DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Memorandum

Date FEB 12 1992

From Richard P. Kusserow
Inspector General

Subject Review of AEtna Life Insurance Company's Compliance With Working Aged Provisions of the Medicare Secondary Payer Program for the Period January 1, 1988 through December 31, 1989 (A-01-90-00509)

TO

Gail R. Wilensky, Ph.D.
Administrator
Health Care Financing Administration

This memorandum alerts you to the issuance on **February** 14,1992 of our final audit report. A copy is attached.

The Medicare secondary payer (MSP) program requires Medicare to be the secondary payer for hospital and medical services provided to certain Medicare beneficiaries. Certain program provisions pertain to beneficiaries age 65 and older who are covered under employer group health plans (EGHP) based on their own employment or that of their spouses of any age. Based on our statistical sample of AEtna Life Insurance Company (AEtna) customers, we estimate that as much as $13.6 million in Medicare payments may have been mistakenly paid during the period January 1, 1988 through December 31, 1989. Responsibility for refunding these mistaken payments lies with AEtna, its customers and the providers of service.

The mistaken Medicare payments occurred primarily because beneficiaries did not always give the providers of service, accurate information on their or their spouses' EGHP coverage and employment status. As a result, EGHP coverage was not always identified or billed to the appropriate payer, AEtna. To a lesser extent, we found instances of clerical errors in the coordination of benefit payments between AEtna and Medicare. Such internal weaknesses resulted in both Medicare and AEtna paying as primary payer. This resulted in duplicate payments or inappropriate secondary payments.

Our report recommends that AEtna (1) continue to work with its customers to ensure that adequate information on proper health coverage billing is provided to enrollees affected by MSP provisions, (2) require that all customers identify to AEtna, at least annually, the working aged Medicare beneficiaries (65 and older) and aged spouses (65 and older) of employees of any age enrolled in their EGHPs, (3) continue efforts to correctly reprocess the identified $1,471,233 in potential mistaken Medicare payments so as to make Medicare a secondary pay source to

AEtna EGHPs and (4) work with the Health Care Financing Administration (HCFA) toward a settlement for those customers not included in our sample. We believe that about $12.1 million in additional Medicare funds may have been mistakenly paid for those customers.

AEtna generally agreed with the first three recommendations. With respect to recommendation number 4, AEtna is willing to consider working towards a settlement after they have the opportunity to fully analyze the claims identified in the review.

In the report, we recognize that once AEtna has had the opportunity to reprocess all claims in question, the amount of identified potential mistaken Medicare payments, as well as our overall estimate, may be adjusted for deductibles, coinsurance, fee limits, etc., that are unique to EGHPs. In addition, we anticipate that some of the identified claims may have already been paid by AEtna as primary. Accordingly, the liability for these claims will be the provider's and not AEtna's. After reprocessing the mistaken claims, and based on the sample results, we would be willing to work with AEtna and HCFA on reaching a settlement.

For further information contact:

Richard J. Ogden
Regional Inspector General
for Audit Services, Region I
FTS: 835-2687

Attachment

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF AETNA LIFE INSURANCE COMPANY'S COMPLIANCE WITH WORKING AGED PROVISIONS OF THE MEDICARE SECONDARY PAYER PROGRAM FOR THE PERIOD JANUARY 1, 1988 THRU DECEMBER 31, 1989

Richard P. Kusserow
INSPECTOR GENERAL

A-O l-90-00509

OFFICE OF INSPECTOR GENERAL

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DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Office of Audit Services
Region 1
John F. Kennedy Federal Building
Boston. MA 02203
(617) 565-2684

CIN: A-01-90-00509

Mr. Ronald Compton
President
AEtna Life Insurance Company
151 Farmington Avenue
Hartford, Connecticut 06106

Mr. Compton:

Enclosed for your information and use are two copies of a Department of Health and Human Services, Office of Inspector General (HHS/OIG), Office of Audit Services (OAS) report entitled, "Review of AEtna Life Insurance Company's Compliance With the Working Aged Provisions of the Medicare Secondary Payer Program for the period January 1, 1988 through December 31, 1989." Your attention is invited to the audit findings and recommendations contained in the report.

The I-IHS action official will contact you to resolve the issues in this audit report. Any additional comments or information that you believe may have a bearing on the resolution of this audit may be presented at that time.

In accordance with the principles of the Freedom of Information Act (Public Law 90-23), OIG/OAS reports issued to the Department's grantees and contractors are made available, if requested, to members of the press and general public to the extent information contained therein is not subject to exemptions in the Act

which the Department chooses to exercise. (See Title 45 Cede of Federal Regulations, Part 5)

Sincerely yours,

Richard J. Ogden
Regional Inspector General
for Audit Services

Enclosure

HHS Contact:
Norma E. Burke
Associate Regional Administrator
Division of Medicare
Health Care Financing Administration
JFK Federal Building, Room 1301
Boston, Massachusetts 02203

SUMMARY

The objectives of this review were to determine whether the AEtna Life Insurance Company (AEtna) has complied with the working aged provisions of the Medicare secondary payer (MSP) program and to identify, for collection, any mistaken Medicare payments made on behalf of Medicare beneficiaries who were covered under AEtna Employer Group Health Plans (EGHP).

Beginning in 1980, the Congress began enacting legislation that made Medicare the secondary payer under certain conditions. With respect to the working aged provisions, this legislation makes Medicare the secondary payer for hospital and medical services involving Medicare beneficiaries age 65 years and older who are covered under EGHPs based on their own employment (the "working aged") or that of their spouses of any age.

Based on a statistical sample of 240 AEtna customers, we estimate Medicare may have mistakenly paid about $13.6 million for hospital and other medical services provided to beneficiaries covered by AEtna EGHPs during the period January 1, 1988 through December 31, 1989. Responsibility for repayment of these mistaken payments lies with AEtna, its customers and the providers of service.

We identified $1,471,233 in potential mistaken Medicare payments for the sampled customers. These mistaken payments occurred primarily because beneficiaries did not always give to the providers of service accurate information on their or their spouse's EGHP coverage and employment status. As a result, EGHP coverage was not always identified or billed to the appropriate payer, AEtna. Also, we found instances of clerical errors at the provider level which resulted in both Medicare and AEtna paying as primary. To a lesser extent, we found instances of misclassification between active and retired individuals which resulted in AEtna inappropriately paying secondary.

Our recommendations, addressed specifically to AEtna, require that AEtna (1) continue to work with its customers to ensure that adequate information on proper health coverage billing is provided to enrollees affected by MSP provisions, (2) require that all customers identify to AEtna, at least annually, the working aged Medicare beneficiaries (65 and older) and aged spouses (65 and older) of employees of any age enrolled in their EGHPs, (3) continue efforts to correctly reprocess the identified $1,471,233 in potential mistaken Medicare payments so as to make Medicare a secondary pay source to AEtna EGHPs and (4) work with the Health Care Financing Administration (HCFA) toward a settlement for those customers not included in our sample. We believe that about $12.1 million in additional Medicare funds may have been mistakenly paid for those customers.

AEtna generally agreed with the first three recommendations. With respect to recommendation number 4, AEtna is willing to consider working towards a settlement after they have the opportunity to fully analyze the claims identified in the review.

