

WRAPPING UP THE PERSONAL INJURY CASE: PROTECTING YOUR CLIENT AND YOUR PRACTICE

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Once a personal injury case is settled, there are usually a number of other issues to be considered. These include the following:

- Medical coverage for the plaintiff
- Investment management
- Structured Settlement
- Special Needs Trust
- Settlement Preservation Trust
- Access to public benefits
- Medicare Set-Aside Arrangement
- Lien resolution
- Qualified Settlement Fund
- Estate planning for plaintiff and family
- Income and estate tax planning
- Probate
- Guardianship
- Care management

1. MEDICAL COVERAGE

One of the most important services that a personal injury lawyer can provide to an injured plaintiff in a litigation settlement is to arrange for the best possible medical coverage.

1.1. Individual Private Medical Insurance

Many plaintiffs in personal injury cases are either uninsured or under-insured. Private medical insurance may be available to pay a significant portion of the medical needs of a person with disabilities. Under Health Care Reform in 2014 persons with pre-existing conditions will be able to obtain medical insurance. Until then, it is possible to obtain private medical insurance with certain limitations. One of the problems with private medical insurance is that coverage is usually limited to acute care, such as that provided by hospital and physician services. Little, if any, coverage is available for chronic care including home and community-based services.

1.2. Family Members

Parents or spouses often have private insurance through their employers. Often these policies will cover a child with disabilities until age 30, if the child is living in the parent's home and is unmarried. If the disability occurred prior to age 22, some insurance companies offer coverage for the child with disabilities who is unmarried and living in the parent's home for so long as the parent is covered by that insurance. These two latter restrictions are significant for

some beneficiaries. It is also limiting to the parent or spouse, because it may limit that person's choice in leaving their job.

1.3. COBRA

Normally under COBRA the person leaving employment can continue medical insurance for 18 months after the termination of employment. If the person is disabled, they are entitled to 29 months of COBRA rather than 18.

1.4. Medicare

A person receiving SSDI for two years will receive Medicare. It is important to obtain a Medicare supplement. There is an open enrollment period for Medicare supplements for six months after the Medicare recipient obtains Medicare Part B. Another option is to enroll in a Medicare Advantage Plan. There is an open enrollment period for Medicare Advantage Plans from January 1 through March 31 of each calendar year. The Health Care Reform may make the Medi-Gap insurance easier so that open enrollment periods may become less important. The plaintiff should obtain Medicare Part A for hospitalizations, Medicare Part B for out-patient services, including physicians, nurses, etc., and Medicare Part D, which is a prescription drug plan.

1.5. Medicaid

An extremely important source of funding for medical needs for persons with disabilities is Medicaid. About 76 percent of persons with disabilities receive their Medicaid through SSI. A person may also be eligible for Medicaid without receiving SSI because of a spend down.

1.6. Medicaid Waiver Programs

Many states have Medicaid Waiver Programs with which disability lawyers must be familiar. These waiver programs cover specific situations, but most provide for significant home care. Many states have Medicaid Waiver Programs for traumatic brain injury offering services beyond home care. In some states, such as Pennsylvania, a parent can be paid under a waiver program to care for a child with disabilities.

1.7. Worker's Compensation

If an injury is related to employment, the plaintiff may be entitled to medical coverage under a Worker's Comp insurance policy or directly from the company. It is often possible to settle a case and retain some coverage through the Worker's Comp carrier. However, where there is a third party liability claim and a Worker's Comp claim, it is much easier to settle the Worker's Comp claim if alternative arrangements can be made for medical coverage.

1.8. TRICARE and CHAMPUS

TRICARE and CHAMPUS are medical insurance programs available to certain Veterans. A determination should be made as to whether the plaintiff is eligible for these benefits, and an application should be made if appropriate.

1.9. New Jersey Family Care

Many low-income plaintiffs can become eligible for medical coverage through New Jersey Family Care. A determination should be made as to the plaintiff's eligibility and an application filed, if appropriate.

2. INVESTMENT MANAGEMENT

Many injured clients are unsophisticated in financial matters and benefit greatly from a connection with a qualified financial advisor. The Center for Fiduciary Studies at the Katz Graduate School of Business at the University of Pittsburgh (CFS)¹ has developed a five-step Investment Process and seven Uniform Fiduciary Standards of Care. The five-step Investment Process is as follows:

- Analyze the current position
- Diversify
- Prepare and Investment Policy Statement
- Implement policy
- Monitor

The seven Uniform Fiduciary Standards of Care are:

- Know standards, laws and trust provisions
- Diversify assets to the specific risk-return profile of the client
- Prepare an Investment Policy Statement
- Use "prudent experts" (money managers) and document due diligence
- Control and account for investment expenses
- Monitor the activities of "prudent experts"
- Avoid conflicts of interest and prohibited transactions

An injured plaintiff who takes advantage of services offered by a qualified investment manager is much more likely to develop a financial plan that will serve him or her well over the plaintiff's remaining life expectancy.

¹ www.learningstore.com

3. STRUCTURED SETTLEMENT

A structured settlement is an annuity that pays the injured plaintiff a series of periodic payments over time, rather than a single lump sum. The annuity is purchased from a highly-rated life insurance company. The defendant, or its insurer, agrees to make future payments to the injured party or directly to a Special Needs Trust. Payments are typically made for the life of the injured party with a guarantee of payment for a minimum number of years.

3.1. Periodic Payment Arrangements

There are a number of variations of Periodic Payment arrangements including the following:

- **Level Payments.** Level payments irregular intervals, often monthly
- **COLA.** Payments that increase periodically, usually with a cost of living rider of 3% per annum compounded
- **Guaranteed Level Payments.** Guarantee level payments at regular intervals, usually monthly for the claimant's lifetime with a guarantee that if the claimant dies before a specified time, usually closely correlated with the expected life expectancy, payments will be continued to the designated beneficiary, typically the claimant's estate, a first party special needs trust, or a family member of the beneficiary
- **POPs.** POPs are regular payments, usually monthly, with additional lump sums at specified future dates that might be used, for example, for college education or other anticipated future expenses.
- **Fixed Term.** Payments at regular intervals over a fixed period of years without reference to the lifetime of the claimant.
- **Step Increases.** Payment schedules with step increases or decreases at fixed times, such as *x dollars* per month until age 18, then *y dollars* a month thereafter.

3.2. Advantages of a Structured Settlement

- **Tax-Free.** The income from the structured settlement is completely tax-free, if it is for a physical illness or sickness or for a Worker's Compensation claim and can be guaranteed for life.
- **Estate Taxes.** The structure can provide funds to pay estate taxes.
- **Public Benefits.** The structure can be used in combination with a special needs trust to maintain public benefits.
- **Protection from Plaintiff.** The structured settlement offers protection against the plaintiff squandering the money. Studies have shown that the average

personal injury settlement lasts three years. If the structured settlement is placed in a trust, it is difficult for the irresponsible plaintiff to sell the structure in the secondary market.

- **Creditor Protection.** A structure guarantees an income that is free from the claims of the injured person's creditors until actual receipt of the funds.
- **Guarantee.** The Periodic Payment is guaranteed.
- **Rated Age.** Utilizing a rated age in a structured settlement often enables a much higher income stream than would be possible from any other investment vehicle.

3.3. Factoring a Structured Settlement

There is a secondary market for the sale of structured settlements. Companies that will buy all or a part of the income stream have a trade organization known as The National Association of Settlement Purchasers (NASP). Most states have adopted some form of the Model State Structured Settlement Protection Act.² The Act provides that a court order is required to effectuate the transfer. The court must find that:

- The transfer is in the best interest of the payee, taking into account the welfare and support of the payee's dependents.
- The payee has been advised in writing by the transferee to seek independent professional advice regarding the transfer and has either received such advice or knowingly waives such advice in writing.
- The transfer does not contravene any applicable statutes or the order of any court or other governmental authority.

