Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

Unidentified Primary Health Insurance: Medicare Secondary Payer Auxiliary File

JUNE GIBBS BROWN
Inspector General

JUNE 2000
OEI-07-98-00180

OFFICE OF INSPECTOR GENERAL

The mission of the Office of Inspector General (OIG) mandated by Public Law 95-452 as amended by Public Law 100-504, is to protect the integrity of the Department of Health and Human Services programs as well as the health and welfare of beneficiaries served by them. This statutory mission is carried out through a nationwide program of audits, investigations, inspections, sanctions, and fraud alerts. The Inspector General informs the Secretary of program and management problems and recommends legislative, regulatory, and operational approaches to correct them.

Office of Evaluation and Inspections

The Office of Evaluation and Inspections (OEI) is one of several components of the Office of Inspector General. It conducts short-term management and program evaluations (called inspections) that focus on issues of concern to the Department, the Congress, and the public. The inspection reports provide findings and recommendations on the efficiency, vulnerability, and effectiveness of departmental programs.

OEI's Kansas City office prepared this report under the direction of James H. Wolf, Regional Inspector General and Brian Pattison, Deputy Regional Inspector General. Principal OEI staff included:

REGION

Linda Paddock, *Project Leader*
Tim Dold, *Team Leader*
Hugh Owens, *Program Analyst*
Deborah Walden, *Program Analyst*
Dennis Tharp, *Program Analyst*
Mike Craig, *Program Analyst*

HEADQUARTERS

Stuart Wright, *Associate Director*
Barbara Tedesco, *Mathematical Statistician*
Linda Moscoe, *Program Analyst*

To obtain copies of this report, please call the Kansas City Regional Office at (816) 426-3697.
Reports are also available on the World Wide Web at our home page address:

http://www.dhhs.gov/progorg/oei

EXECUTIVE SUMMARY

PURPOSE

To determine whether Medicare beneficiaries included in the Health Care Financing Administration's (HCFA) Medicare Secondary Payer (MSP) Auxiliary File have undetected health insurance which is primary to Medicare.

BACKGROUND

Medicare provides health care coverage for eligible beneficiaries age 65 and older, certain individuals under 65 who are disabled, and individuals with kidney failure. However, it is not always the primary insurance payer. In general, Medicare is a secondary payer to:

- coverage under a group health plan provided by an employer of 20 or more persons of working beneficiaries age 65 or older or their spouses;
- coverage under a group health plan provided by an employer of 100 or more persons based on the current employment of disabled beneficiaries or their family members;
- group health plan coverage of beneficiaries who have end stage renal disease during their first 30 months of Medicare eligibility or entitlement; and
- coverage under an automobile, no-fault, liability insurance, or workers' compensation plan.

Providers and Medicare contractors share in the various tasks of primary health insurance detection including the retrieval of primary insurance information for the claim, pre-enrollment surveys of beneficiaries, screening claims, profiling trauma procedures for possible liability coverage, and exchanging computer data through matches.

FINDINGS

Overall, Medicare's Secondary Payer (MSP) Auxiliary File Accurately Documents Primary Insurance

Only 0.43 percent (16 of the 3,250) of beneficiaries in our sample with primary health insurance coverage were not identified by Medicare. In our review of these 16 beneficiaries, we found varying factors for Medicare's status as the secondary payer.

For the five beneficiaries found to have calendar year 1997 services inappropriately paid, Medicare made $8,452 in erroneous payments. Projecting these improper payments to our universe of 25 million beneficiaries, we estimate that the Medicare program inappropriately paid approximately $56 million in 1997.

All Medicare initiatives to detect primary health insurance have contributed to the identification of undetected Medicare secondary payer situations. The IEQ is designed to capture all instances of primary coverage that exist when a beneficiary becomes entitled to Medicare; by virtue of this design, it is unable to document MSP events that occur post-entitlement. We found six beneficiaries in our sample who experienced life changes which gave them group health plan coverage subsequent to their completing the questionnaire.

RECOMMENDATIONS

Based on our analysis, we believe that the Medicare Secondary Payer Auxiliary File generally reflects primary insurance sources. However, we did find some instances where other health insurance was undetected, with losses to Medicare of approximately $56 million. Further, as more individuals work beyond age 65 and are covered by both Medicare and private health insurance, early detection of these primary payers becomes even more important. Moreover, because validity indicators existed only for 20.3 million of the 38.5 million Medicare beneficiaries in 1997, a substantial portion of the Medicare population was not included in the scope of our study. As a result, we do not know the extent of undetected primary coverage within this group.

We believe that opportunities exist to strengthen the cost effective early detection of other primary health insurance coverage both for those currently in the MSP Auxiliary File and those not in the file. To maximize these detection efforts, we recommend that HCFA

Emphasize to Providers the Importance of Reporting Timely Employment and Health Insurance Information

The HCFA should emphasize to providers the requirement that they obtain employment and insurance coverage information during each beneficiary visit, and code the primary payer portion of the claim accordingly. This information is vital to the initial detection of changes in beneficiary health insurance coverage.

Increase the Response Rate for the Initial Enrollment Questionnaire

To the extent that beneficiaries do not respond to the Initial Enrollment Questionnaire, the odds that Medicare will pay for medical care covered by other insurance may be increased. HCFA could do any one or several of the following to increase the response rate.

