

**MEDICARE AND MEDICAID AVOIDING POST-JUDGMENT AND
POST-SETTLEMENT LITIGATION**

**WORKERS' COMPENSATION AND
MEDICARE SET ASIDE ISSUES**

INTRODUCTION

Over the last 10 years workers' compensation practitioners have seen the evolution of the Medicare Secondary Payer Act 42 U.S.C. §1395y(b) as it applies to workers' compensation practice. The Medicare Secondary Payer Act (MSP) was passed in 1980. Parties to workers' compensation claims throughout the country were essentially unaware that provisions thereof would be interpreted as requiring workers' compensation litigants to protect Medicare's interests with regard to future medical expenses. The Center for Medicare and Medicaid Services (CMS) undertook little, if any, action by way of enforcement of its rights under the MSP. The Center for Medicare Services clearly signaled a change in policy and enforcement with the July 23, 2001, Memo authored by Parashar V. Patel, Deputy Director, Purchasing Policy Group, Center for Medicare Management. Therein CMS asserted its rights under the Medicare Secondary Payer Act with regard to litigants of workers' compensation claims. Litigants were advised that the Medicare Secondary Payer Act required litigants to protect Medicare's interests with regard to future medical expenses of workers' compensation claimants.

Since 2001 the Center for Medicare Services has made frequent pronouncements through the use of policy Memoranda with regard to the policies and procedures for workers' compensation claims. Today, all workers' compensation practitioners are familiar with the Secondary Payer Act as well as obligations with regard to protecting Medicare's interests. Protecting Medicare's interests with regard to future medical expenses is often accomplished through the use of a Medicare Set Aside account.

The Medicare/Medicaid and SCHIP Extension Act of 2007 (MMSEA) was enacted in December 2007. Section 111 of the Act included mandatory provisions requiring insurers to regularly report claims and settlements involving Medicare eligible claimants. Its scope applied to not only workers' compensation claims but also auto and liability claims. The enactment of SCHIP has raised red flags with regard to the potential application of the Medicare Secondary Payer Act to civil claims with regard to future medical expenses. It is anticipated that many insurers will begin using Medicare Set Aside arrangements in order to protect Medicare's perceived rights under the Medicare Secondary Payer Act. Set forth herein are the procedures and requirements used to comply with the MSPA in workers' compensation.

STATUTORY AUTHORITY

42 U.S.C. ' 1395y(b)(2)

(http://caselaw.lp.findlaw.com/scripts/ts_search.pl?title=42&sec=1395y)

- (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, or can reasonably be expected to be made under a workmen=s compensation law or plan of the United States or a State or under an automobile or liability insurance policy or plan (including a self-insured plan) or under no fault insurance.

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) Repayment required

(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) 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) Primary plans

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.

(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.

See 42 C.F.R. '411, *et seq.*

“(A) Lump Sum Computation of Future Benefits.

If a lump sum compensation award stipulates that the amount paid is intended to compensate the individual for all future medical expenses required because of the work-related injury or disease, Medicare payments for such services are excluded until medical expenses related to the injury or disease equal to the amount of the lump sum payment.

“(B) Lump Sum Compromised Settlement

- (1) A lump sum compromised settlement is deemed to be a workers’ compensation payment for Medicare purposes, even if the settlement agreement stipulates that there is no liability under the workers’ compensation law or plan.
- (2) If a settlement appears to represent an attempt to shift to Medicare the responsibility for payment of medical expenses for the treatment of a work-related condition, the settlement will not be recognized. For example, if the parties to a settlement attempt to maximize the amount of disability benefits paid under workers’ compensation by releasing the workers’ compensation carrier from liability for medical expenses for a particular condition, even though the facts show that the condition is work-related, Medicare will not pay for treatment of that condition.” 42 C.F.R. § 411.46.

Where there is an allocation for future medical expenses as a part of the workers’ compensation settlement, the Code provides:

“(2) Exception.

If the settlement agreement allocates certain amounts for specific future medical services, Medicare does not pay for those services until medical expenses related to the injury or disease equal the amount of the lump sum settlement allocated to future medical expenses.” 42 U.S.C. § 411.46(d)(2).

