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Report to Congressional Committees

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MEDICARE

Legislative Amendment Would Avoid Adverse Effects on Disabled Beneficiaries

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The Honorable Lloyd Bentsen
Chairman, Committee on Finance
United States Senate

The Honorable John D. Dingell
Chairman, Committee on Energy and Commerce
House of Representatives

The Honorable Dan Rostenkowski
Chairman, Committee on Ways and Means
House of Representatives

Legislation that became effective January 1, 1987, amended Medicare law to require certain employer-sponsored group health insurers that cover disabled beneficiaries to pay the medical claims of such beneficiaries ahead of Medicare. A disagreement has arisen about whether this law applies to health plans sponsored by government employers. The Health Care Financing Administration (HCFA), which administers the Medicare program, interprets the law as applying to government-sponsored health plans. Administrators of federal, state, and local government-sponsored plans, on the other hand, assert that the law does not apply to such plans. Both arguments have merit.

Until this issue is resolved, disabled beneficiaries who have health coverage under Medicare and a government-sponsored plan can be faced with a situation in which neither Medicare nor the plan will pay for services. In fact, this has already occurred in some cases. Also, unless the law applies to government-sponsored plans, a portion of the Medicare savings that were projected when the law was passed will not be realized. We believe that the Congress should amend the law so that there can be no doubt that it applies to government-sponsored plans. This would eliminate the controversy regarding whether Medicare or the government-sponsored health plans pay first, along with the resultant potential for delays in paying beneficiary claims. Also, such an amendment would make the law consistent with similar provisions for other Medicare beneficiaries who are covered by government-sponsored health plans.

Background

The Medicare program, authorized by title XVIII of the Social Security Act (42 U.S.C. 1395), effective July 1, 1966, helps pay medical costs for about 28 million people 65 years old and older. Medicare also serves

about 89,000 persons under 65 who have kidney failure and 2.9 million who are disabled.

Some Medicare beneficiaries also receive health coverage under employer-sponsored health insurance plans. Since 1981 the Congress has enacted a series of amendments to section 1862(b) of the Social Security Act to make Medicare the secondary, rather than the primary, payer when certain types of Medicare beneficiaries are covered under an employer-sponsored group health plan. Prior to these amendments, Medicare would pay first (as primary payer) when this dual coverage existed, and the employer-sponsored insurer would pay at least part of what Medicare did not pay (as secondary payer). The last of these amendments, contained in section 9319 of the Omnibus Budget Reconciliation Act of 1986 (OBRA), made Medicare the secondary payer for disabled beneficiaries covered under "large group health plans" through their own or another family member's current employment. Large group health plans were defined as plans with at least one contributing employer that had 100 or more employees. HCFA estimated that about 230,000 disabled beneficiaries would be covered under a large group employer plan. Although no estimate was made on the number of disabled Medicare beneficiaries who were covered by government plans, the Bureau of Labor Statistics reported that, in 1985, about 17 percent of the nation's work force was employed by government agencies.[1] The Congressional Budget Office estimated that the amendments would save $720 million in Medicare expenditures for fiscal years 1987-89.

To help ensure that employer plans properly treat Medicare as the secondary payer, OBRA provided penalties for not complying. First, it allowed beneficiaries to bring suit for twice the amount owed (double damages). Second and more significantly, it amended the Internal Revenue Code to impose a tax on employers that contribute to noncomplying plans. The tax is 25 percent of an employer's annual contribution to the group health plan.

Disagreement Over Applicability to Government Health Plans

Administrators of health care plans for federal, state, and local government employees have stated that the secondary payer provisions of OBRA do not apply to government-sponsored plans. In their view, Medicare remains the primary payer when such plans are involved. For example, the Office of Personnel Management, which administers the Federal Employees Health Benefits (FEHB) Program, and the Blue Cross/

[1]This estimate excludes the self-employed, agricultural, and military work force.

Blue Shield Association, which provides FEHB coverage to some federal employees and represents member plans that cover state and local governments' employees, have written HCFA stating their rationale for why OBRA's secondary payer provision does not apply to government-sponsored plans.