3.4. Quality of Insurance Company

There are a number of rating companies that evaluate the quality of insurance companies. They include: A.M. Best Company, Fitch Ratings, Moody's Investor Services, Standard and Poors Corporation, and Weiss Research, Inc.

3.5. Structuring the Attorney's Fee

For various reasons, personal injury attorneys may wish to structure their attorney's fees. Personal injury work can be feast or famine, and by structuring fees the lawyer can spread out income over a period of time and achieve tax savings. Fees can also be structured until retirement. If a fee is structured and payment is deferred until retirement, the funds can be invested during the deferral period with the result that the payments will be increased once they begin. By structuring fees, the attorney can defer paying tax until the fee is actually received. If

² Model State Structured Settlement Protection Act, promulgated by The National Conference on Insurance Legislators, www.ncoil.org.

an attorney age 55 plans on retiring at age 65, he can structure his fee with no distributions until age 65. The tax is, therefore, deferred over that 10-year period. If the attorney then decides to take distributions over 15 years, the tax is then deferred over that 15-year period.

4. SPECIAL NEEDS TRUST

4.1. When is a Special Needs Trust Required?

A Special Needs Trust is required to preserve means-tested public benefits. Typically, means-tested public benefits include:

- SSI
- Medicaid
- Medicaid Waiver Programs
- Section 8 Housing
- Food Stamps

Means-tested public benefits do not include:

- SSDI
- Medicare
- Special Education

4.2. Statutory Requirements in Drafting a Special Needs Trust

Self-Settled Special Needs Trusts are governed by the Social Security Act³ and by the Program Operating Manual System of the Social Security Administration.⁴ The trust must contain provisions relating to the following:

- ***Assets of the Individual.*** Assets in the trust are limited to those of the injured plaintiff. The personal injury settlement is an asset of the disabled person and is, therefore, a suitable trust asset.
- ***Under Age 65.*** A Special Needs Trust cannot be established for a person over age 64.
- ***Disabled.*** The beneficiary must be disabled as defined by the Social Security Act.⁵

³ 42 U.S.C. §1396p(d)(4)(A).

⁴ POMS SI 01120.203.

⁵ 42 U.S.C. §1382c(a)(3)(A) and (B).

- ***Sole Benefit of.*** For the sole benefit of the disabled person
- ***Established by.*** Trust established by:
 - Parent or grandparent
 - Guardian
 - Court
- ***Payback***

4.3. Alternatives to Special Needs Trust

There are four alternatives to a Special Needs Trust. These include:

- ***Spend Down.*** Spending down the money on certain approved items, such as buying a home, a vehicle, repayment of debt or taking a vacation. Buying household goods and personal effects are also permitted.
- ***Transfer of Asset.*** The disabled beneficiary may be able to transfer assets to other family members, but this will depend on what benefits the disabled person is receiving. If the individual is receiving SSI, he will lose SSI for three years. If he is receiving an institutional level of Medicaid, he may lose Medicaid for five years. If he is receiving only Medicaid card services, there is no transfer of asset penalty.
- ***Accept the Money.*** Some beneficiaries elect to accept the money, lose their benefits and reapply after they have had a good time squandering the settlement proceeds. If the settlement is large enough, this may be a viable option.
- ***Pooled Trust.*** The Social Security Act provides for the establishment of Pooled Trusts.⁶ If the person is under age 65, funds can be transferred to a Pooled Trust that operates in the same manner of a Self-Settled Special Needs Trust. Essentially a Pooled Trust is a Special Needs Trust. This is a very useful vehicle where smaller settlements are involved. There are six statutory requirements for a Pooled Trust:
 - ***Disabled.*** The individual must be disabled as a defined by the Social Security Act.⁷
 - ***Non-Profit Association.*** The Trust must be operated by non-profit association as defined in §501c of the Internal Revenue Code.⁸

⁶ 42 U.S.C. §1396p(c).

⁷ 42 U.S.C. §1382c(a)(3).

⁸ POMS SI 01120.203 B 2 c.

- *Separate Account.* A separate account must be maintained for each beneficiary.⁹ Monies are pooled for investment purposes, but each beneficiary has a separate sub-account.
- *Solely for the Benefit of.* The account must be maintained for the sole benefit of the individual with disabilities.
- *Established by.* Unlike a Self-Settled Special Needs Trust, a Joinder Agreement for a Pooled Trust may be signed by the individual. The Joinder Agreement can also be signed by the parent, grandparent, guardian or court.
- *Payback.* A Pooled Trust must contain a payback provision repaying the State Medicaid Agency for benefits paid to the disabled individual during his lifetime.

4.4. Constructive Receipt

Payment of funds by the defendant to the plaintiff or the plaintiff's personal injury attorney constitutes constructive receipt by the person with a disability and may cause a loss of means-tested benefits and create tax issues. Payments from the defendant or from the structured settlement should be made directly to the Special Needs Trust.

5. SETTLEMENT PRESERVATION TRUST

There are many situations in which a Special Needs Trust may not be required. It might be advisable to place all or most of the settlement funds in a trust. A Settlement Preservation Trust is designed to protect beneficiaries from exploitation. There may be a bad boyfriend or even a family member waiting in the wings to pounce on the settlement. Many of these beneficiaries have limited capacity. Some even are brain injured and are unable to resist the temptation to either give money away or squander it. Placing the funds in a Settlement Preservation Trust helps solve this problem.

Settlement Preservation Trusts are also useful in many states where there is a minor or incompetent person. Rather than placing the funds in an account with the court, the monies can be placed in a trust with a professional trustee. In the case of a minor, the funds can be held beyond the plaintiff's 18th birthday.

6. PUBLIC BENEFITS

Many injured plaintiffs are unaware of the fact that they are entitled to public benefits. These benefits include:

⁹ POMS SI 01120.203 B 2 d.

- **SSI.** This is a monthly income program. In 2010, it pays approximately \$705.25. Persons eligible for SSI automatically receive Medicaid in New Jersey. Eligibility for SSI is based on income and assets.
- **SSDI.** SSDI is also an income program. Eligibility and the amount of the monthly payment are dependent on the applicant's work history. There are no income or asset tests for SSDI.
- **Section 8 Housing.** Section 8 Housing is low-income housing where, typically, the plaintiff pays 30% of his or her income and the federal government pays the rest. There is no asset test for public housing, but eligibility is based on income. Special housing units exist for persons with disabilities.
- **Group Home.** Many injured plaintiffs are unable to live by themselves in the community. There are group homes available for those who qualify medically. Those who can afford to pay must do so. Those who cannot afford to pay can become eligible for a Medicaid waiver. A special needs trust is usually helpful in achieving financial eligibility.
- **Food Stamps.** Food stamps provide monies for needy families to purchase food. Eligibility is based on federal poverty guidelines issued annually. Financial eligibility is based on household income. There are both asset and income tests for food stamp eligibility.
- **Medicaid Waiver Programs.** Medicaid waiver programs provide a considerable amount of home care to persons with disabilities. While there are income and asset tests for most programs, some programs do not count the income and assets of a parent in determining eligibility. Programs are available to provide up to 16 hours a day of home care in certain situations.

7. MEDICARE SET-ASIDE ARRANGEMENTS

There is an issue as to whether the Medicare Secondary Payer Act applies to third party liability claims and requires a Medicare Set-Aside Arrangement.

7.1. The Argument Requiring MSAs in Liability Cases

Although Medicare has not traditionally enforced its rights under the MSPA with respect to third-party liability cases, it is clear that the Act applies to those cases. Lack of enforcement by Medicare may soon change. Beginning July 1, 2010, all insurers, third-party health plans, self-insured plans, and self-administered plans must identify situations where the Plan is or has been a primary plan to the Medicare program.¹⁰ The Plan must determine whether the claimant is entitled to benefits under the Medicare program and, if so, the Plan must submit a report

¹⁰ 42 U.S.C. §1305, Medicare, Medicaid and SCHIP Extension Act of 2007.

including the identity of the claimant¹¹ and such other information as the Secretary shall specify.¹² This would seem to be the beginning of an enforcement effort by CMS in third-party liability cases.

