

**Testimony of Scott A. Gilliam  
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**On “Protecting Medicare with Improvements to the Secondary Payer Regime”**

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

**June 22, 2011**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

#### *Section 111 Reporting – Penalty Provisions*

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

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

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

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

*One Additional Issue – CMS Mis-identifying Responsible Parties*

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

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

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

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

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

#### *Conclusion*

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

I welcome any questions that you have.