There Is No Free Lunch

Municipalities and Medicare

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Legislative amendment is required to fashion reasonable rules that parties can follow so that settling claims is not fraught with potential unknown and uncountable exposure.

Is a municipality immune from conditional payment liability under the Medicare Secondary Payer Act, 42 U.S.C. §1395y(b)(8)? No. This answer may surprise claims managers for public entities, but the law provides no protection whatsoever for municipalities. Not even federal government agencies are exempt. The rationale is simple: Medicare needs to be made whole. Social Security and Medicare represent 14 percent of the U.S. budget, and Medicare alone has an unfunded liability of $89 trillion. The unfunded liability is the difference between the benefits that have been promised to current and future retirees and what will be collected in dedicated taxes and Medicare premiums. Insufficient taxes are being collected, benefit payments exceed those taxes, and the shortfall must come from somewhere. Medicare has in its crosshairs defendants, both private and public, who must take on this burden, reimbursing Medicare for conditional payments made for an alleged accident.

This article will analyze whether and to what extent a municipality's duties are any different from those of the private sector's under the Medicare Secondary Payer (MSP) Act and will also suggest areas of best practices when handling personal injury claims involving Medicare beneficiaries. The new electronic reporting requirements set forth in amendments to the MSP Act in 2007 make it crucial that the liability practitioner—public or private—take into account the reimbursement amount owed Medicare and properly plan how the parties to a liability claim will deal with it *before* settlement to avoid unnecessary, contingent liability. The article will also address the recent uptick in federal court litigation involving confused parties' attempts to obtain finality for a litigated Medicare-related claim. The authors have concluded that legislative amendment is required to fashion reasonable rules that parties can follow so that settling claims is not fraught with potential unknown and uncountable exposure. Otherwise, the Medicare beneficiary—the person least able to absorb the risk—will more than likely become disenfranchised because of the complications the Medicare issues present.

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Essentially, the MSP Act does not distinguish between private and public entities. The trigger for conditional payment liability is the *payment* to a Medicare beneficiary in exchange for a release or judgment relieving the defendant from further liability for a personal injury claim, no matter how questionable that claim may be. The starting point for Medicare's inquiry is that Medicare paid for medical services that arose out of an accident, not who is responsible for the accident. This query starts early, with the Medicare beneficiary's first visit to a health care provider. The Coordination of Benefits Contractor (COBC) identifies a potential defendant or insurance plan by receiving information from health care providers identifying the defendant or plan as a potential source of primary payments. This information is then transmitted to the Medicare Secondary Payer Recovery Contractor (MSPRC). In turn, the MSPRC investigates and sends notification letters with its stated goal of recouping monies that Medicare paid on behalf of the injured beneficiary. Ignoring these letters may have dire consequences, such as exposure to double damages. *See* 42 C.F.R §411.24(c)(2).

The U.S. Government Will Sue for Recovery

A good example of the national government's focus on collecting Medicare payments is the case of *U.S. v. Paul J. Harris*, No. 5:08CV102, 2009 WL 891931, 2009 U.S. Dist. LEXIS 23956 (N.D. W.Va. 2009). In *Harris*, the government sued a settling plaintiffs' attorney to recover a portion of a Medicare reimbursement amount. After settling the case for $25,000, the defendant, an attorney who represented plaintiff in the underlying action, forwarded to the Centers for Medicare and Medicaid Services (CMS), the agency that administers Medicare and Medicaid, the details of the settlement payment, as well as his attorney's fees and costs. Then he distributed the settlement funds—before the MSPRC notified him of the CMS' demand for payment. The CMS then demanded $10,253.59, and the defendant did not respond. The U.S. government's motion for summary judgment was successful, and judgment was entered in the amount of $11,367.78 plus the amount of interest. *See id.* Mr. Harris lost because he became responsible as soon as a payment was made to the Medicare beneficiary for the settlement. It did not matter that he was not a party to the claim, or that the settlement proceeds, absent his fee, were distributed to the Medicare beneficiary. It only mattered that a payment was made, and under the MSP and related regulations conditional liability reimbursement was required. *See* 42 C.F.R §411.20(a)(2).

