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MEDICARE

More Hospital Costs Should Be Paid by Other Insurers

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Human Resources Division

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January 29, 1987

The Honorable Bob Packwood
Ranking Minority Member
Committee on Finance
United States Senate

Dear Senator Packwood:

Since 1980, the Congress has amended the Social Security Act several times to require that, in certain cases, employer-sponsored group health insurance and accident insurance covering Medicare beneficiaries pay medical claims ahead of Medicare. This report, in response to your request, assesses the Department of Health and Human Services' implementation of these amendments.

The report makes several recommendations to the Department that could substantially increase Medicare's savings from billing other insurers without adversely affecting Medicare beneficiaries' services or increasing their costs. It also offers, as a matter for congressional consideration, legislative options to better ensure that employer-sponsored group health insurance pays claims for covered Medicare beneficiaries ahead of Medicare.

We are sending copies of this report to the Director, Office of Management and Budget; the Secretary of Health and Human Services; the Commissioner, Equal Employment Opportunity Commission; and other interested parties.

Sincerely yours,

Richard L. Fogel
Assistant Comptroller General

Executive Summary

Purpose

To help control rising Medicare costs, the Congress has required that, in certain cases, health and accident insurers covering Medicare beneficiaries pay medical claims ahead of Medicare. While the percentage of beneficiaries having insurance that pays before Medicare is relatively small (an estimated 4 percent), hundreds of millions of dollars in annual savings is achievable by billing such coverage.

The former Chairman of the Senate Finance Committee asked GAO to determine whether the Department of Health and Human Services (HHS), which administers Medicare, could improve existing policies and procedures for identifying and billing other insurers that should pay first for hospital claims.

Background

Medicare serves about 31 million people, most over 65, with estimated expenditures of about $45 billion for hospital services in fiscal year 1986.

If a Medicare beneficiary has other health care coverage—under certain employer group insurance plans, workers' compensation, or an accident insurance policy (e.g., automobile liability coverage)—the law requires that the other insurer generally be the primary payer, paying claims ahead of Medicare. Medicare then acts as a secondary payer, paying only what remains due after the other coverage is exhausted. HHS assigns responsibility for identifying such other insurance to the hospitals and to 61 "intermediaries." These are insurance companies, such as Blue Cross, that contract to process hospital claims on HHS's behalf.

To assess the degree to which hospitals and intermediaries are identifying and billing primary insurers, GAO analyzed 3,052 hospital claims Medicare paid in August 1985, a nationally representative sample. GAO sent questionnaires to the beneficiaries to detect cases in which other insurance was available and possibly should have paid ahead of Medicare. For an in-depth look at procedures used to identify and bill primary insurers, GAO also reviewed seven intermediaries and nine hospitals.

Results in Brief

While HHS has saved hundreds of millions of dollars by identifying and billing other primary insurers, Medicare is still paying substantial amounts that such insurers should pay. In calendar year 1985, GAO estimates, Medicare paid at least $527 million in hospital costs that should have been covered by other insurers. GAO identified three problems that

appear to be the main hindrances to a more effective system for identifying and billing primary insurers.

- Hospitals often do not identify or bill primary insurers as required, and intermediaries have little incentive to require hospitals to improve their performance.
- Some employers were enrolling Medicare beneficiaries inappropriately in group insurance that treats Medicare as the primary payer.
- Weaknesses exist in Medicare procedures for identifying accident insurers responsible for costs paid by Medicare.

Principal Findings

Other Insurers Often Not Billed by Hospitals

GAO's review, as well as a 1986 HHS study of a nationally representative sample of hospitals, showed that hospitals often gathered insufficient information about other insurance resources or billed Medicare even when other insurance was identified. To assess hospitals' procedures for identifying and billing primary insurers, at six of the hospitals reviewed, GAO administered a separate questionnaire to discharged Medicare beneficiaries. Primary insurance was identified and billed by these hospitals in only 17 percent of the cases where the patients indicated, either on the hospital admissions records or in response to GAO's questionnaire, that they had primary insurance coverage for the admission.

Intermediaries Lack Incentives to Improve Hospital Performance

To help assure the correctness of Medicare payments, intermediaries are responsible for monitoring hospitals' billing activities and advising them on appropriate procedures to follow. More training, monitoring, and auditing of hospitals by intermediaries should improve hospitals' performance in identifying and billing other insurers, but for two reasons, intermediaries have little incentive to take these actions. First, the dollar-savings standards set by HHS to assess intermediaries' performance are so low that intermediaries could generally meet them without requiring hospitals to improve their performance.

Second, intermediaries have a disincentive to improve hospitals' performance in identifying and billing primary insurers, for this would increase claims against the intermediaries' own commercial business For example, Blue Cross, an intermediary that processes about 90 percent of Medicare's hospital claims, underwrites about one-third of the

private health insurance in the nation. Thus, it is reluctant to use such practices as screening Medicare hospital claims against lists of its commercial policyholders.

Supplementary Insurance Inappropriately Used for Employed Beneficiaries

When the Congress, in January 1983, made employer-provided health insurance responsible for the health care costs of aged Medicare beneficiaries, it also amended the age discrimination statutes to require that employers offer the same health insurance to Medicare workers and spouses as to their other workers and spouses. The Congress intended that the Equal Employment Opportunity Commission issue regulations to establish a regulatory framework for implementing the legislation. But, because of disagreements between the Commission and HHS over the scope of the regulations, as of December 1986, there were no plans to issue them.

Some employers apparently still provide aged working beneficiaries with supplementary policies that pay only after Medicare, according to information provided by five of the seven intermediaries reviewed. In Michigan, for example, GAO estimates that Medicare paid at least $5.3 million between January 1984 and December 1985 because several hundred health care plans were designed to pay only after Medicare.

Recoveries From Accident Insurers Can Be Increased

The federal government relies on beneficiaries to recover money from accident insurers and then repay Medicare. But Medicare is often unaware that accident insurance is available to cover claims.

No federal requirement exists for attorneys or insurers to report actions taken to recover accidental damages. However, at least one state, California, requires an attorney to notify it when a client who may be Medicaid eligible receives a judgment from an accident insurer. Medicare recoveries in that state are nearly twice those of other states apparently because attorneys do not distinguish between Medicare's and Medicaid's notification requirements and consequently often report such judgments for both programs. GAO believes that HHS has authority to impose a requirement that accident insurers notify Medicare of settlements involving beneficiaries, and that such a requirement would be administratively practical.

Matters for Congressional Consideration

Because the Equal Employment Opportunity Commission has decided against issuing regulations to preclude employers from enrolling aged Medicare beneficiaries in supplementary insurance plans, GAO proposes two options for the Congress to consider: (1) statutorily directing the Commission to promulgate such regulations or (2) amending the Internal Revenue Code to include tax penalties similar to those now used under Medicare provisions covering persons who are eligible for the program because of their disability. (See p. 63.)

Recommendations

To improve hospitals' identification and billing of other insurance, GAO makes a series of recommendations to HHS aimed at increasing intermediary incentives to identify and bill other insurers. These involve (1) increasing intermediary dollar savings standards to levels where intermediaries would have to take action to significantly improve hospital performance; (2) establishing new administrative requirements that would direct intermediaries to perform certain oversight and administrative tasks necessary to improve hospital performance in billing primary payers; and (3) adopting measures that would better assure that hospitals and intermediaries were complying with the administrative requirements. (See p. 37.)

Also, to increase recoveries from accident insurers, GAO recommends that HHS amend its regulations to require accident insurers to notify Medicare of medical payments or other settlements where there are indications (e.g., when a claimant is 65 years or older) that Medicare has a right of recovery. (See p. 50.)

Agency Comments

In commenting on GAO's draft report, HHS and two associations representing the health and liability insurance industry generally agreed with GAO's interpretation of the programs' problems, but differed in several areas on how to best resolve them. The Equal Employment Opportunity Commission also commented on the draft and disagreed with GAO's proposal that the Commission issue regulations. GAO continues to believe that the problems reported will continue in the absence of regulations, and the Commission offered no evidence to the contrary. Because of this, GAO revised and redirected its proposal to the Congress.

GAO's discussions of these comments are included in the relevant chapters, and copies of the comments are included as appendixes IV through VII.

Contents

Executive Summary		2
Chapter 1 Introduction		10
	Background on the Medicare Secondary Payer Program	10
	Objectives, Scope, and Methodology	12
Chapter 2 Medicare Still Paying Many Hospital Claims Other Insurers Should Pay		16
	Medicare Continues to Make Many Erroneous Payments	16
	HHS Studies Also Show Erroneous Payments	17
	Recent Initiatives to Recover Medicare Payments	18
	Conclusion	19
Chapter 3 Intermediaries Need Stronger Incentives to Maximize Medicare Savings		20
	Hospitals Often Not Identifying and Billing Primary Payers	21
	Intermediaries Not Monitoring Hospitals Effectively	26
	Intermediaries Have Little Incentive to Correct Hospital Performance	27
	Conclusions	34
	Recommendations to the Secretary of HHS	37
	Agency Comments and Our Evaluation	38
	Intermediary Comments and Our Evaluation	42
Chapter 4 Changes in Regulations Would Increase Recoveries From Accident Insurers		44
	Relationship Between Medicare and Accident Insurance	44
	No-Fault Insurance: Not Always Payer Before Medicare	45
	Medicare Often Unaware of Accident Insurance Recoveries	46
	Savings Possible Through Better Notification Procedures	48
	Conclusions	49
	Recommendations to the Secretary of HHS	50
	Agency and Insurance Association Comments and Our Evaluation	50

Chapter 5
Regulations Needed to Preclude Inappropriate Use of Supplementary Insurance 54
Some Employers Continue to Enroll Beneficiaries in Supplemental Plans 55
No Federal Guidance on Employers' Responsibilities Available 57
Weaknesses in Enforcement Procedures and Practices 59
Other Secondary Payer Provisions Enforced Through the Tax Code 62
Conclusions 63
Matter for Consideration by the Congress 63
Recommendations to the Secretary of HHS 63
EEOC Comments and Our Evaluation 64
HHS Comments and Our Evaluation 65
Blue Cross/Blue Shield Association Comments 65

Appendixes
Appendix I: Request Letter 66
Appendix II: Methodology Used to Estimate Loss to the Medicare Program by Paying for Hospital Bills That Private Insurers Should Pay 68
Appendix III: Summary of Selected Federal and State Audit Reports on Efforts to Identify and Apply Liable Third-Party Resources for Hospital Costs 72
Appendix IV: Comments From the Department of Health and Human Services 76
Appendix V: Comments From the Equal Employment Opportunity Commission 82
Appendix VI: Comments From the Blue Cross and Blue Shield Association 84
Appendix VII: Comments From the American Insurance Association 88

Tables
Table 1.1: Medicare Amendments Expanding Medicare Secondary Payer Provision 11
Table 2.1: Medicare-Paid Hospital Claims for Which Another Insurer Was Primary Payer (Nationwide Sample, 1985) 17
Table II.1: Summary of Questionnaires Sent and Received 69

Figures

Figure 3.1: Hospital Actions on Admissions With Potential for Other Insurance Coverage 22
Figure 5.1: Relationship Between Medicare and Employer-Provided Group Health Insurance 56

Abbreviations

ADEA	Age Discrimination in Employment Act
BCBS	Blue Cross/Blue Shield Association
COBRA	Consolidated Omnibus Budget Reconciliation Act of 1985
CPEP	Contractor Performance Evaluation Program
DEFRA	Deficit Reduction Act of 1984
EEOC	Equal Employment Opportunity Commission
GAO	General Accounting Office
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
TEFRA	Tax Equity and Fiscal Responsibility Act of 1982

Introduction

In fiscal year 1986, Medicare is expected to pay more than $45 billion for hospital services. Medicare serves about 28 million people 65 years old and older. It also helps pay health care costs for two groups of those under 65: about 2.9 million disabled people and about 89,000 with kidney failure. A portion of these people also have medical coverage under a state workers' compensation program; an automobile, liability, or no-fault insurance policy; or an employer-sponsored group health insurance policy. Historically, when this dual coverage existed, except for workers' compensation, Medicare would pay first (as primary payer), and the other insurance would pay at least part of what Medicare did not pay (as secondary payer).

To reduce Medicare costs without directly or materially affecting the beneficiaries' services, the Congress began in 1980 to make Medicare the secondary payer in certain dual-coverage situations. We were requested by the former Chairman of the Senate Committee on Finance to examine how effectively these secondary payer provisions are working with respect to hospital claims.

Background on the Medicare Secondary Payer Program

Medicare legislation, as first enacted in 1965, made Medicare the secondary payer only where a person was covered by workers' compensation. The Congress subsequently made Medicare the secondary payer in certain other situations through a series of amendments to section 1862(b) of the Social Security Act. The first amendment, contained in the Omnibus Reconciliation Act of 1980, made Medicare the secondary payer when automobile, no-fault or liability insurance is responsible for an injured beneficiary's medical costs. In 5 of the succeeding 6 years, as table 1.1 shows, the Congress amended section 1862(b) to make Medicare the secondary payer when beneficiaries are covered under employer-sponsored group health insurance plans through their own or their spouses' current employment.

Table 1.1: Medicare Amendments Expanding Medicare Secondary Payer Provision

Statute	Made Medicare secondary payer to:	Effective
Omnibus Reconciliation Act of 1980	Coverage under automobile, no-fault, or liability insurance	12/05/80
Omnibus Budget Reconciliation Act of 1981	Employer-sponsored group health insurance coverage for persons with kidney failure during the first year of Medicare eligibility	01/01/82
Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA)	Coverage under employer-sponsored group health insurance, if the working beneficiary or his or her working spouse is 65, but under 70 years old and is working for an employer with 20 or more employees	01/01/83
Deficit Reduction Act of 1984 (DEFRA)	Employer-sponsored group health insurance, by eliminating TEFRA's lower age limit for a working spouse	01/01/85
Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)	Employer-sponsored group health insurance, by eliminating TEFRA's upper age limit	05/01/86
Omnibus Budget Reconciliation Act of 1986	Employer-sponsored group health insurance if the Medicare disabled beneficiary or his or her spouse is working for a large employer (100 or more employees)	01/01/87

These changes have affected many people. The Health Care Financing Administration (HCFA) and the Congressional Budget Office estimate that, excluding the most recent statutory change, about 1.2 million (or 4 percent) of the approximately 31 million Medicare beneficiaries are covered by health or automobile insurance that could be the primary payer for their hospital bills. As of July 1986, no estimates had been made on the number of Medicare beneficiaries whose medical costs could be covered under workers' compensation programs.

Overall responsibility for administering Medicare, including the secondary payer provisions, lies with the Department of Health and Human Services (HHS). Within HHS, HCFA develops program policies, sets standards, and is responsible for ensuring compliance with federal Medicare legislation and regulations, including development of policies and procedures for identifying and billing insurers that should pay before Medicare.

HCFA itself does not process and pay Medicare claims. Instead, it contracts with insurance companies, called intermediaries, to pay hospital claims. Nationwide, HCFA uses 61 intermediaries, most of them Blue Cross plans (48 out of the 61, which process about 90 percent of Medicare's hospital claims). In fiscal year 1985, intermediaries processed

about 12 million Medicare inpatient hospital claims. A major responsibility of these intermediaries is to ensure the accuracy of Medicare payments, which includes reviewing hospital claims and advising hospitals on billing procedures to follow.

Intermediaries are generally paid under cost reimbursement contracts. In fiscal year 1985, Medicare paid intermediaries about $336 million for their efforts. Since 1985, as part of their overall budget, intermediaries were allocated funds to administer the secondary payer program ($28 million for fiscal years 1985 and 1986).

Although intermediaries process claims where Medicare is the secondary payer, the day-to-day identification of sources of payment goes on at the hospital level. Under HCFA's procedures, the approximately 6,000 hospitals that provide services to Medicare beneficiaries are responsible for identifying liable insurers and billing them accordingly. Generally, when Medicare beneficiaries have other insurance that should pay before Medicare, the hospital is required to bill the other insurer for payment before billing Medicare. In some situations where payment from the primary insurance may be delayed, Medicare's payment can be made under the condition that Medicare will be reimbursed.

Objectives, Scope, and Methodology

Initially, we undertook this review to assess efforts designed to ensure that Medicare pays hospital bills only after applicable workers' compensation, automobile, no-fault, liability, or health insurers pay. Our review was shaped further by a March 10, 1986, request from the former Chairman of the Senate Finance Committee (See app. I). He asked that our review address the following questions:

- In 1985, to what extent did Medicare pay hospital bills as primary payer when other insurance resources should have been billed first?
- What improvements in HHS policies and procedures are needed to assure that Medicare's fiscal intermediaries and hospitals (1) identify beneficiaries with private insurance coverage and (2) properly bill Medicare as the secondary payer?
- Are changes in law or regulations needed to enhance the federal government's ability to recover Medicare costs from primary insurers?

To determine the extent that Medicare erroneously paid as the primary payer, we took a random sample of 3,754 hospital bills representative of calendar year 1985 claims that Medicare paid as primary payer in August 1985. We sent questionnaires to the Medicare beneficiaries in

these 3,754 cases, asking them about their insurance coverage so we could determine the possible existence of other insurance that should have paid before Medicare.

To help assure accurate results, we promised beneficiaries that their responses would be treated confidentially; this prevented us from independently verifying the existence, type, and extent of insurance coverage that they reported they had with their insurance companies. However, we pretested the questionnaires by meeting with selected Medicare beneficiaries to discuss their understanding of the questionnaire and field-tested the questionnaire by sending it to 1,000 beneficiaries. Our pretesting, and the fact that beneficiaries would have no reason to report insurance coverage that they did not have, indicate that the responses to the questionnaire would be accurate. Usable responses were received from 3,052 beneficiaries. Based on the beneficiaries' answers, we computed the claims payment error and estimated the loss to Medicare for calendar year 1985. A detailed explanation of this methodology is contained in appendix II.

To determine if there is a need for improving HHS policies and procedures so that Medicare pays appropriately as the secondary payer, we first sought to learn whether hospitals were following prescribed procedures by:

- Visiting a total of nine hospitals in California, Ohio, Massachusetts, and Washington having a large or medium volume of Medicare discharges (e.g., from 2,000 to 7,000 discharges). At these hospitals, we reviewed and tested procedures for treating Medicare as the secondary payer when other insurance resources were available. This included sending an additional 1,900 questionnaires (using the same questionnaire and methodology as the national questionnaire) to beneficiaries who, because of their age or an accident, had possible insurance coverage primary to Medicare. We used the beneficiaries' responses (84 percent responded) to determine if the hospital was identifying available primary insurance resources.
- Reviewing a HCFA study being completed in July 1986 that evaluated the degree to which 60 randomly selected hospitals were following Medicare procedures in identifying and billing other insurers responsible for Medicare costs.

