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Medicare Secondary Payer and Settlement Delay

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The Medicare Secondary Payer Act of 1980 and its subsequent amendments require that insurers and self-insured companies report settlements, awards, and judgments that involve a Medicare beneficiary to the Centers for Medicare and Medicaid Services. The parties then may be required to compensate CMS for its conditional payments. In a simple settlement model, this makes settlement less likely. Also, the reporting delays and uncertainty regarding the size of these conditional payments are likely to further frustrate the settlement process. We provide results, using data from a large insurer, showing that, on average, implementation of the MSP reporting amendments led to a delay in the resolution of disputes involving auto accidents of about six months.

I. Introduction

Medicare is a federal program that covers medical services for qualified beneficiaries. The program is typically open to those over 65 or those who are classified as disabled prior to turning 65. The program was established in 1964 under Title XVIII of the Social Security Act and currently consists of four parts (A–D) that cover hospitalizations, physician services, prescription drugs, and other treatments.

In recent history, Medicare is perhaps best known for the fiscal problems of its trust fund, particularly the hospital insurance known as Medicare Part A.[1] This has led to a variety of proposed fixes, many of which are designed to slow the growth in Medicare expenditures. Less frequently discussed are efforts to improve Medicare's finances by moving some potential expenditures to other insurers or recovering payments from other sources after Medicare has paid for treatment. In this article, we focus on the

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[1]Medicare's trust fund is now projected to run a deficit in 2030 (four years later than the Medicare trustee's 2026 predication in 2013). This improvement is largely driven by slower growth in health-care costs. See 2014 Trustees Report (2007 annual report of the boards of trustees of the federal hospital insurance and federal supplementary medical insurance trust funds, Centers for Medicare and Medicaid Services website http://www.cms.hhs.gov/ReportsTrustFunds/downloads/tr2007.pdf).

consequences of the largest of these policies, the so-called Medicare Secondary Payer (MSP) Act, for the civil justice system. Specifically, we examine the little discussed unintended consequence MSP has had on the settlement dynamics in lawsuits involving Medicare beneficiaries.

Originally, Medicare was the primary payer for anyone over 65. In the parlance of the insurance industry this meant that Medicare paid any medical expenses first and any remaining unpaid bills could be passed on to any additional insurance sources available to the beneficiary. Medicare's status as default primary insurer was modified by the Medicare Secondary Payer Act of 1980, which altered the Social Security Act[2] to make Medicare the secondary insurer and any other insurance covering a beneficiary the primary.[3] In particular, this modification allows the Center for Medicare Services (CMS) to seek reimbursement from a variety of sources labeled the primary insurer by the Act.

The Act, as constructed, clearly envisioned other first-party health insurers, such as a spouse's private health plan, as the target of the cost-saving efforts.[4] However, CMS's subsequent interpretations have also labeled payments in litigation and workers' compensation as primary insurers, and CMS regularly sought to recover from civil litigation proceeds and workers' compensation payments. This interpretation was not well received by the courts[5] and facing the prospect of the courts providing a far narrower interpretation of the Act than CMS advanced, Congress passed the Medicare Modernization Act of 2003 (MMA). Essentially, Congress amended the MSP Act to support CMS's position that the primary insurer was anyone making a payment related to a covered injury.

This change had the potential for far-reaching effects on the civil litigation system. As Swedloff points out, third-party insurers are very different from the health insurers originally envisioned in the MSP Act.[6] Third-party insurers often have no idea whether a plaintiff is a Medicare beneficiary and typically do not have the information required to make such a determination. Moreover, in the case of class action litigation, the defendant may not even know the client's name. The possibility that Medicare could demand payment without being part of the litigation via the subrogation process has the potential to seriously impede the settlement process. In particular, the courts suggested that

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[2]The MSP Act (42 U.S. Code (USC) 1395y(b)(2)) is one of the amendments to the Social Security Act that established Social Security (Public Law (PL) 74–271, 49 Stat. 620), which was approved on Aug. 14, 1935.

[3]More specifically, in insurance law the "primary insurer" is the party responsible for coverage and the "secondary" insurer functions as an excess insurer paying for any expenses not covered by the primary. There are apparently some exceptions for postretirement first-party insurance health plans but all third-party insurers either in the tort system or workers' compensation are primary insurers relative to Medicare.

[4]Rick Swedloff, Can't Settle, Can't Sue: How Congress Stole Tort Remedies from Medicare Beneficiaries, 41 Akron L. Rev. 557 (2008).

[5]See Thompson v. Goetzmann 337 F.3d 489, 493–94 (5th Cir. 2003) and Swedloff, supra note 4.

[6]Swedloff, supra note 4.

CMS's interpretation of the MSP Act would delay settlement because of the need to collect additional information.

All this was largely irrelevant from 2003–2007 since the new MSA statute was generally ignored by litigants. Aside from a handful of mass torts and class actions, it proved very difficult for CMS to determine whether there was litigation concerning an injury that Medicare had covered and plaintiffs' attorneys and their clients did not notify CMS.[7]

This changed in 2007 when Congress passed the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA). Motivated by the perception that there was a pervasive failure to report, this Act required third-party insurers such as liability insurers, no-fault insurers, or workers' compensation plans to notify HHS regarding any judgments, payments, or settlements involving Medicare beneficiaries. The requirements were specifically designed to facilitate HHS's ability to collect funds used to treat beneficiaries. The Act specifies that CMS can recover from insurers, even if it has already paid the plaintiff, from settlement funds, or from plaintiffs' attorneys. The Act also specifies fines for a failure to report.

CMS has often faced considerable delays in producing a list of conditional payments. Beyond this, because CMS asserts that future medical expenses are also covered under the Act, the requirements have generated considerable uncertainty in litigation. In light of this uncertainty it seems likely that it will be more difficult to settle litigation. In particular, it is often difficult to determine whether a settlement has been approved by Medicare and, hence, whether the settlement effectively ends the defendant's financial exposure under the MSP Act.

II. Overview of the Medicare Secondary Payer Act

As noted in Section I, the key issue to understanding the MSP Act's impact on litigation is determining which insurer is primary: Medicare or other sources of insurance. That question hinges on whether payments in the liability system constitute primary insurance in the sense envisioned in the MSP Act. Since 2003, the answer to that question has been yes, and, since 2007, CMS has had at its disposal the tools necessary to enforce the MSP Act in the liability system. Before turning to the impact of the Act on the ability of litigants to resolve their claims, it is important to lay out the process that led to the MMSEA in 2007.

A. History of the Medicare Secondary Payer Act

From 1964 until 1980, Medicare paid benefits without considering whether another insurer could potentially cover the losses. Although litigation involving Medicare beneficiaries certainly existed, the government made no effort to subrogate claims by

[7]Eric Helland & Fred Kipperman, Recovery Under the Medicare Secondary Payer Act: Impact of Reporting Thresholds, Occasional Paper, RAND Institute for Civil Justice (2011).

beneficiaries in the event that Medicare had already paid for medical expenses resulting from the injuries involved in the litigation. In fact, even outside the liability system it appears Medicare made no effort to recover from other insurers in the event that a beneficiary had other sources of insurance, such as medical coverage resulting from auto insurance. During this period, Medicare, like private health insurers, had subrogation rights; it simply did not assert them.

