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Report to Congressional Committees

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MEDICARE

Millions in Disabled Beneficiary Expenditures Shifted to Employers

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Human Resources Division

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The Honorable Lloyd Bentsen
Chairman, Committee on Finance
United States Senate

The Honorable John D. Dingell
Chairman, Committee on Energy and Commerce
House of Representatives

The Honorable Dan Rostenkowski
Chairman, Committee on Ways and Means
House of Representatives

Section 9319 of the Omnibus Budget Reconciliation Act of 1986 (OBRA-86, P.L. 99-509) made Medicare the secondary payer for medical expenses incurred by certain disabled beneficiaries covered by large group health plans (LGHPs).[1] The essential component of this provision, however, applies only until October 1, 1995.[2] To help the Congress evaluate the provision's effect, this section also directed that we determine (1) the number of disabled beneficiaries for whom Medicare became secondary payer because of their own or a family member's employment, (2) the resulting annual cost savings to Medicare, and (3) the provision's effect on employment and employment-based health coverage of disabled beneficiaries and their family members.

In an earlier report to you, we responded to the first of these requirements.[3] This second report addresses the issues of cost savings and effects on employment and health insurance coverage. Our field work was performed between April 1989 and March 1990. A principal source of our cost data was Medicare's intermediary claims data base. Because of the extensive time and resources required, we did not independently examine the internal and automatic data processing controls for this automated system. Except for this limitation, our work was performed in accordance with generally accepted government auditing standards.

[1]Under section 9319, a large group health plan is one covering employees of at least one employer with 100 or more employees on a typical business day during the previous calender year.

[2]The Omnibus Budget Reconciliation Act of 1990 (P.L. 101-508, Sec. 4203(b)) extended the application of the essential component of the secondary payer provision affecting disabled beneficiaries to this date. Under OBRA-86, this provision applied only until Jan. 1, 1992.

[3]Medicare: Employer Insurance Primary Payer for 11 Percent of Disabled Beneficiaries (GAO/HRD-90-79, May 10, 1990).

Results in Brief

In 1988, the OBRA-86 provision saved Medicare an estimated $322 million on the 214,000 disabled beneficiaries covered by an employer-sponsored LGHP through a working family member's participation. Medicare could have saved an additional $148 million had the program not mistakenly paid as primary payer for some health care services provided to these beneficiaries.

Also, in 1989 Medicare saved an estimated $83 million more as the provision had its first full year's effect on 55,000 disabled Medicare beneficiaries who had their own health coverage under employer-sponsored LGHPs. About $39 million of these savings resulted from the provision's application to 26,000 beneficiaries with health coverage through their own employment (trial work programs or extended eligibility after trial work).[4] The remaining $44 million in Medicare cost reductions resulted from the provision's application to a HCFA-estimated 29,000 beneficiaries, who although not working, are considered to have "employee status" and continue to be covered under a former employer's health care plan (see p. 6).

To date, section 9319 of OBRA-86 has had little adverse effect on disabled beneficiaries or their family members in terms of employment or the cost and availability of employer-sponsored health insurance. However, responses to our questionnaires and to proposed regulations revealed that some companies were considering future actions that could adversely affect the relatively small group of disabled beneficiaries with employee status. Although proposed regulations would provide some protection against such actions, these regulations could be circumvented. In fact, HCFA expects that the number of individuals with employee status—and the Medicare savings associated with them—will consistently decline. In part, this is because employers will find ways to avoid the criteria for determining employee status. For example, some companies were considering eliminating right to return to work provisions for disabled individuals.

In proposed regulations, HCFA has identified a broad category of individuals subject to the OBRA-86 provision because of active employee status, listing (1) three factors that each establish employee status and (2) five factors indicative of such status. Several companies have questioned the

[4]Under this program, disabled persons can attempt to re-enter the work force by working up to 9 months—not necessarily consecutively—and continue to receive monthly Social Security benefits and Medicare coverage even though they earned "substantial income" (defined as at least $300 per month and beginning Jan. 1, 1990, $500 per month). A disabled person who continues to work beyond the 9-month trial work period can retain Medicare coverage for at least an additional 39 months.

appropriateness of some of the five indicators. As we advised HCFA, at least one stretches our understanding of what constitutes employee status and, if included in the final rule, increases the likelihood of employers taking adverse employment or health coverage action.

Potential savings from using the proposed factors indicative of employee status do not justify the risks of adverse action associated with these factors. Consequently, we recommend that HCFA delete the factors indicative of employee status from its final regulations. Once this recommendation is implemented, we recommend that the Congress remove the OBRA-86 provision's expiration date.

Background

Medicare is a federal health insurance program that covers most Americans aged 65 or older and some disabled persons under age 65. In 1988, the program included about 3.1 million disabled individuals under age 65. The Health Care Financing Administration (HCFA), within the Department of Health and Human Services (HHS), manages the Medicare program. HCFA contracts with insurance companies—called "intermediaries" under part A and "carriers" under part B—to pay Medicare claims and help ensure that Medicare claims are paid in accordance with the law.

Since 1981, the Congress has enacted a series of amendments to the Social Security Act making Medicare the secondary payer when beneficiaries are covered by certain other health plans. Prior to these amendments, Medicare paid first (as primary payer) and the other plans paid at least part of what Medicare did not pay (as secondary payer). These changes do not directly affect beneficiary health care or benefits. Rather, their purpose is to reduce Medicare expenditures by shifting costs from Medicare to private insurers and self-insuring employers. Ultimately, these increased costs are passed on to plan beneficiaries, workers, or consumers in the form of reduced salary increases and/or premium or product price increases.

The OBRA-86 secondary payer provision, effective January 1, 1987, applied to disabled beneficiaries who had LGHP coverage through a working spouse or other family member. It also applied to disabled beneficiaries who had LGHP coverage through their own direct relationship with an employer—either through trial work or through "employee status" with a former employer. On March 8, 1990, HCFA proposed regulations listing three factors that each establish employee status, such as receipt of payments from an employer that are subject to taxes under

the Federal Insurance Contribution Act. HCFA also listed five factors indicative of employee status, such as having a legally enforceable right to return to work in the event disability ceases and participating in an employer's benefit plan in which only employees may participate. As of December 1990, HCFA was considering comments on the proposed regulations.[5]

Savings Realized Through Family Member's LGHP Coverage

In our May 1990 report, we estimated that approximately 214,000 disabled beneficiaries (8 percent of the disabled Medicare population) had LGHP coverage through a working family member.

To determine the Medicare savings from this group due to the OBRA-86 provision, we compared Medicare payments for 1986 (before the OBRA-86 provision was implemented) and 1988 (after implementation) for two groups of randomly selected disabled beneficiaries:

- A study group of those who had LGHP coverage through a working spouse or other working family member throughout 1988 and
- A comparison group of those who had a working family member but did not have LGHP coverage through that family member during 1988.

We determined the mean Medicare payment for the two groups. Using figures from HCFA's automated data retrieval system (current through 1989), we obtained 1986 and 1988 expenditures under part A (primarily for inpatient hospital services) and part B (for outpatient hospital and physician services). We compared the physician services expenditures from this source to expenditure information from Medicare carrier records and adjusted them for any differences. After further adjusting the expenditure data to reflect outstanding claims, we combined the part A and part B costs for each beneficiary and estimated the mean cost for the two groups.

In 1986, the mean Medicare cost per disabled beneficiary for those with and without LGHP coverage through a working family member was comparable (see table 1). However, the mean Medicare cost for those with LGHP coverage through a family member decreased by $1,430 from 1986 to 1988. For disabled beneficiaries without such coverage, it increased by $181 during this period. Because of the similarity between the two groups and the absence of other explanatory factors, we assumed that

[5]HCFA had instructed Medicare intermediaries and carriers to use these factors as a basis for determining employee status before issuing the proposed regulations.

the difference in mean Medicare costs between the two groups in 1988 was due to the OBRA-86 provision.

