Audit of Orange County's Self-Funded Employee Medical Benefits Insurance Program

Report by the
Office of County Comptroller

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March 16, 2010

Richard T. Crotty, County Mayor
And
Board of County Commissioners

We have conducted an audit of the 2007 medical and pharmaceutical claim payments for the Orange County self-funded employee medical benefits insurance program. The audit was limited to a review of the claims submitted for payment under the terms of the United Healthcare Administrative Services Only agreement with Orange County and the reporting of eligibility by participating organizations to United Healthcare.

We conducted this audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives, except for the limitations described in the Overall Evaluation regarding the data requested and not provided as of the issuance of the report.

Responses to our Recommendations for Improvement were received from the Director of Human Resources and are incorporated herein.

We appreciate the cooperation of the personnel of the County and various participating organizations during the course of the audit.

Martha O. Haynie, CPA
County Comptroller

c: Ajit Lalchandani, County Administrator
Sharon Donoghue, Deputy County Administrator
Ricardo Daye, Director of Human Resources

EXECUTIVE SUMMARY

Executive Summary

We have conducted an audit of the Orange County self-funded employee medical benefits insurance program for 2007. The audit was limited to a review of the claims submitted for payment under the terms of the United Healthcare Administrative Services Only agreement with Orange County and the reporting of eligibility by participating organizations to United Healthcare (UHC). The audit objectives were to gain assurance on the following:

- Whether claims paid in the 2007 plan year were for services received in the plan year by eligible enrollees.

- Whether medical claims processed by UHC were promptly and accurately paid according to plan provisions.

- Whether the Plan Administrator has proper administrative controls and monitoring to help reduce the risk of ineligible claims being incurred and paid with County funds.

In our opinion, Orange County's Human Resources Department's (Plan Administrator) monitoring and administrative controls to reduce the risk of ineligible claims being paid with County funds are not adequate. Based on the results of our testing and the lack of sufficient appropriate evidence, we could not assess whether the UHC claim payment requests paid by the County in the 2007 plan year were for eligible enrollees' services received during the plan year. As noted in the report, this was due to UHC not providing requested data which would allow the reconciliation of the claim payment requests to the claims presented for audit. However, with regard to the claims presented for audit, more than 99 percent were for eligible participants. Opportunities for improvement noted during our review were as follows:

No written procedures describing the process of obtaining approval and granting access to UHC's eligibility maintenance system (UHC eServices) existed.

The Plan Administrator did not maintain documentation of UHC eServices access approvals. As a result, we requested a list from UHC of persons eligible to access UHC eServices and noted that access remained for an intern no longer employed by the Plan Administrator and an employee with an organization no longer participating in the Plan.

Each individual granted access to UHC eServices could view enrollee data for all participating organizations. Further, depending on their permissions, individuals from any of the participating organizations could add, delete, or modify enrollee data without detection.

During our comparison of the eligibility data reported to the Plan Administrator by the participating organizations to the data in UHC eServices used to process

claims, we noted numerous discrepancies between the dates of birth, social security numbers, and eligibility dates. We also found there were no standards or procedures for participating organizations to apply while entering data into UHC eServices. Further, none of the participating organizations maintained an historical list of any changes made to eligibility data throughout the plan year.

Based on the participating agency's eligibility data, claims totaling approximately $237,774 were paid for enrollees that were not eligible to receive services on the date of service recorded in the UHC claim files. As such, it appears the County was paying for medical claims for employees or family members of employees that should have been terminated or did not belong in the plan.

We found some participating agencies did not require new hires electing medical coverage to provide a valid birth certificate, court order, tax return, or marriage certificate to enroll dependents. As a result, the risk that claims are being processed for ineligible dependents increased.

The Plan Administrator and UHC participated in a Shared Savings Plan (SSP). The SSP required the County to pay UHC 35 percent of the discount received on charges on out-of-network claims. A cursory review of the facilities and physicians submitted on the SSP reports found that some of the providers were in-network. When this information was presented to UHC for review, UHC noted numerous SSP errors that should have reduced the amount of shared savings paid to them. Subsequent to being notified of these errors, UHC refunded the County $96,941 for all amounts paid for SSP claims in the 2008 plan year and agreed to review all of the claims submitted for the 2007 plan year for accuracy.

There was no information on the SSP reports that allowed the individual transactions to be traced to bank account activity. Without this information, we were not able to determine if the transactions on the SSP report were for valid claims.

Florida Statutes, working in conjunction with Federal laws, do not allow coverage for a newborn to be denied under an insurance plan if the enrollee notifies the plan administrator within 60 days of the birth or placement of a child. During our review of newborn claims processed, we noted that the participating organizations' requirements and procedures for adding newborns varied. Most either had a policy or orally communicated to their subscribers that they only had 30 days from the date of birth to add the newborn. Some participating agencies stated they have denied a subscriber's coverage of a newborn due to the enrollee's request exceeding this 30 day limit. The Plan Administrator's staff informed us that they have never denied a request for coverage for a newborn between 30 and 60 days after birth, although the County's Enrollment/Change Form notes that such a change can only be done within 30 days.

As a result of the data maintenance and reporting procedures of UHC, we were unable to assess the validity and accuracy of the claims report provided by UHC and were unable to determine if all the monies paid by the County were for valid claims. During the negotiations for the 2010 contract year, the County added a clause to the contract, based on our request, that requires UHC to provide a report that would allow this reconciliation. To date, UHC has not provided an adequate report.

The Plan Administrator concurred with all of the Recommendations for Improvement and steps to implement the recommendations are underway or completed. Responses to each of the Recommendations for Improvement are included herein.