The MSP Act's recovery law and actions that the federal government may take are not limited to attorneys. Everyone associated with a personal injury claim—lawyer, defendant, third-party administrator or insurance carrier—is equally responsible. The court sets forth the following in *Harris*:

> To recover payment, the government may "bring an action against any or all entities that are or were required or responsible… to make payment with respect to the same item or service… under a primary plan." 42 U.S.C. §1395y(b)(2)(B)(iii). Alternatively, the government "may recover under this clause from *any entity that has received payment from a primary plan or from the proceeds of a primary plan's payment to any entity*." *Id.* (emphasis added in original). *See also Cox v. Shalala*, 112 F.3d 151 (4th Cir. 1997) ("In the alternative, the government's right of recovery is subrogated to the rights of an individual or entity which has received a payment from the responsible party."). The federal regulations implementing the MSPS provide the entities in which the government can recover primary payments: *Recovery from parties that receive primary payments.* CMS has a right of action to recover its payments from any entity, including a beneficiary provider, supplier, physician, *attorney*, State agency or private insurer that has received a primary payment. 42 C.F.R. §411.24(g). (emphasis added in original).

See Harris at *7–*8.

The *Harris* case is Medicare's way of serving notice to the plaintiffs' bar of its potential exposure under the law. There is no doubt that other examples will be made. A defiant municipality certainly could be next.

The Law of a Given State Does Not Matter: Medicare Wins

Many municipalities take the position that they are insulated by their respective laws against Medicare conditional payment reimbursement claims. At first glance, the position seems sound. However, federal law has a way of turning on its head the application or validity of local laws. We know, for example, that a Missouri wrongful death statute, Mo. Rev. Stat. §537.808, does not provide for recovery of medical expense by a settling party. A similar statute, which protects a tortfeasor from liability for medical expense costs paid by Medicare, exists in New Jersey; however, this applies to all tort claims. *See* N.J. Stat. Ann. §2A:15–97. Under these state laws, a plaintiff cannot recover Medicare-related expenses. It should follow that Medicare would not pursue reimbursement from parties litigating these claims in jurisdictions with these types of laws. Regrettably, this is not the case, and the CMS has created great uncertainty by reaching beyond these statutes to recover from settlement proceeds.

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In *Mathis v. Leavitt*, 2009 WL 211944 (8th Cir. 2009), plaintiffs commenced a wrongful death action in Missouri state court. The plaintiffs and the defendants agreed to a settlement. Medicare had paid $77,403.67 of Mr. Mathis' medical expenses. The plaintiff's estate argued that it had no duty to reimburse Medicare, based on the state's wrongful death statute explicitly stating this point of law. *See* Mo. Rev. Stat. §537.808. The liability insurer paid $77,403.67 to the state court registry pending resolution of the declaratory judgment action. A petition was initially filed in state court against the Department of Health and Human Services (HHS). The HHS removed the action to federal court. The district court granted summary judgment to the HHS, holding: "Settlement resolved plaintiff's claims for medical expenses; thus, Medicare had the right to reimburse-

ment under 42 USC §1395y." The plaintiffs appealed to the Eighth Circuit, and the Eighth Circuit affirmed.

The same conclusion was reached by the federal court that decided a case involving the New Jersey statute. In *Merrifield v. U.S.*, 2009 WL 1916328, 2009 U.S. Dist. LEXIS 55377 (D. N.J. 2009), the plaintiffs, all New Jersey residents, commenced an action against the U.S. government and the HHS on a theory that the defendants wrongfully, and in violation of the plaintiffs' constitutional due process rights, demanded reimbursement for those medical expenses under to the MSP Act. Plaintiffs argued that CMS was not entitled to reimbursement under the MSP Act because the plaintiffs' medical expenses were not by law an element of recovery against a tortfeasor. *See* N.J. Stat. Ann. §2A:15–97. The plaintiffs did not prevail, even though they did not recover for medical expenses. They still were required to reimburse Medicare.

