

MEDICARE SET ASIDES – PROBLEMS AND SOLUTIONS

1. What is Medicare?

- (a) Medicare consists of Federally-provided medical insurance, which is mandated for some benefits and allows optional coverage for other benefits, all of which are paid for by payroll tax withholding.
- (b) The mandatory portion of Medicare (Part A) covers “major medical expenses,” i.e., hospitalization, skilled nursing home care and hospice care.
- (c) Optional coverage (Part B) covers physician office visits, durable medical equipment, outpatient surgeries, diagnostic imaging studies and intravenous medications.
- (d) In addition, “Medi-Gap plans” are supplemental, private health insurance plans that can cover deductibles and co-payments.
- (e) Medi-Cal (Medicaid) recipients are automatically enrolled in Medicare, based upon financial need, however, not all prescription costs are covered.

2. Definitions and Basic Considerations:

What is a Medicare Set Aside?

A Medicare Set Aside (MSA) consists of money identified or “set aside” in a settlement agreement to cover future medical treatment expenses which would, otherwise, be paid for by Medicare.

The MSA can become a formal agreement between the parties and the Federal Government that will protect an injured worker (Medicare beneficiary/applicant) from losing Medicare benefits after the agreed-upon amount of settlement money has been spent.

3. Why do we care about MSAs?

- (a) The United States government predicts Medicare will run out of money in 2026. It is also estimated that Social Security will exhaust its trust fund in 2033. These constitute the Federal Government's two largest benefit programs and are precarious, in part, due to the recession of 2008.
- (b) Medicare has paid expenses, in the past, which were the obligations of private insurance companies or other "primary payors." In 1966, Congress passed legislation to protect Medicare from being used to subsidize private obligations under workers' compensation, personal injury or other liability contexts. Implementing legislation was passed in 2001. The Centers for Medicare and Medicaid Services (CMS) are now collecting money to prevent the shift of future treatment expenses to the Medicare and Medicaid programs.
- (c) Congress has appropriated money for CMS to implement and enforce legislation with reporting requirements for liability, group health, self-insured and no fault medical insurance programs, including workers' compensation.

4. When must an MSA be considered?

(a) Only when future medical treatment issues are settled, as in a Compromise & Release.

(b) Threshold guidelines for CMS review:

(1) Where an applicant is a Medicare beneficiary and the settlement agreement is greater than \$25,000; or

(2) Where the applicant has a reasonable expectation of becoming a Medicare beneficiary within 30 months and the settlement agreement is greater than \$250,000.

5. A “reasonable expectation” of becoming Medicare eligible is seen if:

Applicant has already filed for Social Security Disability, or Social Security Disability has been denied, and the applicant anticipates re-filing or appealing the denial, or applicant is 62½ years old (less than 30 months from becoming automatically entitled to apply for Medicare at age 65), or applicant has end-stage renal disease.

6. How are the threshold guidelines for CMS review calculated?

CMS includes indemnity benefits and non-medical portions of the settlement agreement in calculating the settlement threshold guideline amounts, set forth above.

Question: Is this right? CMS may want to know about the size of the overall settlement for Social Security Disability purposes, but the Medicare issues are only a function of the value of the future medical treatment rights being settled. Aren't the values of other benefits irrelevant?

7. MSA Considerations:

(a) The above guidelines do not constitute a “safe harbor.” The guiding principle is that Medicare’s interests must be considered and protected in the parties’ settlement agreement involving future medical treatment.

(b) Medicare Set Aside Issues:

(1) The Medicare program, originally enacted in 1965, provides primary health insurance for eligible individuals. It was not intended to relieve other obligors from payment of medical treatment expenses. For example, victims of personal injuries or workers' compensation injuries have a private tortfeasor or workers' compensation benefit provider as the primary obligor or primary payor for medical treatment purposes. Under these circumstances, Medicare is a secondary payor. This was specifically mandated by 42 USC 1395y(b)(2), passed in 1980.

(2) If there is a primary obligor, Medicare either does not pay or can seek recovery for its “conditional” payments. The primary obligor or payor can be a private tortfeasor, liability or automobile insurance carrier, no-fault insurance provider or workers' compensation benefit provider.

(3) The Medicare Secondary Payor Act of 1980, raises two considerations in workers' compensation cases:

(a) Conditional Payments for treatment may be made by Medicare, where that treatment should have been paid for by the workers' compensation provider. Medicare can assert a lien to recover these payments.

(b) The future cost of an injured worker's treatment for industrial injuries cannot be shifted from the workers' compensation benefit provider to Medicare without "considering and protecting Medicare's interests."

8. The Medicare and Medicaid Schip Extension Act (MMSEA) of 2007:

Requires workers' compensation benefit providers to report settlements involving Medicare beneficiaries to CMS or be subject to a penalty of \$1,000.00 per day, per claim. See 42 USC 1395y(b)(8).

Section 111 of the MMSEA (42 USC 1395y(b)(8)), requires responsible reporting entities (RREs or claims administrators) to report all Total Payment Obligations to Claimants (TPOCs or settlements) involving a Medicare beneficiary to the Coordination of Benefits Contractor (COBC) at P.O. Box 33849, Detroit, MI 48232.

9. The SMART Act:

Effective October, 2016, 42 CFR 411.39, allows the parties to negotiate conditional payments, prior to a C&R.

10. Eligibility for Medicare is related to Social Security entitlement:

(a) Entitlement to Social Security can be based upon age (retirement benefits) or disability. Either way, the programs are paid through payroll taxes.

(b) For those born between 1943 and 1954, the full retirement age is 66. For those born in 1960 or later, the full retirement age is 67. Once eligible for Social Security Retirement benefits, these benefits will not be offset by a workers' compensation lump sum settlement.

(c) Social Security Disability benefits, however, are based upon earnings and disability requirements. Social Security Disability benefits may be affected by a worker's compensation settlement.

11. What to consider in determining whether to implement an MSA:

(a) An MSA is not necessary in every settlement of future medical treatment. If the applicant meets the threshold guidelines above, however, it is advisable to provide for an MSA within the terms of the settlement agreement.

