

Addendum A to the
Response to Request for Comment Re Mandatory Reporting
Requirements of Section 111 of the Medicare, Medicaid and SCHIP
Extension Act of 2007
(CMS-10265)

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I. INTRODUCTORY COMMENT

The CMS, via Document CMS-10265 (the “Agency Information Collection Activities: Proposed Collections; Comment Request”), has requested comment regarding the information collection provisions of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA) (42 U.S.C. 1395(b)(7)(8), as to the necessity and utility of the collection provisions for the performance of the agency’s functions, the accuracy of the estimated burden of the collection and reporting provisions, ways to enhance the quality, utility and clarity of the information collection, and the use of automated collections techniques and other forms of information gathering to minimize the information collection burden.

The overall MMSEA and Medicare Secondary Payer Statutes (1980 and 2003) have created an inequitable system to beneficiaries and insurers alike, which results in a reluctance to settle claims or participate in ADR, and increases a likelihood of going to trial (which adds an extra burden to the judicial system).

II. HISTORICAL BACKGROUND

A. LEGISLATIVE HISTORY

For purposes of this Comment, it is noted that the present Medicare statute, as it pertains to Medicare as a Secondary Payer, includes a 1980 enactment, a 2003 modernization (Medicare Prescription Drug, Improvement and Modernization Act) embodied in 42 USC 11395 y (B), 42 CFR 411.20; and new reporting requirements in the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA).

The MMSEA follows several amendments to the Medicare Secondary Payer (MSP) statute initially enacted in 1980. The original statute provided for reimbursement to Medicare by insurance plans, but enforcement lacked uniformity and many questions existed as to how notification was to be made, when reimbursement was owed, from whom, and in what amount.

Subsequent litigation resulted in conflicting decisions as to when and whether Medicare was to be considered a secondary payer. In response, Congress passed the Medicare Prescription

Drug, Improvement and Modernization Act (MMA) in 2003, confirming, *inter alia*, that Medicare was *always* the secondary payer where a primary payer – including a self-insured plan – is available, and that Medicare was entitled to reimbursement from those “responsible” for an incident resulting in medical care to a Medicare recipient. Although these revisions were intended to resolve questions and to facilitate Medicare’s reimbursement process, lack of consistency in understanding and application of the MMA continued to hamper the reimbursement process.

These difficulties were intended to be addressed by the MMSEA enacted in December, 2007. The MMSEA mandates extensive new reporting requirements on Group Health Plans and self-insured plans, many of whose members are represented by MARC. Some of its provisions are to go into effect in January, 2009, with the remainder effective July, 2009.

1. Summary of the New Legislation, the MMSEA

The New Provisions of the MMSEA:

- Add reporting rules but do not eliminate any existing statutory provisions or regulations.
- Do not eliminate the existing CMS processes if a Medicare beneficiary (or his/her representative) wishes to obtain interim conditional payment amount information prior to a settlement, judgment, award, or other payment.
- Include penalties for noncompliance.
- Define who must report: "an applicable plan." "...[T]he term 'applicable plan' means the following laws, plans, or other arrangements, including the fiduciary or administrator for such law, plan or arrangement: (i) Liability insurance (including self-insurance). (ii) No fault insurance. (iii) Workers' compensation laws or plans."
- Define what must be reported: the identity of a Medicare beneficiary, whose illness, injury, incident, or accident was at issue as well as such other information specified by the Secretary to enable an appropriate determination

concerning coordination of benefits, including any applicable recovery claim.

- Set forth when/how reporting must be done:
 - In a form and manner, including frequency, specified by the Secretary.
 - Information shall be submitted within a time specified by the Secretary after the claim is resolved through a settlement, judgment, award, or other payment (regardless of whether or not there is a determination or admission of liability).
 - Submissions will be in an electronic format.

2. Key Provisions under the Drug, Improvement and Modernization Act (MMA) in 2003

In order to understand this commentary regarding the Medicare reimbursement system as a whole, a background of the earlier revisions of the statute is useful.

Issues that arise from the 2003 revision include the definition of “responsible” for purpose of reimbursement obligation, the amounts of recovery, the waiver of recovery, and the lack of a mechanism by which the affected plans may compel the beneficiary’s cooperation in the absence of litigation.

a) The Definition of “Responsible”

In the 2003 Amendment (MMA), “responsibility” is defined as making a payment or becoming obliged to make a payment by way of a judgment. Once “responsibility” is found, the requirement for the primary payer becomes mandatory regardless of assessment of the fault of the defendant(s), or the plaintiff’s comparative fault, or even the absence of the affected plans fault (unless the case proceeds all the way through trial and this issue is determined by the trier of fact), whether a settlement is done entered into for cost reasons or for good will, and even where there is little or no liability of the primary payer’s insured.

Significant regulations, carried forward from the MMA and embodied in the present reimbursement plan, are as follows:

- The Act authorizes Medicare to pay first, although Medicare is *always* the “secondary payer” for purpose of right to reimbursement, and mandates repayment as follows: A primary payer, and an entity that receives payment from a primary plan, “must reimburse CMS for any payment if it is demonstrated that the primary payer has or had responsibility to make payment.” 42 CFR 411.22(a).
- A “primary payer” is defined “as an entity that is or was required or responsible to make payment with respect to an item or service (or any portion thereof) under a primary plan. These entities include, but are not limited to, insurers or self-insurers, third party administrators, and all employers that sponsor or contribute to group health plans or large group health plans. 42 CFR 411.21.
- A “primary plan” means a group health plan or large group health plan, a workers compensation law or plan, an automobile or liability insurance policy or plan (including a self-insured plan), or no-fault insurance. 42 CFR 411.21. “Self-insured” entity includes “any entity that engages in a business, trade or profession, even if it carries its own risk (whether by failure to obtain insurance or otherwise).”
- A primary payer’s responsibility for payment may be demonstrated by (1) a judgment, (2) a payment when conditioned upon the recipient’s compromise, waiver or release (*whether or not there is a determination or admission of liability*) of payment for items or services included in a claim against the primary payer’s insured, or (3) by other means, including but not limited to a settlement, award or contractual obligation. 42 CFR 411.22 (b).

b) Amount of Recovery and Waiver

A significant problem with the recovery of “Conditional Payments”¹ by CMS is that such recovery under the present reimbursement program does not allow for the assessment of comparative fault (as one would expect given the definition of “responsibility” set forth in the Act), *unless the parties have proceeded through trial and have received a judicial determination on the issue.*

In the context of a pre-trial settlement, recovery of conditional payments does not take into account that an affected plan may wish to settle a claim for reasons unrelated to its own or its insured’s liability, if any, or for those situations where a beneficiary may desire, for very logical reasons, to accept an amount in settlement which is less than a potential verdict, since settling relieves the beneficiary of the risk of an adverse outcome at trial.

