ALAN G. HEVESI
COMPTROLLER

110 STATE STREET
ALBANY, NEW YORK 12236

STATE OF NEW YORK
OFFICE OF THE STATE COMPTROLLER

January 9, 2004

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

Re: Report 2003-F-26

Dear Mr. Wheeler:

Pursuant 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 have reviewed the actions taken by officials of the United HealthCare Service Corporation (UHC) as of November 10, 2003, to implement the recommendations contained in our audit report, *New York State Health Insurance Program: Coordination of Medicare Coverage* (Report 2001-S-16). Our report, which was issued on January 16, 2002, reviewed the effectiveness of the system used by the Empire Plan (Plan) of the New York State Health Insurance Program (Program) for coordinating medical claim payments on behalf of Medicare-eligible enrollees and their spouses and dependents.

Background

The Program provides hospital and surgical services and other medical and drug coverage to more than 796,000 active and retired employees of New York State (State) and their dependents. It also provides coverage for more than 392,000 active or retired employees of participating local government units and school districts and their dependents.

The Plan is the Program's primary health benefit plan, providing services at an annual cost of more than $2.9 billion. The Department of Civil Service (Department) contracts with UHC to administer the major medical coverage portion of the Plan. During the year that ended on December 31, 2002, UHC approved more than 10.5 million claims totaling more than $1 billion, and also charged the State about $108 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 that extended Medicare coverage to those who are disabled or suffer from end-stage renal disease. 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, is optional and requires eligible persons to enroll and pay monthly premiums. Medicare requires individuals and care-providers to submit claims for payment in a timely manner (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. By identifying Medicare-eligible Plan members and coordinating payment of their claims with Medicare, the Plan can reduce its expenditures.

Summary Conclusions

In our prior audit, we examined the major medical claims paid during the year 2000 by the Plan on behalf of people who were eligible for Medicare and estimated that $1.7 million of these claims should have been paid by Medicare.

In our follow-up review, we found that UHC officials had recovered $630,253 in claims that Medicare should have paid. We also found that UHC officials are now receiving Medicare eligibility data from the Centers for Medicare and Medicaid Services on a routine basis and are using this data to help prevent improper payments.

Summary of Status of Prior Audit Recommendations

UHC officials have implemented one recommendation and partially implemented two prior audit recommendations.

Follow-up Observations

Recommendation 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.

Status - Partially Implemented

Agency Action - Our prior audit estimated that UHC paid between $747,641 and $1,000,941 in claims (with a mid-point of $874,291) for which Medicare should have taken responsibility. UHC officials said they have recovered $501,481, which is below our projected low-point, and they are continuing their recovery efforts. However, since the payments to be recovered are for claims by non-participating providers, UHC officials can only recover these overpayments when the non-participating providers submit future claims. As such, additional recoveries may be unlikely.

Recommendation 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.

Status - Partially Implemented

Agency Action - Our prior audit found that UHC paid claims totaling $859,886 for members eligible for, but not enrolled, in Medicare Part B. According to UHC officials, based on a review of this population, the actual overpaid amount was $438,962. UHC officials recovered $128,772 of this amount. UHC officials indicated that they are continuing their recovery efforts. However, since UHC officials must seek recovery from Plan members, additional recoveries may be minimal.

Recommendation 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 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.*

Status - Implemented

Agency Action - UHC officials are now receiving Medicare eligibility data from the Centers for Medicare and Medicaid Services on a routine basis. UHC officials are using this data to identify and recover payments they made for claims that were Medicare's responsibility. The use of this data should also help enable UHC officials to prevent future improper payments. UHC officials are also notifying Plan enrollees who are Medicare Part B-eligible, but not enrolled, that they must enroll in Medicare Part B. UHC is also informing these enrollees that UHC will only pay the secondary portion of future claims, as if the enrollees were enrolled in Medicare Part B. In addition, UHC officials are updating their enrollment system with the Medicare eligibility information identified during our audits and sharing this information with the Department.

Major contributors to this report were Ronald Pisani, Dennis Buckley, and Douglas Abbott.

We would appreciate your response to this report within 30 days, indicating any actions planned to address the unresolved issues discussed in this report. We also thank the management and staff of United HealthCare Service Corporation for the courtesies and cooperation extended to our auditors during this review.

Very truly yours,

Frank J. Houston
Audit Director

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