- Conduct a second follow-up 6 months to 1 year after entitlement.
- Conduct the second follow-up as a pilot to test the increase in Initial Enrollment Questionnaire responses.
- Conduct a telephone survey of beneficiaries not responding to the Initial Enrollment Questionnaire in order to determine the reasons for non-response and to improve the questionnaire.

AGENCY COMMENTS

We solicited and received comments on our draft report from HCFA. The HCFA states that, based upon our findings, they are correctly identifying primary insurance for nearly 99.6 percent of the 40 million Medicare beneficiaries. Again, we must caution that our findings can only be projected to the approximately 20.3 million living beneficiaries contained in Medicare's Secondary Payer Auxiliary File. The use of this file does not permit projecting to all Medicare beneficiaries, but only those with records in this file.

HCFA generally concurs with our recommendations that opportunities exist to strengthen early detection of other primary health insurance coverage. They also indicate work has been initiated with the new Coordination of Benefits contractor, which will emphasize to providers the requirement to obtain employment and health insurance information during each beneficiary visit.

We are pleased that HCFA continues to seek out opportunities to strengthen the MSP process and recognize the positive efforts being made through the new Coordination of Benefits contract. We believe the results from a telephone survey of IEQ non-respondents should provide valuable information as to the extent of follow-up efforts that would be productive in ensuring the up-front response to the IEQ. The full text of HCFA's comments are included in Appendix D.

TABLE OF CONTENTS

PAGE

EXECUTIVE SUMMARY 1

INTRODUCTION 5

FINDINGS

Overall, MSP Auxiliary File Accurately Documents Primary Insurance 13

RECOMMENDATIONS 18

APPENDICES

A: Non-respondent Analysis 20

B: Estimates and Confidence Intervals 24

C: Medicare Payments Where Primary Insurance Exists 25

D: Agency Comments 26

INTRODUCTION

PURPOSE

To determine whether Medicare beneficiaries included in the Health Care Financing Administration's (HCFA) Medicare Secondary Payer (MSP) Auxiliary File have undetected health insurance which is primary to Medicare.

BACKGROUND

Medicare was enacted in 1965 to pay for health care services provided to eligible beneficiaries age 65 and older, and certain individuals under 65 who are disabled or have kidney failure (end stage renal disease). Medicare provides coverage under two parts. Part A, hospital insurance, covers inpatient hospital services, skilled nursing home services, home health services, and various other institutional services. Part B, supplemental medical insurance, covers physician, outpatient hospital, and other necessary health services such as diagnostic tests.

The Health Care Financing Administration (HCFA), within the Department of Health and Human Services (HHS), administers the Medicare program by establishing policies, developing operating guidelines, and ensuring compliance with Medicare law and regulations. The HCFA contracts with insurance companies, called intermediaries under Part A, and carriers under Part B, to process and pay claims for covered services. They also perform other administrative and operational tasks, such as reviewing claims, and ensuring that any incorrect payments are identified and returned to the Medicare program.

Although Medicare provides health care coverage for the above referenced individuals, it is not always the primary insurance payer. Growing concern for rising Medicare program costs resulted in the passage of a series of statutory provisions which established Medicare as the secondary payer (MSP) to other private health care insurers in certain situations. In general, Medicare is a secondary payer to:

- coverage under a group health plan (GHP) provided by an employer of 20 or more persons for working beneficiaries age 65 or older or their spouses;
- coverage under a group health plan provided by an employer of 100 or more persons based on the current employment of disabled beneficiaries or their family members;
- group health plan coverage of beneficiaries who have end stage renal disease during their first 30 months of Medicare eligibility or entitlement; and
- coverage under an automobile, no-fault, liability insurance, or workers' compensation plan.

The Health Care Financing Administration is responsible for the implementation of the various MSP provisions. In this role, it educates others about the laws; issues regulations, policy, and operational guidelines; delegates to its Medicare contractors various tasks to detect primary insurance coverage; develops and disseminates tools to enable contractors to better perform their responsibilities; and monitors the performance of the contractors in achievement of their assigned MSP functions.

The most effective way to prevent mistaken Medicare payments is through early identification of beneficiaries with group health plan coverage. When employer group health insurance is identified before Medicare payments for services are made, claims are directed to that insurance company as the primary insurance payer. Medicare has established the following responsibilities related to detection of primary insurance situations.

Provider Responsibilities

Part A procedures require institutional providers to obtain data on beneficiaries' health insurance coverage to identify other insurers who should reimburse health care services prior to Medicare's payment. This is accomplished through use of a series of questions designed to ensure that all hospitals collect similar information regarding potential primary payment sources. In the event that a provider receives payments from both Medicare and a group health plan, they are obligated to refund the Medicare payment.

Part B procedures require non-institutional providers to ask Medicare beneficiaries a series of questions to determine if other health insurance coverage exists as part of each medical service. If other health insurance coverage is identified, providers must bill that insurance company as the primary payer or make adjustments for any duplicate Medicare payments.

Contractor Responsibilities

The HCFA requires contractors to identify MSP claims prior to payment to prevent the more costly and time-consuming task of recovering inappropriate payments. Medicare contractors are required to:

- notify providers of appropriate procedures for properly billing MSP claims;
- audit providers for compliance with billing procedures;
- screen all claims for coverage by another insurer;
- review all claims containing a diagnosis code indicating trauma which may have resulted from an automobile or work-related accident; and
- add, delete, and otherwise maintain MSP data on CWF's MSP Auxiliary File as new information becomes available and in this way share primary insurance information with other contractors.

