June 6, 2014

The Allocation is the Thing:
Allocations on the Merits in Workers' Compensation Awards

On June 3, 2014, the Centers for Medicare and Medicaid Services ("CMS") released version 2.2 of its CMS WCMSA Reference Guide dated May 29, 2014 (the "Guide"). While the Guide contains multiple updates and revisions (primarily with respect to medical payment records), the most critical update lies in Section 4.1.4 (Hearing on the Merits of the Case). CMS has identified that where parties identify which proceeds of the workers' compensation ("WC") award represent non-medical damages as compared to medical damages, and that allocation is approved by a court or other adjudicator (e.g., a state WC board or commission) on the merits, then CMS will accept that allocation. Sophisticated and diligent parties can now use this as a means to further limit related exposure on the MSA issue ***while the traditional WCMSA report (which only calculates medical expenses) no longer represents best practices in the Medicare Secondary Payer ("MSP") compliance context.***

Introduction

On June 3, 2014, the Centers for Medicare and Medicaid Services ("CMS") released version 2.2 of its CMS WCMSA Reference Guide dated May 29, 2014 (the "Guide"). Since its first release in March 2013, the Guide has become the one source of the truth in the Workers' Compensation Medicare Set-Aside ("WCMSA") world. The Guide consolidates all previous guidance from CMS about WCMSAs in one place, and then updates the Guide periodically as CMS guidance changes. Version 2.2 represents the fourth published version of the Guide. Over the past fifteen months, the workers' compensation ("WC") community has learned that the Guide is the place to read not only what CMS expects from parties resolving WC claims involving Medicare interests but also what steps CMS directs parties to take to properly consider its interests in remaining a secondary payer post-settlement.

Garretson Resolution Group ("GRG") has always believed that when it comes to Medicare Set-Asides ("MSAs"), **settlement values drive MSA obligations, not vice versa**. Instead of what a claimant is anticipated to incur for future injury-related care, otherwise covered by Medicare, what really matters is how many dollars are available within the gross award to pay for those future medical expenses. For years, we have spoken about how parties could minimize MSA obligations if they were able to identify those proceeds payable for non-medical expenses versus those payable for medicals. Then, by funding the MSA for the amount earmarked for medicals, parties could adhere and comply fully with any MSA obligation imposed by the Medicare Secondary Payer ("MSP") provisions. In version 2.2 of the Guide, CMS validates that methodology.

Hearings on the Merits of the Case

In Section 4.1.4, CMS discusses Hearings on the Merits of the Case. There, it says:

> "When a state WC judge approves a WC settlement after a hearing on the merits, Medicare generally will accept the terms of the settlement, unless the settlement does not adequately address Medicare's interests. If Medicare's interests were not reasonably considered, Medicare will refuse to pay for

services related to the WC injury (and otherwise reimbursable by Medicare) until such expenses have exhausted the dollar amount of the entire WC settlement. Medicare also will assert a recovery claim if appropriate.

• **If a court or other adjudicator of the merits (e.g., a state WC board or commission) specifically designates funds to a portion of a settlement that is not related to medical services (e.g., lost wages), then Medicare will accept that designation.**" (emphasis added)

Section 4.1.4, specifically the bullet portion of the statement, represents a significant development for all parties attempting to resolve a WC claim while trying to minimize its exposure on the WCMSA issue. The allocation concept is not a new one, either for CMS, the judiciary or GRG. CMS' own policy manual has addressed the concept of judicial allocations on the merits for years, though that has been limited to the conditional payment context.[1] The MSP body of case law that has developed over the past 20 years has also recognized the value, when determining the scope of CMS' recovery rights, in identifying that portion of an award for non-medicals versus that portion for medicals.[2] As CMS has moved forward in recent years to provide greater clarity around how to address its future interest, including the allocation concept as part of the discussion only makes sense. For our part, GRG has been speaking about and applying allocation concepts to MSA issues for close to a decade.

The addition of Section 4.1.4 to the Guide may fundamentally change how parties resolve WC claims. Historically, when an employer or carrier received an MSA report from its trusted vendor containing an exceedingly high figure for the MSA, the parties were, most likely, stuck. Thinking that the entire amount of the MSA would need to be funded as part of any WC settlement and being advised that they must "consider and protect Medicare's interest", the parties would not close future medicals. Instead, they would close the indemnity portion of the WC claim and leave medicals open.

While that remains an option, CMS has now provided an availableand compliant alternative for those interested in closing medicals and keeping the file closed. Instead of the MSA figure driving the potential amount needed to complete a settlement, parties can now agree on a settlement figure, then calculate that portion of the award for medicals versus non-medicals. When such analysis is conducted pre-settlement, one can understand with clarity how a potential settlement value affects the MSA obligation which results.

It is important to note that the Guide does not address nor does Section 4.1.4 change any currently existing reporting obligations linked to MMSEA Section 111 mandatory insurer reporting.[3]

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[1] *See* CMS MSP Manual, Chapter 7, Section 50.4.4 (Designations in Settlements). There, CMS advises, "The only situation in which Medicare recognizes allocations ... 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 designate amounts that are for payment ... not related to medical services, Medicare will accept the Court's designation."

[2] *See*, for example, *Zinman v. Shalala*, 67 F.3d 841, 846 (9th Cir. 1995) and *Benson v. Sebelius*, 2011 U.S. Dist. LEXIS 30438 (Decided March 24, 2011) ("... if a settlement covers both medical and nonmedical costs, CMS's reimbursement may be apportioned so as to reach only the portion of the settlement allocated to cover medical costs.").

[3] Pursuant to Section 6.5.1, Chapter III of the MMSEA Section 111 User Guide: ""No medicals"—If medicals are claimed and/or released, the settlement, judgment, award, or other payment must be reported regardless of any allocation made by the parties or a determination by the court. • The CMS is not bound by any allocation made by the parties even where a court has approved such an allocation. The CMS does normally defer to an allocation made through a jury verdict or after a hearing on the merits. However, this issue is relevant to whether or not CMS has a recovery claim with respect to a particular settlement, judgment, award, or other payment and does not affect the RRE's obligation to report."

Conclusion

In the Guide, CMS has now provided the WC community critical guidance about WCMSAs. Sophisticated and diligent parties will be sure to incorporate the allocation concept into every WC situation that needs to be resolved. Based on this new CMS guidance, a simple MSA report is no longer sufficient as that has the potential to lead to parties overfunding a WCMSA (increasing parties' exposure on the issue in turn). Instead, to be compliant, any WCMSA guidance provided to parties attempting to resolve a WC claim should contain both an analysis of future cost of care needs going forward as well as an analysis of the non-medical component to the claim (using state specific WC statutes to identify factors such as disability rating, body part, number of weeks allowed and dollars per week).

GRG will continue to monitor this rapidly developing area closely and provide updates as warranted. In the meantime, please reach out to John Cattie, our MSA subject matter expert, with questions or concerns about this and other MSA issues by calling (704) 594-1778 or emailing him at jcattie@garretsongroup.com.

GARRETSON
RESOLUTION GROUP

August 14, 2012

Via Electronic Delivery ***http://www.regulations.gov***
Centers for Medicare & Medicaid Services
Department of Health & Human Services
Attention: CMS-6047-ANPRM
Mail Stop C4-26-05
7500 Security Blvd.
Baltimore, MD 21244-1850

Re: CMS-6047-ANPRM

Dear Sir or Madam:

Garretson Resolution Group ("GRG") greatly appreciates the opportunity to provide comments and feedback to the Advanced Notice of Proposed Rulemaking ("ANPRM") with respect to addressing the issue of future medical care in automobile and liability insurance (including self-insurance), no-fault insurance, and workers' compensation claims under the Medicare Secondary Payer ("MSP") Act. GRG has been operating in the MSP compliance space for over a decade, providing services that 1) protect a beneficiary's Medicare benefits, 2) ensure that the Medicare Trust Funds are reimbursed the appropriate amount in settlements and 3) confirm that the parties have satisfied MSP obligations and secure finality in the settlement. We sincerely hope our observations and comments are helpful as CMS drafts rules and regulations in this area (the "Proposed Regulations").

Before specifically addressing the ANPRM, this memo starts with the proposition that CMS's proposed rules must clearly articulate how the following three issues will work operationally: 1) When do future medicals need to be addressed under the MSP Act; 2) how much needs to be "set-aside" to satisfy that obligation; and 3) what should occur after determining that amount. More specifically, this memo provides our comments on how CMS can address those three issues in the Proposed Regulations. Thereafter, we will provide specific comments to the Proposed General Rule and Options contained within the ANPRM. While we generally agree with many of the ideas and theories advanced in the ANPRM in regards to the "When", we understand the need to "fill in the blanks" on the "How?" as well as the "What's Next?" based on our experience. Additionally, we also have included representative comments and suggestions from our plaintiff and defense attorney-clients on their behalf as Exhibit 1.

When do future medicals need to be addressed? Based on our experience in addressing these MSP obligations in thousands of matters for both plaintiffs and defendants, we note that two broad criteria should be met (based on CMS' rules currently established in the WC context)[1] when addressing the issue of future medical expenses in the liability settlement context. First, the individual/beneficiary should possess certain characteristics that, only if possessing all, would lead one to conclude that he or she is a candidate for an MSA. Such a threshold screening profile should include the following characteristics:

[1] Such as 42 C.F.R. §§411.46 and 411.47 as well as CMS Policy Memoranda.

1) the individual/beneficiary possesses the proper Medicare enrollment status (either currently enrolled in the Medicare program or a "reasonable expectation" of such enrollment within 30 months of settlement; and
2) the individual/beneficiary should need future Medicare covered injury-related care (to a reasonable degree of medical certainty).

This threshold screening must be able to be completed pursuant to clear, objective definitions and injury-classifications that allow every case to be quickly screened (without requiring CMS's further involvement or approval) to validate an individual/beneficiary's required action under the Proposed General Rule. Only after an individual/beneficiary is screened and determined to have the proper profile can it be said that Medicare would have any future medical interest that the individual/beneficiary needs to further assess[2]. If an individual/beneficiary does not meet the proper profile, then he or she should be able to "document the file", be able to rely on that determination, and note that the file would be utilized as the basis for any post-settlement audit.

Second, the individual/beneficiary must have received dollars in the settlement, judgment or award which could be said to be reasonably intended to compensate or be "allocated" for future medicals, no matter whether such an allocation is explicit (as a specific designation for future medicals in the settlement agreement) or implicit (that portion of an undifferentiated sum of money which is reasonably intended to compensate a claimant for future medical expenses as opposed to other damage components that have been pled and released). Allocating damages is consistent with stated CMS policy, whereby it recognizes a judicial allocation based on the merits of the case as a valid means of ensuring the beneficiary's non-medical damages are taken into account. CMS cannot treat a beneficiary who has received a verdict or judicial determination differently than one who has chosen to settle, especially given the courts' clear preference to settle claims as opposed to trying cases. There needs to be a settlement allocation solution that possesses the same indicia of reliability as if the parties proceeded to trial and received a verdict from the trier-of-fact. Any allocation must, by necessity, possess the same attributes as a judicial allocation, recognizing that the costs, delay, and uncertainty inherent in proceeding to trial, are the basis for settlement. These attributes equally impact CMS, where the Proposed Regulations do not take into account these settlement realities.

