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4 HEARING ON ``PROTECTING MEDICARE WITH IMPROVEMENTS TO THE
5 SECONDARY PAYER REGIME''
6 WEDNESDAY, JUNE 22, 2011
7 House of Representatives,
8 Subcommittee on Oversight and Investigations
9 Committee on Energy and Commerce
10 Washington, D.C.

11 The Subcommittee met, pursuant to call, at 10:01 a.m.,
12 in Room 2322 of the Rayburn House Office Building, Hon. Cliff
13 Stearns [Chairman of the Subcommittee] presiding.

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

18 Staff present: Stacy Cline, Counsel, Oversight; Todd

19 Harrison, Chief Counsel, Oversight/Investigations; Sean
20 Hayes, Counsel, Oversight/Investigations; Andrew Powaleny,
21 Press Assistant; Alan Slobodin, Deputy Chief Counsel,
22 Oversight; John Stone, Associate Counsel; Alex Yergin,
23 Legislative Clerk; Kristin Amerling, Democratic Chief Counsel
24 and Oversight Staff Director; Alvin Banks, Democratic
25 Assistant Clerk; Stacia Cardille, Democratic Counsel; Brian
26 Cohen, Democratic Investigations Staff Director and Senior
27 Policy Advisor; and Tim Gronninger, Democratic Senior
28 Professional Staff Member.

|
29 Mr. {Stearns.} Good morning, everybody. The
30 subcommittee will come to order.

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

41 Generally, Medicare is the ``primary payer'' for health
42 claims. If a beneficiary has other insurance, that insurance
43 may fill in all or some of Medicare's gaps. However, the
44 Medicare Secondary Payment program identifies specific
45 conditions under which another party is legally responsible
46 to be the primary payer. In such cases, Medicare is only
47 responsible for certain secondary payments. The Medicare
48 Secondary Payment statute was enacted to reduce expenditures
49 under the Medicare program and ensure that Medicare is
50 properly reimbursed for such payments.

51 The law prohibits Medicare payments for any item or

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

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

72 This raises several questions. Why can't CMS more
73 quickly and accurately track medical costs for covered
74 individuals? And is CMS even capable of administering a
75 health payment program for the medical community or

76 accurately tracking costs? Based on a hearing in this
77 subcommittee earlier this year, we already know that CMS
78 cannot accurately measure the amount lost to fraud and that
79 CMS doles out tens of billions of dollars in improper
80 payments every year. And we have yet to see reliable
81 estimates on the total amount of secondary payment
82 reimbursements that remain uncollected by CMS.

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

92 CMS now says that they plan to increase education and
93 awareness for the legal community on the requirements of
94 Medicare Secondary Payer, which has been on the books for
95 almost 30 years. That CMS needs to educate people on a 30-
96 year-old law brings into question what they have been doing
97 for the past 30 years and how effective their outreach
98 efforts have been. I think more needs to be done, obviously.
99 Whenever retailers, insurance companies, and plaintiffs'

100 attorneys are all sending letters to CMS, anxious to pay the
101 Federal Government, and they can't get a complete or timely
102 response about how much they owe, the system is badly broken.

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

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

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

112 [The prepared statement of Mr. Stearns follows:]

113 ***** COMMITTEE INSERT *****

|
114 Ms. {DeGette.} Thank you very much, Mr. Chairman.

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

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

133 We heard the story of one Medicare beneficiary who
134 brought a case against a drunk driver that hit her. The case
135 was ultimately settled. The beneficiary was told years later
136 that she had to pay Medicare back using the proceeds of her

137 settlement for medical costs related to the car accident or
138 that the Treasury Department would seize her Social Security
139 checks. Unfortunately, there are other seniors with similar
140 stories.

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

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

156 To the extent that this is not happening, I want to hear
157 about how the Agency can improve and about whether CMS needs
158 more tools from Congress to make sure that the program works
159 better. I think we can also have illuminating testimony from
160 GAO and representatives from groups that are affected by the

161 Medicare Secondary Payer rules in the second panel today.

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

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

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

184 Congress certainly has a legitimate interest in ensuring

185 our constituents are being treated fairly under Medicare
186 Secondary Payer rules. I look forward to today's hearing and
187 really focusing on the solutions to address any problems that
188 remain.

189 Thank you, and I yield back.

190 [The prepared statement of Ms. DeGette follows:]

191 ***** COMMITTEE INSERT *****

|
192 Mr. {Stearns.} The gentlelady yields back. And the
193 gentleman from Texas, Mr. Burgess, is recognized for 2
194 minutes.

195 Dr. {Burgess.} I thank the chairman.

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

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

215 for another beneficiary.

216 Mr. Chairman, I know our staffs have spoken and I hope
217 we can continue similar oversight into the Medicaid program
218 as well. Congress has clearly agreed through the fall
219 statements regarding health matters in the Deficit Reduction
220 Act, but State Medicare authorities should always work to
221 assure that Medicaid is the payer of last resort. Since
222 1980, statute has required State Medicaid plans to take
223 reasonable measures to avoid medical claims for which the
224 beneficiary has other health insurance that is legally
225 primary to Medicaid. In 2003, audits of six Medicaid
226 authorities uncovered problems with between 20 and 36 percent
227 of claims sampled. Extrapolating nationwide, we could be
228 talking about \$45 billion per year. I also look forward to
229 the updated information from the General Accountability
230 Office on the Medicare Secondary Payment System program.

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

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

238 [The prepared statement of Dr. Burgess follows:]

239 ***** COMMITTEE INSERT *****

|
240 Mr. {Stearns.} Thank you. The gentleman from
241 Pennsylvania, Mr. Murphy, is recognized for 3 minutes.

242 Mr. {Murphy.} Thank you, Mr. Chairman.

243 Only in Washington can someone who wants to send money
244 back to the Federal Government be ignored. But that is the
245 situation we are dealing with now with some of this
246 difficulty we have with this problem. We want to preserve
247 Medicare for seniors. It is important. It is essential.
248 But it is a mess. What is critically important for our
249 seniors' health is also critically ill itself and bleeding
250 money.

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

257 Under the current law, the Medicare Secondary Payer
258 statute is supposed to ensure the taxpayers don't foot the
259 bill for senior citizens' medical expenses if the injury
260 resulted from a case involving third-party liability. That
261 makes sense, but it loses dollars because the system just
262 doesn't work. Plaintiffs and defense attorneys, retailers,

263 employers, and senior citizens all cry out that the system is
264 a mess, but CMS, like Kevin Bacon's character of Chip Diller
265 in Animal House raises his hand and says remain calm; all is
266 well.

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

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

284 The SMART Act will also prevent another kind of horror
285 story. These are cases where Medicare has denied medical
286 treatment to a senior citizen for breast cancer because she

287 received a settlement check related to a chest wall contusion
288 suffered from a slip and fall years ago. This year, Medicare
289 may collect an estimated 230 million from cases like auto
290 accidents and slip-and-falls. And if the SMART Act were
291 enacted into law, Medicare could see annual collections
292 quadruple to \$1 billion per year.

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

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

305 So I thank the chairman for this investigation. We have
306 an opportunity with passing the SMART Act to be responsible
307 stewards of the trust fund, because all of us deeply care
308 about protecting the Medicare benefits that our constituents--
309 --especially our senior citizens--have earned.

310 And I yield back.

311 [The prepared statement of Mr. Murphy follows:]

312 ***** COMMITTEE INSERT *****

|
313 Mr. {Stearns.} I thank the gentleman. The Ranking
314 Member Mr. Waxman from California is recognized for 5
315 minutes.

316 Mr. {Waxman.} Thank you very much, Mr. Chairman.

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

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

336 Medicare.

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

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

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

358 Many of my Republican colleagues have bashed Medicare
359 and supported turning the program over to private insurance

360 companies on the basis that no government program can do an
361 effective job compared to the private sector. We hear these
362 arguments. One of the key talking points is that Medicare
363 has extremely high erroneous payment rates. Their
364 implication is clear that Medicare's error rate is higher
365 than error rates of private insurers. But that simply is
366 false. Earlier this week, the American Medical Association
367 released their annual report card on insurers. The AMA found
368 that Medicare had the highest payment accuracy rate among all
369 providers, 96 percent. Private insurers' payment accuracy
370 rates were five times higher than Medicare. This is a great
371 example of Medicare leading the way and doing better than the
372 private sector when it comes to cutting waste.

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

381 These dramatic changes to Medicare pose a much greater
382 risk to seniors than the problems in the Medicare Secondary
383 Payer program. That is why I sent a letter to Chairman Upton

384 last month asking for hearings on the Republican budget's
385 impact on Medicare and Medicaid. Now that we have started
386 Medicare work in this subcommittee, I hope our next oversight
387 hearing can look at the impacts of the Republican budget on
388 this key program for seniors and the disabled.

389 I yield back the balance of my time.

390 [The prepared statement of Mr. Waxman follows:]

391 ***** COMMITTEE INSERT *****

|
392 Mr. {Stearns.} I thank the gentleman.

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

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

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

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

415 [Witnesses sworn.]

416 Mr. {Stearns.} Thank you. Now, each of you can give
417 your 5-minute opening statement. Ms. Taylor, we will start
418 with you.

|
419 ^TESTIMONY OF DEBORAH A. TAYLOR, CHIEF FINANCIAL OFFICER AND
420 DIRECTOR, OFFICE OF FINANCIAL MANAGEMENT, CENTER FOR MEDICARE
421 AND MEDICAID SERVICES; AND JAMES COSGROVE, DIRECTOR, HEALTH
422 CARE ISSUES, U.S. GOVERNMENT ACCOUNTABILITY OFFICE

|
423 ^TESTIMONY OF DEBORAH A. TAYLOR

424 } Ms. {Taylor.} Good morning, Chairman Stearns and
425 Ranking Member DeGette and members of the subcommittee.

426 Mr. {Stearns.} I think, Ms. Taylor, you have to push
427 the button and bring the mic a little closer.

428 Ms. {Taylor.} Okay.

429 Mr. {Stearns.} There you go.

430 Ms. {Taylor.} Good morning, Chairman Stearns, Ranking
431 Member DeGette, and members of the subcommittee. Thank you
432 for the opportunity to be here today to discuss the Centers
433 for Medicare and Medicaid Services' Medicare Secondary Payer
434 program. The Medicare Secondary Payer program, also known as
435 MSP, is an important program that protects both Medicare
436 beneficiaries and the sustainability of the Medicare program.
437 The purpose of the MSP program is to ensure that Medicare
438 pays primary when appropriate and recovers monies when
439 Medicare should pay secondary to another insurer. While MSP

440 is specific to Medicare, all insurance providers, public and
441 private, utilize a system similar to the MSP to resolve
442 conflicting coverage issues with other carriers. MSP
443 policies establish when certain other insurance payers have
444 primary responsibility for the healthcare services of a
445 person with Medicare.

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

457 The second MSP situation arises when a Medicare
458 beneficiary is harmed or injured and receives a settlement
459 payment from another insurer, usually an automobile liability
460 or workers' compensation insurer. These cases are often
461 referred to as a non-group health plan cases. These cases
462 require close communication and coordination between CMS, the
463 beneficiary, and their representatives, usually an attorney.

464 In order to ensure continuity of care for Medicare
465 beneficiaries, Medicare may pay conditionally for the
466 healthcare of the beneficiary under these situations. If
467 Medicare makes a conditional payment, Medicare has a
468 statutory right to recover from the insurer legally required
469 to pay for this care.

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

479 To facilitate a smooth transition of these mandatory
480 reporting requirements, CMS took a transparent, open approach
481 to establishing the requirements. We developed standardized
482 electronic reporting processes and work collaboratively with
483 the insurance industry to define and test this process. We
484 established a website where insurers can find all official
485 instructions and guidance related to the mandatory reporting
486 requirements. We held town hall conferences with over 34,000
487 representatives from insurance industry, trade associations,

488 and attorney groups, and we developed computer-based training
489 on MSP policies and mandatory reporting requirements.

490 As a result of our efforts, the overall number of MSP
491 records posted to CMS's systems has more than doubled over
492 the past 3 years. This increased activity represents a
493 potential for even greater savings to provider care trust
494 fund in coming years.

495 We continue to leverage technology to improve our
496 processes and further increase our rate of return. We have
497 made Medicare information directly accessible to
498 beneficiaries, their representatives, and the industry. We
499 have expanded the MyMedicare.gov website to provide more
500 information about the MSP program and to assist
501 beneficiaries. We also developed mechanisms to automate many
502 of the reporting and recovery processes.

503 CSM is committed to a transparent MSP process and ensure
504 that Medicare beneficiaries receive the care they need while
505 reducing Medicare payments for claims that are the legal
506 responsibility of another insurer or liable party. We remain
507 committed to improving the MSP program and maintaining strong
508 communications with our beneficiaries, insurers, and other
509 stakeholders.

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

512 [The prepared statement of Ms. Taylor follows:]

513 ***** INSERT 1 *****

514 | Mr. {Stearns.} Thank you. Dr. Cosgrove?

|
515 ^TESTIMONY OF JAMES COSGROVE

516 } Mr. {Cosgrove.} Mr. Chairman, Ranking Member DeGette,
517 members of the subcommittee, thank you for inviting me to
518 speak to you today as you consider potential improvements to
519 Medicare's Secondary Payer process.

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

530 In 1980, Congress made Medicare a secondary payer to
531 other non-group health plans, which include auto or other
532 liability insurance and no-fault insurance. Shortly
533 thereafter, Congress made Medicare the secondary payer in
534 most instances where the beneficiary is currently employed or
535 has a spouse who is currently employed and is covered by an
536 employer-sponsored group health plan. Both group and non-

537 group health plans had a legal obligation to identify
538 situations where they were the primary payers, notify
539 Medicare, and pay appropriately. However, there were
540 concerns that this did not always happen and that Medicare
541 sometimes paid for care that should have been covered by
542 other insurers.

543 The Medicare and Medicaid and SCHIP Extension Act of
544 2007 established specific MSP reporting requirements and
545 fines for noncompliance. For example, non-group health plans
546 must inform CMS when they have reached a settlement with a
547 beneficiary in an MSP situation. The Congressional Budget
548 Office estimated that the law's provisions would help
549 Medicare recover or avoid \$1.1 billion in improper payments
550 over 10 years. Mandatory reporting requirements for group
551 health plans when into effect January 2009. Mandatory
552 reporting for non-group health plans was delayed until
553 January 2011 for certain types of these plans and until
554 January 2012 for the rest.

555 My remarks today will describe the 5 major components of
556 the MSP process for situations involving non-group health
557 plans. These are notification, negotiation, resolution,
558 mandatory reporting, and recovery. The order of the
559 components and the details of the process and CMS's
560 involvement at various stages may vary somewhat depending on

561 the circumstances of the case. I think the best way to
562 understand how the MSP process works in general is through an
563 example, and that is what is included in our written
564 statements.