(b) MSAs can be handled in different ways: A self-administered MSA account can be accomplished by using special language in the settlement agreement. Applicant will, however, still need to account for his or her settlement proceeds to protect Medicare's interests.

(c) Where the settlement exceeds the threshold guidelines, set forth above, it is recommended that the settlement agreement provide for one of the following, (listed in order of increasing formality):

(1) A self-administered MSA;

(2) A custodial account-administered by someone other than the applicant; or,

(3) A formal, written trust account (a Medicare Set Aside Trust or MSAT). This can be structured as part of a Special Needs Trust (SNT) and can be designed to protect an applicant's entitlement to need-based government benefits.

12. Note that the parties cannot waive or diminish Medicare's rights by agreement:

What the parties agree to means nothing to Medicare. What is judicially ordered, approved or found, however, will be honored by Medicare.

Caution! Medicare has a statutory right to be reimbursed for past injury-related medical treatment in full before any other entity receives any funds. This could, potentially, leave an applicant receiving nothing under the settlement agreement, with defendants remaining obligated to Medicare for the balance of Medicare's conditional payments.

A Medicare Set Aside arrangement is not required when the parties compromise applicant's right to past medical treatment. However, where the parties settle future medical treatment rights Medicare considers this a "commutation" and a Medicare Set Aside arrangement may be warranted.

NOTE: MEDICAID is a need-based government program, which is available only to those with limited assets.

MEDICARE is not a need-based program. Medicare pays for hospital charges, physicians, prescription medication, medical rehabilitation services, but not for a group or nursing home, or home health care services.

13. What is required in an MSA?

The Workers' Compensation Medicare Set Aside (WCMSA) is only required to identify and set aside funds intended to pay for medical services due to an industrial injury that would otherwise be covered by Medicare. To analyze this expectancy, CMS

considers the most recent 24-months of active treatment; applicant's prognosis, a life-care plan, if available, and corresponding payment records for prescription payments and medical treatment.

14. Who must be concerned with an MSA? Everyone!

- (a) The U.S. can bring an action “against any entity that has received payment from a primary plan or from the proceeds of a primary plan’s payment to any entity.” See 42 CFR Part 411 and Section 489.20(i)(2)(ii). Such an “entity” can include a Medicare beneficiary, medical provider, physician, attorney or insurer who has received any payment, if those funds, rather than Medicare, should have paid for the injury-related medical expenses. 42 U.S.C. Section 1395y(b)(2)(ii).
- (b) The statute provides that the primary payor may be subject to double damages, plus interest.

15. Sample forms: (Attached)

- (a) **Form Number 1**: Disclosure/Confidentiality of Information (SSA-3288) form and CMS/Medicare Consent to Release of Information form.
- (b) **Form Number 2**: A sample Addendum “A” to a Compromise and Release agreement, pertaining to MSAs.
- (c) **Form Number 3**: A sample Addendum “B” to a Compromise and Release agreement, to be used where applicant is represented by counsel or sophisticated and the settlement amount is significant.

- (d) **Form Number 4**: A sample Self-administered Medicare Set Aside Agreement.
- (e) **Form Number 5**: A sample Addendum “C” to the Compromise and Release agreement, Administering Your Lump Sum Worker’s Compensation Medicare Set Aside Arrangement (WCMSA).
- (f) **Form Number 6**: A sample Addendum “D” (Social Security Disability Addendum) to the Compromise & Release, or “Hartman” formula.

NOTE: Defendants may require applicants to disclose whether or not they are Medicare beneficiaries, currently eligible for Social Security or Medicare benefits, whether they have applied for Social Security and can require applicants to sign the appropriate release forms to permit communication between the claims administrator and CMS, whether a C&R is ultimately agreed upon or not.

Moreover, Workers' Compensation Judges have jurisdiction to order applicant’s answer to these inquiries, since claims handlers, as responsible reporting entities, are required to document the protection of Medicare’s interests.

16. Additional definitions:

- (a) Conditional payments are where Medicare pays first (as in a disputed claim). Medicare then becomes a lien claimant in the applicant’s worker’s compensation case. These cases need to be identified early. If there remains a threshold issue of liability up to settlement, document this to limit what would otherwise become defendants’ liability.

- (b) Defendants may insist upon CMS approval of these settlements, because of Medicare's conditional payments or "lien" rights.

17. What is an MSA Allocation Report?

The MSA Allocation Report should project applicant's future medical treatment costs, both annually and over applicant's lifetime.

NOTE: A "Guaranteed Approval by CMS" may not be desired, because it may not properly challenge CMS' initial allocation.

18. How do I obtain the CMS Determination Letter?

- (a) With the MSA Allocation Report, medical documentation and any trust agreement, CMS will approve the MSA amount or counter with an increased MSA amount.

- (b) The Determination Letter from CMS will be sent to applicant and applicant's counsel. This letter will include instructions regarding administration of the MSA.

19. What obligations are effective as of 2009?

- (a) Primary payors (defendants) must confirm an applicant's Medicare status. Once Medicare eligibility has been confirmed, defendants must place Medicare on notice of the claim. For workers' compensation cases, these reporting procedures must be implemented by July 1, 2009.

- (b) For individual cases being settled, the parties need the SSA-3288 and CMS-Medicare Consent to Release Information form (Attached Form Number 1) signed.

- (c) The civil penalty for defective reporting is \$1,000.00 per day per beneficiary.

20. The WCAB cannot bind the Federal Centers for Medicare and Medicaid Services (CMS):

However it is appropriate for the Appeals Board to approve an addendum to a C&R, signed by the parties, noting their due diligence in addressing the interests of Medicare. See *Isaac v. Paramount Pictures* (2011) 39 CWCR 264.

21. Miscellaneous Considerations:

- (a) Personal injury (civil) claims also need to consider Medicare's interests. Keep this in mind in regard to subrogation settlements. This is something with which personal injury attorneys may not be familiar.
- (b) If the applicant is not competent to sign a settlement agreement, you will need a *Guardian ad Litem* to sign the settlement papers and a custodial or trust account for any MSA.
- (c) Special classes of people may have medical treatment covered by separate programs, such as injured veterans. Others may have health insurance coverage provided for life. These separate sources of coverage can affect your MSA.
- (d) Conditional payment demands from Medicare can be negotiated. Look for non-industrial treatment and reduce Medicare's demand by procurement costs (attorneys' fees and expenses not recovered by applicant). Medicare will consider hardship waivers and reductions in very compelling situations.

