



# THE MONTH IN WASHINGTON

A Federal Report Provided by **LGVA**

## APRIL 2012

Republicans in April continued their attacks on President Obama's two major domestic policy achievements. The House Financial Services Committee approved legislation that would repeal certain key provisions of the financial regulations reform law and reduce funding for the new Consumer Financial Protection Bureau, and a former member of the Bush administration charged that the health care reform law will increase the federal debt. A liberal advocacy group, meanwhile, reported that the budget proposed by House GOP members would cut nearly \$3 trillion from healthcare programs over the next decade.

### ISSUES AND EVENTS

#### **House Panel Rejects Treasury Request, Moves to Limit Dodd-Frank**

Treasury Secretary Timothy Geithner on April 17 sent a [letter](#) to House Financial Services Committee Chairman Spencer Baucus (R-AL) and Ranking Member Barney Frank (D-MA) warning against repeal of Dodd-Frank financial reform law provisions in advance of that panel's scheduled vote the following day to limit the federal government's authority to regulate the financial industry.

But the Committee rejected the Secretary's appeal, voting 31-26 along party lines to use a budget reconciliation measure to repeal provisions in Dodd-Frank that allow the federal government to take over financially troubled banks and to limit the Consumer Financial Protection Bureau (CFPB). Democrats tried unsuccessfully to include several amendments preserving some of the Dodd-Frank measures.

The House committee voted to strip the FDIC of its resolution authority to take over failing banks and to both tighten oversight of the CFPB and reduce its funding. Committee members argued over the intent of the FDIC provisions. Republican members indicated that the provisions were another form of bailout and that they would allow the FDIC to pick and choose winners and losers from the pool of creditors of the financial company. Democrats countered that the provisions are designed to prevent future bailouts and that the provisions would allow the FDIC to liquidate failing firms in an orderly fashion. One of the powers of the FDIC would be to pay those creditors necessary to ensure an orderly

liquidation.

The committee also rehashed much of the debate surrounding the creation of the CFPB. Republicans argued that the bureau is unaccountable and overfunded, as its annual budget is not subject to congressional appropriations. Democrats responded that it was created to be an independent agency that was insulated from political pressures from both Capitol Hill and the Federal Reserve Board.

The vote came in response to a request by the House Budget Committee to meet fiscal reconciliation levels that exceed last summer's debt ceiling negotiations. It was estimated the result of these provisions, if passed, would be savings of more than \$35 billion over ten years.

Geithner said such a move "would critically undermine the government's ability to limit the damage to the economy in the event of future financial crises" and would "weaken the ability of the Bureau to provide stronger protection to consumers against financial fraud and abuse."

The FDIC has long had the power to force failing national banks into receivership and wind them down. Dodd-Frank expanded this power to include large, non-bank financial institutions. Supporters of the legislation argued that the nation may have avoided the financial crisis stemming from the collapse of Lehman Brothers and bailout of AIG if the federal government had had the power to orderly liquidate the firms.

With respect to CFPB funding, Frank fired back, saying, "The effect of this provision would be politicize the process of CFPB funding and likely significantly restrict funds to the new agency, thus hobbling the bureau."

In another attempt to repeal provisions of the financial reform law, Financial Services Committee members on April 19 moved to abolish the Office of Financial Research, an obscure but potentially powerful office created by Dodd-Frank. The office was designed to collect data and conduct research on potential risks to the U.S. financial system.

Saying it "was given essentially unlimited authority," Rep. Francisco Canseco (R-TX) called the office a "threat to democracy." The office is funded through July 21, 2012, by the Federal Reserve; it will then be funded by fees on financial companies with at least \$50 billion in assets.

### **Federal Regulators Will Delay Implementation of Volcker Rule**

The Federal Reserve on April 19 announced that it will delay implementation of the Volcker Rule until July 21, 2014, a two-year extension it said will better enable banks and financial institutions to conform to the measure. The rule proscribes strict limits on the trading and investment activities of FDIC-covered banks, such as prohibiting a bank from trading for profit using its own funds. There has been increasing bipartisan anxiety about

implementation with the original deadline just a few months away.