ACTION PLAN

AUDIT OF ORANGE COUNTY'S SELF-FUNDED EMPLOYEE MEDICAL BENEFITS INSURANCE PROGRAM
ACTION PLAN

NO.	RECOMMENDATIONS	MANAGEMENT RESPONSE			IMPLEMENTATION STATUS	
		CONCUR	PARTIALLY CONCUR	DO NOT CONCUR	UNDERWAY	PLANNED
1.	We recommend the Plan Administrator:					
A)	Develops procedures for documenting, approving, and granting access to UHC eServices;	✓			Completed	
B)	Periodically performs a documented review of UHC eServices access, reconciling individuals with system access to documented approvals; and	✓			Completed	
C)	Works with UHC to restrict access of authorized individuals to their respective organization.	✓			✓	
2.	We recommend the Plan Administrator:					
A)	Ensures participating organizations correct all errors identified by the audit;	✓			Completed	
B)	Continues to implement steps to ensure eligibility data is accurate and uniformly maintained. Additionally, the history of any changes made to eligibility data should be maintained by participating organizations;	✓			✓	
C)	Continues to develop standard eligibility reporting and provide training for individuals with access to UHC eServices; and	✓			✓	
D)	Considers developing performance standards for accurate and timely eligibility reporting that, if not met, would affect participating organization's premium amounts.	✓			✓	
3.	We recommend the Plan Administrator:					
A)	Works with UHC to determine the cause of ineligible enrollees with claims identified and take corrective action;	✓			Completed	

AUDIT OF ORANGE COUNTY'S SELF-FUNDED EMPLOYEE MEDICAL BENEFITS INSURANCE PROGRAM
ACTION PLAN

NO.	RECOMMENDATIONS	MANAGEMENT RESPONSE			IMPLEMENTATION STATUS	
		CONCUR	PARTIALLY CONCUR	DO NOT CONCUR	UNDERWAY	PLANNED
3. B)	Works with UHC to obtain a monthly report of retro-terminations and the related cost to the County. Consideration should be given to requiring participating organizations to refund the County for any claims paid for ineligible enrollees due to retro-terminations;	✓			✓	
C)	Works with UHC to obtain a monthly system report for each participating agency of changes made to enrollee data identifying the date and the individual initiating the change so that these changes can be documented and reviewed. If this report cannot be obtained, participating organizations should be required to maintain evidence of the changes made.	✓			✓	
4.	We recommend the Plan Administrator takes appropriate action to remedy any ineligible dependents found during this review. This action should include removal of the ineligible individual and disciplinary action of the employee, if warranted. In addition, the Plan Administrator should require the participating organizations to obtain a birth certificate, adoption certificate, court order, tax return or marriage certificate to extend coverage to a new dependent for new employees, qualifying events, or during open enrollment.	✓			✓	
5.	We recommend the Plan Administrator continues to work with UHC to resolve the reporting issues with the SSP report. In addition, the Plan Administrator should require UHC to re-adjudicate all in-network providers' claims found to have been processed incorrectly as out-of-network under SSP and refund any additional amounts due.	✓			✓	

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NO.	RECOMMENDATIONS	MANAGEMENT RESPONSE			IMPLEMENTATION STATUS	
		CONCUR	PARTIALLY CONCUR	DO NOT CONCUR	UNDERWAY	PLANNED
6.	We recommend the Plan Administrator requires participating organizations to allow subscribers to add a dependent up to 60 days from the birth or placement of the child. In addition, the Plan Administrator should consider charging subscribers for insurance premiums if the notification is between 31 and 60 days.	✓			Completed	
7.	We recommend the Plan Administrator continues to work with UHC to obtain a report that enables the claim number to be reconciled to the check number.	✓			✓	

INTRODUCTION

Background

Prior to 2007, Orange County (County) had a fully funded health insurance program in which the County remitted premiums to a private health insurance company. This program covered County staff as well as other elected officials and organizations (see table on next page). In 2007, the County along with other elected officials and organizations (participating organizations) moved to a self-funded health insurance program (Plan). Under this type of program, health care costs are paid by the County while a third-party administrator is contracted to administer the plan. The County is the plan sponsor and has the responsibility of providing the funding necessary to pay claims. As a result, the risk of any loss remains with the County. Participating organizations are required to remit biweekly premiums to the County based on prior years' claim experience.

The Plan is administered by United Healthcare Insurance Company (UHC), which provides Administrative Services Only (ASO) for medical and pharmaceutical services. This ASO contract includes access to UHC's provider network, benefit determination, and claim processing, including payment. UHC invoices the County for standard medical ASO fees, which the County pays on a monthly basis.

The Plan is funded through an imprest account in which the County maintains a $271,000 balance. Each business day, UHC notifies the County of the amount needed to be transferred into the imprest account to fund the claims paid by UHC the previous day. Approximately $60.5 million was transferred to this account for the 2007 plan year, representing 367,217 medical claim transactions and 151,372 pharmaceutical claim transactions.

Based on data reported by the Orange County Human Resources (Plan Administrator) and participating organizations, there were approximately 9,959 subscribers and 11,064 dependents enrolled throughout the 2007 plan year. The table on the following page lists the participating organizations and the approximate number of subscribers and dependents (enrollees) under the County's Plan:

Participating Organization	Number of Subscribers & Dependents in Health Plan
Board of County Commissioners (Board)	15,340
Comptroller's Office (COMPT)	478
LYNX	1,859
Central Florida Research Park (CFRP)	2
Supervisor of Elections (SoE)	112
Orlando Orange County Expressway Authority (OOCEA)	116
Metroplan (Metro)	38
Orange County Clerk of Courts (OCCoC)	1,264
Property Appraiser's Office (PA)	312
S.O.B.T. Development Board (SOBTDB)	15
Orange County Tax Collector's Office (OCTC)	410
Housing & Finance Authority (HFA)	24
International Drive Master Transit & Improvement District (IDMTID)	19
Orlando Housing Authority (OHA)	160
COBRA	164
Retiree	704
Survivor	6
TOTAL	21,023

Enrollee eligibility is maintained and reported by each participating organization. To update eligibility data, the Board and Comptroller provide UHC with biweekly electronic files containing current enrollee data. Other organizations manually input changes to the system using UHC's secure website (eServices). Participating organizations pay premiums to the Board based on the number of subscribers and plan selected. Subscribers have a choice between Health Maintenance Organization (HMO) and Point of Service (POS) coverage at the following levels: Employee; Employee plus Spouse; Employee plus Child(ren); and Employee plus Family.

