Memorandum

Date MAY 26 1992

From Richard P. Kusserow
Inspector General

Subject Follow-up Review on General Accounting Office Report, "More Hospital Costs Should Be Paid by Other Insurers" (A-14-92-00375)

To William Toby
Acting Administrator
Health Care Financing Administration

Attached is the report on our follow-up audit of the General Accounting Office (GAO) report entitled, "More Hospital Costs Should Be Paid by Other Insurers" (GAO/HRD-87-43). The objective of our follow-up review was to ensure that the specific audit recommendations unconditionally accepted by the Department of Health and Human Services (HHS) were satisfactorily implemented or appropriately resolved.

The GAO made six recommendations in its report to improve identification of other forms of insurance that should pay for Medicare beneficiaries' medical services before Medicare. Our follow-up review found that HHS has taken appropriate action on all five of the recommendations with which it had agreed. Specifically, the Health Care Financing Administration (HCFA) has:

- increased Medicare secondary payer (MSP) savings goals for intermediaries and has increased the Contractor Performance Evaluation Program standards for MSP performance;
- established the MSP outreach program to improve hospital performance in primary payer billings;
- revised the Hospital Manual to require hospitals to obtain complete information on beneficiaries' other insurance sources;
- revised the regulations to extend the MSP provision of the law to all forms of no-fault insurance coverage; and

- resubmitted its earlier legislative proposal to require primary payers to notify HCFA about individuals who are enrolled in insurance programs to which Medicare is a secondary payer and to notify the Secretary about pending claims from Medicare beneficiaries.

If you have any questions, please call me or have your staff contact George M. Reeb, Assistant Inspector General for Health Care Financing Audits at (410) 966-7104. We would appreciate receiving your comments within 60 days from the date of this memorandum.

Attachment

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

FOLLOW-UP REVIEW ON GENERAL ACCOUNTING OFFICE REPORT, "MORE HOSPITAL COSTS SHOULD BE PAID BY OTHER INSURERS"

Richard P. Kusserow
INSPECTOR GENERAL

A-14-92-00375

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Memorandum

Date MAY 26 1992

From Richard P. Kusserow
Inspector General

Subject Follow-up Review on General Accounting Office Report, "More Hospital Costs Should Be Paid by Other Insurers" (A-14-92-00375)

To William Toby
Acting Administrator
Health Care Financing Administration

The purpose of this follow-up review was to determine if the Health Care Financing Administration (HCFA) has implemented or appropriately resolved the recommendations in the General Accounting Office (GAO) report, "More Hospital Costs Should be Paid by Other Insurers" (GAO/HRD-87-43), issued on January 29, 1987. This follow-up report is issued pursuant to the Office of Inspector General's (OIG) responsibilities under Office of Management and Budget (OMB) Circular A-50 to review and report on management responses to audit findings.

In its report, GAO made six recommendations to improve identification of other forms of insurance that should pay for Medicare beneficiaries' medical costs before Medicare. Our follow-up review found that HCFA has taken appropriate action on all five of the recommendations with which it had agreed.

INTRODUCTION

BACKGROUND

Medicare is a Federal program of comprehensive health insurance covering hospital, physician, and other medical services for the aged, disabled, and those suffering from chronic renal disease. The program is authorized under Title XVIII of the Social Security Act and is administered by HCFA within the Department of Health and Human Services (HHS).

Some beneficiaries have health care coverage in addition to Medicare, such as coverage under certain employer group insurance plans, workers' compensation, or an accident insurance policy (e.g., automobile liability coverage). If a Medicare beneficiary has other health insurance, the law requires in certain situations that the other insurer be the primary payer, paying ahead of Medicare. Medicare then acts as the secondary payer, paying only what remains due after the other coverage is exhausted. Hospitals and intermediaries are responsible for identifying such other insurance. Intermediaries are private insurance companies that contract to process Medicare hospital claims on HCFA's behalf.