The rationale cited by both is based on their reading of the statute itself. Specifically, OBRA added section 1862(b)(4) to the Social Security Act, making Medicare the secondary payer for disabled beneficiaries covered by large group health plans, and section 5000 to the Internal Revenue Code, adding tax penalty provisions for noncomplying employer-sponsored plans. Section 1862(b)(4) adopts the following definition in section 5000(b) of a large group health plan.

"... the term 'large group health plan' means a plan of, or contributed to by, an employer or employee organization (including a self-insured plan) to provide health care (directly or otherwise) to the employees ... that covers employees of at least one employer that normally employed at least 100 employees on a typical business day during the previous calendar year."

Section 5000(d) states that: "For purposes of this section, the term 'employer' does not include a federal or other governmental entity."

The Office of Personnel Management and the Blue Cross/Blue Shield Association contend that section 5000(b) should be read as modified by section 5000(d). Thus they conclude that government-sponsored plans are excluded from the definition of large group health plans for the purpose of the secondary payer provision, as well as the tax provision, contained in OBRA. This position relies on a judgment that the "for purposes of this section" language in section 5000(d) does not merely limit the universe of health plans subject to a tax, but also represents an inseparable element of the Congress' sole expression of which plans are subject to the primary payer mandate of the Social Security Act. Therefore, the act's reference to the Internal Revenue Code, for purposes of defining a large group health plan, necessarily includes the code's explicit exclusion of governmental health plans.

HCFA, based on its reading of the OBRA statute and its legislative history, believes the exclusion of governmental entities in section 5000(d) was intended only to relieve government agencies from the section's tax provisions—not to exempt government entities from the secondary payer provisions. HCFA's point of view focuses on the language of section 5000(d) of the Internal Revenue Code. Section 5000(d) provides that the

exclusion of governmental entities is for the purpose of section 5000. In HCFA's view, the only purpose of section 5000 is the imposition of the tax. In letters to the Office of Personnel Management and Blue Cross/Blue Shield Association, HCFA further states its position as follows:

"The legislative history of section 9319 supports the view that the limitation on the definition of 'employer' in section 5000(d) is intended only for the purpose of the tax penalty provision and was not intended to exempt governmental entities from the Medicare secondary provision. It is clear that under the proposed Senate amendment the Medicare secondary provision was intended to apply to governmental entities. In this connection, the Senate amendment contained a provision for reducing federal financial participation in Medicaid funds for any State which did not comply with the Medicare secondary requirements. The Conference agreement (H.R. Rep. No. 1012, 99th Congress 2nd Sess. 320 (1986)) modified the Senate amendment to 'eliminate reductions in Medicaid funds as a penalty for States which do not comply.' Clearly the Conference agreement could have stated that the new provision did not apply at all to plans of governmental entities. . . . The Conference agreement's very wording ('which do not comply') supports the conclusion that Section 1862 (b)(4) does apply to large group health plans of governmental entities, but there is no penalty for noncompliance by State governments. Moreover, the Congressional Budget Office budget projections for Section 9319 included employees of Governmental entities."

HCFA's reliance on the legislative history is also supported by the fact that the enacted Conference Report suggests no change from the original Senate bill (S. 2706, § 611), which clearly required that all the large group health plans, including government-sponsored plans, will be the primary payer.

In our opinion, both HCFA's and the government plan administrators' interpretations of the law have merit. On the one hand, the statute can be interpreted as excluding government entities only from the tax provisions and not from the secondary payer legislation. Moreover, nothing in the legislative history indicates an intent to exclude government plans. On the other hand, the language in section 5000(d) can be construed as excluding government plans as primary payers for disabled beneficiaries.

Beneficiaries Could Have Delays Getting Their Bills Paid

The Congress expected that the secondary payer provisions would achieve savings without directly or materially affecting beneficiary services. However, if Medicare and the governmental insurers cannot agree on which entity is to pay first, disabled beneficiaries could experience delays in getting medical bills paid.

