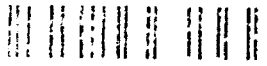
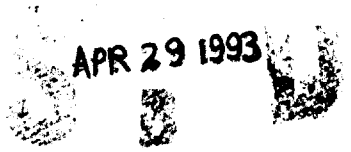
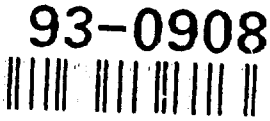






GAO

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

Human Resources Division

B-239899

November 30, 1990

The Honorable John Conyers, Jr.
Chairman, Committee on Government Operations
House of Representatives

Dear Mr. Chairman:

This report responds to your request that we review Michigan's efforts to ensure that private insurers are paying claims for Medicaid recipients who have health insurance. Federal law requires state agencies that administer the Medicaid program to make reasonable efforts to identify liable third parties, including health insurers, and seek recovery when they are identified after Medicaid has paid for program services. GAO and others have reported problems that states have encountered in meeting these requirements. Because an estimated 14 percent of the nation's Medicaid recipients have health insurance, unrecovered payments can result in large losses to the Medicaid program.

The Committee had received allegations that the Michigan program was not recovering payments from Blue Cross and Blue Shield of Michigan (BC/BS), which has an estimated 60-65 percent of the state health insurance market and insures about 7 percent of Michigan's Medicaid recipients. We sought to determine (1) the nature of any problems that might exist and the amounts involved and (2) the adequacy of state Medicaid agency recovery efforts and federal oversight of those efforts.

Results in Brief

Over the past 18 years, the Michigan Medicaid agency has encountered serious problems in recovering payments made for Medicaid recipients insured by BC/BS. Michigan has not fully used its authority or taken all the actions that it could to enforce compliance by BC/BS with Medicaid's third-party recovery provisions. Also, federal and state monitoring and oversight of the Michigan Medicaid recovery program have been ineffective. Because Michigan and BC/BS have not implemented a system for BC/BS to process and pay claims, BC/BS has avoided or forestalled payments to the state's Medicaid program and, in effect, shifted considerable costs to the federal and state governments.

Since August 1988, Michigan has made recovery on none of the medical claims it paid for Medicaid recipients with BC/BS benefits. As of August 1990, agreements Michigan and BC/BS made concerning the development

of a claim processing system have not been implemented. With recoveries from BC/BS indefinitely postponed, the state has accumulated a $59 million backlog of BC/BS claims. Michigan's likelihood of recovering the full amount owed on the backlogged claims from BC/BS has been seriously jeopardized because many of the policies under which the claims are payable include time limits for filing claims that have been exceeded.

We have recommended that the Medicaid statute be changed to allow assessment of double damages on insurers that do not pay when they should. This provision is currently applicable in certain circumstances under the Medicare program. In addition, as a part of another study, we are evaluating more broadly the options available to the federal government when a state, such as Michigan, has not met its responsibilities to recover Medicaid costs. Accordingly, this particular report contains no recommendations.

Background

Medicaid is a federally aided, state-administered medical assistance program that serves low-income people. Within broad federal guidelines administered by the Department of Health and Human Services' Health Care Financing Administration (HCFA), each state designs and manages its own Medicaid program. Under federal regulations, states are required to develop and implement systems to identify recipients with health insurance and assure that insurance benefits are used before Medicaid. When the state learns after it has paid a Medicaid claim that other health insurance exists, federal regulations require it to promptly seek recovery of benefits. Recovery of paid claims from liable insurers reduces federal and state Medicaid costs.

Normally, Medicaid recipients with health insurance obtain it through their or their parent's employer. Children in single-parent families receiving public assistance, for example, qualify for Medicaid coverage and also may be covered under insurance policies of their employed absent parents. In fact, federal child support regulations call for states to request that court orders for child support require absent parents to obtain health insurance coverage for their children when it is available at a reasonable cost.