Second, we visited seven Blue Cross intermediaries that operated in New York, California, Michigan, Florida, Ohio, Massachusetts, and Washington. These intermediaries were selected because they pay a substantial portion of the Medicare inpatient hospital claims. In fiscal year 1985, they processed over 30 percent of Medicare's hospital bills. We reviewed the intermediaries' procedures for processing Medicare hospital bills involving other insurers as primary payers to Medicare, assuring that hospitals bill Medicare only after other available insurance has paid, and reporting savings attributable to the secondary payer program to HCFA.

Third, from HCFA headquarters we obtained savings data that HCFA uses to evaluate its intermediaries' performance in treating Medicare as the secondary payer. We reviewed HCFA's methodology for determining these reported program savings. We interviewed HCFA headquarters officials knowledgeable about the secondary payer program and in February 1986 attended a HCFA-sponsored intermediary conference on the Medicare secondary payer program. We also reviewed reports on HCFA's special studies and projects directed at better identifying Medicare beneficiaries with insurance resources.

To determine if changes in law and regulations are needed to improve Medicare's ability to identify and bill other insurers, we:

- Reviewed laws, legislative history, and regulations relating to the Medicare secondary payer provisions.
- Met with officials of the Equal Employment Opportunity Commission (EEOC) to assess their progress in issuing regulations requiring employers to offer health insurance coverage that treats Medicare as the secondary payer for employed beneficiaries or beneficiaries' employed spouses. At the intermediaries visited, we also obtained information on employer group health plans that were not treating Medicare as the secondary payer.
- Asked Medicare beneficiaries in our questionnaires to tell us confidentially if they had recovered or were in the process of recovering damages from accident insurers. We then determined if Medicare was paying as the primary payer on their medical bills.

Our review included situations where, as of March 1986, Medicare by law was the secondary payer. Accordingly, our review did not take into account the COBRA provisions that became effective on May 1, 1986, or the Omnibus Budget Reconciliation Act of 1986 provisions, effective January 1, 1987. Also, except where noted, our review did not include

Medicare payments made for other than hospital services. In future work we plan to examine the extent that Medicare is used as the secondary payer in reimbursing nonhospital providers.

Our review was performed from February 1985 through July 1986 in accordance with generally accepted government audit standards.

Medicare Still Paying Many Hospital Claims Other Insurers Should Pay

Although the Medicare secondary payer program has saved hundreds of millions of dollars in Medicare costs, significant additional savings are possible. On the basis of our sample of Medicare hospital bills, we estimate that in calendar year 1985 Medicare paid at least $527 million to hospitals that should have been paid by private health insurers, automobile, no-fault and liability insurers, or workers' compensation programs. Although the magnitude of this problem may not have been known, its existence has been shown in audits by HCFA and by HHS's Inspector General.

Medicare Continues to Make Many Erroneous Payments

Through the secondary payer program, Medicare saved $340 million in fiscal year 1985 and $238 million in the first half of fiscal year 1986, Medicare fiscal intermediaries reported to HCFA.[1] These savings represent the amounts paid by insurers that are supposed to cover claims ahead of Medicare. To determine if additional savings were possible, we selected for review a nationwide random sample of 3,754 hospital claims. The sample, drawn from a representative period of calendar year 1985 (Aug. 1985), consisted of claims Medicare had paid as primary payer. For each claim in our sample, we sent a questionnaire to the beneficiary who had been hospitalized, asking for information that would allow us to determine if Medicare should have been the secondary payer of the bill. For example, we asked whether

- the hospital admission was the result of an automobile accident and the beneficiary was covered under an automobile insurance policy and
- the beneficiary or spouse was employed and covered under a employer group health insurance plan.

We received 3,052 usable responses, a response rate of 81 percent. Of those who responded, 150 said they had other insurance coverage. The distribution of these 150 cases across the various types of primary insurance appears in table 2.1. Most cases fell into one of two categories: accidents where the beneficiaries said they had automobile or other liability insurance (50 cases), and services to beneficiaries who said they or their spouse was covered by employer group health plans (92 cases).

[1]Does not include reported savings of $268 million in fiscal year 1985 and $169 million in first half of fiscal year 1986 because, as discussed on page 31, they were subject to overcounting

Table 2.1: Medicare-Paid Hospital Claims for Which Another Insurer Was Primary Payer (Nationwide Sample, 1985)

Primary insurer	Reason why Medicare was secondary	No. of claims erroneously paid by Medicare
Automobile or other insurance liability	Beneficiary injured in accident	50
Employer group health plan	Beneficiary between 65-69 and working	43
Employer group health plan	Beneficiary between 65-69 and spouse working	43
Employer group health plan	Beneficiary under age 65 with kidney failure in first year of Medicare eligibility	6
Workers' compensation	Beneficiary treated for work-related injuries or illnesses	8
Total		**150**

We believe the rate of payment errors occurring in the August 1985 data base reasonably approximates the payment error rate for the entire calendar year. According to HCFA officials, the Medicare-paid claims processed during August 1985 were typical of claims processed during calendar year 1985. We tested this hypothesis by comparing the August claims by volume, primary and secondary payer, age groups, and selected diagnosis codes to similar claims data for a previous and succeeding month. We found the claims for August 1985 to be representative.

Accordingly, using standard statistical procedures, our results for August indicate that 1.7 percent of the payments were made for beneficiaries covered by other insurance that was not being billed before Medicare. The size of the Medicare program gives this relatively small percentage a sizable dollar effect when applied to the calendar year 1985 hospital payments. We estimate that in calendar year 1985, Medicare paid at least $527 million in costs that should have been paid by other insurers. The methodology we used to sample Medicare claims, categorize erroneous payments, and estimate the loss to Medicare is described in detail in appendix II.

HHS Studies Also Show Erroneous Payments

In a number of studies, HHS has also found Medicare to be acting as primary payer when other insurers should be paying. In July 1986, HCFA's Bureau of Quality Control was completing a study of fiscal year 1985 billings for Medicare recipients at 60 randomly selected hospitals

throughout the country. The study addressed the degree to which Medicare was paying for claims when another source of payment had been identified. On the basis of the information obtained at the 60 hospitals, HCFA estimated that in fiscal year 1985, Medicare paid $210 million nationwide in hospital claims that should have been billed to other insurers. This estimate is less than ours because it was based only on cases in which hospital records showed a definite indication that other insurance was available. Our questionnaires also identified insurance resources that hospitals did not identify and thus provide a more complete picture of the extent to which other insurance may have been available.

Other reports, more limited in their scope, also showed that Medicare had paid claims covered by other insurance. Between August 1984 and July 1986, the Office of the Inspector General issued at least 13 reports showing that Medicare acted as the primary payer on claims where it should have been a secondary payer. For example:

- In California, it was estimated that as much as $20 million could have been incorrectly paid by Medicare since October 1981 for beneficiaries suffering from kidney failure who were covered under an employer group health plan, a March 1985 report showed.
- In Missouri, over $5 million was lost in a 2-year period because Medicare paid for hospital costs that should have been paid by employer group health plans, according to a July 1986 report.
- In Texas, it was estimated that between $5.3 million and $9.4 million was lost annually because Medicare paid for medical costs that automobile, no-fault, or liability insurers should have paid, a July 1985 study indicated.

HHS audits and studies are further discussed in appendix III.

Recent Initiatives to Recover Medicare Payments

As we were completing our report in September 1986, HCFA was initiating a program aimed at recovering erroneous Medicare payments that should have been paid by employer-sponsored group health plans. This new program involves sending questionnaires (which HCFA was in the process of mailing) to beneficiaries over the age of 65 to identify available employer-sponsored health insurance coverage. These questionnaires could provide the information needed for HCFA to eventually recover some of the erroneous payments made because employer-sponsored health insurance was not billed as primary payer.

Hospitals Often Not Identifying and Billing Primary Payers

Hospitals have the crucial role in identifying and billing insurers responsible for paying claims. This role is critical to Medicare because of the large number of beneficiaries admitted to hospitals and the frequency with which their insurance status changes. Although HCFA attempts to maintain information on the availability of other insurance coverage for its 31 million Medicare beneficiaries, keeping this information current and accurate is difficult.

For example, older workers who have the opportunity to be covered by employer group health plans have a high rate of turnover in the work force. According to 1985 Department of Labor statistics, over 30 percent of employed male workers 67 years old will not be in the work force the following year. Conversely, 5 percent of the 67-year-olds who are not employed will enter the work force during the next year. Keeping accurate track of insurance benefits would require periodic checks of about 31 million Medicare beneficiaries to determine if their Medicare services should be covered by other health care payers. We do not think this is practical, considering the relatively small percentage of Medicare beneficiaries with other insurance that could be the primary payer for their hospital bills (i.e., estimates are that only about 4 percent are covered under employer-sponsored insurance or automobile liability insurance that would be the primary payer to Medicare).

Hospitals, on the other hand, are in a better position than HCFA to obtain insurance information about the patients they serve, and during admission they normally collect information about payment responsibility for the hospital bill. In May 1984, HCFA issued instructions requiring hospitals to ask Medicare patients, at the time of admission, questions aimed at determining if they had other insurance that should pay before Medicare. These instructions contain guidelines to help hospital admission clerks recognize the circumstances under which Medicare is not the primary payer. For example, hospital personnel are to ask Medicare beneficiaries if they or their spouses are employed and, if so, whether either is covered under an employer group health plan. To help clarify the types of questions that should be asked, HCFA instructions include a sample questionnaire that hospitals can use directly or as a guide in developing their admissions forms.

Analysis of our nationwide sample (discussed in ch. 2) showed that Medicare was paying substantial amounts in claims that should have been paid by other insurers. To determine how effectively hospitals identify insurers that should pay before Medicare, we selected a total of nine hospitals in four states for review. At each hospital, we selected 2

Intermediaries Need Stronger Ir Maximize Medicare Savings

Medicare is erroneously paying man for two main reasons—(1) hospitals billing primary insurers, and (2) int encourage hospitals to improve thei

Although hospitals play a critical ro that should be paying before Medica reviewed generally did not have eff reasonable success. The information cient to identify other insurance, an even when they identified other insu examined in depth, the primary insu billed in only 17 percent of the cases questionnaire or the hospital admiss of other insurance.

HCFA has not established effective in intermediaries monitor hospital perf improve it. With little effort to impr intermediaries can meet the savings them. In part this is because the star potential savings and have been redu identifying other insurance coverage intermediaries are inaccurately tabu the stated savings were actually ach

In addition, intermediaries have a built tals' performance in identifying and pr intermediaries supply about one-third ance in the nation. Therefore, part of th is paid out of their own commercial i reason, intermediaries have a disince readily available that would increase primary payers.

HCFA has several options to develop a increase incentives for fiscal interme formance in identifying and properly

primary payer. For example, hospital admission records for a 65-year-old beneficiary showed that he was employed and covered under his employer's group health plan. Nevertheless, the hospital billed Medicare as the primary payer, and Medicare paid $9,200 while his insurance paid the patient's Medicare deductible of $400 as the secondary payer.

At three hospitals, we did not send questionnaires to the Medicare beneficiaries but did review about 2,500 admission files. We reviewed these files to determine whether the hospital was investigating admissions with an indication of other insurance and, if such insurance was found, whether the hospital billed the appropriate primary payer. We identified 85 admissions in which records indicated a potential for other insurance coverage. In 67 cases (about 79 percent), the hospital had not identified the potential primary insurance or, where coverage was identified, had not billed the appropriate primary payer. For example, a 68-year-old Medicare patient told the hospital her spouse was employed, but the hospital did not follow up to determine if the spouse had an employer group health plan that covered the patient. In another situation, where a Medicare beneficiary was injured in an automobile accident, the hospital billed Medicare, which paid about $3,100 as the primary payer, but according to the hospital records, did not determine if a motor vehicle insurer was available to pay the hospital bill. (The liability insurance issue is discussed in ch. 4.)

HCFA found similar problems in an unpublished national study made available to us in June 1986 as we were completing our work. In this study at 60 randomly selected hospitals across the country, HCFA reviewed all admissions and emergency room visits involving Medicare beneficiaries during February and April 1985. HCFA sought to learn whether hospitals billed other insurers as primary payers when such insurance was identified. In over 45 percent of the cases in which HCFA identified another insurer as primary, the hospitals billed Medicare first. Although the study addressed the extent that hospitals were correctly billing primary insurers when such insurance had been identified, it did not inquire as to whether hospitals identified available insurance on all admissions.

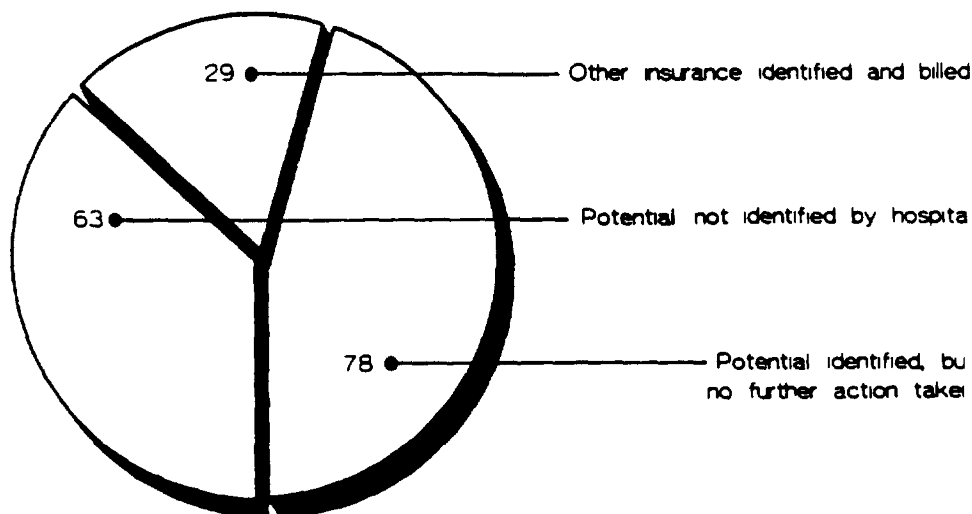
Hospitals Obtain Insufficient Information to Identify Other Insurance

One reason hospitals miss opportunities to collect from other insurers is that they are not obtaining enough information about patients' possible insurance coverage. While all hospitals had procedures to collect some of the information needed to identify such coverage, eight of the nine hospitals we reviewed lacked procedures to collect the information

to 3 months of the period January through August 1985 for detailed review. Additionally, at six of the hospitals, we reviewed about 7,000 admission records and sent questionnaires to about 1,900 of these beneficiaries to identify those under age 70 who could have had insurance coverage primary to Medicare (i.e., because at the time we visited these hospitals, Medicare's secondary payer provisions did not apply to beneficiaries over age 70 who had employer-sponsored health insurance) and those 70 and older who may have been in an accident.

Our results at the six hospitals showed that the hospitals often did not (1) identify the primary payer of a Medicare claim or (2) bill the appropriate primary payer even when it was identified. On the basis of the admission records and questionnaires, we identified 170 admissions from the 7,000 admissions reviewed that had potential for other insurance to be primary to Medicare. In only 29 of the 170 cases (17 percent) did the hospitals identify and bill other insurers, as figure 3.1 shows.

Figure 3.1: Hospital Actions on Admissions With Potential for Other Insurance Coverage



Why were so few cases properly handled? In 63 cases (about 37 percent), the hospitals did not identify potential situations where other insurance could have been available. For example, it appears they did not determine if the patient was employed or whether injuries were accident related. In 78 other admissions (about 46 percent), the hospital identified the potential situations where other insurance coverage was likely but did not investigate its availability or treat the insurer as the

that the questions were asked, the patient was asked to sign the questionnaire, which the hospital then maintained on file.

We found this process to be an effective method for identifying other insurance that would be primary to Medicare. For example, when we sent questionnaires to the Medicare beneficiaries admitted to this hospital, several beneficiaries reported other insurance coverage that would be primary to Medicare. The hospital had correctly identified these situations when it completed the admission questionnaire. This leads us to believe that hospitals can collect sufficient information if they understand what is needed.

Lack of Awareness and Weak Practices When Billing Primary Payers

Another reason hospitals miss opportunities to collect from other insurers is that either hospital personnel were unaware of the secondary payer requirements or weaknesses existed in practices for billing primary insurers before Medicare. Specifically, among the nine hospitals reviewed, we found:

- At six hospitals, personnel responsible for determining and billing primary insurers were not aware of all the situations in which Medicare is the secondary payer. For example, at one hospital, neither the admitting nor the billing clerks we interviewed knew that Medicare should be billed as the secondary payer when insurance coverage was available through the beneficiary's working spouse's employer health plan.
- At two hospitals, the billing systems were established to process Medicare claims on the basis that Medicare was the primary payer. The billing personnel told us that this was done because it was easier and faster to treat Medicare as the primary payer.
- At two hospitals, Medicare patients were allowed to choose on a claim-by-claim basis whether Medicare or their employer group health plan was the primary payer of the hospital bill. However, under federal regulations (42 C.F.R. 405.341), employed Medicare beneficiaries ages 65 through 69 have the option to decline employer group health plan coverage and retain Medicare as the primary payer of covered services, but once enrolled in an employer group health plan, Medicare is the secondary payer for all services covered by the group plan.
- At three hospitals, confusion existed about the roles and responsibilities between hospital admitting and billing offices in determining the primary payer. For example, admitting personnel at one hospital told us that they routinely record that Medicare was the primary payer of the bill and assume that the billing department would follow up and determine if other insurance was available to pay the bill. Billing department

needed to identify all available insurance resources that should pay before Medicare. Seven hospitals, for example, did not include questions on their admissions questionnaires asking if the spouse of a Medicare patient age 65 through 69 was employed and was covered by an employer group health plan. Five hospitals did not ask if a Medicare admission was potentially covered by workers' compensation.

Hospital procedures were further weakened by the hospitals' practices of leaving items blank on admissions forms. All the hospitals left some spaces on the admission form blank when recording responses to questions aimed at identifying other insurance coverage. Because the items were not filled in, there was no assurance that the questions were asked.

