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STATE OF NEW YORK
OFFICE OF THE STATE COMPTROLLER

March 17, 2000

Mr. Barrett A. Toan
President and Chief Executive Officer
Express Scripts
1400 Riverport Drive
Maryland Heights, MO 63043

Re: New York State Health Insurance Program
Payments for Ineligible Claimants
Report 2000-S-9

Dear Mr. Toan:

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 selected medical claims processed on behalf of the New York State Health Insurance Program's Empire Plan (Empire Plan). The scope of our financial-related/compliance audit included claims paid by Express Scripts during the three-year period ended December 31, 1997.

A. Background

The New York State Health Insurance Program (Program) provides coverage for hospitalization, surgical services and other medical expenses for over 760,000 active and retired State employees and dependents. The Program also covers over 290,000 active and retired employees of participating agencies (PAs) and these employees' dependents. PAs are local governmental units and school districts that elect to participate in the Program. 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 is the Program's primary health benefit plan, providing services at a total annual cost exceeding $1.6 billion. CIGNA HealthCare (CIGNA) administers the Empire Plan's prescription drug coverage. CIGNA subcontracts claims processing and vendor payments to Express Scripts (formerly Value Rx), which processes Empire Plan claims at its facilities in Troy, NY and

Bloomington, MN. During the three-year period ended December 31, 1997, Express Scripts paid over 20 million claims totaling almost $800 million and charged the Empire Plan almost $38 million in administrative expenses.

At the time of our audit, the Department administered an automated Enrollment Management System (System) to maintain up-to-date health care insurance enrollment data for all Program participants. For such enrollment data to be accurate, all transactions which change an enrollee's health care coverage status must be entered timely on the System. These transactions result from events such as the start of employment, the termination of employment or a change in insurance coverage. At the time of our audit, Empire Blue Cross Blue Shield (Empire Blue Cross) was responsible for the day-to-day management of updates to enrollment data on the System. Enrollment data was updated in one of two ways: State agencies with on-line access to the System updated the enrollment data themselves through their health benefits administrators; PAs' health benefits administrators, who did not have on-line access, compiled the enrollment change data manually and sent it periodically to Empire Blue Cross for entry on the System. Once enrollment data was changed on the System, Empire Blue Cross updated enrollment files for its own claims processing system within one business day. Empire Blue Cross was also responsible for transmitting enrollment change data, via computer tape, to Express Scripts and other Empire Plan insurers so they could update their own payment systems. Such transmittals generally occurred on a weekly basis. As of January 1, 2000, the Department, rather than Empire Blue Cross, is maintaining enrollment data on the Department's new system, the New York Benefits Eligibility and Accounting System (NYBEAS), and is assuming responsibility for transmitting enrollment change data to insurance carriers.

Health industry experts have cited widespread fraud and abuse as major reasons for the rise in health care costs. One category of fraud and/or abuse is payment for services to ineligible claimants. The Empire Plan's certificates of insurance state that "use of the [Plan benefit] card after eligibility ends constitutes fraud." Two of our prior audits (Report 89-S-134, issued July 25, 1990 and Report 92-S-84, issued September 1, 1992) indicated that payments for ineligible claimants are a continuing problem. During these two prior audits, the insurance carriers involved said that delays in receiving updated enrollment data from health benefits administrators was the major cause of payments being made to ineligible claimants. Report 89-S-134 identified over $600,000 in improper payments for the year ended June 30, 1989; Report 92-S-84 identified over $2.2 million in improper payments during the two years ended September 30, 1991.

As an activity separate from the issuance of this audit report, we will work with our legal staff to determine whether cases we reviewed or patterns of potential fraud and abuse warrant further investigation.

B. Audit Scope, Objective and Methodology

We audited Express Scripts' claim payments during the three-year period ended December 31, 1997. The primary objective of our financial-related/compliance audit was to determine

whether Express Scripts paid claims for services rendered when claimants did not have Empire Plan coverage. This is one of three audits that examine the payment of ineligible claims by Empire Plan insurance carriers during the three-year period ended December 31, 1997. The other two audits involve Empire Blue Cross Blue Shield (Report 98-S-72) and United HealthCare Service Corporation (Report 2000-S-8).

We obtained a summary of enrollment transactions occurring during the audit period and designed computer programs to identify claim payments for services rendered when claimants did not have Empire Plan coverage. Because situations exist where apparently ineligible claimants may actually be valid enrollees, we selected a statistical sample of potentially improper claimants. To determine whether charges for these claimants were properly paid and to quantify the extent of any improper payments, we reviewed the sampled claimants' records with Express Scripts officials.

We did our audit in accordance with generally accepted government auditing standards. Such standards require that we plan and perform our audit to adequately assess those operations which are included within our audit scope. Further, these standards require that we understand the internal control structure and review compliance with the 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.