To assess the degree to which hospitals and intermediaries were identifying and billing primary insurers, GAO analyzed a nationally representative sample of 3,052 hospital claims which Medicare paid in August 1985. The GAO mailed 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.

Although HCFA has reported that it has saved millions of dollars by identifying and billing other primary insurers, GAO found that Medicare was still paying substantial amounts that such insurers should have paid. In Calendar Year 1985, GAO estimated that Medicare paid out at least $527 million in hospital costs that should have been covered by other insurers.

During its audit, GAO identified three problems that appeared to be the main hindrances to a more effective system for identifying and billing primary insurers. The problems identified were:

- Hospitals often do not identify or bill primary insurers as required and intermediaries have little incentives to require hospitals to improve their performance.

- Some employers were enrolling Medicare beneficiaries inappropriately in group insurance that treats Medicare as the primary payer.

- o Weaknesses exist in Medicare procedures for identifying accident insurers responsible for costs paid by Medicare.

The GAO report made six recommendations to correct the identified problems. While the GAO made viable recommendations to aid in reducing inappropriate payments made by Medicare, the underlying material internal control weakness of HCFA's failure to identify Medicare beneficiaries with employer group health plan coverage was not addressed in the GAO report. This material internal control weakness would be corrected if HCFA implemented the recommendations in the OIG Management Advisory Report (MAR) entitled "More Complete Employer Group Health Plan Information is Needed to Administer the Medicare Secondary Payer Program" (A-09-89-00100), dated March 20, 1990. The HCFA generally agreed with our recommendations and reported the material internal control weakness in HHS' Fiscal Years (FY) 1990 and 1991 reports to the President and the Congress under the Federal Managers' Financial Integrity Act, Public Law 97-255.

SCOPE

Of the six recommendations that GAO made to improve the identification and billing of primary insurers, HHS agreed to implement five. This follow-up review examined the actions taken on the five recommendations with which HCFA concurred.

Our review was performed in accordance with generally accepted Government Auditing Standards. We did not review GAO's working papers pertaining to its audit nor did we review HCFA's internal controls over the receipt, evaluation, and implementation of recommendations contained in the GAO audit report. In consonance with OIG policies and procedures, the limited objective of our follow-up review was to ensure that the GAO audit recommendations accepted by HHS were satisfactorily implemented or otherwise resolved. Our review was made pursuant to requirements for audit follow-ups included in OMB Circular A-50.

During our follow-up review, we interviewed knowledgeable officials in HCFA's Bureau of Program Operations (BPO). The BPO has oversight for the Medicare secondary payer (MSP) program. We also reviewed intermediary manuals, MSP

savings reports, legislative proposals, and the applicable laws and regulations. Our follow-up field work was performed at HCFA's headquarters in Baltimore, Maryland in coordination with other MSP reviews being performed by OIG staff.

RESULTS

SPECIFIC RECOMMENDATIONS

The GAO report made six recommendations to correct the identified problems related to billings of primary insurers. The five GAO recommendations that HHS accepted, comments from HHS, and our review of the actions taken on the recommendations are provided in Appendix A. For informational purposes, the one GAO recommendation that HHS did not accept, comments from HHS, and an OIG update are provided in Appendix B.

Our review found that HCFA has taken appropriate action on the five GAO recommendations with which it concurred. Specifically, HCFA has:

- increased MSP savings goals for intermediaries and has increased the Contractor Performance Evaluation Program (CPEP) standards for MSP performance;
- established the MSP outreach program to improve hospital performance in primary payer billings;
- revised the Hospital Manual to require hospitals to obtain complete information on beneficiaries' other insurance sources;
- revised the regulations to extend the MSP provision of the law to all forms of no-fault insurance coverage; and
- resubmitted its earlier legislative proposal to require primary payers to notify HCFA about individuals who are enrolled in insurance programs

to which Medicare is a secondary payer and to notify the Secretary about pending claims from Medicare beneficiaries.

