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What to Look Forward to:

Carty v. Clark

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By Peter Belsito, Esquire

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By: Mark Popolizio, Esquire

The comment period regarding CMS' *Advance Notice of Public Rulemaking (ANPRM)* officially closed on August 14, 2012.

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Mason v. Sebelius (Part II)

Court Rejects Plaintiff's Argument for Proportional Discounting of Medicare's Conditional Payment Claim

By: Jessica Smythe, Esquire

In the case of ***Mason v. Sebelius, et. al.*, Civil No. 11-2370 (JBS/KMW), 2012 WL 3133801 (D. New Jersey July 31, 2012)**, the court denied a plaintiff's motion for reconsideration seeking to reduce Medicare's conditional payment claim in proportion to his total settlement recovery.

The district court's decision in *Mason* rendered on July 31, 2012 is actually the court's second opinion in this case related to the issue of Medicare conditional payments. In March of this year, this case came before the court on plaintiff's declaratory judgment action in which he claimed, in part, that New Jersey's collateral source rule barred Medicare's conditional payment recovery claim. The court rejected plaintiff's arguments and granted summary judgment in favor of the government.

Following this ruling, plaintiff filed a motion for reconsideration which came before the court on July 31. 2012. For the reasons discussed below, the court also denied this motion.

In this article, the author first provides a brief overview of the pertinent facts in *Mason* and the court's March 26, 2012 decision (Mason I). This is followed by an analysis of the plaintiff's arguments on reconsideration and the court's July 31, 2012 opinion (Mason II) rejecting these arguments.

Facts

Plaintiff was injured when he slipped and fell in a casino. Medicare paid for plaintiff's medical expenses incurred as a result of his injuries in the amount of approximately $2,503.

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Plaintiff and his wife filed suit against the casino seeking damages for plaintiff's pain and suffering, medical costs, and his wife's loss of consortium. Plaintiff and his wife later settled their claims against the casino for $40,000. The release signed by the parties did not specifically allocate the settlement funds between plaintiff's medical costs, his pain and suffering, or his wife's loss of consortium claim.

After settlement, Medicare demanded reimbursement of a reduced portion of the medical expenses paid on plaintiff's behalf. Plaintiff sought a waiver of Medicare's claim through the Medicare administrative appeals process which was unsuccessful.

Mason I
(Decided March 26, 2012)

After losing at the administrative appeals level, plaintiff filed suit in the New Jersey federal district court arguing that Medicare's right of reimbursement was barred by the New Jersey collateral source rule, which holds that a tort plaintiff may not receive damages from a defendant when plaintiff has already received a recovery from a different source for the same injury.

Plaintiff argued that since he could not recover his medical expenses paid by Medicare, his tort settlement was therefore "exempt" from Medicare reimbursement.

The court rejected plaintiff's arguments and held that the New Jersey collateral source rule did *not* preclude Medicare's conditional payment claim. Accordingly, the court affirmed the Medicare Appeals Council's determination of the amount plaintiff owed to Medicare and granted summary judgment in favor of the government.

For a more detailed overview of the court's ruling in **Mason I**, please see the author's article entitled ***New Jersey Collateral Source Rule Not a Bar to MSP Recovery*** contained in CPSC's May 2012 newsletter. To obtain this article, click here.

Mason II
(Decided July 31, 2012)

Plaintiff Files Motion for Reconsideration

Following the court's March 26, 2012 ruling, plaintiff filed a motion for reconsideration and/or clarification through which he presented a new argument.

Specifically, on reconsideration plaintiff argued that Medicare was only entitled to reimbursement of an unspecified fraction of his medical expenses as a proportionate share of his total recovery.

Plaintiff based his reasoning on the holding contained in *Arkansas Dept. of Human Svcs. v. Ahlborn,* 547 U.S. 268 (2006). In *Ahlborn,* the United States Supreme Court interpreted the language of the *Medicaid* statute and held that language limited the state's right to seek reimbursement from settlement proceeds paid to a *Medicaid* beneficiary. *See Ahlborn,* at 284-85, 126 S.Ct. 1752. The court in *Ahlborn* noted the Medicaid statute only permitted the state to seek reimbursement "to the extent the settlement payor has legal liability … to pay for care and services available under the plan." 42 U.S.C. § §1396k(a)(1)(A), 1396a(a)(25)(A) (emphasis added).[1]

Following the reasoning in *Ahlborn,* plaintiff argued that Medicare's recovery should likewise be limited, since he settled his claim for "something less" than his actual damages. Therefore, he argued that Medicare should only be able to recover "something less" than the total medical costs paid. (Plaintiff did not specify exactly what portion or amount of his recovery should be reimbursable to Medicare).

