

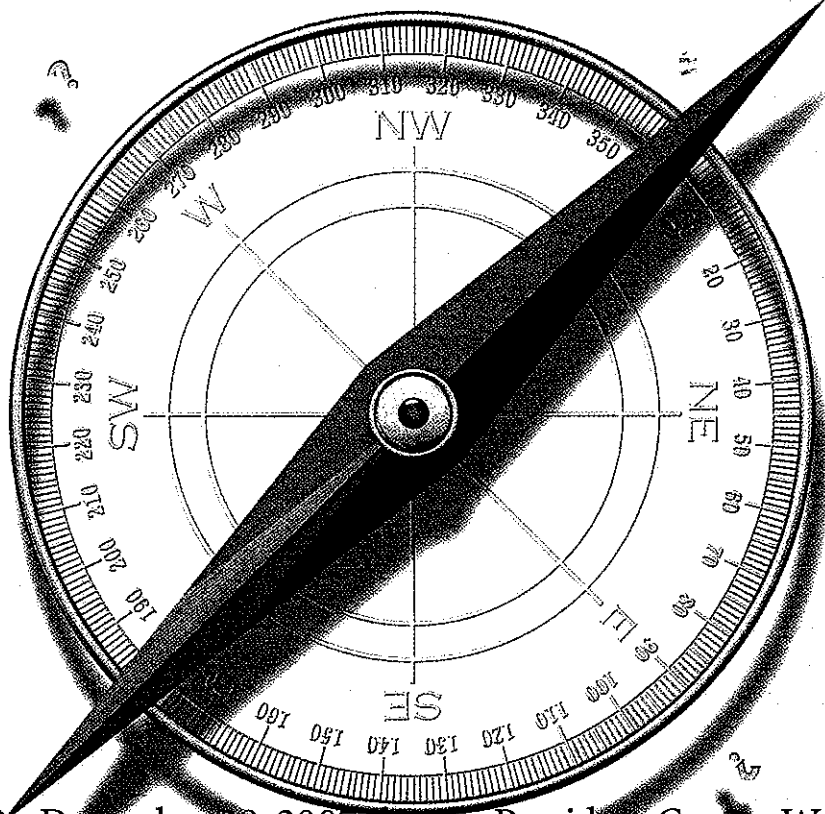


Mission Impossible

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Tort cases that involve a Medicare beneficiary need to be handled differently from all other personal injury claims.

Resolution of a Case with a Medicare Claimant?



On December 29, 2007, former President George W. Bush signed into law the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA or the act). The act protects Medicare's interests in personal injury matters

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when a plaintiff is a Medicare beneficiary. See 42 U.S.C. §1395y (b)(8). Section 111 of the MMSEA contains reporting requirements that, if not followed, could lead to civil penalties and fines. Under the new rules, all insurers with respect to liability, no-fault and workers' compensation, as well as self-insurers (collectively referred to as responsible reporting entities, or RREs), will be required to determine whether a claimant is entitled to Medicare benefits.

Where Do We All Begin?

Is your client an RRE? Your client is an RRE if it funds and pays, in whole or in part, a settlement, judgment, award or other payment to a Medicare beneficiary. An entity is not considered an RRE simply because it reimburses another entity that has paid a settlement, judgment, award or other payment on its behalf, unless that reimbursement is to a third-party administrator or results from a private settlement agreement. If a client has a deductible plan and usually pays settlements directly to a claimant, then it is considered an RRE. If a client simply reimburses an insurance carrier for making payments on its behalf, then that insurance carrier is the RRE.

Starting July 1, 2009, all RREs must track and report claims to determine whether an injured claimant is a Medicare beneficiary. In a March 20, 2009, alert, the Centers for Medicare & Medicaid Services (CMS) delayed implementing the Medicare Secondary Payer (MSP) reporting process by three months, until January 1, 2010. However, RREs must report retroactive to July 1, 2009.

