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GAO

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

Health, Education and Human Services Division

B-260636

March 6, 1995

The Honorable William M. Thomas
Chairman, Subcommittee on Health
Committee on Ways and Means
House of Representatives

Dear Mr. Chairman:

On February 23, in testimony before your Subcommittee, we called attention to certain actions needed to realize savings under the Medicare Secondary Payer (MSP) program.[1] A specific problem that we identified dealt with a recent court ruling that invalidated Medicare procedures for recovering costs from insurers that are responsible for paying claims before Medicare. We agreed to provide suggested legislative language to resolve the problem. The enclosure to this letter contains the suggested language together with a technical explanation.

In effect, the suggested language is designed to provide a clearer statutory basis for existing Medicare regulations. These regulations are critical to the effective recovery of Medicare funds, but were recently invalidated by the courts.

While time did not permit us to submit the proposed language for formal review by the Department of Health and Human Services (HHS), we did discuss the proposed language with HHS legal staff, and the court ruling and its impact on the MSP program with Health Care Financing Administration program officials. They agreed that a legislative remedy is necessary and expressed their support of our efforts to assist your Subcommittee. We understand from them that HHS is preparing a legislative proposal to address this issue, possibly in conjunction with other Medicare issues.

[1]Medicare Secondary Payer Program: Actions Needed to Realize Savings (GAO/T-HEHS-95-92).

If you have any questions concerning the legislative language, please call Craig Winslow in our Office of the General Counsel at (202) 512-8225.

Sincerely yours,

Sarah F. Jaggar

Sarah F. Jaggar
Director, Health Financing
and Policy Issues

Enclosure

CLARIFICATION OF MEDICARE AS SECONDARY PAYER

BACKGROUND

The Medicare Secondary Payer (MSP) provision[1] made Medicare a secondary payer to group health plans as a means of producing Medicare savings.[2] The provision has been amended and strengthened several times since it was enacted in 1981, and the Health Care Financing Administration (HCFA) estimates that the provision saved taxpayers about $3 billion in fiscal year 1994. However, as a result of a recent court decision narrowly construing the MSP provision,[3] unless legislative changes are made, past recoveries of mistaken payments may be jeopardized and future savings will not be fully realized. The following suggested amendment would clarify the MSP provision in response to the decision, to ensure that anticipated savings will be realized.

The main thrust of the MSP provision is to avoid a Medicare payment when private insurance is available to cover the cost of medical expenses incurred by Medicare beneficiaries. If a Medicare beneficiary has private coverage, the MSP provision provides for the private insurer to be the primary payer, and Medicare can avoid paying the medical claim. Much of the savings to date has resulted from such cost avoidance, but it is not always possible for HCFA to know when a beneficiary has private coverage in time to avoid paying. Therefore, the MSP provision also provides that a Medicare payment is conditional when payment "has been made, or can reasonably be expected to be made" by a primary payer. Under the MSP provision, HCFA is authorized in such cases to recover the conditional or mistaken payment from any entity that is required or responsible to pay the claim.

Historically, HCFA has faced difficulty in carrying out the MSP provisions.[4] For example, it originally had to rely primarily on

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[1]42 U.S.C. § 1395y(b) (Supp. V 1993).

[2]128 Cong. Rec. 22402 (1982) (Senator Dole describing the impact of the MSP provision in the Tax Equity and Fiscal Responsibility Act of 1982).

[3]Health Ins. Ass'n of Am. v. Shalala , 23 F.3d 412 (D.C. Cir. 1994), cert. denied, 63 U.S.L.W. 3439 (U.S. Feb. 21, 1995) (No. 94-919).

[4]More Hospital Costs Should Be Paid by Other Insurers (GAO/HRD-87-43, Jan. 29, 1987) and Medicare Secondary Payer Program: Identifying Beneficiaries With Other Insurance Coverage Is

health care providers to identify Medicare beneficiaries who also have private insurance. As a consequence, section 6202 of the Omnibus Budget Reconciliation Act of 1989 (OBRA-89) amended the MSP provision to permit HCFA to match data contained in Internal Revenue Service and Social Security Administration files to identify beneficiaries with private insurance and require employers in such cases to notify HCFA.[5] To date, the data match has been very cost-effective. As a result of the initial data match covering the 1987-90 period, $1.6 billion in notices was sent to private insurers seeking reimbursement on claims Medicare paid that should have been paid by them, from which about $400 million has been collected.

