Taking Medicare and Medicaid's Interests Into Account

Insurance Professionals, Approved Counsel and Mediators for The Doctors Company

Hiersche, Hayward, Drakeley & Urbach, P.C.
Addison, Texas

February 7, 2013

2013 NIMME MSP Conferences

- February 25 and 26; New Orleans, LA
- April 8 and 9; San Diego, CA
- June 24 and 25; Boston, MA
- August 21; Orlando, FL
- September 2013; Chicago, IL
- 941.798.2098 X1450
michael.riccio@gouldandlamb.com

Learning Objectives

When to consider Medicare and Medicaid's interests

How to take Medicare and Medicaid's interests into account

Settling work comp, auto, liability matters

Agenda

An Introduction to the MSP Act

Mandatory Insurer Reporting

Conditional Payment Resolution

Medicare Set Asides

Special Needs Trusts

An Introduction to the Medicare Secondary Payer Act

Old Age Insurance Benefits

38 Million Americans

Receiving Old Age Benefits

Totaling $462 billion

Survivors Insurance Benefits

7 Million Americans

Receiving Survivors Benefits

Totaling $84 Billion

Disability Insurance Benefits

11 Million Americans

Receiving Disability Benefits

Totaling $120 Billion

Medicare

48 Million Americans

Receiving Medicare

Totaling $523 Billion

61 Million Americans & $1.2 Trillion

$462 billion – Retirement

$84 billion – Survivors

$120 billion – Disability

$523 billion - Medicare

The Medicare Secondary Payer Act

The Medicare Secondary Payer Act of 1980
42 USC Section 1395y(b)(2)

The Medicare Prescription, Improvement, and Modernization Act of 2003

The Medicare, Medicaid, and SCHIP Extension Act of 2007.

MSP Contractor Work Load

Post Mandatory Insurer Reporting MSP Contractor Workload Statistics

MSP Contractor Workload	2008	2009	2010	2011	Percentage increase, 2008 to 2011
NGHP MSP situations voluntarily reported to the Coordination of Benefits Contractor	141,890	185,085	357,747	392,254	176
NGHP cases established by the MSP Recovery Contractor	238,293	260,912	413,090	480,188	102
Workers' Compensation Medicare Set-Aside Arrangement proposals submitted to the Workers' Compensation Review Contractor	20,255	24,203	26,296	28,847	42
Total	400,438	470,200	797,133	901,289	125

MSP Contractor Payments

Post Mandatory Insurer Reporting MSP Contractor Payment Statistics

MSP Contractor Payments	**2008**	**2009**	**2010**	**2011**	**Payments Percentage increase, 2008 to 2011**
NGHP MSP Coordination of Benefits Contractor	$40,358,460	$41,794,506	$47,171,893	$41,999,996	4
NGHP MSP Recovery Contractor	$42,014,107	$63,070,146	$53,205,744	$58,130,229	38
NGHP Workers' Compensation Review Contractor	$3,817,289	$5,264,402	$4,986,204	$6,715,620	76
Total	$86,189,856	$110,129,054	$105,363,841	$106,845,845	24

MSP Savings

Post Mandatory Insurer Reporting MSP Situation Saving Statistics

MSP Situation Savings	**2008**	**2009**	**2010**	**2011**	**Percentage increase, 2008 to 2011**
Workers' Compensation	$136,907,844	$107,201,462	$169,960,944	$142,736,039	4
No Fault Insurance	$258,728,298	$248,181,610	$326,282,034	$271,117,941	5
Liability Insurance	$341,702,138	$323,768,272	$424,568,902	$447,889,978	31
Total MSP Situation Savings	$737,338,280	$679,151,344	$920,811,880	$861,743,959	17
Total Approved WCMSA Amounts	$905,202,404	$1,125,261,415	$1,443,739,397	$1,102,662,414	22
Total	$1,642,540,684	$1,804,412,759	$2,364,551,277	$1,964,406,373	17