CONCLUSION

Our follow-up review showed that HCFA has taken appropriate action on all five of GAO's recommendations with which it had concurred. For this reason, we are not making specific recommendations with respect to the programmatic areas included in the GAO's scope of audit. We are currently reviewing various MSP activities within HCFA and will report on our evaluation on an as-needed basis.

STATUS OF GAO RECOMMENDATIONS

AGREED TO BY HHS

This appendix contains the five GAO recommendations with which HHS concurred, comments from HHS, and our review of the actions taken on the recommendations.

GAO RECOMMENDATION 1

The GAO found that the intermediaries have little incentive to maximize the Government's savings in the MSP program because increased Medicare savings come at least in part from their own commercial insurance enterprises. The CPEP, which is HCFA's evaluation program, did not provide this needed incentive. The GAO recommended the Secretary of HHS direct the Administrator of HCFA to revise CPEP to provide the intermediaries with the needed incentives to improve hospital performance in identifying and billing other insurers. To accomplish this, GAO recommended that HCFA implement recommendations 1(A) and/or 1(B):

RECOMMENDATION 1(A) - Increase current savings standards to dollar amounts which intermediaries could not meet without significantly improving hospital performance.

HHS' RESPONSE TO GAO RECOMMENDATION 1(A)

The HHS agreed in principle with this recommendation, stating that savings goals have been set in accordance with actuarial estimates of achievable savings, and that savings goals have been increased as new MSP provisions were added to the law.

OFFICE OF AUDIT SERVICES' REVIEW OF RECOMMENDATION 1(A)

The HHS has increased MSP savings goals. The MSP savings goals and actual MSP savings for FYs 1987 through 1991 are shown below.

FISCAL YEAR	GOALS	SAVINGS
1987	$1,202,677,880	$1,452,492,464
1988	$1,444,319,000	$1,880,571,044
1989	$1,758,646,000	$2,180,593,151
1990	$2,305,823,000	$2,481,526,091
1991	$2,011,231,000	$2,638,970,900

The CPEP standard for MSP performance has been increased. In FY 1988, a contractor had to achieve at least 90 percent of its savings goal in order to obtain a satisfactory performance rating. A 95 percent threshold was required in FY 1989. In FY 1992, HCFA redesigned and simplified CPEP, developing a system of criteria and standards which measure the most significant elements of contractor operations.

We believe that HHS has taken appropriate action on GAO's recommendation. Additional OIG follow-up is not needed.

RECOMMENDATION 1(B) - Establish new administrative requirements that would direct intermediaries to perform certain oversight and administrative tasks necessary to improve hospital performance in billing primary payers.

HHS' RESPONSE TO GAO RECOMMENDATION 1(B)

The HHS concurred with this recommendation. The HCFA stated that it has required intermediaries to intensify their provider training. In addition, HCFA planned to significantly expand the number of hospital MSP audits to be conducted by intermediaries, targeting hospitals which routinely fail to identify and pursue MSP situations.

OFFICE OF AUDIT SERVICES' REVIEW OF RECOMMENDATION 1(B)

On April 1, 1987, HCFA established the MSP outreach program which created new administrative requirements directing intermediaries to perform certain oversight and administrative tasks necessary to improve hospital performance in billing primary payers. The purpose of the outreach program is to provide affected groups and individuals with enough information to recognize circumstances where MSP may be applicable, so that claims are directed to the appropriate primary payer before being submitted to Medicare.

We believe that HHS has taken appropriate action on GAO's recommendation. Additional OIG follow-up is not needed.

GAO RECOMMENDATION 2

The GAO found that hospitals were not obtaining enough information about patients' other insurance coverage.

While all hospitals had procedures to collect some of the information needed to identify such coverage, some did not collect information on all insurance sources such as workers' compensation. Other hospitals did not collect spousal information. The GAO recommended that HCFA require intermediaries to direct hospitals that are not taking steps needed to identify and bill other insurers of Medicare beneficiaries to use a standard admission form designed to collect all required MSP information.

