LIEN RESOLUTION SERVICES, LLC
d/b/a LIEN RESOLUTION USA

www.lienresolutionusa.com

Main Office:
3000 Town Center Drive
Suite 1800
Southfield, MI

P (877) 601-0611
F (248) 351-2211

August 13, 2012

Centers for Medicare & Medicaid Services
Department of Health and Human Services
**Attn: CMS-6047-ANPRM**
P.O. Box 8013
Baltimore, MD 21244-8013

**Re: File Code CMS-6047-ANPRM**
**Public Comment**
**Medicare Program; Medicare Secondary Payer and "Future Medicals"**

Dear Sir/Madam:

Please accept this comment on behalf of Lien Resolution Services, LLC ("LRS") and all those whose signatures follow.

## 1. Introduction

Any rule requiring all cases classified by the MSPRC as "liability" to prepare a Medicare Set-Aside ("LMSAs") would be detrimental to both the Medicare system and its beneficiaries. This is not a question of standardized rules, but rather, it is a question of sustainability. Personal injury cases will become untenable if CMS requires repayment for "future medicals." This harm would greatly reduce Medicare's recoveries of conditional payments as well as proposed recoveries for future payments because plaintiffs and their attorneys would no longer bring those cases.

Any rule requiring LMSAs fails to consider the radical differences between liability cases and workers' compensation cases (where MSAs were first developed). These differences will illustrate the unfair nature of LMSAs. They will also show a general inability to calculate LMSAs adequately serving both CMS and the beneficiaries' interests.

All rules proposed by CMS in Volume 77, Number 116 of the Federal Register will irreparably harm the both plaintiffs and personal injury practice, in turn, shifting the *full burden* of past, present, and future medicals to Medicare.

## 2. CMS/Medicare's Current Legal Right to "Future Medicals" is Tenuous

Under current statutes, federal regulations, and case law, CMS's right to future medicals in liability cases is tenuous at best. The Medicare Secondary Payer ("MSP") statute states that Medicare shall not make payment where "payment has been made or can reasonably be expected to be made under … an automobile or liability insurance policy…" 42 USC 1395y(b)(2)(A)(ii).

This statement is used by CMS to assert a right to the amount *it calculates* as being the full cost of future medical treatment related to a lawsuit. However, the term "payment has been made" simply does not encompass all future medical treatment.

Settlements *can* include repayment for *some* medical expenses. There is no requirement that settlements must include payment of medical expenses. This is true even where a settlement release uses multiple sections and pages to state the settlement releases the defense from any and all future payments relating to that incident. A situation could exist where the plaintiff was unable to prove future medical treatment is necessary, but CMS, through the proposed rules could claim an entitlement to future medicals. This scenario is possible even in settlements.

Next, the ANPRM states, "…section 1862(b)(2)(B)(iii) of the Act provides a direct right of action…to recover conditional payments." The ANPRM also implies Medicare is entitled to take direct action to recover for future medicals, but fails to cite where that recovery is allowed in the statutes. Until CMS provides guidance as to why and where the statutes allow Medicare to recover for future medicals, any and all public comment is incomplete.

Medicare's right to future medicals assumes payment for future medicals has indeed been made in settlement – but liability settlements have too many parts to make that assumption. The cited language from 1395y(b)(2)(A) requires a leap of faith to show that Medicare has a right to an LMSA.

### a. Liability Settlements vs. Workers' Compensation Settlements

An LMSA is neither feasible nor useful to protect Medicare from paying future medicals relating to liability lawsuits. The reasons for this non-feasibility begin with the extensive differences between the Liability and Workers' Compensation systems of recovery for injuries. Workers Compensation allows automatic compensation for on-the-job injuries whereas Liability is a fault-based system. Liability case limitations are vast:

1. Injured plaintiffs (serious or otherwise) almost always recover only partial compensation for their injuries due to:
    a. the defendant's inadequate or substandard insurance coverage;
    b. statutory caps on the liability of governmental defendants; or,
    c. statutory caps on non-economic damages;
2. A plaintiff's recovery may be reduced due to his own contributory fault, which in many jurisdictions reduces their recovery by their own percentage of fault; and,
3. The majority of liability cases are settled, and settlements involve a compromise on many forms of damage that affect a plaintiff's likelihood of success at trial.
4. Liability cases include many different areas of recovery, such as:
    a. Past medical bills;
    b. Pain and suffering;
    c. Lost wages;

d. Loss of future earning ability;
e. Loss of consortium;
f. Loss of companionship;
g. Non-medical costs resulting from injury;
h. Non-medical care and assistance; and finally,
i. Future medical bills.

