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DIVISION OF STATE SERVICES

UNITED HEALTHCARE

NEW YORK STATE HEALTH INSURANCE PROGRAM – WAIVING OUT-OF-POCKET EXPENSES

Report 2006-S-60

AUDIT OBJECTIVE

Our objective was to determine whether United HealthCare adequately addressed the risk that non-participating providers waived members' obligations for out-of-pocket costs and accepted as payment in full the amounts reimbursed to the members under the Empire Plan. Our audit covered the period January 1, 2004 through March 31, 2006.

AUDIT RESULTS - SUMMARY

A healthcare provider can become an Empire Plan participating provider or remain a non-participating provider. If the provider participates, United HealthCare (United) pays the provider for services at a negotiated rate, and the plan member pays a small co-payment to the healthcare provider. If the provider is non-participating, United directly pays the member the lower of the usual and customary charge for the particular service or the provider's billed amount. The member then pays the provider's full charges. Consequently, any difference between the amount reimbursed to the member by United and the amount charged by the healthcare provider to the member becomes an out-of-pocket cost for the member. The out-of-pocket cost is generally substantially more than the co-payment a member would pay for the same service from a participating provider. Consequently, there is an incentive to encourage members to use participating providers.

Non-participating providers must not routinely waive out-of-pocket costs for their Empire Plan members while accepting as payment in full the amount reimbursed by United to the member. The New York State Insurance Department concludes that insurance fraud may result when this happens. The New York Penal Law requires that a person who submits a claim for payment that contains false information, in this case an inflated charge for the service, is committing an insurance fraud.

United has controls to address the risk that providers may waive members' out-of-pocket costs. Specifically, through internal audits and data analyses, United is able to identify (or red-flag) non-participating providers that routinely waive out-of-pocket costs for members. In these cases, United reduces by 20 percent the usual and customary charges that it pays to plan members when out-of-pocket costs have been waived by such providers. We found that these controls were not always followed.

During our audit period, United paid approximately $13 million to plan members for claims originating from providers that United had red-flagged. However, we found that these payments did not reflect the required 20 percent reduction. Thus, the objective of discouraging waiver of out-of-pocket costs was not achieved. The breakdown in controls resulted from manual processing errors and lapses of monitoring by United. Using sampling techniques applied to 124 billings from these red-flagged providers, we estimate that between $620,185 and $997,679 was overpaid to members.

We also found that in 2000 United sought reimbursement of approximately $1.1 million from 15 non-participating providers where United's audits had determined that the non-participating provider waived members' out-of-pocket costs. As of March 2006, six of these providers had made partial reimbursements totaling only $127,000.

Finally, we found that United had not applied its red-flag procedures to non-participating ambulatory surgical centers for several years even though these providers were considered at high risk to waive members' out-of-pocket

costs. Our audit concluded that five such providers were at high risk for waiving members' out-of-pocket costs. We referred these providers to United indicating that member payments for services from these providers should have potentially been reduced by about $4 million.

Our report contains seven recommendations to improve controls over the identification of providers who are waiving out-of-pocket costs. Officials generally agreed with our recommendations and have taken steps to implement changes.

This report, dated March 22, 2007, is available on our website at: http://www.osc.state.ny.us. Add or update your mailing list address by contacting us at: (518) 474-3271 or
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BACKGROUND

The New York State Health Insurance Program (Program) provides health insurance coverage to active and retired State, participating local government and school district employees and their dependants. The Empire Plan is the primary health benefits plan for the Program. The Department of Civil Service (Department) contracts with United HealthCare (United) to process medical claims for the Empire Plan.

Medical providers have the option to decide whether or not they will participate in the Empire Plan. If a provider elects to be a participant in the Empire Plan, United bases reimbursement to providers on a pre-determined fee schedule. Participating providers are paid directly by United and the plan member will be responsible for making only a small co-payment for the service. In contrast, United does not pay a non-participating provider directly.

Reimbursement for services from non-participating providers is made directly to the member. The amount reimbursed is the lower of the provider's bill or the usual and customary rate established for the service by United. The plan member then pays the provider's full charges. Any difference between the amount reimbursed to the member by United and the amount charged by the healthcare provider to the member becomes the member's out-of-pocket cost. Non-participating providers must not routinely waive out-of-pocket costs for their patients. The New York State Insurance Department concluded that insurance fraud may result when a provider routinely waives out-of-pocket costs and accepts the amount an insurer pays the member as payment in full. This position is supported by a State Supreme Court ruling that concluded the practice of waiving these expenses is illegal.

AUDIT FINDINGS AND RECOMMENDATIONS

Overpayments Made For Services Provided by Non-Participating Providers

United conducts internal audits and gathers information from various sources to identify non participating providers (red-flagged providers) who routinely waive the members' out-of-pocket costs. In an attempt to control and discourage these providers from this practice, United reduces, by 20 percent, the usual and customary charges that it pays to the plan participant for such providers. Once the Plan member's yearly out-of-pocket deductible cost has been met, United pays the claims at 100 percent of the usual and customary charges.