NEED FOR LEGISLATIVE CHANGES

The federal court invalidated several interpretive regulations promulgated by HCFA in 1989 that facilitated improved recoveries under the MSP provision.

First, the court held that the MSP provision does not permit HCFA to recover mistaken payments from third party administrators (TPAs), invalidating that portion of HCFA's rule, 42 C.F.R. § 411.24(e), specifically listing TPAs as entities from which HCFA may recover. TPAs typically exercise authority to make discretionary judgments concerning the payment and handling of claims. They process claims for employee health plans and, because they are often charged with deciding which claims to pay or reject for numerous plans, are familiar with the coverage provisions of various plans. As a result, largely because of their expertise, they are often the most logical and efficient place for HCFA to seek recoveries. The court reasoned, nonetheless, that because TPAs generally do not bear the ultimate financial risks, they are not "required or responsible . . . to pay" as that designation is used in the MSP provision. With recoveries from TPAs barred, HCFA will have to deal directly with myriad employers that are often less well-suited to respond than TPAs administering such plans. The suggested amendment would strengthen the statutory language quoted here to clarify that HCFA may recover from entities "responsible for making payment," such as TPAs, and not merely from entities that bear the ultimate financial responsibility for payment.

Second, the court concluded essentially that the MSP provision grants HCFA no greater rights with respect to insurers' claim

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Difficult (GAO/T-HRD-93-13, Apr. 2, 1993).

[5]42 U.S.C. 1395y(b)(5) (Supp. V 1993). This requirement currently expires September 30, 1998.

filing deadlines than insurers' beneficiaries or other private claimants.[6] Thus, the court invalidated HCFA's rule, 42 C.F.R. § 411.24(f), that expressly provided for HCFA to recover after insurers' claim filing deadlines so long as it files its claim no later than 27 months after receiving notice that the private insurer was primary to Medicare. Because HCFA is frequently unable to determine that a beneficiary had coverage primary to Medicare at least until the data match is performed, which takes a minimum of 2 years, this will greatly undermine HCFA efforts to recover mistaken payments. The suggested amendment would ensure that claim filing deadlines set by insurers for beneficiaries and other claimants will not thwart the MSP provision by barring HCFA recovery.

Third, although the court otherwise approved it, the court held that a HCFA rule could not be applied with respect to recovery efforts initiated prior to its promulgation in 1989. The rule, 42 C.F.R. § 411.24(i), expressly permits HCFA to recover conditional payments from an entity that has reimbursed the beneficiary when HCFA cannot recover from the beneficiary and the entity was aware (or should have been aware) that Medicare had made a conditional payment. Although the impact of this holding is not yet clear because the statutory language itself should provide a sufficient basis for validating such recoveries, it has the potential to spawn litigation and undermine the efficacy of HCFA's recovery efforts. The suggested amendment would provide a clearer statutory basis for the regulation at issue.

In addition to limiting the cost-effectiveness of the MSP provision with respect to future Medicare payments, the recent court decision has raised the possibility that HCFA may have to refund hundreds of millions of dollars recovered under HCFA's interpretation of the MSP provision prior to the decision. To prevent this, the suggested amendment would be effective as if included in section 6202 of OBRA-89. Since most of the actions yielding the recoveries cited above were initiated in response to the data match that was begun in 1991, this should preclude any chance that HCFA will have to refund significant sums where private insurance was available to cover the cost of medical expenses that were paid by Medicare.

SUGGESTED LANGUAGE

(a) In General.--Paragraph (2) of section 1862(b) of the Social Security Act (42 U.S.C. 1395y(b)(2)) is amended--

[6]The MSP provision explicitly provides, in fact, that HCFA is already subrogated to any right of an individual or entity to payment from a group health plan in such cases. 42 U.S.C. § 1395y(b)(2)(B)(iii) (Supp. V 1993).

(1) in subparagraph (A), by striking "or" in clause (i), and inserting ", or could have been made" after "expected to be made," and

(2) in subparagraph (B), by striking "against any entity which is required or responsible under this subsection to pay," and inserting "against any entity that made or was responsible for making payment, or that is or should have been required or responsible for making payment under this subsection."

(b) Effective Date.--The amendment made by subsection (a) shall take effect as if included in section 6202 of the Omnibus Budget Reconciliation Act of 1989 (Public Law 101-239).

(108231)

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