1. 1980 Creation of the Medicare Secondary Payer Program

This changed with the 1980 Omnibus Budget Reconciliation Act, which created the MSP program. The explicit intent of the Act was to save Medicare money. Congress and the Carter Administration had grown increasingly concerned about the rising cost of Medicare, and the aim was to shift some of this cost to other sources. The MSP Act, in principle, meant that Medicare no longer paid for services if another insurer could be found.

Exactly what constituted the primary insurer, with Medicare being the secondary insurer, was ambiguous. Clearly, group health plans would be covered, but in the 1990s, HHS also chose to define third-party insurers and settlements or judgments as primary insurers. In effect, HHS chose to interpret the MSP broadly and argued that primary insurers were not only group health plans or auto policies but also payments to beneficiaries by third-party liability insurance, no-fault insurance, and workers' compensation programs.[8]

Liability and workers' compensation programs posed a significant challenge as they paid for injuries only under certain circumstances (i.e., when a judgment or settlement is secured, or if the underlying accident occurred in the course of employment in the case of workers' compensation).[9] Thus, Medicare is the secondary payer under the law for cases where a payment has been made or will be made in the future by some other source. However, Medicare would make conditional payments. These payments are conditional because Medicare asserts a statutory right to be reimbursed if and when a liability defendant or workers' compensation insurer is eventually determined to have responsibility for the injury and resulting medical care. Thus, prior to 2003, HHS asserted that if there was a primary insurer that could be expected to pay now or in the

[8]In fact, the MSP Act is quite broad with respect to recovery. Although the Medicare recipient who receives a payment from a primary payer is responsible for any liens under 42 USC 1395y(b)(2)(B)(iii) of the statute, the government may initiate recovery against anyone involved in a claim: (1) primary payers (i.e., workers' compensation law or plan, liability insurance, no-fault insurance, self-insurance) (42 Code of Federal Regulations (CFR) 411.24(e): "CMS has a direct right of action to recover from any primary payer") or (2) attorneys, beneficiaries, and other entities that receive payment from a primary plan (42 CFR 411.24(g): "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."). It is thus possible that the law will facilitate recovery from a variety of sources.

[9]HHS defines liability insurance as homeowners' insurance, malpractice insurance, products liability insurance, and general casualty insurance and would also include payments under state wrongful death statutes that provide payments for medical expenses.

future, Medicare was the secondary insurer. Moreover, if prompt payment was not expected, say, for example, as in the liability system, then Medicare would conditionally pay for treatment but the primary insurer or the individual receiving the liability or workers' compensation payment was expected to reimburse Medicare.

In general, the courts rejected HHS's claim. In particular, several courts took the view that in the case of liability, HHS would have to join the litigation by subrogation if it wanted to recover its conditional payments.[10] The government solution to the courts' narrower interpretation of the MSP Act was to again amend the MSP Act.

2. The 2003 Amendments to the MSP Act

The 2003 Amendments to the MSP Act[11] essentially codified the HHS view that had been struck down by several courts. Following the Act, HHS could treat tortfeasors or their liability insurers who pay either judgments or settlements to a Medicare beneficiary as primary insurers for the purposes of the MSA. Specifically, under the 2003 Amendments, the Medicare beneficiary had a responsibility to reimburse Medicare for any payments related to the accident that gave rise to the litigation.[12]

Post MMA, a defendant who settles a tort claim with a Medicare beneficiary, along with the beneficiary who recovered the payments, is responsible for reimbursement of Medicare's conditional payments.

With the 2003 Amendments, Medicare acquired a right of reimbursement. In effect, Medicare became a lien holder against the Medicare beneficiary and hence could recover the full amount of its payments related to an injury from any payments the beneficiary/plaintiff received in a case. CMS must verify that its payments and hence its liens are the result of the defendant's conduct. By contrast, private insurers are still governed by their subrogation rights, which means that they effectively must join the case and the amount they are repaid is determined in the litigation process. Further, if the case resolves for less than the private insurer paid toward the victim's loss, it has no further claim against the victim for repayment.[13] Essentially, CMS asserts that although CMS's stated procedures direct it to first attempt to recover from the Medicare beneficiary, it has the right under the law to recover from any of the parties to the litigation. Note that the defendant's exposure does not require admission of liability on the part of the defendant, so settlements are included. Moreover, under the 2003 Amendments, HHS could take money from the plaintiff, an attorney, or the settlement fund itself.[14]

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[10]For a discussion of these cases, see Swedloff, supra note 4.

[11]Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (PL 108–173, para. 301).

[12]Congressional Research Service (2008). Note that the MSP Act applies even if no lawsuit has been filed prior to settlement.

[13]Medicare liens are often called "super liens" since, under the MSP Act, Medicare's claim takes precedence over all other payment rights except plaintiff's attorney fees.

[14]Swedloff, supra note 4.

In many ways, this is particularly problematic for a tort system used to addressing competing claims with a system of subrogation. Based on the 2003 amendments, CMS asserts that the law governing the MSP Act allowed for full reimbursement for conditional payments even if the Medicare recipient has received a discounted settlement from the defendant. Although there have been conflicting opinions in the courts, HHS asserts that under the 2003 law, Medicare does not bear any of the risk of litigation, nor is it bound by settlement discounts. That is, if the plaintiff agrees to a settlement for half her provable damages in light of an expected probability of victory of 50 percent, CMS asserts it can collect all of its conditional payments up to the entire settlement amount.

Despite the 2003 amendments, CMS continued to have difficulty collecting payments, particularly in small cases, either because attorneys and their clients did not always notify CMS of such payments or because CMS was too slow in asserting its interest in these cases. In light of this difficulty, Congress again modified the law to require liability and workers' compensation insurers to report directly to CMS.

3. The Medicare, Medicaid and SCHIP[15] Extension Act of 2007

The Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA)[16] places the reporting requirement on the third-party insurer responsible for the payment to the beneficiary. Under the Act, these third-party insurers are called responsible reporting entities (RREs), which include not only insurers, but any entity making third-party payments in the liability system (such as defendants in class actions). RREs must regularly submit coverage information to HHS, which HHS checks against its list of Medicare beneficiaries. MMSEA also provides civil monetary penalties for noncompliance with the mandated reporting requirements.

The MSP Act and its subsequent modifications give HHS significant enforcement tools. It provides a cause of action against primary plans and any entity that received a third-party payment that fails to provide appropriate reimbursement of Medicare conditional payments (or consider Medicare's future interest). If successful, Medicare may recover double damages.[17] HHS could initiate recovery actions against a beneficiary, provider, supplier, physician, state agency, or attorney that received any part of the proceeds of a payment from a primary plan. The government also retains its subrogation right with respect to any third-party payment. In short, everyone involved in an MSP claim, including attorneys involved in a civil case, has potential exposure to Medicare recovery.[18] Compliance with the reporting requirement is essentially a two-step process. First, an RRE must determine if the individual receiving the payment is a Medicare

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[15]SCHIP is the State Children's Health Insurance Program, which provides matching funds to states to provide healthcare for children.