Table 1: Differences in Medicare Mean Costs Between Study and Comparison Groups (1986 and 1988)

	1986		1988		
Group	No.	Mean cost	No.	Mean cost	Difference
Study group—with LGHP	286	$2,313	409	$883	- $1,430
Comparison group—without LGHP	511	2,044	767	2,225	+ 181

Total Medicare savings resulting from the OBRA-86 provision's effect on disabled beneficiaries with LGHP coverage through a family member was about $322 million[6] in 1988. This estimate results from projecting the reduction in Medicare costs obtained from our comparative analysis to our estimate of all beneficiaries with LGHP coverage through a family member (214,000 or 8 percent of the disabled Medicare population).

While the estimated 1988 savings from the OBRA-86 provision were significant, they could have been greater. Our analysis of the 1988 expenditure data also showed Medicare was the primary payer for claims from some disabled beneficiaries who had LGHP coverage through a working family member. Under these circumstances, Medicare should have been the secondary payer; thus, the payments presumably were made by mistake. Such mistaken Medicare payments for disabled beneficiaries with LGHP coverage through a working family member totaled, we estimate, about $148 million in 1988.[7]

Although we did not attempt to determine why the mistaken payments were made, we previously reported that a principal cause was the failure of Medicare contractors to identify the existence of primary insurance coverage.[8] Legislation passed by the Congress in 1989 that enhances the ability of Medicare contractors to identify primary insurers is expected to reduce mistaken primary payments.

[6]We estimate, at the 95-percent confidence level, that the actual figure is at least $219 million. We adjusted our estimate for the prevalence of disabled adult dependents (primarily children of deceased, retired, or disabled workers who are at least age 18) in our comparison group and the observed difference in average Medicare costs between these individuals and other disabled beneficiaries (see app. I).

[7]We estimate, at the 95-percent confidence level, that the actual amount lost was at least $86 million. See app. 1 for more information about our methodology.

[8]Medicare: More Hospital Costs Should Be Paid by Other Insurers (GAO/HRD-87-43, Jan. 29, 1987); Medicare: Incentives Needed to Assure Private Insurers Pay Before Medicare (GAO/HRD-89-19, Nov. 29, 1988).

Savings Through Employee's Own LGHP Coverage

The OBRA-86 provision also covers about 26,000 disabled beneficiaries who were in trial work programs or in extended eligibility after completing trial work, and were covered through their employer's LGHP. This number, an estimate from our May 1990 report, constitutes less than 1 percent of the disabled Medicare population. In addition, HCFA recently estimated that Medicare was secondary payer for 29,000 beneficiaries[9] in 1989 because they met HCFA factors establishing or indicating employee status. That is, they met one of the three HCFA-proposed factors establishing employee status or one or more of the five indicators of employee status. Although HCFA intended that these indicators show that an individual is an employee within the ordinary understanding of that term, several employers we met with questioned whether the indicators were appropriate determinants of employee status. We advised HCFA officials that one proposed indicator—participating in an employer's benefit plan available only to employees—stretched our understanding of what constitutes an active employee. Comments on the March 1990 proposed regulations criticized the clarity and appropriateness of the five factors indicative of employee status as well as their effect on employers' costs. As of December 1990, HCFA was considering these comments and had not issued final regulations.

We did not perform a statistical analysis to estimate the OBRA-86 provision's savings attributable to beneficiaries with LGHP coverage through trial work or employee status. The trial worker group constituted less than 8 percent of those initially estimated to be affected by the OBRA-86 provision and, when we began data collection for our study groups, HCFA had not prescribed conditions and criteria for determining employee status. If Medicare savings per beneficiary in these groups were comparable to the savings for beneficiaries covered through a family member's health insurance, annual program costs would decrease as follows:

- For those with trial worker involvement, by about $39 million beginning in 1989, and
- For those not working but meeting HCFA's indicators of "employee status," by $44 million in 1989.

HCFA estimates, however, that the number of individuals defined as having employee status will decline by 25 percent annually as

[9]An official agency estimate of this group's size was not available at the time of our May 1990 report. At that time we reported that a HCFA analyst's best guess was that this group totaled 50,000-150,000 individuals. The report also noted that HCFA officials stated this figure was preliminary and might be too low.

employers adjust their personnel policies to avoid meeting HCFA's indicators of employee status. As a result, savings from this group will decline to about $15 million in 1993 and $9 million in 1995. If in 1989 Medicare paid mistakenly as primary payer for these groups of disabled beneficiaries at the same rate as for beneficiaries with coverage through a family member, the program lost potential savings of another $18 million from trial workers and $20 million from those with employee status.

Effect on Disabled Beneficiaries Appears Limited

The OBRA-86 provision has not caused changes to employers' hiring or retention practices that would disadvantage family members of disabled Medicare beneficiaries, nor has it had more than minor effects on health plans. To assess such effects, we used mail questionnaires and interviews and examined selected employer plans. Questionnaires were sent to

- 300 companies randomly selected from Fortune magazine's list of the 1,000 largest U.S. industrial and service companies (to enhance the likelihood of truthful responses, we gave them anonymity) and
- insurance commissioners in the 50 states and the District of Columbia.

In addition, we interviewed officials from large corporations, the health industry, HCFA, and groups that represent the disabled (such as the Paralyzed Veterans of America). Finally, for selected health plans from 51 employers, we compared the coverage provisions in effect before and after implementation of the OBRA-86 provision.[10]

Negligible Effect on Hiring

Only 1 of 154 large companies we surveyed had attempted to avoid hiring employees with a disabled spouse or dependent. The company did not indicate whether this action was as a result of the OBRA-86 provision. (See app. II for a more detailed presentation of the results and app. III for a copy of the questionnaire.) Moreover, officials from nine organizations representing the disabled and three closely associated with the insurance industry told us they were unaware of any instances where the provision adversely affected disabled Medicare beneficiaries or their spouses.

[10]These employers were selected judgmentally based on information provided by a random sample of about 9,000 disabled Medicare beneficiaries (see app. I) that indicated the employers provided LGHP coverage.

Effect on Health Plans Appears Minor

While there have been some changes that could adversely affect health plan coverages provided to employees, including disabled beneficiaries and their families, the OBRA-86 provision appears to have played only a limited causal role in these changes. For example, 36 of the 154 companies responding to our questionnaire indicated that they had increased the employees' share of premiums for health insurance for spouses and dependents. However, company responses cited the OBRA-86 provision as a cause in only 4 of the 36 changes. Further, these changes did not single out the disabled but affected all employees covered by the employers' group health plan.

Of 38 insurance commissioners who responded to our questionnaire (see app. IV), 5 indicated they were aware of post-OBRA-86 changes to employer-based health plans that could negatively affect the disabled. However, the fact that some of these changes also occur among employers not directly affected by the OBRA-86 provision suggests that the changes were related to other factors. For example, in three cases the employer changed insurers and the disabled workers or spouses lost coverage because of a "pre-existing condition" clause. GAO has recently testified and reported that this practice occurs frequently among many small employers.[11]

As with employment effects, officials from organizations representing the disabled and associated with the insurance industry were unaware of any adverse effects of the OBRA-86 provision on coverage of disabled Medicare beneficiaries or their spouses. Although HCFA cited one case in which a disabled beneficiary was disenrolled from a LGHP, this occurred before HCFA issued its proposed regulations covering such actions. In addition, the beneficiary was re-enrolled in the plan after HCFA determined that the action violated OBRA-86's "taking into account" provision. This provision prohibits LGHPs from considering an individual's Medicare status in deciding what health care benefits to provide.

