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MEDICARE SECONDARY PAYER PROGRAM

Identifying Beneficiaries with Other Insurance Coverage Is Difficult

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SUMMARY

Medicare is a federal health insurance program for people age 65 or older, certain younger disabled beneficiaries, and people of any age with permanent kidney failure. Medicare helps pay medical costs for about 35 million beneficiaries under a two-part system: part A, which covers inpatient hospital services, home health services, and various other institutional services; and part B, which covers physician, outpatient, and other health services, such as diagnostic tests. The Health Care Financing Administration (HCFA), as part of the Department of Health and Human Services, administers the Medicare program and operates it with assistance from insurance companies that it contracts with to process and pay claims for covered services.

Beginning in 1980, the Congress enacted a number of laws making Medicare the secondary payer for most beneficiaries covered under employer-sponsored group health insurance. These amendments have reduced Medicare costs by billions of dollars. However, the key to efficient operation of the Medicare Secondary Payer (MSP) program is knowing which beneficiaries have other insurance before claims are paid. Medicare has consistently had problems in identifying these beneficiaries.

Medicare has also had problems recouping funds from other insurers when it discovers that it has mistakenly paid for services for which another insurer was liable. As of January 1993, HCFA contractors had not begun recovery on about $122 million of mistaken payments. They also needed to research claims for about 1.5 million other beneficiaries who were identified as having other insurance.

HCFA has undertaken many actions to better identify beneficiaries with other insurance and to reduce its backlogs of possible mistakenly paid claims. These efforts have ranged from clarifying the Medicare claims forms to matching Medicare beneficiaries against other federal agencies' records to identify those who are employed. As a result, identification of beneficiaries with other insurance has improved. However, the process remains costly and burdensome.

In conjunction with overall national health reform and efforts to reduce the administrative burden in the health care system, GAO believes opportunities exist to identify a more efficient and less costly approach to identify MSP activities. Therefore, GAO believes that the feasibility of HCFA obtaining MSP data from other sources, such as private insurance companies and employers with self-insured plans, should be explored.

Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today to discuss some of the work we have done on the Medicare secondary payer (MSP) provisions. Over the years, efforts have been made to identify working beneficiaries and their spouses whose other health insurance is the primary payer to Medicare and to recover Medicare payments that should have been made by a private insurer.

MSP efforts have reduced Medicare costs by billions of dollars. However, the process of identifying the instances where Medicare is the secondary payer and recovering mistaken Medicare payments is labor intensive, expensive, and often unreliable. Enforcing the MSP provisions has been a longstanding challenge and, despite efforts by the Health Care Financing Administration (HCFA) and the millions of dollars spent to identify primary payers, hundreds of millions of Medicare dollars remain uncollected.

MSP PROVISIONS INTENDED TO SAVE MEDICARE MILLIONS OF DOLLARS

Medicare is a federal health insurance program for people age 65 or older, certain younger disabled beneficiaries, and people of any age with permanent kidney failure. Medicare helps pay medical costs for about 35 million beneficiaries under a two-part system: part A, which covers inpatient hospital services, home

health services, and various other institutional services; and part B, which covers physician, outpatient, and other health services, such as diagnostic tests. HCFA, as part of the Department of Health and Human Services (HHS), administers the Medicare program and operates it with assistance from insurance companies that it contracts with to process and pay claims for covered services.

Fiscal intermediaries are responsible for paying providers of services under part A of the Medicare program, and carriers make payments to beneficiaries and providers of services under part B. In addition to processing medical claims in a timely and accurate manner, these contractors are responsible for detecting and recovering Medicare overpayments.

In enacting the Medicare program in 1965, the Congress made Medicare the secondary payer for beneficiaries also covered by workers' compensation or through the Department of Veterans Affairs. Concerned about the 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 insurers,[1] whose coverage is primary, pay claims before Medicare. Under these provisions, Medicare claims processing contractors have two interrelated responsibilities: (1) to identify beneficiaries with other insurance and, thus, avoid paying claims that other insurers should pay and (2) to identify and recover mistaken payments that were made before determining that the beneficiary had other insurance.

The MSP provisions apply to a relatively small portion of the total number of Medicare-eligible persons. Several years ago, we estimated that 1.5 million Medicare beneficiaries--approximately 4 percent--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.