These same problems were identified in audits conducted by intermediaries. For example, six of the seven intermediaries we visited had conducted 25 audits of hospital secondary payer practices and procedures.[1] Of these audits, 22 noted one or more discrepancies in hospital practices and procedures. Among the discrepancies were lack of procedures to

- obtain data on spousal employment (11 hospitals),
- obtain information on the cause and location of accidents (9 hospitals), and
- obtain workers' compensation data (4 hospitals).

In total, the audits showed that 15 of 25 hospitals did not have adequate procedures for obtaining data to determine whether other insurance was available in one or more of the secondary payer categories. In addition, the audits noted that 21 hospitals did not complete responses to all questions designed to detect secondary payer information, thus providing little assurance that the questions were asked.

During our review, one hospital that had not been collecting the needed information was in the process of modifying its procedures to correct the problem. This hospital started to require that Medicare beneficiaries, at time of admission, fill out a questionnaire designed specifically to identify other insurance coverage. The questionnaire covered the beneficiary's employment, spouse's employment, coverage under an employer group health plan, coverage under workers' compensation, and possible coverage under automobile or liability insurance. To provide assurance

[1] We excluded four audits conducted in California because the intermediary did not retain audit workpapers

hospital per quarter, however, it would take the seven intermediaries from 30 to 103 years to audit all the hospitals they serve.

Also, six of the seven intermediaries were not targeting their audits to the hospitals with relatively low secondary payer claim volume. Only one, Blue Cross of Florida, monitored the frequency of hospital secondary payer claims and targeted audits to hospitals submitting a low volume of secondary payer claims. The audits performed by this intermediary had a significant effect on improving the audited hospitals' secondary payer practices and procedures. For example, we counted secondary payer claims for each of the four hospitals that the intermediary audited and found that, during the 2-month period after the audit, secondary payer claim volume increased 88 percent.

Additionally, 19 of the 22 audits detecting deficiencies did not specifically recommend that the hospital correct all the deficiencies found in the hospitals' practices for identifying other insurers. For example, in 11 of the hospital audits, auditors noted that the hospitals' admission forms did not capture information needed to identify other insurance primary to Medicare. But the intermediaries did not make specific recommendations or suggestions that the hospital correct this practice. By not recommending that hospitals correct their deficiencies, intermediaries are missing an opportunity to improve procedures at the hospital level.

Intermediaries Have Little Incentive to Correct Hospital Performance

As we and others have shown, hospitals are not identifying and billing many claims that should be paid by other insurers. HCFA's study and intermediaries' audits show the problem to be widespread. Our review suggests that more training, monitoring, and auditing would improve hospitals' performance in identifying and billing other insurers. For two reasons, however, intermediaries have little incentive to take these actions:

1. Intermediary performance is measured on a system that allows intermediaries to meet savings standards without necessarily improving performance at the hospital level. The savings standards are set at dollar amounts so low that intermediaries met them without requiring hospitals to identify the large number of additional claims we found in our analysis. The problem is further complicated because the savings being reported by intermediaries are subject to both overcounting and undercounting, making it unclear whether such savings are being realized.

officials, however, accepted the designation made by admitting personnel and billed Medicare as the primary payer.

Intermediaries Not Monitoring Hospitals Effectively

To assure the correctness of Medicare payments, intermediaries are responsible for monitoring hospitals' billing activities and advising them on appropriate procedures to follow. At the seven intermediaries we reviewed, however, we found that

- three intermediaries had done little in the way of training hospital personnel on secondary payer requirements, and
- audits that all seven intermediaries conducted of hospital compliance with secondary payer requirements were either infrequent (although they met HCFA's requirement of one audit per quarter), targeted to hospitals with relatively low secondary payer claim volume, or did not specifically recommend that the hospital correct all deficiencies the auditors found.

Training Often Not Provided

Although HCFA has not required intermediaries to provide specific training to hospitals on secondary payer requirements, it has produced some training materials for this purpose and told intermediaries that educating hospitals on the secondary payer billing responsibilities is important. Between October 1984, when the Medicare secondary payer program began, and May 1986, four of the seven intermediaries we visited had conducted secondary payer training sessions attended by most of the hospitals in their area.

Officials at these four intermediaries told us that training helps increase hospitals' awareness of the importance of the secondary payer program and its requirements. The importance of training was stressed by an official of the Health Insurance Association of America in a December 1984 speech to the National Association of Insurance Commissioners. The key to ensuring that hospitals treat Medicare as the secondary payer, he said, was to retrain hospital personnel who were used to billing Medicare as the primary payer.

Monitoring and Auditing Incomplete

HCFA does not require its intermediaries to monitor hospital Medicare secondary payer activity, except to audit at least one hospital each quarter to determine the hospital's compliance with secondary payer requirements. At the time of our visit, each of the seven intermediaries was meeting the one-audit-per-quarter requirement. At the rate of one

Although this record would indicate considerable success, the system used to establish savings standards and count realized savings has certain weaknesses. Such a system of performance-oriented standards has merit, but the standards are only as good as the data on which they are based and against which they are measured. HCFA's current system does not succeed on either count. Current savings standards are set at dollar amounts substantially below the available level of estimated savings, and the reported savings accomplishments are inaccurate, as noted below.

Standards Do Not Account for Available Savings

HCFA set its overall savings standard for the secondary payer program below the level of estimated available savings. HCFA's standard is that intermediaries achieve at least 90 percent of the total savings goals it establishes for the various categories of Medicare beneficiaries (e.g., those who are between ages of 65 and 69 with employer-sponsored insurance or who have spouses with such insurance). As discussed below, not all categories of savings are included in the goals used to set the standards, and for the categories included, potential savings were reduced to account for expected difficulties in identifying the coverage.

1. HCFA did not include all types of Medicare secondary payer savings in determining the savings standard to which an intermediary would be held accountable. For example, for fiscal year 1985 HCFA did not include in the intermediary standards any savings goals for beneficiaries with kidney failure covered under employer group health plans or beneficiaries covered under workers' compensation programs. For fiscal year 1986, HCFA established separate savings goals for all categories except workers' compensation. In July 1986, HCFA officials told us that the amount of savings available through workers' compensation programs was difficult to estimate and was unknown.

2. In 1985, HCFA did not include in the intermediaries' savings standards $155 million in savings it estimated to be available from a working spouse's employer-sponsored insurance, but allowed the intermediaries to count savings in this category to meet their overall savings standards.

3. In formulating goals for the beneficiaries over 65 covered by employer group health plans, HCFA's actuaries initially assumed that 15 percent of Medicare beneficiaries with employer-sponsored health policies between ages 65 and 69 would not report primary health insurance coverage to hospitals. However, officials who administer the secondary payer program believed that this figure was too low to account for the

2. Intermediaries have a disincentive to improve hospital performance because they are also insurers that write commercial health policies. Improved hospital performance in identifying and billing primary insurers results in increased claims against their commercial lines of business. Also, for the same reasons, intermediaries are reluctant to implement such practices as screening claims against their commercial enrollments to identify incorrect payments made by Medicare.

Intermediary Savings Standards Low, Reported Savings Inaccurate

For fiscal year 1985, HCFA established standards to measure intermediary performance in the Medicare secondary payer program. These standards were incorporated into HCFA's Contractor Performance Evaluation Program (CPEP). CPEP measures intermediary performance in such areas as processing Medicare claims, safeguarding Medicare payments, and dealing with beneficiaries and hospitals. Certain standards, including those for the secondary payer program, were deemed critical in that not meeting them would result in the intermediary failing the entire CPEP.

Failing CPEP is grounds for not renewing the intermediary's contract; however, HCFA believes its efforts should be focused first on getting poorly performing intermediaries to improve before replacing them—a strategy that we agree with.

In fiscal years 1985 and 1986, the CPEP standards required intermediaries to meet at least 90 percent of HCFA's secondary payer savings goals. To help assure that intermediaries took steps to achieve the saving standards, HCFA also required that they spend at least 95 percent of the funds allocated for Medicare secondary payer claim review.

In fiscal year 1985, HCFA established goals for secondary payer savings totaling $414 million. In allocating these amounts to intermediaries, HCFA considers such factors as the number of working aged per contractor, cost per beneficiary served, number of automobile accident injuries, and average expenditure per injury. In addition, HCFA allotted $14 million to intermediaries for performing secondary payer activities to achieve these goals. Of the 61 intermediaries, 52 achieved their savings goals and 58 met the spending requirement. In total, intermediaries reported savings that exceeded the goals by about 14 percent. In fiscal year 1986, HCFA established secondary payer goals of $574 million. During the first half of the fiscal year (the last period for which we obtained information), intermediaries reported that they had met about 61 percent of the overall established dollar savings goal.

Some Savings Overstated by Intermediaries

Until June 1986, HCFA's instructions to intermediaries allowed them to count potential savings that frequently were never realized and, if realized, could be counted again. About $207 million of the intermediaries' $475 million in reported savings counted toward fiscal year 1985 savings goals (44 percent) was subject to overcounting, as was about $139 million of the $348 million in savings reported for the first half of fiscal year 1986 (40 percent).[2]

The counting problems occurred when the intermediaries reviewed hospital claims for indications of other insurance coverage. Intermediaries often check hospital claims against previous claims in which Medicare paid as the secondary payer and against Social Security records that indicate the beneficiary may be employed and thus potentially enrolled in an employer group health plan. When such checks showed that a hospital claim had potential for primary insurance coverage, the intermediary returned the claim to the hospital so that the hospital could bill the potential primary insurer before rebilling Medicare. When the claim was returned on the basis of these indicators, the intermediaries were allowed to count the potential savings as realized.

However, such primary insurance coverage frequently does not materialize. For example, we reviewed New York Blue Cross records from October 1984 to March 1986 and found that 59 percent of beneficiaries identified by these indicators did not have primary insurance coverage. At the other intermediaries reviewed, officials' estimates of the frequency that indicators did not materialize into savings ranged from 23 to 70 percent. Nevertheless, during fiscal year 1985, five of the seven intermediaries were counting these potential savings as realized, which HCFA instructions allowed them to do. When the indicators did result in savings, all seven intermediaries counted the savings again. HCFA instructions did not preclude such double-counting.

Overcounting also occurred when intermediaries based savings on the charges billed by the hospital instead of the amount Medicare would have paid. Four intermediaries used hospital charges as the basis for counting potential savings. Using billed charges as a basis inflates this savings category because, on average, Medicare's actual payment normally is about 23 percent less than billed charges.

[2]Amounts subject to overcounting were those reported by the intermediaries to HCFA as "cost-avoided savings." Because these amounts can be recounted if recovered, some of this amount represents overstated savings

difficulties experienced by hospitals in identifying primary insurers. Consequently, the actuaries reduced their fiscal year 1986 savings projections by 38 percent to recognize the identification problem. Therefore, the savings goal used by HCFA to develop intermediary standards included only 62 percent of the estimated available savings. Further, since the CPEP standard required that 90 percent of the goal to be met, in effect the intermediaries are required to achieve only 56 percent of HCFA's estimated savings.

4. HCFA's fiscal year 1986 estimate of total available savings, on which its standards are based, may be conservative. For example, if HCFA would have based its fiscal year 1986 working aged savings goal on Congressional Budget Office estimates of available savings, the intermediary goal for this category of savings would have been about $634 million—or $269 million more than the $365 million HCFA used when setting intermediaries' fiscal year 1986 standards.

5. HCFA's fiscal year 1985-86 automobile/no-fault and liability goals also may be set below the level of available savings. These goals were based on a sample of Medicare hospital records for which hospitals identified the availability of insurance coverage. However, as we discussed on page 22, hospitals in our sample frequently (37 percent) did not identify potential situations where other insurance could have been available. Therefore, to the extent the hospitals in HCFA's sample had similar problems, the resulting goals would be understated.

HCFA limited its savings standards intentionally, we were told by HCFA officials, because it was uncertain of the number of beneficiaries with insurance that the hospitals and intermediaries could identify and it wanted to get the program underway with standards that were realistically achievable. Also, they told us that as a practical matter, because HCFA included meeting the standards as a critical CPEP requirement, HCFA wanted to assure that they were reasonably achievable.

HCFA's rationale for setting its standards appears reasonable for a program just getting underway. However, as discussed in chapter 2, a substantial portion of potential Medicare savings are not being realized. We believe that it is appropriate after more than 2 years of experience with the secondary payer program to increase the dollar amounts on which the standards are based to levels that will provide incentives to intermediaries to better assure more potential savings are realized.

For example, both Massachusetts Blue Cross and Michigan Blue Cross used information on beneficiaries covered under their commercial insurance plans when it helped them document how they met existing CPEP savings standards. But, using this information did not result in any additional Medicare savings because the cases they identified were those already identified by hospitals and billed correctly to Blue Cross as the primary insurer. More importantly, however, the intermediaries did not use the information to flag future claims for these beneficiaries so it would be useful in helping assure hospitals identify and bill other insurers.

The process used by Michigan Blue Cross worked as follows. During the fourth quarter of 1985, Blue Cross found that in its role as intermediary, it was still $3 million short of its $14.7 million Medicare savings standard. Blue Cross ran a list of the hospital payments it had made between January 1984 and June 1985 for Medicare beneficiaries covered under one of its commercial plans. The list showed $3.2 million in payments that the Blue Cross commercial plans made on behalf of Medicare beneficiaries, which Blue Cross then counted toward its savings standards. However, Blue Cross did not create a process by which future hospital Medicare bills could be screened against a list of these policyholders.

To determine if such a step would likely produce savings for Medicare, we randomly selected 48 of these Blue Cross payments and found that in only 13 cases (27 percent) were the names of policyholders in the intermediary's internal data base used to flag future hospital claims. When flagged, these claims are returned to the hospitals so that the primary payer can be billed ahead of Medicare. Without these screens in place to identify policyholders with Medicare coverage, the intermediary could be making future Medicare payments rather than achieving savings for the government by billing its own Blue Cross insurance plan. Blue Cross of Michigan officials told us that they did not put these screens in place because it would put them at a competitive disadvantage in the private insurance market compared to other insurers that do not have to perform such screens.

In 1984, the Office of Management and Budget suggested that HCFA require all Medicare contractors to match their commercial insurance files against Medicare files to make sure that hospitals were billing Medicare as a secondary payer. During Medicare contract negotiations in August 1984, the Blue Cross and Blue Shield Association (the prime contractor with Medicare for all but 2 of the 48 Blue Cross intermediaries)

In June 1986, HCFA revised its instructions to intermediaries so that they would not allow such overcounting in future reports. HCFA officials told us that the intermediaries' overcounting of savings was originally allowed to get the program off the ground. It was also allowed, they said, to compensate for savings that the intermediaries could not identify, as discussed below.

Unreported Savings Not Counted

On the other hand, we found cases in which realized savings went uncounted, although neither HCFA nor the intermediaries had data on the extent of the problem. HCFA requires hospitals to submit claims, known as "nopayment bills," showing that another insurer has paid everything that Medicare would have paid, even though Medicare is not being billed for reimbursement. Nopayment bills enable intermediaries to determine the benefit period, count savings, and properly compute deductibles as well.[3] In several instances, however, hospitals had failed to submit such bills. The same problem was noted in some audits conducted at hospitals by intermediaries. While the filing of nopayment bills is a Medicare requirement, hospitals have no incentive to submit such bills since they have already been paid and will receive no additional reimbursement from Medicare.

Intermediaries' Dual Role Creates Disincentives for Improving Hospital Performance

Complicating implementation of the Medicare secondary payer program is the fact that the intermediaries also underwrite commercial hospital insurance coverage. For example, Blue Cross plans, which as intermediaries processed about 90 percent of Medicare hospital claims in 1985, also provided private health coverage for about one-third of the nation's population. If intermediaries take a more aggressive role in seeing that hospitals properly bill private health insurance, they save money for Medicare but are likely to cost themselves money in paid-out claims. We found indications that this disincentive does result in intermediaries not using available information that would improve hospital performance at identifying and billing other insurers and increase the savings to Medicare.

[3]Medicare inpatient hospital coverage is based on benefit periods During a benefit period, the first 60 days of inpatient care is paid in full by Medicare except for the inpatient deductible, which in 1986 was $492 The beneficiary is liable for coinsurance for the 61st through the 90th day of care and for any of the 60 lifetime reserve days after the 90th day A new benefit period begins after the beneficiary has not been in a hospital or skilled nursing facility for 60 days and then reenters a hospital

HCFA's own study (completed as of July 1986) supported the same conclusion.

Medicare intermediaries, as fiscal agents for the government in processing hospital claims, are in the best position to monitor hospital billing activities. While it is not practical to expect that hospitals identify and bill Medicare appropriately as secondary payer in all situations, intermediaries can do more administratively to assure that hospitals improve their performance.

HCFA should take action to encourage intermediaries to adopt practices that would result in realizing more of the potential savings available. While this may require additional funding for intermediaries, we believe such additional funding would be warranted because it is cost effective. For example, in fiscal year 1985, HCFA's administrative expenditures of $14 million for the intermediaries' secondary payer activities resulted in realized savings of about $340 million.

While the amount of savings being realized is substantial, our results show that greater savings are possible. However, intermediaries currently have little incentive to maximize the government's savings under the secondary payer program because increased Medicare savings come at least in part from their own commercial insurance enterprises. HCFA's evaluation program, CPEP, does not provide this needed incentive for several reasons. First, it has established performance savings standards that have been easy to meet because savings were inaccurately counted and the standards included a relatively modest portion of all estimated available savings. Second, the CPEP requirement to spend money allocated does not, in itself, assure that intermediaries are performing the activities needed to maximize savings to the Medicare program.

Therefore, we believe the problem can be addressed by taking the following two steps:

- Changing the CPEP standards to provide that intermediaries take actions needed to improve hospital performance in identifying and billing other insurers.
- Requiring intermediaries, through a provision in their contract, to check Medicare beneficiaries against their own policyholders if CPEP standards are not met.

In regard to changing CPEP, there is a need to give intermediaries an incentive that would encourage them to implement the oversight and

opposed the data match concept again because it would put their plans at a competitive disadvantage against other commercial insurers that are not Medicare intermediaries. We agree in principle with Blue Cross's concern. Because of this concern, HCFA and the intermediaries agreed in a compromise that only seven contractors would perform a test demonstration of data matches in fiscal year 1986 with the commercial sides of their businesses.

