April 30, 1996

Mrs. Jeannette Conte
Vice President
New York State Division
Empire Blue Cross and
Blue Shield Center
11 Corporate Woods Boulevard
Albany, NY 12211

Mr. John Toohey
Vice President
Metropolitan Life Insurance Company
New York State Division
Rensselaer Information Systems
500 Jordan Road
Troy, NY 12180

Re: New York State Health Insurance Program Coordination of Medicare Coverage Report 95-S-92

Dear Mrs. Conte and Mr. Toohey:

Pursuant to the State Comptroller's authority as set forth in Section 1, Article V of the State Constitution and Section 8, Article 2 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 a review of the adequacy of Medicare eligibility information the Plan maintains for its enrollees, which is used for claims paid by the Plan's two primary carriers, Empire Blue Cross and Blue Shield (Empire Blue Cross) and Metropolitan Life (Metropolitan), for the year ended December 31, 1994.

The primary objective of our audit was to determine whether Medicare eligibility is identified when Plan claims are processed.

Summary Results of Audit

Because of weaknesses in the Plan's system for identifying Medicare eligibility, we estimate the Plan's two primary carriers paid almost $3.2 million during the audit period for claims that the Medicare Program should have paid. We also determined that the Plan has paid another $248,000 in error due to deficiencies in controls over employment status.

We provided preliminary reports of our audit findings to Empire Blue Cross and Metropolitan officials and we considered their comments in preparing this report. Generally, officials from both carriers agree with our findings.

Background

The New York State Health Insurance Program (Program) provides hospitalization, surgical services and other medical and drug coverage for more than 745,000 active and retired State employees and their dependents. It also provides coverage for almost 326,000 active and retired employees of local government units and school districts that elect to participate and the enrollees' dependents. These entities are called participating agencies (PAs).

The Plan is the Program's primary health benefits plan, providing services to about 887,000 individuals in the Program at an annual cost of more than $1.4 billion. The Department of Civil Service (Department), through its Division of Employee Benefits (Division), contracts with Empire Blue Cross to administer the hospitalization portion of the Plan and with Metropolitan to administer major medical coverage. During the year ended December 31, 1994, Empire Blue Cross approved about 589,000 claims totaling more than $452 million and charged the State about $23.4 million for administrative and other related expenses. During that period, Metropolitan approved about 5.4 million claims totaling more than $624 million and charged the State approximately $97.1 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. Medicare hospital insurance (Part A) is premium-free to those who qualify and pays most costs for inpatient hospital care and medically necessary care in a skilled nursing facility, hospice, or home health care setting. Medicare medical insurance (Part B) helps pay for doctor and outpatient hospital services and other products and services not covered by Part A. Part B coverage requires those who are eligible to enroll and pay monthly premiums. Medicare requires individuals and providers of care to submit claims timely, within 15 to 27 months depending on the date of service, to be considered for payment.

Section 167-a of the Civil Service Law requires employers in the Plan to pay Medicare-eligible enrollees for the cost of monthly Part B premiums when Medicare would be the primary payer of these enrollees' medical expenses. The Department puts indicators, called Medicare credits, on the enrollment records of those Plan members it knows are Medicare's responsibility, and who are employed by or retired from State agencies. These Medicare credits generate either Part B premium payments through the State retirement or payroll systems, or reductions in Plan premiums charged to the enrollees. Medicare credits are not posted to the records of PA members because those agencies pay their employees and retirees directly for the cost of Part B premiums.

When Plan members become eligible for Medicare coverage due to renal failure, or are retired and eligible due to age or disability, Medicare becomes the primary payer of their medical expenses. Thus, by identifying Medicare-eligible enrollees, and coordinating their hospitalization claims with the Medicare Program, the Plan can significantly reduce its health benefits expenditures.

Audit Methodology

Our audit survey revealed that the Plan's enrollment system, which is primarily the responsibility of the Department, does not capture Medicare eligibility information for Plan enrollees. Accordingly, we focused our audit on Plan enrollees who were eligible for Medicare during the audit period. We obtained Medicare eligibility data for these enrollees from the Federal Health Care Financing Administration (HCFA) and retirement data from the two major retirement systems whose retirees the Plan covers: the New York State Employees' Retirement System (ERS) and the New York State Teachers' Retirement System (TRS). We compared this information with Empire Blue Cross and Metropolitan claims data and records from the Plan's enrollment system to identify claims that were not properly coordinated with Medicare.

