

Medicare Myths: What Every Trial Lawyer Should Know About the MSP & Liability Medicare Set Asides

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Passage of Section 111 of the Medicare, Medicaid & SCHIP Extension Act in 2007 (“MMSEA”) and its original reporting deadline of 7/1/09² has caused a tremendous amount of confusion among insurance professionals, lawyers and settlement planners alike. As a result of the MMSEA new discovery is being sought to assist insurers in complying with the reporting requirements. While the new discovery is proper, some changes attributed to the MMSE A are completely inaccurate. For example, some insurers are insisting on putting Medicare on the check claiming the “new law” requires it. Another example is the insistence by some insurers that Medicare Set Asides are now required in all liability cases. Neither is true. The simple fact is that the MMSEA imposes a mandatory insurer reporting requirement upon responsible reporting entities (“RREs”). CMS has created a 224 page manual explaining what is required and defining terms used in the MMSEA. A discussion of all of the aspects of the MMSEA is beyond the scope of this article. I will delve into the MMSEA briefly to explain what it is and what is required, but the focus of this article is what it does not require in an attempt to clear up widespread misconceptions.

Section 111 of the MMSEA

First, what is the MMSEA and what does it require. On December 29th of 2007, President Bush signed into law the Medicare, Medicaid, and SCHIP Extension Act of 2007 (“MMSEA”).³ Part of this Act, Section 111, extends the government’s ability to enforce the Medicare Secondary Payer Act.⁴ As of April 1, 2011, an RRE, (liability insurer, self insurer, no-fault insurer and workers’ compensation carriers) shall determine whether a claimant is a Medicare beneficiary (“entitled”) and if so provide certain

information to the Secretary of Health and Human (hereinafter “Secretary”) Services when the claim is resolved.⁵

Under MMSEA, the RREs/insurers (hereinafter RRE) described above, must report the identity of the Medicare beneficiary to the Secretary and such other information as the Secretary deems appropriate to make a determination concerning coordination of benefits, including any applicable recovery of claim.⁶ Failure of an applicable plan to comply with these new requirements will incur a **civil money penalty of \$1000 for each day of noncompliance** with respect to each claim.⁷ A single claimant can have more than one claim but the penalty is per claim. These new reporting requirements will make it very easy for CMS to review settlements to determine whether Medicare’s interests were adequately addressed by the settling parties.

Section 111 and Resulting New Discovery Requests

As a result of the MMSEA and RREs fear of not reporting promptly and being subjected to fines, many insurers are propounding discovery aimed at securing information to comply with the reporting. The RREs are requesting a Social Security number in order to verify whether a claimant is Medicare eligible. According to CMS, RREs may “submit a query to the COBC to determine Medicare status of the injured party prior to submitting claim information for Section 111 reporting.” The query process is designed to assist RREs in determining whether the claim must be reported or not. The query must contain the client’s SSN or Medicare Health Insurance Claim Number (HICN), name, date of birth and gender of the injured party. The COBC, upon submission of the information outlined above will respond and indicate whether the individual is a Medicare beneficiary. If the injured party is a Medicare beneficiary, the HICN and other information found in the Medicare Beneficiary Database will be provided to the RRE. This process is done electronically with HEW (HIPAA Eligibility Wrapper) software

provided by CMS, but the RRE must have the SSN or HICN. This is the reason why the new discovery requests are being implemented.

MMSEA and Conditional Payments

The stated intent of the new reporting requirements was to identify situations where Medicare should not be the primary payer and ultimately allow recovery of conditional payments. The Medicare Secondary Payer Act (MSP) prohibits Medicare from making payments if payment has been made or is reasonably expected to be made by a workers' compensation plan, liability insurance, no fault insurance or a group health plan. However, Medicare may make a "conditional payment" if one of the aforementioned primary plans does not pay or can't be expected to be paid promptly.⁸ These "conditional payments" are made subject to being repaid when the primary payer pays. When conditional payments are made by Medicare, the government has a right of recovery against the settlement proceeds.

Congress has given the Centers for Medicare and Medicaid Services (CMS) both subrogation rights and the right to bring an independent cause of action to recover its conditional payment from "any or all entities that are or were required or responsible . . . to make payment with respect to the same item or service (or any portion thereof) under a primary plan."⁹ Furthermore, CMS is authorized under federal law to bring actions against "any other entity that has received payment from a primary plan." Most ominously, the government may seek to recover double damages via an independent cause of action.

