

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 ONE HUNDRED TWELFTH CONGRESS

FIRST SESSION

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PROTECTING MEDICARE WITH IMPROVEMENTS TO THE SECONDARY PAYER REGIME

WEDNESDAY, JUNE 22, 2011

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS,
COMMITTEE ON ENERGY AND COMMERCE,
WASHINGTON, DC.

The subcommittee met, pursuant to call, at 10:01 a.m., in room 2322 of the Rayburn House Office Building, Hon. Cliff Stearns (chairman of the subcommittee) presiding.

Members present: Representatives Stearns, Murphy, Burgess, Bilbray, Gingrey, Scalise, Griffith, DeGette, Schakowsky, Green, Christensen, Dingell, and Waxman (ex officio).

Staff present: Stacy Cline, Counsel, Oversight; Todd Harrison, Chief Counsel, Oversight/Investigations; Sean Hayes, Counsel, Oversight/Investigations; Andrew Powaleny, Press Assistant; Alan Slobodin, Deputy Chief Counsel, Oversight; John Stone, Associate Counsel; Alex Yergin, Legislative Clerk; Kristin Amerling, Democratic Chief Counsel and Oversight Staff Director; Alvin Banks, Democratic Assistant Clerk; Stacia Cardille, Democratic Counsel; Brian Cohen, Democratic Investigations Staff Director and Senior Policy Advisor; and Tim Gronninger, Democratic Senior Professional Staff Member.

Mr. STEARNS. Good morning, everybody. The subcommittee will come to order.

OPENING STATEMENT OF HON. CLIFF STEARNS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF FLORIDA

We convene this hearing of the Oversight and Investigations Subcommittee to examine how the Centers for Medicare and Medicare Services (CMS) has been implementing the Medicare Secondary Payment statute. Medicare represents a substantial portion of the federal budget. So with our country facing a \$1.4 trillion deficit and an impending debt limit ceiling vote, we must ensure that CMS is properly guarding the legal and financial interests of Medicare beneficiaries, while protecting the solvency of the program itself.

Generally, Medicare is the “primary payer” for health claims. If a beneficiary has other insurance, that insurance may fill in all or some of Medicare’s gaps. However, the Medicare Secondary Payment program identifies specific conditions under which another party is legally responsible to be the primary payer. In such cases, Medicare is only responsible for certain secondary payments. The Medicare Secondary Payment statute was enacted to reduce ex-

penditures under the Medicare program and ensure that Medicare is properly reimbursed for such payments.

The law prohibits Medicare payments for any item or service when payment has been made or can reasonably be expected to be made by a third-party payer—such as workers' compensation, auto medical insurance, and all forms of no-fault and liability insurance. Medicare Secondary Payer recoveries fall into two main categories: post-payment collections for injuries that have occurred and were paid out by Medicare, and a set-aside account to cover future medical bills.

For post-payment collections, there is widespread concern that CMS is creating unnecessary roadblocks for parties to reach a settlement agreement. Businesses and injured individuals routinely negotiate a settlement but cannot close on the settlement until CMS provides a complete list of all medical costs incurred. We have heard complaints from a variety of interested parties that CMS is not providing this information in a consistent or in a timely manner. CMS's delays cause lawsuits to drag on, hinders timely payments to injured individuals, and causes uncertainty and increases costs for both large and small businesses.

This raises several questions. Why can't CMS more quickly and accurately track medical costs for covered individuals? And is CMS even capable of administering a health payment program for the medical community or accurately tracking costs? Based on a hearing in this subcommittee earlier this year, we already know that CMS cannot accurately measure the amount lost to fraud and that CMS doles out tens of billions of dollars in improper payments every year. And we have yet to see reliable estimates on the total amount of secondary payment reimbursements that remain uncollected by CMS.

In addition to post-payment collections, plaintiffs are supposed to set aside funds to cover future medical costs relating to the initial injury—such as follow-up surgeries or prescription drugs for chronic injuries. However, the reporting requirements are just so weak that CMS may not know about the settlement or whether the set-aside account has been improperly spent on unrelated, non-medical expenses. The result is that CMS continues to pay for an injury that was already paid for by a third party.

CMS now says that they plan to increase education and awareness for the legal community on the requirements of Medicare Secondary Payer, which has been on the books for almost 30 years. That CMS needs to educate people on a 30-year-old law brings into question what they have been doing for the past 30 years and how effective their outreach efforts have been. I think more needs to be done, obviously. Whenever retailers, insurance companies, and plaintiffs' attorneys are all sending letters to CMS, anxious to pay the Federal Government, and they can't get a complete or timely response about how much they owe, the system is badly broken.

Hopefully, our witnesses today can help us better understand the underlying problems, and we can work in a bipartisan manner to fix this.

With that, I would like to welcome our first panel: Deborah Taylor, Director of Financial Management at CMS; and James Cos-

grove, Director of Health Care from the Government Accounting Office. And I look forward to their testimony.

And with that, I welcome the Ranking Member Ms. DeGette from Colorado for an opening statement.

[The prepared statement of Mr. Stearns follows:]

**Opening Statement of the Honorable Cliff Stearns
Chairman, Subcommittee on Oversight and Investigations
“Protecting Medicare with Improvements to the Secondary Payer Regime”
June 22, 2011
(As Prepared for Delivery)**

We convene this hearing of the Oversight and Investigations Subcommittee to examine how the Centers for Medicare and Medicare Services (CMS) has been implementing the Medicare Secondary Payer statute. Medicare represents a substantial portion of the federal budget. So, with our country facing a \$1.4 trillion deficit and an impending debt ceiling limit, we must ensure that CMS is properly guarding the legal and financial interests of Medicare beneficiaries, while protecting the solvency of the program.

Generally, Medicare is the “primary payer” for health claims. If a beneficiary has other insurance, that insurance may fill in all or some of Medicare’s gaps. However, the Medicare Secondary Payer program identifies specific conditions under which another party is legally responsible to be the primary payer. In such cases, Medicare is only responsible for certain secondary payments. This Medicare Secondary Payer statute was enacted to reduce expenditures under the Medicare program, and ensure that Medicare is properly reimbursed for such payments.

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This raises several questions: Why can’t CMS more quickly and accurately track medical costs for covered individuals? And is CMS even capable of administering a health payment program for the medical community or accurately tracking costs? Based on a hearing in this subcommittee earlier this year, we already know CMS cannot accurately measure the amount lost to fraud and that CMS doles out tens of billions of dollars in improper payments every year. And we have yet to see reliable estimates on the total amount of secondary payment reimbursements that remain uncollected by CMS.

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CMS now says that they plan to increase education and awareness for the legal community on the requirements of Medicare Secondary Payer- which has been on the books for almost 30 years. That CMS needs to educate people on a 30 year old law brings into question what they have been doing for the past 30 years and how effective their outreach efforts have been. I think more needs to be done. Whenever retailers, insurance companies, and plaintiff's attorneys are all sending letters to CMS, anxious to pay the federal government, and they can't get a complete or timely response about how much they owe, the system is badly broken. Hopefully our witnesses today can help us better understand the underlying problems, and we can work on a bipartisan basis to fix them.

With that, I would like to welcome our first panel: Deborah Taylor, Director of Financial Management at CMS; and James Cosgrove, Director of Health Care from the Government Accountability Office. And I look forward to their testimony.

OPENING STATEMENT OF HON. DIANA DEGETTE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF COLORADO

Ms. DEGETTE. Thank you very much, Mr. Chairman.

I am pleased that we are having this hearing today on Medicare Secondary Payer issues. We hear over and over again—in fact, I had two town hall meetings this last weekend where I heard from my constituents about how much they value the Medicare program, how important it is to them. Millions of Americans rely on Medicare to pay for visits to their doctors, cover their hospital stays, and help with their prescription drug costs.

This hearing today is very important because the Medicare Secondary Payer program arrangement that you so well described in your opening statement saves taxpayers money while making sure that recipients get the benefits that they need. The Medicare Secondary Payer rules have saved taxpayers over \$50 billion in the last decade, but as you said, the program is not perfect. Beneficiaries, insurance companies, lawyers, and retailers assert that the way the Medicare Secondary Payer process is handled can create confusion and delay.

We heard the story of one Medicare beneficiary who brought a case against a drunk driver that hit her. The case was ultimately settled. The beneficiary was told years later that she had to pay Medicare back using the proceeds of her settlement for medical costs related to the car accident or that the Treasury Department would seize her Social Security checks. Unfortunately, there are other seniors with similar stories.

So, in general, I think that this subcommittee can serve many purposes, and one of the important purposes that we serve is to have sensible congressional oversight of problems with federal programs, because that will then motivate an agency to move more quickly to correct an issue.

I am glad that we have Deborah Taylor here today, the director of Financial Management at CMS because I think it is important that we hear from CMS about problems with the program and how the Agency is acting to address them. We are really asking the Agency to do three things here: first, to protect taxpayer funds; second, to make sure that beneficiaries can fairly get their healthcare costs covered; and thirdly, to work with lawyers and insurance companies to obtain justice in cases where they have been injured or harmed.

To the extent that this is not happening, I want to hear about how the Agency can improve and about whether CMS needs more tools from Congress to make sure that the program works better. I think we can also have illuminating testimony from GAO and representatives from groups that are affected by the Medicare Secondary Payer rules in the second panel today.

You know, we can go on ad nauseam about the problems with this program, but I frankly am most interested in hearing from our witnesses about the solutions to these problems. It is not enough to say that the program is broken. Instead, we have to think creatively about the steps that the Agency can take and whether congressional action is needed to help.

One possible solution is H.R. 1063, the Strengthening Medicare and Repaying Taxpayers Act introduced by our colleague Tim Murphy who was just here a minute ago. And it is a bipartisan bill of which I am a—oh, there he is. They have promoted you—or demoted you as the case may be. This fine legislation would take a number of steps to address the problems associated with Medicare Secondary Payer rules, establish tight new deadlines for CMS to provide information to beneficiaries and their attorneys.

And so even though this is not a legislative hearing, I would like to hear from CMS, GAO, and the other witnesses about whether they think that this type of legislation strikes the appropriate balance between the needs of beneficiaries and the needs of taxpayers and see if they have any suggestions about how this legislation could be improved.

Congress certainly has a legitimate interest in ensuring our constituents are being treated fairly under Medicare Secondary Payer rules. I look forward to today's hearing and really focusing on the solutions to address any problems that remain.

Thank you, and I yield back.

[The prepared statement of Ms. DeGette follows:]

Ranking Member DeGette
“Protecting Medicare with Improvements to the Secondary Payer Regime”
Subcommittee on Oversight and Investigations
June 22, 2011

Thank you, Chairman Stearns. I am pleased that today we are holding this hearing on Medicare Secondary Payer issues. We hear constantly from our constituents how much they value the Medicare program. Millions of Americans rely on Medicare to pay for visits to their doctors, cover their hospital stays, and help with their prescription drug costs.

Typically, the Medicare program is deemed the “primary payer,” meaning it pays medical claims first and up to the limits of its coverage. In certain circumstances, however, Medicare is deemed the “secondary payer.” This occurs when Medicare beneficiaries are working aged and covered by group health insurance through their employers, or already have some medical costs covered by liability insurance, court settlements, or workers’ compensation. In these cases, the other entity or plan pays the medical bills before Medicare does, with Medicare serving as the backstop to pay for all care that is not covered. This arrangement saves taxpayers money while making sure that recipients get the care they need.

Medicare Secondary Payer rules have saved taxpayers over \$50 billion over the last decade. But the program is not perfect. Beneficiaries, insurance companies, lawyers, and retailers assert that the way the Medicare Secondary Payer process is handled can create confusion and delay.

We have heard the story of one Medicare beneficiary who brought a case against a drunk driver that hit her. The case was ultimately settled. The beneficiary was told years later that she had to pay Medicare back – using the proceeds of her settlement – for medical costs related to the car accident or the Treasury Department would seize her Social Security checks. Unfortunately, there are other seniors with similar stories.

I think this Subcommittee can serve an important purpose. Often, sensible Congressional oversight of problems with federal programs will motivate an agency to act quickly to correct the issue. Today, we will hear from Deborah Taylor, the Director of Financial Management at CMS.

It is important that we hear from CMS about problems with the program, and how the agency is acting to address them. We are asking the agency to do three things here – protect taxpayer funds, make sure that beneficiaries can fairly get their health care costs covered, and work with lawyers and insurance companies to obtain justice in cases where they have been injured or harmed. To the extent that CMS is not getting the job done in one of these areas, I want to hear about how the agency can improve – and about whether they need more tools from Congress to make the program work better.

We will also hear from GAO and representatives from groups that are affected by Medicare Secondary Payer rules. I look forward to their testimony and thank them for their appearance before our Subcommittee.

We will discuss the problems associated with this program, but I am most interested in hearing our witnesses provide their views on solutions. It is not enough to say this program is broken; instead, we must think creatively about the steps the agency and Congress can take to resolve the problems and continue to make sure that taxpayer funds are protected.

One possible solution is H.R. 1063, the Strengthening Medicare and Repaying Taxpayers Act. It was introduced by Representative Tim Murphy of Pennsylvania and I am a co-sponsor.

This legislation would take a number of steps to address the problems associated with Medicare Secondary Payer rules, establishing tight new deadlines for CMS to provide information to beneficiaries and their attorneys. I'd like to hear from CMS, GAO, and from our other witnesses about whether they think this legislation strikes the appropriate balance between the needs of beneficiaries and the needs of taxpayers – and to learn about how this legislation could be improved.

Congress has a legitimate interest in ensuring our constituents are being treated fairly under Medicare Secondary Payer rules. I look forward to today's hearing and learning more about solutions to address any problems that remain.

Mr. STEARNS. The gentlelady yields back. And the gentleman from Texas, Mr. Burgess, is recognized for 2 minutes.

OPENING STATEMENT OF HON. MICHAEL C. BURGESS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Mr. BURGESS. I thank the chairman.

This hearing is an example of what this committee does best in exercising its oversight function, in this case, with the Center for Medicare & Medicaid Services and to ensure that the process functions as intended, to ensure today that the Medicare Secondary Payment system is working as Congress intended and to see where improvements can be made if indeed there are problems. And there appear to be.

Now, it should be intuitively obvious to the casual observer that CMS and third-party payers would communicate with each other about what is owed, what has been paid, and even be able to estimate what future costs when a court case lasts for years. However, these communications have only recently been required. Questions, disagreements, and difficulties persist, and many have suggested that improvements can be made. And while the Medicare Secondary Payment System is only a very small element of Medicare, any dollar which is paid that is not Medicare's primary responsibility, it is a dollar that can't be recovered and it is a dollar that is not available to provide another service for another beneficiary.

Mr. Chairman, I know our staffs have spoken and I hope we can continue similar oversight into the Medicaid program as well. Congress has clearly agreed through the fall statements regarding health matters in the Deficit Reduction Act, but State Medicare authorities should always work to assure that Medicaid is the payer of last resort. Since 1980, statute has required State Medicaid plans to take reasonable measures to avoid medical claims for which the beneficiary has other health insurance that is legally primary to Medicaid. In 2003, audits of six Medicaid authorities uncovered problems with between 20 and 36 percent of claims sampled. Extrapolating nationwide, we could be talking about \$45 billion per year. I also look forward to the updated information from the General Accountability Office on the Medicare Secondary Payment System program.

At the end of the day, no one wants a medical provider to bill a wrong payer and no one wants the wrong payer to pay. We want to know that our government programs are ensuring the proper and legally responsible payer meets their responsibility. We don't want beneficiaries to be shouldered with an unforeseen bill due to lagging communications.

Mr. Chairman, I will yield back the balance of my time.

Mr. STEARNS. Thank you. The gentleman from Pennsylvania, Mr. Murphy, is recognized for 3 minutes.

OPENING STATEMENT OF HON. TIM MURPHY, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF PENNSYLVANIA

Mr. MURPHY. Thank you, Mr. Chairman.

Only in Washington can someone who wants to send money back to the Federal Government be ignored. But that is the situation we

are dealing with now with some of this difficulty we have with this problem. We want to preserve Medicare for seniors. It is important. It is essential. But it is a mess. What is critically important for our seniors' health is also critically ill itself and bleeding money.

One aspect of this is that hundreds of millions of dollars that should be repaid to the Medicare Trust Fund are sitting in lawyers' accounts because the Center for Medicare & Medicaid Services won't tell those who want to settle a lawsuit how much the medical bills must be repaid to the government.

Under the current law, the Medicare Secondary Payer statute is supposed to ensure the taxpayers don't foot the bill for senior citizens' medical expenses if the injury resulted from a case involving third-party liability. That makes sense, but it loses dollars because the system just doesn't work. Plaintiffs and defense attorneys, retailers, employers, and senior citizens all cry out that the system is a mess, but CMS, like Kevin Bacon's character of Chip Diller in *Animal House* raises his hand and says remain calm; all is well.

The current MSP system, which we are investigating today, discourages and even prevents companies from settling claims involving Medicare beneficiaries because Medicare won't tell the settling parties how much is owed. That is why I have introduced bipartisan legislation with Representative Ron Kind, the Strengthening Medicare and Repaying Taxpayers Act—the SMART Act—that would compel CMS to provide the medical bills information so the parties can settle within 65 days. This legislation would get money to the trust fund and ensure seniors are paid money that is rightfully theirs quickly.

As Jason Matzus—an attorney from Pittsburgh who is here today—will explain, his clients, some of whom are in ill health and depending on that settlement to pay bills and their mortgage have waited months to hear back from CMS on how much Medicare is owed. If we enact the SMART Act, that senior citizen will receive what is rightfully hers now.

The SMART Act will also prevent another kind of horror story. These are cases where Medicare has denied medical treatment to a senior citizen for breast cancer because she received a settlement check related to a chest wall contusion suffered from a slip and fall years ago. This year, Medicare may collect an estimated 230 million from cases like auto accidents and slip-and-falls. And if the SMART Act were enacted into law, Medicare could see annual collections quadruple to \$1 billion per year.

We will also hear how Medicare spends more money pursuing old claims than the amount owed to Medicare. In one example, Medicare spent more in postage notifying the plaintiff of their obligation than the \$1.59 owed to the trust fund. The SMART Act would reduce these wasteful expenses by ensuring Medicare doesn't spend more money pursuing collections than the amount is actually owed.

According to a new study by the Rand Corporation, if Medicare pursued settlements only greater than \$5,000, the Agency would still recover 98 percent of the \$1 billion I mentioned earlier, but it would reduce the number of claims it dithers away resources on by 43 percent.

So I thank the chairman for this investigation. We have an opportunity with passing the SMART Act to be responsible stewards

of the trust fund, because all of us deeply care about protecting the Medicare benefits that our constituents—especially our senior citizens—have earned.

And I yield back.

Mr. STEARNS. I thank the gentleman. The Ranking Member Mr. Waxman from California is recognized for 5 minutes.

OPENING STATEMENT OF HON. HENRY A. WAXMAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. WAXMAN. Thank you very much, Mr. Chairman.

The Medicare Secondary Payer program is complex and arcane. Few people have heard of this program and even fewer understand it, but that does not mean it is insignificant. The program saves taxpayers billions of dollars helping to make sure that Medicare is not forced to foot the bill in cases where the other insurers should be paying. This is a worthy goal and we all have an interest in making this program work.

We have two panels today, and I hope they will help us answer one simple question: Is the Medicare Secondary Payer program working for taxpayers and Medicare beneficiaries? The problem with answering this simple question is that there can be a tension between what works for the taxpayer and what works for beneficiaries. From the beneficiary perspective, the key goals are speed, simplicity, and certainty. Beneficiaries want Medicare to reduce burdens and rapidly give beneficiaries—especially those caught up in legal cases with insurers because of accidents—the information they need about how much they or their insurer will have to reimburse Medicare.

Taxpayers have different goals. Taxpayers want the program to leave no money on the table, even if that means waiting to be 100 percent certain that all funds owed to taxpayers are repaid. I don't envy the job of CMS in finding the right balance here.

Today, we will hear from CMS about how they have chosen to run the program and the opportunities they see for improvement. We will also hear from GAO about key program areas that need investigation. On the second panel, we will have witnesses representing beneficiaries, trial lawyers, and businesses affected by the Medicare Secondary Payer rules. They feel that CMS has not obtained the correct balance in the way they have chosen to run the program.

This will be a valuable hearing because it can help us determine whether we should enact legislative solutions. Our goal should be to work with CMS and other interested parties to be sure we are appropriately weighing the concerns of beneficiaries and the concerns of taxpayers. Our focus today on making Medicare better, however, we need to recognize how important Medicare is to seniors and to our Nation. And we should renounce efforts to end Medicare as we know it.

Many of my Republican colleagues have bashed Medicare and supported turning the program over to private insurance companies on the basis that no government program can do an effective job compared to the private sector. We hear these arguments. One of the key talking points is that Medicare has extremely high erro-

neous payment rates. Their implication is clear that Medicare's error rate is higher than error rates of private insurers. But that simply is false. Earlier this week, the American Medical Association released their annual report card on insurers. The AMA found that Medicare had the highest payment accuracy rate among all providers, 96 percent. Private insurers' payment accuracy rates were five times higher than Medicare. This is a great example of Medicare leading the way and doing better than the private sector when it comes to cutting waste.

Mr. Chairman, you and other members of your conference voted for the budget that would replace Medicare for people under 55 with a privatized and underfunded voucher system that would cost thousands of dollars more in out-of-pocket healthcare costs every year. Seniors would face the worst of both worlds: the loss of important guaranteed benefits and higher out-of-pocket costs because of the inefficiency of the privatized Medicare model.

These dramatic changes to Medicare pose a much greater risk to seniors than the problems in the Medicare Secondary Payer program. That is why I sent a letter to Chairman Upton last month asking for hearings on the Republican budget's impact on Medicare & Medicaid. Now that we have started Medicare work in this subcommittee, I hope our next oversight hearing can look at the impacts of the Republican budget on this key program for seniors and the disabled.

I yield back the balance of my time.

[The prepared statement of Mr. Waxman follows:]

Statement of Rep. Henry A. Waxman
Ranking Member, Committee on Energy and Commerce
“Protecting Medicare with Improvements to the Secondary Payer Regime”
Subcommittee on Oversight and Investigations
June 22, 2011

Mr. Chairman, the Medicare Secondary Payer Program is complex and arcane. Few people have heard of this program, and even fewer understand it, but that does not mean it is insignificant. The program saves taxpayers billions of dollars, helping to make sure that Medicare is not forced to foot the bill in cases where other insurers should be paying.

This is a worthy goal, and we all have an interest in making this program work. We have two panels today, and I hope that they will help us answer one simple question: is the Medicare Secondary Payer Program working for taxpayers and Medicare beneficiaries?

The problem with answering this simple question is that there can be a tension between what works for the taxpayer and what works for beneficiaries. From the beneficiary perspective, the key goals are speed simplicity and certainty. Beneficiaries want Medicare to reduce burdens and rapidly give beneficiaries – especially those caught up in legal cases with insurers because of accidents – the information they need about how much they or their insurer will have to reimburse Medicare.

Taxpayers have different goals. Taxpayers want the program to leave no money on the table – even if that means waiting to be 100% certain that all funds owed to taxpayers are repaid.

I don't envy the job CMS has in finding the right balance here. Today, we'll hear from CMS about how they have chosen to run the program and the opportunities they see for improvement. We'll also hear from GAO about key program areas that need investigation.

On the second panel, we'll have witnesses representing beneficiaries, trial lawyers, and businesses affected by the Medicare secondary payer rules. They feel that CMS has not obtained the correct balance in the way they have chosen to run the program.

This will be a valuable hearing because it can help us determine whether we should enact legislative solutions. Our goal should be to work with CMS and other interested parties to be sure we are appropriately weighing the concerns of beneficiaries and the concerns of taxpayers

As we focus today on making Medicare better, however, we also need to recognize how important Medicare is to seniors and our nation. And we should renounce the Republican effort to end Medicare as we know it

Many of my Republican colleagues have bashed Medicare and supported turning the program over to private insurance companies on the basis that no government program can do an effective job compared to the private sector. When Republicans make this argument, one of their talking points is that Medicare has extremely high erroneous payment rates. Their implication is clear: that Medicare's error rate is higher than error rates of private insurers.

This is simply false. Earlier this week, the AMA released their annual report card on insurers. The AMA found that Medicare had the highest payment accuracy rate among all providers - 96%. Private insurers' payment inaccuracy rates were five times higher than Medicare. This is a great example of Medicare leading the way and doing better than the private sector when it comes to cutting waste.

Mr. Chairman, you and almost every member of the Republican caucus voted for the Republican budget that would replace Medicare for persons under 55 with a privatized and underfunded voucher system that would cost thousands of dollars more in out-of-pocket health care costs every year. Seniors would face the worst of both worlds: the loss of important guaranteed benefits and higher out-of-pocket costs because of the inefficiency of the privatized Medicare model.

These dramatic changes to Medicare pose a much greater risk to seniors than the problems in the Medicare Secondary Payer Program. That is why I sent a letter to Chairman Upton last month asking for hearings on the Republican budget's impact on Medicare and Medicaid.

Now that we have started Medicare work in this Subcommittee, I hope our next oversight hearing can look at the impacts of the Republican budget on this key program for seniors and the disabled.

Mr. STEARNS. I thank the gentleman.

We welcome our first panel. As mentioned, Deborah Taylor is the Centers for Medicare & Medicaid Services, CMS, chief financial officer, CFO, and director of the Office of Financial Management, OFM. As CMS's senior financial manager executive, she is accountable and responsible for planning, directing, analyzing, and coordinating the Agency's comprehensive financial management functions.

James Cosgrove, a doctor, is a director on the healthcare team at the U.S. Government's accounting office, the GAO, and responsible for GAO studies of healthcare financing and Medicare payment issues with his Ph.D., his doctor's Ph.D.

As you know, the testimony you are about to give is subject to Title XVIII, Section 1001 of the United States Code. When holding an investigative hearing, this committee has a practice of taking testimony under oath. Do you have any objection to testifying under oath? No?

The chair then advised you that under the rules of the House and the rules of the committee, you are entitled to be advised by counsel. Do you desire to be advised by counsel during your testimony today? In that case, please rise and raise your right hand. I will swear you in.

[Witnesses sworn.]

Mr. STEARNS. Thank you. Now, each of you can give your 5-minute opening statement. Ms. Taylor, we will start with you.

TESTIMONY OF DEBORAH A. TAYLOR, CHIEF FINANCIAL OFFICER AND DIRECTOR, OFFICE OF FINANCIAL MANAGEMENT, CENTERS FOR MEDICARE & MEDICAID SERVICES, AND JAMES COSGROVE, DIRECTOR, HEALTH CARE ISSUES, GOVERNMENT ACCOUNTABILITY OFFICE

TESTIMONY OF DEBORAH A. TAYLOR

Ms. TAYLOR. Good morning, Chairman Stearns and Ranking Member DeGette and members of the subcommittee.

Mr. STEARNS. I think, Ms. Taylor, you have to push the button and bring the mic a little closer.

Ms. TAYLOR. OK.

Mr. STEARNS. There you go.

Ms. TAYLOR. Good morning, Chairman Stearns, Ranking Member DeGette, and members of the subcommittee. Thank you for the opportunity to be here today to discuss the Centers for Medicare and Medicaid Services' Medicare Secondary Payer program. The Medicare Secondary Payer program, also known as MSP, is an important program that protects both Medicare beneficiaries and the sustainability of the Medicare program. The purpose of the MSP program is to ensure that Medicare pays primary when appropriate and recovers monies when Medicare should pay secondary to another insurer. While MSP is specific to Medicare, all insurance providers, public and private, utilize a system similar to the MSP to resolve conflicting coverage issues with other carriers. MSP policies establish when certain other insurance payers have primary responsibility for the healthcare services of a person with Medicare.

The MSP program has traditionally had a high rate of return on investment of almost 9 to 1 and over the past decade has returned savings, both cost-avoided savings as well as recoveries, in excess of \$55 billion. There are two types of MSP situations. The vast majority of MSP situations arise when a Medicare beneficiary is covered by an employer's healthcare insurance. This is a highly automated process that allows beneficiary claims to be automatically identified where Medicare is not the primary insurer. In these situations, unnecessary costs are avoided and there is no pay-and-chase required to recover these monies.

The second MSP situation arises when a Medicare beneficiary is harmed or injured and receives a settlement payment from another insurer, usually an automobile liability or workers' compensation insurer. These cases are often referred to as non-group health plan cases. These cases require close communication and coordination between CMS, the beneficiary, and their representatives, usually an attorney. In order to ensure continuity of care for Medicare beneficiaries, Medicare may pay conditionally for the healthcare of the beneficiary under these situations. If Medicare makes a conditional payment, Medicare has a statutory right to recover from the insurer legally required to pay for this care.

Prior to 2008, insurers involved in these types of MSP situations had a limited requirement to report their settlements to CMS. When Congress passed the Medicare/Medicaid and SCHIP Extension Act of 2007, these insurers had a mandatory reporting responsibility to CMS. These mandatory reporting requirements have significantly increased the number of non-group health plan cases and have provided recoveries to the Medicare Trust Fund estimated to be about \$600 million.

To facilitate a smooth transition of these mandatory reporting requirements, CMS took a transparent, open approach to establishing the requirements. We developed standardized electronic reporting processes and worked collaboratively with the insurance industry to define and test this process. We established a Web site where insurers can find all official instructions and guidance related to the mandatory reporting requirements. We held town hall conferences with over 34,000 representatives from insurance industry, trade associations, and attorney groups, and we developed computer-based training on MSP policies and mandatory reporting requirements.

As a result of our efforts, the overall number of MSP records posted to CMS's systems has more than doubled over the past 3 years. This increased activity represents a potential for even greater savings to the Medicare Trust Fund in coming years.

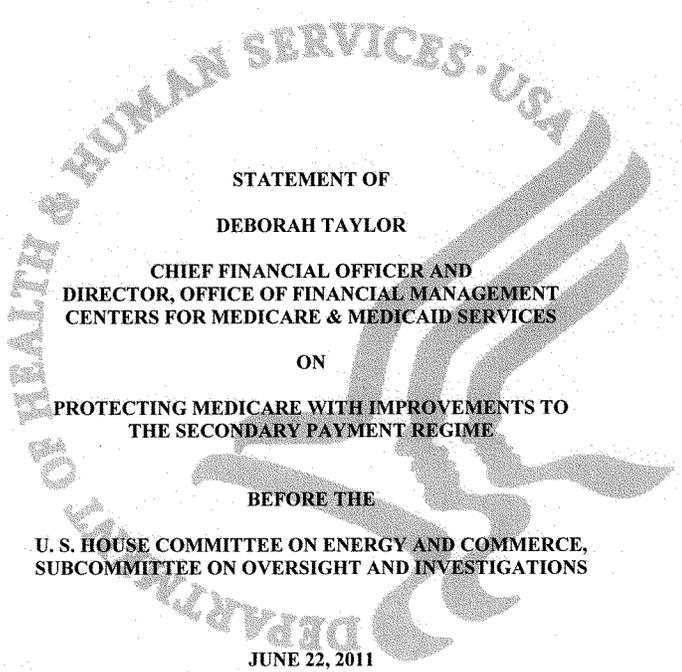
We continue to leverage technology to improve our processes and further increase our rate of return. We have made Medicare information directly accessible to beneficiaries, their representatives, and the industry. We have expanded the MyMedicare.gov Web site to provide more information about the MSP program and to assist beneficiaries. We also developed mechanisms to automate many of the reporting and recovery processes.

CMS is committed to a transparent MSP process and ensuring that Medicare beneficiaries receive the care they need while reducing Medicare payments for claims that are the legal responsibility

of another insurer or liable party. We remain committed to improving the MSP program and maintaining strong communications with our beneficiaries, insurers, and other stakeholders.

This concludes my statement. I would be happy to answer any questions.

[The prepared statement of Ms. Taylor follows:]



STATEMENT OF

DEBORAH TAYLOR

CHIEF FINANCIAL OFFICER AND
DIRECTOR, OFFICE OF FINANCIAL MANAGEMENT
CENTERS FOR MEDICARE & MEDICAID SERVICES

ON

PROTECTING MEDICARE WITH IMPROVEMENTS TO
THE SECONDARY PAYMENT REGIME

BEFORE THE

U. S. HOUSE COMMITTEE ON ENERGY AND COMMERCE,
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

JUNE 22, 2011



**House Committee on Energy and Commerce
Subcommittee on Oversight and Investigations**

Hearing on Protecting Medicare with Improvements to the Secondary Payment Regime

June 22, 2011

Chairman Stearns, Ranking Member DeGette, and Members of the Subcommittee, thank you for the opportunity to discuss the Centers for Medicare & Medicaid Services' (CMS) Medicare Secondary Payer (MSP) reporting and recovery policies regarding Non Group Health Plans (NGHP). Liability insurance (including self-insurance), no-fault insurance, and workers' compensation are generally referred to as NGHP. Section 111 of the Medicare, Medicaid, and SCHIP Extension Act (MMSEA) of 2007 (P.L. 110-173) included new reporting requirements for certain group health plan arrangements and NGHPs, but did not change or eliminate existing MSP requirements. However, the NGHP industry's unfamiliarity with these MSP rules has led to some level of confusion related to the reporting requirements and the responsibility of NGHPs under the law. CMS is committed to a transparent implementation of Section 111 of MMSEA, and we look forward to working with our private and public sector partners as we continue implementing these requirements.

Overview

The MSP law is an important mechanism for protecting the fiscal integrity of the Medicare program and the Medicare Trust Funds. Over the last decade, total MSP savings have exceeded \$50 billion. The MSP law ensures that Medicare does not pay for medical items and services if another entity, such as an NGHP, is responsible for payment of those same medical items and services. MSP policies establish that certain other insurance payers have "primary" payment responsibility before Medicare, which is designated as the "secondary payer" or payer of last resort when another insurer has a legal responsibility to pay for care of a person with Medicare. Terms such as primary and secondary identify the descending order of payment responsibility that an insurer has for a particular claim. For example, if a beneficiary slips and falls in a grocery store, the store's insurance, and not Medicare, may be responsible for health care costs related to that injury.

Medicare has been secondary to workers' compensation since the inception of the Medicare program. In the Omnibus Budget and Reconciliation Act of 1980 (OBRA 1980), Congress expanded the MSP provisions to make Medicare secondary to liability insurance, including self-insurance, and no-fault insurance effective December 5, 1980. And, as noted above, the most recent amendment- the MMSEA- requires certain group health plan arrangements and NGHPs to provide the Secretary of Health and Human Services (HHS) with information identifying situations where the plan is or has been primary to Medicare. While MSP is specific to the Medicare program, all insurance providers, public and private, utilize a system similar to the MSP program to resolve conflicting coverage issues with other carriers.

In order to ensure continuity of care for Medicare beneficiaries, Medicare may pay conditionally in situations where the NGHP does not pay promptly; however, Medicare makes such conditional payments subject to reimbursement. If Medicare makes a conditional payment, Medicare has both a statutory right of recovery from the insurer legally required or responsible to pay for this care, as well as subrogation rights. The MSP statute specifically gives Medicare a priority right of recovery when a NGHP is required or responsible for primary payment, as demonstrated by a settlement, judgment, award, or other payment.

