SPECIAL TOPICS IN GUARDIANSHIP—
COMPROMISING CLAIMS FOR MINORS AND INCAPACITATED ADULTS

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I. INTRODUCTION

Resolving personal injury claims for minors and incapacitated adults requires consideration of a number of issues. A personal injury settlement may require Probate Court approval as well as resolution of liens before the settlement can be finalized. In addition, there may be a need to preserve public benefits available to the minor and incapacitated adult. Under such circumstances, a special needs trust may be required. Consideration of these issues is best done earlier in the litigation process rather than the back end.

II. RESOLVING CLAIMS FOR MINORS

A. Statute controlling minor settlements.

When a minor is injured and a claim is made on his behalf, there may be a need for Probate Court approval of the settlement. A settlement should not be finalized until this issue is considered and addressed. Personal injury attorneys are not always the attorneys best equipped to decide whether Probate Court approval is needed. It may be necessary for an attorney expert in guardianship law to assist with the settlement.

O.C.C.A. § 29-3-3 sets forth the requirements for settling a minor's claim. Under this code section, the following rules apply to minor settlements:

> (b) If the minor has a conservator, the only person who can compromise a minor's claim is the conservator.
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> (c) Whether or not legal action has been initiated, if the proposed gross settlement of a minor's claim is $15,000.00 or less, the natural guardian of the minor may compromise the claim without becoming the conservator of the minor and without court approval. The natural guardian must qualify as the conservator of the minor in order to receive payment of the settlement if necessary to comply with Code Section 29-3-1.
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> (d) If no legal action has been initiated and the proposed gross settlement of a minor's claim is more than $15,000.00, the settlement must be submitted for approval to the court.
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> (e) If legal action has been initiated and the proposed gross settlement of a minor's claim is more than $15,000.00, the settlement must be submitted for approval to the court in which the action is pending. The natural guardian or conservator shall not be permitted to dismiss the action and present the settlement to the court for approval without the approval of the court in which the action is pending.
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> (f) If the proposed gross settlement of a minor's claim is more than $15,000.00, but the gross settlement reduced by:
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> (1) Attorney's fees, expenses of litigation, and medical expenses which shall be paid from the settlement proceeds; and
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> (2) The present value of amounts to be received by the minor after reaching the age of majority
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> is $15,000.00 or less, the natural guardian may seek approval of the proposed settlement from the appropriate court without becoming the conservator of the minor. The natural guardian must qualify as the conservator of the minor in order to receive payment of the settlement if necessary to comply with Code Section 29-3-1.

(g) If the proposed gross settlement of a minor's claim is more than $15,000.00, but such gross settlement reduced by:

(1) Attorney's fees, expenses of litigation, and medical expenses which shall be paid from the settlement proceeds; and

(2) The present value of amounts to be received by the minor after reaching the age of majority

is more than $15,000.00, the natural guardian may not seek approval of the proposed settlement from the appropriate court without becoming the conservator of the minor.

In an effort to explain a somewhat complicated statute, the chart on the following page offers some guidance to the practitioner.

AMOUNT OF THE SETTLEMENT	IS A CONSERVATOR REQUIRED?	HAS SUIT BEEN FILED FOR THE CLAIM?	DOES THE CLAIM NEED PROBATE COURT OR TRIAL COURT APPROVAL?
Gross settlement[1] is less than $15,000.	No, a natural guardian can settle the claim.[2] Note: if a conservator was previously appointed for the minor then the natural guardian cannot settle the claim.	No.	No.
Gross settlement is less than $15,000.	No, a natural guardian can settle the claim.	Yes.	No.
Gross settlement is more than $15,000.	No, if the net settlement after attorney's fees, expenses of litigation, medical expenses and present value of amounts to be received by minor after majority is less than $15,000.	No.	Probate Court approval required.
Gross settlement is more than $15,000.	No, if the net settlement after attorney's fees, expenses of litigation, medical expenses and present value of amounts to be received by minor after majority is less than $15,000.	Yes.	Trial Court approval required (the court where the lawsuit was filed). In addition, the Probate Court must approve the settlement.
Gross settlement is more than $15,000.	Yes, if the net settlement amount is more than $15,000.	No.	Probate Court approval required.
Gross settlement is more than $15,000	Yes, if the net settlement is more than $15,000.	Yes.	Trial court approval required (the court where the lawsuit was filed). In addition, the Probate Court must approve the settlement.

