

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICARE SECONDARY PAYER:
EFFECTIVENESS OF CURRENT
PROCEDURES**



**Richard P. Kusserow
INSPECTOR GENERAL**

AUGUST 1991

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OEI-07-90-00761

EXECUTIVE SUMMARY

PURPOSE

To evaluate Medicare contractor procedures for identifying Medicare beneficiaries who have insurance coverage that is primary to Medicare.

BACKGROUND

Until 1980, Medicare was the primary payer of health care costs for Medicare beneficiaries except when the beneficiary was covered by a worker's compensation program or the Veteran's Administration. Congress became concerned about significant increases in the cost of the Medicare program. As a result, between 1980 and 1986 Congress passed a series of statutory provisions requiring certain private insurers to pay medical claims before Medicare (see Appendix A).

Recent Congressional hearings and media attention have brought the Medicare Secondary Payer (MSP) issue to the forefront. Despite current mechanisms to identify beneficiaries who have primary insurance coverage, many primary payers remain unidentified. The OIG has estimated, based on a random sample of Medicare beneficiaries, that Medicare lost over \$600 million in FY 1988 due to unidentified primary payment sources. The current HCFA actuary estimate of Medicare program losses, due to the contractors' failure to identify primary payment sources and recover inappropriate Medicare payments, has increased to \$1.3 billion for FY 1991.

METHODOLOGY

We solicited medical insurance information from a random sample of 4,371 beneficiaries. We obtained responses from 3,185 beneficiaries. This represents an overall response rate of 72.9 percent. We analyzed the verified cases with unidentified primary payers to determine the reasons why the current system was unsuccessful in identifying the primary payment source.

FINDINGS

Medicare lost at least \$120.0 million in 1988 because contractors are not coordinating with their private insurance operations.

Medicare lost over \$585.3 million because current MSP procedures failed to detect all cases when a beneficiary is covered by a working spouse's EGHP.

Intermediaries and carriers lack coordination, resulting in a \$23.7 million loss to Medicare during 1988.

Contractors lack the internal coordination and systems information needed to identify all MSP situations.

RECOMMENDATIONS

The HCFA should propose legislation to require Medicare contractors to match their health insurance data with Medicare files.

The HCFA should revise all Medicare claims forms to require spousal insurance information before the claim is paid.

The HCFA should continue to refine and improve the MSP component of the Common Working File (CWF).

COMMENTS

The HCFA generally concurs with the recommendations presented in this report. With regard to the recommendation that HCFA propose legislation requiring Medicare contractors to match their health insurance data with Medicare files, the HCFA has proposed legislation to require such matches in the past, but the Congress has not yet enacted it. In fact, section 6202 of OBRA 1989 prohibits the Secretary from requiring such matches. The HCFA indicates it will review the legislative recommendations and take appropriate action as part of the Department's legislative development (A-19) process. The OIG continues to believe this is an important step in determining the primary payer for many beneficiaries.

This final report includes revisions as suggested by HCFA in its "Technical Comments" section of their comments on the draft report. The HCFA's verbatim comments can be found in Appendix C.

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INTRODUCTION

PURPOSE

To evaluate Medicare contractor procedures for identifying Medicare beneficiaries who have insurance coverage that is primary to Medicare.

BACKGROUND

This inspection is a part of an initiative to assess the effectiveness of procedures used to identify Medicare Secondary Payer (MSP) situations. The findings and recommendations presented in this report support the Secretary's objective to enhance cost effectiveness of Medicare reimbursement by ensuring that Medicare reimbursement is secondary to other insurance.

History of MSP Provisions

Medicare helps pay medical costs for approximately 28 million people aged 65 and older and approximately 3 million disabled people. Medicare Part A covers inpatient hospital services, home health services, and other institution-based services. Physician, outpatient hospital, and various other health services are covered by Medicare Part B.

The Health Care Financing Administration (HCFA) is responsible for ensuring compliance with Medicare legislation and regulations. Private insurance companies contract with HCFA to process and pay Medicare claims. These contractors are known as fiscal intermediaries (Part A) and carriers (Part B).

Until 1980, Medicare was the primary payer of health care costs for Medicare beneficiaries except when the beneficiary was covered by a worker's compensation program or the Veteran's Administration. Congress became concerned about significant increases in the cost of the Medicare program. As a result, between 1980 and 1986 Congress passed a series of statutory provisions requiring certain private insurers to pay medical claims before Medicare (See Appendix A).

