Ten Things You Need to Know about Medicaid & Medicare in Your Personal Injury Practice

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I. INTRODUCTION

Personal injury attorneys must become experts in many different areas outside of the rules of evidence and the litigation of claims. In some cases, the personal injury attorney may have to become an expert in certain types of surgeries or medical treatments. In other cases, a personal injury attorney may have to require extensive knowledge about accident reconstruction and the forces of stress on the human body as a result of the physics involved in a car accident. Developing expertise in these types of areas can vary from one case to the next depending on the type of accident or the incident that caused the injury to the client.

The main task for a personal injury attorney is to pursue the litigation and seek justice for her client by recovering damages that will compensate the client for the injury or loss the client experienced. As all experienced personal injury attorneys know, the work of seeking recompense for injuries suffered by the client is only one of the facets of representing clients in this area. Many times litigation will be a lengthy and difficult process and the needs of the client may require the attorney to provide all manor of assistance to the client outside the main responsibility of pursing the litigation. Depending on the client's family situation, the extent of injuries, and economic circumstances, the personal injury attorney can become deeply involved–not only in the personal lives of the clients, but also the lives of their family members. Clients will rely on and turn to their attorneys for advice and help with issues not directly related to the attorney's role as a litigator.

The expertise needed to pursue different types of cases will vary greatly depending on the circumstances of the underlying incident. However, if an advocate is successful in obtaining compensation for the client that will cause the client to have ongoing medical treatment, the personal injury attorney will no doubt be asked questions concerning how the client will pay for the future medical treatment. In most cases of severe and disabling injury, the issue of eligibility for Medicare or Medicaid benefits will most likely arise.

This paper does not cover any issues concerning potential Medicare or Medicaid claims for reimbursement or how to obtain or maintain eligibility for either of these programs. This paper presupposes that the client has eligibility for either the Medicare Program or the Medicaid program. This paper addresses issues that may arise for clients who are beneficiaries of these programs. Some of the subjects discussed may provide information that clients are not aware of that will become important to them as they seek to maximize the benefits available to them from the programs. Additionally, some of the information concerning the Medicare program maybe helpful to the advocate themselves or to their own family who may be eligible for Medicare. Your author has spent many years working with clients receiving benefits from both Medicare and Medicaid. The number of issues that can impact beneficiaries of these programs are unlimited in number and scope. This list of ten things is certainly not exhaustive of the myriad of questions and issues that can arise when someone is using the benefits of these programs, but, the information discussed can be tremendously helpful to the

beneficiaries of these programs. No attempt is made to explain generally about the Medicare or Medicaid program except in instances when specific knowledge of a portion of the law is required to understand the subject matter.

II. ISSUE #1: SHOULD I SIGN UP FOR MEDICARE PART B?

Should I sign up for Part B of the Medicare program (formally know as Supplementary Medical Insurance (SMI) Benefits for the Aged and Disabled)?[1] This is a very common question because there are many individuals who chose to work past the age of 65. In some cases one spouse may retire at age 65 and the other spouse may continue to work past age 65. In the context of a personal injury matter the client may be very young and married to a spouse who is currently working and will continue to work for many years to come. If the retired or injured spouse qualifies for Part A Medicare, that coverage (Part A) is free, not so for Part B. If a person is over the age of 65 and still working, she may be covered by a group insurance policy, likewise the spouse of an injured person may be covered by group insurance provided by their spouse's employer. The person is receiving Part A and needs to decide whether to also take Part B (requires payment of a premium). The issue may also arise when a retired person has health insurance through a spouse who is working or an injured client has group coverage through the employer of their spouse.

To obtain coverage under Part B, a beneficiary must pay a monthly premium. The standard Part B premium amount in 2023 is $164.90 (or higher, depending on income). If a couple's modified adjusted gross income is above a certain amount, they may pay an Income Related Monthly Adjustment Amount (IRMAA). Medicare uses the modified adjusted gross income reported on a person's IRS tax return from two years prior (that is the most recent tax return information provided to Social Security by the IRS) to determine premium amounts. If a couple's yearly income in 2020 was between $182,000 up to $228,000 their Part B premium payment each month in 2022 would be $238.10.

It is possible that the retired or disabled spouse of a currently working person may be covered by a Group Health Plan (GHP) through the working spouse's company. The GHP coverage may be free or cost less than Part B premiums. The client may want to know if there is any reason he or she should take Part B and pay monthly premiums even when they have coverage under a GHP. The monthly cost of the benefit is not the only reason that potential beneficiaries might be concerned about this question. If a client does not sign up for Part B when first eligible, she may have to pay a late enrollment penalty.[2] That penalty comes as increased premiums for as long as the

[1] 42 U.S.C. § 1395j.

[2] 42 C.F.R. § 408.22.

person is enrolled in Part B. The monthly premium for Part B may go up 10% for each full 12-month period that a person could have had Part B but did not sign up for it.[3] Also, if a person does not enroll at initial enrollment, she may have to wait until the General Enrollment Period (from January 1 to March 31) to enroll in Part B, and coverage starts July 1 of that year.

Example: A client's Initial Enrollment Period ended September 30, 2019. She waited to sign up for Part B until the General Enrollment Period in March 2022. Her Part B premium penalty is 20%. (While she waited a total of 30 months to sign up, this included only two full 12-month periods.) She'll have to pay this penalty for as long as she has Part B.

Spouses and workers over age 65 who are covered by a GHP are protected from the increase in Part B premiums based on failure to enroll in Part B during their Initial Enrollment Period because they are allowed a Special Enrollment Period (SEP).[4] The SEP allows a beneficiary to enroll anytime during an 8-month period that begins when she leaves the GHP.

There may be a more important reason for a retired or disabled spouse or currently working individual over age 65 to enroll in Part B other than to prevent and increase in the monthly premium. For retired employees, if the GHP has fewer than twenty employees, then the GHP is secondary to Medicare.[5] For the people with disabilities, a large group health plan is defined as one that covers 100 or more employees.[6] For non-disabled employees the number is 20 or more employees. In cases where the employer has fewer than twenty employees, the beneficiary should contact the Human Resources Department of their employer and determine if Medicare has primary responsibility for coverage. If Medicare is primary, then the beneficiary

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[3] *Id*.

[4] 42 C.F.R. § 407.20(b).

[5] 42 C.F.R. § 411.100.

[6] For Medicare-eligible beneficiaries employed by organizations with fewer than 20 employees (or fewer than 100 employees for the disabled), Medicare generally pays primary and the employer group health plan generally pays secondary. However, those who are covered under group health plans from employers of any size, based on their own or their spouse's current employment, will not be subject to the enrollment limitations or late-enrollment penalties for the period of time in which they have group health plan coverage. See SSA, Program Operations Manual System (POMS), HI 00805.751, "SEP and Premium Surcharge Requirements for the Aged Effective 8/86," at https://secure.ssa.gov/apps10/poms.nsf/lnx/0600805751.

should sign up for Part B. If the GHP has more than nineteen employees, or 100 employees in the case of disabled spouse then it is likely the best decision is to delay enrollment for Part B. The issue of which plan is primary, if not handled correctly, can result in no payment for normally covered expenses. Depending on which plan is primary, if the primary plan does not make a payment toward the bill, then the secondary coverage will most likely not pay anything toward the bill either so there will be no coverage at all.

People with End-Stage Renal Disease (ESRD) will automatically transition to Medicare as primary after the 30th month of diagnosis.