565 We have a graphic, and this is Figure 2 and page 8 in
566 our written statement, but it tries to illustrate graphically
567 how the MSP process might work when a Medicare beneficiary is
568 injured in an automobile accident. In this simplified
569 example, it begins when an injured Medicare beneficiary goes
570 to the hospital. The hospital treats the beneficiary and
571 eventually submits a bill to Medicare. Notification happens
572 when CMS first learns of the MSP situation. In this example,
573 the beneficiary's attorney notifies CMS and requests a list
574 of payments Medicare made to the hospital. CMS's contractor
575 provides this information, and although notified, Medicare
576 may continue to make payments called ``conditional payments''
577 so that the beneficiary will have access to necessary medical
578 care while the beneficiary's attorney negotiates with the
579 automobile insurer.

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

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

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

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

609 other members may have.

610 [The prepared statement of Mr. Cosgrove follows:]

611 ***** INSERT 2 *****

|
612 Mr. {Stearns.} Yes. I will start with my questions.

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

619 Mr. {Cosgrove.} Um-hum.

620 Mr. {Stearns.} --where it seems to be the conflict, is
621 there something you would suggest for Congress to do?

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

626 Mr. {Stearns.} So the answer is no. You don't know?

627 Mr. {Cosgrove.} I don't know.

628 Mr. {Stearns.} Okay. Ms. Taylor, can you provide
629 information on the number of Medicare Secondary Payment cases
630 CMS is handling today?

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

634 Mr. {Stearns.} I need you to pull the mic a little

635 closer if you can.

636 Ms. {Taylor.} I believe for the non-group health plan
637 cases--

638 Mr. {Stearns.} Okay. I got that. This would include
639 liability, workmen's compensation, and no-fault automobile
640 Medicare Secondary Payment cases?

641 Ms. {Taylor.} Correct.

642 Mr. {Stearns.} And that is your number is roughly 400?

643 Ms. {Taylor.} I believe that is the number that we have
644 right now.

645 Mr. {Stearns.} How many were handled last year?

646 Ms. {Taylor.} Last year, probably about the same.

647 Mr. {Stearns.} Okay. Is this typically a number that
648 remains constant every year? Is it roughly about 400?

649 Ms. {Taylor.} What I can tell you is that since the
650 Medicare and Medicaid SCHIP Extension Act of 2007, our
651 casework, our workload has more than doubled.

652 Mr. {Stearns.} Okay. How long, Ms. Taylor, have you
653 been in this position as a CFO?

654 Ms. {Taylor.} For about a year and a half.

655 Mr. {Stearns.} What did you do before that?

656 Ms. {Taylor.} I was the deputy to the director of
657 office--

658 Mr. {Stearns.} Okay. How much money is involved in the

659 Medicare Secondary Payment process each year? How much is
660 reimbursed to the trust fund.

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

664 Mr. {Stearns.} Does CMS keep track of how much money is
665 reimbursed by class or type?

666 Ms. {Taylor.} I believe we have that information but I
667 don't have that--

668 Mr. {Stearns.} For example, how much is workers' comp
669 and, for example, how much is auto accident?

670 Ms. {Taylor.} I believe we can get that information. I
671 just don't have that with me.

672 Mr. {Stearns.} In your opinion, is it being reimbursed
673 by class or type? Is it distinguished?

674 Ms. {Taylor.} I believe it is, yes. I believe our
675 contractor does maintain information about which type of
676 insurer they are working with, yes.

677 Mr. {Stearns.} Do you mind submitting that for the
678 record?

679 Ms. {Taylor.} Sure.

680 Mr. {Stearns.} Okay. Does CMS ever attempt to estimate
681 the number or amount of secondary payment cases under which
682 CMS does not get reimbursed?

683 Ms. {Taylor.} I don't believe we do track that
684 information.

685 Mr. {Stearns.} Um-hum. Who was in this position before
686 you?

687 Ms. {Taylor.} Prior to me Tim Hill had the job that I
688 currently have.

689 Mr. {Stearns.} And how long was he in that position?

690 Ms. {Taylor.} I believe 5 years.

691 Mr. {Stearns.} Okay. Does CMS have an idea how much
692 money that should be reimbursed that is not?

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

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

704 Ms. {Taylor.} We don't keep any records that say we
705 need to suspend this case. It is a--

706 Mr. {Stearns.} I don't mean suspend but I mean let us

707 say a case goes on and on and on and on. Do you as a CFO get
708 a weekly or a monthly record that is saying of these 400
709 cases, 50 of them have gone on for 10 months, 3 months?

710 Ms. {Taylor.} I believe we do get information about the
711 age of the cases.

712 Mr. {Stearns.} That is what I mean, the age of the
713 case.

714 Ms. {Taylor.} What we don't get is the reason for the
715 age.

716 Mr. {Stearns.} Okay.

717 Ms. {Taylor.} So it could sometimes be because the--

718 Mr. {Stearns.} Do you physically see this come across
719 your desk, the age?

720 Ms. {Taylor.} I don't physically get that, no.

721 Mr. {Stearns.} Do you have any interest in seeing that
722 so you can say to the people, let us get moving?

723 Ms. {Taylor.} I have an absolute interest in this MSP
724 recovery process, and it is subjected to our audit by our CFO
725 auditors.

726 Mr. {Stearns.} Okay. How much does CMS spend on
727 conditional payments for treatment and services, coverage for
728 which is the responsibility of non-group health plans on an
729 annual basis? Do you know?

730 Ms. {Taylor.} I do not know. I just know what the

731 annual recoveries are.

732 Mr. {Stearns.} How much does CMS recover annually for
733 these claims?

734 Ms. {Taylor.} Last year, we recovered about \$400
735 million.

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

741 Ms. {Taylor.} I don't have any information on that.

742 Mr. {Stearns.} Does that 4 billion seem reasonable to
743 you?

744 Ms. {Taylor.} I honestly couldn't remark on that. We
745 are relying on the individuals to report these cases to us.

746 Mr. {Stearns.} All right. Thank you.

747 Ms. {Taylor.} Um-hum.

748 Mr. {Stearns.} I recognize Ms. DeGette.

749 Ms. {DeGette.} Thank you very much, Mr. Chairman.

750 Before I begin my questions, I want to welcome these Close Up
751 students who have joined us. What you are seeing today is
752 the legislative process in action, and oftentimes people from
753 the outside world who come in and see us don't realize that
754 much of what we do is in a bipartisan way in Congress. And

755 what we are trying to do in this hearing today is figure out
756 how we can both protect taxpayers and also Medicare
757 beneficiaries in getting more money recovered from these
758 accidents so we can keep our program safe and solvent. So
759 this is an Oversight hearing and this is the kind of work
760 this committee does, and we are delighted to have you, and we
761 are sorry we don't have seats for more of you.

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

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

769 Ms. {Taylor.} That is correct. The number is 58
770 billion.

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

775 Ms. {Taylor.} Yes, that is correct.

776 Ms. {DeGette.} And it is also important, though, that
777 the CMS be responsive to the needs and the concerns of the
778 beneficiaries because it really doesn't make sense either in

779 a fiscal way to have beneficiaries to have to wait months to
780 get basic information that they need to reach settlements in
781 cases. And it frankly seems very unfair for beneficiaries to
782 face huge and unexpected demands to pay funds back to
783 Medicare years after they have settled.

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

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

797 Ms. {Taylor.} We are constantly between that delicate
798 balance of ensuring that the trust fund recover monies while
799 ensuring that our beneficiaries receive the care they need
800 and ensuring that we recover monies that are due back to the
801 trust fund. So yes, that is absolutely--

802 Ms. {DeGette.} And in a timely fashion I would say?

803 Ms. {Taylor.} Absolutely.

804 Ms. {DeGette.} Now, Dr. Cosgrove, can you offer us any
805 insight here based on GAO's work?

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

819 Ms. {DeGette.} By the end of the year. Mr. Chairman,
820 probably I can see a follow-up hearing coming along.

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

825 Ms. {Taylor.} There is probably two sets of things that
826 we have done. One is we are making information more

827 accessible to beneficiaries. So we are providing them
828 education about their responsibilities with MSP, but we are
829 also making it able so that Medicare beneficiaries can see
830 their claims real time and be able to tell their attorneys
831 these are the claims that I know have been processed and paid
832 by Medicare.

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

842 Ms. {DeGette.} And do any of these improvements need
843 congressional action that you think would help?

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

846 Ms. {DeGette.} Thank you.

847 Thank you very much, Mr. Chairman.

848 Mr. {Stearns.} I thank the gentlelady. The gentleman
849 from Texas, Dr. Burgess, recognized for 5 minutes.

850 Dr. {Burgess.} Thank you, Chairman Stearns. And some

851 of my questions are going to follow along the same lines that
852 Chairman Stearns was asking.

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

855 Ms. {Taylor.} So according to our guidelines, we want
856 to work with insurers within 65 days to resolve cases. Then
857 we allow them 30 days for dispute and then another 60 days to
858 sort of resolve that dispute. So ideally, it could take 120,
859 150 days to resolve a case. We do have workload issues, so
860 there are cases that have aged beyond that 150 days. We
861 certainly know that working on a lawsuit takes time. So it
862 can take anywhere between the ideal of 120 days to 6 months
863 to resolve a case.

864 Dr. {Burgess.} Do any of these cases ever linger for
865 years?

866 Ms. {Taylor.} I am not aware of any, but I certainly
867 have heard that there are stories out there that have them go
868 on beyond a year.

869 Dr. {Burgess.} Is there ever a statute of limitations
870 beyond which you would not try to go back and recover from a
871 beneficiary?

872 Ms. {Taylor.} If someone reports something to us, we at
873 least have the responsibility to look into it.

874 Dr. {Burgess.} Having run a medical practice--and I

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

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

891 Dr. {Burgess.} Now, the contractors that you hire, do
892 they have any performance guidelines that they are required
893 to meet?

894 Ms. {Taylor.} They do, yes, but they did not anticipate
895 some of the activities we are seeing now.

896 Dr. {Burgess.} Well, and how are we overcoming that
897 lack of anticipation now?

898 Ms. {Taylor.} We are rewriting a Statement of Work with

899 very different metrics and different performance
900 requirements.

901 Dr. {Burgess.} And these contractors, is this a
902 competitive bidding situation where you put these proposals--

903 Ms. {Taylor.} Yes, it will be going forward.

904 Dr. {Burgess.} It will be but currently are these
905 competitively bid currently?

906 Ms. {Taylor.} The current contractor was not
907 ``competitively bid'' but it was done under all the fall
908 requirements that the government requires.

909 Dr. {Burgess.} But going forward, you are actually
910 going to go beyond that?

911 Ms. {Taylor.} Yes, absolutely.

912 Dr. {Burgess.} How long do you anticipate that will
913 require?

914 Ms. {Taylor.} We expect to have a Statement of Work on
915 the street this fall.

916 Dr. {Burgess.} And you will share that with the
917 committee, obviously.

918 Dr. Cosgrove, let me ask you a question on your Figure 2
919 illustration on page 8. It seems as if--and maybe I missed
920 the discussion--but at some point in these little block
921 diagrams, the mandatory reporting block diagram, there has
922 got to also be an arrow going back to the beneficiary

923 informing them of their responsibilities under this, because
924 what Ms. DeGette said was exactly correct. You have someone
925 who it has been so far removed, the accident, the medical
926 costs, the reimbursement, and now they get this nice check
927 because their government loves them and sent them a check
928 because they were injured and so it is theirs to spend. I
929 mean I understand how that thought process works. How can we
930 improve that loop so that the beneficiary has some
931 understanding of what their obligations are, what their
932 requirements are under the law?

933 Mr. {Cosgrove.} Well, I think that is an excellent
934 point because that is critical for the beneficiary to
935 understand their responsibilities. My understanding from the
936 work that we have done so far is that partly the
937 responsibility is on CMS to provide information to
938 beneficiaries so they know what their responsibilities are.
939 I frankly don't know right now what the non-group health
940 plans' responsibilities are to do similar when the recovery
941 is--

942 Dr. {Burgess.} For notification--

943 Mr. {Cosgrove.} For notification. But that is
944 something we will definitely be looking into.

945 Dr. {Burgess.} All right. Thank you.

946 I yield back, Mr. Chairman.

947 Mr. {Stearns.} The gentleman yields back.

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

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

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

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

969 Ms. {Taylor.} Yes.

970 Mr. {Dingell.} You do? What is that timeline?

971 Ms. {Taylor.} I believe it is 65 days.

972 Mr. {Dingell.} Is it honored?

973 Ms. {Taylor.} We do have workload issues that have
974 created the inability for the contractor to get back--

975 Mr. {Dingell.} I will be asking some information about
976 that. Does CMS or the contractor collect data on the average
977 response time in these communications? Yes or no?

978 Ms. {Taylor.} I believe they do, yes.

979 Mr. {Dingell.} Now, can you tell me what the average
980 response time is? Submit that for the record, if you please.

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

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

990 Mr. {Dingell.} Would you submit that in greater detail
991 for the record, please?

992 Ms. {Taylor.} Yes.

993 Mr. {Dingell.} Now, could you tell me what the average
994 time might be?

995 Ms. {Taylor.} I don't--

996 Mr. {Dingell.} Please submit that for the record.

997 Now, a further concern is the length of time it takes
998 for beneficiaries and their attorneys to obtain a demand
999 letter that informs the beneficiary and their attorney of the
1000 MSP claim. This delay impedes the ability of beneficiaries
1001 and their attorneys to move forward towards a settlement, and
1002 again, ultimately delays reimbursement to Medicare. Does CMS
1003 currently require the contractor to issue a demand letter
1004 within a specific timeline? Yes or no?

1005 Ms. {Taylor.} Yes.

1006 Mr. {Dingell.} You do? Now, would you submit for the
1007 record what that average response time is?

1008 Ms. {Taylor.} Yes.

1009 Mr. {Dingell.} Now, next question. In your opinion,
1010 Director Taylor, what is needed to improve the responsiveness
1011 of CMS and its contractors to beneficiaries and their
1012 attorneys? Is it a new contractor that is better equipped to
1013 handle these claims or is it the need for additional funding
1014 and personnel to manage the caseload? Finally, another
1015 concern raised by a witness on the second panel, Mr. Salm of
1016 Publix, is the inefficiency of pursuing smaller claims. His
1017 testimony cites the example of Medicare pursuing cases as
1018 small as \$1.59. Now, I am just a poor Polish lawyer from

1019 Detroit, but even I know staff time used to collect a claim
1020 here for \$1.59 would far exceed recovery. Question: Does CMS
1021 have in place a threshold for MSP recovery?

1022 Ms. {Taylor.} We do not but we are looking at that,
1023 yes.

1024 Mr. {Dingell.} Do you think that that is something that
1025 you ought to do because you may be wasting money and flailing
1026 around trying to collect money that frankly is far too small
1027 to confer any benefit on you in view of the costs?