The seven contractors selected matched names of persons covered under their employer group health plans with names of Medicare beneficiaries Preliminary results of these tests, as of April 1986, showed that the matches will potentially save Medicare between $2.9 million and $4.3 million for fiscal year 1986.[4] These data match efforts were cost effective, with an estimated return on investment ranging between $4.20 and $7.90 for every $1.00 invested, depending on the type of files matched. Intermediaries are generally opposed to such data matches, however, and it is not clear that they will use the data they collected to screen future Medicare hospital claims.

Six intermediaries were involved in this test, including one of the seven we reviewed in depth. That intermediary, Blue Cross of Florida, found that Blue Cross commercial insurance was available for 444 working aged beneficiaries (e.g., beneficiaries who were between the ages of 65 and 69 and were employed), but after the project was over, the intermediary chose not to use this information to assure that future claims for these beneficiaries were not paid by Medicare. The intermediary officials told us that they did not need to use this information beyond the scope of HCFA's demonstration project requirements because additional savings were not needed for the intermediary to meet its savings goal.

Conclusions

The basic problem when Medicare pays for a claim for which another insurer is liable is that Medicare does not know of the existence of the other insurance. Detecting this insurance presents HCFA with an administrative difficulty because the federal government must depend to a large degree on hospitals to identify and bill the primary insurer responsible for paying the medical costs of Medicare beneficiaries. Our work showed, however, that the hospitals we reviewed lacked procedures to effectively identify and/or bill those who should pay ahead of Medicare.

[4]These are potential savings because, at the time of our review, intermediaries had not yet reprocessed all the incorrectly paid claims that they identified

an incentive to see that hospitals aggressively identify and bill all primary insurers. By imposing this requirement only when standards are not met, the government can give intermediaries an incentive to encourage effective procedures at the hospital level without placing them at a competitive disadvantage for reasons unrelated to their performance.

Recommendations to the Secretary of HHS

We recommend that the Secretary direct the Administrator of HCFA to revise CPEP standards to provide the intermediaries with the needed incentives to improve hospital performance in identifying and billing other insurers. To do this, HCFA should do one or both of the following:

1. Increase current savings standards to dollar amounts that intermediaries could not meet without significantly improving hospital performance. To be meaningful, standards should be challenging but achievable, and mechanisms to better assure that savings are accurately measured need to be developed.

2. Establish new administrative requirements that would direct intermediaries to perform certain oversight and administrative tasks necessary to improve hospital performance in billing Medicare as primary payer. These tasks should include monitoring each hospital's volume of secondary payer claims, increasing training and auditing efforts at hospitals with lower than expected secondary payer claims, and reporting deficiencies to the hospitals so that they can be corrected. A CPEP measurement would also need to be developed to determine acceptable performance in meeting these new requirements.

We also recommend, regardless of which option is pursued, that HCFA require its intermediaries to direct hospitals that are not taking the steps needed to identify and bill other insurers of Medicare beneficiaries to use a standard admission form designed to detect the availability of insurers that should pay before Medicare. The form should be signed by the Medicare patient and maintained in the hospital billing file.

Further, to help assure that intermediaries exercise diligent efforts at improving hospitals' performance in identifying and billing other insurers, we recommend that the Secretary direct the Administrator of HCFA to require, as a contractual condition, that intermediaries screen Medicare claims against their own insurance policyholders when intermediaries do not meet CPEP secondary payer standards.

administrative activities necessary for improving performance at the hospital level. The range of activities available includes monitoring each hospital's volume of secondary payer claims, increasing training and auditing efforts at hospitals with relatively lower than expected secondary payer claims, and reporting the deficiencies to the hospitals so that they can be corrected. HCFA could also authorize intermediaries to require that poorly performing hospitals adequately document their efforts through the use of a standard admission form signed by the Medicare patient and maintained in the hospital's billing files. This would give intermediaries added assurance that hospitals are complying with secondary payer requirements.

Several options exist for HCFA to give the intermediaries incentives to undertake these activities. First, HCFA could use its current CPEP performance-based standards. However, it would need to set the dollar amount of the standards high enough to get intermediaries to take steps to improve hospital performance, but not so high that intermediaries cannot practicably achieve them. We recognize the difficulties involved in setting such standards, as well as accounting for savings realized but not reported by hospitals.

Second, to the extent that HCFA is unable to determine more appropriate savings standards and resolve the problems with counting the savings, HCFA should develop a different approach that is more prescriptive in its intermediary requirements. This approach can be used in lieu of or as a supplement to the savings standards and would require intermediaries to take specific steps to improve hospital performance in identifying and billing Medicare as secondary payer. These could include requirements for increasing hospital training and strengthening intermediaries' monitoring and auditing of hospitals' secondary payer activities. A CPEP measurement would need to be developed to determine the acceptable levels of performance in these areas.

Intermediaries that are not performing well enough to meet the revised standards should be required, as a contractual condition, to screen Medicare beneficiaries against their own commercial policyholders. This would create a new incentive for the intermediary to meet the revised CPEP standards because the intermediary would not want to be placed in a situation to pay as primary payer disproportionately more than its competitors. Such screening would result in the intermediary reimbursing Medicare for all cases where its commercial policies should have paid as primary to Medicare but did not. Because other insurers would not have to perform such screens, we believe intermediaries would have

no-fault and liability insurance. In addition, it has not increased over 1985 levels the annualized goals for spousal and working-aged employer-sponsored health insurance (except to account for new provisions of the law, such as the addition of coverage for those 70 years or older). Further, HCFA established its fiscal year 1987 goals for beneficiaries with kidney failure covered under employer group health insurance at a level 29 percent below the 1986 goal.

HHS did not comment specifically on when it plans to increase its secondary payer savings goals but commented that the goals take into account that not all savings achieved are documented because of hospitals' failure to submit nopayment bills (see p. 32). Although HHS maintains that the savings goals consider nopayment bills, neither HHS nor the intermediaries were able to quantify the amounts of such undocumented savings.

After considering the points raised in the HHS response, we continue to believe that the goals on which the savings standards are based could and should be raised. This is reinforced by the fact that intermediaries generally met their savings standards despite the overall poor performance of hospitals in identifying and billing other insurers. To retain the standards as a viable mechanism for gauging intermediary performance under the program, HHS should (1) increase them to levels high enough that intermediaries will take the steps needed to improve hospital performance and (2) take actions to correct existing problems with counting savings. HHS's comments do not address either issue.

HHS agreed with our recommended second option of establishing new administrative requirements that would direct intermediaries to perform certain oversight and administrative tasks necessary to improve hospital performance. HHS stated that in addition to intensifying provider training in fiscal year 1987, it will also significantly expand the number of hospital secondary payer audits. HHS stated it would target such audits to hospitals that routinely fail to identify instances in which Medicare should be the secondary payer. However, HHS commented that at this time it did not believe that including a CPEP element to ensure completion of these new requirements was essential. We believe that including such an element is essential, however, unless HHS increases its intermediary dollar-savings standards as discussed above. Absent higher dollar-savings standards, intermediary incentives to perform well will remain weak, giving little assurance that new administrative requirements will have their intended effect.

Agency Comments and Our Evaluation

HHS agreed with our findings on hospital performance, although it said our report did not recognize the significant improvements made in its Medicare secondary payer program since its initiation in fiscal year 1985. As an example, HHS cites a 1986 HCFA study showing that hospital performance in properly billing Medicare as the secondary payer had improved 400 percent between fiscal years 1985 and 1986.

We agree that this HCFA study shows a substantial improvement in hospital performance since HCFA's new program was initiated. Nevertheless, much room for improvement remains. For example, the HCFA study shows that hospitals billed other insurers incorrectly in 45 percent of the cases where the hospitals' records indicated that another payer should have been billed before Medicare. In addition, this study did not address the frequency with which hospitals failed to identify the existence of potential insurance coverage. As discussed on page 23, we found this failure to identify other insurers was a main factor contributing to the problems experienced by hospitals in billing primary insurers.

HHS also cited current and planned activities it was undertaking to improve hospital awareness of secondary payer requirements. These included requirements that intermediaries (1) conduct training sessions for hospitals by the second quarter of fiscal year 1987 and (2) make presentations to hospital professional associations regarding hospitals' Medicare secondary payer responsibilities.

Increasing or Revising Standards

HHS agreed in principle with our recommended option of increasing the current dollar savings standards and developing mechanisms to better assure that savings are accurately measured. The agency said, however, that for various reasons related to the newness of the program and the difficulties inherent in identifying certain categories of savings, using less than the full actuarial estimate of potential savings was appropriate.

We agree, and our report acknowledges, that HHS's approach may have been reasonable during the program's first 2 years. However, we found that intermediaries' incentives to achieve higher savings levels were weak, in part because savings standards were set below the level of estimated savings available. To realize more of the potential savings available, more ambitious standards are needed. Although fiscal year 1987 represents the program's third year of operation, HHS has not increased, over fiscal year 1985 levels, the savings goals relating to automobile,

Requiring intermediaries to screen against their commercial files when they do not meet CPEP standards is one way to help ensure improved hospital performance. Intermediaries want to avoid such screening because it would put them at a competitive disadvantage to insurers that do not have to perform such screens. We continue to believe that this would serve as an effective incentive for intermediaries to take the steps necessary (i.e., increased training, monitoring, and auditing) to work with hospitals to establish effective procedures for identifying and billing primary insurers.

While it may be difficult in some cases for contractors to screen their private files against Medicare hospital claims, the results of the pilot project (see p. 34) and intermediaries' own initiatives to document savings (see p. 33) illustrate that it can be cost effective. Further, we are recommending that intermediaries be contractually required to screen hospital claims against their own files only when they do not meet the CPEP secondary payer performance standards.

Other Matters

In a technical comment, HHS questioned our basis for not recognizing, as valid savings, any of the intermediaries' reported "potential savings." These potential savings amounted to about 44 percent of the total savings reported by intermediaries. We did not include these potential savings in our count of the total savings achieved because neither we nor the intermediaries could substantiate that these savings were realized. As described on pages 31-32, all seven of the intermediaries that we reviewed had procedures in place that allowed them to count a claim twice—as a potential savings when they identified the possibility that other insurance may have been available and again if and when the savings were realized. Also, five of the seven intermediaries were counting potential savings even when the savings did not materialize. HHS instructions allowed these overcounting practices, and it was to the intermediaries' advantage to overcount. As a result, it is not clear how much, if any, of the intermediaries' reported potential savings should be counted, and we therefore did not recognize them as "realized" savings. In June 1986, HHS revised its instructions to disallow double-counting, so this problem of determining realized savings should not recur if the instructions are followed.

Using a Standard Admission Form

HHS concurred with our recommendation to require intermediaries to direct that hospitals use a standard admission form in cases where the hospitals are not taking steps to identify and bill primary payers HHS stated that it had already done so in January 1986 by amending section 301 of the Medicare Hospital Manual to specify a list of questions that the hospital should ask the Medicare beneficiaries. HHS stated that these manual provisions also require that the hospital retain a copy of the beneficiaries' responses in patients' files.

We do not believe the agency's actions adequately respond to our recommendation. The questions given in section 301 of the manual are presented as a guide to hospitals and not as a requirement for Medicare payment. Similar charts have been in the manual since 1984, and of the nine hospitals we visited, none were using this chart in identifying primary payers.

Using Intermediary Data to Screen Claims

HHS disagreed with our recommendation that intermediaries not meeting CPEP requirements be contractually required to screen Medicare claims against their own policyholders. HHS stated that its demonstration project showed instances in which matches were not possible because of incompatible records. HHS said that mailing questionnaires to beneficiaries is a more successful and cost-effective method of identifying beneficiaries with insurance coverage.

HHS apparently interpreted the primary objective of our recommendation as assuring capture of information on beneficiaries' insurance coverage. It is not. Rather, the primary objective is to give poorly performing intermediaries an added incentive to assure that hospitals identify and bill primary payers. Our recommendation stems from our finding, which HHS does not take issue with, that hospitals are in the best position to identify and bill primary insurers. When this is done effectively, the government is relieved of both the inappropriate payment for services and the administrative costs of identifying the primary insurer after Medicare has paid erroneously.

Questionnaires are useful in identifying situations where Medicare should be a secondary payer but because they do not improve hospital performance, they should not be relied on as the primary mechanism for assuring that Medicare pays appropriately. Rather, government efforts should focus on ways to encourage intermediaries and hospitals to improve hospital performance in identifying and billing primary payers.

were completing our report. The standards cited by BCBS are much higher than we reported for fiscal year 1986 because they included new secondary payer categories, such as those imposed by COBRA, and because they included savings standards for nonhospital services (i.e., Medicare Part B) not within the scope of our audit. We would point out, however, that in the categories we examined, the savings standards did not increase. For example, the intermediary savings standards for fiscal year 1986 were $574 million, and similar secondary payer categories in fiscal year 1987 were set at $551 million—a reduction of $23 million.

BCBS generally agreed with our option to establish new administrative requirements that would direct intermediaries to perform certain oversight functions and administrative tasks necessary to improve hospital performance in billing primary payers. BCBS also agreed with our recommendation to standardize hospital admission forms for hospitals that are not taking the steps necessary to bill other insurers. BCBS disagreed, however, with our recommendation that Medicare intermediaries not meeting CPEP requirements be required to screen Medicare claims against their own insurance policyholders. Because BCBS's objections to this recommendation were similar to HHS's, our earlier comments apply here as well.

Intermediary Comments and Our Evaluation

The Blue Cross/Blue Shield Association (BCBS) agreed that more secondary payer savings exist than are identified and that the key to realizing these savings is through effective provider education. However, BCBS disagreed with the first recommended option of increasing savings standards. BCBS said increasing such standards could be a disincentive for intermediaries to better educate providers because if the providers identify and bill other insurers more successfully, there is no assurance that the intermediaries will be given credit for the resulting increased savings. In BCBS's view, providers have no incentive to report these savings ("nopayment bills") to Medicare.

Our report (see p. 31) acknowledges a need to develop a system for accurately measuring savings, and this first option is based on such a prerequisite. In any case, provider education on the need to file nopayment bills, like the other Medicare requirements, is a responsibility of the intermediaries and should be part of their secondary payer provider education activities. Filing such bills is important not only in helping intermediaries account for savings needed to document their performance, but also in helping to assure that Medicare beneficiaries are not overcharged for medical expenses because of inaccurate recording of payment data on which their coinsurance and deductibles are calculated.

Other reasons cited by BCBS for not favoring our option of increasing savings standards included (1) the secondary payer program is relatively new, (2) standard setting is a difficult actuarial and budgetary exercise, and (3) the fiscal year 1987 contractor savings standards have already been set at over $1 billion.

In our opinion, the 2 years that HCFA's secondary payer program has been in existence should have given contractors enough experience to allow them to take steps necessary to see that hospitals identify and bill Medicare properly as the secondary payer. The reason we presented this recommendation as an option is that we recognize the difficulty with setting contractor savings standards. We believe it is a worthwhile objective provided that the standards are both challenging and achievable. Our evidence has shown that during the first 2 years of the program, these standards were met by intermediaries, even though hospitals' performance in identifying and billing other insurers was poor.

We did not review in detail the $1.05 billion HHS fiscal year 1987 savings standards cited by BCBS because the standards were published while we

others may know they should make reimbursements but choose not to do so.

The experience of Michigan's intermediary illustrates the difficulty in obtaining information about potential recoveries. The intermediary, Blue Cross of Michigan, identified 6,340 beneficiaries who had incurred over $200 in Medicare costs for trauma-related injuries. Between October 1984 and November 1985, Blue Cross sent one or two questionnaires to each beneficiary asking if a liability insurer was responsible for medical costs and if the beneficiary was anticipating or was involved in any action to recover damages. Only 1,067 (16.8 percent) of the beneficiaries returned the questionnaire, and 158 respondents said they had coverage under either an employer health plan or accident insurance. Blue Cross personnel attributed the low response rate to beneficiary concerns about providing such information.

To overcome beneficiaries' potential reluctance to provide us with complete information, we promised that their answers to our questionnaire would remain confidential and would not affect benefits, reasoning that it was worthwhile to give up the opportunity for recovery in a limited number of circumstances to gain a better picture of the extent of the problem. Our questionnaire results indicate that the number of instances in which Medicare does not learn of other coverage may be sizable. About 18 percent of the cases (27 of the 150 cases discussed on page 16 where Medicare paid the claim when other insurance was indicated) represent situations where the beneficiaries said they had received accident insurance payments.

Of the 3,052 total responses, 510 involved Medicare claims for accidents. Of these 510 respondents, about 9.2 percent said they had recovered or planned to recover from accident insurers. Specifically, 27 (5.3 percent) said they had received insurance payments, 17 (3.3 percent) said they had started legal action to recover damages, and 3 (0.6 percent) said they were planning to do so. In all 47 of these instances, the file listed Medicare as the primary payer, indicating that Medicare paid without knowledge of the potential for recovering its payment.

This does not mean that these 47 recipients were trying to seek payment for services that Medicare already paid for without planning to reimburse Medicare. Our questionnaire did not address their motives or ask whether they intended to notify Medicare about any insurance payment. The results indicate, however, that some insurance payments were being made without an opportunity for Medicare to recover its payment

Changes in Regulations Would Increase Recoveries From Accident Insurers

Under the law, Medicare's responsibility for paying medical costs is secondary to the responsibility of any applicable liability insurer (e.g., insurers covering accidents in an automobile, home, or business establishment). Medicare's role as secondary payer is hampered, however, by two problems:

- Although the law specifies that Medicare is to be secondary to all types of no-fault insurance, HHS regulations currently omit no-fault liability insurance (other than automobile no-fault liability) from this requirement, and HCFA was thus not enforcing this provision of the law. This was the result of an oversight when the regulations were drafted.
- Medicare relies on beneficiaries to identify available accident insurance coverage. This procedure often does not work because Medicare does not learn that a claim it has paid has also been paid or could be paid by an accident insurer.

Changes in HHS regulations would correct these problems.

Relationship Between Medicare and Accident Insurance

According to HHS's health statistics, in 1982 over 1 million people age 65 and older were injured in accidents at locations other than their home. When accidents occur to Medicare beneficiaries, insurance other than Medicare may be available for medical expenses. The Medicare beneficiary may have automobile insurance, for example, or the accident may have taken place at a business that has liability insurance to cover such occurrences.