HHS' RESPONSE TO GAO RECOMMENDATION 2

In responding to the GAO report, HHS stated that it concurred and that it had already taken action to implement the recommendation. In January 1986, HCFA released instructions (section 301 of the Hospital Manual) which required hospitals to obtain answers to a list of questions from every Medicare beneficiary. Questions pertaining to other insurance are on the list.

OFFICE OF AUDIT SERVICES' REVIEW OF RECOMMENDATION 2

The HHS does not require use of a standard admission form. However, it does require specific MSP questions to be asked of every Medicare beneficiary. A questionnaire, found in the Hospital Manual, has been developed from these questions. A copy of the completed MSP questionnaire or equivalent information is required to be on file for audit purposes. If an on-line admission system is used, the above requirement does not apply if the hospital has documented its development procedures for collecting and reporting other primary payer information.

We believe that HHS has taken appropriate action on GAO's recommendation and additional OIG follow-up is not needed. In addition, in our MAR "More Complete Employer Group Health Plan Information is Needed to Administer the Medicare Secondary Program" (A-09-89-00100), the OIG recommended standardizing all Medicare claim forms to detect the availability of other insurance which should pay primary to Medicare. The OIG recommended that HCFA revise all Medicare claim forms to require an answer of "yes" or "no" to the question, "Do you have health insurance as a result of your or your spouse's current employment?". The OIG also recommended that HCFA amend its instructions to Medicare contractors to specify that if the question

pertaining to employee insurance coverage is left blank, the claim should be suspended and returned to the sender with a letter explaining that questions on other health insurance coverage must be answered.

In December 1990, OMB approved a revision of HCFA's Health Insurance Claim Form 1500 which is used by physicians and suppliers to submit claims to Medicare for reimbursement. The revised form went into use in September 1991. It provides more information about whether a beneficiary (or spouse) is covered by other insurance. The new form asks, "Is there another health benefit plan?" and has "yes" and "no" check-off boxes for the response. While this revision may be an improvement, the OIG recommended that this question be further clarified to ask, "Do you have health insurance as a result of your or your spouse's current employment?".

GAO RECOMMENDATION 3

The GAO found that changes in Medicare regulations would increase recoveries from accident insurers. Although the law specified that Medicare was to be secondary to all types of no-fault insurance, HHS regulations omitted no-fault liability insurance (other than automobile no-fault liability) from this requirement, and HCFA was thus not enforcing this provision of the law. Also, Medicare relies on beneficiaries to identify other accident insurance coverage. This procedure often does not work because Medicare does not learn that a claim it paid had also been paid or could be paid by accident insurance. To fully realize Medicare's role as secondary payer, GAO recommended two changes to existing regulations: (1) extend the MSP provisions of the law to all forms of no-fault insurance coverage and (2) 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.

HHS' RESPONSE TO GAO RECOMMENDATION 3

In response, HHS stated that it was in the process of revising MSP regulations so that the no-fault provisions would apply to all forms of no-fault insurance coverage. The proposed regulations would 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.

OFFICE OF AUDIT SERVICES' REVIEW OF RECOMMENDATION 3

This recommendation was partially implemented by HCFA's rule BPD-302-F, which became effective on November 13, 1989. Subpart D of that rule extended the MSP provisions of the law to all forms of no-fault insurance coverage. However, the rule does not require third party insurers to notify HCFA of medical payments or other settlements in those instances in which Medicare has an actual or possible right of recovery. It only requires third party insurers to notify HCFA if they learn (have knowledge) that Medicare made a primary payment for services for which a third party insurer made or should have made the primary payment.

