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MEDICARE SECONDARY PAYER PROGRAM

Actions Needed to Realize Savings

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Mr. Chairman and Members of the Subcommittee:

We are pleased to be here today to highlight recent developments related to the Medicare Secondary Payer (MSP) program that could cost the Medicare trust fund hundreds of millions of dollars. Your Subcommittee recently held several hearings on the Medicare program to identify ways to avoid excessive or unnecessary spending. As you are aware, there are a number of legislative initiatives that are intended to improve the MSP program, which is administered by the Health Care Financing Administration (HCFA), an agency within the Department of Health and Human Services (HHS).

The MSP program helps assure that other health and accident insurers pay medical costs for certain covered beneficiaries before Medicare. To do so, Medicare must obtain data on a beneficiary's private health insurance coverage so that its claims processing systems can assure that other insurers, whose coverage is primary, pay claims before Medicare. This enables Medicare to avoid incurring unnecessary costs. In addition, Medicare retrospectively recovers mistaken payments that should have been paid by other health insurers. Thus, MSP is a major Medicare cost containment measure, saving about $3 billion in fiscal year 1994.

Historically, Medicare has faced many obstacles in carrying out the MSP provisions. When Medicare pays claims that other insurers should have paid, Medicare must recover its costs from the liable insurers. This is difficult. For the past decade, our reports (see Appendix I) and those issued by HHS's Inspector General have shown problems with efforts to identify and collect from insurers that are responsible for paying ahead of Medicare.

I now would like to focus on three specific legislative initiatives intended to improve Medicare's MSP program that I will discuss are the following:

-- The HCFA data match which relies on Internal Revenue Service (IRS), Social Security Administration (SSA), and Medicare records. The anticipated recovery of hundreds of millions of dollars of mistaken payments has been negated by a recent appeals court ruling that invalidates two HCFA regulations that are critical to MSP recoveries.

-- The Medicare/Medicaid data bank. As we previously testified and reported, we believe that the data bank will be expensive and add an unnecessary administrative burden to the nation's employers while achieving little or no savings because there is no assurance that the increased record-keeping requirements would provide needed or additional information on beneficiaries' health insurance coverage.

-- A beneficiary enrollment questionnaire. While this initiative has strong potential for identifying Medicare beneficiaries with other health insurance coverage, it will be some time before HCFA can assess its overall effectiveness.

BACKGROUND

Medicare provides health insurance coverage for over 36 million elderly and disabled Americans. Its coverage is quite extensive, including physician, hospital, home health, skilled nursing home, and various other services.

In enacting the Medicare program in 1965, the Congress made Medicare the secondary payer for expenses also covered by workers' compensation programs. Concerned about escalating costs in the Medicare program, the Congress made several statutory changes during the 1980s that also made Medicare the secondary payer to certain employer-sponsored group health insurance plans and to automobile and other liability insurance plans.

The MSP provisions are intended to assure that Medicare is the secondary payer, that is, other insurers pay claims before Medicare. As a result, Medicare claims processing contractors have two interrelated responsibilities: (1) to identify beneficiaries with other insurance coverage and thus avoid paying claims that other insurers should pay and (2) to identify and recover mistaken payments that were made before it was determined that the beneficiary had other insurance coverage.

The MSP provisions apply to a relatively small portion of the total number of Medicare-eligible persons. Last year, we estimated that no more than 3 million Medicare beneficiaries have other insurance that is primary to Medicare. Nevertheless, because of the size of the Medicare program, the dollar value of Medicare claims subject to the MSP provisions is substantial.

The majority of beneficiaries who are covered by the MSP provisions are the working aged and their spouses. Contractors often must rely on health care providers to identify beneficiaries with other insurance coverage and thus may experience difficulties in screening medical claims when such information is missing. Even more arduous and costly are the contractors' attempts to recover Medicare payments after a claim has been paid. Contractors must search their records, often dating back several years, to determine whether Medicare paid claims for which another insurer was the primary payer and, if so, seek recovery.

