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December 28, 1999

Dr. Michael A. Stocker
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: New York State Health Insurance Program
Coordination of Medicare Coverage - 1998 Claims
Report 99-S-14

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 2, Section 8 of the State Finance Law, we audited hospitalization and major medical claims processed for the New York State Health Insurance Program's Empire Plan (Plan). The scope of our financial-related/compliance audit included medical claims of Plan members for the year ended December 31, 1998.

A. Background

The New York State Health Insurance Program (Program) provides hospitalization, surgical services and other medical and drug coverage to more than 758,000 active and retired State employees or their dependents. It also provides coverage for more than 287,000 other individuals who are either active and retired employees of participating local government units and school districts or dependents of such employees.

The Plan is the Program's primary health benefits plan, providing services to about 854,000 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 and Blue Shield (Empire Blue Cross) to administer the hospitalization portion of the Plan and with United HealthCare Service Corporation (UHC) to administer major medical coverage. During the year ended December 31, 1998, Empire Blue Cross approved over 650,000 claims totaling more than $499 million and charged the State about $22 million for administrative and other related expenses. During that period, UHC approved over 7.7 million claims totaling more than $706 million and charged the State about $88 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.

B. Audit Scope, Objective and Methodology

We audited the Plan's Medicare-related claims for the year ended December 31, 1998. The primary objective of our audit was to determine whether the Plan identifies Medicare eligibility when it processes medical claims for Medicare-eligible Plan enrollees and their spouses and dependents.

Our audit survey revealed that the Plan's enrollment system, for which the Department has primary responsibility, does not always capture Medicare eligibility information for Plan members. Therefore, we focused our audit on Plan members who were eligible for Medicare during the audit period according to Medicare eligibility data for Plan members obtained from the Federal Health Care Financing Administration (HCFA). We compared this information with Empire Blue Cross and UHC claims data to identify claims which were not properly coordinated with Medicare.

We did our audit according to generally accepted government auditing standards. Such standards require that we plan and do our audit to adequately assess those Department, Empire Blue Cross and UHC operations included in our audit scope. Further, these standards require that we understand the internal control systems of the Department, Empire Blue Cross and UHC, and that we review these entities' compliance with the laws, rules and regulations that are relevant to the operations included in our audit scope. An audit includes examining, on a test basis, evidence

supporting transactions recorded in the accounting and operating records and applying such other auditing procedures as we consider necessary in the circumstances. An audit also includes assessing the estimates, judgments and decisions made by management. We believe that our audit provides a reasonable basis for our findings, conclusions and recommendations.

We use a risk-based approach when selecting activities to be audited. This approach focuses on those operations that we identified through a preliminary survey as having the greatest probability for needing improvement. Consequently, by design, we use finite audit resources to identify where and how improvements can be made. Thus, we devote little audit effort to reviewing operations that may be relatively efficient or effective. As a result, we prepare our audit report on an "exception basis." This report, therefore, highlights those areas needing improvement and does not address activities that may be functioning properly.

C. Results of Audit

Because of weaknesses in the Plan's system for identifying Medicare eligibility, we estimate that, during the audit period, the Plan's two primary carriers, Empire Blue Cross and UHC, paid claims totaling $1.8 million which should have been paid by Medicare.

We provided preliminary reports of our audit findings to Empire Blue Cross and UHC officials, and considered their comments in preparing this report. Empire Blue Cross officials agree with our findings and informed us that they have already recovered $619,250 of the $1,090,000 we identified and are actively pursuing the remaining claims. Although UHC officials generally agree with our overpayment estimate, no recoveries have been made to-date. In addition, UHC officials disagree with our observations concerning its cost recovery process.

Inaccuracies in Medicare Eligibility Status

All Medicare-eligible Plan members should be identified so that their claims can be coordinated with Medicare, thereby significantly reducing costs chargeable to the Plan. To develop an estimate of the number of claims that were actually Medicare's responsibility during our audit period, we drew two statistical samples from the claims and charges paid by both Empire Blue Cross and UHC. We compared data from HCFA to claims information obtained from Empire Blue Cross and UHC, and identified 2,556 Empire Blue Cross claims and 35,584 UHC charges for which Medicare was the primary insurer. These claims and charges should have been submitted to Medicare since they were related to services provided to Plan members who were eligible for Medicare at the time services were delivered.

