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CMS Issues Proposed Guidelines for Protecting Medicare's Interests When a Settlement Involves Future Medical Care

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Until now, guidance as to how parties should address future medical care in liability settlements has been virtually non-existent. On June 14, 2012, the Centers for Medicare & Medicaid Services (CMS) released an Advance Notice of Proposed Rulemaking (the Proposed Rule) soliciting comments on a proposal to clarify how Medicare beneficiaries and their representatives can protect Medicare's interests and satisfy their obligations under the Medicare Secondary Payer (MSP) Act when "future medical care" is claimed or the settlement, judgment, award, or other payment releases claims for future medical care.[1] The Proposed Rule represents a significant development in the MSP world because it is the first guidance from CMS on this issue. In it, CMS proposes seven options for handling future medical care in cases involving automobile and liability insurance (including self-insurance), no-fault insurance, and workers' compensation.

Background

Under the MSP provisions, Medicare does not pay for health care items and services to the extent that payment has been made or can be expected to be made by certain types of other insurance, including a group health plan, liability insurance, no-fault insurance, or workers' compensation. However, Medicare can make "conditional payments" for those items and services if the other insurance does not pay promptly. The conditional payments are then subject to repayment when the Medicare beneficiary receives a settlement, judgment, award, or other payment with respect to the injury for which Medicare paid conditional benefits.

If the insurer fails to appropriately repay these conditional payments, Medicare has a direct cause of action for double damages against the insurer.

Future Medical Expenses

In addition to the seven options for facilitating compliance with the MSP provisions, CMS proposes the general rule that 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 one of the proposed options. In addition, CMS provides that Medicare can recover for conditional payments related to the settlement "regardless of when the items and services are provided" under its rights of subrogation and direct right of action.

There has been much controversy regarding whether liability insurers must reimburse Medicare for a beneficiary's future medical care and whether CMS has a right to recover those payments from such insurers. The Proposed Rule makes clear that settling parties must consider future medical care and that CMS deems payments for future medical care to be conditional payments, implying that Medicare has a direct cause of action against insurers that fail to take into account future medical care in settlements.

For example, assume Claimant A is a Medicare beneficiary who suffers a closed head injury that leaves him in a wheelchair. As a result of a lawsuit, Claimant A receives $5 million in exchange for a release of all claims for past and

1 *77 Fed. Reg. 35917 (June 15, 2012).* CMS proposes to define "future medical care" as "Medicare covered and otherwise reimbursable items and services that the individual/beneficiary received after the Date of 'Settlement.'"

future medical care. From the date of incident (DOI)[2] to the date of settlement, Medicare paid $500,000 for items and services related to Claimant A's closed head injury. Claimant A's treating physician indicates that Claimant A will continue to need medical care for his closed head injury. Under the MSP Act, the parties understand that they must reimburse Medicare for the $500,000 conditional payment. However, until now, it was unclear how the parties were required to handle Claimant A's future medical care in order to satisfy their obligations under the MSP Act.

The Seven Options

The Proposed Rule sets forth seven options for addressing future medical care for Medicare beneficiaries, the first four also would be available to those individuals who are not yet Medicare eligible or enrolled. These options do not appear to be mutually exclusive. CMS also is seeking proposals for additional options.

The seven current options provide as follows:

Self-Funding. The Medicare beneficiary or individual pays for and documents all related future medical care and expenses until the settlement proceeds are exhausted.

Defined Settlement Exemption. Medicare would not pursue recovery of future medicals if nine conditions are met for defined liability settlements, including that the accident or illness occurred at least a year before the settlement, the underlying claim does not involve chronic illness or major trauma, the beneficiary does not receive additional settlements, and the claim does not involve a corresponding workers' compensation or no-fault insurance claim.

Physician Attestation. If the Medicare beneficiary or individual receives an attestation regarding the "Date of Care Completion" from a treating physician, Medicare's recovery claim would be limited to payments it made for items and services provided from the DOI through and including the Date of Care Completion.[3] This holds true regardless of the settlement date.

Medicare Set-Aside (MSA). Medicare would not pursue future medicals if the Medicare beneficiary or individual submits a proposed liability MSA for CMS's review and obtains approval. Medicare has established processes to review and approve MSAs in the workers' compensation context, but not for liability settlements. CMS requests input on how an MSA review and approval process should be structured in the liability context. Current regulations do not require MSAs for non-workers' compensation settlements; however, MSAs and the MSA approval process have proved useful in helping parties ensure that they are adequately considering Medicare's interests when structuring settlements.

Low Threshold Reimbursement Options The Medicare beneficiary participates in one of three currently available recovery options for low-dollar liability settlements, which include:

- $300 Threshold – Medicare generally will not pursue recovery of conditional payments if the settlement amount for a trauma-based injury is $300 or less.
- Fixed Payment Option – In general, if the settlement amount is $5,000 or less, a Medicare beneficiary may elect to resolve Medicare's recovery claim by paying a percentage of the gross settlement amount to Medicare, regardless of the amount of conditional payments Medicare has actually 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.

2 "Date of Incident" for an automobile or other discreet accident is the date of the accident. For claims involving exposure, the date of incident is the date of first exposure. For claims involving ingestion, it is the date of first ingestion. For claims involving implants, it is the date of the implant (or date of the first implant if there are multiple implants).

3 CMS proposes to define "Date of Care Completion" as the "date the individual/beneficiary completed treatment related to his or her 'settlement.'"

Upfront Payment. The Medicare beneficiary makes an upfront payment to compensate Medicare for future medical expenses by either (1) obtaining CMS approval of a proposed payment amount in settlements involving ongoing responsibility for medicals or (2) paying a specified percentage of net beneficiary proceeds in settlements that do not involve ongoing responsibility for medicals.

Waiver. No future obligations in cases where CMS granted compromise or waiver of recovery.

Conclusion

Overall, the take-away from the Proposed Rule is that future medical care must be considered by all of the settling parties, including the insurers, and that an MSA is not required in every situation. Until a final rule is issued, the settling parties should continue to take into account Medicare's interests during the settlement process by determining what option is appropriate in light of the particular facts and circumstances, and ensuring that the selected option both properly reimburses Medicare for conditional payments *and* addresses payment for future medical care.

Comments on the general rule, definitions, and seven options posed by CMS are due August 14, 2012.

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