(e) A Medicare Set Aside arrangement should be documented where the applicant is already entitled to Medicare at the time of the settlement, or if it is foreseeable that applicant will require future medical treatment at a time when he or she is likely to be eligible for Medicare.

22. Consider the manner in which applicant is eligible for Social Security benefits:

(a) If eligible for retirement benefits, the C&R will not affect those benefits. If eligible for Social Security Disability benefits, however, a lump sum worker's compensation settlement agreement may affect an applicant's entitlement to those benefits going forward. Social Security Disability is based upon a physical and/or mental impairment that, given the applicant's age, education, occupational history, medical conditions and residual functional capacities, renders him or her unable to engage in any kind of substantial gainful activities for at least 12 consecutive months or which will result in death. See 42 USCA 416(l).

(b) In any case meeting this criteria, applicant should be urged to apply for Social Security Disability benefits promptly, because of the 104-week cap of temporary disability after April 19, 2004. (Labor Code §4656(c)).

- (c) The “80% Rule” is used to calculate the amount by which Social Security Disability benefits are reduced by settlement monies. Social Security Disability benefits are reduced if other publicly mandated benefits exceed 80% of the claimant’s highest calendar year’s earnings in the last five years before the onset of disability, or an average of the highest five consecutive years of earnings. Publicly mandated benefits include State Disability Insurance and workers' compensation indemnity benefits.
- (d) Note that Long-Term Disability plans (LTD) are not “publicly mandated.” Most LTD plans are coordinated with Social Security Disability payments and are, as a result, reduced by the amount of an individual’s Social Security Disability entitlement.
- (e) Social Security Disability benefits are not affected by those portions of the settlement representing attorney's fees, a Supplemental Job Displacement Benefit, penalties, interest, a right to re-open, potential death benefits, mileage reimbursement deducted medical expenses and an MSA, or other deductions from applicant's recovery. (See attached Form Number 6.)
- (f) A Workers' Compensation Judge should be asked to acknowledge and approve the allocations and characterization of settlement proceeds set forth in the Social Security addendum to make sure the settlement results in an adequate recovery. An unanticipated reduction in an applicant's Social Security Disability entitlement could make an otherwise adequate settlement agreement inadequate.

23. The original Order Approving a Compromise and Release agreement should include language protecting an applicant against a Social Security Disability offset, as follows:

“The Court has considered the proposed characterization of proceeds in the Social Security addendum attached to the parties’ Compromise and Release agreement. The Court adopts, incorporates and accepts the proposed allocation of proceeds and finds that the applicant's net recovery is equivalent to the sum of \$_____ per month, for life, because of the applicant's loss of future earning capacity caused by his or her impairments.”

This language should be used whenever necessary to minimize or eliminate a Social Security Disability reduction caused by a worker’s compensation lump sum settlement agreement. Use attached Form Number 6 to document the necessary calculations.

24. Some costs not covered by Medicare:

(a) Medicare Part D does not cover:

- (1) Vitamins
- (2) Supplements
- (3) Over-the-counter medications
- (4) Off-label drugs (see 5/14/2010 memo)
- (5) Limited opioid or opiate-based pain medications

(b) Medicare Parts A & B do not cover:

- (1) Home assistance for laundry, gardening, window cleaning, meal preparations, other maid services
- (2) Mileage reimbursement
- (3) Transportation services
- (4) Home modifications
- (5) Most dental and vision care

See www.Medicare.gov for a drop-down menu of these items.

25. Additional considerations:

- (a) Note that Medicare uses the “average wholesale pricing” of medication costs, even though California defendants can pay reduced prescription costs by fee schedule or agreement (effective April 3, 2009).
- (b) If applicant's life expectancy is diminished, provide actuarial evidence of this. The Workers' Compensation Medicare Set Aside allocation vendor should be provided a copy of the draft C&R with addenda, along with signed release forms.
- (c) CMS is supposed to respond within 15 days to a documented Worker's Compensation Medicare Set Aside. If a letter requiring development of information issues, the average delay is 113 days. Appeal of a CMS denial of a WCMSA is not allowed. See 42 CFR 405.926 and 405.928.

(d) Where a WCMSA approval is pending, a Workers' Compensation Judge may approve a C&R, if:

“Applicant agrees to add funding to the WCMSA from his or her net proceeds from the C&R, if CMS rejects the MSA previously submitted. Applicant agrees to hold defendants and counsel harmless from any additional liability for the MSA amount submitted as of the date of the C&R approval.”

This is going to be a carefully scrutinized settlement term and will likely be approved only where the overall amount of the settlement agreement clearly appears adequate or other exigent circumstances can be shown to a sympathetic Workers' Compensation Judge. Note that paragraph 11 of the C&R form acknowledges that Social Security Disability and Medicare entitlements may be affected by a worker's compensation settlement. It behooves counsel to analyze these consequences carefully to avoid surprises, traps, unhappy clients or the possibility of further, undesired litigation.

26. Things to keep in mind:

- (a) Without proper documentation and planning, a C&R can reduce or eliminate an applicant's Social Security Disability payments;
- (b) Medicare may deny coverage for future medical treatment for body parts injured in a work-related injury;

- (c) Medicare may sue applicant, his attorney and the required reporting entity (carrier or self-insured employer) for twice the past treatment costs and interest;
- (d) Applicant may sue his attorney for malpractice and the insurer for bad faith settlement practices;
- (e) The required reporting entity may be fined \$1,000.00 a day for its failure to report its settlement with a Medicare beneficiary.

27. If things are done right:

- (a) Medicare will continue to provide treatment on behalf of the injured worker outside of the CMS approved Medicare Set Aside;
- (b) A judicial determination of no injury AOE/COE or no injury to specific body parts will be given full faith and credit by CMS;
- (c) An injured worker will have sufficient funds to provide for treatment not covered by Medicare and, therefore, his or her future medical treatment needs will be adequately provided for.

