



## Memorandum

Date · JUL 29 1992

From Richard P. Kusserow  
Inspector General *Bryan Tolson*

Subject Medicare as a Secondary Payer, Nationwide Employer Project  
(A-09-89-00162)

To William Toby  
Acting Administrator  
Health Care Financing Administration

Attached is our final management advisory report entitled "Medicare as a Secondary Payer, Nationwide Employer Project." This report presents the results of our ongoing review of the Medicare secondary payer program (MSP). The principle objective of the review was to determine if Medicare incorrectly paid for services on behalf of working beneficiaries who were also covered under an employer's group health plan (EGHP). The report concludes that, for the participating employers, Medicare often paid for services when other health insurance plans should have been the primary payers.

We contacted 30 large employers, including private corporations and government agencies, and asked them to voluntarily provide EGHP information. We obtained responses from 12, or 40 percent, of the employers. For those 12 employers, we found that Medicare paid for services provided to 1,236 beneficiaries who were actively employed and enrolled in EGHPs. The total of these potentially mistaken payments was \$2,218,824.

To identify MSP situations, we developed a computer data base using information from the Social Security Administration's (SSA) Master Beneficiary Record file and Master Earnings File. This data base contains Medicare beneficiaries who had employment related earnings during the period 1983 through 1988. Our methodology for this study included a series of comparisons between this data base and Medicare's nationwide utilization system that provided identification of Medicare beneficiaries that had a Medicare claim paid on their behalf. This series of data matches enabled us to determine the amount of potentially mistaken Medicare payments.

During the period that our review was being conducted, the Congress included MSP provisions in the Omnibus Budget Reconciliation Act (OBRA) of 1989 and 1990 that required

the Health Care Financing Administration (HCFA) to perform a similar data match project. We were, therefore, able to provide HCFA officials with information to allow them to more effectively implement this legislation. We supplied HCFA with our employer questionnaire, letters received from employers, lists of employer identification numbers and mailing addresses, and the data base we used to identify potential MSP situations.

A significant difference between our MSP project and that required by OBRA 1989 and 1990 is the issue of statistical sampling. While we were able to obtain our results using statistical sampling, the Congress has required HCFA to examine 100 percent of the claims data to determine the probable amount of mistaken Medicare payments. Such intensive claims development procedures is going to prove unnecessarily costly and time consuming for the Government and its contractors. We believe that a statistical sampling approach, rather than an individual claims development approach, is a viable and acceptable method for settlement of these disputed claims.

We also identified several issues that HCFA should consider during the implementation of **OBRA** 1989 and 1990. These include excluding beneficiaries with income that is not related to employment, screening the Medicare paid claims file to eliminate those situations where Medicare payments were not made on behalf of the beneficiary, developing targeting techniques to select those beneficiaries more likely to be covered by **EGHPs**, giving priority to the recovery of large overpayments, developing procedures for processing civil monetary penalty cases, and increasing the savings goals assigned to Medicare contractors. The information we supplied pertaining to these issues has allowed HCFA officials to incorporate these screening mechanisms into their data match project. We have commented on each area. However, because the OBRA 1989 and 1990 data match was in progress at the time of this report, work in many of these areas has already been performed. **We**, therefore, have limited our recommendations to areas in which work has yet to be performed.

We are recommending that HCFA require intermediaries and carriers to examine the claims associated with the **\$2,218,824** of potentially mistaken Medicare payments and initiate recovery actions where appropriate. We are also recommending that HCFA seek legislative authority to require the use of statistical sampling to identify MSP

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situations and determine the amount of mistaken payments made by Medicare contractors. In addition, we are recommending improvements that would enhance implementation of the MSP provisions included in OBRA I.989 and 1990.

In response to the draft report, HCFA officials generally agreed with our findings and recommendations. However, HCFA requested clarification regarding a recommendation to seek legislative authority to use statistical sampling to determine the amount of mistaken payments made by Medicare contractors. The HCFA officials stated that they already have the authority to use statistical sampling in MSP cases and believed that the recommended action is unnecessary.

We recognize that HCFA has the authority to use statistical sampling in MSP cases. However, the Internal Revenue Service/SSA data match legislation requires the examination of 100 percent of the claims data to identify mistaken Medicare payments. Because of the extremely large volume of data involved in this project, we believe that a statistical sampling approach should be considered, and would be agreeable to work with HCFA to develop a legislative recommendation for using sampling.

In addition, HCFA officials stated that they are deferring comment on the recommendations concerning the civil monetary penalties and the MSP savings goals.

Please advise us, within 60 days, of any further actions taken or planned on our recommendations. If you have any questions, please call me or have your staff contact George M. Reeb, Assistant Inspector General for Health Care Financing Audits at (410) 966-7104. Copies of this report are being sent to other top Department officials.