Appendix A includes a summary of benefits for the 2007 plan year.

As part of the self-funded health insurance program, all claims for providers that are out-of-network are eligible for the Shared Savings Program (SSP). The SSP allows the

County to access UHC's discounted prices from a third-party, which may have contracts with the provider or may negotiate a discount with the provider on the specific claim. If the billed amount is discounted through the SSP, UHC is compensated 35 percent of the dollar amount saved.

Scope, Objectives, and Methodology

The audit scope included a review of the internal controls over the medical benefits eligibility and claims processing. The audit was limited to a review of the claims submitted for payment under the terms of the United Healthcare Administrative Services Only agreement with Orange County and the reporting of eligibility by participating organizations to United Healthcare. The period audited was January 1, 2007 to December 31, 2007. The audit objectives were to gain assurance on the following:

- Whether claims paid in the 2007 plan year were for services received in the plan year by eligible enrollees.
- Whether medical claims processed by UHC were promptly and accurately paid according to plan provisions.
- Whether the Plan Administrator has proper administrative controls and monitoring to help reduce the risk of ineligible claims being incurred and paid with County funds.

To achieve our objectives, we performed the following tests:

We created an historical eligibility file by first obtaining a list of all eligible subscribers and dependents from each participating organization for the 2007 plan year, as no historical eligibility file was available. Second, this eligibility file was reconciled to the biweekly reports participating organizations submitted to the Plan Administrator. All differences (enrollees, termination dates, Social Security Numbers, dates of birth, etc.) were researched by the participating organizations and adjustments were made as necessary. As an additional step, we verified that all

enrollees that were in the check register file (listed as an enrollee by UHC) were in the eligibility file. Any differences were also researched by participating organizations and the eligibility file was updated as necessary.

The paid medical and pharmaceutical claims files were obtained from UHC. First, we verified that the enrollees reported in the claims files were in the eligibility file developed above. All enrollees that were in the claims files but not in the eligibility file were researched by the participating organizations. Based on this research, the eligibility file was adjusted as necessary. Next, we determined whether the date of service reported in the claims files fell in between the range of enrollee's eligibility dates reported by the participating organizations in the eligibility file.

For the enrollees having claims with dates of service outside of their reported eligibility dates, we verified that the eligibility file and UHC eServices eligibility dates agreed. Any enrollees with conflicting eligibility dates were researched by the participating organization and corrections were made as necessary to the eligibility file. The claims' dates of service were then tested again and any that fell outside an enrollee's eligibility dates were deemed invalid and reported to the participating organizations.

We obtained eligibility data reports for November 2008 from the Plan Administrator and UHC to perform a second test of current eligibility. We reconciled these lists and any differences were researched by the Plan Administrator and participating organizations. Results were reported to the participating organizations in order that corrective action could be taken.

We obtained the Shared Savings Plan (SSP) reports for the 2007 plan year from the Plan Administrator. We recalculated the SSP report to determine whether the mathematical computations were correct. We determined the type of coverage for the enrollees listed on the SSP report (HMO or POS) and reviewed the number of transactions for reasonableness based on their coverage

type. We verified a sample of vendors listed on the SSP reports and determined whether they were out of network. Additionally, we determined whether the vendors in the SSP reports were also in the check register.

We prepared and issued a Request for Proposal for medical claims auditing services. We contracted with a firm to review and evaluate the claims processing services provided by UHC. The review included operational areas such as Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliance and a review of the SAS 70 report (a report by an independent CPA attesting to the control environment). The main objective of the engagement was to determine whether medical and pharmaceutical claims were accurately processed. Some of the areas included the timeliness of claims processing, payment accuracy, and a determination of whether medical and pharmaceutical services provided to enrollees were in accordance with the Plan. This report was provided to the the County upon completion.

We attempted to assess the validity and reliability of the 2007 claims files obtained from UHC. However, UHC did not provide adequate data to reconcile the claims files to the Detailed Report for Transfer Evaluation (DTR) which UHC provides to support payments made by the County. With respect to the DTR, although valid enrollee social security numbers were listed, we were not able to determine if the enrollees were eligible since the supporting documentation omitted necessary data including the dates of service and claim numbers.

Our scope did not include reviewing the payment reconciliation process or a review of the documentation for eligibility data reported by the Plan Administrator and participating organizations.

Overall Evaluation

In our opinion, the Plan Administrator's monitoring and administrative controls to reduce the risk of ineligible claims being paid with County funds are not adequate. Based on the results of our testing and the lack of sufficient appropriate evidence, we could not assess whether the UHC claim payment requests paid by the County in the 2007 plan year were for eligible enrollees' services received during the plan year. As noted above, this was due to UHC not providing the requested data that would allow the reconciliation of the claim payment requests to the claims presented for audit. However, with regard to the claims presented for audit, more than 99 percent were for eligible participants.

As noted above, UHC's promptness and accuracy of the processing and payment of medical claims in accordance with plan provisions were addressed in a previously issued separate report.

Opportunities for improvement were noted and are described herein.

