Medicare as Secondary Payer

Health Insurance Regulation
Working Paper No. I-14

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Section I. Introduction

Background

Rationale
This legislation was enacted to ensure that Medicare, like Medicaid, always would be payer of last resort in instances where multiple sources of coverage were available.

Statutory Authority
Medicare as Secondary Payer (MSP) legislation was enacted as part of the 1982 Tax Equity and Fiscal Responsibility Act (TEFRA).

Key Elements
Under the new rules, any Medicare-eligible citizen who elected to decline employer-based coverage in favor of Medicare could no longer use an employer-based plan to supplement Medicare. Likewise, elderly workers who decline coverage from work are expected to pay for Medicare Part B premiums, assume all Medicare cost-sharing and lose any coverage for prescription drugs or other health benefits available through the employer’s plan. Employers are barred from compensating employees for dropping their group coverage. Federal law has priority over state laws or private contracts. Coordination of benefit rules require that Medicare be considered a secondary payer whenever an individual has coverage through a) group health insurance; b) automobile or liability insurance; c) workmen’s compensation.

Scope
MSP applies to any Medicare-eligible individual who is eligible for employer-based health insurance coverage.

Theoretical Impact

Costs. MSP is the equivalent of a tax on Medicare eligible workers and theoretically should result in lower cash wages as well as less employment of them (Glied and Stabile 1997). In addition to these labor market effects, there is a compliance cost imposed on health facilities: whenever Medicare patients go to the hospital for inpatient or outpatient care, staff must complete a 30-item MSP questionnaire (AHA 2002).

Benefits. Unlike a traditional mandate, MSP offers no additional benefits to employed Medicare eligibles since they receive the same benefits through their employer that they previously had received from Medicare.

Research Questions

1 Glied and Stabile 1997.
This working paper covers two major topic areas framed within six research questions, all of which are related to the impact of MSP in the U.S. insurance market. Our primary goal was to identify, review, and evaluate the published literature to answer the research questions with the intent of developing an interim estimate of the costs and benefits of MSP; our secondary goal was to identify areas where no evidence exists or where the evidence has important limitations and then describe the type of data that would be needed to more fully address the question. The questions are listed below by topic area, along with a brief description of our analytical approach, including outcomes of interest.

**Costs of MSP**

**Question 1a.** *What is the amount of government regulatory costs related to MSP?* This includes federal costs to monitor and enforce these regulations.

**Question 1b.** *What is the amount of health industry compliance costs related to MSP?* This includes all administrative costs and enforcement penalties borne by parties subject to these regulations.

**Question 1c.** *Is MSP related to use of health care services?* MSP may lead to lower cash wages and less employment of Medicare eligible workers, thus decreasing coverage. Theoretically, decreased access to primary care might result in more avoidable hospital admissions or more emergency room care.

**Question 1d.** *Is MSP related to the cost of health care services?* Whether MSP had a net impact on cost, positive or negative, would depend on relative changes in use for different types of insurance as well as their respective unit costs.

**Benefits of MSP**

**Question 2a.** *What is the value of MSP in health service use?* You mentioned above that there were no added benefits to this funding scheme-if you still plan to explore this area than this question is valuable.

**Question 2b.** *What is the impact of MSP on health outcomes?* Include only if including 2a for same reason as listed above. Without adequate insurance, patients not covered by insurance may not receive health care services that those with undisputed access to insurance receive. In theory, improved access to care could result in less avoidable morbidity and mortality, along with increased patient satisfaction.

**Limitations of Working Paper**
Section II. Methods

Literature Search and Review

Sources

Peer-Reviewed Literature

We performed electronic subject-based searches of the literature using the following databases:

- MEDLINE® (1975-June 30, 2004) and CINAHL® (1975-June 30, 2004) which together cover all the relevant clinical literature and leading health policy journals
- Health Affairs, the leading health policy journal, whose site permits full text searching of all issues from 1981-present
- ISI Web of Knowledge (1978-June 30, 2004) which includes the Science Citation Expanded®, Social Sciences Citation Index®, and Arts & Humanities Citation Index™ covering all major social sciences journals
- Lexis-Nexis (1975-June 30, 2004) which covers all major law publications
- Public Affairs Information Service (PAIS), including PAIS International and PAIS Periodicals/Publishers (1975-June 30, 2004) which together index information on politics, public policy, social policy, and the social sciences in general. Covers journals, books, government publications, and directories.
- Books in Print (1975-June 30, 2004)

A professional librarian assisted in the development of our search strategy, customizing the searches for each research question. In cases where we already had identified a previous literature synthesis that included items known to be of relevance, we developed a list of search terms based on the subject headings from these articles and from the official indexing terms of MEDLINE and other databases being used. We performed multiple searches with combinations of these terms and evaluated the results of those searches for sensitivity and specificity with respect to each topic. We also performed searches on authors known or found to have published widely on a study topic. In addition to performing electronic database searches, we consulted experts in the field for further references. Finally, we reviewed the references cited by each article that was ultimately included in the synthesis. We did not hand search any journals. This review was limited to the English-language research literature. A complete listing of search terms and results is found in Appendix A.

