Stetson's 2024 Conference on Special Needs Planning and Special Needs Trusts

PI Settlements and SNTs

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By: Vincent J. Russo and Marvin Rachlin, *New York Elder Law and Special Needs Practice (West 2024 Edition)*

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N.Y. Elder Law Practice § 2:8 (2024 ed.)

New York Elder Law and Special Needs Practice | May 2024 Update
Vincent J. Russo, Marvin Rachlin

Chapter 2. Practice of Special Needs

§ 2:8. Special needs planning issues

The attorney may be approached by the parents of a child with special needs with various concerns.

The parents may be concerned that they may not be able to leave a bequest to the child for fear of endangering eligibility for some governmental program. On this issue, it will be necessary to determine what benefits the child receives. It could be Social Security Disability Insurance (SSDI), Supplemental Security Income (SSI), Medicare or Medicaid or a combination of them.

It will also be necessary to know the age of the child, where the child lives, and what their special needs are. With a complete understanding of the facts and circumstances, the attorney can start to formulate a plan that will meet the parents' objective of leaving assets to a child without endangering eligibility for means tested governmental programs which are currently providing payments or services and also those that may be applied for in the future.

The attorney may also be retained by a parent whose child is a legal minor (under age eighteen (18)).[1] It is also best if the attorney meets with the parents when the child reaches age 14 due to the SSI transfer penalty and three (3) year look-back rules.[2] Another option that is now available for an over-resourced SSI applicant is to take advantage of an Able Account.[3]

Decision Making. Sometimes, a parent will seek the attorney's counsel when a child is approaching age 18 because the parent will lose the legal authority to act on behalf of their child when the child attains age 18. If the parent informs the attorney that the child lacks the capacity to make financial and medical decisions, and hence, cannot execute a health care proxy, living will or a power of attorney, then the special needs planning attorney will be able to explain the parent's predicament and offer a plan to enable the parent to continue making financial and medical decisions for the child.[4]

In some instances, a parent may be unaware that the parent's authority to make medical decisions for a child who is 18 or older in spite of the fact that there was no greater capacity at age 18 than there was before. The Family Health Care Decisions Act of 2010[5] expanded decision-making authority for patients in a facility-based setting but *excluded* persons with developmental disabilities. There are other laws that govern persons whose treatment is governed by the state Office of Mental Health (OMH) or NYS Office for People with Developmental Disabilities, namely SCPA § 1750(b). The Surrogate's Court Procedure Act identifies "qualified" family members (including parents) to make health care decisions but still limits it to the withholding or withdrawing of life sustaining treatment for end of life decisions and not general medical treatment. A parent would not possess the authority to dictate the place of residence of the child or simple day to day decisions. A special needs planning attorney must be familiar with advance directives and guardianship proceedings in order to be able to properly advise the parents.

Advance Directives. For those individuals with special needs who have requisite mental capacity to understand the meaning and purpose of advanced directives, the attorney would be well advised to recommend that a health care proxy,[6] HIPAA release, living will,[7] and comprehensive durable power of attorney[8] be executed.

Capacity Issues. The special needs planning attorney should meet with the individual with special needs and not rely on the description of others regarding the individual's abilities and capacity. For the individual with some mental capacity, it is important for the individual to be present at the meeting, if possible. Beyond having the opportunity to assess capacity, it is just as important to make the individual a party to the planning that is being explored for their benefit. Not all individuals will have enough mental capacity to participate in planning and to execute legal documents. You may be called upon to represent a legal guardian or an individual who is seeking guardianship in order to plan for someone who has never had the capacity to execute a health care proxy, or any other legal document.

Guardianship. Article 17A guardianships are a valuable tool for special needs planning attorneys. This planning tool can be combined with other tools such as irrevocable trusts, including payback trusts which can be authorized by the Surrogate. When a child reaches age 18 and does not have the ability to make sound decisions, an Article 17A guardianship proceeding should be commenced in the surrogate court in the county where the child resides.[9] Once appointed guardian with-health care decision making authority, the parent can make medical decisions for a child over the age of 18.[10] Powers under an Article 17A guardianship may include authority to make end of life decisions for the child, subject to the statutory requirements.[11]

In addition to health care decisions, the guardian can also make decisions regarding the personal needs of the adult child such as:

i. whether they should travel;

ii. determining who shall provide personal care or assistance;

iii. whether they should have a license to drive;

iv. decisions regarding education;

v. access to or release of confidential records;

vi. choosing their place of abode; and

vii. applying for government or private benefits.

Standby and Alternate Guardians. Parents are faced with the realization that not only is the child with special needs getting older, but so are they. The special needs planning attorney should discuss with the parents who will be the caregiver when the parent or parents are no longer able to provide care either because of illness, disability, or death. The special needs planning attorney should explain that as part of the Article 17A guardianship proceeding, standby or alternate guardians can be appointed, ready to step in whenever the parent/guardian is no longer able to act.[12]

Supported Decision Making. On July 26, 2022, Governor Kathy Hochul signed Supported Decision Making into Article 82 of the Mental Hygiene Law.[13] It provides a formal manner for individuals with intellectual and developmental disabilities to appoint a person to assist them in making decisions. The parties enter into an agreement which identifies the disabled person's supporters and the scope of the agreement. There is a presumption of capacity for all adults unless a legal guardian has been appointed.[14] This law was enacted to encourage support for disabled persons while maintaining their control in decision making. Supported Decision Making can be used in addition to signing advance directives such as a Durable Power of Attorney and Health Care Proxy which appoint an agent to substitute the disabled person's decision making.[15] It is also a less restrictive means to an Article 81 guardianship proceeding.[16]

Health Care Decision-Making. In 1991 the Health Care Proxy became part of New York Law.[17] Once properly executed, the health care proxy allows the principal to designate an agent to make all medical decisions, including end of life decisions for the principal, when the principal does not have the capacity to make their own decisions.

In 1993, the legislature addressed the issue of substituted judgment for individuals who never had the capacity or lost the capacity to execute a health care proxy by passing the Health Care Decisions Act for Persons with Mental Retardation.[18] Guardians appointed pursuant to Article 17A of the Surrogates Court procedure act were given authority to make major health care decisions, including end of life decisions but only for wards that were mentally retarded. It wasn't until the end of 2007 that the same authority was extended to 17A guardians for wards who are developmentally disabled.[19]

It is important to note that health care decision-making under the Family Health Care Decisions Act does not apply to individuals who never had the capacity to make health care decisions for themself.

Testamentary Bequests to a Special Needs Child. The special needs planning attorney should also discuss with the parents how they can leave assets for their child with special needs without affecting eligibility for governmental benefits such as SSI and Medicaid. The attorney will also need to clarify with them that Social Security Disability Insurance and Medicare are not financially means tested. There should be a discussion with them as to the benefits of a lifetime or a testamentary supplemental needs trust for the benefit of their child. Such a trust, when properly drafted, can allow the trust assets to enhance and improve the life and care of the individual with special needs without reducing or eliminating any governmental benefits.[20]

Malpractice and Personal Injury Settlements. Tort attorneys are valuable contacts for special needs planning attorneys. The special needs planner may be contacted by a medical malpractice or negligence attorney who is close to settling a case on behalf of a client in receipt of Supplemental Security Income (SSI) or Medicaid or both. Often, the call will come after the case has been settled and time is of the essence. The tort attorney will be seeking the special needs planning attorney's expertise to protect the eligibility for SSI and/or Medicaid of the client who will soon receive a substantial sum of money. There also may be Medicare and/or Medicaid lien issues that the tort attorney will ask the special needs attorney to help resolve. Further, the settlement may be subject to the Medicare Secondary Payer Act.[21]

There is also a group of special needs attorneys who have focused on settlement planning as its own specific practice area. Settlement planning is a process that integrates immediate and periodic payments by planning for the timely use of funds by using annuities, trusts, taxable investments, and other vehicles. It strives to preserve assets through coordination with other benefits such as Medicaid and Medicare and by prudent estate planning.[22]

First Party Special Needs Trusts. In some cases, the appropriate plan may be to create and fund a First Party Special Needs Trust which can either be a Special Needs Trust (sometimes referred to as a payback trust, or a d(4)(a) trust)[23] or a Pooled Trust (sometimes referred to as a d(4)(c) trust).[24] If a special needs trust is being used, it is important that the trust be prepared and either in place prior to settlement or made a part of the court proceeding, so that the recovery will be paid directly into the trust by court order. This will prevent any break in coverage for a means tested program such as Medicaid or SSI. The special needs planning attorney should also be aware of the 10-day reporting rule for SSI. You have 10 days after the month in which the change occurred to report a change.[25] It is recommended that the notice is sent using a mail tracking mechanism such as overnight courier, registered or certified mail.

As a special needs planning attorney, you may develop a different plan if the client receives community Medicaid in New York, Social Security Disability Insurance and/or Medicare. The attorney will be called on to decide whether a Special Needs Trust is the most appropriate plan. The decision will be based on the client's age, the level of care and the probability of requiring institutional care within the next five years. After analyzing the relevant factors, the special needs attorney may consider presenting two alternatives to the client: one, to create and fund a Special Needs Trust or two, create and fund a Medicaid Asset Protection Trust. To

look ahead five years presents probabilities, but no certainty. Once there has been a full explanation and discussion the client will be able to make an educated choice between a Special Needs Trust and a Medicaid Asset Protection Trust which will not affect community Medicaid but will protect assets after the five-year look back for Medicaid nursing home care and avoid a Medicaid payback. The attorney's case notes should reflect the alternatives that were explained as well as the choice that was made. The same information should be contained in a letter to the client to avoid any question in the future regarding the choice that was made.

Inter-Vivos Third Party Supplemental Needs Trust.[26] There will be times that you are approached by a parent, other relative or friend to create and fund an inter-vivos irrevocable third party supplemental needs trust (Supplemental Needs Trust) for an individual with special needs. Because this is a third party trust, a special needs trust which has a payback provision to the state is not required (unlike a First Party Special Needs Trust). The attorney should explain that after the initial funding, the client (typically the parents) will be able to add additional assets to the existing trust. Testamentary bequests can also be made to the existing trust. If there are other people who may be inclined to make gifts or bequests to the individual with special needs, the client should be advised to inform them that such gifts or bequests can be made to the existing trust, now or in the future without effecting eligibility for programs such as Medicaid or SSI for the child with special needs.

Footnotes

1 For more information go to: http://www.vjrussolaw.com/resources/free-planning-guides/.

2 *See infra* § 10:49.

3 *See infra* § 10:40 Supplemental Security Income—Resources.

4 *See infra* § 9:17.

5 PHL section 29-C.

6 *See infra* § 7:40.

7 *See infra* § 7:30.

8 *See infra* Powers of Attorney Ch 6.

9 *See* § 9:1.

10 It is important to note that health care decision-making under the Family Health Care Decisions Act

does not apply to individuals who never had the capacity to make health care decisions for themself; *see* § 7:27, The Family Health Care Decisions Act, for more details.

11 *See* § 9:6; SCPA §§ 1750, 1759(b).

12 *See* § 9:8.

13 MHL § 82.01.

14 MHL § 82.03.

15 *See infra* §§ 6:1 and 7:1.

16 *See infra* § 9:3; MHL § 82.01.

17 Pub. Health Law § 2977.

18 *See infra* § 7:27.

19 *See infra* § 9:17.

20 *See* §§ 22:7, 22:8.

21 42 U.S.C.A. § 1395y(b).

22 *See* Society of Settlement Planners at http://societyofsettlementplanners.com/.

23 *See infra* §§ 21:16 and 21:17.

24 *See infra* §§ 21:15, 21:19.

[25] *See* https://secure.ssa.gov/poms.nsf/lnx/0502301005.

[26] *See infra* § 21:22.

N.Y. Elder Law Practice § 9:9 (2024 ed.)

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Chapter 9. Guardianships—Article 17A

§ 9:9. Article 17A Guardianships—Special Needs Trusts

Special Needs Planning is not only limited to Article 81 guardianship proceedings. Under Article 17A, the opportunity to preserve the assets of an individual who has intellectual disabilities and/or developmental disabilities exists through the use of Special Needs Trusts.

An application to establish and fund a Special Needs Trust can be brought after a Guardian of the Property has been appointed in the initial Article 17A proceeding. It is good practice to obtain the procedural guidelines from your local Surrogate's Court. The petition to establish the Special Needs Trust should be made at the earliest possible moment, especially where Medicaid benefits are at stake. The timing of the petition can make the difference between assets being deemed available or unavailable for Medicaid eligibility purposes. While local Medicaid agencies have taken the position that a pending Article 17A petition for the appointment of a guardian and the establishment of a Special Needs Trust where the assets have not yet been distributed to the person with a disability deem the assets unavailable, the Social Security Administration may take the position that the assets are available until the Special Needs Trust has been established and funded with said assets.

During this proceeding, as in an 81 proceeding, the assets of the individual are deemed unavailable by the local Medicaid agency because of the inability of the person with a disability to manage their assets. However, the assets would be deemed available upon the appointment of the guardian.[1]

In cases where a guardian is appointed and no application for the Special Needs Trust was made, the disabled person will not be eligible for Medicaid benefits if their assets exceed the resource allowance for Medicaid eligibility.

In many situations, the local Medicaid agency provides a health care safety net for individuals with a disability.

The continuation of Medicaid benefits is in the best interest of the disabled person, and this point should be made clear in the petition as a means of preemptively easing any judicial reluctance to entertain both issues in the initial application.

In the event the disabled person is also receiving SSI benefits and intends to maintain SSI eligibility, it is critical that the attorney advise the client that SSI may take the position that the assets are available until the Special Needs Trust is established and funded with those excess assets, and if the assets exceed the allowable limit, then the individual's SSI benefits may be terminated. In addition, the terms of the Special Needs Trust must mandate the Medicaid be paid back on death to the State before the payment of funeral expenses. For an SSI recipient, the inclusion of an order to prepay a burial before funding the Special Needs Trust is paramount. In cases where an individual's Medicaid eligibility is directly tied to the individual's SSI eligibility and the SSI has been terminated; it is likely that the individual's Medicaid benefits will be terminated as well. In instances where an individual's Medicaid eligibility was determined prior to applying for SSI benefits, it is likely that the individual's Medicaid eligibility will remain unchanged for the duration of the proceeding.

It is very important to pay close attention to provisions of the Article 17A proposed order establishing and funding the Special Needs Trust to make sure that the implementation of the order will achieve the objective of the disabled person which is to protect assets while maintaining government benefits.

In re Larson. The timing of the application is paramount, but in at least one case where nearly everything went wrong, the court found a way to provide the needed relief. In *In re Larson*[2] the court considered the case of a developmentally disabled SSI and Medicaid recipient residing in a New York State operated residential alternative. In 1987, the individual inherited $25,000. The 17A petition was first filed in 1995 seeking authority to establish a supplemental needs trust for the inherited $25,000. Though authorized by the court, the trust was never established or funded. In 2002, the petitioners, joined by the director of the Hudson Valley Developmental Disabilities Service Office, asked the court for permission to transfer the inheritance to New York State to be deposited and administered in a manner similar to a supplemental needs trust.

The Nassau County Surrogate ruled that Mental Hygiene Law § 13.29 authorized the commissioner on behalf of the estate to accept and hold in trust, gifts devises, and so forth, for the maintenance, support, and benefit of one or more patients of a facility.[3] The court ruled that such trust would meet the requirements of federal and state law as an exempt trust. The court noted that 42 U.S.C.A. § 1396p(6) includes any legal instrument similar to a trust. The court therefore approved the transfer to the state for the creation of a trust pursuant to Mental Hygiene Law § 13.29.

Often, the disabled person has assets due to a personal injury or medical malpractice settlement. Again, it is important to carefully review the language of the proposed order or settlement of any third-party action. The proposed order or settlement of a third-party action should provide for a direction to first establish a prepaid funeral account and thereafter fund the Special Needs Trust.

Ahlborn. In the *Ahlborn* case, Heidi Ahlborn was a 19-year-old college student with dreams of becoming a teacher when she became the victim of a car accident. The accident left Heidi with permanent and severe injuries including brain damage. The injuries arising from the accident necessitated care which she was unable to finance. Heidi was determined to be eligible for Medicaid benefits. An action was later commenced against the parties who caused Heidi's injuries. The action sought damages for past medical costs and for permanent injury, future medical costs, past and future pain, suffering and mental anguish as well as past loss of earnings and permanent impairment of future earnings.

Once a settlement was reached, the state imposed a lien against the proceeds for all of its expenditures and not only the amount allocated to past medical payments but from the full settlement. The U.S. Supreme Court determined that any assignment of rights in a third party action could not require an assignment of the right to recover the portion of the settlement that was not allocated to payments for past medical expenses.

The court also agreed with the assertion that the federal anti-lien provisions preclude the attachment or

encumbrance of any part of the settlement not allowed to past medical expense.

For attorneys settling personal injury actions and even medical malpractice actions, the *Ahlborn* decision provided an advocacy opportunity to fund all proceeds but the damages allocable to medical costs into a Special Needs Trust.

Previously, in light of the Supreme Court decision in the *Ahlborn* case,[4] the proposed order or settlement should have contained a specific allocation of damages for past medicals. However, Section 202(b) of the Bipartisan Budget Act of 2013, effectively reversed *Arkansas Dept. of Health & Human Srvs. v. Ahlborn*. The Act, which was signed by President Obama on December 26, 2013, modified portions of the federal Medicaid Act to permit recovery not just for health care items but for "any payments by such third party." Under the Act, the local Medicaid agency was able to assert its lien against the entirety of the award instead of the portion of the award that represented payment for medical expenses. The practical concern with this law was that it would likely make negotiating liens with the local Medicaid agency much more difficult and would limit the amount of funds that would otherwise be available for Special Needs Trusts which could allow an individual to be eligible for Medicaid while permitting the individual to benefit from the trust.

Congress delayed the provision in the budget bill that gives states the ability to recover Medicaid costs from a beneficiary's full personal injury settlement or award by two years. The law ultimately was delayed until October 1, 2017. This meant that Medicaid would continue to only be able to recover from the portion of a personal injury settlement or award that was allocated to past medical expenses.

On February 9, 2018, President Trump signed a budget deal, which included among other issues, a new law, fully repealing Medicaid's expanded rights regarding third party settlements that had become effective October 1, 2017 as part of the Bipartisan Budget Act of 2013. Section 53102[5] of the 2018 Budget Act repeals Medicaid's expanded recovery rights granted in Section 202 of the Bipartisan Budget Act of 2013. This new law conforms to the Supreme Court's prior rulings in Arkansas Dept. of Health and Human Services v. Ahlborn, 547 U.S. 268, 126 S. Ct. 1752, 164 L. Ed. 2d 459 (2006) and Wos v. E.M.A. ex rel. Johnson, 568 U.S. 627, 133 S. Ct. 1391, 185 L. Ed. 2d 471 (2013) limiting Medicaid's recovery in third-party liability settlements based on the allocation of funds under the settlement.

While this may be widely accepted, it is still left to the States to decide to follow such ruling, as was exemplified by *Andrews ex rel. Andrews v. Haygood whereby the Court of Appeals of NC*, even considering *Ahlborn* still decided not to follow the ruling.[6] In its reasoning, the Court in *Andrews* stated the Court *in Ahlborn* was interpreting Arkansas Statute and not its own, quoting earlier cases saying "… it is well settled that "'the construction of the statues of a state by its highest courts is to be regarded as determining their meaning[.]" "[7]

While the use of Special Needs Trusts should always be considered, they should not be used in a mechanical fashion. There are situations where Special Needs Trusts are the perfect fit and where they simply make no sense at all.

Footnotes

1 N.Y.S. Department of Social Services Administrative Directive: 96 ADM-8.

2 In re Larson, 190 Misc. 2d 482, 738 N.Y.S.2d 827 (Sur. Ct. 2002).

3 In re Larson, 190 Misc. 2d 482, 738 N.Y.S.2d 827 (Sur. Ct. 2002).

[4] Arkansas Dept. of Health and Human Services v. Ahlborn, 547 U.S. 268, 126 S. Ct. 1752, 164 L. Ed. 2d 459 (2006). Reversed by the Bipartisan Budget Act of 2013.

[5] PL 115-123, § 53102, February 9, 2018, 132 Stat 299.

[6] Andrews ex rel. Andrews v. Haygood, 188 N.C. App. 244, 248, 655 S.E.2d 440, 443 (2008), aff'd, 362 N.C. 599, 669 S.E.2d 310 (2008) (abrogated by, Wos v. E.M.A. ex rel. Johnson, 568 U.S. 627, 133 S. Ct. 1391, 185 L. Ed. 2d 471 (2013)).

[7] Champion Fibre Co. v. Cozad, 183 N.C. 600, 607, 112 S.E. 810, 813 (1922) (quoting Supervisors v. U.S., 85 U.S. 71, 21 L. Ed. 771, 1873 WL 15960 (1873)).

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N.Y. Elder Law Practice § 21:15 (2024 ed.)

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Chapter 21. Living Trusts

§ 21:15. Medicaid: OBRA 1993 Exempt Trusts—Special Needs Trusts—Overview

The Special Needs Trust, also referred to as a "(d)(4)(A) Trust," a "Disability Trust," a "First Party Special Needs Trust" or a "Payback Trust,"[1] is available only to individuals who are disabled and under the age of 65 years. The trust must be funded with the assets of the individual who is disabled and must be created for their benefit by themself,[2] a parent, a grandparent, or a legal guardian of the individual or a court. The trust must be for the sole benefit of the individual who is disabled. Lastly, the trust must contain a payback provision to the state for Medicaid paid on the disabled individual's behalf.

It is important to note that prior to December 13, 2016, the Special Needs Trust could not be established by the disabled beneficiary of the Trust. On December 13, 2016, the *Cures Act*,[3] containing the *Special Needs Trust Fairness Act*, was signed by President Obama and passed into law. This marks an enormous milestone for

individuals with disabilities. The passage of this legislation establishes liberties for persons with disabilities which had been previously denied to them. Prior to passing the Act, only a parent, grandparent, legal guardian of the disabled individual, or a court could establish a Special Needs Trust on behalf of the disabled individual. Under the new Act, individuals with disabilities who are under the age of 65 and have capacity can create their own Special Needs Trust. It is the author's belief, that the Passage of the *Special Needs Trust Fairness Act* ends the false and degrading presumption that all individuals with disabilities lack the mental capacity to handle their own affairs.

The author is proud of the National Academy of Elder Law Attorneys (NAELA) for spearheading the efforts to get these provisions passed![4] The author is also honored to be a Founding Member and Past President of an organization that continues to pave the way for the betterment of the lives of the elderly and those with special needs.

New York State has implemented the Special Needs Trust Fairness Act effective May 22, 2017.[5]

The Special Needs Trust authorized by OBRA 1993 is exempt for Medicaid eligibility purposes and the funding will not affect the Medicaid eligibility of the individual.

There is a statutory requirement that the disabled beneficiary be under the age of sixty-five (65) upon the creation of the trust. If a Special Needs Trust is created for an individual who is under the age of 65, that trust will remain exempt if the individual lives beyond the age of 65. However, any assets added to the trust after the individual reaches age 65 will be subject to the Medicaid transfer penalty rules.

The Special Needs Trust must contain a payback provision. Upon the death of the individual, any balance left in the trust must be paid back to the Department of Health in an amount not to exceed the Medicaid benefits paid on behalf of the individual during their life.

The language of the federal statute regarding the payback provides that the "… state will receive all amounts remaining in the trust upon the death of such individual up to an amount equal to the total Medicaid assistance paid on behalf of the individual under a state plan under this subchapter."[6] This language raises an issue: whether Medicaid is entitled to recover any assistance paid on behalf of the individual prior to the creation of the trust. Since, upon the death of the disabled individual the balance of the trust funds will not be part of that individual's probate estate, it would not be subject to a Medicaid estate claim.[7] Thus, if the individual received Medicaid assistance prior to the creation of the trust, and if the trust was left with considerable assets after the individual's death, the issue of whether Medicaid benefits granted prior to the creation of the trust are recoverable is an important one.

There is no longer any question in New York State as to whether the payback provision requires payback of all Medicaid previously paid, including payments prior to the creation of the trust. The New York Court of Appeals, reversing an Appellate Division decision, ruled that all Medicaid payments including pre-trust payments are subject to the payback provision.[8]

If the Special Needs Trust is funded with the proceeds of a negligence or medical malpractice suit brought on behalf of the beneficiary of the Special Needs Trust, it is possible that there would be a Medicaid lien against the proceeds for the repayment of Medicaid benefits paid to treat the injury or condition caused by the negligence or medical malpractice.[9] It has been determined that such liens must be satisfied prior to the funding of a Special Needs Trust.[10]

Footnotes

[1] For purposes of this book, the authors will refer to this type of Trust as a "Special Needs Trust" and a Trust set up and funded by an individual for the supplemental needs of a third party as a "Third Party

Supplemental Needs Trust."

[2] 21st Century Cures Act (H.R. 34, 114th Cong. (2015 to 2016)). Section 5007 of the Act, titled "Fairness in Medicaid Supplemental Needs Trusts."

[3] 21st Century Cures Act (H.R.34, 114th Congress (2015 to 2016)). Section 5007 of the Act, titled "Fairness in Medicaid Supplemental Needs Trusts."

[4] *See* https://www.naela.org/Web/Home_Page/Announcements/SNTFMIA.aspx?WebsiteKey=ef1fbf77-8f85-4dfa-8c27-01f22ae4f5c8.

[5] See GIS 17 MA/08 (5/22/17).

[6] 42 U.S.C.A. § 1396p(d)(4)(B)(ii).

[7] *See supra* § 17:3.

[8] In re Abraham XX., 11 N.Y.3d 429, 871 N.Y.S.2d 599, 900 N.E.2d 136 (2008).

[9] *See infra* § 21:17.

[10] See *supra* § 17:19 and *infra* § 21:17.

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N.Y. Elder Law Practice § 21:16 (2024 ed.)

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§ 21:16. Medicaid: OBRA 1993 Exempt Trusts—Special Needs Trust—Administration

Purpose. Special Needs Trusts are intended to supplement rather than duplicate or replace Medicaid benefits. To accomplish this and achieve the benefits of a Special Needs Trust, the trustee's authority must be carefully defined and limited. There has to be a specific limitation to prohibit paying for any expense that would otherwise be paid for by Medicaid or any other means tested entitlement program.[1] Statutory guidance for the language of a Special Needs Trust or Supplemental Needs Trust (trusts established and funded by a person other than the beneficiary) can be found in New York law.[2] It is recommended that the statute be cited in the Trust and that the statutory language be used where appropriate.

Distributions. The elder law/special needs planning attorney drafting a trust pursuant to the statutory exemption of OBRA 1993[3] must use great care to assure that the payments from the trust to the individual do not affect such individual's Medicaid eligibility. Payments from the trust to the individual receive no statutory protection, and must, therefore, be designed so as not to duplicate or replace any Medicaid funding. Any duplication or replacement of Medicaid funding would result in the trust having to pay for expenses that would otherwise be covered by Medicaid.[4] Thus, if a Special Needs Trust authorized the trustee to pay the beneficiary's medical expenses with no qualifying language, trust funds would have to be exhausted before Medicaid would pay any medical expenses.

Care must also be taken to prevent direct payments to the individual, because direct unrestricted payments are income to the individual which would affect their Medicaid eligibility.[5] Provision can be made for the trustee to spend Trust funds on specific items that would not be covered by Medicaid. For example, the trustee could be authorized to purchase a television for the individual. Since a television is not a medical item provided by Medicaid, such authorization or purchase would not affect the individual's Medicaid eligibility. The type and number of items and services that can be authorized by a Special Needs Trust are limited only by the experience of the elder law attorney cognizant of the need to avoid any replacement or duplication of items or services available from Medicaid and of the needs of the beneficiary.

In *Matter of La Barbera (Donovan)*,[6] the court did not authorize a Special Needs Trust because the record did not establish that the current expenses exceeded the income of the individual.

In *Matter of Sutton*, the court ordered the establishment of a Special Needs Trust for an infant Medicaid recipient as requested by the guardian appointed under S.C.P.A. Article 17A. In this case, the infant, who suffered from multiple physical disabilities but had no mental impairments, was entitled to an inheritance from his mother's estate.[7]

Planning for SSI. Special Needs Trusts are a valuable planning tool for Supplemental Security Income (SSI). In New York State, SSI eligibility creates automatic Medicaid eligibility; the special needs trust for an SSI individual must protect not only SSI eligibility, but Medicaid eligibility as well.

Since SSI is a cash maintenance program for living expenses, and Medicaid pays various medical expenses, trust language must not allow duplication of living expenses as well as medical expenses. To properly draft a trust, the elder law attorney must be familiar with the benefits covered and provided by both SSI and Medicaid. Thus, if the trust fully protected assets regarding medical expenses but allowed the trustee to pay for or provide housing or pay utility bills, such powers would affect the beneficiary's SSI eligibility.

A trustee can be authorized to provide many items that would enhance the life of the person with special needs while protecting SSI and Medicaid eligibility. The trust can provide recreational opportunities, trips to see family and friends, and even the purchase of a specially equipped van to permit travel. Entertainment devices, including, but not necessarily limited to, televisions, radios, and computers can be purchased by the trustee for the beneficiary. The trust can be tailored to meet the specific needs of the beneficiary without interfering with SSI or Medicaid eligibility. Certain expenditures by the Trust for the benefit of the beneficiary may reduce or eliminate SSI.[8]

A Special Needs Trust should be designed to meet the special needs of the beneficiary. Doing so will result in a document that enhances the life of the beneficiary while protecting SSI and Medicaid eligibility. Knowing your special needs client will enable you to design a document that will truly benefit the client.

Payback Provisions. Disposition of trust assets upon the death of the disabled beneficiary is also an issue for SSI. Trust provisions that provide for the payment of funeral expenses prior to the payback to Medicaid will not be approved by the Social Security Administration as to SSI. For SSI purposes, the trust may provide for certain allowable expenses such as taxes due from the trust to the State(s) and reasonable fees for the administration of the trust estate before the Medicaid payback to the State(s), and then provide for funeral and other expenses from the remaining balance, if any.[9]

The Social Security Administration has also changed the payback language that it will accept for SSI purposes. The payback provision must not be state specific. SSI requires "the State(s) will receive …," without the naming of a specific state.[10] Notably, the payback language in the Social Security Administration POMS makes specific reference to the term "State(s)." In a 2017 administrative hearing, the Social Security Administration argued that the trust did not meet the special needs exemption rules because the Medicaid reimbursement language within the termination provision of the trust was deficient. In the decision, the Administrative Law Judge held that the repayment language which only referenced "State," in the singular, rather than the plural, did not improperly limit repayment to a particular state, and, therefore, the trust was not deficient and satisfied the special needs exemption rules.[11] Notwithstanding, attorneys must be extremely careful to use the term "State(s)" when drafting Special Needs Trusts.

Early Termination. Prior to the death of the beneficiary, under no circumstances may the beneficiary be authorized to terminate the trust.

The following are circumstances in which early termination may be appropriate:

1. If the Beneficiary is no longer disabled, then the trustee may terminate the trust if the beneficiary no longer meets the medical criteria as disabled;

2. If the Beneficiary becomes ineligible for Supplemental Security Income and Medicaid, or if the beneficiary's eligibility for SSI and Medicaid is terminated, then the trustee may terminate the trust; or
3. If there are insufficient assets held in the trust, then the trustee may terminate the trust during the lifetime of the beneficiary if the trust assets have been reduced to the point that continued administration of the trust is not financially justified.[12]

Planning for Section 8 Housing

The federal government established Section 8 housing that created various public benefit programs, which provide rental subsidies to low income, elderly and disabled individuals in private and government owned housing. Section 8 Housing allows lower income families to have the opportunity to reside in the private sector.[13]

Generally, while assets are reviewed when applying for Section 8 housing, there is no limitation on the value of assets that can be owned. The value of the actual asset is not considered. Instead, the government will calculate the interest, if any, earned from the assets toward the families' income, thereby affecting the family's contribution toward rent.

An individual living in Section 8 housing may have established and transferred assets to a Special Needs Trust to protect and preserve benefits. In the past, the Section 8 recipient had to be concerned that any distributions made from their Special Needs Trust would adversely affect their Section 8 rent calculation.

On June 14th, 2016, the First Circuit in the case DeCambre v. Brookline Housing Authority[14] held that distributions of principal from a special needs trust are not counted as income for purposes of Section 8 calculations.

This decision is a significant holding for the individual applying for Section 8 Housing.

Footnotes

1 *See supra* § 13:1.

2 EPTL § 7-1.12.

3 *See supra* § 21:14.

4 *See supra* § 13:1.

5 EPTL § 7-1.12.

6 Matter of La Barbera (Donovan), 4/26/96 N.Y.L.J. 36, col. 6 (Sup. Ct. Suffolk County).

7 Matter of Sutton, 167 Misc. 2d 956, 641 N.Y.S.2d 515 (Sur. Ct. 1996).

8 *See supra* § 10:42.

9 *See* https://secure.ssa.gov/poms.nsf/lnx/0501120203.

10 POMS § SI 01120.203 (effective date July 26, 2018).

11 Soc. Sec. Dec. (C.M. v. SSA) (August 16, 2017).

[12] POMS § SI 01120.199.

[13] 24 C.F.R. § 5.100; *see,* Evans v. Franco, 93 N.Y.2d 823, 687 N.Y.S.2d 615, 710 N.E.2d 261 (1999).

[14] DeCambre v. Brookline Housing Authority, 826 F.3d 1 (1st Cir. 2016).

N.Y. Elder Law Practice § 21:17 (2024 ed.)

New York Elder Law and Special Needs Practice | May 2024 Update
Vincent J. Russo, Marvin Rachlin

Chapter 21. Living Trusts

§ 21:17. Medicaid: OBRA 1993 Exempt Trusts—Special Needs Trust—Funding and Medicaid Liens

Frequently the need for a Special Needs Trust arises as a result of a recovery in a medical malpractice or negligence action. The services of special needs attorneys are often sought by medical malpractice and negligence attorneys when Medicaid may be involved. A thorough knowledge of Special Needs Trusts is essential to protect the damages recovered.

Funding a Special Needs Trust with the proceeds of a medical malpractice or negligence action against which a Medicaid lien had been placed was usually a problem, depending on the amount of the lien as compared to the amount of the settlement. There were times when Medicaid would voluntarily reduce or waive its lien to permit funding the trust, and times when it would refuse.

In another context, an attempt was made to fund a Special Needs Trust with the monthly Social Security Disability payments being received by the disabled person in an attempt to reduce the income spend down for Medicaid community home care. The Surrogate's Court ruled that the proposed "hoarding" of entitlement funds is contrary to the purpose of the entitlement, and, therefore, violates public policy.[1] The court, on re-argument, reversed itself and permitted the Social Security Disability payments to be paid into the trust.

Later, the same court was confronted with a similar case, this time involving SSI payments.[2] In this case, the

court held that SSI payments which have specific definitions as to what the benefits are for cannot be diverted into a Special Needs Trust.

Litigation arose as to the right of Medicaid to enforce a lien against proceeds that would otherwise go into an exempt Special Needs Trust. Both the New York Supreme Court and the Appellate Division Second Department ruled that Medicaid could not enforce its lien, except from any remaining assets of the Special Needs Trust after the death of the disabled individual.[3]

On appeal[4] the Court of Appeals reversed the Appellate Division, holding that Medicaid was a preferred creditor entitled to recovery from the proceeds prior to funding the Special Needs Trust.

There is no longer any legal issue in New York State regarding the ability of the state to recover its Medicaid lien from proceeds that would otherwise be funded into a Special Needs Trust. Given the state's legal ability to recover, it is up to the elder law/special needs planning attorney to negotiate a reduction or waiver of the lien based on the circumstances of the case. It will be more difficult to negotiate if a large sum of money will be left for the trust after payment of the lien.

The elder law/special needs planning attorney should make every effort to reduce or avoid paying a Medicaid lien which will reduce the amount available to be placed in the trust.[5] Because there is no certainty as to the amount that will be left in the Special Needs Trust following the beneficiary's death, funds that would otherwise have been paid back to Medicaid may be used for the benefit of the beneficiary during their lifetime.

If a Medicaid lien has been filed against the proceeds of an action and the proceeds are intended for a Special Needs Trust, then having the lien waived or reduced will be most difficult. Since there is a legal basis for collecting the lien prior to funding the trust, only special circumstances of the individual case can be used in an effort to waive or reduce the lien.

It is important to understand the limitations that the U.S. Supreme Court has placed on Medicaid recoveries which can result in a reduction of the lien. Medicaid cannot recover any portion of the settlement that is allocated to pain and suffering or for loss of income. Only the portion of the recovery allocated for medical expenses can be claimed by Medicaid.[6]

On December 26, 2013, President Obama signed the Bipartisan Budget Act of 2013. Section 202(b) of the Bipartisan Budget Act of 2013, which modifies portions of the federal Medicaid Act, effectively reversing *Arkansas Dept. of Health & Human Srvs. v. Ahlborn*. The Act was set to take effect on October 1, 2014.[7] This date was pushed back in April of 2014.

HR 4302, which was passed April 2014 by Congress and signed by President Obama, postponed pending Medicare physician payment cuts by one year.[8] At first glance it has nothing to do with Section 202(b), but if you look closely into the legislation there is a one-sentence provision (Sec. 211) that delays the effective date of Section 202(b) of the Bipartisan Budget Act of 2013 for two years. However, revising the effective date of Section 202(b) to October 1, 2016, only delayed the inevitable that Medicaid recipients will receive less in personal injury settlements because their full recovery will be subject to a Medicaid lien. This deadline was further delayed to October 1, 2017, when Medicare Access and the CHIP Reauthorization Act of 2015 (114 P.L. 10) were enacted on April 16, 2015.[9]

As of October 1, 2017, the legislative impact Section 202 of the Bipartisan Budget Act of 2013 has on *Arkansas Dept. of Health & Human Srvs. v. Ahlborn* became effective. Medicaid is now able to assert its lien against the entirety of the award instead of the portion of the award that represents payment for medical expenses. The practical concern with this law is that it will likely make negotiating liens with Medicaid much more difficult and may create problems in setting up Special Needs Trusts as a means to protect a person's eligibility for Medicaid while permitting them to take advantage of funds placed into the trust.

Whenever possible, an attempt should be made by the attorney to have the court, or the parties to a settlement,

allocate an amount for medical expenses. Simply allocating a majority of the funds to pain and suffering rather than medical expenses will likely not be successful. An accurate allocation, considering liability, medical expenses and pain and suffering is most likely to result in a reduction of the Medicaid lien and an increase in the funds available for the trust.

Frequently, a court is involved with the proceeds of a medical malpractice or negligence action on behalf of a disabled person. The services of an elder law attorney are necessary if the proceeds are to be placed into a Special Needs Trust. The elder law attorney should draft the trust and it should be presented to the court to be used as the vehicle into which the funds will be placed. Not only should the language of the trust be carefully drafted to prevent any loss or diminution of Medicaid benefits, but also the timing of the funding of the trust must be carefully planned.

The proceeds of a personal injury or medical malpractice lawsuit will not be counted by Medicaid from the date of receipt or entitlement until the first day of the second month following the receipt or entitlement, provided the individual intends to place the proceeds into a Special Needs Trust.[10]

In addition, such assets will be disregarded from the date a proceeding to place the assets into the Special Needs Trust is commenced, until the resolution of such proceeding.[11] As a result, some alternate source of payment of the individual's medical expenses will have to be found for at least one month, or longer if the Trust is not funded during the same calendar month that the proceeds are made available.