This article will use a real-life fact pattern to highlight the practical, step-by-step reporting requirements. The CMS recently published a User Guide (Version 1.0) that does a relatively good job of setting forth what is required of RREs; however, the practical effects of complying with the requirements have many confused. See <http://www.cms.hhs.gov/>. This article seeks to identify the contingent liabilities created by MMSEA's implementation in conjunction with established MSP rules and to clarify, when possible. The inset accompanying this article is a recommended protocol or checklist that all RREs should consider using as part of their claims-reporting systems. (See page 13.)

The Phone Call

It is late in the afternoon at your law office and the phone rings. Mary Ellen, a long-time client, has a question about a settlement she wants to close before the end of the quarter and wants your advice. She tells you that she has been working on a case for several months in which the claimant sustained a knee injury. The claimant, Tommy, has not quite recovered from his slip and fall accident, but he is a bit tired of the process and wants Mary Ellen to make an offer to him. He is not represented, stricken with terminal bone cancer and is over 65 years old. Mary Ellen would like to settle the case, but she is hesitant. She has heard recent rumblings about Medicare and liability settlements and wants to know if she can settle the case with Tommy, pay the money to him, and close the file. Mary Ellen tells you her common practice is to include in the release that a claimant is responsible for any lien issues, including Medicare's reimbursement amount. She is thinking of having you draft the settlement agreement and wants your opinion on whether she should proceed. What do you tell her?

The answer is not easy. The best advice is to say "it depends," because rules regarding the reimbursement of Medicare are cumbersome, lack finality and work against long-established settlement practices. It is likely that the case will not settle within Mary Ellen's desired time frame, unless she has been proactive with the CMS from the outset. Even so, it is still questionable whether she would be able to distribute the settlement proceeds and close the file without incurring any contingent liability. The CMS demands to be made whole without regard to fault apportionment, which decreases net recovery, or sometimes results in no recovery at all, for the Medicare beneficiary of Tommy's tort claim. Furthermore, a regulatory requirement that everyone involved in the settlement—plaintiff attorney, defense attorney, insurance carrier, or self-insured—share equal responsibility to protect Medicare, which creates a "chilling effect" on settlements and requires implementing burdensome practices to minimize exposure.

Consequently, tort cases that involve a Medicare beneficiary need to be handled differently from all other personal injury claims. The contingent liabilities that will

develop from the MMSEA's implementation will trigger an unequal treatment of the Medicare beneficiary claimant compared with any other tort plaintiff. The MMSEA's impact will delay the distribution of settlement proceeds under the current framework of MSP law because finality is a challenge.

The contingent liabilities that anyone connected with the settlement involving a Medicare beneficiary personal injury settlement are:

- Fines and penalties;
- Reimbursement of CMS through legal action;
- Medicare's interest concerning the treatment of post-settlement medical costs; and
- Private cause of action under the MSP.

Fines and Penalties

The MMSEA has teeth. An RRE administering workers' compensation, general liability and no-fault claims is required to electronically report any settlement, award, judgment or other payment to the CMS. Failure to follow the MMSEA's requirements will subject the RRE to civil penalties of \$1,000 for each day that a claim report is untimely; the penalty is separately applied to each claim that is not reported.

The RRE must be able to identify the claimant as a Medicare beneficiary before it can report electronically to the CMS. To do so, the RRE can ask the claimant, but is not able to rely on the response, and, therefore, must secure a Social Security number to query the CMS for verification. It would be extremely beneficial, and fair, for the CMS to consider adding a "safe harbor" provision. The reporting requirements need an amendment that applies to the RRE that is not told the truth about whether a particular claimant is receiving Medicare.

A claimant is not obligated to provide his or her Social Security number unless litigation is pending, and the claimant in the hypothetical described above, Tommy, could properly withhold his private information. The settlement should not occur without the Social Security number, because if Mary Ellen did make a settlement "payment" her insurance carrier or self-insured plan will be defined as the "primary plan" under the MSP and the reporting obligation will automatically trigger.

However, since the reporting cannot occur without a Social Security number, the "primary plan" is subject to significant penalties and fines because it cannot report.

Privacy Violations and Bad Faith

Private information must be protected. Assuming that Mary Ellen was able to collect the Social Security number, does she

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have appropriate policies in place to protect it from accidental disclosure? Although the CMS program direction for MMSEA §111 mandates that the RRE collect the Social Security number, the RRE is not insulated from privacy liability under that law. The RRE has additional exposure to address.