Those different areas of recovery are *not* usually distinguished or broken down in an allocation of settlement; and, even if they are, Medicare's agents refuse to acknowledge those allocations unless they are made by a judge/jury on the merits of the case. This means Medicare's agents require a mini-trial where settlement was used to avoid the costs of trial. Such processes are often too expensive to warrant their use. Without a fair and reasonable method to determine allocation of settlement (and from what portion future medicals can be taken), any system for future medicals will be a detriment to Medicare and its beneficiaries.

None of the seven options proposed by CMS accounts for these nuances in the allocation of liability settlements.

**b. CMS's Current Backlog of Workers' Compensation MSAs Creates an Unworkable and Burdensome System of Backlog for LMSAs**

CMS's current backlog in approving WCMSAs currently approaches 8-9 months. This results in an 8-9 month delay of settlement. The addition of LMSAs to the already overburdened and backlogged system is simply unfair and unduly burdensome for the plaintiff, his attorney, the defense, and the defense insurance companies. All parties will suffer as a result of the delays.

**c. These Proposed Rules are Invalid and Lack Force of Law**

No *regulations* require MSAs in tort settlements. Any attempt to require one would be invalid unless promulgated by Health and Human Services ("HHS"), and not CMS, because the MSP statute shows that Congress did not delegate authority to HHS to require MSAs in the settlement of tort cases without promulgating regulations that authorize CMS to do so.

These rules must be promulgated *as Federal Regulations* by the Secretary of HHS if they are to have the force of law. While CMS has favored memoranda in recent years, CMS memoranda are not sufficient to create these rules.

**3. Comment on the Proposed Definitions in the ANPRM**

CMS has requested comment on the definitions of five phrases as well as a possible reliance on the Injury Severity Score ("ISS") in relation to the seven options for future medicals. We will list the CMS language and respond with our comment for each:

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

This definition appears fair, although perhaps incomplete. A review of medical dictionaries shows that "chronic" is appropriately considered in the above definition; however, additional explanation could include a statement that it *does not* refer to acute illnesses/diseases and that the symptoms of chronic illnesses/diseases are sometimes less severe than those of the acute phase of the same disease.

b. **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."

This definition is unusable. There is a minimal likelihood a physician will indicate treatment is absolutely and certainly complete. First, there are concerns that a disease, illness, or condition could return sometime in the future. Second, and as a result of the first point, physicians will likely be afraid to make such absolute statements *unless* a safe-harbor is provided to them. Perhaps it is enough to add a simple statement that the physician, "…must be able to attest**, in good faith and in his/her best opinion**, that the individual/beneficiary has completed treatment…" Without such addition, a physician will fear the repercussions of even a minimal chance he is incorrect.

c. **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."

This definition has multiple problems. The first is that it conflicts with the MSP Manual where it states, "There should be no recovery of benefits paid for services rendered after the date of a liability insurance settlement." For years, this manual, intended for CMS contractors, has clearly directed those contractors not to recover benefits for services rendered after the date of settlement. Ctrs. Medicare & Medicaid Servs., *Medicare Secondary Payer Manual* ch.7 §50.5 (Mar. 20, 2009), www.cms.gov/manuals/downloads/msp105c01.pdf. The manual would require change if any of these rules can apply.

The second problem is that it applies to a non-existent series of items and services by saying "received" instead of "receives." It essentially applies to any future medical care after it happened which could create perpetual, ongoing liability for the settling parties.

Finally, the third problem is it conflicts with a more logical definition of the term "Future Medical Care" or "future medicals." That definition would mean *any* case-related medical care to be incurred after the date of settlement. If Medicare contractors were to assume "future medicals" meant care that Medicare pays, they would misread most settlement releases and judgments that are not in the practice of using Medicare-specific definitions. Even "notice" of this Medicare-only definition would not solve that problem. "Future Medical Care" and "future medicals" should mean what they logically seem to mean: all future care. If Medicare would like to differentiate in shorthand to mean "Medicare-covered future care," it should use a term such as "Medicare futures" or "Medicare future medicals."