Since, in some instances, information that may affect the Medicare eligibility of a claim (e.g., employment status, certain medical conditions including end-stage renal disease etc.) was either inaccurate or unavailable on the records provided by Empire Blue Cross and UHC, we had to investigate each sampled claim to determine the extent of Medicare's responsibility. Empire Blue Cross and UHC officials provided us with the additional information required to assess these claims. Based on this review, we determined, with 95 percent confidence, that Empire Blue Cross paid as the primary insurer between $843,000 and $1,337,000 in claims (with a midpoint of $1,090,000) that were the responsibility of Medicare. We also determined with 95 percent

confidence that UHC paid as the primary insurer between $627,000 and $965,000 in charges (with a midpoint of $796,000) that were the responsibility of Medicare.

These claims were paid by the Plan, instead of by Medicare, because neither the Department nor the Plan's carriers tracked Medicare entitlement data on a comprehensive basis during the audit period. Empire Blue Cross officials informed us that the Department is in the process of establishing an agreement with HCFA to obtain Medicare eligibility data. However, since the agreement has not been finalized, approval for access to Medicare data has not yet been granted and no data has been exchanged. We encourage the Department and Plan carriers to pursue the agreement with HCFA to obtain Medicare data and to continue to work together to develop procedures to ensure that all Medicare-eligible claims are processed appropriately.

Cost Recovery Procedures

In our 1997 audit of the coordination of Medicare coverage (Report 98-S-17, issued March 8, 1999), we estimated, with 95 percent confidence, that Empire Blue Cross paid charges totaling between $825,000 and $1,013,000 (with a mid-point of $919,000) that were the responsibility of Medicare. Additionally, using the same statistical parameters, we reported that UHC paid charges totaling between $660,000 and $1,015,000 (with a midpoint of $838,000) that should have been paid by Medicare. A minimal portion of our estimated overpayments may not have been recoverable since the Plan sometimes has a secondary liability. As of September 1999, Empire Blue Cross reported that it had recovered $887,145 (96.5 percent of our mid-point estimate), while UHC reported that it had recovered $151,139 (about 18 percent of the mid-point estimate).

In our judgment, the low rate of recovery by UHC is due, in part, to UHC's cost recovery process. For example, instead of offsetting amounts of identified overpayments against future provider payments (a practice of other Plan carriers), UHC sends letters to the providers who billed the Plan incorrectly. The letters request the providers to bill Medicare for their services and to send UHC the Explanation of Medicare Benefits (EOMB) which the provider subsequently receives from Medicare. UHC uses the EOMB to determine the Plan's secondary liability and the amount that the provider must repay the State. This process is both inefficient and cumbersome. Further, as documented in a follow-up review of our 1996 audit of the coordination of Medicare coverage (Report 99-F-19, issued October 4, 1999), UHC does not systematically monitor the status of its request letters to determine whether providers are complying with UHC recovery efforts. In the follow-up review, it was found that most providers did not cooperate with UHC efforts. Thus, the payments these providers received from the Plan were not returned to the State.

Although UHC has the contractual ability to offset overpayment amounts against future payments to participating providers, it does not exercise this option. UHC officials stated that they consider offset procedures to be overly punitive for providers. UHC officials also said offset procedures are difficult for them to use when a provider does not bill Medicare, because UHC does not know the amount of the Plan's secondary liability. In these cases, UHC officials stated that they would need to estimate the amount of the Plan's secondary liability. UHC officials added that their estimation process for major medical claims is more involved than for the hospitalization claims processed by Empire Blue Cross. However, the Plan contains provisions for estimating the Medicare-approved amount and the Plan's secondary liability specifically for

these circumstances. Additionally, UHC claim processors estimate the Plan's secondary liability now on a pre-payment basis when they know an enrollee is Medicare-eligible. Although UHC officials stated there are "more variables" involved in estimating the Plan's secondary liability on a post-payment basis, they did not identify these variables.

In our judgment, UHC can significantly increase its cost recovery rate by using offset procedures with its network providers. Such procedures encourage the providers to bill Medicare as required, since failing to do so would result in an offset of the entire claim payment amount against a future payment.

Recommendations to Empire Blue Cross and UHC

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.*

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.*

Recommendation to UHC

3. *Improve procedures to maximize the recovery of overpayments identified by audits. In the case of participating providers, consider offsetting against future claim payments. For non-participating providers, monitor the status of request letters and follow-up with those providers who do not respond to the letters.*

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

We would appreciate receiving your response to the recommendations made in this report within 90 days, indicating any action planned or taken to implement them.

We wish to express our appreciation to the management and staff of Empire Blue Cross and UHC for the courtesies and cooperation extended to our auditors during this audit.

Yours truly,

Kevin M. McClune
Audit Director

cc: George Sinnott, Department of Civil Service
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