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STATE OF NEW YORK
OFFICE OF THE STATE COMPTROLLER

January 16, 2002

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

Re: New York State Health Insurance Program
Coordination of Medicare Coverage
Report 2001-S-16

Dear Mr. Wheeler:

According to the State Comptroller's authority as set forth in Article V, Section 1 of the State Constitution and Article 2, Section 8 of the State Finance Law, we audited 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, 2000.

A. Background

The New York State Health Insurance Program (Program) provides hospital and surgical services and other medical and drug coverage to more than 773,000 active and retired State employees and their dependents. It also provides coverage for more than 367,000 other individuals, who are either active or retired employees of participating local government units and school districts or dependents of such employees.

The Plan is the Program's primary health benefits plan, providing services to about 966,000 individuals in the Program at an annual cost of more than $2.2 billion. The Department of Civil Service (Department) contracts with United HealthCare (UHC) to administer the surgical/major medical portion of the Plan. During the year ended December 31, 2000, UHC approved over 8.8 million charges 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 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, is optional and 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. Since the Plan requires that all Medicare-eligible members enroll in Medicare Part B, Medicare also becomes the primary payer of other medical expenses incurred by these Plan members once they enroll. 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, 2000. 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. Therefore, we focused our audit on Plan members who were eligible for Medicare during the audit period according to Medicare eligibility data for Plan members that we obtained from the Federal Centers for Medicare and Medicaid Services (CMS). We compared this information with UHC claims data to identify claims that were not properly coordinated with Medicare. During this and our previous Medicare coordination audits, we identified related matters that the Department, in its capacity as administrator of the Plan and the enrollment system, needs to address to improve the Plan's coordination with Medicare. During two of our previous audits (Report 2000-S-65, issued October 15, 2001 and Report 2001-S-15, issued November 1, 2001), we informed the Department of these matters under separate cover in a management letter dated October 25, 2001.

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 Department and UHC operations included in our audit scope. Further, these standards require that we understand the internal control systems of the Department and UHC and that we review these entities' 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.

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 report 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, UHC paid claims totaling $874,291 that should have been paid by Medicare. We also found that UHC potentially overpaid an additional $859,886 in claims for Plan members who were eligible for, but not enrolled in, Medicare Part B.

We provided preliminary reports of our audit findings to UHC officials and considered their comments in preparing this report. UHC officials agree with our findings. The officials informed us that they are reviewing our audit findings and they will apply the appropriate recovery procedures and remit recoveries to the Plan.

Inaccuracies in Medicare Eligibility Status

All Medicare-eligible Plan members should be identified so their claims can be coordinated with Medicare, thereby significantly reducing costs chargeable to the Plan. To develop an estimate of the number of claims that were actually Medicare's responsibility during our audit period, we drew a statistical sample from the claims paid by UHC. We compared data from CMS to claims information obtained from UHC and identified 21,297 UHC claims for which Medicare was potentially the primary insurer. To the extent Medicare was the primary insurer, these claims should have been submitted to Medicare.

In some instances, information that could affect the Medicare eligibility of a claim (e.g., employment status, certain medical conditions including end-stage renal disease, etc.) was either inaccurate or unavailable on the records provided by UHC. Therefore, we had to investigate each sampled claim to determine the extent of Medicare's responsibility. UHC officials provided us with additional information required to assess these claims. Based on this review, we determined, with 95 percent confidence, that UHC paid as the primary insurer between $747,641 and $1,000,941 in claims (with a midpoint of $874,291) that were appropriately 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. UHC officials informed us that they have signed an agreement with CMS to acquire Medicare eligibility data. UHC officials will use this data to update the enrollment system and improve the Plan's ability to coordinate claim payments with Medicare. We encourage the Department and UHC to continue to work together to develop procedures to ensure that all Medicare-eligible claims are processed appropriately. The use of the Medicare data obtained from CMS could provide the basis for such procedures.

Medicare Part B Eligible Persons Not Enrolled

The Plan requires all Medicare-eligible members to enroll in Medicare Part B. If the Medicare-eligible members fail to enroll as required, the members are responsible for the full cost of medical services that Medicare would have covered. We found that UHC paid an additional $859,886 in claims for members who were eligible for, but not enrolled in, Medicare Part B. UHC officials informed us that they encounter opposition from Plan members who did not enroll in Part B and, therefore, cost recovery is minimal. However, Department officials informed us that, although cost recovery may present a financial hardship for some enrollees in certain cases, they support cost recovery where appropriate. Therefore, UHC officials should work with the Department, the primary administrator of the Plan's enrollment system, to recover overpaid claims where appropriate, to ensure that Plan members enroll in Medicare Part B, and to update the enrollment system accordingly.

Recommendations

1. *Review the population of questionable claims from which we estimated that $874,291 was overpaid. Recover costs for Medicare-eligible claims from the appropriate parties and remit the recoveries to the Plan.*

2. *For the $859,886 in claims attributed to members eligible for, but not enrolled in, Medicare Part B, work with the Department to pursue recovery of claims, where appropriate.*

3. *Continue working with the Department to develop a comprehensive system of procedures and internal controls to improve the processing of Medicare-eligible claims. Address such areas as:*

    - *pursuing Federal Medicare eligibility data so that the Plan's enrollment system reflects accurate Medicare information;*

    - *enrolling in Part B the Medicare-eligible members identified in our audit; and*

    - *updating the Plan's enrollment system with the Medicare eligibility information identified in our audit.*

Major contributors to this report were Lee Eggleston, Ronald Pisani, Dennis Buckley and Craig Coutant.

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

Yours truly,

Kevin M. McClune
Audit Director

cc: George Sinnott, Department of Civil Service
Deirdre A. Taylor, Division of the Budget
Donna Pooley, United HealthCare