In the report, we recognize that once AEtna has had the opportunity to reprocess all claims in question, the amount of identified potential mistaken Medicare payments, as well as our overall estimate, may be adjusted for deductibles, coinsurance, fee limits, etc., that are unique to EGHPs. In addition, we anticipate that some of the identified claims may have already been paid as primary by AEtna. Accordingly, the liability for these claims will be the provider's and not AEtna's. After reprocessing the mistaken claims, and based on the sample results, we would be willing to work with AEtna and HCFA on reaching a settlement.

CQNTENTS

INTRODUCTION

Background

Since the enactment of Medicare in 1965, the program has paid for most health services provided to eligible beneficiaries. Beginning in 1980, however, the Congress began enacting legislation that made Medicare the secondary payer in certain cases. As a secondary payer, Medicare is generally responsible for paying allowable residual charges only after a principal payment had been made by an Employer Group Health Plan (EGHP). By 1987, Medicare secondary payer (MSP) provisions had been made applicable to the working aged (age 65 or older) Medicare beneficiaries and their spouses age 65 or older who were covered by an EGHP as a result of employment. The Medicare beneficiary may have coverage as a result of (1) their employment or (2) employment of their spouse of any age. The EGHP must be from an employer with 20 or more employees. The intent of the legislation was to reduce Medicare expenditures by shifting health care costs to private insurers, self-insuring employers and, more than likely, the employee.

The overall administration of the Medicare program is a responsibility of the Health Care Financing Administration (HCFA). In meeting part of its responsibility, HCFA contracts with private insurers to process and pay Medicare claims. The HCFA's contractors are responsible for ensuring that a Medicare payment is made as a secondary source on behalf of older employees enrolled in EGHPs. The success of the MSP program, however, requires the cooperation not only of the contractors, but also of the employers, health care providers, private insurers and the insured individuals. The system, at the very least, is intricate and complex.

Under the MSP program, employers must offer the same coverage to all employees and their spouses regardless of age. The working elderly, however, are free to elect Medicare as their primary coverage instead of the EGHP offered by the employer. In this case, employers cannot offer these employees or their spouses complementary coverage on a secondary payer basis to supplement their Medicare coverage.

The AEtna Life Insurance Company (AEtna) is a HCFA Medicare contractor in several States and also a private insurer that underwrites and administers employer group health insurance policies on a nationwide basis. In November 1989, AEtna advised us that it issued or administered coverage for about 16,000 employer groups, but not all were subject to the "working aged" provisions of Federal law. According to AEtna, about 13,200 of the policyholders represented small business types. The MSP legislation requires EGHPs, insured or administered by AEtna, to pay as the primary source of payment, medical expenses of working aged beneficiaries enrolled in these plans. AEtna has 35 claims offices across the country that process EGHP claims.

Scope

Our audit was conducted in accordance with generally accepted Government auditing standards. The objectives of the audit were (1) to determine whether AEtna complied with the working aged provisions of the MSP program and (2) to identify for collection any mistaken Medicare payments made on behalf of beneficiaries covered under EGHPs insured or administered by AEtna. Our audit covered the period January 1, 1988 through December 31, 1989.

As part of our examination, we performed a review to understand and assess AEtna's internal control structure. We identified two key control elements essential in the coordination of health benefit payments between Medicare and private health care insurers:

- The identification of the working aged and covered spouses within the EGHPs.

- A generic claims processing system designed to pay benefits primary to Medicare in accordance with MSP provisions.

To review the effectiveness of the internal control structure, we analyzed AEtna's enrollment and claims processing systems as they pertain to MSP compliance. Primarily, we reviewed the claims processing system related to private EGHP claims to (1) determine what information was available relative to employees covered under the MSP provisions and (2) identify the controls in place to ensure that AEtna complied with MSP regulations.

With respect to the control structure, we found that AEtna has a system that edits claims based on age, EGHP code and claim development. Potential MSP claims are coordinated with Medicare to ensure proper reimbursement. However, we discovered during our compliance testing that we could not accurately determine the working aged or spousal population from AEtna's records. We concluded, therefore, that our consideration of the internal control structure could be conducted more efficiently by expanding substantive audit tests, thereby placing limited reliance on AEtna's internal control structure. Accordingly, we:

- Utilized a multi-stage statistical sample approach. Our primary sampling unit consisted of 8 claims offices randomly drawn from a population of 32 of AEtna's 35 claims offices. The 3 offices excluded did not handle the minimum 30 customers required for the secondary sampling unit and, therefore, were excluded from the population. The secondary unit, comprised of 30 randomly selected

customers handled from each office during the entire audit period, totalled 240 customers. Small business EGHPs (less than 50 insured individuals) were excluded from the population of customers.

- Obtained from AEtna a computerized file of enrolled individuals 65 years of age or older from the customers sampled in the eight claims offices.

- Obtained earnings information on AEtna enrollees from the Social Security Administration (SSA). By submitting Social Security numbers (SSN) of insured enrollees found on AEtna enrollment files, SSA retrieved for us related earned income information for the 2 years under audit. As AEtna could not identify working aged beneficiaries, this step began our identification of working aged beneficiaries within AEtna's enrollment files.

- Queried SSA records to obtain SSNs of covered spouses age 65 and older. (AEtna does not maintain the SSNs of spouses.)

- Verified AEtna enrollment information by contacting customers through a voluntary questionnaire. In this questionnaire, we asked the customers to provide us with names of the working aged, SSNs, dates of birth and the periods in which the employees (and spouses, if covered) were working and covered under an AEtna EGHP. We compared the company-supplied information to AEtna's enrollment database.

- Utilized HCFA's Medicare Automated Data Retrieval System (MADRS) database to determine the extent of Medicare payments made for medical services provided to the above identified working aged beneficiaries and spouses.

- Reviewed Medicare contractor records for a selected number of claims to validate Medicare payment information.

- Discussed with AEtna our analysis of selected Medicare payments made on behalf of the working aged and spouses covered under AEtna EGHPs.

- Used a variable appraisal program to estimate the amount of mistaken Medicare payments made on behalf of working aged beneficiaries and covered spouses under AEtna EGHPs.

In completing the above steps, we utilized several computer databases including extracts from AEtna's enrollment and paid claims files, MADRS, SSA's Enumeration Verification System (EVS), SSA's Earnings System, and SSA's Direct Access Retrieval System (SSADARS). We identified several limitations with these computer databases. A glossary attached to this report describes these databases (see Appendix I). Our review was not directed towards assessing the completeness of these databases. In most cases, we relied on data input into the systems. We did, however, test and corroborate data output to establish a reasonable degree of reliability of such information.

For those items tested, we found no instances of noncompliance except for the matters discussed in the FINDINGS AND RECOMMENDATIONS section of this report. With respect to the items not tested, nothing came to our attention to cause us to believe that untested items would have shown results which varied from the results of the tested items.

Subsequent to completing our survey of AEtna's MSP activities, we started our audit fieldwork in January 1990. We completed this effort in June 1991 after extensive verification and evaluation of data received from numerous sources. Audit work was conducted at the Office of Audit Services' offices in Hartford, Connecticut and Boston, Massachusetts and at AEtna's Connecticut offices in Enfield, Middletown and Farmington. We also visited Medicare contractors and providers in Massachusetts and Connecticut. On September 18, 1991, we provided AEtna with a draft report for comment. AEtna's comments are appended to this report (see Appendix III) and summarized starting on page 12.