An additional reason to sign up for Part B upon turning age 65: federal law grants a "guarantee issue" period for Medicare Supplement Insurance Policies (Medigap) coverage for six months upon a beneficiary reaching age 65.[7] Delay in seeking Medigap coverage after that time could subject a beneficiary to exclusion for preexisting conditions. This issue is discussed further below.

III. ISSUE #2: Guarantee issue of Medicare Supplement Insurance

A. What is Medicare Supplemental Insurance

Because Medicare has deductibles and copayments that can be very expensive, most Medicare beneficiaries seek to purchase Medicare Supplemental Insurance (Medigap). These costs associated with Medicare deductibles and copayments, are commonly referred to as "gaps," and can cause financial havoc for individuals on a fixed income. If the Medicare beneficiary has Medigap coverage, then she is assured that no matter how expensive the medical treatment she may undergo, the cost of that treatment will not lead to financial ruin.

For example, Part B generally pays 80% of the medicare approved rate for covered services, and the beneficiary is responsible for the remaining 20%.[8] Cost of care can be very expensive, and the 20% copayment may be many thousands of dollars. A Medigap policy can provide 100% coverage of this copayment such that the beneficiary has no out of pocket costs. In most instances, if a beneficiary has original Medicare (Fee-For-Service Medicare) and a Medigap policy and seeks treatment from a physician who accepts Medicare assignment, then she will never have any out-of-pocket costs for any service covered by Medicare. In 2016, approximately 13.1 million Americans owned a Medicare Supplement insurance policy. That number represents an

[7] 42 U.S.C. § 1395ss(s).

[8] Ctrs. for Medicare & Medicaid Servs., Medicare Benefit Policy Manual, Pub. 100-02, Ch. 3, § 20.3, available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c03.pdf.

increase compared to the 9.7 million who owned a Medigap policy in 2010.[9]

A Medigap or Medicare Supplemental policy is health insurance sold by private insurance companies to fill the “gaps” in Original Medicare Plan coverage (fee for service). A Medigap policy meets the statutory definition of a "Medicare supplemental policy" contained in §1882(g)(1) of title XVIII of the Social Security Act (the Act) and the definition contained in the NAIC Model Regulation that is incorporated by reference to the statute. If a beneficiary has a Medigap policy, then if Medicare pays toward a covered service, the Medigap policy will pay its share of covered health care costs. Generally, Medigap will only pay for a service if that service is covered by Medicare. However, some Medigap policies also cover certain benefits Original Medicare doesn’t cover, like emergency foreign travel expenses. Medigap policies do not include limited benefit coverage available to Medicare beneficiaries such as "specified disease" or "hospital indemnity" coverage. Also, the definition of a Medigap policy explicitly excludes a policy or plan offered by an employer to employees or former employees, as well as that offered by a labor organization to members or former members.

To buy a Medigap policy, the beneficiary must have Medicare Part A and Part B. In addition to the Part B premium, the beneficiary will have to pay a premium to the Medigap insurance company. As long as the premium is paid, the Medigap policy is guaranteed renewable. This means it is automatically renewed each year.

Insurance companies can only sell “standardized” Medigap policies. Medigap policies must follow Federal and state laws. The front of a Medigap policy must clearly identify it as “Medicare Supplement Insurance.” Each standardized Medigap policy must offer the same basic benefits, no matter which insurance company sells it.

It is important to compare Medigap policies because costs can vary. The standardized Medigap policies that insurance companies offer must provide the same benefits. Generally, the only difference between Medigap policies sold by different insurance companies is the cost. Different insurance companies may charge different premiums for the same exact policy. Plan F rates for a 65 year old male during Open Enrollment Period (OEP) in 2016 varied as much as 33%. The highest being $217.00 and the lowest being $155.00.[10] The yearly savings of $744.00 multiplied by the life expectancy of a 65 year-old male of approximately 19 years would result in a difference of $14,136.00 over his lifetime.

Medigap insurance companies are generally allowed to use medical underwriting to decide whether to accept a beneficiary’s application and how much to charge for the

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[9] American Assn. for Medicare Supplement Ins., Medicare Supplement Insurance Statistics and Data – 2018, http://medicaresupp.org/medicare-supplement-statistics/ (last visited Oct. 22, 2018).

[10] *Id.*

coverage. However, during the beneficiary's Medigap Open Enrollment Period (OEP), an enrollee can buy any Medigap policy the company sells, even if they have health problems, for the same price as people with no preexisting health conditions. Every beneficiary has a guaranteed right to purchase a Medigap during her 6-month Medigap Open Enrollment Period. During this time, a beneficiary can buy any Medigap policy sold in her state, even if she has preexisting health conditions. If a beneficiary is 65 or older, this period automatically starts the first month she is enrolled in Medicare Part B. If a beneficiary has delayed enrollment in Part B because she had other credible coverage such as a group health plan, then she still has the right to purchase a Medigap once she enrolls in Part B. If you purchase Medigap after your OEP, the Medigap insurance company can refuse to cover your out-of-pocket costs for these pre-existing health problems for up to 6 months. This is called a "pre-existing condition waiting period." After 6 months, the Medigap policy will cover the pre-existing condition.

For most beneficiaries, the decision to purchase a Medigap policy is a no-brainer. For a fixed premium each month beneficiaries can avoid any exposure to potentially catastrophic health care cost. However, once a decision is made to purchase a Medigap policy, it can be a daunting task to select the best policy for that beneficiary's situation. All Medigap policies must have specific benefits, so the policies can be compared easily. Insurance companies that sell Medigap policies don't have to offer every Medigap plan. However, they must offer Plan A if they offer any Medigap policy. If they offer any plan in addition to Plan A, they must also offer Plan C or Plan F. Each insurance company decides which Medigap plan it wants to sell, although state laws might affect which ones they offer. The Medigap Standard Policy Coverages are confusing because the policy letters start at 'A' and go through 'N' representing 10 different policies, but there are some letters missing(!). There were several other plans sold in the past that are no longer available. Plans E, H, I, and J are no longer sold, but some beneficiaries who had these plans in the past may still have them. Medigap plans that cover the Medicare Part B deductible (Plans C and F in most states) are not sold after January 1, 2020. If a beneficiary purchased a Medigap Plan C or F before January 1, 2020, she will be allowed to keep that plan and the benefits won't change. The fact that these plans are not available now will dramatically affect the size and health cohort group of these plans and will have a profound effect on their cost.

The selection of a Medigap plan for a particular beneficiary is a very complicated process but in many instances, either a Plan G or a Plan N will be the best choice for many beneficiaries. The most popular plan in the country, historically, has been Plan F. The following is the breakdown of the policies purchased in the U. S. in 2016.[11]

[11] *Id.*

Plan F – 60%
N – 11%
D & G – 13%
H, I, J — 5%
C – 6%
A & B – 3%
High Deductible Plan F – 1%
K, L & M – 1%

Note that these figures include several polices that are no longer available. The reason many people chose plan F is that it covers 100% of all of the categories on the Medicare coverage chart. It is an easy decision for beneficiaries who can afford the premium, as they do not have to review all of the different choices that are available. As a result of Plan F no longer being sold, the cohort or risk pool for Plan F will gradually shrink. Concomitantly, as the enrollees of Plan F age, their medical costs will increase causing insurers to charge more for the Plan.