These provisions require private insurers to pay medical claims primary to Medicare if the beneficiary has other health insurance coverage by an employer group health plan (EGHP), a disabled beneficiary's large group health plan (LGHP), a spouse's EGHP, or automobile, no-fault, or liability insurance. If the primary plan does not pay for all covered services, Medicare may pay secondary benefits for Medicare covered services.

Implementation of MSP Provisions

These provisions created a need for a system to coordinate private insurance benefits with Medicare. Currently, Medicare contractors use information from both internal and external

sources to determine the primary payer for claims submitted for reimbursement. In order for the system to be effective, the contractors must have insurance information for each beneficiary that is accurate, complete, and current. Without this information, contractors will continue to pay claims inappropriately.

To insure the contractor has complete and accurate information, the HCFA requires contractors to identify primary payment sources. When a Medicare claim is submitted, the contractor searches MSP history files for health insurance coverage that is provided by another insurer. The most widely used contractor procedures for identifying MSP situations include

- developing leads from HCFA's "Y-trailer" codes;
- screening information included on the claim form;
- querying data in the Common Working File (CWF);
- developing the first claim filed by or on behalf of a beneficiary; and
- reviewing all claims containing medical diagnosis codes indicating trauma—to identify injuries related to automobile, or other traumatic injury cases, including work-related accidents.

These provisions created new functions for Medicare contractors. The contractors are required to screen, identify, and verify claims for other insurance involvement. In addition, contractors are required to make post-payment recoveries when Medicare has paid improperly. The HCFA monitors the contractors' efforts to identify and recover MSP payments by establishing an MSP savings goal for each contractor. The HCFA annually evaluates each contractor's performance using the Contractor Performance Evaluation Plan (CPEP) standards and established goals. The contractor must achieve a savings figure of at least 95% of their MSP savings goal to pass the MSP element of the CPEP review.

Medicare contractors were budgeted approximately \$70 million for administration of the Medicare Secondary Payer provisions during fiscal year (FY) 1989. They reported savings of over \$2.2 billion in FY 1989. According to information obtained from HCFA the funding for MSP activities in FY 1990 was reduced to \$56 million.

Contractors are not the only entities involved in identification of MSP activities. Hospitals are required to ask for all insurance coverage upon admittance. Personnel in physician's offices and/or their billing agents are also required to collect and record complete insurance coverage information. Currently, when a patient has insurance coverage from another source, the provider is required to initially submit the claim to the primary insurer rather than Medicare. If the primary insurer does not reimburse for the total amount of the Medicare allowable, Medicare would then pay the remaining covered services as the secondary payer.

The HCFA has conducted extensive educational programs for the beneficiary and provider communities and private health insurance companies concerning the MSP provisions and claims filing procedures.

Additional Savings Possible

Recent Congressional hearings and media attention have brought the MSP issue to the forefront. Despite current mechanisms to identify beneficiaries who have primary insurance coverage, many primary payers remain unidentified. Studies by the Office of Inspector General (OIG), the General Accounting Office (GAO) and HCFA have confirmed that additional savings and recoveries are possible.

The OIG has estimated, based on a random sample of Medicare beneficiaries, that Medicare lost over \$600 million in FY 1988 due to unidentified primary payment sources. According to the HCFA actuary, the Medicare program lost approximately \$900 million in FY 1990. The current HCFA actuary estimate of Medicare program losses due to the contractors' failure to identify primary payment sources and recover inappropriate Medicare payments, is \$1.3 billion for FY 1991.

METHODOLOGY

We selected a simple random sample from the population of all beneficiaries who received services during 1987. The Office of Inspector General, Office of Evaluation and Inspections maintains a one percent sample of all beneficiaries receiving services under Part B. This sample is a subset of the Part B Medicare Annual Data (BMAD) IV five percent beneficiary sample file maintained by HCFA.

A subsample of these beneficiaries, using sequential sampling, resulted in 6,777 HICNs representing beneficiaries with Medicare claims. We matched these records with the Social Security Administration's (SSA) Master Beneficiary Record (MBR) to obtain demographic data, including current address, and determine the current status of each beneficiary identified. The following table presents the results.

Results of Medicare BMAD IV Match with SSA MBR.