In Michigan, the Medical Services Administration (MSA) administers the state's $2 billion Medicaid program. The federal government funds about 57 percent of Michigan's Medicaid program. Using information it receives from recipients, providers, and health insurers, MSA maintains

an automated file of all Medicaid recipients who have health insurance. MSA uses the file to either avoid payments or seek postpayment recoveries of claims that should be paid by health insurers instead of Medicaid. Payment avoidance occurs when MSA returns incoming claims unpaid so that the insurer pays first. Postpayment recovery occurs when MSA pays the provider of the medical services, then bills the insurer and receives payment that the insurer should have made initially.

BC/BS is involved in providing health insurance to about 7 percent of Michigan's Medicaid recipients. This includes BC/BS plans as well as coverage that it administers for self-insured, employer-sponsored health benefit plans. BC/BS is by far the largest health insurer in Michigan.

Scope and Methodology

We sought to determine the (1) nature of any problems the Michigan Medicaid agency may have in ensuring that BC/BS pays claims for Medicaid recipients it insures and the amounts involved and (2) adequacy of the Michigan Medicaid program's efforts to recover payments for such recipients having BC/BS health insurance. To do so, we interviewed officials from MSA and the Office of Internal Audit in Michigan's Department of Social Services; the Michigan Department of Licensing and Regulation's Insurance Bureau; the Michigan Department of Attorney General; the Michigan Office of the Auditor General; and BC/BS. In addition, we reviewed (1) Michigan's lawsuit against BC/BS,[1] (2) state health insurance laws and regulations, and (3) documentation concerning the handling of postpayment claims with probable BC/BS liability.

In assessing the adequacy of Michigan's recovery efforts, we also tested the accuracy and effectiveness of a separate process used by the state to recover pharmacy claims for recipients with BC/BS pharmacy coverage. To test whether BC/BS was paying when it should under this process, we reviewed a random sample of pharmacy claims that the state believed had BC/BS coverage but that BC/BS rejected. Using documentation provided by BC/BS and the state, we evaluated the reasons why BC/BS did not pay the claims. The claims we reviewed covered the 12-month period ending July 31, 1988—the most recent 12-month period for which complete claims data were available.

[1]Kelly v. Blue Cross and Blue Shield of Michigan, No. 78-835946-CZ (Mich., Wayne Cir. Dec. 11, 1985) (consent decree).