Furthermore, the RRE is under a continuing responsibility to report all claims involving a settlement, award, judgment or other payment to a Medicare beneficiary. Throughout the life of a personal injury claim, the RRE must check and check again to determine if a claimant is a Medicare beneficiary, until the claim is closed. The RRE will be liable for fines and penalties even if it is unaware that it is dealing with a Medicare beneficiary. There is no equal obligation on the part of the Medicare beneficiary or his or her representative. Under the MMSEA, the obligation to identify the Medicare beneficiary rests solely with the RRE. In situations in which a claimant is not a Medicare beneficiary, it is prudent to have protocols in place to ensure that the claimant is checked periodically for Medicare status throughout the life of the claim. (See the inset accompanying this article on p. 13). This practice will increase the likelihood of accurate reporting to the CMS and mitigate fines or penalties that the CMS could potentially assess against an RRE.

Another area of contingent liability concerns the application of a state's "Fair Claim Practices Act." In certain jurisdictions,

the MMSEA dictates when a claim is to be paid after settlement; it remains to be seen whether these state laws conflict with the MSP and MMSEA federal statute. There may be no conflict since the practical effect of the MSP and MMSEA is to force an RRE to withhold distribution until the reimbursement claim is issued by the CMS. Therefore, the MMSEA may not be preempted, and the RRE may find it difficult to reach settlement without being exposed.

CMS Reimbursement Action

Despite its passage in 1980, the MSP was seldom followed by insurance carriers and self-insureds, and, until 2001, it was rarely enforced by the CMS. See 42 U.S.C. §1395y and 42 C.F.R. §411, *et seq.* Even after 2001, the CMS's enforcement was restricted to certain categories of Workers' Compensation cases, and litigation resulted to determine the act's applicability. In 2003, the Medicare Modernization Act (MMA) became law and resolved the conflict between the Fifth Circuit and Eleventh Circuit as Section 301(a) removed the word "promptly" from the MSP statute. See Pub. L. No. 108-173, 117 STAT. 2066, codified in scattered sections of 42 U.S.C. §1395y. See also, *Thompson v. Goetzmann*, 337 F.3d 489 (5th Cir. 2003), and *U.S. v. Baxter*, 345 F.3d 866 (11th Cir. 2003).

Prior to 2003, MSP law was applied so that insurance carriers or self-insureds were only responsible for compliance if they could pay promptly. In cases in which payments could not be rendered promptly, Medicare would pay. "Promptly" was defined under the regulations as within 120 days. See 42 C.F.R. §411.50. Since liability insurance carriers or self-insureds usually did not pay liability claims within that period, the law, apparently, did not apply. By removing the word "promptly," Congress affirmed that Medicare is the secondary payer in all cases in which a primary payer is available.

The MMA, at §301(b), also clarified the meaning of "self-insured plan" as "An entity that engages in a business, trade or profession shall be deemed to have a self-insured plan if it carries its own risk (whether by a failure to obtain insurance or otherwise) in whole or in part." It is now clear that the MSP applies to liability claims and that an RRE must reimburse Medicare

for payments it may have made related to a liability claim.

Reporting

During the investigation of a liability claim, if the claimant is a Medicare beneficiary, the RRE must place the CMS coordination of benefits contractor on notice of the loss. See 42 C.F.R. §411.25(a). An RRE does not need approval from the Medicare beneficiary to make this notice. It should be noted that the trigger to report involves whether there is an expectation of making a payment. If there is no liability and no expectation of making any type of payment, there is no duty to report.

An RRE should take care to supply the CMS with the correct ICD-9 Codes that properly characterize the injuries related to the accident. The CMS allows use of up to five codes to characterize the injuries. The CMS benefits coordinator contractor will enter this information into a database and a working file is created. The information is then transmitted to the Medicare secondary payer recovery contractor. The Medicare secondary payer recovery contractor assembles the data and issues interim payment statements to the Medicare beneficiary. An RRE may receive a copy of that statement from the claimant or from the Medicare secondary payer recovery contractor, with properly signed consent of the Medicare beneficiary. This process is anticipated to take up to six months or longer when the MMSEA goes into effect.

