AMERICAN INSURANCE ASSOCIATION

2101 L Street NW
Suite 400
Washington, DC 20037
202-828-7100
Fax 202-293-1219
www.aiadc.org

August 14, 2012

Via Electronic Submission (http://www.regulations.gov)

Marilyn Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services,
Department of Health and Human Services,
Attention: CMS-6047-ANPRM,
Mail Stop C4-26-05,
7500 Security Boulevard,
Baltimore, MD 21244-1850

RE: CMS-6047-ANPRM

Dear Ms. Tavenner:

The American Insurance Association's Medicare & Medicaid Task Force (AIA's Task Force) appreciates the opportunity to submit comments in response to the advance notice of proposed rulemaking (ANPRM), CMS-6047, entitled Medicare Secondary Payer (MSP) and "Future Medicals." The ANPRM outlines standardized options that CMS is considering making available to beneficiaries and their representatives to clarify how they can meet *their* MSP obligations when future medical care is claimed or the settlement, judgment, award, or other payment releases claims for future medical care. AIA's Task Force is made up of 34 domestic and foreign insurance groups, trade associations, and other stakeholders representing over 300 major insurance companies that provide all lines of property-casualty (p/c) insurance and write more than $159 billion annually in premiums. The comments in this letter focus on the efficiency and effectiveness of the proposed options.

We understand that the proposed options do not seek to place any obligations on an insurer or self-insured with respect to "future medicals," as there is no statutory authority permitting CMS to impose any such obligation or granting it a right of recovery against an insurer or self-insured with regard to "future medicals." CMS' lack of authority with respect to insurers and self-insureds regarding "future medicals" underscores the importance of properly focusing the seven options solely on beneficiaries. The proposed options reflect this understanding by establishing criteria for determining how the beneficiary will protect Medicare's interest. The Overview and Background specifically states:

Medicare pays for medical claims with the expectation that it will be repaid if the beneficiary obtains a "settlement".

As a result, AIA's Task Force respectfully urges CMS to explicitly include language that codifies Congress' clear intent in any rulemaking to confine the options presented only to beneficiaries and their representatives and that reiterates that no obligation is imposed on insurers or self-insureds for medical expenses incurred after the date of a liability settlement. AIA's Task Force also calls on CMS to state unequivocally that these options apply only to:

*"**Beneficiary Proceeds**"….. , "calculated by subtracting from the total "settlement" amount attorney fees and procurement costs 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).*

As explained in more detail below, AIA's Task Force calls on CMS to explicitly reject in its entirety the establishment of a process (Option 4) in liability claims like that in existence today for a limited universe of workers' compensation settlements. That process is inefficient, ineffective, and inadequate to meet the goals of CMS, beneficiaries and their representatives. As proposed, the option would be disastrous, would undercut the ability for insurers, self-insureds, and beneficiaries to handle and timely settle claims.

Discussion

Although insurers and self-insureds have no obligations with respect to future medicals we can offer valuable insight on the tort system and the claims settlement process, because of the volume of claims we see. It is because of our experience in claims handling and not because of any obligations for future medicals, that AIA's Task Force offers these comments and observations on the proposed options. CMS has chosen to consider multiple options for beneficiaries and their representatives to satisfy Medicare's interest with respect to MSP claims involving automobile, liability, workers compensation and no-fault insurance. The universe of claims, while similar by line of business, varies dramatically, in size, scope and the number of potential beneficiaries. CMS should be aware that the universe, of claims subject to "future medicals" is very limited. AIA's Task Force does not believe a single solution would meet the needs of the beneficiaries and that there must be multiple options available to beneficiaries. Based on the ANPRM, the use of any option is solely at the election of a beneficiary; the rules should explicitly state that if they are appropriately used, the election constitutes a complete safe harbor for MSP purposes. Without a safe harbor, the rules could lead to further uncertainty for beneficiaries.

A. Proposed General Rule

- Beginning in the General Rule, the document uses the terms "beneficiaries" and "individuals" almost interchangeably. As a matter of law, MSP applies only to Medicare beneficiaries. It does not apply to all "individuals" and to the extent the ANPRM suggests otherwise, it is an overreach of CMS' statutory authority.

- CMS may be able to withhold benefits after a settlement, but MSP does not require action from the beneficiary other than the repayment of conditional payments.

- The document should explicitly state that the appropriate use of an option confers a "safe harbor" to any beneficiary and/or their representative.

- The document should state how long a beneficiary has to select an option.

- The document should establish a specific time frame within which CMS will confirm that a beneficiary has met his/her obligation.

- The document should make clear that CMS will recognize statutory and common law as well as state regulations with regard to claims handling practices.

- The document uses the term "additional settlements." CMS should define what constitutes an "additional settlement."

B. Definitions

- The Injury Severity Score (ISS) is not an appropriate methodology for prediction of "future medicals" in personal injury claims. It is a methodology used to attempt to appropriately triage patients in a medical setting. As it is a subjective measure, its application would inevitably lead to inconsistent conclusions across claim departments of insurers and self-insureds.