Original Number Selected	6,777
Railroad Retirement Board Beneficiaries	138
Status Indicated as Dead	1,070
Non-Matching Numbers	<u>1,198</u>
Final Number of Beneficiaries	4,371

We deleted Railroad Board retirees from the sample (138 beneficiaries) because the Social Security Administration (SSA) does not maintain their data. We also deleted the 1,070 beneficiaries indicated by SSA as deceased because we were not willing to identify or mail surveys in attempt to obtain proxy respondents. The 1,198 HICNs that did not match with SSA's

MBR represent a problem encountered with the Beneficiary Identification Code (BIC). We were unable to obtain any information on these individuals through the direct match. Therefore, we deleted these individuals from the survey.

We solicited information from the remaining 4,371 beneficiaries. We obtained responses from 3,185 beneficiaries. This represents an overall response rate of 72.9 percent.

We used the BMAD one percent sample and the Medicare Automated Data Retrieval System (MADRS) to gather demographic and utilization information. These systems are also maintained by HCFA. The MADRS provided information on total Part A and Part B expenditures on behalf of each beneficiary.

We asked questions concerning the respondent's supplemental medical coverage. We examined all information for indications of primary payment sources. Where a positive response was noted, OIG staff developed the case to gather more specific information and verify the information provided.

We conducted telephone interviews with the beneficiaries to verify the information they provided and to collect names and addresses of employers and insurance companies. Additional contacts with these employers and with representatives from the involved insurance company were made to further verify Medicare's status as secondary payer. This process enabled us to determine whether Medicare paid appropriately as secondary payer. Medicare contractors provided payment histories and documentation to determine if Medicare payments shown were situations where the contractor paid the claim correctly as the secondary payer.

We analyzed the verified cases with unidentified primary payers to determine the reasons why the current system was unsuccessful in identifying the primary payment source. This analysis was completed by interviewing Medicare contractor staff, private insurance companies, and employers. In addition, we requested documentation from these entities. This documentation included the Medicare billing form, the explanation of benefits from the third party payer, payment information/history printout on the claim(s) in question, and any other documentation supporting development of the claim(s).

FINDINGS

The following findings are based on an analysis of the 34 confirmed overpayment cases. Each case may be included in one or more of the analysis categories. These categories are not mutually exclusive.

Medicare lost at least \$120.0 million in 1988 because contractors are not coordinating with their private insurance operations.

All Medicare contractors have a fiduciary responsibility to the Federal Government to assure that only appropriate Medicare payments are made. The current arrangement creates a potential conflict of interest between the contractors' private insurance business and their Medicare operations.

Insurance companies currently contracting with HCFA to process and pay Medicare claims also conduct private health insurance business. Often the contractor's private business operation insures beneficiaries who are affected by the MSP provisions. Records for private insurance operations and Medicare business operations are maintained separately.

The majority of the Medicare contractors are owned by the Blue Cross/Blue Shield corporation. According to the Blue Cross of America, 87 percent of contractors' private business comes from EGHP coverage for companies offering group health insurance to their employees.

We identified primary insurance coverage on 34 cases. These cases totaled an actual loss to the Medicare program of \$60,502. This projects to an estimated annual loss of over \$637 million¹ in 1988. Further analysis of the 34 overpayment cases shows that Medicare paid as the primary payer in eight (23.5%) of these cases when the beneficiary had primary insurance coverage through an EGHP administered by the contractors' private business operations. These eight cases account for \$11,420 or approximately 18.8% of the total overpayment. When projected to the universe of Medicare beneficiaries, Medicare lost over \$120.2 million due to lack of coordination between Medicare contractors and their private business. Current procedures were not effective in identifying these cases for the contractor.

Of the eight claims that should have been paid by the contractors' private business operations, source claim information was readily available on three. In each of these cases, the claim form indicated that a primary payer other than Medicare was available. The contractor did not provide source claim information for the remaining five claims because the claims were submitted electronically.

¹ For details of this estimate see "Extent of Unrecovered Medicare Secondary Payer Funds"

Medicare lost over \$585.3 million because current MSP procedures failed to detect all cases when a beneficiary is covered by a working spouse's EGHP.

Medicare is the secondary payer when a beneficiary is covered by a working spouses's EGHP. These situations often are the most difficult for contractors to identify. This is illustrated by our of review the 34 overpayment cases identified in the beneficiary survey. Twenty-five of the 34 overpayment cases (73.5 percent) had unidentified primary insurance coverage through the EGHP of a working spouse. Of the \$60,502 identified overpayments, \$54,294 resulted from unidentified spousal insurance coverage. This accounted for \$583.3 million (90 percent) of the annual projected loss to the Medicare program for 1988.

