The Effect of Medicare Set-Asides on Settling Jones Act Personal Injury Cases
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Every clause in a standard settlement agreement has a history. Recently, some employers and insurance carriers have added one more clause to the fold in Jones Act settlements. The new standard language requires acknowledgment that the claimant does not receive Medicare and will not seek Medicare benefits in the next five years. The clause has its roots in a series of legislative amendments to the Social Security Act and accompanying changes to the Code of Federal Regulations. An overview of the changes in the law and in practice will illuminate the narrow history of the “no Medicare” clause in these settlement agreements.

**Medicare Secondary Payer Act as the foundation**

When Medicare was enacted in 1965, Congress intended the program to act as the primary payer of medical expenses for its beneficiaries. With the expanding burden the baby boom generation threatened to place on Social Security and Medicare, however, in 1980 Congress enacted significant changes to the Social Security Act. Among these changes was the addition of the Medicare Secondary Payer Act, which focuses specifically on allocation of medical costs for injured workers and shifts Medicare from primary payer to secondary. The Act created a system to ensure that the primary payer of health costs in a settlement arrangement following an accident pays all it should pay on a claim before Medicare steps in to provide medical claim coverage. Primary payers in this context may include a group health plan, a liability insurer, or a workers compensation program.

To ensure that costs were appropriately shifted, the Medicare Secondary Payer Act included the Medicare set-aside arrangement (hereinafter “MSA”). The Act required that any

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1 Nicole Miklos, *Note: Giving an inch, then taking a mile: How the government’s unrestricted recovery of conditional medicare payments destroys plaintiffs’ chances at compensation through the tort system*, 84 ST. JOHN’S L. REV. 305, 309 (2010).
3 42 U.S.C. 1395y(b).
workers compensation settlement that accounted for future medical expenses protect Medicare’s interests in the arrangement by setting aside funds for those expenses.\textsuperscript{4} Specifically, each settlement agreement that provided funds for future medical costs was required to account for all reasonably foreseeable future medical costs, which may include any services Medicare would normally provide, such as hospital care, doctor visits, skilled rehabilitation, home health or hospice care, or durable medical goods in an MSA.\textsuperscript{5} Once included in the settlement agreement, the MSA would function as the primary coverage for all medical costs.\textsuperscript{6} Medicare would step in to provide secondary coverage once the MSA funds had been exhausted.

To ensure that Medicare’s interests were protected in the settlement, the Act recommended, but did not mandate, that settling parties obtain review and pre-approval of any settlement agreement in which future medical costs were implicated to the Centers for Medicare and Medicaid Services.\textsuperscript{7} There existed no formal appeals process for decisions promulgated by the Centers for Medicare and Medicaid Services. A party could choose to supplement its filings with additional medical records or other evidence, however, to support its claim that funds in an MSA were adequate to respond to the injured individual’s future healthcare needs. If the parties moved forward with a settlement despite Medicare’s denial of the MSA amount, Medicare would wait until the entire settlement amount had been exhausted, which may include funds designated for lost wages, attorney fees, or other such potential elements of a settlement, before stepping in to pay the individual’s medical costs.\textsuperscript{8}

Once the settlement had been finalized, the Act provided that the MSA would function as a primary health insurance policy for future treatment of the injured worker’s settlement-related medical treatment. Even if the injured individual did not yet qualify for Medicare, the funds in the MSA would become available immediately.\textsuperscript{9} The injured individual seeking reimbursement for medical costs must follow the usual Medicare beneficiary reporting and administration

\textsuperscript{4} Id. See also Christopher C. Yearout, Comment: Big Brother is not Just Watching, He’s Suing: Medicare’s Secondary Payer Statute Evolves in Aggressive Pursuit of Fiscal Integrity, 41 Cumb. L. Rev. 117, 121-22 (2010).
\textsuperscript{5} See Matthew L. Garretson, Making Sense of Medicare Set-Asides, 42 TRIAL (2006).
\textsuperscript{6} Id.
\textsuperscript{8} See id. at question 14.
\textsuperscript{9} Gerald Walters, Medicare Secondary Payer (MSP)—Workers’ Compensation (WC) Additional Frequently Asked Questions, Centers for Medicare & Medicaid Services, question 3 (July 11, 2005).
practices, including submission of a full accounting of all monies expended to the lead contractor handling the individual’s MSA.\(^\text{10}\)

Although the Act was a significant improvement upon the original system wherein Medicare often found itself burdened with the claims of injured workers in their entirety, it was significantly flawed. The lack of reporting requirements proved to be the primary difficulty hindering the Act’s effectiveness.\(^\text{11}\) Rather than requiring any of the settling parties to report their agreement, the Center for Medicare and Medicaid Services bore the responsibility of determining who was responsible for payment of medical costs when an employee was injured. With no enforcement of the new law, the significant changes Congress had hoped to achieve were stymied by lack of follow-through and oversight.\(^\text{12}\) As a result, Medicare was left with no one to reimburse it for costs and ended up exactly where it hoped to avoid: acting as a primary payer for the medical costs of injured workers.