HCFA Initiatives

The HCFA has undertaken the following initiatives to identify health insurance that should pay primary to Medicare:

Initial Enrollment Questionnaire Since 1995, HCFA has contracted with Douglas Consulting and Computer Services to survey Medicare beneficiaries for available health insurance coverage. An Initial Enrollment Questionnaire (IEQ) is mailed to beneficiaries 3 months before Medicare entitlement begins. This questionnaire, which is voluntary, asks beneficiaries about their employment status, other health insurance coverage, spouse's employment status, age, and any health insurance coverage purchased through their employer. If the beneficiary does not return the questionnaire within 45 days, a follow-up survey is sent. If the information provided in response to the questionnaire is incomplete or inconsistent, the contractor contacts the beneficiary by telephone. The contractor reported that 70 percent of the surveys are initially returned, which increased to 79 percent after follow-up. If primary health insurance coverage is detected, an indicator of primary health insurance coverage is then electronically integrated with the Common Working File, Medicare's central claims processing file. Where a definitive determination about the absence of MSP is made a result of the IEQ process, a "N" validity code indicator is entered on the CWF MSP Auxiliary File record. In 1997, HCFA estimated this process was instrumental in the annual identification of 110,000 cases of third party health insurance, which generated an estimated annual Medicare Program savings of $425 million.

First Claim Development The Common Working File electronically notifies contractors when the first claim after Medicare entitlement is submitted on behalf of a beneficiary. This process, called "first claim development", is performed by all Medicare intermediaries and carriers. Since 1987, individuals completing Medicare claims are asked to designate if other health insurance exists. If no MSP information is included on the first Medicare claim, the contractor processes it. They then mail a questionnaire to the beneficiary or the servicing provider to determine if the beneficiary or their spouse is covered under a group health plan and make payment adjustments, as necessary, based on the information so received.

IRS/SSA/HCFA Data Match The Omnibus Budget Reconciliation Act of 1989 authorized an exchange of information between the Social Security Administration (SSA) and the Internal Revenue Services (IRS). These computer data exchanges identify beneficiaries or their spouses who are employed and may have health insurance coverage through a group health plan. Through this initiative, the IRS links the names and Social Security numbers of each individual filing joint or separate married income tax returns, and SSA identifies beneficiaries or spouses with earnings posted to their records. The SSA provides employer names and addresses for these beneficiaries to the HCFA contractor, Group Health Incorporated of New York. The contractor develops information about other health insurance coverage and adds, deletes, and otherwise updates the CWF MSP Auxiliary File to reflect the data about other health insurance coverage that it receives pursuant to the IRS/SSA/HCFA Data Match.

Prospective Data Sharing This initiative stems from a 1995 settlement agreement between HCFA and a number of private insurers (The Blue Cross and Blue Shield Association, Blue Cross Blue Shield of Florida, Blue Cross Blue Shield of Massachusetts, Blue Cross Blue Shield of Michigan, Transamerica, and Travelers Insurance Company) over disputed payments for Medicare beneficiaries. A major element of this agreement was the creation of a 3 year data exchange program between these insurance companies and Medicare. Provisions called for sharing private health insurance information with Medicare to identify MSP situations before claims were paid. The Health Care Financing Administration estimates this initiative saved Medicare approximately $720 million in Fiscal Year 1997. The GAO recently found that since 1995, case settlements in which a related company was also a Medicare contractor totaled almost $66 million, with an additional $98 million in claims filed against current and former contractors. These companies processed over 85 percent of all Part A claims, and 60 percent of all Part B claims.

Coordination of Benefits Contract This latest initiative, awarded a multi-year contract in November 1999 to Group Health Incorporated of New York. In this role, Group Health Incorporated will consolidate activities to support the collection, management, and reporting of all health insurance coverage of Medicare beneficiaries for the purpose of implementing an improved plan for coordinating Medicare benefits with all other insurance coverages. These activities include:

- Initial Enrollment Questionnaire
- IRS/SSA/HCFA Data Match
- Voluntary Data Matches through negotiations with employers and other insurers to exchange eligibility information on Medicare beneficiaries
- First Claim Development
- MSP Claims Investigations
- Coordination of Benefits Agreements between HCFA and other health insurers for the exchange of eligibility and paid claims data
- Maintenance of the Common Working File MSP Auxiliary File
- Customer service through a staff charged with validating insurance information, resolving discrepant information and electronically updating beneficiary records

Other Initiatives In addition, Medicare has implemented the following processes:

- establishing secondary payer units within contractors;
- improving education and training for providers and beneficiaries;
- incorporating beneficiary MSP information into the national beneficiary entitlement and utilization data housed on the Common Working File;
- establishing procedures for administrative sanctions of up to triple the amount of damages where Medicare made a primary payment when group health plans were obligated to pay as the primary insurer.

Prior GAO and OIG Work

Numerous reports have been issued by the HHS Office of Inspector General (OIG) and General Accounting Office (GAO)[1] which describe problems associated with the identification of other primary health insurance. These reviews found deficiencies in internal management controls and identified MSP as a material weakness. These reports also noted the conflict of interest when Medicare contractors function as both the Medicare claims processor and the private insurer of Medicare beneficiaries who have additional health insurance.

