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MEDICARE/MEDICAID

Data Bank Unlikely to Increase Collections From Other Insurers

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Mr. Chairman and Members of the Committee:

We are pleased to be here today to discuss the Health Care Financing Administration's (HCFA) efforts to develop the recently enacted Medicare and Medicaid data bank. The Omnibus Budget Reconciliation Act of 1993 (OBRA-93) directed the Secretary of Health and Human Services (HHS) to establish a data bank, beginning in February 1995, that would contain information on all workers, spouses, and dependents that are covered by employer-provided health insurance. Its purpose is to save millions by strengthening processes to (1) identify 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) ensure that this insurance is appropriately applied to reduce Medicare and Medicaid costs.

Our work shows that the data bank will likely achieve little or no savings while costing millions. Rather, we believe that changes and improvements to existing activities would be a much easier, less costly, and thus preferable alternative to the data bank process. This is largely because the data bank will result in an enormous amount of added paperwork for both HCFA and the nation's employers.

With our appearance here today, we are also issuing a report on the data bank program that provides more in-depth information.[1]

BACKGROUND

Medicaid, and in some cases Medicare, is intended to be the payer of last resort for beneficiaries covered under employer group health plans. This means that when beneficiaries have such insurance coverage it should pay them first to reduce Medicare and Medicaid costs. Although the data bank is a recent effort to improve HCFA's ability to identify insurers that are responsible for paying ahead of Medicare and Medicaid, other efforts have been ongoing for several years.

One such system currently operating is the data match. The data match was originally authorized by OBRA-89 and allows HHS to match data contained in several federal information systems--including Social Security Administration (SSA) and Internal Revenue Service (IRS) files--to identify beneficiaries who have potential for health insurance coverage through their or a spouse's employer. In its initial efforts, the data match experienced some problems, such as recovering on older claims, but improvements have been made or are planned for future matches. Section 13561 of OBRA-93 extended HHS's authority to conduct data match activities until

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

September 30, 1998. Beginning in 1995, the data bank will also operate during this period.

THE DATA BANK CREATES AN UNNECESSARY PAPERWORK BURDEN FOR HCFA AND EMPLOYERS

The proposed data bank would create an avalanche of unnecessary paperwork for both HCFA and employers. All employers offering health insurance coverage would have to submit to HCFA details on all those covered by the policy. HCFA estimates that it would have to gather and maintain information on about 160 million people just to be able to identify the approximately 3 million Medicare, and 4 million Medicaid beneficiaries with another source of insurance. The cost to HCFA of establishing and maintaining the data bank over the next 5 years is estimated by the agency at over $100 million.

Employers we spoke with also identified other aspects of the paperwork burden that would be caused by the data bank: the uncertainty, potential cost, and difficulty involved in obtaining sufficient information to meet data bank requirements. The uncertainty stems from the lack of HCFA guidance for employers. As of April 30, 1994, HCFA had not yet published instructions on specific reporting requirements and formats. Secondly, the potential cost to reprogram payroll and personnel systems--while varying widely--could be substantial for some employers. Finally, many employers may be unable to readily obtain some data that only employees, insurers, or unions maintain.

DATA BANK'S LIMITED USEFULNESS RAISES QUESTIONS ABOUT NEED

The purpose of the data bank is to help assure that Medicare and Medicaid pay after other insurance has paid. However, the data bank does not appear to be an effective way to accomplish this purpose. For the Medicare program, we believe that the data bank likely will not provide any useful information beyond what is being collected under HCFA's ongoing data match process. In fact, HCFA anticipates that it will need to use an employer questionnaire similar to that used by the data match to fill information gaps in the data bank. While we recognize that the data match needs further refinement, we believe that overall its process is more effective than the data bank. The data match is capable of providing the same information, at less cost, without creating an additional record keeping burden on HCFA and employers.

In regard to Medicaid, our work suggests that the data bank information would not be timely enough for use by states in their third-party liability activities. The reason is that unlike Medicare, which has authority to recover from insurers regardless of the health insurers' claims filing deadlines, Medicaid programs

are generally subject to such filing deadlines. Therefore, by the time state Medicaid programs receive the data bank information--estimated at about 6 months after the calendar year ends--they would not have enough time to pursue recoveries.

OPPORTUNITIES AVAILABLE TO STRENGTHEN MEDICARE'S AND MEDICAID'S EXISTING PROCESSES

Both the data match and the data bank focus on recovering Medicare and Medicaid payments made in error. This "pay and chase" approach is widely recognized as more costly and less effective than a proactive approach. Instead of attempting to recover funds after they have been paid out, the more efficient approach is to identify the other insurance and have it pay ahead of Medicare or Medicaid. HCFA has some proactive initiatives under development that seem to hold promise.

For example, in fiscal year 1995, HCFA plans to administer a health insurance questionnaire to each beneficiary upon enrollment in the Medicare program. This will provide Medicare valuable information for systematically identifying whether a beneficiary has primary health insurance before it pays the beneficiary's first claim.

In regard to Medicaid, states have made only limited progress in developing systems that effectively identify other insurance when Medicaid eligibility is determined. Federal regulations prescribe specific cost-effective activities that state Medicaid programs are required to adopt in order to identify and recover from other insurers. In a 1991 report[2], however, we concluded that one reason states had not complied with existing federal requirements was that they faced no significant penalty for not complying. In that report, we recommended that the Congress grant HCFA authority to impose penalties on states that were out of compliance, but this recommendation has not been acted on.

CONCLUSIONS AND RECOMMENDATIONS

Although Medicare and Medicaid could realize more savings with better information on beneficiaries' health insurance coverage, establishing the data bank for this purpose does not appear to be the most prudent course of action. The enormous administrative burden the data bank would place on HCFA and the nation's employers, and the more than $100 million it would cost over the next 5 years, likely would do little or nothing to enhance current efforts to identify those beneficiaries who have other health insurance coverages. In our view, the existing processes, with

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[2]Medicaid: HCFA Needs Authority to Enforce Third-Party Requirements on States (GAO/HRD-91-60, Apr. 11, 1991).

planned improvements, could serve the same purpose for less cost and effort.

Therefore, we recommend that the Congress delay the implementation of the data bank until its potential value and benefit can be clearly shown. Meanwhile, the Congress should require the Secretary of HHS to report annually on HCFA's efforts to improve its process for identification and recovery of claims from insurers. It should also amend Medicaid law and authorize HCFA to withhold federal matching funds when states do not comply with federal requirements to identify and recover claims from other insurers.

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Mr. Chairman, this concludes my statement. I would be happy to answer any questions.

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