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OFFICE OF THE
NEW YORK STATE COMPTROLLER

DIVISION OF STATE
GOVERNMENT ACCOUNTABILITY

OFFICE OF THE STATE COMPTROLLER

A SUMMARY REPORT ON AUDITING THE NEW YORK STATE HEALTH INSURANCE PROGRAM - NEW FOCUS AND FUTURE DIRECTIONS

Report 2008-S-130

EXECUTIVE SUMMARY

The New York State Health Insurance Program (NYSHIP) is the nation's largest public sector health insurance program outside the Federal government. NYSHIP covers 1.2 million active and retired State, local government, and school district employees and their dependents, most of whom are enrolled in NYSHIP's Empire Plan.

In the 2007 calendar year, NYSHIP cost the State, other participating public employers, employees and retirees, about $5.4 billion. The State's share of these costs was $2.5 billion, the participating employers' share was $1.9 billion, and the members' share was $1 billion. Most of the costs ($4.4 billion) were to reimburse claims paid by the Empire Plan's four insurance carriers on behalf of the enrolled members.

The Office of the State Comptroller (OSC) regularly conducts audits of NYSHIP. Until recently, the audits focused on claims processing activities in the Empire Plan. As a result of these audits, $136 million in overpayments have been identified and recovered, and improvements were made in the insurance carriers' claims processing practices. We are continuing to perform these kinds of audits, but we have also begun to perform a different type of audit that focuses on individual medical service providers rather than general claims processing activities. This type of audit has considerable cost-recovery potential, because it can focus on providers that are more likely to submit incorrect, invalid or even fraudulent claims which can drive up the cost of insurance for New York State and local governments.

For example, we recently initiated a series of audits that focused on certain providers in the medical/surgical component of the Empire Plan. Our audit of a sample of 22 providers found that 20 of these providers were routinely submitting inflated claims to the Empire Plan, and as a result, had obtained excessive reimbursements from the Plan which are ultimately paid by State and local governments and the Employee Retirement System. We recommended the Empire Plan recover the inflated portions of these reimbursements, an amount we estimated to be about $13.8 million for the periods we audited (about 17 percent of the total $80.7 million the providers billed to the Empire Plan during these periods). We also recommended action be taken to prevent the providers from submitting such claims in the future.

Other recent OSC audits focusing on individual providers have also identified significant overpayments as well as possible fraud. It is thus clear that a focus on providers can do much to help contain costs in the Empire Plan. To assist in containing these costs, improving fraud detection efforts, recovering future overpayments, and to improve their detection efforts, we are working closely with the Empire Plan's insurance carriers, the Department of Civil Service, which administers the Empire Plan and the New York State Insurance Department which oversees insurance industry practices in New York State.

BACKGROUND

NYSHIP was established in 1957 under the provisions of Chapter 461 of the Laws of 1956 which added Article 7 (renumbered Article 11) to the Civil Service Law. Outside of the Federal government, it is the largest public sector health insurance program in the nation, covering 1.2 million active and retired State, local government, public authority and school district employees and their dependents, as follows:

Status as of May 2008	Total
Active Employees	386,000
Retired Employees	205,000
Dependents	638,000
Total Members	1,229,000

NYSHIP is a State program, administered by the New York State Department of Civil Service. However, NYSHIP is also open to other public employers in New York State. If a public authority, local government agency or school district elects to participate in NYSHIP, it signs a participation agreement with the State. Currently, a total of 98 public authorities, 675 local government agencies, and 143 school districts participate in NYSHIP. The State bills the participating employers for the cost of their participation.

NYSHIP provides insurance coverage for the following four types of medical services:

- medical/surgical services,
- hospital services,
- prescription drugs, and
- mental health and substance abuse-related services.

Coverage is provided as part of the terms of employment by the State and other participating employers. The coverage may be provided through NYSHIP's Empire Plan or through a participating Health Maintenance Organization (HMO) (only State employees/retirees/dependents have the option of obtaining coverage through an HMO). About 1.08 million NYSHIP members (88 percent) are enrolled in the Empire Plan, while the remaining 150,000 (12 percent) are enrolled in an HMO.

In the Empire Plan, medical services are usually obtained from participating service providers, who are reimbursed directly by the Empire Plan. Members generally pay only a nominal co-payment when they receive the services. In addition, members are charged an annual insurance premium. Empire Plan members may also choose to go to non-participating providers, but when the members do this, they may pay significantly more, because they are usually responsible for an annual deductible on the services from such providers as well as a portion of the providers' fees (known as coinsurance).