In a 1991 OIG study entitled "Extent of Unrecovered Medicare Secondary Payer Funds," (OEI-07-90-00760), 4,300 beneficiaries were surveyed regarding their medical insurance coverage. The OIG identified primary insurance coverage for 34 beneficiaries (33 with a group health plan and 1 with auto accident insurance) for an actual loss of $60,502, which projected to an estimated Medicare program loss of over $637 million for calendar year 1988.

In a recently issued audit report[2] the OIG found that based upon the IRS/SSA/HCFA data match from 1991 through 1997, HCFA does not have group health plan information for over one million employees. This resulted in the OIG identifying potential savings of approximately $282 million where claims were paid but a primary payer may have existed with liability other than Medicare.

METHODOLOGY

We researched Federal laws, regulations, and Medicare policies addressing the identification and reimbursement of claims for beneficiaries who have coverage through an employer group health plan. We gathered additional information through interviews with a local Medicare intermediary, the Initial Enrollment Questionnaire contractor, and HCFA staff responsible for oversight of the various MSP provisions.

To determine the extent of undetected primary health insurance coverage in HCFA's Medicare Secondary Payer Auxiliary File, we surveyed a stratified sample of beneficiaries in the data system in 1998. This file, which contained approximately

[1]GAO/HEHS-99-115, "Medicare Contractors - Despite Its Efforts, HCFA Cannot Ensure Their Effectiveness or Integrity," July 1999.

[2]"Follow-up Review of the Health Care Financing Administration's Efforts to Assure Employer Group Health Plan Compliance with Medicare Secondary Payer Data Match Requirements," A-02-98-01036, February 2000.

25 million beneficiaries, is housed within the Medicare Common Working File. We also obtained Medicare utilization records from Medicare's 1997 National Claims History file to verify services received by these beneficiaries.

The Common Working File maintains complete claim and entitlement data for all Medicare beneficiaries. When an intermediary or carrier receives a claim, it processes the claim to the point of payment or denial, using data from its own files and information on the claim. Claims are then processed against the Common Working File system to verify utilization and entitlement and check MSP edits to determine whether the claim should be approved for payment.

The MSP auxiliary record is established as a product of the IEQ process or the processing of a Medicare claim. The Common Working File checks its MSP Auxiliary File for the existence of an MSP record, then for relevant data within that record where one exists, before processing claims to adjudication. This procedural flow is used to assure that claims are validated against the most recent primary insurance coverage data.

The Common Working File also updates the MSP Auxiliary File through transactions from contractors and from information provided to HCFA by SSA. The Common Working File and auxiliary file contain a validity indicator field which denotes confirmation that: (1) another insurer other than Medicare is responsible for payment ("Y" in the field), (2) Medicare is the primary payer ("N" in the field), or (3) absence of a "Y" or "N" indicates absence of an MSP.

Our sample included both persons eligible for Medicare due to age 65 as well as those entitled due to disability or end stage renal disease. We categorized the population contained in the MSP Auxiliary File into two strata:

- Stratum 1 - Beneficiaries receiving an IEQ and responding to it, and
- Stratum 2 - All other beneficiaries. This includes beneficiaries either not responding to the questionnaire or never receiving the survey because their entitlement date for Medicare occurred before the Initial Enrollment Questionnaire process began.

We stratified our sample under the assumption that beneficiaries who do not return their Initial Enrollment Questionnaire surveys are more likely to have undetected primary health insurance. We therefore weighted our sample by selecting 35 percent of the sample beneficiaries from Stratum 1 and 65 percent from Stratum 2.

We were aware that the total population in the MSP Auxiliary File contained deceased individuals. We did not survey deceased individuals and they were excluded from our sample popluation. The number of beneficiaries for analysis was 3,250 based on exclusion of deceased beneficiaries and a response rate less than 100 percent.

TABLE 1

Beneficiary Sample Selection

Sample Category	Stratum 1 IEQ Respondents	Stratum 2 All Others	Total
Total Population	2,692,816	22,388,885	25,081,701
Estimated Deceased	102,327	4,701,666	4,803,993
Estimated Population After Excluding Deceased	2,590,489	17,687,219	20,277,708
Random Sample	1,811	3,364	5,175
Sample Deceased	68	703	771
Sample Beneficiaries	1,549	2582	4,131
Sample Beneficiaries Who Responded To Our Survey	1,288	1,962	3,250

As noted above, we developed and mailed surveys to 4,131 beneficiaries, soliciting information about the beneficiary or their spouse's work status in 1997; eligibility for end stage renal disease, Black Lung, Workers Compensation, and disability benefits; and other medical insurance coverage information. We asked beneficiaries to provide us with the names, addresses, and phone numbers of employers and insurance companies where appropriate. A total of 3,250 beneficiaries (1,288 and 1,962 from Stratum 1 and Stratum 2, respectively) returned our survey. This represents a 79 percent response rate.

When responses to our survey identified the potential for additional primary health insurance coverage, we conducted a sequence of steps to determine whether improper Medicare payments had been made. These included:

- retrieving utilization information from the Medicare's Common Working File;
- obtaining secondary payer information from the MSP Auxiliary portion of the Common Working File to determine if Medicare contractors had detected primary health insurance;
- conducting telephone interviews with beneficiary employers and insurance companies to determine eligibility for coverage in 1997 under a group health plan;
- determining the amount payable by the group health plan considering deductibles and coinsurances; and
- calculating improper Medicare payments.