Even prior to 2020, in most instances, Plan G premiums will be much less than the premiums on Plan F. The only difference between the coverage of the two plans is that Plan F pays the Medicare Part B deductible which is $226.00 in 2023. If the yearly cost of a plan F policy is $226.00 more than the Plan G policy, then the Plan G policy is a better value in that it saves the beneficiary money and provides the same coverage.

Many factors can go into the selection of a Medigap policy. In most cases, the coverage available through different policies may be very similar, but the cost effectiveness of the coverage can vary greatly.

B. Importance of Open Enrollment for Client on Disability

The open enrollment period discussed above is only available to persons over age 65 and enrolled in Part B. If the client is under age 65 and has obtained Medicare eligibility as a result of being on Social Security Disability for 24 months, then this open enrollment period is not available to her. Under federal law, the private companies that offer Medicare Supplement plans aren't required to sell the policies to people under 65 who get Medicare due to a disability.

However, if you live in Texas and get Medicare before age 65 because of a qualifying disability, you are entitled to a six-month open enrollment period once you first get Medicare during which you can buy a Medicare Supplement plan without medical underwriting. Texas is one of about 30 states that have laws at the state level allowing individuals under age 65 to purchase Medicare Supplement plans. You must be enrolled in both Part A and Part B to buy a Medicare Supplement plan in Texas. This open enrollment right only applies to Medicare supplement Plan A.[12]

[12] 28 Tex. Admin. Code Ann. § 3.3312 (c)(1)(B)

Advocates who represent clients under 65 eligible for Medicare as a result of disability should make sure their clients understand that it is important that they enroll in Part B Medicare and that they purchase a Medigap policy during their open enrollment period. Failure to complete these two steps could cause the client to spend huge sums on increased monthly Part B premiums, deductible and copayments of Medicare covered medical expenses that they otherwise would not have to pay out of pocket.

IV. ISSUE #3: WHAT IS THE MOST I WILL HAVE TO PAY IF I JOIN A MEDICARE ADVANTAGE PLAN?

Many Medicare beneficiaries join Medicare Advantage plans (MA or Part C) to save money on copayments, coinsurance, and deductibles. Costs of copayments and coinsurance amounts can vary among different Medicare Advantage Plans. Generally, Part C plans will have low copayments such as $10.00 to see a physician or $50.00 for a hospital admission. Copayments are generally flat fees that an enrollee pays for a service or treatment. Coinsurance amounts are generally a percentage of the cost of a service that an enrollee must pay.

All beneficiaries seeking to join an MA should carefully examine the MA's Summary of Benefits information to determine the Plan's premiums and cost sharing requirements. Many potential MA enrollees may concentrate on the Plan premiums and copays for doctor visits and completely ignore the copays for the skilled nursing facility benefit. MA plans must provide the same skilled nursing benefits available under Part A or Part B as a matter of law.[13] Many plans have a co-payment for their skilled nursing facility care benefit that is the same as regular fee-for-service Medicare. The copayment for many Medicare Advantage plans is as much as $226.00 per day. Medicare Advantage plan enrollees may not be aware of this cost until they need long-term care services in a nursing home. Once they are made aware of the co-payment and how much it may cost for up to the 100 days of coverage that is provided by the Medicare Advantage plan, many enrollers may seek to discharge from a Skilled Nursing Facility immediately in order to avoid the huge copayment. However, those patients may be making a rash decision without understanding that there is a maximum out-of-pocket liability they have in their Medicare Advantage plan.

One key difference between Original Medicare and Medicare Advantage (Part C) is that all Medicare Advantage plans have a maximum out-of-pocket (MOOP) spending limit. The MOOP is a yearly cap on the Medicare expenses that a beneficiary must pay. Original Medicare does not have an annual out-of-pocket maximum, meaning there's no limit to how much a beneficiary could spend on health care in a given year. Every Medicare Advantage plan must have a maximum out-of-pocket liability that is set yearly by Centers for Medicare & Medicaid Services (CMS). Once the total out-of-pocket costs

[13] 42 C.F.R. § 422.100.

for Medicare-covered services have been reached, the plan must cover 100% of costs for the remainder of the year. The out-of-pocket maximum varies from plan to plan, and may change from year to year, but the MOOP may change only once a year: on January 1. This maximum out-of-pocket (MOOP) is for both part A and Part B services and includes co-payments, deductibles, and coinsurance amounts paid during the year.

Even if a beneficiary has not paid any money toward her maximum out-of-pocket expense, which is highly unlikely, the maximum out-of-pocket liability for any Medicare Advantage member in 2023 is $8,300.00. Some plans offer an out-of-pocket limit below the $8,300.00 maximum. In many instances, the maximum out-of-pocket expense will be met within the first thirty days of a stay in a Skilled Nursing Facility and if the beneficiary retains status as a skill care designate, then the remaining part of the plan's 100 days of benefit period for that spell of illness will be covered 100% by the Medicare Advantage plan. An understanding of the maximum amount owed may change the ultimate decision a patient makes about leaving a nursing home prematurely.

MA plans are required to give an Explanation of Benefits (EOB) to all enrollees either monthly or on a per-claim basis with additional quarterly summary statements. The EOB must include information about the plan's maximum out-of-pocket (MOOP) spending limit and the enrollee's accumulated out-of-pocket costs to date in relation to their plan's MOOP. Enrollees should carefully monitor these EOBs so that they can be sure they are not paying more than the MOOP for their plan for any covered services–including the costs of skilled nursing home care.

Advocates need to provide information to clients who become eligible for Medicare about their ability to save money on premiums and copayments by joining a Part C plan. The limit on out of pocket expenses is an important factor in deciding to chose Part C over traditional Fee-for-Service Medicare and the purchase of a Medigap policy.

V. ISSUE # 4: Does Medicare Limit How Much A Doctor Can Charge Me?

As the discussion above explains, in most instances, Part B pays 80% of the Medicare approved rate for a covered service.[14] If a beneficiary has a Medigap policy, then the remaining 20% will be covered fully through that policy, and the beneficiary will have no out of pocket cost. This is true as long as the physician "accepts assignment." The phrase "accepts assignment" actually refers to an agreement between the physician or supplier of the service and the beneficiary. In the agreement, the beneficiary transfers to the physician or supplier the right to bill Medicare for the service directly, and in return, the physician or supplier agrees to accept the Medicare approved charge as

[14] 42 C.F.R. § 410.152.

full payment for the services or the items provided.[15] The physician does not seek to collect the bill other than the coinsurance or deductible from the patient. If the physician does not accept assignment, then after a bill is sent to the Medicare administrative contractor (MAC), the payment is sent to the beneficiary and the beneficiary is responsible for paying the provider of the service. A physician or supplier who agrees to accept assignment on all claims for Medicare services, rather than on a claim-by-claim basis, is known as a participating physician or supplier. A physician or supplier may not charge a beneficiary for paperwork involved in filing an assigned claim.

Medicare provides physicians and incentive to accept assignment. Physicians who accept assignment are paid 5% more for a service than nonparticipating physicians. They are listed on directories maintained by Medicare and can use certain insignia in their offices to identify themselves as participating physicians. Medicare operates toll-free telephone numbers that identify the names, addresses, and phone numbers of participating physicians.

