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Medicare: Millions in Potential Recoveries Not Being Sought by Contractors

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Before the Subcommittee on Oversight Committee on Ways and Means House of Representatives

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Mr. Chairman and Members of the Subcommittee:

We are pleased to be here today to discuss our continuing efforts to assess the effectiveness of the Medicare Secondary Payer (MSP) provisions.

The MSP provisions are intended to assure that insurers,<sup>1</sup> whose coverage is primary, pay claims before Medicare. Under these provisions, Medicare claims processing contractors have two interrelated responsibilities: (1) to identify other insurers and, thus, prevent inappropriate Medicare payments, and (2) to identify and recover mistaken payments that were made prior to determining that the beneficiary had other insurance.

Over the past several years, we have issued a number of reports on how well contractors performed the first of their MSP responsibilities. We concluded that, for a number of reasons, they were not very effective at identifying other insurers that should pay before Medicare. While problems remain, recent legislative requirements could enhance contractors' ability to identify primary payers and help avoid future mistaken payments.

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<sup>1</sup>We use the term "insurer" to mean all liable third parties, including insurance companies, third-party administrators, and "self-insured" employer health benefit plans.

This testimony focuses on the second MSP responsibility--part B contractors' (carriers) efforts to recover mistaken Medicare payments after determining that beneficiaries have other insurance. The results of our work to date suggest that this aspect of the MSP program is also plagued with problems. First, carrier systems problems and relaxed payment controls have contributed to the increased volume of mistaken Medicare payments that must be recovered. Second, because of MSP funding cutbacks carriers have done little to collect mistaken payments from other insurers since October 1, 1989.

The Health Care Financing Administration (HCFA) has no reliable information on the size of the backlog or the total dollars associated with mistaken payments. However, based on our work to date, we believe that carriers have paid hundreds of millions of dollars that should be recovered from other insurers.

A recently-initiated Internal Revenue Service (IRS)/Social Security Administration (SSA) data match and a Department of Health and Human Services (HHS) regulation make it imperative that actions are taken immediately to address this problem. The data match could add several million more claims to the existing backlog of mistaken Medicare payments. Further, the HHS regulation limits the time that contractors have to initiate recovery action after they identify another insurer. Thus, unless contractors are given the necessary resources to begin recovering the mistaken payments,

hundreds of millions of dollars owed to Medicare will never be recovered.

We believe that carriers should be adequately funded to recover these mistaken payments and that additional funds will return considerably more than the dollars spent.

MEDICARE AS  
SECONDARY PAYER

Medicare is administered by HCFA within HHS. HCFA contracts with insurance companies 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 claims totaling more than \$11.5 billion in fiscal year 1991.

When the Congress enacted the Medicare program in 1965, it made Medicare the secondary payer for beneficiaries also covered by workers' compensation. The Congress expanded the MSP provisions several times between 1980 and 1987 making Medicare the secondary payer to certain employer-sponsored group health insurance plans and to automobile and other liability insurance plans.

Medicare contractors are generally required to take two actions after determining that the beneficiary has other insurance. First, they enter a "flag" or edit into the claims

processing system so that future claims will be denied by Medicare and sent to the beneficiary's insurer. Second, they are required to research the beneficiary's claims history file to determine if Medicare has paid claims after the effective date of the other insurance coverage and, if so, attempt recovery.

Our earlier reports recommended actions to improve identification of other insurers under the MSP program.<sup>2</sup> Specifically, these reports concluded that Medicare contractors have little incentive to ensure that Medicare pays only after other payers. In part, this is because some insurance companies that serve as Medicare claims processing contractors may have a conflict of interest because they could be the primary insurer for Medicare beneficiaries. We made a number of recommendations to address this problem.

The Administration has reduced the funds available to contractors to carry out their MSP activities. This was particularly true for part B MSP funding which was cut from about \$36 million in fiscal year 1989 to about \$15 million in 1990, a 60-percent reduction.

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<sup>2</sup>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).

MILLIONS IN POTENTIAL RECOVERIES

NOT BEING SOUGHT BY MEDICARE CONTRACTORS

We began work in January 1990 to determine the effect of funding cutbacks on carrier MSP activities. We have completed our work at Blue Cross and Blue Shield of Maryland, the carrier for that state, and at Aetna Life and Casualty, the carrier for Arizona and Nevada. We are continuing work at two California carriers-- Transamerica Occidental Life Insurance and Blue Shield of California--and have just begun at Florida Blue Cross and Blue Shield.