Intermediaries and carriers do not coordinate their efforts, resulting in a \$23.7 million loss to Medicare during 1988.

We found four of the 34 (11.8%) overpayment cases where MSP information was not exchanged between contractors or the information exchanged was inaccurate. These four cases total \$2,257. This amount projects to over \$23.7 million of the total overpayment projection.

Intermediaries and carriers frequently receive claims filed on behalf of the same beneficiary. Current procedures should provide both entities with updated and accurate MSP information concerning the beneficiary's insurance and employment status. The Regional Data Exchange System (RDES) has been the primary mechanism for exchange of MSP information between contractors. All contractors were required to do quarterly updates to this system. These updates include all newly identified MSP cases.

The RDES is no longer used in this capacity. The Common Working File (CWF) has replaced RDES as the primary mechanism for exchanging MSP information between contractors.

Contractors lack the internal coordination, systems, and information needed to identify all MSP situations.

Eleven of the 34 overpayment cases were paid inappropriately due to general deficiencies and/or errors by the contractors. According to existing procedures, Medicare claims should be developed and/or denied when the contractor has information indicating that a private insurance company may be the primary payer. Our analysis of the identified claims, established several areas that resulted in inappropriate Medicare payments. The following is a listing of specific causes for these inappropriate Medicare payments.

- The contractor paid the claim despite a development letter on file at the contractor that indicated EGHP coverage.
- The contractor did not promptly recover an overpayment when information confirming the primary payer was available.

- The contractor paid the claim despite information in the contractor's computer system that the beneficiary's spouse was working.
- The contractor initiated recovery for a beneficiary after it received information that a primary payment source existed. However, the contractor did not make recoveries on all previously adjudicated claims.
- The contractor received information from RDES that indicated there was a primary payment source. However, the contractor did not initiate recovery on the previously paid claims.
- The contractor paid the claim despite information in the contractor's computer system that indicated a primary insurance source.
- The hospital received payment from Medicare and the private insurance source which exceeded its charges. The hospital notified the contractor of this, but the contractor did not initiate recovery of the overpayment.

RECOMMENDATIONS

The first two recommendations have been presented in a previous OIG Management Advisory Report (MAR) entitled "Medicare Secondary Payer: Unrecovered Funds" (OEI-07-90-00764). They are also included in this report because they are supported by the findings of this inspection. We have indicated the current status on those recommendations where HCFA has previously commented.

The HCFA should propose legislation to require Medicare contractors to match their health insurance data with Medicare files.

We recognize that Section 6202(d) of OBRA 1989 prohibits the Secretary from requiring Medicare contractors to match their records with their private business operations. However, we found a substantial number of unidentified MSP cases that would have been identified if this type of match had been required.

The potential for conflict of interest inherent in the corporate structure of the Medicare contractors could be eliminated by requiring regular matches between the contractor's private insurance files and their Medicare files. This matching activity would result in more accurate MSP data for the contractor. The contractor would accurately identify many more MSP situations in the pre-payment phase of processing the Medicare claim allowing contractors to avoid "pay and chase" situations.

The OIG recommends that HCFA pursue a legislative proposal that would require Medicare contractors to match their records with the private health insurance data. This proposal should further require Medicare contractors to review their private insurance files to identify and report potential MSP situations.

The HCFA has disagreed with this recommendation in their comments on the MAR entitled "Medicare Secondary Payer: Unrecovered Funds," because of the provisions of Section 6202 of OBRA of 1989 that prohibit the Secretary from requiring such matches.

The HCFA should revise all Medicare claim forms to require spousal insurance information before the claim is paid.

As of June 20, 1991, the HCFA 1500 claim form submitted by or on behalf of the beneficiary does not ask for complete information concerning spousal employment or insurance coverage. This mechanism would be a useful way to identify a substantial number of cases where the beneficiary is covered by their spouse's EGHP.

We suggest that the following questions be added as part of the claim forms:

- a. Are you covered by medical insurance through your employer?
- b. Are you covered by medical insurance through your spouses employer?

The HCFA has concurred with this recommendation in their comments on the MAR entitled "Medicare Secondary Payer: Unrecovered Funds" and will inform the Uniform Claim Form Task Force (this task force makes Medicare claim form changes) of its concurrence. The OIG will follow through with HCFA on the changes being made to the claim forms.