The Medicare secondary payer recovery contractor will not issue a demand for reimbursement until a case is settled. The Medicare beneficiary is required to supply the information regarding the specific settlement terms, including if appropriate, attorney's fees and expenses. Upon receipt of this information, the Medicare beneficiary will be informed of CMS's subrogation rights as of that date. This right to subrogation interest must be satisfied, consistent with the CMS demand, and/or an amount equal to the settlement payment, if the amount is less than the CMS's subrogation assertion.

Since it is possible that the CMS may take the entire settlement amount, the parties to a liability settlement need to understand the totality of potential exposure stemming from the MMSEA. Consequently, early

reporting to the CMS coordinator of benefits contractor and subsequent follow-up with the Medicare secondary payer recovery contractor for the interim payment statement is critical to the settlement process' success. The initial statement will no doubt have errors that will require sending a corrective letter to the Medicare secondary payer recovery contractor. In Tommy's case, his cancer treatment costs may be intertwined with the treatment costs for his knee. Unless Tommy's two health issues are segregated and addressed separately, Tommy's settlement with Mary Ellen's company may include costs for the cancer treatment and appropriated from the slip and fall settlement proceeds.

To ensure the best possible settlement, an RRE may need to work both sides of the fence to resolve a personal injury claim concerning a Medicare beneficiary. Most claimants are not represented, and they are ill-equipped to deal with the CMS reimbursement process. Peculiarly, an RRE may by default become an involuntary advocate for an unrepresented claimant, seeking to remove unrelated care from interim statements or to perfect a hardship claim. As the CMS does not take into account principles of fault, the total dollars available for a claimant are limited. To encourage settlement, an RRE should assist a Medicare beneficiary.

Opportunity to Reduce Medicare's Reimbursement Amount

As alluded to, there is no allocation of fault by the CMS in a liability settlement. The CMS ignores the parties' allocation in a private settlement agreement or by a court order. The CMS's position is that it is entitled to proceeds of the entire settlement, or at least in an amount that equals the amount that Medicare has already paid. The only exception is a case that has been tried to special verdict in which the damages have been allocated between medical expenses and other damage elements. In this situation, the CMS will only appropriate the medical damages allocation for its recovery.

The CMS demand may be reduced through a hardship petition, to decrease Medicare's reimbursement amount. There is also a reduction for cost a claimant pays to an attorney, called a procurement cost, if the Medicare beneficiary had an attorney.

See 42 C.F.R. §411.37(c). Barring these two narrow reductions, the amount stands and must be paid. Assuming the CMS will not compromise on the Medicare reimbursement amount as of the time of settlement, the minimum threshold for settlements of personal injury claims with a Medicare beneficiary could increase to effectively equal the reimbursement amount. Thus, after July 1, 2009, a "nuisance value settlement" will have to equal an amount in excess of Medicare's subrogation right as of the date of the settlement, regardless of admission or assessments of liability for the personal injury claim. Otherwise, why would a Medicare beneficiary accept a settlement in which he or she receives no money?

All RREs are disadvantaged in this process, since they are not entitled to the information from the Medicare secondary payer recovery contractor without the consent of the Medicare beneficiary. See Privacy Act of 1974, Public Law No. 93-579, 88 STAT. 1897 (Dec. 31, 1974). If a Medicare beneficiary is not vigilant, the MMSEA is sure to impact the settlement. It is difficult to understand how a settlement could be reached if the RRE is not privy to the basic information contained in the Medicare secondary payer recovery contractor's interim statement. There will be a lot of consternation over access to this information since it is an important exposure element for the RRE, if the Medicare beneficiary fails to properly reimburse Medicare within 60 days of payment. See 42 C.F.R. 411.24 (h).

When Can Liability Files Be Closed When the Claimant Is a Medicare Beneficiary?