Opponents of the Volcker Rule have said it is too complex and cumbersome. During the past year, many bankers and regulators have testified before the House Financial Services Committee to complain about it. Senator Michael Crapo (R-ID) introduced a bill in March to delay implementation by one year. Senator Bob Corker (R-TN), a co-sponsor of the bill, said last week, “While I am pleased the regulators have recognized the need for this modest step, ultimately this flawed rule will need to be fixed by Congress so companies across our country will not have to incur higher costs of doing business, which will ultimately be borne by the consumer.”

Barney Frank (D-MA), Ranking Member of the House Financial Services Committee, supported the decision to keep the measure and take whatever time is needed to enable banks to conform to the new rules. Frank released a statement saying in part, “The guidance issued today by the Federal Reserve regarding the Volcker Rule is an appropriate and reasoned approach to the implementation of this important provision. As the statute requires, the board’s position gives the affected institutions time to come into compliance, without any retreat from the application of the basic principle. The two-year period during which the banks will have to come into compliance with the rule will allow a reasonable time for them to make their necessary changes, and will give the regulators the chance to deal with any particular issues that arise from the experience of implementation.”

### **House Panel Grills SEC Chairman on Cost-Benefit Analyses**

The SEC has failed to appropriately consider the costs and benefits of its rules, a key House subcommittee chairman told the agency’s leadership in mid-April.

TARP and Financial Services Subcommittee chairman Patrick McHenry (R-NC) quoted from the D.C. Circuit Court opinion in *BRT v SEC*, which invalidated the SEC’s proxy access on the grounds that the agency had not conducted an appropriate cost-benefit analysis. McHenry said that the DC Circuit has shot down at least three rules in the past two years on similar grounds.

Testifying before Congress for the 42<sup>nd</sup> time, Security and Exchange Commission Chairman Mary Schapiro told the subcommittee the SEC is not averse to cost-benefit analysis. She said the SEC has 28 rules remaining to be finalized under requirements of the Dodd-Frank reforms, and that the agency has tried hard to prioritize the formulation of new rules, starting with those that have statutory deadlines. She said she expects most of the rules required by Dodd-Frank will be completed this year.

Schapiro has at times struggled to convince Republican skeptics that the SEC is capable of handling the vastly increased scope of the agency’s new responsibilities under Dodd-Frank, while at the same time requesting additional funding from lawmakers hostile to the reform law to pay for new economists and accountants to handle the workload, saying

“My view is that we’re still under-resourced to the task we face.”

When asked how she would feel if Congress repealed Dodd-Frank, she said, “It would be a mistake” because “we’re making our way through the rule-making with progress.”

When asked by Rep. Carolyn Maloney (D-NY) how many SEC regulations have been overturned because of systematic failure to do quality cost-analysis, Schapiro responded, “In three years, we have done 51 substantive final rules and one has been challenged.”

McHenry asked Schapiro about whether newly issued guidance on rule-making will be retroactively applied to the 28 rules still awaiting final decisions. She assured him that “staff is reviewing [them] to see if they meet the new criteria” and said the agency performs cost analyses on all of its rules. McHenry challenged that assertion, asking why four of the 28 rules had no cost-benefit analysis. Schapiro responded that those four were delegations of authority not requiring cost analysis.

McHenry also pressed Schapiro about her objections to “crowdfunding,” the ability of businesses to raise capital using social media sites, to which she replied, “The law of the land is the law of the land, whether we agree with it or not. We will do whatever Congress has asked us to do” in permitting the practice with guidance developed by the commission.

### **Ryan Plan Draws Fire for Cuts to Medicare; Democrats Look to Fund Medicaid Expansion**

According to the public advocacy group Families USA, the GOP budget proposed by Paul Ryan (R-WI) would cut as much as \$3 trillion from healthcare programs.