1028 Ms. {Taylor.} We are looking at that, absolutely. We
1029 think we can establish a threshold. I will comment, though,
1030 that it is an automated process. Once a beneficiary's case
1031 is identified and claims are identified associated with that
1032 case, it is an automatic generated bill. So it is not a
1033 manual process--

1034 Mr. {Dingell.} I would like to have you make a
1035 submission for the record on that point.

1036 Ms. {Taylor.} Okay.

1037 Mr. {Dingell.} Next question. Does CMS have in place a
1038 threshold for MSP recovery? I think you have indicated that
1039 it does not, meaning that an MSP claim, if it is less than
1040 the cost of staff time to collect CMS or the contractor would
1041 not pursue? Yes or no?

1042 Ms. {Taylor.} That is correct.

1043 Mr. {Dingell.} All right. Thank you, Mr. Chairman. I
1044 note that I have gone 19 seconds over.

1045 Mr. {Stearns.} Well, I thank the gentleman emeritus of
1046 the full committee. And I hope, Ms. Taylor, that Mr.
1047 Dingell's request, that you made note of them. I didn't see
1048 you make note of them. Our staff did but he has requested
1049 quite a bit of information, which I think would be useful for
1050 both sides to see.

1051 Ms. {Taylor.} Um-hum.

1052 Mr. {Stearns.} And I think his point is well taken that
1053 the fact that you are continuing to pursue something for
1054 \$1.30 or something like that. After 30 years, it seems like
1055 that should have--

1056 Mr. {Dingell.} \$1.59.

1057 Mr. {Stearns.} \$1.59--that after all 30 years, it seems
1058 like you should have thought that out. I would be glad to
1059 yield.

1060 Mr. {Dingell.} --to get answers to the questions and
1061 see to it that they are put into the record and I would ask
1062 unanimous consent that the record remain open for the
1063 purposes of receiving the answers to me that have been
1064 requested.

1065 Mr. {Stearns.} By unanimous consent, so ordered. And
1066 with the emeritus of the full committee's background on

1067 Medicare, it is very helpful for the oversight and I
1068 appreciate his participation with that.

1069 We recognize Mr. Murphy for 5 minutes.

1070 Mr. {Murphy.} Thank you, Mr. Chairman.

1071 Ms. Taylor, you are the chief financial officer and
1072 director of the Office of Financial Management for the Center
1073 for Medicare and Medicaid Services?

1074 Ms. {Taylor.} Correct.

1075 Mr. {Murphy.} All right. Now, you cited us 413,000
1076 cases, which you said is a large number and has strained the
1077 system. Am I correct in that?

1078 Ms. {Taylor.} That is the number for the non-group
1079 health plans.

1080 Mr. {Murphy.} Non-group health plans. And that is the
1081 concern we have talking about here. What is the median value
1082 of those 413,000 claims?

1083 Ms. {Taylor.} I don't have the dollar figures in front
1084 of me. I am sorry about that.

1085 Mr. {Murphy.} Okay. You will get that information to
1086 us? Do you have any information, for example, of how many
1087 might be under \$50 or \$100, \$500, \$1,000?

1088 Ms. {Taylor.} I don't know that off the top of my head
1089 but the reporting requirements is at \$5,000, so \$5,000 for
1090 liability and I believe it is 7,500 for workers' comp.

1091 Mr. {Murphy.} Do you even collect information on things
1092 under \$5,000? I mean you send out letters for \$1.59. We
1093 have that established.

1094 Ms. {Taylor.} Correct.

1095 Mr. {Murphy.} But you don't collect the data on how
1096 many cases you have of that sort of that 413,000?

1097 Ms. {Taylor.} We track how much the cases are but I
1098 don't know that I have that with me at this moment, no.

1099 Mr. {Murphy.} I am confused because on the one hand you
1100 are saying you don't get that information but you can get the
1101 information?

1102 Ms. {Taylor.} If someone reports a case to us, the
1103 threshold is \$5,000 to report a case. So if there is a
1104 settlement for \$3,000, they would not be required to report
1105 that case to us.

1106 Mr. {Murphy.} All right. So if you don't have that
1107 information, you are going to have difficulty giving us that
1108 information. If you don't have the information as a chief
1109 financial officer, you don't have the information you need to
1110 be the CFO. Just my observation. And I would think it is
1111 foolish of me to say if I found a coupon that I could get a
1112 can of tomato soup for 10 cents but I had to drive 100 miles
1113 to the store to get it, somehow in that judgment I would say
1114 it is probably not worth it for me to do that, which brings

1115 us back to this information. And then this tags along with
1116 what the gentleman from Michigan, Mr. Dingell, said on a
1117 number of these claims that are a small number, if the actual
1118 cash value is so small that it would cost us more to pursue
1119 than to get it, but I am not sure you have the data to do
1120 that. It may not be we are able to take action.

1121 But let me ask a couple more things here. So we don't
1122 know the median value of these claims. We don't things about
1123 that. Is it true that in Section 111 of the statute, it is
1124 going to require collection of information so long as it is
1125 greater than one penny, even if there were no medical bills?
1126 Am I correct that that is in the--

1127 Ms. {Taylor.} I am not aware of that portion of the
1128 provision.

1129 Mr. {Murphy.} Okay. It would probably be a good thing
1130 for the CFO to know. My understanding is that is true, and
1131 so if there was a \$25 gift card given out by a store to
1132 settle a potential case with a senior citizen, you would want
1133 to know that, too, as another level of settlement? But I
1134 understand that that is being asked for. Would you get us
1135 that information?

1136 Ms. {Taylor.} Yes.

1137 Mr. {Murphy.} I am frustrated here because we are
1138 trying to get information on something I am not sure you

1139 collect the very data that we are trying to find out. I have
1140 heard the current reporting system is prone to error and that
1141 CMS rejects a high percentage of the reports when first
1142 submitted. Any idea how many reports are initially rejected
1143 versus completed on the initial submission?

1144 Ms. {Taylor.} I am not aware of that number. I do know
1145 that we have reporting requirements and reporting elements
1146 that are required so it would be that cases are rejected
1147 because data is not provided adequately.

1148 Mr. {Murphy.} Are you aware of some I referenced in my
1149 opening statement here that Rand Corporation just completed a
1150 study that found if you only looked at settlements greater
1151 than \$5,000 instead of every single settlement, your
1152 collections would fall by only 2.4 percent, but the number of
1153 claims you were pursuing would fall by 43 percent, and you
1154 still collect roughly \$1 billion from non-group health plans
1155 if you only looked at claims greater than \$5,000. Are you
1156 familiar with that Rand study?

1157 Ms. {Taylor.} I am not familiar with that Rand study.

1158 Mr. {Murphy.} Have you looked at putting in a threshold
1159 dollar level for that, then?

1160 Ms. {Taylor.} We absolutely are looking at that right
1161 now.

1162 Mr. {Murphy.} Okay. Is this just in the earliest

1163 levels of review of this whole issue from your agency?

1164 Ms. {Taylor.} Yes, it is.

1165 Mr. {Murphy.} I guess it comes down to this, too. It
1166 would be very beneficial for Congress and obviously for
1167 Medicare, which I know you care deeply about is financial
1168 stability. That is why you are in the job you are in. It
1169 would help us all--and I think we are on the same team--if we
1170 could find what kind of saving is in this. With Medicare
1171 basically going bankrupt and I am sure you are having many a
1172 nail-biting moment trying to find the dollars for this, it
1173 would really help us if you could just really open all the
1174 drawers and lift up all the rugs and find everywhere possible
1175 in this to make this more efficient.

1176 And I hope you will also take a look at the SMART Act
1177 that a number of us on both sides of the aisle have
1178 submitted. And finally, I might suggest this and ask this:
1179 Have you met with the people who have a stake in this such as
1180 defense attorneys, plaintiffs' attorneys, retailers, senior
1181 citizens to ask for their input on some of this information,
1182 too?

1183 Ms. {Taylor.} I, personally, have met with some of
1184 those organizations, but folks who work for me have met with
1185 many more.

1186 Mr. {Murphy.} Well, I would hope that you will take a

1187 look at our Act and I hope you will sit around and listen to
1188 some of the witnesses today because I think that will be eye-
1189 opening for you.

1190 Ms. {Taylor.} Okay.

1191 Mr. {Murphy.} I yield back my time, Mr. Chairman.

1192 Mr. {Stearns.} The gentleman yields back. The
1193 gentleman from Texas, Mr. Green, is recognized for 5 minutes.

1194 Mr. {Green.} Thank you, Mr. Chairman. And I want to
1195 follow my colleague from Pennsylvania. You are required by
1196 law when you put these payment requirements in place, is that
1197 correct?

1198 Ms. {Taylor.} Correct.

1199 Mr. {Green.} So the first year it is \$5,000 and it goes
1200 down to 2,000 and then \$600. And he mentioned the Rand
1201 study, the Rand Institute for Civil Justice study, but for us
1202 to be able to let you do anything like that, we actually need
1203 to change the law.

1204 Ms. {Taylor.} Correct.

1205 Mr. {Green.} Okay. And I agree with my colleague that,
1206 you know, we need to make sure we get the reimbursement, you
1207 know, instead of double paying. We also need to make sure it
1208 is economically feasible--

1209 Ms. {Taylor.} Um-hum.

1210 Mr. {Green.} --and so whether it be exempting 5,000

1211 because you spend less than--it be like 43 percent or if, you
1212 know, you would only lose \$24 million, it would seem like it
1213 would be cost-effective to do that. So maybe that is
1214 something our committee needs to look at and something we
1215 could work on together.

1216 But my main question is I would like to ask you about
1217 contractor performance to work recovering funds owed to
1218 Medicare under the Secondary Payer rules. In 2006, CMS
1219 consolidated the Medicare Secondary Payer Recovery contracts
1220 into a single \$200 million cost-plus contract. CMS awarded
1221 the contract on a sole-source basis to Chickasaw Nation
1222 Industries, a tribally-owned firm based in Oklahoma, the
1223 contractor responsible for identifying Medicare payments to
1224 be recovered, calculating the total amount of the medical
1225 payments potentially ripe for recovery, issuing recovery
1226 demand letters and tracking secondary payer debt.

1227 In 2009, the Senate Subcommittee on Contracting
1228 Oversight initiated an investigation in the Medicare
1229 Secondary Payer contractor. The investigation revealed there
1230 were ongoing problems with the contract. For instance, CMS's
1231 independent auditors concluded that the combination of
1232 controlled efficiencies constitute a significant deficiency.
1233 CMS has also found that the contractor failed to comply with
1234 contractor requirements. The contractor failed to adequately

1235 manage its cases and had major accounting problems.

1236 Ms. Taylor, in 2010, the Senate Subcommittee on
1237 Contracting Oversight called a hearing and at the hearing
1238 Rodney Benson, Director of Acquisitions and Grants Management
1239 at CMS, testified. It is now a year later and what has CMS
1240 done to improve their performance of that recovery
1241 contractor?

1242 Ms. {Taylor.} I can tell you that we have made several
1243 trips to that contractor. We have put them on corrective
1244 action and, as I mentioned before, we are working on a
1245 Statement of Work that will be released this fall and we will
1246 be re-competing that work.

1247 Mr. {Green.} Is there a way you can get that
1248 information to our committee?

1249 And Mr. Chairman, I would appreciate it if we could see
1250 what the progress has been made with that contractor.

1251 Do the improvements of CMS and the contractor fully
1252 rectify the problems in the process?

1253 Ms. {Taylor.} It has rectified some of the problems,
1254 yes, it has.

1255 Mr. {Green.} How long does that contract run?

1256 Ms. {Taylor.} I believe it is up middle of 2012, June
1257 or July of 2012.

1258 Mr. {Green.} What process would you use to select a new

1259 contractor?

1260 Ms. {Taylor.} It would be a competitive process, so we
1261 would put very specific requirements in a Statement of Work
1262 with performance metrics, and we would be accepting bids and
1263 we would be reviewing those bids based on that Statement of
1264 Work.

1265 Mr. {Green.} Well, I am concerned with the problems
1266 identified with the contractor, and this contractor received
1267 the contract through the sole-source process. And CMS's
1268 internal auditors have found that the contractor failed to
1269 comply with these contract requirements, and I am hopeful
1270 that CMS will continue to address the problems with the
1271 contractor and continue to improve the recovery process,
1272 particularly when the contract is up for renewal.

1273 Ms. {Taylor.} Yeah.

1274 Mr. {Green.} So we don't see what has happened. Again,
1275 if it is a \$200 million contract or \$200 million cost-plus
1276 contract, do you have any idea on how much it has cost us so
1277 far for that contractor?

1278 Ms. {Taylor.} I believe it is a \$55 million contract
1279 annually, so over 4 or 5 years it would be \$200 million, but
1280 yes.

1281 Mr. {Green.} Okay. Outside of working with the
1282 contractor, have there been any penalties on their

1283 reimbursement based on the quality of their work?

1284 Ms. {Taylor.} I am not aware of any, no.

1285 Mr. {Green.} Okay. Mr. Chairman, if we could also
1286 check on that. And I know I am almost out of time, so I
1287 appreciate you.

1288 Mr. {Stearns.} No, Ms. Taylor, I think Mr. Green has
1289 made some very good points. I hope you are keeping copious
1290 notes.

1291 The gentleman from Georgia is recognized for 5 minutes.

1292 Dr. {Gingrey.} Mr. Chairman, thank you. And I want to
1293 thank the first panel and very important hearing and the
1294 information you have given has been straightforward from both
1295 of you, and I certainly appreciate that.

1296 Ms. Taylor, I will direct my first question to you. One
1297 of the main complaints that we have heard from those involved
1298 in the Medicare Secondary Payer process is that they are
1299 unable to get a clear statement from CMS as to the amount
1300 that must be repaid to the Medicare Trust Fund.

1301 Your testimony discusses that if there is a disagreement
1302 on the amount of the money owed to Medicare, an individual
1303 can file for a waiver or seek an appeal. I think it would be
1304 very helpful if you could describe that process to us and how
1305 long it takes.

1306 Ms. {Taylor.} Sure. The waiver process typically is

1307 where there is a small dollar settlement. What happens is
1308 our rights are preserved after the settlement occurs. The
1309 beneficiary deducts attorney fees or any out-of-pocket costs
1310 that the beneficiary incurred as a result of any injury or
1311 harm they suffered. And so the amount that then is in--I
1312 won't call dispute--but the amount that then Medicare can use
1313 to recover any is based on the net, the net of the settlement
1314 minus attorney fees and any out-of-pocket costs to the
1315 beneficiary. If those amounts are less than out-of-pocket,
1316 if the settlement is less than the attorney fees or out-of-
1317 pocket costs incurred by the beneficiary, the beneficiary can
1318 waive any amounts owing to Medicare.

1319 Dr. {Gingrey.} Okay. Thank you. Second question for
1320 you also, Ms. Taylor. Members of the committee have been
1321 informed that the current Medicare Secondary Payer process
1322 contains an unfortunate paradox, in some cases that CMS takes
1323 the position that it cannot or will not specify the amount
1324 owed to the Medicare Trust Fund until after a settlement is
1325 reached, but it is that amount that is needed before the
1326 parties can settle. Why is this? How does that happen?