An attorney representing a Medicare recipient has an obligation to notify Medicare upon being retained¹³ and to see that Medicare's interests are protected.¹⁴ It would appear at this time that Medicare is encouraging parties to calculate a set-aside amount and establish an MSA, even though there is no mechanism for enforcement in a third-party liability case or for CMS review or approval of the proposal.

"At this time, the Centers for Medicare and Medicaid Services (CMS) is not soliciting cases solely because of the language provided in a general release. CMS does not review or sign-off on counsel's determination of the amount to be held to protect the Trust Fund in most cases. We do, however, urge counsel to consider this issue when settling a case and recommend that their determination as to whether or not their case provided recovery funds for future medicals be documented in their records. Should they determine that future services are funded, those dollars must be used to pay for future otherwise Medicare covered case-related services."¹⁵ The only exception to establishing a Medicare Set-Aside Arrangement would be if it can be documented that the beneficiary does not require any further WC claim-related medical services. Presumably, this would also apply in a third-party liability case.¹⁶

There is no formal CMS review process in the liability arena as there is for worker's compensation.

On rare occasions, when the liability is large enough, or other unusual facts exist within the case, the CMS Regional Office will review the settlement and help make a determination on the amount to be available for future services.

It is understood that CMS offices in the Atlanta region and the Dallas region are reviewing Medicare Set-Aside proposals in third-party liability cases and granting approvals.

It is likely that at some point in time insurance companies will begin requiring MSAs in third-party liability cases in order to eliminate any risk on their part for failing to establish an MSA.

¹¹ 42 U.S.C. §1395y(b)(8)(a) & (b).

¹² 42 U.S.C. §1395y(b)(7).

¹³ 42 U.S.C. §1395y(b).

¹⁴ 42 C.F.R. §§411.24 and 411.24(g).

¹⁵ Sally Stalcup, Region 6, MSP Regional Coordinator, Special Needs Alliance Boot Camp, April 10, 2009.

¹⁶ *Id.*

7.2. The Argument Against an MSA Being Required in Third-Party Liability Cases

One argument against an MSA being required in third-party liability cases is based on a letter to Sally Hart at the Center for Medicare Advocacy from Thomas Bosserman stating that "Medicare is the primary payer for accident-related medical services obtained after the Date of Settlement." The only exception to this policy would be if a Liability settlement, judgment, or award specifically includes an *allocation* or designation for future accident-related medical services.¹⁷ It should be noted that this letter significantly pre-dates the Medicare, Medicaid, and SCHIP Extension Act of 2007 and its implementation in third-party liability cases, which will not begin until July 1, 2011. It should also be noted that the letter was written when enforcement of MSAs in WC cases was in its infancy and before guidelines were developed in the WC arena. It is rare that a settlement agreement, release, or court order makes an allocation for future medicals, but this does not mean that the settlement did not include payment for such future medicals.

The Garretson Firm Resolution Group takes a similar position.¹⁸ The Garretson Firm states that CMS has yet to release formal standards or guidance for review of liability insurance settlements. The Paper also states, "The fundamental statutory principle requiring settling parties to consider and protect Medicare's interest in WC settlements already exists and appears to apply to liability settlements as well...The MSA obligation in a liability settlement, however, is only clear (on its face) in the specific case where a definitive allocation for future injury-related medical expenses exists for an injured Medicare beneficiary. An example is a verdict sheet with a future medical expense line item or albeit rare - a settlement release with a definitive allocation for future medical treatment..."

The Medicare Secondary Payer Act has been in effect since 1980. It has not been enforced to date. What is the likelihood of CMS beginning to enforce it now? What is the likelihood of CMS enforcing it retroactively?

CMS acknowledges that it currently does not have the manpower to review every MSA submission in liability cases. Depending on the size of the case and the availability of personnel, it is understood that Dallas, Chicago, Atlanta, and Philadelphia will review MSA submissions.

7.3. When is an MSA not Required?

An MSA is not required if the plaintiff is not a current Medicare beneficiary and has no "reasonable expectation of Medicare enrollment within 30 months of settlement."¹⁹ For purposes of defining "reasonable expectation" CMS includes the following criteria:

¹⁷ Letter to Sally Hart, Center for Medicare Advocacy, from Thomas Bosserman, Health Insurance Specialist, Program Integrity Branch, Division of Financial Management, CMS, July 3, 2002.

¹⁸ MSA White Paper: The Use and Propriety of Medicare Set Asides in Liability Settlements, John Cattie, Matthew Garretson, Sylvius Von Saucken and Jason Wolf (Aug. 19, 2009).

¹⁹ Medicare Secondary Payer (MSP) – Worker's Compensation (WC) Additional Frequently Asked Questions, May 23, 2003.

- Claimant is receiving SSDI benefits at the time of settlement
- Claimant has applied for SSDI or has applied and been denied but anticipates appealing the decision
- Claimant is in the process of appealing and/or re-filing for SSDI benefits
- Claimant is age 62.5 or older at the time of settlement
- Claimant has End Stage Renal Disease (ESRD) but does not yet qualify for Medicare based on ESRD

A Medicare Set-Aside is not required if from the *facts of the case* it is clear that there will be no future medicals.

7.4. Amount of the Set-Aside

There are allocation companies that will calculate the amount of money that should be set aside to satisfy CMS. In a third party liability case, some Regions will review a submission of that calculation and others will not. If a submission is made and CMS does not review it, the party's obligations to consider Medicare's interest should be satisfied. The amount to be set aside is based on only those services that Medicare would provide, that are related to the injury, and in amounts that Medicare would pay. By funding the set aside with a structured settlement, generally a cost saving of roughly 50% is achieved.

8. LIEN RESOLUTION

Prior to a case being resolved, outstanding liens must be satisfied. A list of liens is as follows:

- Medicaid Liens
- Medicare Liens
- Medicare Part D/Medicare Advantage
- ERISA
- State Worker's Compensation
- Federal Employee Compensation Act
- Hospital Liens
- Veterans Administration Claims
- Federal Employee Health Benefits Act
- U.S. Medical Care Recovery Act
- TRICARE Claims

- Welfare Liens
- New Jersey Division of Mental Health Liens
- Charity Care

8.1. Reducing the Medicaid Lien

There are a number of strategies available to reduce the amount of the lien that may be claimed by Medicaid. The Medicaid lien applies only to expenditures made on behalf of the Medicaid recipient prior to settlement. The third party is liable for expenses only from the date of the injury until the date of settlement. Therefore, counsel should report a settlement to Medicaid and obtain release figures, even prior to approval of the settlement by the court.

8.1.1. Pro Rata Share/Ahlborn

After a series of cases around the country divided on the issue of whether the State Medicaid Agency may recover from that portion of a settlement not earmarked for past medical expenses, the U.S. Supreme Court decided the issue in the *Ahlborn* case.²⁰

- ***Assignment of Claim Against Third Party.*** As a condition of Medicaid eligibility, the individual is required to assign to the state any rights to payment for medical care from any third party. The Arkansas statute required that if the lien exceeds the portion of the settlement representing medical costs, satisfaction of the lien requires payment out of proceeds meant to compensate the recipient for damages distinct from medical costs, such as pain and suffering, lost wages, and loss of future earnings. In the *Ahlborn* case, the plaintiff was involved in an automobile accident. Medicaid paid \$215,645.30 on her behalf. Plaintiff filed suit for past medical costs and for other items, including pain and suffering, loss of earnings and working time, and permanent impairment of her future earning ability. The case was settled for \$550,000, which was not allocated between categories of damages. The plaintiff and the State Medicaid Agency stipulated that the settlement amounted to approximately 1/6th of the reasonable value of Ahlborn's claim. The Court held that federal law requires states to ascertain the legal liability of third parties and to seek reimbursement for medical assistance to the extent of such legal liability. The court stated that the federal requirement that states "seek reimbursement for medical assistance *to the extent of such legal liability*" refers to the "legal liability of third parties *to pay for care and services available under the plan.*" Here, because the plaintiff received only 1/6th of her overall damages, the right of the state of Arkansas was limited to 1/6th of the past medical claim or \$35,581.47.