Section 1862(b)(1) of the Social Security Act (42 U.S.C. 1395y(b)(1)) provides that Medicare is to be the secondary payer to accident insurance as follows:

"Payment under this title may not be made with respect to any item or service to the extent that payment has been made, or can reasonably be expected to be made promptly (as determined in accordance with regulations), . . . under an automobile or liability insurance policy or plan or under no-fault insurance Any payment under this title with respect to any item or service shall be conditioned on reimbursement to [Medicare] ."

Under Medicare procedures, the intermediary is required to review Medicare claims for the possibility of accidents, and the hospitals are supposed to ask the beneficiary if an accident insurer is or may eventually be responsible for medical costs. If such coverage is believed to exist (e.g., if the beneficiary has automobile liability coverage), section

1862(b)(1) provides that any payment by Medicare must be conditional—i.e., made on the basis that Medicare is to be reimbursed for any amount for which the insurer is responsible. In those cases where Medicare paid conditionally, the beneficiaries are periodically asked by the intermediary if they have received settlements from the insurers and advised of their responsibility to reimburse Medicare for the conditional payments made. After a beneficiary's claim is settled or adjudicated, Medicare has a right, under section 1862(b)(1), to recover from the insurer or the beneficiary.

Although the government has a valid claim it may pursue against an accident insurer, it relies on the beneficiary to file the claim and collect from the insurer. This approach relieves the government from the administrative burden of initiating legal actions.

No-Fault Insurance: Not Always Payer Before Medicare

In many states, insurers cover medical costs for accidental injuries on a no-fault basis, within specified limits. Under this approach, the insurer is responsible for paying regardless of which party is at fault for the accident. For example, 26 states had mandatory or optional no-fault coverage for medical costs sustained in auto accidents (as of Oct. 1984). Also, in all states, accidents occurring in places other than a person's home may be partially covered under a no-fault provision in a business's or another homeowner's liability insurance.

Section 1862(b)(1) of the Social Security Act states that Medicare is to be the secondary payer where there is no-fault insurance. It does not limit no-fault insurance to automobile insurance. However, the HHS implementing regulations for this section (42 C.F.R. 405.322) defined no-fault insurance in terms of automobile insurance, failing to include other no-fault liability insurance. Based on the regulations, HCFA treats Medicare as the primary payer ahead of no-fault liability coverage, except for automobile liability insurance.

We did not attempt to estimate the amount of money involved, but the results of our nationwide questionnaire provide an indication of the degree to which Medicare may be paying primary to all no-fault liability insurance except automobile. Of the 2,311 usable questionnaires we received for beneficiaries under 70 years old, 45 (about 2 percent) involved nonautomobile accidents occurring in situations in which the

potential existed for liability coverage containing no-fault medical benefits.[1] Almost half (47 percent) involved accidents in a friend's or relative's home or place of business. According to the American Institute for Property and Liability Underwriters, homeowner's liability insurance includes no-fault medical coverage with limits of $500-$2,000 per person, and commercial liability insurance may include no-fault medical coverage with limits of $250-$1,000 per person.

Although the percentage of such claims may be relatively small, in 1985 intermediaries processed about 12 million hospital claims. Reducing payments for even a small percentage of such a large number of claims can produce a sizable savings.

When HCFA drafted the regulations, it excluded no-fault liability coverage through an oversight, the chief of HCFA's Medicare Claims Payment Policy Branch told us. As a result, he said, HCFA is considering amending the regulations to make Medicare secondary payer in all cases involving no-fault liability coverage.

Medicare Often Unaware of Accident Insurance Recoveries

Relying on beneficiaries to initiate action to recover damages from insurers eases the government's administrative burden, but it also results in the government not finding out about many such actions. While Medicare does not find out about accident coverage when the hospital fails to ask beneficiaries at admission about insurance coverage, even if they do ask, available coverage may not be identified. This is because the beneficiary may not know about medical coverage available through accident insurance coverage at the time of admission or may not decide to initiate action to recover accidental damages until after the period of hospitalization.

When Medicare does not find out about such actions, it pays unconditionally as the primary payer. Medicare paid unconditionally for about 17 percent of the beneficiaries responding to our national questionnaire (510 of the 3,052 respondents) who said they were admitted to the hospital because of an accident. In such cases as these, Medicare will not know if the beneficiary obtains a recovery from an accident insurer unless the beneficiary or someone else notifies Medicare. Some beneficiaries may not realize that they are not entitled to receive payment for services Medicare already paid for without reimbursing Medicare;

[1]These cases were not included in our estimate of loss to the Medicare program because the responsibility of the insurers to pay them was not firmly established.

out the law, regulations issued under that authority are valid so long as they are reasonably related to the purpose of the law. We believe imposing notification requirements on insurers is reasonably related to the purpose of section 1862(b)(1), which is to make Medicare payment liability secondary to private insurers.

Need for Notification by Insurers: An Example

In our view, relying on beneficiaries to notify Medicare of accident insurance recoveries is unwise. Although many beneficiaries may be conscientious in reporting insurance claims they have received or expect to receive, the current practice of relying on beneficiaries does not adequately protect the government's interests. The following example, provided to us by HCFA officials, illustrates the point.

A HCFA regional official received a telephone call from an attorney who said he represented some clients who were involved in an action to recover a Medicare beneficiary's medical expenses and damages from an insurer. The attorney did not identify the clients. The medical bills had amounted to $90,000-$100,000, he said, and the proposed settlement was $100,000-$110,000. According to the HCFA file, the attorney said he was calling to obtain a firm commitment from HCFA that his clients would get at least as much from the settlement as would the government.

The HCFA regional official advised the attorney that, although HCFA had authority to compromise settlements, it could not do so without a full review of the specific case. The attorney refused to provide further information without an up-front commitment, which HCFA officials decided they had no authority to give. According to the HCFA file, the attorney stated that he "had no choice but to recommend to his client to settle the case without notifying Medicare."

If the insurer had been required to notify Medicare of the settlement, this situation might not have occurred. The insurer would have an incentive to notify Medicare about the settlement since notification would allow the government to recoup its payments and thus release the insurer from its liability.

Conclusions

Medicare's intended role as a secondary payer for accident-related medical bills can be more fully realized through two changes to existing regulations.

The first change, adding no-fault liability insurance to the types of no-fault policies that are to act as primary payer, basically requires only a change in the wording of the regulation to make it consistent with the law. HCFA officials indicate that they are already studying this change.

The second change, requiring insurers to notify Medicare about paymer of medical bills and any other settlements, requires a change in the regu lations to establish new procedures for insurers. We think the federal government's financial interest in the matter justifies imposing such procedures and that the amount of effort required by insurers can be kept minimal. Notification could be limited to instances in which an insurance company knows that Medicare has paid or has reason to believe that Medicare could pay because of the beneficiary's age. A cop of the notice also could be sent to the beneficiaries or their representatives notifying them that Medicare has a right to recover its payment. Intermediaries that administer the Medicare program could then recove such payments from the settlement, the hospital, or, if need be, the ben eficiary. As an incentive for insurance companies, such notification would help assure that Medicare is reimbursed and at the same time eliminate the insurers' liability for the payments to Medicare.

Recommendations to the Secretary of HHS

We recommend that the Secretary amend regulations implementing sec tion 1862(b)(1) of the Social Security Act to

- extend the Medicare secondary payer provisions of the law to all forms of no-fault insurance coverage and
- require that accident insurers notify Medicare of medical payments or other settlements in instances in which it has reason to believe Medicar has an actual or possible right of recovery.

Agency and Insurance Association Comments and Our Evaluation

HHS commented that it is revising Medicare secondary payer regulation so that they apply not only to automobile no-fault coverage but also to other no-fault insurance coverage. HHS said that the proposed regulations will also provide that insurers remain liable to refund Medicare payments if the insurer fails to consider Medicare's payment and right to reimbursement when it pays an accident claim. HHS indicated that th latter revision would implicitly require insurers to notify Medicare wh they contemplate paying an accident claim, and its approach has the advantage of not relieving insurers of liability if they merely notify Medicare of the accident claim. HHS's proposed action conforms to our recommendation.

HHS also said that it will consider making explicit the notification requirement we recommended. We believe an explicit notification requirement is needed because there will otherwise be no assurance that Medicare will learn of a liability insurance settlement. We agree with HHS that in developing such a notification requirement, Medicare needs to retain the right to be reimbursed by an accident insurer that ignores Medicare's interests.

The American Insurance Association concurred with our conclusion that the law makes Medicare secondary to all forms of no-fault insurance coverage. It concluded, therefore, that our recommendation to extend the Medicare secondary payer provisions of the law to all forms of such insurance coverage "seems appropriate."

The Association did not agree that insurers should be required to notify Medicare of medical payments or other settlements in those instances in which Medicare may have a right of recovery. The Association noted that while this requirement would not seriously impede the ability to investigate and pay claims, it would add one more form to the numerous reporting, disclosure, and notification forms that have become required of insurance claims personnel in recent years. It stated that additional forms should be required only if there is a documented need for the information and a demonstration that insurance companies are the appropriate party to provide the information.

The Association stated that the draft report did not establish the existence of a problem that could best be solved through insurance companies but that from their perspective, it would seem logical to place the notification requirement on the claimant's attorney. They stated that the attorney is in the best position to know whether the claimant has received Medicare benefits and that attorneys could be held accountable for reporting through revised Medicare regulations.

We believe that the evidence supports our conclusion that the government is not in a favorable position to know about actions to recover accidental damages involving Medicare funds. Because these actions are initiated over time at the discretion of the beneficiary, some form of notification to Medicare would help realize additional savings. We continue to maintain that requiring attorneys to notify Medicare of claims settlements, while potentially effective, would be difficult to administer because of the large number of attorneys nationwide and because there is no practical and cost-effective method of enforcement at the federal level. In addition, there may be a constitutional question regarding the

authority of the federal government to impose such a requirement on private attorneys.

On the other hand, under the current federal government requirements, insurers continue to remain liable for Medicare costs under settlements paid even if Medicare does not identify such settlements before they are made. Therefore, we believe it is appropriate to place such a requirement on insurers to protect the government's interests under claims settlements. Further, such a requirement could be largely self-enforcing because insurers would have an incentive to notify and assure payment to Medicare.

Regulations Needed to Preclude Inappropriate Use of Supplementary Insurance

Medicare's intended role as a secondary payer is often not met because regulations and administrative procedures were not established to provide that employers enroll Medicare beneficiaries appropriately in health care plans designed to treat Medicare as a secondary payer. In January 1983, when the Congress made employer-provided health insurance responsible for the health care costs of some Medicare beneficiaries, it anticipated that employers could circumvent this legislation by giving Medicare beneficiaries supplementary health insurance, which pays only after Medicare.

To prevent this from occurring, the Congress required employers to offer the same health insurance to Medicare workers and spouses as they offer their other workers and spouses. The Congress intended that regulations would be issued to assure employers acted accordingly. However, the Equal Employment Opportunity Commission, the agency responsible for issuing these regulations, has not done nor does it plan to do so. Further, weaknesses exist in EEOC's and HCFA's procedures for detecting and resolving situations that arise when employer-sponsored plans are not enrolling beneficiaries in appropriate coverage.

When employers enroll Medicare beneficiaries in plans that treat Medicare as the primary payer, the cost of beneficiaries' medical care may inappropriately revert to Medicare rather than to the employer plan as the Congress intended. Intermediaries told us that employers were enrolling Medicare beneficiaries in plans that treat Medicare as the primary payer in five of the seven states where they operated. While the nationwide magnitude of the problem is not known, it appears to be significant. For example, in Michigan, Medicare paid at least $5.3 million between January 1984 and December 1985, we estimate, because several hundred health care plans were designed to pay only after Medicare. EEOC and HCFA should work together to develop regulations and administrative arrangements to help assure that employers enroll beneficiaries (who elect to participate) in group health plans designed to treat Medicare as secondary payer.

Some Employers Continue to Enroll Beneficiaries in Supplemental Plans

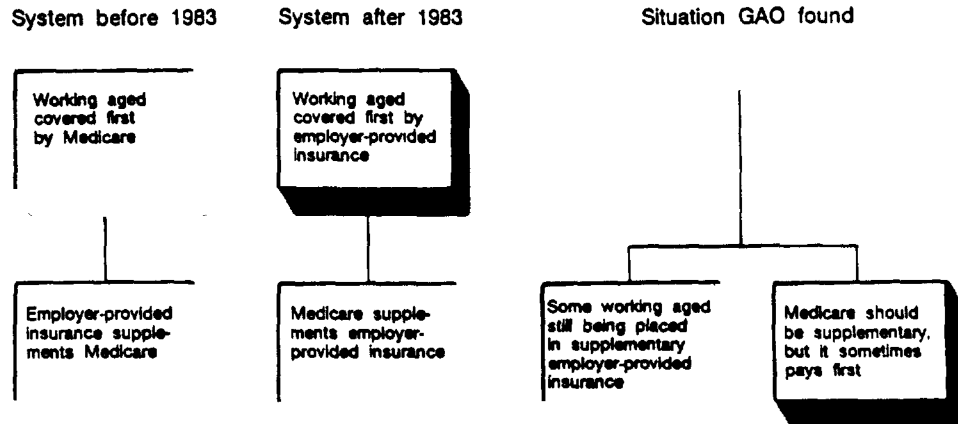
Most Medicare beneficiaries who remain in the work force after turning age 65 are eligible for health care under both Medicare and, if provided through their employer, group health plans. Beneficiaries also may be eligible for these plans if provided through their spouses' employment. These beneficiaries with employer group health plan coverage are referred to as "working aged."[1] Before 1983, the law called for Medicare to be the primary payer for persons in this group. Federal guidelines (29 C.F.R. 860.120) allowed employers to offer plans that would supplement the amount paid under Medicare.

Effective in 1983, the Congress began to shift the role of Medicare from the primary to the secondary payer for the working aged. To assure that employers do not discriminate against older workers by providing them with health insurance that only supplements Medicare, the Congress, in section 4(g) of the Federal Age Discrimination in Employment Act (ADEA), required employers with more than 20 employees to offer the same group health care plans to Medicare working aged beneficiaries or spouses as they offer to other workers and spouses. The Congress intended that the employee have the option of rejecting the plan offered by the employer, thereby retaining Medicare as primary. If the employee elects this option, however, the employer is prohibited from offering a supplemental health care plan to the beneficiary. If the working aged beneficiary does elect any employer group health plan, Medicare is to be the secondary payer.

We found that this intended shift in roles of Medicare and employer group health care plans has not always come about. In five of the seven states covered by the intermediaries we reviewed, Medicare has remained the primary payer for some working aged beneficiaries who had been enrolled in an employer-provided supplemental plan. (Intermediaries in the other two states told us they had no indication that employers were offering supplementary policies to their Medicare beneficiary employees.) The intended roles of Medicare and employer plans before and after 1983, as well as how this situation differed from what we found, are shown in figure 5.1.

[1]Working aged as used here is defined as an individual, age 65-69, entitled to part A of Medicare but employed and covered by reasons of such employment by an employer group health plan The category also covers a beneficiary aged 65-69 whose spouse is an employed individual under age 70 The employer in these cases must have 20 or more employees Effective May 1986, the under age 70 limitations were removed

Figure 5.1: Relationship Between Medicare and Employer-Provided Group Health Insurance



The most complete information on the extent of the problem was in Michigan, where the intermediary had sufficient information to estimate the extent to which such payments occur. For cases this intermediary identified between January 1984 and December 1985, we estimate that Medicare paid about $5.3 million in claims that should have been paid by employer policies.[2] This estimate represents 18 percent of the funds that Michigan was attempting to recover from private insurers. More than 300 employer groups were involved with the cases for which Medicare was not reimbursed.

Data comprehensive enough to estimate the extent that inappropriate payments occur was not available in any other states reviewed. Nonetheless, we found indications of the same problem in four other states. For example:

- Blue Cross of Florida determined that 67 of the 153 employer groups it analyzed (44 percent) were potentially enrolling their working aged in policies that were supplementary to Medicare.
- A Blue Cross of Ohio official estimated that they had 150 to 200 cases of claims that were incorrectly paid as Medicare-primary because

[2]This estimate includes hospital and nonhospital claims During this period Michigan had identified about $29 4 million in Medicare claims for working aged beneficiaries that should have been paid by employer-sponsored group health plans. At the time of our visit in March 1985, these insurers had been billed for $6 4 million of these Medicare costs, but the insurers did not reimburse Medicare for $1 2 million (about 18 percent) specifically because the beneficiaries were covered under supplemental policies We estimated the $5.3 million loss by applying the 18-percent nonreimbursement factor to the $29 4 million in total claims paid by Medicare

employers and insurance companies were incorrectly buying, selling, or reporting supplemental insurance coverage for working aged beneficiaries.

Under existing law and regulations (42 C.F.R. 405.341), Medicare is required to act as a secondary payer for working aged beneficiaries even if a group health care plan says it is supplementary to Medicare. As of July 1986, HCFA instructions allowed intermediaries to make Medicare payments conditionally if the employer group health plan does not pay as primary insurer. If Medicare does not pay, an employee can face a disruptive situation in which initially neither Medicare nor the health care plan will agree to act as the primary payer. In such a case, the beneficiaries may need to take steps (such as initiating legal actions against the employer or petitioning EEOC to file such actions) to secure the employer-sponsored insurance coverage to which they are entitled. The actions the Congress took were designed specifically to ensure that the employer plan would clearly be responsible for these costs. However, as discussed below, a breakdown exists in federal systems for ensuring that employers are enrolling beneficiaries in appropriate insurance coverage.

No Federal Guidance on Employers' Responsibilities Available

When the Congress made Medicare a secondary payer for working aged beneficiaries under TEFRA, it envisioned that employers would be instructed on permissible practices for providing health insurance to employees or their spouses also covered under Medicare. Such guidance does not exist, but is needed because (1) evidence indicates that employers, beneficiaries, or insurance companies are often confused about their responsibilities and rights under legislation making Medicare a secondary payer and (2) employers have little incentive to provide appropriate coverage.