A better alternative is to have the Special Needs Trust prepared and executed prior to the payment of the proceeds and have the proceeds paid directly into the trust, without being made available to the individual. This will help assure a continuity of Medicaid coverage, without the necessity of privately funding medical expenses for one month or longer.

Footnotes

1 In re Lynch, 703 N.Y.S.2d 653 (Sur. Ct. 1999), withdrawn at request of court from Official Publication.

2 In re Ullman, 184 Misc. 2d 7, 707 N.Y.S.2d 603 (Sur. Ct. 2000).

3 Matter of Gibson, 162 Misc. 2d 530, 616 N.Y.S.2d 171 (Sup 1994), amended on reargument, 162 Misc. 2d 587, 620 N.Y.S.2d 729 (Sup 1994), order aff'd, 226 A.D.2d 351, 640 N.Y.S.2d 768 (2d Dep't 1996), rev'd, 90 N.Y.2d 296, 660 N.Y.S.2d 679, 683 N.E.2d 301, 53 Soc. Sec. Rep. Serv. 1010 (1997); Cricchio v. Pennisi, 220 A.D.2d 100, 640 N.Y.S.2d 573 (2d Dep't 1996), order rev'd, 90 N.Y.2d 296, 660 N.Y.S.2d 679, 683 N.E.2d 301, 53 Soc. Sec. Rep. Serv. 1010 (1997); *see also*, Merer v. Romoff, 1/23/97 N.Y.L.J. 28, col. 4 (Sup. Ct. New York County).

4 Cricchio v. Pennisi, 90 N.Y.2d 296, 660 N.Y.S.2d 679, 683 N.E.2d 301, 53 Soc. Sec. Rep. Serv. 1010 (1997), *see also* Calvanese v. Calvanese, 250 A.D.2d 564, 672 N.Y.S.2d 410 (2d Dep't 1998), aff'd, 93 N.Y.2d 111, 688 N.Y.S.2d 479, 710 N.E.2d 1079 (1999) and Matter of Link, 1/6/98 N.Y.L.J. 24, col. 1 (Sup. Ct. Suffolk County).

5 *See supra* §§ 17:15 and 17:17.

[6] Arkansas Dept. of Health and Human Services v. Ahlborn, 547 U.S. 268, 126 S. Ct. 1752, 164 L. Ed. 2d 459 (2006), Reversed by the Bipartisan Budget Act of 2013.

[7] PL 113-67, § 202(c), December 26, 2013, 127 Stat 1165.

[8] PL 113-93, § 211, April 1, 2014, 128 Stat 1040.

[9] PL 114-10, § 220, April 16, 2015, 129 Stat 87.

[10] N.Y.S. Department of Social Services Administrative Directive: 96 ADM-8.

[11] N.Y.S. Department of Social Services Administrative Directive: 96 ADM-8.

End of Document

N.Y. Elder Law Practice § 21:34 (2024 ed.)

New York Elder Law and Special Needs Practice | May 2024 Update
Vincent J. Russo, Marvin Rachlin

Chapter 21. Living Trusts

§ 21:34. Form: Special Needs Trust

Type of Trust: Special Needs Trust for the benefit of a disabled individual under age 65 who is disabled. This form of Trust is funded with the settlement proceeds of a personal injury or malpractice claim.
Medicaid Note: This Trust is being established for asset protection in the context of Medicaid planning. The funding of the Trust is not subject to a Medicaid transfer penalty period and the Trust assets are not considered available for purposes of Medicaid eligibility.

Tax Note: The Trust contains provisions which may adversely affect the Creator, Trustee or beneficiaries as to estate, gift and income taxation.
DRAFTING NOTES: This form is designed for the guidance of the attorney who should analyze each case individually before drafting the trust.

***[NAME OF SPECIAL NEEDS BENEFICIARY]* SPECIAL NEEDS TRUST]**

THIS AGREEMENT made and entered into this *[ordinal number of day]* day of *[name of month]*, *[number of year]*, between *[name of creator]*, Defendant (or *[name of creator]*, the *[parent/grandparent/legal guardian]* of *[name of special needs beneficiary]*), (hereinafter referred to as the "Creator") and *[name of trustee]*, Trustee, residing at *[address of trustee]* (hereinafter referred to as the "Trustee").

WITNESSETH:

[EITHER]:

WHEREAS, by Order of the Supreme Court of the State of New York, County of *[name of county]*, dated *[ordinal number of day]* day of *[name of month]*, *[number of year]*, that portion of the proceeds of the settlement in the action entitled *[name of special needs beneficiary]*, *Plaintiff, v. [name of defendant], Defendant*, as is set forth in the said Order (copy attached hereto as Exhibit "A") shall be placed into this Trust to be held by the Trustee as part of the Trust Estate (said monies being hereinafter referred to collectively as the "Trust Estate") for purposes hereinafter set forth;

[OR]:

WHEREAS, *[list of names of legal guardians]*, the legal guardians of *[first name of special needs beneficiary]* are desirous of creating a Trust with the Court's authority expressly for *[first name of special needs beneficiary]*'s supplemental care, maintenance, support and education in addition to the benefits *[first name of special needs beneficiary]* (hereinafter sometimes referred to as "*[first name of special needs beneficiary]*") otherwise receives or may receive from any local, state or federal government, or from any private agencies, or from any private insurance carriers covering *[first name of special needs beneficiary]*. This Trust is to enable *[first name of special needs beneficiary]* to qualify for medical assistance under the Medicaid program as provided for by the Omnibus Budget Reconciliation Act of 1993 ("OBRA 1993"); and *[OR:]*

WHEREAS, by Order of the Surrogate's Court of the State of New York, County of *[name of county]*, dated *[ordinal number of day]* day of *[name of month]*, *[number of year]*, that portion of the assets of *[first name of special needs beneficiary]* as is set forth in the said Order (copy attached hereto as Exhibit "A") shall be placed into this Trust to be held by *[name of trustee]*, (the "Trustee") as part of the Trust Estate (said monies being hereinafter referred to collectively as the "Trust Estate") for purposes hereinafter set forth.

NOW, THEREFORE, in consideration of the premises and the mutual covenants herein contained, the Trustee agrees to hold the Trust Estate, IN TRUST, for the following uses and purposes and subject to the terms and conditions hereinafter set forth:

ARTICLE I.
GENERAL PROVISIONS

(1) LAWS GOVERNING

This Agreement shall be construed and regulated in all respects by the laws of the State of New York.

(2) NAME OF TRUST

This Trust shall be known as the "*[NAME OF SPECIAL NEEDS BENEFICIARY]* SPECIAL NEEDS TRUST" and it shall be sufficient that it be referred to as such in any deed, assignment, bequest or devise.

(3) TRUST IRREVOCABLE

This Trust is hereby declared to be irrevocable and it shall not at any time, by any person or persons, be amended, altered or modified in any manner. Notwithstanding, the Trustees are empowered to amend this Trust, subject to Court order, so as to: (i) qualify and maintain *[first name of special needs beneficiary]*'s eligibility for benefits under governmental programs, including but not limited to the Medicaid program, and (ii) meet the requirements under OBRA 1993 and the New York State implementing statutes and regulations promulgated pursuant thereto.

(4) PURPOSE

This Trust is created expressly for *[name of special needs beneficiary]*'s supplemental care, maintenance, support and education in addition to the benefits *[name of special needs beneficiary]* (hereinafter sometimes referred to as "*[first name of special needs beneficiary]*") otherwise receives or may receive from or be funded by any local, state or federal government, or from any private agencies, any of which provides or funds services or benefits to developmentally disabled, incapacitated or disabled persons, or from any private insurance carriers covering *[first name of special needs beneficiary]*. This Trust is to enable *[first name of special needs beneficiary]* to qualify for medical assistance under the Medicaid program as provided for by the Omnibus Budget Reconciliation Act of 1993 ("OBRA 1993"). In the administration of the Trust, the Trustees shall undertake all acts necessary to establish and maintain *[first name of special needs beneficiary]*'s eligibility for medical assistance under the Medicaid program.

It is intended that the funding and/or administration of this Trust will not subject *[first name of special needs beneficiary]* to a period of ineligibility under Medicaid law pursuant to 42 U.S.C.A. 1396p(d)(4)(A) and N.Y. Social Service Law Sections 366(2)(b)(2)(iii)(A) and 366(5)(d)(3)(ii)(D), as amended.

It is also intended that this Trust shall be treated as a grantor type trust for federal and state income tax purposes and that the funding of the trust shall not be subject to federal and state gift taxation.

[OPTIONAL:]

(5) ADDITIONS TO CORPUS

[First name of special needs beneficiary], [his/her] guardian, or any duly authorized person on behalf of [first name of special needs beneficiary], with written notice to the Trustee, may add from time to time to the Trust Estate any property by deed, Will, court order or otherwise.]

ARTICLE II.

DISTRIBUTION OF INCOME AND PRINCIPAL DURING LIFETIME OF *[NAME OF SPECIAL NEEDS BENEFICIARY]*

NOTE: The following provision may or may not be approved by a Court, depending upon the Judge. In addition, the local Medicaid agency may object to some of the provisions set forth herein.

(1) DISTRIBUTION DURING *[FIRST NAME OF SPECIAL NEEDS BENEFICIARY]*'S LIFETIME

The Trustee shall hold, manage, invest and reinvest the Trust Estate, and shall pay or apply the income and principal of the Trust Estate in the following manner:

(a) During *[first name of special needs beneficiary]*'s lifetime, the Trustee shall pay from time to time such amounts from income and/or principal ("Trust Funds") for the satisfaction and benefit of *[first name of special needs beneficiary]*'s Special Needs (as hereinafter defined), as the Trustee shall determine in the Trustee's limited discretion, as hereinafter provided. Under no circumstances may the Trustee distribute income or principal directly to *[first name of special needs beneficiary]*. Any income of the Trust not distributed shall be added annually to the principal of the Trust.

(b) The Trustee is prohibited from expending any of the Trust income or principal for any property, services, benefits, or medical care otherwise available from any governmental source or from any insurance carrier required to cover *[first name of special needs beneficiary]*. The Trustee shall seek support and maintenance for *[first name of special needs beneficiary]* from all available public resources, including (but not limited to) the Supplemental Security Income Program (SSI), the Supplemental Income Program (SIP) of any applicable state, the Old Age Survivor and Disability Insurance Program (OASDI), the Medicare program, the Medicaid program and any additional, similar, or successor programs for which *[first name of special needs beneficiary]* is or may in the future be eligible.

(c) "Special Needs" is defined as *[first name of special needs beneficiary]*'s needs that are not covered and/or available by any local, state or federal government, or any private agencies, or any private insurance carriers covering *[first name of special needs beneficiary]*. These special needs include but are not limited to the following:

(i) procurement for *[first name of special needs beneficiary]* of more sophisticated medical, psychological and/or dental treatment, experimental or holistic rehabilitative therapies, private rehabilitative or educational training, and additional home care beyond the care available from any governmental program;

(ii) necessary or reasonable medical costs, drugs, treatment and dietary needs of *[first name of special needs beneficiary]* not available from or covered by Medicaid;

(iii) *[first name of special needs beneficiary]*'s maintenance and living expenses, such as therapy, laundry, diapers, hair cutting and styling, bedding, medical apparatus, supplies and food supplements;

(iv) an automobile and/or van for the benefit of *[first name of special needs beneficiary]*, and modification, improvement and maintenance of such vehicle(s);

(v) items by which *[first name of special needs beneficiary]*'s life will be enriched and made more enjoyable including, but not limited to, furniture, radios, televisions, audio, video and computer equipment, adaptive toys, electronic devices and/or equipment, and the maintenance of same;

(vi) recreational opportunities; trips; family visits; visits to friends and/or relatives; and any other tangible or intangible items which in the sole discretion of the Trustee would enrich or benefit *[first name of special needs beneficiary]*;

(vii) payment of any premiums and deductible amounts for *[first name of special needs beneficiary]* on any health care insurance policies covering *[first name of special needs beneficiary]* or life insurance policies insuring *[first name of special needs beneficiary]* which are not covered by any governmental program and/or any premiums for life insurance on the lives of *[first name of special needs beneficiary]*'s parents or *[first name of special needs beneficiary]*, but only if this Trust is the beneficiary.

(viii) ongoing maintenance of *[first name of special needs beneficiary]*'s primary residence in the community;

(ix) Attorney fees and disbursements and court fees relating to (a) any Guardianship proceeding brought on behalf of *[first name of special needs beneficiary]*, as well as any appeal therefrom and (b) attorney's fees related to the preparation, funding and maintenance of this Trust, and the obtaining of judicial authorization to implement this Trust.

(x) *[first name of special needs beneficiary]*'s income tax obligation, if any.

(d) Under no circumstances shall the Trustee exercise discretion to utilize Trust Funds for the payment of items or services that would otherwise be borne by any publicly funded program including, but not limited to, Social Security Administration, Veterans Administration, Medicaid, and Supplemental Security Income or Public Assistance Programs. The Trustee shall have no authority to pay for items and services provided by any governmental program and neither *[first name of special needs beneficiary]* nor anyone on his/her behalf shall have the right to seek court directed invasion of Trust Funds pursuant to any provision of federal, state or local law.

(e) The provisions of Section 7-1.6 of the Estates, Powers and Trusts Law of the State of New York, or any successor statute thereto, or any similar statute in any other state or jurisdiction shall not be available to require any invasion of Trust Funds by the Trustee or any court.

(f) In the event the Trustee is requested by any department or agency of federal, state or local government to release principal or income of the Trust to or on behalf of *[first name of special needs beneficiary]* to pay for equipment, medication or services that any department, agency or organization is authorized to provide, or in the event the Trustee is requested by any department or agency administering such benefits to petition the court or an administrative agency for the release of Trust Funds for this purpose, the Trustee shall deny such request and is directed to obtain legal counsel to defend, as an expense of the Trust, any contest of this provision or any other legal challenge to the Trust of any nature. The Trustee shall have complete discretion with regard to the defense of any such claim, including the management of all litigation which may result.

[OPTIONAL]

(2) EARLY TERMINATION OF THE TRUST

(a) ***Beneficiary no longer disabled.*** The Trustee, in the Trustee's sole discretion, may terminate the Trust if *[first name of special needs beneficiary]* no longer meets the medical criteria as disabled under the Social Security Administration.

[AND/OR]:

(b) ***Beneficiary becomes ineligible for Supplemental Security Income and Medicaid.*** If *[first name of special needs beneficiary]*'s eligibility for either Supplemental Security Income and/or Medicaid is terminated, the Trustee, in the Trustee's sole discretion, may terminate the Trust.

[AND/OR]:

(c) ***Insufficient Assets.*** The Trustee, in the Trustee's sole discretion, may terminate the Trust during the lifetime of *[first name of special needs beneficiary]* if the Trust Estate has been reduced to the point that continued

administration is not financially justified.

(d) In the event of an Early Termination, the Trustee will dispose of the trust assets as follows:

(i) first, the Trustee may pay the following types of administrative expenses from the Trust prior to reimbursement of medical assistance to the State(s):

• Taxes due from the trust to the State(s) or Federal government due to the termination of the Trust; and

• Reasonable fees and administrative expenses associated with the termination of the Trust.

(ii) second, the Trustee shall pay the State(s), as primary assignee, all amounts remaining in the Trust at the time of termination up to an amount equal to the total amount of medical assistance paid on behalf of the individual under the State Medicaid plan(s); and

(iii) third, the Trustee shall distribute the remaining Trust Estate to *[first name of special needs beneficiary]*.

Other than payment of those expenses listed in SSA POMS § SI 01120.199E.3, no entity other than the beneficiary may benefit from the Early Termination.

In the event that the mere existence of a provision giving the Trustee discretion to terminate the Trust and make distributions would result in a reduction or loss of *[first name of special needs beneficiary]*'s entitlement program benefits, regardless of whether the Trustee actually exercises the discretion, then such provision shall be null and void, *ab initio*.]

ARTICLE III.
DISPOSITION OF TRUST ESTATE UPON *[NAME OF SPECIAL NEEDS BENEFICIARY]*'S DEMISE

(1) DISTRIBUTION OF INCOME AND PRINCIPAL

(a) Upon *[first name of special needs beneficiary]*'s death, the Trustee shall promptly obtain an accounting from the State (or local Medicaid agency of the State) of Medicaid payments, if any, made on behalf of *[first name of special needs beneficiary]* during his or her lifetime.

Upon receipt of such accounting, the Trustees shall pay to the States (or local Medicaid agency of the States) from the Trust Estate the lesser of: (1) the total amount of Medicaid payments made on behalf of *[first name of special needs beneficiary]* to the extent required by law; or (2) the entire balance of the Trust Estate.

Notwithstanding, the following types of administrative expenses may be paid from the Trust prior to reimbursement of medical assistance to the State(s) as set forth above:

• Taxes due from the Trust to the State(s) or Federal government because of the death of the *[first name of special needs beneficiary]*;

• Reasonable fees for administration of the Trust Estate such as an accounting of the Trust to a court, completion and filing of documents, or other required actions associated with termination and wrapping up of the Trust.

(b) Then, the Trustee, in the Trustee's sole and absolute discretion, may pay directly or indirectly from the Trust

Estate, if any, (i) *[first name of special needs beneficiary]*'s funeral expenses, (ii) any and all death taxes imposed on *[first name of special needs beneficiary]*'s estate, (iii) court fees of a probate, administration or estate proceedings relating to *[first name of special needs beneficiary]*'s Estate, and (iv) any and all legal and accounting fees related to *[first name of special needs beneficiary]*'s estate. Any remaining Trust Estate shall be distributed by the Trustee to *[name of beneficiaries]*.

(c) *[First name of special needs beneficiary]* may appoint all or any portion of the principal and any accumulated and accrued income of this Trust to a class of beneficiaries limited to *[first name of special needs beneficiary]*'s immediate family, relatives by blood, marriage, or adoption or charities. No such appointment shall be made to *[first name of special needs beneficiary]*, *[first name of special needs beneficiary]*'s creditors, the *[first name of special needs beneficiary]*'s Estate or the creditors of *[first name of special needs beneficiary]*'s Estate. This limited power of appointment must be exercised by the *[first name of special needs beneficiary]*'s Will, which must be submitted for probate within ninety (90) days of *[first name of special needs beneficiary]*'s death, in the county of Creator's residence, specifically referring to this paragraph. In no event can this limited power of appointment be exercised by *[first name of special needs beneficiary]* through the creation of another power, whether general, non-general or limited. Upon *[first name of special needs beneficiary]*'s death, the Trustee shall pay and distribute the remaining Trust Estate in accordance with the exercise of the *[first name of special needs beneficiary]*'s limited power of appointment as provided for in this paragraph.

(d) In the event that *[first name of special needs beneficiary]* has not exercised the above limited power of appointment, then the Trustee shall pay and distribute the remaining Trust Estate to *[name of beneficiary]*.

ARTICLE IV.
PROVISIONS RELATING TO THE TRUST ESTATE

(1) SPENDTHRIFT PROVISION

No interest in the principal or income of this Trust shall be anticipated, assigned, or encumbered, or be subject to any creditor's claim or to legal process, prior to its actual receipt by *[first name of special needs beneficiary]*. Furthermore, it is the intent of the Trust as expressed herein, that because this Trust is to be conserved and maintained primarily for the supplemental needs of *[first name of special needs beneficiary]*, no part of the corpus hereof, nor principal or undistributed income, shall be subject to the claims of voluntary or involuntary creditors of *[first name of special needs beneficiary]*. No part of the Trust Estate shall be liable to *[first name of special needs beneficiary]*'s creditors during his life or after *[first name of special needs beneficiary]*'s death except as is otherwise provided in this Trust.

(2) POWERS RETAINED BY *[FIRST NAME OF SPECIAL NEEDS BENEFICIARY]*

[First name of special needs beneficiary] has the power to reacquire the Trust principal by substituting other property of an equivalent value.

ARTICLE V.
POWERS AND DUTIES OF TRUSTEE

(1) INVESTMENTS

(a) The Trustees of the Trust established hereunder (including any Successor Trustees) shall have the authority to invest the trust funds in accordance with New York State EPTL 11-2.2 and 11-2.3, and the Trustees in addition are given such powers as are provided in the Fiduciary Powers Act (EPTL 11-1.1).

(2) ADDITIONAL POWERS

(a) In addition to any statutory authority existing regarding the powers of a trustee, any trustee serving hereunder is authorized to seek and retain the services of social workers, consultants or other individuals or agencies, public or private, skilled in the identification and/or provisions of services for disabled, handicapped or mentally ill individuals, the trustee is further authorized to seek and utilize or reject in his sole discretion the counsel and recommendations of any guardian, or physician of *[first name of special needs beneficiary]*. The examples cited herein are not intended to be a limitation of the trustee's authority.

The trustee shall not be liable to any present or future beneficiary for seeking or not seeking the counsel and recommendations of any expert, whether or not expressly named and authorized herein, or for accepting or rejecting all or part of the counsel and recommendations offered by any such expert. Nor shall the trustee be liable for failing to identify or inquire as to the existence of individuals or agencies, public or private that may be available to meet the needs of *[first name of special needs beneficiary]*.

ARTICLE VI.
PROVISIONS RELATING TO TRUSTEE

(1) TRUSTEE'S REPORTING RESPONSIBILITY

The Trustee shall report, at least every twelve months, to *[first name of special needs beneficiary]* and *[his/her]* legal representative, if any, and also to the next successor Trustee, at the most recent address then known to the Trustee. The Trustee's report shall advise of any change in *[first name of special needs beneficiary]*'s eligibility for public benefit programs and shall list all of the receipts, disbursements, and distributions occurring during the reporting period, along with a complete list of the assets held by the Trust. The account shall be deemed to have been delivered when it has been placed in the United States Mail addressed to that person at the person's last known address. A copy of the most recent bank account statement and a copy of the most recently filed trust tax return shall be attached to the accounting. In addition, the Trustee shall render an annual account to each and every other individual or entity entitled to receive such an account from the Trustee under New York State Law.

(2) NOTIFICATION OF NEW YORK STATE DEPARTMENT OF HEALTH

The Trustees shall promptly notify the New York State Department of Social Services of the happening of any one or more of the following events:

(i) Any transaction(s) resulting in the substantial depletion of the Trust principal, in the event that the Trust principal is valued at more than $100,000 dollars.

(ii) The death of *[first name of special needs beneficiary]*;

(iii) Any transaction(s) involving transfers from the Trust principal for less than fair market value, in advance of the making of any such transaction.

(3) AVAILABILITY OF RECORDS

The records of the Trustee, along with all trust documentation, shall be available and open at all reasonable times for the inspection by *[first name of special needs beneficiary]*, and/or his/her legal representative, and by any trust remainderman, during regular business hours upon five calendar days prior written notice to the Trustee.

(4) COMPENSATION

The Trustee shall be entitled to receive the statutory compensation for services rendered hereunder as provided for under New York law and shall also be reimbursed for all reasonable expenses incurred in the management and protection of the Trust Estate and travel and lodging expenses to and from the Trustee's residence and *[first name of special needs beneficiary]*'s residence as frequently as the Trustee determines in the Trustee's sole discretion.

[EITHER:]
(5) BOND

No bond or other security shall be required of any Trustee or Successor Trustee of this Trust, unless ordered by a Court.

[OR:]
(5) JOINT CONTROL

The Trustees must deposit the Trust principal with a depository designated by a Court to be held under joint control. Funds can be withdrawn only with the permission of the Court, and the only investments authorized are those authorized by New York State Surrogate's Court Procedure Act Section 1708, which includes bank deposit investments, U.S. Savings Bonds, treasury bills, notes and bonds and municipal bonds.

ARTICLE VII.
TRUSTEES

(1) APPOINTMENT OF SUCCESSOR TRUSTEES

Upon the death, incapacity, resignation or discharge of the Trustee, *[name of successor trustee]* shall be the Successor Trustee.

(2) REMOVAL AND RESIGNATION OF TRUSTEES

(a) The Trustee shall have the right to resign as Trustee at any time by giving thirty (30) days written notice to that effect to the Successor Trustee hereunder. *[Name of successor trustee]*, as Successor Trustee hereunder, shall have the right to resign at any time, subject to the appointment by a court of competent jurisdiction of a successor to the Successor Trustee.

[OPTIONAL:]

(b) *[First name of special needs beneficiary] shall have the right to remove a Trustee and replace said Trustee with a Successor Trustee, subject to approval of a court of competent jurisdiction.]*

(3) HOLD HARMLESS

No Trustee shall be liable or responsible for any loss or damage arising by reason of any act or omission to or by the Trustee or in connection with any activities carried out under this Trust, except for the Trustee's own gross negligence, willful neglect or unlawful act.

ARTICLE VIII.
COMMON DISASTER PROVISION

If any beneficiary including *[first name of special needs beneficiary]*'s spouse shall die simultaneously with *[first name of special needs beneficiary]* or in such circumstances that there is not sufficient evidence to determine the order of the deaths, then it shall be presumed that *[first name of special needs beneficiary]* survived such beneficiary and the provisions of this Trust shall be construed on that assumption, unless otherwise provided herein.

ARTICLE IX.
MISCELLANEOUS

(1) PARAGRAPH HEADINGS

The paragraph headings used are for convenience only and shall not be resorted to for interpretation of this Trust. Whenever the context so requires, the masculine shall include the feminine or neuter, and vice versa, and the singular shall include the plural and vice versa.

(2) VALIDITY OF PROVISIONS

If any portion of this Trust is held to be void or unenforceable, the balance of this Trust shall nevertheless be carried into effect.

IN WITNESS WHEREOF, *[NAME OF CREATOR]* and *[name of trustee]* have signed and sealed this Trust Agreement.

_____
[Name of creator]
, Creator
By:
[Name of signatory]
[Title of signatory]

_____
[Name of trustee]
, Trustee
[Acknowledgements]
[EITHER:]
EXHIBIT A ORDER SETTLING MEDICAL MALPRACTICE ACTION *[OR:]*

EXHIBIT A ORDER SETTLING PERSONAL INJURY ACTION *[OR:]*

EXHIBIT A DESCRIPTION OF ASSETS CONTRIBUTED TO THE TRUST

Notes

The Trust must be established by a parent, grandparent, or legal guardian of an individual who is under age 65 and disabled, or by a court for such individual.

Under the heading Special Needs Trust, Option One, use this provision when the Trust is being established by a court order.

Under the heading Special Needs Trust, Option Three, use this provision when the Trust is being established in the context of an S.C.P.A. Article 17-A Guardianship proceeding.

Regarding Article I. (1), *see infra* Article I § 21:33 for alternate language as to situs.

Regarding Article I. (2), it is not necessary to refer to the Trust as a Special Needs Trust as long as the Trust conforms to the Medicaid legislation.

Regarding Article I. (5), this would enable the enlargement of trust principal to better meet the beneficiary's needs—but additions to the Trust will increase the fund available for pay back to New York State.

Regarding Article II, NOTE, *see infra* § 21:35 for an alternate provision.

Regarding Article II. (1)(c)(iii), this provision (iii) and provision (viii) below could affect Supplemental Security Income (SSI) benefits. Since SSI benefits are paid for maintenance and living expenses, currently the Social Security Administration is approving trusts with such language. *See supra* § 21:16.

Regarding Article II. (1)(c)(vii), this provision can affect the level of payment from Supplemental Security Income (SSI).

Regarding Article III. (1)(a), *see supra* § 21:16 Special Needs Trust.

Regarding Article III. (1)(b), this provision has been changed from the Morales decision to comply with SSI requirements for approval.

Regarding Article III. (1)(d), this provision will avoid gift taxation under Internal Revenue Code § 2042 due to the limited power of appointment held by the beneficiary ("[first name of special needs beneficiary]").

Regarding Article IV. (1), this provision has been approved by some of the courts but was not permitted under the Goldblatt decision. (Petition of Goldblatt, 162 Misc. 2d 888, 618 N.Y.S.2d 959 (Sur. Ct. 1994)).

Regarding Article IV. (2), this provision will qualify the Trust as a Grantor Trust for income tax purposes.

Regarding Article VI. (5), 18 NYCRR § 360-4.5(b)(5)(iii)(e) requires the Trustee to provide the social services district with proof of bonding if the assets of the trust at any time equal or exceed $1 million, unless the requirement has been waived by a court of competent jurisdiction, and to provide proof of bonding if the assets of the trust are less than $1 million, if required by a court of competent jurisdiction.

Regarding Article VI. (6), this provision can be an option as an alternative to bonding. Petition of Goldblatt, 162 Misc. 2d 888, 618 N.Y.S.2d 959 (Sur. Ct. 1994).

N.Y. Elder Law Practice § 21:35 (2024 ed.)

New York Elder Law and Special Needs Practice | May 2024 Update
Vincent J. Russo, Marvin Rachlin

Chapter 21. Living Trusts

§ 21:35. Form: Variation of Special Needs Trust

Type of Trust: Special Needs Trust for the benefit of an individual under age 65 who is disabled. This form of Trust is funded with the settlement proceeds of a personal injury or malpractice claim.

Medicaid Note: This trust is being established for asset protection in the context of planning. This trust follows the *Morales* type of trust. This type of trust has been followed by certain courts (particularly in guardianship proceedings) and by certain local Medicaid agencies. This form of trust should be utilized in those jurisdictions.

Tax Note: The Trust contains provisions which may adversely affect the Creator, Trustee or beneficiaries as to estate, gift and income taxation.

DRAFTING NOTES: This form is designed for the guidance of the attorney who should analyze each case individually before drafting the trust.

[NAME OF PERSON WITH DISABILITIES] **SUPPLEMENTAL NEEDS TRUST**

This TRUST AGREEMENT made this *[ordinal number of day]* day of *[name of month]*, *[number of year]*, between ***[name of creator]***, as GUARDIAN of the property of ***[name of person with disabilities]***, residing at *[address of guardian]*, *[name of state]*, *[name of creator]*, as "Creator," and *[name of trustee]*, as "Trustee," is established pursuant to an Order of the Supreme Court of the State of New York, ***[name of county]*** County.

ARTICLE I.
GENERAL PROVISIONS

(1) LAWS GOVERNING

This Trust shall be interpreted and the administration of the Trust shall be governed by the laws of the State of New York; provided, however, that Federal law shall govern any matter alluded to herein which shall relate to or involve government entitlements such as Supplemental Security Income ("SSI"), Medicaid, and/or other Federal benefit programs.

With the Court's approval, the situs and governing law of this Trust may be changed by the Trustee.

(2) NAME OF TRUST

This Trust shall be known as the "***[NAME OF PERSON WITH DISABILITIES]*** SUPPLEMENTAL NEEDS TRUST."

(3) DECLARATION OF IRREVOCABILITY

The Trust shall be irrevocable and may not at any time be altered, amended or revoked without Court approval.

(4) PURPOSE

The "Beneficiary" of the Trust is ***[name of person with disabilities]*** (hereinafter sometimes referred to as "***[first name of person with disabilities]***"). The purpose of the Trust is that the Trust's assets be used to supplement, not supplant, impair or diminish any benefits or assistance of any Federal, State, County, City, or other governmental entity for which ***[first name of person with disabilities]*** may otherwise be eligible or which ***[first name of person with disabilities]*** may be receiving. The Trust is intended to conform with New York State EPTL 7-1.12, New York Social Services Law § 366 and 42 U.S.C.A. § 1396p.

(5) ADDITIONS TO PRINCIPAL

With the Trustee's consent, any person may, at any time, from time to time, by Court order, assignment, gift, transfer, deed or will, provide income or add to the principal of the Trust created herein, and any property so added shall be held, administered, and distributed under the terms of this Trust. The Trustee shall execute documents necessary to accept additional contributions to the Trust and shall designate the additions on an amended Schedule A of this Trust.

ARTICLE II.
DISTRIBUTION OF INCOME AND PRINCIPAL DURING *[NAME OF PERSON WITH DISABILITIES]*'S LIFETIME

(1) ADMINISTRATION OF TRUST DURING *[NAME OF PERSON WITH DISABILITIES]*'S LIFETIME

(a) The property shall be held in trust for ***[first name of person with disabilities]***, and the Trustee shall collect income and, after deducting all charges and expenses attributed thereto, shall apply for the benefit of ***[first name of person with disabilities]***, so much of the income and principal (even to the extent of the whole) as the Trustee deems advisable in the Trustee's sole and absolute discretion subject to the limitations set forth below and the Order of the Supreme Court of the State of New York, County of ***[name of county]*** dated *[ordinal number of day]* day of *[name of month]*, *[number of year]* (attached hereto as Exhibit "A"). The Trustee shall add the balance of net income not paid or applied to the principal of the Trust.

(b) Consistent with the Trust's purpose, before expending any amounts from the net income and/or principal of this Trust, the Trustee shall consider the availability of all benefits from government or private assistance programs for which ***[first name of person with disabilities]*** may be eligible. The Trustee, where appropriate and to the extent possible, shall endeavor to maximize the collection and facilitate the distribution of these benefits for ***[first name of person with disabilities]***'s benefit.

(c) None of the income or principal of this Trust shall be applied in such a manner as to supplant, impair or diminish any governmental benefits or assistance for which ***[first name of person with disabilities]*** may be eligible or which ***[first name of person with disabilities]*** may be receiving.

(d) ***[first name of person with disabilities]*** does not have the power to assign, encumber, direct, distribute, or authorize distributions from this Trust.

(e) Notwithstanding the above provisions, the Trustee may make distributions to meet ***[first name of person with disabilities]***'s need for food, clothing, shelter, health care, or other personal needs, even if those distributions will impair or diminish ***[first name of person with disabilities]***'s receipt or eligibility for government benefits or assistance only if the Trustee determines that the distributions will better meet ***[first name of person with disabilities]***'s needs, and it is in ***[first name of person with disabilities]***'s best interests, notwithstanding the consequent effect on ***[first name of person with disabilities]***'s eligibility for, or receipt of benefits.

However, if the mere existence of this authority to make distributions will result in a reduction or loss of ***[first name of person with disabilities]***'s entitlement program benefits, regardless of whether the Trustee actually exercises this discretion, the preceding paragraph shall be null and void and the Trustee's authority to make these distributions shall terminate and the Trustee's authority to make distributions shall be limited to purchasing supplemental goods and services in a manner that will not adversely affect ***[first name of person with disabilities]***'s government benefits. Furthermore, the Trustee's discretion shall be limited to an amount on a monthly basis which will allow ***[first name of person with disabilities]*** to continue to qualify for Supplemental Security Income ("SSI") benefits.

(f) EPTL § 7-1.6 or any successor statute, or any similar statute of any jurisdiction, shall not be applied by any court having jurisdiction of an *inter vivos* or testamentary trust to compel, against the Trustee's discretion, the

payment or application of the trust principal to or for the benefit of ***[first name of person with disabilities]***, or any beneficiary for any reason whatsoever.

ARTICLE III.
DISPOSITION OF TRUST ESTATE UPON *[NAME OF PERSON WITH DISABILITIES]*'S DEMISE

(1) DISPOSITION OF TRUST ON *[NAME OF PERSON WITH DISABILITIES]*'S DEATH

The Trust shall terminate upon ***[first name of person with disabilities]***'s death and the Trustee shall distribute any principal and accumulated interest that then remains in the Trust as follows:

(a) The New York State Department of Health, ***[name of county]*** County Department of Social Services, or other appropriate entity providing medical assistance within the State of New York shall be reimbursed from the Trust Estate, all amounts remaining in the Trust up to an amount equal to the total medical assistance provided to ***[first name of person with disabilities]*** during his/her lifetime, as consistent with Federal and State Law. If ***[first name of person with disabilities]*** received medical assistance in more than one State, then the amount distributed to each State shall be based upon each State's proportionate share of the total medical assistance benefits paid by all States on ***[first name of person with disabilities]***'s behalf subsequent to the funding of this trust.

(b) The Trustee, in the Trustee's sole and absolute discretion, may pay directly or indirectly from the Trust Estate: (i) court fees and administration or estate proceedings relating to this Trust, and (ii) any and all reasonable legal and accounting fees related to the Trust, subject to Court approval.

(c) All remaining principal and accumulated income shall be paid to ***[first name of person with disabilities]***'s heirs at law under the laws of the State of New York.

ARTICLE IV.
POWERS AND DUTIES OF TRUSTEES

In addition to any powers which may be conferred upon the Trustee under the law of the State of New York in effect during the life of this Trust, the Trustee shall have all those discretionary powers mentioned in EPTL §§ 11-1.1 et seq., or any successor statute or statutes governing the discretion of a Trustee, so as to confer upon the Trustee the broadest possible powers available for the management of the Trust assets. In the event that the Trustee wishes to exercise powers beyond the express and implied powers of EPTL Article 11, the Trustee shall seek and must obtain judicial approval.

ARTICLE V.
PROVISIONS RELATING TO TRUSTEE

(1) NOTIFICATIONS TO SOCIAL SERVICES DISTRICT

The Trustee shall provide the required notification to the Social Services District in accordance with the requirements of Section 360-4.5 of Title 18 of the Official Regulations of the State Department of Social

Services, and any other applicable statutes or regulations, as they may be amended. These regulations currently require notification of the creation or funding of the trust; notification of ***[first name of person with disabilities]***'s death; any transactions involving transfers from trust principal for less than fair market value; and in the case of trusts exceeding $100,000, notification in advance of transactions that substantially deplete the trust principal (as defined in that section).

ARTICLE VI.
APPOINTMENT OF TRUSTEE

(1) APPOINTMENTS

(a) ***[Name of trustee]*** is appointed Trustee of this Trust.

(b) If, for any reason, ***[name of trustee]*** is unable to or unwilling to serve as Trustee, then ***[name of trustee successor]*** shall serve as Successor Trustee, subject to the approval of the Supreme Court, ***[name of county]*** County.

(c) Appointment of a Successor Trustee not named in this Trust shall be upon application to the Court.

(2) CONSENT OF TRUSTEE

A Trustee shall file with the Clerk of the Court, ***[name of county]*** County, a "Consent to Act" as Trustee, Oath and Designation, duly acknowledged.

(3) BOND

The Trustee shall be required to execute and file a bond and comply with all applicable law, as determined by the Supreme Court ***[name of county]*** County.

(4) RESIGNATION

A Trustee may resign by giving written notice, a signed and acknowledged instrument, delivered to (i) the Supreme Court, ***[name of county]*** County; (ii) the Guardian of ***[first name of person with disabilities]***, if any; and (iii) ***[first name of person with disabilities]***. The Trustee's resignation is subject to approval of the Supreme Court, ***[name of county]*** County.

(5) DISCHARGE AND FINAL ACCOUNTING OF TRUSTEE

No Trustee shall be discharged and released from office and bond, except upon filing a Final Accounting in the form and manner required by § 81.33 and obtaining judicial approval of same.

(6) ANNUAL ACCOUNTING

The Trustee shall file during the month of May in the Office of the Clerk of the County of ***[name of county]***, an annual report in the form and manner required by Mental Hygiene Law (MHL) § 81.31. Said annual accountings shall be examined in the manner required by MHL § 81.32.

(7) CONTINUING JURISDICTION

The Court shall have continuing jurisdiction over the performance of the duties of the Trustee, the interpretation, administration, and operation of this Trust, the appointment of a successor Trustee and all other related matters.

(8) COMPENSATION OF TRUSTEE

A Trustee shall be entitled to such compensation as may be allowable under the laws of the State of New York. In addition, the Trustee shall be entitled to be reimbursed for reasonable expenses incurred by the Trustee in the administration of this Trust.