²⁰ Arkansas Dep't of Health and Human Servs., v. Ahlborn, 126 S. Ct. 1752 (2006).

- ***Anti-Lien Statute.*** The court also held that 42 U.S.C. §1396p(a)(1) prohibits states from imposing liens "*against the property of any individual prior to his death on account of medical assistance paid ... on his behalf under the state plan.*" This prevents the state from attaching the past *non-medical portion of the settlement*. As a result of this ruling, states can assert a Medicaid lien only against that portion of a settlement earmarked for past medical expenses. The state may not recover against non-medical expense claims, such as pain and suffering, loss or earnings and permanent loss of future earnings. Needless to say, it is good practice in a personal injury settlement to make a clear allocation of damages. The court held that it did not have to reach the question as to whether the anti-lien provisions of the Medicaid statute barred the agency from making subrogation claims. The court specifically reserved that decision for another day.
- ***Allocation.*** Allocation is not only important, but also it must be fair. As Justice Stevens said in the *Ahlborn* opinion, "Although more colorable, the alternative argument that a rule of full reimbursement is needed generally to avoid the risk of settlement manipulation also fails. The risk that parties to a tort suit will allocate away the state's interest can be avoided either by obtaining the state's advanced agreement to an allocation or, if necessary, by submitting the matter to a court for a decision."
- ***Pro Rata Share.*** The significance of the *Ahlborn* case is that it is now clear: Medicaid's right to reimbursement attaches only to the portion of the settlement or judgment or award that represents payment for medical expenses and not for proceeds intended to cover other items, such as pain and suffering and loss of wages. Therefore, under *Ahlborn*, Medicaid may recover only a pro rata share of its claim, which is determined by the ratio that the settlement amount bears to the reasonable value of the total claim.
- ***Future Medicals.*** Throughout the decision the court referred to "medical services" without distinguishing between past and future medical services. To date, State Medicaid Agencies around the country have seemed to focus on collecting for past medicals rather than future medicals.

8.1.1.1. Reasonable Value of the Claim

Cases settle for less than the full value of the case where there are issues with respect to liability or where the recovery is limited by the limits of the insurance policy or by comparative fault or contributory negligence. Some states, by statute, require that the state is a party to the action and may be involved in the settlement negotiation.²¹

The issue now becomes how to value the entire case. What is the reasonable value of the entire claim? The *Ahlborn* court addressed the "risk of settlement manipulation" by reasoning

²¹ Wis. Stat. §49.89.

that "the risk that parties to a tort suit will allocate away the state's interest can be avoided by either obtaining the state's advance agreement to an allocation or, if necessary, by submitting the matter to a court for a decision." Alternatives for establishing the full value of the case might include the following:

- **Medicaid Stipulation.** It may be possible, as in the *Ahlborn* case, to obtain a stipulation between the plaintiff and Medicaid as to the reasonable value of the claim. Post-*Ahlborn* this may be unlikely.
- **Defendant's Stipulation.** Although Medicaid may be unwilling to enter into a stipulation with respect to the fair value of the case, the defendant may be willing to do so. It is questionable as to whether a State Medicaid Agency would accept a stipulation between the plaintiff and the defendant, because such a stipulation might be easily manipulated after the case is settled.
- **Expert Witness.** An expert witness may be obtained to write a report determining the fair value of the case with reasons to support the conclusions. The expert witness might be a personal injury attorney with an outstanding reputation in the community. The expert witness report might be used in negotiating a settlement with Medicaid or admitted to a court as a basis for a court order. The expert witness report might also include a recitation of the reasons why the case was settled for less than the full amount of the loss. These reasons might include the uncertainty of jury verdicts, uncertainty about establishing liability, insured's policy limits, and limited liability insurance coverage of uninsured defendants.
- **Court Order.** A court order may be obtained allocating the settlement among various categories of damages. Any court hearing should be on notice to the State Medicaid Agency.

8.1.1.2. Timing of Ahlborn Lien Resolution

It is good practice to resolve the Medicaid lien prior to final settlement of the case. Pennsylvania has taken the position that it will not enter into *Ahlborn* negotiations *after a settlement has occurred*.²² The letter states, "A personal injury plaintiff is usually deemed as a matter of law to have recovered the full amount of her medical expenses as part of a settlement. A complete settlement of a tort claim waives a plaintiff's right to a judicial determination of his losses, and conclusively establishes the settlement amount as full compensation for damages. *Associated Hosp. Services of Philadelphia v. Pustilnik*, 396 A.2d 1332 (Pa. Super. 1979), vacated on other grounds, 439 A.2d 1149 (Pa. 1981); *Goldberg v. Workmen's Compensation Appeal Bd.*, 620 A.2d 55 (Pa. Cmwlth. 1993). Attempts to introduce evidence of an allocation of damages *after a settlement has occurred* are almost always rejected by Pennsylvania courts. *See, e.g., Strickler v. Desai*, 813 A.2d 650 (Pa. 2002) (emphasis added)." This interpretation is based on Pennsylvania statute and official statements of policy. Under Pennsylvania law in the absence of

²² Letter from Marisa L. Cohan, Department of Public Welfare, Division of Third Party Liability, to Kemp C. Scales, Sept. 27, 2007.

a court order allocating tort proceeds among categories of damages, one-half of the net proceeds are allocated by law to be available to repay injury-related Medicaid expenses.²³ If a beneficiary or other party seeks to obtain a court order limiting the portion of the tort recovery from which Medicaid reimbursement may be paid to an amount less than one-half of the net proceeds, notice must be given to the Department of Public Welfare.²⁴ The Department of Public Welfare is not bound by a private agreement between the parties to a tort claim regarding allocation of proceeds.²⁵

A State Medicaid Agency has issued a Statement of Policy²⁶ stating that the department will recover only from that portion of a tort recovery that represents payment of medical expenses by a third party. The department will not recover from a portion of a tort recovery that represents payment for lost wages, pain and suffering, or other non-medical damages. However, the department will rely on existing statutory law to determine the portion of a tort recovery that represents payment of medical expenses. *Ahlborn* does not affect state laws governing the allocation of tort proceeds. Commonwealth law provides that a complete settlement of a tort claim conclusively establishes the settlement as full compensation for damages, and a plaintiff will not be heard to complain that he settled for less than the full value of the claim. Private parties cannot allocate a settlement to put part of it beyond the reach of the department.

Therefore, in Pennsylvania the Medicaid lien by default attaches to 50 percent of the recovery unless there is a court order on notice to the Department of Public Welfare that there will be a lesser allocation to medicals. A post-settlement allocation will not be considered.

8.1.1.3. *Lien Against Future Medicals*

There is an issue in some states, including Montana, as to whether Medicaid may recover its lien as it exists as of the date of settlement from the portion of the medical expenses allocated for future medical expenses as well as those allocated for past medical expenses. Medicaid's right of recovery is based on federal statutory language under which a Medicaid applicant assigns to the State Medicaid Agency any rights to "medical care." The statute does not specify if that applies to past/future care or both. It seems reasonable to assume that both past and future medical care are included in the assignment.

A Florida court in denying *Ahlborn* relief to an injured plaintiff held that without knowing how much a plaintiff's total damage claim was comprised of medical expenses, there is no way to calculate the medical expense portion of the settlement by simply comparing the damage claim to the ultimate settlement amount. The court stated that the plaintiff should have the obligation to demonstrate with evidence that the lien amount exceeds the amount recovered

²³ Title 55 Pennsylvania Statutes §259.2(b)(2).

