Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

EXTENT OF UNRECOVERED MEDICARE SECONDARY PAYER FUNDS

Richard P. Kusserow
INSPECTOR GENERAL

AUGUST 1991

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OEI-07-90-00760

EXECUTIVE SUMMARY

PURPOSE

To determine the extent of the unrecovered funds related to Medicare secondary payer (MSP) provisions and to identify various options to prevent Medicare program losses due to unidentified primary insurance sources. This report finalizes preliminary findings and recommendations made in a management advisory report (OEI-07-90-00764) issued in June 1990.

BACKGROUND

Congress passed a series of statutory provisions between 1980 and 1986, which made certain other insurers primary to Medicare. These insurers became primary for beneficiaries insured by employer group health plans (EGHPs), automobile medical, no-fault, and liability insurance as well as for end-stage renal disease.

This inspection relates to the Secretary's goal of enhancing the effectiveness of Medicare reimbursement through assuring that Medicare reimbursement is secondary to other insurance.

METHODOLOGY

We selected a sample of all beneficiaries who received services in 1987. We contacted a sub-sample of this group about their medical insurance coverage and about any accidents in which they may have been involved. Almost 73 percent of the beneficiaries responded.

FINDINGS

- Although the Health Care Financing Administration (HCFA) has made extensive efforts to identify MSP situations, we found significant overpayments totaling over $637 million in 1988.

We identified overpayments of $60,502 in our sample which projects to a loss of over $637 million in 1988 to the Medicare program.

- Targeting working spouses and disabled can increase the cost effectiveness of MSP efforts.

The overall cost to benefit ratio in this study was 5.4 to 1. However, the cost-benefit ratio for developing spousal insurance cases was 10.2 to 1 and the cost-benefit ratio for developing disability cases was 11.0 to 1.

RECOMMENDATIONS

The HCFA should take action to prevent Medicare program losses due to unidentified primary insurers. This can be accomplished in a variety of ways. Among them are:

- Revise all Medicare claim forms to require spousal insurance information before claims can be paid.

- Prioritize the information received from IRS and SSA according to those areas with the greatest cost-benefit ratio.

- Propose legislation to establish a Voluntary Disclosure and Recovery Program.

- Establish a national data system containing primary insurance information on all Medicare beneficiaries and their spouses.

- Propose legislation to require Medicare contractors to match their private health insurance records with Medicare files.

- Propose legislation to require all insurers to provide their private health insurance data, including eligibility and claims payment information, to HCFA.

- Recommend to Congress that section 6202 of Public Law 101-239 (as amended by Public Law 101-508) be extended beyond the statute's termination date of September 30, 1995 until legislation is enacted requiring direct employer reporting.

AGENCY COMMENTS

The HCFA commented on an earlier version of this report. They were generally in agreement with the recommendations, except for the matching of contractor private health insurance records with Medicare files. We continue to believe that the matching of records is an important fiduciary responsibility of Medicare contractors who should reference all sources of information to identify primary payer sources.

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INTRODUCTION

PURPOSE

To determine the extent of the unrecovered funds related to Medicare secondary payer (MSP) provisions and the various options available to the Health Care Financing Administration (HCFA) to prevent losses to the Medicare program due to unidentified primary insurance sources. This report finalizes preliminary findings and recommendations made in a management advisory report (OEI-07-90-00764) released to HCFA in June 1990.

BACKGROUND

Title XVIII of the Social Security Act (42 USC 1395), enacted in 1965, established the Medicare program to pay for health care services for eligible beneficiaries age 65 and older. Also, beneficiaries are covered who were disabled and those with end-stage renal disease (ESRD).

Until 1980, Medicare was primary payer for all health care costs (less co-pay and deductibles) for these beneficiaries. Concurrent coverage by other payers was considered secondary. The only exceptions to this rule were services covered by workers' compensation and services by other Federal programs, such as the Veterans Administration.

Growing concern for rising Medicare program costs influenced Congress to pass a series of statutory provisions during the period between 1980 and 1986. (See Appendix A.) These provisions require certain private insurers to pay medical claims before Medicare if the aged or disabled beneficiary has other health insurance coverage by an employer group health plan (EGHP) or by the spouse's EGHP. Medicare is also secondary payer if the beneficiary has an accident and is covered by automobile medical, no-fault, or liability insurance. Another statutory provision made Medicare the secondary payer for items and services furnished to ESRD beneficiaries who are covered under EGHPs during a specified period of up to 12 months.

In general, providers are required to bill other insurers first when a beneficiary falls within one of these categories. Medicare pays any remaining amounts for which it may be responsible.

The HCFA is responsible for ensuring contractors comply with Medicare legislation and regulations. Further, HCFA provides contractors with procedures and instructions concerning the identification of MSP situations and recovery of inappropriate payments. As part of their fiduciary responsibility, contractors should identify and record information for beneficiaries having primary medical insurance coverage.

Medicare contractors were budgeted approximately $115 million for administration of MSP provisions in the law during Fiscal Years (FYs) 1987 and 1988. The data from HCFA shows MSP savings to be $3.3 billion ($1.1 billion for Part A and $.3 billion for Part B for FY 1987 and $1.4 billion for Part A and $.5 billion for Part B in FY 1988). However, difficulties in detecting

primary payment sources still exist which result in substantial losses to Medicare. Despite current procedures for HCFA's educational and outreach programs, Office of Inspector General (OIG) inspections and audits, General Accounting Office (GAO) audits, and HCFA pilot studies have confirmed that additional savings and recoveries are possible. These prior inspections and studies claim estimates of program losses ranging from $300 million to $900 million each year.

Recently, congressional hearings, GAO audits, and media attention have focused on reports of unrealized savings. In addition, lawsuits under Qui Tam provisions of the False Claims Act and Department of Justice actions have brought the MSP issue to the forefront.