28. Possible Solutions:

Where future medical treatment costs, as determined by CMS are exorbitant, consider a reversionary clause in the settlement documents. In this manner, a large amount can be placed into trust to cover future medical treatment needs with a provision to allow unused treatment expenses to “revert” back to defendants in the event these costs end up not being used for any reason, including applicant's premature death.

Alternatively, the parties could settle for only a portion of the expected, future medical treatment needs and provide additionally in the settlement documents that defendants will remain liable for additional medical treatment, if necessary, up to the amount required by the CMS-mandated Medicare Set-Aside.

In the first instance, the C&R would be larger, but with a clause to return the unused portion of applicant's future medical treatment costs back to defendants. In the latter approach, the C&R would be smaller, to begin with. When the funds provided in the smaller C&R are exhausted, however, defendants would need to provide additional funds, up to the limits of the CMS approved MSA.

Finally, look for an insurance vehicle that pays CMS if the WCMSA is deemed inadequate.

29. Conclusion:

- (a) Determine if an MSA is needed.
- (b) Calculate the MSA amount.
- (c) Submit the MSA Allocation Report to CMS for approval, only if necessary.
- (d) Defendants must report settlements involving Medicare beneficiaries.
- (e) Always document the consideration and protection of Medicare's interests, preferably in the C&R itself or, at least, in your file.

30. Example:

A Compromise and Release is considered by the parties to be adequate at \$70,000.

The parties value Applicant's Future Medical Treatment needs to equal \$40,000.

CMS responds with an MSA of \$110,000.

Possible Solutions:

- (a) C&R with open medical for \$30,000
- (b) Full C&R of disputed body parts – limited open medical award for admitted
body parts only
- (c) C&R at \$140,000 with reversionary clause
- (d) C&R at \$70,000 with defendants liable for additional MSA – specified
expenses



Form Approved
OMB No. 0960-0566

Social Security Administration

Consent for Release of Information

TO: Social Security Administration

Name

Date of Birth

Social Security Number: _____

I authorize the Social Security Administration to Release information or records about me to:

NAME

ADDRESS

_____	_____
_____	_____
_____	_____
_____	_____

I want this information released because:

I am currently involved in a workers' compensation or general liability claim and one of the parties to the claim needs the below-reference information on order to comply with the

Medicare Secondary Payor

Act or the Medicare, Medicaid and SCHIP Act of 2007.

(There may be a charge for releasing information)

Please release the following information:

____ Social Security Number

____ Identifying information (includes date and place of birth, parent's names)

____ Monthly Social Security benefit amount

____ Monthly Supplemental Security income payment amount

____ Information about benefits/payments I received from _____ to _____

X Information about my Medicare claim/coverage from _____ to present

(specify) _____

X Medical records

X Record(s) from my file (specify) Date of Medicare or Medicaid entitlement and basis of entitlement; any medical claims or liens filed by Medicare or Medicaid.

X Other (specify): Date disability benefits were applied for; status of application; date disability benefits started, current SSDI payments and anticipated date of Medicare eligibility.

I am the individual to whom the information/record applies or that person's parent (if a minor) or legal guardian. I know that if I make any representation, which I know is false to obtain information from Social Security records, I could be punished by a fine or imprisonment or both.

Signature: _____
(Show signatures, names, and addresses of two people if signed by mark.)

Date: _____ Relationship: _____

Form SSA-3288 (5-2007) EF (5-2007)

CONSENT TO RELEASE

I, _____ (print your name exactly as shown on your Medicare card) hereby authorizes the Centers for Medicare & Medicaid Services, (CMS), its agents and/or contractors to release, upon request, information related to my injury/illness and/or settlement to the individual(s) and/or entities listed below:

CHECK ONLY ONE OF THE FOLLOWING TO INDICATE WHO MAY RECEIVE INFORMATION AND THEN PRINT THE REQUESTED INFORMATION

If you intend to have your information released to more than one individual or entity, you must complete a separate release for each one).

(X) Other:

Name of entity:

(Name and/or firm)

Contact for the above:

Address:

Telephone:

CHECK ONE OF THE FOLLOWING TO INDICATE HOW LONG CMS MAY RELEASE YOUR INFORMATION The period you check will run from when you sign and date below):

() one year () two years () Other _____
(Provide a specific period of time)

Beneficiary's Signature

Date signed

Date of Injury/Illness

Medicare Number

If your Power of Attorney (POA) or legal representative signs this form for you, a copy of their POA or representation papers must be sent to us with this form.

- Completion and signing of this consent form:
- Authorizes release of information to the person named above upon their request. This means that information disclosed to the above named person may be re-disclosed by them and may no longer be protected by law.
- Allows release of Medicare claims and other information related to your injury/illness
- Is for release of information purposes only and does not affect benefits you are entitled to under the Medicare Program.

You have the right to revoke your authorization at any time in writing, except to the extent that CMS has already acted based on your permission. To revoke, send a written request to the address listed below.

Medicare Secondary Payer Contractor

Post Office Box 33828, Detroit, MI 48232-5828

ADDENDUM 'A' TO COMPROMISE AND RELEASE AGREEMENT

Addendum to Paragraph 9 of the attached Compromise and Release Agreement

RE: _____
WCAB No(s):

Allocation of Benefits: Based upon a review of applicant's medical records, \$_____ of the total consideration in this settlement agreement is allocated to applicant's possible future medical expenses related to the injury(ies) referred to in this settlement pursuant to 42 CFR 411.46 and 42 CFR 411.47.

