

THE COMMITTEE ON ENERGY AND COMMERCE
INTERNAL MEMORANDUM



June 17, 2011

TO: Members, Subcommittee on Oversight and Investigations

FROM: Subcommittee on Oversight and Investigations Staff

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

On Wednesday, June 22, 2011, at 10:00 a.m., in room 2322 of the Rayburn House Office Building, the Subcommittee on Oversight and Investigations will hold a hearing entitled “Protecting Medicare with Improvements to the Secondary Payer Regime.” Maintaining the viability and integrity of Medicare is critical. The Medicare Secondary Payer (MSP) system was put in place to protect Medicare funds by ensuring that the Centers for Medicare and Medicaid Services (CMS) is reimbursed, pursuant to law, for health care services that insurance companies or other entities have primary responsibility for payment. The hearing will examine the state of the current system and whether it adequately protects the interests of Medicare beneficiaries, businesses, health plans, taxpayers, and the Medicare Trust Fund.

I. Witnesses

Panel I

Ms. Deborah Taylor
Director of Financial Management
Centers for Medicare and Medicaid Services

Mr. James Cosgrove
Director, Health Care
Government Accountability Office

Panel II

Mr. Marc Salm
Vice President, Risk Management
Publix Super Markets, Inc.

Mr. Scott Gilliam
Vice President
Cincinnati Insurance Company

Additional witnesses may be called at the discretion of the Majority.

II. Discussion

Medicare is usually the “primary payer.” It pays beneficiaries’ health claims first, and if a beneficiary has other insurance, that insurance may fill in all or some of Medicare’s gaps.

However, § 1862(b) of the Social Security Act authorizes the Medicare Secondary Payer (MSP) program, which identifies specific conditions under which another party pays and Medicare is only responsible for qualified secondary payments. Medicare is generally the secondary payer for medical care covered through (1) a group health plan based on either their own or a spouse's current employment; (2) third-party liability insurance including, but not limited to, coverage for health care services related to auto accidents, product liability or medical malpractice claims; (3) third-party no-fault liability insurance; and (4) workers' compensation situations. In certain circumstances, CMS may make a conditional payment for Medicare covered services where another payer is responsible for payment; however, CMS has the right to recover the amount of claims paid by the primary payer or anyone who has received the primary payment.

For example, if a Medicare beneficiary is hit by a car and receives treatment at a hospital, CMS may make a conditional payment for the Medicare-covered expenses. However, if the beneficiary later sues the driver of the car and settles with the driver's insurance company, once the settlement is agreed to, Medicare must be reimbursed because, by statute, it is the secondary, not primary, payer. In addition to reimbursing CMS for claims paid, settling parties must account for reasonably-expected future costs of Medicare-covered expenses that may later arise.

The law authorizes several methods to identify cases when a health plan or insurer other than Medicare is the primary payer and to facilitate recoveries when conditional payments have been made by CMS. However, until recently, third-party insurers have not been required to report cases in which they have become primary payer and Medicare is the secondary payer. With the goal of coordinating payment obligations, section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) set mandatory reporting requirements for all plans that pay for medical services and are primary to Medicare, with fines assessed daily for noncompliance. After several delays in the implementation timeline due to problems with the reporting system, starting January 1, 2011, no-fault and workers' compensation insurers began reporting claim settlements and other payments made to a beneficiary. Liability insurers begin reporting January 1, 2012. In addition to meeting numerous other requirements, reporting entities must obtain and submit the social security numbers of beneficiaries with whom they settle claims.

Unfortunately, many claims cannot be settled in a timely or conclusive manner. Under current law, there is no requirement for CMS to provide, and CMS has not been providing, the parties with amounts due or the amount they should set aside to cover future payments *before* settlement so the parties can appropriately allocate and resolve these Medicare obligations *during* settlement. For workers' compensation cases, CMS has—through informal agency memoranda—created a voluntary procedure for parties to seek review and approval of the medical allocations in their proposed settlements. However, according to various stakeholders, the process for approval is unclear, does not recognize requirements of settlements under state workers' compensation statutes, and causes delay and inefficiency. For liability claims, no such process for prior review and approval even exists. This has created a costly legal nightmare for both large and small businesses.

III. Issues

The following issues will be examined at the hearing:

- What are the savings that could be obtained via changes to MSP regulations or policies at CMS?
- Is CMS utilizing the most efficient methods to determine how much is owed Medicare and then communicating this with interested parties in a timely and effective manner?
- How does CMS currently work with settling parties to ensure they consider Medicare's interests when calculating a settlement?
- Should CMS be authorized to provide settling parties with the amount of the parties' repayment amount to Medicare and future set-aside obligations prior to settlement?
- How will the new CMS reporting requirements better protect the interests of Medicare beneficiaries, businesses, health plans, taxpayers, and the Medicare Trust Fund?
- What other improvements can be made to the MSP system to ensure Medicare is fully reimbursed for conditional payments in a timely and least burdensome manner?
- How does CMS prioritize the recovery of payment for claims from the primary payer or others who received the primary payment?

IV. Staff Contacts

If you have any questions about this hearing, please contact Sean Hayes, Stacy Cline, or John Stone with the Subcommittee on Oversight and Investigations, at (202) 225-2927.