As can be seen from the Secondary Payer Act the statutory scheme is relatively straight forward. Medicare is not required to pay for any item or service to the extent that payment has been made or can reasonably be expected to be made by a primary payer. Primary payers are defined in part as a workers’ compensation law or plan, an automobile or liability insurance policy or no-fault insurance. The Medicare Secondary Payer Act does not specifically address future medical expenses. Regulations under the Act including 42 U.S.C. § 411.46 specifically

addresses future medical expenses as they relate to workers' compensation claims. The Department of Health and Human Services has failed to provide any regulatory direction with regard to ambiguity and confusion over parties' obligations to Medicare with regard to future medical expenses in civil claims.

MEDICARE SET ASIDE REQUIREMENTS

Since 2001 CMS Memoranda have defined CMS policy and procedure for identifying cases where a Medicare Set Aside allocation is necessary. The need for an allocation does not arise in every workers' compensation case. Medicare has defined two classes of Medicare beneficiaries. If the petitioner's workers' compensation claim falls within either class then further efforts must be made to protect Medicare's interests with regard to future medical expense. The classes are:

Class 1: Individuals who are Medicare eligible;

Class 2: Claimants who meet any of the following criteria;

- 1) The individual has applied for Social Security Disability benefits;
- 2) The individual has been denied Social Security Disability benefits, but anticipates appealing that decision;
- 3) The individual is in the process of appealing and/or refiling for Social Security disability benefits;
- 4) The individual is 62 years and 6 months old, i.e., maybe eligible for Medicare based on his or her age within 30 months; or
- 5) The individual has an end stage renal disease (ESRD) condition but does not yet qualify for future Medicare based on ESRD.

Therefore, each workers' compensation claim is handled in part with a determination as to whether these criteria are met. If these criteria are not met, then further consideration is not given to the Medicare Secondary Payer Act. Where, however, the claimant meets the criteria of a Class 1 or Class 2 beneficiary, then further analysis must be undertaken. That analysis includes whether the petitioner is *reasonably likely to incur future medical expense related to the workers' compensation injury*. Where future medical treatment is not reasonably likely to occur, the parties often acquire a statement from a medical provider affirming that proposition.

CMS REVIEW THRESHOLDS

The Center for Medicare Services is ill equipped to review every Medicare Set Aside that is prepared on workers' compensation matters nationwide. In an effort to control its work load, CMS developed review thresholds. Where the thresholds are not met, parties need not submit their Medicare Set Aside proposal to Medicare for approval. Rather, they may proceed with settlement of their case and proceed with funding of the Medicare Set Aside. Where the settlement exceeds the review threshold the Medicare Set Aside proposal must be submitted to Medicare for their approval.

Where a settlement does not meet the review threshold the parties must still fund a Medicare Set Aside. The review thresholds are not a safe harbor but rather simply work load thresholds for CMS. If the petitioner is a Class 1 or Class 2 beneficiary and future medical is reasonably anticipated, then a Medicare Set Aside must be done. In the alternative the parties may leave medical rights open under the Workers' Compensation Act.

CLASS 1 BENEFICIARIES

Where the petitioner is a Class 1 beneficiary (Medicare eligible) the Medicare Set Aside need only be submitted to Medicare for their approval where the settlement amount exceeds \$25,000.

CLASS 2 BENEFICIARIES

The settlement review threshold for Class 2 beneficiaries is \$250,000. Settlements under \$250,000 need not be submitted to Medicare for their approval.

The review thresholds include but are not limited to wages, attorney's fees, all future medical expenses and repayment of any Medicare conditional payments. Payments of past medical expenses are not included in the threshold amounts. Where settlements include structured payments, the amount of the total payments of the structure are counted to determine whether the threshold is met. The cost of the structure is irrelevant.