The HCFA should continue to refine and improve the MSP component of the Common Working File (CWF).

As of December 1990, all contractors who process and pay Medicare claims are using CWF. This system is designed to simplify and improve Medicare claims processing. The CWF establishes a prepayment review and payment authorization process that, when working properly, will significantly reduce claims payment errors and provider overpayments. It will provide the most current and accurate Medicare entitlement and eligibility data on beneficiaries. The CWF should also improve MSP claims processing and exchange of information between contractors.

The MSP component of the CWF was established with data from the Regional Data Exchange System (RDES). Contractor representatives have indicated that this system is not reliable because of incorrect and inconsistent data. Using the RDES to establish this portion of the CWF transferred the incorrect and inconsistent data to the CWF. The CWF will not improve MSP identification and recovery efforts unless all Medicare contractors are receiving reliable and consistent MSP information. The HCFA should work to assure that the problems with the CWF are corrected.

Also, the system has created duplicate auxiliary records for MSP information. One record is a slight deviation. This causes every claim to reject as a potential MSP situation. The contractors have been holding these claims. Obviously, this has created a large backlog. In addition, many auxiliary records have incorrect effective dates. Only the contractor that originally set up the record can change the effective date. This causes confusion when one contractor finds an error but is unable to correct it until they discover which contractor originally set up the MSP file.

AGENCY COMMENTS

The HCFA generally agreed with the recommendations presented in the draft report. The first recommendation has been presented to HCFA in previous OIG reports. The HCFA has indicated that "appropriate action will be taken as part of the Department's legislative development (A-19) process." The OIG continues to believe this is an important step in determining the primary payer for many beneficiaries.

Our second recommendation suggests that Medicare revise all claim forms to require spousal health insurance information. The HCFA indicated that the HCFA 1500 has recently been revised. However, as of June 20, 1991, we were advised that many providers are not using this revised form. They continue to use a version of the HCFA 1500 that does not request spousal health insurance information. The HCFA also indicates that they are considering other modifications but "it will be a time consuming process." We continue to believe that the HCFA 1500 claim form should be revised to request complete employment and health insurance information for the beneficiary and his/her spouse. The HCFA should work to expedite this process.

The HCFA concurs with the recommendation to refine and improve the MSP component of the Common Working File (CWF). As HCFA requested, we have modified the report to detail the specific problems that we have discovered with the CWF.

This final report includes revisions as suggested by HCFA in its "Technical Comments" section of their comments on the draft report. The HCFA's verbatim comments can be found in Appendix C.

APPENDIX A

MEDICARE SECONDARY PAYER LEGISLATION

TITLE OF LAW	PUBLIC LAW	ENACTMENT DATE	EFFECTIVE DATE	DESCRIPTION
Omnibus Reconciliation Act of 1980 (ORA)	96-499	12-05-80	12-05-80	ORA made Medicare the secondary payer to automobile medical, no fault or any liability insurance.
Omnibus Budget Reconciliation Act of 1981 (OBRA)	97-35	08-13-81	10-01-81	OBRA made Medicare secondary payer for end-stage renal disease for up to 12 months following entitlement if the person is eligible for medical insurance under an EGHP.
Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA)	97-248	09-03-82	01-01-83	TEFRA made Medicare benefits secondary if the employee or spouse is age 65 through 69 covered by an EGHP and the employer has at least 20 employees.
Deficit Reduction Act of 1984 (DEFRA)	98-369	07-18-84	01-01-85	DEFRA broadened the definition of working spouse by including spouses age 65-69 of employed individuals under age 65, thereby removing the lower age limit.

MEDICARE SECONDARY PAYER LEGISLATION

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)	98-272	04-06-86	05-01-86	COBRA further broadened the definition of working aged by removing the limitation of age 70 and older.
Omnibus Budget Reconciliation Act of 1986 (OBRA)	99-509	10-21-86	01-01-87	OBRA made Medicare secondary for people under 65 who have Medicare because of disability (other than kidney failure) and who are covered under a LGHP as an employee, employer, self-employed person, business associate, or family member.
Omnibus Budget Reconciliation Act of 1989 (OBRA)	101-239	12-19-89	12-19-89	OBRA provided a two year period for matching IRS tax records to records of the Social Security Administration and the Health Care Financing Administration to identify working beneficiaries and their spouses.