ARTICLE VII.
MISCELLANEOUS

(1) BINDING EFFECT

This Trust shall be binding upon the estate, executors, administrators and assigns of the Creator and any individual Trustee, and upon any Successor Trustee.

(2) SAVINGS CLAUSE

If it is determined that any provision hereof shall in any way violate any applicable law, such determination shall not impair the validity of the remaining provisions of the Trust.

(3) USAGE

In construing this Trust, feminine or neuter pronouns shall be substituted for those of the masculine form and vice versa, and the plural for the singular and vice versa in any case in which the context may require.

(4) HEADINGS

Any headings or captions in the Trust are for reference only, and shall not expand, limit, change, or affect the meaning of any provision of the Trust.

(5) SPENDTHRIFT

To the extent permitted by law, no interest of any beneficiary in the income or principal of any trust shall be

subject to pledge, assignment, sale or transfer in any manner, nor shall any beneficiary have power in any manner to anticipate, charge or encumber his or her interest, nor shall the interest of any beneficiary be liable while in the possession of the Trustee for the debts, contracts, liabilities, engagements or torts of the beneficiary; provided, however, that this exemption shall not apply in any respect to payments made on behalf of ***[first name of person with disabilities]*** for medical assistance provided by the New York State Department of Health, ***[name of county]*** County Department of Social Services, or any entity providing medical assistance in the State of New York.

IN WITNESS WHEREOF, the undersigned have executed this Agreement as of the day and year first above written.

Dated: *[date of execution]*	Creator: *[Name of creator]*
	[Name of creator] as GUARDIAN of the Property of ***[Name of person with disabilities]***
Dated: *[date of execution]*	TRUSTEE: *[name of trustee]*
	[Name of trustee]

[Acknowledgements]
Schedule "A"

[Text dollar amount of money] ($*[dollar amount of money]*) DOLLARS.

Receipt of the above listed items is hereby acknowledged by:

_____
[Name of trustee], Trustee
DATED:
[date of acknowledgement]

_____
WITNESS
Exhibit "A"
Copy of Order and Judgment

Notes

See In Matter of Application of Morales, 1995 WL 469523 (N.Y. Sup 1995).

This trust is referred to as a "Supplemental Needs Trust" which is the same type of trust referred to as a "Special Needs Trust" in § 21:33 *supra*. Certain courts prefer to call this type of trust a "Supplemental Needs Trust."

Regarding Article VI. (2), this provision applies if the Trust being established is within an Article 81 Guardianship.

Regarding Article VI. (3), this provision applies if the Trust being established is within an Article 81 Guardianship.

Regarding Article VI. (4), this provision applies if the Trust being established is within an Article 81 Guardianship.

Regarding Article VI. (5), this provision applies if the Trust being established is within an Article 81 Guardianship.

Regarding Article VI. (6), this provision applies if the Trust being established is within an Article 81 Guardianship.

Regarding Article VI. (7), this provision applies if the Trust being established is within an Article 81 Guardianship.

Statutory Authority

a. 26 U.S.C.A. § 104 – Compensation for injuries or sickness
b. 42 U.S.C.A. § 1382b – Resources
c. 42 U.S.C.A. § 1395y – Exclusions from coverage and Medicare as secondary payer
d. 42 U.S.C.A. § 1396p – Liens, adjustments and recoveries, and transfers of assets
e. 21st Century Cures Act (H.R.34, 114th Congress (2015 to 2016)). Section 5007 of the Act, titled “Fairness in Medicaid Supplemental Needs Trusts.” (PL 114-255, December 13, 2016, 130 Stat1033)
f. NY MHL § 81.21

KeyCite Yellow Flag - Negative Treatment
Proposed Legislation

United States Code Annotated
Title 26. Internal Revenue Code (Refs & Annos)
Subtitle A. Income Taxes (Refs & Annos)
Chapter 1. Normal Taxes and Surtaxes (Refs & Annos)
Subchapter B. Computation of Taxable Income
Part III. Items Specifically Excluded from Gross Income (Refs & Annos)

26 U.S.C.A. § 104, I.R.C. § 104

§ 104. Compensation for injuries or sickness

Effective: March 23, 2018

Currentness

(a) In general.--Except in the case of amounts attributable to (and not in excess of) deductions allowed under section 213 (relating to medical, etc., expenses) for any prior taxable year, gross income does not include--

(1) amounts received under workmen's compensation acts as compensation for personal injuries or sickness;

(2) the amount of any damages (other than punitive damages) received (whether by suit or agreement and whether as lump sums or as periodic payments) on account of personal physical injuries or physical sickness;

(3) amounts received through accident or health insurance (or through an arrangement having the effect of accident or health insurance) for personal injuries or sickness (other than amounts received by an employee, to the extent such amounts (A) are attributable to contributions by the employer which were not includible in the gross income of the employee, or (B) are paid by the employer);

(4) amounts received as a pension, annuity, or similar allowance for personal injuries or sickness resulting from active service in the armed forces of any country or in the Coast and Geodetic Survey or the Public Health Service, or as a disability annuity payable under the provisions of section 808 of the Foreign Service Act of 1980;

(5) amounts received by an individual as disability income attributable to injuries incurred as a direct result of a terroristic or military action (as defined in section 692(c)(2)); and

(6) amounts received pursuant to--

(A) section 1201 of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3796);[1] or

(B) a program established under the laws of any State which provides monetary compensation for surviving dependents of a public safety officer who has died as the direct and proximate result of a personal injury sustained in the line of duty,

except that subparagraph (B) shall not apply to any amounts that would have been payable if death of the public safety officer had occurred other than as the direct and proximate result of a personal injury sustained in the line of duty.

For purposes of paragraph (3), in the case of an individual who is, or has been, an employee within the meaning of section 401(c)(1) (relating to self-employed individuals), contributions made on behalf of such individual while he was such an employee to a trust described in section 401(a) which is exempt from tax under section 501(a), or under a plan described in section 403(a), shall, to the extent allowed as deductions under section 404, be treated as contributions by the employer which were not includible in the gross income of the employee. For purposes of paragraph (2), emotional distress shall not be treated as a physical injury or physical sickness. The preceding sentence shall not apply to an amount of damages not in excess of the amount paid for medical care (described in subparagraph (A) or (B) of section 213(d)(1)) attributable to emotional distress.

(b) Termination of application of subsection (a)(4) in certain cases.--

(1) In general.--Subsection (a)(4) shall not apply in the case of any individual who is not described in paragraph (2).

(2) Individuals to whom subsection (a)(4) continues to apply.--An individual is described in this paragraph if--

(A) on or before September 24, 1975, he was entitled to receive any amount described in subsection (a)(4),

(B) on September 24, 1975, he was a member of any organization (or reserve component thereof) referred to in subsection (a)(4) or under a binding written commitment to become such a member,

(C) he receives an amount described in subsection (a)(4) by reason of a combat-related injury, or

(D) on application therefor, he would be entitled to receive disability compensation from the Department of Veterans Affairs.

(3) Special rules for combat-related injuries.--For purposes of this subsection, the term "combat-related injury" means personal injury or sickness--

(A) which is incurred--

(i) as a direct result of armed conflict,

(ii) while engaged in extrahazardous service, or

(iii) under conditions simulating war; or

(B) which is caused by an instrumentality of war.

In the case of an individual who is not described in subparagraph (A) or (B) of paragraph (2), except as provided in paragraph (4), the only amounts taken into account under subsection (a)(4) shall be the amounts which he receives by reason of a combat-related injury.

(4) Amount excluded to be not less than veterans' disability compensation.--In the case of any individual described in paragraph (2), the amounts excludable under subsection (a)(4) for any period with respect to any individual shall not be less than the maximum amount which such individual, on application therefor, would be entitled to receive as disability compensation from the Veterans' Administration.

(c) Application of prior law in certain cases.--The phrase "(other than punitive damages)" shall not apply to punitive damages awarded in a civil action--

(1) which is a wrongful death action, and

(2) with respect to which applicable State law (as in effect on September 13, 1995 and without regard to any modification after such date) provides, or has been construed to provide by a court of competent jurisdiction pursuant to a decision issued on or before September 13, 1995, that only punitive damages may be awarded

in such an action.

This subsection shall cease to apply to any civil action filed on or after the first date on which the applicable State law ceases to provide (or is no longer construed to provide) the treatment described in paragraph (2).

(d) Cross references.--

(1) For exclusion from employee's gross income of employer contributions to accident and health plans, see section 106.

(2) For exclusion of part of disability retirement pay from the application of subsection (a)(4) of this section, see section 1403 of title 10, United States Code (relating to career compensation laws).

CREDIT(S)

(Aug. 16, 1954, c. 736, 68A Stat. 30; Pub.L. 86-723, § 51, Sept. 8, 1960, 74 Stat. 847; Pub.L. 87-792, § 7(d), Oct. 10, 1962, 76 Stat. 829; Pub.L. 94-455, Title V, § 505(b), (e)(1), Title XIX, § 1901(a)(18), Oct. 4, 1976, 90 Stat. 1567, 1568, 1766; Pub.L. 96-465, Title II, § 2206(e)(1), Oct. 17, 1980, 94 Stat. 2162; Pub.L. 97-473, Title I, § 101(a), Jan. 14, 1983, 96 Stat. 2605; Pub.L. 101-239, Title VII, § 7641(a), Dec. 19, 1989, 103 Stat. 2379; Pub.L. 104-188, Title I, § 1605(a) to (c), Aug. 20, 1996, 110 Stat. 1838; Pub.L. 104-191, Title III, § 311(b), Aug. 21, 1996, 110 Stat. 2053; Pub.L. 107-134, Title I, § 113(a), Jan. 23, 2002, 115 Stat. 2435; Pub.L. 114-14, § 2, May 22, 2015, 129 Stat. 198; Pub.L. 115-141, Div. U, Title IV, § 401(a)(2)(A), Mar. 23, 2018, 132 Stat. 1184.)

Footnotes

[1] Reclassified as 34 U.S.C.A. § 10281.

26 U.S.C.A. § 104, 26 USCA § 104
Current through P.L. 118-82. Some statute sections may be more current, see credits for details.

42 U.S.C.A. § 1382b

§ 1382b. Resources

Currentness

(a) Exclusions from resources

In determining the resources of an individual (and his eligible spouse, if any) there shall be excluded--

(1) the home (including the land that appertains thereto);

(2)(A) household goods, personal effects, and an automobile, to the extent that their total value does not exceed such amount as the Commissioner of Social Security determines to be reasonable; and

(B) the value of any burial space or agreement (including any interest accumulated thereon) representing the purchase of a burial space (subject to such limits as to size or value as the Commissioner of Social Security may by regulation prescribe) held for the purpose of providing a place for the burial of the individual, his spouse, or any other member of his immediate family;

(3) other property which is so essential to the means of self-support of such individual (and such spouse) as to warrant its exclusion, as determined in accordance with and subject to limitations prescribed by the Commissioner of Social Security, except that the Commissioner of Social Security shall not establish a limitation on property (including the tools of a tradesperson and the machinery and livestock of a farmer) that is used in a trade or business or by such individual as an employee;

(4) such resources of an individual who is blind or disabled and who has a plan for achieving self-support approved by the Commissioner of Social Security, as may be necessary for the fulfillment of such plan;

(5) in the case of Natives of Alaska, shares of stock held in a Regional or a Village Corporation, during the period of twenty years in which such stock is inalienable, as provided in section 1606(h) and section 1607(c)

of Title 43;

(6) assistance referred to in section 1382a(b)(11) of this title for the 9-month period beginning on the date such funds are received (or for such longer period as the Commissioner of Social Security shall by regulations prescribe in cases where good cause is shown by the individual concerned for extending such period); and, for purposes of this paragraph, the term "assistance" includes interest thereon which is excluded from income under section 1382a(b)(12) of this title;

(7) any amount received from the United States which is attributable to underpayments of benefits due for one or more prior months, under this subchapter or subchapter II, to such individual (or spouse) or to any other person whose income is deemed to be included in such individual's (or spouse's) income for purposes of this subchapter; but the application of this paragraph in the case of any such individual (and eligible spouse if any), with respect to any amount so received from the United States, shall be limited to the first 9 months following the month in which such amount is received, and written notice of this limitation shall be given to the recipient concurrently with the payment of such amount;

(8) the value of assistance referred to in section 1382a(b)(14) of this title, paid with respect to the dwelling unit occupied by such individual (or such individual and spouse);

(9) for the 9-month period beginning after the month in which received, any amount received by such individual (or such spouse) from a fund established by a State to aid victims of crime, to the extent that such individual (or such spouse) demonstrates that such amount was paid as compensation for expenses incurred or losses suffered as a result of a crime;

(10) for the 9-month period beginning after the month in which received, relocation assistance provided by a State or local government to such individual (or such spouse), comparable to assistance provided under title II of the Uniform Relocation Assistance and Real Property Acquisitions[l] Policies Act of 1970 which is subject to the treatment required by section 216 of such Act;

(11) for the 9-month period beginning after the month in which received--

(A) notwithstanding section 203 of the Economic Growth and Tax Relief Reconciliation Act of 2001, any refund of Federal income taxes made to such individual (or such spouse) under section 24 of the Internal Revenue Code of 1986 (relating to child tax credit) by reason of subsection (d) thereof; and

(B) any refund of Federal income taxes made to such individual (or such spouse) by reason of section 32 of the Internal Revenue Code of 1986 (relating to earned income tax credit), and any payment made to such individual (or such spouse) by an employer under section 3507 of such Code (relating to advance payment of earned income credit);

(12) any account, including accrued interest or other earnings thereon, established and maintained in accordance with section 1383(a)(2)(F) of this title;

(13) any gift to, or for the benefit of, an individual who has not attained 18 years of age and who has a life-threatening condition, from an organization described in section 501(c)(3) of the Internal Revenue Code of 1986 which is exempt from taxation under section 501(a) of such Code--

(A) in the case of an in-kind gift, if the gift is not converted to cash; or

(B) in the case of a cash gift, only to the extent that the total amount excluded from the resources of the individual pursuant to this paragraph in the calendar year in which the gift is made does not exceed $2,000;

(14) for the 9-month period beginning after the month in which received, any amount received by such individual (or spouse) or any other person whose income is deemed to be included in such individual's (or spouse's) income for purposes of this subchapter as restitution for benefits under this subchapter, subchapter II, or subchapter VIII that a representative payee of such individual (or spouse) or such other person under section 405(j), 1007, or 1383(a)(2) of this title has misused;

(15) for the 9-month period beginning after the month in which received, any grant, scholarship, fellowship, or gift (or portion of a gift) used to pay the cost of tuition and fees at any educational (including technical or vocational education) institution;

(16) for the month of receipt and every month thereafter, any annuity paid by a State to the individual (or such spouse) on the basis of the individual's being a veteran (as defined in section 101 of Title 38), and blind, disabled, or aged; and

(17) any amount received by such individual (or such spouse) which is excluded from income under section 1382a(b)(26) of this title (relating to compensation for participation in a clinical trial involving research and testing of treatments for a rare disease or condition).

In determining the resources of an individual (or eligible spouse) an insurance policy shall be taken into account only to the extent of its cash surrender value; except that if the total face value of all life insurance policies on any person is $1,500 or less, no part of the value of any such policy shall be taken into account.

(b) Disposition of resources; grounds for exemption from disposition requirements

(1) The Commissioner of Social Security shall prescribe the period or periods of time within which, and the manner in which, various kinds of property must be disposed of in order not to be included in determining an individual's eligibility for benefits. Any portion of the individual's benefits paid for any such period shall be conditioned upon such disposal; and any benefits so paid shall (at the time of the disposal) be considered overpayments to the extent they would not have been paid had the disposal occurred at the beginning of the period for which such benefits were paid.

(2) Notwithstanding the provisions of paragraph (1), the Commissioner of Social Security shall not require the disposition of any real property for so long as it cannot be sold because (A) it is jointly owned (and its sale would cause undue hardship, due to loss of housing, for the other owner or owners), (B) its sale is barred by a legal impediment, or (C) as determined under regulations issued by the Commissioner of Social Security, the owner's reasonable efforts to sell it have been unsuccessful.

(c) Disposal of resources for less than fair market value

(1)(A)(i) If an individual or the spouse of an individual disposes of resources for less than fair market value on or after the look-back date described in clause (ii)(I), the individual is ineligible for benefits under this subchapter for months during the period beginning on the date described in clause (iii) and equal to the number of months calculated as provided in clause (iv).

(ii)(I) The look-back date described in this subclause is a date that is 36 months before the date described in subclause (II).

(II) The date described in this subclause is the date on which the individual applies for benefits under this subchapter or, if later, the date on which the individual (or the spouse of the individual) disposes of resources for less than fair market value.

(iii) The date described in this clause is the first day of the first month in or after which resources were disposed of for less than fair market value and which does not occur in any other period of ineligibility under this paragraph.

(iv) The number of months calculated under this clause shall be equal to--

(I) the total, cumulative uncompensated value of all resources so disposed of by the individual (or the spouse of the individual) on or after the look-back date described in clause (ii)(I); divided by

(II) the amount of the maximum monthly benefit payable under section 1382(b) of this title, plus the amount (if any) of the maximum State supplementary payment corresponding to the State's payment level applicable to the individual's living arrangement and eligibility category that would otherwise be payable to the individual by the Commissioner pursuant to an agreement under section 1382e(a) of this title or section 212(b) of Public Law 93-66, for the month in which occurs the date described in clause (ii)(II),

rounded, in the case of any fraction, to the nearest whole number, but shall not in any case exceed 36 months.

(B)(i) Notwithstanding subparagraph (A), this subsection shall not apply to a transfer of a resource to a trust if the portion of the trust attributable to the resource is considered a resource available to the individual pursuant to subsection (e)(3) (or would be so considered but for the application of subsection (e)(4)).

(ii) In the case of a trust established by an individual or an individual's spouse (within the meaning of subsection (e)), if from such portion of the trust, if any, that is considered a resource available to the individual pursuant to subsection (e)(3) (or would be so considered but for the application of subsection (e)(4)) or the residue of the portion on the termination of the trust--

(I) there is made a payment other than to or for the benefit of the individual; or

(II) no payment could under any circumstance be made to the individual,

then, for purposes of this subsection, the payment described in clause (I) or the foreclosure of payment described in clause (II) shall be considered a transfer of resources by the individual or the individual's spouse as of the date of the payment or foreclosure, as the case may be.

(C) An individual shall not be ineligible for benefits under this subchapter by reason of the application of this paragraph to a disposal of resources by the individual or the spouse of the individual, to the extent that--

(i) the resources are a home and title to the home was transferred to--

(I) the spouse of the transferor;

(II) a child of the transferor who has not attained 21 years of age, or is blind or disabled;

(III) a sibling of the transferor who has an equity interest in such home and who was residing in the

transferor's home for a period of at least 1 year immediately before the date the transferor becomes an institutionalized individual; or

(IV) a son or daughter of the transferor (other than a child described in subclause (II)) who was residing in the transferor's home for a period of at least 2 years immediately before the date the transferor becomes an institutionalized individual, and who provided care to the transferor which permitted the transferor to reside at home rather than in such an institution or facility;

(ii) the resources--

(I) were transferred to the transferor's spouse or to another for the sole benefit of the transferor's spouse;

(II) were transferred from the transferor's spouse to another for the sole benefit of the transferor's spouse;

(III) were transferred to, or to a trust (including a trust described in section 1396p(d)(4) of this title) established solely for the benefit of, the transferor's child who is blind or disabled; or

(IV) were transferred to a trust (including a trust described in section 1396p(d)(4) of this title) established solely for the benefit of an individual who has not attained 65 years of age and who is disabled;

(iii) a satisfactory showing is made to the Commissioner of Social Security (in accordance with regulations promulgated by the Commissioner) that--

(I) the individual who disposed of the resources intended to dispose of the resources either at fair market value, or for other valuable consideration;

(II) the resources were transferred exclusively for a purpose other than to qualify for benefits under this subchapter; or

(III) all resources transferred for less than fair market value have been returned to the transferor; or

(iv) the Commissioner determines, under procedures established by the Commissioner, that the denial of eligibility would work an undue hardship as determined on the basis of criteria established by the Commissioner.

(D) For purposes of this subsection, in the case of a resource held by an individual in common with another person or persons in a joint tenancy, tenancy in common, or similar arrangement, the resource (or the affected portion of such resource) shall be considered to be disposed of by the individual when any action is taken, either by the individual or by any other person, that reduces or eliminates the individual's ownership or control of such resource.

(E) In the case of a transfer by the spouse of an individual that results in a period of ineligibility for the individual under this subsection, the Commissioner shall apportion the period (or any portion of the period) among the individual and the individual's spouse if the spouse becomes eligible for benefits under this subchapter.

(F) For purposes of this paragraph--

(i) the term "benefits under this subchapter" includes payments of the type described in section 1382e(a) of this title and of the type described in section 212(b) of Public Law 93-66;

(ii) the term "institutionalized individual" has the meaning given such term in section 1396p(e)(3) of this title; and

(iii) the term "trust" has the meaning given such term in subsection (e)(6)(A) of this section.

(2)(A) At the time an individual (and the individual's eligible spouse, if any) applies for benefits under this subchapter, and at the time the eligibility of an individual (and such spouse, if any) for such benefits is redetermined, the Commissioner of Social Security shall--

(i) inform such individual of the provisions of paragraph (1) and section 1396p(c) of this title providing for a period of ineligibility for benefits under this subchapter and subchapter XIX, respectively, for individuals who make certain dispositions of resources for less than fair market value, and inform such individual that information obtained pursuant to clause (ii) will be made available to the State agency administering a State plan under subchapter XIX (as provided in subparagraph (B)); and

(ii) obtain from such individual information which may be used in determining whether or not a period of ineligibility for such benefits would be required by reason of paragraph (1) or section 1396p(c) of this title.

(B) The Commissioner of Social Security shall make the information obtained under subparagraph (A)(ii) available, on request, to any State agency administering a State plan approved under subchapter XIX.

(d) Funds set aside for burial expenses

(1) In determining the resources of an individual, there shall be excluded an amount, not in excess of $1,500 each with respect to such individual and his spouse (if any), that is separately identifiable and has been set aside to meet the burial and related expenses of such individual or spouse.

(2) The amount of $1,500, referred to in paragraph (1), with respect to an individual shall be reduced by an amount equal to (A) the total face value of all insurance policies on his life which are owned by him or his spouse and the cash surrender value of which has been excluded in determining the resources of such individual or of such individual and his spouse, and (B) the total of any amounts in an irrevocable trust (or other irrevocable arrangement) available to meet the burial and related expenses of such individual or his spouse.

(3) If the Commissioner of Social Security finds that any part of the amount excluded under paragraph (1) was used for purposes other than those for which it was set aside in cases where the inclusion of any portion of the amount would cause the resources of such individual, or of such individual and spouse, to exceed the limits specified in paragraph (1) or (2) (whichever may be applicable) of section 1382(a) of this title, the Commissioner shall reduce any future benefits payable to the eligible individual (or to such individual and his spouse) by an amount equal to such part.

(4) The Commissioner of Social Security may provide by regulations that whenever an amount set aside to meet burial and related expenses is excluded under paragraph (1) in determining the resources of an individual, any interest earned or accrued on such amount (and left to accumulate), and any appreciation in the value of prepaid burial arrangements for which such amount was set aside, shall also be excluded (to such extent and subject to such conditions or limitations as such regulations may prescribe) in determining the resources (and the income) of such individual.

(e) Trusts

(1) In determining the resources of an individual, paragraph (3) shall apply to a trust (other than a trust described in paragraph (5)) established by the individual.

(2)(A) For purposes of this subsection, an individual shall be considered to have established a trust if any assets of the individual (or of the individual's spouse) are transferred to the trust other than by will.

(B) In the case of an irrevocable trust to which are transferred the assets of an individual (or of the individual's spouse) and the assets of any other person, this subsection shall apply to the portion of the trust attributable to the assets of the individual (or of the individual's spouse).

(C) This subsection shall apply to a trust without regard to--

(i) the purposes for which the trust is established;

(ii) whether the trustees have or exercise any discretion under the trust;

(iii) any restrictions on when or whether distributions may be made from the trust; or

(iv) any restrictions on the use of distributions from the trust.

(3)(A) In the case of a revocable trust established by an individual, the corpus of the trust shall be considered a resource available to the individual.

(B) In the case of an irrevocable trust established by an individual, if there are any circumstances under which payment from the trust could be made to or for the benefit of the individual (or of the individual's spouse), the portion of the corpus from which payment to or for the benefit of the individual (or of the individual's spouse) could be made shall be considered a resource available to the individual.

(4) The Commissioner of Social Security may waive the application of this subsection with respect to an individual if the Commissioner determines that such application would work an undue hardship (as determined on the basis of criteria established by the Commissioner) on the individual.

(5) This subsection shall not apply to a trust described in subparagraph (A) or (C) of section 1396p(d)(4) of this title.

(6) For purposes of this subsection--

(A) the term "trust" includes any legal instrument or device that is similar to a trust;

(B) the term "corpus" means, with respect to a trust, all property and other interests held by the trust, including accumulated earnings and any other addition to the trust after its establishment (except that such term does not include any such earnings or addition in the month in which the earnings or addition is credited or otherwise transferred to the trust); and

(C) the term "asset" includes any income or resource of the individual (or of the individual's spouse), including--

(i) any income excluded by section 1382a(b) of this title;

(ii) any resource otherwise excluded by this section; and

(iii) any other payment or property to which the individual (or of the individual's spouse) is entitled but does not receive or have access to because of action by--

(I) the individual or spouse;

(II) a person or entity (including a court) with legal authority to act in place of, or on behalf of, the individual or spouse; or

(III) a person or entity (including a court) acting at the direction of, or on the request of, the individual or spouse.

CREDIT(S)

(Aug. 14, 1935, c. 531, Title XVI, § 1613, as added Pub.L. 92-603, Title III, § 301, Oct. 30, 1972, 86 Stat. 1470; amended Pub.L. 94-569, § 5, Oct. 20, 1976, 90 Stat. 2700; Pub.L. 95-171, § 9(a), Nov. 12, 1977, 91 Stat. 1355; Pub.L. 96-611, § 5(a), Dec. 28, 1980, 94 Stat. 3567; Pub.L. 97-248, Title I, § 185(a), (b), Sept. 3, 1982, 96 Stat. 406; Pub.L. 98-369, Div. B, Title VI, §§ 2614, 2663(g)(5), July 18, 1984, 98 Stat. 1132, 1168; Pub.L. 100-203, Title IX, §§ 9103(a), 9104(a), 9105(a), 9114(a), Dec. 22, 1987, 101 Stat. 1330-301, 1330-304; Pub.L. 100-360, Title III, § 303(c)(1), July 1, 1988, 102 Stat. 762; Pub.L. 100-647, Title VIII, § 8103(b), Nov. 10, 1988, 102 Stat. 3795; Pub.L. 101-239, Title VIII, §§ 8013(b), 8014(a), Dec. 19, 1989, 103 Stat. 2465; Pub.L. 101-508, Title V, §§ 5031(b), 5035(b), Title XI, § 11115(b)(2), Nov. 5, 1990, 104 Stat. 1388-224, 1388-225, 1388-414; Pub.L. 103-296, Title I, § 107(a)(4), Title III, § 321(h)(2), Aug. 15, 1994, 108 Stat. 1478, 1544; Pub.L. 104-193, Title II, § 213(b), Aug. 22, 1996, 110 Stat. 2195; Pub.L. 105-306, § 7(b), Oct. 28, 1998, 112 Stat. 2928; Pub.L. 106-169, Title II, §§ 205(a), 206(a), Dec. 14, 1999, 113 Stat. 1833, 1834; Pub.L. 108-203, Title I, § 101(c)(2), Title IV, §§ 431(a), (b), 435(b), Mar. 2, 2004, 118 Stat. 496, 539, 540; Pub.L. 110-245,

Title II, § 202(b), June 17, 2008, 122 Stat. 1638; Pub.L. 111-255, § 3(b), (e), Oct. 5, 2010, 124 Stat. 2641; Pub.L. 114-63, § 2, Oct. 7, 2015, 129 Stat. 549.)

Footnotes

[1] So in original. Probably should be “Acquisition”.

42 U.S.C.A. § 1382b, 42 USCA § 1382b
Current through P.L. 118-82. Some statute sections may be more current, see credits for details.

KeyCite Yellow Flag - Negative Treatment
Unconstitutional or PreemptedNegative Treatment Reconsidered by Florida ex rel. Atty. Gen. v. U.S. Dept. of Health and Human Services, 11th Cir.(Fla.), Aug. 12, 2011
KeyCite Yellow Flag - Negative TreatmentProposed Legislation

United States Code Annotated
Title 42. The Public Health and Welfare
Chapter 7. Social Security (Refs & Annos)
Subchapter XVIII. Health Insurance for Aged and Disabled (Refs & Annos)
Part E. Miscellaneous Provisions (Refs & Annos)

42 U.S.C.A. § 1395y

§ 1395y. Exclusions from coverage and medicare as secondary payer

Effective: April 6, 2022

Currentness

(a) Items or services specifically excluded

Notwithstanding any other provision of this subchapter, no payment may be made under part A or part B for any expenses incurred for items or services--

(1)(A) which, except for items and services described in a succeeding subparagraph or additional preventive services (as described in section 1395x(ddd)(1) of this title), are not reasonable and necessary for the

diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member,

(B) in the case of items and services described in section 1395x(s)(10) of this title, which are not reasonable and necessary for the prevention of illness,

(C) in the case of hospice care, which are not reasonable and necessary for the palliation or management of terminal illness,

(D) in the case of clinical care items and services provided with the concurrence of the Secretary and with respect to research and experimentation conducted by, or under contract with, the Medicare Payment Advisory Commission or the Secretary, which are not reasonable and necessary to carry out the purposes of section 1395ww(e)(6) of this title,

(E) in the case of research conducted pursuant to section 1320b-12 of this title, which is not reasonable and necessary to carry out the purposes of that section,

(F) in the case of screening mammography, which is performed more frequently than is covered under section 1395m(c)(2) of this title or which is not conducted by a facility described in section 1395m(c)(1)(B) of this title, in the case of screening pap smear and screening pelvic exam, which is performed more frequently than is provided under section 1395x(nn) of this title, and, in the case of screening for glaucoma, which is performed more frequently than is provided under section 1395x(uu) of this title,

(G) in the case of prostate cancer screening tests (as defined in section 1395x(oo) of this title), which are performed more frequently than is covered under such section,

(H) in the case of colorectal cancer screening tests, which are performed more frequently than is covered under section 1395m(d) of this title,

(I) the frequency and duration of home health services which are in excess of normative guidelines that the Secretary shall establish by regulation,

(J) in the case of a drug or biological specified in section 1395w-3a(c)(6)(C) of this title for which payment is made under part B that is furnished in a competitive area under section 1395w-3b of this title, that is not furnished by an entity under a contract under such section,

(K) in the case of an initial preventive physical examination, which is performed more than 1 year after the

date the individual's first coverage period begins under part B,

(L) in the case of cardiovascular screening blood tests (as defined in section 1395x(xx)(1) of this title), which are performed more frequently than is covered under section 1395x(xx)(2) of this title,

(M) in the case of a diabetes screening test (as defined in section 1395x(yy)(1) of this title), which is performed more frequently than is covered under section 1395x(yy)(3) of this title,

(N) in the case of ultrasound screening for abdominal aortic aneurysm which is performed more frequently than is provided for under section 1395x(s)(2)(AA) of this title,

(O) in the case of kidney disease education services (as defined in paragraph (1) of section 1395x(ggg) of this title), which are furnished in excess of the number of sessions covered under paragraph (4) of such section, and

(P) in the case of personalized prevention plan services (as defined in section 1395x(hhh)(1) of this title), which are performed more frequently than is covered under such section;

(2) for which the individual furnished such items or services has no legal obligation to pay, and which no other person (by reason of such individual's membership in a prepayment plan or otherwise) has a legal obligation to provide or pay for, except in the case of Federally qualified health center services;

(3) which are paid for directly or indirectly by a governmental entity (other than under this chapter and other than under a health benefits or insurance plan established for employees of such an entity), except in the case of rural health clinic services, as defined in section 1395x(aa)(1) of this title, in the case of Federally qualified health center services, as defined in section 1395x(aa)(3) of this title, in the case of services for which payment may be made under section 1395qq(e) of this title, and in such other cases as the Secretary may specify;

(4) which are not provided within the United States (except for inpatient hospital services furnished outside the United States under the conditions described in section 1395f(f) of this title and, subject to such conditions, limitations, and requirements as are provided under or pursuant to this subchapter, physicians' services and ambulance services furnished an individual in conjunction with such inpatient hospital services but only for the period during which such inpatient hospital services were furnished);

(5) which are required as a result of war, or of an act of war, occurring after the effective date of such individual's current coverage under such part;

(6) which constitute personal comfort items (except, in the case of hospice care, as is otherwise permitted under paragraph (1)(C));

(7) where such expenses are for routine physical checkups, eyeglasses (other than eyewear described in section 1395x(s)(8) of this title) or eye examinations for the purpose of prescribing, fitting, or changing eyeglasses, procedures performed (during the course of any eye examination) to determine the refractive state of the eyes, hearing aids or examinations therefor, or immunizations (except as otherwise allowed under section 1395x(s)(10) of this title and subparagraph (B), (F), (G), (H), (K), or (P) of paragraph (1));

(8) where such expenses are for orthopedic shoes or other supportive devices for the feet, other than shoes furnished pursuant to section 1395x(s)(12) of this title;

(9) where such expenses are for custodial care (except, in the case of hospice care, as is otherwise permitted under paragraph (1)(C));

(10) where such expenses are for cosmetic surgery or are incurred in connection therewith, except as required for the prompt repair of accidental injury or for improvement of the functioning of a malformed body member;

(11) where such expenses constitute charges imposed by immediate relatives of such individual or members of his household;

(12) where such expenses are for services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth, except that payment may be made under part A in the case of inpatient hospital services in connection with the provision of such dental services if the individual, because of his underlying medical condition and clinical status or because of the severity of the dental procedure, requires hospitalization in connection with the provision of such services;

(13) where such expenses are for--

(A) the treatment of flat foot conditions and the prescription of supportive devices therefor,

(B) the treatment of subluxations of the foot, or

(C) routine foot care (including the cutting or removal of corns or calluses, the trimming of nails, and other routine hygienic care);

(14) which are other than physicians' services (as defined in regulations promulgated specifically for purposes of this paragraph), services described by section 1395x(s)(2)(K) of this title, certified nurse-midwife services, qualified psychologist services, and services of a certified registered nurse anesthetist, and which are furnished to an individual who is a patient of a hospital or critical access hospital by an entity other than the hospital or critical access hospital, unless the services are furnished under arrangements (as defined in section 1395x(w)(1) of this title) with the entity made by the hospital or critical access hospital;

(15)(A) which are for services of an assistant at surgery in a cataract operation (including subsequent insertion of an intraocular lens) unless, before the surgery is performed, the appropriate quality improvement organization (under part B of subchapter XI) or a carrier under section 1395u of this title has approved of the use of such an assistant in the surgical procedure based on the existence of a complicating medical condition, or

(B) which are for services of an assistant at surgery to which section 1395w-4(i)(2)(B) of this title applies;

(16) in the case in which funds may not be used for such items and services under the Assisted Suicide Funding Restriction Act of 1997;

(17) where the expenses are for an item or service furnished in a competitive acquisition area (as established by the Secretary under section 1395w-3(a) of this title) by an entity other than an entity with which the Secretary has entered into a contract under section 1395w-3(b) of this title for the furnishing of such an item or service in that area, unless the Secretary finds that the expenses were incurred in a case of urgent need, or in other circumstances specified by the Secretary;

(18) which are covered skilled nursing facility services described in section 1395yy(e)(2)(A)(i) of this title and which are furnished to an individual who is a resident of a skilled nursing facility during a period in which the resident is provided covered post-hospital extended care services (or, for services described in section 1395x(s)(2)(D) of this title, which are furnished to such an individual without regard to such period), by an entity other than the skilled nursing facility, unless the services are furnished under arrangements (as defined in section 1395x(w)(1) of this title) with the entity made by the skilled nursing facility;

(19) which are for items or services which are furnished pursuant to a private contract described in section 1395a(b) of this title;

(20) in the case of outpatient physical therapy services, outpatient speech-language pathology services, or outpatient occupational therapy services furnished as an incident to a physician's professional services (as

described in section 1395x(s)(2)(A) of this title), that do not meet the standards and conditions (other than any licensing requirement specified by the Secretary) under the second sentence of section 1395x(p) of this title (or under such sentence through the operation of subsection (g) or (*ll*)(2) of section 1395x of this title) as such standards and conditions would apply to such therapy services if furnished by a therapist;

(21) where such expenses are for home health services (including medical supplies described in section 1395x(m)(5) of this title, but excluding durable medical equipment to the extent provided for in such section) furnished to an individual who is under a plan of care of the home health agency if the claim for payment for such services is not submitted by the agency;

(22) subject to subsection (h), for which a claim is submitted other than in an electronic form specified by the Secretary;

(23) which are the technical component of advanced diagnostic imaging services described in section 1395m(e)(1)(B) of this title for which payment is made under the fee schedule established under section 1395w-4(b) of this title and that are furnished by a supplier (as defined in section 1395x(d) of this title), if such supplier is not accredited by an accreditation organization designated by the Secretary under section 1395m(e)(2)(B) of this title;

(24) where such expenses are for renal dialysis services (as defined in subparagraph (B) of section 1395rr(b)(14) of this title) for which payment is made under such section unless such payment is made under such section to a provider of services or a renal dialysis facility for such services; or

(25) not later than January 1, 2014, for which the payment is other than by electronic funds transfer (EFT) or an electronic remittance in a form as specified in ASC X12 835 Health Care Payment and Remittance Advice or subsequent standard.

Paragraph (7) shall not apply to Federally qualified health center services described in section 1395x(aa)(3)(B) of this title.

In making a national coverage determination (as defined in paragraph (1)(B) of section 1395ff(f) of this title) the Secretary shall ensure consistent with subsection (l) that the public is afforded notice and opportunity to comment prior to implementation by the Secretary of the determination; meetings of advisory committees with respect to the determination are made on the record; in making the determination, the Secretary has considered applicable information (including clinical experience and medical, technical, and scientific evidence) with respect to the subject matter of the determination; and in the determination, provide a clear statement of the basis for the determination (including responses to comments received from the public), the assumptions underlying that basis, and make available to the public the data (other than proprietary data) considered in making the determination.

(b) Medicare as secondary payer

(1) Requirements of group health plans

(A) Working aged under group health plans

(i) In general

A group health plan--

(I) may not take into account that an individual (or the individual's spouse) who is covered under the plan by virtue of the individual's current employment status with an employer is entitled to benefits under this subchapter under section 426(a) of this title, and

(II) shall provide that any individual age 65 or older (and the spouse age 65 or older of any individual) who has current employment status with an employer shall be entitled to the same benefits under the plan under the same conditions as any such individual (or spouse) under age 65.

(ii) Exclusion of group health plan of a small employer

Clause (i) shall not apply to a group health plan unless the plan is a plan of, or contributed to by, an employer that has 20 or more employees for each working day in each of 20 or more calendar weeks in the current calendar year or the preceding calendar year.