The Empire Plan is administered by four contracted insurance carriers, one for each of the four types of covered medical services. Each carrier is responsible for establishing a network of participating providers in its area of coverage, establishing the reimbursement rates for these providers, processing payment claims from both participating and non-participating providers, and ensuring compliance with the requirements of the Empire Plan. The carriers are fully reimbursed by the State for their claim payments, and are also paid an administrative fee.

When coverage is provided through an HMO, the NYSHIP member must enroll in the HMO and, generally, all covered medical services must be obtained through the HMO. The member usually is required to pay only a

nominal co-payment when he or she receives a service, and is also charged an annual insurance premium. The HMO is responsible for paying the providers, and for negotiating payment rates with the providers. Each of the 12 participating HMOs is responsible for certain geographic areas, and each contracts separately with the State.

The State and the other participating employers pay a certain percentage of the members' health insurance premiums, and the members pay the balance. For example, the State pays 90 percent of the premiums for employees, and 75 percent for dependents.

In the 2007 calendar year, NYSHIP cost the State, the participating employers and employees/retirees a total of about $5.4 billion. The State's share of these costs was about $2.5 billion, the participating employers' share was about $1.9 billion, and the members' share was about $1 billion. The State's share consisted of the following:

- $1.86 billion in Empire Plan claims,
- $147 million in Empire Plan administrative fees,
- $533 million in HMO insurance premiums.

The following table breaks down the nearly $4.4 billion in Empire Plan claims by coverage area:

Type of Coverage	Number of Claims	Cost of Claims
Medical/Surgical	19,900,000	$1.685 billion
Hospital	1,220,000	$1.246 billion
Prescription Drugs	13,000,000	$1.359 billion
Mental Health & Substance Abuse	558,000	$ .077 billion
Total	34,678,000	$4.367 billion

As of January 2008, the four areas of coverage in the Empire Plan were administered by the following four insurance carriers:

Area of Coverage	Insurance Carrier	Since When
Medical/Surgical	United HealthCare	1986
Hospital	Empire Blue Cross and Blue Shield	1957
Prescription Drugs	Medco and United HealthCare	2008
Mental Health & Substance Abuse	Value Options and Group Health Inc.	1999

RESULTS OF RECENT OSC AUDITS

OSC has been auditing NYSHIP on a regular basis since 1990. Until recently, the audits focused on computer analysis of the claims processing activities of the Empire Plan's contracted insurance carriers. The audits found that millions of dollars were overpaid because payments were made on claims that were either not eligible for reimbursement or not eligible for the amounts claimed.

In some instances, the claims should have been paid by other insurers (principally Medicare). In other instances, we found that claims duplicated all or parts of other claims, claims included an incorrect reimbursement rate, or the treated individual was no longer a member of the Empire Plan when the services were provided. From 1999 to 2007, cost savings based on NYSHIP audits totaled $136 million. Included in this is a $27 million settlement based in part on our audit work, that the New York State Attorney General litigated with Express Scripts Incorporated, a former Empire Plan pharmacy benefits manager.

As a result of these audits, millions of dollars in overpayments were recovered and improvements were made in the carriers' claims processing practices. We are

continuing to perform these kinds of audits, but we have also begun to perform a different type of audit that focuses on the records and practices of individual providers rather than solely relying upon analysis of claims processing activities.

This type of audit has considerable cost-recovery potential, because it can focus on providers that are more likely to submit incorrect, invalid or even fraudulent claims. Such providers can be identified through the analysis of provider claims and claim submission patterns, and such analysis has been facilitated by the development and refinement of specialized audit software.

Audits Addressing Non-Participating Providers

We recently initiated a series of audits that focused on certain non-participating providers in the medical/surgical component of the Empire Plan. These providers are subject to less cost control than participating providers, because, unlike the participating providers, they are not tied to a set fee schedule and their reimbursements from the Empire Plan can be significantly higher than the set fee for participating providers. We have found that the non-participating providers' reimbursements from the Empire Plan are typically 77 to 83 percent higher than the set fee for participating providers.

We selected 22 non-participating providers for audit because a preliminary analysis indicated that the providers might be overstating their actual charges to Empire Plan members on their reimbursement claims. Any such overstatements would improperly inflate the providers' reimbursements, because they are usually reimbursed for about 80 percent of their actual charges.

The most common way of overstating these charges is for the non-participating provider to waive the Empire Plan member's co-insurance (i.e., the member's 20 percent share of the bill). Thus, if a non-participating provider charged an Empire Plan member $1,000 for a service, the provider would submit a claim to the Empire Plan for $1,000. The Empire Plan would then reimburse the provider for $800 of this $1,000 (80 percent), and the member would owe the balance. However, if the provider routinely waived the member's share of the charges, the provider should actually be charging the Empire Plan only $800 for the service. In this case, the resulting reimbursement would be only $640 (80 percent of $800), which is $160 lower than the reimbursement on the inflated charge.

