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BEFORE THE

COMMITTEE ON FINANCE

UNITED STATES SENATE

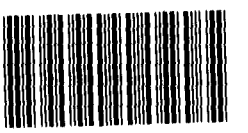
ON

# EFFORTS NEEDED TO RELIEVE MEDICAID FROM PAYING FOR SERVICES COVERED BY PRIVATE INSURERS

Mr. Chairman and Members of the Committee:

We are pleased to be here today to discuss efforts to reduce Medicaid costs by identifying and collecting from private health and liability insurance companies when they are legally liable to pay for services received by Medicaid recipients. On February 12, 1985, we issued a report entitled Improved Efforts Needed to Relieve Medicaid from Paying for Services Covered by Private Insurers (GAO/HRD-85-10). To assess state effectiveness in identifying and using available insurance resources, we reviewed state practices in California, Maryland, Oregon, Pennsylvania, Texas, and Washington. These states account for about 23 percent of Medicaid spending. We also did limited work on recovery from liability insurance companies in New York. We discussed the results of our audit work with officials of these states and incorporated their views in our report.





By using third party insurance resources, federal and state Medicaid costs can be decreased without reducing Medicaid services. In June 1983 Health Care Financing Administration (HCFA) officials estimated that between $500 million and more than $1 billion in state and federal Medicaid funds are spent annually because responsible health and liability insurers do not pay Medicaid recipients' medical bills. More than half of this amount would be federal funds. Also, our analysis of Department of Health and Human Services (HHS) survey data on the Medicaid population is consistent with the HCFA estimate. If states had used the available health insurance resources (excluding liability insurance) to pay the medical bills of Medicaid eligibles to the same extent as the non-Medicaid public used their insurance, we estimated that $750 million annually would have been saved in state and federal Medicaid funds.

The states we reviewed were taking some actions to identify liable insurers and to avoid paying claims and/or collect after paying them. However, while some states were using cost effective techniques for identifying or collecting from liable insurers, others were not. Overall the situation was similar to that existing when we reported on this issue in 1977 (see Problems in Carrying Out Medicaid Recovery Programs from Third Parties, HRD-77-73, May 2, 1977). This lack of improvement, combined with HCFA's estimate of unnecessary Medicaid expenditures for which insurers are liable, lead us to conclude that HCFA needs to take more action in this area.

My statement addresses why we believe HCFA should act to assure Medicaid recipients' insurance resources are used before Medicaid. I will also discuss techniques that the states could employ to more effectively use these insurance resources.

THE MEDICAID PROGRAM

The Medicaid program is a federally aided, state-administered medical assistance program that serves about 22 million low-income people. Within broad federal limits, states set the scope of and reimbursement rates for covered medical services and make payments directly to the providers who render the services. Depending on a state's per capita income, the federal government pays from 50 to 78 percent of the state's Medicaid costs. In fiscal year 1984, Medicaid costs totaled $38 billion; with the federal and state shares equally $21 billion and $17 billion, respectively.

By law, Medicaid is the payer of last resort; that is, Medicaid is to pay for health care only after Medicaid recipients have used all other health care resources, including available private health or liability insurance. In this regard, the Bureau of the Census reported that in 1981 (the most recent available data) about 18 percent of Medicaid recipients were covered by private health insurance.

Normally, Medicaid recipients with private health insurance obtain it though their own or their parents' full- or part-time employment. Working Medicaid recipients consist of three

groups. These groups contain the working poor who have (1) incomes low enough to qualify for Aid to Families with Dependent Children (AFDC) benefits, (2) incomes below the level needed to pay for their medical costs, or (3) lost their AFDC assistance because the income used to compute their eligibility increased above the maximum but they continue to be Medicaid eligible for the succeeding 4 to 15 months.

Also, children in families that qualify for AFDC may also be covered under insurance policies of their employed absent parents, and liability insurers may be responsible for the medical costs when a Medicaid recipient requires medical services because of an automobile, work, or other accident. Medicaid regulations require that states, in administering the program, take all reasonable efforts to identify and collect from liable insurance companies.

## HCFA NEEDS TO STRENGTHEN ITS OVERSIGHT OF STATE PRACTICES

Because of the large reductions to Medicaid expenditures that could result from better use of recipients' insurance coverage, we believe it is incumbent upon HCFA to assure that the states make maximum use of these resources. HCFA's role consists of assuring that states have effective programs for identifying and using available insurance resources. HCFA has used two different approaches to oversee the states' administration of Medicaid--a quality control program and compliance reviews. Neither of these programs has been very effective.

