United States General Accounting Office

GAO

Report to the Committee on Finance, U.S. Senate

February 1992

MEDICARE

Over $1 Billion Should Be Recovered From Primary Health Insurers

GAO/HRD-92-52

GAO

United States
General Accounting Office
Washington, D.C. 20548

Human Resources Division

B-241122

February 21, 1992

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

The Honorable Bob Packwood
Ranking Minority Member,
Committee on Finance
United States Senate

In this report, we respond to your request that we review Medicare contractors' efforts to administer provisions of the Medicare secondary payer (MSP) program. These provisions are intended to make certain that insurers whose coverage is primary pay claims before Medicare. Contractors are responsible for (1) making certain that health providers identify and bill primary insurers, thereby preventing mistaken Medicare payments, and (2) identifying and recovering mistaken payments made before contractors confirmed a beneficiary had other insurance.

We previously reported that contractors were ineffective in identifying primary insurers and avoiding mistaken Medicare payments. We, therefore, recommended actions to improve identification of primary insurers.[1] In this report, we identify contractors' backlogs of mistaken payments and review the effect of recent budget reductions on contractors' efforts, after confirming that beneficiaries have other insurance, to recover these payments from primary insurers.

We did our work relating to budget cuts at three carriers—in Arizona, California, and Nevada—that pay Medicare part B claims for physician, outpatient, laboratory, and certain other medical and health services. At two of these carriers, we determined the extent to which Medicare carriers were recovering mistaken payments by taking random samples of beneficiaries with other insurance.

After we completed our field work at the three carriers, the Health Care Financing Administration (HCFA) surveyed Medicare contractors to determine MSP backlogs. We have included the survey results—which provide nationwide information on unrecovered mistaken payments owed

[1]Medicare: More Hospital Costs Should Be Paid by Other Insurers (GAO/HRD-87-43, Jan. 29, 1987), and Medicare: Incentives Needed to Assure Private Insurers Pay Before Medicare (GAO/HRD-89-19, Nov. 29, 1988).

to Medicare—in this report. (See app. I for a more detailed discussion of our objectives, scope, and methodology.)

Results in Brief

Many Medicare contractors have significant backlogs of mistaken payments for Medicare beneficiaries that are unrecovered from primary health insurers. Responding to a HCFA survey, Medicare contractors recently reported backlogs of over $1 billion in beneficiary claims that they confirmed were mistakenly paid.

In addition to the confirmed backlogs, contractors had reported over 1.1 million beneficiaries who had other insurance. However, the contractors had not yet researched previously paid beneficiary claims to determine what amounts Medicare paid that primary insurers should have paid. Our work suggests that once these claims are researched, an additional $1 billion or more in mistaken payments could be owed by primary insurers.

HCFA has recently initiated an effort that will identify additional primary insurers and could add several million more claims to the existing backlogs of mistaken Medicare payments. Furthermore, millions of dollars that primary insurers owe Medicare may be lost because of a Department of Health and Human Services (HHS) regulation. The regulation limits the time a contractor has to initiate recovery action on a claim after it identifies a primary insurer.

Collections of MSP mistaken payments far exceed carriers' cost of recovery. Nevertheless, Medicare contractors advised HCFA that inadequate MSP funding is the reason for the backlogs of mistaken payments. The fiscal year 1992 HHS budget will not permit contractors to significantly reduce the existing backlogs. This budget is (1) below the fiscal year 1989 funding levels, when claims volume was about 27 percent less and contractors did not have huge MSP backlogs, and (2) about 22 percent less than the Medicare contractors requested.

Background

Medicare helps pay medical costs for about 35 million aged and disabled persons 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 hospital, and other health services, such as diagnostic tests. HCFA, as part of HHS, administers the

Medicare program and is responsible for establishing policy, developing operating guidelines, and ensuring compliance with Medicare legislation. HCFA operates the program with assistance from insurance companies that it contracts with to process and pay claims for covered services. The insurance companies—called intermediaries under part A and carriers under part B—are expected to pay Medicare benefits totaling about $127 billion in fiscal year 1992. The volume of Medicare claims has increased by about 11 percent annually and is expected to exceed 650 million in fiscal year 1992.

In enacting the Medicare program in 1965, the Congress made Medicare the secondary payer for beneficiaries covered by both Medicare and workers' compensation. 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. These changes are commonly referred to as the MSP provisions.