For example, in fiscal year 1992, HCFA saved about $2.8 billion through its pursuit of MSP activities--mostly through avoided costs when providers properly bill other insurers rather than Medicare. The costs to both screen claims and to attempt to recover mistakenly paid claims in fiscal year 1992 amounted to about $90 million.

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[1]We use the term insurer to mean all liable third parties, including insurance companies, third-party administrators, and self-insured employer health benefit plans.

The majority of beneficiaries who are covered by the MSP provisions are the so called working aged and their spouses. Contractors experience difficulty in screening medical claims to identify other primary payers because obtaining information about other insurance from these beneficiaries is difficult. Even more arduous and costly are the contractors' attempts to recover Medicare payments after a claim has been paid and the contractor discovers that the beneficiary has other insurance coverage.

Despite HCFA's efforts to identify insurers that cover Medicare beneficiaries, many claims are still being paid that may be the responsibility of other insurers. Backlogs of mistakenly paid claims have exceeded $1 billion over the past several years. Also, a data match using records from several federal agencies recently helped HCFA identify over a million additional beneficiaries who potentially have other health insurance.

EFFORTS TO ASSURE BETTER IDENTIFICATION OF PRIVATE INSURANCE BEFORE CLAIMS ARE PAID

Over the past several years, we have issued a number of reports on how well contractors performed the first of their MSP responsibilities--identifying cases where beneficiaries or their spouses have private insurance, and avoiding inappropriate

Medicare payments.[2] We concluded that, for a number of reasons, the contractors were not very effective at identifying other insurers that should pay before Medicare. Recent HCFA initiatives have enhanced contractors' ability to identify primary payers and have helped avoid mistaken payments. However, while the process of identifying beneficiaries with private insurance has greatly improved, this activity is costly and is dependent on information that HCFA and its contractors must constantly update.

The following are some of HCFA's current and planned MSP activities:

Beneficiary screening by the provider. HCFA requires part A providers to interview beneficiaries about possible other insurance at the time services are provided and is in the process of also making this mandatory for part B providers. HCFA has also sought revisions to the Medicare claim form that make MSP questions more explicit. Contractors are instructed to reject claims if providers submit claims without answering the MSP questions.

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[2]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)

Common Working File. Since December 1990, contractors share information about MSP situations on a series of regional databases known as the Common Working File. Subsequent claims should be denied, or at least further researched, if a beneficiary has private insurance and a claim is submitted to Medicare as primary payer.

First claim development. Contractors research the first claim of beneficiaries to see if they were working and had private insurance. If this is the case, the information is noted in the Common Working File, subsequent claims are not paid, and recovery of the first claim payment is attempted.

Initial Enrollment Questionnaire (IEQ). This initiative will provide contractors with detailed information about beneficiaries' other insurance at the time they enroll in Medicare. The IEQ project will provide additional information to the Common Working File when information about a beneficiary's other insurance is identified.

All of these approaches attempt to identify the possibility of private insurance coverage--but only at one point in time. Because beneficiaries' employment status is fluid, information collected through these efforts can become obsolete. This places contractors at risk for mistakenly paying claims, and finding

themselves in a pay and chase situation where they spend time and resources to recover these payments.

EFFORTS TO RECOVER MISTAKEN PAYMENTS ARE COSTLY AND LABOR INTENSIVE

The second responsibility of contractors--to identify and recover mistaken payments that were made before determining that the beneficiary had other insurance--is a labor-intensive and costly activity. In April 1991, HCFA instructed contractors to develop a system to identify and report the number and dollar amount of mistaken payments that were unrecovered on a quarterly basis.[3] Before then, HCFA did not regularly collect data on, nor require contractors to identify and report, mistaken payments that were owed by primary insurers. In their July 1991 reports, contractors reported backlogs of about $1.1 billion.

At that time, contractors lacked the necessary resources to recover the backlog of mistaken payments. To help eliminate the $1.1 billion backlog, OMB released funds of about $20 million to Medicare contractors. HHS stated that this funding was sufficient to eliminate all of the backlogs by the end of fiscal

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[3]Contractor backlogs were first discussed in our February 1991 testimony. See Medicare: Millions in Potential Recoveries Not Being Sought by Contractors (GAO/T-HRD-91-8, Feb. 26, 1991). These findings were included in a February 1992 report. See Medicare: Over $1 Billion Should Be Recovered From Primary Insurers (GAO/HRD-92-52, Feb. 21, 1992.)

year 1992. HCFA has recently advised us that the total contractor backlog was reduced to about $122 million at the end of 1992.