HCFA's quality control program is a coordinated effort by both the state and federal governments to ensure that Medicaid funds go only to recipients who are eligible under federal and state law and claims are paid only for covered services to eligible providers in the correct amount. The program is designed to use statistically projectable samples to measure erroneous Medicaid payments resulting from ineligibility.

States are required to correct past eligibility errors and to minimize eligibility errors in the future. If corrective action is needed, each state is required to prepare a corrective action plan and submit it to HCFA for approval. If the corrective action does not reduce eligibility errors below a 3-percent tolerance level, HCFA recovers from the state the federal share of the erroneous payments for ineligible recipients that exceed that level.

Between 1979 and 1982, HCFA used the same quality control sample to calculate erroneous payments resulting from both ineligible recipients and uncollected insurance. However, the process used was not adequate to produce reliable projections of the amount uncollected from insurance.

In a 1981 report on the Medicaid quality control program (GAO/HRD-82-6), we recommended that HCFA change its procedures to improve the third party liability review process used under the quality control program to obtain better data on erroneous payments resulting from uncollected third party resources.

However, in 1982 HCFA discontinued the portion of the quality control program that calculated uncollected insurance because of the limitations on the data developed under it and as part of its effort to reduce state administrative burdens. HCFA decided that, rather than using the quality control program, it would rely on the compliance review process to correct weaknesses in state practices.

HCFA has used compliance reviews in an effort to improve state performance in identifying and applying insurance resources. According to HCFA, pre-1983 reviews of state identification and application of insurance resources represented only a limited evaluation of state efforts. HCFA officials told us that generally the reviews were cursory and, as such, were of limited value in providing guidance to correct weak state practices.

In 1983 HCFA decided to supplement its regular compliance reviews of state practices by selecting 10 states each year to receive a more comprehensive assessment. These assessments looked at more state practices than did the regular compliance reviews and represented an improvement over its previous oversight efforts. However, HCFA has not consistently been able to get states to adopt suggested improvements. We believe this occurs because there are no specific regulatory requirements that link federal financial participation to required state practices for identifying and using Medicaid recipients' insurance resources. Without such requirements, the states we

visited generally viewed HCFA's suggestions for improving their practices as advisory and often did not adopt them. For example, of the 10 states HCFA reviewed in 1983, 6 reports pointed out problems with state practices for identifying or using recipient insurance resources that had been mentioned in HCFA's previous compliance reports and still had not been corrected.

## GAO'S RECOMMENDATION TO IMPROVE HCFA'S OVERSIGHT ACTIVITIES

Our February 12 report recommended that the Secretary of HHS direct the Administrator of HCFA to adopt one of two options to improve state practices for identifying and using Medicaid recipients' insurance resources. The options involve (1) strengthening HCFA's regulatory requirements and its compliance reviews of state programs or (2) using its quality control program to determine the amount of erroneous payments attributable to unrecovered health and casualty insurance and denying federal sharing in such erroneous payments exceeding a specified level of performance.

In commenting on our recommendation, HHS stated that it was reassessing its future strategy for the Medicaid third party liability program with options ranging from continuing its compliance monitoring policy to reinstating a quality control program. HHS stated that a final decision on its strategy was expected soon and that it would select the most cost-beneficial approach.

We believe that any approach HHS selects should have specific criteria and result in adequate data to measure whether those criteria are met. Either option we recommended should provide HHS, and the states, with information and criteria on which to base a decision about the effectiveness of state third party liability operations. Without specific criteria and measurement data, third party liability operations will continue not to realize their full potential, as evidenced by the estimates of available but unused insurance coverage cited in GAO's 1977 and 1985 reports.

## OPPORTUNITIES TO IMPROVE IDENTIFICATION AND USE OF RECIPIENT INSURANCE RESOURCES ARE AVAILABLE TO THE STATES

If HHS implements our recommendation, we believe that there are cost effective techniques available to the states to meet the new requirements without resulting in a loss of federal funding or disruption of the Medicaid program.

The states we reviewed used various methods for identifying health insurance resources for Medicaid recipients. While Bureau of Census statistics and HHS data estimate that nationwide, about 18 percent of all Medicaid eligibles have a health insurance resource available to them, the number of Medicaid recipients these states identified as having such resources ranged between 3.2 and 9.2 percent.