US v. Harris - A Trial Lawyer's Worst Nightmare

The government takes its reimbursement rights seriously and is willing to pursue trial lawyers who ignore Medicare's interest. In U.S. v. Harris, a November 2008 opinion, a personal injury plaintiff lawyer lost his motion to dismiss against the U.S. Government in a suit involving the failure to satisfy a Medicare subrogation claim. The plaintiff, the United States of America, filed for declaratory judgment and money damages against the personal injury attorney owed to the Centers for Medicare and Medicaid Services by virtue of 3rd party payments made to a Medicare beneficiary. The personal injury attorney had settled a claim for a Medicare beneficiary (James Ritchea) for \$25,000. Medicare had made conditional payments in the amount of \$22,549.67. After settlement, plaintiff counsel sent Medicare the details of the settlement and Medicare calculated they were owed approximately \$10,253.59 out of the \$25,000. Plaintiff counsel failed to pay this amount and the Government filed suit.

The motion to dismiss was denied by the United States District Court for the Northern District of West Virginia despite plaintiff counsel's arguments that he had no personal liability. Plaintiff counsel argued that he could not be held liable individually under 42 U.S.C. 1395y(b)(2) because he forwarded the details of the settlement to the government and thus the settlement funds were distributed to his clients with the government's knowledge and consent. The court disagreed. The court pointed out that the government may under 42 U.S.C. 1395y(b)(2)(B)(iii) "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." Further, the court pointed to the federal regulations implementing the MSPS which state that CMS has a right of action to recover its payments from any entity including an attorney.¹⁰ Subsequently, the U.S. Government filed a motion for summary judgment against plaintiff counsel. The United States

District Court, in March of 2009, granted the motion for summary judgment against plaintiff counsel and held the Government was entitled to a judgment in the amount of \$11,367.78 plus interest.

Medicare on the Settlement Check

Most trial lawyers understand their obligations under the MSP with regard to making sure conditional payments are repaid. The problem is the growing misconception among insurers that Medicare should be on the settlement check to insure compliance with the MSP. Some insurers have even been told that the law requires Medicare be on the check. This is simply not so.

I was asked last year by a trial lawyer to assist in a case where Medicare was put on the check despite this not being a term of settlement. The insurer moved to enforce the settlement and plaintiff counsel was forced to defend his position that the law didn't require Medicare be on the check. I provided an affidavit arguing why the law did not require Medicare be on the check. That case resulted in a published Federal District Court opinion, Tomlinson v. Landers, regarding the issue of whether Medicare must be on the check.

The Tomlinson court found definitively that the MSP didn't require Medicare be on the check. The court stated that "federal law does not mandate that a primary payer (or insurer) make payment directly to Medicare." The court did recognize though that "an insurer may be liable to Medicare if the beneficiary/payee does not reimburse Medicare for any amounts owed to Medicare within sixty (60) days." Nevertheless, the court found the defendant's decision to "list Medicare as a payee on the settlement check may have been in [defendant's] . . . best interest, however, [defendant] . . . was not required by federal to include Medicare on the settlement check." Given this fact and the dispute concerning whether Medicare needed to be included on the check illustrated to the court there was no

meeting of the minds in terms of settlement. As a result, the settlement was not enforced and a bad faith action could be pursued. When an insurer takes a similar position in the future, it may open the door to similar holdings and bad faith causes of action.

Medicare Set Asides in Liability Settlements

While “Medicare on the check” is a very problematic issue, a larger issue is the alleged connection between Medicare Set Asides and the MMSEA. CMS has made it very clear in numerous conference calls that the MMSEA is totally unrelated to Medicare Set Asides. In an MMSEA conference call, Barbara Wright, acting director of the Medicare debt management division at CMS, stated that Section 111 of the MMSEA “does not mandate or specify anything about liability set asides.” It can’t be made any clearer than that. There is no relationship between MMSEA and Medicare Set Asides in liability cases. However, Barbara Wright did say in that same teleconference “we have a very informal, limited process for liability set asides.” She acknowledged they didn’t have the “extensive” rules or procedures like the “ones [they] . . . have for workers’ comp.” Finally, she indicated that “CMS approval of a set aside amount is not required. It is a voluntary process.” Each regional office sets its own policy on whether to review liability set asides despite Barbara Wright’s comments. Out of the 10 regional offices informally surveyed, two will not review (Boston and San Francisco).