The concept of determining if the gross settlement proceeds contain an allocation to future medicals (sufficient to fund any MSA obligation) is based upon the previous rules CMS established in addressing future medical expenses in workers' compensation matters, in which CMS provides a default rule at 42 C.F.R. §411.46(d).[3] When providing the Proposed Regulations, CMS should do the same with regards to liability settlements. The basic rule for liability settlements should read as follows: "*Except as specified*

[2] See *Big R Towing v. Benoit*, Civ. Action No. 10-538, 2011 WL 43219 (W.D. La. Jan. 5, 2011) and *Finke v. Hunter's View, Ltd. and Wal-Mart Stores, Incorporated*, Civ. No. 07-4267 (WRW/RLE), 2009 WL 6326944 (D. Minn. Aug. 25, 2009). Determining the proper profile requires a case-specific analysis of such factors as an individual/beneficiary's Medicare enrollment status, determining if claims resolution results in future medicals being closed such that Medicare becomes the primary payer of future injury-related medicals going forward, as well as other relevant definitions).

[3] 42 C.F.R. §411.46(d). "(1) *Basic rule.* Except as specified in paragraph (d)(2) of this section, if a lump-sum compromise settlement forecloses the possibility of future payment of workers' compensation benefits, medical expenses incurred after the date of the settlement are payable under Medicare. (2) *Exception.* If the settlement agreement allocates certain amounts for specific future medical services, Medicare does not pay for those services until medical expenses related to the injury or disease equal the amount of the lump-sum settlement allocated to future medical expenses."

below, if a liability settlement forecloses the possibility of future payment of medical expenses by a primary plan or payer on behalf of an individual/beneficiary, medical expenses incurred after the date of settlement are payable under Medicare." In doing so, the starting point will be the same, no matter what type of claim is in question.

Further, in promulgating the Proposed Regulations, Medicare also should provide an exception to the basic rule stated above. Again, similar to the workers' compensation context, that exception should read as follows: *"If the settlement agreement allocates certain amounts for future medical expenses, Medicare does not pay for those services until medical expenses related to the injury or disease equal the amount of the future medical allocation contained within the settlement amount."* Again, the Proposed Regulations should, at the beginning, mirror the initial rules regarding future medical expenses in workers' compensation matters.

The Proposed Regulations should then divert when it comes to determining the future medical allocation figure due to the inherent differences between liability claims and workers' compensation or no-fault claims. Settlement of liability claims, unlike workers compensation and no-fault claims, are inherently a compromise of claims on the part of the parties. In both workers' compensation and no-fault, once responsibility is accepted, claims for medical expenses are paid in full at 100% value, which drives the value of settlement. Further, there is no recovery for non-economic based damages. The only damage components in a workers' compensation claim are indemnity/wage loss, past medicals and future medicals. CMS implicitly acknowledges this in another one of the regulations created to address future medical expenses in workers' compensation matters.[4] This rule allows parties to allocate damages into different buckets: indemnity/wage loss and medicals. If parties utilize this regulation, so long as they have reasonably assessed the indemnity/wage loss component to the workers' compensation gross award, they can rely on the fact that the balance would be allocated to medicals. Any workers' compensation MSA amount should then be capped by the total amount of that medical allocation.[5] If the gross award also contains an amount for past medical expenses, that amount for future medical expenses could be further reduced (by subtracting past medicals within the award from total medicals within the award). In short, based on the rules provided by CMS, any workers' compensation MSA amount **must** be capped by the gross award, and **should** be capped further based on the identification of any allocation for indemnity/wage loss within the gross award. The amount of this future medical allocation figure represents 100% value for all future medicals funded within the gross award and the maximum possible MSA figure.

Things are not so simple in the liability context,[6] where medical expenses are just one of many factors that drive the value of the case. Other factors include the likelihood of prevailing at trial, other economic and non-economic losses such as lost wages, lost earning capacity, pain and suffering, and/or loss of

[4] 42 C.F.R. §411.47(a)(1). "If a compromise settlement allocates a portion of the payment for medical expenses and also gives reasonable recognition to the income replacement element, that apportionment may be accepted as a basis for determining Medicare payments." Here, where the regulation addresses future medicals, identifying the past medicals and income replacement element (wage loss/indemnity) implictly recognizes the damage components of a workers' compensation settlement.

[5] *Benson v. Sebelius*, 2011 U.S. Dist. LEXIS 30438 (Decided March 24, 2011) ("...if a settlement covers both medical and nonmedical costs, CMS's reimbursement may be apportioned so as to reach only the portion of the settlement allocated to cover medical costs.")

[6] *Zinman v. Shalala*, 67 F.3d 841, 846 (9th Cir. 1995) (where the Court foresaw this inherent problem in liability settlements under the MSP Act).

consortium. Failure to provide a mechanism for allocation of future medicals that is consistent with the compromised nature of liability claims will most likely have a profound chilling effect on the settlement or resolution of such claims. These concerns are only amplified in the context of large-scale mass tort lump sum settlements involving hundreds or thousands of liability claims. For these reasons, CMS should carefully consider the significant differences between liability claims and workers' compensation or no-fault insurance claims before determining the Proposed Regulations.

While the task of determining "allocation" in liability settlements is difficult, precedent for doing so does exist. For the past 17 years, the federal judiciary has recognized the inherent problem facing stakeholders resolving liability claims.[7] Since then (and with increasing frequency over the past 3 years), parties nationwide sought judicial guidance on the issue of allocation of future medical expenses. In reviewing these issues, the courts looked to the then current statutory language of the MSP Act, as well as regulatory guidance, administrative guidance and relevant case law. In every case, the courts, in agreeing that an MSA should be funded, determined what portion of an undifferentiated gross settlement amount represented that portion allocated to future medicals. CMS should follow the judiciary's lead and provide a standardized future medical allocation methodology which takes equitable apportionment into account that parties nationwide can follow and adhere to when addressing future medicals in liability settlements.

How much needs to be set aside? In light of the foregoing, it is critical that CMS adopts a standardized and efficient allocation methodology (which takes into account confounding factors to an individual/beneficiary's full recovery of damages such as disputed liability, policy limits and statutory caps) that parties can follow in making this determination in liability matters. Without a standardized allocation methodology based on theories of equitable apportionment, a) the settling parties are likely to debate the issue of "what is the appropriate allocation" to a degree that will delay disbursements; and b) CMS Regional Offices would face tremendous gridlock due to the lack of efficiency in the allocation process.[8] Because GRG has addressed damage allocation issues in settlements since its inception, we recognize that while critical, this issue is not insurmountable when using the right tools.

Currently, GRG applies a thoroughly vetted future medical allocation methodology to the currently existing statutory, regulatory and administrative guidance from CMS as well as relevant case law when examining future medical expenses obligations under the MSP Act. Below are the inputs our methodology takes into consideration when calculating the future medical allocation figure on behalf of an individual/beneficiary. GRG recommends that CMS consider the following equitable apportionment

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[7] *Zinman* at 846.

[8] The Proposed Regulations CMS promulgates must encourage settlement of claims and lawsuits rather than discourage. There is a long-standing strong judicial policy in favor of settlements over trials (*McDermott, Inc. v. AmClyde*, 511 U.S. 202, 215 (1994)). To encourage settlement, the Proposed Regulations must not only be clear, but also must be self-actuating, predictable and allow for finality. Absent meeting every one of these certainties, individuals/beneficiaries needing future injury-related care may be at a significant disadvantage for the reason that lawyers will not agree to represent them because of the uncertainty and the cost of handling their claims. Further, Medicare beneficiaries will be discouraged from bringing claims, resulting in no return to the Medicare Trust Fund. Finally, defendants and insurers will not agree to settle because of the lack of finality they need to close their files and satisfy insurance and accounting requirements. To facilitate settlements and resolution of liability claims and to speed payment into the Medicare Trust Fund when resolving liability claims, CMS should provide standardized future medical allocation methodology as part of any Proposed Regulations it chooses to promulgate in this area. Such future medical allocation methodology should take into account the inherent nature of liability settlements and the fact such settlement amounts reflect the compromised or reduced value of these claims based on the parties' analysis of *both* quantitative and qualitative factors.

factors as part of any standardized future medical allocation methodology as part of any General Rule promulgated within the Proposed Regulations.

- Procurement cost offsets should be taken off the top. This deduction is already applied in the conditional payment context, and the currently existing regulation supports such an offset.[9] The ANPRM currently takes this into account in Proposed Option 6(b) (Upfront Payments). GRG agrees with this application.

- A deduction from that an amount which represents an individual/beneficiary's out of pocket expenses should be applied. The ANPRM currently takes this into account in Proposed Option 6(b) (Upfront Payments) as well as the regulations previously promulgated by CMS in the workers' compensation context (42 C.F.R. §411.47(b)(1)). GRG agrees with this application.

- Depending on the state of jurisdiction and whether such state has a statute which caps recovery for certain damages, any particular damage category subject to a state cap should be factored accordingly. The ANPRM currently does not take this into account, but GRG recommends that any Proposed Regulations should take this into account so that individuals/beneficiaries are not unjustly penalized due to the fact they happen to reside in a state that caps recovery for certain damages.

- Any standardized future medical allocation methodology must include some deduction for: 1) all other damage components pled/released such as loss of earning capacity and loss of household services; and 2) the impact of financial loss damage components, such as out of pocket expenses and other expenses which a beneficiary carries post-settlement not otherwise covered by insurance coverage relating to the settlement. The ANPRM currently does not take this into account. However, the regulations previously promulgated by CMS in the workers' compensation context (42 C.F.R. §411.47(a)(1)). GRG recommends that any Proposed Regulations should take this into account so that individuals/beneficiaries are not unjustly penalized.

- A ratio percentage that takes into account the gross settlement amount when compared to total damages asserted can be used to determine an allocation to medicals (both past and future) of the net proceeds remaining. The ANPRM currently does not take this into account. However, the regulations previously promulgated by CMS in the workers' compensation context (42 C.F.R. §411.47(a)(2)(i)). GRG recommends that any Proposed Regulations should take this into account so that individuals/beneficiaries are not unjustly penalized.

- A deduction for the amount of past medical expenses billed should be applied. The ANPRM currently takes this into account in Proposed Option 6(b) (Upfront Payments) to the extent that it allows for Medicare's final demand amount to be deducted. GRG agrees with this application, but recommends that any Proposed Regulations should also allow for an offset for other past medical expenses billed. Such application would be consistent with regulations previously promulgated by CMS in the workers' compensation context (42 C.F.R. §§411.47(b)(2) and 411.47(b)(3)). Absent such an application, an individual/beneficiary would be unjustly penalized in the future medical allocation calculation.

[9] 42 C.F.R. §411.37(c). See also *Hinsinger v. Showboat Atlantic City*, 18 A.3d 229 (N.J. Super. Ct. Law Div. 2011).

- Once past medical expenses are deducted, any amounts remaining should represent the future medical allocation figure, assuming the remaining amount is greater than or equal to a beneficiary's actual future Medicare covered injury related care. The ANPRM currently takes this into account in Proposed Option 6(b) (Upfront Payments) to the extent that it provides for a calculation of 'beneficiary proceeds'. However, the ANPRM does not then advise specifically that the "beneficiary proceeds" would not be the final amount owed to Medicare if the individual/beneficiary's future cost of care needs is less than the "beneficiary proceeds" figure. GRG recommends that any future medical allocation methodology promulgated within the Proposed Regulations contains such a statement to clearly advise what the proper amount owed to CMS would be in the event the "beneficiary proceeds" figure exceeds the individual/beneficiary's actual future Medicare covered injury related care needs.