FINDINGS AND RECOMMENDATIONS

The success of the MSP program depends heavily upon insurance companies, their customers and the providers of service to make aged employees or aged spouses of employed individuals aware that their coverage under an EGHP is primary over Medicare. Our computer match of AEtna's data files to Medicare payment records for 240 randomly selected AEtna customers has led to the identification of $1,471,233 in potential mistaken Medicare payments for the working aged population. Based on a statistical projection, we estimate that, for the period January 1988 through December 1989, mistaken Medicare payments were about $13.6 million for all AEtna customers. Refunds to the Medicare program would be payable by either AEtna, its customers or the providers of service.

Our review showed that in the majority of cases resulting in mistaken payments, AEtna did not receive a bill from the provider of services. Rather, bills were sent directly to Medicare. Although AEtna has established some procedures for identifying MSP situations, we found internal control errors that resulted in AEtna improperly paying secondary to Medicare. Similarly, errors in the coordination of health benefit payments at the provider level resulted in primary payments being made by both AEtna and Medicare.

System for Identifying Medicare Secondary Payer Cases

As part of our review to assure that AEtna complied with MSP provisions, we evaluated AEtna's internal control structure for identifying potential MSP cases. In the processing of claims for EGHP enrollees who fall under MSP provisions, AEtna relies significantly upon information supplied by its customers. AEtna's controls for assuring appropriate payments include (1) the age of the insured enrollee and covered spouse - an indicator of Medicare coverage, (2) indicators on the AEtna claim form identifying employment status and (3) claim development whereby information received from prior payments is kept for reference purposes.

AEtna maintains two generic types of filing systems for EGHP claims of its customers. These include (1) direct handled customers who provide AEtna with an up-to-date list of eligible employees/spouses along with other information necessary to process claims submitted directly to them by the providers and (2) standard handled customers who certify that their employees/spouses are eligible before claims are submitted to AEtna

for processing. With respect to the latter customers, complete eligibility information for all employees may not be updated or even available.

AEtna provides coverage utilizing several different funding arrangements. The three primary types of funding arrangements are fully-insured, split-funded and self-insured administrative service contracts. Records for these funding arrangements are maintained using either of the two filing systems described above.

With few exceptions, claims for insured individuals are filed using the SSN of the employee. The spouse's SSN is not obtained or utilized for claims processing. Insured individuals 65 years or older can be identified from AEtna's computerized records by date of birth. Although information regarding employment status is obtained via AEtna's claims form, it is not entered into the claims processing system. Therefore, one cannot identify the number of working aged beneficiaries from AEtna's computerized records.

Identification of Potential Mistaken Medicare Payments

Since AEtna does not capture employment status, nor maintain SSNs for spouses, we relied on SSA earnings and spouse information as well as employer confirmation to identify those individuals subject to MSP provisions. To accomplish our audit objectives, we used a multi-stage statistical sample approach. In this regard, the primary sampling unit was an AEtna claims office and the secondary sampling unit was a customer handled within that office during the entire audit period. We statistically selected a random sample of 30 customers from each of the 8 randomly selected claims offices. In total, we reviewed 240 AEtna customers. Because of the large number of customers that AEtna services, we developed this statistical sampling approach to determine the extent of mistaken Medicare payments made on behalf of working aged beneficiaries and their spouses.

For the sampled customers, we obtained from AEtna a computer tape of all individuals 65 years or older as of December 31, 1989 for whom AEtna had eligibility records (spouses were identified by name and date of birth). For all insured enrollees listed on these records, we obtained SSA earnings information for each SSN. We limited our test work to those enrollees showing earned income of $10,000 or more during 1988 or 1989. The SSNs of the covered spouses of wage earners were obtained using the on-line SSADARS or SSA's EVS match (see Appendix I for definitions). This step was necessary since access to the Medicare payment file can only be made via a Medicare beneficiary's SSN.

We also prepared a questionnaire that was sent to each sampled customer requesting a list of all aged employees/spouses, their SSNs and their coverage dates while employed. Of the 240 customers sampled, 150 responded to our questionnaire and provided us with requested information. We used the information furnished by the customers to verify the records of AEtna and SSA.

Once we identified those individuals who met the age and work status criteria, we then matched their SSNs to MADRS. The MADRS provided summary descriptions of each Medicare payment made during the audit period. The flowchart below illustrates the various computer files we used to identify Medicare payments made on behalf of the working aged and spouses enrolled in AEtna EGHPs.