RECOMMENDATIONS FOR IMPROVEMENT

1. Access to UHC eServices Should Be Monitored and Restricted

Participating organizations are responsible for maintaining eligibility data for enrollees and ensuring that the information in the United Health Care (UHC) system is accurate as UHC relies on this data to process claims. In order to view and update eligibility, UHC grants individuals approved by the Plan Administrator with access to their system (UHC eServices). However, no written procedures exist describing the process of obtaining approval and granting access. During our review, we also had the following concerns regarding UHC eServices access:

A) The Plan Administrator does not maintain access approvals. As a result, we requested that UHC provide a list of all persons with access to UHC eServices with their associated permission level. A review of this list revealed the following:

- The list was incomplete. We found that an employee of the Plan Administrator responsible for granting access was not included. As a result of the Plan Administrator not maintaining an accurate list, we could not determine whether others having access were excluded from the report.

- An intern no longer employed by the Plan Administrator and an employee with an organization no longer participating in the Plan had access to UHC eServices.

B) Unauthorized changes can be made to enrollee data. Each individual that is granted access to UHC eServices can view enrollee data for all participating organizations. Therefore, depending on their permissions, individuals from any of the participating organizations can add, delete, or modify enrollee data without timely detection.

The Plan Administrator should maintain access approvals and set access levels as this is an essential component of a control system. The user's access should be restricted to data needed to administer the plan for their organization or as deemed necessary by the Plan Administrator.

As access is currently granted, unauthorized changes could be made to the eligibility data, either by other participating organizations or individuals that should not have access to UHC eServices. This could result in claims being paid for ineligible enrollees.

We Recommend the Plan Administrator:

A) Develops procedures for documenting, approving, and granting access to UHC eServices;

B) Periodically performs a documented review of UHC eServices access, reconciling individuals with system access to documented approvals; and

C) Works with UHC to restrict access of authorized individuals to their respective organization.

Management's Response:

A) Concur. HR Benefits immediately developed an Access Authorization form for UHC eServices after the need was identified. The form includes the access level needed, the justification for access, in addition to identifying the organization, title, and contact information of the individual seeking authorization. The form then has to be approved and signed by the agency HR Director and submitted to Central HR prior to authorization of access to the system.

B) Concur. HR Benefits has developed an eServices access report that lists current authorized individuals who have access to eServices, denoting the purpose of access and access level needed. An eServices access report will be requested from UHC quarterly to

compare with the report maintained by HR Benefits to confirm accuracy and process updates.

C) Concur. After negotiations, UHC has agreed to HR Benefits' request to re-structure the current policy effective January 1, 2010 so that access levels can be restricted for authorized individuals to only have access to their respective agency participants and eliminating individuals having access to all participating organizations enrollees' information. Challenges with UHC's system has delayed implementation.

2. The Process of Maintaining Eligibility Should Be Improved

During testing of the 2007 claims, we discovered numerous inconsistencies between the eligibility data reported to the Plan Administrator by the participating organizations and the information within UHC eServices. The discrepancies related to information such as dates of birth, social security numbers, and eligibility dates. We also found there are no standards or procedures for participating organizations to apply while using UHC eServices. Further, none of the participating organizations maintained an historical list of any changes made to eligibility throughout the plan year.

Due to the various eligibility errors noted during our testing of the 2007 claims, concerns arose regarding the accuracy of current eligibility data and the processing of on-going claims. As a result, we performed testing to determine the accuracy of the current (November 2008) eligibility data, which needed to be corrected so future claims could be processed using accurate information. Based on a comparison of the data provided by participating organizations and current information from UHC eServices, we noted numerous discrepancies in the data as follows:

- 109 dates of birth needed to be corrected.
- 33 Social Security Numbers needed to be corrected.

- 31 eligible members on the participating organization's lists needed to be added to eServices.
- 41 ineligible members in eServices needed to be terminated.
- 109 eligible enrollees recorded in eServices needed to be added to the participating organization's list.
- 52 ineligible members needed to be deleted from the participating organization's list.

A breakdown of these errors by source or participating organization is as follows:

Source or Organization (ORG)	Date of Birth	SSN	Add to UHC	Delete From UHC	Add to ORG	Delete From ORG	Reported Number of Enrollees
RETIREE	15	2	18	12	48	23	704
COBRA	4	1	1	1	5	2	164
BCC	2	-	4	-	4	4	15,340
LYNX	56	19	6	13	18	8	1,859
SOBTDB	-	-	-	-	-	-	15
OCCoC	8	3	2	11	26	9	1,264
PA	4	1	-	-	-	-	312
OHA	-	-	-	1	-	-	160
METRO	1	-	-	-	-	4	38
SoE	2	2	-	-	-	-	112
COMPT	1	-	-	-	-	-	478
OOCEA	1	3	-	3	-	-	116
OCTC	10	2	-	-	1	2	410
CFRP	1	-	-	-	-	-	2
HFA	1	-	-	-	-	-	24
IDMTID	3	-	-	-	-	-	19
SURVIVOR	-	-	-	-	7	-	6
TOTAL	109	33	31	41	109	52	21,023

Additionally, the following inconsistencies were noted:

- Sixty-nine plan codes, which represent the agency and the plan type, on participating organizations' eligibility lists differed from the plan codes on UHC eServices. Twenty-seven of these discrepancies resulted in different coverage plan types (HMO versus POS).

- Within the participating organizations' eligibility lists, we found numerous plan codes that did not match the plan names in UHC eServices.

- Numerous differences between the spelling of enrollee's first and last names as well as enrollee relationship codes (i.e. enrollees classified as a child in the organization but as a spouse in UHC's eServices) were noted between participating organizations' eligibility list and UHC eServices data.

UHC relies on the eligibility data in UHC eServices when processing claims. It is important that participating organizations maintain historical information for issues that may arise regarding past claims. It is also vital that accurate eligibility data be maintained within UHC eServices and by the participating organizations. With inaccurate eligibility data, claims could be paid on behalf of an ineligible enrollee or a valid claim could be denied. In either of these instances, an independent historical eligibility file should be available to verify the data in UHC eServices.

