

GAO

Care Financing Administration,  
Department of Health and Human  
Services

# MEDICARE

## Millions in Potential Recoveries Not Being Sought by Maryland Contractor

AD-A267 421



DTIC  
SELECTE  
AUG 1993  
S C D

RESTRICTED INFORMATION  
Not to be released outside  
Department of Health and Human Services

93-17167





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

Human Resources Division

B-240808

January 25, 1991

Ms. Gail R. Wilensky, Administrator  
 Health Care Financing Administration  
 Department of Health and Human  
 Services

Accession For		
NTIS	CRA&I	<input checked="" type="checkbox"/>
DTIC	TAB	<input type="checkbox"/>
Unannounced		<input type="checkbox"/>
Justification		
By _____		
Distribution /		
Availability Codes		
Dist	Avail and/or Special	
A-1		

Dear Ms. Wilensky:

**DTIC QUALITY INSPECTED 3**

As part of our efforts to evaluate the adequacy of the Medicare contractor budget for claims-processing and program safeguard activities, we identified a situation that requires your attention. Blue Cross and Blue Shield of Maryland, a Medicare claims-processing contractor, has paid at least \$8.8 million in Medicare claims for which it has identified other health insurers that may have primary payment responsibility under the Medicare secondary payer (MSP) provisions.<sup>1</sup>

Although Blue Cross and Blue Shield of Maryland (the contractor) has identified a private insurer and a corresponding beneficiary policy number for each claim, little has been done to pursue recovery of the related payments. As of October 31, 1990, the contractor had only 1.5 full time equivalent (FTE) staff assigned to recovering these mistaken payments. Contractor officials estimate that the total MSP backlog could be eliminated in a year at a cost of about \$200,000 for the needed staff. The Health Care Financing Administration (HCFA) should determine the staff needed to eliminate the backlog and establish a plan to recover the mistaken payments.

## Background

Medicare, authorized by title XVIII of the Social Security Act, helps pay medical costs for about 33 million aged and disabled people. Medicare provides two forms of protection. Part A—hospital insurance—covers inpatient hospital services, home health services, and various other institutional services. Part B—supplementary insurance—covers physician, outpatient hospital, and other health services, such as diagnostic tests.

When enacted in 1965, Medicare was made the secondary payer for beneficiaries covered by both Medicare and workers' compensation. Several times between 1980 and 1987, the Congress expanded the MSP provisions to make Medicare the secondary payer to insurers that provide

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

coverage to beneficiaries under certain employer-sponsored group health insurance plans and under automobile and other liability insurance plans. We have issued two reports recommending actions to improve identification of primary insurers under the MSP program.<sup>2</sup> Medicare is administered by HCFA within the Department of Health and Human Services (HHS). HCFA is responsible for establishing policy, developing operating guidelines, and ensuring compliance with Medicare legislation. HCFA is also responsible for developing procedures for identifying and billing insurers that should pay medical bills before Medicare. HCFA operates the program with assistance from insurance companies that it contracts with to process and pay claims for covered services.<sup>3</sup> The insurance companies, called intermediaries under part A and carriers under part B, are expected to pay more than \$100 billion for health care services provided to Medicare beneficiaries in fiscal year 1990.

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. Among its Medicare responsibilities, the contractor is to ensure the accuracy of Medicare payments by identifying liable parties that should pay before Medicare and recovering any funds paid because others had primary payment responsibility. In fiscal year 1990, Medicare is expected to pay the contractor about \$19.7 million for claims processing and related activities, including \$1.2 million to carry out MSP activities. In addition to being a Medicare contractor, Blue Cross and Blue Shield of Maryland (BCBSMD) is also a private insurer. As a private insurer, BCBSMD markets its own health insurance plans and serves under contract as a third-party administrator for employer-sponsored health plans.

---

<sup>2</sup>Medicare: More Hospital Costs Should Be Paid by Other Insurers (GAO/HRD-87-43, Jan. 29, 1987). Medicare: Incentives Needed to Assure Private Insurers Pay Before Medicare (GAO/HRD-89-19, Nov. 29, 1988).

<sup>3</sup>On June 14, 1990, we testified before the Subcommittee on Health, House Committee on Ways and Means, concerning the inadequacy of the contractors' budget for carrying out their Medicare responsibilities. We currently have several nationwide reviews under way to assess the effectiveness of contractors' operations, including their efforts to recover mistaken payments under the MSP program.

## Significant Mistaken Medicare Payments by Maryland Contractor

When we visited the Maryland contractor in April 1990, officials told us about a large inventory of potential recoveries that were not being pursued. The inventory was made up of Medicare-paid claims for health care services provided to program beneficiaries. The contractor, however, through subsequent MSP investigative efforts, developed information—including policy numbers—showing that the beneficiaries had other insurance coverage; this coverage may have been responsible for the payments.