1327 Ms. {Taylor.} So the issue there is the amount of time
1328 it takes to process claims. Providers have up to a year to
1329 submit a claim. If that claim is not submitted, Medicare
1330 still preserves the right to collect against that claim so--

1331 Dr. {Gingrey.} Is it the official position of CMS that
1332 they will not provide an amount before settlement?

1333 Ms. {Taylor.} No. CMS provides an interim amount so we
1334 can look through the claim's data and say this is what we
1335 believe the claims are that have been processed. The problem
1336 is we can't finalize that number until after there is a
1337 settlement. Then we can look through the claims and there
1338 can be a lag in the receipt of those claims.

1339 Dr. {Gingrey.} Okay, thank you. Mr. Cosgrove, I want
1340 to direct these questions to you. Does the Government
1341 Accountability Office believe that there are areas of the
1342 Medicare Secondary Payer regime that should be fixed and what
1343 are those areas?

1344 Mr. {Cosgrove.} Well, we don't know yet.

1345 Dr. {Gingrey.} It is a hard question but--

1346 Mr. {Cosgrove.} Right. We don't know yet but that is
1347 exactly the intention of the study that we are undertaking
1348 right now. Certainly, you know, we have heard concerns that
1349 the process may not be working as well as it should be. The
1350 non-group health plans have raised concerns about some of the
1351 difficulties that they are facing, and so one of the key
1352 objectives of the study is to examine the challenges for the
1353 non-group health plans and for CMS in implementing this
1354 process, as well as them also looking at what are the

1355 potential Medicare savings? What are the costs that CMS is
1356 incurring to do this? And what--

1357 Dr. {Gingrey.} Mr. Cosgrove, excuse me for interrupting
1358 you, but you had I think said earlier in your testimony or in
1359 response to a member's question when this study will be
1360 completed. Will you tell me again when that--

1361 Mr. {Cosgrove.} It is expected by the end of this year.

1362 Dr. {Gingrey.} By the end of this year?

1363 Mr. {Cosgrove.} Right. We are in the early stages
1364 right now.

1365 Dr. {Gingrey.} Last question that I had and again it is
1366 for you, has GAO ever done any work evaluating the public's
1367 knowledge of the need to reimburse Medicare? Now, the reason
1368 I ask that question is because this whole issue of
1369 subrogation comes up.

1370 Mr. {Cosgrove.} Um-hum.

1371 Dr. {Gingrey.} And I don't know whether you are aware
1372 of the fact that I have a medical liability tort reform bill
1373 called the HEALTH Act, and one of the provisions in that bill
1374 says ``collateral source disclosure,'' which in most state
1375 courts that is not required and neither the defendants nor
1376 the plaintiff understands the need for that and clearly
1377 doesn't know about this subrogation rule that is in law in
1378 regard to reimbursing Medicare, whereas most probably private

1379 insurance companies don't have any right to subrogation of
1380 that settlement or claim that the plaintiff receives. So the
1381 question, again, has GAO ever done any work evaluating the
1382 public's knowledge of the need to reimburse Medicare?

1383 Mr. {Cosgrove.} I am not aware of any such study.

1384 Dr. {Gingrey.} Do you think that would be important?

1385 Mr. {Cosgrove.} Absolutely. I think it is important.
1386 This is important for beneficiaries. It could be a
1387 substantial financial liability that they face. And they
1388 need to be fully informed.

1389 Dr. {Gingrey.} Well, I think you are right. And I
1390 certainly agree with that. I see I have already gone over my
1391 time, but thank you all. I thank both of you very much. I
1392 yield back.

1393 Mr. {Stearns.} I thank the gentleman. Ms. Schakowsky
1394 is recognized for 5 minutes.

1395 Ms. {Schakowsky.} Schakowsky.

1396 Mr. {Stearns.} Schakowsky, the gentlelady from
1397 Illinois.

1398 Ms. {Schakowsky.} Thank you, my friend, Mr. Chairman.

1399 I am glad that we, on a bipartisan basis, are looking at
1400 ways to make Medicare more efficient. I am grateful to the
1401 evaluators who are looking at it, to you, Director Taylor,
1402 and to my colleagues because I believe in Medicare and that

1403 we want to make this system as strong as possible, the trust
1404 fund as strong as possible.

1405 And when I hear about the problems that we have in
1406 collecting in a timely way from other party payers, I think
1407 about the Republican plan, which would turn over the whole
1408 system to private insurers. And now I am picturing lawyers
1409 and I am picturing a balkanization of lots of different
1410 insurance companies in charge of the whole program and the
1411 effect that that could have on beneficiaries in trying to get
1412 paid for the services that they need.

1413 And I think that making Medicare work better and
1414 collecting where we should is the focus that we ought to
1415 have, not a new system where we say oh, okay, go to private
1416 insurance companies, you figure out how they are going to pay
1417 for in a timely way the healthcare that you need because we
1418 already have evidence that it is difficult. And now we will
1419 set these elderly people free on their own to try and get
1420 that money. So I want this to go right.

1421 So Director Taylor, we are going to hear from witnesses
1422 on the second panel that the current Medicare Secondary Payer
1423 system is ``making it extremely difficult to settle claims in
1424 a prompt and efficient manner.'' That is the Gilliam
1425 testimony. And ``harming beneficiaries and ironically and
1426 unfortunately harming the trust fund as well,'' and that is

1427 from the Matzus testimony. So I wonder if you would respond
1428 to these characterizations.

1429 Ms. {Taylor.} Sure. I will say that one of the things
1430 is we have been working very closely with industry to ensure
1431 that everyone understands their reporting requirements. I
1432 think that it is taking time for everybody to learn sort of
1433 their responsibilities. We have put all of our instructions
1434 out for industry to understand. Our requirements are
1435 automated. We have made it accessible--either automated or
1436 online ability to report to us. And you know, I think we are
1437 doing everything we can to work very closely with industry to
1438 ensure that everyone has an opportunity to improve the
1439 process.

1440 Ms. {Schakowsky.} Let me say this. Years ago when I
1441 was on the Oversight Committee and I worked with Steve Horn
1442 on the Government Efficiency Subcommittee, we would bring in
1443 agencies, and then 6 months later they would come back and we
1444 would say well, have you made progress? And unfortunately,
1445 more often than not it hasn't been made.

1446 And I would suggest, Mr. Chairman, that we do a follow-
1447 up here, you know, that we have identified problems, you have
1448 identified problems that exist, that we hold ourselves and
1449 you accountable to make sure that we come back and check on
1450 that and see if the systems that you have put in place,

1451 perhaps and maybe hopefully a new contractor--by the way, are
1452 we talking again about a single contractor--competitive
1453 bidding for a single contractor?

1454 Ms. {Taylor.} Yes, we are.

1455 Ms. {Schakowsky.} And would you speak to that a little?
1456 Is that the best way to go, do you think having one
1457 contractor handle this?

1458 Ms. {Taylor.} Well, the reason we went to one
1459 contractor is we did have a study by GAO that said we had
1460 misapplication or inconsistent application of our MSP
1461 policies across contractors. So we did consolidate.
1462 Beneficiaries do transition across the country so it made it
1463 difficult for beneficiaries to navigate different
1464 contractors. So we do think it made sense to consolidate
1465 with one contractor.

1466 Ms. {Schakowsky.} Well, then, how can we deal with the
1467 workload issue which you have identified as a big problem?
1468 Are we going to be able to fix that with one contractor?

1469 Ms. {Taylor.} As part of the Statement of Work, we are
1470 looking at parts of the contractor specializing in different
1471 insurer types of reporting that a contractor might have a
1472 unit that deals with just the automobile insurers or that may
1473 deal with the property and casualty insurers or that would
1474 just do workers' comp. so that they specialize and operate

1475 with certain industries and that they do have those skill
1476 sets to navigate.

1477 Ms. {Schakowsky.} I am out of time, but let us get it
1478 right--

1479 Ms. {Taylor.} Um-hum.

1480 Ms. {Schakowsky.} --and let us make sure. We will
1481 check back that we have gotten it right. Thank you.

1482 Ms. {Taylor.} Thank you.

1483 Mr. {Stearns.} I thank Ms. Schakowsky. And now we
1484 recognize Mr. Griffith from Virginia for 5 minutes.

1485 Mr. {Griffith.} Thank you, Mr. Chairman.

1486 Earlier this year, the President issued an Executive
1487 Order requiring agencies to review regulations to determine
1488 how they could be streamlined to operate in the most
1489 effective and efficient manner. Has any part of the Medicare
1490 Secondary Payer process been identified or reviewed as part
1491 of the President's Executive Order, and if so, which parts?

1492 Ms. {Taylor.} We have reviewed the MSP program and we
1493 have at least put forward the need to have more transparency
1494 into the process. So we have looked at issuing regulation
1495 surrounding the MSP program.

1496 Mr. {Griffith.} Okay. But specifically regarding the
1497 President's Executive Order, have any parts been identified
1498 as part of that Executive Order or as a response to that

1499 Executive Order?

1500 Ms. {Taylor.} The main part is that the requirement for
1501 mandatory reporting and what the responsibilities are
1502 surrounding that.

1503 Mr. {Griffith.} And you may not be in a position to
1504 answer these questions and I understand that, but this is
1505 just something I am curious about. When you have somebody
1506 who is injured, and we will use that classic automobile case,
1507 how do you separate out the settlement as being for medical
1508 expenses and for pain and suffering? That would be number
1509 one. Number two, when you are looking at ongoing expenses,
1510 how do you determine, you know, do you keep going on the
1511 ongoing expenses until you have eaten up the entire
1512 settlement or is there some division that is made? And last
1513 but not least along this line of questioning, what provisions
1514 are made to recognize that in a personal injury case that the
1515 plaintiff has borne the expense of paying the attorney out of
1516 the settlement and does, in fact, your process recognize that
1517 and give credit for those attorneys' fees as a part of the
1518 settlement?

1519 Ms. {Taylor.} It does. The part that we recover is the
1520 net of the settlement taking out attorneys' fees and any out-
1521 of-pocket cost for the beneficiary. I think it is more
1522 difficult to define the pain-and-suffering part of that

1523 settlement, and sometimes--we have been told at least--that
1524 the pain and suffering does sometimes include the healthcare
1525 costs for that beneficiary or the future healthcare costs of
1526 that beneficiary. So pain and suffering is defined by what
1527 their injury is and the cost of those healthcare services
1528 that will be needed for them.

1529 Mr. {Griffith.} Now, I guess that is where we have
1530 heard the indication that sometimes it is hard for you all to
1531 give folks a number.

1532 Ms. {Taylor.} Correct.

1533 Mr. {Griffith.} But it also makes it hard for the
1534 people trying to figure out, you know, how to settle a case
1535 without going through a lengthy litigious process when they
1536 don't know what the lien is going to be.

1537 Ms. {Taylor.} Right.

1538 Mr. {Griffith.} All right. I thank you very much and I
1539 yield back my time, Mr. Chairman.

1540 Mr. {Stearns.} The gentleman yields back. Ms. Taylor,
1541 before you go I think, as Mr. Dingell and others have pointed
1542 out, there is a whole list of things we have given you. It
1543 seems like there are lots of times you did not know. It
1544 seems like since you are the CFO, the chief financial
1545 officer, a lot of the questions we asked you, you should have
1546 known. For example, number of claims for small dollar

1547 amounts; two, the response times for getting information and
1548 payments to beneficiaries; three, median amount of the money
1549 involved with the 413,000 cases; number four, your threshold
1550 you didn't seem to be aware of; number five, you had no idea
1551 how much CMS is failing to collect; number six is asking
1552 about the duration time for the claims settlement. You
1553 didn't have any idea. So I just want to tell you I think the
1554 feeling on both sides is that you just didn't seem to know
1555 much, and so we caution you that if you come back for a
1556 second hearing, we expect you to be able to answer these
1557 questions. I assume you will bring staff with you so that
1558 these questions--you can certainly ask your staff to help
1559 you--but to see a CFO know so little was a little
1560 disappointing.

1561 With that, we will have the second panel come up.

1562 And I hope, Ms. Taylor, you will stick around so you can
1563 hear some of the serious problems. This will be beneficial
1564 to you as the CFO to hear the second panel more specifically
1565 address some of the things we talked about.

1566 I want to welcome the second panel. Marc Salm is vice
1567 president of risk management at Publix Super Markets where he
1568 is responsible for claims, consumer litigation, insurance
1569 purchase, and risk transfer. Scott Gilliam is vice president
1570 and government relations officer with the Cincinnati

1571 Insurance Company. He is responsible for representing the
1572 company's interests with state and federal governments, as
1573 well as other outside groups. Jason Matzus is a partner in
1574 the law firm of Raizman, Frischman, and Matzus where he
1575 practices tort and injury law representing dozens of Medicare
1576 beneficiaries. He is also an adjunct professor of law at the
1577 University of Pittsburgh School of Law. Ilene Stein is a
1578 federal policy director for the Medicare Rights Center's
1579 Washington, D.C. office.

1580 I want to welcome the second panel. As you know, the
1581 testimony you are about to give is subject to Title XVIII,
1582 Section 1001 of the United States Code. When holding an
1583 investigative hearing, this committee has a practice of
1584 taking testimony under oath. Do you have any objection to
1585 taking testimony under oath? No?

1586 The chair then advised you that under the rules of the
1587 House and the rules of the committee, you are entitled to be
1588 advised by counsel. Do you desire to be advised by counsel
1589 during your testimony today? In that case, please rise and
1590 raise your right hand. I will swear you in.

1591 [Witnesses sworn.]

1592 Mr. {Stearns.} Thank you very much. And now, Mr. Salm,
1593 we invite you with your 5-minute summary of your opening
1594 statement.

|
1595 ^TESTIMONY OF MARC SALM, VICE PRESIDENT, RISK MANAGEMENT,
1596 PUBLIX SUPER MARKETS, INC.; SCOTT A. GILLIAM, VICE PRESIDENT
1597 AND GOVERNMENT RELATIONS OFFICER, THE CINCINNATI INSURANCE
1598 COMPANIES; JASON MATZUS, PARTNER, RAIZMAN, FRISCHMAN, AND
1599 MATZUS, P.C.P.; AND ILENE STEIN, FEDERAL POLICY DIRECTOR,
1600 MEDICARE RIGHTS CENTER

|
1601 ^TESTIMONY OF MARC SALM

1602 } Mr. {Salm.} Chairman Stearns, Ranking Member DeGette,
1603 and distinguished members of the subcommittee, good morning,
1604 and thank you for holding this hearing today. I am honored
1605 to appear before the subcommittee to share our experience
1606 with Medicare Secondary Payer program and to offer several
1607 suggestions and ways in which the program can be strengthened
1608 to the benefit of Medicare beneficiaries, affected
1609 stakeholders, and taxpayers across the United States.

1610 I am the vice president of risk management for Publix
1611 Super Markets, one of the Nation's largest employee-owned
1612 supermarket chains. In 2010, we employed 148,000 people
1613 across 1,036 stores in five States. In the chairman's
1614 district alone, Publix operates 38 stores. We have 4,495
1615 associates living in your district, Mr. Chairman, and 5,160

1616 associates who work in your district. We are proud that in
1617 the history of Publix Super Markets we have never laid off a
1618 single employee and that we are consistently ranked as one of
1619 the best places to work in the United States. I am also
1620 appearing today as a representative of the MARC Coalition,
1621 which is a broad-based group of affected shareholders.