Court Denies Plaintiff's Motion for Reconsideration

The court rejected plaintiff's argument and denied his motion for reconsideration.

The court first denied plaintiff's motion on procedural grounds. Specifically, the court found plaintiff failed to raise *Ahlborn* in his legal briefs filed initially with the court. Thus, the court ruled that he was now barred from making this argument as part of a reconsideration request.

From a more substantive standpoint, the court went a step further stating that even if it were to reach the merits of his *Ahlborn* argument, plaintiff failed to distinguish the facts of his case from the court's holding in *Hadden v. United States,* 661 F.3d 298 (6th Cir. 2011).

In *Hadden*, the United States Sixth Circuit Court of Appeals rejected the argument that *Ahlborn* applied to Medicare reimbursement based on the fact the *Ahlborn* court only applied to the *Medicaid* statute, not *Medicare*. Thus, the court stated that *Ahlborn* was not relevant to the issues presented for review to the court; namely, Medicare's, and not Medicaid's, right to reimbursement.

In addition, the court distinguished the language in the Medicaid statute from that contained in the Medicare statute. As stated above, with respect to Medicaid reimbursement, the state's right to seek reimbursement is limited to the settlement payor's legal liability to pay medical expenses related to the claim based upon the applicable provisions of the *Medicaid statute*.

The court viewed the Medicare statute to be entirely different on this point. Under the Medicare statute, the court noted that Medicare's right to reimbursement is predicated on the primary plan's demonstration of "responsibility" for payment of medical expenses. The Medicare statute defines "responsibility" to include, in part, the primary plan's payment of a settlement, even if the third party denies liability. This aspect of the MSP statute is without a doubt one of the most controversial aspects of Medicare recovery.

For many, this provision seems counterintuitive in the sense that if a settling tortfeasor strongly disputes liability for a claim, has the medical or legal evidence to support the denial, and the plaintiff's recovery is limited accordingly, then many argue that Medicare's right to reimbursement (like Medicaid's) should be similarly limited. Indeed, this was the argument made to the court in *Hadden* in support of the proposition that apportionment should be applicable to settlements involving Medicare beneficiaries. However, like the Sixth Circuit in *Hadden,* the New Jersey court ultimately dismissed this

reasoning and viewed apportionment of Medicare's right to recovery as inapplicable. On this point, the court stated:

> Plaintiff argues that the Court should apply the *Ahlborn* reasoning in this new statutory context for policy reasons. Specifically, Plaintiff argues that permitting CMS to recover the full value of a beneficiary's medical costs [minus applicable procurement costs] would disincentivize future settlements on the part of Medicare beneficiary plaintiffs.
>
> Whatever the merits of Plaintiff's policy concerns may be, it is not in the Court's power to rewrite the plain text of the statute. As the Court [in *Hadden*] has concluded that the plain text of the statute permits CMS to seek recovery of the beneficiary's costs according to the "responsibility" of the primary insurer or self-insured tort defendant, the Court cannot instead choose to read the text as limiting that authority to the defendant's "liability" as was the case in *Ahlborn.*[2]

The court further emphasized the fact that the plaintiff, through the settlement agreement, released ALL of his claims against the casino, including medical expenses; and, therefore, in reviewing the scope of the release AND the scope of plaintiff's claim against the defendants, the court found that settlement triggered Medicare's reimbursement rights. The court, quoting *Hadden,* stated:

> [A] beneficiary cannot tell a third party that it is responsible for all of his medical expenses, on the one hand, and later tell Medicare that the same party was responsible for only [a portion] of them, on the other.[3]

In closing, it is interesting to note the court could have quickly and easily dismissed plaintiff's motion for reconsideration on procedural grounds. The *Mason* court's willingness, however, to delve beyond the simple procedural defects with the case to address Medicare's controversial practice by Medicare of refusing to reduce its liens based upon apportionment and related principles demonstrates how this issue continues to simmer in settlements and litigation across the country.