We also extracted demographic information retrieved from HCFA's Enrollment Database for use in preparing a non-respondent analysis (See Appendix A.) While the focus of this study involves services rendered in 1997, the Common Working File also contained information on 1998 and 1999 claims billed to Medicare.

We conducted our review in accordance with the ***Quality Standards for Inspections*** issued by the President's Council on Integrity and Efficiency.

FINDINGS

Overall, Medicare's Secondary Payer (MSP) Auxiliary File Accurately Documents Primary Insurance

We examined Medicare's Secondary Payer Auxiliary File which contained information about approximately 20.3 million living beneficiaries in 1997. Each beneficiary record in this file has an MSP validity code showing whether a primary payer other than Medicare existed or not. Our purpose was to determine the accuracy of the data in this file. The use of the Auxiliary File does not permit projecting to all Medicare beneficiaries, but only those with records in this file.

Undetected Coverage

Only a small number of beneficiaries having primary insurance in our sample were undetected by Medicare. Of the 3,250 beneficiaries who returned our survey, 7 percent (241) had additional insurance which was primary to Medicare. We found HCFA processes had previously identified 93 percent of these individuals (225 of the 241) as having a primary insurance. In addition, 101 of these 225 beneficiaries with primary insurance coverage responded to the Initial Enrollment Questionnaire. The remaining 124, while not receiving, or if received, not responding to the Initial Enrollment Questionnaire, were nonetheless detected by Medicare as having primary insurance coverage.

The remaining 16 beneficiaries, or 0.43 percent of our population had primary health insurance coverage which had not been detected by Medicare. For those 16 individuals, we determined Medicare should be secondary payer for

- seven beneficiaries age 65 or older who were working or had a working spouse.
- eight disabled beneficiaries who were working or had a working spouse.
- one beneficiary covered by automobile liability insurance.

Table 2 on the following page summarizes the sampled beneficiaries' responses, and the beneficiaries found to have primary insurance coverage. It also reflects the various weighted percentages in calculation of these figures.

TABLE 2

Beneficiaries with Primary Insurance Other Than Medicare

Category	1997 Study
Total Surveys Mailed	4,131
Total Surveys Returned	3,250
Number of Survey Respondents with Primary Insurance Other Than Medicare	241
Number of Survey Respondents with Primary Insurance Other Than Medicare Whose Coverage Was Not Identified by HCFA	16
Percentages*	
Percent of All Beneficiaries with Records in the MSP Auxiliary File with Primary Insurance Other Than Medicare (weighted projection)	7%
Percent of All Beneficiaries with Records in the MSP Auxiliary File with Primary Insurance Other Than Medicare Whose Coverage Was Not Identified by HCFA (weighted projection)	0.43%
Percent of All Beneficiaries with Records in the MSP Auxiliary File with Primary Insurance Whose Coverage Was Not Identified by HCFA	6%

* Confidence intervals are shown in Appendix B

For analysis purposes, we divided our original sample (4,131) and survey responses (3,250) into three groups: group I consists of beneficiaries receiving an Initial Enrollment Questionnaire and returning it; group II reflects beneficiaries receiving the questionnaire and not returning it; and group III covers beneficiaries that never received the survey because their Medicare entitlement date preceded implementation of the questionnaire process, but they responded to our survey. The results of our analysis are shown in Table 3 on the following page and are discussed further in the following findings.

TABLE 3

Survey Responses

Group	Sampled Beneficiaries	Returned Our Survey
I - Responded to IEQ	1,549	1,288
II - Did not respond to IEQ	454	429
III - Did not receive IEQ	2,128	1,533
Total	4,131	3,250

We believe that Medicare initiatives to detect primary insurance coverage situations have contributed to the identification of undetected primary payer coverage. A number of initiatives have been implemented since our 1991 report which have had a positive impact. Despite being unable to quantify the level of impact of specific HCFA initiatives, we believe that the percentage of beneficiaries for which primary insurance payers were detected demonstrates the Initial Enrollment Questionnaire process is an effective mechanism.

Dollars Lost

Of the 16 beneficiaries in our sample with undetected primary health insurance coverage, we found 5 received medical services which were inappropriately billed and paid by Medicare in calendar year 1997, totaling $8,452. Projecting these improper payments to the total number of beneficiaries in the MSP Auxiliary File, we estimate the Medicare program inappropriately paid approximately $56 million in 1997. At the 90 percent confidence level, this amount ranges between $8,452 and $139 million. The $56 million is only 0.056 percent of the $99 billion in benefits which Medicare paid on behalf of beneficiaries with a record in the MSP Auxiliary File in 1997. In fact, we estimate Medicare also paid $108 billion for the 18 million beneficiaries not in the Auxiliary File, and for which improper payments could have been made.

Appendix C provides a summary of data related to these losses to the Medicare program in 1997 and subsequent instances of undetected primary coverage in 1998 and 1999.

Initial Enrollment Questionnaire

The Initial Enrollment Questionnaire is among the recent Medicare initiatives to identify primary insurance payment sources. The results of our survey look at the effects of this initiative and are presented in Table 4 which is broken down by whether the beneficiary

responded to the questionnaire, received but did not respond, or did not receive the questionnaire.