The present legislation requires the “responsible” primary payer to reimburse Medicare’s full outlay, with the result that the beneficiary may receive nothing from the settlement, thus greatly diminishing a beneficiary’s desire to resolve a case short of trial. In a pre-trial settlement under the present reimbursement system, the attorney is paid (or reimbursement is reduced to reflect) “procurement costs”, Medicare is reimbursed its conditional payments, and the beneficiary may (depending on the total settlement) receive nothing. There is some provision in the Act which would appear to allow CMS to waive its recovery. However, it is uncertain from the language of the statute whether such a waiver may appropriately be based on an assessment of the comparative fault (or lack thereof) of the parties.

Further, according to the Manual (excerpts which follow), waiver of recovery is considered only *after* settlement and may be agreed to only by CMS itself, not by the CMS contractor. (This last provision presents a peculiar dilemma, in that it is MARC’s understanding that *all* CMS recovery collection activity has been or will be subcontracted out to collection agents, with the result that the

¹ “Conditional payment” means a Medicare payment for services for which another payer is responsible, made either on the bases set forth in subparts C through H of this part, or because the intermediary or carrier did not know that the other coverage existed.” 42 CFR 411.21.

entity actually responsible for the collection and attempting to procure reimbursement is not authorized to waive any recovery, even in the appropriate case).

The regulations of particular concern with regard to recovery and waiver are as follows:

Amounts of Recovery of Conditional Payments

- The lesser of (i) the amount of the Medicare primary payment or (ii) The full primary payment amount that the primary payer is obligated to pay under this part without regard to any payment, other than a full primary payment that the primary payer has paid or will make, or, in the case of a third party payment recipient, the amount of the third party payment. 42 CFR 411.24(c).
- If CMS takes legal action, twice the amount of the recovery asserted. 42 CFR 411.24(c).
- Interest if no reimbursement is received within a 60-day period that begins on the date notice or other information is received by CMS that payment has been or could be made under a primary plan.
- Amount of Recovery when primary payment is made as a result of a judgment or settlement:
 - Medicare payments less than judgment or settlement: (1) determine the ratio of the procurement costs to the total judgment or settlement payment. (2) Apply the ratio to the Medicare payment. The product is the Medicare Share of procurement costs. (3) Subtract Medicare share of procurement costs from the Medicare payments. The remainder is the Medicare recovery amount. 42 CFR 411.37(c).
 - Medicare payments equal or exceed the judgment or settlement amount: The recovery amount is the total judgment or settlement payment minus the total procurement costs. 42 CFR 411.37(d).

- CMS Waiver of Recovery -- CMS may waive recovery in whole or in part, if the probability of recovery, or the amount involved, does not warrant pursuit of the claim. 42 CFR 411.28(a).

c) Beneficiary Cooperation

Lastly, there is limited cooperation required of the Beneficiary in the present Medicare reimbursement program. There is no requirement that the beneficiary notify Medicare upon *initiating* pursuit of a claim or a lawsuit. The beneficiary is not required to notify Medicare of a settlement, only to reimburse Medicare once a settlement has been made; the responsibility to notify Medicare of a settlement lies solely with the primary payer. There is no requirement that the beneficiary notify the purported Primary Payer that they receive Medicare, they are or may become Medicare-eligible, or that conditional payments have been made by Medicare on their behalf.

The only beneficiary requirements are that *if* CMS takes action to recover conditional payments, the beneficiary must cooperate (42 CFR 411.23 (a)), and, if CMS's recovery is unsuccessful due to lack of beneficiary cooperation, CMS *may* recover from the beneficiary. (42 CFR 411.23 (b)).

3. Key Provisions from the Manual

The manual provides guidelines for the secondary payer contractors to follow, but *it does not carry the force of law*. Since the Manual is not law, the parties cannot reliably predict whether or when its provisions will be followed.

For example, while the Manual states: "Medicare will accept the Court's designation [allocations of liability payments to non-medical losses]. Medicare does not seek recovery from portions of court awards that are designated as payment for losses other than medical services," this "guideline" is *not codified and there is thus no assurance to beneficiaries that Medicare will not seek recovery of its conditional payments from settlement proceeds over and above the proceeds reflecting the conditional payments*.

Further, the Manual states the contractor has *no authority* to waive reimbursement, which is contrary to the statutory language set

forth above under which it is stated CMS *may* waive recovery. If the contractor cannot waive recovery, and if the contractor is doing *all* CMS collection, then when, if ever, will CMA “waive” its recovery? Under the present statute, the answer is “Never.” Finally, while the Manual provides a suggested Release Agreement form, this is infrequently provided by CMS and, most significantly, the CMS Release does *not* release the Primary Payer.

Other language in the Manual presents difficulty as well. For example:

- 50.1: It is common for insurance companies to settle claims without admitting liability. Therefore, any payment by a liability insurer, except payments under a no-fault clause in a non-automobile policy, constitutes a liability insurance payment whether there has been a determination of liability. In addition, regardless of how amounts may be designated in a liability award or settlement, e.g., loss of consortium, special damages or pain and suffering, Medicare is entitled to be reimbursed for its payments from the proceeds of the award or settlement. (Manual, 50.1).
- 50.4.4: In general, Medicare policy requires recovering payments from liability awards or settlements, whether the settlement arises from a personal injury action or a survivor action, without regard to how the settlement agreement stipulates disbursement should be made. This includes situations in which the settlements do not expressly include damages for medical expenses. Since liability payments are usually based on the injured or deceased person’s medical expenses, liability payments are considered to have been made “with respect to” medical services related to the injury, even when the settlement does not expressly include an amount for medical expenses. To the extent that Medicare has paid for such services, the law obligates Medicare to seek recovery of its payments. The only situation in which Medicare recognizes allocations of liability payments to nonmedical losses is when payment is based on a court order on the merits of the case. If the court or other

adjudicator of the merits specifically designates amounts that are for payment of pain and suffering or other amounts not related to medical services, Medicare will accept the Court's designation. Medicare does not seek recovery from portions of court awards that are designated as payment for losses other than medical services. (Manual, 50.4.4 - Designations in Settlements).

The Federal Claims Collection Act grants Medicare the right to compromise its claims, or to suspend or terminate its recovery action. However, only CMS claims collection officers may take this action.² Consequently, contractors may not, under any circumstances, enter into negotiations (either pre- or post-settlement) with beneficiaries, or their attorneys or representatives, to compromise Medicare's claim. 50.4.2 - Pre-Settlement Negotiations, Compromises, and Discussions With Beneficiaries/Attorneys (Rev. 1, 10-01-03).