After discussing these issues with the Plan Administrator during the course of this audit, steps were taken to address our concerns including standardizing eligibility reporting and working with UHC to develop training for individuals with access to UHC eServices.

We Recommend the Plan Administrator:

A) Ensures participating organizations correct all errors identified by the audit;

B) Continues to implement steps to ensure eligibility data is accurate and uniformly maintained. Additionally, the history of any changes made to eligibility data should be maintained by participating organizations;

C) Continues to develop standard eligibility reporting and provide training for individuals with access to UHC eServices; and

D) Considers developing performance standards for accurate and timely eligibility reporting that, if not met, would affect participating organization's premium amounts.

Management's Response:

A) Concur. HR Benefits provided the participating agencies with their individual organizations discrepancies for immediate review and updating of both UHC eServices and/or agency files. All agencies reviewed and confirmed that the identified discrepancies were corrected. HR Benefits verified in eServices that updates and changes were completed.

B) Concur. HR Benefits has identified a reconciliation process that would ensure accuracy and uniformity of eligibility data through the use of an Access database. The database will be designed to load both the UHC eligibility reports and the eligibility data received from the participating agencies to reconcile with a master eligibility list. This process will identify discrepancies in data provided by participating organizations as well as allowing eligibility queries to be performed in order to confirm accuracy of data submitted. Currently, HR Benefits is continuing to work with participating agencies to address and resolve report formatting issues. The database will be implemented upon completion of 2.C).

C) Concur. HR Benefits has established eligibility reporting standardization and communicated to all participating organizations and implementation is currently underway. HR Benefits also identified key areas that authorized individuals from the participating agencies needed further training in when utilizing the UHC eServices system. HR Benefits worked with the county's UHC Account Manager to establish guidelines and a training course that included processing additions and terminations of coverage, ordering id cards, changing plan codes, using correct relationship codes, retiree processing, print screening

transactions processed, as well as ensuring the accuracy of data input into the system such as legal name and address has been completed. In addition, HR Benefits will host quarterly meetings with UHC and eServices authorized individuals from the participating agencies beginning in 2010 to address when changes occur with UHC, any process changes, in addition to questions or voiced concerns from the agencies.

D**)** Concur. HR Benefits is working with UHC to obtain monthly eServices transaction reports that will assist in establishing performance standards benchmarks for timeliness and accuracy as well as the effects and to determine best corrective actions for participating agencies that are chronically non-compliant.

3. The Plan Administrator Should Work with UHC to Identify the Causes of Claims for Ineligible Enrollees

To test whether claims reported as paid by UHC during the 2007 plan year were for eligible enrollees, we created an eligibility file based on a comparison of the data provided by participating organizations and information from UHC eServices (as noted above in Recommendation for Improvement No. 2). All discrepancies identified were researched by participating organizations and corrections made as necessary to develop an accurate eligibility file of enrollees. Using this data, we compared the date of service reported on the claims by UHC to the enrollees' eligibility dates reported by the participating organizations. If the claim's date of service fell outside of the enrollees' eligibility dates, the claim was considered invalid. Based on data reviewed, the testing results raised the following concerns:

A) Claims presented for audit totaling approximately $237,774 were paid for enrollees that were not eligible to receive services on the date of service recorded in the UHC claim files. The claims broken down by medical and pharmaceutical are as follows:

	Medical		Pharmaceutical	
	Number of Claims	Dollar Value	Number of Claims	Dollar Value
Eligible	366,143	$51,857,849	150,289	$11,349,587
Ineligible	1,074	$ 153,083	1,083	$ 84,691
Total	367,217	$52,010,932	151,372	$11,434,278

Although the $237,774 in claims presented for audit were for ineligible enrollees, this is not considered material when compared to the $63.4 million of claims presented for audit for the 2007 plan year (less than one-half of one percent), efforts to reduce exceptions and health plan costs should be made.

B) For some of the claim exceptions noted, it appeared as if UHC was processing claims with a date of service outside of an enrollee's eligibility dates recorded in UHC eServices. We were informed that both participating organizations and UHC are able to terminate an enrollee's benefits in UHC eServices as of a prior date, referred to as retro-terminations. This practice can result in UHC paying claims for enrollees that, at the date of processing, were eligible in UHC eServices but later become ineligible due to the retro-termination. Currently, no reports are available for the Plan Administrator from UHC to review retro-terminations and the related financial effect. The Plan Administrator should work with UHC to obtain reports showing retro-terminations and as a result, the amount spent on claims for ineligible enrollees. This will allow the Plan Administrator to monitor this practice and take appropriate actions as necessary to prevent retro-terminations from occurring.

C) We requested UHC to provide a report of all ineligible enrollees with claims as noted in A) above, including the following information:

- The individual entering the termination,
- The date the termination was entered into the system, and

- The method of entry (UHC eServices, file upload, etc.) and any other available information such as notes recorded in the electronic file.

We were informed by UHC that their system cannot provide such a report and the research needed to be done manually. UHC agreed to research and provide the requested information for ten enrollees we selected. A manually prepared spreadsheet was provided by UHC including the date the entry was made, the termination date entered, and the method of termination. However, UHC could not provide the individual that entered the termination. We were informed that this information is not maintained in the computer system.

In an attempt to determine which party was responsible for the retro-terminations identified, we requested the participating organizations to provide any available documentation of problems encountered with terminating the ineligible enrollees. However, no documentation was provided. The participating organizations stated that verification of changes to eligibility is not usually verified in UHC eServices. As a result, we were unable to determine who was responsible for the data entry that caused the retro-termination to occur. This information could help identify whether UHC or the participating organizations were financially responsible for the exceptions noted.

