

**Opening Statement of the Honorable Cliff Stearns
Chairman, Subcommittee on Oversight and Investigations
“Protecting Medicare with Improvements to the Secondary Payer Regime”
June 22, 2011
(As Prepared for Delivery)**

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

Generally, Medicare is the “primary payer” for health claims. If a beneficiary has other insurance, that insurance may fill in all or some of Medicare’s gaps. However, the Medicare Secondary Payer program identifies specific conditions under which another party is legally responsible to be the primary payer. In such cases, Medicare is only responsible for certain secondary payments. This Medicare Secondary Payer statute was enacted to reduce expenditures under the Medicare program, and ensure that Medicare is properly reimbursed for such payments.

The law prohibits Medicare payments for any item or service when payment has been made or can reasonably be expected to be made by a third-party payer - such as workers’ compensation, auto medical insurance and all forms of no-fault and liability insurance.

Medicare Secondary Payer recoveries fall into two main categories: post-payment collections for injuries that have occurred and were paid out by Medicare, and a set-aside account to cover future medical bills.

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

This raises several questions: Why can’t CMS more quickly and accurately track medical costs for covered individuals? And is CMS even capable of administering a health payment program for the medical community or accurately tracking costs? Based on a hearing in this subcommittee earlier this year, we already know CMS cannot accurately measure the amount lost to fraud and that CMS doles out tens of billions of dollars in improper payments every year. And we have yet to see reliable estimates on the total amount of secondary payment reimbursements that remain uncollected by CMS.

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

CMS now says that they plan to increase education and awareness for the legal community on the requirements of Medicare Secondary Payer- which has been on the books for almost 30 years. That CMS needs to education people on a 30 year old law brings into question what they have been doing for the past 30 years and how effective their outreach efforts have been. I think more needs to be done. Whenever retailers, insurance companies, and plaintiff's attorneys are all sending letters to CMS, anxious to pay the federal government, and they can't get a complete or timely response about how much they owe, the system is badly broken. Hopefully our witnesses today can help us better understand the underlying problems, and we can work on a bipartisan basis to fix them.

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