CASES WHERE MEDICARE SET ASIDE NOT NECESSARY

Situations will arise where claimants meet the definition of a Class 1 or Class 2 beneficiary but a Medicare Set Aside is not necessary. It is this author's position that a Medicare Set Aside is not necessary where future medical treatment is not *reasonably likely to occur*. CMS itself, however, has taken a more restrictive approach through its policy Memoranda. In its Memoranda of April 22, 2003, CMS stated that it was not necessary to establish a Set Aside if all of the following criteria are met:

1. The facts of the case demonstrate that the injured individual is only being compensated for past medical expenses;
2. There is no evidence that the individual is attempting to maximize the other aspects of settlement (e.g., the lost wage and disability portions of the settlement) to Medicare's detriment; and
3. The individuals treating physicians conclude (in writing) that, to a reasonable degree of medical certainty, the individual will no longer require any Medicare-covered treatments related to the workers' compensation injury.

The additional requirements by Medicare with regard to avoiding the Medicare Set Aside where future medical treatment is not reasonably likely to occur appear overly burdensome and are not consistent. As indicated it is this author's position that if the medical treatment is not

reasonably likely to occur then no Medicare Set Aside is necessary. The additional requirement set forth by CMS that the settlement only be for past medical expenses should be immaterial.

DISPUTED CASES

Medicare classifies workers' compensation cases as either "commutation" or "compromise" cases, or both. Commutation cases include compensation to the individual for future medical expenses resulting from a work related injury or disease. Compromise cases are settlements or awards for current or past medical expenses. It is possible for a case to involve elements of both compromise and commutation. Set Aside arrangements are only used in commutation settlements.

Generally, Medicare will honor judicial determinations with regard to disputed accidents. Where a court of competent jurisdiction deems a condition unrelated the settlement will not need to include future medical for that condition. Medicare will not accept terms of settlement where there is an allocation of funds of any type that does not adequately protect Medicare's interest with regard to future medical expenses. If Medicare's interests are not reasonably considered, Medicare can refuse to pay for services related to the workers' compensation injury until such expenses have exhausted the entire amount of settlement. Medicare may also assert a recovery claim against the parties or their insurer. Petitioner's attorneys are also subject to a recovery claim by Medicare as they receive a fee from the settlement funds.

In disputed cases involving substantial compromise, Medicare will employ a formula to determine whether a reduced Medicare Set Aside amount may be sufficient. Generally, this formula involves establishing what percentage of total pre-settlement payments (medical and TTD) that the medical payments represent and apply such a formula to the post-settlement amounts. They then may accept a reduced MSA as long as the percentage of the MSA to the total settlement equals or is greater to the percentage of medical to total payments pre-settlement. This formula essentially is unworkable in the overwhelming majority of workers' compensation claims and does not, in fact, result in any discounting of the amount of the MSA.

Another method employed to address settlements with substantial compromise is the use of a "zero Set Aside." In cases that are highly contested and extremely doubtful, Medicare may essentially waive the need for a Medicare Set Aside by approving a "zero allocation." For example, a case may have a full value of \$400,000 with \$100,000 of such figure representing future medical expense. Due to the disputed nature of the claim and the likelihood that the petitioner would not prevail, the case then settles for a sum of \$25,000. In such situations Medicare may very well approve a "zero Set Aside" in recognition of the nominal amount of the settlement and disputed nature of the claim.

SET ASIDE ARRANGEMENTS

In the original 2001 CMS Memo, CMS began referring to "Set Aside Arrangements." Medicare requires that funds be set aside to pay for future medical bills incurred because of the work

related condition. The set aside arrangements may be either in the form of a lump sum payment or in a structured annuity. The amount must be sufficient to pay for reasonably expected, causally related medical bills for the life expectancy of the petitioner.

The amount of the future medical expense will be determined through the preparation of a Medicare Set Aside proposal. Numerous vendors exist who prepare Medicare Set Asides for submission to CMS. They will require extensive documentation from the litigants, including complete medical records and bills. Software systems are employed to take data regarding the claimant's condition and prior medical expenses and calculate what is anticipated for future medical expenses. The calculation is based upon the petitioner's life expectancy. CMS does not require that the payments be indexed for inflation, however, they likewise do not allow reduction to present cash value.

In order to communicate with CMS, the Medicare vendor will require the claimant to sign several releases. Releases will include not only the release of Medicare information but also medical records and other data.

CMS has created a checklist detailing the information to be submitted to obtain CMS approval.