Taking Medicare's Interests Into Account

Mandatory Insurer Reporting

Conditional Payment Resolution

Medicare Set Asides Allocations, Approvals, and Administration

Mandatory Insurer Reporting

The Medicare, Medicaid, and SCHIP Extension Act of 2007

Self-Insured, No-fault, Work Comp, Liability

Determine eligibility for Medicare

Submit information to COB

$1,000 per day per file penalty

Mandatory Insurer Reporting Implementation Time Line

Starting 01/01/11

Work Comp RREs report ORM & TPOC settlements, awards, judgments

Starting 01/01/12

Liability RREs report ORM & TPOC settlements, awards, judgments

Mandatory Insurer Reporting Implementation Time Line

TPOC after 10/1/12 more than $5,000 are reportable beginning 1/1/13

TPOC after 10/1/13 more than $2,000 are reportable beginning 1/1/14

TPOC after 10/1/14 more than $300 are reportable beginning 1/1/15

ORM payment for medicals over $750

Mandatory Insurer Reporting Required Information

Health Insurance Claim Number (HICN)
Social Security Number (SSN)
Claimant name, gender, and DOB
Date of Injury (DOI) and state of venue
Description of injury and ICD-9 codes
Insurer name, policy and claim number
Party representative name and address
ORM and TPOC date and amount

Nebraska Federal District Court Finds Plaintiff Must Provide HICN/SSN

- Seger v. Tank Connection, LLC, Roundtable Engineering Solutions, LLC (USDC Nebraska, April 22, 2010).
- Court orders Plaintiff to respond to the interrogatories posed by the Defendants.
- Must provide Medicare Health Insurance Claim Number or his Social Security Number to comply with MIR.

Connecticut Court Finds It Is Permissible to Hold Settlement Funds Until SSN is Provided

- Hackley v. Garofano, (Superior Court of Connecticut, July 1, 2010).
- Court concludes it is permissible to condition disbursement of settlement funds on the provision of social security numbers.
- Defendants are Responsible Reporting Entities that must comply with Medicare Secondary Payer Act.

Oregon Federal District Court Finds Professional Liability Fund is not an RRE

- Oregon State Bar Professional Liability Fund v. HHS, (USDC Oregon, March 29, 2012).
- Court finds it is highly unlikely that Congress expected conditional payment reimbursement from legal malpractice carriers.
- Court concludes OSB PLF is not a liability plan required to comply with MIR.

Conditional Payment Resolution

Primary Payers

42 USC Section 1395y(b)(2)

Group health providers, workers' compensation, liability and no-fault insurers and self-insured entities

Physicians, attorneys, hospitals, or clinics that receive payment from a primary payer

Medicare Conditional Payments

42 CFR Section 411.21

Payments made by Medicare for treatment where primary payer has/may have an obligation to make payment

Primary payers must reimburse Medicare for conditional payments it has made.

Primary Payer Responsibility

42 USC Section 1395y(b)(2)

Responsibility as a primary payer arises even if liability is contested

Responsibility can be demonstrated by settlement, judgment or award

Medicare Right of Action

42 CFR Section 411.24

Medicare has a direct right of action against all primary payers

Medicare beneficiary, medical provider, physician, attorney, state agency or private insurer

Conditional Payment Process

Conditional Payment Letter

Conditional Payment Negotiation

Final Demand

Payment

West Virginia Federal District Court Holds Plaintiff Attorney Responsible for Lien

- US v. Harris (USDC ND West Virginia, November 13, 2008 and March 26, 2009).
- US may bring an action against entities required or responsible to make payment, including a beneficiary, provider, supplier, physician, attorney, state agency, or private insurer.
- Plaintiff attorney ordered to reimburse CMS $11,367.

Federal Circuit Court Relies on Equity to Resolve Medicare Lien

- Bradley v. Sebelius (USCA 11th Circuit, September 29, 2010).
- Circuit Court concluded that per Florida probate court, plaintiff ended up with 2% of damages ($52,500 vs $2.5 mill); requires CMS to reduce its lien accordingly.
- Instead of $22,480.89, Medicare entitled to $787.50, as determined by the allocations of the state probate court.

Alabama Federal District Court Dismisses Medicare Lien Based on SOL

- United States v. Stricker (USDC ND Alabama, September 30, 2010).
- 3 year statute of limitations began running against corporate defendants the date the settlement agreement was approved by state court.
- 6 year statute of limitations began began running against attorney defendants when they received settlement payment.

Florida Federal District Court Dismisses Advantage Plan Reimbursement Action

- Humana Medical Plan v. Reale (USDC SD Florida, January 31, 2011).
- Secretary's authority is limited to making payments conditioned on reimbursement. The US is the only entity with authority to bring an action for reimbursement.
- Therefore, because the Secretary does not have the authority to bring such action, Humana does not have authority either.