Please let us know if you would like additional information about our standard future medical allocation methodology as you draft the Proposed Regulations.

In some way, shape or form, the allocation/apportionment issue must be addressed in the Proposed Regulations to provide stakeholders with uniformity and finality on the issue of future medicals. We recommend that CMS adopt standardized future medical allocation methodology as part of the Proposed Regulations based on equitable apportionment, and have it incorporated into the General Rule.

What should occur after determining the set-aside amount? While the precedent and methodology above lays out a consistent, general approach, it is important that the Proposed Regulations go one important step further: The allocation methodology must be self-actuating, predictable and allow for finality.

For instance, to make the future medicals compliance process self-actuating (*i.e.* to have finality without requiring CMS's review and approval of the application of the allocation methodology), CMS could "certify" certain logic to determine future medical allocations on a third-party neutral basis. Allowing individuals/beneficiaries access to logic "certified" by CMS in the area of future medical allocation would ensure compliance but bridge the resource constraints currently experienced by CMS. Individuals/beneficiaries should have an objective, scalable process at their fingertips that allows them to calculate a future medical allocation amount and have assurance from CMS that such allocation complies with the MSP Provisions. Such an objective, scalable process must be flexible enough to take into account the specific facts of a case, but contain the formulaic logic (based on objective measures as well as Proposed Regulations as implemented by CMS).

While the allocation of future costs of care will not be necessary in every case, the Proposed Regulations should provide clear guidance on how to address the obligation once a determination is made. When a future medical allocation does exist (based on case-specific facts) a liability MSA would be one of a number of options as recognized in the ANPRM. Regardless of the options chosen, all options must satisfy the common goal of covering a defined value of future injury-related care with a source other than Medicare. Following such payments, the beneficiary could once again use his / her Medicare card for injury-related care. While discussed in detail below, some of those clear options could be as follows: 1) self-administer the liability MSA; 2) engage a custodial administrator to administer the MSA on their behalf; 3) utilize a "quick pay" option and continue to use their Medicare card; 4) prepay the MSA amount to CMS and continue to use their Medicare card; 5) utilize a primary payer option; and 6) utilize a qualified settlement fund to develop a "health savings account" or other restricted payment vehicle to be used only for injury-related care and disbursed to the beneficiary only upon proof that such injury-related care has been paid for by another provider. GRG strongly recommends that any of the above options must provide a mechanism to submit the amount of the defined value, the primary payer source, and

provide a date of completion such that Medicare resumes a primary payer status. This functionality is necessary to 1) in the event of a billing error, ensure that CMS can re-direct injury-related care expenses to the primary payer source; and 2) avoid any disruption of Medicare benefits to the beneficiary once the defined future costs of care amount has been exhausted.

Below we provide specific comments and feedback about the proposed rules in CMS' ANPRM. We also provide our thoughts and input regarding the critical concepts that we believe should be adhered to when crafting rules in this area.

CMS Proposed General Rule.

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

GRG Comments

- In our experience, any rule that uses the word 'satisfy' without identifying a means of satisfaction, including how to secure a CMS proof of satisfaction, will result in frozen disbursements as the party paying personal injury claims may demand that plaintiffs obtain a CMS "proof of satisfaction" as a condition to paying the settlement proceeds. We strongly recommend changing the term 'satisfy' to 'consider' Medicare's interest. This is consistent with the proposed options below, noting that only one of the seven proposed options includes obtaining CMS approval (Option 4). As a dedicated MSP compliance provider in this area, we welcome the development of a more formalized approach for addressing these issues to ensure greater compliance with the MSP Act (42 U.S.C. § 1395y(b)(2)). If CMS plans on pursing consideration of future costs of care in liability settlements, the enactment of a general rule is necessary to provide settling parties with greater certainty and comfort when resolving claims, but also will allow individuals/beneficiaries to make more informed decisions at the time of settlement. To clarify the standard by which the Proposed General Rule is to be implemented in the form of Proposed Regulations, we suggest providing an example of the circumstances under which the beneficiary should have reasonably anticipated receiving future medicals. We are concerned that, absent an example, the phrase 'should have reasonably anticipated' is too subjective and will cause confusion absent objective clarity. A sample statement follows:

  > "An individual/beneficiary 'should have reasonably anticipated receiving Medicare covered and otherwise reimbursable items and services after the date of settlement' if 1) he/she does not possess an attestation regarding the Date of Care Completion from his/her treating physician as of the date of settlement; and 2) future medical expenses were a damage component pled and released when resolving the individual/beneficiary's liability claim using any one of the following options…"

- We would further suggest adding to the Proposed General Rule a clear statement as to who is liable to CMS should future medicals not be addressed in resolving the claim as well as what the consequences for non-compliance would be. A sample statement follows:

"If an individual/beneficiary fails to satisfy Medicare's interest with respect to 'future medicals' related to his or her 'settlement' by using one of the following options, then Medicare shall have a priority right of recovery against that beneficiary. Medicare may also refuse to pay for medical expenses related to the liability injury until the entire 'settlement' is exhausted."

- Adding such a statement not only clearly states who is liable to CMS on the issue of future medicals but it also provides the exact same standard as currently exists in the workers' compensation context (though that is widely misunderstood). Including a clear statement regarding which parties are responsible to ensure future medicals are addressed, to what extent each side must address the issue and what the consequences are for failure to address the issue is critical so that the settlement community can properly address the future medicals issue without creating settlement inefficiencies.

- Adding such a statement also provides clear guidance for 'settling' parties by clearly delineating which parties are liable for failure to reimburse CMS for any conditional payments made (parties that made/received payments) versus those liable to CMS if future medicals are not properly addressed (parties that received payments, which can reasonably be expected to pay for future medicals). Such clear guidance would lead to greater settlement efficiencies and would be understandable, as there would be finality to the question of who is responsible for ensuring Medicare remains a secondary payer post-settlement. Without such finality, claims will remain unresolved for longer periods and reimbursement obligations under the MSP Act will remain unaddressed during those periods.

- In the event that CMS declines the opportunity to provide ultimate clarity with regard to who is liable to CMS should future medicals not be addressed, we highly recommend that CMS clearly define the responsibilities and liabilities of each stakeholder (individual/beneficiary, plaintiff attorney and defendant/defense attorney/insurance carrier).

- Further, we recommend the proposed general rule more clearly establish a link between the MSP Act and Medicare's right to remain the secondary payer post-settlement. We recommend a preamble be added to the Proposed General Rule that clearly establishes the link. A sample preamble could be as follows:

> "Section 1862(b)(2)(A)(ii) of the Social Security Act [42 U.S.C. §1395 y(b)(2)], precludes Medicare payment for services to the extent that payment has been made or can reasonably be expected to be made promptly under liability insurance. 42 C.F.R. §411.50 defines the term "liability insurance." Whenever a settlement, judgment or award provides funds for future medical services, it can reasonably be expected that the amount of funds for future medical services are available to pay for future services related to the injuries claimed and/or released in the settlement, judgment, or award. Thus, Medicare should not be billed for future medical services until those funds for future medical services allocated within the settlement, judgment or award are exhausted by payments to providers for services that would otherwise be covered and reimbursable by Medicare. If the settlement, judgment or award does not provide payment for future medical services, there is no reasonable expectation that third party funds are available to pay for those services."

- This preamble is needed because currently, the MSP Act only provides the United States with an action to recovery payments MADE by Medicare. 42 U.S.C. §1395y(b)(2)(B)(iii). One of the

primary difficulties with settling parties addressing future cost of care issues is the inability to point to any clear language in the MSP Act that establishes 1) the requirement to address future medicals and 2) identifies who is liable on the issue of future medicals.

- Further, we recommend that CMS provide standardized future medical allocation methodology as part of the Proposed General Rule as set forth above.

- That standardized future medical allocation methodology should take into account the inherent differences between WC and liability settlements. The composition of a liability settlement is much more complex than a WC settlement. A WC settlement contains a finite number of potential recovery buckets: 1) indemnity; 2) past medical expenses; and 3) future medical expenses. On the other hand, a liability settlement contains many more potential recovery buckets when both economic damages (*i.e.*, past medical expenses, future medical expenses, loss of earning capacity, loss of household services, etc.) and non-economic damages (*i.e.*, pain & suffering, mental anguish, loss of independence, loss of society, etc.) are considered. Typically, these settlements also differ in the fact that settlement proceeds are often allocated specifically in a WC settlement while settlement proceeds are not often allocated specifically in a liability settlement.

- CMS should be mindful of the future medical allocation rules it has previously provided in the WC context, and use those as its launching point. In the WC context, CMS has advised that its basic rule is that Medicare will pay for future injury-related care unless there is an allocation present for future medical expenses.[10] If such an allocation exists, then the beneficiary must spend down and exhaust the amount of that allocation prior to submitting bills to Medicare.[11] Additionally, in the WC rules, CMS acknowledges that parties can allocate damages based on medicals versus indemnity/wage loss.[12] Further, so long as the parties have reasonably assessed the indemnity/wage loss component in a WC award, they can rely on the fact that the balance would be allocated to medicals.[13] Therefore, in the WC context, parties can cap the amount of proceeds payable into an MSA to the amount of an award which is allocated to medicals as opposed to indemnity/wage loss. The same should be permitted in the liability context under the Proposed Regulations.

Proposed Definitions.

"Chronic Illness/Condition: means that the illness/condition persists over a long period of time. The term is generally applied when the course of a disease or condition lasts for more than 3 months. If the individual/beneficiary alleges an injury that is chronic illness/condition, it is presumed that future medical care will be required. Examples of chronic diseases include, but are not limited to: Chronic airflow limitation, including

[10] 42 C.F.R. §411.46(d)(1).

[11] 42 C.F.R. §411.46(d)(2).

[12] 42 C.F.R. §411.47(a)(1).

[13] *Id.*

asthma and chronic bronchitis; cancer; diabetes; quadriplegia; and nephrogenic systemic fibrosis."

- This definition may appear appropriately defined at first because it is based on the standard American Medical Association ("AMA") definition. However, using the strict AMA definition in the MSP context is not understandable or workable, and will not result in settlement efficiencies based on defining the chronic illness or condition purely on a term certain without further explanation.

- For example, an acute injury, such as a femur fracture, may take 8-12 months for the bone remodeling to occur. Based on the AMA definition of 'chronic illness/condition', such an injury would be classified as a chronic illness or condition. The natural healing process should not count against a Medicare beneficiary in establishing the severity of the injury for purposes of determining how to address Medicare's future interest under the MSP Act.

- Also, it may be noted that co-morbidities such as diabetes, depression and obesity may impact healing time beyond the acute period (initial 3 months) protracting recovery well into the chronic phase, but the fracture still should be considered an acute injury rather than a chronic illness/condition.

- Under another scenario, a simple lumbar strain is an acute injury, but it could aggravate (permanently worsen) a pre-existing degenerative lumbar condition resulting in a chronic illness such as chronic pain syndrome requiring life-long treatment or surgery.

- Quadriplegia is noted as a chronic condition. Although the injury results in a chronic (long-term) condition, we believe this should be considered a catastrophic/major trauma secondary to its devastating complications, loss of independence and limitations this condition imposes.

