wiley

ALERT

Section 111 Bulletin: CMS Solicits Comments Defining Obligations To "Protect Medicare's Interests" When Settlement Involves "Future Medicals"

June 15, 2012

Centers for Medicare & Medicaid Services (CMS) has issued an advance notice of proposed rulemaking (ANPRM) soliciting public comments on a regulation proposed to clarify how Medicare enrollees may "protect Medicare's interests" and resolve their Medicare Secondary Payer (MSP) obligations when they receive settlements, judgments, awards, or other payments from insurers related to claims for "future medical care" after the date of settlement. CMS, *Medicare Program; Medicare Secondary Payer and "Future Medicals"*, 77 Fed. Reg. 35917. The ANPRM was published in the Federal Register on June 15, 2012 and seeks public comment by August 14, 2012. The ANPRM states that the proposed regulation does not relate to an insurer's reporting obligations under Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA), but acknowledges that the Agency's implementation of Section 111 has caused Medicare beneficiaries and their attorneys to ask many questions about how they can satisfy their own obligations under the MSP statute. 42 U.S.C. § 1395y(b). As we have reported previously, Medicare beneficiaries have been increasingly frustrated with denials of medical care that have accompanied the implementation of Section 111 reporting. CMS may be attempting, through the proposed regulation, to establish a process that protects the Medicare Trust Fund through upfront coordination of benefits but is less disruptive to beneficiary care than current practices. The ANPRM specifically states that Medicare is prohibited from making payment for medical expenses if payment has been made, or can

Authors

Kathryn Bucher
Partner
202.719.7530
kbucher@wiley.law

Practice Areas

Health Care

Section 111 Insurer Reporting and MSP Reimbursement

reasonably be expected to be made, by a liability, no-fault, or workers' compensation insurer.

CMS proposes to adopt the following general rule, along with seven non-mutually-exclusive "options" for facilitating Medicare beneficiaries' compliance with their MSP obligations:

General Rule: *If an individual or Medicare beneficiary obtains a "settlement" and has received, reasonably anticipates receiving, or should have reasonably anticipated receiving Medicare covered and otherwise reimbursable items and services after the date of "settlement," he or she is required to satisfy Medicare's interest with respect to "future medicals" related to his or her "settlement" using any one of the following options outlined later in this ANPRM.*

This general rule would tell Medicare beneficiaries and their representatives "how they can meet their obligations to protect Medicare's interests" when they receive insurer payments after claiming or releasing a claim for future medical expenses. As we have discussed previously, liability insurers do not have an obligation to reimburse CMS for its payment of a Medicare beneficiary's future medical expenses, nor does CMS have a right to recover such payments from insurers. This distinction in the law explains the ANPRM's focus on regulating the behavior of Medicare beneficiaries.

The first four options outlined by the Agency address Medicare beneficiaries as well as individuals who are not yet Medicare eligible or enrolled. The fifth, sixth, and seventh options would be available to Medicare beneficiaries only. It appears that the options are not mutually exclusive and that CMS would consider adopting more than one. CMS also has requested proposals for additional options. At a high level, the seven current options are:

- **Option 1: The Medicare beneficiary or individual pays for all related future medical care until settlement funds are exhausted.** This option would, arguably, be unfair for beneficiaries whose settlements include payments for past medical expenses and other non-medical losses, such as property damage.
- **Option 2: Medicare does not pursue recovery for "future medicals" from a Medicare beneficiary or individual if the liability settlement is under a certain threshold amount and other criteria are met.** For example, under Option 2.a, the accident must have occurred one year or more before the date of settlement, and the underlying claim must not relate to a chronic illness/condition or major trauma, along with additional criteria. Option 2.b, while stating that Medicare will not pursue recovery under certain circumstances where the claimant is not a Medicare beneficiary, nevertheless suggests the possibility of a regulation that may speak to settlements in which Medicare does not have a reasonably foreseeable interest in future medicals, *i.e.,* settlements where the individual is not a Medicare beneficiary as of the date of settlement, could not expect to become a Medicare beneficiary within 30 months of the date of settlement, and the underlying claim does not involve a chronic illness/condition or major trauma, but the settlement amount is above the threshold.