Based on our preliminary results, it appears that even when carriers have information which indicates that Medicare beneficiaries have other insurance coverage, they are not routinely reviewing previously paid Medicare claims to identify and collect refunds due from private insurers. In addition, we have identified situations where, for various reasons, carriers have paid claims totaling millions of dollars after learning that beneficiaries had primary coverage.

Following is a summary of our work at three of the carriers. Information on the others is contained in attachment I.

## Blue Cross and Blue Shield of Maryland

As discussed in our recently issued report on Blue Cross and Blue Shield of Maryland, we found a large inventory of potential mistaken Medicare payments that were not being recovered.<sup>3</sup> The contractor, through MSP investigative efforts, developed information--including policy numbers--that showed beneficiaries had other insurance that was potentially responsible for the payments.

Using the contractor's handwritten ledgers for this inventory, we developed a listing of 3,059 cases for which Medicare had paid about \$8.8 million during the period 1983 to 1989. We found that a relatively few cases account for a significant portion of these payments. For example, the 128 cases that involve payments of \$15,000 or more account for about \$3.6 million or 40.8 percent of the mistaken payments. (See attachment II for a listing of the 10 largest cases.)

We also found that 13 insurers are each potentially responsible for more than \$100,000 of the payments. Blue Cross and Blue Shield of Maryland is also a private insurer and may be

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<sup>3</sup>Medicare: Millions in Potential Recoveries Not Being Sought by Maryland Contractor (GAO/HRD-91-32, Jan. 25, 1991). Blue Cross and Blue Shield of Maryland is the Medicare contractor for part A services in Maryland and the District of Columbia and for part B services in most of Maryland.

the primary payer for \$4.1 million, or almost half the total mistaken payments identified.

As stated earlier, the contractor was doing little to recover the funds from other insurers before our visit. While it is difficult to determine all the reasons for this, we believe that cutbacks in funds for MSP activities hampered the contractor's attempts to recover part B mistaken payments. The contractor's funding for MSP activities under part B increased in fiscal year 1989, but was reduced by about 51 percent in fiscal year 1990-- from \$738,385 to \$363,900. This was part of a nationwide reduction in MSP funding.

Because of our work at the Maryland contractor, HCFA provided additional fiscal year 1990 funding to the contractor to begin collecting the mistaken Medicare payments. The contractor used our listing and has taken action on about 950 of the larger dollar cases. Since the beginning of fiscal year 1991, the contractor has reduced its recovery efforts and is currently reviewing about 10 cases per week. According to contractor officials, about \$2.3 million had been repaid to Medicare as of February 15, 1991.

Aetna Life and Casualty Company

Aetna processes part B claims for both Arizona and Nevada. We found that, unlike the Maryland carrier, Aetna did not research



its files to identify mistaken Medicare payments after learning that beneficiaries had other insurance. Carrier officials stated that they discontinued such efforts after the October 1989 MSP budget cut because they lacked the resources to identify mistaken payments and seek recoveries. Thus, Aetna had no inventory of mistaken payments for us to review.

To estimate the dollar value of mistaken Medicare payments at this carrier, we selected a random sample of 154 beneficiaries identified as having other insurance. We found that Medicare paid one or more claims totaling about \$83,000 for 71 of the 154 beneficiaries in our sample. As noted in our Maryland work, a significant portion of these potential recoveries is concentrated in a relatively few cases. About \$40,000, or nearly one-half of the mistaken payments in our sample, was contained in about 7 percent of the claims paid.

Based on the results of our sample, we estimate that this carrier may have paid claims of about \$5.5 million with Medicare funds that should have been paid by--and recovered from--private insurers. We estimate that this carrier could recover \$17 for every dollar spent pursuing MSP mistaken payments.

Blue Shield of California

We are also using a random sample for our analysis at Blue Shield of California. We are still in the early stages of our evaluation, in part because we have experienced a number of problems in obtaining payment history data and other information on the cases selected for review.

However, we believe that a conversion to a new claims processing system in August 1990 has added to the number of mistaken Medicare payments made by this carrier. During the conversion, information on 50,000 beneficiaries with primary insurance coverage was deleted for a 2-week period. Thus, the carrier may have paid claims that should have been paid by other insurers.

On February 19, 1991, carrier officials told us they do not know the dollar value of, nor are they attempting to recover, the mistaken payments made during this period. They said that measures have been taken to reenter the deleted beneficiary insurance information but have not provided us with specific details on these measures. However, we identified several other similar cases which indicate that the problem has not been fully corrected.