The Manual provides an MSP Liability case documentation checklist, the components of which are listed below.

- Management control document to RO _____;
- Written request from beneficiary/beneficiary's agent for a reduction in Medicare's recovery, with reason for request _____;
- A statement of the total settlement offered by the liability insurer, or ordered by the court _____;
- Amount the beneficiary/attorney believes Medicare should accept in satisfaction of its claim _____;
- Accounting of procurement costs incurred in the claim settlement _____;
- Dates and types of medical services and names and addresses of providers, physicians, and suppliers _____;

² Based upon our understanding of the statute and the manual, all CMS collections are to be performed by contractors, therefore there will be no opportunity for Medicare to compromise its claims.

- Accounting of beneficiary's out-of-pocket expenses _____;
- Amount of benefits paid on behalf of the beneficiary, broken out by contractor _____;
- Documentation of nature of accident, including dates _____.

There are further concerns raised by the language of the Manual discussing the Release Agreement Form. The Manual states that once the beneficiary agrees to pay Medicare the amount that Medicare will accept in satisfaction of its claim (the full amount, or amount remaining after an appeal or waiver determination), it is the lead contractor's responsibility to obtain the appropriate signatures on a general release after the settlement. A "general release", in the context of Medicare, is an agreement which waives Medicare's right to change the amount of money it is accepting in satisfaction of its claim, and precludes Medicare from later asserting a claim against any outstanding amount not included in the satisfaction, e.g., monies remaining in the case of a partial waiver. The beneficiary agrees to pay/reimburse the amount in question, and is thereafter released from further obligation to reimburse. Medicare has no obligation to pay for any services related to the injury furnished before the date of the settlement that were not brought to Medicare's attention in writing before the settlement was reached. The Manual states this form should be signed either a) when the beneficiary agrees to remit in full, or b) after final disposition of a waiver/appeal request. The RO is responsible for securing a release for claims compromised under FCCA. 50.5.2.4 - Release Agreement Form (Rev. 1, 10-01-03).

As noted above, this Release does *not* include the Primary Payer. Therefore, the party most responsible for seeing that conditional payments are re-paid to Medicare is not released from further liability to Medicare, even after satisfying its obligations to Medicare.

B. The MMSEA Legislation

The new legislation mandates that primary payers report all settlements to Medicare where the settling injured party is a Medicare

recipient. The obligation falls unilaterally upon the insurer or self-insured entity to assess the claimant's entitlement to, or potential entitlement to, Medicare benefits and to report that status to Medicare, subject to a \$1,000 penalty per day for any alleged "failure to report". The MMSEA does *not* place any corresponding responsibility upon the beneficiary.

Section 111(8) governs information to be reported to CMS by or on behalf of Liability Insurance or Self-Insureds:

A liability insurer "shall (i) determine whether a claimant... is entitled to benefits; and (ii) if the claimant is determined to be entitled, submit the [Required Information] with respect to the claimant to the Secretary any form and manner specified by the Secretary. 111 (8) (A).

"REQUIRED INFORMATION includes the identity of the claimant and (ii) such other information as the Secretary shall specify in order to enable the Secretary to make an appropriate determination concerning coordination of benefits, including any applicable recovery claim. 111 (8) (A).

"TIMING: Information shall be submitted... within the time specified by the secretary after the claim is resolved through a settlement, judgment, award, or other payment (regardless of whether or not there is a determination or admission of liability). 111(8)(C).

"ENFORCEMENT: An applicable plan that fails to comply with the requirements... shall be subject to a civil money penalty of \$1,000 for each day of noncompliance with respect to each claimant." 111(8) (E).

"APPLICABLE PLAN" means liability insurance (including self-insurance, no-fault insurance, workers compensation laws or plans. 111 (8) (F)."

III. CLAIMS HANDLING PRACTICE AND THE IMPORTANCE OF FINALITY IN SETTLEMENT

In order to best understand the difficulties posed by the present Medicare reimbursement scheme as set forth in the MMSEA and the

Medicare Secondary Payer Statutes (1980 and 2003), it is helpful to understand how and why General Liability Settlements (GLS) are reached, how reimbursement has worked in the past to allow for the finality and certainty of such settlements in the context of self-insured entities and general liability carriers, and why that finality is crucial to the ability of the affected plans to conduct business.

Group Health Plans and Worker's Compensation Carriers have established relationships with Health Care Providers and are able to quickly assess their responsibility for payment and the cost of medical services. These plans pay health care providers directly for services rendered to subscribers/injured workers, without regard to fault. These plans generally process/pay bills for medical services as they are incurred and consequently do not ordinarily become involved in reimbursing Medicare for past medical expenses.

In contrast, General Liability Carriers (GLC) and Self-Insured Plans (SIP) do not have relationships with health care providers rendering treatment to the Medicare beneficiary or potential Medicare beneficiary. The GLC or SIP must rely on the beneficiary to provide information about eligibility, coverage and medical services rendered. The preferred method is to obtain a records release from the beneficiary so the GLC or SIP may secure this information directly. However, even assuming the beneficiary cooperates (often not the case in an adversarial claims situation), obtaining records takes time, as does evaluation of the issues presented by these claims, including liability, causation, and the extent of injury and medical treatment alleged to be related to the claim.

The mere fact that a GLC or SIP requests medical records from a beneficiary does not automatically mean that it will pay for the loss (or receive all of the applicable medical records). It is the responsibility of the GLC or SIP to pay only after an investigation into the facts of the loss, analysis of the nature and extent of injury/illness, evaluation of the applicable law as it affects a determination of liability and defenses thereto, and the assessment of exposure based upon liability, injuries and jurisdictional nuances. Once that analysis has taken place, the GLC or SIP commences negotiation with the beneficiary to resolve a loss. This negotiation includes the exchange of information and analyses by each side as to liability, past and future medical expenses, lost wages, other miscellaneous incurred

expenses, and pain and suffering. This system of claims handling, negotiation and settlement has worked extremely well for many years, resulting in a decrease in the burden on our trial courts. Indeed, it appears from many knowledgeable sources that *more than 90% of all claims settle before trial.*

The long-standing system under which liability settlements have been reached has also generally involved the agreement between the parties that negotiating for and paying reimbursement to Medicare and other health care providers would be the responsibility of the beneficiary and/or his/her counsel. It was left to the beneficiary and counsel to negotiate the amount of reimbursement to be paid from the settlement proceeds with health care providers. This was a logical method of proceeding, given that the beneficiary's attorney was the individual best situated to advise CMS of the "procurement costs" incurred by the beneficiary in obtaining the settlement and to request the appropriate reduction in reimbursement to be paid to Medicare. This system also had the benefit of allowing the settling plan to know exactly what its loss was, to put at end to that loss, and formulate its business decisions accordingly. These matters are of great significance in the ability of the affected plans to set appropriate reserves and address other budgetary matters required to conduct business.