1622 Let me start by explaining to you what my view is of how
1623 the MSP process works through the following liability
1624 example. Imagine that Mr. Jones, who is a 76-year-old, falls
1625 down a flight of stairs at the Acme Store and is hospitalized
1626 overnight with a broken leg. Mr. Jones is billed \$40,000 by
1627 the hospital, which Medicare covers and pays at some reduced
1628 rate. Let us say for this example \$10,000. Two years later,
1629 Mr. Jones sues Acme. Acme wants to settle, but knowing that
1630 Medicare has paid for Mr. Jones' medical expenses, it knows
1631 that Medicare will have to be reimbursed. Acme asked
1632 Medicare how much it owes for Mr. Jones' care. Medicare,
1633 however, will not tell Acme that figure claiming that it
1634 cannot do so until the case actually settles. Yet Mr. Jones
1635 and Acme cannot settle unless they know Medicare's numbers.

1636 This is the untenable paradox mentioned by Congressman
1637 Gingrey. It is impossible for parties to figure out how much
1638 Medicare has actually paid. At best, the parties will
1639 typically hold a settlement in escrow for months while the

1640 process plays out. And sometimes the Medicare demand comes
1641 back as a very small amount, as we have heard referred to.

1642 Even if the case does settle, Acme and its insurers have
1643 to report the settlement to Medicare under the recent 2006
1644 amendments to the MSP laws. Now, that might sound
1645 straightforward enough, but to do so, we will need Mr. Jones'
1646 Social Security number to verify that he is a beneficiary and
1647 we also have to identify his Health Information Claim Number,
1648 or HICN, as well as 200 other pieces of information about Mr.
1649 Jones, many of which insurers and defendants in cases have
1650 never previously collected. If they fail to report, Acme and
1651 its insurance companies face potential penalties of up to
1652 \$1,000 per day or \$365,000 per year. And some of this data
1653 is very obscure that they have asked us to collect.

1654 This system hurts the beneficiaries who are unable to
1655 receive their settlements quickly because Medicare is getting
1656 in the way. It also hurts the Medicare Trust Fund because
1657 the funds are delayed even as we are prepared to pay, and it
1658 hurts businesses like Publix who have incurred incredible
1659 additional cost due to the inefficiency of today's system.

1660 I want to share with the committee two recommendations
1661 on the way Congress can improve the MSP process and to make
1662 it work more efficiently. First, I recommend that Congress
1663 address the MSP system and allow CMS, before the final

1664 settlement, to provide settling parties with the final amount
1665 of healthcare costs that CMS has previously paid. If
1666 Congress does so, the beneficiaries will be able to settle
1667 faster, the defendants will be able to settle efficiently and
1668 with certainty, and the trust fund will recover more money
1669 faster. This is a true win-win-win for all the parties.

1670 Secondly, I want to recommend a threshold for small-
1671 dollar claims so that we can be sure that the amount of money
1672 that government is pursuing these claims does not exceed the
1673 amount of money that the government will recover from these
1674 claims. And let me explain.

1675 I have seen claims where settlements are being held up
1676 because Medicare has made demands of \$1.59, \$2.81, or other
1677 such small sums. I have a number of examples with me today.
1678 This is a waste of taxpayer resources and it surely costs the
1679 Medicare program more money than they are recovering, even 1
1680 or 2 or \$50 to process these claims. These should all be
1681 exempt from the program.

1682 Now, we heard a reference to the Rand Institute's study,
1683 which was just published yesterday, and I have a copy of the
1684 study with me. And it indicates that if CMS exempted from
1685 MSP all liability claims below \$5,000, they would be reducing
1686 the Agency workload and save costs on an estimated 43 percent
1687 of the claims while only sacrificing 2.4 percent of the

1688 money. That is \$24 million of projected loss on \$1 billion
1689 to be recovered. It is a waste of taxpayer money for the
1690 Agency to spend 43 percent of its time pursuing 2.4 percent
1691 of its dollars. And at Publix Super Markets, we settle
1692 thousands of claims every year below this \$5,000 threshold.

1693 The subcommittee and Congress can bring common sense to
1694 the MSP system by introducing a threshold below which MSP
1695 should not apply. The threshold could be a flat dollar
1696 amount such as \$5,000 as suggested by the Rand Institute, or
1697 it could be set prospectively at the amount of settlement is
1698 likely to yield an MSP collection at or below the
1699 government's recovery cost. This would not only save the
1700 government money but would allow Medicare beneficiaries to
1701 settle small claims without being subject to the extensive,
1702 intrusive, and costly MSP reporting process.

1703 On behalf of Publix Super Markets, I want to thank you
1704 for your leadership in addressing these important issues. In
1705 partnerships with our associates and our customers, we look
1706 forward to working with Congress to address these issues.
1707 Thank you.

1708 [The prepared statement of Mr. Salm follows:]

1709 ***** INSERT 3 *****

1710 | Mr. {Stearns.} Thank you. Mr. Gilliam?

|
1711 ^TESTIMONY OF SCOTT A. GILLIAM

1712 } Mr. {Gilliam.} Thank you, Mr. Chairman, Ranking Member
1713 DeGette, and members of the subcommittee. Good morning and
1714 thank you for this opportunity to provide testimony on how
1715 the Medicare Secondary Payer system can be improved to
1716 protect Medicare beneficiaries in speed reimbursements to the
1717 Medicare Trust Fund.

1718 My name is Scott Gilliam. I am vice president and
1719 government relations officer with the Cincinnati Insurance
1720 Company, one of the Nation's top 25 property casualty insurer
1721 groups marketing business, home, auto, and life insurance in
1722 39 States. I am testifying today on behalf of my company and
1723 the Medicare Advocacy Recovery Coalition, MARC, a group which
1724 seeks to bring improvements and efficiencies to the MSP
1725 system.

1726 Today, I would like to tell you about the numerous
1727 problems the current MSP system has caused not only for our
1728 company but for the innumerable Medicare beneficiaries that
1729 we interact with in the course of settling thousands of
1730 personal injury claims every month. To put this aspect of
1731 our business in perspective, we settled over 40,000 personal
1732 injury liability claims last year, paying out over \$580

1733 million to settle those claims using the services of our 730
1734 field claim representatives who are located around the
1735 country. Unfortunately, the current MSP system is making it
1736 extremely difficult to settle claims in the prompt and
1737 efficient manner we believe injured parties deserve and it is
1738 having significant negative impact on claimants who are
1739 Medicare beneficiaries.

1740 Mr. Salm has already addressed the problems caused by
1741 the backwards manner in which CMS collects reimbursements
1742 owed to the Medicare Trust Fund. In my testimony today,
1743 however, I would like to focus on several critical problems
1744 with the MSP Section 111 reporting process, which imposes
1745 extremely complicated data reporting requirements on those of
1746 us who settle claims with Medicare beneficiaries.

1747 CMS could have implemented the new reporting process
1748 through formal rulemaking, which would have allowed for
1749 stakeholder input. Instead, the Agency created a complex and
1750 broad-reaching system without engaging the affected
1751 community. The resulting MSP reporting system involves a
1752 complex computer submission process that requires responsible
1753 reporting entities, REEs--those of us who settle claims--to
1754 submit a significant amount of data to CMS alerting the
1755 Agency that we have paid a settlement or a judgment to a
1756 beneficiary. Unfortunately, we do not have access to many of

1757 the data elements that CMS requires us to report and
1758 claimants are often unwilling or even unable to provide the
1759 data to us.

1760 To give you an idea of the scope and complexity of the
1761 reporting system, I have brought with me today the CMS user
1762 guide that we have to follow to report the data. It is like
1763 a telephone book. And at my company, we have been spending 2
1764 years trying to implement this, and here is the flowchart we
1765 use in our claims department to try and figure out how to
1766 report the data.

1767 The reporting requirements not only impact the claims-
1768 pending community; they can also have a negative impact on
1769 Medicare beneficiaries as well. Consider what happens when
1770 the Medicare computer system decides that a beneficiary's
1771 current injury or ailment is connected to the primary payer
1772 who reported an unrelated payment in the past. Here is a
1773 good example. We settled a claim with a woman who was in a
1774 car accident and reported the settlement to Medicare. Years
1775 later, the woman was diagnosed with breast cancer, and
1776 Medicare denied coverage for her treatment on the grounds
1777 that her breast cancer was related to the prior car accident.
1778 This may sound absurd, but it is a true story from our claim
1779 files.

1780 Mr. {Stearns.} Could you move the mike just a little

1781 closer? Yeah. Go ahead.

1782 Mr. {Gilliam.} While these reporting requirements are
1783 intended to insure that Medicare is made aware of cases where
1784 it can assert MSP claims, in practice, however, these complex
1785 reporting requirements often slow down settlements and in
1786 many cases prevent settlements from even happening. In these
1787 situations, money that otherwise could have been promptly
1788 returned to the Medicare Trust Fund is delayed, reduced, or
1789 never paid. This is especially true in cases where the
1790 innumerable claimants who are not represented by an attorney
1791 and are intimidated by requests to turn over their private
1792 personal information in order to settle their claim.

1793 One of the particularly problematic elements of the
1794 Section 111 reporting process is that it requires insurance
1795 carriers to collect Social Security numbers or health
1796 insurance claim numbers, HICNs, from all parties with which
1797 we settle claims. Our claimants are loath to provide this
1798 information and in many cases flatly refuse. And it is
1799 little wonder they refuse. Can you imagine having someone
1800 who you believe has caused you an injury and who you are now
1801 considering suing demand that you hand over their Social
1802 Security number.

1803 And to make matters worse, the same Agency that requires
1804 us to collect SSNs or HICNs for Medicare beneficiaries runs

1805 advertising campaigns to prevent Medicare fraud by
1806 discouraging Medicare beneficiaries to give out those
1807 numbers. Shouldn't this be reason enough for CMS to come up
1808 with a better way for us to identify Medicare beneficiaries
1809 for MSP reporting? Perhaps Congress could help the Agency
1810 solve this problem so that we can navigate the process
1811 without requiring disclosure of SS numbers.

1812 A simple solution would be only to require reporting of
1813 the last four digits of the Social Security number, a method
1814 Medicare already uses to match beneficiaries with their
1815 Medicare Part D plan. If CMS can use the last four digits of
1816 an SS number in the Part D program, why can't they use it in
1817 the MSP program?

1818 Another significant problem with the current system is
1819 Draconian penalties. Those of us who pay claims face a
1820 mandatory \$1,000-per-day penalty for failing to properly
1821 report a claim. We agree that harsh penalties should be used
1822 to pursue bad actors who purposefully circumvent the system,
1823 but we also believe that Medicare should promptly--however,
1824 the mandatory penalties for reporting failures mean that even
1825 companies like ours that are doing their utmost to achieve
1826 full compliance can face massive penalties for small errors
1827 or technical problems that occur through no fault of our own.

1828 Our company has invested 2 years of financial and human

1829 resources in developing an information technology system to
1830 manage MSP reporting, and despite our feverish efforts and
1831 full committee compliance, we could still face massive
1832 penalties if even a single data element is entered
1833 incorrectly or our computer systems have a problem or the CMS
1834 problem.

1835 Mr. {Stearns.} Mr. Gilliam, I need you to sum up.

1836 Mr. {Gilliam.} Yes, I will.

1837 I will wrap up quickly. There is another important
1838 issue I want to raise to your attention today. And there are
1839 a number of claims now arising where Medicare is denying
1840 coverage for current ailments based on past claims that we
1841 have paid that are completely unrelated. This is occurring
1842 in hospice cases, hospice patients being denied care because
1843 of an old claim that is not related to their current care.
1844 And with that, I will wait for your questions.

1845 [The prepared statement of Mr. Gilliam follows:]

1846 ***** INSERT 4 *****

|
1847 Mr. {Stearns.} Thank you. And by unanimous consent, we
1848 will put in your book and your chart into the record. So
1849 done.

1850 [The information follows:]

1851 ***** COMMITTEE INSERT *****

1852 | Mr. {Stearns.} Mr. Matzus?

|
1853 ^TESTIMONY OF JASON MATZUS

1854 } Mr. {Matzus.} Good morning, Chairman Stearns--

1855 Mr. {Stearns.} I just need you to pull the mic a little
1856 closer.

1857 Mr. {Matzus.} Good morning. Can everyone hear me?

1858 Okay. Good morning, Chairman Stearns, Ranking Member

1859 DeGette, and members of the subcommittee, thank you for your
1860 leadership in holding this important hearing. I greatly

1861 appreciate the opportunity to testify on how the Medicare

1862 Secondary Payer system impacts Medicare beneficiaries.

1863 My name is Jason Matzus. I am a partner at the law firm

1864 of Raizman, Frischman, and Matzus. My firm is based in the

1865 Pittsburgh area represented by Congressman Tim Murphy of this

1866 committee. I have handled hundreds of personal injury

1867 claims, including those resulting from auto liability and

1868 other personal injury claims. In many of these cases, I am

1869 representing Medicare beneficiaries in their claims against

1870 third parties. In that capacity, I have firsthand experience

1871 with many of the unintended consequences of the MSP system.

1872 I fully support the intent of the MSP requirement to make

1873 sure Medicare is repaid when someone else has accepted

1874 liability for a beneficiary's medical care. But the current

1875 MSP system causes many problems for the beneficiaries I
1876 represent and delays or even prevents full repayment to the
1877 trust fund.

1878 The unfortunate reality is that in practice, the current
1879 MSP system harms not only beneficiaries but the trust fund as
1880 well. The most significant problem my beneficiary clients
1881 face is that the current MSP system administered by the
1882 Center for Medicare and Medicaid Services is running the
1883 process backwards. We cannot get the Final Demand explaining
1884 how much money is owed to Medicare until after a case settles
1885 and is reported to CMS. As the prior witnesses on this panel
1886 have noted, this is causing many significant problems and
1887 harms everyone involved, including, ultimately, the Medicare
1888 Trust Fund itself.

1889 The backward recovery process is creating significant
1890 obstacles that make it very difficult for cases to settle.
1891 The amount of money that will need to be repaid to Medicare
1892 is a critical piece of information, a piece of information
1893 that we currently cannot get when we need it most, during
1894 settlement negotiations. This problem, this lack of critical
1895 information is causing more and more cases to go to trial
1896 instead of being settled simply because nobody has a reliable
1897 final number from Medicare of what the trust fund is owed.
1898 More cases going to trial rather than settling outside of

1899 courtrooms necessarily means that ultimately less money will
1900 be recovered by Medicare. That is obviously contrary to the
1901 primary goal of the MSP system. Thus, the current recovery
1902 process actually works against the goal of recovering as much
1903 money as possible for the trust fund.