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Deference to Agency Action: Successful Challenges to Medicare Are Extremely Rare

The *Merrifield* case is an important reminder of the deference that the federal courts give to the agency that administers Medicare—CMS. That agency has an overwhelming need to bridge the gap between Medicare's promised benefits and what Medicare has on hand to make these payments. Today, Medicare and Social Security consume 14 percent of general income-tax revenues. Ten years from now that consumption will almost double to 27 percent and double again in another 10 years. According to the 2009 Social Security and Medicare Trustee's Reports, without a tax increase, it will be increasingly difficult for the government to continue spending on other initiatives. Congress has, therefore, granted the CMS a great amount of latitude to locate other funding sources.

Consequently, local law has become somewhat irrelevant. What is important is the integrity of the Medicare program in delivering its promised benefits. The *Merrifield* decision demonstrates that there is a price paid for such policy, and the hidden costs that exist are clearly evident. Analyzing *Merrifield* further explains why the CMS does not allow its administrative law judges to hear non case-specific challenges about whether the MSP applies to certain kinds of funds. *See* 42 C.F.R. §405.926(j). As stated in *Merrifield*:

> Pursuant to that regulation, it appears that there is no right for a Medicare beneficiary to appeal the Agency's general determination that lump sum personal injury settlements in New Jersey require MSP reimbursement. Instead, each beneficiary must appeal the determinations made in his or her own case.

A case-by-case review increases the potential for recovery. Access to the federal court is extremely limited unless administrative remedies are exhausted. Fully exhausting remedies could take several years. 28 U.S.C. §1331 authorizes parties to commence actions in federal court to redress claims based on federal statutes and regulations. The MSP Act amended that right with respect to claims involving Medicare. 42 U.S.C. §1395ii, which incorporates 42 U.S.C. §405(h), does not allow any tribunal to review any findings of fact or decision by the agency, except as provided under 42 U.S.C. §405(g). This prohibition of jurisdiction includes constitutionally based claims, which must be redressed through agency appeals before they may be asserted in federal court.

To dispute a Medicare claim, a municipality will need to tender the conditional payments that are owed and assert its defenses before the agency, or otherwise be subject to a penalty and interest. If a municipality is successful, the result cannot be used as precedent for subsequent cases. It must be reasserted. Precedent can only be established if a municipality reaches federal court. The hurdle, therefore, is properly obtaining access to the federal court. Until a judicial determination is made about the applicability of a local law, the MSP Act will control.

Municipalities Are Not Exempt from Electronic Reporting under the MSP Act

To understand Medicare's position regarding the applicability of the MSP law to municipalities, review some of the statements made during conference calls over the last several months. The CMS website contains transcripts from all these conferences. *See* https://www.cms.hhs.gov.

On March 24, 2009, a CMS representative gave the following answer with respect to state municipal risk management:

> **CMS Representative:** We had another question that asked about a state municipal risk management authority where the state law says that business is not insurance and their actions aren't the transaction of insurance. For purposes of this reporting its *CMS's definitions that control not state law*. So we do consider that to be a situation that needs to be reported.
>
> Another state made the comment that medicals remain open in their state and that they believe that this should preclude the need to report ongoing responsibility for medicals. We disagree and we've said in all the teleconferences and in the user guide that ongoing responsibility for medical does need to be reported.
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> . . .
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> **CMS Representative:** We received several questions about government; *whether or why different levels of government should be included as a responsible reporting entity*. They are engaged at minimum in the business of government; *we consider them to be a responsible reporting entity if they don't hold separate policies*.