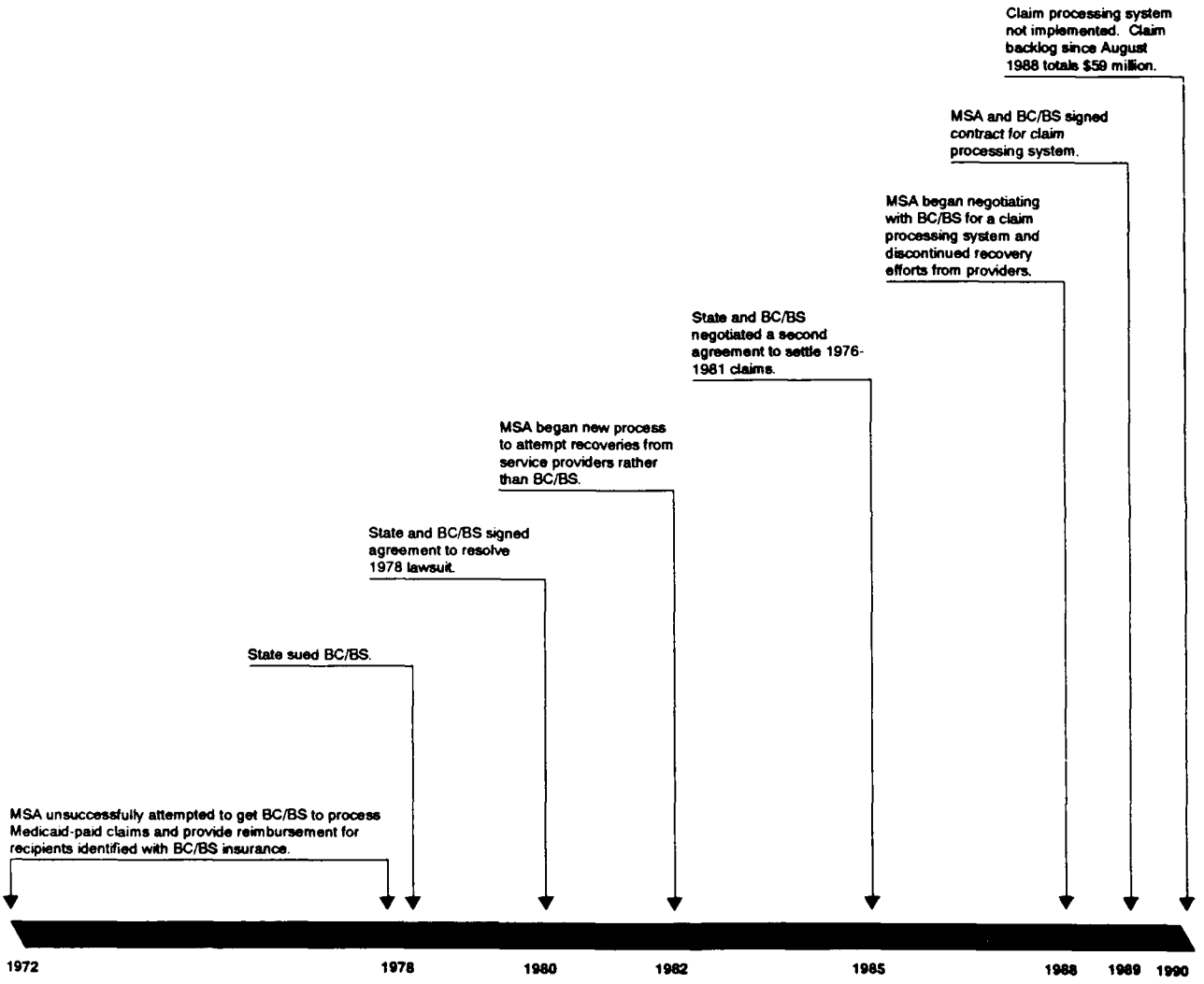
To evaluate the federal oversight of MSA's recovery efforts, we reviewed HCFA's policies, procedures, and practices for monitoring MSA. These included specific oversight efforts to ensure the identification of liability and the accuracy of BC/BS payments to MSA. Additionally, we obtained and reviewed evaluations of the MSA health insurance recovery program by HCFA, the Michigan Office of the Auditor General, and certified public accounting firms.

We conducted our review between July 1989 and August 1990 in accordance with generally accepted government auditing standards.

Longstanding Problems in Recovering Medicaid-Paid Claims Persist

Since 1972, for a variety of reasons MSA has experienced difficulty recovering from BC/BS, although other insurers in the state have routinely processed postpayment claims as submitted to them by MSA (see fig. I for chronology of events). One major reason is that BC/BS has maintained that its computer system is incapable of processing Medicaid claims as submitted by MSA, and that it needs additional information, preferably submitted on BC/BS claim forms. Because of the administrative difficulties involved in meeting BC/BS specifications for payment, the state has been precluded from obtaining significant recoveries.

Figure 1: Significant Events, MSA and BC/BS (1972-1990)



Recovery Problems Begin in Early 1970s

In November 1978, after 6 years of unsuccessful negotiation to have BC/BS process state-paid claims for insured Medicaid recipients, the state filed a lawsuit against BC/BS. The state sought to (1) establish BC/BS liability for 1973-78 claims totaling $47 million and (2) require BC/BS to implement a system for processing and paying past, present, and future claims.

In December 1980, Michigan and BC/BS reached a legal agreement to settle the dispute. As part of the agreement, BC/BS was to

- verify state information on Medicaid recipients with BC/BS coverage by performing a monthly match of its enrollment files against the state Medicaid insurance file,
- reimburse the state for the claims of insured recipients who received services after October 1, 1976 (no provision was made for claims for the 3 earlier years), and
- arrange for the development of a Medicaid claim-processing system and use it to pay future postpayment claims promptly.