Using the contractor's handwritten ledgers for this inventory, we developed a computerized listing of 3,059 cases for which Medicare paid about \$8.8 million during the period 1983 to 1989.<sup>4</sup> (See app.I. for our objectives, scope, and methodology.) These payments represent about 45 percent of the contractor's 1990 Medicare budget for claims processing and related activities.

In analyzing these cases, we found that \$6.3 million (about 72 percent) of the payments at issue were for part A services and \$2.5 million for part B services (see table 1).

**Table 1: Analysis of Medicare Payments That Should Be Recovered**

Dollars in thousands

Dollar range per case	Cases	Part A	Part B	Total	Percent of total
More than \$20,000	74	\$2,354	\$282	\$2,636	30.1
\$15,000 - 19,999	54	806	130	936	10.7
10,000 - 14,999	101	1,025	225	1,250	14.3
5,000 - 9,999	213	1,071	440	1,511	17.3
1,000 - 4,999	801	892	985	1,877	21.4
Less than 1,000	1,816	161	389	550	6.3
<b>Total</b>	<b>3,059</b>	<b>\$6,309</b>	<b>\$2,451</b>	<b>\$8,760</b>	<b>100.1</b>

As shown in table 1, a significant portion of these payments is concentrated in a relatively few cases. For example, the 128 cases that have payments of \$15,000 or more account for about \$3.6 million or 40.8 percent of the mistaken payments. These cases together averaged nearly \$28,000 per Medicare beneficiary, with some exceeding \$50,000.

<sup>4</sup>A case may involve several claims for the same Medicare beneficiary. For example, it may include the claim for the hospital services as well as the claim for the related physician services for the same spell of illness. About 32,400 claims were submitted for the cases included in our analysis.

We also found that 13 insurers are each potentially responsible for more than \$100,000 of the payments, as shown in table 2.

**Table 2: Insurers With Potential Payment Responsibility Exceeding \$100,000**

Dollars in thousands				
<b>Insurer</b>	<b>Cases</b>	<b>Part A</b>	<b>Part B</b>	<b>Total</b>
BCBSMD	1,553	\$2,867	\$1,243	<b>\$4,110</b>
Aetna Life and Casualty	157	369	107	<b>476</b>
Blue Cross/ Blue Shield of D.C.	81	258	33	<b>291</b>
Columbia Freestate	42	206	34	<b>240</b>
Connecticut General	127	202	104	<b>306</b>
Prudential Insurance Company of America	93	197	67	<b>264</b>
Travelers Insurance Co.	102	167	105	<b>272</b>
Metropolitan	78	128	54	<b>182</b>
Lincoln National	41	124	33	<b>157</b>
Equitable Life Assurance Society	63	124	47	<b>171</b>
Carefirst	30	117	27	<b>144</b>
Willse & Associates	101	114	90	<b>204</b>
Blue Cross/Blue Shield of Pa.	8	110	25	<b>135</b>
<b>Total</b>	<b>2,476</b>	<b>\$4,983</b>	<b>\$1,969</b>	<b>\$6,952</b>

As shown in table 2, BCBSMD may be the primary payer for \$4.1 million, or almost half the total mistaken payments identified.<sup>5</sup>

The contractor's ledgers included only a partial listing of the cases in the inventory of potential recoveries. In recent congressional testimony, a contractor official stated, the total backlog probably included more than 7,000 cases.<sup>6</sup> Thus, the total amount of mistaken payments could be significantly more than the \$8.8 million identified in our analysis.

<sup>5</sup>On May 2, 1990, we provided an official of BCBSMD with a listing of cases that made up the \$4.1 million. As of October 31, 1990, no payments had been made to Medicare.

<sup>6</sup>On July 12, 1990, contractor officials testified before the Permanent Subcommittee on Investigations, Senate Governmental Affairs Committee, concerning the MSP program.

## Contractor Doing Little to Obtain Recoveries

Medicare instructions require contractors to pursue the recovery of program funds in cases where they have made Medicare payments for health care services, but later determine that another party may be the primary payer. In our analysis, we identified at least \$8.8 million in such Medicare payments; however, the contractor is doing little to recover the funds from primary insurers.

Attempts to recover part B payments have been hampered by cutbacks in funds for MSP activities. 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 under part B, from \$38.3 million to \$15.2 million.

The contractor notified HCFA, on at least two occasions, that additional staff were needed to recover MSP mistaken payments. As part of its fiscal year 1990 budget narrative to HCFA, the contractor pointed out that certain activities carried out in fiscal year 1989, such as pursuit of MSP recoveries, would be eliminated or reduced drastically because of the cutback in funding. A project designed to collect part B MSP mistaken payments from BCBSMD was stopped because of the budget cutbacks. A contractor official said that the project recovered about \$260,000 that was paid to the Medicare program.