Given this background, it may be seen that a GLC or SIP cannot reasonably be expected to make payment for medical services until its evaluation of a claim is complete, and that it requires significant information, including privileged medical information, in order to do so. (It does happen on occasion that the liability of an insured third party will be sufficiently clear that some medical payments may be made during the evaluation process. However, this is uncommon and, as a general rule, payment by the plan does not and cannot occur until evaluation is complete and an offer to resolve the entire claim can knowledgeably be made.)

With this historical background in mind, the difficulties presented by the Medicare Secondary Payer Statutes (1980 and 2003) become apparent.

A. IMPEDIMENTS TO EFFICIENT CLAIMS HANDLING, FINAL SETTLEMENT AND REIMBURSEMENT PRESENTED BY THE MEDICARE REIMBURSEMENT PROGRAM

Extensive review and analysis have led to the identification of numerous difficulties presented by the PRESENT Medicare reimbursement scheme (embodied in the Medicare Secondary Payer Statutes (1980 and 2003) and the MMSEA) which significantly reduce or even eliminate the ability of the affected plans to settle cases before trial, because the affected plans are deprived of the benefits of pre-trial settlement under the reimbursement system as it is presently framed. Significant reduction in or elimination of the pre-trial settlement of claims will result in a corresponding reduction or elimination in reimbursement obtained by CMS, rather than the increased reimbursement sought by the MMSEA.

The issues of primary concern with regard to the Medicare reimbursement program as it is presently constituted generally fall into three categories:

- The new **reporting requirements** pose problems and impose unilateral burdens on the affected plans.
- The reimbursement program as a whole results in the unwillingness and **inability of affected plans to settle cases before trial** because it does not allow for the finality of settlements, does not take into account well-established principles of comparative liability in determining the amount of reimbursement demanded from an affected plan, and because the payment of even one dollar by a settling plan could expose the plan to responsibility for reimbursing 100% of the claimed conditional payments for both past and future medical expense, again without regard to the actual responsibility of the settling insured. The necessity for the affected plans to proceed through trial in order to get a judicial determination of these issues will result in greatly increased costs for all parties, including CMS, and a delay in the receipt of and a reduction in the amount of reimbursement obtained by CMS.

- Significant constitutional issues are presented by the MMSEA and Medicare Secondary Payer Statutes (1980 and 2003), including demands to an affected plan for reimbursement of 100% of a beneficiary's past and future medical care, possibly without limitation, and without consideration of the comparative liability of the beneficiary and others; the absence of any procedure for review or appeal of Medicare's unilateral determination of how much reimbursement is owed, and from whom, and for how long into the future; the unconstitutional taking of portions of a beneficiary's settlement beyond that amount representing compensation to the beneficiary for medical care paid for by Medicare; due process and equal protection concerns of the senior citizen beneficiaries directly affected by the Medicare reimbursement program; and an improper indirect tax on the American public in the form of increased costs of consumer goods and services as the affected plans necessarily pass along the greatly increased costs they will incur if the present system and the planned revisions set forth in the MMSEA are not revised.

IV. DISCUSSION

1. ISSUES PRESENTED BY NEW REPORTING REQUIREMENTS:

Significant obstacles to claims settlement and resolution, and to prompt reimbursement to CMS, are presented by the new reporting requirements set forth in the MMSEA. An affected plan desiring to settle a case cannot effectively do so until it or the beneficiary receives a statement setting forth the Medicare Reimbursement Demand (see "Medicare MSP Manual", Chap. 7, 50.4.1). The process of obtaining such a Demand from CMS often takes months or years, during which time settlement cannot be finalized or distributed to the injured party (notably, these will be elderly people who will be harmed far more than most groups by a significant delay in the resolution of their cases). While the parties await a Demand for Reimbursement from Medicare, files cannot be closed by the parties, the affected plans or the CMS, and reserves must continue to be held open and revised from time to time as the effort obtain a reimbursement demand from CMS continues.

Although the Medicare Practice Manual suggests that primary plans, such as GLCs and SIPs, desiring to determine the amount of Medicare's current claim should be referred to the beneficiary's representative (assuming there is one) (Medicare MSP Manual, Ch. 7, 50.5.1.1.), in practice this makes little sense, since beneficiaries and even their representatives are typically ill-suited to identify the amount of Medicare's current demand, a process which requires reviewing often complicated EOBs and other forms, and to distinguish treatment related to an accident and thus potentially subject to reimbursement from unrelated treatment. Unfortunately, CMS also struggles with these determinations.

Even when the information is sought by a beneficiary or a beneficiary's representative, they typically encounter a delay of at least several months before the information is provided. Even then, there is no certainty – for the beneficiary or a plan desired to settle short of trial – that the demand is in fact “final”, since Medicare will not execute any Release in favor of the settling plan, even upon receipt of payment of what a beneficiary and plan may understand to be the “final” reimbursement demand based on letters and other communication received from CMS.

It is noted that the MSP Manual states CMS or its representative should “try” to recover Medicare's payments between the date of the settlement but before the funds are disbursed. (Medicare MSP Manual, Ch. 7, 50.3.3). This would, in theory, require CMS or its contractor to provide its demand to the beneficiary or his/her representative and the settling plan in less than 30 days, a not-unreasonable period of time with which to effectuate a settlement. Unfortunately, however, this is not what occurs. Instead, it typically takes months, if not years, for Medicare representatives to issue a “final” demand (and even that demand is far from final; see discussion below regarding the issue of potential demands to a settling plan for reimbursement of the cost of *future* medical care incurred many years after a settlement has ostensibly been finalized and Medicare's “final” demand paid).

CMS incorrectly assumes that non-GHP entities currently collect the data required for reporting. They do not. The present Medicare reimbursement scheme, following the MMSEA, puts the responsibility unilaterally on the affected plans to notify the CMS of

the potential settlement of a claim involving a Medicare beneficiary or potential beneficiary, to obtain the information CMS needs to make its reimbursement demand, and imposes draconian fines of \$1,000 per day on the plans for alleged noncompliance. This unilateral burden is manifestly unfair in that the information demanded by CMS is far more readily available to a beneficiary and his or her counsel/representative, particularly where formal litigation has not been initiated and thus there is no mechanism for an affected plan, through its counsel, to compel disclosure of the information. At the very least, there should be a *mutual* obligation on the beneficiary and/or his/her representative to notify the CMS of a potential third-party claim.