The state agreed to submit claims that included data elements necessary for BC/BS to (1) assure its liability and claim accuracy and (2) process claims on its system.

MSA officials told us that the 1980 agreement did not fully resolve the claim-processing stalemate between the state and BC/BS because they could not give BC/BS all the data elements requested without substantial changes to the state's computer system. In December 1985, after BC/BS had paid $9.1 million as a result of processing a portion of the post-October 1976 claims, Michigan negotiated a second agreement with BC/BS. Under the 1985 agreement, rather than process the remaining claims, BC/BS agreed to pay an additional $9.4 million. In total, BC/BS paid about $18.5 million on claims of $90.7 million accumulated from October 1976 through August 1981.

Fewer Recoveries Than Expected Between 1982-1988

MSA used an alternate approach to obtain recoveries for claims paid from September 1981 through August 1988. Under that approach, when MSA identified a paid claim for a recipient identified as having BC/BS insurance, it did not forward the claim to BC/BS for reimbursement. Instead, it returned the claim to the provider (physician, hospital, etc.) to collect from BC/BS. To recover payments, MSA adjusted the provider's account to reduce its future Medicaid payments.

While workable, this was a slow, labor-intensive process whereby MSA manually processed individual claims. As a result, throughout much of the 1980s a large backlog of unprocessed claims existed, many of which MSA never processed. For example, in an October 1986 audit report, the State Auditor General reported an MSA backlog of unprocessed BC/BS claims totaling over $8 million. MSA was adding claims to this backlog twice as fast as it was processing them.[2]

During the period the state used this approach, it recovered only about $1.9 million for recipients that had BC/BS coverage. Although no information on the precise amounts that should have been recovered is available,[3] we can put the amount recovered into perspective. The $1.9 million (for 7 years of claims) is about 10 percent of what the state recovered from BC/BS under the 1980 and 1985 agreements (for 5 years of claims).

No Recoveries of Medical Claims Since 1988

MSA discontinued its alternate recovery process (for claims paid since August 1988). It did so largely because of provider complaints stemming from frequent errors and MSA concerns that the providers may stop serving Medicaid recipients. Since that time through April 1990, MSA has identified over $59 million in claims for which BC/BS may have some liability.[4] However, since 1988, although claims have been presented to BC/BS, no recoveries have been made.

In July 1988, before discontinuing the alternate recovery approach, MSA officials told us, they began negotiating with BC/BS to develop a claim processing system for direct BC/BS payments to MSA. BC/BS officials told us that a cooperative working environment between BC/BS and MSA was the primary reason they felt a claim processing system could be developed at that time. Prior to 1988, neither side was willing to cooperate with the other, BC/BS officials said. Consequently, the claim processing system called for in the 1980 agreement was not developed.

[2]The claim backlog did not include claims totaling less than $250 per recipient—the state cost-effective-to-pursue threshold for BC/BS claims. The Auditor General estimated that such claims amount to about $2.8 million annually.

[3]State records on the amount of Medicaid claims paid for recipients believed to have had BC/BS coverage were incomplete.

[4]It is unlikely that BC/BS is liable for the full amount because MSA does not screen for BC/BS policy limitations, excluded services, deductibles, or copayment provisions.

In August 1989, the state contracted to pay BC/BS about $400,000, mainly to develop and implement a claim processing system for Medicaid payments. The contract and subsequent modifications involved a three-phase approach, as follows:

- Phase 1. BC/BS was to match its enrollment files with the state Medicaid file to identify recipients with BC/BS insurance. When the contract was signed, BC/BS had already completed phase 1 and had delivered the names of additional Medicaid recipients with BC/BS coverage to MSA on April 28, 1989.
- Phase 2. BC/BS was to develop and implement a system to process MSA claims (exclusive of inpatient hospital claims) for recipients having BC/BS coverage. Phase 2 was originally targeted for implementation in December 1989. At that time, however, it was expanded to include inpatient hospital claims. As part of the expansion agreement, BC/BS advanced MSA $5.0 million on its potential liability on inpatient claims. According to MSA, it initiated this expansion when it identified inpatient claims as low-volume, high-dollar claims that merited expeditious recovery. As of August 31, 1990, none of the phase 2 system had been implemented.
- Phase 3. BC/BS was to develop and implement a system to process a claim form that a provider can submit for BC/BS, Medicare, and/or Medicaid payment and implement a system capable of directly accepting claims. As of August 31, 1990, BC/BS had not begun work on this phase.