TABLE 4

Initial Enrollment Questionnaire Responses

Beneficiary	Group	Spousal Coverage	Medicare Entitlement Type	Medicare Entitlement Date	Insurance Began	1997 Dollars
A	I	No	Aged	1997	1996	$0
B	I	No	Aged	1997	1997	$0
C	I	Yes	Aged	1995	1994	$0
D	I	No	Disabled	1996	1997	$0
E	I	Yes	Disabled	1995	1997	$0
F	I	Yes	Disabled	1995	1979	$0
G	I	Yes	Disabled	1997	1995	$0
H	I	Yes	Disabled	1996	1994	$0
I	II	No	Aged	1996	1994	$309
J	II	No	Disabled	1997	1998	$0
K	II	Yes	Disabled	1995	1997	$0
L	III	No	Aged	1992	1989	$395
M	III	No	Aged	1993	1997	$6,732
N	III	Yes	Aged	1991	1997	$0
O	III	No	Disabled	1985	1995	$797
P	III	No	Auto	1993	N/A	$219

Group I Responded to IEQ
Group II Received but did not respond to IEQ
Group III Did not receive IEQ (as entitlement date proceeded IEQ implementation)

HCFA's initiatives seem to be effective. But, because the instances of unidentified insurance and the actual lost revenues to Medicare were so low, we were unable to distinguish the effects of the Initial Enrollment Questionnaire from all other initiatives. However, the table above clearly indicates that the questionnaire does not identify all instances of primary health insurance coverage.

Our analysis established that the Initial Enrollment Questionnaire did not always identify primary insurance coverage for the following reasons:

- Five beneficiaries did not receive an Initial Enrollment Questionnaire because their entitlement to Medicare occurred before the questionnaire process began.

- Three beneficiaries did not respond to the Initial Enrollment Questionnaire. The contractor reports a 70 percent response rate to the first mailing of the questionnaire. This improves to 79 percent after a follow-up. Nonetheless, we identified 338 beneficiaries (338 of 2582, or 13 percent) who responded to our request but had not responded to the questionnaire or the contractor's follow-up. We also found that of the 454 beneficiaries not responding to the questionnaire, 104 (23 percent) did not respond to our survey. The questionnaire is sent to all newly enrolled beneficiaries within 3 months of their entitlement to Medicare.

  As previously noted, of the five beneficiaries found to have group health coverage with medical services billed to Medicare in 1997, one had not responded to the Initial Enrollment Questionnaire. Additionally, 1 of the 11 beneficiaries we found who had primary insurance coverage but no 1997 Medicare services, did not respond to it.

- Employment and group health plan coverage circumstances can change after the Initial Enrollment Questionnaire is submitted. In fact, 6 of the 15 beneficiaries we identified with group health plan coverage had changes in employment or marital status subsequent to Medicare entitlement.

- Five beneficiaries in our sample with undetected primary payer situations completed the Initial Enrollment Questionnaire, with Medicare payment records indicating that they had no group health plan coverage. For these individuals, our review identified they had primary insurance at the time they completed the questionnaire. While we could not verify specific reasons for the discrepancies, as source documents are not available, we surmise that reporting differences may be the result of erroneous information provided by the beneficiary, or errors in data entry from the initial questionnaire.

RECOMMENDATIONS

Based on our analysis, we believe that the Medicare Secondary Payer Auxiliary File generally reflects primary insurance sources. However, we did find some instances where other health insurance was undetected, with losses to Medicare of approximately $56 million. Moreover, because validity indicators existed only for 20.3 million of the 38.5 million Medicare beneficiaries in 1997, a substantial portion of the Medicare population was not included in the scope of our study. As a result, we do not know the extent of undetected primary coverage within this group.

We believe that opportunities exist to strengthen the cost effective early detection of other primary health insurance coverage both for those currently in the MSP Auxiliary File and those not in the file. To maximize these detection efforts, we recommend that HCFA

Emphasize to Providers the Importance of Reporting Timely Employment and Health Insurance Information

The HCFA should emphasize to providers the requirement that they obtain employment and insurance coverage information during each beneficiary visit, and code the primary payer portion of the claim accordingly as part of their continuing provider education efforts. The ongoing and timely collection of this information is vital to the initial detection of changes in beneficiary health insurance coverage and should decrease the likelihood that claims will be paid subject only to detection in post payment processes.

Increase the Response Rate for the Initial Enrollment Questionnaire

It is clearly advantageous to identify primary coverage at the earliest opportunity, thus preventing inappropriate primary payments by Medicare. Further, as more individuals work beyond age 65 and are covered by both Medicare and private health insurance, early detection of these primary payers becomes even more important. To the extent that beneficiaries do not respond to the Initial Enrollment Questionnaire, the odds that Medicare will pay for medical care covered by other insurance may be increased. HCFA could do any one or several of the following to increase the response rate.

- Conduct a second follow-up 6 months to 1 year after the onset of entitlement, for those beneficiaries who have not received services and, therefore, were not asked to complete first claim development. Because we found 6 of 15 beneficiaries with primary coverage subsequent to Medicare entitlement, this postponement may also

permit detection of beneficiary changes in employment or marital status subsequent to entitlement.

- Perform the second follow-up as a pilot to test the effectiveness of this approach for increasing responses generated by the additional request sent at either the 6th month or anniversary of entitlement.