Medicare contractors rely on health care providers to obtain data on beneficiaries' health insurance coverage and to identify insurers who should pay before Medicare. The contractors should take two actions after learning that a beneficiary has other insurance. First, contractors should enter a "flag" in their claims-processing system so that Medicare will deny future claims and send them to the beneficiary's insurer. Second, contractors should research the beneficiary's claims history file to determine if Medicare has paid claims after the other insurance went into effect and, if so, attempt recovery.

Contractors' MSP Backlogs Exceed $1 Billion

In April 1991, HCFA instructed contractors to develop a system to identify and report, on a quarterly basis, the number and dollar amount of mistaken payments that were unrecovered because of the lack of funds. Prior to that time, HCFA did not regularly collect or require contractors to identify and report mistaken payments that were owed by primary insurers.[2] Initial contractor reports on backlogs were due by June 1, 1991.

Judging from the first two quarterly reports, contractors have significant backlogs of mistaken payments that should be recovered from primary insurers. In the first report about 50 percent of the contractors identified

[2]Medicare: Millions in Potential Recoveries Not Being Sought by Contractors (GAO/T-HRD-91-8, Feb. 26, 1991), presented before the Subcommittee on Oversight, House Committee on Ways and Means.

backlogs of about $990 million. Carriers reported over $179 million in backlogs intermediaries reported over $811 million.[3] The remaining contractors did not provide information on backlogs.

HCFA's analysis of the contractors' reports showed that many contained missing or inaccurate data. For example, some contractors failed to submit complete reports or did not specify the dollar amounts of identified MSP claims. As a result, in late July 1991, HCFA instructed its regional offices to reexamine contractor reports for missing data.

Medicare contractors' second quarterly reports showed backlogs of about $1.14 billion, or about $150 million more than was initially reported. Carriers reported about $155 million in backlogs and intermediaries over $984 million. HCFA found that overall these reports were more accurate than the first ones. About 36 percent of the contractors did not provide information on backlogs.

In addition to the confirmed MSP backlogs, 70 percent of the contractors advised HCFA that they had identified over 1.1 million additional beneficiaries who had other insurance.[4] However, the contractors had not researched these beneficiaries' claims, paid before the contractors confirmed other insurance, to determine amounts paid by Medicare that may be the responsibility of primary insurers. Considering that the average Medicare payment for services provided to enrollees is about $2,800, contractors may have paid more than $1 billion in Medicare claims that are potentially recoverable from primary insurers.

Our work at two carriers shows the magnitude of the problem. At Aetna of Phoenix and Transamerica Occidental of Southern California, we took random samples of 423 beneficiaries who were identified as having other insurance. We found that the carriers had paid one or more claims, totaling $192,161, for 150 of the 423 beneficiaries, before identifying a primary insurer. On the basis of these samples, we estimate that these two carriers made about $36 million in mistaken payments for more than 26,000 Medicare beneficiaries.

[3]We reported previously on contractor problems in recovering mistaken payments. Medicare: Millions in Potential Recoveries Not Being Sought by Maryland Contractor (GAO/HRD- 91-32, Jan. 25, 1991).

[4]Thirty percent of the contractors did not provide information on beneficiaries who had other insurance.

HCFA Data Match May Add Millions of Claims to MSP Backlogs

HCFA has recently initiated a data match that uses Internal Revenue Service (IRS) and Social Security Administration records. Required by the Omnibus Budget Reconciliation Acts of 1989 and 1990, this data match identifies a beneficiary or a spouse with health coverage through an employer-sponsored group health plan.[5] HCFA indicated that identifying spouses with health insurance has been difficult. It believes these spouses make up the largest category of undiscovered MSP savings.

After beneficiary insurance information is obtained, it will be entered into Medicare's automated claims-processing system to prevent Medicare from mistakenly paying MSP claims. In addition, HCFA will use this information 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. The data match will help identify additional primary insurers. It could add millions of mistaken payments to the already large backlog.

Limited Time Remaining for Recovering Many Mistaken Payments

Effective November 13, 1989, HHS regulations limit the time Medicare contractors have for initiating recovery of MSP mistaken payments, including those that will be identified by the HCFA data match. These regulations provide, in effect, that once a mistaken payment has been identified, Medicare 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. For example, Medicare contractors had until December 31, 1991, to inform primary insurers that they owe the program about $420 million in mistaken payments that Medicare contractors identified between November 13, 1989, and September 30, 1990. If timely notification has not been given, Medicare will be unable to recover the mistaken payments.