Medicare's Recovery Process

Medicare's NGHP recovery process is comprised of several steps. Ideally, the beneficiary or his representative notifies CMS' Coordination of Benefits Contractor (COBC) about the beneficiary's pending NGHP claim. The COBC enters and transmits NGHP claim data to CMS' Medicare Secondary Payer Recovery Contractor (MSPRC). The system used by the MSPRC begins to compile conditional payments Medicare has already made on behalf of the beneficiary and his associated health care expenses that are related to the NGHP claim. The MSPRC issues a Rights and Responsibilities letter that requests proof of representation and explains the applicable MSP law to the beneficiary and his lawyer or other representative so that they understand how the MSP recovery process works and what to expect. Once Medicare's computer system has identified Medicare payments for the beneficiary, the MSPRC will review the payment data and identify which payments it believes are related to the beneficiary's NGHP claim. The MSPRC then issues a conditional payment letter, which includes a payment

summary form that lists the payments that Medicare has identified as related to the beneficiary's NGHP claim.

The beneficiary submits to the MSPRC information regarding the gross amount of his settlement, judgment, award, or other payment, along with the amount of attorney fees and any other expenses the beneficiary incurred in order to obtain his settlement, judgment, award, or other payment. The MSPRC will apply a pro rata reduction to account for the attorney fees and costs the beneficiary incurred and then the MSPRC will issue a Medicare recovery demand letter for money owed to the Medicare Trust Funds, if appropriate. Once the beneficiary reimburses Medicare, the MSPRC will close its case and annotate its system accordingly.

If the beneficiary or his or her representative disagrees with the amount of Medicare's recovery claim or believes that Medicare should waive recovery of its claim, the beneficiary or his representative can file an administrative appeal or seek a waiver. The beneficiary demand letter provides information on appeal rights and instructions for filing an appeal or waiver of recovery request.

In instances where a beneficiary or his or her attorney does not proactively notify the COBC of his or her pending case in a timely fashion, Medicare may not learn of the case until the NGHP advises Medicare of the settlement, judgment, award, or other payment. As a result, there may be a delay in issuing the conditional payment letter and completing the recovery process.

The NGHP reporting process established by Congress in MMSEA has significantly increased the number of NGHP cases that have been identified and, as a result, provided additional recoveries for the Medicare Trust Funds. With successful implementation of the Section 111 reporting process and the corresponding increase in the public awareness of their obligations under the longstanding MSP provisions, new NGHP cases have nearly doubled since the passage of MMSEA. To put this in context, the MSPRC received approximately 413,000 new NGHP cases and issued over 74,000 NGHP recovery demands in FY 2010, a significant increase from the 222,000 NGHP cases received and 43,000 recovery demands in FY 2007. We project further

increases in the number of cases reported when mandatory reporting for the remaining liability insurers is implemented, which is scheduled for January 1, 2012.

When a NGHP is properly identified as the primary payer and pays promptly, Medicare often does not receive a bill for the associated services and has no way to calculate associated savings to the program. This is particularly true for no-fault insurance and workers' compensation claims.

Any restrictions on existing MSP rights or recovery processes would adversely affect savings that would otherwise accrue to the Medicare Trust Funds through MSP recovery activities, as well as the \$1 billion per year in cost-avoided savings that CMS is able to track. Proposals that would impose mandatory process changes may affect Medicare's status as a secondary payer or its priority right of recovery, as well as CMS' ability to prioritize its own workload. These changes may also have the unintended effect of undercutting the underlying intent of the statute, increasing costs, and reducing existing savings.

Implementation of Section 111 of MMSEA

CMS implemented the mandatory reporting requirements in Section 111 in a transparent and open manner. To support this transparent approach, CMS has taken several steps:

- Established a website, <http://www.cms.gov/MandatoryInsRep/>, where CMS issues and maintains all official instructions and guidance related to implementation of the new reporting requirements. This includes User Guides for both GHP and NGHP reporting as well as associated ALERT guidelines and other guidance. The website also has a dedicated e-mail resource mailbox to receive concerns and questions. Through the website and e-mail mailboxes, CMS has received over 10,000 questions and comments regarding implementation of Section 111 and has used this information to develop and refine the instructional materials available on the website.
- Held regular town hall conference calls to reach out to representatives of the insurance industry, trade associations, and attorneys. Since January 2008, CMS has held 68 calls with a total of 34,000 participating attendees. After the outreach calls, full transcripts for each call are posted to the dedicated Section 111 website as an educational resource.

- Instituted new beneficiary education efforts through MyMedicare.gov, as beneficiaries are on the front line of receiving health care services.
- Met with various national organizations (and their members) including the American Insurance Association (AIA), the Property and Casualty Insurance Association of America (PCIA), the Physician Insurers Association of America (PIAA), the American Association for Justice (AAJ), and the Medicare Advocacy Recovery Coalition (MARC). CMS has also discussed the new MSP reporting requirements at other conferences sponsored by these organizations and other groups.
- Developed Computer Based Training (CBT) to educate GHPs and NGHPs on MSP provisions, as well as Section 111 reporting. Courses are broken down into manageable, easy to comprehend modules, and training is self-managed, allowing participants to learn as they go. To date, nearly 6,000 individuals have signed up for these CBT courses.

To implement the Section 111 reporting requirements, CMS developed a standardized electronic reporting process in 2009 that was based on a successful voluntary data sharing program established more than a decade ago. The reporting process was also designed to provide feedback to submitters regarding the quality of their reporting data. The goal in developing this reporting process was to ensure that data submitted was timely, accurate and complete, so that CMS would not have to follow-up with NGHP reporters for additional information it needed to properly coordinate benefits or resolve its potential recovery case. This electronic reporting process includes both an electronic file exchange process and a direct data entry option. The process also includes the ability to query for Medicare entitlement data so that the NGHP reporter can better determine whether it should report a particular settlement, judgment, award or other payment to CMS.

To date CMS has received files from more than 12,500 NGHP reporters and the overall number of MSP records posted to CMS' systems has more than doubled over the past three years, thus representing potential for even greater savings to the Medicare Trust Funds in the coming years. We continue to work closely with all parties affected by the Section 111 reporting requirement with the primary goal being to make coordination of benefits with Medicare as efficient and cost effective as possible for all involved.

Leveraging Technology to Improve the Process and Increase Rate of Return

CMS has taken significant steps to make Medicare information accessible to beneficiaries, their representatives, and the industry. We have expanded the MyMedicare.gov website to provide specific beneficiary information in a secure and readily accessible way. Through MyMedicare.gov, a beneficiary can access eligibility and enrollment information, learn about coverage options, review Medicare claims, and view MSP information. Beneficiaries are also able to access payment summary forms that Medicare issues with its conditional payment letters.

The MSP process is one tool CMS utilizes to safeguard taxpayer resources and improve program integrity for situations when Medicare pays a claim that should have instead been paid by a group health plan or other liable party. To maximize the efficiency of the MSP process, CMS has created mechanisms to securely exchange beneficiary data to ensure beneficiary claims are paid timely and to pursue recoveries when necessary. We have also developed mechanisms to automate many of the reporting and recovery processes. Thanks to these technological improvements, MSP activities have provided an average rate of return on recoveries of \$9.32 for each dollar spent since FY 2008, which is one of the highest returns of any CMS program integrity initiative. In FY 2010, the MSPRC program returned \$413 million to the Medicare Trust Funds. The MSPRC has been very successful in safeguarding taxpayer resources and improving the fiscal integrity of the Medicare program.

Conclusion

CMS is committed to a transparent MSP process that ensures that beneficiaries receive the care they need, while reducing Medicare payments for claims that are the legal responsibility of a group health plan, NGHP, or other responsible party. We understand that the MSP process can present challenges to all involved in coordination of benefits between Medicare and other payers. We are committed to maintaining a strong line of communication with beneficiaries, insurance and workers' compensation plans, and other stakeholders on MSP policy in general, as well as the new Section 111 reporting requirements. Additionally, we will look to expand and strengthen our training and education opportunities where possible.

CMS looks forward to working with our partners and beneficiaries in the future to preserve the integrity of the Medicare program and secure the Medicare Trust Funds for future generations. We look forward to working with Congress as well on these important goals.

Mr. STEARNS. Thank you. Dr. Cosgrove?

TESTIMONY OF JAMES COSGROVE

Mr. COSGROVE. Mr. Chairman, Ranking Member DeGette, members of the subcommittee, thank you for inviting me to speak to you today as you consider potential improvements to Medicare's Secondary Payer process.

As has been discussed this morning, this process is intended to protect Medicare's fiscal integrity when a beneficiary's Medicare expenses are potentially covered by another insurer. Congress has spelled out rules for when other insurers must pay first. In such cases, Medicare pays second and is only financially responsible for and should only pay for those Medicare items and services that are not covered by the primary insurer. For example, Medicare has always been the secondary payer when the beneficiary is covered by a workers' compensation plan.

In 1980, Congress made Medicare a secondary payer to other non-group health plans, which include auto or other liability insurance and no-fault insurance. Shortly thereafter, Congress made Medicare the secondary payer in most instances where the beneficiary is currently employed or has a spouse who is currently employed and is covered by an employer-sponsored group health plan. Both group and non-group health plans had a legal obligation to identify situations where they were the primary payers, notify Medicare, and pay appropriately. However, there were concerns that this did not always happen and that Medicare sometimes paid for care that should have been covered by other insurers.

The Medicare and Medicaid and SCHIP Extension Act of 2007 established specific MSP reporting requirements and fines for non-compliance. For example, non-group health plans must inform CMS when they have reached a settlement with a beneficiary in an MSP situation. The Congressional Budget Office estimated that the law's provisions would help Medicare recover or avoid \$1.1 billion in improper payments over 10 years. Mandatory reporting requirements for group health plans went into effect January 2009. Mandatory reporting for non-group health plans was delayed until January 2011 for certain types of these plans and until January 2012 for the rest.

My remarks today will describe the 5 major components of the MSP process for situations involving non-group health plans. These are notification, negotiation, resolution, mandatory reporting, and recovery. The order of the components and the details of the process and CMS's involvement at various stages may vary somewhat depending on the circumstances of the case. I think the best way to understand how the MSP process works in general is through an example, and that is what is included in our written statements.

We have a graphic, and this is Figure 2 and page 8 in our written statement, but it tries to illustrate graphically how the MSP process might work when a Medicare beneficiary is injured in an automobile accident. In this simplified example, it begins when an injured Medicare beneficiary goes to the hospital. The hospital treats the beneficiary and eventually submits a bill to Medicare. Notification happens when CMS first learns of the MSP situation. In this example, the beneficiary's attorney notifies CMS and re-

quests a list of payments Medicare made to the hospital. CMS's contractor provides this information, and although notified, Medicare may continue to make payments called "conditional payments" so that the beneficiary will have access to necessary medical care while the beneficiary's attorney negotiates with the automobile insurer.

Negotiation to reach a settlement takes place between the beneficiary's attorney and the insurer. In this example, the attorney uses the information from CMS to help insure that the settlement includes funds to reimburse Medicare for payments made related to the claim.

Resolution refers to the settlement reached between the beneficiary's attorney and the insurer. In a liability case, the insurer often provides the beneficiary with a lump-sum payment. Mandatory reporting is what happens at this point when the insurer reports the resolution to CMS. In some cases, mandatory reporting may be the first notification that CMS gets of the MSP situation. And recovery happens after mandatory reporting when CMS seeks to recover payments Medicare made related to the claim.

While I can describe the key components of the process, I can't tell you how well the process is working. We are aware that concerns have been raised and are currently evaluating certain aspects of the process related to non-group health plans. Specifically, our study is examining aspects of the MSP process that have presented challenges for both non-group health plans and CMS. And it will also look at how mandatory reporting by non-group health plans is expected to affect CMS's MSP workload, its costs, and Medicare savings.

We expect to complete our work and report on our findings later this year. We look forward to working with you and others in Congress as you consider this very important issue. Mr. Chairman, this concludes my prepared remarks. I would be happy to answer any questions you or other members may have.

[The prepared statement of Mr. Cosgrove follows:]

United States Government Accountability Office

GAO

Testimony
Before the Subcommittee on Oversight
and Investigations, Committee on Energy
and Commerce, House of Representatives

For Release on Delivery
Expected at 10:00 a.m. EDT
Wednesday, June 22, 2011

MEDICARE SECONDARY PAYER

Process for Situations Involving Non-Group Health Plans

Statement of James C. Cosgrove
Director, Health Care



G A O

Accountability • Integrity • Reliability



Highlights of GAO-11-726T, a testimony before the Subcommittee on Oversight and Investigations, Committee on Energy and Commerce, House of Representatives

June 22, 2011

MEDICARE SECONDARY PAYER

Process for Situations Involving Non-Group Health Plans

Why GAO Did This Study

The Centers for Medicare & Medicaid Services (CMS) is responsible for protecting the Medicare program's fiscal integrity and ensuring that it pays only for those services that are its responsibility. Medicare Secondary Payer (MSP) provisions make Medicare a secondary payer to certain group health plans (GHP) and non-group health plans (NGHP), which include auto or other liability insurance, no-fault insurance, and workers' compensation plans. CMS has the right to recover Medicare payments made that should have been the responsibility of another payer, but CMS has not always been aware of these MSP situations. In 2007, Congress added mandatory reporting requirements for GHPs and NGHPs that should enable CMS to be aware of MSP situations. CMS reports that mandatory reporting was pushed back from 2009 to 2011 for some NGHPs and from 2009 to 2012 for others, in part due to concerns raised by the industry.

GAO was asked to present background information about the MSP process as it pertains to NGHPs. To do this work, GAO reviewed relevant CMS documentation, including MSP regulations, manuals, and user guides, and conducted an interview with CMS related to mandatory reporting and the MSP process. GAO shared the information in this statement with CMS. CMS provided technical comments, which GAO incorporated as appropriate. GAO has ongoing work examining challenges related to the MSP process for NGHPs.

View GAO-11-726T or key components. For more information, contact James C. Cosgrove at (202) 512-7114 or cosgrovej@gao.gov

What GAO Found

MSP situations involving NGHPs are triggered by unexpected incidents, such as car accidents or work-related injuries, that involve Medicare beneficiaries and result in medical expenses for which an NGHP—rather than Medicare—has primary responsibility for payment. In these situations, Medicare becomes a secondary payer.

Medicare payments for MSP situations involving NGHPs can vary. In most MSP situations involving NGHPs, Medicare will initially pay for related medical expenses in order to ensure that the beneficiary has timely access to needed care, and later seek to recover those payments. Once CMS is notified of an MSP situation involving an NGHP—by the insurer, the beneficiary, or another party—Medicare may start denying claims or may continue to make payments pending a resolution so the beneficiary has continued access to needed medical services. To help prevent Medicare from making future payments for MSP situations involving NGHPs, a Medicare set-aside arrangement may be created when an individual is expected to have future medical expenses related to an MSP situation. This is a voluntary arrangement where funds are set aside by the primary insurer to pay for related future medical expenses.

The MSP process for situations that involve NGHPs generally includes five basic components (see table 1). The process details, and CMS's administrative tasks, can vary based on when in the process CMS is notified, the type of insurance involved, and the type of resolution reached. CMS contracts with three entities to perform most of its MSP activities.

Table 1: The Basic Components of the MSP Process for Situations Involving NGHPs

Component	Description
Notification	CMS is notified of the MSP situation by the insurer, the beneficiary, or another party. This can occur at any time from the time of the incident through mandatory reporting.
Negotiation	Negotiation takes place between the NGHP and the injured party or his attorney. CMS may provide information to involved parties during the negotiation process.
Resolution	A resolution is reached between the NGHP and the injured party or his attorney.
Mandatory reporting	As required by mandatory reporting requirements, the NGHP reports details of the final resolution to CMS.
Recovery	CMS seeks to recover any MSP payments made.

Source: GAO analysis of CMS documents.

Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today to discuss the Centers for Medicare & Medicaid Services' (CMS) Medicare Secondary Payer (MSP) program. MSP situations arise when other insurers have the primary responsibility to pay for a Medicare beneficiary's medical expenses.¹ In these situations, Medicare is the secondary payer and is only responsible for paying for beneficiaries' Medicare-related health care costs that are not covered by the primary insurer. CMS, the agency within the Department of Health and Human Services (HHS) that administers Medicare, is responsible for protecting the Medicare program's fiscal integrity. To safeguard funds, CMS must take steps to ensure that it pays only for those services that are the responsibility of the Medicare program. Until 1980, Medicare was the primary payer in all situations involving Medicare beneficiaries except those covered by workers' compensation.² In 1980, Congress enacted provisions that made Medicare a secondary payer in all instances to non-group health plans (NGHP)—which include auto or other liability insurance, no-fault insurance, and workers' compensation plans.^{3,4} For example, an NGHP is the primary payer for medical expenses related to injuries that a Medicare beneficiary may sustain in an automobile accident (see figure 1). In 1981 Congress enacted provisions that made Medicare a secondary payer to employer-sponsored group health plans (GHP) in certain situations.⁵

¹ Medicare is the federally financed health insurance program for persons age 65 or over, certain individuals with disabilities, and individuals with end-stage renal disease.

² Workers' compensation is a law or plan of the United States, or any state, that compensates employees who get sick or injured on the job.

³ Omnibus Budget Reconciliation Act of 1980, Pub. L. No. 96-499, § 953, 94 Stat. 2599, 2647 (codified, as amended, at 42 U.S.C. § 1395y).

⁴ Liability insurance is insurance that provides payment based on legal liability for injury or illness or damage to property. It includes, but is not limited to, automobile liability insurance, uninsured motorist insurance, underinsured motorist insurance, homeowners' liability insurance, malpractice insurance, product liability insurance, and general casualty insurance. No-fault insurance is insurance that pays for medical expenses for injuries sustained on the property or premises of the insured, or in the use, occupancy, or operation of an automobile, regardless of who may have been responsible for causing the accident. 42 U.S.C. § 411.50(b).

⁵ Omnibus Budget Reconciliation Act of 1981, Pub. L. No. 97-35, § 2146, 95 Stat. 357, 800. Although persons age 65 or older are eligible for Medicare coverage, some are employed and may receive health insurance coverage through an employer-sponsored GHP.

Figure 1: An MSP Situation Involving an Auto Liability Insurer



A Medicare beneficiary is injured in a car accident and goes to the hospital. The hospital bills Medicare, although the auto liability insurance company is responsible for paying for the beneficiary's treatment. Because the beneficiary has not yet reached a resolution with the auto liability insurance company, Medicare makes payments to the hospital for the care provided. Once the resolution is reached and the beneficiary receives a settlement from the auto liability insurance company, CMS attempts to recover the amount of Medicare's payments from the beneficiary.

Source: GAO (text), FEMA/Casey Dashing (photograph).

When MSP situations have occurred, CMS has not always been notified that beneficiaries had other insurance that should be the primary payer. As a result, Medicare has paid for services that were the financial responsibility of another payer. Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007⁶ added mandatory reporting requirements for GHPs and NGHPs with respect to MSP situations that should enable CMS to be aware of MSP situations. With this information, CMS should be able to identify which payments were made by Medicare that should have been the primary responsibility of another payer, and therefore should be recovered, or situations in which CMS should avoid making payments when another payer should be primary. Section 111 also included penalties for non-compliance with the mandatory reporting requirements (\$1,000 fine per day of non-compliance per claim). The Congressional Budget Office estimated that these provisions for GHPs and NGHPs would save Medicare \$1.1 billion over 10 years in improper payments that could be recovered or avoided by Medicare.

CMS reports that while the implementation of Section 111 added reporting rules for GHPs and NGHPs, it did not eliminate or change any existing MSP laws or regulations, or otherwise change CMS's existing MSP process. Specifically, prior to mandatory reporting requirements, GHPs and NGHPs involved in MSP situations had a legal obligation to notify and repay Medicare when they determined that Medicare should not have paid first. Likewise, Medicare beneficiaries had an obligation to take whatever

⁶Pub. L. No. 110-173, § 111, 121 Stat. 2492, 2497, adding 42 U.S.C. § 1395y(b)(7-8).

actions were necessary to obtain any payment that could be reasonably expected from an NGHP and to cooperate with CMS in any action CMS takes to recover conditional payments. These obligations remain, although prior to mandatory reporting the parties involved in MSP situations may not have always been aware of these obligations.

MSP mandatory reporting requirements have not been fully implemented. GHPs began mandatory reporting in January 2009. While NGHPs were scheduled to begin mandatory reporting in July 2009, CMS reports that this timeline has been pushed back several times, in part due to concerns raised by the industry. Mandatory reporting requirements began in January 2011 for certain NGHPs, including workers' compensation and no-fault insurers. Other NGHPs, including most liability insurers, are required to begin reporting in January 2012. GAO has ongoing work related to mandatory reporting and the MSP process for situations involving NGHPs.

You expressed interest in obtaining information about the MSP process, particularly as it pertains to NGHPs. My statement today will provide an overview of Medicare payments for MSP situations involving NGHPs and the MSP process for those situations, and will also provide illustrations of that process.

For this statement, we reviewed relevant CMS documentation including MSP regulations, manuals, user guides, and information found on the CMS Web site and a contractor's Web site related to the MSP process. We also conducted an interview with CMS officials concerning mandatory reporting and the MSP process. We shared the information in this statement with CMS. CMS provided technical comments, which we incorporated as appropriate. We conducted our work from May 2011 to June 2011 in accordance with all sections of GAO's Quality Assurance Framework that are relevant to our objectives. The framework requires that we plan and perform the engagement to obtain sufficient and appropriate evidence to meet our stated objectives and to discuss any limitations in our work. We believe that the information and data obtained, and the analysis conducted, provide a reasonable basis for any findings and conclusions.

Medicare Payments and the MSP Process for Situations Involving NGHPs

Medicare payments for MSP situations involving NGHPs can vary, depending in part on when CMS is notified that an MSP situation exists. Generally, the MSP process for situations that involve NGHPs includes five basic components—notification, negotiation, resolution, mandatory reporting, and recovery—but the details of the process can differ depending on the particular situation.

Medicare Payments

Medicare payments can vary in different MSP situations. In most MSP situations involving NGHPs, Medicare will initially pay for medical treatment related to the incident, and later seek to recover those payments. These initial payments sometimes occur because medical treatment is provided before CMS is notified of the NGHP MSP situation.⁷ Once CMS is notified that an MSP situation exists and an NGHP should be the primary payer, Medicare may start denying claims. However, according to CMS, in most NGHP MSP situations, even after CMS becomes aware that Medicare is the secondary payer, Medicare will continue to make payments while the situation is pending resolution so that the beneficiary has access to needed medical services in a timely manner. CMS refers to any payments made by Medicare for services where another payer has primary responsibility for payment as “conditional payments.”⁸ For example, an NGHP could dispute that it is responsible for a Medicare beneficiary’s medical expenses and refuse to pay any claims until the matter is investigated and resolved. In those types of situations, Medicare would continue to make conditional payments for the beneficiary’s medical expenses until a resolution can be reached between the beneficiary and the NGHP. Once a resolution is reached between the beneficiary and the NGHP, Medicare will seek to recover any conditional payments made.⁹

⁷This differs from the MSP process for GHPs, in which CMS primarily seeks to prevent mistaken payments by determining whether a Medicare beneficiary has other insurance through a GHP that should be primary to Medicare before any payments are made. This is because, unlike NGHPs, GHPs have an established and ongoing obligation to pay for health care as a primary payer.

⁸The payment is “conditional” because it must be repaid to Medicare when the Medicare beneficiary receives a settlement, judgment, award, or other payment from the NGHP.

⁹This assumes a resolution in which the Medicare beneficiary or someone on his behalf receives a settlement, judgment, award or other payment from the NGHP.

Additionally, to help Medicare prevent making any future payments related to MSP situations involving NGHPs, when a beneficiary is expected to have future medical expenses related to their accident, injury, or illness, CMS states that all parties involved in negotiating a resolution of those situations have responsibilities to protect Medicare's interests. CMS does not require that this be done in any specific way, but one way to accomplish this is through a Medicare set-aside arrangement—a voluntary arrangement where a portion of the proceeds from a settlement are set aside to pay for all related future medical expenses that would otherwise be reimbursable by Medicare.¹⁰ In cases where a Medicare set-aside arrangement is created, Medicare will not make payments for medical expenses related to the MSP situation until the Medicare set-aside arrangement is exhausted.

The MSP Process

The process for MSP situations that involve NGHPs generally includes five basic components—notification, negotiation, resolution, mandatory reporting, and recovery. However, the details of the process, and the administrative tasks that CMS must conduct, can vary depending on when in the process CMS is notified, the type of insurance involved (liability, no-fault, or workers' compensation), and the type of resolution reached. CMS contracts with three entities to perform most of its administrative activities within the MSP process: the Coordination of Benefits Contractor (COBC); the Workers' Compensation Review Contractor (WCRC); and the Medicare Secondary Payer Recovery Contractor (MSPRC) (see app. I).

While the details vary by situation, in general, the roles of these CMS contractors within the MSP process are as follows:

- *Notification:* The COBC is notified that a beneficiary's accident, injury, or illness is an MSP situation and creates a record. Notification can come from various sources—including the beneficiary, an attorney, a physician, or the NGHP—and can occur at various times during the MSP process. While mandatory reporting requires NGHPs to report MSP resolutions to CMS through the COBC, NGHPs or other involved parties may also provide notification to CMS earlier in the process. For example, a beneficiary's attorney could notify CMS of the MSP

¹⁰In situations where a Medicare set-aside arrangement is used, the responsibility for managing the Medicare set-aside funds is not established by CMS and instead can fall to various parties, including the beneficiary themselves or a third-party administrator, such as an attorney.

situation involving an NGHP shortly after an accident occurs. After the COBC receives notification of the MSP situation, Medicare may begin denying claims, or it may continue to make conditional payments.

- *Negotiation:* Negotiation takes place between the NGHP and the injured beneficiary or his representative, such as an attorney. The point in the MSP process at which CMS receives notification can affect the number and amount of conditional payments made by Medicare and whether, and the extent to which, CMS can make information available during the negotiation.¹¹ For example, if CMS has been notified of the situation early in the process, the MSPRC can provide information that may be used during negotiations, informing the beneficiary or his representative, about related claims paid by Medicare. For workers' compensation situations that involve future medical expenses, the WCRC may be involved in reviewing proposed Workers' Compensation Medicare Set-Aside Arrangement (WCMSA) amounts.
- *Resolution:* The resolution is reached between the beneficiary or the beneficiary's attorney and the NGHP.¹² The type of resolution varies and can include the insurer assuming ongoing responsibility for payment of medical claims related to the injury or illness, a lump-sum payment, a Medicare set-aside arrangement, or a combination of any of these. For resolutions that include a WCMSA, no future payments are made by Medicare for medical expenses related to the workers' compensation injury or illness until the set-aside is exhausted. Additionally, CMS requires the administrator of the WCMSA to submit an annual accounting of the set-aside funds to the MSPRC.
- *Mandatory Reporting:* CMS requires the NGHP to report the resolution to CMS through the COBC. Regardless of whether CMS was notified of the MSP situation earlier in the process, after a resolution is reached in which the Medicare beneficiary or someone on his behalf receives a settlement, judgment, award or other payment from the NGHP, NGHPs

¹¹If an NGHP immediately agrees to assume ongoing responsibility for a beneficiary's medical expenses, current and future, then there may not be a negotiation component to the MSP process.

¹²Resolution may also be reached by trial.

are required to report information about the MSP situation and its resolution to the COBC¹³ under mandatory reporting requirements.

- *Recovery:* CMS seeks to recover payments made. After reviewing the resolution, the MSPRC calculates the total amount owed to Medicare and issues a demand for payment—referred to as a demand letter. This letter is typically issued to the beneficiary or his representative, but in certain situations may also be issued to the NGHP. Payment is due to the MSPRC within 60 days of the date of the demand letter. Either payment is received and the case closed, a response is received challenging all or part of the demand, or no response is received. Debt delinquent more than 180 days is referred to the Department of the Treasury for collection action. The beneficiary has the right to question, appeal,¹⁴ or request a waiver of the amount CMS demanded.¹⁵

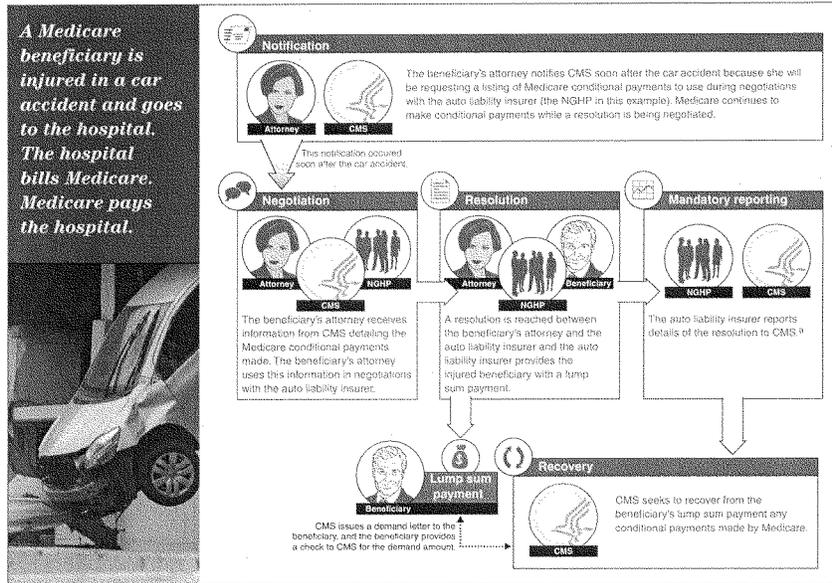
The following figures illustrate the MSP process for situations that involve an auto liability insurer, a no-fault insurer, and a workers' compensation plan:

¹³The data NGHPs are required to submit includes information to identify the beneficiary; information about the injury, accident, or illness; information concerning the policy or insurer; information about the injured party's representative or attorney; and settlement or payment information.

¹⁴Medicare beneficiaries have administrative appeal rights with respect to a MSP recovery claim against them that include five levels. The first level of appeal is to a CMS contractor. The second level of appeal is to an independent contractor to review the decision made at the first level of appeal. The third level of appeal is to an administrative law judge and must meet a minimum monetary threshold. The fourth level of appeal is with the Departmental Appeals Board before the Medicare Appeals Council. The fifth level is with the federal district court and has a minimum monetary threshold.

¹⁵The debt is not referred to Treasury if there is open correspondence related to the debt or if there is a pending appeal or waiver request.

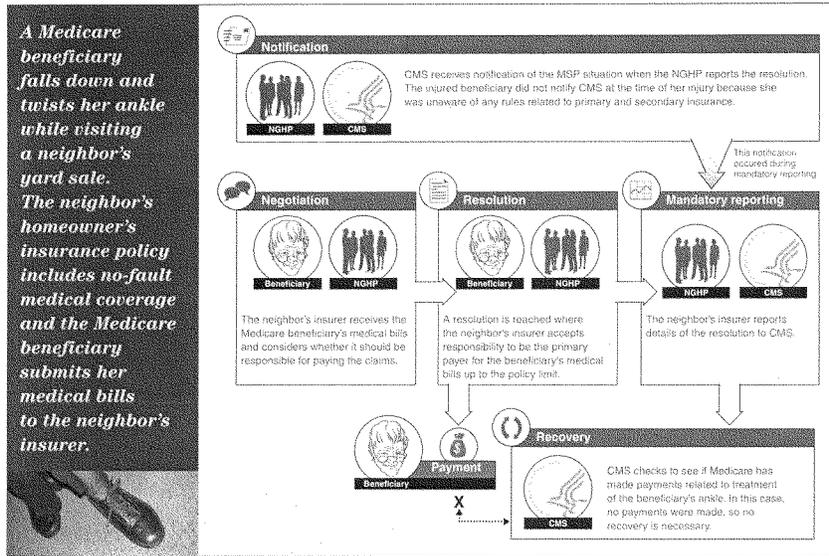
Figure 2: Illustration of the MSP Process for a Situation Involving an Auto Liability Insurer



Source: GAO (process), FEMA/Casey Dethong (photograph), Art Explosion (illustrations).

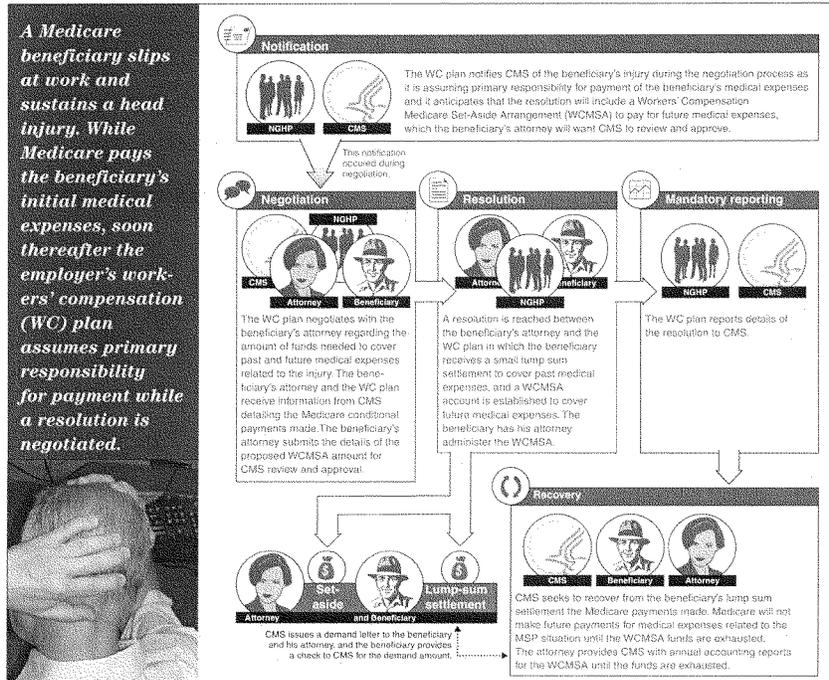
⁹Mandatory reporting for liability insurers who settle with injured beneficiaries with lump sum payments, such as the auto liability insurer in this figure, will be required beginning January 1, 2012.

Figure 3: Illustration of the MSP Process for a Situation Involving No-Fault Insurance



Source: GAO (process), Art Explosion (illustrations).

Figure 4: Illustration of the MSP Process for a Situation Involving Workers' Compensation



Source: GAO (process). Art Explosion (illustrations).

In addition to the steps outlined in the MSP process description, CMS provides oversight of the MSP activities completed by each of the MSP contractors, such as by reviewing regular reports produced by the contractors on their workload and performance. CMS is also responsible for administering the MSP program and establishing the MSP process, and officials do so through activities such as developing program policy and guidance. CMS also maintains Web sites related to parts of the MSP process, from which NGHPs and beneficiaries can obtain information about their responsibilities in MSP situations involving NGHPs.

