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STATE OF NEW YORK
OFFICE OF THE STATE COMPTROLLER

November 8, 2001

Michael A. Stocker, M.D.
President and Chief Executive Officer
Empire Blue Cross and Blue Shield
3 Huntington Quadrangle
Melville, New York 11747

Mr. Channing Wheeler
Chief Executive Officer
United HealthCare
450 Columbus Boulevard
Hartford, CT 06115-0450

Re: Report 2001-F-36

Dear Dr. Stocker and Mr. Wheeler:

Pursuant to the State Comptroller's authority as set forth 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 Empire Blue Cross Blue Shield (Empire Blue Cross) and United HealthCare (UHC), as of October 9, 2001 to implement the recommendations contained in our audit report *New York State Health Insurance Program Coordination of Medicare Coverage - 1998 Claims* (Report 99-S-14). Our report, which was issued on December 28, 1999, reviewed the effectiveness of the Empire Plan's system for coordinating Medicare coverage for Plan enrollees and their spouses and dependents.

Background

The New York State Health Insurance Program (Program) provides coverage for hospitalization, surgical services and other medical expenses for over 773,000 active and retired State employees and dependents. The Program also covers over 367,000 active and retired employees and dependents of local governmental units and school districts that elect to participate. The Department of Civil Service (Department) contracts with insurance carriers to provide all aspects of health insurance coverage, and is responsible for managing and administering the Program. The Empire Plan (Plan) is the Program's primary health benefit plan, providing services at a total annual cost exceeding $2.2 billion. The 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, 2000, Empire Blue Cross approved about 783,000 claims totaling over $638 million and charged the State more than $28 million for administrative and other related expenses. During this period, UHC approved over 8.87 million claims totaling more than $817 million and charged the State about $87 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 most eligible persons, Medicare hospital insurance (Part A) is premium-free, and 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 primary Medicare coverage, the Plan becomes the secondary payer of their medical expenses. Generally, Medicare becomes the primary payer only for retirees. Thus, by identifying Medicare-primary Plan members, and coordinating payment of their claims with Medicare, the Plan can reduce its expenditures.

Summary Conclusions

In our prior audit, we found that because of weaknesses in the Plan's system for identifying Medicare eligibility, Empire Blue Cross and UHC paid claims totaling about $1.9 million that Medicare should have paid.

In our follow-up review, we found that Empire Blue Cross officials recovered $945,000, which falls within the dollar range of claims we estimated that Medicare should have paid. UHC officials recovered $536,229, which is less than the dollar range of claims we estimated that Medicare should have paid. However, we noted that UHC has made significant improvements in its procedures to recover overpayments, although further improvements are possible. We also found that both Empire Blue Cross and UHC are working with the Department to improve their processing of Medicare-eligible claims.

Summary of Status of Prior Audit Recommendations

In our prior report, we made two recommendations that were directed to both Empire Blue Cross and UHC officials, and one recommendation that was directed solely to UHC officials. Empire Blue Cross officials have fully implemented one recommendation, and partially implemented one recommendation. UHC officials have partially implemented three recommendations.

Follow-up Observations

Recommendation 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.

Status - Empire Blue Cross - Fully Implemented
United HealthCare - Partially Implemented

Agency Action - In our prior audit, we estimated that Empire Blue Cross paid claims totaling between $843,000 and $1,337,000 that Medicare should have paid. Empire Blue Cross officials indicated that they recovered $945,176, which is within this range.

In our prior audit, we estimated that UHC paid between $627,000 and $965,000 in claims that Medicare should have paid. UHC officials indicated that they recovered $536,229, which is below this range.

Recommendation 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.

Status - Empire Blue Cross - Partially Implemented
United HealthCare - Partially Implemented

Agency Action - In our prior audit, we found that neither the Department nor the Plan's carriers tracked Medicare entitlement data on a comprehensive basis. While the Department is directly 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 claims are properly coordinated with Medicare. Both Empire Blue Cross and UHC have taken steps to increase assurance that claims are properly coordinated with Medicare. For example, both Empire Blue Cross and UHC officials stated they have procedures to identify and suspend claims with no indication of Medicare eligibility for Plan members who are potentially eligible for Medicare due to age or End Stage Renal Disease (ESRD). These members are then investigated for Medicare eligibility before the claims are paid. The carriers also indicated they routinely provide the Department with reports of Medicare eligibility inaccuracies discovered during claims processing. In addition, UHC officials stated they have been working on an agreement with the federal Centers for Medicare and Medicaid Services (formerly the Health Care Financing Administration) to acquire Medicare eligibility data.

However, although UHC officials indicated they have procedures to identify and suspend ESRD related claims, we have found that these procedures are not always effective. During fieldwork for our Medicare coordination audit for the 2000 calendar year (report 2001-S-16), we reviewed a

sample of 164 claims for Medicare-eligible persons that UHC did not coordinate with Medicare. We found that UHC paid nine claims that should have been paid by Medicare even though the claims had an ESRD related diagnosis code.

We also noted that neither carrier has system edits to identify claims for persons potentially eligible for Medicare due to disability. In our judgment, the carriers should investigate the possibility of identifying distinguishing claim characteristics for disabled Medicare beneficiaries. If such characteristics can be identified, system edits should be established to suspend such claims so Medicare eligibility can be investigated.

Recommendation 3

Improve procedures to maximize the recovery of overpayments identified by audits. In the case of participating providers, consider offsetting against future claim payments. For non-participating providers, monitor the status of request letters and follow-up with those providers who do not respond to the letters.

Status - United HealthCare - Partially Implemented

Agency Action - In our prior audit report, we found that UHC needed to improve its procedures for recovering overpaid claims identified by our audits. For example, instead of offsetting overpayments against future claim payments to providers, UHC sent multiple letters to providers instructing them to bill Medicare and subsequently return Medicare vouchers to UHC. We noted that this process was cumbersome and most providers did not comply. As a result, UHC was not sufficiently successful in recovering the overpayments we had identified.

During our follow-up review, we found that UHC has improved its cost recovery procedures. While UHC continues to send multiple letters to providers, officials informed us that they have procedures for offsetting overpayments against future payments for participating and non-participating providers' claims.

While this process should improve the recovery process, further improvements can be made. For example, UHC officials informed us that a separate letter is sent for each patient with an overpaid claim. In our judgment, this procedure is inefficient and ineffective because it: necessitates sending multiple letters to providers who were overpaid for more than one patient; increases the cost of recovery, which is reimbursed by the State; and, jeopardizes the timely submission of claims to Medicare. We believe it would be more efficient and effective for UHC to send one notification letter to each provider, regardless of the number of patients and claims involved.

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

We would appreciate receiving 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 and UHC for the courtesies and cooperation extended to our auditors during this review.

Yours truly,

Kevin M. McClune
Audit Director

cc: Deirdre Taylor, Division of the Budget
George Sinnott, Department of Civil Service
Josephine Hargis, Empire Blue Cross Blue Shield
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M. Laurie Wasserstein, United HealthCare