The Advent of Set Asides

Despite the lack of connection between the MMSEA and Medicare Set Asides, the issue is still a troubling one. For many years personal injury cases have been resolved without consideration of Medicare’s secondary payer status even though since 1980 all forms of liability insurance have been primary to Medicare. At settlement, by judgment or through an award, an injury victim would receive

damages for future medical that were Medicare covered. However, none of those settlement dollars would be used to pay for future Medicare covered health needs. Instead, the burden would be shifted from the primary payer (liability insurer or Workers' Compensation carrier) to Medicare. Injury victims would routinely provide their Medicare card to providers for injury related care.

These practices began to change in 2001 when Medicare Set Asides (hereinafter "MSA") were officially recognized by CMS for Workers' Compensation cases. Interestingly, around that same time the General Accounting Office was studying the Medicare system and pointed out that Medicare was losing money by paying for care that was covered under the Workers' Compensation system.¹¹ Accordingly, CMS circulated a memo in 2001 to all its regional offices announcing that compliance with the secondary payer act required claimants to set aside a portion of their settlement for future Medicare covered expenses where the settlement closed out future medical expenses.¹² The new "set aside" requirement was designed to prevent attempts "to shift liability for the cost of a work-related injury or illness to Medicare."¹³ Set asides ensure that Medicare does not pay for future medical care that is being compensated by a primary payer by way of a settlement or an award. The procedures and policy for set asides have been developed through subsequent CMS memoranda known as Frequently Asked Questions.

CMS' rationale for creating an MSA is compliance with the Medicare Secondary Payer Act (hereinafter "MSP"). The MSP is a series of statutory provisions¹⁴ enacted in 1980 as part of the Omnibus Reconciliation Act¹⁵ with the goal of reducing federal health care costs. The MSP provides that if a primary payer exists, Medicare only pays for medical treatment relating to an injury to the extent that the primary payer does not pay.¹⁶ The regulations that implement the MSP provide "[s]ection 1862(b)(2)(A)(ii) of the Act precludes Medicare payments for services to the extent that payment has

been made or can reasonably be expected to be made promptly under any of the following” (i) Workers’ compensation; (ii) Liability insurance; (iii) No-fault insurance.¹⁷

There are two issues that arise when dealing with the application of the MSP: (1) Medicare payments made prior to the date of settlement (conditional payments) and (2) future Medicare payments for covered services (Medicare set asides). Since Medicare isn’t supposed to pay for future medical expenses covered by a liability or Workers’ Compensation settlement, judgment or award, CMS recommends that injury victims set aside a sufficient amount to cover future medical expenses that are Medicare covered. CMS’ recommended way to protect future Medicare benefit eligibility is establishment of an MSA to pay for injury related care until exhaustion.

The problem is that MSAs are not required by a federal statute even in Workers’ Compensation cases where they are commonplace. Instead, CMS has intricate “guidelines” and “FAQs” on their website for nearly every aspect of set asides from submission to administration. There are no such guidelines for liability settlements involving Medicare beneficiaries. Without codification of set asides, there are no clear cut appellate procedures from arbitrary CMS decisions and no definitive rules one can count on as it relates to Medicare set asides. While there is no legal requirement that an MSA be created, the failure to do so may result in Medicare refusing to pay for future medical expenses related to the injury until the entire settlement is exhausted. This creates a difficult situation for Medicare beneficiary-injury victims and contingent liability for legal practitioners as well as other parties involved in litigation involving physical injuries to Medicare beneficiaries.

Additionally, problems exist and greater costs may be incurred in the settlement of cases involving Medicare beneficiaries due to the lack of uniformity as well as clarity regarding Medicare Set Asides.¹⁸ The lack of uniformity and clarity comes from the fact that CMS regularly changes its

procedures through publishing new memoranda in the form of FAQs which articulate policy. There have been 11 such memos since the original 2001 memo announcing set asides. Submission of a set aside to CMS for review is sometimes a long process which causes extra costs for parties to the litigation. The amount of the set aside does not take into account that the settlement amount may be lower due to other factors in the settlement apart from medicals. Fees are incurred in preparation of an allocation and submittal to CMS. The costs in creating a set aside may ultimately lower what is available to the injury victim to compensate for non-medical damages. Delays in settlement or the inability to settle cases due to the set aside issue is another significant problem that has a large impact on the tort system. The absence of any law or guidelines in the liability context is a tremendous problem. Since guidelines only exist in Workers Compensation cases, those guidelines are frequently applied to liability settlements. However, this creates many problems as Workers' Compensation cases and liability cases are two very different animals.¹⁹ Thus, codification is vitally important from a systemic and cost perspective for both comp and liability.