See http://www.cms.hhs.gov/MandatoryInsRep/Downloads/MMSEA111March24NGHPTranscript.pdf (emphasis supplied).

On April 9, 2009, a CMS representative asserted that even federal agencies have to comply with the MSP law:

> (**Questioner**)**:** Yes, good afternoon. Miss XXX, in earlier calls and in conversations you had mentioned the—that you were going to speak with the United States Department of Labor in concern—*concerning some of the federal programs*. In our case here at XXX the long shore program that we're con-

cerned about. And I have not seen anything since. I understand a meeting has taken place. I was wondering if we can expect any more information in regard to the federal workers compensation programs?

(**CMS Representative**)**:** We did receive some data from them relatively—not data, some information from them relatively recently about the various (programs) under their purview and we are—that's under review right now.

(**Questioner**)**:** Okay so in other words we should be just—should we be expecting something—a change or not or plan to go forward as is or…

(**CMS Representative**)**:** *Well to the extent that you are—have an individual responsibility as an insurer as opposed to an action on behalf of the government at this point it looks like pretty much you'll be going forward.*

See http://www.cms.hhs.gov/MandatoryInsRep/Downloads/April9NGHPTranscript.pdf (emphasis supplied).

Medicare will require an entity to comply as long as it is responsible for a settlement, award, judgment or other payment to a Medicare beneficiary, whether the entity is private or a local, state or federal agency or entity, without exception. In short, a municipality must report all settlements, awards, judgments or other payments to Medicare and is as responsible as a private entity under the regulations to pay Medicare if the agency or its contractor asserts a conditional payment claim.

Contingent Liabilities on the Horizon

Best Practices

The CMS's new electronic reporting requirements, enacted at the end of 2007, make settlements transparent and serve as a catalyst for contingent liabilities. Most of us are familiar with the $1,000 per day per unreported claim penalty, which is the single driving force within Medicare reporting forcing compliance. While it is important to know about this penalty and to gear up a claims system to identify Medicare beneficiaries, this fine alone should not drive best practices.

To comply with Medicare reporting, obtaining the proper information from the Medicare beneficiary is critical, so that information in a settlement, award, judgment or other payment matches Medicare records. It is the responsibility of the Responsible Reporting Entity (RRE) to collect this information. The RRE is essentially the insurance carrier or self-insured entity. The law does not mandate that a Medicare beneficiary produce this private information; in fact, agency practices teach a Medicare beneficiary to withhold it. Nonetheless, the RRE is subject to penalty, even if it has in good faith attempted to obtain the information and later determined that a Medicare beneficiary was involved in a settlement, award, judgment or other payment.

The collection of this information will increase claim costs. Take care to train claim professionals to seek this information without triggering litigation. Assuming that this private information is collectable, the claims practitioner has yet another hurdle to overcome that increases cost to the case and that is settlement negotiations. In the past, a plaintiff was responsible for the Medicare reimbursement amount and the terms were governed by the settlement agreement or release. The new reporting requirements inform Medicare of the settlement. If proceeds are distributed *before* understanding what is owed to Medicare, the RRE may be responsible for reimbursing Medicare under 42 C.F.R. 411.24(i).

In conference calls, Medicare has stated its intention to pursue the Medicare beneficiary for reimbursement: "If you've got a situation involving worker's comp, liability, no fault, CMS's standard procedure is to pursue recovery from the beneficiaries when there's been a settlement, judgment or award with the beneficiary." *See* CMS Town Hall Transcript, Jan. 22, 2009. However, the MSP Manual, published by Medicare, states otherwise: "Contractors will always try to recover any Medicare payments directly from the insurer before the proceeds of an award or settlement are disbursed." *See* MSP Manual, Chapter 7, §50.53.3. Furthermore, the fact that a settlement has been made between the beneficiary and the liable party does not, necessarily, bind Medicare to that settlement. If the liability insurer was aware of Medicare's interest, but Medicare was not consulted in the settlement, Medicare may pursue the balance of its claim, over and above any amount granted to it in the settlement, against the liability insurer. *See* 42 C.F.R. 411.24(i). The statute as amended in 1980 gives the government the right to recover Medicare payments from liability insurers even if the insurer has already made a liability insurance payment. If the liability insurer does not properly pay Medicare, Medicare has the right to take legal action against the insurer and to collect double damages.