- Conduct a telephone survey of a sample of beneficiaries not responding to the initial questionnaire or its follow-up in order to determine the reasons for non-response and to improve the questionnaire.

Agency Comments

We solicited and received comments on our draft report from HCFA. The HCFA states that, based upon our findings, they are correctly identifying primary insurance for nearly 99.6 percent of the 40 million Medicare beneficiaries. Again, we must caution that our findings can only be projected to the approximately 20.3 million living beneficiaries contained in Medicare's Secondary Payer Auxiliary File. The use of this file does not permit projecting to all Medicare beneficiaries, but only those with records in this file.

HCFA generally concurs with our recommendations that opportunities exist to strengthen early detection of other primary health insurance coverage. They also indicate work has been initiated with the new Coordination of Benefits contractor, which will emphasize to providers the requirement to obtain employment and health insurance information during each beneficiary visit.

We are pleased that HCFA continues to seek out opportunities to strengthen the MSP process and recognize the positive efforts being made through the new Coordination of Benefits contract. We believe the results from a telephone survey of IEQ non-respondents should provide valuable information as to the extent of follow-up efforts that would be productive in ensuring the up-front response to the IEQ. The full text of HCFA's comments are included in Appendix D.

APPENDIX A

Analysis of Respondents vs. Non-respondents

A consideration in surveys of this type is that the results may be biased if non-respondents are different from respondents. To test for the presence of any bias, we compared responders with non-responders, for certain variables, in an attempt to determine how any observed differences might affect the results. We compared age, sex, and disabled vs. aged for each of the two strata sampled. Our analysis (Tables 1-5) demonstrate no significant differences between these two groups.

Tables 1 and 2 below give the breakdown of the sample by sex for each of the two strata, responded to the Initial Enrollment Questionnaire and did not respond to the Initial Enrollment Questionnaire.

Table 1

Responded to IEQ by Sex

	Respondents		**Non-respondents**	
Sex	n	%	n	%
Male	599	46.5	119	45.6
Female	689	53.5	142	54.4
Total	1288		261	

Chi-square= .078 not significant
df=1

Table 2

Did Not Respond to IEQ by Sex

	Respondents		**Non-respondents**	
Sex	n	%	n	%
Male	912	46.5	291	46.9
Female	1050	53.5	329	53.1
Total	1962		620	

Chi-square=.040 not significant
df=1

Tables 3 and 4 show a comparison of the average age of each respondent type for each of the two strata sampled, respondents to the Initial Enrollment Questionnaire and non-respondents to the questionnaire. A t-test was used to determine if a difference occurred between responders and non-responders.

Table 3

Responded to IEQ by Age

	n	Mean Age	Std. Dev.	Std. Error
Responders	1288	64.9	5.72	.16
Non-Responders	455	64.7	6.77	.42

t= .32 not significant

Table 4

Did Not Respond to IEQ by Age

	n	Mean Age	Std. Dev.	Std. Error
Responders	1962	68.5	11.1	.25
Non-Responders	620	67.3	12.7	.51

t=1.98 significant at .05 level

The t-test showed a significant difference between the ages of responders vs. non-responders within the strata for those who did not respond to the Initial Enrollment Questionnaire. Therefore, the average age of the responders to our survey was slightly greater than the average age on those who did not respond to our survey. Since by definition, the disabled population is younger than the aged (Medicare defines all disabled as being under 65), a further analysis was done by aged vs. disabled for only the strata containing the questionnaire non-respondents. It is given in Table 5 on the following page.

Table 5

Did Not respond to IEQ by Disabled vs. Age

	Respondents		**Non-respondents**	
Category	n	%	n	%
Aged	1553	79.2	472	76.1
Disabled	409	20.8	148	23.8
Total	1962		620	

Chi-square=2.55 - not significant
df=1

Appendix B

Estimates And Confidence Intervals

The chart below summarizes the estimated proportions and the confidence intervals for key statistics presented in this report. The estimates refer to the percentage of survey respondents with primary insurance other than Medicare.

Survey Respondents	Weighted Percent	90 % Confidence Interval
Percent of All Beneficiaries with Records in the MSP Auxiliary File with Primary Insurance Other Than Medicare	7%	6% - 8%
Percent of All Beneficiaries with Records in the MSP Auxiliary File with Primary Insurance Other Than Medicare Whose Coverage Was Not Identified by HCFA	0.43%	0.22% - 0.65%
Percent of All Beneficiaries with Records in the MSP Auxiliary File with Primary Insurance Whose Coverage Was Not Identified by HCFA	6%	3.1% - 9.3%