(iii) Exception for small employers in multiemployer or multiple employer group health plans

Clause (i) also shall not apply with respect to individuals enrolled in a multiemployer or multiple employer group health plan if the coverage of the individuals under the plan is by virtue of current employment status with an employer that does not have 20 or more individuals in current employment status for each working day in each of 20 or more calendar weeks in the current calendar year and the preceding calendar year; except that the exception provided in this clause shall only apply if the plan elects treatment under this clause.

(iv) Exception for individuals with end stage renal disease

Subparagraph (C) shall apply instead of clause (i) to an item or service furnished in a month to an individual if for the month the individual is, or (without regard to entitlement under section 426 of this

title) would upon application be, entitled to benefits under section 426-1 of this title.

(v) "Group health plan" defined

In this subparagraph, and subparagraph (C), the term "group health plan" has the meaning given such term in section 5000(b)(1) of the Internal Revenue Code of 1986, without regard to section 5000(d) of such Code.

(B) Disabled individuals in large group health plans

(i) In general

A large group health plan (as defined in clause (iii)) may not take into account that an individual (or a member of the individual's family) who is covered under the plan by virtue of the individual's current employment status with an employer is entitled to benefits under this subchapter under section 426(b) of this title.

(ii) Exception for individuals with end stage renal disease

Subparagraph (C) shall apply instead of clause (i) to an item or service furnished in a month to an individual if for the month the individual is, or (without regard to entitlement under section 426 of this title) would upon application be, entitled to benefits under section 426-1 of this title.

(iii) "Large group health plan" defined

In this subparagraph, the term "large group health plan" has the meaning given such term in section 5000(b)(2) of the Internal Revenue Code of 1986, without regard to section 5000(d) of such Code.

(C) Individuals with end stage renal disease

A group health plan (as defined in subparagraph (A)(v))--

(i) may not take into account that an individual is entitled to or eligible for benefits under this subchapter under section 426-1 of this title during the 12-month period which begins with the first month in which the individual becomes entitled to benefits under part A under the provisions of section 426-1 of this title, or, if earlier, the first month in which the individual would have been entitled to benefits under

such part under the provisions of section 426-1 of this title if the individual had filed an application for such benefits; and

(ii) may not differentiate in the benefits it provides between individuals having end stage renal disease and other individuals covered by such plan on the basis of the existence of end stage renal disease, the need for renal dialysis, or in any other manner;

except that clause (ii) shall not prohibit a plan from paying benefits secondary to this subchapter when an individual is entitled to or eligible for benefits under this subchapter under section 426-1 of this title after the end of the 12-month period described in clause (i). Effective for items and services furnished on or after February 1, 1991, and before August 5, 1997,[1] (with respect to periods beginning on or after February 1, 1990), this subparagraph shall be applied by substituting "18-month" for "12-month" each place it appears. Effective for items and services furnished on or after August 5, 1997,[1] (with respect to periods beginning on or after the date that is 18 months prior to August 5, 1997), clauses (i) and (ii) shall be applied by substituting "30-month" for "12-month" each place it appears.

(D) Treatment of certain members of religious orders

In this subsection, an individual shall not be considered to be employed, or an employee, with respect to the performance of services as a member of a religious order which are considered employment only by virtue of an election made by the religious order under section 3121(r) of the Internal Revenue Code of 1986.

(E) General provisions

For purposes of this subsection:

(i) Aggregation rules

(I) All employers treated as a single employer under subsection (a) or (b) of section 52 of the Internal Revenue Code of 1986 shall be treated as a single employer.

(II) All employees of the members of an affiliated service group (as defined in section 414(m) of such Code) shall be treated as employed by a single employer.

(III) Leased employees (as defined in section 414(n)(2) of such Code) shall be treated as employees of the person for whom they perform services to the extent they are so treated under section 414(n) of such

Code.

In applying sections of the Internal Revenue Code of 1986 under this clause, the Secretary shall rely upon regulations and decisions of the Secretary of the Treasury respecting such sections.

(ii) "Current employment status" defined

An individual has "current employment status" with an employer if the individual is an employee, is the employer, or is associated with the employer in a business relationship.

(iii) Treatment of self-employed persons as employers

The term "employer" includes a self-employed person.

(iv) Application to certain Postal Service annuitants or family members

Nothing in this paragraph shall prohibit a group health plan from determining an individual's eligibility to enroll in a health benefits plan offered under the Postal Service Health Benefits Program under section 8903c of Title 5, in accordance with subsection (e) of such section.

(F) Limitation on beneficiary liability

An individual who is entitled to benefits under this subchapter and is furnished an item or service for which such benefits are incorrectly paid is not liable for repayment of such benefits under this paragraph unless payment of such benefits was made to the individual.

(2) Medicare secondary payer

(A) In general

Payment under this subchapter may not be made, except as provided in subparagraph (B), with respect to any item or service to the extent that--

(i) payment has been made, or can reasonably be expected to be made, with respect to the item or service as required under paragraph (1), or

(ii) payment has been made[2] or can reasonably be expected to be made[2] 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.

In this subsection, the term "primary plan" means a group health plan or large group health plan, to the extent that clause (i) applies, and a workmen's compensation law or plan, an automobile or liability insurance policy or plan (including a self-insured plan) or no fault insurance, to the extent that clause (ii) applies. An entity that engages in a business, trade, or profession shall be deemed to have a self-insured plan if it carries its own risk (whether by a failure to obtain insurance, or otherwise) in whole or in part.

(B) Conditional payment

(i) Authority to make conditional payment

The Secretary may make payment under this subchapter with respect to an item or service if a primary plan described in subparagraph (A)(ii)[3] has not made or cannot reasonably be expected to make payment with respect to such item or service promptly (as determined in accordance with regulations). Any such payment by the Secretary shall be conditioned on reimbursement to the appropriate Trust Fund in accordance with the succeeding provisions of this subsection.

(ii) Repayment required

Subject to paragraph (9), a primary plan, and an entity that receives payment from a primary plan, shall reimburse the appropriate Trust Fund for any payment made by the Secretary under this subchapter with respect to an item or service if it is demonstrated that such primary plan has or had a responsibility to make payment with respect to such item or service. A primary plan's responsibility for such payment may be demonstrated by a judgment, a payment conditioned upon the recipient's compromise, waiver, or release (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary plan or the primary plan's insured, or by other means. If reimbursement is not made to the appropriate Trust Fund before the expiration of the 60-day period that begins on the date notice of, or information related to, a primary plan's responsibility for such payment or other information is received, the Secretary may charge interest (beginning with the date on which the notice or other information is received) on the amount of the reimbursement until reimbursement is made (at a rate determined by the Secretary in accordance with regulations of the Secretary of the Treasury applicable to charges for late payments).

(iii) Action by United States

In order to recover payment made under this subchapter for an item or service, the United States may

bring an action against any or all entities that are or were required or responsible (directly, as an insurer or self-insurer, as a third-party administrator, as an employer that sponsors or contributes to a group health plan, or large group health plan, or otherwise) to make payment with respect to the same item or service (or any portion thereof) under a primary plan. The United States may, in accordance with paragraph (3)(A) collect double damages against any such entity. In addition, the United States may recover under this clause from any entity that has received payment from a primary plan or from the proceeds of a primary plan's payment to any entity. The United States may not recover from a third-party administrator under this clause in cases where the third-party administrator would not be able to recover the amount at issue from the employer or group health plan and is not employed by or under contract with the employer or group health plan at the time the action for recovery is initiated by the United States or for whom it provides administrative services due to the insolvency or bankruptcy of the employer or plan. An action may not be brought by the United States under this clause with respect to payment owed unless the complaint is filed not later than 3 years after the date of the receipt of notice of a settlement, judgment, award, or other payment made pursuant to paragraph (8) relating to such payment owed.

(iv) Subrogation rights

The United States shall be subrogated (to the extent of payment made under this subchapter for such an item or service) to any right under this subsection of an individual or any other entity to payment with respect to such item or service under a primary plan.

(v) Waiver of rights

The Secretary may waive (in whole or in part) the provisions of this subparagraph in the case of an individual claim if the Secretary determines that the waiver is in the best interests of the program established under this subchapter.

(vi) Claims-filing period

Notwithstanding any other time limits that may exist for filing a claim under an employer group health plan, the United States may seek to recover conditional payments in accordance with this subparagraph where the request for payment is submitted to the entity required or responsible under this subsection to pay with respect to the item or service (or any portion thereof) under a primary plan within the 3-year period beginning on the date on which the item or service was furnished.

(vii) Use of website to determine final conditional reimbursement amount

(I) Notice to Secretary of expected date of a settlement, judgment, etc.

In the case of a payment made by the Secretary pursuant to clause (i) for items and services provided

to the claimant, the claimant or applicable plan (as defined in paragraph (8)(F)) may at any time beginning 120 days before the reasonably expected date of a settlement, judgment, award, or other payment, notify the Secretary that a payment is reasonably expected and the expected date of such payment.

(II) Secretarial[4] providing access to claims information through a website

The Secretary shall maintain and make available to individuals to whom items and services are furnished under this subchapter (and to authorized family or other representatives recognized under regulations and to an applicable plan which has obtained the consent of the individual) access to information on the claims for such items and services (including payment amounts for such claims), including those claims that relate to a potential settlement, judgment, award, or other payment. Such access shall be provided to an individual, representative, or plan through a website that requires a password to gain access to the information. The Secretary shall update the information on claims and payments on such website in as timely a manner as possible but not later than 15 days after the date that payment is made. Information related to claims and payments subject to the notice under subclause (I) shall be maintained and made available consistent with the following:

(aa) The information shall be as complete as possible and shall include provider or supplier name, diagnosis codes (if any), dates of service, and conditional payment amounts.

(bb) The information accurately identifies those claims and payments that are related to a potential settlement, judgment, award, or other payment to which the provisions of this subsection apply.

(cc) The website provides a method for the receipt of secure electronic communications with the individual, representative, or plan involved.

(dd) The website provides that information is transmitted from the website in a form that includes an official time and date that the information is transmitted.

(ee) The website shall permit the individual, representative, or plan to download a statement of reimbursement amounts (in this clause referred to as a "statement of reimbursement amount") on payments for claims under this subchapter relating to a potential settlement, judgment, award, or other payment.

(III) Use of timely web download as basis for final conditional amount

If an individual (or other claimant or applicable plan with the consent of the individual) obtains a statement of reimbursement amount from the website during the protected period as defined in

subclause (V) and the related settlement, judgment, award or other payment is made during such period, then the last statement of reimbursement amount that is downloaded during such period and within 3 business days before the date of the settlement, judgment, award, or other payment shall constitute the final conditional amount subject to recovery under clause (ii) related to such settlement, judgment, award, or other payment.

(IV) Resolution of discrepancies

If the individual (or authorized representative) believes there is a discrepancy with the statement of reimbursement amount, the Secretary shall provide a timely process to resolve the discrepancy. Under such process the individual (or representative) must provide documentation explaining the discrepancy and a proposal to resolve such discrepancy. Within 11 business days after the date of receipt of such documentation, the Secretary shall determine whether there is a reasonable basis to include or remove claims on the statement of reimbursement. If the Secretary does not make such determination within the 11 business-day period, then the proposal to resolve the discrepancy shall be accepted. If the Secretary determines within such period that there is not a reasonable basis to include or remove claims on the statement of reimbursement, the proposal shall be rejected. If the Secretary determines within such period that there is a reasonable basis to conclude there is a discrepancy, the Secretary must respond in a timely manner by agreeing to the proposal to resolve the discrepancy or by providing documentation showing with good cause why the Secretary is not agreeing to such proposal and establishing an alternate discrepancy resolution. In no case shall the process under this subclause be treated as an appeals process or as establishing a right of appeal for a statement of reimbursement amount and there shall be no administrative or judicial review of the Secretary's determinations under this subclause.

(V) Protected period

In subclause (III), the term "protected period" means, with respect to a settlement, judgment, award or other payment relating to an injury or incident, the portion (if any) of the period beginning on the date of notice under subclause (I) with respect to such settlement, judgment, award, or other payment that is after the end of a Secretarial response period beginning on the date of such notice to the Secretary. Such Secretarial response period shall be a period of 65 days, except that such period may be extended by the Secretary for a period of an additional 30 days if the Secretary determines that additional time is required to address claims for which payment has been made. Such Secretarial response period shall be extended and shall not include any days for any part of which the Secretary determines (in accordance with regulations) that there was a failure in the claims and payment posting system and the failure was justified due to exceptional circumstances (as defined in such regulations). Such regulations shall define exceptional circumstances in a manner so that not more than 1 percent of the repayment obligations under this subclause would qualify as exceptional circumstances.

(VI) Effective date

The Secretary shall promulgate final regulations to carry out this clause not later than 9 months after January 10, 2013.

(VII) Website including successor technology

In this clause, the term "website" includes any successor technology.

(viii) Right of appeal for secondary payer determinations relating to liability insurance (including self-insurance), no fault insurance, and workers' compensation laws and plans

The Secretary shall promulgate regulations establishing a right of appeal and appeals process, with respect to any determination under this subsection for a payment made under this subchapter for an item or service for which the Secretary is seeking to recover conditional payments from an applicable plan (as defined in paragraph (8)(F)) that is a primary plan under subsection (A)(ii),[5] under which the applicable plan involved, or an attorney, agent, or third party administrator on behalf of such plan, may appeal such determination. The individual furnished such an item or service shall be notified of the plan's intent to appeal such determination[6]

(C) Treatment of questionnaires

The Secretary may not fail to make payment under subparagraph (A) solely on the ground that an individual failed to complete a questionnaire concerning the existence of a primary plan.

(3) Enforcement

(A) Private cause of action

There is established a private cause of action for damages (which shall be in an amount double the amount otherwise provided) in the case of a primary plan which fails to provide for primary payment (or appropriate reimbursement) in accordance with paragraphs (1) and (2)(A).

(B) Reference to excise tax with respect to nonconforming group health plans

For provision imposing an excise tax with respect to nonconforming group health plans, see section 5000 of the Internal Revenue Code of 1986.

(C) Prohibition of financial incentives not to enroll in a group health plan or a large group health plan

It is unlawful for an employer or other entity to offer any financial or other incentive for an individual

entitled to benefits under this subchapter not to enroll (or to terminate enrollment) under a group health plan or a large group health plan which would (in the case of such enrollment) be a primary plan (as defined in paragraph (2)(A)). Any entity that violates the previous sentence is subject to a civil money penalty of not to exceed $5,000 for each such violation. The provisions of section 1320a-7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a-7a(a) of this title.

(4) Coordination of benefits

Where payment for an item or service by a primary plan is less than the amount of the charge for such item or service and is not payment in full, payment may be made under this subchapter (without regard to deductibles and coinsurance under this subchapter) for the remainder of such charge, but--

(A) payment under this subchapter may not exceed an amount which would be payable under this subchapter for such item or service if paragraph (2)(A) did not apply; and

(B) payment under this subchapter, when combined with the amount payable under the primary plan, may not exceed--

(i) in the case of an item or service payment for which is determined under this subchapter on the basis of reasonable cost (or other cost-related basis) or under section 1395ww of this title, the amount which would be payable under this subchapter on such basis, and

(ii) in the case of an item or service for which payment is authorized under this subchapter on another basis--

(I) the amount which would be payable under the primary plan (without regard to deductibles and coinsurance under such plan), or

(II) the reasonable charge or other amount which would be payable under this subchapter (without regard to deductibles and coinsurance under this subchapter),

whichever is greater.

(5) Identification of secondary payer situations

(A) Requesting matching information

(i) Commissioner of Social Security

The Commissioner of Social Security shall, not less often than annually, transmit to the Secretary of the Treasury a list of the names and TINs of medicare beneficiaries (as defined in section 6103(l)(12) of the Internal Revenue Code of 1986) and request that the Secretary disclose to the Commissioner the information described in subparagraph (A) of such section.

(ii) Administrator

The Administrator of the Centers for Medicare & Medicaid Services shall request, not less often than annually, the Commissioner of the Social Security Administration to disclose to the Administrator the information described in subparagraph (B) of section 6103(l)(12) of the Internal Revenue Code of 1986.

(B) Disclosure to fiscal intermediaries and carriers

In addition to any other information provided under this subchapter to fiscal intermediaries and carriers, the Administrator shall disclose to such intermediaries and carriers (or to such a single intermediary or carrier as the Secretary may designate) the information received under subparagraph (A) for purposes of carrying out this subsection.

(C) Contacting employers

(i) In general

With respect to each individual (in this subparagraph referred to as an "employee") who was furnished a written statement under section 6051 of the Internal Revenue Code of 1986 by a qualified employer (as defined in section 6103(l)(12)(E)(iii) of such Code), as disclosed under subparagraph (B), the appropriate fiscal intermediary or carrier shall contact the employer in order to determine during what period the employee or employee's spouse may be (or have been) covered under a group health plan of the employer and the nature of the coverage that is or was provided under the plan (including the name, address, and identifying number of the plan).

(ii) Employer response

Within 30 days of the date of receipt of the inquiry, the employer shall notify the intermediary or carrier making the inquiry as to the determinations described in clause (i). An employer (other than a Federal or

other governmental entity) who willfully or repeatedly fails to provide timely and accurate notice in accordance with the previous sentence shall be subject to a civil money penalty of not to exceed $1,000 for each individual with respect to which such an inquiry is made. The provisions of section 1320a-7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a-7a(a) of this title.

(D) Obtaining information from beneficiaries

Before an individual applies for benefits under part A or enrolls under part B, the Administrator shall mail the individual a questionnaire to obtain information on whether the individual is covered under a primary plan and the nature of the coverage provided under the plan, including the name, address, and identifying number of the plan.

(E) End date

The provisions of this paragraph shall not apply to information required to be provided on or after July 1, 2016.

(6) Screening requirements for providers and suppliers

(A) In general

Notwithstanding any other provision of this subchapter, no payment may be made for any item or service furnished under part B unless the entity furnishing such item or service completes (to the best of its knowledge and on the basis of information obtained from the individual to whom the item or service is furnished) the portion of the claim form relating to the availability of other health benefit plans.

(B) Penalties

An entity that knowingly, willfully, and repeatedly fails to complete a claim form in accordance with subparagraph (A) or provides inaccurate information relating to the availability of other health benefit plans on a claim form under such subparagraph shall be subject to a civil money penalty of not to exceed $2,000 for each such incident. The provisions of section 1320a-7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a-7a(a) of this title.

(7) Required submission of information by group health plans

(A) Requirement

On and after the first day of the first calendar quarter beginning after the date that is 1 year after December 29, 2007, an entity serving as an insurer or third party administrator for a group health plan, as defined in paragraph (1)(A)(v), and, in the case of a group health plan that is self-insured and self-administered, a plan administrator or fiduciary, shall--

(i) secure from the plan sponsor and plan participants such information as the Secretary shall specify for the purpose of identifying situations where the group health plan is or has been--

(I) a primary plan to the program under this subchapter; or

(II) for calendar quarters beginning on or after January 1, 2020, a primary payer with respect to benefits relating to prescription drug coverage under part D; and

(ii) submit such information to the Secretary in a form and manner (including frequency) specified by the Secretary.

(B) Enforcement

(i) In general

An entity, a plan administrator, or a fiduciary described in subparagraph (A) that fails to comply with the requirements under such subparagraph shall be subject to a civil money penalty of $1,000 for each day of noncompliance for each individual for which the information under such subparagraph should have been submitted. The provisions of subsections (e) and (k) of section 1320a-7a of this title shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a-7a(a) of this title. A civil money penalty under this clause shall be in addition to any other penalties prescribed by law and in addition to any Medicare secondary payer claim under this subchapter with respect to an individual.

(ii) Deposit of amounts collected

Any amounts collected pursuant to clause (i) shall be deposited in the Federal Hospital Insurance Trust Fund under section 1395i of this title.

(C) Sharing of information

Notwithstanding any other provision of law, under terms and conditions established by the Secretary, the Secretary--

(i) shall share information on entitlement under part A and enrollment under part B under this subchapter with entities, plan administrators, and fiduciaries described in subparagraph (A);

(ii) may share the entitlement and enrollment information described in clause (i) with entities and persons not described in such clause; and

(iii) may share information collected under this paragraph as necessary for purposes of the proper coordination of benefits.

(D) Implementation

Notwithstanding any other provision of law, the Secretary may implement this paragraph by program instruction or otherwise.

(8) Required submission of information by or on behalf of liability insurance (including self-insurance), no fault insurance, and workers' compensation laws and plans

(A) Requirement

On and after the first day of the first calendar quarter beginning after the date that is 18 months after December 29, 2007, an applicable plan shall--

(i) determine whether a claimant (including an individual whose claim is unresolved) is entitled to benefits under the program under this subchapter on any basis; and

(ii) if the claimant is determined to be so entitled, submit the information described in subparagraph (B) with respect to the claimant to the Secretary in a form and manner (including frequency) specified by the Secretary.

(B) Required information

The information described in this subparagraph is--

(i) the identity of the claimant for which the determination under subparagraph (A) was made; and

(ii) such other information as the Secretary shall specify in order to enable the Secretary to make an appropriate determination concerning coordination of benefits, including any applicable recovery claim.

Not later than 18 months after January 10, 2013, the Secretary shall modify the reporting requirements under this paragraph so that an applicable plan in complying with such requirements is permitted but not required to access or report to the Secretary beneficiary social security account numbers or health identification claim numbers, except that the deadline for such modification shall be extended by one or more periods (specified by the Secretary) of up to 1 year each if the Secretary notifies the committees of jurisdiction of the House of Representatives and of the Senate that the prior deadline for such modification, without such extension, threatens patient privacy or the integrity of the secondary payer program under this subsection. Any such deadline extension notice shall include information on the progress being made in implementing such modification and the anticipated implementation date for such modification.

(C) Timing

Information shall be submitted under subparagraph (A)(ii) within a time specified by the Secretary after the claim is resolved through a settlement, judgment, award, or other payment (regardless of whether or not there is a determination or admission of liability).

(D) Claimant

For purposes of subparagraph (A), the term “claimant” includes--

(i) an individual filing a claim directly against the applicable plan; and

(ii) an individual filing a claim against an individual or entity insured or covered by the applicable plan.

(E) Enforcement

(i) In general

An applicable plan that fails to comply with the requirements under subparagraph (A) with respect to any claimant may be subject to a civil money penalty of up to $1,000 for each day of noncompliance with respect to each claimant. The provisions of subsections (e) and (k) of section 1320a-7a of this title shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a-7a(a) of this title. A civil money penalty under this clause shall be in addition to any other penalties prescribed by law and in addition to any Medicare secondary payer claim under this subchapter with respect to an individual.

(ii) Deposit of amounts collected

Any amounts collected pursuant to clause (i) shall be deposited in the Federal Hospital Insurance Trust Fund.

(F) Applicable plan

In this paragraph, the term "applicable plan" means the following laws, plans, or other arrangements, including the fiduciary or administrator for such law, plan, or arrangement:

(i) Liability insurance (including self-insurance).

(ii) No fault insurance.

(iii) Workers' compensation laws or plans.

(G) Sharing of information

(i) In general

The Secretary may share information collected under this paragraph as necessary for purposes of the proper coordination of benefits.

(ii) Specified information

In responding to any query made on or after the date that is 1 year after December 11, 2020, from an applicable plan related to a determination described in subparagraph (A)(i), the Secretary,

notwithstanding any other provision of law, shall provide to such applicable plan--

(I) whether a claimant subject to the query is, or during the preceding 3-year period has been, entitled to benefits under the program under this subchapter on any basis; and

(II) to the extent applicable, the plan name and address of any Medicare Advantage plan under part C and any prescription drug plan under part D in which the claimant is enrolled or has been enrolled during such period.

(H) Implementation

Notwithstanding any other provision of law, the Secretary may implement this paragraph by program instruction or otherwise.

(I) Regulations

Not later than 60 days after January 10, 2013, the Secretary shall publish a notice in the Federal Register soliciting proposals, which will be accepted during a 60-day period, for the specification of practices for which sanctions will and will not be imposed under subparagraph (E), including not imposing sanctions for good faith efforts to identify a beneficiary pursuant to this paragraph under an applicable entity responsible for reporting information. After considering the proposals so submitted, the Secretary, in consultation with the Attorney General, shall publish in the Federal Register, including a 60-day period for comment, proposed specified practices for which such sanctions will and will not be imposed. After considering any public comments received during such period, the Secretary shall issue final rules specifying such practices.

(9) Exception

(A) In general

Clause (ii) of paragraph (2)(B) and any reporting required by paragraph (8) shall not apply with respect to any settlement, judgment, award, or other payment by an applicable plan arising from liability insurance (including self-insurance) and from alleged physical trauma-based incidents (excluding alleged ingestion, implantation, or exposure cases) constituting a total payment obligation to a claimant of not more than the single threshold amount calculated by the Secretary under subparagraph (B) for the year involved.

(B) Annual computation of threshold

(i) In general

Not later than November 15 before each year, the Secretary shall calculate and publish a single threshold amount for settlements, judgments, awards, or other payments for obligations arising from liability insurance (including self-insurance) and for alleged physical trauma-based incidents (excluding alleged ingestion, implantation, or exposure cases) subject to this section for that year. The annual single threshold amount for a year shall be set such that the estimated average amount to be credited to the Medicare trust funds of collections of conditional payments from such settlements, judgments, awards, or other payments arising from liability insurance (including self-insurance) and for such alleged incidents subject to this section shall equal the estimated cost of collection incurred by the United States (including payments made to contractors) for a conditional payment arising from liability insurance (including self-insurance) and for such alleged incidents subject to this section for the year. At the time of calculating, but before publishing, the single threshold amount for 2014, the Secretary shall inform, and seek review of, the Comptroller General of the United States with regard to such amount.

(ii) Publication

The Secretary shall include, as part of such publication for a year--

(I) the estimated cost of collection incurred by the United States (including payments made to contractors) for a conditional payment arising from liability insurance (including self-insurance) and for such alleged incidents; and

(II) a summary of the methodology and data used by the Secretary in computing such threshold amount and such cost of collection.

(C) Exclusion of ongoing expenses

For purposes of this paragraph and with respect to a settlement, judgment, award, or other payment not otherwise addressed in clause (ii) of paragraph (2)(B) that includes ongoing responsibility for medical payments (excluding settlements, judgments, awards, or other payments made by a workers' compensation law or plan or no fault insurance), the amount utilized for calculation of the threshold described in subparagraph (A) shall include only the cumulative value of the medical payments made under this subchapter.

(D) Report to Congress

Not later than November 15 before each year, the Secretary shall submit to the Congress a report on the single threshold amount for settlements, judgments, awards, or other payments for conditional payment

obligations arising from liability insurance (including self-insurance) and alleged incidents described in subparagraph (A) for that year and on the establishment and application of similar thresholds for such payments for conditional payment obligations arising from worker compensation cases and from no fault insurance cases subject to this section for the year. For each such report, the Secretary shall--

(i) calculate the threshold amount by using the methodology applicable to certain liability claims described in subparagraph (B); and

(ii) include a summary of the methodology and data used in calculating each threshold amount and the amount of estimated savings under this subchapter achieved by the Secretary implementing each such threshold.

(c) Drug products

No payment may be made under part B for any expenses incurred for--

(1) a drug product--

(A) which is described in section 107(c)(3) of the Drug Amendments of 1962,

(B) which may be dispensed only upon prescription,

(C) for which the Secretary has issued a notice of an opportunity for a hearing under subsection (e) of section 355 of Title 21 on a proposed order of the Secretary to withdraw approval of an application for such drug product under such section because the Secretary has determined that the drug is less than effective for all conditions of use prescribed, recommended, or suggested in its labeling, and

(D) for which the Secretary has not determined there is a compelling justification for its medical need; and

(2) any other drug product--

(A) which is identical, related, or similar (as determined in accordance with section 310.6 of title 21 of the Code of Federal Regulations) to a drug product described in paragraph (1), and

(B) for which the Secretary has not determined there is a compelling justification for its medical need,

until such time as the Secretary withdraws such proposed order.

(d) Items or services provided for emergency medical conditions

For purposes of subsection (a)(1)(A), in the case of any item or service that is required to be provided pursuant to section 1395dd of this title to an individual who is entitled to benefits under this subchapter, determinations as to whether the item or service is reasonable and necessary shall be made on the basis of the information available to the treating physician or practitioner (including the patient's presenting symptoms or complaint) at the time the item or service was ordered or furnished by the physician or practitioner (and not on the patient's principal diagnosis). When making such determinations with respect to such an item or service, the Secretary shall not consider the frequency with which the item or service was provided to the patient before or after the time of the admission or visit.

(e) Item or service by excluded individual or entity or at direction of excluded physician; limitation of liability of beneficiaries with respect to services furnished by excluded individuals and entities

(1) No payment may be made under this subchapter with respect to any item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) furnished--

(A) by an individual or entity during the period when such individual or entity is excluded pursuant to section 1320a-7, 1320a-7a, 1320c-5 or 1395u(j)(2) of this title from participation in the program under this subchapter; or

(B) at the medical direction or on the prescription of a physician during the period when he is excluded pursuant to section 1320a-7, 1320a-7a, 1320c-5 or 1395u(j)(2) of this title from participation in the program under this subchapter and when the person furnishing such item or service knew or had reason to know of the exclusion (after a reasonable time period after reasonable notice has been furnished to the person).

(2) Where an individual eligible for benefits under this subchapter submits a claim for payment for items or services furnished by an individual or entity excluded from participation in the programs under this subchapter, pursuant to section 1320a-7, 1320a-7a, 1320c-5, 1320c-9 (as in effect on September 2, 1982), 1395u(j)(2), 1395y(d) (as in effect on August 18, 1987), or 1395cc of this title, and such beneficiary did not know or have reason to know that such individual or entity was so excluded, then, to the extent permitted by this subchapter, and notwithstanding such exclusion, payment shall be made for such items or services. In each such case the Secretary shall notify the beneficiary of the exclusion of the individual or entity furnishing the items or services. Payment shall not be made for items or services furnished by an excluded individual or entity to a beneficiary after a reasonable time (as determined by the Secretary in regulations) after the Secretary has notified the beneficiary of the exclusion of that individual or entity.

(f) Utilization guidelines for provision of home health services

The Secretary shall establish utilization guidelines for the determination of whether or not payment may be made, consistent with paragraph (1)(A) of subsection (a), under part A or part B for expenses incurred with respect to the provision of home health services, and shall provide for the implementation of such guidelines through a process of selective postpayment coverage review by intermediaries or otherwise.

(g) Contracts with quality improvement organizations

(1) The Secretary shall, in making the determinations under paragraphs (1) and (9) of subsection (a), and for the purposes of promoting the effective, efficient, and economical delivery of health care services, and of promoting the quality of services of the type for which payment may be made under this subchapter, enter into contracts with quality improvement organizations pursuant to part B of subchapter XI of this chapter.

(2) In addition to any funds otherwise available, there are appropriated to the Secretary, out of any monies in the Treasury not otherwise obligated, $200,000,000, to remain available until expended, for purposes of requiring multiple organizations described in paragraph (1) to provide to skilled nursing facilities (as defined in section 1395i-3(a) of this title), infection control and vaccination uptake support relating to the prevention or mitigation of COVID-19, as determined appropriate by the Secretary.

(h) Waiver of electronic form requirement

(1) The Secretary--

(A) shall waive the application of subsection (a)(22) in cases in which--

(i) there is no method available for the submission of claims in an electronic form; or

(ii) the entity submitting the claim is a small provider of services or supplier; and

(B) may waive the application of such subsection in such unusual cases as the Secretary finds appropriate.

(2) For purposes of this subsection, the term "small provider of services or supplier" means--

(A) a provider of services with fewer than 25 full-time equivalent employees; or

(B) a physician, practitioner, facility, or supplier (other than provider of services) with fewer than 10 full-time equivalent employees.

(i) Awards and contracts for original research and experimentation of new and existing medical procedures; conditions

In order to supplement the activities of the Medicare Payment Advisory Commission under section 1395ww(e) of this title in assessing the safety, efficacy, and cost-effectiveness of new and existing medical procedures, the Secretary may carry out, or award grants or contracts for, original research and experimentation of the type described in clause (ii) of section 1395ww(e)(6)(E) of this title with respect to such a procedure if the Secretary finds that--

(1) such procedure is not of sufficient commercial value to justify research and experimentation by a commercial organization;

(2) research and experimentation with respect to such procedure is not of a type that may appropriately be carried out by an institute, division, or bureau of the National Institutes of Health; and

(3) such procedure has the potential to be more cost-effective in the treatment of a condition than procedures currently in use with respect to such condition.

(j) Nonvoting members and experts

(1) Any advisory committee appointed to advise the Secretary on matters relating to the interpretation, application, or implementation of subsection (a)(1) shall assure the full participation of a nonvoting member in the deliberations of the advisory committee, and shall provide such nonvoting member access to all information and data made available to voting members of the advisory committee, other than information that--

(A) is exempt from disclosure pursuant to subsection (a) of section 552 of Title 5 by reason of subsection (b)(4) of such section (relating to trade secrets); or

(B) the Secretary determines would present a conflict of interest relating to such nonvoting member.

(2) If an advisory committee described in paragraph (1) organizes into panels of experts according to types of items or services considered by the advisory committee, any such panel of experts may report any recommendation with respect to such items or services directly to the Secretary without the prior approval of the advisory committee or an executive committee thereof.

(k) Dental benefits under group health plans

(1) Subject to paragraph (2), a group health plan (as defined in subsection (a)(1)(A)(v))[7] providing supplemental or secondary coverage to individuals also entitled to services under this subchapter shall not require a medicare claims determination under this subchapter for dental benefits specifically excluded under subsection (a)(12) as a condition of making a claims determination for such benefits under the group health plan.

(2) A group health plan may require a claims determination under this subchapter in cases involving or appearing to involve inpatient dental hospital services or dental services expressly covered under this subchapter pursuant to actions taken by the Secretary.

(l) National and local coverage determination process

(1) Factors and evidence used in making national coverage determinations

The Secretary shall make available to the public the factors considered in making national coverage determinations of whether an item or service is reasonable and necessary. The Secretary shall develop guidance documents to carry out this paragraph in a manner similar to the development of guidance documents under section 371(h) of Title 21.

(2) Timeframe for decisions on requests for national coverage determinations

In the case of a request for a national coverage determination that--

(A) does not require a technology assessment from an outside entity or deliberation from the Medicare Coverage Advisory Committee, the decision on the request shall be made not later than 6 months after the date of the request; or

(B) requires such an assessment or deliberation and in which a clinical trial is not requested, the decision

on the request shall be made not later than 9 months after the date of the request.

(3) Process for public comment in national coverage determinations

(A) Period for proposed decision

Not later than the end of the 6-month period (or 9-month period for requests described in paragraph (2)(B)) that begins on the date a request for a national coverage determination is made, the Secretary shall make a draft of proposed decision on the request available to the public through the Internet website of the Centers for Medicare & Medicaid Services or other appropriate means.

(B) 30-day period for public comment

Beginning on the date the Secretary makes a draft of the proposed decision available under subparagraph (A), the Secretary shall provide a 30-day period for public comment on such draft.

(C) 60-day period for final decision

Not later than 60 days after the conclusion of the 30-day period referred to under subparagraph (B), the Secretary shall--

(i) make a final decision on the request;

(ii) include in such final decision summaries of the public comments received and responses to such comments;

(iii) make available to the public the clinical evidence and other data used in making such a decision when the decision differs from the recommendations of the Medicare Coverage Advisory Committee; and

(iv) in the case of a final decision under clause (i) to grant the request for the national coverage determination, the Secretary shall assign a temporary or permanent code (whether existing or unclassified) and implement the coding change.

(4) Consultation with outside experts in certain national coverage determinations

With respect to a request for a national coverage determination for which there is not a review by the Medicare Coverage Advisory Committee, the Secretary shall consult with appropriate outside clinical experts.

(5) Local coverage determination process

(A) Plan to promote consistency of coverage determinations

The Secretary shall develop a plan to evaluate new local coverage determinations to determine which determinations should be adopted nationally and to what extent greater consistency can be achieved among local coverage determinations.

(B) Consultation

The Secretary shall require the fiscal intermediaries or carriers providing services within the same area to consult on all new local coverage determinations within the area.

(C) Dissemination of information

The Secretary should serve as a center to disseminate information on local coverage determinations among fiscal intermediaries and carriers to reduce duplication of effort.

(D) Local coverage determinations

The Secretary shall require each Medicare administrative contractor that develops a local coverage determination to make available on the Internet website of such contractor and on the Medicare Internet website, at least 45 days before the effective date of such determination, the following information:

(i) Such determination in its entirety.

(ii) Where and when the proposed determination was first made public.

(iii) Hyperlinks to the proposed determination and a response to comments submitted to the contractor with respect to such proposed determination.

(iv) A summary of evidence that was considered by the contractor during the development of such determination and a list of the sources of such evidence.

(v) An explanation of the rationale that supports such determination.

(6) National and local coverage determination defined

For purposes of this subsection--

(A) National coverage determination

The term "national coverage determination" means a determination by the Secretary with respect to whether or not a particular item or service is covered nationally under this subchapter.

(B) Local coverage determination

The term "local coverage determination" has the meaning given that in section 1395ff(f)(2)(B) of this title.

(m) Coverage of routine costs associated with certain clinical trials of category A devices

(1) In general

In the case of an individual entitled to benefits under part A, or enrolled under part B, or both who participates in a category A clinical trial, the Secretary shall not exclude under subsection (a)(1) payment for coverage of routine costs of care (as defined by the Secretary) furnished to such individual in the trial.

(2) Category A clinical trial

For purposes of paragraph (1), a "category A clinical trial" means a trial of a medical device if--

(A) the trial is of an experimental/investigational (category A) medical device (as defined in regulations under section 405.201(b) of title 42, Code of Federal Regulations (as in effect as of September 1, 2003));

(B) the trial meets criteria established by the Secretary to ensure that the trial conforms to appropriate scientific and ethical standards; and

(C) in the case of a trial initiated before January 1, 2010, the device involved in the trial has been determined by the Secretary to be intended for use in the diagnosis, monitoring, or treatment of an immediately life-threatening disease or condition.

(n) Requirement of a surety bond for certain providers of services and suppliers

(1) In general

The Secretary may require a provider of services or supplier described in paragraph (2) to provide the Secretary on a continuing basis with a surety bond in a form specified by the Secretary in an amount (not less than $50,000) that the Secretary determines is commensurate with the volume of the billing of the provider of services or supplier. The Secretary may waive the requirement of a bond under the preceding sentence in the case of a provider of services or supplier that provides a comparable surety bond under State law.

(2) Provider of services or supplier described

A provider of services or supplier described in this paragraph is a provider of services or supplier the Secretary determines appropriate based on the level of risk involved with respect to the provider of services or supplier, and consistent with the surety bond requirements under sections 1395m(a)(16)(B) and 1395x(o)(7)(C) of this title.

(o) Suspension of payments pending investigation of credible allegations of fraud

(1) In general

The Secretary may suspend payments to a provider of services or supplier under this subchapter pending an investigation of a credible allegation of fraud against the provider of services or supplier, unless the Secretary determines there is good cause not to suspend such payments.

(2) Consultation

The Secretary shall consult with the Inspector General of the Department of Health and Human Services in

determining whether there is a credible allegation of fraud against a provider of services or supplier.

(3) Promulgation of regulations

The Secretary shall promulgate regulations to carry out this subsection, section 1395w-112(b)(7) of this title (including as applied pursuant to section 1395w-27(f)(3)(D) of this title), and section 1396b(i)(2)(C) of this title.