Audit trails are an essential component of a well designed system. The audit trail establishes accountability and provides a map to retrace the flow of changes made in the system. The audit trail should include the date each change was made as well as the user ID of the person initiating the change. Additionally, this information should be accessible to authorized individuals for control purposes. Controls should prevent and detect unauthorized changes to

eligibility. Without these controls, Plan costs to the County and participating organizations from retroactive terminations cannot be addressed effectively. Although certain pieces of the information can be obtained, system changes to allow this information to be easily retrieved should be pursued. Further, participating organizations should be required to retain documentation of changes made to eligibility in UHC eServices.

We Recommend the Plan Administrator:

A) Works with UHC to determine the cause of ineligible enrollees with claims identified and take corrective action;

B) Works with UHC to obtain a monthly report of retro-terminations and the related cost to the County. Consideration should be given to requiring participating organizations to refund the County for any claims paid for ineligible enrollees due to retro-terminations;

C) Works with UHC to obtain a monthly system report for each participating agency of changes made to enrollee data identifying the date and the individual initiating the change so that these changes can be documented and reviewed. If this report cannot be obtained, participating organizations should be required to maintain evidence of the changes made.

Management's Response:

A) Concur. HR Benefits identified the primary cause of the retro-terminations being processed in UHC eServices to be participating agencies which were not consistently processing termination of ineligible enrollees timely or verifying whether terminations were correctly processed in the UHC eServices system. As described in the response to recommendation 1.C) HR Benefits provided the participating organizations with UHC eServices

training in addition to continuing work with UHC to receive specific reports as described in response to recommendation 3.B) that will assist in remedying this issue.

B) Concur. HR Benefits is working with UHC to develop monthly reports to identify participating organizations that process retro-terminations, which is terminating enrollee's benefits in UHC eServices as of a prior date of processed claims date. In addition, we are identifying enrollees that are ineligible due to other unknown factors that need to be researched and causes addressed. UHC has advised that after completion of the access level restrictions project as described in response to recommendation 1.C), monthly reports for each organization will be developed that denotes processing date of retro-terminations as well as the claim amount spent for ineligible enrollees. The reports will then assist the Plan Administrator in tracking participating organizations' volume of retro-termination occurrences and completing quality checks as well as providing documentation when establishing corrective actions.

C) Concur. HR Benefits is working with UHC to develop monthly reports denoting all transactions processed in the eServices system for all participating organizations. The report will be used to determine if family status changes are being processed timely and accurately in the system. UHC has advised that after completion of the access levels restriction project as described in response to recommendation 1.C), monthly reports for each organization will be developed that denotes eligibility transactions processed in eServices. The reports will be forwarded to each participating agency for review and to confirm transactions processed. The reports will also provide documentation for when the Plan Administrator is evaluating eligibility reporting compliance, accuracy and participating organization's consistency. In addition, during the eServices system

training all participating agencies were advised that print screens should be kept in their records of all transactions performed in eServices.

4. The Plan Administrator Should Improve the Dependent Eligibility Process

Subscribers or additional enrollees are added by participating organizations during open enrollment each year. In addition, a subscriber can add an enrollee to their plan throughout the year when a qualifying event (e.g. birth, death, change of family status, etc.) occurs.

When participating organizations were surveyed, we found some do not require new hires electing medical coverage to provide a valid birth certificate, court order, tax return, or marriage certificate to enroll dependents. Furthermore, the documentation requested for qualifying events was also not always sufficient. Valid evidence of dependents' eligibility should be required before being added to the plan. Effective for the 2009 plan year, the Plan Administrator requires supporting documents from subscribers adding dependents to the plan during open enrollment. Additionally, the Plan Administrator requires new hires electing medical coverage and enrolling dependents in the plan to submit valid supporting documentation.

During the audit, the Plan Administrator issued a request for proposal to obtain enrollee eligibility testing services from an outside consultant. This service, through various testing methods, will attempt to determine whether all current enrollees on the plan are eligible. Performing this verification in addition to the support requirement mentioned above should identify individuals that are not eligible to be a part of the County's medical plan.

We Commend the Plan Administrator for initiating the enrollee verification testing. **We Recommend** the Plan Administrator takes appropriate action to remedy any ineligible dependents found during this review. This action should include removal of the ineligible individual and

disciplinary action of the employee, if warranted. In addition, the Plan Administrator should require the participating organizations to obtain a birth certificate, adoption certificate, court order, tax return or marriage certificate to extend coverage to a new dependent for new employees, qualifying events, or during open enrollment.

Management's Response:

Concur. HR Benefits has contracted with an independent auditing firm to perform a dependent enrollee verification testing of all subscribers enrolled for the plan year beginning January 1, 2009. The independent auditing firm retained will conduct a dependent verification program to ensure that all dependents enrolled in the medical benefits plan at some point during the 2009 plan year were in fact eligible for coverage.

It is stated in the verification correspondence mailed to all individuals with dependents on the medical plan that any dependents deemed ineligible will be removed from the benefit plans. In addition, the employee will be subject to disciplinary action up to and including termination of employment, will be excluded from benefits coverage and will be required to reimburse the County for the benefits costs paid on behalf of the ineligible individuals. It has also been communicated to the participating organizations that the following documentation should be obtained when extending coverage to a new dependent, for new employees, qualifying events and during open enrollment.

Acceptable documentation for adding dependents to the benefits plans include: Marriage license or certificate and a copy of the front and signature pages of the most recently filed jointly tax return (not required if adding a spouse due to marriage); joint bank account statement or joint credit card statement; Birth certificate (or birth record); Adoption certificate with judge signature; or legal guardianship documents. Additional requirements for 19 to 25 year old dependents include proof of financial dependence, proof of student status or proof of residency.