²⁴ *Id.* at (3).

²⁵ *Id.* at (5).

²⁶ 37 Pa. Bull. 4881 (Sept. 8, 2007).

from medical expenses. The court appeared to include both past and future medical expenses in its reasoning.²⁷

The other side of the argument is that the Medicaid anti-lien provision²⁸ covers liens for payments "paid or to be paid." The federal anti-lien statute limits the state's power to pursue recovery of funds it *paid* on a recipient's behalf,²⁹ which states that no lien may be imposed against the property of an individual prior to his death on account of medical assistance paid or to be paid on his behalf under the state plan "(1) except:

(A) pursuant to the judgment of a court on account of benefits *incorrectly* (emphasis added) ... (b) adjustment or recovery of medical assistance *correctly paid* under the state plan."

This language would seem to limit Medicaid's right of reimbursement to the amount allocated for past care rather than future care.

8.1.1.4. Multiple Jurisdictions

An interesting issue arises where a plaintiff has received Medicaid from more than one jurisdiction. How is the reasonable value of the case determined? To what extent may each jurisdiction assert a claim when state law varies from one jurisdiction to the other? For example, some states require notice to the State Medicaid Agency, others do not. Some states have statutory default provisions, such as the agency is entitled to the amount actually paid not to exceed a certain percentage of the total settlement, i.e., one-third or one-half, others have no such default provisions.

8.1.2. Post-Ahlborn

A series of cases post-*Ahlborn* have raised a number of interesting issues, which are discussed in the following sections.

8.1.2.1. The Effect of a State Statute

- **Full Reimbursement.** In a case decided subsequent to the *Ahlborn* decision, a Florida court seemingly ignored that opinion.³⁰ Anna Ross was the personal representative of her husband, Alexander Ross, who sustained fatal injuries in an automobile accident. Medicaid paid \$168,691.58 for Alexander's medical expenses. Pursuant to the Florida statute, Medicaid received an automatic lien for the full amount of medical expenses paid on his behalf. The case was

²⁷ Smith v. Agency for Health Care Administration, Case No. 5D08-1142, District Court of Appeals of the State of Florida, Fifth District, July Term 2009.

²⁸ 42 U.S.C. §1396p(a).

²⁹ 42 U.S.C. §§1396a(a)18 and 1396p.

³⁰ Ross v. Agency for Health Care Admin., No. 3D05-1626 (Fla. App. 3d Dist. Aug. 16, 2006).

settled for \$925,000. An attempt was made to allocate that sum among the survivors, the attorneys and the Agency, allocating for the Medicaid Agency an amount that satisfied 25 percent of the total Medicaid lien. The court held that the personal representative does not have the right to allocate settlement funds in such a manner, that the Agency receives less than the full amount of its expenditures for medical assistance. The court noted that Florida statutes require that Medicaid be fully reimbursed, unless full reimbursement would take away more than half of a third-party benefit.

- **Default Statutes.** The North Carolina Supreme Court upheld a North Carolina statute requiring payment of the full subrogation amount or one-third of the gross settlement, whichever is less. The court held that the statute complied with *Ahlborn* and the Federal Anti-Lien statute.³¹ The court stated that, "Because *Ahlborn* does not mandate a specific method for determining the medical expense portion of a plaintiff's settlement, we uphold North Carolina's reasonable statutory scheme...." In the case at Bar, the plaintiff obtained a recovery for medical malpractice for injuries sustained at birth. The trial court determined that the North Carolina Division of Medical Assistance (DMA) has subrogation rights to the entire amount of the settlement, limited by the statutory provision that only one-third of the recovery is subject to subrogation.³² Because the amount expended by the DMA was less than one-third of the settlement, the trial court ordered full reimbursement. The supreme court held that *Ahlborn* does not mandate a judicial determination of the portion of a settlement from which the state may be reimbursed for prior medical expenditures. The states were left to decide on measures to employ in the operation of their Medicaid programs.
- **Agreement or Court Order.** Subsequent to the *Ahlborn* case, California amended its statute to limit the State Medicaid Agency's right of recovery to "that portion of the settlement, judgment, or award that represents payment for medical expenses, or medical care, provided on behalf of the beneficiary." The statute goes on to say that all reasonable effort should be made to obtain the Medicaid Director's advance agreement as to that amount, and failing agreement the matter shall be submitted to a court for decision.³³ The court held that absent an agreement between the plaintiff and the State Medicaid Director, a trial must determine the amount to which the State Medicaid Agency is entitled.³⁴
- **Notice.** A subsequent California case held that the plaintiff must notify the State Medicaid Agency of a pending settlement of a personal injury claim so that the State Medicaid Agency could participate in establishing the

³¹ Andrews *ex rel.* Andrews v. Haygood, 362 N.C. 599 (2008).

³² N.C.G.S. §108A-57(a) (2005).

³³ California Welfare and Institutions Code §14124.76(a).

³⁴ Bolanos v. Superior Court, 169 Cal. App. 4th 744 (2008).

percentage of the settlement attributable to medical expenses before the settlement was approved.³⁵

By statute in Mississippi, no compromise with a Medicaid recipient of a claim against any third party is conclusive, unless the State Medicaid Agency has received notice and an opportunity to participate in the settlement.³⁶

- ***Assignment of Rights/Notice.*** In a very thoroughly analyzed opinion, the United States District Court for the Western District of Pennsylvania discussed a Pennsylvania statute providing a Medicaid lien on a personal injury recovery not to exceed one-half of the total recovery, unless a court finds a different allocation for reimbursement for medical expenses. The case discussed the Federal Anti-Lien provisions and the assignment of rights by a Medicaid recipient to the State Medicaid Agency to receive payments for medical care.³⁷ The State Medicaid Agency contended that the statute³⁸ providing that the Department's claim that the plaintiff's recovery is subject to a claim by the State Medicaid Agency not to exceed one-half of the beneficiary's right to recovery is a statutory default rule. The rule is applied only in the absence of a judicial allocation of damages not to exceed the amount actually spent by DPW. The court held that *Ahlborn* does not prohibit states from implementing procedures on how to allocate unallocated settlements.

The court went on to hold that the anti-lien provisions contained in federal law³⁹ ban even a lien on that portion of the settlement proceeds that represents payment for medical care. However, the court held that the state can require assignment of the right or chose in action to receive payments for medical care. The result of the court holding appears to be that Medicaid liens against personal injury settlements are invalid, but that the State Medicaid Agency may intervene in litigation to protect its interests under the assignment of rights from the Medicaid recipient to recover medical expenses from third parties. It would further appear that notice to the State Medicaid Agency would be required to give the agency a meaningful right to assert its claim by intervening in the litigation. Based on this decision, good practice may dictate that even in arbitration or settlement negotiations, the State Medicaid Agency be invited to participate so that the amount of its lien can be determined at that time.

³⁵ *McMillian v. Stroud*, 166 Cal. App. 4th 692, 83 Cal. Rptr. 3d 261 (2008).

³⁶ Miss. Code Ann. §43-13-125(3).

³⁷ *Tristani v. Richman*, 2009 WL 799747 (W.D. Pa. Mar. 25, 2009).

³⁸ 62 PA. Stat. Ann. §1409(b)(11).

³⁹ 42 U.S.C. §1396p(a).

8.1.2.2. *Establishing the Full Value of the Case*

Two New York cases upheld the right of a court to allocate the settlement proceeds between medical and non-medical expenses. In an unpublished case,⁴⁰ the Supreme Court of Queens County ruled that the plaintiff was entitled to a reduction of the Medicaid lien following an *Ahlborn* line of reasoning. The court held that *Ahlborn* suggested a formula to determine what portion of a settlement represents past medical expenses. The court suggested that the ratio between the settlement amount and the actual value of the case should be determined and the ratio should be applied to medical expenses. In *Ahlborn*, the parties stipulated to the full value of the claim. In the *Jain* case, the parties did not stipulate, and the court conducted a hearing and allowed the parties the opportunity to submit evidence. The court then determined the value of the claim and followed the *Ahlborn* formula with respect to the ratio between the settlement amount and the actual value of the case.