The group presented a [study](#) that tallied state-by-state the costs required to implement Ryan’s changes to Medicare and Medicaid. Ryan’s plan would repeal the ACA and would fundamentally restructure Medicaid into a block grant-style program and Medicare into what critics call a voucher system. Families USA claims those cuts, along with Medicare reductions, would reduce spending on the programs by \$2.75 billion over 10 years. According to the report, California would experience the biggest cuts, totaling more than \$300 billion.

House Democrats, meanwhile, are discussing ways to ensure the ACA’s expansion of Medicaid will survive.

While 20 million people are projected to gain health insurance coverage under the ACA’s state operated insurance exchanges, there are an additional 17 million people who will gain coverage under the ACA’s expansion of Medicaid and the Children’s Health Insurance Program (CHIP). However, low reimbursement rates for doctors treating the poorest and sickest patients hamper their ability to take on more patients under the expansion plan.

House Democrats are considering a budget bill that would include a requirement for states to pay physicians accepting Medicaid 100 percent of the current Medicare rates, subsidized for 2013 and 2014 by the federal government. The CBO projected the cost of such a plan would run about \$8.3 billion.

Republican opponents claim such a plan would be a “bait and switch” tactic that only delays the inevitable. They also fear the subsidies might become permanent. But supporters believe a plan to subsidize Medicaid rates temporarily could offer important stabilization until the ACA is fully implemented.

The non-partisan Center for Healthcare Strategies issued a report on the proposal that concluded, “The increased reimbursement could be a powerful tool for bolstering the delivery system, enhancing access, and improving the quality of primary care for current and new beneficiaries.”

### **Dust-Up Over Cost of the Affordable Care Act**

Wrangling over the president’s healthcare reform law continued unabated in April and was centered on a controversial [report](#) issued April 10 by Charles Blahous, one of two public trustees for Medicare and Social Security. Blahous, who served as deputy director of President’s Bush’s National Economic Council and is now a senior research fellow at George Mason University’s Mercatus Center, claimed the ACA will not reduce deficits as promised, but rather will add \$340 billion to the nation’s debt.

Blahous contends the administration “double counted” Medicare savings when scoring the financial impact of the law. The Congressional Budget Office estimated in 2010 that the ACA would cut the nation’s deficit using new fees from health plans and drug companies and reduced reimbursement rates to doctors, hospitals and insurers, with savings projected to be about \$575 billion. With Medicare projected to run dry by 2017, however, these savings were applied to extending the Medicare Trust Fund.

Blahous said the same funds were applied to offset an ACA expansion of Medicare and, therefore, were counted twice. A CBO spokesman defended the scoring saying the CBO scores all federal expenditures the same way.

In a blog posting about his report, Blahous wrote, “Many of the cost-savings measures under the ACA were already required in some form under previous law, and thus their combination with a substantial expansion of federal health entitlements unambiguously worsens the nation’s fiscal predicament.”

Members of the administration bristled at the accusation. According to Jeanne Lambrew, Deputy Assistant to the President for Health Policy, “In another attempt to refight the battles of the past, one former Bush administration official is wrongly claiming that some of the savings in the Affordable Care Act are ‘double-counted’ and that the law actually increases the deficit. This claim is false.”

## **ACA Will Diminish Gaps in Insurance Coverage: Report**

A new [report](#) from the Commonwealth Fund says the Affordable Care Act will decrease or eliminate gaps in health insurance coverage for as many as 25 percent of Americans whose coverage was negatively affected last year by losing or changing a job. The report projected that the gaps in coverage would be greatly reduced because the new law will make it easier and more affordable for individuals to purchase coverage on their own in such circumstances.

“Together, these reforms mean that people who lose their health benefits will be able to turn to a range of affordable insurance options that will enable them to gain insurance immediately rather than enduring months or years without coverage, losing connections to their doctors, and indefinitely delaying preventive care that would help maintain their health,” the report says.