FUTURE RECOVERIES THROUGH THE DATA MATCH PROGRAM WILL NOT BE REALIZED

To help Medicare identify and also recover costs that other insurers are responsible for paying, the Congress provided for HCFA to establish a data match process. The data match process, originally authorized under the Omnibus Budget Reconciliation Act of 1989, allows HCFA to match data contained in several federal information systems--including IRS and SSA files--to identify beneficiaries that have the potential for health insurance coverage through their own or a spouse's employer. Section 13561 of Omnibus Budget Reconciliation Act of 1993 (OBRA-93) extended HHS's authority to conduct data match activities through September 30, 1998. The President's fiscal year 1996 budget proposes legislation that would permanently extend the provision.

To date, the data match program has been cost effective. HCFA records show that an initial data match of IRS/SSA records for the 1987-90 time period has resulted in $1.6 billion in demand notices to insurers for payment to Medicare, of which about $400 million has been collected. In seeking these recoveries, Medicare contractors have incurred about $94 million in administrative costs through fiscal year 1994. However, a May 1994 a federal court ruling invalidated two MSP regulations that HCFA officials view as critical to their continued recovery of MSP mistaken payments.[1]

The first regulation deals with the time frame for recovering MSP mistaken payments. HCFA regulations (42 C.F.R. 411.24(f)) provide that Medicare contractors may recover such payments without regard to any insurer imposed requirements to file a claim within a certain time period. The court ruled that in seeking recoveries from insurers, Medicare must adhere to insurers' "timely filing" requirements that are imposed on other claimants. Generally, this means that claims for reimbursement of health care services must be filed within 1 year after the date of service. However, the data match process does not permit HCFA to meet these time filing requirements. IRS data are for prior tax years and must be matched against SSA wage information. Thus, the data by nature are over a year old before HCFA can begin processing them to identify MSP situations. HCFA's process involves mailing questionnaires to employers, searching Medicare paid claims data, and providing contractors with lists of mistaken payments that must be researched. As a result, Medicare claims are at least 2 years old before HCFA can initiate recovery actions. For example, HCFA has just recently initiated efforts to recover mistaken payments that were identified by the 1991-92

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[1]Health Ins. Ass'n of Am. v. Shalala, 23 F.3d 412 (D.C. Cir. 1994) cert. denied, 63 U.S.L.W. 3439 (U.S. Feb. 21, 1995) (No. 94-919).

data match. HCFA estimates that these claims could result in additional recoveries of about $200 million.

The second regulation deals with Medicare recoveries from third party administrators (TPA). The court ruling invalidated a HCFA regulation (42 C.F.R.411.24(e)) that allows Medicare contractors to recover from TPAs. TPAs typically adjudicate claims and write benefit checks for employers that self-insure. Most self-insured health plans operated by medium and large employers use TPAs. Because one TPA may serve hundreds of employers, they often represent the most efficient entity from which to seek recoveries. Because of the ruling, HCFA will now have to identify the specific employer that provides coverage and separately pursue recovery from each employer. HCFA officials told us that they will face serious administrative complications in recovering Medicare mistaken payments if they are prohibited from recovering directly from TPAs.

The Federal government appealed the court's decision to the Supreme Court, but this week the Court declined to hear the case, leaving the appeals court decision intact. Therefore, without legislative intervention to reinstate these MSP regulations, continued and effective recovery of Medicare mistaken payments from the data match process is not possible. Not being able to effectively recover on previously paid Medicare claims will result in estimated lost savings of at least $600 million over the next five years. Specifically, in regard to the fiscal 1996 budget, HHS estimated that the matches performed in fiscal 1996 could yield $400 million in MSP savings and projected savings of $430 million if the data match is extended beyond 1998. About half of these savings represent recoveries of previously paid claims that will not be collected because of the appeals court decision. In addition, according to HCFA officials, there is now an open question as to whether Medicare will have to refund to insurers amounts already recovered under the data match program since 1993.

LEGISLATION NEEDED TO DELAY DATA BANK IMPLEMENTATION

Another MSP initiative that could have a significant impact on HHS fiscal year 1996 administrative costs for Medicare is the Medicare/Medicaid data bank. Section 13581 of OBRA-93 directed HHS to establish a data bank, beginning in February 1995, that would contain information on about 160 million workers, spouses, and dependents covered by employer group plans. Its purpose is to save millions by (1) identifying the approximately 7 million Medicare and Medicaid beneficiaries who have other health insurance coverage that should pay medical bills ahead of the Medicare and Medicaid programs and (2) ensuring that this insurance is appropriately applied to reduce Medicare and

Medicaid costs. This information would then be used to recover mistaken payments.