Distributing settlement proceeds requires great care so that they reflect best practices that deal with these issues *presettlement* rather than *after* a settlement offer has been accepted. When Medicare is involved, the terms of a settlement agreement or release become very important because these documents govern the rights of the parties post-settlement. To avoid unnecessary bad-faith issues, draft these documents carefully so that they include a number of provisions to protect the RRE should Medicare request reimbursement. Counsel will need to be extremely careful because these documents will become the centerpiece of subsequent disputes that could arise from inquiry by Medicare *after the fact*. Some of examples of the types of provisions and documents requiring scrutiny are waiver of private MSP-law cause of action by the beneficiary, cooperation clause, survival of Medicare consent form and a disbursement timetable.

Additional costs to the insurer will arise from dealing with the MSPRC, which controls information about the medical services. A consistent approach with a contractor is advisable to encourage prompt responses. Also, developing a relationship with a Medicare beneficiary is critical to ensure that you receive information from him or her quickly, as soon as the contractor makes it available to the Medicare beneficiary under the "MSP" tab of his or her MyMedicare.gov personal site. This information from the MSPRC is critical. Without it, a liability practitioner cannot settle a claim in a way that prevents paying Medicare twice. However, even with all available knowledge, a practitioner may have difficulty resolving a case.

Medicare Expects Dollar-for-Dollar Recovery

The Medicare Secondary Payer Act is not concerned with fault. The trigger for responsibility under the act is *payment*

of a settlement, award, judgment or other payment to a Medicare beneficiary. Consequently, handling settlements creates challenges for counsel in cases in which liability is contested but injuries are catastrophic. Medicare will want 100 cents on the dollar, yet a settling party may be less than one percent at fault. Economically, it often makes good business sense to resolve a case with high damages but low liability. If this type of case involves a Medicare beneficiary, however, settlements simply cannot be negotiated. How can a Medicare beneficiary plaintiff accept a settlement if Medicare requires that plaintiff to pay all of it to Medicare? The answer is that he or she will not, unless a defendant is willing to pay a good deal more than the plaintiff's Medicare payment amount.

If proceeds are distributed *before* understanding what is owed to Medicare, the RRE may be responsible for reimbursing Medicare.

Take the case, for example, of *Hadden v. U.S.*, 2009 WL 2423114, 2009 U.S. Dist. LEXIS 69383 (W.D. KY, Aug. 6, 2009). In *Hadden*, the plaintiff, a pedestrian, was injured when he was struck by a utility truck. The utility truck lost control when another car forced it off the road after ignoring a stop sign. The car responsible for setting the events in motion was never identified, and the plaintiff sustained serious injuries for which Medicare paid.

When the case settled, the plaintiff agreed to a nominal amount from the truck company, compared with the amount to which he would have been entitled from the party who ran the stop sign. The utility company settled for economic reasons, probably to avoid unnecessary litigation costs. However, clearly its legal exposure for the accident was minimal. After all, the utility truck was forced off the road by a car that blew through a stop sign. The plaintiff agreed to be responsible for Medicare, and Medicare decided to take most of the settlement, which surprised the plaintiff.

The plaintiff appealed Medicare's position, advocating that the CMS should reduce the amount it requested in reimbursement to line up with the fault allocation as outlined in the settlement documents. The agency disagreed, and so did the district court, which required the plaintiff to give most of his settlement to Medicare.