In the interim, the Centers for Medicare and Medicaid Services provided reporting guidelines to settling employers and Medicare Administrators in an attempt to provide direction for creating MSAs in settlement agreements. One of the more famous reports setting forth guidelines was the 2001 Patel Memorandum.\(^\text{13}\) The Patel Memorandum, sent to Medicare Associate Regional Administrators, provided a clear explanation of the existing MSA reporting requirement and offered Medicare administrators guidance regarding how best to review reported MSAs. At a most basic level, the memorandum first distinguished between settlements made strictly as a compromise and commutative settlements in which the parties agree to fixed sums for losses to the injured plaintiff, including future medical expenses.\(^\text{14}\) Because compromise settlements generally are not based on calculations of actual losses to the plaintiff,

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10 Id.

11 See Brent M. Timberlake & Monica A. Stahly, Essay: Fool me once, shame on me; fool me again and you’re gonna pay for it: an analysis of Medicare’s new reporting requirements for primary payers and the stiff penalties associated with noncompliance, 45 U. RICH. L. REV. 119 (2010).

12 See id.


14 Id. at 2-3.
they are not of a type where set-asides would be appropriate.\textsuperscript{15} On the other hand, so-called commutative settlements, wherein the parties agree to a lump sum payment to include future costs of lost wages and future medical costs related to the injury, are distinct in that the mathematical calculations are apparent and based on estimated future medical and lost wages costs.\textsuperscript{16}

With their mathematical footings, the memorandum explained, commutative settlement agreements provide a template for application of Medicare set-asides. Not even all commutative settlements necessitate MSAs, however. The memorandum further explained that while all settlements should protect Medicare’s interests, an MSA only becomes relevant when certain thresholds are met: (1) the injured individual has a “reasonable expectation of Medicare enrollment within 30 months of the settlement date” and (2) the settlement amount for future lost wages and medical costs is greater than $250,000.\textsuperscript{17} If a settlement agreement meeting the threshold requirements did not account for Medicare’s interests, then once the party became entitled to Medicare, benefits, Medicare could deny the claimant benefits related to the injury.\textsuperscript{18} The Patel Memorandum thus provided to Medicare Administrators a key framework for defining the types of agreements in which MSAs were necessary.

\textbf{2007 Extension Act attempts to enforce the reporting requirement}

Following a largely unsuccessful attempt to shift the Medicare paradigm for injured workers, Congress enacted the Medicare, Medicaid, and SCHIP Extension Act of 2007 (hereinafter “Extension Act”). Among other changes within the Extension Act, Section 111 amended the MSA requirement to include mandatory reporting.

By mandating the report of settlement information to the Centers for Medicare and Medicaid Services for each claim involving a Medicare beneficiary or potential beneficiary, Congress has changed the process by which workers compensation settlement agreements are entered. First, a harsh $1,000 a day penalty for each delayed report provides a negative incentive

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\textsuperscript{15} Id. at 2.
\textsuperscript{16} Id. at 3.
\textsuperscript{17} Id. at 5.
\textsuperscript{18} Id.
}
for reporting.\textsuperscript{19} Second, the Extension Act eliminates any consideration of liability for the injury. Parties must now protect Medicare’s interests even in a nuisance settlement where the employer completely denies liability or liability is never established—as long as the settlement contemplates future medical costs.\textsuperscript{20} Finally, by requiring reporting of all settlements involving Medicare beneficiaries, the Extension Act necessarily implicates old personal injury cases in which there exists ongoing responsibility for medical payments.\textsuperscript{21} Because the Extension Act requires reporting of all personal injury settlements in which an insurance carrier or self-insurer has agreed to ongoing responsibility for future medical costs, this has been interpreted to include any claim on which an insurer continues to make medical payments following a settlement.\textsuperscript{22} This potentially huge undertaking implicates the collection of a large amount of previously uncollected information, which includes the maintenance of records of the Medicare beneficiary status of a long history of claimants on the part of both insurers and Medicare Administrators.

While originally enacted in 2007, the Extension Act along with its many implications to the settlement process has only been implemented since January 2011. The requirements are now put into place, but questions still remain as to the efficacy of the new strict reporting regime.