Mandatory reporting should enable CMS to be aware of MSP situations involving NGHPs and better ensure that it only pays for medical care that is the responsibility of the Medicare program. As noted earlier, GAO has ongoing work related to mandatory reporting and the MSP process for situations involving NGHPs. Specifically, we are examining what aspects of the MSP process for situations involving NGHPs are presenting challenges for CMS and NGHPs, and how mandatory reporting is expected to affect CMS's MSP workload, costs, and Medicare savings associated with NGHP situations.

Mr. Chairman, this concludes my prepared statement. I would be happy to answer any questions you or other members of the subcommittee may have.

Contacts and Acknowledgments

For further information about this statement, please contact James C. Cosgrove at (202) 512-7114 or CosgroveJ@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement. Kathleen M. King, Director; Gerardine Brennan, Assistant Director; Laurie Pachter; Christina Ritchie; Lisa Rogers; Jessica C. Smith; and Jennifer Whitworth were key contributors to this statement.

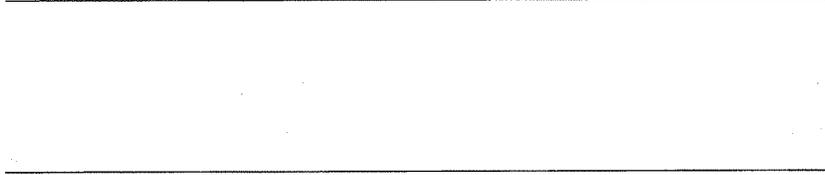
Appendix I: CMS MSP Contractors

The Centers for Medicare & Medicaid Services (CMS) contracts with three entities to perform most of the activities within the MSP process:

- *Coordination of Benefits Contractor (COBC)*: The COBC collects, manages, and maintains information in the CMS data systems about other health insurance coverage for Medicare beneficiaries and initiates MSP claims investigations. The COBC processes information submitted by various parties, including beneficiaries, their attorneys, physicians, and NGHPs. The information the COBC collects is available to other CMS contractors, and it also maintains a national database, the Workers' Compensation Case Control System (WCCCS), to store claimant data about submitted Workers' Compensation Medicare Set-Aside Arrangement (WCMSA) proposals.
- *Workers' Compensation Review Contractor (WCRC)*: The WCRC evaluates proposed WCMSA amounts and projects future medical expenses related to workers' compensation accident, injury, or illness situations that would otherwise be payable by Medicare. The WCRC generally only reviews proposed WCMSA amounts for current Medicare beneficiaries in excess of \$25,000.¹
- *Medicare Secondary Payer Recovery Contractor (MSPRC)*: The MSPRC uses information updated by the COBC as well as information from CMS' systems to identify and recover Medicare payments that should have been paid by another entity as primary payer. Once a resolution has been reached between the beneficiary and the NGHP, the MSPRC calculates the final amount owed to Medicare and issues a demand letter to the beneficiary or other individual authorized by the beneficiary.²

¹The WCRC also reviews proposed WCMSA amounts for injured individuals whose total settlement amounts are valued greater than \$250,000 and where there is a reasonable expectation that the injured individuals will become Medicare beneficiaries within 30 months of the date of the settlement.

²This assumes a resolution in which the Medicare beneficiary or someone on his behalf receives a settlement, judgment, award or other payment from the NGHP.



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Mr. STEARNS. Yes. I will start with my questions.

Dr. Cosgrove, it looks like in this resolution area of your graph is where the main problem is. Do you think Congress should step in and make the Medicare payment that is done first, make this such that after the insurance companies pay, then Medicare steps in? In that one chart dealing with resolution—

Mr. COSGROVE. Um-hum.

Mr. STEARNS [continuing]. Where it seems to be the conflict, is there something you would suggest for Congress to do?

Mr. COSGROVE. It is really premature for me to comment at that time. We have certainly heard concerns by the non-group health plans raised about how this works right now. But that is part of our investigation.

Mr. STEARNS. So the answer is no. You don't know?

Mr. COSGROVE. I don't know.

Mr. STEARNS. OK. Ms. Taylor, can you provide information on the number of Medicare Secondary Payment cases CMS is handling today?

Ms. TAYLOR. I don't have the exact number, but I can tell you that of the non-group health plan cases, I believe we have about 413,000.

Mr. STEARNS. I need you to pull the mic a little closer if you can.

Ms. TAYLOR. I believe for the non-group health plan cases—

Mr. STEARNS. OK. I got that. This would include liability, workmen's compensation, and no-fault automobile Medicare Secondary Payment cases?

Ms. TAYLOR. Correct.

Mr. STEARNS. And that is your number is roughly 400?

Ms. TAYLOR. I believe that is the number that we have right now.

Mr. STEARNS. How many were handled last year?

Ms. TAYLOR. Last year, probably about the same.

Mr. STEARNS. OK. Is this typically a number that remains constant every year? Is it roughly about 400?

Ms. TAYLOR. What I can tell you is that since the Medicare and Medicaid SCHIP Extension Act of 2007, our casework, our workload has more than doubled.

Mr. STEARNS. OK. How long, Ms. Taylor, have you been in this position as a CFO?

Ms. TAYLOR. For about a year and a half.

Mr. STEARNS. What did you do before that?

Ms. TAYLOR. I was the deputy to the director of office—

Mr. STEARNS. OK. How much money is involved in the Medicare Secondary Payment process each year? How much is reimbursed to the trust fund.

Ms. TAYLOR. To the trust fund last year in 2010 we had about \$8 billion, which includes both the group health plan and the non-group health plan cases.

Mr. STEARNS. Does CMS keep track of how much money is reimbursed by class or type?

Ms. TAYLOR. I believe we have that information but I don't have that—

Mr. STEARNS. For example, how much is workers' comp and, for example, how much is auto accident?

Ms. TAYLOR. I believe we can get that information. I just don't have that with me.

Mr. STEARNS. In your opinion, is it being reimbursed by class or type? Is it distinguished?

Ms. TAYLOR. I believe it is, yes. I believe our contractor does maintain information about which type of insurer they are working with, yes.

Mr. STEARNS. Do you mind submitting that for the record?

Ms. TAYLOR. Sure.

Mr. STEARNS. OK. Does CMS ever attempt to estimate the number or amount of secondary payment cases under which CMS does not get reimbursed?

Ms. TAYLOR. I don't believe we do track that information.

Mr. STEARNS. Um-hum. Who was in this position before you?

Ms. TAYLOR. Prior to me Tim Hill had the job that I currently have.

Mr. STEARNS. And how long was he in that position?

Ms. TAYLOR. I believe 5 years.

Mr. STEARNS. OK. Does CMS have an idea how much money that should be reimbursed that is not?

Ms. TAYLOR. I don't think we track it that way, meaning when a case is identified to us, we have to wait until there is, in fact, a settlement. If there is no settlement, the Medicare beneficiary does get paid and they do get their healthcare covered by Medicare. Our primary goal is to ensure that Medicare beneficiaries do receive their healthcare.

Mr. STEARNS. On those 400 cases, do you put a suspense time when you go back to staff and say let us hurry up and try to settle this? Is there any kind of suspense record that you keep?

Ms. TAYLOR. We don't keep any records that say we need to suspend this case. It is a——

Mr. STEARNS. I don't mean suspend but I mean let us say a case goes on and on and on and on. Do you as a CFO get a weekly or a monthly record that is saying of these 400 cases, 50 of them have gone on for 10 months, 3 months?

Ms. TAYLOR. I believe we do get information about the age of the cases.

Mr. STEARNS. That is what I mean, the age of the case.

Ms. TAYLOR. What we don't get is the reason for the age.

Mr. STEARNS. OK.

Ms. TAYLOR. So it could sometimes be because the——

Mr. STEARNS. Do you physically see this come across your desk, the age?

Ms. TAYLOR. I don't physically get that, no.

Mr. STEARNS. Do you have any interest in seeing that so you can say to the people, let us get moving?

Ms. TAYLOR. I have an absolute interest in this MSP recovery process, and it is subjected to our audit by our CFO auditors.

Mr. STEARNS. OK. How much does CMS spend on conditional payments for treatment and services, coverage for which is the responsibility of non-group health plans on an annual basis? Do you know?

Ms. TAYLOR. I do not know. I just know what the annual recoveries are.

Mr. STEARNS. How much does CMS recover annually for these claims?

Ms. TAYLOR. Last year, we recovered about \$400 million.

Mr. STEARNS. My last question is industry experts have told this committee's staff that there is at least \$4 billion a year for the non-group health claims alone that is not making it to the trust fund. Do you confirm that? Do you have any idea how much money CMS is leaving on the table?

Ms. TAYLOR. I don't have any information on that.

Mr. STEARNS. Does that 4 billion seem reasonable to you?

Ms. TAYLOR. I honestly couldn't remark on that. We are relying on the individuals to report these cases to us.

Mr. STEARNS. All right. Thank you.

Ms. TAYLOR. Um-hum.

Mr. STEARNS. I recognize Ms. DeGette.

Ms. DEGETTE. Thank you very much, Mr. Chairman. Before I begin my questions, I want to welcome these Close Up students who have joined us. What you are seeing today is the legislative process in action, and oftentimes people from the outside world who come in and see us don't realize that much of what we do is in a bipartisan way in Congress. And what we are trying to do in this hearing today is figure out how we can both protect taxpayers and also Medicare beneficiaries in getting more money recovered from these accidents so we can keep our program safe and solvent. So this is an Oversight hearing and this is the kind of work this committee does, and we are delighted to have you, and we are sorry we don't have seats for more of you.

I want to ask both of our witnesses, Ms. Taylor, Dr. Cosgrove, about some of the key decisions that Congress is facing as we look at the effectiveness of these Medicare Secondary Payer rules.

Ms. Taylor, I think you had said that the Medicare Secondary Payer program recovered about \$50 billion for taxpayers over the last decade. Is that correct?

Ms. TAYLOR. That is correct. The number is 58 billion.

Ms. DEGETTE. \$58 billion. And so obviously this program is important in making sure that taxpayers are protected and that the Medicare program is not paying bills that other insurers should be paying. Is that correct?

Ms. TAYLOR. Yes, that is correct.

Ms. DEGETTE. And it is also important, though, that the CMS be responsive to the needs and the concerns of the beneficiaries because it really doesn't make sense either in a fiscal way to have beneficiaries to have to wait months to get basic information that they need to reach settlements in cases. And it frankly seems very unfair for beneficiaries to face huge and unexpected demands to pay funds back to Medicare years after they have settled.

You know, I was a lawyer. I practiced law for about 15 years. And what I found when I settled these cases was the beneficiaries get the settlement and they are so happy about it that they spend it right away. And then years later when the government comes back and tries to get this money back, they don't have it anymore and it is a real burden on them. And so I think it might be fair to say there is a tradeoff here between actions that are good for

taxpayers, which is recovering these funds, but then that can burden beneficiaries later.

And so would that be an accurate statement to say sometimes there is a tradeoff there between the taxpayers and the beneficiaries?

Ms. TAYLOR. We are constantly between that delicate balance of ensuring that the trust funds recover monies while ensuring that our beneficiaries receive the care they need and ensuring that we recover monies that are due back to the trust funds. So yes, that is absolutely—

Ms. DEGETTE. And in a timely fashion, I would say?

Ms. TAYLOR. Absolutely.

Ms. DEGETTE. Now, Dr. Cosgrove, can you offer us any insight here based on GAO's work?

Mr. COSGROVE. Well, our work is just beginning right now. And so we starting to talk to the affected parties, which certainly include, you know, the non-group health plans and CMS. And our goal in undertaking the study is to understand what the challenges are but also to understand what the costs are for CMS in terms of implementing the mandatory reporting and what the potential savings might be, you know, which could shed light on and maybe lead towards potential recommendations about improvements for the program, and maybe along such lines as, you know, minimum recovery amounts. But, you know, that is far down the road. We are going to be continuing our work and issuing our report by the end of the year.

Ms. DEGETTE. By the end of the year. Mr. Chairman, probably I can see a follow-up hearing coming along.

I would ask you, Ms. Taylor, what recent action has CMS taken to promote the goals that we talked about here of improving the Medicare Secondary Payer program for beneficiaries and for taxpayers?

Ms. TAYLOR. There are probably two sets of things that we have done. One is we are making information more accessible to beneficiaries. So we are providing them education about their responsibilities with MSP, but we are also making it able so that Medicare beneficiaries can see their claims real time and be able to tell their attorneys, "These are the claims that I know have been processed and paid by Medicare."

The second part is, you know, we have had a huge workload increase because of the mandatory reporting requirements. This is not an industry we dealt with routinely, the liability, the casualty-type insurers, and so we learned a lot over the last 3 years, and we are working to streamline our processes, look at a way to ensure that our contractor has the right skills, and we will be re-competing our contract for these kinds of activities related to the non-group health plans this fall.

Ms. DEGETTE. And do any of these improvements need congressional action that you think would help?

Ms. TAYLOR. I can't think of anything off the top of my head, but we would certainly be happy to work with you.

Ms. DEGETTE. Thank you.

Thank you very much, Mr. Chairman.

Mr. STEARNS. I thank the gentlelady. The gentleman from Texas, Dr. Burgess, recognized for 5 minutes.

Mr. BURGESS. Thank you, Chairman Stearns. And some of my questions are going to follow along the same lines that Chairman Stearns was asking.

Ms. Taylor, how long will you have to wait for a settlement? What is a customary period?

Ms. TAYLOR. So according to our guidelines, we want to work with insurers within 65 days to resolve cases. Then we allow them 30 days for dispute and then another 60 days to sort of resolve that dispute. So ideally, it could take 120, 150 days to resolve a case. We do have workload issues, so there are cases that have aged beyond that 150 days. We certainly know that working on a lawsuit takes time. So it can take anywhere between the ideal of 120 days to 6 months to resolve a case.

Mr. BURGESS. Do any of these cases ever linger for years?

Ms. TAYLOR. I am not aware of any, but I certainly have heard that there are stories out there that have them go on beyond a year.

Mr. BURGESS. Is there ever a statute of limitations beyond which you would not try to go back and recover from a beneficiary?

Ms. TAYLOR. If someone reports something to us, we at least have the responsibility to look into it.

Mr. BURGESS. Having run a medical practice—and I feel your pain. I mean, you are having to deal with insurers and lawyers. I mean, those are the two worst groups that I had to deal with in my professional life. But at the same time, I also know that if the bulk of your accounts receivable, if you will—which is what we are talking about—if it gets up much past 90 to 120 days, that is money that you may just never see. So someone always has to be working that or reestablishing why it is that it is taking so long. Now, does that happen at the level of Center for Medicare & Medicaid Services or—you mentioned a contractor—is that something that is contracted out?

Ms. TAYLOR. It is something that is contracted out. And as I mentioned, this is not an industry we had typically dealt with in the past. We know that we need to change our processes. We probably need some different skill sets at our contractor, and we will be making some changes in that area.

Mr. BURGESS. Now, the contractors that you hire, do they have any performance guidelines that they are required to meet?

Ms. TAYLOR. They do, yes, but they did not anticipate some of the activities we are seeing now.

Mr. BURGESS. Well, and how are we overcoming that lack of anticipation now?

Ms. TAYLOR. We are rewriting a Statement of Work with very different metrics and different performance requirements.

Mr. BURGESS. And these contractors, is this a competitive bidding situation where you put these proposals—

Ms. TAYLOR. Yes, it will be going forward.

Mr. BURGESS. It will be, but currently are these competitively bid currently?

Ms. TAYLOR. The current contractor was not “competitively bid” but it was done under all the FAR requirements that the government requires.

Mr. BURGESS. But going forward, you are actually going to go beyond that?

Ms. TAYLOR. Yes, absolutely.

Mr. BURGESS. How long do you anticipate that will require?

Ms. TAYLOR. We expect to have a Statement of Work on the street this fall.

Mr. BURGESS. And you will share that with the committee, obviously.

Dr. Cosgrove, let me ask you a question on your Figure 2 illustration on page 8. It seems as if—and maybe I missed the discussion—but at some point in these little block diagrams, the mandatory reporting block diagram, there has got to also be an arrow going back to the beneficiary informing them of their responsibilities under this, because what Ms. DeGette said was exactly correct. You have someone who it has been so far removed, the accident, the medical costs, the reimbursement, and now they get this nice check because their government loves them and sent them a check because they were injured and so it is theirs to spend. I mean I understand how that thought process works. How can we improve that loop so that the beneficiary has some understanding of what their obligations are, what their requirements are under the law?

Mr. COSGROVE. Well, I think that is an excellent point because that is critical for the beneficiary to understand their responsibilities. My understanding from the work that we have done so far is that partly the responsibility is on CMS to provide information to beneficiaries so they know what their responsibilities are. I frankly don’t know right now what the non-group health plans’ responsibilities are to do similar when the recovery is—

Mr. BURGESS. For notification—

Mr. COSGROVE. For notification. But that is something we will definitely be looking into.

Mr. BURGESS. All right. Thank you.

I yield back, Mr. Chairman.

Mr. STEARNS. The gentleman yields back.

The gentleman from Michigan, Mr. Dingell, is recognized for 5 minutes.

Mr. DINGELL. Mr. Chairman, you are most courteous. I thank you for having this hearing, and I appreciate your concern for the questions before us, i.e., how long it takes for us to get the answers on the costs and other matters. My questions are for Ms. Taylor. For the following questions, please answer yes or no.

Ms. Taylor, it is my understanding that CMS works with Medicare Secondary Payer recovery contractor that is responsible for determining what MSP payments are subject to recovery, issuing demand letters for this recovery, collection of MSP claims for beneficiaries, making initial determinations for waivers and appeals, amongst other responsibilities. So a common complaint is the general delay in communications. Some say days, some say months. This delay is frustrating to everybody.

Now, does CMS currently require the contractor to respond to communications, whether by mail, email, written correspondence from beneficiaries, or attorneys within a specific timeline? Yes or no?

Ms. TAYLOR. Yes.

Mr. DINGELL. You do? What is that timeline?

Ms. TAYLOR. I believe it is 65 days.

Mr. DINGELL. Is it honored?

Ms. TAYLOR. We do have workload issues that have created the inability for the contractor to get back—

Mr. DINGELL. I will be asking some information about that. Does CMS or the contractor collect data on the average response time in these communications? Yes or no?

Ms. TAYLOR. I believe they do, yes.

Mr. DINGELL. Now, can you tell me what the average response time is? Submit that for the record, if you please.

Now, a very similar complaint is the length of time it takes to identify the amount of MSP payments owed to CMS. Does CMS or the contractor collect data regarding the average time needed to identify and recover funds under the MSP program? Yes or no?

Ms. TAYLOR. That is a difficult one to answer yes or no to. They do whatever is based on the information in the system. So yes, they do it as quickly as they can. The problem is claims lag.

Mr. DINGELL. Would you submit that in greater detail for the record, please?

Ms. TAYLOR. Yes.

Mr. DINGELL. Now, could you tell me what the average time might be?

Ms. TAYLOR. I don't—

Mr. DINGELL. Please submit that for the record.

Now, a further concern is the length of time it takes for beneficiaries and their attorneys to obtain a demand letter that informs the beneficiary and their attorney of the MSP claim. This delay impedes the ability of beneficiaries and their attorneys to move forward towards a settlement, and again, ultimately delays reimbursement to Medicare. Does CMS currently require the contractor to issue a demand letter within a specific timeline? Yes or no?

Ms. TAYLOR. Yes.

Mr. DINGELL. You do? Now, would you submit for the record what that average response time is?

Ms. TAYLOR. Yes.

Mr. DINGELL. Now, next question. In your opinion, Director Taylor, what is needed to improve the responsiveness of CMS and its contractors to beneficiaries and their attorneys? Is it a new contractor that is better equipped to handle these claims or is it the need for additional funding and personnel to manage the caseload? Finally, another concern raised by a witness on the second panel, Mr. Salm of Publix, is the inefficiency of pursuing smaller claims. His testimony cites the example of Medicare pursuing cases as small as \$1.59. Now, I am just a poor Polish lawyer from Detroit, but even I know staff time used to collect a claim here for \$1.59 would far exceed recovery. Question: Does CMS have in place a threshold for MSP recovery?

Ms. TAYLOR. We do not but we are looking at that, yes.

Mr. DINGELL. Do you think that that is something that you ought to do because you may be wasting money and flailing around trying to collect money that frankly is far too small to confer any benefit on you in view of the costs?

Ms. TAYLOR. We are looking at that, absolutely. We think we can establish a threshold. I will comment, though, that it is an automated process. Once a beneficiary's case is identified and claims are identified associated with that case, it is an automatic generated bill. So it is not a manual process—

Mr. DINGELL. I would like to have you make a submission for the record on that point.

Ms. TAYLOR. OK.

Mr. DINGELL. Next question. Does CMS have in place a threshold for MSP recovery? I think you have indicated that it does not, meaning that an MSP claim, if it is less than the cost of staff time to collect CMS or the contractor would not pursue? Yes or no?

Ms. TAYLOR. That is correct.

Mr. DINGELL. All right. Thank you, Mr. Chairman. I note that I have gone 19 seconds over.

Mr. STEARNS. Well, I thank the gentleman emeritus of the full committee. And I hope, Ms. Taylor, that Mr. Dingell's request, that you made note of them. I didn't see you make note of them. Our staff did, but he has requested quite a bit of information, which I think would be useful for both sides to see.

Ms. TAYLOR. Um-hum.

Mr. STEARNS. And I think his point is well taken that the fact that you are continuing to pursue something for \$1.30 or something like that. After 30 years, it seems like that should have—

Mr. DINGELL. \$1.59.

Mr. STEARNS. \$1.59—that after all 30 years, it seems like you should have thought that out. I would be glad to yield.

Mr. DINGELL. —to get answers to the questions and see to it that they are put into the record and I would ask unanimous consent that the record remain open for the purposes of receiving the answers to me that have been requested.

Mr. STEARNS. By unanimous consent, so ordered. And with the emeritus of the full committee's background on Medicare, it is very helpful for the oversight and I appreciate his participation with that.

We recognize Mr. Murphy for 5 minutes.

Mr. MURPHY. Thank you, Mr. Chairman.

Ms. Taylor, you are the chief financial officer and director of the Office of Financial Management for the Center for Medicare & Medicaid Services?

Ms. TAYLOR. Correct.

Mr. MURPHY. All right. Now, you cited us 413,000 cases, which you said is a large number and has strained the system. Am I correct in that?

Ms. TAYLOR. That is the number for the non-group health plans.

Mr. MURPHY. Non-group health plans. And that is the concern we have talking about here. What is the median value of those 413,000 claims?

Ms. TAYLOR. I don't have the dollar figures in front of me. I am sorry about that.

Mr. MURPHY. OK. You will get that information to us? Do you have any information, for example, of how many might be under \$50 or \$100, \$500, \$1,000?

Ms. TAYLOR. I don't know that off the top of my head but the reporting requirements is at \$5,000, so \$5,000 for liability and I believe it is 7,500 for workers' comp.

Mr. MURPHY. Do you even collect information on things under \$5,000? I mean you send out letters for \$1.59. We have that established.

Ms. TAYLOR. Correct.

Mr. MURPHY. But you don't collect the data on how many cases you have of that sort of that 413,000?

Ms. TAYLOR. We track how much the cases are but I don't know that I have that with me at this moment, no.

Mr. MURPHY. I am confused because on the one hand you are saying you don't get that information but you can get the information?

Ms. TAYLOR. If someone reports a case to us, the threshold is \$5,000 to report a case. So if there is a settlement for \$3,000, they would not be required to report that case to us.

Mr. MURPHY. All right. So if you don't have that information, you are going to have difficulty giving us that information. If you don't have the information as a chief financial officer, you don't have the information you need to be the CFO. Just my observation. And I would think it is foolish of me to say if I found a coupon that I could get a can of tomato soup for 10 cents but I had to drive 100 miles to the store to get it, somehow in that judgment I would say it is probably not worth it for me to do that, which brings us back to this information. And then this tags along with what the gentleman from Michigan, Mr. Dingell, said on a number of these claims that are a small number, if the actual cash value is so small that it would cost us more to pursue than to get it, but I am not sure you have the data to do that. It may not be we are able to take action.

But let me ask a couple more things here. So we don't know the median value of these claims. We don't things about that. Is it true that in Section 111 of the statute, it is going to require collection of information so long as it is greater than one penny, even if there were no medical bills? Am I correct that that is in the—

Ms. TAYLOR. I am not aware of that portion of the provision.

Mr. MURPHY. OK. It would probably be a good thing for the CFO to know. My understanding is that is true, and so if there was a \$25 gift card given out by a store to settle a potential case with a senior citizen, you would want to know that, too, as another level of settlement? But I understand that that is being asked for. Would you get us that information?

Ms. TAYLOR. Yes.

Mr. MURPHY. I am frustrated here because we are trying to get information on something I am not sure you collect the very data that we are trying to find out. I have heard the current reporting system is prone to error and that CMS rejects a high percentage of the reports when first submitted. Any idea how many reports are initially rejected versus completed on the initial submission?

Ms. TAYLOR. I am not aware of that number. I do know that we have reporting requirements and reporting elements that are required so it would be that cases are rejected because data is not provided adequately.

Mr. MURPHY. Are you aware of some I referenced in my opening statement here that Rand Corporation just completed a study that found if you only looked at settlements greater than \$5,000 instead of every single settlement, your collections would fall by only 2.4 percent, but the number of claims you were pursuing would fall by 43 percent, and you still collect roughly \$1 billion from non-group health plans if you only looked at claims greater than \$5,000. Are you familiar with that Rand study?

Ms. TAYLOR. I am not familiar with that Rand study.

Mr. MURPHY. Have you looked at putting in a threshold dollar level for that, then?

Ms. TAYLOR. We absolutely are looking at that right now.

Mr. MURPHY. OK. Is this just in the earliest levels of review of this whole issue from your agency?

Ms. TAYLOR. Yes, it is.

Mr. MURPHY. I guess it comes down to this, too. It would be very beneficial for Congress and obviously for Medicare, which I know you care deeply about is financial stability. That is why you are in the job you are in. It would help us all—and I think we are on the same team—if we could find what kind of saving is in this. With Medicare basically going bankrupt and I am sure you are having many a nail-biting moment trying to find the dollars for this, it would really help us if you could just really open all the drawers and lift up all the rugs and find everywhere possible in this to make this more efficient.

And I hope you will also take a look at the SMART Act that a number of us on both sides of the aisle have submitted. And finally, I might suggest this and ask this: Have you met with the people who have a stake in this such as defense attorneys, plaintiffs' attorneys, retailers, senior citizens to ask for their input on some of this information, too?

Ms. TAYLOR. I, personally, have met with some of those organizations, but folks who work for me have met with many more.

Mr. MURPHY. Well, I would hope that you will take a look at our Act and I hope you will sit around and listen to some of the witnesses today because I think that will be eye-opening for you.

Ms. TAYLOR. OK.

Mr. MURPHY. I yield back my time, Mr. Chairman.

Mr. STEARNS. The gentleman yields back. The gentleman from Texas, Mr. Green, is recognized for 5 minutes.

Mr. GREEN. Thank you, Mr. Chairman. And I want to follow my colleague from Pennsylvania. You are required by law when you put these payment requirements in place, is that correct?

Ms. TAYLOR. Correct.

Mr. GREEN. So the first year it is \$5,000 and it goes down to 2,000 and then \$600. And he mentioned the Rand study, the Rand Institute for Civil Justice study, but for us to be able to let you do anything like that, we actually need to change the law.

Ms. TAYLOR. Correct.

Mr. GREEN. OK. And I agree with my colleague that, you know, we need to make sure we get the reimbursement, you know, instead of double paying. We also need to make sure it is economically feasible—

Ms. TAYLOR. Um-hum.

Mr. GREEN [continuing]. And so whether it be exempting 5,000 because you spend less than—it be like 43 percent or if, you know, you would only lose \$24 million, it would seem like it would be cost-effective to do that. So maybe that is something our committee needs to look at and something we could work on together.

But my main question is I would like to ask you about contractor performance to work recovering funds owed to Medicare under the Secondary Payer rules. In 2006, CMS consolidated the Medicare Secondary Payer Recovery contracts into a single \$200 million cost-plus contract. CMS awarded the contract on a sole-source basis to Chickasaw Nation Industries, a tribally-owned firm based in Oklahoma, the contractor responsible for identifying Medicare payments to be recovered, calculating the total amount of the medical payments potentially ripe for recovery, issuing recovery demand letters and tracking secondary payer debt.

In 2009, the Senate Subcommittee on Contracting Oversight initiated an investigation in the Medicare Secondary Payer contractor. The investigation revealed there were ongoing problems with the contract. For instance, CMS's independent auditors concluded that the combination of controlled efficiencies constitute a significant deficiency. CMS has also found that the contractor failed to comply with contractor requirements. The contractor failed to adequately manage its cases and had major accounting problems.

Ms. Taylor, in 2010, the Senate Subcommittee on Contracting Oversight called a hearing and at the hearing Rodney Benson, Director of Acquisitions and Grants Management at CMS, testified. It is now a year later and what has CMS done to improve their performance of that recovery contractor?

Ms. TAYLOR. I can tell you that we have made several trips to that contractor. We have put them on corrective action and, as I mentioned before, we are working on a Statement of Work that will be released this fall and we will be re-competing that work.

Mr. GREEN. Is there a way you can get that information to our committee?

And Mr. Chairman, I would appreciate it if we could see what the progress has been made with that contractor.

Do the improvements of CMS and the contractor fully rectify the problems in the process?

Ms. TAYLOR. It has rectified some of the problems, yes, it has.

Mr. GREEN. How long does that contract run?

Ms. TAYLOR. I believe it is up middle of 2012, June or July of 2012.

Mr. GREEN. What process would you use to select a new contractor?

Ms. TAYLOR. It would be a competitive process, so we would put very specific requirements in a Statement of Work with performance metrics, and we would be accepting bids and we would be reviewing those bids based on that Statement of Work.

Mr. GREEN. Well, I am concerned with the problems identified with the contractor, and this contractor received the contract through the sole-source process. And CMS's internal auditors have found that the contractor failed to comply with these contract requirements, and I am hopeful that CMS will continue to address the problems with the contractor and continue to improve the recovery process, particularly when the contract is up for renewal.

Ms. TAYLOR. Yes.

Mr. GREEN. So we don't see what has happened. Again, if it is a \$200 million contract or \$200 million cost-plus contract, do you have any idea on how much it has cost us so far for that contractor?

Ms. TAYLOR. I believe it is a \$55 million contract annually, so over 4 or 5 years it would be \$200 million, but yes.

Mr. GREEN. OK. Outside of working with the contractor, have there been any penalties on their reimbursement based on the quality of their work?

Ms. TAYLOR. I am not aware of any, no.

Mr. GREEN. OK. Mr. Chairman, if we could also check on that. And I know I am almost out of time, so I appreciate you.

Mr. STEARNS. No, Ms. Taylor, I think Mr. Green has made some very good points. I hope you are keeping copious notes.

The gentleman from Georgia is recognized for 5 minutes.

Mr. GINGREY. Mr. Chairman, thank you. And I want to thank the first panel and very important hearing and the information you have given has been straightforward from both of you, and I certainly appreciate that.

Ms. Taylor, I will direct my first question to you. One of the main complaints that we have heard from those involved in the Medicare Secondary Payer process is that they are unable to get a clear statement from CMS as to the amount that must be repaid to the Medicare Trust Fund.

Your testimony discusses that if there is a disagreement on the amount of the money owed to Medicare, an individual can file for a waiver or seek an appeal. I think it would be very helpful if you could describe that process to us and how long it takes.

Ms. TAYLOR. Sure. The waiver process typically is where there is a small dollar settlement. What happens is our rights are preserved after the settlement occurs. The beneficiary deducts attorney fees or any out-of-pocket costs that the beneficiary incurred as a result of any injury or harm they suffered. And so the amount that then is in—I won't call in dispute—but the amount that then Medicare can use to recover any is based on the net, the net of the settlement minus attorney fees and any out-of-pocket costs to the beneficiary. If those amounts are less than out-of-pocket, if the settlement is less than the attorney fees or out-of-pocket costs incurred by the beneficiary, the beneficiary can waive any amounts owing to Medicare.

Mr. GINGREY. OK. Thank you. Second question for you also, Ms. Taylor. Members of the committee have been informed that the current Medicare Secondary Payer process contains an unfortunate paradox, in some cases that CMS takes the position that it cannot or will not specify the amount owed to the Medicare Trust Fund until after a settlement is reached, but it is that amount that is

needed before the parties can settle. Why is this? How does that happen?

Ms. TAYLOR. So the issue there is the amount of time it takes to process claims. Providers have up to a year to submit a claim. If that claim is not submitted, Medicare still preserves the right to collect against that claim so—

Mr. GINGREY. Is it the official position of CMS that they will not provide an amount before settlement?

Ms. TAYLOR. No. CMS provides an interim amount so we can look through the claim's data and say this is what we believe the claims are that have been processed. The problem is we can't finalize that number until after there is a settlement. Then we can look through the claims and there can be a lag in the receipt of those claims.

Mr. GINGREY. OK, thank you. Mr. Cosgrove, I want to direct these questions to you. Does the Government Accountability Office believe that there are areas of the Medicare Secondary Payer regime that should be fixed and what are those areas?

Mr. COSGROVE. Well, we don't know yet.

Mr. GINGREY. It is a hard question but—

Mr. COSGROVE. Right. We don't know yet but that is exactly the intention of the study that we are undertaking right now. Certainly, you know, we have heard concerns that the process may not be working as well as it should be. The non-group health plans have raised concerns about some of the difficulties that they are facing, and so one of the key objectives of the study is to examine the challenges for the non-group health plans and for CMS in implementing this process, as well as them also looking at what are the potential Medicare savings? What are the costs that CMS is incurring to do this? And what—

Mr. GINGREY. Mr. Cosgrove, excuse me for interrupting you, but you had I think said earlier in your testimony or in response to a member's question when this study will be completed. Will you tell me again when that—

Mr. COSGROVE. It is expected by the end of this year.

Mr. GINGREY. By the end of this year?

Mr. COSGROVE. Right. We are in the early stages right now.

Mr. GINGREY. Last question that I had and again it is for you, has GAO ever done any work evaluating the public's knowledge of the need to reimburse Medicare? Now, the reason I ask that question is because this whole issue of subrogation comes up.

Mr. COSGROVE. Um-hum.

Mr. GINGREY. And I don't know whether you are aware of the fact that I have a medical liability tort reform bill called the HEALTH Act, and one of the provisions in that bill says "collateral source disclosure," which in most state courts that is not required and neither the defendants nor the plaintiff understands the need for that and clearly doesn't know about this subrogation rule that is in law in regard to reimbursing Medicare, whereas most probably private insurance companies don't have any right to subrogation of that settlement or claim that the plaintiff receives. So the question, again, has GAO ever done any work evaluating the public's knowledge of the need to reimburse Medicare?

Mr. COSGROVE. I am not aware of any such study.

Mr. GINGREY. Do you think that would be important?

Mr. COSGROVE. Absolutely. I think it is important. This is important for beneficiaries. It could be a substantial financial liability that they face. And they need to be fully informed.

Mr. GINGREY. Well, I think you are right. And I certainly agree with that. I see I have already gone over my time, but thank you all. I thank both of you very much. I yield back.