MSP Budget Reductions Hamper Carrier Collection of Mistaken Payments

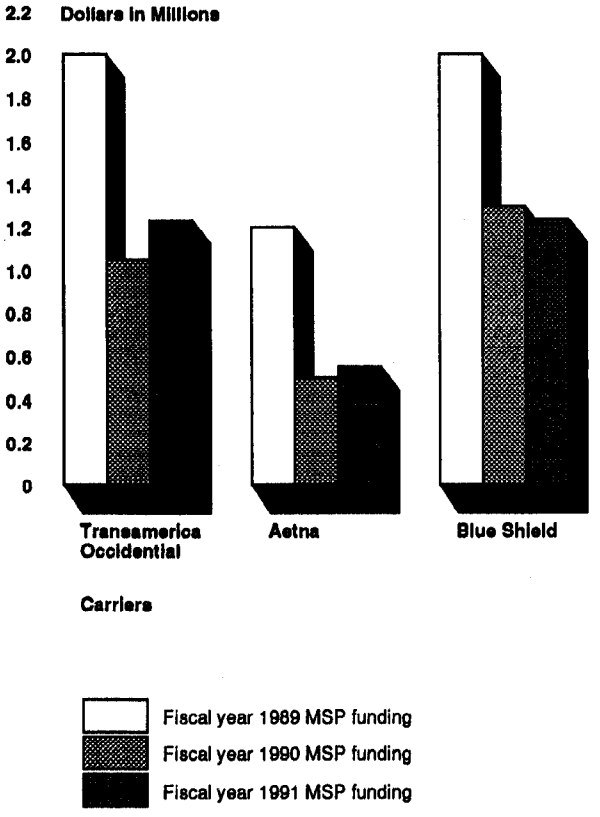
Nationwide, part B funding for MSP activities was reduced from $38.3 million in fiscal year 1989 to $15.2 million in 1990, a 60-percent reduction. Part B MSP budgets remained about the same in fiscal year 1991. Budget reductions caused HCFA to raise the carriers' dollar threshold for reviewing claims to confirm that another insurer was the primary payer. The threshold went from $50 to $250. Thus, claims of less than $250 were paid without confirming if the beneficiary had other insurance coverage. In addition, HCFA informed carriers in October 1989 that the recovery of mistaken payments would be a low-priority activity, to be conducted as

[5]The 1990 act extended the data match program from September 1991 through September 1995.

funding permitted. However, carriers were expected to make sure that Medicare did not pay for beneficiaries who had other insurance.

For the carriers we visited, the effect of budget reductions was evident. They were not recovering identified mistaken payments between late October 1989, when their MSP budgets were cut, and March 1991, when we completed our field work. We observed many claims related to the mistaken payments stored in boxes or filing cabinets. In fiscal year 1990, MSP budgets declined and remained below fiscal year 1989 levels. For example, the carriers we visited had MSP budget reductions of 35 to 59 percent. The reduced funding levels are shown in figure 1.

Figure 1: Carrier MSP Funding



The three carriers had to make significant MSP staff reductions because of the reduced funding. The MSP full-time staffs were reduced from a combined fiscal year 1989 level of 84.6 to a fiscal year 1990 level of 32.5.

The most severe reduction was made at Blue Shield of California, which went from 33.3 full-time staff to 7. Further, a 1990 review by the HHS Office of Inspector General found that seven carriers had reduced MSP full-time staff from 127 in fiscal year 1989 to 48 in fiscal year 1990. As a result, five of the carriers discontinued MSP recovery activities.[6] HCFA realized the effect of the reduced MSP funding early in fiscal year 1991, when many carriers informed HCFA regional offices that they could not process backlogged MSP cases at current funding levels. Any unanticipated increase in claims, HCFA said, would make the backlogs even greater. HCFA provided about $3.9 million to Medicare contractors in fiscal year 1991 so that they could notify primary insurers about the $420 million in mistaken payments by the December 31, 1991, deadline (see p. 5).

The carriers we visited received additional MSP funding and began efforts to recover mistaken payments during the summer of 1991. Additional fiscal year 1992 funds are needed, they stated, to continue these efforts. However, the HCFA fiscal year 1992 MSP budget is $70 million, or about $20 million less than Medicare contractors requested for MSP activities.[7] The 1992 budget, which includes about $2.9 million for the recovery of mistaken payments, is about $8.0 million below the MSP funding levels in fiscal year 1989. During that time claims volume was about 27 percent less and contractors were not faced with huge MSP backlogs.