[16]Section 111 of MMSEA (PL 110–173) adds the reporting requirements for health and liability insurance, no-fault insurance, and workers' compensation (42 USC 1395y(b)(7), (8)).

[17]This right of recovery is typically referred to as a "Medicare lien" although in actuality HHS has far more powers under the MMSEA than is typical for a lien.

[18]See United States v. Stricker et al., No. 09–2423 (N.D. Ala. Dec. 1, 2009).

beneficiary and, second, the RRE must provide CMS certain required information. To determine whether an individual is a Medicare beneficiary, RREs must collect the individual's name, date of birth, sex, Medicare Health Insurance Claim Number, and the last five digits of the potential beneficiary's Social Security Number, as well as information as to whether the claimant is on Social Security Disability and/or has end-stage renal disease. Once this information has been collected, the RRE electronically submits it to CMS to determine the litigant's status as a Medicare beneficiary. If the plaintiff is a Medicare beneficiary, the claim must be reported before beginning litigation or settlement negotiations.

Even if the individual is not a Medicare beneficiary at the start of litigation, the RRE must check throughout the lawsuit in case the individual has become a Medicare beneficiary. When CMS is notified of a Medicare beneficiary's lawsuit, it is supposed to provide the parties to the lawsuit (RREs) any conditional payments it believes CMS is owed. When the litigation is resolved, the RRE must report diagnosis codes for injures or illness, any settlement payments, or judgment, and pay Medicare's lien.

It is easy to see how information requirements alone could cause problems for settlement negations and result in delays. This information is not typically collected by defendants in litigation and parties may be reluctant to provide it.[19] Add to this the presence of conditional payments, which must be reimbursed or contested, and settlement negotiations grow even more complex. However, this may not be the most difficult aspect of a case. In cases involving payments for future injuries, the settlement calculus is even more difficult.

4. Medicare's Future Interest

Because a Medicare beneficiary could use Medicare benefits to pay for future healthcare expenses resulting from the injury that gave rise to the litigation, CMS has argued that Medicare's future costs must also be considered in settlement. Unfortunately, CMS has not provided any guidance on how this consideration is to be made. CMS has provided a series of nonbinding documents or memorandums for workers' compensation claims, but it is unclear how much direction these provide in the litigation context. These agreements are called "Medicare Set-Aside Agreements" (MSAs) and they are an increasing issue in settlement negotiations. Moreover, as the process for determining future costs in liability settlements has not been determined, they generate considerable uncertainty for the litigation process.[20]

According to these memos concerning workers' compensation, future medical costs must be considered if (1) the individual is a Medicare recipient and the total amount of the settlement is greater than $25,000 or (2) it is likely that an individual

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[19]See Helland & Kipperman, supra note 7

[20]These lacks of clarity are in contrast to workers' compensation claims in which a series of memorandum lay out the process of determining whether future medical costs must be considered and appear to expedite claim settlement.

who is not covered by Medicare will be in the next 30 months and the settlement is greater than $250,000.[21]

CMS provides no guidance on MSAs in the liability context, and there is no routine approval of liability insurance MSAs by CMS. Absent any direction, and with the possibility that CMS may attempt to recover future medical expenses from any party to a settlement, the presence of future medical expenses in the presence of the MSA clearly adds a great deal of uncertainty to the settlement process.[22]

5. Strengthening Medicare and Repaying Taxpayers (SMART) Act

In response to growing concern on the part of liability insurers and other parties to the civil justice system, Congress again revised the MSP Act. In December 2012, Congress passed the Strengthening Medicare and Repaying Taxpayers (SMART) Act, which was designed to speed up the process for settling claims involving liability and no-fault cases. The major goal of the SMART Act was to allow parties to determine the exact amount of the conditional payment lien before settlement. Specifically, the SMART Act requires CMS to put in place a process for estimating conditional payments that must be reimbursed. Under the SMART Act, HHS is to establish a webpage that provides information on Medicare payments that are related to a settlement or award. The key change is the Medicare beneficiary or insurer may notify CMS at any time during the 120 days before a settlement, judgment, or payment is reasonably expected and Medicare will have 65 days to post conditional payments on a special webpage.

Although the SMART Act could mitigate some of the impact on the civil justice system caused by the MSP Act, its main provisions are only now being implemented and it does not address the issue of setting up set-aside accounts for future medical bills.

6. Case Load

One final issue for the litigation system is the delay in processing requests for conditional payment information. Reporting under the 2007 Amendments to the MSP Act began for group health plans in 2009 and was phased in completely by 2012 with insurance payments being reported in 2012. Workers' compensation and other liability insurers were required to begin reporting in 2011 subject to certain thresholds that are being phased in through 2015.

This led to a dramatic increase in the number of claims being reported to CMS. A GAO report from March 2012 notes that MSP cases involving liability rose 176 percent

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[21]For example, in Finke v. Hunter's View, 2009 U.S. Dist. LEXIS 126830 (U.S. Dist. Court for Dist. of Minnesota, 5th Div.), the court determined that an MSA was not required for settlement because the plaintiff's future medical expenses would be paid by his wife's private health insurance.

[22]For example, CMS requires that the plaintiff's treating physician certify that treatment is completed by the time of settlement and no future treatment will be required. CMC seems to imply that this will satisfy CMS; however, CMS will not provide documentation that its potential claims are satisfied.

from 2008 to 2011.[23] Given the attending delays in reporting noted by the GAO, it seems clear that the MSA would have an impact on settlement delay.

7. Medicare's Recovery

While we have noted the cost of the MSP Act to the civil justice system in terms of delay in settlement, we have not yet discussed the benefits in terms of additional recovery.[24] Given the costs associated with MSP Act recovery, described in the next section, any cost-benefit analysis requires that we at least understand the benefits associated with recovery. CMS had regularly estimated MSP Act recoveries in the billions of dollars. For example, Deborah Taylor, the CMS Chief Financial Officer and Director, in testimony before the House Energy and Commerce Subcommittee in June 2011, stated that MSP laws and regulations have reduced Medicare spending by an average of about $8 billion a year in recent years and about $50 billion from 2006 to 2012. It is important to note that figure is the avoided payments and recovery from all primary insurers, which principally involves group insurers; liability is only a small portion of this.[25]

The specific recovery from liability and workers' compensation programs is harder to estimate. In 2001, the Government Accountability Office (GAO) examined Medicare's potential recovery from workers' compensation.[26] Although the study provides no estimate of the size of the potential recovery, and could not have done so given the nature of its sample, it has been widely misquoted as claiming that Medicare has lost more than $40 billion because of uncollected secondary payments in workers' compensation.[27] For example, Briscoe et al.[28] state: "A report generated by the Government Accountability Office (GAO) in 1999 [sic] estimated that Medicare had erroneously paid approximately $43 billion between 1991 and 1998 on claims that should have been paid by a primary payer."