Attachment

**Department of Health and Human Services**

**OFFICE OF  
INSPECTOR GENERAL**

**MEDICARE AS A SECONDARY PAYER,  
NATIONWIDE EMPLOYER PROJECT**



**Richard P. Kusserow  
INSPECTOR GENERAL**

**A-09-89-00162**



## Memorandum

Date · JUL 29 1992

From Richard P. Kusserow  
Inspector General *For Bryan Mitchell*

Subject Medicare as a Secondary Payer, Nationwide Employer Project  
(A-09-89-00162)

To William Toby  
Acting Administrator  
Health Care Financing Administration

This final management advisory report entitled "Medicare as a Secondary Payer, Nationwide Employer Project" presents the results of our ongoing review of the Medicare secondary payer program (MSP). The objectives of our review were to (1) determine if Medicare inappropriately paid for services on behalf of working beneficiaries who also had coverage under their employer group health plans (EGHP); and (2) to obtain information which may be useful to the Health Care Financing Administration (HCFA) in effectively implementing MSP provisions included in the Omnibus Budget Reconciliation Acts (OBRA) of 1989 and 1990. These provisions required HCFA to perform data matches and to contact employers to identify beneficiaries covered by EGHPs.

Employer participation in our project was voluntary. Of the 30 employers contacted, 12 participated in the project. Of the 18 employers that were not included, 11 declined, either in writing or verbally, to participate and 3 did not respond after repeated efforts to obtain a response. The remaining four employers were not included because preliminary reviews indicated that the number of Medicare eligible employees covered by EGHPs was not significant.

For the 12 participating employers, we found that Medicare often paid for services when other health insurance was available. Medicare paid for services provided to 1,236 beneficiaries who were enrolled in EGHPs. The amount of potential overpayments totaled \$2,218,824.

We also identified several issues that HCFA should consider during the implementation of OBRA 1989 and 1990. These issues were excluding beneficiaries with income that is not related to employment, screening the Medicare paid claims file to eliminate those situations where Medicare payments were not made on behalf of the beneficiary, developing targeting techniques to select those beneficiaries more

likely to be covered by EGHPs, giving priority to the recovery of large overpayments, developing procedures for processing civil monetary penalty (CMP) cases, and increasing the savings goals assigned to Medicare contractors.

In order for the OBRA 1989 and 1990 data match project to benefit from our data match, we shared with HCFA staff as much information early on as was possible. For example, we provided them with letters from employers indicating that we had not been totally successful in screening out the different types of nonwork-related income such as retirement annuities, disability insurance, and deferred compensation plans. To further expedite the OBRA data match project, we provided HCFA with the data base we used to identify potential MSP situations. We furnished them with our employer questionnaire which HCFA used as a model for their questionnaire. We also provided HCFA staff with a list of employer identification numbers (EIN) and other pertinent information to help compile the employer mailing list.

We are recommending that HCFA require intermediaries and carriers to examine the claims associated with the \$2,218,824 of potentially mistaken Medicare payments and initiate recovery actions where appropriate. We are also recommending that HCFA seek legislative authority to require the use of statistical sampling to identify MSP situations and determine the amount of mistaken payments made by Medicare contractors. In addition, we are recommending improvements that would enhance implementation of the MSP provisions included in OBRA 1989 and 1990. We have commented on each area. However, because the OBRA 1989 and 1990 data match was in progress at the time of this report, work in many of these areas has already been performed. We, therefore, have limited our recommendations to areas in which work has yet to be performed.

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## **BACKGROUND**

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The responsibility for administering the Medicare program rests with HCFA. The HCFA has contracted with private insurance companies (fiscal intermediaries and carriers) to process and pay Medicare claims for covered services. As

part of their responsibilities, the contractors must ensure that Medicare payments are made secondary to EGHPs when provided for under applicable laws and regulations.

The Medicare program initially paid for most health services provided to beneficiaries. Beginning in 1980, however, legislation was enacted that made Medicare the secondary payer in certain cases. These MSP provisions require that other insurers, whose coverage is primary, pay claims before Medicare. By 1987, legislative changes had been enacted that made Medicare the secondary payer to EGHPs for the aged and disabled. In addition, Medicare was made the secondary payer for end stage renal disease (ESRD) beneficiaries during their first 12 months of eligibility and was extended to the first 18 months of eligibility effective November 5, 1990. (See Appendix A for a summary of the major MSP legislation.)

Over the last several years, HCFA has taken a number of steps to implement this legislation. These measures include the first-claim development procedures which withhold payment of the initial Medicare claim until EGHP information is received, the Common Working File (CWF) system which serves as a data base for MSP information, and various outreach activities which educate employers, contractors, providers, insurers, and beneficiaries about the MSP provisions.

Although these actions have been claimed to have saved billions of dollars, HCFA has estimated that one-third of the MSP situations remain undetected. As a result, HCFA has taken additional steps, including advocating passage of the additional MSP provisions in OBRA 1989 and 1990.