It is clear CMS recognizes the necessity of obtaining Social Security Numbers from beneficiaries in order to collect data the affected plans are now required to provide to CMS (see “The Need for Social Security Numbers and/or Health Insurance Claim Numbers” in the Manual). Nevertheless, in the Supporting Statement for the MMSEA (MSP Mandatory Insurer Requirements (P.L. 110-173)), CMS notes that HIPAA and other privacy legislation apply to the information collected, thus precluding the affected plans from obtaining this information unless beneficiaries volunteer to provide it (often unlikely in an adversarial setting) or unless the parties are forced into litigation so they have a mechanism to compel disclosure.

Thus, the affected plans face a Catch-22: They are required to report potential third-party claims involving, and settlements with, Medicare beneficiaries or potential beneficiaries (attempting to identify this group of claimants is another “no win” situation for the affected plans), and will be severely penalized for failing to do so, while at the same time they are deprived of any mechanism short of litigation or voluntary provision by the beneficiary to allow them to lawfully collect the information.

If the affected plans are to comply with this reporting requirement, there must be a procedure put into place which will allow plans ready access, without the barriers of HIPAA or other privacy law, to information from which the plans can reliably determine whether a particular claim involves an actual or potential Medicare beneficiary, and the amount and nature of medical care

provided to the beneficiary, and paid for by Medicare, allegedly as the result of a liability event.

It must be emphasized that the option of litigation to force provision of otherwise confidential, protected medical information, while available, is undesirable for many reasons, not the least of which is the delay in reimbursement CMS will experience if the only manner in which affected plans can achieve a clear determination of, and an end to, their potential responsibility to the beneficiary and CMS is by proceeding through trial and receiving a judicial assessment of to the insured's liability, if any, and the amount of past and present medical care proven to be related to a particular incident. (Please see further discussion below regarding issues related to the present Medicare reimbursement program's adverse impact on ability of affected plans to settle cases).

Fortunately, better alternatives exist. At least one such alternative is a reimbursement plan similar to the Medi-Cal (California Medicaid) system. The Medi-Cal reimbursement program (as revised in 2007) has many aspects which could be readily adopted by CMS (since the Medi-Cal program is Federally-based and already functioning well in a large system) and which CMS believes would remedy many of the significant problems presented by the present Medicare reimbursement program, perhaps most importantly the tremendous increased burden on our trial courts if revisions to the program are not promptly formulated.

For example, the Medi-cal model provides for a pre-approval process, during which the parties mutually gather information to present to the plan in support of a proposed settlement and the recommended reimbursement to Medi-Cal from those settlement proceeds. This process allows for consideration of principles of comparative liability as well as allows for final determination and payment by the settling parties of their responsibility to reimburse Medicare for past *and* future medical expense. In addition, such a program would avoid the problems associated with even the best-intentioned efforts by the affected plans to identify claims involving existing and potential Medicare beneficiaries, and to report that information to CMS.

2. THE CURRENT MEDICARE REIMBURSEMENT PLAN GREATLY REDUCES THE LIKELIHOOD THAT CASES WILL BE SETTLED SHORT OF TRIAL, IMPOSING SIGNIFICANT BURDENS ON ALL PARTIES

The primary obstacles to the ability of the affected plans to settle cases with finality relate to the absence in the present Medicare reimbursement scheme of any consideration of long-accepted principles of comparative liability in regard to Medicare's stated intent to collect all "conditional payments" from settlement proceeds, as well as the apparent "open door" for CMS to come back, even many years after a settlement has ostensibly been finalized, and demand additional reimbursement from a settling plan, again without any consideration of the comparative liability of the plan's own insured, the beneficiary, or any other person or entity.

There is broad acceptance among the affected plans of CMS's desire to obtain fair reimbursement of sums paid out by Medicare as a result of injuries for which an insured third party is *responsible*. However, the emphasis on "responsibility" is significant; inasmuch the present Medicare reimbursement scheme set forth in the Medicare Secondary Payer Statutes (1980 and 2003) and the MMSEA is inconsistent with the principle that a wrongdoer should be responsible for reimbursement *to the extent that the wrongdoer has contributed to the harm*.

Contrary to this well-established legal principle, the present reimbursement system allows CMS to demand repayment of 100% of its conditional payments from an affected plan or beneficiary desiring to settle a case before trial (or, potentially, even before litigation has been initiated), without regard for the extent to which, if at all, the plan's insured is *responsible* for the injury-producing event - and without consideration of the beneficiary's own comparative liability, or the comparative liability of other individuals or entities who may bear far greater responsibility but who are uninsured.

The present system authorizes the CMS to make the reimbursement determination *unilaterally*, without providing any process for review or appeal in the event the plan or the beneficiary disagrees with the CMS reimbursement demand. Under this

scenario, an injured senior beneficiary may receive nothing from a proposed settlement (except for the medical care he or she has received). Such a result appears manifestly unfair and likely unconstitutional, given the reasoning of the United States Supreme Court in the case *Arkansas Dept. HHS v. Ahlborn* 547 U.S. 268, 126 S. Ct. 1752 (discussed further *infra*).

In contrast to the pre-trial settlement context, (again, keeping in mind that in excess of 90% of all cases are resolved before trial), under the present reimbursement program Medicare *will* reduce the amount it will accept for reimbursement *following a judicial determination* of the issues of liability for a particular incident and the amount of past and future damage attributable thereto.

It is difficult to reconcile Medicare's willingness to reduce its demand for reimbursement to comport to a judicial determination of liability and damage following trial, with its *stated unwillingness* to do so in the context of cases the parties desire to settle without incurring the expense and delay necessarily involved if a case must proceed through trial. Indeed, a persuasive rationale for this distinction has not been set forth in any of the extensive materials and legislation reviewed in preparing this Comment, and is difficult to envision. It may well be this is an unintended adverse consequence which was inadvertently overlooked when the revisions were drafted. In any case, this distinction is a significant impediment to case pre-trial resolution and thus to prompt and appropriate Medicare reimbursement. MARC strongly believes all provisions of the present Medicare reimbursement program as a whole, including the new revisions of the MMSEA, must be promptly revised so that the parties are not deprived of their incentive to settle cases before trial.