Of health plans provided by 51 employers, 19 had made one or more changes after the OBRA-86 provision was implemented that potentially could negatively affect coverage of disabled beneficiaries. These changes, however, were not necessarily a consequence of the OBRA-86 provision. For example, the two most common—reducing mental health

[11] Health Insurance: Availability and Adequacy for Small Businesses (GAO/T-HRD-90-02, Oct.16, 1989); and Health Insurance: Cost Increases Lead to Coverage Limitations and Cost Shifting (GAO/HRD-90-68, May 22, 1990).

limits and expanding pre-existing condition clauses—affected non-disabled persons as well as disabled Medicare beneficiaries. Such broad-based coverage changes likely were influenced by economic pressure on employers to reduce health insurance expenses generally. Additionally, an adverse change in one area affecting the disabled sometimes was balanced by an improvement in another area of the same plan that also affected the disabled.

Future Effects Uncertain

To date, the OBRA-86 secondary payer provision appears to have had little effect on the disabled. Although employers were contemplating changes that could affect the disabled, the changes were not a direct response to OBRA-86. One exception is that employers were considering changes in response to OBRA-86 that would adversely affect those disabled with "employee status."

Most employers who stated they were contemplating actions that could adversely affect the disabled did not identify the OBRA-86 provision as the reason. In addition, several factors make it unlikely that the OBRA-86 provision would be the prime motivation for any such actions:

- The added LGHP insurance costs associated with the provision (roughly $400 million annually) are a small part of employers' total health insurance costs ($134.6 billion in 1987) and of the growth in employer health care costs since 1987. According to one recent study, private sector health insurance premiums rose by 12 percent from 1987 to 1988 and by 17 percent from 1988 to 1989.
- Because the provision applies to plans sponsored by an employer of 100 or more persons, the medical costs of one high-cost disabled person presumably are spread over a base of at least 100 employees, thus minimizing the effect on the employer's per-employee health insurance costs.
- Employers have other options for dealing with the extra costs resulting from the provision. In particular, they can shift costs to their employees in the form of smaller salary/wage increases, increased share of premiums, or various other ways. A Department of the Treasury study has shown that this transfer of costs to the workers takes about 1-1/2 years to accomplish completely.

On the other hand, employers were considering actions in response to OBRA-86 that would adversely affect those disabled beneficiaries for whom HCFA's proposed regulations indicated continuing employee status. Frequently, they told us their contemplated actions were related to the OBRA-86 provision. For example,

- 21 were considering establishing an active work period requirement (or increasing an existing requirement) for health plan eligibility for disabled individuals with employee status; of the 21, 12 related the action to the OBRA-86 provision; and
- 12 were considering establishing a separate plan with higher premiums for disabled individuals with employee status; of these companies, 9 described this as related to the provision.

For a more detailed presentation of the results of employer responses related to this group of disabled beneficiaries, see table II.2.

Organizations representing employers, health insurers, and the disabled that we contacted directly expressed concerns about the provision's long-term effects on disabled individuals with employee status. Of the five organizations representing employers and health insurers, three believed employers might be deterred from extending long-term disabled health benefits to employees not presently covered. The Washington Business Group on Health, which represents 150 of the Fortune 500 companies, voiced other concerns. It surmised that the OBRA-86 provision might encourage employers to reduce or eliminate current long-term disability health benefits and discourage providing the right to return to work. A legally enforceable right to return to work if the disabling condition improves is one of five HCFA factors indicative of employee status. It could result in an employer incurring primary health coverage costs associated with such individuals. Also fearing that fewer employers would offer employees the right to return to work was the director of one of the nine organizations we contacted that represent the disabled. The executive director of a second of these organizations believed employers might require disabled employees to begin paying health insurance premiums paid previously by the employers.

Protection Offered by Proposed Regulations

Regulations proposed by HCFA in March 1990 offer the disabled considerable protection against discriminatory practices but do not address all employer actions that could adversely affect health insurance benefits. The regulations would prohibit employers from discriminating in LGHP insurance coverages for the Medicare disabled. In essence, they require that a LGHP not alter coverage because of Medicare entitlement. Thus, an employer would have to offer a disabled Medicare beneficiary the same coverage, enrollment opportunities, and conditions offered to others enrolled in the plan. Employers whose LGHPs do not comply with the requirement precluding discrimination are subject to a 25-percent excise tax on the employer's LGHP insurance expenses.

The proposed regulations should discourage employers from taking some of the adverse actions identified in our questionnaire as under consideration. For example, employers would not be allowed to deny or terminate coverages for Medicare beneficiaries covered under OBRA-86's secondary payer provision or charge higher premiums than charged other persons covered by the employer's plan. But employers could eliminate health insurance coverage of disabled adult dependents (cutting them off at the same age as nondisabled children) and reduce or eliminate cash benefits to disabled nonworking employees. Additionally, employers with whom we met and others who commented on the proposed regulations related to employee status expressed concern with the merit of HCFA's factors indicative of employee status. To reduce costs, several employers claimed they would act to avoid meeting these indicators. HCFA officials believe that such actions are probable and will reduce the number of disabled beneficiaries with employee status by 25 percent annually.

Conclusions

The OBRA-86 secondary payer provision has met its objective of shifting considerable Medicare expenditures to LGHPs apparently without significant adverse effect on disabled beneficiaries or their families. By making Medicare the secondary payer for disabled beneficiaries, the OBRA-86 provision shifted an estimated $322 million in 1988 from Medicare to LGHP expenditures. In 1989, an estimated $39 million more was shifted as the provision affected trial workers. Additionally, roughly $44 million may have been added during 1989, as the law was implemented for those with employee status. Savings for this latter group are expected to decline rapidly in future years—to about $9 million in 1995—as employers act to avoid HCFA's indicators of employee status.

In addition to suffering little adverse effect from the provision, the disabled are safeguarded by regulations proposed by HCFA in March 1990. These rules discourage employers from taking many of the actions they were considering that would discriminate against disabled beneficiaries and their families in regard to health insurance.

Future changes to employer health plans could adversely affect disabled individuals with employee status. Such changes are likely to be related to HCFA's proposed factors indicative of employee status. These factors stretch the ordinary understanding of the term employee and will prompt employer actions to avoid meeting them. HCFA estimates that employer actions to avoid the indicators will cause the number of individuals with employee status to decline by 25 percent annually.

Matters for Consideration by the Congress

The Congress should consider permanent enactment of the OBRA-86 provision. Before taking this action, the Congress should await HCFA's final regulations related to determining employee status and assurance that the regulations employ only objective criteria establishing such status rather than factors indicative of such status.

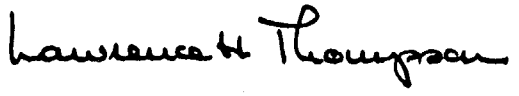
Recommendation to the Secretary of HHS

The Secretary of HHS should delete from final regulations related to determining employee status for disabled individuals not currently working, factors indicative of such status.

The Department of Health and Human Services provided written comments on a draft of this report. We incorporated these comments throughout the report where appropriate and present and evaluate them in appendix VI.

We are sending copies of this report to the Secretary of Health and Human Services, the Administrator of the Health Care Financing Administration, the Commissioner of Social Security, the Director of the Office of Management and Budget, and other interested parties. Copies also will be made available to others upon request.

This report was prepared under the direction of Janet L. Shikles, Director, Health Financing and Policy Issues, who may be reached on (202) 275-5451. Other major contributors are listed in appendix VII.



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Abbreviations

GAO	General Accounting Office
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
LGHP	large group health plan
OBRA-86	Omnibus Budget Reconciliation Act of 1986

Objectives, Scope, and Methodology

Section 9319 of the Omnibus Budget Reconciliation Act of 1986 made Medicare the secondary payer for hospital and other medical expenses of disabled Medicare beneficiaries covered under a "large group health plan" through their own or another family member's current employment. This report responds to the OBRA-86 mandate (sec. 9319(e)) that the Comptroller General study and report to the Congress

- the amount of Medicare program savings achieved annually through this change and
- the effect on employment and employment-based health coverage of disabled individuals and their family members.