In amending section 4(g) of ADEA, which is administered by EEOC, the conferees' report stated that it was the understanding of the conference that regulations would be promulgated ". . . to prevent employers from offering a group health insurance plan or option which is designed to circumvent this provision."[3] The conferees also stated that there was a need for employers to notify affected beneficiaries of their rights to employer group coverage.[4]

[3] H R Rept No 97-760, pp 414-415

[4] H R Rept No 98-861, p 1347

Work was begun on meeting this directive, but it has been discontinued. EEOC issued interim regulations covering the TEFRA provisions in June 1983 and continued to work on draft final regulations for TEFRA and interim regulations for DEFRA, through February 1985. The regulations clarified several aspects of employer responsibilities. For example, under the statutory language, employers are not specifically prohibited from providing Medicare supplemental plans as long as they offer supplemental plans to all employees. The interim regulations prohibited this practice. In December 1985, however, EEOC rescinded the interim regulations and discontinued work toward finalizing them because it disagreed with HCFA on their scope. Specifically, EEOC's interpretation was that employers could provide supplemental coverage to their disabled Medicare beneficiaries after they reach age 65. HCFA believed this to be inconsistent with the law, which includes these beneficiaries under the "working aged" category and therefore does not entitle them to have Medicare as the primary payer when they also have employer-sponsored coverage. Because of this disagreement and subsequent withdrawal of the clarifying regulations, the federal guidance the Congress envisioned does not exist, nor is it planned, according to EEOC officials.

Other evidence from several sources indicates a need for education and clarification of employer responsibilities because employers and beneficiaries are often unaware of or confused about their responsibilities and rights under legislation making Medicare secondary. For example:

- Seven of 11 Medicare contractors responding in January 1986 about a special project informed HCFA that they found that beneficiaries, employers, or insurance companies were often confused about or unaware of legislation making Medicare secondary in certain circumstances. For example, one intermediary said that beneficiaries were concerned about a possible loss of benefits if Medicare paid as the secondary rather than primary payer.
- An October 1985 memorandum to national Blue Cross plan personnel from the vice president and general counsel stated that EEOC's decision to rescind the regulations left employers and health benefit insurers with little guidance on matters that would have been clarified by the regulations, such as informing beneficiaries of their rights to employer group health plan coverage.

Additionally, because of higher premium and administrative costs, employers have little incentive to provide primary rather than supplemental coverage. In May 1984, a Blue Cross and Blue Shield Association

official wrote in an internal memorandum that employers acting responsibly in providing primary insurance to employees have experienced an increase in premiums, and that most employers are not notifying their employees of their option to select a primary payer. Similarly, an April 1983 Health Insurance Association of America bulletin stated.

> "To expect employers to prepare for the worst scenario, to adjust their plans accordingly and voluntarily comply [with section 4(g)] without any instructions from the responsible government agencies wrongly assumes that little administrative work is necessary to accomplish this. In fact, attempting to comply with this statute can be a significant burden on employers and insurers "

Weaknesses in Enforcement Procedures and Practices

Instead of defining impermissible practices through regulations, the chief of staff at EEOC told us in December 1985 that EEOC would enforce section 4(g) on a case-by-case basis when possible violations are brought to its attention. We were advised that EEOC would rely on complaints from beneficiaries and notification from HCFA to identify possible violations. If it decides to pursue a case, we were told, EEOC would then bring action in the courts. Under this approach, impermissible practices that had been described in the interim and draft regulations would have to be established on the basis of case law, that is, when a court determines a practice to be impermissible.

EEOC's current approach, in our opinion, is not likely to work well. As discussed below, it has two main problems: beneficiaries have little motivation to bring complaints as long as someone—including Medicare—pays their claims, and weaknesses exist in HCFA practices to pursue cases and notify EEOC.

Beneficiaries Unlikely to Complain to EEOC

Few cases of violations have been identified through complaints by aggrieved beneficiaries. Although our work and others showed hundreds of instances in which employers enrolled working aged beneficiaries in supplemental insurance, EEOC has filed only five lawsuits for discrimination against beneficiaries related to section 4(g) of ADEA. As of December 1985, four cases had been settled in favor of the Medicare beneficiary, and one case was still pending.

Beneficiaries are unlikely to complain to EEOC about being offered only supplemental insurance because, under the current process, Medicare pays their bills. Under the existing system, hospitals are responsible for identifying the correct payer. Generally, hospitals are relied upon to

determine the type of coverage Medicare patients have. However, seven of the nine hospitals we visited either (1) did not check supplemental policies to see whether the plan should be primary or (2) would generally accept the insurance company's claim that they are secondary to Medicare. For example, admitting personnel at one hospital reviewed told us that they assumed that all supplemental policies were secondary to Medicare. Consequently, they would bill all claims for working aged beneficiaries with supplemental policies to Medicare. Because of these practices, we believe it is unlikely hospitals will identify when supplemented policies should be billed as primary payer. Additionally, since most Medicare beneficiaries are covered under some form of supplementary insurance, it may be administratively unreasonable to expect that hospitals make the determination on each supplemental plan. Further, even when hospitals identify instances where an insurer who claims to be secondary should be primary, Medicare instructions currently allow the intermediary to pay these claims conditionally,[5] until the matter is resolved.

HCFA Has Not Acted to See That Potential Violations Are Reported to EEOC

Federal regulations (42 C.F.R. 405.340) state that HCFA will refer to EEOC any identified cases of apparent employer noncompliance with ADEA. Although intermediaries had identified hundreds of potential instances of employer noncompliance, at the time of our review in May 1986, EEOC officials told us that HCFA had not referred any cases to EEOC.

In four states, the intermediary had alerted HCFA about problems with employers that were enrolling their working aged in supplemental plans yet HCFA did not follow up with the intermediary to assure that these cases were developed and referred to EEOC. For example, in October 1985, Blue Cross and Blue Shield of Michigan, which had identified hundreds of groups offering supplemental plans to working aged Medicare beneficiaries, informed HCFA that its commercial business intended to reimburse Medicare for only a portion of the identified Medicare claims. This letter stated that the intermediary was concerned about the lack of precision of EEOC regulations regarding supplemental policies offered by employers to working aged beneficiaries. The intermediary informed HCFA that it would take several steps to remedy this situation. However, by March 1986, HCFA had not followed up with the intermediary to assure it was taking these steps to remedy the problem. The intermediary official responsible for recovering these payments told us that

[5]Instructions currently in draft form may eliminate this option to pay claims conditionally in most circumstances However, as of July 1986, these instructions had not been issued

they had not attempted recovery from either the commercial side of its business or the employers involved.

HCFA officials told us that they were responding to the problem by drafting instructions intended to clarify the responsibilities of intermediaries for handling potential violations of the legislation. These draft instructions would change the previous policy that intermediaries could conditionally pay claims where the insurer maintains it provides only supplemental or secondary benefits. Additionally, the instructions would require intermediaries to inform the HCFA regional office of insurers who might not be paying claims. The HCFA regional office then could act, as appropriate, to refer the insurance company or plan to the state insurance commissioner and the employer to EEOC. Although these draft instructions provide clearer guidance to intermediaries, intermediaries may view them as problematic for two reasons:

1. Intermediaries have disincentives to pursue cases because as private insurers they may be the ones providing the supplemental group health plans. Under HCFA's instructions, intermediaries would have to turn their own companies in to HCFA or the state insurance commissioner if their private insurance does not pay as the primary payer. For these reasons, we believe it unlikely that intermediaries will want to refer names of employers or insurers whose policies are paying on a secondary rather than a primary basis.

2. Intermediaries view the responsibility as the employer's, not theirs. Officials from BCBS and several intermediaries we reviewed told us they thought it was the employer's responsibility to assure that the correct coverage was offered and that the intermediary was not in a position to unilaterally change the insurance coverage that employers had provided their employees. This also appears to be the view of the insurance industry. In a November 1982 bulletin to insurance companies, the Health Insurance Association of America wrote, "In summary, the onus to comply with ADEA and to inform employees and third party payors [such as insurance companies] of its intent to do so should rest solely with the employer. Third party payors . . . should not be responsible for monitoring policy holder/employer compliance."

Additionally, HCFA's instructions to its regional offices do not specifically direct them to seek out or identify cases for referral, and HCFA's instructions contain no provisions for monitoring the cases identified by intermediaries on the part of HCFA regional or central offices. Without

EEOC clarification of employer responsibilities and some kind of oversight from HCFA, such as closer monitoring of intermediary and regiona office case follow-up, we believe intermediaries will have little incentiv to identify potential cases for referral.

Also contributing to the lack of referrals was an apparent misunderstanding between HCFA and EEOC as to when to refer an instance of potential noncompliance. A HCFA official involved with handling concerns regarding apparent violations of section 4(g) told us that EEOC wanted HCFA to refer cases only if a trend of problems could be established for the same employer. However, an EEOC official told us that EEOC's understanding was that HCFA would refer all instances of apparent noncompliance with section 4(g). This official told us that EEO was planning on acting upon every case referred to it by HCFA or a bene ficiary and that no pattern of violations was necessary. This official wa unaware of the extent of the problem with supplemental plans, which we believe was because HCFA had not referred any cases and few benefi ciaries were complaining.

Other Secondary Payer Provisions Enforced Through the Tax Code

Employer compliance in providing primary health insurance coverage for beneficiaries under age 65 that have kidney failure or are disabled are enforced under the Internal Revenue Code. In the Omnibus Budget Reconciliation Act of 1981, the Congress amended section 162(i) of the Internal Revenue Code to provide that employers cannot deduct their group health insurance expenses if their plan contained provisions that exclude payment of benefits for persons with kidney failure. Similarly, in extending the secondary payer provisions to disabled beneficiaries, the Congress, in the Omnibus Budget Reconciliation Act of 1986, amended subtitle D of the code. This amendment imposed an excise tax on employers, equal to 25 percent of the employers' yearly group healtl plan expenses, if the plan does not properly treat Medicare as a secondary payer. These laws make clear the employer responsibility in pro viding appropriate primary coverage and provide for strong sanctions for noncompliance.

In fact, in enacting the 1986 amendments, the Congress considered abol ishing section 4(g) of ADEA, removing the EEOC enforcement role, and als applying the excise tax to employers that inappropriately enroll working aged beneficiaries in plans that treat Medicare as the primary payer. Senate Bill 2706 contained such a provision, but was dropped by the conference committee.

Conclusions

If the congressional intent of shifting Medicare costs to employer group health plans is to be met under the existing regulatory mechanism, employers need to be informed of their obligations in offering health insurance coverage to the working aged. The Congress had development of such instructions in mind when it shifted responsibility for these health care costs. In our view, EEOC's decision to clarify statutory intent by prosecuting violators on a case-by-case basis is neither consistent with congressional intent nor efficient. Since EEOC has decided not to issue regulations, the Congress has two options.

First, the Congress could statutorily require EEOC to promulgate the regulations needed to clarify section 4(g) of ADEA. Alternatively, the Congress could reconsider using the Internal Revenue Code, as it did for beneficiaries under age 65, to clarify and provide the basis for enforcement of the Medicare secondary payer provisions.

While the issue of regulations and enforcement responsibility is being resolved, current enforcement should be improved. HCFA should take actions to better assure that intermediaries follow up on potential violations and refer these cases to EEOC. Without these and the above actions, the working aged may not receive the insurance coverage to which they are entitled, and Medicare may continue to pay for claims that the Congress intended be paid by employer-sponsored group insurance.

Matter for Consideration by the Congress

The Congress should consider enacting one of two alternatives. First, the Congress could statutorily direct EEOC to promulgate the regulations that it envisioned when it enacted section 4(g) of ADEA. Second, the Congress could amend the Internal Revenue Code to deny to employers a deduction for health insurance premiums or impose a tax on such premiums if the policies provided by the employers do not meet the requirements of the Medicare secondary payer provisions for aged beneficiaries. This would conform the tax treatment for policies not following Medicare's requirement for aged beneficiaries to that for disabled beneficiaries and those with kidney failure.

Recommendations to the Secretary of HHS

We recommend that the Secretary direct the Administrator of HCFA to:

1. Enter into a memorandum of understanding with EEOC on the type of cases to be referred.

2. Establish procedures for identifying and referring potential violations of section 4(g) to EEOC. This can be done, for example, by establishing procedures for monitoring intermediary and regional office case follow-up and referral actions.

EEOC Comments and Our Evaluation

In our draft report we proposed that EEOC issue regulations to clearly state employer responsibility under section 4(g). In response to our draft report, EEOC commented that on December 11, 1985, it published a notice in the Federal Register (50 Fed. Reg. 50,614) officially concluding "that regulations implementing Section 4(g), interim or final, will serve no useful purpose." The rationale for this conclusion stated in the notice is that the DEFRA amendment to 4(g) resolved the most significant ambiguity regarding implementation. Our findings do not support this rationale or conclusion for the following reasons:

1. The DEFRA amendments cited did not clarify implementation methods but merely extended the age group to which the secondary payer provisions apply to beneficiaries covered under their spouse's employer group health plan. In formulating the DEFRA 4(g) amendment, the conferees specifically cited the need for regulations to assure that employers notify Medicare beneficiaries of their rights to employer group coverage.

2. Our review of the minutes of EEOC's deliberations leading to the December 1985 notice shows that a dispute with HCFA over the scope of the 4(g) regulations was the reason cited by EEOC's Commissioners for abandoning efforts to issue regulations. The disagreement in itself shows that 4(g) is subject to different interpretations that need resolution through the regulatory process.

3. The major private health insurance industry associations are on record (see p. 59 and Blue Cross comments below) that regulations implementing section 4(g) are needed to help assure that employers offer appropriate health insurance coverage to the working aged.

EEOC has not provided any new information that would cause us to change our position that the regulations anticipated by the Congress are needed for effective enforcement of section 4(g). But, because it is now unlikely that EEOC will issue regulations on its own initiative, we have withdrawn our proposal that the Commission issue regulations and have added two options that the Congress may wish to consider to better assure that these provisions are enforced.

Concerning our recommendation that the Administrator of HCFA enter into a memorandum of understanding with EEOC on case referrals, EEOC stated that such a formal procedure was not necessary. Alternatively, EEOC suggested that a letter of clarification from EEOC to HCFA should be sufficient to correct any misunderstandings that HCFA may have about types of cases to refer to EEOC. We agree that a less formal approach would meet the overall intent of our recommendation as long as EEOC and HCFA arrived at a common understanding of the types of cases to be referred.

HHS Comments and Our Evaluation

HHS concurred with our recommendations on entering into a memorandum of understanding with EEOC and on establishing procedures for identifying potential violations of section 4(g). HHS stated that there was still a problem with employers offering supplemental coverage to working aged beneficiaries. HHS also cited its revised claims processing instructions as a step it was taking to alleviate the problem. Our recommendation to HHS is designed to correct some of the problems (see pp. 60-62) that we saw with the proposed claims processing instructions cited by HHS, such as the need for closer monitoring of cases identified by intermediaries that show a potential violation of section 4(g). HHS's response did not address this point.

HHS also cited its planned efforts to work with major insurers and state insurance commissions to persuade them to assume more responsibility for assuring that employers are offering appropriate coverage. HHS disagreed with the intermediaries' opinion that employers but not insurers are responsible for offering correct coverage to beneficiaries. HHS's position is that insurers are also responsible. We believe this difference of opinion between HHS and insurers to be significant. As stated on page 61, intermediaries' views that employers are solely responsible for offering working aged beneficiaries appropriate health insurance is widely held among insurers. These different points of view support our recommendation on the need for clarifying regulations and closer monitoring of intermediary performance in identifying and referring potential violations of section 4(g).

Blue Cross/Blue Shield Association Comments

BCBS agreed with our findings and recommendations. It commented that the lack of clear-cut definitions of respective employer obligations has greatly hindered effective secondary payer savings initiatives.

Request Letter

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United States Senate

COMMITTEE ON FINANCE
WASHINGTON, DC 20510

March 10, 1986

The Honorable Charles A. Bowsher
Comptroller General of the United States
United States General Accounting Office
441 G Street, N.W.
Washington, D.C. 20548

Dear Mr. Bowsher:

Early last year I chaired a Finance Committee hearing on third party liability collections in the Medicaid program because the General Accounting Office had reported that the Health Care Financing Administration and the States were not doing enough to assure collections were being made from liable third parties. That hearing led to legislation to improve Medicaid collections, however, as you may know, the concept of third party liability also applies to the Medicare program.

While Medicaid is the payer of last resort in all cases, under the Social Security Act, Medicare is the secondary payer of hospital-related and other medical services when beneficiaries are also covered under an employer's group health insurance plan, or the services received are covered by a liability, automobile, workmen's compensation, or no-fault insurance policy. Thus, Medicare is to pay only after other insurance coverage is exhausted. An estimated 4 percent of the 11 million Medicare hospital claims each year involve persons who have other insurance coverage.

Department of Health and Human Services' (HHS) reports indicate that more than $700 million could be saved in fiscal year 1986 if such insurance resources were used instead of Medicare funds. I would like to know whether, in administering the Medicare program, HHS has effectively carried out the secondary payer requirements, particularly for hospital services. Therefore, I am requesting that your office provide me

The Honorable Charles A. Bowsher
Page Two
March 10, 1986

with information on the HHS program for implementing Medicare secondary payer provisions contained in Section 1862(b) of the Social Security Act. I request that your report include a discussion of the following issues:

-- To what extent, in 1985, did Medicare pay hospital bills as primary payer when other insurance resources should have been billed first?

-- What improvements in HHS policies and procedures are needed to assure that Medicare's fiscal intermediaries and hospitals:

  1) identify those beneficiaries with primary insurance coverage other than Medicare; and

  2) properly bill Medicare as secondary payer?

-- Are changes in law or regulations needed to enhance the federal government's ability to recover Medicare costs from primary insurers?

Answers to these questions, and discussions of any other issues that you believe to be important, would help the Committee in its deliberations regarding the application of secondary payer provisions to Medicare beneficiaries.

Thank you for your assistance in this matter.

Sincerely,

BOB PACKWOOD
Chairman

Methodology Used to Estimate Loss to the Medicare Program by Paying for Hospital Bills That Private Insurers Should Pay

Overall Methodology

We sent questionnaires to a stratified random sample of hospitalized Medicare beneficiaries to identify circumstances in which private insurance existed that should have, but did not, pay the beneficiaries' medical bills before Medicare. We used these data to determine the percentage range of Medicare claims paid erroneously and estimated an annual loss to the Medicare program.

Testing the Questionnaire

To obtain accurate results, we promised beneficiaries that their questionnaire responses would be treated confidentially and furnished them a toll-free number to call if they had questions. This pledge of confidentiality prevented us from verifying insurance coverage with their insurance companies. However, we pretested the questionnaires by meeting with selected Medicare beneficiaries to discuss their understanding of the questions and then field-tested the questionnaires by sending them to 1,000 beneficiaries in the Seattle-Tacoma area.