METHODOLOGY

We selected a simple random sample from all beneficiaries who received services in 1987, which resulted in identifying over 350,000 beneficiaries. Next, we took a sub-sample of this group, using sequential sampling, which identified over 6,700 beneficiaries. We deleted three categories in the sub-sample: Railroad Retirement beneficiaries, deceased beneficiaries, and those beneficiaries with non-matching Health Insurance claim numbers. These groups were dropped because sufficient data was not available to include them in our sample.

After the categories mentioned above were dropped, this left over 4,300 beneficiaries in our sub-sample. We attempted to contact the beneficiaries about their medical insurance coverage and any accidents in which they may have been involved. Almost 73 percent of the beneficiaries responded. More detailed information on the sample selection process is given in the survey methodology section of Appendix B.

FINDINGS

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

➤ ***Although HCFA has made extensive efforts to identify MSP situations, we found significant overpayments totaling over $637 million in 1988.***

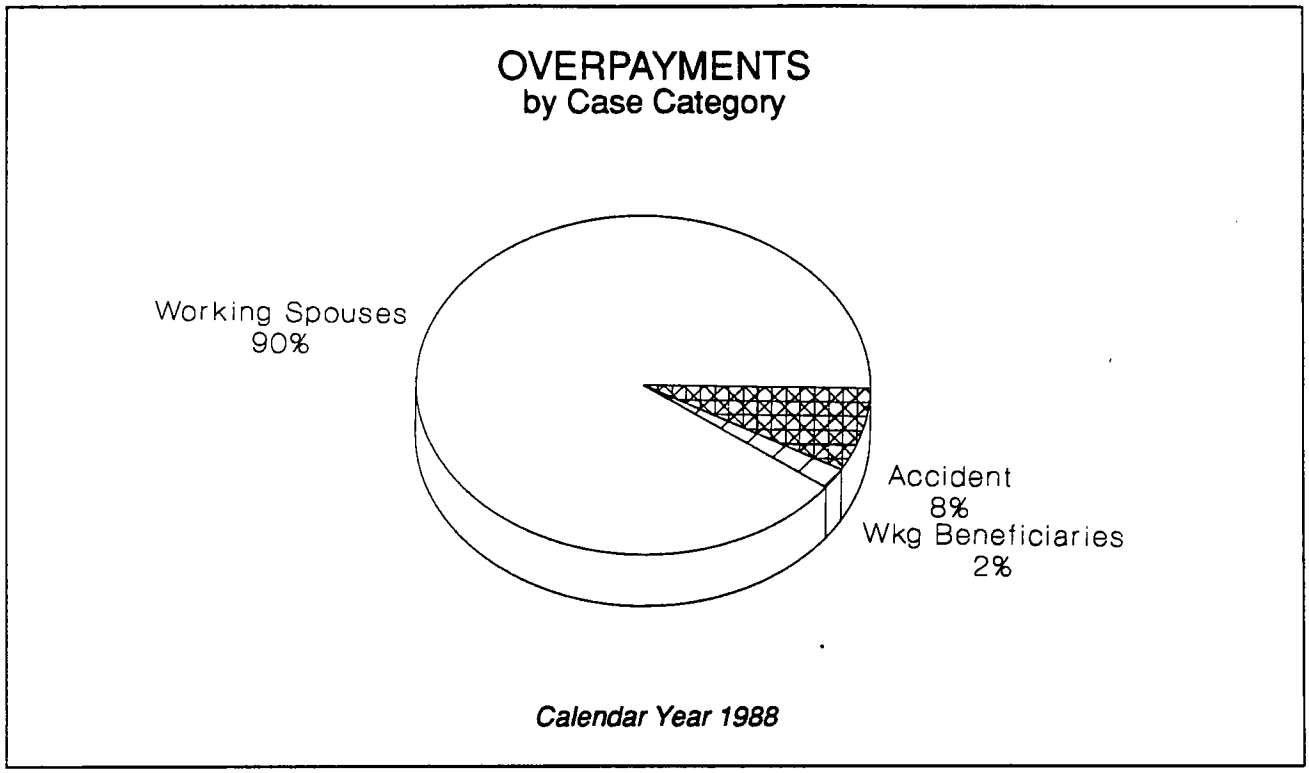
Our total overpayment projects to an estimated loss to the Medicare program of over $637 million in Calendar Year 1988. (See Appendix B.) The completed analysis identified primary insurance coverage on 34 beneficiaries (33 EGHP and 1 accident) out of the 3,185 beneficiaries or about 1 percent of those who responded. (See Appendix C.) We identified $4,744 paid by Medicare in the accident liability case for which a third-party payer had responsibility for payment. This amount represents 8 percent of the total overpayment identified. We established an actual loss to the Medicare program of $60,502, of which Part A payments totaled $29,695 and Part B $30,807.

We found that over $583.3 million of the projected loss to the Medicare program was due to unidentified spousal insurance coverage. Twenty-five of the 33 beneficiaries (76 percent) with EGHP coverage had unidentified primary insurance coverage through their working spouses. Included in the 25 cases were eight disability cases. Of the $60,502 identified, a total of $54,294 was due to this coverage. This was almost 90 percent of the total identified overpayments.

We project an annual loss for unidentified disabled beneficiaries of over $265 million. Nine of the 33 beneficiaries (27 percent) with an EGHP received Medicare coverage because of a disabling condition and accounted for over 47 percent or $28,393 of the total overpayment. Eight of the disabled beneficiaries were insured through their spouses' EGHP and one beneficiary through his own EGHP.

We project an annual loss of almost $16.5 million for unidentified coverage of the working beneficiary. Seven of these 33 beneficiaries (21 percent) had unidentified EGHP coverage through their own employer. This includes one disabled beneficiary. These working beneficiaries accounted for 2 percent or $1,449 of the total overpayment.