**d. 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 an injury caused by blunt object or collision with blunt surface (as in a vehicle accident or fall from a building)."

This definition of physical trauma is sufficient. Additional explanation could be provided to include discussion of abrasions, fractures/breaks, contusions, etc.; however, physical trauma is generally understood to include these injuries anyway, and, the listed definition can be read to include them as well.

**e. 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.
- External."

Reliance on the ISS could be confusing and unreliable because different parties might score the injuries differently. This is especially true if plaintiff and defense each employ their own medical professionals to score the injuries (while also perhaps utilizing an original treating doctor's score). The use of ISS is simply too subjective. Nonetheless, it is commonly understood that an ISS greater than 15 is defined as a major trauma.

**4. Discussion of CMS Proposed General Rule**

CMS's proposed general rule is:

> 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 outlined …

**a. CMS General Rule is Unworkable Due to Conflict with Legal Standards of Proof**

CMS's general rule fails to consider civil law standards of proof. A plaintiff does not prove his need for future care is "reasonably anticipated," he proves future care by a "preponderance of the evidence." This in turn means he proves his case by a more likely than not standard. Reasonable anticipation seems like something less than preponderance of the evidence.

Moreover, discussion of "reasonable anticipation" as a legal standard is limited. In evidence preservation litigation, reasonable anticipation is governed by the *Zubulake* Standard for "reasonable anticipation of litigation." See *Zubulake v. UBS Warburg*, 220 F.R.D. 212 (SD N.Y.2003). That standard provides litigation is *reasonably anticipated* at "such time when a party is on notice of a credible probability that it will become involved in litigation." Does this mean an MSA is only necessary where care is probable? What denotes probability of certain care occurring?

More important, CMS does not recognize such standards of probability when determining WCMSAs. It seems to require all possible care and durable medical equipment be included in an MSA.

Switching to negligence law, foreseeability (proximate cause) is established by proof that the actor, as a person of ordinary intelligence and circumspection, should reasonably have foreseen (or, *reasonably anticipated*) that his or her negligent act would imperil others. Applying this view of reasonable anticipation is unworkable. Nurses and doctors will disagree on what is an ordinary course of treatment for each patient. They will even disagree on what treatment can be reasonably anticipated. Giving unnamed, potentially uneducated (medically) CMS workers the power to adjudicate such decisions is counter to all legal principles.

If the law provides for different meanings for the standard of "reasonable anticipation," how can CMS use it to deprive plaintiffs' of a portion of their settlements? Additionally, how can CMS use a standard different than that for which the plaintiffs recover? The use of reasonable anticipation is unworkable and creates a legal right of action against CMS.

**5. Discussion of Seven Proposed Rules**

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

This option is what the MSA industry calls a "Poor Man's MSA." This option is not an option at all. It is simply a plaintiff's gamble. CMS states, "[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." Upon review it is likely CMS would take a subjective view of what is and is not case-related. This option is therefore unworkable as a disagreement would occur between plaintiff/beneficiary and CMS.

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

- ***i. The amount of liability insurance (including self-insurance) "settlement" is a <u>defined amount</u> or less and the following criteria are met:***
  1. ***The accident, incident, illness, or injury occurred one year or more before the date of 'settlement;'***
  2. ***The underlying claim did not involve a chronic illness/condition or major trauma;***
  3. ***The beneficiary does not receive additional 'settlements;' and,***
  4. ***There is no corresponding workers' compensation or no-fault insurance claim.***
- ***ii. The amount of liability insurance (including self-insurance 'settlement' is a <u>defined amount</u> or less and all of the following criteria are met:***
  1. ***The individual is not a beneficiary as of the date of 'settlement;'***
  2. ***The individual does not expect to become a beneficiary within 30 months of the date of 'settlement;'***
  3. ***The underlying claim did not involve a chronic illness/condition or major trauma;***
  4. ***The beneficiary does not receive additional 'settlements;' and,***
  5. ***There is no corresponding workers' compensation or no-fault insurance claim.***

This option is not a workable option either. Assuming the "defined amount" is a small recovery, this option essentially states that Medicare will not pursue future medicals where future medicals are not recovered. Even if the defined amount were something where recovery of future medicals is plausible (for instance, $250,000 or more), these factors limit future injury cases to mild-moderate trauma/physical injuries that happened more than one year previous. Such cases more often than not have limited medical needs after settlement.