The GAO report actually reviewed workers' compensation claims in Virginia between 1991 and 1998 for 10,000 individuals, found that 26 percent of those individuals had received payment from Medicare, and that a much smaller percentage had received benefits for more than a month. The $43 billion noted by Briscoe et al. refers to the amount that workers received

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[23]GAO, Medicare Secondary Payer: Additional Steps Are Needed to Improve Program Effectiveness for Non-Group Health Plans, GAO-12–333, at 15, Mar. 2012, available at: http://gao.gov/assets/590/589158.pdf.

[24]It is worth noting that these are benefits to CMS and hence the taxpayers but are unlikely to be social benefits in the sense used by economists because they represent a transfer from plaintiffs to CMS.

[25]Protecting Medicare with Improvements to the Secondary Payer Regime, Hearing Before the Subcommittee on Oversight and Investigations of the Committee on Energy and Commerce. House of Representatives (2011), available at: https://archive.org/stream/gov.gpo.fdsys.CHRG-112hhrg74294/CHRG-112hhrg74294_djvu.txt.

[26]Government Accountability Office, Workers' Compensation: Action Needed to Reduce Payment Errors in SSA Disability and Other Programs, GAO-01–367, May 2011. As of May 10, 2011, available at: www.gao.gov/archive/1994/d01367.pdf.

[27]For example, Alex Swedlow, executive vice president of the California Workers' Compensation Institute, pointed this problem out at a 2010 Medicare Session at the Annual Issues Symposium of the National Council on Compensation Insurance.

[28]Bob Briscoe, Christine Fleming & Steve Taylor, The Impact of New Medicare Legislation on Liability Claims Settlements, P&C Perspectives: Current Issues in Property and Casualty, April 2009. As of May 10, 2011, available at: http://insight.milliman.com/search.php?mtid=1077 (page 1).

each year in medical benefits through workers' compensation programs.[29] Thus, $40 billion in uncollected payments over this period, as some have claimed, seems quite high, since $40 billion dollars would represent 20 to 30 percent of total workers' compensation medical payments between 1991 and 1998 according to the GAO. Unfortunately, misunderstandings regarding the GAO study's findings have generated considerable confusion in the public debate about the potential recovery available to Medicare from improved reporting.

A 2011 RAND study examined one aspect of the new reporting requirement: the role of safe-harbor thresholds for reporting.[30] The study used data from the Insurance Research Council's (IRC) "Paying for Auto Injuries: A Consumer Panel Survey of Auto Accident Victims" datasets from 1992–2002 (IRC, 1994, 1999, 2004),[31] and estimated how much Medicare could recover from payments made to auto injury victims under the MSP Act. The study estimated that Medicare could recover about $1 billion a year from auto cases, which are by far the most common type of claims in the liability system. The study also estimated how much of this recovery would exist if cases under $5,000 were exempt from the requirement for reporting the claim to CMS to determine if the claimant has received compensation from Medicare, finding that the amount recovered by CMS from claims under $5,000 is, unsurprisingly, quite small. The study does not attempt to estimate the costs of this recovery.

The RAND study also finds that retaining the threshold limit for reporting claims to CMS at $5,000 would reduce CMS's costs by 1 percent, or $10 million, while reducing the number of these claims that must be reported by 43 percent.[32]

As RAND notes, its findings do not take into account any eventual reductions in payments to Medicare resulting from the fact that CMS accepts less than the amount requested in its initial Conditional Payment Notice (i.e., the Medicare lien). In workers' compensation cases, RAND cites sources suggesting that the average reduction of a conditional payment claim is 85 percent.[33] RAND further finds that much of the 85 percent

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[29]Bob Briscoe, Christine Fleming & Steve Taylor, The Impact of New Medicare Legislation on Liability Claims Settlements, P&C Perspectives: Current Issues in Property and Casualty, April 2009. As of May 10, 2011, available at: http://insight.milliman.com/search.php?mtid=1077 (page 1).

[30]See Helland & Kipperman, supra note 7.

[31]Ins. Research Council, Paying for Auto Injuries: A Consumer Panel Survey of Auto Accident Victims (1994, 19999, 2004), described at: https://www.insurance-research.org/research-publications/paying-auto-injuries-consumer-panel-survey-auto-accident-victims-2004-edition.

[32]The RAND study also finds that for other case types, such as medical malpractice, the same threshold would have a far smaller impact on reporting costs and almost no impact on the government's recovery since these cases typically involve much large claims and are more likely to involve substantial contingent payments by Medicare. See Helland and Kipperman, supra note 7.

[33]The RAND study notes that this is driven largely by CMS's method of determining what it is owed. According to the RAND study (Eric Helland & Fred Kipperman, Recovery Under the Medicare Secondary Payer Act: Impact of Reporting Thresholds, Occasional Paper, RAND Institute for Civil Justice (2011), at 24, n 29).

> CMS's data, like most first-party insurers, are organized by ICD9 codes. They do not attempt to determine potential liability for specific injuries. Thus, when requesting repayment, CMS typically claims all treatment during the time period of the injury, regardless of whether the RRE's client is responsible for that injury. Our data may be more accurate than the typical CMS Conditional Payment Notice because the IRC survey specifically asked respondents about payments made by government insurers related to a specific injury. Nevertheless, the experience from workers' compensation suggests that considerable reductions are typical.

is explained by CMS waiving the lien because the RRE is not actually responsible for the injury that resulted in the conditional payment. This means that a sizable portion of Medicare's requests are for reimbursement for treatment that does not result from the injury at issue in the claim and hence any delay resulting from the requirement in these cases generates no offsetting benefit in the form of higher reimbursement. Put another way, a larger portion of the reductions in Medicare liens is due to Medicare initially overestimating what it is owed rather than some sort of write-off by CMS.

Finally, RAND notes that because of the potential delay, plaintiffs may decide not to file the case.[34] To the extent that litigants are not pursing small claims due to the delays caused by the MSP Act, CMS's recovery is further reduced.

III. The Effect of MSP on Dispute Duration in Auto Accident Cases

The above discussions suggest two possible reasons that the MSP Act could result in delay. The first is that the reporting requirement results in delay as parties must now acquire additional information before resolving a claim. The second, and likely more important, reason is that CMS's presence as a de facto party to the negotiations may increase delay because it may not be timely in providing information on conditional payments required for settlement and because it is often unable to provide information on future costs that are need to ensure that a settlement resolves a defendant's liability. To estimate the impact of the reporting requirement on delay, we use a sample of auto claims whose initiation and resolution cover the implementation of the new reporting requirement.