Section 1862(b) of the Social Security Act, as amended by section 6202 of OBRA 1989, requires data matches between the Social Security Administration (SSA), the Internal Revenue Service (IRS), and HCFA. The purpose of the matches is to identify working beneficiaries and/or beneficiaries with working spouses who are covered by EGHPs. These provisions, which constitute a major change in the MSP identification process, authorize HCFA to contact employers to obtain employer group health coverage information. The data match provisions were extended through September 30, 1995, by OBRA 1990.

PROVISIONS OF THE DATA MATCH PROJECT

The following is a brief summary of key provisions of the data match project authorized by section 6202 of OBRA 1989 and extended by OBRA 1990.

1. The SSA provides names of Medicare eligible beneficiaries to IRS which determines if they had a married filing status (for any specified year after 1986). If so, IRS provides SSA with names and taxpayer identification numbers (TIN) of the spouses.
2. The SSA provides to HCFA: (i) the name and TIN of each beneficiary and spouse who is identified as having received wages from an employer with 20 or more employees, and (ii) the name, address, and TIN of each employer of the beneficiaries and spouses.
3. Under a contract with HCFA, a private contractor contacts the employers (estimated at 1.1 million) to verify employment and availability of group health plan coverage of the beneficiaries and spouses. The employers are required to complete a questionnaire providing information on the coverage.
4. The HCFA compares EGHP coverage information provided by employers with Medicare paid claims files for the individuals. Information concerning potential Medicare overpayments is provided to the contractor for further development.
5. The contractor sorts the potential overpayments by appropriate intermediaries and carriers and sends the information to them for recovery efforts.

The above MSP provisions of OBRA 1989 were enacted during the initial phase of our review. At the time this report was prepared, the provisions were being implemented by the contractor. The implementation of the MSP provisions of OBRA 1989 and 1990 are being evaluated under a separate review.

## METHODOLOGY

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The following paragraphs describe the various phases included in our review, limitations encountered in completing the planned phases, and additional work performed to develop recommendations for implementing the OBRA 1989 and 1990 MSP provisions.

### Phase I

The first phase of our review was to extract from SSA records a computer data file of Medicare eligible beneficiaries who may have been subject to MSP provisions from January 1, 1983 to December 31, 1988. The information was obtained, through computer matching, from the Master Beneficiary Record file and the Master Earnings File. The review was conducted on a year-by-year basis; and we considered the MSP provisions that existed during each year. As noted in the Background section of this report, the provisions changed over this period.

The data file was to include those beneficiaries who, in addition to falling under the above referenced MSP provisions, received income from employers during one or more of the years included in the review. Our assumption was that if beneficiaries had income through employment, they may have had employer sponsored health plan coverage available.

### Phase II

The second phase was to sort the beneficiary information in the data file by EIN. Our data file contained about 1.1 million EINS. Generally, one EIN represented one employer, although some larger employers may have had more than one EIN.

The employers, as identified by their EINS, were then arranged according to the total number of Medicare eligible beneficiaries employed. There were 448 EINS, representing 411 different employers, with 1,000 or more beneficiaries. Thirty EINS were randomly selected from the 448 EINS. The 30 EINS represented 30 different employers.

### **Phase III**

We then contacted, in writing, each of the 30 employers to provide them with information on the project and to ask for their participation. We explained that their participation would be voluntary. Employers expressing a willingness to participate in the project were provided with listings of the beneficiaries. We asked them for employment periods, **EGHPs'** names, policy numbers, and coverage dates. Authorization to collect this information was obtained from the Office of Management and Budget (OMB No. 0990-0184).

### **Phase IV**

The information provided by participating employers was then used to determine if Medicare made payments when the beneficiaries were also covered by EGHPs. This was done by comparing EGHP coverage dates to dates of medical services for which Medicare made payments. The Medicare payment information was obtained from the Medicare Automated Data Retrieval System. This is the data system used by HCFA to record paid claim histories for each beneficiary.

### **Phase V**

The potential overpayments were sorted by contractor (fiscal intermediary and carrier) to enable HCFA to instruct the appropriate contractors to initiate recovery actions. The payments will be considered potential overpayments until the respective contractors coordinate benefits with the EGHPs. Circumstances may exist that would mean that the Medicare payments were appropriately made. For example, some factors to be considered are the exhaustion of benefits and limitations of coverage.

### **Limitations Encountered**

The above phases generally describe our nationwide employer project. However, there were limitations encountered in completing our work. The limitations were **as** follows:

- o Only 12 of the 30 employers we contacted participated in the project.
- o The 12 employers provided the requested information for 2 or more years, but none of them were able to provide it for the entire period planned (January 1, 1983 through December 31, 1988). This is partially

attributable to incomplete data files as described below, as well as other reasons described later in this report.