(4) Credible allegation of fraud

In carrying out this subsection, section 1395w-112(b)(7) of this title (including as applied pursuant to section 1395w-27(f)(3)(D) of this title), and section 1396b(i)(2)(C) of this title, a fraud hotline tip (as defined by the Secretary) without further evidence shall not be treated as sufficient evidence for a credible allegation of fraud.

CREDIT(S)

(Aug. 14, 1935, c. 531, Title XVIII, § 1862, as added Pub.L. 89-97, Title I, § 102(a), July 30, 1965, 79 Stat. 325; amended Pub.L. 90-248, Title I, §§ 127(b), 128, Jan. 2, 1968, 81 Stat. 846, 847; Pub.L. 92-603, Title II, §§ 210, 211(c)(1), 229(a), 256(c), Oct. 30, 1972, 86 Stat. 1382, 1384, 1408, 1447; Pub.L. 93-233, § 18(k)(3), Dec. 31, 1973, 87 Stat. 970; Pub.L. 93-480, § 4(a), Oct. 26, 1974, 88 Stat. 1454; Pub.L. 94-182, Title I, § 103, Dec. 31, 1975, 89 Stat. 1051; Pub.L. 95-142, §§ 7(a), 13(a), (b)(1), (2), Oct. 25, 1977, 91 Stat. 1192, 1197, 1198; Pub.L. 95-210, § 1(f), Dec. 13, 1977, 91 Stat. 1487; Pub.L. 96-272, Title III, § 308(a), June 17, 1980, 94 Stat. 531; Pub.L. 96-499, Title IX, §§ 913(b), 936(c), 939(a), 953, Dec. 5, 1980, 94 Stat. 2620, 2640, 2647; Pub.L. 96-611, § 1(a)(3), Dec. 28, 1980, 94 Stat. 3566; Pub.L. 97-35, Title XXI, §§ 2103(a)(1), 2146(a), 2152(a), Aug. 13, 1981, 95 Stat. 787, 800, 802; Pub.L. 97-248, Title I, §§ 116(b), 122(f), (g)(1), 128(a)(2) to (4), 142, 148(a), Sept. 3, 1982, 96 Stat. 353, 362, 366, 381, 394; Pub.L. 97-448, Title III, § 309(b)(10), Jan. 12, 1983, 96 Stat. 2409; Pub.L. 98-21, Title VI, §§ 601(f), 602(e), Apr. 20, 1983, 97 Stat. 162, 163; Pub.L. 98-369, Div. B, Title III, §§ 2301(a), 2304(c), 2313(c), 2344(a) to (c), 2354(b)(30), (31), July 18, 1984, 98 Stat. 1063, 1068, 1078, 1095, 1101, 1102; Pub.L. 99-272, Title IX, §§ 9201(a), 9307(a), 9401(c)(1), Apr. 7, 1986, 100 Stat. 170, 193, 199; Pub.L. 99-509, Title IX, §§ 9316(b), 9319(a), (b), 9320(h)(1), 9343(c)(1), Oct. 21, 1986, 100 Stat. 2007, 2010, 2011, 2016, 2040; Pub.L. 99-514, § 2, Oct. 22, 1986, 100 Stat. 2095; Pub.L. 100-93, §§ 8(c)(1), (3), 10, Aug. 18, 1987, 101 Stat. 692, 693, 696; Pub.L. 100-203, Title IV, §§ 4009(j)(6)(C), 4034(a), 4036(a)(1), 4039(c)(1), 4072(c), 4085(i)(15), (16), Dec. 22, 1987, 101 Stat. 1330-59, 1330-77, 1330-79, 1330-82, 1330-117, 1330-133; Pub.L. 100-360, Title II, §§ 202(d), 204(d)(2), 205(e)(1), Title IV, § 411(f)(4)(D)(i), (i)(4)(D), July 1, 1988, 102 Stat. 715, 729, 731, 778, 790; Pub.L. 100-485, Title VI, § 608(d)(7), (24)(C), Oct. 13, 1988, 102 Stat. 2415, 2421; Pub.L. 101-234, Title II, § 201(a), Dec. 13, 1989, 103 Stat. 1981; Pub.L. 101-239, Title VI, §§ 6003(g)(3)(D)(xi), 6103(b)(3)(B), 6115(b), 6202(a)(2)(A), (b)(1), (e)(1), 6411(d)(2), Dec. 19, 1989, 103 Stat. 2154, 2199, 2219, 2228, 2229, 2234, 2271; Pub.L. 101-508, Title IV, §§ 4107(b), 4153(b)(2)(B), 4157(c)(1), 4161(a)(3)(C), 4163(d)(2), 4203(a)(1), (b), (c)(1), 4204(g)(1), Nov. 5, 1990, 104 Stat. 1388-62, 1388-84, 1388-89, 1388-94, 1388-100, 1388-107, 1388-112; Pub.L. 103-66, Title XIII, §§ 13561(a)(1), (b) to (d)(1), (e)(1), 13581(b)(1), Aug. 10, 1993, 107 Stat. 593, 594, 611; Pub.L. 103-432, Title I, §§ 145(c)(1), 147(e)(6), 151(a)(1)(A), (C), (2)(A), (b)(3)(A), (B), (c)(1), (4) to (6), (9)(B), 156(a)(2)(D), 157(b)(7), Oct. 31, 1994, 108 Stat. 4427, 4430, 4432 to 4436, 4441, 4442; Pub.L. 104-224, § 1, Oct. 2, 1996, 110 Stat. 3031; Pub.L. 104-226, § 1(b)(1), Oct. 2, 1996, 110 Stat. 3033; Pub.L. 105-12, § 9(a)(1), Apr. 30, 1997, 111 Stat. 26; Pub.L. 105-33, Title IV, §§ 4022(b)(1)(B), 4102(c), 4103(c), 4104(c)(3), 4201(c)(1), 4319(b), 4432(b)(1), 4507(a)(2)(B),

4511(a)(2)(C), 4541(b), 4603(c)(2)(C), 4614(a), 4631(a)(1), (b), (c)(1), 4632(a), 4633(a), (b), Aug. 5, 1997, 111 Stat. 354, 361, 362, 365, 373, 394, 420, 441, 442, 456, 471, 474, 486, 487; Pub.L. 106-113, Div. B, § 1000(a)(6) [Title III, §§ 305(b), 321(k)(10)], Nov. 29, 1999, 113 Stat. 1536, 1501A-362, 1501A-367; Pub.L. 106-554, § 1(a)(6) [Title I, § 102(c), Title III, § 313(a), Title IV, § 432(b)(1), Title V, § 522(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A-468, 2763A-499, 2763A-526, 2763A-546; Pub.L. 107-105, § 3(a), Dec. 27, 2001, 115 Stat. 1006; Pub.L. 108-173, Title III, §§ 301(a) to (c), 303(i)(3)(B), Title VI, §§ 611(d)(1), 612(c), 613(c), Title VII, § 731(a)(1), (b)(1), Title IX, §§ 900(e)(1)(J), 944(a)(1), 948(a), 950(a), Dec. 8, 2003, 117 Stat. 2221, 2254, 2304 to 2306, 2349, 2351, 2372, 2422, 2425, 2426; Pub.L. 109-171, Title V, § 5112(d), Feb. 8, 2006, 120 Stat. 44; Pub.L. 110-173, Title I, § 111(a), Dec. 29, 2007, 121 Stat. 2497; Pub.L. 110-275, Title I, §§ 101(a)(3), (b)(3), (4), 135(a)(2)(A), 143(b)(7), 152(b)(1)(D), 153(b)(2), July 15, 2008, 122 Stat. 2497, 2498, 2535, 2543, 2552, 2555; Pub.L. 111-148, Title I, § 1104(d), Title IV, § 4103(d), Title VI, § 6402(g)(3), (h)(1), Mar. 23, 2010, 124 Stat. 153, 556, 759, 760; Pub.L. 112-40, Title II, § 261(a)(3)(A), Oct. 21, 2011, 125 Stat. 423; Pub.L. 112-242, Title II, §§ 201, 202(a), 203 to 205(a), Jan. 10, 2013, 126 Stat. 2375, 2378, 2380, 2381; Pub.L. 113-188, Title IX, § 902(d), Nov. 26, 2014, 128 Stat. 2022; Pub.L. 114-10, Title V, § 516(a), Apr. 16, 2015, 129 Stat. 175; Pub.L. 114-255, Div. A, Title IV, § 4009(a), Dec. 13, 2016, 130 Stat. 1185; Pub.L. 115-271, Title II, § 2008(c), (d), Title IV, § 4002, Oct. 24, 2018, 132 Stat. 3931, 3959; Pub.L. 116-215, Div. B, Title III, § 1301, Dec. 11, 2020, 134 Stat. 1045; Pub.L. 117-2, Title IX, § 9401, Mar. 11, 2021, 135 Stat. 127; Pub.L. 117-108, Title I, § 101(a)(2)(C), Apr. 6, 2022, 136 Stat. 1136.)

Footnotes

1 So in original. The comma probably should not appear.

2 So in original. Probably should be “made,”.

3 So in original. Probably should be “subparagraph (A),”.

4 So in original.

5 So in original. Probably should be “subparagraph (A),”.

6 So in original. Probably should be followed by a period.

7 So in original. Probably should be “(b)(1)(A)(v))”.

42 U.S.C.A. § 1395y, 42 USCA § 1395y
Current through P.L. 118-82. Some statute sections may be more current, see credits for details.

KeyCite Yellow Flag - Negative Treatment
Proposed Legislation

United States Code Annotated
Title 42. The Public Health and Welfare
Chapter 7. Social Security (Refs & Annos)
Subchapter XIX. Grants to States for Medical Assistance Programs (Refs & Annos)

42 U.S.C.A. § 1396p

§ 1396p. Liens, adjustments and recoveries, and transfers of assets

Currentness

(a) Imposition of lien against property of an individual on account of medical assistance rendered to him under a State plan

(1) No lien may be imposed against the property of any individual prior to his death on account of medical assistance paid or to be paid on his behalf under the State plan, except--

(A) pursuant to the judgment of a court on account of benefits incorrectly paid on behalf of such individual, or

(B) in the case of the real property of an individual--

(i) who is an inpatient in a nursing facility, intermediate care facility for the mentally retarded, or other medical institution, if such individual is required, as a condition of receiving services in such institution under the State plan, to spend for costs of medical care all but a minimal amount of his income required for personal needs, and

(ii) with respect to whom the State determines, after notice and opportunity for a hearing (in accordance with procedures established by the State), that he cannot reasonably be expected to be discharged from the

medical institution and to return home,

except as provided in paragraph (2).

(2) No lien may be imposed under paragraph (1)(B) on such individual's home if--

(A) the spouse of such individual,

(B) such individual's child who is under age 21, or (with respect to States eligible to participate in the State program established under subchapter XVI) is blind or permanently and totally disabled, or (with respect to States which are not eligible to participate in such program) is blind or disabled as defined in section 1382c of this title, or

(C) a sibling of such individual (who has an equity interest in such home and who was residing in such individual's home for a period of at least one year immediately before the date of the individual's admission to the medical institution),

is lawfully residing in such home.

(3) Any lien imposed with respect to an individual pursuant to paragraph (1)(B) shall dissolve upon that individual's discharge from the medical institution and return home.

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

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

(A) In the case of an individual described in subsection (a)(1)(B), the State shall seek adjustment or recovery from the individual's estate or upon sale of the property subject to a lien imposed on account of medical assistance paid on behalf of the individual.

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

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

(ii) at the option of the State, any items or services under the State plan (but not including medical assistance for medicare cost-sharing or for benefits described in section 1396a(a)(10)(E) of this title).

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

(ii) Clause (i) shall not apply in the case of an individual who received medical assistance under a State plan of a State which had a State plan amendment approved as of May 14, 1993, and which satisfies clause (iv), or which has a State plan amendment that provides for a qualified State long-term care insurance partnership (as defined in clause (iii)) which provided for the disregard of any assets or resources--

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

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

(iii) For purposes of this paragraph, the term "qualified State long-term care insurance partnership" means an approved State plan amendment under this subchapter that provides for the disregard of any assets or resources in an amount equal to the insurance benefit payments that are made to or on behalf of an individual who is a beneficiary under a long-term care insurance policy if the following requirements are met:

(I) The policy covers an insured who was a resident of such State when coverage first became effective under the policy.

(II) The policy is a qualified long-term care insurance policy (as defined in section 7702B(b) of the Internal Revenue Code of 1986) issued not earlier than the effective date of the State plan amendment.

(III) The policy meets the model regulations and the requirements of the model Act specified in paragraph (5).

(IV) If the policy is sold to an individual who--

(aa) has not attained age 61 as of the date of purchase, the policy provides compound annual inflation protection;

(bb) has attained age 61 but has not attained age 76 as of such date, the policy provides some level of inflation protection; and

(cc) has attained age 76 as of such date, the policy may (but is not required to) provide some level of inflation protection.

(V) The State Medicaid agency under section 1396a(a)(5) of this title provides information and technical assistance to the State insurance department on the insurance department's role of assuring that any individual who sells a long-term care insurance policy under the partnership receives training and demonstrates evidence of an understanding of such policies and how they relate to other public and private coverage of long-term care.

(VI) The issuer of the policy provides regular reports to the Secretary, in accordance with regulations of the Secretary, that include notification regarding when benefits provided under the policy have been paid and the amount of such benefits paid, notification regarding when the policy otherwise terminates, and such other information as the Secretary determines may be appropriate to the administration of such partnerships.

(VII) The State does not impose any requirement affecting the terms or benefits of such a policy unless the State imposes such requirement on long-term care insurance policies without regard to whether the policy is covered under the partnership or is offered in connection with such a partnership.

In the case of a long-term care insurance policy which is exchanged for another such policy, subclause (I) shall be applied based on the coverage of the first such policy that was exchanged. For purposes of this clause and paragraph (5), the term "long-term care insurance policy" includes a certificate issued under a group insurance contract.

(iv) With respect to a State which had a State plan amendment approved as of May 14, 1993, such a State satisfies this clause for purposes of clause (ii) if the Secretary determines that the State plan amendment provides for consumer protection standards which are no less stringent than the consumer protection standards which applied under such State plan amendment as of December 31, 2005.

(v) The regulations of the Secretary required under clause (iii)(VI) shall be promulgated after consultation with the National Association of Insurance Commissioners, issuers of long-term care insurance policies, States with experience with long-term care insurance partnership plans, other States, and representatives of consumers of long-term care insurance policies, and shall specify the type and format of the data and information to be reported and the frequency with which such reports are to be made. The Secretary, as appropriate, shall provide copies of the reports provided in accordance with that clause to the State involved.

(vi) The Secretary, in consultation with other appropriate Federal agencies, issuers of long-term care insurance, the National Association of Insurance Commissioners, State insurance commissioners, States with experience with long-term care insurance partnership plans, other States, and representatives of consumers of long-term care insurance policies, shall develop recommendations for Congress to authorize and fund a uniform minimum data set to be reported electronically by all issuers of long-term care insurance policies under qualified State long-term care insurance partnerships to a secure, centralized electronic query and report-generating mechanism that the State, the Secretary, and other Federal agencies can access.

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

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

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

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

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

is lawfully residing in such home who has lawfully resided in such home on a continuous basis since the date of the individual's admission to the medical institution.

(3)(A) The State agency shall establish procedures (in accordance with standards specified by the Secretary) under which the agency shall waive the application of this subsection (other than paragraph (1)(C)) if such application would work an undue hardship as determined on the basis of criteria established by the Secretary.

(B) The standards specified by the Secretary under subparagraph (A) shall require that the procedures established by the State agency under subparagraph (A) exempt income, resources, and property that are exempt from the application of this subsection as of April 1, 2003, under manual instructions issued to carry out this subsection (as in effect on such date) because of the Federal responsibility for Indian Tribes and Alaska Native Villages. Nothing in this subparagraph shall be construed as preventing the Secretary from providing additional estate recovery exemptions under this subchapter for Indians.

(4) For purposes of this subsection, the term "estate", with respect to a deceased individual--

(A) shall include all real and personal property and other assets included within the individual's estate, as defined for purposes of State probate law; and

(B) may include, at the option of the State (and shall include, in the case of an individual to whom paragraph (1)(C)(i) applies), any other real and personal property and other assets in which the individual had any legal title or interest at the time of death (to the extent of such interest), including such assets conveyed to a survivor, heir, or assign of the deceased individual through joint tenancy, tenancy in common, survivorship, life estate, living trust, or other arrangement.

(5)(A) For purposes of clause (iii)(III), the model regulations and the requirements of the model Act specified in this paragraph are:

(i) In the case of the model regulation, the following requirements:

(I) Section 6A (relating to guaranteed renewal or noncancellability), other than paragraph (5) thereof, and the requirements of section 6B of the model Act relating to such section 6A.

(II) Section 6B (relating to prohibitions on limitations and exclusions) other than paragraph (7) thereof.

(III) Section 6C (relating to extension of benefits).

(IV) Section 6D (relating to continuation or conversion of coverage).

(V) Section 6E (relating to discontinuance and replacement of policies).

(VI) Section 7 (relating to unintentional lapse).

(VII) Section 8 (relating to disclosure), other than sections 8F, 8G, 8H, and 8I thereof.

(VIII) Section 9 (relating to required disclosure of rating practices to consumer).

(IX) Section 11 (relating to prohibitions against post-claims underwriting).

(X) Section 12 (relating to minimum standards).

(XI) Section 14 (relating to application forms and replacement coverage).

(XII) Section 15 (relating to reporting requirements).

(XIII) Section 22 (relating to filing requirements for marketing).

(XIV) Section 23 (relating to standards for marketing), including inaccurate completion of medical histories, other than paragraphs (1), (6), and (9) of section 23C.

(XV) Section 24 (relating to suitability).

(XVI) Section 25 (relating to prohibition against preexisting conditions and probationary periods in replacement policies or certificates).

(XVII) The provisions of section 26 relating to contingent nonforfeiture benefits, if the policyholder declines the offer of a nonforfeiture provision described in paragraph (4).

(XVIII) Section 29 (relating to standard format outline of coverage).

(XIX) Section 30 (relating to requirement to deliver shopper's guide).

(ii) In the case of the model Act, the following:

(I) Section 6C (relating to preexisting conditions).

(II) Section 6D (relating to prior hospitalization).

(III) The provisions of section 8 relating to contingent nonforfeiture benefits.

(IV) Section 6F (relating to right to return).

(V) Section 6G (relating to outline of coverage).

(VI) Section 6H (relating to requirements for certificates under group plans).

(VII) Section 6J (relating to policy summary).

(VIII) Section 6K (relating to monthly reports on accelerated death benefits).

(IX) Section 7 (relating to incontestability period).

(B) For purposes of this paragraph and paragraph (1)(C)--

(i) the terms "model regulation" and "model Act" mean the long-term care insurance model regulation, and the long-term care insurance model Act, respectively, promulgated by the National Association of Insurance Commissioners (as adopted as of October 2000);

(ii) any provision of the model regulation or model Act listed under subparagraph (A) shall be treated as including any other provision of such regulation or Act necessary to implement the provision; and

(iii) with respect to a long-term care insurance policy issued in a State, the policy shall be deemed to meet applicable requirements of the model regulation or the model Act if the State plan amendment under paragraph (1)(C)(iii) provides that the State insurance commissioner for the State certifies (in a manner satisfactory to the Secretary) that the policy meets such requirements.

(C) Not later than 12 months after the National Association of Insurance Commissioners issues a revision, update, or other modification of a model regulation or model Act provision specified in subparagraph (A), or of any provision of such regulation or Act that is substantively related to a provision specified in such subparagraph, the Secretary shall review the changes made to the provision, determine whether incorporating such changes into the corresponding provision specified in such subparagraph would improve qualified State long-term care insurance partnerships, and if so, shall incorporate the changes into such provision.

(c) Taking into account certain transfers of assets

(1)(A) In order to meet the requirements of this subsection for purposes of section 1396a(a)(18) of this title, the State plan must provide that if an institutionalized individual or the spouse of such an individual (or, at the option of a State, a noninstitutionalized individual or the spouse of such an individual) disposes of assets for less than fair market value on or after the look-back date specified in subparagraph (B)(i), the individual is ineligible for medical assistance for services described in subparagraph (C)(i) (or, in the case of a noninstitutionalized individual, for the services described in subparagraph (C)(ii)) during the period beginning on the date specified in subparagraph (D) and equal to the number of months specified in subparagraph (E).

(B)(i) The look-back date specified in this subparagraph is a date that is 36 months (or, in the case of payments from a trust or portions of a trust that are treated as assets disposed of by the individual pursuant to paragraph (3)(A)(iii) or (3)(B)(ii) of subsection (d) or in the case of any other disposal of assets made on or after February 8, 2006, 60 months) before the date specified in clause (ii).

(ii) The date specified in this clause, with respect to--

(I) an institutionalized individual is the first date as of which the individual both is an institutionalized individual and has applied for medical assistance under the State plan, or

(II) a noninstitutionalized individual is the date on which the individual applies for medical assistance under the State plan or, if later, the date on which the individual disposes of assets for less than fair market value.

(C)(i) The services described in this subparagraph with respect to an institutionalized individual are the following:

(I) Nursing facility services.

(II) A level of care in any institution equivalent to that of nursing facility services.

(III) Home or community-based services furnished under a waiver granted under subsection (c) or (d) of section 1396n of this title.

(ii) The services described in this subparagraph with respect to a noninstitutionalized individual are services (not including any services described in clause (i)) that are described in paragraph (7), (22), or (24) of section 1396d(a) of this title, and, at the option of a State, other long-term care services for which medical assistance is otherwise available under the State plan to individuals requiring long-term care.

(D)(i) In the case of a transfer of asset made before February 8, 2006, the date specified in this subparagraph is the first day of the first month during or after which assets have been transferred for less than fair market value and which does not occur in any other periods of ineligibility under this subsection.

(ii) In the case of a transfer of asset made on or after February 8, 2006, the date specified in this subparagraph is the first day of a month during or after which assets have been transferred for less than fair market value, or the date on which the individual is eligible for medical assistance under the State plan and would otherwise be receiving institutional level care described in subparagraph (C) based on an approved application for such care but for the application of the penalty period, whichever is later, and which does not occur during any other period of ineligibility under this subsection.

(E)(i) With respect to an institutionalized individual, the number of months of ineligibility under this subparagraph for an individual shall be equal to--

(I) the total, cumulative uncompensated value of all assets transferred by the individual (or individual's spouse) on or after the look-back date specified in subparagraph (B)(i), divided by

(II) the average monthly cost to a private patient of nursing facility services in the State (or, at the option of

the State, in the community in which the individual is institutionalized) at the time of application.

(ii) With respect to a noninstitutionalized individual, the number of months of ineligibility under this subparagraph for an individual shall not be greater than a number equal to--

(I) the total, cumulative uncompensated value of all assets transferred by the individual (or individual's spouse) on or after the look-back date specified in subparagraph (B)(i), divided by

(II) the average monthly cost to a private patient of nursing facility services in the State (or, at the option of the State, in the community in which the individual is institutionalized) at the time of application.

(iii) The number of months of ineligibility otherwise determined under clause (i) or (ii) with respect to the disposal of an asset shall be reduced--

(I) in the case of periods of ineligibility determined under clause (i), by the number of months of ineligibility applicable to the individual under clause (ii) as a result of such disposal, and

(II) in the case of periods of ineligibility determined under clause (ii), by the number of months of ineligibility applicable to the individual under clause (i) as a result of such disposal.

(iv) A State shall not round down, or otherwise disregard any fractional period of ineligibility determined under clause (i) or (ii) with respect to the disposal of assets.

(F) For purposes of this paragraph, the purchase of an annuity shall be treated as the disposal of an asset for less than fair market value unless--

(i) the State is named as the remainder beneficiary in the first position for at least the total amount of medical assistance paid on behalf of the institutionalized individual under this subchapter; or

(ii) the State is named as such a beneficiary in the second position after the community spouse or minor or disabled child and is named in the first position if such spouse or a representative of such child disposes of any such remainder for less than fair market value.

(G) For purposes of this paragraph with respect to a transfer of assets, the term "assets" includes an annuity

purchased by or on behalf of an annuitant who has applied for medical assistance with respect to nursing facility services or other long-term care services under this subchapter unless--

(i) the annuity is--

(I) an annuity described in subsection (b) or (q) of section 408 of the Internal Revenue Code of 1986; or

(II) purchased with proceeds from--

(aa) an account or trust described in subsection (a), (c), or (p) of section 408 of such Code;

(bb) a simplified employee pension (within the meaning of section 408(k) of such Code); or

(cc) a Roth IRA described in section 408A of such Code; or

(ii) the annuity--

(I) is irrevocable and nonassignable;

(II) is actuarially sound (as determined in accordance with actuarial publications of the Office of the Chief Actuary of the Social Security Administration); and

(III) provides for payments in equal amounts during the term of the annuity, with no deferral and no balloon payments made.

(H) Notwithstanding the preceding provisions of this paragraph, in the case of an individual (or individual's spouse) who makes multiple fractional transfers of assets in more than 1 month for less than fair market value on or after the applicable look-back date specified in subparagraph (B), a State may determine the period of ineligibility applicable to such individual under this paragraph by--

(i) treating the total, cumulative uncompensated value of all assets transferred by the individual (or individual's spouse) during all months on or after the look-back date specified in subparagraph (B) as 1

transfer for purposes of clause (i) or (ii) (as the case may be) of subparagraph (E); and

(ii) beginning such period on the earliest date which would apply under subparagraph (D) to any of such transfers.

(I) For purposes of this paragraph with respect to a transfer of assets, the term "assets" includes funds used to purchase a promissory note, loan, or mortgage unless such note, loan, or mortgage--

(i) has a repayment term that is actuarially sound (as determined in accordance with actuarial publications of the Office of the Chief Actuary of the Social Security Administration);

(ii) provides for payments to be made in equal amounts during the term of the loan, with no deferral and no balloon payments made; and

(iii) prohibits the cancellation of the balance upon the death of the lender.

In the case of a promissory note, loan, or mortgage that does not satisfy the requirements of clauses (i) through (iii), the value of such note, loan, or mortgage shall be the outstanding balance due as of the date of the individual's application for medical assistance for services described in subparagraph (C).

(J) For purposes of this paragraph with respect to a transfer of assets, the term "assets" includes the purchase of a life estate interest in another individual's home unless the purchaser resides in the home for a period of at least 1 year after the date of the purchase.

(2) An individual shall not be ineligible for medical assistance by reason of paragraph (1) to the extent that--

(A) the assets transferred were a home and title to the home was transferred to--

(i) the spouse of such individual;

(ii) a child of such individual who (I) is under age 21, or (II) (with respect to States eligible to participate in the State program established under subchapter XVI) is blind or permanently and totally disabled, or (with respect to States which are not eligible to participate in such program) is blind or disabled as defined in section 1382c of this title;

(iii) a sibling of such individual who has an equity interest in such home and who was residing in such individual's home for a period of at least one year immediately before the date the individual becomes an institutionalized individual; or

(iv) a son or daughter of such individual (other than a child described in clause (ii)) who was residing in such individual's home for a period of at least two years immediately before the date the individual becomes an institutionalized individual, and who (as determined by the State) provided care to such individual which permitted such individual to reside at home rather than in such an institution or facility;

(B) the assets--

(i) were transferred to the individual's spouse or to another for the sole benefit of the individual's spouse,

(ii) were transferred from the individual's spouse to another for the sole benefit of the individual's spouse,

(iii) were transferred to, or to a trust (including a trust described in subsection (d)(4)) established solely for the benefit of, the individual's child described in subparagraph (A)(ii)(II), or

(iv) were transferred to a trust (including a trust described in subsection (d)(4)) established solely for the benefit of an individual under 65 years of age who is disabled (as defined in section 1382c(a)(3) of this title);

(C) a satisfactory showing is made to the State (in accordance with regulations promulgated by the Secretary) that (i) the individual intended to dispose of the assets either at fair market value, or for other valuable consideration, (ii) the assets were transferred exclusively for a purpose other than to qualify for medical assistance, or (iii) all assets transferred for less than fair market value have been returned to the individual; or

(D) the State determines, under procedures established by the State (in accordance with standards specified by the Secretary), that the denial of eligibility would work an undue hardship as determined on the basis of criteria established by the Secretary.

The procedures established under subparagraph (D) shall permit the facility in which the institutionalized individual is residing to file an undue hardship waiver application on behalf of the individual with the consent of the individual or the personal representative of the individual.

While an application for an undue hardship waiver is pending under subparagraph (D) in the case of an

individual who is a resident of a nursing facility, if the application meets such criteria as the Secretary specifies, the State may provide for payments for nursing facility services in order to hold the bed for the individual at the facility, but not in excess of payments for 30 days.

(3) For purposes of this subsection, in the case of an asset held by an individual in common with another person or persons in a joint tenancy, tenancy in common, or similar arrangement, the asset (or the affected portion of such asset) shall be considered to be transferred by such individual when any action is taken, either by such individual or by any other person, that reduces or eliminates such individual's ownership or control of such asset.

(4) A State (including a State which has elected treatment under section 1396a(f) of this title) may not provide for any period of ineligibility for an individual due to transfer of resources for less than fair market value except in accordance with this subsection. In the case of a transfer by the spouse of an individual which results in a period of ineligibility for medical assistance under a State plan for such individual, a State shall, using a reasonable methodology (as specified by the Secretary), apportion such period of ineligibility (or any portion of such period) among the individual and the individual's spouse if the spouse otherwise becomes eligible for medical assistance under the State plan.

(5) In this subsection, the term "resources" has the meaning given such term in section 1382b of this title, without regard to the exclusion described in subsection (a)(1) thereof.

(d) Treatment of trust amounts

(1) For purposes of determining an individual's eligibility for, or amount of, benefits under a State plan under this subchapter, subject to paragraph (4), the rules specified in paragraph (3) shall apply to a trust established by such individual.

(2)(A) For purposes of this subsection, an individual shall be considered to have established a trust if assets of the individual were used to form all or part of the corpus of the trust and if any of the following individuals established such trust other than by will:

(i) The individual.

(ii) The individual's spouse.

(iii) A person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or the individual's spouse.

(iv) A person, including any court or administrative body, acting at the direction or upon the request of the individual or the individual's spouse.

(B) In the case of a trust the corpus of which includes assets of an individual (as determined under subparagraph (A)) and assets of any other person or persons, the provisions of this subsection shall apply to the portion of the trust attributable to the assets of the individual.

(C) Subject to paragraph (4), this subsection shall apply without regard to--

(i) the purposes for which a trust is established,

(ii) whether the trustees have or exercise any discretion under the trust,

(iii) any restrictions on when or whether distributions may be made from the trust, or

(iv) any restrictions on the use of distributions from the trust.

(3)(A) In the case of a revocable trust--

(i) the corpus of the trust shall be considered resources available to the individual,

(ii) payments from the trust to or for the benefit of the individual shall be considered income of the individual, and

(iii) any other payments from the trust shall be considered assets disposed of by the individual for purposes of subsection (c).

(B) In the case of an irrevocable trust--

(i) if there are any circumstances under which payment from the trust could be made to or for the benefit of the individual, the portion of the corpus from which, or the income on the corpus from which, payment to the individual could be made shall be considered resources available to the individual, and payments from that portion of the corpus or income--

(I) to or for the benefit of the individual, shall be considered income of the individual, and

(II) for any other purpose, shall be considered a transfer of assets by the individual subject to subsection (c); and

(ii) any portion of the trust from which, or any income on the corpus from which, no payment could under any circumstances be made to the individual shall be considered, as of the date of establishment of the trust (or, if later, the date on which payment to the individual was foreclosed) to be assets disposed by the individual for purposes of subsection (c), and the value of the trust shall be determined for purposes of such subsection by including the amount of any payments made from such portion of the trust after such date.

(4) This subsection shall not apply to any of the following trusts:

(A) A trust containing the assets of an individual under age 65 who is disabled (as defined in section 1382c(a)(3) of this title) and which is established for the benefit of such individual by the individual, a parent, grandparent, legal guardian of the individual, or a court if the State will receive all amounts remaining in the trust upon the death of such individual up to an amount equal to the total medical assistance paid on behalf of the individual under a State plan under this subchapter.

(B) A trust established in a State for the benefit of an individual if--

(i) the trust is composed only of pension, Social Security, and other income to the individual (and accumulated income in the trust),

(ii) the State will receive all amounts remaining in the trust upon the death of such individual up to an amount equal to the total medical assistance paid on behalf of the individual under a State plan under this subchapter, and

(iii) the State makes medical assistance available to individuals described in section 1396a(a)(10)(A)(ii)(V) of this title, but does not make such assistance available to individuals for nursing facility services under section 1396a(a)(10)(C) of this title.

(C) A trust containing the assets of an individual who is disabled (as defined in section 1382c(a)(3) of this title) that meets the following conditions:

(i) The trust is established and managed by a nonprofit association.

(ii) A separate account is maintained for each beneficiary of the trust, but, for purposes of investment and management of funds, the trust pools these accounts.

(iii) Accounts in the trust are established solely for the benefit of individuals who are disabled (as defined in section 1382c(a)(3) of this title) by the parent, grandparent, or legal guardian of such individuals, by such individuals, or by a court.

(iv) To the extent that amounts remaining in the beneficiary's account upon the death of the beneficiary are not retained by the trust, the trust pays to the State from such remaining amounts in the account an amount equal to the total amount of medical assistance paid on behalf of the beneficiary under the State plan under this subchapter.

(5) The State agency shall establish procedures (in accordance with standards specified by the Secretary) under which the agency waives the application of this subsection with respect to an individual if the individual establishes that such application would work an undue hardship on the individual as determined on the basis of criteria established by the Secretary.

(6) The term "trust" includes any legal instrument or device that is similar to a trust but includes an annuity only to such extent and in such manner as the Secretary specifies.

(e) Disclosure and treatment of annuities

(1) In order to meet the requirements of this section for purposes of section 1396a(a)(18) of this title, a State shall require, as a condition for the provision of medical assistance for services described in subsection (c)(1)(C)(i) (relating to long-term care services) for an individual, the application of the individual for such assistance (including any recertification of eligibility for such assistance) shall disclose a description of any interest the individual or community spouse has in an annuity (or similar financial instrument, as may be specified by the Secretary), regardless of whether the annuity is irrevocable or is treated as an asset. Such application or recertification form shall include a statement that under paragraph (2) the State becomes a remainder beneficiary under such an annuity or similar financial instrument by virtue of the provision of such medical assistance.

(2)(A) In the case of disclosure concerning an annuity under subsection (c)(1)(F), the State shall notify the issuer of the annuity of the right of the State under such subsection as a preferred remainder beneficiary in the annuity for medical assistance furnished to the individual. Nothing in this paragraph shall be construed as preventing such an issuer from notifying persons with any other remainder interest of the State's remainder interest under such subsection.

(B) In the case of such an issuer receiving notice under subparagraph (A), the State may require the issuer to notify the State when there is a change in the amount of income or principal being withdrawn from the amount that was being withdrawn at the time of the most recent disclosure described in paragraph (1). A State shall take such information into account in determining the amount of the State's obligations for medical assistance or in the individual's eligibility for such assistance.

(3) The Secretary may provide guidance to States on categories of transactions that may be treated as a transfer of asset for less than fair market value.

(4) Nothing in this subsection shall be construed as preventing a State from denying eligibility for medical assistance for an individual based on the income or resources derived from an annuity described in paragraph (1).

(f) Disqualification for long-term care assistance for individuals with substantial home equity

(1)(A) Notwithstanding any other provision of this subchapter, subject to subparagraphs (B) and (C) of this paragraph and paragraph (2), in determining eligibility of an individual for medical assistance with respect to nursing facility services or other long-term care services, the individual shall not be eligible for such assistance if the individual's equity interest in the individual's home exceeds $500,000.

(B) A State may elect, without regard to the requirements of section 1396a(a)(1) of this title (relating to statewideness) and section 1396a(a)(10)(B) of this title (relating to comparability), to apply subparagraph (A) by substituting for "$500,000", an amount that exceeds such amount, but does not exceed $750,000.

(C) The dollar amounts specified in this paragraph shall be increased, beginning with 2011, from year to year based on the percentage increase in the consumer price index for all urban consumers (all items; United States city average), rounded to the nearest $1,000.

(2) Paragraph (1) shall not apply with respect to an individual if--

(A) the spouse of such individual, or

(B) such individual's child who is under age 21, or (with respect to States eligible to participate in the State program established under subchapter XVI) is blind or permanently and totally disabled, or (with respect to States which are not eligible to participate in such program) is blind or disabled as defined in section 1382c of this title,

is lawfully residing in the individual's home.

(3) Nothing in this subsection shall be construed as preventing an individual from using a reverse mortgage or home equity loan to reduce the individual's total equity interest in the home.

(4) The Secretary shall establish a process whereby paragraph (1) is waived in the case of a demonstrated hardship.

(g) Treatment of entrance fees of individuals residing in continuing care retirement communities

(1) In general

For purposes of determining an individual's eligibility for, or amount of, benefits under a State plan under this subchapter, the rules specified in paragraph (2) shall apply to individuals residing in continuing care retirement communities or life care communities that collect an entrance fee on admission from such individuals.

(2) Treatment of entrance fee

For purposes of this subsection, an individual's entrance fee in a continuing care retirement community or life care community shall be considered a resource available to the individual to the extent that--

(A) the individual has the ability to use the entrance fee, or the contract provides that the entrance fee may be used, to pay for care should other resources or income of the individual be insufficient to pay for such care;

(B) the individual is eligible for a refund of any remaining entrance fee when the individual dies or terminates the continuing care retirement community or life care community contract and leaves the community; and

(C) the entrance fee does not confer an ownership interest in the continuing care retirement community or life care community.

(h) Definitions

In this section, the following definitions shall apply:

(1) The term "assets", with respect to an individual, includes all income and resources of the individual and of the individual's spouse, including any income or resources which the individual or such individual's spouse is entitled to but does not receive because of action--

(A) by the individual or such individual's spouse,

(B) by a person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or such individual's spouse, or

(C) by any person, including any court or administrative body, acting at the direction or upon the request of the individual or such individual's spouse.

(2) The term "income" has the meaning given such term in section 1382a of this title.

(3) The term "institutionalized individual" means an individual who is an inpatient in a nursing facility, who is an inpatient in a medical institution and with respect to whom payment is made based on a level of care provided in a nursing facility, or who is described in section 1396a(a)(10)(A)(ii)(VI) of this title.

(4) The term "noninstitutionalized individual" means an individual receiving any of the services specified in subsection (c)(1)(C)(ii).

(5) The term "resources" has the meaning given such term in section 1382b of this title, without regard (in the case of an institutionalized individual) to the exclusion described in subsection (a)(1) of such section.