Excepting the $5 million advance payment, these agreements[5] had the practical effect of indefinitely postponing recoveries from BC/BS. The state, however, is obligated under Medicaid regulations (42CFR 433.139(d)(2)) to seek recoveries within 60 days after the end of the month in which it identifies insurance for a Medicaid-paid claim. MSA was not prompt in submitting claims to BC/BS for payments that Medicaid made between August 1988 and September 1989. MSA did not forward the claims until November 1989, after we questioned MSA's authority to indefinitely postpone seeking recoveries from BC/BS. MSA forwarded additional claims to BC/BS in December 1989 and has continued to do so sporadically since that time. BC/BS is generally obligated under state law to pay claims to beneficiaries within 60 days or incur interest penalties, and Medicaid recipients must assign their rights to such payments to the states. MSA's contract with BC/BS, however, has the

[5]The agreements consist of the August 1989 contract and the December 1989 agreement to include inpatient hospital services claims.

effect of making claim processing and payment contingent on development by BC/BS of a claim processing system.

Further, the agreements may jeopardize MSA's ability to collect on some of the Medicaid-paid claims. BC/BS officials told us that most of the employer-sponsored health benefit plans administered by BC/BS require that, to be reimbursed by BC/BS, claims must be submitted within 12-18 months. The agreements explicitly limit BC/BS liability for the plans it administers (over half of BC/BS's business) to the amounts it collects from the employers. Thus, BC/BS will not be required to pay MSA if the employers do not reimburse BC/BS.[6] Although BC/BS officials told us that it is likely that some of the employers will waive their time limits for filing claims, none of them had agreed to do so at the time we completed our review.[7] Consequently, as time passes, more of the claims will fall outside filing time limits. The amounts in question can be considerable, as almost 30 percent of the claims by dollar value ($16.5 million) were over 12 months old as of July 31, 1990.

Opportunity to Avoid Payments Missed

MSA did not take full advantage of its opportunity to avoid paying claims unnecessarily. By completion of phase 1 of MSA's contract with BC/BS, the number of recipients identified as having BC/BS coverage had significantly increased. This gave MSA an opportunity to avoid the problems it had in obtaining postpayment recoveries from BC/BS. When recipients are known to have insurance coverage at the time MSA receives a claim, MSA can avoid costs by not paying the claim. Providers, when notified of this, directly bill the insurer for payment.

In April of 1989, under phase 1 of its contract with MSA, BC/BS gave the agency the names of an estimated 17,000 Medicaid recipients having BC/BS insurance. This increased the number of recipients MSA had previously identified as having BC/BS coverage by more than 25 percent. The state entered this information into its insurance file in August 1989 and avoided paying claims for services provided before September 1, 1989. However, MSA officials told us that various processing and technical problems precluded use of the data to avoid paying claims for program services provided during the 4-month period, September 1-December 31,

[6]Because these plans are administered by BC/BS—usually for self-insured employers—BC/BS obtains reimbursement for the claims it pays from the employer-sponsor.

[7]As discussed in our report, Medicaid: Legislation Needed to Improve Collections From Private Insurers (GAO/HRD-91-25, Nov. 1990) states are experiencing problems recovering from employer-sponsored health benefit plans. That report includes recommendations for resolving these problems.

1989. Consequently, MSA estimates that during the 4 months, it paid over $1.1 million in Medicaid claims for people with BC/BS insurance.

