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STATE OF NEW YORK
OFFICE OF THE STATE COMPTROLLER

February 25, 2004

Mr. Frank J. Branchini
President and Chief Executive Officer
Group Health Incorporated
441 Ninth Avenue
New York, New York 10001

Re: Report 2003-F-27

Dear Mr. Branchini:

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 Group Health Incorporated (GHI) as of November 13, 2003, to implement the recommendations contained in our audit report, *New York State Health Insurance Program: Coordination of Medicare Coverage* (Report 2001-S-17). Our report, which was issued on February 28, 2002, reviewed the effectiveness of the system used by the Empire Plan (Plan) of the New York State Health Insurance Program (Program) for coordinating medical claim payments on behalf of Medicare-eligible enrollees and their spouses and dependents.

Background

The Program provides hospital and surgical services and other medical and drug coverage to more than 796,000 active and retired employees of New York (State) and their dependents. It also provides coverage for more than 392,000 active or retired employees of participating local government units and school districts and their dependents.

The Plan is the Program's primary health benefit plan, providing services at an annual cost of more than $2.9 billion. The Department of Civil Service (Department) contracts with GHI to administer the mental health and substance abuse portion of the Plan. During the year that ended on December 31, 2002, GHI approved more than 520,000 claims totaling more than $61 million, and also charged the State about $14.4 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 that extended Medicare coverage to those who are disabled or suffer from end-stage renal disease. 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, is optional and requires eligible persons to enroll and pay monthly premiums. Medicare requires individuals and care-providers to submit claims for payment in a timely manner (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. 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 examined the claims for services relating to mental health and substance abuse that were paid during the year 2000 by the Plan on behalf of people who were eligible for Medicare and estimated that $329,539 of these claims should have been paid by Medicare.

In our follow-up review, we found that GHI officials had recovered just $11,007 in claims that Medicare should have paid. We also found that GHI did not work with the Department to pursue recovery of claims for members eligible for Medicare Part B, but who were not enrolled. Although we found that GHI is working with the Department to improve the processing of Medicare-eligible claims, GHI could have done more with the Medicare-eligibility information identified in our audit.

Summary of Status of Prior Audit Recommendations

Of the three prior audit recommendations, GHI officials have not implemented two recommendations and partially implemented one recommendation.

Follow-up Observations

Recommendation 1

Review the population of questionable claims from which we estimated that $329,539 was overpaid. Recover costs for Medicare-eligible claims from the appropriate parties and remit the recoveries to the Plan.

Status - Not Implemented

Agency Action - Our prior audit estimated that GHI paid between $314,972 and $344,105 in claims (with a mid-point of $329,539) for which Medicare should have taken responsibility. GHI officials said they have recovered just $11,007. This low rate of recovery by GHI is due, in part, to GHI's cost-recovery process. GHI officials informed us that they do not offset amounts of identified overpayments against future participating provider payments (a practice of the Plan's other carriers). GHI officials also informed us that, at the time of our prior audit, they did not rely on the Medicare eligibility information that we obtained from the Medicare program. Rather, GHI first confirmed Medicare eligibility with Plan members, and

initiated recovery efforts only for Plan members who positively confirmed their Medicare eligibility. During our follow-up review, GHI officials informed us that they had changed their cost recovery procedures. They added that they will now rely on the Medicare-eligibility information identified in our audits, and will no longer perform the unnecessary member confirmations.

Recommendation 2

For the claims attributed to members who are eligible for Medicare Part B, but not enrolled, work with the Department to pursue recovery of claims, where appropriate.

Status - Not Implemented

Agency Action - In our prior audit, we found claims paid on behalf of Plan members who were eligible for primary Medicare coverage, but had failed to enroll in Medicare Part B. We recognize that these claims are not recoverable from Medicare. However, some of these claims may have been recoverable from the Plan members. GHI officials indicated that a Department "hold-harmless" policy precludes cost recovery from these members. However, the Department's policy applies only to Plan members who have not been notified properly of the need to enroll in Medicare. In addition, these Plan members need to appeal to the Department to be held harmless. According to Department officials, GHI did not work with them to determine which Plan members should be held harmless from recovery.

Recommendation 3

Work 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 that the Plan's enrollment system reflects accurate Medicare information;*
- *Enrolling in Part B the Medicare-eligible members identified in our audit; and*
- *Updating the Plan's enrollment system with the Medicare eligibility information identified in our audit.*

Status - Partially Implemented

Agency Action - In our prior audit, we found that neither the Department nor the Plan's carriers was tracking Medicare entitlement data on a comprehensive basis. In addition, as we previously noted, GHI did not rely on the Medicare eligibility information we provided them during our audit. Instead, GHI attempted to confirm Medicare eligibility status directly with the members. As a result, GHI provided the Department only with copies of correspondence from members who had positively confirmed their Medicare eligibility. Although the Department is ultimately responsible for maintaining the enrollment system, and incorporating Medicare entitlement data into the enrollment system, the Plan's carriers also have a role in

ensuring that claims are coordinated properly with Medicare. GHI officials informed us that they are working to improve their Medicare-coordination procedures. For example, GHI is pursuing an agreement with the Federal Center for Medicare and Medicaid Services to obtain Medicare eligibility data. Such an agreement could significantly improve GHI's ability to identify Medicare-eligible members, and to coordinate its claims properly with Medicare.

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

We would appreciate your response to this report within 30 days, indicating any actions planned to address the unresolved issues discussed in this report. We also thank the management and staff of Group Health Incorporated for the courtesies and cooperation extended to our auditors during this review.

Very truly yours,

Frank J. Houston
Audit Director

cc: George Sinnott, Department of Civil Service
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