The possibility of this occurring is more than conjectural. HCFA has instructed its contractors that process Medicare claims not to act as primary payer for disabled beneficiaries who also are covered by government-sponsored health plans. These instructions do not specifically allow Medicare to pay conditionally even if other insurers refuse to act as primary payer. The Blue Cross/Blue Shield Association has issued a bulletin to its local plans stating HCFA's position and Blue Cross/Blue Shield's disagreement. According to the attorney who drafted the bulletin, the local plans will rely on the individual government employers to decide whether Medicare would be treated as primary or secondary payer. Similarly, in August 1987, the Office of Personnel Management advised about 500 FEHB plans of HCFA's position; however, each plan makes its own decision whether to follow the HCFA policy of treating Medicare as the secondary payer.

When we became aware of this issue, the OBRA secondary payer provisions had been in effect less than 9 months. Because of the short period since implementation and the clear potential that beneficiaries would be adversely affected, we decided against taking the time to measure how many beneficiaries were having problems getting their bills paid. However, we did come across instances in which neither a government plan nor Medicare would agree to pay the disabled beneficiaries' bills as primary payer.

For example, a disabled Medicare beneficiary covered under her husband's FEHB plan incurred over $1,300 in physician bills in May and June 1987. The FEHB plan informed the beneficiary to send the bills to Medicare as primary payer. In July, the Medicare contractor, in accordance with the HCFA instructions, notified the beneficiary to send the bills to the FEHB plan because Medicare was the secondary payer. The beneficiary said she submitted the claims to the FEHB plan in August. She told us that, as of August 28, she had not received a written denial from FEHB, but that the FEHB clerk responsible for processing her claims told her the claims could not be paid because Medicare is the primary payer.

Conclusion

The Social Security Act should be amended to resolve differences in interpretation between HCFA and the administrators of government-sponsored health plans. Amending the act to explicitly state that government-sponsored plans covering disabled beneficiaries are the primary payers would be consistent with other secondary payer provisions of the Social Security Act. These provisions require that governmental plans pay primary to Medicare for covered beneficiaries who are at least

65 years old or have kidney failure. Without legislative action, it is likely that the issue will have to be resolved by the courts, raising uncertainty in the interim as to Medicare's role as secondary payer and causing delays for Medicare beneficiaries in obtaining payment for their medical expenses.

Recommendation to Congressional Committees

We recommend that the legislative committees for Medicare include in their fiscal year 1988 reconciliation bills an amendment to the Social Security Act so that there can be no doubt that Medicare is the secondary payer to government plans under section 1862(b)(4) to the same extent that the section applies to other health plans. This could be accomplished by adding the following underlined clause to section 1862(b)(4)(B)(i):

"The term 'large group health plan' has the meaning given such term in section 5000(b) of the Internal Revenue Code of 1986, and includes governmental entities."

This change would leave governmental entities exempt from any tax penalties for noncompliance. However, the plan would be treated similarly to nongovernment plans in that it would still be subject to double damages if Medicare is not properly treated as the secondary payer.

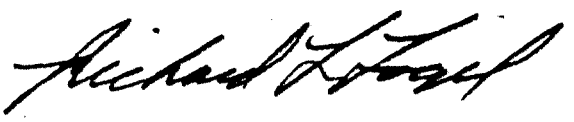
Objective, Scope, and Methodology

OBRA requires that GAO study the impact of the Medicare secondary payer provisions, which became effective for disabled beneficiaries on January 1, 1987. Specifically, the law asks that we provide information to the Congress on the number of disabled beneficiaries for whom Medicare became the secondary payer, the resulting annual savings, and the effect on employment and health insurance coverage of disabled individuals and their family members. We reviewed the legislative history and HCFA correspondence. When we learned of problems with treating Medicare as the secondary payer for beneficiaries covered under government plans, we interviewed officials from the Blue Cross/Blue Shield Association and the Office of Personnel Management.

We are reporting this matter separately because we believe the issue should be resolved quickly to prevent delays in paying disabled beneficiary claims. This portion of the review was conducted in August 1987, in accordance with generally accepted government auditing standards. We did not obtain comments on this report because the HCFA, Office of Personnel Management, and Blue Cross/Blue Shield Association positions

on the matters discussed have been clearly documented in correspondence.

We are sending copies of this report to HCFA; the Secretary of Health and Human Services; the Director, Office of Personnel Management; the Director, Office of Management and Budget; and other interested parties.



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