A Need for Codification – “LMSA”

As uncertain and lacking in formal protections as is the Workers' Compensation system is regarding Medicare set asides, it pales in comparison to the current state of affairs in liability settlements. The only known formal mention of Medicare Set Asides in liability settlements comes in the form of an answer to a FAQ in an April 2003 CMS memo.²⁰ CMS stated:

Third party liability insurance proceeds are also primary to Medicare. To the extent that a liability settlement is made that relieves a Workers' Compensation (WC) carrier from any future medical expenses, a CMS approved Workers' Compensation Medicare Set-aside Arrangement (WCMSA) is appropriate. The WCMSA would need sufficient funds to cover future medical expenses incurred once the total third party liability settlement is exhausted. The only exception to establishing a WCMSA would be if it can be documented that the claimant does not require any

further WC claim related medical services. A WCMSA is also not recommended if the medical portion of the WC claim remains open, and WC continues to be responsible for related services once the liability settlement is exhausted.²¹

While the foregoing is not on point as it addresses the question of whether a set aside is necessary when a 3rd party settlement extinguishes a workers' compensation obligation, it is instructive in the sense that it states CMS's position that 3rd party proceeds are primary to Medicare always. However, a plain reading of the MSP can provide that type of information. There have been some recent statements by CMS officials regarding liability set asides during town hall conferences which gives insight into how CMS views liability set asides. These town hall conferences relate to the new Medicare mandatory insurer reporting requirements under the Medicare, Medicaid & SCHIP Extension Act of 2007 ("MMSEA") which requires insurers and self insureds to report settlements with Medicare beneficiaries to CMS.²² Due to confusion about this law and misinformation that it somehow requires Medicare Set Asides in third party liability settlements; CMS has been forced to address liability Medicare Set Asides during these calls.

In one such call from 2008, Barbara Wright (Acting Director of the Medicare Debt Management division at CMS), said "I don't believe there is a General Counsel Memo that says there are no liability set asides."²³ She went on to say "we have a very informal, limited process for liability set asides. We don't have the same extensive ones we have for worker's comp." Finally, she reiterated an important admission that "CMS approval of a set aside amount is not required. It is a voluntary process." In a more recent call from September of 2009, Barbara Wright again addressed the issue of liability set asides by stating "[t]here is not – the same formal process for liability set asides that there is for Workers' Compensation set asides. However, the underlying statutory obligation is the same."²⁴ In the most recent call in October of 2009, Barbara Wright again emphasized that the review process for liability settlements was voluntary and each CMS regional office makes its own decision whether to

review or not.²⁵ When discussing whether a CMS regional office would review or not she indicated that if the regional office believes there are “significant dollars at issue”, they may review a proposed set aside amount for liability.²⁶ However, she says that the “fact that they decline to review in a particular case does not create any type of safe harbor. So you’re back to an obligation that has existed essentially since 1980.”²⁷

The most recent version of the Medicare Secondary Payer manual, revised on 3-20-09, was updated with references to set asides in the liability context. In Section 20, which contains definitions, set aside arrangement are defined as follows:

An administrative mechanism used to allocate a portion of a settlement, judgment or award for future medical and/or future prescription drug expenses. A set aside arrangement may be in the form of a Workers’ Compensation Medicare Set-Aside Arrangement (WCMSA), No-Fault Liability Medicare Set-Aside Arrangement (NFSA) or Liability Medicare Set-Aside Arrangement (LMSA).²⁸

Clearly CMS has intentions to do something as it relates to liability settlements and set asides since this was included in the MSP manual. The question is what and how will guidelines be developed? Will it be similar to Workers’ Compensation? How will the decidedly different issues involved in liability settlements be addressed?