The HHS submitted an FY 1990 legislative proposal to OMB that would aid identification and recovery of MSP claims. The legislative proposal would require insurers, underwriters, and third party administrators of employer group health plans to notify HCFA about covered individuals who are over age 65, under age 65 and disabled, or diagnosed as having end stage renal disease, and who are enrolled in insurance programs to which Medicare is the secondary payer. It would also require workers' compensation plans, no-fault insurers, liability insurers, and automobile insurers to notify the Secretary about pending claims from individuals entitled to Medicare.

The legislative proposal was not cleared by OMB. In our MAR, "More Complete Employer Group Health Plan Information is Needed To Administer the Medicare Secondary Program" (A-09-89-00100), we recommended that HCFA revise and resubmit its proposal to justify it as the most efficient method for correcting the material weakness and to fully implement the MSP program.

Initially HCFA did not concur. It stated that section 6202 of the Omnibus Budget Reconciliation Act (OBRA) of 1989 which amended section 6103 of the Internal Revenue Code of 1986, included a 2-year provision that would improve MSP identification by instituting a variety of matches between the Internal Revenue Service (IRS), the Social Security Administration, and HCFA. This provision constituted a major change in the MSP identification process. Given this

congressional action, HCFA believed it was preferable to wait and evaluate the success of the new identification procedures in OBRA 1989 before continuing to pursue our recommendation to revise and resubmit its FY 1990 legislative proposal. However, HCFA now believes that obtaining coverage information directly from insurers, underwriters, third party administrators, and employers in the case of self-insured plans, is the most efficient way to identify MSP cases. The HCFA has revised and resubmitted its 1990 legislative proposal in its 1992 legislative proposals.

We believe that HHS has taken appropriate action on GAO's recommendation. Additional OIG follow-up is not needed.

GAO RECOMMENDATION 4

The Congress intended that regulations would be issued to ensure that employers acted in accordance with the MSP provisions. However, the GAO found that the Equal Employment Opportunity Commission (EEOC), the agency responsible for issuing the regulations, had not, nor did it plan to do so. Accordingly, the GAO recommended the Secretary of HHS direct the Administrator of HCFA to do the following: (1) enter into a memorandum of understanding with the EEOC on the type of cases to be referred and (2) to establish procedures for identifying and referring potential violations of section 4(g) of the Federal Age Discrimination in Employment Act to EEOC.

OFFICE OF AUDIT SERVICES' REVIEW OF RECOMMENDATION 4

This recommendation is no longer relevant. The OBRA 1989 repealed the provision in the Age Discrimination in Employment Act of 1967 which required employers to offer coverage under a group health plan to employees and their spouses age 65 to 69 under the same conditions as to any employees or spouses under age 65. The provision remains in the Social Security Act, with violations reportable to the IRS. The OBRA 1989 also enforced the existing IRS provision imposing an excise tax equal to 25 percent of the employer's expense incurred during the calendar year in all employer secondary situations, not just disability. Under

OBRA 1989, HCFA refers discrimination cases to the IRS for enforcement under the excise tax provisions.

We believe that legislation has obturated GAO's recommendation. Additional OIG follow-up is not needed.

GAO RECOMMENDATION

NOT AGREED TO BY HHS

This appendix contains the GAO recommendation with which HHS did not concur, comments from HHS, and an OIG update.

GAO RECOMMENDATION

In its report, GAO recommended "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."

HHS' RESPONSE TO GAO RECOMMENDATION

In response, HHS stated: "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 more successful and cost-effective as a method of identifying working aged/spousal beneficiaries than a data match with contractor private files."

OFFICE OF AUDIT SERVICES' REVIEW OF RECOMMENDATION

The HCFA tried to negotiate a contract amendment that would have required Medicare contractors to perform an electronic cross-match of their private insurance files with Medicare files in an effort to identify Medicare beneficiaries who had private coverage. The contractors claimed the proposed amendment would put them at a competitive disadvantage because other insurers would not be required to perform the same data match.

Because of congressional actions, HCFA abandoned its efforts. The OBRA 1989 contained a provision that prohibits the Secretary from requiring Medicare contractors to cross-match data to identify secondary cases.