In an earlier report (GAO/HRD-90-79, May 10, 1990), we addressed the number of beneficiaries affected.

Estimating the Savings

We made a statistically valid estimate of savings for only the largest group of disabled beneficiaries identified in our May 1990 report as affected by the OBRA-86 provision—214,000 with LGHP coverage through a working spouse or other family member. To determine this group's OBRA-86 provision savings, we compared the average yearly Medicare costs incurred by two sample groups in 1986 (prior to implementation of the provision) with their costs in 1988 (1 year after implementation). The sample groups consisted of

- a study group of beneficiaries with LGHP coverage throughout 1988 through a working spouse or other family member (for whom Medicare should have been secondary payer) and
- a comparison group of beneficiaries who also had a working spouse or other family member, but who did not have LGHP coverage at any time in 1988 (for whom Medicare should have been primary payer).

Because of timing and other methodological considerations, we did not make statistically valid estimates of cost savings associated with another 26,000 trial workers and 29,000 disabled beneficiaries who meet HCFA's definition of current employee. Our savings estimates for these beneficiaries assume the same per beneficiary experience as that found in our statistically valid sample.

Disabled Medicare Beneficiaries Sampled

To determine the number of disabled beneficiaries for whom Medicare became the secondary payer, we sent questionnaires to a random sample of about 9,000 individuals. These consisted of some 6,000 disabled Medicare beneficiaries and 3,000 Social Security beneficiaries awaiting Medicare entitlement. To develop the study and comparison groups for our savings estimates, we sent out a follow-on questionnaire regarding 1988 insurance coverage. This questionnaire went to respondents to the original questionnaire who had indicated that, as of December 31, 1986, they had a working spouse or, in the case of disabled adult dependents, some other working member of the immediate family. We excluded from the follow-on sample beneficiaries who

1. became 65 years old and thus were no longer eligible for disabled Medicare benefits during or before 1988;

2. had died prior to January 1, 1988;

3. were in a health maintenance organization that provided Medicare services for a fixed amount per person at any time during 1988;

4. lived in Hawaii or Alaska or another location outside the continental United States; and

5. had end-stage renal disease (these beneficiaries are covered by their own secondary payer provision).

The original questionnaires are included in our May 1990 report and the follow-on questionnaire in appendix V of this report.

From the 1,201 responses (88 percent) to our follow-on questionnaire, we determined whether the respondents had health insurance coverage during 1988 through a working family member and, if so, with what employer. Then, to determine whether the plan was large or small as defined in OBRA-86, we consulted library resources such as Dun's Marketing Services Million Dollar Directory, Standard and Poor's Register of Corporations, and the American Hospital Guide. We contacted companies with fewer than 100 employees to confirm their size. We also ensured that they did not belong to a multiple employer health plan or a labor union that covered employees of at least one company that employed 100 or more employees.

Nature of the Study and Comparison Groups

Our study group was composed of beneficiaries with LGHP coverage throughout 1988 and thus subject to the OBRA-86 provision. As our comparison group, we used similar beneficiaries without LGHP coverage. These were beneficiaries with a working spouse or other family member who had either no health insurance coverage for the disabled beneficiary or small group health plan coverage throughout 1988. For the purposes of our study, we excluded beneficiaries who had a mix of coverage (large plan and either small plan or no coverage) during 1988. Our study group included 409 beneficiaries who had Medicare eligibility in calendar year 1988 and 286 who had it in 1986. In the comparison group, 767 beneficiaries had Medicare eligibility at some time in 1988, and 511 had it at some time in 1986.

Both sample groups were composed primarily of married Medicare beneficiaries. The proportion of disabled adult dependents in the comparison group, though small (15 percent), was considerably higher than in the study group (5 percent). To control for this factor, we estimated savings separately for beneficiaries who were disabled adult dependents and those who were not, and then combined the results.

Obtaining Data on Medicare Expenditures

We obtained costs for Medicare part A (primarily inpatient hospital services) and part B (primarily physician services) for 1986 and 1988 from HCFA's Medicare automated data retrieval system records as of June 1989. We compared the physician costs for each beneficiary in the Medicare automated data retrieval system record, with the costs in the carriers' records and selected the higher of the two. A HCFA official suggested that differences might be due to the speed at which carriers transmitted data to HCFA. To obtain total part B costs, we then added the part B costs for hospital outpatient services from the Medicare automated data retrieval system. Because not all 1986 or 1988 medical costs had been submitted at the time we requested this data, we adjusted the costs slightly based on HCFA staff cost estimates. Finally, we combined each beneficiary's part A and part B costs in making our analysis.

Determining Effect on Medicare Costs and Savings

We estimated the savings related to the OBRA-86 provision separately for disabled beneficiaries who were disabled adult dependents and those who were not, then combined the results for an overall savings estimate. In making our estimates, we calculated the mean cost per year for our study and comparison groups in 1988 and made similar calculations for 1986. We then estimated statistically the differences between our two groups' mean costs in 1986 and 1988.

We also tested our hypothesis that the mean costs of the study and comparison groups were the same in 1986 (prior to implementation of the provision). The differences in the average 1986 Medicare cost per beneficiary for the study group and the comparison group were not statistically significant at the .05 level of significance.

After statistically estimating the mean difference in the costs of the study and the comparison groups in 1988, we applied it to our statistical estimate of the number of disabled beneficiaries affected by the OBRA-86 provision through a working family member (214,000). This allowed us to estimate the total savings.

In 1988, the difference in average cost per Medicare beneficiary between the study and comparison groups was statistically significant for beneficiaries with working spouses ($1,545) but not for disabled adult dependents ($484).

The overall differences between the mean costs of the study and comparison groups (after combining results for disabled adult dependents and beneficiaries who were not disabled adult dependents) are shown in table 1.

Our approach assumed that the difference between the two groups in 1988 was caused by the OBRA-86 secondary payer provision. To increase our confidence in this assumption, we calculated cost savings differently. Our approach controlled for other factors that could have accounted for the observed differences between the two groups. In this approach, we removed from our study beneficiaries with characteristics that may have affected costs. This included those who died during 1986, 1987, 1988, or (to the extent the information was available) 1989 and beneficiaries with partial years of eligibility in 1986 or 1988.

Using these pared-down study and comparison groups, we estimated the ratio between 1986 and 1988 costs for beneficiaries in the comparison group. We applied this ratio to the 1986 average cost per beneficiary for the study group to estimate what the 1988 costs for this group would have been had the secondary payer provision not been passed. To obtain average savings per beneficiary due to the provision, we subtracted the actual 1988 average cost per beneficiary for the study group from our estimated cost for this group in 1988. As in the first approach, to estimate the total savings we multiplied this average savings per beneficiary by our statistical estimate of the number of disabled beneficiaries affected by the OBRA-86 provision through a working family member.

This alternate approach gave us an estimate of total cost savings ($300 million) similar to the estimate made using our primary approach ($322 million.)

Additional Savings for Beneficiaries With LGHP Coverage Through Their Own Employment

In our May 1990 report, we estimated that 126,000 disabled Medicare beneficiaries had LGHP coverage through their direct relationship with an employer. About 26,000 of these had coverage through (1) their own trial-work employment with substantial gainful activity or (2) their own employment with substantial gainful activity during the 39-month extension of Medicare benefits after completion of trial work. Another 100,000 beneficiaries[1] were not working but had a continuing linkage with an employer constituting employee status. Because the trial worker group constituted less than 8 percent of those affected by the OBRA-86 provision, we did not perform a separate study to estimate directly savings for them. We provided a savings figure by assuming that the per capita savings for this group would approximate savings found in our study of beneficiaries covered through a working spouse.