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

This option *might* be workable if, and only if, the doctor is provided some sort of good faith standard. As noted above, there is a minimal likelihood a physician will indicate treatment is absolutely and certainly complete. First, there are concerns that a disease, illness, or condition could return sometime in the future. Second, and as a result of the first point, physicians are likely fearful to make such absolute statements *unless* a safe-harbor is provided to them. Perhaps it is enough to add a simple statement that the physician, "…must be able to attest**, in good faith and in his/her best opinion**, that the individual/beneficiary has completed treatment…" Without such addition, a physician will fear the repercussions of being incorrect. No such attestations will ever be provided and this option then becomes useless.

***d. Option 4. The individual/beneficiary submits proposed Medicare Set-Aside Arrangement (MSA) Amounts for CMS' Review and Obtains Approval.***

This option is theoretically workable; however, it has many pitfalls. This option refers to a true LMSA.

**i. CMS is Unable to Handle Current WCMSA Workload**

The first concern for true LMSAs is that CMS seems unable to cope with the current workload for WCMSAs. The addition of LMSAs to current CMS workloads would at least double the approval timeframe. Currently, 8-9 month timeframes are experienced throughout the MSA industry.

**ii. LMSAs are Unworkable Without Recognition of Allocations**

The second concern for true LMSAs is the marked difference between liability and workers' compensation. Where workers' compensation cases have relatively simple and spelled-out allocations of different forms of damage and recovery, liability cases do not. However, liability cases have many more forms of damages and recoveries than workers' compensation cases. As a result of the many forms of damages and recoveries, an LMSA could and should be limited only to a fair assessment of the future medicals.

CMS cannot fairly assess future medicals. At the same time, CMS cannot require a hearing on the merits to find a fair allocation of the settlement because such a hearing is tantamount to forcing <u>all</u> liability cases to trial or mini-trial. These hearings could cost tens of thousands of dollars and could easily destroy the legal industry for cases valued under $100,000.00. The system is unworkable unless CMS recognizes allocations as reported by plaintiff attorneys and defense attorneys. Most plaintiff attorneys, defense attorneys, and plaintiffs will not cooperate

with a system that does not account for the different forms of recovery in liability cases. As noted above, these forms of recovery include, but are not limited to:

j. Past medical bills;
k. Pain and suffering;
l. Lost wages;
m. Loss of consortium;
n. Loss of companionship;
o. Non-medical costs resulting from injury;
p. Non-medical care and assistance; and,
q. Future medical bills.

### iii. LMSAs *Must* Include Reductions Pursuant to 42 CFR 411.37

Liability lawsuits are not settled without the work of attorneys. Medicare only receives a recovery as a result of attorney work. This means that 42 CFR 411.37 must be extended to proportionate reductions for LMSAs if CMS is to expect attorney cooperation. Any LMSA should then be reduced by the proportionate amount of attorneys' fees and case expenses/costs incurred to procure that settlement and corresponding LMSA.

### iv. CMS Should Show the WCMSA Process Benefits Medicare Prior to Instituting Any LMSA Process

As of 2007, CMS claimed savings of $180 Million in 2005 and $390 Million in 2006 due to the WCMSA program. Unfortunately, it is impossible to find resources with raw statistics in the two month timeframe allotted for comment on this ANPRM. These statistics are taken from Protocols, LLC's August 23, 2007 blog post regarding the CMS's release of performance statistics in 2007.

We question these savings. First, those 2007 statistics claimed a $187 cost per case review with 64 full-time employees (or contractors' employees) involved in the review process. Does the $180M/$370M saved include that cost? On top of that costs, does the savings include actual amounts paid out by beneficiaries, or is it an estimate based on allocations reviewed by CMS?

We question the actual savings because the MSA allocation industry openly mocks the creation of MSA accounts. Common jokes within the industry include calling MSA accounts the "boat fund" for individuals whose cases recently settled (referencing beneficiaries taking their MSA allotments for down payments on motor boats). The true concern is whether self-administered MSA accounts actually are used for their intended purpose. If they are not used for their intended purpose, the $180M saved in 2005 and the $370M saved in 2006 likely was not saved. CMS's lack of a large staff to oversee and audit MSA accounts is partially to blame.