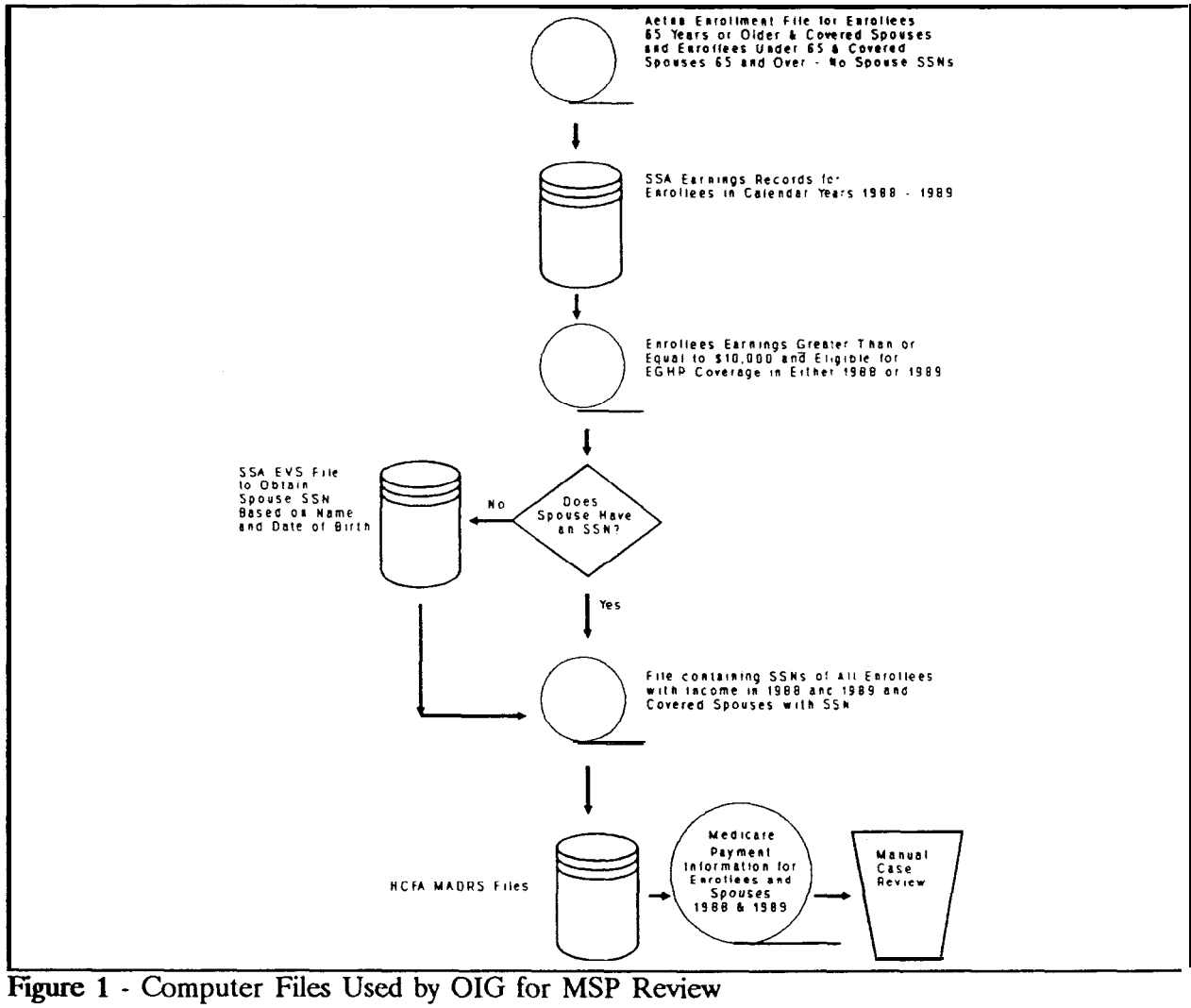

Figure 1 - Computer Files Used by OIG for MSP Review

The resultant product of the above computer matches still required manual case development. To reach a conclusion on each identified enrollee and spouse, we

developed a "coverage window" or the period of time in 1988 and 1989 that the enrollee met the criteria of working aged/spouse enrolled in an AEtna EGHP. Medicare payments falling outside the coverage window were excluded from further review. Information used to ascertain an individual coverage window included determination of:

- Medicare service dates during the same time period as AEtna health benefit coverage dates.
- Benefits offered under the group health plan in which the individual was enrolled.
- Employer corresponding to the earnings previously identified.
- Date on which the enrollee retired.

During our manual review process, we found that most individuals did not fit the MSP criteria because they had (1) cancelled AEtna coverage before or during the audit period, (2) retired on a certain date, thereby showing no subsequent earned income or (3) worked for another employer but had retained the group health benefits of the employer from which they retired (a most common occurrence). In addition, we found customers (previously undisclosed by AEtna) which had cancelled AEtna EGHP coverage before or during the audit period, had no medical coverage with AEtna (i.e., dental plan only) or which had a "major medical" plan with AEtna - a plan whose benefits are secondary to another private insurer's EGHP. The chart below illustrates the extent of adjustments we made to identify potential mistaken Medicare payments:

MEDICARE PAYMENTS OF AETNA ENROLLEES:	
Working and Retired Age 65 and Over	$562254,368
Less: Enrollees with Limited or No Income* in 1988 or 1989	(554,753,988)
Enrollees Eliminated by Manual Review for Reasons Cited Above	(6,029,147)
Working Aged and Covered Spouses with Potential Mistaken Medicare Payments	$1,471,233

* Enrollees with Less than $10,000 in Earned Income in 1988 and 1989.

As noted above, our analysis identified $1,471,233 in potential mistaken Medicare payments. These Medicare payments were for a wide range of medical services, including: hospital inpatient and outpatient, laboratory, radiology, home health and physician services. Extrapolating the results of the statistical sample over the population using standard statistical methods, we estimate that Medicare may have mistakenly paid about $13.6 million for hospital and other medical services provided to beneficiaries covered by an AEtna EGHP during the period January 1, 1988 through December 31, 1989. We attained our estimate by using a multi-stage appraisal program and applying a 90 percent confidence level. The precision of the point estimate at the 90 percent confidence level is plus or minus 41.61 percent. The dollar value of the potential mistaken Medicare payments from the sampled customers along with the point estimate for each claims office is identified in Appendix II.

We recognize that once AEtna has had the opportunity to reprocess all claims in question, the amount of identified potential mistaken Medicare payments, as well as our overall estimate, may be adjusted for deductibles, coinsurance, fee limits, etc., that are unique to the various EGHPs. In addition, we anticipate that some of the identified claims may have already been paid as primary by AEtna. Accordingly, the liability for these claims will be the provider's and not AEtna's.

Improvements are Needed to Reduce Mistaken Medicare Payments

The success of the MSP program depends upon the proper coordination of health benefit payments among the various parties involved. In addition to our audit work at AEtna, we also reviewed MSP policies and procedures at 12 acute care hospitals located in Massachusetts and Connecticut. Providers routinely query Medicare beneficiaries, at least for inpatient hospital admissions, regarding the availability of other health insurance. Providers also rely extensively on Medicare beneficiaries to provide accurate and timely identification of other health insurance coverage. However, our analysis of hospital intake records showed that (1) beneficiaries do not always provide accurate information on their own or their spouses' insurance coverage and employment status and (2) MSP forms used during patient interviews are, in some cases, poorly written and confusing. As a result, EGHP coverage may not always be identified or billed to the appropriate insurer. ***Based on AEtna's review of our identified potential mistakenly paid Medicare hospital claims from the Enjield, Macon and Seattle claims offices, they found that about 62 percent of these claims were never billed to AEtna.***

About 12 percent of the cases reviewed represented internal control weaknesses at AEtna and its customers resulting in AEtna inappropriately paying claims secondary to Medicare. In this regard, we found recurrent instances whereby a customer indicated to us that an enrollee was actively employed but AEtna's records did not reflect this information. For example, we found that an enrollee showed indications of an initial retirement but later returned to active employment with the company. AEtna was not notified of this change. Treating the enrollee as a retiree, AEtna paid secondary.

In the three claims offices mentioned above, our analysis also disclosed that about 26 percent of the mistaken claims were also paid primary by AEtna. Recovery of these overpayments will have to be made at the provider level since AEtna has fulfilled its responsibility under the MSP provisions by paying primary.

Medicare Mistaken Payment Recovery and Recoupment Process

One of the objectives of this review was to identify for collection any mistaken Medicare payments made on behalf of beneficiaries in EGHPs insured or administered by AEtna. We acknowledge that AEtna, as an insurer, has several types of liability and funding arrangements tailored to the needs of its customers. AEtna maintains funding arrangements with customers which include administrative service contracts, fully-insured and split-funded contracts. In each of these arrangements, AEtna's duties and liability for payment of claims varies. In addition, a single customer may have several EGHPs, each having different deductibles, coinsurance and coverage limits. The above factors must be considered to resolve the extent to which AEtna, its customers and the providers of service are liable for repayment of inappropriately paid Medicare claims.