CREDIT(S)

(Aug. 14, 1935, c. 531, Title XIX, § 1917, as added Pub.L. 97-248, Title I, § 132(b), Sept. 3, 1982, 96 Stat. 370;

amended Pub.L. 97-448, Title III, § 309(b)(21), (22), Jan. 12, 1983, 96 Stat. 2410; Pub.L. 100-203, Title IV, § 4211(h)(12), Dec. 22, 1987, 101 Stat. 1330-207; Pub.L. 100-360, Title III, § 303(b), Title IV, § 411(l)(3)(I), July 1, 1988, 102 Stat. 760, 803; Pub.L. 100-485, Title VI, § 608(d)(16)(B), Oct. 13, 1988, 102 Stat. 2417; Pub.L. 101-239, Title VI, § 6411(e)(1), Dec. 19, 1989, 103 Stat. 2271; Pub.L. 103-66, Title XIII, §§ 13611(a) to (c), 13612(a) to (c), Aug. 10, 1993, 107 Stat. 622 to 628; Pub.L. 109-171, Title VI, §§ 6011(a), (b), (e), 6012(a) to (c), 6014(a), 6015(b), 6016(a) to (d), 6021(a)(1), Feb. 8, 2006, 120 Stat. 61 to 68; Pub.L. 109-432, Div. B, Title IV, § 405(b)(1), Dec. 20, 2006, 120 Stat. 2998; Pub.L. 110-275, Title I, § 115(a), July 15, 2008, 122 Stat. 2507; Pub.L. 111-5, Div. B, Title V, § 5006(c), Feb. 17, 2009, 123 Stat. 507; Pub.L. 113-67, Div. A, Title II, § 202(b)(3), Dec. 26, 2013, 127 Stat. 1177; Pub.L. 114-255, Div. A, Title V, § 5007(a), Dec. 13, 2016, 130 Stat. 1197; Pub.L. 115-123, Div. E, Title XII, § 53102(b)(1), Feb. 9, 2018, 132 Stat. 298.)

42 U.S.C.A. § 1396p, 42 USCA § 1396p
Current through P.L. 118-82. Some statute sections may be more current, see credits for details.

McKinney's Mental Hygiene Law § 81.21

§ 81.21 Powers of guardian; property management

Effective: September 25, 2015

Currentness

(a) Consistent with the functional limitations of the incapacitated person, that person's understanding and appreciation of the harm that he or she is likely to suffer as the result of the inability to manage property and financial affairs, and that person's personal wishes, preferences, and desires with regard to managing the activities of daily living, and the least restrictive form of intervention, the court may authorize the guardian to exercise those powers necessary and sufficient to manage the property and financial affairs of the incapacitated person; to provide for the maintenance and support of the incapacitated person, and those persons depending upon the incapacitated person; to transfer a part of the incapacitated person's assets to or for the benefit of another person on the ground that the incapacitated person would have made the transfer if he or she had the capacity to act.

Transfers made pursuant to this article may be in any form that the incapacitated person could have employed if he or she had the requisite capacity, except in the form of a will or codicil.

Those powers which may be granted include, but are not limited to, the power to:

1. make gifts;

2. provide support for persons dependent upon the incapacitated person for support, whether or not the incapacitated person is legally obligated to provide that support;

3. convey or release contingent and expectant interests in property, including marital property rights and any right of survivorship incidental to joint tenancy or tenancy by the entirety;

4. exercise or release powers held by the incapacitated person as trustee, personal representative, guardian for minor, guardian, or donee of a power of appointment;

5. enter into contracts;

6. create revocable or irrevocable trusts of property of the estate which may extend beyond the incapacity or life of the incapacitated person;

7. exercise options of the incapacitated person to purchase securities or other property;

8. exercise rights to elect options and change beneficiaries under insurance and annuity policies and to surrender the policies for their cash value;

9. exercise any right to an elective share in the estate of the incapacitated person's deceased spouse;

10. renounce or disclaim any interest by testate or intestate succession or by inter vivos transfer consistent with paragraph (d) of section 2-1.11 of the estates, powers and trusts law;

11. authorize access to or release of confidential records;

12. apply for government and private benefits;

13. marshall assets;

14. pay the funeral expenses of the incapacitated person;

15. pay such bills as may be reasonably necessary to maintain the incapacitated person;

16. invest funds of the incapacitated person as permitted by section 11-2.3 of the estates, powers and trusts law;

17. lease the primary residence for up to three years;

18. retain an accountant;

19. pay bills after the death of the incapacitated person provided the authority existed to pay such bills prior to death until a temporary administrator or executor is appointed; and

20. defend or maintain any judicial action or proceeding to a conclusion until an executor or administrator is appointed.

The guardian may also be granted any power pursuant to this subdivision granted to committees and conservators and guardians by other statutes subject to the limitations, conditions, and responsibilities of the exercise thereof unless the granting of such power is inconsistent with the provisions of this article.

(b) If the petitioner or the guardian seeks the authority to exercise a power which involves the transfer of a part of the incapacitated person's assets to or for the benefit of another person, including the petitioner or guardian, the petition shall include the following information:

1. whether any prior proceeding has at any time been commenced by any person seeking such power with respect to the property of the incapacitated person and, if so, a description of the nature of such application and the disposition made of such application;

2. the amount and nature of the financial obligations of the incapacitated person including funds presently and prospectively required to provide for the incapacitated person's own maintenance, support, and well-being and

to provide for other persons dependent upon the incapacitated person for support, whether or not the incapacitated person is legally obligated to provide that support; a copy of any court order or written agreement setting forth support obligations of the incapacitated person shall be attached to the petition if available to the petitioner or guardian;

3. the property of the incapacitated person that is the subject of the present application;

4. the proposed disposition of such property and the reasons why such disposition should be made;

5. whether the incapacitated person has sufficient capacity to make the proposed disposition; if the incapacitated person has such capacity, his or her written consent shall be attached to the petition;

6. whether the incapacitated person has previously executed a will or similar instrument and if so, the terms of the most recently executed will together with a statement as to how the terms of the will became known to the petitioner or guardian; for purposes of this article, the term "will" shall have the meaning specified in section 1-2.19 of the estates, powers and trusts law and "similar instrument" shall include a revocable or irrevocable trust:

(i) if the petitioner or guardian can, with reasonable diligence, obtain a copy, a copy of the most recently executed will or similar instrument shall be attached to the petition; in such case, the petition shall contain a statement as to how the copy was secured and the basis for the petitioner or guardian's belief that such copy is a copy of the incapacitated person's most recently executed will or similar instrument.

(ii) if the petitioner or guardian is unable to obtain a copy of the most recently executed will or similar instrument, or if the petitioner or guardian is unable to determine whether the incapacitated person has previously executed a will or similar instrument, what efforts were made by the petitioner or guardian to ascertain such information.

(iii) if a copy of the most recently executed will or similar instrument is not otherwise available, the court may direct an attorney or other person who has the original will or similar instrument in his or her possession to turn a photocopy over to the court for its examination, in camera. A photocopy of the will or similar instrument shall then be turned over by the court to the parties in such proceeding unless the court finds that to do so would be contrary to the best interests of the incapacitated person;

7. a description of any significant gifts or patterns of gifts made by the incapacitated person;

8. the names, post-office addresses and relationships of the presumptive distributees of the incapacitated person as that term is defined in subdivision forty-two of section one hundred three of the surrogate's court procedure

act and of the beneficiaries under the most recent will or similar instrument executed by the incapacitated person.

(c) Notice of a petition seeking relief under this section shall be served upon:

(i) the persons entitled to notice in accordance with paragraph one of subdivision (e) of section 81.07 of this article;

(ii) if known to the petitioner or guardian, the presumptive distributees of the incapacitated person as that term is defined in subdivision forty-two of section one hundred three of the surrogate's court procedure act unless the court dispenses with such notice; and

(iii) if known to the petitioner or guardian, any person designated in the most recent will or similar instrument of the incapacitated person as beneficiary whose rights or interests would be adversely affected by the relief requested in the petition unless the court dispenses with such notice.

(d) In determining whether to approve the application, the court shall consider:

1. whether the incapacitated person has sufficient capacity to make the proposed disposition himself or herself, and, if so, whether he or she has consented to the proposed disposition;

2. whether the disability of the incapacitated person is likely to be of sufficiently short duration such that he or she should make the determination with respect to the proposed disposition when no longer disabled;

3. whether the needs of the incapacitated person and his or her dependents or other persons depending upon the incapacitated person for support can be met from the remainder of the assets of the incapacitated person after the transfer is made;

4. whether the donees or beneficiaries of the proposed disposition are the natural objects of the bounty of the incapacitated person and whether the proposed disposition is consistent with any known testamentary plan or pattern of gifts he or she has made;

5. whether the proposed disposition will produce estate, gift, income or other tax savings which will significantly benefit the incapacitated person or his or her dependents or other persons for whom the incapacitated person would be concerned; and

6. such other factors as the court deems relevant.

(e) The court may grant the application if satisfied by clear and convincing evidence of the following and shall make a record of these findings:

1. the incapacitated person lacks the requisite mental capacity to perform the act or acts for which approval has been sought and is not likely to regain such capacity within a reasonable period of time or, if the incapacitated person has the requisite capacity, that he or she consents to the proposed disposition;

2. a competent, reasonable individual in the position of the incapacitated person would be likely to perform the act or acts under the same circumstances; and

3. the incapacitated person has not manifested an intention inconsistent with the performance of the act or acts for which approval has been sought at some earlier time when he or she had the requisite capacity or, if such intention was manifested, the particular person would be likely to have changed such intention under the circumstances existing at the time of the filing of the petition.

(f) Nothing in this article imposes any duty on the guardian to commence a special proceeding pursuant to this article seeking to transfer a part of the assets of the incapacitated person to or for the benefit of another person and the guardian shall not be liable or accountable to any person for having failed to commence a special proceeding pursuant to this article seeking to transfer a part of the assets of the incapacitated person to or for the benefit of another person.

Credits

(Added L.1992, c. 698, § 3. Amended L.1993, c. 32, §§ 10, 11; L.2004, c. 438, § 16, eff. Dec. 13, 2004; L.2010, c. 27, § 3, eff. Jan. 1, 2011; L.2015, c. 243, § 1, eff. Sept. 25, 2015.)

McKinney's Mental Hygiene Law § 81.21, NY MENT HYG § 81.21
Current through L.2024, chapters 1 to 334. Some statute sections may be more current, see credits for details.

PL 114-255, December 13, 2016, 130 Stat 1033

UNITED STATES PUBLIC LAWS

114th Congress - Second Session

Convening January 06, 2016

Additions and Deletions are not identified in this database.
Vetoed provisions within tabular material are not displayed
Vetoes are indicated by ~~Text~~;
stricken material by ~~Text~~.

PL 114–255 [HR 34]
December 13, 2016
21ST CENTURY CURES ACT

An Act To accelerate the discovery, development, and delivery of 21st century cures, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SEC. 5007. FAIRNESS IN MEDICAID SUPPLEMENTAL NEEDS TRUSTS.

<< 42 USCA § 1396p >>

(a) IN GENERAL.—Section 1917(d)(4)(A) of the Social Security Act (42 U.S.C. 1396p(d)(4)(A)) is amended by inserting "the individual," after "for the benefit of such individual by".

<< 42 USCA § 1396p NOTE >>

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to trusts established on or after the date of the enactment of this Act.

Case Law

a. In re Larson, 190 Misc.2d 482 (2002)
b. Arkansas Dept. of Health & Human Srvs. v. Ahlborn (2006)
c. Wos v. E.M.A. ex rel. Johnson (2013)

190 Misc.2d 482
Surrogate's Court, Nassau County, New York.

In the Matter of the Guardianship of David B. LARSON, a Mentally Retarded Person.

Feb. 14, 2002.

Synopsis
Application was made to create device similar to supplemental needs trust, to provide for inheritance of approximately $25,000 bequeathed to developmentally disabled resident of state facility. The Surrogate's Court, Nassau County, John B. Riordan, J., held that inheritance could be transferred to Commissioner of State of New York, for deposit into account similar to statutory supplemental needs trust, to be used for maintenance of residence.

Approval granted.

Attorneys and Law Firms

****827 *483** Robert, Lerner & Bigler, Rockville Centre, for A. William Larson and another, petitioners.

Eliot Spitzer, Attorney General, New York City (Mark D. Brody of counsel), for New York State Office of Mental Retardation and Developmental Disabilities.

Opinion

JOHN B. RIORDAN, S.

This is an application to create a device similar to a Supplemental Needs Trust pursuant to § 13.29 of the Mental Hygiene Law. The petitioners, A. William Larson and Barbara Peters, are co-guardians of their developmentally disabled son, David. David resides at the Sara Daley State Operated Individualized Residential Alternative which is a residence under the jurisdiction of the New York State Office of Mental Retardation and Developmental Disabilities. He is under the age of 65 and receives both Medicaid and SSI.

In 1987, David's grandmother died and left David an inheritance of approximately $25,000. As David's eligibility for government benefits would have been jeopardized upon the receipt of the inheritance or, in the alternative, the full amount would have to be used to repay Medicaid, an application was made to establish a Supplemental Needs trust. The application was granted by this court on March 9, 1995. For various reasons, the Supplemental Needs Trust was never established or funded.

The petitioners, joined by James Whitehead—the director of the Hudson Valley Developmental Disabilities Services Office, have asked the court for permission to transfer the inheritance to the state to be deposited into a device similar to a Supplemental Needs Trust pursuant to Mental Hygiene Law § 13.29. Such a device would not jeopardize David's eligibility for either Medicaid or SSI because it would be a trust[1] as set forth in 42 U.S.C.A. § 1396p(4)(A), Social Services Law § 366(2)(b)(2)(iv) and 18 NYCRR § 360–4.5(e). The proffered reason behind the ****828** establishment of these accounts is to protect the small inheritance of a developmentally disabled or mentally retarded resident in a state facility when the patient has no responsible relative available or willing to administer the inheritance.

***484** Section 13.29 of the Mental Hygiene Law entitled "Gifts" provides that the Commissioner "on behalf of the state, and if in the public interest shall accept, hold in trust, administer, apply, execute or use gifts, devises, bequests, grants, powers, or trusts of personal or real property made to the state ... which are to be used or may be used for purposes of the office of mental retardation and developmental disabilities, including, but not limited to, the maintenance, support, or benefit of one or more patients in a facility." This section of the law, with variations thereof, has been the law of the State of New York for one hundred and sixty years, having been enacted in 1842 as part of an "act to organize the state Lunatic Asylum, and move effectually to provide for the care, maintenance and recovery of the insane" (¶ 135, L.1842[2]). As originally enacted, the law provided that "managers may take and hold, in trust for the state, any grant or devise of land or any donation or bequest of money or other personal property, to be applied to the maintenance of insane persons and the general use of the state Lunatic Asylum" (¶ 135, § 6, L.1842).

Although the law has been in effect for one hundred and sixty years, there have been only two decisions where section 13.29 of the Mental Hygiene Law has been analyzed by the courts.[3] Where the Commissioner in Lunacy tried to exercise a right of election on behalf of one of his patients, the court held "[i]t is true that this statute vests in the commissioners in lunacy, among other general powers, the right to hold a devise of bequest to any state hospital in trust for the support of an insane person, but the act does not specifically or by inference authorize any election by the commissioner on behalf of a widow in a case of this sort; and, in the absence of clear intent, the courts should not hold the statute sufficiently broad to allow the commissioners to exercise a right which has been given as a personal one to the incompetent" (*Camardella v. Schwartz,* 126 App.Div. 334, 110 N.Y.S. 611).

In the *Matter of Patrick BB,* 284 A.D.2d 636, 725 N.Y.S.2d 731, Patrick, a developmentally disabled man, inherited approximately $20,000 and an application was made, inter alia, to establish a "13.29" fund ***485** with the inheritance. The court held that the statute "regulates the receipt and management of property in the form of 'gifts, devises, bequests, grants, powers, or trusts of property essentially 'made to the state' for the use of petitioner or its facilities.' Supreme Court's order did not 'gift' respondent's inheritance to the State. Clearly, the inheritance remained patient property. Thus, we find Mental Hygiene Law § 13.29(a) inapplicable in the instant case" (*Matter of Patrick BB, supra,* at 638, 725 N.Y.S.2d 731).

In response to the Appellate Division's decision in the *Matter of Patrick BB (supra),* ****829** the petitioners have asked the court for permission to conditionally gift the property to the Commissioner of the State of New York to be held in a "13.29" account.[4]

Guardians of developmentally disabled individuals have been allowed to gift property of the ward under the doctrine of substituted judgment (*Matter of Daly,* 142 Misc.2d 85, 536 N.Y.S.2d 393). The duty of the court is to "inquire as to what a reasonable and prudent person would do in the circumstances" (*Daly, supra,* at 88, 536 N.Y.S.2d 393 citing *Matter of Christiansen v. Christiansen,* 248 Cal.App.2d 398, 56 Cal.Rptr. 505). It is clear that a guardian appointed pursuant to Article 17–A of the Surrogate's Court Procedure Act has the authority, with court permission, to transfer an inheritance to a Supplemental Needs Trust (*Matter of Goldblatt,* 162 Misc.2d 888, 618 N.Y.S.2d 959). A reasonable and prudent person under the circumstances would elect to give the property to the state to be used for his or her own maintenance, rather than have the property used to pay claims for assistance rendered on his or her behalf.

The analysis, however, does not end here. As court approval is required in establishing the device similar to a Supplemental Needs Trust when a developmentally disabled person's property is the subject of the proceeding, the court may condition the "exercise of the privilege in such manner as it believes will sufficiently protect the interest of the disabled person" (*Matter of Goldblatt, supra* at 889, 618 N.Y.S.2d 959 and *DiGennaro v. Community Hospital of Glen Cove,* 204 A.D.2d 259, 611 N.Y.S.2d 591). Accordingly, the device is approved but must include a provision requiring the Commissioner to ***486** file an annual inventory and account with the Surrogate's Court, Nassau County.

All Citations

190 Misc.2d 482, 738 N.Y.S.2d 827, 2002 N.Y. Slip Op. 22024

Footnotes

1 Trust is defined in 42 USCA § 1396p(6) as including "any legal instrument of device that is similar to a trust ...".

2 The law was amended in 1902 and the original board of managers was replaced by a "Commissioner of Lunacy". The primary purpose of the revision, and of subsequent revisions, was to correct the "scandals and all the extravagance which have marked the administration..". (1902 Memorandum filed with Approved Assembly Bill No. 438, Amending the Insanity Law at 75).

3 The Attorney General's office has provided the court with eight additional Supreme Court and Surrogate Court orders where approval for the funding of accounts pursuant to Section 13.29 of the Mental Hygiene Law was given.

4 Pursuant to 42 USC § 1382b(c), where an individual transfers resources for less than fair market value, the individual will be ineligible for SSI for a period of time. The Attorney General has taken the position that the proposed transfer will not effect David's eligibility for SSI benefits because the transfer is for other valuable consideration pursuant to 42 USC § 1382b(c)(1)(C)(ii)(*I*) as any possible claim by OMRDD will be waived.

KeyCite Yellow Flag - Negative Treatment
Superseded by Statute as Stated in L.Q. v. California Hospital Medical Center, Cal.App. 2 Dist., September 30, 2021

126 S.Ct. 1752
Supreme Court of the United States

ARKANSAS DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al., Petitioners,
v.
Heidi AHLBORN.

No. 04–1506.
|
Argued Feb. 27, 2006.
|
Decided May 1, 2006.

Synopsis
Background: Medicaid recipient sued Arkansas Department of Human Services (ADHS), challenging ADHS's assertion of claim or lien against proceeds received by recipient in settlement of personal injury lawsuit. The United States District Court for the Eastern District of Arkansas, 280 F.Supp.2d 881, G. Thomas Eisele, J., granted state's motion for summary judgment, and appeal was taken. The Court of Appeals, 397 F.3d 620,

Colloton, Circuit Judge, reversed. Certiorari was granted.

Holdings: The Supreme Court, Justice Stevens, held that:

Arkansas statute automatically imposing lien in favor of ADHS on tort settlement proceeds was not authorized by federal Medicaid law, to extent that statute allowed encumbrance or attachment of proceeds meant to compensate recipient for damages distinct from medical costs, and

anti-lien provision of federal Medicaid law precluded Arkansas statute's encumbrance or attachment of proceeds related to damages other than medical costs; *Arkansas Dept. of Human Servs. v. Ferrel,* 336 Ark. 297, 984 S.W.2d 807.

Affirmed.

West Codenotes

Limited on Preemption Grounds
West's A.C.A. § 20–77–307(a, c).

****1753 *268** *Syllabus*[*]

Federal Medicaid law requires participating States to "ascertain the legal liability of third parties ... to pay for [an individual benefits recipient's] care and services available under the [State's] plan," 42 U.S.C. § 1396a(a)(25)(A); to "seek reimbursement for [medical] assistance to the extent of such legal liability," ****1754** § 1396a(a)(25)(B); to enact "laws under which, to the extent that payment has been made ... for medical assistance for health care items or services furnished to an individual, the State is considered to have acquired the rights of such individual to payment by any other party for such health care items or services," § 1396a(a)(25)(H); to "provide that, as a condition of [Medicaid] eligibility ..., the individual is required ... (A) to assign the State any rights ... to payment for medical care from any third party; ... (B) to cooperate with the State ... in obtaining [such] payments ... and ... (C) ... in identifying, and providing information to assist the State in pursuing, any third party who may be liable," § 1396k(a)(1). Finally, "any amount collected by the State under an assignment made" as described above "shall be retained by the State ... to reimburse it for [Medicaid] payments made on behalf of" the recipient. § 1396k(b). "[T]he remainder of such amount collected shall be paid" to the recipient. *Ibid.* Acting pursuant to its understanding of these provisions, Arkansas passed laws under which, when a state Medicaid recipient obtains a tort settlement following payment of medical costs on her behalf, a lien is automatically imposed on the settlement in an amount equal to Medicaid's costs. When that amount exceeds the portion of the settlement representing medical costs, satisfaction of the State's lien requires payment out of proceeds meant to compensate the recipient for damages distinct from medical costs, such as pain and suffering, lost wages, and loss of future earnings.

Following respondent Ahlborn's car accident with allegedly negligent third parties, petitioner Arkansas Department of Health and Human Services, then named Arkansas Department of Human Services (ADHS), determined that Ahlborn was eligible for Medicaid and paid providers $215,645.30 on her behalf. She filed a state-court suit against the alleged tortfeasors seeking damages for past medical costs and for ***269** other items including pain and suffering, loss of earnings and working time, and permanent impairment of her future earning ability. The case was settled out of court for $550,000, which was not allocated between categories of damages. ADHS did not participate or ask to participate in the settlement negotiations, and did not seek to reopen the judgment after the case was dismissed, but did intervene in the suit and assert a lien against the settlement proceeds for the full amount it had paid for Ahlborn's care. She filed this action in Federal District Court seeking a declaration that the State's lien violated federal law insofar as its satisfaction would require

depletion of compensation for her injuries other than past medical expenses. The parties stipulated, *inter alia,* that the settlement amounted to approximately one-sixth of the reasonable value of Ahlborn's claim and that, if her construction of federal law was correct, ADHS would be entitled to only the portion of the settlement ($35,581.47) that constituted reimbursement for medical payments made. In granting ADHS summary judgment, the court held that under Arkansas law, which it concluded did not conflict with federal law, Ahlborn had assigned ADHS her right to recover the full amount of Medicaid's payments for her benefit. The Eighth Circuit reversed, holding that ADHS was entitled only to that portion of the settlement that represented payments for medical care.

Held: Federal Medicaid law does not authorize ADHS to assert a lien on Ahlborn's settlement in an amount exceeding $35,581.47, and the federal anti-lien provision affirmatively prohibits it from doing so. Arkansas' third-party liability provisions are unenforceable insofar as they compel a different conclusion. Pp. 1760–1767.

****1755** (a) Arkansas' statute finds no support in the federal third-party liability provisions. That ADHS cannot claim more than the portion of Ahlborn's settlement that represents medical expenses is suggested by § 1396k(a)(1)(A), which requires that Medicaid recipients, as a condition of eligibility, "assign the State any rights ... *to payment for medical care* from any third party" (emphasis added), not their rights to payment for, *e.g.,* lost wages. The other statutory language ADHS relies on is not to the contrary, but reinforces the assignment provision's implicit limitation. First, statutory context shows that § 1396a(a)(25)(B)'s requirement that States "seek reimbursement for [medical] assistance *to the extent of such legal liability* " refers to "the legal liability of third parties ... *to pay for care and services available under the plan,*" § 1396a(a)(25)(A) (emphasis added). Here, because the tortfeasors accepted liability for only one-sixth of Ahlborn's overall damages, and ADHS has stipulated that only $35,581.47 of that sum represents compensation for medical expenses, the relevant "liability" extends no further ***270** than that amount. Second, § 1396a(a)(25)(H)'s requirement that the State enact laws giving it the right to recover from liable third parties "to the extent [it made] payment ... for medical assistance for health care items or services furnished to an individual" does not limit the State's recovery only by the amount it paid out on the recipient's behalf, since the rest of the provision makes clear that the State must be assigned "the rights of [the recipient] to payment by any other party *for such health care items or services*." (Emphasis added.) Finally, § 1396k(b)'s requirement that, where the State actively pursues recovery from the third party, Medicaid be reimbursed fully from "any amount collected by the State under an assignment" before "the remainder of such amount collected" is remitted to the recipient does not show that the State must be paid in full from any settlement. Rather, because the State's assigned rights extend only to recovery of medical payments, what § 1396k(b) requires is that the State be paid first out of any damages for medical care before the recipient can recover any of her own medical costs. Pp. 1760–1762.

(b) Arkansas' statute squarely conflicts with the federal Medicaid law's anti-lien provision, § 1396p(a)(1), which prohibits States from imposing liens "against the property of any individual prior to his death on account of medical assistance paid ... on his behalf under the State plan." Even if the State's lien is assumed to be consistent with federal law insofar as it encumbers proceeds designated as medical payments, the anti-lien provision precludes attachment or encumbrance of the remainder of the settlement. ADHS' attempt to avoid the anti-lien provision by characterizing the settlement proceeds as not Ahlborn's "property," but as the State's, fails for two reasons. First, because the settlement is not "received from a third party," as required by the state statute, until Ahlborn's chose in action has been reduced to proceeds in her possession, the assertion that any of the proceeds belonged to the State all along lacks merit. Second, the State's argument that Ahlborn lost her property rights in the proceeds the instant she applied for medical assistance is inconsistent with the creation of a statutory lien on those proceeds: ADHS would not need a lien on its own property. Pp. 1762–1764.

(c) The Court rejects as unpersuasive ADHS' and the United States' arguments that a rule permitting a lien on more than medical damages ought to apply here either because Ahlborn breached her duty to "cooperate" with ADHS or because there ****1756** is an inherent danger of manipulation in cases where the parties to a tort case settle without judicial oversight or input from the State. As § 1396k(a)(1)(C) demonstrates, the duty to cooperate arises principally, if not exclusively, in proceedings initiated *by the State* to recover from third parties. In any event, the ***271** aspersions cast upon Ahlborn are entirely unsupported; all the record reveals is that ADHS neither asked to be nor was involved in the settlement negotiations. Whatever the bounds of the duty

to cooperate, there is no evidence that it was breached here. Although more colorable, the alternative argument that a rule of full reimbursement is needed generally to avoid the risk of settlement manipulation also fails. The risk that parties to a tort suit will allocate away the State's interest can be avoided either by obtaining the State's advance agreement to an allocation or, if necessary, by submitting the matter to a court for decision. Pp. 1764–1765.

(d) Also rejected is ADHS' contention that the Eighth Circuit accorded insufficient weight to two decisions by the Departmental Appeals Board (Board) of the federal Department of Health and Human Services (HHS) rejecting appeals by two States from denial of reimbursement for costs they paid on behalf of Medicaid recipients who had settled tort claims. Although HHS generally has broad regulatory authority in the Medicaid area, the Court declines to treat the Board's reasoning in those cases as controlling because they address a different question from the one posed here, make no mention of the anti-lien provision, and rest on a questionable construction of the federal third-party liability provisions. Pp. 1765–1767.

397 F.3d 620, affirmed.

STEVENS, J., delivered the opinion for a unanimous Court.

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Opinion

Justice STEVENS delivered the opinion of the Court.

***272** When a Medicaid recipient in Arkansas obtains a tort settlement following payment of medical costs on her behalf by Medicaid, Arkansas law automatically imposes a lien on the settlement in an amount equal to Medicaid's costs. When that amount exceeds the portion of the settlement that represents medical costs, satisfaction of the State's lien requires payment out of proceeds meant to compensate the recipient for damages distinct from medical costs—like pain and suffering, lost wages, and loss of future earnings. The Court of Appeals for the Eighth Circuit held that this statutory lien contravened federal law and was therefore unenforceable. *Ahlborn v. Arkansas Dept. of Human Servs.,* 397 F.3d 620 (2005). Other courts have upheld similar lien provisions. See, *e.g., Houghton v. Department of Health,* 2002 UT 101, 57 P.3d 1067; ****1757** *Wilson v. Washington,* 142 Wash.2d 40, 10 P.3d 1061 (2000) (en banc). We granted certiorari to resolve the conflict, 545 U.S. 1165, 126 S.Ct. 35, 162 L.Ed.2d 933 (2005), and now affirm.

I

On January 2, 1996, respondent Heidi Ahlborn, then a 19–year–old college student and aspiring teacher, suffered severe ***273** and permanent injuries as a result of a car accident. She was left brain damaged, unable to complete her college education, and incapable of pursuing her chosen career. Although she possessed a claim of uncertain value against the alleged tortfeasors who caused her injuries, Ahlborn's liquid assets were insufficient to pay for her medical care. Petitioner Arkansas Department of Health and Human Services (ADHS)[1] accordingly determined that she was eligible for medical assistance and paid providers $215,645.30 on her behalf under the State's Medicaid plan.

ADHS required Ahlborn to complete a questionnaire about her accident, and sent her attorney periodic letters advising him about Medicaid outlays. These letters noted that, under Arkansas law, ADHS had a claim to reimbursement from "any settlement, judgment, or award" obtained by Ahlborn from "a third party who may be liable for" her injuries, and that no settlement "shall be satisfied without first giving [ADHS] notice and a reasonable opportunity to establish its interest."[2] ADHS has never asserted, however, that Ahlborn has a duty to reimburse it out of any other subsequently acquired assets or earnings.

On April 11, 1997, Ahlborn filed suit against two alleged tortfeasors in Arkansas state court seeking compensation for the injuries she sustained in the January 1996 car accident. She claimed damages not only for past medical costs, but also for permanent physical injury; future medical expenses; past and future pain, suffering, and mental anguish; past loss of earnings and working time; and permanent impairment of the ability to earn in the future.

ADHS was neither named as a party nor formally notified of the suit. Ahlborn's counsel did, however, keep ADHS informed of details concerning insurance coverage as they became known during the litigation.

***274** In February 1998, ADHS intervened in Ahlborn's lawsuit to assert a lien on the proceeds of any third-party recovery Ahlborn might obtain. In October 1998, ADHS asked Ahlborn's counsel to notify the agency if there was a hearing in the case. No hearing apparently occurred, and the case was settled out of court sometime in 2002 for a total of $550,000. The parties did not allocate the settlement between categories of damages. ADHS did not participate or ask to participate in settlement negotiations. Nor did it seek to reopen the judgment after the case had been dismissed. ADHS did, however, assert a lien against the settlement proceeds in the amount of $215,645.30—the total cost of payments made by ADHS for Ahlborn's care.

On September 30, 2002, Ahlborn filed this action in the United States District Court for the Eastern District of Arkansas seeking a declaration that the lien violated the federal Medicaid laws insofar as its satisfaction would require depletion of compensation for injuries other than past medical expenses. To facilitate the District Court's resolution of the legal questions presented, the parties stipulated that Ahlborn's entire claim was reasonably valued at $3,040,708.12; that the settlement amounted to approximately one-sixth of that sum; and that, if Ahlborn's construction ****1758** of federal law was correct, ADHS would be entitled to only the portion of the settlement ($35,581.47) that constituted reimbursement for medical payments made. See App. 17–20.

Ruling on cross-motions for summary judgment, the District Court held that under Arkansas law, which it concluded did not conflict with federal law, Ahlborn had assigned to ADHS her right to any recovery from the third-party tortfeasors to the full extent of Medicaid's payments for her benefit. Accordingly, ADHS was entitled to a lien in the amount of $215,645.30.

***275** The Eighth Circuit reversed. It held that ADHS was entitled only to that portion of the judgment that represented payments for medical care. For the reasons that follow, we affirm.

II

The crux of the parties' dispute lies in their competing constructions of the federal Medicaid laws. The Medicaid program, which provides joint federal and state funding of medical care for individuals who cannot afford to pay their own medical costs, was launched in 1965 with the enactment of Title XIX of the Social Security Act (SSA), as added, 79 Stat. 343, 42 U.S.C. § 1396 *et seq*. (2000 ed. and Supp. III). Its administration is entrusted to the Secretary of Health and Human Services (HHS), who in turn exercises his authority through the Centers for Medicare and Medicaid Services (CMS).[3]

States are not required to participate in Medicaid, but all of them do. The program is a cooperative one; the Federal Government pays between 50% and 83% of the costs the State incurs for patient care,[4] and, in return, the State pays its portion of the costs and complies with certain statutory requirements for making eligibility determinations, collecting and maintaining information, and administering the program. See § 1396a.

One such requirement is that the state agency in charge of Medicaid (here, ADHS) "take all reasonable measures to ascertain the legal liability of third parties ... to pay for care and services available under the plan." § 1396a(a)(25)(A) ***276** 2000 ed.).[5] The agency's obligation extends beyond mere identification, however;

> "in any case where such a legal liability is found to exist after medical assistance has been made available on behalf of the individual and where the amount of reimbursement the State can reasonably expect to recover exceeds the costs of such recovery, the State or local agency will seek reimbursement for such assistance to the extent of such legal liability." § 1396a(a)(25)(B).

To facilitate its reimbursement from liable third parties, the State must,

> "to the extent that payment has been made under the State plan for medical assistance in any case where a third party has a legal liability to make payment for such assistance, [have] in effect laws under which, to the extent that payment has been made under the State plan for medical assistance for health care items or services furnished to an individual, the State is considered to ****1759** have acquired the rights of such individual to payment by any other party for such health care items or services." § 1396a(a)(25)(H).

The obligation to enact assignment laws is reiterated in another provision of the SSA, which reads as follows:

> "(a) For the purpose of assisting in the collection of medical support payments and other payments for medical care owed to recipients of medical assistance under the State plan approved under this subchapter, a State plan for medical assistance shall—
>
> "(1) provide that, as a condition of eligibility for medical assistance under the State plan to an individual who ***277** has the legal capacity to execute an assignment for himself, the individual is required—
>
> "(A) to assign the State any rights ... to support (specified as support for the purpose of medical care by a court or administrative order) and to payment for medical care from any third party;
>
> "(B) to cooperate with the State ... in obtaining support and payments (described in subparagraph (A)) for himself ...; and
>
> "(C) to cooperate with the State in identifying, and providing information to assist the State in pursuing, any third party who may be liable to pay for care and services available under the plan ...." § 1396k(a).

Finally, "any amount collected by the State under an assignment made" as described above "shall be retained by the State as is necessary to reimburse it for medical assistance payments made on behalf of" the Medicaid recipient. § 1396k(b). "[T]he remainder of such amount collected shall be paid" to the recipient. *Ibid.*

Acting pursuant to its understanding of these third-party liability provisions, the State of Arkansas passed laws that purport to allow both ADHS and the Medicaid recipient, either independently or together, to recover "the cost of benefits" from third parties. Ark.Code Ann. §§ 20–77–301 through 20–77–309 (2001). Initially, "[a]s a condition of eligibility" for Medicaid, an applicant "shall automatically assign his or her right to any settlement, judgment, or award which may be obtained against any third party to [ADHS] to the full extent of any amount which may be paid by Medicaid for the benefit of the applicant." § 20–77–307(a). Accordingly, "[w]hen medical assistance benefits are provided" to the recipient "because of injury, disease, or disability for which

another person is liable," ADHS "shall have a right to recover from the person the cost of benefits so provided." § 20–77– ***278** 301(a).[6]278 ADHS' suit "shall" not, however, "be a bar to any action upon the claim or cause of action of the recipient." § 20–77–301(b). Indeed, the statute envisions that the recipient will sometimes sue together with ADHS, see § 20–77–303, or even alone. If the latter, the assignment described in § 20–77–307(a) "shall be considered a statutory lien on any settlement, judgment, or award received ... from a third party." § 20–77–307(c); see also § 20–77–302(a) ("When an action or claim is brought by a medical assistance recipient ..., any settlement, judgment, or award obtained is subject to the division's claim for reimbursement of ****1760** the benefits provided to the recipient under the medical assistance program").[7]

The State, through this statute, claims an entitlement to more than just that portion of a judgment or settlement that represents payment for medical expenses. It claims a right to recover the entirety of the costs it paid on the Medicaid recipient's behalf. Accordingly, if, for example, a recipient sues alone and settles her entire action against a third-party tortfeasor for $20,000, and ADHS has paid that amount or more to medical providers on her behalf, ADHS gets the whole settlement and the recipient is left with nothing. This is so even when the parties to the settlement allocate damages between medical costs, on the one hand, and other injuries like lost wages, on the other. The same rule also ***279** would apply, it seems, if the recovery were the result not of a settlement but of a jury verdict. In that case, under the Arkansas statute, ADHS could recover the full $20,000 in the face of a jury allocation of, say, only $10,000 for medical expenses.[8]

That this is what the Arkansas statute requires has been confirmed by the State's Supreme Court. In *Arkansas Dept. of Human Servs. v. Ferrel,* 336 Ark. 297, 984 S.W.2d 807 (1999), the court refused to endorse an equitable, nontextual interpretation of the statute. Rejecting a Medicaid recipient's argument that he ought to retain some of a settlement that was insufficient to cover both his and Medicaid's expenses, the court explained:

> "Given the clear, unambiguous language of the statute, it is apparent that the legislature intended that ADHS's ability to recoup Medicaid payments from third parties or recipients not be restricted by equitable subrogation principles such as the 'made whole' rule stated in [*Franklin v. Healthsource of Arkansas,* 328 Ark. 163, 942 S.W.2d 837 (1997)]. By creating an automatic legal assignment which expressly becomes a statutory lien, [Ark.Code Ann. § 20–77–307 (1991)] makes an unequivocal statement that the ADHS's ability to recover Medicaid payments from insurance settlements, if it so chooses, is superior to that of the recipient even when the settlement does not pay all the recipient's medical costs." *Id.,* at 308, 984 S.W.2d, at 811.

Accordingly, the Arkansas statute, if enforceable against Ahlborn, authorizes imposition of a lien on her settlement proceeds in the amount of $215,645.30. Ahlborn's argument before the District Court, the Eighth Circuit, and this Court ***280** has been that Arkansas law goes too far. We agree. Arkansas' statute finds no support in the federal third-party liability provisions, and in fact squarely conflicts with the anti-lien provision of the federal Medicaid laws.

III

We must decide whether ADHS can lay claim to more than the portion of Ahlborn's settlement that represents medical expenses.[9] The text of the federal ****1761** third-party liability provisions suggests not; it focuses on recovery of payments for medical care. Medicaid recipients must, as a condition of eligibility, "assign the State any rights ... *to payment for medical care* from any third party," 42 U.S.C. § 1396k(a)(1)(A) (emphasis added), not rights to payment for, for example, lost wages. The other statutory language that ADHS relies upon is not to the contrary; indeed, it reinforces the limitation implicit in the assignment provision.

