August 14, 2012

Marilyn Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
CMS–6047–ANPRM
P.O. Box 8013
Baltimore, MD 21244–8013.

DELIVERED VIA ELECTRONIC SUBMISSION

RE: CMS–6047–ANPRM; MEDICARE PROGRAM; MEDICARE SECONDARY PAYER AND "FUTURE MEDICALS"

Dear Acting Administrator Tavenner:

The Medicare Advocacy Recovery Coalition (MARC or the Coalition) is pleased to provide comments regarding the Advanced Notice of Proposed Rulemaking (ANPRM) addressing situations involving future medical expenses in the Medicare Secondary Payer (MSP) context. MARC supports the agency's efforts to secure stakeholder input regarding possible future rulemaking on MSP issues. We believe that the Centers for Medicare and Medicaid Services (CMS) should continue to take steps to make the MSP process more effective, efficient, flexible, and streamlined for all parties involved.

About MARC: MARC was formed in September 2008 by a group of leading stakeholders to advocate on behalf of beneficiaries and affected interests for the improvement of the MSP system. MARC's membership represents virtually every sector impacted by MSP, including plaintiffs and defense attorneys, brokers, insureds, insurers, insurance and trade associations, self-insureds and third-party administrators. MARC and its member companies are committed to achieving an efficient and effective MSP system that protects Medicare beneficiaries and the Medicare Trust Fund, while providing a rational and usable system for all stakeholders. Our members are involved with every aspect of the MSP process, and many of our members handle innumerable cases that involve payments for future medical expenses.

Based on our extensive experience with the current MSP regulations and the impact they have in the real world, MARC respectfully submits the following comments regarding the ANPRM for the treatment of future medical expenses under MSP. Before sharing its comments, however, MARC wishes to note that it will not be commenting upon the questions of whether Medicare Set-Asides (MSAs) are, or are not, appropriate for liability and other NGHP claims. Instead, given the diversity of perspectives within the Coalition, we urge the Agency to review in detail the individual

comments of different MARC Members on that issue, and on the specific Liability Medicare Set Aside (LMSA) questions posed in the Agency's ANPRM. With that note, our comments are as follows:

I) CMS SHOULD UPDATE THE EXISTING MSP REGULATIONS BEFORE ADDRESSING THE SPECIFIC PROCESS FOR CLAIMS INVOLVING FUTURE MEDICAL EXPENSES

Before proposing new regulations addressing future medicals, MARC urges CMS to first address and update its existing regulations related to the recovery of conditional payments. There are a number of systemic inefficiencies in the current MSP system which impede prompt recovery of funds by Medicare, and which also delay settlements and cause significant unintended problems for beneficiaries and parties assuming primary liability.

To this end, MARC urges CMS to focus any future rulemaking efforts on creating a regulatory structure that could inform parties of their conditional MSP payment amount in advance of settlement. As the Agency is aware, the current system of calculating the conditional payment after settlement makes it difficult, or even impossible, for parties to settle their claims, as they cannot accurately predict the actual terms of their settlement without knowing how much money will be required to reimburse Medicare. This systemic problem also significantly delays, and unfortunately often reduces, the amount of money that can be returned to the Trust Fund. Cases that otherwise could have settled promptly are needlessly delayed, thus slowing the parties ability to reimburse Medicare.

MARC strongly urges CMS to develop a regulatory process that would allow parties to request confirmation of the final conditional payment amount when settlement is reasonably expected. This critical change would allow parties to finalize settlement discussions with a true meeting of the minds and would result in more money being returned to the Medicare trust fund faster.

MARC also recommends that CMS take steps to ensure that MSP recoveries are not made when they come at a net financial cost to the Medicare Trust Fund. In our experience, there are numerous conditional payment demands that are made for an amount so low that the amount of the payment does not even come close to covering the cost of the request. MARC appreciates and strongly supports the steps CMS has taken thus far to establish reporting thresholds for some claims. We urge CMS to continue to evaluate ways to reduce wasteful spending by taking additional steps, including proposing new regulations, to remove these net-loss claims from the MSP system.

We also urge CMS to address other systemic problems in the current MSP system. For example, the current MSP Section 111 reporting process requires Responsible Reporting Entities (RREs) to obtain Social Security Numbers (SSNs) or Health Insurance Claim Numbers (HICNs) from beneficiaries with whom they settle claims. In practice, it is extremely difficult to obtain these numbers, as beneficiaries are understandably resistant to providing this sensitive personal information to parties against which they are pursuing a claim. Other federal agencies, and indeed other areas of CMS, frequently urge beneficiaries not to provide this information to third parties in order to prevent identity theft and fraud, including Medicare fraud. MARC urges CMS to propose a regulation that would permit, but not require, the use of SSNs and HICNs for Section 111 reporting. Alternately, CMS could require RREs to report the last four digits of a social security

number plus another identifying field, such as last name or address. This small change would significantly improve the MSP process for all parties involved.

