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March 8, 1999

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 HealthCare Service Corporation
9900 Bren Road East
Minnetonka, MN 55343

Re: New York State Health Insurance Program
Coordination of Medicare Coverage
Report 98-S-17

Dear Dr. Stocker and Dr. McGuire:

According 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 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 that ended on December 31, 1997.

A. 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 either active or retired employees of participating local government units or school districts, as well as 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 Blue Shield (Empire Blue Cross) to administer the hospitalization portion of the Plan and with United HealthCare Service Corporation (UHC) to administer major medical coverage. During the year that ended on December 31, 1997, Empire Blue Cross approved about 672,000 claims totaling more than $503 million and charged the State about $26 million for administrative and other related expenses. During that period, UHC approved about 7.5 million claims totaling approximately $702 million and charged the State about $88 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 of the costs of inpatient hospital care and medically-necessary care provided 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 on a timely basis (within 15 to 27 months after the care was provided, 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, 1997. 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. Accordingly, we focused our audit on Plan members who were eligible for Medicare during the audit period. To identify claims that had not been coordinated properly with Medicare, we obtained Medicare-eligibility data for Plan members from the Federal Health Care Financing Administration (HCFA), and compared this information with Empire Blue Cross and UHC claims data and records from the Plan's enrollment system.

We conducted our audit in accordance with generally accepted government auditing standards. Such standards require that we plan and conduct 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 conducting 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.

C. 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 and UHC, paid claims totaling $1.7 million -- an amount that should have been reimbursed by Medicare.

We provided preliminary reports of our audit findings to Empire Blue Cross and UHC officials, and considered their comments in preparing this report. Officials from both carriers generally agreed with our findings.

Inaccuracies in Medicare Eligibility Status

All Medicare-eligible Plan members should be identified so that their claims can be coordinated with Medicare, thereby reducing costs chargeable to the Plan. We compared data from HCFA with claims information obtained from Empire Blue Cross and UHC, and identified 999 Empire Blue Cross claims and 30,832 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 made before our postpayment audit - is not available on the records we received from Empire Blue Cross and UHC. In addition, 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, as the primary insurer, had paid between $660,000 and $1,015,000 in charges (with a midpoint of $838,000) that were actually the responsibility of Medicare. We also determined, with 95 percent confidence, that Empire Blue Cross, as the primary insurer, had paid between $825,000 and $1,013,000 in claims (with a midpoint of $919,000) 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 had tracked Medicare entitlement data on a comprehensive basis during the audit period. Department officials informed us that they have attempted to obtain access to Medicare eligibility data from HCFA. However, they said HCFA has not yet granted approval for such access. 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. *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 that all Medicare-eligible claims are processed appropriately*.

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

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

Yours truly,

Kevin M. McClune
Audit Director

cc: George Sinnott, Department of Civil Service
Robert L. King, Division of the Budget
Jeanette Conte, Empire Blue Cross Blue Shield

M. Laurie Wasserstein, United HealthCare Service Corporation