Under New York State Penal Law, submitting an insurance claim with false information, such as an inflated charge for service, may constitute insurance fraud. In addition, officials at the Department of Civil Service and the State Insurance Department are concerned that providers who routinely waive Empire Plan members' co-insurance are doing so in order to benefit from the higher reimbursement rates for non-participating providers. Since payments to non-participating providers account for about 30 percent of all claim payments in the medical/surgical portion of the Empire Plan, the potential for overpayments in this area is significant.

We selected 22 non-participating providers to determine if they were, in fact, routinely waiving Empire Plan members' co-insurance. We visited the providers and reviewed their financial records for a random sample of their claims. As is summarized in Exhibit A, we found that 20 of the 22 providers were routinely waiving Empire Plan members' co-insurance, and as a result, were routinely

submitting inflated claims to the Empire Plan. (Two of the providers had not engaged in the practice of routinely waving co-insurance.) For example, one of the providers (the Digestive Health Center of Huntington) was paid $4.6 million by the Empire Plan during our six-year audit period. When we reviewed a random sample of 170 of 1,871 claims submitted by the provider during this period, we found that the provider had waived the Empire Plan member's co-insurance in 168 of the 170 claims, and as a result, had inflated these 168 claims. When the overpayments on these 168 inflated claims ($113,120) were statistically projected to the entire six-year period, the total overpayments for the period were estimated to be about $1.5 million (nearly one-third of the total $4.6 million the provider had billed to the Empire Plan during the period).

We recommended the Empire Plan recover the overpayments made to the 20 providers, an amount we estimated to be about $13.8 million for the periods we audited (about 17 percent of the total $80.7 million the providers billed to the Empire Plan during these periods). We also recommended that the insurance carrier (United HealthCare) work with the Department of Civil Service to pursue actions that would prevent the providers from submitting such claims in the future.

As of July 10, 2008, United HealthCare reported that $3.5 million of the $13.8 million had been recovered, and repayment agreements were in effect for another $5.4 million. In addition, United HealthCare reported that three of the largest providers agreed to join the Empire Plan as participating providers, and participation negotiations are underway with several other providers. This will result in millions of dollars in future savings as these providers will now be reimbursed at the discounted participating provider rates.

Other Provider-Focused Audits

Other recent OSC audits focusing on individual providers have also identified significant overpayments. For example, we audited the claims submitted by a clinic where most of the physicians participated in the Empire Plan (Report 2007-S-54, issued in September 2007). When these physicians provided services to Empire Plan members, the services should have been reimbursed at the rates that were established for participating providers. However, we found the services were inappropriately reimbursed at non-participating rates, which were five times higher than the rates established for participating providers.

The higher rates were paid because the clinic submitted the payment claims as a non-participating provider. The clinic then shared the proceeds with the physicians, which it claimed were its employees. However, we determined that an employer-employee relationship did not appear to exist between the clinic and the physicians; rather, the clinic appeared to be inserting itself as an unnecessary intermediary between the physicians and the Empire Plan in order to charge the Empire Plan the higher non-participating rates.

During the six years we examined, the Empire Plan paid the clinic $3.9 million. We recommended these payments be recovered and all further payments to the clinic be suspended until questions about the legitimacy of its billing practices were resolved.

In another audit focusing on a particular provider (Report 2006-S-54, issued in August 2006), we examined the payments made by

the Empire Plan to a neurosurgeon for extracorporeal shock wave therapy that had supposedly been provided by the neurosurgeon to treat plantar faciitis (an inflammation of the foot). We found that the neurosurgeon was inappropriately paid nearly $1.8 million during our 15-month audit period, because the services claimed by the neurosurgeon were actually provided by other practitioners (generally podiatrists) and these providers billed and were paid by the Empire Plan for those services.

We recommended that the payments to the neurosurgeon be recovered, and when we followed up on this matter with the insurance carrier (Report 2007-F-14, issued in August 2007), we found the carrier discontinued coverage for extracorporeal shock wave therapy, resulting in annual savings of about $4.3 million.

In other recent audits, we identified significant overpayments by selecting random samples of particular types of claims and reviewing the providers' medical records to determine whether the records supported the claims. For example, when we reviewed the medical records for a sample of outpatient consultation claims (Report 2007-S-20, issued in December 2007); we found that 77 of the 284 claims in our sample were not supported by the medical records. In most of these instances, the records supported a less costly medical service than the consultation service claimed. On the basis of our sample results, we estimated that the Empire Plan overpaid service providers between $10.5 million and $17.5 million in our three-year audit period.