It is worth noting that the settlement delay may or may not be a temporary problem. One possibility is that companies and plaintiff's attorneys will eventually adjust to the new environment and our test is measuring only the temporary impact of phasing in the new requirement. While our data do not permit us to completely rule out this possibility, we present evidence below that the delays are the result of the extra cost associated with obtaining information from plaintiffs, which is anecdotally more difficult than one would expect, and difficulties in timely responses from CMS. This combined with uncertainty about future liabilities for third-party insurers due to ongoing treatment suggests that at least some of the estimated impact is permanent.

A. Data

The data used in this study were provided by State Farm Insurance. We use a sample of automobile accidents. The choice to focus on auto accidents is driven by a handful of considerations. First, auto coverage is the main business line of State Farm, and State Farm has the largest market share of any auto insurer in the country, offering policies in all 50 states. Although we cannot determine if State Farm's data are representative

[34]Helland & Kipperman, supra note 7 at 24, n29.

with respect to auto claims, the difference-in-difference nature of our study means that we are comparing State Farm customers to other State Farm customers. Second, settlements in auto cases are relatively quick and orderly, at least compared to other tort cases.[35] Lastly, the RAND analysis of the amount of recovery CMS was likely to receive when the MSP reporting thresholds were phased out was based on automobile accidents cases as well.[36] To allow for comparability with that study, it made sense to focus on auto cases.

The data that we have are a random extract from State Farm's auto cases for which the company collected data regarding Medicare eligibility pursuant to the MSP reporting requirements. In the process of collecting such data, while most of the records did indeed cover MSP-relevant cases, a small fraction of the records involve plaintiffs who are not Medicare eligible and, therefore, MSP is irrelevant for these cases. For our purposes, the important variables contained in these records are whether the plaintiff triggers an MSP report, the E-code suggesting that the medical care was the result of an automobile accident,[37] the date of the accident, the date when the case was resolved either through settlement or trial, the state where the litigation was filed, and various characteristics of the plaintiff, including age and sex. Finally, in specifications that do not include state fixed effects we include a control variable for whether the state has modified the collateral source rule. Under the common law, the plaintiff recovered regardless of whether his or her injuries had also been covered by insurance payments from the plaintiff's insurer. In the 1970s and 1980s, states began modifying these rules to say that if a first-party insurer did not assert its subrogation rights, then the payments to the plaintiff were reduced by the amount of the un-subrogated payments. Because auto insurers and even some health insurers have waived subrogation rights in many small claims, it is possible that these laws speed up claim resolution. Interestingly, the collateral source rule modifications do not affect Medicare liens since the recovery claim held by the Centers for Medicare and Medicaid Services under the MSA preempt any state-level collateral source rule reductions. The summary statistics of the dataset are provided in Table 1, as are the means broken down by claims involving Medicare and non-Medicare claimants both before and after the implementation on October 2011 of the third-party reporting requirements.

B. Identification Strategy

One key issue with estimating the impact of the MSP Act reporting requirements on delays in claim resolutions is that the sample of cases covered by the MSP Act may be very different from those claims that are not covered. Most importantly, the claims

[35]See, for example, Nora Freeman Engstrom, Sunlight and Settlement Mills, 86 NYU L. Rev. 805, 825 (2011).

[36]Helland & Kipperman, supra note 7.

[37]E810–E819.

Table 1: Summary Statistics

	Full Sample		*Medicare Post Oct. 2011*		*Medicare Pre Oct. 2011*		*Non-Medicare Post Oct. 2011*		*Non-Medicare Pre Oct. 2011*	
	Mean	SD	*Mean*	SD	*Mean*	SD	*Mean*	SD	*Mean*	SD
Claim duration in cases	564.29	708.37	201.31	91.48	800.96	824.21	179.47	86.97	962.21	969.62
Claim duration censored at February 2014	0.32	0.47	0.42	0.49	0.28	0.45	0.50	0.50	0.31	0.46
Claimant is male	0.46	0.50	0.43	0.49	0.48	0.50	0.41	0.49	0.45	0.50
Claimant age	66.96	13.01	68.79	12.24	66.60	13.00	44.53	18.85	49.07	15.71
Claim involves a Medicare recipient	0.99	0.10								
Claim resolved after the MSP Act reporting requirement on third-party insurers (October 1, 2011)	0.30	0.46								
Interaction between Medicare claim and post October 1, 2011	0.30	0.46								
State has modified the collateral source rule	0.83	0.38	0.82	0.39	0.83	0.37	0.75	0.43	0.88	0.33
Observations	234,051		70,269		161,428		801		1,330	

covered by the MSP Act reporting requirement are likely to involve a driver over 65.[38]

Our identification strategy involves comparing the duration of MSP-report-eligible cases with noneligible cases before and after the reporting requirements went into effect on October 1, 2011. The prereporting period provides a baseline for the duration of auto accident disputes, and the MSP noneligible cases allow us to control for background changes in the duration of disputes over time. In some specifications, we also include covariates for the state where the litigation was filed, as well as controls for plaintiff characteristics such as age and sex.

Analyzing the data, however, poses two challenges. First, in our data, there are a large number of disputes that had not settled at the point when the data were extracted. Because of this, our estimation strategy must account for censoring. Second, because the inclusion of E-code data was driven by MSP-eligible plaintiffs, most of our data involve the treatment group (i.e., MSP eligible, $n = 231{,}697$), while relatively few cases can be used as the accidental comparison group (i.e., MSP noneligible, $n = 2{,}131$). To ensure balance in our sample, we first examined interval regressions[39] (which allow for censoring) of the case duration using the 2,131 comparison cases and random draws of 2,131 MSP-eligible cases. Specifically, for any given case that has not been settled by the time our sample was created we know the time to settlement is greater than the observed time, that is, $\Pr(Y_i > y_i)$, where y_i is the observed time between the initiation of the claim and its truncation by the creation of the sample and Y_i is the unobserved duration of the claim. Given that 32 percent of our sample is truncated, such a correction is potentially important.

We allowed for a Medicare indicator (to estimate the Medicare case duration baseline) and a post-MSP reporting indicator to allow for a shift in the duration of cases in general. Since only Medicare beneficiaries are actually subject to the reporting requirement, this is a difference-in-difference estimator.[40] Our treatment effect estimate is the coefficient on an indicator that is the interaction of the Medicare indicator and the post-MSP indicator. We resampled the data and ran the regression 1,000 times. Our estimation equation is:

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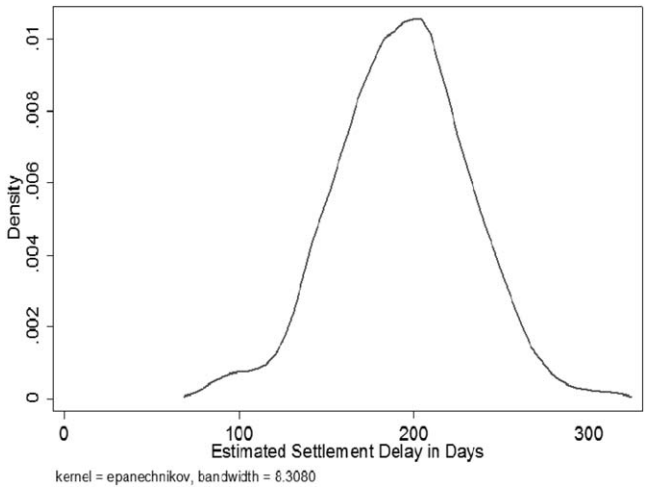
[38]For example, there is some evidence that older drivers are in fact safer and involved in less costly accidents. See David S. Loughran, Seth A. Seabury & Laura Zakaras, Regulating Older Drivers: Are New Policies Needed? (RAND Corp. 2007). To the extent that these are easier claims to resolve, a comparison of MSA Act covered claims with those not covered would find that claims involving older drivers were resolved more quickly. This result, however, would not be caused by the MSP Act reporting requirement but by the fact that claims involving older drivers were both less complex and more likely to involve Medicare conditional payments.