In a second New York case,⁴¹ the Supreme Court of New York applied the rationale in the *Ahlborn* case. The case involved a settlement of \$3.5 million in a medical malpractice case. The State Medicaid Agency filed a lien for \$47,349.58. The court held that *Ahlborn* limits the State Medicaid Agency recovery to the portion of the settlement allocated to past medical expenses, that the court can allocate the settlement proceeds and that funds be disbursed less the \$47,349 claimed by the State Medicaid Agency pending a conference between the parties.

As a practical matter, how can the value of the case be determined? Suggestions include:

- ***Complaint.*** Examine the Complaint.
- ***Life Care Plan.*** What does the Life Care Plan suggest?
- ***Economist Report.*** What does an Economist Report suggest?
- ***Jury Determination.*** The problem with a jury determination is that often the verdict is for a lump sum. To be effective in an *Ahlborn* situation, the jury has to break down the award so that there is specific allocation for past medical expenses.
- ***State Proofs.*** Ask the state if they are going to produce evidence.
- ***Jury Verdict.*** Retain Jury Verdict to make an analysis of the past medicals. This is, in effect, an expert opinion.

A California court proposed a process for valuing the case. The recommended steps are as follows:

- The court requested that the parties attempt to reach an agreement regarding the true value of the case.

⁴⁰ Chambers v. Jain, 2007 N.Y. Slip. Op. 50776 (U).

⁴¹ Luego v. Beth Israel Med. Ctr., 13 Misc. 3d 681, 819 N.Y.S.2d 892 (2006).

- The court recognized that the parties might need to conduct discovery in order to evaluate the lien.
- Failing agreement, the court ordered that either party could seek resolution by the court.

In the California case, the plaintiff produced declarations by a certified public accountant, physician and a certified nurse life care planner to prove the economic value of the case. The State Medicaid Agency said it could not produce additional evidence in support of its lien, because it was never included in the settlement negotiations or proceedings. The Department did not explain why it could not offer its own experts to present evaluation of economic damages. The trial court requested the Department to participate by submitting its reasons for valuing the lien. The Department failed to do so. The court dismissed the Department's objections.⁴²

8.1.2.3. *Notice to Medicaid*

In a Louisiana case, the parties to the suit entered into a consent judgment settling the plaintiff's claims. The settlement represented 25 percent comparative fault on the part of all defendants. The court held that the State Medicaid Agency was limited to 25 percent of the lien asserted. The court stated that "DHH clearly had knowledge of this suit; however, never asserted its rights under La. R. S. 46:446(A). DHH had the opportunity to intervene in this suit, but did not do so." DHH argued that here, unlike in *Ahlborn*, DHH did not stipulate either as to the value of the plaintiff's case or to the amount to which it would be entitled if it could not place a lien on the settlement. DHH maintained that instead of having a judicial determination or stipulation as to the categories of damages, the parties decided on categories of damages and simply asked the court to sanction their agreement. DHH argued that the plaintiff's failure to serve a copy of the petition on DHH resulted in DHH not having the information needed to protect its rights. The State Medicaid Agency acknowledged that plaintiff advised DHH of her attorney's name. DHH requested a copy of the petition for damages, but was never served. The court held that although DHH was never properly served, it did have notice of the case but made no effort to raise any claims it may have against plaintiff or others.

Practice Tip: In a case involving an *Ahlborn* settlement, plaintiff's counsel should always serve formal notification upon the State Medicaid Agency. Some states require notification by statute.⁴³

8.1.3. **Multiple Parties**

Where there are multiple parties involved in an action, the Medicaid lien would appear to extend only to assets recovered by the personal injury victim because no medical expenses were paid by Medicaid as a result of the accident to the remaining parties, such as parents or spouses. In such cases, counsel should carefully allocate the recovery that is between the various parties.

⁴² Lopez v. Daimler Chrysler Corp., 2009 Cal. App. Unpub. LEXIS 8836, Appeal No. C058592 (Nov. 5, 2009).

⁴³ Wis. Stat. §49.89.

8.1.4. Procurement Costs

It is common for State Medicaid Agencies to reduce the Medicaid lien by the amount of the attorneys' fees and costs. These are often called procurement costs. The Utah Supreme Court⁴⁴ held that state law in Utah does not require the state to pay attorneys' fees. Peggy Sue Streight obtained a recovery from an automobile accident case. Medicaid sought recovery. Streight sought a reduction in the Medicaid lien for attorneys' fees incurred by Streight. It should be noted that neither Streight nor her attorneys requested nor obtained the state's consent before entering into the settlement.

A Florida court has held that Medicaid liens due to the State of Florida may not be reduced to reflect attorney's fees and costs attributable to recovering the lien amount from a third-party tortfeasor.⁴⁵ The practice in many other states is to allow a reduction in the Medicaid lien to reflect the attorney's fees and costs attributable to recovering the lien amount. A negotiating strategy with the State Medicaid Agency would be to indicate that absent payment of procurement costs, the plaintiff will not file a suit.

8.2. The Medicare Lien

The Medicare Secondary Payer Act (MSP) governs all claims for recovery of Medicare payments for accidents or injuries.⁴⁶

8.2.1. Medicare's Right of Recovery

Medicare's right of recovery has priority over any subrogated right, and also has priority over Medicaid.⁴⁷

Medicare will recognize a proportionate share of the necessary procurement costs incurred in obtaining a settlement. Procurement costs are court costs and attorney's fees.⁴⁸ Medicare's payment from the beneficiary is reduced by the proportionate share of procurement costs. The reduction for attorneys' fees and expenses is calculated as the percentage of the total settlement sum and serves as the same percentage reduction of the conditional payment amount. (Total attorneys' fees and costs)total settlement amount = percent reduction)

8.2.2. Settlement of Claim

Under certain circumstances, Medicare claims may be waived in whole or in part or may be compromised:

⁴⁴ Streight v. Utah Office of Recovery Servs., 2004 Utah 88, 108 P.3d 690 (2005).

⁴⁵ Florida v. Wilson, No. 1D00-810 (Fla. Dist. Ct. App. Apr. 12, 2001).

⁴⁶ 42 U.S.C. §1395y(b)(2).

⁴⁷ 42 C.F.R. §411.24(j).

⁴⁸ 42 C.F.R. §411.37(c).

- ***Lump-Sum Compromise Settlement.*** Cases will be compromised where there is questionable liability. In such cases, counsel notifies Medicare of the strengths and weaknesses of the defendant's case in order to justify a reduction of the Medicare claim. The beneficiary is entitled to an appeal to adverse decision on the request for waiver or compromise pursuant to section 870(c) of the Social Security Act.

Where there is a "Lump-Sum Compromise Settlement" providing less than total compensation because of questionable liability, Medicare should review the compromise settlement prior to approval by the parties. As long as the settlement provides a reasonable amount for future medical expenses, Medicare will approve the settlement. If Medicare approves a settlement for less than the claimant's outstanding injury-related medical expenses, Medicare applies the settlement proceeds to medical expenses in a coordinated fashion.

EXAMPLE Paul is injured in an automobile accident. Medicare spends \$75,000 on his medical expenses. There is a question as to the actual cause of the accident. Plaintiff's counsel feels that the case is worth \$300,000, but because of the question of liability, recommends a settlement of \$150,000. The proposed allocation would be \$50,000 for past medical expenses; \$50,000 for pain and suffering; and \$50,000 for lost wages. The entire settlement should be submitted to Medicare for approval prior to final approval by the parties. If Medicare is satisfied that liability is questionable, it would probably approve the settlement.

- ***Allocation of Damages Within the Settlement.*** Damages within the settlement are allocated for Medicare claim purposes among past medical expenses, compensatory damages, and pain and suffering. Only the portion of the recovery allocated to past medical expenses is available to satisfy the Medicare claim.