We found that Medicare contractors are not coordinating with their private insurance operations. Medicare paid as the primary payer in eight cases when the beneficiary had primary payer coverage through an EGHP administered by the contractor's private business operation. Three of the cases had identifying information in the file that there was other insurance. The other five cases did not have other insurance information in the file because the claims were submitted electronically.



➤ ***Targeting working spouses and disabled can increase the cost effectiveness of MSP efforts.***

We identified administrative costs accrued by the OIG to detect and develop unidentified primary insurance coverage for the sampled beneficiaries. When compared to the program loss, based upon identified primary insurance coverage, the overall cost to benefit ratio was 5.4 to 1. However, the cost effectiveness of developing insurance information for those respondents who reported that their spouse was insured increased to 10.2 to 1. The development of insurance information concerning disabled individuals had an even higher cost to benefit ratio of 11.0 to 1. (See Appendix D.) The increased ratio equates to a higher overpayment identified for the spousal and disability cases.

RECOMMENDATIONS

The HCFA should take action to prevent Medicare program losses due to unidentified primary insurers. This can be accomplished in a variety of ways. Among them are:

- ***Revise all Medicare claims forms to require spousal insurance information before claims can be paid.***

  We suggest that the following information be obtained as part of the application:

  a. Is the beneficiary covered by an EGHP through his or her own employer or the employer of the spouse?

  b. If yes, enter the name and Social Security number of the person working, the name of the employer, and name of the insurance company.

- ***Prioritize the information received from IRS and SSA according to those areas with the greatest cost-benefit ratio.***

  Section 6202(a) of OBRA of 1989 (Public Law 101-239) established a systematic process of providing MSP information to HCFA. The Act provides that the IRS will furnish spousal information on any Medicare beneficiaries identified by SSA. The SSA will furnish wage information on Medicare beneficiaries and their spouses to HCFA.

  The cost-benefit ratio of developing cases involving the working spouse covered by an EGHP is considerably more than for working beneficiaries covered by an EGHP. This provides justification that initial efforts should develop those cases with indications of a working spouse. In our sample, 25 out of 33 EGHP overpayment cases involved working spouses, which produced our largest portion of the overpayment.

- ***Propose legislation to establish a Voluntary Disclosure and Recovery Program.***

  The program would permit insurers, employers, or third-party administrators, acting within one year of enactment, to identify instances of improper MSP payments and make restitution of the appropriate amounts without threat of future Government action with respect to those claims. The legislation should also provide for a waiver of the existing statute of limitations applicable to improper MSP payments. Any insurer not participating in this program would be subject to a civil penalty of treble damages, plus costs, with respect to all improper MSP claims later identified by the government.

➤ ***Establish a national data system containing primary insurance information on all Medicare beneficiaries and their spouses.***

The HCFA should continue to pursue legislation requiring the insurer, underwriters, and third party administrators of health plans to notify HCFA about covered individuals who are age 65 and over, under age 65 and disabled, or diagnosed as having ESRD, and who are enrolled in insurance programs to which Medicare is secondary payer.

Alternatively, this could be embodied into a broader proposal to establish a national clearinghouse of information pertaining to medical insurance available to beneficiaries of all Federal and State health benefit programs. Under this proposal HCFA would run claims through this clearinghouse in order to identify MSP situations.

➤ ***Propose legislation to require Medicare contractors to match their private health insurance records with Medicare files.***

The HCFA contracts with health insurance companies to adjudicate and pay Medicare claims. In this capacity, Medicare contractors have a fiduciary responsibility to the Federal government to assure that only appropriate Medicare payments are made. If contractors were required to match primary beneficiaries to their private business, all such cases in this inspection should have been identified as a Medicare secondary payer situation. The HCFA should pursue legislation to reverse the OBRA 89 mandate which prohibits such data matches.

➤ ***Propose legislation to require all insurers to provide their private health insurance data, including eligibility and claims payment information, to HCFA.***

The MSP identification efforts would be greatly enhanced by requiring all insurers to report their eligibility and claims information. The matching of Medicare files with this private insurance information could be accomplished by HCFA through a national clearinghouse. This system would provide HCFA with maximum capability to identify MSP situations.

AGENCY COMMENTS

This report is a final version of a management advisory report (MAR) prepared in June 1990 for a congressional hearing on the identification and recovery of Medicare secondary payments. This report was based on data obtained during our field work at that point in time. We have completed the review of data obtained during this study, and have issued this final report.

The HCFA commented in their response to the MAR (see Appendix E) and at an exit conference covering this final report that they were generally in agreement with the recommendations, except for the matching of contractor private health insurance records with Medicare files. We continue to believe that the matching of records is an important fiduciary responsibility of Medicare contractors who should reference all sources of information to identify primary payer sources.

APPENDIX A

MEDICARE SECONDARY PAYER LEGISLATION

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

MEDICARE SECONDARY PAYER LEGISLATION

Deficit Reduction Act of 1984 (DEFRA)	98-369	07-18-84	01-01-85	DEFRA broadened the definition of working spouse by including spouses age 65-69 of employed individuals under age 65, thereby removing the lower age limit.
Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)	98-272	04-06-86	05-01-86	COBRA further broadened the definition of working aged by removing the limitation of age 70 and older.
Omnibus Budget Reconciliation Act of 1986 (OBRA)	99-509	10-21-86	01-01-87	OBRA made Medicare items and services secondary for payment if the disabled beneficiary or spouse is working and covered under a large group health plan.

MEDICARE SECONDARY PAYER LEGISLATION

Omnibus Budget Reconciliation Act of 1989 (OBRA)	101-239	12-19-89	12-19-89	OBRA provided a two year period for matching IRS tax records to records of SSA and HCFA to identify working beneficiaries and their spouses.
Omnibus Budget Reconciliation Act of 1990 (OBRA)	101-508	11-05-90	11-05-90	OBRA provided for the extension of the transfer of data from IRS and SSA to HCFA through September 30, 1995.

