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STATE OF NEW YORK
OFFICE OF THE STATE COMPTROLLER

November 1, 2001

Dr. Michael A. Stocker
President and Chief Executive Officer
Empire Blue Cross Blue Shield
3 Huntington Quadrangle
Melville, NY 11747

Re: New York State Health Insurance Program
Coordination of Medicare Coverage
Report 2001-S-15

Dear Dr. Stocker:

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 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, 2000.

A. Background

The New York State Health Insurance Program (Program) provides hospital services, surgical services and other medical and drug coverage to more than 773,000 active and retired State employees and their dependents. It also provides coverage for more than 367,000 active and retired employees of participating local government units and school districts and dependents of such employees.

The Plan is the Program's primary health benefits plan, providing services to about 966,000 individuals in the Program at an annual cost of more than $2.2 billion. The Department of Civil Service (Department) contracts with Empire Blue Cross Blue Shield (Empire Blue Cross) to administer the hospitalization portion of the Plan. During the calendar year ended December 31, 2000, Empire Blue Cross approved about 783,000 claims totaling more than $638 million and charged the State about $28 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 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, 2000. 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 that we obtained from the federal Centers for Medicare and Medicaid Services (CMS). We compared this information with Empire Blue Cross claims data to identify claims that were not properly coordinated with Medicare. During this audit, we identified related matters that the Department, in its capacity as administrator of the Plan and the enrollment system, needs to address to improve the Plan's coordination with Medicare. We are informing the Department of these issues under separate cover.

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 and Empire Blue Cross operations included in our audit scope. Further, these standards require that we understand the internal control systems of the Department and Empire Blue Cross 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 reports 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, Empire Blue Cross paid claims totaling more than $2.2 million which should have been paid by Medicare.

We provided preliminary reports of our audit findings to Empire Blue Cross 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 $821,617 of the $2,272,360 we identified and are actively pursuing the remaining claims.

Inaccuracies in Medicare Eligibility Status

All Medicare-eligible Plan members should be identified so 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 Medicare's responsibility during our audit period, we drew a statistical sample from the claims paid by Empire Blue Cross. We compared data from CMS to claims information obtained from Empire Blue Cross and identified 2,430 Empire Blue Cross claims for which Medicare was potentially the primary insurer. To the extent Medicare was the primary insurer, these claims should have been submitted to Medicare.

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, we had to investigate each sampled claim to determine the extent of Medicare's responsibility. Empire Blue Cross officials provided us with additional information required to assess these claims. Based on our review, we determined, with 95 percent confidence, that Empire Blue Cross paid as the primary insurer between $1,914,073 and $2,630,647 in claims (with a midpoint of $2,272,360) that were appropriately the responsibility of Medicare.

These claims were paid by Empire Blue Cross, instead of by Medicare, because neither the Department nor Empire Blue Cross tracked Medicare entitlement data on a comprehensive basis during the audit period. Department officials informed us that they have recently obtained Medicare eligibility data through an agreement with CMS. However, the Department has not used this information to update its enrollment system or improve the Plan's ability to coordinate claim payments with Medicare. We encourage the Department and Empire Blue Cross to continue to work together to develop procedures to ensure that all Medicare-eligible claims are processed appropriately. The use of the Medicare data obtained from CMS could provide the basis for such procedures. As previously stated, we are addressing these matters separately with the Department.

Recommendations

1. *Review the population of questionable claims from which we estimated that $2,272,360 was overpaid. 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 improve the processing of Medicare-eligible claims. Address such areas as:*

    - *Pursuing federal Medicare eligibility data so the Plan's enrollment system reflects accurate Medicare information.*

    - *Updating the Plan's enrollment system with the Medicare eligibility information identified in our audit.*

Major contributors to this report were Lee Eggleston, Ronald Pisani, Dennis Buckley 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 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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