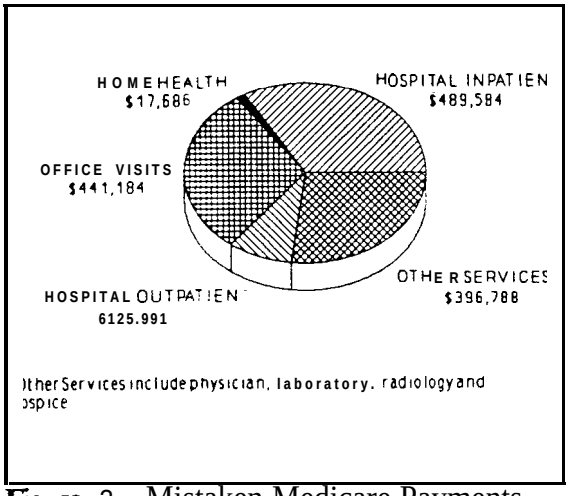

Figure 2 - Mistaken Medicare Payments for the 240 Customers Reviewed

As previously stated, we identified $1,471,233 in potential mistaken Medicare payments (Figure 2 depicts the range of health care service claims associated with this total.) Accordingly, we have provided AEtna with detailed information on the identified $615,575 in inpatient and outpatient claims so that AEtna can begin to reprocess the claims and make the appropriate payments to Medicare. With respect to the remaining $855,658, AEtna has stated that the limited MADRS information on these payments is not sufficient for its reprocessing at this time. Information on these identified payments, consisting of lab services, radiology, home health and physician services, will be provided to HCFA for recoupment by the Medicare contractor which originally paid the claim.

Conclusions

For the period January 1, 1988 through December 31, 1989, we identified significant instances whereby Medicare payments were made primary to AEtna EGHP coverage. We believe that the MSP coordination process needs improvement in identifying insurance sources. We noted that most problems occurred at the provider level with problems going undetected through Medicare and AEtna payment systems. More

emphasis is needed by all involved parties, including: AEtna, Medicare contractors, employers and providers of service, to instruct working aged beneficiaries that Medicare pays secondary to EGHPs. The Federal Government, for its part, has stepped up efforts to enforce compliance with MSP laws. Legislation, both passed and proposed, includes:

- Implementation, through legislation passed under the Omnibus Budget Reconciliation Act (OBRA) of 1989, extended by OBRA of 1990, of an Internal Revenue Service (IRS)/SSA/HCFA Data Match. The purpose of this data match is to identify employers whose health plans are likely to be primary payers to Medicare for certain Medicare beneficiaries. Such employers are presently being contacted to confirm coverage information. This information will be used to both recover mistaken Medicare payments made to individuals covered under an EGHP and to prevent Medicare from making primary payments for such individuals in the future. According to HCFA, this information will feed into the common working file for future MSP control purposes.

- Creation of a "clearinghouse" to systematically collect EGHP information. This information would be obtained from proposed changes to IRS form W-2 which would add a field indicating an employee's health insurance status. The clearinghouse database could be queried before payment of Medicare claims.

We believe it is incumbent upon AEtna as well as its customers to work with the Congress and the Department to achieve the goals of the MSP program.

Recommendations

Our recommendations contained in this report, addressed specifically to AEtna, require that AEtna:

1. ***Continue to work with its customers to ensure that adequate information is given to working aged beneficiaries that Medicare is secondary payer to coverage benefits of an EGHP,***

2. ***Require that all customers identify to AEtna the working aged enrolled in their EGHPs and that this information be updated at least annually,***

3. ***Continue efforts to correctly reprocess the identified $1,471,233 in potential mistaken payments so as to make Medicare a secondary pay source to EGHPs, and***

4. ***Work with HCFA towards a financial settlement for those customers not included in our sample. As indicated, we estimate that the additional amount of mistaken Medicare payments were about $12.1 million for the period January 1, 1988 through December 31, 1989. We believe that a statistical sample approach is a viable and acceptable method for settlement rather than claim-by-claim development which would prove time consuming and costly for both the Government and AEtna.***

Auditee Comments

In summary, AEtna generally agreed with our recommendations. AEtna's responses to our recommendations are summarized below and included in their entirety as Appendix III.

Recommendation No. 1 - While AEtna cannot ensure that adequate information is received by all working aged beneficiaries, it will continue to educate its customers and their employees as to the requirements of MSP. AEtna hopes to use our case-by-case review of potential mistaken Medicare payments from the audit to identify problem areas where it can target its efforts.

Recommendation No. 2 - In response, AEtna stated that it is not in a position to require any action by its customers. However, AEtna will review its current methods for determining the employment status of its working aged beneficiaries and assess whether more effective approaches are available and practical. As discussed in greater detail on pages 4 and 5 of its response, AEtna has expressed concern over the number of enrolled individuals that we identified from customer questionnaires and SSA wage records as working, but, according to its records were in retired plans. AEtna believes that some of these enrollees may be part-time workers, and not eligible for full coverage. However, it also recognizes that conflicts may exist between its records and records maintained by their customers. AEtna will be reviewing the information gathered by the auditors to assess the scope of the problem and then determine what remedial action, if any, is necessary.

Recommendation No. 3 - AEtna is currently engaged in efforts to reprocess the $615,575 in Medicare Part A claims, and is awaiting the submission of information to reprocess the $855,658 in Part B claims.

Recommendation No. 4 - AEtna is willing to consider working towards a settlement, after they have had the opportunity to fully analyze the claims identified in the review. While AEtna recognized that claim-by-claim development will be burdensome for both the Government and AEtna, certain issues need to be resolved. In this regard, AEtna raises the question as to what basis can a settlement be reached considering the precision (plus or minus 41.6 percent) of the report's estimate of mistaken payments. In addition, AEtna believes that after reprocessing the identified mistaken claims,

adjustments to the estimate will be needed to account for the coinsurance and deductibles not payable under EGHPs, and primary payments already made by AEtna. Finally, because of the way EGHPs are funded, payments to Medicare for most of its mistaken payments will have to be borne by AEtna's customers. Before reaching a settlement based on statistical sampling, AEtna would need to develop a methodology for fairly allocating these costs to its customers.

Additional OIG Comments

Our findings are based on a statistically valid sample. The precision percentage of our projection was affected by the quality of information given to us by AEtna on its customers. Some of the problems with AEtna's information on the 240 customers we sampled included (1) group plans with no medical insurance (dental plan only), (2) customers who cancelled AEtna coverage prior to the audit period and (3) major medical plans for which AEtna pays secondary to another private insurer. These customers, treated as zero errors, helped create a high variance in our findings among companies sampled.

As stated on page 9 of the audit report, we recognize that once AEtna has had the opportunity to reprocess all claims in question, the amount of identified potential mistaken Medicare payments, as well as our overall estimate, may be adjusted for deductibles, coinsurance, fee limits, etc., that are unique to the various EGHPs. In addition, we anticipate that some of the identified claims may have already been paid by AEtna as primary. Accordingly, the liability for these claims will be the provider's and not AEtna's. After reprocessing the mistaken claims, we would be willing to work with AEtna and HCFA on reaching a settlement based on the sample results. In the meantime, we will be coordinating our audit efforts with HCFA's OBRA Data Match for those AEtna customers not included in our sample (see page 11).

As a general comment, we would like to respond to a statement that appears on page 2 of AEtna's response;

> "...The OIG auditors did not attempt to identify the amount of primary payments which were correctly made by AEtna and therefore were not made by Medicare..."

We held several meetings with AEtna personnel to discuss the problems we encountered in developing a computer application to quantify primary payments made by AEtna for the working aged. As discussed, we were unable to rely upon AEtna's paid claims file to differentiate between primary and secondary payments. Moreover, we found the AEtna paid claims file was not compatible with MADRS.