- For clarity's sake, the defined term "Beneficiary Proceeds" should be included and used where appropriate as a replacement for the term "settlement."

- The definition of Chronic Illness/Condition should be rewritten as follows to better describe those claims and replace any discussion of Physical and Major Trauma as those definitions are not indicative of "future medicals":

    - *Chronic Illness/Chronic Physical 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 12 months. The Department of Health and Human Services defines the term chronic in its paper entitled, "Multiple Chronic Conditions: A Strategic Framework as "conditions that last a year or more and require ongoing medical attention and/or limit activities of daily living." This paper can be found at:* http://www.hhs.gov/ash/initiatives/mcc/mcc_framework.pdf *If the beneficiary alleges a causally related injury that did not pre-exist the date of loss and is a chronic illness/condition, it is presumed that future medical care will be required. Chronic Physical Condition: refers to an injury (as a wound) to living tissue caused by an extrinsic agent. This also includes but is not limited to 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).*

    - *Examples of chronic diseases and chronic physical conditions include, but are not limited to: chronic airflow limitation, including asthma and chronic bronchitis;*

cancer; quadriplegia; and nephrogenic systemic fibrosis, loss of use of a limb, a cognitive impairment to long term or short term memory, the inability to care or feed oneself.

C. Proposed Options

- Based on its knowledge of claims settlements, AIA's Task Force believes providing multiple options to beneficiaries to address "future medicals" can appropriately protect the rights of CMS and beneficiaries. However, as we have stated above, the references to "individuals" and "settlements" should be deleted.

- Any proposed option addressing "future medicals" in a liability settlement should demonstrate an understanding of p/c industry claims practices and settlement processes. Liability settlements, by their very nature, are the result of compromises of disputed liability scenarios and damages. Settlements are reached based on a wide variety of criteria dependent upon the nature of the claim, legal defenses such as comparative negligence, the location of the loss, time, weather, relationship of the parties, criminal acts, the potential judge or jury, the witnesses, prior settlements, policy limits and other factors too numerous to list.

Option 1: This option appears to be the easiest and least intrusive of all of the options for beneficiaries. The current draft, however, lacks specific guidance on the definitions of the terms *exhausted* and *documentation*. The option also lacks any reasonable time frame upon which the beneficiary could rely to retain records and be subject to Medicare's program integrity efforts.

Suggested Text of Revised Option 1:

Option 1: The *beneficiary pays* for all causally related future medical care until his/her *beneficiary proceeds* are exhausted and documents it accordingly.

The *beneficiary* may choose to govern his/her use of his/her settlement proceeds himself/herself. Under this option, he/she would be required to pay for all causally related care out of his/her *beneficiary proceeds*, until those proceeds are appropriately exhausted. As a routine matter, Medicare would not review documentation in conjunction with this option, but may occasionally request documentation from beneficiaries selected at random as part of Medicare's program integrity efforts *for a period of 18 months after the proceeds are exhausted.*

Option 2 A: Option 2 A would also be a viable option for beneficiaries to demonstrate full satisfaction of "future medicals" with suggested changes.

- It should be limited to beneficiaries.

- The one year time frame is far too long and will unduly delay claim settlements. There are many claims that occur, are reported and settled quickly. Delaying these settlements for a year builds unnecessary costs into the claims process that do not currently exist and harms claimants.

- AIA' Task Force suggests a dollar threshold of $25,000. This will capture a large number of claims with little effort on the part of CMS and its contractors.

- As currently drafted, this option is confusing the issue for beneficiaries by stating that it cannot be used when there is a corresponding no-fault claim. CMS' definition of no-fault claims includes medical payments coverage that is often sold with a $5,000 limit and subject to a policy term of one year. Many beneficiaries will have available medical payments coverage in addition to bodily injury coverage; this exclusion will prevent many beneficiaries from availing themselves of this option in their bodily injury settlement. This exclusion must be removed from Option 2 A if it is to be a viable alternative.

- This option would be viable for beneficiaries that settle small workers compensation claims and it should be offered to them as well.

Suggested Text of Revised Option 2 A:

Option 2: Medicare will consider its' interest in "future medicals" satisfied if the *beneficiary's* case fits all of the conditions:

- The amount of insurance (including self-insurance) *beneficiary proceeds* are *$25,000 or less* and the following criteria are met:

- The accident, incident, illness, or injury occurred *90 days* or more before the date of "settlement."

- The underlying claim did not involve a *chronic illness/chronic physical condition;*

- The beneficiary does not receive additional "settlements."

Option 2 B: Given that this option is an attempt by CMS to extend MSP to every individual who receives a settlement, this option is not feasible or usable. It oversteps CMS' statutory authority in an attempt to deny funds from an individual who may never become eligible for Medicare benefits in their lifetimes.

Option 3: AIA's Task Force views Option 3 as an acceptable, efficient and effective option for Medicare beneficiaries to use if they can meet the criteria, but references to "individuals" should be removed.