Mr. STEARNS. I thank the gentleman. Ms. Schakowsky is recognized for 5 minutes.

Ms. SCHAKOWSKY. Schakowsky.

Mr. STEARNS. Schakowsky, the gentlelady from Illinois.

Ms. SCHAKOWSKY. Thank you, my friend, Mr. Chairman.

I am glad that we, on a bipartisan basis, are looking at ways to make Medicare more efficient. I am grateful to the evaluators who are looking at it, to you, Director Taylor, and to my colleagues because I believe in Medicare and that we want to make this system as strong as possible, the trust fund as strong as possible.

And when I hear about the problems that we have in collecting in a timely way from other party payers, I think about the Republican plan, which would turn over the whole system to private insurers. And now I am picturing lawyers and I am picturing a balkanization of lots of different insurance companies in charge of the whole program and the effect that that could have on beneficiaries in trying to get paid for the services that they need.

And I think that making Medicare work better and collecting where we should is the focus that we ought to have, not a new system where we say oh, OK, go to private insurance companies, you figure out how they are going to pay for in a timely way the healthcare that you need because we already have evidence that it is difficult. And now we will set these elderly people free on their own to try and get that money. So I want this to go right.

So Director Taylor, we are going to hear from witnesses on the second panel that the current Medicare Secondary Payer system is "making it extremely difficult to settle claims in a prompt and efficient manner." That is the Gilliam testimony. And "harming beneficiaries and ironically and unfortunately harming the trust fund as well," and that is from the Matzus testimony. So I wonder if you would respond to these characterizations.

Ms. TAYLOR. Sure. I will say that one of the things is we have been working very closely with industry to ensure that everyone understands their reporting requirements. I think that it is taking time for everybody to learn sort of their responsibilities. We have put all of our instructions out for industry to understand. Our requirements are automated. We have made it accessible—either automated or online ability to report to us. And you know, I think we are doing everything we can to work very closely with industry to ensure that everyone has an opportunity to improve the process.

Ms. SCHAKOWSKY. Let me say this. Years ago when I was on the Oversight Committee and I worked with Steve Horn on the Government Efficiency Subcommittee, we would bring in agencies, and then 6 months later they would come back and we would say well, have you made progress? And unfortunately, more often than not it hasn't been made.

And I would suggest, Mr. Chairman, that we do a follow-up here, you know, that we have identified problems, you have identified problems that exist, that we hold ourselves and you accountable to make sure that we come back and check on that and see if the systems that you have put in place, perhaps and maybe hopefully a new contractor—by the way, are we talking again about a single contractor—competitive bidding for a single contractor?

Ms. TAYLOR. Yes, we are.

Ms. SCHAKOWSKY. And would you speak to that a little? Is that the best way to go, do you think, having one contractor handle this?

Ms. TAYLOR. Well, the reason we went to one contractor is we did have a study by GAO that said we had misapplication or inconsistent application of our MSP policies across contractors. So we did consolidate. Beneficiaries do transition across the country so it made it difficult for beneficiaries to navigate different contractors. So we do think it made sense to consolidate with one contractor.

Ms. SCHAKOWSKY. Well, then, how can we deal with the workload issue which you have identified as a big problem? Are we going to be able to fix that with one contractor?

Ms. TAYLOR. As part of the Statement of Work, we are looking at parts of the contractor specializing in different insurer types of reporting that a contractor might have—a unit that deals with just the automobile insurers or that may deal with the property and casualty insurers or that would just do workers' comp. so that they specialize and operate with certain industries and that they do have those skill sets to navigate.

Ms. SCHAKOWSKY. I am out of time, but let us get it right—

Ms. TAYLOR. Um-hum.

Ms. SCHAKOWSKY [continuing]. And let us make sure. We will check back that we have gotten it right. Thank you.

Ms. TAYLOR. Thank you.

Mr. STEARNS. I thank Ms. Schakowsky. And now we recognize Mr. Griffith from Virginia for 5 minutes.

Mr. GRIFFITH. Thank you, Mr. Chairman.

Earlier this year, the President issued an Executive Order requiring agencies to review regulations to determine how they could be streamlined to operate in the most effective and efficient manner. Has any part of the Medicare Secondary Payer process been identified or reviewed as part of the President's Executive Order, and if so, which parts?

Ms. TAYLOR. We have reviewed the MSP program and we have at least put forward the need to have more transparency into the process. So we have looked at issuing regulations surrounding the MSP program.

Mr. GRIFFITH. OK. But specifically regarding the President's Executive Order, have any parts been identified as part of that Executive Order or as a response to that Executive Order?

Ms. TAYLOR. The main part is the requirement for mandatory reporting and what the responsibilities are surrounding that.

Mr. GRIFFITH. And you may not be in a position to answer these questions and I understand that, but this is just something I am curious about. When you have somebody who is injured, and we will use that classic automobile case, how do you separate out the

settlement as being for medical expenses and for pain and suffering? That would be number one. Number two, when you are looking at ongoing expenses, how do you determine, you know, do you keep going on the ongoing expenses until you have eaten up the entire settlement or is there some division that is made? And last but not least along this line of questioning, what provisions are made to recognize that in a personal injury case that the plaintiff has borne the expense of paying the attorney out of the settlement and does, in fact, your process recognize that and give credit for those attorneys' fees as a part of the settlement?

Ms. TAYLOR. It does. The part that we recover is the net of the settlement taking out attorneys' fees and any out-of-pocket cost for the beneficiary. I think it is more difficult to define the pain-and-suffering part of that settlement, and sometimes—we have been told at least—that the pain and suffering does sometimes include the healthcare costs for that beneficiary or the future healthcare costs of that beneficiary. So pain and suffering is defined by what their injury is and the cost of those healthcare services that will be needed for them.

Mr. GRIFFITH. Now, I guess that is where we have heard the indication that sometimes it is hard for you all to give folks a number.

Ms. TAYLOR. Correct.

Mr. GRIFFITH. But it also makes it hard for the people trying to figure out, you know, how to settle a case without going through a lengthy litigious process when they don't know what the lien is going to be.

Ms. TAYLOR. Right.

Mr. GRIFFITH. All right. I thank you very much and I yield back my time, Mr. Chairman.

Mr. STEARNS. The gentleman yields back. Ms. Taylor, before you go I think, as Mr. Dingell and others have pointed out, there is a whole list of things we have given you. It seems like there are lots of times you did not know. It seems like since you are the CFO, the chief financial officer, a lot of the questions we asked you, you should have known. For example, number of claims for small dollar amounts; two, the response times for getting information and payments to beneficiaries; three, median amount of the money involved with the 413,000 cases; number four, your threshold you didn't seem to be aware of; number five, you had no idea how much CMS is failing to collect; number six is asking about the duration time for the claims settlement. You didn't have any idea. So I just want to tell you I think the feeling on both sides is that you just didn't seem to know much, and so we caution you that if you come back for a second hearing, we expect you to be able to answer these questions. I assume you will bring staff with you so that these questions—you can certainly ask your staff to help you—but to see a CFO know so little was a little disappointing.

With that, we will have the second panel come up.

And I hope, Ms. Taylor, you will stick around so you can hear some of the serious problems. This will be beneficial to you as the CFO to hear the second panel more specifically address some of the things we talked about.

I want to welcome the second panel. Marc Salm is vice president of risk management at Publix Super Markets, where he is responsible for claims, consumer litigation, insurance purchase, and risk transfer. Scott Gilliam is vice president and government relations officer with the Cincinnati Insurance Company. He is responsible for representing the company's interests with state and federal governments, as well as other outside groups. Jason Matzus is a partner in the law firm of Raizman, Frischman, and Matzus where he practices tort and injury law representing dozens of Medicare beneficiaries. He is also an adjunct professor of law at the University of Pittsburgh School of Law. Ilene Stein is a federal policy director for the Medicare Rights Center's Washington, D.C., office.

I want to welcome the second panel. As you know, the testimony you are about to give is subject to Title XVIII, Section 1001 of the United States Code. When holding an investigative hearing, this committee has a practice of taking testimony under oath. Do you have any objection to taking testimony under oath? No?

The chair then advised you that under the rules of the House and the rules of the committee, you are entitled to be advised by counsel. Do you desire to be advised by counsel during your testimony today? In that case, please rise and raise your right hand. I will swear you in.

[Witnesses sworn.]

Mr. STEARNS. Thank you very much. And now, Mr. Salm, we invite you with your 5-minute summary of your opening statement.

TESTIMONY OF MARC SALM, VICE PRESIDENT, RISK MANAGEMENT, PUBLIX SUPER MARKETS, INC.; SCOTT A. GILLIAM, VICE PRESIDENT AND GOVERNMENT RELATIONS OFFICER, THE CINCINNATI INSURANCE COMPANIES; JASON MATZUS, PARTNER, RAIZMAN FRISCHMAN & MATZUS, P.C.; AND ILENE STEIN, FEDERAL POLICY DIRECTOR, MEDICARE RIGHTS CENTER

TESTIMONY OF MARC SALM

Mr. SALM. Chairman Stearns, Ranking Member DeGette, and distinguished members of the subcommittee, good morning, and thank you for holding this hearing today. I am honored to appear before the subcommittee to share our experience with Medicare Secondary Payer program and to offer several suggestions and ways in which the program can be strengthened to the benefit of Medicare beneficiaries, affected stakeholders, and taxpayers across the United States.

I am the vice president of risk management for Publix Super Markets, one of the Nation's largest employee-owned supermarket chains. In 2010, we employed 148,000 people across 1,036 stores in five States. In the chairman's district alone, Publix operates 38 stores. We have 4,495 associates living in your district, Mr. Chairman, and 5,160 associates who work in your district. We are proud that in the history of Publix Super Markets we have never laid off a single employee and that we are consistently ranked as one of the best places to work in the United States. I am also appearing today as a representative of the MARC Coalition, which is a broad-based group of affected shareholders.

Let me start by explaining to you what my view is of how the MSP process works through the following liability example. Imagine that Mr. Jones, who is a 76-year-old, falls down a flight of stairs at the Acme Store and is hospitalized overnight with a broken leg. Mr. Jones is billed \$40,000 by the hospital, which Medicare covers and pays at some reduced rate. Let us say for this example \$10,000. Two years later, Mr. Jones sues Acme. Acme wants to settle, but knowing that Medicare has paid for Mr. Jones' medical expenses, it knows that Medicare will have to be reimbursed. Acme asked Medicare how much it owes for Mr. Jones' care. Medicare, however, will not tell Acme that figure claiming that it cannot do so until the case actually settles. Yet Mr. Jones and Acme cannot settle unless they know Medicare's numbers.

This is the untenable paradox mentioned by Congressman Gingrey. It is impossible for parties to figure out how much Medicare has actually paid. At best, the parties will typically hold a settlement in escrow for months while the process plays out. And sometimes the Medicare demand comes back as a very small amount, as we have heard referred to.

Even if the case does settle, Acme and its insurers have to report the settlement to Medicare under the recent 2006 amendments to the MSP laws. Now, that might sound straightforward enough, but to do so, we will need Mr. Jones' Social Security number to verify that he is a beneficiary and we also have to identify his Health Information Claim Number, or HICN, as well as 200 other pieces of information about Mr. Jones, many of which insurers and defendants in cases have never previously collected. If they fail to report, Acme and its insurance companies face potential penalties of up to \$1,000 per day or \$365,000 per year. And some of this data is very obscure that they have asked us to collect.

This system hurts the beneficiaries who are unable to receive their settlements quickly because Medicare is getting in the way. It also hurts the Medicare Trust Fund because the funds are delayed even as we are prepared to pay, and it hurts businesses like Publix who have incurred incredible additional cost due to the inefficiency of today's system.

I want to share with the committee two recommendations on the way Congress can improve the MSP process and to make it work more efficiently. First, I recommend that Congress address the MSP system and allow CMS, before the final settlement, to provide settling parties with the final amount of healthcare costs that CMS has previously paid. If Congress does so, the beneficiaries will be able to settle faster, the defendants will be able to settle efficiently and with certainty, and the trust fund will recover more money faster. This is a true win-win-win for all the parties.

Secondly, I want to recommend a threshold for small-dollar claims so that we can be sure that the amount of money that government is pursuing these claims does not exceed the amount of money that the government will recover from these claims. And let me explain.

I have seen claims where settlements are being held up because Medicare has made demands of \$1.59, \$2.81, or other such small sums. I have a number of examples with me today. This is a waste of taxpayer resources and it surely costs the Medicare program

more money than they are recovering, even 1 or 2 or \$50 to process these claims. These should all be exempt from the program.

Now, we heard a reference to the Rand Institute's study, which was just published yesterday, and I have a copy of the study with me. And it indicates that if CMS exempted from MSP all liability claims below \$5,000, they would be reducing the Agency workload and save costs on an estimated 43 percent of the claims while only sacrificing 2.4 percent of the money. That is \$24 million of projected loss on \$1 billion to be recovered. It is a waste of taxpayer money for the Agency to spend 43 percent of its time pursuing 2.4 percent of its dollars. And at Publix Super Markets, we settle thousands of claims every year below this \$5,000 threshold.

The subcommittee and Congress can bring common sense to the MSP system by introducing a threshold below which MSP should not apply. The threshold could be a flat dollar amount such as \$5,000 as suggested by the Rand Institute, or it could be set prospectively at the amount of settlement is likely to yield an MSP collection at or below the government's recovery cost. This would not only save the government money but would allow Medicare beneficiaries to settle small claims without being subject to the extensive, intrusive, and costly MSP reporting process.

On behalf of Publix Super Markets, I want to thank you for your leadership in addressing these important issues. In partnerships with our associates and our customers, we look forward to working with Congress to address these issues. Thank you.

[The prepared statement of Mr. Salm follows:]

TESTIMONY OF MR. MARC SALM
VICE PRESIDENT, RISK MANAGEMENT
PUBLIX SUPER MARKETS, INC.

BEFORE THE
UNITED STATES HOUSE OF REPRESENTATIVES
COMMITTEE ON ENERGY AND COMMERCE
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATION

HEARING ON
"PROTECTING MEDICARE WITH IMPROVEMENTS
TO THE SECONDARY PAYER REGIME"

JUNE 22, 2011

Chairman Stearns, Ranking Member DeGette, and distinguished Members of the Subcommittee, good morning. My name is Marc Salm and I am Vice President of Risk Management for Publix Super Markets, Inc. in Lakeland, Florida. In that capacity, I oversee our handling and management of all third party, workers compensation and related claims, and am responsible for our company's administration of our Medicare Secondary Program compliance efforts. I am honored to appear before the Subcommittee to share our company's experiences with the Medicare Secondary Payer (MSP) program; our perspective on how the program is actually working across America, including in the five states in which Publix does business; and to offer several suggestions for ways in which the MSP program could be strengthened to benefit the Medicare Trust Fund, Medicare beneficiaries, affected stakeholders and taxpayers across the United States.

About Publix

Publix was founded by the late George W. Jenkins in 1930 in Winter Haven, Florida. Today we are proud to be the largest *employee-owned* supermarket chain in the United States, and one of the top ten largest-volume supermarket chains in the nation. In 2010, we employed more than 148,500 people across the 1,036+ stores we operate across five states (735 in Florida; 180 in Georgia; 44 in South Carolina; 47 in Alabama; and 30 in Tennessee). We are proud that Publix has been recognized

for 14 consecutive years as one of the “100 Best Companies to Work For” and according to the America Customer Satisfaction Index have been the top ranked grocery store for customer satisfaction for 17 consecutive years. In our 81-year history, Publix has never had a layoff. Mr. Chairman, in your district alone, Publix operates 38 Stores, with 4,495 Publix Associates living in your District, and 5,168 Associates working in your District.

Our Mission at Publix is to be the premier quality food retailer in the world. To that end, we are committed to be passionately focused on customer value; intolerant of waste; dedicated to the dignity; value and employment security of our associates; devoted to the highest standards of stewardship for our stockholders; and involved as responsible citizens in our communities. It is those values that bring me before you today, and that give my company great concern and interest in the operations of the MSP program.

The Medicare Advocacy Recovery Coalition (MARC)

In addition to testifying today on behalf to Publix, I am appearing before you today as a representative of the Medicare Advocacy Recovery Coalition, known as the MARC Coalition. The Coalition was formed in September of 2008 to advocate improvements to the MSP program. The Coalition has been working with both the Centers for Medicare and Medicaid Services (CMS) and the Congress to better understand MSP issues, to ensure that the program is working effectively and efficiently, and to improve the process for beneficiaries, the Trust Fund, and affected stakeholders. MARC’s membership represents virtually every sector impacted by MSP, including plaintiffs and defense attorneys, brokers, retail businesses, insurers, trade associations, major employers and third-party administrators. Thus, I welcome the chance to present to you MARC’s perspective today as well.

What is the MSP Program?

The principle behind MSP is simple – if Medicare has paid for health care costs, and another responsible party is identified that is liable for those same costs, the responsible party should reimburse Medicare for what has already been paid. The principle, adopted into the Social Security Act in 1980 through Section 1395y(b)(2) of the Medicare statute, is simple in theory, but difficult in practice. While CMS by and large has been successful in implementing the program for group health coverage, there is wide recognition that implementation has not been effective in what CMS refers to as “non-group health” cases – meaning liability cases such as slip and fall accidents, no-fault such as auto insurance, and workers compensation claims. Let me provide an example of how the program works.

Imagine Mr. Jones, a 76-year-old beneficiary, who falls down a flight of stairs at the Acme store, and is hospitalized with \$50,000 in health care costs, which Medicare pays. Two years later, Mr. Jones sues Acme, who is insured by Choice Insurance. Acme denies responsibility but wants to settle the case, and Mr. Jones, on the advice of his lawyer, is prepared to accept \$120,000 on his \$1 million claim. Once the settlement is paid, however, existing MSP law will turn Medicare’s \$50,000 payment into a “conditional payment,” and the Medicare Trust Fund, now the “secondary payer,” is entitled to reimbursement. Under the law today, Mr. Jones, Acme and Choice are each responsible to reimburse Medicare once the settlement occurs. Due to the risk of having to pay twice, Acme and Choice are unwilling to actually settle with Mr. Jones without resolving the MSP issue first. Yet, none of the parties can act, as Jones, Acme, and Choice are each unable to determine exactly how much the Trust Fund is owed, because there is no mechanism for Medicare to provide that information before settlement. And even if they could determine the amount (as is sometimes the

case), they have no way to repay the funds to the Trust Fund at the time of settlement.¹ Given the uncertainty, the settlement falls through and Mr. Jones is forced to a trial where he risks an uncertain recovery.

Even if the case does settle, Acme and Choice will be faced with having to report the settlement to Medicare under a recent 2007 amendment to the MSP laws. To do so, they will need Mr. Jones' Social Security number, so they can verify he is a beneficiary and identify his "HICN" – the Medicare Health Information Claim Number, as well as 200 other pieces of information about Mr. Jones that traditionally insurers and defendants in cases never collect. If Acme and Choice fail to report the settlement, they face a potential penalty of \$1,000 dollar per day – or \$365,000 per year. Even if Acme and Choice want to report, Mr. Jones may not answer the question as to whether he is a beneficiary (for example, he might be 45 years old but on Social Security Disability Insurance), or he will refuse to provide his Social Security number. Yet, even if the beneficiary does not provide the information so that Acme and Choice could report, the penalties still accrue if a settlement occurs. Obviously, this has a significant effect on the decision-making process of the parties' willingness to settle.

At Publix, we are dedicated to excellent customer service, and my job is to resolve valid claims quickly and fairly. Yet, it is impossible for us to send Medicare the funds that it is owed, and Medicare cannot timely tell us exactly how much it is owed. The result is a loss for beneficiaries, who are unable to receive their settlements quickly because Medicare is getting in the way, the Medicare Trust Fund, which is delayed in receiving the funds we are prepared to pay, and retailers, who incur incredible additional costs due to the inefficiencies of today's system.

¹ See, e.g., *Medicare Won't Let clients repay government, lawyers say*, Miami Herald, June 10, 2009 (documenting inability of settling parties to repay the Trust Fund); *Medicare's Repo Men*, Mother Jones, October 8, 2009 (same).

Suggestions for Improvement of the Program

I want to share with the Committee two recommendations on ways in which Congress could improve the MSP process. First, I would recommend to the Committee that a pathway be created to allow CMS to provide settling parties with the amount of the “conditional payment” – the amount of health care costs that CMS has previously paid for before a settlement is paid to the beneficiary – before the settlement is completed. Second, I recommend the Committee consider imposing a “threshold” for *de minimis* claims to assure that CMS is not pursuing claims that will yield less than the costs of recovery. Allow me to explain both proposals in detail.

A. Allow CMS to provide the “conditional payment” amount *before* settlement

The current MSP system delays settlements when beneficiaries are injured. In the typical liability case – *e.g.*, a slip and fall in a store, it is usual for Medicare to pay for health care related to the injury until a settlement is reached. Yet, under today’s system, neither the beneficiary nor the settling party knows how much money Medicare will expect in reimbursement when they are negotiating the settlement.

This data gap is not CMS’ creation – in fact, recent court decisions have found that Medicare is not “secondary,” and thus no amount can be provided, until a settlement is complete.² Yet, without knowing how much must be repaid to the Trust Fund, settlements are delayed because the beneficiary cannot determine how much of the settlement he or she will keep and how much will have to be reimbursed to the Trust Fund, and the settling defendant (itself liable to the Trust Fund for the repayment if the beneficiary does not reimburse the agency) will not risk settlement without being assured that the Trust Fund is repaid.

² *See, e.g., Portman v. Goodson*, No. 2011 U.S. Dist. LEXIS 19491 (W.D. Ky. Feb. 28, 2011). In this case the Court granted HHS’s motion to dismiss Ms. Portman’s efforts to bring CMS into litigation to provide the amount of “conditional payments” that were owed to CMS so that the parties could settle the case. The Court found that until the settlement was complete the statute did not implicate Medicare.

Why am I advocating this solution today? Retailers, like my company, thrive when we provide excellent customer service. Part of that service is taking responsibility when accidents happen, and settling claims promptly and effectively. Yet, under today's MSP system, everyone is hesitant to settle with beneficiaries, only to risk having to pay a second time if Medicare comes back to request its repayment from those same settlement funds. While almost all companies would prefer quick resolutions of claims, MSP rules may force cases to trial. When claims that would otherwise be settled promptly go through litigation, both the beneficiary and the Medicare Trust Fund may fail to receive any compensation.

In sum, today's system harms beneficiaries, who may be denied – and at best are delayed in receiving – their intended settlements. It also harms retailers and other businesses, which want to resolve claims to the benefit of their customers, but cannot due to the increased risk of potential double liability. Ironically, and equally important, the current MSP system harms the Medicare Trust Fund, which is unable to recover at all if settlements are not concluded. In contrast, if Congress could create the pathway that allows parties to receive the final amount owed to the Trust Fund *before* settlements and empowering CMS to provide that figure, beneficiaries will be able to settle faster, defendants will be able to settle efficiently and with certainty, and the Trust Fund will recover more money faster – a true win, win, win for all involved.

B. The MSP System Is Inefficient – Often Involving Claims Where the Cost of Collection Exceeds the Amount of Recovery

Many claims settled with Medicare beneficiaries involve *very* small total payments. For example, in many situations, even when a company has no liability, it may offer a beneficiary a relatively small payment purely as a customer service gesture when a customer has had a bad experience because it is the right thing to do and it is good for business. . No matter how small the amount, however, CMS still pursues each and every claim, even when its costs of collection are

vastly greater than the amount it will collect. For example, if it costs Medicare \$350 in contractor and staff time to collect any single claim, taxpayers and the Medicare program are clearly losing money if CMS pursues recoveries below this amount. Yet, Medicare is pursuing cases for \$1.59!

My \$1.59 example is not an exaggeration – I personally have seen settlements which were delayed while the funds sat in escrow until Medicare’s final demand was received for \$1.59. And I have seen numerous other examples of Medicare pursuing two dollar, four dollar, and similar minimal dollar cases. The harm to beneficiaries is serious, as the elderly are kept waiting for their settlements. The harm to taxpayers is equally serious, as the government is clearly losing money on these cases.

Medicare should not waste taxpayer money pursuing MSP claims when the amount recovered will not even pay for postage required to request the repayment. I respectfully suggest that this Subcommittee and the Congress bring common sense to the MSP system by introducing a threshold below which MSP will not apply. The threshold could be set by CMS prospectively at the amount of settlement likely to yield an MSP collection at or below the government’s recovery cost. This would not only save the government money, but would allow Medicare beneficiaries to settle small value cases without being subjected to extensive, intrusive and costly MSP reporting requirements. Most importantly, this change would allow the MSP system to maximize its returns without wasting the resources of taxpayers, Medicare beneficiaries, or stakeholders.

There are several other recommendations we have to improve the administration of the MSP program, such as eliminating the required use of Social Security numbers and improving the current reporting process to avoid punishing good faith compliance efforts in the same manner as the bad actors trying to evade the system altogether. Similarly, the CMS “Recovery Contractor,” called the MSPRC, could be more customer service oriented by having more phone lines for calls, not putting you on hold for hours when you call, and having a dedicated customer service

representative for entities like Publix, so that when questions arise we are dealing with a single person familiar with our claims, rather than having to start from the beginning each time we have a question. I have multiple examples I can share with you of situations where my staff has had to wait on hold for hours to talk to someone at the MSPRC so that we can resolve a customer issue and resolve an MSP claim. I understand my fellow witnesses will be touching on these issues, but welcome further discussion with you on these and related subjects.

Conclusion

On behalf of Publix Supermarkets, thank you for your leadership in addressing these important issues, which have the potential to negatively impact so many Medicare beneficiaries and to threaten the continued solvency of the Medicare Trust Fund. In partnership with our Associates and Customers, we look forward to working with the distinguished Members of this Subcommittee, the full Energy and Commerce Committee, and the Congress to address these challenges and ensure the prompt repayment of dollars owed to Medicare, in order to strengthen this critical program for the future.

Mr. STEARNS. Thank you. Mr. Gilliam?

TESTIMONY OF SCOTT A. GILLIAM

Mr. GILLIAM. Thank you, Mr. Chairman, Ranking Member DeGette, and members of the subcommittee. Good morning and thank you for this opportunity to provide testimony on how the Medicare Secondary Payer system can be improved to protect Medicare beneficiaries in speed reimbursements to the Medicare Trust Fund.

My name is Scott Gilliam. I am vice president and government relations officer with the Cincinnati Insurance Company, one of the Nation's top 25 property casualty insurer groups marketing business, home, auto, and life insurance in 39 States. I am testifying today on behalf of my company and the Medicare Advocacy Recovery Coalition, MARC, a group which seeks to bring improvements and efficiencies to the MSP system.

Today, I would like to tell you about the numerous problems the current MSP system has caused not only for our company but for the innumerable Medicare beneficiaries that we interact with in the course of settling thousands of personal injury claims every month. To put this aspect of our business in perspective, we settled over 40,000 personal injury liability claims last year, paying out over \$580 million to settle those claims using the services of our 730 field claim representatives who are located around the country. Unfortunately, the current MSP system is making it extremely difficult to settle claims in the prompt and efficient manner we believe injured parties deserve and it is having significant negative impact on claimants who are Medicare beneficiaries.

Mr. Salm has already addressed the problems caused by the backwards manner in which CMS collects reimbursements owed to the Medicare Trust Fund. In my testimony today, however, I would like to focus on several critical problems with the MSP Section 111 reporting process, which imposes extremely complicated data reporting requirements on those of us who settle claims with Medicare beneficiaries.

CMS could have implemented the new reporting process through formal rulemaking, which would have allowed for stakeholder input. Instead, the Agency created a complex and broad-reaching system without engaging the affected community. The resulting MSP reporting system involves a complex computer submission process that requires responsible reporting entities—REEs, those of us who settle claims—to submit a significant amount of data to CMS alerting the Agency that we have paid a settlement or a judgment to a beneficiary. Unfortunately, we do not have access to many of the data elements that CMS requires us to report and claimants are often unwilling or even unable to provide the data to us.

To give you an idea of the scope and complexity of the reporting system, I have brought with me today the CMS user guide that we have to follow to report the data. It is like a telephone book. And at my company, we have been spending 2 years trying to implement this, and here is the flowchart we use in our claims department to try and figure out how to report the data.

The reporting requirements not only impact the claims-pending community; they can also have a negative impact on Medicare beneficiaries as well. Consider what happens when the Medicare computer system decides that a beneficiary's current injury or ailment is connected to the primary payer who reported an unrelated payment in the past. Here is a good example. We settled a claim with a woman who was in a car accident and reported the settlement to Medicare. Years later, the woman was diagnosed with breast cancer, and Medicare denied coverage for her treatment on the grounds that her breast cancer was related to the prior car accident. This may sound absurd, but it is a true story from our claim files.

Mr. STEARNS. Could you move the mic just a little closer? Yes. Go ahead.

Mr. GILLIAM. While these reporting requirements are intended to insure that Medicare is made aware of cases where it can assert MSP claims, in practice, however, these complex reporting requirements often slow down settlements and in many cases prevent settlements from even happening. In these situations, money that otherwise could have been promptly returned to the Medicare Trust Fund is delayed, reduced, or never paid. This is especially true in cases where the innumerable claimants who are not represented by an attorney and are intimidated by requests to turn over their private personal information in order to settle their claim.

One of the particularly problematic elements of the Section 111 reporting process is that it requires insurance carriers to collect Social Security numbers or health insurance claim numbers, HICNs, from all parties with which we settle claims. Our claimants are loath to provide this information and in many cases flatly refuse. And it is little wonder they refuse. Can you imagine having someone who you believe has caused you an injury and who you are now considering suing demand that you hand over their Social Security number?

And to make matters worse, the same Agency that requires us to collect SSNs or HICNs for Medicare beneficiaries runs advertising campaigns to prevent Medicare fraud by discouraging Medicare beneficiaries to give out those numbers. Shouldn't this be reason enough for CMS to come up with a better way for us to identify Medicare beneficiaries for MSP reporting? Perhaps Congress could help the Agency solve this problem so that we can navigate the process without requiring disclosure of SS numbers.

A simple solution would be only to require reporting of the last four digits of the Social Security number, a method Medicare already uses to match beneficiaries with their Medicare Part D plan. If CMS can use the last four digits of an SS number in the Part D program, why can't they use it in the MSP program?

Another significant problem with the current system is Draconian penalties. Those of us who pay claims face a mandatory \$1,000-per-day penalty for failing to properly report a claim. We agree that harsh penalties should be used to pursue bad actors who purposefully circumvent the system, but we also believe that Medicare should promptly—however, the mandatory penalties for reporting failures mean that even companies like ours that are doing their utmost to achieve full compliance can face massive penalties

for small errors or technical problems that occur through no fault of our own.

Our company has invested 2 years of financial and human resources in developing an information technology system to manage MSP reporting, and despite our feverish efforts and full committee compliance, we could still face massive penalties if even a single data element is entered incorrectly or our computer systems have a problem or the CMS problem.

Mr. STEARNS. Mr. Gilliam, I need you to sum up.

Mr. GILLIAM. Yes, I will.

I will wrap up quickly. There is another important issue I want to raise to your attention today. And there are a number of claims now arising where Medicare is denying coverage for current ailments based on past claims that we have paid that are completely unrelated. This is occurring in hospice cases, hospice patients being denied care because of an old claim that is not related to their current care. And with that, I will wait for your questions.

[The prepared statement of Mr. Gilliam follows:]

**Testimony of Scott A. Gilliam
Vice President & Government Relations Officer
The Cincinnati Insurance Companies**

On "Protecting Medicare with Improvements to the Secondary Payer Regime"

**Before the Subcommittee on Oversight and Investigations
Energy and Commerce Committee
United States House of Representatives**

June 22, 2011

Chairman Stearns, Ranking Member DeGette, and members of the Subcommittee:

Good morning and thank you for this opportunity to provide testimony on how the Medicare Secondary Payer (MSP) system can be improved to protect Medicare beneficiaries and speed reimbursements to the Medicare Trust Fund.

My name is Scott A. Gilliam and I am Vice President and Government Relations Officer with The Cincinnati Insurance Company, the lead subsidiary of the Cincinnati Financial Corporation. We stand among the nation's top 25 property casualty insurer groups based on net written premium. We market business, home, auto, and life insurance through independent agencies in 39 states. We have approximately 2,850 associates at our headquarters building in Fairfield, Ohio – just north of Cincinnati – which support nearly 1,200 associates in field locations, including over 900 claims representatives. To put our claims operation in context, in 2010 we settled over 40,000 personal injury liability claims and paid out settlements for those claims in excess of \$580 million.

In my position I am responsible for all government relations activities for Cincinnati Insurance and I represent my company with numerous insurance industry trade, advocacy and public policy groups, including the Medicare Advocacy Recovery Coalition (MARC). Before joining Cincinnati Insurance I practiced law in Toledo, Ohio where my practice focused on personal injury defense and insurance coverage disputes. I am also a Past President of the Ohio Association of Civil Trial Attorneys, the civil defense bar in Ohio.

Today I would like to tell you about the numerous problems the current MSP system has caused not only for our company and the businesses we insure, but for the innumerable Medicare Beneficiaries that we interact with every day. My company is in the claims settling business and we settle thousands of personal injury claims every month. Every time we have a claim made against a policy, we endeavor to settle that claim as quickly, as fairly, and as efficiently as possible.

Unfortunately, the current MSP system is making it extremely difficult to settle claims in the prompt and efficient manner we believe injured parties deserve and is having a significant negative impact on claimants who are Medicare beneficiaries. As Mr. Salm addressed in his testimony, under the current MSP system, it is extremely difficult to settle a claim when neither party has the complete information they need to make a settlement decision. Without knowing what the conditional payment to Medicare will be, the parties can not reach a decision about an appropriate settlement amount, and all too often, the settlement is needlessly drawn out or falls apart entirely.

In my testimony today, however, I would like to focus on several critical problems with the MSP Section 111 reporting process. Congress enacted the MSP laws on December 5, 1980, but many of the current problems with the system arise from recent changes. In December 2007, Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA) created new and extremely complicated data reporting requirements for insurers, self-insureds, and workers' compensation carriers who settle claims with Medicare beneficiaries.

CMS could have implemented the new reporting process through formal rulemaking, which would have allowed for stakeholder input. Instead, the Agency created a complex and broad reaching system through informal industry guidance without engaging the effected community. While the reporting system was initially required to be up and running in 2009, CMS delayed its startup and is phasing in implementation. The MSP reporting system involves a complex computer submission process that requires the Responsible Reporting Entities (REEs), i.e. the entity that paid

part or all of a settlement to a beneficiary, to submit a significant amount of data to CMS alerting the agency that the RRE has entered into a settlement, judgment, award, or other payment with a Beneficiary. Many of these required data elements are information that an RRE does not have access to and that claimants are often unwilling, or even unable, to provide. To give you an idea of the scope and complexity of the reporting system, I have brought with me Version 3.1 of CMS User Guide for implementing the Section 111 reporting system.