APPENDICES

Glossary

The following terms and definitions are presented for general information.

Administrative Service Contract (ASC)	Agreement between AEtna and an organization whereby the organization pays AEtna a fee to process claims. Health benefits are paid by the organization.
AEtna Enrollment Files	(Also known as the AEtna Family File.) An extract of EGHP enrollment information provided to us by AEtna for the 240 customers under review. Eligibility information reflects the status of enrollees and spouses at the time the extract was made (early 1990) and not during the audit period. In addition, AEtna does not maintain the SSN of the covered spouse on the enrollment files.
Claims Office	An AEtna field office which processes insurance claims for selected customers. Customers may fall within the same regional area as the claims office but workload distribution may affect the assignment of policyholders. Large customers may be handled out of several claims offices.
Covered Spouse	An individual eligible for EGHP benefits based on the employment of a spouse.
Customer	Any organization that obtains coverage with AEtna. Customers include insured policyholders, administrative service contract holders and split-funded arrangements.

Direct Handled	An AEtna filing system for EGHP claims. Direct handled customers provide AEtna with a list of eligible employees along with other information necessary to process claims.
EGHP	Employer Group Health Plan - Insurance plans offered by customers underwritten by AEtna. A customer may offer several EGHPs of varied coverage. Each EGHP may be expressly written to address the needs of specific groups (i.e., management, unions, plant locations, retirees, etc.). We did not include small business EGHPs (less than 50 insured individuals) in our statistical sample because AEtna could not provide the exact number of enrolled individuals in these plans.
Enrollee	An individual eligible for benefits under an AEtna-insured or administered EGHP based on employment.
EVS	Enumeration Verification System - An SSA computer database which verifies that a given SSN is assigned to the individual whose name and date of birth are submitted.
Mistaken Payment	A primary Medicare payment made on behalf of a Medicare beneficiary, age 65 years and older, who is insured under an EGHP based on his/her own employment or that of his/her spouse of any age.
MADRS	Medicare Automated Data Retrieval System - A computer database operated and maintained by HCFA. The MADRS contains summary information on Medicare claims processed nationwide. Because of its summary nature, many MADRS records require further support to determine the validity of the payment.

Medicare Contractor	An organization contracting with the Federal Government to process Medicare claims.
MSP	Medicare Secondary Payer provisions of the Social Security Act makes Medicare a secondary payer to an EGHP in certain situations. The MSP provisions apply to claims for medical services involving automobile accidents, liability, no-fault, workers' compensation, disability, black lung disease, end stage renal disease, the Veterans Administration and the working aged. The report addresses only the working aged provisions.
Policyholder	An organization, usually an employer, who contracts with AEtna for insurance coverage of its members, employees, families, etc. Policyholders pay premiums to AEtna for such coverage. A policyholder may have several EGHPs.
Split-Funded Group Plan	A group health insurance policy in which an employer is directly responsible for benefit payments to its employees up to a certain liability limit. Over this limit, AEtna assumes payment of claims.
SSA Earning System	An SSA database employed to obtain an individual's earned income through input of the enrollee's name, date of birth and SSN. This database does not, however, identify the employer connected with the earnings. Further manual research of on-line SSA data was required to identify the employer.

SSADARS	Social Security Administration Direct Access Retrieval System - An on-line access computer database which provides general information on individuals' earnings, employers and cross-references to spouses.
Standard Handled	An AEtna filing system for EGHP claims. Standard handled customers certify to AEtna that their employees/spouses are eligible before claims are submitted to AEtna for processing. Enrollment records are created only upon initial submission of a claim to AEtna. Therefore, AEtna does not maintain complete enrollment files for enrollees of these customers.
Working Aged Provision	Medicare beneficiary age 65 or older who is covered by an EGHP as a result of their employment or the employment of their spouse of any age.

Statistical Estimate Of Mistaken Medicare Payments - AEtna Life Insurance Company - January 1, 1988 through December 31, 1989

AEtna Claims Office	AEtna Customers Ponulation	Sampled	Dollar Value of Errors	Customers With Errors	Point Estimate
El Paso	41	30	$ 72,614	6	$ 99,239
Enfield	111	30	309,312	19	1,144,454
Fresno	104	30	115,813	11	401,487
Macon	66	30	240,036	15	528,080
Peoria	48	30	293,929	14	470,287
Richmond	58	30	253,166	25	489,454
San Antonio	46	30	95,403	12	146,285
Seattle	43	30	90.960	12	130.376
	517	240	$1,471,233		3,409,662

Statistical Estimate of Mistaken Payments for All Claims Offices' $13,638,642

[1] To estimate the potential mistaken Medicare payments at the 32 claims offices included in our population, we used a multi-stage statistical sample approach. Extrapolating the results of our statistical sample, we concluded that the most likely dollar impact of mistaken payments at the 32 claims offices is $13,638,642. The precision of the point estimate at the 90 percent confidence level is plus or minus 41.61 percent.

October 17, 1991

Mr. Richard J. Ogden
Regional Inspector General for Audit Services
Department of Health and Human Service5
Office of Inspector General
John F. Kennedy Federal Building
Boston, Maeeachueette 02203

Re: Report of Compliance with MSP Program

Dear Mr. Ogden:

I am responding to the letter and accompanying draft report which you eent to Mr. Ronald Compton, Preeident of Aetna Life Insurance Company ("Aetna") on September 18, 1991. Your letter was received by Mr. Compton on September 20, 1991. The purpose of this letter is to provide you written comments on the draft report entitled "Review of Aetna Life Insurance Company'8 Compliance With The Working Aged Provisions Of The Medicare Secondary Payer Program For The Period January 1, 1988 Through December 31, 1989" (the "Report").

The audit of Aetna's compliance with the Medicare Secondary Payer ("MSP") program began in April, 1989. Aetna has fully cooperated with the Office of Inspector General ("OIG") throughout the audit process. Detailed explanations and demonstrations of Aetna'8 eystems were provided to OIG personnel. Thoee pereonnel were also given free access to information available through Aetna'5 on-line claim5 payment systems. A considerable amount of data were extracted from Aetna'8 computer files and effort8 were made to fully respond to auditor inquiries. In short, Aetna ha8 devoted several hundred hours of etaff and computer time to assisting the OIG in its audit.

The Report indicate8 that some information that would have been helpful to the auditor8 was not found in Aetna's record8 (e.g., spousal social security numbers). It should be noted that Aetna keep8 information necessary to meet it8 business need5 and meet etatutory and regulatory requirements. Some information that the auditor5 would have found helpful is unneceeeary for Aetna's business and is not required for any legal or regulatory purpose.

Objectives of The Audit

The title of the report indicate5 that the purpoee of the audit was to assess Aetna's compliance with the MSP Program. This is confirmed in the summary which states that the review had two

purposes: to determine whether Aetna complied with HSP and to identify for collection any mistaken Medicare payments made on behalf of Medicare beneficiaries covered under Employer Group Health Plane (EGHPs) insured or administered by Aetna.

Although a primary purpoee of the audit was to assess Aetna's compliance with HSP, very little of the Report is devoted to such an assessment. Rather, the Report is primarily devoted to the second purpose of the audit, quantifying miotaken Medicare payments.