The court's comments also come at a very interesting time as a Writ of Certiorari is pending before the U.S. Supreme Court with respect to the 6th Circuit's decision in *Hadden.* It is anticipated that the Supreme Court in the next several weeks will be making a decision on whether to hear the *Hadden* case. CPSC will continue to monitor the status of the *Mason* case, along with the pending *Hadden* appeal, and will keep the industry apprised accordingly.

About the Author

Jessica Smythe, Esquire is a national Medicare Secondary Payer compliance consultant with Crowe Paradis Services Corporation. Prior to joining Crowe Paradis, Jessica was a North Carolina defense attorney. Her clients included national and international corporations, self insured companies, insurance carriers and TPAs. Jessica, consequently, dealt with the issues of Medicare compliance while defending claims and now uses this practical knowledge in her current role as a compliance consultant and national speaker. Jessica can be reached at jsmythe@cpscmsa.com.

Endnotes

[1] *Mason v. Sebelius, et. al.*, Civil No. 11-2370 (JBS/KMW), 2012 WL 3133801, at *3 (D. New Jersey July 31, 2012).

[2] *Id.* at *4.

[3] *Id.* at *3; citing *Hadden v. United States,* 661 F.3d 298, at. 302 (6th Cir. 2011).

Carty v. Clark

Potential Exposure for Conditional Payments Post-Settlement Does Not Bar Release of Settlement Funds

By Peter Belsito, Esquire

An interesting new conditional payment case was recently addressed by the United States District Court for the Eastern District of Pennsylvania.

In the case of ***Carty v. Clark*, No. 11-6083, 2012 WL 2890184 (E.D. Pa. June 14, 2012),** the parties reached a settlement agreement under which the settlement funds were to be held in escrow pending plaintiff counsel's production of Medicare's "final" conditional payment figure. Plaintiff's counsel obtained this information, but the defendant refused to release the settlement funds due to concerns over a hospital bill which was not included in CMS' final demand letter.

For the reasons discussed below, the Honorable Thomas J. Rueter (United States Magistrate Judge) issued a "Report and Recommendation" ordering that the defendant release the settlement funds per the terms of the parties' settlement agreement and other reasons.

This article summarizes the court's decision and highlights larger MSP issues for consideration as follows:

Background

On April 5, 2012, the parties reached a settlement of this liability claim for the sum of $90,000. Under the terms of the agreement, the settlement funds were to be held in escrow by defense counsel until plaintiff's counsel produced a Final Demand Letter from the Medicare Secondary Payer Recovery Contractor (MSPRC) specifying the final amount due to Medicare's conditional payment claim.

After entering into this agreement, plaintiff's counsel advised the MSPRC of the settlement and requested CMS' "final" conditional payment demand. On May 1, 2012, plaintiff

received the Final Demand Letter from the MSPRC which demanded full reimbursement by June 29, 2012. Plaintiff's counsel then sent the Final Demand Letter to defense counsel who acknowledged receipt of same on or about May 1, 2012.

Despite receiving the Final Demand Letter, defense counsel refused to release the escrowed settlement funds because the letter did not reference certain bills from Chester-Crozer Hospital. The Chester-Crozer bills were submitted to Medicare for payment on four separate occasions. However, Medicare had denied payment each time, with Medicare's last noted denial being October 26, 2011.

Plaintiff then filed a Motion to Enforce Settlement seeking the immediate release of the settlement funds, along with attorney fees and sanctions against the defendant.

Court Enforces the Settlement

The plaintiff's motion was referred to the Honorable Thomas J. Rueter (United States Magistrate Judge) who issued his opinion in the form of a "Report and Recommendation."

After reviewing the matter, Judge Rueter recommended that the court *grant* plaintiff's motion to the release of the settlement funds; but *deny* plaintiff's request for attorney fees and sanctions.