Representative of the complexity of the MSP reporting system is its reliance on the specific ICD-9 Diagnosis Codes associated with a claimant's alleged injury. While ICD-9 codes attempt to specify the exact nature of an individual's injury, even doctors don't always agree on what ICD-9 Code is appropriate for a patient's condition. When a claimant has seen multiple physicians, they may have multiple different ICD-9 codes. It is particularly challenging to identify the correct ICD-9 code when a claimant did not actually incur any injury or require significant medical care. In fact, for many claims the only medical care involved is a trip to the doctor's office to get checked out or trip to an emergency room for observation, with no injury, no broken bones – nothing to diagnose. While there is an appropriate ICD-9 code for such situations, V71.4 (Observe-accident NEC), or V70.0 (Routine medical exam), CMS does not allow us to use these codes for reporting purposes. What a perfect catch-22. CMS won't allow us to use the correct ICD-9 diagnosis code but if we do not report an ICD-9 code in our Section 111 claims file, the claim will be kicked back and we will be out of compliance and facing a potentially large, mandatory fine.

The reporting requirements can have a significant negative impact on Medicare beneficiaries as well. An injured person's settlement that we are completely willing to pay out can be held up because the injured person refuses to provide us with the diagnosis code associated with the injury they sustained for privacy reasons. And even when the Medicare beneficiary does give us their ICD-9 Code, that doesn't prevent problems from occurring years after their claim is settled. Consider

what happens when the Medicare computer system decides that the diagnosis code for a beneficiary's current injury or ailment is connected to the diagnosis code for an old MSP claim, prompting Medicare to take the position that they are not responsible for covering the costs of the new, and totally unrelated, ailment. For example, imagine we settle a claim with a woman who was in a car accident and suffered chest wall contusions and report the settlement to Medicare. Years later, that woman is diagnosed with breast cancer and Medicare denies her claim for treatment on the grounds that her breast cancer is related to her prior car accident and claims that we are responsible. This may sound absurd, but unfortunately this actually occurred.

While these reporting requirements are intended to ensure that Medicare is made aware of cases where it can assert MSP claims, in practice, however, these complex reporting requirements often slow down settlements, and in many cases prevent settlements from even happening. In these situations, money that otherwise could have been promptly returned to the Medicare Trust Fund is delayed, reduced, or never paid. This is especially true in cases for the innumerable claimants who are not represented by an attorney and are intimidated by requests to turn over their private personal information in order to settle their claim.

In fact, as a result of the problems caused by the current reporting system, many Medicare beneficiaries decide to drop their claim rather than deal with the hassle of the MSP system. In other instances, the MSP system makes it impossible for the two parties to come to an agreement, and as a result the case goes to court. When a case goes to court, not only does it waste judicial resources, it also increases the possibility that the claimant will not recover at all. And if the claimant does not recover, neither does the Medicare Trust Fund.

CMS Should Not Require Insurers to Obtain Social Security Numbers from the Public

One of the particularly problematic elements of the Section 111 reporting process is that it requires insurance carriers to collect Social Security Numbers (SSNs) or Health Insurance Claim Numbers (HICNs)¹ from all parties with which we settle claims. Our claimants are loath to provide this information and in many cases flatly refuse. And it is little wonder that they refuse. Can you imagine having someone who you believe has caused you injury and who you are now considering suing, demand that you hand over your sensitive personal information? Some claimants will eventually grudgingly agree to provide us with their SSN or HICN, but others would rather forgo their claim then hand this sensitive information over to a stranger.

A recent lawsuit in Connecticut state court illustrates the problem with obtaining a claimant's SSN or HICN. In *Hackley v. Garafolo*² a teenager was injured in a car accident. The young man and his family were perfectly willing to accept the settlement that the defendant's insurance company offered. However, to ensure that they were compliant with the MSP reporting requirements, the insurance company requested the teenager's SSN. The family flatly refused to provide the number and the insurance company was unable to write the settlement check without obtaining the required information. Eventually, the family took the matter to the Judge in the case asking him to enforce the settlement. The judge, however, refused to enforce the settlement given the insurer's need to verify that the teen was not a Medicare beneficiary, which the judge determined, was a critical component of the agreement. The young man and his family were denied the settlement proceeds, and the auto insurer could not settle the claim. Why was the insurer so insistent that it get the SSN? Because the extraordinary \$1,000 per day per claim mandatory penalty for failure to report makes it

¹ A HICN is a beneficiary's Medicare number, and it is made up of the individual's SSN plus one additional digit.

² *Hackley v. Garafolo*, No. CV095031940S (Sup. Ct. Conn., July 1, 2010).

imperative for an insurer to verify that it is not settling with a Medicare beneficiary. And today the only way to verify a claimant's Medicare status is by checking the SSN or HICN. We doubt that the overseers of the MSP system ever intended for settlements with beneficiaries to be scrapped and reimbursements to the Trust Fund scuttled because of a beneficiary's reluctance to provide his SSN. But that is exactly what is happening given the reluctance of insurers to face unconscionable fines for failing to obtain the SSN for every settling claimant.

And to make matters worse, the same agency that requires us to collect SSNs or HICNs from Medicare beneficiaries is also running an advertising campaign to prevent Medicare fraud by discouraging Medicare beneficiaries from giving these numbers out. Shouldn't this be reason enough for CMS to come up with another way for us to identify Medicare beneficiaries for Section 111 reporting purposes? The claims settlement community has been asking CMS for the last two years to find another identification solution; however, it has yet to happen. Perhaps Congress can help the Agency solve this problem, so that we can navigate the MSP process without requiring disclosure of SSNs, which we don't want to collect anyway and which many beneficiaries will not give us.

We are quite certain that there is a better way to identify Medicare beneficiaries that does not require injured parties to hand over their sensitive personal information. The Medicare Part D E-1 Query Process, which is used to match beneficiaries with their Medicare Part D Plan, provides an excellent alternative approach. That process uses only the last four digits of an individual's SSN. In my experience, individuals are much more comfortable providing that limited information rather than their full SSN or HICN. If CMS can use the last four digits of a SSN in the Part D program, they should be able to take the same approach for MSP purposes.

Section 111 Reporting – Penalty Provisions

Another significant problem in the current MSP system is the Draconian penalties. Those of us who pay claims face mandatory \$1,000 per day per claim penalties for failure to properly report a

MSP claim. We agree that harsh penalties should be used to pursue bad actors that purposefully circumvent or game the MSP system. We also believe that Medicare should be promptly and completely repaid for any MSP liability. However, the mandatory penalties for reporting failures mean that even companies that are doing their utmost to achieve full compliance can face massive penalties for small errors or technical problems that occur through no fault of their own. Our company has invested a significant amount of financial and human resources in developing an information technology system to manage the MSP reporting process. Despite our feverish efforts, significant investments, and full commitment to compliance, we could still face massive penalties if even a single data element is entered incorrectly or if either our computer systems, or even CMS' computer systems, experience a technical problem during reporting.

In light of the complexity of the reporting system, penalties should be imposed on a discretionary basis (the current fines are mandatory) and CMS should have authority to select an appropriate penalty amount up to \$1,000 per claim per day. A safe harbor for good faith reporting would also provide those of us who pay claims much needed protection when we are doing our utmost to report full and accurate information to CMS. (Indeed, the Connecticut case I referred to above may never have happened if the insurer in that case knew that they would not be penalized for their good faith efforts to determine that the teen was not a Medicare beneficiary.)

Appropriate safe harbors and penalty discretion would allow CMS to work cooperatively with the claims paying community to resolve any issue that may arise, while still pursuing bad actors with the full force of the law. Let me be very clear – I am not advocating that Congress water down the penalty provisions; but I believe it will significantly improve MSP administration if we create the needed discretion to ensure that good faith compliance efforts are not penalized in the same way as bad actors should be.

One Additional Issue – CMS Mis-identifying Responsible Parties

There is another very important issue I want to raise for you today, which we are beginning to see more of in the past several months, but which has the potential to harm tens of thousands of Medicare beneficiaries in the coming years. Specifically, we are beginning to see numerous instances where CMS is denying a Medicare beneficiary coverage, and identifying my company, or some other claims paying entity, as responsible for *all* of a beneficiary's current health care costs simply because we settled a small case with the beneficiary years ago. Let me give you several examples:

In the first case, a beneficiary fell at one of our policyholder's stores in September 2009 and hit their knee and head. We paid the health care costs due to the injuries and closed the claim in September 2010. This year, some 18 months after the event, the beneficiary went to a doctor for gynecological treatment and Medicare denied coverage for the claim on the grounds that we were responsible. Even after we clarified that the gynecologist visit had *nothing* to do with the slip and fall, the doctor insisted on billing the beneficiary directly because of Medicare's denial.

In a second case, a woman slipped and fell at another of our policyholder's stores in June 2008, hurting her pelvis and arm. Although we believe our policyholder had no liability, we settled the claim for a \$4,800 medical payment. Knowing that claimant was a beneficiary, we notified Medicare that we had taken care of the medical costs associated with the accident and closed our file. More than two years later, in December 2010, the claimant slipped and fell in her home, injuring her head and upper arm. Despite the lack of any connection between her June 2008 fall on our insured's premises and her new fall at home in December 2010, Medicare denied coverage for treatment of her more recent fall and identified us as the responsible party even though we had nothing to do with her at home accident. Despite repeated efforts to clarify this misunderstanding, Medicare is *still* denying the woman coverage for her fall at home.

Finally, in the past several weeks we have been contacted by beneficiaries in several cases in which Medicare is denying coverage for very ill people – one even in hospice – in situations in which we have never heard of the beneficiary and have never provided them with any coverage or a policy. Apparently these families are reaching out to us because Medicare is identifying our company as the “responsible party” – even though we have no record of providing a policy or paying a claim to that beneficiary.

My company has dozens of these types of cases, and I have heard of hundreds more that are occurring across the country every week. Every one of these cases is happening because the MSP system is wrongfully denying beneficiary coverage for unrelated claims. Although it is impossible to know the number, it is probably safe to say that thousands of beneficiaries are being harmed by wrongful denial of Medicare coverage for unrelated claims. We urge the Congress to monitor this issue and consider ways in which misidentification of the responsible party could be prevented.

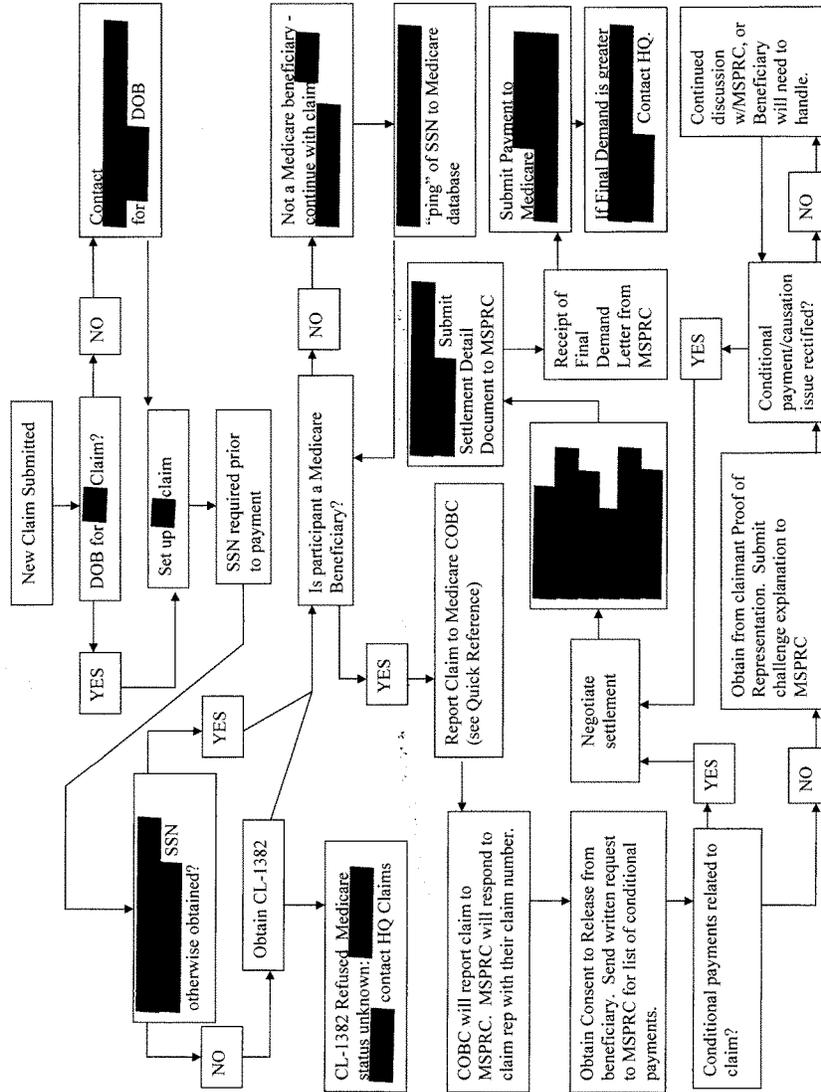
Conclusion

My company is fully committed to repaying the Medicare Trust Fund in full for all MSP claims. We also believe, however, that Medicare beneficiaries should not be punished for the bad luck of having been injured. Their claims should not be needlessly held up, they should understand exactly what they will recover from a claim before signing a settlement agreement, and they should not have to give up sensitive personal information in order to be compensated for having been injured. A more sensible and efficient MSP system would allow claims to be settled promptly, which would let both the injured beneficiary and the Medicare Trust Fund receive their compensation in the timely fashion that they deserve. We want to do right by Medicare and we want to do right by beneficiaries. We just need a sensible MSP system that will allow us to do what we do best, settle claims and make things right for injured parties.

I welcome any questions that you have.

Mr. STEARNS. Thank you. And by unanimous consent, we will put in your book and your chart into the record. So done.

[Some of the information is available at <http://www.lightspeedclaim.com/docs/NGHPUserGuideV3.1.pdf>. The rest of the information follows:]



Mr. STEARNS. Mr. Matzus?

TESTIMONY OF JASON MATZUS

Mr. MATZUS. Good morning, Chairman Stearns—

Mr. STEARNS. I just need you to pull the mic a little closer.

Mr. MATZUS. Good morning. Can everyone hear me? OK. Good morning, Chairman Stearns, Ranking Member DeGette, and members of the subcommittee, thank you for your leadership in holding this important hearing. I greatly appreciate the opportunity to testify on how the Medicare Secondary Payer system impacts Medicare beneficiaries.

My name is Jason Matzus. I am a partner at the law firm of Raizman, Frischman, and Matzus. My firm is based in the Pittsburgh area represented by Congressman Tim Murphy of this committee. I have handled hundreds of personal injury claims, including those resulting from auto liability and other personal injury claims. In many of these cases, I am representing Medicare beneficiaries in their claims against third parties. In that capacity, I have firsthand experience with many of the unintended consequences of the MSP system. I fully support the intent of the MSP requirement to make sure Medicare is repaid when someone else has accepted liability for a beneficiary's medical care. But the current MSP system causes many problems for the beneficiaries I represent and delays or even prevents full repayment to the trust fund.

The unfortunate reality is that in practice, the current MSP system harms not only beneficiaries but the trust fund as well. The most significant problem my beneficiary clients face is that the current MSP system administered by the Center for Medicare & Medicaid Services is running the process backwards. We cannot get the Final Demand explaining how much money is owed to Medicare until after a case settles and is reported to CMS. As the prior witnesses on this panel have noted, this is causing many significant problems and harms everyone involved, including, ultimately, the Medicare Trust Fund itself.

The backward recovery process is creating significant obstacles that make it very difficult for cases to settle. The amount of money that will need to be repaid to Medicare is a critical piece of information, a piece of information that we currently cannot get when we need it most, during settlement negotiations. This problem, this lack of critical information is causing more and more cases to go to trial instead of being settled simply because nobody has a reliable final number from Medicare of what the trust fund is owed. More cases going to trial rather than settling outside of courtrooms necessarily means that ultimately less money will be recovered by Medicare. That is obviously contrary to the primary goal of the MSP system. Thus, the current recovery process actually works against the goal of recovering as much money as possible for the trust fund.

Even if I settle a case without knowing the final number, which happens, there are still extreme delays in getting that Final Demand amount from Medicare. Even once the beneficiaries have settled their claims or won their case in Court and the required reporting has been made to Medicare, my client still must wait and

wait and wait to receive anything from their settlements. It is not at all uncommon for it to take 6 months or even a year just to resolve the MSP portion of a claim. My firm alone has had many instances of such cases for beneficiaries when it took that long. Of course, my beneficiary clients are not the only ones who are waiting to be paid during this time. The Medicare Trust Fund also does not get reimbursed until we are told the Final Demand amount. In the aggregate, these delays translate into millions of dollars of lost revenue annually for the Medicare Trust Fund. A system that harms both the Medicare beneficiaries and the trust fund simply cannot be right.

These long delays are causing significant financial strains for many beneficiaries who have been injured. At my firm, we have had instances where the Medicare beneficiary faced the prospect of foreclosure on their home because of the delay in getting the Medicare reimbursement resolved. This can happen when a Medicare beneficiary is counting on the settlement proceeds to reimburse them for the out-of-pocket costs associated with their injury such as co-pays, uncovered medical services, and lost wages. Fortunately, we have avoided that calamity, but the issues are real. Tragically, a colleague of mine has told me of an instance where the beneficiary has died during the interim period waiting for the MSP portion of the claim to be resolved after the case is settled.

I strongly urge this committee and Congress to empower Medicare to provide a Final Demand amount before settlements occur so that everyone would know how much money is owed and would be able to settle accordingly. If that were to occur, the beneficiaries that I represent would be far better off than they are today and the trust fund would recover many millions of dollars more than is the case today. If this simple change occurred, both beneficiaries and Medicare could receive their reimbursements much faster than they do today.

Let me be clear. We are ready and able to reimburse the trust fund, but we need your help to clear the bureaucracy out of the way and make a sensible MSP system that will actually work. One month ago, I had the privilege of meeting with Representative Tim Murphy along with approximately 30 other lawyers from the Pittsburgh area on this issue, all interested stakeholders on this issue. As we asked Congressman Murphy last month, I join with my colleagues in respectfully urging you to allow us to quickly and efficiently resolve MSP claims. I thank you for the opportunity to testify today before the subcommittee and I welcome any questions that you have.

[The prepared statement of Mr. Matzus follows:]

**Testimony of Jason Matzus
Partner, Raizman Frischman & Matzus
Pittsburgh, Pennsylvania**

Hearing on “Protecting Medicare with Improvements to the Secondary Payer Regime”

**Before the Subcommittee on Oversight and Investigations
Committee on Energy and Commerce
United States House of Representatives**

June 22, 2011

Chairman Stearns, Ranking Member DeGette, and members of the Subcommittee:

Thank you for your leadership in holding this important hearing. I greatly appreciate the opportunity to testify on how the Medicare Secondary Payer (MSP) system impacts Medicare beneficiaries and to share some ideas on how the system could be improved to better serve beneficiaries and the Medicare Trust Fund.

My name is Jason Matzus, and I am a lawyer who represents many Medicare beneficiaries in claims against third parties. In my capacity as a lawyer for beneficiaries, I have first-hand experience with many of the unintended consequences of the MSP system. While I fully agree with the underlying principle of MSP – to repay the Medicare Trust Fund for health care it has covered if another source has agreed to pay for that care through a judgment or settlement – I can tell you directly that the MSP process as it is structured today harms beneficiaries, and in turn, postpones, and in some instances eliminates, reimbursement to the Trust Fund.

Background

By way of my background, I am a partner in the law firm of Raizman Frischman & Matzus, P.C., based in the Pittsburgh area represented by Congressman Tim Murphy of this Committee. Since entering my law practice, I have handled hundreds of personal injury claims, including those resulting from automobile accidents, truck accidents, medical mistakes, airplane accidents, construction site and industrial accidents, premises liability, and defective products. I also speak

extensively across Pennsylvania on the topics of personal injury law, insurance law, trial presentation techniques, and trial strategy and tactics. Currently I also serve as an Adjunct Professor of Law at the University of Pittsburgh School of Law.

How is the MSP Process Actually Affecting Beneficiaries?

Let me explain how I see the MSP process actually working in the cases my colleagues and I handle. In my experience, it is harming beneficiaries, and ironically and unfortunately, harming the Trust Fund as well. The foremost problem that I and my clients encounter in resolving claims is that the Centers for Medicare and Medicaid Services (CMS) is running the process backwards. As has been explained, Medicare will not provide a "Final Demand Letter" specifying the amount that must be reimbursed to the Trust Fund from settlement or judgment proceeds, until after the case has been settled and the attorney reports the settlement of the case to Medicare. This poses obvious problems for every interested party, including Medicare.

Medicare's recovery process in this regard creates significant obstacles in getting cases settled. It denies everyone of necessary and critical information. It negatively impacts claim resolution and causes more cases to go to trial simply because nobody has a reliable final number from Medicare of what the Trust Fund is owed. This ultimately results in less money being recovered by Medicare, which is obviously contrary to one of the goals of the MSP system. Thus, the recovery process actually works against the goal of recovering as much money as possible for the Trust Fund.

Another significant problem involves the extreme delay in getting Final Demand figures from Medicare, which ultimately impedes the parties' ability to distribute money back to Medicare and to the beneficiary. Distributions are delayed even after a case is settled or has gone through trial. It is not uncommon for it to take six months to one year to resolve the MSP portion of a claim. Indeed, my firm has handled dozens of such cases for beneficiaries when it took that long. In the

aggregate, this delay has to translate into millions of dollars of lost revenue annually for the Medicare Trust Fund, simply as a function of the time-value of money. Along the way, beneficiaries get frustrated. Given the quagmire of the MSP process, there are certain cases where the hassle of dealing with MSP causes everyone to walk away from otherwise legitimate cases before they are brought – harming both beneficiaries who cannot recover, as well as the Trust Fund, that now has no settlement from which to collect. That cannot be right.

Let me give you a specific example I just learned about – I have a colleague who has just settled a case for \$400,000 on behalf of a Medicare beneficiary in her mid-80s. Although the case has been settled for weeks, the settlement funds sit in an attorney escrow account waiting for final demand figure from Medicare. The beneficiary is in failing health, and it is unclear that by the time Medicare is able to provide a final demand the beneficiary will still be alive.

Every day of delay in getting the settlement into the hands of the beneficiary not only harms the Trust Fund, but can have severe financial consequences for the beneficiary as well. For example, in my firm's work with beneficiaries, we have had instances where the Medicare beneficiary faced the prospect of foreclosure on their home because of the delay in getting the Medicare reimbursement resolved. This can happen when beneficiaries are counting on the settlement proceeds to reimburse them for their co-pays and uncovered medical services, the costs of which have forced them to skip mortgage payments. Fortunately, we have avoided that calamity, but it is a real consequence visited upon Medicare beneficiaries simply because of the delay in the current Medicare claim recovery process.

Conclusion

Congressional action is needed to empower Medicare to provide a final demand at the time of settlement, so that everyone would know what is owed and would be able to settle accordingly. If that were to occur, the beneficiaries that I represent would be far better off than they are today, and

the Trust Fund would recover many millions of dollars more (and faster) than is the case today. Let me be clear – we are ready and able to reimburse the Trust Fund – but we need your help to clear the bureaucracy out of the way, so that we can do so quickly.

One month ago, I had the privilege of meeting with Representative Tim Murphy along with approximately 30 other lawyers from the Pittsburgh area on this issue. While our group represented a broad cross-section of stakeholders, we all shared a common perspective when it came to how the MSP program is actually working, or more precisely, how it is not working. Everyone in the room wanted to reimburse the Trust Fund in those cases where payment was required – we simply were prevented from doing so by Medicare. As we asked Congressman Murphy last month, I join with my colleagues in respectfully urging you to allow us to quickly and efficiently resolve MSP claims. We need to do so, not only for our own interests, but for the sake of beneficiaries who deserve better treatment, as well as for the Trust Fund, which so badly needs the funds.

Again, thank you for the opportunity to testify today before the Subcommittee. I welcome any questions you have.

Mr. STEARNS. I thank the gentleman. Ms. Stein, welcome, for your 5-minute opening statement.

TESTIMONY OF ILENE STEIN

Ms. STEIN. Good morning, Chairman Stearns, Ranking Member DeGette, and other distinguished members of the subcommittee. I thank you for the opportunity to testify today about the current Secondary Payer program and the difficulties Medicare beneficiaries face navigating this system.

I am Ilene Stein, Federal Policy Director for the Medicare Rights Center. Medicare Rights is a national, nonprofit consumer service organization that works to ensure access to affordable healthcare for older adults and people with disabilities. Last year, we assisted more than 14,000 Medicare beneficiaries and nearly 4,000 healthcare professionals through our national helpline. These calls inform our public policy efforts and allow Medicare Rights to bring the voice of Medicare beneficiaries to the national conversation about Medicare.

For the health and integrity of the Medicare program, a robust Secondary Payer regime is necessary. However, the current system is flawed in both policy and implementation. The results can be devastating for Medicare beneficiaries. Not only do individuals receive demands from Medicare for large amounts of money that, in some cases, they do not owe and/or cannot pay, but in certain situations, Medicare will cease coverage because cases were improperly closed by CMS and MSPRC.

Though not all-inclusive nor mutually exclusive, the problems we identified with the Secondary Payer process fall into 5 categories. The first is untimely collection of Medicare's share of settlements. Currently, there is no established time frame by which Medicare must tell individuals what they owe if they have settled a liability case. If a beneficiary settles without knowing the Medicare costs, Medicare may come back years later and collect a sizeable portion of the settlement to Medicare. In some cases, given the lapse in time and because the beneficiary is unaware that Medicare is owed money, settlement funds may no longer exist.

The second issue is that CMS and MSPRC often miscalculate the amount that Medicare is owed. Frequently, callers to our helpline receive notices from MSPRC requesting repayment for treatments that are unrelated to injuries associated with a previous accident. This is because CMS and the contractor do not properly segregate claims related to accidents from other claims completely unrelated to those past injuries.

The third issue concerns beneficiaries' difficulty in obtaining information about their cases from CMS and MSPRC. Callers experience extremely long hold times, and even when individuals are able to reach customer service representatives, they receive inaccurate or incomplete information.

Fourth, beneficiaries who manage to get an explanation often find the source of the issue to be that CMS and MSPRC did not properly close their case. As a result, even though the insurance company has closed the case, the Medicare system believes that Medicare is still a secondary payer. Consequently, Medicare conditionally pays, sending demands for reimbursement to beneficiaries

or stops paying for services altogether. Such a serious matter should be resolved quickly but it often can take up to a year to get the case closed.

Finally, notices sent to consumers by MSPRC are not clear. While they speak to appeal rights, they do not contain detailed information on how to request an appeal or about the documentation necessary to be successful. Notices also fail to elucidate the hardship waiver process available if consumers are unable to pay Medicare the money being requested.

There are several steps that can be taken legislatively or administratively that would help solve many of the problems that beneficiaries encounter. Ideally, as soon as incidents are reported to Medicare, Medicare would then provide the insurer and the beneficiary with an estimate of the conditional payments made by Medicare for treatment related to the injury, as well as an estimate of future treatment.

Medicare collection practices should ensure timely recovery. Medicare Secondary Payer claims should not be initiated more than 2 years after the settlement has been made. This would also help to ensure that in settlement negotiations and legal proceedings, all parties are able to consider Medicare's claims. CMS and its contractors should be required to improve the notices provided to consumers. Specifically, the notices' language must be more consumer-friendly, and the notices should include more detailed information about appeal and hardship waiver rights and process.

MSPRC should be required to maintain a transparent, easy-to-use process through which beneficiaries and their representatives can obtain information about their cases. This means both ensuring shorter call times, and more importantly, assigning a specific staff member to cases who can be reached directly.

CMS and its contractors should develop a better process for separating claims that are and are not related to an accident. CMS and the contractor should also be required to make decisions expeditiously when beneficiaries dispute the inclusion of claims because they do not believe that they relate back to an accident.

Thank you again for the opportunity to testify today. I would be happy to respond to any questions from the committee.

[The prepared statement of Ms. Stein follows:]

Statement by Ilene Stein, Federal Policy Director
Medicare Rights Center
on
Protecting Medicare with Improvements to the Secondary Payer Regime
Before the
House of Representatives
Committee on Energy and Commerce
Subcommittee on Oversight and Investigations
June 22, 2011 at 10 a.m.
2125 Rayburn House Office Building
Washington, DC

Good morning, Chairman Stearns, Ranking Member DeGette, and other distinguished members of the sub-committee. I thank you for the opportunity to testify today about the current secondary payer program and the difficulties Medicare beneficiaries face when navigating this system.

I am Ilene Stein, federal policy director for the Medicare Rights Center (Medicare Rights). Medicare Rights is a national, nonprofit consumer service organization that works to ensure access to affordable health care for older adults and people with disabilities through counseling and advocacy, educational programs, and public policy initiatives. Last year, we assisted more than 14,000 Medicare beneficiaries and nearly 4,000 health care professionals through our national helpline. Additionally, Medicare Rights' online educational tool Medicare Interactive received 420,000 site visits. Through our advice and counseling, we were able to assist beneficiaries in understanding their Medicare coverage and their rights within the Medicare program, and in accessing needed prescriptions and health services. These calls inform our public policy efforts and allow Medicare Rights to bring the voice of Medicare beneficiaries to the national conversation about Medicare.

Like all health insurers, Medicare has established rules about when it will make primary insurance payments. The purpose of the Medicare Secondary Payer policy is to ensure that Medicare does not make primary insurance payments for services covered by another payer or insurer. For example, if an individual with Medicare is in an accident, it may be determined through settlement or other legal proceedings that the insurance of the party

at fault is the primary payer for medical services related to incident. Medicare will not, and should not, pay for those services. If Medicare has paid for services during the pendency of the settlement, the program is entitled to recover these costs. Medicare contracts with a private entity, the Medicare Secondary Payer Recovery Contractor (MSPRC), to determine the claims for which Medicare is secondary payer, the amounts owed to Medicare, which party is responsible for payment, and to process collections.

For the health and integrity of both the Medicare trust fund and the Medicare program, a robust secondary payer regime is necessary. Therefore, we support the program's right to collect payment for services for which the program should not be paying. However, the current system is flawed in both policy and implementation. The results can be devastating for Medicare beneficiaries. Not only do individuals receive demands from Medicare for large amounts of money that, in some cases, they do not owe and/or cannot pay, but in certain situations, Medicare will cease coverage because cases were improperly closed by MSPRC.

Though not all-inclusive nor mutually exclusive, the problems we identified with the secondary payer process fall into five categories: untimely collection of Medicare's share of settlements; MSPRC calculation errors; difficulty obtaining information about the secondary payer case from MSPRC; difficulty resolving cases with MSPRC; and problems with notices, appeals, and the hardship waiver process.

I. Untimely collection of Medicare's share of settlements

Currently, there is no established timeframe by which Medicare must tell individuals what they owe if they have settled in a liability case. We know that beneficiaries who contact Medicare before a settlement is finalized experience long wait times before they receive an estimate of Medicare's costs, causing undue delay and injecting uncertainty into the settlement process. If a beneficiary settles without knowing the Medicare costs, he or she may end up owing a sizeable portion of the settlement to Medicare. We have seen cases where after a settlement is reached, MSPRC contacts a beneficiary and

recoups almost the full amount of a settlement. Moreover, in other cases, because the beneficiary is unaware that Medicare has the right to recoup money, and because in many cases MSPRC reaches out to the beneficiary years after a case is settled, it is likely that the settlement is already partially or fully spent. This creates a precarious financial situation for the beneficiary.

Unfortunately, for many beneficiaries who call our helpline, Medicare was not contacted at the time of settlement. Currently, the burden lies with the beneficiary to notify Medicare of settlement, but unless he or she is represented by an attorney knowledgeable about the program, they have no way to know this obligation exists. For this reason, we appreciate new requirements that would create obligations for other, more empowered parties to contact Medicare, with notice to the beneficiary and his or her representative.

II. MSPRC calculation errors

MSPRC often miscalculates the amount that Medicare is owed. Frequently, callers to our helpline receive notices from MSPRC requesting repayment for treatments that are unrelated to injuries associated with a previous accident. This is because the contractor does not properly segregate claims related to an accident from other claims completely unrelated to those past injuries. In these cases, not only can MSPRC send a demand letter to a beneficiary to recoup past coverage, but it may prospectively deny coverage for care or even begin to automatically deduct money from Social Security checks. Moreover, as is the case with the MSPRC notice for settlements, these demands, reductions and terminations occur years after the accident took place and, in some cases, years after the MSPRC case was supposedly closed.

An illustrative example comes from a Medicare beneficiary from Florida who called our helpline this year:

Ms. B and her husband were in an auto accident in August 2000 in which they sustained no injuries, but were taken to the hospital as a precautionary measure

and received X-rays at minimal cost. Despite the low cost of the hospital visit, Medicare is seeking recovery of about \$26,000 for payments made for treatments of cancer, rheumatoid arthritis, and other injuries and diseases that are completely unrelated to the accident.

III. Difficulty obtaining information about the secondary payer case from MSPRC

If beneficiaries have questions about a notice received because it requires payment for services unrelated to a past accident or references an accident that occurred several years ago, or if they received no notice at all but are unable to access any Medicare coverage, it is extremely difficult to obtain information pertinent to their cases. First, it is our experience that wait times to speak with a customer service representative (CSR) often exceed 30 minutes and can exceed an hour. Of course, this assumes the beneficiary is able to get through at all, since the phone line is sometimes busy. Wait times and unanswered lines discourage beneficiaries from obtaining necessary information and resolving their case.

Second, MSPRC representatives routinely provide incomplete or inaccurate information, which necessitates further phone calls. Because Medicare beneficiaries are not assigned an individual caseworker, each time a beneficiary contacts MSPRC he or she must initiate a whole new discussion of the case issues. We suspect that MSPRC case logs are lacking because information that should have been recorded in earlier calls does not appear on file when subsequent calls are made. When beneficiaries have asked to speak with a supervisor, their requests have been refused.

IV. Difficulty resolving cases with MSPRC

If beneficiaries are finally able to reach a knowledgeable customer service representative, many times they find the source of the issue is that MSPRC did not properly close a case. As a result, though the insurance company has closed the case, the Medicare system

believes that Medicare is still a secondary payer. Consequently, Medicare stops paying for services.

Such a serious matter should be resolved quickly. But in order to close a case, MSPRC requires that the beneficiary obtain additional documentation that the case was closed by the insurer who covered accident-related costs, and that medical records demonstrate claims in dispute are unrelated to previous accidents or incidents. To our knowledge, this requirement is not detailed in any written notice.

A client story from New York illustrates the difficulties beneficiaries face simply trying to close cases:

Ms. B was in a car accident, and at the time of the accident her automobile insurance paid for all related hospital and physician bills. Several years after the accident, she received a notice from MSPRC indicating that she owed money for recent treatments unrelated to those that resulted from the car accident. When she was able to reach an MSPRC representative, she was told that in order to close the case in MSPRC's system she must obtain a letter from her auto insurance company certifying that they had in fact paid primary on medical claims related to the accident. This was difficult to obtain because the accident had occurred several years earlier. However, after much effort Ms. B was able to obtain the letter. She submitted the letter MSPRC three separate times, but the case remained open. During this time, Ms. B continued to receive demand letters. After multiple calls to MSPRC, Ms. B was told by a customer service representative that she needed to obtain documentation from the hospital where she was treated for injuries related to the accident demonstrating what services she received and for what conditions. Again, given that the accident occurred several years ago, these records were difficult to obtain. Even after this documentation was promptly sent by the hospital to the contractor, the case remained open for several months.