See <http://www.cms.hhs.gov/WorkersCompAgencyServices/Downloads/wcchecklist.pdf>. The CMS has also created a sample submission that outlines the information required and provides examples of the type of information to be submitted.

See <http://www.cms.hhs.gov/WorkersCompAgencyServices/Downloads/samplesubmission.pdf>.

A cover letter should be submitted with the settlement documents outlining the following information:

- § Claimant information including:
 - B Name
 - B Address, telephone, fax, and email address
 - B Health insurance claim number (HICN)
 - B Social Security number (SSN)
 - B Gender
 - B Date of birth
 - B Proposed settlement date
 - B Age
 - B Median rated age and documentation from life insurance companies
 - B Life expectancy
 - B (See <http://www.cdc.gov/nchs/products/pubs/pubd/lftbls/life/1966.htm>)

- § Entitlement information

- B Indicate whether claimant is entitled to Medicare Part A (hospital insurance) and/or Part B (medical insurance). If the claimant is not a current Medicare beneficiary, describe how the claimant satisfied the current non-beneficiary threshold.

§ Injury information

- B Description of injury
- B Date of injury
- B Diagnosis codes

§ MSA administrator

§ Claimant=s attorney

§ Employer

§ Employer attorney

§ Workers= compensation insurance carrier

§ State of jurisdiction and venue

§ Total workers= compensation settlement and payout structure

§ Proposed MSA exclusive of administrative fees

§ MSA fees and expenses

§ MSA calculation method, i.e., fee schedule or full charges

§ Consent to release form signed by claimant

§ Life care plan

§ Medicare will consider a life care plan from a non-treating physician if the physician does all of the following:

- B Examines the workers= compensation claimant;
- B Reviews the claimant=s medical records;
- B Contacts any of the claimant=s treating physicians (if applicable);
- B Is available to answer the CMS=s questions;
- B Prepares a report that summarizes the above; and

- B Offers a written medical opinion as to all of the reasonably anticipated future medical needs of the claimant related to the claimant=s work injury.

- § The CMS does not consider such a life care plan automatically conclusive. The CMS may not credit the report if there is information that calls the evaluation or plan into question, such as contrary evidence or internal conflicts, or if the plan is not credible on its face. See the April 22, 2003 CMS memo, Q&A 15.

- § Example life care plans are available at <http://www.prc-usa.com/pdfs/Jane%20Doe%20Life%20Care%20Plan.pdf> and http://www.mkapple.org/sample_life_care_plan.html.

- § Proposed Workers= Compensation Settlement Agreement - Provide a copy of the proposed settlement agreement.

- § Set-aside agreement

- § Medical records

- § Medical records should be provided that outline the current medical care that the claimant regularly receives. The record should show that the work-related condition is stable. Medical documentation should be supported by a minimum of two years of medical documentation and back to the date of the work-related injury. The records should describe the expected recovery, the projected recovery period and the date at which the patient achieved maximum medical improvement.

- § The records and reports should also identify the specific types of medical services, the frequency/duration of the medical services/items and the projected costs of the medical services/items related to the work injury/disease that are expected in the future in light of the claimant=s condition. ICD-9 diagnosis codes should be included, if available.

- § Workers= compensation payment history (including prescriptions after January 1, 2007).

The CMS recently created a central depository for workers= compensation settlement approvals. All proposed workers= compensation settlements should be submitted to:

CMS
c/o Coordination of Benefits Contractor
P.O. Box 33849
Detroit, MI 48232-5849
Attention: WCMSA

When evaluating a MSA proposal CMS will take several facts into consideration. CMS will use the following criteria to determine whether parties are improperly attempting to shift liability to Medicare for the cost of a work related injury or illness. Those criteria are:

1. Date of entitlement to Medicare;
2. Basis for Medicare entitlement;
3. Type and severity of injury or illness;
4. Age of beneficiary;
5. Workers= compensation classification of beneficiary;
6. Prior medical expenses paid by the workers= compensation carrier due to the injury or illness in the one- or two-year period after the condition has stabilized;
7. Amount of lump sum or of structured settlement;
8. Whether the commutation is for the beneficiary=s lifetime or for a specific time period;
9. Whether the beneficiary is living at home, living in a nursing home, or receiving assisted living care; and
10. Whether the expected expenses for Medicare-covered items and services are appropriate in light of the beneficiary=s condition. From the July 31, 2001 CMS memo, Q&A 5.