- o Unfortunately, the data file provided by SSA could not be manipulated to exclude some beneficiaries who were not employed during the years reviewed. These beneficiaries had income from sources other than salaries and wages, such as pensions and disability insurance.
- o The data file used by HCFA to record paid claims information could not readily provide payment data for 1983, and the file provided by SSA did not include beneficiary information for Calendar Year (CY) 1984.

#### Developing Recommendations for Implementing the **OBRA** 1989 and 1990 Provisions

During our review, we became aware that legislation had been enacted in **OBRA 1989** and 1990 that required a data match project similar to this one. We, therefore, shared with HCFA information on problem areas identified during our review and included appropriate recommendations in this report to enhance implementation of OBRA 1989 and 1990.

We also performed an analysis to determine if certain factors, such as earnings and age, could be used to identify beneficiaries with a greater likelihood of having EGHP coverage. We believe that the results of this analysis should be of help in developing priorities in the work being accomplished under the MSP provisions of OBRA 1989 and 1990, and are presenting these results for consideration by HCFA.

Our field work was performed at **HCFA's** central office in Baltimore, Maryland and the Office of Audit Services' Region **ix** field office in Seattle, Washington. We performed our field work from September 1989 to February 1991. No site visits were made to verify the accuracy and completeness of EGHP information obtained from employers. Also, we did not validate the accuracy of the information provided by SSA and HCFA.

## **RESULTS OF REVIEW**

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Overall, 12 of the 30 employers selected participated and provided requested information, although not to the extent we originally contemplated. Information obtained from the 12 employers showed that Medicare paid for services when other health insurance **was** available. Our review showed that Medicare paid for the services provided to 1,236 beneficiaries who were also covered by **EGHPs** during the period the services were provided. The amount of potential overpayments totaled **\$2,218,824** for these beneficiaries. The actual amount of overpayments must be determined by HCFA through additional research and follow-up by the appropriate intermediaries and carriers.

Our review also disclosed several areas where improvements could be made to more effectively implement MSP provisions included in OBRA 1989 and 1990. These include:

- o Excluding beneficiaries with nonwork-related income.
- o Screening the Medicare paid claims file before contacting employers to eliminate situations where no Medicare payments were made during the period reviewed.
- o Targeting and giving priority to those beneficiaries more likely to have EGHP coverage.
- o Giving priority to the identification and recovery of high dollar overpayments.
- o Developing detailed procedures for processing CMP cases.
- o Increasing the savings goals assigned to contractors.

### **Results of Employer Data Match**

Thirty employers were sampled from 448 **EINs** having 1,000 or more employees with Medicare eligibility. Of the 30 employers sampled:

- o 12 agreed to participate,
- o 11 declined to participate,
- o 3 did not respond even after three certified letters were sent to each,
- o 2 agreed to perform preliminary reviews of a limited number of employees, and declined to proceed with the full project because they believed the preliminary results did not warrant additional work, and
- o 2 performed limited reviews but were subsequently eliminated because none of the employees reviewed was covered by EGHPs.

The nonparticipating employers offered various reasons for deciding not to be included in our review. The reasons included the lack of available or readily available information, reluctance to divert staff from other priorities, costs of such an undertaking, major system changes in process, seizure of records due to bankruptcy, and concerns for potential liability.

The extent of participation for the 12 employers is shown below.

<u>Years of Employers* Participation</u>	<u>Number of Employers</u>
1984-1987	1
1984-1988	5
1985-1986	1
1985-1988	1
1986-1988	1
1987-1988	3
Total	<u>12</u>

For the periods shown in the above schedule, the employers indicated that they reviewed 19,143 employee records to determine if the beneficiaries had EGHP coverage. Of the 19,143 beneficiaries, the employers identified 4,661 that had coverage. For each of these beneficiaries, the

employer provided health insurance information, including names of the insurers and coverage dates.

To determine if Medicare paid when these beneficiaries were enrolled in EGHPs, we matched their coverage dates with the service dates on the Medicare paid claims file. Of the 4,661 with coverage, Medicare paid for services provided to 1,236 beneficiaries during the time of their EGHP coverage. Medicare paid \$2,218,824 on behalf of these beneficiaries. The following schedule shows the results for each employer.

----- Beneficiaries -----				
employer	Reviewed	With EGHP	With Services	Potential Overpayment
1	1,925	553	157	\$ 243,764
2	1,030	31	11	10,408
3	1,332	425	101	101,612
4	2,316	27	8	3,552
5	1,156	711	156	379,014
6	525	119	13	2,383
7	4,376	1,455	416	814,058
8	1,403	266	59	83,224
9	993	860	213	300,411
10	2,314	167	79	239,257
11	1,024	14	7	10,171
12	749	33	16	30,970
Totals	<u>19,143</u>	4, <u>661</u>	<u>1,236</u>	<u>\$2,218,824</u>

The percentages of beneficiaries with EGHP coverage varied significantly among employers. These percentages ranged from 1 percent to 87 percent with an average of 24 percent. Similarly, there was a wide variance in the percentages of beneficiaries with coverage that received Medicare services. These percentages ranged from 11 percent to 50 percent, respectively.