MSA officials told us that they will seek recovery of these payments when BC/BS implements its system for processing Medicaid claims. As discussed above, however, it is uncertain when this will occur. The longer it takes to implement the system, the lower the likelihood of MSA's recovering its payments.

Weak Internal Controls Also Reduce Recoveries

Although the provision in the 1980 agreement calling for a BC/BS system to process Medicaid medical claims has not yet been implemented, BC/BS began using such a system for processing pharmacy claims in 1980.[8] To ascertain whether MSA was recovering the amounts it should on pharmacy claims, we tested the recovery process for the 12-month period ended July 1988. Pharmacy recoveries from BC/BS were a matter of concern because they had declined over the years from 9.0 percent of the amount claimed in 1982 to 3.5 percent in 1989.

During the 12-month period we tested, BC/BS rejected most of the claims that MSA submitted for recovery, paying only $.5 million of the $11.7 million in claims. In rejecting most of the claims, BC/BS indicated that either recipients did not have BC/BS coverage or their coverage excluded pharmacy benefits.

Although BC/BS documented the reasons for rejecting each claim, MSA neither reviewed the documentation nor pursued claims that, in our view, still had potential for recoveries. Many rejections appeared to be the result of

1. correctable MSA errors (for example, the claims MSA submitted to BC/BS had an incorrect or missing provider code) or

2. possible BC/BS errors (for example, BC/BS records available at MSA showed that some recipients actually had pharmacy coverage for the service dates for which BC/BS had rejected the claims on the basis of no pharmacy coverage).[9]

[8]These represent about 8 percent of total state Medicaid program costs.

[9]MSA has an on-line computer terminal connected to the BC/BS enrollment files, which it uses to verify BC/BS coverage.

We estimate that MSA follow-up could have resulted in additional recoveries of $.3 to $1.9 million.[10] Also, MSA lacked controls to ensure that recoveries of paid pharmacy claims are timely. For example, BC/BS took an average of 6 months from the receipt of a claim from MSA to the time it submitted a payment.[11]

After we brought the missed potential collections to the attention of HCFA regional officials in October 1989, they asked MSA to investigate the situation and explain state procedures to correct the problem. MSA said that higher priorities limited its review of recovery rates for pharmacy claims. However, MSA speculated that BC/BS might not have incorporated updated drug and provider codes into its claim processing system. MSA told HCFA that BC/BS had verbally agreed to reprocess all pharmacy claims if a deficiency existed.[12]

Monitoring and Oversight Weak

Federal monitoring and oversight of Michigan's Medicaid recovery program has been ineffective. HCFA performed two different reviews of the Michigan program in 1989, but neither detected that MSA was not promptly seeking recoveries from BC/BS. Moreover, until we brought it to HCFA's attention, HCFA was unaware that MSA had discontinued its alternate recovery process for Medicaid recipients with BC/BS coverage or that the August 1989 three-phase contract with BC/BS had been finalized.

We discussed MSA's recovery problems with HCFA regional officials in October 1989. As a result, HCFA corresponded with the state to follow up on some of the issues we raised. Also, in light of the deficiencies that we noted, HCFA regional officials said that they may need to update their audit plans and approaches.

State monitoring and oversight of Michigan's Medicaid recovery program also has been ineffective. Between 1985 and 1988, audits by the Michigan Office of the Auditor General and a certified public accounting

[10]We used a 95-percent confidence level for our projection. This means that chances are 95 out of 100 that the true recovery value for the pharmacy claims lies within the estimated recovery range.

[11]As discussed on p. 8, state law generally requires BC/BS to pay claims within 60 days or incur interest penalties.

[12]MSA and BC/BS suspended processing pharmacy claims around August 1989, thinking they could quickly correct the coding problems, MSA officials told us. They indicated that BC/BS resumed processing in July 1990, even though the coding problems had not been corrected.

firm identified deficiencies similar to those we found and made recommendations to improve recovery efforts. MSA did not implement the recommendations, and the Auditor General has no authority to require MSA compliance with its recommendations for correction.