- Simply put, a 3 month term certain will improperly expand acute injuries, treating them as chronic illnesses or conditions, and which would not take into account the body's natural healing process. To account for this discrepancy, we recommend that this definition be that of a physical/mental impairment that is expected to last more than 12 months. This 12 month standard follows a current definition of disability under Section 1862(c)(A)(3) of the Act.

"Date of Care Completion: means the date the individual/beneficiary completed treatment related to his or her 'settlement.' The individual/beneficiary's treating physician must be able to attest that the individual/beneficiary has completed treatment and that no further medical care related to the 'settlement' will be required."

- The concept behind this definition is appropriate because it sets a standard which is both readily understood and applied.

- We recommend, however, that CMS adopt a more precise standard regarding the treating physician's attestation. For example, a treating physician who attests that, in his/her opinion, taking all facts and circumstances about the individual/beneficiary's condition into account, it is more likely than not that the individual/beneficiary has completed treatment and no more

additional care related to his/her 'settlement' will be required takes into account the objective realities of what physicians would be comfortable attestting to in the settlement context.[14]

"Future Medical Care ('future medicals'): means Medicare covered and otherwise reimbursable items and services that the individual/beneficiary received after the Date of 'Settlement'. This definition specifically applies to items and services related to the individual/beneficiary's settlement, judgment, award or other payment."

- Generally, this definition is appropriate because it sets a standard which is both readily understood and applied based on industry practices (that Medicare would not otherwise have to pay but for the alleged injury, incident or event). However, this definition omits the treatment of future prescription drug coverage.

- Based on industry practice and the current debate about the meaning of future medicals, we recommend CMS clarify its position with regards to prescription medications. In our experience, many individuals/beneficiaries confuse the components of future injury-related care treatment with respect to prescription medications and other similar services/expenses. Absent such clarity, settling parties will continue to look to the Workers' Compensation Policy memoranda for guidance. This is an extremely relevant issue given the fact that such current guidance includes prescription drug coverage in the components of future medical care despite the fact that a Prescription Drug plan, but not CMS, has made those payments.

- Also, this term is likely to be confused with Maximum Medical Improvement ("MMI"), and as a result, CMS should lend clarity. Again, providing examples will lend such clarity. An individual/beneficiary could be at MMI but require future medical care inclusive of prescription medications or palliative care measures. MMI is defined as a medical condition that is static and well stabilized. It also refers to a status where patients are as good as they are going to be from the medical and surgical treatment available to them. It can also be conceptualized as a date from which further recovery or deterioration is not anticipated, although over time (beyond 12 months) there may be some expected changes. MMI is not predicated on the elimination of symptoms and/or subjective complaints.

"Physical Trauma: refers to an injury (as a wound) to living tissue caused by an extrinsic agent. This also includes blunt trauma, which refers to injury caused by a blunt object or collision with a blunt surface (as in a vehicle accident or fall from a building)."

- Generally, this definition is appropriate because it is easily understandable and reflects current industry practices.

- However, this term should have different nomenclature in order to better align with other definitions.

- Possibly renamed as "Acute Trauma" as CMS listed in proposed definition of "chronic illness/condition."

[14] Based on generally accepted civil standard of preponderance of the evidence.

"Major Trauma: major trauma means serious injury to two or more Injury Severity Score ("ISS") body regions or an ISS greater than 15. The ISS body regions include the following: Head or neck; Face; Chest; Abdomen; Extremities; and External."

- This definition is usable, but not as helpful as establishing a presumptive rule concerning the requirement of future medical care in a 'settlement' as the Abbreviated Injury Scale ("AIS"), which is more specific.

- Use of AIS (instead of ISS) creates more certainty and a more usable set of medical standards to implement.

    - AIS utilizes 6 severity types of injury: Minor; Moderate; Serious; Severe; Critical; and Maximal (currently untreatable).
    - AIS also uses 9 body regions (head, face, neck, thorax, abdomen, spine, upper extremity, lower extremity, and external/other.
    - By contrast, ISS utilizes 6 body regions (head or neck, face, chest, abdomen, extremities and external), and no types of severities of injury.
    - Further, now is the time to provide more specific identification and localization of injuries in establishing a workable standard, especially in lieu of ICD-10 codes, expected to be implemented in October 2014.

- Finally, a name change to the term "Catastrophic Trauma/Injury" will be more consistent with industry practice, based on our experience.

    - This is associated with life altering functional deficits and loss of independence.

Proposed Options.

Option 1 – **"The individual/beneficiary pays for all related future medical care until his/her settlement is exhausted and documents it accordingly."**

- Proposed Option 1 is overbroad and represents an unworkable solution in its current form.
- First, having the individual/beneficiary pay for all related future medical care until his/her entire settlement is exhausted and documents it accordingly, in and of itself, appears to conflict with CMS' current recovery rules, and at least one court's opinion on its application thereof with respect to liability Medicare Set-Asides.[15]
- However, with slight changes to the language, this option becomes more functional. We recommend Option 1 read as follows "*The individual/beneficiary does not bill or authorize his/her medical provider to bill Medicare for any related future medical care until the portion of his/her settlement allocated to future medicals services (in accordance with standardized policy suggested and adopted by CMS as set forth above) or expenses is exhausted, and is documented accordingly.*"
- A refined statement such as this offers a more precise and exacting standard since it ensures CMS does not receive bills for future medicals services, but only with regard to that portion of an individual/beneficiary's gross recovery allocated for future medicals (see allocation discussion and methodology on page 4 and 5 above).

[15] 42 C.F.R. §411.37. See also *Hinsinger v. Showboat Atlantic City*, 18 A.3d 229 (N.J. Super. Ct. Law Div. 2011).

- These changes will clarify that individuals/beneficiaries that can utilize other benefits, programs or means of coverage to pay for related future medical care are not required to further act in addressing Medicare's future interests.
- Further, Proposed Option 1 should clarify the form of documentation and the length of time by which documents should be retained.
    - For example, we recommend an affidavit be executed by the individual/beneficiary, which attests that he or she will not submit or authorize his/her medical providers to submit bills to Medicare for future injury-related care until that portion of the settlement proceeds appropriately allocated to future medicals (as defined above) have been exhausted and the individual/beneficiary will retain copies of documents of such for a period of 6 years after the date of settlement/judgment/award.[16] By so doing, this will create the necessary clarity to create the uniform implementation of Proposed Option 1.

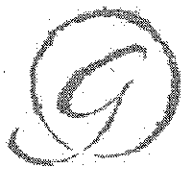
- Further, these changes fully embrace the meaning and spirit of the MSP Act, whose intent is to ensure the Medicare Trust Funds remain the secondary payer post-settlement.

Option 2(a) - **"Medicare would not pursue 'future medicals' if the individual/beneficiary's case fits all of the conditions under either of the following headings:**

> **The amount of liability insurance (including self-insurance) 'settlement' is a defined amount or less and the following criteria are met:**
>
> - **The accident, incident, illness or injury occurred one year or more before the date of 'settlement';**
> - **The underlying claim did not involve a chronic illness/condition or major trauma;**
> - **The beneficiary does not receive additional 'settlements'; and**
> - **There is no corresponding workers' compensation or no-fault insurance claim."**

- Both Proposed Options 2(a) and 2(b) would establish a safe harbor which creates a uniform application, as well as settlement efficiencies. We recommend that CMS adopt its current workload review thresholds in WCMSA situations and apply actual safe harbors to the LMSA context.
- This Proposed Option 2(a) represents a "safe harbor" for those individuals/beneficiaries who qualify. In short, if the gross settlement for a claim involving soft tissue or acute injuries is less than 'x' and sufficient time has passed since the date of injury and the individual/beneficiary has no other related claims pending and there is no workers' comp or no-fault component, then no MSA would be needed.
- GRG supports a safe harbor option such as that posed here, and would recommend that the defined amount should range between $25,000 and $250,000 because such a range is consistent with the workload review thresholds provided in workers' compensation for the individual or beneficiary.

[16] 28 U.S.C. §2415. "...every action for money damages brought by the United States or an officer or agency thereof which is founded upon any contract express or implied in law or fact, shall be barred unless the complaint is filed within six years after the right of action accrues ..."



- Providing such a range as the defined amount would address the vast majority of policy limit matters where the severity of injury is not either a chronic illness/condition or a major trauma.
- Consistent with industry practice, establishing the safe harbor amount between $25,000 to $250,000 will avoid the timely and burdensome analysis of the need to address future medicals, where no future medical allocation likely exists in the first place. In our experience, a significant number of settlements have been delayed based on the parties' concern of creating an MSA where insufficient funds existed in the first place.

Option 2(b) - **"Medicare would not pursue 'future medicals' if the individual/beneficiary's case fits all of the conditions under either of the following headings:**

The amount of the liability insurance (including self-insurance) 'settlement' is a defined amount or less and all of the following criteria are met:

- **The individual is not a beneficiary as of the date of 'settlement';**
- **The individual does not expect to become a beneficiary within 30 months of the date of 'settlement';**
- **The underlying claim did not involve a chronic illness/condition or major trauma;**
- **The beneficiary does not receive additional 'settlements'; and**
- **There is no corresponding workers' compensation or no-fault insurance claim."**

- This Proposed Option 2(b) also represents a "safe harbor" provision, but one extended only to those individuals who are not current Medicare beneficiaries and do not expect to become a beneficiary within 30 months of the settlement. This represents a safe harbor based on an individual lacking the proper Medicare enrollment status to warrant an MSA.
- A safe harbor provision for those individuals who lack the proper Medicare enrollment status (either currently enrolled or "reasonable expectation" of enrollment within 30 months of settlement) would create settlement efficiencies. However, we recommend CMS clarify the phrase 'expect to become a Medicare beneficiary within 30 months of the date of settlement'.
- In conjunction with this Proposed Option 2(b), we recommend CMS apply the standard of "reasonable expectation" as is currently in use in workers' compensation context when determining workload review thresholds.
- We recommend that, consistent with addressing future medicals in WC context where individual is not yet Medicare enrolled at the time of settlement, that CMS adopt a $250,000 gross settlement safe harbor, following CMS Policy Memoranda and the rationale that if an individual is not yet Medicare enrolled and would not become one within 30 months of date of settlement, that $250,000 would be exhausted before Medicare is expected to pay any future medicals.
- Establishing these clear criteria will expedite the settlement process; provided, however, each of these steps are properly documented as part of a settlement process.
- GRG would also recommend that this safe harbor based strictly on enrollment status should be extended for all liability settlements and not limited to a defined settlement amount. If an individual is not a current Medicare beneficiary at the time of 'settlement' and does not possess a "reasonable expectation" of Medicare enrollment within 30 months of settlement, that individual should not need to take further steps to protect Medicare's future interest other than evidencing that he/she lacks the proper enrollment status.