While the Report says little about Aetna's compliance, an analysis of the information contained in the report demonstrates that Aetna achieved a remarkably high degree of accuracy in processing MSP claims given the large number of claim dollar-e involved. The Report notes that the audit first identified all Medicare payments made on behalf of over-65 beneficiaries covered under EGHPs insured or administered by Aetna. The auditors then went through several steps to identify the amount of such payments that may have been mistaken. Starting with a univeree of $562,254,368 in Medicare payments, only $1,471,233 were identified as potentially mistaken, amounting to a mistaken payment rate by Medicare of less than 0.30.

Further examination of the report shows that for about 88% of the approximately $1.5 million in potential mistaken payments by Medicare, Aetna either paid primary benefits or never received a claim for benefits. A5 will be discussed below, even for the small number of remaining claims in which Aetna paid secondary benefite, Aetna'e payments were highly accurate according to the employment information provided to Aetna by its customera.

The Report's focus on quantifying potential mietaken Medicare payments also leads to an understatement of Aetna's compliance with HSP. The OIG auditors did not attempt to identify the amount of primary payment8 which were correctly made by Aetna and therefore were not made by Medicare. By including such Aetna primary payments in the audit sample, the Report could have reflected the total amount of health benefits paid (by both Aetna and Medicare) on behalf of Medicare beneficiaries. Insuch an expanded universe the relatively slight number of potentially mistaken Medicare payments would become even less significant.

The second purpoee of the Report was to identify potential mistaken Medicare payments for collection. The implication of the Report is that any such potential mietaken Medicare payments would be recoverable from Aetna. However, upon close reading of the Report, it becomes clear that a substantial portion of the potential mistaken payments would not be Aetna's liability. As will be more fully explained below, for many of these mistaken payments Aetna already made a proper primary payment. Recovery of Medicare's overpayments in such cases would properly be from the providers or beneficiaries who received double payment. The Report also recognizes that in many cases, the primary payment

obligation would be the responsibility of a self-insured ECHP and not Aetna. Finally, a claim-by-claim review of identified potential overpayments is likely to reveal that coinsurance and deductibles will apply, with the responsibility for such amounts remaining with Medicare as the secondary payer.

Categories of Mistaken Medicare Payments

The Report identifies three categories of potentially mistaken Medicare payments: claims which were never received by Aetna; claims for which both Medicare and Aetna made a primary payment; and claims for which Aetna made a secondary payment. In order to put the Report in the proper context it is worthwhile to examine the nature of these "mistakes."

Claims Not Received by Aetna: Aetna cannot pay claims it does not know about. Based on an analysis of potentially mistaken Medicare payments made with respect to beneficiaries covered under EGHPs administered through three of Aetna's claim offices, the Report estimates that Aetna never received claims for 62% of the potentially mistaken Medicare payments. Hedicare did receive those claims and paid them without ever notifying Aetna.

Since the inception of the working aged provisions of the MSP law, Aetna has provided its customers with notice of the law's requirements. According to the Report's findings, despite this effort, a number of working aged covered under Aetna insured or administered EGHP's have failed to submit their health benefit claims to Aetna. As will be discussed below, *Aetna* will continue to work with its customers to inform their employees about the HSP program.

Regardlees of any educational efforts which are undertaken, some beneficiaries will nevertheless neglect to file their claims with Aetna. In such cases it is incumbent upon the Medicare contractor to recognize that Medicare is the secondary payer and instruct the beneficiary to submit the claim to the EGHP in the first *instance.* The Medicare contractors manual is very *clear* as to the requirements of "first claim development." In investigating contractor claims for reimbursement, we have become aware of a number of instances in which contractors made mistaken primary payments despite having information in their records that EGHP coverage was primary. Aetna *wants* to fulfill its obligations to make primary payments when appropriate and when claims for benefits are submitted in a timely fashion. We can fulfill this obligation if contractors receive the proper funding and incentives to *avoid* making mistaken payments when they have information indicating that the beneficiary has primary EGHP coverage.

Medicare and Aetna Both Paid Primary: The Report indicates that for about 26 percent of the potentially mistaken Hedicare primary payments, Aetna also made a primary payment. In nearly all of tneae cases providers have received a windfall double payment.

Again, mistaken Medicare payments could be avoided if Medicare contractors did not make primary payments when they have information showing primary EGHP coverage.

In order to reduce the number of cases in which both Aetna and Medicare make primary payments, Aetna follows a procedure for notifying the Medicare contractor whenever a claim submission includes information indicating Medicare may have made a mistaken primary payment. Our notification includes a request for instructions as to where to send Medicare's reimbursement if Medicare did in fact make a mistaken payment.

Aetna Paid Secondary: The Report implies that for 12% of the potentially mistaken Medicare payments Aetna may have made secondary payments when it had a primary payment obligation. The Report points to what are described as "internal control weaknesses at Aetna and its customers resulting in Aetna inappropriately paying secondary to Medicare."

The vast majority of these cases are the result of Aetna having information in its files that the beneficiary is covered as a retiree. Aetna obtains this information from the beneficiary himself (when the claim form is submitted) or from the employer providing the EGHP coverage.

The Report recognizes that Aetna generally obtains eligibility information from its customers in one of two manners. In a 'standard handled" case, the customer verifies eligibility each and every time a claim is submitted. Therefore the beneficiary's status as a retiree is confirmed by the employer with each claim submitted. In a "direct handled" case, the employer provides Aetna with eligibility information every month. In these cases, Aetna's information that a beneficiary is retired is confirmed on a monthly basis.

The Report infers the existence of "internal control weaknesses" as a result of the audit's identification of individuals as actively employed when Aetna's records showed these individuals to be retired. For a large (but unspecified) number of these cases, the auditors determined the employment status of an individual based upon Social Security wage records. The auditors assumed that any individual earning 910,000 or more per year would qualify for primary coverage under an EGHP.

Under the HSP law, an individual who is covered under an EGHP as a retiree is entitled to primary Medicare coverage. However, if that individual returns to work for the same employer, current MSP regulations require the EGHP to pay primary benefits if that individual would qualify for coverage as an active employee. In other words, if the EGHP requires non-retired employees to work a minimum number of hours per week to qualify for coverage, a re-employed retiree working the same number of hours must receive primary EGHP coverage.

Host EGHP's require employees to work at least half-time (e.g. 17½-30 hours per week) to qualify for coverage under an EGHP. Xany re-employed retirees are rehired by their employers because of their experience and highly developed skills. Such individuals employed at even a modest wage can easily earn 510,000 in a year and not qualify for EGHP coverage as active employees.

In the remaining cases identified as active employees the auditors relied upon questionnaires completed by some of the customers that were part of the audit sample. While Aetna has not yet fully reviewed these questionnaires, it appears that our customers may have provided the auditors with information which conflicts with information those same customers have provided Aetna on either a monthly basis or *on* a claim-by-claim basis. Aetna will attempt to resolve each such conflict as we process the potential mistaken Medicare claims identified by the audit.