1904 Even if I settle a case without knowing the final
1905 number, which happens, there are still extreme delays in
1906 getting that Final Demand amount from Medicare. Even once
1907 the beneficiaries have settled their claims or won their case
1908 in Court and the required reporting has been made to
1909 Medicare, my client still must wait and wait and wait to
1910 receive anything from their settlements. It is not at all
1911 uncommon for it to take 6 months or even a year just to
1912 resolve the MSP portion of a claim. My firm alone has had
1913 many instances of such cases for beneficiaries when it took
1914 that long. Of course, my beneficiary clients are not the
1915 only ones who are waiting to be paid during this time. The
1916 Medicare Trust Fund also does not get reimbursed until we are
1917 told the Final Demand amount. In the aggregate, these delays
1918 translate into millions of dollars of lost revenue annually
1919 for the Medicare Trust Fund. A system that harms both the
1920 Medicare beneficiaries and the trust fund simply cannot be
1921 right.

1922 These long delays are causing significant financial

1923 strains for many beneficiaries who have been injured. At my
1924 firm, we have had instances where the Medicare beneficiary
1925 faced the prospect of foreclosure on their home because of
1926 the delay in getting the Medicare reimbursement resolved.
1927 This can happen when a Medicare beneficiary is counting on
1928 the settlement proceeds to reimburse them for the out-of-
1929 pocket costs associated with their injury such as co-pays,
1930 uncovered medical services, and lost wages. Fortunately, we
1931 have avoided that calamity, but the issues are real.
1932 Tragically, a colleague of mine has told me of an instance
1933 where the beneficiary has died during the interim period
1934 waiting for the MSP portion of the claim to be resolved after
1935 the case is settled.

1936 I strongly urge this committee and Congress to empower
1937 Medicare to provide a Final Demand amount before settlements
1938 occur so that everyone would know how much money is owed and
1939 would be able to settle accordingly. If that were to occur,
1940 the beneficiaries that I represent would be far better off
1941 than they are today and the trust fund would recover many
1942 millions of dollars more than is the case today. If this
1943 simple change occurred, both beneficiaries and Medicare could
1944 receive their reimbursements much faster than they do today.

1945 Let me be clear. We are ready and able to reimburse the
1946 trust fund, but we need your help to clear the bureaucracy

1947 out of the way and make a sensible MSP system that will
1948 actually work. One month ago, I had the privilege of meeting
1949 with Representative Tim Murphy along with approximately 30
1950 other lawyers from the Pittsburgh area on this issue, all
1951 interested stakeholders on this issue. As we asked
1952 Congressman Murphy last month, I join with my colleagues in
1953 respectfully urging you to allow us to quickly and
1954 efficiently resolve MSP claims. I thank you for the
1955 opportunity to testify today before the subcommittee and I
1956 welcome any questions that you have.

1957 [The prepared statement of Mr. Matzus follows:]

1958 ***** INSERT 5 *****

|
1959 Mr. {Stearns.} I thank the gentleman. Ms. Stein,
1960 welcome, for your 5-minute opening statement.

|
1961 ^TESTIMONY OF ILENE STEIN

1962 } Ms. {Stein.} Good morning, Chairman Stearns, Ranking
1963 Member DeGette, and other distinguished members of the
1964 subcommittee. I thank you for the opportunity to testify
1965 today about the current Secondary Payer program and the
1966 difficulties Medicare beneficiaries face navigating this
1967 system.

1968 I am Ilene Stein, Federal Policy Director for the
1969 Medicare Rights Center. Medicare Rights is a national,
1970 nonprofit consumer service organization that works to ensure
1971 access to affordable healthcare for older adults and people
1972 with disabilities. Last year, we assisted more than 14,000
1973 Medicare beneficiaries and nearly 4,000 healthcare
1974 professionals through our national helpline. These calls
1975 inform our public policy efforts and allow Medicare Rights to
1976 bring the voice of Medicare beneficiaries to the national
1977 conversation about Medicare.

1978 For the health and integrity of the Medicare program, a
1979 robust Secondary Payer regime is necessary. However, the
1980 current system is flawed in both policy and implementation.
1981 The results can be devastating for Medicare beneficiaries.
1982 Not only do individuals receive demands from Medicare for

1983 large amounts of money that, in some cases, they do not owe
1984 and/or cannot pay, but in certain situations, Medicare will
1985 cease coverage because cases were improperly closed by CMS
1986 and MSPRC.

1987 Though not all-inclusive nor mutually exclusive, the
1988 problems we identified with the Secondary Payer process fall
1989 into 5 categories. The first is untimely collection of
1990 Medicare's share of settlements. Currently, there is no
1991 established time frame by which Medicare must tell
1992 individuals what they owe if they have settled a liability
1993 case. If a beneficiary settles without knowing the Medicare
1994 costs, Medicare may come back years later and collect a
1995 sizeable portion of the settlement to Medicare. In some
1996 cases, given the lapse in time and because the beneficiary is
1997 unaware that Medicare is owed money, settlement funds may no
1998 longer exist.

1999 The second issue is that CMS and MSPRC often
2000 miscalculate the amount that Medicare is owed. Frequently,
2001 callers to our helpline receive notices from MSPRC requesting
2002 repayment for treatments that are unrelated to injuries
2003 associated with a previous accident. This is because CMS and
2004 the contractor do not properly segregate claims related to
2005 accidents from other claims completely unrelated to those
2006 past injuries.

2007 The third issue concerns beneficiaries' difficulty in
2008 obtaining information about their cases from CMS and MSPRC.
2009 Callers experience extremely long hold times, and even when
2010 individuals are able to reach customer service
2011 representatives, they receive inaccurate or incomplete
2012 information.

2013 Fourth, beneficiaries who manage to get an explanation
2014 often find the source of the issue to be that CMS and MSPRC
2015 did not properly close their case. As a result, even though
2016 the insurance company has closed the case, the Medicare
2017 system believes that Medicare is still a secondary payer.
2018 Consequently, Medicare conditionally pays, sending demands
2019 for reimbursement to beneficiaries or stops paying for
2020 services altogether. Such a serious matter should be
2021 resolved quickly but it often can take up to a year to get
2022 the case closed.

2023 Finally, notices sent to consumers by MSPRC are not
2024 clear. While they speak to appeal rights, they do not
2025 contain detailed information on how to request an appeal or
2026 about the documentation necessary to be successful. Notices
2027 also fail to elucidate the hardship waiver process available
2028 if consumers are unable to pay Medicare the money being
2029 requested.

2030 There are several steps that can be taken legislatively

2031 or administratively that would help solve many of the
2032 problems that beneficiaries encounter. Ideally, as soon as
2033 incidents are reported to Medicare, Medicare would then
2034 provide the insurer and the beneficiary with an estimate of
2035 the conditional payments made by Medicare for treatment
2036 related to the injury, as well as an estimate of future
2037 treatment.

2038 Medicare collection practices should ensure timely
2039 recovery. Medicare Secondary Payer claims should not be
2040 initiated more than 2 years after the settlement has been
2041 made. This would also help to ensure that in settlement
2042 negotiations and legal proceedings, all parties are able to
2043 consider Medicare's claims. CMS and its contractors should
2044 be required to improve the notices provided to consumers.
2045 Specifically, the notices' language must be more consumer-
2046 friendly, and the notices should include more detailed
2047 information about appeal and hardship waiver rights and
2048 process.

2049 MSPRC should be required to maintain a transparent,
2050 easy-to-use process through which beneficiaries and their
2051 representatives can obtain information about their cases.
2052 This means both ensuring shorter call times, and more
2053 importantly, assigning a specific staff member to cases who
2054 can be reached directly.

2055 CMS and its contractors should develop a better process
2056 for separating claims that are and are not related to an
2057 accident. CMS and the contractor should also be required to
2058 make decisions expediently when beneficiaries dispute the
2059 inclusion of claims because they do not believe that they
2060 relate back to an accident.

2061 Thank you again for the opportunity to testify today. I
2062 would be happy to respond to any questions from the
2063 committee.

2064 [The prepared statement of Ms. Stein follows:]

2065 ***** INSERT 6 *****

|
2066 Mr. {Stearns.} I thank Ms. Stein. Mr. Gilliam, looking
2067 at that report, have there been other versions of this? I
2068 understand there has been three versions of this 200-plus-
2069 page report that is guidance? Is that true?

2070 Mr. {Gilliam.} Yes, Mr. Chairman. The copy I have
2071 Version 3.1.

2072 Mr. {Stearns.} Okay. So there has been at least three
2073 versions. Now, has this provided you with any kind of
2074 guidance? Just yes or no.

2075 Mr. {Gilliam.} Kind of.

2076 Mr. {Stearns.} Not really, okay. Mr. Salm, I just want
2077 to quickly take us through the recovery process here for
2078 liability insurance, no-fault insurance, and workmen's
2079 compensation just to make sure all of us understand it
2080 correctly.

2081 The first step in the MSP recovery process is that you
2082 report your case to a contractor at CMS, correct?

2083 Mr. {Salm.} Well, no, sir.

2084 Mr. {Stearns.} Okay.

2085 Mr. {Salm.} You have to understand that especially from
2086 a liability standpoint we have a tremendous amount of
2087 process, the American legal system, that goes on before we
2088 ever get to this.

2089 Mr. {Stearns.} So that is not the first step?

2090 Mr. {Salm.} No. Well, the first step as far as the
2091 Agency is concerned is that they want us to report the
2092 settlement to the Agency. Okay? But before we go through
2093 that, we would go through an entire claims operation, a
2094 litigation operation. Understand that from our standpoint,
2095 this is coming very near the end of the process. And speed
2096 is a great priority at the end of the process because
2097 frequently we don't get to this number until we are actually
2098 facing a trial date.

2099 Mr. {Stearns.} So once a case has been established,
2100 then you receive a Rights and Responsibilities letter about
2101 protecting Medicare's interest in the settlement
2102 negotiations, is that correct?

2103 Mr. {Salm.} There is a Rights and Responsibilities
2104 letter, right, that talks about that.

2105 Mr. {Stearns.} Then you are supposed to receive a
2106 conditional payment letter? Is that right?

2107 Mr. {Salm.} At some point you are supposed to receive a
2108 conditional payment letter. I can tell you that in the times
2109 that my adjusters have requested the conditional payment
2110 letter, including the appropriate release from claimants, we
2111 have never received a conditional payment letter.

2112 Mr. {Stearns.} Well, isn't that the law that you are

2113 supposed to receive a conditional payment letter?

2114 Mr. {Salm.} Well, we can get the amount of the payments
2115 made by Medicare but we can't get a letter that actually
2116 indicates how much money we owe Medicare until after we
2117 report to them how much we have settled the lawsuit for.

2118 Mr. {Stearns.} And how long does it generally take CMS
2119 to provide you with a conditional payment amount?

2120 Mr. {Salm.} The conditional payment amount, once we
2121 make the request, I have never seen one less than 90 days,
2122 and more likely it is more like 6 months.

2123 Also, Mr. Chairman, if I note when we get the
2124 conditional payment amount from Medicare, it says right on
2125 the letter that we get, and I have a copy of it, it says,
2126 ``This is not a bill. Do not send a payment at this time''--
2127 right on the document.

2128 Mr. {Stearns.} Can we get a copy of that?

2129 Mr. {Salm.} Absolutely.

2130 Mr. {Stearns.} And make it part of the record?

2131 Mr. {Salm.} Absolutely.

2132 Mr. {Stearns.} And this is prior to settlement, right?

2133 Mr. {Salm.} This would be prior to settlement, yes,
2134 sir.

2135 Mr. {Stearns.} How and when are changes in this amount,
2136 as well as the amount of future payments you are responsible

2137 for communicated to you and other parties in the lawsuit?

2138 Mr. {Salm.} I don't know.

2139 Mr. {Stearns.} Let me ask each of you. You describe
2140 this bureaucratic inefficiency, and I think you have touched
2141 on it. What is the number one thing--we will just go from my
2142 left to right--that you would like to see changed
2143 immediately?

2144 Mr. {Salm.} I would like to be able to get the amount
2145 that we owe Medicare before we settle the claim.

2146 Mr. {Stearns.} And what would that duration be
2147 generally, just average?

2148 Mr. {Salm.} How long would it take us? I think the
2149 timeline set forth in H.R. 1063, which would be either 65 or
2150 95 days would be sufficiently quick so we could resolve
2151 lawsuits.

2152 Mr. {Stearns.} Okay. Mr. Gilliam, name one thing that
2153 you would like to see fixed.

2154 Mr. {Gilliam.} What he said plus responsiveness from
2155 MSPRC. We are waiting for Final Demand letters from them for
2156 11 months, 12 months, 14 months, 18 months, 6 months, 6
2157 months, 7 months, 7, 7, and 8. They never send letters. We
2158 are on hold for 56 minutes or an hour or 90 minutes when we
2159 are trying to call them.

2160 Mr. {Stearns.} Now, Ms. Taylor said that there are

2161 413,000 cases and she couldn't even answer the duration time,
2162 but you are giving us some pretty dramatic long durations
2163 here of even trying to get information.

2164 Mr. {Gilliam.} And many of these are after seven to ten
2165 attempts at phone calls--

2166 Mr. {Stearns.} And you are on the phone for an hour?

2167 Mr. {Gilliam.} Ninety minutes.

2168 Mr. {Stearns.} Ninety minutes?

2169 Mr. {Gilliam.} One time they hung up, then they
2170 transferred us, and then we were on hold for 90 minutes.

2171 Mr. {Stearns.} And is there music going on?

2172 Mr. {Gilliam.} I don't know.

2173 Mr. {Stearns.} I hope the people you are talking to are
2174 people in the United States.

2175 Mr. {Gilliam.} Pardon?

2176 Mr. {Stearns.} Are the people you are talking to in the
2177 United States?

2178 Mr. {Gilliam.} Yes.

2179 Mr. {Stearns.} They don't farm it out to India, do
2180 they?

2181 Mr. {Gilliam.} No.

2182 Mr. {Stearns.} Okay. Mr. Matzus, what is the number
2183 one thing that you think?

2184 Mr. {Matzus.} Mr. Chairman, the number one priority

2185 would be to get the Final Demand number from Medicare prior
2186 to the settlement.

2187 Mr. {Stearns.} Okay. And Ms. Stein?

2188 Ms. {Stein.} Well, kind of two. I have got the statute
2189 of limitations on how long it would take for Medicare to
2190 collect their share, as well as more transparency with the
2191 contractor. We also experienced long wait times and have
2192 difficulty resolving cases. It requires us to resend
2193 documentation over and over again. We have cases that have
2194 lasted over a year to close.

2195 Mr. {Stearns.} Have you had the experience as Mr.
2196 Gilliam to talk about 90 minutes on the phone?

2197 Ms. {Stein.} Yes. I would say the least amount of time
2198 we have to wait on the phone is about 30 minutes. We have
2199 had to wait up for over an hour, I think an hour and 20
2200 minutes.

2201 Mr. {Stearns.} So you have waited an hour and 20
2202 minutes. So you have one of your employees just putting it
2203 on speaker and waiting there all during that period of time?