- **Option 3: The Medicare beneficiary or individual provides an attestation regarding the "Date of Care Completion" from the treating physician.** If medical care is completed prior to settlement, Medicare's recovery claim would be limited to conditional payments made prior to the Date of Care Completion. If care is completed after settlement, the ANPRM states that Medicare would be able to pursue recovery for related conditional payments up until the date of settlement and then would have an "interest with respect to future medical care" that would extend from the date of settlement through the Date of Care Completion. The ANPRM does not specifically state that CMS would deny payment for related medical services during the period the beneficiary is to use settlement funds for care, but we presume this would be the case. Alternatively, CMS could seek recovery of any expenses it may otherwise pay from providers or the beneficiary, but CMS would not have a legal basis to recover such payments from insurers as "conditional payments."
- **Option 4: The Medicare beneficiary or individual submits a proposed liability Medicare Set-Aside Arrangement (MSA) for CMS's review and obtains approval.** CMS currently reviews workers' compensation MSAs over a certain threshold to determine whether the proposed set-aside amount is sufficient to meet a Medicare beneficiary's future medical expenses. The Agency is soliciting comments on whether it should adopt a similar MSA approval process for liability settlements. Although there are proponents for MSAs, particularly where a beneficiary's future medical costs are fixed or predictable, there are important countervailing considerations, particularly for insurers, with introducing a regulatory provision that will require or encourage MSAs in the liability and no-fault insurance context. This type of regulation may only serve to impede and increase the costs of settlement.
- **Option 5: The Medicare beneficiary participates in one of three currently available recovery options for low-dollar liability settlements, if applicable.** These options include:

  - $300 Threshold - Under most circumstances, Medicare will not pursue recovery of conditional payments if the settlement amount for a trauma-based injury is $300 or less.
  - Fixed Payment Option - Under most circumstances, if the settlement amount is $5,000 or less, a Medicare beneficiary may elect to resolve Medicare's recovery claim by paying 25% of the gross settlement amount to Medicare, regardless of the amount of conditional payments Medicare has made on the beneficiary's behalf.
  - Self-Calculated Conditional Payment Option - When a Medicare beneficiary anticipates obtaining a settlement of $25,000 or less for a trauma-based injury that occurred at least six months prior to the election of this option, and for which all care has been completed, the Medicare beneficiary may self-calculate Medicare's recovery claim, subject to Medicare's review and approval.
- **Option 6: The Medicare beneficiary makes an upfront payment to compensate Medicare for future medical expenses.** If an insurer accepts Ongoing Responsibility for Medicals (ORM) for the Medicare beneficiary's lifetime or the life of the injury, Medicare may review and approve a proposed amount to be paid as an upfront lump sum payment. This payment would compensate Medicare for the full cost of all related future medical care and could be used in place of an MSA. In settlements that do not involve

an acceptance of ORM, a beneficiary may elect to pay Medicare a specified percentage of the settlement to compensate Medicare for the beneficiary's future medical expenses.

- **Option 7: The Medicare beneficiary obtains a compromise or waiver of recovery.** CMS has the right today to waive or compromise a Medicare beneficiary's debt to Medicare, and the ANPRM requests comment on whether this approach is practical with respect to future medical expenses. It seems likely that CMS will continue to exercise discretion in this area.

The Wiley Rein Section 111 Team will continue to follow developments related to CMS's rulemaking in this area. Comments on the general rule, definitions, and seven options posed by CMS are due August 14, 2012. Please contact us with any questions or interest you may have in filing comments.

Our Section 111 Team routinely covers the Section 111 NGHP teleconferences held most months by CMS, and we send periodic Alerts to our clients addressing notable Town Hall discussions and other Section 111 developments. We also maintain a searchable electronic database of Town Hall transcripts back to October 2008. Please let us know if you would like more information about any Section 111 topic. You also may access our Section 111 webpage and other Section 111 Bulletins and articles we have published at www.wileyrein.com/section111.