It must be emphasized that under the Medicare reimbursement program as presently framed, the only manner by which an affected plan can avoid the potential of having to pay 100% of Medicare's demand for reimbursement, even in a case in which the insured bears little or not responsibility for an injury-producing event, is for the affected plan to proceed to trial to obtain the necessary judicial determination. If this occurs, there is ample evidence *the government will suffer most directly and severely*.

Recent studies have established what MARC's members have long known: That settlement short of trial is the best alternative for all parties to a claim, and that when cases *do* proceed to trial; defendants receive far better outcomes, in a significantly higher percentage of cases, than do plaintiffs. (*Let's Not Make a Deal: An Empirical Study of Decision Making in Unsuccessful Settlement*, Negotiations, Journal of Empirical Legal Studies, Vol. 5, Issue 3, Pp. 551 – 591, September 5, 2008.) Indeed, it is widely recognized that most cases result in a defense verdict.

The Medicare reimbursement program further reduces the incentives the affected plans have to settle short of trial in that it authorizes CMS to demand reimbursement of *future* medical costs from an affected plan for care provided to a beneficiary many years after a settlement has ostensibly been "finalized" and reimbursement made to CMS, again without regard to the actual harm caused by the settling party, if any, in the incident, or the comparative liability of the beneficiary and others, and without any mechanism for challenge or appeal by the affected party of Medicare's unilateral determination that reimbursement is owed by a settling plan, including the potential for reimbursement for future medical care paid for by Medicare even years after a settlement has been effected and Medicare's "final" demand for reimbursement paid.

The potential responsibility of a settling plan for reimbursement to Medicare of future medical expense even years after a particular case has ostensibly been settled will have a **clear chilling effect on settlement**, particularly since the affected plans are denied review or appeal of Medicare's unilateral determination that reimbursement is owed. This prospect means the affected plans will be unable to close their files, and reserves will have to be set and remain open on an affected plan's books indefinitely, resulting in a negative impact on the ability of the affected plans to conduct business. Of course, Medicare will be unable to close its files as well, significantly contributing to increased administrative costs for the government which do not appear to have been factored into the economic analysis of the impact of the present planned revisions contained in the MMSEA.

The possibility of responsibility by the affected plans to reimburse Medicare for "conditional" payments for medical care even

years after a settlement has been reached and reimbursement paid to CMS results in other harsh penalties to affected plans. For example, if Medicare is forced to initiate suit to recoup conditional payments, then primary plans and beneficiaries could be responsible to pay interest on the amount of reimbursement, as well as damages in the amount of *double* Medicare's conditional payments. 42 U.S.C. §1395y (b) (2) (B) (ii), (iii); 42 CFR §411.24 (c) (2), (h).

There is some indication in the Manual, but not in the legislation itself, that reimbursement of "conditional payments" *will not be demanded or sought by Medicare after a settlement has been finalized*. In that regard, the Manual states: "[T]here should be no recovery of benefits paid for services rendered after the date of a liability insurance settlement" (Chap. 7, Section 50.5). This is a concept with which MARC heartily agrees. However, it would appear this statement is dicta rather than law, and that the actual provisions of the Medicare statutes, which permit Medicare to demand reimbursement from a settling plan even years after a settlement has ostensibly been finalized, will take priority over the comment in the Manual. Unfortunately, the mere possibility that Medicare might not choose to act on its right to seek these future payments does not provide the plans with sufficient reassurance that they can settle cases with finality and certainty. Thus, MARC anticipates the plans will be required to proceed all the way through trial in order to obtain the requisite judicial determination on issues of liability and damage so that it can in fact close its books on a particular loss.

Further, under the present Medicare reimbursement program,, CMS can recover the entire amount of an award or settlement as reimbursement, *even where the settlement denominated a portion of the medical treatment as being for care of pre-existing conditions unrelated to the accident*. (Medicare MSP Manual, Ch. 7, 50.4.4.4.)

This provision causes the understandable concern by the affected plans that CMS might make the same "mistake" in the assertion of a demand for reimbursement of *future* medical care as it may in mistakenly claiming reimbursement of past medical expense for unrelated conditions, particularly since the affected plans have no procedure available to them for judicial review or appeal of any Medicare reimbursement determination. Given the provisions of the Medicare reimbursement program as present framed, it does not

strain credulity to envision a situation where a demand is made by CMS to a settling plan, many years after the settlement, for reimbursement of the cost of medical care *unrelated* to the injury resulting in the earlier settlement and reimbursement.

Further, under the present Medicare reimbursement program, and specifically under the MMSEA, a settlement payment *in any amount* triggers the reporting requirement, penalties for failure to comply with those requirements, and the potential for 100% responsibility for reimbursement of past and future medical care provided by Medicare. (42 U.S.C. §1395y (b), subsection 1862(b)(2)(B)(ii)). As a consequence, the present Medicare reimbursement program is likely to lead to elimination of the common business practice of nominal and/or goodwill settlement offers. These offers may be made by affected plans or businesses, even where it is recognized by all concerned that the paying entity bears little or no responsibility for the subject incident, to engender continued customer goodwill and/or to quickly end an expensive claims process.

Given these consequences of the current Medicare reimbursement program, it is not difficult to understand why the affected plans will simply be unable to settle claims, and will be forced to proceed to trial so they may put on evidence as to the liability of the beneficiary and others, and evidence as to the relationship – or lack thereof – of any claimed past or future medical care to the subject incident.

If the affected plans are required to proceed to trial because they cannot reasonably and with finality settle claims, the costs to the plans will be massive – *but the costs to the government will be enormous as well*. The Medicare Trust Fund will also incur additional costs and disbursements: For example, as beneficiaries wait to resolve their claims, a well-recognized psychosomatic component is at work, driving the need for additional medical treatment. The fact that a beneficiary was injured is certainly bad enough, but litigation - a process which constantly reminds them of the injury - usually results in additional medical care, and thus additional cost to Medicare as the matter wends its way through the system, potentially all the way through trial. To avoid this phenomenon, prompt and final settlement of claims is the best option for all parties, including CMS.

Unfortunately, under the Medicare reimbursement program as presently framed, settlements will drop dramatically, and the costs to the government will increase just as dramatically.

It appears beyond any reasonable question, therefore, that under the Medicare Secondary Payer Statutes (1980 and 2003) and the new MMSEA, the likelihood is CMS will wait far longer for any reimbursement at all, and will incur the significant expense of continued claims management/tracking through trial (potentially including the costs associated with intervention, if CMS determines it must participate in litigation in some cases). If more cases proceed to trial, CMS will in all probability recover less in the majority of cases than its the “conditional payments” it asserts, and less than would have been offered to CMS by the parties if a pre-trial settlement could appropriately be reached with finality. Indeed, might well receive nothing, given that most cases which proceed to trial result in complete defense verdicts.