Even if the parties are able to reach a settlement agreement, the next roadblock is whether distribution of the proceeds should occur *before* the CMS issues its reimbursement demand letter. MMSEA reporting will cause reluctance on the part of the RRE to distribute the settlement without adequate assurance that it will not have to pay again. There are limited ways this can be accomplished. First, an RRE can issue a two-party check payable to the CMS and the Medicare beneficiary. However, a state's escheatment law may be implicated if the check is not negotiated in a timely manner, involving the state in the process. Another method is to demand indemnity from the

claimant in a release agreement, but if the CMS is not able to secure the funds, an RRE will probably not fare any better in a collection process either. Finally, an RRE can simply hold on to the funds until the CMS has properly responded with its demand, which offers the most security, although still fraught with exposure.

With the third option, the RRE is a trustee of an involuntary trust arrangement. These funds cannot be distributed without approval of the Medicare beneficiary, and if they are released without approval, it could subject the RRE to trustee liability. One theory of liability arises by not allowing the Medicare beneficiary sufficient time to present his or her hardship case or reduction for procurement costs. The CMS will not consider these beneficiary requests after receipt of the funds, and they are deemed waived.

42 C.F.R. §411.24(i) requires an RRE to pay the reimbursement amount, even if it already has paid the Medicare beneficiary. This regulation is problematic because it forces the RRE to retain the funds to avoid paying the CMS again. Since the CMS has no obligation to respond within a particular time period, costs will increase as claims will unquestionably take longer to close. Contingent liability will exist, as the shelf life of claims will likely increase, necessitating larger reserves to cover these exposures.

Returning to Mary Ellen, she may have settled her case with Tommy, but will have to wait to distribute funds. Such files are held in open status with active reserves. These reserves generate exposure that increases over time. Until paid, there is a possibility the settlement may be rejected or a demand for it is amended. Until the Medicare secondary payer recovery contractor issues a demand letter, the case is not "actively" settled. Mary Ellen's desire to close the claim's file at the end of the quarter will certainly be frustrated as the CMS may take four, and possibly up to eight months to finalize its demand. The CMS estimates that about 2.7 million liability cases will be reported under the MMSEA. The data will then be sent to the Medicare secondary payer recovery contractor for recovery processing. This additional work, without additional staff or budget for the Medicare secondary payer recovery con-

tractor, will result in even more delay, possibly 12 to 18 months, before a response is received. As mentioned, the CMS is under no required time frame to respond.

Furthermore, Mary Ellen is required to electronically report the settlement as she has reached a "total payment obligation to the claimant." See User Guide (Version 1.0), at 111. It does not matter if she has not issued the settlement payment. The CMS wants to know about the total payment obligation to the claimant, even if funds are withheld, so it may begin the recovery process as it deems appropriate. The obligation for electronically reporting the settlement amount rests solely with an RRE and cannot be transferred to the claimant or the claimant's attorney. Anyone connected with a claim still has an obligation to manually report. This reporting protocol is in effect for both non-litigated and litigated claims. Parties as such will be automatically locked into a second round of negotiations, resulting in distaste for handling Medicare beneficiary losses.

The Medicare reimbursement obligation is no longer an administrative function that can be addressed by the Medicare beneficiary's attorney on the back end. Nor is it a subject that RREs can address through an indemnification clause in its release agreement. Rather, it has evolved into one of the most demanding conditions precedent in any settlement agreement, often requiring counsel to affirmatively notify the CMS of plaintiffs who are settling and then to proactively satisfy the CMS's interests prior to disbursement of settlement proceeds to any plaintiff that is a Medicare beneficiary.

Medicare's Interest with Regard to Future Medical

Medicare secondary payer laws require that Medicare's interest be taken into consideration when resolving a liability and workers' compensation case. If Mary Ellen were handling a worker's compensation case, her ability to navigate this process is guided by the CMS memoranda that specifically set forth the steps required to obtain compliance. For Mary Ellen's liability case, no such guidance is provided, which leads to significant questions about exposure post-settlement. Mary Ellen will need to determine on her own how to satisfy the law, and there is no safe harbor for her decision.