Likewise, in estimating the cost savings associated with the nonworking employees to whom HCFA is considering applying the provision, we did not estimate per capita savings. Instead we applied the per capita savings we found for beneficiaries covered by a working family member. Our decision was based on methodological considerations and the time frame of our study. HCFA did not delineate this group until after we had conducted our initial random sample of disabled Medicare beneficiaries to identify potential participants in our comparative study. Developing reliable estimates of savings for this additional group would have involved

- resampling the disabled Medicare population to identify these beneficiaries,
- contacting former employers of beneficiaries to determine whether (1) the beneficiary met any of HCFA's indicators of employee status and (2) the health plan was a large or small group health plan, and
- requesting 1988 cost data for these beneficiaries from HCFA and from Medicare carriers.

[1] 1Since our May 1990 report, HCFA has estimated that there were 29,000 disabled beneficiaries in this group in 1989 and that this number will decrease by 25 percent annually. Our cost savings estimates in this report use HCFA's more recent figure.

In addition, we could not expect the 1988 cost experience for this group of beneficiaries to be typical of subsequent years, because HCFA did not define this group until April 1988, and the list of indicators underwent change during subsequent months. As a result, the 1988 data would reflect generally an after-the-fact effort on the part of the Medicare contractors to recover primary payments already made. For 1989, however, we assumed that the average savings attained in 1988 for beneficiaries covered under the act through a spouse's employer-sponsored LGHP coverage would approximate the savings for nonworking persons with LGHP coverage through an employer. The medical costs for the two groups should not differ materially.

Estimating Savings Not Achieved

To estimate the dollars lost because of Medicare's paying mistakenly as primary payer, we first determined the total dollars Medicare spent in 1988 as primary payer for disabled beneficiaries in our sample (409 beneficiaries with LGHP coverage) who were affected by the OBRA-86 provision through a working family member. This figure used cost data obtained from HCFA and the carrier. We reduced this amount by what Medicare should have paid as secondary payer. HCFA's contract actuary estimated this at 5 percent for part A Medicare and 30 percent for part B Medicare. After computing the average mistaken payment per beneficiary, we applied it to our statistical estimate of beneficiaries affected through a working family member (214,000).

Identifying the Effect on the Disabled and Their Families

We focused our review of section 9319's effects on (1) the extent to which employers changed their health plans to the disadvantage of disabled beneficiaries, (2) the extent to which employers have incorporated hiring and retention practices that work to the disadvantage of persons with disabled family members, and (3) the effect of HCFA's definition of "employee status" (for determining whether an individual is subject to the Medicare secondary payer provision) on employment-based health coverage of long-term disabled individuals.

To determine the extent of these potential effects, we developed and pretested a questionnaire and sent it to a randomly selected group of 300 companies. These were from Fortune magazine's lists of the 500 largest U.S. industrial companies and the 500 largest service companies. We received 154 responses for a 51-percent response rate. Questionnaire results are summarized in appendix II and the questionnaire is displayed

Table II.2: Employer Actions Affecting Disabled Beneficiaries With "Employee Status"

Action affecting disabled beneficiaries	Implemented (1987 or 1989)	Under consideration	OBRA-related	
			Yes	No or not specified
Do not extend long-term disability insurance to new employee groups	0	7	6	1
Do not offer health insurance coverage to employees who become long-term disabled in the future	0	9	7	2
Discontinue disability health insurance after a limited period of disability—for currently disabled employees	2	9	6	5
Discontinue disability health insurance after a limited period of disability—for employees who become disabled in the future	4	17	11	10
Limit disability insurance, after a period of disability, to what the company would pay as secondary payer to Medicare—for currently disabled employees	0	11	7	4
Limit disability insurance, after a period of disability, to what Medicare would pay as secondary for employees who become disabled in the future	0	16	9	7
Reduce or eliminate disability cash benefits to compensate for higher health care costs—for currently disabled employees	0	2	2	0
Reduce or eliminate disability cash benefits to compensate for higher health care costs—for employees who become disabled in the future	0	5	3	2
Eliminate the right to return to work provisions—for currently disabled employees	1	6	3	4
Eliminate the right to return to work provisions—for employees who become disabled in the future	1	10	5	6
Set up a separate health plan for disabled employees only, with the employees paying a higher share of costs to compensate for the shift to primary payer	3	12	10	5
Establish or increase a requirement for a certain number of years of active employment before employees who become disabled are eligible to receive health insurance coverage	0	21	12	9

Questionnaire Sent to Large Companies

U.S. GENERAL ACCOUNTING OFFICE
STUDY OF DISABLED MEDICARE SECONDARY PAYER PROVISION

INSTRUCTIONS

Please read each question carefully. The answers you give are very important to our study. We would like you to complete the questionnaire as soon as you receive it. When you are finished, remove the post card and place the questionnaire in the business reply envelope. Mail the envelope and post card separately to us. No postage is required.

This questionnaire is divided into two parts. Part I asks questions relating to health insurance benefits for long-term disabled beneficiaries, and Part II relates to health insurance benefits for spouses and dependents of regular active employees. Your company's identity and responses will be anonymous. If you have any questions about the questionnaire or this study, please call Sherry Davis or Ike Eichner at (206) 442-5356.

PART I: HEALTH INSURANCE BENEFITS FOR LONG-TERM DISABLED (LTD)

Some companies continue to provide income and/or other benefits to employees (or disability retirees) who are no longer working because of a long-term (2 years or longer) disability. Questions in this Section ask about health insurance benefits you may provide these Long-term Disabled (LTD) individuals.

1. Does your company have any LTD (over 2 years) individuals to whom you provide an income and/or offer other benefits? (Check one)

   [ ] YES

   [ ] NO (SKIP TO PART II ON PAGE #4)

2. Does your company offer health insurance coverage to these LTDs? (Check one)

   [ ] YES

   [ ] NO (SKIP TO PART II ON PAGE #4)

3. Does your company offer health insurance coverage to the spouses or dependents of these LTDs? (Check one)

   [ ] YES

   [ ] NO

4. Has your company become primary payer to Medicare for any of these LTDs under the disabled Medicare secondary payer provision as implemented by the Health Care Financing Administration (HCFA)? (Check one)

   [ ] YES

   [ ] NO (SKIP TO PART II ON PAGE #4)

   4a. For how many LTDs?

   _____
   (Number)

   4b. Please estimate the additional annual costs you expect your health care plan(s) to incur as a result of becoming primary payer for these LTDs?

   $_____

5. HCFA uses any one of seven indicators, as stated in its Medicare Hospital Manual (Transmittal No. 555, dated November 1988), to determine whether a disabled person is an "employee" and, thus, should receive primary medical coverage through his or her own employer's health insurance plan. For each of the seven indicators listed below, please tell us, "Yes", "No" or "Don't Know", whether the indicator causes any of your company's LTDs to become "employees".

	Yes	No	Don't Know
a. "The individual is receiving payments from an employer that are subject to taxes under the Federal Insurance Contributions Act (FICA) or would be subject to such taxes except that the employer is one that is not required to pay such taxes under the Internal Revenue Code."	[ ]	[ ]	[ ]
b. "The individual is termed an employee under State or Federal law or in accordance with a court decision."	[ ]	[ ]	[ ]
c. "The employer pays the same taxes for the individual as he pays for actively working employees."	[ ]	[ ]	[ ]
d. "The individual continues to accrue vacation time or receives vacation pay."	[ ]	[ ]	[ ]
e. "The individual participates in an employer's benefit plan in which only employees may participate."	[ ]	[ ]	[ ]
f. "The individual has rights to return to duty if his or her condition improves."	[ ]	[ ]	[ ]
g. "The individual continues to accrue sick leave."	[ ]	[ ]	[ ]

6. There are changes in health insurance benefits and employment practices a company can make to reduce its costs for health insurance as a result of becoming primary payer for LTDs. For each possible change listed below, please indicate whether your company has considered the change and if so, the status of that change in your company and whether your action/decision was related, at least in part, to becoming primary payer.