[1] Gross settlement means "the present value of all amounts paid or to be paid in settlement of the claim, including cash, medical expenses, expenses of litigation, attorney's fees, and any amounts paid to purchase an annuity or other similar financial arrangement." O.C.G.A. § 29-3-3 (a).

[2] The payer of a settlement should obtain an affidavit from the natural guardian pursuant to O.C.G.A. § 29-3-1 (c) stating that the value of the settlement does not exceed $15,000, that no conservator has been appointed for the minor, and that the affiant is the natural guardian of the minor.

B. Petition to Probate Court

Minor settlements are accomplished by petitioning the Probate Court for approval of the settlement. As discussed above, the natural guardian may also need to petition the Probate Court to be appointed as conservator. Forms for petitioning the Probate Court for a conservatorship (GPCSF 30) and for approval of minor settlements (GPCSF 19) can be found at www.gaprobate.org.

Once the petition to compromise the claim is filed with the Probate Court, the Judge may appoint a guardian *ad litem* to review the petition. After the guardian's review, and barring any unusual issues, the Court enters an Order allowing the natural guardian or conservator to compromise the claim as outlined in the petition. Settlement papers may then be executed by the natural guardian or the conservator and settlement funds disbursed pursuant to the Probate Court's Order approving the petition.

In cases where the net settlement amount exceeds $15,000 and suit has been filed, the conservator will be required to obtain trial court approval of the terms of the settlement as well as Probate Court approval. There is some disagreement among practitioners as to whether this two step process is required. The statute is somewhat ambiguous but it appears that where the net settlement exceeds $15,000, trial and Probate Court approval must be obtained.

III. RESOLVING CLAIMS FOR INCAPACITATED ADULTS

The Georgia Guardianship Code also has provisions for compromising claims for incapacitated adults. O.C.G.A. § 29-5-23 addresses compromising claims for incapacitated adults. A conservator must be appointed for an incapacitated adult. Once the conservator is

appointed, he or she can enter into a settlement on behalf of the ward, without Probate Court approval, where the gross amount of the settlement is less than $15,000. In cases where the proposed gross settlement amount is more than $15,000, the conservator must obtain Probate Court approval.

Forms for petitioning the Probate Court for a conservatorship (GPCSF 30) and for approval of minor settlements (GPCSF 19) can be found at www.gaprobate.org.

IV. SPECIAL ISSUES IN RESOLVING CLAIMS

A. Resolving liens

1. Medicare

a. Medicare as secondary payor

Federal law provides that when Medicare benefits are paid on behalf of a Medicare beneficiary, there is a right of recovery when the beneficiary has another available source for the benefits. 42 U.S.C.A. § 1395y (b). This federal law, referred to as the Medicare Secondary Payer statute, provides that Medicare will not make payments with respect to any item or service where payment has been made, or reasonably can be expected to be made, by worker's compensation, third-party liability insurance, no-fault insurance or a group health plan. 42 U.S.C.A. § 1395y (b); 42 C.F.R. §§ 411.20 et seq.