V. Problems with notices, appeals, and the hardship waiver process

Finally, notices sent to consumers by MSPRC are incomplete, not written in a consumer-friendly manner, and lack important information about the appeals and the hardship waiver process. While the letter mentions an appeal right, it does not thoroughly spell out the appeals process. Additionally, the notice lacks information about the availability and process for requesting a financial hardship waiver.

If beneficiaries feel that they are unable to pay the amount owed to Medicare, waivers are allowed in very limited and specific circumstances. Poverty alone is not a sufficient basis for granting a waiver. In addition, beneficiaries who request waivers are required to provide extensive documentation about both their case and their income and assets. If a waiver is denied, there is no right to an appeal. Overly restrictive and arbitrary eligibility requirements for waivers, requirements for such extensive and specific documentation, and limited appeals rights may explain why beneficiaries who call our helpline are reluctant to request waivers and why those who do are often denied. This chips away at the financial security of people living on very limited incomes, and threatens their access to needed health services. Nearly half of Medicare households have incomes below \$22,000 per year. Despite this sobering statistic, rates of appeals and hardship waiver requests are surprisingly low.

Recommendations

Contractor error and poor program administration can be fixed administratively and do not require Congressional intervention. Medicare Rights and the Center for Medicare Advocacy have requested a meeting with the Centers for Medicare & Medicaid Services (CMS) to discuss these obstacles and potential solutions. Other obstacles, however, are rooted in the statutory and regulatory framework of the secondary payer regime and may require statutory changes.

There are several steps that can be taken legislatively or administratively that would help solve many of the problems that beneficiaries encounter:

- Ideally, as soon as incidents are reported to Medicare, Medicare would then provide the insurer and the beneficiary with an estimate of the conditional payments made by Medicare for treatment related to the injury, as well as an estimate of future treatment.
 - There is precedent for Medicare pre-determining the program's share of costs in the context of worker's compensation. In those cases, Workers' Compensation Medicare Set-aside Arrangements (WCMSAs) can be formulated. These arrangements allow a portion of the worker's compensation settlement to be used for future medical and prescription drug expenses related to the on-the-job injury.
- Medicare collection practices should ensure timely recovery. Medicare Secondary Payer claims should not be initiated more than two years after the settlement has been made. This would also help to ensure that in settlement negotiations and legal proceedings all parties are able to consider Medicare's claim.
- CMS and its contractors should be required to improve the notices provided to consumers. Specifically, the notices' language must be more consumer-friendly, and the notices should include more detailed information about appeal and hardship waiver rights and processes.
- MSPRC or any future contractor should be required to maintain a transparent, easy-to-use process through which beneficiaries and their representatives can obtain information about their cases. This means both ensuring shorter call times and, more importantly, assigning a specific staff member to cases who can be reached directly.
- The hardship waiver process should be made more transparent and less burdensome on consumers. The rules should be revised to waive Medicare Secondary Payer recovery up to a reasonable amount for low-income consumers in all circumstances.

- CMS and its contractor should develop a better process for separating claims that are and are not related to an accident. CMS and the contractor should also be required to make decisions expediently when beneficiaries dispute the inclusion of claims because they do not believe they relate to an accident.

It is imperative that any changes to the law do not require beneficiaries to forfeit rights to request a hardship waiver or appeal.

Out of respect for the committee's time, I have just given an overview of the issues that people with Medicare face in the context of Medicare Secondary Payer. Thank you again for the opportunity to testify today—I'd be happy to respond to any questions from the committee.

Mr. STEARNS. I thank Ms. Stein. Mr. Gilliam, looking at that report, have there been other versions of this? I understand there has been three versions of this 200-plus-page report that is guidance? Is that true?

Mr. GILLIAM. Yes, Mr. Chairman. The copy I have is Version 3.1.

Mr. STEARNS. OK. So there has been at least three versions. Now, has this provided you with any kind of guidance? Just yes or no.

Mr. GILLIAM. Kind of.

Mr. STEARNS. Not really, OK. Mr. Salm, I just want to quickly take us through the recovery process here for liability insurance, no-fault insurance, and workmen's compensation just to make sure all of us understand it correctly.

The first step in the MSP recovery process is that you report your case to a contractor at CMS, correct?

Mr. SALM. Well, no, sir.

Mr. STEARNS. OK.

Mr. SALM. You have to understand that especially from a liability standpoint we have a tremendous amount of process, the American legal system, that goes on before we ever get to this.

Mr. STEARNS. So that is not the first step?

Mr. SALM. No. Well, the first step as far as the Agency is concerned is that they want us to report the settlement to the Agency. OK? But before we go through that, we would go through an entire claims operation, a litigation operation. Understand that from our standpoint, this is coming very near the end of the process. And speed is a great priority at the end of the process because frequently we don't get to this number until we are actually facing a trial date.

Mr. STEARNS. So once a case has been established, then you receive a Rights and Responsibilities letter about protecting Medicare's interest in the settlement negotiations, is that correct?

Mr. SALM. There is a Rights and Responsibilities letter, right, that talks about that.

Mr. STEARNS. Then you are supposed to receive a conditional payment letter? Is that right?

Mr. SALM. At some point you are supposed to receive a conditional payment letter. I can tell you that in the times that my adjusters have requested the conditional payment letter, including the appropriate release from claimants, we have never received a conditional payment letter.

Mr. STEARNS. Well, isn't that the law that you are supposed to receive a conditional payment letter?

Mr. SALM. Well, we can get the amount of the payments made by Medicare but we can't get a letter that actually indicates how much money we owe Medicare until after we report to them how much we have settled the lawsuit for.

Mr. STEARNS. And how long does it generally take CMS to provide you with a conditional payment amount?

Mr. SALM. The conditional payment amount, once we make the request, I have never seen one less than 90 days, and more likely it is more like 6 months.

Also, Mr. Chairman, if I note when we get the conditional payment amount from Medicare, it says right on the letter that we get,

and I have a copy of it, it says, “This is not a bill. Do not send a payment at this time”—right on the document.

Mr. STEARNS. Can we get a copy of that?

Mr. SALM. Absolutely.

Mr. STEARNS. And make it part of the record?

Mr. SALM. Absolutely.

Mr. STEARNS. And this is prior to settlement, right?

Mr. SALM. This would be prior to settlement, yes, sir.

Mr. STEARNS. How and when are changes in this amount, as well as the amount of future payments you are responsible for communicated to you and other parties in the lawsuit?

Mr. SALM. I don’t know.

Mr. STEARNS. Let me ask each of you. You describe this bureaucratic inefficiency, and I think you have touched on it. What is the number one thing—we will just go from my left to right—that you would like to see changed immediately?

Mr. SALM. I would like to be able to get the amount that we owe Medicare before we settle the claim.

Mr. STEARNS. And what would that duration be generally, just average?

Mr. SALM. How long would it take us? I think the timeline set forth in H.R. 1063, which would be either 65 or 95 days would be sufficiently quick so we could resolve lawsuits.

Mr. STEARNS. OK. Mr. Gilliam, name one thing that you would like to see fixed.

Mr. GILLIAM. What he said plus responsiveness from MSPRC. We are waiting for Final Demand letters from them for 11 months, 12 months, 14 months, 18 months, 6 months, 6 months, 7 months, 7, 7, and 8. They never send letters. We are on hold for 56 minutes or an hour or 90 minutes when we are trying to call them.

Mr. STEARNS. Now, Ms. Taylor said that there are 413,000 cases and she couldn’t even answer the duration time, but you are giving us some pretty dramatic long durations here of even trying to get information.

Mr. GILLIAM. And many of these are after seven to ten attempts at phone calls—

Mr. STEARNS. And you are on the phone for an hour?

Mr. GILLIAM. Ninety minutes.

Mr. STEARNS. Ninety minutes?

Mr. GILLIAM. One time they hung up, then they transferred us, and then we were on hold for 90 minutes.

Mr. STEARNS. And is there music going on?

Mr. GILLIAM. I don’t know.

Mr. STEARNS. I hope the people you are talking to are people in the United States.

Mr. GILLIAM. Pardon?

Mr. STEARNS. Are the people you are talking to in the United States?

Mr. GILLIAM. Yes.

Mr. STEARNS. They don’t farm it out to India, do they?

Mr. GILLIAM. No.

Mr. STEARNS. OK. Mr. Matzus, what is the number one thing that you think?

Mr. MATZUS. Mr. Chairman, the number one priority would be to get the Final Demand number from Medicare prior to the settlement.

Mr. STEARNS. OK. And Ms. Stein?

Ms. STEIN. Well, kind of two. I have got the statute of limitations on how long it would take for Medicare to collect their share, as well as more transparency with the contractor. We also experienced long wait times and have difficulty resolving cases. It requires us to resend documentation over and over again. We have cases that have lasted over a year to close.

Mr. STEARNS. Have you had the experience as Mr. Gilliam to talk about 90 minutes on the phone?

Ms. STEIN. Yes. I would say the least amount of time we have to wait on the phone is about 30 minutes. We have had to wait up for over an hour, I think an hour and 20 minutes.

Mr. STEARNS. So you have waited an hour and 20 minutes. So you have one of your employees just putting it on speaker and waiting there all during that period of time?

Ms. STEIN. Indeed. I actually have personally waited on the phone for—

Mr. STEARNS. You personally have waited?

Ms. STEIN. Yes, sir.

Mr. STEARNS. And during that time, is there somebody that comes in during those hour and 20 minutes that says thank you for holding? Or is it just a dead phone or what is it?

Ms. STEIN. The case I handled is probably 2 years old. It is mostly just music, I think.

Mr. STEARNS. Just music?

Ms. STEIN. But I do have to say that once we do actually reach an operator, we will have maybe a several-minute conversation where they say please resend your documentation. It isn't on file. And then you have to call back again.

Mr. STEARNS. I will just close. When you do this, do you have to put things through like they want information keyboarded in that you have to put in a lot of documentation before they even talk to you?

Ms. STEIN. In some cases, yes. It depends on the case.

Mr. STEARNS. You have got to put the case number, dates, and things like that in before they even go further? But you can't talk to anybody first. You are talking to a computer, right?

Ms. STEIN. Right. Well, and also if somebody has a representative, they have to submit the documentation, the Appointment of Representative form as well, which often gets lost.

Mr. STEARNS. OK. My time has expired. The gentlelady is recognized.

Ms. DEGETTE. Thanks. To follow up on that, Mr. Gilliam, the other problem is people don't have one customer service agent assigned to them, so let us say you have 10 cases, you have to call back each time with each separate case, right? You can't just call someone up and go, OK, here are the 10 issues I want to talk to you about.

Mr. GILLIAM. That is correct. Every time we call, and if we are lucky enough to get through, it starts over with somebody new, and they won't even accept emails.

Ms. DEGETTE. Right.

Mr. GILLIAM. It has to be phone calls or in writing.

Ms. DEGETTE. Yes. Mr. Matzus, I have a question for you. In the earlier panel, somebody was talking about the medical costs vis-a-vis the settlements of these lawsuits. They are talking about the medical costs versus the pain and suffering. And I wasn't a personal injury lawyer but I hung around with a bunch of them, and my understanding of the way these cases are usually settled you have got a clear statement of the medical costs and then you may have pain and suffering or whatever else, but the medical costs aren't normally the pain and suffering, correct?

Mr. MATZUS. No, Congresswoman.

Ms. DEGETTE. I mean, normally those are two different areas.

Mr. MATZUS. That is correct.

Ms. DEGETTE. Especially in the settlement, right?

Mr. MATZUS. Medical costs are a separate silo.

Ms. DEGETTE. That is correct.

Mr. MATZUS. Separate and distinct from the recovery for non-economic damages—

Ms. DEGETTE. Right.

Mr. MATZUS [continuing]. Such as pain and suffering.

Ms. DEGETTE. Right.

Mr. MATZUS. That is correct.

Ms. DEGETTE. And so that is why you need to have the medical cost information up front at settlement so we can accurately figure out how much the victims needed to be compensated and then how much needed to be reimbursed to Medicare out of that settlement, right?

Mr. MATZUS. It is a necessary and critical part of the equation to figure out what is a fair value at which to agree to settle.

Ms. DEGETTE. I have got to say we rarely ever see the grocery stores and the trial lawyers sitting at the same table agreeing on an issue. So I wish those Close Up kids were still here to see this.

Mr. SALM. Mark this day on the calendar, I think, Mr. Chairman.

Ms. DEGETTE. Yes, right. Exactly.

Ms. Stein, I wanted to ask you about a little bit of what you were talking about and what I mentioned in my opening statement about the program's beneficiaries because we keep hearing these stories about Medicare coming after beneficiaries years after the cases have been settled for reimbursement for medical expenses. And the case I talked about in my opening statement was an 81-year-old woman who got hit by a drunk driver. She got \$20,000 from automobile insurance in a settlement and then 13 years later, so add that up, 94 she is now, Medicare sends her a letter demanding repayments of medical services over a decade old. Have you heard similar stories about beneficiaries being contacted by Medicare years after settlement demanding payment?

Ms. STEIN. Yes, we have heard cases like that. And this kind of speaks to the hardship waiver process. It is pretty difficult to get a waiver. The process is burdensome to consumers and the situations that hardship waivers apply to are somewhat arbitrary. For example, somebody who is on SSI, which is obviously low income, that doesn't necessarily automatically make them eligible for some type of waiver, either full or partial waiver.

In my written testimony I talked about—and this speaks back to the idea that claims aren't properly segregated—that individuals who were in car accidents, you know, 5 to 10 years ago suddenly receive bills from Medicare or no longer able to receive Medicare coverage going forward because they claim that, you know, a broken hip that they received in their kitchen relates back to a car accident that happened, you know, over 5 to 10 years ago.

Ms. DEGETTE. So there needs to some kind of a time frame. Claims shouldn't be initiated maybe 2 years after settlement or something like that, correct?

Ms. STEIN. Yes.

Ms. DEGETTE. But that does lead us to a question, and I am wondering if any of you have an opinion on this is it makes perfect sense to me to have all of the data at settlement or shortly thereafter, but you have a little tension here because if you have medical claims that continue to come in, we want to assure that the taxpayer gets reimbursed for those expenses, but on the other hand, you want to have a quick settlement. So what can we do to make that system work better so we have some closure early on at settlement or soon after but at the same time we are not leaving medical costs out there that could be recaptured?

Mr. GILLIAM. If I could jump in there. In probably 95 percent of the cases, when we are ready for the Medicare number, the treatment is basically done. It is typical that when we try and settle claims—and Jason knows this—we want to get all the numbers together. In most cases, the plaintiff is done treating and so we have all the data, and that is when we need to know what Medicare owes. And at that point, all of the Medicare-paid treatment has been completed and we don't understand why they can't tell us what that number is.

Ms. DEGETTE. Does everybody else pretty much agree with that statement?

Mr. SALM. Yes, we very much agree with this. Plaintiffs' lawyers don't bring cases to resolution or settlement until they know what the total medical care is that they want to get reimbursed for. And another point is made that in the normal practice of subrogation, what normal insurance companies, corporations do all the time, if you are ever going to get your money, you have to make a decision to cut off, sort of chasing the dollars at some point because you are just not going to get enough money to justify the effort you put into it.

So Mr. Gilliam and I make decisions on subrogation every day and we say OK, we will take X number of dollars now because we don't think we are going to get X plus 20 later or it is just going to take too much time.

Ms. DEGETTE. Thank you.

Thank you, Mr. Chairman.

Mr. STEARNS. The gentleman from Pennsylvania is recognized for 5 minutes, Mr. Murphy.

Mr. MURPHY. Thank you, Mr. Chairman.

I think the more I hear, the more it boggles the mind and breaks the heart when we hear of what happens to seniors.

A couple of things first. Mr. Gilliam, in retail settings, I understand that sometimes someone may get injured but they said, look,

I am not going to sue the store or anything. Accidents happen, but I need you to make sure my medical expenses are taken care of. And sometimes stores say we still want to show good faith effort. Here is a gift card to use at our store, things like that. That happens, am I correct?

Mr. GILLIAM. Yes, that happens thousands of times a year.

Mr. MURPHY. Do you have to report that number yet?

Mr. GILLIAM. We don't have to report that number yet, but we will have to—

Mr. MURPHY. But you will?

Mr. GILLIAM [continuing]. Report that number in 3 years.

Mr. MURPHY. So if someone gets a \$25 or \$50 gift card off their groceries, will Medicare, according to the new rules, come after them and say you owe us that money to reimburse for medical expenses?

Mr. GILLIAM. Absolutely. We will have to report that under the new rules. We will have to report that under the process and Medicare—we become a primary payer in that case.

Mr. MURPHY. So you have someone who is living off Social Security and they think, my goodness, I get basically a half a bag of groceries for free here. Now, Medicare is going to come back and say we want that food back. We need that 25 or \$50 back. That is what you are telling me?

Mr. GILLIAM. That is what I am telling you, yes, sir.

Mr. MURPHY. Breaks the heart.

Mr. Matzus, when you were describing this case of someone who died before—while someone is waiting for this claim, does it actually impose other hardships upon the seniors on a couple levels? Number one, do you know of any cases out there where, because of the amount of money that is kind of in the air, or in the claims to be made my Medicare against someone to come up with some reimbursements, that seniors may actually delay other healthcare because they don't have the money to take care of themselves?

Mr. MATZUS. Congressman Murphy, I think—as everybody on the panel can appreciate—most Medicare beneficiaries have limited financial resources. A small change in their monthly costs can push them very quickly beyond the financial tipping point from which they cannot or will have a very difficult time recovering. And oftentimes, when you have to make a decision between paying for current uncovered Medicare services that you need versus paying other bills, people choose to pay for the necessary uncovered medical services and in essence are robbing Peter to pay Paul.

Mr. MURPHY. And on this, I am assuming while you are working on a case, they are also accruing other legal expenses which, because of the delays and people having to sit on the phone and wait for calls, am I correct on that, too?

Mr. MATZUS. Congressman Murphy, the way our firm operates, it is a contingency-fee basis, so we don't bill our clients based upon an hourly rate.

Mr. MURPHY. Some may do that?

Mr. MATZUS. Some firms may.

Mr. MURPHY. So in some cases it may cost the seniors even more? So the delay is costing seniors not only they are delaying

some care, maybe not getting some care, maybe having to pay back grocery money, et cetera.

If the parties settle without the Final Demand letter, what happens to the seniors' settlement money? Anybody know?

Mr. MATZUS. If I may, typically, the settlement money is held in a law firm's client trust account or escrow account pending final notice from Medicare of what amount is owed. And then distribution is only made after the Final Demand figure.

Mr. MURPHY. What if that Final Demand figure is much higher than the conditional payment? Who pays the difference? Has that happened?

Mr. MATZUS. It can happen. Colleagues have reported that happening. It has not been my personal experience where there has been a significant difference, but in theory, you know, the beneficiary and/or the law firm and/or the liability carrier is potentially responsible. We don't have the opportunity to go back in time and get a second bite at the apple in a liability settlement. Once a case is settled, it is settled. The money that is received is the only money that will be received.

Mr. MURPHY. Does it take as long if you are dealing with private insurance companies as it takes with Medicare?

Mr. MATZUS. To get the final lien figure? No.

Mr. MURPHY. How long would they typically take?

Mr. MATZUS. We always have the final lien figure in advance of—

Mr. MURPHY. So it is humanly possible to do this?

Mr. MATZUS. It is. By way of example, Medicaid—

Mr. MURPHY. Now, I know that the CFO of CMS has other things to do today, but I would hope in something that would save taxpayers billions, save seniors a lot of headache, and maybe save some lives here, I hope that that information is getting to her.

One other thing I want to read briefly—and this is from a magazine called Mother Jones—not my usual reading, but I found it interesting that it talks about a case here—and I would like to submit this for the record, too, Mr. Chairman—

Mr. STEARNS. By unanimous consent, so ordered.

Mr. MURPHY [continuing]. Where someone actually got snared by Medicare twice. It says the first time in 2002 when the Agency began seizing her only income of \$498 monthly Social Security check for nearly 3 years until she repaid more than \$16,000, her settlement minus legal fees. After that, she thought her troubles were over, but in 2008, Medicare returned for more. That \$66,000 bill not only failed to recognize that Coury had already repaid what she owed, it also far exceeded the \$20,000 she had received from her daughter's insurance company in the first place. And eventually, this person, a former accountant, discovered that Medicare had included every procedure Mollie had undergone since her accident, including unrelated care like open-heart surgery and treatment for emphysema. And, of course, cases like this abound.

[The information follows:]

Mother Jones

Medicare's Repo Men

Granny beware—Medicare's "debt collectors" could be coming soon to a nursing home near you.

By [Stephanie Mancimer](#) | Thu Oct. 8, 2009 2:59 AM PDT

One hot summer evening in 1995, Sumaya Coury was driving her 81-year-old mother, Mollie Coury, and some of her friends back to Los Angeles after a trip to San Diego to play bingo. Around midnight, Sumaya's Cadillac slammed into the car of a drunk driver who'd parked and passed out in the middle of the five-lane 210 freeway, east of Pasadena. Mollie's legs were crushed; doctors thought she'd never walk again. But after weeks in hospital, she regained her mobility, and eventually put the accident behind her. Then, 13 years later, in the fall of 2008, [Medicare](#) [1] sent Mollie some staggering news: She owed \$66,000 for what the agency said were medical expenses related to the accident. If she didn't pay within 60 days, the Treasury Department would seize her Social Security checks until the money was repaid.

The reason for the enormous bill? After the accident, Coury had received about \$20,000 from her daughter's insurance policy. This settlement subjected her to an obscure law called [Medicare Secondary Payer Act](#) [2], created decades ago to prevent Medicare from paying medical expenses that were the responsibility of private insurers or other parties. Here's how it works: If a Medicare recipient gets in a car crash or is injured by a defective pacemaker, the government picks up the hospital tab. But if that person receives a payment from a legal settlement, insurance policy, or jury award that covers accident-related medical bills, Medicare is entitled to its money back.

So far, so reasonable. The law saved taxpayers nearly \$7 billion in 2008, according to the [Centers for Medicare and Medicaid Services](#) [3] (CMS). Most of this sum came from Medicare ensuring the correct parties got billed in the first place. But in recent years, Congress has pushed Medicare to aggressively pursue debts from injured elderly people who have won compensation through lawsuits or liability insurance.

This can work well when the government calculates its share before plaintiffs get their checks. Attorney Matt Garretson says his firm alone has probably generated at least \$100 million for

Medicare through litigation over the prescription painkiller Vioxx [4]. But those settlements were paid out long before any of the plaintiffs ever got a dime. Chasing debts *after* a payout is far less lucrative—and a lot more prone to error. That's because compensation often comes years after an accident, forcing Medicare and its contractors to sift through mountains of medical bills to determine which ones are accident related. And contrary to popular opinion, most lawsuits involve relatively small sums. Of the \$1 billion Medicare recovered from collections last year, only about \$7 million came from "post-payment" liability insurance and tort cases. For people on the receiving end of the collections process—mostly elderly car accident victims like Mollie Coury—it can be a traumatic ordeal.

Coury actually got snared in Medicare's net twice, the first time in 2002, when the agency began seizing her only income, a \$498 monthly Social Security check, for nearly three years until she repaid more than \$16,000 (her settlement minus some legal fees). After that, she thought her troubles were over. But in 2008, Medicare returned for more. Its \$66,000 bill not only failed to recognize that Coury had already repaid what she owed; it also far exceeded the \$20,000 she'd received from her daughter's insurance company in the first place. Eventually, Sumaya, a former accountant, discovered that Medicare had included every procedure Mollie had undergone since her accident, including unrelated care like open-heart surgery and treatment for emphysema.

Sumaya, who was herself battling lung cancer, tried repeatedly to straighten out the problem. Instead, Medicare stopped paying her mother's medical bills. Mollie so feared visiting the doctor that when she suffered internal bleeding from complications from a hiatal hernia, she refused to go to the hospital and nearly died. "It's like a nightmare," says Sumaya. "They should be paying *her* for all the harassment."

Despite its good-government origins, Medicare's debt recovery program has not been a model of efficiency. The Government Accountability Office discovered that during the 2001 fiscal year, other parties were responsible for nearly \$2 billion in outstanding Medicare debts, but the Centers for Medicare and Medicaid Services had only referred about \$47 million for collection. In the 2003 fiscal year, the agency employed more than 50 collection contractors, yet recouped just 38 cents for every dollar it spent trying to gather old debt from employer-sponsored health plans. During that same period, eight of those contractors didn't process a single case, yet still received a total of \$1.8 million.

Congress pressed CMS for improvements. So in 2006, the agency consolidated collection activities into one massive contract, worth \$72.5 million in the first two years. Under a law permitting the government to grant no-bid contracts to Native American corporations, it awarded the deal to [Chickasaw Nation Industries](#) [5], based just outside of Oklahoma City. The contract gave the firm \$32.5 million the first year and \$40 million the second. (Michael Webb, CNI's head of business development, says the agency granted the sole-source contract based on work the company was already doing handling medical records for the Indian Health Service.) It was CNI that sent Coury her \$66,000 bill. Webb told *Mother Jones* he couldn't comment on individual cases and referred questions to CMS, which also wouldn't comment on specific cases. However, agency officials said mistakes were inevitable in a system that processes more than 300,000 new liability claims and more than a million pieces of correspondence every year.

According to CMS officials, the Chickasaws have stepped up Medicare recoveries, but errors persist. Part of the problem is that for many years, Medicare had no systematic way of learning when someone got a settlement or judgment, making its collection efforts hit or miss. For a while, the agency tried to lean on plaintiff lawyers, threatening to sue them if they turned over settlement or insurance money to their clients before paying any Medicare liens. In many cases, though, courts sided with the lawyers who argued that Medicare was exceeding its authority. The issue was headed to the Supreme Court, but in 2003, Congress passed the Medicare drug benefit and included a small provision that officially put the onus on lawyers to make sure Medicare got its money.

As it turns out, lawyers found complying with the law a real challenge, largely because Medicare often can't tell them just how much their clients owe. When it does, it's often spectacularly wrong. And, they say, getting a straight answer from Medicare and its contractor is a process that can outlive the beneficiaries. Arizona lawyer Frank Verderame once held more than \$160,000 in trust accounts for more than three years because Medicare ignored his requests for an accounting for five of his clients. In 2006, he sued Medicare to try to free his clients' money. In response, Medicare sent an itemized bill in excess of \$50,000 for someone Verderame estimated only owed \$15,000. Medicare eventually settled the whole case for about \$2,500, he says. "These old folks are real sweet, greatest generation folks. They just want to do what's fair and they don't begrudge having to pay the government—until this happens. Then they get pissed," he says.

After forcing plaintiffs' lawyers to serve as Medicare's debt collectors failed to produce the desired results, Congress passed new debt-collection measures as part of the 2007 SCHIP reauthorization. Starting next year, insurance companies must report any settlements or judgments involving Medicare beneficiaries to CMS. If a Medicare beneficiary fails to reimburse the agency for health care costs it paid, the agency can punish the insurance company with double damages. This gives the insurers a big incentive to make sure Medicare gets paid first—and will hopefully cut down the number of cases where Medicare chases down old debts years after the fact, as the insurance companies are better placed to work out the bills than plaintiff lawyers because they do it all the time. Still, it's not a perfect solution. The prospect of harsher penalties is already leading to insurance company overkill that, combined with Medicare's bureaucracy, has kept some elderly folks from receiving money that's rightfully owed them.

Take the case of 87-year-old Hannah Cohen, who was hit by a car in 2005. She sued the driver and got an \$18,000 settlement in December 2007. Knowing that the feds were more aggressively pursuing such payments, the driver's insurance company had a policy of making Medicare a payee on any settlement check for plaintiffs older than 62. But Cohen, an Israeli citizen, was ineligible for Medicare, and therefore owed nothing. Still, it took more than a year—and a lawsuit—for Cohen's lawyer to extract her money from the insurance and Medicare bureaucracy. Cohen's lawyer has another similar case pending.

After all of Sumaya Coury's calls and letters, in March, a contractor working for Medicare wrote to say that her mother, who is now 95, now owes only \$18,378.40—a little more than the amount she repaid four years ago. Sumaya hired a lawyer to deal with the mess. One day, she says, she complained to an employee of the Chickasaw contractor that the situation was "totally bizarre." The woman replied, "Oh no, it's not. It happens every day."

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Links:

- [1] <http://www.motherjones.com/politics/2008/09/medicares-poison-pill>
- [2] <http://www.cms.hhs.gov/MEDICARESECONDPAAYERANDYOU/>
- [3] <http://www.cms.hhs.gov/>
- [4] <http://www.motherjones.com/mojo/2008/01/roger-clemens-strikeout-secret-vioxx>
- [5] <http://www.chickasaw.com/>

Mr. MURPHY. And I am hoping that one of the outcomes of this hearing, Mr. Chairman, is that we hear from cases throughout the country. We have just got to fix this problem. It is hurting too many seniors and hurting the taxpayers. And I join my colleague from Colorado in saying when you have retailers, plaintiffs' attorneys, defense attorneys, those advocates of senior citizens all agreeing this has to be fixed, it is time to fix it. And I yield back my time. Thank you.

Mr. STEARNS. The gentleman yields back his time. We recognize the chairman emeritus of the Energy and Commerce Committee, Mr. Dingell from Michigan, for 5 minutes.

Mr. DINGELL. Mr. Matzus, the issues will be directed at you. It sounds like the Medicare Secondary Payer reimbursement process is lengthy, burdensome, and complex for beneficiaries and attorneys to navigate. Why doesn't Medicare pursue reimbursement from the primary payer directly?

Mr. MATZUS. Congressman Dingell, my hunch on that would be from a cost-efficiency standpoint, it is more cost effective for Medicare to recover money in a passive manner as opposed to direct intervention in pursuit of claims.

Mr. DINGELL. All right. Now, what happens if beneficiaries decide they don't want to pursue claims? For example, if an 89-year-old woman broke her leg in a car accident and then decided not to file an insurance claim or pursue any other form of recompense, wouldn't Medicare then be stuck with all the bills without any form of reimbursement?

Mr. MATZUS. In practical reality—

Mr. DINGELL. That is a very real problem, isn't it?

Mr. MATZUS. It is.

Mr. DINGELL. All right. And I am sorry to hurry you, but time here is limited.

It is my understanding from your testimony that if you are unable to reimburse Medicare until after the parties have reached a settlement, you have a Final Demand letter from CMS and those often take many months or even years to get. Is this is the case? Yes or no?

Mr. MATZUS. Yes.

Mr. DINGELL. OK. Now, what happens to the beneficiary's settlement money in the intervening time? Is the beneficiary able to access the money?

Mr. MATZUS. No.

Mr. DINGELL. In your experience from working on such cases, how long is the settlement money typically in limbo before Medicare is reimbursed?

Mr. MATZUS. A short period of time would be 3 or 4 months. A typical period of time is probably 6 to 9 months or longer.

Mr. DINGELL. Now, you and I are both attorneys and I am sort of curious. As a fellow attorney, how does this affect the attorney-client relationship?

Mr. MATZUS. It creates significant problems with the attorney-client relationship.

Mr. DINGELL. Now, the next question is to you again, Mr. Matzus, Mr. Salm, and Mr. Gilliam. Mr. Matzus, Mr. Salm, and Mr. Gilliam, has your business or other businesses similar to yours

incurred additional costs as a result of lengthy and burdensome Medicare Secondary Payment reimbursement process? Yes or no?

Mr. SALM. A big yes. Yes, we have.

Mr. DINGELL. OK. Mr. Matzus?

Mr. MATZUS. Yes.

Mr. DINGELL. Mr. Gilliam?

Mr. GILLIAM. Yes.

Mr. DINGELL. OK. Now, what effects have these costs had on your business? Starting with Mr. Salm, Mr. Gilliam, and then Mr. Matzus.

Mr. SALM. The first effect we have had is we have spent hundreds of thousands of dollars in an attempt to get Medicare the data that they need in the workers' comp setting. The second effect it has had is delayed the resolution of liability claims while we have been waiting to figure out what Medicare's number is and get the money to Medicare. The longer a case stays open, the more the case costs somebody like Publix Super Markets and the slower it is to get to the beneficiaries.

Mr. DINGELL. So it hurts most everybody involved?

Mr. SALM. Yes, it absolutely hurts the primary company like Publix, it hurts an insurance company like Cincinnati, it hurts the plaintiff's attorney, who is waiting to get his money and to deal with client, and of course it hurts the person that we are all talking about here, the beneficiary, because these are people who are waiting for their money in a liability claim situation.

Mr. DINGELL. All right. Mr. Gilliam, your additional comments?

Mr. GILLIAM. Yes, we have incurred hundreds of thousands if not millions, complying with this reporting manual trying to collect the data and keep it safe from hackers so we can report it. It so delays the claims settlement process, and at my company, we have a philosophy. We are in the claims-paying business. We like to speedily end claims. We don't like to have people upset that they are waiting, and the longer we have to keep a file open, the more it costs us and takes our adjusters away from handling current claims as they shepherd these old claims.

Mr. DINGELL. Mr. Matzus?

Mr. MATZUS. Congressman, more important than the costs to our firm are the costs and the financial consequences as well as the emotional consequences to Medicare beneficiaries. While putting more work and time into a case does increase our cost, most importantly, the significant costs by the delay are borne by the Medicare beneficiaries.

Mr. DINGELL. Thank you. Now, last question, gentlemen. What expectations do you have for the future if costs associated with Medicare Secondary Payment reimbursements remain the same or increase? In other words, what does the future hold if costs remain the same or increase? And don't be shy.

Mr. MATZUS. The nightmare continues and gets worse. We end up spending all of our time dealing with computers and being on the phone for an hour and a half when we could be helping people.

Mr. DINGELL. Now, we also have reason to think that it will probably increase over time, do we not? And that means there will be a multiplier effect take place, does it not?

Mr. GILLIAM. If they would simply start over and ask us what kind of data do we already collect, we might already have the data they want but they ask us to collect all this ridiculous data that doesn't really help them identify who owes them money. Talk to us about what we already have and maybe we already have it.

Mr. DINGELL. My time has expired and I thank the chair for it, but would you each submit to us for purposes of the record your suggestions about what should be done to correct this intolerable situation and to make it better from your standpoint, from the standpoint of the patients and the beneficiaries, and from the standpoint of the government, if you please.

And I would ask, Mr. Chairman, that the record remain open for that purpose.