	STATUS OF CHANGE:				RELATED TO BECOMING PRIMARY PAYER:	
	Rejected/ Never Considered	Implemented	To Be Implemented	Still Under Consideration	Yes	No
a. Not extend LTD health insurance to new employee groups (for example, administrative staff).	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
b. Not offer health insurance coverage to employees who become LTD in the future.	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
c. Discontinue LTD health insurance altogether after some limited period of disability (for example, one or two years) - for present LTDs.	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

	Rejected/ Never Considered	STATUS OF CHANGE: Implemented	To Be Implemented	Still Under Consideration	RELATED TO BECOMING PRIMARY PAYER: Yes	No
d. Discontinue LTD health insurance altogether after some period of disability (for example one or two years) - for employees who become LTDs in the future.	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
e. Limit LTD health insurance after some period of disability (for example, one or two years) essentially to what the company would pay as secondary payer to Medicare - for present LTDs.	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
f. Limit LTD health insurance after some period of disability (for example, one or two years) essentially to what the company would pay as secondary payer to Medicare - for employees who become LTDs in the future.	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
g. Reduce or eliminate disability cash benefits to compensate for higher health care costs - for present LTDs.	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
h. Reduce or eliminate disability cash benefits to compensate for higher health care costs - for employees who become LTDs in the future.	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
i. Remove the right-to-return-to-work provisions - for present LTDs.	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
j. Remove the right-to-return-to-work provisions - for employees who become LTDs in the future.	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
k. Set up a separate health insurance plan for LTDs only, with the employees paying a higher share of costs than presently to compensate for the shift to primary payer.	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
l. Establish or increase a requirement for a certain number of years of active employment before employees who become LTD are eligible to receive health insurance coverage.	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
m. Other (Please list each change)	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

_____

_____

(If more room is needed, please continue on a separate sheet of paper.)

PART II: HEALTH BENEFITS FOR SPOUSES OR DEPENDENTS

7. Does your company pay or subsidize any of the costs of health insurance coverage for the spouses or dependents of any of its active employees?

[ ] YES [ ] NO

STOP! THIS COMPLETES THE QUESTIONNAIRE. PLEASE PLACE THE COMPLETED QUESTIONNAIRE IN THE BUSINESS REPLY ENVELOPE. MAIL THE ENVELOPE AND POST CARD SEPARATELY TO US, AS SOON AS POSSIBLE. THANK YOU FOR YOUR COOPERATION.

8. There are changes in health insurance benefits and employment practices a company can make to reduce its costs for health insurance as a result of becoming primary payer for disabled spouses or dependents. For each change listed below, please indicate whether your company has considered the change, and if so, the status of that change in your company and whether your action/decision was related, at least in part, to becoming primary payer.

	STATUS OF CHANGE:				RELATED TO BECOMING PRIMARY PAYER:	
	Rejected/ Never Considered	Implemented	To Be Implemented	Still Under Consideration	Yes	No
a. Eliminate health insurance coverage for spouses or dependents.	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
b. Shift more costs for spouses or dependents to the workers in the form of increased worker premiums.	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
c. Eliminate health insurance coverage of disabled adult dependents (cut off disabled children at same age as non-disabled children).	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
d. Reduce maximum lifetime health insurance payments for disabled spouses or dependents.	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
e. Attempt to avoid hiring employees with disabled spouses or dependents.	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
f. Attempt to dismiss employees with disabled spouses or dependents.	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
g. Other (Please list each change)	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

_____

_____

(If more room is needed, please continue on a separate sheet of paper.)

STOP! THIS COMPLETES THE QUESTIONNAIRE. PLEASE PLACE THE COMPLETED QUESTIONNAIRE IN THE BUSINESS REPLY ENVELOPE. MAIL THE ENVELOPE AND POST CARD SEPARATELY TO US, AS SOON AS POSSIBLE. THANK YOU FOR YOUR COOPERATION.

Questionnaire Sent to State Insurance Commissioners

U.S. GENERAL ACCOUNTING OFFICE
STUDY OF DISABLED MEDICARE SECONDARY PAYER PROVISION

INSTRUCTIONS

Please read each question carefully and provide the best answer you can without extensive research. If possible, complete the questionnaire as soon as you receive it. When you are finished, place the questionnaire in the addressed envelope and mail it. No postage is required. If you have additional questions about the questionnaire or this study, please call Ike Eichner or Lori Pang in our Seattle office at (206) 442-5498, any afternoon.

Before you begin, please provide us with the name and telephone number of an individual we can contact in case we have questions about your answers:

_____
Name

_____
Area Code Telephone Number

1. Are you aware of any changes in employment-based health insurance plans since January 1, 1987 which you believe are disadvantageous to the disabled or their families AND may have resulted from Medicare's becoming secondary payer for certain disabled Medicare beneficiaries? (CHECK ONE)

YES
[ ]
|
|
|
V
GO TO NEXT PAGE

NO
[ ]
|
|
|
V
SKIP TO QUESTION #4

2. How significant a problem do you believe these changes pose for the disabled or their families in your state? (CHECK ONE)

[ ] 1. very significant

[ ] 2. somewhat significant

[ ] 3. neither significant nor insignificant

[ ] 4. somewhat insignificant

[ ] 5. very insignificant

[ ] 6. don't know

3. What is the principal impact of the changes? (CHECK ALL THAT APPLY)

[ ] 1. loss/reduction of coverage for disabled spouses of employees

[ ] 2. loss/reduction of coverage for disabled adult dependents of employees

[ ] 3. loss/reduction of coverage for long-term disabled retirees

[ ] 4. other (please explain)

_____

4. State laws or regulations may exist which prevent employers and insurance companies from making specific kinds of changes in health insurance plans in response to the disabled Medicare secondary payer provision. Below we have listed specific changes which employers and insurance companies may wish to make in response to the disabled Medicare secondary payer provision. For each change, please indicate whether the change is forbidden under your state's law or regulations. (CHECK ALL THAT APPLY)

	uncertain	not forbidden	forbidden		If forbidden, is the law applicable to negotiated contracts? Yes	No
1. dropping provisions which allowed totally disabled dependents to continue coverage beyond the age cut-off for non-disabled dependents.	[ ]	[ ]	[ ]	=>	[ ]	[ ]
2. refusing to cover totally disabled spouses/dependents of active workers.	[ ]	[ ]	[ ]	=>	[ ]	[ ]
3. refusing to cover totally disabled retirees under age 65.	[ ]	[ ]	[ ]	=>	[ ]	[ ]
4. extending the time frame of the pre-existing condition clause to limit liability for medical care related to a spouse/dependent's disability.	[ ]	[ ]	[ ]	=>	[ ]	[ ]

STOP! THIS IS THE END OF THE QUESTIONNAIRE. PLEASE PUT THIS QUESTIONNAIRE IN THE ADDRESSED ENVELOPE AND MAIL IT AS SOON AS POSSIBLE. THANKS AGAIN FOR YOUR HELP!

Follow-On Questionnaire Sent to Medicare Beneficiaries

U.S. GENERAL ACCOUNTING OFFICE
STUDY OF MEDICARE'S SECONDARY PAYER PROGRAM
FOR DISABILITY BENEFICIARIES

<——LABEL

INSTRUCTIONS

Please read each question carefully and answer ONLY those that apply to your situation. The answers you give are very important to our study, so please try to be as accurate as possible. If you need help answering these questions, please ask a close friend or relative to assist you.

We would like you to complete the questionnaire as soon as you receive it. When you are finished, place the questionnaire in the addressed envelope and mail it. No postage is required. If you have additional questions about the questionnaire or this study, please call Lori Pang or Ike Eichner collect in our Seattle office at 1-206-442-5356, any afternoon.