The Sample

To select a nationwide sample of Medicare payments, we obtained a list of claims paid by Medicare that the intermediaries reported to HCFA during August 1985. The list included the two types of hospital claim records referred to by HCFA as the "UNIBILL" and "PATBILL." This list was the most current and complete national Medicare-paid hospital claims data base that was available when we organized our data collection effort. The claims in this data base represented claims submitted by 95 percent of all fiscal intermediaries, accounting for about 96 percent of Medicare claim volume in fiscal year 1985.

We made two types of adjustments in the universe of claims. We withdrew claims for (1) beneficiaries who had died or (2) which Medicare had paid as a secondary payer for the hospital stay.[1] We selected the cases in our universe for which it was possible that Medicare had paid as the primary payer when it should have paid as a secondary payer. Medicare should be the secondary payer to auto accident and liability insurance and workers' compensation; however, for beneficiaries under age 70 who are covered by employer group health plans, Medicare also should be the secondary payer. Therefore, from each of the two record types (UNIBILL and PATBILL), we separately sampled those beneficiaries age 70 and older who had been treated for conditions that could have

[1]Since 11 intermediaries were not using a code to indicate on claims that Medicare is the secondary payer, some of the claims they submitted may have been incorrectly coded as the primary payer To address this we followed up on sampled claims from these 11 intermediaries to verify that Medicare paid as the primary payer

been caused by an accident and sampled those beneficiaries that were under age 70.

Table II.1 shows the number of questionnaires sent and received.

Table II.1: Summary of Questionnaires Sent and Received

	Questionnaires		
Age group	**Sent**	**Received**	**Usable**
Under age 70	2,855	2,479	2,311
Age 70 and older	899	788	741
Total	**3,754**	**3,267**	**3,052**

Questionnaire Follow-Up

Some questionnaires were returned incomplete because the beneficiary had moved and no forwarding address was available or the beneficiary had died. We considered these questionnaires as unusable. We considered the other questionnaires we received as usable and reviewed each response to detect instances where a primary payer to Medicare existed. Some of these questionnaires were not filled out completely or had inconsistent answers; in these situations we called the beneficiaries to obtain clarification. We sent a second questionnaire to beneficiaries who did not respond to the first.

Results Used to Calculate the Projectable Error Rate

Using the data for each group, we calculated the mean payment error amount for hospital inpatient payments in the August 1985 universe of claims using standard statistical procedures. In making these calculations, we lowered the amount for the under-70 age groups by 23 percent to account for some situations in which medical insurance is available through a small employer. Under the law, employers of less than 20 employees can have group health plans that treat Medicare as primary. HCFA actuaries have determined, based on Bureau of Labor statistics, that 23 percent of all workers work for such small employers.

Our projections show that 1.78 percent of the reimbursements for August should have been paid by other insurers. This figure is subject to sampling error of 0.46 percent. This means that we are 95 percent confident that the true percentage payment errors lies between 1.32 and 2.24 percent.

Estimating the Loss to Medicare

In our judgment, the rate of payment errors occurring in the August 1985 data base approximates the rate of payment errors for the entire calendar year. According to HCFA officials, the Medicare-paid claims processed during August 1985 were typical of claims processed during calendar year 1985. We tested this hypothesis by comparing claims volume, primary and secondary payer claims, age groups, and selected diagnosis (trauma code) data in August to similar data for a previous and succeeding month and found the data for August 1985 to be representative.

Accordingly, we used the August payment error rate to estimate the calendar year 1985 loss to Medicare. We obtained the amount of estimated Medicare expenditures for hospital inpatient services in calendar year 1985 of about $44.5 billion and multiplied the August projected erroneous payment rates against this figure. We then reduced this estimate by 15 percent to reflect HCFA's estimate of the average amount that Medicare still would pay after the primary insurance has paid. HCFA also uses this reduction factor in making savings projections in the Medicare secondary payer program. Therefore, assuming August to be a typical month, we estimate, with 95-percent confidence, that the loss is at least $527 million.

We further believe this estimate to be conservative for two reasons. First, we excluded from our 150 erroneous payments 20 cases in which the beneficiaries said they had initiated (17) or were planning (3) legal action to recover accidental damages. Since Medicare should have paid conditionally on these claims but did not, we could have considered them erroneous payments. However, since the eventual outcome of these legal actions is unknown, Medicare cannot be firmly established a the primary payer. To the extent that these cases are resolved in the beneficiaries' favor, Medicare would be the secondary payer and our estimate is understated.

Second, we significantly underestimated the magnitude of accident insurance covering the beneficiaries 70 years and older. For this group we sampled only those claims with a principal diagnosis code that intermediaries use to screen claims (trauma codes). However, in analyzing the results of our sample for those beneficiaries involved in acci dents that had potential for insurance coverage, we noted that these principal diagnosis codes are not a good indicator of beneficiaries involved in such accidents. For example, we found that the principle diagnosis codes relied on by the intermediaries to indicate accidents

were not used in 90 percent of the cases where beneficiaries under age 70 told us they had accident coverage.

Summary of Selected Federal and State Audit Reports on Efforts to Identify and Apply Liable Third-Party Resources for Hospital Costs

GAO Report

The Congress Should Consider Amending the Medicare Secondary Payer Provisions to Include Disability Beneficiaries (HRD-85-102, Sept. 30, 1985).

GAO concluded that disabled Medicare beneficiaries covered by their spouse's employer-sponsored group health insurance are essentially sim ilar to aged and end stage renal disease beneficiaries covered by such insurance. This report recommended that the Congress consider extending Medicare's secondary payer status to disabled beneficiaries. This recommendation would result in substantial savings to the Medicare program and should not directly affect the coverage of services or the costs to beneficiaries.

HHS and HCFA Reports

Medicare Secondary Payer Provision: Automobile Liability and Medical Insurance State of Missouri, HHS, Office of Inspector General, Region VII (Dec. 1985).

Medicare Secondary Payer Provision: Automobile Medical and No-Fault Insurance: State of Colorado, HHS, Office of Inspector General, Region VII (Dec. 1985).

Medicare Secondary Payer Provision: Automobile Medical and No-Fault Insurance: North Dakota, HHS, Office of Inspector General, Region VII (May 1, 1985).

These reports estimated that from June 6 to December 31, 1983, the Medicare program overpaid $3,481,334 in Missouri, $1,050,640 in Colorado, and $211,336 in North Dakota, in cases in which automobile insur ance should have been the primary payer.

The Colorado and North Dakota reports recommended that the contractors

- establish a collection unit and implement procedures to identify trauma procedures and pursue collection of third-party liability resources regardless of the nature of the accident;
- review services provided resulting from accidents retroactive to June 6 1983, and pursue recovery from providers and/or responsible third-party insurers; and
- establish liaison with the state highway department, receive copies of automobile accident reports for injured individuals over age 64, and pursue collection of automobile medical and no-fault insurance.

The Colorado report mentioned that contractors were finding that some beneficiaries do not have automobile insurance. However, it points out that since Colorado state law requires that motor vehicle owners without insurance are personally responsible for liability actions and for medical items and services furnished to persons who should have been covered if insurance was in force, Medicare would be the secondary payer.

Medicare as a Secondary Payer for Medical Services Related to Automobile Accidents in Massachusetts, HHS, Office of the Inspector General, Region I (June 1985).

This review found that providers/practitioners do not always bill and collect from third-party payers and that an intermediary was not identifying and processing as required all hospital claims with accident-related diagnosis codes. Two intermediaries and one carrier servicing beneficiaries in Massachusetts made $640,312 in erroneous Medicare payments during the sample period, and the regional Office of Inspector General projected that $3.6 million could be saved annually in Massachusetts if third-party payers were routinely identified and billed as the primary payer. The report also found that registry of motor vehicle records were an excellent source for identifying Medicare beneficiaries involved in automobile accidents and could be used to recover a significant portion of erroneous payments.

Program Inspection Report of Medicare as a Secondary Payment Source for Accident-Related Claims in the State of Washington, HHS, Office of Inspector General, Region X (Aug. 31, 1984).

This report found that hospitals had properly identified the primary payer for the 30 outpatient claims reviewed; however, in 4 of the 784 inpatient claims reviewed, Medicare had been incorrectly billed as the primary payment source when secondary payer situations may have existed. It also found that the intermediary did not pursue inpatient claims that had been identified by the hospitals as secondary payer situations. The Office of Inspector General projected that nationally the Medicare program may be losing $33 million annually because of the identification and pursuit problems found in the review. The report attributed the exceptions found in the review to hospitals not having effective systems to relay information obtained after admission to the billing departments. It recommended that a standardized questionnaire be completed before patient discharges and forwarded promptly to billing departments.

Medicare Third Party Liability (TPL): Auto Accident Victims, HHS, Of
of Inspector General, Region VI (July 2, 1985).

This report estimated that the annual Medicare loss due to the failur
pursue third-party liability in Texas was $5.3 to $9.4 million, and it p
jected this estimate to $37.0 to $65.8 million nationally. The report in
cated that the contractor did not have a process to identify and pursu
adjustments or collect incorrectly paid Medicare benefits.

Medicare Secondary Payer Provision: End Stage Renal Disease: South
Dakota, HHS, Office of Inspector General, Region VIII (Nov. 30, 1984)

Medicare Secondary Payer Provision: End Stage Renal Disease: Colo-
rado, HHS, Office of Inspector General, Region VIII (Dec. 4, 1984).

These reviews estimated that Medicare paid $519,122 in South Dakot
and $1,963,819 in Colorado as the primary payer when employer gro
health plans should have been billed as the primary payer for the re
disease services. The review of patients receiving services and discus
sion with personnel at the hospital visited in each state showed that
information on employer group health plan coverage was document
the patient file, but the facility did not bill Medicare properly.

Medicare Secondary Payer Provision: End Stage Renal Disease, HHS,
Office of Inspector General, Region VII (Aug. 24, 1984).

Medicare Secondary Payer Provision: End Stage Renal Disease, HHS,
Office of Inspector General, Region VII (Apr. 3, 1985).

These reviews looked at renal disease facilities and at intermediaries
Missouri, Iowa, and two Kansas counties. They found that providers
were not furnishing employer group health plan information to the
fiscal intermediary, which in turn did not have a process to identify
pursue adjustments or collection of incorrectly paid Medicare benefit
They also noted that coordination of effort by the intermediary and
rier concerning the Medicare secondary payer provision had not bee
realized. The reports projected that $4,907,000 in overpayments had
occurred in Missouri and in the two Kansas counties and $4,445,000
overpayments occurred in Iowa.

Medicare Secondary Payer Provisions for End Stage Renal Disease: C
fornia, HHS, Office of Inspector General, Region IX (Mar. 1985).

This review found that although information on employer group health plan coverage was usually documented in the patient billing records, most of the Medicare billing was not done properly. The inspection team identified $4,877,692 that was incorrectly paid by Medicare as the primary payer, and estimated that total overpayments in California could be as much as $20 million.

Medicare Secondary Payer Provision—Working Aged in Colorado, HHS, Office of Inspector General, Region VII (July 1986).

Medicare Secondary Payer Provision—Working Aged in Missouri, HHS, Office of Inspector General, Region VII (July 1986).

The Office of Analysis and Inspections reviewed 50 beneficiary discharges, randomly selected at each of four hospitals in Colorado, and 75 beneficiary discharges, randomly selected at each of four hospitals in Missouri. Each review found examples of working aged beneficiaries who had not been identified by the contractors or hospitals. Projecting to the 21 largest short-term hospitals in Colorado, the office estimated that Medicare, during an 18-month period, had overpaid $4,342,446. Making a similar projection to the 30 largest hospitals in Missouri, the office estimated that Medicare, in a 2-year period, had overpaid $5,023,759. In each report, recommendations were made for the Medicare contractors to implement current guidelines according to federal regulations, ensure correct Medicare payments, and initiate recovery action for all improper payments, retroactive to January 1, 1983.

Comments From the Department of Health and Human Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington D C 20201

NOV 14 1986

Mr. Richard L. Fogel
Director, Human Resources
Division
U.S. General Accounting Office
Washington, D.C. 20548

Dear Mr. Fogel:

The Secretary asked that I respond to your request for the Department's comments on your draft report, "Medicare: More Hospital Costs Should Be Paid By Other Insurers." The enclosed comments represent the tentative position of the Department and are subject to reevaluation when the final version of this report is received.

We appreciate the opportunity to comment on this draft report before its publication.

Sincerely yours,

Richard P. Kusserow
Inspector General

Enclosure

Comments of the Department of Health and Human Services on the General Accounting Office Draft Report, "More Hospital Costs Should Be Paid by Other Insurers"

Overview

At the request of the Chairman of the Senate Finance Committee, GAO undertook to determine whether the Department could make improvements in existing policies and procedures for identifying and billing other insurers that should pay first for hospital claims.

GAO estimates that, in calendar year 1985, Medicare paid at least $527 million in hospital costs that should have been covered by private health insurers, workers' compensation programs or accident insurers. GAO identified the following problems to be the main hindrances to a more effective system for identifying and billing primary insurers:

- hospitals often do not identify or bill primary insurers as required, and intermediaries have little incentive to require hospitals to improve their performance;
- some employers were enrolling Medicare beneficiaries inappropriately in group insurance that treats Medicare as primary payer; and,
- weaknesses exist in Medicare procedures for identifying accident insurers responsible for costs paid by Medicare.

We note that most of the field work on this report took place in FY 1985 which was the first year that the Medicare Secondary Payer (MSP) program was implemented in a systematic manner. During FY 1985 many new procedures were developed and implemented to aid in the identification and proper billing of MSP claims. These new procedures required a relearning of Medicare billing requirements with the performance of both hospitals and intermediaries gradually improving. A 1986 Health Care Financing Administration (HCFA) study indicates that hospitals' performance improved 400 percent between FY 1985 and FY 1986. We believe the report does not sufficiently recognize the significant improvements made in the MSP program since its initiation just over 2 years ago.

The GAO report states that "HCFA set its overall savings standard for the secondary payer program below the level of available savings." Because FY 1985 was our first year of establishing MSP goals, we only established them for two categories -working aged and automobile liability cases. The TEFRA and DEFRA working aged goals were based on the HCFA Actuary's estimate of their potential savings to the program. The "spousal" (DEFRA) goal was not released until March of 1985. In establishing the goal, we acknowledged that the identification of "spousal" savings would be much more difficult to achieve than the other working aged savings. Thus, we believed it was appropriate to use less than the full actuarial estimate because we had no simple means to identify "spousal" cases. We subsequently developed beneficiary mailings as a means of identifying spouses and now enforce all goals. The automobile medical, no-fault and liability goal was based on a HCFA study of potential savings in this category, which exceeded the Actuary's estimate. We believe that our setting and enforcement of goals was appropriate considering the newness of the MSP effort.

Page 2

We concur with various conclusions regarding hospitals' poor performance in identifying beneficiaries who have insurance primary to Medicare. We have undertaken several activities which are designed to promote hospital awareness of MSP and to improve their performance. For example, since the inception of the MSP program, HCFA has required intermediaries to train hospitals on MSP issues. Our first MSP conference in July of 1984 included a protocol for hospital review. In the fall of 1985 we released to all intermediaries an MSP videotape and associated training materials for hospital admissions and billing offices. To strengthen the program, HCFA took further action in 1986 to require all intermediaries to conduct comprehensive training on MSP for all hospitals' admissions and billing offices. Although intermediaries have held previous training sessions, we are requiring all intermediaries to conduct another round of training by the second quarter of FY 1987. This training is now underway.

In addition to formal training, HCFA is undertaking an intensive public/professional relations "Outreach" effort to inform hospital and medical professional associations regarding hospitals' MSP responsibilities. In FY 1987, all intermediaries will be required to make presentations on MSP to meetings of hospital professional associations. HCFA will also reach out to these organizations through mailings, newsletter articles in their association newsletters and presentations at national meetings.

GAO Recommendation

That the Secretary direct the Administrator of HCFA to revise the Contractor Performance Evaluation Program (CPEP) standards to provide the intermediaries with the needed incentives to improve hospital performance in identifying and billing other insurers. To do this HCFA should do one or both of the following:

1. Increase current savings standards to dollar amounts which intermediaries could not meet without significantly improving hospital performance. To be meaningful, standards should be challenging but achievable, and mechanisms to better assure that savings are accurately measured need to be developed.

Department Comment

We agree in principle with this recommendation. Our savings goals are set in accordance with actuarial estimates of achievable savings. They have been increased as new MSP provisions are added to the law and as we become more knowledgeable about how to set goals. The goals do take into account that some savings are achieved that contractors are unable to report; i.e., failure of the hospital to submit a no-payment bill.

GAO Recommendation

2. Establish new administrative requirements that would direct intermediaries to perform certain oversight and administrative tasks necessary to improve hospital performance in billing Medicare as primary payer. These tasks should include monitoring each hospital's volume of secondary payer claims, increasing training and auditing efforts at hospitals with lower than expected secondary payer claims, and reporting deficiencies to the hospitals so that they can be corrected. A CPEP measurement would also need to be developed to determine acceptable performance in meeting these new requirements.

Page 3

Department Comment

We concur. As noted above, HCFA has required the intermediaries to intensify greatly their provider training. We will also, for FY 1987, expand significantly the number of hospital MSP audits to be conducted by intermediaries and require a careful selection of hospitals to be subjected to review. Hospitals routinely failing to identify accurately and pursue MSP situations will be targeted for such audits. At this time, we do not believe it is essential to include a CPEP element to ensure completion of these new requirements.

GAO Recommendation

Regardless of which option is pursued, HCFA should require its intermediaries to direct hospitals that are not taking the steps needed to identify and bill other insurers of Medicare beneficiaries to use a standard admission form designed to detect the availability of insurers that should pay before Medicare. The form should be signed by the Medicare patient and maintained in the hospital billing file.

Department Comment

We concur and, in fact, have already accomplished this task. In January of 1986, HCFA released instructions (Section 301 of the Hospital Manual) specifying a list of questions which the admissions office should ask every Medicare beneficiary. These questions address every category of possible insurance coverage. Moreover, the hospital is to keep a copy of the beneficiary's responses in its patient file. This requirement mandates a complete and consistent identification process.

GAO Recommendation

That the Secretary direct the Administrator of HCFA to require, as a contractual condition, that intermediaries screen Medicare claims against their own insurance policyholders when intermediaries do not meet CPEP secondary payer standards.