Budget Process Constrains Carrier Funding

The Budget Enforcement Act of 1990 imposed new constraints on federal funding. In general, this law provides that federal discretionary spending, which includes Medicare contractor expenditures, be subject to spending limits. Medicare contractor savings achieved through payment safeguard activities, such as MSP, do not count as offsets to any increased spending for additional recoveries.[8] Thus, increased spending for these activities, including MSP recoveries, would require cuts in other federal programs to remain within the established budgetary limits.

The Congress resolved a similar problem, funding IRS enforcement activities, by permitting additional funding for enforcement activities

[6]Office of Inspector General, HHS, testimony presented before the Subcommittee on Oversight, House Committee on Ways and Means (Feb. 26, 1991).

[7]The budget includes $6.6 million for Group Health Incorporated to obtain beneficiary insurance information for the HCFA data match project.

[8]Contractors are required to perform other safeguard activities, including a review of all claims to determine medical necessity and appropriateness and the audit of providers' cost reports that are reimbursed on a cost basis.

without cutting spending elsewhere. The law provides for discretionary spending limits to be increased if additional appropriations are made for IRS compliance spending. Consistent with the act, the anticipated effect of this budgeting mechanism was to authorize increased expenditures for specific activities likely to produce a reduction in federal spending.

Several times previously, we reported and testified on the need for adequate funding of contractor MSP activities and other payment safeguards that help ensure the accuracy of Medicare payments. In our February 1991 testimony, we said that the proposed fiscal year 1992 funding was insufficient to address the carriers' backlogs of mistaken payments—estimated at about $200 million.

The Health Insurance Association of America, whose membership includes several Medicare contractors, shared our concerns. The association stated that the lack of adequate MSP funding has prevented Medicare contractors from recovering annually hundreds of millions of dollars in mistaken payments.[9] Intermediaries and carriers do not have the staff, the association added, to cope with the work load, and HCFA's overall contractor budget is so tight that reallocating sufficient funds from other essential activities to strengthen the MSP effort is impossible.

We previously suggested that the Congress consider establishing a mechanism, similar to that applicable to IRS funding, to facilitate adequate funding of Medicare program safeguard activities.[10]

Additional MSP funding is an appropriate investment that will enable Medicare contractors to recover over $1 billion in mistaken Medicare payments. For example, our work at two carriers shows that collections of mistaken MSP payments far exceeds the carriers' cost of recovery. On the basis of our cost-benefit analysis, we estimate that for every dollar spent, Transamerica Occidental can recover $8.65 and Aetna Life and Casualty can recover $14.65.

[9]Mistaken and Unrecovered Medicare Payments, statement presented to the House of Representatives, Committee on Ways and Means, Subcommittee on Oversight.

[10]Medicare: Further Changes Needed to Reduce Program and Beneficiary Costs (GAO/HRD-91-67, May 15, 1991).

Contractors Could Use Contingency Funds to Recover Mistaken Payments

While contractors lack the necessary funds to recover mistaken payments, another part of the Medicare budget has grown significantly over the past several years. Historically, an increasing part of the budget has been set aside in a contingency fund to cover unanticipated administrative expenses. The fund, as a line item in the HCFA budget, has grown from $20 million, or 2 percent of the fiscal year 1985 contractor budget, to $257 million, or 15 percent of the 1992 budget.

HCFA monitors contractor expenditures and work loads throughout the year and requests the release of contingency funds. Such requests and the supporting justifications go through HHS and must ultimately be approved by the Office of Management and Budget (OMB). Unused contingency funds are not carried over from year to year.

Contingency funds have been used for unanticipated increases in work load or operating costs. For example, early in fiscal year 1991, HCFA requested that OMB release $101.3 million to fund increases in claims work load and legislatively mandated activities. Included in HCFA's request was $3.1 million for Medicare contractors to process backlogged mistaken payments. Such funds, HCFA estimated, would result in the recovery of about $50 million. During February 1991, OMB released $75 million. However, by reallocating funds within the contractor budget, a HCFA official said, the additional MSP funding was provided and contingency funds were not released.

Conclusions

In the last decade, the Congress has made several changes to the MSP program. These changes have been made to help reduce Medicare costs by making certain insurers the primary payers for beneficiary services. However, amounts owed by other health insurers are unrecovered or, in many cases, unidentified even after Medicare contractors have confirmed that beneficiaries have other health insurance that provides primary coverage. Nationwide, large backlogs of mistaken payments remain unrecovered.

