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

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

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

JUNE 22, 2011

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

About Publix

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

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

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

The Medicare Advocacy Recovery Coalition (MARC)

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

What is the MSP Program?

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

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

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

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

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

---

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

Suggestions for Improvement of the Program

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

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

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

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

---

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

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

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

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

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

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

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

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

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

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

Conclusion

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