Department Comment

We do not concur with this recommendation. The data match demonstration conducted by HCFA is cited to support the recommendation. We believe the demonstration illustrates the impracticality of a contractual condition. In a number of instances, the contractor record systems were so incompatible that no match was possible. As a result, HCFA tested an identification methodology utilizing beneficiary mailing in five States. Beneficiary mailings proved much more successful and cost-effective as a method of identifying working aged/spousal beneficiaries than a data match with contractor private files.

GAO Recommendations

That the Secretary amend regulations implementing section 1862(b)(1) of the Social Security Act to:

- extend the Medicare Secondary Payer provisions of the law to all forms of no-fault insurance coverage; and,

Page 4

- require that accident insurers notify Medicare of medical payments or other settlements in those instances in which Medicare has an actual or possible right of recovery.

Department Comment

We are in the process of revising the Medicare secondary payer regulations so that the no-fault provisions, which presently apply only to automobile no-fault coverage, will also apply to other no-fault insurance coverages. The proposed regulations will also provide that insurers are liable to refund Medicare payments if the insurer failed to consider Medicare's payment and right to reimbursement when it paid an accident claim. The latter revision would implicitly require insurers to notify Medicare when they contemplate paying an accident claim, and has the advantage of not relieving insurers of liability if they merely notify Medicare of the accident claim. We will also consider making explicit the notification requirement recommended by GAO, while retaining Medicare's right to be reimbursed by an accident insurer that ignores Medicare's interests.

GAO Recommendations

That the Secretary direct the Administrator of HCFA to do the following:

1. Enter into a memorandum of understanding with the Equal Employment Opportunity Commission (EEOC) on the type of cases to be referred.
2. Establish procedures for identifying and referring potential violations of Section 4(g) to EEOC. This can be done, for example, by establishing procedures for monitoring intermediary and regional office case followup and referral actions.

Department Comment

We concur with the recommendation. HCFA has been negotiating and will continue to negotiate with EEOC on various working aged provisions. However, we believe that our outreach effort with employers and insurers takes a more positive approach to the problem. In addition, pending instructions will direct contractors to deny Medicare claims where the employer group health plan (EGHP) indicates that it will only pay supplemental benefits for working aged/spousal beneficiaries. Beneficiaries and providers will be advised that Medicare cannot process the claim until the EGHP has made payment. In certain instances (unassigned Part B claims), beneficiaries may be put at risk because, under this policy, neither the EGHP nor Medicare will pay until the other party pays. However, as a result of section 9319 of Public Law 99-509 (the Omnibus Budget Reconciliation Act of 1986), with respect to items and services provided on or after January 1, 1987, beneficiaries have a cause of action with double damages payable when a third party which should pay primary to Medicare fails to do so. These instructions are expected to be issued in the next several months.

These instructions will also provide specific guidance to contractors on the procedures to follow in recovering prior improper Medicare payments from insurers, providers, and beneficiaries. If the responsible party does not reimburse the Medicare program, the case will be referred to the contractor's regional office. The regional office will review and further develop the case. As appropriate, referrals will be made to the Department of Justice, EEOC, the State Insurance Commission, Department of Labor or other regulatory body.

Page 5

Other Matters

— Overcounting of Savings

The GAO report alleges that 44 percent of the intermediaries' savings in FY 1985 were subject to overcounting. The 44 percent figure is derived from the total amount of cost avoided savings; however, no data is presented to show that any of this amount is invalid. Because we recognize that there is potential for overcounting, we have revised the savings reporting requirements. HCFA's revised contractor procedures and instructions are now being implemented at all contractors so as to eliminate any potential overcounting in the future.

— Employers Offering Supplemental Coverage

HCFA recognizes that this is still a problem. We have been working with major insurers and State insurance commissions to persuade insurers and third party administrators to assume more responsibility for assuring that employers are offering the appropriate coverage. These efforts will continue.

HCFA is actively pursuing recovery of prior improper Medicare payments in States where beneficiary mailings have been conducted. In California and Michigan, where the first such mailings were conducted in FY 1985, over $20 million has been recovered to date.

HCFA believes that employers have not been pressured by employees/providers to provide proper coverage, because Medicare would always make conditional payment. Our new contractor instruction (discussed above) should encourage employers to correct the coverages which are offered employees.

In addition to revising the claims processing instructions, HCFA will undertake, in FY 1987, an outreach effort to employers and insurers to advise them of their responsibilities in providing coverage to the working aged. This effort is necessary to increase the information available to employers and insurers about Medicare and insurance requirements.

— Weaknesses in Enforcement Procedures and Practices

In discussing the draft instructions which would prohibit conditional primary Medicare payments where an employer group health plan maintains that it pays only secondary benefits, GAO expressed concern that Medicare intermediaries consider employers rather than insurers to be responsible for offering correct coverage to beneficiaries.

HCFA has consistently taken the position that insurers as well as employers are responsible under the law to pay primary benefits and to reimburse the Medicare program for conditional primary payments. (See Section 405.344(b)(2)(i) of the Regulations.) However, the Deficit Reduction Act of 1984 made the Government's right to recover from insurers more explicit, by stating that the Government may take legal action to recover conditional Medicare payments from any entity responsible for payment.

Comments From the Equal Employment Opportunity Commission

OFFICE OF THE CHAIRMAN

EQUAL EMPLOYMENT OPPORTUNITY COMMISSION
WASHINGTON, D C 20507

NOV 21 1986

Mr. Richard Fogel
Assistant Comptroller General
Human Resources Division
United States General Accounting Office
Washington, D.C. 20548

Dear Mr. Fogel:

We have reviewed the draft of General Accounting Office (GAO) report Number GAO/HRD-86-00, entitled "Medicare: More Hospital Costs Should be Paid by Other Insurers." In the draft report, GAO recommends that EEOC issue regulations to clarify employers' responsibilities under Section 4(g) of the Age Discrimination in Employment Act (ADEA). GAO also recommends that the Secretary of Health and Human Services direct the Administrator of the Health Care Financing Administration (HCFA) to enter into a memorandum of understanding with EEOC on the type of cases to be referred for litigation and to establish procedures for identifying and referring potential violations of Section 4(g) to EEOC. We will respond to each of these recommendations.

First, while the draft report recommends that EEOC issue regulations to clarify employers' responsiblities under Section 4(g) of the ADEA, the Commission voted to officially rescind the then current interim regulations on September 30, 1985. On November 19, 1985, the Commission voted unanimously to submit to the Office of Management and Budget, pursuant to Executive Order 12291, a notice to rescind the Interim Rules Implementing Section 4(g) of the ADEA. On December 11, 1985, a notice was published in the Federal Register (50 Fed. Reg. 50,614), which stated that the Commission had officially concluded "that regulations implementing Section 4(g), interim or final, will serve no useful purpose."

Although the draft report recommends that the administrator of HCFA be directed to enter into a memorandum of understanding with EEOC on the type of cases to be referred for litigation and to establish procedures for identifying and referring potential violations of Section 4(g), we do not believe that such a formal procedure is necessary. To the extent that there are misunderstandings between HCFA and EEOC as to when to refer an instance of noncompliance, we believe that a letter of clarification from EEOC to HCFA concerning referrals should be sufficient to correct any misunderstandings. Since the draft report states that some

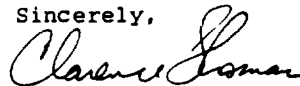
-2-

HCFA personnel have indicated that they are operating under the impression that EEOC wanted HCFA to refer cases only if a trend of problems could be established for the same employer, this mistaken view should be easily corrected with the letter of clarification. Moreover, the letter would make EEOC's position clear, that HCFA should refer all instances of apparent noncompliance with Section 4(g) to EEOC. This is specified in HCFA's own regulations at 42 C.F.R. Section 405.340 (1985).

> (c) Referral of Cases to Equal Employment Opportunity Commission (EEOC)
> HCFA will refer cases of apparent non-compliance with the requirements of the ADEA to the EEOC.

If you have any questions concerning this matter, please let me know.

Sincerely,



Clarence Thomas
Chairman

Comments From the Blue Cross and Blue Shield Association

Blue Cross and **Blue Shield** Association

Medicare

676 North St Clair Street
Chicago Illinois 60611
312/440-6000

October 31, 1986

Richard L. Fogel
Assistant Comptroller General
United States General Accounting Office
Human Resources Division
Washington, D.C., 20548

Dear Mr. Fogel:

Thank you for the opportunity for the Blue Cross and Blue Shield Association to review and comment on your draft report to Congress entitled: "Medicare: More Hospital Costs Should Be Paid By Other Insurers". We appreciate the General Accounting Office's examination of Medicare as Secondary Payor (MSP) program initiatives by the Health Care Financing Administration and the Medicare contractors in order to recommend improvements to current enforcement mechanisms through further legislation, revising regulation, increasing funding for provider, employer and beneficiary education, and addressing incentives and goals for contractor performance.

With regard to the Report's specific recommendations, we offer the following comments:

1. Increase contractor dollar savings standards to levels where they would have to take action to significantly improve hospital performance.

   We strongly disagree with the premise and recommendation that increasing contractor goals will improve hospital MSP performance. MSP claim development by Medicare contractors is a labor intensive activity to assure that claims are not paid or payment is recouped, where another payor is primary.

   We agree that more MSP savings exist than are presently identified and that the key to these savings is effective provider education. However, where providers are educated to consistently bill the primary payor, a higher percentage of program savings fall into cost avoidance, true savings to the Medicare program but only evidenced by reduced Trust Fund outlays. As there is no incentive for the provider to identify such claims, contractors cannot take credit for these activities. Without recognition of cost avoidance as a legitimate and measurable factor in MSP savings achieved, increases to current dollar and savings ratio performance goals act as a disincentive to provider education activities.

Page 2
USGAO: R.L.FOGEL

Aggressive pursuit of these savings by HCFA as a major Medicare program goal is less than five years old. Goal setting, as this report recognizes, is a difficult actuarial and budgetary exercise. The FY87 total savings goal (excluding PL99-509 addition of disabled beneficiaries) is already set at approximately $1,050,000,000. Contractors will be expected to achieve a cost benefit savings ratio of 60:1.

Where savings goals have proved problematic, HCFA and contractor work groups (including Blue Cross/Blue Shield Association) are gathering and validating state-specific data pertinent to each MSP category to ensure challenging but achievable goals.

2. Establish new administrative requirements that would direct intermediaries to perform certain oversight and administrative tasks necessary to improve hospital performance in billing primary payors.

We agree that the key to effective capture of MSP dollars is effective education and active monitoring of provider billing practices. We (BCBSA) provided the prototype for the admission questionnaire now included in the provider instructions and provided input on the video tape prepared and distributed to contractors as a provider education tool.

We agree with your recommendation for expanded and more consistent use of the admission questionnaire by providers for more complete and efficient capture of beneficiary MSP data. However, there has been a general reluctance on the part of the Government to increasing informational demands on the beneficiaries.

We have participated in HCFA MSP Work Groups which have explored and tested various information gathering techniques for use with providers and beneficiaries. Like GAO, HCFA and the Medicare contractors have found that use of beneficiary questionnaires, locally and nationally has been cost effective and productive in definitively identifying primary payors.

We would stress that oversight requirements or additional administrative tasks should be carefully tested and evaluated for their return on investment factor before any new national administrative requirements are mandated. We would not wish to see introduction of provider monitoring activities which did not prove cost effective or diverted administrative energies and funding from achieving the current expected savings ratio.

Page 3
USGAO-R.L.Fogel

3. Adopt measures that would better assure that hospitals and intermediaries were complying with the administrative requirements.

We believe the best proof of beneficiary, provider and contractor compliance with administrative requirements for Medicare as Secondary Payor is increased MSP savings. If the methodologies are effective, as suggested above, then it should be readily apparent as MSP savings are reported throughout the year by the contractors via MSP summary reports and are provided to HCFA on a per claim basis via UNIBILL. Secondary level monitoring activities which do not directly affect or increase savings for MSP, are not in the current spirit of results (rather than process) oriented performance measures for contractors.

4. Recommendation that the Secretary of DHHS direct the Administrator of HCFA to require, as a contractual condition, that intermediaries screen Medicare claims against their own insurance policyholders when intermediaries do not meet CPEP MSF standards.

The Medicare contractors are already on record to HCFA as objecting to this methodology, because such a cross-matching of beneficiary/subscriber files by either manual or automated methods on a regular basis has not proven cost effective.

In addition, we firmly believe that such an activity places the Medicare contractor at a competitive disadvantage, providing incentives for employers to move away from doing business with Medicare contractors and toward either "self-insurance" or toward underwritten contracts offered by non-Medicare insurers. Medicare contractors should not be placed at a competitive disadvantage solely by virtue of their being Medicare contractors.

Recognizing the competitive disadvantage, HCFA also agreed to explore other alternatives. HCFA is in process of establishing automated regional MSP Data Bases with the Medicare contractors which will permit quarterly exchange of other payor data related to a specific Medicare beneficiary, developed independently by the various Medicare contractors within the Region. The data exchange will also permit inter-regional transfer of information to assist multi-state and multi-regional contractors. As this information is based on bona fide contractor developed MSP claim information, rather than on a random search of private insurer files, we believe this activity to be significantly more cost effective and equitable.

Page 4
USGAO:R.L.FOGEL

5. Recommendation that EEOC issue regulations to clarify employers' responsibilities under section 4(g) of the Age Discrimination in Employment Act.

   We agree whole-heartedly with this recommendation. The lack of clear-cut definitions of respective employer obligations regarding notice to the employee, group health plan coverage requirements, beneficiary selection options, as well as potential sanctions against the employer for failure to provide coverage as primary payor have greatly hindered effective MSP Working Aged savings initiatives.

   We believe that the adoption in the Omnibus Budget Reconciliation Act of 1986 of the Administration's proposal for imposition of a twenty-five percent excise tax on health benefit plan contributions for employers not in compliance with section 1862(b)(4)(A)(i) of the Social Security Act serves to underline Congress' perception of the employer responsibilities with regard to Medicare as Secondary Payor.

   We concur with the Report findings that beneficiary appeal mechanisms for challenging employer non-compliance also need to be expeditiously agreed upon by EEOC and HCFA and the accepted methodology disseminated to beneficiaries and providers.

Again, we thank you for this opportunity to comment. If you or your staff have any questions related to our comments, please feel free to contact me or Ms. Norma L. Border, at (312)440-5899.

Sincerely,

Donald R. Cohodes, Administrator
Federal Programs Division

DRC:NB:nb

Comments From the American Insurance Association

AMERICAN INSURANCE ASSOCIATION

85 John Street
New York N Y 10038
(212) 669-0400

November 6, 1986

Richard L. Fogel
Assistant Comptroller General
United States General Accounting Office
Washington, DC 20548

Dear Mr. Fogel:

The American Insurance Association (AIA) is a trade association representing 175 property and casualty insurance companies which do business throughout the United States. We have been asked to comment on Chapter 4 of the GAO draft report on the need to strengthen Health Care Financing Administration efforts to help assure that Medicare does not pay hospital costs that other insurers should pay. Chapter 4 deals principally with changes needed in federal regulations to increase Medicare's ability to identify beneficiaries' recoveries for health costs from accident insurers by requiring them to notify Medicare of such recoveries.

Recommendation to extend Medicare Secondary Payor Regulations to all forms of no-fault insurance

As the draft of Chapter 4 indicates, this proposal is in the nature of a technical correction, extending the regulations to effectuate the intent of the statute. The statute [42 U.S.C.A. 1395y(b)(1)] makes Medicare secondary to, among others, liability insurance and no-fault insurance. Either way, it would appear that the medical payments coverage commonly included in homeowners or commercial liability policies should be primary. As such, the proposal to amend the existing regulations seems appropriate.

Recommendation that insurers be required to notify Medicare of payments/settlements from which Medicare may have right of recovery

At the outset, we note that the proposal does not appear to distinguish between imposing a notification requirement upon first-part payors (e.g., Blue Cross or A&H carriers) and liability carriers. Although the phrase "accident" insurance is used, the statute and the examples used (see reference on page 42 to auto liability and the page 47 reference to California) would seem to indicate that the proposal would apply to P&C carriers and not merely A&H. Our remarks are from the perspective of a liability carrier.

Now on p 44
Now on p 48

PETER LARDNER CHAIRMAN EDWARD [illegible] VICE CHAIRMAN DEROY C THOMAS VICE CHAIRMAN ROBERT E VAGLEY PRESIDENT

Standing alone, the notification requirement would not seriously impede the ability to investigate and pay claims. However, it would add one more form to the numerous reporting, disclosure and notification forms that have become required of insurance claims personnel in recent years. In view of the voluminous paperwork already required, and in view of the public awareness of insurance costs, additional forms should only be required if there is both a documented need for the information and a demonstration that insurance companies are the appropriate party to provide the information.

Now on p 46

A careful reading of the draft fails to establish the existence of a problem which can best be solved through insurance companies. For example, the last three lines at the bottom of page 44 imply that hospitals may fail to inquire about other insurance coverage. Even if such a failure does occur (nowhere does the draft actually state that this failure is a problem or that it even occurs), it is quite a leap of faith to conclude that Medicare has lost a reimbursement opportunity. Where the hospitals fail to inquire, there may be no other applicable coverage elsewhere, or the claimant may subsequently disclose the fact of other insurance.

Now on p 47

The figures cited at the middle of page 46 are similarly inconclusive. Only 5.3 percent of the Medicare recipients whose claims resulted from accidents had actually received other insurance payments. This represented less that 1 percent of all Medicare recipients in the sample.

Now on p 48

If revised notification procedures are really necessary, it seems logical to place the requirement on claimant's attorneys, as California has done (see page 47). The attorney is in the best position to know whether his client has received Medicare benefits. The draft states that "compliance with a national requirement on attorneys would be difficult to enforce and an incentive could more easily be developed for insurers to comply." We do not believe this assertion is accurate. A claimant's attorney that disregards Medicare's reimbursement rights could be held accountable to Medicare by appropriate regulation. Arguably, the attorney incurs civil liability under the common law even without a new regulation, to say nothing of the ethical implications.

The duty to inquire and disclose should be placed upon someone who stands in a position of trust with respect to the claimant, such as his or her legal representative. Given the concerns associated with the cost and unavailability of property and casualty insurance, and the desire for prompt settlements which may be delayed through additional administrative burdens, the claimant's attorney, rather than the insurer, is the better available option.

Regards,

George Klotzbaugh
Counsel

JLK/la

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