The study tracked individuals who investigated purchasing their own health insurance and found that 55 percent did not purchase health insurance because the premiums were too expensive.

## **ACA Funding to IRS Questioned**

House Ways and Means Committee Chairman Dave Camp (R-MI) and Oversight Subcommittee Chairman Charles Boustany (R-LA) in April sent a [letter](#) to IRS Commissioner Douglas Shulman requesting details about funds allocated to the IRS to implement the ACA after they learned the Obama administration was funneling nearly \$500 million to the agency outside normal appropriations channels.

Money for the Health Insurance Reform Implementation Fund (HIRIF) has been allocated by the Health and Human Services Department for ACA implementation and includes an original request for \$144 million for information technology and another \$43 million for tax administration and compliance. The president’s budget for 2012 requested \$473 million and 1,269 new IRS employees, followed by a 2013 budget request for an additional \$360 million and 589 new IRS employees to implement the ACA.

The two Ways & Means Committee leaders said they want to know what, if any, additional funds may have been requested and how that money will be spent. Opponents of the ACA have tried to cut off funding to implement it, especially funding required to implement the controversial “individual mandate” provision that allows the IRS to enact financial penalties against those who fail to purchase health insurance. Republicans have said they will try to freeze implementation efforts until after the Supreme Court rules on the constitutionality of the ACA and its individual mandate sometime in June.

## **MedPAC Biannual Report: Comments on Dual Eligibles, Out-of-Pocket Caps**

The Medicare Payment Advisory Commission on April 5-6 held public meetings to issue commentary and recommendations on several key healthcare issues. MedPAC published its twice yearly [report](#) in March and will present recommendations to Congress in June.

Among the key items discussed at last month's meetings was the announcement of a series of health law demonstration programs scheduled to go into effect next year, including programs to deal with the expense of "dual-eligibles." Most dual-eligible patients are over 65 and very poor - frequently nursing home residents who have exhausted their assets. About one-third of dual eligibles are younger than 65, but have been disabled for more than two years, and they are often developmentally disabled. These patients require specialized care coordination because of their multiple healthcare needs. Yet getting them access to complex care is often a challenge with fewer doctors and insurance agencies accepting Medicaid patients.

There will be 700,000 dual eligibles from California in the demonstration programs, which will be implemented through the Centers for Medicare and Medicaid Services (CMS). CMS reported that it will enroll up to 2 million of the nation's 10 million dual eligibles in the demonstration programs.

The objective is to develop more efficient care delivery systems for these patients. Other goals are to discourage unnecessary use or duplication of services and to provide flexibility for individual states to negotiate the right balance of benefits with CMS that will best suit their population needs.

One of the demonstration programs recommended to MedPAC would automatically enroll dual eligible patients into managed care plans. But some commissioners and staff expressed concerns about whether automatic enrollment was an appropriate avenue. "Perhaps we should be talking to [patient advocacy groups] more about this," said Commissioner Ronald Castellanos.

Unless the automatic enrollment process has a mechanism to select a managed care system that will provide the right combination of services needed by a given patient, Castellanos cautioned, there is a danger that patients could be moved from one inadequate system into another. While there was an "opt out" clause in the plan, there was still concern.

"People can opt out but they have to have something to opt into," said Castellanos. "Where the hell are they going to go?"

Also discussed was:

- the commission's recommendation to cap out-of-pocket medical expenses, a cost that can wreak havoc for patients with catastrophic illness.
- a proposal a combined deductibles for Part A inpatient and Part B outpatient

services. Co-pays may vary according to providers and types of services; currently patients are required to pay a percentage of costs.

- a recommendation that HHS apply a fee for some supplemental insurance to shift some of the costs without increasing overall costs.

Restructuring Medicare and Medicaid payments has been an increasingly difficult challenge to ignore, but the political will to tackle implementation has been absent.