2204 Ms. {Stein.} Indeed. I actually have personally waited
2205 on the phone for--

2206 Mr. {Stearns.} You personally have waited?

2207 Ms. {Stein.} Yes, sir.

2208 Mr. {Stearns.} And during that time, is there somebody

2209 that comes in during those hour and 20 minutes that says
2210 thank you for holding? Or is it just a dead phone or what is
2211 it?

2212 Ms. {Stein.} The case I handled is probably 2 years
2213 old. It is mostly just music I think.

2214 Mr. {Stearns.} Just music?

2215 Ms. {Stein.} But I do have to say that once we do
2216 actually reach an operator, we will have maybe a several-
2217 minute conversation where they say please resend your
2218 documentation. It isn't on file. And then you have to call
2219 back again.

2220 Mr. {Stearns.} I will just close. When you do this, do
2221 you have to put things through like they want information
2222 keyboarded in that you have to put in a lot of documentation
2223 before they even talk to you?

2224 Ms. {Stein.} In some cases, yes. It depends on the
2225 case.

2226 Mr. {Stearns.} You have got to put the case number,
2227 dates, and things like that in before they even go further?
2228 But you can't talk to anybody first. You are talking to a
2229 computer, right?

2230 Ms. {Stein.} Right. Well, and also if somebody has a
2231 representative, they have to submit the documentation, the
2232 Appointment of Representative form as well, which often gets

2233 lost.

2234 Mr. {Stearns.} Okay. My time has expired. The
2235 gentlelady is recognized.

2236 Ms. {DeGette.} Thanks. To follow up on that, Mr.
2237 Gilliam, the other problem is people don't have one customer
2238 service agent assigned to them, so let us say you have 10
2239 cases, you have to call back each time with each separate
2240 case, right? You can't just call someone up and go, okay,
2241 here are the 10 issues I want to talk to you about.

2242 Mr. {Gilliam.} That is correct. Every time we call,
2243 and if we are lucky enough to get through, it starts over
2244 with somebody new, and they won't even accept emails.

2245 Ms. {DeGette.} Right.

2246 Mr. {Gilliam.} It has to be phone calls or in writing.

2247 Ms. {DeGette.} Yeah. Mr. Matzus, I have a question for
2248 you. In the earlier panel, somebody was talking about the
2249 medical costs vis-à-vis the settlements of these lawsuits.
2250 They are talking about the medical costs versus the pain and
2251 suffering. And I wasn't a personal injury lawyer but I hung
2252 around with a bunch of them, and my understanding of the way
2253 these cases are usually settled you have got a clear
2254 statement of the medical costs and then you may have pain and
2255 suffering or whatever else, but the medical costs aren't
2256 normally the pain and suffering, correct?

2257 Mr. {Matzus.} No, Congresswoman.

2258 Ms. {DeGette.} I mean, normally those are two different
2259 areas.

2260 Mr. {Matzus.} That is correct.

2261 Ms. {DeGette.} Especially in the settlement, right?

2262 Mr. {Matzus.} Medical costs are a separate silo.

2263 Ms. {DeGette.} That is correct.

2264 Mr. {Matzus.} Separate and distinct from the recovery
2265 for noneconomic damages--

2266 Ms. {DeGette.} Right.

2267 Mr. {Matzus.} --such as pain and suffering.

2268 Ms. {DeGette.} Right.

2269 Mr. {Matzus.} That is correct.

2270 Ms. {DeGette.} And so that is why you need to have the
2271 medical cost information up front at settlement so we can
2272 accurately figure out how much the victims needed to be
2273 compensated and then how much needed to be reimbursed to
2274 Medicare out of that settlement, right?

2275 Mr. {Matzus.} It is a necessary and critical part of
2276 the equation to figure out what is a fair value at which to
2277 agree to settle.

2278 Ms. {DeGette.} I have got to say we rarely ever see the
2279 grocery stores and the trial lawyers sitting at the same
2280 table agreeing on an issue. So I wish those Close Up kids

2281 were still here to see this.

2282 Mr. {Salm.} Mark this day on the calendar, I think, Mr.
2283 Chairman.

2284 Ms. {DeGette.} Yeah, right. Exactly.

2285 Ms. Stein, I wanted to ask you about a little bit of
2286 what you were talking about and what I mentioned in my
2287 opening statement about the program's beneficiaries because
2288 we keep hearing these stories about Medicare coming after
2289 beneficiaries years after the cases have been settled for
2290 reimbursement for medical expenses. And the case I talked
2291 about in my opening statement was an 81-year-old woman who
2292 got hit by a drunk driver. She got \$20,000 from automobile
2293 insurance in a settlement and then 13 years later, so add
2294 that up, 94 she is now, Medicare sends her a letter demanding
2295 repayments of medical services over a decade old. Have you
2296 heard similar stories about beneficiaries being contacted by
2297 Medicare years after settlement demanding payment?

2298 Ms. {Stein.} Yes, we have heard cases like that. And
2299 this kind of speaks to the hardship waiver process. It is
2300 pretty difficult to get a waiver. The process is burdensome
2301 to consumers and the situations that hardship waivers apply
2302 to are somewhat arbitrary. For example, somebody who is on
2303 SSI, which is obviously low income, that doesn't necessarily
2304 automatically make them eligible for some type of waiver,

2305 either full or partial waiver.

2306 In my written testimony I talked about--and this speaks
2307 back to the idea that claims aren't properly segregated--that
2308 individuals who were in car accidents, you know, 5 to 10
2309 years ago suddenly receive bills from Medicare or no longer
2310 able to receive Medicare coverage going forward because they
2311 claim that, you know, a broken hip that they received in
2312 their kitchen relates back to a car accident that happened,
2313 you know, over 5 to 10 years ago.

2314 Ms. {DeGette.} So there needs to some kind of a time
2315 frame. Claims shouldn't be initiated maybe 2 years after
2316 settlement or something like that, correct?

2317 Ms. {Stein.} Yes.

2318 Ms. {DeGette.} But that does lead us to a question, and
2319 I am wondering if any of you have an opinion on this is it
2320 makes perfect sense to me to have all of the data at
2321 settlement or shortly thereafter, but you have a little
2322 tension here because if you have medical claims that continue
2323 to come in, we want to assure that the taxpayer gets
2324 reimbursed for those expenses, but on the other hand, you
2325 want to have a quick settlement. So what can we do to make
2326 that system work better so we have some closure early on at
2327 settlement or soon after but at the same time we are not
2328 leaving medical costs out there that could be recaptured?

2329 Mr. {Gilliam.} If I could jump in there. In probably
2330 95 percent of the cases, when we are ready for the Medicare
2331 number, the treatment is basically done. It is typical that
2332 when we try and settle claims--and Jason knows this--we want
2333 to get all the numbers together. In most cases, the
2334 plaintiff is done treating and so we have all the data, and
2335 that is when we need to know what Medicare owes. And at that
2336 point, all of the Medicare-paid treatment has been completed
2337 and we don't understand why they can't tell us what that
2338 number is.

2339 Ms. {DeGette.} Does everybody else pretty much agree
2340 with that statement?

2341 Mr. {Salm.} Yes, we very much agree with this.
2342 Plaintiffs' lawyers don't bring cases to resolution or
2343 settlement until they know what the total medical care is
2344 that they want to get reimbursed for. And another point is
2345 made that in the normal practice of subrogation, what normal
2346 insurance companies, corporations do all the time, if you are
2347 ever going to get your money, you have to make a decision to
2348 cut off, sort of chasing the dollars at some point because
2349 you are just not going to get enough money to justify the
2350 effort you put into it.

2351 So Mr. Gilliam and I make decisions on subrogation every
2352 day and we say okay, we will take X number of dollars now

2353 because we don't think we are going to get X plus 20 later or
2354 it is just going to take too much time.

2355 Ms. {DeGette.} Thank you.

2356 Thank you, Mr. Chairman.

2357 Mr. {Stearns.} The gentleman from Pennsylvania is
2358 recognized for 5 minutes, Mr. Murphy.

2359 Mr. {Murphy.} Thank you, Mr. Chairman.

2360 I think the more I hear, the more it boggles the mind
2361 and breaks the heart when we hear of what happens to seniors.

2362 A couple of things first. Mr. Gilliam, in retail
2363 settings, I understand that sometimes someone may get injured
2364 but they said, look, I am not going to sue the store or
2365 anything. Accidents happen, but I need you to make sure my
2366 medical expenses are taken care of. And sometimes stores say
2367 we still want to show good faith effort. Here is a gift card
2368 to use at our store, things like that. That happens, am I
2369 correct?

2370 Mr. {Gilliam.} Yes, that happens thousands of times a
2371 year.

2372 Mr. {Murphy.} Do you have to report that number yet?

2373 Mr. {Gilliam.} We don't have to report that number yet,
2374 but we will have to--

2375 Mr. {Murphy.} But you will?

2376 Mr. {Gilliam.} --report that number in 3 years.

2377 Mr. {Murphy.} So if someone gets a \$25 or \$50 gift card
2378 off their groceries, will Medicare, according to the new
2379 rules, come after them and say you owe us that money to
2380 reimburse for medical expenses?

2381 Mr. {Gilliam.} Absolutely. We will have to report that
2382 under the new rules. We will have to report that under the
2383 process and Medicare--we become a primary payer in that case.

2384 Mr. {Murphy.} So you have someone who is living off
2385 Social Security and they think, my goodness, I get basically
2386 a half a bag of groceries for free here. Now, Medicare is
2387 going to come back and say we want that food back. We need
2388 that 25 or \$50 back. That is what you are telling me?

2389 Mr. {Gilliam.} That is what I am telling you, yes, sir.

2390 Mr. {Murphy.} Breaks the heart.

2391 Mr. Matzus, when you were describing this case of
2392 someone who died before--while someone is waiting for this
2393 claim, does it actually impose other hardships upon the
2394 seniors on a couple levels? Number one, do you know of any
2395 cases out there where, because of the amount of money that is
2396 kind of in the air, or in the claims to be made my Medicare
2397 against someone to come up with some reimbursements, that
2398 seniors may actually delay other healthcare because they
2399 don't have the money to take care of themselves?

2400 Mr. {Matzus.} Congressman Murphy, I think--as everybody

2401 on the panel can appreciate--most Medicare beneficiaries have
2402 limited financial resources. A small change in their monthly
2403 costs can push them very quickly beyond the financial tipping
2404 point from which they cannot or will have a very difficult
2405 time recovering. And oftentimes, when you have to make a
2406 decision between paying for current uncovered Medicare
2407 services that you need versus paying other bills, people
2408 choose to pay for the necessary uncovered medical services
2409 and in essence are robbing Peter to pay Paul.

2410 Mr. {Murphy.} And on this, I am assuming while you are
2411 working on a case, they are also accruing other legal
2412 expenses which, because of the delays and people having to
2413 sit on the phone and wait for calls, am I correct on that,
2414 too?

2415 Mr. {Matzus.} Congressman Murphy, the way our firm
2416 operates, it is a contingency-fee basis, so we don't bill our
2417 clients based upon an hourly rate.

2418 Mr. {Murphy.} Some may do that?

2419 Mr. {Matzus.} Some firms may.

2420 Mr. {Murphy.} So in some cases it may cost the seniors
2421 even more? So the delay is costing seniors not only they are
2422 delaying some care, maybe not getting some care, maybe having
2423 to pay back grocery money, et cetera.

2424 If the parties settle without the Final Demand letter,

2425 what happens to the seniors' settlement money? Anybody know?

2426 Mr. {Matzus.} If I may, typically, the settlement money
2427 is held in a law firm's client trust account or escrow
2428 account pending final notice from Medicare of what amount is
2429 owed. And then distribution is only made after the Final
2430 Demand figure.

2431 Mr. {Murphy.} What if that Final Demand figure is much
2432 higher than the conditional payment? Who pays the
2433 difference? Has that happened?

2434 Mr. {Matzus.} It can happen. Colleagues have reported
2435 that happening. It has not been my personal experience where
2436 there has been a significant difference, but in theory, you
2437 know, the beneficiary and/or the law firm and/or the
2438 liability carrier is potentially responsible. We don't have
2439 the opportunity to go back in time and get a second bite at
2440 the apple in a liability settlement. Once a case is settled,
2441 it is settled. The money that is received is the only money
2442 that will be received.

2443 Mr. {Murphy.} Does it take as long if you are dealing
2444 with private insurance companies as it takes with Medicare?

2445 Mr. {Matzus.} To get the final lien figure? No.

2446 Mr. {Murphy.} How long would they typically take?

2447 Mr. {Matzus.} We always have the final lien figure in
2448 advance of--

2449 Mr. {Murphy.} So it is humanly possible to do this?

2450 Mr. {Matzus.} It is. By way of example, Medicaid--

2451 Mr. {Murphy.} Now, I know that the CFO of CMS has other
2452 things to do today, but I would hope in something that would
2453 save taxpayers billions, save seniors a lot of headache, and
2454 maybe save some lives here, I hope that that information is
2455 getting to her.

2456 One other thing I want to read briefly--and this is from
2457 a magazine called ``Mother Jones''--not my usual reading but
2458 I found it interesting that it talks about a case here--and I
2459 would like to submit this for the record, too, Mr. Chairman--

2460 Mr. {Stearns.} By unanimous consent, so ordered.

2461 [The information follows:]

2462 ***** COMMITTEE INSERT *****

|

2463 Mr. {Murphy.} --where someone actually got snared by
2464 Medicare twice. It says the first time in 2002 when the
2465 Agency began seizing her only income of \$498 monthly Social
2466 Security check for nearly 3 years until she repaid more than
2467 \$16,000, her settlement minus legal fees. After that, she
2468 thought her troubles were over, but in 2008, Medicare
2469 returned for more. That 66,000 bill not only failed to
2470 recognize that Cory had already repaid what she owed, it also
2471 far exceeded the \$20,000 she had received from her daughter's
2472 insurance company in the first place. And eventually, this
2473 person, a former accountant, discovered that Medicare had
2474 included every procedure Molly had undergone since her
2475 accident, including unrelated care like open-heart surgery
2476 and treatment for emphysema. And, of course, cases like this
2477 abound.

2478 And I am hoping that one of the outcomes of this
2479 hearing, Mr. Chairman, is that we hear from cases throughout
2480 the country. We have just got to fix this problem. It is
2481 hurting too many seniors and hurting the taxpayers. And I
2482 join my colleague from Colorado in saying when you have
2483 retailers, plaintiffs' attorneys, defense attorneys, those
2484 advocates of senior citizens all agreeing this has to be
2485 fixed, it is time to fix it. And I yield back my time.

2486 Thank you.

2487 Mr. {Stearns.} The gentleman yields back his time. We
2488 recognize the chairman emeritus of the Energy and Commerce
2489 Committee, Mr. Dingell from Michigan, for 5 minutes.

2490 Mr. {Dingell.} Mr. Matzus, the issues will be directed
2491 at you. It sounds like the Medicare Secondary Payer
2492 reimbursement process is lengthy, burdensome, and complex for
2493 beneficiaries and attorneys to navigate. Why doesn't
2494 Medicare pursue reimbursement from the primary payer
2495 directly?