Despite any contrary provision of state law or assertion by a primary payer, Medicare benefits are secondary to benefits payable by the primary payer. 42 C.F.R. § 411.32. Where a primary payer cannot reasonably be expected to make prompt payment, Medicare may make a conditional payment, conditioned on reimbursement of the payment by the primary payer. 42 U.S.C.A. § 1395y (b) (2) (B); 42 C.F.R. § 411.24. Medicare then has a right of recovery for the

conditional payments that should have come from a primary payer. 42 C.F.R. § 411.24; 42 U.S.C.A. § 1395y (b) (2) (B) (iv).

b. Medicare's right of recovery

Medicare has several options available for recovery of conditional payments. Medicare can recover by direct collection or by offset against money that Medicare owes to an entity responsible for refunding the conditional payment. 42 C.F.R. § 411.24 (d). Medicare may file a direct action to recover from any primary payer (i.e., a liability insurance carrier, workers' compensation carrier, or group health plan). 42 C.F.R. § 411.24 (e). Medicare can also assert its right of recovery against any party that received a primary payment, such as the beneficiary himself, a health care provider or supplier, or an attorney for the beneficiary. 42 C.F.R. § 411.24 (g). When Medicare has made a conditional payment, it is subrogated to any individual beneficiary, health care provider or supplier, insurer, or attorney who may be entitled to payment by a third party. 42 C.F.R. § 411.26 (a). Medicare can also intervene in any action against a third party in order to recover the conditional payments. 42 C.F.R. § 411.26 (b).

Attorneys handling personal injury claims on behalf of elderly or disabled clients are cautioned to follow the appropriate procedures in notifying Medicare of a potential primary payer. Failure to follow these procedures can result in a number of penalties against the attorney representing the Medicare beneficiary. In order to enforce the right of recovery for conditional payments, a number of strict regulations have been put in place. For instance, Medicare can seek a recovery directly from the attorney representing the Medicare beneficiary and Medicare can charge interest if the reimbursement is not received within sixty days after Medicare receives notice of a personal injury settlement. 42 C.F.R. § 411.24 (g), (m).

Attorneys representing third parties or their liability insurance carriers are also cautioned

when handling claims by elderly or disabled plaintiffs. Medicare is authorized to bring a direct action against a liability insurance carrier (or other primary payer, such as a worker's compensation carrier) to recover conditional payments. 42 C.F.R. § 411.24(e). If Medicare takes legal action to recover against a liability insurance carrier (or other primary payer), then it may recover double the amount of the conditional payments from the primary payer. 42 C.F.R. § 411.24(c)(2).

c. Resolving Medicare's reimbursement claim

The attorney representing an elderly or disabled client (or a minor child) should inquire early in the representation process what benefits the client receives. In the event that the client is Medicare eligible, the attorney has an obligation to notify Medicare of the potential personal injury claim. Medicare contracts with a "Coordination of Benefits Contractor" (COBC) that is responsible for gathering information about Medicare secondary payer claims. Upon assuming representation of a client who has received Medicare benefits, the attorney should contact the COBC, either in writing or by telephone or on-line,[3] and provide the client's name, Medicare Health Insurance Claim Number, beneficiary's gender and date of birth, beneficiary's address and telephone number, date of injury, description of injury, type of claim (i.e. liability insurance), insurance carrier's name and address, attorney's name and the law firm name, address and

[3] Medicare now provides a web-based tool for resolving liability insurance recovery cases. See Medicare Secondary Payor Recovery Portal at https://www.cob.Medicare.hhs.gov/MSPRP/ . This portal gives attorneys representing Medicare beneficiaries the ability to access and update certain case specific information on line rather than the prior system which required either written communication or telephone calls to the Medicare Secondary Payer Recovery Contractor. The web-based tool will allow attorneys to submit proof of representation or consents to release documentation on-line, request conditional payment information on-line, dispute claims included in the conditional payments letter, and submit case settlement information.

telephone number.

After the COBC receives the information from the attorney, a Medicare secondary payer contractor ("MSPRC") will be assigned to the recovery claim and all further communications will be with the Medicare secondary payer contractor. Once the Medicare secondary payer receives the recovery claim, the attorney representing the elderly or disabled client can request an itemization of charges that Medicare is claiming for reimbursement. At this point, Medicare will provide a conditional payment letter which is subject to change. Medicare can seek recovery for charges from the date of the injury through the date of any settlement.