Before you begin, please give us your telephone number or a telephone number of someone who can reach you in case we have questions about your answers:

(_____)
Area Code Telephone Number

1. At any time during 1988, did you have another health insurance plan at the same time you had Medicare? [CHECK THE ANSWER OR ANSWERS THAT BEST DESCRIBES YOUR SITUATION]

[ ] 1. YES, through my present employer

[ ] 2. YES, through my former employer

[ ] 3. YES, through my husband's or wife's employer

[ ] 4. YES, through my parent's or guardian's employer

[ ] 5. YES, through another source:

_____
(Please Specify)

IF YOU CHECKED "YES," PLEASE TURN THE PAGE AND CONTINUE ANSWERING THE QUESTIONS . . . . . .

[ ] 6. NO, I did not have health insurance anytime in 1988.

V

STOP → STOP! IF YOU CHECKED "NO," DO NOT ANSWER ANY MORE QUESTIONS. PLEASE PUT THIS QUESTIONNAIRE IN THE ADDRESSED ENVELOPE AND MAIL IT AS SOON AS POSSIBLE.

2. During 1988, did you receive health insurance other than Medicare from **ONLY ONE PLAN** or from **MORE THAN ONE PLAN?** (CHECK ONLY ONE)

ONLY ONE PLAN	MORE THAN ONE PLAN
[ ]	[ ]

PLEASE SKIP TO QUESTION #7 ON PAGE 4.

3. Were you covered by this same health insurance plan for **ALL** of 1988 (January through December)? (CHECK ONE)

[ ] YES ---> SKIP TO QUESTION #5

[ ] NO

3a. In 1988, which months were you covered by this health insurance plan? (CHECK ALL THAT APPLY INCLUDING PARTIAL MONTHS)

[ ]	1. JANUARY	[ ]	7. JULY
[ ]	2. FEBRUARY	[ ]	8. AUGUST
[ ]	3. MARCH	[ ]	9. SEPTEMBER
[ ]	4. APRIL	[ ]	10. OCTOBER
[ ]	5. MAY	[ ]	11. NOVEMBER
[ ]	6. JUNE	[ ]	12. DECEMBER

4. What was the reason you did not have health insurance for the entire year (all 12 months) of 1988? (CHECK ONLY ONE)

[ ] 1. I retired

[ ] 2. I dropped my health coverage

[ ] 3. I changed jobs

[ ] 4. I lost my job

[ ] 5. My employer canceled medical health plan

[ ] 6. My spouse (husband or wife) and I were divorced or legally separated

[ ] 7. My spouse/parent/guardian died

[ ] 8. My spouse/parent/guardian retired

[ ] 9. My spouse/parent/guardian dropped health coverage

[ ] 10. My spouse/parent/guardian changed jobs

[ ] 11. My spouse/parent/guardian lost job

[ ] 12. My spouse's/parent's/guardian's employer canceled medical health plan

[ ] 13. Other: _____

_____
(Please Specify Reason)

5. How were your health bills paid in 1988? (CHECK ANY THAT APPLY).

[ ] 1. Only Medicare was billed

[ ] 2. Only the health insurance plan was billed

[ ] 3. Medicare was billed first; the health insurance plan was billed second

[ ] 4. The health insurance plan was billed first; Medicare was billed second

[ ] 5. Don't know

[ ] 6. Other (Please Explain)

_____

_____

6. Please provide the OFFICIAL health insurance plan's name and the name and address of the company/employer that provided the plan in 1988.

Name of Insurance Plan: _____

Company/Employer Name: _____

Company/Employer Address: _____

_____

_____

STOP. THIS IS THE END OF THE QUESTIONNAIRE. PLEASE PUT THIS QUESTIONNAIRE IN THE ADDRESSED ENVELOPE AND MAIL IT AS SOON AS POSSIBLE. THANKS AGAIN FOR YOUR HELP!

Note: Answer questions 7, 8, 9 and 10 only if you had more than one health insurance plan during 1988.

7. During 1988, if you had insurance other than Medicare:

   [ ] were you covered by two or more plans at the same time?

   [ ] or did you switch from one plan to another?

8. Were you covered by health insurance through one plan or another during all 12 months of 1988? (CHECK ONE)

   [ ] YES —> GO TO QUESTION #9

   [ ] NO

   |
   V

   8a. In 1988, which months were you covered by one health insurance plan or another? (CHECK ALL THAT APPLY INCLUDING PARTIAL MONTHS)

[ ]	1. JANUARY	[ ]	7. JULY
[ ]	2. FEBRUARY	[ ]	8. AUGUST
[ ]	3. MARCH	[ ]	9. SEPTEMBER
[ ]	4. APRIL	[ ]	10. OCTOBER
[ ]	5. MAY	[ ]	11. NOVEMBER
[ ]	6. JUNE	[ ]	12. DECEMBER

9. How were your health bills paid in 1988? (CHECK ANY THAT APPLY)

   [ ] 1. Only Medicare was billed

   [ ] 2. Only the health insurance plan was billed

   [ ] 3. Medicare was billed first; the health insurance plan was billed second

   [ ] 4. The health insurance plan was billed first; Medicare was billed second

   [ ] 5. Don't know

   [ ] 6. Other (Please Explain)

   _____

   _____

10. For EACH health insurance plan you had during 1988, please provide the OFFICIAL plan name and the name and address of the company/employer which provided that health insurance plan.

    Name of Insurance Plan #1: _____

    Company/Employer Name: _____

    Company/Employer Address: _____

    _____

    _____

    Name of Insurance Plan #2: _____

    Company/Employer Name: _____

    Company/Employer Address: _____

    _____

    _____

    Name of Insurance Plan #3: _____

    Company/Employer Name: _____

    Company/Employer Address: _____

    _____

    _____

STOP. THIS IS THE END OF THE QUESTIONNAIRE. PLEASE PUT THIS QUESTIONNAIRE IN THE ADDRESSED ENVELOPE AND MAIL IT AS SOON AS POSSIBLE. THANKS AGAIN FOR YOUR HELP!

Comments From the Department of Health and Human Services

Note: GAO comments supplementing those in the report text appear at the end of this appendix.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

DEC 10 1990

Mr. Lawrence Thompson
Assistant Comptroller General
United States General
Accounting Office
Washington, D.C. 20548

Dear Mr. Thompson:

Enclosed are the Department's comments on your draft report, "Medicare: Millions In Disabled Medicare Beneficiary Expenditures Shifted to Employers." The comments represent the tentative position of the Department and are subject to reevaluation when the final version of this report is received.

The Department appreciates the opportunity to comment on this draft report before its publication.

Sincerely yours,

for Richard P. Kusserow
Inspector General

Enclosure

Comments of the Department of Health and Human Services on the General Accounting Office Draft Report, "Medicare: Millions in Disabled Medicare Beneficiary Expenditures Shifted to Employers"

Overview

The Omnibus Budget Reconciliation Act of 1986 (OBRA 86) made Medicare secondary payer for medical expenses of certain disabled beneficiaries covered by large-group health plans (LGHPs). It also directed the General Accounting Office (GAO) to assist Congress' evaluation of the provision by determining: (1) the number of disabled beneficiaries for whom Medicare is secondary payer because of their own or a family member's employment; (2) the resulting annual cost savings to Medicare; and (3) the provision's effect on employment and employment-based health coverage of disabled beneficiaries and their family members. A previous GAO report ("Medicare: Employer Insurance Primary Payer for 11 Percent of Disabled Beneficiaries," May 10, 1990) addressed the first requirement. This report addresses the second and third requirements.

GAO recommends that Congress consider extending the Medicare secondary payer (MSP) for the disabled provision beyond the original sunset date of December 31, 1991. GAO also recommends that Congress defer permanent enactment until: (1) the Health Care Financing Administration (HCFA) implements final regulations defining employee status and providing protections to disabled Medicare beneficiaries with LGHP coverage; and (2) the appropriateness of HCFA's policy can be assessed on determining employee status and the experience of disabled individuals with employee status under the policy.

