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October 4, 1999

Michael A. Stocker, M.D.
President and Chief Executive Officer
Empire Blue Cross Blue Shield
622 Third Avenue
New York, NY 10017-6758

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

Re: Report 99-F-19

Dear Dr. Stocker and Mr. Wheeler:

Pursuant to the State Comptroller's authority as set forth 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) and United HealthCare Service Corporation (UHC), as of September 7, 1999 to implement the recommendations contained in our audit report, *New York State Health Insurance Program Coordination of Medicare Coverage* (Report 97-S-20). Our report, which was issued on April 29, 1998, 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 758,000 active and retired State employees and dependents. The Program also covers over 287,000 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 Empire Plan (Plan) is the Program's primary health benefit plan, providing services at a total annual cost exceeding $1.6 billion. The Department of Civil Service (Department) contracts with Empire Blue Cross to administer the hospitalization portion of the

Plan and with UHC to administer major medical coverage. During the year ended December 31, 1998, Empire Blue Cross approved over 650,000 claims totaling almost $500 million and charged the State more than $22 million for administrative and other related expenses. During this period, UHC approved over 7.7 million claims totaling more than $706 million and charged the State about $87.8 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 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 Medicare coverage, Medicare becomes the primary payer of their medical expenses. Thus, by identifying Medicare-eligible 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 and UHC paid claims totaling $3.2 million which Medicare should have paid.

In our follow-up review, we found that Empire Blue Cross and UHC officials have recovered only a small portion of the overpayments we identified. We also found that the Department has made progress in establishing an agreement with the Federal Health Care Financing Administration (HCFA) for acquiring Medicare eligibility data. This data would allow the Plan's carriers to more accurately coordinate claims with Medicare. However, until this agreement is finalized and eligibility data is exchanged, the Plan's carriers will continue to pay claims which Medicare should pay.

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. Empire Blue Cross and UHC officials have partially implemented these recommendations.

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 - Partially Implemented

Agency Action - In our prior audit we found that Empire Blue Cross paid claims totaling $1.59 million which Medicare should have paid. Empire Blue Cross officials reported that they recovered $261,901, but were unable to make further recoveries because of Medicare time filing requirements.

Empire Blue Cross officials informed us that while they were attempting to reestablish an agreement with HCFA to obtain Medicare eligibility data, the Medicare time filing deadline passed. As a result, Empire Blue Cross lost the ability to make further recoveries on the claims we identified. In our follow-up review, we found that the Medicare data Empire Blue Cross was seeking would only impact its ability to recover a portion of the claims in the population. However, Empire Blue Cross officials chose not to pursue the remaining claims. As a result, the officials lost the ability to make significant recoveries on these claims since the Medicare time filling deadline passed.

In our prior audit, we also found that UHC paid claims totaling $1.65 million which Medicare should have paid. UHC officials reported that they investigated and attempted to recover these overpayments. However, UHC officials have recovered only $123,945 of the estimated $1.65 million we identified.

Auditors' Comments - UHC's procedures for recovering improper payments need improvement. UHC's procedures for seeking recoveries include sending letters to providers requesting that the providers bill Medicare for the services that were improperly paid by the Plan. If and when the providers bill Medicare they are then requested to send UHC the explanation of Medicare benefits so that the Plan's secondary benefits can be determined. However, since the providers have already been paid by the Plan they lack the incentive to resubmit claims. As a result, many providers ignore UHC's request and do not bill Medicare; hence, the Medicare time filling deadline passes and the Plan's ability to recover is lost. For example, of the 59 charges in the audit sample that were determined to be overpaid, no recovery was made on 37 charges since the providers did not respond to UHC's request that claims be submitted to Medicare. In addition, UHC does not have procedures to ensure adequate follow-up with unresponsive providers. As a result, UHC did not follow-up on 28 of these 37 charges.

Since UHC has the ability to offset against future payments to participating providers, we believe that UHC should exercise this option. Doing so would eliminate UHC's reliance on uncooperative providers and would help to ensure that audit recoveries are maximized.

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, we found that neither the Department nor the carriers tracked Medicare entitlement data on a comprehensive basis. As a result, claims were paid by the Plan's carriers instead of by Medicare, since the carriers had no way to accurately identify Medicare-eligible Plan members.

Empire Blue Cross officials informed us that the Department is in the process of establishing an agreement with the Federal Health Care Financing Administration (HCFA) to acquire Medicare eligibility data. This data would help ensure that Medicare-eligible Plan members are identified and that claims for these individuals are coordinated appropriately. In addition, UHC officials informed us that they have been working on a separate agreement with HCFA to acquire Medicare eligibility data on a monthly basis. If an agreement is reached, UHC could identify Medicare eligibility on a more timely basis, thus reducing the impact of the Medicare time filing requirements on recoveries.

Major contributors to this report were Lee Eggleston, Ronald Pisani, Dennis Buckley, Dave Fleming and Douglas Abbott.

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 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
George Sinnott, Department of Civil Service
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