APPENDIX B

PREVIOUSLY PUBLISHED REPORTS

1. Priority Audit Memorandum - Survey of the Tax Equity and Fiscal Responsibility Act of 1982 - March 7, 1984, Control Number: ACN-03-42009
2. Medicare Secondary Payer Provision End-Stage Renal Disease - Program Inspection Report - August 24, 1984, Control Number: 1-07-4001-14
3. Medicare Secondary Payer Provision End-Stage Renal Disease - South Dakota - November 20, 1984, Control Number: 1-08-4009-14
4. Medicare Secondary Payer Provision End-Stage Renal Disease - Colorado - December 4, 1984, Control Number: 1-08-4001-14
5. Medicare Secondary Payer Provision End-Stage Renal Disease - Program Inspection Report - April 3, 1985, Control Number: 1-07/08-4002-14
6. Medicare Secondary Payer Provision Automobile Medical and No-Fault Insurance - North Dakota - May 1, 1985, Inspection Control Number: 03-08-5001-14
7. Program Inspection of Medicare as a Secondary Payment Source for Beneficiaries with End-Stage Renal Disease in the State of Oregon - May 10, 1985, Inspection Control Number: 3-10-4008-14
8. Medicare as Secondary Payer for Medical Services Related to Automobile Accidents in Massachusetts - June 1985, Control Number: 1-01-4105-31
9. Medicare as a Secondary Payer for Medical Services Related to Automobile Accidents in Massachusetts - Boston - June 1985, Control Number: 1-01-4105-32
10. Report by the Comptroller General of the United States. The Congress Should Consider Amending the Medicare Secondary Payer Provisions to Include Disability Beneficiaries - September 30, 1985, Control Number: GAO/HRD-85-102
11. Medicare Secondary Payer Provision Automobile Liability and Medical Insurance - State of Missouri - Program Inspection Report - December 1985, Control Number: 3-07-5001-32
12. Medicare Secondary Payer Provision Automobile Medical and No-Fault Insurance - State of Colorado - Program Inspection Report - December 1985, Control Number: 3-08-5002-14

13. Medicare Secondary Payer Provision Credit Balances in Medicare Beneficiary Hospital Accounts, Control Number: OPI-85-070-040
14. Medicare Secondary Payer Provision Working Aged in Missouri - July 1986, Control Number P-07-86-00079
15. Medicare Secondary Payer Provision Working Aged in Colorado - July 1986, Control Number: P-07-86-00071
16. OIG Audit Report - Medicare Overpayments for Services Provided to Beneficiaries with End-Stage Renal Disease - April 28, 1987, Control Number: A-10-86-62003
17. OIG Audit Report - Retirees of Exempt State and Local Governments Could Cost Medicare \$12.8 Billion over the Next 5 Years - September 10, 1987, Control Number: CIN A-09-86-62050
18. Amending the Medicare Secondary Payer Provision for ESRD Beneficiaries Could Save the Medicare Program \$3 Billion Over the Next 5 Years - December 1, 1987, Control Number: CIN-A-10-86-62016
19. Medicare as a Secondary Payment Source - End-Stage Renal Disease - January 1988, Control Number: OAI-07-86-00092
20. Medicare as a Secondary Payment Source - January 1988, Control Number: OAI-07-86-00017
21. Medicare as a Secondary Payment Source: Medicare Beneficiaries Covered By Employer Group Health Plans - February 1988, Control Number: OAI-07-86-00091
22. Nationwide Review of Medicare as Secondary Payer for the Period September 1, 1983 through November 30, 1985, Control Number: CIN A-10-86-62005
23. Medicare: Incentives Needed to Assure Private Insurers Pay Before Medicare - November 1988, Control Number: GAO/HRD-89-191
24. Management Advisory Report: Medicare as Secondary Payer — A Restitution Proposal, Control Number: AO-12-89-00002
25. Management Advisory Report: More Complete Employer Group Health Plan Information is Needed to Administer the Medicare Secondary Payer Program, Control Number: A-09-89-00100
26. Draft Management Advisory Report: MSP Survey - Contractors Questionnaire, Control Number: A-09-89-00151

27. **Management Advisory Report: Medicare Secondary Payer: Unrecovered Funds**
(OEI-07-90-00764)