In May 1994 we issued a report and testified that the proposed data bank would create an avalanche of unnecessary paperwork for both HCFA and employers and will likely achieve little or no savings while costing millions. The cost to HCFA of establishing and maintaining the data bank over 5 years was estimated by the agency at over $100 million. As a result, we recommended that the data bank be delayed until its potential benefit could be clearly demonstrated.[2]

While the Congress did prevent HCFA from using fiscal year 1995 appropriated funds for implementing the data bank, this restriction expires at the beginning of fiscal year 1996. At that time, the OBRA-93 provision would apply, and HCFA would be required to implement the data bank with fiscal year 1996 funds. We believe our 1994 recommendation is still appropriate and that the Congress should continue to delay the implementation of the data bank until its potential value and benefit can be clearly shown.

ENROLLMENT QUESTIONNAIRE HAS POTENTIAL TO STRENGTHEN MSP PROCESSES

MSP works best when Medicare has accurate, up-to-date information that enables it to keep from paying claims for which other insurers are responsible for paying. To enhance this ability, section 151(a) of the Social Security Act Amendments of 1994 directed HCFA to develop and mail questionnaires to Medicare beneficiaries upon enrollment. The questionnaires are to obtain information on whether the individual is covered by a health plan that should pay claims ahead of Medicare. HCFA anticipates mailing about 200,000 questionnaires a month. As of February 2, 1995, the first mailing was in process. In fiscal year 1996, HHS has budgeted $3.6 million to continue this activity.

While the questionnaire has strong potential to strengthen the MSP process and improve savings, it also has several built-in limitations. First, consistent with the statute, completing the questionnaire is essentially voluntary, so the extent to which beneficiaries will return it is not yet known. Second, because the questionnaire is administered only once, the information is accurate only as long as there is no change in the beneficiaries' health insurance coverage.

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[2]Medicare/Medicaid: Data Bank Unlikely to Increase Collections From Other Insurers (GAO/HEHS-94-147), May 6, 1994.

As a result, more experience with the questionnaire will be needed before HCFA can assess whether the questionnaire's results will provide sufficient information that will result in additional MSP savings.

CONCLUSIONS

Mr. Chairman, our work suggests that several actions are needed to maximize the savings available under the MSP program. First, because MSP recovery efforts of previously paid Medicare claims have, in effect, been negated by a recent appeals court ruling, legislation is needed to assure effective recovery of MSP mistaken payments. We would be happy to work with your staff to develop suggested language to remedy this problem. Second, we continue to support our earlier recommendation that funding for the Medicare/Medicaid data bank be delayed until its potential value and benefits can be demonstrated.

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This concludes my prepared remarks. We will be happy to answer any questions you may have.

For more information on this testimony, please call Frank Pasquier, Assistant Director, at (206) 287-4861. Other major contributors included Alfred Schnupp and Craig Winslow, Office of the General Counsel.

RELATED GAO PRODUCTS

Medicare: More Hospital Costs Should Be Paid by Other Insurers (GAO/HRD-87-43, Jan. 29, 1987).

Medicare: Incentives Needed to Assure Private Insurers Pay Before Medicare (GAO/HRD-89-19, Nov. 29, 1988).

Medicare: Millions in Potential Recoveries Not Being Sought by Maryland Contractor (GAO/HRD-91-32, Jan. 25, 1991).

Medicare: Millions in Potential Recoveries Not Being Sought by Contractors (GAO/T-HRD-91-8, Feb. 26, 1991).

Medicare: Over $1 Billion Should Be Recovered From Primary Health Insurers (GAO/HRD-92-52, Feb. 21, 1992).

Medicare/Medicaid: Data Bank Unlikely to Increase Collections From Other Insurers (GAO/HEHS-94-147, May 6, 1994).

Medicare/Medicaid: Data Bank Unlikely to Increase Collections From Other Insurers (GAO/T-HEHS-94-162, May 6, 1994).

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