[The information follows:]

Statement for the Congressional Record
Submitted in Connection with the Hearing Entitled
“Protecting Medicare with Improvements to the Secondary Payer Regime”
Held Before the Subcommittee on Oversight and Investigations
Energy and Commerce Committee
United States House of Representatives
On June 22, 2011

Statement Submitted by Marc Salm
Vice President, Risk Management
Publix Supermarkets, Inc.
July 7, 2011

I would like to thank Chairman Stearns, Ranking Member DeGette, and the Members of this Subcommittee for conducting a hearing on the improvements that are needed in the Medicare Secondary Payer (MSP) program. I submit this statement for the record in response to two questions posed by Chairman Emeritus Dingell. I would be happy to answer any additional questions that the members of the Subcommittee may have.

QUESTION 1: WHAT IS THE MOST CRITICAL CHANGE NEEDED IN THE MSP SYSTEM?

***Answer:** Medicare should be required to provide settling parties with the amount of their MSP repayment obligation during, rather than after, the settlement process. Congress should also establish a MSP threshold to make sure that Medicare does not waste taxpayer resources pursuing claims that are worth less than the Agency spends pursuing the claim – such as the \$1.59 example raised during the hearing.*

In my experience, the most significant problems with the current MSP system stem from the fact that parties cannot know how much money will have to be repaid to Medicare until after they settle a claim. Settling parties need this information during the settlement process, so that they can account for that repayment when they agree upon a final settlement figure, and timely repay the Trust Fund at the time of settlement, rather than months later.

Without knowing how much must be repaid to Medicare upfront, beneficiaries have no way of knowing how much of their settlement, if anything at all, they will ultimately be able to keep. Companies like mine are also afraid that if the beneficiary cannot or does not repay Medicare in full, they will have to pay the settlement twice – once to the beneficiary and then again to Medicare. Even cases that do settle often take much longer to negotiate, which can increase the beneficiary's legal fees. Since Medicare's recovery is reduced by the cost of bringing the claim, including attorney's costs, the longer a claim takes and the more fees that the beneficiary incurs, the less Medicare recovers.

As I and my fellow panelists noted during the hearing, the inability to get this critical information during settlement causes innumerable problems and negatively impacts beneficiaries, businesses, and the Medicare Trust Fund. These problems created by Medicare are not only financially costly to all involved, but also cause real harm to beneficiaries. Companies like mine want to be able to do the right thing for our customers when they are injured, and we want to repay Medicare in full. To do this, however, we need Medicare to allow us to get the information we require, settle these claims, compensate the injured parties, and promptly reimburse the Medicare Trust Fund. This change would be better for beneficiaries, better for America's businesses, and better for taxpayers.

The MSP regime should also have a threshold, below which Medicare will not pursue claims. It is a waste of taxpayer and business resources for Medicare to pursue claims that will return only \$1.59 to the Medicare trust fund. Beneficiaries should not have to deal with the hassle and confusion of the MSP process when it costs Medicare more to send out the demand letter than the claim is worth. While my company is completely committed to repaying Medicare what it is owed, it is simply wasteful for Medicare to pursue MSP payments worth less than the cost of collection.

Companies like mine frequently settle very low dollar claims with customers. In many of these instances, the customer may have no actual medical costs whatsoever. We sometimes use gift cards or merchandise to make sure our customers know that we care about them. This is the right thing to do, even when we do not believe we were at fault in any way. When we settle a claim, even a very small one, we have the individual sign a document that releases us from any liability associated with the incident in return for the compensation we are providing. This is routine practice in the insurance industry, but without a MSP threshold even these claims would be reportable.

While CMS has established an interim “reporting” threshold for MSP claims, the Agency has made it clear that it intends to phase down, and eventually eliminate, this threshold. It simply does not make sense for Medicare to pursue MSP claims that return less money to the Trust Fund than the Agency spend on pursuing the claim. No business in America would run that way, and the federal government should not waste taxpayer resources trying to collect \$1.59.

QUESTION 2: WHAT SHOULD BE DONE TO CORRECT THE PROBLEMS WITH THE CURRENT MSP SYSTEM?

***Answer:** Create a more timely process for CMS to tell parties how much needs to be repaid to Medicare before settlement, so that the Trust Fund can be repaid promptly without interfering with settlement negotiations. Also create a threshold to prevent taxpayer resources from being wasted pursuing claims worth less than the costs of recovery.*

The Saving Medicare and Repaying Taxpayers (SMART) Act, H.R. 1063, introduced this spring by Representatives Tim Murphy and Ron Kind, would fix both of the problems I addressed above. This important legislation would establish a more sensible, streamlined, and cost-effective MSP regime.

Section 1 of the SMART Act improves the efficiency of the MSP regime by allowing CMS to inform settling parties of their MSP amount before settlement. If this bill is enacted, CMS will provide the amount due within 65 days of a request, which is the timeframe the Agency says it should currently take to provide the final demand amount after the parties settle. This simple change will eliminate uncertainty and help parties settle these claims much faster so that Medicare and the beneficiary can be reimbursed more quickly and beneficiaries can timely access their settlement proceeds.

Section 2 of the SMART Act increases Medicare's efficiency and prevents waste by ensuring that the government does not spend more money pursuing a MSP claim than the claim is actually worth. Rather than set a firm dollar limit, the SMART Act directs the CMS Actuary to annually establish a threshold at the amount of settlement likely to yield an MSP repayment at or below the government's recovery cost. Claims that fall below that threshold will not be subject to the MSP regime.

These changes will save taxpayer and business resources, and allow Medicare beneficiaries to settle cases and timely access their settlement funds without MSP getting in the way. The provisions create a true win-win-win – more funds for the Trust Fund faster, quicker access for beneficiaries to their settlement funds, and timely and efficient settlement resolution for settling parties. Most importantly, this change will maximize MSP returns without wasting resources.

Thank you again for the opportunity to testify and to submit this statement for the record. I look forward to working with Members of this Subcommittee to improve the MSP regime.

Respectfully Submitted,

Marc Salm
Vice President, Risk Management
Publix Supermarkets, Inc.

Statement for the Congressional Record
Submitted in Connection with the Hearing Entitled
“Protecting Medicare with Improvements to the Secondary Payer Regime”
Held Before the Subcommittee on Oversight and Investigations
Energy and Commerce Committee
United States House of Representatives
On June 22, 2011

Statement Submitted by Scott A. Gilliam
Vice President & Government Relations Officer
The Cincinnati Insurance Companies
July 7, 2011

Thank you for the opportunity to testify before the House of Representatives Committee on Energy and Commerce Subcommittee on Oversight and Investigations, as well as for the opportunity to submit this additional written statement for the record. As requested by Chairman Emeritus Dingell, I am submitting this statement for the record addressing two questions; first, what aspect of the current Medicare Secondary Payer (MSP) system I believe most needs reform; and second, what solutions I would propose to improve the MSP system.

QUESTION 1: WHAT IS THE MOST CRITICAL CHANGE NEEDED IN THE MSP SYSTEM?

***Answer:** The Centers for Medicare & Medicaid Services (CMS) must implement a system to quickly and efficiently determine Medicare's recovery interest before we settle a claim with a Medicare beneficiary, and provide us with assurance that the amount of the reimbursement requested by Medicare is a final demand.*

While there are many changes that must be made to the MSP system, my company believes that most critical need is for CMS to bring efficiency, common sense and finality to the MSP system. My company is in the claims settling business and we settle thousands of personal injury claims every month. Every time we have a claim made against a policy, we endeavor to settle that claim as quickly, as fairly, and as efficiently as possible.

Unfortunately, the current MSP system is making it extremely difficult to settle claims in the prompt and efficient manner we believe injured parties deserve and is having a significant negative impact on claimants who are Medicare beneficiaries. Under the current MSP system, it is extremely difficult to settle a claim when neither party has the complete information they need to make a settlement decision before they settle the claim. Without knowing what the final amount owed to Medicare will be, the parties cannot reach a decision about an appropriate settlement amount, and all too often, the settlement is needlessly drawn out or falls apart entirely.

Simply put, we need to have a method and means to be able to quickly and efficiently determine what Medicare's recovery interest is so that we can promptly settle claims and have finality with those settlements. To make that happen, we need to have Medicare's recovery demand before we settle and we need to receive that number in a timely fashion. We also need assurance that once we get that final demand that it is indeed a final demand, and that we will not be getting a letter from Medicare six months after we settle a claim demanding more money.

But under the current MSP system, CMS does not follow any of these common sense principles of claim settlement. CMS will not give us a recovery demand before we settle. Nor will CMS give us a timely request for a recovery demand. CMS also refuses to give us assurance that their recovery demand is a final demand. If a private insurer acted in these ways, the insurer would be subject to disciplinary action by their state insurance regulator.

QUESTION 2: WHAT SHOULD BE DONE TO CORRECT THE PROBLEMS WITH THE CURRENT MSP SYSTEM?

Answer: Passage of H.R. 1063, The Strengthening Medicare and Repaying Taxpayers (SMART) Act, would correct the most pressing problems with the current MSP system.

The SMART Act (H.R. 1063), introduced by Representative Murphy and Representative Kind, provides solutions to many of the problems with the current MSP system. Section 1 of the SMART Act improves efficiency by requiring CMS to inform settling parties of their MSP amount before settlement. Section 2 of the SMART Act increases Medicare's efficiency by ensuring that the government does not spend more money pursuing a MSP claim than it will actually recover from that claim. Section 3 of the SMART Act will protect stakeholders that make good faith efforts to comply with Medicare's complex MSP reporting requirements. Section 4 of the SMART Act protects Medicare beneficiary's social security numbers and Medicare numbers and directs CMS to identify an alternate approach to identifying beneficiaries for the purpose of MSP reporting that will not utilize either SSNs or HICNs. Finally, section 5 of the SMART Act will provide Medicare beneficiaries and stakeholders certainty and finality by establishing a statute of limitations for all MSP claims.

Thank you again for the opportunity to testify regarding the MSP system and the many problems that it is causing for beneficiaries, businesses, and for the Medicare Trust Fund itself. I hope this statement for the record provides additional clarity on how the current MSP requirements should be improved to create a more effective system that will be less burdensome to stakeholders and can better achieve its goal of returning resources to the Medicare Trust Fund. I urge this Subcommittee to consider the SMART Act, which provides solutions to many of the problems identified during the June 22nd hearing and enjoys broad-based support among impacted stakeholders.

Respectfully Submitted.

Scott Gilliam
Vice President & Government Relations Officer
The Cincinnati Insurance Companies

Statement for the Congressional Record
Submitted in Connection with the Hearing Entitled
“Protecting Medicare with Improvements to the Secondary Payer Regime”
Held Before the Subcommittee on Oversight and Investigations
Energy and Commerce Committee
United States House of Representatives
On June 22, 2011

Statement Submitted by Jason Matzus
Partner, Raizman Frischman & Matzus
Pittsburgh, Pennsylvania
July 7, 2011

Thank you for this opportunity to provide additional feedback regarding how the Medicare Secondary Payer (MSP) regime can be improved. As I noted during my testimony, the problems caused by the current MSP system are impacting my Medicare beneficiary clients every day. I am pleased to have this opportunity to bring these issues to the attention of the Subcommittee and to recommend solutions that would produce better outcomes for the Medicare beneficiaries that I represent. During the hearing, Chairman Emeritus Dingell requested that I submit answers to two questions for the record. This statement responds to the questions posed by Chairman Emeritus Dingell.

QUESTION 1: WHAT IS THE MOST CRITICAL CHANGE NEEDED IN THE MSP SYSTEM?

Answer: Revise the MSP regime so that Medicare will provide the final demand amount before parties settle a claim rather than afterwards.

As I mentioned in my testimony, beneficiaries and their representatives need information upfront when they are making decisions about settlement. Without knowing the final demand amount, the injured beneficiary has no way of knowing whether or not they will be able to enjoy any of the proceeds of their claim. Settlements account for more than just medical expenditures; they

compensate injured parties for their pain and suffering and other economic costs. Without any certainty about their recovery, many of my clients are uncertain about settling.

Medicare's inability to provide the final demand amount, or even a consistently reliable conditional estimate, is getting in the way of the normal operation of our justice system. No one prefers to see more cases go trial that could have settled out of court. It costs more time and money for both the plaintiff and the defendant, it wastes judicial resources, and in many cases, it reduces the total recovery for the injured party. Most important, it is denying beneficiaries access to settlement amounts, which in many cases they need and are relying upon to pay day-to-day bills. The current MSP regime, however, is unintentionally delaying settlements, and in some situations causing cases to needlessly go to trial, because Medicare will not provide the final demand amount.

As a result, the MSP regime harms Medicare beneficiaries. While non beneficiaries can settle their claims on the merit's of their case, Medicare beneficiaries have a more difficult time reaching settlement and are often delayed in accessing their settlement funds. While I completely agree that Medicare's right should be protected and the Trust Fund should be repaid in full, surely a sensible MSP system can be established that will not harm beneficiaries.

Currently, CMS cannot even provide a final demand amount in a reasonable time frame after the parties have settled. As I mentioned during my testimony, it frequently takes months and months, even after a case settles, for CMS to provide the final demand amount. During that time, my beneficiary clients cannot access their settlement proceeds. This puts a financial and emotional strain on my clients, who have already suffered economically and physical as a result of their injury.

It also damages the attorney-client relationship, as many of my clients simply do not understand why I am telling them that they cannot receive any of their settlement funds. Instead of going to my beneficiary clients, the settlement proceeds must sit in my firm's client escrow account for months on end, waiting for Medicare to tell us how much money has to be repaid. I want to

repay Medicare, my clients want to receive their settlement, and I have to imagine that taxpayers would like to see the Medicare Trust Funds promptly reimbursed. Instead, however, we must all wait for CMS to navigate its own complex bureaucracy and provide the final demand amount.

QUESTION 2: WHAT SHOULD BE DONE TO CORRECT THE PROBLEMS WITH THE CURRENT MSP SYSTEM?

Answer: The MSP regime could be significantly improved by requiring the Centers for Medicare and Medicaid Services (CMS) to provide its final demand to parties during the settlement process.

I urge Congress to find a way to protect both the Medicare Trust Fund and injured Medicare beneficiaries by creating a more sensible MSP system and directing Medicare to provide the final demand amount before settlements, rather than after-the-fact. This solution will allow the settlement process to proceed as it normally would and will prevent cases from needlessly going to trial. It will also allow parties to promptly repay Medicare once the settlement is final.

To fix this problem, I urge Congress to pass the Saving Medicare and Repaying Taxpayers Act (H.R. 1063), which provides much-needed solutions to many of the most critical problems with the MSP regime. Section 1 of this important legislation, introduced by Representative Murphy and Representative Kind, will direct CMS to provide the final demand amount within 65 days when parties submit a request indicating that they reasonably expect to settle a claim in the next 120 days.

With this solution, my beneficiary clients and I will know how much money must be repaid to Medicare, and can factor that number into our settlement negotiations. This simple change will provide much-needed certainty that will allow cases to settle faster. As a result, my injured client and the Medicare Trust Fund can both be reimbursed far more quickly than they do today. This is a common-sense solution that will have a significant positive impact on my Medicare beneficiary

clients. It will also provide more settlement to move forward, thus securing a right of recovery for Medicare, and allowing parties to send the reimbursement check to Medicare promptly after settlement.

Thank you for this opportunity to provide testimony and respond to Chairman Emeritus Dingell's questions. I would be happy to provide any additional information that this Subcommittee may require.

Respectfully Submitted,
Jason Matzus
Partner, Raizman Frischman & Matzus

Mr. STEARNS. All right. The gentleman's request is obliged with. And the gentleman from Georgia, Mr. Gingrey, is recognized for 5 minutes.

Mr. GINGREY. Mr. Chairman, thank you.

Mr. MATZUS, you had, in responding to Mr. Dingell in regard to the amount of time, the so-called limbo period I think you said 3 to 4 months but typically 6 to 9 months, let us reference a medical malpractice tort case where there is a settlement or a judgment in fact. During that period of time, that limbo period, who actually controls the proceeds?

Mr. MATZUS. The proceeds are typically provided to the law firm, the plaintiff's law firm, and the money is held in the plaintiff's firm's escrow account.

Mr. GINGREY. All right. And thank you for that answer. So the money is controlled during that limbo period by plaintiff's attorney, by the law firm. And you say it is placed in escrow. Are there limitations in regard to what you can do with that escrow account? Let us say can you put it in a money market fund? Can you put it in a local bank? And if there is interest generated on that money during that interim, who does that interest go to? Does it go to the plaintiff, the injured party, or does it go to the law firm?

Mr. MATZUS. It goes to neither as I understand it.

Mr. GINGREY. Well, who does it go to? Does it go to charity?

Mr. MATZUS. If there is interest occur, that is a good question, I don't exactly know. Typically, if the money is held in a client-on-trust account, the interest would, I guess, ultimately in the aggregate go to the particular State's Client Trust program.

Mr. GINGREY. Well, in my humble opinion, I would think it should go to the injured party, to the plaintiff ultimately.

Mr. MATZUS. I agree.

Mr. GINGREY. Let me ask this question of Ms. Stein.

You are an advocate for Medicare beneficiaries and we appreciate that. In regard to this requirement to pay back Medicare for the cost that they have incurred and this subrogation requirement that is in the law, if the injured party is still living and it has been 2 years later that they get this demand letter from Medicare, does Medicare have the authority within the law to put a lien on Social Security benefits as an example if that happens to be their only asset?

Ms. STEIN. Yes, they could actually begin to deduct money from the Social Security benefits.

Mr. GINGREY. And if the individual is deceased by the time they get the demand letter, the lien would be against their estate if they have any value there?

Ms. STEIN. Yes, I believe that is the case.

Mr. GINGREY. All right, thank you. Let me ask one quick question of everybody. We heard Ms. Taylor testify that CMS does provide Medicare Secondary Payment reimbursement amount in a timely manner. However, the testimony of this panel, the four of you seem to contradict that statement. Let me just ask you one by one starting with Mr. Salm. Does CMS consistently provide the amount owed to Medicare in a timely fashion before the case is settled, yes or no?

Mr. SALM. No. They can't. The regulations prohibit them from giving us the final payout amount before the case is settled.

Mr. GINGREY. Do they provide you—I will add to is—a reasonable estimate of what the costs are?

Mr. SALM. They provide a conditional payment letter. The time that it takes to get the conditional payment letter ranges between—for a party like mine—never and 6 months. But we make an awful lot of requests for these and they frequently respond back we have no record of this file.

Mr. GINGREY. And again, I wanted all of you to answer this and I am expanding the question a bit. But if they make an estimate, would it be reasonable to say that then the maximum amount that they could eventually recover would be within a certain percentage point above that estimate and no more?

Mr. SALM. I think that is fair.

Mr. GINGREY. Let us go ahead, Mr. Gilliam.

Mr. GILLIAM. We never get timely numbers. I don't know of any instance where we got a timely number. I think Ms. Taylor talked about 65 days. If they gave us a number at 65 days, we would be dancing in the street and back home in Cincinnati and not here in Washington.

Mr. GINGREY. Mr. Matzus?

Mr. MATZUS. The CPL letters, the conditional payment letters, are not generally provided timely within the 65-day period. In regard to your last point about if Medicare was limited in the amount that they could recover by percentage above the figure in the CPL, that would be very, very helpful. Currently, there is no such limitation. So from a practical perspective, the CPL number is meaningless because it is not a final number.

Mr. GINGREY. Right. And finally, Ms. Stein?

Ms. STEIN. I agree. I think that it would extremely helpful to limit it. I think it would also help in closing cases in a timely manner. So, again, when claims aren't properly segregated, individuals aren't receiving notices, you know, 10 years later or they are not able to access Medicare coverage because there has been a lien against them.

Mr. GINGREY. Right, thank you.

Thank you, Mr. Chairman, for your patience with us.

Mr. STEARNS. Well, thank you. And I just want to follow up with what you had indicated. Actually, this Mother Jones article, Ms. Coury, who got into an automobile accident in 1995, Medicare actually confiscated her Social Security check of \$498 in 2002, so she was 88 years old and Medicare came in and confiscated it for 3 years until she repaid more than \$16,000, her settlement minus some legal fees. So I mean that is an egregious example.

In closing, I just want to put into the record—I have in my hand MSP demands for \$1.59, \$2.81, and \$4.82. I ask unanimous consent that they be made part of the record.

[The information follows:]

1. \$1.59

MON 04/20/09 11:23AM



Learn about your letter at www.msprc.info 04/30/2009

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Dear [Redacted]

Please note that if we know that you have an attorney or other individual representing you in this matter, we are sending him/her a copy of this letter. If you have an attorney or other representative for this matter and his/her name is not shown as a "cc" at the end of this letter (indicating that he/she is receiving a copy), please contact us immediately. If you have any questions regarding this letter and are represented by an attorney or other individual in this matter, you may wish to talk to your representative before contacting us.

We are writing to you because we recently learned that you have made a liability claim relating to an illness, injury or incident occurring on or about 04/17/2007 and obtained a recovery. We have determined that you are required to repay the Medicare program \$1.59 for the cost of medical care it paid relating to your liability recovery. (The term "recovery" includes a settlement, judgment, award or any other type of recovery.)

We hope that you will find answers to some of the questions you may have about this letter below. Parts I and II of this letter explain the federal law that requires you to pay Medicare back and the way we determined the amount you are required to repay. We have provided instructions for repaying Medicare in Part III of this letter. You have the right to appeal our determination if you disagree with it, and you also have the right to request that the Medicare program waive recovery of the amount you owe in full or in part. Instructions for requesting waiver of recovery and appeal are provided in Part IV of this letter. Part V of this letter explains the interest charges that apply if you do not repay Medicare within sixty (60) days from the date of this letter and tells you about certain actions Medicare may decide to take if you fail to repay the amount you owe. Finally, Part VI identifies whom you should contact if you have questions about this letter.

I. Why am I required to repay Medicare?

You are required to repay Medicare because Medicare paid for medical care you received related to your liability recovery. The Medicare Secondary Payer (MSP) law allows Medicare to pay for medical care received by a Medicare beneficiary who has or may have a liability claim. However, the law also requires Medicare to recover those payments if payment of a liability settlement, judgment, recovery, or award has been or could be made. Congress passed the MSP law because it wanted to make sure that the Medicare Trust Funds would have enough money to pay for medical care that beneficiaries may need in the future. Congress decided that, if a liability recovery was available to pay for a Medicare beneficiary's medical care, then that money should be used to pay for the care and any amounts already paid by Medicare should be refunded to the Medicare Trust Funds.

If you would like to read the MSP law, you can find it in Title 42 of the United States Code, Section 1395y(b)(2). You can also find the regulations that explain how the Medicare program recovers amounts it is owed under the MSP law in Title 42 of the Code of Federal Regulations, beginning at Section 411.20. You can also learn more about how the MSP law works by contacting your local Social Security office or by visiting www.medicare.gov.

II. How did Medicare decide how much money I owe?

The Medicare program paid \$2.45 for medical care related to your liability recovery. We have enclosed a list of the payments Medicare made related to your recovery with this letter. The Medicare program generally reduces the amount a Medicare beneficiary is required to repay to take into account the costs (such as attorney's fees) paid by the beneficiary to obtain his or her liability recovery. You can find the formula we use to decide how much the amount of this reduction should be at 42 C.F.R., sub-section 411.37. We have applied the formula and determined that the amount you owe Medicare is \$1.59.

This letter relates only to money paid from your current recovery. If, in the future, you receive additional money from this liability recovery, or any other liability recovery, you must let us know.

III. What do I need to do to repay Medicare the amount I owe?

You must repay Medicare \$1.59 within sixty (60) days of the date of this letter 04/30/2009 . Please send a check or money order for \$1.59 , made payable to Medicare, to us at the address listed at the end of this letter. Please make sure to include your name and Medicare number on the check or money order and include a copy of this letter with your payment.

IV. What rights do I have if I disagree with the amount this letter says I owe or think that I should not have to pay Medicare back for some other reason?

Right to Request a Waiver – You have the right to request that the Medicare program waive recovery of the amount you owe in full or in part. Your right to request a waiver is separate from your right to appeal our determination, and you may request both a waiver and an appeal at the same time. The Medicare program may waive recovery of the amount you owe if you can show that you meet both of the following conditions:

1. This overpayment (for purposes of requesting waiver of recovery, the amount you owe is considered an overpayment) was not your fault, because the information you gave us with your claims for Medicare benefits was correct and complete as far as you knew, and when the Medicare payment was made, you thought that it was the right payment;

AND

2. Paying back this money would cause financial hardship or would be unfair for some other reason.

If you believe that both of these conditions apply to you, you should send us a letter that explains why you think you should receive a waiver of the amount you owe. If you request a waiver, we will send you a form asking for more specific information about your income, assets, expenses, and the reasons why you believe you should receive a waiver. If we are unable to grant your request for a waiver, we will send you a letter that explains the reason(s) for our decision and the steps you will need to follow to appeal that decision if it is less than fully favorable to you.

Right to Appeal – You also have the right to appeal our determination if you disagree that you owe Medicare as explained in Part I of this letter, or if you disagree with the amount that you owe Medicare \$1.59 as explained in Part II of this letter. To file an appeal, you should send us a letter explaining why you think the amount you owe Medicare is incorrect and/or any reason(s) why you disagree with our determination. Once we receive your request for appeal, we will decide whether our determination that you must repay Medicare \$1.59 is correct and send you a letter that explains the reasons for our decision. Our letter will also explain the steps you will need to follow to appeal that decision if it is less than fully favorable to you.

You have 120 days from receipt of this letter 04/30/2009 to file an appeal. We must assume that you received this letter within five (5) days of the date of the letter 04/30/2009 unless you furnish us with proof to the contrary.



MAY 2 2007 11:27AM

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NW. 008 P. 2

If you do not already have an attorney or other representative and you want help with your appeal or request for waiver, you can have a friend, lawyer, or someone else help you. Some lawyers do not charge unless you win your case. There are groups, such as lawyer referral services that can help you find a lawyer. There are also groups, such as legal aid services, that will provide free legal services if you qualify.

V. What happens if I do not repay Medicare the amount I owe?

Please note that, if you do not repay Medicare in full by 06/28/2009, you will be required to pay interest on any remaining balance, from the date of this letter, at a rate of 11% per year. If the debt is not fully resolved within 60 days of the date of this letter, interest is due and payable for each full 30 day period the debt remains unresolved. By law, all payments are applied to interest first, principal second. You can find the regulation that explains interest charges at 42 C.F.R., sub-section 411.24(m). To avoid having to pay interest, you should repay Medicare in full within sixty (60) days of the date of this letter, even if you decide to request a full or partial waiver of the amount you owe or decide to appeal our determination (see Part IV) of this letter. If you receive a waiver of recovery or if you are successful in appealing our decision, Medicare will refund amounts you have already paid.

If you are unable to repay Medicare in one payment, you may ask us to consider whether to allow you to pay in regular installments. If you make installment payments, you should be aware that your payments will be applied to any interest due first and then to the outstanding principal amount.

You should also be aware that if you do not repay Medicare in full, it may decide to recover any amounts you owe (including accrued interest) from any Social Security or Railroad Retirement benefits to which you might otherwise be entitled, or from future Medicare payments. Your failure to respond as requested within sixty (60) days of the date of this letter may result in the initiation of additional recovery procedures without further notice, including referral to the Department of Justice for legal action and/or the Department of the Treasury for other collection actions. You should be aware that the Debt Collection Improvement Act of 1996 requires Federal Agencies to refer debts to the Department of the Treasury or its designated debt collection center for recovery actions including collection by offset against any monies otherwise payable to the debtor by any agency of the United States and through other collection methods. Under this and other authorities (31 U.S.C. 3720A), the Internal Revenue Service may collect this debt by offset against tax refunds owed to individuals or other entities.

VI. The amount requested in this letter may not include payments received prior to the issuance of this demand letter dated 04/30/2009. Upon issuing a check, please deduct previous payments made to the MSPRC for the above referenced debt.

VII. Who should I contact if I have questions about this letter?

This office is the Medicare contractor responsible for handling your case. If you have any questions about this letter, or questions about Medicare's recovery rights in general, please contact MSPRC LIABILITY at 1-866-677-7220 (TTY/TDD: 1-866-677-7294 for the hearing and speech impaired) or the address listed below. Please also make sure that any letters you send us include your name, your Medicare Health Insurance Claim Number (this is the number found on your red, white and blue Medicare card), and the date of the illness, injury or incident. Providing us with this information will help us respond more quickly to any questions you may have.

Sincerely,

Medicare Secondary Payer Recovery Contractor
PO BOX 33828
DETROIT MI 48232-5828

Enclosure: Payment Summary Form

SGLDBLNGHP



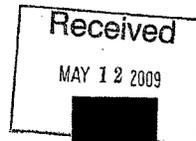
BURGESS, KERNBACH & PERIGARD, PLLC
TRIAL ATTORNEYS AND COUNSELLORS AT LAW
SUITE 140
10680 MAIN STREET
FAIRFAX, VIRGINIA 22030-3811

JACK T. BURGESS**
MICHAEL A. KERNBACH***
GREGORY P. PERIGARD**

* ADMITTED IN VA.
* ADMITTED IN D.C.
* ADMITTED IN N.Y. AND FL.

TELEPHONE (703) 273-0888
FACSIMILE (703) 273-3907
WEBSITE: WWW.BURGESS-LAW.COM

PRINCE WILLIAM, VA OFFICE
(703) 898-0688



May 8, 2009

Mr. [REDACTED]

Re: Our Client: [REDACTED]
Your Insured: [REDACTED]
Date of Accident: 4/17/07
Claim Number: [REDACTED]

Dear [REDACTED]

With reference to the above matter, enclosed please find confirmation from the Center for Medicare and Medicaid Services that the total amount owed to Medicare out of [REDACTED]'s third-party personal injury recovery is \$1.59. Accordingly, it is respectfully requested that you immediately issue payment to the Center for Medicare and Medicaid Services in the amount of \$1.59 and that you forward the remaining settlement proceeds in the amount of \$4,498.41 to my attention. Please provide me with a copy of your transmittal letter to the Center for Medicare and Medicaid Services. Once these payments have been made, your file in this matter may be closed.

Thank you for your kind attention in this matter. If you should have any questions, please do not hesitate to contact me.

Very truly yours,
[REDACTED]

GPP/jrf
enclosure
cc: Mr. [REDACTED]

2. \$2.81



108348
3/21/09



Learn about your letter at www.msprc.info

PLEASE REFRAIN FROM MAKING PAYMENT AT THIS TIME

08/26/2009

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RE: Name of Beneficiary: [REDACTED]
HIC#: [REDACTED]
Date of Injury/Illness/Incident: [REDACTED]

Dear [REDACTED]

Please note that if we know that you have an attorney or other individual representing you in this matter, we are sending him/her a copy of this letter. If you have an attorney or other representative for this matter and his/her name is not shown as a "cc" at the end of this letter (indicating that he/she is receiving a copy), please contact us immediately. If you have any questions regarding this letter and are represented by an attorney or other person in this matter, you may wish to talk to your representative before contacting us.

This letter follows a previous letter notifying you/your attorney of Medicare's priority right of recovery as defined under the Medicare Secondary Payer provisions. Conditional Medicare payments have been made related to your workers' compensation claim. These conditional payments are subject to reimbursement to Medicare from proceeds received pursuant to a workers' compensation settlement, judgment, award, or recovery. (The term "resolution" includes a settlement, judgment, award, or any other type of resolution.)

rcwep1

7/10/09

However, we ask that you refrain from sending any monies to Medicare prior to your submission of settlement/resolution information and receipt of a demand/recovery calculation letter from our office. This will eliminate underpayments, overpayments, and/or associated delays.

Currently, Medicare has paid \$2,811 in conditional payments related to your claim. Attached you/your attorney will find a listing of claims that comprise this total. Please take a look at this listing and advise us if you/your attorney disagree with the inclusion of any claim in whole or in part and explain the reasons why you/your attorney disagree(s).

Please be advised that we are still investigating this matter to obtain any other outstanding Medicare conditional payments. Therefore, the enclosed listing of current conditional payments (including a response of a zero amount) is not a final listing and will need to be updated once we receive information about final resolution of this matter from you. It would be in your best interest to keep Medicare's payments and your obligation under the law to satisfy Medicare's claim in mind when negotiating and accepting a final dollar amount in resolution of the workers' compensation claim.

If the case has been resolved, please furnish our office with a copy of:

- 1) The settlement/resolution agreement from the workers' compensation carrier showing the total amount of the settlement, signed and dated, and
- 2) Your closing statement reflecting the actual amount of the attorney's fees and costs. We request that you also include a statement that these fees and costs are being borne by the beneficiary.

Thank you for your assistance and cooperation in this matter. If you have any questions regarding this matter, please contact us at 1-866-677-7220 (TTY/TDD: 1-866-677-7294 for the hearing and speech impaired).

Sincerely,

Medicare Secondary Payer Recovery Contractor
PO BOX 33831
DETROIT MI 48232-5831

Enclosure: Payment Summary Form

cc: [REDACTED]

SGLWCPNGHP

3. \$4.82

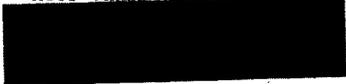


23404 -
2-17-70



Learn about your letter at www.msprc.info

PLEASE REFRAIN FROM MAKING PAYMENT AT THIS TIME 07/16/2009
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RE: Name of Beneficiary: [REDACTED]
HIC#: [REDACTED]
Date of Injury/Illness/Incident: [REDACTED]

Dear [REDACTED]

Please note that if we know that you have an attorney or other individual representing you in this matter, we are sending him/her a copy of this letter. If you have an attorney or other representative for this matter and his/her name is not shown as a "cc" at the end of this letter (indicating that he/she is receiving a copy), please contact us immediately. If you have any questions regarding this letter and are represented by an attorney or other person in this matter, you may wish to talk to your representative before contacting us.

This letter follows a previous letter notifying you/your attorney of Medicare's priority right of recovery as defined under the Medicare Secondary Payer provisions. Conditional Medicare payments have been made related to your workers' compensation claim. These conditional payments are subject to reimbursement to Medicare from proceeds received pursuant to a workers' compensation settlement, judgment, award, or recovery. (The term "resolution" includes a settlement, judgment, award, or any other type of resolution.)

However, we ask that you refrain from sending any monies to Medicare prior to your submission of settlement/resolution information and receipt of a demand/recovery calculation letter from our office. This will eliminate underpayments, overpayments, and/or associated delays.

Currently, Medicare has paid \$4.82 in conditional payments related to your claim. Attached you/your attorney will find a listing of claims that comprise this total. Please take a look at this listing and advise us if you/your attorney disagree with the inclusion of any claim in whole or in part and explain the reasons why you/your attorney disagree(s).

Please be advised that we are still investigating this matter to obtain any other outstanding Medicare conditional payments. Therefore, the enclosed listing of current conditional payments (including a response of a zero amount) is not a final listing and will need to be updated once we receive information about final resolution of this matter from you. It would be in your best interest to keep Medicare's payments and your obligation under the law to satisfy Medicare's claim in mind when negotiating and accepting a final dollar amount in resolution of the workers' compensation claim.

If the case has been resolved, please furnish our office with a copy of:

- 1) The settlement/resolution agreement from the workers' compensation carrier showing the total amount of the settlement, signed and dated, and
- 2) Your closing statement reflecting the actual amount of the attorney's fees and costs. We request that you also include a statement that these fees and costs are being borne by the beneficiary.