In related news, a Kaiser Family Foundation report claimed in April that Medicare benefits are not as generous as most private employer-sponsored healthcare insurance plans. While the average value of the Medicare plan is almost as good as the Blue Cross-Blue Shield basic plan offered to federal employees – about 97 percent of the value – the Kaiser report said the typical large employer health insurance plan is better than both. The comparison did not include the fact that Medicare doesn't offer dental insurance, while most private employer plans do. Kaiser said Medicare's coverage equals about 93 percent of the value of a typical large employer private insurance plan.

The Kaiser report did acknowledge that Medicare patients pay less for out-patient services than most privately ensured patients and that Medicare coverage is often better than plans offered to many small business employees.

### **Institute of Medicine Report Says U.S. Chronically Underfunds Public Health**

In a [report](#) released on April 10, the Institute of Medicine (IOM) called for more than doubling federal spending on public health from \$11.6 billion to \$24 billion annually. Public health programs like diet and nutrition services, smoking cessation, prevention for diseases like diabetes, and illnesses related to obesity represent just \$251 per capita (annually) in spending, compared to more than \$8,000 per person for medical care.

“The country's failure to maximize the conditions in which people can be healthy continues to take a growing toll on the economy and on society,” said IOM Chairwoman Marthe Gold. “As the backbone of the health system, public health departments could help communities and other partners engage in efforts and policies that lead to better population health.”

The IOM recommends communities receive a minimum package of public health services from state and local governments that could be financed with a new transaction tax on medical services. President Obama's ACA created a \$15 billion Prevention and Public Health Fund to help state's finance such programs, but the fund already has been cut by \$5 billion by congressional lawmakers who have dipped into it to offset other expenses.

### **HHS Announces New Rule to Simplify Healthcare Administration**

The Department of Health and Human Services on April 9 announced a new rule

designed to cut red tape and make healthcare administration simpler under the Health Insurance Portability and Accountability Act (HIPPA). The proposed changes are required and financed by the ACA and would save health care providers and health plans up to \$4.6 billion over the next 10 years, according to estimates released by HHS.

Currently, when physicians and health administrators bill insurance providers they use “identifier” codes with no standardized names or numbers. For example, treatment codes for trauma or impact injuries like “bumped into a door” are not standardized and often result in mistakes, improper routing, delays and re-submissions. The new rule proposes that each insurer or administrator have a unique identifier of standardized length and format that will be more easily read by computers. The result should be fewer mistakes and the opportunity for more providers to automate billing procedures.

The new rule also allows for a delay in compliance for the new codes to classify diseases and health problems. That rule was to be effective October 1, 2013, but has been moved to October 1, 2014, based on feedback from providers that they would not be ready in time for the ACA’s initial deadline.

“The new health care law is cutting red tape, making our health care system more efficient and saving money,” Secretary Sebelius said. “These important simplifications will mean doctors can spend less time filling out forms and more time seeing patients.”

### **GAO Report Looks at Antitrust Issues for Exclusive Provider Collaborations**

The Government Accountability Office in April released a [report](#) requested by lawmakers that looked at how new exclusive provider collaborations, like accountable care organizations (ACOs), may be interpreting antitrust laws and what guidance regulating agencies have provided for them. The report found there are differing views among stakeholders in the healthcare industry and among antitrust experts about whether current guidance is sufficient or not.

The issue is especially relevant to health insurance providers because clinical experts are supporting the theory that greater collaboration and coordination in how patients receive treatment can significantly reduce costs and medical errors while improving medical outcomes and patient satisfaction. Many patients receive treatment in a range of settings, such as surgery in a hospital, followed by home care in their house, then rehabilitation and follow-up care in a different facility. The Affordable Care Act provides incentives for ACOs that are eligible to participate in the Medicare Shared Savings program, but questions remain about whether exclusive arrangements among providers should be more tightly regulated.

The Federal Trade Commission and the Antitrust Division of the Department of Justice, the agencies responsible for enforcing federal antitrust laws, have issued general guidance for the business community and specific guidance for health care providers on the application of antitrust laws, but “perspectives differed on the sufficiency of guidance on

clinical integration,” according to the GAO.