MARC also urges CMS to develop regulations that would establish Section 111 reporting safe harbors for RREs who make good faith efforts to comply with the reporting process and to establish a statute of limitations for MSP claims that will provide all parties involved with a measure of certainty and finality.

In addition to these structural changes, MARC respectfully urges CMS to address through rulemaking the existing MSA process for workers compensation claims before turning to set asides in liability and other Non Group Health Plan (NGHP) claims situations. The current MSA process has created significant confusion for stakeholders, and is currently the subject of extensive delays and backlogs. We urge CMS to address this process, with particular attention to how the MSA timelines and thresholds for inclusion are handled, before expanding a process that is not efficient today – either for the Agency or for affected stakeholders.

II) CMS SHOULD REVISE THE PROPOSED DEFINITION OF THE TERM "CHRONIC ILLNESS" AND SHOULD TAKE AN ALTERNATE APPROACH TO ESTABLISHING THE "DATE OF CARE COMPLETION" THAT DOES NOT REQUIRE A PHYSICIAN CERTIFICATION

MARC supports CMS' efforts to establish clear and precise definitions, based on stakeholder input, for terms used in the MSP process. Many of the terms that are important to the MSP process already have a generally accepted specific meaning in the industry. In the past, discordance between these generally accepted meanings and how CMS has utilized the terms in the MSP context has caused considerable confusion for stakeholders. Many of these terms are also defined in state laws that impact the industry or have been given specific meaning in state and federal case law. We urge CMS to following these existing definitions, where available, to reduce confusion and promote consistency in how MSP claims are administered. MARC is pleased to have this opportunity to provide feedback on how these terms should be understood and applied.

We also urge CMS to be as precise as possible in defining terms that will be used in connection with MSP claims. Settling parties must utilize these terms in setting terms of settlements, and confusion or imprecision is likely to lead to protracted litigation about what particular terms mean and what CMS intended in setting the definition. Such litigation only further delays the return of MSP funds to the Medicare Trust Fund.

If CMS moves forward with the ANPRM, we urge CMS to revise the definition of "Chronic Illness." We believe that the appropriate time period for qualifying as a "chronic" illness is more appropriately set at one year. Diseases and conditions that last for three months may or may not be truly chronic, and the three year time period would sweep in numerous temporary conditions.

MARC also urges CMS to revise its approach to establishing the "Date of Care Completion." We recommend removing any requirement for a physician's attestation. In light of physician workloads, it is likely to be very difficult for beneficiaries to secure such an attestation from their treating physician. Further, many physicians will charge the beneficiary to provide such an attestation, further limiting the recovery to a beneficiary. There could also be considerable

confusion over which physician is the appropriate doctor to sign the attestation where, as is frequently the case, a beneficiary is receiving care from numerous providers. Physicians are also likely to be resistant to signing such an attestation out of concern for potential liability. A physician may be resistant to asserting that all care has completed for a patient when he or she is only familiar with the care he or she is providing.

MARC recommends that instead, CMS should allow either of the settling parties to sign the attestation as to the date of care completion. These parties are in the best position to understand the full gambit of care that the beneficiary is receiving and understand when that care to a close. Allowing the settling parties to sign an attestation would also prevent unnecessary delays that are likely to occur if a doctor's signature is required.

III) MARC COMMENTS ON THE ANPRM OPTIONS

MARC supports CMS' proposal to provide settling parties with flexibility in handling MSP claims that involve liability for a beneficiary's future medical expenses. Such flexibility will give the parties the ability to determine the best way to proceed in light of the unique facts and circumstances present in each individual claim. MARC offers the following specific comments regarding Options 1, 3, 4, 5 and 7 presented in the ANPRM, and refers CMS to comments from individual MARC members on all other proposed Options, which MARC will not address here.

a. Option 1

MARC understands Option 1 to be the current requirement of the statute for handling all medical expenses in MSP claims and thus does not provide a change from the current situation. Based on our experience, the MARC Coalition believes that it is unlikely that a Beneficiary would select Option One and agree to resolve a claim under this situation. Thus from a claims management perspective this Option is not likely to provide a workable avenue to resolving claims.