“Fugitive” Literature

In some cases, relevant “fugitive” literature was cited, in which case we made every effort to track it down. We also performed systematic Web searches at the following sites:

- Health law/regulation Web sites
- Health industry trade organizations
- State agency trade organizations and research centers
- Major health care/health policy consulting firms
- Health policy research organizations
- Academic health policy centers
- Major health policy foundations

These searches varied by site. In cases where a complete publications listing was readily available, it was hand-searched. In other cases, we relied on the search function within the site itself to identify documents of potential relevance. Because of the volume of literature obtained through the peer-reviewed literature, including literature syntheses, we avoided material that simply summarized existing studies. Instead, we focused on retrieval of documents in which a new cost estimate was developed based on collection of primary data (e.g., surveys of state agencies) or secondary analysis of existing data (e.g., compilation of agency enforcement costs available from some other source). We excluded studies that did not report sufficient methodological detail to permit replication of their approach to cost estimation.
### Inclusion Criteria

We developed the following inclusion criteria:

- **Sample:** wherever results from nationally representative samples were available, these were used in favor of case studies or more limited samples.
- **Multiple Publications:** whenever multiple results were reported from the same database or study, we selected those that were most recent and/or most methodologically sound.
- **Outcomes:** we selected only studies in which a measurable impact on costs was either directly reported or could be estimated from the reported outcomes in a reasonably straightforward fashion.
- **Methods:** we only selected studies in which sufficient methodological detail was reported to assess the quality of the estimate provided.

Where possible, we limited the review to studies using from 1975 through June 30, 2004 reasoning that any earlier estimates could not be credibly extrapolated to the present given the sizable changes in the health care industry during the past two decades. Other exclusions were as follows:

- Unless we had no other information for a particular category of costs or benefits, we excluded qualitative estimates of impact.
- Estimates of impacts derived from unadjusted comparisons were discarded whenever high quality multivariate results were available to control for differences between states or across time.
- Estimates that focused on measuring system-wide impact generally were selected over narrower estimates (e.g., per capita health spending vs. cost per inpatient day) on grounds that savings achieved in one sector may have induced higher spending elsewhere in the system; hence narrower comparisons might inadvertently lead to an inappropriate conclusion.

### Section III. Results

#### Empirical Evidence

We could find only two studies that provided us material for the cost impact of MSP:

- **Public Administration Benefits: Medicare Savings.** OMB estimated that Medicare savings due to MSP were one half percent of Medicare expenditures in 1985 (cited in Glied and Stabile 1997).
- **Indirect Costs: Lower Employment Rates.** Using pooled CPS data on labor force participation for men and women over 65 and 40-64 for the years 1980-1982 and 1985-1986, Glied and Stabile (1997) find that MSP had no significant effect on hourly wages or hours worked, but reduced employment rates by 4.5 percent and labor force participation by 4.7 percent (uncorrected for serial correlation).

#### Net Assessment

We have calculated the regulatory costs in the following fashion (minimum and maximum parameter estimates are shown in parentheses: full details of methods and sources are in Table E-14).

- **Public Administration Benefits: Medicare Savings.** We estimate Medicare savings at one half percent of total Medicare spending and assume this is just a transfer of costs to the private sector.
• **Compliance Costs: Administrative Costs.** We estimate compliance costs assuming 10 minutes to fill out the MSP form for all Medicare hospital patients and monetize this using the same hourly hospital cost figure ($19.68) as was used for state indigent care mandates.

• **Indirect Costs: Productivity Losses.** We estimate productivity losses by applying the employment rate reductions from the CPS data and monetize these based on the median earnings reported for all workers over age 65.

These calculations result in estimated costs of $3.2 billion (3.0, 3.5). Total benefits are $1.9 billion (1.7, 3.6).