Significant program savings are not being realized because contractors do not have the funds they need to recover MSP mistaken payments. The fiscal year 1992 MSP funding levels are below the amounts provided in fiscal year 1989, yet the number of beneficiary claims is significantly higher, and large backlogs remain. Increased funding of MSP activities is essential if over $1 billion in mistaken payments are to be recovered.

One way to increase MSP funding would be for the Congress to amend the Budget Enforcement Act. The Congress, in debating the need for increased contractor funding, could consider establishing a mechanism to facilitate increased funding of Medicare payment safeguard activities, particularly the recovery of MSP mistaken payments. This recovery would be of substantial benefit to the government.

An alternate solution to the funding problem would be for HCFA to request and for OMB to release a portion of the contingency funds contained in the 1992 budget. Contractors could use these funds to begin recovering amounts owed to Medicare by primary insurers.

Recommendation

We recommend that the Secretary of HHS direct the Administrator of HCFA to initiate a request to OMB to release the necessary contingency funds for use in recovering mistaken payments owed to Medicare.

We did not obtain written agency comments on this report. We did, however, discuss its contents with HCFA officials who agreed with the report's findings and conclusions. We incorporated their comments where appropriate.

We are sending copies of this report to the Secretary of HHS; the Administrator of HCFA; interested congressional committees and subcommittees; the Director, OMB; and other interested parties. Copies will also be made available to others on request.

Please call me on (202) 512-7119 if you or your staffs have any questions concerning this report. Other major contributors are listed in appendix II.

Janet L. Shikles

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Director, Health Financing
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Contents

Abbreviations

HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
IRS	Internal Revenue Service
MSP	Medicare secondary payer
OMB	Office of Management and Budget

Objectives, Scope, and Methodology

Our review was directed at MSP activities under the Medicare part B program. It was begun because of a nationwide 60- percent funding reduction in fiscal year 1990. Our objectives were to determine (1) if significant backlogs of unrecovered mistaken MSP payments existed and (2) the effect of the budget cuts on carriers' efforts to recover Medicare mistaken payments after learning that Medicare was not the primary insurer. Our work was carried out at (1) Aetna Life and Casualty Company, a carrier serving Arizona and Nevada; (2) Blue Shield of California, the carrier for Northern California; and (3) Transamerica Occidental Life Insurance Company, the carrier for Southern California.

At all three carriers, we (1) reviewed MSP funding and staff allocations before and after the budget reductions and (2) determined the carrier efforts to identify and recover mistaken MSP payments. We also discussed resource issues with carrier officials, as well as HCFA headquarters and regional staff. We reviewed MSP legislation and HCFA guidance relating to carrier MSP activities.

Using contractor computerized files, we estimated the backlogs of unrecovered mistaken payments at Aetna Life and Casualty Company and Transamerica Occidental Life Insurance Company. We selected random samples of 423 beneficiaries who were identified as having other insurance. We determined the effective date of the beneficiary's primary insurance and reviewed Medicare payment history files (from Jan. 1, 1987, to Sept. 1, 1990) to identify potential mistaken payments made while the other insurance was in effect. Based on our samples, we estimate that these two carriers had about $36 million in unrecovered mistaken payments.[1] These results were discussed with carrier representatives. Where appropriate, we incorporated their comments.

In addition, we developed models to estimate the cost to recover mistaken payments made by Transamerica Occidental and Aetna Life and Casualty. For these carriers, we identified recovery activities (such as researching a beneficiary's claims history, preparing refund requests, processing refunds, or withholding payment on future claims in the amount of the mistaken payment); the time required to complete each activity; and the associated staff costs for each activity. In addition, direct and overhead costs were calculated. We also calculated a cost-benefit ratio for each carrier, based on HCFA estimates that 75 percent of mistaken payments are recoverable. Each carrier reviewed and commented on the costs associated

[1]At the 95-percent confidence level, we estimate the unrecovered mistaken payments to be between $22.7 and $51.7 million.

with identification and recovery of mistaken payments. Their comments were considered in our estimates.

After we completed our work at the carriers, HCFA surveyed Medicare contractors to determine unrecovered mistaken payments. We included the survey results in this report but did not review the reporting requirements or assess how each contractor determined its reported backlogs. We did our work between August 1990 and May 1991 in accordance with generally accepted government auditing standards.

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