We conducted our audit according to generally accepted government auditing standards. Such standards require that we plan and perform our audit to adequately assess those operations which we include within our audit scope. Further, these standards require that we understand the internal control structure and review compliance with applicable laws, rules and regulations that are relevant to the operations which are 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.

Our consideration of the internal control structures at the Department, Empire Blue Cross and Metropolitan focused on administrative controls, which we define as the procedures concerned with the decision-making processes leading to management's authorization of transactions. Specifically, these controls relate to claim payment decisions. Our audit identified improvements needed in these areas which we further describe in the "Medicare Eligibility Status Inaccuracies " and "Employment Status Inaccuracies" sections of this report.

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.

Major contributors to this report were David R. Hancox, Carmen Maldonado, Frank Russo, Ronald Pisani, Pamela Matthews, David Fleming, and James Nellegar.

Medicare Eligibility Status Inaccuracies

All Medicare-eligible Plan enrollees should be identified so that their claims can be coordinated

with Medicare, thereby significantly reducing costs chargeable to the Plan. We compared data from HCFA, ERS and TRS to claims information obtained from Empire Blue Cross and Metropolitan and identified more than 9,000 charges involving Medicare-eligible enrollees.

We identified 3,482 claims where Medicare eligibility preceded the date service was provided to the enrollees. These charges should have been submitted to Medicare, since Medicare was the primary insurer. In some circumstances, information that may affect the Medicare eligibility of a hospitalization claim is not available from the Empire Blue Cross record, such as when an enrollee has received service in a Veteran's Administration hospital. Also, Medicare benefits may be exhausted, which cannot be determined until a claim has been submitted to Medicare. Therefore, each claim must be investigated to determine Medicare's responsibility. To develop an estimate of the actual number of those claims that are Medicare's responsibility, we reviewed a statistical sample with Empire Blue Cross officials. Based on this review, we estimate that Empire Blue Cross paid 1,151 claims, totaling $2.5 million, that should have been paid by Medicare.

We found that Metropolitan paid 8,309 charges for $672,267 that Medicare should have payed. We believe additional charges totaling $62,259 may have been paid in error; however, Metropolitan officials decided that pursuing these charges would not be cost-effective.

These exceptions occurred because the Plan's enrollment system database does not capture Medicare eligibility information. However, during our audit, Empire Blue Cross reached an agreement with HCFA to obtain Medicare eligibility information for New York State enrollees. Empire Blue Cross will share Medicare eligibility data with Metropolitan. This new process should ensure that the Plan's carriers have current Medicare information for claims processing. We encourage the Plan's carriers and the Department to continue working together to ensure all Medicare-eligible charges are processed appropriately.

Employment Status Inaccuracies

Generally, Medicare becomes the primary payer of medical expenses when Medicare-eligible enrollees are retired. Because the Plan's carriers rely on the Department's enrollment system to determine whether enrollees were retired or actively employed at the date of service, the enrollment system must accurately reflect retirement dates.

We obtained retirement dates for all enrollees receiving a retirement benefit from the ERS or TRS and compared these dates with the dates of service on claims for Medicare-eligible enrollees paid by Empire Blue Cross and Metropolitan. For claims where Medicare enrollees were listed as actively employed on the Plan's enrollment system, but retired according to retirement information, we investigated employment status. We reviewed payroll records maintained by the State Comptroller's Office to verify employment status for State employees. In addition, we contacted health benefit administrators at the PAs to verify employment status for PA employees. We identified 135 enrollees listed on the Department's enrollment system as actively employed although they were retired at the date of service. Based on our review of these enrollees' claims, we identified 1,652 Plan charges totaling $248,000 that Medicare could have paid. However, because Medicare's time filing limit on some of these charges has expired, only $117,000 of the charges are recoverable.

As with the "Medicare Eligibility Status Inaccuracies" section of this report, these exceptions occurred because the Plan's enrollment system database does not contain accurate eligibility

information.

Recommendations to Empire Blue Cross and Metropolitan

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

2. *Continue efforts to develop a comprehensive system of procedures and internal controls to ensure all Medicare-eligible claims are processed appropriately.*

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 Metropolitan for the courtesies and cooperation extended to our auditors during this examination.

Very truly yours,

Robert H. Attmore
Deputy Comptroller

cc: George Sinnott, Department of Civil Service
Patricia A. Woodworth, Division of the Budget