Option 3(a) - **"The individual/beneficiary acquires/provides an attestation regarding the Date of Care Completion from his/her treating physician.**

> **Before Settlement – When the individual/beneficiary obtains a physician attestation regarding the Date of Care Completion from his or her treating physician, and the Date of Care Completion is before the 'settlement', Medicare's recovery claim would be limited to conditional payments it made for Medicare covered and otherwise reimbursable items and services provided from the Date of Incident through and including the Date of Care Completion. As a result, Medicare's interest with respect to 'future medicals' would be satisfied. The physician must attest to the Date of Care Completion and attest that the individual/beneficiary would not require additional care related to his/her 'settlement.'"**

- Proposed Option 3(a) presents a workable solution by providing clear protocols attesting to the lack of future medicals creates both settlement efficiencies and reflects current industry practices; provided however, CMS also adopts the Date of Care Completion definitional changes recommended above.
- In conjunction with the standard of physician attestation standard of 'more likely than not' identified in the Date of Care Completion above, we recommend that CMS also ask that the individual/beneficiary attest that he/she will not seek future injury-related care once being provided with a treating physician attestation.
- To compliment the physician attestation that no further treatment is required, GRG recommends that where a physician attests to the clinically-recommended ongoing care (type of care and frequency), and supports the attestation with a document that defines the cost of such care (covered by Medicare and at Medicare rates), a quick pay option should exist. Where the attestation and supporting rate documentation support the result that projected care will not exceed $5,000, a quick pay option consistent with that value should be accepted by CMS.
- This concept provides an option to quickly establish and satisfy the future medical obligation as an alternative to generating a result, setting aside funds and then administering.

Option 3(b) – **"The individual/beneficiary acquires/provides an attestation regarding the Date of Care Completion from his/her treating physician.**

> **After Settlement – When the individual/beneficiary obtains a physician attestation from his or her treating physician after settlement regarding the Date of Care Completion, Medicare would pursue recovery for related conditional payments it made from the date of incident through and including the date of 'settlement.' Further, Medicare's interest with respect to future medical care would be limited to Medicare covered and otherwise reimbursable items and/or services provided from the date of 'settlement' through and including the Date of Care Completion. The physician must attest to the Date of Care Completion and attest that the individual/beneficiary would not require additional care related to his/her 'settlement.'"**

- Proposed Option 3(b) presents a workable solution, however, GRG again stresses the importance of defining liability with respect to the addressing future medical care in personal injury settlements as it relates to the beneficiary and other settling parties as recommended above on page 7.
- Without adopting a clear standard for who is liable for future medicals, we see parties not settling cases and instead, waiting until they are able to receive an attestation letter from the treating physician.

Option 4 - **"The individual/beneficiary submits proposed Medicare Set Aside Arrangement (MSA) amounts for CMS' review and obtains approval."**

- The use and application of work load review thresholds in the workers' compensation context to obtain approval has been inefficient and misunderstood. Instead, we strongly recommend CMS consider either adding necessary resources to accommodate any request for approval and satisfaction, or state that CMS does not review any liability Medicare set-asides as the process is self-actuating. GRG recommends the latter, noting that beneficiaries and those that produce the product (plaintiffs' counsel or MSP compliance entities) are already bound by the integrity of their work product.
- GRG agrees that absent a self-actuating only solution, CMS should include some ability for the individual/beneficiary to submit a proposed MSA to CMS for review and approval. At the end of the day, it is the individual/beneficiary's Medicare card at risk if this issue is not appropriately addressed and allowing the individual/beneficiary certainty with regards to the final figure is the desired result.
- Having said that, if CMS fails to provide standard future medical allocation methodology and such allocation is not self-actuating (see discussion above), CMS would need to have the resources in place in order to provide a timely review of the MSA proposal for audit purposes. Utilizing a tool such as a web portal, which CMS has instituted in the WC context, would be a very good start.
- However, CMS has not provided the standardized future medical allocation methodology an individual/beneficiary should utilize in calculating the amount of the liability MSA proposal. As we recommended above, CMS should provide a standardized future medical allocation methodology as part of any general rule which is promulgated. Our suggestions as to what factors such methodology should take into consideration are provided above on page 5.

Option 5 - **"The beneficiary participates in one of Medicare's recovery options. Recently, we [CMS] implemented three options with respect to resolving Medicare's recovery claim in more streamlined and efficient manners. Before we [CMS] issue a demand letter, the beneficiary or his/her representative may participate in one of three recovery options, which allow the beneficiary to obtain Medicare's final conditional payment amount before settlement. The three recovery options are as follows:**

> **$300 Threshold – If a beneficiary alleges a physical trauma-based injury, obtains a liability insurance (including self-insurance) 'settlement' of $300 or less, and does not receive or expect to receive additional 'settlements' related to the incident, Medicare will not pursue recovery against that particular 'settlement.'**
>
> **Fixed Payment Option – When a beneficiary alleges a physical trauma-based injury, obtains a liability insurance (including self-**

insurance) 'settlement' of $5,000 or less, and does not receive or expect to receive additional 'settlements' related to the incident, the beneficiary may elect to resolve Medicare's recovery claim by paying 25 percent of the gross 'settlement' amount.

Self-Calculated Conditional Payment Option – When a beneficiary alleges a physical trauma-based injury that occurred at least 6 months prior to electing the option, anticipates obtaining a liability insurance (including self-insurance) 'settlement' of $25,000 or less, demonstrates that care has been completed, and has not received nor expects to receive additional 'settlements' related to the incident, the beneficiary may self-calculate Medicare's recovery claim. Medicare would review the beneficiary's self-calculated amount and provide confirmation of Medicare's final conditional payment amount.

Each of the options is employed in such a way that Medicare's interest with respect to future medicals is, in effect, satisfied for the specified 'settlement.' Therefore, when a beneficiary participates in any one of these recovery options, the beneficiary has also met his/her obligation with respect to future medicals. We [CMS] solicit comment on proposed expansions of these options and the justification for that proposed expansion, as well as any suggestions about how to improve the three options we recently implemented."

- GRG agrees that when the three options above also satisfy the future medical component, that will drive settlement efficiencies.
- Notwithstanding the foregoing, we are not aware of many settlement situations where the above options are being utilized currently. In essence, Proposed Option 5 would serve as an additional "safe harbor" for lower dollar settlements, but thresholds should be raised from current amounts to have greater effect and allow greater participation, which would relieve stress on the MSPRC. Over time, as more data is collected, thresholds could be raised to bring more recoveries into the fold. We recommend raising the $300 threshold to $500 and raising the fixed payment threshold to $10,000.
- GRG notes that if the Self Calculation option is selected, the beneficiary will have a treating physician letter, so this is duplicative measure as compared to Proposed Option 3.

Option 6(a) - **"The beneficiary makes an upfront payment. If ongoing responsibility for medicals was imposed, demonstrated or accepted from the date of 'settlement' through the life of the beneficiary or life of the injury, we [CMS] may review and approve a proposed amount to be paid as an upfront lump sum payment for the full amount of the calculated cost for all related future medical care. This option would generally apply in workers' compensation, no-fault insurance situations or when life-time medicals are imposed by law. In effect, this option may be used in place of administering a MSA if we [CMS] have reviewed and approved a proposed MSA amount. We [CMS] solicit comment on how to develop this process, the efficacy of it, and whether it would be utilized."**

- GRG fully endorses an option providing for an upfront payment to satisfy any obligation for future medicals if ongoing responsibility for medicals was imposed, demonstrated or accepted, which we believe would be utilized with certain changes noted below.
- We recommend that using present value of full calculated future costs of care would be more accepted by the settlement community as opposed to full costs, as the use of present value calculations has precedent in other areas (such as income taxation), and is a readily accepted method to account for future events in present day terms.[17]
- We recommend that CMS clarify the term 'life of the beneficiary' in terms of how that figure (in terms of years) would be used to calculate the upfront payment amount. In doing so, we recommend CMS look to the CDC Table 1 as the tool used to conduct such a calculation.
- For both Proposed Options 6(a) and 6(b), we recommend specific examples be provided for each.
- Proposed Option 6(a) states that this would generally apply in workers' compensation cases. Would this then modify the currently existing rules regarding future medicals in workers' compensation cases as set forth in 42 C.F.R. §§411.46 and 47? If so, should there be any integration with those regulations?
- We recommend that CMS clarify the term 'life of the injury'. We recommend that CMS provide the standard upon which this will be determined (AMA, PDR, etc.). Also, we recommend that the standard applied be consistent with that imposed in other parts of the rules.
- We further recommend that CMS establish a refund procedure for instances when the beneficiary passes away without having exhausted those funds sent to CMS in the form of the upfront payment. If a beneficiary chooses this option, and CMS' intent is to not repay the balance remaining, CMS should expressly indicate this result as part of this option 6(a). One option includes providing a reversionary interest rule for higher dollar value future medical care allocations. In the absence of a reversionary interest (as part of this prepayment option), beneficiaries with those higher dollar value allocations would most likely choose an administrative solution that would protect their ability to recover the funds in the event of premature death.
- We recognize that the concept of 'ongoing responsibility for medicals' ("ORM") is a concept which originated and applies in the MMSEA Section 111 context, but not MSP context. We recommend that CMS clarify whether ORM in this context is intended to be the same as is currently applied in the MMSEA Section 111 context.
- We recognize that an upfront payment could be made for all situations based on Proposed Option 6(a) as currently proposed. However, that condition (where ongoing responsibility for medicals has been imposed, demonstrated or accepted) has not yet been defined. We recommend adding examples for ongoing responsibility imposed, demonstrated or accepted to clarify when this condition is met.

Option 6(b) – **"The beneficiary makes an upfront payment (If ongoing responsibility for medicals was not imposed, demonstrated or accepted). If a beneficiary obtains a 'settlement', our [CMS] general rule stated previously applies to the 'settlement', and ongoing responsibility for medicals has not been imposed on, demonstrated by or accepted by the defendant, the beneficiary may elect to make an upfront payment to Medicare in the amount of a specified percentage of 'beneficiary proceeds.' This option would most often apply in liability insurance (including self-insurance) situations, primarily due to policy caps. For the purposes of this option, the term 'beneficiary proceeds' would be calculated by subtracting from the total 'settlement' amount attorney fees and procurement costs**

[17] See 26 U.S.C. §7520 (providing the use of valuation tables to value term interests and future interests).

borne by the beneficiary, Medicare's demand amount (for conditional payments made by Medicare), and certain additional medical expenses the beneficiary paid out of pocket. Such additional medical expenses are specifically limited to items and services listed in 26 U.S.C. 213(d)(1)(A) through (C) and 26 U.S.C. 213(d)(2). The calculation of beneficiary proceeds does not include medical expenses paid by, or that are the responsibility of, a source other than the beneficiary."