The GAO summary said, “Stakeholders’ perspectives differed as to whether the agencies should permit greater use of exclusive collaborative arrangements, which restrict the ability of providers within a collaborative arrangement to contract with other arrangements or health plans. The use of exclusive arrangements has the potential to improve or reduce competition, depending on the circumstances.”

Finally, the report said, stakeholders’ perspectives differed on the adequacy of guidance related to which collaborative arrangements are exempt from the antitrust analysis and therefore are presumed to be lawful (known as being within a safety zone). There were differing opinions about whether those safety zones should be expanded.

## **RELATED NATIONAL AND INDUSTRY NEWS**

### **CalPERS, CalSTRS Executives Named to Investors Advisory Committee**

Joseph Dear, CalPERS Chief Investment Officer, and Anne Sheehan, Director of Corporate Governance at the California State Teachers’ Retirement Systems (CalSTRS), were named in April to the Security and Exchange Commission’s new Investors Advisory Committee. The Committee is a newly formed board of 21 members who will advise the SEC on financial policy issues as part of the 2010 Dodd-Frank Wall Street Reform and Consumer Protection Act.

The Investors Advisory Committee will have the authority to submit findings for review and recommendations to the SEC on issues relating to the regulation of securities, trading and fees, and initiatives to protect investor interests, as well as to help the SEC set regulatory priorities.

According to SEC Chairman Mary Schapiro, “The SEC’s new Investor Advisory Committee is made up of individuals with a broad range of backgrounds and experiences.” Schapiro added, “I look forward to their insight and recommendations as to how we can further the SEC’s critical investor protection mission.”

The new committee members were nominated by the five sitting SEC commissioners, who were seeking individuals to represent a wide range of interests, including those of senior citizens, mutual fund investors, pension funds and state securities regulators. The complete list is as follows:

- Darcy Bradbury, Managing Director and Director of External Affairs, D.E. Shaw & Co., L.P.
- J. Robert Brown, Jr., Law Professor, University of Denver
- Joseph Dear, Chief Investment Officer, California Public Employees’ Retirement System
- Eugene Duffy, Partner and Principal, Paradigm Asset Management Co., LLC

- Roger Ganser, Chairman of the Board of Directors, BetterInvesting
- James Glassman, Executive Director, George W. Bush Institute
- Craig Goetsch, Director of Investor Education and Consumer Outreach, Iowa Insurance Division
- Joseph Grundfest, William A. Franke Professor of Law and Business, Stanford Law School
- Mellody Hobson, President and Director of Ariel Investments, LLC
- Stephen Holmes, General Partner and Chief Operating Officer, InterWest Partners
- Adam Kanzer, Managing Director and General Counsel of Domini Social Investments and Chief Legal Officer of the Domini Funds
- Roy Katzovicz, Partner, Investment Team Member and Chief Legal Officer, Pershing Square Capital Management, L.P.
- Barbara Roper, Director of Investor Protection, Consumer Federation of America
- Kurt Schacht, Managing Director, CFA Institute
- Alan Schnitzer, Vice Chairman and Chief Legal Officer, The Travelers Companies, Inc.
- Jean Setzfand, Director of Financial Security, AARP
- Anne Sheehan, Director of Corporate Governance, California State Teachers' Retirement System
- Damon Silvers, Associate General Counsel, AFL-CIO
- Mark Tresnowski, Managing Director and General Counsel, Madison Dearborn Partners, LLC
- Steven Wallman, Founder and Chief Executive Officer, Foliofn, Inc.
- Ann Yerger, Executive Director, Council of Institutional Investors

### **CalPERS Leads Group of Investors to Discuss 'Going Concern' Issues with SEC, PCAOB**

The SEC, the Federal Accounting Standards Board and the Public Companies Accounting Oversight Board should do more to improve transparency, credibility and accountability of financial statements by improving rules related to "going concern" issues for public companies, according to a group of investors.