MACs are required to mail directories of participating physicians and suppliers to beneficiaries for no charge upon request.[16]

If a physician or supplier does not accept assignment, she can charge more than the Medicare approved rate for a service. Nonparticipating physicians are limited to charging 115% of the Medicare approved rate.[17] The limiting charge is 115% of 95% of the payment basis applicable to participating suppliers. If the beneficiary has a Medigap policy, then the Medigap would only pay 20% of the Medicare approved rate. The beneficiary would be responsible for the remaining balance. A nonparticipating physician or supplier who accepts assignment for some Medicare covered services is not ordinarily precluded from billing the patient for other Medicare covered services for which the nonparticipating physician or supplier does not accept assignment and is also not precluded from billing the patient for services that are not covered by Medicare. However, a physician or supplier may not attempt to circumvent the Medicare allowed amount limitation by “fragmenting” bills. Bills are “fragmented” when a physician or supplier accepts assignment for some services and claims payment from the beneficiary for other services performed at the same place and on the same occasion.

Although physicians can choose whether to accept assignment, some practitioners who provide services under the Medicare program are required to accept assignment for all Medicare claims for their services. This means that they *must* accept the Medicare allowed charge amount as payment in full for their practitioner services.

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[15] 42 C.F.R. § 424.55.

[16] 42 U.S.C. § 1395u.

[17] 42 C.F.R. § 414.48.

The beneficiary's liability is limited to any applicable deductible plus the 20% coinsurance.

The practitioners' services to which mandatory assignment applies are services of:

- Physician assistants;
- Nurse practitioners;
- Clinical nurse specialists;
- Clinical psychologists;
- Clinical social workers;
- Certified Registered Nurse Anesthetist (CRNA);
- Nurse midwives;
- Registered dietitians/nutritionists;
- Anesthesiologist assistants; and
- Mass immunization roster billers.

A Mass Immunization Roster Biller can only bill for influenza and pneumococcal vaccinations and administrations. These services are not subject to the deductible or the 20% coinsurance. A Mass Immunization Roster Billers is a non-traditional provider that is usually ineligible to enroll in the Medicare Program, such as a supermarket, senior citizen home, or public health clinic.

Ambulance providers and suppliers must accept the Medicare allowed charge as payment in full and may not bill or collect from the beneficiary any amount other than the unmet Part B deductible and Part B coinsurance amounts.[18]

There are medical services that are not billable under Medicare and the cost of such services are not impacted by whether the provider accepts assignment.

VI. ISSUE #5: HELP MY CHILD IS LOSING THEIR MEDICAID BENEFITS

Many times when handling a personal injury case for a child, the advocate will be repeatedly queried by the parents about the impact the proceeds of the lawsuit will have on the government benefits that their child receives. Sometimes, parents may not even be clear as to the exact program that provides the benefits for the child. The child may have been on benefits for many years and the parents do not remember the specifics of the program and also may be reluctant to make any inquiry about the program for fear that any contact with a governmental agency could risk loss of the benefits.

Nonetheless, the parents are concerned that the proceeds from personal injury litigation will cause their child to lose important benefits. Most experienced personal injury attorneys realize that certain government benefits are means-tested and that a

[18] 42 C.F.R. § 414.610(b).

recovery of almost *any* amount of money can cause a beneficiary to lose eligibility for those government programs. Medicaid benefits are often the benefits most beneficiaries are afraid of losing. Many years ago, your author received a call from a parent of a young person (over 18) who had been on Medicaid benefits for his entire life and who was residing in a personal care home that had been paid for by his Medicaid benefit. The young person had thrived in this environment and the parents had been told that because the father was retiring and now drawing Social Security benefits, that their child would lose his Medicaid benefits. The child had been disabled since birth and had received a significant settlement that was placed into a Special Needs Trust such that the settlement proceeds did not disqualify him from receiving Medicaid benefits. The parents were frantic because they had been told by the agency that operated the personal care home that the young person would be discharged from the personal care home if he lost his Medicaid.

I inquired why that would be a problem because the large Special Needs Trust that the child had could easily pay the cost involved in staying in the personal care home. The parent informed me that the personal care home refused to accept a cash payment for the room and board and other services that the personal care home provided and Medicaid was the only option. The manager of the personal care home stated they would only accept Medicaid payments and would not allow the family to privately pay for the young person to stay in the home. If the young person lost his Medicaid benefits, he would have to leave. The family was distraught because they believed that the young person's well being would be endangered if he was required to leave and under no circumstances could they tolerate the child losing his Medicaid benefits.

The child was receiving Medicaid benefits because he was eligible for the Supplemental Security Insurance program (SSI) based upon his disability and his limited countable assets and lack of income. These are the requirements for SSI. The beneficiary's Medicaid benefits were piggybacked on his eligibility for SSI benefits: if he lost SSI he would lose his Medicaid.

The beneficiary was set to receive Social Security Disability Benefits (SSDI) based on the earnings record of his father, who had recently retired and was drawing Social Security himself. The amount of the beneficiary’s monthly Social Security Disability check would exceed the income limit for the SSI program and he would be disqualified from receiving SSI and, in turn, would lose Medicaid benefits that are piggybacked on SSI eligibility. The family was adamant that they would not want the increased monthly benefit if it resulted in their child losing his SSI-linked Medicaid. I was able to explain to them that the young person would not lose his Medicaid as a result of getting Social Security Disability and receiving a higher check because of a program call Adult Disabled Child Benefits.

The program was originally called Disabled Adult Child (DAC) but Social Security now refers to it as Childhood Disability Benefit (CDB). However, many times the

program is still referred to as the DAC program.

This program is interesting because it involves different aspects of the four major government benefit programs SSI, SSDI, Medicaid and Medicare.

The facts that give rise to eligibility for Childhood Disability Benefits are the following:[19]

a person who is disabled prior to age 22; [20]

a parent of the person either becomes eligible for Social Security Disability themselves or starts drawing Social Security Benefits or passes away with eligibility for Social Security Benefits.

This makes the child of the person eligible to draw Social Security Disability on the earnings record of her parent. The check that the child receives most often will exceed the SSI income limit which will, in turn, cause her to lose her SSI. A child can receive up to half of their parent's full retirement or disability benefits, or 75 percent of their deceased parent's basic Social Security benefit. Twenty-four months after they start their eligibility for Social Security Disability they will become eligible for Medicare. [21]

Under this program, beneficiaries will continue to receive their Medicaid benefits without regard to losing their SSI so long as they continue to meet the requirements of eligibility for SSI other than the income requirement–meaning that they cannot have assets that would be disqualifying and they must be considered disabled under the rules of the Social Security disability program.

Parents of children and young people on SSI-linked Medicaid need to be made aware that the CDB program will affect the person at some point in their lives. Many times the change over to SSDI may not happen until the person is in her 40's of 50's depending on the age and health of her parents. The advocate for a person on SSI benefits should make it a point to explain this program. If the family has an understanding of what will happen when the parents start drawing their social security or become disabled themselves or one of the parents passes away, it can prevent a huge amount of consternation and panic for all involved.

VII. ISSUE #6: DO I QUALIFY FOR A MEDICARE SAVINGS PROGRAM?

"Medicare Savings Programs" is the formal name for a group of programs including Qualified Medicare Beneficiary (QMB) Program, Specified Low-Income

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[19] SSA §202(d)(1); 20 CFR §404.350, POMS §RS 00203.001.

[20] Medicaid for the Elderly and People with Disabilities (MEPD) § A-2310.

[21] 42 C.F.R. § 406.12 (a).

