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April 29, 1998

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

Dr. William W. McGuire
President, Chairman & CEO
United Health Care Service Corporation
9900 Bren Road East
Minnetonka, MN 55343

Re: New York State Health Insurance Program
Coordination of Medicare Coverage
Report 97-S-20

Dear Dr. Stocker and Dr. McGuire:

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 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, 1996.

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.

Summary 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 Blue Shield (Empire Blue Cross) and United Health Care Service Corporation (UHC), paid claims totaling $3.2 million which Medicare should have paid.

We provided preliminary reports of our audit findings to Empire Blue Cross and UHC 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 to more than 750,000 active and retired State employees and their dependents. It also provides coverage for more than 280,000 other individuals, who are active and retired employees of participating local government units and school districts and their dependents.

The Plan is the Program's primary health benefits plan, providing services to about 850,000 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 to administer the hospitalization portion of the Plan and with UHC to administer major medical coverage. During the year ended December 31, 1996, Empire Blue Cross approved about 621,000 claims totaling more than $508 million and charged the State about $25 million for administrative and other related expenses. During that period, UHC approved about 6.5 million claims totaling more than $704 million and charged the State about $87.4 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 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.

Audit Methodology

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. Accordingly, we focused our audit on Plan members who were eligible for Medicare during the audit period. We obtained Medicare eligibility data for Plan members from the Federal Health Care Financing Administration (HCFA). We compared this information with Empire Blue Cross and UHC claims data and records from the Plan's enrollment system 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 operations which are included within our audit scope. Further, these standards require that we understand the internal control system and review 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.

In planning and doing our audit, we considered internal control systems at the Department, Empire Blue Cross and UHC. Our consideration of the internal control systems focused on the controls related to claim payment decisions.

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.

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. We compared data from HCFA to claims information obtained from Empire Blue Cross and UHC, and identified 2,101 Empire Blue Cross claims and 45,356 UHC charges related to services provided to Plan members who were eligible for Medicare at the time the services were delivered. These claims were not submitted to Medicare, although Medicare was the primary insurer. However, since a number of factors can affect the payment of such claims, each claim must be investigated to determine the extent of Medicare's responsibility. For example, in some circumstances, information that may affect the Medicare eligibility of a claim - such as a claim adjustment prior to our postpayment audit - is not available on the records we received from Empire Blue Cross and UHC. Also, Medicare benefits may be exhausted, a fact that cannot be determined until a claim has been submitted to Medicare.

To develop an estimate of the number of claims that were actually Medicare's responsibility during our audit period, we statistically sampled the claims we identified and reviewed the selected claims with UHC and Empire Blue Cross officials, who provided us with additional information. Based on this review, we determined with 95 percent confidence, that UHC paid as the primary insurer between $1.39 million and $1.91 million in charges (with a midpoint of $1.65 million), that were the responsibility of Medicare. We also determined with 95 percent confidence, that Empire Blue Cross paid as the primary insurer between $1.4 million and $1.78 million in claims (with a midpoint of $1.59 million), 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. In 1995, Empire Blue Cross initiated a project to electronically match the Plan's enrollment data with HCFA eligibility files. Through this match, Empire Blue Cross intended to better identify Medicare-eligible Plan enrollees, and to share this eligibility data with UHC. However, as detailed in our audit report 97-F-36, Empire Blue Cross did not perform the matches on a regular basis, and the matches did not identify all Medicare-eligible enrollees, spouses and dependents. As a result, the Plan's carriers do not have current Medicare information for use in claims processing. We encourage the Department and Plan carriers to continue to work together to ensure that all Medicare-eligible claims are processed appropriately.

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.*

Major contributors to this report were William Challice, Frank Russo, Ronald Pisani, Pamela Matthews and David Fleming.

We would appreciate receiving a 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 examination.

Yours truly,

Carmen Maldonado

Carmen Maldonado
Audit Director

cc: George Sinnott, Department of Civil Service
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