The unfortunate outcome of the *Hadden* decision demonstrates that the values that parties once assessed as reasonable in resolving these matters short of trial are no longer valid. If Medicare demands full reimbursement, public policy promoting settlements will be turned on its ear. Economics will dictate trial over settlement, and the outcome of a trial is never a guarantee. In fact, a recent study found that the verdicts that plaintiffs received were 40 percent less compared with what they were offered in potential settlements. *See* Randall L. Kiser, Martin A. Asher & Blakeley B. McShane, *Let's Not Make a Deal: An Empirical Study of Decision Making in Unsuccessful Settlement Negotiations*, Journal of Empirical Studies, Vol. 5, Issue 3 (Sept. 2008).

Federal Court Litigation Increases as Litigants Seek Medicare-related Claim Finality

Medicare's insistence on a dollar-for-dollar payback, irrespective of a defendant's fault, is but one example of increasing the number of cases that must be tried to verdict, increasing dockets in nearly every jurisdiction. Furthermore, Medicare's failure to accept the allocation of settlement proceeds to the different categories of damages is also problematic. New statutory requirements generally create new points of law, and from litigation, consensus emerges to give litigants direction. This particular MSP Act issue, however, is quite procedural in nature, and litigation has not provided clarity. For instance, in *Herb v. Ansurt, et al.*, 2009 U.S. Dist. LEXIS 621 (E.D. P.A. 2009), the federal magistrate concluded that meaningful settlement discussion could not occur without lien information from Medicare. The court ordered the MSPRC to explain why the final amount of its lien could not be provided to the plaintiff in a timely fashion, defined as "in 30 days." If it couldn't, the order would become absolute and the MSPRC had to provide the information by a certain date. In conversation with counsel for the defense, these writers were told that that the MSPRC completely ignored the order; however, the final payoff information was received within a few months of the decision.

In *Tomlinson v. Landers*, 3:07-CV-1180-J-TEM, 2009 WL 1117399, U.S. Dist. LEXIS 38683 (M.D. Fla. 2009), the defendant moved to enforce a settlement agreement with the plaintiff. In *Tomlinson*, the defendant was insured under a policy with $100,000 policy limit. The defendant issued a joint check to the plaintiff and CMS because the defendant received notice indicating it might have to reimburse Medicare. There was no prior discussion about this with plaintiffs' counsel, the check was returned, and the plaintiff's counsel requested that insurer reissue the check. The court rejected the settlement, holding there "was no meeting of the minds." The insurance carrier responded that it had to include Medicare, citing 42 C.F.R. 411.24(i), which indicated that the carrier *might* be responsible to pay Medicare. The court held that there is no requirement that a defendant list Medicare as a payee on the check, although CMS has recommended this practice in educational programs. This practice would be in the "best interest" of the carrier, but certainly not a requirement of the law.

The same issue was litigated in *Wall v. Leavitt*, Civ. No. S-05-2553 FCD GGH, 2008 WL 4737164, 2008 U.S. Dist. LEXIS 89880 (E.D. Cal. Oct. 29, 2008), and the court arrived at a completely different conclusion: "While recognizing in many cases, that including Medicare as a payee on one check (which realistically means that Medicare must ultimately negotiate the check and place all the MSP and non-MSP money in its accounts), will inevitably cause a delay in return of non-MSP monies to a beneficiary, there appears to be no other viable mechanism with which to retain Medicare's priority of recovery on MSP monies." *Id.* at 39.

It should be noted that, during a conference call, a CMS representative stated the following on this point:

(**CMS Representative**): Nothing has changed in any of our recovery processes or the underlying statute or regulations for that. As we've said our standard process is to *pursue recovery against the beneficiary's settlement, judgment or award or other payment.*

Insurers who wish to protect themselves may do it in a variety of ways; we've heard of situations where if the attorney holds on to the check until he has the demand amount and goes back to the insurer the insurer will trade it in or replace it with two checks, one specifically to Medicare for the correct amount and one to the beneficiary and their attorney in place of what started out as a three-party check.

