H. CARL MCCALL
STATE COMPTROLLER

A.E. SMITH STATE OFFICE BUILDING
ALBANY, NEW YORK 12236

STATE OF NEW YORK
**OFFICE OF THE STATE COMPTROLLER**

December 5, 1996

Dr. Michael A. Stocker
President
Empire Blue Cross Blue Shield
622 Third Avenue
New York, NY 10017-6758

Re: Report 96-F-7

Dear Dr. Stocker:

According 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 reviewed the actions taken by officials of Empire Blue Cross Blue Shield (Empire Blue Cross), as of October 9, 1996, to implement the recommendations included in our prior audit report 94-S-26, issued on August 12, 1994, concerning hospitalization claims processed on behalf of the State Employees Health Insurance Program's Empire Plan (Plan).

## Background

The State Employees Health Insurance Program (Program) provides hospitalization, surgical services, and other medical and drug coverage for over 700,000 active and retired State employees and dependents. It also provides coverage for over 300,000 active and retired employees and dependents of local government units and school districts that elect to participate. These entities are referred to as participating agencies (PAs).

The Plan is the State's primary health benefit plan, providing services to about 890,000 enrollees at an annual cost which exceeds $1.6 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. During the year ended December 31, 1995, Empire Blue Cross approved over 670,000 claims totaling more than $540 million and charged the State about $26 million for administrative and other related expenses.

Medicare is a Federal health insurance program created in 1966 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 providers to submit claims timely, within 15 to 27 months, depending on the date of service.

When retired Plan enrollees become eligible for Medicare coverage due to a disability, and apply for Medicare benefits in a timely manner, Medicare becomes the primary payer of their medical expenses. Thus, by identifying Medicare-eligible enrollees, and coordinating their hospitalization and medical claims with the Medicare Program, health benefit expenditures chargeable to the Plan can be significantly reduced.

Section 167-a of Civil Service Law requires employers in the Plan to pay Medicare-eligible enrollees for the cost of monthly Part B premiums. The Department posts indicators, called Medicare credits, to the enrollment records of enrollees it knows are Medicare-eligible and are employed or retired from State agencies. Using the Medicare credit, the State then generates a payment to the enrollee through the State payroll system. No Medicare credits are posted to the records of PA enrollees because those agencies pay their own employees and retirees directly.

**Summary Conclusion**

In our prior audit, we concluded that because of weaknesses in the Plan's system of controls, the Plan paid more than $7 million for claims of almost 3,000 disabled enrollees, whose medical care expenses were primarily the responsibility of the Medicare Program.

In our follow-up review, we found that Empire Blue Cross officials have made significant progress in improving the Plan's system of controls. Procedures are in place, or are in the process of being developed, for identifying Plan enrollees whose medical care expenses are primarily the responsibility of the Medicare program. In addition, Empire Blue Cross officials have recovered over $3.5 million from the Medicare program for claims identified in the prior audit as having been inappropriately paid by the Plan.

**Summary of Status of Implementation**

Empire Blue Cross officials have fully implemented three, and partially implemented one of our four prior audit recommendations.

**Follow-up Observations**

**Recommendation 1**

*Work with the Department to establish a comprehensive system of controls that will establish and maintain the status of each enrollee's Medicare eligibility and ensure Medicare-eligible claims are processed appropriately.*

Status - Partially Implemented.

Empire Blue Cross Action - Empire Blue Cross officials are conducting a matching program to identify Plan enrollees who are or have been Medicare eligible. This matching program is a two-phase process. Phase I is focusing on enrollees under the age of 65. In May 1995, a match was performed. Over 300,000 enrollees were checked for Medicare eligibility, and 5,539 were found to be currently Medicare-eligible or at one time were Medicare-eligible. Phase II will expand upon phase I by matching under age 65 enrollees against any subsequent Medicare updates, and adding enrollees 65 and over without Medicare information to the enrollment files. Eventually, Empire Blue Cross officials hope to include spouses and dependents in the match.

Auditors' Comments - Empire Blue Cross officials have made significant progress in implementing this recommendation. However, a major portion of the match, phase II, has just recently begun. Additionally, the match described only includes Medicare records for the northeastern United States, and many Plan enrollees reside outside the northeast. Therefore, such enrollees would not be identified from the match. Blue Cross officials are unsure if it would be cost effective to do a match with Medicare records outside the northeast. We believe Empire Blue Cross should complete the match so that an accurate cost benefit analysis can be made.

**Recommendation 2**

*Recover all appropriate funds and remit those recoveries to the State.*

Status - Fully Implemented.

Empire Blue Cross Action - As of July 2, 1996, Empire Blue Cross officials have recovered over $3.5 million from Medicare. Any future recoveries are on hold pending the outcome of a nationwide agreement recently reached between the Blue Cross Blue Shield Association, and the Health Care Financing Administration and Medicare (HCFA/Medicare). The agreement was reached on behalf of certain Blue Cross Blue Shield Plans, including Empire Blue Cross Blue Shield. Under the agreement HCFA/Medicare releases the Empire Plan from any claims inappropriately paid by Medicare for the period January 1, 1983 to July 18, 1995. In return, the Empire Plan releases HCFA/Medicare from claims paid by Empire Blue Cross that should have been paid by Medicare for the same period. The Empire Plan was not required to participate in this agreement. However, the decision to opt into the agreement was recently made by the Department of Civil Services' Division of Employee Benefits. Therefore, any additional recoveries associated with audit report 94-S-26 cannot be fully determined at this time.

**Recommendation 3**

*Review all existing information which may indicate an enrollee is Medicare eligible.*

Status - Fully Implemented.

Empire Blue Cross Action - Exceptions identified from the matching program discussed in Recommendation 1 are manually reviewed by the Membership Department at Empire Blue Cross. Cases where Medicare is the primary carrier are referred to the Department, and the enrollee's enrollment record is updated. Also, when claims are processed, a manual review to determine Medicare eligibility is conducted when an enrollee has had claims paid by Medicare in the past, regardless of the enrollee's current enrollment record.

**Recommendation 4**

*Inform the Department of all enrollment system errors discovered during claims processing.*

Status - Fully Implemented.

Empire Blue Cross Action - Monthly notifications are sent to the Department regarding situations when a Plan enrollee/dependent is entitled to Medicare and previous Medicare eligibility was not reflected in the enrollee/dependent records. These situations are identified during claims processing or in the matching process discussed in Recommendation 1.

Major contributors to this report were Carmen Maldonado, Frank Russo, Brian Reilly and Robert Backus.

We would appreciate 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 Empire Blue Cross for the courtesies and cooperation extended to our auditors during this review.

Yours truly,

David R. Hancox
Director of State Audits

cc: Patricia Woodworth
George C. Sinnott
Jeannette Conte