We use a risk-based approach when selecting activities to be audited. This approach focuses our audit efforts on those operations that we identify 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

We reviewed enrollment data and supporting documentation for a stratified statistical sample of 322 potentially ineligible claimants and for another 50 claimants for whom we had no record on the enrollment history file provided by Empire Blue Cross. As a result of these reviews, we estimated that Express Scripts paid between $630,605 and $1,102,506 (with a midpoint of $866,556) for ineligible claimants during the three-year period ended December 31, 1997. Delays in State agency and PA health benefit administrators' transmittal of enrollment change data to Empire Blue Cross accounted for between $556,017 and $862,183 (with a midpoint of $709,100) of these improper payments. Delays occurring sometime between Empire Blue Cross' posting of System data and Express Scripts' updating its own enrollment data accounted for between $74,588 and $240,323 (with a midpoint of $157,456) of the improper payments.

We provided a preliminary report of our audit findings to Express Scripts officials, and considered their comments in preparing this report. Although Express Scripts officials did not specifically comment on our findings, they stated that they are working with the Department to determine methods of pursuing related recoveries. Prior to our audit, Express Scripts officials had identified and recouped about $1.5 million for additional claims paid improperly during our audit period.

Payments for Ineligible Claimants

Express Scripts maintains a claims processing system which includes edits intended to detect and prevent improper payments. Edits identify claims which should not be paid for various reasons, including the claimant's ineligibility because coverage has expired. For these edits to be effective, however, State agency and PA health benefits administrators must first enter the enrollment changes on the System (or NYBEAS, as of January 1, 2000) or timely forward enrollment changes for data entry. During our audit period, Express Scripts was also dependent on Empire Blue Cross' prompt weekly transfer of enrollment transactions that had been entered on the System. We found that Express Scripts' claims processing edits were generally adequate to prevent payments to claimants who were known to be ineligible. However, these edits could not prevent most of the improper payments we found because health benefits administrators had not timely transmitted enrollment change data to notify Empire Blue Cross of claimants' ineligibility.

By matching claims history records against enrollment transactions during the three years ended December 31, 1997, we identified 12,335 potentially ineligible claimants for whom Express Scripts paid prescription drug claims totaling almost $2.4 million. Because several factors (such as total disability, enrollment data errors and dual coverage) can cause eligible claimants to appear ineligible, we decided to perform a statistical sample of these claimants. Our resulting sample size was 322 claimants, for whom Express Scripts paid a total of $455,436 on 6,803 claims.

We reviewed enrollment data and supporting documentation for each of the 322 claimants. As a result of this review, we found that Express Scripts improperly paid $159,198 for sampled ineligible claimants. Delays in health benefits administrators' transmittal of enrollment change data to Empire Blue Cross accounted for $135,816 (85.3 percent) of the improper payments. Delays occurring sometime between Empire Blue Cross' updating of the System and Express Scripts' updating its own enrollment data accounted for $23,382 of the improper payments. (Empire Blue Cross officials were unable to document when they transmitted enrollment updates to Express Scripts; likewise, Express Scripts officials were unable to document when they received this data). We projected the results of the sample, with 95 percent confidence, to the entire population of 12,335 potentially ineligible claimants as follows:

Projected Findings

	Midpoint	Lower Limit	Upper Limit
Delay in Initial Transmittal to Empire Blue Cross	**$674,373**	$521,290	$827,456
Transmittal Delays between Empire Blue Cross and Express Scripts	**146,222**	63,354	229,089
Total	**$820,595**	$584,644	$1,056,545

In addition to the claimants cited above, we identified 728 claimants with claims paid totaling $259,049 during the three years ended December 31, 1997, for whom we had no record on the enrollment history file provided by Empire Blue Cross. We reviewed documentation for 50 claimants whose claims accounted for $157,257 (60.7 percent) of the above total. We found that 35 of these claimants were eligible for coverage, and that Express Scripts' payments were proper. These claimants' missing enrollment history records were the result of clerical errors in recording identification numbers. However, 15 of the 50 claimants were ineligible, resulting in Express Scripts' overpaying $45,961 to these claimants. Delays in health benefits administrators' transmittal of enrollment change data to Empire Blue Cross accounted for $34,727 (75.6 percent) of this amount. Delays occurring sometime between Empire Blue Cross' updating of the System and Express Scripts' updating of its own enrollment data accounted for $11,234.

Recommendations

1. *Review the claims in the audit population.*

2. *Attempt to recover and remit to the State the estimated $866,556 ($820,595 plus $45,961) paid for ineligible claimants.*

Major contributors to this report were Lee Eggleston, Ronald Pisani, Joel Biederman, David Fleming, Philip Gadomski, Laura Smith and Richard Thomas.

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

Yours truly,

Kevin M. McClune
Audit Director

cc: Charles Conaway, Division of the Budget
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