The remainder of my statement deals with the opportunities we identified for states to improve their practices for assuring that private insurers pay before Medicaid.

## IMPROVING IDENTIFICATION OF INSURANCE RESOURCES WHEN DETERMINING MEDICAID ELIGIBILITY

Some of the states we reviewed had better techniques for soliciting information from recipients about insurance coverage when the state determined, or periodically redetermined, program eligibility. These are the primary times when a state has direct contact with recipients. Therefore, they are good times for the states to get information on insurance coverage from the recipients. However, California, Pennsylvania, and Texas asked only general questions about insurance coverage such as "Do you or your family have any of the following insurance coverages: life, burial, medical/health or dental, or mortgage?" There are other questions whose answers can provide better indications that insurance coverage exits.

A case in point is Washington. It once asked recipients only questions similar to those in the states mentioned above but improved its insurance coverage identification rate by incorporating six questions indicative of the presence of insurance coverage. These questions include whether any member of the recipient's family is working, is a member of a union, or has recently been in an accident for which medical services were received. If a question is answered affirmatively, the caseworker is instructed to follow up to determine whether insurance exists. Between July and December 1983, the first 6 months after Washington revised its eligibility determination form, the number of Medicaid recipients with insurance identified through

the interview process increased 12.6 percent even though the total number of Medicaid recipients decreased 4.9 percent.

Another problem we identified relates to the information obtained if the questions asked the recipients indicate insurance coverage. In these cases, caseworkers need to obtain information on the name of the insurance carrier, coverage dates, and the type of insurance coverage (that is, hospitalization, dental). In California, Maryland, and Texas, caseworkers did not obtain all of this information at the time of eligibility determination, and subsequent attempts to obtain it were either not made or unsuccessful. In California, for example, caseworkers failed to obtain such information for 71 percent of the recipients who said they had health insurance.

Progress has recently been made in identifying insurance coverage for some recipients. . In 30 states the Social Security Administration (SSA) currently determines Medicaid eligibility for about 10 percent of the Medicaid population who are Supplemental Security Income (SSI) recipients. During that SSI eligibility process, SSA had not obtained the name and address of the insurance carrier and policy number for those covered by health insurance. Without this information, knowledge of insurance was of little use to the states.

In 1977 we recommended that SSA provide the states with the insurance information they need to adequately pursue liable insurers for SSI recipients. In 1983, HCFA and SSA pilot tested a program which showed that net annual savings of $69.5 million could be achieved by implementing the project nationwide.

We again proposed in 1984 that SSA provide detailed insurance information on Medicaid/SSI applicants to states in which SSA determines Medicaid eligibility. Effective January 2, 1985, HCFA and SSA agreed to offer the improved data collection services to the states that pay for it. Providing this information to the states should help them assure that insurance companies pay before Medicaid and thereby help reduce Medicaid costs.

MORE COMPUTERIZED DATA MATCHING NEEDED

States can cost effectively increase identification of third party resources by using computerized matching techniques. Two states we visited, Washington and Oregon, had adopted data matching programs that identified three different types of recipients who were likely to have insurance coverage not found through eligibility interviews. One data match program initiated by Washington in February 1982 matches the computerized Medicaid eligibility file with other state data files. This produces employment information on two groups with potential health insurance coverage--employed absent parents whose dependents are Medicaid eligibles and employed Medicaid eligibles. The state then follows up with employers to verify the type and extent of health insurance coverage. Although this match cost only about $33,000 to develop and operate during its first year of operation, it saved an estimated $2.2 million in Medicaid costs by identifying Medicaid recipients with health insurance coverage.

Another program developed by Washington in June 1982 matches computerized personnel records of state employees with Medicaid eligibility files. This match identifies full-time state employees, all of whom have employer-sponsored health insurance, that are also Medicaid eligibles. According to state records, during a 6-month period this match detected an average of 165 Medicaid recipients a month with health insurance that the state had not known about. While this project cost about $13,000 to develop and operate, it saved an estimated $300,000 in its first year of operation.

Although Bureau of the Census data show that almost half of the Medicaid recipients working full time have health insurance available through their employers, California, Maryland, and Pennsylvania had not implemented data matches of Medicaid recipients against unemployment insurance files that identify employed persons. Texas and these three states were also not performing data matches against state employee files. California had pilot tested a match with state employee files in two counties. The state estimated that if the match was implemented statewide at a cost of about $50,000, it could save approximately $1.3 million annually.

