expenses from any settlement you receive. This is called subrogation or third-party reimbursement, and a lien may be placed on your settlement by your employee health plan.

What is Your Obligation as a Beneficiary of an Employee Health Plan?

Unlike the governmental health plans discussed above, any obligation you may have under an employee health plan is determined by the language contained within the plan or policy. You should have a copy of this document, which must be given to you by your employer under federal law. If you cannot find your copy, ask your lawyer if you should request one from your employer immediately.

Search the plan document or policy for any section entitled "Subrogation," "Third Party Liability," "Third Party Reimbursement," or something similar. This section will describe what rights the employee health plan may have to impose a lien upon your settlement. It also may state what your obligations are as a beneficiary to cooperate in the plan's

lien recovery effort. Employee health plans often will contain provisions to reduce or eliminate your medical coverage if you fail to cooperate.

For this reason, it is important that any lien rights held by your employee health plan be addressed before your settlement. Waiting until after you obtain a settlement may result in you losing certain ability to negotiate a lower lien amount.

As soon as you have found the plan document, deliver a complete copy to your attorney and discuss any questions you may have concerning the contents of the document.

What Can Be Done to Ensure the Most Favorable Result?

Your attorney and his or her firm dedicate their time to maximizing any settlement you may receive. However, the rules surrounding healthcare liens concern a different area of the law requiring a different focus. Both private and governmental healthcare liens constitute a complex field with potential impact on future healthcare coverage for you and your family.

The Garretson Resolution Group's (GRG) dedicated staff has a sound knowledge of these developing laws and legal processes and can help resolve these matters in your best interest. GRG's experience helps to provide you with the best result, maximizing your recovery and helping to protect your health benefits.

Conclusion

1) Your attorney has taken all the above mentioned issues into account and is committed to securing the most favorable results for you. These efforts include having the resources with the appropriate experience and knowledge to both evaluate your healthcare provider's right of recovery and satisfy the provider's interest in the most efficient and favorable fashion. By providing you with these materials, your attorney is making sure you are aware of the obligations associated with your healthcare plan. Please be aware your attorney's firm has a formalized means of addressing these issues and we ask that you do not duplicate these efforts as this could lead to significant delays.

2) We trust you find this guide beneficial and that it provides you a peace of mind that your attorney has taken into consideration your best interest in both securing the best results in your settlement and your continued access to quality healthcare.

Matt Garretson
Founder

Matt Garretson is the founding partner of Garretson Resolution Group (GRG), which provides mass tort/class action settlement allocation and fund administration services. The company also handles Medicare/Medicaid reimbursement claims, government benefit strategies, and probate administration for individual and mass tort plaintiffs. He received his BA from Yale University and his law degree at Kentucky's Salmon P. Chase College of Law.

Matt is a frequent speaker at Continuing Legal Education seminars about lawyers' professional responsibilities - including liens and reimbursement claims - in individual and mass tort settlements. He has spoken about these issues at over 100 seminars sponsored by numerous state trial lawyer and state bar associations, The America Bar Association, The American Association for Justice, and other organizations. Furthermore, Matt is the author of a legal text book published by West Publishing entitled *Negotiating and Settling Tort Cases*. In addition, he has authored several articles[1] regarding professional responsibility in individual and mass tort settlements that have been published in many national, state as well as international publications. In 2005, Loyola University Journal of Public Interest Law published an article he authored entitled, "A Practical Approach to Avoiding Conflicts of Interest in Aggregate Settlements."

Matt has served as adjunct professor at Salmon P. Chase College of Law, where he teaches law practice management and emphasizes how to avoid professional liability claims. Matt serves as the special master and/or administrator of settlement funds throughout the country in many product liability, civil rights and church-related sexual abuse matters. His role in numerous high profile church-related sexual abuse and civil rights settlements (including the historic Cincinnati police brutality/racial profiling settlement) led to his selection by Lawyers Weekly as 1 of 5 "Lawyers of the Year" in Ohio for 2003. He was nominated by his peers and selected as an Ohio Super Lawyer - Rising Star in 2005 and 2006. His work was featured in the LA Times in January 2005.

Jason Wolf
President

Jason's extensive operational and management experience was instrumental in Garretson Resolution Group's (GRG) role in pioneering the field of third party Medicare Compliance in both single event and mass tort settlement programs. By identifying the needs of the settlement community and designing proprietary work flow processes, methodologies and systems, GRG built a practice that now employs over 80 professionals to serve its national client base.

Jason takes great pride in the firm's leading position of recognizing issues in the changing landscape of healthcare providers' role in settlements. Jason's role in building strong business relationships with federal agencies, all state agencies, private health care plans and third party recovery contractors has assisted in the firm's success in facilitating fair agreements between interested parties (plaintiff, plaintiff counsel, defense, health care plan). GRG serves clients nationwide to ensure compliance with federal, state, military and private health care plans by defining and resolving obligations. GRG's work in mass tort settlements is nationally recognized and has resulted in formal appointments as "Lien Resolution Administrators" in dozens of settlements. GRG is the court appointed lien resolution administrator in the 60,000 claimant / $4.5 billion Vioxx settlement program. Jason has lectured to attorney and healthcare organizations, conferences and associations on various subjects including lien resolution in personal injury settlements, workers' compensation settlements and compliant use of Medicare Set-Aside funds.

Jason earned his graduate and undergraduate degree from Eastern Michigan University.

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