[and]

Medicare Set Aside Issues: Applicant stipulates that (s)he is not currently receiving Social Security Disability or Medicare benefits. In addition, applicant stipulates that (s)he has not applied for or been denied Social Security Disability or Medicare benefits. Applicant is not in the process of appealing or re-filing for Social Security Disability or Medicare benefits and is not planning to apply for Social Security Disability or Medicare benefits within the next 30 months. Applicant warrants that (s)he does not have End Stage Renal Disease (ESRD). Applicant agrees to execute such documents and authorize such inquiries as may be necessary to confirm the foregoing and to allow defendants to obtain appropriate consent forms and obtain approval of this settlement agreement from the Centers for Medicare and Medicaid Services (CMS). In addition, applicant agrees to maintain a self-administered Medicare Set

Aside Trust for possible further medical treatment needs which may arise as a result of the industrial injury(ies) settled hereby in the amount of \$ _____. This sum is intended to provide an amount sufficient to satisfy applicant's expected needs for medical treatment, which would otherwise be covered by Medicare over applicant's lifetime. Applicant agrees to hold defendants and counsel harmless from any impact this settlement agreement may have on applicant's possible, future Medicare or Social Security benefits.

[or]

Medicare Set Aside Issues: Applicant has applied for Social Security Disability and Medicare benefits. Applicant warrants that (s)he does not have End Stage Renal Disease (ESRD). Applicant agrees to execute such documents and authorize such inquiries as may be necessary to confirm the foregoing and to allow defendants to obtain appropriate consent forms and obtain approval of this settlement agreement from the Centers for Medicare and Medicaid Services (CMS). In addition, applicant agrees to maintain a self-administered Medicare Set Aside Trust for possible further medical treatment needs, which may arise as a result of the industrial injury (ies), settled hereby in the amount of \$ _____. This sum is intended to provide an amount sufficient to satisfy applicant's expected needs for medical treatment, which would otherwise be covered by Medicare over applicant's lifetime. Applicant agrees to hold defendants and counsel harmless from any impact this settlement agreement may have on applicant's possible, future Medicare or Social Security benefits.

ADDENDUM 'B' TO COMPROMISE AND RELEASE AGREEMENT

Addendum to Paragraph 9 of the attached Compromise and Release Agreement

INFORMED CONSENT

RE: _____

WCAB No(s):

I understand and acknowledge that:

9(h) The settlement of my workers' compensation case by Compromise and Release settlement agreement with the third-party administrator and the employer named above (hereinafter "defendants") means that these defendants will not be responsible for any future medical expenses or indemnity payments after the date of signing the Compromise and Release.

9(i) My condition as a result of my settled work injury(ies) may be considered a pre-existing condition for purposes of health care insurance and a health insurance provider may not pay for medical expenses that are the result or a consequence of my settled work injury(ies).

9(j) I will be responsible for all future medical expenses related to my settled work injury(ies), I will receive no further payments from defendants and may not seek reimbursement for any future expenses from defendants.

9(k) Any future medical expenses that are the result of my settled work injury(ies) will have to be paid by me from the proceeds of my settlement. I must make appropriate arrangements to ensure that I have sufficient funds available from the proceeds of the Compromise and Release to pay any future medical expenses to cure or relieve the effects of my settled work injury(ies).

- 9(l) The amount received by me from the Compromise and Release will be considered by the Social Security Administration and the Health Care Financing Administration in determining eligibility for any benefits I may be entitled to receive. By receiving a lump sum settlement, monthly payments from Social Security Disability to me may be reduced.
- 9(m) The Medicare Set-Aside funds (hereinafter MSA funds) in this case are to be self-administered by me. I have been provided directives issued by CMS regarding my rights and responsibilities in this regard. I understand that the MSA funds must be placed in an interest bearing account and this account must be separate from my personal savings and checking accounts. The funds in this account may only be used for payment of medical services related to my settled work injury(ies) that would otherwise be paid by Medicare.
- 9(n) It is not the intention of defendants to shift responsibility of future medical benefits to the federal government. The sum of \$_____ is to finance my payment of future medical treatment expenses which would otherwise be paid by Medicare. Upon proof that my Medicare-covered expenses exceed \$_____, those expenses will be forwarded by me, with proper documentation, to Medicare for payment of covered expenses. I hereby acknowledge that it is my responsibility to maintain records, including bills for services Medicare would normally cover, related to my work-related injury(ies) totaling the amount of \$_____ before Medicare will make payment on any covered expenses related to my settled work injury(ies).

- 9(o) The above allocation is based upon the California Worker's Compensation Fee Schedule. I will make my best effort to obtain medical services from providers that accept this Fee Schedule.
- 9(p) By agreeing to this Compromise and Release, my Social Security and Medicare benefits may be reduced due to the amounts received in this Compromise and Release settlement agreement. I understand this risk, elect to accept any effect this settlement may have on my Medicare or Social Security benefits and to proceed with settlement of my workers' compensation benefits by entering into this Compromise and Release settlement agreement.
- 9(q) Social Security Supplemental Security Income (SSI) is a benefit for those disabled persons who have limited income and resources. I understand and acknowledge that by agreeing to receive a lump sum settlement, I may become ineligible for SSI benefits.
- 9(r) The Social Security Administration (SSA) is not bound by the provisions set forth in this Compromise and Release regarding allocation of funds. SSA may withhold payment of medical claims under Medicare until I have paid the equivalent of the sum allocated for future medical care as set forth above. Additionally, SSA may apply credit against funds allocated to permanent disability per their own formula, or consider those sums in their calculation of credit in a manner that may vary from one office to another of the SSA.
- 9(s) The possible consequences of this Compromise and Release upon Social Security, Medicare and medical benefits have been fully discussed with me by my attorney, or I have been advised to seek the advice of an attorney who specializes in Social Security Benefits or the advice of the SSA before agreeing to this Compromise and Release

agreement.

9(t) The specific characterization of the settlement proceeds in this matter, as set forth above, is an essential element of this Compromise and Release. It is specifically requested that the Workers' Compensation Judge approving this Compromise and Release make a specific finding in the Order Approving this settlement ratifying the characterization of the benefits set forth in this Addendum.

9(u) Applicant agrees to hold defendants, defendants' agents, administrators, attorneys and assigns, along with applicant's counsel, harmless from any impact or effect this settlement agreement may have on applicant's Social Security or Medicare benefits or entitlement.

9(v) By signing this Addendum, I acknowledge that I have read and understand all the terms of the Compromise and Release settlement agreement, Addenda and related documents. I further acknowledge that my attorney has discussed and explained these documents to me in the presence of a witness of my choice, if desired, and I am satisfied with this explanation.