Traditionally, the vendor will handle the submission of the Medicare Set Aside proposal to CMS. Currently it takes approximately 60 to 90 days to receive a response from Medicare. On occasion, Medicare Set Aside proposals are deemed insufficient for lack of supporting information or data. Such instances can result in substantial delay in receiving a determination from CMS. Once a CMS approval letter is issued the MSA can be funded.

Claimants are directed to deposit lump sum set aside funds into an FDIC insured interest bearing account. Claimants are required to provide CMS with an annual accounting of payments from the account for medical expenses relating to the workers' compensation injury. Only such expenses that would have been covered by Medicare should be paid from the Medicare Set Aside account. If the Medicare Set Aside account funds are insufficient and run out prior to death of the claimant, Medicare will then cover such medical expenses for the remainder of the claimant's life or eligibility for Medicare.

Where the claimant is a Class 2 beneficiary (not yet Medicare eligible) and the Set Aside is approved by CMS, the Set Aside will only include future medical expenses that arise after the

claimant becomes Medicare eligible. Medical expenses between the time of settlement and the claimant's Medicare eligibility must be paid from another source.

If a claimant's condition improves subsequent to settlement such that they no longer are on Social Security Disability or have Medicare benefits, then CMS will not allow the release of the MSA funds. They will, however, allow the MSA funds to continue to be used for medical expenses related to the injury.

APPEALS

CMS has no formal process for appealing the rejection of a Medicare Set Aside. If litigants believe that additional evidence not previously considered by CMS would warrant a change in the CMS determination, then the litigant may resubmit the case with additional evidence and request re-evaluation. If the parties then fail to establish a Medicare Set Aside in an amount accepted by Medicare, then CMS will exclude payments for medical expenses related to the injury until such time as all settlement funds are expended. If a Medicare beneficiary's claim is denied then a beneficiary may appeal that particular claim denial through the Medicare Administrative Appeals process.

ENFORCEMENT

Where the litigants fail to comply with the requirements of the Medicare Secondary Payer Act the Center for Medicare and Medicaid Services can pursue two forms of remedy. The first is that under the Medicare Secondary Payer Act, Medicare can deny payment of any future medical expenses related to the injury or illness. Generally CMS has stated that all such claims for Medicare benefits will be denied for that treatment until the entire settlement amount is exhausted.

Secondly, where litigants fail to satisfy a Medicare lien (conditional payments) or the primary payer fails to account for future medical expense then CMS has a right to a private cause of action against the workers' compensation carrier. 42 U.S.C.§1395y(b)(3)(A); 42 C.F.R.§411.24. Such actions may be brought up to three years from the date that the item of service was provided 42 U.S.C.§1395y(b)(2)(B). In addition, CMS has a right of recovery of its payments from any entity, including the beneficiary, provider, supplier, physician, attorney, state agency, or private insurer that has received third party payment 42 C.F.R.§411.24(g).

Where CMS initiates legal action to recover conditional payments double damage are available 42 C.F.R.§411.24(c). Such damages are not limited to the amount of settlement but extend to all payments made by CMS for work related charges 42 C.F.R. §411.24. As such, insurers can potentially be liable for triple payment, once to the claimant and double to CMS.

WORKERS' COMPENSATION SETTLEMENT LANGUAGE

The material terms of a workers' compensation settlement are identified on the State of Illinois Settlement Contract under the heading "terms and conditions." In cases involving Medicare Set Asides, the settlement language will identify the basis of the petitioner's Medicare eligibility or potential eligibility and further note that Medicare's interests under the Secondary Payer Act are recognized. Often times the Settlement Contract further documents that the contract is proceeding with Workers' Compensation Commission approval and in the event CMS rejects the MSA proposal, the parties will then fund the settlement in an amount as recommended by CMS. Recently, many CMS proposals have been rejected and the CMS recommended amount is substantially higher than the proposal. As such, workers' compensation Settlement Contracts

now often include language that the respondent shall have the option to either fund the Medicare Set Aside in the amount approved by CMS or, in the alternative, leave medical rights open. A sample of workers' compensation Settlement Contract language follows:

The parties have further considered the interests of the Center for Medicare Services and possible applicability of the Medicare Secondary Payer Act. As such, the parties further agree to allocate a sum towards future Medicare covered expenses. In addition to the settlement sums identified above, the respondent agrees to fund a Medicare Set Aside account based upon estimated annual medical expenses of \$*. Said Medicare Set Aside account will be funded up front with a lump sum totaling \$* and further funded through issuance of an annuity, payable for life only, producing future annual payments of \$*, commencing in ****, 200*, through *** 20**. The parties further understand and agree that the Set Aside proposal will be submitted to CMS for approval and in the event CMS rejects said proposal and provides revised figures for the Medicare Set Aside account, then the respondent shall be responsible to fund said account in the amount so designated by the Center for Medicare Services, or in the alternative, at respondent's insurers option the settlement can be amended to leave the petitioner's medical rights open in lieu of a Medicare Set Aside account. Said Medicare Set Aside account funds shall be deposited in a federally insured interest bearing account. Future interest payable to said account shall further be used by the petitioner for future Medicare covered expenses. Petitioner expressly understands that failure to pay Medicare covered expenses from said account may result in the loss of future Medicare benefits for treatment associated with the afore described occurrence. If payments from the Medicare Set Aside account are used to pay for services that are not covered by Medicare, Medicare will not pay injury related claims until these funds are restored to the Medicare Set Aside account and then properly exhausted. The claimant further understands that annual reporting must be prepared for submission to Medicare to include summaries of the transactions and status of the account. These summaries are to include the date of each service procedure performed, diagnosis and paid receipt or cancelled check. The claimant further agrees to hold harmless and indemnify the respondent, *** Insurance Company, Heyl, Royster, Voelker & Allen and the firm of ** from any cause of action, including but not limited to an action to recover or recoup Medicare benefits or loss of Medicare benefits, if CMS determines that the money set aside was spent inappropriately or for any recovery sought by Medicare including past, present and future liens.

RELEASE LANGUAGE – CIVIL CLAIMS

Where a Medicare Set Aside account is being established and funded as a part of a civil settlement, language similar to that set forth above should be incorporated into the plaintiff's release. Each release must be tailored to the specific facts and circumstances of the civil

settlement. Where a claimant is not a Medicare eligible individual that information should be identified in the release. Where a claimant meets the definitions of Class 1 or Class 2 beneficiaries that should also be specifically addressed. Depending on the particular settlement, suggested language below may fit the particular circumstance.

Plaintiff agrees to indemnify and hold harmless (defense firm, defendant) (insurer) from any and all claims arising out of inaccurate information or misrepresentations by the plaintiff with regard to plaintiff's Social Security number, Medicare status, and Social Security status.

Plaintiff represents and affirms that he/she is not currently drawing Social Security retirement, Social Security Disability benefits, nor Medicare benefits and that no such benefits have been drawn for the preceding five (5) years. Plaintiff further represents and affirms that he/she is not Medicare eligible.

Plaintiff further stipulates, agrees, and represents that he/she has not had any medical bills paid by Medicare and/or Medicaid which in any way relate to the alleged injuries arising from the above-captioned cause of action.

Plaintiff further stipulates and agrees that he/she is younger than 65 years of age and is not qualified in any manner for Medicare and/or Medicaid benefits nor that he/she is a Social Security retirement beneficiary or Social Security disability beneficiary.

Plaintiff has a good faith belief that he/she shall not need nor apply for Medicare coverage within thirty (30) months from the date of signing this agreement.

Plaintiff further agrees that he/she is responsible for satisfying any and all claims of lien or rights to reimbursement for conditional payments by Medicare arising out of treatment for injuries alleged to have occurred as a result of the incident which is the subject matter of the above-captioned cause of action. Plaintiff agrees that he/she shall indemnify and hold harmless the parties, their insurers and (defense firm) from any claim for reimbursement of Medicare payments or conditional payments arising out of injuries which are the subject matter of the incident identified in the above-captioned claim.