Or they may simply only do a three-party check. Or, you know, however they wish to handle it. But I mean that hasn't changed and it's not part of the Section 111 reporting process.

See https://www.cms.hhs.gov (emphasis supplied).

Why Not Adopt an *Ahlborn*-Like Formula?

Congress must amend the MSP law to include levels of fault, much as the U.S. Supreme Court decided in *Arkansas Department of Health and Human Services v. Ahlborn*, 547 U.S. 268 (2006). In 1996, Heidi Ahlborn, 19 years old at the time, was seriously injured in a car accident with the defendant. Ms. Ahlborn received $215,645 in medical benefits under the Medicaid program administered by the Arkansas Department of Health and Human Services (ADHS), and she assigned her right of recovery against the tortfeasor in the amount of the Medicaid payments. Ms. Ahlborn settled with the tortfeasor for $550,000, which, by all accounts, was a fraction of the total value of the damages. The parties, in fact, stipulated that the total value of Ms. Ahlborn's claim was over $3,000,000. In a decision written by Justice John Paul Stevens, the U.S. Supreme Court held that the "Arkansas statute automatically imposing a lien in favor of the ADHS on tort settlement proceeds was not authorized by the federal Medicaid Law…." *Id.* at 268. The Court held that if the plaintiff compromised for one-sixth of the total loss, then the ADHS should also collect only that amount, one-sixth of $215.645, or $35,581.47.

The defendant in *Ahlborn* was a municipality, and municipalities across the country have had to adapt their lien systems to accommodate this decision. The reasoning in *Ahlborn* begs the question, if municipal Medicaid programs must compromise their liens, why must not Medicare compromise its reimbursement claims? Given that the U.S. government seeks maximum reimbursement amounts, why does Medicare expect a dollar-for-dollar recovery if public policy finds settlements desirable? Currently, many trials that would have previously resulted in settlement will have the unintended consequence of securing less money for Medicare reimbursement.

Conclusion

A new dawn has risen in the administration of municipal liability claims. Reporting is an issue that all entities—public or private—will soon overcome. The tsunami that no one sees is how Medicare will treat the information from the well over 2.7 million liability claims that are reported each year. The CMS has been charged with increasing recovery of conditional payments. If a liability claims administrator is not prepared for the Medicare agenda, great resources will be expended responding to MSPRC inquiries concerning conditional payment reimbursement. Your best defense is to have a best practices plan in place to address these inquiries, and, when possible, to prevent them. Appropriate resources and investment is required now to avert the unavoidable surge in inquiries from Medicare.

We all know that Medicare is broke. We also know that if Medicare pays for medical expenses to a beneficiary harmed by another's negligence, then the tortfeasor should reimburse Medicare. However, Medicare and the CMS and its contractors, the COBC and MSPRC, will need to devise a better reporting mechanism that guarantees quicker communication of the total reimbursement amount related to a tort. Congress will also need to seriously consider amending the law to incorporate an *Ahlborn*-like formula. Municipalities across the country are compromising liens in line with the *Ahlborn* decision. If Medicare will not compromise its claimed reimbursements amounts in proportion to plaintiffs' compromised settlements, trials will result. Medicare will receive even less reimbursement than it would have through reasonable settlements.

All litigants, private and public, as well as insurers, third-party administrators, self-insureds, plaintiffs and plantiffs' counsel will be affected by the MSP law. Attorneys for the defense of private entities and municipalities should proactively handle a claim involving a Medicare beneficiary. As practitioners, we can no longer wait for the eleventh hour to begin discussions with Medicare. We request that Medicare do likewise by providing timely and accurate information about Medicare reimbursement amounts. The Medicare Advocacy Recovery Coalition (MARC) has already made a positive impact to change the current law and will continue to raise awareness about its present consequences. MARC could certainly use financial help and support as it continues to effect positive change in the MSP law. *See* http://www.marccoalition.com/. Our collective effort can make a difference. No one is asking for a free lunch. FD