Medicare Beneficiary (SLMB) Program, Qualified Individual (QI) Program, and The Qualified Disabled and Working Individual (QDWI) Program. The Medicare beneficiaries eligible for these programs are often referred to as Dually Eligible Individuals.[22] Although they are actually Medicaid programs, the beneficiaries of the programs are all Medicare recipients. The Medicare Savings Programs use Medicaid funds to help eligible persons pay for all or some of their out-of-pocket Medicare expenses, such as premiums, deductibles, and coinsurance. These costs are the same costs that are discussed in Article III above. In Texas, the programs are found in the Medicaid for the Elderly and People with Disabilities Handbook Chapter Q, Medicare Savings Program MEPD, Q-1000. These programs can provide substantial savings to a Medicare enrollee. The average out-of-pocket costs for a Medicare enrollee without a supplement in 2021 is more than $5,000.00.[23] Additionally, if a person qualifies for QMB, SLMB, or QI, she is eligible for the Low-Income Subsidy (LIS) program, also referred to as the Extra Help program. LIS provides prescription assistance for Medicare beneficiaries enrolled in Medicare Part D who have limited income and resources.[24] This benefit alone is estimated by the Social Security Administration to be worth $5,100.00.[25] The Qualified Disabled and Working Individual (QDWI) Program is the smallest of the MSPs, with fewer than 519 individuals enrolled in 2018.[26] It consists of persons who were on Social Security Disability Benefits and lost their Medicare when they went back to work.[27] QDWI does not include automatic enrollment in Part D LIS.

The Qualified Medicare Beneficiary (QMB) program covers the Medicare Part A and Medicare Part B premiums, deductibles, coinsurance, and copayments for eligible

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[22] Judith A. Stein & Alfred J. Chiplin, Jr., *2019 Medicare Handbook* 10-14 (2019).

[23] Kaiser Family Foundation, How Much Do Medicare Beneficiaries Spend Out of Pocket on Health Care?, available at https://www.kff.org/medicare/issue-brief/how-much-do-medicare-beneficiaries-spend-out-of-pocket-on-health-care/ (2022).

[24] Texas Health and Human Servs., Medicaid for the Elderly and People with Disabilities Handbook, Q-1200 Medicare Improvement for Patients and Providers Act of 2008 (MIPPA), (Sept. 1, 2013), available at https://hhs.texas.gov/laws-regulations/handbooks/medicaid-elderly-people-disabilities-handbook/chapter-Q-medicare-savings-program/Q-1000-medicare-savings-programs-overview Q1200.

[25] Social Security Administration | Publication No. 05-10508 February 2022 Understanding the Extra Help with Your Medicare Prescription Drug Plan.

[26] CMS Medicare-Medicaid Coordination Office analytics webpage: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-MedicaidCoordination-Office/Analytics.html

[27] Medicaid and CHIP Payment and Access Comm'n Issue Brief, *Medicare Savings Programs: New Estimates Continue to Show Many Eligible Individuals Not Enrolled*, (Aug. 2017), available at https://www.macpac.gov/wp-content/uploads/2017/08/Medicare-Savings-Programs-New-Estimates-Continue-to-Show-Many-Eligible-Individuals-Not-Enrolled.pdf.

enrollees. The Specified Low-Income Medicare Beneficiary (SLMB) program covers only the Medicare Part B premium. The Qualified Individual (QI) program covers the Medicare Part B premium and individuals who qualify for Medicaid cannot receive QI benefits. The Qualified Disabled and Working Individuals (QDWI) program covers only the Medicare Part A premium, but has the highest qualifying income maximum. A person may qualify for this Medicare Savings Program if she is a working disabled person under 65, has lost her Medicare premium-free Part A benefits because she went back to work, and isn't getting medical assistance from the state.

The programs have asset limits, but for Texas QMB, there are no transfer of asset penalties. This means if a person has more than the allowed amount of resources she can give away assets and immediately qualify for the program. [28]

The following charts show the income and asset requirements for MSP eligibility and the benefits of each program:

QMB Monthly Income Limits for 2023 (up to 100% of FPL + $20.00*)

	Individual	**Couple**
Income	$1,133.00	$1,526.00
Asset Limits	$9,090.00	$13,630.00

SLMB Monthly Income Limits for 2023 (less than 120% FPL+ $20*)

	Individual	**Couple**
All states except Hawaii and Alaska	$1,359.00	$1,831.00
Asset Limits	$9,090.00	$13,630.00

[28] Medicaid for the Elderly and People with Disabilities (MEPD) § Q-1000, Medicare Savings Programs Overview.

QI Monthly Income Limits for 2023 (less than 135% FPL+ $20*)

	Individual	Couple
All states except Hawaii and Alaska	$1,529.00	$2,060.00
Asset Limits	$9,090.00	$13,630.00

QDWI Monthly Income Limits for 2023 (up to 200% FPL+ $65+$20*)

($65= monthly SSI earned income exclusion.)

	Individual	Couple
All states except Hawaii and Alaska	$2,265.00	$3,052.00
Asset Limits	$4,000.00	$6,000.00

* $20 = monthly SSI general income exclusion

VIII. ISSUE #7 CAN MY MEDICARE SKILLED NURSING OR HOME HEALTH BENEFITS BE TERMINATED BECAUSE I AM NOT IMPROVING?

During the time that a personal injury lawsuit is pending, the client's medical needs and subsequent treatment will continue. Due to nature of the injuries and a client's age, as well as other comorbidities, the client's medical condition may become more complex and require new or different treatment modalities. If the injuries result in chronic medical issues, the client will often seek the advice or assistance of her personal injury attorney in obtaining needed medical care to cope with these long term medical problems. Medicare beneficiaries who need long term treatment for certain non-acute issues face continuing problems with Medicare coverage of such treatment. Most entities that provide out-of-hospital care for Medicare beneficiaries such as Skilled Nursing Facilities and Home Health agencies look upon Medicare reimbursement as a short term rehabilitation benefit. In fact, even a cursory investigation will reveal the most Home Health agencies will tell the beneficiary if you have plateaued and can not improve your condition, Medicare will cease to pay for any further treatment.

This bromide has been firmly entrenched in the lexicon of the Medicare program for many decades. "If you are not improving, then Medicare will not pay for your treatment." During your author's 30 year history with this insidious misrepresentation of the rules for Medicare coverage, this has been the retort given repeatedly to individuals who need continued treatment such as physical therapy to maintain their current level of functioning.

The origination of this misinterpretation of Medicare law and regulations is somewhat hazy. After many years of dealing with the issue, the best explanation is that a Contractor Manual that Medicare put out many years ago had language that resulted in denials of medical billing for therapy that did not have restorative potential. Over time, this idea permeated the Medicare universe such that almost any Home Health agency will tell you that this is in fact Medicare's coverage rule for this type of treatment.

This is wrong: it has never been Medicare's rule or regulation that Medicare will not pay for a treatment that does not have restorative potential.

In a previous paper, entitled *The Almost Perfect Case Appeal of a Denial of Skilled Nursing Care Benefits*, your author covered this topic extensively.[29]

42 C.F.R. § 409.32(c) states:

> The restoration potential of a patient is not the deciding factor in determining whether skilled services are needed. Even if full recovery or medical improvement is not possible, a patient may need skilled services to prevent further deterioration or preserve current capabilities. For example, a terminal cancer patient may need some of the skilled services described in Sec. 409.33.[30]

This section of the C.F.R. has not changed since 2001. Although it would appear that the law was quite clear concerning the "medical improvement standard" as far back as 2001, it took a Federal class action lawsuit filed in 2011 and an additional six years of litigation to finally put to rest this problem that has plagued beneficiaries and resulted in wrongful denials of care since at least 2001.