During the audit period, United paid approximately $13 million to plan members for claims submitted by red-flagged providers. However, even though United should have reduced payments by 20 percent for plan participants that had not yet met their annual deductible for out-of-pocket costs; we found the reductions were not consistently taken due to manual processing errors. We also found United officials were not monitoring these claims to ensure that the proper reductions were made.

For example, for one of these providers, United paid members a total of $304,900 for claims. We believe overpayments of $60,980 were made on behalf of providers that waived out-of-pocket charges when United did not apply the 20 percent reduction. United officials indicated to us that they assumed this provider would become a plan participant and as a result did not take the reduction. United officials stated there was no follow-up review done to determine whether this provider ever became a plan member or was no longer waiving out-of-pocket costs.

To estimate the dollar impact resulting when United failed to consistently take, where warranted, the 20 percent reduction, we selected a random sample of 124 billings submitted by red-flagged providers, reviewed the selected bills with United officials and evaluated the effect of the errors. We found United did not consistently take the 20 percent reduction in 61 of the 124 bills where a reduction should have taken place. Based on the sample results, we estimate, with a 95 percent confidence level, United overpaid members between $620,185 and $997,679 for services provided by red-flagged providers.

Additionally, United conducted audits of certain non-participating providers who appeared to be inappropriately waiving the balance of the fees. Based on these audits, United requested reimbursements in 2000 totaling approximately $1.1 million from 15 non-participating providers who they believed were inappropriately waiving out-of-pocket costs. However, we determined that, as of the end of March 2006, 6 providers made only partial reimbursements to United totaling $127,000.

Even when United may have reduced payments by 20 percent, United continued to credit members' annual deductible amount as if they had paid all out-of-pocket costs. This practice allows members to reach their yearly deductible limit prematurely. Since members prematurely reach their deductible for out-of-pocket costs, the 20 percent payment reduction to these members for red-flagged provider services will prematurely cease.

Recommendations

1. Determine the amount of overpayments to Plan members for services to red-flagged providers where payments were not accurately reduced by 20 percent. Recover from the providers and remit the overpayments to the State.

2. Implement automated controls in the claims processing system to reduce payments by the 20 percent for red-flagged providers.

3. Improve the monitoring over the processing of red-flagged provider claims to ensure the reductions are consistently being taken.

4. Recover from providers the remaining almost $1 million overpayment that United's auditors found and remit this to the State.

5. Stop crediting members' deductible limit with the full payment of out-of-pocket costs for their use of red-flagged providers.

Potential for Additional Providers Waiving Out-of-Pocket Costs

The Department and United officials informed us that non-participating ambulatory surgical centers are at a high risk to illegally waive out-of-pocket costs to plan participants. However, in the last several years, United has not used its procedures to red-flag such providers.

During our audit period, $54 million was paid to Plan members for services from non-participating ambulatory surgical centers. We selected a judgmental sample of 192 billings from these non-participating ambulatory surgical centers and applied United's procedures to determine whether there was an indication that the ambulatory surgical centers were waiving out-of-pocket costs and needed to be red-flagged. From our review, we identified five providers who show a high probability that they are waiving members' out-of-pocket costs and needed to be red-flagged. These five providers billed Plan members almost $20.4 million for the audit period. Since these providers were never red-flagged, about $4 million (20 percent of $20.4 million) was not reduced from the members' payments as required by United's procedures. We referred names of these providers to United officials for additional review.

Recommendations

6. Investigate the non-participating ambulatory surgical providers identified in this audit that may be waiving out-of-pocket costs.
7. Recover and remit to the State member overpayments.

AUDIT SCOPE AND METHODOLOGY

We conducted our performance audit in accordance with generally accepted government auditing standards. Our audit primarily focused on non-participating providers who waived members' out-of-pocket costs during the period January 1, 2004 through March 31, 2006.

We used data analysis techniques to identify and analyze all payments for services rendered by non-participating providers to members. We also interviewed Department and United officials to obtain an understanding of the controls in place to identify and monitor the practice of waiving out-of-pocket costs. Using a 95 percent confidence, we also statistically sampled 124 billings submitted by red-flagged providers and reviewed the selected records with United officials. In addition, we judgmentally sampled 192 billings for ambulatory surgical centers. We then reviewed copies of checks and claims for those records to identify providers for potential waiving of out-of-pocket costs.

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.

AUTHORITY

The audit was performed 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 certain payments made by the New York State Health Insurance Program's Empire Plan to non-participating providers for the period January 2004 through March 2006.

REPORTING REQUIREMENTS

We provided a preliminary copy of this report to United officials for their review and comments. We considered United's comments in preparing this report. United officials generally agree with our recommendations and included the actions planned or taken to implement them.

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.

CONTRIBUTORS TO THE REPORT

Major contributors to this report were Kenneth Shulman, Robert Wolf, Mary Roylance, David Fleming, Kathleen Garceau, Ashley Nightingale, and Ekaterina Merrill.