## NEED TO IMPROVE LIABILITY INSURANCE IDENTIFICATION

Improvements can be made in identifying liability insurance coverage. In the six reviewed states where information on liability insurance identification practices was available, we

found wide variations in the amount of states' liability collections. California had significantly higher liability collection rates than other states primarily because of two factors. First, California has legislation requiring that the attorney representing a Medicaid recipient in a liability-related accident notify the state. This practice resulted in 41 percent of the liability collections in California. Secondly, accident-related claims are identified by screening claims for medical services indicative of an accident, such as fractures or internal injuries, and then following up on them to identify whether an insurer is liable. California pursues all cases when the claims total more than $500 and all cases over $50 if the provider indicates that an accident had occurred. In contrast, Pennsylvania and Texas followed up only on claims involving $1,000 or more.

## COST AVOIDANCE NORMALLY IS BETTER THAN PAYING CLAIMS AND TRYING TO COLLECT

How states elect to use identified insurance resources can also affect Medicaid costs. Most states require health care providers to seek payment from identified health insurers before billing Medicaid. This is known as "cost avoidance." However, 14 states pay providers and then try to recover the money from liable insurers, a method often referred to as "pay and chase." Two of the states GAO reviewed (California and Maryland) used the pay and chase method. Because this method requires considerable administrative work, these states were not seeking recovery of millions of dollars in Medicaid costs.

For example, in fiscal year 1983, Maryland paid $19.5 million in medical bills for Medicaid recipients whom state records showed had health insurance coverage. Because of the work involved in recovering payments from insurers, the state did not try to recover payments made on pharmacy, home health, and nursing home claims and generally did not seek recovery on claims under $200. As a result, Maryland sought recovery for only $7.3 million, or 37 percent, of the $19.5 million.

California often did not follow up on health insurance carriers that did not respond to the state's request for reimbursement. From 1977 through 1983, insurance companies had not responded to about 87,000 claims totaling about $158 million that the state sent them.

Under a cost avoidance system, states would not experience such problems because providers would be responsible for collecting first from health and no-fault insurers, billing Medicaid only after these resources are exhausted. Administrative costs would also be reduced.

In our May 1977 report, we questioned the wisdom of the pay and chase approach when Medicaid recipients have private health insurance. On June 4, 1984, HHS published proposed regulations related to our 1977 recommendation. The proposed regulations would require states to use cost avoidance techniques when the state has established the probable existence of a liable third party at the time the Medicaid claim is filed. The proposed regulations leave it up to the states to establish procedures

for determining when health insurance probably exists.

Because of this discretion, we question how effective this proposed regulation will be in assuring that states make maximum use of the cost avoidance approach in applying health insurance resources. For example, the California official in charge of recovering Medicaid funds told us that, in his opinion, the state would be in compliance with the proposed rules because it had established procedures to (1) avoid significant amounts of Medicaid costs for recipients with Medicare coverage and (2) encourage providers to bill insurance companies before Medicaid. Therefore, he said that even though California was using a pay and chase approach to recover Medicaid costs from liable insurers, this regulation, if made final, would not direct the state to change its system.

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

# SUMMARY OF GAO TESTIMONY BEFORE THE SENATE COMMITTEE ON FINANCE, REGARDING EFFORTS NEEDED TO RELIEVE MEDICAID FROM PAYING FOR SERVICES COVERED BY PRIVATE INSURERS

Medicaid, a federally aided, state-administered medical assistance program for low-income people, should be relieved of health care costs if some other party is legally responsible to pay. Nevertheless, states receive bills for Medicaid recipients who have coverage under health and liability insurance. State Medicaid administrative systems often do not identify the liable insurers or redirect these medical bills to them. As a result, the Health Care Financing Administration estimates that Medicaid pays annually from $500 million to more than $1 billion that private insurers should be paying.

Because of the large reductions to Medicaid expenditures that could result, GAO believes that HCFA should assure that the states have effective programs for identifying and using available insurance resources.

Accordingly, GAO recommended that the Secretary of Health and Human Services direct the Administrator of HCFA to either strengthen Medicaid's regulatory requirements and its compliance reviews of state programs or use its quality control program to determine the amount of erroneous payments attributable to unrecovered health and casualty insurance. HCFA should also deny federal sharing in erroneous payments exceeding a specified level of performance.