Practice Tip: One way to reduce a Medicare lien would be by a court order allocating the settlement among the various components, including medical, upon notice to Medicare.

8.3. Medicare Part D/Medicare Advantage

Medicare Part D provides prescription coverage to eligible beneficiaries. Medicare Part D is covered by the Prescription Drug Plans (PDP). PDP is similar to Medicare Managed Care Plans known as Medicare Advantage, and they have a separate right of recovery from Medicare. Both Medicare Part D and Medicare Managed Plan will need to initiate their own recovery efforts since they are not part of the traditional Medicare recovery effort.

It can be argued that Medicare Part D and Medicare Advantage do not have any lien rights against personal injury settlements.⁴⁹ This is not to say that they have no recovery rights. Any recovery rights are based in contract rather than the MSPs statute.

Technically, Medicare Part C Plans have the same right of reimbursement as traditional Medicare Parts A and B, but do not have a lien. They are reimbursed according to the insurance contract and governing state law. The obligation to repay is set forth in federal law.⁵⁰ "If a Medicare enrollee receives from a Medicare Advantage organization covered services that are also covered under State or Federal workers' compensation, any no-fault insurance or any liability insurance policy or plan...the MA organization may bill...to the Medicare enrollee to the extent he or she has been paid by the carrier, employer or entity for covered medical expenses."

The Medicare statute says, "The eligible organization may...charge or authorize the provider of such services to charge...such member to the extent that the member has been paid under such law, plan, or policy for such services."⁵¹ While traditional Medicare has an automatic statutory right of recovery,⁵² the Medicare Advantage Plans have only a right to recover but no statutory claim. While Medicare must be given affirmative notice of a third party liability claim, there is no such requirement for Medicare Advantage Plans. CMS maintains records of all third party liability claims involving traditional Medicare recipients, but does not maintain similar records for Medicare Advantage Plan recipients. There's no single source through which to verify coverage, payments or reimbursement rates.

It is important in settling a claim involving a Medicare Advantage Plan to be aware that there may be a Medicare lien for the traditional Medicare Parts A and B for conditional payments made under the Medicare Secondary Payer Act, as well as a right of recovery for Medicare Advantage for payments made by the MA Plan. In resolving a Medicare Advantage claim, the attorney should contact the MA provider requesting a claims itemization and should include a HIPAA release. The attorney should also request a copy of the Summary Plan Description (SPD). The plan's right of recovery should be assessed and negotiated based on the subrogation language found in the SPD and governing law.

8.4. ERISA

There are two types of ERISA Plans, those that are self insured and those that are insured by third party insurance companies. Self Funded ERISA Plans are governed by the ERISA statute. Subrogation under ERISA Plans insured by third party insurance companies are governed by state insurance laws. In a self funded ERISA Plan, there is federal preemption and the ERISA Plan may have a lien on a third party liability recovery. This will depend on the

⁴⁹ Medicare Reimbursement Claims, Frank Verderane, American Association for Justice teleseminar (April 24, 2007) <fverderane@plattner-verderane.com>.

⁵⁰ 42 C.F.R. §422.108(d).

⁵¹ 42 U.S.C. §1395mm(e)(4).

⁵² 42 U.S.C. §1395y.

language in the Plan. In third party liability cases where the ERISA Plan is insured by a third party insurance company, there will be no ERISA lien.

8.4.1. Appropriate Equitable Relief

Relief under ERISA is based on equitable principles, rather than legal relief, in the form of money damages for breach of contract.⁵³

8.4.2. ERISA Qualification

To qualify as an ERISA plan, a plan must be:

- A Plan, funded program;
- Established or maintained by an employer or employee organization, or both;
- For the purpose of providing medical, surgical, hospital care, sickness, accident, disability, or other encumbered benefits stated in ERISA to participants or their beneficiaries.

It is clear that a medical insurance policy covering a self-employed person and spouse does not constitute an ERISA plan. In addition, ERISA does not apply to church, government or farm plans or self-pay insurance contracts.⁵⁴

8.4.3. Plan Language

An ERISA plan can recover for damages received from third parties where the plan language clearly establishes such a right. This Sereboff court did not address the issue of a "make whole doctrine," because it was not property before the court. Since an ERISA plan's right to reimbursement is based in equity, it is subject to equitable defenses based upon a strict reading of the actual contract language.

8.4.4. Specific Identifiable Fund

The Plan's right of recovery must be against a specific, identifiable fund, such as the tort recovery as opposed to a claim against the general assets of the plaintiff. Such a claim against general assets would be a claim at law, rather than in equity.

⁵³ Great West Life & Annuity Ins. Co. v. Knudson, 534 U.S. 204, 122 S. Ct. 708 (2002) largely overturned by Sereboff v. Mid-Atlantic Med. Servs., Inc., 547 U.S. 356 (2006).

⁵⁴ 29 U.S.C.A. §1003(b).

8.4.5. Derivative Claims

An ERISA lien is enforceable against the settlement of the injured beneficiary on whose behalf benefits are paid, but it is likely unenforceable against the derivative claims of others related to the incident.⁵⁵

8.4.5.1. *Wrongful Death*

State law often protects wrongful death claims from subrogation, so allocating more to wrongful death and less to the survival claim may reduce the lien. Also, the survival claim may be subject to federal or state estate or inheritance taxes. Medicare and Medicaid can collect even from wrongful death, because federal law preempts state law.

8.4.5.2. *Loss of Consortium*

Allocation of loss of consortium claims to those who do not have responsibility for medical bills, such as a spouse or child of the injured party, may avoid or reduce the health care lien.

8.5. State Worker's Compensation

Where there is a State Worker's Compensation claim and also a third party liability case and the third party liability case settles, there is a worker's comp lien against the third party liability proceeds. Frequently the worker's comp lien is negotiable because the worker's comp carrier is anxious to get the plaintiff off its books.

8.6. Federal Employees Compensation Act

Federal Employees Compensation Act (FECA) is the federal equivalent of State Worker's Compensation. It covers benefits under the Longshore and Harbor Worker's Compensation Act and the Federal Employees Compensation Act. Essentially the federal government has a lien under either of these two acts.⁵⁶

In cases where the third party liability recovery is obtained pursuant to a settlement the plaintiff's attorney is responsible to obtain settlement authority from the client's employer **prior to** entering into any Release or receiving any payment.

8.7. Hospital Liens

Every hospital, nursing home, licensed physician or dentist shall have a lien for services rendered, by way of treatment, care or maintenance after, to any person who shall have sustained

⁵⁵ Admin. Comm. of the Wal-Mart Stores, Inc. v. Gamboa, 479 F.3d 538 (8th Cir. 2007).

⁵⁶ 5 U.S.C. §§8131 and 8132

personal injuries in an accident as a result of negligence or alleged negligence of any other person.⁵⁷ Hospital liens are very difficult, if not impossible, to negotiate.

8.8. Veterans Administration Claims

The Veterans Administration (VA) has a right of recovery against a third party when the VA pays for medical treatment on behalf of the Veteran or his family.⁵⁸ The VA has a lien in favor of the United States against any recovery the Veteran or his family subsequently receives from a third party for the same treatment.

In any case where the Veteran is furnished care or services for a non-service-connected disability, the United States has a right to recover or collect reasonable charges for such care or services from a third party to the extent that the Veteran (or the provider of the care or services) would be eligible to receive payment for such care or services from such third party, if the care or services had not been furnished by a department or agency of the United States.⁵⁹

8.9. Federal Employee Health Benefits Act

Federal Employee Health Benefit Act (FEHBA) provides group health insurance benefits to federal employees.⁶⁰ The federal government enters into private contracts with insurance carriers. The federal statute does not contain lien language but most Plans contain subrogation or reimbursement provisions.