\textbf{Settling defendants respond to the regulations}

Given the strict reporting requirements matched with little guidance, settling defendants in workers compensation cases found themselves in a difficult position early on when attempting to comply with the requirements of the Extension Act. In response and to best protect their financial interests against a possible lawsuit, employers have added a clause to all workers compensation settlement agreements to ensure that Medicare funds are not implicated in the settlement. Most agreements containing the clause are compromise settlements: nominal settlements where the parties may not have considered the specific reasoning behind the amount paid to the injured employee. Instead, payment has been made as an act of compromise to appease the injured party and compensate the party for nominal past expenses, which may incidentally include past medical expenses. These agreements by their very nature should not

\textsuperscript{20} \textit{See id.} at 41.
\textsuperscript{21} \textit{Id.} at 42.
\textsuperscript{22} \textit{Id.}
implicate Medicare. By adding the clause affirming that the plaintiff has no reasonable
expectation of seeking Medicare benefits in the next five years, however, the employer and its
insurance carrier are given added protection from claims made against them by Medicare in the
future.

In larger settlements where past and future medical costs are considered in conjunction
with other factors, the Medicare set-aside may enter into the settlement picture. As described
above, these commutative settlement agreements provide the injured individual with an agreed-to
sum for future medical services and future lost wages. These are settlements for which Congress
designed the MSA and which MSAs now must be reported to the Centers for Medicare and
Medicaid under the Extension Act. The primary problem with the Extension Act requirements
lies in the significant delay between submission of an MSA for review by the Centers for
Medicare and Medicaid Service and ultimate approval of the set-aside. In a relatively fast-paced
field in which employers and their insurers routinely handle large numbers of workers
compensation claims, Medicare delays provide significant problems in allowing parties to move
forward following an agreement.

Parties to workers compensation settlements have responded to review delays in two
ways: (1) splitting the settlement and (2) settling before approval. In the first scenario, which
Medicare Administrators have suggested, the parties split the settlement into two sections. They
first settle the wage-loss and indemnity portion of the claim. Once Medicare Administrators
approve the MSA, the parties officially settle the medical portion of the claim. Under the
second scenario, the parties settle the claim before the MSA has been approved. As added
assurance, when parties settle before approval they often agree on who will bear the risk if the
Centers for Medicare and Medicaid Services denies the MSA and demands more money for
future medical costs. In most instances, either the employer agrees to supplement the MSA with
the additional funds or the injured individual agrees to take money from the indemnity portion
of the settlement and re-allocate the funds into the MSA. With a built-in “Plan B,” these parties
can leave the negotiating table with a firm deal prior to MSA approval. Of course, the federal

23 Edward M. Welch, Dealing With Medicare in Workers’ Compensation Claims, Michigan State University (2008),
24 Id. at 8.
25 Id.
government’s official position on this second scenario is that it will disregard the unapproved MSA entirely and wait until all of the settlement funds are exhausted before stepping in to pay the injured worker’s medical costs.  

**Conclusion**

Over the past thirty years, Medicare set-aside regulations have gradually shaped Jones Act personal injury cases. As Congress and the Centers for Medicare and Medicaid Services have more tightly regulated settlement agreements involving future medical costs, employers and their insurers have responded by slightly changing their approach to these settlements. A simple addition of a clause to the standard settlement agreement has provided what seems to be adequate protection in compensatory settlement cases. Ensuring that plaintiffs are not on Medicare and have no reasonable expectation of seeking Medicare benefits within the next five years provides protection for employers and their insurance carriers against future claims for reimbursement by Medicare. To avoid fines and possible litigation, parties must be particularly sensitive to following the MSA reporting requirements in the Extension Act in larger settlements that involve commutative agreements for future medical costs. Whether parties choose to split a settlement or settle before MSA approval, an employer and an injured individual must be sensitive to the demands of the Extension Act in order to ensure that their settlement agreement remains intact throughout the duration of its dispensation of benefits to the injured individual.

For better or worse, Congress has changed the function, but not necessarily the face of Medicare from its origins as primary payer of medical benefits for all beneficiaries to a secondary safety net when primary funds run dry. In creating new laws and regulations, Congress has shifted primary financial responsibility for injured workers to workers compensation funds, leaving Medicare benefits to individuals who have no other certain means by which they can pay for healthcare costs. This change, while revolutionary in some respects, may actually bring the spirit of Medicare benefit payments closer to their roots in Lyndon Johnson’s Great Society: allocating medical funds to those who cannot pay—not supplementing medical funds for those who are already well-funded.

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