APPENDIX C

HEALTH CARE FINANCING ADMINISTRATION COMMENTS



Memorandum

JUN - 3 1991

Date Gail R. Wilensky, Ph.D. *grw*
From Administrator
Subject OIG Draft Report: "Medicare Secondary Payer (MSP): Effectiveness of Current Procedures" (OEI-07-90-00761)
To Inspector General
Office of the Secretary

We have reviewed the above referenced draft report evaluating the effectiveness of current procedures to identify Medicare beneficiaries who have insurance coverage that is primary to Medicare. OIG found that:

- o Medicare contractors are not coordinating with their private insurance operations when the private insurance side of the corporation is the primary payer.
- o Beneficiaries who are covered by a working spouse's employer group health plan are least likely to be identified for MSP purposes.
- o Medicare contractors lack the internal coordination and systems information needed to identify all MSP situations.
- o Medicare intermediaries and carriers fail to exchange accurate MSP data.

Based on these findings, OIG makes three recommendations to enhance the cost effectiveness of Medicare reimbursement by ensuring that Medicare reimbursement is secondary to other insurance. HCFA concurs with the two management recommendations. OIG's legislative recommendation will be reviewed and appropriate action taken as part of the Department's legislative development (A-19) process.

Attached are our comments on OIG's specific recommendations. Thank you for the opportunity to comment on this draft report. Please advise us whether you agree with our position on the report's recommendations at your earliest convenience.

Attachment

Comments of the Health Care Financing Administration
on the OIG Draft Report: Medicare Secondary
Payer: Effectiveness of Current Procedures
(OEI-07-90-00761)

OIG recommends three actions for improving the effectiveness of contractor MSP identification procedures. Two of these have previously been identified by OIG and addressed by HCFA. Following are comments on each of the recommendations and some technical comments on the draft report.

OIG Recommendation

HCFA should propose legislation to require Medicare contractors to match their health insurance data with Medicare files.

HCFA Response

HCFA will review the legislative recommendation and appropriate action will be taken as part of the Department's legislative development (A-19) process.

In the past, HCFA has proposed legislation to require such matches, but the Congress has not yet enacted such legislation. In fact, as OIG pointed out, section 6202 of OBRA 1989 prohibits the Secretary from requiring Medicare contractors to match their private insurance data with Medicare data. There are, however, various other HCFA activities and legislative proposals for obtaining information on primary coverage of Medicare beneficiaries.

OIG Recommendation

HCFA should revise all Medicare claim forms to require spousal information before the claim is paid.

HCFA Response

The basic Medicare claim form, HCFA 1500, has recently been revised to request information about spousal insurance coverage, and about any coverage beneficiaries may have through employment. We are also considering recommending additional revisions to the HCFA 1500 to require more information on primary insurance and spousal eligibility, but it will be a time consuming process. Additional changes must be cleared with the appropriate work groups and multiple users, and approved by the Office of Management and Budget under the Paperwork Reduction Act. In the interim, we plan to reemphasize to physicians and suppliers who prepare this form, their responsibility for collecting information about primary insurers.

OIG Recommendation

HCFA should continue to refine and improve the MSP component of the Common Working File (CWF).

HCFA Response

We agree with OIG's recommendation. As HCFA expected, the data initially loaded into the CWF contained some inconsistencies. However, the information obtained from the IRS/SSA/HCFA data match project will be loaded into the CWF and will take precedence over conflicting data. We are also pursuing data match projects with the Department of Labor's Black Lung Program, the Department of Veterans Affairs and many State agencies to secure better MSP data.

OIG's draft report does not provide details concerning the specific problems with CWF data noted by Medicare contractors. This information would be helpful in determining the particular refinements and improvements that may be necessary. We therefore request that in the final report, OIG provide a further description and analysis of the CWF system problems that its study revealed.

Technical Comments

On page 1, last paragraph, third line, the text should read "a disabled beneficiary's LGHP" instead of "a disabled beneficiary's EGHP."

The last sentence of the last paragraph on page 1 should be revised to read: "If the primary plan does not pay for all covered services, Medicare may pay secondary benefits for Medicare covered services."

On page 2, the last bullet point in the middle of the page should be revised to read: "reviewing all claims containing medical diagnosis codes indicating trauma--to identify injuries related to automobile, or other traumatic injury cases, including work-related accidents."

On page 12, the first item in the right column should be revised to read: "OBRA 1986 made Medicare secondary for people under 65 who have Medicare because of disability (other than kidney failure) and who are covered under a LGHP as an employee, employer, self-employed person, business associate, or family member." ...