In summary, if the affected plans cannot settle their cases and are forced to trial, it is likely the amount of reimbursement to CMS, if any, will be *less* than CMS would receive were it to agree to a “settlement pre-approval” process with a provision for swift judicial review in the event CMS determined not to approve a proposed settlement and reimbursement amount. (See discussion of Proposed Alternatives, below).

3. CONSTITUTIONAL ISSUES PRESENTED BY THE PRESENT MEDICARE REIMBURSEMENT PROGRAM (MEDICARE SECONDARY PAYER STATUTES (1980 AND 2003) and MMSEA (2007))

There are significant constitutional questions presented by aspects of the present Medicare reimbursement program in view of the absence of any procedure for review or appeal of Medicare’s unilateral decision as to how much reimbursement is owed by an affected plan or beneficiary, and Medicare’s intent to collect the full amount of its conditional payments from settlement proceeds, even where the settlement includes compensation to the beneficiary for other elements of damage aside from the cost of medical care paid for by Medicare, such as lost earnings, and pain and suffering.

The issue of whether a reimbursement program may lawfully seek to collect its lien from settlement proceeds in excess of the amount of the settlement denominated as compensation for medical care, has been addressed dispositively by the United States Supreme Court in *Ahlborn*, (Id.)

In *Ahlborn*, the U.S. Supreme Court *unanimously* held that the Arkansas Medicaid reimbursement scheme was unconstitutional to the extent the State sought to assert its lien against a settlement which contemplated payment to the settling beneficiary for more than her medical damage, noting that the Federal anti-lien provision (42 USC 1396p(a)) specifically prohibited the State from doing so. The Supreme Court agreed the State's right of recovery extended only to recovery of medical payments and where, as in *Ahlborn*, the settlement proceeds sought to be attached included compensation for more than medical payments, the State could recover only that portion of the settlement denominated as representing compensation for medical care. (*Ahlborn, Id.*, at 285-285, noting that, "[t]he State [cannot] force an assignment of, or place a lien on, any other portion of [the beneficiary's] property.")

If the present Medicare reimbursement program represented by the Acts of 1980, 2003 and 2007 is not revised to make clear that CMS will not and does not seek to assert liens against portions of settlement proceeds except those denominated as compensation for medical costs paid for by Medicare, it is certain litigation will ensue in the State and Federal Courts until the issue is finally settled, likely by the United States Supreme Court.

Based upon the helpful reasoning of *Ahlborn*, and the extensive discussion of Federal reimbursement law therein, it is anticipated that any portion of the present Medicare reimbursement program which purports, as the present scheme does, to authorize the government to collect settlement proceeds paid to a beneficiary as compensation for elements of damage other than medical care, will be struck down by the reviewing Courts.

In addition to issues of due process, equal protection, and unlawful taking presented by the present Medicare reimbursement program, there is the further reality that the ability of the affected plans to conduct business will be even more adversely impacted as

regulations continue to be imposed and collection and enforcement efforts are increased. The present plan will, as noted, result in the inability of affected plans to settle cases short of trial, thus greatly increasing the costs the plans must bear for litigation. These substantial costs cannot be borne by the affected plans alone; they will, of necessity, be passed along in the form of increased cost of goods and services provided by the affected plans, resulting in an improper and unlawful indirect tax on the American consumer.

These constitutional issues will likely result in litigation in Federal and State Courts, leading to delay in resolution of these matters, thus adding to the costs for all parties *including the government* as cases proceed through the courts.

V. SUGGESTIONS FOR AN ALTERNATIVE MODEL

The foregoing discussion is intended to set forth the difficulties inherent in the Medicare reimbursement program in its present form. Fortunately, there are alternatives upon which revisions to the Medicare reimbursement program could be modeled to avoid the very serious problems which will flow from the present program, including a tremendously increased burden on our trial courts if cases cannot be settled with finality.

The possibilities for revision and approach to these problems are numerous, and MARC wishes to begin a dialogue with CMS in order to arrive at a revised program which meets the needs of all concerned: the need for CMS to obtain prompt and reasonable reimbursement of “conditional payments” it has made, while preserving the very important ability of beneficiaries and affected plans to settle cases before trial, with finality and certainty, so that none of the parties involved – nor the courts – are burdened by the very significant increase in trials which is sure to follow if settlement is essentially taken off the table as an option for beneficiaries and carriers.

In discussing these issues MARC is willing to consider many points of view, and has devoted extensive time and analysis to evaluating several programs already in existence. Fortunately, MARC has identified reimbursement programs which provide the government entity seeking reimbursement with increased collections in a much shorter time frame, and apply the same principles to

reimbursement obligations in the context of pre-trial settlement as they do to reimbursement obtained following trial.

One such alternative has particular strengths in that it is based upon Federal guidelines, is consistent with current Federal law, and appears to have been drafted with the *Ahlborn* reasoning and holding specifically in mind: the Medi-Cal reimbursement program revised by California in 2007. It is expected the Medi-Cal reimbursement program, unlike the current Medicare reimbursement scheme, would pass constitutional scrutiny.

Revision of the present Medicare reimbursement program to comport with the Medi-Cal reimbursement program or a similar model has substantial benefits and would further the government's goal of prompt and appropriate reimbursement of Medicare payments, while avoiding the morass of issues which the present legislation will create.

Because the Medi-Cal model is already in place and is based upon existing Federal guidelines and statutes, it is anticipated revision of the existing Medicare statutes could be readily accomplished to adopt or incorporate the best aspects of the Medi-Cal reimbursement program and other similar reimbursement plans.

With these goals in mind, it is recommended that discussion of concepts for revisions to the present Medicare reimbursement program take place without and further delay, including consideration the following proposals:

- A revised Medicare reimbursement plan would benefit from including a provision to require notification to CMS by the beneficiary (individually or through counsel) *and* the affected plan within thirty (30) days of the date either learns a claim has been or may be asserted by a beneficiary or potential beneficiary. Such a provision would provide CMS with early notification of a potential claim and of its potential right to reimbursement, and would alleviate the affected plans of their present unilateral obligation to provide notice when the information is generally much more readily available to the beneficiary.