b. Option 3

MARC supports the approach presented in Option 3. As discussed above, we urge CMS to revise its approach to the "Date of Care Completion" to remove all requirements for a physician's signature. Instead, we urge CMS to implement Option 3 allowing the settling parties to sign the certification regarding the date on which care has concluded.

c. Option 4

MARC urges CMS to improve the current MSA system for workers compensation cases before proposing any new regulations.

d. Option 5

MARC respectfully requests that CMS clarify how the three agency policies announced within the last year connect with future medical expense issues. We understand that the existing $300 threshold, the fixed MSP payment option, and self-calculated conditional payment option only

address conditional payment recoveries. We are uncertain as to whether CMS intends for these existing options to satisfy any MSP liability for future medical expenses as currently structured, or if settling parties would be required to take additional steps to account for such expenses. We recommend that CMS revisit this issue and clarify for the stakeholder community how these conditional payment policies intersect with the resolution of future medical issues.

e. Option 7

MARC strongly supports the proposed Option 7 to allow beneficiaries to obtain compromises or waivers of recovery. We urge CMS to enhance its system of waivers to provide relief to beneficiaries who would be harmed by application of a MSP recovery. We also urge CMS to waive MSP recovery wherever the cost of collection on the claim would exceed the amount recovered. Such low-dollar value claims waste Medicare's resources and place an unnecessary burden on Medicare beneficiaries and settling entities. We urge CMS to continue to identify situations in which waiver of MSP recovery is justified.

IV) CMS SHOULD CLARIFY HOW SETTLING PARTIES WILL SELECT AND PROCEED UNDER A SELECTED OPTION AS WELL AS HOW VARIOUS OPTIONS WOULD BE ADMINISTERED

If CMS moves forward with the proposed Options, we urge the Agency to provide stakeholders with clarity regarding the process for settling parties to select an Option and implement it as part of any settlement. To this end, we urge CMS to consider and clarify for stakeholders: (1) whether the settling parties must inform CMS of the option chosen, and if so, when and in what form such notification must occur; (2) whether the beneficiary will be required to notify, and or gain agreement of, the party with whom he or she is settling or otherwise resolving a claim; (3) whether settling parties may alter the chosen course of action over time after initially selecting one Option; and (4) for those Options that involve CMS review, what the timeframe will be for such review and approval process.

MARC also urges CMS to clearly specify that the once a beneficiary has selected an Option, CMS will not pursue an RRE if the beneficiary fails to comply with all of the requirements of that Option. Based on our experience, it is not always possible for a settling entity to ensure that a beneficiary complies with all the steps necessary for full compliance with MSP. Settling entities can thus face situations where they have made every effort to protect Medicare's interest but the claim is not in full compliance with all CMS requirements due to a beneficiary's actions or inactions.

V) ADDITIONAL ITEMS THAT SHOULD BE ADDRESSED IN FUTURE RULEMAKING

The NGHP industry relies on certainty and finality in order to timely settle claims, which is critical to protecting beneficiaries and returning funds promptly to Medicare. Bright line rules are critical to securing settling entities the certainty that they need to administer claims and make settlements. The MSP process will work more efficiently if all parties have a clear understanding of what to expect from the process and the timeline for reaching resolution.

In addition, we note that many settlements, by definition, represent a compromise of a beneficiary's claim (and, by association, of Medicare's claims as well). CMS has taken the position that the MSP conditional payment component of a liability claim cannot be compromised by a beneficiary in an undifferentiated settlement, and that CMS is entitled to 100% reimbursement of its conditional payment irrespective of whether the beneficiary settles for pennies on the dollar or receives an entire recovery of the claim. 42 C.F.R. §§ 411.46 and .47 address allocation of such undifferentiated settlement amounts in workers compensation cases and allow entities settling those claims to also compromise Medicare's rights to full reimbursement of conditional payment amounts. We urge the Agency to adopt similar regulations in the remainder of NGHP (liability and no-fault) claims as well.

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MARC supports CMS' efforts to improve the MSP program. We appreciate the opportunity to provide these comments and would welcome the opportunity to discuss specific ways to enhance how future medical expenses are treated in MSP cases, as well as other program enhancements that would make the MSP system more efficient, effective, and streamlined so that it will return resources to the Medicare Trust Fund and protect Medicare beneficiaries without posing an unreasonable burden on affected stakeholders. Thank you for your consideration, and please feel free to contact David Farber at 202.457.6516 or dfarber@pattonboggs.com if you have any questions or would like additional information.

Respectfully Submitted,

The Medicare Advocacy Recovery Coalition (MARC)