- An upfront payment option likely to apply in policy limit cases such as Proposed Option 6(b) creates clarity and promotes efficiency in the settlement context.
- The allocation methodology under Proposed Option 6(b) allows CMS to prioritize future medicals for CMS over other liens for past medicals. We recommend other liens for past medicals as part of the reduction calculation for determining "beneficiary proceeds".
- GRG strongly recommends that any type of formulaic calculation of 'beneficiary proceeds' must include some accounting for: 1) the impact of financial loss damages components, such as out of pocket expenses and other expenses which a beneficiary carries post-settlement not otherwise covered by insurance coverage relating to the settlement; and 2) other damage components pled/released such as loss of earning capacity, loss of household services and non-economic damages like pain & suffering, mental anguish and disfigurement.
- Proposed Option 6(b), in terms of past medical expenses, currently only accounts for a beneficiary's Final Demand figure provided by CMS and other expenses as limited by 26 U.S.C. §213(d)(1)(A) through (C) and 26 U.S.C. §213(d)(2).[18] Limiting the recognition of a beneficiary's past medical expenses to the Final Demand amount and other taxable deductions is inappropriate when addressing the issue of future medicals in the liability context. CMS should allow the beneficiary to apply all past medical expenses billed as that is the process permitted in the majority of states nationwide in that beneficiaries, when awarded damages by a trier of fact, is awarded amounts for past medical expenses billed as opposed to simply a Final Demand figure.
- Further, by using only a Final Demand figure in the calculation, Proposed Option 6(b) would not be a viable option for the beneficiary as such figure cannot be provided by CMS until at least 45 days post-settlement.
- We recognize that the reference to and use of the medical expense definition listed in 26 U.S.C. §213(d) creates a workable standard which would be understandable. However, limitation of medical expenses recognized by the calculation to those contained within 26 U.S.C. §213(d)(1)(A) through (C) and 26 U.S.C. §213(d)(2) reduces the amount of actually paid "out-of-pocket' expenses that a beneficiary may have incurred. For example, household services or modifications, COBRA or insurance premiums, would not be permitted in the calculation of 'beneficiary proceeds.'
- Further, we recommend that CMS not only have the listing of the statutory citation in the Proposed Option 6(b), but use the interpretation of those definitions as examples (*i.e.*, Section 1.2.3-1(e) or regulations enacted in support of 26 U.S.C. 213(d)).
- An additional concern is that the upfront payment option, or for that matter, any future medical care consideration, does not properly account for the fact that parties other than the injured Medicare beneficiary have legally cognizable claims which are not subject to inclusion as part of a future medical care analysis. For example, proceeds awarded for loss of consortium accrue to a spouse or loved one, not to the beneficiary, and such proceeds should not be applied when calculating amounts payable to CMS in the form of an upfront payment in order to satisfy a

[18] Essentially, 26 U.S.C. §213(d)(1)(A) through (C) and 26 U.S.C. §213(d)(2) are tax deductions allowable during a taxable year which are not compensated for by insurance or other means.

beneficiary's obligations related to future medicals under the MSP Act. Instead, such proceeds should be deducted from the gross award as an 'above the line' deduction.

- Another concern is that the current methodology does not reflect differences between Medicare-covered and non Medicare-covered medical expenses in the upfront payment. Any final option promulgated should ensure that any upfront payment to CMS relates only to future medical expenses which are otherwise covered by Medicare.
- We recognize that the concept of 'total payment obligation to the claimant' ("TPOC") (*i.e.*, what happens if ongoing responsibility for medicals was not imposed, demonstrated or accepted) is a concept which originated and applies in the MMSEA Section 111 context, but not the MSP context. We recommend that CMS clarify whether TPOC in this context is intended to be the same as is currently applied in the MMSEA Section 111 context.
- We recognize that an upfront payment could be made for all situations based on Proposed Option 6(b) as currently proposed. However, that condition (where ongoing responsibility for medicals has not been imposed, demonstrated or accepted) has not yet been defined. We recommend adding examples for ongoing responsibility not imposed, demonstrated or accepted to clarify when this condition is met.
- In terms of what percentage of the beneficiary proceeds should be payable to CMS in the form of an upfront payment, GRG recommends no greater than 10% of beneficiary proceeds be payable, following the standard set forth in H.R. 2641[19] and other proposed legislative remedies addressing WCMSAs.
- If a beneficiary chooses this option, and CMS' intent is to not repay the balance remaining, CMS should expressly indicate this result as part of this Proposed Option 6(b). One option includes providing a reversionary interest rule for higher dollar value future medical care allocations. In the absence of a reversionary interest (as part of this prepayment option), beneficiaries with those higher dollar value allocations would most likely choose an administrative solution that would protect their ability to recover the funds in the event of premature death.

Option 7 - **"The beneficiary obtains a compromise or waiver of recovery. If the beneficiary obtains either a compromise or a waiver of recovery, Medicare would have the discretion to not pursue future medicals related to the specific 'settlement' where the compromise or waiver of recovery was granted. If the beneficiary obtains additional 'settlements', Medicare would review the conditional payments it made and adjust its claim for past and future medicals accordingly. We [CMS] specifically solicit comment on whether this approach is practical and usable, as it relates to 'future medicals.'"**

- GRG believes Proposed Option 7 is not practical if Medicare has discretion to pursue future medicals even when the beneficiary obtains a compromise or waiver of recovery.
- Instead, when a beneficiary obtains a compromise or waiver of recovery, that compromise or waiver of recovery should be comprehensive.
- When CMS grants a request for compromise or waiver, that approval should be inclusive of both reimbursement obligations and the need to consider future medicals under the MSP Act. It's difficult to conceive of a fact pattern where the beneficiary successfully makes a hardship or equity argument which would only apply to past medicals and not future medicals.

[19] Medicare Secondary Payer and Workers' Compensation Settlement Agreements Act of 2009, 111th Congress, 1st Sess.

Other Alternatives Not Contemplated.

Qualified Settlement Fund ("QSF") Option.

- GRG recognizes that the use of QSFs increases settlement efficiencies and there is a strong public interest in resolving liability claims via settlement.[20]
- GRG recommends that CMS adopt a QSF Option which would be available when gross settlement value totals or exceeds $1,000,000.
- The QSF Option would involve the parties establishing a QSF into which settlement proceeds are paid. Once paid, the QSF assumes the defendant's liabilities with respect to any MSP obligations, including an exemption for the transferor to the QSF and/or the Responsible Reporting Entity from reporting under Section 111 of the MMSEA. Then, the plaintiff addresses all past and future medical expense obligations on their timetable and in conjunction with the administrator of the QSF. Such a formalized process, which represents best practices in today's modern settlements, would permit all the settling parties to resolve their differences via settlement, but adopt a formalized process to ensure MSP obligations for all parties have been met.
- CMS has previously recognized QSFs as a viable settlement option in its MMSEA Section 111 Alert dated September 30, 2011 titled "Reporting Exception Related to Certain Liability Insurance (Including Self-Insurance), No-Fault Insurance, and Workers' Compensation Total Payment Obligation to the Claimant (TPOC) Settlement, Judgments, Awards, or other Payments, Where the Funds At Issue Have Been Paid Into a Qualified Settlement Fund (QSF) Under Section 468B of the Internal Revenue Code (IRC) Prior to October 1, 2011."
- If such option is promulgated in the Proposed Regulations, similar to an exception provided by CMS in the bankruptcy context, GRG recommends that parties selecting this QSF Option in addressing future medicals be granted an exception from reporting for MMSEA Section 111 purposes since the purpose and intent of establishing and funding a QSF is to ensure that all past and future medical expense obligations are addressed compliantly.
- Such an option promotes the three purposes of the MSP Act (allowing the defendant to walk away and close its file with confidence that it will remain closed, ensuring that the Medicare Trust Funds are reimbursed appropriately as well as determining the extent to which it does not have to pay for any future medical expenses, thereby protecting a beneficiary's future Medicare benefits).

Primary Payer Option.

- GRG recommends that CMS provide a Primary Payer Option in the Proposed Regulations, which would operate as follows.
- Under the Primary Payer Option, if a primary payer is shown to exist by attestation and the beneficiary's calculated future cost of care figure (or the future medical allocation figure) is less than the lifetime caps or fixed payment terms still available and payable to the beneficiary under the terms of the insurance policy, then no MSA would be needed and the individual/beneficiary could satisfy any obligations for future medicals by selecting the Primary Payer Option.
- The Primary Payer Option would also provide CMS with a tracking mechanism to show that the amount which would have been set aside has been paid by the Primary Payer instead of by Medicare.
- This option provides the most secure means to ensure there is no burden shift, but places the determination of how best to use settlement funds in the hands of the beneficiary.

[20] *McDermott, Inc. v. AmClyde*, 511 U.S. 202, 215 (1994).

For example, where a beneficiary has health insurance that covers medical expenses related to the settlement, and can prove that the coverage is greater than the amount that would be set aside, the beneficiary can show that Medicare's interests in remaining a secondary payer post-settlement have been satisfied without the need for a LMSA.

Due Process System.

- In moving to provide the Proposed Regulations, if CMS disagrees to a process which allows for MSAs (determined by a third-party neutral and pursuant to an approved allocation methodology) to be self-actuating and fails to provide standard future medical allocation methodology based on equitable apportionment theories to which individuals/beneficiaries may refer, CMS should also clearly set forth the procedures by which a LMSA determination by CMS, where appropriate, can be identified. Just as it provides for in the conditional payment context, CMS should identify the system by which questions relating to future medical expenses are to be efficiently and effectively treated. Providing such clarity will benefit beneficiaries and the Medicare Trust Fund alike by promoting a consistent, efficient application of the rules concerning future medical expenses relating to settlements. For example, will CMS use the same post-final demand procedures that currently exist through independent contractors such as Maximus, which when further appealed, would submit those issues to an Administrative Law Judge, and then the Medicare Appeals Council? GRG submits that some level of administrative remedies need to be clearly set forth in the Proposed Regulations, whether by citation or otherwise, such that parties to a settlement understand their ability to exhaust administative remedies.

While CMS is actively seeking to provide formal rules and regulations around the issue of liability settlements and future medicals, GRG suggests that CMS take this opportunity to clearly set forth an appeals process which would apply to this issue. Currently, no appeals process is in place, either for liability settlements or workers' compensation settlements. If CMS insists that the MSP Act provides it with a right to not pay certain future medical expenses, there must be a process in place whereby an individual or beneficiary can appeal a determination made by CMS which has a substantial effect on his/her due process rights as well as his/her property rights (in the form of settlement proceeds). Such an appeals process should mirror the process in place for appealing determinations with regard to conditional payment reimbursement.

We appreciate the opportunity to provide the foregoing comments and suggestions.

Kindest Regards,

Matthew L. Garretson
Founder
Garretson Resolution Group

EXHIBIT 1

Defense-oriented clients' comments:

1) Basically I have to go back to the "catch 22" that has clouded this issue and forestalled enactment of MSA's on liability claims for all these years. That is the issue of compromise in liability settlements. This problem as it relates to lien reimbursement still exists yet CMS, in an effort to make Medicare solvent, has decided to ignore it and proceed forward without any solution. It is just a fact of our legal system that a liability claim is not owed until the jury says so. Settlements prior to that point are a compromise between the opposing parties and so, to be fair, somehow that compromise needs to be translated to the lien. Yet CMS has not built into the system a means to do so, much less devised a means to compromise future medical expense. I have no suggestions on how to do so, but I certainly think that being more aggressive with MSA's to relieve Medicare of the burden is only compounding the problem. It may well even be counterproductive by making compromised settlements even more difficult. CMS, as one small arm of the Federal Government, needs to look more at the common good and not try to solve one problem at the expense of creating or adding to a bigger problem. Discouraging compromise settlements means more injured people will actually continue to receive Medicare conditional benefits while their claims are being litigated. Litigating more claims through trial will clog our Court systems and increase the administrative burden. Justice for injured people will be delayed and probably less people will actually be compensated by defendants.