SIZE OF EXISTING INVENTORY  
OF MISTAKEN PAYMENTS IS UNKNOWN

HCFA does not regularly collect--nor require contractors to keep--management information on the number of mistaken payments made or the dollar value potentially due back to Medicare. HCFA recently surveyed the Medicare contractors on this matter, but the results are unreliable.

We believe that the part B claims inventory alone probably numbers in the millions. As cited in our June 14, 1990 testimony given before the Subcommittee on Health, House Committee on Ways and Means, we believe the dollar value of funds that could be collected from insurers is at least \$200 million.<sup>4</sup>

HCFA recently reallocated \$3 million from other parts of the contractors' 1991 budget to fund efforts to pursue and recover mistaken Medicare payments. HCFA expects to recover about \$50 million, a small portion of the dollars associated with the entire inventory of MSP claims.

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<sup>4</sup>Medicare: Effects of Budget Reductions on Contractor Program Safeguard Activities (GAO/T-HRD-90-42, June 14, 1990).

DATA MATCH COULD IDENTIFY  
ADDITIONAL MISTAKEN MEDICARE PAYMENTS  
THAT SHOULD BE RECOVERED

A recently-initiated IRS/SSA data match could add several million more claims to the existing backlog of mistaken Medicare payments. Required by the Omnibus Budget Reconciliation Acts of 1989 and 1990, the data match between IRS and SSA is intended to help identify beneficiaries who have other insurance coverage. IRS records for tax years 1987 through 1989 were used to identify Medicare beneficiaries and their spouses who were employed. The SSA master earnings files were used to identify the employers, and the results have been provided to HCFA.

Employers now must be contacted to determine if they provide health insurance to Medicare beneficiaries and, if so, the effective date of the coverage. HCFA awarded a contract to Group Health Incorporated (GHI), a Medicare carrier in New York, to obtain the insurance information. As information is obtained, GHI will enter beneficiary insurance data into the automated claims processing system used by Medicare contractors to prevent future claims payment. HCFA officials told us that the cost of the contract will be \$14.2 million over a 3-year period.

HCFA also will use beneficiary insurance data to determine if Medicare mistakenly paid claims while the beneficiary had other

coverage. Using its claims history file, HCFA will provide Medicare contractors with listings of mistaken payments that should be developed and recovered from other insurers. Thus, this project could add significantly to an already large inventory of mistaken Medicare payments that are not being collected.

Excluding the funds for the GHI contract (\$6.6 million), the fiscal year 1992 budget requests \$25.8 million to fund carrier MSP activities. This includes funds to develop the mistaken payments that will be identified by the data match project. While this is a small increase over the 1991 funding level, carriers will receive about \$10.2 million less for MSP in 1992 than in fiscal year 1989, the year before the major budget cut.

HHS REGULATIONS LIMIT TIME FOR  
RECOVERING MISTAKEN PAYMENTS

Effective November 13, 1989, HHS regulations limit the time for initiating recovery of mistaken payments. These regulations state that contractors must initiate recovery action within 15 to 27 months after identifying another insurer as being primary or the insurer will no longer be held liable for the amount mistakenly paid by Medicare. Thus, the clock may have already started ticking on thousands of Medicare claims where carriers have identified another insurer (after November 13, 1989) but are not seeking recovery. Further, HCFA officials told us that the primary insurer

will be considered "identified" at the time the contractors receive their individual output tapes from the IRS/SSA data match. Unless timely recovery actions are initiated on these mistaken payments, Medicare may be unable to recover millions of dollars of claims that other insurers are responsible for paying.

#### CONCLUDING REMARKS

In a time when Medicare costs are increasing rapidly, we believe that Medicare carriers should be attempting to recover the hundreds of millions of dollars potentially owed to the Medicare program by other insurers. The IRS/SSA data match and HHS regulations highlight the need to adequately fund carrier operations so that they can carry out this important MSP function. We are pleased to see that the 1992 budget request contains an increase for carrier MSP activities. However, this funding may be insufficient to address the existing backlog of mistaken payments, as well as the additional workload that will be created by the data match.

As was the case with the Maryland carrier, we believe that HCFA should work with each contractor to (1) determine the full scope of the problem, (2) develop an estimate of the resources needed to correct it, and (3) establish a plan, including milestones, for seeking recoveries. HCFA must decide the most appropriate method of funding contractor efforts to recover

mistaken Medicare payments. Perhaps this can be done through a combination of redirecting existing resources and requesting additional MSP funds. It is clear that this MSP activity is very cost effective and, in our opinion, every dollar spent for this effort is a wise investment.

