ALAN G. HEVESI
COMPTROLLER

110 STATE STREET
ALBANY, NEW YORK 12236

STATE OF NEW YORK
OFFICE OF THE STATE COMPTROLLER

January 23, 2003

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

Re: Report 2002-F-54

Dear Mr. Wheeler:

Pursuant to the State Comptroller's authority as set forth 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 United HealthCare (UHC) as of December 18, 2002, to implement the recommendations contained in our audit report, *New York State Health Insurance Program: Coordination of Medicare Coverage* (Report 2000-S-65). Our report, which was issued on October 15, 2001, reviewed the effectiveness of the Empire Plan's system for coordinating Medicare coverage for Plan enrollees and their spouses and dependents.

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 376,000 active or retired employees of participating local government units and school districts and their dependents.

The Empire Plan (Plan) is the Program's primary health benefit plan, providing services to almost one million individuals in the Program at an annual cost of more than $2.5 billion. The Department of Civil Service (Department) contracts with UHC to administer the surgical/major medical portion of the Plan. During the year that ended on December 31, 2001, UHC approved more than 9.6 million charges at a total cost of more than $903 million and, in addition charged the State about $92 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 chronic renal failure. For most 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, requires eligible persons to enroll and pay monthly premiums. Medicare requires individuals and care-providers to submit payment claims 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 primary Medicare coverage, Medicare becomes the primary payer of their medical expenses. Since the Plan requires all Medicare-eligible members to enroll in Medicare Part B, Medicare also becomes the primary payer of other medical expenses incurred by the 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 is primarily responsible for maintaining the Plan's enrollment system, including updates that reflect current Medicare eligibility information. UHC also plays a role in the coordination of claims with Medicare (e.g., by maintaining edits that flag potential Medicare-eligible claims and by obtaining Medicare eligibility data and sharing the results of its review with the Department). Therefore, the Department and UHC need to work together to provide reasonable assurance that Medicare reimbursable claims are being processed properly.

Summary Conclusions

In our prior audit, we estimated that, because of weaknesses in the Plan's system for identifying Medicare eligibility, UHC had paid claims totaling $734,752 that should have been paid by Medicare. We also found that UHC may have overpaid an additional $556,366 in claims for Plan members who were eligible for, but not enrolled in, Medicare Part B.

In our follow-up review, we found that UHC officials had recovered $514,336 of claims that Medicare should have paid and were in the process of collecting another $70,130. However, they were unable to recover $154,898, primarily due to Medicare's time limits for filing. We also found that UHC officials had recovered just $29,925 of the $556,366 in overpayments we had identified for Plan members who were eligible for, but had not enrolled in, Medicare Part B. UHC is working with the Department to improve the processing of Medicare-eligible claims.

Summary of Status of Prior Audit Recommendations

Of the three prior audit recommendations, UHC officials have implemented two recommendations and partially implemented one recommendation.

Follow-up Observations

Recommendation 1

Review the population of questionable claims from which we estimate that $734,752 was overpaid. Recover costs for Medicare-eligible claims from the appropriate parties and remit the recoveries to the Plan.

Status – Implemented

Agency Action – In our prior audit, we estimated that UHC had paid claims totaling between $609,809 and $859,695 (with a midpoint of $734,752) that Medicare should have paid as the primary insurer. Based on a review of the entire population of questionable claims, UHC officials determined that the actual overpaid amount was $739,364. The officials indicated that they had recovered $514,336 of claims that Medicare should have paid and were in the process of collecting another $70,130. However, they were unable to recover $154,898, primarily due to Medicare's time limits for filing.

Recommendation 2

For the $556,366 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 – In our prior audit, we found that UHC may have overpaid an additional $556,366 in claims for Plan members who were eligible for, but had not enrolled in, Medicare Part B. According to a review of this population by UHC officials, the actual overpaid amount was $386,167. UHC officials indicated that they had recovered $29,925 of this amount and were still pursuing $114,836. The officials also indicated that they are not pursuing the remaining $241,406 due to Medicare's time limits for filing.

Auditors' Comments – Since the population includes Plan members who were eligible for, but not enrolled in, Medicare Part B, Medicare's filing limits do not apply in this case. During our prior audit, Department officials informed us that it might not be appropriate to seek direct cost recovery from some of the Plan members involved with these claims. Therefore, UHC officials should work with the Department to pursue recovery of the claims, where appropriate.

Recommendation 3

Continue working with the Department to develop a comprehensive system of procedure 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 Medicare Part B the Medicare-eligible members identified in our audit.*
- *Updating the Plan's enrollment system with the Medicare eligibility information identified in our audit.*

Status – Implemented

Agency Action – In our prior audit, we found that neither the Department nor UHC tracked Medicare entitlement data on a comprehensive basis. We recognize that the Department is

ultimately responsible for maintaining the enrollment system and incorporating Medicare entitlement data into the enrollment system. However, we believe the Plan's carriers also have a role in ensuring that claims are coordinated properly with Medicare. UHC officials informed us that they update their enrollment system with Medicare eligibility data obtained under an agreement with the Centers for Medicare and Medicaid Services (CMS). However, they also stated that this agreement prevents them from sharing the CMS data with the Department. They said they notify Plan enrollees who are eligible for Medicare Part B, but have not enrolled in the program that they must do so, informing them that UHC will only pay the secondary portion of future claims in any case. They said they update their enrollment system with the Medicare eligibility information identified during our audits, and share the information with the Department as well.

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

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

Very truly yours,

Frank J. Houston
Audit Director

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