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STATE OF NEW YORK
OFFICE OF THE STATE COMPTROLLER

October 20, 2003

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 2003-S-12

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 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, 2002.

A. Background

The New York State Health Insurance Program (Program) provides hospital and surgical services and other medical and drug coverage to more than 796,000 active and retired State employees 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 dependents of such employees.

The Plan is the Program's primary health benefits plan, providing services to about 1 million individuals in the Program at an annual cost of more than $2.9 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, 2002, UHC approved over 10.5 million charges totaling more than $1 billion and 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 to extend 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 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. The Department is primarily responsible for maintaining the Plan's enrollment system, including updating this system 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 properly processed.

B. Audit Scope, Objective, and Methodology

We audited the Plan's Medicare-related claims for the year ended December 31, 2002. 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 showed that neither the Department nor the Plan's insurance carriers tracked Medicare eligibility information on a comprehensive basis. Therefore, we focused our audit on Plan members who were eligible for Medicare during the year ended December 31, 2002, 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. In this audit and in our previous audits of the Plan's Medicare coordination issues, we have 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. We inform the Department of these matters in a separate letter.

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 our audit efforts 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 reports on an "exception basis." This report, therefore, highlights those areas needing improvement and does not address activities that may be functioning properly.

C. Internal Control Assesment

Our consideration of the internal control structure at UHC focused on the control procedures for identifying Medicare eligibility when processing Plan claims. Our audit identified the need for improvements in this area, which we further describe in the "Inaccuracies in Medicare Eligibility Status" and "Medicare Part B Eligible Persons Not Enrolled" sections of this report.

D. 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 $627,497 that should have been paid by Medicare. We also found that UHC potentially overpaid an additional $649,619 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 informed us that they have already recovered $29,134 of the $627,497 we identified and will continue to review the population of questionable claims. For the Medicare Part B population, UHC officials informed us that they continue to pursue recovery from members where appropriate, and will 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. We compared data from CMS to claims information obtained from UHC and identified a population of 13,175 UHC claims for which Medicare was potentially the primary insurer. From this population, we selected a statistical sample of 167 claims and reviewed these claims with UHC officials. Based on the results of this review, we estimated the dollar amount of claims that were Medicare's responsibility during our audit period. To the extent Medicare was the primary insurer, these claims should have been submitted to Medicare.

Since, in some instances, information that may 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 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 a review of the 167 statistically-sampled claims, we determined, with 95 percent confidence, that UHC paid (as the primary insurer) between $472,311 and $782,683 in claims (with a midpoint of $627,497) that were appropriately the responsibility of Medicare.

Thus, UHC, rather than Medicare, paid these claims because neither the Department nor UHC tracked Medicare eligibility information on a comprehensive basis during the audit period. As a result of our prior Medicare audit recommendations, in May of 2002, UHC officials began obtaining Medicare eligibility data from CMS 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 UHC officials to prevent further improper payments. However, UHC officials informed us that due to data transmission problems, UHC was unable to obtain data from CMS as frequently as originally planned. As a result, UHC was unable to identify certain claims that were Medicare's responsibility. UHC officials have also updated their enrollment system based on the Medicare data we provided through our Medicare audits. Through the use of the data obtained from CMS and our Medicare audits, we estimate that for the audit period, in addition to the amounts we identified, UHC officials also identified more than $908,000 in claims that UHC paid as the primary insurer that were the responsibility of Medicare. We estimate that UHC has already recovered over $621,000 of this amount. We encourage UHC officials to continue to improve 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 to ensure that all Medicare-eligible claims are processed appropriately.

Medicare Part B Eligible Persons Not Enrolled

The Plan requires all Medicare-eligible members to enroll in Medicare Part B. If a Medicare-eligible member fails to enroll as required, the member is responsible for the full cost of medical services that Medicare would have covered. However, in June 2002, the Department issued Policy Memo 70r1 (Medicare Hold Harmless Policy). This policy temporarily waived a member's financial responsibility for Medicare-eligible claims in situations where the member was either not informed or misinformed concerning the Plan's requirement for them to enroll in Medicare.

For the year ended December 31, 2002, we determined that UHC paid $649,619 in claims for members who were eligible for, but not enrolled in, Medicare Part B. However, because of the Plan's Medicare Hold Harmless Policy, cost recovery from the Plan members involved in some of these claims may not be 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 $627,497 was overpaid. Recover costs for Medicare-eligible claims from the appropriate parties and remit the recoveries to the Plan.*

2. *For the $649,619 in claims attributed to members eligible for, but not enrolled in, Medicare Part B, work with the Department to pursue the recovery of claims, where appropriate, and remit the recoveries to the Plan.*

3. *Continue working with the Department to develop a comprehensive system of procedures*

and internal controls to improve the processing of Medicare-eligible claims for the entire Plan. Address such areas as:

- *assisting the Department in obtaining 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.*

4. *Continue efforts to recover the estimated $908,000 in overpayments identified through the UHC match with CMS and through prior OSC audits; and remit the recoveries to the Plan.*
5. *Continue to improve procedures for exchanging Medicare eligibility data with CMS.*

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.

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 HealthCare