- A revised Medicare reimbursement plan should involve consideration of establishing a mechanism whereby affected plans are permitted to access otherwise privileged information, such as Social Security Numbers and information regarding medical claims paid by Medicare as a result of an event for which the insured is allegedly responsible, for the limited purpose of complying with CMS reporting requirements, without violating HIPAA or other state and Federal privacy laws. This would permit the plans to meet their notification obligations to CMS, and would facilitate the process of gathering information necessary for a full evaluation of a particular case, with the goal of improving claims handling and, in most cases, leading to settlement.
- A revised Medicare reimbursement plan would address and likely resolve the greatest difficulties presented by the present scheme if it were to adopt some version of the Medi-Cal program's pre-settlement approval process. This process requires the parties to seek approval of a proposed settlement, including the reimbursement to Medicare proposed therein, presenting CMS with evidence supporting the planned settlement amount, including evidence as to liability (including the comparative liability of the plaintiff and others), past and future medical costs and the likelihood of proving these damages at trial, and other factors affecting case, as well as the amount proposed by the parties to be reimbursed to Medicare.

Such a plan allows the parties to explain to CMS the factors relating to the decision to settle for a certain amount, thus providing CMS with an understanding of the comparative liability and damages issues as the parties view them, as well as other factors affecting the amount of the settlement agreed upon (for example, witness credibility, jurisdictional nuances, strength of evidence, etc.), thus providing fairness and *finality* to the settling plan, as well as to the beneficiary and the government. Such a process would result in pre-trial settlement, which would of course get reimbursement into

the government's hands more quickly and reliably than any other method MARC has identified.

- A revised Medicare reimbursement plan should consider a limitation on the recovery of attorneys' fees by the plaintiff's/claimant's counsel, in recognition of the fact that if cases are required to go through trial, in the majority of cases counsel would receive no fee at all. The Medi-cal model sets counsel's fees (the "procurement costs") to 25% of the total settlement. Similarly, a revised Medicare reimbursement program should consider limitation of CMS recovery of its "conditional payments" – no matter their total amount -to no more than 50% of the total settlement sum, thus ensuring that the beneficiary would always receive something from the settlement. Such a proposal spreads the risk, and the benefit, of possible future medical care equitably among the parties: In some cases, the beneficiary might require future medical care as a result of an injury, resulting in additional potential cost to Medicare which would not be subject to a claim for reimbursement. In far more cases, however, it is anticipated CMA will receive reimbursement from a settlement which encompasses the possibility of future medical care which *never occurs*. Under either scenario, the parties and the government benefit from early resolution of the claim by settlement rather than having to proceed through trial, with all the difficulties, expenses and risks attendant thereto.
- In the event CMS or its contractor do *not* approve a proposed settlement for any reason, a revised Medicare reimbursement plan should consider a procedure for prompt judicial review so the parties are afforded a determination of the issues of liability, damage and reimbursement by an impartial judicial entity, rather than the unilateral determination lying solely in CMS's discretion, as does the present plan. Under such a program, as in the Medi-cal reimbursement program, the parties and CMS would have the opportunity to present evidence on the issues without incurring the significant costs associated with proceeding through trial. This

provision would alleviate the very real concern of affected plans that the Medicare reimbursement program as presently framed does not provide any mechanism for judicial review or appeal of a determination of and demand for reimbursement by CMS.

In addition to revision to reflect these aspects of the Medi-Cal reimbursement program and similar models, it is recommended that a revised Medicare reimbursement plan consider setting a “settlement threshold”, perhaps \$10,000, so that no reimbursement to CMA would be demanded or owed when settlements are less than the threshold. However, CMS would still be protected from potential misuse of this provision, in that the obligation to notify CMS as set forth above would still apply, so CMA would be aware of the pendency of all claims, even those which may ultimately result in settlement under the threshold. Further, upon settlement under the threshold, CMS would be provided with proof of payment sufficient to establish the beneficiary had in fact received less than the threshold amount in settlement. Such a provision would permit affected plans and businesses to continue to settle cases nominally or on a goodwill basis when it is recognized, as is often the case, that the paying entity bears little or no responsibility for the incident, and/or that there has been little or no damage. It is anticipated CMS would realize substantial savings in not having to keep track of such relatively small claims over extended periods of time as they move toward trial (which MARC believes will occur if revisions to the present reimbursement system are not promptly made), a savings which would likely offset any loss of reimbursement which might have been realized from these small settlements.

Finally, a revised Medicare reimbursement plan must, in fairness, provide the settling plan as well as the beneficiary with a Release and Satisfaction promptly upon receipt by CMS of payment of the agreed reimbursement. The Release and Satisfaction must understandably be sufficient to assure the settling parties that they are immune from further reimbursement demands or collection efforts by CMS with regard to a settled matter, particularly as to possible demands for reimbursement related to future medical care, and that they may safely close their files and move forward, knowing the settlement is in fact *final*.

There are numerous benefits to these proposed revisions to the present Medicare reimbursement program, not the least of which is simple fairness and swiftness to injured senior citizens who may not have the luxury of time to proceed through trial, and who often live on fixed or limited incomes. Further, if these or other similar revisions are adopted, an injured beneficiary would always receive at least a portion of the settlement proceeds. In contrast, under the present Medicare reimbursement program, an injured beneficiary may end up with nothing, a result which is manifestly unfair, likely unconstitutional, and ignores that in virtually any injury requiring medical care there is at least some element of pain and suffering to the injured individual.

VI. CONCLUSION

Liability Insurance Carriers and Self Insured Plans cannot operate in a world of open-ended exposure: they require a finality of liability. In order for there to be finality, it is imperative the affected plans not be unfairly burdened with reimbursement demands far in excess of their actual responsibility, or for potentially unlimited future medical care reimbursement, particularly in the absence of any procedure for review. It is clear pre-trial settlements will not be practicable for the affected plans and will likely disappear unless there are revisions made to the present Medicare reimbursement program embodied in the Medicare Secondary Payer Statutes (1980 and 2003) and the MMSEA to address these realities. If settlements are not possible, serious harm will be incurred by all involved – perhaps most particularly the government itself.

Consideration and discussion by CMS and the affected plans, beneficiaries and their counsel of these recommended revisions to the present Medicare reimbursement program would provide essential fairness to the parties, the possibility of swift reimbursement to the government, and a process of judicial review in the event of lack of agreement as to any aspect of the settlement, including the amount of reimbursement proposed to be shared with CMS. These or similar revisions would permit the parties to avoid trial in many cases, a factor which benefits all. In addition, such a plan would result in a return of certainty to the settlement process, an increase in the amount of reimbursement to CMS and a great reduction in the amount of monitoring and “paperwork” (even electronic) required to follow a case through trial.

MARC requests CMS consideration of this Response, and the opportunity to work collaboratively with CMS to revise and clarify the Medicare Secondary Payer Statutes (1980 and 2003) and the MMSEA as necessary, to remedy these issues without delay, for the benefit of all.

Respectfully submitted,

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