In addition to confirmed MSP backlogs, in their July 1991 quarterly reports contractors advised HCFA that they had identified over 1.1 million additional beneficiaries who had other insurance. Contractors had not yet researched these beneficiaries' claims to determine amounts paid by Medicare that may be the responsibility of other insurers. In our February 1992 report, we estimated that these contractors may have paid more than $1 billion in Medicare claims that are potentially recoverable from primary insurers. As of January 1, 1993, contractors needed to determine if Medicare mistakenly paid claims for about 1.5 million beneficiaries with other insurance.

A further HCFA initiative will add to the backlog of mistaken payments. Required by the Omnibus Budget Reconciliation Acts of 1989 and 1990, HCFA has initiated a data match that uses Internal Revenue Service (IRS) and Social Security Administration records. This data match identified beneficiaries or their spouses with health coverage through an employer-sponsored group health plan. HCFA has indicated that identifying spouses with health insurance has been difficult, yet it believes that these spouses make up the largest category of unidentified insurance coverage.

After beneficiary insurance information is obtained through this data match, it will be entered into Medicare's automated claims-processing system to prevent Medicare from mistakenly paying MSP claims. It will also be used to determine prior mistaken payments. HCFA will give Medicare contractors lists of mistaken payments that should be investigated and, if appropriate, recovered from primary insurers. As of March 1993, information on the employment and the health insurance coverage for about 1.8 million medicare beneficiaries had been obtained from employers.

Despite its efforts, several barriers have made it difficult for HCFA to effectively identify other insurers and realize the potential recoveries from MSP activities. First, contractors have lacked the resources to identify and pursue confirmation and recovery. On a number of occasions, we have testified before various House and Senate committees on the importance of adequately funding claims processors for their MSP and other safeguard activities. We also have suggested a modification to the budget process that would make it easier for the Congress to assure safeguard activities are adequately funded.

In addition to inadequate funding, time limitations may hamper recovery of a significant portion of the contractor backlogs. As noted in our February 1992 report, HHS regulations limit the time Medicare contractors have for initiating recovery of MSP mistaken payments, including those identified by the HCFA data match.

These regulations provide that once a mistaken payment has been identified, contractors must inform the primary insurer of its payment responsibilities within 15 to 27 months, depending on when in the calendar year the mistaken payment is identified. The HHS Inspector General recently estimated that Medicare may not be able to recover about $135 million in mistaken payments because its contractors did not send out demand letters for claims that expired in December 1991.

Finally, there is concern that MSP screening activities may be hampered by a conflict of interest on the part of contractors. In many instances, it is the private insurance business of the contractor that is the primary payer for claims subject to the MSP provisions.

CONCLUSION

The key to efficient operation of the Medicare secondary payer program is to avoid paying claims for which other insurers are liable. Contractors need accurate information to identify those beneficiaries and their spouses who have other insurance, and must determine if their private insurance company is the primary payer. However, once a claim is mistakenly paid, the contractors find themselves in a pay and chase situation. This labor-intensive process of communicating with private insurance companies to recover the mistaken payments after the fact is

burdensome and expensive. This is the case not just for Medicare, but for private insurance companies who must search their records, often dating back several years, to determine if, in fact, they were the primary payer.

HCFA has expended substantial effort to better identify beneficiaries subject to MSP provisions and to avoid paying claims when another insurance company is the primary payer. As discussed, HCFA's efforts have ranged from clarifying the Medicare claim form that specifically asks beneficiaries for information about other insurance to initiating a beneficiary eligibility questionnaire when a person becomes eligible for Medicare. These efforts seem reasonable in providing contractors with information about other beneficiary insurance coverage.

However, current approaches rely on providers and beneficiaries to provide information at a point in time and do not guarantee that contractors have and act on the most current and reliable information. Rather, private insurance companies and employers are in the best position to routinely identify policyholders and employees who might be eligible for Medicare.

In conjunction with overall national health reform and efforts to reduce the administrative burden in the health care system, we believe there are opportunities to identify a more efficient and less costly approach to MSP activities. We have discussed with

your staff undertaking a study to explore the feasibility of HCFA obtaining MSP data from other sources, such as private insurance companies and employers with self-insured plans.

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