On March 3, 2011 the Center for Medicare Advocacy and the Medicare Advocacy Project of Vermont Legal Aid, Inc. filed suit in a case which became known as *Jimmo v. Sebelius*.[31] The principal plaintiff was Glenda Jimmo, a 71-year-old legally blind woman who had lost her right leg due to complications from diabetes. A private Medicare contractor denied her coverage for nurses and home health aides because "her condition was stable with no acute changes."[32]

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[29] Pi-Yi Mayo, *Tracks of the Future of Elder Law*, Seminar Paper for the National Acad. of Elder Law Attorneys Inst. (Nov. 1, 2001), 3-4, available at https://mayopoland.com/wp-content/uploads/2015/03/Almost_Perfect_Case_WEB.pdf.

[30] 42 C.F.R. § 409.32(c).

[31] *Jimmo v. Sebelius*, No.5:11-cv-17, 2011 WL 5104355 (D. Vt. Oct. 25, 2011).

[32] *Id*.

Eventually, the parties reached an agreed settlement in January of 2013, but it took several more years of litigation to finally get the Centers for Medicare and Medicaid Services to issue revised program manuals.

Specifically, in accordance with the settlement agreement, the manual revisions clarify that coverage of skilled nursing and skilled therapy services in the skilled nursing facility (SNF), home health (HH), and outpatient therapy (OPT) settings "…does not turn on the presence or absence of a beneficiary's potential for improvement, but rather on the beneficiary's need for skilled care." Skilled care may be necessary to improve a patient's current condition, to maintain the patient's current condition, or to prevent or slow further deterioration of the patient's condition.[33]

The Medicare Benefit Policy Manual states:

> A patient's overall medical condition, without regard to whether the illness or injury is acute, chronic, terminal, or expected to extend over a long period of time, should be considered in deciding whether skilled services are needed. A patient's diagnosis should never be the sole factor in deciding that a service the patient needs is either skilled or not skilled. Skilled care may, depending on the unique condition of the patient, continue to be necessary for patients whose condition is stable.[34]

Hopefully, this issue will finally be put to rest, but if history is any indicator, this problem will continue to plague beneficiaries in the future. Any advocate who is involved with a case of denial of benefits because the patient has "plateaued" should go first to the Center for Medicare Advocacy's website.[35] The website contains a vast amount of information on how to fight such denial.

IX. ISSUE #8 DO I NEED TO WORRY ABOUT MEDICAID ELIGIBILITY IF I CAN AFFORD PRIVATE INSURANCE?

When settling a personal injury case, the issue of how the proceeds from the settlement will impact eligibility for Government benefit programs is an important one. Most experienced personal injury attorneys are familiar with the need to take specific steps to preserve eligibility for such benefits by placing the funds in a Special Needs

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[33] Ctrs. for Medicare & Medicaid Servs., *Jimmo v. Sebelius Settlement Agreement Fact Sheet*, available at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/Jimmo-FactSheet.pdf (last visited Oct. 22, 2018).

[34] Ctrs. for Medicare & Medicaid Servs., Medicare Benefit Policy Manual, Pub. 100-02, Ch. 7, § 40.1.1, (Rev. May 07, 2021), Medicare Benefit Policy Manual, Pub. 100-02, Ch. 8, § 30.2.2.1, (Rev. August 5, 2021) available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c07.pdf.

[35] Ctr. for Medicare Advocacy, http://www.medicareadvocacy.org/ (last visited May 14th., 2022).

Trust. This topic is not about how to create or how to utilize such a Trust to maintain eligibility for benefits. This discussion is about why government benefits may still be important if the client will have sufficient assets from the settlement of the lawsuit to purchase private insurance.

As set forth above in article VI. above, many times the need to maintain Medicaid eligibility does not even involve the issue of payment for medical care but other services that are dependent on Medicaid eligibility (like ability to stay in a group home).

In cases of severe injuries with significant recoveries, the question arises, “why jump through all of the hoops necessary to qualify for a means tested program when we can just buy insurance?”

This discussion involves the assumption that a severely injured person with extensive medical treatment requirements that may include expensive prescription medication costs will be able to purchase medical insurance that will cover her extensive costs.

This ability to purchase medical insurance without undergoing underwriting requirements is a tenant of the Affordable Care Act (Obama Care). The Affordable Care Act (ACA) generally requires health insurance issuers to offer all of their individual market and group market plans to any eligible applicant in the state. Coverage cannot be denied or rates based on preexisting conditions of the individual seeking to purchase the coverage. A pre-existing condition is any health condition or illness that was present before the coverage effective date, regardless of whether medical advice or treatment was actually received or recommended. [36]

The ACA requires health insurance issuers to accept any individual who applies for a policy, subject to certain exceptions. This provision is called guaranteed issue or “guaranteed availability." Individual market coverage offered through and outside the Marketplace may restrict guaranteed issue coverage to certain specified Open Enrollment and special enrollment periods.[37] Additionally, the Affordable Care Act generally requires health insurance issuers to renew or continue in force coverage at the option of the policyholder. This is called “guaranteed renewability."[38] To ensure continuity of coverage for consumers if an issuer is undergoing a corporate reorganization, a product transferred from one issuer to a different issuer within an issuer's controlled group may be considered to be the same product for purposes of guaranteed renewability if certain criteria are met.

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[36] 45 CFR § 144.103 - Definitions.

[37] 45 CFR § 147.104 - Guaranteed availability of coverage.

[38] 45 CFR § 148.122 - Guaranteed renewability of individual health insurance coverage.

At first glance, the question of whether to seek or to maintain Medicaid eligibility may seem like an easy one to answer. If a client has the resources and the ability to purchase private health care insurance, why would she go through the crucible that is required to qualify or maintain eligibility for Medicaid? The answer lies in the specific facts of the case. If the client has expensive treatment needs or other care expenses that would be covered by Medicaid and would potentially, within a short period of time, exhaust a significant amount of the resources of the individual, then it may behoove the person to take all necessary steps to insure that she could immediately seek Medicaid eligibility in the event there were some change in her ability to purchase private insurance.

The benefit of guaranteed issue and guaranteed renewability is absolutely dependent on the ACA. If the ACA were to be repealed or the provisions concerning preexisting conditions were to be modified, then coverage for an individual with complex and expensive medical needs may be unobtainable at any price. If those medical expenses had to be paid out of the resources of the person–even for a short period of time (while taking steps to qualify for Medicaid)–the loss of resources could be catastrophic to a person's financial well being. If the individual were a minor or an incapacitated person, then the time involved in seeking court approval of the creation of a special needs trust or to take other action to qualify the individual for Medicaid could take an extended amount of time during which the private pay costs of such medical treatment could be exorbitant.

The guaranteed issue provisions of the ACA have been modified once by the Patient Protection and Affordable Care Act; Market Stabilization Rule on June 19, 2017.[39] The ACA provisions concerning the guaranteed issue or guaranteed renewability can be modified or even eliminated at anytime. It is incumbent on advocates for clients facing huge medical bills to determine if it is worthwhile to put in place protections against further changes in the existing law or regulations.