These wide variances may be due to the employers' type, size, number of part-time versus full-time employees, and quality and cost of EGHP coverage available. Also, the differences could be attributed to the degree of compliance by employers and employees with the MSP provisions. These

variances can also be attributed to the data base used in our review which contained large numbers of beneficiaries with low MSP potential. These issues, which are discussed below as well as suggestions for improvement, should be addressed in implementing the MSP provisions of OBRA 1989 and 1990.

#### **OBRA 1989 and 1990 - MSP Provisions**

The contractor, selected by HCFA to carry out the data match project required by OBRA 1989 and 1990, will be using a methodology somewhat similar to ours. The experience gained in our review should be of benefit to HCFA and its contractor in the implementation of the OBRA data match project. Accordingly, as previously discussed, we shared information early on with HCFA to expedite implementation of the OBRA 1989 and 1990 data match project. Also, we are including comments in this report on each problem area identified during our review. However, because the OBRA 1989 and 1990 data match was already in progress at the time of this report, we have limited our recommendations to the areas that HCFA could implement. Specifically, we recommend that HCFA exclude from the data matches beneficiaries with nonworking-related income, give high priority to the recovery of high dollar overpayments, develop detailed procedures for **processing** CMP cases, and increase the MSP savings goals assigned to contractors.

In addition, we are recommending that HCFA seek legislative authority to require the use of statistical sampling to identify MSP situations and determine the amount of mistaken payments made by Medicare contractors. Sampling has attained the status of a science, and is used extensively in private industry. It is a widely accepted technique for determining damages. By reviewing a representative subgroup of a larger pool, the technique of sampling allows valid conclusions to be drawn about the nature of the entire group. Sampling's predictive power makes it ideal for calculating the damages owed by one party to another in complicated situations. Whenever the amount of data involved is simply too huge to afford a comprehensive review, the use of a statistically valid sample allows for damages to be determined while avoiding the burdensome task of individual claim development. We believe that the claim-by-claim method of determining the amount of mistaken payments mandated by OBRA 1989 and 1990 is an onerous and unnecessarily costly approach to the MSP issue.

**Eliminating Nonwork-Related Income.** When performing the OBRA data match, HCFA should be careful to eliminate all nonwork-related categories of income. In the data base used in our review to identify Medicare beneficiaries with income, we did not screen out beneficiaries having retirement annuities, disability insurance, deferred compensation plans, and other nonwork-related income.

Several employers declined to participate because the majority of the beneficiaries identified were not paid as employees of the company or were not employed for the periods requested. For example, 1 employer declined further participation after a review of 672 beneficiaries disclosed that none were covered by the company's EGHP. All but two of the beneficiaries were policyholders receiving long term disability payments.

Another employer agreed to review 20 beneficiaries on our list. Finding that the beneficiaries were all retirees receiving pensions (Form W-2P earnings), the employer declined to do any further work.

If beneficiaries with nonwork-related income were eliminated from the data matches, the number of records selected for review would be substantially reduced and a much higher percentage of beneficiaries with EGHP coverage would be selected. This process would reduce the workload that employers would be asked to undertake and enhance employer cooperation.

**Screening the Medicare Paid Claims File.** The initial listings of Medicare beneficiaries could be reduced further by comparing the listings to the paid claims file before queries are made of employers. Such a screening process, prior to seeking employer involvement, would reduce the number of records to be reviewed because many beneficiaries will **not** have received medical services paid by Medicare for particular years. Thus, a beneficiary with no Medicare services for a given year would be deleted from that year's listing prior to requesting employer input.

Our review queried employers for EGHP information prior to determining if the beneficiaries had medical services that were paid by Medicare. For the 12 employers participating, 73 percent of the beneficiaries with EGHP coverage had not received Medicare services.

**Targeting Beneficiaries with EGHP Coverage.** The data base used in our review contained in excess of 16 million beneficiaries who received income from about 1.1 million employers. Our analysis indicated that if low-income beneficiaries had been excluded, the review would have been more effective. In addition, we performed a statistical analysis of certain characteristics of our population of employees and determined that other factors, such as age and gender, were also indicative of the probability of EGHP coverage.

Some of the employers selected by our sample employed large numbers of part-time people who did not have EGHP coverage.

Using income levels as a factor in selecting beneficiaries would have helped avoid unnecessary work. For example:

- o One employer, a county government in the State of Washington, was shown in our data base as having 1,030 Medicare eligible employees. This employer elected to participate in our review. However, it had only 31 employees covered by an EGHP. This county had a unique program allowing senior citizens to work part-time to satisfy property tax requirements. Health benefits were not provided to these part-time employees.
- o Another employer, a large fast food chain, was shown as having 1,518 Medicare eligible employees. In response to our inquiry, this company informed us that most of its older employees worked less than 20 hours a week and would not have health benefits. This employer declined to participate in our review.