**Acronyms**

- MSP: Medicare as Secondary Payer
- TEFRA: Tax Equity and Fiscal Responsibility Act
- CSP
- OMB: Office of Management and Budget
Listing of Included Studies


17. Rogers, Coutney A. "Subrogation and Medicare: Eleventh Circuit Holding Facilitates Enforcement


Listing of Excluded Studies

Key for Reasons for Exclusion

1. Studies with no original data
2. Studies with no outcomes of interest
3. Studies performed outside U.S.
4. Studies published in abstract form only
5. Case-report only
6. Unable to obtain the article


Appendix A. Evidence Tables
Appendix B. Search Strategies

Database: Ovid MEDLINE(R) <1966 to July Week 4 2004>
Search Strategy #1: ALL
--------------------------------------------------- -----------------------------
1  (Medicare secondary payer or MSP).mp. [mp=title, original title, abstract, name of substance word, subject heading word] (1647)
2  (medicare and secondary payer).mp. [mp=title, original title, abstract, name of substance word, subject heading word] (44)
3  (msp and medicare).mp. [mp=title, original title, abstract, name of substance word, subject heading word] (12)
4  2 or 3 (45)
5  limit 4 to (english language and yr=1975 - 2004) (45)
6  from 5 keep 3-5,7-8,10,12-25,27-36,38-43 (36)

Database: CINAHL - Cumulative Index to Nursing & Allied Health Literature <1982 to June Week 1 2005>
Search Strategy: ALL
--------------------------------------------------- -----------------------------
1  (Medicare secondary payer or MSP).mp. [mp=title, subject heading word, abstract, instrumentation] (29)
2  (medicare and secondary payer).mp. [mp=title, subject heading word, abstract, instrumentation] (6)
3  (msp and medicare).mp. [mp=title, subject heading word, abstract, instrumentation] (0)
4  2 or 3 (6)
5  limit 4 to (english language and yr=1975-2004) (6)
6  from 5 keep 1-3,5-6 (5)

Database: ISI Web of Science <1978 to July 31, 2004>
Search Strategy #1: ALL
--------------------------------------------------- -----------------------------
1  TS=(Medicare AND secondary payer) OR TS=(MSP AND Medicare) DocType=All document types; Language=English; Databases=SCI-EXPANDED, SSCI, A&HCI; Timespan=1978-2004
2  Of these, 4 selected for detailed review

Database: Lexis-Nexis <1975 to July Week 4 2004>
Search Strategy #1: ALL
--------------------------------------------------- -----------------------------
1  Full text search for Medicare secondary payer (40)
2  Of these, ??? selected for detailed review

Database: PAIS <1975 to July Week 4 2004>
Search Strategy #1: ALL
--------------------------------------------------- -----------------------------
1  ( Medicare )and( secondary payer ) and (LA:PAIS = ENGLISH) and (PY:PAIS = 1975-2004) (1)
2  Of these, 1 selected for detailed review

Database: Dissertation Abstracts <1975 to July Week 4 2004>
Search Strategy #1: ALL
--------------------------------------------------- -----------------------------
1  kw: Medicare and ((kw: secondary and kw: payer)) and yr: 1975-2004 and ln= "english" (4)
2  Of these, 3 selected for detailed review

Database: Books in Print <1975 to July Week 4 2004>
Search Strategy #1: ALL
--------------------------------------------------- -----------------------------
3  kw: Medicare and ((kw: secondary and kw: payer)) and yr: 1975-2004 and ln= "english" (2)
4  Of these, 2 selected for detailed review

Database: Health Affairs <1981 to July Week 4 2004>
Search Strategy #1: ALL
---------------------------------------------------
Of these, 4 selected for detailed review
Appendix C. Web Sites Used in I-14 Literature Search

Health Law/Regulation Web Sites
We began searching at Web sites known to specialize in health law and regulation generally or specific topics included in this review:

- American Health Lawyers Association
  http://www.healthlawyers.org/ (no documents found)
- Findlaw.com—health law
  http://www.findlaw.com/01topics/19health/index.html (no documents found)
- Health Care Compliance Association
  http://www.hcca-info.org/ (no documents found)
- HealthHippo
  http://hippo.findlaw.com/hippohome.html (no documents found)
- National Health Care Anti-fraud Association (NHCAA)
  http://www.nhcaa.org/ (no documents found – member-only site)

Health Industry Trade Organizations

Health Insurance Regulation
For health insurance regulation, we searched the following industry and state agency trade organization Web sites:

- American Association of Health Plans (AAHP)
  http://www.aahp.org/ (no documents found)
- Health Insurance Association of American (HIAA)
  http://www.hiaa.org/index_flash.cfm (no documents found)
- Blue Cross and Blue Shield Association (BCBSA)
  http://www.bluecares.com/ (no documents found)
- National Committee for Quality Assurance (NCQA)
  http://www.ncqa.org/ (no documents found)
- National Association of Insurance Commissioners (NAIC)
  http://www.naic.org/ (no documents found)

State Agency Trade Organizations and Research Centers
For state agency trade organizations and health policy research centers specializing in state health policy issues not accounted for above, we searched the following Web sites:

Executive branch

- National Governors Association (NGA)
  http://www.nga.org/ (no documents found)
- National Association of State Budget Officers (NASBO)
  http://www.nasbo.org/ (no documents found)
- Association of State and Territorial Health Officers (ASTHO)
  http://www.astho.org/ (no documents found)
- National Association of Health Data Organizations (NAHDO)
  http://www.nahdo.org/default.asp (no documents found)
- National Association of State Auditors, Comptrollers and Treasurers (NASACT)
  http://www.nasact.org/ (no documents found)

Legislative branch

- National Conference of State Legislatures (NCSL)
http://www.ncsl.org/ (no documents found)
• Council of State Governments (CSG)  
  http://www.csg.org/csg/default (no documents found)
• National Academy of Public Administration (NAPA)  
  http://www.napawash.org/ (no documents found)

State Health Policy Research Centers
• National Academy of State Policy  
  http://www.nashp.org/ (no documents found)
• Pew Center on the States  
  http://www.stateline.org/ (no documents found)
• State Health Policy Web Portal Group  
  http://www.hpolicy.duke.edu/cyberexchange/Whatstat.htm#States
  Rather than search 50 individual sites, we queried by e-mail the directors of all centers included in
  this group for relevant reports/studies their centers had conducted or that had been conducted by
  agencies in their states

Health Care/Health Policy Consulting Firms
For major health care/health policy consulting firms, we searched the following sites. Some of these
specialize in human resource consulting, but were included in the event they had done industry-wide
studies of regulatory costs:
• Buck Consultants Inc.  
  http://www.buckconsultants.com/ (no documents found)
• Deloitte & Touche  
  http://www.deloitte.com/vs/0%2C1616%2Csid%25253D2000%2C00.html (no documents found)
• Ernst & Young LLP  
  http://www.ey.com/global/content.nsf/US/Home (no documents found)
• Hewitt Associates LLC  
  http://www.hewitt.com/ (no documents found)
• Milliman USA Inc.  
  http://www.milliman.com/ (no documents found)
• PricewaterhouseCoopers LLP  
  http://www.pwcglobal.com/ (no documents found)
• Towers Perrin  
  http://www.towers.com/towers/default.asp (no documents found)
• Watson Wyatt Worldwide  
  http://www.watsonwyatt.com/ (no documents found)

Health Policy Research Organizations
For major health policy research organizations, including “think tanks” and some advocacy groups, we
searched the following sites:
• Abt Associates  
  http://www.abtassoc.com/ (no documents found)
• Alliance for Health Reform  
  http://www.allhealth.org/ (no documents found)
• AcademyHealth  
  http://www.academyhealth.org/index.html (no documents found)
• The Advisory Board Company  
  http://www.advisoryboardcompany.com/ (no documents found – member-only site)
• American Enterprise Institute (AEI)  
  http://www.aei.org/ (no documents found)
• Battelle
http://www.battelle.org/ (no documents found)
• Brookings Institution
http://www.brook.edu/ (no documents found)
• Cato Institute
http://www.cato.org/ (no documents found)
• Center for Budget and Policy Priorities (CBPP)
http://www.cbpp.org/ (no documents found)
• Center for Health Affairs (Project HOPE)
  http://www.projecthope.org/ (no documents found)
• Center for Health Care Strategies (CHCS)
http://www.chcs.org/ (no documents found)
• Center for Study of Health Systems Change (CSHSC)
  http://www.hschange.com/ (no documents found)
• Employee Benefits Research Institute (EBRI)
http://www.ebri.org/ (no documents found)
• Heritage Foundation
http://www.heritage.org/ (no documents found)
• Institute of Medicine (IOM)
http://www.iom.edu/ (no documents found)
• Lewin Group
  http://www.Quintiles.com/Specialty_Consulting/The_Lewin_Group/default.htm (no documents found)
• Mathematica Policy Research (MPR)
  http://www.mathematica-mpr.com/HEALTH.HTM (no documents found)
• National Bureau of Economic Research (NBER)
  http://papers.nber.org/papers/w6277.pdf
• National Health Policy Forum
http://www.nhpf.org/ (no documents found)
• RAND Health
http://www.rand.org/health_area/ (no documents found)
• Research Triangle Institute (RTI)
  http://www.rti.org/ (no documents found)
• Urban Institute
http://www.urban.org/ (no documents found)

**Major Health Policy Foundations.** For major health policy foundations, we searched the following sites:

• California Healthcare Foundation
  http://www.chcf.org/ (no documents found)
• Commonwealth Fund
  http://www.cmwf.org/ (no documents found)
• Robert Wood Johnson Foundation
  http://www.rwjf.org/index.jsp (no documents found)
• Henry J. Kaiser Family Foundation
  http://www.kff.org/ (no documents found)
• United Hospital Fund
  http://www.uhfnyc.org/ (no documents found)