DC Federal District Court Finds CMS Entitled to Full Reimbursement in Wrongful Death

- Benson v. Sebelius (USDC District of Columbia, March 24, 2011).
- Because plaintiff received settlement that included compensation for his mother's medical costs, Medicare is entitled to reimbursement.
- Absent evidence that plaintiff did not claim medical expenses paid by Medicare in wrongful death, CMS due reimbursement.

Kentucky Federal District Court Finds Settlement Delay Due to Lien is Not Bad Faith

- Wilson v. State Farm Mutual Automobile Insurance Company (USDC WD Kentucky, June 14, 2011).
- State Farm's delay in payment did not constitute bad faith.
- Court concluded that State Farm had a "reasonable foundation" to delay settlement by seeking assurances concerning the amount and payment of the Medicare lien.

6th Circuit Court Finds Medicare Owed Full Lien Despite 10% Recovery

- Hadden v. United States, (USCA 6th Circuit, November 21, 2011).
- Circuit Court finds that MSP requires Hadden to fully reimburse Medicare.
- Despite receiving only 10% of damages, Hadden owes $62,338.07 in conditional payments out of the $125,000 settlement.

South Dakota Federal District Court Concludes Settlement is Evidence of CP Responsibility

- Salveson v. Sebelius (USDC SD South Dakota, May 11, 2012)
- Since no court issued findings or obtained a verdict setting out a percentage of liability or amount of damages, Hadden applies.
- A payment conditioned upon the recipient's release, whether or not there is admission of liability, is all that is needed to trigger Medicare's interests.

3rd Circuit Court Finds MAOs May Seek Double Damages from Primary Payer

- Humana Medical Plan v. Glaxo Smith Kline, LLC (USCA 3rd Circuit, June 28, 2012).
- Per 42 USC §1395y(b)(3)(A), Humana can bring suit for double damages when primary plan fails to reimburse Medicare Advantage Organization secondary payer.
- Per 42 CFR §422.108, MAO has the same rights that the Secretary of HHS exercises under the MSP regulations.

New York Federal District Court Finds State Law is Preempted by MAO Statute

- Potts v. The Rawlings Company (USDC SD New York, September 25, 2012).
- Per 42 U.S.C. §§ 1395w-21–1395w-29, Section 5-335 of GOL (NY's anti-subrogation statute) is preempted as it applies to MAO's reimbursement rights.
- Court rules that MAOs have the same reimbursement rights as HHS under the MSP provisions.

MSPRC Announces $300 Conditional Payment Threshold on Liability Settlements

Liability settlement, judgment, award releases physical trauma injury/accident only

Liability settlement, judgment, award of $300 or less. No other settlements, judg, awards

Medicare has not issued a demand letter or request for reimbursement

CMS Announces 25% of Settlement Option to Resolve Recovery Claim

If liability claim for physical trauma injury

Settlement, judgment, award is $5,000 or less, and not expect to receive other payments

Medicare has not issued a demand letter or request for reimbursement

CMS Offers Conditional Payment Resolution Option Prior to Settlement

If liability settlement is for physical injury, not related to ingestion/exposure/implant

Liability settlement, judgment, award is $25,000 or less and written physician attestation that no medical treatment has occurred 90 days prior to submission

DOA occurred 6 months before proposal

CMS Announces MSP Recovery Portal is Open for Business

Submit Proof of Representation, Consent to Release, Request CP amount updates

Dispute claims included in CP letter and upload supporting documentation

Submit case settlement information and upload supporting documentation

HR 1845: Strengthening Medicare and Repaying Taxpayers (SMART) Act 2012

120 days before expected date of settlement, may notify Secretary and obtain conditional payment amount from website

If settle case within 65 days of accessing CMS website, website request is final demand

SOL is 3 years from date of the receipt of notice of a settlement, judgment, award.

Medicare Set Aside Allocations and Approvals

Current Medicare Beneficiaries

If a Medicare beneficiary, allocation submitted for approval if settlement more than $25,000

Future Medicare coverage is assured after allocation has been properly exhausted.

Must always take Medicare's interest into account when dealing with a beneficiary

Medicare Eligible Within 30 Months of Settlement

If expected to become Medicare beneficiary within 30 months of settlement

Settlement is above $250,000, allocation submitted to CMS for approval.