Department's Comment

See comment 1.

The draft report's recommendations have been rendered obsolete in part by Congress' recent extension of the provision's sunset from December 31, 1991 to September 30, 1995. (Section 4203(b) of the Omnibus Budget Reconciliation Act of 1990). The report's analyses of program savings and the provision's effects on employment costs and health coverage still have important implications for the continuing development of policy in this area and for Congress' ultimate assessment of whether to enact the provision permanently.

See comment 2.

We believe, however, that the draft report employs unreliable data in deriving its estimate of the provision's savings, specifically with respect to savings for individuals who are not actively working but who are still treated as employees by the employer which provides the health coverage.

Page 2

The May 1990 GAO report estimated that 340,000 disabled Medicare beneficiaries were subject to the MSP for the disabled provision. This figure was based on separate estimates of 214,000 Medicare-eligible family members of employed individuals, 26,000 actively working beneficiaries, and 100,000 beneficiaries who were not actively working but who are still treated as employees by the employer which provides the health coverage. Pending final regulations, HCFA has adopted the policy that certain disabled individuals who are not actively working retain employee status when their employers continue to treat them as employees. HCFA contractor manuals list "indicators" of employee status to guide contractors in making such determinations. These indicators were included in the proposed regulations on the MSP for the disabled provision.

The present draft report employs these figures to develop its estimate of the cost savings that can be attributed to the provision. The reliability of the draft report's cost savings estimates thus depends directly upon the reliability of the previous report's estimates of affected beneficiaries.

As the Department noted in comments on the draft version of the previous GAO report, these estimates carry very different levels of statistical reliability. The estimate of 214,000 family members of employed individuals is statistically strongest, since it is based on a scientific sampling of disabled Medicare beneficiaries. However, the estimate of 100,000 disabled employees not actively working is problematic, since it is based only on the "best guess" of Medicare program staff.

See comment 2.

Since GAO completed its initial report on the MSP for the disabled provision, the HCFA Office of the Actuary has prepared a report projecting probable secondary payer savings associated with disabled individuals who are not actively working but who retain employee status. The actuary's estimate of the savings for this group is much lower than the GAO report's estimate. The actuary estimates that in fiscal year 1990, Medicare will be secondary payer for 22,000 disabled individuals enrolled in Medicare Part A and 20,000 enrolled in Part B because of HCFA's policy on determining employee status. On this basis, the actuary estimates savings from the policy on employee status of $43 million in fiscal year 1990, in comparison to the GAO's estimate of $200 million per year.

Furthermore, the actuary projects a progressive decrease in realized savings from the policy on employee status to $17 million in fiscal year 1995 as employers adjust their personnel policies in order to avoid meeting the indicators which establish employee status under HCFA's current policy (e.g., by ceasing to extend a right to return to duty to individuals who have stopped active work because of a disabling condition). Commenters on the proposed regulations have indicated that employers are considering such adjustments.

See comment 2.

We believe that the actuarial projections of the savings associated with individuals with employee status carry a higher degree of reliability than an estimate based on a "best guess." We therefore recommend that GAO's estimate of savings for individuals with employee status be revised in accordance with the HCFA actuary's projections. If GAO does not accept the actuary's actual figures on savings, then GAO's own savings figures should at the very least be revised to reflect the probability that savings from the implementation of the existing policy on employee status will decrease over time as employers adjust their policies to avoid meeting HCFA's employee factors.

As an additional comment, we would simply like to highlight the fact that the employer questionnaires were sent to very large companies; i.e., 300 companies from Fortune magazine's list of the 1000 largest U.S. industrial and service companies. The responses are not necessarily indicative of how smaller firms might have reacted to the MSP disability provisions. It is possible that smaller firms could be affected more by the provisions since their operating revenue is lower and they do not have as many employees to whom they can shift some of the higher health care costs.

See comment 3.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

JAN 24 1991

Mr. Lawrence H. Thompson
Assistant Comptroller General
United States General
Accounting Office
Washington, D.C. 20548

Dear Mr. Thompson:

Enclosed are Department comments that supplement the comments we provided you on December 10, 1990 on your draft report, "Medicare: Millions In Disabled Medicare Beneficiary Expenditures Shifted to Employers." These supplemental comments, like the original comments, represent the tentative position of the Department and are subject to reevaluation when the final version of this report is received.

The Department appreciates the opportunity to comment on this draft report before its publication.

Sincerely yours,

Richard P. Kusserow
Inspector General

Enclosure

Supplemental Comments of the Department of Health and Human Services on the General Accounting Office Draft Report "Medicare: Millions in Disabled Medicare Beneficiary Expenditures Shifted to Employers"

Now on pp. 3, 4, and 7.

The draft report describes the proposed regulations published on March 8, 1990, which would place in regulations HCFA's policy to consider beneficiaries, who are not actively working, to be employees for purposes of the Medicare secondary payer provisions if they are treated as employees by their employers. (See pages 4, 5 and 9.) GAO expressed concerns about this policy and noted that public comments were "generally critical" of those indicators HCFA uses to determine when such beneficiaries are employees.

Commenters on this policy in the proposed regulation were uniformly critical. Among other things, commenters stated that employers are contemplating changes in treatment so that such disabled beneficiaries are no longer employees. By eliminating various forms of beneficial treatment, which result in determinations that such persons are employees, the employer may avoid the cost of providing the primary health coverage that would otherwise be required. Such actions would adversely affect disabled beneficiaries. Other commenters questioned the clarity of the rules to be applied, and asserted that employers and insurers would have difficulty knowing when they must provide primary health coverage. Some questioned the underlying basis for concluding that affected beneficiaries, who are treated beneficially by their employers, are employees. We are currently evaluating these comments in preparation for publication of a final regulation.

The proposed regulations would not protect disabled beneficiaries from all adverse measures which employers might adopt to avoid increased costs. We agree with GAO that disabled Medicare beneficiaries may be vulnerable to the adverse affects of employer responses to this policy.

The following are GAO's comments on the letters from the Department of Health and Human Services dated December 10, 1990, and January 24, 1991.

GAO Comments

1. As HCFA points out, our report's analysis of savings is important for the Congress's ultimate assessment of whether to enact the provision permanently. The draft report recommended that the Congress extend the OBRA-86 provision's sunset and was provided to congressional staffs on October 12 and 15, 1990. The Congress extended the provision in the Omnibus Budget Reconciliation Act of 1990 (P.L. 101-508, Nov. 5, 1990). Our draft recommended extension rather than permanent enactment because of our concern that the provision would promote employer actions that could adversely affect disabled individuals that HCFA defined as having employee status.

2. Our draft used HCFA's rough approximation that 100,000 beneficiaries would meet regulatory indicators of employee status because our analysis began before regulations defining the group were issued. We are adjusting our estimate of the OBRA-86 provision's savings to incorporate HCFA's new estimate that 22,000 disabled beneficiaries will have employee status in 1990 (29,000 in 1989) and their projection that this number will decline by 25 percent annually as employers adjust personnel policies to avoid meeting regulatory indicators of employee status.

The new estimate indicates that potential savings to Medicare through shifting of costs to employers are $44 million in 1990 (using GAO's per beneficiary cost estimates) and decreasing rapidly—not the $150 million that would have resulted from the earlier approximation of 100,000 individuals with employee status. In addition, HCFA's assertion that individuals with employee status will decline rapidly because employers will act to avoid the regulatory indicators, indicates that the risk of adverse employment or health insurance action to disabled individuals with employee status is substantial. We used this new information to adjust our report recommendation.

3. HHS offered several technical comments. These were considered and revisions made where appropriate.

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