[39]The interval is between the date of the underlying incident and the date the case is terminated, unless the case is never terminated in our sample, in which case the second interval is right censored as of the date our data were drawn from the State Farm system, which was the end of the first quarter of 2014.

[40]In one way this underestimates the impact of the MSPA reporting requirement. Since essentially all claims must check whether the plaintiff is a beneficiary, the Act has the potential to increase claim duration in all cases. We do not, however, have the ability to estimate the difference-in-difference model without treating non-Medicare-eligible plaintiffs as our control group. In practice, given that many of the causes of delay, such as producing a MSA agreement, occur only with beneficiaries, this impact on our estimates is likely slight.

Figure 1: Distribution of settlement delay effects of MSP.



NOTE: This figure presents the kernel density plot of the coefficient estimates on the interaction of the MSP_i (equal to 1 for claims after October 2011) and $Medicare_i$ (Medicare claims). The model is estimated using an interval regression and was run 1,000 times, drawing a new sample of MSP-eligible claims to create a sample weighted equally between cases resolved before and after October 2011. For each regression, the sample size is 4,262 cases.

$$time_i = \alpha + \beta_1 MSP_i * Medicare_i + \beta_2 MSP_i + \beta_3 Medicare_i + \gamma X_i + \theta_i + \epsilon_i,$$

where $time_i$ is the duration of case i, α is the intercept, MSP_i is an indicator variable equal to 1 in the post October 2011 reporting period, $MSP_i{*}Medicare_i$ is an indicator equal to 1 if the dispute is covered by the MSPA reporting requirement (i.e., claims involving a Medicare beneficiary in the post October 2011 period), $Medicare_i$ is an indicator equal to 1 if the plaintiff is a Medicare beneficiary, X are our control variables for age and sex, θ_i are state of claim fixed effects, and ϵ_i is the error term.

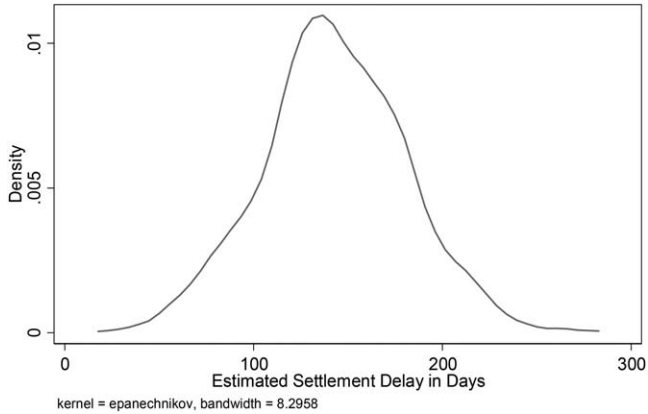
Figure 1 provides the distribution of the estimated treatment effect from the 1,000 draws.

The mean estimated delay associated with MSP-eligible cases after the reporting trigger went into effect is 194 days with a median of 195 days. The smallest estimated delay was 77 days, and the largest was 316 days. Every estimate was positive, and more than 99 percent were statistically significant at the 10 percent level. In sum, for almost every sample of Medicare beneficiaries we draw from out data, we find a delay relative to our smaller sample of nonbeneficiaries.

Figure 2 provides the distribution of the estimated coefficients when the state of filing fixed effects are added to account for any idiosyncratic duration differences driven by individual state court systems. One concern is that the distribution of cases across states is changing over our sample period.

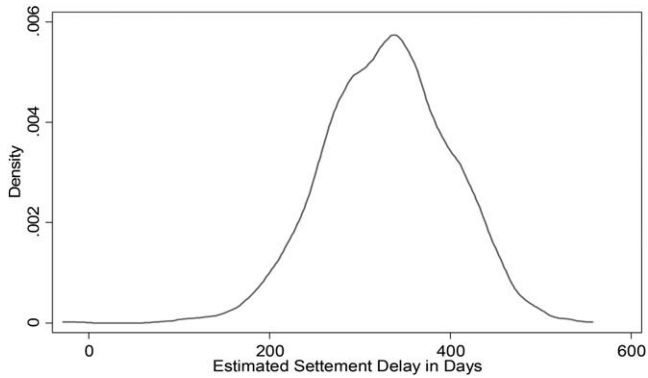
The distribution appears to be shifted to the left slightly, with the median estimated delay being 141 days with a mean of 143 days. The largest estimated delay is 274

Figure 2: Distribution of settlement delay effects of MSP, controlling for state fixed effects.



NOTE: This figure presents the kernel density plot of the coefficient estimates on the interaction of the MSP_i (equal to 1 for claims after October 2011) and $Medicare_i$ (Medicare claims). The model is estimated using an interval regression and includes state fixed effect. The model was estimated 1,000 times, drawing a new sample of MSP-eligible claims to create a sample weighted equally between cases resolved before and after October 2011. For each regression, the sample size is 4,262 cases.

Figure 3: Distribution of settlement delay effects of MSP, controlling for state fixed effects and plaintiff age/sex.



NOTE: This figure presents the kernel density plot of the coefficient estimates on the interaction of the MSP_i (equal to 1 for claims after October 2011) and $Medicare_i$ (Medicare claims). The model is estimated using an interval regression and includes state fixed effect and controls for plaintiff gender and age. The model was estimated 1,000 times, drawing a new sample of MSP-eligible claims to create a sample weighted equally between cases resolved before and after October 2011. For each regression, the sample size is 4,262 cases.