Medicare may claim the entire settlement amount as an allowance for future medicals.

Medicare Set Aside Allocations

Claimant’s life expectancy or rated age

Future medical needs related to claim that Medicare would otherwise cover

Medical services priced at work comp or usual & customary fee schedules

Medicare Set Aside Approvals

Life Care Plan

2 years of medical records showing related care and treatment

Payout showing medical care authorized and paid for during life of claim

Legal pleadings, orders, settlement

Medicare Set Aside Appeals

No formal appeals process, ability to be heard, or introduce evidence

If CMS determination contains obvious mistakes, CMS Regional Office

If disagree with CMS determination, may request reevaluation, submit evidence

Medicare Set Aside Account Funding

MSA funding must be kept in separate interest bearing account

MSA may be funded with lump sum or through structure/annuity

If structured, seed with 2 years of treatment and medication, remainder divided by life expectancy for annual

Medicare Set Aside Administration

Self or professionally administered

Accident related medical/prescription only

Must be Medicare covered

Payment per WC or Usual/Customary fee

Annual/exhaustion accounting to CMS

Minnesota Federal District Court Concludes No MSA Necessary in Liability Claim

- Finke v. Hunter's View (USDC Minnesota, August 26, 2009).
- The court concluded that there was no reason for the parties to set aside any certain amount for future Medicare claims.
- Claimant unlikely to become Medicare beneficiary in foreseeable future, as other coverage available.

Louisiana Federal District Court Determines MSP Compliance by Ordering MSA Allocation

- Big R Towing, Inc. v. Benoit (USDC WD Louisiana, January 5, 2011).
- Parties reached settlement in Jones Act liability case for $150,000.
- Court held evidentiary hearing finding that in order to take Medicare's interest into account, Benoit will set aside $52,500.00 from the settlement for payment of future medical benefits related to claim.

Louisiana Federal District Court Concludes Medicare's Interests Adequately Protected

- Schexnayder v. Scottsdale Insurance Company, (USDC WD Louisiana, July 28, 2011).

- Court ordered $239,253.84 out of the $2.1 million settlement to be utilized to pay for future medical items or services related to the claim that would be otherwise covered by Medicare.

Arkansas Federal District Court Affirms MSA Takes Medicare's Interest Into Account

- Smith v. Marine Terminals of Arkansas, (USDC ED Arkansas, August 9, 2011).
- $14,647.00, out of the $1.0 million settlement, is approved to be set aside for future medical expenses associated with treatment required for injuries sustained in the claimed accident.
- Court found MSA fairly and reasonably takes Medicare's interest into account.

Louisiana Federal District Court Finds $3,200 Protects Medicare's Interests

- Frank v. Gateway Insurance Company, (USDC WD Louisiana, March 13, 2012).
- $3,200 should be available for future medical services related to claim that would otherwise be covered by Medicare.
- Since CMS provides no procedures to protect Medicare's future interests with settlement of third-party claims, Medicare's interests have been adequately protected.

Florida Federal District Court Finds No MSA Necessary Based on Agreement

- Bruton v. Carnival Corporation (USDC SD Florida, May 2, 2012).
- Court finds that Plaintiff executed a general release with appropriate Medicare provisions and thereby complied with the terms of the Agreement.
- Court finds that Defendant, having failed to make payment to Plaintiff as required by Agreement, was in breach of Agreement.

Louisiana Federal District Court Orders MSA Funded, Medicare Adequately Protected

- Bertrand v. Talen's Marine & Fuel, LLC, (USDC WD Louisiana, June 4, 2012).
- $64,866.88 out of the settlement proceeds for payment of future medical items covered by Medicare, related to claim.
- Since no other procedure to protect Medicare's interests, Court finds that Medicare's interests adequately protected

Louisiana Federal District Court Approves MSA Based on G&L Expert Testimony

- Bessard v. Superior Energy Services (USDC WD Louisiana, August 30, 2012).
- Based on G&L expert testimony, Court finds parties/attorneys were not attempting to maximize settlement to Medicare's detriment.
- Court concluded Mr. Bessard shall allocate $6,701.00 to pay future medical services covered by Medicare, related to lawsuit.