There is an increased responsibility to clearly understand the health condition and prognosis of a given claimant. The health condition and future medical responsibility must be reviewed, independent of liability determination, and must be assessed and documented in some manner. How that documentation should occur is subject to debate and beyond the scope of this article. Suffice it to say that it will be an issue in every settled case involving a Medicare beneficiary as each party will have a different perspective, which must somehow be reconciled. If not properly addressed, the CMS could terminate future benefits related to an injury or file a recovery action for mistaken payments it may make for those future benefits. If a recovery action is pursued, the statute empowers the CMS to recover double damages. See 42 C.F.R. §411.24(c)(ii)(2).

Mary Ellen, therefore, cannot, with confidence, resolve her case with Tommy, unless Tommy returns to his pre-accident condition, there are no planned future medicals, and medical information to support that conclusion is documented. As presented here, Tommy is not at his pre-accident health condition—he has ongoing problems with his knee. This situation creates a dilemma for the practitioner that will need to be addressed on a case by case basis. If improperly assessed, Mary Ellen could expose her RRE. Thus, the case remains a quagmire. Future medical costs are anticipated that can be directly traced to the tort in question.

MSP Private Cause of Action

The MSP statute allows for a private cause of action against an RRE that fails to reimburse Medicare or otherwise make primary payment. See 42 U.S.C. §1395y(b)(3)(A). Tommy can sue to recover in damages twice the amount, if his Medicare benefits are suspended because the agreement did not properly protect Medicare's interest. Not only does Tommy have that right, but the government does, as well.

The private cause of action is not limited to filing against an RRE as it stands today. Anyone involved in the settlement of a claim with a Medicare beneficiary is potentially a defendant. Plaintiffs' lawyers, defense lawyers, insurance carriers, self-insureds, third-party administrators,

and other entities falling under the auspice of an RRE are equally responsible and exposed. See 42 C.F.R. 411.24 (g); see also 42 C.F.R. §411.26³(a). This exposure creates an ineffective right to counsel in every case. As mentioned, the rules are not developed in this arena, and it will be difficult to obtain an agreement about what needs to be done in any case, especially one of significant value.

Conclusion

The enactment of MSP in 1980 was created, in part, to continue Medicare's attempt to curb rising costs. The MSP provided protection for Medicare in cases in which Medicare beneficiaries suffered personal injuries requiring medical treatment under circumstances in which a third party was responsible for the accident or injuries, similar to the protection that the original Medicare Act provided to work-related injuries. The MSP statutes have been reinforced through the MMSEA, and generally require insurers and self-insurers to pay for a Medicare beneficiary's treatment if another plan—workers' compensation, liability, self-insured or no-fault—has, or can be reasonably expected to have, responsibility for making medical payments. In those instances, Medicare becomes the secondary payer, and the plan becomes the primary payer responsible for the costs of the claimant's medical care. With the passage of the MMSEA and its enforcement of increased requirements to protect Medicare's interests, RREs will now have additional duties to investigate personal injury claims.

Medicare should be reimbursed for monies it paid on behalf of a beneficiary if the injury was caused by an RRE. The way the federal government is collecting this money, however, leads to the complications discussed above. The hypothetical fact pattern described was purposefully uncomplicated. What happens if Tommy is re-injured, while at a nursing home, as a result of the nursing home's negligence? What if Mary Ellen is one of two or more potential defendants, separate RREs that each need to report to the CMS? There is no question that nuisance value settlements cannot be entered into after July 1, 2009. This will have the effect of keeping monies in the reserves of insurers and self-

MMSEA Implementation—Protocol for the Responsible Reporting Entity

With its expanded enforcement authority, civil penalties and broad scope, the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) will have a sweeping impact on insurance companies and self-insured companies. This will usher in a fundamental change to the way personal injury claims are documented, investigated, evaluated, negotiated and settled by insurance carriers and self-insureds. Unfortunately, the specific requirements, policies, and procedures for complying with the requirements of the MMSEA are not yet finalized. The User Guide released by the Centers for Medicare & Medicaid Services (CMS) on March 16, 2009, does provide clarity on some issues, but the issues articulated in this article are still alive and well.