APPENDIX B

MEDICARE SECONDARY PAYER BENEFICIARY SURVEY

Survey Methodology, Response Analysis and Savings Projections

Survey Methodology

The beneficiaries selected for the Medicare secondary payer (MSP) survey were selected using a simple random sample from the population of all beneficiaries purported to have received services some time during 1987. A one percent sample of all Medicare beneficiaries receiving services under Part B is maintained by the Office of Inspector General, Office of Evaluation and Inspections. This file is a subset of the Part B Medicare Annual Data (BMAD) IV 5 percent beneficiary sample file maintained by HCFA.

For 1987, this 1 percent sample contains 352,385 separate beneficiary Health Insurance Claim Numbers (HICN). A subsample of these beneficiaries, using sequential sampling, resulted in 6,777 HICNs representing beneficiaries with Medicare claims. These records were matched with the Social Security Administration's (SSA) Master Beneficiary Record (MBR) to obtain demographic data, including current address, and determine the current status of each beneficiary identified. The following Table 1.1 gives the results of this matching process.

TABLE 1.1
Results of Medicare BMAD IV Match with SSA MBR.

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

Railroad Board retirees were deleted from the sample (138 beneficiaries) because SSA does not maintain their data. The 1,070 beneficiaries indicated by SSA to be dead were deleted because we chose not to identify or to obtain proxy respondents. The 1,198 HICNs that did not match with SSA's MBR represent a problem encountered with the Beneficiary Identification Code (BIC). We were unable to obtain any address information on these individuals. Therefore, we did not contact these individuals. The estimated populations of beneficiaries receiving services, based upon the subgroups resulting from the sample, are given in Table 1.2.

TABLE 1.2
Estimated Population Sizes

	Sample	Est. Population
Original Sample	6,777	35,238,500
Railroad Retirement Board	138	718,800
Dead	1,070	5,563,700
Non matches	1,198	6,229,300
Survey Contacts	4,371	22,728,000
Respondents	3,185	16,561,100
Non Respondents	1,186	6,166,900

Contacts were made with the remaining 4,371 beneficiaries. About 3 weeks later, we followed up with those beneficiaries who were not responsive to our initial efforts to contact them. A total of 3,185 beneficiaries had been contacted and responded by March 1, 1990. This represents an overall response rate of 72.9 percent.

Partial demographic and utilization information was gathered from two sources: 1) the BMAD one percent sample and 2) the Medicare Automated Data Retrieval System (MADRS), also maintained by HCFA. As mentioned earlier, address information came from SSA files. The MADRS provided information on total Part A and Part B expenditures on behalf of each beneficiary.

We discussed supplemental medical coverage that an individual might possess as well as any accidents in which they may have been involved. Where a beneficiary made a positive response, the specific information was developed by OIG field staff to obtain employer and insurers names and addresses. Contacts with employees and insurers were made to verify whether Medicare was the primary or secondary payer.

Response Analysis

An important consideration in studies of this type is the bias that may be present in the results if the non respondents and others not contacted are different than the 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, Part A reimbursed amounts and Part B allowed amounts.

Table 2.1 gives the breakdown of the sample by sex.

TABLE 2.1

Sex	Respondents n	%	Non Respondents n	%	Non Matching n	%	Dead n	%
Male	1192	37.4	512	43.2	434	36.2	317	32.9
Female	1993	62.6	672	56.8	764	63.8	752	67.1
Unknown	0	-	2	-	0	-	1	-
Total	3185		1186		1198		1070	

The non respondents tended to have a higher proportion of males while the beneficiaries determined to be dead have a slightly lower proportion of males, when compared to the respondents. Those beneficiaries who were not contacted for reasons of non match appear to emulate the respondents with respect to sex. Attached to this appendix, in Table I, is a further breakdown of the sub groups, cross tabulating by age and sex. The average ages are listed at the bottom of the tables. For those HICNs that were not matched, no age information was available.

Table I shows that the average age of the respondents is greater than that of the non respondents. For both of the sexes, the age distributions are skewed towards the lower end of the age distribution for the non responders when compared to the responders. As might be expected, beneficiaries determined to have expired were considerably older than both the respondents and the non respondents. This table would suggest that age is also a factor in determining the response status of a beneficiary.

Table 2.2 presents the average Part A reimbursement and the average Part B reimbursement, as determined from the MADRS file, for each of the sub populations included in the sample.

TABLE 2.2
Average Reimbursement by Sub Population

Part A

	Total		Male		Female		Unkn
Population	**n**	**Avg**	**n**	**Avg**	**n**	**Avg**	**n**
Responses	746	$6159.01	286	$7124.78	460	$5558.55	
No Response	140	$3766.31	67	$3659.42	73	$3864.41	
Non Match	-	-	-	-	-	-	1198
Total	1354	$6444.21	557	$7133.55	797	$5962.46	

Part B

	Total		Male		Female		Unkn
Population	**n**	**Avg**	**n**	**Avg**	**n**	**Avg**	**n**
Responses	3185	$1108.31	1192	$1259.33	1993	$1017.98	
No Response	1184	$437.46	512	$435.53	672	$438.93	2
Non Match	1198	$99.58	434	$93.23	764	$103.18	
Total	6636	$840.81	2429	$1019.95	4207	$737.39	3

The unmatched population's Part A utilization is unknown because they were not found on the MADRS file. For Part B reimbursed amounts, this table shows both male and female unmatched beneficiaries used Part B services sparingly, approximately 10 percent of what the respondents use. This is probably why they weren't matched, many of them had no Medicare utilization. We also compared Part A and Part B reimbursed amounts for calendar year 1988. The average Part A reimbursed amount for respondents was $6159.01 and $3766.31 for non respondents, while the average Part B reimbursed amount for respondents was $1108.31 and $437.46 for non respondents. Only 12 percent of non responders used Part A services, versus 23 percent of responders.