To determine if we could target beneficiaries with a high probability (or a low probability) for having EGHP coverage, we took two random samples of beneficiaries. The first sample consisted of 82 beneficiaries with EGHP coverage and the second sample consisted of 118 beneficiaries without EGHP coverage. The samples were taken from CY 1988 information provided by 7 of the 12 employers that participated in our review. When we took the samples, only seven of the employers had provided coverage information. From SSA records, we obtained earnings and other beneficiary information, such as gender, other income, and age.

Using the above information, we set up a **statistical** model using a technique called discriminant analysis.<sup>1</sup> We found that earnings was a significant factor in determining whether beneficiaries had EGHP coverage. By using earnings up to the Federal Insurance Contribution Act ceiling as the only factor, our model produced the following results:

- o Of the beneficiaries with coverage, the model accurately predicted 48 percent of the time that the beneficiaries had such coverage.
- o For beneficiaries without coverage, our model predicted correctly 87 percent of the time that employees would not have such coverage.

In our samples, beneficiaries with EGHP coverage earned, on average, \$17,555 annually whereas those beneficiaries without coverage earned \$3,305.

Other information could also be used to target beneficiaries with a higher probability of being covered by **EGHPs**. If gender, other income, and age were added in addition to earnings in the above statistical model, the predictability of EGHP coverage would be improved.

Prioritizing Recovery of High Dollar Overpayments. In recovering overpayments, priority should be placed on high dollar services. Our evaluation demonstrated that although inpatient hospital services accounted for only 3 percent of the services, they represented 48 percent of the potential overpayments. As shown by the schedule below there were 303 inpatient services averaging \$3,509 compared to 6,264 claims for supplementary services averaging \$128.

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<sup>1</sup> Discriminant analysis techniques are used to classify individuals into one of two or more alternative groups (or populations) on the basis of a set of measurements. The populations are known to be distinct, and each individual belongs to one of them. These techniques can also be used to identify which variables contribute to making the classification. (A.A. Afifi and Virginia Clark, Computer-Aided Multivariate Analysis, Wadsworth, Inc., California, 1984, p. 247.)

<u>Type of Service</u>	<u>Number of Services</u>	<u>Service Amounts</u>	<u>Average Amount Per Service</u>
Hospital Services			
Inpatient	303	\$1,063,158	\$3,509
Outpatient	<u>2,163</u>	<u>355,481</u>	\$ 1164
Subtotals	2,466	\$1,418,639	
Supplementary Services	<u>6,264</u>	<u>800,185</u>	\$ 128
Totals	<u>8,730</u>	<u>\$2,218,824</u>	

In addition, for some supplementary services, the paid claims file does not include the information necessary to effectively perform the research to identify potential MSP overpayments. For office visits, the file does not include the specific carriers that processed the claims or the dates of service. As a result, it would be necessary to identify the appropriate carriers and request paid claim histories before potential overpayments could be established. Because of additional work required to research these claims and the relatively small dollar amounts, they should be given lower priority.

Developing Procedures for CMP. The HCFA should develop detailed procedures for handling CMP cases. During the process of gathering information for our review, it became apparent that some employers were not willing to provide the required information. Although the data match project authorized by OBRA 1989 and 1990 requires employer participation through the threat of CMP, some employers may still be unwilling to provide the requested information.

Because of the large volume of employers (1.1 million), even a small percentage of uncooperative employers, could generate a significant number of CMP cases. In preparation for this eventuality, HCFA needs to develop procedures for handling CMP cases. These procedures should include proper cutoff dates, supporting documentation, and referral procedures.

**Increasing the MSP Savings Goals.** With the identification of additional beneficiaries with EGHP coverage, HCFA should increase the savings goals assigned to Medicare contractors. One objective of the OBRA data match project will be to update CWF with new MSP information. The HCFA has estimated that a significant number of new beneficiaries with EGHP coverage will be identified. As a result, additional savings will be realized by the contractors. Because these savings goals are used to measure contractor performance in the MSP program, the goals will need to be increased to reflect these additional savings.

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## **RECOMMENDATIONS**

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We recommend that HCFA:

1. Require the intermediaries and carriers to examine the claims associated with the \$2,218,824 in potential overpayments identified from our review and initiate recovery actions where appropriate. This can be accomplished by forwarding our listings of potential overpayments, which have been provided to HCFA, to the respective intermediaries and carriers.
2. Take the following actions in the implementation of the data match project required by OBRA 1989 and 1990:
  - a. Exclude from the data matches beneficiaries with nonworking-related income such as retirement pensions, disability insurance, and deferred compensation plans.
  - b. Give priority to the recovery of high dollar overpayments.
  - c. Develop detailed procedures for processing CMP cases.
  - d. Increase the savings goals assigned to Medicare contractors.