Table 2: Interval Regression Estimate of MSP Delay—Full Auto Sample

Variables	*(1)*	*(3)*	*(5)*
Interaction between Medicare	270.906***	221.516***	338.747***
claim and post October 1, 2011	(64.836)	(62.799)	(72.188)
Claim involves a Medicare recipient	−150.200***	−88.465	238.980***
	(57.229)	(54.763)	(54.183)
Claim resolved after the MSP Act	−1,267.179***	−1,151.410***	−1,206.593***
reporting requirement on third-party insurers	(64.700)	(62.614)	(72.011)
Claimant is male			41.098***
			(6.776)
Claimant age			−18.597***
			(0.372)
State has modified the collateral source rule	358.634***		
	(7.049)		
Observations	233,797	233,828	213,239
State fixed effects	No	Yes	Yes

NOTE: Interval regression estimates of the duration auto accident claims resolved between February 1, 2010 and February 14, 2014. *,**, and *** indicate significance at the 10 percent, 5 percent, and 1 percent levels, respectively. Robust standard errors are in parentheses.

days, and the smallest is 26 days. Once again, all the estimates are positive and 90 percent are statistically significant at the 10 percent level.

Similar results hold if we include controls for the plaintiff's sex and age, as shown in Figure 3.

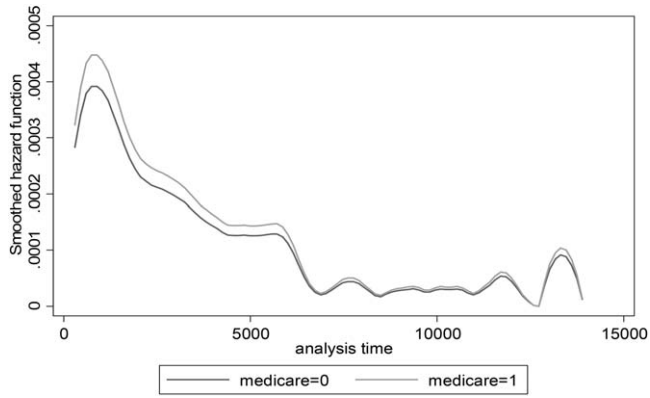
In this model, with the plaintiff age and sex controls, as well as the state fixed effects, the median estimated delay is 333 days with a mean of 330 days. The smallest estimated delay is actually negative at −28 days, although only one iteration yielded a negative result. The largest delay is 558 days. In terms of statistical significance, almost 98 percent of the estimated effects are statistically significant at the 10 percent level.

These results provide some confidence that using all the auto accident data will not generate problems due to balance issues in the sample, as the resampling exercises generated fairly stable results. Table 2 provides interval regression estimates for the baseline model, the model including state fixed effects, and the model including state fixed effects and the plaintiff's age and sex.

The three models presented above all suggest large and statistically significant delays associated with the adoption of the MSP reporting requirement relative to cases unaffected by the MSP reporting requirements. The model with state fixed effects and controls for plaintiff characteristics yields an estimate of 339 days.[41]

[41]To further examine the generality or robustness of our results, we also examined the models above separately by sex and found no important difference in our Medicare * MSP effect (using only observations where the insured is male, including age controls and state fixed effects: 369-day delay; using only observations where the insured is female, including age controls and state fixed effects: 341-day delay). Also, if we estimate the models separately by state, the same general story emerges, although for some states, there are too few observations from which to estimate the models.

Figure 4: Hazard rates pre-MSP.



NOTE: This figure shows the smoothed hazard rates for a Cox proportional hazard model. The model is estimated using pre October 2011 data and shows the daily settlement hazard rates for those plaintiffs who are and are not eligible for Medicare, who would be covered by the reporting requirements after the grace period ended in October 2011.

One possibility, as noted above, is that our results are driven by a one-time transition effect that is worked out in short order, implying that MSP does not generate ongoing delay costs. To examine this, we reestimated the interval regressions dropping incidents that occurred in the last quarter of 2011 and all of 2012. By doing so, our Medicare * MSP estimate will be driven by cases arising from accidents in 2013. In all models, the estimated treatment effect is even larger than that presented in Table 2. This suggests that any transition period extends throughout our dataset.

C. Timing of Settlement

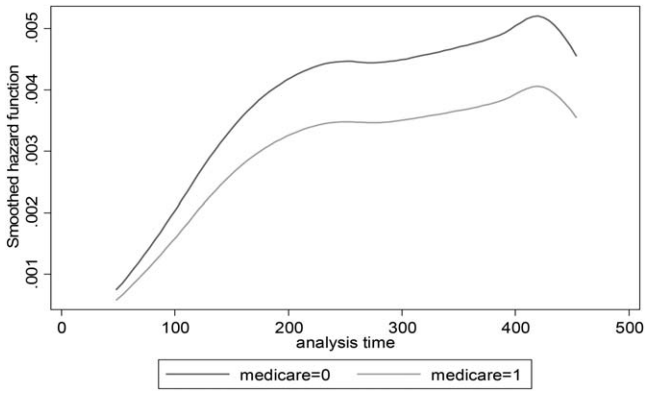
While the interval regression technique accounts for censoring, an alternative approach would be to estimate the duration of settlements using hazard models. These models essentially estimate the likelihood of a settlement each day the case is "at risk." In this way, they provide us with an impact of the MSP Act reporting requirement at each stage of the dispute.

Again, given the robustness of the resampling approaches, it would appear to be reasonable to include all the auto accident data, as balance issues do not appear to be driving our estimates.

Figure 4 shows the hazard probabilities for Medicare and non-Medicare plaintiffs before the MSP reporting requirement went into effect. For long-duration cases, the two hazard functions track each other quite closely, while for short-duration cases, Medicare plaintiffs appear to be more likely to settle at each duration.

Figure 5, however, shows that after the MSP reporting requirements go into effect, Medicare plaintiffs are much less likely to settle at every duration. Moreover, this impact grows the longer the case remains unsettled. We mentioned two potential causes for the

Figure 5: Hazard rates post-MSP.



NOTE: This figure shows the smoothed hazard rates for a Cox proportional hazard model. The model is estimated using post October 2011 data and shows the daily settlement hazard rates for those plaintiffs who are and are not eligible for Medicare, who are covered by the reporting requirements after the grace period ended in October 2011.

reporting requirements' hypothesized impact on settlement time. The first was that the data reporting requirement delayed cases as parties were forced to exchange more information than they would have before the requirement or because CMS delays in providing information on conditional payments delay settlement. While both of these could be true, it is unclear why that effect would grow the longer the case remains unsettled. A more likely explanation is that Medicare Set Asides and the uncertainty these create for claim resolution are having a disproportionate impact on longer, and likely larger, claims that often include provisions for future health-care damages.

To refine this investigation, in Table 3 we provide hazard ratios from a Cox proportional hazard model that controls for Medicare beneficiary status, an indicator for whether

Table 3: Cox Proportional Hazard Model of Effect of MSP on Settlement

	Hazard Ratio		
Interaction between Medicare claim and post October 1, 2011	0.69***	0.75***	0.78***
	(0.05)	(0.05)	(0.07)
Claim involves a Medicare recipient	1.14***	1.07	0.83***
	(0.06)	(0.05)	(0.04)
Claim resolved after the MSP Act reporting requirement on third-party insurers	12.03***	10.71***	9.05***
	(0.85)	(0.78)	(0.85)
Claimant age			1.02***
			(0.01)
Claimant is male			0.95***
			(0.01)
State effects	No	Yes	Yes

NOTE: Cox proportional hazard model of the probability an auto accident claims settles for 233,828 claims resolved between February 1, 2010 and February 14, 2014. *,**, and *** indicate significance at the 10 percent, 5 percent, and 1 percent levels, respectively. Robust standard errors are in parentheses.

the case was filed after the MSP reporting trigger went into place, and an interaction of these indicators, capturing the treatment effect of the MSP reporting regulation. We also provide estimates from the model that includes state fixed effects and estimates from the model that includes state fixed effects, an age control, and an indicator for plaintiff sex.