CMS Publishes First Liability Medicare Set Aside Memorandum

Physician certifies in writing that treatment for injury has been completed

Physician certifies future medical services will not be required

No need for beneficiary to submit the certification or LMSA amount for review

CMS Opens Work Comp Medicare Set Aside Portal to Public

Workers' Compensation Medicare Set Aside Portal (WCMSAP) is open to public

Attorneys, Medicare beneficiaries, claimants, carriers and MSA vendors may use site

May enter case information directly instead of submitting such WCMSAs on paper or disc.

CMS Publishes Advance Notice of Proposed Rulemaking on MSP Future Medicals

CMS is soliciting comments on 7 options on how to protect Medicare's future interests

Auto, liability (including self-insurance), no-fault insurance, and workers' compensation

General rule is that if claimant settles case, must take Medicare's interest into account

HR 5284: The MSP and WC Settlement Agreement Act of 2012

Exempts work comp settlements of less than $25,000

Also exempts work comp settlement less than $250,000 if not a Medicare beneficiary

Allows for safe harbor MSA of 15 percent of the total settlement amount

Medicare Set Aside Administration

Taking Medicare's Interest Into Account

Settled the file!

Took Medicare's interests into account by putting together MSA!

Sent it to the CMS for approval!

Received CMS approval!

Done, right?

But, What If …

- What if the claimant is unable to manage his/her own funds?
- What if the claimant has an appointed guardian or has been declared incompetent?
- What if the ongoing medical treatment expected is lengthy, complicated, or difficult to price?

But, What If …

- What if the claimant has moved or anticipates moving to another state and as a result new physicians are or will be involved demanding a different fee than originally anticipated?
- What if the account value is such that the potential for improper use is a worry for all involved?
- What if the claimant has a very limited educational experience or is unable to read/write in English?

Medicare Secondary Payer Act

- Medicare shall not make payments with respect to any item or service to the extent that payment has been made, or can reasonably be expected to be made, under a workmen's compensation law or plan of the United States or a State or under an automobile or liability insurance policy or plan including a self-insured plan or under no fault insurance. 42 U.S.C. § 1395y(b)(2)(A).

US Causes of Action

- The United States may bring an action against any entity which is required or responsible to make payment with respect to such item or service and may collect double damages against that entity, or against any other entity that has received payment. 42 USC Section 1395y(b)(2)(B).

Medicare Permitted Actions

- If CMS determines that the parties' settlement represents an attempt to shift responsibility from the responsible primary parties/carrier to Medicare, CMS can disregard the settlement provisions.
- Medicare will pay no benefits to the claimant for any medical services that may be linked to the claimed or resulting injury until the entire settlement amount is exhausted. 42 CFR § 411.46.

MSA Administration Policies

- CMS policies created through published memorandums since 2001 restrict the use of MSA funds.
- Payment of fees for trustees, custodians and administrators may not be made from the funds in the MSA.

Self Administration

- The claimant may self-administer his or her own MSA, if permitted under state law.
- A self-administered arrangement is subject to the same rules/requirements as a professionally administered set-aside arrangement. (4/21/03 Memo Q8)

Professional Administration

- MSAs can also be administered by a professional administrator.
- When a claimant designates a representative payee, appointed guardian/conservator, or has been declared incompetent by a court, that information must be in the MSA arrangement proposal sent to CMS. (10/15/04 Memo Q2)

Annual Accounting Summaries

- Administrator of the set-aside arrangement must forward annual accounting summaries to the CMS contractor responsible for monitoring the case.
- Medicare contractor is responsible for verifying that no payments from Medicare are made for medical expenses related to the injury or illness/disease until the MSA is exhausted. (7/23/01 Memo Q3)

Administrative Fees/Expenses and/or Attorney Costs

- Administrative fees/expenses for administration of the MSA and/or attorney costs associated with establishing the MSA cannot be charged to the set-aside arrangement.
- Payment of these costs must come from some other payment source that is completely separate from the MSA funds. (5/7/04 Memo)

Treatment of Taxable Interest

- If interest income earned on MSA account, claimant or administrator may pay "cost that is directly related to the account" to cover the additional tax liability.
- Such documentation should be submitted along with the annual accounting. (7/11/05 Memo Q6)

Requesting Termination of Account

- The administrator should not release set-aside funds for any purpose other than the purpose for which the MSA was established without review from CMS.
- Effective August 25, 2008, the July 11, 2005 authorization to "Terminate MSA Account," has been rescinded. (7/11/05 Memo Q10 and 8/25/08 Memo)

Funds Left After Death of Claimant

- Once the RO and the contractor verify that all claims have been paid, then any amount left in the MSA account may be disbursed pursuant to State law.

