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STATE OF NEW YORK
OFFICE OF THE STATE COMPTROLLER

June 6, 2006

Mr. Tracy Bahl
Chief Executive Officer
United HealthCare
1114 Avenue of the Americas - Floor 35
New York, NY 10036

Re: New York State Health Insurance Program
Selected Manually-Processed Claims
Report 2005-S-56

Dear Mr. Bahl:

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 audited selected manually-processed medical claims for the New York State Health Insurance Program's Empire Plan for the period January 1, 2003 through June 30, 2005.

A. Background

The New York State Health Insurance Program (Program) provides hospitalization, surgical services and other medical and drug coverage to more than 822,000 active and retired State employees and their dependents. It also provides coverage for more than 422,000 active and retired employees of participating local government units and school districts and their dependents.

The Empire Plan (Plan) is the Program's primary health benefits plan for about one million enrollees at an annual cost of $4 billion. The Department of Civil Service (Department) contracts with United HealthCare (UHC) to administer the medical/surgical and major medical portions of the Plan. During the year ended December 31, 2005, UHC approved over 13.9 million claims totaling almost $1.4 billion and charged the State about $144 million for administrative and other related expenses.

Generally, UHC's claims processing system (System) automatically adjudicates provider claims. However, if a claim has a component the System is not able to recognize or calculate, UHC must manually process the claim. About 23 percent of UHC's total paid claims are manually processed. In these cases, a claim is assigned one of 13 codes and is reviewed by a claims processor

or, when necessary, by a nurse or other medical specialist. Once a determination is made to pay, reject or adjust the claim, the claims processor will allow the claim to continue with automatic adjudication. A claim may also be suspended in the system if more information is needed from the provider or insured. By their nature, manually processed claims are inherently more at risk for error.

UHC has a 13-week training program for all new claims processors. In addition, UHC provides training when a new policy is implemented. UHC's Quality Assurance Division (Division) reviews a random sample of claims on a daily basis, and compiles the most common errors on a monthly and annual basis. This process is used both as a monitoring activity and to identify staff training needs.

B. Audit Scope, Objectives and Methodology

The primary objectives of our performance audit were to determine whether selected manually-processed claims indicating a need for medical review were paid correctly. We identified 760,000 such claims totaling about $170 million for the 30-month period January 1, 2003 through June 30, 2005. To accomplish our audit objectives, we statistically sampled these claims and reviewed sampled claims with the assistance of UHC's staff. Based on this review, we estimated the number and dollar amount of overpaid claims.

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 UHC 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 whom 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

From our audit population of claims requiring manual medical review, we randomly selected 463 claims totaling $1,697,167. We found that 28 of the 463 sampled claims (6 percent) were overpaid by a total of $20,073. Based on this review, we estimate, with 95 percent confidence, that UHC overpaid between $1,887,594 and $5,523,756 (midpoint $3,705,675) due to human error.

The extent of the overpayments we identified indicate the need for improvement in UHC's quality assurance and training efforts for manually processing claims that require medical review. For example, when the Division selects a sample of claims for quality review, there is no assurance that every claims processor is included in the sample.

UHC officials advised us that they have implemented four system updates to decrease the need for future manual processing. We encourage UHC to continue implementing updates to further decrease the need for manual claims processing. We also encourage UHC officials to review and enhance their quality assurance and training programs to mitigate future overpayments.

Under its contract with the State, UHC is reimbursed for its total costs. The State, local employers and enrollees contribute to the costs of the Plan. Thus, overpaid claims result in increased costs for these parties.

We provided a preliminary copy of the matters contained in this report to UHC officials and considered their comments in preparing this report. UHC officials generally agreed with our findings and informed us that they will pursue recovery of overpaid claims identified in our audit.

Recommendations

1. *Recover the overpayments identified in our audit sample and remit the recoveries to the Plan.*

2. *Continue identifying and implementing system updates to decrease the need for manual processing.*

3. *Review the quality assurance and training programs to identify opportunities to decrease overpayments due to human error.*

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.

Major contributors to this report were Kenneth Shulman, Ronald Pisani, Lynn Freeman, Jennifer Mitchell, Nicholas Angel, and Paul Bachman.

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,

Steven E. Sossei
Audit Director

cc: Daniel Wall, Department of Civil Service
Lisa Ng, Division of the Budget
Carl Mattson, United HealthCare