X. ISSUE #9: MEDICARE SAVINGS ACCOUNTS WHEN MEDICARE AND MEDICAID DO NOT PLAY WELL TOGETHER

There is still debate in some circles about the necessity to create a Medicare Set-Aside Account (MSA) for an individual who settles a personal injury lawsuit and is or will be on Medicare in the near future. Even if you believe that no Medicare Set Aside is currently required and should not be done in any case at this time, it is clear that the Centers for Medicare & Medicaid Services (CMS) is proceeding with rule-making to put in place regulations dealing with MSAs in third-party liability cases. The discussion that follows assumes that sometime in the near future the debate over the necessity to create an MSA in third-party liability cases will be settled and MSAs will be required in third-party liability cases where damages are awarded for future medical expenses and the person meets certain criteria regarding eligibility for Medicare benefits.

[39] Federal Register / Vol. 82, No. 73 / Tuesday, April 18, 2017 / Rules and Regulations 18347.

MSAs when the facts involve a plaintiff who is over 65 years of age, can be a problem if the person is a dually eligible individual (meaning they have both Medicare and Medicaid). The problem is that money set aside in the MSA is considered a countable resource by the Medicaid Program. If the amount of the MSA exceeds $2,000 then the beneficiary of the MSA would lose her Medicaid benefits.

If the plaintiff in such a case is below age 65, the solution is readily available. The MSA account is simply made a sub-ccount of a special needs trust.[40] If the subaccount complies with the currently unwritten rules that CMS applies to MSA accounts, then the risk that Medicare will refuse to pay future medical bills based on the Medicare Secondary Payer rules will be eliminated. Further, if the subaccount is placed inside a special needs trust that meets all of the requirements to make the assets in the trust an uncountable resource for Medicaid purposes, then the person will be able to maintain her Medicaid Eligibility without regard to the amount of assets in the trust as a whole or the amount of assets in the MSA subaccount. This is the easy case. MSA subaccounts have been used in this manner with special needs trust for many years and have been accepted by both Medicare and Medicaid.

The problem arises when the plaintiff in such a lawsuit is over the age of 65 years and, therefore, ineligible to utilize a special needs trust to render the assets as an uncountable resource for Medicaid purposes.

A Medicaid beneficiary cannot have more than $2,000 in countable resources in her name and still maintain eligibility for Medicaid.[41] Medicare will refuse to pay for any future medical bills that were covered by the settlement unless funds are placed in an MSA. This dilemma exists even though the assets in the MSA are restricted from being spent on anything other than the medical expenses of the beneficiary. The safe harbor provisions of the special needs trust rules will not apply to any trust arrangement made by an individual over the age of 65 years. Even with the restrictions on the usage of the funds, the funds will still be a countable resource for Medicaid purposes and if more than $2,000, will disqualify the individual from Medicaid eligibility.

Consider the following example: Mary, a 72-year-old wife and mother, has been on Medicare since she turned 65. Several years ago, she entered a nursing home because of her extensive medical needs. Mary's husband John lives in their home and to preserve the assets of the couple so that John would have sufficient income and assets to pay for his living expenses, John sought the help of an elder law attorney and applied for Medicaid benefits on behalf of his wife. The last several years, her care in the nursing home has been paid for by the Medicaid Program. John was allowed to

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[40] Texas Health and Human Servs., Medicaid for the Elderly and People with Disabilities Handbook, F-6710 Special Needs Trust.

[41] Texas Health and Human Servs., Medicaid for the Elderly and People with Disabilities Handbook, F-1300, Resource Limits.

keep their home, his truck, and their modest nest egg that includes savings accounts, stocks and bonds, and individual retirement accounts totaling $300,000. You represented Mary in a medical malpractice case and secured a settlement for her in the amount of $250,000. Mary had very complicated medical issues prior to the lawsuit and these medical issues were exacerbated by the mishandling of her medical care. It is vital that Mary continues to receive her Medicare benefits to cover the cost of her future medical care and that she maintains her Medicaid eligibility to cover the cost of her nursing home care.

It is clear that Mary cannot utilize a special needs trust with an MSA subaccount inside it to protect the resources from being counted against her by Medicaid and in turn disqualify her from her Medicaid benefits. At first glance, this seems to create an irreconcilable issue where the rules of Medicare and Medicaid are in conflict that would prevent us from maintaining eligibility for both of the benefit programs. If Mary were to lose her Medicaid, then she would have to privately pay the cost of her nursing home care which will in most instances exceed $6,000 per month. If she were to be denied Medicare coverage for a medical bill that is related to the injuries the result of the malpractice suit the cost could be extremely expensive.

As is most often the case in complicated legal matters, the exact facts of each case can dictate the solution to the problem. There may be several different possible plans that could solve Mary's predicament for the benefit of both Mary and her family. Mary's long-term prognosis will play a large part in creating a strategy to preserve both her Medicare and her Medicaid eligibility. The age and health care needs of her husband can be an important factor in designing a plan. The medical and financial needs of her children could also be an important factor. Depending on the specific facts of Mary's case, it may be possible to obtain the desired result using a qualified structure that would meet both the Medicare and Medicaid rules.[42] The use of a qualified structure is only one of the possible solutions to our dilemma. The important thing to learn from this scenario is that the standard solution of using special needs trust will not work in this case so we must seek other strategies to obtain the desired result. While it may seem impossible to meet the requirements of both the Medicare and the Medicaid Program, there are solutions. It is important that advocates are aware that there are planning opportunities that will allow for Mary to maintain her Medicare and Medicaid benefits. Even though Medicare and Medicaid may seemingly conflict, it is possible to get them to come together on a solution that will work for clients like Mary.

XI. ISSUE #10: BITS AND PIECES

This section is devoted to specific Medicare and Medicaid rules that may prove to be important in planning for the client after the settlement or judgement in a personal

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[42] Texas Health and Human Servs., Medicaid for the Elderly and People with Disabilities Handbook, F-7000, Annuities, §358.335. Treatment of Annuities with a Purchase or Transaction Date on or after February 8, 2006.

injury case. Personal injury attorneys should be aware of these types of issues that are not prevalent in all cases but can be very important depending on the specific circumstances of a case.

A. Deeming Rules

It is well known that a recovery made on behalf of a child if it exceeds $2000.00 can if not handled correctly disqualify the child from receiving means tested benefits like Medicaid. But, monies recovered (resources) or income received by others such as parents can also disqualify a child under age 18 given certain circumstances. The rules that govern this area are referred to as Deeming Rules. A child under age 18 who is applying for or receiving SSI, and who lives in the same household as his or her parent(s) or the spouse of a parent, is presumed to share in the parents' income.[43] Deeming continues through the month the child attains age 18 and meets all other requirements of the definition of a child. A child who is away at school may be considered to be temporarily absent from the parents' household and may also be subject to deeming.[44] A child for SSI purposes, according to the Social Security Act, is neither married, nor the head of a household, and is either under age 18, or under age 22 and a student regularly attending school, college, or training that is designed to prepare him or her for a paying job.[45] The income and resources of the spouse of a natural or adoptive parent (stepparent) who lives with the eligible child are deemed to the child only when the natural or adoptive parent also lives in the household with the stepparent and the child.