3. Seek legislative authority to require the use of statistical sampling to identify MSP situations and determine the amount of mistaken payments made by Medicare contractors.

**HCFA's** Comments and **OIG's** Response

The HCFA concurred, for the most part, with our findings and recommendations. However, HCFA officials stated that they already have the authority to use statistical sampling in MSP cases, as in other areas of payment safeguard activities, and believe that the recommended action is unnecessary.

We agree that HCFA has the authority to use statistical sampling in MSP cases and other areas of payment safeguard activities. However, in the OBRA 1989 and 1990 IRS/SSA data match project, the Congress has required HCFA to examine 100 percent of the claims to determine the probable amount of mistaken Medicare payments. Such intensive claims development procedures would be extremely costly and time consuming for the Government and its contractors. We believe that a statistical sampling approach, rather than an individual claims development approach, is a viable and acceptable method for settlement of the claims. Therefore, HCFA should seek legislative authority for the use of statistical sampling in the OBRA 1989 and 1990 IRS/SSA data match project. We would be agreeable to assist HCFA in developing such an approach.

In addition, HCFA officials stated that they are deferring comment on the recommendation concerning the CMP until discussions between HCFA and the Office of Inspector General are completed. They also stated that they are deferring comment on the recommendation concerning MSP savings goals until their review of the MSP savings goals is completed.

The **HCFA's** comments are presented in their entirety in Appendix B of this report.

## **APPENDICES**

## MEDICARE SECONDARY PAYER LEGISLATION

Title of Law	Effective Date	Description
Omnibus Reconciliation Act (ORA) of 1980	12-05-80	The ORA made Medicare the secondary payer for automobile medical, no-fault, and liability insurance claims.
Omnibus Budget Reconciliation Act (OBRA) of 1981	10-01-81	The OBRA 1981 made Medicare benefits secondary to employer group health plans during a period of up to 12 months for beneficiaries with end stage renal disease (ESRD).
Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982	01-01-83	The TEFRA of 1982 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.
Section 2344 of the Deficit Reduction Act (DEFRA) of 1984	07-18-84	This section of DEFRA of 1984 made explicit the Federal Government's right to recover Medicare payments directly from third parties when Medicare is the secondary payer.
Section 2301 of the Deficit Reduction Act (DEFRA) of 1984	01-01-85	Section 2301 of DEFRA 1984 broadened the definition of working aged by including spouses age 65 through 69 of employed individuals under age 65, thereby removing the lower age limit for the employed individuals.

## MEDICARE SECONDARY PAYER LEGISLATION

Title of Law	Effective Date	Description
Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985	05-01-86	The COBRA of 1985 further broadened the definition of working aged by removing the limitation of age 70 and older.
Omnibus Budget Reconciliation Act (OBRA) of 1986	01-01-87	The OBRA 1986 made Medicare the secondary payer for certain disabled individuals covered under an EGHP (a plan with at least one employer of 100 employees).
Omnibus Budget Reconciliation Act (OBRA) of 1987	01-22-88	The OBRA 1987 revised the ESRD secondary payer provisions to require providers and suppliers to bill EGHPs before billing Medicare.
Omnibus Budget Reconciliation Act (OBRA) of 1989	12-20-89	The OBRA 1989 required IRS, SSA, and HCFA to exchange information annually to help improve the identification of Medicare beneficiaries who are covered by private insurance.
Omnibus Budget Reconciliation Act (OBRA) of 1990	11-05-90	The OBRA 1990 extended: (1) the period that Medicare benefits are secondary to an EGHP for ESRD beneficiaries from 12 to 18 months, and (2) the OBRA 1989 data exchange authority from September 30, 1991 to September 30, 1995.



## Memorandum

MAR 13 1992

Date  
From  
Subject  
To

J. Michael Hudson  
Acting Administrator *J. Michael Hudson*

OIG Draft **Management** Advisory **Report**: "Medicare as a Secondary Payer,  
Nationwide Employer Project" (A-09-89-00162)

Inspector General  
Office of the Secretary

We have reviewed the above-referenced draft management advisory report concerning Medicare as a secondary payer (MSP). The **report** presents the results of the nationwide employer project undertaken as part of **OIG's** ongoing review of the MSP program. **OIG** reviewed data provided **voluntarily** by 12 large employers and concluded that Medicare often paid for services when other insurers should have been the primary payers.

We generally concur with the recommendations contained in this report and have already taken actions to implement several of **the** requested actions. Our detailed comments are attached.