In recommending that the settlement funds be released, Judge Rueter found that the settlement terms were "clear and unambiguous" in that under the settlement agreement the defendant *"had an obligation to release [the settlement funds] to plaintiff's counsel upon receipt of the Final Demand Letter."*[1] On this point, the court noted that defense counsel acknowledged that this language was in fact unambiguous at the motion hearing.[2]

With respect to the Chester-Crozer's hospital bills, Judge Rueter stated:

> The court credits [plaintiff counsel's] testimony and finds that the Chester–Crozer Hospital bill is not a Medicare lien, because Medicare did not make payment on this medical bill.
>
> While defendants speculate that, despite the Final Demand Letter, Medicare may one day pay the Chester–Crozer Hospital bill and seek reimbursement from plaintiff and/or defendants, this concern does not justify the abdication of their clear obligation under the Release to pay the $90,000 to plaintiff now. As the Pennsylvania Superior Court has held, defendants cannot assert 'Medicare's right to reimbursement as a preemptive means of guarding against [their] own risk of liability.' *Zaleppa v. Seiwell,* 9 A.3d 632, 638 (Pa.Super.Ct.2010).[3]

Accordingly, Judge Rueter found that *"[u]nder the clear and unambiguous terms of the Release, defense counsel must release the $90,000 to plaintiff."*[4]

However, Judge Rueter recommended that plaintiff's claim for attorney fees and sanctions be *denied* finding that the defendant "did not act in bad faith, vexatiously, wantonly, or for oppressive reasons"[5] under applicable law. Nonetheless, he recommended that the defendant be held responsible for any interest that Medicare assessed against the plaintiff in the event that defense counsel did not release the funds in sufficient time to allow the plaintiff to tender reimbursement to Medicare by the MSPRC's due date of June 29, 2012.

In the Bigger Picture

The issues raised in *Carty* highlight some of the challenges and uncertainties facing settling parties concerning Medicare conditional payments.

One such issue involves dealing with the fact that, in most cases, the parties are unable to obtain CMS' "final" conditional payment demand *prior* to settlement. This is a result of CMS' current policy of not releasing a Final Demand Letter without first receiving evidence of that the settlement has been finalized.[6]

The inability to make this determination can place the parties in a difficult predicament during the settlement process as they are unable to determine their potential reimbursement obligations. For primary payers, this problem is further compounded by the fact that they remain at risk for potential liability if CMS seeks reimbursement from the claimant, but he or she fails to repay Medicare. Specifically, under 42 C.F.R. 411.24 (h) and (i), if CMS requests reimbursement from the plaintiff and he or she does not reimburse Medicare within 60 days from receipt of a primary payment, the primary payer must then *"reimburse Medicare even though it has already reimbursed the beneficiary or other party."*

Given this potential liability, it is not uncommon for defendants (as was the case in *Carty*) to insist that the settlement funds not be disbursed until after CMS' "final" demand is received. In *Carty*, the plaintiff agreed to this provision and the settlement monies were held in escrow until the plaintiff lawyer obtained CMS' final demand from the MSPRC. While this worked out in *Carty*, this approach is often times not agreeable to the plaintiff. In those instances where the plaintiff refuses to hold the settlement funds until Medicare's final conditional payment figure is determined, primary payers are then faced with a number of practical challenges, including the plaintiff potentially raising bad faith issues.[7]

Another major concern for the defendants in *Carty*, which ended up being the main reason the defendants were reluctant to release the settlement monies, related to hospital bills that Medicare had denied and were not included within CMS' "final" demand. The defendants were concerned that Medicare could come back at some later point and demand reimbursement, despite CMS' issuance of Medicare's "Final Demand Letter." In essence, the issue being *"just when is Medicare's 'final' demand, 'final'?"*

A complete examination of this complex topic is beyond the scope of this article. However, in general this issue raises questions concerning the scope of Medicare's rights under the MSP, CMS' administrative practices, consideration of estoppel and other legal arguments, and the practical or legal recourses (if any) that primary payers may have to protect themselves. The court in *Carty* found that the terms of the settlement agreement precluded the defendants from retaining the settlement proceeds for this possible contingency. Further, the court indicated that the defendant could not

"preemptively" assert Medicare's rights in this regard citing the *Zaleppa v. Seiwell* case.[8]

It is interesting to note that some of the issues that surfaced in *Carty* are currently the subject of reform efforts in Congress. For example, the *Strengthening Medicare and Repaying Taxpayer's Act (SMART Act) (H.R. 1063/S.1718)* would permit the parties to obtain Medicare's "final" conditional payment amount *prior* to settlement in certain instances. In general, the SMART Act proposes that the parties could request CMS' final conditional payment amount starting 120 days prior to the reasonably expected date of settlement. CMS would then be required to provide this figure within 65 days from its receipt of this request. The bill further proposes that this amount *"shall constitute the conditional payment subject to recovery."*[9]