5. The Shared Savings Plan Reporting Should Be Modified

When enrollees, regardless of their plan type, obtain services from in-network providers, the amount charged to the County for the total claim is the amount contracted between UHC and the provider. In instances where enrollees obtain services from non-contracted providers that accept UHC and out-of-network providers, UHC attempts to obtain a discount on the amount billed. These discounts are part of a program referred to as "shared savings," which is part of the contract between the County and UHC. All of these claims are eligible for the Shared Savings Plan (SSP). During the 2007 plan year, UHC agreed to report all claims processed under the SSP to the Plan Administrator and likewise, the County agreed to pay UHC 35 percent of all savings obtained.

UHC reported that 1,729 claims were submitted for the SSP during the 2007 plan year with a total savings to the County of $192,284. UHC was paid approximately $67,441 for these shared savings. Relating to this, we had the following concerns with the SSP report:

- A cursory review of the facilities and physicians submitted on the SSP reports found that some of the providers were in-network. UHC agreed but maintained that some of the claims paid as out-of-network were later found by them to be in-network and credited on subsequent shared savings reports. According to UHC, this error is due to providers' contracts being retro-loaded into UHC's system. UHC is currently in the process of reviewing all of the 2007 claims submitted under the SSP to ensure all credits were given to the County. However, in the claims that have been reviewed, several additional in-network providers have been identified that were not detected by UHC.

- We were not able to reconcile the individual SSP transactions for each claim to the payment Detailed Report for Transfer Evaluation (DTR), which UHC

provides to support payments made by the County. As noted elsewhere in the report, this was due to UHC not providing sufficient data to reconcile the claim numbers to the DTR. Without this information, we are not able to determine if the transactions on the SSP report are for valid claims.

Subsequent to discussing the issues with UHC and the Plan Administrator, UHC refunded the County $96,941 for all amounts paid for SSP claims in the 2008 plan year. However, as it is likely that some of the refunded amounts are related to providers that were in-network (as noted above), the claims should be re-adjudicated by UHC to account for any cost differences. Re-adjudication could result in a refund for the difference between the in-network and out-of network charges, as it is likely that the in-network claim charge would have been less.

We Recommend the Plan Administrator continues to work with UHC to resolve the reporting issues with the SSP report. In addition, the Plan Administrator should require UHC to re-adjudicate all in-network providers' claims found to have been processed incorrectly as out-of-network under SSP and refund any additional amounts due.

Management's Response:

Concur. HR Benefits is working with UHC to address and resolve Shared Savings plan reporting issues. UHC returned all SSP payments made to them for the 2008 plan year in addition to the payments for plan year 2009. SSP invoices were initially withheld until UHC could provide an acceptable explanation of SSP claims review process and an explanation of how inconsistencies would be remedied. HR Benefits also implemented an additional step of review for UHC that includes reviewing the top dollar claims from each report to verify that the claims are eligible for the SSP in addition to submitting the claims identified as being in-network for re-adjudication and refunding the County any monies due.

6. Changes Should Be Made in the Newborn Claim Policy

Florida Statutes do not allow coverage for a newborn to be denied under an insurance plan if the enrollee notifies the plan administrator within 60 days of the birth or placement of a child. Title XXVII, Part A, Subpart 1, Sec. 2723 of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) allows State law to change established standards with respect to group health plans requiring enrollees to make changes within 30 days of a qualifying event as long as the change allows a greater period. During our review of newborn claims processed, we noted that the participating organizations' requirements and procedures for adding newborns varied. Most either had a policy or orally communicated to their subscribers that they only had 30 days from the date of birth to add the newborn. Some stated they have denied a subscriber's coverage of a newborn due to the enrollee's request exceeding this 30 day limit. Plan Administrator staff informed us that they have never denied coverage for a newborn between 30 and 60 days after birth, although the County's benefits enrollment/change form notes that such a change can only be done within 30 days.

Section 641.3 (9), Florida Statutes, states, "…A contract may require the subscriber to notify the plan of the birth of a child within a time period, as specified in the contract, of not less than 30 days after the birth…" However, Section 627.6578 (2), Florida Statutes, states, "…if timely notice [30 days] is not given, the insurer may charge an additional premium from the date of birth or placement. If notice is given within 60 days of the birth or placement of the child, the insurer may not deny coverage of the child [emphasis added] due to the failure of the insured to timely notify the insurer of the birth or placement of the child…"

Based on information provided by the Plan Administrator and participating organizations, neither assess a premium if the notification is between 31 and 60 days.

We Recommend the Plan Administrator requires participating organizations to allow subscribers to add a

dependent up to 60 days from the birth or placement of the child. In addition, the Plan Administrator should consider charging subscribers for insurance premiums if the notification is between 31 and 60 days.

Management's Response:

Concur. Once identified, HR Benefits immediately updated the OC Employee Benefits Wellness for Life Plan booklet and communicated to the participating organizations to allow newborn and adopted dependents to be enrolled in the plan within 60 days of birth or placement. In the case where the participant fails to enroll the new dependent within 31 days of the event but enrolls the new dependent within 60 days of the event, the participant will be required to pay an additional premium from the date of birth or placement.

7. A Report Should Be Obtained to Reconcile Reported Claims to the Amounts Paid for Claims

To provide funding to pay the processed claims, UHC notifies the Plan Administrator of the amount needed to be transferred to fund the previous day's cleared checks. This amount is then transferred to UHC to fund the claims. UHC provides the County a monthly report called the Detailed Report for Transfer Evaluation as support for imprest account funding being requested. The report represents all payments that have cleared the bank for medical and pharmaceutical claims, although it does not currently include a claim number.