In a March 2, 1990, letter, the contractor informed the HCFA Philadelphia Regional Office that (1) the part B staffing had been reduced by 69 percent as a result of the fiscal year 1990 budget cutback and (2) 40 percent of available staff were assigned to pursuing HCFA-required activities that produced minimal savings rather than pursuing MSP recoveries. The contractor requested approval to focus resources on MSP recovery activities, but the HCFA regional office denied this request. Currently, only .5 FTE staff is assigned to recovering part B mistaken payments from private insurers.

The MSP budget for part A was increased slightly for fiscal year 1990. However, contractor officials stated that they had insufficient staff to pursue recovery of part A MSP mistaken payments for the past several years. In the fiscal year 1989 budget submission to HCFA, the contractor noted that there was a backlog of 6,000 part A MSP cases that needed to be resolved. The contractor requested funding for three FTEs, but received funding for only one. The contractor made a similar request in its fiscal year 1990 budget, but again received funding for one FTE.

---

In a March 2, 1990, letter to the HCFA Regional Office, the contractor requested additional funding for another 1.5 FTE to recover part A payments. Because no additional funds were received for recovery activities, the contractor again informed the regional office in June that additional resources were needed for part A recoveries. In a July 11, 1990, letter, the HCFA Regional Office advised the contractor that no additional funds were available.

Contractor officials believe that the prospects for recovery are high in most of the identified cases because they already know the name of the other insurer and the beneficiaries' insurance policy number. Contractor officials also believe that with an additional \$200,000, the backlog of MSP mistaken payments can be recovered within 1 year. For part A cases, the contractor can, after written notification, recover such payments by offsetting against future payments due to providers of the medical services in question. The part B mistaken payments must be recovered from the primary insurer rather than from the provider of the service.

---

## Conclusions

Over the past several years, we have issued reports that generally focused on the problems of identifying other insurers that have the responsibility of paying before Medicare. This MSP problem, however, is of a different nature. The contractor, through its investigative efforts, has succeeded in identifying other parties that may owe Medicare at least \$8.8 million. However, the contractor lacks the resources to recover these amounts. We believe that any additional funding of the contractor's activities to recover these payments may return considerably more than each dollar so expended.

---

## Recommendations

We recommend that you work with the contractor to (1) determine the full scope of the problem and the resources needed to correct it and (2) establish a plan, including milestones, for seeking recoveries. We recommend also that HCFA closely monitor the contractor's performance in meeting the milestones set for the recovery activity.

---

As you know, 31 U.S.C. 720 requires the head of a federal agency to submit a written statement on actions taken on our recommendations to the House Committee on Government Operations and the Senate Committee on Governmental Affairs not later than 60 days after the date of the report. Such a written statement must also be submitted to the

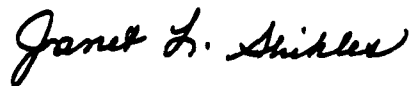
---

House and Senate Committees on Appropriations with the agency's first request for appropriations made more than 60 days after the date of the report.

Copies of this report are being sent to the contractor, BCBSMD, and to interested congressional Committees and Subcommittees; the Director, Office of Management and Budget; and other interested parties. Copies will also be made available to others on request.

Please call me on (202) 275-5451 if you or your staff have any questions concerning this report. Other major contributors to this report are listed in appendix II.

Sincerely yours,



Janet L. Shikles  
Director, Health Financing and  
Policy Issues

# Objectives, Scope, and Methodology

---

The primary objective of our review was to determine (1) the number of claims and dollars that the contractor paid for which other health insurers may have primary payment responsibility under the MSP program and (2) contractor efforts and resources devoted to pursuing MSP recoveries.

To accomplish our first objective, we obtained and reviewed handwritten ledgers, identifying potential recoveries that were maintained by the contractor. Using these ledgers, we developed a computer printout and summarized data for 3,059 MSP cases. This summary analysis, provided to the contractor on May 2, 1990, identified the Medicare beneficiaries, the Medicare benefits paid for services rendered, and the name of the beneficiaries' private insurer.

To accomplish our second objective, we reviewed budget information for fiscal years 1987 through 1990 and determined the staff assigned to MSP collections and contractor requests for resources to pursue recoveries. We met with contractor officials and HCFA headquarters and regional staff to discuss resource issues and the need for additional funding. We also met with a representative of BCBSMD to discuss potential mistaken payments owed the Medicare program. Finally, we reviewed the MSP legislation and regulations to determine procedures for recovering such payments.

We performed our work between March and July 1990 in accordance with generally accepted government auditing standards.

---

# Major Contributors to This Report

---

**Human Resources  
Division,  
Washington, D.C.**

Jane L. Ross, Senior Assistant Director  
Terrence J. Davis, Assistant Director  
Alfred R. Schnupp, Senior Division Evaluator  
Norman Jones, Jr., Evaluator-in-Charge  
Kenneth H. Brake, Senior Evaluator  
Gloria E. Taylor, Evaluator