Given all of the foregoing, legal practitioners, Medicare beneficiary-injury victims and insurers are left guessing as to what to do when a liability settlement is achieved. Is a set aside necessary? If so, how do parties determine if they are necessary? Is it only “significant dollars” cases? What rules apply if you do create a set aside? Do we look to the 12 CMS memoranda? What about the differences between Workers’ Compensation cases and liability cases? Will CMS take into account policy limits in a liability case in determining the sufficiency of an allocation? What happens if policy limits are \$50,000 and the future Medicare covered services are \$150,000? Will CMS take into account comparative

fault/contributory negligence issues that may reduce recovery? What about statutory or constitutional caps on damages? Can CMS fail to pay for Medicare covered services post liability settlement for the Medicare beneficiary-injury victim if there is no set aside created?

It should be painfully obvious from the foregoing discussion that codification of set asides is imperative. Given the possible loss of Medicare benefits, as threatened by CMS, a Medicare beneficiary has significant risks when it comes to Medicare Set Asides with little or no corresponding legal remedies. Significant delays persist in the Workers' Compensation MSA process which in some instances leads to settlements falling apart.²⁹ In addition, liability cases brought on behalf of Medicare beneficiaries may decrease due to the possibility of having to put all of the net proceeds into an MSA. As Rick Swedloff put it in his 2008 law review article, it creates a classic situation of "can't settle, can't sue".³⁰ In the context of conditional payments, he said that the "MSP discourages Medicare beneficiaries and their contingency fee attorneys from bringing suit in simple tort disputes."³¹ That statement is all the more profound today in the face of the increasing complexities of conditional payments and the confusion over Medicare Set Aside issues.

What to do?

The question becomes what to do when faced with an insurer who insists on a Medicare Set Aside in a liability case. A trial lawyer could ask for the insurer's legal basis for mandating a Medicare Set Aside in a liability case. You can ask for a cite to the federal statutes, code of federal regulations, case law or any rules/process regarding Medicare Set Asides for liability cases. There are currently none, no one will find any law that directly addresses the issue of Medicare Set Asides for liability cases. However, I am not advocating ignoring Medicare's interest under the Medicare Secondary Payer Act. To adequately protect yourself and a client who is a Medicare beneficiary or reasonably expected³² to

become a Medicare beneficiary within 30 months of settlement, a Medicare Set Aside evaluation may be in order. As described below, this is a voluntary process and CMS may not review the proposed set aside.

A trial lawyer may want to take the position that the insurer should bear the costs of the MSA evaluation and costs of the set aside (including professional administration of the account). In addition, there are many non-Medicare medical expenses that must be considered in arriving at a settlement for future medical costs (i.e., certain durable medical goods, custodial care, certain prescription medications and the Part D donut hole to name a few). If a set aside will be established, a thorough examination of non-Medicare expenses along with an allocation of future Medicare covered future services should be undertaken. There are other options besides a formal set aside if a trial lawyer is faced with an insurer who requires addressing Medicare's interest.

One option is to estimate the future Medicare covered expenses the client will potentially incur and document that amount in the settlement agreement. The estimate can be created from doctors reports or life care plans. The client then sets aside this amount and is told to use it for future Medicare covered expenses. No submission to CMS is done if this option is exercised. However, the release provides evidence that Medicare's interests were taken into account at settlement. Since CMS admits there is no formal review process for liability settlements and submission is voluntary, an argument can be made that all the current law requires has been done and then some.

Another option is to do the formal allocation report and again document it just like was mentioned in the foregoing paragraph. Since CMS does not guarantee a review of a liability set aside, a formal allocation along with documenting it in the settlement agreement provides the necessary evidence that Medicare's interest were adequately addressed. A formal allocation also gives the trial

attorney a third party who is independent to review the future medical expenses and determine what is Medicare covered and what is not. This is an important piece of protection for the trial attorney as it provides an extra layer of E&O protection.

Conclusion

It is this author's opinion that Medicare protocols and procedures regarding the repayment of conditional payments should not change due to MMSEA. However, insurers' behavior will and has most certainly changed. Insurance companies are fearful of all the reporting requirements under MMSEA because failure to comply is a \$1,000 per day, per claimant fine. For a large insurer, that is significant exposure. Therefore, new discovery has been created to help insurers comply. Medicare may be put on the settlement check and unfortunately some insurers are insisting on Medicare Set Asides in liability cases. Federal law does not require Medicare be placed on the check, a fact confirmed by the Tomlinson decision. Federal law does not contain any codification of the obligation to create a Medicare Set Aside in liability cases. However, each trial lawyer and law firm will have to interpret the MSP laws and deal with the insurers on these issues to protect the client as well as their practices. There are many unanswered questions that persist with little clarity or law to help guide trial lawyers.