Although we have not yet had an opportunity to confirm the employment status of individuals whom the auditors have identified as active employees (or their spouses), we should note that the questionnaires sent out to employers may well have identified re-employed retirees who are not eligible for coverage as active employees. The questionnaire asked employers to list all active employees (full and part-time) over age 65. It did not ask employers to differentiate among the employees listed as to which would qualify for coverage as active employees. It is quite possible (perhaps probable) that a *number* of employees listed are re-employed retirees who do not meet the minimum work requirements for coverage under the employer's plan. Coverage for these employees would be as retirees and therefore secondary to Medicare.

Although we believe that the audit may have overstated the number of individuals who are misidentified in Aetna's records as retirees, it is likely that our examination of information gathered by the auditors will reveal some conflicts in classifications of some individuals. The primary coverage status of re-employed retirees had been unclear until new HSP regulations became effective in November, 1989. The audit period by and large preceded the new regulations. Reports of primary coverage status submitted to Aetna prior to the effective date of the regulations may well be different from the status the auditors may have assigned by applying the new regulations.

Aetna will be reviewing the information gathered by the auditors to assess the scope of this problem and then determine what remedial action, if any, is necessary.

Funding Arrangements

The Report alludes to the fact that Aetna has a wide variety of funding arrangements with its customers. Before specifically commenting on the Report's recommendations, I would like to

expand upon the nature of these funding arrangements.

Group health coverage, particularly in the large case market examined by the auditors, is essentially a mechanism for funding the cost of health care claims (and related administration) for employees. These arrangements run from self-insured plans in which the employer bears the full responsibility for paying claims, to experience-rated insured plans in which Aetna pays claims, but passes claim costs on to the customer through experience-rated premium adjustments. Regardless of the funding arrangement used, the vaet majority of claim costs eventually are borne by the customer, with Aetna providing the services necessary to administer the plan and control costs. Aetna administers these plans based upon the eligibility information it receives from its customers.

Wost of our large case plans are either self-insured, with Aetna providing administrative services only, or 'split-funded", with customers' dollars ueed to pay most claims and Aetna assuming liability only for claims in excess of pre-determined monthly or annual limits. In 1989 over 90% of all claim payments made by Aetna in the large case market were made with customer funds.

To the extent that claims for recovery are made by Medicare for claims which were never filed with Aetna, or for individuals for whom Aetna did not have accurate employment status information, Aetna will need to determine on a claim-by-claim basis the entity which is financially responsible for payment. In most cases, the costs of recovery will ultimately be borne by the employer rather than by Aetna.

Responses To Specific Recommendations

We have reviewed the specific recommendations addressed to Aetna and make the following responses:

Recommendation One - *Continue to work with its customers to ensure that adequate information is given to working aged enrollees that Medicare is secondary payer to coverage benefits of an EGHP.*

Response: Aetna has provided its customers with information about HSP since the advent of the program. While Aetna cannot ensure that adequate information is received by all working aged enrollees, we will continue our efforts to educate our customers and their employees as to the requirements of HSP. We hope to use our case-by-case review of potential mistaken Medicare payments from the audit to identify problem areas where we can target our efforts.

Recommendation Two - *Require that all customers identify to Aetna the working aged enrolled in their EGHP's and that this information be updated at least annually.*

Response: Aetna is not in a position to require any action by our customers. However, we will review our current methods for determining the employment status of our working aged enrollees and assess whether more effective approaches are available and practical. We will also use the audit results to assess the accuracy of the information we currently are receiving and target those areas in which accuracy can be improved.

Recommendation Three - *Continue efforts to correctly reprocess the identified $1,471,233 in potential mistaken payments so* as *to make Medicare* a *secondary pay source to EGHPs.*

Response: Aetna believes that under MSP laws and regulations, it may deny claims which are not filed in accordance with contractual time limits. However, because of our efforts to fully cooperate with the audit, Aetna will not assert any such rights to deny claims which were identified as part of the audit and which are submitted in a timely fashion. Aetna is currently engaged in efforts to reprocess the $615,575 in Medicare Part A claims which were submitted. We are awaiting submission of information necessary to reprocess the $855,658 in Part B claims. It is our understanding that this information will be submitted by a number of different Medicare contractors. We encourage the Health Care Financing Administration to coordinate the process of submitting these claims for reprocessing 50 that they may be submitted in a timely fashion and in a format that will facilitate processing. Aetna and its customers will be prejudiced by extended delay in submitting the claims as the administrative burden of processing a claim increases with the passage of time.

Recommendation Pour - *Work with HCFA towards a financial settlement for those customers not included in our sample. As indicated, we estimate that the additional amount of mistaken Medicare payments were about $12.1 million for the period* January *1, 1988 through December* 31, *1989. We believe that a* statistical *sample approach* is *a viable and acceptable method for settlement rather than claim-by-claim development which would prove* time *consuming and costly for both the Government and* Aetna.

Response: While Aetna recognizes that claim-by-claim development will be a burdensome undertaking for both the Government and Aetna, there would be many problems that would need to be resolved before a settlement based upon the Report's projections could be achieved. First, as the Report notes, the precision of its estimate at the 90 percent confidence level is plus or minus 41.61%. This precision range amounts to a spread of $11,350,077. Upon what basis can parties agree to a settlement within such a huge spread?

Furthermore, the Report notes that its estimate does not take into account co-insurance and deductibles not payable under the EGHPs. Medicare would remain liable for such amounts. Some method would need to be developed to determine how much of the estimated mistaken paymente would remain the responsibility of Hedicare after the calculation of co-ineurance and deductiblea. Also, our reprocessing of identified potentially mistaken claims is likely to reveal that a number of them were not in fact "mistaken" or that Aetna already made a primary payment. If thie occurs, further adjustments to the projection will be required.

Finally, as noted earlier, because of the way EGHPs are funded, payments to Medicare for most of its mistaken payment6 will have to be borne by Aetna's customers. These customer6 have a wide variety of funding arrangements. Also, as noted in Appendix II of the Report, the auditor6 found a very wide variation among customers as to the amount6 of potential mistaken Medicare payments. *Before* reaching a settlement based *upon* a statistical sampling, Aetna would need to develop a methodology for fairly allocating these coots to its customers. It is not presently clear that any such fair methodology can be developed.

Despite the difficulties in achieving a settlement based upon the Report'6 projections, Aetna will be willing to consider this matter further. Once we have had an opportunity to fully analyze the Part A and Part B claims identified by the audit, and conduct an independent assessment of the audit results, we would be prepared to discuss possible approaches to achieving a comprehensive statistical settlement that address the concern6 outlined above.

Conclusion

I appreciate the opportunity to respond to the Report and to present "Aetna'6 side of the story". HSP has proven to be a very complicated program to administer. We are pleased to see that the Report bear6 out what we have believed all along - that a6 an administrator and insurer of EGHPs, Aetna has done an outstanding job of meeting it6 obligation6 under XSP.

The report does reveal that in a relatively small number of cases the Hedicare program continues to make mistaken primary payments. The vast majority of these cases involve claims which were never submitted to Aetna for payment, or for which Aetna and Medicare both made a primary payment. Aetna stands willing to work with Medicare to eliminate these problem areas. Aetna also intend6 to closely examine the audit results to determine where it can effectively tighten it6 own procedure6 to reduce further the number of mistaken Medicare payments.