Table 2.3 compares respondents, non respondents, dead and unmatched groups by Part B allowed amount categories, as determined from the BMAD IV beneficiary sample file. Included in this table are the results of a contingency table analysis to compare the distributions of the three sub groups, non respondents, non matches and dead beneficiaries, with the respondent category. The Chi-square value assesses to what extent two distributions are alike. The larger the value of the Chi-square, the greater the probability that the two distributions are different.

TABLE 2.3
Distribution of Sampled Beneficiaries
By Part B Allowed Amounts and Response Category

Allowed Amount	Respondents		Non Respondents		Non Match		Dead	
	N		N		N		N	
0	53	1.7%	86	7.3%	158	13.2%	52	4.9%
$1-$99	638	20.0%	423	35.7%	850	71.0%	375	35.1%
$100-$299	658	20.7%	321	27.1%	115	9.6%	136	12.7%
$300+	1,836	57.6%	354	29.9%	75	6.3%	506	47.3%
Total	3,185		1,184		1,198		1,069	
Chi-Square (vs Resp)			550.675		3126.545		238.956	

These results indicate that the three sub groups not participating in the survey are substantially different with respect to their utilization of Part B services. Whereas approximately 78 percent of the respondents had allowed services in excess of $100, only 57 percent of the non respondents, 16 percent of the non matches and 60 percent of the dead beneficiaries received services in excess of this amount. This result is consistent with the data in Table 2.2. The conclusion being that responders to this survey tended to use more services, or more expensive services, than the groups not included in the follow up.

The results of this analysis would indicate that there are some significant differences between those who responded and those beneficiaries not participating, including the non responders, those not matched, and those expiring prior to our contact. Differences exist both by sex and age, and with respect to the dollar amounts expended for services on behalf of the beneficiaries. This implies that making projections beyond the responders may not be appropriate and, if made, must be qualified with appropriate adjustments.

Savings Projections

Of the 3,185 beneficiary contacts, 280 had positive responses requiring follow-up. Additional Medicare secondary payer overpayments were found to exist for 34 respondents. These payments totaled $60,502.04. Thus 1.07 percent of respondents had MSP savings previously unidentified. Approximately half of the total amount identified occurred under Part A (49.1 percent).

To project these findings to the universe of respondents presents no problem. Projecting our results to the other subgroups in the original sample, the non respondents, the non matches and the dead beneficiaries, is problematic because of their non representation in our sample. As shown above, there appears to be substantial differences between these subgroups and the

respondents. However, it may be reasonably assumed that the population of beneficiaries who did not respond would also have MSP overpayments.

In an attempt to project our results to the non participating populations, we have made certain assumptions. Since the sample of beneficiaries was drawn from the BMAD IV Beneficiary Sample, we arrayed the savings by strata based on Part B allowed amounts per beneficiary as recorded in this file. Table 2.3, above, shows the breakdown of the subgroups into this stratification. Table 3.1, below, compares the 34 beneficiaries with MSP savings to the sample of respondents.

TABLE 3.1
Distribution of Sample Respondents

Allowed Amount	Number in Sample N	Number in Sample %	Number with Savings N	Number with Savings %	Percent with Savings
$0	53	1.7	1	3.0	1.9
$1-$99	642	20.2	10	29.4	1.6
$100-$299	654	20.5	3	8.8	0.5
$300+	1836	57.6	20	58.8	1.1
TOTAL	3185		34		1.1

It was also noted in Table 2.3, that the subgroups in the sample varied greatly by these Part B strata. Consequently, the projections developed here are based upon the strata defined by the Part B allowed amounts. We assumed that those beneficiaries in a given strata, as defined in Table 3.1 and regardless of the subgroup in which they were a member, would produce MSP overpayments equal to the appropriate strata in the respondents subgroup. Implied in this assumption is that all of the other differences identified earlier with respect to age and sex, are either related to services received, as expressed by the Part B allowed amount, or unrelated to MSP savings. For convenience, the overpayment projections are presented by subgroup so that their contribution to the total may be determined.

For each strata, an average overpayment per respondent was calculated, with an associated standard error. This strata specific average was then applied to the other subgroups. Total overpayment projections represent the sum of the projections across the strata within a subgroup, and then across each subgroup. Variances for these estimates were calculated appropriately.

Table I shows sampled beneficiaries by age, sex, and response sub group. Table II includes all classes of beneficiaries, Table III, beneficiaries with working spouses, Table IV, beneficiaries that are working, and Table V gives savings estimates for beneficiaries associated with a disability.

TABLE I

Distribution of Sampled Beneficiaries by Age, Sex and Response Sub Group

	Respondents				Non Respondents				Dead*			
	Male		Female		Male		Female		Male		Female	
	n	%	n	%	n	%	n	%	n	%	n	%
<65	152	12.8	109	5.5	150	38.9	172	32.6	20	6.3	13	1.7
65-69	283	23.7	421	21.1	99	25.7	97	18.4	31	9.8	22	2.9
70-74	366	30.7	551	27.6	65	16.9	118	22.3	48	15.1	81	10.8
75-79	223	18.7	409	20.5	41	10.7	72	13.6	62	19.6	107	14.3
80-84	105	8.8	288	14.5	18	4.7	41	7.8	61	19.2	129	17.2
85+	63	5.3	215	10.8	12	3.1	28	5.3	95	30.0	398	53.1
Unkn	—	-	-	-	127		144	-			2	
Total	1192		1993		385		528		317		750	
Avge Age	70.8		74.6		69.2		72.7		78.9		84.5	