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² This date has been pushed back several times and is now slated for 4/1/11.

³ Medicare, Medicaid, and SCHIP Extension Act of 2007 (P.L. 110-173). This Act was passed by the House on December 19, 2007, and by a voice vote in the Senate on December 18, 2007.

⁴ Medicare, Medicaid, and SCHIP Extension Act of 2007 (P.L. 110-173).

⁵ *Id.*

⁶ *Id.*

⁷ *Id.*

⁸ 42 U.S.C. § 1395y (2007).

⁹ *Id.*

¹⁰ See 42 C.F.R. 411.24 (g).

¹¹ Edward M. Welch, *Medicare and Worker's Compensation After the 2003 Amendments*, WORKERS' COMPENSATION POLICY REVIEW, at 5 (March/April 2003).

¹² Parashar B. Patel, *Medicare Secondary Payer Statute: Medicare Set-Aside Arrangements*, Centers for Medicare and Medicaid Services Memorandum, July 23, 2001.

¹³ *Id.*

¹⁴ The provisions of the MSP can be found at Section 1862(b) of the Social Security Act. 42 U.S.C. § 1395y(b)(6) (2007).

¹⁵ Omnibus Reconciliation Act of 1980, Pub. L. No. 96-499 (Dec. 5, 1980).

¹⁶ 42 CFR § 411.20(2) Part 411, Subpart B, (2007).

¹⁷ *Id.*

¹⁸ Eric J. Oxfeld, *Congress Must Reform Medicare Set Asides*, FLA. UNDERWRITER, May 2006, at S-9.

¹⁹ *Zinman v. Shalala*, 67 F.3d 841, 846 (9th Cir. 1995). The Zinman court recognized how different Workers' Compensation settlements are from liability. The court pointed out that "[a]pportionment in workers' compensation settlements therefore involves a relatively simple comparison of the total settlement to the measure of damages allowed for individual components of the settlement, pursuant to a prescribed formula. Tort cases, in contrast, involve noneconomic damages not available in workers' compensation cases, and a victim's damages are not determined by an established formula. Apportionment of Medicare's recovery in tort cases would either require a factfinding process to determine actual damages or would place Medicare at the mercy of a victim's or personal injury attorney's estimate of damages."

²⁰ Thomas Grissom, *Medicare Secondary Payer – Workers' Compensation (WC) Frequently Asked Questions*, Question 19, Centers for Medicare and Medicaid Services Memorandum, April 22, 2003.

²¹ *Id.* (emphasis added)

²² Medicare, Medicaid and SCHIP Extension Act of 2007 (P.L. 110-173). This Act was passed by the House on December 19, 2007, and by a voice vote in the Senate on December 18, 2007. It was signed into law by President Bush on December 29, 2007.

²³ Barbara Wright, MMSEA October 29, 2008 NGHP Transcript at P. 18

²⁴ Barbara Wright, MMSEA September 30, 2009 NGHP Transcript at P. 25

²⁵ Barbara Wright, MMSEA October 22, 2009 NGHP Transcript at P. 65

²⁶ *Id.*

²⁷ *Id.*

²⁸ Medicare Secondary Payer (MSP) Manual (Rev. 65, 03-20-09).

²⁹ Eric J. Oxfeld, *National Issues Impacting Workers' Compensation*

³⁰ Rick Swedloff, *Can't Settle, Can't Sue: How Congress Stole Tort Remedies from Medicare Beneficiaries*, 41 AKRON L. REV. 557 (2008).

³¹ *Id.*

³² Reasonable expectation is defined as an individual that has applied for Social Security Disability Insurance ("SSDI") benefits; has been denied SSDI but anticipates appealing that decision; is in the process of appealing and/or refilling for SSDI; is 62 years and 6 months old (i.e., may be eligible for Medicare based upon his/her age within 30 months); or has End Stage Renal Disease (ESRD) condition but does not yet qualify for Medicare based upon ESRD.