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April 19, 1999

Dr. Michael A. Stocker
President and Chief Executive Officer
Empire Blue Cross and Blue Shield
622 Third Avenue
New York, NY 10017-6759

Mr. Channing Wheeler
CEO
United HealthCare Service Corporation
450 Columbus Boulevard
Hartford, CT 06115-0450

Re: New York State Health Insurance Program
Report 98-F-56

Dear Dr. Stocker and Mr. Wheeler:

According 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 reviewed the actions taken by officials of Empire Blue Cross and Blue Shield (Empire Blue Cross) and United HealthCare Service Corporation (UHC), as of March 15, 1999, to implement the recommendations included in our prior audit report, *New York State Health Insurance Program, Coordination of Medicare Coverage for Spouses and Dependents* (Report 96-S-62). Our report, which was issued on May 2, 1997, focused on the Empire Plan's (Plan) coordination of Medicare coverage for spouses and dependents for the year ended December 31, 1995.

Background

The New York State Health Insurance Program (Program) provides hospitalization, surgical services, and other medical and drug coverage to more than 750,000 active and retired State employees and their dependents. It also provides coverage for more than 280,000 other individuals who are either active or retired employees of participating local government units or school districts, as well as their dependents.

The Plan is the Program's primary health benefits plan, providing services to about 850,000 individuals in the Program at an annual cost of more than $1.6 billion. The Department of Civil Service (Department) contracts with Empire Blue Cross to administer the hospitalization portion of the Plan and with UUHC to administer major medical coverage. During the year ended December 31, 1995, Empire Blue Cross approved about 674,000 claims totaling more than $540 million and charged the State about $25.8 million for administrative and other related expenses. During that period, UHC (formerly MetraHealth) approved about 5.9 million claims totaling more than $687 million and charged the State approximately $96.9 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 eligible persons, Medicare hospital insurance (Part A) is premium-free, and it pays most of the cost of inpatient hospital care and medically-necessary care provided 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 on a timely basis (within 15 to 27 months after the care was provided, depending on the date of service).

When Plan members, including covered spouses and dependents, become eligible for Medicare coverage, Medicare becomes the primary payer of their medical expenses. Thus, by identifying Medicare-eligible spouses and dependents, 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 for spouses and dependents of Plan enrollees, Empire Blue Cross and UHC paid almost $739,000 for claims which Medicare should have paid. We also found that the Plan paid another $28,000 in error due to deficiencies in controls over enrollees' employment status.

In our follow-up review, we found that Empire Blue Cross and UHC officials have recovered only a small portion of the identified overpayments. In addition, further improvements are needed in identifying spouses and dependents of Plan enrollees who are Medicare eligible.

Summary of Status of Prior Audit Recommendations

In our prior report, we made two recommendations, which were directed to both Empire Blue Cross and UHC officials. We consider the two recommendations to have been partially

implemented. Empire Blue Cross officials recovered about $55,000 of approximately $78,000 in recoverable claims. However, UHC officials did not recover any of approximately $364,000 in recoverable claims.

Follow-up Observations

Recommendation 1

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

Status - Partially Implemented

Agency Action - In our prior audit, we estimated that Empire Blue Cross paid as the primary insurer about 200 claims, totaling almost $375,000 that were, instead, the responsibility of Medicare. Of the $375,000 in Empire Blue Cross claims, approximately $297,000 are not recoverable as a result a nationwide settlement agreement between several Blue Cross Blue Shield companies and the Federal Health Care Financing Administration (HCFA). According to the agreement, known as the Medicare Secondary Payer (MSP) Settlement, HCFA/Medicare released the participating Blue Cross Blue Shield companies from all MSP claims for services from January 1, 1983 to July 18, 1995. In return, the Blue Cross Blue Shield companies released HCFA/Medicare from all claims for reimbursement they had against Medicare.

Empire Blue Cross officials indicated that they recovered $55,163, but were unable to make further recoveries because of the MSP settlement.

In our prior audit, we also identified more than 4,500 UHC charges, totaling almost $364,000 that were, instead, the responsibility of Medicare. UHC officials have not recovered these improperly paid claims.

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 - In our prior audit and in earlier audits (Reports 94-S-26, 95-S-23 and 95-S-92) we found that claims were paid by the Plan, instead of by Medicare, because neither the Department nor the Plan's carriers had tracked Medicare entitlement data on a comprehensive basis during the audit period. To address this concern, Empire Blue Cross began a project in 1995 to electronically match the Plan's and HCFA's enrollment data

to better identify Medicare eligibles. The results were to be shared with UHC. However, as noted in our follow-up report 97-F-36, the matches were not all-inclusive and were not done on a regular basis. In addition, HCFA no longer allows Empire Blue Cross access to Medicare eligibility data, thus precluding this project until a formal data access agreement can be executed. Empire Blue Cross officials indicated that they are continuing to work with the Department to develop and refine a formal set of controls to ensure accurate tracking of Medicare eligibility. Department officials added that they have attempted to obtain Medicare eligibility data from HCFA, but were not yet granted approval for such access.

Contributors to this report were Frank Russo, Ronald Pisani, and Pamela Matthews.

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

Yours truly,

Kevin M. McClune
Audit Director

cc: Charles Conaway, Division of the Budget
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