** One dead beneficiary was of unknown sex.*

TABLE II

Calculated Savings Total Overpayments All Classes of Beneficiaries

Allw amt	Resp	Avg Reimb	s.e.	Est Popln	Est Recov
0	53	$1.51	1.510	275,585	$416,030
$1-$99	638	$23.21	12.727	3,317,421	$76,997,350
$100-$299	658	$0.49	0.412	3,421,416	$1,676,494
$300+	1836	$24.66	9.717	9,546,686	$235,421,275
	3,185	$18.99		16,561,108	$314,511,148
Non Resp.					
0	86	$1.51	1.510	447,176	$675,067
$1-$99	423	$23.21	12.727	2,199,482	$51,049,967
$100-$299	321	$0.49	0.412	1,669,110	$817,864
$300+	354	$24.66	9.717	1,840,701	$45,391,684
	1,184	$15.91		6,156,468	$97,934,582
Non-Match					
0	158	$1.51	1.510	821,556	$1,240,239
$1-$99	850	$23.21	12.727	4,419,762	$102,582,676
$100-$299	115	$0.49	0.412	597,968	$293,004
$300+	75	$24.66	9.717	389,979	$9,616,882
	1,198	$18.26		6,229,265	$113,732,802
Dead					
0	52	$1.51	1.510	270,385	$408,180
$1-$99	375	$23.21	12.727	1,949,895	$45,257,063
$100-$299	136	$0.49	0.412	707,162	$346,509
$300+	506	$24.66	9.717	2,631,058	$64,881,898
	1,069	$19.95		5,558,501	$110,893,650
Totals	**6,636**			**34,505,342**	**$637,072,181**
				L 90%	$437,798,254
				U 90%	$836,346,109
				Precision	31.3%

TABLE III

Calculated Savings Total Overpayments Beneficiaries with Working Spouses

Allw ::nt	Resp	Avg Reimb	s.e.	Est Popln	Est Recov
0	53	$1.51	1.510	275,585	$416,134
$1-$99	638	$22.46	12.719	3,317,421	$74,509,284
$100-$299	658	$0.49	0.412	3,421,416	$1,676,494
$300+	1836	$21.55	9.364	9,546,686	$205,731,082
	3,185	$17.05		16,561,108	$282,332,993
Non Resp.					
0	86	$1.51	1.510	447,176	$675,236
$1-$99	423	$22.46	12.719	2,199,482	$49,400,356
$100-$299	321	$0.49	0.412	1,669,110	$817,864
$300+	354	$21.55	9.364	1,840,701	$39,667,104
	1,184	$14.71		6,156,468	$90,560,559
Non-Match					
0	158	$1.51	1.510	821,556	$1,240,549
$1-$99	850	$22.46	12.719	4,419,762	$99,267,855
$100-$299	115	$0.49	0.412	597,968	$293,004
$300+	75	$21.55	9.364	389,979	$8,404,047
	1,198	$17.53		6,229,265	$109,205,455
Dead					
0	52	$1.51	1.510	270,385	$408,282
$1-$99	375	$22.46	12.719	1,949,895	$43,794,642
$100-$299	136	$0.49	0.412	707,162	$346,509
$300	506	$21.55	9.364	2,631,058	$56,699,307
	1,069	$18.22		5,558,501	$101,248,740
Totals	**6,636**			**34,505,342**	**$583,347,747**
				L 90%	$388,500,515
				U 90%	$778,194,979
				Precision	33.4%

TABLE IV

Calculated Savings Total Overpayments Working Aged Beneficiaries

Allw amt	Resp	Avg Reimb	s.e.	Est Popln	Est Recov
0	53	$0.00	0.000	275,585	$0
$1-$99	638	$0.73	0.495	3,317,421	$2,421,718
$100-$299	658	$0.00	0.000	3,421,416	$0
$300+	1836	$0.54	0.366	9,546,686	$5, 155,210
	3,185	$0.46		16,561,108	$7,576,928
Non Resp.					
0	86	$0.00	0.000	447,176	$0
$1-$99	423	$0.73	0.495	2,199,482	$1,605,622
$100-$299	321	$0.00	0.000	1,669,110	$0
$300+	354	$0.54	0.366	1,840,701	$993,978
	1,184	$0.42		6,156,468	$2,599,600
Non-Match					
0	158	$0.00	0.000	821,556	$0
$1-$99	850	$0.73	0.495	4,419,762	$3,226,426
$100-$299	115	$0.00	0.000	597,968	$0
$300+	75	$0.54	0.366	389,979	$210,589
	1,198	$0.55		6,229,265	$3,437,015
Dead					
0	52	$0.00	0.000	270,385	$0
$1-$99	375	$0.73	0.495	1,949,895	$1,423,423
$100-$299	136	$0.00	0.000	707,162	$0
$300	506	$0.54	0.366	2,631,058	$1,420,771
	1,069	$0.51		5,558,501	$2,844,195
Totals	**6,636**			**34,505,342**	**$16,457,738**
				L 90%	$8,856,625
				U 90%	$24,058,850
				Precision	46.2%

TABLE V
Calculated Savings Total Overpayments Disabled Beneficiaries

Allw amt	Resp	Avg Reimb	s.e.	Est Popln	Est Recov
0	53	$0.00	0.000	275,585	$0
$1-$99	638	$6.16	4.410	3,317,421	$20,435,316
$100-$299	658	$0.00	0.000	3,421,416	$0
$300+	1836	$13.32	7.673	9,546,686	$127,161,856
	3,185	$8.91		16,561,108	$147,597,172
Non Resp.					
0	86	$0.00	0.000	447,176	$0
$1-$99	423	$6.16	4.410	2,199,482	$13,548,806
$100-$299	321	$0.00	0.000	1,669,110	$0
$300+	354	$13.32	7.673	1,840,701	$24,518,136
	1,184	$6.18		6,156,468	$38,066,942
Non-Match					
0	158	$0.00	0.000	821,556	$0
$1-$99	850	$6.16	4.410	4,419,762	$27,225,734
$100-$299	115	$0.00	0.000	597,968	$0
$300+	75	$13.32	7.673	389,979	$5,194,520
	1,198	$5.20		6,229,265	$32,420,254
Dead					
0	52	$0.00	0.000	270,385	$0
$1-$99	375	$6.16	4.410	1,949,895	$12,011,353
$100-$299	136	$0.00	0.000	707,162	$0
$300	506	$13.32	7.673	2,631,058	$35,045,697
	1,069	$8.47		5,558,501	$47,057,050
Totals	**6,636**			**34,505,342**	**$265,141,418**
				L 90%	$134,970,997
				U 90%	$395,311,840
				Precision	49.1%