Upon settlement of a personal injury claim on behalf of a Medicare beneficiary, the attorney must notify Medicare of the date of settlement, the settlement amount, and the amount of any attorney's fees and other procurement costs in the case. Medicare will then respond with a final recovery demand letter. Care should be taken to review the interim conditional payment letter and the final recovery demand letter to determine whether all of the charges claimed by Medicare are in fact related to the client's injury and to determine whether Medicare reduced their final recovery claim by the cost of procurement.

The cost of procurement includes attorney's fees and expenses of litigation incurred by the Medicare beneficiary in obtaining a settlement or judgment. In determining the final recovery amount, Medicare must reduce its claim by the cost of procurement. This is accomplished through a formula set forth in 42 C.F.R. § 411.37. Once a settlement or judgment is received by the client, the Medicare reimbursement is due within sixty days. Failure to reimburse Medicare within sixty days may result in interest being charged by Medicare. 42 C.F.R. § 411.24 (m).

2. Medicaid

Federal law provides that when benefits are paid on behalf of a Medicaid beneficiary and a third-party is ultimately liable for those benefits, the state administering the Medicaid plan will seek reimbursement for the Medicaid benefits paid on behalf of the Medicaid beneficiary. 42 U.S.C.A. §1396a (a) (25) (A). As a condition of receiving Medicaid benefits, the Medicaid beneficiary must assign to the state his right of recovery against the responsible third-party to the extent of the Medicaid benefits received. 42 U.S.C.A. §1396k (a) (1) (A).

Georgia statutory law also addresses the state's right of recovery. O.C.G.A § 49-4-148 provides that when the Georgia Department of Community Health pays medical assistance for a Medicaid beneficiary, the Department can seek reimbursement when a third-party is responsible for the injury. In order to enforce this reimbursement claim, the Department has three available options. First, the department takes an assignment from the Medicaid beneficiary when payments are made on his behalf and can use this assignment to bring a direct action against the responsible third-party. O.C.G.A. § 49-4-149 (d). Second, the department is subrogated to the extent of the reasonable value of the medical benefits paid to the right of a Medicaid beneficiary to receive benefits under a private health insurance contract. O.C.G.A. § 49-4-149 (c). Finally, the department has a lien for benefits paid on behalf of the Medicaid beneficiary where such payments were the responsibility of a third-party. O.C.G.A. § 49-4-149 (a). The department can perfect and enforce their lien using the Georgia hospital lien statutory provisions. O.C.G.A. §§ 44-14-470 through 44-14-473.

When an elderly or disabled client (or a minor child) receives Medicaid benefits, the attorney representing the client must notify the Georgia Department of Community Health of the

intent to initiate a personal injury claim on behalf of the Medicaid beneficiary. O.C.G.A. § 9-2-21 (c). Upon settlement of the claim, the Medicaid reimbursement claim must be resolved. Attorneys representing the responsible third-party must also ensure that the Medicaid claim is resolved so that the Department does not later assert a direct action against the responsible third-party.

B. Considering Medicare's interest in relationship to future medical expenses

In addition to resolving Medicare recovery claims for past benefits paid, attorneys representing Medicare beneficiaries must also consider obligations for future Medicare payments. Medicare uses the Medicare Secondary Payer statute to take the position that it is also the secondary payer *after* the settlement of worker's compensation claims. Medicare will not pay for future medical expenses that relate to a worker's injury until all worker's compensation benefits, including a lump sum settlement of future medical expenses, have been exhausted.

In protecting its claim as secondary payer in the worker's compensation context, the Medicare relies upon 42 C.F.R. §§ 411.46 and 411.47. These regulations prevent the worker's compensation carrier from shifting its liability as primary payer for the employee's injury to Medicare. The regulations require a worker's compensation settlement agreement to make a reasonable allocation of a portion of a lump sum settlement to future medical expenses. If such an allocation is not made, then Medicare will make this allocation.

As a result of the Medicare Secondary Payer statute and this regulation, "Medicare Set-Aside Trusts" were developed to serve as a vehicle for allocating future medical expenses. Since the original Medicare set-aside trusts were developed, Medicare has issued direction regarding the approval of worker's compensation settlements and Medicare set-aside arrangements.