First, ADHS points to § 1396a(a)(25)(B)'s requirement that States "seek reimbursement for [medical] assistance *to the extent of such legal liability* " (emphasis added) and suggests that this means that the entirety of a

recipient's settlement is fair game. In fact, as is evident from the context of the emphasized language, "such legal liability" refers to "the legal liability of third parties ... *to pay for care and services available under the plan*." § 1396a(a)(25)(A) (emphasis added). Here, the tortfeasor has accepted liability for only one-sixth of the recipient's overall damages, and ADHS has stipulated that only $35,581.47 of that sum represents compensation for medical expenses. Under the circumstances, ***281** the relevant "liability" extends no further than that amount.[10]

Second, ADHS argues that the language of § 1396a(a)(25)(H) favors its view that it can demand full reimbursement of its costs from Ahlborn's settlement. That provision, which echoes the requirement of a mandatory assignment of rights in § 1396k(a), says that the State must have in effect laws that, "to the extent that payment has been made under the State plan for medical assistance for health care items or services furnished to an individual," give the State the right to recover from liable third parties. This must mean, says ADHS, that the agency's recovery is limited only by the amount it paid out on the recipient's behalf—and not by the third-party tortfeasor's particular liability for medical expenses. But that reading ignores the rest of the provision, which makes clear that the State must be assigned "the rights of [the recipient] to payment by any other party *for such health care items or services*." § 1396a(a)(25)(H) (emphasis added). Again, the statute does not sanction an assignment of rights to payment for anything other than medical expenses—not lost wages, not pain and suffering, not an inheritance.

Finally, ADHS points to the provision requiring that, where the State actively pursues recovery from the third party, Medicaid be reimbursed fully from "any amount collected by the State under an assignment" before "the remainder of such amount collected" is remitted to the recipient. § 1396k(b). In ADHS' view, this shows that the State must be paid in full from any settlement. See Brief for Petitioners 13. But, even assuming the provision applies in cases where the State does not actively participate in the litigation, ADHS' conclusion rests on a false premise: The ***282** "amount recovered ... under an assignment" is not, as ADHS assumes, the entire settlement; as explained above, under the federal statute the State's assigned rights extend only to recovery of payments ****1762** for medical care. Accordingly, what § 1396k(b) requires is that the State be paid first out of any damages representing payments for medical care before the recipient can recover any of her own costs for medical care.[11]

At the very least, then, the federal third-party liability provisions *require* an assignment of no more than the right to recover that portion of a settlement that represents payments for medical care.[12] They did not mandate the enactment of the Arkansas scheme that we have described.

***283** IV

If there were no other relevant provisions in the federal statute, the State might plausibly argue that federal law supplied a recovery "floor" upon which States were free to build. In fact, though, the federal statute places express limits on the State's powers to pursue recovery of funds it paid on the recipient's behalf. These limitations are contained in 42 U.S.C. §§ 1396a(a)(18) and 1396p. Section 1396a(a)(18) requires that a state Medicaid plan comply with § 1396p, which in turn prohibits States (except in circumstances not relevant here) from placing liens against, or seeking recovery of benefits paid from, a Medicaid recipient:

> "(a) Imposition of lien against property of an individual on account of medical assistance rendered to him under a State plan
>
> "(1) No lien may be imposed against the property of any individual prior to his death on account of medical assistance paid or to be paid on his behalf under the State plan, except—
>
> "(A) pursuant to the judgment of a court on account of benefits incorrectly paid on behalf of such individual,

or

"(B) [in certain circumstances not relevant here]

. . . . .

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

****1763** "(1) No adjustment or recovery of any medical assistance correctly paid on behalf of an individual under the ***284** State plan may be made, except [in circumstances not relevant here]." § 1396p.

Read literally and in isolation, the anti-lien prohibition contained in § 1396p(a) would appear to ban even a lien on that portion of the settlement proceeds that represents payments for medical care.[13] Ahlborn does not ask us to go so far, though; she assumes that the State's lien is consistent with federal law insofar as it encumbers proceeds designated as payments for medical care. Her argument, rather, is that the anti-lien provision precludes attachment or encumbrance of the remainder of the settlement.

We agree. There is no question that the State can require an assignment of the right, or chose in action, to receive payments for medical care. So much is expressly provided for by §§ 1396a(a)(25) and 1396k(a). And we assume, as do the parties, that the State can also demand as a condition of Medicaid eligibility that the recipient "assign" in advance any payments that may constitute reimbursement for medical costs. To the extent that the forced assignment is expressly authorized by the terms of §§ 1396a(a)(25) and 1396k(a), it is an exception to the anti-lien provision. See *Washington State Dept. of Social and Health Servs. v. Guardianship Estate of Keffeler,* 537 U.S. 371, 383–385, and n. 7, 123 S.Ct. 1017, 154 L.Ed.2d 972 (2003). But that does not mean that the State can force an assignment of, or place a lien on, any other portion of Ahlborn's property. As explained above, the exception carved out by ***285** §§ 1396a(a)(25) and 1396k(a) is limited to payments for medical care. Beyond that, the anti-lien provision applies.

ADHS tries to avoid the anti-lien provision by characterizing the settlement proceeds as not Ahlborn's "property."[14] Its argument appears to be that the automatic assignment effected by the Arkansas statute rendered the proceeds the property of the State.[15] See Brief for Petitioners 31 ("[U]nder Arkansas law, the lien does not attach to the recipient's 'property' because it attaches only to those proceeds already assigned to the Department as a condition of Medicaid eligibility"). That argument fails for two reasons. First, ADHS insists that Ahlborn at all times until judgment retained her entire chose in action—a right that included her claim for medical damages. The statutory lien, then, cannot have attached until the proceeds materialized. That much is clear ****1764** from the text of the Arkansas statute, which says that the "assignment shall be considered a statutory lien on any settlement ... *received by the recipient from a third party*." Ark.Code Ann. § 20–77–307(c) (2001) (emphasis added). The settlement is not "received" until the chose in action has been reduced to proceeds in Ahlborn's possession. Accordingly, the assertion that any of the proceeds belonged to the State all along lacks merit.

Second, the State's argument that Ahlborn lost her property rights in the proceeds the instant she applied for medical assistance is inconsistent with the creation of a statutory ***286** lien on those proceeds. Why, after all, would ADHS need a lien on its own property? A lien typically is imposed on the property of *another* for payment of a debt owed by that other. See Black's Law Dictionary 922 (6th ed.1990). Nothing in the Arkansas statute defines the term otherwise.

That the lien is also called an "assignment" does not alter the analysis. The terms that Arkansas employs to describe the mechanism by which it lays claim to the settlement proceeds do not, by themselves, tell us whether the statute violates the anti-lien provision. See *United States v. Craft,* 535 U.S. 274, 279, 122 S.Ct. 1414, 152 L.Ed.2d 437 (2002); *Drye v. United States,* 528 U.S. 49, 58–61, 120 S.Ct. 474, 145 L.Ed.2d 466 (1999). Although denominated an "assignment," the effect of the statute here was not to divest Ahlborn of all her property interest; instead, Ahlborn retained the right to sue for medical care payments, and the State asserted a

right to the fruits of that suit once they materialized. In effect, and as at least some of the statutory language recognizes, Arkansas has imposed a lien on Ahlborn's property.[16] Since none of the federal third-party liability provisions excepts that lien from operation of the anti-lien provision, its imposition violates federal law.

***287** V

ADHS and its *amici* urge, however, that even if a lien on more than medical damages would violate federal law in some cases, a rule permitting such a lien ought to apply here either because Ahlborn breached her duty to "cooperate" with ADHS or because there is an inherent danger of manipulation in cases where the parties to a tort case settle without judicial oversight or input from the State. Neither argument is persuasive.

The United States proposes a default rule of full reimbursement whenever the recipient breaches her duty to "cooperate," and asserts that Ahlborn in fact breached that duty.[17] But, even if the Government's ****1765** allegations of obstruction were supported by the record, its conception of the duty to cooperate strays far beyond the text of the statute and the relevant regulations. The duty to cooperate arises principally, if not exclusively, in proceedings initiated *by the State* to recover from third parties. See 42 U.S.C. § 1396k(a)(1)(C) (recipients must "cooperate with the State in identifying ... and providing information to assist the State in pursuing" third parties). Most of the accompanying federal regulations simply echo this basic duty; all they add is that the recipient must "[p]ay to the agency any support or medical care funds received that are covered by the assignment of rights." 42 CFR § 433.147(b)(4) (2005).

In any event, the aspersions the United States casts upon Ahlborn are entirely unsupported; all the record reveals is that ADHS, despite having intervened in the lawsuit and ***288** asked to be apprised of any hearings, neither asked to be nor was involved in the settlement negotiations. Whatever the bounds of the duty to cooperate, there is no evidence that it was breached here.

ADHS' and the United States' alternative argument that a rule of full reimbursement is needed generally to avoid the risk of settlement manipulation is more colorable, but ultimately also unpersuasive. The issue is not, of course, squarely presented here; ADHS has stipulated that only $35,581.47 of Ahlborn's settlement proceeds properly are designated as payments for medical costs. Even in the absence of such a postsettlement agreement, though, the risk that parties to a tort suit will allocate away the State's interest can be avoided either by obtaining the State's advance agreement to an allocation or, if necessary, by submitting the matter to a court for decision.[18] For just as there are risks in underestimating the value of readily calculable damages in settlement negotiations, so also is there a countervailing concern that a rule of absolute priority might preclude settlement in a large number of cases, and be unfair to the recipient in others.[19]

***289** VI

Finally, ADHS contends that the Court of Appeals' decision below accords insufficient weight to two decisions by the Departmental Appeals Board of HHS (Board) rejecting appeals by the States of California and Washington from denial of reimbursement for costs those States paid on ****1766** behalf of Medicaid recipients who had settled tort claims. See App. to Pet. for Cert. 45–67 (reproducing *In re Washington State Dept. of Social & Health Servs.,* Dec. No. 1561, 1996 WL 157123 (HHS Dept.App. Bd., Feb. 7, 1996)); App. to Pet. for Cert. 68–86 (reproducing *In re California Dept. of Health Servs.,* Dec. No. 1504, 1995 WL 66334 (HHS Dept.App. Bd., Jan. 5, 1995)). Because the opinions in those cases address a different question from the one posed here, make no mention of the anti-lien provision, and, in any event, rest on a questionable construction of

the federal third-party liability provisions, we conclude that they do not control our analysis.

Normally, if a State recovers from a third party the cost of Medicaid benefits paid on behalf of a recipient, the Federal Government owes the State no reimbursement, and any funds already paid by the Federal Government must be returned. See 42 CFR § 433.140(a)(2) (2005) (federal financial participation "is not available in Medicaid payments if ... [t]he agency received reimbursement from a liable third party"); § 433.140(c). Washington and California both had adopted schemes according to which the State refrained from claiming full reimbursement from tort settlements and instead took only a portion of each settlement. (In California, the recipient typically could keep at least 50% of her settlement, see App. to Pet. for Cert. 72; in Washington, the proportion varied from case to case, see *id.,* at 48–51.) Each scheme resulted in the State's having to pay a portion of the recipient's medical costs—a portion for which the State sought partial reimbursement from the Federal Government. CMS (then called HCFA) denied this partial reimbursement ***290** on the ground that the States had an absolute duty to seek full payment of medical expenses from third-party tortfeasors.

The Board upheld CMS' determinations. In California's appeal, which came first, the Board concluded that the State's duty to seek recovery of benefits "from available third party sources to the fullest extent possible" included demanding full reimbursement from the entire proceeds of a Medicaid recipient's tort settlement. *Id.,* at 76. The Board acknowledged that § 1396k(a) "refers to assignment only of 'payment for medical care,' " but thought that "the statutory scheme as a whole contemplates that the actual recovery might be greater and, if it is, that Medicaid should be paid first." *Ibid.* The Board gave two other reasons for siding with CMS: First, the legislative history of the third-party liability evinced a congressional intent that "the Medicaid program ... be reimbursed from available third party sources to the fullest extent possible," *ibid.;* and, second, California had long been on notice that it would not be reimbursed for any shortfall resulting from failure to fully recoup Medicaid's costs from tort settlements, see *id.,* at 77. The Board also opined that the State could not escape its duty to seek full reimbursement by relying on the Medicaid recipient's efforts in litigating her claims. See *id.,* at 79–80.

Finally, responding to the State's argument that its scheme gave Medicaid recipients incentives to sue third-party tortfeasors and thus resulted in both greater recovery and lower costs for the State, the Board observed that "a state is free to allow recipients to retain the state's share" of any recovery, so long as it does not compromise the Federal Government's share. *Id.,* at 85.

The Board reached the same conclusion, by the same means, in the Washington case. See *id.,* at 53–64.

Neither of these adjudications compels us to conclude that Arkansas' statutory ****1767** lien comports with federal law. First, the Board's rulings address a different question from the one ***291** presented here. The Board was concerned with the Federal Government's obligation to reimburse States that had, in its view, failed to seek full recovery of Medicaid's costs and had instead relied on recipients to act as private attorneys general. The Board neither discussed nor even so much as cited the federal anti-lien provision.

Second, the Board's acknowledgment that the assignment of rights required by § 1396k(a) is limited to payments for medical care only reinforces the clarity of the statutory language. Moreover, its resort to "the statutory scheme as a whole" as justification for muddying that clarity is nowhere explained. Given that the only statutory provisions CMS relied on are §§ 1396a(a)(25), 1396k(a), and 1396k(b), see *id.,* at 75–76; *id.,* at 54–55, and given the Board's concession that the first two of these limit the State's assignment to payments for medical care, the "statutory scheme" must mean § 1396k(b). But that provision does not authorize the State to demand reimbursement from portions of the settlement allocated or allocable to nonmedical damages; instead, it gives the State a priority disbursement from the medical expenses portion alone. See *supra,* at 1762. In fact, in its adjudication in the Washington case, the Board conceded as much: "[CMS] may require a state to assert a collection priority over funds obtained by Medicaid recipients in [third-party liability] suits *even though the distribution methodology set forth in section [1396k(b)] refers only to payments collected pursuant to assignments for medical care*." App. to Pet. for Cert. 54 (emphasis added). The Board's reasoning therefore is internally inconsistent.

Third, the Board's reliance on legislative history is misplaced. The Board properly observed that Congress, in crafting the Medicaid legislation, intended that Medicaid be a "payer of last resort." S.Rep. No. 99–146, p. 313 (1985). That does not mean, however, that Congress meant to authorize States to seek reimbursement from Medicaid recipients themselves; in fact, with the possible exception of a lien ***292** on payments for medical care, the statute expressly prohibits liens against the property of Medicaid beneficiaries. See 42 U.S.C. § 1396p(a). We recognize that Congress has delegated "broad regulatory authority to the Secretary [of HHS] in the Medicaid area," *Wisconsin Dept. of Health and Family Servs. v. Blumer,* 534 U.S. 473, 496, n. 13, 122 S.Ct. 962, 151 L.Ed.2d 935 (2002), and that agency adjudications typically warrant deference. Here, however, the Board's reasoning couples internal inconsistency with a conscious disregard for the statutory text. Under these circumstances, we decline to treat the agency's reasoning as controlling.

VII

Federal Medicaid law does not authorize ADHS to assert a lien on Ahlborn's settlement in an amount exceeding $35,581.47, and the federal anti-lien provision affirmatively prohibits it from doing so. Arkansas' third-party liability provisions are unenforceable insofar as they compel a different conclusion. The judgment of the Court of Appeals is affirmed.

It is so ordered.

All Citations

547 U.S. 268, 126 S.Ct. 1752, 164 L.Ed.2d 459, 74 USLW 4214, Med & Med GD (CCH) P 301,841, 06 Cal. Daily Op. Serv. 3597, 2006 Daily Journal D.A.R. 5159, 19 Fla. L. Weekly Fed. S 169

Footnotes

* The syllabus constitutes no part of the opinion of the Court but has been prepared by the Reporter of Decisions for the convenience of the reader. See *United States v. Detroit Timber & Lumber Co.,* 200 U.S. 321, 337, 26 S.Ct. 282, 50 L.Ed. 499.

1 ADHS was then named Arkansas Department of Human Services.

2 Affidavit of Wayne E. Olive, Exhs. 5 and 6 (Mar. 6, 2003).

3 Until 2001, CMS was known as the Health Care Financing Administration or HCFA. See 66 Fed.Reg. 35437.

4 The exact percentage of the federal contribution is calculated pursuant to a formula keyed to each State's per capita income. See 42 U.S.C. § 1396d(b).

5 A "third party" is defined by regulation as "any individual, entity or program that is or may be liable to pay all or

part of the expenditures for medical assistance furnished under a State plan." 42 CFR § 433.136 (2005).

6 Under the Arkansas statute, ADHS' right to recover medical costs appears to be broader than that of the recipient. When ADHS sues, "no contributory or comparative fault of a recipient shall be attributed to the state, nor shall any restitution awarded to the state be denied or reduced by any amount or percentage of fault attributed to a recipient." § 20–77–301(d)(1) (2001).

7 The Arkansas Supreme Court has held that ADHS has an independent, nonderivative right to recover the cost of benefits from a third-party tortfeasor under § 20–77–301 even when the Medicaid recipient also sues for recovery of medical expenses. See *National Bank of Commerce v. Quirk,* 323 Ark. 769, 792–794, 918 S.W.2d 138, 151–152 (1996).

8 ADHS denies that it would actually demand the full $20,000 in such a case, see Brief for Petitioners 49, n. 13, but points to no provision of the Arkansas statute that would prevent it from doing so.

9 The parties here assume, as do we, that a State can fulfill its obligations under the federal third-party liability provisions by requiring an "assignment" of part of, or placing a lien on, the settlement that a Medicaid recipient procures on her own. Cf. §§ 1396k(a)(1)(B)–(C) (the recipient has a duty to identify liable third parties and to "provid[e] information to *assist the State in pursuing* " those parties (emphasis added)).

10 The effect of the stipulation is the same as if a trial judge had found that Ahlborn's damages amounted to $3,040,708.12 (of which $215,645.30 were for medical expenses), but because of her contributory negligence, she could only recover one-sixth of those damages.

11 Implicit in ADHS' interpretation of this provision is the assumption that there can be no "remainder" to remit to the Medicaid recipient if all the State has been assigned is the right to damages for medical expenses. That view in turn seems to rest on an assumption either that Medicaid will have paid all the recipient's medical expenses or that Medicaid's expenses will always exceed the portion of any third-party recovery earmarked for medical expenses. Neither assumption holds up. First, as both the Solicitor General and CMS acknowledge, the recipient often will have paid medical expenses out of her own pocket. See Brief for United States as *Amicus Curiae* 12 (under § 1396k(b), "the beneficiary retains the right to payment for any additional medical expenses personally incurred either before or subsequent to Medicaid eligibility and for other damages"); CMS, State Medicaid Manual § 3907, available at https://www. lexis.com>Legal>Secondary Legal>CCH>Health Law>CMS Program Manuals>CCH CMS Program Manuals P 3907 (as updated Mar. 25, 2006, and available in Clerk of Court's case file) (envisioning that "medical insurance payments," for example, will be remitted to the recipient if possible). Second, even if Medicaid's outlays often exceed the portion of the recovery earmarked for medical expenses in tort cases, the third-party liability provisions were not drafted exclusively with tort settlements in mind. In the case of health insurance, for example, the funds available under the policy may be enough to cover both Medicaid's costs and the recipient's own medical expenses.

12 ADHS concedes that, had a jury or judge allocated a sum for medical payments out of a larger award in this case, the agency would be entitled to reimburse itself only from the portion so allocated. See Brief for Petitioners 49, n. 13; see also Brief for United States as *Amicus Curiae* 22, n. 14 (noting that the Secretary of HHS "ordinarily accepts" a jury allocation of medical damages in satisfaction of the Medicaid debt, even where smaller than the amount of Medicaid's expenses). Given the stipulation between ADHS and Ahlborn, there is no textual basis for treating the settlement here differently from a judge-allocated settlement or even a jury award; all such awards typically establish

a third party's "liability" for both "payment for medical care" and other heads of damages.

13 Likewise, subsection (b) would appear to forestall any attempt by the State to recover benefits paid, at least from the "individual." See, *e.g., Martin ex rel. Hoff v. Rochester,* 642 N.W.2d 1, 8, n. 6 (Minn.2002); *Wallace v. Estate of Jackson,* 972 P.2d 446, 450 (Utah 1998) (Durham, J., dissenting) (reading § 1396p to "prohibi[t] not only liens against Medicaid recipients but also any recovery for medical assistance correctly paid"). The parties here, however, neither cite nor discuss the antirecovery provision of § 1396p(b). Accordingly, we leave for another day the question of its impact on the analysis.

14 "Property" is defined by regulation as "the homestead and all other personal and real property in which the recipient has a legal interest." 42 CFR § 433.36(b) (2005).

15 The United States as *amicus curiae* makes the different argument that the proceeds never became Ahlborn's "property" because "to the extent the third party's payment passes through the recipient's hands en route to the State, it comes with the State's lien already attached." Brief as *Amicus Curiae* 18. Even if that reading were consistent with the Arkansas statute (and it is not, see *infra,* at 1764), the United States' characterization of the "assignment" simply reinforces Ahlborn's point: This is a lien that attaches *to the property of the recipient*.

16 Because ADHS insists that "Arkansas law did *not* require Ahlborn to assign her claim or her right to sue," Brief for Petitioners 33 (emphasis in original), we need not reach the question whether a State may force a recipient to assign a chose in action to receive as much of the settlement as is necessary to pay Medicaid's costs. The Eighth Circuit thought this would be impermissible because the State cannot "circumvent the restrictions of the federal anti-lien statute simply by requiring an applicant for Medicaid benefits to assign property rights to the State before the applicant liquidates the property to a sum certain." App. to Pet. for Cert. 6. Indeed, ADHS acknowledges that Arkansas cannot, for example, require a Medicaid applicant to assign in advance any right she may have to recover an inheritance or an award in a civil case not related to her injuries or medical care. This arguably is no different; as with assignment of those other choses in action, assignment of the right to compensation for lost wages and other nonmedical damages is nowhere authorized by the federal third-party liability provisions.

17 See, *e.g.,* Brief for United States as *Amicus Curiae* 14 (alleging that Ahlborn "omitt[ed] or understat[ed] the medical damages claim from her lawsuit and attempt[ed] to horde for herself the third-party liability payments"); *id.,* at 15 ("[H]aving forsaken her federal and state statutory duties of candid and forthcoming cooperation[,] respondent, rather than the taxpayers, must bear the financial consequences of her actions"); *id.,* at 21, 24 (referring to Ahlborn's "backdoor settlement" and "obstruction and attrition," as well as her "calculated evasion of her legal obligations").

18 As one *amicus* observes, some States have adopted special rules and procedures for allocating tort settlements in circumstances where, for example, private insurers' rights to recovery are at issue. See Brief for Association of Trial Lawyers of America 20–21. Although we express no view on the matter, we leave open the possibility that such rules and procedures might be employed to meet concerns about settlement manipulation.

19 The point is illustrated by state cases involving the recovery of workers' compensation benefits paid to an employee (or the family of an employee) whose injuries were caused by a third-party tortfeasor. In *Flanigan v. Department of Labor and Industries,* 123 Wash.2d 418, 869 P.2d 14 (1994), for example, the court concluded that the state agency could not satisfy its lien out of damages the injured worker's spouse recovered as compensation for loss of consortium. The court explained that the department could not "share in damages for which it has provided no compensation" because such a result would be "absurd and fundamentally unjust." *Id.,* at 426, 869 P.2d, at 17.

 KeyCite Yellow Flag - Negative Treatment
Declined to Extend by Farah v. Department of Medical Assistance Services, Va., February 17, 2022

133 S.Ct. 1391
Supreme Court of the United States

Aldona WOS, Secretary, North Carolina Department of Health and Human Services, Petitioner
v.
E.M.A., a minor, by and through her guardian ad litem, Daniel H. JOHNSON, et al.

No. 12–98
|
Argued Jan. 8, 2013.
|
Decided March 20, 2013.

Synopsis
Background: Guardian at litem for minor child, who had been a recipient of Medicaid benefits and who had received an award from settlement of medical malpractice suit, brought § 1983 action against North Carolina Department of Health and Human Services, which had placed Medicaid lien on settlement proceeds, seeking declaratory and injunctive relief for deprivation of child's rights under federal Medicaid anti-lien provision. The United States District Court for the Western District of North Carolina, Richard L. Voorhees, J., 722 F.Supp.2d 653, granted summary judgment in favor of State. Guardian appealed. The United States Court of Appeals for the Fourth Circuit, Davis, Circuit Judge, 674 F.3d 290, vacated and remanded. Certiorari was granted.

The Supreme Court, Justice Kennedy, held that North Carolina statute governing the State's reimbursement from the proceeds of tort damages recovered by a Medicaid beneficiary is preempted by the federal Medicaid anti-lien provision, to the extent that the North Carolina statute can be interpreted as creating a conclusive presumption that one-third of a Medicaid beneficiary's tort recovery represents compensation for medical expenses, abrogating *Andrews v. Haygood*, 362 N.C. 599, 669 S.E.2d 310.

Court of Appeals affirmed.

Justice Breyer filed a concurring opinion.

Chief Justice Roberts filed a dissenting opinion, in which Justice Scalia and Justice Thomas joined.

West Codenotes

Recognized as Preempted
West's Ann.Cal.Penal Code § 599f(b)

Limited on Preemption Grounds
West's N.C.G.S.A. § 108A–57

****1392** *Syllabus*[*]

The federal Medicaid statute's anti-lien provision, 42 U.S.C. § 1396p(a)(1), pre-empts a State's effort to take any portion of a Medicaid beneficiary's tort judgment or settlement not "designated as payments for medical care," ****1393** *Arkansas Dept. of Health and Human Servs. v. Ahlborn,* 547 U.S. 268, 284, 126 S.Ct. 1752, 164 L.Ed.2d 459. A North Carolina statute requires that up to one-third of any damages recovered by a beneficiary for a tortious injury be paid to the State to reimburse it for payments it made for medical treatment on account of the injury.

Respondent E.M.A. was born with multiple serious birth injuries that require her to receive between 12 and 18 hours of skilled nursing care per day and that will prevent her from being able to work, live independently, or provide for her basic needs. North Carolina's Medicaid program pays part of the cost of her ongoing medical care. E.M.A. and her parents filed a medical malpractice suit against the physician who delivered her and the hospital where she was born. They presented expert testimony estimating their damages to exceed $42 million, but they ultimately settled for $2.8 million, due in large part to insurance policy limits. The settlement did not allocate money among their various medical and nonmedical claims. In approving the settlement, the state court placed one-third of the recovery into escrow pending a judicial determination of the amount of the lien owed by E.M.A. to the State. E.M.A. and her parents then sought declaratory and injunctive relief in Federal District Court, claiming that the State's reimbursement scheme violated the Medicaid anti-lien provision. While that litigation was pending, the North Carolina Supreme Court held in another case that the irrebuttable statutory one-third presumption was a reasonable method for determining the amount due the State for medical expenses. The Federal District Court, in the instant case, agreed. But the Fourth Circuit vacated and remanded, concluding that the State's statutory scheme could not be reconciled with *Ahlborn.*

Held: The federal anti-lien provision pre-empts North Carolina's irrebuttable statutory presumption that one-third of a tort recovery is attributable to medical expenses. Pp. 1396 – 1402.

(a) In *Ahlborn,* the Court held that the federal Medicaid statute sets both a floor and a ceiling on a State's potential share of a beneficiary's tort recovery. Federal law requires an assignment to the State of "the right to recover that portion of a settlement that represents payments for medical care," but also "precludes attachment or encumbrance of the remainder of the settlement." 547 U.S., at 282, 284, 126 S.Ct. 1752. *Ahlborn* did not, however, resolve the question of how to determine what portion of a settlement represents payment for medical care. As North Carolina construes its statute, when the State's Medicaid expenditures exceed one-third of a beneficiary's tort recovery, the statute establishes a conclusive presumption that one-third of the recovery represents compensation for medical expenses, even if the settlement or verdict expressly allocates a lower percentage of the judgment to medical expenses. Pp. 1396 – 1398.

(b) North Carolina's law is pre-empted insofar as it would permit the State to take a portion of a Medicaid beneficiary's tort judgment or settlement not designated for medical care. It directly conflicts with the federal Medicaid statute and therefore "must give way." *PLIVA, Inc. v. Mensing,* 564 U.S. ——, ——, 131 S.Ct. 2567, 180 L.Ed.2d 580. The state law has no process for determining what portion of a beneficiary's tort recovery is attributable to medical expenses. Instead, the State has picked an arbitrary percentage and by statutory command labeled that portion of a beneficiary's tort recovery as representing payment for medical care. A State may not evade pre-emption through creative statutory interpretation or description, "framing" its law in a way that is at odds ****1394** with the statute's intended operation and effect. *National Meat Assn. v. Harris,* 565 U.S. ——, ——, 132 S.Ct. 965, 181 L.Ed.2d 950. North Carolina's argument, if accepted, would frustrate the Medicaid anti-lien provision in the context of tort recoveries. It lacks any limiting principle: If a State could

arbitrarily designate one-third of any recovery as payment for medical expenses, it could arbitrarily designate half or all of the recovery in the same way. The State offers no evidence showing that its allocation is reasonable in the mine run of cases, and the law provides no mechanism for determining whether its allocation is reasonable in any particular case.

No estimate of an allocation will be necessary where there has been a judicial finding or approval of an allocation between medical and nonmedical damages. In some cases, including *Ahlborn,* this binding stipulation or judgment will attribute to medical expenses less than one-third of the settlement. Yet even in these circumstances, North Carolina's statute would permit the State to take one-third of the total recovery. A conflict thus exists between North Carolina's law and the Medicaid anti-lien provision.

This case is not as clear-cut as *Ahlborn* was, for here there was no such stipulation or judgment. But *Ahlborn* 's reasoning and the federal statute's design contemplate that possibility: They envisioned that a judicial or administrative proceeding would be necessary where a beneficiary and the State are unable to agree on what portion of a settlement represents compensation for medical expenses. See 547 U.S., at 288, 126 S.Ct. 1752. North Carolina's irrebuttable, one-size-fits-all statutory presumption is incompatible with the Medicaid Act's clear mandate that a State may not demand any portion of a beneficiary's tort recovery except the share that is attributable to medical expenses. Pp. 1398 – 1399.

(c) None of North Carolina's responses to this reasoning is persuasive. Pp. 1399 – 1402.

674 F.3d 290, affirmed.

KENNEDY, J., delivered the opinion of the Court, in which GINSBURG, BREYER, ALITO, SOTOMAYOR, and KAGAN, JJ., joined. BREYER, J., filed a concurring opinion. ROBERTS, C.J., filed a dissenting opinion, in which SCALIA and THOMAS, JJ., joined.

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Opinion

Justice KENNEDY delivered the opinion of the Court.

***630** A federal statute prohibits States from attaching a lien on the property of a Medicaid beneficiary to recover benefits paid ****1395** by the State on the beneficiary's behalf. 42 U.S.C. § 1396p(a)(1). The anti-lien provision pre-empts a State's effort to take any portion of a Medicaid beneficiary's tort judgment or settlement not "designated as payments for medical care." *Arkansas Dept. of Health and Human Servs. v. Ahlborn,* 547 U.S. 268, 284, 126 S.Ct. 1752, 164 L.Ed.2d 459 (2006). North Carolina has enacted a statute requiring that up

to one-third of any damages recovered by a beneficiary for a tortious injury be paid to the State to reimburse it for payments it made for medical treatment on account of the injury. See N.C. Gen.Stat. Ann. § 108A–57 (Lexis 2011); *Andrews v. Haygood,* 362 N.C. 599, 604–605, 669 S.E.2d 310, 314 (2008). The question presented is whether the North Carolina statute is compatible with the federal anti-lien provision.

I

When respondent E.M.A. was born in February 2000, she suffered multiple serious birth injuries which left her deaf, blind, and unable to sit, walk, crawl, or talk. The injuries also cause her to suffer from mental retardation and a seizure disorder. She requires between 12 and 18 hours of skilled nursing care per day. She will not be able to work, live independently, or provide for her basic needs. The cost ***631** of her ongoing medical care is paid in part by the State of North Carolina's Medicaid program.

In February 2003, E.M.A. and her parents filed a medical malpractice suit in North Carolina state court against the physician who delivered E.M.A. at birth and the hospital where she was born. The expert witnesses for E.M.A. and her parents in that proceeding estimated damages in excess of $42 million for medical and life-care expenses, loss of future earning capacity, and other assorted expenses such as architectural renovations to their home and specialized transportation equipment. App. 91–112. By far the largest part of this estimate was for "Skilled Home Care," totaling more than $37 million over E.M.A.'s lifetime. *Id.,* at 112. E.M.A. and her parents also sought damages for her pain and suffering and for her parents' emotional distress. *Id.,* at 64–65, 67–68, 72–73, 75–76. Their experts did not estimate the damages in these last two categories.

Assisted by a mediator, the parties began settlement negotiations. E.M.A. and her parents informed the North Carolina Department of Health and Human Services of the negotiations. The department had a statutory right to intervene in the malpractice suit and participate in the settlement negotiations in order to obtain reimbursement for the medical expenses it paid on E.M.A.'s behalf, up to one-third of the total recovery. See N.C. Gen.Stat. Ann. §§ 108A–57, 108A–59. It elected not to do so, though its representative informed E.M.A. and her parents that the State's Medicaid program had expended $1.9 million for E.M.A.'s medical care, which it would seek to recover from any tort judgment or settlement.

In November 2006, the court approved a $2.8 million settlement. The amount, apparently, was dictated in large part by the policy limits on the defendants' medical malpractice insurance coverage. See Brief for Respondents 5. The settlement agreement did not allocate the money among the different claims E.M.A. and her parents had advanced. In ***632** approving the settlement the court placed one-third of the $2.8 million recovery into an interest-bearing escrow account "until such time as the actual amount of the lien owed by [E.M.A.] to [the State] is conclusively judicially determined." App. 87.

E.M.A. and her parents then filed this action under Rev. Stat. § 1979, ****1396** 42 U.S.C. § 1983, in the United States District Court for the Western District of North Carolina. They sought declaratory and injunctive relief, arguing that the State's reimbursement scheme violated the Medicaid anti-lien provision, § 1396p(a)(1). While that litigation was pending, the North Carolina Supreme Court confronted the same question in *Andrews, supra*. It held that the irrebuttable statutory presumption that one-third of a Medicaid beneficiary's tort recovery is attributable to medical expenses was "a reasonable method for determining the State's medical reimbursements." *Id.,* at 604, 669 S.E.2d, at 314. The United States District Court, in the instant case, agreed. *Armstrong v. Cansler,* 722 F.Supp.2d 653 (2010).

The Court of Appeals for the Fourth Circuit vacated and remanded. *E.M.A. v. Cansler,* 674 F.3d 290 (2012). It concluded that North Carolina's statutory scheme could not be reconciled with "*Ahlborn* 's clear holding that the general anti-lien provision in federal Medicaid law prohibits a state from recovering any portion of a settlement or judgment not attributable to medical expenses." *Id.,* at 310. In some cases, the court reasoned, the actual portion of a beneficiary's tort recovery representing payment for medical care would be less than one-third. North Carolina's statutory presumption that one-third of a tort recovery is attributable to medical

expenses therefore must be "subject to adversarial testing" in a judicial or administrative proceeding. *Id.,* at 311.

To resolve the conflict between the opinion of the Court of Appeals in this case and the decision of the North Carolina Supreme Court in *Andrews,* this Court granted certiorari. 567 U.S. ——, 133 S.Ct. 99, —— L.Ed.2d —— (2012).

II

***633** At issue is the interaction between certain provisions of the federal Medicaid statute and state law. Congress has directed States, in administering their Medicaid programs, to seek reimbursement for medical expenses incurred on behalf of beneficiaries who later recover from third-party tortfeasors. States must require beneficiaries "to assign the State any rights ... to support (specified as support for the purpose of medical care by a court or administrative order) and to payment for medical care from any third party." 42 U.S.C. § 1396k(a)(1)(A). States receiving Medicaid funds must also

> "ha[ve] in effect laws under which, to the extent that payment has been made under the State plan for medical assistance for health care items or services furnished to an individual, the State is considered to have acquired the rights of such individual to payment by any other party for such health care items or services." § 1396a(a)(25)(H).

A separate provision of the Medicaid statute, however, exists in some tension with these requirements. It says that, with exceptions not relevant here, "[n]o lien may be imposed against the property of any individual prior to his death on account of medical assistance paid or to be paid on his behalf under the State plan." § 1396p(a)(1).

In *Ahlborn,* the Court addressed this tension and held that the Medicaid statute sets both a floor and a ceiling on a State's potential share of a beneficiary's tort recovery. Federal law requires an assignment to the State of "the right to recover that portion of a settlement that represents payments for medical care," but it also "precludes attachment or encumbrance of the remainder of the settlement." 547 U.S., at 282, 284, 126 S.Ct. 1752. This is so because the beneficiary has a property right in the proceeds of the settlement, bringing it within the ambit of ****1397** the anti-lien provision. *Id.,* at 285, 126 S.Ct. 1752. ***634** That property right is subject to the specific statutory "exception" requiring a State to seek reimbursement for medical expenses paid on the beneficiary's behalf, but the anti-lien provision protects the beneficiary's interest in the remainder of the settlement. *Id.,* at 284, 126 S.Ct. 1752.

A question the Court had no occasion to resolve in *Ahlborn* is how to determine what portion of a settlement represents payment for medical care. The parties in that case stipulated that about 6 percent of respondent Ahlborn's tort recovery (approximately $35,600 of a $550,000 settlement) represented compensation for medical care. *Id.,* at 274, 126 S.Ct. 1752. The Court nonetheless anticipated the concern that some settlements would not include an itemized allocation. It also recognized the possibility that Medicaid beneficiaries and tortfeasors might collaborate to allocate an artificially low portion of a settlement to medical expenses. The Court noted that these problems could "be avoided either by obtaining the State's advance agreement to an allocation or, if necessary, by submitting the matter to a court for decision." *Id.,* at 288, 126 S.Ct. 1752.

North Carolina has attempted a different approach. Its statute provides:

> "Notwithstanding any other provisions of the law, to the extent of payments under this Part, the State, or the county providing medical assistance benefits, shall be subrogated to all rights of recovery, contractual or otherwise, of the beneficiary of this assistance.... The county attorney, or an attorney retained by the county or the State or both, or an attorney retained by the beneficiary of the assistance if this attorney has actual notice of payments made under this Part shall enforce this section. Any attorney retained by the beneficiary of the assistance shall, out of the proceeds obtained on behalf of the beneficiary by settlement with, judgment against, or otherwise from a third party by reason of injury or death, distribute to the Department the ***635**

> amount of assistance paid by the Department on behalf of or to the beneficiary, as prorated with the claims of all others having medical subrogation rights or medical liens against the amount received or recovered, but the amount paid to the Department shall not exceed one-third of the gross amount obtained or recovered." N.C. Gen.Stat. Ann. § 108A–57(a).

Before *Ahlborn* was decided, North Carolina and the state courts interpreted this statute to allow the State to "recover the costs of medical treatment provided ... even when the funds received by the [beneficiary] are not reimbursement for medical expenses." *Campbell v. North Carolina Dept. of Human Resources,* 153 N.C.App. 305, 307–308, 569 S.E.2d 670, 672 (2002). See also *Ezell v. Grace Hospital, Inc.,* 360 N.C. 529, 631 S.E.2d 131 (2006) (*per curiam*). Under *Ahlborn,* however, this construction of the statute is at odds with the Medicaid anti-lien provision, which "precludes attachment or encumbrance" of any portion of a settlement not "designated as payments for medical care." 547 U.S., at 284, 126 S.Ct. 1752.

