CMS, Claims Managers Discuss Reforms to MSP in House Testimony

The House Committee on Energy and Commerce Subcommittee on Oversight and Investigations on June 22nd received testimony from a line-up of witnesses representing insurance carriers, self-insured employers and attorneys. Witnesses pointed out a laundry list of issues with Section 111 reporting, the lack of a final demand letter for conditional payment recovery from CMS to enable the timely settlement of claims, difficulties with requiring claimants to provide social security numbers, the unintended consequences of the $1,000 per day fines for failing to report under Section 111, and confusion about who is responsible for reporting and reimbursement for conditional payments.

Rep. Cliff Stearns (R-FL), Chairman of the Oversight and Investigations Subcommittee noted in reviewing the hearing that Deborah Taylor, Chief Financial Officer and Director of the Office of Financial Management, Centers for Medicare and Medicaid Services (CMS), was unable to answer numerous questions for example: (1) number of claims for small dollar amounts outstanding; (2) the response time for getting information and payments to beneficiaries; (3) median amount of money involved with the 413,000 outstanding cases; (4) the threshold for not seeking funds; (5) how much CMS is failing to collect; (6) duration time for the claim settlement. Ms.Taylor had submitted testimony that

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

Other witnesses outlined many of the problems they have dealing with CMS. Marc Salm, Vice President, Risk Management, Publix Super Markets, Inc., testified, "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 tine to collect a 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!" Another witness noted that CMS spent 14 months pursuing $16.

Scott Gilliam, Vice President, Cincinnati Insurance Company, also noted the difficulties in getting information from CMS. Gilliam noted the lack of responsiveness of the Medicare Secondary Payer Recovery Contractor, "We are waiting for final demand letters from them for 11 months, 12 months, 14 months, 18 months, 6 months, 6 months, 7 months, 7, 7, and 8 – they never send letters. We are on hold [on the telephone] for 56 minutes or an hour or 90 minutes."

Chairman Stearns stated in conclusion that he would likely hold another hearing in the future. He also entered into the record the case of Mollie Coury, who at age 81 was injured in an auto accident in 1995. Thirteen years later, Medicare demanded $66,000 because she received an insurance settlement of $20,000. Medicare then proceeded to seize her only income, a monthly social Security check for $498 while she was 94 years old.