Under the *Medicare Secondary Payer and Workers' Compensation Settlement Agreement Act of 2012 (H.R. 5284)*, CMS would have 90 days to provide a "workers' compensation claimant or payer" with conditional payment documentation after receiving a request for this information by these parties. The bill then proposes that payment of the determined conditional payment amount, after the deduction of certain permitted costs, *"shall discharge further liability with respect to the conditional payment."*[10]

In closing, *Carty* demonstrates some of the significant challenges primary payers presently face in trying to completely protect themselves from liability under the MSP. From the above discussion, the sobering reality may be that, despite these efforts, iron clad protection on the various MSP fronts may not necessarily be achievable in all circumstances under current conditions. As part of this evaluation, it is interesting to consider how the proposed reforms under the SMART Act or H.R. 5284 could potentially mitigate the types of issues currently confronting litigants as illustrated in *Carty*.

About the Author

Peter Belsito has worked in various departments at Crowe Paradis Services Corporation (CPSC) since joining the company in 2007. Mr. Belsito has written extensively on Medicare Secondary Payer issues, and is a nationally recognized speaker. He is a graduate of the University of Massachusetts and Brooklyn Law School. He is licensed to practice law in New York State and the Commonwealth of Massachusetts. He is a member of the Massachusetts Bar Association, and the National Alliance of Medicare Set-Aside Professionals. Peter can be reached at pbelsito@cpscmsa.com or (978) 766-2138.

Endnotes

[1] *Carty v. Clark*, No. 11-6083, 2012 WL 2890184, at *1 (E.D. Pa. June 14, 2012).

[2] *Id.*

[3] *Id.* at *2. *Zaleppa* involved a claim for injuries arising from an automobile accident that resulted in a judgment against the defendant, Seiwell, in the amount of $15,000. The defendant subsequently filed a post-judgment motion to seeking a court order to either include Medicare on the draft satisfying the verdict payment, or that the funds be held in escrow pending proof that any Medicare conditional payment claim be satisfied.

However, the court denied the motion, holding that the MSP did not confer private parties with the right to enforce Medicare's right of recovery; particularly, as was the case in *Zaleppa*, where Medicare's reimbursement rights have not been triggered. According to the court: *"Nothing [in the MSP] ... expressly authorizes a primary plan to assert Medicare's right to reimbursement as a preemptive means of safeguarding against its own risk of liability. The [MSP] sets forth only one method for the United States government to recover the funds which it dispersed through conditional Medicare payments. Under the [MSP], only the Unites States government is authorized to pursue its own right to reimbursement." Zaleppa v. Seiwell,* 9 A.3d 632, 638 (Pa.Super.Ct.2010).

[4] *Carty*, No. 11-6083, 2012 WL 2890184 at *2.

[5] *Id.* at *2, citing *Atwell v. U.S. Air,* 1990 WL 167955, at *1 (E.D.Pa. Oct. 29, 1990) (denying request for attorney fees where defendant's delay in payment under settlement agreement was not in bad faith).

[6] As stated, under CMS' current policy, the parties are unable, in most cases, to obtain Medicare's "final" conditional payment figure until after the settlement has been finalized. However, CMS has recently released three new options allowing parties to determine the amount of Medicare's conditional payment recovery claim *prior* to settlement. However, these policies are limited to only certain physical trauma liability claims, and there is host of criteria which must be met.

By way of example, under CMS' new *Self-Calculation Method*, for certain physical liability claims settling for $25,000, or less, CMS will allow the beneficiary to self-calculate a proposed "final" conditional repayment amount for the agency's approval prior to settlement if the beneficiary can demonstrate that treatment is completed and can otherwise meet several additional criteria. Under CMS' *Fixed Percentage Option*, for certain physical trauma liability settlements of $5,000, or less, a beneficiary may submit a request to CMS permitting him or her to simply pay Medicare 25% of the gross settlement in satisfaction of any conditional payment claims. CMS has also introduced a *$300 low threshold* option through which Medicare may agree to waive its conditional payment claim for certain physical trauma liability settlements of $300 or less. To learn more about these new options, see www.msprc.info.