APPENDIX C

Medicare Payments Where Primary Insurance Exists

	Identified Savings 1997	1998	1999	Notes
6 Working Aged Beneficiaries				
2 of which did not receive the IEQ	$ 395	$ 396	Not elig	MSP ended 8/31/98
	$6,732	$ 3	Not elig	MSP ended 8/1/98
1 of which did not respond to the IEQ	$ 309	$ 279	Not elig	MSP ended 1/1/99
3 of which responded to IEQ	No svcs	No svcs	Potential dollars*	MSP ended 7/1/99
	No svcs	No svcs	Not elig	MSP ended 6/30/98
	No svcs	No svcs	Potential dollars*	MSP continues
1 Beneficiary with a Working Aged Spouse did not receive the IEQ	No svcs	Not elig	$ 119	Elig 2/97 and 1-6/99
3 Working Disability Beneficiaries				
1 of which did not receive the IEQ	$ 797	$ 757	$ 228	MSP continues
1 of which did not respond to the IEQ	Not elig	No svcs	Potential dollars*	MSP continues
1 responded No to IEQ in 1996	No svcs	No svcs	Potential dollars*	MSP continues
5 Disability Beneficiaries with Working Spouses				
1 of which did not respond to the IEQ	No svcs	No svcs	Potential dollars*	MSP continues
2 of which responded to the IEQ in 1995	No svcs	No svcs	Potential dollars*	MSP continues
	No svcs	No svcs	Potential dollars*	MSP continues
2 of which responded to the IEQ in 1996	No svcs	No svcs	Potential dollars*	MSP continues
	No svcs	$13,420	Not elig	MSP ended 10/1/98
1 Aged Beneficiary with Auto Accident in 1997	$ 219			

*Possible dollar loss

APPENDIX D

Agency Comments

DEPARTMENT OF HEALTH & HUMAN SERVICES Health Care Financing Administration

The Administrator
Washington, D.C. 20201

DATE: JUN 1 2 [illegible]

TO: June Gibbs Brown
Inspector General

FROM: Nancy-Ann Min DeParle
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "Unidentified Primary Health Insurance: Medicare Secondary Payer Auxiliary File," (OEI-07-98-00180)

Thank you for the opportunity to review the above-mentioned report. We appreciate the OIG's acknowledgment of the overall accuracy of the Medicare Secondary Payer (MSP) Auxiliary File, and of the relatively low number of Medicare beneficiaries with Medicare improperly identified as their primary health insurance coverage. HCFA has taken steps to strengthen our Medicare Secondary Payer Auxiliary File and our data match as well. HCFA has established effective procedures to assure that all employer group health plans respond to requests for information as part of the MSP data match, including the assessment of civil monetary penalties (CMPs).

This report concluded that only .43 percent of beneficiaries with primary insurance were not identified by Medicare. That means that we are correctly identifying this information for nearly 99.6 percent of the 40 million Medicare beneficiaries. While this shows that we have had significant success in identifying correctly who should pay each claim, we remain committed to taking further steps to improve our results and strengthen the Medicare program.

Last year, we hired a new national Coordination of Benefits (COB) contractor who will coordinate our efforts to ensure private companies pay their share of Medicare beneficiaries' health care bills. By consolidating these efforts into a single contract, HCFA also expects to improve service to Medicare beneficiaries, health care providers, insurance companies, and employers. The contract will also help Medicare increase the roughly $3 billion that Medicare saves each year by ensuring that private insurance companies pay their share of Medicare beneficiaries' health care bills.

Our response to the OIG recommendations are as follows:

OIG Recommendation

HCFA should emphasize to providers the importance of reporting timely employment and health insurance information.

HCFA's Response

We concur. HCFA's Coordination of Benefits contract (COB), which was awarded in November 1999, details the development and implementation of an MSP Outreach and Education program for our coordination of benefits partners. These partners include Medicare beneficiaries and providers, as well as health plans, employers, and attorneys. We will also emphasize these points during other provider education activities.

OIG Recommendation

HCFA should increase the response rate for the Initial Enrollment Questionnaire (IEQ) by any one or several of the following steps:

- Conducting a second follow-up 6 months to 1 year after entitlement.
- Conducting a second follow-up as a pilot to test the increase in the IEQ responses.
- Conducting a telephone survey of beneficiaries not responding to the IEQ in order to determine the reasons for non-response and to improve the questionnaire.

HCFA's Response

While we agree with the intent of this recommendation, we believe that our existing protections and the additional steps that we are already taking will achieve the same results. The private contractors that process Medicare claims already send a second questionnaire, called the First Claim Development, to all Part A providers who submit a first claim on a beneficiary who did not respond to the initial mailing. This questionnaire is similar to the IEQ. If a beneficiary's first claim is a Part B claim, the follow-up letter will be sent to the Part B provider under our new national COB contract.

In addition, we have already contracted with The Barents Group and its subcontractor, Sutton Social Marketing, to conduct a study of HCFA's MSP survey tools to determine why some beneficiaries do not respond to the IEQ and, for those who do respond, why their responses may contain inaccuracies. As part of this project, Barents is testing the effectiveness of the IEQ mailing, its useability and readability, and will review the IEQ process to recommend improvements. We are also considering having the COB contractor conduct a telephone survey on non-respondent beneficiaries, as you propose in this recommendation.

Attachment

Technical Comments

On page 1 under "background" (arrow #3), add after Medicare "eligibility or" and similarly, on page 4 under "background" (arrow #3), add after Medicare "eligibility or".

On page 6 under "Initial Enrollment Questionnaire" change the word "primary" to "other" in the following sentence: "This questionnaire, which is voluntary, asks beneficiaries about their employment status, primary health insurance coverage, spouse's employment status, age, and any health insurance coverage purchased through their employer."

On page 8 under "Prior GAO and OIG Work" change "HCFA/IRS/SSA data match" in the third paragraph to "IRS/SSA/HCFA data match".

On page 17 under "Increase the Response Rate for the Initial Enrollment Questionnaire" in the first sentence of the second paragraph change "eligibility" to "entitlement".