8.10. U.S. Medical Care Recovery Act

The U.S. Medical Care Recovery Act (MCRA)⁶¹ applies in all cases in which the United States provides or pays for medical care for a military person or dependent injured in a third party liability case. Under MCRA the government has a right to recover, either directly or indirectly, the value of medical treatment for which it pays or provides. The federal government may require an injured person to assign his claim to the government if the injured person does not pursue the claim.

8.11. TRICARE Claims

TRICARE claims are covered under the Federal Medical Care Recovery Act (FMCRA).⁶² The right of recovery includes care that may be received by the beneficiary at the Uniformed Services facility or under TRICARE, or both. Each branch of the service has a slightly different model agreement that must be signed when private counsel is asserting a

⁵⁷ N.J.S.A. 2A:44-36

⁵⁸ 38 U.S.C. §1729.

⁵⁹ 42 U.S.C. §1729(a)(1).

⁶⁰ 5 U.S.C. §8901

⁶¹ 42 U.S.C. §§2651-2653 (MCRA)

⁶² 42 U.S.C. §§2651-2653

separate cause of action to recover for injury-related care paid by TRICARE/CHAMPUS on a contingent basis.

8.12. Welfare Liens

In New Jersey, there is a lien against real and personal property of a person who has been assisted by or received support from any municipality or county. This is true whether a person has been in a county facility or at home.⁶³

8.13. New Jersey Division Of Mental Health Liens

The New Jersey Division of Mental Health Services has a lien against persons who receive treatment at psychiatric facilities. A person with a mental illness who is over the age 18 and is being treated in a state psychiatric hospital shall be liable for the full cost of his treatment, maintenance and all necessary related expenses.⁶⁴ In New Jersey, every person is personally liable for his maintenance and all necessary expenses incurred in a state or county institution.⁶⁵ These liens can easily be negotiated because of special legislation.⁶⁶

8.14. Charity Care

New Jersey has a Charity Care program for certain uninsured individuals. Generally, a person is eligible if family gross income is less than or equal to 300% of the poverty level for that individual's family size. Under Charity Care, a person receives reduced or free hospital care. There is a sliding scale based on income which specifies the percentage of hospital charges for which the person who is eligible for Charity Care is responsible. There are also asset eligibility requirements for full Charity Care and reduced charge Charity Care.⁶⁷ There is no provision in the statute for a lien for the Charity Care payment.

9. QUALIFIED SETTLEMENT FUND

A Qualified Settlement Fund (QSF) is also known as a 468b Trust. The Internal Revenue Code authorizes the establishment of QSFs.⁶⁸ The purpose of these funds is to permit the defendant in certain types of litigation to deposit funds into a trust and to receive a full and complete release of liability. The defendant is entitled to a current income tax deduction for the amount paid into the fund at the time the funds are deposited into the trust. There is an exception from the general rule under which the tax deduction is not permitted until the funds are actually disbursed to the plaintiff, which is normally the time in which the plaintiff has received the "economic benefit" of the settlement. There is an issue as to whether a QSF is valid if there is a single claimant. Generally, a husband and wife would be considered a single claimant. However, if funds are

⁶³ N.J.S.A. 4:4-91

⁶⁴ N.J.S.A. 30:4-60(c)(1)

⁶⁵ N.J.S.A. 30:4-66

⁶⁶ N.J.S.A. 30:4-60(c)(6)

⁶⁷ N.J.S.A. 26:2H-18.60

⁶⁸ I.R.C. §468(b).

deposited in the QSF to satisfy not only the plaintiff's claim but also claims of Medicaid, Medicare, other Lienholders and even the personal injury attorney's fee, then an argument could be made that each of those entities are separate claimants.

9.1. Advantage to the Parties

The advantage to the QSF is that the defendant can "pay and go" and the plaintiff has time to deal with issues such as lien resolution, allocation of the recovery among various plaintiffs, and purchase of structured settlements. The QSF avoids constructive receipt by the plaintiff's attorney. The plaintiff's attorney's fees and costs can immediately be paid from the QSF.

9.2. Code Requirements

The QSF must meet all of the following requirements:

- ***Court Order.*** The QSF must be established by a court order that extinguishes completely the defendant's liability.⁶⁹
- ***Qualified Payments.*** No amount may be transferred other than in the form of qualified payments.⁷⁰
- ***Independent Administrator.*** The QSF must be administered by persons, a majority of whom are independent of the taxpayer.⁷¹
- ***Personal Injury Death or Property Damage Claims.*** A QSF must be established for the principal purpose of resolving and satisfying present and future claims against the taxpayer arising out of personal injury, death or property damage.⁷²
- ***No Beneficial Interest.*** The taxpayer may not hold any beneficial interest in the income or corpus of the Fund.⁷³
- ***Election.*** An election must be made by the taxpayer.⁷⁴

10. ESTATE PLANNING FOR DISABLED PERSONS AND/OR FAMILY

10.1. Estate Planning for Disabled Person

Many injured plaintiffs are disabled but competent and have no Will, Living Trust, Living Will, Power of Attorney or other estate planning documents. Some of those plaintiffs do

⁶⁹ I.R.C. §468b(d)(2)(A).

⁷⁰ I.R.C. §468b(d)(2)(B).

⁷¹ I.R.C. §468b(d)(2)(C).

⁷² I.R.C. §468b(d)(2)(D).

⁷³ I.R.C. §468b(d)(2)(E).

⁷⁴ I.R.C. §468b(d)(2)(F).

have documents but are outdated, perhaps even because of the personal injury settlement. These documents should be reviewed and modified or replaced, if needed.

10.2. Estate Planning for Family of Disabled Person

If the plaintiff is a minor child who is likely to be receiving means-tested public benefits, it is important that the parents' estate planning documents not leave any assets to the child with disabilities, but rather to a third party special needs trust.

11. INCOME AND ESTATE TAX PLANNING

- ***Income Tax.*** There are a number of strategies to reduce the income tax impact of a personal injury settlement. A qualified investment manager can assist in this regard.
- ***Estate Tax.*** Currently, there is no federal estate tax, but most commentators feel that the tax will soon be reinstated with an exemption of between \$3.5 million and \$5 million. Tax rates will likely be between 35% and 45%. In addition, New Jersey has an estate tax of amount in excess of \$675,000. The rates range from 4.8% to 16%. New Jersey also has an inheritance tax. Essentially, spouses and blood relatives are exempt, but the tax rate for others who might inherit range between 11% and 16%.

Pennsylvania does not have an estate tax, but does have an inheritance tax. Spouses and an inheritance by a parent from child 21 years of age or younger are exempt. For others, the tax rate ranges from 4.5% to 15%. Proper tax planning can mitigate the losses caused by payment of these taxes.

12. PROBATE

In cases involving wrongful death claims, there must be a probate of the decedent's will, or absent a will intestacy proceedings must be filed so that someone may qualify to administer the estate and file the claim. An elder and disability law firm can be a useful ally in this process.

13. GUARDIANSHIP

In cases involving a mentally-incapacitated plaintiff, a guardian must be appointed. In cases involving a minor a guardian ad litem must be appointed to process the claim. Again, an elder and disability law firm can be a valuable ally.

14. CARE MANAGEMENT

Many plaintiffs suffering from severe disabilities will require on-going care management. In addition to the care being provided by family members, a care manager can be employed to work with the family to develop a care plan, to obtain the necessary services, to monitor the implementation of the plan, and to make adjustments on an on-going basis.

15. CONCLUSION

Settling a personal injury claim or obtaining a jury verdict is critical to the future of the injured party. However, many injured plaintiffs require considerable additional services. In order to best serve the plaintiff and to protect against potential malpractice claims against the personal injury firm in the future, an alliance should be considered with a qualified elder and disability law firm. The elder and disability law firm can provide many of the services in-house, and can arrange to out-source the others and serve as the back office for the personal injury law firm in this regard.

Please don't hesitate Begley, Begley & Bookbinder at (856) 235-8501 for assistance in this regard.