Another MSA allocation firm requested CMS performance statistics for 2005 to 2009. A compilation of those statistics can be found at https://members.royal-medical.com/files/ROYAL_MSA_CONSULTANTS_PRESS_RELEASE_TEMPLATE.pdf. Those statistics show that 85.2 percent of the 4,516 listed MSAs were self-administered. By 2009 the self-administration number had risen to 96.0 percent. It is ignorant to think that a high percentage of self-administered MSAs were properly administered. The injured beneficiaries lack the requisite medical knowledge to follow an MSA and they lack the motivation to try to administer the MSA.

These statistics and CMS's inability to account for a percentage of properly administered WCMSAs leads us to believe CMS cannot handle the workload of LMSAs and that requiring such would only benefit the MSA allocation firms (including LRS). CMS and Medicare might actually be hurt by requiring LMSAs because the huge amount of small value cases would likely plummet (it is difficult enough as it is to convince plaintiffs to accept settlements where they only take home 30 percent of the actual settlement amount). If LMSAs are required, eventually plaintiffs and plaintiff attorneys would not bring these small value lawsuits.

Similarly, plaintiff attorneys are hurt because their case expenses increase and their fees correspondingly decrease. As noted above this decrease may eventually prove to be too much and lead to fewer cases being brought, in turn hurting Medicare's long term recovery efforts. Such a decline in cases also hurts defense attorneys.

While no recent statistics are timely available for our review, we are skeptical LMSAs would lead to beneficial and sufficient recovery to justify their requirement.

### v. Even if LMSAs are Required, Their Allocation and Administration Should Differ From WCMSAs

WCMSAs are set up so that the individual pays for his case-related, Medicare-covered care directly. This means doctors and hospitals often recover at the full billed amount. If a new LMSA program is instituted a move away from the current procedure would benefit all parties involved. LMSA accounts should be set up for payment by Medicare at Medicare rates. This savings would be beneficial to everyone involved. We believe defense insurers would be most excited by such a system because of the potential to lower settlement amounts (an MSA at Medicare rates is much lower than an MSA at full-billed rates).

This system could also benefit Medicare because CMS and the COBC could coordinate payment from MSA accounts for MSA-approved care, mitigating any loss from the huge number of self-administered accounts (this change seemingly fits as a potential mix of Option 4 and Option 6).

### vi. Conclusions for Option 4 – LMSAs

So many rules and regulations are needed for LMSAs to appropriately consider Medicare interests *and* the actual outcome of the underlying lawsuit that the idea of requiring LMSAs becomes unworkable. At least the following must occur for LMSAs to be useful:

- 1 – CMS must be able to handle the influx of LSMAs while reducing the 8-9 month delays experienced for WCMSAs;
- 2 – CMS must recognize allocations in an efficient manner without court involvement;
- 3 – CMS must recognize reductions for settlement procurement;
- 4 – CMS must show LMSAs will aid the Medicare program (and that WCMSAs have done so) through actual amounts-saved;
- 5 – CMS must create a system that benefits Medicare without harming the beneficiaries.

Such a system does not seem possible. The current WCMSA system involves a great deal of waste as seen by the MSA Allocator Industry's jokes regarding accounts. <u>While short-term gain for Medicare is possible, any LMSA system would likely cause long-term damage to the personal injury field and therefore long-term damage to Medicare recovery efforts.</u>

### *e. Option 5. The beneficiary participates on one of Medicare's recovery options*

This option is fair to individuals with *extremely* small settlements. It is not useful to those with settlements greater than $300, $5,000, or $25,000 (the maximums for Medicare's three recovery options). However, this option does not solve the issue of future medicals because it does not address them. The $300 minimum settlement for any Medicare recovery is too small to consider future care as is the $5,000 maximum for Medicare's flat-25 percent recovery. Then, the $25,000 maximum for Medicare's self-calculated repayment clearly indicates care must be completed. As a result, this option is rarely used.