In early April, representatives from CalPERS, COPERA and Legg Mason shared recommendations for improvements around going concern matters with the SEC, following a presentation at the PCAOB's Investor Advisory Group. Typically, going concern opinions are provided by auditors at a point at which it is usually too late to save a company from bankruptcy, the investors said.

Following a formal presentation to the PCAOB by the going concern taskforce, which also included the AFL-CIO, the group met with SEC Commissioner Elisse Walter. Although Walter was present for the PCAOB's meeting, she suggested she could benefit from a follow-up discussion.

The trigger for a going concern opinion was a top priority of the investor group consideration of the issue. Auditors assume that every company can continue as a going concern, but if conditions are revealed during the audit that there is substantial doubt of the company's ability to continue as a going concern in the next 12 months, the firm must tailor its audit opinion to reflect that doubt.

This threshold is too high, the group told the PCAOB and Commissioner Walter. Instead, they recommended that the auditor use a "more likely than not test" when considering whether to include a going concern opinion in its audit report.

The investors also recommended that the PCAOB revise its audit standards to require an auditor to perform procedures designed to examine a company's ability to continue as a going concern. (Currently, auditors are only required to use information gathered during the audit, not obtain independent evidence to analyze going concerns.) In addition, the group asked the SEC to consider enhanced disclosures of risks that could affect a company's financial health and outline key performance indicators that investors could analyze for themselves. Similarly, the investor group called upon FASB to require a company to disclose conditions that could make it impossible for a company to meet its obligations.

It is unclear whether any of the regulators will seek to implement these recommendations.

## CALIFORNIA CONGRESSIONAL DELEGATION NEWS

### Medicare Fraud, Waste, Abuse in Spotlight

California Representative Wally Herger (R), Chairman of the House Ways and Means Subcommittee on Health, in early April joined three other prominent Republicans with oversight and jurisdiction over the Centers for Medicare and Medicaid Services (CMS) to request answers about what is being done to limit fraud, waste and abuse in Medicare.

Herger, along with House Oversight Subcommittee Chairman Charles Boustany, M.D. (R-LA), Senate Finance Committee Ranking Member Orrin Hatch (R-UT), and committee member Tom Coburn (R-OK), sent a [letter](#) dated April 2 to Acting CMS Director Marilyn Tavenner asking whether CMS is doing all it can to limit and prevent financial fraud, waste and abuse.

In particular, lawmakers wanted to know what efforts have been made to deal with "nominee owners," also known as non-group health plans (NGHPs) when Medicare is a secondary payer (MSP) to other insurers. These entities provide contract services to collect payment on behalf of Medicare providers and insurers.

The Government Accounting Office (GAO) in March published a [report](#) that revealed significant increases in the instances of NGHP and MSP situations. The GAO report said, for example, that from 2008 to 2011, there was an increase of more than 50 percent in

voluntarily reported situations from CMS's three in-house contractors who deal with NGHP and MSP payments; in total, they were up from about 142,000 to about 392,000. It listed several ways that CMS could improve its performance, including better screening, better cost recovery efforts and improved mandatory reporting.

Citing the recent indictment of a nominee owner is charged with stealing \$20 million from Medicare over a five-year period, the congressmen wrote, "This indictment [demonstrates] that CMS's provider screening efforts are still not effectively safeguarding the Medicare program from individuals intent on committing fraud within the program and that CMS should revise its screening efforts to address nominee owners."

Health and Human Services Secretary Kathleen Sebelius took up the challenge with public comments about Medicare fraud. Speaking at the Regional Healthcare Fraud Prevention Summit in Chicago on April 4, she said, "We have a simple message to criminals thinking about committing Medicare fraud: don't even try. Thanks to health reform and our administration's work, we have new tools and resources to catch criminals and stop Medicare fraud before it happens."

She said new tools offered by the Affordable Care Act include tougher sentencing for criminal abuses, an expansion of services by the three CMS contractors (mentioned in the GAO report), and greater coordination between federal agencies.