Suggested Text of Revised Option 3:

Option 3: The *beneficiary* acquires/provides an attestation regarding the Date of Care Completion from his/her treating physician.

A. Before Settlement--When the *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 *beneficiary* would not require additional care related to his/her "settlement."

B. After Settlement--When the *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 *beneficiary* would not require additional care related to his/her "settlement."

Option 4: Based on the existing inefficiencies and use problems plaguing the current Workers Compensation MSA review process, a process limited to a subset of workers' compensation claim settlements, AIA's Task Force objects to extending the MSA process to the much larger universe of liability claims. The number of claims within the United States involving bodily injury payments is estimated in the millions annually. At present, this is a flawed process for the current volume of workers' compensation Medicare set-aside (WCMSAs) reviews, which are less than 30,000 annually.

The unintended consequences of offering this as an option in the liability setting will be numerous. Tort settlements will grind to a halt and administrative costs will increase exponentially. Already overburdened and underfunded state and federal courts will be unable to move cases. It will fail to assure CMS of the outcomes that it is seeking. Given that CMS does not recognize allocations, it will force parties into litigation in pursuit of certainty on issues such as the amount of "future medicals," if any. Settlements of multiparty litigation will be chilled since the beneficiaries will want to know exactly how much they will get, thereby not allowing parties to separately settle. Lastly, this option would pull insurers and self-insureds into a process that the ANPRM specifically applies only to beneficiaries and their representative. Liability insurers when settling claims *do not admit* to liability *nor do they have a statutory duty or ongoing responsibility for future medical care and payments*.

Option 5: AIA's Task Force acknowledges that these options are in existence today, but suggests that they are of little to no value given their limitations. To increase the viability and effectiveness of this option, AIA recommends the following changes:

- The $300 threshold should be doubled to $600,
- 25 % of a settlement under $5,000 requirement should be lowered to 10%,
- Option 5 should include ingestion, implantation or exposure injuries,
- The self-calculation timeframe should be reduced to 90 days.

Suggested Text of Revised Option 5:

Option 5: The beneficiary participates in one of Medicare's recovery options. The three recovery options are as follows:

- *$600* Threshold-- If a beneficiary alleges an injury, obtains a liability insurance (including self-insurance) "settlement" of *$600* 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 *10* percent of the gross "settlement" amount.

- Self-Calculated Conditional Payment Option--When a beneficiary alleges a physical trauma-based injury that occurred at least *90 days* 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.

Option 6: This option is acceptable with two changes. There is only one state (Michigan) that allows for lifetime medical coverage under No-Fault insurance and that should be specifically referenced in paragraph A as the only instance where no-fault insurance is implicated. In paragraph B, ongoing medical is never imposed, or demonstrated by or accepted by the defendant in liability claims. AIA's Task Force believes that the prior guidance in Option 5 is too high, 25% on $5,000 settlements is unreasonable. Option 6 B will only be viable if; CMS establishes a realistic percentage.

Suggested Text of Revised Option 6:

Option 6: The Beneficiary Makes an Upfront Payment

A. If Ongoing Responsibility for Medicals was imposed, demonstrated or accepted and medicals are calculated through the life of the beneficiary or the life of the injury.

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 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, *and Michigan* 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 have reviewed and approved a proposed MSA amount.

B. If Ongoing Responsibility for Medicals was Not Imposed, Demonstrated or Accepted.

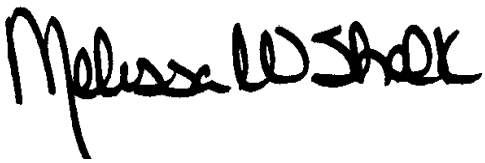
If a beneficiary obtains a "settlement," our general rule stated previously applies to the "settlement," the beneficiary may elect to make an upfront payment to Medicare in the amount of a specified percentage of "beneficiary proceeds." See our comment above. This option would most often apply in liability 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 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.

Option 7: In light of the numerous claims that have been and will be reported under MMSEA Section 111 when the thresholds drop to $300 in 2015, this option may be the best way to address this type of settlement in an expeditious manner. We suggest that due to compromises by beneficiaries, insurers and self-insureds in the settlement of claims that create allocation issues many claims might be deemed worthy of compromise by CMS.

Recommendations

AIA's Task Force suggests that no one option is the solution that will give beneficiaries and CMS their optimum outcome and no one option must be selected over all others. CMS should consider the use of these options in place of the WCMSA option currently in place today. Option 4 is categorically unworkable. The comments outlined above are offered to CMS to help create fair, effective and efficient processes to handle the repayment of conditional payments along with considering "future medicals" of current beneficiaries. AIA's Task Force looks forward to continuing to engage with CMS on this important topic and appreciates the efforts to address our principal concerns.

Respectfully submitted,



Peter R. Foley
Vice President Claims Administration

Melissa W. Shelk
Vice President – Federal Affairs