In response to *Ahlborn,* the State advanced—and the North Carolina Supreme Court in *Andrews* accepted—a new interpretation of its statute. Under this interpretation the statute "defines 'the portion of the settlement that represents payment for medical expenses' as the lesser of the State's past medical expenditures or one-third of the plaintiff's total recovery." *Andrews,* 362 N.C., at 604, 669 S.E.2d, at 314. In other words, when the State's Medicaid expenditures on behalf of a beneficiary exceed one-third of the beneficiary's tort ****1398** recovery, the statute establishes a conclusive presumption that one-third of the recovery represents compensation for medical expenses. Under this reading of the statute the presumption operates even if the settlement or a jury verdict expressly allocates a lower percentage of the judgment to medical expenses. See Tr. of Oral Arg. 10, 16–17. Cf. *Andrews, supra,* at 602–604, 669 S.E.2d, at 313.

III

A

***636** Under the Supremacy Clause, "[w]here state and federal law 'directly conflict,' state law must give way." *PLIVA, Inc. v. Mensing,* 564 U.S. ——, ——, 131 S.Ct. 2567, 2577, 180 L.Ed.2d 580 (2011). The Medicaid anti-lien provision prohibits a State from making a claim to any part of a Medicaid beneficiary's tort recovery not "designated as payments for medical care." *Ahlborn, supra,* at 284, 126 S.Ct. 1752. North Carolina's statute, therefore, is pre-empted if, and insofar as, it would operate that way.

And it is pre-empted for that reason. The defect in § 108A–57 is that it sets forth no process for determining what portion of a beneficiary's tort recovery is attributable to medical expenses. Instead, North Carolina has picked an arbitrary number—one-third—and by statutory command labeled that portion of a beneficiary's tort recovery as representing payment for medical care. Pre-emption is not a matter of semantics. A State may not evade the pre-emptive force of federal law by resorting to creative statutory interpretation or description at odds with the statute's intended operation and effect.

A similar issue was presented last Term, in *National Meat Assn. v. Harris,* 565 U.S. ——, 132 S.Ct. 965, 181 L.Ed.2d 950 (2012). That case involved the pre-emptive scope of the Federal Meat Inspection Act, 21 U.S.C. § 601 *et seq.* The Act prohibited States from imposing " '[r]equirements ... with respect to premises, facilities and operations' " at federally regulated slaughterhouses. *National Meat Assn.*, 565 U.S., at ——, 132 S.Ct., at 969 (quoting § 678). The State of California had enacted a law that prohibited slaughterhouses from (among other things) selling meat from nonambulatory animals for human consumption. *Id.,* at ——, 132 S.Ct., at 970 (citing Cal.Penal Code Ann. § 599f(b) (West 2010)). California sought to defend the law on the ground that it did not regulate the activities of slaughterhouses but instead restricted ***637** what type of meat could be sold in the marketplace after the animals had been butchered. 565 U.S., at —— – ——, 132 S.Ct., at 972–973.

The Court rejected that argument. It recognized that if the argument were to prevail, "then any State could impose any regulation on slaughterhouses just by framing it as a ban on the sale of meat produced in whatever way the State disapproved. That would make a mockery of the [Act's] preemption provision." *Id.,* at ——, 132 S.Ct., at 973. In a pre-emption case, the Court held, a proper analysis requires consideration of what the state law in fact does, not how the litigant might choose to describe it.

That reasoning controls here. North Carolina's argument, if accepted, would frustrate the Medicaid anti-lien provision in the context of tort recoveries. The argument lacks any limiting principle: If a State arbitrarily may designate one-third of any recovery as payment for medical expenses, there is no logical reason why it could not designate half, three-quarters, or all of a tort recovery in the same way. In *Ahlborn,* the State of Arkansas, under this rationale, would have succeeded in claiming the full amount it sought from the ****1399** beneficiary had it been more creative and less candid in describing the effect of its full-reimbursement law.

Here the State concedes that it would be "difficult ... to defend" a law purporting to allocate most or all of a beneficiary's tort recovery to medical expenses. Tr. of Oral Arg. 20. That is true; but, as a doctrinal matter, it is no easier to defend North Carolina's across-the-board allocation of one-third of all beneficiaries' tort recoveries to medical expenses. The problem is not that it is an unreasonable approximation in all cases. In some cases, it may well be a fair estimate. But the State provides no evidence to substantiate its claim that the one-third allocation is reasonable in the mine run of cases. Nor does the law provide a mechanism for determining whether it is a reasonable approximation in any particular case.

***638** In some instances, no estimate will be necessary or appropriate. When there has been a judicial finding or approval of an allocation between medical and nonmedical damages—in the form of either a jury verdict, court decree, or stipulation binding on all parties—that is the end of the matter. *Ahlborn* was a case of this sort. All parties (including the State of Arkansas) stipulated that approximately 6 percent of the plaintiff's settlement represented payment for medical costs. 547 U.S., at 274, 126 S.Ct. 1752. In other cases a settlement may not be reached and the judge or jury, in its findings, may make an allocation. With a stipulation or judgment under this procedure, the anti-lien provision protects from state demand the portion of a beneficiary's tort recovery that the stipulation or judgment does not attribute to medical expenses.

North Carolina's statute, however, operates to allow the State to take one-third of the total recovery, even if a proper stipulation or judgment attributes a smaller percentage to medical expenses. Consider the facts of *Ahlborn*. There, only $35,581.47 of the beneficiary's settlement "constituted reimbursement for medical payments made." *Ibid.* North Carolina's statute, had it been applied in *Ahlborn,* would have allowed the State to claim $183,333.33 (one-third of the beneficiary's $550,000 settlement). A conflict thus exists between North Carolina's law and the Medicaid anti-lien provision.

The instant case, to be sure, is not quite so clear cut; for there was no allocation of the settlement by either judicial decree or binding stipulation of the parties. But the reasoning of *Ahlborn* and the design of the federal statute contemplate that possibility. When the State and the beneficiary are unable to agree on an allocation, *Ahlborn* noted, the parties could "submi[t] the matter to a court for decision." *Id.,* at 288, 126 S.Ct. 1752.

The facts of the present case demonstrate why *Ahlborn* anticipated that a judicial or administrative proceeding ***639** would be necessary in that situation. Of the damages stemming from the injuries E.M.A. suffered at birth, it is apparent that a quite substantial share must be allocated to the skilled home care she will require for the rest of her life. See App. 112. It also may be necessary to consider how much E.M.A. and her parents could have expected to receive as compensation for their other tort claims had the suit proceeded to trial. An irrebuttable, one-size-fits-all statutory presumption is incompatible with the Medicaid Act's clear mandate that a State may not demand any portion of a beneficiary's tort recovery except the share that is attributable to medical expenses.

B

North Carolina offers responses to this reasoning, but none is persuasive.

**1400 First, the State asserts that it is doing nothing more than what *Ahlborn* said it could do: "adop[t] special rules and procedures for allocating tort settlements." 547 U.S., at 288, n. 18, 126 S.Ct. 1752. This misreads *Ahlborn*. There the Court, citing an *amicus* brief, referred to judicial proceedings some States had established for allocating tort settlements where necessary for insurance or tax purposes. See Brief for Association of Trial Lawyers of America, O.T. 2005, No. 04–1506, pp. 20–21 (citing *Henning v. Wineman,* 306 N.W.2d 550 (Minn.1981), and *Rimes v. State Farm Mut. Auto. Ins. Co.,* 106 Wis.2d 263, 316 N.W.2d 348 (1982)). Those examples illustrated the kind of "special rules and procedures for allocating tort settlements" that *Ahlborn* considered. The decision did not endorse irrebuttable presumptions that designate some arbitrary fraction of a tort judgment to medical expenses in all cases.

Second, North Carolina contends that its law falls within the scope of a State's traditional authority to regulate tort actions, including the amount of damages that a party may recover. This argument begins from a correct premise: In our federal system, there is no question that States possess *640 the "traditional authority to provide tort remedies to their citizens" as they see fit. *Silkwood v. Kerr–McGee Corp.,* 464 U.S. 238, 248, 104 S.Ct. 615, 78 L.Ed.2d 443 (1984). But North Carolina's law is not an exercise of the State's general authority to regulate its tort system. It does not limit tort plaintiffs' ability to recover for certain types of nonmedical damages, and it does not say that medical damages are to be privileged above other damages in tort suits. All it seeks to do is to allocate the share of damages attributable to medical expenses in tort suits brought by Medicaid beneficiaries. A statute that singles out Medicaid beneficiaries in this manner cannot avoid compliance with the federal anti-lien provision merely by relying upon a connection to an area of traditional state regulation.

Third, North Carolina suggests that even though its allocation of one-third of a tort recovery to medical expenses may be arbitrary, other methods for allocating a recovery would be just as arbitrary. In the State's view there is no "ascertainable 'true value' of [a] case that should control what portion of any settlement is subject to the State's third-party recovery rights." Brief for Petitioner 26–27. As explained earlier, allocations, while to some extent perhaps not precise, need not be arbitrary. See *supra,* at 1399. In some cases a judgment or stipulation binding on all parties will allocate the plaintiff's recovery across different claims. Where no such judgment or stipulation exists, a fair allocation of such a settlement may be difficult to determine. Trial judges and trial lawyers, however, can find objective benchmarks to make projections of the damages the plaintiff likely could have proved had the case gone to trial.

In the instant case, for example, the North Carolina trial court approved the settlement only after finding that it constituted "fair and just compensation" to E.M.A. and her parents for her "severe and debilitating injuries"; for "medical and life care expenses" her condition will require; and for "severe emotional distress" from her injuries. App. 82. What portion of this lump-sum settlement constitutes "fair *641 and just compensation" for each individual claim will depend both on how likely E.M.A. and her parents would have been to prevail on the claims at trial and how much they reasonably could have expected to receive on each claim if successful, in view of damages awarded in comparable tort cases.

**1401 This relates to North Carolina's fourth argument: that it would be "wasteful, time consuming, and costly" to hold "frequent mini-trials" in order to divide a settlement between medical and nonmedical expenses. Brief for Petitioner 28. Even if that were true, it would not relieve the State of its obligation to comply with the terms of the Medicaid anti-lien provision. And it is not true as a general proposition. States have considerable latitude to design administrative and judicial procedures to ensure a prompt and fair allocation of damages. Sixteen States and the District of Columbia provide for hearings of this sort, and there is no indication that they have proved burdensome. Brief for United States as *Amicus Curiae* 28–29, and n. 7. See, *e.g.,* Cal. Welf. & Inst. Code Ann. § 14124.76(a) (West 2011); Mo.Rev.Stat. § 208.215.9–11 (2012); Tenn.Code Ann. § 71–5–117(g)–(i) (2012); *In re E.B.,* 229 W.Va. 435, ——, 729 S.E.2d 270, 297 (2012). Many of these States have established rebuttable presumptions and adjusted burdens of proof to ensure that speculative assessments of a plaintiff's likely recovery do not defeat the State's right to recover medical costs, a concern North Carolina raises. See, *e.g.,* Haw.Rev.Stat. § 346–37(h) (2011 Cum.Supp.) (rebuttable presumption of a one-third allocation); Mass. Gen. Laws, ch. 118E, § 22(c) (West 2010) (rebuttable presumption of full reimbursement);

Okla. Stat., Tit. 63, § 5051.1(D)(1)(d) (West 2011) (rebuttable presumption of full reimbursement, "unless a more limited allocation of damages to medical expenses is shown by clear and convincing evidence"). Without holding that these rules are necessarily compliant with the federal statute, it can be concluded that they are more accurate than the procedure North Carolina has enacted.

***642** The task of dividing a tort settlement is a familiar one. In a variety of settings, state and federal courts are called upon to separate lump-sum settlements or jury awards into categories to satisfy different claims to a portion of the moneys recovered. See *supra,* at 1400. See also, *e.g., Green v. Commissioner,* 507 F.3d 857, 867–868 (C.A.5 2007) (separation of compensatory from noncompensatory damages for tax purposes); *Donnel v. United States,* 50 Fed.Cl. 375, 386–387 (2001) (separation of employee severance bonus from other payments for tax purposes); *In re Harrington,* 306 B.R. 172, 182–183 (Bkrtcy.Ct.E.D.Tex.2003) (separation of pain-and-suffering damages from other damages for purposes of bankruptcy exemption); *Colorado Compensation Ins. Auth. v. Jones,* 131 P.3d 1074, 1077–1078 (Colo.App.2005) (separation of economic from noneconomic damages for purposes of insurance subrogation); *Spangler v. North Star Drilling Co.,* 552 So.2d 673, 685 (La.App.1989) (separation of past damages from future damages for purposes of calculating prejudgment interest). Indeed, North Carolina itself uses a judicial allocation procedure to ascertain the portion of a settlement subject to subrogation in a workers' compensation suit. It instructs trial courts to

> "consider the anticipated amount of prospective compensation the employer or workers' compensation carrier is likely to pay to the employee in the future, the net recovery to plaintiff, the likelihood of the plaintiff prevailing at trial or on appeal, the need for finality in the litigation, and any other factors the court deems just and reasonable." N.C. Gen.Stat. Ann. § 97–10.2(j) (Lexis 2011).

North Carolina would be on sounder footing had it adopted a similar procedure for allocating Medicaid beneficiaries' tort recoveries. It might also consider a different one along the lines of what other ****1402** States have done in Medicaid reimbursement cases.

***643** The State thus has ample means available to allocate Medicaid beneficiaries' tort recoveries in an efficient manner that complies with federal law. Indeed, if States are concerned that case-by-case judicial allocations will prove unwieldy, they may even be able to adopt *ex ante* administrative criteria for allocating medical and nonmedical expenses, provided that these criteria are backed by evidence suggesting that they are likely to yield reasonable results in the mine run of cases. What they cannot do is what North Carolina did here: adopt an arbitrary, one-size-fits-all allocation for all cases.

Fifth, and finally, North Carolina contends that in two documents—a July 2006 memorandum and a December 2009 letter responding to an inquiry from a member of North Carolina's congressional delegation—the federal Centers for Medicare and Medicaid Services approved of North Carolina's statutory scheme for Medicaid reimbursement. In the State's view, these agency pronouncements are entitled to deference. See Brief for Petitioner 33–36 (citing *Chevron U.S.A. Inc. v. Natural Resources Defense Council, Inc.,* 467 U.S. 837, 104 S.Ct. 2778, 81 L.Ed.2d 694 (1984)).

The 2006 and 2009 documents, however, no longer reflect the agency's position. See Brief for United States as *Amicus Curiae* 8–34. And at any rate, the documents are opinion letters, not regulations with the force of law. We have held that "[i]nterpretations such as those in opinion letters—like interpretations contained in policy statements, agency manuals, and enforcement guidelines, all of which lack the force of law—do not warrant *Chevron*-style deference." *Christensen v. Harris County,* 529 U.S. 576, 587, 120 S.Ct. 1655, 146 L.Ed.2d 621 (2000). These documents are " 'entitled to respect' " in proportion to their " 'power to persuade.' " *Ibid.* (quoting *Skidmore v. Swift & Co.,* 323 U.S. 134, 140, 65 S.Ct. 161, 89 L.Ed. 124 (1944)). Insofar as the 2006 and 2009 documents approve of North Carolina's statute, they lack persuasive force for the reasons discussed above.

* * *

***644** The law here at issue, N.C. Gen.Stat. Ann. § 108A–57, reflects North Carolina's effort to comply with federal law and secure reimbursement from third-party tortfeasors for medical expenses paid on behalf of the State's Medicaid beneficiaries. In some circumstances, however, the statute would permit the State to take a

portion of a Medicaid beneficiary's tort judgment or settlement not "designated as payments for medical care." *Ahlborn,* 547 U.S., at 284, 126 S.Ct. 1752. The Medicaid anti-lien provision, 42 U.S.C. § 1396p(a)(1), bars that result.

The judgment of the Court of Appeals for the Fourth Circuit is affirmed.

It is so ordered.

Justice BREYER, concurring.

I join the Court's opinion with one qualification: My concurrence in the Court's views rests in part upon the fact that the federal agency that administers the Medicaid statute, known as the Centers for Medicare & Medicaid Services, has reached the same conclusion.

The question before us is how to measure what share of a judgment or settlement of an accident victim's lawsuit represents payment (or reimbursement) for health care items (or services) for which a State has already paid on behalf of the victim. The statute is silent on the question. It simply says that a State may recover the amount of "payment" that the State has made on behalf of the victim "for medical assistance for health care items or ****1403** services" from funds that "any other party" has paid "for such health care items or services." 42 U.S.C. § 1396a(a)(25)(H). Moreover, the question focuses upon a comparatively minor matter of statutory detail, not a major issue of far-reaching statutory policy. It concerns everyday administration. It calls for expertise of a kind that the administering agency is more likely than a court to possess. And any of several different answers to the question would seem reasonable. Under these circumstances, ***645** normally we should find that Congress delegated to the agency authority to fill the statutory gap, and we should uphold the agency's conclusion as long as it is reasonable. See *Chevron U.S.A. Inc. v. Natural Resources Defense Council, Inc.,* 467 U.S. 837, 844, 104 S.Ct. 2778, 81 L.Ed.2d 694 (1984).

Here, however, the agency did not engage in rulemaking procedures, it did not carefully consider differing points of view of those affected, it did not set forth its views in a manual intended for widespread use, nor has it in any other way announced an interpretation that Congress would have "intended ... to carry the force of law." *United States v. Mead Corp.,* 533 U.S. 218, 221, 121 S.Ct. 2164, 150 L.Ed.2d 292 (2001). Indeed, the agency does not claim that it exercised any delegated legislative power.

Neither do the documents in which the agency set forth its position (a memorandum and a letter) have much " 'power to persuade.' " *Christensen v. Harris County,* 529 U.S. 576, 587, 120 S.Ct. 1655, 146 L.Ed.2d 621 (2000) (quoting *Skidmore v. Swift & Co.,* 323 U.S. 134, 140, 65 S.Ct. 161, 89 L.Ed. 124 (1944)). Their reasoning is skimpy. And the conclusion now advanced by the agency represents a radical departure from the agency's previous position. See App. to Pet. for Cert. 129a, 141a–142a. Thus, the Solicitor General does not ask us to defer to the agency's views—and understandably so.

Nonetheless, the Administrative Procedure Act is not the tax code. And cases that seek to determine whether Congress intended courts to give weight to agency views provide rules of thumb, general principles meant to guide interpretation, not rigid rules that narrowly confine it. They seek to advance Congress' intent as embodied in particular statutory schemes by helping courts to determine whether, and how, Congress intended those courts to respect an agency's expertise when reasonably exercised in particular cases. They seek to allocate the law-interpreting function between court and agency in a way likely to work best within any particular statutory scheme. But they do not purport to do more than ***646** that. In particular, they do not set forth all-encompassing absolute rules, impervious to nuance and admitting of no exceptions. Felix Frankfurter's observation, made many years ago, remains valid today: "The problems subsumed by ... 'administrative discretion' ... must be related to ... the particular interest ... as to which 'administrative discretion' is exercised." The Task of Administrative Law, 75 U. Pa. L.Rev. 614, 619–620 (1927). That is to say, "the standard doctrines of administrative law ... should not be taken too rigidly." Jaffe, Administrative Law: Burden of Proof and Scope of

Review, 79 Harv. L.Rev. 914, 918 (1966).

Thus, even though this case does not fall directly within a case-defined category, such as "*Chevron* deference," "*Skidmore* deference," "*Beth Israel* deference," "*Seminole Rock* deference," or deference as defined by some other case, I believe the agency, in taking a position, nonetheless retains some small but special "power to persuade." *Skidmore, supra,* at 140, 65 S.Ct. 161. See generally Eskridge & ****1404** Baer, The Continuum of Deference: Supreme Court Treatment of Agency Statutory Interpretations from *Chevron* to *Hamdan*, 96 Geo. L.J. 1083 (2008). And I would consequently to some degree take account of, and respect, the agency's judgment.

I cannot measure the degree of deference with the precision of a mariner measuring a degree of latitude. But it is still worth noting that the agency's determination has played some role in my own decision. That is because the agency, after looking into the matter more thoroughly (perhaps after notice-and-comment rulemaking), might change its mind. Given the nature of the question and of the agency's expertise, courts, I believe, should then give weight to that new and different agency decision. Cf. *National Cable & Telecommunications Assn. v. Brand X Internet Services,* 545 U.S. 967, 980–986, 125 S.Ct. 2688, 162 L.Ed.2d 820 (2005). In my view, today's decision does not freeze the Court's present interpretation of the statute permanently into law.

With that understanding, I join the Court's opinion.

Chief Justice ROBERTS, with whom Justice SCALIA and Justice THOMAS join, dissenting.

***647** The State of North Carolina paid for E.M.A.'s medical expenses under its Medicaid plan. E.M.A. sued those alleged to have caused her injuries, eventually settling for an amount that included, among other things, medical expenses already covered by North Carolina. The federal Medicaid statute requires North Carolina to recoup those expenses. But neither the Act nor the regulations issued under it tell States how to determine what portion of a third-party recovery should be attributed to medical expenses. The Court concludes that North Carolina's law addressing that question is nonetheless preempted by the Act.

The Court's reading of the Act, while plausible, is not compelled by the statutory text or our precedent. It has the unfortunate consequence of denying flexibility to the States—and, by necessary implication, the Secretary of Health and Human Services—in resolving a policy question with broad significance for this complicated program. In short, the result is both unnecessary and unwise. I therefore respectfully dissent.

I

Medicaid is a cooperative federal-state program designed to provide medical assistance to certain needy populations. The basic idea is simple: The statute—as interpreted by the Secretary of HHS—sets out the requirements for an eligible Medicaid program. If States decide to enroll and comply with those requirements, they get federal money. If they don't, they don't. The federal contribution is not enough to fully fund any State's program; States contribute anywhere from 17 to 50 percent of the costs. See 42 U.S.C. § 1396d(b) (2006 ed., Supp. V). The States have considerable discretion in structuring and administering their programs, subject of course to federal law and regulations.

***648** In practice, it's not always so simple. The books are thick with federal regulations that States must

interpret and reconcile. By my count, at least 39 federal-court opinions, including one of our own, have reiterated Judge Friendly's observation that Medicaid law is "almost unintelligible to the uninitiated." See *Schweiker v. Gray Panthers,* 453 U.S. 34, 43, 101 S.Ct. 2633, 69 L.Ed.2d 460 (1981) (quoting *Friedman v. Berger,* 547 F.2d 724, 727, n. 7 (C.A.2 1976)); see also 453 U.S., at 43, n. 14, 101 S.Ct. 2633 (quoting the District Court's description of Medicaid in ****1405** *Friedman* as "an aggravated assault on the English language, resistant to attempts to understand it"). "Perhaps appreciating the complexity of what it had wrought, Congress conferred on the Secretary exceptionally broad authority to prescribe standards for applying certain sections of the Act." *Schweiker, supra,* at 43, 101 S.Ct. 2633. But where the law and the Secretary are silent on a specific question, it is up to the States—sometimes informally advised by the federal Centers for Medicare and Medicaid Services—to make sense of it all in running their programs.

The relevant provisions here require that North Carolina (1) pay for certain people's medical care, (2) make reasonable efforts to recoup from liable third parties (such as tortfeasors and insurers) any medical expenses it paid, and (3) not recoup such payments by imposing a lien on the beneficiary's property. See *ante,* at 1396 – 1397; see also 42 U.S.C. § 1396a(a)(25)(B) (2006 ed.). To comply, North Carolina pays for a beneficiary's medical expenses on the condition that any such expenses the beneficiary recovers from third parties will go towards repaying the State. See N.C. Gen.Stat. Ann. § 108A–59(a) (Lexis 2011).

The difficulty, however, is that tort victims seldom seek only medical expenses. Take this case: E.M.A. and her parents sought damages not only for medical expenses, but for lost income, pain and suffering, and other things, and ended up settling all these claims for a lump sum of $2.8 million. Such a situation poses the question of how much ***649** North Carolina can recoup—indeed, under federal law, *must* recoup—from a lump sum that reflects more than just medical expenses.

This puts North Carolina in a tight spot. If it fails to recover what it must, it violates federal law. If it takes a beneficiary's property beyond medical expenses, it violates federal law. Trying to navigate between these competing requirements—with no interpretive guidance from the Secretary of HHS—North Carolina elected to resolve the problem by laying out ground rules in advance, conditioning a beneficiary's right to recover from third parties on the beneficiary's willingness to fully repay the State, or, at a minimum, define one-third of her damages as "medical expenses," whichever is less. N.C. Gen.Stat. Ann. §§ 108A–59(a); 108A–57(a); see also *Andrews v. Haygood,* 362 N.C. 599, 603–604, 669 S.E.2d 310, 313–314 (2008).

II

The Court states that "[t]he problem" with North Carolina's designation—actual expenses or one-third of the recovery, whichever is less—"is not that it is an unreasonable approximation in all cases," and acknowledges that "[i]n some cases, it may well be a fair estimate." *Ante,* at 1399. According to the Court, however, because North Carolina's law provides no "mechanism for determining whether it is a reasonable approximation in any *particular* case," *ibid.,* (emphasis added), it "directly conflict[s]" with the "clear mandate" of the federal Medicaid statute, and is therefore preempted. *Ante,* at 1399 (quoting *PLIVA, Inc. v. Mensing,* 564 U.S. ——, ——, 131 S.Ct., at 2577–2578 (2011) (internal quotation marks omitted)), 10. This reflects a basic policy judgment: that segregating medical expenses from a lump-sum recovery must be done on a case-specific, after-the-fact basis, rather than pursuant to a general rule spelled out in advance.

The problem is that the Court can point to no statutory or regulatory requirement, much less an unambiguous one, ***650** requiring such an approach. The federal statute, which provides that States must recoup ****1406** medical expenses owed by third parties, and which prevents States from placing a lien on a beneficiary's property, says nothing about how to comply with these two requirements in the event of a settlement. See *ante,* at 1402 (BREYER, J., concurring) ("The statute is silent on the question").

Nor does our case law. As the Court acknowledges, our decision in *Arkansas Dept. of Health and Human Servs. v. Ahlborn,* was an easy one. 547 U.S. 268, 126 S.Ct. 1752, 164 L.Ed.2d 459 (2006). There, the underlying tort suit settled for $550,000, and the Medicaid beneficiary and the State of Arkansas stipulated that only $35,581.47 of the settlement represented medical expenses. The State nonetheless claimed it "was entitled to a lien in the amount of $215,645.30"—*i.e.,* the total amount paid by the State for the beneficiary's health care. *Id.,* at 274, 126 S.Ct. 1752. The question was whether the State could demand this money in light of its stipulation that only $35,581.47 reflected medical expenses. The answer, of course, was no. The State is only entitled to recover medical expenses; nothing else. So when Arkansas contended that it was entitled to money the beneficiary had received for something other than medical expenses, we had no trouble rejecting that argument. That proposition—that States may not take money that is unrelated to medical expenses—does not help answer the question here: May a State condition Medicaid benefits on a beneficiary agreeing to define one-third of a tort recovery as reflecting "medical expenses"?

The Court recognizes that *Ahlborn* "had no occasion to resolve" the question "how to determine what portion of a settlement represents payment for medical care," *ante,* at 1393, but then promptly proceeds as if *Ahlborn* had done just that. The Court quotes *Ahlborn* for the proposition that a State may not claim any portion of a tort recovery "not 'designated as payments for medical care,' " and then faults North Carolina's law because it "sets forth no process for determining ***651** what portion" is "attributable to medical expenses." *Ante,* at 1397, 1398 (quoting 547 U.S., at 284, 126 S.Ct. 1752), 1398. *Ahlborn* spoke of "designated" amounts because, as noted, there was a stipulated designation in that case. What to do when there is no such stipulation—when it's not clear "what portion of a settlement represents payment for medical care"—is a different question. The Court assumes the answer must be the same: that the settlement must be parsed in every case, so that there is an actual, after-the-fact designation in every case. If the parties do not agree on one, as they did in *Ahlborn,* there must be a process in place for reaching a case-specific attribution.

The nature of the "process" contemplated by the majority is unclear, but it must involve an effort to determine what claims would have succeeded had there been a trial, what the damages would have been for the separate claims, and so on—the very sort of inquiries settlement is intended to obviate. The Court talks of addressing these concerns through "rebuttable presumptions and adjusted burdens of proof to ensure that speculative assessments of a plaintiff's likely recovery do not defeat the State's right to recover medical costs," but ominously declines to give any assurance "that these rules are necessarily compliant with the federal statute." *Ante,* at 1401.

Nothing in *Ahlborn* requires all this, and North Carolina has taken a different approach. It has adjusted its tort law to account for its obligations under federal Medicaid law by requiring that beneficiaries pay the State back in full or designate one-third of any recovery as "medical expenses," whichever is less. This approach ****1407** allows beneficiaries to obtain settlements, "meet[s] concerns about settlement manipulation," *Ahlborn, supra,* at 288, n. 18, 126 S.Ct. 1752, complies with the statutory obligation that States make reasonable efforts to recover medical expenses from liable third parties, and guarantees that the beneficiary will never have to give back more than she has already received from the State.

***652** There's nothing unusual about such an approach. States define the contours of their own tort law all the time, setting rules about who may recover in particular circumstances, what claims may be alleged, which parties are liable, what defenses may be asserted, what damages are recoverable, and so on. Doing so does not amount to imposing a lien on any property to which an individual has a vested right under state tort law. The Court says North Carolina cannot rely on its "traditional authority to regulate tort actions" because its rule in this case is not an exercise of its "general authority." *Ante,* at 1400. The Court cites no support for this vague new limitation on a State's power to define tort remedies under state law, and I am aware of none.

In fact, federal law says nothing about how States must define the recovery available to a Medicaid beneficiary suing a third party. That silence is a good indication that Congress did not mean to strip States of their traditional authority to regulate torts. See *Wyeth v. Levine,* 555 U.S. 555, 565, 129 S.Ct. 1187, 173 L.Ed.2d 51 (2009) ("[I]n all pre-emption cases, and particularly in those in which Congress has legislated in a field which

the States have traditionally occupied, we start with the assumption that the historic police powers of the States were not to be superseded by the Federal Act unless that was the clear and manifest purpose of Congress" (internal quotation marks and ellipses omitted)). The closest the Medicaid Act gets to this topic is its requirement that States have "in effect laws under which ... the State is considered to have acquired the rights of such individual to payment by any other party for such health care items or services." See 42 U.S.C. § 1396(a)(25)(H). That Congress has said nothing else about what recovery a State must allow, though clearly aware of the traditional power of States to regulate recoveries under private law, should be worth something. Cf. *Bonito Boats, Inc. v. Thunder Craft Boats, Inc.,* 489 U.S. 141, 166–167, 109 S.Ct. 971, 103 L.Ed.2d 118 (1989) ("The case for federal pre-emption is particularly weak where Congress has indicated its awareness of ***653** the operation of state law in a field of federal interest, and has nonetheless decided to stand by both concepts and to tolerate whatever tension there [is] between them" (internal quotation marks omitted)).

The majority nonetheless dismisses North Carolina's solution as an arbitrary "one-size-fits-all" approach, *ante,* at 1399, that has no "logical" endpoint; one that, if accepted, could permit States to "designate half, three-quarters, or all of a tort recovery in the same way." *Ante,* at 1398, 1399. This is an age-old objection to any line-drawing, to which Justice Holmes provided a familiar response: "Neither are we troubled by the question where to draw the line. That is the question in pretty much everything worth arguing in the law." *Irwin v. Gavit,* 268 U.S. 161, 168, 45 S.Ct. 475, 69 L.Ed. 897 (1925). Whatever the case "as a doctrinal matter," it is *in fact* "easier to defend North Carolina's" one-third designation than the Court's hypothetical where a State allocates all of a recovery to medical expenses. *Ante,* at 1399. In addition, the majority's hobgoblin is less frightening when we remember that North Carolina never takes back more than what it paid for such expenses.

****1408** The reasons for drawing a bright line, as North Carolina has, are obvious and familiar. See generally Scalia, The Rule of Law as a Law of Rules, 56 U. Chi. L.Rev. 1175 (1989). Bright lines provide clear notice; here that means beneficiaries know exactly where they stand with respect to reimbursing the State as they negotiate settlements with third parties. Such clear rules are easy, cheap, and administrable—laudable qualities in the context of a vast and intricate program. The Court's approach, on the other end, requires the time of lawyers and judges, and that time costs money—money better spent on providing health care to the needy. Or so the State, responsible for administering its program, could conclude, and nothing in the statute, regulations, or our precedent says otherwise.

The majority points out that nearly one-third of the States conduct hearings of the sort it contemplates. *Ante,* at 1401. ***654** Good for them. The whole point of our federal system is that different States may reach different judgments about how to run their own different programs. Such flexibility is particularly important in this context, where Medicaid spending is the largest component of most state budgets. The Court also notes that, in other areas, courts have undertaken the work of "separat[ing] lump-sum settlements or jury awards into categories to satisfy different claims." *Ibid.* My point is not that the work required by the Court cannot be done—just that it has not been required by Congress or the Secretary.

On that note, it's bad enough that the Court finds the State's reasonable effort to reconcile its competing obligations preempted. What is doubly unfortunate is that the Court's analysis necessarily implies that the Secretary's hands are also tied. The Medicaid Act is Spending Clause legislation, and such legislation is binding on States only insofar as it is "unambiguous." See *Pennhurst State School and Hospital v. Halderman,* 451 U.S. 1, 17, 101 S.Ct. 1531, 67 L.Ed.2d 694 (1981). In addition, the anti-lien provision only precludes North Carolina's law if, as the Court acknowledges, there is a "direct conflict" between the two. *Ante,* at 1398 (quoting *PLIVA, Inc.,* 564 U.S., at ——, 131 S.Ct., at 2577–2578 (internal quotation marks omitted)). The Court says—wrongly, I believe—that there is. *Ante,* at 1399 ("An irrebuttable, one-size-fits-all statutory presumption is incompatible with the Medicaid Act's *clear mandate* that a State may not demand any portion of a beneficiary's tort recovery except the share that is attributable to medical expenses" (emphasis added)). But if North Carolina's approach directly conflicts with an unambiguous, clear mandate in the Act—such that any presumption against preemption is overcome, see *Wyeth, supra,* at 565, n. 3, 129 S.Ct. 1187—it's hard to see how the Secretary could adopt a similar approach. See *Chevron U.S.A. Inc. v. Natural Resources Defense Council, Inc.,* 467 U.S. 837, 842–843, 104 S.Ct. 2778, 81 L.Ed.2d 694 (1984) ("If the intent of Congress is clear, that is the end of the matter; for the court, as well as the agency, ***655** must give effect to the

unambiguously expressed intent of Congress").

The concurrence wishes this were not so, see *ante,* at 1404 ("today's decision does not freeze the Court's present interpretation of the statute permanently into law"), but fails to acknowledge the express rationale of the Court's opinion. There is no other way to read the majority opinion than as foreclosing what the concurrence would like to leave open.

Or is there? In exactly two sentences, the Court seems to falter and lose the courage of its conviction that a State must have a process in place for an individual ****1409** allocation of medical expenses in every case. The Court views the problem with North Carolina's law as being that "the State provides no evidence to substantiate its claim that the one-third allocation is reasonable in the mine run of cases." *Ante,* at 1399. That thought does not resurface until five pages later—and only then—when the Court says that States "may even be able to adopt *ex ante* administrative criteria for allocating medical and nonmedical expenses, provided these criteria are backed by evidence suggesting that they are likely to yield reasonable results in the mine run of cases." *Ante,* at 1402.

I am not sure whether this is a concession that individualized hearings may not be required after all, but if it is, it is flatly contrary to the rest of the opinion. It is also quite odd to suggest that the problem with North Carolina's law would go away if only the State provided some sort of study substantiating the idea that one-third was a good approximation in most cases. North Carolina is not a federal agency, whose actions are subject to review under the Administrative Procedure Act's "substantial evidence" test. See 5 U.S.C. § 706(2)(E). We have never before, in a preemption case, put the burden on the State to compile an evidentiary record supporting its legislative determination. The burden is, of course, on those challenging the law. See ***656** *Pharmaceutical Research and Mfrs. of America v. Walsh,* 538 U.S. 644, 661–662, 123 S.Ct. 1855, 155 L.Ed.2d 889 (2003) (plurality opinion) ("We start ... with a presumption that the state statute is valid, and ask whether petitioner has shouldered the burden of overcoming that presumption" (citation omitted)). We have said that, as a general matter, "Congress is not obligated, when enacting its statutes, to make a record of the type that an administrative agency or court does to accommodate judicial review." *Turner Broadcasting System, Inc. v. FCC,* 520 U.S. 180, 213, 117 S.Ct. 1174, 137 L.Ed.2d 369 (1997) (internal quotation marks omitted). Sovereign States should be accorded no less deference.

Keep in mind that the basis for all this is a federal law that prohibits liens for medical assistance, but says *nothing* about how medical and nonmedical expenses are to be allocated. It is hard enough to figure out what the Medicaid Act means by what it *says* ; we should not read so much into its silence.

Ultimately, it is a basic policy judgment whether the Medicaid program is best served in this instance by post hoc individualized determinations, or whether the issue may be addressed in advance, through a general rule, as North Carolina has done here. See *ante,* at 1402 (BREYER, J., concurring) ("any of several different answers to the question would seem reasonable"). The Court can point to nothing that delegates to it the prerogative to make that judgment. Rather, States and the Secretary—working together—should be afforded the leeway to make their joint venture a workable one.

Because North Carolina's law does not conflict with federal law, I would let it be. I respectfully dissent.

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Footnotes

* The syllabus constitutes no part of the opinion of the Court but has been prepared by the Reporter of Decisions for the convenience of the reader. See *United States v. Detroit Timber & Lumber Co.,* 200 U.S. 321, 337, 26 S.Ct. 282, 50 L.Ed. 499.

End of Document

Checklist for Self-Settled Special Needs Trust

Document or Action *(cross out those not needed)*	**Responsible Team Member**	**Due Date**	**Completed Date (initials)**
TYPE OF TRUST			
Established by:			
Beneficiary			( )
Court with Petition			( )
Parent/Grandparent/Guardian			( )
Include Trust Protector provisions			( )
Join Pooled Trust			( )
TRUSTEE AND ADVISOR			
Identify Trustee(s)			( )
Obtain Contact Information for Trustee(s)			( )
Obtain bond from bonding company			( )
MISCELLANEOUS ISSUES			
Confirm Medicaid Lien is paid			( )
Obtain court docs from PI attorney			( )
Determine whether MSA is required			( )
Obtain confirmation of benefits			( )
Identify interested parties			( )
Service on interested parties			( )
OTHER DOCUMENTS			
Consent of Trustee			( )
Trustee Fee Declaration			( )
Court Petition			( )
Notice of Hearing			( )
Proposed Order			( )
Bond			( )
Trust Certification			( )
Continued Care Plan/Contract			( )

STEPS TO BE TAKEN ONCE PETITION HAS BEEN SUBMITTED TO COURT			
Serve Notice, Petition, and supporting documents on all parties			( )
Confirm GAL has been appointed			( )
Contact GAL to review trust			( )
Obtain bond from bonding company			( )
Confirm receipt of Medicaid letter re review of trust			( )
Review Tentative Ruling			( )
POST ESTABLISHMENT			
Obtain trust signatures			( )
Obtain Tax ID Number			( )
Trustee Instruction Letter			( )
Distribution Memo			( )
Confirm funding of trust			( )
SSA Notification Letter			( )
Disengagement Letter			( )
Trustee Representation Agreement			( )
Identify Professionals (CPA, financial advisor, care manager, etc.)			( )
Schedule regular meetings with Trustee			( )
Schedule regular meetings with Professionals and Trustee			( )

MSA = Medicare Set-Aside
GAL = Guardian Ad Litem
CPA = Certified Public Accountant