2) In short, it seems the options are either overly simplistic or too complicated. It is also frustrating that CMS simply does not understand (or want to acknowledge) the realities of liability settlements. In particular, CMS continues to fail to account for the fact that liability settlements are often largely for the recovery of non-economic damages (i.e., pain & suffering), and that they are based on compromise recoveries for the several types of damages available. Furthermore, CMS' implementation of a liability MSA process seems concerning because fails to recognize an inherent problem; it seems it would necessarily require that qualifying settlements include an allocation for future medical damages, and this, in turn, would require the agreement (or at least acquiescence) of the liability defendants/insurers. The problem here is that these defendants/insurers would also be expressly denying liability for injury and damages altogether, in the same breath, so to speak. In addition, some of CMS' other suggested approaches do not seem especially realistic in practice. For example, while the idea of including a physician attestation is a good one in theory, unfortunately, it has proven somewhat difficult to use given that many physicians now seem very reluctant to opine the patient's treatment has "ended" (perhaps because of fear by reprisals by CMS?). On the complex side, option 2 seems one of the best examples. Certainly, the idea of a minimum threshold for settlements, below which no recovery for futures would even be considered, is a good one. However, it seems a much higher threshold than they are considering (up to $100,000 seems reasonable) would be necessary to make this option truly useful. (Indeed, with settlements for less than $100,000, the recoveries are typically limited to just pain & suffering and past medical – typically, no real or significant claim for ongoing injury is included.) Moreover, the confusing and exhaustive criteria presented in this option (i.e., for "major trauma" vs. "physical trauma" vs. "chronic illness" – and also incorporating the ISS scale) would make it effectively difficult to use, at best. Finally, even the options currently in place (such as option 5), really have not been all that useful because they require a certain level of "sophistication" that many beneficiaries simply lack. In our experience, most beneficiaries are not even capable of accessing the MSPRC website, let alone "self-calculate" a conditional payment, and/or use the "percentage of settlement" option.

3) I like the idea of giving more responsibility to the attorney who represents the claimant. I like the idea of the "up front" payment to Medicare. It seems that ordinary humans and their health care providers probably have a hard time sorting out which services to bill Medicare and which services to pay from a trust. Reducing the length of time many administrators are involved would overtime reduce health care costs by cutting down administrative overhead for health providers, private insurers and federal contractors. I'd also like to comment on recent experiences with Medicare's aggressive cost-recovery against group health plans. The amount of effort to resolve alleged underpayments by group health plans to Medicare/Medicaid beneficiaries is huge, often for small sums.

4) Preliminary thoughts on the options: first, it is frustrating that CMS seems to continue to ignore or minimize the fact that liability settlements are vastly different from work-comp and even no-fault in a variety of ways. Based on the ANPRM, it seems CMS continues to view liability settlements as solely involving recovery for medicals only, or primarily – and thus continues to ignore the general nature of the "lump sum" settlements (which include non-economic damages as well as "other" economic damages, such as lost wages, and which expressly do not incorporate specific allocations of damages within the agreements). Furthermore, it seems CMS does not recognize that the available options to date – such as the "self-calculated conditional payment" option and "lump sum-low value settlement" option- are better in theory than in practice because of the true lack of understanding or sophistication (in particular, the lack of internet ability) in the target population. Overall, it seems the first step would be to institute a defined minimum threshold for "futures" recovery – such that settlements below a reasonable amount (say, $100,000, or even $50,000), would be exempt from future medicals recovery.

5) The problem I see with processes that are solely focused on a beneficiary's follow-through (like option 1) is that they depend on (1) a plaintiff or plaintiff's attorney that are savvy enough to recognize their obligation and who are also (2) on board with resolving it. Defendants should be left with an option to deal directly with Medicare (e.g. the possibility of making the "up front" payment in option 6 directly to Medicare on the beneficiary's behalf rather than relying on the beneficiary to make such a payment out of the settlement proceeds). We can always draft releases that allow for recourse if plaintiffs don't follow through, but as we all know, it takes time and money to enforce these agreements, and they don't assuage the CMS's desire to get paid in the meantime from whomever it can.

Plaintiff-oriented client's comments:

1) Seems to me Medicare set-asides in civil cases would have a chilling effect on settlements. I have several clients who won't even participate in a lawsuit if they have to turn around and give all or most of the money to Medicare for future medical costs. They already paid for Medicare benefits by working previously in their work lives. Also, without settling, Medicare won't be able to recover past medical expenses paid. I am against them recouping any money (much like private insurers) but I think any amount they be repaid for future medical care should be small and definite so we know how to advise our clients.

2) I have never understood how Medicare can assert a lien on something that may never occur. The fact that something is unknown should alone be the basis to avoid a set aside.

3) One thing I am very concerned about is that the regulations very clearly spell out the fact that any continuing/future obligation to protect Medicare interests ONLY applies to care/services that are directly related to the injury that was the subject of the law suit recovery. We as attorneys for injured plaintiffs are not permitted to offer evidence of future care that "might" be necessary as a

result of the primary injury and Medicare should not expect to have a set-aside for care that "could be" necessary or for care for a condition that "might not" have developed had the primary injury not occurred.

4) I think it is ridiculous to have an MSA requirement. It is one thing to bog down and make cases difficult to settle due to delays in getting conditional and final payment letters. To have to deal with future medicals, makes it easier to try the case than settle. Most cases, even for Medicare recipients due not involve definite future medicals. We generally don't ask for future medicals in settlement because of its speculative nature and the desire to compromise. Of course, there are exceptions, but it is difficult to evaluate. The defendants will almost always make a counter offer reducing the amount of the initial demand for various factors, liability, causation, doubt, cheapness, wanting a discount to avoid trial, etc. It is impossible to determine the real value future medical adds to the overall settlement. Delays in having to get Medicare approve it are strongly opposed. MSRP is slow and difficult to get information from. They can always put us off by claiming some document was missing. No phone call, no nothing, just start over. The private contractors enjoy the power (AETNA-Rawlings) and are tough to negotiate with. They try to argue against reductions even for attorney fees and costs and want letters from doctors to reduce other medical, when doctors are not available or willing to help. This is a nightmare, and more regs will only make worse. It will definitely contribute to me deciding to retire early. It is too difficult to handle cases, attempt to settle them, and be bogged down with delays and lack of communication. It ain't working and only getting worse.

5) I guess where I am somewhat at a loss in all this MSA guidance is where will exposure cases fit in? Neither of the proposed options fit well in our situation, where all of our clients are injured as a result of asbestos exposure.

6) The speed of response needs to be improved by CMS. We need a clear and speedy process on reductions where appropriate. There needs to be an "outer limit", i.e., if client is not disabled and younger than 3 years from Medicare eligibility, that should be the end of the MSA inquiry.

7) The first thought that comes to mind is that most third party tort claims originate from motor vehicle collisions. In NC, the minimum liability insurance limits are $30,000 per person. I suspect over 80% of the drivers in NC have only minimum limits. With the cost of medical care many times the most basic testing will exceed the minimum limits. There must be some provision to allow the client to receive compensation. If the attorney is working only for Medicare, the client will be dissatisfied. If the attorney has to create a set aside trust with limited benefits, it is not worth the time.

8) I would like to see, if possible, Medicare/CMS take into account that settlements are often compromises of claims based on factors other than the severity or immediacy of the injuries and related care. Medicare/CMS should reduce its surbro interests and/or future care offset requirements in some fashion to recognize that our clients usually are not being fully compensated. Because the client is not being made whole, a corresponding reduction in the repayment and offset is appropriate. In whatever algorithm ends up being used to determine if an MSA is required or to what extent it is required to be funded, it would be good to have the liability/success probability be a factor (if my client is taking 50 cents on the dollar to reflect the reality that there's a 50/50 chance of an outright loss, Medicare/CMS should only realistically expect and require repayment/offset at 50 cents on the dollar, too).

9) No one should have to set aside money that they are not paid for. I would suggest that in any settlement the parties agree on an amount that is being paid for future medicals. If there is a

settlement of 150k and the parties agree that it is reasonable to allocate 10k for future medical based on a variety of factors, including but not limited to the insurance, independent medical exams, the treating physician exams, pre-existing problems, etc. I believe that it is a tremendous burden on these victims if they actually have to set aside a large portion of their settlement that reflected pain and suffering, lost wages, etc.

10) Obviously some solution is required to the morass out there now in the non-WC field. In the pre-payment option, presumably there would be a discount from the prospective amount of the MSA.

11) Medicare should waive reimbursement on any claim in which its conditional payments are less than $1,000. In cases where the claimant has counsel, the attorney should advise Medicare in writing of those medical bills which are being claimed as damages in the tort action. Medicare should respond within 60 days after receiving counsel's listing of damages with its own listing of conditional payments and the amount sought IF claimant recovers. Continue the current formula for reduction for "procurement costs." Claimant's counsel shall pay Medicare 60 days after receiving funds from the tortfeasor's carrier, unless there is a bona fide dispute as to the amount of the lien. In no case may Medicare's share of the recovery exceed one third of the gross.

12) I have represented many workers' compensation claimants in settlements that required a Medicare Set-aside, beginning with the original "Patel" memo. I want to point out that the phrase "CMS further acknowledges that while such guidance and a corresponding process has been available in the workers' compensation context" does not fairly characterize CMS's approach in that arena. The fact that participants must always "consider Medicare's interests" in any settlement, and the knowledge that the review guidelines are not a safe harbor, has led to great uncertainty when settling a WC claim where the review thresholds do not apply. As a result, insurers are increasingly allocating an arbitrary portion of the settlement proceeds to future medical treatment. This trend seems to be founded on a strategy to report increased medical claim costs, and thereby justify higher premiums, rather than a true concern for CMS risk in cases where the claimant has not applied for SSDI. The point is simply that as long as there is an open-ended exposure to "consider Medicare's interests" even in cases that do not meet specific guidelines, CMS guidance is useless as a practical matter. The system needs a safe harbor provision. As an aside, why not pay the MSA directly to Medicare at settlement and avoid the pretense that claimants can self-administer the set-aside funds for the remainder of their lifetime?

13) I would be much easier if in cases where a set aside is required if Medicare would simply accept a sum certain up front to be paid to Medicare and thereafter Medicare makes payment for all medical expenses when the individual is eligible. There should be no requirement for a prepayment or set aside on any case where the settlement is below $250,000 and the individual is not receiving Medicare or doesn't expect to for at least 60 months. For a person currently on Medicare, if there is a need for future medical care, an upfront payment in an amount equal to no more than 25% of the post attorney fee and cost value of the settlement should be paid to Medicare subject to a maximum as determined by a Physician's statement as to what the reasonable future medical expense might be that are related to the injury.

14) My suggestion is simplicity. Use the doctor certification no future medical exclusion and then create a future medicals tax. 3 percent on all net liability settlements paid to CMS for people under 40 and say 5 percent for people over 40 up to 60 and 10 percent for any current Medicare recipient. It's all arbitrary and argument so give it predictability and simplicity and compliance is easy. Especially with lawyers.

15) I have long thought that the easiest way to address this issue is through a small "tax" on recoveries for any plaintiff who is Medicare eligible. I expect that the real medical expenses paid by Medicare that are causally related to injury claims could be studied and reasonably estimated, and that a very small tax, perhaps less than 1% on all resolutions would cover it. Any approach similar to the way WCMSA's operate will discourage so many claims that Medicare and the injury victims will end up as losers.

16) This is the problem with toxic torts case. Take for instance a gentleman diagnosed with multiple myeloma allegedly as a result of benzene exposures. The defendants will fight you tooth and nail asserting that benzene does not cause multiple myeloma. In Texas, with the extensive tort reform we've had, it is a tough expensive battle to fight. I just had a gentleman die with over $600,000 in paid medicals. He died so futures never became an option, but if he had not, we cannot afford to pay back past and then also set aside future. The client would get nothing, so what's the point in filing these cases anymore. If CMS insists on future set asides, I think they will stop collecting much of the past because it simply becomes uneconomical to work these cases so the defendants then get away with murder and CMS does not collect at least the past meds. The cost to litigate with all the pay backs does not justify the expense, time and risk involved.