Registration

Self-insurance, no-fault insurance, self-insureds, and others who are designated as RREs must begin to register with the CMS's coordinator of benefits contractor between May 1, 2009, and June 30, 2009. Although an RRE may use an agent to perform the task of reporting actual claims, the RRE must itself register and appoint that agent. The RRE will remain solely responsible for ensuring

that the requirements of CMS are being followed, regardless of who is reporting the actual claim. The RRE cannot contract away this responsibility and, upon registering, will receive notification via email of a profile that will include, in part, the RRE's reporting ID. The RRE will also receive the assigned seven day file submission time frame within each quarter for submitting reportable claims.

Reporting Protocols

CMS, in its User Guide, has issued updated data protocols that it will require from RREs. The information to be reported includes very specific information, some of which is not generally obtained through normal investigative protocols, such as ICD-9 Event Codes; ICD-9 Diagnosis Codes; Date of Birth; Social Security Number; or Plan information. Work flows at claim operations will have to be adjusted to allow for the proper collection of data. Failure to properly append the data will result in an error and the RRE will have a quarter to correct it. It is an open question as to what would happen if the information is not corrected after that quarter.

Report Timing

CMS will also dictate when this re-

quired information must be submitted. In cases in which no money is paid on the claim at all until the time of settlement, RREs will only be required to report on a claim at the time of settlement, judgment, award or other payment. Technically, and disavowing the above advice with respect to reporting early, an RRE is not required to report until the case settles. However, in instances of ongoing responsibility for medical payments, the CMS will require reporting immediately and no settlement agreement is required. The RRE must report only the start date of the obligation and then monitor the claim until the medical payment obligation has ended. At that point, the RRE must report the termination of medical payments.

Reporting Thresholds

In the March 20, 2009, "Alert" issued by the CMS, there is a stated exception to reporting on small claims. The CMS reiterated that the thresholds are for purpose of the MMSEA reporting and does not relieve an RRE of any responsibility under the Medicare Secondary Payer process. For liability cases with a one-time settlement, the initial threshold for bodily injury payment is \$5,000, between July 1, 2009–December 31, 2010.

For the next two years, the amount is reduced to \$2,000 for year two and to \$600 for year three. There is no threshold for ongoing responsibility for medicals.

Query Function

The CMS will make available a process by which an RRE can verify if a claimant is a Medicare beneficiary. Once per month, an RRE will be allowed to submit a file with all of the claims it may want to check for Medicare beneficiary status. The RRE must submit the request with the Social Security Number, name, date of birth and gender of the injured party, for each request. The CMS will match the data against government's systems and provide a response file in 14 days. The file will contain essentially a "yes" or "no" answer to Medicare beneficiary status. If the answer is "yes," the CMS will provide the Health Identification Number to be used on all future electronic reporting. A data sharing agreement must be executed with the CMS before any access is provided. If the CMS response is "no," then there is no guarantee that claimant is not a Medicare beneficiary. The claims reporting process must somehow account for such false negatives, with continued inquiries.

insurers alike, which is the exact opposite effect anticipated by the government. In turn, those most vulnerable in our society will be harmed from the delays caused from unintentional consequences of the MSP and MMSEA. Aside from the fact that RREs will have difficulty closing their files, the normal "churn" of the settlement economy will also be impacted, grinding to a halt. The CMS estimates 2.7 million cases are reported each year. As more of the baby boomers retire, that number will increase exponentially. If the settlement economy is interrupted by significant delay, especially in these uncertain economic times,

what is the real cost of the Medicare, Medicaid, and SCHIP Extension Act of 2007? Other methods exist for the simple recovery of these entitlement payments. We have experience working with them every day in our practices when working with state Medicaid agencies. If Medicare could imitate these its recovery processes, in a manner similar to the Medi-Cal recovery process, formulas could be used to automatically apply what is owed to Medicare. The process would allow finality without interference in settlements, promoting the important public policy of encouraging settlements.

Change is needed to avert disastrous unintentional consequences and a coalition of trade associations, insurers, self insureds, third-party administrators, MSAs and attorneys has come together to lead the reform. The Medicare Advocacy Recovery Coalition (MARC) has already made a positive impact to change the law and will continue to raise awareness about its present consequences. For more information about MARC, see <http://www.marccoalition.com>. There are no sides to this issue. Our collective effort can make a difference. It is not an option to do nothing. We are all at risk for "Medicare Impossible." **FB**