Thank you for your assistance and cooperation in this matter. If you have any questions regarding this matter, please contact us at 1-866-677-7220 (TTY/TDD: 1-866-677-7294 for the hearing and speech impaired).

Sincerely,

Medicare Secondary Payer Recovery Contractor
PO BOX 33831
DETROIT MI 48232-5831

Enclosure: Payment Summary Form

cc: [REDACTED]

SGLWCPNGHP

4. \$36.75

However, we request that you/your attorney refrain from sending any notices to Medicare prior to submission of settlement information and receipt of a demand/recovery calculation letter from our office. This will eliminate underpayments, overpayments, and/or associated delays.

Currently, Medicare has paid \$36.75 in conditional payments related to your claim. Attached you/your attorney will find a listing of claims that comprise this total. Please take a look at this listing and let us know if you/your attorney disagree with the inclusion of any claim in whole or in part and explain the reasons why you/your attorney disagree(s).

Please be advised that we are still investigating this case file to obtain any other outstanding Medicare conditional payments. Therefore, the enclosed listing of current conditional payments (including a response of a zero amount) is not a final listing and will need to be updated once we receive final settlement information from you. It would be in your best interest to keep Medicare's payments and the statutory obligation to satisfy Medicare in mind when the final dollar amount is negotiated and accepted in resolution of the claim with the third party.

If the case has settled, please furnish our office with a copy of:

- 1) The settlement agreement from the third party payer showing the total amount of the settlement, signed and dated, AND
- 2) Your closing statement reflecting the actual amount of the attorney's fees and costs (excluding medical bills).

Thank you for your assistance and cooperation in this matter. If you have any questions regarding this matter, please contact us at 1-866-677-7220 (TTY/AD: 1-866-677-7294 for the hearing and speech impaired).

Sincerely,

Medicare Secondary Payer Recovery Contractor
PO BOX 33828
DETROIT MI 48232-5828

Enclosures: Payment Summary Form
cc:

SGLLCPNGHP



Payment Summary Form

REPORT NUMBER: DATE RECEIVED:
 CONTRACTOR: MEDICARE SECONDARY PAYER RECOVERY CONTRACTOR
 CASE ID:
 BENEFICIARY NAME: CASE TYPE: LIABILITY
 BENEFICIARY HICN: DATE OF INCIDENT:

TOS	ICK	LINE	PROCESSING CONTRACTOR	PROVIDER NAME	DIAGNOSIS CODE	FROM DATE	TO DATE	TOTAL CHARGES	REIMBURSED AMOUNT	CONDITIONAL PAYMENT
71	62020806822570	1	852		70531	12/20/2008	12/20/2008	\$20.00	\$5.36	\$5.36
71	62020806822570	1	852		8833	12/20/2008	12/20/2008	\$10.00	\$0.00	\$0.00
71	62020806822570	2	852		8830	12/20/2008	12/20/2008	\$144.00	\$31.39	\$31.39

SUM OF TOTAL CHARGES: \$174.00
 TOTAL CONDITIONAL PAYMENTS: \$66.75

5. \$42.50



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Learn about your letter at www.msprc.info

PLEASE REFRAIN FROM MAKING PAYMENT AT THIS TIME 06/10/2009
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RE: Name of Beneficiary: [REDACTED]
HIC#: [REDACTED]
Date of Injury/Illness/Incident: [REDACTED]

Dear [REDACTED]

Please note that if we know that you have an attorney or other individual representing you in this matter, we are sending him/her a copy of this letter. If you have an attorney or other representative for this matter and his/her name is not shown as a "cc" at the end of this letter (indicating that he/she is receiving a copy), please contact us immediately. If you have any questions regarding this letter and are represented by an attorney or other person in this matter, you may wish to talk to your representative before contacting us.

This letter follows a previous letter notifying you/your attorney of Medicare's priority right of recovery as defined under the Medicare Secondary Payer provisions. Conditional Medicare payments have been made related to your workers' compensation claim. These conditional payments are subject to reimbursement to Medicare from proceeds received pursuant to a workers' compensation settlement, judgment, award, or recovery. (The term "resolution" includes a settlement, judgment, award, or any other type of resolution.)

However, we ask that you refrain from sending any monies to Medicare prior to your submission of settlement/resolution information and receipt of a demand/recovery calculation letter from our office. This will eliminate underpayments, overpayments, and/or associated delays.

Currently, Medicare has paid \$42.50 in conditional payments related to your claim. Attached you/your attorney will find a listing of claims that comprise this total. Please take a look at this listing and advise us if you/your attorney disagree with the inclusion of any claim in whole or in part and explain the reasons why you/your attorney disagree(s).

Please be advised that we are still investigating this matter to obtain any other outstanding Medicare conditional payments. Therefore, the enclosed listing of current conditional payments (including a response of a zero amount) is not a final listing and will need to be updated once we receive information about final resolution of this matter from you. It would be in your best interest to keep Medicare's payments and your obligation under the law to satisfy Medicare's claim in mind when negotiating and accepting a final dollar amount in resolution of the workers' compensation claim.

If the case has been resolved, please furnish our office with a copy of:

- 1) The settlement/resolution agreement from the workers' compensation carrier showing the total amount of the settlement, signed and dated, and
- 2) Your closing statement reflecting the actual amount of the attorney's fees and costs. We request that you also include a statement that these fees and costs are being borne by the beneficiary.

Thank you for your assistance and cooperation in this matter. If you have any questions regarding this matter, please contact us at 1-866-677-7220 (TTY/TDD: 1-866-677-7294 for the hearing and speech impaired).

Sincerely,

Medicare Secondary Payer Recovery Contractor
PO BOX 33831
DETROIT MI 48232-5831

Enclosure: Payment Summary Form

cc

SGLWCPNGHP

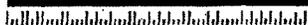
6. \$44.83



Learn about your letter at www.msprc.info

06/29/2009

66-1 SP 0.440



RE: Past-due debt owed CMS as of 06/29/2009: \$44.83
 Date debt became past-due: 06/15/2009
 Date of Demand Letter previously sent: 04/16/2009
 Debt Identification Numbers: [REDACTED]
 Taxpayer Identification Number (TIN): [REDACTED]
 Beneficiary's Name: [REDACTED]
 Beneficiary's HIC: [REDACTED]
 Date of Incident: [REDACTED]

**NOTICE OF INTENT TO REFER DEBT TO THE DEPARTMENT OF
 TREASURY OR A DEPARTMENT OF TREASURY DESIGNATED DEBT
 COLLECTION CENTER FOR CROSS-SERVICING AND OFFSET OF
 FEDERAL PAYMENTS**

Please note that it is possible that this letter is being sent to you by a Medicare contractor other than the one who issued the request(s) for repayment that is (are) attached to this letter. This situation would occur whenever one contractor has assumed responsibility for a particular workload from another contractor (usually because the initial contractor is leaving or has left the Medicare program).

The Centers for Medicare & Medicaid Services (CMS) has determined that you are indebted to the Medicare program for the amount shown above and that this amount is delinquent. The amount shown includes principal and interest. This debt arose under the Medicare Secondary Payer (MSP) provisions of the Social Security Act. CMS has the right to collect this debt through offset of any payments due to the debtor. In addition, the Debt Collection Improvement Act (DCIA) of 1996 requires Federal agencies to refer delinquent debts to the Department of Treasury and/or a designated Debt Collection Center (DCC) for collection through cross-servicing, including the Treasury Offset Program (TOP). Under TOP, delinquent Federal debts are collected through offset from other Federal agency payments you may be entitled to, including the offset of your income tax refund through the referral of this debt to the Internal Revenue Service (IRS), and Federal benefit payments such as Social Security retirement or disability benefits. Treasury or a designated DCC uses various collection tools to collect the debts, including offset, demand letters, phone calls, referral to a private collection agency and/or referral to the Department of Justice or agency counsel for litigation.

The purpose of this notice is to inform you of our intention to refer your debt to Treasury/a designated DCC, under the provisions of the DCIA, Title 31 United States Code, Section 3711 to collect this debt. This referral will permit the Department of Treasury and/or a designated DCC to use the aforementioned means of collection as well as to permit administrative offset of payments you may be receiving from other Federal agencies. During this collection process, interest will continue to accrue on the debt and you will remain legally responsible for any amount not satisfied through the collection efforts.

Please read the following instructions carefully as they may assist you in resolving this matter prior to referral.

Challenging the Indebtedness:

You have the right to request an opportunity to inspect and copy records relating to the debt. This request must be submitted in writing to the address listed below. Additionally, you have a right to present evidence that all or part of your debt is not past due or legally enforceable. In order to exercise this right, this office must receive a copy of the evidence to support your position. Please include a copy of this notice when corresponding with the agency regarding this matter. You must submit any evidence that the debt is not owed or legally enforceable within 60 days of the date of this letter. We will notify you within 30 days of receipt of the information of our determination as to whether the debt is still past due and legally enforceable. Failure to present any evidence will result in the automatic referral of the debt to the Department of Treasury/a designated DCC for cross-servicing/offset actions.

If you have questions concerning this debt, extended repayment plans, and/or relating to the submission of evidence, you may contact:

MEDICARE SECONDARY PAYER RECOVERY CONTRACTOR
Telephone Number: 1-866-677-7220
TTY/TDD: 1-866-677-7294

If you call, please be sure that you have this letter available so that you can readily provide us with the identification information provided at the beginning of the letter.

Sincerely,

MEDICARE SECONDARY PAYER RECOVERY CONTRACTOR

Enclosures:
Claims Summary
cc: [REDACTED]

SGL210NGHP



Payment Summary Form

REPORT NUMBER: [REDACTED]
 CONTRACTOR: 7901-MEDICARE SECONDARY PAYER RECOVERY CONTRACTOR
 DATE: 06/29/2009
 CASE ID: [REDACTED]
 CASE TYPE: LIABILITY
 DATE OF INCIDENT: 2008
 BENEFICIARY NAME: [REDACTED]
 BENEFICIARY HICN: [REDACTED]

TOS	ICN	LINE	PROCESSING CONTRACTOR	PROVIDER NAME	DIAGNOSIS CODE	FROM DATE	TO DATE	TOTAL CHARGES	REIMBURSED AMOUNT	CONDITIONAL PAYMENT
B	520208218292140	1	520	[REDACTED]	V714, E8889	07/21/2008	07/21/2008	\$32.00	\$6.54	\$6.54
B	520208218292140	2	520	[REDACTED]	V714, E8889	07/21/2008	07/21/2008	\$16.00	\$5.98	\$5.98
B	520208218292140	3	520	[REDACTED]	V714, E8889	07/21/2008	07/21/2008	\$30.00	\$6.24	\$6.24
B	520208218292140	4	520	[REDACTED]	V714, E8889	07/21/2008	07/21/2008	\$16.00	\$5.68	\$5.68
B	520208218292140	5	520	[REDACTED]	V714, E8889	07/21/2008	07/21/2008	\$32.00	\$6.24	\$6.24
B	520208218292140	6	520	[REDACTED]	807D2, E8889	07/21/2008	07/21/2008	\$37.00	\$7.71	\$7.71
B	520208218292150	1	520	[REDACTED]	807D2	07/21/2008	07/21/2008			

SUM OF TOTAL CHARGES: \$182.00
 TOTAL CONDITIONAL PAYMENT: \$44.03

7. \$69.62

However, we request that you/your attorney refrain from sending any monies to Medicare prior to submission of settlement information and receipt of a demand/recovery calculation letter from our office. This will eliminate underpayments, overpayments, and/or associated delays.

Currently, Medicare has paid \$69.62 in conditional payments related to your claim. Attached you/your attorney will find a listing of claims that comprise this total. Please take a look at this listing and let us know if you/your attorney disagree with the inclusion of any claim in whole or in part and explain the reasons why you/your attorney disagree(s).

Please be advised that we are still investigating this case file to obtain any other outstanding Medicare conditional payments. Therefore, the enclosed listing of current conditional payments (including a response of a zero amount) is not a final listing and will need to be updated once we receive final settlement information from you. It would be in your best interest to keep Medicare's payments and the statutory obligation to satisfy Medicare in mind when the final dollar amount is negotiated and accepted in resolution of the claim with the third party.

If the case has settled, please furnish our office with a copy of:

- 1) The settlement agreement from the third party payer showing the total amount of the settlement, signed and dated, AND
- 2) Your closing statement reflecting the actual amount of the attorney's fees and costs (excluding medical bills).

Thank you for your assistance and cooperation in this matter. If you have any questions regarding this matter, please contact us at 1-866-677-7220 (TTY/TDD: 1-866-677-7294 for the hearing and speech impaired).

Sincerely,

Medicare Secondary Payer Recovery Contractor
PO BOX 33828
DETROIT MI 48232-5828

Enclosures: Payment Summary Form

cc: [REDACTED]

SGLLCPNGHP



Payment Summary Form

ENROLL NUMBER: [REDACTED]
 CONTRACTOR: MEDICAL SECURITY PATIENT RECOVERY CONTRACTOR

DEF ID: MCRW

BENEFICIARY NAME: [REDACTED]
 BENEFICIARY PTID: [REDACTED]

CASE ID: [REDACTED]
 CASE TYPE: LIABILITY
 DATE OF INCIDENT: [REDACTED]

TOS	ICN	LINE	PROCESSING CONTRACTOR	PROVIDER NAME	DIAGNOSIS CODE	FROM DATE	TO DATE	TOTAL CHARGES	REIMBURSED AMOUNT	CONDITIONAL PAYMENT
71	95220630470520	1	951	[REDACTED]	71941.72761	05/25/2006	09/29/2006	\$30.00	\$25.39	\$29.39
71	95220630470520	1	951	[REDACTED]	71941.9549.7	10/16/2006	10/16/2006	\$115.00	\$40.23	\$40.23
71	95220630470510	2	951	[REDACTED]	71941.9549.7	10/16/2006	10/19/2006	\$245.00	\$0.00	\$0.00

SUM OF TOTAL CHARGES: \$450.00
 TOTAL CONDITIONAL PAYMENT: \$69.62

8. \$72.22



45320-00483
61013



Learn about your letter at www.msprc.info

PLEASE REFRAIN FROM MAKING PAYMENT AT THIS TIME 06/25/2009



P153401



RE: Name of Beneficiary
HIC#
Date of Injury/Times and Date

Dear

Please note that if we know that you have an attorney or other individual representing you in this matter, we are sending him/her a copy of this letter. If you have an attorney or other representative for this matter and his/her name is not shown as a "cc" at the end of this letter (indicating that he/she is receiving a copy), please contact us immediately. If you have any questions regarding this letter and are represented by an attorney or other person in this matter, you may wish to talk to your representative before contacting us.

This letter follows a previous letter notifying you/your attorney of Medicare's priority right of recovery as defined under the Medicare Secondary Payer provisions. Conditional Medicare payments have been made related to your workers' compensation claim. These conditional payments are subject to reimbursement to Medicare from proceeds received pursuant to a workers' compensation settlement, judgment, award, or recovery. (The term "resolution" includes a settlement, judgment, award, or any other type of resolution.)

However, we ask that you refrain from sending any monies to Medicare prior to your submission of settlement/resolution information and receipt of a demand/recovery calculation letter from our office. This will eliminate underpayments, overpayments, and/or associated delays.

Currently, Medicare has paid \$72,221 in conditional payments related to your claim. Attached you/your attorney will find a listing of claims that comprise this total. Please take a look at this listing and advise us if you/your attorney disagree with the inclusion of any claim in whole or in part and explain the reasons why you/your attorney disagree(s).

Please be advised that we are still investigating this matter to obtain any other outstanding Medicare conditional payments. Therefore, the enclosed listing of current conditional payments (including a response of a zero amount) is not a final listing and will need to be updated once we receive information about final resolution of this matter from you. It would be in your best interest to keep Medicare's payments and your obligation under the law to satisfy Medicare's claim in mind when negotiating and accepting a final dollar amount in resolution of the workers' compensation claim.

If the case has been resolved, please furnish our office with a copy of:

- 1) The settlement/resolution agreement from the workers' compensation carrier showing the total amount of the settlement, signed and dated, and
- 2) Your closing statement reflecting the actual amount of the attorney's fees and costs. We request that you also include a statement that these fees and costs are being borne by the beneficiary.

Thank you for your assistance and cooperation in this matter. If you have any questions regarding this matter, please contact us at 1-866-677-7220 (TTY/TDD: 1-866-677-7294 for the hearing and speech impaired).

Sincerely,

Medicare Secondary Payer Recovery Contractor
PO BOX 33831
DETROIT MI 48232-5831

Enclosure: Payment Summary Form

SGLWCPNGHP



Payment Summary Form

REPORT NUMBER:
CONTRACTOR:

BENEFICIARY NAME:
BENEFICIARY HICN:

DATE OCCURRED:

CASE ID:
CASE TYPE: WORKERS' COMPENSATION
DATE OF INCIDENT:

TOS	ICN	LINE	PROCESSING CONTRACTOR	PROVIDER NAME	EMERGENCY CODE	FROM DATE	TO DATE	TOTAL CHARGES	REIMBURSED AMOUNT	CONDITIONAL PAYMENT
71	540202354752060	1	31140		4658/3540	12/29/2002	12/18/2002	\$122.00	\$60.83	\$60.86
71	540202354752060	2	31140		4658/3540	12/18/2002	12/18/2002	\$90.00	\$11.34	\$11.34

SUM OF TOTAL CHARGES: \$202.00
TOTAL CONDITIONAL PAYMENTS: \$72.20

Mr. STEARNS. And Mr. Salm, is this a frequent instance of where Medicare is spending, you know, 43 percent of its time for pursuing 2 percent of its dollars?

Mr. SALM. It is impossible for me to tell how frequent it is given the difficulty of collecting information, but I have additional claims with me for \$36.75, \$42.50, \$44.83, and I think the biggest one I have is \$69.62. When you consider that there is \$1 billion at stake, it seems to me that this is not a good use of our government's time.

Mr. STEARNS. On the \$36, how long did it take?

Mr. SALM. I can't tell you. I am sorry.

Mr. STEARNS. Yes, OK.

Mr. GILLIAM. Mr. Chairman, if I could jump in, we have a claim that we have been waiting for 14 months for Medicare to accept our payment of \$16.54.

Mr. STEARNS. \$16?

Mr. GILLIAM. Yes. We have called them. We have written them, and so 14 months later, a file is still open waiting for a release from Medicare and they haven't even cashed our check for \$16.54.

Mr. STEARNS. I wonder why they haven't cashed your check? Part of the bureaucracy.

Mr. MATZUS, is this sort of typical of the frequency? Or how frequent does this occur in your litigation?

Mr. MATZUS. It doesn't occur in our litigation.

Mr. STEARNS. Do you have your mic on? It doesn't occur?

Mr. MATZUS. It doesn't occur—

Mr. STEARNS. OK.

Mr. MATZUS [continuing]. In our practice.

Mr. STEARNS. OK. Ms. Stein, is this—

Ms. STEIN. Mostly the clients that call us tend to have Medicare claims higher amounts, above \$5,000, but we did have a case recently that was \$35.

Mr. GILLIAM. And to make you more angry, 24 months for a \$91 payment. We are waiting 24 months.

Mr. STEARNS. Twenty-four months for a \$91 payment.

Mr. GILLIAM. To be accepted.

Mr. STEARNS. Wow. Well, I think we have finished our hearing.

Ms. DeGette, is there anything you would like to add?

With that, I think we will close the hearing. I want to thank you for your forbearance, for waiting as the second panelists. I think clearly this agency, Medicare, has not worked well with the Secondary Payment and we, as Members of Congress, are going to have a second hearing if possible on this, and we look forward to trying to solve these problems. And thank you for your interest.

[Whereupon, at 12:26 p.m., the subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]

**Opening Statement of the Honorable Fred Upton
Chairman, Committee on Energy and Commerce
“Protecting Medicare with Improvements to the Secondary Payer Regime”
June 22, 2011**

(Remarks as Prepared)

Thank you, Mr. Chairman, for convening this hearing to address the ways that we may improve our Medicare Secondary Payer regime; a system that, while laudable, is difficult for both beneficiaries and primary payers to navigate.

The Secondary Payer system was designed to protect Medicare funds from disbursement when a third-party payer was primarily responsible for the medical bills of a beneficiary. Unfortunately, “uncertainty” is the word that most appropriately describes the current Secondary Payer system. Due to complex repayment and reporting requirements, beneficiaries and primary payers are often confused as to who is responsible for repayment to the Medicare fund, a fact that undercuts the system’s goal of prompt repayment. This issue is further complicated by the fact that there is no requirement for CMS to provide the parties with the amount due, or the amount they should set aside to cover future payments, *before* settlement so they can appropriately allocate and resolve these Medicare obligations *during* settlement. The end result is uncertainty for all parties involved. CMS is unsure when it will receive repayment. The primary payer is unsure about its bottom line, and the beneficiary, who Medicare is meant to protect, is unsure if they will receive the coverage they were promised.

Maintaining the viability and integrity of Medicare is critical to this committee. We must examine whether the Secondary Payment system is achieving this goal. I look forward to today’s testimony and to improving the Secondary Payment regime as we know it.

Thank you, Mr. Chairman. I yield back the balance of my time.

**Opening Statement of the Honorable Joe Barton
Chairman Emeritus, Committee on Energy and Commerce
Subcommittee on Oversight & Investigations Hearing
“Protecting Medicare with Improvements to the Secondary Payer
Regime”
June 22, 2011**

Thank you, Mr. Chairman for conducting this hearing today.

Protecting Medicare with Improvements to the Secondary Payer must be one of our most urgent matters in this Congress to effectively ensure that the Centers for Medicare and Medicaid Services (CMS) is properly maintaining the interests of its beneficiaries, while at the same time protecting the program from going bankrupt.

It is increasingly important to determine those areas that have been abused by ‘the system’, and recover what can be recovered back the Medicare System. It is easy to see how Medicare as a secondary payer, particularly in terms of worker’s compensation cases, and auto accident claims could get abused.

CMS is responsible for seeing to it that the information flow from one agency to another is smooth, and claims get processed correctly in a timely manner. It has been brought to our attention that CMS has NOT been consistent with providing needed information for claims to be processed properly, OR in a timely manner.

It was alarming to hear in our last hearing that CMS does not even have a proper accounting of how many billions of dollars has been lost in improper payments in this system.

If we had just the money BACK from the annual misappropriation of funds from this CMS agency, we could be on the right track to saving our Medicare Program. The unreasonable delays, ineffective communications, and ever changing guidance documents, of which the CMS department themselves

cannot follow, needs to end. I look forward to the testimony of the witnesses today and I am in the hopes that with this hearing we can indeed see some of the necessary changes needed to thoroughly fix this problem. Thank you and I yield back.

Congressman Marsha Blackburn
Opening Statement for Energy and Commerce
Oversight and Investigations Subcommittee Hearing
“Protecting Medicare with Improvements to the Secondary Payer Regime”
June 22, 2011

Thank you, Mr. Chairman.

As we all know, Medicare on its current path is unsustainable. That is why today’s hearing is so important.

Here we have a system, the Medicare Secondary Payer system, in which CMS pays for billions of dollars of care it is ultimately not responsible for. Clearly, this is a problem.

We have the opportunity today to find ways to reform and improve this broken system and ultimately further protect the fiscal integrity of the Medicare program. By ensuring CMS has an adequate system in place to recoup these claims, we can make certain that those responsible for paying for medical care do so – not taxpayers.

Additionally, it is my hope that this committee can continue to use our oversight authority to shine a light on the inefficiencies of big government and burdensome regulations that consistently plague the current Administration.

While my colleagues on the other side continue to accuse Republicans of wanting to end Medicare, we continue to work towards solutions that will put Medicare on a more sustainable path thus ensuring access to care for current and future beneficiaries.

Thank you, Mr. Chairman, and I yield back the balance of my time.

Statement from Representative John D. Dingell
House Committee on Energy and Commerce
Subcommittee on Oversight and Investigations
“Protecting Medicare with Improvements to the Secondary Payer Regime”
June 21, 2011

Thank you Mr. Chairman for holding today’s hearing.

It is clear from the witnesses before us today more must be done to ensure the Medicare Secondary Payer Program is working efficiently and effectively toward securing reimbursement for the Medicare program, while also being cognizant of the needs of the beneficiaries and their attorneys.

It is critical that we use today as an opportunity to explore the root of the problems in MSP collection practices – whether it is contracting issues, funding issues, personnel issues, or caseload issues. It is also clear that we must use today and the time moving forward to truly gather the data behind the problems. Each of the witnesses on the second panel offer a compelling story of troubles that beneficiaries or their employers have had in their interactions with the MSP process, but I think what is lacking is spot on data collection. It is my hope that today’s questioning and my colleague Congressman Pete Stark’s GAO request will be able to reveal such data today and moving forward.

I would remind my colleagues that the need to collect reimbursement for our Medicare program is a vital tool to helping to maintain the solvency of Medicare. In fiscal year (FY) 2010 the MSP program was able to return \$413 million to the Medicare Trust Funds. Since FY2008 the MSP process has collected an average rate of return on recoveries of \$9.32 for each dollar spent. These successes should serve as a strong example of the work CMS is doing to root out waste, fraud, abuse or improper payments in our Medicare programs. While it is clear that there is much more to do, I do not believe Chairman Ryan’s proposal to end Medicare as we know it will do anything to alleviate the issue of waste, fraud, abuse or improper payments in our health system.

I look forward to working with my colleagues and CMS to improve the MSP program so that beneficiaries and their attorneys can access their settlements in a timely and transparent manner, and to ensure that the MSP process is able to fully collect the payments owed to Medicare.

Thanks you.

**Deborah Taylor's
Additional Written Questions for the Record
From
Energy & Commerce Subcommittee on Oversight and Investigations
On
"Protecting Medicare with Improvements to the Secondary Payer Regime"**

June 22, 2011

The Honorable Cliff Stearns

- 1. How much money is reimbursed to the Medicare Trust Fund annually by class or type? For example, how much is reimbursed for workers' compensation? Auto accidents?**

Answer: The Medicare Secondary Payer Recovery Contractor (MSPRC) tracks amounts returned to the Medicare Trust Funds using accounts receivable postings. Below are the amounts posted to the accounts receivable in FY 2010 by category.

Non-group Health Plan		\$332,454,689
Liability	\$292,201,524	
No-Fault	\$ 30,716,530	
Workers' Compensation	\$ 9,536,635	
Group Health Plan		\$156,895,346
Total		\$489,350,035

Note: The \$413M, referenced in testimony, represents cash deposits to the bank in FY 2010 and the \$489M represents the accounts receivable (AR) postings in FY 2010. The largest variance is due to treasury collections that are applied to ARs. These collections are not reflected as cash deposits. Also, cash deposits often occur the year prior to the initial AR posting. For example, a cash deposit is made September 30, 2009, however, the AR posting does not occur until October 15, 2010.

- 2. What is the average response time by the Medicare Secondary Payer Recovery Contractor (MSPRC)?**

Answer: The MSPRC does not track an overall average response time but does track a response time for certain activities. The MSPRC reports the following response times for its activities.

Responses to conditional payment requests	80 days
Responses to modify the conditional payment amount	79 days
Responses to notices of settlements	58 days

Responses to appeals and redeterminations

92 days

We are aware of situations in which these average timeframes have been exceeded. While CMS has not validated this information, we have conducted onsite reviews at the MSPRC and are working with the MSPRC to make improvements and facilitate timely responses.

3. What is the average time needed to identify and recover funds under the MSP program?

Answer: The MSPRC reports that it takes an average of 58 days from receipt of the notice of settlement to the issuance of the demand letter. CMS has not validated this information. We are aware of situations in which this average timeframe has been exceeded.

The MSPRC collects 65% of non-group health plan demands within 60 days; and 84% within 180 days.

4. What is the average time it takes beneficiaries and their attorneys to obtain a demand letter from the MSPRC?

Answer: The MSPRC reports it takes an average of 58 days from receipt of the notice of settlement to the issuance of the demand letter. CMS has not validated this information. We are aware of situations in which this average timeframe has been exceeded.

The CMS is working with the MSPRC to make improvements in this process. On July 1, 2011, CMS approved a plan to prioritize the processing of certain correspondence types, including notices of settlement, so demand letters are issued timely. Timely is defined as 20 days if the case was established prior to settlement and the initial conditional payment letter was issued and up to 125 days if the case was not established or the initial conditional payment letter had not been issued. We will continue to monitor these activities and make revisions as necessary.

5. Does CMS have in place a threshold for MSP recovery? Do you think this is something you would need?

Answer: On June 30, 2011, CMS instructed the MSPRC not to issue demand letters when it determines the amount owed Medicare is \$25.00 or less. Since much of the case development has already occurred, it costs very little to issue the final demand letter. In addition, CMS is exploring implementing other thresholds including a minimum dollar threshold for reporting and repaying, and a threshold for obtaining final conditional payment amounts prior to settlement.

We believe we have sufficient authority under current law to make necessary changes to improve the MSP program. CMS can use the Secretary's Federal Claims Collection Act (FCCA) authority to establish recovery thresholds for MSP. The CMS needs to carefully consider any mandatory threshold amounts since this would effectively make Medicare

primary for amounts under the threshold. The establishment of a threshold could change industry behavior and disadvantage the Medicare program.

6. How much money is CMS failing to collect in MSP claims?

Answer: The CMS has no way to estimate the value of the MSP claims that have not been settled or reported. The Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) made reporting of settlements mandatory. This has dramatically increased the number of MSP situations reported to Medicare. As a result, MSP recoveries have increased from \$261 million in 2007 to \$413 million in 2010.

7. How many of the workers' compensation Medicare set-asides submitted were approved upon first submission?

Answer: Below are statistics for determinations on Workers' Compensation Medicare set-asides for the period from November 2004 through June 2011.

Approved set-aside amount as submitted	67,902
Approved with no-set-aside needed	9,536
Countered with a lower set-aside amount	9,600
Countered with a higher set-aside amount	29,507
Returned under review threshold	7,976
Total Determinations	124,521

(Note: The CMS reviews proposed Medicare set-aside amounts for beneficiaries if the settlement amount is greater than \$25,000. The CMS reviews proposed set-asides for individuals that expect to be Medicare beneficiaries within 30 months, if the settlement amount is over \$250,000.)

8. What was the primary reason for rejection?

Answer: Medicare does not reject proposed Medicare set-aside amounts. Rather, CMS approves the proposed set-aside amount or responds with a higher or lower counter-offer when it believes the proposed set-aside amount is inappropriate. The primary reason CMS responds with a counter-offer is because the proposed set-aside amount did not adequately account for future medical services or prescription drug expenditures. The CMS also returns set-aside proposals without review if they are under established thresholds.

9. What was the total value of the workers' compensation Medicare set-asides approved last year?

Answer: The CMS approved \$1.4 billion in workers' compensation set-asides during CY 2010.

- 10. The purpose of the Section 111 MSP Reporting requirements is to determine when there is a “primary” payer of medical bills and Medicare is secondary. Why does CMS require reporting of a settlement, judgment or award, paid under a liability policy that typically does not pay for bodily injury and thus does not include the medical payments on which the reporting requirements are based?**

Answer: The Medicare program has a priority right of recovery against liability insurance settlements, judgments, awards or other payments where medicals have been claimed, released or effectively released. Determining whether there is a MSP recovery claim for a specific settlement is Medicare’s responsibility rather than the Responsible Reporting Entity’s responsibility. The CMS is exploring if it can limit reporting for certain types of policies that frequently do not involve medical care if the only basis for reporting would be a broad general release. The Agency must use care in developing any such limitations in a manner that appropriately protects the Medicare trust funds and preserves the Secretary’s recovery authority.

- 11. Under the CMS guidance on Section 111 MSP Reporting, “foreign entities” are required to report claims that involve a Medicare beneficiary. The definition of “foreign entities” in the CMS guidance is overly broad and uses improper terminology (for example referring to entities “registered” in a U.S. jurisdiction – insurance companies are “licensed” not registered.) Under what legal authority does CMS extend its authority to entities not doing business in the United States? How is it possible to possibly subject them to penalties for violating their own country’s privacy laws because of information required to be reported by CMS?**

Answer: The CMS has not extended its authority to entities not doing business in the United States. We have issued instructions regarding what constitutes “doing business in the United States” for purposes of Section 111 reporting. Certain foreign entities have taken issue with these instructions, including alleged conflicts between these instructions and their privacy laws. The CMS continues to engage in discussions with the industry on this issue.

- 12. Accident & Health (A&H) products are written by health insurers and life insurers (which combined write \$171 billion in premiums), as well as property-casualty insurers (which write \$7 billion in premiums). A&H products are defined under state insurance codes as a distinct kind of insurance. The state insurance codes have statutes and regulations which apply specifically to A&H. A&H products have never been regulated under state insurance codes or regulations as a “no-fault insurance” coverage. However, CMS has defined such products as no-fault insurance for NGHP MSP reporting purposes. Under what specific legal authority can CMS pursue reporting for claims under Accident & Health products for NGHP, but not pursue reporting for GHP or life insurers that in fact sell the vast majority of those A&H products? CMS’s current policy position puts property/casualty insurers at a competitive disadvantage.**

Answer: The CMS understands that Medicare’s definition of “no-fault insurance” differs somewhat from the industry’s use of the term. However, CMS is bound by the federal Medicare statutory and regulatory definitions and must employ these in implementing the MMSEA Section 111 reporting instructions. The CMS has not exempted any insurer from reporting accident and health insurance that constitutes “no-fault insurance” under the Medicare program’s definition of that term. The implementation instructions are based upon the type of insurance to be reported, not whether a particular entity is a property or casualty insurer. Accident and health insurance that constitutes no-fault insurance must be reported pursuant to CMS’ rules for NGHP reporting, regardless of the type of insurer that sold the policy in question. All insurers are treated equally under CMS’ instructions, thus no insurer should be competitively disadvantaged.

The Honorable Tim Murphy

1. What is the median value of the 413,000 claims for non-group health plans?

Answer: CMS cannot provide a median value for the 413,000 non-group health plan cases because the value of the case cannot be determined until there is a settlement, judgment, award or other payment. During FY 2010, CMS issued non-group health plan demands on 74,098 settled cases. Below is the median value of those cases.

<u>Type</u>	<u># of Settled Cases</u>	<u>Median</u>	
<u>Average</u>			
Liability Insurance	59,802	\$1,022	\$5,738
Worker’s Compensation	4,250	\$ 532	\$3,373
No-Fault Insurance	10,046	\$ 560	\$3,144
All cases	74,098	\$ 915	\$5,251

2. How many are below \$50, \$100, \$500, \$1,000?

Answer: CMS issued 74,098 non-group health plan demands in FY 2010. Below is a breakdown of the demands by dollar value.

<u>Demand Amount</u>	<u>Number of Demands</u>	<u>Total Demand Value</u>
\$50 and below	4,250	\$116,767
\$51 to \$100	4,228	\$316,030
\$101 to \$500	18,808	\$5,171,980
\$501 to \$1000	11,146	\$8,025,530
Total demands \$1000 or less	38,432	\$13,630,307
Total demands over \$1000	35,666	\$375,426,936
Total All Demands	74,098	\$389,057,243