Medicare does not require a similar set-aside arrangement in the context of a third-party

liability personal injury case.[4] At the present time, Medicare only requires that its interests as secondary payer be considered with regard to any payments that might have been made prior to the liability settlement. 42 C.F.R. § 411.20.

At this point, there is very little direction from Medicare on this issue. Medicare issued a memorandum on September 30, 2011, that provides limited information about proposed liability Medicare set-aside arrangements. In this memorandum, Medicare states that:

> Where the beneficiary's treating physician certifies in writing that treatment for the alleged injury related to the liability insurance (including self-insurance) "settlement" has been completed as of the date of the "settlement", and that future medical items and/or services for that injury will not be required, Medicare considers its interest, with respect to future medicals for that particular "settlement", satisfied. If the beneficiary receives additional "settlements" related to the underlying injury or illness, he/she must obtain a separate physician certification for those additional "settlements."
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> When the treating physician makes such a certification, there is no need for the beneficiary to submit the certification or a proposed LMSA amount for review. [Medicare] will not provide the settling parties with confirmation that Medicare's interest with respect to future medicals for that "settlement" has been satisfied. Instead, the beneficiary and/or their representative are encouraged to maintain the physician's certification.[5]

[4] Medicare has proposed regulations pertaining to Medicare set-asides in third party liability personal injury cases. It is anticipated that these regulations will be adopted sometime this year.

[5] Medicare Memorandum regarding Liability Insurance Settlements and Future Medicals (Sept. 30, 2011), available at www.Medicare.gov.

C. Preserving public benefits

When a claimant is the recipient of certain public benefits, consideration must be given to preserving these benefits when settling a claim. In some cases a special needs trust may be needed to preserve essential public benefits. The phrase "special needs trust" has come to mean any type of trust that meets the needs of a disabled individual. A common misconception is that all such trusts preserve the disabled individual's eligibility for public benefits. Whether a special needs trust is required depends, however, on the type of benefits available to the claimant.

1. Government benefits impacted by personal injury settlements.

Confusion arises because of the many public benefits that may be available to a claimant. Essentially, there are two types of public benefits: those which are need-based and those which are employment-related. Examples of need-based public benefits include Supplemental Security Income (SSI) and Medicaid. Employment-related benefits include Social Security benefits for retirement, survivors or disability, and Medicare.

2. Use of special needs trusts to protect need-based benefits.

When a personal injury claim is resolved on behalf of a claimant, consideration must be given to whether the person is disabled and dependent on need-based benefits. When both circumstances exist, then a special needs trust is required. Creation of a special needs trust will preserve need-based benefits such as Medicaid and SSI. Special needs trusts that accomplish this preservation of benefits are known as "self-settled special needs trusts."

These special needs trusts were recognized under federal law when Congress enacted the Omnibus Budget Reconciliation Act of 1993 (OBRA 93). Under OBRA 93, a self-settled special needs trust will not be counted as an available resource to the disabled beneficiary for purposes of determining his or her eligibility for Medicaid. 42 U.S.C.A. §1396p (d) (4) (A), (C). A

similar federal statute recognizes that self-settled special needs trusts will not be counted as an available resource for purposes of determining eligibility for SSI. 42 U.S.C.A. §1382b (e).

When a special needs trust is needed to preserve public benefits such as Medicaid and SSI, a specialist in this area should be consulted. A practitioner unfamiliar with setting up special needs trusts is entering a landmine if he or she attempts to do this work without advice from a specialist.

III. CONCLUSION

Early conversations with clients are recommended in order to determine what issues need to be addressed upon settlement of personal injury claims. There may be a need to associate an expert in guardianship or special needs trust in resolving such claims. Moreover, properly settling a claim for minors or incapacitated adults takes more time than a conventional personal injury settlement. It is best to let the client know on the front end that additional hoops must be jumped through before he or she will get their settlement check at the end of a case.