APPENDIX C

SUMMARY OF IDENTIFIED MSP CASES

Total Respondents = 3,185

Total Overpayment Cases = 34

CLASS	RESPOND-ENTS	CASES	%	OVER-PAYMENT	% OF TOTAL	COST TO BENEFIT RATIO
1A	108	8*	7%	$ 1,463.64*	2%	.3 TO 1.0
1B	105	25	24%	$54,294.36	90%	10.2 TO 1.0
1C	67	1	1%	$ 4,744.04	8%	1.2 TO 1.0
Totals	280	34	32%	$60,502.04	100%	5.4 TO 1.0

Class IA includes those respondents who indicated they were working for an employer with 20 or more employees during 1988.

Class IB includes those respondents who indicated their spouse worked for an employer with 20 or more employees during 1988.

Class IC includes those respondents who indicated that they were involved in either an automobile or personal injury accident in 1988.

Every respondent in these three classes was contacted to gather additional employment and insurance information. This allowed staff to identify and verify actual MSP situations.

**This includes one disabled beneficiary for whom Medicare paid $14.46.*

APPENDIX D

CALCULATIONS OF COST-BENEFIT RATIOS

The overall cost ratio was calculated as follows:

Variable Costs

Labor	$9,488.00	
Telephone	$114.00	
Total Variable Costs$		9,602.00

Fixed Costs

Rent/Utilities	$615.00	
Mailing Costs	$1,085.00	
Total Fixed Costs		$1,700.00
Total Variable and Fixed Costs		$11,302.00

Cost-Benefit Ratio

Total Overpayment		$60,502.04
Total Costs		$11,302.00
Cost-Benefit Ratio		5.4:1

The cost benefit of developing responses that were identified as working spouses was calculated as follows:

Variable Costs

Total Variable Costs		$ 9,602.00
Total Number of Responses	280	
Cost per Response		$34.29
Number of Spousal Insurance Responses	105	
Variable Costs of Spousal Insurance Responses		$3,600.45

Fixed Costs

Total Fixed Costs	$ 1,700.00
Total Variable and Fixed Costs	$ 5,300.45

Cost-Benefit Ratio

Total Overpayment on Spousal Insurance Responses	$54,294.36
Total Costs	$ 5,300.45
Cost-Benefit Ratio	10.2:1

The cost benefit of developing responses that were identified as disabled beneficiaries was calculated as follows:

Variable Costs

Total Variable Costs		$9,602.00
Total Number of Responses	280	
Cost per Response		$ 34.29
Number of Disabled Beneficiaries	26	
Variable Costs of Beneficiary Case Development		$ 891.54

Fixed Costs

Total Fixed Costs	$ 1,700.00
Total Variable and Fixed Costs	$ 2,591.54

Cost-Benefit Ratio

Total Overpayment on Disabled Beneficiaries	$28,393.41
Total Costs	$ 2,591.54
Cost-Benefit Ratio	11.0:1

APPENDIX E

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care
Financing Administration

SEP 17 1991

Memorandum

Date

From Gail R. Wilensky, Ph.D. GRW
Administrator

Subject Management Advisory Report: "Medicare Secondary Payer (MSP): Unrecovered Funds" (OEI-07-90-00764)

To The Inspector General
Office of the Secretary

Thank you for the opportunity to comment on the subject management advisory report. The report restates three recommendations the Office of the Inspector General (OIG) made in separate audits of the MSP program and offers three additional recommendations. Our position with respect to each of these recommendations is as follows:

- OIG recommends that Medicare claims forms be revised to require spousal insurance information before the claim is paid. HCFA concurs with this recommendation.

- OIG recommends that HCFA prioritize the information received from SSA according to areas of greatest cost/benefit ratio. HCFA concurs with this recommendation.

- OIG recommends that HCFA propose legislation to establish a voluntary disclosure and recovery program. Since the initial provision on debarment of Medicare fiscal agents if they fail to participate has been dropped from the legislative proposal, HCFA supports OIG's legislative proposal.

- OIG recommends that HCFA consider establishing a national data system containing primary insurance data on beneficiaries and their spouses. HCFA believes further study is needed to determine the impact of this proposal.

- OIG recommends that HCFA propose legislation to require Medicare contractors to match their private health insurance data with Medicare files. HCFA disagrees with this recommendation, because Congress recently passed legislation prohibiting such a requirement. We have no reason to believe that Congress has changed its position on this issue.

- OIG recommends that HCFA propose legislation to require all insurers to provide their health insurance data, including eligibility and claims payment information, to HCFA. We are unsure of OIG's objective. It would appear that this proposal is intended to give HCFA and OIG stronger authority to require insurers to provide the information necessary to determine MSP recoveries. In its current form, we cannot agree with this recommendation, because it would be unnecessarily burdensome both to employers and to HCFA. However, we would be willing to discuss with OIG how to better frame this proposal to establish such authorities.

The attached paper discusses each recommendation and provides additional comments on statements in, and the methodology of, the subject report. Please advise us whether you agree with our position on the report's recommendations at your earliest convenience.