- This may involve holding the MSA open for a period after the date of death, as providers, physicians, and other suppliers are permitted to submit their bill to Medicare 15 to 27 months after the date of service. (4/21/03 Memo Q21)

Payments Not Covered By Medicare

- If the contractor discovers that payments from the MSA have been used to pay for services that are not covered by Medicare, then CMS will not pay Medicare claims.
- The RO will notify the MSA administrator that approval of the MSA is withdrawn until the funds used for non-Medicare approved expenses are restored to the MSA. (7/23/01 Memo Q4)

Items/Services Later Covered

- Should a MSA provide for items and services that are not covered by Medicare but later become covered, those funds should then be considered part of the set-aside and treated accordingly.
- These funds do not have to be transferred to a separate MSA bank account or be included in the annual MSA accounting. (7/11/05 Memo Q15)

If Administrator Refuses Payment

- If the administrator refuses to make payment and the provider, physician or other supplier then submits the claim to Medicare, RO to determine whether Medicare should pay the claim.
- If a determination to deny the claim is made, then Medicare's regular administrative appeals process would apply to the claim. (7/23/01 Memo Q12)

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Allowed Payment Amounts

- There are two distinct payment amounts for providers, physicians and other suppliers for covered services when funds are held in a set-aside arrangement.
  - 1) Amounts used to construct the set-aside arrangement.
  - 2) Full actual charges or WC fee schedule amounts. (7/23/01 Memo Q9)

Unspent Structured Funds

- If funds are not exhausted during the given period, then the excess funds must be carried forward to the next period.
- The threshold after which Medicare would begin to pay claims related to the injury would then be increased in any subsequent period by the amount of the carry-forward.
- This carry-forward process continues until the accumulated carry-forward plus the payment for a given year is exhausted. (4/22/03 Memo Q10)

Use of Funds Before Entitled to Medicare

- For claimants who are not yet Medicare beneficiaries but CMS has approved a MSA, the MSA may be used prior to him/her becoming a beneficiary.
- The above answer replaces the Answer in the July 23, 2001 Memorandum and in the May 23, 2003 Memorandum. (7/11/05 Memo Q3)

Claims Settled Before 1/1/06

- The claimant cannot use the MSA funds to pay for prescription drug expenses related to the injury if the original MSA approved by CMS did not include monies for such prescription drug expenses.
- If the settlement included an allocation for non- Medicare covered prescription drug expenses, the claimant must exhaust those funds prior to billing Medicare for prescription drugs. (7/24/06 Memo Q6)

Special Needs Trusts Administration

Who Can Get SSI?

- A person age 65 or older with limited income and resources.
- A child or adult, of any age, who is disabled or blind with limited income and resources.

Income for SSI Purposes

- Earned income includes wages, net earnings from self-employment and income received from sheltered workshops.
- Unearned income includes all income that is not earned, such as Social Security benefits, workers' or veteran's compensation, pension, support and maintenance in kind, annuities, rent, and interest.

89

Income for SSI Purposes

- In 2013, a person who has unearned income of less than $710.00 a month will qualify for a federal SSI payment. A couple can qualify with unearned income of less than $1,066.00 per month.
- Because a large portion of earned income is disregarded, in 2013, a person who earns up to $1,433.00 a month can receive SSI. A couple may receive SSI with earned income of less than $2,105.00 per month.

90

Items Not Considered Income

- Medical care and services (including reimbursements and payments of health insurance premiums by others);
- Social services;
- Income tax refunds;
- Payments by credit life or credit disability insurance;
- Proceeds of a loan;
- Bills paid by someone else for things other than food, clothing, or shelter.

91

Resources for SSI Purposes

- In order to be eligible for SSI in 2013, a person may have monthly resources up to $2,000; a couple may have monthly resources up to $3,000.
- The resource limit for a couple applies even if only one member of a couple is eligible. The couple's resources are counted as if both members are eligible.

92

Items Not Considered Resources

- A home (and adjacent land) is not counted.
- Personal effects or household goods with a total value of $2,000 or less are not counted.
- The value of one car is not counted.
- Life insurance policies with a total face value of $1,500 or less per person.

