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STATE OF NEW YORK
OFFICE OF THE STATE COMPTROLLER

July 29, 2002

Michael A. Stocker, M.D.
President and Chief Executive Officer
Empire Blue Cross and Blue Shield
3 Huntington Quadrangle
Melville, New York 11747

Re: Report 2002-F-16

Dear Dr. Stocker:

Pursuant to the State Comptroller's authority as set forth in Article V, Section 1 of the State Constitution and Article II, Section 8 of the State Finance Law, we have reviewed the actions taken by officials of Empire Blue Cross Blue Shield (Empire Blue Cross), as of July 9, 2002, to implement the recommendations contained in our audit report *New York State Health Insurance Program Coordination of Medicare Coverage* (Report 2000-S-20). Our report, which was issued on March 14, 2001, reviewed the effectiveness of the Empire Plan's (Plan) system for coordinating Medicare coverage for Plan enrollees and their spouses and dependents.

Background

The New York State Health Insurance Program (Program) provides coverage for hospitalization, surgical services and other medical expenses for over 790,000 active and retired State employees and dependents. The Program also covers over 376,000 active and retired employees and dependents of local governmental units and school districts that elect to participate. The Department of Civil Service (Department) contracts with insurance carriers to provide all aspects of health insurance coverage, and is responsible for managing and administering the Program. The Plan is the Program's primary health benefit plan, providing services at a total annual cost exceeding $2.5 billion. The Department contracts with Empire Blue Cross to administer the hospitalization portion of the Plan and with United HealthCare to administer major medical coverage. During the year ended December 31, 2001, Empire Blue Cross approved more than 816,000 claims totaling over $706 million and charged the State about $35.5 million for administrative and other related expenses.

Medicare is a federal health insurance program created in 1965 to provide medical coverage for people aged 65 or older. In 1973, Congress passed legislation to extend Medicare coverage to those who are disabled or suffer from chronic renal failure. For most eligible persons, Medicare

hospital insurance (Part A) is premium-free, and it pays most costs of inpatient hospital care and medically necessary care in a skilled nursing facility, hospice or home health care setting. Medicare medical insurance (Part B), which helps pay for doctor and outpatient hospital services and other products and services not covered by Part A, requires eligible persons to enroll and pay monthly premiums. Medicare requires individuals and providers of care to submit claims for payment timely (within 15 to 27 months, depending on the date of service).

When Plan members, including covered spouses and dependents, become eligible for primary Medicare coverage, the Plan can become the secondary payer of their medical expenses. Generally, the Plan becomes the secondary payer only for retirees. Thus, by identifying Medicare-primary Plan members, and coordinating payment of their claims with Medicare, the Plan can reduce its expenditures.

Summary Conclusions

In our prior audit, we found that because of weaknesses in the Plan's system for identifying Medicare eligibility, Empire Blue Cross paid claims totaling about $1.2 million that Medicare should have paid.

In our follow-up review, we found that Empire Blue Cross officials recovered $802,000 of claims that Medicare should have paid, and were unable to recover an additional $255,000 due to Medicare's time filing limits. We also found that Empire Blue Cross is working with the Department to improve the processing of Medicare-eligible claims.

Summary of Status of Prior Audit Recommendations

Of the two prior audit recommendations, Empire Blue Cross officials have implemented one recommendation and partially implemented one recommendation.

Follow-up Observations

Recommendation 1

Review the questionable claims identified by our audit. Recover costs for Medicare-eligible claims from the appropriate parties and remit the recoveries to the Plan.

Status – Implemented

Agency Action – In our prior audit, we estimated that Empire Blue Cross paid claims totaling between $1,077,803 and $1,294,339 that Medicare should have paid. According to Empire Blue Cross officials, based on their review of the entire population of potential findings, the actual overpaid amount was $1,057,000. The officials reported that they recovered $802,000, but were unable to recover the remaining $255,000 due to Medicare's time filing limits.

Recommendation 2

Continue working with the Department to develop a comprehensive system of procedures and internal controls to ensure all Medicare-eligible claims are processed appropriately.

Status – Partially Implemented

Agency Action – Empire Blue Cross officials stated they have procedures to identify and suspend claims for Plan members who are potentially eligible for Medicare due to age or End Stage Renal Disease (ESRD). These members are then investigated for Medicare eligibility before their claims are paid. Empire Blue Cross officials also indicated they routinely provide the Department with reports of Medicare eligibility inaccuracies discovered during claims processing. In addition, the officials stated they have been working on an agreement with the federal Centers for Medicare & Medicaid Services (CMS - formerly the Health Care Financing Administration) to acquire Medicare eligibility data.

During our follow-up review, Empire Blue Cross officials informed us that they analyzed a random sample of claim findings from a previous Coordination of Medicare Coverage audit (Report 99-S-14). Officials compared the diagnoses on the sampled claims to the top 10 chronic conditions for under 65 disabled Medicare beneficiaries, according to a report published by CMS. Empire Blue Cross officials stated their analysis revealed that the majority of diagnoses on the sampled claims were unrelated to the top 10 chronic conditions. However, in our judgment, Empire Blue Cross should perform a more comprehensive analysis, including a comparison of claim characteristics of disabled and non-disabled Medicare beneficiaries of a similar age group.

Major contributors to this report were Ronald Pisani, David Fleming and Maria Harasimowicz.

We would appreciate receiving your response to this report within 30 days, indicating any action planned or taken to address any unresolved matters discussed in this report. We also thank the management and staff of Empire Blue Cross for the courtesies and cooperation extended to our auditors during this review.

Yours truly,

Kevin McClune
Audit Director

cc: Deirdre A. Taylor, Division of the Budget
George Sinnott, Department of Civil Service
Josephine Hargis, Empire Blue Cross Blue Shield
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