Attachment

Comments of the Health Care Financing Administration on the Office of the Inspector General (OIG) Report on "Medicare Secondary Payer (MSP): Unrecovered Funds" (OEI-07-90-00764)

OIG Recommendation 1

Revise all Medicare claims forms to require spousal insurance information before the claim can be paid.

HCFA Response

HCFA has informed OIG (in response to OIG Management Advisory Report A-09-89-00100) that we will advise the Uniform Claim Form Task Force of our concurrence with this recommendation to require spousal information on claims forms. The Uniform Claim Form Task Force is responsible for making changes to the Medicare claim forms.

OIG Recommendation 2

Prioritize the information received from SSA according to those areas with the greatest cost/benefit ratio.

HCFA Response

HCFA staff have discussed this issue with OIG staff prior to the issuance of this report. We fully agree with this recommendation. As we develop potential MSP situations with employers, we will give priority to situations that appear to have the greatest payback, including spousal case development.

OIG Recommendation 3

Propose legislation to establish a Voluntary Disclosure and Recovery Program.

HCFA Response

OIG made this recommendation in a prior report (AO-12-89-00002). This report contained a provision to debar Medicare contractors from the program if they failed to participate in the disclosure program and if the Federal government identified improper payments. In discussions with OIG, staff have

agreed to remove the debarment provision. HCFA now supports OIG's legislative proposal and is working with OIG to rewrite it.
We believe that the Department of Health and Human Services (DHHS) and the Department of Justice (DOJ) already have authority to announce a general amnesty from the litigation related to violations of the MSP provisions. We suggest that OIG and HCFA consider proposing that, while the Voluntary Disclosure and Recovery Program is being considered by Congress, DHHS and DOJ announce a 1-year general amnesty program for those other payers that voluntarily repay Medicare.

OIG Recommendation 4

Consider establishing a national data system containing primary insurance information on all Medicare beneficiaries and their spouses.

- HCFA could accomplish this by continuing to pursue legislation to require insurers, underwriters, and third party administrators of health plans to notify HCFA about covered individuals who are: over age 65, under 65 and disabled or diagnosed as having End Stage Renal Disease, and who are enrolled in insurance programs to which Medicare is secondary payer.

- Alternatively, this could be absorbed into a broader proposal to establish a national clearinghouse of information pertaining to medical insurance available to beneficiaries of all Federal and State health benefit programs. Under this proposal, HCFA would run its claims information through this clearinghouse in order to identify MSP situations.

HCFA Response

HCFA is currently finalizing a FY 1992 legislative proposal on insurer reporting which will permit us to obtain more timely MSP information.

The propriety of establishing a national clearinghouse is currently under discussion at the Budget Summit. We intend to discuss this issue further with the Congressional Budget Office staff to determine potential Medicare savings. We do, however, believe that further study is necessary to assess its impact on the way our programs are currently administered.

OIG Recommendation 5

Propose legislation to require Medicare contractors to match their private health insurance data with Medicare files.

HCFA Response

Section 6202(d) of the Social Security Act prohibits the Secretary from requiring the contractors to perform data matches against their private records as a condition for entering or renewing the contracts. We believe that it would not be prudent or practical to propose elimination of this prohibition. Congress has clearly stated its position in opposition to such a requirement.

OIG Recommendation 6

Propose legislation to require all insurers to provide their health insurance data, including eligibility and claims payment information, to HCFA.

HCFA Response

This proposal appears to go beyond our legislative proposal to require insurer reporting discussed under Recommendation 4. In addition, read broadly, the proposal could require the submission of unnecessary information that would be burdensome both to insurers and to HCFA. We are unsure of OIG's objective. We believe this proposal is intended to give HCFA and OIG stronger authority to require insurers to provide the information necessary to determine the amounts of Medicare recoveries. If our belief is correct, HCFA does not need all of this information on an ongoing basis.

We would support legislation that would require insurers, and entities responsible for payment under employer group health plans (including insurers and third party administrators), upon request from Medicare, to submit information pertaining to medical policies, benefit eligibility, policy limitations and exclusions and payment information relating to their obligations to make primary payment for services provided to Medicare beneficiaries. We are willing to discuss with OIG how to better frame this proposal to establish such authorities.

General Comments

Background Statements

The report indicates that, prior to 1980, Medicare was always the primary payer for services provided to Medicare beneficiaries. Medicare has always been the secondary payer for services covered by workers' compensation programs. Medicare also has always been prohibited from paying for services authorized by other Federal programs, such as the Veterans Administration.

The report compares MSP program savings and contractor administrative expenses for fiscal years (FY) 1987 and 1988. The figures cited are $1.4 billion in savings and $115 million in administrative expenses. The correct figure for MSP savings is $3.3 billion ($1.1 billion for Part A and $.3 billion for Part B in FY 1987 and $1.4 billion for Part A and $.5 billion for Part B in 1988).

Methodology and Savings Estimates

OIG sampled beneficiaries were enrolled in Part B and received Medicare covered services in 1987. This sample contains at least two sources of errors which could cause the sample to underrepresent MSP situations. First, some beneficiaries who are affected by the working aged and disability provisions elect not to participate in Part B because their employer based coverage is such that purchasing Part B coverage is not cost effective and because there is no penalty for delayed enrollment. Second, some MSP beneficiaries were excluded because their primary coverage was such that no Medicare secondary payments were due. There is also one source of error that could cause beneficiaries to be falsely identified as MSP beneficiaries. Individuals enrolled in Part B only are not affected by the working aged or disability provisions. Thus, beneficiaries with employer health plan coverage through their own or a spouse's employer who are enrolled in Part B but not covered under Part A should not be considered MSP beneficiaries.

The exclusion of the Railroad Retirement Board (RRB) beneficiaries could also bias the estimates. We do not know what proportion of RRB beneficiaries have employer health plan coverage as a spouse of an employed individual or if