DATED: _____
_____ Applicant

LAW OFFICES OF

DATED: _____ By: _____
Attorney for Applicant

LAW OFFICES OF

DATED: _____ By: _____
Attorney for Defendants

SELF ADMINISTERED MEDICARE SET-ASIDE AGREEMENT

This Medicare Set-aside Agreement (the "Agreement") is made and entered into by and between _____ and _____ (the "Payor"), and _____.

RECITALS:

A **Purpose.** This Agreement is for the benefit of _____, (the "Beneficiary"). The Beneficiary is _____ years old and is a resident of San Diego, California. The funds placed in this Medicare Set-aside Account (the "Account") may be used to pay future medical expenses incurred by the Beneficiary for treatment for the work-related injury which occurred to the Beneficiary's _____ on _____ which also resulted in _____, and during a period of cumulative trauma that began on _____ and ended on _____, that would otherwise be covered by Medicare.

The Beneficiary has a medical history which is significant for the following which are not related to the work injury:

The Beneficiary and Payor have entered into an agreement to settle the Beneficiary's future medical benefits due under the California Workers' Compensation Act.

Pursuant to federal law, the interests of Medicare must be considered and protected in all workers' compensation settlements. The Payor and the Beneficiary enter into this Agreement and establish this Account for the Beneficiary as a reasonable consideration of Medicare's interests in this settlement. Approval from the Centers for Medicare and Medicaid Services ("CMS"), was requested. A copy of said approval is attached hereto as Exhibit A, and is incorporated herein by this reference.

This "Account" is being created for the payment of the Beneficiary's future work-related injury medical treatment expenses that would otherwise be paid by Medicare. The Account shall be funded by the Structured Settlement Provider identified in **Exhibit A** attached hereto, in the amount and manner specified in **Exhibit B**, attached hereto. The Beneficiary agrees to use this Account for the purpose stated herein and shall not submit any work-related injury medical treatment expenses that would otherwise be paid by Medicare to Medicare unless the Account is exhausted. The Beneficiary may call 1-800-Medicare for assistance in determining whether an expense may be paid from this Account. Further, the Beneficiary should be certain that no amount in excess of the California workers' compensation Official Medical Fee Schedule is paid from the Account for medical expenses. The Beneficiary agrees to abide by additional terms and conditions as stated in this Agreement.

AGREEMENT:

NOW, THEREFORE, in light of the foregoing and in consideration of the mutual covenants set forth in this Agreement, Payor and Beneficiary, intending to be legally bound, agree as follows:

1. FUNDING

The "Account" shall consist of and be limited to the assets described on the attached **Exhibit B**, which is incorporated herein by this reference, plus any interest earned thereon minus any disbursements made pursuant to the terms of this Agreement.

2. DUTIES AND OBLIGATIONS OF PAYOR

Upon funding by lump sum or purchasing an annuity to fund this Account, as provided in **Exhibit B**, the Payor shall be discharged from any and all duties and obligations to the Beneficiary with regard to this Agreement

3. DUTIES AND OBLIGATIONS OF BENEFICIARY

3.1 **The Account.** The Beneficiary accepts and agrees to hold, invest, administer and distribute funds from the Account as set forth in this Agreement. The money in said Account must be placed in an interest bearing account at an FDIC insured banking institution separate from the Beneficiary's personal savings or checking account.

- 3.2 **Distributions of Principal and Income.** During the lifetime of the Beneficiary, the Beneficiary may distribute amounts from the Account pursuant to the terms of this Agreement to the extent reasonable and necessary, the Beneficiary may deplete the funds in the Account prior to the Beneficiary's death. Money from this Account may only be used to pay medical expenses which are related to the work injury which would otherwise be payable by Medicare. The interest earned on this Account may be used to pay reasonable copying, postage and banking expenses related to managing said Account. If this Account is used to pay for services other than those identified herein, Medicare will not pay injury related claims until said funds are restored to this Account and properly exhausted.
- 3.3 **Reporting and Record Keeping.** The Beneficiary shall maintain accurate records of the distributions and expenditures from this Account, including dates, purposes and payees thereof, and further shall maintain a receipt or other evidence of each such distribution or expenditure. The Beneficiary shall complete the self-attestation document attached hereto as **Exhibit C** each year and forward the same to the Structured Settlement Provider identified in **Exhibit A** along with any requested documentation concerning Account expenditures. Should the Account ever be permanently exhausted, the Beneficiary shall inform the lead contractor of such.

- 3.4 **Taxes.** The Beneficiary shall ensure that appropriate tax returns are filed when necessary and that all required taxes on the Account are paid. Taxes on the interest accrued on this Account may be paid from the Account.

4. TERMINATION OF ACCOUNT AND AGREEMENT

This Agreement shall be terminated only upon as follows:

- 4.1 **Exhaustion of the Account.** This Agreement shall terminate if the Account is permanently exhausted after paying the Beneficiary's medical treatment expenses as provided herein and no additional funding is anticipated.
- 4.2 **Death of Beneficiary.** Unless sooner terminated by exhaustion of the Account, this Agreement shall terminate as soon as practicable following the death of the Beneficiary. All medical expenses incurred by the Beneficiary during the term of the Agreement must be submitted to the Beneficiary's estate no later than 180 (one hundred eighty) days after the Beneficiary's death. After the payment of all such expenses, any amount remaining in the Account shall be paid to the estate of the Beneficiary.
- 4.3 **Loss of Medicare Eligibility.** This Agreement and Account shall not terminate even if the Beneficiary's Medicare eligibility is terminated. The Medicare Set-aside funds may, however, continue to be used to pay expenses which would otherwise be covered by this Agreement.

5. INDEMNIFICATION

- 5.1 Beneficiary shall indemnify, defend and hold Payor, and its respective officers, directors, employees' counsel or agents, free and harmless from and against any and all liabilities, damages, losses, claims, costs or expenses, including reasonable attorneys' fees (collectively "Claims"), that are hereafter made or brought against Payor arising from or attributable to the Beneficiary's performance of obligations under this Agreement.
- 5.2 The Beneficiary agrees to hold harmless, defend and indemnify Payor from any cause of action and other claim, including but not limited to an action to recover or recoup Medicare benefits or a loss of Medicare benefits if CMS determines that the money set aside was spent inappropriately or for any recovery sought by Medicare, a Medicare Advantage Plan or a Medicare Prescription Drug plan for past, present, or future claims or liens.