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Mr. Chairman, this concludes my prepared statement. My colleagues and I will be pleased to answer any questions you and the other members of the Subcommittee may have.

PRELIMINARY RESULTS OF GAO  
WORK AT TWO MEDICARE CARRIERS

Transamerica Occidental Life Insurance

At Occidental, one of the two California carriers, the situation was similar to that at Aetna. According to carrier officials, prior to the October 1989 budget reductions, MSP staff would research carrier payment files to identify mistaken Medicare payments and seek recovery when beneficiaries had other insurance. Like Aetna, Occidental has discontinued such efforts.

We have not completed our analysis of the files for a sample of 350 beneficiaries and, thus, are unable to estimate the amount of uncollected mistaken payments at Occidental. However, to illustrate the magnitude of the problem, we developed information on 89 beneficiaries identified during a two-day period in September 1990 as having other insurance. The carrier did not review its payment history for these beneficiaries to determine if another insurer, rather than Medicare, should have paid prior claims. Our analysis showed that 63, or 70 percent of the beneficiaries sampled, had submitted one or more prior claims totaling about \$76,500. For one beneficiary alone, we identified 153 claims totaling about \$42,000 that may have been the responsibility of another insurer.



Blue Cross and Blue Shield of Florida

We have just begun our work at Blue Shield of Florida. However, carrier officials told us that a HCFA directive-- implemented during the period October 1, 1989 to September 30, 1990--coupled with a system limitation significantly increased the number and amount of Medicare payments that should have been made by other insurers.<sup>1</sup>

They explained that before that period, on claims of \$50 or more, the carriers were required to determine if beneficiaries had other insurance coverage. Because of the budget cutbacks, HCFA raised the threshold for claim development from \$50 to \$250. Claims of less than \$250 were automatically paid without determining if the beneficiary had other insurance coverage.

Florida carrier officials told us that, before October 1990, their processing system did not have the capability to positively identify beneficiaries who had previously reported other insurance coverage. As a result, the carrier had to continually redevelop insurance coverage information by sending letters of inquiry to the beneficiaries before claims could be paid. Thus, the HCFA

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<sup>1</sup>The other carriers included in our review did not implement the directive.

directive affected a much larger volume of claims at the Florida carrier than might have been the case elsewhere.

Carrier officials advised HCFA that about 360,000 claims representing about \$34 million were paid automatically during the time the HCFA directive was in effect. It is highly probable that many of these claims were for beneficiaries who had previously reported other insurance coverage and, thus, would have been denied had the carrier's system contained an insurance indicator.

Carrier officials told us that, as of October 1990, they were developing all MSP claims over \$50 and an insurance indicator was added to their system. Since we have just initiated our work at this carrier we have not verified these changes.

TEN LARGEST MEDICARE CASES THAT  
SHOULD BE RECOVERED BY MARYLAND CONTRACTOR

<u>Insurer</u>	<u>Part A Dollars</u>	<u>Part A Claims</u>	<u>Part B Dollars</u>	<u>Part B Claims</u>	<u>Total Dollars</u>	<u>Total Claims</u>
Blue Cross/Blue Shield of Maryland	124,591.41	5	12,290.82	50	136,882.23	55
Blue Cross/Blue Shield of Maryland	97,419.02	19	11,118.31	68	108,537.33	87
Blue Cross/Blue Shield of Pennsylvania	83,082.00	27	8,339.30	93	91,421.30	120
I.L.A Benefit Fund	62,351.83	4	9,607.36	29	71,959.19	33
Columbia Freestate	67,661.51	20	1,644.27	59	69,305.78	79
Blue Cross/Blue Shield of Maryland	59,118.66	78	7,377.07	79	66,495.73	157
Carefirst	54,912.38	7	10,764.46	62	65,676.84	69
Blue Cross/Blue Shield of Maryland	57,732.01	7	71.12	3	57,803.13	10
Mass Mutual	49,212.20	9	7,702.91	62	56,915.11	71
Columbia Freestate	<u>44,730.10</u>	<u>5</u>	<u>4,947.61</u>	<u>0</u>	<u>49,677.71</u>	<u>5</u>
Total	<u>700,811.12</u>	<u>181</u>	<u>73,863.23</u>	<u>505</u>	<u>774,674.35</u>	<u>586</u>