Across the models, the MSP reporting requirements appear to be associated with a 20–30 percent decline in the likelihood of settlement at any given time during the process. This difference is statistically significant.

All the foregoing results are robust to using other background hazard models (e.g., Weibull, exponential, etc.), and they are also robust to censoring pre-MSP cases at the MSP trigger date as well as throwing out cases that spanned the reporting trigger date. The results are also robust to accounting for the fact that fewer periods are observed post-MSP than pre-MSP (e.g., examining only the first year after the case is filed and censoring any case that has not terminated within one year). Thus, regardless of the modeling approach taken, it appears as though the MSP reporting requirement is associated with a statistically significant and substantively significant delay in the timing of case settlements/terminations. While the data we use do not allow us to distinguish between the effect of the change in the settlement dynamics modeled above, uncertainty regarding future Medicare expenses, delay in CMS providing information regarding its conditional payments, or some combination of these factors appears to be generating this observed delay.

IV. Conclusion

Using data from State Farm Insurance, a large nationwide auto insurer, we estimate that the MSP Act reporting requirement is associated with an average delay of six months or longer in claim resolution. The requirement, which is designed to increase Medicare's recovery of conditional payments made to plaintiff's in litigation, is quite broad and as such includes a wide variety of claims. Before turning to whether some narrowing of the reporting requirement is justified, it is important to discuss the cost associated with the delay in claims resolution estimated in this study.

A. The Cost of Delay

The results of the above estimation indicate that the MSP Act's 2007 reporting requirements are associated with an average delay of six months. The remaining question is: What is the cost of this delay to the civil justice system and the litigants? The cost of delay has proven extremely difficult to estimate given that researchers rarely have access to data on litigation costs. Moreover, much of the existing empirical work has been done on delay as a function of discovery costs.[42] It is unclear how relevant this literature

[42]See Emery G. Lee III &Thomas E.Willging, Fed. Judicial Ctr., Preliminary Report to the Judicial Conference Advisory Committee on Civil Rules 2 (2009), available at http://www.fjc.gov/public/pdf.nsf/lookup/dissurv1.pdf/$file/dissurv1.pdf, which examines the impact of increased discovery and the attendant costs on litigation delay. See also Danya Shocair Reda, The Cost-and-Delay Narrative in Civil Justice Reform: Its Fallacies and Functions, 90 Or. L. Rev. 1085, 1103–11 (2012) (discussing the 2009 FJC study).

actually is to the delay estimated in this study. The reason is that the reporting requirement triggers both an increase in cost due to the need to acquire additional information, much like an increase in discovery, and also, perhaps more importantly, the law creates uncertainty, which makes claim resolution more difficult.

Thus delay may create higher attorney fees for both plaintiffs and defendants as lawyers and their staff need time to acquire and file the required data with CMS. Since these data could be collected by paralegals, it may be relatively inexpensive in the context of the civil justice system. But as Helland and Kipperman note, even the least expensive participants in the civil justice system are relatively costly.[43] Using the Laffey Index,[44] a cost measure used in lodestar-method calculations of attorney fees, Helland and Kipperman cite the costs of a paralegal with four or fewer years of experience as $105 per hour.[45] Clearly, hourly rates for other legal professionals are significantly higher. If even a fraction of the estimated six months' of delay estimated in this study are driven by additional attorney or staff time, the costs could be considerable.

Yet this is unlikely to be the only cost associated with the delay. In many states, delay mechanically translates into higher payments due to prejudgment interest requirements. Since these rates are often set by statute above market interest rates, delay represents at a minimum a transfer from defendants to plaintiffs.[46]

Finally, there is some evidence that court congestion changes the bargaining position of plaintiffs relative to defendants. Heaton and Helland find that changes in expenditures reduce defendants' payments to plaintiffs.[47] A 10 percent increase in court expenditures increases the payment to plaintiffs by approximately 2 to 3 percent. This finding is relevant since it suggests that plaintiffs are willing to pay, in the form of reduced compensation, to avoid delay.

Moreover, many of these claims will result in minimal recovery for CMS (see Helland and Kipperman, and the discussion above).[48] This suggests a more complex cost-benefit analysis than a simple tally of Medicare's recovery from the reporting requirement. To the extent that the delays estimated here are independent of eventual recovery (i.e., small auto claims are not resolved proportionally faster so as to mitigate their small eventual recovery), then several policy changes could make the system more efficient.

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[43]Helland & Kipperman, supra note 7.

[44]U.S. Attorneys' Office, Laffey Matrix (2010). As of December 2010, available at: http://www.lb7.uscourts.gov/documents/ILSD/07-3142.pdf.

[45]Helland & Kipperman, supra note 7.

[46]See George Priest, Private Litigants and the Court Congestion Problem, 69 Boston Univ. L. Rev. 527–59 (1989).

[47]Paul Heaton & Eric Helland, Judicial Expenditures and Litigation Access: Evidence from Auto Injuries, 40(2) J. Legal Studies Article 2 (2011). Available at: http://chicagounbound.uchicago.edu/jls/vol40/iss2/2.

[48]Helland & Kipperman, supra note 7.

B. Policy Options

We suggest two potential changes to the MSP Act reporting requirement. The first would be an expansion of threshold for reporting found in the SMART Act. Helland and Kipperman examine a $5,000 threshold and find minimal losses associated with Medicare recovery even assuming that all cases under this threshold will not pay any Medicare liens.[49] The findings of the current study suggest that the considerable number of auto claims removed from the reporting requirement would be resolved far more quickly with this threshold.

A more sweeping reform would be the return to pre-2003 subrogation rules. The 2003 Amendments to the MSP Act essentially codified CMS's position that payments in the liability system were essentially insurance and, hence, CMS was entitled to recover its conditional payments as it would be from any first-party insurer. Yet, as noted above, this is not the position of any other insurer in the tort system. These insurers must join ongoing litigation and subrogate the plaintiff's claim in order to recover. As Swedloff notes, this would have several advantages over the current system but, most importantly for our study, it would force CMS to prioritize its recovery efforts.[50] This would almost certainly result in CMS not pursing auto claims and refocusing its efforts on mass torts and class actions, as it did prior to the 2007 reporting requirement. While this would likely result in far greater recovery losses than a reporting threshold, it would also remove almost all the cost associated with the delays estimated in this study.

[49]Helland & Kipperman, supra note, 7.

[50]Swedloff, supra note 4.