6. GENERAL PROVISIONS

- 6.1 **Governing Law.** This Agreement, the construction and enforcement of its terms, and the interpretation of the rights and duties of the parties hereunder shall be governed by the laws of the State of California.
- 6.2 **Medicare Coverage for Other Conditions.** The Beneficiary's entitlement under this Agreement to make payment(s) from the Account for work-related medical expenses that Medicare would otherwise cover is not intended to impair or otherwise affect the Beneficiary's right to coverage

under Medicare for medical and related expenses for conditions not related to the Beneficiary's work-related injury(ies).

- 6.3 **Facsimile Signatures.** Facsimile signatures of all parties on this Agreement or on any document or instrument delivered pursuant to this Agreement shall be deemed to be original signatures and shall be sufficient to bind the parties.
- 6.4 **Binding Effect.** This Agreement shall be binding upon and shall inure to the benefit of each of the parties and their respective heirs, successors, assigns and legal representatives.
- 6.5 **Waiver.** No waiver of any right under this Agreement shall be effective for any purpose unless in writing and signed by the party possessing said right. Any such written waiver shall not be construed to waive any subsequent right or other term or provision of this Agreement.
- 6.6 **Counterparts and Execution.** This Agreement may be executed in one or more counterparts, each of which shall be deemed an original, all of which, taken together, shall constitute one and the same instrument binding on all the parties hereto, notwithstanding that all of the parties are not signatories to the original or the same counterpart.

- 6.7 **Construction.** The parties agree that each party and its attorney has reviewed and revised this Agreement and that any rule of construction to the effect that ambiguities are to be resolved against the drafting party shall not apply in the interpretation of this Agreement or any amendment or exhibits hereto.
- 6.8 **Notices.** Any notice permitted or required hereunder shall be in writing and shall be deemed to have been given (a) on the date of delivery if delivery of a legible copy was made personally or by facsimile transmission or (b) on the second business day after the date on which mailed by registered or certified mail, return receipt requested, addressed to the party for whom intended at the address set forth on the signature page of this Agreement or such other address, notice of which is given as provided herein.
- 6.9 **Partial Invalidity.** Each term and provision of this Agreement shall be valid and enforceable to the fullest extent permitted by law. If any term of this Agreement or the application thereof to any person or circumstance shall, to any extent, be held to be invalid or unenforceable, then the remainder of this Agreement and the application of such term or provision to persons or circumstances other than those to which it is held invalid or unenforceable shall not be affected thereby.

6.10 **Arbitration.** Any dispute arising in connection with the interpretation or endorsement of the provisions of this Agreement, or the application or validity thereof, shall be submitted to arbitration. Such arbitration proceeding shall be held in San Diego, California or a mutually agreeable location, in accordance with the rules of the American Arbitration Association. This agreement to arbitrate shall be specifically enforceable. Any award rendered in any such arbitration proceedings shall be final and binding on each of the parties hereto, and judgment may be entered thereon in any court of competent jurisdiction.

6.11 **Agreement** This Agreement may be amended or modified only by a written instrument signed by the party alleged to be bound by such amendment or modification.

7. EFFECTIVE DATE OF AGREEMENT

The effective date of this Agreement is the date that the initial payment of money for the Medicare Set-aside Account is received by Beneficiary. This Agreement shall be considered executory until the effective date. No rights, obligations or duties shall be created hereunder unless the Beneficiary is alive on the effective date.

ACKNOWLEDGMENT/ACCEPTANCE BY PARTIES

Acceptance by Payor

The undersigned, a duly authorized representative of Payor, acknowledges that the undersigned has reviewed and accepted the Basic Provisions, the Terms and Conditions and all Exhibits comprising this Agreement, and agrees that, upon execution of this Agreement by all parties and delivery of funds to the Beneficiary, Payor shall be legally bound.

"PAYOR"

date

By _____

Acceptance by Beneficiary

The undersigned, the designated Beneficiary, acknowledges that the undersigned has reviewed, accepted and approved this agreement and agrees that, upon execution of this Agreement, Beneficiary shall be legally bound.

"BENEFICIARY"

date

Approved in Form and Content by Counsel for Beneficiary

date

EXHIBITS TO SELF-ADMINISTERED MEDICARE SET-ASIDE AGREEMENT

Exhibit A

Identity of the Structured Settlement Provider

Exhibit B

Structured settlement amount; payment structure

Exhibit C

Self-Attestation Form (See Materials, Form #5)

[This form is not required at the time of the Compromise and Release approval, but is a necessary form to advise applicant of the workers' compensation Medicare Set Aside (WCMA) procedures and is, therefore, a helpful document to have as part of the package of workers' compensation settlement documents.]

ADDENDUM 'C' TO COMPROMISE AND RELEASE AGREEMENT

ADMINISTERING YOUR LUMP SUM WORKERS' COMPENSATION

MEDICARE SET ASIDE ARRANGEMENT (WCMSA)

RE: _____

WCAB No(s):

You have chosen to personally administer the WCMSA account established as part of a workers' compensation settlement. It is important that you understand the Centers for Medicare & Medicaid Services' (CMS) policies regarding Workers' Compensation Set-Aside Arrangements (WCMSAs).

Medicare regulations, as found in Title 42 of the Code of Federal Regulations §411.46, state that Medicare will not pay for Medicare-covered medical expenses or Medicare-covered prescription drugs expenses related to your work-related injury until the WCMSA funds have been exhausted.

Your WCMSA funds must be used to pay for all Medicare-covered medical services and Medicare-covered prescription drug expenses related to the workers' compensation injury, illness or disease. A CMS lead Medicare contractor will monitor your expenditures from the WCMSA account upon receipt of the annual self-attestation letter that you are required to submit. Once the lead contractor has confirmed that the WCMSA funds have been exhausted

appropriately, Medicare will begin paying for Medicare covered services related to the workers' compensation injury, illness or disease.