Similarly, when we reviewed the medical records for claims involving certain types of evaluation and management services (Report 2006-S-11, issued in November 2006), we found that the providers often billed the Empire Plan for a higher paying service than was actually provided, and as a result, the providers were often overpaid for these services. We estimated that, in the one-year period reviewed, these overpayments totaled as much as $6.5 million.

In addition, while most of our audits have addressed the medical/surgical component of the Empire Plan, there are also opportunities for improvements in the other components of the Plan. For example, in a 2002 audit, we identified questionable pricing practices by Express Scripts, then responsible for administering the Empire Plan's prescription drug coverage (Report 2001-S-52). Our disclosures prompted the State Attorney General's Office to begin an investigation of Express Scripts.

We were asked to assist in this investigation, and using electronic data analysis techniques to review subpoenaed data and records, we identified more than $76 million in potential overbillings by the carrier (drugs were inappropriately billed at higher brand-name reimbursement rates rather than lower generic rates) and drug manufacturer rebates were not shared with the State as required by the carrier's contract with the State. In August 2004, the Attorney General filed a lawsuit against the carrier. In July 2008, the Attorney General secured a $27 million settlement.

CONCLUSION

Our recent audit results have shown that, by focusing more emphasis on providers, we will significantly effectuate the amount of overpayments recovered by the State and thereby assist in containing costs of the Empire Plan. We note that these cost-containment efforts benefit local taxpayers as well as State taxpayers, because the participating local governments pay the same health insurance costs as the State. We also note that, as the number of retirees in the

Empire Plan grows and as retirees live longer, it will be more important than ever for the State's health insurance costs to be brought under better control.

Our recent audits could not have been as successful as they were without the cooperation of the insurance carrier for the medical/surgical portion of the Empire Plan (United HealthCare) and the other State agencies with oversight responsibilities in this area (the Department of Civil Service, the State Insurance Department, and the State Attorney General's Office). We are committed to continuing these partnerships, just as we are committed to continuing our focus on provider-based audits.

Exhibit A

Overpayments to Non-Participating Providers
Who Routinely Overstated Their Actual Charges to Empire Plan Members
As Identified by Recent OSC Audits

Provider	Total Amount Billed to Empire Plan During Audit Period	Inflated Portion of Billings	Percent of Total Billings Inflated	Audit Period	Audit Report Number
Endoscopy Center of Long Island	$12.4 million	$2.7 million	22 %	6 years	2007-S-73
Capital Region Ambulatory Surgery Center	$12.9 million	$2.4 million	19 %	6 years	2007-S-72
Digestive Health Center of Huntington	$ 4.6 million	$1.5 million	33 %	6 years	2007-S-87
Day Op Center of North Nassau	$ 6.1 million	$1.5 million	25 %	6 years	2007-S-120
Day Op Center of Long Island	$13.4 million	$1.4 million	10 %	6 years	2007-S-86
South Shore Ambulatory Surgery Center	$12.4 million	$1.0 million	8 %	7 years	2008-S-11
Dr. Anker and Dr. Cussatti	$ 5.2 million	$ 744,055	14 %	7 years	2008-S-43
Long Island Center for Digestive Health	$ 2.6 million	$ 624,278	24 %	1.5 years	2008-S-28
Dr. Edward Fryman (Podiatrist)	$ 2.1 million	$ 507,786	24 %	7 years	2008-S-44
Kips Bay Endoscopy Center	$ 1.68 million	$ 214,520	13 %	7 years	2008-S-33
Guthrie Same Day Surgery Center	$ 506,171	$ 200,216	40 %	5 years	2008-S-32
Fifth Avenue Surgery Center	$ 1.42 million	$ 178,633	13 %	7 years	2008-S-34
Brooklyn Endoscopy & Ambulatory Surgery Center	$ 1.0 million	$ 177,610	18 %	3.5 years	2008-S-41
Ambulatory Surgery Center of Westchester	$ 1.22 million	$ 140,656	11 %	7 years	2008-S-35
HealthMark Medical, Inc.	$ 398,377	$ 117,451	29 %	7 years	2008-S-39
Ambulatory Surgery Center of Brooklyn	$ 468,784	$ 117,160	25 %	7 years	2008-S-42
Eye Surgery Center of Westchester	$ 718,369	$ 104,202	14 %	7 years	2008-S-30
Westfall Surgery Center	$ 422,554	$ 98,418	23 %	7 years	2008-S-36
Mid-Manhattan Surgi-Center	$ 370,782	$ 77,946	21 %	7 years	2008-S-40
Center for Specialty Care	$ 802,578	$ 48,213	6 %	7 years	2008-S-37
Total	$80.7 million	$13.8 million	17 %		