93

Medicaid Basics

- The Medicaid program provides medical benefits to aged and disabled with limited income and resources.
- Although the federal government establishes general guidelines, the Medicaid program requirements are established by each State.
- Whether or not a person is eligible for Medicaid will depend on the State where he or she lives.

94

Medicaid Basics

- States are required to include certain types of individuals or eligibility groups under their Medicaid plans. States may also include other groups.
- States' eligibility groups are considered in one of the following:
  - categorically needy,
  - medically needy, or
  - special groups.

Special Needs Trust Basics

- While there are different types of special needs trusts, they all share the common trait of maintaining eligibility for means tested government assistance programs such as Medicaid and Supplemental Security Income (SSI).
- Unlike Medicare Set Asides, there is no inherent requirement that special needs trusts only be used for medical care services and prescription drugs.

Penalty Periods

- If the individual transfers his/her assets for less than full fair market value, a penalty period will be imposed during which the individual will be ineligible for government assistance.
- On February 8, 2006, President George Bush signed the Deficit Reduction Act of 2005, changing the look back period from three years to five years.

Irrevocable Trusts

- As a general rule, assets held in a traditional trust will normally be counted as an available resource without regard to the individual's specific program.
- Revocable trusts are treated no differently than any other asset since the individual retains the legal authority to control the trust assets and/or revoke the trust instrument.
- On the other hand, irrevocable trusts are treated differently than revocable trusts since the individual does not retain legal control to revoke the trust.

Payments From SNT

- If any payment can be made, either to the individual or for the benefit of the individual, the portion that could be paid will be considered as an available resource.
- If any payments are actually made, payments made to the individual or made for the individual's benefit will be considered income to the individual, and the income rules will apply.
- Payments for any other purpose will be considered a transfer of assets for less than fair market value, and the transfer rules will apply.

For Individual's Benefit Only

- The second criteria is whether any portion of the trust can be used for something other than the individual's benefit.
- Any portion of the trust from which no payment can be made, either to the individual or for the benefit of the individual, will be considered a transfer of assets for less than fair market value, and the transfer rules will apply.

Types of SNTs

- There are generally 3 types of special needs trusts:
  - Third Party Special Needs Trusts
  - Disability Special Needs Trusts
  - Pooled Special Needs Trusts

Third Party SNT

- First requirement is that the trust be established by someone other than the trust beneficiary. Third Party Trusts are usually established by parents, grandparents, aunts, uncles, siblings, friends, or other independent party with no legal duty to support the trust beneficiary. A spouse can not be considered a third party.
- The second key requirement is that the trust be established with funds in which the beneficiary has no ownership interest. They can be revocable or irrevocable, and do not require any "payback provisions."

Disability SNT

- The Trust must be established solely for the benefit of an individual who is disabled as defined by law and who is under 65 years of age.
- It may only be established by the individual's parent, grandparent, legal guardian, or a Court.
- It must be established with assets belonging to the individual.
- Any funds that happen to remain in the Trust at the individual's death must be used to reimburse the State for Medicaid benefits provided over the individual's lifetime (payback provision).

Pooled SNT

- The Trust must be established and managed by a non-profit association.
- The Trust must maintain separate accounts for each Beneficiary, but the funds are pooled for purposes of investment and management.
- Each separate Trust account must be established solely for the benefit of an individual who is disabled as defined by law, and it may only be created by that individual, the individual's parent, grandparent, legal guardian, or a Court.

Pooled SNT

- Unlike a Disability Special Needs Trust, there are no age restrictions or requirements.
- Any funds that remain in an individual's account at that individual's death may be retained by the Trust. Any funds not retained by the Trust must be used to reimburse the State (modified payback provision).

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  - GL-Professional Administration Quote
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- LinkedIn
  - Medicare and Medicaid Compliance Group
  - Florida Workers' Compensation Group
  - Social Security Benefits Group
  - Hispanic Issues and Demographics Group
  - MSA and SNT Administration Group (soon)
- Twitter
- Facebook

Thank You!

Rafael Gonzalez

Director of Medicare Compliance and Post-Settlement Administration

Gould & Lamb, LLC

101 Riverfront Blvd., Suite 100

Bradenton, Florida 34205

rafael.gonzalez@gouldandlamb.com

941.798.2098

www.gouldandlamb.com