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STATE OF NEW YORK
OFFICE OF THE STATE COMPTROLLER

December 27, 2004

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 2004-S-27

Dear Mr. Wheeler:

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 the coordination of Medicare coverage for the New York State Health Insurance Program's Empire Plan (Plan) for the year ended December 31, 2003.

A. Background

The New York State Health Insurance Program (Program) provides hospital and surgical services and other medical and drug coverage to more than 790,000 active and retired State employees and their dependents. It also provides coverage for more than 396,000 active or retired employees of participating local government units and school districts and dependents of such employees.

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 on a timely basis (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. The Department of Civil Service (Department) is primarily responsible for maintaining the Plan's enrollment system, including updates to reflect current Medicare eligibility information. Insurance carriers also have a role in the coordination of claims with Medicare (i.e., by maintaining edits to flag potential Medicare-eligible claims and by obtaining Medicare eligibility data and sharing it with the Department, etc.). Therefore, the Department and its carriers need to work together to provide reasonable assurance that Medicare-reimbursable claims are processed properly.

B. Audit Scope, Objective and Methodology

We audited the coordination of Medicare coverage for the New York State Health Insurance Program's Empire Plan (Plan) for the year ended December 31, 2003. The primary objective of our performance 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.

To accomplishment our audit objective, we compared data from the Center for Medicare and Medicaid Services (CMS) with claims information obtained from United HealthCare (UHC) to determine our audit population. Since some 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, we used statistical sampling techniques to determine the extent of Medicare's responsibility. UHC officials provided us with additional information to assist our review of the statistically sampled claims. Based on the results of this review, we estimated the dollar amount of claims that were Medicare's responsibility during our audit period.

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.

In addition to being the State Auditor, the Comptroller performs certain other constitutionally and statutorily mandated duties as the chief fiscal officer of New York State, several of which are performed by the Division of State Services. These include operating the State's accounting system; preparing the State's financial statements; and approving State contracts, refunds, and other payments. In addition, the Comptroller appoints members to certain boards, commissions, and public authorities, some of who have minority voting rights. These duties may be considered management functions for purposes of evaluating organizational independence under Generally Accepted Government Auditing Standards. In our opinion, these management functions do not affect our ability to conduct independent audits of program performance.

C. Results of Audit

Because of weaknesses in the Plan's system for determining Medicare eligibility, we estimate that UHC paid claims totaling $364,861 during the audit period that should have been paid by Medicare. Using additional identification procedures because the UHC data were inaccurate, we found an additional $149,825 in payments made by UHC instead of Medicare. In addition, we found that UHC potentially overpaid an additional $871,688 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. The officials informed us that they already recovered $35,667 of the $364,861 we identified, and that they would continue to review the questionable claims. They also said they would continue to pursue recovery from the Medicare Part B-eligible members, where appropriate, and would remit any recoveries to the Plan.

Medicare Eligibility Status

All Medicare-eligible Plan members should be identified so their claims can be coordinated with Medicare. Such coordination can significantly reduce costs chargeable to the Plan. We identified a population of 11,439 UHC claims with a total value of more than $1.2 million for which Medicare may have been the primary insurer. From this population, we selected a statistical sample of 203 claims and reviewed them with UHC officials. Based on our review of 203 statistically-sampled claims, we determined, with 95 percent confidence, that UHC paid as the primary insurer, between $300,416 and $429,307 in claims (with a midpoint of $364,861) that were actually the responsibility of Medicare.

We subsequently identified 2,012 additional claims totaling $149,825 that UHC also did not coordinate properly with Medicare. We were unable to include these claims in the primary audit population because the records UHC provided contained inaccuracies. For example, the field used to identify employee status indicated that the employees were working full-time when, in fact, they were retired. As a result, we excluded these claims from our primary audit population.

UHC, rather than Medicare, paid the 2,012 uncoordinated claims because neither it nor the Department had tracked Medicare eligibility information on a comprehensive basis during the audit period. As a result of our prior Medicare audit recommendations, UHC officials began obtaining Medicare eligibility data from CMS in May of 2002 and are now using this data to update their enrollment system. This data enables UHC officials to identify and recover payments they made for claims that were Medicare's responsibility. It also enables them to prevent further improper payments. However, UHC officials informed us that they did not begin obtaining data from CMS as often as they wanted to until 2003. As a result, UHC was unable to determine that certain claims were Medicare's responsibility. UHC officials have also updated their enrollment system, using the data we provided through our Medicare audits. Reviewing that data as well as other information we obtained from CMS, we estimate that UHC officials also identified an additional $237,144 in claims that UHC, acting as the primary insurer, had paid inappropriately during the audit period. These claims were the responsibility of Medicare. We estimate that UHC has already recovered $199,332 of this amount, and we encourage UHC officials to continue improving their procedures for utilizing

the Medicare data obtained from CMS and our audits. We also encourage the Department and Plan carriers to continue to work together to develop procedures for ensuring that all Medicare-eligible claims are processed appropriately.

Medicare Part B-Eligible Persons

The Plan requires all Medicare-eligible members to enroll in Medicare Part B. Those who do not are responsible for the full cost of medical services that Medicare would have covered. However, in June 2002, the Department issued a Medicare Hold Harmless Policy. This Policy temporarily waived members' financial responsibility for Medicare eligible claims if the member had either not been informed or had been misinformed about the requirement.

For the year that ended on December 31, 2003, we determined that UHC had paid $871,688 in claims for Medicare Part B-eligible members who had not enrolled. However, because of the Plan's Medicare Hold Harmless Policy, it may not be appropriate to pursue cost recovery from some of these individuals. Therefore, to ensure that Plan members do enroll and to keep the enrollment system up to date, UHC officials should work with the Department, which is the primary administrator of the Plan's enrollment system, to recover overpaid claims where appropriate.

Recommendations

1. *Review the population of questionable claims, from which we estimated $364,861 has been overpaid. Recover the costs of Medicare-eligible claims from the appropriate parties and remit them to the Plan.*

2. *For the $149,825 in additional claims we identified, recover costs for Medicare-eligible claims from the appropriate parties and remit the recoveries to the Plan.*

3. *Work with the Department to recover $871,688 in claims that were attributed to members who were eligible for, but were not enrolled in, Medicare Part B.*

4. *Work with the Department to develop a comprehensive system of internal controls that will improve the processing of Medicare-eligible claims for the entire Plan. Address such areas as:*

    - *Sharing eligibility data with the Department so that the Plan's enrollment system reflects accurate Medicare information;*

    - *Informing the Medicare-eligible members identified in our audit that they are responsible for enrolling in Medicare Part B; and*

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

Major contributors to this report were 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,

David R. Hancox
Audit Director

cc: George Sinnott, Department of Civil Service
Robert Barnes, Division of the Budget
Carl Mattson, United HealthCare