[7] See e.g., *Wilson v. State Farm Mutual Automobile Insurance Company*, No. 3:10-CV-256-H, 2011 WL 2378190 (W.D. Ky., June 15, 2011). In *Wilson*, the carrier refused to tender the settlement until the parties received Medicare's final conditional payment figure. The plaintiff then sued the carrier for bad faith. However, the federal court for the Western District of Kentucky ruled the carrier did not act in bad faith, as defined under Kentucky law, by delaying payment of the policy proceeds pending the determination of Medicare's reimbursable conditional payment amount. Based on the relevant facts, the court found that the carrier acted reasonably under Kentucky law in regard to withholding payment pending a determination of whether Medicare had a conditional payment claim.

[8] See discussion under n. 3 above.

[9] *Strengthening Medicare and Repaying Taxpayers Act*, H.R. 1063 and S. 1718, 112th Cong. §2 (2012). For a complete review of the SMART Act proposals as discussed in this article, and the other reform proposals contained therein, see the article ***Reforming Medicare Secondary Payer Compliance –The SMART Act ..Is There Hope on the Horizon?*** authored by Mark Popolizio, Esquire of Crowe Paradis. This article can be obtained at http://www.cpscmsa.com/uploads/FWCI%20April%202012%20Article%20Only.pdf.

[10] *Medicare Secondary Payer and Workers' Compensation Settlement Agreement Act of 2012*, H.R. 5284, 112th Cong. 2d Session, §5(B)(i)(2012).

ANPRM Comment Period Closes

By: Mark Popolizio, Esquire

The comment period regarding CMS' *Advance Notice of Public Rulemaking (ANPRM)* officially closed on August 14, 2012.

Over the past several weeks, various non-group health plans (NGHP) stakeholders and other claims professionals have been submitting their comments and responses to CMS' *Advance Notice of Public Rulemaking (ANPRM).*

Through the ANPRM, CMS proposes seven options aimed at ensuring that Medicare's future medical interests are "satisfied" in relation to NGHP settlements. The ANPRM's proposals focus heavily on liability claim settlements, including one proposal calling for the formal extension of CMS' Medicare set-aside (MSA) program to liability claims.

Since their release in June, CMS' ANPRM proposals have generated much interest (and concern) throughout the NGHP claims arena. These proposals are significant in that the current regulations under the Medicare Secondary Payer (MSP) statute do not contain a specific mandate requiring CMS to review and approve future medical allocations; nor do they contain any provisions addressing specific options to address Medicare's "future interests." In this regard, all post-settlement MSP compliance activities regarding Medicare's future medical interests have been voluntary up until this point.

Through the ANPRM, CMS now proposes to officially amend 42 C.F.R. Parts 405 and 411, signaling the agency's apparent intent to establish more formal legal regulations and provisions regarding post-settlement MSP compliance obligations regarding Medicare's future medical interests.

As of the time this article was prepared, CMS had already started posting several of the submitted ANPRM commentary responses it has received from the public on its designated regulations website (address noted below). In the coming weeks, it is anticipated that the number of posted submissions will significantly increase as the agency continues to process all the submissions received during the comment period.

Looking forward, it will be necessary to monitor CMS' next steps regarding the ANPRM, which may include release of a proposed "Final Rule" for public comment, or the release of a revised set of ANPRM proposals for a second comment period. CPSC will monitor all events in this regard and keep the industry apprised accordingly.

To learn more about CMS' ANPRM proposals, the reader may wish to consult the following sources:

- Federal Register, Volume 77, No. 116 (June 15, 2012): click here.
- CPSC's June article on the ANPRM click here.
- CMS' ANPRM website http://www.regulations.gov. (Please refer to file code CMS-6047-ANPRM when searching under "Advanced Search." You will then be able to view Medicare Programs: *Medicare Secondary Payer and Future Medicals.*)

For more information, please do not hesitate to contact the author at his listed contact information below.

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Mark Popolizio, Esquire is Section 111 Senior Legal Counsel for Crowe Paradis Services Corporation. Mark is a nationally recognized authority in MSP compliance. He has authored numerous articles on MSP issues including MMSEA Section 111, MSAs and conditional payments. Mark is a regularly featured presenter at national seminars and other industry events. Prior to dedicating his practice to MSP compliance in 2006, Mark practiced workers' compensation and liability insurance defense for ten years representing carriers, employers, third party administrators and self insureds. Mark is based out of Miami, Florida and can be reached at mpopolizio@cpscmsa.com or (786) 459-9117.

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