Thank you for the opportunity to review and comment on this draft management advisory 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 OIG's Draft Management Advisory Report:  
"Medicare as a Secondary Payer,  
Nationwide Employer Project"  
(A-09-89-00162)

OIG Recommendation

Require the intermediaries and carriers to examine ~~the claims associated with~~ **\$2,218,824** in potential overpayments identified from our review and initiate **recovery** actions where appropriate. This can be accomplished by forwarding our listings of potential overpayments, which have been provided to **HCFA**, to the respective intermediaries and carriers.

HCFA Response

We concur with this recommendation subject to the availability of resources. The cases will be included in the data match work for the affected contractors.

OIG Recommendation

Take the following actions in the implementation of the data match project required by OBRA 1989 and 1990:

- a. Exclude from the data matches beneficiaries with-nonworking-related income such as retirement pensions, **disability** insurance, and deferred compensation plans.
- b. Give priority to the recovery of high dollar overpayments.
- c. Develop detailed procedures for processing civil monetary penalty (CMP) cases.
- d. Increase the savings goals assigned to Medicare contractors.

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### HCFA Resuonse

The following responds to each requested action:

- a. We concur. This action has already been taken.
- b. HCFA continues to pursue the maximum possible return on Medicare secondary payer (MSP) administrative dollars by setting priorities. We set priorities in the context of **fulfilling** all statutory and regulatory functions within the constraints of available resources. High-dollar recoveries are **given** first priority unless prohibited by statute or regulatory requirements. This policy is specified in contractor manual instructions.
- c. We are **deferring** comment on this recommendation until discussions between HCFA and OIG concerning the **CMP** issue are completed.
- d. We would like to defer comment on this recommendation until our review of the MSP savings goals is completed.

### OIG Recommendation

Seek legislative authority to require the use of statistical sampling to identify MSP situations and determine the amount of mistaken **payments** made by Medicare contractors.

### HCFA Resuonse

HCFA already has the authority to use statistical **sampling** in MSP cases, as in other areas of payment safeguard activities, and believes that the recommended action is unnecessary.

However, the recommendation raises a point upon which we **would** like further clarification. It appears that the report is recommending that a sampling methodology replace the methodology currently being used in the **IRS/SSA** data match. Under the data match, contractors are able to make MSP recoveries on a case-by-case basis because we have been able to **obtain** explicit information from employers about individual employees.

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General Comments

Background. page 3. last **paragraph** - To avoid misunderstanding, the last sentence of this paragraph should be revised to read: "The data match provisions were extended through September 30, 1995, by **OBRA** 1990,"

Appendix - In order to be more specific, the fourth entry, the Deficit Reduction Act of 1984 (**DEFRA**), needs to be identified as Section 2301 of **DEFRA**. Another reference to **DEFRA** should be added, as follows: Title of Law: Deficit Reduction Act of 1984 (**DEFRA**, Section 2344); Effective Date: **07-18-84**; Description: "Made explicit the Federal government's right to recover Medicare payments directly from third parties where Medicare is the secondary payer."

Appendix - Insert the following between **OBRA** 1986 and **OBRA** 1989: Title of Law: Omnibus Budget Reconciliation Act of 1987 (**OBRA** 1987); Effective Date: 01-22-87 Description: "Revised the ESRD secondary payer provisions to require providers and suppliers to bill **EGHPs** before billing **Medicare**."

Attached are additional **pencilled** corrections to the Appendix.

# DRAFT

## APPENDIX

### MEDICARE SECONDARY PAYER LEGISLATION

Title of Law	Effective Date	Description
Omnibus Reconciliation Act of 1980 (ORA)	12-05-80	ORA made Medicare the secondary payer for automobile accident-related claims, medical, no-fault, and liability insurance claims.
Omnibus Budget Reconciliation Act of 1981 (OBRA)	10-01-81 01-01-82	OBRA made Medicare benefits secondary to employer group health plans during <sup>a period of up to</sup> the first 12 months of entitlement for beneficiaries with end stage renal disease (ESRD).
Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA)	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) Section 2301)	01-01-85	DEFRA broadened the definition of working aged by including spouses age 65 through 69 of employed individuals under age 65, thereby removing the lower age limit <sup>for the</sup> employed individual.
Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)	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 1986)	01-01-87	OBRA 1986 made Medicare the secondary payer <sup>for certain</sup> <del>the</del> disabled beneficiary or family member covered under an EGHP and an employer in that group has at least <del>100</del> employees. (a plan with at least one employer of 100 employees).
Omnibus Budget Reconciliation Act of 1989 (OBRA 1989)	12- <sup>20</sup> <del>19</del> -89	OBRA 1989 required IRS, SSA, and HCFA to exchange information annually to help improve the identification of Medicare beneficiaries who are covered by private insurance.
Omnibus Budget Reconciliation Act of 1990 (OBRA 1990)	11-5-90	OBRA 1990 extended: 1) the period that Medicare benefits are secondary to an EGHP for ESRD beneficiaries from 12 to 18 months, and 2) the OBRA 1989 data exchange authority from September 30, 1991 to September 30, 1995.