17) I would like to explain the particular difficulty MSA's pose in benzene litigation in the hope that you would take this message to CMS during the notice and comment period. Benzene litigation is somewhat unique from other litigation in that it involves claims for many different diseases including, acute myeloid leukemia, non-Hodgkin's lymphoma, Hodgkin's lymphoma, chronic lymphocytic leukemia, chronic myeloid leukemia, myelodysplastic syndrome (MDS), multiple myeloma, bladder cancers, and others. Many of our clients are Medicare beneficiaries due to age or disability and their benzene-induced cancers are usually extremely expensive to treat. In my experience, benzene plaintiffs either pass away or achieve remission of their disease during the pendency of the litigation. Obviously, MSA's are not an issue in the death cases, but pose a major concern in the cases where our clients are in remission at the time of settlement. CMS should have an absolute exemption in cases where the medical records clearly indicate the patient is in remission. To require otherwise is to ask the lawyers and doctors to be clairvoyants who can divine which, if any, of the patients will come out of remission and require future treatment. Statements regarding remission in the medical records should be the only proof required to meet the exemption. CMS should not require an affidavit, letter, or certification of remission from the treating physician to qualify for the MSA exemption. To require physicians to attest or certify that a patient is "cured" and "will not need additional injury-related care" is an unreasonable request. It unreasonably intrudes on the doctor-patient relationship by forcing doctors to make unequivocal statements about future care and treatment that they may not ordinarily make. It could also expose doctors to potential liability if their statements prove to be false.

18) In Minnesota, work comp is primary in our workplace product liability actions. We are currently working with Garretson on resolving CMS liens for past payments, even though those liens would later be resolved in the work comp action. (Often we are able to resolve the products case before the comp case can be resolved. We work with the comp lawyers to get the lien payments we make reimbursed from the comp carrier, but it obviously would be better if CMS only pursued the primary payers. This is especially true in terms of future medical, where comp with pay all of those claims into the future, while we would need to take expensive steps to set up some type of system that in the end would not increase Medicare's reimbursement. It would be great if CMS would accept a form in a work place injury case identifying the comp claim and responsible parties, and waive any obligations from the products action.

19) In Michigan auto cases, the law provides for payment of related medical bills indefinitely. There should be an exemption from MSA for auto injury cases in Michigan. Secondly, many serious injury cases are settled for much less than bills because of liability insurance coverage or maximum limits issues. There has to be some mechanism to address these situations. For instance, on a slip and fall where liability is an issue (open and obvious) insurance limit (assume $100,000) and medical bills (assume $250,000). Why would the injured party sue to turn all money over to Medicare, and what attorney would do this? There should be a mechanism to deal with these types of situations.

20) The comments and thought process I have, I would be as follows: 1. Have the treating physician (or other expert physician familiar with the area of treatment), who was responsible for generating the medical expenses for Medicare, complete an evaluation form indicating whether or not there will be any future treatment and, if so, what that treatment would be, and the estimated costs thereof, with a percentage likelihood of whether the treatment will be necessary, incorporating the proposed life expectancy of the plaintiff in the underlying case. The form would have boxes and lines describing the condition, the treatment, the cost, etc., in a uniform type that could be filled out by the physician in any case. Obviously if the physician indicated there would be no future treatment arising out of the accident, there should be no set aside. Further, I believe the physician would have to take into consideration the age of the person involved, since a great majority of the persons receiving this future care are over 65 and they have been injured, there may be the likelihood that a doctor, as opposed to being so blunt as to say the person will die soon, could give an estimation of how long the likelihood of future care would be, and what the frequency and/or cost would be. 2. I believe there should be a minimum value of future costs, such as anything below a specific number not require a set aside, i.e., something like $1,000 of future care would be ignored. 3. I don't think the idea of an up-front payment from settlement will ever fly with plaintiffs, and/or it will discourage plaintiffs from wanting to pursue a case. Obviously, if the plaintiff thinks he/she is never going to see any money and the only people that will recover it are going to be the attorneys and the Social Security Administration, they may well say don't bother going forward with the case, or will militate towards forcing all of these cases to go to trial. 4. I like the concept of the injury severity score. Another potential would be to look at the determination of a jury after a trial to see what the future medical expenses designated by the jury are, and determine a percentage of how much should be set aside, based on the cost of care, cost per year, life expectancy, etc.

21) As to determining whether an MSA is warranted and /or the appropriate amount, Plaintiff's counsel must be able to determine how liability questions impact any analysis. Suppose there is a terribly injured client, even with substantial future medical needs, if liability is hotly contested (which is often the case)a settlement may be appropriately deeply discounted. The acknowledgement that liability questions often adversely affect settlements should be considered by Medicare when determining whether or how much of an MSA is appropriate.

22) Minimum thresholds of, say, $100,000 gross settlement or $50,000 net to client after a/f, expenses, AND meds paid from settlement proceeds would be helpful. They need better staffing and to become more timely in responding. Insurance companies should not be a responsible party for non-compliance, so as to maybe remove them as an obstacle to releasing funds in a case that the attorney is comfortable with but the insurance co isn't.

23) 1. The Need to Establish a Substantial Minimum Threshold for Cases Requiring Future Medical Set-Asides: In my State, for example, minimum insurance limits for auto policies are $25,000. Often, the severity of the injury and the past medical costs would warrant a limits offer even if there is the potential for future medical costs. In those cases, it is financially prohibitive to

establish the likelihood and costs of future medicals through medical testimony or a life care planner. It would seem to me that Medicare could avoid substantial commitment of scarce personnel and resources to potentially poor recovery cases by simply setting a fairly high threshold (perhaps $250,000 or $300,000) to settlements that will be reviewed and considered for LMSA's. 2. The Need to Take into Consideration Real-World Settlement Considerations such as Questionable Liability Issues, Medical Causation, Likelihood of Future Care, or Limited Funds. You touched on this a bit in the Q&A, particularly with respect to limited funds, and my comment above also touches on that aspect. I am not certain where this would best be addressed in the comment process; however, some flexibility MUST be accorded to situations where there is questionable liability and/or limited settlement funds available. Often these two issues will converge in the same settlement. Liability cases are very different from worker's compensation cases. Comp involves strict liability and a statutory obligation to provide lifetime medical care for the work-related injury. Liability cases require proof of fault, proximate cause, and require substantial (or even clear and convincing) evidence of the necessity and cost of future medicals. Very often, these issues are hard-fought disputes. For example, plaintiff alleges that defendant's failure to properly screen and hire its drivers results in its negligent hire of a driver who is a wanted criminal. During a traffic stop, the driver bolts, and a police chase ensues. The driver collides with the plaintiff. Plaintiff alleges that the defendant's failure to follow certain proposed safety guidelines resulted in a collision, which caused an injury to the plaintiff's spine, resulting in fusion surgery. The plaintiff's physician states that it is "possible" that future care might be needed, and it will depend on plaintiff's pain levels over the next few years. The defendant maintains that (1) the injury was not the proximate result of its negligent hire, but of an efficient intervening cause (criminal act of the driver); (2) that the injury and surgery was the result of a pre-existing degenerative condition for which the plaintiff had previously discussed surgery; (3) that the driver passed a rigorous screening process and that no reasonable employer would take the steps that the plaintiff's expert says would be required; (4) that the prospect of future surgery is unclear at best, and that plaintiff failed to get sufficient evidence to allow a jury to award future medicals. Finally, the driver's arguably criminal act brings insurance coverage into question and a declaratory judgment action has been filed, and the insurance policy would only provide $250,000 in limits. In case like this, the defendant often will be willing to settle to avoid potential, if questionable, liability and also to avoid upsetting an insured and inviting even more litigation for bad faith failure to settle . However, the settlement might be only about 40%-50% of its limits, even though potential damages are much, much higher. It seems to me that Medicare rules must be able to articulate and accept Alborhn-type allocations of recovery. This could be accomplished either in the "discretionary" waiver option (which should have fairly concrete and understandable rules in place as to when and under what circumstances part or all of a claim would be waived), or under the any of the other proposed procedures whereby a fixed sum (MSA or pre-paid or otherwise) are established. 3. The Need to Allow the Parties to Allocate Settlement Funds. The parties know their cases best. If the defendant and the plaintiff understand and agree--- and the evidence supports -- that the bulk of the damages in the case are for past damages and pain and suffering, their allocation should be given credence, unless there is outright fraud. And while there is some risk that some parties might act badly, I think that given the penalties, most lawyers would err on the side of giving honest assessments to their cases. 4. The Need to have a way to Quickly and Finally Resolve Disputes. Currently, the Medicare review process for conditional payment reimbursements is cumbersome and time-consuming. There is no way that I know of to submit a proposed settlement to a Court, have Medicare submit to that Court's Jurisdiction, and to effectively resolve issues. Medicare needs to be willing to allow its decisions and positions be subject to court consideration and review, especially with respect to future LMSA issues. These will be fraught with pitfalls and the parties need to be able to quickly and finally resolve any disputes.

24) My concerns are settlements that are resolved where there is a long-standing pre-existing problem where: 1. there are liability issues; 2. the aggravations are minor and short term; 3. there is contributory negligence. These cases are generally resolved with Blue Cross or other healthcare carriers as they regularly reduce liens to accomplish a settlement on past payments. That is my concern when considering a set aside for potential future medical expenses.

25) Chronic injury is so broad as to include soft tissue cases -- thus, we will have to do set asides whenever a client has a soft tissue injury that does not resolve. We will need to get serious cooperation with the medical profession to obtain physician care attestations. How can we be sure that the medical profession will give us the information we need? In my personal injury practice, I almost always ask the treating docs, what, if any, future treatment my clients need, and if so what is the likely cost. They might scribble down some cryptic notes on treatment, but never give cost information. I cannot imagine that docs will attest to anything concrete, or will engage in defensive medicine which will drive up the set aside amounts. In cases with values less than $100,000 in value, it will be cost prohibitive to get a life care planner involved to work up the costs. I think the safe harbor amounts (those amounts which can be repaid by flat amount or percentage of settlement) need to be increased substantially. For instance, it does not make economic sense to do all the work being required if the net settlement to client (that could be subject to a set aside) is less than $20,000. Timeliness of responses from CMS/Medicare is a key. How can we even negotiate a settlement without knowing the lien amount for treatment to date, and the amount of the likely MSA (that's where the docs will be key)?

26) My concern is how they define "chronic illness," and "major trauma," because I really don't know what falls in-between. For example: what if a claimant has a degenerative condition and needs a hip implant, which turns out to be defective and they need future surgery, etc. What if a claimant had taken medication for a chronic condition which causes cancer or a cardiovascular event or condition? I think this should to be defined more clearly.

27) I think some of the definitions are vague & leave too much room open for interpretation. Example-Chronic illness/condition lasting for more than 3 months. That's the majority of cases we deal with - even the non-catastrophic cases. Date of Care Completion - I rarely ever see a treating physician give indication of 'completed treatment' & no further medical care needed. Major Trauma - do not care for the Injury Severity Score (ISS) - which does not take into consideration the complexity or complications of the major trauma - only that there's more than 1 body part involved. I applaud CMS' effort to work this out, but also think they'll be creating more chaos in our field.

28) Any rule of regulation should contain a general standard to determine the need for an MSA. Suggested language is as follows, "In order that an MSA be required, it must be demonstrated that based upon a reasonable degree of medical certainty, future medical expenses will be required for the condition/illness covered by the settlement." Definition of Chronic Illness/Condition should include "lasting longer than the reasonable expected recovery time".