Spouse-to-spouse deeming of income and resources can be involved in the eligibility or the payment determination, or both, for an eligible individual who lives with an ineligible spouse. [46]

Aliens who seek admission to the United States must establish that they will not become "public charges." Many aliens establish that they will not become public charges by having "sponsors" who pledge to support them. Since October 1980, the law has required that a sponsor's income and resources (and those of the sponsor's living-with spouse) be considered when determining an alien's SSI eligibility and payment amount.[47] Sponsor-to-alien deeming may apply regardless of whether the alien and sponsor live in the same household. Also, sponsor-to-alien deeming may apply regardless of whether or not the sponsor actually provides the alien with any support.

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[43] SSA POMS SI 01320.500.

[44] SSA POMS SI 01310.165

[45] SSA POMS SI 00501.010D.

[46] SSA POMS SI 01330.100. , SSA POMS SI 01320.400.

[47] SSA POMS SI 01320.900.

These rules can disqualify a child, spouse or alien even if the correct measures are taken to make sure that the recovery of the client is properly considered and the correct measures taken to prevent the client's assets or income from disqualifying them.

B. There Are Many Different Medicaid Programs

If you represent a client that is receiving government benefits one question that will confront almost every advocate is will the proceeds from my recovery cause me to lose my benefits? In order to answer this question we need to know the source of benefits the client is receiving. Some benefits such as Social Security Disability (SSDI) and Medicare are not means tested so no matter how large the recovery it alone will not affect the client's benefits. The best way to understand this is to use the example of Oprah Winfrey or Bill Gates. If either of these well know icons were to become disabled they could qualify for Social Security Disability. The fact that they are very wealthy does not have any impact on their ability to qualify for SSDI.

This will not be the case for the majority of clients that have significant medical bills and are unable to work because of their injuries. Most of these clients will have exhausted all of their resources and will be receiving government benefits that are means tested programs. Some parts of the benefits that the client might be eligible for are cash assistance programs such as Supplemental Security Insurance (SSI). But the most important benefit that the client may be eligible for is medical coverage through Medicaid. In order to determine the effect of a recovery in a personal injury case on Medicaid benefits we have to know what type of Medicaid program the client is on. It may not be easy to make that determination. Many clients that have been on Medicaid benefits for years may have no idea what program provides their benefits.

There is no one-Medicaid program. There are many different Medicaid programs with different eligibility criteria and different benefits. Below is a list of some of the commonly utilized Medicaid programs. The listing is not by any means exhaustive and is not sorted based on the benefits that the program provides but is only included to illustrate the many different programs that exist. Some of the programs are referred to as “mandatory coverage groups” and others are referred to as “optional coverage groups” by the Texas Administrative Code. The difference between the programs is that some of the programs are mandated by the Federal rules for the State to participate in the Medicaid program and others are provided as additional programs by the State that the Federal rules do not require.[48]

1. Supplemental Security Income (SSI) eligible. In accordance with 42 CFR §435.120, this mandatory coverage group covers a person who is aged, blind, or disabled and is receiving SSI or deemed to be receiving SSI. The Social Security Administration (SSA) determines eligibility for SSI under Title XVI of the Social Security Act. If SSA determines that a person is eligible for SSI, Texas Medicaid accepts SSA's

[48] 1 Tex. Admin. Code Ann. §358.107.

determination as an automatic determination of eligibility for Medicaid.

2. Coverage for certain aliens. In accordance with 42 CFR §435.139, an alien, as defined in 42 CFR §435.406, is provided services necessary for the treatment of an emergency medical condition, as defined in 42 CFR §440.255.

3. Disabled adult child. In accordance with §1634(c) of the Social Security Act (42 U.S.C. §1383c), this mandatory coverage group covers a person who:

a. is at least 18 years of age;

b. became disabled before 22 years of age;

c. is denied SSI because of receipt of or an increase in Retirement, Survivors, and Disability Insurance (RSDI) disabled children's benefits received on or after July 1, 1987, and any subsequent increase; and

d. meets current SSI criteria, excluding the RSDI benefit described in subparagraph (C) of this paragraph.

4. Historical 1972 income disregard. In accordance with 42 CFR §435.134, this mandatory coverage group covers a person who:

a. was receiving both public assistance and Social Security benefits in August 1972; and

b. meets current SSI eligibility criteria, excluding from income the October 1972 cost-of-living adjustment (COLA) increase in Social Security benefits but not excluding subsequent COLA increases in Social Security benefits.

5. Title II COLA disregard (Pickle). In accordance with 42 CFR §435.135(a) - (b), this mandatory coverage group covers a person who:

a. has been denied SSI for any reason since April 1977; and

b. meets current SSI eligibility criteria, excluding from countable income any Social Security COLA increases received after the person last received both SSI and Social Security benefits in the same month.

6. Disabled widow's or widower's COLA disregard. In accordance with 42 CFR §435.137, this mandatory coverage group covers a person who:

a. is 50 to 60 years of age;

b. is ineligible for Medicare;

c. was denied SSI due to an increase in a disabled widow's or widower's and surviving divorced spouse's RSDI; and

d. meets SSI eligibility criteria, excluding from countable income the RSDI benefit and any subsequent COLA increases in RSDI.

7. Early age widow's or widower's COLA disregard. In accordance with 42 CFR §435.138, this mandatory coverage group covers a disabled person who was denied SSI due to early receipt of Social Security widow's or widower's benefits and:

a. is at least 60 years of age;

b. is not eligible for Medicare; and

c. meets current SSI eligibility criteria, excluding from countable income the RSDI benefit and any subsequent COLA increases in RSDI.

8. Institutional. In accordance with 42 CFR §435.211, this optional coverage group covers a person who would be eligible for SSI, as specified in 42 CFR §435.230, if the person were not in an institutional setting.

9. Institutional special income limit. In accordance with 42 CFR §435.236, this optional coverage group covers a person who has lived in an institutional setting for at least 30 consecutive days, as described in §358.433 of this chapter (relating to Special Income Limit), and is eligible under the special income limit.

10. §1915(c) waiver program. In accordance with 42 CFR §435.217, this optional coverage group covers a person who would be eligible for Medicaid if institutionalized, but is living in the community and receiving services under a §1915(c) waiver program.

11. Medicare Savings Program. In accordance with 42 U.S.C. §1396a(a)(10)(E) for this mandatory coverage group, Texas Medicaid may determine eligibility for a person who meets the criteria in Chapter 359 of the TAC (relating to Medicare Savings Program) for a Medicare Savings Program, which uses Medicaid funds to help the person pay for all or some of the person's out-of-pocket Medicare expenses, such as premiums, deductibles, or coinsurance.

12. Medicaid Buy-In Program. In accordance with §1902(a)(10)A)(ii)(XIII) of the Social Security Act (42 U.S.C. §1396a(a)(10)(A)(ii)(XIII)) for this optional coverage group, Texas Medicaid may determine eligibility for a person with a disability who is working and earning income and meets the criteria established in Chapter 360 of the TAC (relating to Medicaid Buy-In Program).

13. Medicaid Buy-In for Children. In accordance with §1902(cc) of the Social Security Act (42 U.S.C. §1396a(cc)) for this optional coverage group, Texas Medicaid may determine eligibility for a child with a disability who meets the criteria established in Chapter 361 of the TAC (relating to Medicaid Buy-In for Children Program).

XII. CONCLUSION

The title to this paper is somewhat presumptuous in that it is impossible to narrow down the subject matter to ten things that you should know about Medicare and Medicaid. The ten things that are covered herein are things that your author has received questions about over the years and some more arcane subjects that may assist personal injury attorneys in counseling their clients as well as providing information that may be helpful in dealing with Medicare decisions for themselves and their families.