2496 Mr. {Matzus.} Congressman Dingell, my hunch on that
2497 would be from a cost-efficiency standpoint, it is more cost
2498 effective for Medicare to recover money in a passive manner
2499 as opposed to direct intervention in pursuit of claims.

2500 Mr. {Dingell.} All right. Now, what happens if
2501 beneficiaries decide they don't want to pursue claims? For
2502 example, if an 89-year-old woman broke her leg in a car
2503 accident and then decided not to file an insurance claim or
2504 pursue any other form of recompense, wouldn't Medicare then
2505 be stuck with all the bills without any form of
2506 reimbursement?

2507 Mr. {Matzus.} In practical reality--

2508 Mr. {Dingell.} That is a very real problem, isn't it?

2509 Mr. {Matzus.} It is.

2510 Mr. {Dingell.} All right. And I am sorry to hurry you
2511 but time here is limited.

2512 It is my understanding from your testimony that if you
2513 are unable to reimburse Medicare until after the parties have
2514 reached a settlement, you have a Final Demand letter from CMS
2515 and those often take many months or even years to get. Is
2516 this is the case? Yes or no?

2517 Mr. {Matzus.} Yes.

2518 Mr. {Dingell.} Okay. Now, what happens to the
2519 beneficiary's settlement money in the intervening time? Is
2520 the beneficiary able to access the money?

2521 Mr. {Matzus.} No.

2522 Mr. {Dingell.} In your experience from working on such
2523 cases, how long is the settlement money typically in limbo
2524 before Medicare is reimbursed?

2525 Mr. {Matzus.} A short period of time would be 3 or 4
2526 months. A typical period of time is probably 6 to 9 months
2527 or longer.

2528 Mr. {Dingell.} Now, you and I are both attorneys and I
2529 am sort of curious. As a fellow attorney, how does this
2530 affect the attorney-client relationship?

2531 Mr. {Matzus.} It creates significant problems with the
2532 attorney-client relationship.

2533 Mr. {Dingell.} Now, the next question is to you again,

2534 Mr. Matzus, Mr. Salm, and Mr. Gilliam. Mr. Matzus, Mr. Salm,
2535 and Mr. Gilliam, has your business or other businesses
2536 similar to yours incurred additional costs as a result of
2537 lengthy and burdensome Medicare Secondary Payment
2538 reimbursement process? Yes or no?

2539 Mr. {Salm.} A big yes. Yes, we have.

2540 Mr. {Dingell.} Okay. Mr. Matzus?

2541 Mr. {Matzus.} Yes.

2542 Mr. {Dingell.} Mr. Gilliam?

2543 Mr. {Gilliam.} Yes.

2544 Mr. {Dingell.} Okay. Now, what effects have these
2545 costs had on your business? Starting with Mr. Salm, Mr.
2546 Gilliam, and then Mr. Matzus.

2547 Mr. {Salm.} The first effect we have had is we have
2548 spent hundreds of thousands of dollars in an attempt to get
2549 Medicare the data that they need in the workers' comp
2550 setting. The second effect it has had is delayed the
2551 resolution of liability claims while we have been waiting to
2552 figure out what Medicare's number is and get the money to
2553 Medicare. The longer a case stays open, the more the case
2554 costs somebody like Publix Super Markets and the slower it is
2555 to get to the beneficiaries.

2556 Mr. {Dingell.} So it hurts most everybody involved?

2557 Mr. {Salm.} Yeah, it absolutely hurts the primary

2558 company like Publix, it hurts an insurance company like
2559 Cincinnati, it hurts the plaintiff's attorney who is waiting
2560 to get his money and to deal with client, and of course it
2561 hurts the person that we are all talking about here, the
2562 beneficiary, because these are people who are waiting for
2563 their money in a liability claim situation.

2564 Mr. {Dingell.} All right. Mr. Gilliam, your additional
2565 comments?

2566 Mr. {Gilliam.} Yes, we have incurred hundreds of
2567 thousands if not millions complying with this reporting
2568 manual trying to collect the data and keep it safe from
2569 hackers so we can report it. It so delays the claims
2570 settlement process, and at my company, we have a philosophy.
2571 We are in the claims-paying business. We like to speedily
2572 end claims. We don't like to have people upset that they are
2573 waiting, and the longer we have to keep a file open, the more
2574 it costs us and takes our adjusters away from handling
2575 current claims as they shepherd these old claims.

2576 Mr. {Dingell.} Mr. Matzus?

2577 Mr. {Matzus.} Congressman, more important than the
2578 costs to our firm are the costs and the financial
2579 consequences as well as the emotional consequences to
2580 Medicare beneficiaries. While putting more work and time
2581 into a case does increase our cost, most importantly, the

2582 significant costs by the delay are borne by the Medicare
2583 beneficiaries.

2584 Mr. {Dingell.} Thank you. Now, last question,
2585 gentlemen. What expectations do you have for the future if
2586 costs associated with Medicare Secondary Payment
2587 reimbursements remain the same or increase? In other words,
2588 what does the future hold if costs remain the same or
2589 increase? And don't be shy.

2590 Mr. {Matzus.} The nightmare continues and gets worse.
2591 We end up spending all of our time dealing with computers and
2592 being on the phone for an hour and a half when we could be
2593 helping people.

2594 Mr. {Dingell.} Now, we also have reason to think that
2595 it will probably increase over time, do we not? And that
2596 means there will be a multiplier effect take place, does it
2597 not?

2598 Mr. {Gilliam.} If they would simply start over and ask
2599 us what kind of data do we already collect, we might already
2600 have the data they want but they ask us to collect all this
2601 ridiculous data that doesn't really help them identify who
2602 owes them money. Talk to us about what we already have and
2603 maybe we already have it.

2604 Mr. {Dingell.} My time has expired and I thank the
2605 chair for it, but would you each submit to us for purposes of

2606 the record your suggestions about what should be done to
2607 correct this intolerable situation and to make it better from
2608 your standpoint, from the standpoint of the patients and the
2609 beneficiaries, and from the standpoint of the government, if
2610 you please.

2611 And I would ask, Mr. Chairman, that the record remain
2612 open for that purpose.

2613 Mr. {Stearns.} All right. The gentleman's request is
2614 obliged with. And the gentleman from Georgia, Mr. Gingrey,
2615 is recognized for 5 minutes.

2616 Dr. {Gingrey.} Mr. Chairman, thank you.

2617 Mr. Matzus, you had, in responding to Mr. Dingell in
2618 regard to the amount of time, the so-called limbo period I
2619 think you said 3 to 4 months but typically 6 to 9 months, let
2620 us reference a medical malpractice tort case where there is a
2621 settlement or a judgment in fact. During that period of
2622 time, that limbo period, who actually controls the proceeds?

2623 Mr. {Matzus.} The proceeds are typically provided to
2624 the law firm, the plaintiff's law firm, and the money is held
2625 in the plaintiff's firm's escrow account.

2626 Dr. {Gingrey.} All right. And thank you for that
2627 answer. So the money is controlled during that limbo period
2628 by plaintiff's attorney, by the law firm. And you say it is
2629 placed in escrow. Are there limitations in regard to what

2630 you can do with that escrow account? Let us say can you put
2631 it in a money market fund? Can you put it in a local bank?
2632 And if there is interest generated on that money during that
2633 interim, who does that interest go to? Does it go to the
2634 plaintiff, the injured party, or does it go the law firm?

2635 Mr. {Matzus.} It goes to neither as I understand it.

2636 Dr. {Gingrey.} Well, who does it go to? Does it go to
2637 charity?

2638 Mr. {Matzus.} If there is interest occur, that is a
2639 good question, I don't exactly know. Typically, if the money
2640 is held in a client-on-trust account, the interest would, I
2641 guess, ultimately in the aggregate go to the particular
2642 State's Client Trust program.

2643 Dr. {Gingrey.} Well, in my humble opinion, I would
2644 think it should go to the injured party, to the plaintiff
2645 ultimately.

2646 Mr. {Matzus.} I agree.

2647 Dr. {Gingrey.} Let me ask this question of Ms. Stein.

2648 You are an advocate for Medicare beneficiaries and we
2649 appreciate that. In regard to this requirement to pay back
2650 Medicare for the cost that they have incurred and this
2651 subrogation requirement that is in the law, if the injured
2652 party is still living and it has been 2 years later that they
2653 get this demand letter from Medicare, does Medicare have the

2654 authority within the law to put a lien on Social Security
2655 benefits as an example if that happens to be their only
2656 asset?

2657 Ms. {Stein.} Yes, they could actually begin to deduct
2658 money from the Social Security benefits.

2659 Dr. {Gingrey.} And if the individual is deceased by the
2660 time they get the demand letter, the lien would be against
2661 their estate if they have any value there?

2662 Ms. {Stein.} Yes, I believe that is the case.

2663 Dr. {Gingrey.} All right, thank you. Let me ask one
2664 quick question of everybody. We heard Ms. Taylor testify
2665 that CMS does provide Medicare Secondary Payment
2666 reimbursement amount in a timely manner. However, the
2667 testimony of this panel, the four of you seem to contradict
2668 that statement. Let me just ask you one by one starting with
2669 Mr. Salm. Does CMS consistently provide the amount owed to
2670 Medicare in a timely fashion before the case is settled, yes
2671 or no?

2672 Mr. {Salm.} No. They can't. The regulations prohibit
2673 them from giving us the final payout amount before the case
2674 is settled.

2675 Dr. {Gingrey.} Do they provide you--I will add to is--a
2676 reasonable estimate of what the costs are?

2677 Mr. {Salm.} They provide a conditional payment letter.

2678 The time that it takes to get the conditional payment letter
2679 ranges between--for a party like mine--never and 6 months.
2680 But we make an awful lot of requests for these and they
2681 frequently respond back we have no record of this file.

2682 Dr. {Gingrey.} And again, I wanted all of you to answer
2683 this and I am expanding the question a bit. But if they make
2684 an estimate, would it be reasonable to say that then the
2685 maximum amount that they could eventually recover would be
2686 within a certain percentage point above that estimate and no
2687 more?

2688 Mr. {Salm.} I think that is fair.

2689 Dr. {Gingrey.} Let us go ahead, Mr. Gilliam.

2690 Mr. {Gilliam.} We never get timely numbers. I don't
2691 know of any instance where we got a timely number. I think
2692 Ms. Taylor talked about 65 days. If they gave us a number at
2693 65 days, we would be dancing in the street and back home in
2694 Cincinnati and not here in Washington.

2695 Dr. {Gingrey.} Mr. Matzus?

2696 Mr. {Matzus.} The CPL letters, the conditional payment
2697 letters, are not generally provided timely within the 65-day
2698 period. In regard to your last point about if Medicare was
2699 limited in the amount that they could recover by percentage
2700 above the figure in the CPL, that would be very, very
2701 helpful. Currently, there is no such limitation. So from a

2702 practical perspective, the CPL number is meaningless because
2703 it is not a final number.

2704 Dr. {Gingrey.} Right. And finally, Ms. Stein?

2705 Ms. {Stein.} I agree. I think that it would extremely
2706 helpful to limit it. I think it would also help in closing
2707 cases in a timely manner. So, again, when claims aren't
2708 properly segregated, individuals aren't receiving notices,
2709 you know, 10 years later or they are not able to access
2710 Medicare coverage because there has been a lien against them.

2711 Dr. {Gingrey.} Right, thank you.

2712 Thank you, Mr. Chairman, for your patience with us.

2713 Mr. {Stearns.} Well, thank you. And I just want to
2714 follow up with what you had indicated. Actually, this Mother
2715 Jones article, Ms. Cory, who got into an automobile in 1995,
2716 Medicare actually confiscated her Social Security check of
2717 \$498 in 2002, so she was 88 years old and Medicare came in
2718 and confiscated it for 3 years until she repaid more than
2719 \$16,000, her settlement minus some legal fees. So I mean
2720 that is an egregious example.

2721 In closing, I just want to put into the record--I have
2722 in my hand MSP demands for \$1.59, \$2.81, and \$4.82. I ask
2723 unanimous consent that they be made part of the record.

2724 [The information follows:]

2725 ***** COMMITTEE INSERT *****

|
2726 Mr. {Stearns.} And Mr. Salm, is this a frequent
2727 instance of where Medicare is spending, you know, 43 percent
2728 of its time for pursuing 2 percent of its dollars?

2729 Mr. {Salm.} It is impossible for me to tell how
2730 frequent it is given the difficulty of collecting
2731 information, but I have additional claims with me for \$36.75,
2732 \$42.50, \$44.83, and I think the biggest one I have is \$69.62.
2733 When you consider that there is \$1 billion at stake, it seems
2734 to me that this is not a good use of our government's time.

2735 Mr. {Stearns.} On the \$36, how long did it take?

2736 Mr. {Salm.} I can't tell you. I am sorry.

2737 Mr. {Stearns.} Yeah, okay.

2738 Mr. {Gilliam.} Mr. Chairman, if I could jump in, we
2739 have a claim that we have been waiting for 14 months for
2740 Medicare to accept our payment of \$16.54.

2741 Mr. {Stearns.} \$16?

2742 Mr. {Gilliam.} Yes. We have called them. We have
2743 written them, and so 14 months later, a file is still open
2744 waiting for a release from Medicare and they haven't even
2745 cashed our check for \$16.54.

2746 Mr. {Stearns.} I wonder why they haven't cashed your
2747 check? Part of the bureaucracy.

2748 Mr. Matzus, is this sort of typical of the frequency?

2749 Or how frequent does this occur in your litigation?

2750 Mr. {Matzus.} It doesn't occur in our litigation.

2751 Mr. {Stearns.} Do you have your mike on? It doesn't
2752 occur?

2753 Mr. {Matzus.} It doesn't occur--

2754 Mr. {Stearns.} Okay.

2755 Mr. {Matzus.} --in our practice.

2756 Mr. {Stearns.} Okay. Ms. Stein, is this--

2757 Ms. {Stein.} Mostly the clients that call us tend to
2758 have Medicare claims higher amounts, above \$5,000, but we did
2759 have a case recently that was \$35.

2760 Mr. {Gilliam.} And to make you more angry, 24 months
2761 for a \$91 payment. We are waiting 24 months.

2762 Mr. {Stearns.} Twenty-four months for a \$91 payment.

2763 Mr. {Gilliam.} To be accepted.

2764 Mr. {Stearns.} Wow. Well, I think we have finished our
2765 hearing.

2766 Ms. DeGette, is there anything you would like to add?

2767 With that, I think we will close the hearing. I want to
2768 thank you for your forbearance, for waiting as the second
2769 panelists. I think clearly this Agency, Medicare, has not
2770 worked well with the Secondary Payment and we, as Members of
2771 Congress, are going to have a second hearing if possible on
2772 this, and we look forward to trying to solve these problems.

2773 And thank you for your interest.

2774 [Whereupon, at 12:26 p.m., the subcommittee was

2775 adjourned.]