Instructions for establishing and administrating a WCMSA account are listed below. If you have any questions regarding these requirements, please contact the CMS lead Medicare Contractor at the following address:

MSPRC
P.O. Box 33828
Detroit, MI 48232-5828
(Attn: MSP-Medicare Set-aside Reconciliation)

Establishing and Using your Medicare Set Aside Account:

- WCMSA funds must be placed in an interest-bearing account, separate from your personal saving or checking account.
- WCMSA funds may only be used to pay for medical services and prescription drug expenses related to your work injury that would normally be paid by Medicare.
- Examples of some items that Medicare does not pay for are: acupuncture, routine dental care, eyeglasses or hearing aids, etc.; therefore, those items cannot be paid from the WCMSA account. You may obtain a copy of the booklet "Medicare & Your" from your Social Security office for a more extensive list of services not covered by Medicare.
- If you have a question regarding Medicare's coverage of a specific item, service, or

prescription drug, to determine if you may pay for it from the WCMSA account, please call 1-800-Medicare (1-800-633-4227) or visit CMS' website:

<http://cms.hhs.gov/home/medicare.asp>

Please note: If payments from the WCMSA account are used to pay for services other than Medicare allowable medical expenses related to medically necessary services and prescription drug expenses, Medicare will not pay injury related claims until these funds are restored to the WCMSA account and then properly exhausted.

Record Keeping:

- As administrator of the account, you will be responsible for keeping accurate records of payments made from the account. These records may be requested by CMS' lead Medicare contractor as proof of appropriate payments from the WCMSA account.
- You may use the WCMSA account to pay for the following costs that are directly related to the account:

Document copying charges

Mailing fees/postage

Any banking fees related to the account

Income tax on interest income from the set-aside account

- Annually, you must sign and forward a copy of the attached self-attestation form, which states that payments from the WCMSA account were made for Medicare-covered medical expenses and Medicare-covered prescription drug expenses related to the work-related injury, illness or disease.

- An annual accounting shall be submitted to the Medicare lead contractor listed on Page 1 of this instruction no later than 30 days after the end of each anniversary year (beginning with one year from the date of settlement).
- The annual self-attestation should continue through depletion of the WCMSA account.
- **DO NOT SEND YOUR ANNUAL ACCOUNTING DIRECTLY TO CMS.** Please send your annual account to the CMS lead Medicare contactor noted above.

This form should be completed annually and mailed to MSPRC, P.O. Box 33828, Detroit, MI 48232-5828 stating one year from the date of settlement.

NOTE: Please make several copies of this form because you must send this form to the Medicare contractor each year until all of your WCMSA has been spent.

DATE: _____

Total WCMSA amount noted in CMS' written opinion: \$_____

Individuals that have a CMS-approved WCMSA as part of a workers' compensation settlement agreement may only use the funds in the WCMSA account to pay for Medicare-covered medical services and Medicare-covered prescription drug expenses that are related to the workers' compensation injury, illness or disease.

(Please check)

I, the undersigned attest that I have a lump sum WCMSA and have used the monies from the WCMSA account for the period of _____ to _____ to pay for the following:

Medical services: \$ _____

Prescription drug expenses: \$ _____

I, the undersigned, attest that I have a lump sum WCMSA and have COMPLETELY EXHAUSTED the monies in the WCMSA account to pay for the following:

Medical services: \$ _____

Prescription drug expenses: \$ _____

I acknowledge and understand that failure to follow any of the Medicare requirements for the use of this money will be regarded as a failure to reasonably recognize Medicare's interests and that Medicare will deny coverage for all medical treatments and prescription drug expenses due to my work-related injuries up to the total workers' compensation settlement amount.

DATED: _____
Signature

DATED: _____
Witness

The CMS reserves the right to audit how you spent the funds in your WCMSA account. Therefore, CMS recommends that you retain your WCMSA records for a period of seven (7) years. However, please do not send your receipts or bank statements to CMS or the Medicare contractor identified above.

FORM NUMBER 6
(“Hartman” Formula)

SOCIAL SECURITY DISABILITY ADDENDUM “D” TO COMPROMISE AND
RELEASE AGREEMENT

RE: _____

WCAB No(s):

1. Applicant's pre-injury earning capacity is \$ _____ per year, which is
\$ _____ per month.
2. Applicant's date of birth is _____ .
3. Applicant's life expectancy is _____ years, which is _____ months.
4. Applicant's permanent and stationary date is _____ based on the report
of Dr. _____ dated _____.
5. Applicant's permanent disability is _____ %, based on the report of Dr. _____
dated _____.

6. Applicant requests an allocation/characterization of settlement proceeds as follows:

GROSS SETTLEMENT: _____

LESS APPLICANT’S ATTORNEY’S FEES: _____

LESS SUPPLEMENTAL JOB DISPLACEMENT
BENEFIT: _____

LESS MEDICARE SET ASIDE TRUST: _____

LESS PENALTIES: _____

LESS OTHER DEDUCTIONS: _____

TEMPORARY DISABILITY BENEFITS: _____

LEGAL OR MEDICAL EXPENSES DEDUCTED
FROM APPLICANT'S PROCEEDS:

AMOUNTS ALLOCATED TO PURCHASE ANNUITIES
OR STRUCTURED SETTLEMENTS:

LESS PRESENT VALUE OF FUTURE
MEDICAL TREATMENT:

MEDICAL TREATMENT*

NET PROCEEDS TO APPLICANT:

*The present value of future medical treatment includes \$ _____ per month for life for medical expenses not covered by Medicare or other insurance such as mileage reimbursement, deductibles, co-payments, and Applicant's share of prescription costs.

Applicant requests that the WCAB make a finding that Applicant's net proceeds, based on this allocation, of \$ _____, be designated towards his or her loss of future earnings, equivalent to \$ _____ per month for life on account of his or her loss of bodily functions which will interfere with his or her ability to engage in gainful employment for the rest of his or her life due to the industrial injuries that are settled herein. These net proceeds represent future permanent disability payments beginning on _____.

DATED: _____

Applicant

Applicant's Attorney