Authority Available to Enforce Insurer Compliance Not Used

States have the principal responsibility—both as regulators of insurers and as administrators of Medicaid—for taking actions to ensure that insurers comply with Medicaid requirements. In our view, MSA has not taken all the actions that it should, allowing BC/BS for nearly 18 years to avoid paying claims for many of the Medicaid recipients it insured. For example, MSA has not

- asked the state Insurance Bureau to assist it in obtaining BC/BS compliance. The Insurance Bureau has considerable leverage over insurers because it enforces the requirements they must meet to do business in Michigan. Insurance Bureau officials told us that BC/BS has the same obligation to pay Medicaid claims as other insurers. They said MSA could have sought the Bureau's assistance to administratively resolve the problem or return to court if necessary.
- monitored BC/BS compliance with the 1980 agreement. Though there have been some interpretation problems and uncertainty about MSA's and BC/BS's responsibilities under the agreement, MSA has not sought legal clarification or enforcement of the agreement. MSA told us that this may have been due to staff turnover during the past decade.
- in effect, required in its agreements that BC/BS promptly pay claims for which it is liable and thus preserve the state's right to recover on older claims.

Medicaid Needs Delinquent Insurer Penalties

Unlike the Medicare program, Medicaid does not provide federal penalties for insurers who do not comply with federal requirements to pay the claims of insured program recipients. In our view, this gives insurers an incentive to avoid or delay paying the claims of Medicaid recipients because doing so saves them money. That is, if and when the insurers pay, they usually pay only what they originally owed. Medicare law has been amended to countervail this incentive by providing for "double damages" (double the amount originally owed) in situations where insurers do not pay when they should. We have recommended amending the Medicaid statute to incorporate provisions similar to those of the Medicare program.[13] If such legislation was enacted, anyone—including

[13]GAO/HRD-91-25, Nov. 1990.

the state—could sue an insurer for double damages if the insurer failed to comply with requirements for the payment of health services provided to insured Medicaid recipients.

Conclusions

To the extent that insurers can establish legal or administrative barriers to delay or postpone payments to the state, it is in their financial interests to do so. Our past work has shown that insurers act on these interests, and this appears to be true in Michigan as well. Ineffective state management, coupled with lack of HCFA leadership, has allowed millions in Medicaid payments to go unrecovered from BC/BS. Until corrective actions are taken, Michigan and the federal government will continue to pay Medicaid claims for which BC/BS is liable.

Currently, we are evaluating HHS's options to deny federal Medicaid funding for claims for which a state like Michigan has not met its responsibilities to recover Medicaid costs. That evaluation of HCFA oversight and sanction authority involves issues that are beyond the scope of this review. The results of that evaluation, together with any recommendations, will be included in a subsequent report. In the meantime, we continue to believe that our recommendation to amend Medicaid law to provide federal penalties for delinquent insurers, if implemented, could help resolve Michigan's Medicaid recovery problems.

As you requested, we did not obtain written comments on this report, but we did discuss its contents with MSA, BC/BS, and HCFA officials. We have incorporated their comments where appropriate.

As arranged with your office, unless you publicly announce its contents earlier, we plan no further distribution of this report until 30 days after its issue date. At that time, we will send copies to the Secretary of Health and Human Services and other interested parties and make it available to others on request. Please call me on (202) 275-5451 if you or your staff have any questions about this report. Other major contributors are listed in appendix I.

Sincerely yours,

for Mark V. Nadel

Janet L. Shikles
Director, Health Financing
and Policy Issues

Major Contributors to This Report

Human Resources Division, Washington, D.C.	Jane L. Ross, Senior Assistant Director, (202) 275-6195 Edwin P. Stropko, Assistant Director Donald J. Walthall, Assignment Manager
Detroit Regional Office	Philip J. Andres, Evaluator-in-Charge Jean T. Shanahan, Evaluator Javier J. Garza, Evaluator
Office of the General Counsel, Washington, D.C.	Craig H. Winslow, Attorney-Adviser