### *f. Option 6. The beneficiary makes an upfront payment*

#### i. Part A – Where Ongoing Responsibility for Medicals is Imposed

This option is flawed. Part (a) of Option 6 discusses an upfront payment *by the beneficiary* if Ongoing Responsibility for Medicals ("ORM") is imposed upon the defense-insurance company. If the defense-insurance company has a continuing obligation to pay for case-related medical expenses there should be no future medicals allocated in a settlement. This situation cannot exist.

#### ii. Part B – Where Ongoing Responsibility for Medicals is Not Imposed

Part (b) of Option 6 discusses the same upfront payment if ORM is not imposed. This is CMS's first recognition of the limits of liability cases where it discusses policy caps. This option still fails to account for the non-medical portions of recovery and for liability concerns (e.g., contributory negligence) and settlement reductions resulting from those concerns. To assume all settlements include full recovery of Medicare's conditional payments and potential future payments is short-sighted.

We also question the long-term damage to personal injury lawsuits and the Medicare recovery program caused by recovery of future medicals. Part (b) seems to suggest a percentage of recovery will be paid to Medicare as "future medicals." Imagine this percentage is just 12.5 percent. Combine that with a conditional payments reimbursement to Medicare of 30 percent in a situation where procurement costs (attorneys' fees and costs) were a reasonable 36 percent of the settlement. That leaves just 21.5 percent of the settlement to the plaintiff – if no other "liens" are claimed. We are certain no plaintiff will settle his case knowing he is to receive just 21.5 percent of the proceeds.

Next, look at a situation where the specified future medicals percentage is higher at 17 percent. There the plaintiff only receives 17 percent of the settlement himself. And if the case procurement costs increase (as they often do in liability cases) above 40 percent the plaintiff may only end up with 13 percent of the settlement. This system would not be utilized.

A percentage-based system will irreparably damage the personal injury field, in turn, shifting the *full burden* of past, present, and future medicals to Medicare.

### *g. Option 7. The beneficiary Obtains a Compromise or Waiver of Recovery*

If a beneficiary obtains a compromise or waiver of recovery Medicare's conditional payments are not fully paid. It seems logical to assume that no future medicals would be paid under such circumstances. This option is sensible and fair where it is necessary. It would likely be one of the most used options due to the difficulties encountered in most personal injury settlements. As a result, CMS gains nothing by imposing rules and requirements for LMSAs.

## 6. All "Future Medicals" Decisions Should Wait for Section 111 Reporting Data

Section 111 Reporting began January 1st, 2012 and has just recently expanded to include cases settled in the $25,000-$50,000 range. Eventually, a large sample size of the data CMS collects will provide better guidance than any public comments. This data in turn should show the average percentage of settlement from which Medicare collects.

## 7. Conclusions – CMS Would Cause More Harm to Personal Injury Cases, its Beneficiaries, and Eventually Itself, if it Imposes Rules for LMSAs

LIEN RESOLUTION SERVICES, LLC
d/b/a LIEN RESOLUTION USA

www.lienresolutionusa.com

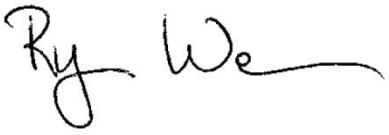
All rules proposed by CMS in Volume 77, Number 116 of the Federal Register will irreparably harm the both plaintiffs and personal injury field, in turn, shifting the *full burden* of past, present, and future medicals to Medicare.

Even LMSAs with strict reduction rules for allocations and procurement costs will cripple the system. CMS is already unable to handle WCMSAs within a reasonable time period. The addition of LMSAs will lead to settlement delays greater than one year. Then, when the LMSA is finally reviewed by CMS it will likely lead to an unworkable settlement where the plaintiff is expected to take home a smaller percentage of the actual settlement amount. Plaintiffs will be less likely to settle, costs of lawsuits will skyrocket, and attorneys will stop bringing lawsuits. Medicare will then have the full burden of paying past, present, and future medicals with minimal reimbursement from the few cases still filed by a then-crippled legal industry.

*CMS's proposed rules for recovery of future medicals will create a modest short-term gain with devastating long-term losses.* We suggest CMS concentrate on the data it compiles from Section 111 Reporting and revisit future medicals in liability cases sometime in the future.

A petition for all those who agree with this analysis can be found at http://www.ipetitions.com/petition/lrs

Respectfully Submitted,
**Lien Resolution Services, LLC**



Ryan J. Weiner