As part of our audit, UHC provided files containing claims paid during the 2007 plan year. These claims files did not include the check number contained in the Detailed Report for Transfer Evaluation. As a result, we were unable to assess the validity or accuracy of the claims report provided by UHC. Further, we were unable to determine if all the monies transferred were for valid claims as prior to 2007, UHC was responsible to fund all approved claims (the Plan was a fully funded health insurance program.)

During the audit process, we have been working with UHC to obtain a report that would allow the reconciliation of the claims files and the Detailed Report for Transfer Evaluation. During the negotiations for the 2010 contract year the County added a clause to the contract based on our request that requires UHC to provide a report that identifies the member identity, amount of payment, claim number associated with payment and the related check number. In addition, the amendment requires UHC to provide a quarterly comprehensive claims and eligibility report to the County. To date, UHC has not provided us with an adequate report to reconcile the amounts paid to the claims file.

We Recommend the Plan Administrator continues to work with UHC to obtain a report that enables the claim number to be reconciled to the check number.

Management's Response:

Concur. UHC has agreed to assist HR Benefits by providing a claim financial extract (Mod6 report) on an annual basis. The report will include the member identity, amount of payment, claim number associated with payment and the related check number. In addition, UHC is required to provide quarterly comprehensive claims and eligibility reports as part of the January 1, 2009 contract negotiations.

APPENDIX A- BENEFITS SUMMARY

Benefit	**HMO**	**Choice In-Network**	**Plus POS Out-of-Network**
Pre-existing Conditions	Covered in Full	Covered in Full	Covered in Full
DEDUCTIBLE			
Individual/Family	None	None	$500 / $1000
Lifetime Maximum	Unlimited	Unlimited	$1,000,000 per covered person
OUT OF POCKET MAXIMUM			
Individual/Family	n/a	$1500 / $3000	$3,000 per person + deductible not to exceed $6,000 per family.
Coinsurance	None	20%	*40% after calendar year deductible
Unmarried Dependents	Covered to the age of 19, or until the end of the calendar year in which the dependent child reaches age 25 who is primarily dependent on the insured for support and maintenance or a full or part time student.	Covered to the age of 19, or until the end of the calendar year in which the dependent child reaches age 25 who is primarily dependent on the insured for support and maintenance or a full or part time student.	
PHYSICIAN OFFICE VISITS			.
Preventive Care	$15 copay	$15 copay	Coverage is for state mandated benefits only. Refer to Certificate
Primary Care	$15 copay	$15 copay	*40% after calendar year deductible.
Specialist	$15 copay	$15 copay	*40% after calendar year deductible
HOSPITAL ADMISSION	$250 per admission	20%	*40% after calendar year deductible.
OUTPATIENT SERVICES			
Surgical Care	No Copay	20%	*40% after calendar year deductible.
X-Rays, Diagnostics and Lab	No Copay	20%	*40% after calendar year deductible.
Urgent Care	$35 copay	$35 copay per visit	*40% after calendar year deductible.

Benefit	HMO	Choice In-Network	Plus POS Out-of-Network
Emergency Room (Waived if admitted)	$75 copay	$75 copay per visit	*40% after calendar year deductible.
Ambulance	No copay	20%	Same as in-network benefit.
Allergy Testing & Treatment	$15 copay	$15 copay	*40% after calendar year deductible.
Vision Care – annual eye exam every other year	$15 copay	$15 copay	Not covered
Home Healthcare	No charge. Requires prior notification.	20% Requires prior notification.	*40% after calendar year deductible. Limited to $3,000 per calendar year.
Prosthetics	No copay Initial purchase only Maximum $50,000 per calendar year.	20% Initial purchase only Maximum $50,000 per calendar year.	*40% after calendar deductible, Initial purchase only. Maximum $50,000 per year.
Durable Medical Equipment	No copay Prior notification is required for items over $1000. Maximum of $50,000 per calendar year.	20% Prior notification is required for items over $1000. Maximum of $50,000 per calendar year.	*40% after calendar year deductible. Prior notification is required for items over $1000. Maximum of $50,000 per calendar year.
Short Term Rehabilitation	$15 copay per visit Limited to 20 visits per calendar year for speech, occupational, and physical therapy. Cardiac rehab is limited to 36 visits per calendar year.	$15 copay per visit. Limited to 20 visits per calendar year for speech, occupational, and physical therapy. Cardiac rehab is limited to 36 visits per calendar year.	* 40% after calendar year deductible. Limited to 20 visits per calendar year for speech, occupational, and physical therapy. Cardiac rehab is limited to 36 visits per calendar year.
MENTAL HEALTH			
Inpatient Requires prior Authorization with UBH.	$250 copay per admit 30 day limit per calendar year.	20% (30 day limit)	No benefits
Outpatient Requires prior authorization with UBH.	$15 copay individual $10 copay group 30 visits per calendar year.	20% (30 visit limit)	No benefits

Benefit	**HMO**	**Choice In-Network**	**Plus POS Out-of-Network**
SUBSTANCE ABUSE			
Inpatient Requires prior authorization with UBH.	$250 copay per admit 30 day limit per calendar year.	20% (30 day limit)	No benefits
Outpatient Requires prior authorization with UBH.	$15 copay individual $10 copay group 30 visits per calendar year	20% (3 visit limit)	No benefits
Skilled Nursing	No Charge – limited to 60 days per calendar year. Requires prior notification.	20% - limited to 60 days per calendar year. Requires prior notification.	*40% after calendar year deductible. Limited to 60 days per calendar year. Requires prior notification.
Prescription Drugs	$10 copay for generic $25 copay for brand name preferred $40 copay for brand name non-preferred. Up to 31-day supply. Mail order available - up to a 90-day supply / 2.5 copays	$10 copay for generic $25 copay for brand name preferred $40 copay for brand name non-preferred. Up to 31-day supply. Mail order available – up to a 90-day supply / 2.5 copays	*40% after calendar year deductible